Effects of a Tobacco-Free Work Site Policy on Employee Tobacco Attitudes and Behaviors, Travis County, Texas, 2010–2012

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Methods
Integral Care and Austin Public Health conducted a web-based employee survey 6 months before and 6 and 12 months after implementation of the policy to measure tobacco use prevalence and attitudes among employees.

Outcome
Employees had significant improvements in tobacco use prevalence and attitudes toward the tobacco-free policy from pre-implementation to post-implementation. Tobacco use prevalence among staff decreased from 27.6% to 13.8%, and support for the policy increased from 60.6% to 80.3% at 12 months post-implementation.

Interpretation
Adoption of 100% tobacco-free campus policies in behavioral health settings can result in significant reductions in staff tobacco use. Leadership should provide staff with education, training, and cessation support before adoption of tobacco-free work site policies to ensure success.
care professionals, in particular, have a smoking prevalence that exceeds that of the general population (6).

While behavioral health care professionals recognize the negative health effects of smoking and the importance of addressing tobacco use among their patients and clients (7,8), the establishment of tobacco-free policies in treatment settings has faced obstacles. Staff cite concerns that tobacco-free policies could negatively impact staff–client relationships (9–12). Organizational barriers include common practices such as promoting patient or client smoking for behavioral reinforcement and staff members and patients smoking together (6,13). Additionally, low levels of staff knowledge, confidence, skills, and perceived responsibility and a lack of training and tobacco use cessation support and resources for patients and staff (6,11) further impede policy adoption and implementation. Staff support is considered crucial to successfully implementing tobacco-free policies in behavioral health treatment settings (14,15). Yet, there is limited research examining 1) the use of participatory methods to address the abovementioned barriers to behavioral health staff support and 2) staff attitudes toward tobacco-free workplace policies and the prevalence of tobacco use among staff before and after policy adoption. We sought to determine whether comprehensive planning before the implementation of a tobacco-free work site policy could decrease employee tobacco use.

Community Context

In Travis County, Texas, in 2010, 13.4% of the population with frequent mental distress were current smokers, compared with 10.7% of the population not reporting mental distress (16). No local data on the prevalence of tobacco use among health care professionals in behavioral health care settings exist, though research suggests that the prevalence of smoking among nonphysician health care professionals, and specifically behavioral health care professionals, remains high (4–6,13).

On February 1, 2011, Integral Care (formerly Austin/Travis County Integral Care), a local authority for behavioral health and developmental disabilities in Austin, adopted a 100% tobacco-free campus policy. This policy prohibited the use of all forms of tobacco and covered all property owned, leased, or used by Integral Care, including indoor and outdoor spaces and common areas, parking lots and driveways (inside and outside personal vehicles), company vehicles, and residential treatment facilities in Travis County. At that time, Integral Care employed about 600 individuals and served about 27,000 consumers at 44 locations each year.

Before the 2011 policy, Austin Public Health, formerly Austin/Travis County Health and Human Services, engaged staff and administration at Integral Care in a comprehensive planning process comprising assessment, communication, training, and cessation resources. This process was part of a broader community-level effort in Austin and Travis County, under the Communities Putting Prevention to Work initiative from the Centers for Disease Control and Prevention to Work. Integral Care communication strategy began 5 months prior to the effective date of the tobacco-free campus policy to gradually introduce the policy, address staff and consumer resistance to the change, and give tobacco users time to prepare for the change. The internal communication strategy, “We Can Quit” (Figure), consisted of positive, nonpunitive messaging via multiple pathways with the goal of educating staff and encouraging tobacco use cessation. Integral Care created a policy change homepage on the employee intranet that included organization and community cessation resources, information on the health consequences of tobacco use, and policy implementation updates. Integral Care also sent organization-wide emails on cessation success stories, policy updates, memoranda, and cessation resources. Brochures and flyers were distributed, and signage was posted at all campus facilities. The external communication strategy comprised memoranda to In-
Integral Care contractors and leased properties regarding the policy change as well as organizational newsletters and reports to partners in Austin/Travis County. Via a link on the Integral Care homepage, the information from the intranet page was available to the public. At the time, the local health department, Austin Public Health, was also implementing an extensive media campaign on the dangers of tobacco use and secondhand smoke exposure. Integral Care held a media launch event with Austin Public Health to celebrate the policy effective date.

| Year and Month | Activity |
|----------------|----------|
| 2010 June      | Austin Public Health awards Integral Care with subrecipient grant from Communities Putting Prevention to Work |
| July           | Integral Care policy approved by board of trustees |
| August         | Integral Care staff survey (6 months pre-implementation) |
| September      | Internal communication begins (signage, brochures, intranet, cessation resources) |
| December       | External communication begins; signage posted on properties |
| 2011 January   | Staff training and education; media event with Austin Public Health |
| February       | Implementation of tobacco-free workplace policy |
| March          | Tobacco Use Assessment (EHR) Implemented |
| August         | Integral Care staff survey (6 months post-implementation) |
| 2012 February  | Integral Care staff survey (12 months post-implementation) |

Staff training began 90 days before policy implementation (Box) and included education on 1) assessing and treating tobacco use in Integral Care consumers within the clinical setting and 2) how to engage Integral Care staff and consumers about the policy outside the clinical setting. Integral Care implemented the tobacco treatment template from the American Academy of Family Physicians in electronic medical records and trained all clinicians in the Ask and Act treatment protocol (20), pharmacologic treatments, the epidemiology of tobacco use and mental illness or addiction comorbidity, and motivational interviewing techniques. Tobacco use cessation counselors were trained to provide brief (minimum of 15 minutes) counseling sessions for consumers, with up to 6 sessions.
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available to each consumer. Treatment plans and billing reimbursements were adjusted to include tobacco cessation counseling, and staff were trained on accounting for this time. To assist in enforcement, Integral Care staff were also trained on engaging any staff, consumers, and visitors not complying with the policy using brief, nonconfrontational, scripted messages.

During the 6 months before policy implementation (Box), Integral Care also began a comprehensive education and cessation support program for both employees and consumers. Cessation support included free cessation counseling through the Employee Assistance Program and nicotine replacement therapy for both staff and consumers. Additionally, staff were eligible for reimbursement of their first tobacco cessation medical office visit and Zyban (GlaxoSmithKline; tobacco cessation prescription medicine) at no cost. Community cessation resources (eg, the Texas Quit Line) were also promoted by Integral Care.

Design and analysis

In August and September 2010, 6 months before policy implementation, an 18-question web-based pre-implementation survey was administered to all clinical and nonclinical employees at Integral Care; employees were sent an email with a hyperlink to the survey. The pre-implementation survey had demographic and health questions and 11 questions regarding tobacco use, policy attitudes, and preferred cessation resources. The survey (including additional questions) was administered again at 6 and 12 months post-implementation. Pre- and post-implementation surveys asked Integral Care employees about current tobacco use (ever and while at work), knowledge about the health effects of tobacco use and secondhand smoke, desire to quit, preferred cessation methods, policy support, and willingness to enforce the policy. Response categories for policy support and for willingness to enforce the policy were collapsed from yes, no, and maybe into yes and no/maybe. The post-implementation surveys included 8 additional questions on previous quit attempts, awareness and use of cessation resources, and attitudes about training, enforcement, and compliance. Survey questions relating to the pre-implementation policy environment were modified in the post-implementation surveys to reflect the change in conditions. For example, the pre-implementation survey question “Would you support a tobacco-free policy?” was changed to “Do you support a tobacco-free policy?” The question “Would you be willing to assist in the enforcement of the tobacco-free workplace policy?” was changed to “Do you assist in enforcing the tobacco-free workplace policy?”

Pre- and post-implementation survey respondents were not matched, but the only significant difference among the samples in the 3 surveys in terms of sex, age, education, or position was the proportion of staff with a high school diploma or general equivalency diploma as their highest level of education (pre-implementation vs 12 months post-implementation) (Table 1). In each survey, roughly half of respondents were younger than 40 years of age, and approximately three-quarters of respondents were women. The percentage of respondents with a bachelor’s degree or higher was 76% or higher across the 3 surveys. Additionally, survey participants’ demographic characteristics (sex, age, and education) were compared with demographics of the entire Integral Care staff (obtained from de-identified employee data). Race/ethnicity of employees was not provided and was not collected in the survey. No significant differences in sex, age, or education were observed between the survey participants and the study population.

Pearson \( \chi^2 \) tests were performed to compare survey samples and to compare pre- and post-implementation survey data on tobacco use prevalence, attitudes toward tobacco use, and tobacco-free workplace policy support and to compare tobacco use prevalence change for sex, age, education, and position subgroups. Significance was set at \( \alpha = .01 \). Statistical analysis of survey data was performed using Stata 14.0 (StataCorp LP). Research was approved by Integral Care’s Board of Trustees and by the Integral Care Institutional Review Board.

Outcome

Of approximately 612 eligible Integral Care staff, 246 employees completed the pre-implementation surveys in August and September 2010; 230 employees completed a post-implementation survey at 6 months in July and August 2011 and 234 employees completed a post-implementation survey at 12 months in February through April 2012 (Table 1). Demographic characteristics were missing for 21 respondents in the 6-month post-implementation survey and 12 respondents in the 12-month post-implementation survey. The response rate for the pre-implementation survey was 40.2%, for the 6 months post-implementation survey was 37.6%, and for the 12 months post-implementation survey was 38.2%.

Tobacco use among staff declined significantly from 27.6% in the pre-implementation survey to 11.6% in the 6-month post-implementation survey (\( \chi^2 = 18.47; P < .001 \)) and to 13.8% in the 12-month post-implementation survey (\( \chi^2 = 13.43; P < .001 \)) (Table 2). There was no significant change in tobacco-use prevalence between the 6- and 12-month post-implementation surveys.

Staff support for the tobacco-free campus policy increased significantly from 60.6% to 83.9% from pre-implementation to 12 months post-implementation (Table 2) (\( \chi^2 = 31.53; P < .001 \)). Policy support also increased significantly between the 6-month post-implementation (71.8%) and the 12-month post-implementation surveys (\( \chi^2 = 9.48; P = .002 \)). Among tobacco users, there was a significant increase in support of the policy from the pre-imple-
Most respondents were aware of the cessation services provided by Integral Care in both the 6-month (185; 80.4%) and 12-month (206; 88.0%) post-implementation surveys; tobacco users specifically reported only marginally higher awareness of resources in both post-implementation surveys. Cessation services were not offered to Integral Care staff at the time of the pre-implementation survey, and thus the question was not included in the pre-implementation survey.

In addition, 73% of respondents in the 6-month post-implementation survey and 69% in the 12-month post-implementation survey reported that they felt adequately trained or competent to engage consumers about the tobacco-free policy. There was a significant increase in the percentage of respondents who reported currently assisting in enforcement at 6 months (61.6%) and 12 months post-implementation (66.1%) compared with respondents who reported that they would be willing to assist in enforcement of the policy in the pre-implementation survey (48.0%) (Table 2). Among tobacco users specifically, this significant increase was observed between pre-implementation survey (26.5%) and 6 months post-implementation (64.0%) as well as between pre-implementation and 12 months post-implementation (54.8%). There was a small but nonsignificant decrease in the proportion of tobacco users willing to enforce the policy between 6 and 12 months post-implementation.

In the pre-, 6-month post-, and 12-month post-implementation surveys, 71.7%, 84.0%, and 74.2%, respectively, of tobacco users responded yes or maybe to the question of whether they wanted to quit using tobacco. Of tobacco users, 64.2%, 72.0%, and 64.5%, respectively, responded yes or maybe to the question of whether they were seriously considering quitting in the next 6 months. Approximately half of all tobacco users in the 6-month post-implementation and 12-month post-implementation surveys (56.0% and 45.2%, respectively) had made a quit attempt in the past 9 months (the question was not asked in the pre-implementation survey).

**Interpretation**

This study evaluated the effects of a 100% tobacco-free campus policy at a large multisite provider of behavioral health and development disabilities services on staff tobacco use rates and staff attitudes toward a tobacco-free campus policy. The objectives of this engagement and planning process (assessment, communication, training, and cessation resources) were all met during the 18-month period. Assessment using web-based surveys of employees was carried out at 6 months before and 6 and 12 months following policy implementation. Regarding communication, survey results indicated that nearly 70% of respondents at both 6 and 12 months post-implementation felt adequately trained in engaging consumers regarding the policy; over 80% of respondents (and over 90% of tobacco users specifically) in both post-implementation surveys were aware of cessation resources. Outcomes of interest for the policy implementation also demonstrated improvement. Staff attitudes in support of tobacco-free policies increased significantly, and staff tobacco use prevalence decreased. Across all 3 surveys there was a high percentage of tobacco users (>64%) intending to quit tobacco in the next 6 months.

This evaluation demonstrates that a comprehensive implementation plan combining education, communication, and cessation support for staff before a tobacco-free policy adoption can contribute to reduced staff tobacco use and increased support for the policy after adoption. The components of education and training for staff regarding smoking behaviors and risks and smoking cessation treatment options for clinical populations have been recommended and linked to the success of smoke-free initiatives in inpatient mental health facilities (15,18). To our knowledge this is the first study of a policy implementation that has incorporated components to address staff tobacco use before implementing the policy in the patient population. Staff commonly cite low or lack of support for tobacco-free policies from the organization in which they work (12,19). Thus, addressing staff needs is an important first step to successfully implementing tobacco-free policies in behavioral health services settings.

Changes that were not significant at 6 months post-implementation (eg, support for the policy among non–tobacco users) were significant at 12 months post-implementation. This indicates that attitudes toward a tobacco-free policy can continue to improve after implementation and suggests that attitudes (and possibly social norms) may not change until after a policy is implemented and individuals can observe consequences or implications of the change.
This study has several limitations. Integral Care provides developmental disabilities services in addition to behavioral health services. Staff providing these services made up 18% of full-time employees in 2011 and may be different than staff working in traditional behavioral health care settings. Additionally, we did not obtain information on staff turnover. Staff may have not received the full implementation if they left or were hired during the 6 months before implementation during which communication, education, and training were conducted. Though survey response rates were averages, staff who answered the surveys may have been systematically different than those who did not participate and may not represent the characteristics and attitudes of the Integral Care study population. We were also unable to link pre-implementation and post-implementation survey respondents. However, the only significant difference in demographic characteristics among the pre-implementation and post-implementation survey samples was in the proportion of staff with a high school diploma or general equivalency diploma as their highest level of education (pre-implementation vs 12 months post-implementation). There were no significant differences in the demographic characteristics between any pre-implementation or post-implementation survey samples and the entire Integral Care employee population. However, because employee race/ethnicity data were either not available or not collected, and disparities in tobacco use exist among racial/ethnic groups in the general population, we cannot determine the contribution of race/ethnicity to study findings. Additionally, tobacco users who quit may have been more willing to answer the post-implementation surveys than those who did not quit.

Finally, Integral Care was a sub-recipient of the Communities Putting Prevention to Work grant received by Austin Public Health in 2010. The grant funds provided Integral Care with funding for personnel, operating expenses (including signage), and indirect expenses to plan and execute the policy change. An intervention of this scale may not be feasible for smaller behavioral health providers.

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Table 1. Characteristics of Surveyed Staff at 6 Months Before and 6 and 12 Months After Implementation of a Tobacco-Free Workplace Policy at Integral Care, Austin, Texas, 2010–2012

| Characteristic                          | 6 Months Before Policy Implementation (July–August 2010), n (%) | 6 Months After Policy Implementation (July–August 2011), n (%) | 12 Months After Policy Implementation (February–April 2012), n (%) |
|----------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|
| Total                                  | 246 (100)                                                       | 209 (100)                                                       | 222 (100)                                                       |
| Sex                                    |                                                                 |                                                                |                                                                |
| Male                                   | 58 (23.6)                                                       | 49 (23.4)                                                       | 58 (26.1)                                                       |
| Female                                 | 188 (76.4)                                                      | 160 (76.6)                                                      | 164 (73.9)                                                      |
| Age                                    |                                                                 |                                                                |                                                                |
| ≤30                                    | 60 (24.4)                                                       | 48 (23.0)                                                       | 54 (24.3)                                                       |
| 31–40                                  | 61 (24.8)                                                       | 61 (29.2)                                                       | 63 (28.4)                                                       |
| 41–50                                  | 55 (22.4)                                                       | 43 (20.6)                                                       | 46 (20.7)                                                       |
| 51–60                                  | 48 (19.5)                                                       | 37 (17.7)                                                       | 43 (19.4)                                                       |
| ≥60                                    | 22 (8.9)                                                        | 20 (9.6)                                                        | 16 (7.2)                                                        |
| Position at Integral Care              |                                                                 |                                                                |                                                                |
| Administration                         | 108 (43.9)                                                      | 99 (47.4)                                                       | 86 (38.7)                                                       |
| Allied health professional             | 25 (10.2)                                                       | 24 (11.5)                                                       | 26 (11.7)                                                       |
| Direct care staff                      | 83 (33.7)                                                       | 69 (33.0)                                                       | 90 (40.5)                                                       |
| Nursing                                | 9 (3.7)                                                         | 5 (2.4)                                                         | 2 (0.9)                                                         |
| Physician                              | 3 (1.2)                                                         | 3 (1.4)                                                         | 3 (1.4)                                                         |
| Other                                  | 18 (7.3)                                                        | 9 (4.3)                                                         | 15 (6.8)                                                        |
| Education                              |                                                                 |                                                                |                                                                |
| High school or general equivalency diploma | 34 (13.8)                      | 19 (9.1)                                                       | 12 (5.4)                                                         |
| Associate’s degree                     | 24 (9.8)                                                        | 16 (7.7)                                                        | 25 (11.3)                                                       |
| Bachelor’s degree                      | 73 (29.7)                                                       | 70 (33.5)                                                       | 70 (31.5)                                                       |
| Master’s degree                        | 95 (38.6)                                                       | 87 (37.8)                                                       | 97 (41.5)                                                       |
| MD or PhD degree                       | 8 (3.3)                                                         | 5 (2.4)                                                         | 7 (3.2)                                                         |
| Other                                  | 12 (4.9)                                                        | 12 (5.7)                                                        | 11 (5.0)                                                        |

*Job/position categories were chosen to determine employee involvement with Integral Care consumers and do not reflect education levels.

b $\chi^2 = 9.32$, df = 1; $P = .002$. 

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Table 2. Changes in Tobacco Use and Support for a Tobacco-Free Campus Policy at 6 Months Before and 6 and 12 Months After Implementation, Integral Care, Austin, Texas, 2010–2012

| Characteristic                              | 6 Months Before (July–August 2010) (N = 246) | 6 Months After (July–August 2011) (N = 216) | 12 Months After (February–April 2012) (N = 224) | P Value  |
|--------------------------------------------|-----------------------------------------------|---------------------------------------------|------------------------------------------------|---------|
|                                            | No. of Respondents | % (n)                      | No. of Respondents | % (n)                      | No. of Respondents | % (n) | 2010 vs 2011 | 2010 vs 2012 | 2011 vs 2012 |
| Tobacco use prevalence                     | 246                      | 27.6 (68)                  | 216                      | 11.6 (25)                  | 224                      | 13.8 (31) | <.001        | <.001         | .48a        |
| Supports tobacco-free workplaceb           | 246                      | 60.6 (149)                 | 216                      | 71.8 (155)                 | 224                      | 83.9 (188) | .11          | <.001         | .002        |
| Support among tobacco users                | 68                       | 26.5 (18)                  | 25                       | 60.0 (15)                  | 31                       | 64.5 (20) | <.001        | .003          | .73         |
| Support among non–tobacco users            | 178                      | 73.6 (131)                 | 191                      | 27.8 (139)                 | 193                      | 87.0 (168) | <.001        | .86c          | <.001 <.001 |
| Assists in enforcement of tobacco-free workplace policyd | 246                      | 48.0 (118)                 | 216                      | 61.6 (133)                 | 224                      | 66.1 (148) | .003         | <.001         | .33         |
| Willingness among tobacco users            | 68                       | 26.5 (18)                  | 25                       | 64.0 (16)                  | 31                       | 54.8 (17) | .001         | .006          | .49c        |
| Willingness among non–tobacco users        | 178                      | 56.2 (100)                 | 191                      | 60.7 (116)                 | 193                      | 67.9 (131) | .38          | .02           | .14         |

a Nonsignificant increase in proportion observed.
b The survey 6 months before implementation asked, “Would you support a tobacco-free policy?” The surveys after implementation asked, “Do you support a tobacco-free policy?”
c Nonsignificant decrease in proportion observed.
d The survey 6 months before implementation asked, “Would be willing to assist in the enforcement of the tobacco-free workplace policy?” The surveys after implementation asked, “Do you assist in enforcing the tobacco-free workplace policy?”

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