



## Smoking Policies and Practices in State Psychiatric Facilities: Survey Results from 2008

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### Executive Summary

The 2007/2008 Smoking Practices and Policy project of NRI constitutes a detailed survey to assess state psychiatric facilities' current smoking policies and practices for staff and individuals served, with new questions targeting nicotine replacement therapy offerings, funding policies, and discharge care planning practices. The results indicate that in the last two years, more facilities have become smoke-free for individuals served and addressed staff smoking behaviors. This study is a follow-up and expansion to the 2006 survey conducted by NRI that identified specific components of state psychiatric facilities' smoking policies and practices, and a short environmental scan conducted by NASMHPD in 2005.

The survey findings include the following:

- 49% of facilities that responded to the survey are non-smoking.
- 52% of facilities categorized as non-smoking converted in the past two years.
- 37% of facilities that permit smoking perceive themselves as non-smoking because they significantly limit access to smoking areas.
- 46% of facilities that permit smoking expect to change their policy to further limit smoking access.
- Two to three times as many facilities that permit smoking reported conflict, coercion, and complaints related to smoking than those with a smoke-free campus.
- Major barriers of going smoke-free are resistance from staff, clients, advocates, and unions.
- Major facilitators of going smoke-free are national trends and state policy.
- Most facilities assess a client's smoking status at intake.
- 80% of facilities offer nicotine replacement therapy (NRT) and 60% offer cessation counseling.
- Most facilities do not address smoking cessation treatment in discharge plans.

### Recent Literature

Smoking is a significant public health challenge being addressed in both inpatient and outpatient mental health services. Persons with mental illness are estimated to constitute 44-46% of the United States tobacco market (Prochaska, Fletcher, Hall, and Hall, 2006). It has been estimated that upwards of 80% of persons with a mental illness are labeled as smokers (Green et al. 2008). According to Green and Hawranik (2008), by 1992 all hospitals in the country, regardless of type, were to move towards smoke-free buildings. However, there are currently many hospital buildings where individuals served are permitted to smoke, especially in psychiatric hospitals.

The original reason for hospitals to become smoke-free was to protect against the harmful effects of second-hand smoke. The mental health community has become sensitized to the role that smoking plays in the elevated morbidity and mortality of persons with a serious mental illness. A study conducted by the NRI and funded by the federal Center for Mental Health Services concluded that persons with a mental illness die (on average) 25 years earlier than the general population (Lutterman, et.al. 2003). The NRI study highlighted the need to address physical health conditions of persons with a serious mental illness since these co-occurring physical conditions are often either neglected or misdiagnosed. Therefore, to effectively address smoking by persons with a serious mental illness, mental health providers must collaborate to raise awareness regarding the harmful effects of smoking and offer continued support and treatment both as individuals move in and out of psychiatric facilities.

Despite the data documenting high levels of smoking among persons with a mental illness, many mental health professionals do not incorporate smoking reduction into an individual's treatment plans. Green and Hawranik (2008) suggest that policy makers and clinicians should design treatment protocols for smoking as is the case with other addictive disorders. As this becomes the case, increasing numbers of psychiatric facilities would aggressively offer nicotine replacement therapies including gum, spray, patch, and medications coupled with supportive counseling and "quit lines" to assist individuals served in this effort. Thus, becoming a smoke-free facility entails decreasing exposure to second-hand smoke and helping individuals served achieve a healthier lifestyle.

NRI's previous 2006 survey found that of the 181 returned surveys, 59% of state psychiatric facilities still allowed smoking (Monihan et al, 2006). Several reasons were provided by psychiatric facilities that had not made their facility campus smoke-free. One reason offered was that if a facility moves toward a smoke-free status, the level of conflict between individuals served and staff would increase. Psychiatric facilities expressed a concern that individuals served may lose their ability to connect and socialize with others. Another common belief was that individuals served would discharge themselves against medical advice if they were not permitted to smoke. Many of these traditional beliefs have effectively halted efforts to make all psychiatric facilities smoke-free.

## **Methods**

The 2008 survey was distributed to 219 state psychiatric facility directors via email (or hard copy if requested). There were 164 surveys returned producing a response rate of 75% and representing 43 states. The survey consisted of 33-items including, but not limited to, questions related to demographics, policy, nicotine replacement treatment(s), milieu management, and aftercare planning. There were two questions targeted to facilities that permit smoking to discover reasons for their having not transitioned to a smoke-free environment. There were three questions targeted to facilities that do not permit smoking to discover their perceived outcomes due to a non-smoking policy.

To provide an opportunity for comparison with the 2006 NRI survey results, definitions of "smoking" and "facility premises" were replicated from the earlier survey. "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 lawns. To differentiate the smoking policies, the seven-option list from The Joint Commission’s recent survey was adapted. The 2006 NRI survey did not explicitly list policy options but instead asked respondents to self-select the version of the survey that represented their smoking status (Permitted versus Not Permitted).

In the 2008 survey, each respondent selected the most appropriate smoking policy from a list of seven options, ranging from the most liberal policy (no restrictions on smoking indoors or outdoors) to the most restrictive policy (smoking prohibited indoors and outdoors). For the purposes of analysis, a facility was categorized as “non-smoking” if the respondent checked one of the following policies:

- Smoking is prohibited on facility premises (indoors and outside); there are no designated smoking areas on the campus, but there are 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. The policy applies to clients, visitors, and employees. (n = 9)
- Smoking is prohibited on all facility premises (indoors and outside). There are no designated smoking areas on the campus; the facility is totally a smoke-free campus. The policy applies to clients, visitors, and employees. (n = 71)

NRI categorized a facility as “smoking” if the respondent selected one of the following responses:

- Smoking is allowed indoors and is NOT limited to designated smoking areas. (n = 0)
- Smoking is prohibited indoors, except in designated smoking areas. It is permitted outdoors. The policy applies to clients, visitors, and employees. (n = 7)
- Smoking is prohibited inside all facility buildings. It is permitted outdoors. The policy applies to clients, visitors, and employees. (n = 35)
- Smoking is prohibited inside all facility buildings and on most facility property outdoors. Smoking allowed in designated outdoor smoking areas. The policy applies to clients, visitors, and employees. (n = 40)
- Smoking is prohibited inside all facility buildings and on most facility property outdoors; only clients and visitors are permitted to smoke in designated outdoor smoking areas; hospital employees are not allowed to smoke on facility premises or adjacent properties. (n = 2)

The survey design included multiple choice, multiple response, and several open-ended questions. Respondents were requested to email, fax, or mail responses to the NRI within a defined period of time. There were three reminder emails sent to target the respondents who had not completed the survey. The data collection period spanned from March 2008 to May 2008. An Access database was designed to store the data from each facility. Each facility received a unique id and the responses were manually entered into the system. Survey results were analyzed using general descriptive statistics and t-tests or Chi-squares between groups. Statistical significance was evaluated with an alpha level of .05 for all tests.

## **Findings**

Utilizing NRI's non-smoking operational definitions, 49% (80/164) of the facilities were categorized non-smoking, the vast majority of which (89%) are totally smoke-free campuses. For those facilities categorized as smoking, only 8% allow smoking inside the facility in designated smoking areas, 42% allow smoking outdoors, and 50% allow smoking outdoors only in designated areas. It should be noted that 44% of facilities categorized as smoking responded to survey questions intended for non-smoking facilities, and only 63% of facilities categorized as smoking responded to questions intended for facilities that permit smoking. Therefore, some facilities that limit access to smoking equate this practice to being a non-smoking facility.

### *Demographics*

Respondents were asked to identify populations served based on a list of eight different possibilities representing different age groups 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; and forensic. For purposes of analysis, children and youth were combined.

- Forty-three percent (43%) of facilities serve only a single population:
  - 9.3% serve only children/youth,
  - 25.3% serve only adult,
  - 6.8% serve only forensic, and
  - 1.2% serve only geriatric.
- Fifty-seven percent (57%) of facilities serve a combination of populations:
  - 25.3% serve children/youth as well as adults and the majority of these facilities also serve forensic and/or geriatric, and
  - 32.1% serve adults and either forensic and/or geriatric.

More facilities provide acute care than long-term care for children/youth and adult populations.

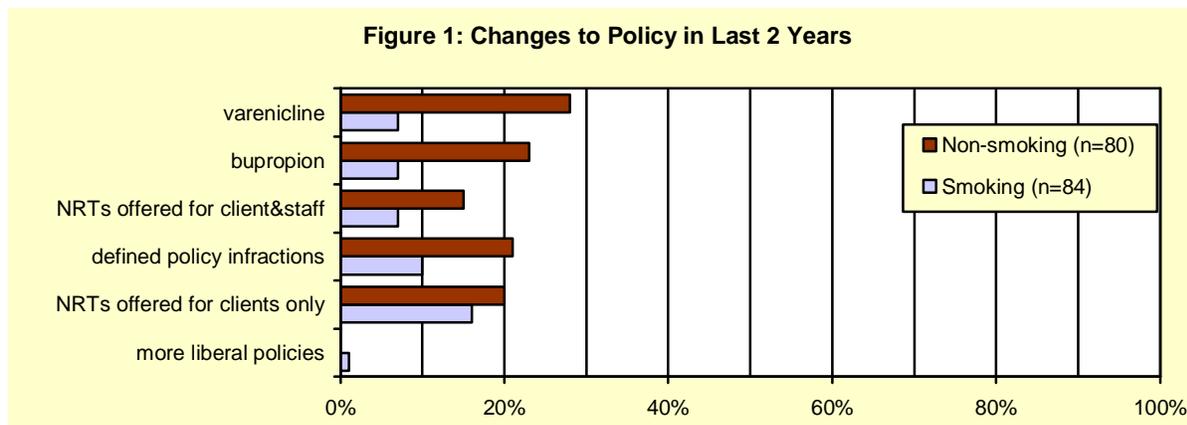
There were few differences in population served and smoking policy. Facilities categorized as non-smoking included a greater proportion of the facilities that provide adult acute care, forensic services and long-term care. Facilities categorized as smoking included a greater proportion of the facilities that serve only adults or adult and youth.

Respondents were also asked to indicate total beds and staffing. Facilities range in size from 16 beds to 1,362 beds (*Mean*=225; *SD*=195): 42% have less than 150 beds, 34% have 150-299 beds, and 24% have 300 or more beds. More of the facilities with 150-299 beds were categorized as non-smoking than smoking. Facilities also range in staffing capacity (*Mean*=544; *SD*=433): 31% have less than 300 staff, 40 % have 300-599 staff, and 29% have 600 or more staff.

### *Policy*

Among facilities categorized as non-smoking, 57% indicated that their policy changed within the last two years, with the majority of these indicating becoming smoke-free throughout the entire facility. In contrast, 44% of the facilities that allow smoking have made a change in their policy within the last two years. Figure 1 displays some of the policy changes made by facilities categorized as non-smoking and smoking based on a multiple response list. By policy, some non-

smoking facilities added smoking cessation treatment, particularly medications. For those facilities categorized as smoking that changed their policy, 30% have restricted access to smoking, 7% have become smoke-free for individuals served only, and 16% have added medications to assist individuals served to reduce smoking. There was a statistically significant difference between facilities categorized as smoking versus non-smoking in regards to policy changes in the following areas: offering varenicline ( $p=.001$ ), offering bupropion ( $p=.01$ ), and for defining policy infractions ( $p<.05$ ). In each case, a greater proportion of facilities categorized as non-smoking adopted a policy change in the given area. A subsequent section discusses actual treatment penetration.



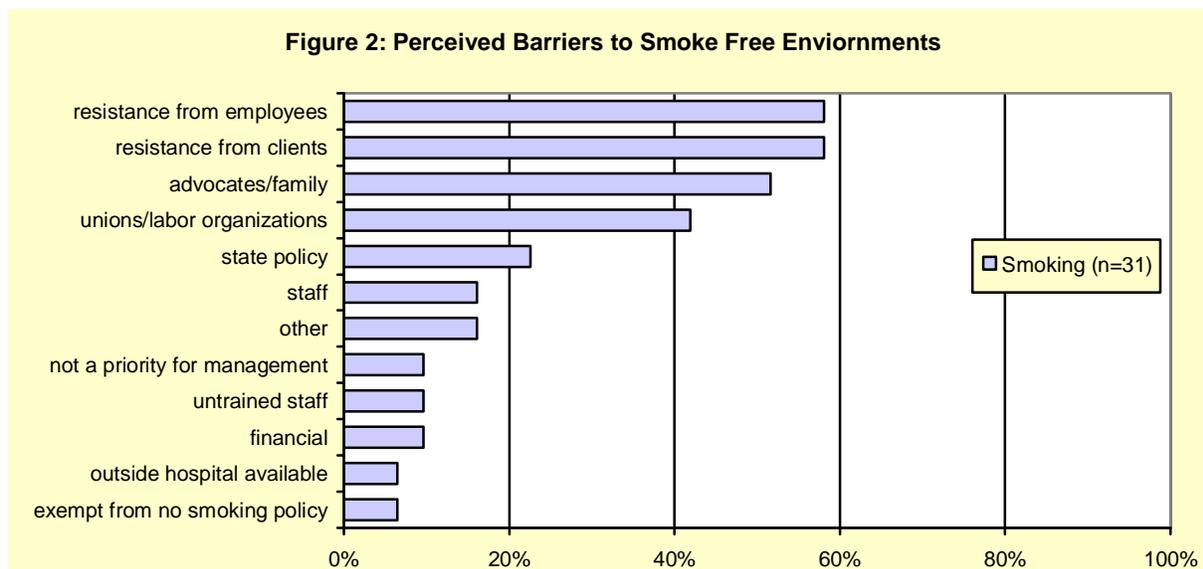
Guidance for the movement toward a smoke-free environment came from several sources. Seventy percent (70%) of facilities categorized as non-smoking and 69% of facilities categorized as smoking responded that they were influenced by national emphasis on smoking cessation. A majority of facilities categorized as non-smoking (53%) and smoking (58%) have a designated committee to focus on addressing smoking/tobacco practices and policies. A majority of state psychiatric facilities categorized as non-smoking (70%) believed that their state's policy towards smoking had an effect at the local level. While this question was targeted for non-smoking facilities, many facilities that permit smoking responded to the question: 57% of these facilities indicated that they were becoming smoke-free as a result of their respective state policies.

### *Changes Planned*

Of the facilities categorized as smoking, 46% noted they will change their smoking policy for individuals served in the future. The most frequent changes to be made are prohibiting smoking altogether and/or establishing smoke-free grounds (30%). Fifty-five percent (55%) of the facilities that permit smoking will make changes to their staff smoking policies in the future. Similar to the changes proposed for individuals served, these facilities will prohibit smoking altogether and/or establish smoke-free grounds.

Six percent (6%) of non-smoking facilities are planning to make changes to their policy for individuals served and 6% predict to change their staff policies. Most facilities predict that the policy changes will occur within the next 1-3 months for both staff and individuals served. Anticipated changes include prohibiting smoking altogether, having smoke-free grounds, and encouraging voluntary smoking cessation.

As noted previously, 63% of facilities categorized as smoking responded to the two survey questions targeted for facilities that permit smoking. Among these respondents, 16 facilities (30%) planned to become smoke-free within the next 12 months. Facilities indicating that they would not be changing in the next 12 months were asked to identify barriers to change. Eighty-three percent of these facilities identified barriers from a multiple response list as displayed in Figure 2; more than half of these facilities identified three or more barriers.

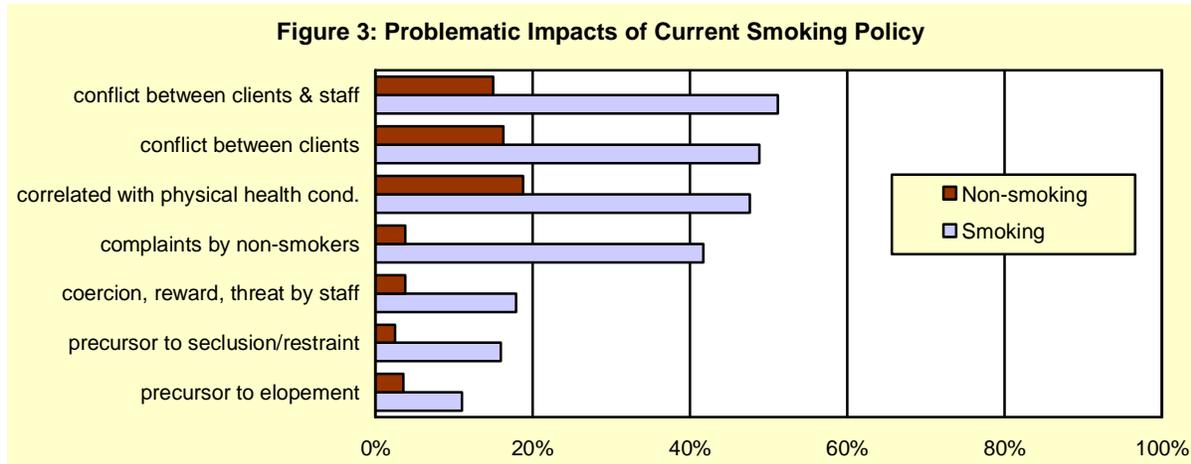


### *Milieu Concerns*

Many facilities reported concerns about becoming smoke-free and its perceived adverse effects on the safety and comfort of individuals served and staff. Respondents were asked to select from seven specific issues and were provided space for indicating “other” concerns. Figure 3 illustrates the percentages of facilities that chose each of the specific issues. There were significant differences between facilities categorized as smoking versus non-smoking as to whether they believed smoking policy effected the following areas: conflict between individuals served and staff; conflict between individuals served; correlated with physical health conditions; complaints by non-smokers; coercion, reward and threat by staff; and precursor to seclusion and restraint. In each case, a much greater proportion of facilities categorized as smoking identified the issue as affecting the milieu.

A total of 60% of facilities categorized as non-smoking identified no issues; 36% identified between 1-3 issues; and 4% identified 4 or more issues. A total of 27% of facilities categorized as smoking identified no issues; 44% identified between 1-3 issues; and 29% identified four or more issues.

Very few facilities, regardless of smoking policy reported unplanned discharges (against medical advice, non-compliance with treatment, treatment not completed) that were due to the facility’s restrictions on smoking (8% of facilities categorized as non-smoking and 5% of facilities categorized as smoking).

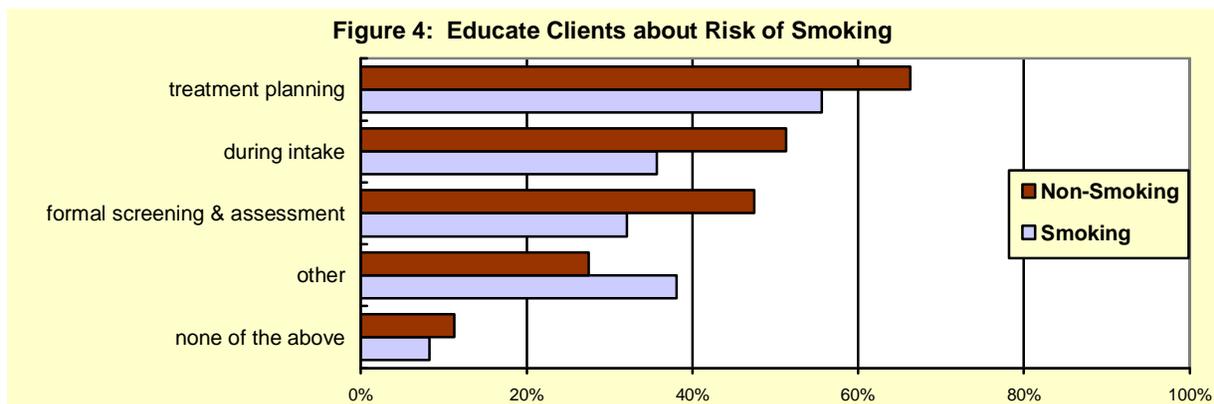


Concern has been noted on the potential for fires and elopements due to a restricted smoking policy. Respondents were asked to indicate whether there were any fires and/or elopements due to their smoking policy. A similar proportion of facilities categorized as non-smoking versus smoking reported fires related to smoking (22% and 21%, respectively). Nearly half as many facilities categorized as non-smoking versus smoking reported elopement due to smoking practices (18% and 33%, respectively).

Facilities categorized as non-smoking prohibit the sale of smoking tobacco products and the use of smokeless tobacco products. Facilities that permit smoking allow the sale smoking tobacco products (39%) and the use of smokeless tobacco products (43%).

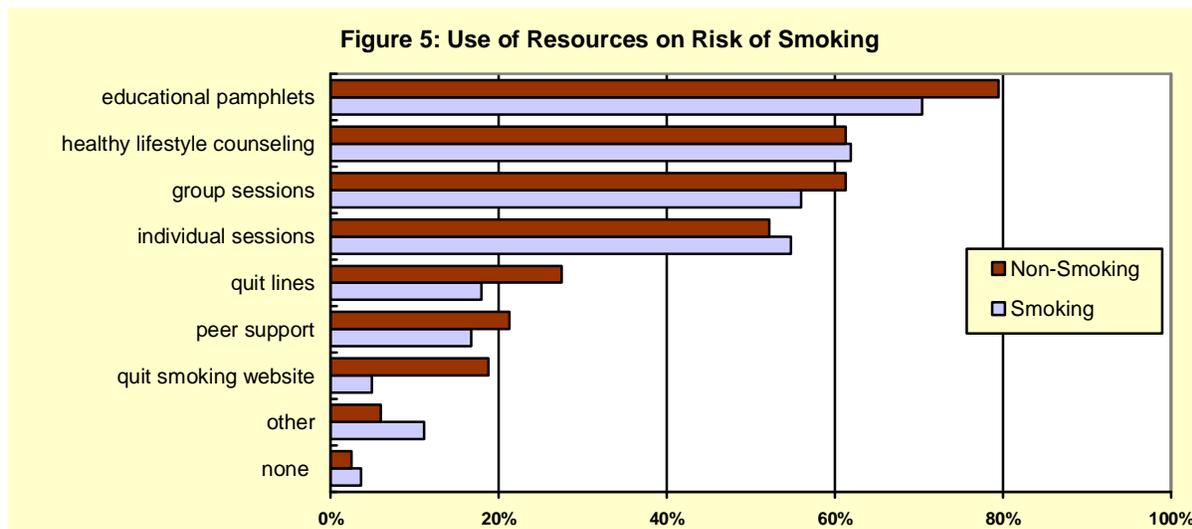
*Intake and Treatment Planning*

Findings regarding intake and treatment planning indicate that the majority of facilities whether categorized as non-smoking or smoking believe that approximately 61-80% of their populations are smokers. Ninety-four percent of non-smoking facilities assess an individual’s smoking status at intake, and 88% of facilities categorized as smoking assess smoking status. Figure 4 highlights the percentage of facilities categorized as non-smoking and smoking that educate individuals served about the risk of smoking during specific intake and treatment activities, which were provided as a multiple response list.



### Treatments Offered

Figure 5 represents the percentage of facilities categorized as non-smoking and smoking offering different resources regarding the risks of smoking. Respondents were asked to select from a multiple response list. Educational pamphlets and healthy lifestyle counseling are available at more than 60% of facilities, whether categorized as non-smoking or smoking.



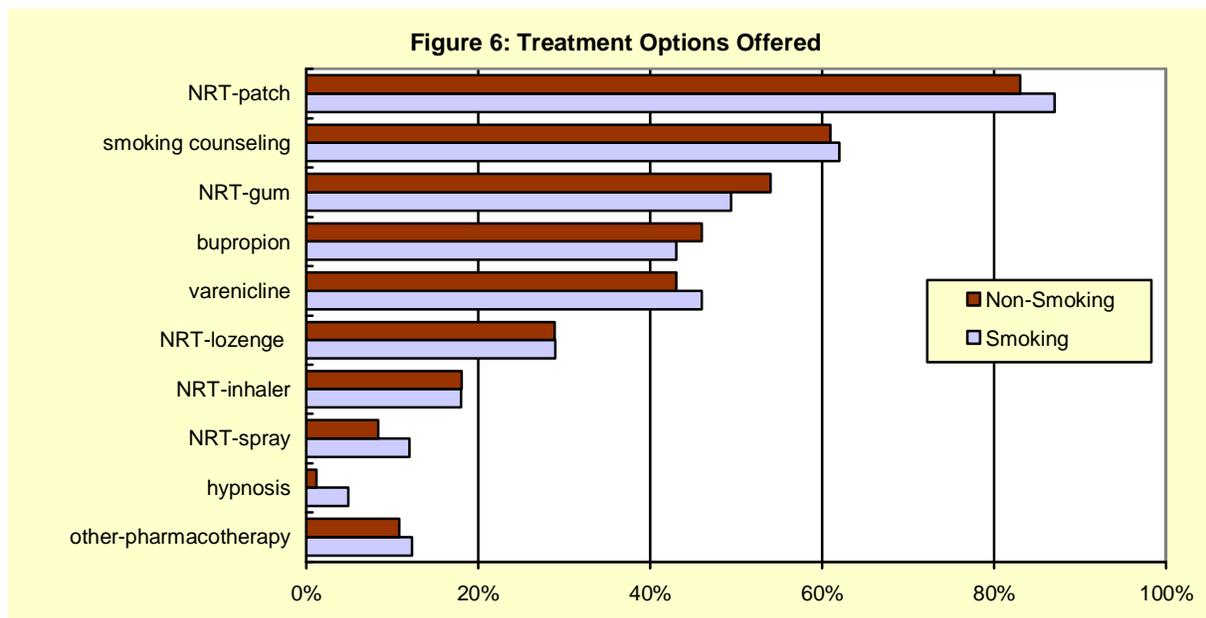
At least 60% of facilities categorized as non-smoking and smoking indicated they offered smoking cessation counseling sessions on a weekly basis. Facilities categorized as non-smoking that indicated they offered smoking cessation noted attendance at the following rates: 7% well-attended 51% average attendance, and 42% poor attendance. In comparison, facilities categorized as smoking that offered smoking cessation programs indicated the following: 12% reported well attended, 34% reported average attendance, and 54% reported poor attendance. Respondents indicated that they motivate individuals served to attend cessation programs through various methods, including part of their treatment; encouraged by staff; peer reinforcement; tangible incentives; tied to privileges; and all sessions are voluntary.

Most facilities reported that staffs from various disciplines provide education and services related to smoking to individuals served. Nursing was the most common discipline to provide these services (83% of facilities categorized as non-smoking and 75% of facilities categorized as smoking), followed by psychiatry (63% and 66%, respectively), and social work (46% and 50%, respectively).

While multiple disciplines provide services, trainings to staff specifically targeted toward smoking were reported in less than half the facilities, regardless of smoking policy. The most frequently reported training areas were: prescription medication interaction with smoking (46% facilities categorized as non-smoking and 37% facilities categorized as smoking), medication treatment for smoking (46% and 32%, respectively), and assessment of smoking use and dependence (41% and 31%, respectively). Few facilities reported training for awareness of quit lines (22% and 17%, respectively) or coordination with community resources (24% and 13%,

respectively). One-third of facilities (35%), regardless of smoking policy, reported using the NASMHPD Toolkit on Tobacco-Free Living in Psychiatric Settings.

Figure 6 represents the percentages of facilities categorized as non-smoking and smoking offering different treatment options. Respondents were queried on their use of nicotine replacement therapies (NRT) in its various forms. As the figure indicates, the patch, smoking counseling, gum, and bupropion are the most common treatments offered at facilities categorized as non-smoking and smoking. On average, facilities categorized as non-smoking and smoking offer between two and five treatments. There are no significant differences between the treatments that are offered by smoking versus non-smoking policy.



### *Funding Sources for Treatments*

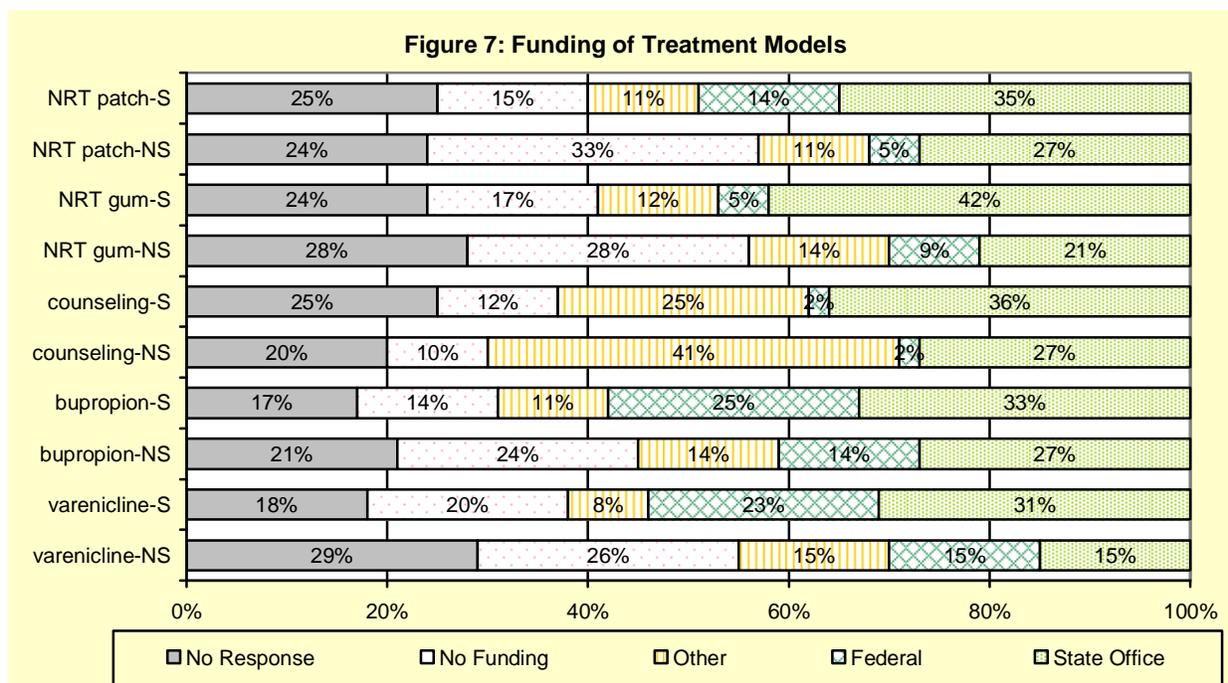
Various treatment options are provided in many facilities regardless of their smoking policy. Respondents were asked to identify funding sources for each treatment from the following: Medicare, Medicaid, State Mental Health Office, Other, or None. It was possible for facilities to indicate a combination of funding sources for each treatment. For purposes of summarizing and analyzing funding sources, Medicare and Medicaid were designated as “federal;” and when “other” was indicated in addition to state and/or federal, the response was counted with State and/or Federal. It was rare for both federal and state resources to be used; in these cases, the responses were counted with state (less than 5% of facilities). In general, there were differences in how the facilities funded treatments, as shown in Figure 7. In the chart, “NS” designates responses from facilities categorized as non-smoking and “S” designates smoking.

In facilities categorized as non-smoking, more facilities indicated there was no funding support for either varenicline or bupropion. Where funding was provided, more facilities indicated state support for bupropion than varenicline; an equal proportion of facilities indicated receiving federal support for varenicline and bupropion; and more facilities indicated “other” funding for varenicline than bupropion. In facilities categorized as smoking, a greater proportion of facilities

indicated receiving state support than federal funds for both varenicline and bupropion; a smaller proportion of facilities indicated use of “other” funding; and a small proportion indicated no funding support.

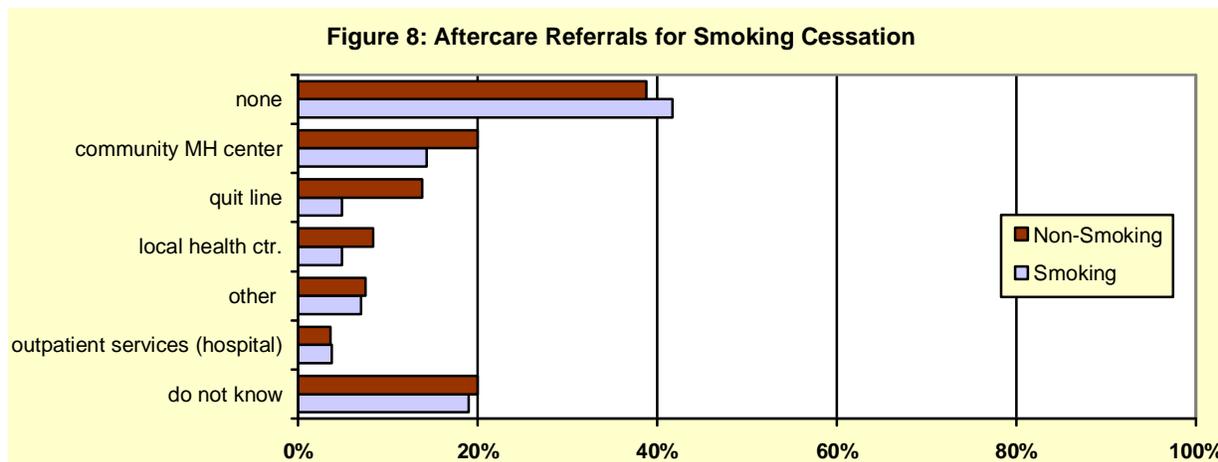
Smoking counseling was offered at a similar rate at facilities whether categorized as smoking or non-smoking (more than 60% of facilities). For non-smoking facilities, smoking counseling was paid for using “other” dollars followed by state dollars. For facilities categorized as smoking, smoking counseling was funded by state dollars, followed closely by “other” dollars.

NRTs are provided by a majority of facilities whether categorized as non-smoking or smoking. The two most frequent NRTs are the patch and gum. In facilities categorized as non-smoking, more facilities indicated that there was no funding to support these therapies. The second most common funding stream was state dollars. More facilities categorized as smoking funded NRTs through state dollars followed by federal and other dollars.



*Aftercare Planning*

Most facilities fail to address smoking cessation in discharge planning. Survey results indicated that only 14% of facilities categorized as non-smoking and 11% of facilities categorized as smoking specify an individual’s smoking status in the discharge plan. As indicated in Figure 8, 40% of facilities do not refer individuals served for outpatient services specific to smoking cessation, and approximately 20% of facilities were unable to answer the question. A small percentage of facilities categorized as non-smoking and smoking refer clients to traditional treatment areas (CMHCs) and fewer facilities refer to general health providers for smoking cessation treatment. Twenty-seven percent (27%) of facilities indicated only one referral destination for smoking cessation treatment.



## **Discussion**

This 2008 survey highlighted findings in relation to smoking policies, milieu management, treatment cessation programs and services, funding for cessation services, and aftercare planning. Specifically, this study found that there has been movement to establish smoke-free buildings and campuses since 2006. The 2008 survey indicated that more facilities categorized as non-smoking moved towards establishing a smoke-free campus, rather than restricting smoking areas. The survey predicts that this trend toward a smoke-free campus will continue in coming years. Figure 8 indicates that staff, family, clients, and unions/labor can be an impediment to establishment of smoke-free policies. Other reported impediments include competing priorities, management changes, and other concerns that impact a facility's change. The greatest facilitators of going smoke-free are national trends and state policy.

For both facilities categorized as non-smoking or smoking, psychopharmacology was one of the most common changes that management instituted. However, as represented in Figure 7, facilities categorized as non-smoking versus smoking pay for these services using different funding streams. Many facilities categorized as non-smoking did not have funds to pay for either varenicline or bupropion. The facilities categorized as smoking appear to receive most of their funding for these two drugs through either state or federal funding.

More inquiry is needed to determine the reasons for funding differences in facilities categorized as non-smoking and smoking. In healthcare environments, it is important to adequately fund treatment to address not only mental health conditions, but also general health status. Thus, nicotine addiction would be addressed to mitigate the harmful effects of tobacco use. If persons with mental illnesses die 25 years earlier than the general population due to untreated co-morbid medical conditions, researchers and policymakers must understand the ways in which treatment can be funded and assist those states and facilities by creatively pooling funds to meet the needs of all individuals who are served by psychiatric facilities.

There was a significant difference between facilities categorized as non-smoking versus smoking regarding how policies affect the facilities' treatment milieu. Two to three times as many facilities that permit smoking reported conflict, coercion, and complaints related to smoking than

those with a smoke-free campus. In addition, more facilities that permit smoking reported elopements due to smoking than facilities that do not permit smoking. A similar proportion of facilities categorized as smoking versus non-smoking reported fires related to smoking. These findings relate to earlier literature that documents the myths that many facilities hold regarding eliminating smoking and alleged increased levels of conflict. The results of this survey indicate the reverse of this myth in that non-smoking facilities appear to experience less conflict and complaints in relation to their non-smoking policies.

Another area examined is the coordination of care upon discharge and the availability of smoking cessation treatment post-discharge. As the findings indicate, there is a high percentage (above 85%) of facilities whether categorized as non-smoking or smoking that screen for smoking at intake. However, that figure drops to approximately 60% of facilities using treatment planning to educate individuals served on risks of smoking and less than 15% of facilities recording the individual's smoking status as part of the discharge care plan. In addition, the majority of facilities do not refer individuals served for smoking cessation treatment upon discharge. This lack of information creates a challenge for outpatient providers to continue the individual's smoking cessation regimen when the individual served is transferred to a community-based provider. This area could be more effectively addressed via improved communication and planning between inpatient providers and local programs.

Overall, the current study indicates that smoking policies in state psychiatric facilities are moving toward a holistic health framework by addressing individuals' overall health status including smoking. The data indicate that in the last two years, more facilities have become smoke-free for individuals served and addressed staff smoking behaviors. The survey predicts that this trend will continue. The perception that limiting individuals' smoking is a precursor to negative behavior continues to impede more facilities from becoming smoke-free. While screening for smoking is more common, and multiple treatment options are provided, educating individuals served about the risks of smoking and attendance at smoking cessation classes lags significantly behind.

Continued collection and analysis of longitudinal data is needed to understand better the link between smoking policy and practice in state psychiatric facilities. While the policy delineation provides clear distinction for a smoke-free campus, some facilities inappropriately interpreted limiting smoking to designated outside areas as equating to being a non-smoking facility. A follow-up survey using the 2008 tool is warranted to re-assess facilities' smoking practices and policies, and the changes that are occurring across multiple years.

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## **Acknowledgement**

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