



Smoking Policies and Practices: Survey Results

Prepared for
NASMHPD Commissioner Meeting
July 2006

National Prevalence-23%

- 2002-number ex-smokers exceeded number of current smokers
- 2005-total cigarette sales decline
- 2005-total cancer deaths decline

For Persons with Mental Illness

- Prevalence=75%
- Consume 44% of all cigarettes nationally
- Smoke heavier
- Smoke more efficiently

SMHA Hospital Smoking Survey

- Survey conducted March-April 2006
- 222 Hospitals Surveyed
- 181 Responded (82%)

Overall

- 41% - no-smoking on premises
- Over 90% have a written policy
- Over 50% have a committee
- Less than 30% offer cessation sessions at least weekly
- 70% incorporate addressing smoking issues in staff training

Smoking and Risks

| Environmental Issues | Not Permitted | Smoking |
|--|----------------------------|---------|
| Seclusion/Restraint related to smoking | 6% | 30% |
| Coercion/threats related to smoking | 18% | 49% |
| Health concerns related to smoking | 23% | 68% |
| Elopement related to smoking | Not a question on the tool | 29% |
| Fires related to smoking | | 30% |

*Percent of facilities reporting these issues.

Facilities that Permit Smoking

How access is controlled:

- 95% allow no indoor smoking
- 75% escort patients to smoke
- 70% have established smoke times
- 63% have designated areas
- Most allow 4-6 smoke breaks/day

Facilities that permit smoking

- 56% sell tobacco
- 42% vary policy by unit
- 34% moderate smoking permissions based on privilege status

Movement toward No-smoking

| | Percent of Facilities |
|-----------------------------|-----------------------|
| Overall | 55% |
| When is change anticipated: | |
| Within 6 months | 30% |
| Within the year | 41% |
| More than a year | 29% |

Note: 2% of facilities that currently do not allow smoking on premises also anticipate changes.

Aspects of No-Smoking Policy

55% plan to change their smoking policy, which would incorporate the following:

- 34% plan to go no-smoking
- 29% plan to go to smoke-free facility grounds
- 14% plan to reduce areas available to smoking
- 10% plan to change location of smoking sites
- 8% plan to reduce breaks

Note: 10% are changing more than one aspect of the policy

Smoking not permitted

- 83% of no-smoking facilities converted from smoking establishments since 2000
- On average for past 4 years one facility converts to no smoking every month
- 84% of no-smoking facilities transition to smoke-free in a year or less

Smoking Not Permitted

Most cited motivators while changing to no-smoking facility:

- Promoting a healthier environment
- Promoting healthier lifestyles
- More time for active treatment and improved group attendance
- Less incidents and fire dangers
- State requirements

Smoking Not Permitted

Most cited advantages to becoming no-smoking facility:

- Health of patients have improved
- Grounds/environment are cleaner
- Decrease in behavioral problems related to smoking habits
- More time for treatments
- Increase in staff satisfaction
- Less violence

Smoking Not Permitted

Disadvantages to becoming no-smoking facility:

- Increase of contraband/creating a black market
- Some staff and patients are still resistant
- New admission nicotine withdrawal
- More “police work” for staff regarding searches

Smoking Permitted

Most cited motivators to continue to allow smoking:

- Patient rights
- Decrease agitation in patients
- Used in de-escalation of some situations
- Smoking is used as reward or incentive to comply with staff

Smoking Permitted

Most cited obstacles to change:

- Staff fear patients reaction
- Patient advocacy groups and patient rights
- Fear of change
- Staff resistance
- Opposition from staff who smoke

Smoking Permitted

Most cited issues smoking facilities would like information on:

- Facilities who have made successful transitions
- Smoking elimination techniques
- A model of a nonsmoking facility in a tobacco state

Conclusion

- Going no smoking reduces violence and coercion
- Change is possible and in fact planned by more than half of the facilities
- Trend suggests that within the next few years, more than 70% of state psychiatric hospitals will be no-smoking

Contact Information

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THE IMPACT OF SMOKING

Morbidity and Mortality In Persons with Severe Mental Illness

- Harder to quit
- Higher rates of disease and premature death and reduced quality of life
- People with schizophrenia have 20% shorter life spans
- People who smoke with substance use disorders have death rates 4X those who do not

Environmental Tobacco Smoke and Non-smokers

- Increased risk with higher dose exposure
- Equal to EPA Group A carcinogen
- Multiple health effects including asthma, CAD and cancers of the lung
- Restricting smoking in the workplace

Treatment and the Therapeutic Milieu

- Medication blood levels
- Nicotine may modulate cognition, psychiatric symptoms and medication side effects
- Precursor to S&R
- Precursor to threats and coercion between patients
- Environmental health problems

Consumer Autonomy: Choice and Recovery

- Right to “smoke” and autonomy
- Smoke breaks are a time to relate
- Consumers want to quit
- Long-term facilities as “home”
- Right to safe, healthy and effective treatment environment

Smoking and Recovery

- Wellness is a basic and central aspect of achieving recovery
- Life style change toward wellness
- Individualized treatment and support to choose wellness
- Socialization and recreational activities
- All persons approach

Highlighted Facility Experiences

Decreased Violence

- Review of findings from 26 international studies reporting effectiveness of smoking bans in inpatient psychiatric settings
 - More problems anticipated than occurred
 - No increase in aggression
 - No increase in use of seclusion
 - No increase in discharges AMA
 - No increase in use of as-needed medication

Decreased Violence

- Texas Experience
 - Vernon State Hospital
 - Significant decline in number of sick call, disruptive behaviors and verbal aggression
 - Wichita Falls State Hospital
 - Decreased episodes of physical and verbal aggression
 - Decrease in injuries to patients and staff
- North Coast Behavioral Healthcare Facilities in Ohio
 - Decreased violence

Staff Issues

- Literature and meeting participants
 - considerable preparatory work with staff necessary to ensure full compliance

Staff Issues

- Opposition at Wichita Falls State Hospital
 - Employees went directly to the media with complaints
 - Media had already been informed by administration
 - Patients' rights organizations found legislators sympathetic to 'right to smoke' issue

Staff Issues

- Oklahoma Department of Mental Health and Substance Abuse Services
 - No changes in staff recruitment or retention were observed
- Pennsylvania
 - Labor unions credited with stopping implementation
 - ‘Right to smoke’ issue

Staff Issues

- Minnesota and California
 - Lack of consensus at various leadership levels led to difficulties
 - In California labor unions negotiated ‘overtime pay’ due to additional time necessary to smoke away from the facility

Costs and Benefits

- Oklahoma Department of Mental Health and Substance Abuse Services (seven mental health and four residential substance abuse facilities)
 - Employees
 - \$25,000 for nicotine replacement products for 375 employees (one-time expense)
 - Consumers
 - \$100,000 annual, ongoing expenditure (8,864 consumers) for nicotine replacement products
 - \$2500 for signs and posters (one-time expense)
 - Maintenance work

Costs and Benefits

- Ohio- three of nine state facilities went smoke free in 2003
 - \$14,000 to \$20,000 lost annually from cigarette sales at AVI at Northfield (supported patient entertainment fund)
 - Wellness Coordinator hired for each facility
 - Smoke detectors purchased with voice reminder system

Different Treatment Settings and Populations

Represented at the technical report meeting

- Civil psychiatric facilities
- Acute care facilities
- Long term facilities
- Maximum security forensic facilities
- Residential drug and alcohol facilities

Lessons Learned

- Make tobacco cessation a critical objective in achieving goal of improving overall health, wellness and recovery.
- Provide leadership with consistent talking points
- Ensure broad participation in planning and implementation

Lessons Learned

- Ensure adequate time to plan and implement new policies
 - States surveyed averaged 9 months
 - A year and a half is recommended
- Improve treatment and the milieu to support the goal of health, wellness and recovery

Best Practices in Smoking Cessation

No Smoking Policies

- State law, employee feelings, labor union positions need to be taken into account
- Should be implemented across the board
- Consumer violation should be treated as a treatment issue
- Staff violation should be treated as a personnel issue

Implementing Organizational Change

- Many resources available
 - New Jersey Tobacco Dependence Program
 - Consultation, program and policy development, training, program and clinical support
 - “12 Steps for Change” model

Prevention

- All non-smoking and former smoking consumers should be offered primary and relapse prevention programming.

Cessation Treatment

- Available strategies include
 - FDA approved medications
 - Nicotine anonymous
 - Quit lines
 - Various forms of psychosocial treatment
 - Behavioral therapies
 - Motivational enhancement approaches
 - Social and peer support

Cessation Treatment

- Ancillary interventions
 - Education to address medical co-morbidities
 - Share rapid benefits of quitting
 - Discuss cost of cigarettes
 - Program enrichment options to replace smoke breaks

BALANCING VALUES

Individual Rights and Public Health

- Limitation of 'absolute' freedom
- Spending taxpayer's dollars wisely
- Protecting from second hand smoke
- Supporting health, wellness and recovery

State Operated Services Role

- Individualized treatment
- Supportive environment with the same standards and expectations
- Understanding of rights
- Life style change
- Smoking prevention and cessation services

Final Point

- Addiction is not a real 'choice'.
Quitting smoking is.

RECOMMENDATIONS

Recommendations for Facilities

- Smoking cessation and prevention and be smoke-free
- Implement no smoking policy over time
- Increase awareness of NRT options
- Offer 'optimized' tobacco cessation treatment
- Encourage smoke free homes
- Support self-help

Recommendations for Community Service Systems

- Smokers Anonymous
- Quit Line
- Address community-based smoking cessation programs and services understanding of mental illness
- Address community-based mental health programs and services understanding of smoking cessation

Recommendations for Key Stakeholders

National Decision Makers

- Support of State Mental Health Authorities' inpatient facilities should be encouraged.
- Toolkits should be developed for best practices and technical assistance to SMHAs wanting to go tobacco free.

National Decision Makers

- Medicare Part D plans should cover NRT
- State Medicaid should cover smoking cessation and prevention including NRT.
- Studies should be done to look at long- term benefits of facilities going smoke free

State Mental Health Commissioners

- SMHA inpatient facilities should be encouraged and supported in their efforts to provide smoking cessation and prevention and in going smoke free with *focus on wellness*.
- Offer cessation support including NRT for staff as well as consumers

State Mental Health Commissioners

- Work with the community to ensure tobacco cessation help is available for discharged patients.
- SMHA facilities should not sell tobacco products.

Position Statement

- As physicians, we commit to educating individuals about the effects of tobacco and facilitating and supporting their ability to manage their own physical wellness.
- As administrators, we will commit the leadership and resources necessary to create smoke free systems of care.

Position Statement

- NASMHPD is committed to doing their part to assist individuals in going smoke free and will continue to advocate for those with mental illness in their right and hope to be well in recovery.