Title of Project. Wellness & Recovery Learning Community

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Organization. National Council for Behavioral Health in partnership with Behavioral Health and Wellness Program

Inclusive Dates of Project. April 2015 – August 2016

EVALUATION REPORT

Prepared by Behavioral Health & Wellness Program, University of Colorado, School of Medicine

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Wellness and Recovery Learning Community Final Evaluation Report

Structured Abstract

In August 2015, the National Council for Behavioral Health in collaboration with the Behavioral Health & Wellness Program kicked off an eight-month learning community designed to improve the provision of tobacco cessation services to both the staff and clients of substance use treatment centers. Selected organizations were required to attend four webinars and four one-on-one consultations with subject matter experts. Pre-post progress was assessed using tools aimed to measure organizational change, as well as staff and clients' attitudes and behaviors. WRLC facilitated quality improvement strategies using a Plan-Do-Study-Act model.

Initial goals and potential associated barriers fell into three categories: Training, Operations, and Funding. All organizations developed a training goal. All organizations identified an operations-based goal. Anticipated barriers included:

- Competing demands, especially for primary care providers including nurses, physicians, and psychiatrists
- Previous lack of success implementing tobacco-free policies
- Variability of organizations' treatment sites potentially necessitating different policy approaches
- Patient welfare (e.g., concerns regarding increased agitation, leaving against medical advice)
- Potential decreased census

Early in the project, organizations voiced anxiety related to setting organizational tobacco services and support goals, specifically around implementing tobacco-free policies. But as agencies met early project goals, their confidence increased and sites extended initiatives into other tobacco control areas including tobacco-free campus policies. All three survey instruments indicated significant progress was made in all major areas of tobacco control including implementation of the "5As" model, providing pharmacotherapy and counseling, quitline referrals, referrals to other community services, and the development of tobacco free policies for both staff and clients.

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Wellness and Recovery Learning Community Evaluation Report

Purpose

The University of Colorado, Behavioral Health and Wellness Program (BHWP) was contracted by National Council for Behavioral Health (National Council) to serve as educators, technical assistance consultants, and evaluators of the Wellness and Recovery Learning Community (WRLC) program, funded by a grant from Pfizer, Inc. The program was intended to reduce health outcome disparities related to tobacco use among people with substance abuse disorders by improving evidence-based and best practice tobacco prevention and cessation efforts in the WRLC participant sites.

Scope

Overall Goal & Objectives

In alignment with the Healthy People 2020 Tobacco Use goal, the overall goal of the Wellness & Recovery Learning Community (WRLC) is to reduce tobacco-related illness, disability and death in adults with substance use disorders in the state of Florida.

The National Council for Behavioral Health (National Council) in partnership with the University of Colorado Department of Psychiatry, Behavioral Health and Wellness Program (BHWP) aimed to accomplish the following objectives:

- Increasing tobacco screening in the WRLC participating organizations;
- Increasing access to tobacco cessation counseling services and FDA-approved pharmacotherapy in the WRLC participant sites;
- Strengthening cross-system collaboration between WRLC participant sites and the Bureau of Tobacco Free Florida (Florida's Tobacco Quitline Administrator); and
- Increasing knowledge in both the substance use treatment and tobacco control fields on tobacco cessation evidence-based and best practices and care coordination for adults with substance use disorders.

Background & Context

The burden of tobacco-related illnesses, disability and death in America is disproportionately experienced by the most vulnerable populations. The 50th Anniversary Surgeon General's Report on Smoking and Health shows great progress has been made in reducing tobacco use in the United States, yet people with substance use disorders have not benefited from the same advancement. In 2013, the Centers for Disease Control and Prevention reported that roughly 18.1% of the general population

smokes[1], while, alarmingly 77-93% of people receiving care in substance use treatment settings use tobacco[2]. [3]Although, Florida's smoking rates in the general population are lower than the national average (16.8%)[4], the high rate of tobacco use in people with substance use disorders combined with the low rates of screening and cessation services offered, demonstrates that disparities persist in tobacco cessation prevention and treatment for people with substance use disorders.

To address and eliminate these disparities, the National Council for Behavioral Health in collaboration with the Behavioral Health and Wellness Program designed the implementation and evaluation of the Wellness and Recovery Learning Community which aimed to improve the overall health of people with substance use disorders in the state of Florida by improving tobacco prevention and cessation efforts in seven substance use treatment agencies and programs; and strengthening cross-systems collaboration.

Methods

BHWP designed three survey instruments and administered each of them prior to the start of the program in August 2015 and again at its conclusion in May the following year. The top-level survey, the Organizational Self-Assessment, was specifically designed to capture intervention-related effects. A second survey aimed at sites' staff was also designed to capture program-related changes, although it was assumed such effects might be diluted due to changes in staff during the eight-month program and changes in survey participation. A final, client-level, survey, was used to provide feedback to program administrators at participating sites as part of a continuous quality improvement assessment. Data from these three surveys was supplemented with qualitative data collected at the initial meeting in August, during technical assistance calls, and at a final summary group phone call at the end of the program.

Project Initiation

In August 2015, National Council and BHWP met with representatives from seven WRLC organizations during a brief introductory presentation at the Florida Alcohol and Drug Abuse Association (FADAA) annual conference in Orlando. Major themes of the presentation included: An introduction to integrating nicotine dependence treatment into existing workflows, the "5As" and the "2As and an R" frameworks[5], basic assessment

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[1] Centers for Disease Control and Prevention. 2013. "Early Release of Selected Estimates Based on Data From the 2012 National Health Interview Survey." Accessed January 28, 2015, http://www.cdc. gov/nchs/nhis/released201306.htm#8.
[2] Signal Behavioral Health Network. 2009. Tobacco Treatment for Persons with Substance Use Disorders: A Toolkit for Substance Abuse Treatment Providers. Colorado: Tobacco Use Recovery Now! (TURN).
[3] Substance Abuse Mental Health Services Administration. 2011. "State Profile – United States, National Survey of Substance Abuse Treatment Services (N-SSATS)". Accessed October 12, 2014, http://wwwdasis.samhsa.gov/webt/state_data/US11.pdf.
[4] American Lung Association. 2015. "State of Tobacco Control 2015, Highlights: Florida". Accessed February 4, 2015, http://www.stateoftobaccocontrol.org/state-grades/florida/highlights.html.
[5] "The 5As (Ask, Advise, Assess, Assist, and Arrange) is a recognize best practice in the treatment of nicotine dependence in clinical settings. It is described in detail in Fiore et al. (2008) along with its truncated counterpart, "The 2As and an R"; the R stands for "Refer."

tools (i.e., Fagerström Test for Nicotine Dependence and the Heavy Smoking Index), and an introduction to WRLC quality improvement elements.

Representatives from Tobacco Free Florida and FADAA also presented to the group, as did a representative from Florida's Area Health Education Centers (AHECs), which offer tobacco cessation staff training as well as cessation groups and classes statewide.

Afterward, BHWP staff worked with agency representatives to develop project goals. To facilitate this goal setting, BHWP guided participants through a "SMART" goals process.[6] Goals were recorded on DIMENSIONS Action Plan (DAP) forms (*Appendix A*), which prompt participants to identify two short-term organization-level goals with deadlines within 3-6 months, anticipated barriers, and measurable indicators of goal completion.

Initial goals and potential associated barriers fell into three categories: Training, Funding, and Operations. All seven organizations developed a training goal with three organizations planning to meet with and have their staff trained by the Florida Quitline. All seven organizations also identified an operations-based goal and these included:

- Identifying an onsite "champion" to spearhead tobacco control initiatives (1 site)
- Identifying tobacco users at intake (2 sites)
- Developing a pilot "5As/2As-R" project (1 site)
- Referring tobacco users to treatment (2 sites)
- Educating young clients about tobacco's harms (1 site).

Early in the project, site leads voiced anxiety around setting organizational tobacco services and support goals, specifically related to becoming tobacco-free organizations. Reasons for trepidation included:

- Competing demands, especially for primary care providers including nurses, physicians, and psychiatrists
- Previous lack of success implementing tobacco-free policies
- Variability of agency treatment sites potentially necessitating different policy approaches
- Patient welfare (e.g., increased agitation, leaving against medical advice)
- Potential decreased census (i.e., patients refusing to enter treatment and, thus, having worse outcomes)

Other reported barriers included:

- Lack of funding/ inability to charge for services
- Lack of staff buy-in; an unwillingness or inability to prioritize nicotine dependence (identified as a barrier for 4 sites)
- Staff who used tobacco
- General resistance to change

[6] *SMART goals are Specific, Measurable, Achievable, Realistic, and Timely. SMART goals are a standard way of articulating goals in such a way that success can be measured concretely.*

Staff Education and Technical Assistance

During the course of the WRLC program, participating organizations attended four webinars (one every other month). In the alternating months between webinars, participants also met via phone with the BHWP for one-on-one technical assistance for 30 minutes.

Webinars

Webinars were retooled as necessary based on sites' progress to date. Topics of the webinars were:

1. Tobacco Use Screening and Assessment
2. Tobacco Cessation Counseling and Pharmacotherapy
3. Program Scalability and Sustainability
4. Overall Sustainability of New Programming

Technical Assistance Consultation

Each organization participated in four one-on-one technical assistance calls throughout the program, which the National Council coordinated and recorded. Consultation calls provided WRLC sites the opportunity to make regular progress updates based on DAP goals. If goals had been achieved, new goals were developed. It was expected that sites' goals would change over time as DAP goals are intended to be achievable in approximately three months and the WRLC program ran for eight months. The series of consultation calls was followed by a final wrap-up webinar to help participating agencies summarize their progress. Participation in the final round of Staff Surveys (see below) was limited. Two of seven sites had low staff participation and a third had a lower participation specifically from its clinical staff. However, all sites participated in all four one-on-one calls and the Organizational Self-Assessment. As such, we are able to make conclusions about the overall success of the program with confidence.

Results

Prior to the start of program activities and again following the series of consultation calls and webinars, participating sites completed three surveys. Two, the Organizational Self-Assessment (OSA) and the Staff Survey of Attitudes and Practices ("Staff Survey"), were designed to capture immediate, short-term results of involvement in the Learning Community. The third—a convenience sample survey of clients—was designed to provide participating organizations a snapshot of their client base at two points in time.

Organizational Self-Assessment

WRLC participants were selected specifically because they represented a range of readiness to add or augment tobacco-related services and supports as well as their current activity regarding such activities. At the beginning of the program a representative from each organization completed an OSA asking them to rank their organization's "Stage of Change"[7] for a variety of services and supports such as

[7] *The Transtheoretical Model (a.k.a. the Stages of Change model), developed by Drs DiClemente Prochaska, is a way of standardizing the level of readiness to implement changes along a 5-point*

referring to the Florida Quitline, prescribing cessation medications (e.g., bupropion and varenicline), or offering counseling options for consumers (*Appendix B*).
The OSA consists of 29 questions across 9 categories. Each category also has an open response for sites to offer qualitative information on those topics.The categories in the OSA are:

A. Tobacco Education and Support (3 questions)
B. Tobacco Screening and Treatment Planning (4 questions)
C. Tobacco Usage Interventions: Onsite Nicotine Replacement Therapy and Medication Prescribing (3 questions)
D. Tobacco Usage Interventions: Onsite Psychosocial Services (3 questions)
E. Tobacco Usage Interventions: Community Referrals (3 questions)
F. Tobacco Usage Interventions: Peer Services (2 questions)
G. Tobacco Control Policy (5 questions)
H. Outcomes (2 questions)
I. Sustainability (4 questions)

Stage of Change was ranked on a five-point Likert scale with the following levels:

1. Not currently considering/decided against
2. Considering but not yet actively planning
3. Actively planning for the next 3-6 months
4. Schedule in the next 3 months
5. Currently offering

These roughly correspond to the traditional Stages of Change scale of pre-contemplative, contemplative, preparation, action, and maintenance. These same participants filled out the survey again at the end of the program. *Figure 1* depicts aggregate change over time across evidence-based tobacco control strategies. Progress toward more robust tobacco cessation services and support operations is indicated by a general shift from yellow to red.

WRLC participants began working on their original DAP goals immediately, and all had completed their initial goals by the second technical assistance consultation call. The most important of these goals was arranging meetings with their AHECs. These relationships quickly led to the completion of several common goals: AHECs were able to offer training to staff, provide guidance on how to refer appropriately to the state quitline, and connect organizations to other necessary resources including educational materials and community-based nicotine dependence support groups.

One site had already been connected to their AHEC, which was running a support group on-site once per quarter. However, it became clear that groups were too infrequent. During the course of the WRLC, the frequency of the groups was increased to once per month and then increased again to twice per month. In addition to providing additional support, the increased frequency enhanced the visibility of

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spectrum. It was initially designed to assist clinicians helping individuals through a behavioral change process, but was later shown to be effective at the organizational level.

tobacco cessation services and emphasized the organizational commitment to offering these services under a greater "whole health" umbrella.

Another site had previously added tobacco-related questions to their electronic health record, but clinicians were not consistently asking clients about their tobacco use. This site had initially decided to pilot a 5As program in only one site, but as a result of the education they received as part of the WRLC webinars, decided that a broader initial implementation was not only advisable, but achievable.

During each phase of revisiting and revising of DAP goals, participants were asked about anticipated barriers. Some of these barriers (e.g., "staff is not 100% behind this initiative") were present and realistic. But in most instances, the anticipated barriers failed to materialize. Instead, actual barriers included unstable staffing and system complexity. For example, the death of a staff member spearheading agency WRLC activities led to understandable goal delays. When such barriers were encountered, BHWP and National Council staff successfully acted to reassure sites and to assist them in scaling back goals as needed.

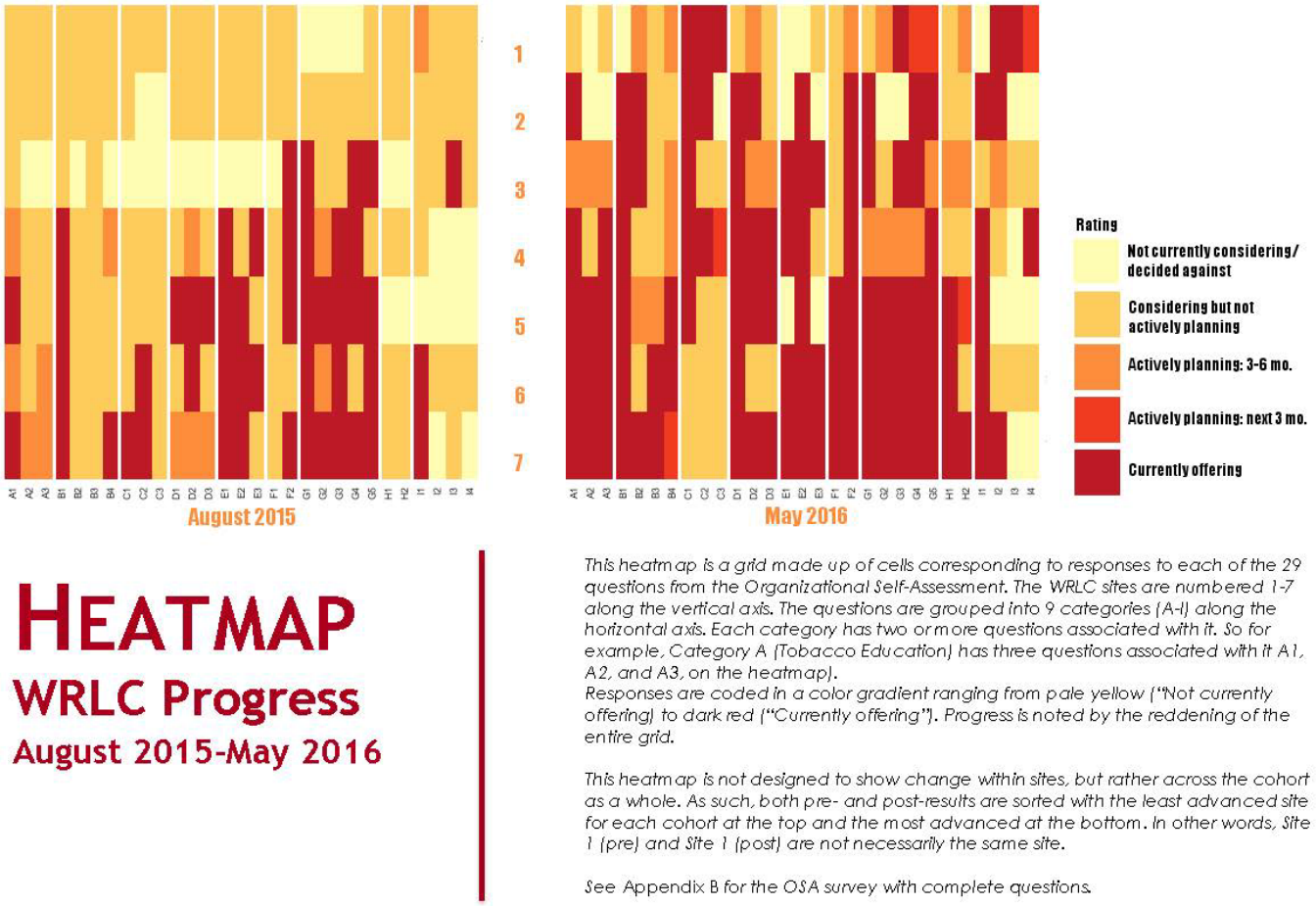


Figure 1: Organizational Self-Assessment survey responses during the pre-and post-program periods

Staff Survey

The National Council and BHWP expected some level of staff resistance to integrating tobacco cessation services into daily practice. In response, WRLC was designed to influence both attitudes about nicotine use and dependence as well as to increase staff proficiency in effectively treating nicotine dependence.

To track changes in the above, sites were asked to disseminate a pre-post survey to all agency staff via SurveyMonkey (*Appendix C*). The survey focused on two areas, attitudes (of all respondents) and skills (of respondent staff with direct client contact). We hypothesized that staff-level progress measured by the staff survey would mirror organization-level change measured by the OSA as staff—especially clinical staff—are responsible for the daily execution of tobacco-related procedures (e.g., asking clients at intake and at follow-up visits about their tobacco use).

Of the seven WRLC participating agencies, six administered pre- and post-staff surveys. Of those six, two sites had very low post-survey participation (n= <7 in both cases) making pre-post comparisons infeasible. Below we describe the outcomes from the four sites that did have adequate pre-post participation.

Attitudes

The Attitudes section of the Staff Survey asked respondents to rate on a five-point scale their agreement on six questions related to tobacco use and treatment (Strongly disagree, Disagree, Neutral, Agree, and Strongly Agree). The six statements were:

1. *It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.*
2. *Not allowing smoking in residential treatment is good for the health of the employees and the clients.*
3. *I think people should be allowed to smoke wherever they want.*
4. *People will not seek services here if we are tobacco free.*
5. *I would support a tobacco-free policy at this treatment agency and/or residential setting.*
6. *Tobacco cessation services should be a part of wellness services for employees and clients.*

Differences between the pre- and post-program periods were mixed but generally positive, and in many cases, substantially so. One site however, saw declines on 4 of the 6 questions. One saw declines on 2 questions. And one saw a decline in only one question. Table 1 summarizes the progress across all sites on all questions.[8]

[8] *Tables 1 and 2 summarize change pre-post. For actual response summaries, see Appendix D.*

Percent Change in WRLC All Staff Attitudes

		Gateway	Henderson	Lifestream	Westcare
It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.	**ALL AGREE**	*-6.83*	1.99	13.69	0.0
Not allowing smoking in residential treatment is good for the health of employees and clients.	**ALL AGREE**	*-0.64*	8.02	4.28	11.12
I think people should be allowed to smoke wherever they want.	**ALL DISAGREE**	5.06	5.1	9.14	0.0
People will not seek services here if we are tobacco free.	**ALL DISAGREE**	*-12.28*	*-1.43*	3.38	1.7
I would support a tobacco-free policy at this treatment agency and/or residential setting.	**ALL AGREE**	4.83	*-1.78*	*-4.33*	7.41
Tobacco cessation services should be a part of wellness services for employees and clients.	**ALL AGREE**	*-1.49*	0.21	3.24	5.56

***Table 1: Staff Attitudes**. Numbers are the absolute difference in the number of staff responding "Agree" or "Strongly Agree" to the question. Green denotes positive change from pre- to post-survey periods. For example, the number of staff agreeing or strongly agreeing the statement "Not allowing smoking in residential treatment is good for the health of employees and client," rose from 82.7 to 90.72, +8.02%. See Appendix D for actual pre-post figures.*

On whether persons with mental illnesses/addictions were able to quit smoking one site jumped over 13 points from 69.6% to 83.3% (Agreeing or Strongly Agreeing). At another site the combined number of those Agreeing and Strongly Agreeing stayed the same, but those Strongly Agreeing jumped over 20 points from 35.2% to 55.6%. Meanwhile, for this site, those who Disagreed (1.9%) dropped to 0% while those who were neutral moved nearly 2 point to 11%.

On the question of whether a tobacco-free policy led to improved health, four sites saw improvements while one saw a minor and statistically insignificant decline (moving from 75.0% to 74.4%). Other organizations saw large gains of 4%, 8%, and 11% more people either Agreeing or Strongly Agreeing with the statement.

On the question of whether smoking should be permitted without restrictions all sites but one saw improved numbers. At that site, the combined Disagree and Strongly Disagree score remained the same (77.8%) but 13% moved from Disagree to Strongly Disagree.

Two questions on tobacco-free policies showed mixed results. Three of the of four agencies saw improvements in the reported belief that clients would seek services elsewhere if a tobacco-free policy were implemented. In one of those cases, strong disagreement jumped from 7.4% to 19.2%. At another site, strong disagreement climbed 4%. However, one site moved in the opposite direction, dropping over 12% in Strongly Disagree and Disagree combined. This substantial drop is paradoxical considering that support of implementing a tobacco-free policy at that site rose nearly 5% over the

same period. Two other sites saw a decline in support for an organization wide tobacco-free policy.

Finally, three of the four sites saw minor increases in support for tobacco cessation services as part of an overall wellness program for clients and employees. At all four sites, including the one that saw a minor decline (1.5%) support for such services was strong (~80-85%) across all sites at both assessment points.

Behaviors

While changes in attitudes were mixed across the four sites, changes in the provision of evidenced-based tobacco cessation *practices* were overwhelmingly positive. One of the four sites completing pre- and post-surveys, had only one clinician able to respond to questions related to their provision of services to clients. As a result, the following summary captures change for three sites.

The Staff Survey asked respondents to respond to seven statements with the frequency they provided certain tobacco cessation services on a five-point scale (Never, Rarely, Sometimes, Usually, and Always). The questions were:

1. *I screen every client for tobacco use at intake.*
2. *I screen every client for tobacco use at all subsequent visits.*
3. *I advise all my clients who use tobacco to quit at every visit.*
4. *I offer FDA-approved tobacco cessation medications to all my clients who use tobacco.*
5. *I offer tobacco cessation counseling to all my clients who tobacco.*
6. *I refer all my clients who use tobacco to the Bureau of Tobacco Free Florida Quitline*
7. *I refer all my clients who use tobacco to other community tobacco cessation services (i.e., support groups).*

Across all questions and all three sites, summing the totals of those who Always or Usually perform these services for their clients, increases were observed. Consistent with the existing evidence base, asking clients about their tobacco use was performed more frequently than other services. In the post-survey period over more than 55% of staff responded Always or Usually to asking about tobacco use, with one site jumping from 32.7% to 55%.

Percent Change in WRLC Clinical Staff Practices

		Gateway	Henderson	Westcare
		Total Change	Total Change	Total Change
I screen every client for tobacco use at intake.	Usually + Always	14.84	3.66	22.35
I screen every client for tobacco use at all subsequent visits.	Usually + Always	12.07	4.41	22.92
I advise all my clients who use tobacco to quit at every visit.	Usually + Always	17.79	3.8	8.88
I offer FDA-approved tobacco cessation medications to all my clients who use tobacco	Usually + Always	27.47	3.1	10.0
I offer tobacco cessation counseling to all my clients who use tobacco.	Usually + Always	21.75	-2.86	10.0
I refer all my clients who use tobacco to the Bureau of Tobacco Free Florida Quitline	Usually + Always	1.02	5.26	5.92
I refer al my clients who use tobacco to other community tobacco cessation services (i.e., support groups)	Usually + Always	12.44	5.85	5.0

Table 2: Staff Practices. *Numbers are the absolute difference in the number of staff responding "Agree" or "Strongly Agree" to the question. Green denotes positive change from pre- to post-survey periods. See Appendix D for actual pre-post figures.*

Asking at subsequent visits dropped considerably from asking at intake, but the pre-post change was positive across all sites. Significant progress was made, with one site moving from 2% (Always + Usually) to 25% and another site moving from 19.4% to 31.4%.

Advising was performed less frequently than asking [at intake] with the largest absolute increase being +18% pre-post. The largest relative increase saw one site moving from 6.1% to 15.0% an increase of 146% between the two surveys.

Improvements were also made in the provision of FDA-approved medications, quitline referrals, and referrals to community services, although overall provision of these services remained low. One site did increase quitline referrals to 22.9% (+5.3%), Another site increased community referrals by 12.5%. That same site also significantly increased the provision of cessation medications from 9.7% (Usually + Always) to 37.2%.

Client Surveys

A template client survey was designed by the BHWP Evaluation team and provided to sites as a Word document so they could add their own header, watermark, or template and make any adjustments to the introductory/explanatory paragraph (*Appendix E*). The method of collecting responses was left to the individual sites with the instruction that they collect at least 20 responses. The surveys were collected twice, once at the beginning of the program and once following the wrap-up webinar. Six of seven sites administered the initial survey, and five of these six sites also completed the post-survey. Convenience samples of clients were obtained, with pre-post surveys potentially completed by different clients. Therefore, this methodology limits any general conclusions that can be made.

The survey is divided into three major sections. In the first section, clients are asked demographic questions assessing age, sex, race/ethnicity, types of services they are receiving and period of time they have been receiving those services. In the second section, consumers are asked whether or not their provider assessed their history of tobacco use and, (if a current or former tobacco user), whether they were asked about their knowledge and ability to live a tobacco free life. Clients are asked if they *currently* use tobacco and, if so, they are asked several questions both in regard to their use (e.g., which products, how much), their willingness/desire to quit, and also what treatment services they have used and been offered. Finally, all respondents are asked six questions related to their attitudes concerning tobacco use and tobacco free policies. 424 clients completed the pre-survey, and 320 completed the post-survey (not all clients answered all questions).

Demographics

Although there are significant differences between some sites with regard to the age and sex of the respondents, these differences largely disappear in the aggregate. Both pre- and post-surveys had a similar breakdown between men and women (pre: 58.3% male, post: 58.8% male). The mean age pre and post was 37.1 and 35.9 years respectively (median ages were 33 and 32, respectively). Pre-post respondents were predominantly White (69.7% and 70.9%, respectively) with the second highest racial group represented being African-American/Black (23.7%, 21.8%). Across both client samples, the "average" respondent is a 36-37 year-old male who has received substance abuse services (59.1%) for over 4 months (49.2%), and smokes.

Age, Sex, & Race, Percent Self-Identified at each Site

		WRLC Sites							All Sites
		DISC	Gateway	Henderson	Lifestream	Operation PAR	SFWC	Westcare	Pre-Post Summary
Age Pre	*Mean*	28.3	39.3	43.4	42.9	30.3	*NA*	29.8	**37.1**
	StDev	7.0	13.5	14.6	13.7	8.5	*NA*	8.5	**13.4**
	Median	26.0	36.0	44.5	40.0	29.0	*NA*	28.5	**33.0**
	Mode	26.0	29.0	58.0	30.0	24.0	*NA*	25.0	**37.1**
	Range	17 - 45	18 - 62	19 - 65	21 - 56	18 - 58	*NA*	18 - 78	**17 - 78**
Age Post	*Mean*	*NA*	39.0	43.4	40.6	35.0	32.0	32.7	**35.9**
	StDev	*NA*	11.0	13.4	14.4	11.6	10.6	9.9	**11.8**
	Median	*NA*	37.0	41.0	42.0	30.5	29.0	30.5	**32.0**
	Mode	*NA*	30.0	34.0	47.0	24.0	19.0	26.0	**35.9**
	Range	*NA*	23 - 66	23 - 66	21 - 63	23 - 55	19 - 55	19 - 58	**19 - 66**
Sex Pre	*Male*	25.0	62.5	69.6	52.0	30.6	*NA*	78.1	**58.0**
	Female	75.0	37.5	26.1	48.0	69.4	*NA*	21.9	**40.8**
	Other	0.0	0.0	4.3	0.0	0.0	*NA*	0.0	**0.7**
Sex Post	*Male*	*NA*	53.1	61.7	68.2	62.5	46.7	60.3	**58.4**
	Female	*NA*	46.9	36.2	31.8	37.5	46.7	39.7	**40.0**
	Other	*NA*	0.0	2.1	0.0	0.0	6.7	0.0	**0.9**
Race Pre	*White*	58.3	50.0	31.8	76.7	91.2	*NA*	88.4	**63.9**
	Af.-Am.	41.7	42.3	56.1	15.5	7.0	*NA*	7.0	**21.7**
	Asian	0.0	0.0	31.8	0.0	0.0	*NA*	0.0	**21.7**
	Am. In.	0.0	0.0	0.0	0.9	0.0	*NA*	0.0	**0.2**
	More than 1	0.0	1.9	4.5	6.0	1.8	*NA*	4.7	**3.8**
	Other	0.0	5.8	7.6	0.9	0.0	*NA*	0.0	**2.1**
Race Post	*White*	*NA*	67.4	29.3	73.9	90.5	42.9	85.7	**63.1**
	Af.-Am.	*NA*	30.4	51.2	13.0	4.8	33.3	12.0	**19.4**
	Asian	*NA*	2.2	0.0	4.3	4.8	9.5	0.0	**1.6**
	Am. In.	*NA*	0.0	2.4	0.0	0.0	4.8	1.5	**1.3**
	More than 1	*NA*	0.0	12.2	8.7	0.0	4.8	0.8	**2.8**
	Other	*NA*	0.0	4.9	0.0	0.0	4.8	0.0	**0.9**

Table 3: Age, Sex, & Race of WRLC Sites

Previous Tobacco Use and Ability or Desire to Quit

Of the 717 respondents who answered both questions "Have you ever been a regular tobacco user?" and "Are you currently a regular tobacco user?" 65.5% reported that they were regular tobacco users and 91.2% of the tobacco users reported using cigarettes. In Florida, the current adult smoking rate is 17.5%. In comparison, the WRLC data supports the extremely high smoking rate for clients with behavioral health conditions including substance abuse disorders.

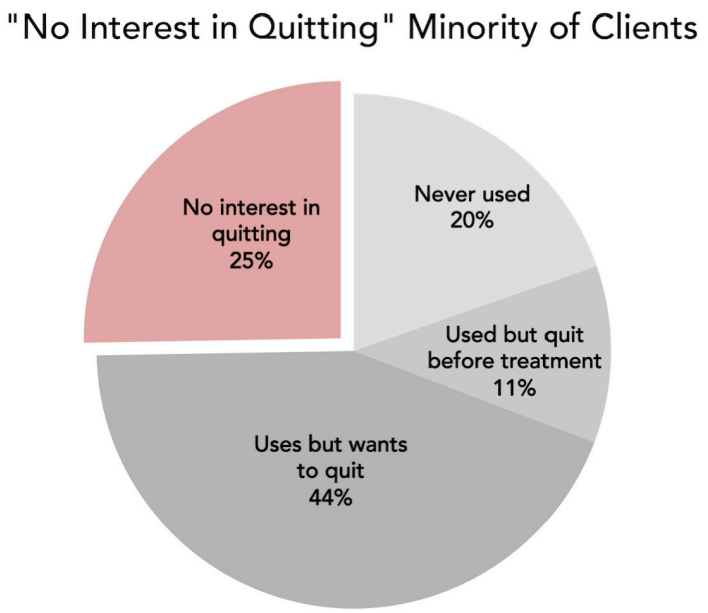


***Figure 2**: Those clients who both smoke and express no desire in quitting make up a quarter of clients receiving treatment at WRLC sites.*

There were many similarities between pre-post respondents. Not only were rates of current use similar in both groups (64.5% and 67.7% respectively), but so were their preferred products (cigarettes: 90.2% 92.5%, cigars; 10.9%, 8.0% and e-cigarettes: 5.6%, 5.2%). In both groups, the modal range of cigarettes per day was the same (6-10/day), with approximately half reporting smoking less than half a pack daily (52.3% and 48.6%).

Comparing the pre-post surveys, ex-smokers were more likely to report having the knowledge and confidence to lead a tobacco free life (knowledge: 90.0 and 92.3). Confidence in particular was greatly increased (78.0% to 88.0%). For the post-survey, more ex-smokers reported planning or actively taking steps toward living a tobacco free life (82.4% to 88.5%; 78.0% to 83.8% respectively).

Current Tobacco Cessation Supports and Referral to Services

Across pre-post client samples, around a third of respondents had either already quit tobacco or had never used at all (35.7%, 32.3%). Of those that reported being a "current user" many had already tried to quit or were actively trying to do so during the survey period (15.4%, 14.6%). Well over half of current users (67.7% and 57.5%) wanted to quit within the next 3-6 months. The number of current users who express "no desire to quit" constituted a minority of both groups (35.0%, 40.6%). Those who express having no desire to quit made up only one quarter of all respondents.

Survey respondents were asked if they had been offered any of five tobacco treatment services during the time they were enrolled in services (advised to quit, medication, counseling, referral to the quitline, or referral to community services. Across time, there was improvement in all five of the service categories. The smallest gains were made in the provision of medications (16.5% to 17.0%) and in community referrals (13.5% to 17.5%). The small increase in the provision of medications is most likely explained by the fact that five of the seven sites never expressed an interest in enhancing this service and may not have appropriately trained staff prescribers. Of the remaining two sites, at the WRLC's end one was still exploring the option of increasing prescribing of cessation medications.

The largest increases in the provision of services were seen in referrals to counseling (from 16.2% to 24.7%), and in referrals to the Florida Quit Line (from 17.0% to 22.5%). Clients' reports of referrals to community services matches staff self-reports regarding increases providing this service. At the same time, the percentage of clients recalling being advised to quit is higher than expected and somewhat contradictory to staff-reported frequencies. Furthermore, although this increase is important, it is not a large change given actual increases in other tobacco cessation services. For example, the proportion of clients referred to counseling services increased by 8.5% after the WRLC, while the rate of clients being advised to quit improved by 3.3%. Moreover, an overall rate of 41.3% of advising to quit would be substantially lower than the majority of studies' findings for this particular service which range from 53-84%, but is consistent with pre-established numbers in Florida.

Attitudes

Percent Change in WRLC Client Attitudes

		Never Users	Ex Users	Current Users
It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.	**All Agree**	-19.0	18.0	-0.3
Not allowing smoking in residential treatment is good for the health of employees and clients.	**All Agree**	-18.1	2.6	0.9
I think people should be allowed to smoke wherever they want.	**All Disagree**	11.6	8.6	2.4
People will not seek services here if this agency is tobacco-free.	**All Disagree**	1.3	-16.2	5.7
I would support a tobacco-free policy at this treatment agency/residential setting.	**All Agree**	-10.8	9.7	0.0
Helping employees and clients quit tobacco should be a part of helping them live healthier lives overall.	**All Agree**	-23.3	6.3	2.7

Table 4: Client Attitudes: *Numbers are the absolute difference in the number of staff responding "Agree" or "Strongly Agree" to the question. Green denotes positive change from pre- to post-survey periods.*

The only significant difference between pre- and post-survey respondents as a group was in the relative proportion of Never Users, Ex-Users and Current Users, with the post-survey group having a much higher proportion of Current Users. Perhaps relatedly, the biggest difference in outcomes were seen in the attitudes portion of the client survey, with a great deal of those differences explained by a net negative shift in attitudes specifically among those who self-identified as never having been a regular tobacco user. Why this would be the case is unknown. We had hypothesized that due to the churn of clients entering and exiting treatment over the course of the program's eight months, we would see no discernible shifts in attitudes. However, due to the fact that most clients taking the survey had been receiving treatment for four months or longer, it is at least feasible that some of the positive outcomes observed were due to the staffs' increased prioritization and delivery of these services.

The biggest gain was made among ex-users on the question of whether or not cessation is possible among those with mental health or substance abuse disorders with agreement jumping 18% from 70% to 88%. Most of the other gains were small, even if

they were larger than anticipated. It is worth noting that although much of the movement among Never Smokers was negative, agreement was still fairly large, relatively speaking. For example, more than half (52.9%) of never smokers agreed that tobacco free policies were good for the health of employees and staff. And, similarly, although the largest regress was in agreement with whether or not tobacco cessation should be a part helping employees and clients live healthier lives (-23.3%) the overall agreement (49.0%) was still higher than it was among current users (46.0%).

Conclusions

Lessons Learned

The following emergent themes were culled from WRLC assessments, surveys, and the series of individual technical assistance calls.

Take Action: During the final webinar, one site mentioned that they had initially been concerned there was not enough time to execute their plans. However, they decided to "jump right in" and were surprised to find that progress was easier than anticipated. While there was often anticipatory anxiety regarding rapid improvement goals, realistic incremental actions decreased initial concerns.

Incremental Change Matters: Many sites learned that they were able to build off the services and supports they already implemented (e.g., increasing the frequency of groups already offered). Other sites learned that initial goals were too limited. Large goals that seemed out of reach early on appeared much more viable once initial steps had been achieved. For example, some organizations that did not intend to offer tobacco cessation counseling, actually added these services. Other organizations that did not initially intend to adopt organization-wide tobacco-free policies realized that such a goal was realistic.

Encourage Treatment and Referral: Improvements were made across the 5As (ask-advise-assess-assist-arrange) at all sites according to all three assessment tools. However, treatment, referral and follow-up are still lower than desirable (i.e., assess, assist, arrange). Continued practice improvement would include facilitating and systematically tracking counseling, cessation medication prescribing, and referral to other community cessation supports.

Focus on Staff Attitudes: Previous studies on the execution of tobacco cessation programming emphasizes that most feared undesirable outcomes never materialize. For example, agitation among clients with behavioral health concerns rarely escalate as believed, but rather go down. As a result, staff tend to view such programming more positively as time goes on. And that did occur for most sites across measures. It is also known, however, that staff that persist in their own tobacco use during the execution of tobacco cessation programming are more likely than non-tobacco-using staff to blame negative events on new services directions and policy.

Census Numbers are a Concern. While sites generally reported clients were less likely to seek services elsewhere if they went tobacco free, there were several sites were some staff moved in the opposite direction over time. These staff reported that a tobacco-free policy would lead to less clients seeking services at their agency. It is unclear if census rates actually changed for any of the participating agencies. But given this common and ongoing concern, more attention should be paid to tracking and reporting on census. Sites might then transparently address this issue if it does indeed exist.

Staff and Client Engagement is Paramount: WRLC sites engaged their staff and clients by requesting input on core aspects of their proposed programmatic and/or policy changes. Based on this input, sites made critical alterations to implementation strategies including policy messaging, timelines, and incentives offered to those who joined cessation programs. This increased staff's willingness to participate in the programming even if initially they might not be completely convinced of its value.

Communication is Critical: One site changed "smoke breaks" into "for you time." This messaging changed an explicit endorsement of smoking to a socially minded support of personal improvement. In another instance, a site's wellness committee directly addressed physicians' concerns that engaging clients regarding smoking was too time consuming, given the daily competing demands they faced. These concerned providers were engaged through extra effort to communicate the steps being taken to decrease any new burdens related to the WRLC initiative.

WRLC led to widespread practice improvements in the provision of tobacco cessation services to both the employees and clients of substance abuse treatment centers. The learning community sought to meet agencies "where they were at" in their readiness for organizational change and build goals individualized to sites' motivational level and capacity. The learning community demonstrated that a short-term practice improvement project can realize significant gains in implementing evidence-based tobacco control strategies. At the same time program outcomes suggest ongoing directions for continuous quality improvement, such as expanded tobacco cessation treatment capacity, tobacco-free policy and enforcement, and assessment of impacts on agency census.

Appendices

Appendix A: DIMENSIONS Action Plan

DIMENSIONS Action Plan

Reset Form

Name: _____ **Date:** _____

Training Location: _____

Organization Name: _____

_____

Best Way to Contact You:

☐ Email: _____

☐ Phone: _____

Position (check all that apply):

☐ Administrator ☐ Other (specify): _____
☐ Peer Advocate _____
☐ Provider _____

DIMENSIONS training attended:

☐ Tobacco Free Policy – Fundamentals
☐ Tobacco Free Program – Advanced Techniques
☐ Tobacco Free Program – Fundamentals
☐ Well Body Program – Advanced Techniques
☐ Well Body Program – Fundamentals
☐ Other (specify): _____

Readiness for change (check one):

☐ Pre-contemplation: *Not considering change*
☐ Contemplation: *Considering change*
☐ Preparation: *Making concrete plans for change*
☐ Action: *Actively taking steps toward change*
☐ Maintenance: *Sustaining changes already made*

Based on readiness for change, I will work to achieve the following goal(s) over the next 3-6 months.
Consider SMART goal criteria (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely).

Goal #1:
Completion of Goal #1 will be evidenced by:
Potential barriers to achieving Goal #1:
Goal #2:
Completion of Goal #2 will be evidenced by:
Potential barriers to achieving Goal #2:

Signature: _____

Appendix B: Organizational Self-Assessment

WRLC Self-Assessment Post

Thank you for your participation in the Florida Wellness and Recovery Learning Community (WRLC)! Part of our wrap-up activities include a re-evaluation of the status of your tobacco control activities.

The Organizational Self-Assessment Survey is designed to evaluate your agency's current stage of readiness (or actions) related to tobacco cessation services. The survey should take 15-20 minutes; we strongly encourage you to answer all questions in a single session.

Your participation in this follow-up assessment critical, as it allows us to evaluate the utility of our training and technical assistance program as well as all of the progress your agency has made through the WRLC.

As before, individualized results will only go to your organization. We will provide a personalized assessment report for your organization that includes: 1) Scores and stage of readiness for each category, 2) Recommendations for next steps, and 3) Links to salient resources.

It may be tempting when completing the assessment to provide the best representation of your organization. However, we ask that you answer with how the majority of your organization operates, rather than a very limited subsection, to accurately measure the needs and resources of the majority. Please make use of the "Additional Comments" option for each section to provide any clarifying details about size/scope or your efforts.

We truly appreciate your commitment to the goals of this project and the time you are devoting to this portion of the evaluation.

WRLC Self-Assessment Post

1. Please provide information about yourself and your organization.

Name:	
Title or Role:	
Organization:	

WRLC Self-Assessment Post

For each tobacco control strategy, please indicate your organization's status for tobacco control initiatives:

2. Tobacco Education and Support

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Provide tobacco education to consumers	○	○	○	○	○
Provide training to staff on evidence-based tobacco cessation strategies and interventions	○	○	○	○	○
Development of tobacco cessation materials (brochures, posters, literature, handouts)	○	○	○	○	○

3. Please provide any additional details regarding your organization's tobacco education and support initiatives (optional).

WRLC Self-Assessment Post

4. Tobacco Screening and Treatment Planning

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Ask/Document tobacco use for all clients at intake	○	○	○	○	○
Ask/Document tobacco use for all clients at every visit	○	○	○	○	○
Advise tobacco users to quit at every visit and document	○	○	○	○	○
For tobacco users, treatment plans include cessation goals	○	○	○	○	○

5. Please provide any additional details regarding your organization's tobacco screening and treatment planning (optional).

WRLC Self-Assessment Post

6. Tobacco Usage Interventions: Onsite Nicotine Replacement Therapy and Medication Prescribing

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Nicotine Replacement Therapy (NRT) prescribed onsite	○	○	○	○	○
Bupropion /Zyban /Wellbutrin prescribed onsite	○	○	○	○	○
Varenicline/ Chantix prescribed onsite	○	○	○	○	○

7. Please provide any additional details regarding your organization's tobacco usage interventions for onsite nicotine replacement therapy and medication prescribing(optional).

WRLC Self-Assessment Post

8. Tobacco Usage Interventions: Onsite Psychosocial Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Motivational interviewing for tobacco cessation occurring onsite	○	○	○	○	○
Individual tobacco cessation counseling occurring onsite	○	○	○	○	○
Tobacco cessation groups occurring onsite	○	○	○	○	○

9. Please provide any additional details regarding your organization's tobacco usage interventions for onsite psychosocial services.

WRLC Self-Assessment Post

10. Tobacco Usage Interventions: Community Referrals

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Referrals offsite for Nicotine Replacement Therapy or other medication	◯	◯	◯	◯	◯
Referrals to Quitline	◯	◯	◯	◯	◯
Referrals to other agencies for tobacco support services	◯	◯	◯	◯	◯

11. Please provide any additional details regarding your organization's tobacco usage interventions for community referrals (optional).

WRLC Self-Assessment Post

12. Tobacco Usage Interventions: Peer Services

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Peer-led services onsite for tobacco cessation	◯	◯	◯	◯	◯
Peer-led services onsite not focused on tobacco	◯	◯	◯	◯	◯

13. Please provide any additional details regarding your organization's tobacco usage interventions utilizing peer services (optional).

WRLC Self-Assessment Post

14. Tobacco Control Policy

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Tobacco-free agency (interior)	○	○	○	○	○
Campus/facility tobacco-free (entire grounds)	○	○	○	○	○
Tobacco-free signage & advertising onsite	○	○	○	○	○
Specific enforcement procedures and policies	○	○	○	○	○
Tobacco cessation support for staff	○	○	○	○	○

15. Please provide any additional details regarding your organization's tobacco-free policy initiatives (optional).

WRLC Self-Assessment Post

16. Outcomes

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Create and utilize tobacco indicators and measures	○	○	○	○	○
Monitor and evaluate tobacco indicators and measures	○	○	○	○	○

17. Please provide any additional details regarding your organization's tobacco control measures and outcomes (optional).

WRLC Self-Assessment Post

18. Sustainability

	Not currently considering/ Decided against	Considering, but not yet actively planning	Actively planning for 3-6 months from now	Scheduled in the next 3 months	Currently occurring
Electronic health record infrastructure includes tobacco use and treatment fields	○	○	○	○	○
Determine if tobacco cessation services will be available to community members	○	○	○	○	○
Process in place to track how individuals/clients were referred/heard about tobacco cessation services (marketing)	○	○	○	○	○
Organization bills for tobacco prevention and cessation services	○	○	○	○	○

19. If your organization currently bills for tobacco prevention and cessation services, who do you bill? Please mark all that apply.

- ☐ Not applicable to my organization-we do not currently bill for tobacco cessation services
- ☐ Grants
- ☐ Medicare
- ☐ Medicaid
- ☐ Private Insurance

Other (please specify)

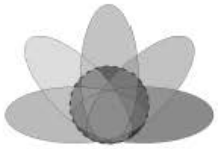
20. Please provide any additional details regarding your organization's tobacco control sustainability (optional).

WRLC Self-Assessment Post

Thank you for your time in completing this survey. Your input is greatly appreciated.

You will receive a customized report for your organization that includes: 1) Scores and stage of readiness for each category, 2) Recommendations for next steps, and 3) Links to salient resources. You will receive your tailored report with your organization's results.

If you have any questions, please contact Jim Pavlik (Jim.Pavlik@UCDenver.edu) at the Behavioral Health and Wellness Program.



Behavioral Health & Wellness Program

University of Colorado Anschutz Medical Campus
School of Medicine

Appendix C: Staff-Level Survey

WRLC Staff Survey - Post

Learning Community Follow-up Assessment

Thank you for your participation in the Florida Wellness and Recovery Learning Community. We hope that the training and support provided by the Behavioral Health & Wellness Program and the National Council for Behavioral Health have given you the tools necessary to build a successful tobacco cessation program.

We greatly appreciate your completing this follow-up assessment, which helps us evaluate the utility of our training program as well as the progress you have made toward meeting the your agency's specific goals!

Your commitment to the goals of this project and the time you are devoting to these efforts are extremely valuable!

WRLC Staff Survey - Post

Primary Role

1. At which organization do you work?

* 2. What is your primary role at your agency (check all that apply)?

- [ ] Leadership/ management
- [ ] Administrative assistant
- [ ] Facility services
- [ ] Inpatient mental health clinician/ case manager
- [ ] Inpatient addictions clinician/ case manager
- [ ] Outpatient mental health clinician/ case manager
- [ ] Outpatient addictions clinician/ case manager
- [ ] Residential mental health clinician/ case manager
- [ ] Residential addictions clinician/ case manager

Other (please specify)

WRLC Staff Survey - Post

Tenure

* 3. How long have you been at your current agency?

Years

Months

WRLC Staff Survey - Post

Demographics

4. What is your age?

Years

* 5. What is your gender?

- ◯ Male
- ◯ Female

* 6. Which one of the following categories best describes you?

- ◯ Hispanic or Latino
- ◯ White
- ◯ Black, African American
- ◯ Asian
- ◯ Native Hawaiian, Other Pacific Islander
- ◯ American Indian, or Alaskan Native

Other (please specify)

WRLC Staff Survey - Post

Tobacco Use #1

* 7. Have you been a regular tobacco user in your lifetime?

- ◯ Yes
- ◯ No

WRLC Staff Survey - Post

Tobacco Use #2

8. Are you currently a regular tobacco user?

- ◯ Yes
- ◯ No

WRLC Staff Survey - Post

Tobacco Products

* 9. During the past week, which type(s) of tobacco or nicotine did you use?

- ☐ Cigarettes
- ☐ Chew
- ☐ Cigars
- ☐ Snuff/Snus
- ☐ E-Cigs
- ☐ None

Other (please specify)

10. During the past week, how many cigarettes (or other tobacco products) did you smoke or use in an average day?

- ◯ Quit
- ◯ 1-5
- ◯ 6-10
- ◯ 11-20
- ◯ 20+

WRLC Staff Survey - Post

Desire to Quit

* 11. If you are currently using tobacco, check the box below which best describes you.

- ◯ I have tried to quit unsuccessfully
- ◯ I would like to try to quit over the next month (30 days)
- ◯ I would like to try to quit over the next 6 months
- ◯ I have no interest in quitting

WRLC Staff Survey - Post

Tobacco Attitudes

* 12. For the following items, please circle the best response using the scale below:

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree
It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.	◯	◯	◯	◯	◯
Not allowing smoking in residential treatment is good for the health of employees and clients.	◯	◯	◯	◯	◯
I think people should be allowed to smoke wherever they want.	◯	◯	◯	◯	◯

People will not seek services here if we are tobacco-free.	◯	◯	◯	◯	◯
I would support a tobacco-free policy at this treatment agency and/or residential setting.	◯	◯	◯	◯	◯
Tobacco cessation services should be a part of wellness services for employees and clients.	◯	◯	◯	◯	◯

WRLC Staff Survey - Post

Patient Contact

* 13. Are you an employee who has **direct contact** with clients?

- ◯ Yes
- ◯ No

WRLC Staff Survey - Post

Tobacco Skills & Knowledge

14. Please answer the following questions by circling the best response using the scale below:

	Never	Rarely	Sometimes	Usually	Always
I screen every client for tobacco use at intake.	◯	◯	◯	◯	◯
I screen every client for tobacco use at all subsequent visits.	◯	◯	◯	◯	◯
I advise all my clients who use tobacco to quit at every visit.	◯	◯	◯	◯	◯
I offer FDA-approved tobacco cessation medications to all my clients who use tobacco.	◯	◯	◯	◯	◯

I offer tobacco cessation counseling to all my clients who use tobacco.	○	○	○	○	○
I refer all my clients who use tobacco to the Bureau of Tobacco Free Florida Quitline.	○	○	○	○	○
I refer all my clients who use tobacco to other community tobacco cessation services (i.e. support groups).	○	○	○	○	○

WRLC Staff Survey - Post

Conclusion

Thank you for your time in completing this survey. Your input is greatly appreciated.

If you have any questions, please contact Jim Pavlik (Jim.Pavlik@UCDenver.edu) at the Behavioral Health and Wellness Program.

Appendix D: Staff Response Tables: Attitudes and Practices

Staff Attitudes

		Site 2		Site 3		Site 4		Site 7	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.	Strongly disagre	2.78	2.56	2.99	1.03	2.68	1.52	0	0
	Disagree	2.78	7.69	2.99	1.03	3.57	3.03	1.85	0
	I am neutral	5.56	7.69	10.45	12.37	24.11	12.12	9.26	11.11
	Agree	47.22	41.03	47.76	46.39	38.39	45.45	53.7	33.33
	Strongly Agree	41.67	41.03	35.82	39.18	31.25	37.88	35.19	55.56
	ALL AGREE	88.89	82.06	83.58	85.57	69.64	83.33	88.89	88.89
Not allowing smoking in residential treatment is good for the health of employees and clients.	Strongly disagre	0	2.56	3.01	0	2.68	3.03	5.56	3.7
	Disagree	19.44	7.69	1.5	1.03	0.89	4.55	11.11	3.7
	I am neutral	5.56	15.38	12.78	8.25	21.43	15.15	27.78	25.93
	Agree	30.56	35.9	29.32	25.77	25	27.76	24.07	25.93
	Strongly Agree	44.44	38.46	53.38	64.95	50	51.52	31.48	40.74
	ALL AGREE	75	74.36	82.7	90.72	75	79.28	55.55	66.67
I think people should be allowed to smoke wherever they want.	Strongly disagre	61.11	59.97	59.4	64.95	44.64	48.48	42.59	55.56
	Disagree	19.44	25.64	29.32	28.87	25	30.3	35.19	22.22
	I am neutral	16.67	10.26	8.27	5.15	24.11	12.12	14.81	14.81
	Agree	0	5.13	2.26	1.03	1.79	4.55	3.7	3.7
	Strongly Agree	2.78	0	0.75	0	4.46	4.55	3.7	3.7
	ALL DISAGREE	80.55	85.61	88.72	93.82	69.64	78.78	77.78	77.78
People will not seek services here if we are tobacco free	Strongly disagre	16.37	5.26	40.3	44.33	22.32	24.24	7.41	19.23
	Disagree	22.22	21.05	34.33	28.87	30.36	31.82	37.04	26.92
	I am neutral	30.56	28.95	20.15	19.59	33.04	31.82	27.78	30.77
	Agree	19.44	42.11	2.24	5.15	9.82	7.58	16.67	23.08
	Strongly Agree	11.11	2.63	2.99	2.06	4.46	4.55	11.11	0
	ALL DISAGREE	38.59	26.31	74.63	73.2	52.68	56.06	44.45	46.15
I would support a tobacco-free policy at this treatment agency and/or residential setting.	Strongly disagre	5.56	2.63	9.7	9.28	6.25	4.55	9.26	7.41
	Disagree	16.67	10.53	2.24	1.03	0	6.06	11.11	11.11
	I am neutral	19.44	23.68	8.96	12.37	15.18	15.15	20.37	14.81
	Agree	22.22	31.58	23.88	20.62	32.14	28.79	37.04	25.93
	Strongly Agree	36.11	31.58	55.22	56.7	46.43	45.45	22.22	40.74
	ALL AGREE	58.33	63.16	79.1	77.32	78.57	74.24	59.26	66.67
Tobacco cessation services should be a part of wellness services for employees and clients.	Strongly disagre	2.78	2.56	6.72	4.12	1.79	1.52	1.85	0
	Disagree	0	5.13	2.24	5.15	3.57	0	0	0
	I am neutral	11.11	7.69	6.72	6.19	16.07	16.67	18.52	14.81
	Agree	33.33	30.77	23.88	27.84	28.57	39.39	46.3	25.93
	Strongly Agree	52.78	53.85	60.45	56.7	50	42.42	33.33	59.26
	ALL AGREE	86.11	84.62	84.33	84.54	78.57	81.81	79.63	85.19

Staff Practices

		Site 2		Site 3		Site 7	
		Pre	Post	Pre	Post	Pre	Post
I screen every client for tobacco use at intake.	Never	32.26	31.43	22.32	27.17	57.14	40
	Rarely	19.35	2.86	12.5	5.63	6.12	5
	Sometimes	3.23	5.71	12.5	9.86	4.08	0
	Usually	16.13	17.14	19.64	25.35	6.12	5
	Always	29.03	42.86	33.04	30.99	26.53	50
	Usually + Always	45.16	60	52.68	56.34	32.65	55
I screen every client for tobacco use at all subsequent visits.	Never	61.29	54.29	30	34.29	75	50
	Rarely	12.9	11.43	27.27	17.14	14.58	20
	Sometimes	6.45	2.86	20	21.43	8.33	5
	Usually	9.68	8.57	11.82	21.43	2.08	10
	Always	9.68	22.86	10.91	5.71	0	15
	Usually + Always	19.36	31.43	22.73	27.14	2.08	25
I advise all my clients who use tobacco to quit at every visit.	Never	41.94	31.43	34.86	30	59.18	40
	Rarely	12.9	8.57	17.43	18.57	26.53	15
	Sometimes	25.81	22.86	22.94	22.86	8.16	30
	Usually	0	8.57	13.76	15.71	4.08	15
	Always	19.35	28.57	11.01	12.86	2.04	0
	Usually + Always	19.35	37.14	24.77	28.57	6.12	15
I offer FDA-approved tobacco cessation medications to all my clients who use tobacco	Never	77.42	54.29	74.04	74.29	95.92	90
	Rarely	9.68	2.86	10.19	8.57	2.04	0
	Sometimes	0	5.71	7.41	5.71	2.04	0
	Usually	3.23	14.29	3.7	7.14	0	5
	Always	6.45	22.86	4.63	4.29	0	5
	Usually + Always	9.68	37.15	8.33	11.43	0	10
I offer tobacco cessation counseling to all my clients who use tobacco.	Never	64.52	62.86	42.06	44.29	75.51	80
	Rarely	12.9	5.71	14.02	20	16.33	0
	Sometimes	12.9	0	19.63	14.29	8.16	10
	Usually	3.23	8.57	13.08	10	0	5
	Always	6.45	22.86	11.21	11.43	0	5
	Usually + Always	9.68	31.43	24.29	21.43	0	10
I refer all my clients who use tobacco to the Bureau of Tobacco Free Florida Quitline	Never	51.61	54.29	46.3	42.86	73.47	55
	Rarely	6.45	14.29	20.37	15.71	10.2	5
	Sometimes	25.81	14.29	15.74	18.57	12.24	30
	Usually	9.68	2.86	11.11	15.71	2.04	10
	Always	6.45	14.29	6.48	7.14	2.04	0
	Usually + Always	16.13	17.15	17.59	22.85	4.08	10
I refer al my clients who use tobacco to other community tobacco cessation services (i.e., support groups)	Never	58.06	40	34.26	38.57	77.55	70
	Rarely	6.45	11.43	22.22	20	10.2	5
	Sometimes	19.35	20	22.22	14.29	12.24	20
	Usually	3.23	8.57	12.96	20	0	5
	Always	12.9	20	8.33	7.14	0	0
	Usually + Always	16.13	28.57	21.29	27.14	0	5

Appendix E: Client-Level Survey

WRLC Client Survey

Dear (Agency Name) Client:

(Agency name) is developing plans to enhance their tobacco cessation services and tobacco-free policies. We are very interested in your opinions on this issue. Your answers will help us make better choices for all clients.

This survey should take about 5 minutes to complete. *Your participation in this survey is confidential and anonymous*. Staff members at (agency name) will NOT see your responses. Surveys will be returned to a separate organization that is helping us with this program.

Thank you for taking the time to complete this survey. If you have any questions, or need any additional information, please contact your provider.

_____

1. **What services are you receiving? (Check all that apply.)**

   - ☐ Mental health services
   - ☐ Addictions services
   - ☐ Other health care services
   - ☐ Housing assistance
   - ☐ Court ordered services
   - ☐ Other, please specify: _____

2. **How long have you been receiving services at (agency name)?**

   - ☐ Less than 1 week
   - ☐ 1 to 4 weeks
   - ☐ 1 to 3 months
   - ☐ More than 3 months

3. **What is your age? _____**

4. **What is your sex?**

   - ☐ Male
   - ☐ Female
   - ☐ Other

5. **Which one of the following categories best describes you?**

   - ☐ Hispanic or Latino
   - ☐ White
   - ☐ Black, African American
   - ☐ Asian

- ☐ Native Hawaiian, Other Pacific Islander
- ☐ American Indian, or Alaskan Native
- ☐ Other, please specify: _____

6. Did a staff person at this agency ask you about your tobacco use during your <u>first visit</u>?

- ☐ Yes
- ☐ No
- ☐ Don't know

7. Have you been a regular tobacco user in your lifetime?

- ☐ Yes
- ☐ No **(If No, please skip to question 9)**

IF YES,

Please answer the following questions EVEN IF you have successfully quit using tobacco products:

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
7a. I have the <u>knowledge</u> I need to lead a tobacco-free life.	**1**	**2**	**3**	**4**
7b. I <u>plan</u> to take (or continue to take) steps towards living a tobacco-free life in the next 30 days.	**1**	**2**	**3**	**4**
7c. I am <u>currently</u> taking steps towards living a tobacco-free life.	**1**	**2**	**3**	**4**
7d. I am <u>confident</u> I have the ability to live a tobacco-free life.	**1**	**2**	**3**	**4**

8. Do you currently use tobacco?

- ☐ Yes
- ☐ No **(If No, please skip to question 9)**

IF YES,

8a. During the past week, which type(s) of tobacco or nicotine did you use? (Check all that apply)

- ☐ Cigarettes

- ☐ Chew
- ☐ Cigars
- ☐ Snuff/Snus
- ☐ E-Cigs
- ☐ Other:_____
- ☐ None

8b. During the past week, how many cigarettes (or other tobacco products) did you smoke or use in an average day?

- ☐ Quit
- ☐ 1-5
- ☐ 6-10
- ☐ 11-20
- ☐ 20+

8c. If you are <u>currently using</u> tobacco, check all that apply.

- ☐ I have tried to quit since I started receiving services at (agency name)
- ☐ I would like to try to quit over the next month (30 days)
- ☐ I would like to try to quit over the next 6 months
- ☐ I have no interest in quitting

8d. Have you ever used the services of the Tobacco Free Florida Quitline?

- ☐ Yes
- ☐ No

Please answer the following questions about your experiences at <u>this agency</u>:

8e. Were you asked about your tobacco use during your <u>follow-up visits</u> at this agency?

- ☐ Yes
- ☐ No

8f. Were you ever <u>advised to quit</u> using tobacco by a staff person at this agency?

- ☐ Yes
- ☐ No

8g. Were you ever <u>offered medications</u> to help you quit using tobacco by a staff person at this agency?

- ☐ Yes
- ☐ No

8h. Were you ever <u>offered counseling</u> to help you quit using tobacco by a staff person at this agency?

☐ Yes
☐ No

8i. Were you ever <u>referred to the Tobacco Free Florida Quitline</u> by a staff person at this agency?

☐ Yes
☐ No

8j. Were you ever <u>referred to other community services</u> to help you quit using tobacco by a staff person at this agency (e.g. support groups)?

☐ Yes
☐ No

For the following items, please circle the best response using the scale below:

	Strongly Disagree	**Disagree**	**I am Neutral**	**Agree**	**Strongly Agree**
9. It is possible for persons with mental illnesses and addictions to quit smoking or using other tobacco products.	**1**	**2**	**3**	**4**	**5**
10. Not allowing smoking in residential treatment is good for the health of employees and clients.	**1**	**2**	**3**	**4**	**5**
11. I think people should be allowed to smoke wherever they want.	**1**	**2**	**3**	**4**	**5**
12. People will not seek services here if this agency is tobacco-free.	**1**	**2**	**3**	**4**	**5**
13. I would support a tobacco-free policy at this treatment agency and/or residential setting.	**1**	**2**	**3**	**4**	**5**
14. Helping employees and clients quit tobacco should be a part of helping them healthier lives overall.	**1**	**2**	**3**	**4**	**5**