# Final Executive Summary: An Evaluation of the Perinatal Tobacco Cessation Efforts in Massachusetts

Prepared by Tufts Interdisciplinary Evaluation Research (TIER) for the Massachusetts Tobacco Cessation and Prevention Program (MTCP) of the Massachusetts Department of Public Health (MDPH)

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## Background

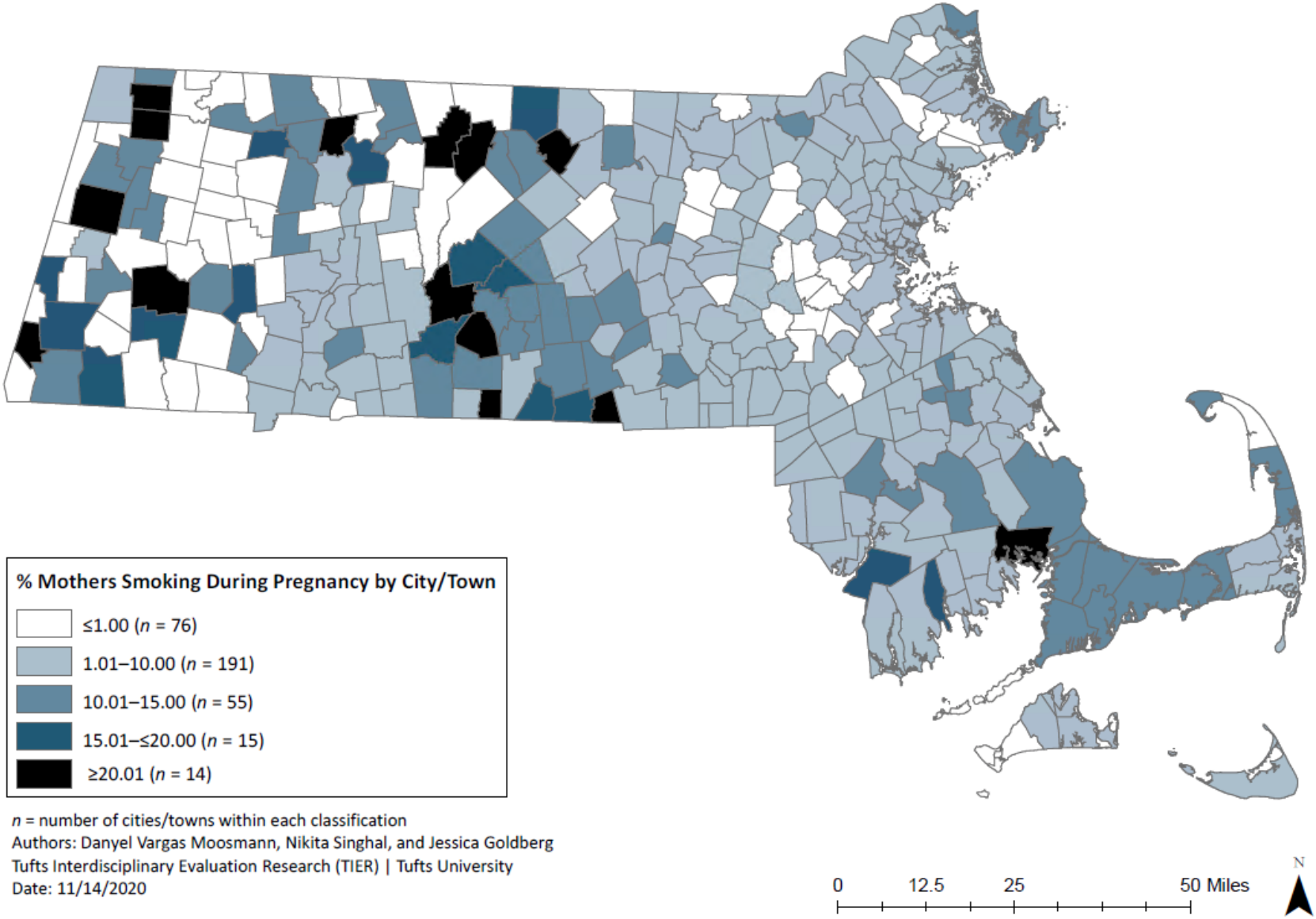
According to 2018 data from the Pregnancy Risk Assessment Surveillance System (PRAMS), 17.7% of women nationwide reported cigarette smoking during the three months before pregnancy, 8.1% during the last three months of pregnancy, and 11.7% postpartum. Women living in Massachusetts used tobacco at lower rates—13% reported smoking cigarettes during the three months before pregnancy, 4.7% during the last three months of pregnancy, and 8.3% during the postpartum period.[1] According to 2017 Massachusetts electronic birth certificate data, White Non-Hispanic mothers were the most likely to report having smoked during pregnancy (6.4%), followed by Hispanic mothers of all races (3.5%) and Black Non-Hispanic mothers (3.1%), with Asian Non-Hispanic mothers reporting the lowest rates (0.9%).[2,a] Geographically, the three municipalities in Massachusetts with the highest rates of smoking during pregnancy were North Adams (33.28%), Orange (30.52%), and Adams (26.58%).[3] See Figure 1 on the following page for a heatmap of the percent of mothers who reported smoking during pregnancy by Massachusetts city or town.

In a recent study of smoking and drug use in a prenatal population, researchers found that women who smoke cigarettes were over four times more likely to have co-occurring substance use; half of current smokers also used cannabis, and almost two thirds used some other type of illicit drug.[4] Smoking among perinatal individuals who also are using other drugs is of particular concern because of the potential additive risks of adverse fetal outcomes. Among smoking cessation programs available in Massachusetts, only QuitLine—The Massachusetts Smokers' Helpline—includes a tailored component for pregnant individuals who smoke, and only Clinical Effort Against Secondhand Smoke Exposure has developed a unique framework to address tobacco cessation among parenting families.

While the Massachusetts Tobacco Cessation and Prevention program (MTCP) has made great strides in addressing tobacco use through programs such as QuitLine, engagement of the prenatal population has been less robust than expected. For instance, data shared with our team by MTCP showed that only a fraction of the individuals who accessed QuitLine identified as pregnant,[b] suggesting that this program may not be reaching its intended population. In 2020, the MTCP team contracted with TIER to gain a better understanding of how they might be able to better tailor their tobacco[c] cessation efforts to meet the unique needs of pregnant and parenting people in Massachusetts, with the goal of promoting quit success. MTCP was particularly interested in understanding the intersections among tobacco use, substance use, and other behavioral health issues in this population.

[a] Data on Native Americans were not available.
[b] Based on unofficial data shared by MTCP with TIER; we do not report actual numbers because these data were preliminary and only used to explore trends.
[c] Throughout the report, tobacco refers to both tobacco and nicotine products.

***Figure 1. Percent of Mothers Reporting Smoking During Pregnancy Out of All Live Births in Massachusetts from 2012–2016 by City or Town[5]***



## Current Evaluation

The aims of this evaluation were to learn about:

- The prevalence of tobacco use among pregnant and parenting populations in Massachusetts
- Substance use treatment and family support provider preparedness to support tobacco cessation efforts among pregnant and parenting clients, and providers' current practices related to working with clients who use tobacco
- Factors related to tobacco reduction or cessation among substance use treatment and family support program clients

We employed the following mixed methods evaluation activities:

- Literature review synthesizing findings from studies focused on the current state of tobacco use among pregnant and parenting individuals highlighting population- and individual-level interventions employed to address tobacco use, as well as contextual factors that may influence quit success
- Compendium of tobacco treatment programs in Massachusetts
- Heatmap of percent of mothers reporting smoking during pregnancy by Massachusetts city or town
- Focus groups and one-on-one interviews with 20 community stakeholders[d]
- Survey of 157 substance use treatment providers and 277 family support providers on how they approach tobacco use with their pregnant and parenting clients

For focus groups and interview data, we conducted a thematic analysis of the major categories of discussion across interview and focus group transcripts using NVivo 12,[6] looking for themes that informed the goals of the study and contextualized data collected through quantitative methods. For survey data, we conducted descriptive, bivariate, and multivariate analyses in SPSS 26[7] and Stata 17.[8]

### Sample Characteristics

#### *Interviews and Focus Group Samples*

Twenty stakeholders from multiple regions of Massachusetts participated in one-to-one interviews or focus groups, including one parent, 12 family support providers, and seven individuals who either provide direct services in or oversee BSAS-licensed substance use treatment programs.

#### *Survey Samples[e]*

Four hundred thirty-four individuals across Massachusetts completed the survey; 157 providers from BSAS-licensed treatment centers and 277 providers from family support programs.

[d] Our original evaluation had included 10 focus groups with pregnant or parenting individuals, but due to COVID-19 and appertaining recruitment difficulties, we shifted our focus entirely to collect data from substance use treatment providers and family support providers through focus groups, interviews, and surveys.

[e] We removed survey respondents from the analytic sample that did not complete more than 20% of the survey; nine respondents were removed from the substance use treatment provider sample and seven were removed from the family support provider sample.

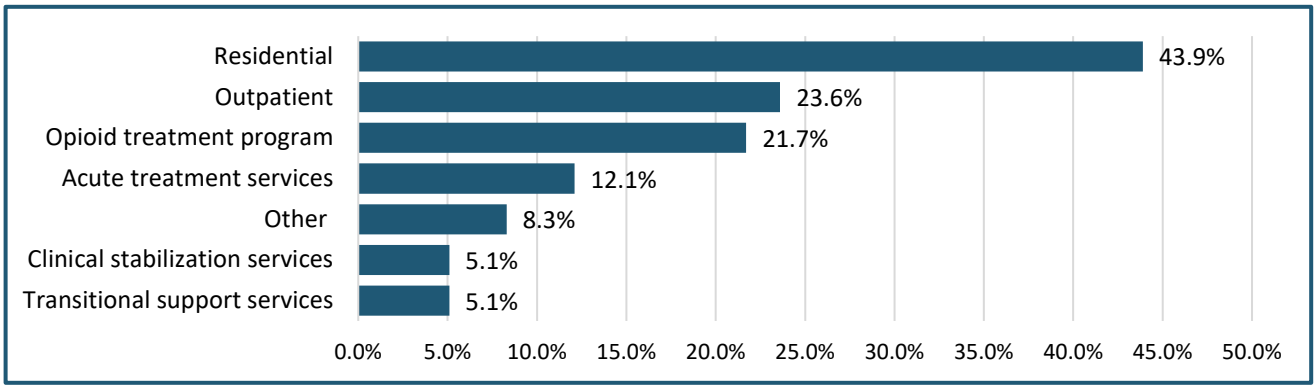
### *Substance Use Treatment Providers: Program Type and Roles*

Nearly two-thirds of substance use treatment providers (63.1%) were frontline staff, 28.7% were clinical or program directors, and 8.3% had "other" roles. Ninety-two percent of substance use treatment providers worked directly with clients, and 21.6% served as Tobacco Education Coordinators in their programs.

**Tobacco Education Coordinators (TECs):** TECs are a requirement of all BSAS-licensed treatment programs and serve as a resource to staff and clients regarding tobacco or nicotine education and treatment. They are trained by the Institute of Health and Recovery's (IHR's) Tobacco, Addictions, Policy and Education (TAPE) Project. The TAPE Project offers consultation and training to programs funded by MDPH's BSAS on nicotine addiction and its impact on overall health and recovery from substance use, as well as cessation programs.

As shown in Figure 2, substance use treatment providers represented a mix of centers, with providers from residential, outpatient, and opioid treatment programs representing the largest proportion of treatment center types.

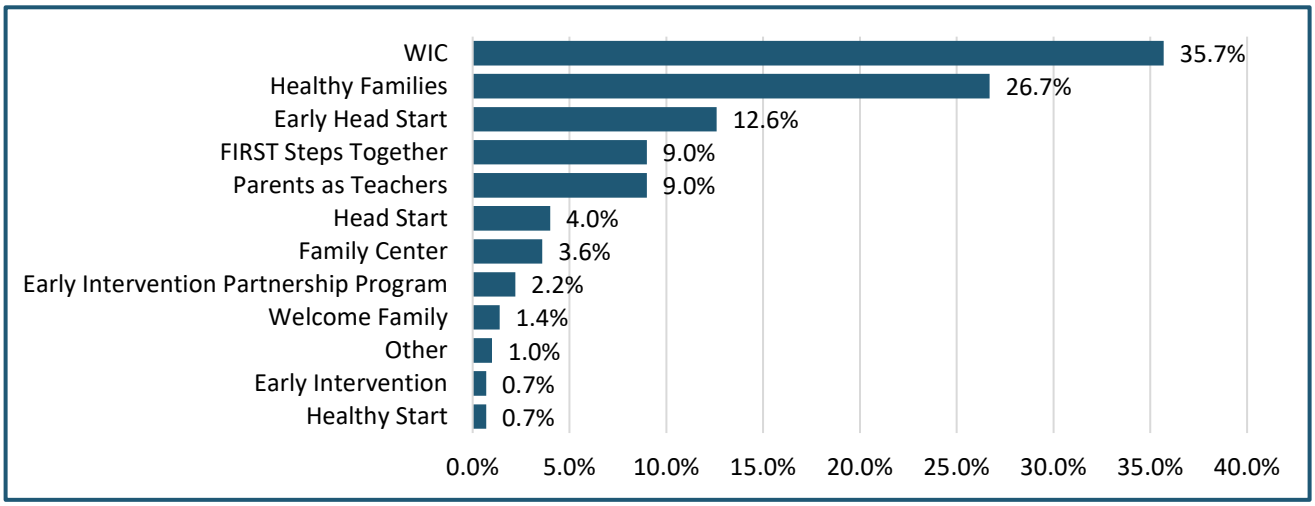
***Figure 2. Distribution of Providers Across Substance Use Treatment Programs (n = 157)***




### *Family Support Providers: Program and Roles*

Nearly three-quarters of family support providers (72.5%) worked directly with clients, slightly more than one-fifth (22.0%) were directors or supervisors who did not work directly with clients, and 5.8% had "other" roles. As shown in Figure 3, family support providers represented a mix of models, with providers from Women, Infants, and Children Nutrition Program (WIC), Healthy Families Massachusetts (HFM), and Early Head Start (EHS) representing the largest proportion of programs.

***Figure 3. Distribution of Family Support Providers Across Program Models (n = 277)***




### *Race and Ethnicity*

Nearly two-thirds of all providers[f] self-identified as White; with fewer than one-fifth identifying as Hispanic, Latino/a, or Latinx; and around 10% identifying as either multiracial/ethnic[g] or Black/African American.

### *Regions Providers Served*

Providers reported on which regions most of their clients lived. A third of providers worked with clients who lived in the state's Western region, nearly a quarter with clients who live in the Southeast, and almost one fifth worked with clients who lived in the Northeast, Boston, or Central regions. The Metro West region was the least well-represented in the respondent sample.

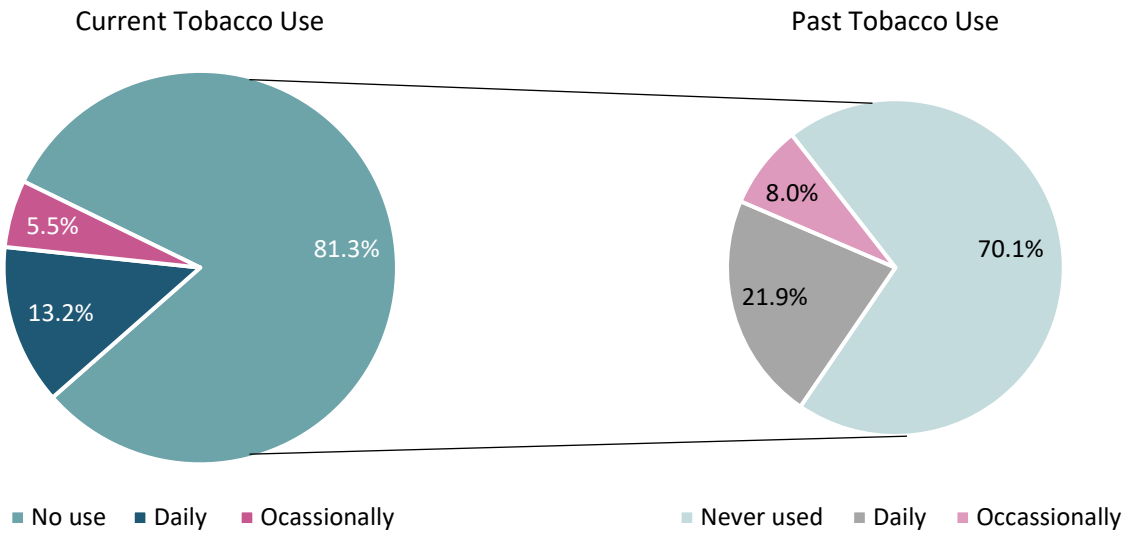
### *Tobacco Use among Providers*

We asked providers about their personal tobacco use. Of those who answered ($n$ = 433), most *did not currently use* tobacco (81.3%). Of the providers who reported *no current use* ($n$ = 352), 70.1% reported *never using* tobacco in the past. Of past users, about three-quarters reported having *used it daily*. See Figure 6. Substance use treatment providers were more likely than family support providers to report that they *currently used* tobacco ($\chi^2$ (2) = 22.96, $p$ < .001), and that they had used *daily* in the past ($\chi^2$ (2) = 24.42, $p$ < .001).

[f]When we use the term "providers" without specificizing provider type we mean all providers across both types.

[g] Multiracial or multiethnic comprises more than one race (e.g., Black or African American & White) or at least one race and one ethnicity (e.g., Black or African American & Hispanic or Latino).

***Figure 4. Tobacco Use Status Among Providers***




## Aim 1—Understand the prevalence[h] of tobacco use among pregnant and parenting clients of substance use treatment and family support programs in Massachusetts

Findings from surveys, focus groups, and interviews suggested that substance use treatment providers and family support providers regularly work with pregnant and parenting clients who use tobacco, reinforcing that this group of providers is well-positioned to address this issue in Massachusetts. Nearly 75% of survey respondents estimated that at least some of their pregnant clients used tobacco and nearly 90% estimated that some of their parenting clients did. Survey and focus group findings corroborated research suggesting strong associations between smoking prevalence and substance use disorder,[9] with substance use treatment providers in our samples being more likely than family support providers in our samples to estimate higher levels of tobacco use among their clients. It should be noted, however, that many of the family support providers we spoke with also mentioned that they were not sure whether their clients used tobacco, because they did not always ask and did not observe clients using tobacco (particularly since the COVID-19 pandemic).

Also consistent with national- and state-level data,[1] cigarettes and e-cigarettes were the most common types of tobacco products used, with focus group participants perceiving a recent increase in the use of e-cigarettes, as vaping is seen among clients as less stigmatized and a healthier option. Providers also talked about the role of marijuana in tobacco use, mentioning that, since its recent legalization, it has become almost as common as cigarettes among some of their families.

## Aim 2—Understand substance use treatment and family support provider preparedness to support tobacco cessation efforts, and how preparedness differs between the two provider types

According to survey findings, only around a third of providers reported that they had received training to deliver an intervention around supporting clients with tobacco cessation, with half being trained to provide *education through formal curriculum or resources* and one third being trained to provide *individual coaching or*

[h]As footnoted in the introduction, we assessed "prevalence" using administrative data from MTCP as well as provider estimations gathered through surveys and focus groups.

*counseling.* Indeed, the top four barriers selected by survey respondents were all either directly or indirectly related to training: *insufficient training*, *unsure where to refer clients*, *not knowing whether client used tobacco*, and *not sure how to bring it up with clients outside of screenings*. Family support providers reported receiving less training than substance use treatment providers.

Among focus group and interview participants, on the other hand, most providers recalled being trained at least once in tobacco cessation approaches. Similar to survey findings, however, substance use treatment providers were more likely than family support providers to say they had been trained. Particularly among those who had received one of the trainings implemented by the Institute for Health and Recovery (IHR), there was a general sense that they had been helpful in educating them about the harmful effects of tobacco and providing them with valuable resources. But there also was a pervasive perception across focus groups and interviews that the training they received had been insufficient; while they valued the resources and education, they expressed a need for more training on *how* to approach clients about smoking.

When responding to the survey, providers indicated it was *extremely important* to have quitting tobacco conversations with their clients, both from their own and their programs' perspectives. Findings from the focus groups and interviews, in contrast, suggest that providers are quite ambivalent about the importance of addressing tobacco with their clients. That is, while they acknowledged its importance *in theory*, they were ambivalent about operationalizing this in practice. Substance use providers tended to focus on the harm reduction model, ranking tobacco low on participants' hierarchy of needs and, therefore, low on their own lists of priorities. Thus, it is possible that survey respondents rated the importance of addressing tobacco from more of a theoretical orientation (e.g., smoking is bad for you so of course it is important to address the subject with clients) rather than considering the question in terms of their own beliefs, attitudes, and day-to-day practice. Relatedly, while less than a quarter of survey respondents selected *beyond the scope of my work* as a barrier, this was one of the most salient themes that emerged during our focus groups and interviews; that addressing tobacco use with clients not only fell outside of their program's scope but in some cases may actually hinder their ability to effectively serve families.

Average scores on provider confidence indicated that respondents were *somewhat confident* in their ability to have conversations about quitting with clients. This finding is more aligned with what emerged from the focus groups and interviews; for the most part, providers felt moderately confident about some aspects of addressing tobacco, noting, for instance, that their ability to build rapport with clients and their knowledge about concrete resources had equipped them to talk with clients about this issue. But focus group participants—particularly family support providers—expressed quite a bit of trepidation about how to broach the topic without stigmatizing or shaming clients. And substance use treatment providers, as forementioned, were not confident that they even *should* be bringing this up with clients—in fact, some felt adamantly that they should not.

Providers who smoked formerly or had never smoked (versus those who smoked currently) were more likely to perceive addressing tobacco with clients as important, but only former smokers (versus never smokers) had higher levels of confidence. Focus group data provided little support for the former finding, but quite a bit for the latter. Former smokers expressed greater comfort with talking to clients about quitting, while current smokers expressed feeling very uneasy, and hypocritical, when addressing client tobacco use.

## Aim 3—Understand substance use treatment and family support provider practices related to working with clients who use tobacco, and how these practices differ between the two provider types

We were interested in learning about the extent to which providers incorporated the 5 A's (Ask, Advise, Assess, Assist, Arrange) into their practice.

**Ask**. Most providers reported that their program required universal screening, with substance use treatment providers being more likely to report this than family support providers. Slightly more than three quarters of providers said they initiate conversations regardless of program screening requirement, yet nearly a fifth of all providers surveyed reported never bringing up tobacco use at all. Family support providers were more likely to initiate conversations about tobacco than substance treatment providers, as were providers who had been trained, perceived the topic as important, or were former smokers themselves. Interestingly, confidence was not related to the likelihood of initiating conversations. Focus group and interview data told a starkly different story, with most providers indicating that they did not ask clients about their tobacco use outside of the required screenings. In fact, when we asked providers to consider what they would do in the hypothetical situation in which there were no program requirements or expectations regarding screening, most responded that they would not bring it up at all. Providers felt strongly that if clients wanted support with quitting, they would ask for this support themselves, as many of them worked in programs where participants determine the goals they would like to work towards and staff support them along the way.

**Advise**. Around half of survey respondents reported that they advised clients about the effects of tobacco on health through pamphlets and discussions. More staff endorsed discussing fetal and child health over client health. Focus group participants mentioned many strategies they have used to advise clients, underscoring that they typically would only offer advice to clients who approached them for support.

**Assess**. Very few of the survey respondents indicated that used the "stage of change" assessment with clients. Almost half reported that they just ask clients if they are ready to quit, and around third assessed client readiness using a scale from 1–10. Substance use treatment providers were more likely than family support providers to indicate that they use all three assessment methods. Focus group and interview data corroborated these findings. Most family support providers indicated that they "just ask", and substance use treatment providers were more likely to mention a specific assessment strategy. Interview and focus group participants stated that while clients were generally not ready to quit, some were more receptive to conversations around reducing the amount that they smoked.

**Assist**. Survey respondents indicated that their most common approach to assisting clients with cessation was to provide self-help materials or information about support service options and approaches, with substance use treatment providers being more likely to endorse this option. The top three services providers referred clients to were: clients' PCP, OBGYN, or clinic/hospital, Massachusetts QuitLine, and their program's in-house counseling/cessation supports and groups; substance use treatment providers were more likely than family support providers to refer clients to medical providers and their programs' in-house cessation services. Focus group participants did not have much experience actively referring clients to services, given how few of their clients indicated readiness to quit. They were, however, very knowledgeable about the services and resources available to clients.

**Arrange**. Slightly more than a third of staff followed-up with clients about a cessation-related referral or scheduling follow-up visits/contacts with clients, with substance use treatment providers being more likely to schedule follow-up visits/contacts with clients.

### Aim 4—Understand factors related to tobacco reduction or cessation among substance use treatment and family support program clients

Survey respondents reported on which tobacco cessation programs or services were most effective for their clients. Unsurprisingly, these aligned with where providers most often referred clients. Slightly more than half of providers selected client's PCP, OBGYN, or a clinic/hospital, with around a quarter of providers selecting Massachusetts' QuitLine, and their program's in-house counseling cessation supports and groups. While this question was not included on the survey, we asked focus group and interview participants to estimate the proportion of their clients who had successfully quit their tobacco use. Across both types of providers, answers ranged from none to "maybe 1 or 2."

When selecting which barriers appear to hinder their clients' quit success the most, the top three endorsed by survey respondents were experiencing mental health challenges or high stress levels, living with someone who smokes, and experiencing economic stressors. Focus group and interview participants, when discussing barriers, highlighted the important role tobacco products seem to play in their clients' lives, including their perceived function as a stress reliever, anxiety reducer, and—for those who are in recovery especially—a substitute for substances they believe to be even worse for them. Providers also noted the ways in which smoking can comprise a core part of clients' social identities—a way to connect with others and ground themselves. Providers also commented on how hard it can be for clients to quit when smoking is embedded into the culture among their family, friends, and communities. Finally, focus group and interview participants identified several factors related to racial inequity as barriers for clients who attempt to quit or reduce tobacco use, including provider bias, lack of access to culturally appropriate materials and services in their own languages, and policies that disproportionately affect the BIPOC community.

Focus group and interview participants also identified factors which they have observed to facilitate their clients' quit success and reduction, including concern about one's physical health or of the child/fetus, having nonjudgmental providers who understand relapse and who embrace a harm reduction approach, monetary incentives, having a strong support system, and removing structural barriers (e.g., providing free access to NRTs and adopting smoke-free policies at treatment centers).

## Recommendations

Findings from this evaluation suggest that Massachusetts providers who work outside medical settings with pregnant and parenting families are not consistently engaging their clients about tobacco use *and* that they are well-positioned to do so through the personalized relationships they have with families. We focus here on two sets of recommendations that we believe will help support MTCP and BSAS in their efforts to more effectively address tobacco use among pregnant and parenting populations: (1) systematically integrate smoking cessation practices into family support programs and (2) build capacity for substance use treatment providers to address tobacco use.

### Systematically Integrate Smoking Cessation Practices into Family Support Programs

There is a wealth of family support programs in Massachusetts, including two evidence-based home visiting models that are funded through the federal Maternal, Infant, and Early Childhood Home Visiting program

(MIECHV), one of the most comprehensive Early Intervention (EI) programs in the country, EHS, WIC. Integrating smoking cessation best practices into such programs could be an effective way to support pregnant and parenting populations with tobacco cessation in the Commonwealth.

### *Train providers in both the 5 A's and 5'Rs*

Very few of the surveyed family support providers reported using the 5 A's and 5 R's.[i] Family support programs may consider adapting a program like You Quit Two Quit,[10] which provides resources and trainings around the 5 A's and 5 R's specifically tailored to pregnant women, as well as first-time mothers experiencing low-income or who have been previously incarcerated population of women. You Quit Two Quit has publicly disseminated: (1) its tobacco screening and cessation resources including three bilingual versions; (2) recommendations on how providers can support patients who are not yet ready to quit; and (3) educational materials and resources for healthcare settings to share with patients as needed. All these materials can be found on their website: https://youquittwoquit.org. Given this program appears to be time efficient (i.e., interventions occur within 15-minutes) and shown to be effective with tobacco cessation among families, MTCP could consider using You Quit Two Quit with providers who work with families across the Commonwealth.

### *Ensure tobacco cessation approaches are women-centered*

The majority of providers we surveyed indicated that they were more likely to advise clients to quit by focusing on fetal health and child's health, rather than their client's health. While the strategy of focusing on fetal health has been shown to be motivational for parents—as well as linked to decreases in tobacco use throughout pregnancy—it has also been found to be less effective postpartum and for longer-term abstinence.[11,12] Researcher Lorraine Greaves has recommended that programs should consider using a "women-centered" approach when employing tobacco cessation interventions with clients by: (1) always putting women's health *first*, prior to pregnancy, prenatally, and postpartum; (2) empowering women to help build confidence in themselves; and (3) supporting women's overall health along with their social priorities.[13]

A woman-centered approach in a family support program setting could include, for instance, using motivational interviewing techniques guided by questions around *why* women want to reduce or quit using tobacco for themselves.[13] Using a women-centered framing when developing policies, trainings, and implementation supports could be particularly important for family support providers, who expressed serious concerns about worsening the sense of stigma and shame their tobacco-using clients already feel. This framing may also help to address providers' perceptions that addressing tobacco use in their clients is somehow undermining the strengths-based, family-driven approach that undergirds their work.

### *Connect pregnant women with evidence-based programs*

We know that family support providers are referring clients to outside tobacco cessation interventions, with the QuitLine being the second-most common referral after medical provider. Programs could also consider integrating existing evidence-based interventions into service offerings, such as the Baby & Me Tobacco Free Program (BMTFP) and the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program, each of which is explained below.

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[i] The 5 R's is considered an add-on of the 5 A's intervention, which consists of identifying **R**elevant reasons for quitting for the specific user, **R**isks of continuing tobacco use, **R**ewards associated with tobacco cessation, and **R**oadblocks that interfere with quitting efforts (and how to move past them). The framework concludes with **R**epetition to ensure that providers engage patients in these conversations at each visit.

BMTFP, which uniquely targets women over the course of their pregnancy and one-year postpartum, with the goal of preventing tobacco relapse, has been found to be particularly effective with tobacco cessation among pregnant women within the WIC setting. The program incorporates various psychosocial, evidence-based interventions such as counseling and financial incentives, the use of breath tests (versus self-reported data), continuity postpartum, and concurrently supporting other members of the household with smoking cessation. Research studies evaluating BMTFP across different service locations have deemed it effective,[14-16] and the program has been labeled a "best practice" by the Association of Maternal and Child Health Program.[16]

SCRIPT, a program that seeks to reduce smoking among pregnant women, supports participants through a detailed self-evaluation, a motivational DVD called Commit to Quit, comprehensive counseling using the 5 A's delivery mechanism, and follow up support postpartum. While initially developed to be implemented by prenatal care providers, with a strong evidence base in this setting,[17] this program has been effectively adapted for use in family support settings,[18] including Florida MIECHV, a home visiting program that has been implementing SCRIPT in partnership with other agencies and organizations.[j]

### *Work in collaboration with family support program administrators*

Finally, MTCP should engage in deliberate collaborations with some of the agencies that administer many of the family support programs named above, including the Bureau of Family Health & Nutrition, also at MDPH, which administers MA MIECHV, EI, WIC, Early Intervention Parenting Partnerships (EIPP), FIRST Steps Together, and Welcome Family; the Children's Trust, which administers HFM and the Family Centers; and the Massachusetts Head Start State Collaboration Office, which administers EHS. Through this type of interagency collaboration, MTCP could learn more about where the gaps in training and referrals are among these family support programs and co-create more system-level strategies to address these gaps, including joint funding applications, cross agency policies, some shared agreement around best practice standards, standard trainings across programs, and a shared vision for what tobacco cessation in family support programs should look like in the long-term.

## Build Capacity for Substance Use Treatment Providers to Address Tobacco Use

The preponderance of evidence suggests that substance use treatment centers are a logical place to focus cessation efforts. And yet, as suggested by findings from this evaluation and corroborated by a substantial body of research, substance use treatment providers appear apprehensive to adopt evidence-based tobacco cessation practices in their work. Even among the substance use treatment program directors we spoke with, there was a disconnect between what they *knew* to be true about addiction and cigarettes, and what they *felt* they were able to implement in their daily practice. Here we make recommendations in the areas of provider knowledge and self-efficacy, attitudes, and beliefs about the importance of tobacco cessation treatment, and organizational and structural supports.

### *Provider Knowledge and Self-Efficacy*

The importance of training cannot be overstated. More than half of the substance use treatment providers who responded to the survey indicated that they had been trained, and most focus group participants recalled being trained as well. But at the same time, the majority of providers we spoke with expressed a need for training related to *how* to engage clients in conversations related to tobacco reduction and cessation. We

[j] See http://www.flmiechv.com/new-home-visiting-resources-available-for-families-using-tobacco/

suggest post-training follow-up with providers employing components that may help them become more comfortable with the *how* piece of addressing tobacco use with families and avoid feeling stuck at the 'assess' phase of the 5 A's when clients indicate they are not yet ready to quit. For example, following conversations with clients around readiness to quit—and learning why clients are not yet ready to quit—providers can bring these reasons to post-training follow-ups and together role play the 5 R's accordingly. In addition to providing real-time support to providers, this will also help MTCP understand where providers are getting stuck when addressing tobacco use and how to tailor trainings moving forward.

### *Provider Attitudes and Beliefs*

Substance use treatment providers explained that their clients determine the addiction treatment goals they would like to focus on, and then they co-develop a service plan based on those goals. In many ways, the 5 A's model appeared to conflict with this client-driven model, whereby providers are expected to repeat the intervention even when clients initially indicate that they are not ready to quit. Substance use treatment providers we spoke with were fairly united in their use of a harm reduction framing when considering whether and how to address client tobacco use in the context of substance use recovery.

According to providers, many of the materials and trainings they have been exposed to approach this issue too bluntly. Consider, for instance, this "myth about smoking and pregnancy" described in the "Toolkit to Stop, or Decrease, Tobacco Use" distributed to providers:

> ***Myth: Smoking fewer cigarettes or switching to e-cigarettes during pregnancy is OK.***
>
> ***Fact****: There is no safe amount of smoking. Every puff of a cigarette releases harmful chemicals that will reach your baby and affect your health too. E-cigarettes are also not harmless (more information). The nicotine in e-cigarettes is harmful for developing babies and impacts the development of their brains and lungs.*

This kind of messaging does not seem to resonate with substance use treatment providers. Rather the lack of nuance seems to instill a sense of wariness in providers, confirming their suspicions that those who are setting their program's tobacco cessation policies and administering trainings do not fully appreciate the nature of their work as rooted in a harm-reduction framework.

This is a challenging issue to overcome, and we do not pretend to have the answers. But one avenue to explore may be to appeal to providers' convictions about the importance of fairness and equity. While the impulse may be well-meaning and client-driven, providers may be inadvertently discouraging clients from seeking treatment for tobacco use, as research suggests that clients with substance use disorder are more interested in quitting tobacco than is often estimated.[19,20] Many providers also raised the issue of racial equity when talking about facilitators and barriers to quitting. Framing this issue in those terms may be a more effective education and training strategy than attempting to disabuse them of the idea that harm reduction is the right approach.

## *Organizational Support*

Participants shared how difficult it is to be the only one who is promoting tobacco cessation in a program where so many staff smoke; how challenging it can be to address tobacco use when the subject never comes up during supervision; and how ingrained the "smoking culture" can be in these centers, where social breaks are often structured around smoking and vaping. For tobacco cessation integration efforts to be successful, some of these environmental barriers need to be addressed.

There are structural changes that can support substance use treatment providers' efforts to address tobacco use in these settings. Through interview and focus groups, participants shared how smoking is a form of stress

relief and a way to socialize with others in the community. Studies that highlight the perspectives of clients and providers at residential treatment centers have provided further context on how to tailor services to this subpopulation, including providing structural "replacements" for the perceived benefits of smoking through adapting the center's external environment to be more conducive to stress relief and facilitating peer supports for both clients and staff around smoking. One avenue for reducing structural barriers to cessation would be for Massachusetts to enact a more ambitious tobacco-free policy for state-licensed substance use treatment centers than currently exists. BSAS has instituted guidelines restricting tobacco use in buildings, and within 20 feet of building perimeters,[k] but has stopped short of a comprehensive prohibition of tobacco use on facility grounds. This kind of policy has yielded positive effects in several other states, including New York, Texas, and New Jersey.[21-24]

[k] See https://www.mass.gov/doc/dph-bureau-of-substance-abuse-services-standards-of-care/download

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