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Second-hand smoke exposure and mitigation strategies among home visitation workers

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Abstract

Objectives—Protection of workers from second-hand smoke (SHS) in occupational settings is an important policy priority yet little attention has been given to SHS protection for home visitation health workers, who number almost two million in the United States. Self-reported SHS exposure, SHS mitigation strategies, and suggestions for further SHS exposure reduction approaches were obtained from home visitation health workers in Massachusetts.

Methods—Across-sectional survey was conducted among Massachusetts Early Intervention workers at their statewide conference in April, 2010.

Results—Eighty-three percent of the N=316 respondents reported at least one hour per month of SHS exposure, and 16% reported at least 11 hours per month. Nevertheless, only 22% of workers counseled clients on maintaining a smoke free home. Fewer than 30% of workers had ever voiced concerns to their employing agency and just 12% had raised their concerns directly with clients. Only 14% stated that their agency had rules designed to protect workers from SHS.

Conclusions—SHS exposure occurs frequently among home visitation health workers. The data point to a substantial population who are not protected from SHS exposure by formal policies.

Keywords

Secondhand smoke; exposure; self-report; workplace; home

Introduction

Over the past 25 years, policy initiatives have been established to protect the public from health risks of exposure to second-hand smoke.^{1–3} All 50 U.S. states now have at least some legal restriction on indoor smoking in workplaces and other public places, and 26 states have state-wide, comprehensive workplace smoking bans.⁴ These groundbreaking policy initiatives have been credited with lowering SHS exposure among workers,^{5–9} nonsmokers & children,^{10,11} reducing smoking behavior,^{12–14} and changing public norms around tobacco use.^{15,16} Since 2004, Massachusetts has had a statewide indoor smoking ban for workplaces, bars and restaurants. Personal bans on smoking in the home have also produced reductions in secondhand smoke (SHS) exposure and health benefits for children, including

reductions in Sudden Infant Death Syndrome SIDS and asthma symptoms.^{17,18} In recent years, new indoor and public smoking bans have proliferated beyond workplaces to provide protection for other populations including children. In addition to long-standing bans on smoking in federally-funded day care and school facilities, bans on smoking in cars in which a child is present, smoking in home day care centers, and smoking in foster homes, now exist in some U.S. states.^{2,19} Smoking bans in multi-unit dwellings have been introduced in some public housing developments in the U.S.²⁰ and Canada.²¹ Nevertheless, domestic environments present a conundrum for policymakers who seek to protect nonsmokers from secondhand smoke exposure (SHS exposure and mitigation strategies). Private homes have traditionally not been amenable to the legislative initiatives that established protections for workers in workplaces or other public places.

Home visitation outreach or health workers spend much of their working time in private homes, and often work with disadvantaged populations, among whom smoking prevalence tends to be higher.²² Without a formal legal ban or workplace policy, this group of workers may be at risk of chronic exposure to SHS. SHS exposure and SHSe mitigation strategies among home workers have not previously been reported.

Early Intervention (EI) programs, funded by the United States Department of Education, exist in all 50 U.S. states and provide a home visitation service available to families of very young children with developmental delay. The purpose of this study was to measure the self-reported frequency and duration of Massachusetts Early Intervention workers' exposure to SHS in the course of their home visitation duties, and to describe strategies used by workers to mitigate exposure via counseling or other engagement with clients. Additionally, the study aimed to describe workers' knowledge of their agency's policies regarding working in homes with SHS.

Methods

Study procedure and survey

A cross-sectional paper and pencil survey was conducted among attendees at the Massachusetts Annual Early Intervention Consortium Conference in April, 2010. The purpose-designed survey included questions on demographics, occupation, exposure to second-hand smoke, current SHSe mitigation strategies, and future strategies or policies supported by EI workers to reduce SHSe.

The study was reviewed and approved by The Massachusetts Department of Public Health Bureau of Family Health and Nutrition and the managing office of the Early Intervention Programs. Ethical approval and oversight of human subject protections was provided by Harvard School of Public Health's Office of Human Research Administration (IRB), the ethical review board. Respondents were provided a passive informed consent cover letter that detailed the research purpose, contact information, and assurance of confidentiality.

Participants

Eligible participants were Southern New England Early Intervention workers attending the Massachusetts Early Intervention Consortium Annual Meeting, whose position currently required in-home visits with families. There were 593 Early Intervention-affiliated attendees registered. Three-hundred and sixteen of the 593 registered EI workers (53%) completed the survey.

Survey Domains

The survey included the following domains: SHS exposure, use of SHS mitigation strategies, and knowledge of agency rules. A measure to estimate *SHS exposure* was created from a composite of three variables: average number of in-home visits per month, average length of visit ranging from less than 15 minutes to more than three hours, and specific number of visits in which the EI worker smelled smoke. In-home visits were typically scheduled for one-hour. Thus, for each in-home visit in which the worker smelled smoke, one hour of SHSe was assumed for calculation of monthly SHSe. Questions on *mitigation strategies* included questions on client counseling to reduce SHS, previous concerns with SHS, degree of comfort discussing SHSe risks, and degree of comfort discussing ways to reduce SHS in the home. Questions on *knowledge of agency rules* included workers' knowledge of agency policies on smoking during home-visits as well as any complaints workers may have addressed with their manager or group leader regarding SHSe.

Statistical Analysis

Survey responses were analyzed using Stata 10.0.²³ Categorical variables were tabulated with row frequencies and continuous variables with means (& 95% confidence intervals) and medians.

A main outcome of interest was whether EI workers counseled their clients on making their homes smoke-free during the six months leading to survey administration. To better understand determinants and predictors of this outcome, a multivariate logistic regression was employed. Regression coefficients were exponentiated to produce odds ratios (ORs). Given the importance of this outcome in understanding the likelihood of an EI worker counseling clients to make their homes smoke-free, we felt it was important to incorporate variables that may play a role in an EI worker deciding to counsel or not. These predictors included: ever voicing concern about SHS exposure to a manager (binary), Comfort discussing SHS risks with clients (4-tier categorical), Age (5-tier categorical), length of time working in EI program (5-tier categorical), smoking status (binary), knowledge of organizational rules (binary), hours of exposure (continuous), and comfort addressing SHS in home with client (4-tier categorical). Due to the exploratory nature of the study, the final regression model presented is simultaneously inclusive of all of the latter variables regardless of their significance

Results

Surveys were conducted with 316 (53%) of the estimated 593 eligible Early Intervention workers attending the statewide conference. More than 60% of individuals had worked in Early Intervention for three or more years and 21% were former smokers. Participant characteristics are presented in Table 1.

Early Intervention workers' exposure to SHS

On average, EI workers had current caseloads of 18 families and made a total of 60 visits per month (see Table 1). SHS was smelled or observed on an average of 6.8 visits per month (11%), and active smoking was observed during 1.3 of the 60 visits (2%). Of the 296 respondents who answered the question, 83% reported at least 1 hour per month of SHSe with a median of 3.5 hours per month. In all, 16 percent of EI workers reported 11+ hours of SHSe per month.

Strategies used by EI workers to reduce SHS

During the six months before survey administration, 22% of EI workers counseled their clients on ways to make their home smoke-free. Of those performing the counseling, 33%

perceived clients' responses to be mostly or somewhat positive, while 48% perceived their clients to be indifferent. Only 19% of respondents perceived a negative response by clients. A logistic regression found that increased likelihood of EI worker to client counseling was significantly associated with previously voicing concern about SHSe to the EI agency manager (OR 5.58, 95% CI 2.37–13.11), self-reported “very comfortable” discussing the risks of SHS (OR 18.1, 95% CI 1.82–179.90) and increased exposure to SHS (OR 1.11, 95% CI 1.06–1.16). EI worker age, and time working in the EI program were not significantly associated with an increased likelihood of counseling ($p > .05$ for both) (see Table 2).

Respondents were asked about other actions taken during home visits in the past six months. Strategies employed by workers included asking clients about their knowledge of the risks of SHS exposure (18%), discussion based around SHS handouts or brochures (11%), and providing SHS handouts for further information (7%). Less than 5% provided smoking cessation counseling, noted client smoking status in the client file, left cessation hand-outs with the client, or referred the client to a quit line.

Only 17.1% of respondents reported feeling very comfortable discussing the risks of SHS with clients in their home. Among EI workers with the most exposure (11+ hours per month), only 12.5% felt very comfortable discussing SHSe risks and only a third felt very comfortable asking clients not to smoke in their homes. EI workers were asked whether they had ever expressed concern to a manager/leader regarding SHSe during their home visits, with 17.3% of EI workers having ever expressed such concern. Of EI workers with 6–10 hours of exposure, 20.9% expressed concern and among those with the most exposure (11+ hours per month), 12.5% had ever voiced concerns about exposure to their manager or team leader (Figure 1).

EI workers' knowledge of agency rules regarding SHSe

Only 14% of EI workers reported knowledge of rules in place at their organization to request that clients do not smoke before or during the visit. More than 30% stated that the client should never be able to smoke in their presence; other less frequent responses included the client being able to smoke before they arrive but not in their presence (26%). Sixty-six percent wanted their agencies to have clients sign a written form of the rules when they first enroll, with 37% stating that clients should receive a periodic reminder of the rules. Fifteen percent were opposed to the agency making any rules at all.

Discussion

A high incidence of at least minimal exposure to second hand smoke, and little workplace protection, was observed among this sample of home visitation workers in Massachusetts. More than 80% of home visitation workers reported at least one hour per month of exposure to SHS and 16% reported at least 11 hours of exposure per month. Despite regular exposure to SHS in the course of their home visitation duties, only 14% of participants were aware of any organization rules requiring a non-smoking period prior to or during a home visit. While home visitation workers expressed broad support for minimizing SHSe, only 22% of the sample reported having discussed SHS mitigation strategies with their clients.

The US Surgeon General's²⁴ conclusion that there is no safe level of exposure to SHS underscores the continuing risk facing home visitation workers compared with other workers whose workplaces are protected by smoking bans. Estimation of the precise health risks faced by EI workers is not possible based on the present data, but recent studies indicate that workers regularly exposed to SHS report symptoms of respiratory illness²⁵ and decreased pulmonary function.²⁶ To successfully protect home visitation workers from SHSe, multiple approaches may be required. Effective SHSe reduction strategies must recognize the delicate

balance of organizational, professional and personal relationships that exist between agencies and their governing health departments, agency workers and their clients. Issues of personal autonomy and health care priorities may also impact the degree to which a client can reasonably be required to maintain a smoke-free home for the purpose of home visits. Accordingly, a continuum of strategies may be proposed to protect home visitation workers from SHSe, which range from voluntary agreements and training, to implementation of formal policy at an organizational or government level.

Even among workers who reported the highest levels of SHSe, few felt comfortable talking with clients about smoking cessation or second-hand smoke exposure prevention. Although a third of workers encountered positive responses, a large proportion reported that such discussion tended to evoke indifferent responses, while one in five experienced a negative response. Failure to elicit a positive response from clients may be a disincentive to client counseling on SHS strategies. New agency-led policies that provide brief behavioral or client-centered counseling training for home-based workers supported by their agencies may be helpful. There is precedent for such training of community health workers. Castenada and colleagues²⁷ concluded that successful programs employing community health workers must: i) address the social risk or the impact that training may have on long-term sustainability in the relationship between the trusted health worker and their clients; ii) increase participant self-efficacy; iii) provide material resources to lay health influencers; and iv) work to create a community of practice in which trainees undergo training collectively and seek common goals.

While legislation and policies to prevent workplace exposure among hospitality workers has proven successful, making new laws or regulations that require parents not to smoke in their own homes while engaged in voluntary state funded programs may present difficulties. In particular, legislation of smoking behavior in a private home may be considered outside the realm of government regulation. However, the legal environment of individual states in the U.S. can provide opportunities for executive policy strategies. For example, under Massachusetts Law, the Bureau of Family Health and Nutrition routinely develops and promulgates uniform rules and standards for the provision of Early Intervention services. Therefore, new rules and standards to protect home visitation workers from SHSe could include simple written agreement letters between agencies receiving state funding, home visitation workers, and their clients. Implementing such a policy could also serve to create incentives for individuals to smoke fewer cigarettes or at a minimum, reduce time of exposure for others in the home.

Several limitations of the study must be noted. The data rely on self-report of exposure, which may be susceptible to recall error as well as response bias among workers with a high or low sensitivity to SHSe. The low smoking prevalence in Massachusetts compared with the U.S. national rate may limit generalizability of these findings. However, the likelihood of a home visitation worker encountering SHS may be greater in states or regions with a higher smoking prevalence. The very low smoking rate reported by this sample, is unlikely to be representative of other types of workers, and may have introduced a response bias owing to a possible heightened sensitivity to SHS among nonsmokers. Further, this study obtained responses only from a subset of Massachusetts EI workers who attended the annual statewide meeting. Future studies should explore patterns of SHSe among nationally representative samples of EI and other home visitation worker groups, including home health aides and visiting nurses. Finally, recent concerns have been raised regarding exposure to third hand smoke, which may be an additional exposure risk in dwellings with a substantial amount of SHS.²⁸ While self-report measures of SHSe have good validity,²⁹ future research efforts with home visitation workers should corroborate self-report measures using SHSe biomarker measures.

Home-based workers often work in challenging situations for low pay. This study of Massachusetts home visitation workers has identified potential workplace risks of second hand and third hand tobacco smoke exposure. Given the lower smoking rate in Massachusetts compared with most other U.S. states,³⁰ there is a possibility that exposure to second-hand smoke for home-based workers would be higher in other states. Because some 1.7 million persons are employed as home health workers and personal and home care aides in the U.S.,³¹ it is important to more fully document their exposure to SHS and evaluate their employer's or agency's readiness to protect this growing workforce. Even in states with comprehensive clean indoor air laws, those working in homes remain largely unprotected by formal policy from workplace SHS. The development of formal policy strategies to protect home visitation health workers, as well as the potential for home visitation health workers to engage clients with brief smoking cessation³² or SHS reduction interventions,³³ require further attention from public health researchers and policy makers.

What this Paper Adds

This paper describes a survey of self-reported secondhand smoke (SHS) exposure among home visiting health workers in Massachusetts, and the strategies used by those workers to reduce their SHS exposure.

Home visiting health workers, who currently number approximately 1.7 million in the United States, are not generally protected by workplace smoking bans when making private home visits. This is a previously undocumented population at risk for SHS exposure, and for whom little or no formal policy for protection from exposure appears to exist. The present data provide the first known insight into SHS exposure encountered in the course of home visiting duties for Early Intervention workers, including frequency and duration of exposure, expressed concerns, and strategies used to reduce exposure. Potential strategies for protecting this sizeable workforce are outlined.

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Figure 1.
Expressed Concern About SHS by Exposure Level

Table 1

Characterization of Survey Respondents

	Percent (%)	N
Total	100	316
Age		
<26	8.4	26
26–35	36.0	112
36–45	25.1	78
46–55	14.5	45
56+	16.1	50
Length of Time in EI Program		
< 1 year	13.6	42
1–2 years	22.1	68
3–5 years	25.0	77
6–9 years	14.9	46
10 years +	24.4	75
Smoking Status		
Current smoker every day	1.0	3
Current smoker some days	1.0	3
Former, but not current smoker	20.1	62
Never smoked regularly	78.0	241
Monthly SHS Exposure		
0 Hours	16.7	51
1–5 Hours	47.2	144
6–10 Hours	20.3	53
11–15 Hours	4.9	15
16–20 Hours	4.9	15
>20 Hours	5.9	18
Caseload		
Mean	17.6	
Median	18	
Range	[0–100]	
In-Home Visits/Month (at least one client in caseload)		
Mean	60.1	
Median	60	
Range	[0.5–99.9]	
In-Home Visits with SHS Smell/Month		
Mean	8.2	
Median	5	
Range	[1–80]	

Table 2

Likelihood of EI Workers Counseling Clients on Making their Homes Smoke-free

Parameter	n	Odds Ratio	L 95% CI	U 95% CI
Ever voiced concern about SHS to manager/leader				
No	248	1.0	--	--
Yes *	52	5.5	2.4	13.1
Comfort discussing SHS risks with clients				
Not at all	34	1.0	--	--
A little	96	3.9	0.4	35.4
Somewhat	127	4.2	0.5	39.0
Very *	53	18.1	1.8	179.9
Increasing Exposure (SHS smell visits) *	305	1.1	1.1	1.2
Age				
<=25	26	1.0	--	--
26-35	112	4.2	0.7	26.9
35-45	78	2.3	0.3	15.8
46-55	45	4.3	0.5	36.0
>=56	50	5.9	0.7	51.3
Time working in EI program				
Less than a year	42	1.0	--	--
1-2 years	68	0.4	0.1	1.8
3-5 years	77	0.7	0.2	2.7
6-9 years	46	0.8	0.2	3.1
10 + years	75	0.4	0.1	1.8
Ever Smoker				
No	241	1.0	--	--
Yes	68	1.4	0.6	3.5
Knowledge of organizational rules regarding smoking ban during visit				
No	261	1.0	--	--
Yes	45	1.6	0.6	4.5
Comfort asking client to not smoke while in their home				
Not at all	25	1.0	--	--
A little	56	6.1	0.6	58.1
Somewhat	120	3.7	0.4	32.0
Very	104	4.9	0.6	42.1

* significant at p<.05 level