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Tobacco-free grounds implementation in California residential substance use disorder (SUD) treatment programs

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ABSTRACT

Smoke-free laws and policies have contributed significantly to the decline in smoking in the U.S, but are not often applied in high-prevalence smoking populations where they are most needed. Smoking among clients in publicly funded substance use disorder (SUD) treatment is 3–4 times higher than the general population, and little is known about tobacco policies programs have adopted. To identify the prevalence of tobacco-free grounds and other smoking policies in California's publicly funded, adult, residential SUD programs. Using a California DHCS contact list of 1,921 publicly funded, non-medical, SUD programs, 362 were eligible to participate in a brief semi-structured phone survey concerning indoor and outdoor smoking for staff and clients and other tobacco policies. Of 259 programs that completed the survey, 28 (10.8%) reported tobacco-free grounds. 91 (35.1%) expressed interest in implementing tobacco-free policies and 23 have plans to do so. Nearly all programs ($n = 253$, 97.7%) had some policy restricting e-cigarette use, and 110 (43.5%) of these reported a complete ban on e-cigarette use. 124 (47.9%) had policies prohibiting staff and clients smoking together. Most California residential SUD programs allow outdoor smoking for staff and clients and few have adopted tobacco-free grounds policies. Given the reported interest in adopting tobacco-free policies, the high density of smokers in the SUD population, and the association of tobacco-free policies with lower client and staff smoking rates, state licensing and regulatory agencies, as well as county health departments, should work with SUD programs to adopt tobacco-free policies.

KEYWORDS

Tobacco cessation services;
addiction treatment;
smoking; policy

Introduction

The prevalence of cigarette smoking among U.S. adults was 14% in 2017, but smoking is more prevalent in subgroups: 23% among those without a high school education, 25% among those who are uninsured, and 35% among those reporting serious psychological distress.¹ Among 4 million people (aged 12 and older) who receive substance use disorder (SUD) treatment annually² smoking rates are very high. A recent survey of clients ($N = 1,702$) enrolled in 24 SUD treatment programs recruited from 14 states reported a 77.6% smoking prevalence.³ In addition to smoking at higher rates, smokers with co-occurring SUDs smoke more heavily⁴ and are less successful in quitting smoking⁵ when compared to general population smokers. Persons receiving SUD treatment, over time, are nearly twice as

likely to die of tobacco-related causes compared to the general population.⁶ Many smokers in SUD treatment are interested in quitting smoking,⁷ and there is evidence that quitting smoking improves other drug treatment outcomes.^{8–10}

Smoke-free laws and policies have contributed to the decline in smoking in the U.S., but are often not applied in high prevalence smoking populations.¹¹ Workplace smoking bans increase cessation and reduce cigarette consumption,^{12,13} and offer one approach to reduce smoking in SUD settings. One type of workplace smoking ban suited to SUD programs is a tobacco-free grounds policy, which bans smoking on all indoor and outdoor program grounds.¹⁴ Tobacco-free grounds policies have been implemented in over 4,000 hospitals and clinics,¹⁵ and over 2,000 colleges and universities¹⁶ across the US.

Tobacco-free grounds policies have also been implemented, by government agencies, in some states. New Jersey implemented tobacco-free grounds in residential SUD treatment programs in 2001. One year post-intervention, all programs provided assessment or treatment for tobacco dependence, 80% had treatment available for smoking staff, and 85% offered nicotine replacement therapy (NRT) to the clients they served.¹⁷ The New Jersey policy was encouraged but not enforced, and some programs later rescinded it.¹⁷ New York State implemented tobacco-free grounds in all publicly-funded SUD treatment programs in 2008. In one study, this policy was associated with a significant decrease in client smoking prevalence (69.4% to 62.8%),¹⁸ and in another, it was associated with increased use of tobacco cessation services.¹⁹ Oregon mandated all residential SUD programs to have tobacco-free grounds in 2013. Most programs (70%) adopted the policy by 2014, corresponding with an increase in programs screening for tobacco use (92% vs. 83%), and an increase in referrals of clients (51% vs. 32%) to the Oregon Quitline.²⁰ From 2010 to 2013, Utah implemented tobacco-free campus policies in SUD and mental health facilities, although little published information is available.²¹ An academic-community partnership implemented the Taking Texas Tobacco Free initiative in 18 local mental health authorities in Texas, and reported increased tobacco assessments and increased tobacco cessation intervention conducted by providers.²²

Tobacco-free grounds in SUD treatment are associated with lower staff smoking rates,²³ smoking fewer cigarettes per day among clients, and lower rates of staff and clients smoking together.²⁴ One program reported that implementing tobacco-free grounds had no affect on client census.²⁵ Two residential programs implementing tobacco-free grounds prospectively reported a significant decrease in client smoking prevalence (92.5% v. 67.6%) and a significant increase in tobacco services received by clients.²⁴

In 2015, one-third of U.S. SUD treatment programs had smoking bans on their property.^{26,27} Papers concerning tobacco-free grounds policies in New Jersey,¹⁷ New York¹⁸ and other states²⁸ report that residential treatment programs

encounter more barriers to implementing these policies than do outpatient programs, and Shi and Cummins²⁷ found that residential programs (as compared to nonresidential programs) were less likely to have tobacco-free grounds.

California has a large publicly-funded SUD treatment system, serving 249,000 annual admissions representing 195,000 unique individuals.²⁹ Residential treatment admissions accounted for 15.8% of the total system admissions.²⁹ The California Tobacco Control Program (CTCP) currently identifies persons with SUDs as a priority population.³⁰ In 2018, the CTCP launched an initiative designed to help residential behavioral health programs implement tobacco-free grounds.³¹

To our knowledge, no studies have reported on tobacco-related policies among residential SUD treatment programs in California. We report on a survey of California publicly-funded residential SUD treatment programs, designed to learn what proportion of licensed programs have implemented tobacco-free grounds policies, and key features of those policies.

Methods

Program identification

Eligible were all California-licensed, non-medical, residential SUD treatment programs, serving adults. Programs serving youth, programs located in correctional settings, and Veteran's affairs (VA) programs were excluded, as tobacco policies in these programs are governed by legal or regulatory policies set above the program level.

The California Department of Healthcare Services (DHCS) maintains a public list of all non-medical drug abuse treatment programs that are licensed and/or certified by the State.³² The list includes program name, address, phone number, service type, resident occupancy and capacity, and service population. Service type indicated whether the program provided services in residential, nonresidential, detoxification, both residential and detoxification, group home (youth), or correctional settings. The service population code indicated whether the program served women only, men only, both men and women, women and children, families, or youth.

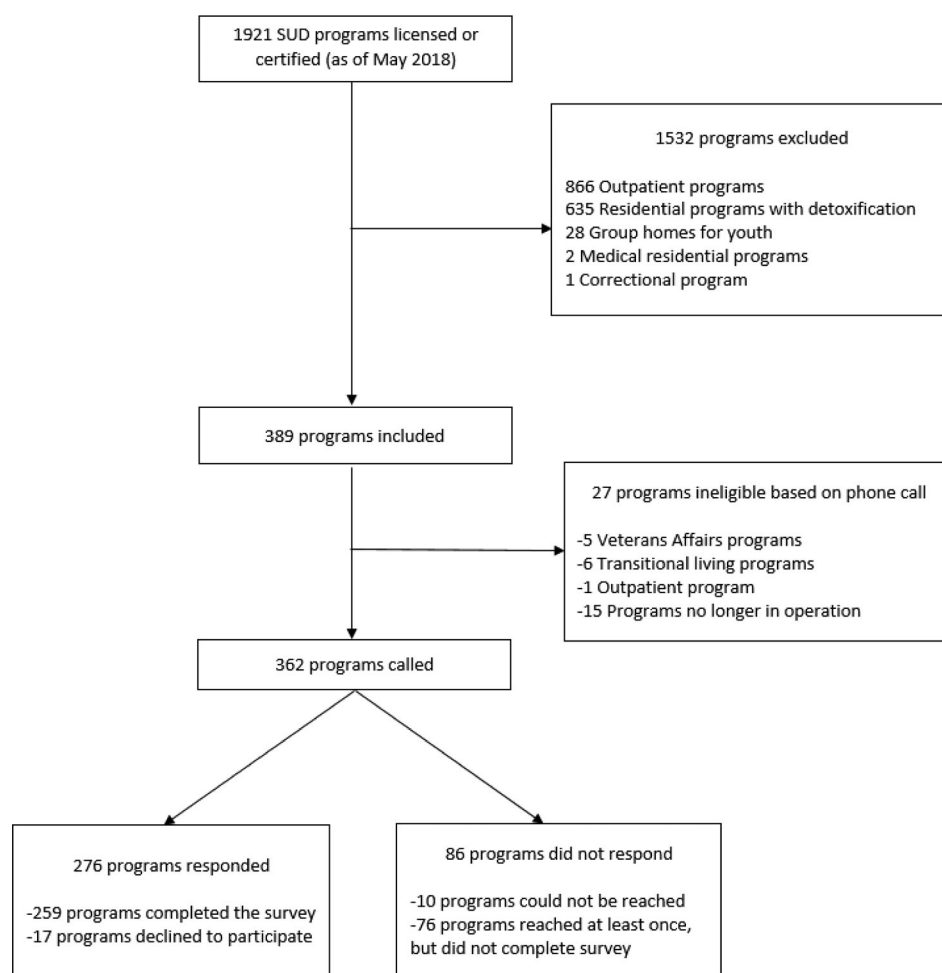


Figure 1. Flow chart of study inclusion.

The DHCS program list is updated periodically. We used the version posted in May 2018, which listed a total of 1,921 licensed or certified drug abuse treatment programs. We first filtered the list using adult residential program type only, yielding a shorter list of 389 California licensed adult residential programs. In the process of calling the 389 programs, 27 were found to be ineligible due to either service type or population. The final number of eligible programs was 362 (Figure 1).

Measures

Data were collected using a brief (approximately 5 minute) structured phone survey. The survey asked the name of the respondent and the respondent's role in the program and verified basic program information reported in the DHCS listing (e.g., address, total number of beds).

Tobacco-free grounds was assessed using questions modified from Muilenburg et al.²⁶ The respondent was asked whether smoking was permitted indoors for anyone and, if yes, whether there were designated indoor smoking areas for clients and/or staff. The respondent was then asked whether smoking was allowed outdoors within program grounds and, if yes, whether there were designated outdoor smoking areas for clients and/or staff. If smoking was not allowed either indoors or outdoors on program grounds, for clients and staff, then the program was coded as having tobacco-free grounds. Programs that did not have tobacco-free grounds were asked if they had implemented tobacco-free grounds in the past, and if they had plans to implement tobacco-free grounds in the future.

Given use of e-cigarettes in this population,^{33,34} the survey asked whether current smoking policies extended to e-cigarettes. Last, as the

practice of staff and clients smoking together has been associated with higher rates of staff smoking and fewer tobacco-related services for clients,²⁴ respondents were asked whether the program had a policy prohibiting staff from smoking with clients.

Procedures

Survey data collection

Phone survey data were collected between June 2018 and February 2019. The data collection protocol was to call each program, up to a maximum of three calls per program, using the phone number listed in the State directory. If calling a program's listed phone number resulted in an incomplete call (e.g., wrong number, disconnected line) on the first try, the research assistant (RA) used the internet to search for updated program contact information.

Initially, phone surveys were conducted by four RAs who had participated in survey development. Subsequently a fifth RA was trained in phone survey procedures by first observing phone surveys and then conducting surveys while supervised. Overall, 84% of programs were called by two RAs (JW, DY), while 16% were called by the other three RAs.

Phone calls were guided by a script (<https://doi.org/10.6084/m9.figshare.9750611.v4>) that identified the caller and the reason for the call. If the respondent felt able to answer questions about the program's tobacco policy, then the respondent completed the phone survey. If the respondent felt unable to answer these questions, then the RA asked to speak with a staff member or administrator who could answer the questions. If no one was available to answer questions, the RA requested contact information for a program administrator, recorded the name and number of the person, and used that contact information for future calls. In 7 cases, respondents asked to complete the survey by email. Survey respondents included program directors and program managers, counselors, administrative assistants, and compliance, human resource and quality assurance personnel.

Descriptive data include survey response and completion rates, number and proportion of

programs reporting tobacco-free grounds, electronic cigarette policies, and whether tobacco policies included prohibiting staff and clients from smoking together. Procedures were approved by the University of California San Francisco Institutional Review Board under expedited review and with waiver of written consent.

Results

Survey response and completion

Among 362 eligible programs, 276 were reached (76.2% contact rate), 17 programs (4.7%) declined participation, and 259 (71.5%) completed the survey. The remaining facilities either could not be reached by phone ($N = 10$), or were reached at least once but did not complete the survey after 3 calls ($N = 76$).

Tobacco-free grounds

Among programs completing the survey, 28 (10.8%) reported having tobacco-free grounds. While not asked systematically as part of the survey, some programs volunteered additional information. Thirteen programs required clients to quit smoking upon enrollment, while nine programs permitted smoking off of program grounds. The remaining 6 programs did not describe their tobacco-free grounds policy.

Some programs reported reasons for implementing tobacco-free grounds. These included contractual requirements with funding sources, viewing nicotine as an addictive substance on par with other addictive substances, a program focus on wellness incompatible with tobacco use, and/or because children also lived in the facility. Two programs had previously experienced a fire in their program while one program, located in a forested environment, was concerned about potential fire risk associated with smoking outdoors. Among the 28 programs that had tobacco-free grounds, 10 programs were for women or women with children only, 5 programs were for men only, and 13 programs served both women and men.

Of programs completing the survey, 91 (35.1%) expressed interest in implementing tobacco-free policies and, of these, 23 were

planning to implement tobacco-free grounds. Thirteen programs reported having implemented and rescinded tobacco-free grounds. Reasons these programs abandoned tobacco-free grounds included concerns about client census and client retention, concerns expressed by staff and clients about how tobacco-free policy may impact client recovery, and threats from a referral source to stop referring clients. Of the programs that had implemented and then rescinded tobacco-free grounds, 5 planned to re-introduce the policy in the future.

Policies on electronic cigarettes and staff and clients smoking together

Nearly all programs ($n = 253$, 97.7%) had some policy restricting the use of e-cigarettes. Of those, 166 (65.6%) restricted use of e-cigarettes to the same times and locations as combustible cigarettes, while 110 (43.5%) reported a complete ban on e-cigarette use on program grounds. E-cigarette restrictions included requiring vaping liquids to be sealed and inspected when they were brought into the program, banning devices that produced slight vape clouds that were difficult to detect, banning e-cigarettes for clients but not for staff, and keeping e-cigarettes locked in an office when clients were not on smoke breaks. Participants reported that restrictions or complete bans on the use of e-cigarettes were intended to prevent use of other substances in the devices, prevent surreptitious indoor use, and in one case because an e-cigarette had previously exploded inside of the program. With regard to staff and clients smoking together, close to half ($n = 124$, 47.9%) said they had policies prohibiting this practice in their program.

Discussion

Of the California residential programs completing the survey, 10.8% said they had tobacco-free grounds, meaning that smoking was prohibited anywhere indoors and outdoors within program grounds. This is lower than the 32.5% reported in a national sample of programs,²⁶ and lower than the 34.5% of programs reporting tobacco-free grounds in the 2018 N-SSATS.³⁵ However,

those reports did not break out tobacco-free grounds policies specifically among residential programs. Shi and Cummins²⁷ found that residential programs (as compared to nonresidential programs) were only half as likely to report tobacco-free policies. This converges with current findings for California, where 26% of all programs have tobacco-free grounds,³⁵ but 10.8% of residential programs reported tobacco-free grounds in the current study. That residential programs report a lower rate of tobacco-free grounds, as compared to all programs, supports the contention that residential programs may have greater difficulty in implementing tobacco-free policies.¹⁸ Last, the 10.8% figure in California offers a benchmark against which to compare any future change in tobacco-free grounds implementation, which may occur in context of funding initiatives (e.g.³¹), regulatory changes, or legislative mandates.

Over one-third of programs surveyed (35.1%) expressed interest in implementing tobacco-free policies, and 23 of those programs planned to implement such policies. This suggests that many California residential SUD programs are concerned about smoking rates among the population they serve, and have considered program-level action even in the absence of any state-level guidance or mandate. If the responsible DHCS regulatory office provided direction on tobacco-free policies, over 45% of California residential SUD programs would either have some interest developing such policies (35.1%) or would already have such policies in place (10.8%).

Efforts to implement tobacco-free grounds should take seriously reports where programs tried and then rescinded this policy. No published studies of tobacco-free grounds to date have reported negative impacts in SUD treatment. Concerns about negative impacts on client recovery are counter to existing literature,^{23–25} and threats of decreasing referrals from outside sources should be addressed by educating referral sources. All of these challenges would be mitigated by state regulatory requirements for tobacco-free grounds, which create a “level playing field” for programs in terms of referrals, client census, and retention.

Anecdotally, programs reported two approaches to implementing tobacco-free grounds. One approach required clients to quit smoking at the time of admission, resulting in enforced abstinence. This more restrictive approach may require additional client incentives to remain in a tobacco-free program, for example a court mandate to participate in treatment or a child custody agreement tied to treatment participation. The less restrictive approach required no smoking on program grounds, either indoors or outdoors, but allowed clients to smoke when able to leave program grounds. In the case of a small urban program this may be as easy as walking across the street, but in larger urban programs or spacious or heavily forested rural programs the challenge of leaving program grounds can be greater.

In one study of SUD programs, 23.6% of respondents had used an e-cigarette or vaping devices in the past 30 days, and 14.9% reported using these devices on a daily or weekly basis.³⁶ In the current study, nearly all programs reported having an e-cigarette/vaping policy in place. Anecdotal reports from respondents suggest that some reasons for vaping device restrictions were to avoid client use of low volume smoke devices where use was hard to detect, and to minimize risk that clients would use vaping devices to administer substances other than nicotine.

There is a tradition, in community-based SUD treatment, to hire staff from the ranks of persons who completed treatment and are in recovery. This builds SUD treatment staff who often have lived experience relevant to counseling others, and may enable access to professionally dedicated staff at lower cost.²⁴ However, as smoking prevalence is elevated among SUD clients, so may it be elevated among SUD staff. The practice of staff and clients smoking together normalizes a health risk behavior³⁷ and is associated with clients receiving fewer tobacco-related services.²⁴ Policies prohibiting staff and clients from smoking together are achievable even in the absence of tobacco-free grounds, and in the present study two-thirds of programs reported having such policies. However these policies require monitoring and enforcement to be effective, as prior research found that 27% of clients in tobacco-free grounds

programs reported observing staff and clients smoking together.³⁸

Included in this study were California residential SUD programs only, and results may not generalize to other states, or to outpatient programs. While 71.5% of the intended programs completed the survey, we have no information concerning tobacco policies in the non-responding programs. The survey itself was brief, in order to support a high response rate, but this also limited the amount of detail collected. The presence or absence of tobacco-free grounds policies, program interest in implementing tobacco-free grounds, and a few additional questions were asked systematically. Information about whether tobacco-free policies required clients to quit smoking while in the program, and examples of e-cigarette restrictions were not systematically collected and may not represent all programs surveyed. Survey respondents included staff in a range of positions, not restricted to program leadership, and this may lead to some unknown error associated with inaccurate reporting. However, at least for the primary measure of presence or absence of tobacco-free grounds policies, we anticipate that all staff would be aware of the policy. Survey responses relied on staff self-report, and there could be a tendency to overstate program tobacco control policies. Interviews with program directors,²⁸ or surveys of program staff³⁹ or clients⁴⁰ may reduce potential for bias or error in reporting.

In California, the tobacco control program is located in the state department of public health (DPH) while the SUD treatment regulatory authority is located in a separate department (DHCS). The tobacco control program has shown interest in improving tobacco-related policies in SUD treatment, but the DHCS treatment licensing authority has not. Consequently, further implementation of tobacco-free grounds in drug treatment will occur, as with many policies in the history of tobacco control, program by program or perhaps county by county. The potential to reach California smokers through drug treatment programs, however, is high. Given annual admissions of 195,000 unique persons²⁹ and a 76.3% smoking prevalence,⁴¹ the California drug abuse treatment system reaches nearly 150,000

California smokers each year. Few health care systems can reach this density of smokers, and few healthcare systems would remain passive in the face of this tobacco-related health burden.

While this study was conducted in California, findings have broad relevance both for SUD treatment and for tobacco control. An estimated 2.4 million persons receive SUD treatment in specialty care settings in the US annually.² Over two-thirds of those persons are smokers,³ making smoking the single most prevalent co-occurring health risk factor for this population, and leading to both premature and excess tobacco-related mortality.⁶ Every state government should be concerned with these health disparities and, while every state has the opportunity for policy intervention to reduce smoking in SUD service populations, few states have acted.^{17,19–22}

Disclosure statement

The authors have no conflicts of interest to disclose.

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