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Installation Tobacco Control Programs in the U.S. Military

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ABSTRACT Tobacco use prevalence is unacceptably high in the U.S. military, and the Department of Defense and service branches have implemented tobacco control policies and cessation programs. To explore aspects of programs regarded as exemplary by their services, we visited four installations, nominated by their service's health promotion leaders, and conducted interviews, observations, and focus groups. Installations included Naval Hospital Guam, Tripler Army Medical Center, MacDill Air Force Base, and the Naval Hospital at Marine Corps Air Ground Combat Center Twentynine Palms. The tobacco control managers (TCMs) at the programs studied were all civilian employees, highly motivated and enthusiastic, and had remained in their positions for approximately a decade. Other commonalities included support from command, a "culture" of health, and location in warm climates. Programs varied in their involvement in establishing designated tobacco use areas, and length and requirement of attending cessation classes; however, no evaluation of cessation programs is currently underway. TCMs should be more engaged in policy discussions for the larger installations they serve. A strong policy framework and command support for TCMs will be necessary to achieve the goal of a tobacco-free military.

INTRODUCTION

Tobacco use prevalence is unacceptably high in the U.S. military, although there is great variation among populations and services. For example, tobacco use prevalence, including both smokeless and smoking, is lowest among Air Force personnel (40%), and highest among Marines (61%).[1] Tobacco use rates also vary significantly by rank; for example, cigarette smoking prevalence is 30% for the lowest ranking personnel but only 3.7% for the highest.[1] Military tobacco use is associated with training injuries,[2] premature discharge,[3] lower cardiorespiratory fitness,[4] and reduced troop readiness and increased costs for the Department of Defense (DoD).[3]

The DoD and service branches have implemented tobacco control and cessation programs. For example, tobacco use is prohibited in government vehicles and buildings (except some types of housing)[5] and during basic training. Although some aspects of tobacco control programs are controlled by DoD or service-level policies, there is variation in implementation. To explore aspects of programs regarded as exemplary by their services, we visited four installations and conducted a comparative analysis.

METHODS

We asked service-level health promotion leaders from each of the services (Army, Navy, Air Force, and Marine Corps) to nominate installations with outstanding tobacco control programs. Installations selected were Naval Hospital Guam, Tripler Army Medical Center, MacDill Air Force Base, and the Naval Hospital at Marine Corps Air Ground Combat Center Twentynine Palms. We contacted the tobacco control manager (TCM) at each installation and described the project. TCMs facilitated our visits, arranging interviews, observations, and focus groups. There was some variation in study activities among installations (Table I).

We also collected and reviewed program documents and other materials. In the interviews and focus groups, we explored general awareness about tobacco use and tobacco control policy in the military, details about the program, what made the program exemplary, and experience with the program. The open-ended, semistructured interviews and focus groups were audiotaped and transcribed verbatim. Complete transcripts were reviewed and major themes identified in order to prepare a comparative case analysis of these programs' features, and the perceptions of those working within, supervising, and utilizing them. We used NVivo software for data management and analysis. Study procedures were approved by institutional review boards at the University of California, San Francisco; the National Development and Research Institutes; and the Office of the Assistant Secretary of Defense for Health Affairs.

RESULTS

In interviews and focus groups, participants identified commonalities and differences between their programs and those of other facilities (Table II), discussed how installation culture shaped the views of tobacco on base, and described tobacco's effects on the military mission.

Leadership Support

Respondents at all sites said that support from installation and medical treatment facility (MTF) command leadership was critical to sustaining their programs. One remarked

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TABLE 1. Methods

	Naval Hospital Guam	Tripler Army Medical Center	MacDill Air Force Base	Marine Corps Air Ground Combat Center Twentynine Palms
Interview With TCM	X	X	X	X
Interview With TCM's Superior	X	X	X	X
Interview With Health/Hospital Command	X	__	X	X
Interview With Line Command	__	__	__	X
Focus Group With Cessation Services Users	X	__	X	X
Interview With Exchange Manager	X	N/A	X	__
Exchange Observation	X	N/A	X	X

that "this command is very special because our leadership understands the value of health." That understanding was demonstrated with unusual personnel commitments: "to hire two people in a small command like this to do health promotion/wellness, is unheard of" (Twentynine Palms). Command support also was crucial for integrated programs that involved prescribing physicians, pharmacists, health educators, and others because "when you take a provider out of clinic to [provide cessation services], that's great . . . but it still impacts" the staff time available to see patients (MacDill). Presenting to a tobacco cessation class might not show up on productivity measures the way seeing patients would, so "the leadership needs to have . . . the buy in" (MacDill). This comment speaks to the role of institutional metrics. If program activities do not "show up" on usual measures, their value may be challenged in settings where leaders are less supportive.

A commander described his role in supporting tobacco control as "communicat[ing] to people . . . about the policy. And it has to be active." He continued, "we've got to have things for [personnel] to do . . . . [I]f we can keep them busy, especially doing things physical, then they don't need to smoke. They don't want to smoke. They don't have time to smoke" (Guam). This leader challenged common misconceptions about tobacco: that its use by military personnel is normal, that it is compatible with vigorous physical activity, and that it is needed to combat boredom. He aimed at addressing the boredom and stress of personnel in ways that complemented, rather than threatened, the military mission.

Culture

Participants identified a "culture" of health on their installations as helping to make their tobacco control programs exemplary. This "culture" had numerous facets. Most simply, a leader at Guam identified the "peer pressure of the majority of people not smoking" as key. At MacDill, a focus group participant commented that the base was populated by multiple branches: "We have the Marines, and the Army, and the Navy, and the Coast Guard, and no one branch wants to be outdone . . . . The more we see other branches working out, the healthier we want to be." This suggests that establishing competition among the services might enhance tobacco control.

Another participant pointed out that MacDill housed major commands, which meant a larger-than-typical proportion of officers: "They have big staffs. They don't accept . . . smoking. And they're in charge of the policies for their services." One participant suggested that the Air Force had "an advantage because the Wing commanders tend to be pilots. They're not allowed to smoke in the aircraft. So . . . most of them wind up stopping if they ever smoked." Leadership was crucial. A participant at Twentynine Palms said: "If you see your

TABLE II. Features of Tobacco Control Program Sites

	Naval Hospital Guam	Tripler Army Medical Center	MacDill Air Force Base	Marine Corps Air Ground Combat Center Twentynine Palms
Program Site	Hospital on Own Grounds, Separate From Main Navy Installation	Stand-Alone Medical Center (Includes Veterans Affairs Facility)	HAWC (Fitness Facility) on Main Installation	Hospital Grounds on Main Marine Corps Installation
Program Manager	Civilian	Civilian	Civilian	Civilian
Smoke-Free Status/ Policy Development	Hospital Grounds Tobacco-Free; no Involvement With Smoke-Free Policies on Main Installation.	Grounds not Smoke-Free Though a Policy Being Planned; Veterans Affairs Required to Furnish Smoking Areas.	Policy Requiring Annual Reduction of Designated Tobacco Use Areas Installation-Wide; HAWC Grounds not Separate From Main Installation.	Hospital Grounds Tobacco Free; no Involvement With Smoke-Free Policies on Main Installation.
Cessation Program	4-Week Class Offered, but not Required (Per Navy Policy) to Obtain Cessation Pharmaceuticals	10-Week Cessation Class Required to Obtain Cessation Pharmaceuticals	4-Week Class Required to Obtain Cessation Pharmaceuticals	No Cessation Class; Counseling/Pharmaceuticals Offered on Individual Basis
Climate	Tropical	Tropical	Subtropical	Desert

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leadership outside at the smoke pit ... it's one thing, but my experience [is having] an XO [executive officer] and CO [commanding officer] who have been PTing [exercising] and eating healthy ... You ... feel that culture of wellness and you want to jump on board."

Climate

All installations studied were in warm climates, and at three of them, participants mentioned the weather as contributing to their success. One commented: "here in the desert ... at 120 degrees, it's less likely you're going to go out and smoke a cigarette" (Twentynine Palms). Another noted that going to an out-of-the-way smoking area in the tropics meant "two things are going to happen. Either you're going to get wet [from rain] or you're going to get a sunburn ... or both ... So, you need sunscreen to go smoke a cigarette, and you'd better take an umbrella" (Guam). However, participants also thought that being located in a temperate climate, "fosters outdoor activity," which led to "healthier lifestyles" (Guam; also MacDill).

Tobacco-Free Areas

Controlling where tobacco products could be used was of particular significance at two installations. At Guam, the MTF occupied its own campus, entirely separate from the main installation; in compliance with service-level regulations, it was tobacco free. Respondents discussed the benefits of making it inconvenient to smoke. The TCM explained that "we do not designate in the policy a tobacco use [area]. And that was done on purpose by command decision where we want to send the message that if we're a tobacco-free ... compound, that there is no place within our control where one is authorized to smoke." He acknowledged that there was a spot contiguous with but not under the authority of the facility where tobacco use was allowed. However, on the main installation, the health promotion office had no influence over the placement or condition of tobacco-free areas.

At MacDill, the tobacco control team included a representative of the Civil Engineering department, which established designated tobacco use areas. The installation also had a new policy (yet to be implemented) that the number of tobacco use areas was to be reduced annually by 5%. This was the only installation that made mention of policy encompassing property beyond the MTF. At the cessation program focus group, several people mentioned that there appeared to be fewer tobacco use areas at this installation than at others, and that this was helpful to them. One participant remarked, "This is the only base I've ever been to that has designated smoking areas, [on] the flight line." (Since it is outdoors, smoking could be allowed anywhere on the flight line.) She continued, "They have it marked on a map, 'These are the places you're allowed to smoke.' The rest of the base is supposed to be off-limits. ... And other bases don't have that. They have ... the trash cans outside the BX [base exchange store] with the ash trays on top." Creating environments where smoking is less normalized and visible has been shown to encourage cessation and reduce relapse in civilian settings.[6–9] Clearly, service members also notice and respond to such environmental cues.

Health personnel thought that rules about tobacco use should apply across all products. The medical facility commander at Guam, when asked whether there should be different policies for smoking and smokeless answered that "From the Navy's point of view and a health point of view, no, I think you could make the argument that in both cases there's a cost and an impact on readiness." However, numerous participants suggested that when regulations about tobacco use applied to smokeless as well as smoked tobacco, there was less compliance among smokeless users. A focus group participant in Guam said that rules prohibiting tobacco in offices and vehicles included smokeless tobacco, but it was "overlooked because you really can't catch it. It's not leaving a scent in the car" (also Twentynine Palms, MacDill).

Others reported better adherence to the rules. The TCM at Guam reported that "There's awareness that there's no tobacco use [for medical staff] while in uniform. I will admit in days past—it's been about two or three years now—I would from time to time see people dipping in the command, where they would not smoke because you can dip and hide it." At MacDill, a focus group participant said that at her previous station "you were allowed to dip [at work]. ... But down here, MacDill rules [say] even smokeless tobacco ... has to be used in a smoke pit."

Pros and Cons of Cessation Classes

Both opinion and practice were divided about cessation classes, particularly over requiring attendance to obtain pharmacotherapy. Tobacco control personnel at Tripler, which requires a 10-week class, seemed aware that they were in a minority in this regard. The TCM there said, "if someone's got some major disease, and you say, 'Well, we can really treat it well. Or we can kind of do this and ... 10 percent of you will get better here. ... I don't get that." In his view, providing less structured social support meant that fewer attempts would be successful, and "after every failure experience, people are going to have a long period of time" before they try again. He was unpersuaded by the idea that requiring classes made cessation less convenient, regarding this as an excuse. Clinicians reported that patients said, "there's a three-month wait list to get into your program," although they had new groups every month. "But it's part of the nature of addiction, right? And [quitting] ... seems like a really good idea until [you're] right there."

MacDill required a 4-week class to access pharmacotherapy. The program manager realized that longer classes meant that fewer people completed the program, saying "Once they get their meds, they're gone." She studied the curriculum and determined that "four weeks was best." Asked whether requiring attendance might discourage some people, one of the clinicians replied, "all we're really talking about is access to the

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medications … you've got websites, you've got helplines. You have lots of free resources that folks, on their own time, whenever it fits their schedule … can pursue." Requiring the class, in addition to being regarded as the most effective, also made patient follow-up easier.

Navy policy (that also covers the Marine Corps) prohibits requiring attendance at cessation classes. The Navy installation offered a 4-week class or individual counseling, which the TCM recommended. Twentynine Palms provided cessation services individually. The TCM there said that "when I stopped offering the class, my business went through the roof." She said that she "lost the people that needed hand-holding"—that is, those that needed the social support of a class. She continued, "But you know what? At the end of the day, they've still got to do it themselves anyway. And I gained the people that didn't want to come to the class." The TCM's manager agreed that the class requirement was sometimes perceived as a barrier, and that without it a different set of tobacco users might be inspired to try to quit. "So the ones that are actively coming in … they probably need less direction …. The ones [clinicians] grab, it's like, 'I haven't really thought about [quitting].' And you're like … 'if you give the call right now …. you'll have something in hand by either the end of the day, or by tomorrow.'" He thought this was more attractive than recommending a class that might start in days or weeks. The delay meant "they're gone …. The door just shut …. I missed the opportunity …." This approach was considered more appropriate for a training base, where personnel were particularly transient, and also because young Marines were described as being from an "I want it now, I want it yesterday generation." A class was also seen as a "loss of manpower hours" and a potential cause of conflict for participants with their immediate superiors, who would have to give them permission to attend during workdays.

At three locations we spoke to people who had used the cessation services; some of them had attempted to quit at previous installations as well. At two locations, participants commented that at their previous installations, cessation classes "tried to scare you into quitting" (Guam; also MacDill). Participants disliked this approach. One commented: "stuff like that doesn't impress me. I got to the point where, if a doctor told me I was going to die in two months if I didn't quit smoking, I would just have answered, 'Well, I guess I'm going to die'" (Guam). Another claimed: "You can't scare somebody into quitting smoking," because "no smoker believes that [cancer is] ever going to happen to them" (MacDill). The programs at their current installations were described favorably. A participant at Guam emphasized the TCM's point that, beyond the physical addiction, the main reason people used tobacco was for "comfort." At Tripler, the TCM echoed this idea, saying that in his program, "we tell people … this is not the most difficult thing they've done in their life. …. Nobody's going to be shooting at them. They're not going to get blown up …. It's uncomfortable, but we've all been uncomfortable before." He thought that this concept resonated with participants. At least one cessation participant found this insight very helpful, saying, "understanding the comfort factor that made me go back to smoking even after I was well beyond the [physical] addiction" enabled him to say, "well, that's not a good enough reason to have one. So I'm just not going to" (Guam).

Some participants compared their experiences at other installations. A participant at MacDill commented that a program at another installation was "almost like death by PowerPoint, …. It was three days a week for four weeks, and … by the end of the class you wanted to smoke because you were like, 'Oh my god! Why?'" Another participant appreciated the comprehensiveness of the program at MacDill, which included talks about dental health, nutrition, and weight. At Twentynine Palms, one quitter had attended a class at another location, and although he neither completed the class nor successfully quit on that occasion, he recalled it favorably and drew on some of the lessons learned there. He commented about the Twentynine Palms program that a class "would make it a little better—it's almost like having an accountability … to show up the following week and look at each other and be like, 'So how did you do?'"

All cessation programs served both smokers and smokeless tobacco users, and indicated that they were aware of specific differences between smokers and dippers. For example, the MacDill TCM described a scenario in which a dipper came to the tobacco cessation class and said, "his buddy got put on Chantix. Well, his buddy's a smoker, so they might say, 'have you ever tried gum or lozenges,' [because dippers are] used to having something there in the side of their cheek."

The Air Force program was run out of the Health and Wellness Center (HAWC), which has numerous health programs and is attached to the fitness center, rather than from the MTF. The one complaint that was voiced involved "scheduling, because the Air Force is 24-hour ops, and the HAWC is not …. Sometimes it's hard [for people on night shifts] to get to a noon-time or a 1 o'clock class because that's when they're supposed to be sleeping." These findings suggest that further research systematically comparing the success of different types of models for cessation programs within the military context would be valuable.

Tobacco Sales

TCMs seemed to have good relationships with exchange store managers. Several TCMs mentioned that the exchanges provided space or donated goods to raffle for health fairs, or posted health-program signage. However, tobacco sales, promotion, and pricing policies were not in the purview of TCMs. Tobacco products display areas in the exchanges were uniform from location to location. The tobacco industry has ensured that tobacco sales on military installations will continue,[10,11] and policy efforts have failed to substantially increase prices.[12,13] Given the tobacco industry's influence on military tobacco sales[10,14,15] encouraging more display of counter-marketing materials in these settings may be advantageous.

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Impact on Mission

Asked whether tobacco use affected the capacity of the military to fulfill its mission, most respondents replied affirmatively. The specific consequences of tobacco use mentioned ranged widely, including a propensity to illness and lost work time (MacDill, Twentynine Palms, Guam), impaired wound healing, the financial consequences of illness among families exposed to secondhand smoke (Twentynine Palms, Guam), and dental problems (Guam). The cost of purchasing tobacco products, particularly for low-ranking personnel or those with families, was also mentioned as possibly contributing to poorer nutrition (Twentynine Palms, MacDill). However, another officer and physician, while aware of the "long-range health" issues, said that "candidly, I'm not real sure I've seen [that] it affects somebody's ability to walk out the door and go to sea, or go to the desert or do whatever they have to do" (Guam).

The harm mentioned most frequently, and discussed in greatest detail, by enlisted personnel particularly, but also by leaders, was the time lost to cigarette breaks (Twentynine Palms, MacDill). Health personnel were unsure about how much practices regarding "smoke breaks" had changed. For instance, one said that formerly there were "advantages to smoking because you could get a break [but] you don't see that anymore" (MacDill). However, the TCM at Guam reported that "I still have my patients tell me ... that smokers get more break time." An Air Force officer, asked about this situation, thought that "it's changed, but I don't know to what degree" (MacDill). However, the one line commander interviewed, asked about the official policy of one morning and one afternoon break for everyone, said, "I don't know about that specifically—if that's a policy. If it is, it's not one that's abided by, certainly." Asked if smokers took more breaks, he responded, "Oh, yeah, yeah, absolutely" (Twentynine Palms).

DISCUSSION

The exemplary tobacco control programs we studied shared some characteristics. First, they were led by highly motivated civilian employees. The fact that they were civilians meant that, unlike military personnel, they could remain at their location for years or decades, establish effective systems and relationships, and advocate for those systems through changes in command. Second, in accordance with DoD policy, they all offered a complete range of pharmaceuticals, including nicotine replacement therapy in various forms, bupropion, and varenicline.

In other respects, there were significant differences among them, particularly in the length and availability of cessation classes. These differences point to a key weakness in the DoD tobacco control program: there is no formal evaluation system in place. Because military personnel generally move every 2 to 3 years, the installation programs themselves do not have the capacity to do extended participant follow-up. However, active duty Air Force personnel are required to undergo annual dental exams, at which tobacco use status is recorded. Thus, it would be possible to do preliminary assessment of what locations appear to have the most effective programs, but no such effort is currently being made.

Some variation in program structure may be appropriate. For example, having no class at a Marine Corps training base, where personnel are young, impatient, and likely to be deployed (either to combat missions or to remote training areas) and thus unable to predict their schedules, may in fact be optimal. Whether this model would be suitable for installations where personnel are older, with more established tobacco use habits and assignment stability that allow for class attendance, is unknown. Likewise, it is unclear whether the differences in length of class have an impact on who decides to participate and their success rates.

Programs varied in their coordination with aspects of tobacco control other than cessation. At MacDill, the program worked with the civil engineering team on establishing designated tobacco use areas. At other installations, tobacco control programs had limited involvement with smoke-free regulations. One drawback of locating programs in MTFs could be that those administering the tobacco cessation program do not see the daily realities of tobacco use, because their own campuses have stronger smoke-free regulations than the rest of the installation. This may discourage them from pushing for policy options other than the cessation on which they are focused.

One policy area with which TCMs and their supporters might consider engaging is the apparently lax enforcement of rules about "smoke breaks." Although officers and medical personnel seemed to believe that these rules had been made stricter, enlisted personnel generally told a different story, in which smoke breaks were routine, allowing smokers more time off their jobs and flexibility in their days. Enlisted personnel also identified these breaks as likely having an impact on the military mission. Developing installation or service-wide standards about breaks—and enforcing them—could both encourage cessation and discourage uptake of cigarettes. In addition, enforcement of regulations limiting smokeless tobacco use to designated areas seemed to be lacking in most locations.

LIMITATIONS

Research at military installations is challenging, most notably because access to installations and military personnel is tightly controlled. Programs were chosen by their respective services as "exemplary"; how this determination was reached is unknown. It also is unknown whether the sites are representative of their respective services, or whether they illustrate more general differences or similarities among the services. There are no data about the programs' comparative effectiveness at tobacco use prevention or cessation, a notable finding in itself. The study was performed only at the described

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locations; it is unknown whether or how many "nonexemplary" locations share aspects of the programs discussed here. Interviews and focus groups were set up by the TCMs at each location. We had no access to people who used the cessation programs but were unsuccessful in quitting. We also had limited access to line (nonhealth) command personnel; their perceptions of the programs could be different. All locations were in warm-weather climates; numerous participants mentioned this as contributing to a "healthy culture," but the degree to which this contributed to perceptions of or actual program success is unknown.

CONCLUSIONS

A Defense Advisory Committee on Tobacco has prepared recommendations for DoD-wide tobacco control policy; they have not yet been released. Policy change represents the best option for ending the tobacco epidemic.[16] In this regard, the military has some advantages and some disadvantages compared to civilian institutions. Because it is both responsible for and dependent on the good health of its members, and because it has the authority, it could implement stringent rules about tobacco use (such as prohibiting tobacco use in uniform, during duty hours, or altogether). Such rules are beyond the scope of most civilian organizations. However, there are restrictions on the policy options available. For instance, recent Congressional action requires military exchanges to continue to sell tobacco products.[17] There is a history of Congress stepping in at the behest of the tobacco industry when military tobacco control proponents attempt to establish strong policies,[10,11,18] so there may be reluctance to act aggressively.

Nonetheless, this study suggests that the military as an institution is not fully engaged in tobacco control efforts. Evaluation of cessation programs is lacking, so there is no clear direction for improvement. Despite regulations to the contrary, there was widespread acknowledgment that smokers routinely got more breaks than nonsmokers. TCMs were only sometimes engaged in policy discussions for the larger installations they served, being restricted for the most part to MTF grounds. This represents an untapped resource. TCMs might also have ideas about how to structure and enforce break rules or other policy innovations.

The TCMs at the programs studied were all highly motivated and enthusiastic, and had served in their positions for long periods. Such experience and longevity, although desirable, cannot necessarily be replicated at other locations. The personality and stability of civilian leaders cannot substitute for making tobacco control a command priority; dependence on individual commitment is ultimately a weakness for the institution as a whole. A strong policy framework and command support for TCMs will be necessary to achieve the goal of a tobacco-free military.[17,19]

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