General Attitudes Towards and Barriers to Integrating Tobacco Cessation Interventions into Substance Abuse Facilities: A Study of R.J. Blackley in Butner, North Carolina

By

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ABSTRACT

Patients in clinical settings for alcohol and drug addiction treatment are likely to be smokers and over their lifetime are more likely to die from tobacco-related causes rather than their addictions. A compelling case also exists for incorporating tobacco cessation interventions into these settings to enhance patient health outcomes, but it has not been common to do so partially due to staff and patient resistance. The following study provides a qualitative analysis of data gathered from the Alcohol and Drug Abuse Treatment Center in Butner, North Carolina regarding staff attitudes towards the introduction of a tobacco cessation program as the center is in the process of becoming a smoke-free campus and employees are helping design the transition. Twenty conversational semi-structured interviews were performed with members of the leadership team, design team, and other front-line staff members to gain a better understanding of existing perceptions about tobacco cessation, the process in place for the transition to a tobacco free campus, and any barriers to success. The interviews were analyzed and general attitudes about tobacco cessation programs in clinical behavioral health settings were assessed. Finally, using the appraised qualitative data, further recommendations are provided to potentially allow other addiction treatment centers to implement similar programs to address tobacco usage amongst their own patients.

INTRODUCTION

Cigarette smoking is commonly regarded as one of the largest causes of premature death and most preventable forms of death in the United States (Cummings, Rubin & Oster, 1989; Conway, Hurtado & Woodruff, 2012; Knudsen & White, 2012). While cigarette smoking has significantly decreased in the general population since the publication of the first Surgeon General's report in 1964, health complications associated with smoking and tobacco use are still a predominant issue in today's society. In 1966, the rate of tobacco use in the nation was 40.7%, whereas in 2012 only around 20.1% of the adult population smoked on a regular basis (Conway, Hurtado & Woodruff, 2012; Knudsen & White, 2012). However, certain subgroups of the population continue to be more affected by cigarette smoking than others. Behavioral health facilities, including addiction treatment centers, tend to have a higher prevalence of tobacco users amongst their patients. Among those attending addiction treatment facilities, between seventy and eighty percent of individuals are typically reported as tobacco users. In addition, those with diagnosed substance abuse disorders tend to consume more cigarettes in a day than the average smoker, further endangering their health (Knudsen & White, 2012; "Tobacco Use Cessation," 2011). Those with psychiatric disorders consume over a third of the cigarettes smoked by nicotine-dependent individuals. Psychiatrists working with substance abusers and patients with behavioral disorders are also more likely to encounter individuals who are nicotine-dependent, with nearly one in five reporting half or more of their patients as smokers (AAMC, 2007).

Studies have demonstrated that cigarette smoking is more likely to cause premature death in individuals with substance use disorders rather than their alcohol or

drug addictions (Knudsen & White, 2012; Heffner & Anthenelli, 2009). Studies have also shown that tobacco use has an impact on the recovery of patients seeking addiction treatment. Continued smoking after discharge has been associated with an increased likelihood of their addiction, whereas tobacco cessation has been associated with a decreased likelihood of relapse (Knudsen, Studts, Boyd & Roman, 2010). In fact, a twenty-five percent increase in long-term sobriety from alcohol and other drugs occurred in those who were provided tobacco cessation treatment in addition to their other addiction treatments (Prochaska, Delucchi & Hall, 2004; Heffner & Anthenelli, 2009). This statistical evidence conclusively displays that smokers definitively have much higher susceptibility to the potential of health related illness or death, despite the intervention of addiction treatment centers. However, when patients are provided with cessation treatment, the susceptibility decreases dramatically, which could possibly indicate that there is some correlation between treatment and mentality or attitudes of the patients who have long been addicted to smoking or tobacco use.

Staff attitudes and beliefs in addiction treatment facilities can substantially affect organizational readiness to change and ultimately patient responses to tobacco cessation interventions. The attitudes and beliefs of clinicians may hinder the improvement as well as the implementation of such initiatives**.** Patients can detect any negative perspectives, which can often cause them to be less receptive to the integration of tobacco use cessation services (Professional Development Program, Rockefeller College, University at Albany, State University of New York, 2009). Therefore, staff attitudes and beliefs deserve a thorough understanding. In this paper, attitudes and barriers are assessed from the analysis of primary data collected through semi-structured interviews at the R.J.

Blackley ADATC in Butner, North Carolina.

Over the years, the attitudes towards smoking have shifted significantly in the general population. Fewer than fifty percent of American adults believed that smoking caused lung cancer in the 1950s, which changed to ninety-two percent in 1986 (Schwartz, 1992). One reason that the cultural attitudes towards smoking are changing may be a direct result of growing clinical experience within addiction treatment centers. Addiction treatment staff members are moving from only asking patients about their tobacco use to additionally assessing willingness to quit, advising tobacco users to quit, and trying to increase motivation to quit. Higher levels of tobacco use cessation services were typically associated with having supportive program managers, more knowledge about the Public Health Service guidelines, and positive attitudes about the integration of tobacco use cessation in addiction treatment services (Knudsen & White, 2012). However, health care professionals in these facilities continue to have varying attitudes towards the integration of tobacco cessation ranging from fully supporting the integration of tobacco use cessation in addiction treatment facilities to believing such integration would complicate recovery of other addictions. Understanding the relationship between tobacco addiction and the addiction to other drugs and alcohol, social constructs towards tobacco, and tobacco advertisement strategies are all facets that shape clinician attitudes and beliefs (Professional Development Program, Rockefeller College, University at Albany, State University of New York, 2009).

Nearly a century ago, alcohol, opiate, and cocaine addiction all were treated concurrently with tobacco dependence (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). Today, many individual, organizational, and cultural barriers exist to the

successful implementation of tobacco dependence in addiction treatment programs (Heffner & Anthenelli, 2009). These include but are not limited to the negative attitudes of health care professionals towards integration of tobacco cessation, the lack of education and tobacco cessation training, personal tobacco use history, inadequate resources, patient resistance, the lack of time, and the existing cultural and financial barriers (Knudsen & White, 2012). In 1996, the American Psychiatric Association released a formal treatment guideline recommending that patients with psychiatric diagnoses be simultaneously treated for their nicotine dependence (AAMC, 2007). However, without the removal of the previously listed barriers and an altering of staff attitudes, it would be extremely difficult and taxing to implement this guideline and similar ones.

LITERATURE REVIEW

The following review was conducted to assess the attitudes towards and barriers against incorporating tobacco cessation interventions in substance abuse facilities as well as to understand the recommendations that have been provided at other facilities.

Attitudes

According to staff members of New Jersey residential addiction treatment programs, smoke breaks no longer interrupt treatment of substance dependence and alcohol abuse. Clients and staff members are cutting down on their tobacco use as a result of the integration of tobacco cessation services. Nicotine dependence is being acknowledged as an addiction and being addressed as one. Patients also do not leave

treatment early as a result of treating tobacco dependence in such facilities (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006).

Many negative attitudes are viewed throughout the nation. The idea that quitting smoking will pose a risk to sobriety was reported by over 10% of staff members in a number of studies (Guydish, Passalacqua, Tajima & Manser, 2007; Heffner & Anthenelli, 2009). However, little evidence exists suggesting that tobacco cessation has a negative influence on substance use disorder recovery, and interventions either have a positive effect on sobriety or are unrelated to abstinence from alcohol and other substances (Heffner & Anthenelli, 2009). Some staff members believed that treating other addictions was more important and required more immediate treatment (Guydish, Passalacqua, Tajima & Manser, 2007; Knudsen, Studts, Boyd & Roman, 2010). The misconception that patients are not interested in quitting was also a belief expressed by many staff members in different studies (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006; Guydish, Passalacqua, Tajima & Manser, 2007; Heffner & Anthenelli, 2009; Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). Some program directors even believed that patients would benefit from their tobacco use during their addiction treatment and that staff smoking with patients helped to build rapport (Guydish, Passalacqua, Tajima & Manser, 2007; Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). Staff members of some substance abuse facilities believed that tobacco is not a real drug and that treating tobacco simultaneously with other drugs is difficult (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). The fear that there will be reduced admissions and decreased revenue as a result of the integration of tobacco cessation services also existed (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006).

Barriers

Substance abuse treatment counselors often do not receive formal nicotine dependence training. In one study, with lower levels of staff skills, less tobacco-related intake procedures were conducted (Knudsen, Studts, Boyd & Roman, 2010). When counselors with 20 or more hours of annual nicotine dependence training were compared to those with less than 5 hours of training, the well-trained individuals demonstrated more positive attitudes towards the integration of tobacco cessation and were more likely to address tobacco cessation with the patients (Guydish, Passalacqua, Tajima & Manser, 2007).

In the literature, staff smoking ranged from 14-40% in addiction treatment facilities. Smoking staff members are less likely to participate in discussions of treating patient nicotine dependence and less likely to encourage patients to participate in tobacco cessation programs than their non-smoking counterparts (Guydish, Passalacqua, Tajima & Manser, 2007). However, one study found that staff smoking was not a barrier to adopting tobacco-related intake procedures (Knudsen, Studts, Boyd & Roman, 2010).

Another barrier seen in the literature is inadequate staffing. There is a lack in staff that is able to provide appropriate tobacco cessation services and a lack in administrative staff that is necessary to support such services (Guydish, Passalacqua, Tajima & Manser, 2007).

Many individuals perceived a lack of time to deliver tobacco cessation services to be a barrier to successful integration in substance abuse facilities. Any tobacco cessation services will take away from the already demanding treatment protocol for other alcohol and drug abuse (Knudsen, Studts, Boyd & Roman, 2010).

While patient resistance is seen as a barrier, staff resistance is typically greater, particularly among smoking staff (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). Coverage for tobacco dependence may also be limited and available treatment resources may pose a problem (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

Recommendations

Staff members should be thoroughly prepared and trained to integrate tobacco cessation services (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). When staff members are provided with the skills and knowledge to treat tobacco dependence, they soon realize that it is not just the duty of primary care physicians but also theirs to treat tobacco dependence alongside other addictions. Once staff members learn how to appropriately educate and motivate their patients, the patients can increase their commitment to quitting their tobacco use (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). Additionally, training can have an important clinical effect in promoting tobacco cessation because it could increase the rate of delivery of tobacco cessation services among staff members (Olano-Espinosa et al., 2013). Anecdotal evidence particularly tends to be a more powerful motivator than citing research for staff and patients to reexamine their beliefs (Heffner & Anthenelli, 2009).

One reason that staff tobacco cessation is important is because those who quit their tobacco use serve as a real benefit to the integration of such services (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). Staff smoking does not exist unvaryingly and prevalence may be lower where staff members are more educated and professionally trained (Guydish, Passalacqua, Tajima & Manser, 2007). Therefore,

tobacco-dependent staff should be provided with resources, support, and motivation to quit their tobacco use in order to improve the health of their families and patients in addition to their own health (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

A few other recommendations existed in the literature such as having Nicotine Replacement Therapy readily available for both staff members and patients who smoke (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). Changing the attitudes and beliefs of individual providers and organizations is also a critical component. If staff members believe that tobacco use will harm rather than help recovery, tobacco cessation integration will be hindered (Heffner & Anthenelli, 2009; Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). One study recommended having alternatives to 'smoke breaks', for instance having 'popcorn breaks,' would call for a more pleasant transition to a tobacco-free environment. ' The 'popcorn break' alternative would ensure that the changes being made are not purely seen as losses such as losing the right to smoke (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

In a primary care setting, patients are more likely to become tobacco-free if the providers are educated on how to help them, clinical procedures are performed to track them, and there are organizational policies in place. Patients should be screened upon admission and tracked upon discharge. The policy changes should involve reimbursement and coverage and should include performance measures to increase the rate of delivery of tobacco use cessation services and their effectiveness. Additional research on the best incentives and most effective strategies for staff members to intervene should be conducted (Ockene, 1999). Clinicians should discuss quitting smoking with patients, prescribe nicotine patches and gum, assess patient willingness to quit, and encourage

participation in tobacco use cessation. Such interventions will improve clinician adherence to tobacco use guidelines and help patients succeed in their efforts. They will help clinicians overcome any perceived barriers (Meredith, Yano, Hickey & Sherman, 2005).

BACKGROUND

The Alcohol and Drug Abuse Treatment Centers of North Carolina are inpatient treatment facilities for patients with addictions. There are three centers in the state that treated 4,483 patients in 2010 (Duda & Rash, 2011). In this year, data from the North Carolina Treatment Outcomes and Program Performance System, or NC-TOPPS, found that 85% of those admitted into the centers reported having smoked any cigarettes prior to admission. R.J. Blackley in Butner, one of the three ADATCs of North Carolina, reported a smoking rate of 81% for admitted patients (NC Department of Health and Human Services, 2010). All three facilities are tobacco free, however, patients who smoke are provided opportunities to do so outside the facility several times a day. In July of 2014, a North Carolina state regulation went into effect that will require the facilities to become tobacco free campuses completely. As a result, patients will no longer be able to smoke inside or outside the facility. The University of North Carolina at Chapel Hill's Gillings School of Global Public Health, specifically faculty within the Public Health Leadership Program, is helping the centers design a transition to a tobacco-free environment.

The questions explored in this paper are as follows:

- First, what attitudes do health care professionals possess about the

integration of tobacco cessation activities into addiction treatment at R.J. Blackley?

- Second, what barriers, either real or perceived, affect the integration of such services at the center?
- Finally, what insight does this data provide to facilitate a smoother implementation of tobacco cessation programs at the ADATCs and similar facilities?

METHODS

In this study, twenty one-hour conversational semi-structured interviews of R.J. Blackley staff members were analyzed. Interviewees were selected to include members of the leadership team and design team, in addition to other staff members. The leadership team included individuals who were the advocates and ultimately decision makers for the project. The design team included those responsible for the implementation of the tobacco cessation program at R.J. Blackley. The other staff members included front line staff involved in daily patient care who would be impacted by the implementation of the program. A table of the interviewees is included below with their respective job titles and roles in the tobacco cessation project.

Table 1. R.J. Blackley Interviewee Groups

Tobacco Cessation Team	Job Title
Leadership Team	Agency Director
	Clinical Director
	Medical Director
	Director of Nursing
Design Team	Staff Development Coordinator
	Nurse Educator
	Program Director
	Recreation Therapy Supervisor
	PA and Tobacco Cessation Work Group member
	QI Clinical Manager and RN
Other Staff Members	Discharge Planner
	Health Care Technician
	Housekeeping/Environmental Services
	Information Technology Manager
	HR Manager
	Risk Manager
	Recreation Therapy
	2nd Shift Registered Nurse
	Budget Officer

Some individuals from the design team were also a part of the leadership team; however, because they were more intimately and regularly involved in the tobacco cessation program, they have been categorized as members of the design team.

The semi-structured interviews were conducted by a team of UNC Gillings School of Global Public Health graduate students and faculty in a series of back-to-back sessions over a period of two days. Faculty conducted the leadership interviews and the graduate students interviewed the design team and staff members. An interview guide was prepared and jointly reviewed by the interview team before the interviews were conducted.

After conducting the semi-structured interviews, the data was coded and

organized for interpretation using the ATLAS.ti software. All of the interviews were reviewed a first time, which entailed marking data segments and devising a potential list of codes. The second time the interviews were reviewed, additional codes were added and a finalized list was created. The categories used to organize the codes were Roles, Barriers, Recommendations, Positive Attitudes, and Negative Attitudes. The third and last time the interviews were reviewed, the existing codes were applied to the appropriate data segments. A complete list of codes used can be found in Appendix I. A table of findings can be viewed in Appendix II.

RESULTS

The following results are organized into the overall attitudes and barriers for each tobacco cessation group interviewed.

Results from Leadership Team Interviews

Overall Attitudes

The leadership team members expressed a mixture of positive and negative attitudes about tobacco cessation treatment at R.J. Blackley. Favorably, the leaders felt that the same skills and guidance that the employees have been using to treat addiction, particularly motivational interviewing, should be applied to tobacco cessation. The interviewees felt that the addiction treatment environment and skilled employees are already in place and tobacco cessation could be easily integrated into the mission of the center. They also believed that tobacco use should be regarded as an addiction, and cessation should be quickly executed, especially since it helps with the treatment of corresponding addictions.

Staff will be thrilled when smoking goes away. – Leadership Team Member

On the other hand, the leaders were contradictorily less than enthusiastic about employees undergoing further tobacco cessation education. Some leaders believed that smoking is a right that should not be intruded on, especially when it comes to the staff. Taking away the tobacco use rights of patients might also leave them with no incentive to pursue complete sobriety.

Perceived Barriers

The main barriers to successful implementation of tobacco cessation expressed by the leadership team were staff resistance, staff tobacco use, patient resistance, and a lack of resources. Staff turnover and staff shortage, in addition to a lack of time, were also perceived as major barriers.

Staff Resistance

Most of the leadership interviewees believed staff resistance to be a significant barrier to successful tobacco cessation integration. Concerns about staff anxiety regarding a loss in business due to a decline in patients and also over an increase in patient aggression from the inability to smoke during breaks were expressed. Additionally, the staff may also be uncooperative, particularly among psychiatrists who might view tobacco cessation treatment as the responsibility of the medical team and not the responsibility of the behavioral health providers. Leadership team members also felt that staff may see patient smoking as a right. Also mentioned was the belief that front line staff might be more reluctant due to the fact that they would be dealing with the patient dissatisfaction on a first-hand basis.

Staff Tobacco Use

There was a popular belief amongst leadership team members that staff should have the right to smoke if they chose to do so. However, some leadership team members felt that staff who implemented tobacco use would definitely act as a major barrier for change. According to facility regulation, staff is allowed to smoke off the premises or in their cars. The leaders all agreed in their separate interviews that the staff members who smoked would act as a source of deterrence for patients who wish to stop smoking by seeking professional help.

Patient Resistance

Additionally, most of the leadership individuals interviewed expressed their concern with tobacco-using patients. Smoking patients would most likely be hesitant to quit and could prefer to focus on one addiction at a time. Some could even become aggressive with the elimination of smoking breaks. Although some of the leadership team believed that very few patients would not want any help with tobacco cessation during their stay at the facility, others believed that the majority of patients would not want tobacco dependence treatment.

Lack of Resources

The lack of medication resources was a concern for half the leadership team. With a tobacco-free environment, patients would want patches and other forms of Nicotine Replacement Therapy. However, the following concern was perceived as an inefficient usage of resources:

> *Should we be spending money on nicotine patches on people who have no desire to quit whatsoever? – Leadership Team Member*

Currently, the facility does not allow patients who smoke to use patches but will provide gum for those who would like to treat their withdrawal symptoms while reducing their tobacco use.

Other Barriers

Some of the other barriers expressed by the leadership team included staff turnover, staff shortage and a lack of time. Within the facility, a time constraint on the treatment provided to patients already exists, which would just become more of an issue as the patient volume increases and tobacco cessation is implemented.

Results from Design Team Interviews

Overall Attitudes

Not surprisingly, the design team had generally positive attitudes towards a tobacco cessation program. Perhaps because of their involvement with UNC, this group embraced the idea that tobacco addiction should be treated, and that since the tobacco cessation training is in place, quick integration of tobacco cessation needs to be accomplished. This group expressed approval of the smooth transition to becoming tobacco free and mentioned that with adequate organization, many successful treatments could be available. A belief also surfaced that the majority of the staff knows that tobacco cessation integration is necessary and they would support the process.

> *Most of them [the staff] know in their hearts that it is the best thing to do and will stand behind whatever we do. – Design Team Member*

However, despite the generally positive attitudes, some concerns were expressed. Skepticism was shown about the desire of current smokers to consider tobacco cessation, and questions arose about whether staff had the responsibility to help patients quit their

tobacco use. Some members felt that tobacco cessation integration could interrupt effective and efficient patient care for some of the professionals.

Perceived Barriers

The main barriers expressed by the design team were staff resistance, staff tobacco use, lack of communication, and patient resistance. Additionally, staff turnover and shortage and a lack of time were viewed as barriers.

Staff Resistance

A majority of the individuals on the design team were concerned that staff resistance would be an issue. They mentioned that nurses would be worried about backlash from patients as a result of the smoke-free policies, despite knowing that it is what is best for the patients. Another mentioned that colleagues would be reluctant to report any violations of the tobacco-free policy on behalf of the staff. Some respondents mentioned that the leadership team might not be fully on board with the idea. Concerns were expressed over whether or not staff would see smoking as a legitimate addiction and within the scope of R.J. Blackley's mission. Differing viewpoints amongst the staff may also lead to too much discussion and not enough action.

Staff Tobacco Use

Most of the design team individuals believed smoking amongst the staff to be a barrier. Current staff smokers may continue to smoke and the front-line staff may consume a high rate of cigarettes daily.

Lack of Communication

Some of the design team saw the lack of communication as a barrier, and the majority interviewed recommended further communication for the successful

implementation of the project. The individuals mentioned that communication has historically been inconsistent and has continually been a big issue. In particular, communication between the nursing staff and other staff members is weak.

Patient Resistance

Most of the design team members expressed concern about resistance amongst the patients. Nurses are worried that there might be patient backlash when the facility becomes smoke-free. Many patient frustrations and agitations are anticipated. Since smoking is often an outlet for R.J. Blackley patients, some believe patients will be unhappy and behavioral issues may escalate. Patients already at the facility will experience greater difficulty.

Other Barriers

Other barriers to successful implementation as seen by the design team include staff turnover, staff shortage and a lack of time. Maintaining continuity and transferring information can be difficult when staff turnover is high. Staff members need to be provided with the resources they need to support patients and themselves. Additionally, going tobacco free will reduce the amount of time the nursing staff will have with patients and the available health care staff needs to provide patients with coping strategies.

Results from Other Staff Member Interviews

Overall Attitudes

The majority of attitudes for the other staff members group were more positive, and only one negative attitude about the integration of tobacco cessation was explicitly conveyed. The most common sentiment expressed within this group of staffers was that

the addition of tobacco cessation practices would lead to a more productive staff. Many reasons were provided for the increase in productivity, among them having less to clean due to the tobacco-free policy. Another reason provided is that going tobacco-free would lead to a staff that has more energy and is able to work more efficiently, partly because the staff would not be taking smoking breaks. According to these staff members, reducing safety issues associated with lit cigarettes and not having to take cigarette inventory would improve staff workloads. Some staffers believed tobacco cessation could help with the treatment of other addictions. One suggestion involved employees sharing literature that indicates that if cessation were incorporated into the treatment of other addictions, tobacco use cessation would be easier. According to some of the other staff members, smoking should be treated like any other addiction. The fact that nicotine is a "legitimate addiction" and should consequently be treated in the facility alongside other addictions was discussed. Also, smoking can coincide with stress and should be treated as an equally important addiction. Some other positive attitudes expressed included that the transition will be easier after a smoke-free facility policy has been adopted. Tobacco cessation integration also would not interfere with effective and efficient patient care and would instead affect the treatment of other addictions more positively. The only negative attitude expressed in this group was that nicotine recovery could complicate the recovery from other addictions.

Perceived Barriers

The main barriers expressed by the group, other staff members, were staff resistance and patient resistance to tobacco cessation integration and staff who currently smoke. Additionally, staff turnover and staff shortage were viewed as barriers.

Staff Resistance

Nearly half of the staff members group believed that staff resistance was a key barrier to a smooth transition. Some of these individuals thought that other staff members felt that going tobacco-free would be disrupting the patient and staff members' rights. According to this group, some staff members would comply while others would not. One response indicated that the front-line staff would be more resistant to the initiative than others.

Staff Tobacco Use

Despite the belief of a few that smoking staff would play a key role in helping others to better understand the process of tobacco cessation, the majority of the responding group, other staff members, viewed staff tobacco use as a barrier. Additionally, although many predicted an increase in productivity if the staff halt their tobacco use while at work, legislation may initially cause anger and frustration for them therefore temporarily reducing productivity. Monitoring staff smoking on the grounds and in their cars after the policy takes place was also found to be a concern. Another response mentioned that employees should not smell of smoke around the patients.

Patient Resistance

The majority of the other staff members' responses mentioned patient resistance as an important barrier since they had already experienced issues with the patients on rainy days when smoking breaks have been eliminated in the past. Patients may feel that their rights are being taken away by the facility. This group also felt that patients are accustomed to having smoke breaks, are allowed to smoke as a reward, and are kept calm by smoking. For these reasons, they would likely be significantly impacted and would

need additional and alternative healthy ways to relieve tension. Concerns were expressed that patient noncompliance would increase along with violent reactions towards staff. One response mentioned that a patient with a mental illness might demonstrate more aggression than others.

Other Barriers

Staff turnover and staff shortage and were listed as other barriers to incorporating tobacco cessation. Many change initiatives exist that have to pass accreditation and meet state requirements and staff members may find it difficult to be prepared without being notified of changes well in advance.

Interviewee Recommendations

There were several common recommendations suggested by all three teams. The recommendations include communication, training of staff and management, staff tobacco cessation, providing resources specifically nicotine replacement therapy, and changing the attitudes and beliefs of staff members. The other staff members also suggested some alternatives to smoking.

Communication

Within the leadership team, many ideas were brought forth as to how communication can improve. Psychiatrists alongside other health care professionals need to be provided with all of the same updates when taught how to be effectively involved in patient tobacco cessation. There needs to be a consensus amongst the leadership team before ideas are implemented. Staff members should give each other feedback. Computerized means of communication such as a U-drive, a file container that provides disk space for staff to store work files, were suggested.

The design team also suggested communication as an important means of moving forward. Posters should be put up around the hospital, in the nurses' mailroom and in the staff break rooms so that encouraging tobacco-free messages can be delivered to both patients and staff. There should be a way that everyone gets together once a week that accommodates all shifts. All staff members also need to effectively disseminate information and communicate. The meetings should be less frequent but longer. There should be an agenda, everyone's roles should be well defined, and meeting minutes should be provided for those who could not attend. The leadership team should make a conscious effort to communicate directly with the other employees so that they are more accepting of the changes being made.

Among the other staff members, almost all interviewees mentioned some form of communication as a solution to some of the barriers. Supervisors should be prepared and should follow-up with staff members on a regular basis. Communication should not occur entirely via e-mail and managers should make an effort to converse with the teams. Hospital liaisons should be brought on board so that they are aware of all of the changes made. Community organizations should also be brought on board to spread the messages that R.J. Blackley hopes to promote. New employees should be informed about the tobacco-free policies as they are being interviewed. Like the design team suggested, posters should be posted across the facility with promotional messages and the negative consequences of smoking and the leadership team should effectively communicate with all employees to maximize endorsement of the policies.

Training of Staff and Management

The leadership team all agreed that the ongoing training was a necessary component of a successful transition. Training the staff on how to conduct a smoking cessation program can be a successful way of aiding in their own tobacco cessation. Educational classes for staff and patients alike should be provided as well as feedback to staff members. Posters should be posted on staff bulletin boards that explain the smoke-free process and provide resources for helping patients and staff quit.

Members of the design team mentioned similar ideas on how to effectively train the staff. They approved of the online curriculum with its available tools that is being introduced into the centers. The staff should be introduced to an active tobacco cessation program with training relevant to what they will be facing. Nurses should be introduced to the QuitlineNC, which provides free cessation services to any North Carolina resident who needs help with their tobacco use, and taught how to help with patient tobacco cessation. The responses included the idea of a curriculum taught by nurses with standard checklists to keep up with patient participation.

Other staff members requested continual training as well. Patients as well as staff members should be trained on tobacco cessation with guidelines about the program, steps to follow, and the advantages of not smoking. Training materials and resources should be provided to guide staff members in their efforts to help patients quit. Since staff members are the enforcers, it was suggested that they be trained in coping with this role and empowering themselves and others. A video titled, "Uppers, Downers and All Arounders" was recommended for staff viewing. The belief that training will ultimately change attitudes was also expressed.

Staff Tobacco Cessation

Nearly half of the design team felt that it was necessary to address smoking issues amongst employees. Patients and staff members alike should be educated and re-educated about the QuitlineNC. Resources should be available and support should be provided for all of the smoking staff.

Most of the other staff members believed that smoking staff members should be provided tobacco cessation and therapy first before the patients. Tobacco cessation could increase the productivity for smoking staff members. Resources and education should be provided to all staff members for their personal tobacco cessation.

Provide Resources (Including Medications)

Among the leadership team, a strong movement for providing patients with easy access to medications and other resources exists, with three of the four individuals pushing for nicotine replacement therapy.

> *Provide quit packs to help figure [out] if gum or patch works for the smokers – [they] should be easily accessible. – Leadership Team Member*

The design team and other staff members agreed that resources such as gum and nicotine patches should be provided as a supplement to tobacco.

Change Attitudes and Beliefs

Most of the leadership team believes that in order for everyone to be on board with this project, the attitudes and beliefs of some staff members must change. This serves as a key component in providing services that change patients' addictive behaviors. It was also advised that introducing literature to the staff would demonstrate the effectiveness of going tobacco-free and help alter the behaviors. If staff members are

provided with evidence and get rid of all misinformation, they are more likely to change their attitudes and alter their behaviors. The center should sell individuals on the idea that nicotine addiction is a true addiction and should be treated as such.

One design team response suggested that changing attitudes and beliefs would play a key role in the transition to a smoke-free environment. The entire mindset towards tobacco cessation needs to change among all members.

The other staff members recommended changing the attitudes and beliefs of staff members. Empowering the nursing staff to follow up any reported incidences would lead to a change in behavior among some of the significant enforcers.

Provide Alternatives to Tobacco Use

Other staff members expressed that it would be important to find alternatives to smoking for patients, since little to no other activities are offered. Outside the formal programming, patients do not currently have many additional activities to partake in. Nearly half said that exercise and recreational activities are great ways to improve overall health of patients while getting their minds off of smoking. Patients should receive access to the onsite gym. According to this group, exercise is a great coping strategy while dealing with withdrawal symptoms. Another alternative that was brought was the use of electronic cigarettes, since patients have asked about them.

DISCUSSION

Among the groups interviewed at R.J. Blackley, there were definitive similarities and differences of the positive attitudes that were presented. A few from the leadership and design teams believed that the infrastructure to implement cessation is already in

place. They also believed that there would be a smooth transition to a smoke-free environment; therefore, cessation should be incorporated as quickly as possible. The leadership team and other staff members mentioned that tobacco should be treated as an addiction and that its cessation could help treat alcohol and drug abuse as well. However, many differences were presented during the semi-structured interviews. The leadership team mentioned that the same skillsets could be used to treat all addictions alike. Much of the staff is looking forward to eliminating smoking on the facility. The design team focused on how smoking should be treated equally as important as other addictions. The majority of the staff would support the program and tobacco cessation should even be included in the facility's mission statement. Other staff members mentioned that cessation would improve productivity and that implementing such programs would not disrupt patient care.

The negative viewpoints also differed between groups. The leadership team mentioned that employees should not have to go through tobacco cessation education and that smoking is a patient and staff member's right. The design team said that smokers would not consider cessation, staff members in the facility should not have to help patients quit their tobacco use, and integration would significantly disrupt patient care. A response from the other staff members included some misinformation as it stated that tobacco cessation could complicate recovery from other addictions.

Throughout the literature, many key themes on attitudes, barriers, and recommendations were provided as seen below.

Attitudes:

1. The same skills are used to treat all addictions.
2. Treating tobacco will help with the treatment of other addictions.
3. Tobacco use is an equally important addiction.

4. Tobacco cessation services will lead to a more productive staff that can help patients in their smoking cessation efforts.
5. Some staff members may be misinformed about the success of tobacco use cessation interventions (*i.e. the belief that tobacco cessation integration will disrupt treatment of other addictions*)

Barriers:

1. Staff resistance hinders the transition process to tobacco-free grounds.
2. Smoking staff members are not displaying a consistent message.
3. Lack of communication among staff members may produce discrepancies in treatment.
4. Patient may resist participating in tobacco use cessation services.
5. Patients will need a variety of medication resources in order to succeed in their cessation.
6. It may be difficult to continue training staff members with staff turnover and staff shortage.
7. A decrease in time spent with patients makes it difficult to address smoking among clients.

Recommendations:

1. Communication is important for a unified effort towards tobacco cessation
2. Training of staff/management increases rate and effectiveness of delivery of tobacco cessation
3. Smoking staff members who have gone through smoking cessation can play a supportive role in patient smoking cessation.
4. Different forms Nicotine Replacement Therapy in order to allow for maximum impact since patients may need individualized care depending on what works for them.
5. Changing provider attitudes and beliefs by sharing literature, anecdotes, and other forms of knowledge is important for organizational readiness to change and patient response to treatment.
   Patients will experience difficult times throughout their treatment and will need alternative activities to smoking to keep their minds off of the addiction.\

These themes highly resembled those found in the results of the R.J. Blackley interviews.

Some of the positive attitudes found in the literature were also demonstrated in the R.J. Blackley interviews. For instance, treating tobacco as an equally important addiction is a theme common to both (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). The negative attitudes displayed across the three groups were commonly shared by other health care professionals working in addiction treatment settings and were often directly contradicted by the literature. Often times, individual

rationalizations to smoke arise from treatment providers, support group sponsors, and relatives. Just as some of the other staff members believed that it would be harmful to sobriety to quit tobacco use, so too do many of the health care professionals working in addiction treatment settings (Guydish, Passalacqua, Tajima & Manser, 2007; Heffner & Anthenelli, 2009; Knudsen, Studts, Boyd, Roman, 2010). The idea that tobacco cessation will negatively impact patients is a belief of both the design team and the health care professionals found in the literature (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006). Some of the leadership and design team believed that many patients would not want nicotine care whereas the literature stated that substance abusers are typically interested in quitting and will take advantage of the opportunities provided to them (Heffner & Anthenelli, 2009).

With the exception of the lack of communication, all other barriers found in the interviews were also presented in the literature. Staff concern over a decline in the number of patients that centers receive after tobacco-free policies take place is common to the leadership team as well as other centers (Foulds, Williams, Order-Connors, Edwards, Dwyer, et al., 2006; Knudsen, Studts, Boyd, Roman, 2010). The lack of time as a result of already having to treat other substance dependences seemed to be a concern of both staff members in the literature, leadership team, and the design team alike (Knudsen, Studts, Boyd & Roman, 2010). However, the literature displayed more concerns about a lack of training of the staff than did the staff members at R.J. Blackley (Guydish, Passalacqua, Tajima & Manser, 2007; Knudsen, Studts, Boyd & Roman, 2010). Although the interviewees did recommend continuing to be trained and updated on new information, they did not see the lack of training as a barrier likely as a result of the

tobacco cessation training that they were receiving from UNC. A lack of time and staff shortage and staff turnover were also barriers seen more frequently in the literature than in the interviews. Relative to other facilites, R.J. Blackley patients may not be experiencing as much of a shortage of providers and therefore not experiencing as long of waits for treatment.

The staff members in R.J. Blackley provided many recommendations for facilities that are going or plan on going tobacco-free that coincide with some of those present in literature. Studies have shown that training staff members increases the rate of delivery of tobacco cessation advice among health care professionals (Olano-Espinosa et al., 2013). As suggested by some of the staff members at R.J. Blackley and in the literature, providing literature that demonstrates that concurrent treatment of nicotine can enhance patients' likelihood of freedom from their primary addiction would help to eliminate some of the negative attitudes (Knudsen & White, 2012). However, in addition to research findings, sharing anecdotal evidence can serve as a useful tool for health care professionals (Heffner & Anthenelli, 2009). Educational efforts will help to eliminate many of the myths that exist with concurrent treatment. Providing professionals with additional knowledge and skills for counseling and treating their patients will increase their likelihood of viewing tobacco cessation as a part of professional practice for addiction treatment facilities (Knudsen & White, 2012).

The literature also supports active programs to promote staff tobacco cessation. Guiding current staff members towards their own personal tobacco cessation can result in a more positive and encouraging environment for patients trying to quit smoking (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006). Although smoking staff

members should be encouraged to quit, their experience with the process can be very helpful when assisting patients through their tobacco cessation (Knudsen & White, 2012). A few of the individuals interviewed believed that the former smokers on the staff should be a part of the teams that help patients. Those who were former smokers will be able to provide unique support to fellow staff members and patients who desire to stop their tobacco use.

All groups agreed with the literature that resources, particularly nicotine replacement therapy, should also be available to patients and staff members who desire to quit their tobacco use. Different medications work for different people and having a limitation on availability can hinder a patient in his or her path towards recovery (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

The literature as well as all groups of interviewees mentioned that in order to ensure success in providing tobacco cessation treatment, health care professionals involved must be on board with the ideas behind the integration of nicotine dependence treatment with other addictions. Therefore, while many staff members do have positive attitudes towards the integration, changing any negative attitudes and beliefs is an important resolution **(**Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

Providing alternatives to tobacco use is essential to the success of the patients in these centers as the other staff members suggested. Exercise programs, for instance, can take a patient's mind off of smoking and channel out negative thoughts in a healthy way. As mentioned earlier in the literature review, also having alternatives to smoke breaks, such as popcorn breaks, will allow for a smoother transition (Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006).

R.J. Blackley would particularly benefit from transparency in communication across the staff, making sure that staff members are informed of updates regularly and through diverse manners. If staff members are not kept up to date and aware of the process timeline, everyone will be on different pages and the process will not move forward as a unit. All staff members should be continually trained with and kept up to date on the latest research and recommendations. Yet, learning through and using the experiences of fellow smokers in treatment who have successfully quit is also an important way to ensure the success of future patients. The staff should be motivated to discontinue their tobacco use and interested individuals should be provided with resources and connected with the QuitLineNC. While all misinformation should be addressed during training, the center must continue to change any negative attitudes towards tobacco cessation since success will be a team effort. Lastly, providing alternatives to smoking, such as a recreation center, can serve as an effective coping mechanism for patients going through addiction treatment and tobacco cessation alike. While some evidence about successful implementation of tobacco cessation integration in addiction treatment facilities is provided from the literature, there should be ongoing efforts to review the success of any applied suggestions.

CONCLUSION

In behavioral health facilities, there are a variety of attitudes and perceived barriers to the implementation of tobacco cessation (Ockene, 1999; Meredith, Yano, Hickey & Sherman, 2005; Olano-Espinosa et al., 2013; Knudsen & White, 2012; Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006; Guydish, Passalacqua, Tajima &

Manser, 2007). Although there have been many positive attitudes towards the integration of tobacco cessation into addiction treatment, not all individuals were fully convinced that concurrent treatment is effective and not enough action is being taken by those who are (Ockene, 1999). Health care professionals have the capacity to truly influence patients and reduce their tobacco use since they are one of the key sources of information and support. Many of those working in addiction treatment facilities are encouraging the initiation of tobacco cessation interventions and hopefully with some recommendations and guidance, more professionals will be motivated to do the same.

If the recommendations were to be implemented, the results could encourage health care professionals within R.J. Blackley and across the nation to behave in a way that can impact many patients' lives. With an increase in tobacco cessation education, resources, and communication, health care professionals will have a heightened awareness and ability to improve attitudes towards tobacco cessation integration into addiction facilities. There will be an increase in productivity, more motivation, and even an enhanced skillset among healthcare professionals. These changes could play a significant role in influencing the behavior of health care professionals, including the use of tobacco cessation treatment guidelines, counseling techniques, materials, and encouraging positive views towards becoming tobacco-free. Ultimately, the patients and staff members will benefit and more individuals will participate in the tobacco cessation interventions (Ockene, 1999; Meredith, Yano, Hickey & Sherman, 2005; Olano-Espinosa et al., 2013; Knudsen & White, 2012; Ziedonis, Guydish, Williams, Steinberg & Foulds, 2006; Guydish, Passalacqua, Tajima & Manser, 2007).

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APPENDIX

Appendix I: Codes

Categories	**Codes**
Leadership Team Roles	Agency Director
	Clinical Director
	Medical Director
	Director of Nursing
Design Team Roles	Staff Development Coordinator
	Nurse Educator
	Program Director
	Recreation Therapy
	PA and Smoking Cessation Work Group member
	QI Clinical Manager and RN
Other Staff Member Roles	Discharge Planner
	Health Care Technician
	Housekeeping/Environmental Services
	Information Technology Manager
	HR Manager
	Risk Manager
	Recreation Therapy
	2nd Shift Registered Nurse
	Budget Officer
Positive Attitudes	More productive staff
	Smoking cessation helps with other addictions
	Optimistic towards tobacco-free environment
	Quick integration
	Infrastructure in place
	Agrees with tobacco-free policy
	Policies will not interfere with effective and efficient
	Same skills used to treat tobacco as any other addiction
	Smoking should be treated as an addiction
Negative Attitudes	Smoking is a right – should not intrude
	Employees should not be forced to have smoking
	Policies will interfere with effective and efficient
	Not employee's responsibility to help patients quit
Barriers	Staff turnover/shortage
	Lack of training
	Staff smoking
	Safety of employees
	Patient resistance
	Staff resistance
	Lack of resources
	Lack in communication
	Time
	Little to no barriers
Recommendations	Provide alternatives to tobacco use
	Staff tobacco use
	Training of staff/management
	Communication
	Electronic cigarettes
	Sensitivity
	Supervision
	Provide resources (including medications)
	Change attitudes/beliefs
	Therapy sessions for tobacco cessation

Appendix II: Key Informant Interview Questions

Key Informant Interview Questions

1. Could you briefly describe your role in the facility?

2. What kind of care do you and your staff provide to patients?

3. Does this care include addressing patients' smoking needs? What activities do this entail?

4. Do you or your staff currently help patients with smoking cessation? What activities do this entail?

5. How will these activities need to change as the NC law requiring the ADATC to become a smoke free campus comes into effect?

    a. Do you or your staff have any concerns about implementing the smoke free campus regulation? If so could you describe what these concerns might be?
    b. How do you think a smoke-free campus might affect you in providing effective and efficient patient care?
    c. What do you think about the idea of providing smoking cessation assistance to all smokers when the smoke free campus law goes into effect?
    d. What steps would need to be taken to implement a smoking cessation program successfully?
    e. How would the introduction of a smoking cessation program change your work? Would this change be positive or negative?
    f. Can you think of any barriers that would affect the successful implementation of a smoking cessation program?
    g. How can these barriers be addressed?

6. Are you aware of the smoking cessation training and implementation support currently being provided by UNC? Are you or members of your staff currently part of this project?

7. What do you think is the primary goal for the RJB smoking cessation program?

8. How can UNC help the ADATC comply with the smoke free campus regulation?

9. Anything else that might be useful as we start working with the design team?

Appendix III: Table of Findings

Interviewee Type	Domain	Findings	Frequency
Leadership	Overall Attitudes	Cessation helps treat addiction	1
		Same skills used to treat addiction and tobacco use alike	2
		Integration of tobacco cessation should be quickly executed	1
		Already have skills and infrastructure to incorporate smoking cessation	1
		Staff will be thrilled when smoking goes away	1
		Tobacco should be treated like an addiction	1
		Employees should not have to go through tobacco cessation education	1
		Smoking is a right that should not be intruded on (especially for staff)	1
	Staff Resistance	Possible anxiety over loss of business and increase in patient aggression	1
		Uncooperative staff, particularly psychiatrists who see tobacco dependence as more of a medical model than psychiatric holistic model	1
		Staff may see smoking as a right	1
		Some staff more on board than others	1
	Staff Tobacco Use	Tobacco-using staff may be reluctant	1
		Smoke could bother patients	1
	Patient Resistance	Smoking patients will be hesitant to quit/would prefer to focus on one addiction at a time	1
		Some smoking patients may be aggressive with the elimination of smoking breaks	1
		Many smoking patients will not want nicotine care and medications	1
		There may be increase demand for patches	1
	Lack of Resources	Patients will want patches	1
		Should money be spent on patches?	1
	Other Barriers	Staff turnover and shortage	1
		Lack of time	1

Appendix III Continued next page

Interviewee Type	Domain	Findings	Frequency
Design	Overall Attitudes	Smoking should be treated as an equally important addiction	3
		Integration of tobacco cessation should be quickly executed	1
		Already have skills and infrastructure to incorporate smoking cessation	1
		The majority of the staff will support the program	1
		The mission statement should change to include smoking cessation	1
		Current smokers will not consider tobacco cessation	1
		It is not staff responsibility to help patients quit tobacco use	1
		Tobacco cessation integration will interrupt patient care	1
	Staff Resistance	Nurses concerned about backlash from patients	1
		Colleagues would be reluctant to report staff violations	1
		Leadership team might not be fully on board	2
		Staff may not see smoking as legitimate addiction and within scope of mission	1
		Politics between staff members	1
	Staff Tobacco Use	Smoking among staff is a barrier to tobacco cessation implementation	4
		Current staff smokers would continue to smoke and front-line staff may be high smokers	1
	Lack of Communication	Communication has historically been inconsistent	1
		Communication is a big issue	1
	Patient Resistance	Patient backlash and behavioral issues may escalate	2
		Patient frustrations and agitations	1
	Other Barriers	Staff turnover and shortage	1
		Lack of time	1

Appendix III Continued next page

Interviewee Type	Domain	Findings	Frequency
Other Staff Members	Overall Attitudes	Tobacco cessation will lead to more productive staff	3
		Cessation helps treat addiction	2
		Tobacco should be treated like an addiction	2
		Tobacco cessation integration will not interrupt patient care	2
		Nicotine recovery could complicate recovery from other addictions	1
	Staff Resistance	Staff may view smoking as a right that should not be intruded on (especially for staff)	2
		Front-line staff more resistant than others	1
	Staff Tobacco Use	Legislation may frustrate smoking staff, leading to decreased productivity	1
		Difficult for state to monitor staff smoking on facility	1
		Smoke could bother patients	1
		Staff smokers would help understand the process	2
	Patient Resistance	Patient backlash, especially on rainy days without smoking breaks	2
		Patients may feel their rights are being taken away	1
		Patients will be more impacted than staff members and will need healthy ways to relieve tension	1
		Patient with mental illness might demonstrate more aggression than others	1
	Other Barriers	Staff turnover and shortage	1
		Lack of time	1