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Barriers and facilitators to tobacco cessation in a nationwide sample of addiction treatment programs

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ABSTRACT

Introduction: Smoking rates among addiction treatment clients are 3–4 times higher than those of the general population. Recent studies indicate that ceasing tobacco use during treatment may improve recovery outcomes. Across the United States, publicly funded addiction treatment programs vary widely in terms of their tobacco policies and tobacco cessation services offered to clients.
Methods: The study reported here is the qualitative component of a larger study. Twenty-four programs were recruited from a random sample of publicly funded programs participating in the NIDA Clinical Trials Network. Semi-structured interviews were administered by phone to program directors. ATLAS.ti software was used to facilitate thematic analysis of interview transcripts.
Findings: While all directors expressed interest in helping clients to quit smoking, they cited numerous barriers to implementing tobacco policies and services. These included *smoking culture*, *client resistance*, *lack of resources*, *staff smoking*, *and environmental barriers*. Directors also cited several factors that they believed would support tobacco cessation. These included *financial support*, *enhanced leadership*, *and state mandates against smoking in addiction treatment programs*.
Conclusion: Addiction treatment programs are beginning to place more emphasis on tobacco cessation during treatment. However, furthering this goal requires substantial infrastructural and cultural change. These qualitative study findings may help to inform Single State Agencies (SSAs) to support publicly funded addiction treatment programs in their tobacco cessation efforts. In order to maximize effectiveness, state-level policies regarding tobacco cessation during treatment should be informed by ongoing dialogue between service providers and SSAs.

1. Introduction

Smoking rates among addiction treatment clients are 3–4 times higher than those of the general population, routinely reaching prevalence rates of about 70% (Guydish et al., 2011). Several studies indicate that tobacco cessation during treatment may improve recovery outcomes (Prochaska, Delucchi, & Hall, 2004; Tsoh, Chi, Mertens, & Weisner, 2011). Recently, Single State Agencies (SSAs) for addiction treatment services in a few states have issued policy guidelines or mandates for tobacco-free grounds in order to encourage programs to include tobacco cessation as a treatment goal. The most comprehensive example to date is the New York State 2008 smoking ban in all state-certified addiction treatment facilities (New York State Office of Alcoholism and Substance Abuse Services (OASAS), 2008). In addition to requiring over 1000 treatment programs to have tobacco-free grounds, the policy required programs to offer tobacco cessation services to clients. Five years after the policy was initiated, smoking rates among staff decreased and clients reported smoking fewer cigarettes per day (CPD) (Pagano et al., 2015).

SSA policy guidelines, especially when tied to funding initiatives, can influence how treatment programs adopt policies and services (Chriqui, Terry-McElrath, McBride, & Eidson, 2008). Knudsen and Abraham (2012) found that programs were significantly more likely to provide medication-assisted treatment if they were located in states whose SSAs supported this. The likelihood increased if medication purchases were covered through state funding contracts. According to a study by Rieckmann, Kovas, Cassidy, and McCarty (2011), SSAs that contract directly with programs may exert more influence on adoption of evidence-based practices than SSAs that contract indirectly through counties or other sub-state level agencies.

In addition to the state policy context, program directors and administrators play a major role in the initiation and success of tobacco cessation efforts (Knudsen, Muilenburg, & Eby, 2013). Surveys of New York State program administrators concerning the SSA-mandated tobacco ban revealed positive (e.g., increased patient awareness about the health risks of tobacco use) as well as negative experiences (e.g., difficulties with policy enforcement) (Brown, Nonnemaker,

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Federman, Farrelly, & Kipnis, 2012; Eby & Laschober, 2013a, 2013b, 2014). One study found that predictors of adopting tobacco cessation services included financial resources, the ability to obtain reimbursement for services provided, and smoking "culture" within programs (Eby, Laschober, & Muilenburg, 2015). A survey of program administrators identified "psychological climate for change" (i.e., perceived program support, perceived smoking culture, and beliefs about tobacco bans) as a predictor of tobacco ban implementation (Muilenburg, Laschober, Eby, & Moore, 2015). These studies demonstrate the intertwining of factors related to both program administrators and SSAs in creating conditions of possibility for tobacco cessation within treatment programs.

Despite considerable survey research on the views of program directors and administrators regarding smoking policies within their programs, there are few qualitative studies that examine program directors' efforts to implement organizational change related to staff and client tobacco use. One exception is a study of the effects of the New York State tobacco ban as reported by directors of publicly funded addiction treatment programs there (Eby, Sparks, Evans, & Selzer, 2012). The most commonly reported positive outcomes were behavior changes (e.g., less smoking, increased intentions to quit) and increased awareness about the dangers of smoking and available cessation resources. The most commonly reported negative consequences were the reinforcement of maladaptive behaviors among clients (e.g., lying, "dealing" cigarettes) and difficulty enforcing the tobacco ban.

A number of studies have examined barriers to tobacco policy and service implementation within addiction treatment programs. Knudsen, Studts, Boyd, and Roman (2010) found that barriers cited by program directors included organizational culture (i.e., the belief that tobacco cessation is a low priority) and low levels of staff training related to tobacco cessation. McCool, Richter, and Choi (2005) identified low levels of staff training as the primary barrier to implementing tobacco cessation services in outpatient addiction treatment. Review papers have reported that barriers to tobacco cessation within treatment include staff attitudes toward tobacco, staff smoking, inadequate staff training in tobacco cessation, concern among staff and administrators regarding potential loss of clients, difficulty enforcing tobacco policies, and limited resources to address tobacco use (Guydish, Passalacqua, Tajima, & Manser, 2007; Ziedonis, Guydish, Williams, Steinberg, & Foulds, 2006).

The present study examines facilitators of, and barriers to, tobacco use policies and tobacco cessation services as reported by directors from a nationwide sample of addiction treatment programs participating in the NIDA Clinical Trials Network (CTN). Here, the term "tobacco use policies" refers to rules specifying where on facility grounds smoking is allowed (if at all), which kinds of tobacco products are permitted, and consequences for violating smoking rules. Recent national surveys indicate that around one-third of addiction treatment programs in the U.S. have instituted tobacco-free grounds (Muilenburg et al., 2015; Shi & Cummins, 2015). "Tobacco cessation services" can include individual or group counseling to aid clients or staff in quitting, as well as the provision of nicotine replacement therapy (NRT) or other pharmacotherapy. A recent study based on data from the National Survey of Substance Abuse Treatment Services (NSSATS) (Substance Abuse and Mental Health Services Administration, 2008) shows that 46% of U.S. addiction treatment facilities offer tobacco cessation services (Shi & Cummins, 2015). An overview of state-level policies for tobacco cessation in addiction treatment found that 22% of U.S. states (11/50) currently have established policies (Krauth & Apollonio, 2015).

2. Methods

2.1. Program Selection and Recruitment

This paper reports on a qualitative component of a larger study that included client-level survey data (Guydish et al., forthcoming). The current study is based on semi-structured interviews with directors from programs sampled for the survey component. For the parent study, a stratified random sample of publicly funded addiction treatment programs in 14 states was drawn from the NIDA CTN. The CTN is a national network of 13 research Centers or "nodes," where each node includes one or more university partners and a number of addiction treatment programs. The population of programs in the parent study was the 2013 list of CTN-affiliated treatment programs (N = 166) identified in previous research (Abraham & Roman, 2010; Bride, Abraham, & Roman, 2011; Olmstead, Abraham, Martino, & Roman, 2012). Eligible for inclusion were CTN-affiliated programs that were: a) publicly funded, b) moderate or large in size (at least 60 active patients), and c) willing to assign a staff liaison to coordinate data collection with the study team. Excluded were a) privately funded programs, b) adolescent programs, and c) criminal justice or hospital-based programs that would require local institutional review board (IRB) approval in addition to approval from our university IRB. We focused on publicly funded programs since more than three-fourths of all addiction treatment is provided in the public sector.

Eligible programs (N = 48) were categorized as outpatient (n = 29), inpatient/residential (n = 14), or methadone clinics (n = 5). This breakdown of programs by type is similar to the national breakdown found in the NSSATS. To recruit 25 programs—a goal that was established to attain a patient sample of roughly 1000 per study wave—and also permit a 25% refusal rate, we drew a random sample of 33 programs stratified by program type. The 33 randomly selected programs included 15 outpatient, 13 residential, and all 5 methadone programs.

The research team then contacted the CTN node where each program was affiliated, and the coordinator in each node contacted the selected programs to assess their initial interest. At this stage, 6 programs were found to be no longer active in the CTN, 1 program declined participation, 1 was a passive refusal, and 1 program was not needed to meet patient recruitment goals for the survey. The final sample for the qualitative study included directors from 8 outpatient, 9 residential, and 7 methadone programs (N = 24) (See Table 1 for interviewee characteristics).

Although the NIDA CTN is a large system, there may be few CTN-affiliated treatment programs in any single state. Identification of programs by state and program type (methadone, residential, outpatient) could permit identification of specific programs by persons within the CTN network. To protect program identities, we refer to programs by program type and region. A summary of tobacco policy and services by program type within regions is included in Table 2.

Table 1
Interviewee Characteristics (N = 24).

Characteristic	N (%)
Age (n = 22)	
M (SD)	51 (10.9)
Gender (n = 24)	
Female	14 (58.3)
Race/Ethnicity (n = 22)[1]	
White	20 (83.3)
Native American	2 (8.3)
African American	1 (4.2)
Latino/Hispanic	1 (4.2)
Education (n = 23)	
Some college	3 (13.0)
Bachelor's degree	4 (17.4)
Master's degree	13 (56.5)
Doctoral degree	3 (13.0)
Current smoker (n = 23)	
Yes	4 (17.4)
In recovery from substance abuse (n = 22)	
Yes	2 (9.1)

Note. Due to missing data, the denominators for each characteristic may vary; the *n* is noted in each case.
[1] Interviewees were able to choose more than one category for race/ethnicity.