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QUITTING TOGETHER: FORMATIVE RESEARCH TO DEVELOP A SOCIAL MARKETING PLAN FOR SMOKING CESSATION AMONG WOMEN IN A RESIDENTIAL TREATMENT FACILITY FOR SUBSTANCE ABUSE RECOVERY

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THESIS

A thesis submitted in partial fulfillment of the
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ABSTRACT OF THESIS

QUITTING TOGETHER: FORMATIVE RESEARCH TO DEVELOP A SOCIAL MARKETING PLAN FOR SMOKING CESSATION AMONG WOMEN IN A RESIDENTIAL TREATMENT FACILITY FOR SUBSTANCE ABUSE RECOVERY

Both smoking addiction and illicit substance abuse are prevalent issues in the United States today. Furthermore, these are issues that have significant impact on women's health and mental state. Despite research that shows that smoking cessation coupled with substance abuse recovery can decrease likelihood of relapse post-recovery, few substance abuse recovery facilities today offer smoking cessation programming options. To address the issue of smoking addiction on top of substance abuse recovery, formative research was conducted through this study to determine the underlying causes of smoking habits coupled with recovery efforts and the attitudes. Through focus group sessions with women in a residential treatment facility in the southeastern US, a determination of the specific audience's motivations to smoke and perceived self-efficacy to quit smoking was made. Based on the findings of this formative research, a full social marketing plan was then developed to offer an intervention program option for smoking cessation among a target audience of women undergoing residential treatment for substance abuse. The study conducted and the social marketing developed from it proposes a pilot program that may be implemented in other similar settings with similar populations in the future.

KEYWORDS: Smoking, Smoking Cessation, Long-Term Recovery, Substance Abuse Disorder, Residential Treatment

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Chapter One: Introduction

In 2017, 46% of adult Americans reported knowing at least one close friend and/or family member who was either currently struggling or had previously struggled with drug addiction (Gramlich, 2017). This percentage, reflecting almost half of the nation's population, encompasses the 20 million Americans above the age of 12 currently suffering from substance abuse disorders (SUD) (National Institute on Drug Abuse, n.d.). While individuals may become addicted to a wide range of substances, opioids, which are classified as depressants and include prescription medications, heroin, and synthetic drugs such as Fentanyl (National Institute on Drug Abuse, n.d.), have quickly risen in recent years to be the most abused drugs in the US (Bell, 2017). With more than 90 Americans dying from opioid overdoses daily, the term "epidemic" seems to be the most fitting way to refer to this widespread addiction (National Institute on Drug Abuse, n.d.).

While the effects of SUD are impactful on an individual regardless of gender, men and women do experience, engage in, and react to substance abuse differently. Studies show that while men are more likely than women to abuse various illicit substances, women show a faster progression in dependence on specific substances including opioids despite having used them in smaller amounts and for less time, resulting in more clinically complex profiles of women who must undergo substance abuse recovery treatment (Greenfield, Back, Lawson, & Brady, 2010). The differentiating variables leading to substance abuse in women range from biological factors, to family medical history, to current circumstances, and so on. In light of these and other differences concerning gender, female-only residential treatment facilities provide programs tailored specifically to the needs of women battling SUD (Condron, 2017).

The therapeutic communities that residential treatment facilities provide for women offer programs for addiction treatment for a wide variety of illicit and even legal substances, such as tobacco. Still, overcoming smoking addiction does not currently appear to be a top priority for most available programming (MacLaren, 2016) despite the National Institute on Drug Abuse's classification of nicotine as a drug of abuse. Among the typical population of recovery treatment recipients, nearly 97% enter recovery programs with simultaneously preexisting smoking addictions (McClure, Campbell, Pavlicova, Hu, Winhusen, Vandrey, Ruglass, Covey, Stitzer, Kyle, T.L., & Nunes, 2015). Without anti-smoking programming available in these facilities, some studies have even found that users of illicit substances who enter a treatment center without a smoking addiction often leave with one (Friend & Pagano, 2004). As such, there is a need for the implementation of smoking cessation programs in residential treatment facilities in order to aid residents in graduating from their programs completely "free" of any addictions.

The following study will examine a female-only residential treatment facility in the southern US whose residents include women typically between the ages of 24-38 who represent the expected profile of women who suffer from SUD. Through the analysis of in-depth focus groups with residents at a the treatment facility, the underlying reasons behind why women undergoing substance abuse recovery treatment choose to smoke will be examined, followed by the proposal of a social marketing plan to promote smoking cessation through programming provided for the residents.

Chapter Two: Literature Review

Addiction, Recovery, & Relapse

In the 1990s, the rate at which doctors prescribed extra strength pain relievers to patients increased as a result of claims from pharmaceutical companies that it was impossible for individuals to become addicted to prescription opioids (National Institute on Drug Abuse, 2017). Unfortunately, these claims were soon debunked, as misuse of these prescription opioids soon showed to be what we know now are highly addictive substances. Given their ability to relieve pain as prescription opioids are technically intended to do, these substances are still prescribed as patients often genuinely need them. The addictive power of opioids lies within their power to alter an individual's state of mind to reflect euphoria (National Institute on Drug Abuse, 2017), which, for any individual experiencing severe pain due to illness or injury, is a state that may be quickly craved or developed into a habit. Unfortunately, this sensation is experienced similarly for anyone taking these powerful controlled substances regardless of whether or not they are in pain to begin with, potentially leading to recreational abuse and illicit creation of substances whose side effects mimic that of prescription opioids such as heroin and synthetic opioids. The positive sensations provided by opioids are only short-term, leaving individuals who become addicted in a constant state of craving of those feelings.

A sensation of craving is one of the most identifiable features of substance abuse disorders that may result from a variety of different types of substances, illicit or otherwise. Addiction is a disease that is identified by repeated, compulsive behaviors in spite of negative consequences associated with those behaviors (Parekh, 2017). Addiction alters how an individual functions on a daily basis in ways that negatively affect

interpersonal and professional relationships, and unfortunately, it is not likely to simply disappear overnight. Therefore, recovery treatment for assisting addicts in overcoming their debilitating SUD are crucial and must be made available in strategic, multi-faceted ways (National Institute on Drug Abuse, 2012a). Treatment options for recovering addicted users are available in outpatient, inpatient, and residential settings. In all of these settings, the primary goal of programming is to promote recovery from addiction disease and to prevent the likelihood of future relapse.

Residential Treatment for Substance Abuse Disorders

Residential treatment facilities, similar to the center analyzed in this study, are available to recovering addicts in the form of short-term or long-term programs. The programming provided by residential treatment facilities to address the complicated nature of SUD and others include 24-hour available care in a non-hospital, therapeutic community setting. In this setting, residents become active members of a support group that includes opportunities for socialization in addition to medical and psychiatric intervention services (Condron, 2017). Programs available vary in length with an average duration of 6-12 months, and the goal of every facility is to provide personalized treatment for each of its residents that leads to graduation of the residents from their specific programs, so that they may become fully productive members of society thereafter (National Institute on Drug Abuse, 2012b). The benefits of recovery through residential treatment facilities are mostly credited to the wide variety of programming offered for recovering residents. At the top of the list of these benefits is the fact that residential treatment facilities offer residents the opportunity to be a part of a tight-knit community of individuals with similar circumstances in a way that outpatient treatment

cannot. Beyond this, however, residential treatment facilities also offer opportunities for residents to receive personalized medical and psychological treatment, detox services when experiencing withdrawal, nutritional services, specifically targeted support groups, individual and family therapy and skills training, aftercare planning assistance, and more, all onsite within one private and safe living environment.

The success of such programs is widely noted. Long-term programming in such a facility is ideal, as direct correlations between length of stay and likelihood of recovery have been noted in past research (Condron, 2017). A 2016 study conducted by Recovery Brands found that relapse rates significantly decrease from a 36.2% likelihood of relapsing among individuals who remain in treatment for less than 90 days to only a 27.2% likelihood of relapse when individuals remain engaged in their recovery programs for periods of longer than 90 days (Condron, 2017). Of course, the effectiveness of recovery treatment varies from one individual to the next, but residential treatment facilities and long-term recovery are beneficial.

In addition to their usually comprehensive and extensive programming, female-only residential treatment facilities aim to provide programs tailored specifically to the needs of women battling substance abuse disorders (Condron, 2017). Studies conducted thus far on gender-specific substance abuse treatments show promise, but cannot yet provide conclusive evidence due to the minimal amount of studies conducted to date (Greenfield et al., 2010). However, what has been determined regarding differences in women's goals for substance abuse recovery treatment identifies important differences that need to be addressed in intervention and recovery programs for women. Among contributing factors to SUD that are specific primarily to women and need to be

addressed in recovery are the likelihood of these women to have suffered from some form of domestic abuse, concerns related to motherhood, and other complex factors (Greenfield et al., 2010).

Unfortunately, despite previous research conducted specifically to directly address the problem of SUD in women and men alike, no treatment option thus far has been found 100% effective for preventing relapse in any population. In fact, of all the individuals who seek treatment for SUD in the US annually, anywhere between 40% and 60% relapse each year (McLellan, Lewis, O'Brien, & Kleber, 2000). Stimuli that influence relapse are often referred to as "cues" that are associated with drug intake, including exposure to the drug itself or just simply the environment in which the drug was previously used (Van Gucht, Van den Bergh, Beckers, & Vansteenwegen, 2010). Relapse prevention researchers and practitioners are constantly searching for new strategies to decrease relapse by examining the connections between these various cues and risk of relapse. Then, through treatment, programs are designed to condition recovering individuals to be prepared to combat these influential risk factors and to overcome the temptation of relapse.

Interestingly enough, even though smoking has been determined to be a co-occurring issue in individuals suffering from substance abuse (McClure et al., 2015) as nicotine at times is the leading substance of choice for many addicts, smoking cessation programs are usually not implemented in most residential treatment facilities (MacLaren, 2016). Given the understanding of relapse "cues" as features of the environment one commonly associates with SUD, smoking is likely one of these cues and should therefore be taken into consideration as a relevant issue to address as part of an overall recovery

intervention. However, despite the prevalence of smoking among the general population at only 16.8% as of 2014 (Jamal, Homa, O'Connor, Babb, Caraballo, Singh, Hu, & King (2015), the prevalence of smoking among adults in treatment for SUD specifically was reportedly as high as 70% at that same time (Guydish, Yu, Le, Pagano, & Delucchi, 2015). Given the potential for smoking as a cue for relapse, combined with the concerns of smoking's negative side effects in general, this population presents a critical need for smoking cessation in order to lessen the likelihood of post-treatment relapse.

Smoking and Substance Abuse

As of 2015, more than an estimated 36.5 million individuals were reported as smokers nationwide (Centers for Disease Control and Prevention, 2016). Tobacco and nicotine, the primary components of a cigarette, are dangerous in ways that differ from illicit substances, such as opioids, but, in many ways, are just as detrimental. While opioid abuse is dangerous in its ability to cause an overdose with just one use, cigarettes' negative side effects accumulate over the course of many years to result in long, painful deaths in more than half of smokers who begin in adolescence (World Health Organization, 1995). Reactions to tobacco are similar to those of opioids; both tobacco and heroin result in a release of the chemical dopamine, alerting sensations of reward and pleasure in the user's brain (National Institute on Drug Abuse, 2017). The addictive power of nicotine in cigarettes leads to withdrawal when an individual makes attempts to quit, just as other highly-abused substances do. According to a Pew Research study conducted in 2014, smoking is most common among poor and less-educated populations (DeSilver, 2014), and rural communities are determined to have the highest levels of opioid abuse. Moreover, in terms of relapse, some research shows that cigarette smoking

is seen as a factor decreasing long-term effectiveness of treatment programs (Owen, 2011). As the leading preventable cause of death and disease in the U.S. today killing more than 480,000 Americans annually (Centers for Disease Control and Prevention, 2018), smoking is "by far the most harmful and deadly" (p. 205) in comparison to other substances of abuse (Baca & Yahne, 2009).

The connections between SUD and smoking habits continue when looking specifically at a female population. While men are more likely to smoke than women just as they are also more likely to fall victim to SUD, a 2015 report conducted by the Center for Disease Control and Prevention showed 13.6 percent of U.S. adult women are smokers, falling just short of the percentage of men who smoke at 16.7 percent (Centers for Disease Control, 2016). In a 1996 study conducted by Copper, Goldenberg, Das, Elder, Swain, and Norman, women specifically reported positive correlations among feelings of stress, depression, and low self-esteem with motivations to smoke. Additionally, they also reported a higher likelihood to smoke and abuse other substances during pregnancy if they had been physically or sexually abused, and pregnancy itself led to feelings of psychosocial stress and depression that prompted both smoking and SUD simultaneously (Copper et al., 1996). To contribute to further concern of the interaction between these types of dependence in this population, the negative side effects of smoking are even greater among women than they are for men as more gender-specific complications that result from smoking are present for women. Many of these intensified consequences relate to issues concerning motherhood such as cervical cancer, rapid arrival of menopause, osteoporosis, infertility, and, if the woman smokes while pregnant, detrimental effects on a child in the womb including mortality of the child (Mermelstein

& Borelli, 1995). Yet, despite the enhanced nature of the downsides of smoking for women, women continue to smoke, especially when they find themselves in stressful environments that also lead to SUD. In many cases, women even prefer the more dangerous mentholated versions of cigarettes (Haas, Sorensen, Hall, Lin, Delucchi, Sporer, & Chen, 2008). For these reasons, it is even more crucial for a residential treatment facility designed for improving the health of women suffering from SUD to implement smoking cessation campaigns concurrently.

Past research references a variety of motivations to smoke for women in general. However, the motivations to smoke for women undergoing SUD recovery in a residential treatment facility are not as widely noted and likely vary in some ways from those of women in general as the circumstances of this more specific segment of a female population are so complex. Such motivations are necessary to understand for the purpose of identifying what drives this specific population's smoking habits so that these desires and needs may be addressed in another more effective and less dangerous way. Therefore, an essential research question to ask when analyzing the qualitative data presented in this study is as follows:

RQ1: For women seeking substance abuse treatment, what are the motivational factors for smoking?

Smoking in Recovery

As previously mentioned, the average percentage of smokers among those suffering from SUD is exponentially higher than among a population not struggling with addiction for a number of reasons, from the classification of smoking as a "cue" associated with prior drug use to the fact that it is an SUD itself. The combination of

nicotine and tobacco with other substances of abuse is “synergistic” (Prochaska, Delucchi, & Hall, 2004, p. 1144) and may be responsible for amplified negative consequences (Bien & Burge, 1990). Of course, to add concurrent efforts for cessation of a legal substance like nicotine to the already complex and specifically-designed recovery programming for SUD caused by illicit substances presents a rather extreme challenge for treatment specialists. In general, given most individuals begin smoking when their brains are still developing as adolescents, often driven by societal pressures and/or rebellious tendencies, addiction to tobacco and nicotine often forms early on in a smoker, making quitting all the more challenging (Jarvis, 2004). Furthermore, the likelihood of smoking cessation among heroin users, for example, is noted through past research to be significantly lower than that of those not suffering from opioid-related SUD (Sullivan & Covey, 2002). By compounding the difficulty of quitting smoking with recovery from a concurrent SUD, treatment specialists justify a lack of anti-smoking programming with insistence that it is a waste of resources that will likely not even be effective on a problem less severe and that it discourages residents of treatment facilities by expecting too much of them all at once in terms of detox (Knudsen & Roman, 2015; Gulliver, Kamholz, & Helstrom, 2006).

In spite of the prevalence of assumed failure of smoking cessation programming when combined with SUD treatment, most research actually shows that such a combination may be the most effective way to address these coexisting issues (U.S. Department of Health and Human Services, 2007). While the findings of research in support of simultaneous treatment for smoking and other SUD may be modest, their clinical significance is of the utmost importance in this debate (Baca & Yahne, 2009).

Furthermore, tobacco treatment combined with SUD treatment likely lessens the likelihood for relapse in the long term. In an intervention-based study conducted by Prochaska, Delucchi, and Hall (2004), findings showed that combining smoking cessation interventions with SUD treatment resulted in a 25 percent greater likelihood of avoiding relapse. Furthermore, an overwhelming majority of smokers in the general population express a desire to quit smoking (Centers for Disease Control and Prevention, 2005), and smokers undergoing SUD treatment for additional addictions are no exception to this desire as they too recognize the negative side effects of smoking (Clemmey, Brooner, Chutuape, Kidorf, & Stitzer, 1997; Hughes, 2002).

In light of the risks associated with smoking, especially when seeking long-term SUD recovery, it seems that residential treatment facilities remain somewhat incomplete without anti-smoking programs. However, given the inherent challenging nature of addressing these compounding issues through recovery treatment, strategy must guide the development of such programming. Therefore, this study offers recommendations for smoking cessation among women in residential treatment facilities guided by principles of social marketing and based on the findings from the formative research regarding the smoking behaviors.

Social Marketing for Smoking Cessation

Social marketing, according to strategic communication and marketing specialist Alan Andreasen, is "the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of their society" (Andreasen, 1995, p.7). Social marketing is an extended branch of

traditional, commercial marketing practices to incite more than just purchase behavior, but potentially life-altering behavior. While traditional commercial marketing often only goes as far as to sell a product alone, social marketing goes a step further to sell an *idea* that is associated with a specific product. Therefore, communication enacted via social marketing must be highly persuasive, requiring knowledge and application of strategic communication theories. Social marketing is unique in that it approaches challenging issues relevant to society, including smoking and substance abuse, by designing messages that utilize "behavioral theory, persuasion psychology, and marketing science with regard to health behavior, human reactions to messages and message delivery, and the 'marketing mix' or 'four Ps' of marketing" (Evans, Silber-Ashley, & Gard, 2007, p. 1). The "four Ps" of marketing include product, price, place and promotion, which are the key elements of focus when designing any commercial marketing plan. Social marketers determine what these "four Ps" are according to the behavior change that is being promoted.

Social marketing methods have been used to promote smoking cessation in a number of contexts. For example, in 2014, the nonprofit organization, ClearWay Minnesota, aimed to promote smoking cessation among Minnesotans through the organization's QUITPLAN services. In order to make persuasive efforts as effective as possible, extensive quantitative and qualitative research was conducted to determine what inspired residents of the state to engage in smoking behaviors. In addition to collecting data from research participants categorized as current smokers, former smokers who changed their behaviors previously were also included in the study in order to gain perceived insights regarding what does and does not work in smoking cessation

programs. Online methods were used to conduct the study and findings led to a complete "re-vamping" of QUITPLAN services through a social marketing campaign. The newly strategized campaign included a reduction of personal identifiable information requested from those receiving quitting services, integration of more tools to aid in quitting, such as text and email programs and more, a starter kit to encourage adoption of smoking cessation behaviors, and further promotion of the benefits of quitting in contrast with the costs of continuing to smoke, all in accordance with what the audience requested through the online formative research conducted (Lee & Kotler, 2016). In the end, the campaign that resulted was a reflection of what would best appeal to the audience as a testament to the value that social marketing places on thorough target audience analysis.

Just as marketers who aim to sell products on the shelves of stores must conduct audience research in order to develop targeted and specific messages encouraging customers to buy products, social marketers must do the same. The end results and the type of behavior change desired differ, but the methods are similar. Therefore, the ClearWay Minnesota QUITPLAN services case study emphasizes one very important component that cannot be overlooked when developing a social marketing plan: research. Without the proper background knowledge of what the target audience is, what leads to its current behaviors, and what might appeal to it in encouraging the cessation of those behaviors, a social marketing plan simply cannot reach its full potential.

To fully understand a target audience, Prochaska, Norcross, and DiClemente (1994) proposed the Stages of Change model, a framework for understanding an audience's current likelihood to engage in a desired behavior change. The five steps in the original model include 1) Precontemplation, 2) Contemplation, 3) Preparation, 4) Action, and 5)

Confirmation. At any time in the behavior change process, an individual may fall within the spiral of the stages of change in any of the six categories. Of course, the ultimate goal is "termination", but advancement to this stage in the process cannot occur overnight, and often times even the most specific segment of a population can include members at various points in the process. Before the individual's stage in the behavior change process can even be considered, the individual's currently held attitudes toward a promoted behavior change must be identified. By applying an understanding of where the target audience currently stands in its attitudes toward a desired behavior change, the elements of a social marketing plan are more likely to appeal to an audience in its current state as strategically as possible. This way, a target audience consisting of members who are at various points in the behavior change process can be addressed in a way that connects most effectively with all of its currently held attitudes and beliefs. With this in mind, a final research question asked through this study is as follows:

RQ2: What are the current attitudes toward smoking cessation held by women in a residential treatment facility for SUD recovery?

This study uses qualitative data collected through focus groups with the residents of a female-only treatment facility to determine themes that arise regarding important concepts that must be addressed to encourage smoking cessation among this target audience of women battling SUD and smoking addiction simultaneously. Analysis of these themes and trends expressed among participants will guide the strategy for the social marketing plan proposed.

Chapter Three: Method

In this study, four focus group sessions were conducted with participants (N=42) from a residential treatment facility for women in the southeast. The median age of participants was 31.5 years old (range: 19-54 years), and a majority of these participants represented white/non-Hispanic demographics (76.2%). The remaining participants either identified as African-American (7%) or chose not to disclose (16.7%). Participating residents were in treatment for a variety of SUD including alcohol use (2.4%), other drug use (47.6%), or a combination of both alcohol and drug use (50%). Among the participants, a vast majority reported having smoked at least 100 cigarettes in their lifetime (98%), and a still rather high percentage of respondents also reported having smoked just within the past 30 days (93%). The number of reported past attempts to quit smoking was between 0-20 (median: 1). When asked to rate the importance of smoking to their daily lives on a scale of 0-10 (0=not important at all and 10=most important goal in life), the median rating reported by participants was 7, showing a rather high value placed on smoking behaviors. To emphasize this value, respondents also rated their confidence in their own smoking cessation abilities on a scale of 0-10 (0=not confident at all and 10=100% confident) with a rather low median of 2.

Measures

Focus group discussion was facilitated by trained moderators who prompted participants to engage in group discussions of connections among SUD recovery programming, smoking habits, and the prospect of smoking cessation. Structured questions asked by the moderator in all four focus group sessions included: “What is the first thought that comes to mind when you hear the word ‘cigarette’?”, “Who/what has

the most influence on your health habits?", "How do you think smoking affects your health?", "What comes to mind when you are thinking of smoking cessation as part of your recovery?" "Have you or anyone you know ever experienced successful smoking cessation attempts?", "Why would you want to quit smoking?", "What would you need to have/do in order to successfully quit smoking?", "Would a smoking cessation support group within this facility be a positive or negative thing for encouraging smoking cessation?", "What are your thoughts on the hypothetical prospect of this facility establishing anti-smoking policies?", and more prompts that all revolved around the same concerns of smoking and SUD recovery.

Data Analysis

Focus group sessions were audio recorded with participant permission and then transcribed by a graduate student verbatim. The principal investigator of the present study then developed a codebook inductively based on themes that presented themselves throughout the data. The principal investigator and two graduate students coded the focus groups together to ensure that the codebook sufficiently addressed themes that arose throughout the data. Through multiple group coding sessions, the codebook was finalized for moving forward with the coding of all four focus group transcripts, resulting in an average pairwise percent agreement among all three coders of 88 percent, deemed an acceptable agreement percentage for moving forward with analysis of the coded data (Hopkins, Clegg, & Stackhouse, 2015).

Chapter Four: Results

Through analysis of the inductive reviews, four primary themes arose from the focus group data that aided in developing an understanding of what drives the population's current smoking behaviors. These themes included: 1) motivation to smoke, 2) motivation to quit smoking, 3) desire to quit smoking, and 4) perceived efficacy to quit smoking. Each theme, exemplars of it, and their connections to the proposed social marketing plan are detailed in the following sections.

Motivation to Smoke

Throughout the focus groups, residents referenced a variety of reasons they are driven to smoke, but certain motivations stood out as especially relevant to this theme. These motivations emerged both as responses to prompts from the moderator, as well as organically in conversations among participants. Motivations that stood out as most common within this theme included smoking for stress relief, smoking as an addiction, and smoking for social belonging.

Residents throughout all four focus group sessions emphasized stress relief as a motivation for smoking when asked by the moderator about the first thought that came to their minds when they hear the word "cigarette". Given their circumstances as currently undergoing SUD recovery, many of the residents expressed perspectives reflective of a concern that it is "*overwhelming to quit smoking on top of everything else in such a stressful environment,*" implying that the general recovery environment adds a level of stress to their daily lives that they believe smoking alleviates. Outside of the general stresses associated with recovery treatment, however, many residents insisted that smoking helps to ease an even wider range of heightened emotions, such as irritability,

paranoia, or even depression. One resident in particular shared, "*I noticed, you know, during periods of depression or a lot of stress or grieving, that's all I would do is smoke. Like, when my husband died, for example, the first two weeks I did not eat, but I smoked and smoked and smoked. I must've went through, I don't know, four or five cartons.*" The individuals in this facility see smoking as an effective stress reliever, perhaps for no other reason than out of habit, thus corresponding with their addictions.

In terms of addiction, which is an especially relevant factor for this population, many women expressed addiction to nicotine as one of their primary motivators for smoking. One resident insisted that, "*in a lot of ways it's more addictive than drugs*", emphasizing this point by sharing that she was "*in prison for two years and do not think about doing pills or anything, but as soon as I left prison, I lit up a cigarette*." Additionally, beyond their addictions to the substance of nicotine itself, many women explained that they often smoked cigarettes to complement their illicit drug abuse, "*I'd get high and be like, I need a cigarette*." Another stated, "*after I would snort dope or a pill, I'd want to smoke a cigarette. It's just, I don't know, you get like, when you're getting high, you've got a routine you like to do, a way you like to do things*." This "routine" view of smoking as a complement to drug abuse highlighted the concern of smoking as a compulsive habit among many of these women. Beyond the chemically addictive substance of nicotine, it was noted by one woman that she "*might not even really need the nicotine but I want to smoke; like my hand, like I want to do, actually physically do that part of it*."

Of course, knowing that the addictions these women are in recovery for first and foremost are results of illicit substance abuse, the appeal of smoking within a residential

treatment facility also lies in its status as a legal addiction that women can engage in with less severe or immediate consequences. For some, they saw smoking as a "*reward [for] you know staying sober and doing what I'm supposed to be doing*," essentially trading one addiction for a seemingly less detrimental one. Residents appeared to feel strongly that the negative consequences of tobacco use were simply not as severe as the consequences of illicit substance abuse, emphasized by one respondent who claimed, "*I'm not going to go out here and make really, really bad decisions because I'm you know a tobacco user*." While these residents do recognize that smoking is an addiction, they appear to also be under the impression that their other addictions are of greater concern.

A final, and perhaps the most interesting motivation to smoke, expressed by the focus groups' participants was for social belonging. Many of the women expressed that they mostly smoked socially, with the "smoke porch" of the facility being a popular place to go for gossip, social support, etc. Outside of the facility, they also explained that smoking at their workplaces gave them a break from the work day during which they would socialize and catch up with their coworkers. For some, they even began smoking primarily for social belonging, "*so like, peer pressure*." The social pressure to smoke is so powerful for some that one resident shared that she has experienced times when she may have just recently smoked on her own "*and then 20 minutes later, somebody will be like, do you want to smoke; yeah I'll go smoke and like I know I don't need it*." As for the members of the facility who did not smoke or who had at least tried not to smoke in the past, they explained that staying away from the "smoke porch" when it appeared that all the other facility residents were out there smoking together led to feelings of exclusion: "*I*

don't know, I guess [I did not quit successfully] because everybody else was going outside and smoking. I would get left in the house by myself so I said 'hell with it' and I started going outside and smoking with them." When residents were asked if they believe they allowed other individuals in their lives to negatively influence their health habits, one woman even explained her motivation to smoke as a combination of difficulty of struggling with addiction with smoking's social motivations by simply stating, "*it's really hard to not want to smoke when everyone around you is chain smoking I guess*". The apparent fear of social exclusion was strong among the study's participants, and often the only way the women in this facility believe they can avoid exclusion is to partake in smoking behaviors with the majority of the facility's residents.

Motivation to Quit Smoking

The ultimate goal of this study is to determine a social marketing plan for smoking cessation among this group, so a particularly interesting theme that arose through focus groups reflected what these women believe would motivate them to actually quit smoking. Again, responses throughout all four focus groups were similar. The majority of responses that reflected potential motivators for smoking cessation included financial and health concerns, concern for family and loved ones, and fear of social stigmas.

Beginning with the motivations that were most expected, women in all four focus groups expressed both financial and health concerns as results of their smoking behaviors. Financially, the women agreed largely that smoking is an expensive habit to maintain, as many of them answered a question of what smoking cessation would result in for them with a response of "*more money*." The women also openly recognized the

negative side effects they knew smoking had on their overall health, discussing concerns of lung cancer, asthma, chronic obstructive pulmonary disease, and more. One woman shared a story of an impactful experience she had learning about smoking's negative side effects early on in life: "*I remember when I was in public school, I was like in 7th or 8th grade; I was in the office for some reason but they had this poster up and it was like half a woman; like on one half it was like just the whole body you know and on the other half it was just the insides and it was a really pretty girl but like it said, if smoking did to your outside what it does to your inside, would you still smoke*." Of course, while the woman found this educational example impactful and memorable even in adulthood, it apparently has not served as a great enough motivation alone to quit smoking at this time in her life. Furthermore, while the vast majority of women also recognized the financial burden that buying cigarettes puts on them weekly, they continue to do so, sacrificing other necessary expenses to fulfill their smoking addictions. It is clear from these responses regarding financial consequences and poor health that knowledge and awareness of their current smoking behavior's negative impacts on their lives is not the issue driving the continuance of smoking among this study's population. Education of a cigarette's most obvious and negative side effects on an individual's functional needs is clearly not enough alone to drive smoking cessation, so other motivators addressing more psychological factors were also noted in the women's responses.

Another primary motivation to quit that was highlighted in many residents' responses included concern for family and loved ones. As many of the residents of the facility are mothers, a lot of them expressed that caring for their children motivated their past efforts to quit smoking or could serve as a future motivator for doing so. One

woman's response to what motivated her to quit smoking in the past was that her 13-year-old son "*knows, you know he's seen it, you know family members and stuff has got cancer and things and the one thing he asked me not to do is not to start back smoking. So that gave me an incentive not to do it.*" Another new mother expressed concerns that, "*well like now, I feel like maybe I need to try to quit again because I'm all [my baby] has*." However, parental concerns were not the only driving motivations for consideration to quit, as one woman shared the following anecdote: "*I mean yeah, I've got a brother with [cystic fibrosis] and we could never smoke around him. And one time my grandmother was like griping at me and my mom and she was like, well you all should feel bad for smoking because what if [name omitted] needed a lung transplant one day and your lungs are so bad because you smoke. And then I went in the other room and cried*." The concern for loved ones as a motivation to quit smoking also extended according to these women beyond health concerns to issues of social stigmas. In one experience shared by a resident, her young son's interaction with the other children in his community was affected by his grandmother's smoking: "*You know and like I didn't smoke at the time but you know my mom smokes and she owns her own home and if she wants to smoke in the house, she does. I mean it's not you know dirty and we don't know […] grew up around it but one time we were over there and the doorbell rang and it was a little girl who lives next door asking my son to play. I said, yeah well come on in. And she said, no I can't because my mamaw […] says I smell like cigarettes every time I leave here. And I thought, you know and we don't realize but you know you put them on the school bus and they smell like cigarettes you know just by being around it.*"

Concerns of social stigmas expressed by the women were not always selfless, however, as many women explained that their primary motivation for attempting to quit smoking while pregnant was not solely for the health of the baby, but rather because of the ways others in public would perceive the behavior: "*Yeah like when I was pregnant, I didn't want to be in public smoking a cigarette. You know it looks bad*." Concerns of social stigmas also reflected concerns of vanity. While some women did claim that smoking to lose weight and control their appetites motivated them to keep up the habit, more often they complained about the "*nasty*" and "*disgusting*" ways cigarettes impacted their outward appearances. Women discussed the ways cigarettes stained their hair, teeth, and nails, as well as the way it stains the furniture and walls inside the homes of individuals who regularly smoke indoors. They also talked about how smokers typically have more wrinkled skin than non-smokers, with one woman insisting that, "*a person that smokes or drinks looks a lot older than a person that doesn't*." In connection with concerns of social stigmas and the way others perceive them, the smell of cigarette smoke was also noted as a negative side effect that led to social concerns: "*I'm kind of like battling the way I smell whenever I smoke or I'm talking to somebody that's a smoker and I'm like, whew*."

Interestingly, motivations to smoke and motivations to quit smoking intersected in regards to a certain trend: desire for social belonging. The women insisted that they smoked when they were around other smokers in order to fit in, yet they felt ashamed of their smoking habits and the effects they have on their overall persona when in public and surrounded by non-smokers.

Desire to Quit Smoking

While perceived self-efficacy is apparently rather low among the study's participants, a presence of a desire to quit was also important to note and certainly arose as its own theme throughout the data collection. Throughout all four focus group sessions, while consideration of smoking cessation during recovery was emphasized as especially challenging and/or its success unlikely, no participant ever responded to the prospect of smoking cessation in general as a negative behavior to adopt on its own. When asked what would be a negative outcome of quitting smoking, one resident even replied with a simple "*nothing*." A desire to quit smoking among the population was noted in a variety of ways throughout all four sessions. For instance, while long-term personal success in smoking cessation was only admittedly present in one resident's experience, numerous individuals throughout all four focus group sessions admitted to past attempts at smoking cessation, reflecting at least a previous desire to quit. Furthermore, some statements were explicitly made to emphasize that popular opinion among the participants reflected an assumption of a desire to quit among the majority: "*I feel like most people I talk to who are active smokers, they're not happy with it, they're not content with being a smoker*" and "*Everybody, they all want to quit, or most people do*." Many residents also shared personal recall of knowledge shared with them via credible sources regarding the greater benefits of smoking cessation for their population's specific circumstances as recovering addicts: "*I think [my doctor] said there's like a 40 percent more chance that you'll stay sober if you quit*." While the accuracy of such a claim and the source from which it was reported are uncertain, sharing information like

this still reflects an opinion among the population that smoking cessation can have benefits of even greater value for this particular population.

Perceived Efficacy to Quit Smoking

The residents who participated in this study reflected mixed opinions on their own perceived efficacy to quit smoking. For some, a perceived ability to change their own smoking behaviors was encouraged by the fact that they knew others who had successfully quit smoking: family, friends, facility staff, etc. Some residents shared their own personal experiences with past attempts to quit that they believe showed promise for future cessation attempts: "*I was fine [when I previously quit]; no I was fine when I was in prison. I mean I was good. After a while, hell I didn't have no choice. So shit, I had to quit thinking about it*." One focus group participant even shared with the group that she had successfully quit for an extended period of time at the point of the focus group session: "*I was also incarcerated for two years and I quit and I, currently I've not [smoked] since May the 1st and I've smoked for over 20 years but I still haven't picked it up*."

Just as it was mentioned in the previous two exemplars, past attempts to quit among these women were often a result of forced quitting, either through incarceration or through a SUD rehabilitation program in another facility. With this in mind, residents were asked their thoughts on what would hypothetically happen if the current facility instated anti-smoking policies, to which many residents responded after hesitation with acknowledgement of the likely effectiveness of such a policy: "*Well I mean I guess I just wouldn't be smoking. I mean we wouldn't have a choice you know*." One resident even admitted that attempting to quit smoking on top of her recovery treatment "*makes me feel*

better. Because I don't know, it makes me feel like I have that much willingness," reflecting smoking cessation success as an added motivator for her to feel proud of her achievements and to continue her journey toward full recovery. Also in regards to the prospect of smoking cessation on top of SUD recovery, another resident neutrally remarked that, "*It'd be kind of like just like any other addiction; it can go better, it can go bad just depending on how you work with it and how you let it affect you*." However, reactions to the prospect of being required to quit while in recovery were less than supportive from the majority of respondents.

Considering almost every participant in the focus groups was an active smoker, it is inevitable that responses to questions about the likelihood of smoking cessation in general, as well as on top of SUD recovery were not entirely positive. When discussing past attempts to quit smoking, one resident explained the following regarding the cause of her personal failed attempt: "*No [I was not successful when I tried to quit in the past]. But I think back then, like I wasn't in my; emotionally, mentally I wasn't in the right places at all so trying to quit something when you don't want to or you don't have the drive is pretty much very hard*." This enhanced difficulty of smoking cessation for recovering addicts emerged as a trend in the women's responses, especially when considering what it would be like to quit smoking during SUD treatment. One resident explained that she had not even considered quitting on top of her recovery because "*you're going through a hard time right now; you're going through your recovery*," implying that to add another cessation effort on top of that would be incredibly challenging. Another explained that feeling excluded from the crowd—again reflecting a strong intrinsic desire for social belonging—would also inevitably lead to failure in

attempted smoking cessation during SUD recovery: "*I mean you sit there, you take everything else away, there's nothing else to do, you know what I'm saying; everybody else is going outside to smoke and you're just sitting there*."

When asked to hypothetically consider the prospect of anti-smoking policies at their current facilities, responses from the majority of participants were overwhelmingly negative. Recalling a past experience in a recovery facility that banned smoking, one resident shared, "*Well it was awful really. We could only smoke when like you could sneak and do it. I mean and we were all on edge and irritated when we didn't have it so it was bad*." Other residents vocalized their assumptions that such policies would be detrimental to the women's overall recovery effectiveness due to a firm belief that "*it's not healthy to give up everything at once*." This belief was reiterated by numerous residents with claims like, "*Trying to quit drugs, trying to quit smoking, trying to quit cussing; it don't work out*" and "*I've quit enough, I'm not quitting my cigarettes*." On the way out of her focus group session, one particularly opposed participant to anti-smoking policies even urged one of the focus groups' moderators, "*Please don't ever suggest that you take the cigarettes from here because then half my friends will leave and they're already leaving*." Overall, feelings toward smoking cessation abilities did not reflect much confidence or optimism from participants. Their perceived efficacy to successfully quit smoking, especially while in recovery, is not particularly high based on the focus group data collected.

Ultimately, attitudes toward smoking cessation were conflicted but did reflect an overall recognition of the benefits of smoking cessation outweighing its cons. While the

population's perceived ability to quit reflected less optimism, a desire to quit was still largely present.

Chapter Five: Discussion

This study's purpose is to determine through formative research the most strategic way to promote smoking cessation to a population of women undergoing long-term SUD recovery in a residential treatment facility. The research questions proposed in this study are asked to develop better understanding of a specific population of women undergoing SUD treatment in regards to their motivations and attitudes held toward smoking and smoking cessation behaviors. Through identifying possible answers to these research questions, a general profile of the target audience was determined, thus aiding in the development of a social marketing plan for smoking cessation promotion to this particular audience. In reviewing the thematic analysis conducted following the formative research, one particular theme arose in a variety of relevant ways through the women's discussions: an inherent need for social belonging, thus illuminating arguments for the prospect of applying social support approaches to developing the subsequent social marketing plan. The following discussion outlines the details of these findings and their relevance to social support approaches, and the resulting social marketing plan to address these findings is included in this report as Appendix A.

Attitudes toward Smoking Cessation

In order to develop a social marketing plan to promote smoking cessation behavior to this population, an analysis of the target audience's attitudes toward the recommended behavior change is crucial for understanding how to strategically design messages directed to these individuals. Thus, the second proposed research question in this study focused primarily on understanding the audience's current attitudinal state toward the proposed behavior change, which must be understood first and foremost

before identifying appropriate ways to disseminate strategic messages. Throughout the four focus group sessions conducted in this study, insight into the audience's attitudes toward the desired behavior change of smoking cessation was provided and made apparent through the final two themes noted in the data analysis: desire to quit and perceived self-efficacy to quit. Identification of these themes in the audience's discussions highlighted a conflict between a desire to take action and a perceived inability to follow through with that action based on current circumstances. This presents both an opportunity and a challenge in designing smoking cessation messages for this audience, because while the audience is open to the prospect of adopting the desired behavior, it is simultaneously still actively engaging in behavior that is opposite of what is to be promoted due to an assumption of failure. Therefore, messages promoting smoking cessation to this audience must be designed and delivered in ways that improve the perceived self-efficacy of the audience members so that their desire to adopt the promoted behavior seems more feasible.

Utilizing social support strategies to enhance perceived self-efficacy with this audience presents a viable and likely effective approach to take, especially considering the audience's value of social belonging that was highlighted by an analysis of its motivations. Social support has been noted by prior research as an effective approach to aid in increasing perceived self-efficacy of individuals. Social factors including strong affiliation with a group advocating for a desired health behavior combined with encouragement from members of the social support group to engage in that behavior is noted in past research as effective positive reinforcement for enhancing self-efficacy beliefs for behavior change (Guan & So, 2016). Such an approach is applied to a variety

of behavior change programming, with Alcoholics Anonymous (AA) being one example of this. Through AA, group members engage in a 12-step recovery process to move away from alcohol abuse behaviors in an interactive, supportive group setting. The program is often described as more community-focused than treatment-intensive, an approach seen by many as more effective as group members are surrounded by similar others in an environment that is constantly advocating for a particular goal (National Public Radio, 2014). Given AA's noted effectiveness in overcoming substance abuse via social support, the same approach has been applied to smoking cessation efforts in the past. One particular example of social support groups designed for smoking cessation include the national nonprofit organization Nicotine Anonymous (NicA). NicA has adopted the 12-step AA approach to provide smokers with in-person group settings through which they can meet with others struggling with smoking cessation to receive social support for quitting (Nicotine Awareness, 2015). Of course, social support need not occur only in face-to-face settings, providing support for the consideration of using a SNS to allow for residents to work on adopting smoking cessation behaviors through an online community, a concept that directly relates to the first research question's focus on motivations.

Motivating the Target Audience

The primary goal of this study's first research question was to develop an understanding of what motivates women to smoke during SUD recovery treatment, which also shed light on what might potentially motivate these women to actually quit smoking. The data showed that motivators were all driven by needs or desires expressed by the women, thus encouraging a goal of this study to propose alternative ways to address these identified needs in ways that do not involve smoking. Interestingly, motivations to smoke

and motivations to quit smoking intersected in regards to a certain trend: desire for social belonging. The women insisted that they smoked when they were around other smokers in order to fit in, yet they felt ashamed of their smoking habits and the effects they have on their overall persona when in public and surrounded by non-smokers. This desire for social acceptance is reflective of the inherent psychological need for belongingness through love and relationships that all humans possess to some extent (Maslow, 1943). With the desire for belongingness among this target audience so strong, then this ought to be utilized in developing strategies for the promotion of smoking cessation. If the "status quo" of the recovery environment these women reside in were to shift from one that promotes smoking behaviors to one that rather encourages and fosters smoking cessation, then this may increase the likelihood of smoking cessation among these women, hopefully resulting in a long-term decrease in their likelihood for substance abuse relapse.

Of course, to change the entire culture of an audience's social habits overnight is unrealistic; however, to offer outlets for social interaction that reduce the opportunity for individuals to engage in social smoking behaviors in hopes that long-term smoking cessation could be gradually achieved is a more attainable goal. Fortunately, technology today provides outlets that allow for interpersonal communication 24/7 that does not require face-to-face interaction through the use of social networking sites, otherwise known as SNSs. These SNSs are defined by Boyd and Ellison (2007) as "web-based services that allow individuals to construct a public or semi public profile within a bounded system, articulate a list of other users with whom they share a connection, and view and traverse their list of connections and those made by others within the system"

(p. 211). Today, 69% of all U.S. adults are active on some form of SNS, and a staggering 73% of all U.S. women are included in that total (Pew Research Center, 2018). With the prevalence of SNSs in today's society and among a population comprised of women specifically, it is likely that the women undergoing treatment in residential treatment facilities like the one in this study are active on SNSs in their daily lives. SNSs provide a social platform to their users in a similar way to how the "smoke porch" at the residential treatment facility in this study does. If these women were to become involved in a SNS that not only provided them with social inclusion, but, also, with social support for their complicated circumstances, then perhaps their need for social belonging could be fulfilled through this online platform in a productive way, rather than through bonding via continued substance abuse.

In recent years, health issue-specific SNSs have advanced to the forefront of methods for providing social support for individuals experiencing similar health issues. These health issue-specific platforms function like most other SNSs, featuring posts by individuals that their connections can interact with socially and interpersonally. However, in a health issue-specific SNS, users can join an online community that promotes a sense of exclusivity and safety through which their topics of discussion can revolve primarily around specific health concerns (Phua, 2013). Smoking cessation has been a topic of a number of health issue-specific SNSs in the past, and research on these past efforts to promote smoking cessation via an online community reflect positive findings for improving long-term smoking cessation, perceived self-efficacy to quit, and enhancing likelihood to quit in the first place (Cobb, 2010; Phua, 2011; Phua, 2013; Stoddard, Delucchi, Munoz, Collins, Perez-Stable, & Augustson, 2005). Knowing that health issue-

specific SNS efforts have been successful in the past encourages a belief that a similar SNS for smoking cessation specifically among women undergoing substance abuse treatment could prove helpful for effectively promoting such a behavior change. Hence, the social marketing plan that accompanies this study proposes the development of an exclusive group via a SNS created specifically for women undergoing SUD recovery treatment.

To combine both an interpersonal, face-to-face format for social support combined with online component for it in this case provides social support to residents via multiple communication channels, likely improving the effectiveness and recognition of the messages promoting smoking cessation. Therefore, the social marketing plan developed incorporates messages that would appeal to the full target audience in the form of a multi-faceted campaign. Careful selection of the proposed plan's product, price, and place results in a promotional strategy that integrates reiteration of the added benefits of smoking cessation to overall recovery with encouragement via social support and interaction for adopting smoking cessation behaviors (see Appendix A). Ultimately, the integration of these various message strategies and approaches should aid in the audience members' journeys toward the desired behavior change, potentially leading to an impact of long-term recovery from all abused substances.

Limitations

Limitations of this study revolve mostly around its generalizability to a wider population. While the sample that participated in the focus group sessions may reflect a similar profile of the population of the typical female-only residential treatment facility, there is no sufficient evidence to support that this sample is truly representative of this

population in its entirety for the sake of the study's replication. Repetition of this study with residents of multiple facilities would likely provide a more complete profile of this population for future studies and implementation of the proposed social marketing plan.

Conclusion

Despite the occasional contradictory opinions of healthcare professionals on whether or not it is essential to implement anti-smoking programming during substance abuse treatment, the benefits of smoking cessation for all individuals cannot be ignored. Given that smoking cessation leads to so many positive outcomes for any individual, combined with the research that does support simultaneous smoking cessation with SUD recovery for long-term sustainable recovery (Owen, 2011), smoking cessation support should be made a priority of residential treatment facility's programming. If the purpose of undergoing residential treatment is to fully recover without relapse, then implementing smoking cessation programs during the recovery process seems is critical. Of course, smoking cessation is a daunting task for any avid smoker, so programming must be developed in strategic and targeted ways.

To guide the proposal of potential strategies, formative research of the population was conducted, revealing among the study's sample a primary desire for social belonging, as well as currently conflicted attitudes toward the prospect of smoking cessation concurrent with SUD recovery. This target audience analysis resulted in the development of a full social marketing plan for the promotion of smoking cessation to women in a residential treatment facility. Addressing smoking cessation via a health issue-specific SNS for women involved in a face-to-face smoking cessation support group at the facility provides an opportunity for the women to feel engaged in an

exclusive social support system that they can access at all times, as well as continue to engage in it after graduating from their SUD recovery programs. If effective, the implications of a program like this for similar facilities nationwide are positive and encouraging for a gradual progression to healthier lifestyles for all women, but especially for women recovering from substance abuse issues. The ultimate goal of recovery programming is complete sobriety, and abstaining from tobacco use should be prioritized as part of that journey to sobriety and overall healthier living.

Appendix A: “Quit Crew” Social Marketing Plan

Background and Purpose

In 2017, 46% of adult Americans reported knowing at least one close friend and/or family member who was either currently struggling or had previously struggled with drug addiction (Gramlich, 2017). This percentage, reflecting almost half of the nation’s population, encompasses the 20 million Americans above the age of 12 currently suffering from substance abuse disorders (SUD) (National Institute on Drug Abuse, n.d.). While individuals may become addicted to a wide range of substances, opioids, which are classified as depressants and include prescription medications, heroin, and synthetic drugs such as Fentanyl (National Institute on Drug Abuse, n.d.), have quickly risen in recent years to be the most abused drugs in the US (Bell, 2017). With more than 90 Americans dying from opioid overdoses daily, the term “epidemic” seems to be the most fitting way to refer to this widespread addiction (National Institute on Drug Abuse, n.d.).

While the effects of SUD are impactful on an individual regardless of gender, men and women do experience, engage in, and react to substance abuse differently. Studies show that while men are more likely than women to abuse various illicit substances, women show a faster progression in dependence on specific substances including opioids despite having used them in smaller amounts and for less time, resulting in more clinically complex profiles of women who must undergo substance abuse recovery treatment (Greenfield, Back, Lawson, & Brady, 2010). The differentiating variables leading to substance abuse in women range from biological factors, to family medical history, to current circumstances, and so on. In light of these differences and other

concerning gender, female-only residential treatment facilities provide programs tailored specifically to the needs of women battling SUD (Condron, 2017).

The therapeutic communities that residential treatment facilities provide for women offer programs for addiction treatment for a wide variety of illicit and even legal substances, but overcoming smoking addiction does not currently appear to be a top priority for most available programming (MacLaren, 2016) despite the National Institute on Drug Abuse's classification of nicotine as a drug of abuse. Among the typical population of recovery treatment recipients, nearly 97% enter recovery programs with simultaneously preexisting smoking addictions (McClure, Campbell, Pavlicova, Hu, Winhusen, Vandrey, Ruglass, Covey, Stitzer, Kyle, & Nunes, 2015). Without anti-smoking programming available in these facilities, some studies have even found that addicts of illicit substances who enter treatment without a smoking addiction often leave with one (Friend & Pagano, 2004). As such, there is a need for the implementation of smoking cessation programs in residential treatment facilities in order to aid residents in graduating from their programs completely "free" of any addictions.

This social marketing plan will look specifically at smokers in a residential treatment facility for women in the southeastern United States. In this facility, women recovering from SUD are welcomed into a community environment where the primary goal for all residents is to not only recover from their addictions, but achieve independent living. The facility's residential population typically consists of approximately 100-130 women, all above the age of 18. These women often come from low-income, rural areas of the southeastern region of the United States. Their education is usually limited, and they often come into the facility after leaving circumstances of abuse and/or homelessness.

Almost 33% of the women who enter this facility do so when pregnant or as young mothers, and they continue to raise their young children throughout the duration of their stay in the facility. Women entering the facility do so with the intent of recovering from various SUD, with opioid dependency being one of the most common. During their stay, these women undergo inpatient recovery treatment through a variety of programs. From medical assistance and detox to group therapy through 12-step guidance, the facility offers residents a variety of interventions and programs. Yet, programming for smoking cessation is not currently included in the facility's list of offerings.

Programs for smoking cessation have not been prioritized in this residential treatment community for the same reasons they are not in so many other similar facilities: to add concurrent efforts for cessation of a legal substance, such as nicotine to the already complex and specifically-designed recovery programming for SUD caused by illicit substances presents a rather extreme challenge for treatment specialists. In general, given most individuals begin smoking when their brains are still developing as adolescents, often driven by societal pressures and/or rebellious tendencies, addiction to tobacco and nicotine often forms early on in a smoker, making quitting all the more challenging (Jarvis, 2004). Furthermore, the likelihood of smoking cessation among heroin users, for example, is noted through past research to be significantly lower than that of those not suffering from opioid-related SUD (Sullivan & Covey, 2002). By compounding the difficulty of quitting smoking with recovery from a concurrent SUD, treatment specialists justify a lack of anti-smoking programming with insistence that it is a waste of resources that will likely not even be effective on a problem less severe and that it discourages

residents of treatment facilities by expecting too much of them all at once in terms of detox (Knudsen, 2016; Gulliver, Kamholz, & Helstrom, 2006).

However, in spite of the prevalence of assumed failure of smoking cessation programming when combined with SUD treatment, much research actually shows that such a combination may actually be the most effective way to address these coexisting issues (U.S. Department of Health and Human Services, 2007). While the findings of research in support of simultaneous treatment for smoking and other SUD may be modest, their clinical significance is of the utmost importance in this debate (Baca & Yahne, 2009). Furthermore, tobacco treatment combined with SUD treatment likely lessens chances of relapse in the long term. In an intervention-based study conducted by Prochaska, Delucchi, and Hall (2004), findings showed that combining smoking cessation interventions with SUD treatment resulted in a 25 percent greater likelihood of avoiding relapse. Furthermore, an overwhelming majority of smokers in the general population express a desire to quit smoking (Centers for Disease Control and Prevention, 2005), and smokers undergoing SUD treatment for additional addictions are no exception to this desire, as they too recognize the negative side effects of smoking (Clemmey, Brooner, Chutuape, Kidorf, & Stitzer, 1997; Hughes, 2002).

In light of the risks associated with smoking, especially when seeking long-term SUD recovery, it seems that residential treatment facilities remain somewhat incomplete without anti-smoking programs considering their potential to positively affect the overall recovery process. However, given the inherent challenging nature of addressing these compounding issues through recovery treatment, strategy must guide the development of such programming. Therefore, the purpose of the social marketing plan that follows is to

propose a program that encourages smoking cessation behaviors among women in this residential treatment facility in hopes that this behavior change may ultimately result in decreased likelihood of relapse in the long term.

Focus

Guided by formative research, the focus of this program revolves around the promotion of smoking cessation via social support. Qualitative data collected prior to the development of this plan shows social belonging to be a highly motivating factor both for smoking behaviors and for smoking cessation among women undergoing substance abuse recovery treatment in a residential facility. The value placed on social belonging by this target audience led to consideration of social support as a potential approach to incorporate into smoking cessation programming to aid in increasing perceived self-efficacy to quit among the target audience. Social factors including strong affiliation with a group advocating for a desired health behavior combined with encouragement from members of the social support group to engage in that behavior are noted in past research as effective positive reinforcement for enhancing self-efficacy beliefs for behavior change (Guan & So, 2016). This approach has been applied to a variety of behavior change programming, such as Alcoholics Anonymous (AA); through AA, group members engage in a 12-step recovery process to move away from alcohol abuse behaviors in an interactive, supportive group setting. The program is often described as more community-focused than treatment-intensive, an approach seen by many as more effective as group members are surrounded by similar others in an environment that is constantly advocating for a particular goal (National Public Radio, 2014). Given AA's noted effectiveness in overcoming substance abuse via social support, the same approach

has been applied to smoking cessation efforts in the past. One particular example of social support groups designed for smoking cessation include the national nonprofit organization Nicotine Anonymous (NicA). NicA has adopted the 12-step AA approach to provide smokers with in-person group settings through which they can meet with others struggling with smoking cessation to receive social support for quitting (Nicotine Awareness, 2015).

In-person social support programming is not the only method previously applied to smoking cessation efforts, however, as online communities have also been successful in providing smokers with virtual social support groups for smoking cessation. These online social support groups for smoking cessation often follow the format of a health issue-specific social networking site (SNS), a type of online community that has recently advanced to the forefront of methods for providing social support for individuals experiencing similar health issues. These health issue-specific platforms function like most other SNSs, featuring posts by individuals that their connections can interact with socially and interpersonally. However, in a health issue-specific SNS, users can join an online community that promotes a sense of exclusivity and safety through which their topics of discussion can revolve primarily around specific health concerns (Phua, 2013). Smoking cessation has been a topic of a number of health issue-specific SNSs in the past, and research on these past efforts to promote smoking cessation via an online community reflect positive findings for improving long-term smoking cessation, perceived self-efficacy to quit, and enhancing likelihood to quit in the first place (Cobb, 2010; Phua, 2011; Phua, 2013; Stoddard, Delucchi, Munoz, Collins, Perez-Stable, & Augustson, 2005). Given the success of health issue-specific SNS communities, a smoking cessation

SNS specifically designed for women undergoing substance abuse treatment could prove helpful for effectively promoting behavior change, thus resulting in long-term SUD recovery for this audience.

Given the extensive advocacy for social support as a viable strategy for the promotion of health behavior change, this plan's focus is addressed through two main components of the proposed plan, both of which address smoking cessation through social support approaches:

1. The promotion of the benefits of smoking cessation in contrast with the costs of continued smoking behaviors for recovering addicts via traditional social support group intervention.
2. The encouragement of smoking cessation behavior adoption and continued maintenance via a health issue-specific social networking site with exclusive access to interaction with other support group members.

With its value on social belonging and interaction in mind, the target audience of this plan is anticipated to find the integration traditional social support group strategies with online community involvement as a successful strategy for aiding in the adoption of smoking cessation behaviors.

Situational Analysis

In order to appropriately design and implement a plan specific to the residential treatment facility involved, an analysis of this facility's current strengths, weaknesses, opportunities, and threats must conducted. Internally, determining the facility's strengths and weaknesses give insight into the facility's current programming, the community it offers, the lifestyles of its residents, and more. From an external perspective,

opportunities for the facility to take advantage of are important to know for moving forward with an effective plan, while recognizing the potential threats to that facility and its residents is just as vital for the plan to be appropriately implemented. With the target audience in mind, the following SWOT analysis was conducted:

- STRENGTHS
  - Voluntary facility
  - Desire for SUD recovery among residents in the facilities
  - Provide residents both a home to live in as well as a social community to belong
  - Allow for family and professional lives to continue
  - Variety in treatment lengths
  - Fully staffed
  - Offers variety of classes/programs already
  - Has offered smoking cessation in past
- WEAKNESSES
  - No anti-smoking policies in place currently
  - No anti-smoking programming in place currently
  - Some staff members currently smoke
  - Other treatments prioritized before smoking cessation
  - Treatment can only last so long – all residents must leave eventually
  - Strong smoking culture among residents
- OPPORTUNITIES
  - Develop anti-smoking programming

- Develop programming that fulfills the same needs smoking supposedly does for the women
- Enforce stricter restrictions on smoking
- Support from outside organizations
- Community members/staff that can serve as spokespersons for smoking cessation
- Utilize social support and/or pressure as encouragement for smoking cessation
- Promotion of the smoking cessation as a strategy for improving chances of long-term recovery
- Emphasis on social pressure to quit smoking behaviors rather than to engage in them

❖ THREATS

- Cannot monitor residents when they leave the premises/when they graduate from the program
- Outside of recovery and back with old contacts, temptations to engage in substance abuse and smoking is much greater
- Defiance of any new policies if they were to be instated
- Backlash to discouraging smoking when nicotine is the only legal substance residents of the facility can use

Target Audience

Formative research was conducted on a sample of the facility's population prior to the development of this plan in order to guide understanding of the more complex aspects of

the audience's attitudes and beliefs toward smoking cessation. The sample consisted of 42 of the facility's female residents, all of whom were between the ages of 19 and 54 ($\bar{x}$= 31.5) and mostly Caucasian. From this sample, female representatives of the facility engaged in focus group discussions about their smoking habits, their recovery experiences, and more, providing insight for a full profile of a typical member of the plan's primary target audience segment.

Members of the sample were all staying in the facility to address their need for recovery from dependence on either alcohol, illicit drugs, or a combination of both. On top of their need for SUD recovery, an overwhelming majority of these women (93%) also reported having smoked a cigarette within the last 30 days, and almost all of them (98%) admitted to having smoked at least 100 cigarettes in their lifetime. Clearly, SUD and tobacco addiction were both heavily present among the group, highlighting the prevalence of what are both life-threatening issues among the target audience.

Given the audience's current status as residents of this treatment facility, the audience members are in the maintenance stage of behavior change in terms of seeking long-term recovery. However, in regards to their smoking behaviors, residents appeared to be conflicted between the stages of precontemplation and contemplation. Through in-depth discussions, the women revealed that they felt torn on their attitudes toward the idea of smoking cessation. On one hand, the women recognized numerous benefits that smoking cessation would provide them, ranging from better health to better finances and so on. When considering these potential benefits, the concept of smoking cessation seemed to appeal to the majority of the group. However, residents also simultaneously insisted that their current smoking behaviors benefitted them in very specific ways including stress

relief and social inclusion, coupled with the widely held assumption among the women that smoking cessation during SUD recovery was simply too challenging of a prospect for them to realistically achieve. Hence, these mixed attitudes toward the proposed behavior change leaves the audience conflicted in its readiness to act, a conflict that must be addressed through strategic messaging.

Through discussion, the target audience members revealed a variety of their primary motivators for smoking. Most common among these were stress relief, smoking addiction, and desire for social belonging. In contrast, residents also noted what might motivate them to quit smoking, focusing on concerns for their health and finances, family/loved ones, and fears of social stigmas. Throughout what they expressed as their motivations both to smoke and to quit smoking, it was revealed that the women appeared to strongly value "fitting in" with social norms and being accepted as part of an in-group. For example, the prevailing social norm in US culture is that smoking is an unhealthy and unattractive habit. Hence, when in public and surrounded primarily by non-smokers, the women recounted times that they lied about their smoking behaviors or smoked in secret, ashamed of the ways others might perceive their addiction. Yet, while "at home" in their residential treatment community where a majority of residents are active smokers, they saw engaging in smoking behaviors as a primary method for socializing with other residents. In this facility, they see smoking on the porch of the facility with other smokers in the community as the most commonly accepted way to be connected with the residential "in-group." This desire for and active pursuit of social belonging came up as perhaps the most popular theme throughout these women's discussions, making social

support and inclusion the primary incentives of the proposed social marketing plan in accordance with the target audience's values.

Behavior Objectives & Goals

In order to achieve the ultimate goal of smoking cessation among this target audience, a number of more specific objectives were identified. These objectives identify the ideal outcomes that should result from this proposed plan in terms of the behaviors, knowledge, and beliefs of the target audience.

- Objectives
  - Behavior objectives:
    - To make conscious efforts to quit smoking
    - To attend social support groups for smoking cessation while residing in the facility
    - To remain active in the online social support community for smoking cessation after graduation from the residential treatment facility
  - Knowledge objectives:
    - To understand that smoking is a substance abuse disorder with detrimental consequences
    - To understand that smoking cigarettes during recovery can increase chances of SUD relapse
    - To understand that other women struggle with smoking cessation on top of SUD recovery as well
  - Belief objectives:

        - To believe that long-term smoking cessation and long-term, successful recovery go hand-in-hand
        - To believe that smoking cessation during SUD recovery is both possible and rewarding
        - To believe that social belonging via social support for recovery is more beneficial than social belonging via group substance abuse

- Goals
    - By the end of the first year, beginning January 1, 2019, decrease the percentage of residents who report having smoked in the past 30 days by 10% compared to the preceding year.
    - By the end of the second year, ending December 31, 2020, increase the percentage of active program participants who have been in the facility for minimum of six months and who report not smoking for at least three consecutive months by 5% compared to the beginning of the program implementation.

Barriers, Benefits, & Motivators

Determining the target audience's potential barriers, benefits, and motivators regarding the proposed smoking cessation behaviors was an important purpose in conducting formative research prior to the development of this plan. Recognition of these elements reiterate the target audience's conflicted attitudes toward the adoption of smoking cessation behaviors. Identification of these factors serve as a guide for the strategic design of this social marketing plan's approach.

Barriers. A number of barriers to smoking cessation exist for this target audience. Many of these barriers highlight the challenges of smoking cessation in general, while some are even more specific to the particular circumstances of women who are actively recovering from SUD. Some of these barriers relate directly to what motivates these women to smoke in the first place, as not being able to fulfill the need that smoking currently fulfills for them seems like a high cost to consider. Barriers are especially important to consider for this social marketing plan, as addressing and eliminating aspects of these perceived barriers is one of the main purposes of the proposed program. Some of the potential barriers this audience might face for achieving successful smoking cessation include:

- Fear of exclusion from social groups of smokers
- Temptation to smoke due to "peer pressure"
- Anticipated challenges of battling the addiction
- Fear of weight gain
- Added pressure of recovering from other addictions simultaneously
- Fear of frustration/stress caused by quitting a powerful habit
- Assumption that quitting would eliminate a primary stress/coping strategy
- Smoking is the one legal substance these women can use, so it seems unnecessary to give it up while they are in the process of quitting illicit substance abuse
- Smoking gives the impression that it is a stress reliever to these women

Benefits. While the costs of smoking cessation for this target audience are noted and relevant to consider, the benefits of smoking cessation for them are not only clear but they are also powerful and straightforward. Although the benefits of smoking

from these smokers' perspectives may sometimes outweigh the benefits of smoking cessation, the benefits of smoking cessation are undeniable. Since many of these perceived benefits would appeal not just to the target audience, but likely to most individuals in general, they should certainly be highlighted as key points of messages conveyed to the audience through this social marketing plan. Some of these benefits include:

- Improved health
- Decreased judgment from non-smokers
- No fear of harming others through second-hand smoke
- Lack of odor
- Improved physical appearance (i.e., no more teeth, hair, or nail stains)
- Reduce risk of death from smoking-related illnesses
- Increase expendable income
- Aids in long-term SUD recovery

Motivators. Directly related to the benefits of smoking cessation are the motivators that would appeal to this group. These motivators are determined through an understanding of what the benefits of the behavior are combined with the inherent values and desires of the target audience. These motivators would serve as positive encouragement for the target audience to adopt the proposed behavior. They include:

- Fear of disappointing family/loved ones
- Desire for social acceptance by those in the cessation group
- Encouragement from successful quitters
- Feelings of achievement/reward

Competition & Influential Others

Some additional considerations to make in this plan relate to competing behaviors, as well as the influential external sources to which the target audience may turn. Of course, the ultimate alternative to smoking cessation is the initial smoking behavior being addressed. Yet, this is not the only behavior that smoking cessation finds itself in competition with. Other alternative behaviors that compete with organic smoking cessation include using nicotine replacement substances (i.e., Chantix, patches, gum, etc.) or smoking electronic cigarettes. In terms of these smoking alternatives that provide individuals with some sort of substance to replace their smoking behaviors, these offer what appear to be the "easier" route to smoking cessation. In the case of medications that aid in smoking cessation, these often are prescribed or at least promoted by medical doctors and do provide those attempting to quit with some assistance in doing so. However, these just provide another substance to individuals. Many find themselves becoming dependent on them, and many individuals who participated in formative research before this study even reported smoking in spite of the concurrent use of such alternatives. As for use of electronic cigarettes, while this alternative may provide what is considered an ultimately less harmful alternative to smoking behaviors, it still has its own negative side effects, and is also a more costly alternative.

While promoting a behavior change that is seen by this target audience as challenging to adopt, a helpful approach to planning includes consideration of who/what else the audience listens to, watches, and potentially looks to for guidance in decision-making. Examples of these influential others include:

- Other residents in recovery

- Successfully recovered addicts
- Support staff of the facility
- Family/loved ones

Among these influential external audiences, promotion of smoking cessation is likely common from most of these others. However, some of these sources may also engage in smoking behaviors along with the target audience. If they do not engage in the behaviors themselves, then perhaps they promote the conception that smoking cessation during recovery is too much to take on. Regardless, knowing that social pressure to quit smoking does exist, this is important to emphasize in messages directed to the target audience in order to address its needs for social belonging in a way that does not result in engaging in undesirable behavior.

Positioning Statement

It is important for women in residential treatment facilities for substance abuse disorders to see smoking cessation as an achievable goal that will enhance long-term recovery success and can be achieved with the help of social support.

Social Marketing Mix

The effectiveness of social marketing herein lies in its method of applying what are known to be effective, traditional commercial marketing practices to incite more than just purchase behavior, but potentially life-altering behavior. Social marketing is unique in that it approaches challenging issues relevant to society, including smoking and substance abuse, by designing full plans that utilize "behavioral theory, persuasion psychology, and marketing science with regard to health behavior, human reactions to messages and message delivery, and the 'marketing mix' or 'four Ps' of marketing"

(Evans, Silber-Ashley, & Gard, 2007, p. 1). The "four Ps" of marketing include product, price, place and promotion, which are the key elements of focus when designing any commercial marketing plan. In the current case of developing a plan for smoking cessation, these "four Ps" were determined based on this plan's purpose and focus in accordance with a full understanding of the target audience. In this way, the marketing mix of this plan provides a solution to the noted problem in a way that strategically appeals to the target audience.

Product. The product platform for any social marketing plan is most effective when comprised of three main components: the core product, the actual product, and the augmented product. These three aspects of the current plan's product platform are as follows:

- Core: Smoking cessation
- Actual: In-person social support groups encouraging smoking cessation
- Augmented: Membership to an exclusive online smoking cessation support group

The core product relates directly to the plan's overall purpose: smoking cessation, which results in an overall healthier lifestyle and even has the potential to enhance likelihood of long-term SUD recovery. Of course, as appealing as the benefit of good health may be, it cannot be "sold" to the target audience without more tangible features associated with actually achieving it. Thus, the next two pieces of the plan connect more so to the more physical aspects of the product, or the aspects of the product that can be used by the audience to reach this ultimate benefit. The first of these, the actual product, is the in-person social support groups the audience can participate in, thus providing the audience with the ability to socialize. Finally, to enhance the appeal of the actual product, the

augmented product access to the online community provides audience members an additional appealing feature that serves as complementary to their initial interaction with the actual product. This augmented product provides consumers the added benefits of 24/7 access, freedom of expression via profile creation and real-time updates, and more. The augmented product also allows the community that is built through the social support group to continue beyond the residents' treatment programs. By staying actively involved in the online group after leaving the facility, they will continue to receive encouragement for sustained smoking cessation and recovery behaviors, as well as potentially encourage others at earlier stages in their quitting process with their own success stories. These three levels of the product combine to offer the "consumers" within this target audience a product that has the potential to effectively fulfill components of their symbolic, functional, and experiential needs if utilized properly.

Price. The price of the proposed product platform involves more than just how much the product may monetarily cost its "consumers." Additional costs to consider are any monetary or nonmonetary incentives offered to the target audience to engage with the proposed product platform, as well as any monetary or nonmonetary disincentives noted for not taking advantage of what the product platform has to offer. These potential costs to consider include the following:

Monetary cost of tangible goods/services offered by the product platform. Participation in both aspects of the social support group both in person and via the online community is free and open to all residents within the treatment facility. There is no monetary cost to a resident to join and attend the in-person group, and there is also no monetary cost to a resident for joining and actively participating in the online support

group, even upon graduation from recovery services. However, as far as nonmonetary cost of joining the support group is concerned, the following could be potentially "costs" of the program:

- Time spent in in-person social support group sessions that could be spent doing other things (i.e., sleeping, exercising, spending time with family, eating, etc.).
- Time spent online in virtual support group that takes away from interpersonal time spent with family, friends, or others.
- Giving up the addiction/habit of current smoking behaviors.
- Exclusion from social groups of smokers.

Consideration of these costs both monetary and nonmonetary will certainly play a role in the target audience's decision of whether or not to engage in smoking cessation behaviors. Given the nonmonetary costs of the proposed plan are numerous and rather impactful, consideration of potential incentives to quit smoking as well as disincentives to continue smoking are important to emphasize through the price platform of this plan's marketing mix.

Monetary incentives. While there are no immediate financial offerings for joining the support group, incentives of monetary value will be provided throughout one's membership in the support group in a number of ways via corporate partnerships with local businesses. These corporate partnerships would ideally be formed with local organizations who could provide residents with rewards for their success in the program in ways that would motivate them to continue their smoking cessation efforts. Therefore, monetary incentives offered should relate directly to the motivations to quit smoking that

the target audience identified through formative research. With this in mind, some examples of these potential monetary incentives include:

- For each month a group member remains "smoke-free", she receives a free/discounted one-month membership to a local gym.
- Free, healthy meals would be provided by local restaurants at select social support group meetings.
- Gift cards to stores that do not sell cigarettes would be given to members of the support groups as rewards for various achievements in their smoking cessation journeys (i.e., sharing an example of a time that a group member said "no" when offered a cigarette).

These examples are just potential ideas for monetary incentives to offer, but it is important that whatever monetary incentives are offered throughout the implementation of this plan coincide with the plan's overall purpose and target audience.

Monetary disincentives. While there will not be any fines or taxes implemented for refusal to join the support group, an important monetary disincentive for continued smoking behavior is the cost of regularly purchasing cigarettes. If members of the target audience continue to smoke, they will spend extensive funds on cigarettes that they could otherwise save for other costly tangible items such as food, clothes, and more.

Nonmonetary incentives. The nonmonetary incentives that accompany this plan should all appeal to the target audience's expressed desire for social belonging, as well as potentially addressing their other motivations for smoking cessation. Examples of these include:

- Social inclusion in an exclusive group.

- ❖ Entertainment via an online platform.
- ❖ Social support and encouragement.
- ❖ Friendship with other group members.
- ❖ Improved health if group participation is effective.
- ❖ Praise from friends and family outside of the group for successful participation in smoking cessation efforts.
- ❖ Improved personal odor as smoking habits subside.

Nonmonetary disincentives. Disincentives for not joining the support group relate most obviously to the negative health side effects of continued smoking behavior, but also relate to some other potential outcomes of not participating in the group, such as:

- ❖ Exclusion from the group that does actively participate in the program.
- ❖ No access to the online social networking site offered to program participants.

Place. The third component of the marketing mix, place, is the component of the plan that identifies where the desired behavior should be performed and when. This defines when and where the elements of the product platform are utilized in order to reach the ultimate behavior change of smoking cessation. The two different approaches to social support offered by this plan, one being in-person and one being online, essentially identify two different "places" through which this plan is implemented. In these two different places, different aspects of the plan occur at different times.

In-person support groups. The first place where the target audience can go to access the proposed program is the residential facility itself. Upon arriving to the facility to begin treatment, residents will be invited to the in-person support group. The resident may choose to join the support group immediately or later on in her recovery process as

admission to the group is rolling, allowing for new participants to join at any time. Additionally, since each resident's stay in the facility varies depending on her treatment duration, residents may also discontinue their involvement in the support group at any time, as no one's residential time in the facility is permanent. Support group sessions will occur biweekly on the residential campus and will ideally occur at a time and place that does not conflict with other residential recovery programs/classes/activities. Attendance to sessions will be voluntary, but highly encouraged to all participants.

Online social support community. Access to the online community serves as an added component of social support following joining the in-person social support group. However, access to this online platform will not be available to a participant until she has completed her first phase of recovery programming as her access to technology will be limited until that point. Once a resident participating in the in-person support group has full internet and technology access, she will be invited to join the online social networking site. Once the user has access to the online site, the "place" she must go to receive social support becomes essentially ubiquitous. Considering group members are encouraged to remain active in the online support group even after their time in the residential facility has ended, she can essentially access the social support group at any time from any place where she has online access.

Promotion. The final component of the marketing mix, promotion, focuses on the messages, messengers, and creative strategies that will be distributed and implemented to make the program effective and to make its purpose and presence known to its target audience.

Key messages. Numerous messages could be used to promote smoking cessation behaviors ranging from educational messages about the dangerous side effects of smoking to the emotional messages that address how smoking affects the health of loved ones through second-hand smoke, but the key message that must be reiterated throughout this plan is one that appeals most directly to the target audience and its current circumstances. While smoking cessation seems like an unlikely and/or irrelevant prospect to much of the target audience while in residential treatment, SUD recovery on the other hand is their primary goal and reason for entering the facility in the first place. Hence, connecting smoking cessation with effective SUD recovery is highly relevant to the audience's current goals and interests. The key message that should be emphasized throughout promotion of this program, then, is one that highlights the likelihood of relapse to decrease when smoking cessation efforts are combined with SUD recovery efforts. If residents can see a direct connection between these two behaviors throughout all messages promoting the program, then additional messages to follow can address the other numerous points that can be made regarding why individuals should quit smoking in general.

Additional messages conveyed both through promotion of the program, as well as through its execution should revolve around the benefits of smoking cessation versus the costs of continued smoking behaviors by directly addressing the factors residents expressed would motivate them to quit smoking. Furthermore, to further encourage and appeal to the audience's desire for social belonging, an emphasis on smoking cessation through as a "group effort" through this program should be made.

With these key message strategies in mind, messages to promote joining the social support program/quitting smoking in general could include the following:

- "What is the point in spending time and money on residential treatment and recovery if you're just going to relapse and end up back here shortly after you leave? If you quit smoking now, your chances of relapse decrease significantly. Join 'Quitting Together' social support group today to improve your chances of staying sober for good."
- "The secret's out about the key to long-term recovery… Come to 'Quitting Together' social support group to learn what that secret is!"
- "Staying sober is easier in treatment than it is in the real world, but do you know what is even easier than all of that? Being a friend. Come to 'Quitting Together' support group to be a part of the community where quitting is winning."
- "What do cigarettes and opioids have in common? They both just want to see you fail… But in our circle, we just want to see you QUIT! 'Quitting Together': It's time for you to join the community where quitting is winning."
- "'Quitting Together' social support group: We're there to cheer you on when you're winning by quitting."

Messengers. Messages of smoking cessation through social support group sessions will be first promoted by the group's leader, who will be a current staff member of the facility who has previously smoked but has now successfully quit. In addition to this leader, guest speakers who have successfully quit both smoking and substance abuse behaviors will be invited to come share their personal quitting stories with the group whenever possible. Beyond the group leaders, however, messengers of the program's

purpose will be the group members themselves, reflecting an emphasis on word-of-mouth (WOM) promotion for this program. Once group members reach the point in their membership where they are more active via the SNS than they are via in-person sessions, messages promoting and encouraging smoking cessation behaviors are to be conveyed entirely by the group's members. Placing the power of promotion in the target audience's hands allows program participants to serve as ambassadors for their own in-group, giving them the opportunity to publicly express to others their social affiliation and to serve as opinion leaders in promoting a culture shift in the facility from one that fosters a smoking environment to one that rejects it.

Creative strategies. In order to effectively promote the proposed program and its purpose of encouraging smoking cessation among residents in this facility, some creative strategies must be applied to attract the attention of potential group members. These creative strategies are detailed in the following bullet points:

- Program name: "The Quit Crew"
- Tagline: Together, we are "crushing" the quitting game.
    - This theme of "crushing the cessation game" will be used throughout the program in numerous ways. Group members will be invited to share via in-person sessions, as well as through the online group the ways that they "crush" the urge to smoke in their daily lives. In person, sharing these stories of "crushing it" will open each group session. Online, group members will be invited to share stories of "crushing it" via posts shared with the group at any time, followed by #crushedit, providing a hashtag that can be searched within the group by all of its

members to read past stories of overcoming urges to smoke. Occasionally, contests will be held among group members where they can share stories of how they #crushedit for other members of the group to vote on. Winners of the contests would receive gift cards or other monetary incentives shared by corporate partners.

- Communication channels
    - Promotional flyers/handouts distributed throughout the facility to raise awareness of the program
        - Would be best as a visual infographic detailing the primary benefits of the group as well as its main features
    - In-person group sessions
    - Online community, where members can interact with one another via:
        - Direct messaging
        - Public posts to the whole group
        - Posting photos
        - Sharing links to resources
        - Posting videos, both live and pre-recorded

The online support group should be structured in a way that adheres to typical standards for health-issue specific SNSs. This includes having a focus on the health issue-specific behavior in focus (in this case, smoking cessation with elements of SUD recovery), featuring typical social media features like the ones mentioned above in the outlined communication channels for the group, not being sponsored by any sort of pharmaceutical or medical agency, and managed by a moderator or facilitator (Phua,

2013). The social media features of the group will be especially beneficial in allowing group members to feel some sense of control over their smoking behaviors (Kontos, Emmons, Puleo, & Viswanath, 2010) as well as to feel a stronger sense of interconnectedness with the other members of the group (Phua, 2013). Past research shows that such an effect is connected to improved self-efficacy among individuals to see smoking cessation as a feasible and attainable goal (Fishbein & Capella, 2006; Gunther & Storey, 2003; Reed, Lange, Ketchie, & Clapp, 2007; Yanovitzky, Stewart, & Lederman, 2006), directly addressing the issues with perceived self-efficacy that that target audience possesses. Additionally, since the members of the group will all be both recovered smokers as well as recovering/recovered substance abusers, discussion within the group will not be limited to smoking cessation efforts only. To create a sense of full community, discussion will be open to (albeit monitored by the group moderator as well) to all topics, especially those related to recovery from any and all substance abuse disorders. This should encourage the women to interact with the other group members on a deeper social level than just through discussions of smoking behaviors.

Monitoring & Evaluation

In order to determine the effectiveness of the program both for short-term smoking cessation efforts, as well as for long-term overall recovery sustainability, methods for monitoring and evaluation of the plan must be put into place. Through monitoring and evaluation, not only will the facility be able to determine whether or not the program is a necessary resource, but it will also provide support for whether or not similar programming should be implemented in other residential treatment facilities like

it in the future. In order to effectively monitor and evaluate this plan's effectiveness, its inputs, outputs, outcomes, and impact will need to be measured.

Inputs. The inputs that this project will consist of include the various resources allocated by the facility to implement it. These will be measured by itemizing the various input components, which will include:

- Time spent by the group leader in support group sessions.
- Corporate partners' monetary contributions to the program.
- Time spent by staff to promote joining the group.
- Time spent to create the online support group.
- Initiative and time taken to invite members of the facility support group to join the online Group.

Outputs. The output or process measures of this project look at how the various input measures were utilized by quantifying them. These include:

- Number of support group sessions held and the amount of time each session took.
- Number of corporate "gifts" provided and for what amount.
- Various communication tactics used to promote participation in the group.

Outcomes. The outcomes identify and quantify the actual results of the program, more so on the audience side. These are the factors that resulted from the inputs and outputs utilized. These are:

- Number of residents who attend support group sessions over the course of the two-year measurement period.
- Number of residents who joined the online community over the course of two year measurement period.

- Number of women who participate in the program who report attempting to quit smoking.
- Number of women who report sustained smoking cessation behaviors upon leaving the facility.
- Change in knowledge/beliefs among residents that smoking cessation and long-term recovery are directly related.

When monitoring and evaluating the effectiveness of this program, these outcome measures are crucial for quantifiable measurement. Therefore, the following techniques and methods will be used to measure these components:

- Attendance will be taken at the beginning of every in-person support group session. From this, names of residents who attend sessions will be recorded, as well as the number of times each resident attends the sessions. This will be beneficial not only for determining the reach of the program over the two-year measurement period, but also for determining how active a resident's participation in the group is to see if correlations can be drawn between how many times a resident attended the group sessions and other outcome measures like successful cessation. Specifically, the desired correlation to be found would be a positive relationship between increases in membership numbers and decreases in reported smoking behaviors.
- The number of residents who join the online support group will be monitored throughout the measurement period to determine the total number of group members at all times. Each member's ongoing activity in the group will also be monitored as her engagement with the page (i.e., number of posts liked, number

of comments on posts, number of personal posts shared, etc.) will also be recorded.

- Through formative research, it was determined through this plan that 93% of the sample reported smoking a cigarette within the last 30 days. Using this percentage for comparison, measurement of smoking cessation efforts, knowledge, and sustainability will be recorded via the following methods:
    - Upon entering recovery, all residents will be asked to complete a survey regarding their current smoking habits and attitudes toward smoking. Each resident will be asked through the survey if they have smoked in the past 30 days, as well as whether or not they know and believe that smoking cessation during recovery will improve their chances of long-term recovery. These survey results will be kept on file and their results compared to a similar exit survey taken by the residents where these same questions will be asked of them in a survey they take upon graduating from their respective recovery programs. However, added to this exit survey will be a question of whether or not the resident was involved in the "Quit Crew" cessation group and for how long as well as the duration of time they spent in recovery in general. Responses from those who report being in recovery for at least three months and participating in "Quit Crew" for at least six sessions will be included in evaluation of the program. From this evaluation, the hope is that the total percentage of residents who report having smoked in the last 30 days is reduced from 93% to 83% by the end of the two-year measurement period.

- To determine whether or not smoking cessation and substance abuse recovery are sustained, the online group will be utilized to ask participants to answer questions in a survey every three months over the course of the two-year measurement period. In this survey, group members will be asked to identify whether they are current or graduated residents, the approximate amount of time since their last smoked cigarette, and whether or not they are still sober. Every three months, these questionnaires will be shared with residents via the online platform. By the end of the two-year measurement period, the hope is that the percentage of women who report continued sobriety and smoking cessation will increase from the results of the first online survey to the results of the last online survey (i.e., from survey 1 to survey 8) by 10%.

Impact. The final measures of impact, while perhaps the most valuable and purposeful, are not so easily measured and quantified in a limited measurement time period. However, these are the most desirable of results that could come from this program, and relate directly back to the overall purpose of the program. While these may not be measured entirely during the two-year measurement period, they are important to note. They include:

- Long-term successful recovery.
- Better health.
- Better appearance.
- Improved financial well-being.
- Improved family relations.

The cost of these measurement and evaluation methods is minimal. Each survey conducted for collecting evaluation data will be done via a free survey development website and shared via a link to the free survey. To provide incentives to group members for survey completion, entrance into a raffle for a gift card or some other reward provided by a corporate sponsor will be offered to group members each time the survey links are distributed. However, rewards for survey completion will not be contingent on the types of responses group members give. For instance, if a member of the group is still actively smoking, she will still be encouraged to answer the survey questions honestly, regardless of whether or not her responses reflect successful smoking cessation efforts. Responses will be recorded anonymously to reduce the likelihood of a resident feeling pressured to give untruthful answers just to appease group facilitators. Furthermore, group members will not receive any sort of consequence administered by group facilitators if their smoking cessation efforts are not successful.

Budget

Given the partner organization's status as a nonprofit facility combined with the extensive resources it already has, the total proposed budget for this project is $0.

Table 1: Budget

Item	Cost	Description
"Quit Crew" group announcements/weekly meeting reminders	$0	Will be distributed via the facility's current communication tools including newsletters/emails
Space for group sessions	$0	Will be an available room/space on the facility's campus
Group leader	$0	Will be a facility staff member
Set-up/maintenance of online community	$0	Will be a private group made available through a free, previously existing SNS (Facebook)
Evaluation surveys	$0	Will be developed and distributed via a free online survey design site
Rewards/gifts from corporate sponsors	$0	Will come at no cost to the facility other than noting the corporate partner as a sponsor of the facility in other promotional materials and on the facility's website
TOTAL	**$0**	

Implementation Plan for January 1, 2019, Launch

The following implementation plan details the various action items that must occur for the program, who will complete those action items, when they will be completed and how much they will cost the organization. This implementation plan has been organized according to two phases, with the first focusing on the program's actual product (in-person support groups) and the second focusing on the augmented product (online support group).

Table 2.1: Phase 1 Implementation Plan

Phase 1: In-Person Smoking Cessation Support Groups			
What will be done?	**Who will be responsible?**	**When will it be done?**	**How much will it cost?**
Begin holding biweekly in-person support group sessions	Facility staff group leader	By the end of January, 2019	$0
Promote participation in the group	Facility staff via regular communication channels and residents via WOM	Ongoing	$0
Participants join the group	Residents	Ongoing	$0
Evaluate residents' initial smoking habits and attitudes toward smoking and cessation	Facility staff	Ongoing, varied by resident depending on when treatment begins	$0
Evaluate residents' smoking habits and attitudes toward	Facility staff	Ongoing, varied by resident depending	$0

smoking and cessation		on when treatment ends	

Table 2.2: Phase 2 Implementation Plan

Phase 2: Online Smoking Cessation Support Group			
What will be done?	**Who will be responsible?**	**When will it be done?**	**How much will it cost?**
Online group will be available and ready for residents to join	Facility staff group leader	By the end of January, 2019	$0
Residents invited to join group	Facility staff group leader	Ongoing, dependent on whether or not resident is far enough along in treatment to have online access	$0
Interaction among members (sharing "crushing" stories, discussing and	Group members (both current and graduated facility residents)	Ongoing	$0

sharing resources, etc.)			
Evaluate residents' retention of smoking cessation and sobriety behaviors	Facility staff group leader	Every three months via online survey beginning at the end of March 2019	$0

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EDUCATION

University of Kentucky
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Master's Thesis: *"*Quitting Together: Formative Research to Develop a Social Marketing Plan for Smoking Cessation Among Women in a Residential Treatment Facility for Substance Abuse Recovery"

University of Kentucky
Bachelor of Arts in Integrated Strategic Communication, May 2017
Minor: Communication GPA: 3.925

PROFESSIONAL POSITIONS

Graduate Teaching Assistant – University of Kentucky Department of Integrated Strategic Communication (August 2017 – present)

Marketing & Promotions Coordinator – Paul Miller Motor Company (August 2017-present)

Scholarship Fundraising Coordinator – ClearWater Academy (May 2017 – August 2017)

Dean's Office PR Intern – UK College of Communication & Information (August 2016 – May 2017)

Field Ops Marketing Intern – St. Jude Children's Research Hospital (May 2016 – August 2016)

Delta Delta Delta Collegiate Chapter President – Delta Rho Chapter (December 2015 – December 2016)

Marketing Intern & File Clerk – Drew, Eckl & Farnham, Attorneys at Law (May. 2015 – August 2015)

SCHOLASTIC AND PROFESSIONAL HONORS

Summa Cum Laude Bachelor of Arts Graduate 2017
Graduate Teaching Assistantship 2017 – 2018

EXTRACURRICULAR ACTIVITIES

University Scholars Program 2016 – 2018
A program for highly motivated students to begin graduate studies during the senior year of undergraduate school

College of Communication & Information Student Ambassador 2014 – 2017

Represented the UK College of Communication & Information at university-wide recruitment efforts

Student Leadership Council 2017
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