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How can we help African American substance users stop smoking? Client and agency perspectives

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Abstract

Research is needed to better understand barriers to smoking cessation and sustained abstinence among racial/ethnic minority polydrug users. We conducted community dialogue groupsinvolving 49 clients in substance use treatment programs with predominantly ethnic minority clientele and individual dialogues/interviews with seven program providers (stakeholders). Most clientswere African American, under 40 years old, women, current smokers and high school graduates.Smoking cessation services in these programs were considered inadequate and community programs insufficiently culturally tailored, and economically and geographicallyinaccessible. Participants discussed individual “willpower” and choice; agency tobacco-related programs and policies; the relationships betweensmoking, smoking cessation and treatment goals; and steps needed to reshapeagency services and policies to provide greater support for smoking cessation in this at-risk population.

Keywords

African American; cigarette smoking; substance use disorder treatment; qualitative methods; tobacco control policy; smoking cessation

INTRODUCTION

Cigarette smoking is widespread among persons in substance use disorder (SUD) treatment programs, with rates two to four times higher than those in the general population, underscoring the need for evidence-based smoking cessation strategies and tobacco-free standards in these programs(Cupertino et al., 2013; Hall & Prochaska, 2009). Persons in SUD programs are interested in smoking cessation(Tremain et al., 2016) and not fearful of the implications of quitting for sobriety(Richter, Hunt, Cupertino, Garrett, & Friedmann, 2012). Smoking cessation interventions do not dissuade smokers from entering SUD treatment, do not increase the number of patients leaving early(Williams et al., 2005),nor undermine treatment goals.Smoking cessation is associated with better alcohol and drug abstinence rates(McClure et al., 2015; McKelvey, Thrul, & Ramo, 2017; Prochaska, Delucchi, & Hall, 2004; Stuyt, 2015) and decreased recidivism to heroin use(Hser, McCarthy, & Anglin, 1994).Short-term smoking cessation rates in this population may be comparable to those in the general population(Hall & Prochaska, 2009; Prochaska et al., 2004).Despite mixed findings(Friend & Pagano, 2004) and small sample sizes, short-term smoking cessation studies in this population report reduced smoking at the end of cessation treatment with relapse common(Prochaska et al., 2004).

While research onsmoking cessation programming in SUD treatment(Hunt et al., 2014; Knudsen, 2017)continues to grow,little is known about the specific needs of racial, ethnic, gender and other minority subgroups within SUD treatment. In particular, African Americans are disproportionally represented in SUD treatment settings[(Substance Abuse and Mental Health Services Administration - Center for Behavioral Health Statistics and Quality (SAMHSA), 2009)]targeted in tobacco marketing;(Balbach, Gasior, & Barbeau, 2003; Lee, Henriksen, Rose, Moreland-Russell, & Ribisl, 2015)and disproportionately suffer from smoking-related diseases(Fagan, Moolchan, Lawrence, Fernander, & Ponder, 2007; Ho & Elo, 2013).Nevertheless, too little research has examined socio-cultural influences on smoking cessation specific to African Americans in SUD treatment.

METHODS

To address this gap, in 2009 Healthy African American Families (HAAF), a community-based agency in south central Los Angeles serving African American and other racial/ethnic communities, partnered with UCLA faculty to conduct group dialogues with persons in SUD treatment and individual dialogues/interviews with program providers (stakeholders). Goals included capturing views of tobacco use in this community's own voice and identifying how to tailor(Knudsen, 2017) and schedule (concurrent, delayed)(Cooney et al., 2015)programming to optimize smoking cessation.

A Community Councilcomprising five community members and stakeholders, invited to participate based on their expertise in SUD treatment and community leadership, assisted the research team on a volunteer basis. The research partners and Community Council included three African American men, six African American women, two Asian men, one non-Hispanic Caucasian man, and two non-Hispanic Caucasian women. Two Council members were smokers; others were former smokers.

Research activities were conducted collaboratively, led jointly by community and academic co-principal investigators, andguided by the Community Partnered Participatory Research Model (CPPR)(Jones & Wells, 2007)and the Health Behavior Framework (HBF)(Bastani et al., 2010). The CPPR emphasizes procedures that ensure true equity with community input from project selection and design to implementation, data analysis, and dissemination. A CPPR project includes community and academic partners in all phases of the research and decision-making, shares leadershipand resources equitably, highlights the critical importance of evidence while simultaneously valuing the relevance ofcommunity experience, and emphasizes two-way capacity development.(Jones & Wells, 2007) The HBF is a multi-dimensional, conceptual/theoretical perspective that synthesizes major theoretical formulations, takes account of sociocultural and individual factors, and has been used to examine health practices in research involving diverse populations.(Bastani et al., 2010)We report results of these group discussions and interviews, illustrated by selected verbatim quotes from anonymous participants.

The study was reviewed and approved by the University’s Office for Human Research Protection (Institutional Review Board). Informed consent was obtained from all participants included in the study.

Recruitment

Participants were recruited from SUD treatment agencies serving predominantly under-resourced African American clients in South Los Angeles.Agencies were selected on the basis of convenience. Participation opportunities were publicized via flyers and word of mouth in the African American community and in SUD treatment settings. A $25 participation incentive was offered. Inclusioncriteria included: 18 years or older, smoked at least 100 cigarettes in lifetime, self-identified current or prior participation in a SUD treatment program. While some participants may have used other types of tobacco products, we specifically focused on cigarette use because the community partner emphasized that cigarettes were far and away the most common form of tobacco use among persons in treatment for SUD. Participation was voluntary. Interested persons (n=72) contacted the research staff and completed a telephone screening to confirm eligibility; 57 persons met the inclusioncriteria. HAAF recruited seven counselors and administrators(stakeholders)for 30–60 minute interviews, three from the same venues as group participants and four from other SUD agencies serving the community. Stakeholders received a $50 participation incentive.

Procedures

The research team developed a guide for the group sessions and individual stakeholder dialogues/interviews, based on the team’s reading of the scientificliterature and the

community partner's experience in working with this population. The guidefocused on participants'knowledge andbeliefs regarding: **tobacco use** (health consequences, cost, effect on abstinence from other substance use); **smoking cessation** (likelihood of successful quittingwhile in SUD treatment, health consequences, ability to cope with stress, sobriety and effect on abstinence from other substance use); **current agency programming/ practices/policies**[leadership/staff/client receptivity to implementing new/revised anti-tobacco programming/policies; barriers/steps to address barriers (optimal timing, evidence-based strategies, strategies to cope with stress, staff perceptions/practices, available resources)];**tobacco use in the African American community** (norms, unmet needs, cessation resources, barriers to impact by community anti-tobacco programs/policies, industry targeting). Two community partner staff members experienced in collaborating with the SUD treatment community and in leading community group dialogues received a half day training before conductingthe group sessions and stakeholder interviews under the community Principal Investigator's supervision.

Forty-nine of the 57 eligible clients participated. Their experience reflected exposure to the major treatment approaches, including inpatient treatment, outpatient treatment, and medically-assisted treatment. Five group discussions were conducted, each lasting 60 minutes. These groups included clients and former clients exclusively. Two groups included nine participants. The other three groups included 8, 11 and 12 participants. Two group discussions took place in a local church; the remaining three took place in local SUD treatment centers.Two groups included former SUD treatment clients (n=16); the remaining groups included only current clients of local SUD treatment programs (n=33).To protect privacy and confidentiality, participants remained anonymous, usedaliases in the sessions, and were asked not to discuss the session outside of the meeting; contact information was destroyed after the session. Participants completed a brief survey prior to each session, providing demographic and tobacco related information. Stakeholders did not participate in any of the group sessions.

Group discussions and interviews were audiotaped, verbatim transcripts of the tapes prepared, and the audiotapes erased. The written transcripts were reviewed to ensure that all themes included in the discussion guide (see above) were considered and further sessions and interviews were not required.

Data Analysis

Three team members independently coded the transcripts' content into primary themes and subthemes drawn from the a priori, literature-based themes in the discussion guide.Coding differences were resolved through discussion and consensus.(Krueger & Casey, 2015) Grounded theory was not the basis for identifying new themes from analyses of the transcripts.

RESULTS

Participant characteristics

Forty-eight group participants provided demographic and smoking-related information. Participant characteristics are reported in Table 1. Most were African American (83.3%); had high school or less education (66.6%); were 39 years old or younger (70.8%); and were women (75%), including eight pregnant women. A majority had health insurance (58.3%) and a regular health care provider (54.2%). Of the 43 participants providing complete information, mostwere current smokers(72.1%)and the restwereformer smokers. Most (79.0%) started smoking before initiating other substance use and 66.7% of the current smokers had tried to quit in the past year. On a scale from 1–10 with 10 indicating a great desire to quit, most (80.5%) marked six or higher. Among the seven stakeholders, there were four smokers, one former smoker, two non-smokers; two men and five women; six African Americans and one non-Hispanic Caucasian. Five stakeholders worked in in- and out-patient facilities, one in a public housing setting, one in a shelter. While services were provided to people of all race/ethnicities, all of these treatment settings served predominantly African American and Latino clients.

Community dialogue groups(former/current SUD treatment clients)

Cigarette smoking and addiction.—When specifically asked if smoking is an addiction, *s*ome participants described cigarettes as a “drug,” smoking as an addiction, and a return to smoking after a period of abstinence as a “relapse.”However, most clients distinguished between smoking cigarettes and addictive behavior, describing smoking as discretionary, a habit or elective health behavior. One client explained that

> “when I smoke a cigarette it don’t set up no phenomenal urge… cigarettes ain’t took me to my bottom, cigarettes ain’t never made me go in a bank and rob, cigarettes ain’t never made me want to steal from my momma.” Different from other substances, smoking cigarettes is “a choice…it’s like whenever I want I can, you know, quit…” and that “…I smoke ‘cause I want to smoke and I like the way it makes me feel……that ain’t got nothing to do with no doggone relapse. I smoke because I like cigarettes…”

Cessation and abstinence were seen as requiring willpower, that “you have to want it for yourself. If I really want to stop smoking I can and I know I can because I done it before.” Cessation programswere not considered to be critically important.”No, I don’t think so. It’s your willpower….You gotta have willpower….” Reasons for relapse after periods of abstinence included stress, end of an acute illness, others smoking, or because they themselves “started back using drugs…”

Cigarette smoking and other substance use.—Most participants viewed cigarette smoking as a way to facilitate recovery from other substance use, because “smoking cigarettes does make it kind of easier…it helps with stress…” it helps one stay “relaxed” and “…clean, it helps you deal with it, it makes you comfortable, it makes you calm” and smoking cessation could interfere with treatment goals. A few participants did not share this view, with one participant saying”I think smoking cigarettes don’t have nothing to do with

you being clean and sober…don't have nothing to do with getting high…" While considered worthwhile, smoking cessation was deemedbest *after*recovery from other substance use.One participant explained "I'm working on my recovery right now…for me it's one thing at a time. I can't quit everything at once…"

Although for one participant "smoking cessation classes at state hospital… just made me want to smoke…" others described treatment, when significant life changes were occurring, as a good opportunity for smoking cessation.One participant explained that "…when I stopped using the drugs it was easier for me to put the cigarettes down… and I didn't really fully pick back up smoking cigarettes again until I started back using drugs…" Another stated "…it would have been a lot easier to deal with not smoking in a protected environment while I'm in recovery… than to deal with the struggle now…"

Cessation.—Some smokers expressed doubts about the health consequences of smoking or that cessation actually improved health but most wanted to quit, primarily for health reasons; cost of cigarettes also was noted. But relative to other life stressors, smoking cessation was a low priority. One participant explained that "cigarettes [and] second-hand smoke, that's the least of our problems. You walk out of your house and get shot to death… you know so it's not like smoking is on the high priority list you know. I be stressed out more by stuff than smoking a cigarette." When incarcerated or in treatment settings where smoking was not permitted, without exception, participants resumed smoking immediately upon release. During pregnancy some women smoked, but most described quitting or reducing smoking; post-partum return to smoking was common. Some family and friends discouraged quitting, to avoid friction resulting from the stress of withdrawal. More commonly, family and friends encouraged cessation, offering advice and prayer. Participants described taking steps in their cars andhomes to limit secondhand smoke exposure, such as never smoking in cars or at home in rooms when children were present or not smoking among non-smokers or persons trying to quit.

Group members described strategies they had tried or believed would help achieve smoking cessation: acupuncture, exercise, hobbies, listening to music, watching TV, keeping a diary, reading, quitting 'cold turkey', "keeping busy," replacing "an unhealthy habit with a healthy habit," "putting something in my mouth instead of a cigarette," and prayer or participation in a faith-based program. Participants reported learning about nicotine replacement therapies (NRT)(e.g., nicotine transdermal patch and nicotine gum)(Stead et al., 2012) and quitlines from physicians, billboards, and television commercials, but none reported success in using these resources. One participant described smoking while wearing the patch and "it made me really sick so I took off the patch and continued to smoke." Whileseveral clients indicated that they might try NRT in the future, reasons for nonuse included fear of sideeffects or use of unfamiliar pharmacotherapy, distrust of effectiveness,andtaste (nicotine gum). Reflecting the view of several participants, one client said,

> "…nicotine gum tastes like tar [laughter] and I'm not putting a patch of nicotine on me because I'm already putting in enough nicotine in my body, so why would I put a patch on me and make more nicotine come in my body? You know what, if I

> really wanted to quit smoking, just like I quit smoking crack, I'd quit smoking. I'd quit."

Cost, lack of awareness of accessible resources such as low-cost or free community programs, insurance-provided or health system programs were also noted as barriers to NRT use. One participant explained that "[a grocery store chain in the city] got a program… where they were giving out patches and gum. None of that program went to [areas in which participants lived] …" Quit-lines were described as unsatisfactory. One woman "called that 1–800 BUTTS [quitline] and it was a joke…they was like, 'you can put a rubber band around your wrist and every time you think about smoking, you can pop yourself'… I ain't poppin' myself with no daggone rubber band…" Another woman "tried the hotline but … they just started asking me questions that didn't have nothing to do with no cigarettes… I told her I was in the mood to quit RIGHT NOW! She was on another page. I hung up the phone and lit a cigarette…"

Program elements.—Participants described smoking cessation programs in the treatment setting as inadequate,of limited quality and focus,offering only "…brochures, films about the health effects of tobacco use, and talk about the "places you can go, and all that." When asked what *should* be included, they emphasized reinforcing awarenessof smoking's health consequences through "education" that included:graphics, visual presentations, testimonials, field [trips] to hospital[s] where everybody is sick and dying …" and tailored information,"get[ting] a picture of my lungs just to see how damaged they really are."Consistently, counseling and social support were noted, "a 12 step process" or "buddy system" during treatment and afterward"cause we go home and they still smoking so we need something stronger to support us,"and individual tailoring, because "what it will take for each person might be something different." Most considered it worthwhile to offer multiple strategies, including meditation,relaxation skills training and NRT. While describing NRT as a smoking cessation modality that they had not used and probably would not use themselves, most nevertheless supported makingthis and all other conventional smoking cessation resources available to all people trying to stop smoking. One person argued for mandatory group sessions. Most said programming should be voluntary, providing support for "people that want to quit."

Smoke-free settings.—Most participants argued against mandating smoke-free environments,with one person explaining

> "absolutely not[because]smoking cigarettes [is] a temporary stress reliever… [and] people in facilities are coming off emotional roller coasters and dealing with issues they haven't dealt with in a long time, so that compounded with…not being allowed to smoke [it would be a] big fiasco."

A few otherssaw the need for smoke-free settings to accommodate nonsmokers and those trying to stop smoking and to promote smoking cessation, that "you won't feel the urge so much if it's a non-smoking facility." One participant noted that "basically facts don't work, because the television will tell you that there's rat poison in cigarettes and people are still smoking…so I think it's the environment that you're in…" One former smoker stoppedsmoking when she "started hanging around non-smoking people" in a faith-based

program that provided support for smoking cessation. Another explained that “if you’re around people that don’t smoke then you’re not about to smoke…” and still another “…if I come off a bus into a program and nobody’s smoking and I haven’t smoked for a year, no I’m not gonna want to smoke.” A current smoker stated that if a facility banned smoking “I could stop smoking, ‘cause nobody around me would be smoking.”

Lax enforcement of rules was described as undermining cessation.”People smoke in their rooms, they go outside, they go on a pass, you know they still smoke, they sneak a cigarette…” and, in some inpatient settings, cigarettes were provided by staff and programs “[gave] smoke breaks or whatever.” One woman observed that rules were not enforced because

> “…so many people that would rather leave than quit smoking, [facilities] have lapsed their policy on [not allowing] smoking a lot, because they don’t want to … lose clients. But I think if they stood firmer on the no smoking policy…and followed that up with some education about smoking, that would improve their rates [of smoking cessation].”

Another explained that to enforce a policy, “top down” commitment at the corporate level and local staff efforts were needed, and both of these elements frequently were lacking.

Community intervention.—Participants noted the need for greater community efforts including anti-smoking media messages and free cessation programs. The view of public anti-tobacco policies, such as taxation, varied. One participant observed that “…if the [cigarette] price continues to increase…people will be more prone to stop, because they cannot afford it…” but another commented that “…every time they put a tax on them [cigarettes]… well who does it hurt? Us! It ain’t them paying no taxes, they shipping them to us.” Participants resented tobacco industry practices, but could not agree on policies to protect peoplefrom such practices.

Stakeholder dialogues/interviews

Stakeholders reported that most clients smoked, some wanted to quit, butcessation was not a priority for clients or treatment agencies; agencies focused on “get[ing] people clean and sober, off whatever drug they’re on…getting people off those drugs that have caused the serious challenges in their lives…In reality it is better to smoke a cigarette then to go out there and hit a crack pipe.” One stakeholder explained that “years” were required to institute the policy prohibiting smoking within twenty feet of the facility, and even that was not always observed. Financial support might encourage agency leadership to promote smoking cessation,as it did for motivating agencies to address mental health issues, important in SUD treatment. Staff beliefs and practices needed to be addressed, possibly including cessation programs and preferential hiring of non-smokers, as “unfortunately [staff]… smoke… right next to the building so it’s a poor witness to the clients,” and “[agencies] just have not been able to master that monster…”

Current anti-smoking programming was described as minimal, including discussing nicotine, the health consequences of tobacco use, occasional availability of NRT when the facility was visited by “outside programs” [probably Los Angeles County Department of

Public Health], and referral to cessation services elsewhere when a client expressed interest in quitting.Stakeholders either did not mention NRT or other pharmaceuticals, noted they were acceptable but not critical in comprehensive programming offering all options for persons interested inquitting, or were negative about their use. Stakeholders indicated that "the patch [could] be a trigger to cause them to use again…" or the "pill [could] make them sick." One stakeholder, a smoker, noted that "[NRT] …works for some, and not others." This stakeholder added that it really is a matter of the will to quit that is key, that these are "just aids, they're crutches, and crutches have to be used properly, and they're only meant to be temporary." She noted that she knew a man who ended up in a hospital because of using the patch while smoking. He was not ready to quit and "damn near killed himself." Another noted that clients could buy the patch if they wanted. "I would not stop them…but I would have to define what are you buying this patch for, are you really trying to quit?" Still another explained that

> "I know for a fact that them patches don't work, they too expensive, and I know people that smoke with them things stuck right on their arm, so that wouldn't be my first choice. And that gum is nasty and expensive, too. Besides, people need something to do with their hands and mouth when they quit. That's why so many gain weight when they stop smoking…"

With respect to Chantix, this stakeholder noted

> "Have you seen these commercials? Did you pay attention? The side effects of that mess is damn near as bad as smoking a cigarette. I'll take my chances, at least I'll get some pleasure out of it. That stuff got people suicidal. And if you can't pick up the phone to call NO-BUTTS, I know you ain't calling the suicide hotline. [laughter] But it's not funny, all those commercials about new drugs got side effects as long as my arm, they got something for whatever ails you now…may cause nauseas, drowsiness, and in a few cases has been known to cause severe depression that can lead to suicidal thoughts. I'm not trying to be funny, but that sounds like both cancer and chemotherapy to me."

Stakeholders knew about the 1–800 NO BUTTScontact number for the California quitlinefrom advertisements, "occasional e-mails and handouts" and pamphlets, but did not actively recommend this to clients because they were not convinced that quitlines could help their clients stop smoking. One stakeholder, a smoker, explained that she never knew anyone in "real life" who stopped smoking using NRT or the quitline, having seen this "only on TV." Nevertheless, if a client expressed interest in stopping, she provided encouragement including advice to "just stop," not buy cigarettes and avoid other smokers. Another, also a smoker, would provide help because

> "that's part of my job, even more than that, part of my commitment to my clients, whatever I can do to support them…point them in the right direction to get the help they need as they begin their new lives, and if quitting smoking was a part of that by their own decision I would do it in a heartbeat."

However, for the most part, stakeholdersmade clear that their agencies' primary focus was on facilitating their clients' recovery from dependency on other drug use or alcohol use.

Five of the six stakeholders who commented on their agencies' policies indicated that their facilities were smoke-free but allowed smoking 20 feet from the facility in compliance with state law. Another stakeholder, who provided services in a housing complex, said that smoking was not permitted in the individual apartments, but residents were allowed to smoke in a community room. None of the stakeholders defended more extensive limitations.For most of the stakeholders, added restrictions would "be the hill that a lot of people would die on…it would just be too hard." Smoking "is what takes the edge off of not being able to use" and, if anything there would need to be a program that "eases people off." Another explained that while it might be ideal to "get it all out of the way…that might not work for everybody as some people might need that cigarette habit to get them through their stressful times without using." Reflecting on the need for support, a stakeholder noted

> "You gotta understand, we not talking about people with the best, how can I put it, people with the best coping skills for lack of a better word. They need all the help they can get. I think that whatever it takes for a person to stay clean, then they should have that option."

Smoking cessation programming could be made available, but only if it "wouldn't impede our efforts to get people off drugs. That's our first priority."

A minority of stakeholders saw a need for greater efforts, holding that agencies should make clear that they considered smoking a serious addiction and their focus was on addressing *all* addictions including tobacco use. They should discourage the "I can deal with it later" view and should promote non-smoking meetings. A non-smokingstakeholder explained

> "as far as policies, agencies should think about not just addressing AOD [alcohol and drugs], but ATOD [alcohol, tobacco and drugs], … that we are mitigating all substances that are addicting, whether you smoke it, you inhale it, you shoot or you roll it, or it comes pre-rolled, but anything that is addictive, we're taking a stand against it …."

This stakeholder explained that agencies would like clients to be free of all substance use, including tobacco, but

> "it's the last drug, the last drug that they have, and so I think that if we ask people to do cold turkey….there may be some pushback, but like I say every drug, you know, tobacco, has to go, everything, when you're getting ready to detox, everything…if you're cleaning out, you're just cleaning out…if you kick something so hard [alcohol and other substances] you may as well go ahead and kick it all."

Another nonsmoker, said "…to me it is, I mean, just get it over with, while you have the chance, I mean knock it out… When we welcome people into our doors it's with the understanding that they will cease to use all substances."Treatment programs need to reinforce what people already know about tobacco productsand their health effects, to address the "whole person,"to clarify why smoking and using the patch simultaneously pose risk, and to provide information about available cessation resources. One counselor explained that reading materials alone would not suffice because of low literacy in the client population. Videos, exercise and meditation sessions, rewards for quitting, andwriting activities that reflect on "the journey"--the process of stopping smoking, returning to

quitting after a relapse to smoking, and staying quit in the face of diverse challenges – were suggested.One stakeholder pointed out that most of her agency's clients were polydrug users and this was addressed in their program; tobacco use could easily be included as just another addictive substance.

Participants had mixed views regarding use of NRT and other pharmacotherapy to address nicotine addiction and negative views regarding quitlines. There was considerable agreement thatto be comprehensiveprograms could provideNRT and other pharmacotherapy such as Chantix. But this should occur only as long as these programs emphasizedsocial support, 12-step approaches, in-depth counseling and other strategies already part of their agencies' efforts and only as long as such programming did not interfere with the agency's primary goals of addressing their clients' other substance use.Likewise,innovative community programs areneeded thatinvolvenon-drug users and peer support "to build a village." This stakeholder expressed willingness to implement programmingwith proven efficacy in communities of color, but that

> "… a lot of times they'll create programs [tailored for whites] and they don't create them for our community but then they try to bring them in our community and then they don't work and they try to make it like it's the community's fault, when it's not, because you have not dealt with the people that you're working with….our issues are different and our hurts and pains come from a different place…"

DISCUSSION

Decline in U.S. tobacco use prevalence has been uneven across population subgroups. Strategies are needed to assist those, such as African American polydrug users, where declines have fallen short of thoseobserved more generally. More research among racial and ethnic minority polydrug users is needed to ensure provision of programming tailored to the sociocultural requirements of these populations. Results from our community dialogue groups and stakeholder dialogues/interviews suggest several themes relevant to such interventions.

Researchers need to address why it is that these African American SUD treatment clientsviewed as ineffective cessation strategiesthat the research evidence suggests are effective in increasing smoking abstinence (7-day point prevalence abstinence)among persons from other ethnic groups in SUD treatment: use of NRT (Stead, Koilpillai, Fanshawe, & Lancaster, 2016; Stead et al., 2012) and quitlines.[(Centers for Disease Control (CDC), 2014)(Thurgood, McNeill, Clark-Carter, & Brose, 2016)Partricipants in our study provided one possible reason for this. It may not be that these strategies do not "work" for this population. Rather, it may be that there has been a lack of access to or experience with comprehensive tobacco use prevention proramming that included NRT supported by counseling and promotion of sustained quitline use. Clients point to the extensive tobacco industry promotion of smoking in African American and Latino neighborhoods and a lack of adequate tobacco use cessation resources in their communities. Well-crafted, tailored messages and programs developed through community-academic research efforts is vital in order to address beliefs about tobacco use and cessation held by African American SUD

treatment clients that have been disconfirmed in other SUD treatment populations.These beliefs include,for example, that cigarette use is fundamentally less addictive thanuse of other addictive substances,(Pontieri, Tanda, Orzi, & DiChiara, 1996) and thatsuccessful smoking cessation ismostly a matter of individual “will.”(Ussher, Kakar, Hajek, & West, 2016)

While excellent community interventions are needed, so too is programming within SUD treatment agencies themselves. Several stakeholders asserted that smoking cessation is not their priority, and virtually all underscored that it is not their agencies’ priority. To achieve change, addressing staff and agency leadershipbeliefs and resulting practices is essential. In a number of instances, stakeholders shared client beliefs, seemingly unaware that anti-tobacco programs and smoking bans canenhance achievement of agency drugtreatment goals:smoking cessation can increase the likelihood of future, long-term abstinence from illicit substance use(McKelvey et al., 2017). By contrast, continued smoking can undermineachievement of substance use abstinence and sobriety.(McClure et al., 2015)It is unknown whether a full-service community-academic smoking cessation program including NRT and individual counseling, implemented as part of an existing SUD treatment program, would be effective in addressing these client and staff beliefs. It is unknown if addressing these client and staff beliefs would reduce tobacco use among African Americans. The way to test this is to develop and provide such a program, tailored for this population, and then to evaluate rigorously its impact on the 12 month follow-up 7-day point prevalence abstinence rates of clients and staff.

Strengths and limitations.

Thisstudywas designed to capture the voices of a largely overlooked constituency within the field of drug addiction treatment: predominantly African American smokers in SUD treatment. Although only persons in the Los Angeles area were included, the themesregarding the unmet need for tobacco cessation programmingthat emerged resonate with those expressed by clients and stakeholders in other locales,(Campbell, Le, Tajima, & Guydish, 2017; Cookson et al., 2014; Wilson et al., 2016). Thisincreases confidence that our results illuminate problems and opportunities associated with smoking cessation efforts during SUD treatment more generally.

Conclusion.

Virtually all clients and stakeholders shared the view that smoking cessation programming in treatment settings serving African American and other minority substance users is inadequate. Similarly, disadvantaged polydrug using populations have not experienced higher recidivism to their other substance use when exposed to high-quality smoking cessation programs.(Hickman, Delucchi, & Prochaska, 2015).**Steps are needed to move beyond the current limited, voluntary smoking cessation programs available in many states.SUD treatment policymakers and agency leadershipserving these communitiesneed to show buy-in with respect to the challenge that tobacco use poses to their clients’ health and need to be open to evidence that smoking abstinenceimproves treatment of addiction to illicit substance use.**A five-year follow-up evaluation of a

mandatory statewide ban on smoking in New York state drug treatment centers may give the reader pause inasmuch as smoking prevalence among clientsdid notdrop significantly during that period.(Pagano et al., 2016)Stronger evidence of client benefit is needed foragencies to be able torebut skeptical client and staff beliefs, to institutionalize mandatory, tailored,evidence-based smoking cessation programs,to enforcetobacco control policiesmore vigorously, and to affirmtheir commitment to making effective, targeted community anti-tobacco programsgeographically and economically accessible to the African American client in drug abuse treatment.

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Table 1:

Participant (Client/Former Client) Characteristics (N=48)

	N	%
Gender		
Female	36	75.0
Male	12	25.0
Age		
18–29	13	31.3
30–39	19	39.6
40–49	7	14.6
≥50	4	14.6
Education		
Less than High School completion	15	31.3
High School graduate	17	35.4
Some college/vocational training	11	22.9
College graduate	5	10.4
Race/Ethnicity		
African American	40	83.3
Hispanic/Latino	5	10.4
Other (Pacific Islander, Native American)	2	4.2
Missing	1	2.1
Insurance		
Yes	28	58.3
No	20	41.7
Regular Health Care Provider		
Yes	26	54.2
No	22	45.8
Smoking Status		
Current Daily	30	62.5
Not daily	5	10.4
Missing	1	2.1
Former	12	25.0
Age of smoking Initiation		
≤12	7	14.6
13–15	13	27.1
16–18	16	33.3
≥19	10	20.8
Missing	2	4.2
Smoking initiation in relation to other substance use		
Smoking initiated before other substance use	34	70.8

Smoking initiated after other substance use	9	18.8
Missing	5	10.4
Tried to stop smoking in the prior year		
(current smokers only, n = 36)		
Yes	23	63.9
No	11	30.6
Missing	2	5.6