Smoking Policies and Practices in State Psychiatric Facilities: Survey Results from 2011

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Introduction

Since 2006, NRI has been surveying state psychiatric facilities on their smoking policies and practices. In 2005, NRI performed the analysis of the initial environmental scan conducted by NASMHPD to develop a baseline of information. At that time, there was a 55% response rate and only 20% of facilities indicated that they prohibited smoking. In 2006, NRI developed a refined survey with more variables, such as developing operational definitions of smoking and non-smoking; environmental and safety issues; staff training; and treatment options. Facilities self-identified whether they prohibit or allow smoking by the version of the survey they completed. The 2006 survey had an 82% response rate and 41% of facilities indicated that they prohibit smoking. In 2008, NRI refined the 2006 survey to provide a hierarchy of policy statements in order to refine and categorize facilities as either "prohibiting" or "allowing" smoking and adding questions to focus on treatment and continuity of care. The 2008 survey had a 75% response rate and 49% of facilities were categorized as prohibiting smoking.

Our multi-year survey results indicate a clear movement toward facilities prohibiting smoking in their facilities; however, a significant proportion of facilities still allow smoking and identified specific barriers to policy and practice changes. Over the past several years there have been concerted efforts by national groups (for example, NASMHPD, CDC, and SCLC) to provide facilities with toolkits and other resources to promote a smoke-free environment in psychiatric facilities. The main goal of the 2011 survey was to identify the status of state psychiatric facilities movement toward smoke-free environments.

Methods

Target Population

The 2011 survey was distributed to 206 state psychiatric facility directors via email with a link to a web-based survey (or hard copy if requested). Facilities that served only youth were removed from the survey pool. There were four follow-up attempts to target respondents who had not completed the survey. The data collection period spanned from October – December 2011.

Instrument

Using the survey from 2008, NRI reduced the instrument to 22 items by removing items with little to no variation, and improved the wording of items to clarify intent. The survey items included questions related to demographics, policy, milieu management, education and treatment, and aftercare planning. There was one open-ended question for facilities that allow smoking to assess challenges in restricting smoking. There was also one open-ended question for those facilities that prohibit smoking to determine outcomes attributed to the smoke-free policy.

To provide an opportunity for comparison with earlier NRI survey results, definitions of smoking and facility premises were replicated from earlier surveys. "Smoking" was defined as a legalized

form of tobacco in any form (e.g., cigarette, cigar, chewing, or pipe) regardless of the age of the individuals served. "Facility premises" was defined as building, balconies, patios, courtyards, areas adjacent to exit doors, parking areas, and lawn expenses.

The seven-level policy hierarchy was also utilized from the 2008 survey. A facility was classified as prohibiting smoking if it selected one of two policy levels that totally restrict smoking on facility premises for patients, visitors, and employees. One policy level allows for remote locations outside the smoke-free perimeter of the campus (e.g., parking lots, storage warehouses, etc.) that are not covered by the smoke-free policy. A facility was classified as allowing smoking if it selected any of five policy levels that permit smoking in designated areas ranging from inside buildings to outside areas.

Respondents

There were 165 surveys returned from 44 states, territories and the District of Columbia, representing 80% of state psychiatric facilities in 2011. The majority of respondents were facility directors, though, quality managers tended to be respondents on follow-up requests.

Facility population was classified along two dimensions: age and service level. Respondents selected from a list of 8 different possibilities representing different populations and settings: children, under 12 years of age (acute and/or long-term), youth 12-18 years (acute and/or long-term); adult (acute and/or long-term); geriatric; forensic; and other. For purposes of analysis, children and youth were combined. (No facility served only youth).

- 75% of facilities serve adult, 55% serve forensic, and 24% serve geriatric
- 17% of facilities that serve adults also serve children/youth
- More facilities provide acute care (66%) than long-term care (46%) for adult populations.

Facility size ranged from 16 to 1,527 beds. Forty-three percent (43%) of facilities have less than 150 beds, 36% have 150-299 beds, and 21% have 300 or more beds.

Findings

Utilizing NRI's operational definitions, 79% of the facilities were categorized as prohibiting smoking (n=131), the vast majority of which (95%) are totally smoke-free campuses. For those facilities categorized as allowing smoking (n=34), 3% allow smoking inside the facility in designated smoking areas, 24% allow smoking outdoors, and 74% allow smoking outdoors only in designated areas. Three percent (3%) of the facilities that prohibit smoking and 41% of facilities that allow smoking also allow the use of smokeless tobacco products. None of the facilities that prohibit smoking and 21% of facilities that allow smoking also permits the sale of tobacco products on facility premises.

Among facilities that allow smoking, 50% use escorts to smoking areas (n=17) and 88% of these facilities also have established smoking times, while the remaining facilities rely on patient privileges and designated smoking areas.

Unless otherwise indicated, all figures and charts are based on 131 facilities indicating smoking prohibited and 34 facilities indicating smoking allowed.

Policy

Among facilities that prohibit smoking, 18% indicated that their policy was changed within the last two years. Similarly, 21% of the facilities that allow smoking have made a change in their policy within the last two years. Table 1 below summarizes the changes enacted in the past two years.

Table 1. Summary of changes to written patient policy on smoking among facilities that enacted changes in the past two years

	Prohibit (n=23)	Allow (n=7)
Went smoke-free throughout the entire campus	74%	--
Restricted smoking areas	--	57%
Defined smoking policy infractions and/or consequences	30%	29%
Offered nicotine replacement therapy (NRT) to patients only	17%	43%
Offered NRT to patients and staff	13%	14%

Changes Planned

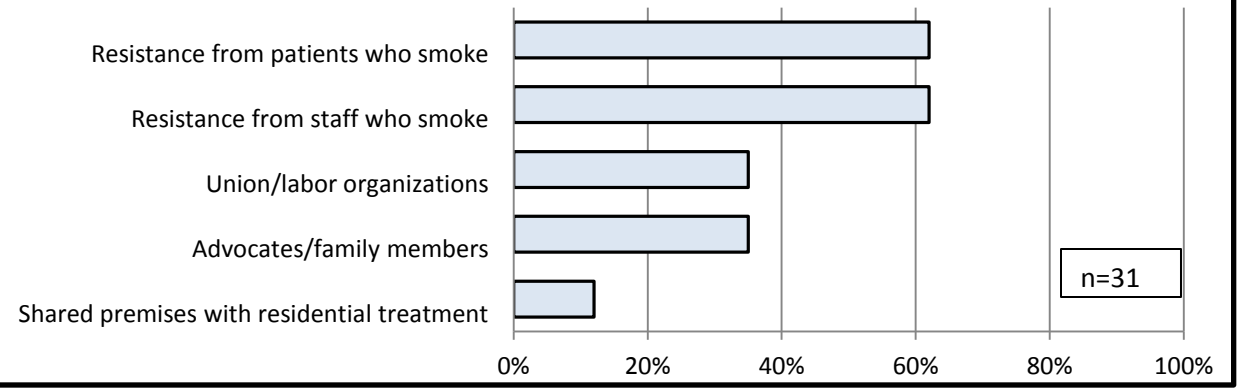
Of the facilities that allow smoking, 35% (n=12) noted they will change their written smoking policy for patients in the future. The most frequently indicated changes to be made are prohibiting smoking altogether and/or establishing smoke-free grounds, and offering voluntary smoking cessation. Thirty-five percent (35%) of the facilities that allow smoking will make changes to their staff smoking policies in the future. Similar to the changes proposed for patients, these facilities will prohibit smoking altogether and establish smoke-free grounds.

Of the facilities that prohibit smoking, none indicated that they will change their written smoking policy for patients and only 2 (1.5%) indicated they will change their written staff policies.

Milieu Concerns

Respondents were asked to identify barriers that may impede their facilities from becoming a smoke-free environment. Among facilities that allow smoking, 91% (n=31) indicated as least one barrier including those displayed in Figure 1.

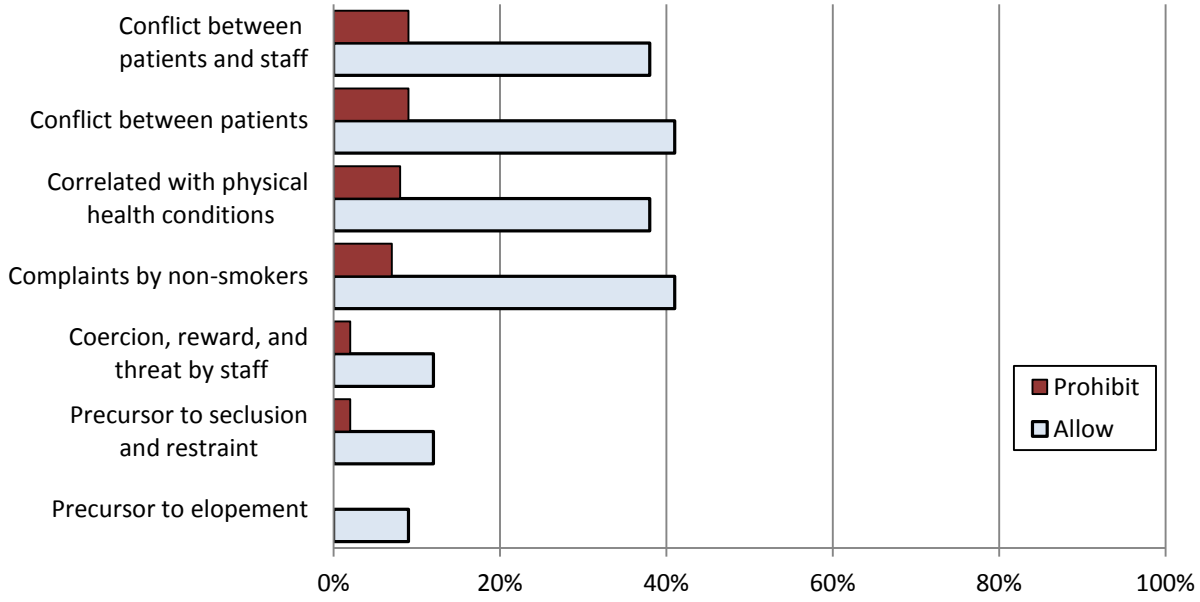
Figure 1. Percent of facilities that allow smoking that identified barriers to change



A few facilities identified barriers related to financing or staff training, representing these issues at less than 10% of the facilities. On average, facilities that allow smoking identified 0 to 9 barriers. In contrast, only 6% of facilities that prohibit smoking identified barriers and tended to indicate the same concerns voiced by facilities that allow smoking.

Respondents were asked to select from seven specific concerns about becoming smoke-free and its adverse effects on milieu and were provided space for indicating "other" concerns. A majority of facilities that prohibit smoking (75%) indicated no concerns while a minority of facilities that allow smoking (29%) indicated no concerns. Figure 2 illustrates the percentages of facilities that chose each of the specific issues from a multiple response list. There were notable differences between facilities that prohibit versus allow smoking as to whether they believed smoking policy impacts the identified areas.

Figure 2. Pecent of facilities that identified potential areas of concern related to smoking policy



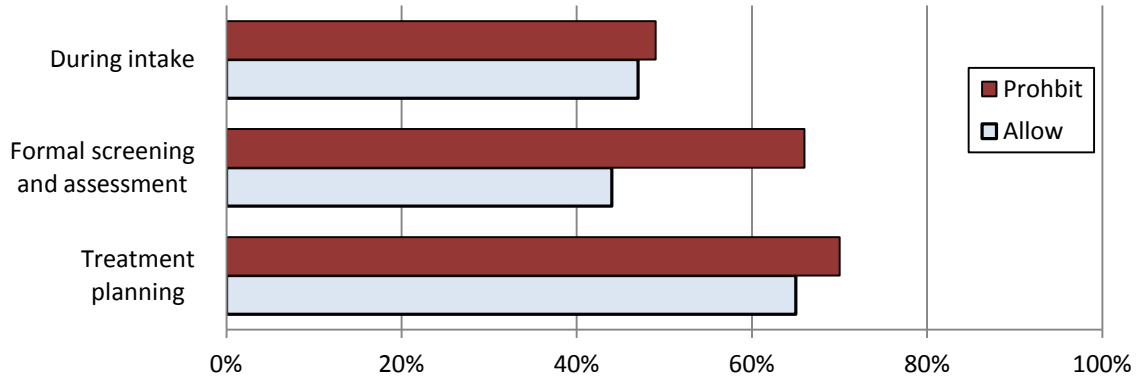
In each case, a much greater proportion of facilities that allow smoking identified the issue as a concern. Among facilities that allow smoking, 44% identified between 1-3 issues and 24% identified 4 or more issues.

Intake, Education, and Treatment Planning

A majority of facilities that prohibit smoking indicated that less than 60% of their population use tobacco on a daily basis at the time of admission; however, 17% of facilities indicated that this figure was unknown. A majority of facilities that allow smoking indicated that less than 60% of their population use tobacco on a daily basis at the time of admission, and 6% of facilities were not able provide a response.

At intake, 97% of facilities that prohibit smoking and 100% of facilities that allow smoking assess the patient's smoking status. Figure 3 highlights the percentage of facilities that actively promote and educate patients about the risks of smoking during specific intake and treatment activities.

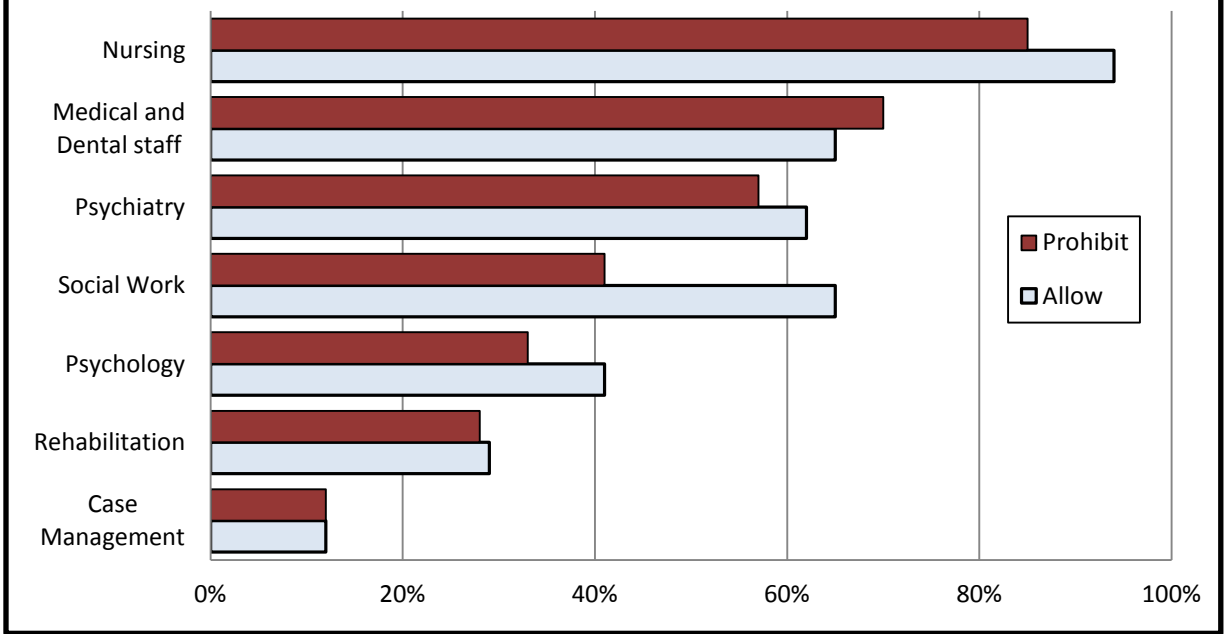
Figure 3. Percent of facilities indicating when clinical staffs actively promote and educate patients about the risks of smoking



Staff Responsible for Smoking Treatment

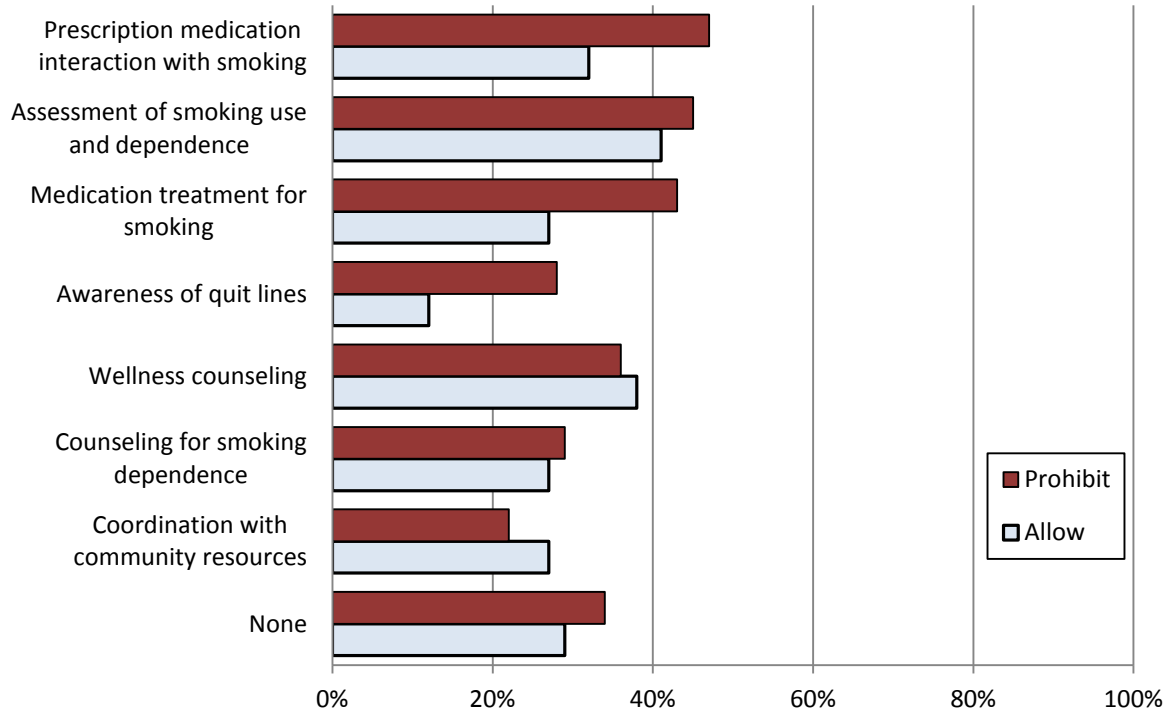
Most facilities reported that staff from various disciplines provide patients with education and services related to smoking. Nursing was the most common discipline to provide these services, followed by medical and dental staff. Figure 4 displays the percent of facilities that use identified clinical specialties.

Figure 4. Percent of facilities that use identified clinical specialties to provide education and services related to smoking



While multiple disciplines provide services, trainings to staffs specifically targeted toward smoking were reported in 62% the facilities, regardless of smoking policy. The different areas for training are provided in Figure 5.

Figure 5. Percent of facilities providing training to clinical staff

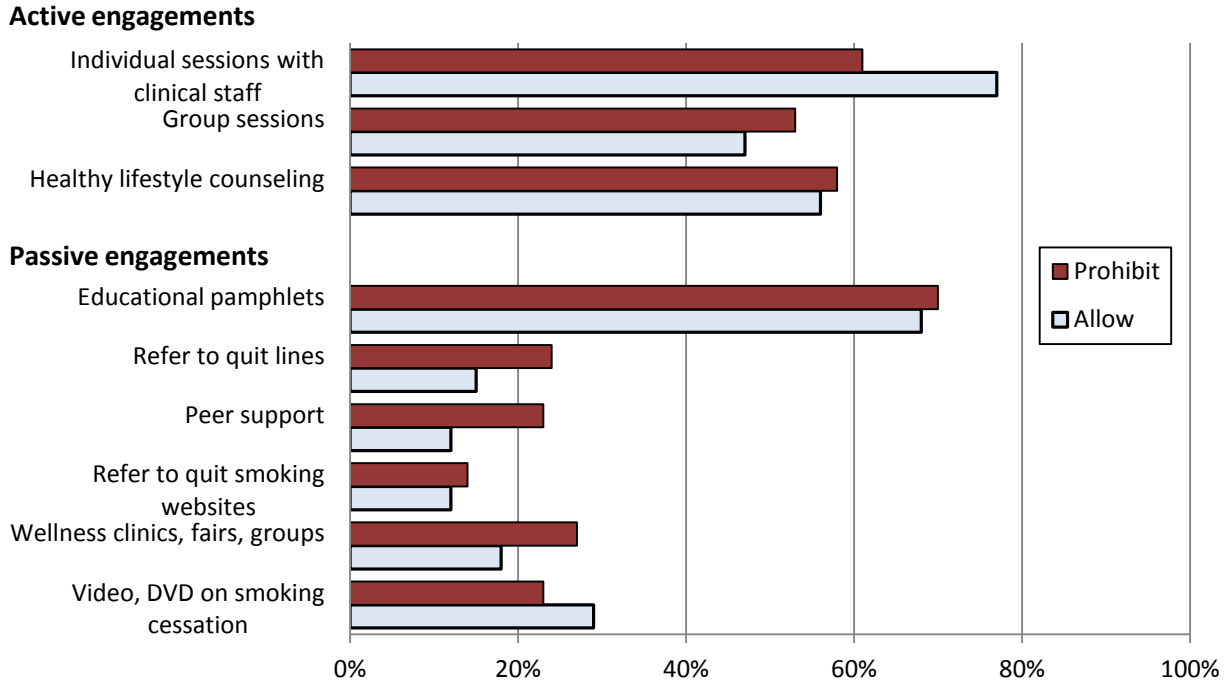


Another resource available to staff are smoking cessation toolkits that contain practical information and research to assist a variety of stakeholder groups in learning and implementing smoke-free policies and practices. Only 14% of facilities that prohibit and 9% of facilities that allow smoking reported using a Toolkit, while 22 % and 18% respectively do not know if the facility is using a toolkit.

Treatments Offered

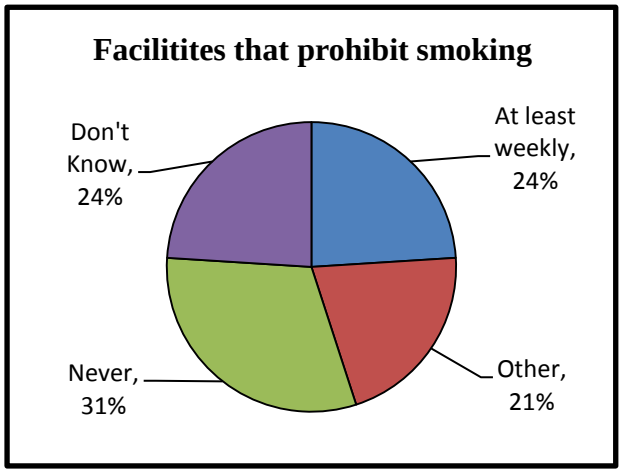
Educational resources that describe the risks of smoking are available in a variety of formats and distributed in both passive and active engagements with patients. Four percent of facilities that prohibit smoking and 3% of facilities that allow smoking offered no educational resources. In order to determine the diffusion of educational materials regarding the risks of smoking, facilities were classified based on the number of venues used to provide these materials. A minimum combination of at least 2 active and 2 passive engagements was used to identify breadth of diffusion. A similar level of breadth was found for facilities that prohibit smoking (36%) and facilities that allow smoking (35%). Figure 6 below identifies the specific types of engagements when educational resources are shared with patients.

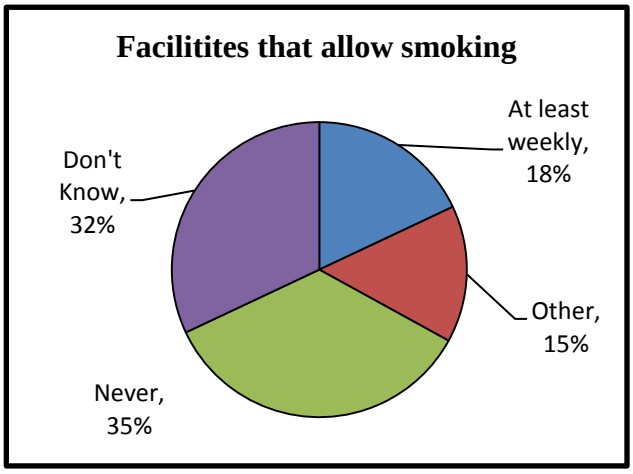
Figure 6. Percent of facilities that utilize specific venues for sharing educational resources



Smoking cessation group sessions are offered on a regularly scheduled weekly basis at less than one-quarter of the facilities. As depicted in Figure 7, more facilities indicated that sessions were never offered or that it was unknown whether session are offered.

Figure 7. Percent of facilities offering regularly scheduled smoking cessation sessions

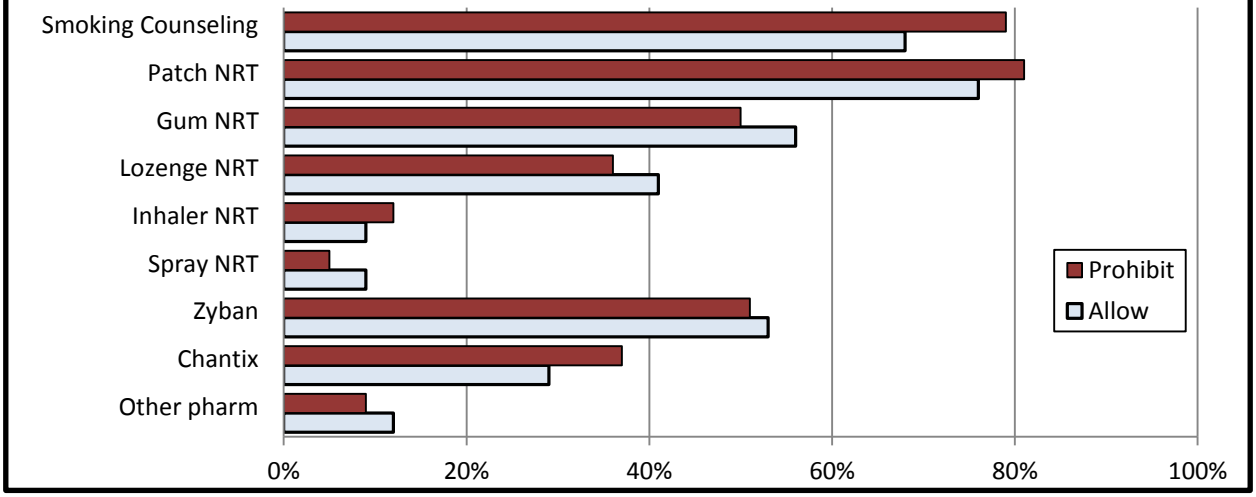




Smoking cessation treatment options may include smoking counseling, nicotine replacement therapy, and pharmacotherapy as these have been identified as best practices. Facilities were also

asked to identify whether hypnosis was offered: only one facility provided such service. Facilities were asked to identify the specific forms of NRT and pharmacotherapy. Overall, 48% of facilities offered all three treatment models while only 3% of facilities offered only NRTs. Figure 8 presents the percentage of facilities offering specific treatment options.

Figure 8. Percent of facilities that utilize specific treatment options

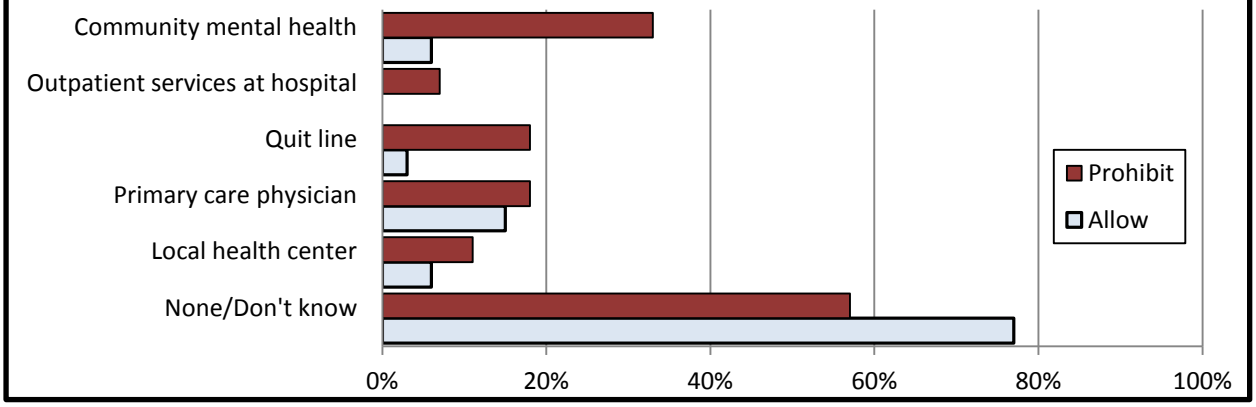


Aftercare Planning

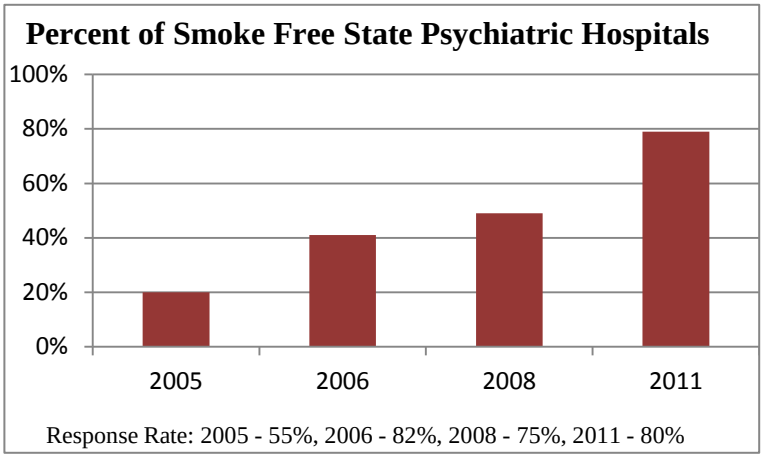
Aftercare planning includes providing the patient with a plan, providing the next care provider with a plan, and providing specific referrals for follow-up relating to smoking cessation. It was assumed that the aftercare plan for the patient and the aftercare plan for the next provider are considered distinct. However, survey results indicate that facilities responded identically to these two questions. Forty percent (40%) of facilities that prohibit smoking and 32% of facilities that allow smoking include patient's smoking status in both aftercare plans.

As indicated in Figure 9, referrals can be made to a number of difference service providers. Eighteen percent (18%) of facilities indicated only one referral destination for smoking cessation treatment. More than half of the facilities indicated no referrals specifically targeting smoking behaviors. Few facilities used health care providers such as primary care physicians and local health centers.

Figure 9. Percent of facilities providing referrals to specific providers



Summary of Key Findings



Between 2008 and 2011, the proportion of state psychiatric facilities that prohibit smoking rose from 49% to 79%. Facilities that continue to allow smoking cite common barriers, most notably, resistance from patients and staff that smoke, unions and advocates. In addition, half of the facilities utilize staff time to escort patients to areas designated for smoking.

Various clinical specialties are used to provide educational and treatment services related to smoking, from nursing to social work. Overall, 62% the facilities provide some training to clinical staff in regards to treatment for smoking dependence, with a greater emphasis on assessment and medications.

Nearly all facilities assess smoking status of patients on admission. While there are active and passive engagements with patients to provide educational materials that address risks of smoking, only 35% of facilities offer a breadth of options. Among treatment options, smoking cessation group sessions are either not offered at all or not offered on a consistent basis to provide true benefit. Almost half of the facilities offer a compliment of evidence based treatments (smoking counseling, NRT, and pharmacotherapy), indicating the more than half of the facilities are not equipped with resources to treat smoking dependence.

At the time of discharge, less than half of the facilities indicate the patient's smoking status in both the aftercare plan given to the patient and the plan given to the next care provider. Eighteen percent of facilities indicated only one referral destination for smoking cessation treatment and more than half the facilities indicate no referrals are specifically made to address smoking behavior.

While policy implementation has occurred at a number of facilities over the past several years, staff training, active treatments, and continuity of care are not widespread. Regardless of smoking policy, facilities would benefit from resources to build staff competencies, to augment staff with specialists, and to promote patients continuation of smoking cessation treatments after discharge.

Acknowledgement
The 2011 project has been supported by the University of San Francisco's Smoking Cessation Leadership Center.

Suggested Citation for this report:
Schacht, L., Ortiz, G, and Lane, Jr., G.M. (2012, April). Smoking policies and practices in state psychiatric facilities: Survey results from 2011. Falls Church, VA: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI).