A Comparative Analysis of Smoking Policies and Practices among State Psychiatric Hospitals

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Executive Summary

The health and environmental effects of smoking are being reflected in the smoking policies and practices of state psychiatric hospitals. A recent survey of these hospitals found that 41% do not permit smoking for patients, 12% plan to eliminate smoking within the next year, and another 17% plan to change their smoking policy in the future. Substantially more of the hospitals that permit smoking experienced environmental/safety issues related to smoking and tobacco as compared to the group of hospitals that do not permit smoking. Over 90% of all hospitals offered multiple forms of treatments to their patients that smoke, while some differences in practices were found between hospitals that permit smoking compared to hospitals that do not permit smoking. Most hospitals that do not permit smoking reported the transition period was a year or less and that the health of patients has improved and that more time is available for active treatment.

Introduction

Recent attention to the health and environmental effects of smoking has prompted new actions in a number of states that restrict areas where smoking is permitted. The Surgeon General's office has produced a multitude of reports over the past two decades focusing on the affects of smoking, both in terms of physical health and mental health. In addition to health conditions caused or exasperated by smoking, a clear economic burden for medical care and lost productivity is attributable to smoking practices[1]. The Surgeon General's report also indicates that the states spend an estimated $12 billion on "treating smoking attributable diseases",[1] representing a large economic burden to public institutions. Compounded with the existing financial strain for treating these diseases, persons with mental illness are noted to be twice as likely to smoke tobacco as the general population and to smoke more heavily.[2]

State mental health agencies and state medical directors are interested in the status of their state psychiatric hospitals in the general movement toward non-smoking environments. Their interests reflect awareness of the costs of smoking and the treatment implications for persons residing in hospitals. In May 2005, they enlisted the support of the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute (NRI) to conduct a brief survey on the policies regarding smoking for staff and patients in state psychiatric hospitals. This survey was comprised of seven questions to collect basic information on current smoking policies such as location of areas where smoking is permitted, number of smoke breaks, and policy change towards smoke-free environment.

The results of this initial survey indicated wide variation in policies and practices among the responding hospitals.[3] The results reflect only 55% of all state psychiatric hospitals. Of the hospitals that responded to the initial survey, 20% stated that smoking was not permitted entirely on hospital grounds. Most hospitals offered cessation treatments and/or programs. Of those

hospitals that allowed smoking, some hospitals appear to allow smoking on units, and while the average number of smoke breaks a day was six, some hospitals indicated unlimited access.

This early survey offered limited information on the smoking policies of state psychiatric hospitals. When attempting to interpret the results, a number of important follow-up questions were identified. One major area of concern was definition. The survey tool did not include a definition of terms which lead some hospitals to indicate smoking was not permitted on hospital grounds but that there were organized smoke breaks for patients. Including policy related to either staff or patients in the tool may have also contributed to apparent inconsistencies. The second major area of concern was provision of treatments. While a majority of hospitals indicated that nicotine replacement treatment medications were on formulary and patient cessation groups were conducted, the survey did not ascertain the actual utilization of these services. The final area of concern was understanding the motivators and obstacles for change. As indicated by the initial survey results, many hospitals plan to implement changes in smoking policies and become smoke-free environments. The lessons and experiences from hospitals that have successfully transitioned to non-smoking could prove helpful to hospitals beginning the process to become smoke-free.

To address the foregoing concerns and to serve the interests of the state psychiatric hospitals who are also enrolled in NRI's Behavioral Healthcare Performance Measurement System™ (BHPMS), the NRI created a second survey to investigate and provide hospitals with information and resources on moving towards a smoke-free establishment. The results would also be available to the medical directors for their technical report on the same issue. The focus of this most recent survey was to probe more deeply into the current and planned policies and practices regarding smoking for patients.

Methods

All state psychiatric hospitals were targeted to receive the survey. "Smoking" was defined as any lighted tobacco product (e.g. cigarettes, cigars, etc.). "Smoking on premises" was defined as any area where the facility has governance, including any buildings, balconies, patios, courtyards, areas adjacent to exit doors, parking areas, and lawn expanses. Hospitals were defined into two groups: hospitals that permit smoking on premises and those that do not. Separate survey tools were developed for each of the stated groups. Hospitals were instructed to complete only the one survey tools that aligned with their current practices. The surveys contained a common set of questions for comparative purposes, as well as specific questions for the particular group of hospitals. The survey for hospitals that permit smoking contained 20 questions, whereas the survey for hospitals that did not permit smoking contained 14 questions. Some questions included multiple parts to delineate difference aspects of an issue, and there was a mix of qualitative and quantitative items. Common questions addressed policy, environmental issues, staff training, prescribing practices and treatments. Questions specific to hospitals that permit smoking addressed prevalence, access to smoking areas, and issues of changing to non-smoking. Questions specific to hospitals that do not permit smoking addressed several aspects of the change process. Both surveys also included an open-ended item to elicit specific areas where hospitals desired additional information in order to support a non-smoking environment.

Surveys were distributed via email to directors and administrators of state psychiatric hospitals with an introductory message from NRI and Joseph Parks, MD as the NASMHPD medical directors' liaison. A total of 222 surveys were distributed via email, followed by a postcard reminder after two weeks, and an email reminder after four weeks. The survey tools were also posted on the web for convenient access. The data collection period spanned between March 6 and April 27, 2006. A total of 181 surveys were completed and returned (82% response rate). Forty-four states (88%) were represented in responses. Survey results were analyzed using general descriptive statistics, correlations among questions, and t-tests between groups. Statistical significance was evaluated with an alpha level of 0.05 through all tests.

Findings

Surveys were returned from 82% of all state psychiatric hospitals. Among responding hospitals 41% are non-smoking and 59% permit smoking by patients on hospital premises. Nearly all hospitals have written smoking/non-smoking policies. More than half the hospitals that do not permit smoking and almost two-thirds of the hospitals that do permit smoking have a designated committee on issues related to smoking. The presence of a designate committee could reflect forthcoming changes in policy. However, among hospitals that permit smoking, hospitals that are not planning changes were just as likely as those that are planning changes to have such a committee.

Overall Comparison

Three specific environmental/safety issues in relation to smoking and tobacco use were identified on the survey. In all cases, significantly more hospitals that permit smoking experienced these issues than those that do not permit smoking. One of the many concerns of facility staff is the relationship between smoking and aggression. Many of hospitals that permit smoking expressed concern that patient agitation would increase if smoking was no longer allowed. However, as shown in Figure 1, significantly fewer hospitals that do not permit smoking experienced aggression issues related to smoking or tobacco use compared to hospitals that permit smoking.

Figure 1: Environmental/safety issues related to smoking and tobacco

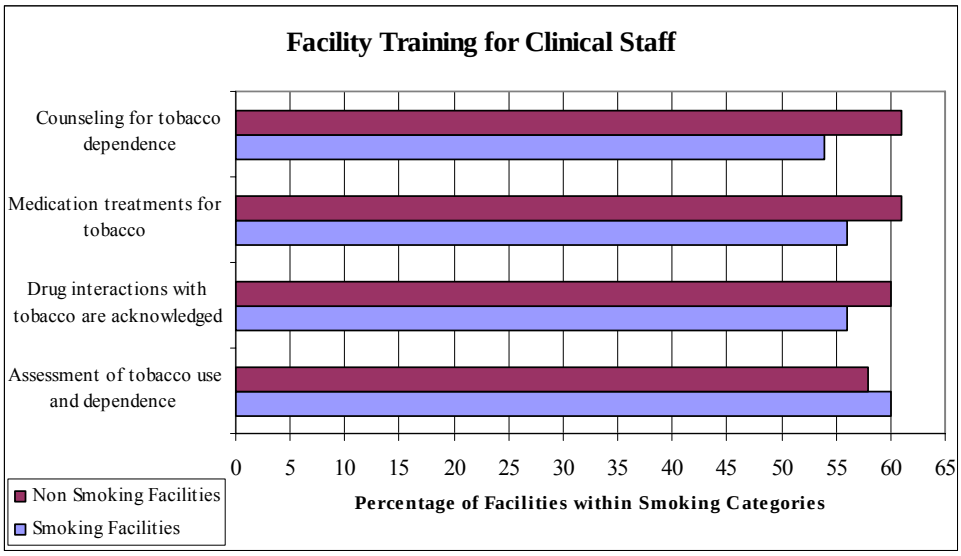
Issue:	Smoking Not Permitted (%)	Smoking Permitted (%)
Smoking/tobacco as precursor to seclusion/restraint	5	34
Smoking/tobacco users and coercion/threats among patients and staff	18	49
Smoking/tobacco related to other health conditions	22	66
No environmental/safety issues	**61**	**47**

Although 22% of hospitals that do not permit smoking experienced health conditions in relation to smoking or tobacco use, a much greater proportion of hospitals that permit smoking (66%) experienced those same issues. Finally, almost seven times as many hospitals that permit smoking experienced issues of smoking/tobacco as a precursor to seclusion or restraint as compared to hospitals that do not permit smoking.

About 70% of all hospitals provide training for clinical staff in assessing and treating patients who smoke. Four specific components of training are shown in Figure 2. There were no significant differences between the hospital groups on these four components. Many hospitals

are cognizant of smoking issues when training clinical staff to provide appropriate services to their patients who smoke. Many hospitals provide training in all four areas (34%).

Figure 2: Components of clinical staff training that addresses smoking issues of patients



While there was no difference between the hospital groups in terms of clinical training in medication treatment and drug interactions, there was a significant difference between these groups in prescribing practices. Sixty-six percent of hospitals that do not permit smoking indicated prescribing practices are modified for patients who smoke compared to 49% of hospitals that permit smoking. This difference may be a reflection of the more immediate needs of patients who smoke when entering a non-smoking hospital.

Over 90% of hospitals in both smoking and non-smoking environments offered multiple forms of treatments to their patients. Forms of treatment included nicotine replacement therapies (NRT) such as the patch, gum, lozenges, sprays, and/or inhalers; antidepressant medications specifically used for cessation; acupuncture; hypnosis; and smoking cessation sessions. A similar proportion of hospitals that permit smoking and those that do not permit smoking reported using NRTs (94%). However, there was a significant difference in the prescribing of antidepressants for purposes of smoking cessation. Fifty-three percent of hospitals that permit smoking stated they used antidepressant for smoking cessation, compared with 36% of hospitals that do not permit smoking. Less than 30% of hospitals offer regularly scheduled smoking cessation sessions at least weekly and most of these hospitals reported low to moderate attendance.

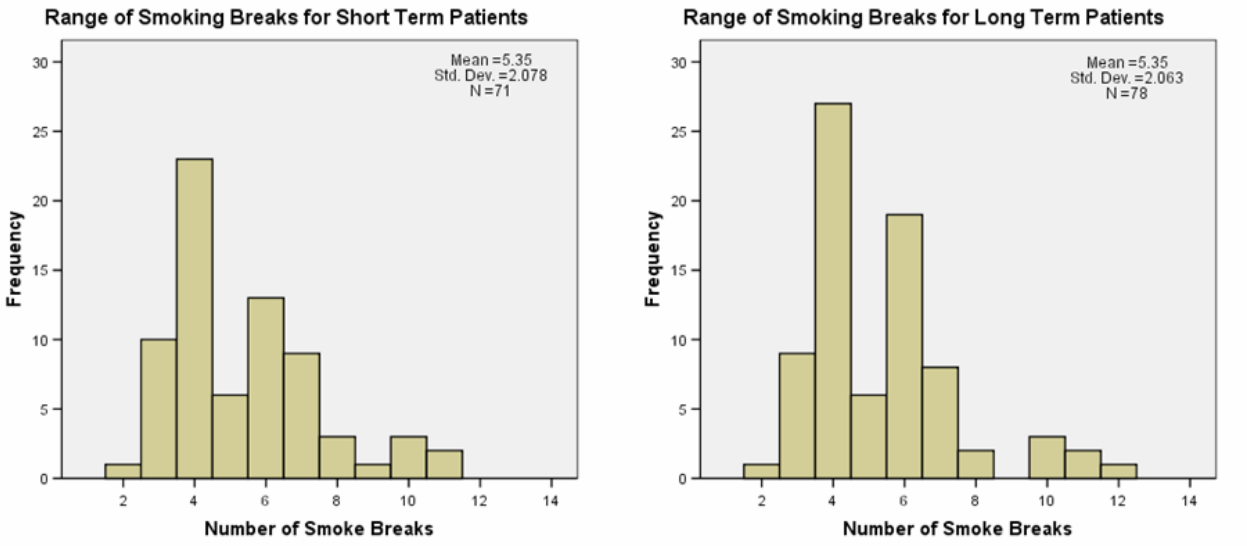
Hospitals that permit smoking

Hospitals that permit smoking typically have constructs or protocols by which they allow patients to smoke. The vast majority of hospitals do not allow smoking inside the buildings. Notably, less than 2% of hospitals permit smoking on living units. Established smoking times, designated smoking areas, and patient escort to smoking areas were overwhelmingly implemented. In fact, 44% of hospitals that permit smoking implemented all three of these controls. Smoking permissions based on privilege status was also indicated widely (34% of

hospitals). Many hospitals stated that gaining access or permission to smoke was a motivator for patients to comply with staff.

Figure 3 illustrates the distribution of smoke breaks given to patients across hospitals reporting a defined number of breaks. There was no significant difference in these patterns between short term and long term patients. In addition, 6% of hospitals reported unrestricted access to smoking areas and 25% of hospitals reported no defined breaks. Approximately 10 hospitals provide less than four smoke breaks per day for either short term or long term patients. On average, hospitals provide five smoke breaks per day; possibly fostering a pattern of tobacco dependence.

Figure 3: Number of smoke breaks provided for patients



Of those hospitals that permit smoking, more than half stated that they intended to change or modify their smoking policy sometime in the future. The most common change was an intent to prohibiting smoking for patients altogether (34%), followed by a plan to move towards smoke-free grounds (29%), reduce smoking areas (14%), and reduce number of smoke breaks (8%). Only 10% of these hospitals indicated that more than one aspect of the policy was expected to change. Among hospitals expecting to change, 71% indicated the change would occur within the year. Seemingly, much of the focus is to move toward a smoke-free environment for patients in the near future.

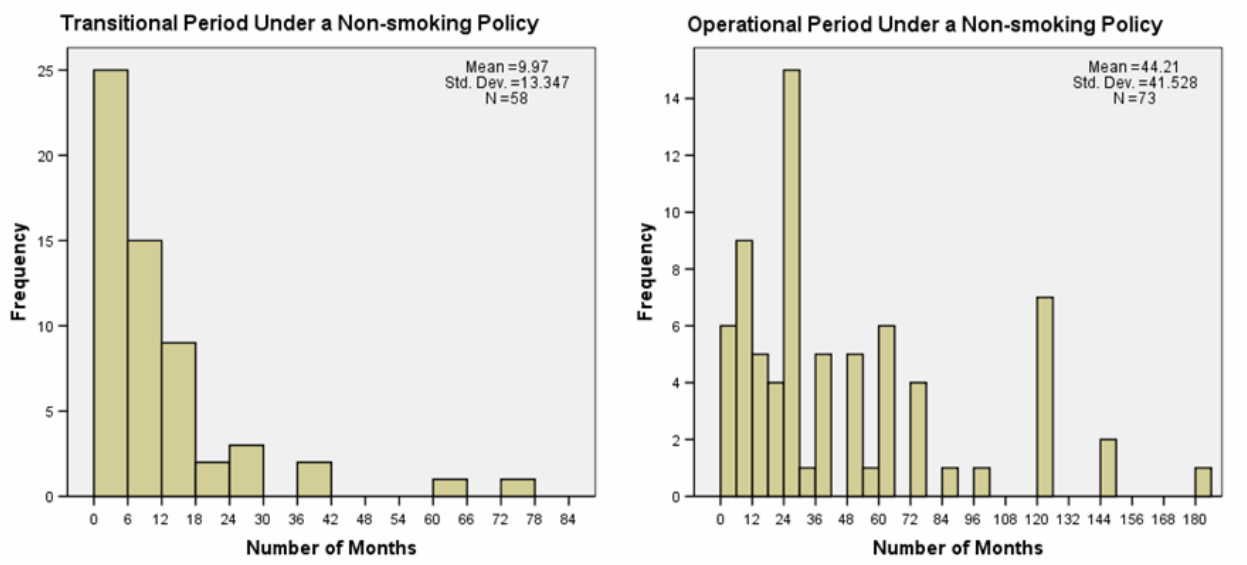
Hospitals that do not permit smoking

Of all the responses, 41% of hospitals state that smoking is not permitted on the premises or grounds. On average, these hospitals have been operating as non-smoking establishments for almost 4 years. The average transition time to implement non-smoking policies was 10 months.

As shown in Figure 4, most hospitals (84%) were able to transition to smoke-free environments in a year or less, and the most common transitional period was less than 6 months. Within the past 6 years, 83% of hospitals that now do not permit smoking made the change from smoking establishments. A number of hospitals have been operating as non-smoking establishments for

over 10 years. Some hospitals were not able to reported transitional periods (23%), several indicating they have been operating under a non-smoking policy since opening.

Figure 4: Transitional and operating periods for non-smoking hospitals (Note: Scales are different between graphs.)



Discussion

The survey of state psychiatric hospitals suggests a nationwide movement towards adopting a non-smoking policy for patients. Over one-third of hospitals that permit smoking have reduced the number of smoke breaks over the past two years. Interestingly, there was no relationship between the recent reduction in the number of smoke breaks and whether hospitals were planning additional changes to policy. Of the 32 hospitals that are planning to adopt a non-smoking policy for patients or smoke-free grounds, 21 of these hospitals intend to change within the year. Potentially, 52% of all state psychiatric hospitals could be smoke-free within a year. When the projection includes hospitals that anticipate changing in more than a year, more than 70% of state psychiatric hospitals could be non-smoking within the next few years.

There are environmental consequences for permitting smoking on the hospital's premises which places additional strain on those hospitals. Financial and staff resources are taxed to accommodate patients who smoke, in terms of health care and active treatment time. Hospitals that permit smoking report a high prevalence of smokers among their patient population, reflective of the Surgeon General's findings. Specifically, more than half of the hospitals that permit smoking report that more than 60% of their patient population smokes. Since most hospitals do not permit smoking inside buildings, staff resources are allocated to chaperoning patients to smoking areas. More than half of the hospitals that permit smoking also indicated that tobacco products are sold legally on hospital premises. For these hospitals, an obstacle to change may well include a financial impact for this lost resource. Finally, more of the hospitals that permit smoking maintain a designated committee on issues related to smoking, limiting staff resources for other treatment issues. Many hospitals that do not permit smoking stated that, since the hospital adopted a non-smoking policy, the health of patients has improved and that more time is available for active treatments.

Awareness of the impact of smoking on general health and psychiatric treatment is evident in the practices being adopting by many hospitals in each group. There are wide variations in the choices among the treatment models. While the training of clinical staff in a majority of hospitals addresses smoking issues, the training is not universal. In addition, more hospitals offer NRTs and antidepressants than regularly scheduled smoking cessation sessions. A substantial proportion of hospitals indicate using antidepressants for cessation purposes as well as NRTs, both of which require the attention of physicians.

It was observed that almost seven times as many hospitals that permit smoking experienced issues of smoking/tobacco as a precursor to seclusion or restraint as compared to hospitals that do not permit smoking. Given the Surgeon General's report, it can be assumed that the prevalence of smoking among psychiatric hospital patients would be independent of the hospital's policy on smoking. Contrary to concerns of hospitals that permit smoking, hospitals that do not permit smoking indicated that they experienced a decrease in behavior problems related to smoking, What appears as a potential obstacle to change was not experienced by some hospitals that were successful at changing to non-smoking establishments.

On the survey, hospitals were also asked a series of open-ended questions to explain motivations and obstacles about adopting a smoke-free policy or retaining a smoking environment. A follow up report on these areas will be available at a later date.

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