# Culture in Evaluation #8:
## Substance Abuse Facilities

**TCEC**
**Tobacco Control Evaluation Center**

*With the realization that substance abuse and smoking dependency are interrelated, the substance abuse population has become a priority for eliminating tobacco-related health disparities (Fagan et al. 2004). Many substance abuse programs do not, however, integrate treatment of nicotine dependence among this population. Historically, smoking has been viewed as an entirely separate issue than alcohol or drug abuse and therefore treatment programs would not implement any type of cessation treatment concerning tobacco use (Bobo et al., 1995). On the contrary, individuals have often times been dissuaded from attempting to quit smoking while in a substance abuse program out of concern it might be too difficult and compromise sobriety (Prochaska et al., 2004). Research indicates that concurrent treatment for tobacco and other substances is effective, and combining treatments has been found the most useful and successful way to treat concurrent addictions (U.S. Department of Health and Human Services, 2007). Because of the "synergistic" benefit of integrating smoking cessation into substance abuse treatment (Baca & Yahne, 2009), some treatment providers are supportive of integrating the two (Fuller et al., 2007). As tobacco control programs begin targeting substance abuse facilities, questions of how to conduct tobacco control intervention and evaluation activities in this environment become increasingly important.*

## Tobacco Use Among Substance Abusers

To understand the importance of targeting the substance abuse population with tobacco control programs, a look at tobacco dependency among this population is instructive. Drug and alcohol abusers have an extremely high rate of nicotine dependence (Richter et al., 2002; Bien & Burge, 1990). Although the rate of smokers in the US general population is 21% (CDC, 2009), rates of smoking for those in alcohol or substance abuse

treatment range from 80% to 98% (Baca & Yahne, 2009). Substance abusers tend to have started smoking at a younger age and progress quickly to nicotine dependency (Hayford et al., 1999; Hays et al., 1999). Moreover, they are also more likely to be heavy smokers and experience greater difficulty with quitting (Richter et al., 2002).

## Risk and Vulnerability of Substance Abuse Population

Some populations are particularly affected by substance abuse; the following table shows that Native Americans and persons reporting mixed race have a particularly high incidence of drug abuse:

| Demographics of Substance Abuse and Dependence Population | |
|---|---|
| Demographic Group | Substance Abuse Rate Per US Population |
| Persons Aged 12 or Older | 9.0% |
| Males | 12.5% |
| Females | 5.7% |
| White | 9.4% |
| Black | 8.5% |
| Hispanic | 8.3% |
| American Indian | 13.4% |
| Native Hawaiians or Pacific Islanders | 9.9% |
| Persons Reporting Two or More Races | 10.8% |

Source: National Survey on Drug Abuse and Health, 2007.

In 2007, the National Survey on Drug Abuse and Health reports that 3.9 million persons aged 12 or older received some kind of treatment for a problem related

to the use of alcohol or illicit drugs. Of these, 2.2 million persons received treatment at a self-help group, and 1.7 million received treatment at a rehabilitation facility as an outpatient.

While drug use carries high risks, the risks of using tobacco are much more pronounced. In the United States, tobacco is responsible for approximately 438,000 deaths annually (CDC, 2008). In comparison, alcohol and illicit drug use are responsible for 75,766 (CDC, 2004) and 20,950 (CDC, 2007) premature deaths, respectively. Such numbers document that tobacco use is not only the most harmful and deadly substance, it is also a great risk to alcohol and illicit substance abusers. As Baca and Yahne (2008:205) write, [m]ore deaths are caused each year by tobacco use than by all deaths from HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined."

## Tobacco Cessation Treatments for Those in Substance Abuse Programs and Policy Implications

Treatment for tobacco dependence is still rare for those who are patients in substance abuse programs (Baca & Yahne, 2009). Much of this can be attributed to limited patient and staff tobacco treatment knowledge as well as limited tobacco treatment resources (Asher et al., 2003). Baca and Yahne (2009) note the ambivalence of providers regarding smoking cessation, reflecting a fear among the recovery community that quitting smoking might jeopardize a patient's substance abuse treatment. Some providers may even rely on cigarettes to help stabilize patients' moods (Richter, 2006).

It is important to know that much like the US general population (Hyland et al., 2004), smokers both recognize the harmful effects of smoking (Clemney et al., 1997) and desire to quit (Hughes, 2002). Studies show that substance abuse patients also have a willingness to be treated for smoking dependence along with their other drug and alcohol abuse (Bobo et al., 1996; Frosch et al., 1998; Richter et al., 2001; Seidner et al., 1996). Finally, there is considerable research documenting the immediate and long term health benefits of smoking cessation among substance abuse patients (Baca & Yahne, 2009; White, 2007).

Concurrent treatment for tobacco and other substances has been found to be effective, and research demonstrates that treating patients concurrently is the most successful way to treat multiple addictions (U.S. Department of Health and Human Services, 2007). Further, studies show that smoking cessation treatment—in conjunction with alcohol and drug abuse treatment—does not jeopardize recovery goals (Burling et al., 1991; Burling et al., 2001; Reid et al., 2007), and smoking cessation has even been found to improve substance abuse treatment outcomes (Friend & Pagano, 2005). For instance, Lemon, Friedmann, and Stein (2003) found that a correlation existed between tobacco cessation and abstinence from drug use. They asserted that a concurrent smoking cessation plan may benefit patients in their treatment for illicit drug use. Other studies have found similar correlations between tobacco cessation and drug use, including methadone maintenance (Frosch et al., 2000), as well as opiates and cocaine (Shoptaw et al., 2002). Baca and Yahne (2009) thus argue that tobacco cessation should always be offered to substance abuse patients who smoke.

As part of the smoking cessation treatment, education and training of staff is essential because of the role staff play in treatment, as their beliefs, habits and considerations tend to extend to the patients (Zullino et al., 2000). Counselors who do not smoke are more likely to address the smoking issue, while alternately, counselors who do smoke are less likely to address smoking with their patients (Bobo et al., 1995).

## Policy Enactment

Policy changes have been enacted in the US to include tobacco treatment for substance abuse patients (Baca & Yahne, 2009). In fact, health care professionals working with Medicare and Medicaid now have guidelines to address smoking dependence among their drug abuse patients (Fiore, Bailey, & Cohen, 2000). Much of the policy, however, begins at the local level, including at the facilities themselves.

Policy changes at the local treatment center level are important to better move in the direction of smoking cessation at drug abuse facilities. Ziedonis et al. (2006) recommend enacting policies to restrict staff smoking

with the substance abuse patients.  Smoking staff members have been found to be common in treatment centers (Hahn, Warnick, & Plemmons, 1999), and researchers advocate that staff should be persuaded to be good role models and abstain from smoking with patients, whether in designated off-building smoke areas or not.  Counselors smoking with patients only help to reinforce the perception that tobacco use is not a substance abuse issue.  Moreover, designated smoke areas not only create a situation where counselors and patients smoke together, but it also serves to reinforce the perception that tobacco is not a concern in the treatment of patients.  Baca and Yahne (2009) thus argue that treatment centers should set a goal to have 100% cessation by staff members, reflecting the value and importance of smoking cessation in general.  Baca and Yahne (2009) suggest that cessation treatment for staff not only helps the individual staff members, but also strengthens the program as a whole.

In addition, Baca and Yahne (2009) note the importance of smoking cessation programs and recommend that these always be offered to both patients and staff.  Patients should be encouraged to quit smoking, whether it be concurrent or subsequent to substance abuse treatment.

In terms of policy, staff training is critical.  Smoking cessation programs require staff training before the implementation of programs (Hoffman & Slade, 1993).  Further, smoking cessation programs are most effective when staff is trained and supportive of the program that integrates it as part of chemical dependency treatment (Campbell, Krumenacker, & Stark, 1998).

## Planning Your Evaluation: *Getting to Know the Community*

Before evaluating a tobacco control program connected to a substance abuse facility, it is important to get to know the major players of the facility (i.e. board members, executives, administrators, and counselors).  They will be important in helping you to gain access to the substance abuse facility and may provide valuable insight into the functioning of the program. Initial key informant interviews with this personnel will help you:

- Learn the routines of the treatment community—when the clinics open and close, when

people get off work, and so on.

- How treatment is conducted and how and when group work is facilitated.

- What the smoking behavior is among staff and patients and what the smoking or non-smoking rules are in and around the facility.

- Gain trust of the treatment community—because of the perception of outsiders, particularly those from community organizations, evaluators need to gain the trust of the key operatives from the treatment center(s).  Evaluators should expect skepticism and mistrust.

- Minimize the fears the treatment community may have about you as an outsider by building a relationship with them as trustworthy, caring person.  This will take time.  As you become known to the people, they will be more likely to trust you and participate in your tobacco control evaluation activities.

## Promoting Participation in your Evaluation Activities

The key to promoting participation in evaluation is to work with facility personnel. In particular:

- Select times that are convenient for the staff at the facility.  Take their many obligations into consideration while scheduling your evaluation activities.

- Make staff and patients feel valued.  Convey appreciation for them assisting you.  Explain to them why their participation is necessary.

- Provide incentives for participation—a gift card from a local business, cash, or something useful the staff and patients.

- In some instances, for instance when a focus group is scheduled, serve refreshments.  Food symbolizes hospitality and conveys to participants that you value their time.  It can also function as an "icebreaker" during evaluation activities or meetings.

- Ask people who give you a contact if you can mention them as the source of the information.  Confidentiality is vital in conducting research with this population (Brody and Waldron, 2000),

and maintaining their confidentiality shows your respect for them.

- Frame the evaluation in terms of protecting staff and helping patients. Treatment staff and personnel have become increasingly aware of tobacco's harmful impact on both staff and patients and many have become vocal supporters of smoke-free workplace policies in order to protect the workers from the danger of secondhand smoke.

## Creating/Adapting Data Collection Instruments for Evaluation

The most likely sources of information for a tobacco control project are administrators, staff, and patients. It is therefore important to keep in mind who the audience is when developing a data collection instrument and to tailor questions to the appropriate population group. The most challenging group to address is the patients, since their personal backgrounds, literacy levels, and cultural understandings may differ greatly. Many of those seeking treatment for substance abuse may have learning disabilities, low levels of education, mental health issues, or a history of head injuries (Kessler et al., 1994), which may lead to issues related to patients properly reading, understanding and responding accurately to a survey or interview instrument.

- Figure out which data collection methods will work best to gather the type of information you need. For instance: does it make sense to talk to patients individually or is a focus group more feasible since group activities may already be part of the treatment approach.
- Take the literacy levels, education and language of respondents into consideration when designing the format and type of data collection, and when writing survey and interview questions.
- Always pretest data collection instruments with members of the treatment community (who are not already in your planned sample). Ask if the wording of the questions makes sense and if they would recommend changes to questions.

- Make sure to report the results of the evaluation back to communities who participated through a variety of methods such as community debriefing meetings, public service announcements in local media, articles in area, or work-related newsletters.

## Collection Data

Data collection methods will depend on the type of objectives that have been identified. Most likely, objectives will fall into categories related to a) the adoption of smoke-free policies on facility grounds, b) cessation services provided to patients, and c) staff training in tobacco cessation treatment. With these in mind, a variety of evaluation activities may be conducted.

In evaluating the adoption of a smoking-ban policy, it would be recommended to conduct observations at both the pre- and post-adoption stage. Observations would need to be unobtrusive, and we encourage you to recruit facility staff to assist you. Key informant interviews of facility leadership and staff may be beneficial to evaluate smoking-ban policies. Interviews of patients may also be carried out to better understand a program policy or cessation treatment services' effectiveness.

Additionally, a survey of patients may be administered to better analyze the effectiveness of a treatment program's policies. The survey could be tacked onto the patient intake survey, or else carried out separately. Surveys, both pre- and post-adoption, may be useful if cessation services are implemented as well. Similarly, if the objective relates to staff training, a staff satisfaction survey should be administered.

Tobacco cessation is often highly variable with periods of abstinence and relapse. In order to distinguish changes in tobacco use that is directly related to treatment or policy, assessment of extended periods—waves—of baseline and follow-up use is crucial for a high level evaluation. Information could first be gathered from patients via their initial intake interviews conducted by treatment officials. Follow-up surveys may be conducted on a consistent basis thereafter.

In conducting an assessment of the substance abuse population, confidentiality is crucial and essential.

Patients may be concerned regarding the loss of their privacy and confidentiality due to the fact that a breach could result in damage to reputation, personal relationships, loss of employment or criminal prosecution.  As such, it is highly recommended that evaluators use an informed consent form in working with patients.  The form should outline the methods in place to ensure patients' confidentiality and privacy.  Moreover, patients must have the right to choose whether to participate or not.  Voluntariness of consent to research is a basic tenet of ethical research standards (Brody & Waldron, 2000).  Finally, it is typically expected by law that minors require parental permission in order to give consent to a study (Alderson & Morrow, 2004).

## Collecting Data: *Types of Evaluation Based on your Objectives*

To meet the various tobacco policy and cessation program-related objectives, evaluation of substance abuse facilities and substance abusers would invariably require surveys, observations and/or key informant interviews.  Along these lines, data would need to be collected from either substance abuse treatment leadership, staff or patients.  Therefore, we've distinguished data collection recommendations based on these groups and the types of methods that would most likely be used for each.

## Treatment Facility Leadership: *Key Informant Interviews*

Conducting interviews of key leaders may be the most effective way of gathering vital information regarding almost all aspects of a facility's treatment programs, policies, staff and patients.  This method requires the evaluator to develop and maintain contacts with key leaders and build trusting relationships, while simultaneously learning the language, behavior, norms, beliefs and attitudes of the population studied (Denzin, 2002).  Key informant interviews of treatment facility leaders should thus glean valuable information prior to, and after tobacco policies and cessation programs have been adopted.

- Obtain a buy-in from key facility leaders regarding the value of the evaluation process

and the importance of the type of evaluation you intend to carry out.

- Try to convince the leadership that tagging survey questions onto the patients' intake survey would be beneficial to them and to your objectives.

- Plan to combine education interventions with your key informant interviews to minimize contact frequency.

- In almost all cases we would recommend both a pre- and post-adoption interview of these leaders.  For the post-adoption interview, find out what was effective and what wasn't; the challenges and barriers they faced in implementing policies; and what could be learned about concurrent treatment based on their experiences.

## Staff: *Key Informant Interview; Focus Groups; Training Satisfaction Survey*

Obtaining information from staff may be culled from a number of methods.  Similar to treatment facility leaders, key informant interviews conducted both pre- and post-policy adoption would be beneficial in gleaning a wide array of information regarding many aspects of the substance abuse treatment program's policies, as well as the staff's overall level of support and so on.  Focus groups of staff members may also be carried out in an effort to ascertain myriad data pertaining to the program, staff, and patients.  Finally, because staff training will be an essential component to adopting and implementing concurrent tobacco cessation programs, a staff training satisfaction survey will also need to be administered.

- Try to obtain staff support in your evaluation activity.  For instance, perhaps they could assist with both pre- and post-adoption observations.

- If staff training is part of the process evaluation, a staff satisfaction survey should be given to assess its effectiveness.

- Avoid asking direct or penetrating questions.  Word things in a way that gets at informa-

tion using the third person or a situational context (e.g., "Other facilities have become smoke-free and noted how much healthier the staff seemed. Did you find this true at this facility?").

- In conducting interviews or focus groups, consider asking the same question in more than one way and providing necessary context for difficult phrases in order to help clarify the intended meaning.

- Ensure you're getting the real story by asking the person/group the same question in several ways during the interview or focus group. Gather data from more than one person.

## Patients: *Intake and Cessation Surveys; Observations; Interviews*

Evaluation of tobacco policy objectives such as smoke-free facilities or outdoor areas and cessation may include patient surveys Policy objectives may also include observations. In each of these cases, it is necessary to carry out both pre- and post-policy adoption assessments if policy implementation is the goal. Survey questions may be tacked onto the intake survey that facilities are required to do. If this is not possible, then there is the potential to conduct a separate survey of patients, and examples of reliable tobacco-related testing instruments can be found on the Tobacco Control Evaluation Center website. During observations of the facility grounds and patient smoking it is crucial to be unobtrusive. Moreover, it may be beneficial to recruit staff members to carry out observations.

While surveys and observations may seem like a natural evaluation activity for this population, because of the potential stigma faced by patients in substance abuse treatment (Carroll, 1995), collecting reliable and valid information may be a bit difficult. As mentioned above, a focus group may be a feasible and useful way of gathering information on policy related questions. Researchers have noted that most individuals involved in drug and alcohol abuse and seeking treatment are open about their drug use and drug lifestyle (Schreiber, 1992). In general data collection activities should consider the following:

- Make sure the wording, images and directions are appropriate and clear, and that all language or images have only one meaning to the patients.

- Pay attention to the context of what is being communicated. Look to non-verbal cues to inform you as much as the words being spoken. You will need to rely on your homework about each culture to pick up on cultural specificities.

- Accept what an individual cannot say about a person or situation and don't press for more information directly.

- It is important to note that most individuals with substance abuse disorders never will be treated formally (Kessler et al., 1994). It is therefore critical to recognize that findings will be based on the small minority of abusers who seek treatment and the findings do not necessarily extend to all drug abusers.

- Observations of patient and staff behavior need to be unobtrusive.

- Invite patients to tell you their stories about the topic (e.g. their smoking behavior and cessation efforts, their life histories as it relates to the subject, etc.). Substance abusers have been found to be responsive to questions regarding their past drug usage (Schreiber, 1992).

- Treat an interview or focus group like a conversation. Ask insightful questions and be a good listener, just like if you were having a conversation with someone new and were interested in them. It is also important to recognize that substance abusers often have related issues such as learning disabilities, low levels of education, mental health disorders, or a history of head injuries (Kessler et al., 1994). It is therefore important that the patients can understand and accurately respond to interview questions.

Other general suggestions to consider:

- Be humble about entering a treatment community. Let your attitude demonstrate that you are there because you want to learn from them.

- Address staff by their names and titles (e.g. Mr. Lutz or Dr. Jones). Find out what the patients

want to be called (i.e. by their first name, or as Mrs. Smith, etc.).  Speak in respectful tones and avoid being brash.

• Assessment should occur in waves.  If possible, obtain adequate baseline and follow-up measures.

• Make sure to include an adequate sample size.

• For focus group discussions, decide in coordination what community space is accessible, non-threatening and comfortable for participants.

• Don't try and use street talk or slang.

• Review surveys, questionnaires, and interviews with community researchers to ensure that questions are understandable, respectful and effectively "get at" the evaluation objectives. Rely on the community researchers' expertise in regard to community participants' literacy skills and understanding and comfort with the interview process.

• Make sure you follow up questions with probes. Ask, how?  Why?  Additionally, ask the respondent to elaborate and clarify answers.

• Collect demographic information about youth in the community in order to identify the characteristics of who you are dealing with. Knowing the various subgroups (e.g., LGBT, ethnic groups, Goths vs. jocks, etc.) may give you clues about how to access them or where to look for key informants who serve them.

• Start with county statistics to get information about the size and demographic make-up of the total youth population. Then conduct key informant interviews with teachers or organizations that serve youth. They can help you to determine the various subgroups within the population and ways to gain access to them.

• Facebook can also be used to search for and collect information about populations or locations. Looking into the interests, educations, histories and activities of "friends" can give you clues about the subgroups that exist in your

community and schools (Silbert-Geiger, 2010).

• Once you have identified key youth leaders, conduct interviews or focus groups with them and invite them to participate in your evaluation activities. These leaders will be able to tell you what will and won't work when interacting with young people. Ask them how adults and researchers are likely to be perceived by youth and the best ways to engage them.

• Learn about the cultural norms of the young, such as how they dress, interact and communicate with each other. Also try to find out what the current trends are and what youth are interested in.

• Find out where young people like to hang out, both physically and on the internet. These places can serve as potential spots for recruiting participants. Make a map of important gathering places and mark the locations of youth service providers and schools.

• Learn the routines of youth in the community. What times are they in school? What do they do after school? On the weekends? When do their sports teams practice and play games? When would they most likely be available?

## Conclusion

It is important to note that most individuals with substance abuse disorders never will be treated formally in any type of clinical setting (Kessler et al., 1994).  It is therefore critical to recognize that evaluation findings will be based on the small minority of abusers who seek treatment and the findings do not necessarily extend to all drug abusers.

Further, because this is a relatively new area of tobacco research and evaluation, it is recommended that you disseminate your findings to others in tobacco prevention.  Jurisdictions and municipalities around our state (and beyond) may desire to someday adopt and implement smoke-free and cessation policies related to substance abuse treatment programs.  Hence, sharing this information with those in our field will undoubtedly benefit tobacco prevention efforts.  Finally, to repeat

one of our aforementioned recommendations, make sure you report the results and findings of the evaluation back to the treatment facilities and all those who participated.

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**Suggested Citation:**

Satterlund, Travis D. 2009. "Individuals in Substance Abuse or Recovery." Culture in Evaluation Series. Tobacco Control Evaluation Center, U.C. Davis, 2009. http://www.tobaccoeval.ucdavis.edu