sonoma county
DEPARTMENT OF HEALTH SERVICES

2014 *Assessment of Smoking Policies and Practices in Residential and Outpatient Treatment Facilities in Sonoma County*

Terese Voge, Project Director
Sonoma County Department of Health Services
Health Policy Planning and Evaluation Division
490 Mendocino Ave., Ste. 103
Santa Rosa, CA 95401
707-565-6613
707-565-6619 (fax)
Ellen.swedberg@sonoma-county.org

2014 Assessment of Smoking Policies and Practices in Residential and Outpatient Treatment Facilities in Sonoma County

Contents

ACKNOWLEDGEMENTS

The 2013-2014 Alcohol, Other Drugs (AOD), and Behavioral Health Treatment Providers Workgroup of the Coalition for a Tobacco-free Sonoma County was instrumental in conducting this assessment. We would also like to acknowledge the treatment staff and facilities who participated in this assessment.

This publication was supported, in part, by the Cooperative Agreement 1H75DP004611-01 from The Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

MAIN FINDINGS

- Staff have varying levels of awareness about their facility's smoking policy.
- About 4 in 10 facilities have a smoking policy that offers the highest level of protection by prohibiting smoking on all facility premises and that applies to clients, visitors, and employees.
- About 3 in 10 facilities provide adequate protection by having a policy that prohibits smoking in all areas but not the totality of the facility premises and applies to clients, visitors, and employees, but allows smoking in designated outdoor smoking areas. At about 3 in 10 facilities there was no simple majority agreement among responding staff on the facility's smoking policy type.
- Almost 7 in 10 facilities reported that the facility's smoking policy was written.
- Overall, the majority of staff are satisfied with their facility's smoking policy. At four of the six facilities were the majority of staff report being unsatisfied with the facility's smoking policy, there were was little staff agreement on what was included in the facility's smoking policy.
- About 1 in 5 facilities' staff report disagreement or strong disagreement that the facility's smoking policy is actively enforced by all staff. Of these facilities (n=5), four of them were facilities with staff disagreement about the facility's type of smoking policy.
- Overall, there were low levels of support for cessation services and education.

BACKGROUND

Smoking is the leading preventable cause of death in the United States, causing about one in five deaths. Smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer [1].

In the past twenty years, numerous studies have demonstrated higher rates of smoking among Americans with substance use disorders (SUDs) and/or mental illness than among individuals without these conditions; higher rates of smoking for nearly every type of behavioral health condition, and; about half of smokers who access tobacco treatment services in community settings or through quit lines report a behavioral health condition [2] [3]. Individuals with SUDs or mental illness suffer from increased tobacco-related morbidity and mortality compared to those without behavioral disorders [2]. In a 2013 *American Journal of Public Health* commentary, authors called for the designation of smokers with behavioral health co-morbidities as a tobacco use disparity group, and stressed the need for strategies to addressing tobacco use among these populations in medical settings [2].

To reduce the high smoking prevalence and associated tobacco-related morbidity and mortality among populations with SUDs and mental illness, there has been increasing interest in adopting smoke-free policies and providing cessation resources in relevant treatment facilities. However, provision of cessation services and smoke-free environments remain low in these settings. In Oregon, a study found that only 15% of its community-based residential and mental health and substance addiction treatment facilities had voluntarily implemented 100% smoke-free campus policies, and about half of its facilities offered follow-up referrals and cessation medications at discharge for residents who quit smoking in residence [3]. In a nationally representative study of adult outpatient substance abuse treatment facilities, about half agreed that their staff had the skills to treat clients' tobacco dependence; one-third of facilities reported protocols, procedures, or curricula to guide staff in how to treat tobacco dependence among clients, and; about one-third of facilities had staff that had been trained specifically for treating tobacco dependence [4]. According to a 2014 Substance Abuse and Mental Health Services Administration (SAMHSA) report, about a quarter of the nation's 9,048 mental health treatment facilities that responded to the survey question about smoking cessation programs actually offered services to quit smoking, with variation by facility treatment setting (57% of inpatient only programs provided smoking cessation services, compared to 17% of outpatient only settings) [5]. In a 2004 meta-analysis of smoking cessation interventions in 19 randomized controlled trials with individuals in current addiction treatment or recovery, smoking cessation interventions were statistically significant at post treatment. Smoking cessation interventions provided during addiction treatment were associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs [6]. Thus, despite clear evidence that these populations are vulnerable to smoking and smoking-related morbidity and mortality, and that smoking cessation intervention can reduce smoking and increase sobriety, on the whole, few policies and practices are in place to prevent tobacco-related illness and death.

Each year, over 500 Sonoma County residents die of cancer, cardiovascular disease, and respiratory diseases attributable to their smoking [7]. In Sonoma County in 2011-2012, 27% of adults who needed help for emotional/mental health problems or their use of alcohol or drugs were current smokers, compared to 11% of adults who did not need this help that were smokers (statistically significant, *p-value<0.05*) [8]. The County of Sonoma Department of Health Services was able to provide the best

practice of education and training to substance use and mental illness treatment facilities about the health effects of tobacco dependence among these populations.

METHODS

The Assessment of Smoking Policies and Practices in Residential and Outpatient Treatment Facilities (ASPP) in Sonoma County was conducted from July to September, 2014. The aims of the assessment were to determine the types of smoking policies, staff satisfaction with smoking policy, and frequency and support for tobacco assessment and cessation practices/services in Sonoma County residential and outpatient treatment mental health and substance abuse facilities. The assessment was modeled, in part, after the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) and The Joint Commission surveys.

Workgroup members from the AOD and Behavioral Health Treatment Providers Workgroup used a facility list of residential and outpatient treatment facilities located in Sonoma County to call facilities and ask for their participation in a 2014 Smoke Free Treatment Assessment. This facility list was developed over the course of a year, and included facilities that serve large numbers of clients, long-standing facilities throughout Sonoma County, and facilities that receive large numbers of referrals. A special outreach effort was made to include facilities that serve minority populations. This facility list, while not comprehensive of all residential and outpatient treatment facilities in Sonoma County, was believed to represent a great majority of AOD and behavioral health clients served in Sonoma County treatment facilities. Of the 41 identified facilities on the facility list, 71% (n=29) were successfully contacted via phone as part of the 2014 Smoke Free Treatment Assessment provided a contact email address, and were informed that they would receive an email with an invitation to participate in the ASPP.

The ASPP was distributed electronically via Survey Monkey to Sonoma County residential and outpatient treatment facilities using the contact information from the 2014 Smoke Free Treatment Assessment. The contacts at these facilities were asked to send the assessment link to staff at their facility; all staff were informed that taking the survey was voluntary and anonymous to the individual, and that findings at the facility level would be reported. Workgroup members requested that at least 10 facility staff participate in the assessment, if possible.

The ASPP queried staff about the facility's smoking policy. Respondents could select one of six descriptions that best fit their facility's policy, or select "other." At many facilities there was a lack of agreement about the facility's policy among responding staff. Facilities with 50% or less agreement on the facility's policy among staff were categorized as having an "unknown" policy in the analysis. There were other measures in the assessment that lacked agreement among responding staff. These were: smoking policy enforcement by all staff, staff satisfaction with smoking policy, and changes to the smoking policy. Facilities with greater than 50% agreement on these measures among responding staff were categorized as such.

For tobacco use and cessation practices and services measures, self-identified clinical staff were considered most knowledgeable respondents, and their responses were used to make the final determination on these questions. As noted previously, facilities with greater than 50% of staff reporting "strong support" or "support," or facilities with greater than 50% reporting "always" or "sometimes" were categorized as such.

Descriptive statistics were provided in this report. Bivariate and multivariate analyses were not conducted. No significance testing was conducted.

RESULTS

An exact facility ASPP response rate was not determined, as it was unclear how many facilities exist under some umbrella organizations in Sonoma County. Of the 41 identified treatment facilities identified through the 2014 Smoke Free Treatment Assessment, 71% (n=29 facilities) participated. These 29 facilities were invited to participated in this ASPP; all but one (n=28 facilities) participated. Two-hundred and fourteen (214) staff respondents completed the ASPP; however, two respondents were excluded from this analysis as one did not include a facility name and the other did not submit valid responses.

Facility and Staff Demographics

For this analysis, there were 212 staff respondents (range 1-30 staff respondent per facility) from 28 mental health or substance abuse treatment facilities in Sonoma County (data not shown). A majority (57%, n=16) of the facilities were residential; 43% (n=12) were outpatient facilities. Of 211 respondents who provided data on position type, 50.2% (n=106) were clinical staff; 19.9% (n=42) were management staff, and; 19.0% (n=40) were clerical staff (data not shown).

Table 1. Staff respondents, by 28 participating facilities (n=212 staff respondents)

Facility name	Facility Type
A Step Up	Residential
Azure Acres	Residential
Buckelew Programs	Residential
Creekside Rehabilitation	Residential
DAAC Turning Point Orenda Detox	Residential
DAAC Turning Point Residential	Residential
Mary Isaac Center - COTS	Residential
Mill Street Supportive Housing	Residential
Mountain Vista Farm	Residential
Norton Center - PES	Residential
Progress Foundation - Parker Hill Place	Residential
Progress Foundation - Transitional	Residential
Progress Foundation Crisis - Residential	Residential
TLC Child & Family Services - Residential	Residential

Victor Treatment Centers	Residential
Women's Recovery Services	Residential
Chanate Hall	Outpatient
Community & Family Service Agency	Outpatient
DAAC Outpatient - Methadone & OPT	Outpatient
DAAC Outpatient Perinatal / Court D	Outpatient
FACT (S.C. BH)	Outpatient
Goodwill Wellness & Advocacy Center	Outpatient
Petaluma Peoples Services Center	Outpatient
Russian River Empowerment Center	Outpatient
Santa Rosa Community Health Centers	Outpatient
Sonoma County Indian Health Project	Outpatient
Sonoma Valley Community Health Centers	Outpatient
West County Health Centers	Outpatient

Facility Smoking Policy Type, Enforcement, Staff Satisfaction, and Changes

Facility Smoking Policy. At many facilities, there was disagreement among staff about the smoking policy type. Respondents were asked to select from six descriptions that best described their facility's smoking policy. Of the 28 responding facilities:

- Thirty-nine percent (39%) reported Policy A, the most comprehensive smoking policy.
- Twenty-nine percent (29%) reported Policy B, which allows smoking in designated outdoor smoking areas.
- The facility policy was considered to be unknown at 29% of the facilities because there was no simple majority agreement among responding staff.
- One facility reported Policy D, or "other" (Table 2).

Table 2. Facility Smoking Policy (n=28 facilities)

	n	%
A. Smoking is prohibited on ALL facility premises (indoors and outside). There are no designated smoking areas on the campus; the facility is totally a smoke-free campus. The policy applies to clients, visitors, and employees.	11	39.3

B. The smoking policy allows clients, visitors, and employees to **smoke only in designated outdoor smoking areas**. The policy prohibits smoking inside all facility buildings and on most facility property outdoors.	8	28.6
C. Policy unknown; no simple majority agreement among staff.	8	28.6
D. Other.	1	3.6

Of the facilities with Policy A, 5 were residential and 6 were outpatient facilities. Of facilities with Policy B, all but one (n=7) were residential facilities (data not shown).

Written policy. Respondents were queried whether or not their facility's smoking policy was written. Among responding facilities, 68% reported a written smoking policy; 18% of facilities reported that it was unknown whether the policy was written or not, and; 14% reported an unwritten smoking policy (Table 3).

Table 32. Written Smoking Policy (n=28 facilities)

	n	%
Yes, smoking policy is written.	19	67.9
No, smoking policy is not written.	4	14.3
Unknown; no simple majority agreement among staff.	5	17.9

Among staff at the same facility, there was lack of agreement on whether the facility's smoking policy was written or not (data not shown).

Policy enforcement by all staff. Eighteen percent (18%, n=5) of facilities reported "strong disagreement" or "disagreement" that the smoking policy was actively enforced by all staff. Of these five facilities, four of them where facilities were the smoking policy type was unknown (data not shown).

Staff satisfaction with the facility's smoking policy. At least a majority of staff reported being "satisfied" or "very satisfied" about their facility's smoking policy at 79% (n=22) of facilities. Of the six facilities with staff dissatisfaction with the smoking policy, 67% (n=4) of those facilities' smoking policy type was unknown (data not shown).

Changes to facility's smoking policy since April 2013. At three facilities, the majority of responding staff reported, "I don't know," or, "I did not work here before April 2013," to the question about smoking policy changes since April 2013. These responses were excluded from this analysis. Among the

remaining 25 facilities, 16% (n=4) reported changes to the facility's smoking policy since April 2013; 76% (n=10) reported no changes, and; 8% (n=2) did not answer this question (data not shown).

Facility Support of Cessation Education and Services

Respondents were asked about the level of support ("strong support," "support," "somewhat supported," "not applicable," "I don't know") staff receive to address tobacco use with clients. Clinical staff were considered the most knowledgeable respondents and their responses were used to make facility determinations. Twenty-eight percent (28%) of facilities reported "strong support" or "support" for "making/facilitating referrals to physicians for nicotine replacement therapy for clients." Up to date tobacco/cessation information given to staff to share with clients and providing nicotine replacement therapy to clients was "strongly supported" or "supported" by 24.0% and 20.0% of facilities, respectively (Table 4).

Table 4. Facility support of cessation education and services, according to clinical staff (n=28 facilities)

	"Strongly supported" or "Supported"
	n (%)
Making/facilitating referrals to physicians for nicotine replacement therapy for clients	7 (28.0)
Up to date tobacco/cessation information is given to staff to share with clients	6 (24.0)
Providing nicotine replacement therapy (patches or gum) to clients	5 (20.0)
Staff are trained about tobacco/nicotine addiction	4 (16.0)
Staff are trained as cessation facilitators	3 (12.0)
Incentives for clients to quit smoking	0 (0.0)

Frequency of tobacco use assessment, intervention, cessation services, and referrals

Respondents were asked to describe frequency ("never," "sometimes," "always", "I don't know") with which tobacco use was addressed with clients at the facility. Clinical staff were considered the most knowledgeable respondents to describe frequency of these services and their responses were used to characterize their facility's tobacco-related services. Half (50%, n=14) of facilities reported that smoking interventions were documented in client treatment plans "always" or "sometimes." Staff discussion of cessation when a client introduced it as a topic for discussion and client receipt of referrals to 1-800-NOBUTTS occurred "always" or "sometimes" at 46.4% of facilities (Table 5).

Table 5. Frequency of tobacco use assessment, intervention, referrals, and services, according to clinical staff (n=28 facilities)

	"Always" or "Sometimes"
	n (%)
Smoking interventions are documented in client treatment plans	14 (50.0)
Cessation is discussed by staff when a client introduces it as a topic for discussion	13 (46.4)
Clients receive referrals to 1-800-NOBUTTS	13 (46.4)
Clients are screened for smoking issues at intake	12 (42.9)
Staff or physicians regularly work one-on-one with clients about cessation	12 (42.9)
Active referrals are made for nicotine replacement therapy	11 (39.3)
Cessation education is integrated in treatment groups	7 (25.0)
Upon discharge, plans are made for medications, follow up referrals to help with smoking cessation	5 (17.9)
Weekly cessation groups are available on site	4 (14.3)
Clients are transported to cessation off-site or staff discusses off-site cessation classes with clients	2 (7.1)

Very few facilities offered weekly cessation groups on site (14.3%) or transportation to off-site cessation or discussed off-site cessation classes with clients (7.1%) (Table 5).

LIMITATIONS

Some of the assessment questions may not have been applicable to all facilities, depending on the type of facility, services provided by that facility, and the type of patients at the facility. For questions with greater than 50% of respondents selecting “not applicable,” related to facility support of staff to work with tobacco-using client, then the service or practice was considered inapplicable to the facility and the level of support was not reported. When this issue was discussed with the AOD and Behavioral Health Treatment Providers Workgroup, members noted that there were tobacco-related services and practices not applicable to responding organizations in which less than 50% of staff reported “non-applicable.” An example included a facility that provides short-term emergency care in which it would not be appropriate to expect group services. For questions related to the frequency of tobacco cessation practices and services offered to clients, respondents were not provided with a “not applicable” answer choice. Thus the findings reported in Table 4 (facility support of staff) and 5 (frequency of services offered to clients) were potentially underestimated, as facilities that should have been excluded from these questions were included.

The representativeness of these findings are limited due to the following: (1) while Sonoma County’s Treatment Facility List is believed to be comprehensive and representative of the vast majority of people seeking behavioral health or substance abuse treatment in Sonoma County, this Facility List may not represent all treatment facilities and patients receiving treatment, and; (2) about one in four of the identified facilities did not participate in the ASPP. These facilities could be different than the participating facilities, and thus limit the representativeness of the findings.

CONCLUSIONS

Smoking Policy, Type, and Enforcement. We found that there was staff disagreement on the smoking policy type within facilities, as well as incongruence between staff at the same facility about support for cessation services and frequency of cessation practices. Overall, we found that almost four in ten facilities had a comprehensive smoke-free policy (no smoking anywhere), and almost three in ten facilities only allowed smoking in designated outdoor smoking areas. However, almost three in ten facilities did not have staff agreement on the policy type, and so we were unable to determine those facility's smoking policy. Almost seven in ten facilities reported a written smoking policy. About one in five facilities reported "strong disagreement or disagreement" that the smoking policy was actively enforced by all staff. Almost four in five facilities reported being "satisfied or very satisfied" with the facility's smoking policy.

Facility Support and Frequency of Cessation Services. Overall, clinical staff reported low facility support of cessation education and services. Facilities reported the strongest leadership support for "making/facilitating referrals to physicians for nicotine replacement therapy to clients," and no "support or strong support" for "incentives for clients to quit smoking." The most frequent tobacco use service was the documentation of smoking interventions in client treatment plans, which was reported at half of the facilities "always" or "sometimes." Very few facilities reported that plans upon client discharge were made for medications and follow up referrals for smoking cessation happened frequently; weekly cessation groups also did not occur frequently.

POTENTIAL ASSESSMENT QUESTION REVISIONS

While the ASPP asked respondents about the number of *annual clients served*, staff respondents reported such a wide range of *annual clients served* that the data were not useful. Thus, facility determination of clients served was unable to be determined. Similarly, respondents were asked to report the number of staff at their facility, and wide ranges were reported, preventing a final determination. In order to better characterize these facilities, the AOD and Behavioral Health Treatment Providers Workgroup will utilize the annual 2014 Smoke Free Treatment Assessment to determine annual facility client and staff numbers. These will be used to categorize service levels in the next ASPP.

After initial review of this report, members of the AOD and Behavioral Health Treatment Providers Workgroup discussed reconsidering the decision to use the 51% threshold used to determine policy type, written policy type, level of support, and frequency of services for the next ASPP. This Workgroup may make a future recommendation for a higher threshold to determine these outcomes. Members of this Workgroup also identified terms that may have been misinterpreted in the ASPP, and these include; "designated outdoor smoking areas" compared to informal or "suggested" smoking areas, and "remote locations outside the smoke-free perimeter of the campus."

REFERENCES

1. *The health consequences of smoking—50 years of progress: A report of the surgeon general.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. **17**.

2. Williams, J.M.S., M.L.; Griffiths, K.G.; Cooperman, N. , *Smokers with Behavioral Health Comorbidity Should Be Designated a Tobacco Use Disparity Group.* Am J Public Health, 2013.
3. Drach, L., et al., *Promoting smoke-free environments and tobacco cessation in residential treatment facilities for mental health and substance addictions, Oregon, 2010.* Preventing chronic disease, 2012. **9**.
4. Hunt, J.J., et al., *Capacity of US Drug Treatment Facilities to Provide Evidence-Based Tobacco Treatment.* American Journal of Public Health, 2013: p. e1-e3.
5. *About 1 in 4 Mental Health Treatment Facilities Offered Services to Quit Smoking*. 2014, Substance Abuse and Mental Health Services Adminstration, U.S. Department of Health and Human Services.
6. Prochaska, J.J., K. Delucchi, and S.M. Hall, *A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery*. 2004, American Psychological Assn.
7. *Sonoma County Smoking-Attributable Mortality Among Adults Age 35 years and Older, 2006-2010 Annual Average*. 2012, County of Sonoma.
8. *California Health Interview Survey (CHIS) 2011-2012*. UCLA Center for Health Policy Research.