
SMOKING POLICIES AND PRACTICES IN STATE PSYCHIATRIC FACILITIES

In Spring 2008, the National Association of Mental Health Program Directors (NAMHPD) conducted a survey of Department of Mental Health facilities across the state of Missouri. All eleven facilities were represented in the sample. Two of the eleven are children's facilities.

Summary of Findings

- All facilities have a no-smoking policy for all clients, employees, and visitors. This policy was instituted by the director of the Comprehensive Psychiatric Services division within the Department of Mental Health in January 2008.
- For the most part, the effects of the no-tobacco use policy have been positive. Fewer interruptions and arguments, cleaner air, less administrative time spent on cigarette related issues, and less trading for cigarettes have emerged following the policy enforcement. Only a couple of negative effects have developed, including increased "sneaking" of cigarettes and selling of cigarettes at exorbitant rates. According to one respondent, "patients have responded very well to a smoke-free environment."
- Most respondents felt that the new smoking policy improved facility climate. Some of the more significant issues related to smoking had included fires, conflict, and tobacco used as coercion.
- All but one adult facility have some form of smoking cessation treatment for clients. The Patch, gum and Chantix (varenciline) are most frequently offered, followed by individual counseling and Zyban (bupropion). One facility also offers NRT therapy for staff.
- Many respondents expressed an interest in technical assistance to help staff and clients adjust to a smoke-free facility. The greatest interest was in training for clinicians in supporting a smoke-free lifestyle, assistance dealing with smoking contraband, and tobacco cessation assistance for staff members.

Detailed Findings

Tobacco Use Policy

- In the eleven facilities surveyed, all have a current smoking policy that prohibits smoking on all facility premises (indoors and outdoors). This policy was instituted by the director of the Comprehensive Psychiatric Services division within the Department of Mental Health in January 2008. The no-smoking policy applies to all clients, employees, and visitors.
- No tobacco products are available to buy legally on any of the campuses.
- The policy applies to all tobacco products including smokeless tobacco, such as chew or snuff.
- Five facilities converted previously designed smoking areas and put them to other uses.

Effects of Smoke-free Policy

For the most part, the effects of the no-tobacco use policies have been positive. Sites reported (1) entry into tobacco cessation programs by staff; (2) fewer arguments among clients about smoking times and “fresh air opportunities”, (3) less interrupted treatment time; (4) far less contraband and trading for cigarettes, (5) less administrative time spent investigating missing cigarettes, and (6) better use of staff time. Two sites reported some negative effect of policy, included sneaking cigarettes causing fire hazards, and selling of cigarettes at exorbitant rates. All in all, however, there were many more positive effects mentioned than negative. According to one respondent, “patients have responded very well to a smoke-free environment.”

Current Treatment Options

All but one adult facility has some form of smoking cessation treatment for clients. Seven facilities offer the Patch, gum and Chantix (varenciline), six have individual counseling available, and five use Zyban (bupropion). Some facilities also offer lozenges and inhalers. One facility also offers NRT therapy for staff. Five of nine facilities began offering these treatments in the past two years.

Negative Effects of Smoking in Mental Health Facilities

Smoking practices have affected how business is run in the facilities. One hospital saw smoking or tobacco use correlated with other physical health conditions. Another saw smoking used by staff to coerce, reward, or threat. Another still saw an increase in conflict between patients regarding smoking practices. One experienced that the staff members were not working. Three facilities reported having a client elope, leave the area defined by their privilege status, while they were on a smoke break. Two of the facilities expressed concern about fire safety and three of the eleven had reported having had fires in the facility caused by smoking with one of those fires having been in the past year. Five of the facilities had no concerns of this nature concerning smoking practices.

Tobacco Use

All but one adult facility and both children's facilities assess client smoking status when clients enter the facility. Two adult facilities reported rates between 21%-40%, three reported 41%-60%, two reported 61%-80%, and two reported rates of 81% to 100%. The two children's facilities report little to no smoking.

Assessment and Education

Education of smokers of the risks of their smoking can happen at any point in the stay. Eight of the nine adult facilities, and one of the two children's facilities, provide education on smoking risks. Most commonly, this occurs during the treatment planning process, intake or formal screening. One facility provides education through healthy living education, one as part of substance use groups, and one as part of after care plans.

To implement smoking cessation programs, the facilities chose the educational resources that they thought would best suit their needs. Educational pamphlets and group sessions are offered at most facilities (nine). Eight facilities offer healthy lifestyle counseling or a wellness group, and seven offer individual counseling for clients. Six refer their clients to quit lines, four have access to quit smoking websites, and two have peer support available.

Facilities have a range of professionals who address client smoking. Most have nurses (nine facilities) and psychiatrists (eight facilities); six have social workers, four have psychologists, three have rehabilitation counselors and two have case managers. One facility uses a health educator, and another uses a substance abuse counselor.

Smoking Cessation Sessions

Six of nine facilities hold smoking cessation sessions. Five hold them weekly, and one holds them daily. Three facilities have average attendance at their sessions, while the others have poor attendance. Motivation is used to try to increase client attendance.

Specialty Training

Specialty training for staff on tobacco cessation treatment is offered at some but not all facilities. Most common was training regarding interactions with prescription medication, followed by training in the assessment of smoking use and dependence and training for medication treatments of smoking. Counseling for smoking dependence, training on awareness of quitlines and referral sources, and training for Wellness Counseling were also mentioned.

Resources

Six of the facilities are using the recently produced NASMHPD Toolkit on “Tobacco-Free Living in Psychiatric Settings: A Best Practices Toolkit Promoting Wellness and Recovery.” Three facilities use the Colorado’s Toolkit for Mental Health Providers. One uses the ALA Freedom from Smoking Training.

Aftercare

Only one facility specified the client’s smoking status in aftercare plans. In six of the eleven, staff check for no-smoking policies in housing considered as part of the aftercare plan. Two facilities recommend their clients to quit lines after discharge to keep up with smoking cessation practices.

Technical Assistance

When asked about interest in technical assistance involving smoking policies, the greatest interest was in training for clinicians in supporting a smoke-free lifestyle, assistance dealing with smoking contraband, and tobacco cessation assistance for staff members.

Summary of Findings

Tobacco Use Among Missouri Consumers of Comprehensive Psychiatric and Substance Abuse Services

The Missouri Department of Mental Health (MDMH) received a grant from the Missouri Foundation for Health to determine the prevalence of tobacco use among consumers of mental health services. MDMH contracted with the Missouri Institute of Mental Health (MIMH) to conduct the surveys and questionnaires necessary to gauge usage. During the summer of 2008, MIMH assessed the prevalence of tobacco use among Missouri psychiatric and substance abuse consumers. Consumers included in the study received services from the Division of Comprehensive Psychiatric Services (CPS) and/or the Division of Alcohol and Drug Abuse (ADA) within Missouri's Department of Mental Health. A total of 586 persons receiving services from five Community Mental Health Centers (CMHCs) completed an anonymous one-page questionnaire about their tobacco use. In addition, 68 mental health and substance abuse agencies funded by MDMH completed an on-line survey regarding their smoking policies and practices. This summary highlights the major findings from these two assessments.

What is the Prevalence of Tobacco Use by Missouri CPS/ADA Consumers?

- Tobacco use among Missouri consumers of comprehensive psychiatric and substance abuse services ("consumers") is considerably higher than that of the general population in Missouri and the nation as a whole. **Twice** as many Missouri consumers use tobacco than Missourians generally, with around 64% of consumers reporting regular use compared to 24.5% of adult Missourians. Tobacco use among these Missouri consumers is more than **three** times the tobacco use rate in the general population nationally (19.8%) (Behavioral Risk Factor and Surveillance Survey (BRFSS), 2007).
- Tobacco use among Missouri consumers is also higher than comparable consumer use rates nationally. While 64% of Missouri CPS/ADA consumers use tobacco, approximately 44% of adults with serious psychological distress (SPD) nationally smoke cigarettes (National Survey on Drug Use and Health (NSDUH), 2006). Regular tobacco use among persons with drug and alcohol problems nationally is estimated to be approximately 50% (Lasser et al, 2000).
- Most Missouri CPS/ADA consumers (87%) surveyed who use tobacco products regularly use them every day. Almost all (97%) of regular users smoke cigarettes. Around 18% also smoke cigars, and around 9% also chew tobacco.
- Reported reasons for CPS/ADA consumer tobacco use include to relieve stress and relax (67%), because they are addicted (51%), for enjoyment (36%), to relieve boredom (30%), and to feel comfortable in social settings (22%).

Barriers to Tobacco Cessation

General population

Higher use rates among Missourians may be due to several factors, including weaker smoking ordinances, a lesser amount of funding for tobacco prevention, and lower excise taxes. For individuals experiencing mental illness, higher rates may also be attributable to a culture among those with mental health disorders that supports tobacco use, lenient tobacco use policies in provider agencies, a lack of tobacco cessation programs at many mental health and substance abuse provider agencies, and a lack of pressure from primary care physicians to quit smoking.

- *Weaker smoking ordinances.* Research indicates that enforcing smoke-free ordinances reduces smoking consumption and increases smoking cessation (Moskowitz, et al., 2000). Missourians are permitted to smoke in more public places than the majority of states in the nation. Twenty-four states currently have comprehensive smoke-free policies prohibiting smoking in almost all public places, as well as in restaurants and bars. Missouri does not exclude smoking in bars or restaurants. Furthermore, fewer Missourians are protected by smoke-free policies at government and private workplaces, retail stores, and recreation/cultural facilities. According to Missouri State Statute, bars and restaurants that seat less than 50 people, bowling alleys, billiard parlors, retail tobacco shops, rooms and halls used for private social functions, limousines and taxicabs where the driver and all passengers agree to smoking, stage performances including smoking, indoor sports stadiums seating more than 15,000 people, and private residences are not considered public places for the purposes of indoor smoking regulation (Revised Statutes of Missouri, Sect. 191.769, 2008). At the state level, only one smoking ban proposal has been submitted to the Missouri General Assembly; this failed before reaching a hearing. As of August 2008, only nine cities, including Kansas City, had enacted bans on smoking within all bars, restaurants, and similar places. Proposals to restrict smoking in public places have been rejected in six locations, including St. Louis County and Jefferson City. Most Missourians (80%) do not support smoking bans. In 2007, Forbes Magazine rated St. Louis as the “best city for smokers” in the United States.
- *Insufficient funding for tobacco prevention.* The Centers for Disease Control (CDC) has recommended that Missouri spend approximately \$73 million annually for tobacco control. Recent data show that in 2008, Missouri spent 3.7 % of the recommended amount on tobacco prevention programs. Only one state in the nation spends less on tobacco prevention than Missouri (Robert Wood Johnson Foundation, 2008).
- *Lower excise taxes.* The excise tax rate for cigarettes in 2008 for Missouri was \$.17 per pack compared to the national median of \$1.00. Again, this tax rate is second lowest in the nation. (Federation of Tax Administration, 2008). Excise taxes have been used for community, media, and school prevention programs. Research has shown that increasing the excise tax rate on cigarettes is one of the most effective strategies in decreasing tobacco consumption. (CTFK, 2008).

Consumers

In addition to the barriers to quitting noted above for all Missourians, persons with mental illness and substance abuse have additional factors that may explain their higher use rates.

- ***Lenient Tobacco Use Policies in Provider Agencies.*** According to our survey of Missouri mental health and substance abuse provider agencies, only 22% are smoke free. 37% allow smoking in outdoor designated areas, and 28% allow smoking anywhere outside on provider property.
- ***Lack of Tobacco Cessation Programs in Provider Agencies.*** Most Missouri provider agencies do not offer in-house tobacco cessation programs, but rather refer consumers to external tobacco cessation programs or quitlines. Around 1/3 offer individual counseling on tobacco cessation, and approximately 25% offer nicotine replacement patches. Almost 70% of agencies would be interested in some kind of technical assistance on tobacco cessation. Training clinicians in supporting a smoke free lifestyle and training on tobacco cessation programs, followed by addressing staff tobacco use were the most common requests for assistance.
- ***Lack of Pressure from Primary Care Physicians.*** According to this 2008 consumer survey, the vast majority of consumers (72.3%) who see a primary care physician regularly report that their doctor asks about their tobacco use habits. However, less than half of doctors (42%) follow up by asking the patient if s/he wants to try to quit. The U.S. Public Health Service has established guidelines for physicians that urge them to ask all patients about use patterns and to encourage quitting; compliance rates in the general population of physicians are approximately 86%. These data suggest that primary care physicians in Missouri serving persons with mental illness or substance abuse issues are less likely to ask about tobacco use or to encourage quitting.¹ Furthermore, studies indicate that many clinicians who provide services to persons with mental illness believe that it is more difficult for persons with mental illness and substance abuse issues to quit than adults in the general population.
- ***Culture of Tobacco Use.*** With tobacco use prevalence rates higher in Missouri than nationally among the general population, it is hardly surprising that Missouri CPS/ADA consumers use more than their counterparts nationally. According to El-Guebaly, et al. (2002) “smoking is a major part of their daily routine and constitutes an activity that provides some structure to a day with few activities.” Furthermore, studies of the general population have found that being in daily contact with other smokers may reduce successful quitting (Richmond et. al., 1993); this would undoubtedly also be the case for persons with mental illness and substance use and may partially explain their higher use rates. 22% of consumers surveyed reported that they smoked to feel more comfortable in social settings.
- ***Tobacco Industry Targeting.*** It is estimated that persons with mental illness consume around 50% of all tobacco products in the nation (Lasser et al., 2000). With decreased smoking rates in the general population and high use rates among persons with mental illness, market strategies utilized by some tobacco companies have specifically targeted those with mental health disorders. Strategies employed included distribution of free cigarettes in mental health facilities (Morris et al., 2003).

¹ In 1999, guidelines were established by the U.S. Public Health Service recommending that physical health care providers ask their clients about their smoking habits. In 2000, guidelines were updated to: (1) ask every patient about tobacco use, (2) advise smokers to quit, (3) assess their willingness to quit, (4) assist with treatment and referrals, and (5) create follow-up contracts. (Fiore, 2000). In 2007, the Association of American Medical Colleges reported that 86% of physicians ask patients about their smoking status and advise clients to quit but only 13% refer smokers to treatment and only 17% arrange follow-up. (AAMC, 2007).

- **Fewer internal resources.** The National Institute of Cancer and other researchers have recently introduced the concept of “hardening” wherein certain sub-populations, like consumers, may have a harder time quitting smoking because of fewer resources on a personal level to overcome addiction which thus present greater barriers to behavioral change (NIC, 2000).

An Additional Barrier: The Benefits of Smoking

- Among psychiatric/substance abuse consumers who smoke in Missouri, 67% report that they smoke to relieve stress and relax, 51% use tobacco because they are addicted, 36% smoke for enjoyment and 30% smoke out of boredom.
- While the harmful effects of smoking have been well documented, there is some evidence that smoking may provide limited benefits to some persons with mental illness. Persons with schizophrenia who smoke may experience increases in energy and motivation as a result of smoking. Some consumers have reported that smoking can improve concentration and cognitive functioning, particularly among persons with psychotic illnesses. Smoking has also been shown to improve mood and enhance enjoyment (Morris et al., 2007).

Why Quit?

- Despite the benefits of smoking, cessation for persons with mental illness can improve the physical health consequences of tobacco use, reduce the financial burden incurred by the purchase of tobacco, increase self-esteem, and reduce consumers’ feelings of stigma (Johnson, 2006). The life span of persons with mental illness has been estimated to be 25 years shorter than those without mental illness (National Comorbidity Survey- Replication, 2005). A large portion of those who die early die from smoking-related illnesses.
- According to our survey, 56% of Missouri consumers who regularly use tobacco would like to quit. This compares to 74% of adults nationally (Gallup Poll, July 14, 2008). Among Missouri consumers, health and cost were the leading reasons given for wanting to quit.
- 66% of current tobacco users indicated that they tried to quit in the past but were unsuccessful. 74% of current users tried to quit on their own, with nicotine replacement therapy used far less often than within the general population and other methods even less frequently. Prior studies have shown that persons with mental illness find it more difficult to quit than the general population (Dani & Harris 2005).

Effective Approaches to Eliminating Tobacco Use

Significant research has been conducted on successful methods to quit using tobacco products among the general population. Hopkins et al., 2001, found the following methods to be successful: (1) increasing the price of tobacco products; (2) mass media campaigns; (3) increased excise taxes; (4) tobacco prevention programs; (5) combined quitline/education/therapy interventions; (5) health care provider assessment of tobacco use and counseling; (5) provider counseling to patients, including brief advice; and (6) pharmacologic treatment of nicotine addiction (including use of nicotine patch and gum, and bupropion)” (Hopkins et al., 2001).

Effective methods for quitting tobacco use for persons with mental illness have also been established. Johnson et al. , 2006, found the following approaches to be effective: (1) integrating tobacco treatment for persons with mental illness or addictions into existing mental health and addiction services; (2) counselor and health care provider support and training to incorporate brief interventions into their practices; (3) nicotine replacement therapy for all individuals with mental illness or addictions who are willing to quit or reduce their smoking; (4) medication monitoring in first few months for individuals who are taking anti-psychotic medications and are trying to quit smoking; and (5) smoke free spaces for consumers (Johnson et al., 2006). Other research has found that nicotine replacement therapy in combination with individual or group counseling using motivational interviewing or cognitive behavioral therapy to be effective (Morris et al., 2006). Generally, the most effective programs appear to be those that include more than one approach.

Toolkits to provide assistance to health care professionals are available. The University of Colorado – Denver has developed a comprehensive toolkit on tobacco cessation with specific steps for practitioners to take in working with consumers. They promote an “ask/advise/refer/assist/assess” approach for health professionals to follow with practical and detailed examples at each step to facilitate successful interventions.

(See http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MHToolkit.pdf.)

The National Association of State Mental Health Program Directors has also developed the “Best-Practices Toolkit Promoting Wellness and Recovery” for use in psychiatric settings.

(See http://www.nasmhpd.org/general_files/publications/NASMHPD.toolkitfinalupdated90707.pdf.)
