

Regular article

## How is tobacco treatment provided during drug treatment?

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### Abstract

The purpose of this study was to obtain descriptions of tobacco treatment services across different substance abuse treatment settings. We conducted mixed-method assessments in eight facilities among eight directors, 25 staff, 29 clients, and 82 client charts. Measures included systems assessment, chart reviews, and semistructured interviews. Although many programs reported they offer key components of evidence-based treatment, few actually provided any treatment and none did so systematically. Many addressed tobacco as part of drug education or part of a health promotion session. Chart reviews suggested that provision of tobacco treatment is rare. By many reports, clients had to specifically request treatment and few staff reported encouraging unmotivated smokers to quit. Systems to facilitate consistent, evidence-based tobacco treatment and to implement quality improvement were nonexistent. The findings imply that drug treatment facilities may need to build capacity in several domains to deliver care that is consistent with national guidelines. © 2012 Elsevier Inc. All rights reserved.

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### 1. Introduction

More than three quarters of clients in treatment for substance use disorders smoke cigarettes (Best et al., 1998; Hughes, 1993; Kalman, 1998; Poirier et al., 2002; Richter & Ahluwalia, 2000) and are highly interested in quitting smoking (Doll, Peto, Boreham, & Sutherland, 2004; Hser, Anglin, & Powers, 1993; Hughes & Kalman, 2006; Hurt et al., 1996; McCarthy, Zhou, Hser, & Collins, 2002; Nahvi, Richter, Li, Modali, & Arnsten, 2006; Peto et al., 2000; Richter, McCool, Okuyemi, Mayo, & Ahluwalia, 2002; Velicer et al., 1995). Moreover, they are able to quit. Large-scale smoking cessation trials among alcohol-dependent patients have achieved long-term quit rates of 10%–15% among those who received counseling and

pharmacotherapy (Burling, Burling, & Latini, 2001; Joseph, Willenbring, Nugent, & Nelson, 2004; Kalman et al., 2001). Three randomized, controlled trials among methadone patients also achieved good within-treatment quit rates, ranging from 9% to 33%, although most clients quickly relapsed following treatment (Reid et al., 2008; Shoptaw et al., 2002; Stein et al., 2006). One of the three studies demonstrated significant differences in quit rates between experimental and control groups at follow-up (Reid et al., 2008). Numerous studies have demonstrated that offering tobacco treatment to substance abuse clients does not threaten abstinence from other drugs of abuse and in many cases actually improves other drug outcomes (Clemmey, Brooner, Chutuape, Kidorf, & Stitzer, 1997; DiFranza & Guerrero, 1990; Frosch, Shoptaw, Jarvik, Rawson, & Ling, 1998).

Tobacco treatment guidelines recommend that smokers with chemical dependence be offered both medication and counseling for assistance in quitting. Current U.S. guidelines and reviews by Kalman (1998) and Richter and Arnsten

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(2006) suggest the following approach: (1) identify smoking status at every visit (ask); (2) advise smokers to quit (advise); (3) assess readiness to quit (assess); (4) if not ready to quit, provide brief intervention to increase readiness; (5) if ready, provide counseling/pharmacotherapy for cessation (assist); (6) consider treating substance abuse problems with medications that target their problems but may also help with smoking cessation (for example, naltrexone for alcoholism); (7) use combination pharmacotherapy for smoking cessation when clients are unsuccessful with one medication; (8) follow up on smokers' quit smoking attempts (arrange); (9) eliminate practices and policies that undermine clients' interest in quitting or quit attempts; and (10) incorporate tobacco treatment systems into practices to ensure consistent identification, treatment, and follow-up (Fiore, 2008; Kalman, Morissette, & George, 2005; Richter & Arnsten, 2006).

However, substance abuse treatment facilities rarely provide these treatment elements to their clients. For example, many (54%) Canadian facilities report they provide only "informal" tobacco treatment to their clients (Currie, Nesbitt, Wood, & Lawson, 2003), yet few provide individual or group cessation counseling (10%) or pharmacotherapy (1%). Somewhat more U.S. facilities provide formal counseling (38%) and pharmacotherapy (17%; Currie et al., 2003; Friedmann, Jiang, & Richter, 2008). Neither of these studies described the type or intensity of counseling provided, and it is not clear how many clients actually received services. Walsh, Bowman, Tzelepis, and Lecathelinais (2005) estimated that Australian substance abuse treatment programs provide brief advice to quit to 36% of clients who smoke, education about the risks of smoking to 39%, counseling to quit to 26%, and quit smoking medications to 15%. However, these services are not systematically provided; the decision to treat a client's smoking and the types of treatments offered are left up to individual staff members.

Hence, we know very little regarding how tobacco treatment is delivered in facilities, including how or whether smoking status and interest in quitting are assessed, how facilities address unmotivated smokers, who is responsible for delivering care, what is the type/intensity/duration of counseling provided, how services are paid for, whether any systems are in place to facilitate care, or how quality of care is monitored. The purpose of this study was to obtain detailed qualitative and quantitative descriptions of tobacco services delivery across different substance abuse treatment settings. This study was part of a larger project to develop and validate a brief measure of tobacco treatment services in drug treatment (R21 DA020489; PI, Richter). The findings of this study are particularly relevant to providers who are considering providing tobacco treatment in their substance abuse facilities and to policymakers interested in understanding and increasing the adoption of tobacco treatment in substance abuse facilities.

## 2. Methods

### 2.1. Facility sample and participants

We conducted the study among substance abuse outpatient facilities in a metropolitan area in the Midwestern United States. We aimed to recruit a purposive sample of 6–12 facilities stratified by several variables that correlate to treatment provision—specifically profit versus nonprofit facilities and methadone versus nonmethadone facilities (Friedmann et al., 2008; Richter, Choi, McCool, Harris, & Ahluwalia, 2004). We also sought to observe facilities that provided either high or low levels of tobacco treatment services. To select facilities, we assembled a large target pool of eligible facilities, stratified by profit/nonprofit, methadone/nonmethadone, and tobacco service status. We collected data from sequential facilities until saturation was reached—the point at which new respondents no longer expressed novel opinions or information (Glasser & Strauss, 1967). We decided to initially recruit eight sites, conduct data collection and preliminary analyses, then recruit more sites as needed to reach theoretical saturation.

We conducted first mail- and then telephone-based recruitment of facilities. Our eligibility criteria restricted participation to clinics that (a) serve predominantly adults and (b) provide outpatient treatment. To identify our initial study population of facilities, we used the Substance Abuse and Mental Health Services Administration Substance Abuse Facility Treatment Locator ([www.findtreatment.samhsa.gov](http://www.findtreatment.samhsa.gov)) to identify all metropolitan area outpatient facilities that served adults ( $N = 51$ ). To these 51 facilities, we sent invitations that (a) described the study, (b) encouraged clinic directors to return a self-addressed response form indicating whether they were interested in participating, and (c) notified directors that we would call shortly to invite them by telephone. Of the 51 facilities, 2 responded immediately to the mailing and declined to participate, reducing the candidate pool of facilities to 49. We began the telephone-based phase of recruitment and called through the remaining list of 49 facilities until we recruited an initial purposive sample of 8 facilities, with at least 1 facility in each strata (methadone/non; public/private; provide tobacco treatment/not). We had to contact only 12 facilities by telephone to fill this initial sample. Of the 12 facilities that completed telephone screening, 2 were ineligible, 2 refused, and 8 were eligible and agreed to participate in the study. After conducting data collection and preliminary analyses at these 8 sites, study staff agreed that director, staff, and client responses to interview questions were becoming repetitive, and recruitment was closed because saturation was reached.

### 2.2. Procedures

The design was a cross-sectional survey of facilities conducted to the point of theoretical saturation. We used a

multimethod approach to data collection that included quantitative surveys, qualitative interviews, and chart reviews.

Over a 3-month period in 2008, research staff visited each study clinic. We worked with the clinic staff liaison to schedule the date and time of the visit, recruit staff and clients, schedule interviews, and troubleshoot difficulties. Data collection lasted 1 1/2 to 2 full days depending on the number of interviews conducted; interviews lasted approximately 40 minutes. Staff and clients were recruited based on a convenience sample for the scheduled days the interviews were to take place. Subjects provided verbal consent before the interview began. Participants received a \$25 gift card to reimburse them for their time. The study liaison was reimbursed \$100, and each facility was reimbursed \$500 to compensate for staff time spent in data collection.

### 2.3. Measures

#### 2.3.1. Quantitative measures

We used a screening survey to identify eligibility and categorize facilities within our stratification scheme. The screening instrument included the two eligibility variables (adult-oriented, outpatient) and the three stratification variables (profit or nonprofit, methadone or nonmethadone, and high or low/no intensity of tobacco treatment). We used brief quantitative surveys to collect demographic information, smoking status, and smoking patterns from all participants at the time of the interview. The System Assessment Checklist, adapted from a study of tobacco treatment in safety-net health care facilities, was conducted among clinic directors (Zapka et al., 2005). This survey assessed the types of services provided and systems in place to support tobacco treatment. It directed the interviewer to collect office forms and other office supports for prompting tobacco treatment and documenting treatment provided.

#### 2.3.2. Qualitative measures

We conducted qualitative interviews among all participants. Open-ended questions began with a “grand tour” question that asked participants to describe how their clinic currently treats cigarette smoking among clients. Specific probes followed, for clients targeting the services they received, for staff targeting their role in providing or facilitating services. To better understand organizational readiness for change and what motivated providers to offer tobacco treatment, directors and staff were asked another set of questions regarding how the clinic came to offer services and what aspects of leadership, philosophy, or resources were key in the decision to offer services.

#### 2.3.3. Chart reviews

Chart data were collected to validate director reports of current clinic forms and services (as reported during completion of the System Assessment Checklist). Facilities with client databases generated lists of active charts. Research staff randomly selected 10–12 charts for the clinic

liaison to pull for review. No facilities without an electronic database of client’s chart numbers were willing to permit staff to randomly select charts from their paper files. Filing practices in these clinics varied widely. In these cases, research staff instructed the clinic liaison to select 10–12 charts of active clients in the most random fashion possible. Chart review items included whether the chart included a specific location to record smoking status, interest in quitting, and other aspects of treatment provision; whether any mention of tobacco treatment was made in the record; and whether any office systems such as treatment reminders were present in the record.

### 2.4. Analysis

Demographic and other quantitative data were analyzed using SPSS. All qualitative interviews were audio-recorded and transcribed. Coding was performed using Ethnograph VI by three authors of this article (Hunt, Richter, and Garrett). We developed a set of codes using content analysis as described by Miles and Huberman (1984). We selected a small group of transcripts that all coders read separately and “open-coded,” identifying key words, themes, and descriptions of behavior. We then grouped these themes into categories, developed a code name for each category, and generated a list of codes we applied to the text data.

We assessed interrater reliability for nine key codes. Percentage agreement across all codes was 87%, with a substantial kappa score of 0.66 (ranging from 57% to 74% across codes), which is considered good interobserver agreement (Argesti, 1990; Sierra & Cardenas, 2007).

## 3. Results

Total data collection consisted of 62 in-depth interviews among 8 clinic directors, 25 staff (2–4 per clinic), and 29 clients (4–5 per clinic), as well as 82 chart reviews. We first described features of our sample, including facilities, directors and staff, clients, and charts reviewed. We described the findings of our qualitative interviews. We then compared data from the Systems Assessment Checklist and chart reviews to examine concurrence between director reports of services provided and documentation of services provided.

### 3.1. Sample characteristics

Facility characteristics are shown in Table 1. Three facilities had fewer than 10 staff members, two had between 10 and 25 staff, and two had 60–75 staff members. Most of the facilities were nonmethadone ( $n = 6$ ) and provided low no treatment of tobacco ( $n = 6$ ). Slightly less than half were for-profit.

With respect to using tobacco on premises, none of the eight facilities allowed smoking inside the facility. Three facilities are located on smoke-free campuses. One facility

Table 1  
Characteristics of drug treatment facilities

No. of staff	No. of clients	Methadone	Profit status	Self-reported treatment level	In/outdoor smoking policy
6	70	No	For-profit	High <sup>a</sup>	Smoke-free campus
22	80	No	Nonprofit	High <sup>a</sup>	Outside only
2	120	No	For-profit	Low/no <sup>b</sup>	Off-site only
6	112	No	For-profit	Low/no <sup>b</sup>	Smoke-free campus
60	32	No	Nonprofit	Low/no <sup>b</sup>	Outside only
75	270	No	Nonprofit	Low/no <sup>b</sup>	Outside only
13	220	Yes	Nonprofit	Low/no <sup>b</sup>	Outside only
11	340	Yes	Nonprofit	Low/no <sup>b</sup>	Smoke-free campus

<sup>a</sup> High-intensity tobacco treatment is defined as individual/group counseling and/or pharmacotherapy.

<sup>b</sup> Low-intensity/no tobacco treatment is defined as brief advice, educational materials, or no formal services.

does not have a smoke-free campus policy, but the director reported the staff is required to go off-site to smoke. The other four facilities permit smoking on clinic grounds in designated areas.

Among directors and staff, more than two thirds of the respondents were female (69%) and White (69%), and most were non-Hispanic (91%). Forty-two percent had a bachelor's degree, whereas 46% had completed some form of graduate school. Many staff and directors played multiple roles in the facility, including counseling, administrative, and medical. Almost one third self-identified as smokers. Only two (25%) directors reported that any staff completed training in how to help clients quit smoking. More than half of directors (63%) reported that their facility has treated tobacco from 1–5 years, and 37% reported their facility has been treating tobacco for 10–25 years.

Participating clients were predominantly male (55%), White (69%), and non-Hispanic (96%). Most (69%) were younger than 45 years and (76%) were between 18 and 35 when first entered treatment. Most client respondents were current smokers (90%).

Charts that were reviewed consisted of 55% males, with an average age of 37 years, and the clients had been in the facility for an average of 17 months. Charts indicated that 59% ( $n = 48$ ) were smokers, 24% ( $n = 20$ ) were nonsmokers, and 17% ( $n = 14$ ) charts did not identify smoking status.

### 3.2. Qualitative perspectives

Table 2 provides a list of code definitions related to how tobacco treatment was provided in facilities along with the number of participant comments within each code. In the text, we indicate comments made by directors and staff with D/S; comments by clients are denoted by a C.

### 3.3. Asking about smoking status

Most directors and staff ( $n = 22$ ) reported that smoking status was collected on the intake evaluations. Other staff

Table 2  
Code definitions and the number of participants that provided comments within each code

Process	Definition	<i>n</i>
Ask	How staff identifies smokers.	42
Advise/assess	How brief advice to quit is delivered.	6
	How tobacco is addressed among unmotivated smokers.	13
Behavioral treatment (assist)	How staff decides to treat clients' tobacco dependence.	47
	General impressions on how tobacco treatment is provided.	56
	How counseling is provided for clients motivated to quit.	12
Pharmacotherapy (assist)	Staff roles in treating tobacco dependence.	30
	Tobacco is used as an educational tool to treat other drugs.	8
	How pharmacotherapy was incorporated into tobacco treatment.	13
Referral (assist)	Attitudes toward tobacco treatment pharmacotherapy.	6
	Referring client to another site or resource for tobacco treatment.	12
	How clinics follow up with clients to support abstinence.	7
Follow-up (arrange)	What was the outcome and how did the participant feel about the outcome?	7
	What types of office systems (prompts, stickers, flowcharts, and software) support efforts to treat tobacco?	12
	Who leads clinic efforts to treating tobacco dependence?	27
Systems/leadership	Whether there are incentives or consequences for staff regarding whether or not they treat clients' tobacco dependence.	12
	How is tobacco treatment paid for?	10
	How does the facility know that tobacco dependence is being treated according to standard or protocol? How do they know if tobacco dependence treatment is effective and are there any quality improvement initiatives in place?	19
	Need for support or program for tobacco dependence.	8

members reported using different methods of identifying smoking status, such as asking about smoking in group sessions ( $n = 3$ ) and informal observation, for example, noticing the smell of tobacco on clients ( $n = 6$ ). Few ( $n = 3$ ) reported that smoking status was not collected. No facilities had carbon monoxide monitors to assess smoking status.

We always start with marijuana, heroin, meth, hallucinogens, alcohol, pain killers and I made this list over and over and over and suddenly realized...suddenly it dawned on me it was like, you know, we really should add tobacco on there and because I'm a smoker I didn't think about it. – Staff

You smell it on them all the time. I mean all you have to do is walk into the room and you know that more than one of them is a smoker in there. – Staff

### 3.4. Advice to quit, tobacco education, and assessing interest in quitting

Some (5 D/S and 1 C) reported their facility provided brief advice to quit to clients. Several clients ( $n = 12$ ) stated that “not much” was done around tobacco or that it had never been addressed during their drug treatment. However, one director at one facility offered brief advice often:

It's just when I would be out on the patio smoking on one of our smoke breaks after dinner or whatever, she's like you girls need to quit doing that one of these days, it's just not good for you, you're going to want to be around for your babies. You know, she put a little bird in your ear, a little peck, peck, pecking at you, you know. – Client

Very few ( $n = 5$ ) directors and staff reported they try to motivate unmotivated smokers, and 4 reported they specifically avoided trying to motivate smokers to quit. However, a number of programs noted they provided education about tobacco in their drug or health education sessions. Many (11 D/S and 3 C) provided education around tobacco, including the harmful health effects of tobacco, and some (5 D/S and 1 C) included tobacco education as part of a health/wellness section of drug treatment.

Well he talks to us about...he talks sometimes about what different drugs do with nerve receptors and he included tobacco in that and what different drugs do with the brain, like how it denies oxygen to the brain and that kind of thing, he includes tobacco in those discussions. – Client

Because no staff discussed how they assessed interest in quitting, it was not clear how staff decided whether to offer or provide treatment. A little over half of directors and staff ( $n = 18$ ) said they would discuss tobacco when a client “brought it up.” In many programs (6 D/S and 1 C), clients had to express a desire to quit before staff would discuss smoking cessation. Other reasons for deciding to treat tobacco are that it was in the curriculum (3 D/S), to

contribute to the health of clients (12 D/S and 2 C), or because of the no smoking policy of facility (2 D/S).

We'll provide the information, but it's really their responsibility to take the initiative to step up and say, ah, I think I might want to stop smoking too. – Director

It's client directed. If the client wants to...all clients are asked if they want to address smoking cessation and if they do then we do, if they don't, we don't. – Staff

Unless you ask them about addressing the tobacco situation and then they will address it but if you never say anything then they would never say anything about it. – Client

If some client was dying from emphysema or something it might end up on the treatment plan. – Staff

### 3.5. Assisting with quitting

#### 3.5.1. Counseling

Staff offered descriptions of how tobacco treatment was integrated into drug treatment. Half of the directors said that tobacco treatment is incorporated into the day-to-day roles of staff. Very few ( $n = 3$ ) directors and staff mentioned that tobacco was in the treatment curriculum. Tobacco was mainly addressed when the topic was raised in either individual (9 D/S and 1 C) or group (4 D/S and 3 C) sessions. There was a variety of lengths of tobacco treatment discussed: 10 minutes, part of an hour session, one session (only if on treatment plan), two sessions (part of curriculum), six months, ongoing, and no set amount of time. Some (8 D/S and 1 C) said tobacco dependence was addressed in one-on-one counseling. However, some clients ( $n = 7$ ) denied there was any treatment at all in the facility.

So I know that they have those skills, the counselors do, and are able to apply those to tobacco and nicotine use as well as other drug use. – Director

And we do touch on the topic (tobacco) but it's not as focused as, because we only have a couple of hours once a week so it's more focused on their substance abuse. – Staff

Well, there is no treatment for nicotine in this program. – Client

Interestingly, some ( $n = 5$ ) directors and staff reported they used tobacco as a tool to treat other drugs, such as how addiction or withdrawal feels or to introduce a discussion of other drugs. This was not for the purpose of helping smokers quit but to assist in the treatment of other drugs.

I find that it's a powerful drug to use as an example because it is so easy to define what a craving is when you're talking about nicotine. – Director

It's a great example to use, because not everybody may understand being addicted to cocaine, but most everybody understands smoking. – Director

Table 3  
Aggregate clinic-level perspectives regarding tobacco service delivery

Director	Staff	Clients
<p>Staff says tobacco treatment is proactively offered, clients say it is not</p> <ul style="list-style-type: none"> <li>• If tobacco use shows up on assessment, clients will be asked if they want to address it. Brief advice is offered for motivation. An intern offers a group.</li> <li>• Tobacco treatment is integrated into part of the substance abuse treatment program, but most clients are not interested in quitting. If someone is really interested in quitting smoking, something can be done for them.</li> <li>• A person on staff will work either individually or as a group with anybody interested in quitting tobacco. One staff member runs a group but clients are not interested.</li> </ul>	<p>Referrals are given to patients.</p> <ul style="list-style-type: none"> <li>• Some information is available to patients, such health articles and community resources.</li> <li>• If tobacco use is on treatment plan or clients desire it, clients are encouraged to give up the habit.</li> <li>• Tobacco is discussed briefly but there is no curriculum.</li> <li>• “It is considered one of the drugs and we do talk about it, we do explain it, but most people know already what it is and how addictive it is and all that.”</li> <li>• “I think we only hit on it one time in 15 weeks.”</li> <li>• There is no formal program. Referrals to community resources are made.</li> <li>• One counselor has “nicotine cessation” tapes that clients can use. There are posters in rooms on the harmful effects of smoking. There are pamphlets at the nursing station.</li> <li>• A counselor provides encouragement and discusses medications.</li> <li>• One counselor, who had never worked with anyone on tobacco, said “if interest is shown early on and by the time they have a little bit more stability in clean time then they’re really maybe ready to address quitting smoking.”</li> </ul>	<ul style="list-style-type: none"> <li>• “Well there is no treatment for nicotine in this program.”</li> <li>• “It’s [tobacco treatment] never been mentioned to me there before.”</li> <li>• “Smoking has never come up.”</li> <li>• “I haven’t really heard anything about smoking.”</li> <li>• “It is not really addressed that much. The program does not think it’s as much a necessity as it is treating the drug and mental illness.”</li> <li>• “I’ve never heard them address the fact of tobacco here.”</li> <li>• “I haven’t had anyone talk to me.”</li> </ul>
<p>Staff says tobacco treatment is offered proactively, clients say it is addressed mainly reactively—in response to client requests</p> <ul style="list-style-type: none"> <li>• Started using a curriculum module on tobacco after a client noticed it and expressed interest in it. Any discussion beyond this could be pursued if clients express interest—either in individual or group sessions.</li> <li>• Everybody gets brief treatment but to get counseling, the client would need to ask for it—either by circling it on a form or asking to include it on the treatment plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Discussions around tobacco are relaxed. If someone is trying to quit, encouragement is given in individual and group sessions.</li> <li>• Tobacco is discussed in health/wellness and stress management modules. One counselor notes he points out the facts but does not try to sway anyone’s decisions, and has never treated anyone for tobacco use only.</li> <li>• Another counselor discusses own experiences with smoking and quitting when asked. He notes there is no curriculum or strategy because there hasn’t been a need yet.</li> <li>• All addictions are treated equally.</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco was addressed one time, when smoking was brought up in group by another client. Counselor offered referrals.</li> <li>• Smoking has been brought up in group sessions with other clients.</li> <li>• One client mentioned that discussions on tobacco were “hit and miss” and that tobacco use was talked about in group for a “brief minute.”</li> <li>• Tobacco is discussed in sessions as a gateway drug, how it can be connected with other drug use, and as it affects health.</li> <li>• “Talks about tobacco every couple of weeks.”</li> <li>• “I really haven’t heard them talk too much about tobacco.”</li> </ul>
<p>Staff and clients agree tobacco education is routinely provided and treatment is provided if/when clients ask for it</p> <ul style="list-style-type: none"> <li>• The nurse will often discuss tobacco use in the health and wellness assessment. If the individual brings it up, the counselor can work with them on quitting tobacco use. They do some groups on cross-addictions and will talk about smoking. Some clients attend an education group that includes tobacco use.</li> <li>• The program itself does not have any groups focused on tobacco use. Counselors are trained and have the skills to help clients quit.</li> </ul>	<ul style="list-style-type: none"> <li>• Drug and alcohol is main focus. Tobacco is not really addressed; program is probation and parole driven.</li> <li>• “All clients are asked if they want to address smoking cessation and if they do then we do, if they don’t we don’t.”</li> <li>• Education, information, and referral to community resources for tobacco are provided.</li> <li>• “Of course tobacco doesn’t get the time and attention that the other substances do.”</li> <li>• One counselor noted he will address smoking if clients report escalation in tobacco use.</li> <li>• One counselor discusses the health effects of smoking and refers to resources and classes in the community.</li> <li>• “I’m not going to put a treatment .it’s your treatment plan, you don’t want to work on that issue well I’m not going to make you work on an issue, not that, you know, I can.”</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss using same skills to stop smoking as you would use to stop using drugs or alcohol. Discuss tobacco every once in awhile.</li> <li>• Saw a video on the health effects of smoking. “They just give you the knowledge and they say it’s an addiction, it’s bad, it’s not good for you, you know, but we get to decide yes or no.”</li> <li>• Tobacco was brought up in the health and wellness class and the nurse has talked about it.</li> <li>• The health effects of smoking are discussed.</li> <li>• One client reported tobacco was addressed when he asked for it—he was as given a referral to a quitline.</li> <li>• “They don’t really stress tobacco treatment but if you ask for it, they will help you.”</li> <li>• Acupuncture, meditation, and other quit methods were discussed.</li> </ul>

(continued on next page)

Table 3 (continued)

Director	Staff	Clients
	<ul style="list-style-type: none"> <li>• “If I have a client that is interested in treatments, as a social worker we do a lot of case management and may find..I will find an agency that treats the tobacco use. Giving them information maybe off the internet about health risk.”</li> <li>• Counselor stated that it depends on how serious the counselor thinks tobacco use is.</li> </ul>	
Staff says tobacco addressed if/when clients request, clients say tobacco information and support for quitting is proactively offered		
<ul style="list-style-type: none"> <li>• Tobacco treatment is not part of the curriculum—not a scheduled topic. It is addressed in group depending on whether anyone brings it up</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco use is “touched on”; it is brought up in group but clients usually shut it down.</li> <li>• There is a small education component in the outpatient program.</li> <li>• “I don’t really treat them for their tobacco..focus more on substance abuse..and legal cases.”</li> </ul>	<ul style="list-style-type: none"> <li>• They provide brief advice often (“harping”) to quit cigarettes.</li> <li>• Tobacco treatment is provided but it is up to the client whether or not to accept it.</li> <li>• “They have pamphlets and counselors that can help you.”</li> <li>• At first session, clients are told there is help if they want to pursue it.</li> <li>• Gum is available if client asks for it.</li> </ul>

### 3.5.2. Clinic level summaries of directors', staffs', and clients' perspectives on tobacco treatment

It is important to note there were numerous discrepancies in reports from directors, staff, and clients regarding tobacco counseling (see Table 3). In many facilities ( $n = 4$ ), directors and staff reported that they provided referrals and/or counseling was available on request, but clients stated they were not doing much if anything about tobacco. In other facilities ( $n = 2$ ), all agreed that tobacco was being addressed; however, clients reported less intense treatment than directors and staff, and in one facility, all agreed that tobacco was addressed as an education topic in a health and wellness class. Interestingly in one facility, the director reported that counselors are trained and have the skills to treat tobacco use, yet staff and clients stated that referrals seem to be what happens most often. In the face of these differing reports in clinics, it seems likely that these clinics are not routinely providing uniform treatment.

### 3.5.3. Pharmacotherapy

Some ( $n = 6$ ) directors and staff reported that they discuss pharmacotherapy with clients. Very few directors and staff ( $n = 3$ ) reported that their facility had the ability to prescribe pharmacotherapy. Only one facility had patches and gum available on site. Half of the directors said they do not encourage pharmacotherapy because they do not want to encourage chemical help, they believed staff and clients are opposed to it, clients cannot afford them, and they did not have the skills to help clients decide which medication would be best for them. One director reported resistance from clients after suggesting clients consider using quit-smoking medications. Only one staff member voiced strong support for the use of pharmacotherapy because he believed it works.

But we do talk about pharmacological supports. We do talk about using over the counter nicotine replacement therapies as a way of supporting that transition. – Director

And I’m surprised, honestly, at the number of people when I suggest that, even the over the counter stuff to just take the edge off during the transitions, how opposed a lot of people are to that. – Director

I wouldn’t have a clue. So maybe it’s just the lack of confidence on my own part to maybe help a client choose the right replacement. You know, would I be helping...would I be helping them choose the right form of therapy. – Staff

### 3.5.4. Referral

Very few ( $n = 6$ ) directors and staff reported they had a system for referrals to off-site smoking cessation programs. Some ( $n = 8$ ) directors and staff reported they had, on occasion, referred to programs in the community. Some ( $n = 3$ ) reported referring specifically for pharmacotherapy, and one director reported never having made any referrals for smoking cessation. Referrals appeared to be informal, taking the form of verbal referral or handing clients a list of resources. In most cases, staff referred clients to their doctor for pharmacotherapy and to various programs, such as quitlines, community programs, and primary care, for counseling services. Some ( $n = 3$ ) directors and staff expressed a need for more community support/programs. A few staff ( $n = 2$ ) said they would like a treatment program in their facility, and a few clients ( $n = 2$ ) said they would like a treatment program for tobacco but did not specify whether they would prefer one in the community or within the drug treatment program.

If we have somebody that really...that really says hey I really want to quit smoking and everything, we just give them a copy of the list and say these are people that really specialize...they have specialty programs for quitting smoking. – Director

I always go to...whatever I can find on the internet is my best friend. And I will call United Way, I will call anybody in this State to try to find...cause I don’t know, I don’t have a resource guide anymore like I used to have. – Staff

There's nothing for cigarettes. There's not one group that I seen that's out there on the streets that you can actually go join and get help for it. There's none. It's either do it on your own or get cancer and die. That's just basically how that goes.  
– Client

### 3.6. Arranging follow-up and monitoring outcomes

#### 3.6.1. Follow-up

Some (4 D/S) reported no follow-up on tobacco. Some (2 D/S) reported they followed up with clients by placing tobacco on the treatment plan and asking clients about progress. Others (7 D/S) agreed there was no formal follow-up but that progress was reviewed if tobacco was on the treatment plan.

#### 3.6.2. Outcomes

Some staff reported positive outcomes from helping smokers try to quit, such as cutting back ( $n = 2$ ) and quitting ( $n = 2$ ). Others reported not knowing what happened with their clients' smoking ( $n = 4$ ) or that in general, clients continued to smoke ( $n = 4$ ). Some clients ( $n = 2$ ) reported improvements such as not smoking inside and trying to quit.

Yes, the biggest outcome is that he went from probably smoking four packs a day to probably a pack a day. – Staff

### 3.7. Systems and leadership

#### 3.7.1. Office systems

In response to our interview question on whether the facility had any office systems in place, such as chart stickers, checklists, or other means of reminding staff to address smoking among clients, all staff and directors responded no.

#### 3.7.2. Incentives and consequences

In response to our interview question regarding what incentives or consequences were in place to encourage staff to treat tobacco, several staff ( $n = 5$ ) said that an incentive was having a healthier client or the feeling of making a difference. Some directors and staff ( $n = 6$ ) reported it is an expected part of their job and there would be disciplinary action if it were not covered.

I don't know honestly if anyone else [in the facility] does classes on it. My incentive is just if one person would quit... It's my own personal incentive. – Staff

#### 3.7.3. Payment for treatment

For the most part, there appeared to be no specific funding stream for providing tobacco treatment. More than half of the directors ( $n = 5$ ) reported that their programs were self-pay, and two reported that treatment would be reimbursed through state or county funding. Some directors ( $n = 5$ ) reported that tobacco dependence treatment, when provided, would be included at no extra charge to the client.

So if we're talking about health and wellness and the nurse is doing that and she's talking about tobacco using that's how that would get paid for, just as a part of our regular service package. – Director

#### 3.7.4. Quality assurance

Almost half ( $n = 16$ ) of directors and staff said that there was no quality assurance procedures in place to make sure tobacco dependence treatment is up to standard. Others (5 D/S) said that they discussed tobacco dependence treatment in staff meetings and had to trust that their staff was performing treatment to standard. Some ( $n = 8$ ) directors and staff said there was no formal outcome evaluation or quality improvement for tobacco treatment.

So whatever staff tells me they did I just have to believe them cause I surely ain't sitting in them groups everyday for that. I do once a year...I take their word for it. They say they did it, they did it. They say they didn't, they didn't. – Director

#### 3.7.5. Leadership

Some ( $n = 7$ ) directors and staff said no one oversees tobacco treatment or that staff is left to police themselves. Almost half ( $n = 14$ ) of directors and staff said that the clinic director/program manager was responsible for overseeing tobacco treatment. Few ( $n = 3$ ) directors and staff said multiple people are responsible for overseeing tobacco treatment, ranging from director, to supervisor, nurse, and staff members, and others could point to a specific person.

I think the leadership, the program managers they are again, just because we are in a smoke free environment, they're always looking at ways that they can provide like treatment and address all addictive lifestyles, and the nicotine right now we allow the clients to choose, but it's coming. We know we're going to get a formal program. – Staff

### 3.8. Quantitative findings

Table 4 compares the findings from the Systems Assessment Checklist to the findings from chart reviews of clinic records. Only five directors reported they had a system for routinely collecting smoking status, but their facilities outperformed these reports as six facilities had a specific location to record smoking status, and 83% of all charts had smoking status recorded. Varying percentages of directors reported their facility had systems for tracking progress on cessation, providing referrals, documenting provision of cessation medication, and reminding clinicians to address tobacco. However, no charts had specific locations for any of these activities, and no charts had any documentation in any other part of the record that these activities had ever occurred with any client.

We also reviewed charts for other aspects of tobacco treatment (not shown). One facility had a specific location in its charts for documenting interest in quitting smoking. A different clinic had a location to record interest in receiving tobacco treatment. No clinic had locations in charts for



Table 4  
Comparison of director reports and chart documentation of tobacco treatment

Have a system for:	Director report % have system	Have location in chart to document (documentation in any location in % of charts)
Documenting smoking status	63	6 of 8 clinics had a specific location to document smoking status in at least 80% of charts (smoking status was available in 83% of charts)
Documenting progress in tobacco treatment	63	No charts had a specific location to record progress (no entries on cessation progress found)
Providing referrals for tobacco treatment	38	No charts had a specific location to document referrals for tobacco treatment (no entries on tobacco treatment referrals found)
Documenting pharmacotherapy for smoking cessation	75	No charts had a specific location for documenting medication provision (no entries on cessation medication found)
Reminding/prompting providers to ask about tobacco use status	75	No charts had tobacco treatment reminders such as stickers, checklists, or flow charts

recording whether tobacco treatment was offered or to record outcomes of tobacco treatment.

We also reviewed all charts for any mention of tobacco or tobacco treatment in any location of the record (not shown). Although most directors and staff reported they provided some form of tobacco treatment, if only to clients who requested it, very few charts indicated tobacco was addressed at all during the course of treatment. In the 30 days prior to the site visit, only 2% of charts indicating that the client was a smoker had any entry related to tobacco, other than recording smoking status. Across the entire course of drug treatment (which ranged from less than 1 month to 25 years across charts), only 19% of charts indicating that the client was a smoker had any entries related to tobacco or tobacco treatment.

#### 4. Discussion

Although a number of programs reported they offer counseling, pharmacotherapy, and other key components of evidence-based tobacco treatment, few actually provided any treatment and none did so systematically. Nearly all routinely assessed smoking status, but only one facility assessed interest in quitting. Few reported they encourage unmotivated smokers to quit, and some reported they specifically avoided doing so. Many addressed tobacco as part of a drug education or as part of a health promotion session. Some staff and clients noted that treatment was provided through referrals. In most cases, staff referred clients to their doctor for pharmacotherapy and to various programs, such as quitlines, community programs, and primary care, for counseling services. According to many reports, clients had to specifically request treatment in order for staff to provide it. Half of directors reported that staff were expected to deliver treatment as a part of their day-to-day responsibilities. None of the facilities had designated tobacco treatment staff. Within several facilities, staff and clients denied that treatment ever occurred even though directors reported services were available.

The intensity and duration of counseling varied from one 10-minute session, to two sessions, to “6 months,” which suggests that most facilities did not meet the minimum

standard of four sessions (Fiore, 2008). Interestingly, several staff reported using tobacco as a didactic tool for the treatment of other drugs of addiction. No dedicated funding stream for treating tobacco existed, and no facility used any form of office systems to ensure routine implementation of tobacco assessment or treatment. Although nearly half of facilities had no quality monitoring or improvement in place, some reported they discussed tobacco treatment during their staff supervision meetings.

Although pharmacotherapy is recommended in the treatment of all smokers unless contraindicated (Fiore, 2008), pharmacotherapy was not routinely encouraged, and nicotine patches and gum were available in only one facility. Review of client charts suggests that provision of tobacco treatment is rare, even though in the charts reviewed, 56% of clients smoked.

In the facilities we visited, formal guidelines and expectations for treating tobacco from leadership appeared to differ from employee-driven norms and practices. We identified discrepancies between directors, staff, and client reports and chart documentation within the same facilities. This echoes discrepancies between client and staff reports of tobacco treatment provided in methadone facilities reported by Olsen, Alford, Horton, and Saitz (2005) and illustrates the differences between the formal and informal norms of organizations. Formal dimensions consist of the official guidelines or policies of the organization, whereas informal dimensions are the employee-generated norms that may not correspond and may conflict with written guidelines (Ferrante, 2006). Both influence behaviors observed within the organization.

Our findings confirm and augment the findings of other studies. Richter et al. (2004) and Walsh et al. (2005) found that even in facilities that report providing tobacco services, few clients actually received treatment (Richter et al., 2004; Walsh et al., 2005). However, Walsh et al. also reported that the decision to treat a clients' tobacco dependence was left to the clinical judgment of individual staff members. In our interviews, staff left the decision to the clients. According to most staff, tobacco was addressed only if clients brought it up; clients had to ask for or even insist on tobacco treatment before it was provided.

Interestingly, the most common form of tobacco treatment seemed to be drug education or health/wellness groups. Tobacco treatment was often referred to as “education about the harmful effects of tobacco.” Education may have been offered as a way to motivate smokers to want to quit. Unfortunately, there is no evidence that purely informational approaches are effective in increasing motivation or helping smokers quit, or even more broadly that drug education is effective in treating drug dependence (Fiore, 2008; Miller, Sorensen, Selzer, & Brigham, 2006).

Systems to facilitate consistent, evidence-based tobacco treatment and to implement quality improvement were nonexistent in our sites. This is not surprising as the entire U.S. drug treatment system, which is in fact a patchwork of private and for-profit facilities operating under an even more patchwork regulatory system, is plagued by inconsistent application of evidence-based treatment (Lamb, Greenlick, & McCarty, 1998). Hence, it is important to find measures that can track adoption of tobacco treatment systems and quality improvement in order to evaluate whether national efforts to create a more evidence-based drug treatment system are in fact working.

These data are limited in that they rely on self-reports from a nonrandom sample of directors, staff, and clients at substance abuse treatment facilities in one Midwestern city. Only eight facilities were included, which undoubtedly limits the generalizability to all drug treatment facilities. We did attempt to include in our sample a broad range of facilities, including some that provide tobacco treatment. On close inspection, however, very little was being done in any of the facilities. Hence, this study must be viewed as an in-depth look at tobacco treatment in a region that does not have a mandate or resources to treat tobacco in the context of drug treatment. The study may be difficult to replicate because qualitative data are very much a result of the skills of interviewers; although the study staff used the same question guide, the ability to identify and explore novel participant reports (the entire focus of our interviews) may differ from one research team to the next. Not enough charts were sampled to provide reliable estimates of the prevalence of tobacco treatment in participating facilities.

In terms of strengths, the coupling of both quantitative and qualitative data gives a more complete picture of the tobacco treatment process in participating facilities. Facilities included a range of treatment approaches. Differing levels of personnel along with clients were interviewed to obtain a variety of perspectives of tobacco treatment provided during drug treatment.

It is heartening to note that with the exception of one staff member who pointedly placed his cigarette pack on his desk during his interview, none of the participating directors, staff, or clients questioned the value of providing tobacco treatment as a part of drug treatment. It appears that, at least in this Midwestern city, the field has moved beyond challenging whether it is a good idea to provide treatment.

Because this was a purposeful sample in one Midwestern city, the findings from this study do not reflect the distribution of how tobacco treatment is provided in all facilities. However, the findings may be useful in helping treatment professionals recognize similar discrepancies between guidelines and practice within their own facilities. Drug treatment facilities with these types of treatment gaps must build capacity in several domains in order to deliver care that is consistent with national guidelines. They should incorporate an assessment of interest in quitting into their intake procedures. This could include training in brief advice to quit smoking. Many facilities have received training in motivational counseling applied to other drugs of abuse; it might be relatively easy to help programs routinely implement motivational counseling to increase clients' readiness to quit smoking cigarettes. Included in this training could be an agenda-setting protocol to help clients prioritize their health concerns and decide how they want to sequence their efforts to address each. Counselors need training in how to treat tobacco dependence and especially in helping clients select cessation medications. Change here might be led by states, which often license providers and contract with them for services and who are in a position to encourage or require that facilities receive training and adopt innovations in treatment. Importantly, facilities and drug treatment purchasers must develop procedures for obtaining prescriptions for smokers and identify resources to help smokers obtain medications. Some facilities may opt to refer clients to other sites for tobacco treatment, but this relies on a capacity to provide intensive counseling and pharmacotherapy, which have been found effective in clinical trials to treat tobacco dependence that does not exist in many communities. Some facilities refer to state quitlines, but there have been no published studies exploring the effectiveness of quitlines in treating smokers in substance abuse treatment (Morris, 2010). There have been a handful of abstracts that suggest that quitlines can significantly intervene with this population, but more research needs to be conducted (Morris, 2010).

In the short term, facilities could help clients apply for and obtain medications through pharmaceutical company free and reduced drug programs. This type of program is widely used in safety net health clinics and could readily be adopted by drug treatment programs. Hopefully, more resources for medications and counseling will become available in the United States with the advent of health care reform. For example, the U.S. Secretary of Health and Human Services recently announced that treating tobacco dependence is part of a new strategic initiative for HHS systems (Prevent and Reduce Tobacco Use). This might auger more systematic provision of cessation assistance through Medicaid and that facilities should be encouraged to become Medicaid-eligible providers.

The findings also have implications for future research, especially our goal of developing brief and sensitive measures of tobacco treatment in drug treatment. The information provided from in-depth interviews helped

identify a number of issues that are important to measure and promote tobacco treatment in drug treatment. In general, facilities are doing very little. Hence, any measure of tobacco treatment in drug treatment facilities must be sensitive to low rates of treatment delivery. In addition, directors tended to report that services are available even when no clients actually receive these services or at least no services had been documented in the clients' treatment record. Therefore, it is important to devise a method to elicit self-reports that are based on the actual number of clients who have received tobacco services. All respondents agreed that tobacco was dependence forming and harmful; therefore, attitudes toward the health effects of tobacco may not account for much variance in treatment implementation. Most facilities reported providing some form of tobacco education in drug education; hence, a scale might assess this type of treatment provision and explore whether it is a marker of willingness to provide tobacco treatment or as a displacement of effort better focused on behavioral counseling and pharmacotherapy. When treatment happens, it is often informal and/or opportunistic. This suggests that it might be important to differentiate between opportunistic treatment (e.g., "when a client brings it up") and systematic, routine treatment. It will be important to study additional samples of substance abuse facilities in other parts of the United States, such as places that have policies in place requiring drug treatment facilities to treat tobacco dependence, to see how the results differ. Future studies should ascertain how widely held these practices are and what contributes to a more systematic method of tobacco treatment.

Little to date has been reported regarding how tobacco services are integrated into the workflow of drug treatment facilities. Consequently, we have not been in a position to develop effective training or to accurately measure tobacco treatment services currently available. In our small sample of facilities, few provided any evidence-based tobacco treatment, and none did so systematically. This is particularly disturbing because most clients in treatment for substance abuse problems smoke cigarettes and a large proportion of those who continue to smoke will suffer and die from tobacco-related illnesses.

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