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Title:

Systemic Factors That Perpetuate Smoking Among Community and Institutionalised Public Mental Health Service Populations.

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A thesis submitted for the Degree of Doctor of Philosophy in the Department of Social Administration and Social Work in the Faculty of Social Science at the Flinders University of South Australia.
## Contents

**ABSTRACT:** ........................................................................................................................................ 9  
Declaration:........................................................................................................................................ 10  
Declaration:........................................................................................................................................ 11  
Declaration:........................................................................................................................................ 11  
**ACKNOWLEDGEMENTS:** ................................................................................................................ .. 12  
**LIST OF TABLES:** .............................................................................................................................. 13  
**LIST OF FIGURES:** ............................................................................................................................ 15  
**CHAPTER ONE - OVERVIEW........................................................................................................... 16  
(1.1) INTRODUCTION: ......................................................................................................................... 16  
(1.2) PURPOSE OF THE STUDY: .......................................................................................................... 17  
(1.3) STATEMENT OF THE PROBLEM: ............................................................................................... 18  
(1.4) SIGNIFICANCE, UNDERLYING ASSUMPTIONS AND RATIONALE: ...................................... 18  
(1.5) AIMS AND OBJECTIVES: ............................................................................................................. 20  
(1.6) DESIGN:...................................................................................................................................... 21  
(1.7) CONCLUSION:............................................................................................................................... 21  
**CHAPTER TWO - LITERATURE REVIEW.......................................................................................... 22  
(2.1) INTRODUCTION: ........................................................................................................................ 22  
(2.2) SMOKING AS A PUBLIC HEALTH PROBLEM: .......................................................................... 22  
(2.2.1) Prevalence of Smoking and History of Smoking Behaviour: .................................................... 22  
(2.2.2) Smoking Related Morbidity as a Public Health Concern: ..................................................... 23  
(2.2.3) The Duplicity of Industry and Complicity of Governments: .................................................... 24  
(2.2.4) Smoking and Litigation: ........................................................................................................... 25  
(2.2.5) Economic Elasticity and Smoking Behaviour: ....................................................................... 26  
(2.2.6) Economic Costs of Smoking: ................................................................................................... 26  
(2.2.7) Why People Smoke: ................................................................................................................ 28  
(2.3) THEORIES OF DRUG DEPENDENCE: ....................................................................................... 29  
(2.3.1) History:.................................................................................................................................... 29  
(2.3.2) The Pharmacology of Smoking: ............................................................................................... 29  
(2.3.3) Current Definitions: .................................................................................................................. 31  
(2.3.4) Recent Progress with Theories of Physical Dependence: ....................................................... 34  
(2.3.5) Psychological Theories of Dependence: .................................................................................. 35  
(2.3.6) A Dependent Personality – State or Trait? ............................................................................. 36  
(2.3.7) Smoking as a Learned Behaviour: ........................................................................................... 38  
(2.3.8) Smoking Cessation Interventions: ........................................................................................... 40  
(2.4) SMOKING AND MENTAL ILLNESS: ......................................................................................... 42  
(2.4.1) Introduction: ........................................................................................................................... 42  
(2.4.2) Co-morbid Nicotine Dependence and Mental Illness: ............................................................ 43  
(2.4.3) Schizophrenia and Smoking: .................................................................................................. 44  
(2.4.4) Bipolar Affective Disorder and Smoking: .............................................................................. 48  
(2.4.5) Major Depression and Smoking: ............................................................................................ 50  
(2.4.6) Borderline Personality Disorder and Smoking: ..................................................................... 54  
(2.5) OTHER INFLUENCES ON SMOKING IN PSYCHIATRIC SETTINGS: ................................. 56  
(2.5.1) Introduction: ........................................................................................................................... 56
STUDY ONE: CLIENTS WHO HAVE SUCCESSFULLY QUIT ..................................................... 101
(4.1) INTRODUCTION: ............................................................................................................. 101
(4.2) THEMES: .......................................................................................................................... 103
(4.2.1) The Process of Quitting: .................................................................................................. 103
(4.2.2) Smoking and Mental Illness: ........................................................................................... 111
(4.2.3) Smoking Relapse, Hospital, and Peer Reinforcement: .................................................... 113
(4.3) PRELIMINARY DISCUSSION: ............................................................................................ 114
(4.4) CONCLUSION: .................................................................................................................... 117

CHAPTER FIVE................................................................................................................................... 118
(5.1) INTRODUCTION: ................................................................................................................... 118
(5.2) SCHIZOPHRENIA (N=6): .................................................................................................... 119
(5.2.1) ‘At least I’ve got a smoke’ (Jenny) - The Freedom to Smoke in the Perceived Absence of Other Freedoms: ................................................................. 121
(5.2.2) ‘Why Quit, I’ve still got schizophrenia haven’t I?’ (Mark) - The Experience of Powerlessness and Existential Despair: ................................................................. 123
(5.2.3) “Making Sure of Supply” (Jean) - Cigarettes as a Core Need: ........................................ 125
(5.2.4) “It’s part of me” (Jenny) - Smoking and Identity: ............................................................... 127
(5.2.5) Smoking to Manage the Symptoms of Mental Illness - Self-Medication: ...................... 128
(5.2.6) Desire to Quit Smoking: .................................................................................................... 131
(5.2.7) Smoking Reinforcement and Acceptance of Smoking: ................................................... 134
(5.2.8) Other Drugs: .................................................................................................................... 138
(5.2.9) Summary: ........................................................................................................................ 139
(5.3) BIPOLAR AFFECTIVE DISORDER (N=6): ..................................................................... 140
(5.3.1) Control and Smoking: ....................................................................................................... 141
(5.3.2) Reinforcement of Smoking by Others: ............................................................................. 148
(5.3.3) Boredom - “Well, you’re just so bored to tears and you just smoke and smoke.” (Roy): 153
(5.3.4) The Quitting Process: ...................................................................................................... 154
(5.3.5) Cigarettes as a Mood Stabiliser - Self Medication: ............................................................ 159
(5.3.6) Making Sure of Supply: .................................................................................................... 161
(5.3.7) Cigarettes as Companions: ............................................................................................... 163
(5.3.8) Other Drugs: .................................................................................................................... 163
(5.3.9) Summary: ........................................................................................................................ 164
(5.4) MAJOR DEPRESSION (N=6): ........................................................................................... 165
(5.4.1) The Freedom to Smoke: .................................................................................................... 166
(5.4.2) Making Sure of Supply: .................................................................................................... 168
(5.4.3) Cigarettes as a Friend and Identity as a Smoker: .............................................................. 170
(5.4.4) Cigarettes as a Physical Comforter: ................................................................................... 172
(5.4.5) Control and Smoking: ....................................................................................................... 174
(5.4.6) Awareness of Harms - Smoking as a Death Wish: A Slow Suicide: ................................. 177
(5.4.7) Reinforcement and Acceptance of Smoking by Others: ................................................. 178
(5.4.8) Other Drugs: .................................................................................................................... 183
(5.4.9) Smoking to Self-Medicate Illness Symptoms: ................................................................. 183
(5.4.10) Quitting Smoking: .......................................................................................................... 188
(5.4.11) Smoking and Boredom: .................................................................................................. 195
(5.4.12) Summary: ........................................................................................................................ 196
(5.5) BORDERLINE PERSONALITY DISORDER (N=6): ..................................................... 197
(5.5.1) Control: ............................................................................................................................. 198
CHAPTER SIX

(6.1) INTRODUCTION: ................................................................. 235
(6.2) INTRODUCTION TO THEMES: .............................................. 236
(6.3) STAFF SMOKING BEHAVIOUR: .......................................... 236
(6.4) STAFF ATTITUDES TO CLIENTS’ SMOKING: ......................... 241
(6.4.1) Clients Need to Smoke ...................................................... 242
(6.4.2) Staff Determine Intervention Priorities ......................... 247
(6.4.3) Resolution of Ethical Dilemmas Regarding Smoking: ........ 254
(6.5) CIGARETTES AS A TOOL: POWER AND CONTROL BY STAFF: ............................................. 261
(6.5.1) The History of Control: ..................................................... 262
(6.5.2) A Structure of Control - Management Versus Care: .......... 263
(6.5.3) Smoking as a Tool for Reward and Punishment: .............. 265
(6.5.4) Occupational Health and Safety Considerations ................ 267
(6.5.5) Occupational Therapists: .................................................. 274
(6.5.6) Psychologists: ................................................................. 277
(6.5.7) Other Drugs: .................................................................... 288
(6.6) PROFESSIONAL ROLE DIFFERENCES REGARDING SMOKING: ............................................. 271
(6.6.1) Social Workers: ............................................................... 274
(6.6.2) Nurses: ............................................................................. 275
(6.6.3) Doctors: ........................................................................ 277
(6.6.4) Psychologists: ................................................................. 277
(6.6.5) Occupational Therapists: .................................................. 279
(6.7) THE CULTURE OF SMOKING WITHIN THE MENTAL HEALTH SETTINGS: ....................... 279
(6.7.1) The Hospital Culture: ....................................................... 279
(6.7.2) Community Culture: ....................................................... 288
(6.7.3) Comparison of the Hospital and Community Smoking Culture: ........................................ 292
(6.8) CONCLUDING COMMENTS ON STAFF INTERVIEWS: .................................................. 296
CHAPTER SEVEN: ........................................................................................................................... 298
(7.1) INTRODUCTION: .................................................................................................................. 298
(7.1.1) The Psychiatric Inpatient Setting: .................................................................................. 298
(7.1.2) The Community Mental Health Service Setting: ......................................................... 299
(7.1.3) The Community Hostel Setting: .................................................................................. 299
(7.2) DESCRIPTION OF THE SETTINGS: ............................................................................... 299
(7.3) DATA COLLECTION: ........................................................................................................ 301
(7.4) DATA ANALYSIS: ............................................................................................................. 302
(7.5) COMMUNICATING FINDINGS: ........................................................................................ 302
(7.6) RESULTS FROM THE SETTINGS .................................................................................... 303
(7.6.1) The Acute Locked Ward: (beds = 10) ........................................................................... 303
Dominant Characteristics of the Acute Locked Ward: ................................................................. 304
(7.6.2) The Extended Care Locked Ward: (beds = 11) .............................................................. 306
Dominant Characteristics of the Extended Care Locked Ward: ................................................... 308
(7.6.3) The Open Ward: (beds = 24) ........................................................................................ 309
Dominant Characteristics of the Open Ward: .......................................................................... 311
(7.6.4) Extended Care Open Wards: (beds = 24) .................................................................... 312
Dominant Characteristics of the Extended Care Open Ward: ................................................... 313
(7.6.5) The Canteen, Grounds, and Outside the Revenue Department: ................................... 314
Dominant Characteristics of the Canteen and Grounds: ............................................................ 315
(7.6.6) The First Community Hostel: (beds = 24) .................................................................... 316
(7.6.7) The Second Community Hostel: (beds = 24) .................................................................. 318
Dominant Characteristics of the Community Hostels: .............................................................. 319
(7.7) QUANTITATIVE RESULTS FROM OBSERVATION SHEETS: ....................................... 319
(7.7.1) Method: .......................................................................................................................... 319
(7.7.2) Results - Staff Smoking Behaviours: .............................................................................. 321
(7.8) Smoking Area Observations: ............................................................................................ 328
(7.8.1) Method: .......................................................................................................................... 328
(7.8.2) The Acute Open Ward Smoking Area: .......................................................................... 329
(7.8.3) The Extended Care Open Ward Smoking Area: ............................................................ 330
(7.8.4) The Locked Wards: ........................................................................................................ 332
(7.8.5) The Community Hostels: ............................................................................................... 333
(7.8.6) Further Analysis of Observations - Differences Between the Settings: ......................... 335
(7.9) CONCLUDING THEMES FROM THE PARTICIPANT OBSERVATIONS
METHODOLOGY: ........................................................................................................................... 343
(7.9.1) Theme (1) A Systemic Problem: ................................................................................... 343
(7.9.2) Theme (2) Smoking as a Tool - An Instrument of Treatment: ....................................... 345
(7.9.3) Theme (3) Smoking as a Social Currency: ..................................................................... 347
(7.9.4) Theme (4) Attitudes of Staff: .......................................................................................... 348
(7.9.5) Theme (5) Us and Them: ............................................................................................... 349
(7.9.6) Theme (6) The Absence of a Clinical Approach to Smoking: ....................................... 351
(7.10) CONCLUSION: ............................................................................................................... 352
CHAPTER EIGHT: ........................................................................................................................ 354
THE INTEGRATION OF THE TRIANGULATED DATA ................................................................ 354
(8.1) INTRODUCTION: ................................................................................................................. 354
(8.2) SECONDARY ANALYSIS OF THE TRIANGULATED DATA: ............................................................... 354
  (8.2.1) Smoking as a Primary Activity (The Players): ................................................................. 357
  (8.2.2) Smoking as a Multifaceted Tool (The Roles): ............................................................. 358
  (8.2.3) Us and Them (The Rules of Communication): ............................................................ 358
  (8.2.4) Systemic Issues (The Structures, Ideologies and Artefacts): ..................................... 359
  (8.2.5) Grief and Loss (Beliefs and Attitudes): .......................................................................... 360
  (8.2.6) Quitting Experience (Beliefs and Attitudes): ............................................................... 360
  (8.2.7) Diagnostic Differences Between Client Smokers (Players and Roles): ....................... 360
  (8.2.8) Differences Between Hospital and Community Staff (Players and Roles): .............. 361
  (8.2.9) Professional Ethical Responses and Dilemmas (Beliefs and Attitudes): ................. 361
  (8.2.10) Cultural Transfer - Hospital to Community (Rules of Communication): ................ 361
  (8.2.11) A Hierarchy of Values (Attitudes and Beliefs): .......................................................... 362
  (8.2.12) Staff Smoking- Differences According to Setting (Players and Roles): ...................... 362
  (8.3) AN ECOLOGICAL FRAMEWORK FOR UNDERSTANDING THE SMOKING CULTURE: ............................................................... 363
  (8.4) DEVELOPING A THEORY OF SMOKING AND MENTAL ILLNESS: ................................. 365
    (8.4.1) Attitudes and Values: .................................................................................................. 365
    (8.4.2) Organisational Culture and Group Dynamics: ......................................................... 366
    (8.4.3) Power Relationships: ............................................................................................... 368
    (8.4.4) The Physical and Social Environment in which the System Exists: ....................... 369
  (8.5) CONCLUSION: .................................................................................................................. 369

CHAPTER NINE: CONCLUSIONS........................................................................................................ 371
  (9.1) INTRODUCTION: ................................................................................................................. 371
  (9.2) GENERAL CONCLUSIONS AND IMPLICATIONS: ............................................................... 372
    (9.2.1) Poverty: ......................................................................................................................... 372
    (9.2.2) Existential Despair: ...................................................................................................... 372
    (9.2.3) Impoverished Learning Environments: ....................................................................... 373
    (9.2.4) Clinical Use of Smoking: ............................................................................................. 373
    (9.2.5) A Culture of Smoking: ................................................................................................. 373
    (9.2.6) Nicotine Withdrawal: ................................................................................................... 374
    (9.2.7) Mentally Ill Clients Can Quit: ...................................................................................... 374
    (9.2.8) A Community Response is Needed: ............................................................................ 375
    (9.2.9) Conflict Between Staff and Clients: ............................................................................ 375
    (9.2.10) Occupational Health, Safety and Welfare Issues: .................................................. 377
    (9.2.11) Moving Forward: ....................................................................................................... 378
  (9.3) CONCLUSION: ..................................................................................................................... 379
  (9.4) VALIDITY, RELIABILITY & LIMITATIONS OF THE RESEARCH FINDINGS: ............... 379
  (9.5) ETHICAL CONCERNS: ......................................................................................................... 382
  (9.6) IMPLICATIONS FOR FURTHER RESEARCH: ....................................................................... 385

GLOSSARY: ....................................................................................................................................... 387

APPENDICES: ................................................................................................................................... 390
  Appendix A: ................................................................................................................................. 391
  Interview Guide: Successful Client Quitters: ............................................................................... 391
  Appendix B: ................................................................................................................................... 392
ABSTRACT:

Despite a vast body of research on smoking, quit rates for people with a concurrent mental illness remain extremely low. Research has established that these groups smoke more heavily, for more years and in greater proportions than the general population - up to 90% compared with 25% respectively. This thesis reports on the findings of a study investigating the barriers to quitting among community-based and institutionalised psychiatric populations. Participants were drawn from the four diagnostic categories of schizophrenia, bipolar affective disorder, major depression and borderline personality disorder. Interviews were performed with smokers from each diagnostic group as well as with clients who had successfully quit smoking. Multi-disciplinary staff from community and inpatient mental health services were also interviewed. Participant observation of inpatient settings and community hostels completed the triangulation of method.

The findings suggest that there are significant barriers to quitting for clients and staff as a consequence of a culture that reinforces smoking. Once a person is socialized into the culture, quitting is most unlikely. Among the most important systemic factors reinforcing smoking are the use of cigarettes to help manage psychosis and other symptoms of mental illness, to cope with feelings of helplessness, stigma and despair and the use of smoking to control client behaviour. The use of cigarettes in facilitating and regulating staff-client interactions was found to be significant, as was the extent of smoking by staff in response to the dynamics of the settings. The historical context for current clinical practices within mental health settings are explored. From a sociological viewpoint, then, smoking is a necessary addiction.

The consequences of this finding for clients and staff are explored. Among the conclusions drawn are recommendations regarding the management of smoking within mental health settings that address the needs of clients and staff and provide support for the complex change processes that are required. Ethical, administrative and medico-legal liability problems are identified and suggestions for further research are proffered. Finally, the thesis considers the implications of these findings for understanding the role of smoking behaviour in institutions generally.
Declaration:

“I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another except where due reference is made in the text.”

______________________________
Sharon Lawn
Declaration:

I believe that this thesis is properly presented, conforms to the specifications for the thesis and is of sufficient standard to be, Prima facie, worthy of examination.

__________________________

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Declaration:

I believe that this thesis is properly presented, conforms to the specifications for the thesis and is of sufficient standard to be, Prima facie, worthy of examination.

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ACKNOWLEDGEMENTS:

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LIST OF TABLES:

Table 4.1: Characteristics of Client Participants who are Successful Quitters of Smoking. 102

Table 5.1: Characteristics of Client Participants’ Smoking Behaviours 119

Table 5.2: Characteristics of Participants with a Diagnosis of Schizophrenia 120

Table 5.3: Characteristics of Participants with a Diagnosis of Bipolar Affective Disorder 141

Table 5.4: Characteristics of Participants with a Diagnosis of Major Depression 166

Table 5.5: Characteristics of Participants with a Diagnosis of Borderline Personality Disorder 198

Table 5.6: Summary of Themes from the Diagnostic Groups 222

Table 5.7: Triangulation Phase One: Summary Themes from Clients Who Smoke 234

Table 6.1: Profession and Setting 237

Table 6.2: Profession and Location 235

Table 6.3: Staff Smoking and Professional Characteristics: Inpatient and Community Staff 237

Table 6.4: Characteristics of Inpatient Staff 237

Table 6.5: Characteristics of Community Staff 237

Table 6.6: Triangulation Phase Two: Summary Themes from Inpatient and Community Staff Interviews 297

Table 7.1: Number of Visits Performed in Mental Health Settings 302

Table 7.2: Locked Ward Nursing Staff Attribution of Smoking: Smoking Pattern 323

Table 7.3: Locked Ward Nursing Staff Attribution of Smoking: Nursing Care 323
Table 7.4: Locked Ward Nursing Staff Attribution of Smoking: Work Related Stress
Table 7.5: Open Ward Nursing Staff Attribution of Smoking: Smoking Pattern
Table 7.6: Open Ward Nursing Staff Attribution of Smoking: Nursing Care
Table 7.7: Open Ward Nursing Staff Attribution of Smoking: Work Related Stress
Table 7.8: Comparison of Smoking Attribution for Locked and Open Ward Nurses
Table 7.9: Observations of Smoking for the Acute Open Ward Smoking Area
Table 7.10: Observations of Smoking for the Extended Care Open Wards Smoking Area
Table 7.11: Observations of Smoking for the Extended Care Open Wards Separation of Long-stay and Rehabilitation Wards
Table 7.12: Observations from the Locked Wards Smoking Areas
Table 7.13: Observations from the Locked Wards Separation of Acute and Extended Care Locked Wards
Table 7.14: Observations from the Hostels’ Smoking Areas
Table 7.15: Observations from the Hostels Separation of Hostel One and Hostel Two
Table 7.16: Percentage of Clients in the Smoking Area According to the Total Number of the Group in the Smoking Area and The Setting
Table 7.17: Percentage of Smokers in the Group According to the Total Number of the Group and The Setting
Table 7.18: Percentage of Passive Smokers According to the Total Number of the Group and The Setting
Table 7.19: Cigarettes Smoked Compared to the Number of Smokers and The Settings
Table 7.20: Morning and Afternoon Smoking in the Acute Open Ward 341
Table 7.21: Morning and Afternoon Smoking in the Extended Care Open Ward 342
Table 7.22: Morning and Afternoon Smoking in the Community Hostels 342
Table 7.23: Summary Themes from Participant Observation of the Settings 356
Table 8.1: Systematic Integration of the Triangulated Data – Stage One 355

LIST OF FIGURES:

Figure 2.1: The Path to Drug Dependence – A WHO Definition 33
Figure 3.1: Representation of Systematic Integrational Analysis of the Triangulated Data 98
Figure 3.2: Representation of Points of Commonality and Difference 98
Figure 3.3: Representation of Bronfenbrenner's Ecological Framework 100
Figure 7.1: Clients in the Group as a Percentage of the Total Group 336
Figure 7.2: Staff in the Group as a Percentage of the Total Group 336
Figure 7.3: Percentage of Smokers in the Group for the Settings 337
Figure 7.4: Passive Smokers as a Percentage of the Total Group 339
Figure 8.1: Points of Commonality and Difference – Stage Two 356
Figure 8.2: An Ecological Framework Applied to the Culture of Smoking - Stage Three 364
Figure 9.1: Pathways to Assault in a Locked Ward 376
CHAPTER ONE - OVERVIEW

(1.1) INTRODUCTION:

The thesis reports qualitative, exploratory research undertaken by the researcher while employed as a social worker at a community mental health service in the southern area of Adelaide, South Australia. The smoking behaviours of community public mental health service clients are explored as these relate to their mental illness as well as their beliefs and attitudes to quitting smoking. The system of care in which smoking behaviours by clients and staff occurs is also explored. The implications of findings for more effective smoking intervention programs for mental health service clients are considered.

This chapter describes the problem and its significance, the rationale and underlying assumptions of the study. The structure, aims and objectives of the study are presented. A brief description of the research design and the structure of the thesis is given.

A review and discussion of the existing related literature from the various professional fields of understanding and expertise is provided in Chapter Two. Central to this review is the evolution of our current bio-psycho-social model of addictive behaviour. This is followed by a more focused review of research on smoking and mental illness. The absence of a clear understanding of the role played by existential variables as these interact with mental illness to influence smokers’ lifestyle choices is of particular interest here. The Grounded Theory and ethnographic methodologies involved with participant observation of the mental health service settings are described and explored further in Chapter Three. Chapter Three also includes a detailed outline of and justification for the particular triangulation method used for this study. An explanation of the audit process used for each of the three phases of data collection and analysis also occurs in Chapter Three.

Chapter Four reports the results from the pilot study performed with identified successful quitters with a current mental illness. Preliminary themes are identified and these results are used to inform further data collection, including those about the potential barriers to quitting for smokers with a mental illness. Chapters Five, Six, and Seven in turn present the results of client and staff interviews and participant observations of the settings. Results from the thematic analysis of interviews with each of the four diagnostic groups of current smokers are described. A brief comparative discussion outlines differences between the diagnostic groups as derived from interviews with client participants who
smoke. Results of the thematic analysis of interviews with mental health service staff from the community and hospital setting are described and common themes for both these analyses are outlined in the relevant chapters.

In Chapter Eight the results from Chapters Four, Five, Six and Seven are then summarised and brought together, representing the core data set from each component of the research. A systematic integrational analysis of the triangulated data is defined prior to the secondary analysis of the data. The sociological framework of culture is applied to the triangulated data set, detailing its influence on the smoking behaviours of people suffering from mental illness and the role of mental health service staff and the settings. Bronfenbrenner’s Ecological Framework is applied. Several theories are reflected upon with regard to the framework of culture and integrated into a new understanding that more fully reflects the complexity of smoking behaviours and their determinants for people with a mental illness in these settings.

Final interpretation of results, implications and general conclusions are drawn in Chapter Nine. The limitations of this study are examined. The ethical considerations are identified and discussed. Finally, suggestions for further research are made.

(1.2) PURPOSE OF THE STUDY:

This research comprised three distinct studies that were triangulated in order to provide a thorough description and understanding of the smoking behaviours of community and hospital-based psychiatric populations in the public mental health system. This was done in order to identify barriers to quitting and develop more effective interventions for these groups based upon a deeper understanding of their smoking behaviours. Subjects suffering from schizophrenia, depression, bipolar affective disorder and borderline personality disorder were studied to identify similarities and differences in their smoking behaviours. Their perceptions of smoking as it related to their illness, nicotine dependence and the cultural contexts in which smoking developed and currently occurred for these groups were systematically explored. Mental health service staff who work in the community and inpatient treatment settings were interviewed to gain their perspective. Participant observation of the settings was then performed. Successful quitters with a mental illness were also interviewed in order to explore ‘the negative case’, that is, how they had succeeding in quitting despite the presence of mental illness.
These interviews also offered preliminary insights into the phenomenon of smoking, quitting and mental illness.

(1.3) STATEMENT OF THE PROBLEM:

The high incidence of smoking amongst people with a mental illness is clearly a serious public health problem. Despite the vast body of literature and research on cigarette smoking, quit rates for people with a concurrent mental illness remain extremely low. This is so even though such research has clearly established that these groups smoke more heavily, for more years and in greater proportions than the general population; up to 90% compared to 25% for the general population (Baigent, Holme, & Hafner, 1995; Watt & Hocking, 1996). This suggests that there may be barriers to quitting for smokers with a concurrent mental illness that may have been overlooked. It also suggests that current smoking cessation interventions made available by mainstream anti-smoking campaigns are not adequately addressing the health needs of people with a mental illness. The reasons for this remain unclear, indicating that there may be practical, physical and social reasons why such help does not reach or is not accessed by these groups. There may also be cultural and existential reasons to do with current understanding of the phenomenon of smoking and mental illness.

(1.4) SIGNIFICANCE, UNDERLYING ASSUMPTIONS AND RATIONALE:

Research in the area of smoking and mental illness has increased, especially within the fields of medicine, psychiatry and psychology. In spite of this, there has been a general absence of social research looking also at the social implications of smoking and mental illness. The social work profession has historically failed to be involved in such research despite the relevance that a social understanding of the problem would bring. A shift in thinking is beginning to emerge in the field, evidenced by such researchers as William Miller (1990) who has recognised that existing knowledge is not enough and that the existential meaning of dependence needs to be considered. This is echoed by Barber’s (1995a) call for greater exploration and recognition of the social origins of addiction. Quality of life, stigma, financial impacts of smoking and quality and meaning of social support networks are rarely the focus of the existing literature. The current literature does not explain why some people suffering from a mental illness succeed in quitting smoking whereas others fail, despite having similar psychiatric diagnoses, severity of symptoms and levels of nicotine dependence.
No study has yet explored similarities and differences between subjects who suffer from DSM IV defined illnesses as these relate to smoking and quitting behaviours. In this respect, this research is internationally unique. Also, basic demographic data on people with a mental illness who smoke is seriously deficient in existing research literature (Farid, Bird, & Naik, 1998).

There is growing recognition and greater understanding that conjoint treatment for people with concurrent mental illness and drug dependence is needed for both issues to be treated more effectively (Carey, 1996; Brady, Hiam, Saemann, Humbert, Fleming & Dawkins-Brickhouse, 1996; Fariello & Scheidt, 1989; Tsuang, Ho, Eckman, & Shaner, 1997). The researcher’s own experience as a key worker in mental health services has provided much anecdotal evidence that many people with a mental illness wish to quit smoking but cannot within the existing social and organisational milieux which appear to contain disincentives and barriers to quitting. As a social worker in the field, several ethical dilemmas arise with regard to seeing clients’ quality of life challenged as a consequence of their smoking. These dilemmas include: the cycle of smoking-related poverty; stigma and social exclusion; issues of fairness and equity of treatment and access to services. There are also social justice issues to do with how these groups are viewed and therefore how they have their needs defined, recognised and then met within the dominant political and social structures. Their ability to live autonomously and to recover from illness seems to bear some relationship to their smoking behaviour and its effects. Quality programmes, informed by empirical data that accurately address the specific needs of smokers with a concurrent mental illness and clearly describe their perceived barriers to quitting, are needed if a meaningful and ethical response is to be made for smokers with a concurrent mental illness who wish to quit.

Research to date has not been undertaken to describe the perspectives of smokers with a mental illness with regard to what their smoking means to them, what their illness means to them in the context of continuing smoking, trying to quit smoking and successfully quitting smoking. No thematic analysis using a qualitative methodology exists in current research for smokers with a mental illness. The actual words and descriptions of the process and the struggle of trying or wanting to quit smoking are absent from the literature. Detailed case studies describing how people with a mental illness have successfully quit smoking are likewise absent from the literature, as are the perspectives of mental health workers. Valuable insights and strategies for these populations may have been overlooked as a consequence of these gaps.
As cultural attitudes towards smoking change, those who remain smokers are increasingly likely to be people who find quitting the most difficult. One such group are these people with a mental illness and also addicted smokers. It would appear that current public health policy of providing economic incentives for quitting, via increased tobacco prices and taxes, may well be having unintended consequences for this vulnerable group in society. It may be placing them at risk from even greater poverty as a consequence of their addiction which is not specifically catered for by current quit programs. This may, in turn, affect their mental health.

The knowledge that smoking is a serious health hazard is well established (US Department of Health and Human Services, 1988). Links between smoking and mental illness, in particular, the ability to quit, reasons for commencing and continuing to smoke, interactions with medications and psychiatric symptoms are also becoming more apparent as research continues. These are reviewed in the following chapter. However, it is this researcher’s impression that existing anti-smoking campaigns may well be misinformed in assuming that interventions can be applied in the same manner to people with a mental illness as they are to the mainstream population of smokers wishing to quit. It is also this researcher’s experience that many people with a mental illness want to quit but are unable to do so.

The reasons why people with a mental illness smoke are not well understood. The greatest gap in current understanding appears to be about the personal meaning that smoking has for individuals with a mental illness. The researcher assumes that smokers with a mental illness may not be a homogeneous group, that their needs and experiences of smoking and trying to quit may be different. By exploring the problem, and comparing and contrasting smokers with different mental illnesses, different quitting strategies may be determined, dependent on the particular features of their illness.

(1.5) AIMS AND OBJECTIVES:

This study has a number of diverse aims and objectives. These are:

To describe the experience of smoking for people with a mental illness as it relates to their attempts to quit and to manage their mental illness.

To describe in a holistic way the phenomena of concurrent smoking and mental illness within mental health service settings.
To interpret and understand the phenomena of concurrent smoking and mental illness by looking at the person, the setting and the system, viewed through multiple theoretical lenses.

To identify barriers to quitting for smokers who suffer from a mental illness.

To contribute to research in the field of smoking and mental illness, in particular, to build on the limited self-report data currently available.

To contribute to strategies which smokers with a mental illness may be able use to assist them to quit smoking. To further contribute to strategies for health professionals and anti-smoking campaign workers, based on this understanding, that will enhance their knowledge and skills in providing support for people with a mental illness who may wish to quit smoking.

To identify focus areas for policy development with regard to cigarette smoking within mental health service settings.

(1.6) DESIGN:

A combination of open-ended interviews with clients and treatment providers was performed, followed by participant observation of smoking behaviours in the settings in which mental health service clients live and receive treatment. Using a grounded theory research design for data analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Ertmer, 1997), themes emerged from the data to propose hypotheses regarding the links between mental illness and smoking behaviours. The grounded theory approach was used because of its suitability to the exploration of the mentally ill smokers’ subjective perspectives, to investigate, “relatively uncharted waters, or to gain a fresh perspective in a familiar problem” (Stern, 1987, p.79). It also helped avoid the common pitfall of many grounded theory studies which have, as Becker (1993) argues, “addressed what was going on but the underlying how and why were absent” (p.254). A more detailed explanation of the methodology used in this study occurs in Chapter Three.

(1.7) CONCLUSION:

This chapter has given an introductory overview of the study purpose, justification, aims and objectives, design and a summary of contents of the chapters to follow.

NB. Throughout the thesis, except where otherwise stated for quantitative results, numbers represented as percentages, as decimal values, or with more than two numerals will appear in their numerical form, not their written form.
CHAPTER TWO - LITERATURE REVIEW

Tobacco is linked to more deaths than the, “total number killed by alcohol, drugs, AIDS, murder, suicide, road crashes, rail crashes, air crashes, poisoning, drowning, fires, falls, lightning, electrocutions, snakes, spiders and sharks”.

This statement was part of evidence provided by the Australian Council on Smoking and Health (ACOSH) to the Senate Committee of the Australian Parliament looking at the tobacco industry and the costs of tobacco related illness (Australian Parliament, 1995, p.1).

(2.1) INTRODUCTION:

This chapter reviews the literature on cigarette smoking as a public health problem and the current understandings and intervention methods used to assist people to quit. It includes a discussion of theories of dependence, change and relapse and the role of smoking as a learned behaviour. Much of the research available applies to the general population. This is followed by a more specific review of the literature on smoking among psychiatric populations. This incorporates a review of smoking in psychiatric settings, the effects of smoking bans, the role of institutional arrangements and culture.

(2.2) SMOKING AS A PUBLIC HEALTH PROBLEM:

(2.2.1) Prevalence of Smoking and History of Smoking Behaviour:

In Australia, according to the National Drug Strategy Household Survey of 1998, approximately 27.7% of men and 28.3% of women fourteen years and over smoked regularly, smoking twenty or more cigarettes per day. The highest rate of smoking was found to occur in the 20-29 years age group, with 33% or men and 31% of women reported being regular smokers (Australian Institute of Health & Welfare, 2000). Smoking is more prevalent among blue collar workers and the unemployed than white collar workers and more prevalent for those with lower levels of education (Winstanley, et al., 1995; Hill, White, & Scollo, 1998). Rates of smoking for Indigenous Australians are high; 53.6% for men and 45.8% for women (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 1997). The prevalence of smoking for people with mental illness has not been determined, although it is believed to be among the highest for any group of smokers. Known statistics will be reported in the
latter part of this review. It is estimated that more than 80% of smokers express the desire to quit, with
35% who try to stop smoking each year and only 5% who are successful (American Psychiatric
Association, 1994). A recent review of studies concluded that almost 90% of smokers who quit
eventually relapse, especially in the first month with about half of these in the first three days (Ockene,
et al., 2000). Smokers, regardless of their mental health status, clearly have difficulty in quitting.

(2.2.2) Smoking Related Morbidity as a Public Health Concern:

Links between smoking and cancer of the lung were first confirmed by Doll and Hill (1950; see also
1964). Since then, the evidence for smoking as a serious public health concern has been growing. In its
opening address, The National Tobacco Strategy 1999 to 2002-03 describes tobacco smoking as, “the
single largest preventable cause of premature death and disease in Australia” (The National Tobacco
Strategy, Background Paper, 1999, p.1). Tobacco smoking accounts for 3-5 million deaths worldwide
each year, with this figure predicted to reach ten million per year in the decade 2020-2030. Seventy
percent of these deaths are expected to occur in the developing countries (World Health Organisation,
1998). Each year, approximately 22,500 Australians die from drug-related causes. Of these, 18 600 or
approximately 80% are directly related to tobacco smoking (Single & Rohl, 1997, Higgins, Cooper-
Stanbury & Williams, 2000; Commonwealth Dept of Health & Aged Care, 1999). More recent research
suggests that this figure is underestimated (Ridolpho & Stevenson, 2001). Globally, tobacco is the
leading risk factor for disease burden, accounting for 10% of the total burden when mortality,
disability, impairment, illness and injury are quantified (Lopez, 2000). In the United States, yearly
mortality from smoking is estimated at 430,000, with 40,000–67,000 of these who die as a result of
environmental tobacco smoke or passive smoking (Houston & Kaufman, 2000). Estimates for Australia
are not known, although the hazards of passive smoking have been confirmed (Byrd, Shapiro &
Scheidermayer, 1989; National Health and Medical Research Council, 1997; Office of Environmental
Health Hazard Assessment, 1997; The Cancer Council Australia, 2001).

The Royal College of Physicians of London published the first major authoritative report on smoking
and health in 1962, being the forerunner to many other major reports, such as that of the U. S. Surgeon
General in 1964. Since that time, the links between smoking and disease have been well established,
with more than 57,000 scientific articles published on the subject (Australian Parliament, 1995). Both
the Royal College of Physicians of London and the U. S. Surgeon General have been responsible for

The rate of smoking has been shown to correlate positively with the likely development of a number of cancers. This involves a dose-response relationship with heavier smoking presenting more risks for the smoker (US Department of Health and Human Services, 1989). Statistics from 1997 confirm that 20% of all deaths from cancer in Australia were caused by smoking (Australian Institute of Health and Welfare & Australasian Association of Cancer Registries, 2000). The poverty of data on the physical health status of mental health populations is noted. The few available studies will be discussed later.

(2.2.3) The Duplicity of Industry and Complicity of Governments:

Evidence has also emerged indicating that tobacco companies in the United Kingdom and the United States have known of these health risks of tobacco use and of the addictiveness of nicotine for more than thirty years (Glantz, et al., 1995). Despite this knowledge about the harmful effects of tobacco, Orford (1985) argues that, “acceptance has been so great, the licit involvement of governments and commerce so strong, and until very recently the dangers of the drug so ignored, that tobacco has scarcely been recognised as a ‘drug’ at all” (p.55). As a demonstration of this lack of commitment by governments, Chapman (2000) compiled figures on recent Australian federal government budget commitments to major public health programs and compared these with deaths from associated causes for the years 1994 to 2003. AIDS control received an average commitment of $49.5 million per year, this being $264 706 committed per death from AIDS. The Black-spot road safety program received an average commitment of $38.1 million per year, this being $419, 619 committed per death from road accidents. The National Tobacco Campaign 1999-2003 has received a commitment of $2 million per year, this being $112 committed per death from smoking. Figures for other public health concerns are also noted (Chapman, 2000). Tobacco companies have continued to lobby government on economic grounds, arguing that governments risk huge legal costs and massive job losses for workers if they curtail the tobacco industry in Australia (Philip Morris, 2000). Of relevance here is the apparent imbalance in funding for different public health problems, arguably dependent on their political popularity and the ethics of continuing to ignore this inequity for smokers with mental illness. Mental illness accounts for 20% of disease burden in Australia, however, national expenditure for mental health represents only 5% of the total expenditure on health (Andrews, Hall, Teesson & Henderson,
There appear for inequities in both policy areas, tobacco control and mental health. Smokers with a mental illness may therefore be doubly vulnerable.

(2.2.4) Smoking and Litigation:

Tobacco is a legal substance and smoking is not an illegal activity. However, there are agreed restrictions on its use, for example, the sale of tobacco to minors (those under 18 years) is deemed an offence in Australia and there are widespread bans on its use on public transport and in public places. The Occupational, Health, Welfare and Safety Act of 1986 has led to widespread smoking restrictions and bans in the workplace. The Morley Decision of 1991 furthered this requirement, with several cases successfully tested in the Australian court system since that time (Winstanley, et al., 1995).

The tobacco industry continues to defend itself by saying that tobacco is a legal product and, therefore, that people have a right to smoke. Chapman, Borland, Hill, Owen & Woodward (1990) have suggested that powerful groups with financially vested interests have backed the ‘right’ to smoke. However, the growing number of successful claims by individuals and groups and the growing amount of evidence indicating the harms of smoking suggest that this view is no longer tenable (Cohen, 1999: Roston, 2000).

No studies exist looking at the legal aspects of smoking in psychiatric settings. Therefore, drawing from studies that look at the prison system, which has similar institutional arrangements, is warranted. Biggins and Wares (1993) argue that the dilemma of smoking in prisons is due to the fact that they are, “the workplace of some people and the living space of other” (p.327). Therefore, dilemmas exist in balancing rights and interests that exist for both parties, especially where they exist in conflict with each other. Appelbaum (1995) has looked at the issue of the patients’ right to smoke.

(2.2.5) Economic Elasticity and Smoking Behaviour:

Chapman (2000) calls for increased tobacco control arguing that those who see tobacco as a legitimate product and tobacco control as jeopardising the financial benefits gained through tobacco excise are ill-informed regarding its social costs and the ethics of continuing to support its revenue-raising role. A number of researchers have found that the price and demand relationship of some commodities is not very elastic, that is, raising taxes on them leads to reduced demand for those commodities. The poor
have been found to quit smoking more in response to price rises than those with higher disposable incomes (Chapman, 1995a; Townsend, Roderick & Cooper, 1994; Wasserman, Manning, Newhouse & Winkler, 1991). A recent global report by the World Bank (Jha & Chaloupka, 1999) found that raising taxes on tobacco by 10% would lead to a 4% reduction in demand for cigarettes in high income countries and an 8% reduction in demand in low income countries. In a review of thirty-five years of policy on tobacco consumption, Bardsley and Olekalns (1999) argued that increasing the price of cigarettes has had the greatest impact on consumption declining, with education and reduced advertising having minimal effects. However, their conclusions are strongly challenged by other researchers on methodological grounds (Chapman, 1999; Borland, 1999). Raising taxes is clearly effective in reducing consumption and is also thought to discourage children and adolescents from commencing smoking, although some researchers have raised questions about the efficacy of this approach with adolescents (Doran, Girgis & Sanson-Fisher, 1998). Unfortunately, where government taxes on tobacco have increased, research has found that government revenue from those taxes has also been disproportionately high. That is, the expected decline in consumption from the act of raising taxes has not occurred. Increased revenue from increased taxes has been found to be disproportionately more, suggesting that some smokers are slow to respond to price rises. Their smoking behaviour has remained elastic, despite price rises. Smokers with a mental illness may fit this description. The World Bank report (Jha & Chaloupka, 1999) also raises the concern that increasing taxes will encourage the proliferation of black market tobacco. From the researcher’s experience in the field ‘chop chop’, or black market tobacco, is increasingly being bought as a cheaper option by community mental health clients. The World Bank report also expresses concern that increasing taxes on tobacco will have a disproportionate impact on poor consumers because taxes consume a higher share of their income than rich consumers. It further suggests that the loss of perceived benefits of smoking to lower income smokers may be comparatively greater than for higher income smokers.

(2.2.6) Economic Costs of Smoking:

A number of researchers have attempted to quantify the costs and benefits of tobacco smoking to the Australian Community. A report by ACIL Economics and Policy (1994), an independent body funded by the Tobacco Institute of Australia, concluded that smokers, “more than pay their way in the community,” by providing $12.5 billion net benefits; that they subsidise our health care services and are taxed over and above any costs to the community. In 1995, the Australian Federal Government
collected $3.8 billion in sales and excise taxes for alcohol and tobacco, however, only $36 million of this was spent on programmes to decrease use. In South Australia, for the same year, only five per cent of revenue raised was returned to treatment programmes, with similar figures for other states (Meade, 1995). Collins and Lapsley (1996) conducted Commonwealth funded studies in 1988 and 1992 looking at the economic and social costs of smoking to the Australian community. Tangible costs to the smoker, other individuals, to business and to government such as costs of medical treatment, loss of productivity and work days, were quantified. Direct health care costs to the Australian community were estimated to be $833 million. Costs of passive smoking and reduced productivity were not included. Intangible costs such as loss of enjoyment of consumption forgone and the value of loss of life to the deceased were also not quantified. Pain and suffering caused to the individual, family and friends and loss of enjoyment of life were not included. The total for tangible and intangible costs of smoking for 1992 was $12,736.2 million (Collins & Lapsley, 1996). The net total of government revenue from the sale of tobacco in 1991-2 was $2,473.9 million. In 1997-8 this figure was estimated to be $4,231.6 million (Higgins, et al., 2000, p.12). In 1996-7 the total number of hospital episodes attributable to drug use was 256,991, with 149,834 or approximately 60% being due to tobacco (Higgins, et al., 2000). This suggests that smoking involves substantial costs for the smoker and the community and that these costs outweigh the benefits of revenue received from tobacco sales.

Smoking is an expensive habit. The social implications of this expensive habit for people on limited incomes are recognised (McCreadie & Kelly, 2000). Some have questioned whether people with mental illness who are chemically dependent should be allowed to spend their funds as they choose, without supervision, or to receive government payments at all. In the U.S., specific restrictions on pension eligibility exist where the person is dependent on substances. Time restrictions on pension payments and the obligation to seek treatment are part of these conditions (Rosenheck, 1997). Research has found that controlling the supply of pension funds to people with substance dependence does not necessarily alter their desire for substances, although it may assist in imposing some control and thereby improving treatment effectiveness, quality of life (Rosenheck, Lam & Randolph, 1997) and compliance with treatment (Shaner, et al., 1997).

Clearly, the human costs of smoking for the individual and the community are substantial. Of relevance here is the identification of who bears that cost, how disproportionate that cost is and how the community and society respond to this. Raising the cost of cigarettes to depress the demand for them
has been shown to induce some smokers to quit or cut down their consumption, and to prevent others from commencing smoking (Jha & Chaloupka, 1999; Centers for Disease Control and Prevention, 2000). A Canadian study looking at disadvantage and low quit rates found that peoples’ immediate circumstances were overwhelming motivators to continue smoking as a mechanism for coping with those circumstances, regardless of long-term goals for better health and financial stability (Stewart, Brosky, et al., 1996; Stewart, Gillis, et al., 1996). With this in mind, the impact of price rises on the smoking behaviours of people with mental illness has not been studied and, therefore, price increases as sufficient motivators for change cannot be assumed for this group.

(2.2.7) Why People Smoke:

The experiences of non-mentally ill smokers, regarding their decision to smoke and their attempts to quit, have been well documented (see for example: Bott, Kuckelman Cobb, Scheibmeir & O’Connor, 1997; Marlatt & Gordon, 1985; Prochaska & DiClemente, 1982, 1984). However, a recent qualitative study of Australian smokers from the general population (Carter, Borland & Chapman, 2001) confirmed that there is little information about cultural and socio-economic influences on smoking and quitting in Australia. These researchers found significant social, emotional and temporal roles of smoking. These roles included cigarettes as a friend, smoking for relief of boredom and as an activity between tasks and paired with other activities. They concede that qualitative and quantitative research is needed to address the gap in knowledge about specific groups within the general population. Smokers with a mental illness do appear to smoke for many of the same reasons as smokers without a mental illness, that is, to relieve boredom and stress, as a companion and to alleviate depressed mood (Addington & Duchak, 1997; Bellack & DiClemente, 1999). They also smoke for sedation and to induce pleasurable effects and to relieve anhedonia (Carton, Jouvent & Widlocher, 1994; Muesler, Nishith, Tracy, DeGirolamo & Molinar, 1995). The self-medicating and pharmacological aspects of smoking for people with a mental illness are also now understood more clearly (Adler, et al., 1993). In particularly, the role of smoking in reducing the side effects of neuroleptic medications and relieving positive and negative symptoms of schizophrenia is established (Forchuk, Norman, Malla, Vos & Martin, 1997). However, there appear to be differences in the degree to which these aspects are important for people with a mental illness, related to their illness and social context. Smoking for companionship and cigarettes as friends are examples that will be explored further in the results and
discussion section. The current research articulates some of these influences on people in mental health settings.

(2.3) THEORIES OF DRUG DEPENDENCE:

(2.3.1) History:

The public and political responses to drug use in general have varied over time, swinging between moral, social learning and disease conceptions of this behaviour. The focus of intervention has, at different times, shifted from the person to the drug to the person, with drug use being perceived as either sinful and prohibited or as an illness and treated as a disease according to the public culture of the day (Barber, 1995a; Orford, 1985; Jarvik, 1970; Russell, 1971; Jaffe, 1977; Van Lanker, 1977). The moral model of addiction sees the person’s sin and weakness as the cause of their current predicament. It follows then that, “anyone can do well if only [he or she] tries. All one needs is willpower and the desire to do good” (Drew, 1987b, p.48). The disease model of addiction holds that the person is unable to exert control over their drug use due to physiological and genetic predisposing factors. It absolves the person from accepting personal responsibility for his or her condition but paradoxically requires the person to abstain from use, therefore implying that control is possible (Marlatt & Gordon, 1985). These models may not be mutually exclusive. Modern treatments have arguably been influenced and driven by both concepts with the language used being similar (see Davies, 1979; Orford, 1986). One way past this dilemma is offered by the compensatory model in which, “people are seen as not responsible for the problem but responsible for solutions” (Brickman, et al., 1982, p.14). Marlatt and Gordon’s (1985) relapse prevention model, based on social learning principles, similarly asks for participation and responsibility without blaming the individual.

(2.3.2) The Pharmacology of Smoking:

Nicotine has been identified as the addictive component of tobacco (US Dept of Health and Human Services, 1988). It is one of approximately 4000 chemicals found to be present in tobacco, many which are poisonous, including several known carcinogens (US Dept of Health and Human Services, 1989). Unlike patterns of consumption for other drugs, most people who smoke are addicted to nicotine, with only 11% of smokers who do not smoke daily (Borland, 1994). Nicotine has a number of pharmacological properties that act on the smoker during the process of smoking and as a result of
withdrawal from the drug. It is a psychoactive drug causing chemical or biological changes in the brain, taking only eight to ten seconds to reach the brain (US Dept of Health and Human Resources, 1988). Nicotine has biphasic effects, acting as a stimulant when low doses are consumed, stimulating the sympathetic nervous system and increasing heart rate and blood pressure. In high doses, it acts as a relaxant (Pollin, 1982; US Dept of Health and Human Services, 1988; Winstanley, et al., 1995). Hence, its pharmacological properties have the capacity to interact in complex ways with psychological and social aspects of smoking behaviour. Another major component of tobacco, carbon monoxide, is produced by the incomplete combustion of the tobacco as it burns at relatively low temperature. Its main effect is to impair the transportation of oxygen in the blood because it binds preferentially with haemoglobin, thereby reducing the effective quantity of oxygenated blood. It therefore impairs the supply of oxygen to organs and tissues (US Dept of Health and Human Services, 1984).

Decreased levels of dopamine release in the brain are understood to be one of the factors responsible for the negative symptoms of schizophrenia, such as amotivation and emotional blunting. Nicotine is understood to improve the level of certain brain activities by increasing the activity of neurotransmitters such as dopamine (Lohr & Flynn, 1992). Problems with maintenance of attention and selective processing of sensory information, otherwise known as sensory gating, have been studied by Adler et al. (1993). Smoking has been shown to give transient improvement in this process (1993). This is discussed further in this chapter with regard to people suffering from schizophrenia.

Smoking also increases the metabolism of a number of medications prescribed for the treatment of mental illness. Hence, it appears to act to relieve the parkinsonian side effects of a number of anti-psychotic medications. Conversely, higher doses of anti-psychotic medications are often required because of enzyme induction causing the increased rate of metabolism of neuroleptic medications (Schein, 1995). These are frequently used to effectively treat mentally ill smokers, making them more prone to other movement disorders such as tardive dyskinesia because their dosage has to be increased to counteract the increased metabolism (American Psychiatric Association, 1994). These aspects are also further mentioned in the section dealing with smokers with schizophrenia. There is emerging evidence that smoking also has pharmacological effects on anti-depressant medications (Carton, et al., 1994).
Highly dependent smokers have been shown to demonstrate a number of behaviours associated with pharmacological addiction, including smoking within half an hour of waking, rating the first cigarette of the day as the most important and smoking more than twenty-five cigarettes per day (Fagerstrom, 1978; Fagerstrom & Schneider, 1989). They can experience significant withdrawal symptoms when ceasing tobacco consumption. These symptoms include craving, dysphoria or depressed mood, insomnia, irritability, frustration or anger, anxiety, difficulty concentrating, restlessness, decreased heart rate and increased appetite or weight gain (American Psychiatric Association, 1994). The relationship between addiction, withdrawal symptoms and tolerance to nicotine is complex. Anxiety levels, for example, have been shown to decrease following smoking cessation (West & Hajek, 1997), despite the overwhelming belief that they increase after cessation and contribute to smoking relapse. The significance of this for mentally ill smokers and the need for accurate recognition of these symptoms by treatment providers are explored in the current study. The strength of addiction to nicotine has been determined as equal to or more powerful than addiction to other drugs such as heroin and cocaine (Lynch & Bonnie, 1994). Clearly, quitting is difficult. There may be factors that make quitting especially difficult when the person also has a mental illness.

(2.3.3) Current Definitions:

By the 1960’s it became clear that efforts to distinguish between addiction and habituation had become unworkable due to inconsistencies and ambiguities between the disease and moral explanations for excessive drug use. The World Health Organisation (1964), by example, substituted both terms with the concept of ‘dependence’ (1964). It defined drug dependence using the following criteria:

- Highly controlled or compulsive patterns of drug-taking occur;
- The drug is mood altering or psychoactive;
- The drug functions as a reinforcer, directly strengthening behaviour that leads to further drug use;
- Stereotypical patterns of use are evident;
- There is use despite harmful effects;
- Tolerance leads to increased use; and
- Withdrawal is experienced by the user, that is, they return to use to alleviate symptoms,

(WHO, 1964; Davis, 1996).
The current definition of drug dependence, as per the WHO International Classification of Diseases (ICD-10), describes it as a cluster of behavioural, cognitive and physiological phenomena involving three or more of the following:

- A strong desire or sense of compulsion to take the substance;
- Impaired capacity to control substance-taking behaviour…or by a persistent desire or unsuccessful efforts to reduce or control substance use;
- A physiological withdrawal state. For tobacco withdrawal, any two of the following signs are present – craving for tobacco, malaise or weakness, anxiety, dysphoric mood, irritability or restlessness, insomnia, increased appetite, increased cough, mouth ulceration, difficulty in concentrating;
- Evidence of tolerance to the effects of the substance;
- Preoccupation with substance use; and
- Persistent substance use despite clear evidence of harmful consequences,

(WHO, 1996).

In 1981 the World Health Organisation developed a model of drug dependence that incorporated the moral and disease model as well as learning and existential models of drug dependence. This model is given in Figure 2.1. It outlines antecedents to drug use within the social realm and the individual realm of the person, both distal and immediate, involved in the path to drug use. It further outlines the aversive and reinforcing consequences of that use leading to drug dependence, involving tolerance and withdrawal symptoms.
Figure 2.1: The Path to Drug Dependence – A WHO Definition

(World Health Organisation, 1981)
The common issue in research on drug dependence is “the lack of single, simple and scientifically satisfying model of etiology” (Miller, 1980). Davis (1996) states that, “physical symptoms are not the sole basis of dependence; it is only when they are set in the context of psychological and social factors that the full meaning of dependence can be appreciated” (p.8). Drug dependence is therefore recognised as a problem involving biological, psychological and social pressures. Orford (1985) identifies a crucial point which serves to challenge and caution the reader in accepting the application of a single theory of dependence to all smokers. He notes that appetitive behaviour, “can serve many different functions for different people and in addition it can serve different functions for a single individual” (p.135). Lichtenstein and Brown (1980) have highlighted several practical factors that serve to maintain the tenacity of the smoking habit. These include:

- The pharmacological action of nicotine on the brain;
- “No other substance can provide so many kinds of rewards, is so readily and cheaply available and can be used in so many settings and situations”;
- The negative consequences are “delayed and probabilistic”;
- The sheer number of trials is important in maintaining the habit; “each puff is an occasion for experiencing one or more of the rewards”, as noted above; and
- The environment, through advertising, has served to model and encourage smoking (1980, pp.172-173).

Genetic and environmental factors have been proposed as significant reasons for smoking initiation and reinforcement to continue smoking (Kendler, et al., 1993; Noble, et al., 1994; True, et al., 1997). Familial factors regarding the maintenance of smoking behaviour and reinforcement of dependence have also been proposed (Heath & Martin, 1993). Smoking as an anticipatory rite of passage into adulthood is also proposed (Robb, 1986). In addition, recent research (Jarratt, 2000) has also suggested that there may be gender differences in response to nicotine and that these need to be considered in cessation attempts. Based on the use of either nicotine or placebo inhalers with thirty-two non-smoking university students, that research concluded that nicotine tends to calm women and provoke men.

(2.3.4) Recent Progress with Theories of Physical Dependence:

Smoking causes significant pharmacological and psychological dependence with continued use, nicotine being the pharmacologically addictive agent. Withdrawal symptoms vary in severity from
individual to individual. They include lower pulse and blood pressure, sleep disturbance, slower reactions, constipation, tension, irritability, restlessness, depression, weight gain and difficulty with concentration; some of these symptoms persisting for several months after cessation of smoking. The reasons for this are unclear. Pharmacological research has been directed towards looking at the reward centres of the brain, the limbic system, chemical interactions with other substances, identifying particular receptors and genetic susceptibility. Much energy has been given to testing pharmacological agents that alter the neurotransmitter system of the brain, especially the mesolimbic dopamine system (see Litten and Allen (1999) for a more detailed review the current progress in research in this area).

(2.3.5) Psychological Theories of Dependence:

Much psychological research has been undertaken to determine why people smoke, the process of quitting and smoking relapse (Ashton & Golding, 1989; Carmody, 1989; Carton, et al., 1994; Eysenck, 1965, 1980, 1991; Gale & Ney, 1989; Gilbert & Wesler, 1989; Glynn & Sussman, 1990; Hunt & Matarazzo, 1970; Ikard & Tomkins, 1973; Killen, et al., 1997; Marlatt & Gordon, 1985; McKennell & Thomas, 1967; Miller, 1980; O’Connor, 1989; Pomerleau, 1997; Pomerleau & Pomerleau, 1989; Pomerleau, et al., 1993; Russell, Peto & Patel, 1974; Schatcher, 1973; Shiffman, 1993b; Smith, 1970; Sutton, 1989). Despite the findings of these researchers, smoking remains a significant problem to overcome for those wishing to quit. The Australian Smoking Cessation Consortium recently summarised the subjective reasons why people smoke. “Smoking gains much of its power through its association with people, places, experiences and emotions…cigarettes become an intricate part of the way in which they deal with their lives, whether it be dealing with stressful situations, having a drink with mates or relaxing after dinner. Smoking plays roles: roles related to socialisation, caring for oneself and managing the flow of time in the day” (Carter, et al., 2001, p.2).

Khantzian (1995) sees suffering as being at the heart of addictive disorders, arguing that it reflects major problems with self-regulation of the four main areas of psychological life: feelings, self-esteem, relationships and self-care. “Individuals are not apt to become drug dependent if they are more or less in touch with and able to bear and express their feelings, if they feel good about themselves, if they have reasonably healthy relationships with others, and if they have an adequate capacity for self-care. Biological or genetic susceptibility, cultural norms or oppressive social conditions further contribute to or amplify the psychological vulnerabilities” (Khantzian, 1995, p.17). In support, Anda et al. (1999)
studied the role of childhood trauma in determining the risk of becoming dependent on nicotine. They concluded that nicotine is used to alleviate the long-term emotional and psycho-biological wounds of adverse childhood experiences, set in the context of poor parenting and consequent low self-esteem (see also Renolds & Frank, 2000; Anda, et al., 2000). Some researchers have suggested that low self-esteem does not adequately account for the perceived inability of some smokers to quit, that more complex factors must be considered (Renolds & Frank, 2000; Norman, Conner & Bell, 1999).

Orford (1985) devised a theory of restraint as part of a psychological explanation for dependence, or what he refers to as ‘excessive appetites.’ He included drinking, gambling, drug-taking, eating and sexuality in this definition. Conflict, loss, ambivalence and social reaction associated with the excess are at the centre of understanding this view (see also Orford, 1986). Strongly influenced by the work of Janis and Mann (1977), Orford (1985) proposed that, to understand excessive behaviour, the balance between inclination and restraint must be understood. This is seen to have multiple origins and to be multifaceted, subject to individual differences in experience and interpretations. It is also seen as highly variable and unpredictable. “Increased costs may make for more effective restraint, but instead, or in addition, may serve to increase the functional value of the appetitive behaviour” (Orford, 1985, p.210). Extreme costs leading to lack of restraint may pose further problems because they, “may deprive the individual of the very social supports and resources which constituted the main sources of pre-existing restraint upon further excess” (Orford, 1985, pp.210-211). Support for this argument can be found in Tober’s (1991) work on precontemplators. She argued that the direction of change is not necessarily predicated on the amount of suffering experienced, that is could just as readily lead to increased abuse of the drug. Tober (1991) identified two significant fallacies applied to change in addictive behaviour, the first being, “that greater suffering...will always lead to behaviour change,” and second, “that behaviour change will result only from increased suffering” (p.27). Effective restraint appears to rely on identification with the dominant culture and inclusion in it. Such a framework can readily be applied to people with a mental illness as an example of an extremely isolated and stigmatised group that may not therefore have these connections available to them. We therefore need to ask: why it is that people get to a position of believing that they have little to lose by continuing to smoke?

(2.3.6) A Dependent Personality – State or Trait?

Some researchers have looked at different types of personality to explain why some people are more susceptible to smoking dependence than others. One such example, informed by the work of Floyd
Allport in the 1930’s, found the degree of social conformity to be one of the most significant predisposing personality variables determining excessive appetite (see Jessor & Jessor, 1977). Eysenck's typological theory (1967) incorporating the three basic dimensions of personality: extroversion, neuroticism, and psychoticism, has also formed the framework for many studies looking at personality determinants of smoking. Orford (1985) argues that “[m]uch personality research has been post hoc, based upon examination of people whose appetitive behaviour has already come to notice as being excessive. This fact immediately gives rise to the most challenging question: Are we witnessing the causes of excess or its consequences?”(p.146). Smith (1970), for example, reviewed several studies’ findings on personality and smoking which confirmed that smokers were more likely to be extroverted and to have anti-social tendencies, more likely than non-smokers to think that what happens to them is due more to chance than to their own actions or skills and more likely to be impulsive and have oral cravings and habits such as nail biting and pen chewing with some evidence that their mental health is poorer. Lipkus, Barefoot, Williams & Siegler (1994) performed a twenty-year follow-up study of nearly 5000 college students enrolled at the University of North Carolina to investigate personality predictors of smoking initiation and cessation. They confirmed that indicators of impulsivity, rebelliousness, sensation-seeking, gregariousness and hostility were predictors of smoking initiation and that “people who continue to smoke were more hostile and engaged more often in sensation-seeking behaviours” (p.152). Others have also suggested that personality factors such as extroversion, rebelliousness, anti-social tendencies, risk-taking and social deviance are positively correlated with smoking (Grunberg, Winder & Wewers, 1991; Simon, Sussman, Dent, Burton, & Flay, 1995).

Waldeck and Miller (1997) looked at self-report data on caffeine, alcohol and nicotine use by 332 young adult university students and found gender differences. For women, higher impulsivity was found to correlate with higher use of nicotine but not caffeine, whereas the opposite was found to be so for men. Patton, Barnes and Murray (1997), reviewing the smoking personality typology literature, performed a more recent study with 346 Canadian smokers in which a battery of personality scales were applied. They concluded that the strength of the relationship between smoking and personality is weak and contradictory, although they suggest that a subgroup of smokers exist who are more anxious and have strong antisocial tendencies and therefore warrant further study. Diaz and Fruhauf (1991) also challenged the notion of an addictive personality, arguing that it is not a fixed phenomenon, but capable of change over time. “The more experiences of dependence, loss of control and surrender to external
sources of regulation, the more difficult it would be for an individual to exercise executive control over his or her behaviour. Actual experiences of addictive behaviours reinforce a concept of self as helpless and dependent, undermining feelings of self-efficacy and competence” (p.102; see also Martin & Otter, 1996). Their comments support the current thinking regarding dependence as a ‘state’, not a ‘trait’ (see also Miller & Rollnick, 1991).

(2.3.7) Smoking as a Learned Behaviour:

The dominant feature of the psychological literature has been the central role of Learning Theory to explain the insidious development of habitual dependent behaviour. Pavlov’s research on classical conditioning and later work by Skinner (1953), Wikler (1965) and Bandura (1977) on operant conditioning has informed much of the existing research. Skinner (1953) proposed a unidirectional, causal model that he referred to as ‘reciprocal determinism’. This model sees the environment as the ultimate determinant of behaviour (see also Wilson & O’Leary, 1980). Bandura (1977) proposed a more complex model in which antecedent and consequent external events are mediated largely by internal cognitive processes (see also Wilson & O’Leary, 1980). In this respect, the connection between stimuli and responses becomes virtually automatic through experience, usually through repeated trials. It involves diminished awareness and increasing independence from the conditions that stimulated the initial learning of the behaviour. Thus, the primary reinforcer no longer plays as significant a role in the maintenance of the behaviour. Secondary reinforcers take over (Hunt & Matarazzo, 1970). Classical conditioning processes involve the person’s ability to discriminate, by setting rules for consumption and ability to generalise. This involves the pairing of drug use with other activities such as smoking when watching television, when drinking, or when distressed and leads to “the increasing misattribution of meaning to internal psycho-physiological states. Thus, internal cues that might otherwise be interpreted as fatigue, tension, or confusion, or else not labelled at all, may be interpreted as indicating a need to [light up a smoke]” (Orford, 1985, p.190). Ultimately, as concluded by Barber, “addictive behaviours are attempts at coping, albeit maladaptive ones” (1995a, p.24).

In their review of studies to that time, Leventhal and Cleary (1980) saw emotional regulation as the key to smoking behaviour becoming a dependent behaviour. They proposed two mechanisms to explain how negative emotions came to be linked to lowered nicotine levels: the first being the opponent-process theory, earlier proposed by Solomon and Corbitt (1974), that assumes no conditioning process
or susceptible personality type. Instead, it proposes that the human brain seeks emotional homeostasis and achieves this by opponent regulatory forces acting to suppress high levels of arousal, both positive and negative (Orford, 1985; Barber, 1995a). The second mechanism is based on conditioning. “If people use smoking to control their reactions to stress, the anxiety would reappear when smoking stops and hence anxiety would be conditioned to a fall in nicotine levels” (Orford, 1985, p.203). This explains the mechanisms that integrate and sustain external stimulation cues (for example, social events and boredom) and internal stimulation cues (sensations from drops in nicotine plasma levels) and subjective emotional experience combined with automatic and motor reactions; that is, the links are conditioned and become part of the memory schema (Leventhal and Cleary, 1980). Similarly, reviewing several earlier studies, O’Connor (1989) proposed that smoking is a result of negative reinforcement, that is, people smoke to decrease negative and aggressive affect associated with nicotine withdrawal more so than to elevate mood or for pleasure.

An alternative explanation for this phenomenon can be found when considering the role of attribution theory and how people rationalise their situations. Miller and Porter (1988) define this as the principles people follow in order to seek answers to their causal questions. According to Kelley (1972) the attribution process further helps the individual comprehend their environment, promoting a sense of control over it. People tend to attribute success to internal events and failure to external events. However, in a person with low self-esteem, the tendency is to do the reverse (Miller & Porter, 1988). As a consequence, such individuals are likely to internalise self-blame for negative events and to have a diminished sense of personal control, with inappropriate guilt being preferable to a sense of randomness or chaos. This is similarly described by Seligman’s learned helplessness model (Garber & Seligman, 1980).

Eiser, Sutton and Weber (1978) found that smokers who perceived themselves to be more addicted also perceived quitting as more difficult. They were also more likely to be dissonant about their smoking and to have recently failed at attempts to quit. This is similar to a later study by Gossop, Eiser and Ward (1982) who looked at the attitudes, beliefs and expectations of sixty inpatients and forty outpatients of a London drug dependence unit. They found that those who saw their addiction as a form of sickness were least likely to remain in treatment and that outpatients were more resistant to quitting their drug use. Dependence as a moral dilemma for the person’s conscience and value system also needs to be considered, in particular, the need to restore self-respect and self-control where unresolved
dissonance is created because of the difference between actual and ideal behaviour. In reviewing the literature, Orford (1985) highlighted the work of Aronfreed (1968) who discussed the role of fear, guilt and shame as versions of aversive affective states that develop with excessive appetites. Dependence is also a subjectively experienced phenomenon in which the person is rewarded, “by the enjoyment of oral, manual and respiratory manipulations involved in the process of lighting, puffing and handling cigarettes... and the perceived diminution of unpleasant affective states of anxiety, tension, boredom, or fatigue” (Lichtenstein & Brown, 1980, p.173). This suggests that there are significant implications for people with a mental illness who experience the negative psychological and social consequences of that illness.

(2.3.8) Smoking Cessation Interventions:

A number of studies have contributed to our understanding of the psychology of drug dependence, the process of quitting and relapse to drug use. Marlatt and Gordon’s (1985) work on relapse prevention, encompassing the cycle of behaviours and responses, is regarded as highly relevant to any cessation treatment. Prochaska and Dilclemente’s (1984) transtheoretical stages of change model describes the various stages through which smokers pass in their experience of use and readiness for change. These stages include precontemplation, contemplation, preparation, action and maintenance, though Prochaska and DiClemente (1992) acknowledge that this is not necessarily a straightforward, linear process. Their model provides a readily understood description of the processes of change. Its best use is in identifying at what stage the drug-dependent person may be to target intervention appropriately, though this has been challenged more recently (Davidson, 1992, 1998; Barber, in press). One of the model’s most concerning problems is its lack of attention to precontemplators. The needs and experiences of smokers with a mental illness do not appear to be adequately described by the transtheoretical model. This will be explored later. Conversely, the work of Janis and Mann (1977) on decision-making processes and the work of Miller on motivational interviewing (Miller & Rollnick, 1991) provide useful practical steps to assist people to move from one stage to the next in the change process. Self-efficacy and coping mechanisms have been clearly identified as important to quitting success by these theorists (see also Miller, 1980; Cummings, Gordon & Marlatt, 1980; Garcia, Schmitz & Doerfler, 1990). One aspect of the decisional conflict theory of Janis and Mann (1977) is defensive avoidance, that is, “there is a strong tendency for people to withdraw from making a decision at all if all the options that are open seem to involve major ‘losses’ or ‘costs’” (Orford, 1985, p.243). Under these circumstances, continued dependence provides a major alternative to dealing with decisional
conflict and creates a vicious cycle regarding the drug use which has potential influences on other areas of the person’s life. For smokers with a mental illness, their illness symptoms and the losses and costs already inherent in this, may further complicate this process.

The efficacy of behavioural treatments, regardless of degree of pharmacological dependence, has been proven (Cipciripini, et al., 1995). However, while identifying the importance of self-efficacy and confidence levels in quitting, few researchers have asked what variables determine these different levels of self-efficacy (Brandon, Zelman & Baker, 1987; Leventhal, Baker & Brandon, 1989; Pommerleau & Pommerleau, 1989). Only by asking smokers about their perceptions and meaning of their smoking at a more complex, deeper level can we elicit this information. Others have suggested that smoking dependence is a form of ‘learned helplessness’ (Anda, et al., 1990), or given it labels such as ‘poor motivation’, ‘personality disorder’, ‘selective inattention’ and ‘defensive avoidance’ (Orford, 1986). Frustration, self-depreciation and demoralization associated with the failure to quit lead to lower positive expectations for change and lowered self-efficacy. They act as powerful obstacle to change. Therefore, the infusion of hope is seen as a critical goal of treatment. Any treatment needs to acknowledge that people rarely want to change the behaviour, only its consequences (Kanfer, 1986). It is not surprising therefore that therapist empathy has been found to be a significant predictor of outcome regardless of treatment approach (Miller & Rollnick, 1991).

The wish for greater self-control has been found to be the most significant reason for quitting smoking (Addington, el-Guebaly, Duchak & Hodgins, 1997). A recent survey found that concern for future health risk and lowered fitness were the most salient reasons for wanting to quit smoking. Cosmetic reasons such as smell and tar staining were found to be salient for women. The cost of cigarettes had some relevance for poorer smokers, and changing community values and pressure from family and friends were also important motivators to quit (Carter, et al., 2001). Research has also found that the vast majority of smokers would quit if they could do so painlessly (McKennell & Thomas, 1967; Mullins & Borland, 1996).
(2.4) SMOKING AND MENTAL ILLNESS:

(2.4.1) Introduction:

Research has clearly established that people with a mental illness smoke more heavily, for more years and in greater proportions than the general population; up to 88% compared to 25% for the general population (Goff, Henderson & Amico, 1992; Watt & Hocking, 1996). Using data from the National Survey of Mental Health and Well-being of Adults in 1997, Jorm (1999) found this association to be particularly prominent in the 18-39 year old age group. Despite the vast body of literature and research on cigarette smoking, the majority of research has concluded that quit rates for people with a concurrent mental illness continue to be extremely low (Addington, et al., 1997; Glynn & Sussman, 1990; Goff, et al., 1992; Hughes, Hatzukami, Mitchell & Dahlgren, 1986; Watt & Hocking, 1996; Ziedonis & George, 1997). Of note, Lasser et al. (2000) surveyed 4411 participants from the US National Co-Morbidity Survey and noted substantial quit rates equivalent to the non-mentally ill, even though they were found to be twice as likely to smoke in the presence co-morbid mental illness. Likewise, there is a growing literature emphasising the possibility of links between nicotine withdrawal and mental illness relapse (Glassman, 1993; Glynn & Sussman, 1990; Greeman & McClellan, 1991; Hall, Munoz, Reus, Sees, Duncan, Humfleet & Harris, 1996; Stage, Glassman & Covey, 1996).

Current smoking cessation interventions made available by mainstream anti-smoking campaigns do not appear to be adequately addressing the health needs of people with mental illness. The reasons for this remain unclear. The high incidence of smoking amongst all people with a mental illness is a concerning public health problem. In a fifteen-year follow-up of 179 patients with schizophrenia in the community, Brown, Birtwhistle, Roe and Thompson (1999) found that 22% had died, 11% from cardiovascular and respiratory diseases; this being twice the expected rate for the general population. Similarly, others have found an increased rate of heart and lung disease for people with mental illness who smoke (Mortenson & Juel, 1993). Oddly, others have found reduced lung cancer risk for smokers with schizophrenia (Gulbinal, et al., 1992). This may be related to neuroleptic induced prolactin release (Goff, et al., 1992). The presence of fewer health promoting behaviours and poorer nutrition for people with mental illness has also been proposed to help explain their greater risk of premature death (Holmberg & Kane, 1999; see also Davidson, et al., 2001). Nicotine dependence is linked to dependence on other substances such as alcohol, marijuana and caffeine (Berlin, Spreux-Varoquaux,
Said & Launay, 1997). Pharmacological links and habitual links related to pairing of activities involving consumption, as part of the dependence cycle, need further exploration.

Smoking has been associated with other drug use disorders (Kandel, et al., 1997; Miller & Gold, 1998). Smokers with schizophrenia, for example, have been found to be two to three times more likely to have another substance use disorder than smokers without a mental illness (Ziedonis, Kosten, Glazer & Frances, 1994). Overall, the view of drug dependence and psychiatric illness as diseases that may be linked remains strong, as evidenced by statements such as Minkoff’s: “They are both chronic, incurable, biological brain diseases characterized by a lack of control of thought and behaviour.” (1994, p.59) A benefit of this approach, in contrast to a completely moral view, is that people may more readily accept treatment (Orford, 1985).

(2.4.2) Co-morbid Nicotine Dependence and Mental Illness:

A review of the existing research on smoking and mental illness has found significant co-morbidity (George & Krystal, 2000). A US study of more than 50,000 white middle-aged male health professionals, biennially surveyed between 1984 and 1994, found that smoking and suicide were linked. The relative risk of suicide was found to be 4.5 times more for heavy smokers compared with non-smokers and 1.4 for former smokers. These figures remained relatively the same even after allowing for potential confounding factors such as age, body mass, mental status, level of activity, cancer history and alcohol consumption (Miller, Hemenway & Rimm, 2000). These researchers did not determine the nature of this link.

Several reasons for ongoing co-morbid nicotine dependence and mental illness have been suggested. Smokers with schizophrenia are thought to use cigarettes to self-medicate the effects of negative symptoms of their illness (Lohr & Flynn, 1992; Sandyk & Kay, 1991; Ziedonis & George, 1997). Smoking has also been reputed to have anti-depressant effects in people suffering from unipolar depression with smoking cessation attempts being causally implicated in the relapse of these people’s depression (Glassman, 1993; Worthington, et al., 1995). Research has also shown that smoking relapse is more likely in the presence of negative mood states (Shiffman, Hickcox, Paty & Gnys, 1996). Nicotine’s role in regulating a dysfunctional dopamine system, by augmenting dopamine release, has been proposed as the mechanism involved in smoking dependence for people suffering from
schizophrenia and depression (Glassman, 1993). More generally, mesolimbic dopaminergic pathway activity in the brain has been found to be especially important in mediating reward in nicotine dependence (Koob, 1992; Pontieri, Tanda, Orzi, & DiChiara, 1996). Smoking has also been shown to mitigate the side effects of neuroleptic medications that are widely used by psychiatric populations, to treat their mental illness. One such side effect, neuroleptic induced parkinsonism, has been increasingly found to be less common in smokers (Decina, et al., 1990; Goff, et al., 1992; Sandyk, 1993; Ziedonis & George, 1997). Recent biological in-vivo research with non-psychiatric populations has confirmed that smoking and the development of dependence are associated with increased dopamine activity in the basal ganglia of the brain and that smokers have special sensitivity to presynaptic dopaminergic activation by nicotine (Salokangas, et al., 2000). This is significant because dopamine activity is central to understanding the course and progress to mental illness. Nicotine and alcohol dependence are thought to be caused by a similar dopamine-related mechanism (Tiihonen, et al., 1998). A further biological study has found connections between low dopaminergic neurotransmission and detached personality, being one of the first studies to test for biological explanations and psychological traits. They further speculate that a combination of genetic factors and environmental influences on brain development during childhood and adolescence are responsible and there may be links between motivation and reward processes also for this presentation (Laakso, et al., 2000). The role of nicotine in improving cognitive function has also been proposed, although it is unclear whether nicotine has direct positive effects on cognitive function in smokers or whether it plays a role in reversing cognitive deficits (Adler, et al., 1993; Taiminen, et al., 1998). Smoking has also been proposed to have a protective effect against dementia, but this has not been confirmed in a report reviewing the evidence (Brayne, 2000).

(2.4.3) Schizophrenia and Smoking:

Schizophrenia is a mental illness characterised by two or more of the following symptoms, each present for a significant period of time during a one-month period. These symptoms are: delusions; hallucinations; disorganised speech; grossly disorganised or catatonic behaviour; and negative symptoms, that is, affective flattening, avolition, or anhedonia. For a significant period since onset of the illness, the person also experiences dysfunction in one or more of the major areas of functioning, such as work, interpersonal relations, or self-care. Symptoms persist for at least six months, with schizoaffective or mood disorders, substance abuse and general medical conditions being excluded or
ruled out as causes of the symptoms (Kaplan, Sadock & Grebb, 1994; American Psychiatric Association, 1994).

Between 74% and 92% of people with schizophrenia smoke, compared to 25% for the general population (Hughes, et al., 1986; Glynn & Sussman, 1990; Goff, et al., 1992; Leon, et al., 1995; Watt & Hocking, 1996;). Smoking rates for people suffering from schizophrenia are also higher than for people suffering other psychiatric illnesses (Ziedonis & George, 1997). McEvoy and Brown (1999) found that more than 80% of people with schizophrenia were established smokers by the time of their first episode of psychosis. They suggested that this high prevalence is therefore directly related to the illness itself and the person’s attempts to self-medicate their symptoms, and not to features of its treatment. Others have suggested that smoking may play a causal role in the onset of schizophrenia (Kelly & McCreadie, 1999). Substance abuse is generally associated with poorer overall functioning (Kovasznay, et al., 1993), increased psychotic symptoms, homelessness, violence, non-compliance with treatment and greater use of crisis services for people with schizophrenia (Dixon, 1999; Muesler, et al., 1998; Seibyl, et al., 1993; Soyka, et al., 1993). People suffering from schizophrenia who smoke also require higher doses of neuroleptic medications, generally have more hospitalisations and earlier onset of their illness and have higher Brief Psychiatric Rating Scale scores (Goff, et al., 1992; Haywood, et al., 1995; Sandyk & Kay, 1991; Ziedonis, et al., 1994). They also have increased risk of suicide (Cohen, Test & Brown, 1990; Soyka, et al., 1993).

Several theories have been proposed for the high incidence of smoking for these people. A brief review of the main theories follows:

**Smoking to Self-Medicate Mental Illness**

Some authors have suggested that smoking is used to self-medicate the negative symptoms of schizophrenia, with nicotine acting on the dopamine system of the brain to help regulate it and overcome problems with motivation, commitment and affective flattening (Sandyk & Kay, 1991; Lohr & Flynn, 1992; Glassman, 1993; Ziedonis & George, 1997). The stimulant effect of nicotine is relevant here. The positive symptoms of schizophrenia (conceptual disorganisation, delusions and hallucinations) are also reported to be influenced by nicotine action, increasing symptomatology (Ziedonis, et al., 1994). However the chemistry of this interaction is less clear (Forchuk, et al., 1997). Others have challenged the self-medication hypothesis for schizophrenia and drug use, suggesting that
a model incorporating stress, personality traits and coping is more appropriate (Blanchard, Brown, Horan & Sherwood, 2000).

**Smoking to Overcome Cognitive Deficits**

It has also been suggested that smoking is used to overcome deficits in attention, concentration, memory and cognition related to schizophrenia (Adler, et al., 1993; Addington & Duchak, 1997; Taiminen, et al., 1998). Nicotine has been shown to improve sensory gating so that smoking alleviates processing difficulties regarding sensory information in people suffering from schizophrenia. Auditory sensory gating deficits are found in more than 75% of people with schizophrenia. Adler et al. (1993) found that the auditory evoked response for people with schizophrenia is different to the general population and that these deficits are temporarily normalised by nicotine use for people with schizophrenia. In this way, nicotine stimulates the nicotinic receptors in the brain to normalise gating deficits, albeit with transient effects. If so, such deficits would make the quitting process more difficult to master, given the complex processes thought to be necessary to institute and maintain change (Bellack & DiClemente, 1999). Research has also suggested that such cognitive deficits also impair the response to information about the harms of smoking (Randolf, Goldberg & Weinberger, 1993).

**Mental Illness and Nicotine Withdrawal**

Physical withdrawal from nicotine has been shown to worsen psychiatric symptoms in smokers and to increase the potential for illness relapse (Glynn & Sussman, 1990; Greeman & McClellan, 1991; Glassman, 1992, 1993). The pharmacological interactions of nicotine with psychiatric medications and its influence on dopaminergic activity in the brain has been mentioned. The psychological aspects of learning habit replacement and the need to find new ways to relieve anxiety and boredom may also be associated with problems of withdrawal. The symptoms associated with that withdrawal, such as increased agitation, restlessness, and insomnia are also common forerunners to illness relapse and may raise the person’s fears even further. A complex web of learned responses, based on physical symptoms of withdrawal and subjective responses, may therefore guide the person’s decision to keep smoking, rather than attempt to quit. These ideas will be explored later.

**Nicotine, Cigarette Smoke and Neuroleptic Medication Interactions**

Smoking has been shown to have long term interactions with neuroleptic medications, in particular, neuroleptic induced parkinsonism has been found to be less common in smokers (Goff, et al., 1992;
Menza, Grossman, Van-Horn, Cody & Forman, 1991; Sandyk, 1993; Ziedonis & George, 1997). However, tardive dyskinesia and akathisia are more prevalent among smokers with schizophrenia due to their need to take higher doses of neuroleptic (Glassman, 1993; Hughes, et al., 1996; Yassa, Korpassy & Ally, 1987; Ziedonis & George, 1997). These relationships have already been described in the section on the pharmacology of smoking. Therefore, there may be strong pharmacological reasons for continued smoking for people with a mental illness.

Few self-report studies on smoking and schizophrenia exist (Addington, et al., 1997; Glynn & Sussman, 1990). In those that do exist, the reasons for smoking and other substance use are consistent with self-medication theory. The findings also support the social reasons for smoking by people with schizophrenia, that is, boredom relief, identity beyond that of the diagnosis, and to facilitate social connection. Addington et al. (1997), using Curry’s ‘Reasons for Quitting Scale,’ assessed the motivation of sixty outpatient smokers suffering from schizophrenia. They found that their subjects were motivated to quit, but that cognitive, social and affective deficits need to be recognised and accommodated in quit programmes (see also Curry, Wagner & Grothaus, 1990). Glynn and Sussman (1990) provide the only research that has directly asked smokers with schizophrenia why they smoke, without using preconceived scales. They interviewed fifty-nine subjects and found that they smoked for similar reasons to the general population, that is, mainly for relaxation, stress relief, and out of habit. Reported reasons for wanting to stop smoking were health concerns, dislike of dependence and the desire to save money.

No purely qualitative studies that ask outpatient community mental health clients with schizophrenia about their motives for smoking and perceived barriers to quitting yet exist. This may be due to concerns about validity and reliability, with regard to subjects’ recall about the reasons for use and subjective effects of using tobacco, given the presence of cognitive problems in these people. Addington and Duchak (1997), referring to the ideas of Noordsy et al. (1991) on alcohol use and schizophrenia also suggest that, “meaning may be attributed to events retrospectively, which is of particular concern because of the mechanisms of denial and rationalisation that are often associated with addiction” (1997, p.332). However, it is equally true that people’s perceptions of their circumstances do influence their actions.
(2.4.4) Bipolar Affective Disorder and Smoking:

Bipolar Affective Disorder (BPAD) is a mental illness characterised by significant mood disturbance, with mania being the most recognizable sign. The person with this diagnosis may also experience episodes of depression. During the period of mood disturbance, three or more of the following symptoms are persistent and present to a significant degree: inflated self-esteem or grandiosity; decreased need for sleep; more talkative than usual or pressure to keep talking; flight of ideas or racing thoughts; distractability; increase in goal-directed activity; and excessive involvement in pleasurable activity. The mood disturbance causes marked impairment in occupational functioning, social activities, and relationships with others and excludes the influence of substance abuse or general medical conditions. Psychotic symptoms can be experienced as part of the illness (Kaplan, et al., 1994; American Psychiatric Association, 1994).

In their review of BPAD and substance use disorder, Strakowski and DelBello (2000) found that substance abuse by this group is state dependent, that is, more of the substance is used when the person with BPAD is manic. Others have identified cases of acute mania following abrupt nicotine withdrawal (Benezzi, 1989). Strakowski and DelBello (2000) suggest four reasons for drug use in this diagnostic group, each reason contributing to knowledge but each being insufficient as an explanation on its own. The reasons for drug use are:

1. Substance abuse occurs as a symptom of bipolar disorder;
2. Substance abuse is an attempt by bipolar patients to self-medicate symptoms;
3. Substance abuse causes bipolar disorder; and
4. Substance use and bipolar disorder share common risk factors.

People with BPAD and depression have been found to have significant problems with spatial and holistic tasks (Robertson & Taylor, 1985) and problems with attention, memory and visio-spatial function (Bulbena & Berrios, 1993). Van Gorp et al. (1998) found significant long-term cognitive impairment in people with long-standing BPAD, especially where they had a history of alcohol abuse. The implications of these findings for the person’s ability to fulfil the cognitive planning and processing necessary to quit smoking are apparent.
In general, much of the research on BPAD and substance abuse continues to focus on alcohol and illicit drug abuse. This is because the rates of alcohol use are high for this group (Brady & Sonne, 1995; Brady, Sonne & Ballenger, 1995; Estroff, Dackis, Gold & Pottach, 1985; Gawin & Kleber, 1984; Nunes, et al., 1990; Muesler, Yarnold & Bellack, 1992; Sonne, Brady & Morton, 1994). These researchers have not mentioned nicotine dependence, despite the probability that it precedes all other substance use and despite its recognition as a significant problem for people with a mental illness, with a prevalence more than twice that of the general population (Gonzales, et al., 1998; Hughes, et al., 1986; Watt & Hocking, 1996).

Between 35% and 54% of people with BPAD are thought to be smokers (Goff, et al., 1992; de Leon, et al., 1995). A Spanish study by Gonzalez-Pinto et al. (1998), looking specifically at tobacco smoking and BPAD, cited only two previous reports on smoking and BPAD patients, these being brief case studies of four patients (Glassman, 1993; Pine & Hatterer, 1994). In this Spanish study, fifty-one people with BPAD and 517 controls from the normal population were surveyed using self-report data. Of those with BPAD, 51% were found to be current smokers compared to 33% for the control group, with 72% having commenced smoking prior to the onset of their BPAD. They were also more likely to have a father who smoked, especially the male participants and both sexes were more likely to be heavy smokers compared to the control group.

Of the limited literature for this diagnostic group, the study of greatest significance, from which others appear to have drawn heavily, is the National Institute of Mental Health Epidemiological Area (ECA) study (Regier et al. (1990). These researchers demonstrated that BPAD is associated with the highest risk of any axis one disorder for a coexistent abuse of drugs or alcohol and that this is several times higher than for those with unipolar depression. Their study also showed that those people with BPAD are six times more likely than the general population to have a substance abuse disorder, this being even greater for those who experience mania. Of those participants surveyed for the ECA study, 60.7% abused alcohol or other drugs, 46.2% abused alcohol and 40.7% abused, or were substance dependent. More than 60% or those with mania had a substance abuse history and almost 50% of those with depression had a substance abuse history. However, no specific data was presented on nicotine dependence in this survey.
A United States study, using structured interviews with forty-four inpatients and outpatients of a psychiatric facility in South Carolina (Sonne, et al., 1994), found that the course of BPAD is clearly complicated by substance abuse. These complications include increased hospitalizations, greater incidence of dysphoric or mixed mania, earlier onset of mood problems and greater likelihood of reporting increased frequency of mood swings. Of the thirty participants who were current drug users, twenty-four reported using drugs to help with mood management compared to one of the fourteen non-users. Of the twenty-four drug users mentioned, twenty-one clearly specified drug use to medicate either manic or depressive symptoms. These findings support the self-medication theory of drug use in this population. Although this study looked exclusively at alcohol, cannabis, cocaine and opiate abuse, there are implications for the role of nicotine dependence that need to be explored. In particular, they found that cocaine and alcohol withdrawal is associated with a process they called ‘kindling’, or progressively escalating neuronal sensitivity leading to successively shorter periods of remission between episodes of illness. It is unfortunate that this study did not report on the prevalence or severity of nicotine dependence in these people because, if nicotine withdrawal has similar negative implications for prognosis, then it is imperative that more effective smoking cessation interventions are developed for people with BPAD.

Another United States study using semi-structured interviews with 188 outpatients of a Washington psychiatric hospital (Feinman & Dunner, 1996), found that differences in the course of BPAD occur between those with substance abuse prior to the onset of illness and substance abuse after onset. Early onset was found to correlate with subsequent drug use, suggesting that early onset either predisposes such people towards substance abuse or that they represent a distinct group at risk of developing both disorders (1996). These findings support those of Morrison (1974).

The poverty of research and knowledge about the interaction between BPAD and nicotine dependence has prompted the current qualitative study that begins by asking the people themselves about their experience of the phenomenon.

(2.4.5) Major Depression and Smoking:

Major Depression is a mental illness characterised by five or more of the following symptoms which have been present for a two-week period or longer. These symptoms are: depressed mood most of the
day, marked diminished interest or pleasure in all, or almost all, activities most of the day and nearly every day; significant weight loss when not dieting, weight gain, decreased or increased appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or a specific plan for committing suicide; and bereavement symptoms that persist for longer than two months. The symptoms cause significant distress and impairment in social and occupational functioning and exclude the influence of substance abuse or medical conditions as causes (Kaplan, et al., 1994; American Psychiatric Association, 1994).

The association between cigarette smoking and depression has been noted and studied by a number of researchers for some time (Anda, et al., 1990; Breslau & Johnson, 2000; Carmody, 1989; Carton, et al., 1994; Covey, Glassman & Stetner, 1990, 1997; Hughes, et al., 1986; Kendler, et al., 1993; Kinnunen, Doherty, Militello & Garvey, 1996; Tso, et al., 2000). Despite this research activity, the experiences of the depressed people themselves have received little attention. Research has largely focusing on pharmacological explanations of the associations between the two phenomena. Hughes (1988) showed that people with depression were more likely to smoke than the general population. He also proposed that their smoking was a self-medicating response to alleviate dysphoric mood. Khantzian (1985) had earlier found that self-medication by using drugs, was common among depressed persons (see also Weiss, Griffin & Mirin, 1992). A study by Hughes et al. (1986) confirmed the difference between depressed smokers and non-depressed smokers from the general population, with 49% of former group being smokers and 30% of the latter group being smokers. These differences were noted earlier by others (Mathew, Weinman & Mirabi, 1981), and confirmed by all later studies. The life-long prevalence of depression and smoking has also been noted (Glassman, et.al.,1990; Breslau, Kilbey & Andreski, 1991).

A United States study by Kendler et al. (1993), involving self-report data from 1566 female twins proposed three possible explanations for the high rate of smoking for people with depression:

1. Smoking causes depression, or depression causes smoking;
2. Common environmental or social factors indirectly link them; or
3. Common genes increase the vulnerability to both conditions.
These researchers dismissed the first explanation, concluding that common genetic factors were the most likely explanation with environmental and social influences being also likely to play a role. More recently, it has been argued that smoking and depression are linked through shared deprivation variables within the person’s history and current circumstances (Roy, et al., 2001). Several years earlier, Eysenck (1965) had suggested a connection between the risk of smoking and depression based on the genetic component of personality traits. A recent survey of clinical and epidemiological literature (Swendsen & Merikanga, 2000) concluded that substance use disorders and depression are risk factors for each other.

A French study by Carton et al., (1994) studied smoking and emotional regulation in seventy-six depressed inpatients and ninety-six non-depressed controls from the general population. These researchers found that depressed smokers were more likely to smoke in negative emotional situations, were more likely to use smoking for its sedative and stimulant effect and were more likely to use cigarettes to regulate emotions. They also noted the sensation-seeking role of smoking for depressed smokers seeking to counteract anhedonia.

Other researchers have looked closely at the self-medication role of cigarettes for depressed smokers and concluded that, “not only can nicotine withdrawal provoke depression in smokers with a history of depression, but also that nicotine may, in some persons, act as an anti-depressant” (Worthington, et al., 1996, p.520). Others have noted this relationship (Glass, 1990; Glassman, et al., 1990; Glassman, 1992, 1993; Hawkins, 1997; Hughes, et al., 1986). The positive influence of nicotine on the release of dopamine in the brain, and therefore the role in reward and hedonistic pathways has been proposed for depressed smokers (Carton, et al., 1994; Glassman, 1993). This suggests that there may be significant pharmacological barriers to quitting for these smokers.

With regard to smoking initiation, the relationship between depressive states and smoking has been found to be established early in the person’s life, with the presence of depression or depressive mood in childhood or adolescence significantly increasing the risk of smoking initiation at that time. Depression was found to precede smoking initiation in a number of studies although the direction of causality remains unclear (Breslau & Johnson, 2000; Escobedo, Kirch & Anda, 1996; Escobedo, Reddy & Giovini, 1998; Kandel & Davies, 1986; Stefanis & Kokkevi, 1986). Likewise, smoking has been causally linked to the onset of depression (Brown, Levinsohn, Seeley & Wagner, 1996; Johnson,
Cohen, Dohrenwend, Link & Brook, 1999; Wu, 1999). Others have proposed that smoking and depression share common genetic factors (Kendler, et al., 1993), and similar childhood and social risk factors (Fergusson, et al., 1996). A recent US study using two samples of 8704 and 6947 adolescents concluded that prior smoking is a powerful determinant of depression. They advocated the use of anti-depressants in non-depressed young smokers to assist them to quit (Goodman & Capitmas, 2000).

With regard to quitting, depressed smokers have been found to be less likely to quit smoking than non-depressed smokers, failing at more than twice the rate (Anda, et al., 1990; Glassman, Stetner & Walsh, 1988). They have also been found to experience more intense withdrawal symptoms when they do try to quit (Hall, Munoz & Reus, 1992; Hall, et al., 1996). Shiffman (1982) had earlier confirmed that a history of depression was positively correlated with the risk of smoking relapse, with depression cited as the common antecedent of smoking relapse. Co-morbidity of alcoholism and smoking has also been found to severely impair the ability of these smokers to quit, especially for men (Covey, Glassman & Stetner, 1997). A United States Study by Anda et al. (1990), using data from the National Health and Nutrition Examination Survey, followed the progress of 870 participants over a nine-year period. These researchers found that the percentage of cigarettes smoked increased with the severity of the person’s depression and that quit rates decreased with increased severity of symptoms. In addition to this, a number of case studies have been recorded, citing the development of depression in ex-smokers with no notable history of depression (Bock, Goldstein & Marcus, 1996), and ex-smokers with a history of depression (Stage, Glassman & Covey, 1996). The importance of monitoring illness symptoms during the cessation process and the potential value of incorporating anti-depressants as part of the process, especially for those with a history of depression, has been suggested and found to be useful (Borelli, et al., 1996; Churchill, Pariser, Larson & Disaver, 1989; Dalack, Glassman, Rivelli, Covey & Stetner, 1995, 1996; Glassman, et al., 1990; Glassman, 1993; Killen, et al., 2000).

Clearly, depressed mood has a profound influence on the person’s sense of self-efficacy, their likelihood of being able to think positively about their situation and their ability to persist with the quitting process. For smokers suffering from depression, their depressive symptoms may persist over several years, or recur from time to time, despite treatment with appropriate medications. This suggests that there may be unexplored effects of their mental illness that influence their smoking behaviour. Ethically, where depressed smokers may wish to quit but feel that they are unable, it would seem inappropriate merely to wait until their illness is ‘cured’ to provide cessation assistance.
Borderline Personality Disorder (BPD) is a mental illness characterised by a pervasive pattern of instability or interpersonal relationships, self-image and affect, with marked impulsivity involving five or more of the following: frantic efforts to avoid real or imagined abandonment; unstable and intense personal relationships with extremes of idealization and devaluation; identity disturbance; impulsivity in, for example, spending, substance use, sex and binge eating; recurrent suicidal behaviour, gestures, or threats, or self-mutilation behaviour; affective instability; chronic feelings of emptiness; inappropriate, intense anger; and transient stress-related paranoid ideation or severe dissociative symptoms. Substance abuse and a history of child sexual or physical abuse are common in people with this diagnosis (Kaplan, et al., 1994; American Psychiatric Association, 1994).

The rate of co-morbid BPD and substance abuse has been found to be high, ranging from 55% upwards (Dulitt, et al., 1990; Hatzitaskos, Soldatos, Kokkevi & Stefanis, 1999; Nace, 1990; Trull, et al., 2000). Unfortunately, few studies have looked specifically at nicotine and many studies have neglected to include nicotine as a drug of abuse, focusing on heroin, alcohol, cocaine and benzodiazepine abuse. In a major review of seventeen studies on BPD and substance abuse conducted between 1987 and 1997, Trull et al. (2000) proposed several reasons for co-morbidity between the two conditions. The two are thought to share common risk factors for initiation, for example, childhood trauma (see also Brown & Anderson, 1991; Parrott, 2000; Sabo, 1997). Once co-morbidity develops, each disorder serves to maintain the other; that is, they have reciprocal effects in which the existence of one fosters greater chronicity of the other. Impulsivity and inhibition are characteristic of people with both conditions. Both are a means of affect regulation in the presence of affect instability, especially smoking to cope with negative affective states and tension (see also Hatzitaskos, et al., 1999). Trull et al. (2000) also argue that deviance proneness is shared for both conditions, that is, the presence of behaviours that violate social norms is shared. Finally, inherited neurobiological vulnerability derived from family history of mood or disinhibitory psychopathology, for example, serotonin deficiency that is inherited, combined with the prevalence of dysfunctional family environments, is common to both.

There exists a substantial literature on personality traits as predictors of smoking initiation, continuance and cessation. Patton et al. (1997) highlighted the role of high neuroticism, lower self-esteem and ego strength and higher psychoticism in predicting the person’s likelihood of becoming a smoker. Waldeck
and Miller (1997) collected self-report data on licit substance use and impulsivity using a multi-scale questionnaire with 332 young adults. They found that smoking is positively related to personality factors such as, “extroversion, rebelliousness, anti-social tendencies, risk-taking and social deviance” (p.270; see also Beckwith, 1986; Grunberg, Winders & Wewers, 1991; Simon, Sussman, Dent, Burton & Fray, 1995). A large prospective study by Lipkus et al. (1994) of 3810 men and 836 women over a twenty-year period found that indicators such as impulsivity, rebelliousness, sensation-seeking and hostility were the best predictors of smoking initiation (See also Eysenck, 1980).

A history of abusive relationships in childhood, often in the context of poor parenting and bonding problems, is considered to be a significant contributor to problems with personality development in adulthood (Laporte & Guttman, 1996; Milton et al., 1999; Tyrer, 1988; Van der Kolk, Hostetler, Hermon & Fisler, 1994; Weston, Ludolph & Misle, 1990). An understanding of these central features of BPD provide clear links to understanding their vulnerability to drug use and abuse and their choices regarding health behaviours. A qualitative study by Hall (2000), who interviewed twenty adult females with a history of child abuse, found that most participants misused substances, with eleven of the twenty participants using five or more substances. Reasons given for substance use were: to avoid feelings, to escape and to avoid problems, in response to anger, for retaliation, to achieve peacefulness, to fit in and to overcome depression. Tobacco was not mentioned in this study. A study of 110 children aged ten to thirteen years looked at smoking and other health-related behaviours and found that smoking positively related to greater exposure to violence. Exposure to community violence and family violence were found to impact health locus of control, that is, lowering the person’s belief in their ability to take charge of their health in positive ways (Fick & Thomas, 1995; see also Hawkins, Catalano & Miller, 1993; Lewis & Lewis, 1982). Others have challenged the self-medication role of drug use for people with BPD (Castaneda, 1994).

The social context in which this group has received treatment for their mental ill has been less than favourable, with frustration and hostility often shown by service providers towards them (Contemporary Clinical Challenges in Psychiatry Conference, 1999). Smoking interventions focusing on cognitive behavioural therapy that addresses learned, maladaptive behaviours has been shown to be successful for people with BPD (Fisher & Bentley, 1996). By looking specifically at the smoking behaviours of smokers with borderline personality disorder, the current study aims to contribute to the
limited knowledge of smoking for this group. In particular, it hopes to describe how these smokers compare to the general population of smokers and to the other diagnostic groups.

(2.5) OTHER INFLUENCES ON SMOKING IN PSYCHIATRIC SETTINGS:

(2.5.1) Introduction:

Several researchers have attempted to refocus their attention on the theory of dependence, given that smokers have continued to smoke despite much research on the subject (Barber, 1995a, 1995b; Black, 1991; Drew, 1986, 1987a, 1987b, 1990; Marlatt & Tapert, 1993; Miller, 1990; Room, 1987; Shiffman, 1993a). Many are realising that biological, psychological, and social variables account for only minor proportion of the variance in addictive behaviours while most of the variance remains unexplained (Miller, 1990). The self-medication theory of dependence, that proposes that people smoke to cope with adverse external pressures and internal negative states, assumes that if the adverse conditions are treated or changed the drug dependence will no longer fulfil this need and will vanish (Gold & Miller, 1994). For people with a mental illness, little exploration of what these people are medicating in their social world and where they gain their sense of self and meaning has occurred beyond looking at the physical symptoms of illness. Drew (1990), equating drug workers with Nero, “fiddling while Rome burns,” goes further in arguing that we have indulged in irrelevancies. “We have pursued an abstract scientific course rather than responding to existential needs. We have produced a psycho-bio-social model of drug dependence that excludes the essence of human existence - options, freedom of choice and the centrality of value systems” (Drew, 1990, p.208). Drew (1987a) insightfully suggested a way forward, saying that the problem with the disease model is that, “[it] has professionalised healing and increased the reluctance of ordinary people to become involved in helping their drug using neighbours, because that has become the job of experts...It has mystified ordinary behaviour and minimized autonomy and self-governance...[It] has promoted the reductionist approach to human behaviour which proposes that the whole of the person is no greater than the sum of those discrete aspects of his behaviour that can be studied in isolation” (p.48). The researcher suggests that the existential experiences of the smoker may provide clues to understanding the phenomenon of dependence better than what is known at this time, that this may be lacking in current research. Miller (1990), by suggesting that we need to explore the spiritual aspects of addiction, promotes a similar argument. O’Hagan (1987), in support of Drew, has devised an eight-faceted model to replace the disease
concept. He suggests that there is a need to ‘walk around the octagon’ in order to see the different disciplinary facets of understanding, instead of standing still to view only one perspective.

(2.5.2) The Role of Organisations:

Central to the notion of change is the need to understand why change does not occur. Nisbet (1972) states, “there is not the slightest possibility of understanding the mechanisms of change unless we understand, or at least recognize seriously, the mechanisms of fixity and persistence” (p.6). Schon (1972) refers to this phenomenon as ‘dynamic conservatism’ in which organisations tend to offer services and behave in set ways rather than respond by modifying services according to changing needs. Schon (1972) further argues that a lack of co-ordination in service systems creates both horizontal and vertical fragmentation. “The result is that there exist almost no points at which public action might effectively move the system as a whole” (p.94). In this climate, agency discretion is used to work against change via control of access, duration of stay and control of the portion of the clients’ ‘life space’ that the agency takes up, extending its service beyond the actual disability. In the extreme, the agency becomes the person’s total environment. The fragmentation of staff in the psychiatric inpatient settings and its effects is a demonstration of Schon’s (1972) ideas. Ogburn (1972) argues that the culture of organisations itself is innately resistant to change. He cites seven reasons for this, involving cultural and psychological aspects:

1. Difficulties of invention in that it is easier to use existing forms of behaviour than to create new ones;
2. Vested interests exist with power of particular groups being exerted to maintain the status quo;
3. The power of tradition;
4. Habit;
5. Social pressure by the group to conform to existing behaviours;
6. Forgetting the unpleasant thereby the past appears brighter than it actually was; and
7. Psychological traits such as anxiety about the uncertainty of change.
(2.5.3) The Role of Institutions:

Rhodes (1991), in her study of two United States acute psychiatric units, highlights the inherent contradictions that exist within mental health settings, where staff provide care and therapy but also act as agents of social control. Foucault (1977) describes psychiatric patients as the object of knowledge and the subject of discipline. He argues that staff are therefore placed in a paradoxical position. Foucault (1977) describes the historical context for power relationships and social control functions of mental health settings, focusing on the emergent asylums as sites of discipline and surveillance and the transfer of these values to current mental health treatment. Goffman (1961a, 1961b, 1961c) gives a detailed description of how power was displayed and used in the asylums of the past. Parallels to the present day psychiatric hospital are evident. On entering the total institution, the person was said to begin, “a series of abasements, degradations, humiliations and profanations of self” (Goffman, 1961c, p.23). This involved role dispossession and a lack of work that led to a demoralisation of the individual over time. In these settings, tobacco was used as a source of reward, with clients receiving a tobacco ration as part of a privilege system (Shlomowitz, 1990).

Interactions with institutions and other organised systems are based on power relationships established as part of the cultural beliefs and values of the setting. Cultural power means, “control over the means of value creation, interpretation and maintenance,” (Jessop, 1972, p.58) and involves control over economic, political and social power. Within institutions and organisations, both culture and power relationships exert a significant influence on the behaviours of their members. It is unclear what role smoking plays in this.

Community hostels are another form of institution where many people with mental illness reside. The role of smoking in hostels has not been studied. Suto and Frank’s (1994) qualitative study of ten people in a board and care hostel in California, found that hostels steeped in institutional routines had a significant influence on how people oriented to time and future; that they were very much oriented to the present or to a few hours into the future. The paucity of social roles and the dominance of familiar and predictably timed routines, repeated day in and day out, provided residents with significant temporal reference points. Examples of these were clear expectations of what happens before and after meals and routines around the giving of daily pocket money and cigarettes. Routines facilitated future expectation, fundamentally organising the person’s time into past, present and future. However, they
argue that the balance in these temporal markers is too much weighted in the present, resulting in the immediate fulfilment of the person’s wishes at the expense of allowing and encouraging them to develop skills for flexibility, long-term planning and autonomous decision-making. This has implications for smokers residing in hostels that need further exploration.

(2.5.4) Architectural Determinism – A Smoking Environment:

The work of Rudolf Moos (1976) on the physical characteristics of the milieu and its influence on the behaviours of its members is relevant here. Moos (1976) argued that the physical and social environment cannot be understood independently of each other and that behaviour therefore cannot be studied apart from the environment in which it occurs. Moos’ theory of architectural determinism concludes that, “man-made physical environments may profoundly influence psychological states and social behaviour” (Moos & Insel, 1974, p.8). The reasons for behaviour and environmental congruence are argued to be due to a combination of learning theories (Wicker, 1974). This involves operant and classical learning by positive and negative reinforcement, involving stimulus and response interactions, repeated over time and in various situations. Behaviour settings theory sees people obtaining satisfactions from, for example, peer smoking to overcome boredom and provide companionship and autonomy. Social exchange theory, involves the selection of settings on the basis of reward or cost analysis. Finally, observational learning theory involves the person’s behaviour being affected and influenced by observing and learning from the actions of others and the consequences of their actions. Peer smoking as a potential barrier to quitting needs investigation, given these processes.

(2.5.5) The Role of Group Dynamics:

An understanding of the concept of the group (Lewin, 1948) is also useful in understanding organisational culture and interactions between and interdependence among its members, in particular, peer smoking groups. Forsyth (1999) defines a group as, “two or more interdependent individuals who influence one another through social interaction” (p.6), involving shared social identity. Group conflict and oppression can be regarded as, “different manifestations of the same basic human predisposition to form group-based social hierarchies” (Sidanius & Pratto, 1999, p.38). The rules, procedures and actions of social institutions produce group-based social hierarchy. It can be conscious, deliberate, overt, unconscious, unintended and covert (Sidanius & Pratto, 1999). Theories of group dynamics are influenced by Skinner’s (1953) behavioural approach, known as social exchange theory, in which
rewards are maximised and costs are minimised as part of a negotiated process of interaction (Forsyth, 1999). Deviance has specific functions for groups. It is accepted as part of and as a requirement of group formation, expressed as a need for ‘other’ in order to define self. It also allows for displacement of hostilities onto a scapegoat in order to maintain group equilibrium and maintain boundaries (Dentler & Erikson, 1984). These processes may be relevant to psychiatric settings and smoking behaviour within those settings.

(2.5.6) Smoking by Minority Groups as an Expression of Power:

The notion of substance use by minority groups in order to experience personalised power, albeit brief and artificial, is worth exploring. Barber, Punt and Albers (1988) convincingly argued that this was exactly what Aborigines on Palm Island were doing with their alcohol use. They suggested that the politics of empowerment would be more effective in lessening the problem of alcohol abuse than education about alcohol use. Roche and Ober (1997) examined the problem of smoking by Aborigines, a marginalised group that has smoking rates approximately twice that of the general population in Australia. They argued that smoking is adaptive in the same way as drinking alcohol, despite its adverse consequences, suggesting that it aids social cohesion and solidarity, acting as a symbol of exchange and as a symbol of coping and being in control. “Sharing a cigarette has also become one of the ways in which indigenous people have been able to reaffirm, strengthen and maintain their cultural identity in an environment that is often hostile and constantly changing” (Roche & Ober, 1997, p.130). It may be that there are parallels between these behaviours and that of smoking in people with mental illness.

A Canadian study by Stewart et al. (1996a, 1996b), looking at disadvantage and the link to low quit rates, concluded that day-to-day barriers to quality of life and empowerment were likely to act as barriers to quitting. Therefore, long-term goals were perceived as irrelevant because immediate circumstances are overwhelming motivators to continue smoking as the mechanism to cope with those circumstances. Again, this may be relevant to smoking in people with mental illness.

(2.5.7) Cigarettes and Violence in Institutional Settings:

In settings where cigarettes are an item of value to the members and where others control access to those valued items, there is potential for conflict. Such may be the case in psychiatric settings where
staff have a role in making decisions about distribution and access to cigarettes by clients. Morrison (1990a) states that, “patient-staff conflict over the enforcement of rules and denying of requests is identified as a major cause of assaults” (p.17). Rolfe (1995) reviewed the phenomenon of violence towards nursing staff in psychiatric settings. However, he made no mention of smoking.

Others have argued that violence in psychiatric settings is a product of the socio-cultural field, not just a symptom of the person’s disorder (Stanton and Schwartz, 1954; Lion, 1987). Lion (1972) argues that, “the patient’s aggressive behaviour represents a defensive stance against overwhelming feelings of helplessness and fragility” (p.3) in psychiatric settings. A Belgian study of reported verbal and physical assaults in closed wards over an eleven-month period in 1996-7 by Nijman and Rector (1999). They discovered that the lack of psychological space involving the lack of privacy and ability to get rest in these settings triggered aggression. Katz and Kirkland (1990) studied violent and peaceful psychiatric wards and concluded that staff behaviour was a major influence on the level of violence. In wards where there was strong and supportive leadership, there was less violence. Where staff spent more time with patients, the level of violence declined, whereas increased levels of violence were noted in wards where nursing staff spent more time in the glassed nurses’ station, this being how staff communicated their fear of violence by clients. The role of environment, systems and structures and relationships to increased violence, especially the lack of structured activities and overcrowding, was also recognised to contribute to violence. Rolfe’s (1995) own study of forty-nine assaults in a 110 bed psychiatric setting over a six-month period found that 53-90% of these assaults occurred in the context of staff-client interactions, with the clients’ mental state relevant to only 10% of all incidents. Blair (1991) noted that taking something away from a client, such as cigarettes, led to an increased risk of assault towards the limit setter.

(2.5.8) The Effect of Smoking Bans On Psychiatric Settings:

By the late 1980’s in the United States, the harms of smoking and passive smoking were beginning to influence psychiatric settings with increasing calls for smoking bans and increasing likelihood of successful litigation against administrations that ignored the harms of smoking. In 1992 exemptions previously in place for psychiatric inpatient units in the United States ended, with many sites attempting to become smoke-free. During this period, a number of studies were conducted to monitor
the transition. A number of US studies from the late 1980’s and early 1990’s have documented the experiences of psychiatric settings where smoking bans were introduced.

Resnick and Bosworth (1989) performed the first known study on this topic. They looked at the effects of a smoking ban on an acute twelve bed locked unit in Oregon in 1986. They surveyed clients (N=165) and multi-disciplinary staff (N=25) about their attitudes to a ban, before and after the ban was imposed. Results were generally favourable, although problems with smuggling of cigarettes and increased fire risks were noted. The overall positive result may have also been skewed given that, at that time, Oregon had an adult smoking rate of 19% when the national average was 30%. The majority of clients thought smoking areas should be provided. In addition, sixty clients admitted consecutively (thirty prior to and thirty after the ban) were reviewed to determine the incidence of need for prn (as needed) medication, seclusions, restraint orders, calls or security backup and discharge against medical advice. Resnick, Gordon and Bosworth (1989) performed a second study in 1987 involving a phone poll of forty-nine Oregon psychiatric facilities. They spoke with either the head nurse or the program director from each site (N=18), representing a participation rate of 100%, with each having participated in the initial study (Resnick & Bosworth, 1989). Results showed a significant increase in positive attitudes towards smoking bans and their successful implementation, with half of the state’s psychiatric wards becoming smoke free within one year of the initial ban.

Thorward and Birnbaum (1989) studied the effects of a smoking ban on a Washington 17 bed locked unit at time of implementation and twelve months later (1987-1988). Clients and staff filled in the Moos Ward Atmosphere Scale six months prior to the ban and six months after the ban was implemented. Records were kept, documenting use of prn medications pre and post-ban and staff recorded incidents in case notes related to the smoking ban and its effects. As with other studies, these researchers found the uptake of NRT gum as an alternative to smoking was low. Admission rates did not drop after the implementation of the smoking ban. However, violations of the smoking ban were significant. No change in patients’ post-admission smoking behaviour was observed as a result of the ban; they continued to smoke.

Smith and Grant (1989) looked at three psychiatric units (forty-two beds) within a private (not-for-profit) general hospital psychiatric service in Seattle in 1987. Pre and post-ban questionnaires to staff provided the main data in conjunction with client interviews just prior to discharge. With the settings,
doctors expressed less concern than nurses did. They saw a smoking ban as an opportunity for new skills to be learned by clients, such as improved self-control and relaxation. Nurses anticipated many more adverse smoking-related events, such as elopement, verbal threats, inappropriate attention-seeking and injury to self and others. However, this was not matched by actual incidents which were markedly less than expected. Events related to nursing tasks were noted to have become more problematic after the ban. These included gaining client co-operation, calming clients, and discussing treatment. Staff smokers were noted to be more concerned than staff non-smokers. Several clients acknowledged violating the ban while at the hospital. 54% of patients interviewed expected to reduce their smoking significantly after discharge. Overall, the positive effects of the ban, such as increased self-esteem with temporary mastery and self-control by clients, outweighed negative ones. Staff anticipated more smoking-related problems than actually occurred. Higher functioning clients who were given more autonomy were observed to tolerate the bans better than more severely disturbed clients, thought to be due to their greater ability to participate in out-of-hospital activities. Preparation for the ban included several staff meetings to provide opportunities for staff to verbalize their concerns and to problem-solve. Staff education about use of NRT and techniques for handling nicotine withdrawal was also provided. More problems related to the ban were noted when the emphasis was on smoking passes to leave the hospital to smoke compared to self-control procedures.

Greeman and McClellan (1991) studied a sixty bed psychiatric unit within a 600 bed Veterans Affairs Medical Centre in Minnesota over a two-year period following the implementation of a smoking ban. Although fewer privileges favouring smokers above non-smokers and a system whereby less able clients were escorted off the grounds by willing clients in order to smoke or to purchase cigarettes. A special unit that allowed smoking for involuntary disturbed clients was recommended.

Erwin and Biordi (1991) studied two acute care wards (forty-two beds) at a Veterans’ Affairs hospital in Illinois in 1990. Nursing staff completed questionnaires asking about nursing interventions, based on Levine’s Four Conservation Principles of Nursing as it relates to addressing the needs of patients who have the urge to smoke – patient energy, structural integrity, personal integrity and social integrity. Questions centred around how often nurses gave alternative options to clients, such as exercise options, intervening directly to promote non-smoking, individualized care to encourage alternative coping and involving significant others in care. One month after the ban’s implementation, approximately 75% of nursing staff reported that the non-smoking policy was a success.
Taylor et al. (1992) performed a prospective study involving fifty multi-disciplinary staff of a 934 bed New York psychiatric setting in 1989-1990 pre and post the imposition of a smoking ban for clients. The experiences of 232 clients were also monitored. A log was kept of prn medication use, seclusion, restraint, elopement, incident reports, and smoking-related discharges. Staff attitudes to a ban were found to be more positive after the ban was in place. No significant differences in demographic or diagnostic variables were found. No significant differences in the level of disruptive incidents during smoking and non-smoking conditions were noted, despite 60% of client participants being involuntarily hospitalised. The rate of patient smoking remained at 53% for both periods suggesting that the policy change did not deter smokers from admission or from smoking. A two-month preparation period prior to the ban involved community and staff meetings and advertising of the impending ban to clients. NRT gum and candy was made available to clients after the ban, however they were not taken up substantially as alternatives by clients. The effect of the ban on clients’ attitudes was not examined. Staff had already experienced a two-year staff ban at that stage and only eight of the fifty staff involved in the study identified themselves as smokers. This may have influenced the findings.

Velasco et al. (1996) studied the effects of a smoking ban on a Kentucky twenty-five bed locked unit at implementation and at two-year follow-up (1991-1993). The initial study was reported by Ryabik Lippman and Mount (1994). The first period involved observations for a six week period just prior to implementation of the ban and six weeks immediately after with staff daily documenting number of security calls, application of seclusion and restraint, verbal assaults and physical assaults per shift, use of prn, number of clients receiving NRT and number of discharges against medical advice per day. Velasco et al. (1996) They found a significant increase in verbal assaults and prescribing of prn medication for anxiety immediately after the ban, but not two-years later. No significant increase in physical assaults, use of seclusion, or discharge against medical advice was observed, beyond the first week of the ban. The use of NRT was greater immediately after the ban and at two-year follow-up, gum being available in the first period and both gum and patches available in the second period. The application of ‘soft’ restraints (cloth posey vests) was significant at two-year follow-up, though the reason for this could not be explained. Education of staff about nicotine withdrawal to help staff differentiate between nicotine craving and psychiatric symptoms, to provide alternative activities and encourage the use of NRT was recommended.
Smith, Pristach and Cartagena (1999) surveyed sixty acute psychiatric inpatients (forty-four smokers) admitted to a hospital with a smoking ban in place. Using the Brief Psychiatric Rating Scale (BPRS) and the Nicotine Withdrawal Checklist (NWC), they found that smokers and non-smokers showed no statistical difference in their BPRS scores. However, high NWC scores were significant for smokers and positively correlated with high Fagerstrom dependence scores.

(2.5.9) Smoking By Psychiatric Nurses:

The rate of substance use by nurses; in particular, the rate of smoking by psychiatric nurses is high compared with nursing in other health-related fields. The reasons for this are unclear, though some have suggested that this may be largely due to accessibility, the emphasis on medication use and work-related stress (Griffith, 1999; Plant, Plant & Foster, 1991; Rowe & Clark, 2000; Tagliacozzo, Sci & Vaughn, 1982; Trinkoff & Storr, 1998). When smoking bans have been imposed, the rate of smoking by staff has been shown to decline with many staff taking the opportunity to quit once bans are imposed (Borland, Chapman, Owen & Hill, 1990; Chapman, et al., 1999). It is unclear whether such restrictions would influence psychiatric staff in this way and what influence their smoking may have on clients.

(2.6) CONCLUSION:

Research consistently shows that rates of smoking are significantly greater in populations where mental illness is also present. When people with mental illness attempt to quit smoking, they are highly vulnerable to relapse to smoking, especially in the presence of unstable mental illness and other stressors. Many reasons for this have been proposed including those associated with shared neurobiology of mental illness and nicotine, self-medication of symptoms, psychosocial coping responses, environmental factors, psychological factors and systemic factors. No studies have looked specifically at potential differences in the smoking behaviours according to diagnosis. No studies have incorporated an holistic approach to the phenomena of smoking and mental illness. This thesis acknowledges the entrenched nature of smoking by many public mental health service clients and explores the phenomenon of smoking within mental health service systems.
CHAPTER THREE - METHODOLOGY

(3.1) INTRODUCTION:

This chapter outlines the rationale for using qualitative research designs to explore the topic of smoking and mental illness as an integrated methodology. The chapter comprises four sections, the first three being a description of the methodology used to collect data on smoking involving clients, staff and the settings. The final section describing the secondary analysis and integration of these three phases into an overarching theory of triangulation methodology. The term ‘triangulation’ is used as a research methodology in its own right, not merely as a description of how data is obtained from various sources. The first section describes the use of a grounded theory design for client participants. The second section describes a similar use of grounded theory design for staff participants. The third section describes the collection of data via participant observation of mental health service settings, incorporating both an ethnographic design and quantitative data collection during observations and self-report smoking consumption by nursing staff. A description of the auditing of the research methodology concludes this section.

(3.2) SECTION ONE – THE CLIENTS:

(3.2.1) Rationale for using a Qualitative Research Design:

Qualitative research designs were used for this study because of their ability to describe social phenomena and to explain them. Such designs are inductive and process oriented, focusing on dynamic reality and interchange in naturalistic settings (Woods & Catanzaro, 1988a). This is in distinct contrast to the positivistic or quantitative researcher who “listens with the idea that the accounts provided by the respondent are subjective and ultimately must be verified by science” (Hammersley & Atkinson, 1983, p.105). Bargar and Duncan (1982) highlight the significant role of qualitative research methods in beginning the process of understanding phenomena by acknowledging the role of “intuitive hunches” (p.3). Thus, there is a recognition and acceptance of qualitative research as “blatantly interpretative” (Kirk & Miller, 1986, p.5). Qualitative research is important in discovering new ideas (Mills, 1959). Kirk and Miller (1986) note the many examples of great discoveries that have been made by accident and how the hypo-thetico deductive method can prevent the discovery of new information.
The basic assumptions underpinning qualitative research are “that the perspective of others is meaningful, knowable, and able to be made explicit” (Patton, 1990, p.278). Qualitative research ultimately sees people “as persons, who construct the meaning and significance of their realities...They do so by bringing to bear upon events a complex personal framework of beliefs and values, which they have developed over their lives to categorise, characterise, explain and predict the events in their worlds” (Jones, 1985, p.46). Points of commonality with others cannot be assumed as self-evident in this process. Given the disproportionately high number of people with mental illness who smoke and the apparent ineffectiveness of smoking cessation campaigns for these populations, the researcher hypothesised that there were potential meanings associated with smoking and possible barriers to quitting for these populations that have been overlooked. The researcher decided that their discovery would be best achieved and understood by returning to the beginning and asking the people themselves, in their words, and on their terms.

(3.2.2) The Use of Grounded Theory- A Definition:

Grounded theory was developed by Glaser and Strauss (1967) in the 1960’s as the theoretical framework for their study of staff managing dying patients. Strauss, a qualitative researcher, saw the need to get out in the field in order to understand what is going on, that is, to develop theory based on reality. Glaser, a quantitative researcher, saw the value of qualitative methods but also the need for them to be more explicit and systematic in order to reach a broader audience (Strauss & Corbin, 1990). Their emphasis was on discovery through the ‘constant comparative analysis’ of data, that is, collection and analysis of data going hand in hand. This process involves coding, comparison and clustering, labelling and categorising, further data collection and coding, recoding where indicated and continual testing of hypotheses against the data as they arise. In this way a framework builds giving order to the relationship between categories and leads to the development of an overarching theory. Categories are perceived as “saturated” when no new datum emerges to challenge or alter the core category (Chenitz & Swanson, 1986). Theory is “grounded in the behaviours, languages, definitions, attitudes and feelings of those studied” (Denzin, 1978, p.78), with the emphasis being on what is unique about human conduct, that is, “human emotional experiences” (Denzin, 1978, p.43).

Symbolic interaction provides the theoretical base for grounded theory, and originated primarily from the work of Mead (1934) Blumer (1969) and Denzin (1970,1978). Mead (1934) theorised about how,
through social interaction, the individual achieves a sense of self, that is, how the concept of “self” and
the capacity to see self as “other” are learned through play and social interaction as a child. Blumer
(1969) identified three basic premises. “Human beings act toward things on the basis of the meanings
that the things have for them” (p.2). “The meaning of such things is derived from, or arises out of the
social interaction that one has with one’s fellows...[and]The meanings are handled in and modified
through an interpretative process used by the person in dealing with the things he encounters” (Blumer,
1969, p.2).

Denzin (1978) identifies three basic assumptions of symbolic interaction. Social reality viewed as a
social production. People are capable of engaging in ‘minded’ ‘self-reflexive behaviour’, that is,
“capable of shaping and guiding their own behaviour and that of others” (p.7). Lastly, humans interact
with one another in their interpretation and definition of the world, that is, “Interaction is symbolic
because it involves the manipulation of symbols, words, meanings and languages...humans learn their
basic symbols, their conceptions of self and the definitions they attach to social objects through
interaction with others” (Denzin, 1978, p.7).

Symbolic interaction also recognises the importance of a broad social, political and economic context
for understanding how shared definitions and meanings develop within groups, populations and society
at large (Chenitz & Swanson, 1986). In support of this approach, Wilson (1977) argues for research
that is in-depth and emphasises a cultural perspective, and occurs in the field where the contextual
variables are operating. With these ideas in mind, the researcher set out to understand these processes
of social interaction and their interpretation by clients and staff within mental health settings as they
relate to smoking and the meanings that have developed as part of these processes.

(3.2.3) The Processes of Grounded Theory:

Grounded theory has a number of key elements and features. Specific sampling methods and data
collection techniques as well as methods to ensure rigour and comprehensiveness are combined within
a substantial coding system that enables conceptual development and depth. The researcher aims to
discover dominant themes which form the conceptual framework from which a central category and
emergent theory are formed (Glaser & Strauss, 1967). This involves a concurrent, cyclical process of
data collection, examination, coding, categorising, theorising and conceptualising, that is, hypotheses
and theories emerge concurrently with data collection and data analysis and remain provisional until saturation of the data occurs. The researcher’s theory is validated against or modified by the data, by the researcher continually moving between deductive and inductive thinking. The “grounding” is complete when there is no further modification of results from the continued data collection.

The central criteria for determining the applicability of the theory to the particular phenomenon under study is that it should “fit” the everyday reality of the area under study. It should “make sense” to those being studied and workers in the area. It should be able to be applied to various contexts related to the phenomenon and it should provide action strategies for controlling the phenomenon (Strauss & Corbin, 1990). The researcher made several presentations of preliminary findings to mental health clients and staff at conferences and other forums once data collection was complete. This gave the opportunity to test the ideas proposed and for them to be verified as ‘making sense’ to those being studied in their various settings and contexts. Clear areas for intervention and change became apparent, based on the ideas proposed.

Theoretical sensitivity is also a central value of grounded theory. It is gained from immersion in the literature and from professional and personal experience. It involves, “the attribute of having insight, the ability to give meaning to data, the capacity to understand and capability to separate the pertinent from that which isn’t” (Strauss & Corbin, 1990, p.43; Glaser, 1978). The researcher had prior experience of working in all of the mental health settings in which this research took place and she had also been a smoker in the past. Throughout the period of study, the researcher immersed herself in a broad range of literature on the subject of smoking and mental illness.

(3.2.4) Successful Quitters – A Pilot Study:

As part of the formulation of ideas from which to proceed with interviews with current smokers, a pilot study was performed involving clients who had successfully quit smoking. Key workers were approached and asked to identify potential participants who might agree to be interviewed. Information sheets ensuring confidentiality and voluntariness of participation were distributed as part of this process. The selection criteria for successful quitters were that: 
1. Their mental state was stable at time of interview, as determined by the person and confirmed by their key worker and doctor;
2. They were a current client of the mental health service;
3. They had experienced mental illness for ten years or more;
4. They had been abstinent from smoking for six months or more;
5. That they had smoked for at least five years prior to quitting;
6. Their previous smoking behaviour met the criteria for dependent smoking as per the Fagerstrom Nicotine Tolerance Questionnaire (Fagerstrom, 1978; Heatherton, et al., 1991)

Once identified, successful quitters were interviewed individually using open-ended, exploratory questioning. Interviews were audio-taped with their permission and then transcribed. Where further questions arose or points required clarification, further contact was made with the participants. Coding and analysis of interviews followed the grounded theory method. Thematic analysis of the data was undertaken as per the process described for interviews with clients and staff in the following sections of this chapter. The results of this pilot phase are reported in Chapter Four.

(3.2.5) Sampling:

The method of sampling used to select client participants was “purposive” (Patton, 1990). The researcher had initially proposed a random sampling method whereby the names of interested clients would be gathered, thirty from each diagnostic group, from which names would be drawn from a hat for each group to be interviewed until saturation of themes had been achieved. However, the researcher was concerned that asking people to be potential participants and then not interviewing them would be harmful, especially to those who wished to quit. This concern was confirmed by discussions with key workers and clients and the ethics committee. Also, the researcher did not receive the number of names expected from the process as it was originally proposed. Ethics committee approval for this change was sought and granted. The practical application of this sampling technique involved enlisting the help of key workers who approached potential participants from their case loads. Following a thorough explanation and understanding of the selection criteria, as given by the researcher, key workers nominated clients based their judgement of the extent to which the potential participants met the selection criteria, as well as their willingness to participate.
These criteria were:

1. The person was a current smoker;
2. The person’s mental state was stable at the time of interview, as verified by the researcher with the person’s worker and doctor on the day of interview;
3. The person had a clear and agreed upon diagnosis, not complicated by other factors such as personality problems unless where this was the diagnosis sought;
4. Clients who expressed being happy with their smoking were not excluded, that is, smokers at the various stages of change) were eligible for participation in the study (see literature review and recruitment section below for discussion of Prochaska & DiClemente, 1984);
5. Persons from culturally and linguistically diverse groups were not excluded; and
6. Equal numbers of male and female participants were sought where practicable.

The sample was purposive in the sense that the potential participants’ smoking habits and their diagnoses were known and fell within one of the four groups under study. The diagnosis of potential participants was initially confirmed with the key worker and the doctor for each participant and then by checking their case notes. Where there was any doubt about the diagnosis, for example, due to discrepancies between each of these sources, these participants were excluded from the study. A blinded, independent opinion was sought from a consultant psychiatrist at the completion of the interview process. He reviewed the case notes of all participants and sought further clarification from community and hospital case notes where necessary in order to establish the diagnosis.

Data were compared, contrasted and confirmed and representativeness was achieved by further theoretical sampling once the initial core categories were identified (Strauss & Corbin, 1990). This continued until saturation point was reached with each of the four diagnostic groups, that is, when no new data was found to add significant meaning to the general category. While following strictly the processes laid down by the grounded theory methodology, the researcher found that, in realistic terms, there would always be some new data because of the unique experience of every individual. Therefore, absolute saturation was not seen as possible to achieve. Saturation point for the most dominant ideas
emerged once four to five people were interviewed from each diagnostic group. The decision to interview six participants from each diagnostic group was made as a precautionary measure.

(3.2.6) Site:
Study participants were current clients of community mental health services within the inner southern area of a metropolitan city in Australia, comprising approximately 340 consumers, aged 18 - 65 years, servicing a total regional population of approximately 65 000 adults. Of the total number of current consumers of the service, 52% were male and 48% were female; 86% were on a disability support pension or unemployment benefit; 52% had a primary diagnosis of schizophrenia, 33% had a primary diagnosis of an affective disorder (BPAD or depression), and 7% had a primary diagnosis of personality disorder (Department of Human Services, 1999). The mental health service was a state funded public health service providing case management, clinic and consultancy services to a wide range of people who experience mental illness in the community. Case management followed the Kanter (1989) model that emphasises the primary, multifaceted role of the key worker (see Glossary). Interviews were conducted at the clinic and in participants’ homes. The inner southern area concerned is typically suburban with most housing initially established in the late 1940s and 1950s onwards. It contains a reasonable mix of social strata, that is, people from diverse occupational, educational, cultural, religious and social backgrounds. It is well serviced with public amenities and shops. Public housing is prominent in a number of suburbs within the region, as are people on government benefits. Community mental health clients are found in all suburbs with the region, but disproportionately so in these particular suburbs.

(3.2.7) Recruiting:
The researcher sought the assistance of other key workers via the distribution of an introductory letter (see Appendix B), clearly stating the expectations of, and criteria for involvement, to each of their clients who were current smokers. These expectations and criteria were thoroughly explained to key workers during a staff education session prior to distribution of the introductory letters to promote uniformity of understanding and prevent bias in the final sample. In particular, key workers were asked to stress to potential participants that the research was not intended to judge their smoking behaviours, that is, it was not a quit smoking campaign. Key workers were also asked to stress that the researcher was interested in interviewing current smokers who were not planning to change their current level of smoking (precontemplators), smokers who were ambivalent about their smoking (contemplators),
smokers who wanted to quit (preparation) and smokers who were trying unsuccessfully to quit (action/relapse). That is, potential participants were at different stages of the change process as outlined by Prochaska and DiClemente’s (1984) Transtheoretical Model of Change. No one group was excluded. Those clients who wished to participate in the study were then directly contacted by the researcher or via their key worker. In this way, clients’ privacy was assured. After thoroughly explaining the process to the client in person, the researcher and the client completed consent forms prior to interviewing, for those clients who wished to proceed.

(3.2.8) Participants:

All participants were current clients of the community mental health service living within the inner southern mental health service catchment area. All participants elected to be interviewed in their homes except for three participants with a borderline personality disorder, two of these being subject to protocols stating clinic visits only, for safety reasons. Participants were drawn from both the Community Care Team and the Mobile Assertive Care Service (see Glossary). The participants’ age range was 25-63 years. Twelve were men and twelve were women. The majority of participants started smoking in their teens, had smoked for more than ten years (usually much longer), smoked high tar cigarettes, smoked more than twenty cigarettes per day and lived alone in public housing. All participants were unemployed at the time of interviews and follow-up contact. All received a government pension (twenty-two received the Disability Support Pension and two received the Sole Parent Benefit). Participants had a range of educational experience; however, most had not completed year twelve. All participants were Caucasian and of English speaking background. The use of interpreters was planned for and accommodated into the interview process. However, key workers did not provide the names of any such participants for this study.

(3.2.9) Data Collection:

The researcher collected data from clients according to the four people-oriented mandates with regard to collection of qualitative data suggested by Lofland (1971). These mandates were also followed for other phases of data collection:

1. The researcher “must get close enough to the people and situation being studied to personally understand in depth the details of what goes on.”
2. The researcher “must aim at capturing what actually takes place and what people actually say.”

3. “Qualitative data must include a great deal of pure description of people, activities, interactions, and settings.”

4. “Qualitative data must include direct quotations from people.”

(Patton, 1990, p.32)

Interviews were faithfully recorded and multiple notes were taken about interviewees’ non-verbal responses and other body language. Also, several information sources were sought and used to increase the trustworthiness of the data, by allowing validation and cross-checking and to provide a more comprehensive perspective (Patton, 1990). These sources included family members and other supports, consultation with workers and doctors and perusal of case-notes, especially where there was some difficulty with the person’s memory of events related to dates or the chronology of events. All such contact occurred with the full knowledge and consent of the person who was interviewed. Consultation with experts in the fields of drug dependence and mental health was also undertaken as part of this process; that is, seeking “knowledge” according to several different perspectives. Transcripts of actual interactions were also combined with observations and reflections to build a comprehensive picture of the experience and meanings associated with being a smoker with a concurrent mental illness. In this way, data sources, perspectives and methods were “pitted against one another in order to cross-check data and interpretations” (Guba, 1981, p.85).

Data collection from client participants occurred over a period of four months. This included initial interviews and follow-up contact which occurred in-person or on the phone. Most client participants had contact with the researcher two to three times over the period of interviewing. In addition to actual interviews and discussions during follow-up, the researcher talked with key workers and doctors about ‘their’ clients, as well as referring to case notes to help build a picture of the clients’ situation and experience of illness.

The researcher alone performed interviews and follow-up contact; no other persons were involved in this process. All participants were fully informed of the researcher’s position as a key worker from the agency where they received service, that is, they were aware that the researcher was ethically bound to notify the agency of any concerns regarding their safety or deterioration of mental state as stated in the
Mental Health Act and the policies of the agency. The researcher stressed that all information discussed during contact would remain confidential, that involvement was completely voluntary and that information could be discussed or disclosed freely without fear of prejudice to any future treatment at the mental health service, excluding information indicating evidence of danger to self or others.

Participants were interviewed informally, using an open-ended, semi-structured style of questioning. They were able to explore particular areas of interest regarding their smoking as they felt inclined to do so. This allowed individual and unique experiences to be discussed, therefore allowing the emergence of potentially new information rather than the researcher imposing the structure for the interviews. The researcher approached the interviews with general areas of interest to cover. A checklist, or interview guide, incorporating ideas gained from interviews with successful quitters and from the literature, was used at the final stages of each interview to ensure uniformity in the general areas covered (see Appendix C). The interview guide covered general areas based on knowledge and insights gained from informal discussions with consumers, staff, and other professionals in the field of addiction and mental health, based on a thorough literature review. Personal as well as work experience and anecdotal evidence was also incorporated into the interview guide. Some of these areas included talking about the meaning of their smoking to them, the meaning of their illness to them, experiences of past attempts to quit, experiences while in hospital, and describing ‘a typical day’ as a smoker. Basic demographic details were collected informally as the interview proceeded. Determination of the clients’ Fagerstrom (Fagerstrom, 1978, Fagerstrom & Schneider, 1989) scores was performed as part of the interview process (See Appendix D). Any demographic detail not able to be collected at interview time was gained from perusing case notes immediately following preparation of transcripts. Verification of demographic details was also done at this time.

Of the twenty-four smokers interviewed, twenty-two consented to be audio-taped during the interview. These interviews were subsequently transcribed. Interviews were conducted informally and within a therapeutic framework, therefore every word uttered by participants was not transcribed; only those relevant to their smoking experience. On several occasions and with several participants, the researcher explored briefly other issues as these arose during the interview process. This was done in order to develop and maintain rapport and to allow for the particular mental health needs of participants at the time. Being flexible during interviews enhanced the flow of interviews and participants were observed by the researcher to be more relaxed as a consequence of this style being used. During the process of...
transcribing interviews, the researcher made judgements about the relevance of data to be included in transcripts. Tangential information with no bearing on this study was not included. Portions of conversation during interviews such as basic re-reading of the information sheet, signing of the release of confidential information form, leaving the interview to get drinks and answering phone calls were also not included. The actual words of the participants in response to the researcher’s comments and questions were transcribed verbatim at all times. The actual words of the researcher were not transcribed verbatim unless the researcher felt that they had particular bearing on the participants’ responses. The researcher’s component of interviews was placed in brackets alongside each participant response. As part of the transcribing process, the researcher used the numbering option on the computer word processor used for typing transcripts. This allowed the researcher to number each new idea as it arose in the interview and aided the process of manual cross-referencing of ideas at the later stage of coding and thematic data analysis.

The researcher endeavoured to include as much observed body language and non-verbal communication and gesturing as possible in the transcripts, linking them directly to the relevant points at which they were observed during interviews. Observations and reflections of the process and of participants’ responses were noted during the typing of transcripts; the pages of transcript being halved, with the actual transcribed words appearing on the left-hand side and observations, reflections and the emerging categories being hand written on the right-hand side. In addition to this, the researcher kept a reflective journal in which ideas were written as they came to light during transcribing, re-reading of transcripts, reading of the existing literature, conversations with staff, presentations and consultations, contact with supervisors and attendance at conferences and seminars. The researcher had access to this journal twenty-four hours per day throughout the course of the research in order to store ideas that could be later explored in the analysis stage and discussion of results. These data were used in the analysis to add complexity of understanding and meaning to the verbal data, often clarifying the context in which statements were made.

As interviews were performed, the researcher met with supervisors to identify and verify the main categories and themes which emerged from the preliminary analysis of the interviews. The insights and ideas gained from this process were then explored, verified or challenged in subsequent interviews as part of the process of building the thematic analysis towards theory development. Dr Rene Pols performed the role of second coder to the researcher. Thus, an inter-coder reliability checking process
was established for all interviews with client and staff participants in the study. A random sample of
two transcribed, coded interviews from each diagnostic group, coded by the researcher and the second
coder, taken and checked by the auditor during the audit process, confirmed inter-coder reliability of
eighty-five percent or more.

Follow-up contact with participants served to clarify and verify these categories and to gain further
extensions of ideas that were in turn added to the data and incorporated into the final stages of the
thematic analysis process. The interview process continued until the researcher, with verification from
supervisors, was satisfied that distinctive patterns of responses had emerged in order to propose
hypotheses. Using the grounded theory approach, the researcher anticipated starting with relatively
broad themes and questions which became more focused as interviewing proceeded (see Strauss &
Corbin, 1990; Leedy, 1997).

Two current smokers requested that their interviews not be taped, due predominantly to their
experiences of psychosis and uneasiness with recording devices. This preference was clearly expressed
as an option in information letters prior to interviews commencing. In such cases, the interviewer took
comprehensive notes to record data about the interview, with participants’ consent, during and
immediately following each interview so as not to compromise the accuracy of responses.
Demonstrating sensitivity and establishing trust were seen as essential during contact with this client
group. Refusal by some clients to participate in this study, because of the use of a tape recorder, could
have seriously affected the validity of the sample. The researcher also recognised that performing one
interview only may not be appropriate or enough contact time for some consumers. This was
particularly so for those consumers with shorter attention spans, lesser tolerance for interaction,
behavioural difficulties, or problems with the side effects of their illness or medications. Therefore
follow-up contact served dual purposes. Coding of these interviews then followed the same process as
for audio-taped interviews.

(3.2.10) Manual versus Computer assisted Data Collection and Analysis:

Computer programmes such as Nudist and Ethnograph were not considered to be the most suitable for
data collection and analysis in this study. This decision was made after reviewing the concerns of
several authors (Merriam, 1998; Richards, 1998; Richards & Richards, 1994; Tesch, 1990; Weitzman
& Miles; 1995). The researcher reviewed the last five years of qualitative health research papers and verified that manual (for example, cut and paste) methods were still being used with similar rigour despite the surge in interest in computer programmes. It appeared that computer use was determined by personal choice, access and comfort with the programmes. Non-use of these programmes did not appear to affect the quality of findings for these papers. Krothe and Pappas (1998) reviewed the field and concluded that, “the technology enhances the process of QDA [qualitative data analysis] but is not sufficient to achieve final negotiation and articulation of emergent themes” (p.563). Richards and Richards (1994), the originators of the Nudist programme, also acknowledge this problem. In general, a number of qualitative researchers, in particular those who have studied vulnerable populations and taboo areas, have argued that computer programmes cannot replace the personal intuition necessary in the building of themes and negotiating the data; verbal discussion and negotiation of common understandings is still necessary even with computer use (Krothe & Pappas, 1998). The ability to build a complete impression and intuitive feel for the total interview also cannot be achieved using computers. The depth of meaning in data is achieved by what Richards and Richards (1991) refer to as, “hovering over the text and rethinking its meaning, then rising from it to comparative imaginative reflections” (p.260). In studies such as this one, where unstructured data were used, computer use may have jeopardised contextual understanding of the data. This concerned how words, actions and reflections were viewed in relation to their position in a sequence of words, action and reflections. “Any technique that relies on segmenting and decontextualising [as such programmes do] puts this ability at risk” (Richards & Richards, 1991, p.244). Neither did this study seek to quantify the appearance of terms and themes in the data for which computer programmes are particularly suited. There are also problems with remaining sensitive to the data and the continuous process of inductive/deductive reasoning necessary for developing depth in understanding with computer use. In support, Becker (1993) argues that this, “results in flat and oversimplified descriptive results” (p.258). Computer programmes also have a tendency to shape the direction of the data, therefore jeopardising the inductive process essential to qualitative research. Merriam (1998) illustrates this concern for tools shaping the task by reminding us of the old proverb - “If all you have is a hammer, everything looks like a nail” (p.174). Finally, although computer programmes can add complexity and density to the coding process for the experienced computer user, in the hands of a novice, they can pose more problems than they create advantages (Richards & Richards, 1991). The researcher regarded herself as a novice.
(3.2.11) Data Analysis:

Constant comparative analysis of data was an ongoing feature of the study, occurring throughout the process of data collection rather than at the conclusion of data collection. In this sense coding and analysis of the data occurred simultaneously with theorising about the data. The data was “constantly compared” via the process of starting with an incident or idea which was in turn compared to another incident or idea in the same or another set of data, leading to the development of tentative categories which were then compared to each other. This was done in order to build complexity of meaning and understanding from the ground up so that the overarching theory could be clearly demonstrated to have arisen from the data in which it was ‘grounded’. As recommended by Catanzaro (1988), a combination of the two types of content analysis used for most qualitative research was chosen for this study rather than the exclusive use of one or the other. These types are latent analysis, which is concerned with the meaning within each passage of the text and manifest analysis, where the text is divided into units of meaning via words and themes, that are then quantified.

The researcher sought to analyse the effect of self within the research process and to acknowledge the therapeutic nature of the interaction in the process of data collection in which the researcher was not merely a neutral observer. Rose and Webb (1998) refer to this approach as “reflexive” because it recognises that the researcher brings their own history and biases to the interview and research process. It also complements the notion that qualitative research of this type is a symbolic interaction. Data analysis in this context goes beyond factual description to a more intuitive level of understanding of what the person says and its meaning (Rose & Webb, 1998). It is akin to the social work skill of “tuning-in” (for example, see Shulman, 1999).

Rigour in data analysis was achieved by also using field notes and reflexive notes to supplement data collection in what Rose and Webb (1998) refer to as thinking, assimilating, intuiting, interpreting and understanding in a constant comparative way.

The researcher alone performed and transcribed all interviews in order to maintain a high level of intimacy with the data and familiarity with earlier and later interviews. In this way, the researcher was able to demonstrate what was done and why it was done, that is, to clearly outline the decision trail in data analysis. Being present at the interviews, listening to the tapes, transcribing the tapes, reading the
transcripts and repeating these steps over and over allowed the researcher to become highly familiar with the data. This enabled attention to particular details and fostered an overall feel for the meaning of the data (Rose & Webb, 1998; Polit & Hungler, 1995).

Meetings with supervisors were an opportunity to discuss any disagreements or differing perspectives about the emerging themes. The researcher repeatedly returned to the literature to build an holistic understanding of the data and to reflections of the interviews. This helped to resolve any differences or fill any gaps in understanding as these occurred. Gaining the perspectives of workers and other experts from the various disciplines ensured that this understanding remained balanced.

Using the coding techniques described by Strauss and Corbin (1990), data was analysed using three distinct and rigorous levels of coding. The first level was open coding in which the properties and dimensions of the data were identified, compared with those identified in the data collected from other participants and clustered with like codes within relevant provisional categories. The actual words and phrases used by participants were examined line-by-line to create “in-vivo” codes as well as codes using terms from existing literature (Strauss & Corbin, 1990). Preliminary labels were then entered in the right-hand-side of the transcripts. These labels aimed to encompass the participants’ meanings, often using the actual words of participants to name the concepts, rather than professional terminology. In this way, meanings were not decontextualised or distorted to reflect researcher biases. They remained faithful to and represented the language of participants. Throughout the process, the naming of codes and categories originated from three sources: participants’ own words; the researcher’s understanding of what was meant; and from outside sources such as the existing literature. The determination of categories followed the four criteria recommended by Merriam (1998), that is, that they should be:

1. Exhaustive - all relevant data of the study should be able to be put in a category;
2. Mutually exclusive - data should fit only in one category otherwise more conceptualization is necessary to achieve this;
3. Sensitized - the meaning should be clearly understood by the reader; and
4. Conceptually congruent - categories at the same level should be at the same level of abstraction. (p.184)
The next level of analysis involved developing descriptive categories from the initial concepts from the previous stage. By comparing, clarifying and differentiating concepts, they could be clustered and therefore reduced to fewer, more abstract categories (Strauss & Corbin, 1990). Highlighter pens in different colours were used for this process. Notes regarding decision-making accompanied this process and were used to demonstrate and justify each direction in which abstraction occurred. This was an essential part of the audit process to be discussed later. The copy, cut and paste functions of the word processor were sufficient to assist in organising the data into categories at this and all other stages.

At the next stage of analysis, known as axial coding, the data from these categories were repeatedly re-examined, interpreted and compared as part of the inductive/deductive reasoning process. They became sub-categories from which more complex categories could emerge to be compared and contrasted to each other. While open coding fractured or separated the data, axial coding put it back together again in new ways (Strauss & Corbin, 1990). This was done by posing questions to determine conceptual labels and how categories might be related to one another. This involved the process of specifying the phenomenon or central idea (category) then asking what were the causal conditions and context in which it arose and was embedded. Finally, questions were asked about the intervening conditions bearing on the actions and interactions between the smokers and their smoking and their consequences (Strauss & Corbin, 1990). Examples of such questions were:

1. What does this response tell me about the use of medication?
2. Does the timing of this person’s smoking bear any relationship to what is known about changes in mood at different stages of illness and under certain conditions?
3. What is currently known about this subject; how is this information different or the same and how can this be explained in relation to what has been said about ....?

The decision-making process was clearly shown in what Strauss and Corbin (1990) refer to as logic diagrams. These served to clarify and uncover the relationship between categories and to explain how these relationships were decided upon. This assisted the researcher in managing the data. It assisted the auditor and others to understand the process of theory development followed by the researcher and to
raise any concerns. Coding at the axial level involved dividing the transcripts into columns in which the incident or observation was identified, a code name given to it and a theoretical note attached in the third column. Memos were the means of writing thoughts and hypotheses down. They took the form of comparative memos and hypothesising memos, thus facilitating the inductive/deductive process. Visual representations of the analytical scheme began to develop at this level (for more detail see Strauss & Corbin, 1990).

The final level of coding was selective coding in which the processes involved in the previous level were continued at a higher level of abstraction and refinement in order to move towards the identification of a central theory. Merriam’s (1998) caution about the need to think conceptually instead of linearly was heeded at this stage, as was the danger of remaining too close to the data, therefore hindering theory formulation. At this level, the researcher sought to ground the theory by validating it against the data. For this process, the theory was laid out in a combination of diagrams and narratives or statements of relationship which were validated by using examples from the data, for example, when ... then.... The aim was, ”to fit in a general sense and in most cases, not necessarily in every single case” (Strauss & Corbin, 1990, pp.138-9). Where data emerged that did not fit, known as the emergence of the ‘negative case’, the decision-making trail was traced back through the levels of analysis to determine and explain the conditions causing the variation. Memos and reflective notes became important here (Strauss & Corbin, 1990). Operational notes were also important at the selective coding level, giving directions to go to this point or check that information (Strauss & Corbin, 1990). After satisfaction with the theoretical framework was achieved, the researcher retraced her steps to fill in any gaps and missing details in the categories as part of a general review and checking process. Results of interviews with clients who were current smokers are reported in Chapter Five. (See Appendix E for examples of transcribed interviews and data analysis sheets for client interviews)

(3.3) SECTION TWO – THE STAFF:

(3.3.1) Introduction:

The grounded theory methodology used for client interviews was similarly used for staff interviews, the rationale being that staff perspectives were largely absent from the existing literature. Therefore, allowing staff to describe their experiences of smoking and of clients’ smoking in an inductive and open-ended way, ensured that any new ideas could emerge.
(3.3.2) Sampling:

The method of sampling used to select staff participants was a combination of purposive and random sampling. The researcher sought out particular individuals because of the area or setting in which they worked and at other times, potential participants were approached at random. Interviews with some staff were purposive in that, within each discipline type, a balance of representatives from various settings was sought. For example, within the nursing profession community and inpatient open, locked and extended care staff were sought. (see Glossary for descriptions of each setting type).

In the community setting, this involved interviews with staff from both the community care team (CCT) and the mobile assertive care service (MACS). These two groups were thought likely to have the potential to have long-standing professional relationships with clients. Staff employed in the assessment and crisis intervention service (ACIS) were not included in this study because their contact with clients is normally brief and superficial. In the inpatient setting, sampling involved staff from each type of ward setting. Across the sample group, representatives from each discipline were purposively sought within each type of setting except where there was no discipline representative employed in that setting. This was the case, for example, for the inpatient occupational therapist where no locked ward person existed in this role. Professional discipline did not determine the order in which staff were interviewed, as there was no predetermined order or preference given to any one individual or profession. In most cases, more than one representative from each specific discipline in each setting was interviewed. In the locked ward and open ward, for example, more than one nursing staff member was interviewed. The selection of participants was also influenced by staff availability at the time, their other work commitments and the practical feasibility of organising meeting times which suited both the researcher and the potential staff interviewee.

Staff were included in the study regardless of whether they were current smokers, ex-smokers, or individuals who had never smoked. Administrative support staff were not included in the sample, as the researcher sought to gain the perspective of those staff who had direct contact and interaction with clients. Likewise, administrative staff were not included for this reason. All staff interviewed were current employees of the mental health service settings studied. No in-depth interviews were performed with hostel staff.
(3.3.3) Site:
Staff from the community setting came from the same inner southern community public mental health service where clients who were interviewed received their service. Most of these staff performed the role of key worker for the clients. The reader is therefore referred to the previous description of the community setting. The inpatient setting was a stand-alone public psychiatric hospital that served the inpatient care needs of clients across a metropolitan area of approximately one million people. Its wards included the state acute locked ward and open wards designated for the various northern, eastern, southern and western regions of the city. Two of these wards had recently moved to regional locations to become psychiatric wards within general public hospitals. The site also included the extended care locked ward and several extended care open wards.

(3.3.4) Recruiting:
Ethical clearance to perform interviews with inpatient staff was gained from the appropriate committee for the hospital following formal letters of request to the hospital executive director and clinical director. Ethical clearance to perform interviews with community staff was gained from the relevant committee for the community mental health service. Staff from various disciplines were approached and asked if they would consent to be interviewed following the distribution of information sheets and preliminary discussions with staff groups in each setting. The researcher’s status as a worker in the field and her pre-existing rapport with several of the settings and their staff also assisted the process of recruitment. Confidentiality was assured.

(3.3.5) Participants:
Staff participants were drawn from the professional disciplines of psychiatry and medicine, nursing, social work, occupational therapy and psychology. In total, twenty-six staff were interviewed; thirteen from the community setting and thirteen from the inpatient setting. Staff participants had at least four years experience of working in the field of mental health, the longest being thirty-five years. The majority of staff had a rich experience and work history of working and training in various types of settings, not merely their current one. For example, it was common for social workers and nurses especially to have worked in hospital open and locked wards as well as community settings and common for all inpatient staff to have had experience and contact with all setting types at the hospital.
This enhanced their ability to speak on the broader cultural aspects of smoking at the hospital and to make comparisons of the various settings in which they worked, especially if they were previously at the hospital and now in the community. The decision to withhold greater detail about staff participants status and roles was made prior to entrée in the field due to the ethical demands of confidentiality and the potential that some staff could be identifiable because of the limited number of staff in certain positions. For example, some positions existed where there was only one known person in that position at a particular site, therefore their identity would be clearly known to other staff. All staff were currently employed fulltime. All staff participants were interviewed while on duty at their respective sites, except for one community staff participant who met the researcher at an alternative site based on mutual convenience on the day of interview. As stated earlier, staff smoking status was mixed.

(3.3.6) Data Collection:

Staff interviews followed the same process described for client interviews. All staff consented to their interview being audio-taped. Follow-up contact with staff occurred over the course of the research, giving the opportunity for any clarification, elaboration or new ideas to emerge from discussions with staff. Data collection occurred over a period of four months. As per interviews with clients, staff were fully aware of the researcher’s identity, work history and the research aims. Confidentiality of information and voluntary participation was stressed to all participants. Participants were interviewed informally using an open-ended, semi-structured style of questioning to allow for the participants’ meanings and emphases to emerge. A checklist guided the interview. The general areas covered with staff participants were guided by the following: (see Appendix F for Staff Interview Guide)

- The researcher’s impressions of areas needing further exploration, as suggested by the analysis of interviews with clients;
- Previous discussions with staff in the various settings as part of feedback obtained from presentations of papers; and
- The researcher’s own knowledge and experience of working in all of the settings being studied. This included an exploration of the culture of care, staff and client relationships, professional rivalries and debates about the mental health system and policy within the current political climate.
(3.3.7) Data Analysis:

The constant comparative method of data analysis described for client interviews was similarly used for staff interviews. As a result of the politically and ethically sensitive nature of much that transpired during staff interviews, the researcher was vigilant in maintaining confidentiality as well as making regular contact with supervisors to debrief and discuss the ramifications of the data. In particular, it became quickly apparent that the findings of the study could potentially place the researcher in the position of whistleblower given the overwhelming grievances and problems identified by staff participants about the system of care, various professions and particular individuals. The legal consequences of systemic abuse, or inaction and unethical practice were clearly identified by several participants. The data analysis was enhanced by the recognition of these concerns. The discussions with and advice of the auditor are gratefully acknowledged. As part of final closure of data collection following the participant observation phase, the researcher presented preliminary findings to staff in the settings, in particular, to the Clinical Nurse Managers’ meeting at the hospital. Ethical practice concerns were raised at this time. Further activities and consequences of the research are noted in the endnote to this thesis. Results of interviews with staff are reported in Chapter Six. (See Appendix G for examples of transcribed interviews and data analysis sheets for staff interviews and Appendix H for copy of Audit Report for client and staff interviews)

(3.4) SECTION THREE – PARTICIPANT OBSERVATION OF THE CLIENTS AND STAFF IN THEIR ENVIRONMENT:

(3.4.1) Introduction:

Following qualitative interviews with clients and staff the triangulation process was completed by participant observation of the settings described during interviews, to assess the validity of the interview data. In this way, themes from interviews could be tested, verified, or modified to give a more detailed and accurate understanding of the phenomenon of smoking by clients and staff within mental health settings. The term participant observation originated from the work of Lindemann in 1924. Lindemann emphasised the importance of researching a culture from within, using observation as opposed to approaching it from outside (see Friedrichs & Ludtke, 1975). Three mental health settings were identified for participant observation: the psychiatric inpatient setting, the community mental
health service setting and the community hostels. Participant observation of the community mental health service setting did not proceed. Reasons for this will be discussed in the results section.

(3.4.2) Justification for Using the Participant Observation Methodology:

Jorgensen (1989) states, “The methodology of participant observation is exceptional for studying processes, relationships among people and events, the organisation of people and events, continuities over time, and patterns as well as the immediate socio-cultural contexts in which human existence unfolds” (p.12). Jorgensen (1989) further identifies the conditions for suitability when little is known about the phenomenon, when differences exist between the view of insiders as opposed to outsiders, when the phenomenon is obscured from the view of outsiders and when it is hidden from public view. All of these conditions were thought to exist in the mental health setting.

Patton (1980) states several advantages of direct contact with the environment being studied. It allows greater understanding of the context, therefore providing a more holistic approach to the data and allows an inductive approach by experiencing first hand the phenomenon. It provides the opportunity to see things that may otherwise escape conscious and routine awareness among participants because it is taken for granted. It provides an opportunity to learn about things people may be unwilling to talk about in interviews, such as taboo topics and provides the opportunity to move beyond individual perceptions. It also allows the researcher use direct experience as a resource in order to understand and interpret phenomena.

The study of smoking for mental health clients and the settings and staff with whom they interact clearly met all of the above criteria. The everyday life of mental health clients and staff could therefore be best understood by observing the natural environment in which they interact. Comprehending the culture and language used by the participants to communicate meanings and to understand how this had been perpetuated over time was seen as central to the development of the thesis. The advantages of participant observation identified by Friedrichs and Ludtke (1975) were particularly relevant for studying mental health clients, that is, it did not depend on the verbal capabilities of the interviewees and it aided the comprehension of situations and understandings that were difficult to get out through questioning alone. The sensitivities and cognitive difficulties of many people experiencing mental illness were therefore accounted for in this type of methodology. It also gave an opportunity to describe
the extent of passive smoking in clients and staff; patterns and intensity of smoking to assist the management of clients, differences in the settings and to verify occupational health and safety concerns made by staff.

Participant observation is also cited as a good support methodology for qualitative interviews, its purpose being to better understand the relationship between behaviour and culture, and to further validate the qualitative data. Therefore the role of participant observation in hypothesis testing of ideas and themes from the interviews was apparent. For this research, analysis of the qualitative interviews and the trustworthiness of the results confirmed by the audit process, clearly established a thematic framework that could then be standardised and applied to an observation schedule to be used for the participant observation phase.

(3.4.3) The Pilot Period:

A one-month pilot study preceded the main participant observation period. It was performed by the researcher to gain familiarity with the settings and rapport with the participants. This habituation of the environment served to improve the validity and reliability of observations by allowing the observed to become familiar with the researcher’s presence and go about their usual day in their usual manner without staging activities or behaviours for the researcher. The pilot period was also used to identify and resolve any problems and barriers to access, to test a series of observation sheets that had been devised from interview data from the previous phases and to make any adjustments accordingly. Regular meetings with an independent auditor occurred throughout the total participant observation period. At the conclusion of data collection, the audit report confirmed that the research was conducted ethically, according to clearly described and justified methods and that a clear audit trail was established. The decision to enlist the auditor was made to strengthen the validity of the data, as suggested for this methodology (Guba, 1981; Rodgers & Cowles, 1983; Rodwell & Byers, 1997; Rose & Webb, 1998). (See Appendix I for copy of Audit Report for participant observation.)

(3.4.4) Description of the Settings:

The participant observation occurred over a period of six months in the second half of 2000 and early 2001. Each type of inpatient ward was visited multiple times, at different times in the day and different days of the week. Two community hostels within the hospital’s catchment area were also visited in the
same way as part of the participant observation methodology. Staff and clients involved in the two previous interview phases of the study identified with the hospital as their designated inpatient facility.

(3.4.5) The Observation Sheets:

Predetermined standardised observation sheets were used, based on the themes that emerged from the qualitative interviews with clients and staff during the earlier phase of the project. Ideas for the structure of the observation sheets were gained from adaptation of observation instruments used for evaluation of teacher-student interactions, exchanges and environments (Simon & Boyer, 1974). Observed behaviours and interactions were counted and recorded using ticks. An extensive descriptive and detailed commentary and reflective notes were kept to support and illustrate the meaning and impact of what the researcher observed, including the researcher’s own feelings and reactions to observations. As suggested by Jorgensen (1989) all observations were recorded at the time they occurred or as soon after, with details of date, place, time, main activity and players being recorded. A variety of observations were used. Quantitative measures were used for staff smoking and smoking area smoking activity. Several other quantitative sheets were proposed, tested during the pilot phase and found to be problematic. The proposed sheets included:

1) Unobtrusive measures - measures of physical aspects of the environment, such as wear and tear in specific areas and use of ashtrays, as noted by Patton’s (1980) reference to the study by Wolf and Tymitz measuring wear on rugs to indicate popularity of particular areas of the National Museum of Natural History Smithsonian Institute.

2) Sequential measures of interactions between participants - looking at roles, types of behaviours and responses, source, direction of behaviours, modes of communication and their functions and the circumstances under which certain behaviours occurred.

3) Descriptive measures - detailing the type of encounters and social milieu of the settings in which they are observed, the composition of the group, their language and behaviours.

4) Frequency measures - counting of particular types of events and interactions over set periods of time as a proportion of time spent on overall roles for staff and overall activity for clients.
This included counting the consumption of cigarettes for participants over set periods. Measures also reflected the proportion of people engaged in certain activities and the proportion of time they spent in those activities.

5) Dummy observation and recording was also used, that is, giving the appearance of actively observing and recording at times when this was not the case and likewise, appearing not to be observing and recording when this was, in fact, the case. This procedure was performed in order to improve the validity and reliability of observations and to avoid “staged” activity by participants.

6) Staff self-report smoking behaviour sheets. Staff were approached and asked if they were current smokers and if they would be prepared to complete details of their reasons or smoking at each smoking occasion. A series of reasons for smoking were determined from prior interviews with clients and staff and through consultation and verification with staff during the pilot period.

As suggested by Friedrichs and Ludtke (1975), the researcher performed a pilot study; this is described above. The pilot study enabled the researcher to test the viability of observation sheets, familiarise herself with the recording process and identify any potential problems, changes needed, or fine tuning to the observation sheets and overall methodology. Feedback was sought from staff and clients, with positive claims that there was no disruption to the usual routine and interaction noted by the researcher’s presence. (See Appendix J for examples of observation sheets)

(3.4.6) Participants:

The participants comprised inpatient staff and clients present in the nominated wards, as mentioned above, at the time of the researcher’s presence at the hospital. It also included participants present in the grounds of the hospital. These participants were potentially from other wards and were observed as part of the social milieu of the hospital grounds. At the hostels, participants included staff and clients.
(3.4.7) Gaining Entry and Recruitment of Participants:

The researcher made several enquiries of administrative staff at the hospital prior to entering the field. The director of services and clinical director of services were approached and given a detailed outline of the proposed project. Due to the different wards being aligned with different administrative regions and funding bodies, permission needed to be sought from two separate ethics committees. The Flinders University of South Australia Social and Behavioural Research Ethics Committee was sent copies of all correspondence with these committees as required by university research regulations. Initial concerns and requests for clarification by these committees were quickly responded to with extensive written detail and reassurances about the process of participant observation being proposed by the researcher.

The researcher emphasised that staff would be given information about the project via staff meetings prior to its commencement. The clinical nurse consultant in each ward was identified as a significant person with whom to negotiate entry, given their role as ‘gate keeper’ in managing the daily activity of the ward. The significant practical, hands-on role of the nursing staff was respected also. The importance of the primary nurse was built upon, with the researcher using their role to establish greater trust and rapport with clients and to help ease their concerns about the researcher’s presence. Joint ward meetings between staff and clients were identified as a useful forum for explaining the purpose of the study and the researcher’s presence also. An information sheet for staff and patients was distributed as part of this process. The researcher also sought and gained the permission and advice of consumer and carer groups, including the Schizophrenia Fellowship and the Southern Consumer Advisory Group prior to entering the field. This served as a means of promoting voluntariness and alleviating concerns regarding confidentiality.

Experience of previously working in this setting and entering it to interview staff enhanced the preparation for entering to observe the participants. The researcher’s prior work experience in the open, locked and extended care settings gave her the advantage, once in the setting, of gaining greater access and making the role of participant observer more convincing to other members. It also allowed the researcher to travel along the continuum from complete observer to complete participant with skill and comfort, therefore enriching the significance of the observations (Leedy, 1997). Awareness of the visible and the invisible aspects of the setting and the players within that setting was part of the researcher’s knowledge prior to entering the field. Jorgensen (1989) suggests that observing the
invisible requires trust and confidence by the insider to speak to the researcher. Acceptance of the researcher by the participants was particularly relevant in the locked wards and for the culture of the nursing staff role as a ‘closed shop’ to outsiders. The researcher was accepted and granted access to insider knowledge by these participants. Jorgensen (1989) further suggests that participants need to see some gain from the research, that is, a reciprocity of exchange needs to exist for greater access and participation to occur. For this study, staff were keen to participate because they saw the research as an attempt to address their grievances about the system of care and their working conditions. For clients, there was the potential to influence or improve the treatment they received.

Gaining entry to the community clinic setting and the hostel setting was similar, with official letters requesting entree permission and detailing the terms and aims of the research. Ethics approval was sought and gained for these setting also. Two non-government community rehabilitation facilities were approached, following ethical approval to do so, in an attempt to broaden the picture of smoking activity by mental health clients in community settings. One of these organisations consented to the researcher’s visits for observation purposes; however, results will not be reported here. Access to the other organisation was denied. (see Appendix K for copies of information letters distributed in the settings)

(3.4.8) Data Collection:

Extensive journal notes were kept, recording observations, interactions and reflections from each setting and each visit, either as the settings were being observed or as soon as possible after this took place. The researcher was present in each setting in varying lengths of time as observer and participant, dependent on the setting, the needs of staff and clients and the circumstances on the day. (See Appendix L for examples of journal notes)

Following negotiation of entry, settings were visited at random with no predetermined order in mind, occurring in blocks of three to five hours, at various times during the day and evening, Monday to Sunday, dependent on times and days agreed by the managers and the researcher’s availability, given commitments to fulltime work elsewhere. This allowed for constant comparative observation of the different settings as well as repeated observation of the individual settings. The number of visits to each setting was determined as the participant observation proceeded. Decisions to perform further visits were made on the basis of patterns emerging and needing to be checked out. Decisions to cease further
visits were made once the repetition of patterns of behaviour and observation of environmental aspects occurred four or more times. For example, at the first visit a series of general observations were made. These observations were either observed with enhanced understanding or refuted at the second visit. The third visit was an opportunity to confirm the presence of particular aspects observed in earlier visits, and further visits were done to verify previous observations. Where unexpected observations were made, these were noted, with hypotheses made and tested by further observations and reflections and discussions with participants, the auditor and supervisors. Examples of this were the reflective discussions that took place on the similarities and differences noted between the hostels and extended care wards and hypothesising about the reasons for differences in interaction styles between patients of extended care wards in comparison to clients of open wards.

(3.4.9) Data Analysis:

As described by the ethnographic method, data collection and data analysis tended to occur simultaneously using the constant comparative method of checking and cross referencing the data (Leedy, 1997). Journal notes, memos, supervision notes and artefacts were organised and arranged according to each setting. They were chronologically ordered so that all the data pertaining to each setting could then be read and re-read several times and coded for recurrent themes and patterns and any leads followed up. As with the earlier interview phases, one of the researcher’s supervisors (R. G. Pols) acted as second coder of the data. The methods used to determine overarching themes for each setting are discussed in the results chapter. The researcher made repeated observations and descriptions of each setting. From these, a narrative account of each setting was made as a preliminary entrée into the analysis of the data. Quantitative data was analysed using descriptive and inferential statistics.

(3.4.10) The Research Audits:

The trustworthiness of the research methodologies and findings were audited using the method devised by Guba (1981) and Schwandt and Halpern (1988). The auditors were persons who had both methodological expertise and familiarity with the substantive issues of the study. The auditor for the client and staff interviews was a senior social worker who was on-site in the community setting where the researcher also worked and in whom there was mutual trust. Rodwell and Byers (1997) discuss the importance of trust in avoiding the problems of manipulation and distortion of the audit process. This also incorporated the need for the auditor to be in close proximity to the researcher and the research
environment to access all necessary documents. This was particularly relevant for the auditor’s role in checking client consent forms and gaining informal feedback from clients and staff about their involvement in the research. The auditor for the participant observation of the settings was a lecturer in the department of nursing at Flinders University of South Australia. They had expertise in qualitative methodologies and mental health issues.

Copies of the proposed research, the ethics committee proposal, transcripts of interviews, the reflective journal and all accompanying notes, memos and diagrams documenting the decision-making process involved in the thematic analysis and eventual theory formulation process were given to the auditors. This was done in stages using data from the four diagnostic groups to divide up the process so that the volume of data did not overwhelm the auditor. For staff data and participant observation data, the procedure was similar, with presentation and discussion of data occurring in batches and stages as the analysis proceeded.

The researcher spent several organised sessions with the auditors verbally explaining the research process used, clarifying any areas needing further explanation and providing any additional insights where the process was unclear. As part of this process, the auditors made notes about the content, issues raised, questions needing clarification and specific claims to be pursued later to determine whether findings were credible, dependable and confirmable. The auditor’s aims were to check for any bias and how this might have affected the inquiry process, to establish evidence of fully informed consent, to confirm fairness by tapping the perspectives of all stakeholders, and to confirm evidence of increased insight as a result of the interviews by checking the structure of questions and the quality of responses, and the logic used by the researcher during the analysis of data (Rodwell & Byers, 1997). The researcher provided the auditor with a list of aims. These were then used as a checklist for ensuring all aspects of the audit were covered and responded to in the final report. (See Appendices H and I)

The four criteria outlined by Guba (1981) were followed in the audit process; that is:

1) Truth Value - otherwise known as internal validity or credibility. Findings and interpretations were checked with the various data sources.

2) Applicability - otherwise known as external validity, generalizability, or transferability. It relied on the existence of ‘thick’ descriptions about each context.
3) Consistency - otherwise known as reliability, dependability or replicability. This involved planning the process of how data was collected, analysed and interpreted, that is, establishing an ‘audit trail’, as well as triangulating the data sources in order to avoid the problems associated with multiple realities and shifting perceptions when using human subjects.

4) Neutrality - otherwise known as objectivity or confirmability. By reviewing all available data and the process of analysis, the auditor checked that there was freedom from bias, interests and motives on the part of the researcher which threatened these conditions.

In addition to these criteria, verification of use of the four basic types of documentation, proposed by Rodgers and Cowles (1993) as necessary for a comprehensive audit trail to be established, was achieved. These four types of documentation were contextual (for example, field-notes and descriptions of non-verbal behaviours), methodological (for example, supervision notes and questions raised to be explored further), analysis (for example, theoretical notes, memos and identification of negative cases) and personal response documentation (for example, reflective journal and debriefing notes). Both audits were performed before final closure of the data analysis and became part of the data analysis process. They therefore served to enhance the critical questioning necessary for the researcher to complete the study and created opportunities for new observations and insights to enhance the study.

(3.5) SECTION FOUR – INTEGRATION OF THE TRIANGULATED DATA:

(3.5.1) Introduction:

The smoking behaviour of clients with mental illness was a complex phenomenon. This research firstly sought to describe this complex phenomenon in detail from multiple perspectives, using a variety of checks on the internal validity of the observations. Secondly, it sought to integrate the different perspectives by systematically incorporating the different data into a single social framework. Thirdly, it sought causal relationships within the data that assisted in understanding this phenomenon so that a theory of smoking in people with mental illness could be constructed. This was done in a systematic, stepwise secondary analysis of the data.

This study has gathered substantial cross-disciplinary data that requires cross-disciplinary understandings and interpretations. By using more than one qualitative methodology (grounded theory and ethnography), as well as a range of quantitative data collection methods (self-report, survey and observation sheets), multiple perspectives are applied to assist in interpreting and understanding the
data. This research sought to effectively build a formal understanding to describe and explain the phenomenon of smoking in mental health settings. In this sense, an integration of methodologies, involving data collection and data analysis occurred. Limiting the research to one methodology would have produced only a substantive theory about this phenomenon, one that would require examination of the phenomenon in many different types of situations. In saying this, the researcher acknowledges that this thesis is not a definitive account of the phenomenon, as many areas for further research can be identified.

By looking at the perspectives of each group and behaviour in each setting individually and in isolation using varied methodologies, systematically hypothesising about the data, the problem being investigated was approached from its various vantage points. The complexity of explanations for the phenomenon of smoking in mental health settings became quickly apparent, as each article read for the literature review added pieces to the jigsaw, or created holes and did not provide a picture of what the overall problem looked like. Extensive literature searches were performed in order to build a more complete picture to examine and explain the data, each perspective adding depth to the overall findings.

O’Hagan (1987) encouraged researchers and workers in the field of addiction studies and treatment to take a walk around the octagon to look at the problem from several angles. However, he did not advise the reader about how each perspective could be successfully incorporated with the other perspectives. The current research shows how this can be done in an integrated way, building each component of data collection along the way and understanding the significance of what is collected by applying knowledge from multiple fields of expertise and theory. The eclectic approach espoused in social work theory was an ideal base from which to launch into the research.

A significant goal of this research was to show that research could be done effectively in fields that involve taboo issues or where conventional methods of research and intervention appear to have had little impact despite the persistence of the problem. This is what Drew (1987a) meant when he called for new approaches to the old problem of substance addiction. Drew’s (1987b) insightful and clever demand for the emperor to be clothed, for theories of addiction to recognise the complexity of the process, rather than to assert theories reflecting particular professional domains and understandings, is noted. Likewise, Miller’s (1990) call for more emphasis on and study of spiritual variables in addictions research, is recognition of the limits of the existing literature regarding this problem.
(3.5.2) An Integrated Method - The Steps:

An integrated approach that defines triangulation as a method of analysis in its own right needs to demonstrate that it is a systematic and objective process of inquiry that protects validity and addresses reliability. The current research has attempted to demonstrate how an integrated approach to social phenomena can be taken. It involved the following reproducible steps within the three phases involved in understanding the phenomenon described at the introduction to this section: The three phases are demonstrated in Chapter Eight.

(1) The Descriptive Phase

In this phase, the phenomenon and its component parts are looked at individually, and in isolation beginning with the meanings attributed to the phenomenon by the individuals and groups at hand. This involves extensive description of the phenomenon from the perspective of each group. Varied techniques, sources and methodologies are used to gather data about the phenomenon. This includes understanding the individual’s experience of the phenomenon and observation of the environmental context in which it occurs. Constant comparison and extensive note-taking and cross-referencing with the existing research literature are part of this process. Bridges between the different perspectives are sought as part of thorough investigation, questioning and hypothesising about points of difference, uniqueness and divergence in the data. This involves describing and highlighting points of commonality and difference for each of the data sources. Summary tables of the main points pertaining to the phenomenon according to each data source as part of this process then results in a core data set, with each table validating the data in each of the other tables. Diagrammatic representation of the data is then used to display the relationships between the three sets of data, highlighting the central area of shared phenomenology and other areas of similarity and uniqueness. The following figures represent the process that was undertaken.
Figure 3.1: Representation of Analysis of the Triangulated Data - Stage One

Figure 3.2: Representation of Points of Commonality and Difference - Stage Two
(2) Building a Framework – A Secondary Analysis

As part of beginning to comprehend the summarised results in the tables and diagram, systematically hypothesise about the data, from as many disciplinary perspectives as possible. As suggested by O’Hagan (1987), take a walk around the octagon and look at the phenomenon from its various vantage points. Seek out experts on the various perspectives and research the broad range of perspectives thoroughly as part of this activity. This requires stepping back from the closeness required for the descriptive phase of data collection and analysis, viewing the data sources in summary form for their points of similarity and difference, and how the patterns that emerge may be explained by the various perspectives. A dominant framework then emerges in which a secondary analysis of the data can occur. For the current study, the sociological framework of culture emerged as the dominant framework to explain the various players, roles, rules, beliefs and values, communications and interactions and conflicts that emerged from the various data sources used to investigate the phenomenon of smoking and mental illness within the public mental health system.

(3) Comprehensive Analysis – Towards a Theory of the Phenomenon

In this final phase in understanding the phenomenon, further understanding of forces that create, maintain and perpetuate the phenomenon according to the framework applied in phase two, are then able to be investigated, applied or discarded and incorporated into the analysis. This involves a comprehensive systems approach to the analysis. Bronfenbrenner’s (1979) ecological framework has been applied in this research. An investigation of theories from multiple fields of knowledge is applied to assist in explaining the processes at work within that framework. Practical examples from the data are used to demonstrate these processes. An example of this is the investigation of research literature on the purposes and consequences of institutionalisation as part of an understanding of the culture of organisations and its power structures and values, followed by a return to the data to find practical examples of these processes in action.
(3.6) CONCLUSION:

This chapter has provided a detailed description of the grounded theory research methodology and ethnographic participant observation methodology followed for this study. The rationale for using these research designs was given. An extensive description of the sampling methods, the sites, recruiting methods and the participants was followed by full detail of the data collection and analysis techniques used, and the audit trail used to enhance the quality of the study. The triangulation and integration of methodologies was described. The steps involved in applying an integrated approach to research on social phenomena were proposed. This involved the three phases of description, secondary analysis and comprehensive analysis.
CHAPTER FOUR

STUDY ONE: CLIENTS WHO HAVE SUCCESSFULLY QUIT

(4.1) INTRODUCTION:

Successful quitters with a mental illness were interviewed as a pilot to the main body of data collection. Following their full and informed consent about the process of interviews and use of data, semi-structured, open-ended interviews was used to ask these participants about their reasons for quitting, what their smoking behaviour had been prior to quitting, what supports they used and about their motivation to stay quit. They were not directly asked about perceived links between their mental illness and their previous smoking or relapse potential. Comments about this and the hospital setting were made of their own accord. Confidentiality was assured and names have been altered for the purpose of reporting results.

The method of sampling and selection was purposive. Successful quitters were found to be rare and difficult to find within the total group of registered clients of the mental health service. Quitters were selected on the basis that they had an Axis One diagnosis, they had previously smoked for at least five years, they had been smoke-free for six months or more and that they had suffered from a mental illness for ten years or more, that is, that they had a significant period of having both a mental illness and a nicotine addiction. All potential clients who were identified by these criteria by their key worker were interviewed. Two of the four quitters (Roy and Mathew) declined to have their interview taped for transcription due to their suspicion of the process, involving paranoia related to their illness. All participants were verified, by doctors and key workers, to be stable in their mental health at time of interview. Diagnosis was confirmed by an independent psychiatrist’s review of case notes for each participant. Five men and one woman were interviewed. Direct quotes have been used except for interviews in which participants declined to have the interview tape-recorded. Extensive notes were taken in these instances. Direct quotes appear in bold italics. The following table summarises the demographic results of interviews with successful quitters.
Table 4.1: Characteristics of Client Participants who are Successful Quitters of Smoking.

<table>
<thead>
<tr>
<th>Names/Pseudonym</th>
<th>Jim</th>
<th>Graham</th>
<th>Ken</th>
<th>Mathew</th>
<th>Roy</th>
<th>Helen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnosis</td>
<td>Schizophrenia*</td>
<td>Schizophrenia</td>
<td>Depression</td>
<td>Schizophrenia</td>
<td>Schizoaffective Disorder</td>
<td>Schizoaffective Disorder</td>
</tr>
<tr>
<td>Age</td>
<td>42</td>
<td>40</td>
<td>52</td>
<td>37</td>
<td>40</td>
<td>41</td>
</tr>
<tr>
<td>Income Type #</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
</tr>
<tr>
<td>Highest Education</td>
<td>Tertiary</td>
<td>Year 10 (16yrs)</td>
<td>Year 10 (16yrs)</td>
<td>Year 9 (15 Yrs)</td>
<td>Year 10 (16 Yrs)</td>
<td>Year 9 (15 Yrs)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Divorced</td>
<td>Divorced</td>
<td>Married</td>
<td>Single</td>
<td>Married</td>
<td>Single</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Public/Rental</td>
<td>Public/Rental</td>
<td>Private/Owned</td>
<td>Private/Rental</td>
<td>Public/Rental</td>
<td>Public/Rental</td>
</tr>
<tr>
<td>Started Smoking</td>
<td>11yo</td>
<td>12yo</td>
<td>13yo</td>
<td>10yo</td>
<td>17yo</td>
<td>21yo</td>
</tr>
<tr>
<td>Previous Smoking</td>
<td>30-60</td>
<td>60+</td>
<td>25</td>
<td>25-50+</td>
<td>30-70</td>
<td>25-40</td>
</tr>
<tr>
<td>Tar Strength</td>
<td>16mg</td>
<td>16mg</td>
<td>12mg</td>
<td>16mg</td>
<td>16mg</td>
<td>4-16mg</td>
</tr>
<tr>
<td>No. Quit Attempts</td>
<td>Multiple @</td>
<td>Multiple</td>
<td>4 times</td>
<td>Multiple</td>
<td>Multiple</td>
<td>5 times</td>
</tr>
<tr>
<td>Years Smoked</td>
<td>29</td>
<td>25</td>
<td>35</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Place of Interview</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Work</td>
</tr>
<tr>
<td>Interview Length</td>
<td>1.5 Hrs</td>
<td>2 Hrs</td>
<td>1.5 Hrs</td>
<td>0.5 Hrs</td>
<td>1 Hr</td>
<td>1.5 Hrs</td>
</tr>
</tbody>
</table>

* - Schizophrenia (Schizophrenia)
** - Schizoaffective Disorder (Schizoaffective Disorder)
# - Disability Support Pension provided by the Commonwealth Government
@ - Multiple ≥10

All of these successful quitters started smoking with peers, prior to identified onset of their mental illness although, on reflection, many clearly identified that they had stressful life circumstances that drew them to peers and/or to smoking for support and comfort at the time of smoking initiation. Many of these participants started smoking in the context of alcohol and other drug use around the same time.

Results are organised into general themes. Although each participant described their experience of quitting as unique, there are a number of similarities in their experience that will be highlighted in this chapter. Actual quotes from the participants have been used to demonstrate the themes throughout. These appear in bold print.
(4.2) THEMES:

(4.2.1) The Process of Quitting:

The Point of Change - The Decision to Quit

All successful quitters could clearly articulate either actual cathartic events or circumstances contributing to the build up of motivation to a peak decision to quit smoking. All noted the grinding effect of poverty on their decision. All noted the growing concern for their physical health over time. It is also noted that three of these participants, Graham, Mathew and Roy, clearly identified their change to more effective anti-psychotic medication (clozapine) as the main reason for their ability to quit successfully. Ken and Helen also clearly named their anti-depressant medication playing a significant part in reducing their cravings for cigarettes.

(Graham)

It was either giving up smoking or not eat…When you’re given $100 per week [finances administered by public trustee] and you spend $60-$70 on smokes, it doesn’t leave you with much. I got fed up with it.

(Graham)

When you’re growing up you think, “it will never happen to me”. But I noticed it was starting to interfere with my physical fitness.

(Graham)

I saw the writing on the wall that smokes would be prohibited soon. Clozapine helps you to think clearer. You feel sharper with your thinking.

(Jim)

I was fed up with doing nothing. It had to change. I was fed up with being ill. For some people who develop an illness early it may be different. For me, I had a great sense of what was missing because I’d had a great job and money in the past and I knew how different it was to what things were like when I became ill and was smoking away what little I had.
(Ken)
The strange thing is, as soon as I’d had the real threat of death with the aneurism, my depression buggered off. I rallied I suppose. It’s the opposite of what you’d expect. I call it the self-preservation thing because the threat of death was right there.

(Mathew - He commenced on clozapine 6 years ago which led to a dramatic improvement in his ability to live independently and to cope with his positive symptoms)

(Roy)
My wife has asthma and we both get bronchitis which, over time, was getting worse. On the days when I was smoking more because my mental health was worse, I would feel much worse physically. I also gradually developed the sense that I was getting older and that things had to change. The crunch came when I had a significant scare that pushed me towards quitting. I thought I was having a heart attack at the time.

(Helen)
I wasn’t enjoying it, probably up to a point. It was starting to get in the way and I was feeling like a real slob and looking at the ashtrays and it started to repulse me. I was going to church at the time and most of my church friends didn’t smoke and they would give me a hard time about it…They said it in a nice way, not making me feel stressed out about it…I’m the sort of person that when I decide something, I’ve decided….The ads on the television and the publicity about quitting also turned my stomach and this helped me to quit and get more motivated. I’d be watching it and I’d say to myself, “I’ve got to give up, I’ve got to”. It just reinforced it.

History of Multiple Attempts to Quit Smoking
All of these participants recounted several years of wanting to quit smoking prior to actually being successful quitters. Most had used nicotine patches and gum more than once. Two had not used these aides at all. What was apparent from these interviews was that quitting required persistence and multiple attempts. All of these successful quitters had quit successfully in the past, usually more than three times, although only for brief periods of three months or less since being diagnosed with a mental illness.
(Graham)

I’ve been trying to give up for years. I tried everything; patches, gum, and the four Ds.

**Taking Charge of the Process of Quitting**

These participants demonstrated a commitment and determination to take control of the process of quitting and to take responsibility for the change in their smoking behaviour. They were well informed about the physical and psychological components of addiction to cigarettes and took action to combat these triggers while attempting to quit and stay quit.

(Graham – when asked how he made himself determined to quit)

You get mobile. You find things to do. You tell yourself with the four D’s. You ask for non-smoking meal areas at the pub.

(Graham)

I’d weigh myself every few days because I knew that weight gain was a potential problem that I would need to keep an eye on. I had a strong sense of thinking of my physical health at the time…I also stopped going to the pub for a while because I knew this would be risky for relapse to smoking.

(Jim)

I try to steer clear of places where there’s a smoking environment, like some pubs and nightclubs. I just don’t go to those places now.

(Jim)

People don’t just smoke one day and stop the next. There’s got to be some build up of motivation and planning…You’ve got to go into it in the right frame of mind. You’ve got to be confident in yourself that you can actually do it.

(Ken)

I said, and keep saying to myself now, “I choose not to smoke today”. I’m still convinced three and a half years later that if I had a cigarette today that I’d be back to smoking full time. It doesn’t bother me at the moment because I’m feeling strong in that area. I have the opportunity to have cigarettes
and can afford them now but I choose not to...I found cutting down was easy. I just didn’t smoke inside or in the car. Like it used to be at one stage that every time the phone rang, I'd light a smoke to answer it.

(Roy)
I didn’t like the taste of the nicotine gum or the chewing. I still wanted a cigarette...It wasn’t breaking the habit cycle at all. I needed something to keep my hands busy and I saw it as just replacing one habit with another. When I was using patches I had a really strong desire to go to the shop to buy smokes to avoid the pain, but I chose to go to the GP instead.

Keeping Busy and Distracted
As part of the quitting process, these participants recognised the need to keep busy and vigilant to combat the urge to smoke. They increased their physical exercise, attended more activities in their local community and rehabilitation centres and sort out the company of non-smokers. One man concentrated on caring for his pet dog, achieving the double effect of incorporating more physical activity into his day and gaining comfort by patting his pet. All participants demonstrated a clear understanding of the routines and triggers to their smoking within their home environments and set about challenging them consistently and often. They challenged their central identity as a smoker by separating the smoking and relegating it to the position of unwanted behaviour. Stress balls were noted to be effective and kept as mementos of the successful struggle to quit.

(Graham)
I used a stress ball, one with a face that has expressions when you squeeze it. I pulled the paintwork off it, fiddled with it in my fingers as part of it. I still keep this as a reminder of the time when I was quitting. I still do lots of woodwork to keep my hands busy.

(Jim)
I have a chair in the lounge-room where I would sit to have a smoke and coffee in the morning. As part of quitting, I just chose to sit in a different chair, moved around, or had a shower instead of making a coffee first thing in the morning like I always had done as part of some smoking ritual. I also kept changing my routine all the time so as not to get back into a new habit. I also shifted smoking to be an outside only activity. Before, the smoking was very much part of me, especially
when I was more unwell. By doing these things, I was trying to separate the smoking from me as a person, so it was external to me and no longer automatic.

(Roy)
A few months ago I was tempted to smoke again, but I kept busy and distracted myself by washing the inside walls to get rid of the smoke stains. It helped to reinforce the reason for quitting. I listened to the nicobait relaxation tape as well…I also threw all the ashtrays away and the lighter, and finished the cigarettes I had open and gave the two unopened packets to the mental health service for staff to give to someone else. I drink a lot more coffee, especially in the morning. I know it’s just a replacement for smoking but I feel that it is ultimately healthier.

Having Clear and Realistic Expectations
These participants had a clear and realistic expectation of what the process of quitting involved and the difficulties they would face. They had learned from previous experience. They were very aware of the physical and habit components of smoking behaviour. They had done their homework.

(Graham)
I didn’t say, “that’s it”. I told myself I’m going to make it through the first hour, and then the next, and the next, setting small goals for myself in attainable time frames. I gradually learned by failing. Each time you just get stronger and stronger with the motivation. I just sat there and worked through each five minutes until the urge passed, and built up to half and hour and so on.

(Jim)
That’s where people make the mistake. They think the patches are going to cure the problem without having to tackle the habits and then they wonder why they’ve failed…You change your habits and learn from your attempts…(Using lower milligram cigarettes as part of the quitting process) I didn’t cut the number of smokes down. I didn’t want to affect myself too much. I kept within the limits that I set for myself. I was prepared for the degree of difficulty. Some people drop down too fast and they just resort to smoking the higher milligrams again. I took a bit of a study on myself and I said, “Now this is how I’m going to do it,” so I had a very clear idea of how I smoked and when I smoked.
Keeping Motivated

These successful quitters were able to effectively reinforce the benefits of quitting by reminding themselves of their achievements, especially during times when their motivation to stay quit was at risk. They did not fall into the abstinence violation effect trap, that is, they did not perceive slip ups as moments of excessive self-blame and therefore place themselves in the psychological vulnerable position of giving in and recommencing smoking at their previous level (Marlatt & Gordon, 1985). Instead, they quickly got back on track with their quit attempts if they momentarily slipped back into smoking. They set up systems for themselves to provide safety nets and reminders of their goals. Like Jim, who took great pride in showing me all of the household goods he had been able to buy with money he would have otherwise spent on cigarettes, these people made sure that the reminders of their success were apparent. They gave themselves rewards regularly as part of this process.

(Graham)

I’d go to the GP every week for about a month to have a peak flow meter reading. Every week I could see my lung capacity improving. I used it for feedback and encouragement to continue to quit…And you’ve got to watch your weight while you’re quitting…I remember all the former problems that I’ve now overcome as reinforcement to stay quit. I’d think of all the good reasons to give up and all the bad reasons for smoking. I’d tell myself, “you’re got to give up. You’re going to do it. You’re going to get there. Just try again”. I’d get back on track quickly and wouldn’t tell myself I’d blown it, just that I’d slipped up. I constantly reassured myself. It was bullshit to tell myself I couldn’t do it because I had a mental illness. I refused to accept that.

(Ken – following an operation for a collapsed lung)

I remember all the black shit and stuff they got out of my lung, that I had to keep coughing up after the operation in order to reinflate the lung, and it was agonising, and I thought, I remember thinking, “I don’t ever want to smoke again because, Jesus Christ, I never want to have to go through that again”. It was like the “It will never happen to me,” stuff was actually happening…Like there wasn’t willpower involved in my case. It was taken out of my hands by circumstances.

(Mathew)

I’m comfortable living in my own place and independent. It’s precious to me; it’s everything.
(Roy – his wife’s success in giving up helped to motivate him, as well as the house becoming smoke-free. He saw her saving lots of money and giving herself rewards which became an incentive for him to also quit.)

I tried rewarding myself with small rewards and often and therefore was still able to also have the reward of money being saved in the bank…Now we have been able to have holidays as a family which has had many positive impacts, especially for our child. We used to have a very tight budget every fortnight, struggling most of the time. Not having to worry has been good.

(Helen)

I reward myself every month by buying something like clothes, new glasses, concert tickets, seeing a movie, or getting a hair cut. That’s what kept me going mainly. It’s nice to have the money to do things. It’s nice to be able to do a lot of good things. In the past I was always short of money because of the smoking.

Life after Quitting - Improved Self-Efficacy

These people described themselves and saw themselves as achievers. They were proud of themselves and this gave them a sense of purpose and power that they said they did not possess prior to quitting.

(Graham – when at the drop-in mental health service rehabilitation centre)

I don’t sit outside with the smokers. I can’t stand it; their lack of motivation. What annoys me is that they’re constantly thinking about the next cigarette, and borrowing or scabbing off each other. I draw the line now. I have more self-respect; my values are different about myself now…It’s a loss of dignity when you have to ask for a smoke from others…I realised the cost before but it doesn’t hit you until you’ve got money in your hand and seeing what else you could do with it. It’s a huge difference.

(Jim)

I’m glad I’ve given up smoking. It was hard, like climbing walls all day, but I got there. It’s great not smoking. I can walk the hills at Uni. I used to get puffed out at the start of the year but now it’s not a problem.
This was described in a unique way by Roy, who now felt that he could safely leave the ‘old culture’ of interaction between mental health service clients behind.

(Roy)

When I was approached by smokers at the hospital or the clinic for a smoke in the past, I used to feel obligated and often intimidated and threatened, especially if they were bigger than me. Now I have a newfound freedom and sense of power by being able to say “no” and follow through because the people who come up to me soon realise that I can’t give them a smoke and they go away. The changes to smoking policies have helped too by restricting the opportunities of being intimidated for cigarettes at the shops and when I’m out.

Support to Quit

None of these successful quitters had found groups offered by mainstream quit services to be helpful. They said that they had difficulty attending groups where they did not know people due to their feeling a lack of confidence in themselves and feeling a sense of stigma in having a mental illness. The female participant had attended a quit group run by the mental health service for clients of the service and this had been described as beneficial. Two participants had never contacted the Quitline; the other four participants made comments that demonstrated that they found this service unhelpful or inadequate for their needs. One man suggested weekend group support for people with a mental illness who are trying to quit, identifying this as a trigger period for relapse due to lack of contacts and organised activities on weekends.

(Jim –on the Quitline)

They just weren’t there to give you support, like the time you need support is the night times and on weekends and they’re not in the office then.

(Helen –said she found the Quitline useless, not accessible enough and felt like they brushed her off.)

Many of these successful quitters had strong support networks which included family, friends and treatment providers. What was important was not that there were several supports, but that the support was genuine and consistent, and accessible when needed. The person’s mental illness as the lesser focus also appears to have been important in helping these quitters to feel more confident in quitting.
(Jim)
Friends would urge me on to keep going. If I did smoke they’d frown upon it, but otherwise they’d hardly mention it…I told people that I was quitting all the time and they would say, “good, great”. They used to ask if I’d had a smoke this week and I’d say no or yes and so on, and they’d just keep encouraging me. They didn’t get sick of me talking about it because it occurred in just casual conversation…They’d tell me not to smoke. They’d distract me and talk to me. They’d invite me up for tea or something…You just need background support…The main thing is you’ve got to do it yourself. You can’t rely on other people because ultimately it’s your own decision.

(Graham)
I just used myself mainly. I thought others might think worse of me if I reneged on my decision to quit. Only my GP knew of my decision to quit. He didn’t talk about the schizophrenia at all. He checked my lungs every week and my blood pressure. He was reliable and consistent in his response. She believed in me and we had an excellent relationship. She gave me a sense of hope that I didn’t have before. She treated me like a person, you know…One of the most supportive people I found was the chemist. He gave me credit on patches. I hardly knew him before I started trying to quit smoking.

(Helen)
When I first quit smoking, I told everyone. Each week when I’d get another week under my belt without a smoke, I’d go up to friends and say that I hadn’t smoked and they would say, “That’s great”. This level of support wasn’t there a few years ago for me.

Apart from the experience of Graham, the input from general practitioners, psychiatrists and mental health service key workers appeared to be limited.

(4.2.2) Smoking and Mental Illness:
These participants believed that the physical effects of symptoms and side effects, as well as the emotional effects of having a mental illness label played a significant role in their ability to overcome the need for cigarettes. How they personally felt about their situation appeared to matter, especially how it influenced their self-efficacy with quitting, their sense of hope and purpose in quitting and how others perceived them. All of these participants clearly delineated the ideal time for quitting as being when their mental illness was stable. They did not contemplate quitting when they were unwell. All
described how they had used cigarettes to self-medicate the physical and emotional effects of their mental illness. For all of these participants the threat of relapse to smoking, in the context of their mental illness relapse, was described as an ever present possibility to be guarded against.

(Graham - a heavy drug user in past, 4-5 cones per day, alcoholic, licit drug seeker of benzodiazepines) I took what ever I could lay my hands on just to get through the day. I’d put the stereo on and blow myself away as a short-term solution for sheer relief from symptoms. I chose the easy option because of the other stresses in my life; the family court case and problems with having an illness labelling me as a second-class citizen in the eyes of the law. I found this very demoralising. I felt powerless.

(Graham – once he started on clozapine)
I had a sense of great hope for the future that I hadn’t had before. Oh, it’s living; it’s really living…As soon as you take clozapine everything changes. Before it’s like your head’s on two different levels… My self-confidence and self-esteem soared. I now do things that I wouldn’t have attempted before.

(Jim)
Confidence is a big barrier when you’re unwell…I smoked a bit heavier initially when I was the most unwell, up to 50 per day for about 2 years, and then went back to 25 per day…The side effect medication also affects your level of smoking. It cuts them out a little bit, it calms you down so you don’t’ get so restless and feel like needing to smoke so much.

(Ken)
I think I actually smoked less when I was really unwell with depression because I spent most of the day asleep on the couch…(On quitting) I think, at that stage, I wasn’t depressed. I think if I had been suffering from depression as well, I don’t think I could have given up and come to that statement of choosing not to smoke.

(Mathew – said he smoked from the age of ten. From this age he said he started using many licit and illicit drugs and lived on the street, spending some time in jail in his late teens. He said he never told
his parents about hearing voices, that he chose to use drugs instead, smoking every day to ‘medicate’ the paranoia.)

(Helen – talking about the role of stress and relapsing to smoking when voices get too bad) That’s a major thing for me. I was hearing voices and staff and when I’m like that the first thing I do is go out and buy cigarettes, because the voices get too much for me.

The participant with the most chronic and debilitating symptoms described the unique way that his mental illness influenced his smoking and quitting.

(Mathew – When he quit a few years ago, he said the voices told him to quit, believing that he would die if he didn’t quit. He relapsed to smoking after the voices commanded him to start smoking again when he was in hospital. Also, he said that while his illness is well managed and treatment is effective, he doesn’t have the urge to smoke, but has relapsed quickly when this has not been the case.)

(4.2.3) Smoking Relapse, Hospital, and Peer Reinforcement:

All of these successful quitters clearly described the role of the hospital in reinforcing smoking behaviour. This occurred predominantly in the context of peer smoking with other inpatients as part of socialising and relief from boredom within the inpatient environment. Many of these participants had relapsed to smoking during periods of hospital admission.

(Graham)

I started smoking again in hospital because of peer pressure, boredom, no windows in hospital to look out. I used to catch the bus home to have a shower just for something to do while there…It’s hard when most of your friends smoke and it’s what you tend to do when you’re together. Everybody I know smoked.

(Jim)

In hospital it’s hard because there’s nothing to do and you’re just sitting around and wasting time so you just smoke, and everybody does it. It’s bad news in hospital. If you’ve got a cigarette you can get anything you want because they’re like gold. It’s sheer boredom. You get sick and tired of being by yourself so you sit with the others and smoke. The staff would spend much of the time in the nurses
station or in their offices writing reports or something and just come out every now and then, and have a smoke too...It's very tricky to know how to entertain people I suppose, especially when they’re sedated and they’re all different and there for different reasons.

(Roy)

I had my first hospital admission while working as an 18-year-old. I’d started with friends at the industrial workshop where I worked as a 17-year-old. Hospital made me a regular smoker and from then on…(several years later following brief period of quitting) I became increasingly withdrawn and depressed and eventually suicidal and was admitted to hospital where I resumed smoking again. The first smoke was offered by another patient who said, “It give you confidence”.

(Helen – on being in hospital and around the other patients)

I really felt isolated because I wasn’t smoking and it was awful because all the other people were. I felt like I wanted to fit in. I decided to watch TV and I slept instead. I was really doped up anyway. It meant I didn’t get to mix with other people. I would have liked to have been more sociable, but I wasn’t going to go out there and have a smoke. I couldn’t have gone out there and not had a smoke…The nurses feel that they are helping the patients by giving them smokes, but they could try saying no.

(4.3) PRELIMINARY DISCUSSION:

Several points arise from this pilot study. These participants descriptions were consistent with the determination and action processes expressed as part of Prochaska and DiClemente’s stages of change process (1984). This included reaching the point at which they decided to quit and making multiple attempts prior to successfully quitting, They also describe the decision to quit as a cathartic experience, similar to the case studies of mainstream quitters described by Koski-Jannes (1998). The notion of self-efficacy is central to understanding the person’s decision to quit and determination to proceed with their attempt to quit. Marlatt and Gordon (1985) describe relapse as a combination of high-risk situations, coping responses and self-efficacy appraisals of the capacity to cope with the high-risk situations. A study by Garcia, Schmitz and Doerfler (1990), involving thirty-six people self-attempting to quit without treatment support, found that the temptation to smoke and successful avoidance led to subsequent higher levels of self-efficacy, with unsuccessful avoidance leading to reduced self-efficacy. Although this study was limited in that it focused on young adults who had only been smoking for a
short time, its findings suggest that success and failure in avoiding temptation plays a significant role in eventual success with quitting. The implications for smokers with a mental illness who may have repeated failed attempts to quit or avoid smoking is an important consideration worth investigating. It is worth noting that Cohen, et al. (1989), in a review of ten United States prospective studies, found that light smokers (≤ 20 cigarettes per day) were more likely to quit than heavy smokers (≥ 21 cigarettes per day) and that no relationship was found between the number of previous quit attempts and the probability of success on a current attempt. In another study, Hughes (1992) concluded that withdrawal severity did not necessarily differ between heavy and light smokers and that increased depression was a potent predictor of relapse rather than degree of withdrawal symptoms. This suggests that other variables may be predictive of relapse, such as complex social and psychological factors.

A study by Curry, et al. (1990), involving a thirty-six item Reasons for Quitting Scale given to a sample of 1368 mainstream smokers who expressed interest in quitting, found that smokers with higher levels of intrinsic relative to extrinsic motivation were more likely to achieve abstinence. They defined intrinsic motivation as rewards internal to the person, such as concern for health and desire for self-control. Extrinsic motivation was defined as behaviour performed for extrinsic reward, such as to save money or for social influence, such as relief from nagging by others. The successful quitters who participated in the current study demonstrated a significant degree of intrinsic motivation. They were concerned for their physical health and said that they wanted to regain control over their lives. However, it is unclear whether stigma and perceived social exclusion, reinforcement to smoke by others, the degree of control by others and self-control that may or may not be perceived, occur in distinct ways for people with mental illness within mental health settings or how this might influence smoking behaviour. This also needs further investigation.

The current participants emphasised the role of constructive support to quit. In particular, the sense of acceptance as a person by the support network, beyond being seen as a case of mental illness, appeared to be important in helping these participants feel able to attempt to quit. The practical role played by the GP in helping Graham to quit is noted. Cohen and Lichtenstein (1990a) performed a longitudinal one-year study looking at positive and negative behaviours at partner and friend supports as perceived by 221 mainstream smokers who were attempting to stay quit. They found that positive support such as co-operation and reinforcement for quitting, when compared with negative support such as nagging,
policing, and shunning by the support network, was overwhelming linked to successful quitting. Negative support was more likely to induce failure to quit.

Ten case studies of successful quitters without a mental illness have been reported by Bott et al. (1997). The themes identified by them were: the significant struggles involved in attempting to quit, the personification of the cigarette involving issues of loss of cigarettes as a friend, the planning involved in order to successfully quit, the replacement of habits and the hope and belief that this time would be different. Although successful quitters who participated in the current study were only briefly interviewed, they did identify similar processes involved in their quitting attempts, especially their struggles to quit, the role of planning and the replacement of habits. Reasons for the absence of comment on the other themes identified by Bott et al. (1997) is worth investigation. Changes brought about by the effective treatment of the mental illness with medications, notably clozapine and the impact of this on the person’s sense of control and hope in the future are worth further investigation. Pharmacological interactions between quitting smoking and clozapine have been suggested (Albanese, Khantzian, Murphy & Green, 1994; George, Sernyak, Ziedonis & Woods, 1995; George, et al., 2000; McEvoy, et al., 1995b). The current participants confirmed that they perceived links between their past smoking behaviour and the management of their mental illness, that they had self-medicated the physical and emotional effects of having a mental illness and that quitting when their mental illness was stable was essential. They were all aware of the powerlessness invoked by having a mental illness. Roy’s comment about the power and freedom that he felt as a non-smoker is interesting. It demonstrates the significance of needing to feel in control and the extent to which behaviours involving smoking may affect other core interactions for smokers with a mental illness. All successful quitters confirmed the dominant role of the psychiatric hospital in reinforcing smoking behaviour and the high risk of relapse during admission periods because of this. In general, the role of mental illness in increasing the risk of relapse for these participants in their attempts to quit needs further consideration.

A more recent study of quitting by Carter, et al. (2001) acknowledged the social, emotional and temporal roles of smoking, not just its physiological role for dependent smokers. They defined eleven barriers to quitting and staying quit: putting on weight; feeling irritable; having cravings; making social situations difficult; having difficulty coping with stress; having difficulty coping with boredom; having difficulty concentrating; feeling dizzy or light-headed; needing to avoid alcohol; not being able to find a fun substitute; and feeling a sense of loss (p.59). It is not clear from interviews with quitters with a
mental illness whether these barriers to quitting are relevant to their experience, as not all were mentioned during interviews. By interviewing current smokers with mental illness who have had failed attempts to quit, a more complete picture of the barriers to quitting may emerge. In a review of studies of mainstream quitters, Carter, et al. (2001) identified five themes representing their experience of being a successful quitter. The themes were: the importance of willpower and control; quitting as bereavement – the loss of an old friend; redefining the self as a non-smoker; quitting as a rite of passage; and quitting as cleansing. The current participants were clearly similar to mainstream quitters in their descriptions of how they quit, covered by theme one describing the process of quitting. However, their experience shows marked divergence with their descriptions of the role of mental illness and the system of psychiatric treatment and care in reinforcing smoking behaviour. Further investigation is warranted here.

(4.4) CONCLUSION:

Overall, the comments of these successful quitters offer a number of clues indicating areas that could be targeted to assist people with a mental illness to quit more effectively. These include the importance of determining adequate and effective treatments, building of confidence and self-efficacy, the provision of more accessible support services, the possibility of expanding the role of the general practitioner (GP) and changes to the system of care to prevent inadvertent reinforcement of smoking. These results cannot be generalised to the wider population of people suffering from mental illness due to the small sample size and non-differentiation between diagnostic groups. These results also offer a number of areas for further investigation with current smokers suffering from a mental illness. These include the degree of perceived control, the level and type of supports that exist for quitting, the role of families and peers, the role of mental health service staff, beliefs about smoking, beliefs about mental illness, perceived linked between smoking and mental illness, access to and use of the quit line, concern for physical health, knowledge of harms of smoking and levels of motivation to quit. These ideas were used to inform the open-ended questions and checklist used in interviews with clients who were current smokers. The results of those interviews are given in the following chapter, as part of the building process of describing the experience of smoking and barriers to quitting for people with a mental illness.
CHAPTER FIVE

STUDY TWO: CLIENTS WHO SMOKE

- “In order to understand why persons act as they do we need to understand the meaning and significance they give to their actions...to understand other persons’ constructions of reality we would do well to ask them (rather than assume merely by observing their overt behaviour) and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a priori by ourselves) and in a depth which addresses the rich context that is the substance of their meanings (rather than through isolated fragments squeezed into a few lines of paper)” (Jones, 1985, p.46).

(5.1) INTRODUCTION:

This chapter reports the results of data collected from the first of three phases of research involving client interviews, staff interviews and participant observation of inpatient and community mental health settings. This first stage involved a grounded theory thematic analysis of semi-structured, open-ended interviews with a purposive sample of community-based public mental health service clients who were current smokers.

Twenty-four clients of the community mental health service were interviewed, six from each of the nominated diagnostic groups. Participants’ age range was 25 -63 years; twelve were men and twelve were women. The majority of participants started smoking in their teens, had smoked for more than ten years (usually much longer), smoked high tar cigarettes, smoked more than twenty cigarettes per day and lived alone in public housing. All participants were unemployed at the time of interviews and follow-up contact. All received a government pension (twenty-two received the disability support pension and two received the sole parent benefit). Participants had a range of educational experience; however, most had not completed the final year of secondary schooling, year twelve. These results are summarised in Table 5.1. All participants were Caucasian and were of English speaking background. No participants from a CALD (culturally and linguistically diverse) or indigenous background nominated to be part of the study; therefore findings cannot reflect their smoking patterns.

A number of theoretical constructs emerged from the data, many that confirmed and enhanced current understandings of smoking and mental illness, such as the role of cigarettes in managing the symptoms of illness. However, several themes not found in existing literature also emerged. These were: existential roles for smoking in alleviating the effects of stigma, promoting positive and negative
freedoms, providing core needs as part of quality of life decisions and the perceptions of the nature and degree of interaction between psychiatric symptoms and the ‘need’ to smoke. The prominent role of the system of care in the initiation of smoking and its continuance as part of treatment and care of people with a mental illness was apparent from client comments.

Table 5.1: Characteristics of Client Participants’ Smoking Behaviours

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Age</td>
<td>43</td>
<td>42</td>
<td>25-63</td>
</tr>
<tr>
<td>Years Smoked</td>
<td>27</td>
<td>24</td>
<td>4-50</td>
</tr>
<tr>
<td>Current Smoking per day @</td>
<td>40 cigs</td>
<td>35 cigs</td>
<td>20-100 cigs</td>
</tr>
<tr>
<td>Cigarette Strength mgs #</td>
<td>12-16</td>
<td>12-16</td>
<td>8-16</td>
</tr>
<tr>
<td>Age of Smoking Initiation</td>
<td>15 years</td>
<td>14 years</td>
<td>10-24 years</td>
</tr>
<tr>
<td>Previous Quit Attempts *</td>
<td>multiple</td>
<td>multiple</td>
<td>0-multiple</td>
</tr>
</tbody>
</table>

@ - Cigarettes were standard size tailor-made by the manufacturer or rolled by the purchaser from tobacco and papers.

# - Mean and Median values stated as per actual market availability according to level of tar content in milligrams, not statistical values which were 13.66mgs(mean) and 14mgs(median). One participant was experimenting with 1mg cigarettes at the time of interviewing, however, their usual consumption preference was for higher tar cigarettes. The figures reflect this higher figure.

* - Figures for actual number of Quit attempts could not be determined. Multiple means ≥ 10 attempts.

The results from client interviews are divided into four sections based on mental illness diagnosis. Actual quotes from the participants have been used to demonstrate the themes throughout. These appear in bold print italics.

(5.2) SCHIZOPHRENIA (N=6):

All participants with a diagnosis of schizophrenia suffered from chronic paranoid schizophrenia. Their age range was twenty-nine years to forty-nine years, with all experiencing their first episode of psychosis as teenagers or young adults. Their smoking experience ranged from eighteen to thirty-five years. Current smoking consumption ranged from twenty-five cigarettes to 100 cigarettes per day, with all smoking high tar cigarettes. All except one participant said that they started smoking in their late childhood to teens in the context of peer activity. Rod commenced smoking while an inpatient in the psychiatric hospital at the age of twenty-one. All participants cited heavier consumption of cigarettes during admissions to hospital and when their mental illness was less stable. Only one participant had a
current partner, the remainder lived alone in public rental accommodation. All received a government disability pension. Two participants had a tertiary degree and one participant (Rod) had made intermittent attempts to complete a tertiary degree however, all were unemployed. All six participants had made equal to or more than ten attempts to quit smoking in the past and all obtained high Fagerstrom scores of ten or eleven indicating that they were heavily physically dependent on nicotine (See Appendix D). Four of the six participants had cited problems with alcohol use in the past. Two of these no longer drank alcohol; the other two continued to consume three or more standard alcoholic drinks per day. Cost was cited as a significant reason for choices about alcohol use and non-use, especially when cigarettes and caffeine products also needed to be incorporated into the budget. Caffeine use was high for this group (See Table 5.2).

Table 5.2: Characteristics of Participants with a Diagnosis of Schizophrenia

<table>
<thead>
<tr>
<th>Names/Pseudonym</th>
<th>Jenny</th>
<th>John</th>
<th>James</th>
<th>Mark</th>
<th>Jean</th>
<th>Rod</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>29</td>
<td>45</td>
<td>36</td>
<td>38</td>
<td>49</td>
<td>40</td>
</tr>
<tr>
<td>Income Type</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
<td>DSP</td>
</tr>
<tr>
<td>Highest Education</td>
<td>Tertiary</td>
<td>Tertiary</td>
<td>Year 11 (17yo)</td>
<td>Year 11 (17yo)</td>
<td>Year 8 (14yo)</td>
<td>Tertiary *</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Divorced</td>
<td>Divorced</td>
<td>Married</td>
<td>Single</td>
<td>Separated</td>
<td>Single</td>
</tr>
<tr>
<td>Accommodation</td>
<td>Public Rental</td>
<td>Public Rental</td>
<td>Private Rental</td>
<td>Public Rental</td>
<td>Public Rental</td>
<td>Public Rental</td>
</tr>
<tr>
<td>Started Smoking</td>
<td>11yo</td>
<td>15yo</td>
<td>14yo</td>
<td>16yo</td>
<td>14yo</td>
<td>21yo **</td>
</tr>
<tr>
<td>Current Smoking</td>
<td>@ 50+</td>
<td>30</td>
<td>25</td>
<td>35</td>
<td>50-70</td>
<td>50-100</td>
</tr>
<tr>
<td>Tar Strength</td>
<td>16mg</td>
<td>12mg</td>
<td>12mg</td>
<td>12mg</td>
<td>16mg</td>
<td>16mg</td>
</tr>
<tr>
<td>No. Quit Attempts</td>
<td>&gt;10</td>
<td>&gt;10</td>
<td>4 times</td>
<td>&gt;10</td>
<td>&gt;10</td>
<td>5 times</td>
</tr>
<tr>
<td>Years Smoked</td>
<td>18</td>
<td>30</td>
<td>22</td>
<td>22</td>
<td>35</td>
<td>19</td>
</tr>
<tr>
<td>Fagerstrom Score</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Smoking- Interview</td>
<td>6-7</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>7-8</td>
</tr>
<tr>
<td>Place of Interview</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
<td>Home</td>
</tr>
<tr>
<td>Interview Length</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.25 hours</td>
<td>0.75 hours</td>
</tr>
<tr>
<td>Past Alcohol Use</td>
<td>Social only</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Social only</td>
<td>Yes</td>
</tr>
<tr>
<td>Current Alcohol</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Current Caffeine</td>
<td>10+</td>
<td>10+</td>
<td>5***</td>
<td>8</td>
<td>15+ (tea)</td>
<td>15+ (tea)</td>
</tr>
</tbody>
</table>

# - Disability Support Pension provided by the Commonwealth Government
* - Rod had made a number of attempts over several years to complete tertiary studies
** - Started Smoking in Hospital
@ - cigarettes smoked per day
*** - James reported prior coffee consumption of 25-30 cups per day

Results from interviews with participants with a diagnosis of schizophrenia are organised into the following eight themes.
(5.2.1) ‘At least I’ve got a smoke’ (Jenny) - The Freedom to Smoke in the Perceived Absence of Other Freedoms:

The feeling of safety and reassurance that came with having an assured supply of cigarettes was clearly and strongly expressed by all participants with a diagnosis of schizophrenia. Cigarettes played a significant role as the marker that kept every other aspect of their lives in control.

(John)
*Smoking gives me control, especially when everything else is difficult to control...They seem to form the foundation from which I can tackle other things.*

The use of cigarettes in this role was perceived to be learned and reinforced over time. The original experience of smoking was reported to be part of the person’s attempt to relieve feelings of self-doubt and to gain social inclusion. One participant described her initiation into smoking in the context of being abused and neglected within a household struggling to accommodate a mentally ill parent without support from mental health services.

(Jenny)
*It was a rebellious thing and it made me feel good because it was one part of my life that I did have control and it was nice to have control when other things were out of control.*

The experience of having a psychiatric diagnosis and the perceived stigma associated with this became part of the everyday experience of those interviewed. The unpredictability of the course of the illness and its destructive effects on relationships, financial security and self-worth came to affect the very core of these people’s being. The most striking feature of their decision to continue smoking was the sense of freedom it gave in the presence of overwhelming powerlessness to predict their future and lack of freedom in deciding that future. Smoking appeared to become a search for more autonomy.

(Rod)
*I’m told by the doctors that I have to take medication. I get detention slapped on me and get locked up. A lot of the things I get told but I can choose to smoke and drink. So when there’s not many choices, to have something you can choose to do is pretty good you see.*
(Jenny)

At least I’ve got a smoke.

James’ comments give clues to the unique experience and significance of this source of freedom in the presence of a psychotic illness:-

(James)

Smoking gives me a feeling of freedom that I just don’t have with other parts of my life. I can choose when I have my next smoke but I can’t choose not feeling stressed or intimidated by my thoughts. I can’t choose not to take medication because of the consequences of this.

This perceived lack of freedom was most pronounced while the smokers were being treated in inpatient psychiatric facilities. This role of smoking was inadvertently reinforced by the system of care and the staff administering that care. Talking about her experiences in the locked ward, Jenny’s comments and her choice of words, referring to the smoking area as ‘a cage’ (as it is referred to by staff also), demonstrate the depth of deprivation she felt:

(Jenny)

The whole experience of being locked in a cage for five minutes to have a cigarette, it’s just a horrible experience. I didn’t like it at all...it’s like you get out of this cage and get into the other cage but at least I’m having a smoke and they can’t control that bit.

Mark’s experience of the open ward was similar:

(Mark)

I just wanted to get back to my house and freedom. Like they let me out and let me go to town, but it wasn’t the same. They used to get you up at 8 am and have breakfast, then have a shower and then what do you do for the rest of the day...Every day the same; set meals, medication. A routine I had no say in. At home you can smoke when you want and as often as you want.

All participants related stories of cigarettes being used, by staff, as tools to reward or punish patients in order to control their behaviour. John’s comments on how this felt exemplify the dehumanising effects
of this that he felt. It also exemplifies the likely consequences for people who experience involuntary admission to a mental hospital:

(John – When asked about being in the locked ward and being permitted to smoke every hour) I thought it was a fairly good thing for me and others. Sometimes the smokes were almost used like blackmail so that, if you didn’t do the right thing, the cigarettes were denied you. So if you’re someone who usually smokes a cigarette every twenty minutes or so you’d be frantic. It takes away your sense of being a person.

Smoking was perceived as one of the most effective means of avoiding illness relapse, with all its associated consequences, such as the loss of self-identity, loss of stability in one’s environment and relinquishing control to others. It therefore served to protect whatever remaining freedoms these smokers still possessed.

(James -In desperate tones and appearing to be totally consumed with the daily ritual of monitoring his smoking and illness) I’ve lost so much already. I don’t want to lose the rest. It’s a constant struggle with an unknown future. I want to stay with what I know and if I smoke then everything else seems more manageable.

(Mark)
It relaxes me and I can control it. I can say I’m going to have a smoke every half and hour whereas I can’t say, ‘well no, I’m not going to get unwell this year.’ I’m not too sure on that one. It could happen anytime; you don’t know. I can do all the right things, have my tablets, see my doctor and all that hoohah, but you still don’t know, do you?

(5.2.2) ‘Why Quit, I’ve still got schizophrenia haven’t I?’ (Mark) - The Experience of Powerlessness and Existential Despair:

These smokers continued to smoke because they saw no compelling reason not to do so. They believed that their life path had been pre-destined by the presence of an incurable illness, that there was no clear evidence that another, better life was possible or indeed likely. Hence, continuing in familiar circumstances was seen as the most reliable means of self-preservation. Participants described the pain, powerlessness and despair they felt with an eerie calmness. They had resigned themselves to the loss,
alienation, stigma, and powerlessness that came from their having this mental illness. This absolute sense of despair, of giving in to the dominant, stigmatising view of their illness, strongly influenced their beliefs and those of others around them, in their ability to quit smoking. Talking about people with a mental illness in general, Jenny’s observation was:

(Jenny)

I’ve heard people say that it’s not even worth helping them. There’s the whole issue of ‘why bother’ which you get assumed about you by others, especially because you’ve got an illness that’s going to stay with you as a label for ever...That’s a prejudice I have to live with forever...It’s a real resignation about what you can’t change. Like, life’s shit anyway so you might as well smoke. It’s like a really big message from a lot of people saying that they accept that they’re killing themselves. Like it’s a really slow form of suicide that’s not conscious...it’s to do with some deeper feeling they have about themselves.

Continuing to smoke acted as a shield, protecting these smokers from further pain and disappointment.

(Mark – Talking about the prospect of quitting)

I’m just not sure what else there is. What would I do with myself? I don’t expect my current situation to be any different. I’ve organised my life to live within my capacity. That way you don’t get sad about missing things. Sometimes I get sad and ask, ‘Why me? Why did I get this illness?...I don’t even know if I went to the doctor and he told me I had to give up smoking whether I would or not, even if it came to that, if I had cancer or something. Seems I’ve got an illness, like, it would be good to go wouldn’t it. I wouldn’t have the illness no more. I wouldn’t have to worry about it...Even if I did give up smoking, I’ve still got schizophrenia, haven’t I? How much pain is enough before you draw the line?’

This message ‘why bother’ was unfortunately given to one man by the Quitline he had contacted for help with quitting, reinforcing his sense of disillusionment and detachment.

(James – He said the Quitline adviser’s message for him was:) 

You haven’t got a hope in hell of quitting with schizophrenia.
The effect of this information became obvious when he later spoke about what he thought of his ability to quit.

(James)
I'd need to know for certain that it would make a big difference and I don't think that's possible because I'm a schizophrenic and that's permanent.

The descriptions of what it is like to have a mental illness, and the destruction of life purpose so vital in quitting, are poignantly and sometimes graphically, exemplified by John’s descriptions of his experiences:

(John)
This schizophrenia really wrecks your life, you don’t really have a life, you have only an existence. I don’t feel like I’ve got a proper life at the moment, it’s just a thing without purpose. It becomes a day to day thing. You don’t have hopes and goals like before...The first smoke of my day is just to get through the terrible shock of being awake again.

(5.2.3) “Making Sure of Supply” (Jean) - Cigarettes as a Core Need:
Cigarettes were overwhelmingly rated as a core need by all participants, given greater importance than food. Security of accommodation was the only other core need to be given the same priority. At times, however, the financial burdens and risks involved in ensuring the continued supply of cigarettes meant that even this was sometimes threatened. The process of ensuring supply was described as a constant, vigilant, often all-consuming part of the person’s thoughts and plans.

(Jean)
I've had lots of times when I've lived on rice and potatoes. I'll buy the dog food before I'll buy my own food, because I know I can go without if I have to. I've always budgeted for smokes. I always make sure I've paid the bills too, because I don't want to be out on the streets. Feeling secure is pretty important to me and being independent. I don't want to lose that as well. By pension day I've usually run out of smokes, so I wake up at the earliest possible time to get to the bank. I've been out at 2 am in the past because I couldn’t wait any longer for daylight.
The fear of illness relapse was a paramount consideration for these smokers. Connections between their smoking and illness management were clearly made, especially how they managed their stress levels. Thus ensuring supply was seen as vital to avoid the deleterious physical, psychological and social consequences of relapse. The level of fear of recurring psychotic symptoms cannot be overstated, often leading people to live very deprived and driven lives. One man who watches the clock throughout the day and night to time the smoking of his cigarettes to occur every half an hour was asked about this:

(Mark)

I need them that often. It makes me feel safer to know that I can watch the clock and see when the next one is coming. It's predictable which is more than I can say for other things. (such as voices)...I've thought about whether I'd get unwell if I tried to quit. I know I don't want to end up in hospital again. I know that.

(Jean - Speaking of her last hospital admission and the fear of illness relapse in the context of having no cigarettes)

It terrified me when I was unwell. I don't ever want that to happen again. The voices were horrifying, worse than anything I experienced as a child. (abused) I thought I was being burned alive and that people were going to murder me.

The desperate lengths to which these people would go to ensure the supply of cigarettes, sometimes putting all else at risk, are illustrated by Mark and Jean’s comments:

(Mark)

The first time when I had no money and I couldn’t get credit at the deli, I used to go around the streets looking for butts...looking for butts... I don’t know where or who they came from but I’d unroll them and join them all up again into one. It was just a smoke wasn’t it. I’ve been that bad. When you can’t have a smoke you just go around knocking on people’s door asking for smokes and some I didn’t even know the people, and they’d say, ‘Who are you and what do you want?’ Some just used to swear at me and push the door in my face, bang the door. It was just a smoke...I would have done anything for one at the time.
Every time I’d run out of smokes I’d grab something and take it to [pawn shop]. I ended up with about 50 things in there, so I’d be giving them up to a third of my pension each fortnight in interest payments. (The response when she asked them to ban her from pawning more belongings) They told me I was one of their best customers. I’d walk in and they’d say ‘hello’ …and we’d have a laugh and a chat.

(5.2.4) “It’s part of me” (Jenny) - Smoking and Identity:

The role and importance of identity as a smoker and cigarettes as a friend for people with a mental illness and particularly those who experience psychosis, emerged as a significant theme. The role of smoking as part of identity was a complex and sometimes contradictory phenomenon for these smokers. Their comments demonstrate that they relied on smoking for identity but also acknowledged that, by smoking, they were often seen as separate from others with whom they wished to identify in order to feel ‘normal’.

None of my other family members smoke or ever did smoke. I’m different, I suppose, aren’t I? I’ve got schizophrenia; they haven’t.

One of the things I feel is that I was meant to smoke because it was how I differentiated myself from the rest of my family who don’t smoke.

With regard to their psychotic experiences, the importance of being able to describe oneself as ‘a smoker’, as a tangible ‘anything’ was described as extremely important and sometimes vital for smokers with schizophrenia. Given the fear engendered by not knowing what or who is real or unreal while experiencing the positive symptoms (voices / hallucinations) of a psychotic episode, it is not surprising that being defined as, and defining oneself as, a smoker and being able to do so with such repetition, each time a cigarette was lit, was so important for these people. Jenny’s comments on the prospect of quitting demonstrate the interaction between psychosis and identity.
(Jenny)

*It's part of me. Stopping would be like becoming a different me.*

Smoking became the means for these people to differentiate themselves from their family and others, to have an identity when they weren’t sure at times, a way of finding a sense of autonomy and self when sometimes life seemed like a mere vacuum. Smokes as a friend, was understood as a natural progression in this schema. The significant role played by cigarettes as a friend cannot be overstated. Smokes became the friend that provides what they lacked in other relationships.

(Jenny)

*Who else have I got? They’re always there. They’re good friends and they don’t criticise you.*

Smoking aided identity formation in other ways. It helped smokers with schizophrenia feel ‘normal’, just like other people, to be doing what other people were doing and to not let the identity as a person with schizophrenia dominate.

(Jean)

*When I’m at the shops I feel like people are looking at me and saying, ‘she’s got schizophrenia.’ I’m conscious that I look different because of the side effects of medication, especially the way I walk and how my mouth looks. (Abnormal lip and tongue movements typical of tardive dyskinesia from years of talking anti-psychotic medications) It really makes me feel sad. The smoking camouflages it. It makes me feel more like other people, more normal.*

(5.2.5) Smoking to Manage the Symptoms of Mental Illness - Self-Medication:

These smokers used cigarettes as a tool to manage and cope with their mental illness, both physically and psychologically. Their rate and style of smoking was directly determined by the status of their mental illness at the time. The well understood uses of cigarettes for stress relief, relaxation, as an aid to decision-making and motivation and stalling decisions were cited by many participants. Smoking was particularly linked to mood management and illness symptoms.
(Jean)

_Sometimes when I have a smoke it means I don’t have to think; it gives me time out. If I had more time to think, I’d probably just get depressed about my situation...just knowing they’re there is enough to keep me calm. But when I run out of them I panic...Sometimes I’m just sick of being sick. Smoking is like a pacifier; it’s like taking a tablet._

(Mark)

_Sometimes I can’t go out because of my illness._ (Talking about a recent episode of illness) _I stayed inside and smoked my head off. I found it hard to even go to the letterbox, let alone the front door…I smoked differently; inhaled more and smoked it right down so that I didn’t even realise it until I looked._

All participants were aware of the physical health consequences of their smoking. They chose to smoke regardless of this knowledge. They were fully aware of support services and many could recall the anti-smoking advertisements readily from various media sources. Likewise, all participants with schizophrenia were acutely aware of their physical dependence on nicotine and smoked according to this need for nicotine, often demonstrating that they were titrating the dose. The usual pattern of consumption was for the person to have five or six smokes within the first hour after rising in the morning, ‘just to get the nicotine level up,’ with maintenance doses during the day, tapering off consumption at night as their body became saturated with nicotine. These smokers rarely wasted their time or money on lower milligram cigarettes; they bought sixteen milligram cigarettes purely for their nicotine effect.

(Jenny)

_You have to keep a level up and you feel like you need a cigarette. I find it’s important to have that cigarette, like it’s something your brain and your body’s doing automatically to let you know that your nicotine level is dropping…it’s a physical thing of actually needing it._

All participants with schizophrenia identified, often with amazing control and precision, the interaction between their mental illness and their nicotine intake. Popular notions of this group as being ‘out of control’ and dependent on others were directly refuted by the findings of this study. They were acutely aware of their smoking patterns and habits from the moment they got up in the morning to when they...
went to bed at night. Some monitored their intake as if it were an obsession; cigarettes were merely the vehicles of administration of this ‘medication’.

(Mark – When asked how often he smokes)

*Every half an hour. I’ve got the clock there to time myself. If I’m home I watch the clock to time myself and if I’m out I just keep asking people what the time is…It makes me feel safer to know that I can watch the clock and see when the next one is coming. It’s predictable which is more than I can say for other things.*

Smoking was also used as a social tool by participants, often compensating for loneliness and social isolation. For some the daily ritual of buying a packet of cigarettes from the local shop gave them the reason and motivation to get up and out of the house.

(John)

*I do think it fits into a loneliness pattern too. If you have no real reason but you just feel suddenly very lonely, it’s something to do, because you have to go out, you have to find a shop, or somebody, or something.*

Related to this sub-theme is the significance of boredom and how it was perceived by the smokers. Many of the existing studies on smoking describe boredom as being when the person has a sense of blankness or numbness and chooses to smoke because there is nothing else to do. These smokers’ comments challenge these notions. Three of the six people interviewed with schizophrenia made no reference to boredom. The other three clearly described their boredom as a lack of life purpose.

(John)

*It’s a lack of feeling that there are other things worth doing. Because I haven’t really had a boring week. I’ve had things I’ve done, but more that what I’ve done has seemed to lack a purpose; it’s been mundane.*

Unique to this study were the findings that smoking played a role in alleviating the positive symptoms of schizophrenia, a role identified with clarity by more than half of the participants. These smokers were compliant with medications and were deemed to be managed appropriately by their doctors.
Hence, their reluctance to quit smoking was understandable when they were still clearly experiencing distressing symptoms while being optimally treated for their mental illness. It could be argued that they were making every effort to manage their illness responsibly based on what knowledge and resources were available to them and their doctors.

*(John)*

*The smoking keeps the negative thoughts from getting too bad; it sort of kills them in a way, like I know they’re not really my thoughts...Physiologically it changes me so that the negative thoughts don’t build up. It’s a bit like a dripping tap with the negative thoughts so at those times I smoke more to stop it from dripping. And at the moment there doesn’t seem to be any better solution to stopping the negative thoughts than smoking.*

*(Jean)*

*S sometimes if I keep thinking too much, it’s like a snowball effect and I feel like it moves towards paranoid thinking and that frightens me. The smoking stops that feeling. That’s what holds me back from quitting.*

(5.2.6) Desire to Quit Smoking:

** Quitting Beliefs and Attempts**

All participants with schizophrenia said that if they could quit ‘painless’, they would without hesitation, but few thought they could be successful at quitting, given the presence of their mental illness. They had made several attempts to quit smoking, four of them making more than ten attempts in the past. All took responsibility for their smoking and for change. They were very aware of the habits associated with their smoking. Many of these smokers had made attempts to quit with this knowledge in mind. However, these smokers reported significant anxiety and other symptoms of nicotine withdrawal when they did attempt to quit and this is what they said significantly contributed to their smoking relapse in the short-term.

*(Rod – on quitting smoking)*

*It was hell. I climbed walls.*
(James)
I used crown mints whenever I felt like having a cigarette…I would also lock the smokes in the shed so that they weren’t so accessible. I tried to change my routine…I was just a wreck. My anxiety level was off the scale. I couldn’t stand still for more than a few seconds.

(Jenny)
There are real physical symptoms with giving up smoking and I think that’s ignored…I would like to give up smoking but I just don’t think I can.

Cutting Down versus Cold Turkey
These participants said that they would and could cut down their cigarette consumption in preference to cutting them out altogether. They stressed their need for nicotine to assist the management of their mental illness, as previously stated and therefore concluded that some ongoing source of nicotine was essential to their well-being. They said that they recognised the risks in merely cutting down cigarette consumption given that their symptoms and mood might vary and lead to relapse to former smoking levels. This was perceived as the preferred option to being without cigarettes altogether. In particular, they identified the first cigarettes in their day as those that they could not cut out because they were seen as essential to helping these smokers get the thoughts prepared for the day. These smokers feared the consequences of ceasing smoking altogether, but could clearly identify times when they were able to cut down. This was most successful when nicotine replacement therapy was also used. All participants had experienced some relief from using nicotine replacement therapy, although results were mixed.

(Mark)
I’ve tried cutting down. In the new year I’ll try going back down to every hour. I don’t know. I was just getting too uptight. I just couldn’t do it every hour.

(James)
I used patches for about two months and only smoked four cigarettes a day while using patches. I rationalised it and allowed myself to smoke because I believed that I would never be able to quit completely because of the schizophrenia. Cutting down from thirty-five to four per day was the best possible option.
(Jean)
I've tried patches as well and I've just continued to smoke while I was using them. I think I was expecting them to do it all for me.

Nicotine Replacement Therapy
All of these participants were on very low incomes, living from hand to mouth with each fortnightly pension payment and spending up to a half of their pension on cigarettes. Therefore they said they rarely reached a point of being able to afford nicotine replacement therapies, given that they insisted on also having cigarettes on hand as a safety net in case their quit attempt failed.

(Jean)
I was going to try nicotine gum but I haven’t got around to it yet. I just never seem to have the extra money to buy them because I’ve always spent it on smokes.

Support to Quit
The sense of exclusion from mainstream quit programmes was strongly felt by all those interviewed. They cited feeling that there was a lack of understanding of their needs associated with having a mental illness, feeling judged, a need to feel worthwhile and to have more meaningful relationships in order to be able to quit successfully. The perceived hopelessness of effective Quitline help for smokers with schizophrenia has been mentioned in theme two. Comments by these participants indicated that other means of delivering the quit message may be more effective for smokers with a mental illness.

(Jenny)
Yes, I’ve got the Quitbook before, but somehow it wasn’t enough. Like I can read all about it and, sure, I know that’s it’s bad for you but that’s not enough.

(John)
I rang the Quitline. That was just a waste of time. I think I was just feeling like I couldn’t cope with anything and thought well…’Why bother ringing. A phone call is not going to help you stop just like that. I don’t remember whether I got through. I think I just got a recorded message.
I’ve heard it on the TV and radio that you can ring the Quitline...I watch those ads on TV where they squeeze the stuff out of the person’s lungs [grimaces] and I wonder am I like that inside and I have a smoke while I’m watching.

Response to Smoking Policy Changes
All participants were concerned about policy changes regarding smoking, particularly in public places. They emphasised their concerns for their basic rights and freedoms, suggesting that the new policies would have greater consequences for those who felt the most powerless. The fear of having a ‘double dose’ of stigma, previously for their mental illness and now also for their smoking, was pronounced. They were also concerned about becoming more socially isolated, with smokers being driven behind closed doors.

(Mark - Who says he relies on going to the pub each day to get at least one square meal and to see other people)
If they banned smoking in the pub then I just wouldn’t go to the pub. I’d buy take-away and bring it home, and drink at home alone.

(Jean)
Now that you can’t smoke at the shops, I get quite anxious. I can’t stay there for too long and usually have to rush out or rush home to have a smoke. It’s getting to the stage where you’re really made to feel like an outsider... You get a double dose.

(John)
Telling people not to smoke doesn’t work; being judgmental or putting them down. For people who are struggling anyway and don’t have much confidence and feel isolated, to feel further stigmatised for their smoking, it makes quitting even harder.

(5.2.7) Smoking Reinforcement and Acceptance of Smoking:
Peer Reinforcement
For most smokers with schizophrenia, their smoking started with peers, often at school where lunch money was budgeted to incorporate cigarettes. Smoking was a central component of their rite of passage into adulthood and peer acceptance was central to their decision to start smoking.

(Mark - Who said he was very overweight and subject to teasing at school)
I smoked so that I could fit in with other kids. I found out at that age that if I smoked I could have friends...I did a lot of things just to feel wanted and accepted.

(Jenny)
It was the ‘in thing’ to do with other kids. It was rebellious. I wasn’t meant to do it so that made me feel good.

These smokers described their smoking continuance as being strongly influenced by peers who also smoked. This incorporated a degree of identity-seeking and acceptance-seeking in the context of social isolation. They noted that many of their friends were fellow mental health service clients and that smoking is quite acceptable during activities with other clients.

(John)
Most of the people I’ve known over the years have been smokers. I really can’t remember anyone I’ve known as a friend who hasn’t been a smoker...It’s not the smoke; it’s the friendship and being accepted...part of the companionship is smoking together.

(Paul – Talking of friends and smoking)
We would all look after each other with smokes if someone ran out.

(Jenny)
It’s quite acceptable amongst my friends. There’s no pressure by anyone I know; they all smoke.

(John – Talking about the drop-in centre)
Those who don’t smoke feel left out.

The Inpatient Setting
Several comments were made about the hospital environment and the system of care in mental health generally. The impression gained from all participants was that, if people went into hospital as non-smokers, in all probability they would leave as smokers. They saw the peer pressure to smoke and the lack of other activities to occupy them as key causal factors in this.

(Mark)

*Sometimes I never used to smoke. It was just good being around other people but they all used to smoke so I just joined in. It was a real social thing. Sometimes it was better than the treatment. Some of the nurses used to come out and have a smoke and talk to you. They’d be talking to you just as a friend, not like when you were talking to the doctor...Seeing them smoking there and talking seemed less intimidating. It helped step over the barrier of us and them.*

In one extreme instance, one person recounted her observation of staff treatment of another client with schizophrenia and brain injury who was prone to wandering from the ward. She stated that staff had encouraged this client to commence smoking to give him something to do so that he would not pester them. He was also encouraged to smoke to ensure that he would not wander too far from the ward or abscond, due to the need to come back every hour or so for his next cigarette. The reasons for this practice may be more complex than this person’s interpretation.

**Responses of Service Providers**

Most participants said that their psychiatrist rarely mentioned their smoking. If they did, they gave it a negative, judgemental connotation or openly accepted their smoking. The assumption gained by these smokers was that their doctor was clearly demarcating the area of their responsibility for treatment and smoking cessation was not included in that area. Community mental health service key workers were also described to be accepting of smoking by these participants and often assisted these smokers to budget for cigarettes.

(Jenny- Talking about her doctor)

*He doesn’t really talk about it. I have a smoke before I go in there to prepare me to sit there for an hour and I think he’s aware of that…but generally it’s not a topic we discuss because we’re talking about other issues.*
(Mark)
The psychiatrist doesn't encourage me to quit because she's a smoker herself. I bring it up sometimes; she says there’s nothing wrong with it and that I probably need to smoke for my illness.

Family Reinforcement of Smoking – “they accept that I need them” (James)
The majority of these participants spent their childhood in family environments where smoking was accepted and even encouraged.

(Jean)
Both my parents were smokers as well as all my siblings. Mum used to hand them around at home.

(Rod – Talking about his parents)
They smoke and they’re happy to give me some. They only say no if they haven’t got any money either.

Families tended to respond to the person’s current smoking needs with acceptance, that smoking was somehow helping them to manage their illness and was therefore to be condoned, regardless of other consequences of smoking. The held belief was that their mentally ill relative ‘needed’ to smoke and therefore allowances needed to be made for their smoking. This included lending them money for cigarettes and ensuring their supply of cigarettes during periods as an inpatient in hospital.

(John)
Mum has given me some money over the years and that has allowed me to keep smoking and that probably kept me from going totally crazy.

(James – Talking of his partner’s response not that he is on different medication that appears to be improving his mental health)
She doesn’t like me smoking and she tells me so more now. She never used to. I guess she thought I needed it more then to help with the anxiety I’d feel.

For some participants, a more negative message was given by family members who saw them as ‘a lost cause’ and therefore beyond help with their smoking.
(Jenny)

*I wanted to go to Smoke-Enders but my partner said it wasn’t worth it. It was pretty clear what he thought of me.*

Regardless of which attitude the person received from their family, the outcome of them receiving little pressure to quit was the same; they continued to smoke and to feel that they needed to smoke.

(5.2.8) Other Drugs:

Caffeine

All participants with a diagnosis of schizophrenia were heavy caffeine drinkers, citing that they always paired their caffeine intake with cigarette smoking, especially first thing in the morning upon rising from bed. Two of the six participants reported drinking tea rather than coffee because it was cheaper and therefore better suited to their need for strong and large quantities of caffeine in the context of strict budgets. Cola drinks were bought regularly, where finances permitted. One participant, James, said that he managed to cut down on smoking when he also simultaneously cut down on his coffee intake.

Alcohol

Likewise, alcohol was used by all participants with schizophrenia, more often than not paired with their smoking, with heavier smoking being reported when they were drinking alcohol. There was general acceptance that drinking and smoking go together as a natural activity, that drinking triggered smoking. Some of these participants also said they used alcohol to help manage their illness symptoms.

(Mark)

*I drink alcohol every day, usually just one or two when I’m having lunch at the pub... when you drink, you just smoke one after the other don’t you. Because smokes and booze go together for me, for lots of people, doesn’t it?*

(James)

*I also drank a lot of alcohol from an early age. I’ve always been a bad sleeper and I discovered that alcohol helped me to sleep. It helps the tablets to work better as well.*
Marijuana

Five of the six participants with schizophrenia had a history of marijuana use, with one reporting current use (Rod). The participant who had never smoked marijuana was Jean who was the eldest of the group. Four of the five participants who had smoked marijuana said they started smoking it as teenagers as part of peer activity and that marijuana had a direct impact on the mental illness, with all except Rod stating that it had a detrimental impact.

(Mark)

I became unwell when I was in my twenties. I used to smoke dope, nearly every day, 2 or 3 times a day, every day. The doctor thinks that I might have got unwell earlier if I’d started smoking dope in my teens. The last time I had a smoke of dope I only had one puff and I had to go to hospital. I went crazy…I used to get into the wrong crowd, drinking a lot, smoking a lot. I did a lot of things just to feel wanted and accepted. I’m not the only one though; there are plenty of others I’ve met.

(5.2.9) Summary:

Participants with a diagnosis of schizophrenia clearly described the use of cigarettes to promote autonomy and a sense of freedom in the face of mental illness and its detrimental consequences. They demonstrated a significant degree of internal control, ensuring their cigarette supply and monitoring their nicotine intake closely. The permanency of their illness, its detrimental effects on their lives and their sense of despair and hopelessness in recovery was openly expressed and reflected in their comments. These participants used cigarettes for positive symptom relief from psychotic thoughts, and negative symptom relief such as negative mood state, amotivation and anhedonia. Smoking provided these participants with a structured activity that they could rely on to keep them anchored and more secure in their identity, especially in the face of psychotic symptoms. They often felt socially and emotionally excluded from others and hence, cigarettes became a substitute for the lack of understanding others. These participants started smoking with adolescent peers under similar circumstances to other smokers. They experienced overwhelming acceptance and reinforcement from family, community mental health staff and the inpatient system of care for their current smoking to continue. Most of these participants said that they would prefer to be non-smokers but felt unable to quit successfully given the presence of their mental illness. (A summary of results from each diagnostic group appears at the end of this chapter – Table 5.6)
(5.3) BIPOLAR AFFECTIVE DISORDER (N=6):

Participants with a diagnosis of BPAD ranged in age from twenty-two years to fifty-nine years, with all of them experiencing their first episode of mood disorder as late teens or young adults. Their smoking experience ranged from thirteen years to thirty-eight years. Current smoking consumption ranged from twenty cigarettes to more than fifty cigarettes per day, with higher tar cigarettes preferred. All except for one participant said that they started smoking in their late childhood to teens in the context of peer activity. The eldest participant from this group started smoking at the age of twenty-one years. All participants cited heavier consumption of cigarettes during admissions to hospital and when their mental illness was less stable. All participants with BPAD lived alone, five of these being divorced. The two eldest participants with BPAD owned their own unit. These two participants had also successfully held paid employment for several years previously. The remaining participants lived in rental accommodation. All currently received a government pension as a result of their mental illness. Level of education was mixed and all were unemployed at the time of interviews. All six participants had made several attempts to quit smoking in the past and all obtained high Fagerstrom scores of eight to eleven indicating that they were heavily physically dependent on nicotine (See Appendix D). All except one participant with BPAD had a noted history of alcohol abuse and all currently used alcohol regularly and sometimes excessively. Caffeine use was high for this group. (See Table 5.3)
Table 5.3: Characteristics of Participants with a Diagnosis of Bipolar Affective Disorder

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<td>Depression / Mixed</td>
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Table 5.3: Characteristics of Participants with a Diagnosis of Bipolar Affective Disorder

### Results from interviews with participants with a diagnosis of BPAD are organised into the following eight themes.

#### (5.3.1) Control and Smoking:

Participants with BPAD overwhelmingly emphasised control in most comments they made about their smoking. Examples of this were their claims not to have any control over the habits surrounding their smoking, their incessant seeking of control over their mood via smoking and their tendency to relinquish all control over their smoking when unwell. They made several statements about their attempts to quit smoking in the context of their illness that reflected a black and white view of their ability to control the circumstances of their lives. Examples of these statements were that: you either have control or you have none, you can either quit or you can’t, you either smoke or you quit, you’re either well or you’re unwell. They spoke as if there was no middle ground, no transition, no learning...
possible and that change was somehow beyond their control. In this respect, few of these participants saw planning and longer term goal-setting as important for them. They also showed little understanding of the smoking relapse process.

(David)

There’s two extremes. I either don’t work at all and ensure that things are in control, or I work to excess. There’s no middle. I’ve either been a fifteen year old working two shifts a day or I’ve been a thirty-five year old who’s just looking after a child.

The Lack of Control - “I’m as Weak as Water” (Sally)

Smoking was expressed as an automatic activity for these smokers. They were rarely fully aware of their consumption pattern until after the fact when the cigarettes were gone. Mirroring their black and white interpretations of most other aspects of their day, they either had smokes or they had none, this being realised often only when the packet was seen to be empty. These participants could not clearly say how many cigarettes they smoked each day or how much money they spent on cigarettes each week.

(Joan)

If I’m sitting here at the table I do tend to have the cigarettes next to me and watching TV is another thing that’s bad because I smoke a lot more too. I just don’t even count the smokes. I’m not even aware of how much I’m smoking a lot of the time.

(Carmel)

I know that one drink is the same as cigarettes. One is not enough and a hundred is too many. There’s no grey. I’m either smoking or not smoking, like with drinking.

(Roy – Talking about his cigarette consumption)

I just do it at random, like it’s automatic. I’ve never taken much notice...Either you smoke or you don’t smoke.
Of note was the positive effect of, and reliance on, external constraints on and by these smokers. One lady, Joan, spoke of when only packets of twenties were available for purchase in the past and how this limited her smoking. She now buys cartons and smokes the packets of cigarettes in them until they are gone, describing this as ‘like a trick,’ meanwhile relinquishing all control. Like all other participants with BPAD, the lack of finances also acted as an external limit setter for Joan. Like others, at these times, her usual response was simply to go without cigarettes until money became available again. Joan’s sense of having no control over her smoking, at one stage in her life, took on the extreme of fuelling despair about control over other aspects of her life, prompting suicidal thoughts. The ‘tunnel vision’ of people with BPAD when depressed is of particular note here, especially the suddenness and often unnoticed intensity of this ‘all or nothing’ view of their situation and therefore the potential risks to their safety.

Interactions Between Smoking and Mental Illness: “When I’m well I can quit, just like that! When I’m unwell, I’ll smoke my head off.” (Roy)

These participants described their smoking as unimportant, almost irrelevant to their lives when they were well. In stark contrast, their smoking was described as all-consuming when they were mentally unwell. They often chain smoked at these times. They expressed feeling totally bewildered as to the reasons for this, again seeing no middle ground. All participants with BPAD said that their smoking controls them, not that they have control over it. Their tendency to relinquish control was particularly noted when they described being more mentally unwell. At these times they were not prepared to take charge. The immediate satisfaction of short-term needs was their priority at these times.

(Joan)

If I’m not well, I just don’t even think about it; I just smoke. You see, if I’m well, I can cut back and I do and I cut back more than...in fact there have been times when I’ve just tried to stop altogether
but after two days I’m just a wreck and then I find it just doesn’t work. I just chain smoke and you feel worse. You just end up smoking more.

(Sally)
When I’m unwell I feel like I just have to smoke, but then when I'm well, I seem to be able to go without if I haven’t got any. There doesn’t seem to be a middle. Mum says that about the rest of my life as well. It’s the jumping from not needing to needing that’s the dilemma. Like, I’m fine if no-one hassles me and if I’m not stressed out... When I get upset I tend to smoke and not remember having smoked them all until the end of the day when I look at the packet and wonder how I got through all that many smokes. I did that last night. I thought these two packets were going to last me until Wednesday and normally they should have but I realised they weren’t going to and I had no control over stopping myself from smoking them. I got the shock of my life when I smoked the carton (smoked 200 cigarettes in one night recently)...I ended up going and getting my lungs checked.

(Sean)
When I’m unwell, it’s like tunnel vision, but when I’m well, I have no problems stopping, cutting down, or choosing when I smoke.

These smokers talked about the important interaction of their BPAD with their smoking at these times when they are unwell, especially their shortened memory and attention span. Roy’s comments, in particular, highlight the potential difficulties faced by these smokers and others on psychiatric medications when trying to quit smoking.

(Sally)
That’s when I’ll light a smoke and then light another one because I’ve forgotten that I’ve already got one on the go. I make a joke of it now but it’s not OK really.

(Carmel)
I don’t have a clear idea of how much I smoke at these times. Sometimes I have days where I’ll get to the end of the day and I’ll look at the packet and I won’t remember how I could have smoked all those cigarettes.
(Roy)
What happens is that you completely lose your memory and it takes you about two weeks to get it back. (In hospital) I didn’t know where I was or what was happening. I think being over-medicated had something to do with it so that, when you’re out in the community, it’s a battle to keep track of everything and to plan and think clearly and be conscious of what you’re doing and thinking. I know some people who are like that all the time.

Smoking to Prevent Illness Relapse - Order Versus Chaos
For these participants, smoking provided a predictable, reliable source of external control, especially as they felt uncertain about other forces at work on their lives.

(Carmel)
When everything else is haywire, they’re something I can sit down and know I can do. I can know what they’re going to feel like and taste like...and that’s comforting.

(Sean)
The smokes are a constant thing, even when everything else is out of control with cash converters [pawn shop] and the public trustee and bills. At least the smokes are predictable when the future is always uncertain.

These smokers described their smoking as the control mechanism that helps regulate their mood, preventing illness relapse; that is, cigarettes were being used as a mood stabiliser, similar to their medications. These people made direct associations between trying to quit smoking and the fear of illness relapse. As with smokers with a diagnosis of schizophrenia, these smokers said that they experienced increased stress with nicotine withdrawal. This in turn led to increased arousal with associated symptoms of mood instability. They chose to continue smoking in response to this dilemma, recognising that this creates a vicious cycle of it’s own in which the smoking ‘treatment’ becomes part of the problem, as suggested by Joan:

(Joan)
It’s hard when you’ve got a mental illness. You’ve got to be really well to make the grade and like I nearly did end up in hospital one time when I tried to quit because of the withdrawal symptoms. But
it’s like it’s sort of a circle. Like when I can’t sleep and I don’t and then my smoking almost doubles then and I’m in real trouble then (with lack of sleep causing mania to escalate).

David’s comments exemplify the unique dilemmas for this group, many who said that they enjoy their smoking and enjoy being high. The suggestion here is that, in some way, they chose to relinquish control because they liked the feeling of having little control. Such comments demonstrate a lack of conviction to one or other path with regard to quitting smoking. Thus, the person continues to struggle with both, feeling as they would like versus doing as they should, intermittently, depending on which takes priority at the time.

(David)
I’ve become used to my lifestyle...so any changes to it becomes abnormal, and smoking is just a habit that I’ve put in as part of the control mechanism. It’s what keeps me well...But, I like being high. That’s the hardest part of my illness, because I actually like my illness, but it’s not something I’m allowed to do. It’s got big consequences for me. That’s what stops me (from quitting). I know how to get to a high; that’s easy.

Striving for Control - ‘Driver in Control’ (Sean)
These participants clearly demonstrated that they were able to take charge of their smoking at times. They were able to go without cigarettes and to tolerate the physical withdrawal symptoms in the short term. The men particularly, perhaps as a show of strength, wanted to be seen to be exercising control over their smoking. One man did this by having a complex routine of cigarette and patch use. Another man remained convinced that quitting was a black and white issue, denying the potential struggle involved.

(Roy - Who questioned whether others trying to quit really wanted to and saying that it was what caused them to fail in their attempts)
I’d quit because I wanted to quit and that would be the end of it.

Control of Needing - the Freedom to Smoke as a Wish for Autonomy
Participants with BPAD were divided about their expression of smoking as a source of freedom, depending on whether they displayed predominantly manic or depressive features of their illness, and
how well they were able to manage their illness. Joan, whose illness was the least stable of the group and who expressed mainly mixed depressed affect, emphasised the consuming nature of her smoking and made no comments pertaining to this theme. Carmel, who was consumed with depressed feelings also made no comment about freedom. Her sense of powerlessness was strongly felt. Four participants, who experienced mainly hypomanic episodes, were much more defiant and protesting about their smoking experience. David talked about the control of the smoking routine in the hospital locked ward as ‘Gestapo-ish’. Sean talked about his need to smoke in terms of choosing to smoke, that is, as a show of strength, suggesting he could rise above needing by choosing. Roy, similarly, expressed being perplexed by needing to go to the shop for cigarettes, saying he feels a lot freer when he doesn’t need to do this. His comments about smoking coincidentally mirror similar comments about medication compliance, posing dilemmas for these people and the professionals trying to promote treatment.

(Roy)

_I’ve got this thing in me and I always have had where I don’t want to have to rely on anyone or anything. I just want to do it on my own._

Sally, who was ‘busy’ during the interview, expressed the greatest protest about her smoking, using cigarettes for short-term reward and enjoyment in defiance of her father’s authority. She also displayed an absence of feeling stigmatised by her smoking or her illness, similar to other participants with more frequent hypomania. Rather, the need to protect her autonomy was stressed, especially because this was perceived as completely relinquished during the manic phase of illness when carers ‘took over’. The all or nothing dilemma for the person and carers emerged again.

(Sally)

_I don’t feel stigmatised about having an illness. Other people put me in that but I don’t care a rats arse about what they think. Most of the time, if my illness is not bothering me, then I don’t bother about it and it’s just that everyone else is saying, “Oh, you’re sick,’ and I’m thinking, “I wish you’d just get out of my bloody life, you know”... You see Dad’s very controlling. When I get ill, he’s very controlling and he comes around to my house and gives me structure in the chaos and that’s nice when you’re really ill, but when you’re normal, it’s like, “Get out of my house.”_
(5.3.2) Reinforcement of Smoking by Others:

Initiation and Peer Pressure to Smoke

“It was just the done thing. Everyone did it.” (Roy)

Most participants with BPAD said that they started smoking in their teens to show off and rebel, to demonstrate their independence, to prove their rite of passage into adulthood, and to feel socially accepted by peers who figured strongly in this process. The one participant who started smoking later, Roy, did so with friends at the pub when he was twenty-one. The significant role played by peers is noted for this group, especially their susceptibility to relapse to smoking when in the presence of peers, relinquishing control in preference to fun and pleasure seeking. These smokers were leaders and trend-setters with their peers, showing flamboyance and individuality.

(Carmel)

I started smoking when I was 15 years old, hiding under the stairs at the girls’ high school. We used to have a few puffs before school. It was just something to be one of the big girls. And then I went on to be an apprentice hairdresser and it was the thing to wear a white uniform and smoke white cigarettes with little gold bands on them. It was part of being part of something. I used to go home on the train learning how to smoke because I couldn’t do it.

(Sally)

I started smoking as a 14-year-old on the oval at school with friends and trying to show off to my older sister by buying a packet and smoking behind the shed at home. I was out to prove something. I became a regular smoker when I got a part-time job at 15 years and was able to buy my own cigarettes.

Only one participant has a different experience to the others. David’s smoking initiation at age ten, while attending boarding school, was described as a response to loneliness and isolation from family. His peers became his ‘family’ in this sense and he was drawn to smoking when they smoked.

Reinforcement by Family - “My mother says I’m weak” (Joan)

These participants often relied on family to limit set their consumption of cigarettes, relinquishing control themselves. This was not without its contradictions and dilemmas however, as most participants
felt judged and derided by their families because of their smoking and supposed weakness in not quitting or controlling consumption.

(Carmel)
I don’t get the feeling when I’m out that people are judging me when I smoke. My parents do. The other day I went there and he (father) was counting how many I had and told me it was too much, because they’re non-smokers, and I thought I had been doing pretty good. I thought, “Don’t you realise how much I’m doing in an effort to get well, by trying to give up alcohol?”...My parents say mainly negative things that come across as a put down; “you could,” and “you should.” It makes me feel bad. It seems to make you want to smoke more because you feel uncomfortable and bad about yourself.

(Joan)
I usually cut back when I’m away. I stay with my mother over Christmas and she doesn’t smoke so I have to go outside, so she puts restrictions on my smoking and that helps. But this time, it didn’t seem to help. She was going on about my smoking...My mother says she’s ashamed of me smoking out in public...My mother says I’m weak, but there’s a bit more to it than just that.

(Sean)
Mum is often critical but she always caves in and gives me money for smokes when I badger her enough for them. Then she calls me weak-willed.

One lady, Sally, who also made the most protestations in this group about her right to smoke, described her family as colluding with the dependence and with beliefs about her illness needs. Their control of the relationship and Sally’s contradictory statements are worthy of consideration. Sean experienced similar responses, from his mother, that verged on sabotage of his independence at times, of being set up to fail and then being told by them, “I told you you were weak.”

(Sally – Describing what she does when she runs out of cigarettes)
I just ended up borrowing some money from mum. She really gets shitty with me and I might borrow money for no other reason than to buy cigarettes and she gets shitty and says, “I’m not feeding you addictive habit. It’s your problem; get rid of it.” She refuses sometimes so I just go without...My
parents don’t like my smoking. They’re always having a go at me, but I think they give in because of my illness. They make allowances for me, They would do that for a normal person...They still give me money anyway...They go, “Oh, here we go again. Get my purse,” and it reverts to childhood. Can I have a lolly type of stuff.

Sally continued to describe how her parents keep her in a dependent, sick role, using her need for cigarette as the vehicle for control. The carers’ dilemma, of when to step back and when to trust and give responsibility once it has been relinquished during illness relapse, is evident in Sally’s comments about her family, as is the ambivalence about control itself.

(Sally)

Even mum says, “Oh, you’re mentally defective,” when she doesn’t want to hear what I have to say...She’s tried to control me all my life, like I am an adult. What more do you have to prove? That I can give up cigarettes, I suppose...(If she did quit) I think they would have less control and I’d have more, like they couldn’t dominate any more because I’d be in control. In an odd sort of way, my smoking serves a purpose for them, I suppose. I’m not sure what mum would have to do if she didn’t need to ring me every day.

Reinforcement by Doctors and Workers - “like it’s not important” (Carmel)

These participants all felt that their doctors condoned their smoking, believing that they needed to smoke, that there were other priorities related to illness and treatment, and that they were incapable of quitting because of their illness. The perception of these smokers was that doctors believed that advice on smoking just wasn’t relevant to their role as treatment providers.

(Carmel – Talking about her GP)

The doctor hasn’t mentioned it, which is almost like condoning it, like it’s not important...He doesn’t say anything. He knows I smoke but he and the key worker have been working together to try to get me straightened out with the drinking. It’s one thing at a time.

(Joan - suggesting that the professionals collude with the dependence)

It’s sort of known among the professional people, like an unwritten law, but they don’t talk a lot about it.
Reinforcement in The Hospital Setting

- (Joan - Whispering) “It was like a jail there you know!”

The participants with BPAD spoke about their hospital experiences in relatively positive terms, superficially, especially if they were experiencing the depressed phase of their illness. They were generally willing and dependent, easily cajoled and accepting of limits set by others. For many, going to hospital was a relief because someone else was taking control and setting limits at a time when these participants felt they could not do this themselves. Sally’s and Carmel’s comments provide a good summation of these participants’ views and experiences of the psychiatric ward as the place where they went to be cared for and to get well.

(Sally)

Like, I found hospital controlling, but being controlled was OK because I needed someone else to do it because I couldn’t make decisions for myself. It’s like everything is chaotic and I can go to hospital to have a rest from the chaos. It’s almost a relief to have the structure and support around you.

(Carmel)

I went to the locked section for one night. I can’t remember what it was called. I don’t remember much about it. It didn’t feel oppressive. I think I was so sick that I didn’t care…I couldn’t eat when I first went there. I hadn’t eaten for a couple of months. The smokes probably filled a great hole. When I went to the open ward, I’d sit outside with the jolly crew of smokers from when we were allowed to have our first smoke. That used to be a real comfort thing.

Unfortunately, these people’s willing co-operation with the system also meant that they were potentially vulnerable to excessive control by others and easily led, as Joan’s sometimes almost pathetic comments indicated. Upon hearing her rationalisation of her treatment, the researcher was reminded that care does not mean incarceration, that is, psychiatric hospitals are not jails. Participants who were more manic as part of their hospitalisation were treated with similar consequences, as Sally’s comments show.
I’ve been to [the locked ward] twice. At the time I just thought, “This is it. I’ve been locked up for life. That’s it!” I had these dreadful fears that I wouldn’t be leaving. We could smoke in [the locked ward], oh, yes, but they (the nurses) had the cigarette lighters and I felt so embarrassed going to ask for my cigarette to be lit, but you know they were trying to get me going and if you’re really depressed you won’t do a thing...At [the locked ward], they treated me very nicely. I don’t remember how much I smoked but I think I was able to have one whenever I was able to have one...I was just too unwell. So I don’t even remember whether I wanted more than they gave me. I know I was craving for them. They (the nurses) were very very good because they let us out in the quadrangle. In fact, I was scared there because of the other people there. (Whispers) It was like a jail there you know. I used to feel guilty for asking for a smoke when they were busy and they’d go, “click,” and light your cigarette as if you were inconveniencing them or as if it was a way of controlling your behaviour to keep you out of their way.

I remember getting angry with the nurse because he stood over me...He stood over me to find out how much money I had in my purse. And I felt like saying, “Well, it’s none of your bloody business,” and I cracked a nana, and threw everything on the ground, you know. And I said to him later that I wanted to go to the shop to get some cigarettes because I didn’t have any left and he wouldn’t let me. I never thought to get any cigarettes before I went there.

Again, Joan’s comments give enormous insights into the hospital culture and treatment methods, past and present, with regard to smoking and how this has changed over time, not always for the better.

I’ve had a lot to do with [the psychiatric hospital]. Once I was there for three months; that was years ago...but then they had day care units. It’s terrible if you go there now. They don’t have any of that. There’s just nothing to do now except smoke...But I’ve never rolled my own and when you’re in hospital you never accept other peoples’ when they’ve rolled them because you could be smoking anything. (Giggles, indicating she is aware of the problem with marijuana in hospital) I shouldn’t say this because how do I know that I wouldn’t have smoked dope like they do. You don’t know do you? The last time I was there, there wasn’t much at all to do. Years ago we had lots of craft and art and
other things with the occupational therapist and it did stop me from wanting to go outside and have a smoke. I probably smoked less in hospital because they would set limits whereas, at home, I didn’t have other people there to do this for me.

These smokers said that they smoked more once they went to the open ward, due to the absence of staff to limit their consumption, and because the culture of interaction with other patients was more social in the open setting. David’s comments highlight a particular problem with the way staff monitor cigarette distribution. This has implications for conditioned smoking and the establishment of nicotine dependence.

(David)

Hospital is really boring. The staff and the doctors never mention it, but when you go out the door you get bombarded by people smoking. In the lock up section you have to wait and ask for smoked and that’s hard, that freedom being taken away...Like I’ve been there when I’ve wanted two cigarettes for one half an hour time period and not one for another three hours and you’re taking cigarettes when you don’t really feel like one because you know that you’re not going to have one for the next period. You have to smoke by their rules. It’s like a bit of social control. You can’t predict that everyone’s going to want a smoke every half and hour because not everyone’s like that.

(5.3.3) Boredom - “Well, you’re just so bored to tears and you just smoke and smoke.” (Roy):

These participants stressed the role of boredom for their smoking continuance. By this they meant not being occupied enough for the level of stimulation they felt they needed and endless empty space without having purposeful activity. Smoking became something to do when there was nothing better to do, to overcome restlessness and to relieve nervous energy, a ‘gap filler’. Roy’s comments highlight the problems with boredom, particularly in the hospital setting, with decreased motivation influencing the person’s ability to take part in organised activities when this is contrasted with the manic patient’s need to ‘slow down’ as part of their recovery.

(Roy)

The days I smoked more there, there was probably less to do. It’s hard to tell, because you’re on so much medication, you hardly know where you are. That’s the funny part of hospital. I know they
help you but they give you an injection that makes you feel like doing nothing; just sleeping and sitting around... (and smoking)

For Joan, this dilemma continued to influence her home life, with boredom being expressed as the struggle to find activity within the limits of what her illness allows. She could not do nothing, but she was limited in what she could realistically do because of her symptoms; therefore she was caught between the two extremes. Little wonder that something like smoking, being so portable, readily accessible, and simple to perform became part of her routine, and the routine of others in similar situations with illness symptoms and medication sedating effects.

(Joan)
To tell you the honest truth, I’m not occupied enough really, and yet I’m not well enough. I’m not well enough to go out and do what I used to, and it’s a real dilemma because you’ve got to keep occupied but you’re not well enough to get through tasks and following through. It’s a real problem.

(5.3.4) The Quitting Process:

Why Quit - “Well, what would I do anyway” (Sally)
- “I enjoy smoking” (Joan)

Smokers with BPAD spoke about being very ambivalent about quitting, at times being quite despondent about the instability of their illness which sometimes needed vigilant management, and relapse sometimes occurring regardless of their and their doctor’s best efforts to prevent it. This was tempered with their admission of truly enjoying smoking and seeking short-term gratification. They also perceived more existential barriers to quitting smoking, especially the lack of seeing purpose in setting longer-term goals because of their illness. Their enjoyment of smoking was in direct contrast to their level of despair at having a mental illness. This was perceived to be a complex relationship with many inherent inconsistencies which directly contributed to the person’s ambivalence and shifting commitment.

(Joan)
It’s all the self-esteem stuff about having an illness that really gets you down...I got really upset about my illness last year. It happens sometimes. I felt depressed. It was around Christmas time. I
was really furious because I was taking my anti-depressants and all my medication and all the things you’re meant to do, and I told Dr.... and he said, “Unfortunately, we’ve got to increase your medication,” and I said, “But I’m taking my medication,” but it wasn’t holding it. You really get depressed just having an illness sometimes. (Regarding her smoking) It’s very automatic most of the time, I suppose, which is bad. But it’s company and I don’t have much else in my life, and it’s comforting, so it makes it harder when part of you wants to quit also, because you remain very ambivalent about it all; you rebel against it. You come up with reasons for not quitting and it gets the better of you. And the trouble is... (whispers) I enjoy it. And when you can’t do other things either because you can’t afford to do them, like I can’t afford to run a car. If I could then I could get out more but then I think, “Well, what would I do anyway?”

These smokers, particularly if they showed depressive symptoms, said they ‘just gave in’ each time they thought of quitting smoking because they perceived themselves as hopeless. They related this lack of volition directly to their illness, to a lack of hope, of not seeing too far into the future.

(Carmel - re having an illness)

I don’t like it one little bit. I know I’ve got it. It’s very soul destroying. Through my illness I’ve hurt a lot of people who I didn’t mean to hurt. I’ve lost friends because of it. (Pauses and wavens near tears) It’s very soul destroying, it really is. When you feel like you’re just not as good as other people in other areas, it gives you very low self-esteem which makes it so much harder when you’re confronted by something like this, like wanting to give up smoking but feeling like you can’t... The future doesn’t look all that hopeful at the moment. I can’t even see it. Like, it’s not like I don’t think there’s no future if I don’t give up cigarettes. That’s not what I mean at all. I’m just having trouble even getting through a day at a time at the moment. It has the opposite effect of me saying to myself, “Well, why quit?” That’s just how I’m feeling. Hope’s a hard thing to get just like that.

Even the participants who believed they were managing better stressed that they don’t set longer term goals for themselves, they were resigned to living in the here and now, to continue smoking, and take life as it came at them. They seemed relatively contented with this approach, compensating for any limitations on their lifestyle choices with cigarettes. They expressed the sense that their lives were predetermined anyway, given that they have BPAD. The issue of reward and relinquishing control seemed relevant here also.
(Sally)
I think it’s because I don’t look too far ahead. I just take every day as it comes. I’m not thinking about tomorrow and the closest thing I’m thinking about is Thursday (payday). Well, I don’t set goals for myself anymore...It’s like accepting the way things are for me.

(David)
I’m used to my life. I’m used to what I can do...The only thing I’ve got to get right and happy in my life is my own stability and my own family and things like that and really, smoking doesn’t affect any of that. I don’t like to smoke around my daughter but, otherwise, giving up is not going to make a lot of difference in my life...I’ve got to lead a certain kind of life with this illness anyway, so why can’t I have a few comforts, given that.

Quitting Beliefs - “I’m as weak as water” (Sally) - “I’d just do it” (Roy)
When asked about quitting, these participants said that, ultimately, they would not give up smoking because they enjoyed it. This was despite being aware of and emphasising their concern about the health and financial costs of smoking. However, they also discounted their ability to quit smoking and remain non-smokers. As per their comments about control, this confidence level was determined by their current mental state, with those people most stable seeing the least problems with quitting.

(Sally)
I wish I had the guts to give up. I just don’t think I’ve got the guts.

(Roy – Asked what would happen if he tried to quit now)
I’d be pretty successful. I’ve just done it before when I’ve been well. I’d just give up and not smoke. There’d be no preparation. I’d just do it.

Attempts to Quit - “I just gave in” (Joan)
All participants demonstrated that they could and had successfully stopped smoking when they were mentally well in the past. Most had stopped smoking cold turkey after reaching a level of determination about quitting and following through with it.
I’ve had times when I could stop smoking for several days at a time, usually to save money and to pay bills.

The times when I’ve stopped smoking, it’s been when I’ve been calm. I could do it now.

Unfortunately, all relapsed quickly when new stresses presented in their lives, especially when their mood deteriorated. They generally had several cycles of quitting and smoking, however, contrary to generally understood knowledge about the quitting process, these failures did not help build their resolve to eventually quit successfully. It usually reinforced their sense of failure, despair, and perceived lack of control when unwell.

Like I read books on quitting and everything. It’s not that I don’t understand, but it didn’t help me. Like they say it’s the first 36 hours that’s the worst and if you can get through that then it gets easier. But if I can get through a week and then break down then there’s something else happening there, isn’t there?..I was under stress and I just thought I just can’t stand this any longer and the pressures I’ve been through in my life and this illness. I just gave in. Maybe I’m weak like my mother said.

Abstinence versus Cutting Down - “It’s either all or nothing” (Roy)

Five of the six participants with BPAD stated that complete abstinence would be the only way that they could quit and remain that way. This view was in line with their black and white view of decision-making in other areas.

I think in the longer term, cutting down is the harder of the two options...The risk is always there that when times are not so good, that I’ll smoke more of them. That’s why you can’t have them in the scenario at all.
(Carmel)

Abstaining is the only solution. Just cutting down is just too much temptation. It’s either all or nothing.

Only one participant, Joan, spoke of cutting down as the preferred option. Her comments demonstrate the fear of illness relapse and the need to have a safety net to protect her mood, her emotions, and her self-worth.

(Joan)

I think at the moment it would be better for me just to cut down. That way I would get the best of both worlds, so I could smoke if I really needed to. Like I get so upset with myself when I start again if I’ve tried to stop...so cutting down would solve that problem of feeling bad about yourself, of making one decision and then having to go back on it.

Nicotine Replacement Therapy

Five of the six participants had not tried nicotine patches or gum, although they had heard favourable reports about their effectiveness. Cost was stated as the main barrier to use, but also the belief that they should be able to quit without help. One person had problem with gum due to having false teeth. The only person who had used patches was David, whose complex ritual of cigarette and patch use represented more a misuse of patches to fulfil a need for control, rather than any genuine attempt to quit smoking completely. He was using patches intermittently with cigarettes at the time of interview and had been for some months.

(David)

What I’ve found is that the patch works while I’m busy; that fine. And the chewing gum...It’s a good ‘stat filler’ if I’ve got to go to mum’s place where I know I can’t smoke. I can last a couple of hours and I’m just fine.

Support to Quit – The Quitline

Participants with BPAD had limited or no experience with seeking support from the Quitline. The reasons for this were not clear, with participants making a range of comments.
(Joan)
I’ve never contacted them.

(David)
No, because I don’t really read much to be honest. I find it hard to concentrate usually on too much reading.

(Roy)
I never watch TV, therefore I don’t tune in to the quit campaigns.

(Sean)
I’m aware of the quit campaigns and the literature but I’d just prefer to do it on my terms, not theirs.

Smoking Policy Changes
These smokers accepted the need for policy changes restricting smoking in public places. Their comments in this regard reflected a belief that they had no control over the decisions made by policy makers; they were blasé about it. However, they also responded overwhelming by saying that the changes would not affect them directly because they would merely find ways around the system of changes. Some said they would stay at home more. Others said they would choose only social venues that allowed smoking. One man said he would take his nicotine gum with him while out.

(5.3.5) Cigarettes as a Mood Stabiliser - Self Medication:
These participants were not prepared to compromise their symptom management needs; theirs was a total giving in to its influence. Smoking served a number of medicating roles for people with BPAD. They particularly emphasised the use of cigarettes to aid sleep, motivation, stress, and to stabilise mood swings. These emphases are not surprising given that they are significant problems for people with this illness when they are unwell. The participants identified these as signs of and also precipitants to illness relapse; that is, the lack of sleep, the build up of stress, over-activity and mood instability. No mention was made by these smokers of cigarettes aiding concentration.

Increased stress levels were directly related to increased consumption of cigarettes, often to excess for this group, such as the lady who smoked a carton in one night of mania. All participants with BPAD
said they woke during the night to have a cigarette, sometimes more than once. None explained this as a physical need based on nicotine withdrawal; rather, they said it was habit driven. This suggests a limited, faulty understanding of some of the reason for their smoking.

*(Joan – Regarding her waking at night)*

*I think it developed over time so that I’m not actually waking up to have a smoke but that it is just a habit of waking. I’ll wake up and I’ll have a coffee and have a couple of cigarettes and go back to bed and that’s a normal pattern...I think my body has learned that that’s just how you get back to sleep. When I’m unwell I don’t push myself. I make sure I’m not putting myself under any more pressure.*

These smokers also used cigarettes to reward themselves for activity, to structure their day, and to motivate themselves to complete tasks and move onto other tasks. Smoking was also used to avoid other commitments when these people felt depressed. At these times they just sat and smoked incessantly.

*(Sally)*

*After she (daughter) starts school, I’ll probably have another coffee, and sit around and have about three smokes. It's almost like I structure my day around my smoke and vice versa or if I’ve got something I’ve got to do, then I have smoke first to work out how I’m going to do it. Or if there’s something I don’t want to do, I’ll have a smoke to delay the decision. I’ve done that heaps of times.*

These smokers made very clear links between their mood and their smoking. More than half the participants said that they believed that they would have been smokers if they hadn’t developed BPAD. They emphasised that when they felt more depressed they smoked more, feeling lost in the all-consuming nature of it, using cigarettes to relieve the despair and sense of not having any purpose in life.

*(Carmel)*

*And I’m feeling a bit lost in myself, so to get past that lost feeling, I’ll have a smoke. Oh, I don’t know what to do with the day and I don’t know what to do with my life.*
(Sally)

*When I’m really depressed if I get that bad I'll go to the doctor because if I just sit and vegetate I’ll just shut myself off from the world and smoke heaps.*

Likewise, these participants made clear connections between their smoking and being hypomanic, saying that their consumption would go up dramatically at these times in an attempt to stabilise their mood.

(Roy)

*The Bipolar goes together with smoking because when you start to get manic you smoke more because it tends to calm you down and you tend to drink more for the same reasons...you try to cure yourself. You try to stop it from going even higher, and you do it with drinking because alcohol’s a good sedative and smoking’s a good sedative, you know...I wouldn’t have been smoking again if I hadn’t gone through this high again.*

David’s unique, albeit confusing and distorted comments about the use of patches and the effect on his mood provided an interesting slant on the barriers to quitting for this group.

(David)

*S有时候 I feel more energetic than I’d like (when using the patches). When I've got the patch on I get more energy than I'm used to so then I withdraw back to using a cigarette to take the energy level away and that’s where the mood stabilising comes in...I think I’m just used to having control over my energy level and for want of a better word, a bit sedated, but I find it hard with the patches because it doesn’t have that sedating effect so I’ve lost control of something I’ve had control of all my life.*

(5.3.6) Making Sure of Supply:

These participants remained inconsistent about their means of ensuring the supply of cigarettes. They spoke of incorporating cigarettes into their usual budget as a core need, but also regularly ran out of their supply and responded in ad hoc ways, either going without until payday, asking friends for cigarettes, or borrowing and paying back later. This often added to their sense of having little control over the process of supply. They did not say that they re-rolled butts or that they compromised their
other core needs, such as food and rent. The one participant who did admit to this was Joan, who also struggled the most, out of this group, with her ongoing illness management.

(Joan)
Well, I borrowed from a friend and I paid them back today. See, that’s dreadful and it was only because of the smokes. In the past, if it was late at night I really would climb walls. This service station here would be closed so I’d walk way up the other end of the road. This was last year when I was in a bad stage, and I just knew and thought, “Well, what would I do all night?” I was desperate. I’ve gone through my bin a few times and re-rolled the butts. It’s a dirty filthy habit but you’ve got to at the time. And there’s a loan that I took out which no-one else knows about and I truly believe if I didn’t smoke then I wouldn’t have had to take it out.

(Sean)
I continually run short each week with the allowance that the public trustee gives me. I usually end up cutting corners or lying to the key worker about my need for extra money for clothes and outings and things like that. Sometimes, I’ve hocked things at cash converters [pawn shop]. I’ve got a regular line of credit at the deli, but I’m continually robbing Peter to pay Paul. I just get anxious.

The other feature of this group was that they were relatively financially stable and could afford to buy their cigarettes and meet their other commitments without too much difficulty. The one exception was Sean whose finances were administered by the public trustee due largely to problem gambling. Excessive smoking and spending in the context of manic phases were what tended to lead these smokers to develop further financial problems, albeit sometimes with devastating outcomes, not trying to meet their usual supply needs.

(Sally)
Just knowing that I’ve got smokes makes me feel better, but it doesn’t worry me until I’ve actually run out...It’s very much part of my budget. The food never gets cut down. The cigarettes do before I’ll do that. But then I’ve got enough money to do both usually. I can manage it.
It's strange because surely I could think of something better to do with the money but the difference I suppose is that I know exactly what to expect from smokes whereas I don’t necessarily from a movie or something. I might pay my money and then not like it anyway. This way I get small amounts of pleasure, often, and at a reasonable low cost, when I want and need them...So other goals keep from being a priority because smoking’s so much more reliable and predictable.

(5.3.7) Cigarettes as Companions:

Participants with BPAD spoke about the companionship provided by cigarettes, although this role was not emphasised in any significant despairing way. The role was a peripheral one for them, with no intense commitment or loyalty to ‘the smoke’. Their smoking was predominantly automatic, used as a relief from boredom and blankness, a short-term comfort to start and end the day with, a thing to be used for its utility value. The absence of cigarettes did not elicit images of grief or loss for these smokers. Only one participant, Joan, suggested some intensity of feeling in this respect and even this was tempered with the capacity for distractibility when the cigarettes’ significance was passed over to other roles. Other participants with BPAD made no mention of cigarettes in this context.

(Joan)

If I haven’t got them (smokes), it’s like there’s a part of me missing, and yet I have forgotten them from time to time... I would just forget them.

(5.3.8) Other Drugs:

Caffeine

All participants with BPAD were heavy caffeine users, especially coffee. Many of them brewed their own in order to make it very strong; the average consumption of coffee being ten to fifteen cups per day. They said that they always paired their smoking with caffeine consumption, first thing in the day when they woke up and each time that they smoked during the day. These smokers were aware of the habitual connection between their caffeine use and their smoking. One lady spoke about the interdependence of the two substances, even though she did not use this knowledge as a means of cutting down her consumption voluntarily.
(Sally)
*If I haven’t got any smokes then I stay off the coffee more.*

**Alcohol**

Three of the six participants with BPAD mentioned alcohol use and smoking; two of these had been heavy alcohol users in the past. They recognised that they used alcohol to self-medicate at times in their lives when they had greater stress. They were also aware of alcohol as a cue to smoking. One lady defended her smoking as the lesser of evils, in contrast to alcohol, in the context on illness management.

(Joan)
*And it’s not drinking which could be worse. And I think if I didn’t smoke, I could have drank and drinking with tablets is very dangerous. Smoking doesn’t interfere you see, you can still get on with things.*

**(5.3.9) Summary:**

Participants with a diagnosis of BPAD clearly described the use of cigarettes to help manage their mood. They demonstrated minimal internal control over their consumption of cigarettes especially when unwell. At these times, smokers with BPAD were noted to consume extraordinarily high quantities of cigarettes and to have little memory of their smoking behaviour. Ensuring their cigarette supply and monitoring the nicotine intake was often based on impulse and variation in mood state rather than any forward planning. Many of these smokers enjoyed their smoking and were very sociable with other smokers. The presence and unpredictability of their mental illness and its detrimental effects on their lives, was a source of frustration for these smokers. Their descriptions of smoking to modulate their mood are striking. The central role of cigarettes for these smokers was their utility value as an object that they could use automatically and immediately. These participants started smoking under similar circumstances to other smokers, that is, with adolescent peers. They experienced acceptance and reinforcement for their current smoking to continue, from family, community mental health staff and the inpatient system of care. Most of these participants said that they would prefer to be non-smokers but felt unable to quit successfully given the presence of their mental illness. They actively attempted to quit on a regular basis but did not adhere to this commitment in the longer term, especially in the context of mood variation. (see summary of results in Table 5.6)
(5.4) MAJOR DEPRESSION (N=6):

Participants with a diagnosis of major depression ranged in age from thirty-four years to sixty-one years, with all experiencing their first episode of depression in their teens or earlier. Their smoking experience ranged from twenty-three years to fifty years. Current smoking consumption ranged from twenty-five cigarettes to more than forty cigarettes per day, with higher tar cigarettes preferred. Several participants with major depression said that they started smoking to cope with their circumstances and mood rather than initiation in the context of peer activity. Many participants cited lighter consumption of cigarettes during admissions to hospital and when their mental illness was less stable. Two of these participants lived with partners. The others were either single or divorced. All except one of these participants lived in public rental accommodation. All participants had experienced intermittent paid employment in the past. Level of education was mixed with none holding tertiary qualifications and all were unemployed at the time of interviews. Beth and Ron had a small amount of casual employment (approximately three hours per week). All currently received a government pension as a result of their mental illness. Three of the six participants had made no attempts to quit smoking in the past and all obtained high Fagerstrom scores of nine to eleven indicating that they were heavily physically dependent on nicotine (See Appendix D). Three participants with major depression had a noted past history of alcohol abuse, while two others who currently used alcohol had unknown histories in this regard. Four participants currently used alcohol regularly and sometimes excessively. Caffeine use was high for this group. (See Table 5.4)
Results from interviews with participants with a diagnosis of major depression are organised into the following eleven themes.

### (5.4.1) The Freedom to Smoke:

These participants expressed strongly the sense of independence that smoking gave them. They perceived few opportunities to have control and power over decisions in other parts of their lives. This view reflected a perceived lifetime of powerlessness and lack of choice, with few pleasures being remembered. Their current situation, constantly struggling to make ends meet, albeit paradoxical regarding their spending on cigarettes as a source of financial strain, served to reinforce smoking continuance as a freedom when there were few other pleasures available or likely to become available to them in the future.

*(Jack)*

*It’s an important thing in my life that I do have the freedom to smoke because things have happened so often to threaten that freedom. It’s not so much that other things are beyond my control. It’s more that I don’t have the freedom to choose any other things. Like the pension is all accounted for even*
before I get it. Like I’ll get uptight and depressed on the Tuesday and the Wednesday before pension
day because I know that things will be the same as they were last fortnight. It means I can never
relax because I have to count every penny all the time. You’re constantly vigilant.

These people believed that they were, and lived their current lives as if they were ‘locked in’ to their
current situation, fearing further hurt and failure and stuck with the loss, remorse, and regret for the
consequences of a past they could not change or move forward from.

(Ron - Who lives in public rental accommodation with his two dogs)
I think I’ve lost a lot financially, emotionally, and otherwise, but I haven’t lost the smokes...
(regarding a recent problem with housing)It was like an invasion. It was threatening my security. it’s
like what else can they take away from me? What else do I have to give up? Whereas I can go to the
shops and buy a packet of smokes and they can all go to hell. It’s a choice I can make without
pressure...It’s a sense of not being able to find enjoyment in other things because of having
restrictions in so many other things I do...They’ve taken everything else away from me - house,
money, everything - but they can’t take that (smoking) away from me. It’s something that I can still
do. Before I became depressed I used to be able to do lots of things. That’s all changed. The smoking
is a little bit of independence; of me making the choices and decisions. The cigarettes and the dogs
are the two things that are mine.

(Jack)
All the ‘notts’ and ‘shoulds’ but none of the ‘can’ and ‘could’ things. Smoking was something I
could (emphasised) do.

(Sylvia)
I haven’t always had the freedom to do things in my life, especially in the last twenty-five years, not
with spending a lot of time in hospital or in Yatala (prison), and in two marriages that were awful.
Now I think I want to do the right thing by my children, so I keep my life in order and I smoke
because it’s one of the few things I can enjoy.
For one lady, who felt quite powerless about other decisions regarding her future, having the ability to freely choose to smoke was expressed even more strongly as a freedom to choose how she lives but also how she dies.

(Beth)
A couple of months ago I was told it was a matter of a lifetime care and having to take tablets indefinitely and that was a bit of a hiccup. Before that when I would get really down, I’d think that there was no point in continuing taking tablets and seeing doctors...The degree to which it was my decision within my control has changed. Sometimes I resent it because it’s prolonged my life and I just rail against it sometimes, by smoking all the more.

For Anne, who felt stigmatised by her family and therefore didn’t tell them about her smoking, continuing to smoke was an expression of self-determination. She described a past experience of quitting and relapse in smoking in the context of this. Instead of finding the process of quitting smoking easier as time progressed, as would be expected, Anne said it became harder because she felt that her ability to be self-determining was being swamped by her parents’ authority. Beforehand, her smoking had at least been a form of personal protest against their dominance and this is what she returned to gain some control and freedom back.

For Sylvia, continuing to smoke literally gave her freedom by protecting her from harm while she lived in a hostel. Smokes were a tool used to buy her safety. She did not believe that being a non-smoker would have protected her from the demands of other residents.

(Sylvia)
I’ve been threatened by other residents with schizophrenia for a smoke. They’ll do anything. One guy threatened to bash me up if I didn’t give him one.

(5.4.2) Making Sure of Supply:

All participants with depression emphasised the high priority they gave to cigarettes in their budget. They were all able to maintain secure accommodation and a basic food supply, although at times these were threatened. Cigarettes were perceived as a core need, and security of supply was a frequent preoccupation for these participants. Having cigarettes available, whether they were smoking them or
not, was paramount to maintaining their sense of calm and was almost an unconscious part of their routine.

(Anne)
I go to some length to make sure I’ve got them, so it’s always planning, planning ahead....

(Ron - Who said he has never had a time when he has run out of cigarettes)
My priorities are to feed the dogs and feed myself. I always budget for smokes but not at the expense of going without food or doing something criminal or stupid or whatever...I’ve always made sure I’ve got the money. I can certainly cut down on the food bill.

Three participants commented on how the lack of cigarettes tended to make them feel that they needed them all the more, how this became an all-consuming preoccupation when supply was threatened by a shortage of funds.

(Ron)
I find when I’ve got a bit more money to play with, I tend to be able to cut down on cigarettes. I don’t need them as much. When things are getting more desperate and I know I shouldn’t have a cigarette, that’s when I tend to smoke more and I will have a cigarette...when money is tighter, I’ve got to make sure I’ve got enough for smokes. It’s a dreadful situation...everything else I ultimately irrelevant.

The reasons for this prioritising of cigarettes can be understood by Jack’s comments:

(Jack)
I can’t afford to have the smokes but I can’t afford not to have them. It’s a case of weighing up the immediate instead of the long-term and I just don’t think that far into the future. I don’t see much hope in it.

Mick’s comments give clues to how cigarettes came to be relied upon and how the portability and accessibility of cigarettes discouraged him from finding other means to satisfy his needs.
(Mick)

Smokes only cost about $9 a packet. Speed costs about $50. So it’s within my grasp to keep smoking, by buying some, waiting for pension day, or borrowing a smoke or money off someone.

For these smokers, the tyranny of making sure of supply was predominantly expressed as an internal emotional struggle involving depressed mood rather than overt behaviours such as begging, stealing, or picking up butts. Ultimately, these people could wait for their next pension day without jeopardising other commitments or needs, or at least juggle these to ensure some supply of cigarettes. The one participant with depression whose need was expressed more strongly, also experienced psychotic features when becoming unwell. The researcher believes this influenced her past cigarettes seeking behaviour.

(Sylvia)

When I went to Yatala I just kept smoking. I was relieved because I had somewhere to live. When they discharged me I just walked the streets looking for butts... The smokes controlled me in the past because I used to pick up butts. I never told my boys or anyone else that till now. And re-rolling the butts in the ashtray is something I’ve done a lot. (quickly) But I’ve never gone through bins. I haven’t ever got to that. I make sure now that I never run out of smokes. I structure my day so that it doesn’t happen and I don’t have to look for butts.

(5.4.3) Cigarettes as a Friend and Identity as a Smoker:

All participants with depression stressed the centrality of smoking to their identity. They described their smoking as giving purpose for their being and for social interaction and connection. For all of these smokers, their smoking had been with them all of their adult lives and for much of their adolescence as well. Giving up smoking was beyond their comprehension. Such was their attachment that they personified their cigarettes.

(Jack)

You can’t throw fifty years away as if they didn’t exist…I never see myself as a non-smoker.

(Beth) I’ve been smoking since I was seventeen and now I’m Sixty-three, so that’s a long time to try to give up.

(Anne)
It’s more than just using it to cope with things. It’s a whole way of being.

One man described the historical development of his current identity as a smoker, and the perceived links to his depression.

(Mick)

*It's just always been there from such an early age that it’s just a habit now... I never had a full grip on my childhood. There was always something wrong and I never knew what. It just got worse and worse so I turned more and more to smoking and drugs and alcohol... I was quite a heavy smoker all the time I smoked and I’d often smoke between lessons and after school on my own (age 11).*

For all these people, smoking had become a tool for social connection; a means of avoiding and distracting their thoughts so that the depression did not take over and consume them.

(Ron)

*Going down to the shop to buy smokes each day is an outing for me, especially some days when I literally wouldn’t see anyone. If I don’t get out after a day or so, I feel like I’m going nuts. It gives me a sense of connection at least. It’s part of being human, isn’t it?*

One man who had been violent and abusive to former partners clearly used cigarettes to suppress that part of his identity.

(Jack - talking about quitting)

*I’d just get extremely irritable and angry and anxious; all the things I try to suppress by having a smoke. I just don’t want other people to see that part of me.*

All participants with depression clearly described the cigarettes as a friend who gave them security and companionship when this was often seen as lacking in other parts of their lives. The smokes became a reliable substitute, particularly when their depression and its consequences led to profound isolation for these people.
(Mick)

Giving up smoking would leave a very big hole like losing a friend.

(Sylvia)

I feel frightened without cigarettes. I feel quite panicky. I’d pick up butts again. I suppose it’s almost like the smokes are a companion for me. I’ve smoked them for nearly fifty years now. I couldn’t imagine what it would be like without them.

Some people would say the smokes are wasting money but I haven’t got much else. It’s a real companion when I’m on my own, which is most of the time.

(Anne)

There’s something else happening there for people who really don’t see a lot of people or have a lot else.

(5.4.4) Cigarettes as a Physical Comforter:

For these smokers with depression, the process of smoking was akin to receiving physical and emotional comfort each time they smoked. The overwhelming observations by the researcher during interviews were the ways participants used touch, as if the physical connection to the cigarette served some significant calming purpose. There was a strong tendency for these participants to hold the smoke, to stroke, fondle and play with it, to carry the packet in their hands most of the time, or to have it in direct view and regularly look at it. These participants were very aware of this preoccupation and made clear links between this aspect of their smoking and their mood state.

(Ron)

It’s the occupying of the hands. It’s the concentration on something else other than the shit going on around the place.

Literally seeing them in front of me is somehow comforting.

(Sylvia)

It helps stop me from crying because I get in such a state that I can’t smoke when I cry. It helps calm me down.
(Beth - When asked what she thought would happen if she gave up smoking)

For starter, my arms would be in ribbons. (Said while scratching her arms where there were already old scratch marks) I have (emphasised) to do something with my hands and I have to do something with them all the time. Just one thing is not enough because I get all jittery if I don’t. And I also need to do something with my mouth because without something there I would bite the inside of my mouth. I think it’s just a nervous habit... It’s a comfort thing. It’s a private comfort that I just have for me to keep myself afloat.

The focus on the physical process of smoking was also evident by these smokers expressing a preference for eight to twelve milligram cigarettes. They cited clear sensation preferences in their choice and their use of words was interesting.

(Jack - Regarding the lower milligram tar cigarettes)

There’s just no satisfaction going down your throat. It’s like sucking in fresh air. The 12 mg are good for flavour and satisfaction. The 16mg are too strong. They burn your throat.

(Beth)

When I feel down, it’s like there’s a great big hole inside and the smoke fills it up, in the same way that some people eat food. It’s the depth of that feeling that others don’t seem to understand.

Several of these smokers identified themselves as being susceptible to visual cues to smoke.

(Jack - Talking about advertisements for cigarettes)

Like the one on the side of the buses we catch to the shop. I think, “Isn’t that horrible?” and then I light up another cigarette. It makes me want a cigarette. It’s a reminder. I’ve also heard that from quite a few other people. They just don’t take in the negative information.

Anne’s comments provide some clues to how cigarettes came to fulfil the role of physical and emotional comforter for these people.
(Anne)

*It becomes such a part of what you do. It’s so predictable. You can rely on the smokes being there. I know what to expect from the taste. I know it's going to light a certain way and take a certain amount of time to smoke...When you’ve got something so reliable, predictable and enjoyable, it’s hard to give it up.*

(5.4.5) Control and Smoking:

Discussions about the sense of control over smoking elicited complex and sometimes contradictory responses from these participants. Five of the six people interviewed with major depression stated, without hesitation, that the cigarettes control them and that they have little or no control over their consumption of and need for cigarettes. Only one person expressed control over their smoking and this was expressed in the context of quite deprived circumstances where even a little self-control was perceived as significant.

(Mick)

*I really feel that a lot of the time the smoking and the depression is not in my control. The smoking comes in when I’m most down. I always have a smoke then, or any time I suppose, but especially when I’m down and it’s not something I feel I can control. I really don’t see that I can cut down.*

(Jack)

*I think the smokes very much take control of me.*

These participants seemed to choose to relinquish control, to externalise the source of control. They held generally negative views about their abilities and had little volition. Their tendency to nominate external sources of control from outside of themselves and their own resources demonstrated their lack of understanding of the processes necessary for them to plan to quit and to avoid relapse.

(Ron)

*I’d like them to take me to hospital for three or four days and tie me down and give me a sleeping drug for that time and I’d probably wake up and not want a smoke.*
However, they also clearly described occasions when they were able to exercise much control and could abstain from smoking altogether, despite their physical dependence on nicotine.

(Ron)
In the evenings when I’m sitting at home, I don’t smoke after 7pm. If I’m out I’ll continue to smoke but when I walk in the door that’s the end of it. I’ll read or watch TV for awhile but I set limits on myself...I don’t smoke more if I buy cartons. They’re there but my attitude is that if I take one packet out then there’s one missing. Inevitably that packet will come out. I’m not saying it won’t, but while it’s full it’s less likely to come than when it’s less...it helps police the situation and I find that it is an option for me to stop me from smoking more.

(Beth)
I have at times slowed it down a lot and I didn’t smoke much when my children were small. When I was pregnant it was very little in these days, probably no more than 3 or 4 a day... When I was nursing, I became part-time and got down to working 4 hour shifts, so I wouldn’t take my smokes with me and I got down to about 4 a day.

Reasons for these inconsistencies in the ability to control their smoking intake are suggested by Ron’s comments on learned self-reward and reactions to choice being threatened.

(Ron)
I told my doctor I was going to time my smoking as a way of cutting down. The trouble was I sat here and watched the timer go around and I was almost saying, “for God’s sake, go quicker.” I found that I wanted a smoke at the end of it whereas, if I hadn’t been watching, I probably wouldn’t have been thinking about it. It’s almost like an expectation I’ve built up by then, like I deserve the smoke by waiting for it.

(Ron)
The more I’m jammed against a wall the more I want a smoke. It’s the security that smoking gives that’s the most significant.
Others spoke about how their depression symptoms interfere with their ability to practice control over their smoking when they are more unwell.

(Anne)
I’m not even aware of my smoking when I’m in hospital. I just do it. They’re just there. I’m just lost in feeling depressed. It’s just so automatic at the time.

(Jack)
I do smoke them differently when I’m unwell. I think I smoke less. When I enjoy a smoke I’ll smoke them right down to the butt, but when I’m unwell, I’ll quit often smoke them without even thinking about what I’m doing and butt them out without even finishing them. When you’re more depressed your mind’s in a different state, of not even thinking about the smokes. You’re feeling more frustrated and driven by other things.

This group of participants were also unsure of their routine consumption of cigarettes. They claimed to be oblivious to their consumption, indicating that it depended on their mood on any given day. They identified no clear pattern of consumption other than the first cigarette of the day which can be clearly linked to their physical dependence need for nicotine when they first wake up.

(Ron - When asked how much he spends on cigarettes each week)
I have no idea and I don’t want to know and I’m not going to tell you anyway. (in jest) Far too much.

The habits surrounding their smoking were described as quite automatic. Most of these participants were not aware of how many they smoked. They seemed oblivious to their routines with smoking and pairing of activities with smoking.

(Mick)
There’s no time when I’m not smoking. I smoke at least every half an hour, probably every 20 minutes. It’s pretty automatic. I don’t think about it, I just reach for the smoke and it’s there. I don’t always remember lighting a smoke.
(Jack)
I quite often don’t remember lighting up a smoke. Five are for need and the other five are just wasted. I don’t remember them at all.

(Anne)
There’s no set pattern. Just whatever. I don’t think there’s any real routine.

(5.4.6) Awareness of Harms - Smoking as a Death Wish: A Slow Suicide:
All participants with depression were aware of the physical health effects and consequences of their smoking, however, they chose to smoke in spite of this knowledge and the adverse health symptoms already evident for some.

(Sylvia)
It gives me bronchitis but it helps my mind feel better.

(Anne - Who recently had serious health complications as a result of her smoking)
I do like smoking but I also understand that it’s not good for me. I’m aware of the hazards as far as my health is concerned.

The reasons for continuing to smoke were closely linked to how these people felt about their situation, and were strongly influenced by their sense of anomie and hopelessness. Continuing to smoke reflected a ‘death wish’, an expression of extreme and fixed powerlessness, an escape from their current mental anguish, a means of achieving what they could not do otherwise; a means of ending their life with the least pain. In an unusual way, it became a means of exercising some control when there were few perceived opportunities to do so otherwise.

(Jack)
I think if the doctor told me I had a choice between smoking and dying, I’d keep smoking. I just know I couldn’t go through the withdrawal symptoms and (wife) would probably be better off without me being cranky all the time. I don’t think other people would really care anyway.
(Beth)

It doesn’t bother me from a health point of view at all because I don’t want to live a long life. So it doesn’t bother me at all…If I was told by my doctor that I should quit, I would choose to still smoke. Everyone sort of assumes that you want a long life, but I haven’t for a long time. So in order to quit, I’d have to want to live. I find myself relieved at those situations. (When she has tests for health problems) I find myself saying to myself, there may be no need to quit because I might have galloping cancer and it’s too late and I would choose not to have anything done anyway so why stop smoking. (pause) I’d almost wish it; it’s almost a relief that something might be there… I have no intention of being old and not being independent. So life’s not valuable to me in that sense.

(5.4.7) Reinforcement and Acceptance of Smoking by Others:

All participants with depression commenced smoking between the age of eleven and fourteen, except for one lady from what she says was a relatively sheltered upbringing, who commenced smoking when she became independent and commenced work at the age of seventeen. For most of these participants, smoking initiation occurred in the context of peer pressure, as for the general population of smokers, but this was not cited as the main influence on their smoking. All participants described an environment in which they grew up surrounded by family and a culture that accepted and sometimes, positively encouraged their smoking. Many cited their smoking as a rite of passage into adulthood. Buying their own cigarettes was a marker for development as was commencing paid employment and being able to buy their own. Smoking became a source of identity and belonging and occurred in environments that reinforced this as a means of self-expression.

(Mick)

I’ve been smoking since I was about eleven (Mid 1970’s); that’s twenty years or more. It started with school friends at school. It was just cool to smoke back then and everyone smoked so it was just the way things went.

(Beth)

It was a silly reason I suppose. I was working in the theatre at the time (the late 1950’s), and with the grease paints and things backstage you couldn’t do anything in between items and lots of the girls smoked and I thought they looked very sophisticated and I joined in.

(Jack)
I started when I was twelve (the late 1950’s) and I’ve been smoking ever since, with friends at school too. You could go up to the tobacconist and buy a packet of five cigarettes even at that age.

(Ron)
It seemed like the sociable thing to do and mum and dad said I could have a smoke when I could afford to buy my own. It wasn’t a thing where I was influenced by peers. I might have done it to rebel against dad because he was a reformed smoker. I don’t think it was for that reason but I think it spurred me on a bit more, like “Up yours, Charlie,” because we didn’t get along that well and it was like, “I’ll smoke because I can afford to buy my cigarettes.”

All participants with depression cited strong family reinforcement of their smoking, for some even open encouragement. Their parents were, overwhelmingly, role models for these people. It needs to be noted that five of the six participants had parents from the British Isles where smoking prevalence was high.

(Sylvia)
My mother didn’t seem to make a big fuss about it. She wouldn’t buy them but she let me smoke at home. I was fourteen then. I used to spend my dinner money on them.

(Anne)
I started getting them by pinching them from my mother. Both my parents were very heavy smokers and my father not only smoked cigarettes but smoked a pipe as well as cigars. My mother just hates cigarettes.

(Jack)
My mother smoked occasionally. Father smoked a pipe, and two brothers smoked cigarettes. So it was very acceptable to smoke in the house.

Impressions gained from interviews with these participants were that they struggled during their adolescent years, they did not feel that they were fully acknowledged by their families or peers, and therefore strove to gain a sense of autonomy and independence, among other things, by smoking.
Once these participants were diagnosed with depression and became clients of mental health services, their relationship with their family changed with regard to their smoking. They increasingly perceived that double standards were being applied to their smoking, with families not longer accepting the person’s choice to smoke. Families were perceived as judgmental regarding their spending on cigarettes versus other needs, given their limited funds. However, the complicity of families in assisting participants financially to buy more cigarettes was also noted. Participants suggested that this was based on the families’ beliefs about the person’s capacity for self-control, their dependence on cigarettes, their ‘weakness’ and their need for cigarettes to manage their mood and illness.

(Mick)

*Both my brothers and sister smoke. I’m not sure whether my parents put pressure on my brothers and sister. I don’t think they do so much. My parents say I can’t afford to smoke...They say, “Oh, you can do without that cigarette. It’s costing you money. You can’t afford it, blah, blah, blah.” And I say, “I know, I’ve heard it all before.” It just goes straight over my head.*

(Mick – Asked what he does when he has run out of cigarettes)

*I usually get on the phone to mum or dad and they always help me out. They don’t like to and they still complain about it, but they do help me out.*

These participants had a great deal to say about their smoking in the context of psychiatric hospital and community mental health settings. They felt that their smoking was either ignored, minimised, or totally misunderstood by their doctors. Some felt that doctors and workers in mental health positively reinforced their smoking. Overall, these people were getting very mixed messages from ‘the experts’.

(Sylvia)

*I’ve been to my doctor (GP) and he told me I should give up smoking, but my psychiatrist has told me that it would be dangerous for me to quit. I couldn’t anyway. He told me not to worry about it.*

(Beth)

*I did think of patches but my key worker said that, because of the way I smoke, it could be harmful to relinquish the nicotine. He didn’t think it would be a good idea.*
Dr... used to mention my smoking to me, especially the financial cost, but she hasn’t said anything to me lately because she’s smoking herself. She’d say things like, if I stopped smoking I could afford to go on a holiday.

She (psychiatrist) knows that I smoke but she doesn’t mention it. She has never said that I should stop it and never asked me about my smoking.

They know I do smoke...My psychiatrist... I don’t know that she’s ever said anything. It’s just ignored as if it’s not important. It’s not even in the equation.

One man spoke at length about his psychiatrist’s and key worker’s attitude towards his smoking. He expressed the helpfulness of their reactions. Unlike the other five participants with depression, he was actively preparing to try to quit smoking at the time of interviewing. He felt that their reactions were supportive of this goal.

They both talk about it. They show concern for me rather than being judgmental. They don’t agree with it (the smoking) but they try to understand.

I think we shared and communicated more that day sitting and having a smoke and talking about things than anything else. It was terribly important to me. You don’t know how much that meant to me because I wasn’t being treated like a patient or a weirdo or whatever you want to call it. Officially, I suppose, they shouldn’t have been doing it.

The ways in which smoking was accepted, reinforced, and used as a tool in treatment and symptoms management in inpatient setting was also noted by these participants. Smoking was used by staff in these settings as a therapeutic tool to build rapport and facilitate assessment processes.
(Sylvia)

One night in hospital when I couldn’t sleep, one of the nurses could see that I wasn’t quite right and I went down to her and said I couldn’t sleep and could she give me something and she said, “Would you like a cigarette?” and I said, “Oh, I’d love one.” She knew what I needed, even though it wasn’t allowed. I went to sleep then.

(Anne)

The first time I went to (Private hospital), my primary nurse, she was a smoker, so when it was my turn during the course of the day to sort of sit down with her, she’d always have a smoke...We’d just go out and sit in the garden and it was fine. It helped build up the relationship.

(Ron)

A nursing sister told me if I smoke, I’ll never have dementia or Alzheimer’s.

For many of these people, smoking was cited as an activity when there was just nothing else to do while in hospital. The poverty of organised activities or encouragement by staff to participate in what was available, and the dominant focus on pharmacological treatments, was noted. Staff smoking for stress relief while on their break and therefore acting as role models for patients was also observed by these people.

(Jack) It’s very boring because of the environment. There’s just nothing to do. You don’t see the staff unless they come down for a smoke and even then they don’t usually talk to you.

The silent condoning of smoking as a social activity as part of community rehabilitation programmes, and the assumed acceptance of these people’s ‘need’ to smoke was also mentioned.

For one lady with depression, the hospital environment and her smoking behaviour interacted in more complex cultural ways. Hospital provided sanctuary and security; a shield from the perceived stigma of her usual environment.
(Beth)
I did quite often walk around the grounds of the hospital by myself. It was a haven to me... At [the hospital] you can sit on a quiet seat and have a smoke under a tree somewhere and digest everything.

(5.4.8) Other Drugs:
All except one participant with depression were heavy caffeine drinkers; most participants using between ten and twenty plus cups of tea or coffee per day on a regular, longstanding basis. Three participants regularly drank more than twenty caffeine drinks per day. Pairing of smoking and caffeine intake was prevalent; usually the norm.

(Jack)
I’ll have three or four smokes in bed with cups of tea (black) before I get up. Then during the day, I’ll just keep smoking every twenty minutes or so, usually with a cup of tea as well.

Alcohol was also paired with smoking in the past or present by each of these participants. Three of the six people with depression described themselves as ex-alcoholics. Case notes confirmed a history of alcohol misuse for each of these people, that is, its use was harmful to their physical health and social functioning. The other three were current alcohol drinkers, with a daily consumption of at least two to three standard drinks. One of the six people with depression also reported episodic amphetamine use. He said his smoking rate doubled at these times.

(5.4.9) Smoking to Self-Medicate Illness Symptoms:
For all participants with depression, smoking and their illness had clearly identified self-reported origins in their youth. Problems with relationships, with families and a strong sense of alienation from family, of not being understood or having their needs acknowledged or respected were noted. many of these people clearly described the development of their depression. Smoking merely became one of the dominant tools for helping them get through this period in their lives, learned and reinforced over time, the withdrawal effects of their dependence on nicotine acting as a catalyst in the process. Many suggested that they were self-medicating their problems with cigarettes, long before they came to the attention of mental health services.

(Mick - Smoking)
That’s what I’ve always used when I’m depressed…It’s just always been there from such an early age that it’s just a habit now. I first got diagnosed with depression when I was twenty-three. I was depressed way before that. I always knew there was something wrong with me. I just didn’t know what, and my parents didn’t help me out. I think it started when I was in my teens... It just got worse and worse so I turned more and more to smoking and drugs and alcohol.

(Jack)

I smoked more because of my stress from my father (Described by him as dominant and abusive)...all my life. Right from when I was young; a child. Because of the way I was treated by my father, I always felt I couldn’t speak up. I could never answer back or express my opinion. it put me in a position where I feel I have to submit to everyone else’s thinking...smoking was something I could (emphasised) do...It really worries me seeing myself angry and I suppose there’s a bit of history in that, seeing my father that way and hating all it represents.

(Sylvia – Who said she spent much of her childhood in an orphanage)

This one particular sister used to call me an elephant. I’ve always felt a bit nervous and struggled, even before I became unwell...sometimes I wonder my sister was like that to me. It was because she could dominate me I suppose.

(Beth)

It happened years ago. I suppose I had my first nervous breakdown when I was eleven. I’ve been seeing people and taking medication since I was nineteen but have been depressed for much longer. My parents didn’t believe in giving children medication for depression. They thought it was something that just required thinking your way out of.

All of these smokers believed that smoking helped them to focus and concentrate. They used role of smoking regularly.

(Mick)

I smoke to help me think more clearly.
(Ron)

It clears the fog somehow...I’ve found I can concentrate better after I’ve had a smoke, like when I’ve got to sit down to make a shopping list.

(Sylvia)

I think I smoke to try and sort my mind out. It helps me to make decisions about what I have to do. It gives me a space to think almost.

A multitude of comments were made by all participants with depression about their smoking and links to their illness management. Cigarettes were used openly to self-medicate depressed mood states. Participants clearly identified cigarettes as tools to relieve pressure, for stress and anxiety relief and as a quick and readily available solution to these problems.

(Mick)

Nothing relieves the pressure like having a smoke...I still tend to take a lot of tablets and drink a lot and smoke a lot to blot everything out. It’s just easier; it’s what I know. Yeah, I’m self-medicating to blot it out. (When asked what it is?)...the disappointment about my life and how it’s going. I’ve got better as I’ve got older...Before, I just wanted to kill myself all the time...Sometimes I just feel like going out and getting wasted.

(Ron)

It’s the concentrating on something other than the shit going on around the place, and hence, the cigarettes serve a real purpose in helping me to cope. The minute I get down in the dumps, up go the cigarettes...And I don’t care what anyone says, they’re still a very calming influence on me. It’s that tremendous feeling of, “Oh God, it’s a relief.” It’s quick and it’s there, you don’t have to go searching for a solution. It’s there ready. I don’t smoke a set amount every day. I smoke according to how the day has been emotionally.

Smoking was also used to boost confidence, as part of helping with anxiety and was cited as a regularly used tool for communication to overcome social phobia.
(Jack)
I don’t speak very fluently, so the smokes help give me confidence to carry on light conversation...it frightens me that I might have to go over it so that others understand me...Like this morning when I rang the specialist...it took me all morning, stewing over the call and smoking one after the other to get to the point of being able to pick up the phone. Terrified. The smoking went sky high, because each time I’d think about the call, I’d tell myself, “Oh, I’ll just have another one and then I’ll be all right to call.” That went on about four hours. It doesn’t actually solve the problem, but I wish it did...They (smokes) make it a lot easier to get over some of those feelings of self-doubt when you’re with other people. They add to the level of comfort, but mainly to relieve stress regardless of what else is happening...The smoking helps give me strength to go out in public.

(Beth)
When I go to the clinic and talk with my psychologist for an hour and I can’t smoke then, so I smoke when I come out and usually before I go in.

(Anne -Regarding her rate of smoking)
It depends on whether I’m seeing my parents because they give me a really hard time about the problems I’ve got.

These people also used smoking as a form of therapy for their feelings and problems. What is unclear is whether the cigarettes actually help the person to move on from their problems or whether they continue to ruminate about them regardless.

(Sylvia)
(When smoking) I think about my children and the things that have happened, what I’ve done in my life and ask myself questions about why things have happened.

Ultimately, the process of smoking served to distract attention from the person’s problems altogether. It became a way of blocking out the unbearable. It also served a functional role in helping them to overcome their suicidal thoughts; a way of delaying any decision on this. This was particularly the case when they were more unwell, but also explained much of their automatic smoking at other times. Three people with depression described their smoking at these times.
(Mick)
I smoke to blot out the suicidal feelings and when this does not work, I resort to abusing other drugs such as alcohol and keep taking tablets until I’m asleep.

(Sylvia)
When I’ve been unwell, oh, I smoke like I don’t even know I’m smoking. I put it in the ashtray and then have another one without even realising. Once I smoked a carton in two days. I just smoked and smoked and smoked to block out all the suicidal thoughts and negative feelings and worries, or I’d just keep smoking and listening to it (the suicidal thinking).

(Beth)
I can’t do one thing at once. It has to be several so I’m constantly distracting myself in some small way from the worries and the urge to take the next step to finishing it.

One man, who expressed many of his responses during the interview as if protesting, described how his smoking helped him to cope with the stigma of having a mental illness and the sense of exclusion and powerlessness that this created for him. He also suggested that smoking was a proven treatment for him when other treatments had been less than satisfying. What was unclear is how much of this feeling was a result of self-deprecation and, if so, the role of cigarettes in giving him some sense of control and responsibility for managing his illness, and strength to cope with day to day living.

(Ron)
I feel quite stigmatised by having an illness. It took a long time for me to get past a lot of the rubbish that happened to me when I was unwell initially with people laughing at me and saying, “Look at him, isn’t he a big sook.” When I get home and shut the door, then I feel it. I can be strong when I’m out...but then when I get home I find I’m crying alone...and smoking. I’ve smoked one after the other at those times to try to calm myself down...it’s all very well to say, “Don’t do this and don’t do that,” without having or being given some crutch to go and do it. It’s like there’s some puritanical turkey sitting in some place with no idea. They just don’t realise how much the smokes help when other things haven’t.
(5.4.10) Quitting Smoking:

Beliefs about Quitting - ‘The Magic Pill’ (Ron)

Of the six smokers with depression, only one, Ron, showed any practical understanding of the process of quitting and the habits that would need to be challenged in order to quit. All said that they would give up, or seriously consider it, if they could do so painlessly. The degree of contemplation about quitting, however, fluctuated with fluctuations in mood. These smokers displayed much ambivalence about quitting, citing that smoking was enjoyable to them at times, especially when they perceived few other pleasures in the presence of depressed mood and lack of purpose and hope in other aspects of their lives. Overall, most participants with depression showed little insight into the difficulties that they would need to overcome in order to quit.

(Mick)

I remember just saying enough is enough and I stopped. (No preparation) I stopped for about half a day and I just started again because I was getting stressed.

Even Ron fluctuated in this respect, at times being quite practical, but giving in at other times. The persistence and energy needed to sustain the process of quitting seemed to be significant here. Ron’s comments reflected the general feeling of others, that they often just did not have the strength to follow through with quitting.

(Ron)

I’ve locked the cigarettes in the shed in the past…To quit, I think I’d need the magic pill.

Others simply had never attempted to quit.

(Jack)

Not any serious effort. I’ve thought of cutting down more recently because of the finances but not before that at all in the past forty years. I need cigarettes. They serve a purpose for me. You’d feel miserable anyway, so is it really worth it? Is it really worth putting yourself through more misery than I’m already experiencing...It’s just too hard.

(Beth)

I feel quite bad about my smoking but I can’t stop.
These people perceived clear links between their smoking continuance, their inability to quit and the presence of their mental illness. It was noted, however, that these perceptions were quite fixed and total, leaving little room for development of new ways of perceiving the situation.

(Jack)

*If I didn’t have any stress, I think I’d be able to quit reasonably well.*

(Beth - *When asked if she thought she would smoke if she didn’t have a mental illness*)

*I don’t know. I can’t remember life without feeling depressed. I wish I’d never started. I bitterly regret starting and if I hadn’t been introduced to it, I don’t think I would have been tempted.*

(Ron - *Regarding his beliefs about quitting if he didn’t have an illness*)

*I probably still would have smoked... I think quitting would have been easier if I hadn’t become unwell, because I probably would still have had a certain job, and security wouldn’t have been so important. My life would have been more secure anyway, financially and otherwise.*

Meaningful and understanding relationships, as a prerequisite of emotional stability and self-worth, were cited as the most necessary thing needed in order to quit smoking by these people.

(Mick)

*If I had a job, I think I’d probably still smoke. If I had a relationship that was going really well, that would make a difference because I’d feel more worthwhile, that I’d be actually doing something with my life.*

(Sylvia)

*I’d be likely to pack up smoking with someone who understood me and what the smoking means for me than not, you know. Being judged just makes you feel like you want to smoke more.*

At times, the sense of hopelessness and despair about their circumstances strongly influenced their decisions about even attempting to quit.
(Mick)

Sometimes I just feel hopeless and helpless, like I'm not going to achieve anything in life...Sometimes I feel quite alone and isolated.

(Jack - When asked about having money spare after quitting smoking)

Then I thought, well what would I do with the extra money anyway? I wouldn’t go anywhere probably, so I might as well keep smoking...I just don’t think that far into the future. I don’t see much hope in it.

Nicotine Replacement

In their discussions about nicotine replacement therapy (NRT), these smokers displayed an over-reliance on these aids to achieve smoking cessation. The complexity of the process of quitting was not considered. Nor was the over-reliance on smoking to alleviate their problems, in the absence of other strategies. Therefore, as soon as their mood took a turn for the worse, they were likely to give up their attempts to quit or cut down. For some, this reinforced the sense of failure over and over again, serving to lock them into the belief that quitting was impossible for them.

(Ron)

I know that when I had the gum, I was down to smoking about three or four a day and then a new problem would emerge and the smoking would just go straight back to where it had been before. And invariably there will always be things that come along. It just seems like a hopeless situation.

Of the participants with depression, the three men had tried nicotine patches before; one had also tried gum. The three women had never tried patches, although Sylvia had tried gum with no effect. The use of patches brought mixed results and were ultimately unsuccessful. The main reason for attempting to quit was cited as the financial burden of continuing to smoke and patches were believed to be the least stressful means of achieving this - a magic pill. Responsibility for the success of the process was always perceived to exist external to the person.

(Mick)

Patches didn’t do a thing...I just didn’t feel the effect at all.
(Jack)
I tried patches about two years ago for financial reasons. The general pattern of having no money left after the food and smokes and bills were paid just got to me...While I was on patches I was still smoking the same anyway, so they really didn’t work at all. I went to my doctor for a prescription. He just wrote it out and gave it to me. He didn’t say anything.

(Ron)
I was put on patches by my GP and it almost killed me. The chemist told me the doctor was wrong because I was put on the full strength nicotine patch straight away which was actually more than I was getting in the smokes. It gave me hideous nightmare, hallucination, so much so that it was becoming a concern to my psychiatrist.

Sylvia expressed a real concern regarding the use of patches for people with depression, applicable to people with other disturbances of cognition and concentration, which has not been considered by professionals and NRT manufacturers.

(Sylvia)
I’ve heard they’re dangerous if you smoke with them on and I’d worry that I’d forget to take the patch off.

The practical problems with purchasing nicotine replacement products while on a limited income, with all of the pension being accounted for each fortnight, were highlighted by Ron and give real insights into the obstacles faced for these people in their attempts to quit smoking.

(Ron)
I really do think the patch people and the government need a bloody good kick up the bum...It angers me that you’re put under the stress and pressure and then you go to get patches and you just can’t afford it. If you’re down to your last cent anyway and then you’re encouraged to go out and spend up to $80 on something that you don’t even know whether it’s going to work or not and it didn’t. My chemist tried to help by giving me half a script. He said to me, “Doesn’t your doctor realise how much this is going to cost?” I didn’t have that kind of money on me. The idiot of a doctor had the idea that if you gave up smoking you’d have the money but if you haven’t given up smoking in the
meantime, then you’ve literally had no opportunity to have any extra money. You’ve got the cigarettes there; you start the patches there (Same point). There’s no extra money in the middle. They just don’t realise that basic fact.

Quitting Versus Cutting Down
The general feeling by two participants was that quitting would be better that just cutting down. This showed a recognition of the potential for smoking rates to fluctuate with changes in mood, giving less rather than more control by choosing to cut down.

(Ron)
My doctor said to me it’s not an option (to cut down) because he knows damn well it will go back up again as soon as there’s some crisis and I know that too.

(Beth)
I don’t think there’s any point in just cutting down because you’re still smoking so the potential for the habits and smoking more is still there. It’s either a black of white area; you either do or you don’t. Just cutting down is just putting grey into the mixture.

The other participants had mixed views on this topic, demonstrating the degree of ambivalence they felt and the variance in their understanding of the quitting process.

(Sylvia)
I think cutting down is quite OK. If you feel like a cigarette then I think, why not.

(Mick)
Well, you’re better off quitting, aren’t you? Cutting down is more feasible though. If I had more strategies for cutting down, that would help for sure.

(Jack - regarding his attempts to cut down to lower milligram cigarettes)
I found I just smoked more, sometimes twice as many, because they just didn’t do anything, didn’t satisfy the need. I don’t think I really wanted to quit, more that I wanted to be seen to be doing the right thing.
Attitudes towards Quit Campaigns and Tobacco Policy Changes

These smokers tended to ‘tune out’ to the various advertisements and quit campaign information available. They expressed feelings of alienation from it’s messages and felt that it was condescending, disempowering, and judgemental, and showed little understanding of their struggles with depression.

(Beth)

*It's not at all helpful when they say that you will get set backs and that everyone does. It misses the point and just goes straight over my head. It makes me feel worse, more alienated, as if they haven’t really understood at all.*

(Ron)

*If the Quit ads come on TV, I’ve got the remote control. I flick the channel. I can’t stand it. Here we go again. You’re telling me something I don’t want to do. It’s ‘Zieg heil bang’...It’s too agro. it’s inciting other people to say, “Oh, there’s something wrong with them, they smoke.” It’s like having a double whammy. It's hard enough to get by with problems. They're just adding another one to it. I found the Quit book talked down to you somehow.*

Five of the six participants with depression expressed many concerns about the recent tobacco policy changes, restricting smoking in public, restrictions on availability and potential price rises. They saw several adverse consequences of these changes for the depression and overall wellbeing. Many feared that the changes would alienate them from what little public life they had and drive them further into isolation.

(Ron)

*The week that the changes happened at the market, I found I was coming home early because I was starting to say to myself, “I can’t be bothered with this.” So I was losing that bit of interaction with other people and it was becoming a chore. The pleasure of it (shopping) was diminished.*

(Mick)

*I just don’t go to those places (where smoking is now banned)...I won’t be going to pubs anymore cause when you drink, you’ve got to smoke; that’s just part of it. So I'll probably buy take-away. It*
will make me more isolated, definitely. It will be a big part of the depression. I’d be under a lot more pressure from others to quit. I don’t know how I’ll cope with this.

(Jack)

People will just become more outcast. I feel it happening already. It’s just a hopeless situation... What ever happened to freedom of choice... For me it will mean that a lot of tasks that I do in public like going to the shops and other places where there won’t be smoking allowed, will become more stressful than they already are... I’ll have to go into the carpark with the other outcasts. The smoking gives me the strength to go out in public.

(Beth)

It’s like being stigmatised twice, for my smoking and my illness. I think if you are a smoker and nobody else is, it makes you feel a bit inferior at the time; that you can’t manage without them and everyone else is managing. It makes you feel different, which you really don’t need when you’ve got depression.

One man raised very unique concerns about possible unintended consequences of the tobacco policy changes in hotels, suggesting further polarising and compounding of social problems within certain groups in the community with regard to gambling.

(Ron)

When we go out I have two beers before dinner and then a couple of smokes after dinner. You can’t do that anymore at the pub. I know there are ways of getting around that still, like sitting in the gaming room before dinner. I don’t want to do that, nor do I want to sit in the front bar, so I have to leave and get up and go out for a walk either to the gaming room or out on the street. So it’s actually pushing me into the gaming room to spend money on the bloody poker machines because you look like a damned idiot if you just go in there to have a smoke... I feel that I’m strong enough not to start up a gambling habit but I’ve seen others who aren’t. I wonder if their gambling started in a subtle way like this.

One woman’s absence of any comment on the subject was noted. Her degree of powerlessness over the course of her life, first being incarcerated in an orphanage, then in jail, and then in long-stay psychiatric
wards and poor quality community hostels was noted. The researcher’s understanding of this was that this woman was effectively silenced by her experiences.

Ultimately policy changes were seen to lack forethought and an understanding of the problems faced by some people who continue to smoke. The motives of policy makers were called into question by one man.

(Ron)

I figure if they really want people to quit, they’d make all these chewing gums and patches and things cheaper. It’s disgraceful.

(5.4.11) Smoking and Boredom:

Only one of these participants claimed that he smoked at times because he was bored.

(Mick)

It’s just relaxing, it’s something to do, it breaks the monotony.

The other five people with depression clearly and openly denied that they smoked because they were bored at the time. All were able to describe their smoking as fulfilling some purpose, either as a motivator, to distract their thinking, to help stop them from feeling ‘lost’, or some other reason related to the management of their depressed mood.

(Ron)

Smoking seems to segment the tasks. It fragments; if you do this you can have a cigarette and if you do that you can have a cigarette...(It actually gets you to do things?) Yes, it’s a motivator.

(Jack)

I don’t think boredom came into it with me. I smoked more because of the stress from my father.

(Anne)

At the moment smokes fill up a lot of the purpose I have in my day...It’s just a whole way of being.
I never smoke when I'm doing something but I'll smoke to fill in the time if I haven't got much to do. It's like not knowing what to do.

It's like boredom. I seem to fill up my life with things and in the end it tends to snowball and get too much. None of it seems to have a purpose after awhile.

Beth went on to describe what at first could be interpreted as boredom but which demonstrated the very real problems faced by some people with feelings of stress and anxiety and depression.

I have things to do so it's not a case of filling in my time with other things. It's because I can't concentrate enough to read or watch TV or things like that. I can't just do one thing at once.

(5.4.12) Summary:

Participants with a diagnosis of depression clearly described the use of cigarettes to promote autonomy, albeit in the context of avoiding the potential for oblivion through feeling completely lost and swamped by their depression. The pervasiveness of their illness symptoms involving a deep sense of despair and hopelessness and helplessness was openly expressed and reflected in their comments. These participants used cigarettes for physical comfort and for relief from the grinding nature of their negative mood state. Smoking provided these participants with an automatic activity that they could rely on as non-threatening. They often withdrew socially and emotionally from others and hence, cigarettes became a substitute, often in the context of intense underlying feelings of guilt, loss, and anger towards others and themselves. These participants described their smoking initiation in the context of anxiety and problems with coping in their relationships and environments at the time. They often felt separate to peers. They experienced overwhelming acceptance and reinforcement for their current smoking to continue, from family, community mental health staff and the inpatient system of care. Most of these participants said that they would prefer to be non-smokers but felt unable to quit successfully, given the presence of their mental illness, without strong external intervention. Like the BPAD group, participants with depression did not trust themselves to attempt cutting down in preference to ceasing smoking altogether. They had made few attempts to quit and displayed minimal awareness of or
(5.5) BORDERLINE PERSONALITY DISORDER (N=6):

Participants with a diagnosis of borderline personality disorder (BPD) ranged in age from twenty-five years to fifty-seven years. Their smoking experience ranged from four years to forty-three years. Current smoking consumption ranged from ten cigarettes to more than fifty cigarettes per day. Only one of these smokers (Joe) nominated a routine number of cigarettes consumed; the other smokers in this group varied their consumption. The cigarette strength also varied for most of these smokers, with lower tar cigarettes preferred for their taste and higher tar cigarettes preferred for their impact. Several participants with BPD said that they started smoking as a form of rebellion with peers or for the perceived drug effect of cigarettes. Admissions to hospital had varied effects on these smokers’ level of cigarette consumption. They reported smoking more when they were alone. Only one of these participants lived with a partner. The others were either single or divorced. One lived in a privately run supported residential facility. The other five participants lived in public rental accommodation. The two male participants had worked more than five years ago. The four women had never undertaken paid employment. Level of education was low for all of these participants, with none completing school past the age of sixteen years. All currently received a government pension as a result of their mental illness. Five of the six participants had made more than ten attempts to quit smoking in the past and all obtained high Fagerstrom scores of nine to eleven indicating that they were heavily physically dependent on nicotine (See Appendix D). One participant (Joe) said that he had made no attempts to quit smoking although he talked a great deal about it during the interview. Five participants reported past and current problems with alcohol abuse. Kathy reported no use at all. Caffeine use was very high for this group, with caffeine toxicity noted for the two male participants.
Table 5.5: Characteristics of Participants with a Diagnosis of Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Names/Pseudonym</th>
<th>Paul</th>
<th>Kathy</th>
<th>Sandra</th>
<th>Susan</th>
<th>Julie</th>
<th>Joe</th>
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<tbody>
<tr>
<td>Age</td>
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<td>25</td>
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<td>(16yo)</td>
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<td>14yo</td>
<td>14yo</td>
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<td>10-20+</td>
<td>25-30+</td>
<td>15-20+</td>
<td>25</td>
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<td>&gt;10</td>
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<td>0</td>
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<td>5</td>
<td>12</td>
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<td>43</td>
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<td>10</td>
<td>9</td>
<td>10</td>
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<td>11</td>
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<tr>
<td>Smoking- Interview</td>
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<td>5 cigs</td>
<td>2 cigs</td>
<td>6 cigs</td>
<td>6+ cigs</td>
<td>4 cigs</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
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<td>20+</td>
<td>10+ (coke)</td>
<td>20+</td>
<td>15-20+</td>
<td>25+</td>
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</table>

# - Disability Support Pension provided by the Commonwealth Government
@ - Cigarettes smoked per day

Results from interviews with participants with a diagnosis of borderline personality disorder are organised into the following eight themes.

**5.5.1) Control:**

**Control by Smoking - Rebellion and Protest Against Control by Others**

These smokers expressed clear protest against the authority of others, especially service providers. Smoking was one means of asserting themselves, of being self-determining, when other aspects of their lives seemed out of their control, or when they perceived having no say in determining their future. These smokers smoked in an attempt to regain power and control in their relationships with others.

*(Kathy)*

_When you’re locked up and treated like animals in a cage, you choose to smoke because there’s not much else that you can choose. If you fight back then they throw you in seclusion...When other things are so restricting on you, it’s one thing you can decide to do to nark them, to show them that they’re really not controlling you. Like if you’re surrounded by rules and you feel you’re never part of making any of them, you feel powerless; you feel very powerless...Like times I was in the hospital*_

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in the past, if they (the staff) gave me that sort of stuff (judging her and trying to control her smoking) I’d just bounce off the walls and laugh at them. I’d give it back to them. When you’re just confronted by people who are just labelling and judging and trying to take control. The doctor I’ve got now tries to give me some control with the management plans and things. The smoking is just there in the background going up and down with the level of control...Every time I go to see my doctor I have to have a smoke before I see her because it gets you so stressed and agitated to have to talk about your illness in their territory and on their terms.

(Julie -In response to pressure from others about her smoking)
I think, “God, I don’t have much else to do in life. Why can’t I smoke?” even though I know I’d save a hell of a lot of money from it. I end up smoking more ‘cause I end up saying, “Right you bastard, I’m not taking your advice. I’m gunna [going to] have one anyway, so there.” You do, you rebel against them, just to piss people off.

Smoking became a way of creating order in what often seemed like chaos for these smokers. Cigarettes were cited as a steady, predictable crutch, a provider of structure that these smokers could lean on when life was less than stable for them.

(Kathy)
Like when other things are unpredictable and not going well, you can rely on a smoke; it’s consistent, you know it will be there, you can get a handle on it when other things are out of control.

However, even this relationship was not without its contradictions and feelings of ambivalence at times, as Julie and Sandra’s comments show:

(Julie)
The times when I don’t like to have a smoke is during the day when I’ve got nothing else to do. It’s the times when I feel least in control that I don’t like it.

(Sandra)
Sometimes, I wish I’d never started smoking. I don’t know why that is. Sometimes it annoys me when I get stressed out and have to have a smoke. I get annoyed with having to depend on smokes, of them controlling me.
Similarly, there were times when these smokers said they used the prospect of quitting to their advantage, to assert themselves when they felt pressured in their relationships with others, in order to regain some power and control in those relationships, especially with family. Thinking in this way kept some hope alive for them that the negative assessments by others could be overturned. Unfortunately, failure only served to reinforce those assessments, fuelling these people’s feelings of despair and hopelessness and need for control in the longer-term and resorting back to their former chaotic behaviour.

(Susan)

*If you can tell people that you’re giving up or that you’re trying to give up, they think that’s great and you feel better about yourself, and you can say, “At least I’m trying,” and that settles mum down a bit. I’ve learnt it as a response for her and she doesn’t hassle me too much.*

(Paul)

*The more people put you down, the worse you feel, especially if you’ve been put down by your parents all your life, like, “You’re not good enough,” or “You’re worthless.” So giving up smoking is not like giving in to them. It’s actually getting them off my back. It’s like proving to myself that I can do it. (That the parents’ assessment is wrong)*

The origins of the need for order and control are suggested by Susan and Kathy’s comments about their early life with parents. Again, their emphasis on relationships and loss and grief regarding these, are to be noted.

(Susan)

*When I’m under pressure it doesn’t always make me smoke more. It makes me feel angry because they’re not accepting me as a person. I just want to get rid of them in my life sometimes, especially my mum who gives me major problems. I just keep trying to work it out but she keeps chopping and changing all the time. I never know where I stand with her. It’s like I’m always on edge because I’m never sure what her reaction is going to be...When I was growing up and living there, she’s barge in all the time, and I’d hear her coming, and I was just waiting for the impact a lot of the time.*
(Kathy - Who said both parents had severe psychotic illnesses and intellectual disability) I'd come home from high school to find me dad talking to the walls most nights. What sort of life is that, and mum going ga-ga in another room. When I got raped one day after school, they just covered it up and said nothing...It wasn’t till I moved to a shelter when I was eighteen that I even learned to use a knife and fork. Now it’s like I’m the parent and they’re the children. Sometimes I just wish they weren’t there.

Control of Nicotine Dependence and Consumption

These smokers had several, often contradictory, comments about their level of control over their smoking. They all were able to describe their daily consumption from start to finish and were well aware of the habits and rituals concerning that consumption. They knew the strategies effective in cutting down and avoiding cues to smoke, such as putting them out of sight, or taking none or a limited number of cigarettes with them on outings. They were also able to challenge peer pressure to smoke. The emphasis, by this group, on physical health benefits of quitting was noted. They spoke at length about being aware of the damage smoking was doing to their bodies, and seemed genuinely concerned by this. However, they chose to smoke despite these harms. They also seemed to contradict themselves by claiming no control over their smoking, almost suggesting a self-punishing pattern, performing a number of relationship roles with themselves; playing victim, accuser, rescuer and responsible advocate. Claiming no control seemed to help justify the failure they felt.

(Paul)

I usually just reach for a smoke and light it up without even thinking about it. I have many a time during the day when I have a cigarette in my hand and I can’t remember having lit it. Often, I'll be walking around the house doing something and I'll realise I've put a cigarette down and I'll say, “Oh, I forgot about that.” It makes me feel weak, as if I've got no willpower. Sometimes it makes me feel angry with myself...Continuing to smoke seems to be like I'm continuing to put myself down, and that's not helping the depression...I don’t feel I have control of the smoking at the moment. It’s got control of me, like the alcohol did...I feel I’m responsible for the change. You’ve got to fix your own problems.
The smokes are my crutch. I lean on them. They definitely control me ‘cause I smoke them even if I feel sick or if I don’t want them, or if they taste foul. But I still smoke them and I hate that because I think I really want to give up because I’m lying in bed at night and I can feel my breathing and my lung. I’m practically choking for air.

Only one of these participants, Kathy, claimed any control over their smoking consumption. The other five clearly demonstrated it but didn’t claim ownership of it. The participants with personality disorder did not tend to smoke a particular strength or brand of cigarettes consistently. They recounted smoking varying strengths and amounts per day according to their mood and cigarette availability; sometimes varying for no particular reason. They were also able to go without cigarettes if forced to by their circumstances, without showing outward signs of anxiety.

Control of Illness Symptoms - Self Medicating Mood By Smoking
All participants with personality disorder emphasised the use of cigarettes to manage the symptoms of their illness. Cigarettes were used to aid concentration and decision-making, to assist with sleep, lessen anxiety, and provide relaxation. In particular, smoking was strongly linked to mood management. These smokers made several references to smoking for the relief of stress and pressure. This pressure was felt, both internally and externally, as part of relationship worries, particularly the pressure created by attempts by others to control those relationships. Sometimes, the source of the pressure could not be accounted for, being described as something inside them.

It helps me get through the anxiety when I’ve got things to do that I’m worried about... Just knowing they’re there makes me feel calmer and more in control of other things...If I didn’t have any cigarettes there, I’d be really all over the place. It’s like it gives a structure, a meaning to doing things.

I smoke 8mg, sometimes 12mg, sometimes 16mg. It depends how I feel. I smoke the stronger one when I feel really really depressed... There’s nothing really nice about smoking. It's just that it really
helps relieve the pressure that I’m under. It’s different to stress. It’s like everything is going to build up and explode.

At other times, cigarettes were used to completely block affect, to avoid the feelings of anxiety, stress, and pressure altogether; a way of these people giving themselves ‘time out’.

(Kathy - When asked if she liked smoking)

Nup. It just puts your mind on something different than what’s going on around you. It blocks it out...Sometimes when I’ve got something to decide, having a smoke is like time out so that I don’t have to think about other things. So, if I’ve got a lot on my mind, that’s what keeps the smoking going.

Smoking was also used as a form of anger management in relationships with others. The passivity of smoking in this role was significant for this group, as were the consequences of not being able to vent their anger in more productive ways to significant others. Self-harming behaviours such as cutting and overdosing with licit drugs were common for these participants.

(Julie - In response to her partner one day during an argument)

I was really mad with him so I stormed into the spare room and had a smoke.

Smoking played the role of non-threatening, non-judgmental pacifier, not unlike the role of a counsellor, for these smokers. Cigarettes were perceived as the preferred, quick option to other forms of stress relief in the first instance. They were seen as a less harmful, self-harming activity. Smoking was used to provide an ongoing feeling of safety for these participants. It was seen as essential in avoiding the build up of symptoms of stress and anxiety beyond controllable levels. In this way smoking ultimately protected them from the shift to acting out and suicidal thinking, or helped restore some equilibrium when they were in this state. These smokers recounted feeling stressed much of the time, often losing the battle to control their mood, resulting in regular episodes of acting out their emotions with self-harming behaviour.

(Paul - Who says he overdoses on medications and alcohol on a near weekly basis)
I've even chain smoked. Normally it's been in a very stressful situation. I was using cigarettes to relieve the stress. I knew someone who used to cut their throat and arms to release the stress.

(Sandra - Talking about when she quit smoking for a week)
I just went really crazy so I started up again. I got really depressed and suicidal so I started back on smokes. There didn't seem to be any in-between; it was just feeling OK and smoking or feeling suicidal.

(Susan - Talking about her waking at night)
Well, what happens in the night is I sort of dream and I'm half awake and half asleep and I feel if I get up and have a smoke I can get back to sleep properly. Sometimes when I can't sleep it helps, you know, just smoking, 'cause I don't tend to stay relaxed for too long. And if I can't sleep, that can lead on to other stuff. (suicidal thoughts)

Unique to this group was the use of cigarettes for their euphoric effect when smoked in large quantities, and especially following periods of what some participants described as planned withdrawal to heighten this effect. These participants clearly seemed to enjoy the euphoric feeling induced, despite the accompanying nausea they often felt. The reasons for seeking the euphoric and nauseating effects of nicotine overdose were more clearly understood as an escape from the painful reality of their immediate circumstances; of blocking them out, of exercising some control, albeit distorted, over them.

(Kathy)
The 16mg sometimes makes me feel ill so I have to cut down. It's a choice, it's not just a willy nilly [uninformed] decision. When I'm really really unwell, I smoke 16mg 'cause they give you more of a buzz, a head spin, which if you're wanting to escape the anxiety feeling, a head spin can be one way of getting out of that feeling.

(Julie)
When you haven't had one for a while, they make you feel a bit dizzy, a bit funny in the head. But dope does the same thing. It makes me spin out a little bit. It makes me feel weird and like my coordination goes a bit weird as well... Usually when I wake up the first thing I'll do is reach for a smoke straight away and usually when I do that, I'll smoke it that quickly that I'll make myself sick
and really dizzy. I hate that feeling. I have about 5 or 6 smokes within the first hour, just waking up. I love smoking first thing in the morning.

(Susan - Talking about when she started smoking and why she continued smoking)
And like they really spun me out. I felt really dizzy, and, and I really liked that, and I just got stuck on liking that. I kept on smoking because I liked the feeling. But I don’t really get that any more unless I stop smoking for a day or so and then start again. I like the high, the light-headed feeling.

(5.5.2) Boredom – “There’s just nothing else to do and that worries me” (Sandra):
These participants described times when their smoking was interpreted, by them, purely as an activity to fill in time, to fill in the emptiness, ‘the blanks’, as ‘just something to do,’ a habit to keep them occupied and stimulated. In this respect, these people mirrored mainstream smokers.

(Paul)
I’ve had times when I’ve smoked just because I was bored, when there’s nothing to do, so I’ve just sat around and smoked.

(Kathy)
If I’m on my own and doing nothing and there’s nothing on TV, then I smoke after tea, but less if there’s something good to watch on TV. The middle of the day and the weekends are the worst, especially because there’s less to do. There’s usually a lot of boring sport on TV on the weekends. When I was working at the rehab place I didn’t smoke anywhere near as much.

However, smoking also provided more than boredom relief in this simple sense for these smokers; it provided a controlled and structured way out of the blank state in which they perceived that they had a loss of control. Smoking was a way of ‘getting back’ control at these unpleasant times.

(Julie)
The times when I don’t like to smoke is during the day when I’ve got nothing else to do. It’s the times when I feel least in control that I don’t like it.
Susan gave insights into how this complex interaction of smoking and boredom influenced her ability to cope with her illness symptoms while in hospital, in particular, in finding ways to relieve her symptoms. Of note is the portability and accessibility of cigarettes and their benefit in being a safer option to relieving her frustration than self-harming, which she suggests might ultimately happen if left without relief. Her comments mirror a more general and frustrating problem in the recovery process for many people with a mental illness.

(Susan)

*It just helps me get through the boredom. I remember at one stage, I said to the nurse, “I can’t do anything and I can’t just do nothing,” like I was stuck, and just felt really bad.* (suicidal)

(5.5.3) Making Sure by Controlling Supply:

These smokers went to great lengths to ensure the supply of cigarettes, often jeopardising stability in other core areas of need. Cigarettes were considered as high a priority as food and other bills; often greater priority was given to them. Supply was often gained by securing credit at the local deli, by pawning goods, by ‘scabbing’ from friends, neighbours and strangers, by exchanging sometimes treasured belongings with acquaintances, or by re-rolling butts from ashtrays or off the streets.

(Joe)

*Fortunately, because I’m an addicted smoker, I can get credit at the shop, so once a day I go down and get a packet of smokes and make them last me till the next day then get another one. If I didn’t get credit I’d be unable to get cigarettes and I’d be crawling up the wall...The deli are kind enough to help me, but I can never get out of that credit system, because I never have any money to spare.*

(Julie)

*I’ve gone as far as giving ornaments away to neighbours and stuff in exchange for smokes but not more than that, or when I’ve got plenty of dope, give them some dope in exchange for smokes. It doesn’t feel too good though ‘cause afterwards I think, “Imagine what they thought of me,” ‘cause I’ve got a lot of pride. Sometimes, I don’t worry about it and sometimes I do. Sometimes I’m just glad I’ve got a smoke.*
Unfortunately, these actions would sometimes compromise other parts of these people’s lives, especially their relationships with others, jeopardising their sense of self-worth and sense of purpose in life. A vicious cycle of needing, loss and debt would be created.

(Joe)

*When I’ve got rollies, I can re-roll the butts. In the past I’ve got hooked up with Cash Converters. I started by going through the shed for anything I wasn’t using when I’d run out of money for smoke. Initially, I wasn’t aware that you could get a loan and pay them off; 300% a year it was (25% per month). So initially I was selling things that were un-needed, but then I found that if you had things you didn’t necessarily want to get rid of, you could get a loan on it. And I got into a real shit. It got me so stuck that I went to Target because they had a system where you could get an account with $500 credit. But then I got to the stage where I’d go to Target and get something I didn’t really need like a BBQ grill, then I’d take that to Cash Converters with the receipt still on there and borrow money off that which was only 25% of the money I’d paid...I didn’t know where to turn...There’s literally no way out of that situation unless you rob a bank and I’m no thief. There were some personal items that I needed by that stage, like the heater, and some special items, like dad’s gold watch which he’d given me just before he died.*

One lady, describing the impact of knowing that she could book up smokes at her local shop, demonstrated how cigarettes had been given a status over and above her usual budget. Her comments also show how her need was exploited by the shop owner, leaving her vulnerable to ongoing abuse and exploitation in this type of exchange.

(Julie- Talking about the 7-day shop nearby. Prices for items tend to be more because of this status) *I always make allowances for the dope and then the food shopping and then we’ve got gas and electricity. I allow for that but I never allow for smokes ‘cause I’m so used to booking them up...The deli’s really good. They let us book up heaps. As soon as they found out we was mental patients, I think they took advantage of it ‘cause it’s so expensive there. It’s in their interests to let us book up stuff there.*

Another lady, who says she always budgets for smokes and will ask friends or strangers for smokes if she runs out, spoke of a quite unique way of getting around the supply problem when friends and others
were not accessible. Her actions could be interpreted as the ultimate exercise in control over her need, simply by switching off completely until time passed. It also served to avoid the demoralising action of begging.

(Kathy)
I just try to keep my mind occupied as much as I can. It makes me sleep more, like I find I sleep a lot more when I don’t have smokes. It passes the day way. Especially because it’s the Tuesday night and payday is the Wednesday. It’s one solution to waiting.

A third lady, who lived in a hostel, said she does beg for cigarettes from other residents and from strangers in the streets nearby, often with unfortunate consequences for her safety. Her actions, to ensure the supply of cigarettes, have also been interpreted by others as promiscuous.

(Sandra - Who claims to have been raped four times by people she has met in the streets near her hostel, in the context of initiating contact with them to ask for a smoke)
It’s stressful (running out of smokes). I ask other people here for a smoke. When that doesn’t work (often so), I go around the streets looking for cigarette butts or go through the ashtray to make up a smoke from the bits. It’s difficult to ask other people for a smoke because they say, “Oh, not you again.” It doesn’t help you feel less depressed either or feel good about yourself.

(5.5.4) Quitting Smoking:
Controlling the Process
All participants with personality disorder had tried to quit smoking in the past. Difficulty with concentration and anxiety were cited as the main reasons for relapsing. These smokers tended to want to stop smoking cold turkey, possibly because they sought maximum control and autonomy in the process. They were aware of the Quitline, quit materials and other services, but wanted to do it on their own, their way.

(Kathy)
I’ve tried chewies, like Extra (lollies), to keep my mouth occupied to try to cut down, but they never did. I just kept smoking as well. I’ve actually got the Quitbook. I reckon it would be hard. Like some people say you should stop smoking straight off, which is OK if you’ve got other strategies and
haven't already got anxiety. I read it but I had problems with it. I just thought I might be able to try it and do it on my own.

One man’s comments suggest that intervention by others may have served to undermine his quit attempt, with him returning to smoking as a defiant response to the authority of his doctor. Maximum autonomy and maintaining power and control over the process appear to be important prerequisites for any quitting attempt and intervention with this group.

(Paul)
I’ve tried to quit four times; chewing gum (lollies), just not buying cigarettes, going cold turkey. I was not very successful. The longest period I lasted was three months and that was for health reasons. I was told by my doctor that I had to quit; I had pneumonia. They said, “Give up smoking or you’ll kill yourself.” So I waited for my lungs to clear up and then I started smoking again.

Quitting Beliefs
These smokers stressed that, in order to successfully give up smoking, they needed to be mentally well. They all made comments that implied a belief that one day they would be non-smokers, that their control over the cigarettes would eventually win out. Several of these smokers said that they would continue to smoke if they didn’t have an illness, but that it would be less, and only when they chose to, for the enjoyment of smoking, not for need. The control issue was evident again. Greater sense of purpose in life and sense of self-worth were cited, by all of these participants, as a significant motivation for quitting. The fear of failure, of letting themselves and significant others down, was perceived as the greatest determinant of remaining smokers and not attempting to quit. The fear of illness relapse was not perceived as the motivation here.

(Susan)
Like if I had other things like the soccer and sport it would be different, but it just kept getting interrupted all the time by my problems. Like I just can’t seem to get anywhere or make any commitments when I’m like that. I don’t like seeing too far ahead into the future but I do and that’s what makes it harder for me, because it just seems so far out of reach; it’s frustrating. Giving up is hard and you’ve got to have the courage to try to do it again. It’s not the fear that I’ll become unwell. It’s that I’ll fail again, that you won’t be able to do it, that it’s too hard. When you’ve got people
waiting in the wings to judge you, it’s a big risk to take. But I’ve had that all my life I suppose. Sometimes, it’s just safer to keep smoking.

(Joe)

If you haven’t got anything worthwhile in your day, then you’re not going to fee worthwhile as a person and it’s going to be really hard to give up smoking. The only time I feel guilty is the fact that I’m spending so much on cigarettes that I could be paying that money to take me dog to the vet or put more money in the plate a church. It takes away you self-dignity and when you’re struggling with those things anyway, it doesn’t seem fair.

Attitudes towards Smoking Policy Changes

These participants had varying reactions to the introduction of greater restrictions on smoking in public places. Some spoke of being made to feel like outcasts, ‘like a leper’. Others were worried that their already limited social interaction would be further restricted by the changes due to their continuing ‘need’ to smoke.

(Susan)

Well, it’s hard being in someone else’s house or somewhere like the movies and not being allowed to smoke. I’d rather miss out and sit at home and be allowed to smoke which is also a problem because I need to be with people for their support as well sometimes.

Three of the six participants, perhaps as a show of strength and self-protection, made compromising statements, agreeing with the policy changes, but saying that their own lifestyles would not be greatly affected by the changes. What is unclear here is the degree to which these people may have already felt like outsiders and therefore beyond the influence of these changes.

(Julie)

When that change to places came out in January (no smoking in Cafe’s and places where food was served), I was a bit annoyed at first and then I thought, “Fair enough, there’d be lots of people who don’t smoke who wouldn’t like the smell of smoke while they’re eating.” And I think it’s good in a way because if you go somewhere were you can’t smoke, it makes you wait for that little while. But we’re home most of the time except pension day. That’s our big day out. The trains and buses and
smoking changes have never bothered me. I’ve always lit up as soon as I’ve got off and had one just before I’ve got on.

Nicotine Patches and Gum
These smokers were aware of how to use nicotine patches and gum. Some had used them before, but they had not found them to be effective in either helping them to quit or to cut down. Two of the participants had never tried patches or gum, citing the cost as the main barrier (as did all participants). One of these ladies was living in a hostel and her finances were under the supervision of a public administrator. She was therefore limited to a small daily allowance. One lady, who was noted for her use and abuse of several types of drugs, also misused nicotine patches. She demonstrated much interest in patches while being interviewed, possibly because she hoped to get a free supply from the researcher.

(Julie)
Eventually, I will quit, but I definitely need patches to help me. At the moment I haven’t got the money for the patches, ‘cause I can’t book them up ‘cause they’re at the chemist...The other day when I had a patch on and I was sitting down having a smoke, I was spinning out, my heart was beating faster and going berserk. When I know that I’m going to smoke more then I’ll just rip the patch off. If I can stay on the patches, I feel like I can eventually give up ‘cause they take away the needing for a cigarette.

Others in this group showed a clear understanding of the complexities of the quitting process and the use of nicotine replacement therapy, despite their sense of disillusionment with the process.

(Paul)
I tried gum because I recognised that I needed to keep myself busy, to keep my mouth moving; it didn’t work though. It didn’t work at all. It didn’t help me to cut down. It was a waste of time.

(Susan)
It doesn’t help the habit. That’s the problem with them.
Abstinence Versus Cutting Down

Four of the six participants thought that cutting down on the rate of smoking would not work in the longer term; quitting altogether was seen as the best option. One participant had no view for or against either path. The one participant who did think cutting down would work for her, Kathy, also demonstrated the most control in other areas also. She thought quitting outright would be too much to ask, that leaving her options open would give her more choice and flexibility.

Attitudes Toward The Quitline

These smokers felt excluded by the current methods of advice provided by quit campaigns and other services about smoking. They stressed that information that was more personalised and individualised, such as that found in more meaningful relationships, would be more valuable to them. Trusting relationships were a significant prerequisite to any contact that they felt they could enter into with others. The Quitline counsellors were perceived as strangers, therefore they could not establish trust with them.

(Joe)

You see the Quitline; they just class you as a smoker and all smokers are the same. They don’t know your personal circumstances, daily routines, whether you work or don’t work, other things that may impinge on it all, what other stresses you’ve got, and your ability to overcome things. Now I’ve got some information I didn’t know about and you’ve had the decency to sit down and find out what it’s like personally...I know I could ring the Quitline but I’ve found it’s not personal enough. They don’t know enough about illness. It makes me feel a bit isolated from them, because they don’t understand. They’ve never been there...You see this Quitline, they just class you as a smoker and all smokers are the same. They don’t know your personal circumstances, daily routine, whether you work or don’t work, or other things that may be impinging on it all.

(Julie)

I’ve never rung the Quitline. I don’t think they’d help. I don’t like the idea of ringing up a stranger and trying to get comfort from them. I don’t think it would work.
(5.5.5) Smoking as a Comforting Friend:

Four of these six participants described cigarettes as a friend, particularly when they felt more alone and isolated, cut off from other people. The cigarettes became like a helper, compensating for the loss or lack of meaningful relationships, filling in when workers and other supports were unavailable to them, hence consumption increased at these times. However, this relationship was one-sided in that the smoke was passive, trustworthy and non-threatening.

(Joe)

Like I don’t have much in my life, and smoking’s been with me a long time, It’s reliable, it doesn’t let me down, it doesn’t answer back...It shares much of my day to day life with me, it’s there when I’ve gone through most things, I suppose.

(Susan)

When you’re on your own it’s (smoking is) like a companion. Other things tend to be a bit more unpredictable in my life. The smokes are the same all the way through, they’re reliable, their trustworthy.

(Sandra)

People frown at you and say you must be weak, and you should do this and you shouldn’t do that; from strangers and people I know. It makes me feel like running back to the hostel where everything feels more safe, where I won’t be judged, and usually having a smoke. It makes me feel really sad, and I’m made to feel bad just because I smoke...(Regarding her suicidal thoughts) Sometimes people don’t believe me...and they say things to put me down, and sometimes they just don’t bother including me in things because they think that I just can’t do them.

The people who did not describe cigarettes as a companion tended to describe them as a tool, something to be used, or abused, needed for their effect on mood management, rather than for companionship. These smokers, incidentally, were also the ones who did not live alone, they had partners.
All six smokers described their cigarettes as providing them with physical comfort also, especially when they were on their own. Cigarettes provided security, even if they were not being smoked at the time.

*(Sand*ra - *Who wore a lot of jewellery on her hands)*

*Just having a box of smokes there, even if I’m not smoking at the time, knowing that I’ve got smokes, is like a comfort to me, just in case I might need them.*

*(Susan)*

*It’s like giving yourself something, you know, just like instead of overeating, like a comfort thing when you’re on your own.*

Cigarettes were a means of physical self-reward, and were stressed by all participants as something to do with their hands, and as a substitute for food, their other main comforter. While being interviewed, all participants played with their hands. One lady patted her cat throughout the interview and said this helped her to smoke less. Another lady who, said she would eat more if she didn’t smoke, further said:

*(Julie - Also a heavy wearer of jewellery)*

*I’m used to doing something with my hands. I’ve got lots of rings and bracelets for that reason, so I can fiddle with them. I twiddle my fingers or pick at the skin on the corners of my fingernails*

*(Joe)*

*I buy fruit and eat carrot and celery sticks so that I’ve got something instead of having a smoke all the time. It’s something to put in you mouth and in your hands. It’s a real oral thing.*

*(5.5.6) Compensating for Poor Relationships - “Why Quit - I Deserve Something” (Joe):*

These participants described their smoking continuance as a form of compensation for losses in other parts of their lives. These losses all related to relationships with others and indicated a degree of self-reward and self-pleasure from smoking in the face of being made to feel bad and feeling sad. These smokers seemed to draw much of their sense of self from their interactions with others. Their relationships were highly important to them. Therefore, rejection was strongly felt and needed to be
compensated for from within. They also seemed to be caught between hanging on to their goals of having jobs and ‘normal’ lives, and giving in completely to the despair of having a mental illness.

*(Joe)*

I’ve been trying to find the word for my smoking. It’s sort of a condolence. Like, I don’t have much in my life, and smoking’s been with me for a long time...When you don’t have much in your life, it’s a bit hard giving up something so familiar. I could cut down, but I’d find it hard to quit. And I think, “Well, why do I have to quit? I deserve something. I need this to keep me going.”

...At the moment I’m putting limits on my smoking but as far as quitting, I’m not looking forward to that. If I get this job, then that will help me because I’ll have more purpose to quit. It gives you motivation that I just don’t have at the moment because I’m not sure where life’s heading.

(5.5.7) Acceptance and Reinforcement of Smoking by Others:

Peer Initiation

Only two of the six participants with BPD started smoking as teenagers, two of these started smoking prior to their teens, reflecting their strong sense of rebellion against the adults around them. Two people began smoking as adults, with peers but in the context of smoking to cope with stress, this being learned from peers. Peer pressure was cited as the main influence on initiation, with only one person, Joe, talking about their smoking as a rite of passage phenomenon. What is significant for this group is not that they were necessarily influenced by peers, but that they were drawn to their peers as their most significant supports as a way of escaping the various abuses they perceived within their families.

*(Paul - Who began smoking aged eleven years)*

When things are pretty lousy in the rest of your life, you tend to look to friends. I’d go to school with a black eye and people would ask me what happened, and I’d tell them I was in a punch up. I wouldn’t tell them my father had hit me. I’d just act tough instead by hanging out with the smokers and trying not to think about it.

*(Sandra - A mildly intellectually disabled lady who started smoking aged 16 years)*

I was at home. I thought I’d buy a packet and give them a try because I was stressed out because my father used to beat me up. He did that for a long time and by the time I got to 16 I thought it was a bit much. I’d go out to find some friends just to get out, away from him.
Kathy and Susan started smoking in their early twenties. Their smoking at that time appeared to fulfil more self-medicating needs due to the presence of anxiety, social isolation and stigma, and other stresses in their lives at the time. They learned from adult peers that smoking was one way of coping with this.

(Kathy - Who was living in a hostel and said she began smoking during the time when the hostel was to be closed down and residents moved on. Her parents, both with mental illnesses and intellectual disabilities, had been unable to care for her since she was a teenager. She had also been physically and sexually abused by a family member on more than one occasion) I just started stressing, like you don’t know what to do when you go into one place and you feel settled and then everything is turned upside down again. It was the change. I was only about two months off being independent. It felt like going backwards in some ways, of actually having to do it again. Like having the rug pulled out from under you.

Of note for this group is that they all spoke about abuse occurring in their childhood. Five of the six participants experienced financial hardship and deprivation. Four of the six said they were physically and sexually abused as children and one person described their experience of psychological abuse, this form of abuse being present for a number of others also.

Family
Three of the six participants had several immediate adult family members who also smoked, thereby acting as role models throughout the person’s childhood and currently. These participants made no mention of family members challenging them about their smoking. Those participants whose immediate family did not smoke, spoke of feeling outcast from family and judged by them. Their contact with family was stressful most of the time, regarding most aspects of their lives.

Doctors and Mental Health Key Workers
Four of the six participants with personality disorder said their doctor and worker never mentioned their smoking. Joe said that his doctor spoke about it but said Joe had no problems with his smoking. One participant claimed that professionals’ comments had the opposite effect on increasing her smoking consumption, suggesting some rebellion against their professional service provider.
The Hospital Setting - “Open season for smoking” (Kathy)
The culture of smoking in the psychiatric hospital featured strongly in comments by this group of smokers. Cigarettes became part of the treatment, part of the management of the environment for both staff and patients. These participants stressed the role of smoking in alleviating boredom while in hospital and of their stimulus seeking because of their boredom. They said there was nothing else to do with their time while in hospital. They said their rate of smoking increased while in hospital because of this. They were also acutely aware of the social role smoking fulfilled for themselves and other clients. A need to care for others, unrequited in this group, was a feature of this group while in hospital; of having no responsibility for others. This may be part of this group’s meaning of boredom, stressing relationships again as giving purpose. Smoking became the vehicle for relationship building.

(John - On being in hospital)
Oh, I smoke one after the other, that’s what everyone does because you just get so bored; there’s just nothing to do. I definitely smoke more in hospital...And also because you’ve just got no responsibilities, nothing to worry about when you go there. You’re in your own little world. You’re just walking around and go and have a cigarette all the time because there’s just nothing else to do.

These participants spoke at length about the use of cigarettes, by staff, for behaviour control. The descriptions and interpretations of staff behaviour, made by these participants, clearly show the use of cigarettes to manipulate and modify patients’ behaviour. The emphasis on ‘good’ and ‘bad’ behaviour, especially commented on by female participants, was noted. This appeared to reflect traditional gender socialisation, which encouraged and sought passivity in these women.

(Kathy - On the acute locked ward)
It’s worse because you’re actually hanging out because there’s literally nothing to do...They treat the patients differently too. They’re a bit more short tempered because, in the locked ward, a lot of the staff don’t want to hang around while everyone has a smoke. Whereas, in the open ward, you can come and go. The other thing is how they manipulate you. Like the other day in (the locked ward) they kept saying, “If we don’t stop hanging around the nurses station, then at smoke time we just won’t give the smokes out.” So that’s real manipulation in some ways. It’s like putting kids in front of the TV to keep them quiet. It’s almost like they’re using smokes as medication.
(Sandra - Who said she experienced intense suicidal thoughts when in hospital)

I’ve had several times when I’ve been in there and the nurses have told me that if I’m good and behave and try to settle down, that I can have a smoke. It makes me feel mad (angry). I think feeling like this helps me to get better.

The comments made by this group suggest that treatment options were currently restrained by systemic problems as much as they are by the need for better staff awareness of the impact of their care on patients. Julie’s general insights into staff behaviour and the hospital environment suggested that hospital was not necessarily where patients with a personality disorder go to get well. Neither is it where they go to overcome the conditioned responses involving mood management and social control for which cigarettes appear to be used for and by this group.

(Julie)

All the therapy’s done amongst the patients, not the bloody nurses or doctors. You just go to them when you need something. Smoking’s just a way of keeping the patients out of their hair sometimes, it seemed. I know if I had to work in a mental hospital the patients would drive me crazy as well. It’s a wonder they’re all not on valium [diazepam]. I’d say they need something when they get home to relax, some of the sights I’ve seen. I’ve always been good when I’ve got in there, and known what to do to get well, but some of them are a bit far gone. I haven’t had a bad admission. I’ve dealt with a lot of things at home.

(5.5.8) Other Drugs:

These participants were heavy users of substances, often pairing them with their smoking as part of the same habitual, social and self-medicating rituals.

Caffeine

Strong pairing of smoking and caffeine consumption was noted. Two of the men in this group had hospital admission histories involving caffeine toxicity. Four of the six participants consumed, on average, more than fifteen caffeine drinks per day and always with a cigarette; some participants averaged twenty to twenty-five per day.
When I used to stay up all night and drink coffee, that used to make me smoke more...When we get a bit high and that, we’ll stay up all night or a few nights in a row and just drink coffee after coffee and smoke our heads off.

Alcohol
Four of the six participants had histories of alcohol misuse; two of these reported themselves as still heavy drinkers. One lady, Kathy, who was earlier noted for her emphasis on control, said she had never drunk alcohol before. All participants who were alcohol drinkers stressed that they chain smoked at these times.

Prescription Drugs
Five of the six participants abused prescription drugs, regularly seeking and using more of their prescribed medications, or ‘doctor shopping’ for benzodiazepines, in particular. They stated that their smoking increased when they were less successful at obtaining these drugs.

Marijuana
Tobacco smoking and marijuana smoking were also strongly paired. Only one participant mentioned this drug as being part of her current routine of drug use. Kathy, again, had no history of using marijuana; three other participants did have such histories.

But like I’ve smoked marijuana too since I was twelve, and of course every time I have a pipe of that I feel like a cigarette straight after. When I smoke dope, it (smoking) tops it off...I think I’d smoke the same if I didn’t smoke dope, maybe a bit more.

Amphetamines
Only one participant also spoke about using amphetamines. Her comments about cutting down her smoking are interesting.
(Julie)

That’s when I started smoking heavily too, when I was into powders. Speed and that makes you smoke heaps. When I stopped it about four years ago, I cut down at first with my smoking.

(5.5.9) Summary:

Participants with a diagnosis of BPD clearly described the use of cigarettes to promote autonomy and a sense of freedom in the face of perceived judgement and rejection by others. Hence, they smoked to rebel and protest against their perceived social outcast status. In this they demonstrated a significant degree of internal control, ensuring their cigarette supply and monitoring the nicotine intake closely. These participants used cigarettes for relief of negative mood, boredom and for companionship by a non-judgemental other. Smoking provided these participants with a structured activity that gave them a sense of control and security in their identity, especially in the face of thoughts of acting out and self-harm. They often felt socially and emotionally excluded from others and hence, cigarettes became a substitute, providing comfort and self-reward. Deliberate nicotine withdrawal to achieve a feeling of euphoria and once they recommenced smoking was common for this group. In this way, negative thoughts and feelings, and escalation of tension and potential self-harm could be avoided. These participants started smoking under similar circumstances to other smokers, that is, with adolescent peers as a form of rebellion. They experienced overwhelming acceptance and reinforcement for their current smoking to continue from family, community mental health staff and the inpatient system of care, albeit by their smoking behaviour being ignored or interpreted it as bad behaviour. Most of these participants said that they would prefer to be non-smokers, however, they also appeared to rely on their ambivalence and secretiveness to maintain the upper hand, to control their relationships with others in a protective and sometimes combatant way. (A summary of results appears in Table 5.6)

(5.6) SMOKING AND MENTAL ILLNESS – DIAGNOSTIC CHARACTERISTICS AND DIFFERENCES:

Several themes common to all diagnostic groups were found, as shown by the thematic results. All client participants spoke about control by smoking, existential reasons for smoking, self-medication by smoking, cigarettes as a friend, identity as a smoker, patterns of reinforcement and acceptance of their smoking by others and their experiences of attempting to quit. Within these general themes there appeared to be differences in how participants with a mental illness perceived and displayed smoking behaviour and barriers to quitting according to their psychiatric diagnosis. No studies exist in which
psychiatric diagnosis has been specifically studied in a comparative way in respect of smoking. This study suggests that there may be grounds for examining smoking behaviours diagnostically. Table 5.6 below is used to guide the comparative analysis.
Table 5.6: Summary of Themes from the Diagnostic Groups

<table>
<thead>
<tr>
<th>Theme</th>
<th>Schizophrenia</th>
<th>Bipolar Affective Dis.</th>
<th>Depression</th>
<th>Personality Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Control</td>
<td>Smoking promotes autonomy and freedom</td>
<td>Automatic, black and white interpretations</td>
<td>Smoking to avoid oblivion; being lost</td>
<td>Smoking for autonomy via rebellion and protest</td>
</tr>
<tr>
<td>- source of control</td>
<td>Internal control</td>
<td>External control</td>
<td>being lost</td>
<td>Internal control</td>
</tr>
<tr>
<td>(2) Why Quit?</td>
<td>Despair, hopelessness</td>
<td>‘I enjoy this’</td>
<td>‘I’d almost wish it’</td>
<td>‘I deserve something’</td>
</tr>
<tr>
<td></td>
<td>Permanency of illness</td>
<td></td>
<td>Smoking for self-destruction</td>
<td></td>
</tr>
<tr>
<td>(3) Self-medication</td>
<td>Positive and negative</td>
<td>Mood stabiliser</td>
<td>Physical comforter</td>
<td>Euphoric experience</td>
</tr>
<tr>
<td></td>
<td>Symptom relief</td>
<td></td>
<td></td>
<td>Misuse and escape/comfort</td>
</tr>
<tr>
<td>(4) Identity</td>
<td>Response to chaos of symptoms, leading to</td>
<td>No relationship found</td>
<td>To block non-preferred identity</td>
<td>To build individuality</td>
</tr>
<tr>
<td></td>
<td>Insecure identity</td>
<td>- utility value only</td>
<td>To hold on to meaning</td>
<td></td>
</tr>
<tr>
<td>(5) Cigarettes as a friend</td>
<td>Anthromorphized</td>
<td>cigarettes are a thing</td>
<td>Social Anxiety</td>
<td>Anthromorphized</td>
</tr>
<tr>
<td></td>
<td>Substitute for lack of</td>
<td>- automatic activity</td>
<td>- others are beyond reach &amp; threatening</td>
<td>- preferred substitute to hostile others/families</td>
</tr>
<tr>
<td></td>
<td>Understanding other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Reinforcement &amp; Acceptance</td>
<td>Staff, family &amp; hospital</td>
<td>Staff, family &amp; hospital</td>
<td>Staff, family &amp; hospital</td>
<td>Staff, family &amp; hospital</td>
</tr>
<tr>
<td>- initiation</td>
<td>Peer start</td>
<td>Peer start</td>
<td>Self-medication prior to diagnosis</td>
<td>Peer start – weaker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Relationship though</td>
</tr>
<tr>
<td>(7) Quitting Beliefs &amp; Attempts</td>
<td>Wants to quit</td>
<td>Wants to quit</td>
<td>Wants to quit</td>
<td>Wants to quit</td>
</tr>
<tr>
<td>- preferred method</td>
<td>Cutting down</td>
<td>Cold turkey</td>
<td>Cold turkey</td>
<td></td>
</tr>
<tr>
<td>- Nicotine patches</td>
<td>Some experience of use with positive effect</td>
<td>Misuse and problems with commitment to process</td>
<td>Little or no experience of use</td>
<td></td>
</tr>
<tr>
<td>- Aware of habits</td>
<td>Very aware of habits</td>
<td>Aware but chaotic</td>
<td>Oblivious to habits</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(5.7) COMPARATIVE ANALYSIS OF THEMES:

The seven comparative themes drawn from the results of interviews with clients are summarised (see Lawn, Pols, & Barber, in press).

(5.7.1) Cigarettes as a Symbol of Control:

The feeling of safety, reassurance and predictability that came with having an assured supply of cigarettes was clearly and strongly expressed by all participants. Cigarettes were described as the marker that kept every other aspect of their lives in control. Smoking served a symbolic purpose by allowing these smokers greater freedom to participate in social activity and to perform basic tasks. This was especially so for participants with a diagnosis of schizophrenia. The most striking feature of their decision to continue smoking was the sense of freedom it gave in the presence of overwhelming powerlessness to predict their future and lack of freedom in deciding that future. Smokers with schizophrenia focused heavily on internal control. Smoking thus became a search for more autonomy and control of their lives. All participants perceived smoking as one of the most effective means of avoiding illness relapse.

Participants with BPAD overwhelmingly emphasised control in most comments they made about their smoking. They either incessantly sought control, claimed to have none, or claimed complete control, depending on their mental state at the time. Mirroring their black and white interpretations of most other aspects of their day, they either had cigarettes or they had none, this being realised often only after the packet was empty. Smoking provided order in the chaos, especially when they were unwell. This in turn created a continual shifting of commitment in the change process regarding quitting, depending on which desire took priority at the time, with the outcome that no change occurred.

Participants with depression were filled with regret and remorse, anger, guilt, or loss that was perceived as non-recoverable. Their smoking became part of their identity and self-definition to the extent that quitting smoking would amount to being set adrift. These smokers were the only group who smoked less when they were more unwell. For these participants, control was something external to them and beyond their capacity. To quit they said they would need a magic pill, or some external influence that would perform the task for them. It is interesting that the successful quitter with a diagnosis of depression described exactly this process as a significant part of how he
achieved abstinence. Further research with successful quitters with a diagnosis of depression would be needed to confirm this relationship.

For participants with a personality disorder, freedom to smoke and control was expressed as rebellion and protest. Their smoking gave them power, particularly while they were in hospital and under the control of staff. Like their counterparts with a diagnosis of schizophrenia, smokers with a personality disorder demonstrated a high degree of internal control.

(5.7.2) ‘Why Quit’ - Despair and Hopelessness in the Presence of Mental Illness:

All participants were aware of the adverse health effects of smoking, and the various resources available to help people to quit; the majority or these participants chose not to use them, perceiving little hope for their future recovery from their mental illness. For many, continuing to smoke acted as a shield, protecting these smokers from further pain and despair. The stigmatising effects of having a mental illness were particularly apparent in comments by those with schizophrenia who, coincidentally, expressed no concern for their physical health during interviews.

Participants with BPAD fluctuated in their perceptions of their smoking. Ultimately, the enjoyment of smoking despite the consequences overcame any desire to quit. These smokers, particularly if they showed depressive symptoms, said that they, “just gave in,” each time they thought of quitting smoking because they perceived themselves as hopeless. They related their lack of volition directly to their illness and to a lack of hope for recovery.

Participants with depression particularly talked about their smoking in the context of their physical health. For many, declining physical health through smoking was perceived as a solution to their mental anguish, a way out, an alternative to taking direct action, to suicide.

Participants with a personality disorder described their smoking as a form of compensation for losses in other part of their lives. Their losses all related to relationships with others. They smoked for self-reward and self-pleasure in the face of being made to feel bad, feeling sad and strong feelings of rejection by significant others.
(5.7.3) Smoking to Self-Medicate Illness:

All participants described the use of cigarettes to deal with the physical symptoms of their illness. Whilst many of their descriptions could be interpreted as craving and nicotine withdrawal, participants perceived their symptoms as clear signs of imminent illness relapse. Smoking was the nearest, most familiar and effective treatment available to them. Participants with schizophrenia, in particular, emphasised a direct medicating role of smoking. These smokers could recount the reason for almost every cigarette they consumed during the day and night, as if they were titrating the dose of nicotine and they described it using this ‘medical’ language. They seemed the very aware of their physical addiction to nicotine and usually smoked only stronger16mg cigarettes to gain the maximum effect. This was not the case for the other diagnostic groups.

Smoking appeared to serve a number of medicating roles for participants with BPAD. They particularly emphasised the use of cigarettes to aid sleep, motivation, stress, and to stabilise mood swings, but made no mention of smoking to aid concentration. These smokers made clear links between their mood and smoking, with more than half of the participants saying that they believed they would not have been smokers if they hadn’t developed BPAD. They also directly attributed their smoking relapse to illness relapse. One participant said she smoked two hundred cigarettes in one night during a manic phase.

Participants with depression, like others in the study, smoked for stress and anxiety relief, and relaxation, however they were also preoccupied with the physical comforter, nurturer role of cigarettes. The process of rolling, lighting and holding the cigarette, of feeling the warm smoke enter the lungs, the emphasis on hand to mouth associations; these were particularly pronounced for this group, and acted as strong secondary reinforcers. The preference for nicotine gum because of the chewing action was also noted.

On a different tangent were the participants with a personality disorder who described the pleasurable and euphoric effects of smoking following withdrawal periods, both imposed by lack of finances or voluntary and to escape the distress of feeling unwell.

(5.7.4) Smoking for Identity:

For all participants, identifying themselves as a smoker emerged as a significant theme. When experiencing psychosis, the importance of being able to describe oneself as ‘a smoker’, as a tangible
‘anything’ was extremely important for smokers with schizophrenia. Given the fear engendered by the relapse of positive symptoms (voices / hallucinations), it is not surprising that being defined as a smoker, and being able to do so with such repetition, each time a cigarette was lit, was so important for these people. For most participants, smoking became their means of differentiating themselves from their family and others, to have an identity when they weren’t sure at times; a way of finding a sense of autonomy and self when sometimes life seemed like a mere vacuum.

Participants with BPAD described their smoking as predominantly an automatic activity; it was more a thing to be used for its utility value in illness management and for pleasure.

For participants with depression, smoking had become a tool for social connection; a means of avoiding and distracting their thoughts so that negative thoughts did not take over and consume them. Being able to call themselves smokers allowed them to block their anger; it became a preferred identity.

For participants with BPD, being a smoker was how they defined themselves as distinct from others who they perceived as judgemental. They took on this identity as a form of protest.

(5.7.5) Cigarettes as a Friend:

Cigarettes as a friend, was understood as a natural progression in this schema. Their role cannot be overstated, however, for this population which includes some of the most isolated, and stigmatised members of society. Cigarettes symbolically become the friend that provided what they lacked in other relationships; one of their few meaningful activities. In particularly, those smokers who experienced psychosis anthropomorphized cigarettes so that the cigarette took on its own identity and ‘personhood’.

Again, participants with BPAD described their smoking as predominantly an automatic activity. They expressed no intense loyalty to the cigarette, nor did they describe images of grief and loss at not having them; it was more a thing to be used for its utility value in illness management and for pleasure.
All participants with depression clearly described their cigarettes as a friend who gave them security and companionship. The cigarettes became a reliable and trustworthy substitute over which they could exercise control.

Four of the six participants with a personality disorder described cigarettes as a comforter, particularly when they felt more alone and isolated. The cigarettes became a helper, compensating for the loss and lack of meaningful relationships, filling in when workers and other supports were not available to them. Hence, smoking increased at these times. However, this friendship was one-sided in that the cigarettes were passive, trustworthy and non-threatening.

(5.7.6) Reinforcement and Acceptance of Smoking:

All participants cited multiple experiences and circumstances which reinforced their smoking. Most grew up in families where parents were smokers. Most of their peers and acquaintances were also smokers. Service providers and family members were perceived to directly or indirectly condone or collude with their smoking. Smokers with schizophrenia, BPAD and personality disorder shared similar experiences of smoking initiation with their non-mental health peers; often at school, or at their first job. Smoking was a central component of their rite of passage into adulthood and peer acceptance was central to their decision to smoke. Smokers with depression clearly described struggles in relationships, anxiety and depression prior to their smoking initiation. One man described smoking every recess and lunch-time on his own at school to alleviate his anxiety symptoms. He was then eleven years old.

The impression gained from all participants was that, if people went into hospital as non-smokers, in all probability they would leave as smokers, literally because of peer pressure to smoke, the lack of other activities to occupy them while there and reinforcement by the institution. Several comments were made about the hospital environment and the system of care generally, especially in the locked ward where patients were provided with ward cigarettes. Several participants, regardless of their diagnosis, said that the most comforting times in hospital were when their nurse spent time with them having a smoke. Most participants said that their psychiatrist rarely mentioned their smoking and, if so, they gave it a negative, judgmental connotation which further lowered their self-esteem and sense of powerlessness. The assumption was that doctors were clearly demarcating the area of their responsibility for treatment, and smoking cessation was not included in that area.
Families tended to condone smoking as helping the person to manage their illness; as one of their few pleasures, believing that their mentally ill relative ‘needed’ to smoke. For some, a more negative message was given by family members who saw them as ‘a lost cause’ and therefore beyond help with their smoking. Regardless of which attitude the person received from family, the outcome was that they received little reinforcement to quit.

(5.7.7) Quitting Beliefs and Attempts:

Most participants had tried to quit smoking in the past and all said that if they could quit ‘painlessly’, they would without hesitation. Few participants thought they could be successful at quitting, given the presence of their illness. Participants with schizophrenia displayed the most planning and insight into the quitting process; the people with depression showed the least, and had made the fewest attempts to quit smoking; some had never attempted. Participants with BPAD had often made multiple attempts to quit with no clear plan or preparation. Participants with a personality disorder often claimed to have no control over their smoking but appeared to exercise the reverse.

Views about cutting down on cigarettes, versus total abstinence, varied. Participants with schizophrenia believed that cutting down would be more realistic, explaining that they could benefit both ways by cutting down on costs while maintaining the medicating role of nicotine. Participants with BPAD perceived an all or nothing choice, recognising that having cigarettes available would be too much temptation for them. Participants with depression were less aware of their daily consumption and often totally oblivious to their smoking habits. Participants with personality disorder had mixed views.

Few participants had tried nicotine replacement therapy (NRT), citing cost as the main barrier. Participants with depression believed they would smoke while wearing the patches, either because they would forget they were wearing them or because patches would not satisfy the craving. Participants with schizophrenia had found patches useful, but the pressure of illness symptoms were cited as the main reason for their smoking relapse. For participants with BPAD, short-term commitment and chopping and changing appeared to work against them in their attempts to stay quit. Participants with personality disorder were interested in the euphoric effects of misusing NRT.
The sense of exclusion from mainstream quit programmes was strongly felt by all those interviewed. They felt misunderstood and judged. The need to feel worthwhile and to have more meaningful relationships with those assisting them, was emphasised.

All participants were concerned about smoking policy changes, particularly in public places. The fear of increased social isolation and having a ‘double dose’ of stigma, already for their mental illness and now also for their smoking, was pronounced.

In summary, the client participants of this study did demonstrate differences in their smoking behaviours and perceptions of barriers to quitting according to their psychiatric diagnosis. This suggests that any attempts to assist these people to quit must incorporate an understanding of these differences.

(5.8) CONCLUDING COMMENTS FROM CLIENT INTERVIEWS:

As part of the interviews with clients, the interviewer concluded by asking participants how they had found the process of being interviewed and talking about their smoking. These results are given here. The overwhelming response was positive and it was noted that many participants appeared to gain greater self-efficacy and hope in the prospect of attempting to quit. Many said it had been the first time that they had been listened to in a way that the meaning they attributed to their smoking could be heard and not silenced. This was perceived as an empowering experience for them. Comments from each participant are provided for the readers’ information and interest. These interviews took place in 1998-9. Since that time Jean has died from respiratory and heart failure, Sylvia has died from complications of asthma and diabetes and Ron has successfully remained quit for the past 6 months

(5.8.1) Schizophrenia:

(Mark)

\textit{I was a bit nervous when I knew you were coming. I was looking at the clock thinking, ‘She’s going to be here soon. What am I going to say?’ I thought you’d try to convince me to quit but that’s not what we did at all. It’s my own choice.}

(John)

\textit{It’s stressful because smoking is a stress. Not too stressful.}
(Rod)
Rod said he found the interview ‘interesting’, and a bit confronting at times. He requested that the tape be turned off once the interview got to the point of what he described as sharing more meaningful information. He was very keen to be interviewed and phoned several times to make sure I was coming.

(James)
James did not want any of the interview taped, citing his delusions and paranoia about tape recorders. He said it would be too distracting and distressing to be taped. He said he found the interview very helpful and appeared to be relieved to have someone to talk to.

(Jean)
I don’t mind. I hope something comes of it.

(Jenny)
It’s OK. I feel good. It’s interesting to think about it and to talk about it. I was actually thinking the other day that I could give it (quitting) another try.

(5.8.2) Bipolar Affective Disorder:

(Joan)
You haven’t stressed me out talking about my smoking. It’s been quite helpful really. People don’t really ask you about your smoking. You just know that they don’t approve of it and then you feel really guilty. It’s a terrible thing.

(Carmel)
It’s quite different. I’ve never done it before. It’s not threatening at all. I haven’t talked about it before but I’ve certainly racked my brain about it, which has been frustrating when you can’t talk about it. It’s been good to talk to you actually.

(Sally)
Well, I was a bit dubious at first because I didn’t have any smokes today…Actually, I thought I’d be more grumpy than I am…so you’ve distracted me from the urges.
(David)
It’s been fine; really good.

(Roy)
It’s not something you can get your head around easily. It’s not black and white after all, like it’s talking about things that I don’t normally consciously talk about. I wondered what you would want to ask about like, either you smoke or you don’t smoke.

(Sean)
(He said he was dubious at first, and feared being judged about his smoking, but found the interview helpful to understand more about his dependence on cigarettes. He did not want the interview taped saying this made him anxious.)

(5.8.3) Major Depression:

(Beth)
I’m OK. I’m starting to get itchy feet though.

(Mick)
It’s all right. I don’t mind. Talking about it didn’t make me feel guilty.

(Ron)
It would seem that asking people what smoking means to them is the logical thing to do. It doesn’t concern me being interviewed about lots of things. If it doesn’t help me then at least it might help someone else, then that’s OK. I’ve found it extremely interesting. There’s not enough of this sort of way of looking at things.

(Sylvia)
I’ve been asked before and the lady asked me why I smoked but she didn’t give me any time to think about it so I said I didn’t know...It’s nice being able to talk about my smoking to someone who’s not critical. I’d be likely to pack up smoking with someone who understood me and what the smoking means to me than not, you know. Being judged just makes you feel you want to smoke more.
Anne
It was good, not a problem at all. I was nervous beforehand. I think it’s very interesting that you’ve taken this on.

Jack
I appreciated being given the time and have someone listening without being judgemental.

5.8.4 Borderline Personality Disorder:

Paul
It’s all right. It’s really good In-fact.

Kathy
It’s quite interesting. I’ve felt that other people have missed the point about smoking but you seem to have hit the nail on the head.

Sandra
It’s all right. I’m keen to get out and have a smoke but.

Susan
It’s OK.

Julie
It’s all right. I don’t mind talking about it.

Joe
It’s been fine...Now I’ve got some information I didn’t know about and you’ve had the decency to sit down and find out what it’s like personally. Like I’ve never really talked with anyone whether they’re professional people or non-professional people about what it’s like to smoke for me.

5.9 CONCLUSION:

This chapter has provided results from interviews with community mental health service clients who were current smokers at the time of interviews. Comments made by the clients strongly suggest that they had learned to associate the need to smoke with the need to manage their mental illness,
that the two phenomena were closely linked. This is demonstrated by their use of cigarettes to
directly manage the symptoms of their illness, as well as the perceived consequences of having a
mental illness label. Clients made many comments about the system of care in which they sought
treatment for their mental illness and about the staff administering that treatment. This suggests that
the behaviours and attitudes of staff and the psychiatric system in which they work have played a
significant role in how clients view their smoking. Therefore, interviewing staff who were
responsible for providing direct care to clients were seen as an essential step in understanding the
phenomenon of smoking and mental illness. To assist the integration of results from the client
interviews with results from the staff interviews and participant observation phases of the research,
a summary table of main themes is provided here. (See Table 5.7) A summary table for each study
will be provided at the end of each chapter of results. These tables will then form the diagrammatic
tool to assist integrated discussion of results in Chapter Eight. Further discussion of results from
interviews with clients appears in Appendix M as diagnostic differences are not the focus of this
thesis.
Table 5.7: Triangulation Phase One: Summary Themes from Clients Who Smoke

<table>
<thead>
<tr>
<th>High Order of Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cigarettes as a Core Need</td>
</tr>
<tr>
<td>- Ensuring supply</td>
</tr>
</tbody>
</table>

Desperation – demeaning behaviours, planning, begging

Poverty

A Multi-Faceted Tool
- To modulate affect
- Self-medication
- Coping with powerlessness and despair
- Illness relapse and nicotine withdrawal
- Socialisation, connection, identity, a friend
- Comforter, stress reliever

Us and Them – stigma and exclusion

Power and Control
- Autonomy, rebellion, freedom, self-determination
- Slow suicide

Grief and Loss

Attitudes and Beliefs and Smoking and Quitting

Systemic Reinforcement and Acceptance
- Reward and punishment
- The hospital culture
- Peers and family
- System responses
- Staff responses and supports
- Routines and habits, conditioning
- Lack of concern for physical health

The Quitting Process

The Environment and Terminology of ‘the cage’
CHAPTER SIX

STUDY THREE: INPATIENT AND COMMUNITY STAFF

(6.1) INTRODUCTION:

This section reports on the results of analysis of interviews with twenty-six staff, thirteen from the inpatient psychiatric setting and thirteen from the community mental health setting. Participants were drawn from the five disciplines that contribute to treatment and care of people with a mental illness in these settings. They included nursing, social work, psychiatry and medicine, psychology and occupational therapy. Selection of participants was limited by availability of staff, especially in the professions of psychology and occupational therapy where inpatient employment is low. Participation was voluntary. Nursing staff made up the largest group of participants, being the profession with the highest numbers of staff employed, especially in the inpatient setting. In the inpatient setting, staff representatives were drawn from locked, open and extended care wards. In the community setting, staff representatives were drawn from the Community Care Team (CCT) and Mobile Assertive Care Service (MACS). The following tables outline staff characteristics. Table 6.1 describes the number of staff from each discipline who were interviewed from the inpatient and community setting. Table 6.2 further identifies the particular settings from which each of the staff from different disciplines came.

Table 6.1: Profession and Setting

<table>
<thead>
<tr>
<th>Profession</th>
<th>Inpatient</th>
<th>Community</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Nursing (PN)</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Social Work (SW)</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatry (PM)</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Psychology (P)</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Occupational Therapy (OT)</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>13</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 6.2: Profession and Location

<table>
<thead>
<tr>
<th>Location within the Setting</th>
<th>PN</th>
<th>SW</th>
<th>PM#</th>
<th>P*</th>
<th>OT**</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Inpatient)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locked Ward</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Open Ward</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Extended Care Ward</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>(Community)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Care Team CCT</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>
# - All psychiatrists interviewed provided services to the full range of settings studied
* - Inpatient psychologists provided specialist services in each inpatient setting, as required
** - Limited numbers of occupational therapists were employed in inpatient settings. They had restricted roles and were not employed to work in the locked settings at all.

(6.2) INTRODUCTION TO THEMES:

Staff responses can be grouped into five main themes that emerged from the data:

1) Their own smoking behaviour and smoking interactions with clients
2) Their attitudes towards smoking and ethical response to clients’ smoking
3) Smoking as a tool within their work environment
4) Professional differences regarding smoking issues
5) The culture of smoking within the settings

Themes have been arranged in an order that helps to build a picture of smoking activity within psychiatric settings by using a systems framework that begins with the staff themselves, then the immediate environment of the setting and the clients and their daily interactions. These human interactions are set within the framework of their organisational groupings, based on daily practice roles and responsibilities and lastly, the wider organisational culture in which staff work and in which smoking occurs. The aim of using this layered approach is to build an increasingly rich descriptive account of smoking activity within psychiatric settings from which the context can be more fully understood. In this way an overarching theory will emerge that can be articulated and interpreted in the discussion of the findings, as is required by the grounded theory process described in the methodology section. Themes are not completely mutually exclusive. Rather, each theme aims to describe and emphasise a particular aspect of what staff said about smoking and the context in which smoking occurred.

(6.3) STAFF SMOKING BEHAVIOUR:

Of the staff interviewed from both the inpatient and community settings, seven were current smokers and five of these were currently working in inpatient settings. They accounted for 26.9% of the total number of staff interviewed for the study, with 30.8% of staff who had never smoked, and 42.3% who were ex-smokers. The following table summarises these results:
Table 6.3: Staff Smoking and Professional Characteristics: Inpatient and Community Staff

<table>
<thead>
<tr>
<th>Profession</th>
<th>Never Smoked</th>
<th>Ex Smoker</th>
<th>Current Smoker</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Nurse</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>2</td>
<td>3</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>11</strong></td>
<td><strong>7</strong></td>
<td><strong>26</strong></td>
</tr>
<tr>
<td><strong>Percentage Score</strong></td>
<td><strong>30.8%</strong></td>
<td><strong>42.3%</strong></td>
<td><strong>26.9%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Of the total number of inpatient staff interviewed, 30.8% had never smoked, 30.8% were ex-smokers, and 38.4% were current smokers. By comparison, of the total number of community staff interviewed, 30.8% had never smoked, 53.8% were ex-smokers, and 15.4% were current smokers. These results are summarised in the following tables:

Table 6.4: Characteristics of Inpatient Staff

<table>
<thead>
<tr>
<th>Profession</th>
<th>Never Smoked</th>
<th>Ex Smoker</th>
<th>Current Smoker</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Nurse</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>2</td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>5</strong></td>
<td><strong>13</strong></td>
</tr>
<tr>
<td><strong>Percentage Score</strong></td>
<td><strong>30.8%</strong></td>
<td><strong>30.8%</strong></td>
<td><strong>38.4%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 6.5: Characteristics of Community Staff

<table>
<thead>
<tr>
<th>Profession</th>
<th>Never Smoked</th>
<th>Ex Smoker</th>
<th>Current Smoker</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Nurse</td>
<td>1</td>
<td>2</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>2</td>
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<td>Occupational Therapist</td>
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<td><strong>Total</strong></td>
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<td><strong>Percentage Score</strong></td>
<td><strong>30.8%</strong></td>
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All staff interviewed commented on the prevalence of smoking by staff and several staff noted the history of staff smoking within mental health services. Although only two of the four inpatient nurses interviewed were current smokers, comments about the high level of nursing staff smoking were common and the statistics represented in this sample may not have accounted for currently smoking nurses who chose not to participate in this study. One inpatient nurse estimated that 75% of current nursing staff of locked wards were smokers. Each direct quote from staff indicates their discipline, setting and smoking status.

*(Grace – psychiatric nurse / community / ex-smoker)*

One clear picture in my mind was in third year, 1978...when you went into the staff meeting in the morning, everyone smoked. There’d be about 2 people in the staff of twenty to thirty people who didn’t smoke. All the staff smoked.

One nurse who had worked in the hospital for thirty-five years recounted his experience of smoking. The future legal implications will be discussed elsewhere.

*(Terry – psychiatric nurse / inpatient / extended care wards / smoker)*

It was actually work that started me smoking...I was a non-smoker when I started psych nursing. Back in those days the tobacco was supplied by the hospital in bulk in big brown paper bags, and nurses, especially in the K ward (locked) because of the patients inability to roll their own cigarettes, we used to spend hours just sitting there rolling up cigarettes in bulk, and because the patients were incapable of lighting their own or handling matches safely, quite often it was expected that nurses would light the cigarettes for them and then hand them the lit cigarette. That’s how I started smoking.

Many inpatient staff spoke about how the hospital environment exerted pressure on them to smoke, indicating that smoking served similar social and emotional purposes for them as it did for patients. These included smoking to facilitate communication between peers, to relieve boredom and alleviate stress. Staff also noted differences in their smoking behaviour dependent on whether they were working in the community or inpatient setting.

*(Sasha - occupational therapist / inpatient / ex-smoker)*

So I took up smoking because it was the only way that I could get nursing staff to spend any time with me apart from direct confrontational arguments. I’d go out the back and have a fag with
them, and that’s where they were anyway. They were smoking more than the patients. They were inside and the staff were outside smoking. The only way I could get any informal conversation going at all was to be smoking with them.

(Jane - social worker / community / ex-smoker)
When I’m away from the hospital I have not wanted to smoke at all, for about 3 or 4 months. It was strange, almost like the hospital culture was rubbing off on me. The time I worked at the locked ward, I hadn’t smoked for 2 years or 18 months...I smoked continuously for the first 2 months that I worked in the locked ward...to be able to catch up with my social work counterpart was a really joining experience, to be able to debrief...and to be able to just go back and have a fag was just our way of communicating.

Smoking activity was described as part of the relationship between staff, especially direct peers. It was incorporated into their daily interactions with other staff. Staff ex-smokers identified these peer benefits of smoking.

(Sam - occupational therapist / community / ex-smoker)
Sometimes I’ll go out here and sit with the smokers, and have a coffee and sit with them while they’re smoking and I’d find that I’d be privy to information that I would otherwise not be privy to. It was like a debrief for the end of the day...all the staff get-togethers and Christmas parties, and it would be all the party people, the smokers, who would stay on.

Several staff had been smokers in the past and these staff said they could identify strongly with the clients’ struggles to giving up smoking and smoking for stress relief. Many staff identified with clients’ need to smoke, based on their own use of cigarettes or, where they were ex-smokers, their memory of their own former smoking. Non-smokers could also empathise with both clients and staff who were smokers. Staff beliefs about clients’ need to smoke will be discussed further in the next theme.

(Marg – psychiatric nurse / inpatient ward / smoker)
(Regarding condoning clients’ smoking) To tell you honestly, it’s probably my own nicotine addiction...When I’m stressed about something, I usually have a cigarette and pace.
I remember when I was young and smoking was one of those things you could do because I was quiet and shy and smoking helped in social situations. It really means that you don’t have to participate…If you’re smoking in a group, you’re not noticed as being any different, and that was good.

Kathryn – psychologist / community / ex-smoker

I just remain non-judgemental about it, you know. That’s because I’ve been a smoker and I know how hard it is to give up…you have to be ready mentally.

(Jean - social worker / inpatient / non-smoker)

And the environment must be so reinforcing for staff also...everything in their daily work environment says it’s OK to smoke, that this is how you get time out and how you resolve stress.

(Janet – psychiatric nurse / inpatient / locked ward / non-smoker)

In a ward like this where it’s fairly full on all the time for staff, it’s a good way of getting away from it all just for 5 minutes. It’s relaxing before you have to go back in again. I know quite a few who only smoke at work and never do much at home...It’s part of the culture of the place.

The use of cigarettes to establish and maintain rapport with the clients and to gather information from clients while they were in hospital was clearly described, with acceptance, by the large majority of inpatient staff interviewed. This was so regardless of their professional discipline and whether they were smokers or not. Cigarettes were openly incorporated into everyday interactions between staff and patients and non-smoking staff were described by some as less communal. Likewise, community staff, particularly those who were current or past smokers, expressed support for the role of cigarettes in establishing and maintaining rapport with clients. This was not so apparent for non-smoking staff, however most of these staff allowed clients to smoke in their presence and accepted this as part of their usual interaction.

(Ros - social worker / inpatient / ex-smoker)

If they’ve just lit a cigarette and I don’t need to see them in my office because we’re not using the phone, I’m quite easy to do what we call, ‘walk around’ interviews. I have no problem with that. I don’t ask them to put it out. I’ll just accept that and I won’t worry about the passive smoking stuff so long as it’s out in the fresh air and stuff.
(Alison - career medical officer / inpatient / non-smoker)

The nursing staff regularly have a smoke with them as part of the treatment and care. Having a smoke with them has some therapeutic benefit sometimes.

(Sue – social worker / community / smoker)

(On smoking with clients and the relationship with clients)

It probably improves it…Like people are certainly very comfortable about the fact that I’m a smoker like them, and they prefer that, and they often ask if, once they are transferred out, whether their new worker will also be a smoker, It’s one of the very first questions they ask me.

Some staff struggled with this way of relating to clients. They spoke of the pressure involved in being required to step into the patients’ smoking culture in order to establish rapport and to gain access. Many staff did not identify this as a problem for them, or as a health concern while others showed that it was an ethical dilemma for them.

(Jane - social worker / community / ex-smoker)

And when I was working in the long-term wards, my ability to empathise and almost openly to model smoking behaviour at different points in time in my career when I didn’t have different tools. And realistically, by the nature of the clients that I worked with in extended care, who were really hard to work with and really hard to engage with. And part of working with really difficult clients is trying to find an entry point where you can develop rapport with them. And what was more easy than sitting around with them and having a smoke? It was easy to do this in the community also, but even more so in the hospital ward…you were almost conducting group work over an informal cigarette.

Ultimately, staff comments demonstrate that most staff recognised, accepted and often did not challenge smoking activity within their work environment so that smoking continued unchecked. A description of staff attitudes to clients’ smoking will help build an understanding of how and why this recognition and acceptance was present.

(6.4) STAFF ATTITUDES TO CLIENTS’ SMOKING:

Clinical staff within inpatient and community mental health services provide the primary care role for clients of these services. The community staff participants provided case management to the
clients who were interviewed in the first phase of the research. The attitudes and beliefs of staff are significant in shaping the culture of the service and how treatment and care occur in practice. Therefore, describing what staff think about clients’ smoking and how this influences the decisions they make with and for clients and the priority they give to the smoking issue, is essential in understanding why they do what they do. In this section, three main areas will be described, each with sub-themes to illustrate the range of responses.

(6.4.1) Clients Need to Smoke

Most staff, especially inpatient staff, spoke about their overwhelming acceptance of clients’ smoking based on the belief that clients ‘need’ to smoke. This will be explored by describing three main areas of attitudes held by staff: smoking to cope with mental illness, level of illness chronicity, meeting existential needs.

Smoking to Cope with the Symptoms and Consequences of Mental Illness

Most staff, in varying degrees, believed in and condoned the role of cigarettes in helping clients, especially as it related to symptom management, anxiety, agitation and illness relapse prevention. Their comments demonstrate that they often failed to recognise the symptoms of nicotine withdrawal by clients and therefore interpreted this as escalation of illness symptoms requiring relief with cigarettes.

(Sue - social worker / community / smoker)

There’ve been people here who are just so determined to get cigarettes that workers have just said, “OK. It’s not worth it.” Buying them smokes seemed to almost prevent an admission. It’s the reality of needing that’s the issue...It’s the same for psychotic experiences; it seems real to them and that needs to be respected.

(Marg – psychiatric nurse / inpatient / smoker)

We’ve had people agitated and escalating and we have desperately found cigarettes. All of the nursing staff have given cigarettes to give this person...If it’s going to reduce the negative impacts of their illness, then surely it’s helpful.

(Grace – psychiatric nurse / community / ex-smoker)

I can see why people with schizophrenia smoke when they’re trying to cope with the voices because almost nothing is normal in those situations.
(Ruth – psychiatric nurse / community / non-smoker)

If it stops them from getting agitated and anxious, then I think the benefits in the short-term are worth it.

In their comments, staff did not say that cigarettes directly serve a self-medication role for illness symptoms. Rather, smoking was believed to fulfil the role of helping clients to cope with the symptoms of their mental illness. Staff believed that the presence of cigarettes allowed clients to participate more fully in other activities, to provide stress relief and to overcome the sedating effects of their illness medications. The level of acceptance of clients’ smoking by staff reflected a willingness to allow whatever helps to provide comfort, as defined by the clients, in the face of often difficult to treat illness. In this sense, staff were not using their health care expertise and knowledge of addiction and dependence to assist clients. Clients and staff appeared to be blind to the role of nicotine withdrawal that caused agitation, anger, craving need, discomfort and anxiety. They accounted for these symptoms by comprehending them as symptoms of the clients’ mental illness.

(Sue – social worker / community / smoker)

It’s hard to tell them not to use cigarettes when the fact is that they are trying to deal with symptoms that feel out of control…a lot of people we see have lost a lot of social skills through having an illness and therefore rely more heavily on the smokes and don’t have as many skills to get past the dependence on smoking.

(Jill – psychiatric nurse / community / ex-smoker)

I think a lot of people with schizophrenia are quite introverted and with paranoid schizophrenia, quite a loner where you face problems where you don’t fit into society as a normal person would. So you’re often in your own little world…You’re often just sitting. You can’t concentrate on TV. You don’t want to talk to a lot of other people because there’s so much going on in your own mind and if there’s not then you’re probably sedated with the medications you’re on which slows you down. So what do you do? You smoke cigarettes.

(Alison – career medical officer / inpatient / non-smoker)

I think it’s very difficult for them to quit if they’ve got a psychotic illness that’s not under control. It’s comforting to them sometimes; it calms them down.
(Kathryn – psychologist / community / ex-smoker)

It helps people cope with their feelings…I would never tell anyone they should give up smoking.

The perceived lack of other resources, rehabilitation activities and effective medications was noted, as was the frustration of non-medical professionals about the over-reliance on medications as the ‘cure all’. Overall, staff felt frustrated by this dichotomy of condoning smoking as helpful while also recognising its harms and consequences for the person’s health and finances. Only two of the twenty-six staff interviewed expressed a different view this, a psychiatrist and a psychologist from the community setting.

(Robyn – consultant psychiatrist / community / ex-smoker)

I’m sure if nicotine stopped voices that much, they’d be selling nicotine patches in the treatment of schizophrenia.

(Brian – psychologist / community / non-smoker)

I think people act on their perceptions if it suits them at the time. When they draw the line between being a smoker and being a schizophrenic, it’s a very convenient rationalisation for them.

Greater Chronicity of Illness Means Greater Need for Cigarettes

The clients’ level of functioning and degree of illness effects were considered to be important determinants of the person’s level of need for cigarettes. Staff variously condoned clients’ smoking according to this, especially those staff in extended care and MACS settings. Clients in these settings were characterised by having chronic mental illness. They lived at the hospital, in supported care, or received intensive community input over an extended period. For these clients, assistance to stop smoking was given low priority because smoking was perceived to be a central part of their daily experience and illness management. Note the inconsistency in Brian’s comments here compared with the previous section.

(Brian - psychologist / community / non-smoker)

(Regarding a co-worker’s heavy involvement in ensuring the cigarette supply for a client) He [the client] was four years in extended care, and for God’s sake, four years in extended care is enough to change anyone. I suspect that all he did for so long was line up for his smokes so it just
became his reason for living almost. It was one of the few things he could actually do; was light a cigarette.

These staff saw themselves as having greater responsibility for assisting clients to obtain cigarettes, arguing for their needs on humanitarian and benevolent grounds, or from strictly institutional grounds. In this respect, the management of symptoms and avoidance of adverse social and financial consequences of clients’ need for cigarettes, by ensuring the supply of cigarettes, were given greatest attention by staff. These consequences included the social stigma of begging and looking for butts on the street and the financial burden of pawning goods for cigarettes.

(Terry – psychiatric nurse / inpatient / smoker)
(Explaining the process of handing out cigarettes as part of the daily routine)
The illness is best managed with the rigid structure because once you start to vary from the routine, they tend to become easily confused, because of their cognitive function problems, and disorientated about what the routine is going to be.

(Bob - consultant psychiatrist / inpatient)
I focus very much on the disfiguration such as the nicotine stained teeth and fingers, etc. I’ll even get the dentist to do a scourge (scour) of everyone’s teeth to try and make their appearance seem more normal and acceptable in the wider community...They’re more noticeable in the community if they look different.

The attitudes of community staff were noticeably different from inpatient staff in that clients were encouraged to take more responsibility for meeting and planning for their needs. However, this also was dependent on an assessment of the client’s level of judgement and ability to cope in the face of illness symptoms.

(Jane - social worker / community)
And I just think that it’s Friday and I’m not going to be able to pick up the phone again till Monday. Just see what they do. I step back and see how they resolve it for themselves. I just don’t feel it’s my onus if they relapse because they don’t have a smoke...So you make an assessment of their level of ability to think and cope. And for extended care you just have a different level of responsibility for clients who have been in the hospital for the past five years.
Existential Needs
Several staff believed that smoking performed a number of existential roles for clients. These included the role of smoking to fill the vacuum of daily existence and to compensate for the effects of isolation and loneliness by providing clients with companionship and a sense of belonging when around other smokers. Staff expressed deep sadness, pity and concern for clients. Most staff felt powerless to effect genuine improvement for ‘their’ clients, several staff perceiving clients to be ‘a lost cause’, as people who smoke in the face of incurable illness and should therefore be left to smoke.

(Sue - social worker / community / smoking)
I think smoking becomes their friend and it doesn’t matter to them what else happens with their social skills...It’s a real problem if you can’t even order a cup of coffee or take yourself off for a walk somewhere because you feel you can’t approach other people. So you think, “What the hell do you do with your life?” You just sit home and smoke.

(Alison – career medical officer / inpatient / non-smoker)
They spend a huge amount of time in their own company, so it’s a thing that they can do, to identify it as a friend.

(Jean – social worker / inpatient / non-smoker)
Even the pantry staff regularly give patients smokes because they feel sorry for them...They don’t have much. It’s a sense that they need them and it’s a small thing to give.

(Kathryn – psychologist / community / ex-smoker)
What else have they got in their life? It’s a comfort, it’s nurturing...They’ve got no money and no friends...They don’t know anyone who goes on bloody holidays...It’s something they see on TV. It’s displaced from them. It’s over there somewhere.

((John – consultant psychiatrist / inpatient / ex-smoker)
In my heart of hearts, with patients with schizophrenia, I feel that they haven’t got much left for them, so good luck to them, if they want to smoke, let them.

In general, inpatient staff tended to express attitudes that reflected the belief in smoking as one of the clients’ few pleasures, whereas community staff comments reflected a tendency to give the
client more responsibility for their choices. Staff in the locked settings directly placed the pleasure of having a cigarette in the context of clients being deprived of other pleasures and basic freedoms in those environments.

(Janet – psychiatric nurse / inpatient / non-smoker)
(On the locked ward) When they’re in here, they’ve go so little anyway, that’s one of the pleasures that they’ve got

Many staff of both inpatient and community settings openly accepted the role of cigarettes as a core need for clients and therefore played an active role in helping clients to obtain cigarettes and ensuring an ongoing supply. Staff incorporated cigarettes as core items in budgets for clients in their dealings with the public trustee for clients on Administration Orders. Community staff tended to take the approach of allowing the person a period of problem-solving on their own if they came to staff requesting financial assistance to buy more cigarettes, rather than assisting immediately. Overall, however, staff emphasised that their clients’ needed to smoke and staff either advocated harm minimisation as the more realistic option to quitting, advocated for cigarettes, or expressed their opposition to smoking but continued to incorporate the supply of cigarettes as part of their interaction with clients. A health promotion approach with the aim of smoking cessation, as a universal part of health settings, was absent in comments made by the majority of staff.

(Kym - social worker / acute locked / non-smoker)
(When the ward supply of cigarettes was recently cut) We had to beg, borrow, and ask relatives to bring smokes in.

(6.4.2) Staff Determine Intervention Priorities

Staff described how they determined their priorities and how and whether they broached the issue of smoking with clients, according to three main areas of decision-making: prioritising of risks to clients’ mental health and well-being, prioritising of professional roles by staff and perceptions of who is responsible for action to assist clients who wish to change their smoking behaviour.

The Priority of Risks to Clients’ Mental Health and Well-being:

Staff in the inpatient and community settings were unanimous in the belief that there exists a time and place for talking with clients about their smoking. They agreed that it was not appropriate to
raise the topic of quitting or cutting down when the person was acutely unwell. Various reasons for this were proposed. Staff believed that there was no value in introducing strategies requiring more thinking and planning when someone was psychotic due to their level of cognitive impairment at the time. Inpatient staff also saw the role of assisting people to quit as a community role for when the person was out of hospital, in their own environment and recovered from the acute phase of illness.

The nature of the hospital setting posed unique concerns and arguments by staff to justify smoking by clients. The ward milieu in which patients lived and interacted in close proximity to each other, often while in a disturbed or unsettled state, was noted. Clients’ abilities to resolve conflict and to manage their emotions were seen to be challenged under these circumstances. This was particularly so for clients who were detained against their will because they were deemed to be a danger to themselves or others under the Mental Health Act. Under these circumstances, smoking was given lesser priority than concern for the treatment of the person’s mental illness and concern for the safety of the group. Nicotine dependence was also treated differently to other drug dependence.

(Marg - psychiatric nurse / inpatient / open ward / smoker)

What they do here is going to impact on their ability to stay in an open ward, and on all the other clients as well. If they get toey at home and smack the wall because they haven’t got a cigarette, that’s one thing. If they get toey here and smack the wall; number one, they’re likely to end up in the closed ward; number two, there are likely to be other people around because basically it’s a small community here at any one point in time and whatever one person does is likely to impact on others...and if it’s going to actually increase the anxiety for other people and end up with three of them transferred to the locked ward then I have a problem with that.

Clients were also seen to have more immediate, more serious problems needing attention while they were acutely unwell, as demonstrated, with indignation, by Sasha:

(Sasha - occupational therapist / inpatient / ex-smoker)

I think when people use the duty of care argument to stop people from smoking, then they don’t understand the notion of duty of care. For me, I think it’s absolutely farcical and insulting. If I’m sitting here with a guy who’s trying to deal with something like understanding what’s going on in his world and why people are doing stuff to him, and someone who’s very anxious and
depressed, and I’m talking to them about cigarette smoking, when they’re talking to me about something like suicide?...There’s a time and place for those things, and that’s not the time.

Staff also worried that restricting clients’ smoking at the times when they were unwell would only hinder their recovery, that it would be like enforcing a ‘double dose’ of suffering involving withdrawal and illness symptoms. This was seen as unfair and unnecessary.

(Ros - social worker / inpatient / open ward / ex-smoker)

*I don’t think this is the time for major decision-making. It’s unfair to put them through more trauma.*

(Grace – psychiatric nurse / community / ex-smoker)

*I wouldn’t be talking to them about stopping smoking when they were very unwell. Then I wouldn’t be talking to them about it at all. This is not about torture.*

Staff comments on how they prioritise their decisions about whether they challenged the clients’ smoking or not, appeared to have much to do with how staff perceived short-term versus longer-term consequences for clients. The longer-term physical effects and risks of smoking were seen as the lesser of evils when compared with the immediate effects of mental illness symptoms, level of distress and the consequences of relapse for the person.

(Jane - social worker / community / smoker)

*You don’t want a client at that level of personal distress that they are risking their own personal safety for a cigarette. And people’s judgements are so impaired and when you’re prioritising what you’re there to do, you don’t give a rats about their addiction at that time. The addiction is by far the lesser of the evils that you’re dealing with at the time. It’s just so low on the list of priorities.*

(Sasha - occupational therapist / inpatient / ex-smoker)

(Reflecting on her time working in the community) *I’ve had clients who I’ve case managed who my main job has been to ring up the police to make sure he made it through his next pay cheque. It’s a long way from the Quitline.*

Cigarettes were seen as helpful for clients’ symptom management, whereas illicit drugs were seen to exacerbate the symptoms of the person’s mental illness. Doctors emphasised duty of care to
combat illicit drug use as their immediate priority, perceiving illicit drugs to have more immediate effects and consequences for the person and others.

(Robyn - consultant psychiatrist / community / ex-smoker)

*I'm probably more concerned with people’s marijuana smoking. The consequences catch up with them a lot quicker, like in three or four years. Whereas, for smoking, it might be thirty years. You have more time to do something about it.*

Clients’ deteriorating physical health and problems with them intimidating other clients or being intimidated by other clients in order to get cigarettes were the only exceptions that prompted staff to intervene to limit clients’ smoking. Smoking was also seen as only one in a long line of complex problems needing attention and intervention. Therefore, it was low on the list of priorities for staff.

**Staff Prioritise their Professional Role**

Separate to any concerns for clients, staff comments demonstrated that they made priority distinctions about whether to intervene based on perceptions of their professional role. In the community, staff spoke about all the competing demands on their time and about the lack of resources necessary to address clients’ needs and their own needs. In the hierarchy of time and resource management, addressing the smoking problem received low priority except when workers were diligent in assisting clients with the supply of cigarettes. Doctors said that they did not have the luxury of time to spend talking to clients about smoking and quitting, due to staffing pressures. Others saw no therapeutic value in challenging the person’s smoking. Doing so was in fact seen as undermining their role with the client and the success of treatment.

(Alison - career medical officer / inpatient / non-smoker)

*My priorities are simple and that’s getting the patient well enough to go home. I’m not prepared to, I wouldn’t say exacerbate their illness, but perhaps make less rapport with them. I think the rapport is just as important. If I haven’t got rapport then my job is just so much harder. If I’m going to lose that rapport by continually suggesting or saying that they can’t smoke I don’t believe that’s the right thing to do for the patient at the time. It’s a case of not doing more harm, of maleficence.*

When smoking was discussed with clients, staff said it was usually in relation to other problems such as finances, hygiene and fire risks. Kate’s comments suggest a more concerning reason for
why clients’ smoking tends to be ignored or given less priority and this will be explored in the later theme of smoking culture.

(Kate - trainee psychiatrist / inpatient / smoker)

*Their physical illnesses seem to be hidden as they get older so that the doctors don’t notice so much because they don’t see them as much. It’s always put second to their mental illness. Certainly, in the general hospital, we see a lot of elderly people with smoking related diseases, and then at the bottom of the page it says, ‘schizophrenia’.*

**Who is Responsible for Providing Assistance with Quitting?**

The type of setting largely determined how staff prioritised smoking and assistance with quitting. In the locked ward, nursing staff focused on the short-term goal of getting clients to open wards, explaining that length of stay was often too short for them to be of any practical benefit in starting smoking intervention strategies with clients. Hence, staff said they handed out cigarettes to those clients who had their own supply on an hourly basis and provided ward cigarettes provided by hospital funds at the rate of six per day to those clients who had no cigarettes and no money. The provision of NRT as an alternative to smoking was considered, although staff said there was no clear clinical or administrative policy on this.

(Kate - trainee psychiatrist / inpatient / smoker)

*(Regarding the supply of nicotine patches to patients by the hospital pharmacy) Occasionally they’ll supply and occasionally they won’t. There’s no clear policy within the hospital on the provision of patches. More so, I’ve seen the trend of sending the patient outside the hospital for them.*

Some staff, notably social workers, expressed total frustration at working within a medical system that appeared to have double standards regarding smoking by clients while they were receiving treatment.

(Kim - social worker / inpatient / non-smoker)

*We treat everybody else’s addiction. If they’re somebody who comes in if they’re withdrawing from alcohol, we immediately put them on a diazepam regime. If somebody comes in and they’re withdrawing from nicotine, well it’s just tough luck. We really should be treating their withdrawal as well...It’s a bit of a contradiction isn’t it. The doctors are happy to categorise it as a
mental illness but not happy to recognise that it also needs treatment...They won’t even write nicobait patches scripts...They just say, “Speak to the social worker.”

The open ward staff described their role with clients as fragmented and not likely to be as consistent as more long-term follow up in the community. The provision of assistance with ensuring the continued supply of cigarettes for clients who wanted to smoke, assistance with quitting for those clients who sought this option, or with rehabilitation to help get the person ready to quit was seen as the role of the community key worker. The community key worker did not necessarily hold this view of total responsibility. Hence, tensions between inpatient and community staff often ensued over who was responsible for ensuring the supply of cigarettes to clients while they were hospitalised.

(Ros - social worker / inpatient / ex-smoker)
We have very limited resources. It should be up to the community teams to help provide funds for people when they run out of cigarettes. When the person’s acutely unwell, I think it’s absurd that the community worker should tell the doctor to prescribe patches. Really that is less than helpful. That is things that when the patient is more well and ready for discharge that they can tackle, that they hopefully can manage more effectively with the community worker once they’re home again.

Inpatient staff of all disciplines said they clearly delineated the staff role and saw their responsibility as protecting clients from intimidation and manipulation by other clients seeking cigarettes. Locked ward and extended care ward staff used this justification for keeping cigarettes in the nurses’ station and taking control of how cigarettes were dispensed. A determination about open ward clients’ ability to carry their own cigarettes during the day was also based on this concern for their welfare.

(Alison - career medical officer / inpatient / non-smoker)
If you’ve got a patient who’s fairly timid and they’ll just hand over their whole packet with the stand over tactics of some of the other patients and that isn’t possible to really monitor all the time.

Many key workers said that they were prepared to encourage clients to quit, although few staff actively assisted clients with the process of quitting, perceiving clients’ smoking and the worker
working in a smoky environment as ‘just part of the job’. Many key workers expressed concern for the high incidence of smoking amongst clients, but felt frustrated when this involved taking action.

(Grace – psychiatric nurse / community / ex-smoker)
If key workers don’t confront some of the issues around smoking with clients then nobody will.

In general, most community staff saw the client as either solely or largely responsible for their smoking and for change. This was part of their belief in the centrality of clients’ taking responsibility in order to succeed in rehabilitation to community life.

(Jane - social worker / community / smoker)
In the community I have a different sense of responsibility and perspective of where my clients sit in the grand scheme of human life, and I have more patience and stand back and say, “That’s not my responsibility. If you haven’t got smokes, what have I done to have to resolve it? Deal with it yourself.”

Many staff from both the inpatient and community settings considered that they had no role with the client’s smoking. They said that to do so had simply not occurred to them, or it was simply accepted as part of the daily life of the clients to the point that it was ignored and given no priority.

(Kim - social worker / inpatient / non-smoker)
I don’t think we actually think too much about smoking until we actually sit down like this and start talking about it, and thinking about what we’re doing. It rears its head every so often and then it seems to go away again and be submerged by other things.

(Chris - psychologist / inpatient / smoker)
(On observing clients’ smoking) I don’t really take the time to do this...It’s as if it’s just accepted and expected behaviour.

The comments of many inpatient staff suggest that they saw action on policy decisions about smoking within the hospital as someone else’s responsibility. In particular, doctors said they could do little while the barrier of a predominantly pro-smoking nursing staff existed. Nurses spoke of following the lead from medical staff.
(Bob – consultant psychiatrist / inpatient / non-smoker)

(On smoking) It's something that's largely nursing reinforced, and from a medical side, I've got to convince my nursing staff to give up first.

(Janet – psychiatric nurse / inpatient / non-smoker)

(Regarding doctors and the smoking issue) They tend to lump everything on to the nursing staff, rather than buy into it themselves.

(Paul – psychiatric nurse / inpatient / ex-smoker)

I give out cigarettes only when I have to, only because it’s ward policy for nurses to perform this role.

(Kate - trainee psychiatrist / inpatient/smoker)

I think, eventually, it will require legislation that just swoops down and says that there would be no more smoking for patients and staff. That's the only way it’s going to make a change...we will have to wait and see.

(6.4.3) Resolution of Ethical Dilemmas Regarding Smoking:

This sub-theme describes what staff said about the issue of smoking from a professional ethics perspective. Most staff interviewed said smoking by clients posed dilemmas for them. In their role as health care service providers, staff saw themselves as working within a system in which cigarette smoking was actively incorporated into treatment and management. This was despite staff also acknowledging smoking as harmful to clients’ health and wellbeing.

(Grace – psychiatric nurse / community / ex-smoker)

I think, “What kind of nurse would I be if I encouraged people to do things that were not good for their health?”

Some staff said they had no dilemma here. The majority of comments by all staff, about others in the multi-disciplinary teams in which they worked, showed a significant degree of frustration regarding the smoking issue. Some staff coped with this by blaming other professions or placing responsibility for change onto others, as mentioned in the previous section. A few staff chose to distance themselves from the debate altogether.
If they want to smoke, that’s fine by me. I haven’t really thought about it that much. I just never think about it.

It’s not a dilemma for me as a doctor. Everyone has a responsibility for their own welfare.

In their role as health care service providers, staff made decisions about their ethical stance on the issue of smoking and smoking by clients, according to various ethical principles. This determined their actions and inaction within the system of care. Staff made several rationalisations about clients’ smoking. These can be grouped into three main areas of ethical decision-making:

- The right to smoke- self-determination;
- Free and informed choice to smoke; and
- The hierarchy and priority of concerns and harms.

Rights and Self-determination to Smoke

When asked what they thought about clients’ smoking, most staff interviewed spoke of their belief in clients’ right to smoke. Staff were mindful of imposing their own value judgements on clients and mindful of the power imbalance in their relationship with clients. Staff were particularly concerned for those clients hospitalised against their will, in hostels and under Administration Orders for financial management. Staff identified strongly with the role of smoking as giving the client greater opportunity for autonomous activity, as already highlighted in their comments on clients’ ‘need’ to smoke. Staff spoke of the need to compensate clients for clients’ perceived lack of choices within the system of care.

I try to give them as much freedom to do as they wish, as they can, which usually involves buying as much cigarettes as they can. I generally like to give people as many choices as I can in every aspect of their life. I don’t tend to make social choices for them. I think that's their business...I believe that people have choices, but that mental health clients often have choices taken away from them, and I think every opportunity that we have to give choices back to them, I try and do that.
(Sam - occupational therapist / community / ex-smoker)

They smoke out of hospital, so why should it suddenly mean they be made to not smoke in hospital. When we’ve taken away everything else, all other rights. Are we going to take that away as well?

Several staff said they did not make a judgement about clients’ smoking. They expressed concern about portraying double standards with clients, particularly when they were smokers themselves. These staff used the explanation of smoking as a right, as a legal, publicly acceptable activity to justify their stance.

(Kate - trainee psychiatrist / inpatient / smoker)

We have a duty of care for their physical health by pointing out that smoking is detrimental and for giving them options for if they ever want to quit. But having said that, it is their right to smoke. It’s not an illegal drug. It’s not against hospital policy to smoke, so personally, I don’t take a huge stand on it. And also, a lot of mental health staff, particularly talking about nurses in this case in the ward setting; they certainly have a smoking culture. It’s hard to say that to patients, that you’re cutting down their smokes, because it’s a smoking culture amongst the staff.

A small number of staff questioned those who claimed to be making value free judgements as misguided in their ethical thinking. They argued that actions are never value free. These staff said that they regularly strove to assist their clients to quit smoking.

(Grace – psychiatric nurse / community / ex-smoker)

If we had safe cigarettes tomorrow, I suppose my argument would end, but they’re not safe and they never have been and the politics of smoking is just disgusting. I’m sure the human rights arguments came from the tobacco companies...Often people, in the pursuit of what they perceive as their human rights, present spurious arguments. You can’t argue with, “Well, I like it and I’m going to do it.” You can’t argue with that if the person knows the risks and they choose, but misinformation, you can argue with, and I tend to give people articles and cartoons.

Other staff appeared genuinely to struggle to work out their own ethical stance. They recognised the complex web of competing forces at work with regard to the treatment of mental illness and the perceived roles of smoking for clients in alleviating symptoms, relieving boredom, filling an existential vacuum and helping build rapport with others. Some staff explained their ethical stance
in the context of it being the person’s right to smoke, seeing the presence of mental illness or the system of care as being of minimal influence.

*(Janet – psychiatric nurse / inpatient / non-smoker)*

I just think everyone has got the right to choose to do what they want to do…They were smoking before they were detained so what rights have we to stop them from smoking once they’re detained.

One concerned but disheartened staff participant, speaking of inpatient and community settings, had much to say on this type of moral stance, suggesting that it was an attempt by these staff to excuse themselves from the ethical debate.

*(Jane - social worker / community / ex-smoker)*

It’s also easy to rationalise by saying it’s their quality of life, it’s their only pleasure. We don’t have to question it or push very hard for it. It’s like sometimes it just comes out of the too hard basket so it’s easier to just say it’s us granting them their self-determination and therefore we don’t have to do anything about it…The times when I’ve heard the most ludicrous responses to duty of care. People will explain anything as duty of care if they thought they wanted to justify it. It’s such a nebulous concept that people use it to justify so much wank that stops them from having to think. I’ve heard staff use the argument that it’s our duty of care to let them smoke. It’s similar for the concept of self-determination. When we don’t feel we’ve got the power to challenge their smoking, it’s like it’s OK to say well it’s their self-determination and I think that’s the tokenistic way that we can feel that, “we've given them their self-determination. Isn’t that good of us?” I don’t think that gets explored very much.

Concern for the consequences of passive smoking and the rights of non-smoking clients to clean air was raised briefly by one staff participant. The majority of staff made no comments about passive smoking. Those who did directed their comments at staff occupational health and safety concerns within their work environment.

*(Alison – career medical officer / inpatient / non-smoker)*

I don’t condone it in that it’s their right because I think they’re also involving other people in it when they’re close to them, smoking next to them. There’s still that passive smoking thing; however, probably 95% of our patient smoke so they’re only giving it to one another.
Community staff, in particular, spoke about the dilemma of deciding how to respond to clients’ smoking while visiting clients in their own homes. Staff reactions were mixed, although most community staff saw the person’s right to smoke as greater in their own environment than it would be in other settings. This was so even though many staff said they personally opposed smoking. These staff described how they attempted to position themselves to be away from the stream of cigarette smoke at these times. One staff participant highlighted a unique dilemma for non-smoking community staff, particularly when visiting those clients on Treatment Orders, the legal authority under the Mental Health Act that is given to mental health services to take action to enforce clients’ compliance to agreed treatment.

*(Brian - psychologist / community / non-smoker)*

*(In the community)* It’s their home. I wouldn’t tell them not to smoke in their home. If they were in my area, I wouldn’t let them smoke. I would ask them not to...(in their homes) I don’t feel that I’ve got a right to ask them not to...But I reserve the right to not have to sit in it, and I suppose that could become potentially difficult because I have a legal obligation to visit these people and if they are going to be in an environment that is totally obnoxious to me then I feel that I don’t have to do that, so I suppose there is the potential there for an impasse.

**Free Informed Choice to Smoke**

Staff also spoke of clients’ smoking as an informed choice made freely without restriction and based on clients’ full knowledge of the harms and costs of smoking. Some staff used this reasoning even when they also acknowledged that choice was not fully informed. Staff did not see a duty of care to intervene with these clients regarding their ‘choice’ to smoke despite the harms. However, staff used the duty of care argument when seeking guardianship orders for treatment and financial management with regard to other ‘choices’ made by clients that were deemed to be harmful to their health. Staff also used this argument when clients’ spending on cigarettes occurred at the expense of meeting core commitments like accommodation costs.

*(Robyn - consultant psychiatrist / community / ex-smoker)*

You can tell people. I see all the advertising campaigns on the TV and they do too. Look, I can tell people all the bad effects. They have a kind of bravado about it. I think people have the right to smoke if they want to...it’s a choice they make.
(Peter - psychologist / community / non-smoker)
If they come to me and say they’ve got no money and they need food, it’s a hard decision. Like if I think that they’re starving because I think they’ve spent it all on alcohol or drugs, cigarettes, pokies, whatever, I sort of believe that’s a conscious choice they make, not an illness. So it’s a choice; not a wise one, but I wouldn’t bail them out.

(Chris - psychologist / inpatient / smoker)
I understand the issues of cognitive deficit and not being able to adequately determine whether you’re going to smoke or not but I think that same argument runs for people of certain intellectual capacities or...things in our society such as poverty, abuse and unemployment.

Only two staff clearly argued that smoking was not an informed choice by clients. One person spoke of the interaction of mental illness with smoking and the other person spoke of the role of addiction influencing the smoker’s decision-making capacity. This was separate from staff comments and beliefs about clients’ need to smoke, to be discussed elsewhere.

(Terry – psychiatric nurse / inpatient / smoker)
This ward helps them limit because it recognises that it is not informed consent to smoke. That’s right. Other workers are like fence sitters who just say it’s their right to smoke rather than buying into the debate. It’s very much individualised here according to the person’s capacity, or also their financial capacity to buy smokes.

(Bob - consultant psychiatrist / inpatient / non-smoker)
Anything that has a primary addiction habit means it is not a level playing field. It is not a free choice, and I don’t pretend that it is. Therefore, we as professionals must assist. Therefore they are not making an informed choice because of the clearly addictive nature of the stuff...There always exists some restraint.

Hierarchy of Moral / Ethical Concerns and Conflicts
The third form of reasoning used by staff in deciding their ethical stance on clients’ smoking was to propose a hierarchy of ethical concerns that guided them in prioritising harms and duty of care towards clients. Related to the staff prioritising of their actions, as discussed in the previous sub-theme, many staff perceived smoking as less visibly damaging than more immediate problems faced by clients.
(Terry – psychiatric nurse / inpatient / smoker)

I accept that it affects their health in a derogatory way, however, I think the greater priority is the immediate client and staff safety. And if withholding cigarettes is going to increase client irritability and the potential for aggression or violence, I think the long-term decline in their health is the lesser of evils, because of the potential that the immediate violence can cause. And I’ve seen the results of that, and that has an immediate and devastating effect on people’s lives....

Several staff, informed by their beliefs and attitudes about mental health clients, drew from the ethical notions of non-maleficence (do no harm) and beneficence (do good) to inform their decision-making about clients’ smoking. This was particularly so for inpatient staff who said they often saw clients at a greater level of distress than those staff in the community. The pressure felt by inpatient staff to meet clients’ immediate needs was a significant difference identified by staff about the two settings. Concern for long term consequences were outweighed by meeting short term needs to smoke.

(Kate - trainee psychiatrist / inpatient / smoker)

To forcibly ban these people from smoking every time they go into hospital, if this is one of the few things they can do to occupy themselves...it’s a matter of weighing up doing more harm or less harm and doing as little harm as possible. So, unless they’re getting physically more and more ill by smoking, then I would have to say let them smoke.

(Marg – psychiatric nurse / inpatient / smoker)

Once they go to the locked ward, you have taken away everything...They can’t even choose when they have a cigarette or if they’re going to have one. They have no choice left at all. It’s completely taken away, and I can’t condone that just over a couple of cigarettes...Once they’re here, my aim is to keep them on an open ward and to get them as well as soon as I can, to get them back to the community where they belong, and then the choice is theirs. While they’re acutely unwell, and probably agitated, what right do I have to agitate them further by telling them they can’t have a cigarette. And to me, I would consider that to be abusive.

One staff participant made several angry comments about the prevalence of debate on the smoking issue in contrast to debate about other practices occurring within the hospital setting. Her hierarchy of concerns was clear and smoking was low on her list. Her comments point to other ethical
concerns within mental health services and to the conditions in which staff and clients spend their day.

(Sasha - occupational therapist/ inpatient / ex-smoker)

(If there was a smoking ban in the hospital) I think we’d distress an awful lot of people unnecessarily, and a whole lot of staff would be distressed also, and some would leave. That would be close to bordering on cruel. How could we say that we are doing that for their health, but feeding them such low quality food, and housing them absolutely inadequately? And if we’re talking about care, maybe we should be talking about actually how often someone manages to get a shower in [extended care ward], or how often a really unwell woman has been left to menstruate without pads, those type of things. If we’re so concerned about physical care, has anyone cleaned those guy’s teeth in the last four years. Oh Christ, they should get back to reality...I find it hypocritical that we’ll give them a drug that will reduce their bone density, but we’ll go on about their smoking...It amazes me that you can’t even get a bloody condom in this hospital for free.

The majority of staff, regardless of the professional alliances or practice setting, spoke openly about smoking reinforcement and acceptance within the mental health system. They proposed various reasons for their actions that appeared to be based on their beliefs and attitudes towards mental illness, mental health clients and the system of care. This in turn informed how they acted or did not act to assist clients with their smoking and quitting. The sub-themes described in this section have highlighted the complexity of staff decision-making and attitudes about clients’ smoking. Many staff stated that the interview process had been their first opportunity to openly think about the ethics of their actions and attitudes and to articulate the complexity of the debate.

(6.5) Cigarettes as a Tool: Power and Control by Staff:

In the previous themes, staff comments have indicated that they believe clients use cigarettes for a variety of reasons. Likewise, staff have also indicated that they use cigarettes to perform a number of roles with clients.

(Janet – psychiatric nurse / inpatient /non-smoker)

It’s a good way of establishing rapport with a patient and getting good relationships so that you can get a working relationship with them. When they first come in and they really don’t’ want to
be there, it’s a good opportunity to sit there and they’re more relaxed so they’re more likely to talk to you, so you’ve got a better idea of what’s going on.

This theme describes the most dominant theme to emerge from interviews with staff, that is, the use of cigarettes as a management tool to manage clients’ perceived mental illness symptoms and behaviour. In the same way that clients said they used cigarettes to manage the symptoms of their illness, staff condoned and reinforced this same process stating that they used cigarettes to reward and punish clients in order to assert control over their behaviour. They did this in response to occupational health and safety concerns regarding verbal and/or physical threats made towards them by clients. This was especially evident in comments by staff from inpatient locked and extended care settings. All of these measures were described as having developed over time and become an entrenched part of the daily interactions between staff and clients. The effects of nicotine withdrawal were not mentioned.

(6.5.1) The History of Control:

Several staff spoke about the historical development of this use of cigarettes, citing several decades of official hospital policy of providing a tobacco ration for clients in expectation of behaviour and treatment compliance. Terry’s previous comments, referring to the 1960’s, about nursing staff duties to roll and distribute and light cigarettes for clients have already been noted.

(Grace – psychiatric nurse / community / ex-smoker)
(Speaking of her time working in the hospital in the early 1970’s) And cigarettes were a currency. If you wanted the patients to do something, you could give them a cigarette and they’d probably do it. In fact, I can remember my first ward, the charge sister saying, “Go and run this errand and I’ll give you a cigarette. Go and make you bed and I’ll give you a cigarette...” It was how you got things done...If you wanted to talk to someone about something, you’d kind of offer them a cigarette and at least you got their attention for the time it took to smoke a cigarette. It was a salesman kind of ploy.

(Peter – psychologist / community / ex-smoker)
(Of the hospital and smoking in the 1970’s) Smoking was seen as something that was therapeutic, and that was the last thing that you would deprive people of if you wanted to keep them unstressed, or pleasant, or non-aggressive, or whatever.
In the past, I understand that smokes also used to be used as reward on behaviour programs, and that was the expectation that I would do that too when I came here, and, ‘no way’…But unfortunately it can occur. It is a practice that’s used.

One staff participant described the consequences of the power exercised by staff over clients, claiming that the system of care leads to situations of abuse of power.

Like, back in the 1970’s there was a lot of abuse. I worked in a lot of security hospitals where people [staff] who wouldn’t hurt a fly, once they’re exposed to that environment, you see people change, and it’s quite true what they say about power corrupting, very much.

Other staff described the existence of an inherent and traditional power difference, between staff and clients, that served to create an inequitable relationship even prior to the person entering hospital and therefore raising clients’ vulnerability to abuse.

The other thing is the whole notion of self-efficacy that people who are in a hospital situation don’t feel powerful in their own right, and that’s often true of so many other aspects of their lives such as accommodation and finances. So the whole notion of “I can manage to change this in my life [of overcoming the need for cigarettes]”, is a difficult notion.

A Structure of Control - Management Versus Care:

All staff spoke about an inherent structure that existed within the mental health system that created and perpetuated power imbalances between staff and clients, placing staff in the dominant role. Staff were not necessarily happy with that role. Several staff noted the effect the setting and of having locked doors separating staff and clients and the ‘us and them’ situation that this created.

(talking about the locked ward at the hospital) It didn’t have a positive feeling at all. The ceiling was too low; the sound was deadening; and it had the feeling of being in a waiting room all your life…The smoking area is really a cage like you put animals in. When I was acting ADON (Acting Director of Nursing), I remember one day I went into the cage, and there were several
smoking staff in there at the time and the interaction was that a group of staff had a conversation and the patients were kind of, “sit down and shut up.” It was perhaps not quite to the extent that that’s what they were told, but it was quite clear that the dominant activity going on there was staff having a smoke and talking to each other...

(Paul – psychiatric nurse / inpatient / ex-smoker)

If they didn’t smoke, they wouldn’t come back to the door every half an hour either. There’s something about having a closed door between us that makes the difference. It’s a real power thing. It’s a typical us and them situation. The staff retreat to be behind the closed door...It seems to be institutionalised. I mean, even if you didn’t follow that procedure, just merely by being here and being exposed to the way the ward operates, the policy, and the staff; staff tend to adopt a certain mentality of control, just because of the environment. It’s easy to give people cigarettes. It’s easier than not giving them.

(Kim – social worker / inpatient / non-smoker)

Simply having the door as the barrier; that becomes part of the reward/punishment stuff. It’s not that the person has deliberately used it in that way; it’s just the fact that it’s a locked door. It’s very disempowering. But it’s not just that; it’s the sense of a locked ward where all your belongings are taken away from you. Your smokes are taken off you. Your laces and belts and jewellery are taken off you, actually encouraging you to come to the door every five minutes if you want something.

(Liz - occupational therapist / community / ex-smoker)

(Of the hospital system) It’s very similar to the prison system, the difference being that in prison people have more control over what they are able to do a lot of the time...they’re allowed to carry their smoke and lighters around with them.

(Jane - social worker / community / ex-smoker)

We look at managing; we make sure they are managed over the weekend, or in hospital, etc. Often, we focus more on how we cope with our clients, what we can best do to not make them cause stress to us, than we do about helping them make their lives better and making gains for themselves. That’s because...[this] is extremely tedious and there are pressures on us in the work place that mean that we can’t always do that, to make substantial investments in clients and to be
persistent and tenacious in that...and often our service is fragmented and compartmentalised and having pressures to deal with just what's in front of you at the time.

The extended care wards were identified by staff as areas where staff control over clients was very pronounced. This was based on cigarette distribution to clients being overseen by nursing staff as part of routine policy on the wards.

(Sue – social worker / community / smoker)

There seems to be even more paternalism in the extended care wards. People are handed out cigarettes as if they had no self-discipline. Almost all extended care nursing staff do control cigarettes on the ward and you do see them, yeah, packaging them all up in lots of 5 and 10 with all the names written on them. “Here’s your cigarettes. Don’t ask for any more until tonight or when the next lot comes, or whatever”. Most people get them dished out 2 or 3 times a day in a package already made up and that’s amazing. It’s been like it as long as I’ve known.

(6.5.3) Smoking as a Tool for Reward and Punishment:

Several comments were made by staff about the giving and withholding of cigarettes as part of everyday staff - client interactions in order to influence clients’ behaviour.

(Kate - trainee psychiatrist / inpatient / smoker)

When you’re in the locked ward where there has to be supervised smoking, it does give you some bargaining power in terms of, “I’ll talk to you now. Sit down and we’ll have an interview and then you can have a smoke.”

(Sasha - occupational therapist / inpatient / ex-smoker)

I’ve seen nursing staff who will bow their head and tote their forelock and hide the cigarettes in the top drawer and measure them out, because they can. It’s a control thing. And if they haven’t got the skills to relate to someone like a bloody human being, and have to do it by measuring out the smokes, and when they arrive in the paddy wagon, it’s like, “Just see the doctor and then we’ll take you out for a smoke.”
(Janet – psychiatric nurse / inpatient / non-smoker)

(On the locked ward) Why should we be so like prison wardens and say, “No, you can’t have one [a cigarette]?” I think a lot of the time it’s power games with some nurses…like, “I’m the nurse and I’m looking after you and I can tell you what to do,” kind of thing. That’s the feeling I get from a lot of the nurses.

(Paul – psychiatric nurse / inpatient / ex-smoker)

I’ve often heard it said that smoking here is a privilege, and that privilege will be taken away, and that is reinforced time and time again. I’ve heard it said by the nurses many, many times to the patients, “If you’re good you can have your smoke,” But if we didn’t have the cigarettes, then we wouldn’t have the problem, possibly.

(Janet – psychiatric nurse / inpatient / non-smoker)

I remember an incident once when we had some exams here for the doctors and they were bribing patients to agree to sit in and be used in the exam, like, “We’ll give you 20 extra cigarettes if you agree to do this.” I just thought it was amusing...If they’re going to do something, then they should get some benefit from it, if that’s the reward they want.

(Sue – social worker / community / smoker)

(On the hospital) In such a controlled environment and because of the punishment system and the reward system, there tends to be a fair bit of that in the locked wards where, “You’ll get a cigarette when you behave”.

This use of reward was particularly noted in the extended care wards where the distributing of cigarettes was described as a core part of nurses’ duties to maintain the order of the setting.

(Terry – psychiatric nurse / inpatient / smoker)

Because the majority of the ward are heavy smokers, the patients here tend to watch each other, so if one gets an extra smoke then the rest will want it, and staff here have learnt very quickly that it’s unfair to do something for one and not the other because they have to do the same for everyone, and it becomes a very expensive exercise after a while. So generally the staff don’t, except the rare occasions if the patient does something like a favour or something like that, then we slip them a ‘good one’ [better brand].
(6.5.4) Occupational Health and Safety Considerations:

Many inpatient staff described their work environment as a place where staff control over clients was continually tested, in that they continually needed to assert their authority over potentially violent clients and deal with potentially out of control situations. The inpatient nursing staff, in particular, highlighted their fear of assault by clients. They saw the use of cigarettes as directly improving the safety of the work environment, even though smoking was not officially sanctioned as part of hospital occupational health and safety policy in this respect. The use of cigarettes to improve the overall safety of the setting for both staff and clients was also noted. This was not restricted to the nursing profession.

(Terry – psychiatric nurse / inpatient / smoker)
Both from a nurses and client management perspective, if you can keep the ward running smoothly and minimising the amount of aggression, by allowing them to smoke, then allowing them to smoke facilitates that. By all means, I’d rather have a smooth running ward than go home with a broken arm.

(Jill – psychiatric nurse / community / ex-smoker)
It’s just too complex to think about really. I just treat it as a day to day thing. It’s just in the too hard basket. Smoking is an easy solution and sometimes it’s the only one there readily available when someone is about to snot you one...Letting them smoke is the easy option.

(Janet – psychiatric nurse / inpatient / non-smoker)
I think that because in the inpatient setting you’ve got so many patients in close proximity to one another, that if one gets agitated because they haven’t got their cigarettes, then it could just upset all the other people around them, or they could just go around pestering or being a nuisance to other patients, saying, “Can I have a cigarette?” So in the inpatient setting we try to ensure that they have cigarettes to keep them settled. And I think the consequences of not giving them a cigarette can be a lot worse than giving them. Like, I’ve seen patients hit because they’ve been pestering other patients for a cigarette because they haven’t got any...(If there was a smoking ban) I think there would be more medication given; I definitely think a greater amount of PRN would be given, especially for agitation, and things like that. And there’d be a lot more incidents and violence as well.
(Liz – occupational therapist / community / ex-smoker)

(Remembering her inpatient experience) A lot of the inpatient staff, particularly the nursing staff, were scared a lot of the time, were really unsure about what they could do to actually control situations or get on top of clients who were actually in the ward. It’s management of safety and I think that initial attitude that they actually give out…like when they hear that someone is coming in that is male, 25, and actively psychotic, they have this sudden defensive reaction. If they come in the paddy wagon, it’s easy to give them a smoke. It’s like whew [relief].

(Alison – career medical officer / inpatient / non-smoker)

(If the hospital was non-smoking) I think we’d have some very irate, aggressive, irritable, difficult to manage patients…

At a more routine, day to day level, many inpatient staff commented on how staff control the supply of cigarettes (and lighters in some settings) to clients as a way of keeping the peace, to ensure the smooth running of the setting, to reduce fire risks and in the best interests of the clients for their protection and the protection of others. This idea is further illustrated in the section describing the culture of smoking with the settings. Of note, most staff descriptions of inpatient routines and rules about smoking clearly placed the nursing staff in the direct role of control over cigarette supply and distribution to clients.

(Alison – career medical officer / inpatient / non-smoking)

The nurses don’t normally try to limit too much unless there’s a problem with other patients and with staff and then they try to limit it to one every couple of hours. They keep the cigarettes locked up in that case and hand them out one by one. The problem they find when they hand them out in packets is that the other patients who smoke are congregating with that patient, almost demanding at times to get smokes from them so one of the things they try to do is to keep the cigarettes in the nursing station…especially if you’ve got a patient who is fairly timid and they’ll just hand over their whole packet with the stand over tactics of some of the other patients, and that’s impossible to really monitor all the time.

(John – consultant psychiatrist / inpatient / smoker)

You don’t want patient X to be exploited so why not try to manage the exploitation. That’s what the nurses are there for.
(Kate – trainee psychiatrist / inpatient / smoker)

When the patients come in and ask for their cigarettes, it means it’s one extra contact that they might not have had with the nursing staff, otherwise you might never see them...So it gives them a reason for having to make contact with the nurses. Like, I’ve been in areas where the nurses would go out the back to smoke with the patients and that way they would get some information...It’s fairly acceptable practice, and all the nurses do that.

(Terry – psychiatric nurse / inpatient / smoker)

(On the extended care ward where nurses keep clients’ cigarettes in named pigeonholes within the nursing area and distribute them to clients) Most people here don’t carry their own smokes on them. There’s one or two that can. The nurses decide who can by first of all considering the risk factor that they’re not going to be a fire danger to the ward, that they can comply with the rules about not smoking indoors, or in their rooms, but also not vulnerable to being stood over by those who are persistent in the know about cigarettes from others. Some people, because they’re incapable of handling money, effectively have canteen accounts...They’re allowed to purchase up to $2 or $3 in items on a daily basis. It’s a vulnerable situation, of being vulnerable to being ripped off by others if they had the money on them, due to stand over behaviour and so on.

(Terry – psychiatric nurse / inpatient / smoker)

(On the supply of cigarettes to clients in the locked ward if they haven’t had the opportunity to buy their own) It’s to keep some semblance of behavioural order, I suppose. It’s certainly a big factor in those environments and also the resentment of seeing other clients who might have heir own smokes when they don’t have any themselves, that can provoke them to some extent. So yes, it can help keep the peace in those environments.

This perceived need to keep peace and order extended to the wider community, with staff identifying further consequences of denying clients cigarettes in the hospital setting.

(Terry – psychiatric nurse / inpatient / smoker)

(Regarding a smoking ban) I think people from the hospital would start going around knocking on doors, or walking around the streets looking for butts, or accosting people in the street...That would certainly increase; and the criminality aspects.
Only one staff participant challenged the notion of staff overseeing the distribution of cigarettes and lighters to clients in order to improve safety on the ward.

*(Paul – psychiatric nurse / inpatient / ex-smoker)*

*One of the reasons why we hold the cigarettes and tobacco here is because they say it’s a safety issue…I don’t know. Like I worked at [the gaol] for 4 years and certainly all the inmates there had their own cigarettes and lighters and they didn’t go around setting fire to their cells or things like that…*(If they had their cigarettes to carry on them?)* Oh, I think they’d feel a bit more in control, rather than everything being taken away from them.

In inpatient settings, staff said that the key-locked nurses station door provided a significant barrier between them and clients, as well as protection from potentially violent or difficult client behaviour. One staff participant commented on how the current system and its structures operate to disempower clients. He made suggestions about how this could be changed and gave evidence for these suggestions.

*(John - consultant psychiatrist / inpatient)*

*I’ve had an interesting experience with the locked ward. as an example of disempowering people, there was a time about two years ago or so when the hospital nurses went on strike and they all went out. It was quite amazing and so a lot of us decided, regardless of what the rights of the nurses were, you couldn’t leave the patients without any care, so we volunteered to provide that. Another doctor and I spent the first afternoon looking after people in [the locked ward]...We simultaneously decided that this was ridiculous so we just opened the door and said to the patients, “Well, there you are, just take one when you want one,” and I swear to you the smoking went down. The other interesting thing was they didn’t come intruding into the nurses space...they didn’t feel as intimidated by the barrier.*

One staff participant argued that the smoking policy change of banning smoking indoors had a significant and noticeable effect of the power differential between staff and clients in the inpatient locked setting.

*(Jill – psychiatric nurse / community / ex-smoker)*

*It changed when the rules changed which meant that you could only smoke outside which meant you had to open all the doors up, which meant you had to have a certain amount of staff in the*
courtyard with the clients. That’s when it became a really noticeable issue of control between the
client saying, “I want a cigarette”, and the staff having to say, “Well, we can’t go out right now”.
It created tension. So it was a staffing issue around smoking rather than a safety issue of the
ward in general.

Of note, staff did not emphasise a concern for passive smoking within the work environment. Most
staff did not make any mention of this. Smoking was overwhelmingly accepted as part of the work
setting by all disciplines involved in interviews. Some community staff said that they sat ‘upwind’
of clients who were smoking, or asked clients if they would refrain from smoking during their
contact with staff. They did not say that the reasons for this were related to their own health
concerns, although this could be implied from their body language while being interviewed.
Smoking was more readily described as a social habit that these participants disliked.

(6.6) PROFESSIONAL ROLE DIFFERENCES REGARDING SMOKING:

In this section, each profession’s response to the smoking issue is described individually. Professional
differences and similarities in attitudes towards smoking and clients with mental
illness are demonstrated by what each professional group said about itself and what each
profession said about other professions within the system. By describing how the professions within
the system saw themselves and each other, it is hoped that a greater understanding of how the
system has responded to the issue of smoking within these mental health settings will be evident.

(Kim - social worker / inpatient / non-smoker)

There seems to be a delineation of roles that each profession uses to protect itself and smoking is
in the too hard basket.

(6.6.1) Social Workers:

Social workers expressed many reflective and critical comments about the problem of smoking,
taking an holistic approach that encompassed both the inpatient and community setting. Their
comments suggested a substantial level of frustration within a system that they saw as dominated by
the politics of medical and nursing roles. They felt little capacity to make lasting positive change for
clients. All social workers interviewed believed that doctors avoided the smoking issue, either
deliberately, or as a feature of their role and routine within the treatment settings.
(Jean – inpatient / non-smoker)

The doctors are in the background not saying very much. They don’t buy into it. They rotate around the place and they aren’t into the routine.

One social worker saw the nursing staff as being scape-goated by the doctors. She saw the doctors as ultimately responsible for leading decisions about smoking policy.

(Jane – community / ex-smoker)

I think for doctors to say that their biggest barrier is the nurses is an easy cop out. They [the nurses] are such an easy target and when they’re trying to get people to give up smoking, blaming the nursing staff is a quick solution...passing off blame is rife. I think the nurses are incredibly threatened by resources, by management, by community staff telling them what to do, that other staff from outside the hospital also often project that they have a monopoly on what great and what’s better...inpatient staff get really entrenched in the way they act.

All social workers said they felt pressure from the system of care and from other professions, especially from the nurses who they said pressured them to collude with the process of ensuring the supply of cigarettes to clients. Social workers described this as feeling like a process of entrapment in which their professional and personal values were being compromised.

(Jean – inpatient / non-smoker)

It just seems like a farce to be asked by the nursing staff, “What are you going to do as a social worker to give them more money so that they can still smoke as much as they need?”...And they say, “Well you have to do something about it because they have a right to smoke”.

(Kim – inpatient / non-smoker)

And sometimes you’ll interview patients who have been refused cigarettes and they will be looking at the clock and they’ll say, “Do you mind if I go out and get my cigarette now because I won’t get one otherwise?” and that can be frustrating. You end up making allowances in your work to fit in with the smoking regime. It’s a real dilemma...You worry that you’re actually colluding with the process.
Social workers expressed much concern about this pressure forcing them back into a welfare role, that is, a lesser skilled role of acquiring basic items for clients rather than being seen as having skills within the professional areas of assessment and therapy.

*(Kim – inpatient / non-smoker)*

*(When the ward cigarette supply was reduced)* I was initially angry and I wrote to the committee outlining the difficulties posed to the social workers. Again, it puts the social work role back to a welfare role where you’re trying to scrounge money.

They said they felt powerless and isolated, even from social work colleagues, at times. Whatever smoking stance they took kept them in a politically less powerful position, with the dominant system remaining intact. Whether they took a stand and refused to assist clients to get cigarettes, or whether they took on this role, they saw themselves as ‘selling out’ their values by not acting in the best interests of the client, or feeling that they were not aligned with the values of the service either. Social workers expressed a high degree of anger, despair and anxiety about their own profession. They felt disillusioned with the system of care for clients and with the smoking issue. They were well aware of the dilemmas posed by the problem of smoking; most social workers said they made adaptations accordingly.

*(Jane - community / ex-smoker)*

I’d moved from the point, on the one hand, of hating the fact that, as a paid clinician, I was spending my time going to the shop and buying fucking smokes for people and often that would take an hour and a half of every day with the bank run for a number of people. And I was developing a relationship with the woman at the bloody smokes shop because I was there so often...I found that very degrading but then I’d combat that ethically by saying this is seen as a client need and this is what I’m called up for, that’s great, you know. Who am I to be sanctimonious about that I should only be a clinician?...On the flip side of the coin, you had clients who were so diempowered and had had so much removed from them that, to be able to go to the shop and get them a bloody chocolate bar and a packet of smokes that they wanted, was so enabling and allowed me to work with them in such a different way from what the doctors and nursing staff did because I didn’t have the same power kick...but I actually resented the time I had to spend doing that.
(6.6.2) Nurses:

Like their social work counterparts, the inpatient nursing staff made several comments about doctors’ non-involvement in the smoking issue and pressure from doctors for nurses to ‘just fix it’. Community nursing staff expressed more autonomy in their roles and made few comments about other professions.

(Paul – inpatient / ex-smoker)

*The nurses get a lot of pressure from the doctors to just fix it. Yeah, doctors don’t give a shit about rules. It’s just easy to give them cigarettes.*

(Jill – community / ex-smoker)

[The doctors] step back and say, “You handle it”. They expect you to manage the short-term needs. It's like it's not an issue of harm from smoking; it's more of an issue of managing the clients’ behaviour and symptoms at the time.

Nurses said they felt much pressure in their roles, often simply because of their close proximity to clients and the smoking and their role in providing direct care. Inpatient nurses who were not smokers said they reluctantly performed their role in handing out cigarettes to clients, finding ways around pressure from the system of care to perform this duty, rather than challenging it outright.

(Paul – inpatient / ex-smoker)

*I give out cigarettes only when I have to, only because I’m following ward policy. I try not to...I won’t stay out there. I’ll only light one person’s cigarette and then I’ll ask them to all get a light off each other. I won’t hang around out there, mainly for my own health because of the passive smoking.*

(Janet – inpatient / non-smoker)

*I hate it. I absolutely hate it being out with the patients while they’re smoking. So I stand in the doorway or keep away.*

Nurses made few direct comments about their professional practice in relation to smoking. The majority of comments they made concerned the use of cigarettes to settle clients and to establish rapport with them, as previously mentioned. Inpatient nursing staff said they were just too busy
being caught up in the day to day care routine of managing clients’ mental state to develop a stand on the issue of smoking, as described in the section on ethics. Community nurses said that they could distance themselves from the pressure to assist clients to get cigarettes, unless they were forced into this role as financial liaison person for Guardianship Board Administration Orders where the client has been deemed to be incapable of managing their financial affairs.

(Jill – community / ex-smoker)
I put a lot of pressure back on them [the clients]…Unless I’m administering an Admin Order then it’s not my problem.

(Ruth – community / non-smoker)
I’ve had people who go into hospital without smokes and I just think that’s their problem. It’s not my problem to provide them with a harmful substance…We each have responsibility for ourselves.

(6.6.3) Doctors:

Doctors made very few comments about other professions in the context of smoking; most made no comments. Those doctors who did comment directed their comments at the nursing staff.

(Bob – inpatient / non-smoker)
It’s something that’s largely nursing staff reinforced, and from a medical side, I’ve got to convince my nursing staff to give up first.

(Alison – inpatient / non-smoker)
It’s easier for me than the nursing staff to stand back from it because I don’t smoke. Most of the nursing staff smoke and they find it beneficial. Most of them find they can go out with the patients and have a smoke…I’ve seen them with a patient of mine who’s been very irritable, walked out and was going to storm off, and the nurses would say, “Let’s just go outside and have a cigee (cigarette),” and they’ve settled down, and they often do. Whereas, I wouldn’t have been able to do that in that manner…I can’t go out with them and have a cigarette.
(Alison – inpatient / non-smoker)

*The nursing staff excuses for going outside to have a cigee (cigarette) with the patients are phenomenal.*

The greatest pressure for doctors not to smoke appeared to come from peers via a process of shaming of each other in order to reinforce non-smoking within the profession. Doctors who were smokers said they never smoked in front of clients.

(Bob – inpatient / non-smoker)

*Out of my staff, smoking has decreased dramatically. There are 2 who I know smoke, but they won’t smoke in my company or even when we’re out socially, so that the sense of shame is fairly high.*

Most comments about smoking came from the least experienced, least qualified doctor, who said she was still learning and questioning what her medical peers had grown accustomed to as part of their professional hierarchy and leadership role.

(Kate – inpatient / smoker)

*(Deciding whether a patient has greater or lesser access to their cigarettes)*

*It seems that the nurses and social workers usually leave that decision up to the doctors...We have to be the big bad one who takes away their freedom to smoke.*

Doctors’ comments about their own profession demonstrated that clients’ smoking was largely an irrelevant issue for them, the mental illness having a far greater priority. They abrogated responsibility for involvement by defining the smoking problem as not part of their role. Again it was the least experienced doctor who made comments that showed the greatest questioning of professional values with regard to client care and smoking.

(Kate – inpatient / smoker)

*In mental health it’s such that you’ve asked it so many times [whether clients smoke or not]...you become complacent. [Does it worry you?] Yes it does...I’m trying to keep checking on myself about my values. I think it’s really gotten to be a non-issue. It just bubbles away in the background until there’s a real concern for their physical health.*
(6.6.4) Psychologists:

Of all staff interviewed, psychologists made the least comments about their own and other professions. They saw themselves as completely autonomous and separate from other professions and the day-to-day care of clients, preferring the role of ‘specialist’ who provided therapy to usually willing clients and consultation to other professions.

(Brian – community / non-smoker)

I don’t have anything to do with their smoking. I don’t try to influence their smoking at all…I don’t talk to them about it. If they did mention it, I’d have no hesitation in talking to them about it because my view is totally negative. (On quitting) Until you’re absolutely convinced that that’s what you want to do, then you’re wasting your time.

The inpatient psychologist made the most comments regarding professional differences. She described her professional dilemmas regarding smoking within the setting.

(Chris – inpatient / smoker)

I think the nurses construct their role in a very different way because they actually have different tasks to perform, so they stand in a different relationship to power and consideration of issues and patient behaviour as well. Where you stand professionally in relation to issues of power depends very much on what your rights and obligations are, where you have to be cautious, and also how you construct your profession. And I think psychology constructs it’s profession as being people who listen to the words of others and try to understand their world and then help those people negotiate that world to the goals that are appropriate...It's a culture that’s very much negotiated in the nurses’ station and it has a history. If you stand apart from that culture, it’s a difficult place to stand.

(6.6.5) Occupational Therapists:

The lack of occupational therapy services and staffing at the inpatient setting had forced the two occupational therapists there to limit their role and work with particular individuals rather than install group programs. Their services were seen as outside the system of care and constantly under threat from further funding cuts. They felt powerless and saw other staff in this way also. They presented themselves as mere observers of all that was wrong with the system, with little or no effect on it or the smoking within it. It sometimes made them respond with frustration and anger.
(Sasha – inpatient / ex-smoker)

I think there are different levels of skill and anxiety and inadequacy amongst the staff. I think there’s a lot of staff who are hiding quite nicely behind their mobile phones, and rules about there being two people together at all times, and all that type of stuff. I’d be concerned about how their own personal growth has been arrested in that environment, because they’re obviously not treating the person as a human. It’s like, “They’re fucked, so don’t worry about it.” The thing about our clients is that there but for the grace of God go I, and some of the staff attitudes seem to forget that...Nursing staff are in a very difficult position because they often end up doing the shit jobs. They get placed in an absolutely adversarial role and they’re not supported. It concerns me that the doctors don’t ask their patients about their smoking. For me that passes the boundary of duty of care, especially when it is obvious that the person has a physical illness because of their smoking.

Community occupational therapists stated that they were submerged also in the minutiae of their clients’ day to day functioning, as taught to them during their professional training. They revelled in the small achievements and details of their clients’ lives in order to explain their action and inaction.

(Sam – community / ex-smoker)

(On working with clients) We’re trained to work out whether it’s a motivational issue, a routines issue or perhaps whether they have a processing or sequencing problem...It’s a revelling in the fine details.

(Liz – community / ex-smoker)

If you’ve got too large a case load, you can’t actually spend time intensively with an individual to work on those issues that are important. It’s more ad hoc, two steps forward and two steps back all the time.

All occupational therapists remarked on the clients’ sense of well-being and autonomy as the priority. Smoking was seen as part of this if smoking contributed to clients’ social and emotional well-being by giving them a sense of purpose. In many of their remarks, occupational therapists saw themselves and the clients as equals, their professional role allowing them to carry this stance.
(Liz – community / ex-smoker)

(On the focus of her role) **Definitely well-being, and I think there’s that need to treat them as being unique and as being human and to acknowledge that they are a person first...and that the majority of people have a need for meaning and some sort of purpose.**

(Sasha – inpatient / ex-smoker)

**Quite often, because I didn’t have to take a punitive role around the smoking, it gave me a higher status with the patients, or openings to start relationships with them...I’ve never been placed in a position where I’ve had to be either really punitive or really controlling around someone’s smoking. I have at times wished I could have taken that easy road out...The thing that I try to establish as a first thing in the relationship with clients is dignity.**

Overall, each profession made general comments about client care that reflected their roles and responsibilities within the multi-disciplinary team. However, debate about the smoking issue, rather than being a team approach to the problem, tended to fuel inter-disciplinary professional rivalries, especially in inpatient settings. Most comments reflected a high degree of powerlessness, despondency and acceptance by all staff within the mental health system. The high prevalence of smoking by clients seemed too hard for staff to address and few saw it as their responsibility. This warrants an investigation into the systemic culture of the settings in which the staff worked.

**6.7) THE CULTURE OF SMOKING WITHIN THE MENTAL HEALTH SETTINGS:**

In order to progress to an understanding of the current context in which smoking by staff and clients occurs, its level of acceptance and reinforcement and barriers to quitting, the culture in which it developed and now occurs needs to be described. This theme highlights the emergent role of cigarettes and interactions involving cigarettes as a currency for social, economic and political interactions and exchanges between the parties that make up the cultural landscape of the mental health settings. Staff participants’ comments on the culture of the inpatient and community settings are noted separately. Their comments about perceived differences between the two settings are then reported.

**6.7.1) The Hospital Culture:**

Many comments were made about the hospital culture by both inpatient and community staff. Most participants in this study had trained in or had recent experience of working in inpatient wards and
used the hospital setting as their point of reference to describe the overall culture of mental health services. In this sense the power exerted by the inpatient setting in shaping both inpatient and community mental health culture was significant, with many facets of hospital life transferred over to the community setting. Three aspects of the culture of inpatient psychiatric settings will be described, as highlighted by inpatient and community staff who were interviewed: the environment of the hospital, the barter system and reinforcement and acceptance of smoking.

**The Environment of the Hospital**

Several staff participants recounted their knowledge of smoking policy in the hospital in the past, with many highlighting that there were plenty of opportunities to smoke and plenty of smokers, staff and clients. In this respect, they described an historical level of acceptance of smoking as a shared activity by both staff and clients, of unwritten rules that all are aware of.

*(Peter - psychologist / community / ex-smoker)*

*(As a student at the hospital in the 1970’s)* I couldn’t actually pick out who were the patients and who were the staff. Almost everyone smoked...they literally hid behind a cloud of smoke.

*(Sam - occupational therapist / community / ex-smoker)*

*(Of the hospital)* It’s not just a staff attitude. It’s the way the wards are set up as well and there’s a history of people and how they have been treated that makes a difference...[they] get used to how they treat each other.

Staff described the physical structure and layout of the hospital wards and the organisational structure of routines around doctors’ and nurses’ duties as contributing greatly to the elevation of the role of smoking and its core place in daily activity within the setting. This was particularly evident in comments about locked wards, but was equally applied to open wards where each external area immediately outside the ward was called ‘the smoking area’. Each of these areas was described as a centre for interactions between clients. This was also seen as a focal point for staff and client interactions, as was the nurses station door.

*(Grace - psychiatric nurse / community / ex-smoker)*

*(Of the acute locked ward)* I don’t think there’s much in the way of one to one therapeutic activity that happens. It’s kind of, “Let’s wait for the medication to work,” and that’s not enough...There’s just nothing to do. You can’t even go and have a shower in the daytime...the
only normal thing they can do at the time is to smoke. We talk about normalisation and a home
type atmosphere, and we build waiting rooms.

(Kim - social worker / inpatient / non-smoker)
You often get people who come in who just automatically come up to the door asking for
cigarette, and you say, “but you don’t smoke,” and they say, “oh, that’s right.” Because it relieves
the boredom, they go out there and see all the others doing it.

One nurse described the effect that such a system and its structures had on his approach to his work.

(Paul – psychiatric nurse / inpatient / ex-smoker)
I’ve worked in a lot of hospitals around the country and security hospitals and things; mainly
locked settings. No community. I’m institutionalised. It’s quite a culture.
There’s a lot of similarities to be drawn between the prison system and the closed wards here; the
seclusion rooms are like isolation cells; locked doors; staff with keys; there’s a great similarity.
That’s why I can roam between a prison system and a closed setting somewhere with little
difficulty...you can run on autopilot.

Another nurse described his view of his work environment:

(Terry – psychiatric nurse / inpatient / smoker)
It’s home for a lot of these people...and the beauty of this particular geographical setting being
an advantage is because it’s got the garden buffer, a wide green buffer between them and the
community, which is gradually being encroached upon unfortunately. This plan is truly a
sanctuary for some of the people here.

A psychologist described how his experience of the inpatient setting influenced his views about the
system of care and the clients:

(Peter – psychologist / community / ex-smoker)
(Reflecting on the inpatient environment and the clients there) It’s like a gaol. They’ve learned to
survive and some of them may be lost in their world of hallucinations and so on but the majority
of people in the hospital didn’t seem to be doing that. They just seem to have this knack of not
being stressed out by not doing anything…They smoked like cows in a paddock munching on grass every so often.

The impact of these arrangements for staff and clients, with regard to smoking, was of much concern to many staff participants. Of particular note was the perceived sense of powerlessness, expressed by staff, to have any meaningful influence on improving the current situation. Mirroring the clients’ conditioned social behaviour, staff said they found it easier to deal with just what was in front of them on a day to day basis.

(Paul - psychiatric nurse / inpatient / ex-smoker)
And they know the routine. It’s just, “Oh, we’re in [locked ward],” (Knock, knock, knock on the nurses’ station glass door) It’s just an instant thing. They turn off to it and so do the staff.

(Sasha - occupational therapist / inpatient / ex-smoker)
I think the demoralisation and the lack of skills amongst staff, and the lack of support for staff working in this environment, is what perpetuates that system where little is done to overcome the problems of the hospital culture where staff continue to be fully aware of the stand over tactics, and the violence that occurs in order to get cigarettes.

(Jane - social worker / community / ex-smoker)
(the inpatient settings) The staff are a lot more under threat. They’re much more disempowered themselves. It’s worse than it used to be. The skill level and just the turn around in staff is horrendous. There’s not the continuity on the ward or the sense of nurturing needed to teach different ways of doing things. I think when you’ve got the constant fluidity of staff moving through with huge amounts from agency nursing staff, they get to a point of only doing what they need to do to get through the day and saying, “I’m only going to do what I’ve got on my plate.”

(Bob - consultant psychiatrist / inpatient / non-smoker)
One of the beautiful anecdotes recently was the patient who wanted to select the ward he wanted to go to, based on the smoking area. And people said he didn’t have insight (laughs)...He’d methodically worked out what his priority was right down to the ward. (He went on to describe each extended care ward criteria for admission, based on level of ability / disability. It became a description based on the person’s level of smoking.)
The Barter System

One aspect of the hospital culture, described at length by staff participants, was the extensive informal barter system used by patients involving cigarettes as tradable commodities. Again, staff spoke about the historical beginnings of this practice. A tobacco ration was, in fact, a formal part of hospital policy for clients throughout the nineteenth century in psychiatric settings. According to Peter, this practice continued up until the 1970’s and only changed when people with a psychiatric illness became eligible for government pensions and benefits for the first time and therefore could buy their own cigarettes. Hence, the source of supply changed but the practice continued as an understood activity within the system of care.

(Peter - psychologist / community / ex-smoker)
(Previously inpatient in 1970’s)

By having a tobacco ration, in effect, people took up smoking because they got a ration. It was like being in gaol. If you give up this something, that’s still a tradable commodity. If you didn’t smoke, you still got a ration. You could barter with other people.

Several staff described their full knowledge of the current informal system of barter with and for cigarettes, often with amusement, but always with acceptance of its practice. This acceptance was true of all staff interviewed from all professional disciplines. Many staff made direct reference to the setting parallelling a gaol culture where levels of hierarchy and understood rules of interaction and survival exist between ‘inmates’, one of these being that ‘you don’t rat on your mates’ to the staff.

(Ros - social worker / inpatient open ward / ex-smoker)

They know how to trade with each other. It’s quite a little community with the trading. And it’s also an emotional thing where they’ll give someone a hug and say, “Hi, (and give them all these positives) and by the way do you have a smoke?” And they have a system where people genuinely haven’t had cigarettes and then they’ve traded and you’ll find they’ll usually repay in kind when their next payday comes and they can buy a packet.

(Terry – psychiatric nurse / inpatient / smoker)

They’re vulnerable to being stood over by those who are persistent in the know about cigarettes from others. Because once they get out and in the grounds, there is a lot of trading; very much so. One of our clients has quite a little business going. He purchases his own cigarettes on a daily
basis and then sells them to other clients at a slight profit...They have $2 or $3 a day pocket money, no more, and whatever money they’ve got left over, they’re then able to buy any extra cigarettes that they might need.

(Bob - consultant psychiatrist / inpatient / non-smoker)

The currency of cigarettes is the other fascinating thing that exists in the hospital. It definitely happens in extended care. And, occasionally we have entrepreneurial people who charge considerably more than the cost of the cigarettes, or they’ll actually use cigarettes in order to get sexual favours...But it’s a case of knowing that it’s happening because a lot of these people are reticent to tell staff about other patients’ behaviour because it’s part of the culture that exists that you don’t tell. It has its own social rules...Smoking still accounts for the main form of language amongst the mentally ill.

The barter and sale in other drugs was also fully known by staff. They said they felt ineffective in preventing it’s occurrence, other than token attempts to contact police when they sighted known dealers in action on hospital grounds. A number of clients of extended care wards and other inpatient wards were known by staff as dealers.

(Terry – psychiatric nurse / inpatient / smoker)

There’s quite a healthy little skirt (drug dealers living nearby) around the hospital that do this (come into the hospital to deal in illicit drugs), and the oval over the other side of the hospital grounds has quite a little conglomerate of people that gather there doing their deals.

Reinforcement and Tacit Acceptance of Smoking
Several mechanisms were reported for the reinforcement and acceptance of smoking by clients and staff within inpatient settings. This too had a history according to staff participants. The structure of brief breaks for staff on duty in order to promote equity between smokers and non-smokers is one example of this.

(Grace – psychiatric nurse / community / ex-smoker)

(Reflecting on her time working in the hospital)

A smoke between the meals and morning tea break gave people just a little pause. And one ward that I worked in, they had devised a scheme where everyone had a break whether they smoked or not, because someone had decided that this [only letting smokers have a break] was inequitable.
Staff suggested several reasons for their current attitudes towards clients’ smoking; many of these touched on in previous sections. Smoking was seen as therapeutic and the last thing you would deprive clients of when they are unwell. Staff also believed that imposing smoking bans would jeopardise the doctor-patient relationship and effective treatment.

(Kate – trainee psychiatrist / inpatient / smoker)

*We tend to be a little bit guilty this was [condoning smoking], but I feel we really can’t work very well with an acutely unwell patient otherwise and we really do have to wait until they settle down before we can tackle it. Otherwise, we’d have many failures.*

Staff also believed that clients had nothing else to do and should be allowed to smoke as a result. Staff said that they found observing clients’ smoking behaviour was an effective assessment tool for observing their level of interaction and degree of paranoia or other mental illness symptoms.

(Chris – psychologist / inpatient / smoker)

(Noting that many staff case note entries were based on observations of clients’ behaviour while they were outside in the smoking area smoking) *Where there are limited activities for people, then one of the activities they are able to do is to sit out the back smoking which is actually something that isn’t frowned upon, but sitting in you room watching TV is frowned upon because it is perceived as being isolative.*

Overwhelmingly, staff comments demonstrated that they believed that the entrenched smoking culture was ‘just the way it is in psychiatric settings’ where many staff and clients smoke.

(Kate - trainee psychiatrist / inpatient / smoker)

(When she started as a trainee) *I remember thinking that everyone smokes, and getting to the point of forgetting to ask people how much they smoke. In general hospitals, that’s a compulsory question you have to ask patients to know what their physical health has been...you become complacent.*

Several staff talked about the use of ward cigarettes, that is, cigarettes bought by the hospital using canteen fundraising. These cigarettes were supplied to the locked wards for nurses to ration out to detained patients who had no cigarettes of their own and no access to cigarettes by other means.
It was $7,500 worth of cigarettes provided to the locked ward last year for ward cigarettes. It just escalated. I understand from the committee that it was meant to be $2,500 and it just seemed to escalate over the past few years. The staff just kept asking for more and more cigarettes...My concern is that one day the hospital will be sued. They never ask the patients if they have their own. They just keep dishing them out, and the patients who have their own get 6 free cigarettes per day.

Some staff spoke about the recent change in this activity, which now excludes distribution of cigarettes to minors and prohibiting them from smoking altogether. As mentioned previously, staff identified this change as leading to much distress for these clients, increasing assaults and verbal aggression in the locked wards by them and against them by other patients.

In the past couple of years we have enforced the under 18 rule for people in the locked ward, but before that, if they wanted smokes, then they were given smokes just like everybody else.

They became very distressed because a lot of them are heavy smokers and they get withdrawals. Some of them have been smoking for years, some since they were seven.

Many staff said that they were not happy with the current situation but felt that little could be done to change the current culture, given the perceived lack of resources and lack of alternative activities provided for clients.

If we only provide leisure time activities or groups of people watching TV or board games which nobody ever plays, or pool, or going for a walk, or sitting out the back smoking, we are inadvertently promoting it.

There is no activity in the hospital other than having a smoke out the back of the wards. The quality of activity that is provided is embarrassing.
Staff perceived that hospital administration was silent on the smoking issue and therefore accepted the current culture of smoking in the inpatient setting.

*(John - consultant psychiatrist / inpatient / ex-smoker)*

*I installed extractor fans and decided that there would be a smoking room...It wasn’t until probably several years later that the management discovered that the fans and the smoking were there, and they just elected to not know...If the truth be known, the court would rather not know.*

Admission of clients to the inpatient setting was seen, by all staff interviewed, as the surest initiation into smoking for clients if they had entered as non-smokers.

*(Jane – social worker / community / ex-smoker)*

*I know I had a lot of clients who weren’t smokers before they came into the locked ward and started smoking.*

*(Sue – social worker / inpatient / non-smoker)*

*I used to get quite frustrated with the way people used to learn to smoke while they were in hospital and came out smokers and couldn’t give up.*

*(Alison – career medical officer / inpatient / non-smoker)*

*The other unfortunate thing here is that, if they weren’t smoker before, they soon become smokers in hospital...(regarding those under 18 years old) We do know that they’re probably encouraged by some of the other unwell patients to do it and unfortunately there are areas that they can smoke that we’re not able to see them. It’s the same with other drugs…other patients will say to them, “Here, this will relax you. Why don’t you have a puff?”*

Staff spoke about their fears that future smoking bans would be imposed by management as a consequence of economic arguments rather than because of genuine concern for clients’ welfare. Participants commented on how doctors appeared to have quit smoking in droves as knowledge of the harms of smoking has emerged. They also commented positively on how young nurses coming into the system were predominantly non-smokers. Several staff comments reflected their increasing concern for the legal consequences of failing to address the smoking issue in the inpatient setting, although only one participant cited an actual case of successful litigation against the hospital involving passive smoking.
(Grace – psychiatric nurse / community/ ex-smoker)

*We put cages in the locked wards so people could smoke and I think that’s appalling, and I know that we’ve paid out nurses compensation because of the health effects of secondary smoke.*

(Paul – psychiatric nurse / inpatient / ex-smoker)

*It doesn’t take much to put 2 and 2 together and come up with a lawsuit 10 years down the track.*

Staff were increasingly concerned about the dangers of passive smoking and the greater ability of staff to escape from the smoke filled environment, whereas clients were seen to lack or be restricted in this choice. Staff said that smoking and non-smoking clients were often all in together in smoke filled environments in which the legal rights of non-smoking patients to avoid passive smoking were still largely ignored. Despite these concerns, staff continued to place themselves in situations where they were passive smoking and continued to distribute cigarettes to clients.

(6.7.2) Community Culture:

The culture of the community mental health service setting, as well as the community environment in which staff and clients interacted, showed similarities to and differences from the inpatient culture. In this section, staff comments on community staff reinforcement and acceptance of clients’ smoking and the impact of mainstream community cultural pressures to quit smoking are described. Like their inpatient counterparts, community staff participants’ comments demonstrated a range of reasons for the degree of smoking by clients. Some comments were also made about the hostel settings within the community. These will be noted along with the comparisons staff participants made between the hospital and community culture at the end of this section.

**The Reinforcement and Acceptance of Smoking**

Like their inpatient counterparts, the majority of community staff interviewed expected that their clients would be smokers rather than non-smokers.

(Robyn – consultant psychiatrist / community / ex-smoker)

*In my clients, I would expect them to be smoker rather than non-smokers because that’s the way things are and I tend to be a bit surprised when I come across someone who doesn’t smoke.*
The majority of staff believed that smoking would place significant limitations on and challenges to any long-term successful interventions with clients. Smoking was understood to be as much of a disability as the mental illness of the person by some staff, causing as many problems for the client; socially, financially and psychologically.

(Sam – occupational therapist / community / ex-smoker)

For many of the clients, when I started in this team, it was quite obvious, quite apparent, that the smoking was more of a disability than the mental health issues.

Community staff expressed differing views about client and staff smoking ranging from total acceptance to firm opposition. The majority of staff, however, supported their clients’ need to smoke, perceiving them as vulnerable and in need of protection in the community, as mentioned previously.

(Jane - social worker / community / ex-smoker)

There were times in the community when, if a client of mine ran out of smokes and he had 4 or 5 days to go before he got his money, I was more like to cross boundaries and even dip into my own pocket on 2 or 3 occasions to buy the client smokes, because I knew that the rules were so difficult.

(Marg – psychiatric nurse / inpatient / smoker)

(When she worked in the community recently) I certainly gave people the odd cigarette, like if I went around to visit and it’s the day before payday. I’d usually sit with them and have a cigarette with them, and give them one to have later...I think a part of it was because I had it on me, and I know what it’s like as a smoker not to have one on me...So I know the feeling they have about that. But I certainly never gave people smoke to get them through a day or more.

(Sue - social worker / community / smoker)

I think everyone in this team would have assisted people in their smoking. Certainly, everyone would have driven clients to shops to buy cigarettes. And if you’re that much against it you wouldn’t would you?
Staff also clearly described a sub-culture of mental health clients in the community, one that possessed observed the rules of barter and exchange of cigarettes, similar to their inpatient counterparts. This subculture was also seen to exist for illicit drug use by clients.

(Grace – psychiatric nurse / community / ex-smoker)

Community clients have a knack of getting what they need from each other. They tend to congregate together and share around until payday.

(Melanie - occupational therapist / community / non-smoker)

I guess I just take smoking as part of their diet, so it’s not something I go into depth about...Smoking also features around the clients anyway. They have a way of helping people out by giving them a smoke, withholding it if they don’t like that person, or a barter system. They do that at the hostel; they do that amongst themselves here at the clinic...It’s very much part of their occupation...They understand when someone needs a cigarette.

Many community staff said they were very concerned about the entrenched use of cigarettes by community mental health clients. They described clients as polarised from mainstream culture. They viewed policy and social changes regarding smoking as having had little impact on the mental health population. One nurse noted some of the paradoxes and problems faced by community clients regarding smoking.

(Grace - psychiatric nurse / community / ex-smoker)

I hope that society will get more and more restricted with what you can do with smoking. I don’t like that people can smoke in gaming rooms for instance. They seem to have become the culture of like what bowling alleys used to be. Yes, they are very welcoming and of course they provide food in those areas which is significant for many of our clients who don’t have much or don’t have the skills to cook much for themselves or don’t have the motivation.

Several community staff said they coped with the dilemma of appearing to condone clients’ smoking by clearly demarcating their role and their level of responsibility for clients’ various needs. Some staff subtly suggested that some clients took on a ‘sick’ role to account for their smoking. Some staff appeared to blame clients for their predicament, particularly when clients’ smoking seemed too entrenched to envisage any solution. Staff expressed frustration with ‘rescuing’ their clients repeatedly from the financial turmoil created by their perceived need for cigarettes, making
comments that indicated that they held clients completely accountable for their smoking and their claimed inability to quit.

(Jill – psychiatric nurse / community / ex-smoker)
In the community, if it’s Friday and the client has run out of smokes, then I’m more likely to say, “Well, you fix it”...It’s just one aspect of their life that they need to organise.

(Ruth – psychiatric nurse / community / non-smoker)
I think they are colluding by allowing people to smoke. If everyone who had a mental illness smoked then I would agree that smoking helps them, but they don’t. I think they’ve made a choice...I don’t think anybody needs cigarettes...It’s an addictive thing for the community at large...(Visiting clients at home and them asking if it’s OK to smoke) If you say to them, “Well, yes I do mind,” then they’re a bit taken aback because they’re so accustomed to other people saying, “No, I don’t mind.” They’re accustomed to workers accepting it. They are not really asking permission...I’ll make a choice not to go into that sort of environment.

Incongruence was common in comments by community staff. For example, one community nurse claimed that community clients have coped with the cigarette price increases and smoking policy changes and restrictions. However, she also stated that she did not think these changes would have any significant effect on lowering the consumption of cigarettes by clients. She saw them as addicted and choosing to continue to smoking.

Community staff said they were very aware of the social factors that perpetuated clients’ smoking in the community, particularly peer smoking and the perceived lack of meaningful activity and purpose for many clients.

(Peter - psychologist / community / ex-smoker)
There’s nothing that I would see meaningfully happening and so smoking becomes part of things that they do like eating, drinking; it passes the time.

(Kathryn - psychologist / community / ex-smoker)
With the clients, it’s almost like there are dual systems operating, so that for us the pressure is immediate but for them, because a lot of their social group smoke, it’s not.
This view was also accepted and reinforced at the community rehabilitation house where staff made allowances for clients who were smokers and gave them a designated smoking area which took on a sub-culture of its own. One occupational therapist explained this.

(Melanie - occupational therapist / community / non-smoker)

I suppose I really do try to accommodate the needs of clients. I suppose they need to smoke, like if I’m running groups, I’ll incorporate smoke breaks because I’ll see clients getting really agitated and really needing a smoke. So in order for them to even get there, it’s a sense that they’re OK to bring their smokes with them. They wouldn’t get there otherwise...We want the rehab house to be a place where they can come and learn...so to set rules like “You can’t smoke at all,” would mean that people wouldn’t turn up.

(6.7.3) Comparison of the Hospital and Community Smoking Culture:

A number of staff had clearly begun to question and express concern about the hospital and community cultural environments in which clients’ smoking occurred. They saw the culture of the hospital and community settings as being manifestly different, due primarily to structural and practical differences between the two settings. Staff also commented on the pros and cons of each setting. They saw the hostel environment as a special case in which the worst elements of each setting came together to perpetuate an overwhelmingly smoking culture for clients who lived there.

Staff commented on the lack of meaningful activities for clients in both the hospital and community setting. Smoking reinforcement was, however, perceived to be stronger in the hospital setting because the clients’ response and reactions were perceived to be more constrained by the physical restrictions of the environment. The community was seen to provide more opportunities for diverse activities, provided that clients took up those opportunities.

(Ros - social worker / inpatient / ex-smoker)

There’s a camaraderie that goes on around smoking; a social interaction. It gives them something to break the ice with...They are also in closer proximity to strangers when they’re in hospital and it’s a challenge to them. They have to socialise more, sharing meals, and space with people. I think basically we’re social animals. It's very difficult not to join in, to decline gracefully and still maintain social contact with people here. When they’re at home on their own, there aren’t the social challenges there.
One staff participant proposed that the structural differences in the settings directly affected clients’ sense of power and control over their smoking and therefore their ability and motivation to quit. Several community staff spoke of several clients in the community who wished to quit smoking or who were contemplating quitting. In contrast, hospital staff rarely mentioned their clients in this respect. The priority of treatment of their mental illness has been discussed, however, there may be other reasons for this difference.

_(Sasha - occupational therapist / inpatient / ex-smoker)_

_(On how the community clients are different to hospitalised clients)_ That’s easy. Their power base is bigger. They’re not in ‘our’ building. They’re not classified as an inpatient. We don’t have a hold of their car keys or their cigarettes. We don’t know what’s in their pocket.

Another staff participant argued that the greater sense of freedom for clients in the community did not necessarily mean that their quality of life was better than inpatient clients.

_(Terry – psychiatric nurse / inpatient / smoker)_

_The hospital is actually more social than what I understand is often a very isolated existence for some who might only see their community nurse. And it depends how you look at it in the hospital; less freedom or more structure. You can have all the freedom in the world but be sitting in a unit all by yourself._

Another staff participant drew direct associations with how she works differently with clients in each setting, according to the influences of the setting.

_(Jane - social worker / community / ex-smoker)_

_The focus in the hospital is still that they need their smoke and even in the community, but that seems to be changing...And now back in the community, I haven’t smoked for some time, and I have clients now who run out of smokes, and I say, “I don’t care. You have a choice. You’ll get through it.” I have a different level of feeling that I have to rescue them, like the dangers of someone not having a cigarette in the locked ward are quite different to the community._

Staff also made comments on how they saw the current anti-smoking climate influencing the smoking behaviours of mental health service clients in the community, in contrast to the hospital setting. Staff views varied in this respect.
(Liz - occupational therapist / community / ex-smoker)

I think there’s a need in group programmes like that to set some boundaries for what is, and when is, acceptable and unacceptable smoking behaviour because that is what general society is like. They are in the community and need to learn the norms, else they won’t fit in...There needs to be some acknowledgement of, “This is what the rest of society does in relation to smoking.”

(Jane - social worker / community / ex-smoker)

(Challenging the previous comment by Liz and others, and questioning whether we have really come very far in our attitudes in the community)

I don’t like that belief at all. I think that it clashes with something else in that a lot of the clients we work with, and the clients certainly from my background in extended care, there are a lot of clients who just don’t want to be in the community, and it’s our dictate that we have a mental health policy that says we think it’s good for them, and that we think that’s a better way for them to live. I’ve worked with just as many clients who don’t like to be in the community, that like the institution, that would like the institution to be a bit more friendly, but have more social supports in the hospital and more friendships there, and in some respects have a better quality of life...We don’t often ask clients about whether they want to be in the community. I think that’s just as much an institutional mentality as what it is about putting people in hospital.

Staff in the MACS team, in particular, said they were aware of the dilemmas involved for staff working with people who had been transferred from the hospital setting to the community after extended periods as inpatients. The reality of clients’ enculturation into smoking was noted.

(Brian - psychologist / community / non-smoker)

(Regarding a colleague in MACS who worked diligently to organise and co-ordinate a client’s cigarette supply with the Public Trustee and local deli owner) He was four years in extended care, and for God’s sake, four years in extended care is enough to change anyone. I suspect that all he did for so long was line up for his smokes, so it just became his reason for living almost. It was one of the few things that he could actually do, was light a cigarette.

Several staff expressed frustration with the lack of continuity in care between the inpatient and community settings. They commented on how staff of each setting sometimes disregarded each others’ input with clients, with the result that little consistency was achieved. This was viewed as
detrimental to any consistent intervention with the client and their wish to quit smoking or remain a smoker.

*(Liz - occupational therapist / community / ex-smoker)*

Hospital is a small part of a person’s whole life, and you have to take it in that context, whereas, when I was in the hospital system, there was a great deal of thought as to what’s the management plan for that person in the community and how can we continue that while they are in hospital and then continue for when they go home. That continuity of care doesn’t seem to be there. It’s like, “Well, you’re in a different place, and this is how you have to function here.”

Community-based hostels were described as a blending of cultures between the hospital and community setting; often their worst elements. Although they were located in the community, hostels were described by staff as places that often mirrored the environment of an extended care hospital ward where the majority of clients were smokers. Staff noted the strong peer smoking reinforcement, the lack of alternative activities and the regimentation of meals, medication, money and cigarette distribution that occurred in hostels. The central focus of smoking in the lives of hostel clients was noted.

*(Sue - social worker / community / smoker)*

In boarding houses, smoking is the one connecting factor that all of them, whether they’ve got an intellectual disability, whether they’re female or male, or what nationality. Smoking is the one thread that links the whole lot together. I suppose because it’s such a social experience; their only social activity I suppose. To be able to sit and talk, even if they don’t say much, just, “Hi, how are you going?” and to be able to smoke while you’re doing that and to be part of that group is very important...Most of the boarding houses dole out cigarettes at certain times as well, and everyone lines up and they follow that hospital system of packaging them up and having people’s names on them. It’s like an extension of the hospital ward.

*(Sam - occupational therapist / community / ex-smoker)*

Their behaviour would centre around finding or obtaining cigarettes in any other way they could, like barter, exchanges and looking for butts and, in the boarding houses, actually prostituting themselves for cigarettes.
Some staff expressed concerned about the impact of smoking policy changes, especially rising prices. This was of particular concern for hostel clients who had little money to spare after paying hostel fees. Staff said they believed that clients would continue to smoke at their current level even after cigarette prices increased. This assumption was based on practical experience also.

(Jean – social worker / inpatient / non-smoker)

They’re set into a rigid pattern of fees and they would see that there is less room for negotiation. The other thing is that you’ve got so many reinforcers around you in that environment and it’s like you only have $70 a fortnight left after you pay the fees in order to get every other need. For the people living independently in the community, they’re able to switch to home brand products or to ask for food parcels to compensate for the price increases. They have a bit more flexibility and movement when they live on their own. Hostel clients don’t have this option.

(6.8) CONCLUDING COMMENTS ON STAFF INTERVIEWS:

Staff expressed many concerns about the high rate of smoking by clients within the community and inpatient settings. They expressed feeling overwhelmingly powerless to deal with this problem, given the entrenched culture of smoking in mental health settings. They responded in a range of ways, many of which overtly or inadvertently reinforced the problem. Most staff said that they found the interview process gave them the opportunity to discuss their views on smoking in a productive way. Many said that it had been their first opportunity to more fully consider the ethical dilemmas associated with smoking in their workplace.

From the comments made by staff, several points are the same, similar, or bear direct relationships to comments made by clients who were interviewed. The high order of priority given to cigarettes and the central role of smoking in helping staff to cope with and to manage the mental health service environment is of particular note. Many aspects of mental health service settings appeared to influence smoking behaviours for both clients and staff. To further validate the comments of clients and staff and to elicit more detailed information on the dynamics of interactions involving smoking, participant observation of the settings was seen to be necessary. Distinctions between the settings were also implied by clients and staff and these needed to be tested and understood more fully. The hospital setting emerged as a primary setting in which the smoking behaviours and dynamics of interaction described by clients and staff were concentrated. It was therefore targeted for participant observation. The participant observation data follows in the next chapter.
Table 6.6 below summarises the points raised by staff. As with client interview results, these points will form a component of the triangulation of results to be discussed in Chapter Eight.

**Table 6.6: Triangulation Phase Two: Summary Themes from Inpatient and Community Staff Interviews**

<table>
<thead>
<tr>
<th>High Order of Priority for Clients</th>
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<tbody>
<tr>
<td>- priority of harms and risks</td>
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<td>- neglect of physical health</td>
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<th>Professional Ethical Responses/Dilemmas</th>
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<td>Attitudes and Beliefs</td>
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<tr>
<th>Clinical Management Tool</th>
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<tbody>
<tr>
<td>- rapport, routine, symptom management, behaviour management, relapse prevention, assessment, conditioning</td>
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<th>Personal Management Tool</th>
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<tr>
<td>- stress, boredom, debrief, break-time, time out, socialisation, belonging, addiction, relaxation, conditioning</td>
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<tr>
<td>- skills and training, coping and support</td>
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<tr>
<td>- nicotine withdrawal versus illness management</td>
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<th>Us and Them – fear, stigma, paternalism</th>
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<th>Control</th>
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<th>Poverty</th>
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<th>Systemic Issues</th>
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<td>- historical context/culture of smoking</td>
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<tr>
<td>- duty of care, breaches</td>
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<td>- abuse and neglect</td>
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<td>- reinforcement</td>
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<th>Professional Differences</th>
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<th>Legal Issues and Occupational Health and Safety</th>
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<td>- violence</td>
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<td>- passive smoking</td>
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<td>- health problems</td>
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<th>Environment and Terminology – ‘the cage’, ‘inmates’, ‘a lost cause’</th>
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<th>The Community Hostel – Mirror of the Asylum</th>
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<th>Differences between Hospital and Community Staff</th>
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CHAPTER SEVEN

STUDY FOUR: PARTICIPANT OBSERVATION OF MENTAL HEALTH SETTINGS

(7.1) INTRODUCTION:

Using the ethnographic method of qualitative inquiry, this phase of the research aimed to study the cultural group (staff, patients and hostel clients) in their natural setting (hospital and hostel) during a prolonged period of time collecting primarily observational data. The purpose was to observe and describe the cultural patterns of behaviour, the perspectives of the participants and the setting in which the culture is manifested. This involved describing the relationships between culture and behaviour by getting out into the settings to have a good look at what goes on within them. Following qualitative interviews with clients and staff, triangulation of the data collection and the primary analysis was completed with participant observation of the settings described by clients and staff during the interviews. The main objectives of the participant observation were to observe participants’ smoking behaviours first hand and to test and to verify the qualitative data regarding smoking behaviours within the systems of care, as suggested by client and staff interviews. These aspects were summarised in table seven in the client results chapter and table thirteen in the staff results chapter. Three mental health settings were identified for participant observation for the following reasons:

(7.1.1) The Psychiatric Inpatient Setting:

The decision to perform the participant observation study in the inpatient setting was based on the political, socio-cultural and anthropological significance of the findings from the qualitative interviews. Historical and current systemic barriers to quitting were identified by participants, emanating from the mental health system in general. In many respects, the hospital was identified as a ‘total institution’ that appeared to shape and guide the beliefs and attitudes about mental illness held by staff and clients. In this setting, cigarettes were identified as the currency by which economic, social and political exchange took place between the various players. An enculturation process was described by participants. Once entered into, escape from the smoking behaviour, reinforced by the culture, appeared to be extremely difficult for clients.
(7.1.2) The Community Mental Health Service Setting:

This setting was likewise identified by staff and client participants as a place where interactions between members were perceived to be shaped and reinforced by the culture of the service and system of care. However, the influence of larger societal pressures for change in smoking behaviours was also evident and a more powerful reality for community clients. The community system of care appeared to respond to these changing trends towards smoking cessation more readily than its inpatient counterpart. The reasons for this require further exploration and elucidation beyond the scope of this thesis. Attempts to undertake participant observation of this setting proved problematic due to the nature of interactions between staff and clients occurring predominantly in clients’ homes. Issues of privacy and confidentiality could not be overcome. The auditor confirmed the researcher’s concerns and participant observation within this setting did not proceed.

(7.1.3) The Community Hostel Setting:

The cultural significance of smoking within mental health hostels was also defined by participants. A number of participants claimed that this environment reflected aspects of institutional care and reinforcement of a smoking culture among its members, both staff and clients. The hostel was described, by some participants, as a mirror image of the extended care ward, with the same level of institutionalised formal and informal rules, routines and behaviours in respect of smoking. Testing these ideas was therefore of interest.

(7.2) DESCRIPTION OF THE SETTINGS:

Participant observation occurred at the psychiatric hospital and two community hostels where mental health clients were housed.

The hospital was a public stand-alone psychiatric facility within a metropolitan area of Australia. The metropolitan area served by the hospital comprised a population of approximately one million people. The hospital had a current population of approximately three-hundred and fifty patients (clients) and a staff population of four-hundred and fifty nurses and three-hundred professional and service staff. It comprised a series of open, locked and extended care wards staffed by multi-disciplinary teams with staff drawn from the professions of psychiatry, general medicine, nursing, social work, psychology, occupational therapy, administrative and ancillary services and volunteers.
The hospital had a significant history with several of the buildings being declared by the National Trust for preservation. The hospital displayed many features of a ‘total institution’ (Goffman, 1961a, 1961b, 1961c) with many of the clients having the majority of their needs met within the hospital grounds and subject to set routines and schedules imposed by the system of care. In the past, the hospital also had workshops, orchards and market gardens within its grounds, now lying idle or sold off for housing as it is increasingly encroached upon by the surrounding suburb. At the time of participant observation, the remaining grounds comprised expansive shady lawn areas under tall pines and gums. There was a sense of sanctuary within the hospital grounds in contrast to a number of secluded areas within these grounds, better known these days for their drug dealing activity and sexual exchanges. The various buildings were mainly one and two storeys with gargoyle statues still keeping watch on some of the corners of the older buildings. The hospital was bounded at its entrance side by a low wall; it’s taller counterpart having been removed in 1964 with the process of deinstitutionalisation. Remnants of the mote, used to prevent escape, still existed outside the entrance to the main building. Regarding the various wards, all had an outside area, designated for smoking and recreation, where both clients and staff congregated. This had become the social hub of each ward and this was the primary place for performing the participant observation. Up until May 2001, the hospital canteen held a license to sell tobacco and provided free cigarettes to indigent patients in the locked wards.

Participant observation also occurred in two hostels within the region. The first of these had a resident population of twenty-four with predominantly older clients between the ages of 45-80 years. The second hostel had a resident population of twenty-four with predominantly younger men and women between the ages of twenty-five to fifty years. Both hostels were characterised by set routines and rules of behaviour, set meals, shared day areas, shared bathrooms and toilets and few single rooms, most clients sharing bedrooms with one to five others. Bedrooms were often sparse and cramped with only a few personal belongings of residents visible. Many clients had few belongings. Both hostels had outside covered areas with seating where the predominant activity appeared to be smoking. Both hostels housed male and female clients, the first with predominantly female clients and the second with predominantly male clients. The hostel staff were non-professionals, with minimal nursing or mental health training. Local GPs visited the hostels regularly, at set times to see clients for medical review and to administer psychiatric treatments. Most clients had an assigned key worker from the community mental health clinic, with a clinic doctor or psychiatrist overseeing the psychiatric medication needs. During the day clients either remained at the hostel or went out to the nearby shops and streets. Some attended rehabilitation
activities or sheltered workshops. These hostels were chosen because they were typical of hostels that house mental health clients, as per the researcher’s knowledge and experience. They also covered a wide range of client characteristics concerning age variation and level of disability and ability, as well as offering two distinct examples of informal and formal care practices, together giving a good general picture, also based on the researcher’s knowledge and experience of such settings.

(7.3) DATA COLLECTION:

The settings were visited at random, except at the locked wards where negotiation of entry was made with the CNC for the ward prior to each visit. Extensive journal notes were kept, recording observations, interactions and reflections from each setting and each visit, either as the settings were being observed or as soon as possible after this took place. The researcher was present in each setting in varying lengths of time as observer and participant, dependent on the setting, the needs of staff and clients and the circumstances on the day. For example, in the acute locked ward, observation from the nurses’ station was the dominant mode of data collection, because the staff expressed concern for their own stress levels if required to watch out for the researcher’s safety, on top of performing their usual duties with clients. However, this did not limit direct participation with staff within the staff areas. In the extended care locked ward, the opposite was the case, with the researcher being a full participant with staff and clients, due to the nature of the setting and its routines being undertaken by the group as a whole. In this setting, interaction with both staff and clients was extensive, sharing daily routines such as meals and movement en masse to and from the different areas of the building as a group. Similar high levels of interaction and inclusion as participant were also possible at the community hostels and at the hospital canteen and its immediate surroundings. Notes and observation sheets were kept with the full knowledge and acceptance of participants, with many sitting next to or near the researcher at these times. All questions put to the researcher were answered openly and often provided the foundation from which further conversation took place. The researcher remained flexible at all times, displaying a full range of behaviours along the continuum of complete observer through to complete participant, dependent on the circumstances at the time. A small number of artefacts were collected. These included the hospital smoking policy, floor plans of some of the settings and transcripts of smoking signs and rules. The total number of visits to each type of setting was as follows:
Table 7.1: Number of Visits Performed in Mental Health Settings

<table>
<thead>
<tr>
<th>Setting</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Locked Ward</td>
<td>4</td>
</tr>
<tr>
<td>Extended Care Locked Ward</td>
<td>5</td>
</tr>
<tr>
<td>Acute Open Ward</td>
<td>9</td>
</tr>
<tr>
<td>Extended Care Open Ward</td>
<td>8</td>
</tr>
<tr>
<td>Canteen/Grounds of Hospital</td>
<td>5</td>
</tr>
<tr>
<td>Community Hostel (1)</td>
<td>6</td>
</tr>
<tr>
<td>Community hostel (2)</td>
<td>6</td>
</tr>
</tbody>
</table>

(7.4) **DATA ANALYSIS:**

As per the methodology chapter, data collection and data analysis tended to occur simultaneously using the constant comparative method of checking and cross referencing the data. Journal notes, memos, supervision notes, audit session notes, artefacts and data from observation sheets were drawn together to form the overall results of participant observation.

(7.5) **COMMUNICATING FINDINGS:**

Results from the participant observation phase are presented in the following ways: firstly, snapshots are given in the form of vignettes that describe a typical day in the life of the people in each setting, the aim being to present a holistic description of the everyday experiences of staff and clients in the settings. Each vignette is followed by a description of the dominant characteristics of that setting and participants within it, that is, the most prominent cultural patterns that emerged in relation to smoking. These dominant characteristics were determined by coding the data collected from each observation period in that setting, then drawing together all the data from that setting into chronological order and recoding the data from this larger data set. As mentioned above and in Chapter Three, constant comparison of the data was part of this process, being particularly important in testing ideas and leads. These dominant characteristics reported about the settings and interactions between its members were routinely apparent during all visits. A description of quantitative data from the observation sheets is then provided. In the final section, all aspects of the participant observation are drawn together as a series of themes that describe the overall picture of life in these settings.
(7.6) RESULTS FROM THE SETTINGS

(7.6.1) The Acute Locked Ward: (beds = 10)

Afternoon in the nurses’ station sitting room leading into the work area overlooking the clients’ day room. The clients’ area, with its absence of décor except for foam seats in the centre of the room and a television attached high up in one corner, is in stark contrast to the cramped and narrow nurses’ area, crowded with desks and other office furniture and several years collections of cartoons and memos stuck haphazardly on every piece of available wall space. It’s hard to decide who is in the fish bowl, the staff or clients; who is the watcher and who is being watched, as each is separated from the other by a series of waist high glassed panels and doors that allow for complete vision by all to all daytime areas. The nurses have just finished supervising lunch. Keys sound to unlock the series of doors that lead all back through to the day room. A male nurse comes through from the adjoining door, ready with the ice-cream container of cigarette packets, ready at the nurses’ station door. He stands with the door ajar and calls out in a loud voice: “Who wants a smoke?” He calls again just in case some of the patients didn’t hear the first time. Next to him, stuck on the glass, is the smoking policy for the ward and details about the hazards of smoking and passive smoking. As quickly as he has reached the door from one direction, the patients have come through and some are already lined up waiting for their cigarette. The smokers’ cage is a small concrete-floored room of approximately two metres by three metres, attached to the ward with wire mesh on the two exterior walls to give access to the open air and therefore fulfilling the smoking policy requirements of no smoking indoors. It becomes quickly crowded with eight of the ten patients and two staff members, all smoking. One nurse squats on the concrete floor of the cage, rolling herself a smoke, engaging in calm conversation with one of the clients. It’s an opportunity to relate to some of the clients and get to know them better. Others stand concentrating on the ritual, tolerating each others’ company momentarily, nervous and suspicious, relieved to finally have something to do. The two non-smokers wander aimlessly in the day area unattended.

As the afternoon wears on, the staff busy themselves with answering phones and doing paperwork. They take turns at sitting in the patient day area, reading the paper, coming in to the nurses’ station for respite periodically. Clients pace aimlessly in the day area, occasionally coming near the glass to look in to see what the staff are doing. Staff tend to remove themselves into the second room away from clients’ view; clients tend repeatedly to approach the glass to glare silently through at staff or bang on the nurses’ station door for attention when they see a staff member in the work station.
There doesn’t appear to be a happy medium; the barrier is fixed. The staff continue with their tasks, sometimes offering calm reassurance, sometimes ignoring, knowing that the requests for cigarettes will be denied as it’s not smoke time yet. In the day room, a client lies on the foam couch in the middle of the room sleeping, a blanket half falling on the floor next to him. Others pace and hover. Few clients exchange words with each other. Many stare suspiciously, walking guardedly within the small empty space of the day room. The main entertainment is watching the nurses move around from behind the glass. The grassed enclosure that serves as an exercise yard opens to the fresh air but is not used today; the door remains locked. Through the wire mesh of the cage and the nurses’ station glass, the blue sky is clearly visible.

In the seclusion corridor, a young female client cries out and bangs defiantly on the locked door leading into nurses’ sitting room, the Venetian blinds drawn from the nurses’ side to give them some respite from her gaze. The nurse calls out gruffly, “Have patience, I can’t do everything at once.” The client wails, paces, staggers, acts confused as the nurse reassures her finally, “Have a bit of a rest and then I’ll take you out for a smoke.” A short time passes and the secluded client becomes restless again, “I have rights you know.” The nurses retort, “We have rights too, not to be yelled at.” Two nurses stand quietly, imposing, speaking softly to the patient at the doorway. The desired effect is achieved; she settles briefly. They re-enter the staff area, shutting the door quickly behind them and agree that this case warrants giving her a cigarette to pacify her, sooner rather than later. She is taken through the doors and assisted to smoke, then returned to the seclusion corridor. All is calm. Meanwhile, another nurse hurries to the nearby shop to purchase cigarettes for his client. He’s on his tea break and happy to oblige. Outside in the ‘sheep run’, the security corridor between the locked wards, a casual agency nurse sits alone, relieved to be having a break away from the milieu, smoking hard on a cigarette.

**Dominant Characteristics of the Acute Locked Ward:**

**Smoking as a core activity**

Of the total number of patients present in the acute locked ward, most or all were observed to participate in the smoking routine at each designated smoking time. All cigarette packets were kept together, labelled and ready near the nurses’ station door leading directly to the patient area. Clients often knocked on the locked nurses’ station door or stood next to it waiting for some response from staff. Staff often went about their duties within the nurses’ station in spite of this, often only responding when the client’s behaviour appeared to escalate. Clients frequently needed to be told to
wait when they requested cigarettes outside of the designated smoke time. Staff smokers were frequently observed to join in the smoking routine with clients during these designated smoking times. Several staff commented on the problems associated with having clients who were under 18 years old on the ward, where they were established smokers but denied participation in the smoking routine. Verbal and physical aggression by clients, towards staff and other clients in the context of cigarette supply and the smoking routine, was commonly reported by all staff who were spoken to during the participant observation period.

**A low stimulus environment**

Apart from set meal times and set smoking times, other structured activities were absent. The clients’ television was switched on at various times, although few clients were observed to be watching it. Most clients paced or wandered back and forth in the day area or sat, usually alone, or slept, especially throughout the afternoon. Nurses variously took turns at spending time in the clients’ day area, some reading the newspaper, doing a cross word puzzle, or playing simple card games with a client. The workload of nursing staff was observed to be unpredictable; sometimes they were very busy making phone calls and organising around particular requests, and at other times experiencing extended periods with few duties other than being present on the ward. Reading and sitting talking with other staff was common. Most staff took the opportunity to have their lunch break away from the ward altogether. Doctors usually only entered the clients’ area to perform detention reviews and clinical reviews, otherwise they made notes and performed other duties in the staff areas often away from clients’ direct vision or away from the ward altogether.

**The nurses’ station door**

The nurses’ station door acted as the most common point of interaction between staff and clients, with shared smoking in the smoking cage being the second most frequent interaction point. Meal times were the third most frequent interaction periods, this being when medications were also routinely distributed. Individual nursing care duties involving personal care for clients was also a routine part of the day, as were detention reviews where nurses accompanied doctors into the clients’ area. The nurses’ station door was the point where most requests were made and most interaction was initiated between staff and clients once they were on the ward. It was also therefore a common point from which refusals or limit setting by staff and protests by clients occurred. The promise of cigarettes was often made by staff in order to manage clients’ mood and behaviour. Conversely, clients were regularly heard to threaten to ‘act out’ when denied cigarettes outside the
designated times. During the observation period, no reference to the use of NRT was made, and none was observed to be offered or used.

(7.6.2) The Extended Care Locked Ward : (beds = 11)

It’s 7.25am. The nurses have congregated in the nurses’ station for handover. The room is extremely cramped, with staff standing huddled together, those without seats leaning against the wall and the doorway. The dull lighting hides the ageing paint and evidence of disrepair. The last of the night staff have just gone. A couple of clients in the corridor tap tap on the small, high glass window separating the staff and patients. No response given except for a silent glance. “They know the rule – requests only at the designated time.” The glass dulls their voices. They gesture for cigarettes in almost playful defiance, testing the limits. “They know that smoke time is not for another five minutes. The limit setting and consistency is important in helping them with their cognitive disorganisation.”

Out in the entry area, now a makeshift space for the medication trolley, one nurse takes ironic delight in showing me the stair case leading to a now disused part of the building; the vinyl covered steps scarred with the many butts that were stamped out as clients and staff from another era entered the building, the black dots appearing less and less as they ascended. He recounts vivid scenes of smoke filled rooms. “Everyone smoked”. The burn holes on the floor underneath each window are large and profuse where once there were large ashtrays. Renovations have been a long time coming here. He recounts the day management came for a tour during a rain storm, to find “buckets here and there catching the leaks and possum piss running down the walls…They don’t come here very often. We’ve been waiting years for the plumbing to be fixed.”

Smoke time every hour, on the half hour. Everyone cues ready as usual, some chatting and more sociable, others quiet and withdrawn. They all know the routine. Most have been here a number of times before from the open wards and are known to the staff. Their faces express an odd mixture of disappointment at being here again and jovial camaraderie. Some are watching and waiting. Most are in their late twenties and thirties. They pass through the doors one by one once everyone is assembled, cigarette in hand, after the nurse has attentively handed them out one by one from the makeshift lunchbox, making sure each client has their own cigarettes according to the names on each box. One client doesn’t have any. Today is payday but the revenue department is not open yet. It’s too early. The nurse provides him with one so he doesn’t miss out. He has been good this
morning and the nurse perceives that he needs a smoke as much as the others. In the courtyard, we enjoy the morning air and light conversation. Everyone is satisfied.

The staff take the opportunity to talk about their concerns as they smoke and watch the patients. It’s time out for everyone. They are disgruntled with the social worker refusing to do a bank run for smokes money for the clients now that the case aide’s contract will not be renewed. “Isn’t that her role after all. For what else do these patients need in reality.” One nurse tells me how this environment is much less severe than the prison system where people sometimes go a whole week without cigarettes. Another nurse talks about a young female client, how she has been transformed in the system of care here, how in the past she was rewarded with food to comfort and settle her excessive, often unmanageable behaviour. Attractive then, she is now obese and hardly recognisable as her former self. She returns here often, rarely out for a day before some act of self-harm brings her back to familiar surroundings again.

It’s late morning now. It’s going to be a scorcher today. The day room is filled with both clients and staff, passing time. It’s too hot to go outside. Here and there clients lean against the wall, sit on the floor, or lie down on one of the foam couches. Smoke time. The nurse positions herself at the door to the smokers’ cage, a shady room buttressing the outside with wire mesh and railed seats all the way round the edges. She holds the lunch box of cigarette packets under her arm, lighter attached at one corner with a string. She tells them in her organised voice to line up along the line, marked with tape stuck on the grubby carpet on an angle to the door. They do so without argument, one behind the other, waiting for all to assemble before the door is opened. She calls out and reminds them to ‘Get in line”, as they increasingly crowd her. Another nurse comes to her aid with another lighter, one each side of the line. They create a smooth production line through the door, lighting cigarettes as they go. The usual nurse sits out there with them, smoking and supervising. Another nurse takes the opportunity to duck out the back to have a quiet smoke on his own. I ask a nurse why this ward is particularly sociable with staff spending much of their time during the day in direct contact with clients. “I suppose we try to make the best of it seems we’re all in here together. Then everyone is better off.” In the smokers’ cage, the nurse is lecturing one client about the risks of sharing butts and transmitting diseases. Others sit more quietly, concentrating on their smoking ritual.

It’s afternoon and hot. Lunch is over. The cutlery has been counted and is all accounted for. The clients and staff have moved back to the day area. One nurse decides to spend some time outside with her clients under the trees in the enclosed yard. She takes their smokes with her; a bonus
smoke to help set the recreation time. Lunch was stodgy today. One nurse shows his disgust. “The dietician should be sacked. Do they realise the level of bowel cancer and other physical illnesses in these people.” The chooks [chickens] appreciate the left-overs. Inside, two nurses sit planning and reading up on their notes. They’re organising the shopping list for the afternoon in preparation for the weekend ahead. There is much discussion about where the best prices for smokes and coke are, and what shops are a rip off. One nurse rings the supermarket to check their specials for the day. In the day room, one client maintains her stance not to eat or drink. Her goal: “To die”. She continues to join the smokers’ queue throughout the day.

**Dominant Characteristics of the Extended Care Locked Ward:**

**Togetherness**

The style of interaction between the staff and clients was the most noticeable feature of this setting. Both staff and clients shared a very high rate of smoking and smoking together during the set smoking periods. Staff in this setting spent much time in the clients’ area and in direct contact with them, often playing pool or in light conversation. Staff routinely joined in during meal times also. At these times, the uniforms worn by staff were arguably the only feature that clearly distinguished them from the clients; as one staff member put it, “We’re as institutionalised as the patients”. Humour was common between them and the group cohesion, ritualised routines and regimentation was striking.

**The centrality of smoking**

The regimentation and routines involving smoking appeared to form the foundation from which all other activities and routines were measured and prescribed. Meals, ward rounds, movements between the day-time area and the night-time area were always preceded or followed by a smoking period. Cigarettes packets were individually labelled, budgeted for and bought by staff from the canteen on campus, and metered out at set times and lit by staff. An important role for each nurse was to ensure that their clients had sufficient funds from their pension, managed via the revenue department, for the purchase of enough cigarettes to meet their immediate needs. All clients were observed to be smokers and were totally reliant on staff to ensure their supply of cigarettes whilst in the ward.
Together but separate

Under these circumstances, daily care was described by staff as a process of behaviour modification, the goal being to help clients learn that there are consequences for actions. This interaction occurred in the context of a parenting role, with many of the clients known to these staff over a long period of years. However, this was tempered, at all times, by the potential for violence by clients, and the conscious process of providing maximum security care with all its attendant keys, locked doors and regimentation. The starkness and poverty of the décor was oddly balanced by the chooks that roamed the internal enclosure. In response, the clients ‘played the game’ and largely co-operated with the institutional rules and routines, their goal being to be seen to be behaving in order to gain the freedom of the hospital grounds once more. The revolving door cycle of clients returning to the ward was regarded as inevitable. Hence, coexistence by staff and clients in this ward was always flavoured with an ‘us and them’ ambience to all activities and interactions between staff and clients. The sociability and communal feel on the ward served to reduce the incidence of violence and to help alleviate stress levels for both staff and clients, as they each dealt with the incarceration. Within this context, staff also felt separate from their colleagues in other wards and particularly suspicious of management whom they perceived as having little understanding of the realities of care in the context of incarceration. One staff member explained the ward’s uniqueness in this way, “We’ll have them even though all others have rejected them.” Staff enjoyed their exclusiveness, their high walls allowing them a peculiar type of autonomy within a system that they saw as largely foreign to them. For example, they recounted with delight, the day that they managed to get a donkey inside their enclosure without the knowledge of the rest of the hospital. This ward truly felt like an asylum enclosed within the larger system.

(7.6.3) The Open Ward : (beds = 24)

Early morning driving into the hospital grounds past the open ward enclosure set aside for the early morning risers prior to the main entrance door being unlocked for the day. It’s a crisp and clear morning. A group of six clients and a night-staff member congregate, smoking, inside the open door leading into the activity room that doubles as a staff meeting room for ward rounds. They’ve learnt that the fire alarms don’t go off if they blow the smoke towards the open door. On the wall the sign reads, “This room is a declared non-smoking area.” Someone has blocked out the ‘non’ with paint some time ago by the look of the faded colours.
Late morning outside the main entrance door to the ward, numerous clients congregate; some in small groups, some more isolative, suspicious, openly voicing or mumbling paranoid ideas, sitting away at a safe distance; sitting against the wall, lying on the grass, or sitting at the table and chairs next to the door. All are smoking. Some sit, others stand and pace up and down the path leading to the ward. It’s a day like every other day. The boredom is numbing. Mealtime gives brief relief. The radio blares out across the whole area. No-one is listening to it. One client is intrusive and suspicious. He sets the mood for the area. The other clients keep their distance. They feel uneasy needing to be in the same area in order to smoke. The reminder of his unsettledness isn’t helping them. They focus on the smoking and draw hard. Inside, the staff are constantly on the move, getting requested items for their clients, answering phones, running errands, or writing notes. The smokers among them come out to join the patients for a smoke when they have a free moment. A client comes in to use the nurses station phone to give a relative a call to negotiate them bringing in some clothes for her. Another client, having just had a shower, sits at the desk as his nurse helps him comb through his long matted hair. The environment is reassuring as they chat amongst themselves.

One client returns from her walk around the grounds; it’s her fifth for the afternoon, she says. She sits and lights a cigarette and is momentarily occupied and relieved. Another client joins us, looking perplexed, “I’ve got to try not to keep sleeping all day.” He lights another cigarette and stares out across the lawn. Inside, clients sit on the worn and grubby lounge chairs lined up in the small foyer adjacent to the door, watching the activity as nurses and clients come and go. Occasionally, one gets up to have a cigarette outside. It’s a continual rotation of sites throughout the afternoon. The music blares on in the background.

Early evening now, and the smokers’ area is busy with people as they wait for teatime to come. The sun has set and a light shower falls as people huddle under the narrow eaves next to the front door to the ward. The music is still loudly playing. A nurse has popped out to join the group and grabs a quick smoke before teatime. A new arrival under escort, comes despondently up the path to the ward, bag in hand. He goes in with his nurse, dropping his bag at the nurses station door and comes outside to have a smoke and make small talk with us, as if practising a polite initiation in this unfamiliar group with whom he will be spending the next few weeks. He nervously asks for a light and takes a deep breath.
Dominant Characteristics of the Open Ward:

**Boredom**
The high level of perceived boredom experienced by clients was the most striking feature of this setting. Although there were opportunities to participate in or initiate other activities, such as playing pool, going for walks, joining in token occupational therapy art groups, and so on, the majority of clients in the open wards sat outside in the smoking area immediately in front of the ward, went to the canteen, or roamed the grounds to fill in their inpatient days. The expectation that they would eventually be leaving and returning to their community homes was played out as a process of waiting and making the most of the company while they were there. As time and treatment proceeded and these clients began to recover from the mental illness relapses that brought them into the hospital, they became more sociable and sometimes more restless. Smoking served to fill in the time; “There’s just nothing else to do.” Sharing cigarettes served as an icebreaker to initiate newcomers, or when clients sought out the company of others to relieve their boredom.

**The nurses’ station door**
The use of the nurses’ station door as a formal barrier between staff and clients was observed in each open ward, being closed when confidential staff discussions were in progress or when staff were absent, hence preventing tampering or theft of confidential notes and belongings. The degree to which this barrier took on a combatant feel varied between each individual open ward. This appeared to be due to the physical design of the different wards, as much as the group ethos of the staff within each different open ward. In some wards, the nurses’ station door was kept open at most times when staff were in the nurses’ station. This allowed for more open interaction with clients and attending to their individual needs. However, in other wards, the nurses’ station door was always kept shut whether staff were present or not. These wards were characterised by quick entries and exits of staff. The barrier served to keep clients out and distant from staff. In one such ward, the physical design of the nurses’ station, with its high windows and corner position made it appear more like a fortress. A couple of boxes of matches were conspicuously placed on the window sill outside the door so that clients could help themselves, and not need to bother staff with any requests.

**The primacy of the here and now**
The focus on immediate treatment, illness symptom management and day-to-day monitoring of clients’ mental state was also a noticeable priority in the open wards. What happened beyond the
internal walls of the ward was perceived variously as beyond the control or influence of staff and therefore not their business or responsibility. The immediate priority of ensuring that clients had access to their finances and hence, an uninterrupted supply of cigarettes, was stressed in day to day planning with and for clients. All else could wait until the patient was discharged, to be resolved once they were back in the community.

(7.6.4) Extended Care Open Wards: (beds = 24)

Early morning. It’s 7am. Upon arriving at the ward, the nurses’ station door is quickly and firmly shut behind us. We’re in a fishbowl again. The nurses move into the second room to talk away from view of the clients. From time to time, a client approaches the outer door, knocking incessantly. Staff respond with delay, ignoring, or providing a quick, brief response, then return their focus to the ‘handover’. Staff express their level of powerlessness on the smoking issue. I’m advised not to tell the patients that I’m a social worker for fear that they will hound me for money for cigarettes if I do. I leave the nurses inside with their heater, put on my gloves, shut the door and go out to meet the patients.

In the smoking area next to the front door to the ward, the grass is littered with more than three-hundred butts. A cleaner is busy sweeping the concrete. The dust and ash flies up. The clients sit silently on the lined up metal seats along the window next to the door of the ward, smoking one after the other; most are in their thirties. They don’t appear to feel the cold. My teeth chatter as I tuck my hands into my sleeves for warmth. No one speaks, except to say hello, then contemplative silence or blank looks again. They look at the ground or stare down the path out into the grounds. There is a chorus of coughing. One man verges on choking before his splits on the concrete in front of us. Nearby, an occasional sparrow comes down onto the table to peck at any crumbs left from the day before. I strike up a conversation with a male patient. He proceeds to explain the ward routine to me. Asking for a piece of paper, he proceeds to write in rote fashion the various meals and organised activities for the week. His face is vacant and emotionless. His eyes seem like bottomless pits of despair.

_A client from the adjacent ward comes over from his smoking area across the way. “Please give me a smoke love? I’ll give you $3 dollars for it.” He realises I’m not a smoker and moves away, picking up butts next to the ashtray on the ground as he goes. He gets no response, not even a glimpse, from the other clients. The staff are nowhere to be seen out here._
Dominant Characteristics of the Extended Care Open Ward:

Us and them
The physical and emotional distance between staff and clients was the most striking feature of their interaction in the extended care open wards. Staff clearly saw themselves as providing paternalistic and regimented care to dependent clients. Staff rarely interacted with clients, other than at the nurses’ station door or when in the smoking area themselves. Smoking as a transaction involving basic human contact was therefore elevated in significance for clients. Staff regularly talked about the clients in the third person, despite the clients being present at such time. Structure and routine and predictability were the order of the day. Hence, many clients were left to sit outside or to roam the grounds, returning to the ward for meals and bed. Many clients in these wards had their cigarette supply controlled by staff, with a daily allowance from the revenue department and cigarettes rationed from individually labelled pigeon holes in the staff area.

Life in a vacuum
The lack of interaction between the clients was also noticeable. Although they often shared the same living and smoking spaces, most rarely spoke to one another in conversation, except to ask for a cigarette or a light. The level of distress or paranoia from illness symptoms combined was noted. The perceived vacuum existence for many of the clients observed while near the ward, was also noted. Satisfying the nicotine addiction and ensuring the next cigarette seemed to be of greatest priority to these clients. There were few friends here, each client observed to be ultimately watching out for themselves and watching their backs; often silent, offering few signs of recognition to those nearby and staring out the corner of their eyes as others approached. Requests for cigarettes by other clients were usually denied, as all were on strict budgets. They seemed afraid to relate, as these clients had shared living space for years in some cases and they knew who could be trusted to pay back and who could not.

The acceptance of smoking
The attitudes of staff towards smoking, their level of acceptance and the proportion of staff smokers on the particular ward (especially where they were in leadership positions), appeared to influence how the ward staff as a whole perceived and responded to clients’ smoking. In wards where most nursing staff smoked, there appeared to be a higher level of client smoking and a greater belief in clients’ need for cigarettes and inability to quit.
(7.6.5) The Canteen, Grounds, and Outside the Revenue Department:

All roads lead to Rome. Like ants, the clients come from each corner and crevice of the surrounding buildings. Sitting on a park bench along the stone wall bounding the open lawn on one side; the canteen on another side, several tall trees providing much shade to the tables and chairs at the other end and just beyond them, the revenue department. Further off, the gated entrance to the administration buildings. It’s approaching 9am. Outside the big wooden door of the revenue department, patients begin to line up ready for opening time. More clients emerge one by one in all directions from the various corners and cracks between the buildings. Payday means cigarettes. Some are lying on the grass, others crouch against the wall or sit on the concrete and smoke while they wait, others wait patiently and watch in expectation or borrow a smoke and promise to pay back once they get paid. Everyone is co-operative for this very important task for the day. Not long to wait now!

As the morning progresses, the canteen area of tables and chairs becomes a hive of activity and sociability as clients sit in groups, chatting. They come and go, calling out greetings to each other from across the way, or sitting for extended periods at the tables smoking and talking, catching up with their fellow clients. “How have you been?” “How long is it since you were last here?” “A couple of years ago.” “See ya. I’m off to see so and so in ….. ward now.” Occasionally, a staff member passes through on their way to another part of the hospital or to grab something from the canteen. The chatter quietens or stops as the clients watch the staff pass through. Sometimes they hiss and mumble. The staff do not stay, but hurry on their way. This is not staff territory.

One by one, the clients check me out to make sure I’m not a staff member before they will offer further conversation. Two clients sit at a distance. They sneer and mumble. Eventually, one comes up to me to ask what I’m doing. We tentatively shake hands and our conversation begins. He speaks of his lack of hope and feelings of powerlessness and dependence on the hospital and of the disappointment of being here again. A lady sitting quietly nearby, watching all this time, finally summons up a question for me, “Are you the police?” She pauses for a few moments and then has another try, “Have you ever lived in Canberra?” I reply in the negative to both questions. Later in the morning, a patient who tells me she has been here for more than thirty years, comes over and joins me. She insists that I share her coke with her. She respects that I’m a non-smoker and says, “I wish I was.” We chat about how nice the surroundings are; “It’s freer here. The ward is depressing;
it’s staff territory.” Then she gathers up her bags and is on her way, but not before handing me an apple. Under the trees, the garden workmen sit at the tables and chairs having their morning break. A female client comes from nowhere, wearing a combination of bright, mismatched clothing, plastic bags and extra clothes in hand, and immediately asks them politely for a smoke. One is given without hesitation and she is scurrying on her way again as quickly as she came.

It’s lunchtime now; the canteen is deserted except for those clients who don’t like the menu for today – fish. The ladies serving in the canteen know all the regulars. It’s a daily ritual. A large glass screen with holes in it separates them from the customers. They are curt, impatient, emotionless. Outside, I’m joined by an Aboriginal man who has seen me buy a can of coke from the canteen and has seen me put my change in my pocket. He says, “By the way, have you got twenty cents for a phone call?” and soon followed with, “Can I have some of your coke, please?” Another male client approaches us and asks the man for a light. He fumbles through his pockets, at which the other man becomes abusive and starts threatening to kick him. They make aggressive gestures to each other before the other man leaves. “It’s a jungle out here,” he mumbles.

**Dominant Characteristics of the Canteen and Grounds:**

**Territorial activity**

The communal atmosphere and the sense of the canteen being clients’ territory, as opposed to the ward which was perceived by the clients as staff territory was in striking contrast in both the clients’ descriptions and actions in the settings. The table and chairs outside the canteen served as a meeting place where clients could talk freely without staff presence. They congregated regularly as part of their social interaction away from the ward. Staff rarely entered these communal meeting places. When they did, they came and went quickly and sometimes awkwardly, only sometimes acknowledging the clients and usually not speaking at all. In response, the chatter between clients would stop abruptly as a staff member approached, accompanied by suspicious jeers and derogatory mumbles until the staff were gone again. In line with these unspoken territorial rules, clients did not enter into staff administration areas. Large iron locked gates bared entry on the weekends, and despite them being open during the week for anyone to pass through, clients did not enter into this territory.
A market place
Smoking was a constant activity in the background, and served to mark the sociability of the occasion in these settings. Observing clients who were not smoking was a rare occurrence. Joining together to smoke was observed to be how these clients clearly strengthened their group cohesion in these settings. However, this also meant that cigarettes were a much sought after commodity, competitively vied for like a commodity in short supply. Under these circumstances the full range of talents and abuses were able to emerge and to flourish, dependent on the skills and personalities of the people involved. A market economy of barter and negotiation was routinely observed, with exchange items including clothing, food, money, other personal belongings, threats and intimidation. Although no direct observations were made of patients exchanging cigarettes for sex, staff spoke of this as ‘common knowledge’. Hospital clients were also noted to be providing very healthy business to a nearby pawn shop.

(7.6.6) The First Community Hostel: (beds=24)

Break of day at the hostel. It’s 7.30am. It’s cool and mild. The smoking area is deserted. The chairs are lined up ready for today’s activity. The seven ashtrays have been emptied the previous night and are lined up ready for today’s deposits, though already they have received the offerings from those who couldn’t sleep. The ten kilogram coffee tin, now a makeshift ashtray, sits amongst them ready to help cope with the load of butts envisaged for the day. The concrete has been swept early, the table sparkles. Inside the sounds from the kitchen as the cook busily prepares breakfast. An occasional sound of showers and running water as the clients slowly emerge from their beds.

A middle-aged man comes out in his pyjamas, half down on one side and surveys the smokers’ table and sifts through the ashtrays for butts. No luck yet today; they’re all smoked down to the filters. Straight back inside. The usual three elderly ladies come out together. They light up their smokes and make small talk. “I like your jumper.” “It’s Tuesday today, isn’t it?” The middle-aged man rushes back out now, stands over the ladies and immediately asks them for a smoke. The second lady says, “I’m not meant to give them to you,” but she relents. He makes conversation with them as they all smoke together. Two male clients come out and take up positions alongside the ladies. The staff member comes out. “You didn’t give him one did you? He’s not meant to ask for them. I’ll get his in a minute. You mustn’t give them away. He gets his own money for smokes.” The tall lady replies. “No, we didn’t give him one,” as they all look like the cat that swallowed the bird. The staff member shakes her head and returns a cigarette to her to make up for the one she gave away.
When the staff member is gone, they all confer and stress to the second lady that she only gets five cigarettes and they have to last her for the morning. She immediately gives this cigarette to the man. “Now you only have four left.” The three women leave and the three men stay. The middle-aged man breaks wind loudly as he smokes his second cigarette. He stands pressured, restless, already lining up his next cigarette as he finishes his second. He persists with one man and then the other, over and over again asking, “You got a smoke? You got a smoke?” They remain silent. He returns inside to try his luck later.

The staff member moves busily here and there, getting breakfast organised and supervising the showering, as she is the only one on duty so far. One lady has been incontinent again. A mop and bucket appear instantly. The smell of cigarettes and toast and the sound of clients being directed here and there fills the morning air. The three ladies have returned to have a smoke. A small lady has sat down and begins patiently to roll a cigarette. The middle-aged man is outside again. He stands silently over her, insistently. He has apparently cornered her inside. The coughing is horrendous from all. She tells him to sit but he says no, preferring to stand, shuffling his feet in expectation. She hands him a smoke and proceeds to roll herself one. Through the sliding door, a lady in the adjoining room sits patiently as the staff member attends to her personal care. The staff member hands her the three cigarettes she is rationed for the morning. Her eyes beam as she holds them tightly between her fingers. “OK sweetheart, enjoy.” The middle-aged man has, in the space of thirty minutes, managed to bottle [cadge] five cigarettes so far. He persists again as he stands over one lady, holding a half-smoked cigarette behind his back. She yells back at him after his third plea, “No.” He eventually leaves. Before she finishes her first cigarette, she lights the second from it. The third follows in similar style. No more now till late afternoon, unless someone responds to her pleas beforehand.

It’s 9am now. Another lady is showered, dressed and she’s off to the bank and then local shops to buy more cigarettes. She returns in minimum time. She says she plans to sit and smoke for most of the day. “I’m sixty soon. I’ve done my jobs for the day, so I can do what I want to now.” A younger man sits quietly at one end of the table, in the corner as he does most days, smoking, silently observing the antics of the middle aged man and the others. He’s passing time. A young man in his early twenties quickly comes out to the smokers’ area. “Do you want some coke for a smoke, please, do you want some?” “No,” the old lady replies gruffly. He immediately moves to the next person and gets the same response. He goes to the butts and lights what seems like nothing left of a cigarette and sucks quickly on it. He persists with the ladies. “It’s nice and cold. You can have as
much as you want? Please?” he asks each person who comes out. There are nine smokers now. The elderly lady who had given one away previously says, “I’ll get into trouble if I give you one”. He leaves abruptly again. Another elderly lady returns from her brief walk, through the cloud of smokers. She’s an ex-smoker and rarely sits in this area now due to her asthma. She huffs and puffs as she goes. The ladies congregate again in peaceful, polite conversation. They share a light and smoke, attempting the small social graces. The young man comes again, holding out his coke. This time, he’s successful with the lady who rolled her own beforehand. They all sit or stand around smoking, concentrating, saying little to one another.

(7.6.7) The Second Community Hostel: (Beds=24)

Mid-morning at the hostel, coming up the driveway, the area is strewn with clients sitting on the plastic seats or on the curbing, or standing, pacing aimlessly and all smoking. Most are in their twenties and thirties. They have many more years of this existence. I have the overwhelming sense of this not being a home, rather a place for people to exist in parallel, together but separate, as few words are exchanged with each other, only the occasional vacant look or stare. Talking to a young female resident, “It’s really hard here because everyone smokes. I find I’ve got less to look forward to the longer I’m here. I spend most of the day doing the circuit of the hostel, pacing through the building and up and down the drive, over and over, smoking.” This is a common activity for many clients.

Late afternoon now and we’re sitting under the large veranda at one of the many tables and chairs. Ashtrays are strewn throughout the area although the blackened concrete, strewn with cigarette butts, suggests that few people use them. Twelve clients sit or stand as a fragmented group; few talk to each other. Next to me, one man looks beseechingly and attempts the social graces. He deserves whatever conversation I can offer him. He talks about his dreams of meeting a lady and having a life together. He’s been here for five years now. He manages a half smile through his blackened, crumbling teeth. His fingers are stained from many years of smoking. Life here appears to have a dampened pace. “It’s just good to have someone to talk to. You know you can get pretty lonely, even when there are other people around. Will you be coming here to visit me again?” A staff member is shuffling through the storage cupboard next to us, cigarette hanging out the side of his mouth for the duration. At regular intervals, he shares the cigarette, exchanges puffs with one of the female clients. It’s a ritual requiring few words.
Evening now: single rooms, individual televisions and four walls. Clients emerge occasionally to have a smoke. It provides intermittent relief in the later hours of the day and into the night. Beyond the front gate, the suburb sleeps.

**Dominant Characteristics of the Community Hostels:**

**Quality of life**
The impoverished lifestyle of the clients of the community hostels was the most noticeable feature of these settings. Their day seemed to be filled with little more than eating, sleeping and smoking. Their actions seemed to be beyond a mere loss of hope; they spoke and acted as if they were powerless to participate in any future other than the banal existence in which they currently found themselves. Each day seemed the same, with activities and expectations having shrunk to wondering when and where the next cigarette was coming from. Long-term goals were spoken of as if they were dreams, with the reality of the present totally dominant.

**Asylum in the community**
These community hostels bore a striking resemblance to the extended care open wards. They shared the same routines and regimentation and lack of other meaningful activity, so that smoking together formed one of the few meaningful exchanges between clients. The staff were often scarce, except when they were also coming out to the smoking area for a smoke. Cigarette supplies were kept by staff and strictly controlled and meted out to those clients who were deemed to be ‘at risk’ if allowed to carry their own cigarettes. Standover intimidation and trade involving cigarettes was rife in the hostels. Smoking leftover butts was common. It was more a case of who got to the ashtrays first rather than which clients chose this level of self-degradation. Dependence on government benefits, coupled with hostel fees that used up the vast proportion of these benefits, meant that these clients, like their inpatient counterparts, were usually extremely poor. Cigarettes were scarce and prized commodities.

**(7.7) QUANTITATIVE RESULTS FROM OBSERVATION SHEETS:**

**(7.7.1) Method:**
As part of the participant observation methodology of the inpatient setting and hostels a number of observation sheets were used to gather quantitative data as a way of observing and measuring the actions and interactions of staff and clients in relation to smoking. An extensive journal was kept,
recording observations and reflections while using these sheets. They are described here, and will be referred to in discussion of the overall results. These sheets were not used in the community setting which did not lend itself to collection of data in the same way. In the community there was not a ‘captive’ audience as was the case in the hospital or hostels. The validity and reliability of making individual observations of client and staff interactions while in people’s private homes was seen to be problematic. This omission of the community setting, taking these methodological problems into account, was discussed with and agreed by the auditor to be justified, as noted previously.

As a result of the staff interview process, performed prior to the participant observation phase of research, the smoking behaviours of inpatient nursing staff were identified as significant because of their reported high incidence of smoking, estimated to be between 50% and 100% for nursing staff on some inpatient extended care wards. Inpatient nurses were also of interest because of their close and regular proximity to clients in the hospital environment and their direct role in the supply and dispensing of cigarettes to patients, and monitoring of patients’ smoking. During the period of the participant observation, inpatient nursing staff from various wards were asked if they were smokers and, if so, whether they would consent to fill in daily sheets to record their cigarette consumption and smoking behaviours while at work. This involved staff nominating self-reported reasons for their smoking. They were asked to complete a minimum of two sheets, each sheet representing one day’s cigarette consumption while on duty (twelve hours). Definitions of each reason for smoking were clearly described and explained to each participating nursing staff member prior to their completion of the sheets. They were asked to fill in the sheets as they smoked, or as soon as possible after smoking. The practical demands of the environments on nursing staff and their role in the primary care of patients was acknowledged. Participation was voluntary, with confidentiality and anonymity assured. No names were recorded and completed sheets were sent to the researcher via mail or fax. Prior to this phase, dummy sheets were shown to nursing staff in all wards during the pilot phase to determine the appropriateness and accuracy of the reasons nominated on the sheets. This followed the researcher’s initial nomination of reasons, as noted from staff interviews in the second phase of the research.

NB. For this quantitative section, numbers will be given in their numerical form rather than in written form.
(7.7.2) Results - Staff Smoking Behaviours:

Nursing staff generally appeared to be hesitant in talking about their own smoking behaviours. The researcher spent much time establishing rapport with nursing staff in the various settings, although the sense of some distance was apparent throughout the period of the participant observation. The researcher expected this, based on prior knowledge of working in the setting and nursing staff trepidation in trusting ‘outsiders’ and those from other professional disciplines. In total 15 staff participated, 4 from locked wards, 5 from open wards, and 6 from extended care wards. Most staff filled in 2 sheets; 3 staff filled in 3 sheets; and 1 staff participant filled in 1 sheet. Nurses could nominate 1-2 reasons for the one occasion of smoking. Data from locked and open ward staff have been differentiated because nursing staff involvement in the smoking sequence of patients in the locked settings clearly offered patterns of cigarette use by staff. All nurses involved were working 12-hour shifts. No gender distinctions were made. Staff requested that identification of ward setting, other than open or locked, remain anonymous. Therefore, any potential differences between the settings based on this cannot be determined.

From the 4 staff from locked wards, 9 days of recorded smoking consumption were received, with individual consumption ranging from 10 to 16 cigarettes in any one day while on duty. The total recorded number of cigarettes consumed by these 4 staff was 117. The median number of cigarettes consumed per day was 13.5 and the mean was 13.

From the 11 staff from open wards, 23 days of recorded smoking consumption were received, with individual consumption ranging from 4 to 16 cigarettes in any one day while on duty. The total number of cigarettes consumed by these 11 staff was 193; the median number of cigarettes consumed per day was 7 and the mean was 8.39. The range of daily cigarette consumption by open ward staff was 4 to 16 cigarettes.

From these figures it appeared that the locked ward staff in this sample tended to smoke more cigarettes per day, on average, than their open ward counterparts. With this in mind, closer analysis of the reasons staff gave for their smoking was sought. As part of this process, the researcher chose to combine the variables of smoking at break time and smoking between tasks in order to be able to group the variables into sets of even numbers to enable analysis to occur more easily. Variables were grouped into three types:
The first type of nominated behaviours dealt specifically with nursing staff smoking patterns. These variables were: smoking due to addiction, smoking to have a break, socialising with staff and other nominated reasons.

The second type of nominated behaviours dealt specifically with staff smoking as it occurred in the context of direct contact with clients. These variables were: smoking to socialise with clients, to establish rapport with clients, to assist assessment of clients and to manage clients’ behaviour.

The third type of nominated behaviours dealt with how nursing staff smokers used their smoking to cope with and respond to the setting. These variables were: stress relief, time out, boredom, debriefing and other.

Where a staff participant nominated one reason for smoking, this was given a count of one. Where they nominated two reasons for smoking, each reason was given a count of 0.5. Counts for each reason were then added together, with the overall figure for each reason given a percentage score of the person’s overall nominated reasons for smoking. For example, referring to Table 7.3, smoker three in the locked ward setting recorded 22 smoking occasions while at work during the 2 days that they recorded their smoking behaviour. Of these occasions, smoker three nominated 4 occasions when they smoked with a client to manage the client’s behaviour. Of these occasions, smoker three nominated 4 occasions when they smoked with a client to manage the client’s behaviour. When reasons for their smoking, directly associated with clients, were added together, results for smoker three revealed that 47.73% of their cigarette consumption occurred in the context of direct nursing care contact with clients.

The following seven tables 7.2 to 7.8 represent results from the nursing staff self-report smoking sheets. The last of these tables draws together the results of the previous six tables in order to make some comparisons of the locked and open ward nursing staff smoking patterns. Results should be interpreted with caution given the small sample size, method of sampling, and potential for the self-report data to be unreliable. These points are discussed further in Chapter Nine.
Table 7.2: Locked Ward Nursing Staff Attribution of Smoking While at Work:

**Smoking Pattern**

<table>
<thead>
<tr>
<th>Staff Smoking</th>
<th>Occasions</th>
<th>Add</th>
<th>Brk</th>
<th>SS</th>
<th>Ot</th>
<th>Total</th>
<th>%</th>
<th>Smoking Sequence</th>
<th>%</th>
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Add = Addiction  
Brk = Break Time  
SS = Socialising with Staff  
Ot = Other (writing notes)

Table 7.3: Locked Ward Nursing Staff Attribution of Smoking While at Work:  
**Nursing Care**

<table>
<thead>
<tr>
<th>Staff Smoking</th>
<th>Occasions</th>
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<th>Rap</th>
<th>Ass’t</th>
<th>M’tC</th>
<th>Total</th>
<th>%</th>
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SC = Socialising with Clients  
Rap = Rapport Building with Client  
Ass’t = Assessment of Client  
M’tC = Management of Client

Table 7.4: Locked Ward Nursing Staff Attribution of Smoking While at Work:  
**Work Related Stress**

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<th>Staff Smoking</th>
<th>Occasions</th>
<th>Str</th>
<th>T Out</th>
<th>Bor</th>
<th>Deb</th>
<th>Total</th>
<th>%</th>
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Str = Stress Relief  
Tout = Time Out  
Bor = Boredom  
Deb = Debrief
Table 7.5: Open Ward Nursing Staff Attribution of Smoking While at Work: Smoking Pattern

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<th>Staff Smoking</th>
<th>Occasions</th>
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<th>SS</th>
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Add = Addiction  
Brk = Break Time  
SS = Socialising with Staff  
Ot = Other (writing notes)

Table 7.6: Open Ward Nursing Staff Attribution of Smoking While at Work: Nursing Care

<table>
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<th>Staff Smoking</th>
<th>Occasions</th>
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<th>M’t C</th>
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<td></td>
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<td>7</td>
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<td>3.85</td>
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<td>9</td>
<td>7</td>
<td>2</td>
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<td>11</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>193</td>
<td>24.5</td>
<td>8</td>
<td>2.5</td>
<td>36</td>
<td>18.65</td>
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</tr>
</tbody>
</table>

SC = Socialising with Clients  
Rap = Rapport Building with Client  
Asst = Assessment of Client  
M’t C = Management of Client
Table 7.7: Open Ward Nursing Staff Attribution of Smoking While at Work: Work Related Stress

<table>
<thead>
<tr>
<th>Staff Smoking</th>
<th>Occasions</th>
<th>Str</th>
<th>T Out</th>
<th>Bor</th>
<th>Deb</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>21</td>
<td>1.5</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>9.5</td>
<td>45</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
<td>13.33</td>
<td></td>
</tr>
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<td>4</td>
<td>26</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
<td>4</td>
<td>15.38</td>
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<td>1</td>
<td></td>
<td>2.5</td>
<td>8.06</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>15</td>
<td></td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>8</td>
<td>13</td>
<td>2</td>
<td>1</td>
<td></td>
<td>4</td>
<td>30.77</td>
<td></td>
</tr>
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<td>9</td>
<td>7</td>
<td></td>
<td>1</td>
<td>1</td>
<td>14.28</td>
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<td></td>
</tr>
<tr>
<td>10</td>
<td>25</td>
<td>3</td>
<td></td>
<td>3</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>16</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9</td>
<td>56.25</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>193</td>
<td>10</td>
<td>12</td>
<td>11</td>
<td>9</td>
<td>42</td>
<td>21.76</td>
</tr>
</tbody>
</table>

Str = Stress Relief
TOut = Time Out
Bor = Boredom
Deb = Debrief

Table 7.8: Comparison of Smoking Attribution for Locked and Open Ward: Nurses

<table>
<thead>
<tr>
<th>Staff Attribution of Smoking</th>
<th>Locked Ward</th>
<th>%</th>
<th>Open Ward</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction</td>
<td>17.5</td>
<td>14.96</td>
<td>51</td>
<td>26.42</td>
</tr>
<tr>
<td>Break Time</td>
<td>10</td>
<td>8.55</td>
<td>33.5</td>
<td>17.36</td>
</tr>
<tr>
<td>Socialising with Staff</td>
<td>7.5</td>
<td>6.41</td>
<td>13</td>
<td>6.73</td>
</tr>
<tr>
<td>Other</td>
<td>17.5</td>
<td>9.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29.91</td>
<td></td>
<td>59.59</td>
<td></td>
</tr>
<tr>
<td>Socialising with Clients</td>
<td>23</td>
<td>19.66</td>
<td>24.5</td>
<td>12.70</td>
</tr>
<tr>
<td>Rapport Building</td>
<td>14</td>
<td>11.96</td>
<td>8</td>
<td>4.14</td>
</tr>
<tr>
<td>Assessment of Clients</td>
<td>2.5</td>
<td>2.14</td>
<td>1</td>
<td>0.52</td>
</tr>
<tr>
<td>Management of Clients</td>
<td>13.5</td>
<td>11.54</td>
<td>2.5</td>
<td>1.29</td>
</tr>
<tr>
<td>Total</td>
<td>45.30</td>
<td></td>
<td>18.65</td>
<td></td>
</tr>
<tr>
<td>Stress Relief</td>
<td>3.5</td>
<td>2.99</td>
<td>10</td>
<td>5.18</td>
</tr>
<tr>
<td>Time Out</td>
<td>13</td>
<td>11.11</td>
<td>12</td>
<td>6.22</td>
</tr>
<tr>
<td>Boredom</td>
<td>4</td>
<td>3.42</td>
<td>11</td>
<td>5.70</td>
</tr>
<tr>
<td>Debrief</td>
<td>8.5</td>
<td>7.26</td>
<td>9</td>
<td>4.66</td>
</tr>
<tr>
<td>Total</td>
<td>24.79</td>
<td></td>
<td>21.76</td>
<td></td>
</tr>
</tbody>
</table>

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Results from Tables 7.2 to 7.8 indicate that the overall reasons for smoking given by staff in the locked settings are different to the reasons given by open ward staff. Of the total number of reasons given for smoking, staff in the locked ward nominated reasons to do with their smoking pattern 29.91% of the time whereas open ward staff nominated these reasons 59.59% of the time. It is noted, however, that locked ward staff also nominated smoking as part of the clients’ smoking sequence 52.93% of the time. Locked ward staff nominated reasons for smoking to do with direct contact with clients 45.3% of the time, whereas open ward staff nominated these reasons for smoking only 18.65% of the time. Staff in the locked ward nominated reasons to do with their own coping mechanisms while at work 24.79% of the time, whereas open ward staff nominated these reasons for smoking 21.76% of the time. These results confirm the many comments made by staff about the nature of their interactions with clients, dependent on whether they were in locked or open wards. For example, locked ward staff were observed to be more sociable with patients and they said that ‘we’re all in here together’. Open ward staff, especially in the extended care wards were observed to be more likely to leave patients to their own devices and to have little direct contact with them other than at the nurses station door. Due to the non-uniformity in the number of sheets recorded by staff participants, the small sample size and the difference in participation rates between the number of locked ward staff compared to the number of open ward staff, statistical comparisons of the variables would be unjustified. However, the percentages noted do suggest that there may well be differences in the nature of work in the two different types of setting that influence the reasons for smoking by staff. The nature of care in the locked settings with closer proximity of locked ward nursing staff to patients, greater frequency of contact and more disturbed behaviour and greater severity of illness of patients may have had some influence here. In the open settings, nursing staff appeared to have frequently nominated their break time as a reason for smoking, possibly also influenced by the structure of the work commitments and ability to leave the ward and move around the hospital with more ease than their locked ward counterparts. The category of ‘Other/non-determined’ included smoking while making entries in case notes but, in the majority of recordings, was not elaborated by the staff concerned.

High rates of staff smoking, as part of the ward smoking sequence of patients, were noted for all 4 staff participants in the locked wards. Overall, they nominated smoking in this context 52.9% of the time. The presence of a structured smoking sequence for which staff were actively involved in monitoring the safety of patients in the smokers’ cage during these times, may have acted as an inadvertent trigger to smoking by staff. It may also help to explain why they appeared to smoke more cigarettes, while on duty, than their open ward counterparts.
Table 7.8 provides a comparison of each variable for locked and open ward nursing staff as a percentage of the total nominated smoking occasions for the particular setting. Of note, locked ward staff said they smoked 11.54% of the time to manage clients whereas their open ward counterparts only nominated smoking for this reason 1.29% of the time. Smoking to help establish rapport with clients was also noticeably higher for locked ward staff than for open ward staff. Open ward staff nominated addiction as a significant reason for their smoking, compared to locked ward staff. This may be due to the availability of a smoking sequence for locked ward staff, that is, they have more opportunity to smoke as an accepted part of their job on the ward if they are smoking while supervising patients’ smoking. Being able to do this at regular hourly intervals may mean that locked ward staff do not feel the effects as nicotine withdrawal as readily as open ward staff. As expected due to their closer proximity to patients throughout the day, locked ward staff nominated smoking to socialise with clients more often than open ward staff. They also nominated smoking for time out and to debrief more often than open ward staff. Features of the work environment, especially the inability to readily leave the environment, are relevant here. Results that were not expected were the higher figures of smoking for stress relief nominated by open ward staff, 5.18% compared to 2.99% for locked ward staff. The reasons for this are unclear but may be due to locked ward staff being specifically trained for and used to dealing with locked environments. Also, staff may have been reluctant to nominate this reason, because it may have been interpreted by them as non-coping. The tradition of toughness will be discussed in chapter eight. Likewise, staff did not nominate smoking to aid assessment as frequently as was expected. The possible reasons for this are raised in theme (2) at the conclusion of this chapter.

The results from the above tables are interesting and suggestive of patterns of nursing staff smoking behaviour, however, they are not conclusive and cannot be generalised to the larger nursing population of the hospital (N=450). Distinctions between open and locked ward nursing staff can be inferred but are limited by the sample size and methodology. Non-smoking nursing staff and staff from other disciplines were not surveyed. The convenience sampling method limits the overall conclusions that can be drawn because the representativeness of the sample is unknown. Therefore, only descriptive results can be given here, with inferences for further investigation elsewhere with a larger sample.

From these figures, it is apparent that smoking by these staff occurs in relation to a wide range of activities within their working day, directly related to their interaction with clients and how they cope in their work environment. All staff surveyed smoked at various points throughout their 12-hour shifts and all reported smoking because of addiction to nicotine. Staff from both the open and
locked ward settings also appeared to smoke often in the context of socialising with clients. These results concur with the results of client and staff interviews.

(7.8) Smoking Area Observations:

This section describes the method used to collect data from the settings. The aim of the observations was to check on self-report data of roles and behaviours and interactions between staff and clients. From this point, the further aim was to discover patterns of similarity and difference between the settings. This included patterns of overall cigarette consumption, passive smoking and peer smoking. Results from each of the settings are then given individually. This is followed by an analysis of the settings using the simple counting process to compare percentages for the variables. A poisson distribution test has been performed to further describe the data and confirm relationships within and between the variables.

(7.8.1) Method:

Smoking area observations were conducted for the acute and extended care locked, acute open and extended care open wards of the hospital setting, as well as at the community hostels. Observation sheets were also used to record the levels of smoking for the areas where smoking was most frequently observed and accepted as areas in which smoking could occur. In the extended care open ward, the acute open ward and the community hostel the observed area comprised seating for clients for socialisation and recreation. The primary activity in these areas was observed to be smoking. Over time, each of these areas had become known as ‘the smoking area’.

Permission to undertake the observations was sought and gained from the Clinical Nurse Manager for each ward during the pilot period. Following this, visiting days and times occurred randomly, based on the researcher’s time and other commitments. This was the case for all other settings also, except the community hostels and the locked wards where the researcher contacted the sites within 24 hours of visiting these sites to gain approval to visit each time.

As per the information sheet distributed to observed participants at the commencement of the participant observation period, the researcher made numerous visits to each site to allow participants to become comfortable with the methodology and the researcher’s presence. This habituation of the settings was seen as crucial to ensure the reliability of observations. The
researcher completed observation sheets on each occasion, at various times during the day and evening, regardless of whether these occasions would appear in the final reporting of the data. The researcher sat in the smoking area and recorded the number of cigarettes consumed, the number of people smoking at each 10 minute interval, whether they were clients or staff and the number of those present who were not smoking at the time (passive smokers). The ten minute interval recording occurred over a continuous 3 hour period (Total=18 ten minute intervals). Ten minutes was determined to be the approximate time that it takes to smoke a cigarette. The method of counting acknowledged that, during a ten-minute period, a smoker could finish their cigarette and remain in the area as a non-smoker. Under these circumstances they were counted as a smoker only. Also, the counting method acknowledged that people could enter the area briefly and leave again, that is, they did not have to remain in the area for the total period in order to be counted. During any ten-minute period, each person was only counted once. This was determined by what activity they were predominantly doing during the 10 minute period. A smoker was deemed to be a person who was actively smoking their own cigarette, or sharing a cigarette with another person. A passive smoker was deemed to be a person who was not actively smoking. They could therefore be a non-smoker or a smoker who was not smoking at the time of observations. All of these observations required the researcher to be diligent in the recording and observation of participants entering and leaving the smoking area. The researcher consulted a statistician following the data collection to determine whether detailed statistical analysis could be performed on the data. Several problems were identified, both with the method of data collection and the method of counting and recording. The results are given with these limitations in mind. These results did not acknowledge the occurrence of smoking outside the observed areas and did not analyse the composition of the smoking area group in relation to the total population of the setting. They also did not account for the smoking behaviours of individuals and their repeated presence in the smoking area; for example, some people were present and smoking during the entire 18 intervals of time.

The descriptive results from each setting appear in the following seven tables. Further analysis of these results, comparing the settings with each other, occurs after this descriptive section.

(7.8.2) The Acute Open Ward Smoking Area:

The acute open ward was visited 9 times to record data in the area immediately outside the entrance door to the ward. This area was where clients sat or stood to be outside the ward for a change of scenery, to smoke or to get fresh air, or to talk to other clients away from staff. The acute open ward
visits occurred between the hours of 6.30am and 10.30pm, across all seven days of the week. Each recording period was 3 hours.

Results from table sixteen will be used as an example of how to read all tables for this section: Nine visits occurred to the acute open ward smoking area, constituting 27 hours of recording and 162 recording intervals (10 minutes each). The total number of cigarettes consumed for the 9 visits was 752, being consumed by a total of 708 smokers. The total number of people in the smokers’ area for the 9 visits was 821, 760 of these being clients and 61 of these being staff. Of the 821 people in the smokers’ area, 113 of them were not smoking at the time. This occurred for 68 of the 162 smoking intervals recorded.

Table 7.9: Observations of Smoking for the Acute Open Ward Smoking Area

<table>
<thead>
<tr>
<th>The Acute Open Ward (9 visits)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>752</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>708</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>821</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>760</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>61</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>113</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>68</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>162</td>
</tr>
</tbody>
</table>

From these figures, it is apparent that clients used the observed area very regularly, in order to smoke. Passive smokers were present almost half the time that smokers were also present. The sociability of this outside area of the ward is noted in the description of the ward environment. More than 1 in 6 clients present in the area were passive smokers while they were in the area. All staff members observed in the area were smoking at the time of observations.

(7.8.3) The Extended Care Open Ward Smoking Area:

The extended care open wards were visited 8 times, as per the criteria described for the open ward, to record data in the area immediately outside the entrance door to the wards. Designation of clients to particular wards was based on their level of mental illness, chronicity and prospects of rehabilitation back to community living. The long-stay ward housed clients who were resident and expected to be resident at the hospital for between 2 and 5 years. The rehabilitation focus ward housed clients who were resident and expected to be resident at the hospital for between 3 and 12
months. Each of the extended care wards was visited 4 times, the long-stay ward during the time periods from 6.30am to 8.30pm and the rehabilitation focus ward during the time periods from 7am and 8.30pm. These two types of extended care wards were selected to provide a picture of the range of extended care settings. Asylum wards were not observed.

Table 7.10: Observations of Smoking for the Extended Care Open Wards Smoking Area

<table>
<thead>
<tr>
<th>Extended Care Open Ward (8 visits)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>454</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>391</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>553</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>510</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>43</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>162</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>85</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>144</td>
</tr>
</tbody>
</table>

Distinguishing between the different types of extended care open wards, by separating out the results of observations, yields further patterns.

Table 7.11: Observations of Smoking for the Extended Care Open Wards

<table>
<thead>
<tr>
<th>Observations</th>
<th>Long-stay Ward (4 visits)</th>
<th>Rehab Focus Ward (4 visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>188</td>
<td>266</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>145</td>
<td>246</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>220</td>
<td>333</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>214</td>
<td>296</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>75</td>
<td>87</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>33</td>
<td>52</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>72</td>
<td>72</td>
</tr>
</tbody>
</table>

In the long stay extended care ward (2-5 years), most clients’ cigarette supply was closely monitored and rationed by staff. Therefore they had limited access to cigarettes. Clients also tended to sit separate to one another in this area, due possibly to their heightened level of paranoia and symptom distress. Therefore direct contact leading to passive smoking potential was less likely than their more sociable counterparts in the rehabilitation-focus extended care ward. This latter setting was more focused on structured rehabilitation, with clients often participating in ward activities together. These clients were more able and more communal than in other extended care open wards, and therefore more interactive, with a greater potential to sit together, and with more control over...
their own cigarette supply. The total number of clients for each of these wards was the same (N=24). Staff in the rehabilitation focus ward appear to socialise significantly more often with clients in the smoking area that their long-stay ward counterparts. All staff in the observed areas were smoking at the time.

(7.8.4) The Locked Wards:

The locked wards were visited 9 times to record data in the area designated as the smoking area for the ward. Both wards contained a small smoking room as part of the internal structure of the building, with wire mesh on the outer wall to allow smoke to escape to the outside air. These smoking ‘cages’ were a compromise to allow smoking in an area of convenience, given the nature of the settings as locked and the policy ban on smoking within the interior of the buildings. The extended care locked ward also had a large internal garden area open to the sky, bounded on all four sides by the ward building, that was used for smoking by the group at certain times in the day. The acute locked ward had a small outside grassed area bounded by a security fence, however this was rarely used by clients or staff. Both wards had strict routines regarding the dispensing of cigarettes to clients. The acute locked ward distributed cigarettes hourly for patients who had their own supply and 6 times per day at set intervals for those who had none. The extended care locked ward dispensed cigarettes to patients every hour. Therefore, the researcher could not use the 10-minute interval method of recording smoking activities for these settings. Instead, the smoking activities at each designated smoking period were recorded. Results from both settings are given in total and then individually in separate tables as follows:

Table 7.12: Observations from the Locked Wards Smoking Areas

<table>
<thead>
<tr>
<th>The Locked Wards (8 visits)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>468</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>452</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>474</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>336</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>136</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>22</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>18</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>39</td>
</tr>
</tbody>
</table>
Table 7.13: Observations from the Locked Wards
Separation of Acute and Extended Care Locked Wards

<table>
<thead>
<tr>
<th>Observations</th>
<th>Acute Locked Ward (4 visits)</th>
<th>Extended Care Locked Ward (5 visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>216</td>
<td>252</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>216</td>
<td>236</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>230</td>
<td>244</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>174</td>
<td>162</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>56</td>
<td>80</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>24</td>
<td>15</td>
</tr>
</tbody>
</table>

From this data the routine of clients and staff being together in the smoking area is apparent. The designated purpose of the area as a smoking area needs to be acknowledged, hence the dominant activity for both clients and staff at these times is smoking. Of note in the extended care locked ward is that the total population of patients (N=11) smoked at all designated smoking periods and that most staff smoked at these times also (N= 5-6). Data for range, median and mean were not determined for this setting due to its set routine and requirement for certain numbers of staff to be present with clients in ‘the smokers’ cage’, with only one cigarette provided to clients at each smoking interval. Of further note in the extended care locked setting, the number of cigarettes consumed was more than the number of smokers present, despite the policy of one cigarette per person at smoking times. This is explained by the observation of some staff smoking more than one cigarette at some of these times and the granting of a further cigarette to patients at certain times, especially in the early morning when the group smoked in the garden area of the ward. Staff who were non-smokers did not tend to nominate for the duty of supervising clients during smoking periods; staff who were current smokers tended to perform this role. Non-smoking staff tended to observe from the nurses’ station in the acute locked setting. Again, passive smoking was noted in each setting on approximately half of the observed occasions.

(7.8.5) The Community Hostels:

Two community hostels were visited 12 times in total to record data in the area immediately outside the entrance door to the hostel, nominated for smoking and daytime outside seating and recreation. Visits to the first hostel occurred between the hours of 6.30am and 9.30pm, over seven days. Visits
to the second hostel occurred between the hours of 7.30am and 10pm over seven days also.
Combined results are given followed by separate table for each hostel as follows:

Table 7.14: Observations from the Hostels’ Smoking Areas

<table>
<thead>
<tr>
<th>The Community Hostels (12 visits)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>878</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>799</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>901</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>862</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>39</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>104</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>69</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>216</td>
</tr>
</tbody>
</table>

Table 7.15: Observations from the Hostels
Separation of Hostel One and Hostel Two

<table>
<thead>
<tr>
<th>Observations</th>
<th>Hostel One (6 visits)</th>
<th>Hostel Two (6 visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes consumed</td>
<td>361</td>
<td>517</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>322</td>
<td>475</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>371</td>
<td>530</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>363</td>
<td>499</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>Passive Smokers / Total</td>
<td>49</td>
<td>55</td>
</tr>
<tr>
<td>Occasions- Passive Smokers Present</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>108</td>
<td>108</td>
</tr>
</tbody>
</table>

The first hostel observed had a mixture of younger and older clients, with predominantly older clients. Its environment was highly regimented by staff, with several clients required to ask staff for their cigarette ration for the day. The second hostel observed housed clients who were predominantly under 50 years of age. Many of these clients were away from the hostel during the day and returned to the hostel for the evening meal. Each hostel housed the same numbers of clients (N=40). Of note was the higher number of cigarettes consumed compared to the number of smokers during the observations that occurred in the early morning at each site. The role of nicotine withdrawal, given that this was early in the day when clients were first waking, may have played a role here. Some clients were given their morning ration of, for example, 3 or 5 cigarettes for the morning and chose to smoke them as quickly as they could. The consistent and repeated use of the smoking areas by several clients throughout the day was noted, as was the high level of staff
smoking interaction in the smoking area of the second hostel. The frequency and high number of passive smokers was also noted, with several clients observed to sit next to smokers in order to inhale their cigarette smoke, presumably when they had run out of their own supply. Differences between each hostel were noted, with the number of cigarettes consumed and the number of smokers being higher at the second hostel. This may be due the client population at this site being generally younger and more able to move in and out of the area. In the first hostel, many clients were frail and spent much of their day sitting indoors.

(7.8.6) Further Analysis of Observations - Differences Between the Settings:

General patterns from the above tables were further analysed by making comparisons based on percentage scores for specific variables as they occurred in the different settings. These are shown in the following tables and figures.

Table 7.16: Percentage of Clients in the Smoking Area According to the Total Number of the Group in the Smoking Area and The Setting

<table>
<thead>
<tr>
<th>Setting No.</th>
<th>Setting Type</th>
<th>Number of the Group</th>
<th>Number of Clients Present</th>
<th>% of Clients in the Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Open Ward</td>
<td>821</td>
<td>760</td>
<td>92.57</td>
</tr>
<tr>
<td>2</td>
<td>Ext.Care Rehab. Ward</td>
<td>333</td>
<td>296</td>
<td>88.89</td>
</tr>
<tr>
<td>3</td>
<td>Ext. Care Long-stay Ward</td>
<td>220</td>
<td>214</td>
<td>97.27</td>
</tr>
<tr>
<td>4</td>
<td>Ext. Care Wards (both)</td>
<td>553</td>
<td>510</td>
<td>92.22</td>
</tr>
<tr>
<td>5</td>
<td>First Hostel</td>
<td>371</td>
<td>363</td>
<td>97.84</td>
</tr>
<tr>
<td>6</td>
<td>Second Hostel</td>
<td>530</td>
<td>499</td>
<td>94.15</td>
</tr>
<tr>
<td>7</td>
<td>Hostels (both)</td>
<td>901</td>
<td>862</td>
<td>95.67</td>
</tr>
<tr>
<td>8</td>
<td>Acute Locked Ward</td>
<td>230</td>
<td>174</td>
<td>75.65</td>
</tr>
<tr>
<td>9</td>
<td>Ext. Care Locked Ward</td>
<td>244</td>
<td>164</td>
<td>67.21</td>
</tr>
<tr>
<td>10</td>
<td>Locked Wards (both)</td>
<td>474</td>
<td>338</td>
<td>71.31</td>
</tr>
</tbody>
</table>
Figure 7.1: Clients in the Group as a Percentage of the Total Group

Figure 7.2: Staff in the Group as a Percentage of the Total Group

The percentage of clients present in the smoking area appears as the inverse of the graph for staff. Clearly, in all settings, the majority of people in the smoking areas are clients, with differences between the open and locked settings being reflected. Again, the smoking sequence in the locked wards and the role of staff is relevant here.

From these figures, it can be seen that significantly more staff are present in the smoking area within the locked wards (setting numbers 8-10) that in the open wards (setting numbers 1-4). This is most likely due to their role in supervising smoking in the locked settings. Also, very low percentages of staff were observed to be present in the long-stay extended care open ward. This confirms other observations made during the participant observation period, where staff were observed to leave clients very much to their own devices in this setting. Differences in the level of disability and sociability of the client group in the different extended care wards have already been noted. These results confirm those observations.
The community hostels had similar very low percentages of staff presence in the smoking areas (setting numbers 5-7). The low ratio of staff to clients in these settings, especially in the early morning and later afternoon, may also account for this low figure. Differences between the hostel may be associated with the ethos of the individual hostels and their general make-up of clients, the first hostel housing largely older residents and possessing a more paternalistic ethos and separation between staff and clients than the second hostel.

*Differences in the observed smoking activity in the different settings can be shown by looking at differences in the percentage of smokers present in the settings as shown by the following table and figure.*

**Table 7.17: Percentage of Smokers in the Group According to the Total Number of the Group and The Setting**

<table>
<thead>
<tr>
<th>Setting No.</th>
<th>Setting Type</th>
<th>Number of Smokers Present</th>
<th>Number of the Total Group</th>
<th>% of Smokers Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Open Ward</td>
<td>708</td>
<td>821</td>
<td>86.24</td>
</tr>
<tr>
<td>2</td>
<td>Ext. Care Rehab. Ward</td>
<td>246</td>
<td>333</td>
<td>73.87</td>
</tr>
<tr>
<td>3</td>
<td>Ext. Care Long-stay Ward</td>
<td>145</td>
<td>220</td>
<td>65.9</td>
</tr>
<tr>
<td>4</td>
<td>Ext. Care Wards (both)</td>
<td>391</td>
<td>553</td>
<td>70.71</td>
</tr>
<tr>
<td>5</td>
<td>First Hostel</td>
<td>332</td>
<td>371</td>
<td>89.49</td>
</tr>
<tr>
<td>6</td>
<td>Second Hostel</td>
<td>475</td>
<td>530</td>
<td>89.62</td>
</tr>
<tr>
<td>7</td>
<td>Hostels (both)</td>
<td>807</td>
<td>901</td>
<td>89.57</td>
</tr>
<tr>
<td>8</td>
<td>Acute Locked Ward</td>
<td>216</td>
<td>230</td>
<td>93.91</td>
</tr>
<tr>
<td>9</td>
<td>Ext. Care Locked Ward</td>
<td>236</td>
<td>244</td>
<td>96.72</td>
</tr>
<tr>
<td>10</td>
<td>Locked Wards (both)</td>
<td>452</td>
<td>474</td>
<td>95.36</td>
</tr>
</tbody>
</table>

**Figure 7.3: Percentage of Smokers in the Group for The Settings**
These results indicate high percentages of smoking activity in the locked wards (setting numbers 8-10) and confirm the general observations made throughout the participant observation of the settings. In these settings, all clients were smoking due to the observed period and the observed area being specifically for smoking. Therefore the interpretation of the figures needs to acknowledge this difference between observations made in this setting compared to other settings where the observed areas had the potential to be used for activities other than smoking. Even given this distinction, the overall percentages for all settings are high, indicating that most people took the opportunity to smoke while in these areas. The absence of other activities, or lack of participation in other activities, was observed during the period of data collection. This was especially noted at the hostels. In the extended care open wards, where the percentage of smokers appears to be less than other settings, the rationing of cigarettes and the limited availability of funds to purchase cigarettes may have influenced the figures for these settings. Some clients from these settings were observed to be regular visitors to the canteen area and the grounds of the hospital, as well as outside shops and streets. Therefore, they may well have been doing some of their smoking away from the wards.

Another facet of the smoking area observations was the degree of passive smoking activity in the different settings. Questions arose from the observations of the settings and the levels of disability and access to funds to purchase cigarettes, and the potential impact of these circumstances on the rates of passive smoking. The following table and figure summarises these results.

**Table 7.18: Percentage of Passive Smokers According to the Total Number of the Group and The Setting**

<table>
<thead>
<tr>
<th>Setting No.</th>
<th>Setting Type</th>
<th>Number of the Group</th>
<th>Number of Passive Smokers</th>
<th>% Passive Smokers in Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Open Ward</td>
<td>724</td>
<td>94</td>
<td>12.98</td>
</tr>
<tr>
<td>3</td>
<td>Ext. Care Long-stay Ward</td>
<td>220</td>
<td>75</td>
<td>34.09</td>
</tr>
<tr>
<td>4</td>
<td>Ext. Care Wards (both)</td>
<td>553</td>
<td>162</td>
<td>29.29</td>
</tr>
<tr>
<td>5</td>
<td>First Hostel</td>
<td>371</td>
<td>49</td>
<td>13.21</td>
</tr>
<tr>
<td>6</td>
<td>Second Hostel</td>
<td>530</td>
<td>55</td>
<td>10.38</td>
</tr>
<tr>
<td>7</td>
<td>Hostels (both)</td>
<td>901</td>
<td>104</td>
<td>11.54</td>
</tr>
<tr>
<td>8</td>
<td>Acute Locked Ward</td>
<td>216</td>
<td>14</td>
<td>6.48</td>
</tr>
<tr>
<td>9</td>
<td>Ext. Care Locked Ward</td>
<td>236</td>
<td>8</td>
<td>3.39</td>
</tr>
<tr>
<td>10</td>
<td>Locked Wards (both)</td>
<td>452</td>
<td>22</td>
<td>4.87</td>
</tr>
</tbody>
</table>
These figures confirm other observations during the period of participant observation, that is, that passive smoking was highest in the extended open care settings (setting numbers 2-4). The reasons for the higher percentage of passive smokers in the extended care open settings can be attributed to the rationing of cigarettes and the shortage of funds to purchase cigarettes by clients in these settings. As observations confirm, many clients in these settings deliberately sat next to other clients who were smoking when they did not have cigarettes of their own. Similar figures should have been expected from the hostels where rationing and shortage of funds by clients was likewise noted. However, this is not shown to be the case (setting numbers 5-7). The reasons for this remain unclear, although there may be differences between the hospital and community client group that need further investigation. The very low rates of passive smoking in the locked wards (setting numbers 8-10) is to be expected, as all of the clients were smoking at the times observed due to this being the designated activity at the time and non-smoking clients were generally not allowed in the area. However, this means that all of the passive smokers were staff in the area to supervise clients’ smoking. The acute locked ward possessed almost twice as many passive smoking staff as the extended care locked ward. The reasons for this are unclear, although other observations of these two settings demonstrate that the environment of the acute setting revealed more of an us and them air compared to the extended care setting where staff described themselves as being as institutionalised as the clients, with higher rates of smoking as a group than their acute ward counterparts. This suggests an enculturation of long-stay staff into the smoking routine. In the open ward, clients had usually had access to money in order to purchase cigarettes, or had relatives (or community key workers) who were able to ensure the supply of cigarettes to them. Their rates of passive smoking can be related to their observed sociability of the observed area.
Once the results of observations were gathered and tabled as percentages, further questions arose from the data. The Poisson test, or Z test was therefore applied to the data, measuring potential differences between the periods of time using a simple count principle, with any difference determined as significant if a score of $\geq 1.96$ was achieved. This was based on the principle of the expected value for two counts of the same activity, for example smoking, being zero. Any difference between the two counts could then be analysed using the following formula to obtain a z score. This particular formula was chosen due to the small sample size and sampling method. It was useful to assist in the inference of results and was not meant to be taken as exact (Armitage & Berry, 1996).

$$Z = \frac{(x_1 - x_2)}{\sqrt{x_1 + x_2}}$$

One would expect the number of cigarettes smoked in each ten-minute interval to be the same as the number of smokers present in each ten-minute interval, that is, for the expected value to be the same. However, this was not the case in the settings, especially in the mornings. The following table summarises the results using the Poisson test. The locked settings are not included due to their rule of one cigarette per smoking occasion.

Table 7.19: Cigarettes Smoked Compared with the Number of Smokers and The Settings

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>$x_1$</th>
<th>$x_2$</th>
<th>$z$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Open Ward</td>
<td>666</td>
<td>628</td>
<td>1.06</td>
</tr>
<tr>
<td>Ext. Care Rehab. Ward</td>
<td>266</td>
<td>246</td>
<td>0.88</td>
</tr>
<tr>
<td>Ext. Care Long-stay Ward</td>
<td>188</td>
<td>145</td>
<td>2.36</td>
</tr>
<tr>
<td>Ext. Care Wards (both)</td>
<td>454</td>
<td>391</td>
<td>2.17</td>
</tr>
<tr>
<td>First Hostel</td>
<td>361</td>
<td>322</td>
<td>1.49</td>
</tr>
<tr>
<td>Second Hostel</td>
<td>517</td>
<td>475</td>
<td>1.33</td>
</tr>
<tr>
<td>Hostels (both)</td>
<td>878</td>
<td>797</td>
<td>1.98</td>
</tr>
</tbody>
</table>

$x_1 =$ number of cigarettes smoked  
$x_2 =$ number of smokers present  
$Z = \geq 1.96$ (significant)

The higher rate of smoking by the smokers present in the extended care long-stay open ward was found to be significant with $z=2.36$. When figures were combined for the extended care open wards,
this figures remained significant with $z=2.17$. When the figures for the hostels were combined, they were also found to be significant with $z=1.98$. In the absence of cigarette rationing and unlimited funds, these figures were expected to be even higher for the hostels and extended care settings. In the open ward, this smoking behaviour was not found to be significant.

Data from observations made in the morning, prior to lunch at 1pm, were compared with data from observations made in the afternoon and evening, after 1pm, to see if clients smoking patterns are different at different periods in the day. In order to achieve equivalent periods of time to then analyse data from the open ward setting, one of the nine three hour observation occasions was randomly selected out, leaving eight three hour periods, four in the am period and four in the pm period. Observation data for the locked settings, the extended care wards, and the hostels did not require any adjustments as equal numbers of am and pm observations were achieved. The results are as follows:

Table 7.20: Morning and Afternoon Smoking in the Acute Open Ward

<table>
<thead>
<tr>
<th></th>
<th>am</th>
<th>pm</th>
<th>$z$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes Consumed</td>
<td>360</td>
<td>306</td>
<td>2.09</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>329</td>
<td>299</td>
<td>1.20</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>386</td>
<td>338</td>
<td>1.78</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>362</td>
<td>307</td>
<td>2.13</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>24</td>
<td>31</td>
<td>-0.94</td>
</tr>
<tr>
<td>Passive Smokers</td>
<td>57</td>
<td>39</td>
<td>1.84</td>
</tr>
<tr>
<td>Occasions – Passive Smokers</td>
<td>33</td>
<td>23</td>
<td>1.34</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>72</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

Smokers in the acute open ward smoked more cigarettes in the morning and this was found to be significant ($z=2.09$). These findings support findings from client interviews and from observations made of the setting throughout the participant observation. Clients stated that they smoked more in the morning to overcome the nicotine withdrawal experienced as a consequence of sleeping. Several clients, especially those with schizophrenia, described having several cigarettes first thing in the morning to raise the level of nicotine in their system. This is confirmed by the Poisson test. As expected, given this result, the number of smokers in the area in the morning was significantly higher than compared to the numbers for the afternoon. Although not significant, the score for passive smoking is high ($z=1.84$) and heading in the right direction, with 12.98% of the group being passive smokers in this setting, according to the previous percentages table.
Table 7.21: Morning and Afternoon Smoking in the Extended Care Open Ward

<table>
<thead>
<tr>
<th>The Extended Care Open Ward</th>
<th>am</th>
<th>pm</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes Consumed</td>
<td>236</td>
<td>218</td>
<td>0.84</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>190</td>
<td>201</td>
<td>-0.56</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>266</td>
<td>287</td>
<td>-0.89</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>259</td>
<td>261</td>
<td>-0.09</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>17</td>
<td>26</td>
<td>1.37</td>
</tr>
<tr>
<td>Passive Smokers</td>
<td>76</td>
<td>86</td>
<td>-0.78</td>
</tr>
<tr>
<td>Occasions – Passive Smokers</td>
<td>38</td>
<td>37</td>
<td>0.11</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>72</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>

No variable showed significant differences between morning and afternoon in the extended care open ward setting. Given that cigarettes were rationed and in short supply due to these clients’ lack of funds to smoke at will, this result is not surprising. The long-term nature of their residence at the hospital would suggest that they had learned to ration out the supplies of cigarettes they did possess. This is supported by observations made in which very few of these clients were observed to oblige others in their requests for cigarettes. Overall, the sense was gained that these clients closely guarded their supply and made it last for the day, and this is what account for the lack of significance of differences between the morning and afternoon.

Table 7.22: Morning and Afternoon Smoking in the Community Hostels

<table>
<thead>
<tr>
<th>The Community Hostels</th>
<th>am</th>
<th>pm</th>
<th>z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes Consumed</td>
<td>452</td>
<td>426</td>
<td>0.88</td>
</tr>
<tr>
<td>Smokers / Total</td>
<td>389</td>
<td>408</td>
<td>-0.67</td>
</tr>
<tr>
<td>Group in the Area / Total</td>
<td>443</td>
<td>458</td>
<td>-0.50</td>
</tr>
<tr>
<td>Clients in the Area</td>
<td>425</td>
<td>437</td>
<td>-0.41</td>
</tr>
<tr>
<td>Staff in the Area</td>
<td>18</td>
<td>21</td>
<td>-0.48</td>
</tr>
<tr>
<td>Passive Smokers</td>
<td>54</td>
<td>50</td>
<td>0.39</td>
</tr>
<tr>
<td>Occasions – Passive Smokers</td>
<td>40</td>
<td>29</td>
<td>1.32</td>
</tr>
<tr>
<td>Intervals Recorded</td>
<td>108</td>
<td>108</td>
<td></td>
</tr>
</tbody>
</table>

Similar to the extended care open wards, no significant differences were found between the morning and afternoon smoking behaviours of clients at the hostels. This is assumed to be the result of similar conditions related to rationing and finances, as well as learned coping with these conditions by spreading the consumption of cigarettes over the day. It is also assumed that greater access to
funds and therefore more readily available cigarette supply would have influenced these results and made several of the smoking behaviours significant. In these settings, some clients were given a set number of cigarettes by staff in the morning and a set number of cigarettes in the afternoon. Several residents at the first hostel actively sought cigarettes from other residents throughout the day, with varying degrees of success. Intimidation of other residents for cigarettes was observed during visits to occur more frequently and more persistently in the early and mid-morning.

(7.9) CONCLUDING THEMES FROM THE PARTICIPANT OBSERVATIONS METHODOLOGY:

The following six themes provide a summary of the most dominant ideas to emerge from the qualitative and quantitative data collected during the participant observation phase. They do not have a particular order of priority and are not mutually exclusive. The complex nature of interactions and behaviours in the context of smoking, combined with a long history of their cultural development, meant that many behaviour patterns were interconnected and difficult to unravel from each other.

(7.9.1) Theme (1) A Systemic Problem:

The entrenched nature of smoking activity within all settings was an overwhelming feature noted throughout the participant observation period. Smoking was a tool serving many purposes for the different groups observed. It was woven into the central fabric of daily life encompassing therapeutic, social, political and economic exchange in all settings. It occurred within a foundation of beliefs and attitudes that served to perpetuate powerlessness and inaction, so that each group tended to pass responsibility for action onto others while the social, legal, ethical and occupational health and safety aspects of the smoking problem remained untouched and unchallenged. Smoking therefore acted as a symbolic currency within a dysfunctional system, with staff saying, “We’re as institutionalised as the patients”.

In the hostels and the inpatient wards, staff openly acknowledged the occurrence of barter and standover tactics between residents, as well as begging, scavenging for butts and harassment of shoppers for cigarettes in the local streets and shopping areas. Staff responded with the provision of medication and large ashtrays, while the social context remained unchanged. They were keen to have ‘the problem’ of smoking fixed, but didn’t see that they had a role to play or duty here. They
either saw themselves as powerless in the face of ‘the problem’, being drawn into the purposelessness it created and enormity of it, or not responsible for it or for initiating change. As the participant observation progressed, the feeling of becoming personally overwhelmed with the size of the problem of entrenched smoking behaviour and inertia of the system to fix it, was apparent. In many settings, some staff pleaded for assistance but continued to act out the dominant reinforcing culture of smoking, in the absence of any preferred replacement culture. Other staff, already drawn into the purposeless mood of the settings, remained passive within it, focusing on the day to day tasks at hand. The effect of this system on the clients seemed devastating, with many spending their day in a vacuum, ‘waiting for nothing’. During one visit to one of the extended care open wards, several patients spoke about their wish to quit smoking. However, the ability to maintain their motivation and take constructive action to quit in the presence of overwhelming pressure to smoke within the daily experience of care, was a constant dilemma.

Within the system of care, other dilemmas were also apparent. In the locked wards, nursing staff had recently raised concerns with management about the legal and ethical implications of continuing to supply cigarettes to clients under the age of eighteen years. When their concerns went unheeded, they sought advice from the Crown solicitor’s office and imposed a smoking ban for these clients. This inadvertently raised the comb atant nature of staff-client and client-client interactions, increasing the instances of violence towards staff and also between clients. One nurse described their loss of the ideals of care and any remnant of job satisfaction as the nurses were now forced to use control and force to shackle a young client because he became abusive and threatening while demanding a cigarette. The hospital pharmacy department’s refusal to supply NRT to such clients in these settings only added insult to injury for staff; costs being given as the reason by management. However, nursing staff argued that the cost of occupational health and safety claims and the current cost of hospital provided cigarettes far exceeded these potential costs. Their mistrust of management was heightened. They were despondent at being seen as expendable.

The structure of the work within such settings created its own dilemmas for staff, especially in the locked settings where there was a noticeable absence of meaningful rehabilitation activities and resources for this. Other wards were similar though. During quiet times staff were tied to the immediate environment, unable to leave or to get absorbed in any activity that required much concentration or time due to the nature of the setting requiring them to be constantly in limbo ready to react to clients’ demands. Under such circumstances, smoking provided a convenient, readily available source of activity to relieve the monotony of the setting and many staff took up this
option, as shown by table 7.12 which indicates that locked ward staff who smoked took the opportunity to join patients in the smoking sequence more than half of the time that they were smoking. Non-smoking staff were able to find alternative ways to fill in these times also, often reading or chatting to other staff. Spending time with clients was one option among many, to relieve the monotony of the setting. Both locked and open ward staff nominated socialising with clients as a common reason for their smoking. The smoking routine and the perceived need for staff to light clients’ cigarettes and sit with them was another source of dilemma and potential conflict between smoking and non-smoking staff who were in effect passive smokers at these times. This was due to the perceived safety and fire risks associated with these clients. These smoking behaviours appeared to maintain the status quo within the setting.

(7.9.2) Theme (2) Smoking as a Tool - An Instrument of Treatment:

Within each setting, smoking was observed as a tool, fulfilling a variety of purposes for the smokers, both clients and staff and the institution also. The most common purpose for clients appeared to be the use of smoking to fill in time and break up the monotony of the day. Within the hospital wards, as well as at the hostels, the act of smoking formed part of a continual rotation of activity, sites and scenery in the absence of other stimulation. Smoking was used to compartmentalise the long slow day into more tolerable pieces. Mealtimes complemented the smoking activity as a central activity for clients to look forward to and to give some order to the day. Conversely, staff were also aware of the role of smoking and relied on it to act as ‘babysitter’ in the absence of other activities within the hospital. They seemed to lack motivation to initiate or provide alternative activities to clients. Both staff and clients readily succumbed to the utter boredom of the settings. At the hostels, clients regularly paced up and down, waiting for nothing, to alleviate the monotony of the setting, while staff were poorly resourced and scarce much of the time.

The primary function of smoking to satisfy the person’s addiction to nicotine was accepted as given by participants, with people in all settings observed to be smoking en masse and in greater quantity in the early morning when the craving and withdrawal following periods of sleep were evident. Although this aspect of staff self-report data was not analysed, the researcher noted that this reason for smoking tended to be nominated consistently during the first two hours of the nurses’ shift. Secondary, or latent, functions of smoking are also of great interest here. Within a system built around routines, smoking provided a central structure to all other routines and processes. This was
especially evident in the locked wards where all other activity appeared to be dependent on the timing of the smoking routine, which occurred rigidly each hour or each half hour, depending on the particular ward. The only other routine to provide such a structure was mealtime. For clients, the smoking routine acted as a vehicle for human contact with other clients and with staff. It provided one of the few opportunities for clients to feel ‘normal’. All other activities followed and were dependent on either the timing of smoking or eating. Nursing staff in all settings busied themselves each day with the important task of ensuring the supply of cigarettes to clients, with ‘smoke runs’ to the local shops forming one of their many core duties. Nurses expressed much animosity towards social workers who refused to ensure the supply of funds for purchasing cigarettes for clients.

In these settings where few rewards and pleasures were apparent, smoking provided an easy, readily accessible source of gratification within the vacuum of daily existence. The exchange of cigarettes between clients, for money, food, drugs, sex, or other favours, was spoken of as common knowledge by staff and clients and was observed as part of the daily life of the setting. Cigarettes provided the currency for which most other activities and interactions were exchanged between staff and clients and clients and clients. Within a system dominated by routines and external controls, the ability to smoke provided one of the few opportunities to act autonomously. Within the locked wards, especially, smoking provided ‘time out’ from the pressures and rigidity of the setting, for both clients and staff. This was confirmed by nursing staff self-report data. During the smoking times, staff and clients in these settings appeared to call a truce from the usually combatant air within the setting, both gaining some relief from it by smoking. However, cigarettes were also clearly and consistently used as reward by staff to manage clients’ behaviour, to pacify distressed or disruptive clients, to foster compliance and co-operation, and to foster conformity to the system and its rules and routines. Staff in one locked ward spoke openly about the allocation of twenty cigarettes per client per day, this incorporating the seventeen cigarettes that they would consume each hour at smoke time between 6.30am (first smoking time for the day) and 11.30pm (last smoking time for the day), with the remaining three cigarettes used to reward good behaviour. This also provided an important means of assessing the person’s readiness to progress to an open ward. Clients quickly learned these rules of engagement with staff. Staff, demonstrating the importance of smoking within the hospital setting provided several anecdotal scenarios. One nurse in a locked ward where cigarettes were dispensed each hour, recounted an incident of assault of a staff member by a client in order to instigate a transfer to the other locked ward where cigarettes were offered every half hour.
For nursing staff particularly, being involved in the distribution of and act of smoking with clients provided them with fundamental opportunities to interact and establish rapport with clients. Smoking allowed nursing staff to assess clients’ mental state and progress. As smokers, they were privy to information that they would not otherwise hear from clients. Hostel staff noted the same benefits of involvement in the smoking ritual with clients. Though never overtly incorporated into policy and procedure, in reality, many nurses had grown to rely on this interaction and many expressed their sense of inadequacy in their professional capacity when they gave up smoking and the realisation that they would have to find new ways to perform these tasks, that did not involve smoking. Interestingly, smoking to aid assessment of clients was not nominated by nurses as frequently as the researcher expected. This does not match what the researcher observed and what participants during staff interviews and participant observation frequently told. Staff may have been reluctant to admit to this use of cigarettes, or they may have been so used to smoking while performing this task that it did not occur to them to nominate it.

(7.9.3) Theme (3) Smoking as a Social Currency:

In all observed settings, social activity between participants was most pronounced in the context of smoking which served as a social tool. The smoking area of each setting was observed to be a hive of activity and social stimulation that was not apparent in other areas within the settings. It was where people came together to talk, or merely to be with others, to gain some sense of human connectedness, especially in the long-stay open wards. Notably, nursing staff from both the locked and open settings who completed self-report smoking sheets nominated socialising with clients while smoking more often than socialising with other staff; the former occurring twice as often or more. In the open wards, the smoking area was often the first point of reference for new arrivals and served as a type of initiation into the ward and the group. Smoking provided a comfortable and safe means of initiating conversation, meeting others for the first time, portraying oneself as non-threatening and alleviating one's own nervousness about being with others. Staff openly encouraged this peer interaction and used it to aid their assessments of the person's level of paranoia, withdrawal, inhibition, irritability and other components of sociability with others. In the locked wards, smoking with others was perceived as a 'normalising' activity. The act of smoking and sharing cigarettes, or going to the shops together to buy cigarettes, gave people the opportunity to share and relate to others in a democratic way, whether they were staff or clients. Within this context, clients who were non-smokers were seen to receive less attention from staff, to be less
interactive and to stand back from the group, suggesting that their needs were not being given as much attention because of their non-smoking status.

However, there existed the usual pitfalls that one would expect in any society where the currency is in demand and supply is curtailed by lack of resources or access. Within the hostels and the extended care open wards, an hierarchical social structure was evident between those who possessed cigarettes and those who were forced to beg, trade or threaten others for cigarettes. The group clearly knew who within its ranks was reliable at paying back for borrowed smokes and who was not, who needed to be looked after within the group by giving them cigarettes and who was a threat if their requests were refused. Within the wards and grounds of the hospital, this daily ritual of determining where one was placed in the hierarchy was played out, sometimes with open acts of violence between clients. In this context, staff feared violence by clients if clients were not provided with sufficient cigarettes. Similar interactions were observed at the hostels. This reliance on cigarettes as social currency, involving the co-existence of smoking and socialisation within the one area, had a number of pitfalls. People found themselves in close proximity to others who were at times quite unwell or distressed and this was seen to aggravate their own illness symptoms and level of distress. Further to this, the demoralising effects on the person and their sense of value and purpose, of begging on a regular basis, was clearly observed.

(7.9.4) Theme (4) Attitudes of Staff:

Throughout the wards and hostel settings, the overwhelming prevailing attitude towards clients and their smoking was that there was little that could be done to change the current situation, that there was little hope of them giving up smoking, that the situation was unresolvable. Therefore, no attempt was made to alter the daily routines and rituals around smoking. In the extended care wards, staff largely left clients to sit in the smoking areas among their peers or roam the grounds, while staff remained indoors. In the hostels, the situation was the same because “everyone smokes here.” As one nurse explained it, “The poor devils are not able to quit. They use the cigarettes to help them with their illness, so why not let them smoke.” Ultimately, staff felt powerless to change the situation. Neither did staff feel it was their responsibility to act on the smoking issue, reflecting the ethos of the system of care. My experiences during the participant observation period clearly demonstrated that these smokers were motivated to quit and wanted to quit. However, they felt powerless to initiate or maintain the quitting process within the environments in which they found themselves.
The attitudes of many staff, especially nurses, towards clients’ smoking, involved a weighing up of harms. They assumed that the client’s mental illness would always be present and that there was little hope of genuine recovery. The stigma of mental illness was perceived as a lifelong influence on the person. Hence, comments like the following were common; “Whose purposes are we serving by insisting that these poor buggers give up smoking? Would they really benefit?” Many nursing staff felt that the best they could do was to create a secure environment, to protect the person from themselves and the outside world; to create an institution. The ability of clients to achieve meaningful rehabilitation into the community was not within these staff’s daily experience. They saw little evidence of progress and whatever small gains did occur were quickly squashed with the revolving door effect as the same faces came and went and came again.

During the period of participant observation, there were numerous occasions when nursing staff took many pains to let me know how much they knew about smoking, how they had read the most current literature and research. Despite this, they appeared not to apply their knowledge to the populations within their care. Instead, they busied themselves with their day to day routines of ensuring the supply of cigarettes for their clients, seeking out the best bargains from the local supermarkets to help make their money go further. Their actions were determined by their attitudes, of which the following was common; “Smokes money is their priority; for what else do these patients need, in reality?” They deplored the hospital canteen for charging up to $1 more per packet than the price ‘outside’. They supported clients’ ‘need to smoke’ for self-medication purposes and sneered at management whom they perceived as attempting to soothe their own consciences by expressing concern about the smoking issue. Few staff believed that clients could quit successfully. This was in contrast to the majority of clients who spoke to the researcher stating that they did want to quit but felt unable to, lacking the power to do so given the overwhelming reinforcement to smoke while at the hospital, as well as feeling unsupported in their efforts when they did try to quit.

(7.9.5) Theme (5) Us and Them:

In all settings, the fundamental and unresolved dilemma of incarceration versus care underpinned the often combatant and coercive nature of interactions between the participants. The threat of detention and seclusion that could deprive basic freedoms, down to the counting of cutlery in locked settings, were characteristic of this dilemma. For much of the time in the hospital environment, staff physically separated themselves from clients. Whatever happened outside the boundary of the ward
was perceived as none of their concern or responsibility. Many wards were physically structured to create barriers between staff and clients, the most obvious being the use of keys throughout the hospital and the often-closed nurses’ station door. This door was frequently held ajar by staff as they spoke to clients so that they could keep one foot inside and one foot outside and could readily close it if needed. During quiet times, staff frequently retreated into the staff area away from clients’ gazes, to seek some relief from the combatant environment and the incessant banging on the nurses station door. In the hostels, many clients paced up and down the driveway but did not go outside the gate. Staff frequently used the analogy of the prison system to describe their work situation and clients and hostel residents referred to themselves as ‘inmates’.

All seemed suspicious of ‘outsiders’; staff were distrustful of change or anyone who might represent management. Clients distrustful of staff, their conversation and demeanour changing whenever staff were present. This was particularly noticeable when staff entered areas deemed to be client territory, such as the smoking areas outside the wards and the grounds in front of the canteen. One client, summing up the atmosphere at the canteen, stated “It’s freer here. The ward is depressing. It’s staff territory.” Fragmentation into ‘us and them’ occurred at all levels and between all participants: staff to client, ward to ward, client to client, staff to staff, discipline to discipline and hospital to community. Each ward setting possessed its own unique variation on the dominant culture of paternalism, and each compared itself to other wards, painting itself in a more favourable light than its counterparts. Each hostel was a hidden ward community within the community. The staff in one ward spoke proudly about their ward’s resistance to change. A past episode of smuggling a donkey into the ward enclosure was seen as a triumph against management by staff and clients. Within their enclosure and high walls, pet chooks roaming the yard symbolised their opposition to progress. They described their ward as the last bastion of a former era of institutionalisation and worked hard to create a homely environment within the limitations of their gaoler role. “I suppose we try to make the best of it, seems we’re all in here together, then everyone is better off.” Management was perceived to be ignorant of the daily experience and needs of clients and staff, rarely visiting the wards. Staff recounted their many experiences of client violence towards themselves and coworkers and felt expendable in the eyes of management. Doctors came and went, keeping their interaction within a tight range, the smoking issue being, “of no concern to them.” Meanwhile, the paranoia of psychotic illness bubbled along as part of the fabric of daily life, influencing all participants’ behaviours and interactions, acting as a ‘de facto’ barrier to cohesion. Within this context, the exercise of power could be clearly seen, cigarettes acting as a prized commodity and source of influence and control over the behaviour of others.
staff ultimately exercised power over clients. Clients variously made small attempts to regain some of this power by identifying strongly with their peers, defying staff requests, or engaging in barter and intimidation for cigarettes.

(7.9.6) Theme (6) The Absence of a Clinical Approach to Smoking:

Many of the decisions made by staff about the care of clients in the inpatient and community settings involved significant mistaken attribution of smoking as therapeutic. Staff failed to distinguish between illness relapse and agitation due to illness symptoms and nicotine withdrawal symptoms. At no time when clients were displaying agitation did staff equate this with withdrawal from nicotine. It was always perceived as symptoms of their mental illness. Clients also misinterpreted the situation in this way. Alternatives to finding cigarettes to alleviate the agitation were not usually explored by staff or clients. Nicotine replacement therapy (NRT) was beginning to be discussed by some staff as an alternative management tool for some clients. This was more often based on staff frustration with cigarette supply problems than with any concern for the harms of smoking to the client or recognition of repeated nicotine withdrawal, especially in the locked wards. No formal policy and commitment to the use of NRT existed at the time of participant observation. The generally held belief was that clients would refuse NRT, preferring to smoke. The risks and dilemmas involved in monitoring compliance with NRT within the hospital grounds was perceived to create further unwanted problems for staff and clients. It just seemed too hard. The current system of ‘letting them smoke’ remained as the preferred option. This was so whether staff were smokers or non-smokers and existed across all disciplines and administration.

The diligence of inpatient staff in ensuring the supply of cigarettes to clients was often based on concern for client’s immediate needs to be pacified and concern for staff safety and workplace comfort. Staff either weighed up the short and long term harms of smoking and chose the short term option, or they did not think about the situation in this way at all. In some wards, the distribution of cigarettes to patients was done in rote fashion. It had become part of the daily routine and was not questioned. This was especially the case in the extended care open wards. In the locked wards, where staff and clients were in closer proximity and clients were acutely unwell, cigarette distribution was a conscious decision by staff to alleviate suffering and promote safety for staff and clients. The community hostels mirrored the extended care open wards. Many hostel clients were responsible for their own cigarettes. Those clients who were deemed as not responsible received
their cigarettes as a ration from staff. They were then left to their own devices and the interactions and influences of ‘the pack’, with little or no staff supervision.

Like their client counterparts, most staff believed that clients who smoked needed cigarettes in order to manage their mental illness symptoms and that not having cigarettes on hand would worsen their mental state. The use of cigarettes by nursing staff who smoke to manage clients’ symptoms and behaviour was a significant part of their clinical practice. Like their client counterparts, staff also used cigarettes to cope with the environment in which they found themselves and the pressures of their role. In the locked settings, these staff clearly became bound up in the smoking sequence and the rote nature of smoking activity in the settings. There was little thought about the principles of health promotion for themselves or clients.

A small number of staff understood that there were pharmacological links between smoking and psychiatric medications, however, they did not appear to apply this knowledge to their daily practice. Smoking was automatically accepted as the norm. Staff expressed surprise when they came across clients who did not smoke. There was an overall absence of concern for physical health throughout the settings, the focus and priority being to treat the mental illness alone and to vacate beds. Social workers and occupational therapists stood outside this dominant focus, with little power or influence. Responsibility for the clinical management of smoking was absent. The various disciplines tended to shift responsibility for action to each other. This usually involved debates about who was responsible for ensuring supply of cigarettes rather than any combined effort to promote non-smoking or harm minimisation as a clinical team.

(7.10) CONCLUSION:

This chapter has provided a rich description of smoking behaviours in the inpatient settings and community hostels. It has explored, in detail, the complex interactions and motivations for smoking behaviours by clients and staff within mental health settings, providing context and texture to the data from client and staff interviews in the preceding chapters. The concluding themes have attempted to draw together the dominant ideas from the three aspects of data collection (client interviews, staff interviews and participant observation) as part of the process of building a picture of an overarching theory that will explain why smoking is so prevalent in these settings and amongst these populations. Further discussion of these themes followings in chapter eight.
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Table 7.23: Summary Themes from Participant Observation of the Settings
CHAPTER EIGHT
THE INTEGRATION OF THE TRIANGULATED DATA

(8.1) INTRODUCTION:

This chapter begins by describing the integration of data from client and staff interviews and participant observation of the settings, as described in Section Four of the methodology chapter. A series of tables and figures is provided, each building on its predecessor. The first of these brings together the themes from each study. (see Table 8.1) The second stage is represented by a Venn diagram showing points of commonality in and difference between the studies. (see Figure 8.1) An ecological framework is then used to assist in understanding the culture of smoking within the mental health settings. (see Figure 8.2) Culture is discussed as the emergent sociological framework for the research.

(8.2) SECONDARY ANALYSIS OF THE TRIANGULATED DATA:

This section draws together the common themes derived from the studies outlined in Chapters Five, Six and Seven. The thematic analysis described how smoking was used within the treatment environment of staff and clients as a currency for clinical, social and political exchange. By looking at the forces that exist in these settings, an understanding is gained of the system of care in which smoking by the mentally ill and mental health service staff occurs and is perpetuated. Analysis of results from interviews with successful quitters is used to further inform the discussion.

A core data set from each of the three studies is shown in tabular form (see Table 8.1). From this table, points of commonality and difference are drawn (see Figure 8.1), in order to begin the process of interpreting the interrelationships between the data.
Table 8.1: Systematic Integration of the Triangulated Data—Stage One

Client Interviews

- High Order of Priority for Clients
  - priority of harms and risks
  - neglect of physical health
- Professional Ethical Responses/Dilemmas
  - Attitudes and Beliefs
  - Clinical Management Tool
    - rapport, routine, symptom management, behaviour management, relapse prevention, assessment, conditioning
  - Personal Management Tool
    - stress, boredom, debrief, break-time, time out, socialisation, belonging, addiction, relaxation, conditioning
    - skills and training, coping and support
    - nicotine withdrawal versus illness management
- Us and Them – fear, stigma, paternalism
- Control
- Poverty
- Systemic Issues
  - historical context/culture of smoking
  - duty of care, breaches
  - abuse and neglect
  - reinforcement
- Professional Differences
  - Legal Issues and Occupational Health and Safety
    - violence
    - passive smoking
    - health problems
  - Environment and Terminology – ‘the cage’, ‘inmates’, ‘a lost cause’
- The Community Hostel – Mirror of the Asylum
- Differences between Hospital and Community Staff

Participant Observation of the Settings

- Smoking as Primary Activity
  - Staff and clients
  - Enculturation
  - Smoking sequences and routines
  - Lack of clinical approach
- Priorities
  - Neglect, Apathy, Powerlessness and Collusion
  - Attitudes and Beliefs
  - Health – Lack of concern
  - Poverty, demonisation, dehumanisation
  - Us and Them
    - Denigration of territory
    - Clinical staff and administration
    - Staff and clients
    - Interdisciplinary
- Culture of Smoking
  - The asylum culture
  - Token economy, trade/barter, intimidation, currency
  - Acceptance and reinforcement
- The System as a Dominance Hierarchy
  - Bureaucracy, organisational culture
  - Control and fear
- The Environment and Terminology – ‘the cage’, ‘inmates’
  - A Multi-Faceted Tool
    - Boredom relief: Stress relief, power protection, socialisation, connection, clinical management, exchange
  - Mental Illness versus Nicotine Withdrawal
  - Occupational Health and Safety
  - Legal issues
    - Evident but rarely expressed
    - Passive smoking
    - Violence
  - Community Hostels
    - Stigma, despair, quality of life, reinforcement
A number of propositions arose from the above Venn diagram. The data appeared to provide descriptions of four domains: themes that were common to all three studies, themes that were unique to client interviews, themes that were unique to staff interviews and themes that were shared by staff interviews and participant observation of the settings.

Themes that were common to all three studies are represented by the central area shared by all three sets of data. They were:

- Smoking as a Primary Activity
- Smoking as a Multifaceted Tool
- ‘Us and Them’
- Systemic Issues
Themes unique to client interviews were:
- Grief and Loss
- Quitting Experience
- Diagnostic Differences Between Client Smokers

Themes unique to staff interviews were:
- Differences Between Hospital and Community Staff
- Professional Ethical Responses & Dilemmas

Themes common to staff interviews and participant observation of the settings were:
- Cultural Transfer – Hospital to Community
- A Hierarchy of Values held by Staff
- Staff Smoking- Differences According to Setting

Once the domains of the data were recognised, it became clear that the sociological framework of culture could be applied to the data sets. This interpretive process could then be used to begin the process of developing an integrated theory of smoking and mental illness. Culture is defined here as consisting of, “conventional patterns of thought and behaviour, including values, beliefs, rules of conduct, political organisation, economic activity and the like, which are passed on from one generation to the next” (Hatch, 1985, p.178). The culture of an organisation determines how it defines itself, how it solves problems, how it perceives its members and how it responds to change. In this respect, culture involves various players, with various roles and rules for behaviour, interaction and communication, informed by beliefs and attitudes, set in the context of established rites, structures, artefacts and ideologies that together serve to perpetuate the culture (Jones & May, 1992). Each point common to all three studies is discussed in turn with differences in emphasis highlighted. These are followed by discussion of themes unique to client interviews and staff interviews and then themes shared by staff interviews and participant observation of the settings. The components of culture, as mentioned here, appear in brackets with each relevant theme presented.

(8.2.1) Smoking as a Primary Activity (The Players):

Results of all three studies confirmed that smoking was a primary activity in mental health settings, that is, it formed a central part of the daily experience of all the players. An extensive history of
smoking in the settings was apparent. The extensive use of areas outside each inpatient ward and community hostel for smoking, the lengths taken by clients and staff to ensure the supply of cigarettes as a core need, as well as the smoking sequence in the locked wards were examples of the primacy of smoking activity in the settings.

(8.2.2) Smoking as a Multifaceted Tool (The Roles):

Clients and staff participants of this study described the social, personal and temporal habits of smoking in much the same way as non-mentally ill smokers described them, that is, to fill in time, to relieve boredom, to move from one activity to the next, for stress relief, to aid concentration, for relaxation and as part of socialising with others (Carter, et al., 2001). However, the clients who participated in this study and the staff participants who treated them appeared to use cigarettes and smoking behaviours as part of a much more complex set of social rules for interactions and learned responses in dealing with mental illness. The use of cigarettes for clinical purposes, for power and control, ensuring safety and for social and economic exchange have been noted.

(8.2.3) Us and Them (The Rules of Communication):

In each phase of the research findings there were multiple examples of how smoking was used by clients and staff as a source of power and control. Beyond the effects of the drug itself, the role of cigarettes in mediating social interactions has been noted. The use of cigarettes by clients in order to feel a sense of control over their illness symptoms and to gain a sense of autonomy within a system of care in which they felt a loss of personal identity was described in Chapter Five. The involvement of staff in the supply of cigarettes to clients and the consequences of this for transactions of power between them was described in Chapter Six. The inter-disciplinary rivalries and tensions, fuelled by the system’s reliance on a continuous supply of cigarettes to clients in the hospital setting, have been noted. As a consequence of this, no united focus on overcoming the smoking problem was apparent; the high level of smoking was likely to continue unabated. The smoking sequence in the acute locked settings was akin to the calling of a truce, during which clients and staff laid down their fear and mistrust of each other and joined together to have a smoke in the smokers’ cage. This was a unique finding of the research. The aggravating effect on hostility by the frequent nicotine withdrawal observed in clients, especially in the acute locked ward, was likewise an unexpected finding.
The terminology of ‘the cage’ and ‘the fishbowl’, with clients and staff describing themselves as ‘inmates’ seemed to perpetuate an environment in which combatant interactions were the norm. In support of this idea, Barrett (1996) notes the important role of language in defining social relationships within psychiatric settings. The physical environment of the settings, with glassed, locked doors between clients and staff also appeared to promote a divisive, combatant air between clients and staff. The design of the acute locked setting mirrored Bentham’s prototype panopticon from which it only took a single gaze to see all areas (Roach-Anleu, 1999). The banality of the settings and the lack of other meaningful activity was also noted by clients and staff to have a negative effect on the sense of control and power they felt. For clients, it appeared to diminish their sense of control. For staff it gave them greater control but paradoxically appeared to induce an ‘us and them’ air in the settings. This ultimately drew many staff into a culture that fostered powerlessness in the longer term. The comments made about ‘running on autopilot’ and being ‘as institutionalised as the patients’ were examples of this effect.

(8.2.4) Systemic Issues (The Structures, Ideologies and Artefacts):

As noted above, the smoking areas outside each ward and the smokers’ cages in the locked wards appeared as control points for social interaction and exchange in the settings. Clients and staff described a system of care that overwhelmingly accepted and reinforced the multiple roles of smoking despite the physical harms, professional concerns or contradictions, economic and social costs, or legal and occupational health, safety and welfare concerns for clients and staff. The current system was described in the context of its historical cultural antecedents. Staff possessed full knowledge of cigarettes being used by clients in exchange for food, sex and other drugs. Staff were also fully aware of the standover and barter for cigarettes by clients and the use of cigarettes for reward by staff. Confusion, ambivalence and powerlessness were noted in comments made by staff when speaking about their ethical responses to the smoking issue. Their sense of professional demoralisation was evident. They expressed the ethical dilemmas involving smoking by clients as not resolvable. Each professional group appeared to be struggling to preserve its own patch in the face of this situation, with many staff appearing to blame staff from other professions for inaction on the smoking problem. The animosity this created between the disciplines only served to alienate them further from each other. Clients stood by, watched and smoked.
(8.2.5) Grief and Loss (Beliefs and Attitudes):

A unique finding of this research is its articulation of the meaning of smoking to clients and the importance they attributed to existential barriers to quitting. Grief and loss seemed to be a central feature of their experience of mental illness. It acted as a barrier to quitting. This was not clearly understood by staff. During participant observation clients were often observed to be fearful, sad and isolative, appearing lost in their thoughts and distant. Because they were not interviewed in depth during this phase, the researcher can only infer what they were feeling from their body language.

(8.2.6) Quitting Experience (Beliefs and Attitudes):

Client interviews provided a unique opportunity to determine the range of experiences of client smokers, with diagnostic differences being suggested by the results. Client interviews also provided a unique contribution to understanding the specific meaning of precontemplation (Prochaska & DiClemente, 1984) for this group of smokers. Many clients, in fact, said that they had made a number of sincere attempts to quit smoking, without success. Interviews with successful quitters established that people with mental illness could quit and that they may experience the quitting process in similar ways to non-mentally ill smokers. They described being aware of the habits around their smoking and implementing effective strategies to address these habits. They also described their motivation for quitting in much the same way as mainstream smokers, that is, for better physical health and to save money (Carter, et al., 2001). However, no clients said that they smoked, or resisted quitting, in order to keep their weight down, unlike non-mentally ill smokers (Carter, et al., 2001). Comments made by staff and observations of the settings revealed a belief that clients were unable to quit successfully. The general sense gained from these two phases of research was that quitting was not possible for people with mental illness, that they had little or no control over their smoking consumption.

(8.2.7) Diagnostic Differences Between Client Smokers (Players and Roles):

Indepth interviews with client smokers revealed differences in their smoking behaviours and perceptions of barriers to quitting according to their psychiatric diagnosis. An understanding of these differences may be useful in assisting these smokers to quit, cut down and to manage their
illness symptoms more effectively. These differences have been explored in Chapter Five and Appendix M.

(8.2.8) Differences Between Hospital and Community Staff (Players and Roles):

Staff made several comments on the differences between hospital and community settings with regard to the level of reinforcement of smoking. The hospital was seen as more reinforcing of smoking. Hospital and community staff generally varied in their beliefs about clients’ ability to quit smoking. Community staff demonstrating a greater belief in the clients’ responsibility for smoking and quitting. Community hostels were perceived to mirror the institutional aspects of the hospital. Community staff seemed more autonomous in their roles whereas hospital staff were bound by their traditional professional roles within the hierarchy of the hospital system. These points were less apparent from client interviews and participant observation of the settings. Lack of observation of community staff in their setting prevented further comparisons.

(8.2.9) Professional Ethical Responses and Dilemmas (Beliefs and Attitudes):

Staff interviews revealed that many staff had significant ethical dilemmas about their role with clients in relation to smoking and mental illness management. Staff described their concerns in great detail during interviews. Professional differences were also apparent from staff interviews. During participant observation of the settings, these ethical dilemmas were less apparent. During this latter study, staff appeared to be absorbed in the cultural milieu of the settings. Many of their actions and interactions with clients appeared to be habitual and automatic and overwhelmingly driven by acceptance of the culture of smoking. Clients did not perceive that staff had dilemmas in their role. Clients were preoccupied with ensuring the supply of cigarettes and seemed to view staff as part of the dominant system in which they the clients were disempowered.

(8.2.10) Cultural Transfer - Hospital to Community (Rules of Communication):

Only one of the clients interviewed in Study Two lived in a community hostel. Therefore little data specific to hostels was gained during this phase of data collection. However, staff made many comments about the community hostels as mirroring the inpatient long-stay wards. Most of the staff interviewed had trained in the hospital setting. Their attitudes and beliefs about clients appeared to be negatively influenced by that experience. Comparison of the hostels with inpatient wards
revealed few perceived differences in the activities involving smoking. Trade, barter and intimidation by clients and reinforcement by staff were apparent and common to both settings. An attitude of ‘let them smoke’ prevailed.

**(8.2.11) A Hierarchy of Values (Attitudes and Beliefs):**

Staff interviews provided unique data on the personal, clinical, social and professional attitudes and values held by staff that determined their ethical responses to smoking and mental illness. To the researcher’s knowledge, no other study exists that has explored staff views in this way. Comparative analysis of how each profession responded to smoking within psychiatric settings was also unique to this research. This was based on an understanding of their roles and interactions with each other as treatment providers. An absence of concern for the physical health consequences of smoking was noted for the majority of client and staff participants. The lack of focus on legal concerns was also prominent in all three phases of the research. Clients made no mention of it. Only a small number of staff made reference to passive smoking and occupational health and safety in the context of smoking. No mention was made of the legal consequences of colluding with the supply of cigarettes to clients or the reinforcement of smoking within the hospital setting. Multiple occasions of passive smoking by non-smokers was observed, especially non-smoking clients. This was also observed for staff who were required to monitor clients’ smoking in the locked settings.

**(8.2.12) Staff Smoking- Differences According to Setting (Players and Roles):**

In their interactions with clients, staff in different settings appeared to use cigarettes in similar ways such as to establish rapport with clients. However, the use of smoking by staff for their own stress management appeared to vary according to the setting in which staff worked. Staff in the locked settings appeared to use smoking to cope with the pressures of their setting more so than open ward staff. They seemed more enculturated into smoking with clients. The smoking sequence played an important role in this enculturation process. Community staff appeared to be less likely to be smokers and more likely to be ex-smokers than their inpatient counterparts.

In summary then, throughout the three phases of research (Study Two, Three and Four), the acceptance of the culture of smoking within mental health settings was apparent. Smoking served multifaceted roles and functions within the culture. Complex rules of interaction existed between the players. These rules were informed by beliefs and attitudes held by the players about the centrality of smoking within the culture and about mental illness and smoking. The underlying
ideology was a product of the historical context in which smoking occurred within mental health services over time, current practices and the statutory acts that maintained the relationships between the players. It was a culture with many artefacts and agreed terminology. Finally, there existed many forces that served to maintain and perpetuate the culture of smoking with mental health settings.

(8.3) AN ECOLOGICAL FRAMEWORK FOR UNDERSTANDING THE SMOKING CULTURE:

Bronfenbrenner’s (1979) ecological framework is used here to provide a comprehensive, theoretical perspective for understanding the culture of smoking within mental health settings. This framework provides a useful understanding of the various components of systems, emphasising the importance of understanding the players, their interrelationships with each other in the settings as well as the larger contexts in which those settings and relationships are embedded. In this way, comprehensive analysis of the data, as outlined in section four of the methodology chapter is undertaken. Bronfenbrenner (1979) defines the four main components of the framework as follows:

Microsystem – “a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics” (p.22).

Mesosystem – “the interrelations among two or more settings in which the developing person actively participates” (p.25).

Exosystem – “one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting containing the developing person” (p.25).

 Macrosystem – “consistencies, in the form and content of lower-order systems (micro-, meso-, and exo-) that exist, or could exist, at the level of the subculture or the culture as a whole, along with any belief systems or ideology underlying those consistencies” (p.26).
Applying the ecological framework shown in Figure 8.2 to the current research, immediate relationships between client and client and clients and staff exist in the microsystem. The supply and use of cigarettes by clients and staff and the activity of smoking, barter and intimidation all occur in this microsystem. The interrelations among inpatient clients and the community, as well as community-living clients and their mental health service, the hospital and the wider community are examples of relationships within the mesosystem. Quit services, general health services, police and media, consumer groups, mental health legislation and the community’s relations with the mental health institutions represent relationships within the exosystem. At the macrosystem level, belief systems and ideologies that influence the culture as a whole are apparent. These beliefs filter down through each of the three lower-order systems. They include society’s fear of mental illness, notions of stigma and deviance. Beliefs about institutionalisation and patterns of group organisation and bureaucracy also occur at this level of the system.
(8.4) DEVELOPING A THEORY OF SMOKING AND MENTAL ILLNESS:

Bronfenbrenner (1979) made two significant and relevant points when devising his framework. He stressed that the best way to understand something is to try to change it, that this would clarify the different levels of resistance to change and the degree of embeddedness of a particular behaviour or activity. Bronfenbrenner also stressed that change in one system was likely to promote change in other systems. These two points are critical in understanding the current research, in particular, the barriers to quitting experienced by smokers with a mental illness and by those who attempt to assist them to quit. Building on Bronfenbrenner’s framework, the current research has found that several aspects of relationships between clients and staff within mental health settings appear to be central to understanding the culture of smoking at each of the four ecological system layers. They include the attitudes and values that determine communication styles and actions between the participants within the system, the nature of group organisation and organisational culture, power relationships and the physical and social environment in which the system exists. These aspects filter through each of Bronfenbrenner’s system layers, via a complex two-way process of learning and transfer between the layers. It is these aspects of the system that both clients and staff identified as perpetuating the culture of smoking. These points are briefly discussed in the section 8.4.1 to 8.4.4, with each applicable ecological system layer identified in the context of these points. This form has been taken in the discussion to emphasise how these points cross system layers and are transported between the macrosystem and the microsystem.

(8.4.1) Attitudes and Values:

The culture of smoking in the mental health setting appeared to be influenced by underlying attitudes and values held by the participants of this study. The historical context of this has been explored previously. These beliefs and attitudes were determined at the macrosystem level and involved notions of deviance and stigma. They encompassed beliefs and values about the mentally ill that seemed to influence all layers of the system and determined responses by clients and staff. Inherent in the notion of deviance is social control. “Whenever we use such terms as persuade, restrain, discipline, coerce, penalise, reward, direct, manage or regulate to describe aspects of the activities of individuals or groups, organisations or societies, we are talking about the exercise of social control over peoples’ bodies, minds, and behaviour” (Edwards, 1988, p.1). All of these facets of social control were evident in the settings observed for this study. Cigarettes provided the means by which social control of ‘deviant’ clients was organised. Further to this, the various groups within
the dominant hierarchy of the mental health settings accepted their roles and positions and behaviours. Staff accepted that clients needed to smoke and clients accepted their labels as mentally ill smokers. In these settings, ensuring the supply of cigarettes was observed to represent one of the means by which these positions were maintained. Staff smoking represented the mechanism for interaction in this context. The many ethical dilemmas expressed by the staff participants about the smoking behaviours of clients in this study highlighted the inherent dilemma of staff providing care but also acting as agents of social control (Foucault, 1977; Rhodes, 1991).

‘Us and them’ relationships, with staff in many settings distancing themselves from clients, suggest that the notion of deviance as a component of group dynamics was acting to maintain group equilibrium and boundaries between staff and clients. (Dentler & Erikson, 1984). Wing (1967) argues that deviant behaviour of the mentally ill may be compliance with expectations of the sick role involving exemption from normal social roles and personal responsibility, this being part of the equilibrium process within group hierarchy. In such a system, responsibility is separated from social action so that social problems are individualised leading to a tendency to blame the individual (Conrad & Schneider, 1985). These interactions were noted in the microsystem relationships between many clients and staff. Staff did not appear to accept any responsibility for assisting clients to quit smoking. Smoking was largely described as a client right and an individual choice by staff. The larger system appeared also to accept this situation by having no clear policy on smoking and passive smoking by staff or clients. The system as a whole did not seem to perceive its role in contributing to or perpetuating the deviant behaviour. In this way the transfer of attitudes and values could be seen across each layer of the system.

(8.4.2) Organisational Culture and Group Dynamics:

The culture of an organisation is central to how one understands social relationships between its members (Jones & May, 1992). At the microsystem and mesosystem levels, observation of the mental health settings revealed complex subgroup arrangements, each with its own sub-culture based on specific shared meanings and symbols. The separation of mental health settings into client and staff and separation of staff into professional disciplines were examples of this phenomenon. The hierarchical organisation within and between the professions was a further influence on the day to day interactions, relationships and transfer of meaning and culture. At the exosystem and macrosystem level, the structural relationship between the psychiatric hospital and the larger society also appeared to influence the culture of the settings, with rules, policies and official ideology.
tending to reflect, reinforce and reproduce the dominant culture (Jones & May, 1992). The Guardianship Act and The Mental Health Act are examples of overt shared meanings and symbols. An extensive literature exists on the role of the psychiatric institutions over time, in particular, descriptions of the social, political and economic purposes they have served for the wider community (Dwyer, 1987; Rhodes, 1991; Shlomowitz, 1990).

Understanding the forces that influence change in organisations is also important. Hasenfeld (1983) argues that human service organisations are often resistant to change because, “they are public bureaucracies run by powerful interest groups with a vested interest in the stability of organisations” (p.100; see also Ramon, 1992). Clients are often powerless in these organisations. Mental health services also experience public pressure to contain the mentally ill, based on negative macrosystem beliefs held by the larger community about the mentally ill.

Central to the notion of change is the need to understand why change does not occur. Schon’s (1972) concept of ‘dynamic conservatism’ is demonstrated by these findings, in particular, the fragmentation of the professional disciplines and the impact of this on smoking within the settings. Ogburn’s (1972) explanation of why organisations are resistant to change is also evident here, that is, staff and clients tended to use existing forms of behaviour management, out of habit, rather than create new ones. The use of cigarettes by staff to manage clients in mental health settings acted as the mechanism for many of the rules of interaction, and procedures and actions taken in the settings. Their use took all the forms suggested by Sidanius and Pratto (1999), involving a high level of passive and active co-operation by the groups with lower status in the hierarchy, often by their deferential behaviour towards those with higher status in the system. The passive line up of clients at the nurses’ station door to receive cigarettes is an expression of this process.

The system of exchange and barter of cigarettes throughout the settings is an example of Skinner’s (1953) social exchange theory as an activity in subcultures (see also Forsyth, 1999). Sykes’ (1958) descriptions of prisoners’ social arrangements in response to the system, with its detail on the pecking order involving exchange of goods such as cigarettes, clothing, food and gestures of deference between prisoners, was similar to that observed in the mental health settings.

Weber’s concept of bureaucracies, in which there is a focus on informal organisation and subgroup dynamics and activities in response to bureaucratic structures, can also be applied to the findings. Many of the interactions between clients and staff at the microsystem level can, as Weber’s concept
of bureaucracy suggests, be “viewed as a spontaneous and functional adaptation by human actors to the problems of bureaucratic life” (Britan & Cohen, 1980, p.11). Several examples of this were evident in the current study. Staff appeared to be heavily involved in the supply of cigarettes to clients through multiple informal arrangements ranging from providing cigarettes bought with canteen volunteer funds to nurses doing smoke runs for clients during their lunch break. The presence of chickens and a donkey in the extended care locked setting symbolises this adaptation to the setting. A further factor in group dynamics is the notion of secondary adjustments that exist within institutions. These involve, “practices that do not directly challenge staff but allow inmates to obtain forbidden satisfactions or to obtain permitted ones by forbidden means” (Goffman, 1988, p.53). With this comes a kind of code or informal social control by the group to prevent informing staff. This mechanism was evident in the trade and stand-over for cigarettes, a practice that was fully known by staff and largely ignored. It involved a shared code of conduct by clients, such as the way that the hostel clients refused to tell the staff member that one of the male clients had been begging for cigarettes.

(8.4.3) Power Relationships:

Within the mental health settings cigarettes appeared to perform a central role in how individuals and groups asserted power and control. It also appeared to involve the mechanisms of reward described in social exchange theory. French and Raven (1959) argue that the inherent mechanism of rewards heightens power when the rewards are valued, when the group relies on the power holder for the resources and when the power holder seems credible. In a system in which cigarettes were valued by clients and staff, where clients relied on staff for the supply of cigarettes and where clients were dependent on the system for their care and treatment, cigarettes clearly became a central force in power relationships. Cultural power via, “control over the means of value creation, interpretation and maintenance” (Jessop, 1972, p.58), comprising economic, political and social power, is also useful in understanding smoking within the settings. Economic power involved the distribution of ward cigarettes as well as the trade and stand-over for cigarettes in the hospital grounds. Political power was exemplified by the Mental Health Act that enabled detention and involuntary treatment. Social power could be seen in the deference shown to psychiatrists. Observations suggest that cigarettes were variously used by clients and staff to assert power. The comments on freedom and protest made by clients were attempts to assert power and to combat the power of others over them. The notion of substance use by minority groups in order to experience
personalised power (Barber, et al., 1988; Roche & Ober, 1997), has been demonstrated by these findings.

(8.4.4) The Physical and Social Environment in which the System Exists:

Several physical and social aspects of the settings appeared to contribute to and reflect beliefs about the mentally ill across all four layers of the ecological system. The culture of smoking in the settings appeared to be communicated within and between the various groups of players by fear. This involved the belief that the mentally ill were potentially violent because of their mental illness. Decisions and relationships at the exosystem, mesosystem and macrosystem level seemed to be influenced by these beliefs and values. Conversely, the flow of beliefs and values also occurred from the macrosystem to the microsystem and influenced how staff viewed clients in this way. The result was that, in the microsystem, staff feared assault by clients if cigarettes were not provided. Clients said they smoked because they feared illness relapse. Case notes, numbers and labels were used to identify clients. Keys and locked doors separated clients and staff. Smoking occurred in the absence of other meaningful activities. Clients said they felt disempowered within this system.

There is an extensive literature on the rates of assault upon nurses in psychiatric settings. According to the literature, up to 80% of nurses have experienced assault (Baxter, Hafner & Holme, 1992), with assaults accounting for 70% of all work-related injury for nurses (Lawson, 1992). Morrison (1990a) concluded that organisational norms that emphasise control of patients’ behaviour via the enforcement of rules and denial of requests promote a ‘tradition of toughness’; that they promote violence (see also Harrington, 1974; Morrison, 1990b). Burrows (1994) found that restricted movement, inhospitable décor, inadequate activities and lack of information led to increased rates of assault. Both staff and clients, especially those in the locked wards, identified the presence of these problems (see also Blair & New, 1991). Authoritarian and confrontational styles by staff have also been found to increase violence risk (Grainger & Whiteford, 1993), as have authoritarian and inflexible approaches to treatment (Tardiff & Sweillam, 1982). The use of the nurses’ station door to separate staff and clients, especially in the locked setting, is noted here.

(8.5) CONCLUSION:

This chapter has described the culture of smoking within mental health settings using a sociological framework. The various components of a cultural framework, as they apply to the results of this
study, have been given. The forces at work in perpetuating a smoking culture have been suggested. Bronfenbrenner’s ecological systems framework was applied to understand how the culture of smoking has developed and is perpetuated. Theories that contribute to further understanding the relationships within and between Bronfenbrenner’s system layers have been outlined. The following chapter examines the implications of the culture of smoking in mental health settings.
CHAPTER NINE: CONCLUSIONS

(9.1) INTRODUCTION:

This thesis began by asking questions about the barriers to quitting for smokers with a mental illness. These questions were based on research that showed poor quit rates and high smoking rates in this group of smokers, despite the vast body of research and clinical knowledge that exists on the topic. Through interviews with clients and the staff who treat them, it became apparent that many system-based forces exist to perpetuate smoking behaviour, forces that are beyond the control of the individual client. These barriers to quitting for mentally ill clients have not been detailed previously. Participant observation of the mental health settings confirmed and clarified these complex forces. Within the mental health treatment milieu these forces appeared to pose significant barriers to quitting for both clients and staff smokers. A widespread culture of smoking within mental health settings was identified and described.

Returning to the aims of this research then, this thesis has described the experience of smoking for people with a mental illness, as it relates to their attempts to quit and to manage their mental illness. It has described the phenomena of concurrent smoking and mental illness within mental health service settings and interpreted the phenomena of concurrent smoking and mental illness by looking at the person, the setting and the system. These phenomena have been viewed through multiple theoretical lenses. Systemic barriers to quitting for smokers who suffer from a mental illness, and for staff smokers, have been identified and discussed. The rest of this chapter draws general conclusions about the implications of the smoking culture for quitting among mentally ill smokers. In addition, implications for legal and occupational health and safety responses are briefly considered, as are the implications of introducing smoking bans and other restrictive measures within mental health settings. An approach that addresses smoking behaviours and interactions within each of the systems outlined by Bronfenbrenner’s ecological framework is proposed. Finally, limitations of the research and ethical concerns are discussed. Suggestions for further research are given.
(9.2) GENERAL CONCLUSIONS AND IMPLICATIONS:

(9.2.1) Poverty:
Smoking contributed to significant economic and social disadvantage for all of the client participants of this study. They were returning approximately 27.7% of their total income to the government treasury in excise taxes on tobacco (Lawn, 2001; see also McCreadie & Kelly, 2000). Clients therefore demonstrated the inelasticity of their responses to cigarette price rises. It follows that policies that increase the cost of cigarettes raise significant equity and social justice questions (Polgar, McGartland, & Hales, 1996), because of their potential to exacerbate the poverty of these people. Recommendations restricting payment of government benefits to mentally ill smokers (Rosenheck, 1997; Shaner, et al., 1997), as a means of reducing their spending on cigarettes and prevalence therefore of smoking in this group, may likewise be misdirected. On the other hand, interactions that emphasise a sharing of power and decision-making between clients and staff may avoid the unconstructive interactions that have been highlighted by the current research. However, economic motivation for quitting may have some relevance, as shown by comments made by successful quitters who participated in the current study. They suggested that economic motivation played a useful part in their decision to quit (see also Leong & Horn, 1989).

(9.2.2) Existential Despair:
Mentally ill smokers in this study appeared to be well aware of the risks of their smoking. Their tendency to minimise the risks appeared to be due to their loss of hope of recovery, their sense of stigma and perceived powerlessness. They chose to smoke, knowing the risks, because they did not view the alternative as improving their situation. Staff generally held similar beliefs about clients. The cultural reasons for this acceptance of smoking by the mentally ill were explored earlier in this thesis.
The social and physical conditions experienced by clients, especially in the inpatient wards and community hostels, appeared to influence how they perceived themselves within the system of care. The reasons why they smoked and appeared to make no effort to quit appeared to be as much to do with the treatment they received from others as it was about their own difficulties dealing with mental illness. Their comments seemed to demonstrate deep-seated existential despair about their situation, as a direct consequence of their experience of mental illness and the system’s treatment of them. Addressing the grief and loss experienced by people with a mental illness (Lafond, 1994;
Lafond, 1998) may therefore be a useful component of smoking cessation programs targeting this group.

(9.2.3) Impoverished Learning Environments:

The nature of the physical environment in which smoking interactions occurred between clients and staff was also shown to encourage smoking and discourage quitting. Solutions therefore need to address the impact of the environment on its members and the relationships that are fostered as a result of structures within the settings. (see Moos & Insel, 1974; Moos, 1976; Blair & New, 1991). Improvements in the physical structure and appearance of the settings are indicated so that smoking is not perceived as the dominant activity. The introduction of more meaningful alternative activities is also indicated (Davidson, 1999).

(9.2.4) Clinical Use of Smoking:

This research has highlighted the complicated role played by staff within mental health settings where many clients are involuntary participants. Nurses in particular performed complicated roles with clients. They acting as custodian, carer, cigarette source, counsellor, educator, behaviour modifier and gaoler (see Sykes, 1958 for parallels within the prison system). Smoking appeared to provide the means by which these role conflicts were eased for nursing staff. The latent consequence of this was that smoking was condoned, so much so that it was increasingly relied upon to facilitate interaction. Nursing staff who did not smoke commented on their perceived loss of this care option once they stopped smoking. The promotion of clinical alternatives for staff is indicated so that they do not rely on smoking to manage clients.

(9.2.5) A Culture of Smoking:

In the inpatient and community settings, many examples of smoking reinforcement and conditioned smoking were apparent for clients and staff. This appeared to be a group-based phenomenon within the cultural milieu. It was not limited to individual experiences. The majority of staff appeared to accept clients’ smoking, seeing it as a central part of the dominant culture of the settings. Staff relied heavily on medications to treat clients. One consequence of this was that, when medications were not adequate, staff were left with few other effective alternatives to assist clients with their symptoms and distress other than to let them smoke or to smoke with them to give them a sense of comfort and support. In the same way that many clients said that they had learned to rely smoking to self-medicate, it appears that staff had acquired the belief in these benefits of smoking for clients.
By using cigarettes to overcome clients’ agitation, clients’ nicotine withdrawal was not addressed by staff. This has significant implications for successful recovery from mental illness, especially as smoking affects the metabolism of psychotropic medications. The findings suggest that these systemic patterns of learning and reinforcement need to be challenged and replaced within treatment environments.

(9.2.6) Nicotine Withdrawal:

No clear policy to guide interventions with clients wishing to quit or to provide NRT to clients was apparent. Throughout the participant observation period, no doctor was observed to make the diagnosis of nicotine withdrawal for agitated clients who were in their care. This was especially so for clients in locked wards where they were subjected to repeated, enforced nicotine withdrawal. The effect of the culture was so strong that doctors omitted to recognise the pharmacology of nicotine. They accepted an explanation that fitted in with cultural beliefs rather than one provided by their professional training. The number of cigarettes supplied as part of the smoking sequence in locked wards would not have been sufficient to address clients’ nicotine withdrawal symptoms (Schein, 1995). It arguably incited clients who continued to seek and demand cigarettes outside the designated time, further increasing the threat of violence in the settings. A commitment by doctors to diagnose nicotine withdrawal and to treat it accordingly with NRT is needed. Fundamental support by the hospital to provide NRT, as it does other pharmacological treatments, would also be part of this process. Support for more effective interventions and strategies at a day to day level of clinical care are also indicated.

(9.2.7) Mentally Ill Clients Can Quit:

Interviews with successful quitters established that people with mental illness can quit and that they may experience the quitting process in similar ways as non-mentally ill smokers. They described being aware of the rituals surrounding smoking and of implementing effective strategies to overcome these habits. They also described their motivation for quitting in much the same way as non-mentally ill smokers, that is, for better physical health and to save money. This suggests that the strategies in Marlatt and Gordon’s (1985) relapse prevention model and Janis and Mann’s (1977) balance sheet of costs and benefits of smoking and quitting may be relevant to smokers with mental illness. Gaining a sense of control over their mental illness and hope for improvement in their situation were significant factors for successful quitting. This is consistent with the overall findings. More intensive and assertive support for smokers with a mental illness is also indicated to
help them better distinguish between illness symptoms and nicotine withdrawal and to encourage them to persist when they are attempting to quit or cut down their cigarette consumption. Consumer advocacy movements and peer role models, to show that quitting is possible to both clients and service providers, could be encouraged. Subsidised nicotine patches could also be considered to help overcome barriers to the use of NRT due to poverty, as expressed by clients. A public health approach that focuses on prevention and early intervention may help to address the problems of initiation into smoking for people who are vulnerable to developing mental health problems.

(9.2.8) A Community Response is Needed:

In the hostels, as with other mental health settings, limited social roles and predictable routines were important in promoting the use of cigarettes as temporal reference points, that is, markers for orientating the person to time, place and person. These predominantly orientated the person to the present or to a few hours into the future (Suto & Frank, 1994), resulting in the immediate fulfilment of the person’s wishes. It discouraged them from developing skills for flexibility, long-term planning and goal-setting and autonomous decision-making. This has further consequences for smoking reinforcement and the planning needed to quit smoking. A community response that addresses the negative effects of institutionalisation and encompasses the mentally ill as more fully participating members, with equal access to resources and supports, is suggested.

(9.2.9) Conflict Between Staff and Clients:

In the current study, problems with communication over the supply of cigarettes, especially in the locked wards, were seen to contribute to violence. This was heightened by the stress of nicotine withdrawal when supply did not match demand. The cycle of environmental communication problems, leading to violence, has been studied (Nijman, Cumpo, Ravelli & Merckelbach, 1999; Nijman & Rector, 1999), though no mention of the role of nicotine withdrawal was made. Figure 9.1 illustrates these potential pathways to violence involving smoking in the locked ward.
Figure 9.1 Pathways to Assault in a Locked Ward

NB. The Researcher acknowledges the contribution of Dr R.G. Pols to the development of this figure.
Staff appeared to be misattributing nicotine withdrawal as an increased potential for violence by clients. They responded by ensuring the supply of cigarettes to clients rather than providing them with NRT or other clinical support. Clients appeared to be misattributing nicotine withdrawal as a sign of impending illness relapse. In a system where nicotine withdrawal was not recognised or treated and where control over the supply and distribution of cigarettes existed, there appeared to be a heightened potential for violence. In such a system, the less powerful (the client) could not directly retaliate because the winner was extremely powerful, distant and hard to locate (the psychiatrist who had detained them). Hence, individuals often responded by turning aggression onto others who were more accessible (the nurses), who then became the scapegoats. This cycle was described and observed in all the mental health settings. Some have suggested that the style of mandatory aggression management training provided to staff has fostered the expectation that clients will be violent (Lion, 1987). Under these circumstances combative interactions, fear and assaults may become self-fulfilling prophecies. This is especially so when nicotine withdrawal is ignored and therefore likely to exacerbate such escalating violence. More effective use of prn medications, NRT, diversionary strategies and support may contribute to increased safety, especially in the inpatient setting.

(9.2.10) Occupational Health, Safety and Welfare Issues:

When attempting to address concerns about smoking and occupational health and safety for staff, psychiatric institutions and prisons share similar dilemmas. They are, “the workplace of some people and the living space of other” (Biggins & Wares, 1993, p.327). Balancing any rights of clients to smoke in their living space with the rights of staff to a smoke-free work environment becomes difficult, especially in the locked settings where staff have designated roles in supervising clients while they are in the smokers’ cage. A number of examples from the current research suggested that occupational health and safety for staff may have been compromised, with the potential for legal claims in some situations. These included the use of cigarettes in the absence of commitment to NRT use for clients experiencing nicotine withdrawal in locked wards and assaults occurring as a consequence of this. Staff roles in purchasing and dispensing cigarettes to clients, passive smoking by staff during the supervision of clients smoking in ‘the smokers’ cage’ and passive smoking by clients were also noted. Clients’ initiation into smoking while unwell was also noted. Appendix N contains a briefing paper on these problems to the Department of Human Services for South Australia. It outlines a series of issues, based on legal interpretation and advice gained during the course of the research.
(9.2.11) Moving Forward:

Imposing smoking bans as a solution to the culture of smoking within mental health settings has been considered, tried and studied. Overall, the results are mixed. Unintended negative consequences of such a policy change are evident in each study. The current study has demonstrated nursing staff’s reliance on smoking to assist with the clinical management of clients. Helping nursing staff to find alternative clinical options may be effective in overcoming this problem. Extensive consultation, collaboration and co-ordination of efforts across the disciplines, provision of alternative activities, dietary changes, clear protocols and family support as part of preparation for bans have been suggested (Erwin & Biordi, 1991). More effective measures to accommodate clients who are unable to tolerate abrupt abstinence, greater awareness of the ban prior to admission and greater support for and education of direct-care staff by administration has also been suggested (Greeman & McClellan, 1991). A preparation period prior to the smoking ban involving community and staff meetings and advertising the impending ban to clients have also been proposed (Taylor, et al., 1992).

Further implications for smoking bans within inpatient settings are apparent from the current research findings. In the absence of NRT, adequate alternative activities and training for staff, increased distress and unrest by clients would be expected, especially in the locked settings. Where exceptions were made within locked wards, the role of nursing staff in monitoring safe use of cigarettes in ‘the cage’ would need to be reviewed. In the absence of staff smoking while at work, alternative means of stress relief, clinical management of clients and other forms of support for staff would need to be developed. Clients may interpret restrictions as a further source of powerlessness and control by others, with implications for staff morale as agents of further social control. Trade and standover for cigarettes within the grounds of the hospital may increase, with potential for such activities to spread beyond the hospital grounds to nearby shops and houses. Black market use and sale of tobacco within mental health settings may also increase as may use of other drugs. Imposition of a smoking ban for inpatients may also confuse the clinical picture for client smokers when they return to the community. The cigarette smoke interaction with anti-psychotic drug metabolism would need to be considered, given the expectation that many clients would return to smoking on discharge. Community mental health teams would need to be aware of this as part of improved co-ordination of follow-up. The benefits and achievements of a smoking ban during an inpatient stay could gain greater meaning for discharge if there were co-ordinated efforts by community staff to help clients who wish to stay quit as part of discharge planning.
(see Appendix O for Briefing Paper to DHS)

(9.3) CONCLUSION:

This research has investigated smoking and mental illness from several perspectives and shown that there are significant issues and implications for clients, staff and the psychiatric settings. Any strategies aimed at reducing the prevalence of smoking among mental health service clients and staff would benefit from acknowledging the complex role and functions of smoking for these groups. The process of quitting may be better understood if systemic cultural issues are taken into account. Building a health promotion approach to clinical treatment and care of the mentally ill is also proposed. These findings show is that there appear to be significant barriers to quitting for clients and staff as a consequence of a culture that overwhelmingly reinforces smoking. Once a person is exposed to that culture and is caught up in the learned ways of coping and interacting inherent within it, they are likely to become part of a systematic response to the problem. The pharmacological interactions of smoking with mental illness play a vital role in mediating the process. Addiction and withdrawal, management of psychosis, the notion of a system dealing with helplessness and despair, victimization and containment of system specific aggression, combined with the influence of history and culture all form complex interrelationships that help explain the high prevalence of smoking within mental health settings for both clients and staff.

In conclusion, change that addresses aspects of the mental health system at each of the four layers of interaction and influence within the ecological framework may help to change the culture of smoking. Understanding and responding to the problem needs to occur at the level of direct interaction and intervention with clients and clinical staff, at the level of mental health service provision and policy formulation, as well as at the level of the larger society. This research has argued that the process of quitting and any interventions hoping to reduce the prevalence of smoking for mental health clients and staff, need to acknowledge the complex, multifaceted roles of smoking within mental health settings.

(9.4) VALIDITY, RELIABILITY & LIMITATIONS OF THE RESEARCH FINDINGS:

This study has a number of limitations that need to be acknowledged. Firstly, the potential for participant selection bias was apparent, given the purposive sampling used and the voluntariness of participation. The potential for differences in systems of care also exists. These participants talked
about, and were observed in, one institution in one state within Australia. This may not reflect the
total Australian public mental health system’s experience or the international and private mental
health system experience. Due to the small sample size and method of sampling used, the findings
of this study cannot be generalised to the total community mental health population. The researcher
also fully acknowledged the bias that was brought to the research setting by her own professional
training and personal and cultural background (Schwartz & Schwartz, 1955).

Due to the lack of qualitative studies involving psychiatric populations, the potential for cognitive
distortions due to illness presentation during the data collection phase cannot be determined. There
is also concern about the validity of retrospective comments made during interviews, especially
comments made by clients about their past experiences. A person’s current depressed mood may
foster a negative bias towards recounting past events and experiences unfavourably. The researcher
made every attempt to minimise this potential by including only those participants whose mental
state was stable at the time and by triangulating the methodology.

The absence of in-depth interviews with inpatient clients, especially those in long-stay wards, was a
significant limitation of this study. The research also acknowledges that administrative staff were
not interviewed except where they possessed dual administrative and clinical roles. The inability to
develop a methodology in which effectively to perform participant observation of community staff
and clients within their community environment would have also allowed for a more balanced
understanding of the phenomenon, especially given that some clients of community mental health
services have not experienced inpatient admissions to the psychiatric hospital.

The researcher is an ex-smoker, not a current smoker and therefore could not fully identify with all
participants during interviews and participant observation of the settings. The researcher was also
not suffering from a mental illness. These conditions for being a full participant were not seen as
necessary. However, they have a bearing on the study and they need to be acknowledged as a
limitation. This is particularly relevant for the hospital setting and hostel setting where the
researcher effectively was part of the cultural milieu during the day but able to leave at night.
Therefore she was not fully exposed and subject to the restrictions experienced by others in the
setting. The researcher could not therefore fully experience the phenomena being observed. Obvious examples are the inability to experience restrictions of freedom and stigma first-hand.
The validity and genuineness of observations was enhanced by habituation of the settings to lessen the researcher’s obtrusiveness in the settings and to promote familiarity with participants and their routines. As well as this, the researcher did not make known to staff or client participants exactly when she was recording data and when she was merely observing. This overcame ‘staged’ interactions for the researcher’s benefit. Therefore, observations made were more likely to be valid and reliable than if this precaution had not been taken.

The researcher also acknowledges that the selective perception of incidents and situations varied with different individuals (Friedrichs & Ludtke, 1975), depending on their mental state at the time. As well as this, the selective perceptions of the researcher have the potential to vary over time (Friedrichs and Ludtke (1975). Cultural bias (Patton, 1980) and the potential for “observer drift” (Robson, 1993, p.224) were recognised by the researcher and acknowledged. Inter-observer agreement checks to minimise this potential problem (Robson, 1993) were performed. To combat these potential problems, the researcher trialed observations and regularly debriefed with supervisors. She also kept copious reflective, descriptive notes about the observations. She was disciplined in recording these notes as soon after the observations as practicable. The use of standardised observation sheets, based on the results of the fully audited qualitative data prior to entering the field also helped to overcome potential threats to validity and reliability and to enhance replicability. Field observations were limited to particular groups and areas and to particular times in the day. This was acknowledged and overcome by multiple periods of time spent in each of the settings, with varied timing of visits to incorporate the potential for observing the maximum variety of participants and interaction conditions.

The researcher was attuned to the potential for affective changes due to immersion in the settings being observed. As described by Schwartz and Schwartz (1955), these influences can be subtle but are an inevitable product of becoming involved in the emotional life of the participants. Regular debriefing with supervisors and diligent reflective notes were kept to combat this potential influence on the observation data.

Miles and Huberman (1994) argued that the social context of qualitative research is always changing and it cannot be replicated in the same way as quantitative research. They determined that keeping clear records of the research process and its findings that could then be audited was how replicability of qualitative research could be determined. All phases of data collection and analysis were fully and independently audited and found to be sound. A clear audit trail was established.
(9.5) ETHICAL CONCERNS:

Confidentiality was a significant concern for the researcher and the ethics committees, given that the research involved involuntary clients, stigmatised groups and taboo issues. The researcher was therefore acutely aware of the confidentiality and privacy needs of research participants. Their key worker provided all potential client participants involved in interviews with an information sheet prior to contact with the researcher. Consent forms were signed by all participants prior to their participation. Participation was voluntary and participants could terminate the interview at any time, choose not to answer particular questions and choose not to have certain sections of the interview taped. The researcher was sensitive to the psychotic symptoms that often involve paranoid delusions regarding tape recorders and other mechanical devices. The researcher was also sensitive to the potential stress that being interviewed by a stranger can involve for people with a mental illness. No records identified individual participants. All data were coded and pseudonyms were used. The ethics committee expressed concern that some clients would not identify with some of the terms used in the information sheet. In particular, recognition and acceptance that clients had a mental illness needed to be expressed sensitively. Therefore, requesting the person’s participation as a ‘client’ of the mental health service, not as ‘a person with a mental illness’ was the preferred option. During participant observation, the potential negative impact of the researcher’s presence on the clients’ mental health status was recognised. Hence, habituation in the settings occurred.

Participation by staff was voluntary and confidentiality was assured. All staff participants were given pseudonyms. Where a staff member, or client, may have been identifiable to readers familiar with the settings, such as a Clinical Nurse Consultant in a particular type of setting, the status of the participant was not identified. Information sheets were provided to participants in each setting prior to entry. The consumer advisory body was consulted on the potential impact of performing participant observation of the settings. Their approval was obtained. This was agreed to by the ethics committee and the consumer advisory group, as an acceptable alternative to obtaining individual consent of all inpatient clients.

Several ethical concerns pertained to this project, hence detailed description of the processes used, exactness in that process and regular updates to the appropriate ethics committees were given. Foremost among these concerns, as Friedrichs and Ludtke (1975) suggest, were the political consequences of studies such as this that illustrate the mechanism of discrimination, the relationships between participants, and the subtle and obvious forms of social control. Punch (1994)
warns of the essentially political nature of all field research and suggests that some resolution of this
be achieved by open discussion of any moral dilemmas. As a consequence of this concern, the
researcher did not present any findings from staff interviews and participant observation until after
participant observation of the settings was complete, based on the concern that this may influence
the ongoing collection of data. However, once this point was reached, the researcher made several
presentations to groups within the settings and at conferences and forums. The feedback of results
to participants was a significant consideration. The researcher also gave written feedback to the
Assistant Director of Nursing and the Clinical Director of the hospital and met with the hostel
managers to discuss the findings. The researcher offered further input to any working parties,
interventions and policy plans that were proposed as a result of the findings. The researcher made
every effort to make her role and purpose clear to all participants and to provide informal feedback
and descriptive information to them prior to leaving the field settings. Participants’ reactions to this
feedback then became part of the data, which was incorporated into the analysis once the researcher
left the field, as suggested by Patton (1980).

Other ethical considerations included the danger of becoming too immersed in the setting, or ‘going
native’ (Friedrichs & Ludtke, 1975, p.35). The researcher avoided becoming overwhelmed by the
culture of the settings by maintaining her other regular work as a distraction and by maintaining
regular supervision and auditor contact to debrief. Intra-role conflict, brought about by the
necessary separation of participation and observation in which one demanded action and the other
demanded interaction (Friedrichs & Ludtke, 1975, p.35), was also acknowledged. The researcher
resolved this problem by maintaining regular supervision to promote objectivity.

The potential existed for the researcher to see herself or be seen by those involved as a spy or a
voyeur (Friedrichs & Ludtke, 1975). Every effort was made clearly to define the purpose of the
researcher’s presence in the settings to all participants. Many staff were already familiar with the
researcher as a worker in the mental health field. Many clients knew of the researcher as a mental
health worker. No covert observations were made. The researcher maintained an openness within
the settings.

Safety issues for self and others were apparent. The researcher was bound by her own status as an
employee of a mental health service to adhere to policies regarding safety in the settings being
observed. The researcher also had a duty of care to report any abuses and safety concerns to the
appropriate bodies. This included such incidents as illicit drug dealing and consumption within the
grounds of the hospital, sexual harassment or abuse by clients towards other clients and threats of violence. Any concerns were reported to the Clinical Nurse Consultant of the ward. Safety regulations were adhered to while visiting research participants in their own home. For people who were under the influence of alcohol or other drugs, in particular illicit drugs, interviews were postponed. Likewise, the researcher verified with the potential participants’ doctor and key worker that the client was clinically able to tolerate being interviewed and, if so, verified their current mental state with those workers on the day of the interview. Where the researcher had concerns for the participant’s safety or mental state, or the safety of others as a result of information shared in the interview, she was ethically and legally bound to relate those concerns to the relevant mental health service. The intensity of the suicidal thoughts of one participant with depression was relayed to their key worker with the client’s permission and knowledge. Due to the protocols in place for home visits to some clients, usually due to safety concerns, clinic visits were negotiated with these participants and their workers.

At the end of each contact with client participants, the researcher debriefed with them regarding the content of what had been discussed to ensure that clients’ mental state had in no way been adversely affected by the content of the interviews or the process. The researcher was also sensitive to the potential for the interview process to bring on cravings via smoking-related cues and, as Wright et al. (1998) warn, of “colluding with the interviewee’s own perception of their ‘helplessness’, [that is] powerlessness to overcome their addiction” (p.530). To help overcome this, participants were made aware of the aims of the study and forewarned about the contents of the interview in order to assess their level of informed consent before proceeding with the interview.

Passive smoking considerations for the researcher needed to be addressed when in the company of participants who were smoking and when in settings where smoking was occurring. The researcher made every effort to position herself appropriately, given this concern.

The issue of researcher role boundaries posed further ethical problems. The researcher had completed accreditation at a ‘train-the-trainer’ course run by Quit Victoria. Information about quitting was provided via brochures, contact numbers and advice when this was requested by participants, as suggested by Wright et al. (1998). Where participants attempted to draw the researcher into a more therapeutic role, the person’s need to ventilate their concerns was accepted. However, they were encouraged to refer to their designated key worker for further support and advice.
(9.6) IMPLICATIONS FOR FURTHER RESEARCH:

Further research is indicated into several aspects of the current research. The use of smoking by staff within psychiatric settings and the existential roles of smoking for people with mental illness, using a larger randomised sample would be useful. This latter research could incorporate a control group of non-mentally ill smokers. Further research with successful quitters, using a larger sample, would provide insights into how quitters overcome the barriers to quitting within the system. A study that involves participant observation of other psychiatric settings would be needed to test the generalisability of the findings to other states and countries. Differences may also exist between public and private mental health settings, as well as stand-alone psychiatric hospital and mainstream hospital settings. Further research on smoking initiation and its relationship with the onset and path of mental illness is also indicated. This could involve an investigation of the person’s level of social supports during this formative stage. It may provide useful data to prevent later nicotine dependence in this population. Diagnostic differences in smoking initiation, smoking behaviour and quitting beliefs and actions were also suggested by the current research. Research with a larger, random sample would be needed to test these findings. This is also the case with staff interview findings, particularly with regard to the differences between the different disciplines noted here.

The use of and reliance on cigarettes by nursing staff to cope with their day-to-day work roles was supported by the quantitative data of nursing staff smoking collected for the current research. Although sample size was small and the method of recruitment was not completely random, the results are interesting and raise the possibility of patterns of usage consistent with observations made during participant observation of the settings. In particular, greater clinical use of cigarettes to manage patients is noted in the locked settings. Further research, performed systematically across mental health settings may prove useful in testing the current findings.

From the descriptive statistics outlining the smoking behaviours of staff, there may to be differences in the rates of ex-smokers and current smokers when comparing inpatient staff with their community counterparts. Inpatient staff appear to be more likely to be current smokers, while community staff appear to be more likely to be ex-smokers. The reasons for this difference could be related to increased social pressure to quit in the wider community setting in contrast to the inpatient institution with its cultural acceptance of smoking. The institution is possibly shielded from external social pressure to quit. These perceived cultural differences are worthy of further investigation.
The current research also hypothesised that the misattribution of nicotine withdrawal to impending illness relapse or violence by clients was a central problem within the current system of care in the inpatient setting. A survey by Fottrell (1980) of violent incidents in a United States psychiatric setting found that 30% of violent incidents occurred between 7am and 9am and especially on Mondays following periods of inactivity. The findings of the current study suggest that smoking by clients was heavier in the mornings. A more comprehensive, systematic process of observation and data collection including nicotine levels may confirm these results and uncover further patterns within the settings.

The use of other licit drugs by people with mental illness and the interactions and relationships of those drugs with smoking requires further study. Caffeine has both stimulant (US Dept of Health & Human Services, 1988, Benowitz, 1990) and withdrawal effects (Simmons, 1996, Swanson, et al., 1994, Swanson, et al., 1997). Mentally ill smokers may use such drugs and caffeine and alcohol in similar way and for similar purposes as they use cigarettes. This needs to be examined more closely.

In conclusion, this research has described the culture of smoking in mental health settings and identified a number of barriers to quitting for clients and staff. It has raised several questions for further research beyond the scope of this thesis.
Glossary:

Abstinence Violation Effect (AVE)
- refers to the phenomenon whereby the processes of cognitive dissonance and internal causal attribution lead the person back into their former drug use. In this process, the person misattributes a minor slip for a major relapse to drug use. They convince themselves that this slip is a major failure on their part and they might as well revert to their former drug using behaviour.

Autonomy
- “independence of action, speech and thought…the ability to make rational and free decisions, and the ability to identify accurately one’s desires and to assess what constitutes one’s own best interests (Agich, 1990, p.12).

Classical Conditioning and Drug Use
“Environmental stimuli can also become conditioned by the drug’s effects so that they themselves become cues or triggers to craving or the desire to perform the addictive behaviour (Davis, 1996, p.9).

Control
- the power of directing, commanding or dominating.

Culture
- “conventional patterns of thought and behaviour, including values, beliefs, rules of conduct, political organisation, economic activity and the like, which are passed on from one generation to the next” (Hatch, 1985, p.178). Culture involves various players, with various roles and rules for behaviour and interaction, set in the context or established rites and ideologies that together serve to perpetuate the culture.

Deviance
“the label attached by a more powerful group or section of the population to weaker individuals or groups whose behaviour is viewed as undesirable or offensive in some way (Edwards, 1988, p.6).
Drug Dependence
“a compulsion or strong desire to engage in the behaviour, and overwhelming priority or salience being given to the behaviour; an impaired capacity to control the behaviour; and distress if prevented from carrying out the behaviour (Davis, 1996, p.11).

Hospital Wards
Open ward
- Patients in the open ward have freedom of movement in the grounds of the hospital. Their stay in hospital is usually voluntary. They may be detained under the Mental Health Act if they are an absconding risk and this is determined to be detrimental to their recovery. Their stay in hospital is short term. Once sufficiently recovered, they return to the community.

Locked Wards
- Patients are detained inside the ward and its immediate internal surroundings. They cannot leave of their own free will as all doors are locked. Their personal possessions are kept by staff. Once they are no longer deemed to be a danger to themselves or others, or can be managed adequately in the open setting, they are usually transferred to an open ward.

Extended Care Open Wards
Patients in extended care wards are usually subject to continuing detention orders as determined by the Mental Health Act. Their stay in hospital ranges from a number of weeks or months to a number of years, dependant on the severity of their illness and rehabilitation potential. They have freedom of movement in the grounds of the hospital. If their situation deteriorates, they may spend a short period of time in the extended care locked ward.

Key Worker
The professional who performs a case management role with clients of the community mental health service. They are drawn from the disciplines of social work, psychology, nursing, and occupational therapy.

Kanter Model of Case Management
- A clinical model involving 13 distinct activities with and for client. These are: engagement, assessment, planning, linkage with community resources, consultation with families and other caregivers, maintenance and expansion of social networks, collaboration with physicians and...
hospitals, advocacy, individual psychotherapy, training in independent living skills, psychoeducation, crisis intervention and monitoring (Kanter, 1989).

**Locus of Control**
- “a generalised expectancy regarding an individual’s beliefs concerning his or her personal control over situations (Martin & Otter, 1996, p.121).

**Operant Conditioning and Drug Use**
- “the behaviour is controlled by the stimuli preceding it and the reinforcing consequences following it (Davis, 1996, p. 8).

**Paternalism**
The principle or practice of managing the affairs of others as a father manages the affairs of children

**Social control**
-“to persuade, restrain, discipline, coerce, penalise, reward, direct, manage or regulate to describe aspects of the activities of individuals, groups, organisations or society (Edwards, 1988, p.1),” in order to exercise control over people’s bodies, minds, and behaviour.
APPENDICES:

(A) Successful Quitters – Interview Guide

(B) Introductory Letter to Clients & Staff

(C) Client Smokers – Interview Guide

(D) The Fagerstrom Dependence Scale

(E) Examples of Transcribed Interviews and Data Analysis Sheets - Clients

(F) Staff – Interview Guide

(G) Examples of Transcribed Interviews and Data Analysis Sheets – Staff

(H) Audit Report – Client and Staff Interviews, Ms Shaun Byrne

(I) Audit Report – Participant Observation of the Settings, Ms Judith Condon

(J) Examples of Observation Sheets

(K) Participant Observation Information Sheets

(L) Examples of Journal Notes

(M) Diagnostic Differences Between Clients Who Smoke

(N) Department of Human Services - Issues Paper:
Occupational Health, Safety & Welfare and Legal Implications Of smoking in Psychiatric Settings.

(O) Department of Human Services – Briefing Paper
Research on Smoking Bans in Psychiatric Settings
Appendix A:

Interview Guide: Successful Client Quitters:

Reasons for quitting

Reasons for smoking initiation and continuance when they were smokers

Their smoking behaviour prior to quitting (amount, type, strength, duration)

The process of quitting
methods and strategies tried
supports used
number of attempts and how they interpreted these attempts
motivation to stay quit

The role of illness

Quality of life issues pre and post quitting
Appendix B:

Introductory Letter to Clients:

Dear

As part of my thesis at Flinders University, I am conducting research looking at why clients of Southern Mental Health Services smoke cigarettes and their experiences of trying to quit. There has been a great deal of research about the effects of smoking and mental illness on each other. However, I believe that your ideas may help to identify new information to help explain why current treatment approaches seem to be largely ineffective for mental health service consumers who wish to quit. In this study I will be interested to find out what you think about your smoking habits and what you think about your illness, how smoking affects that illness and how the illness affects your smoking behaviour, what you have tried in your attempts to quit smoking, what has worked and what has not, and why you think this is so.

Of course, if you have been a smoker and successfully quit within the past ten years, I will be very interested in how you did it and what you think of this now.

With your permission, I would like to interview you informally, once or twice for approximately 1/2 - 1 hour, either at your home, at our office, or a place that you and I mutually feel comfortable with.

I recognise that some information discussed in this study may be of a sensitive nature.

During the interview, should you wish to participate, it is stressed that you can choose not to answer some questions. Your involvement in this study is completely voluntary, and your non-participation will not affect your treatment at Southern Mental Health in any way. Should you decide to withdraw from the study you may do this freely and without prejudice to any future treatment at Southern Mental Health. It is stressed that you are under no obligation to participate in the study and can withdraw at any stage.

All participants’ details will remain completely anonymous. Your name, address, details of illness, or any other personal details will be kept strictly confidential. Findings from the study may be published at a later stage, and may be used to train staff and other professional in order to provide a better service to consumers. The interview will take approximately one hour to complete. You may wish to talk with me for a longer or shorter time. This is OK. A tape recorder will be used during the interview to assist the interviewer to accurately recall what has been talked about in the interview. Tape recording will not be used, if this is your wish, for all or part of the interview. All information collected will remain anonymous and will be stored securely for the legal period of seven years then destroyed. No information discussed will be entered into your medical records and will not interfere in any way with your ongoing care at Southern Mental Health.

Please consider being involved. Your valuable ideas may assist workers to better understand the problems faced by people with a mental illness who are trying to quit smoking. If you require any further information or have any concerns about the study, please contact me (8375 6000). My supervisors, Prof. Jim Barber and Dr Rene Pols, can be contacted at Flinders University on (8201 2216) and Flinders Medical Centre on (8204 4916), respectively. This study has been reviewed by the Clinical Investigations (Ethics) Committee at Flinders Medical Centre. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Executive Secretary of the Committee, Ms. Carol Hakof (8204 4507). Your participation will be greatly appreciated.

Yours Sincerely,

Sharon Lawn - Social Worker
Information Sheet for Key Workers:

Dear

Re: Nicotine Dependence and Mental Illness Research

Earlier this year I spoke with you and other team members about a research project aimed at identifying ways to assist those clients of our service who wish to quit smoking.

As you are well aware in your day to day interaction with clients, the detrimental economic, social, psychological, and physical consequences of nicotine dependence are significant, often directly influencing your effectiveness in assisting clients’ rehabilitation and recovery from their illness. There has been a great deal of research on the pharmacological and psychological aspects of nicotine dependence and addiction. However, few self-report studies exist which explore clients’ perspectives of the links between smoking and illness and how this effects their ability to quit. No study of South Australian community mental health clients has been performed. Current cessation interventions have largely been informed by findings of studies of the general population with little exploration of strategies for our clients other than to recommend the use of nicotine patches or gum, and anti-depressants in some cases. This is despite smoking rates among the mental ill being up to three time higher that the general population.

I plan to investigate the perceptions and experiences of clients in four main diagnostic groups - Schizophrenia, Depression, Bi-polar Affective Disorder, and the Personality disorders - in order to avoid viewing mental health service clients as one homogeneous group with the same experiences. I hope to generate new insights into potential differences and explore their ramifications for treatment.

I envisage three stages within the research.

(1) In-depth interviewing
- I am seeking the names of 30 clients from each diagnostic group from which I will randomly select 10 people from each to be interviewed. I am asking you to assist me by asking clients on your caseload if they would like to participate in this study. I am interested in interviewing those clients who currently smoke and do not wish to quit as well as those who do. I am also very interested in speaking with any clients who have successfully quit smoking within the past ten years, concurrent with having a mental illness at that time.

(2) A structured questionnaire at a later stage which further explores and tests findings of Stage One.
- I hope to enlist your help more fully here, in administering the questionnaire to your clients. I believe your rapport with them will be a significant in mediating their comfort with the process. Conversely, you may have some clients who may not mind being given the questionnaire directly by the researcher. I envisage that the questionnaire would take not more than three quarters of an hour to complete and full briefing by the researcher is proposed beforehand regarding its structure.

(3) A possible third stage may be to recruit a group of consenting clients into a smoking cessation program in order to operationalise information gained from stages one and two. An outcome evaluation of its effectiveness could then be performed.

I ask you to stress to your clients that this is a voluntary process and that all personal details will be kept strictly confidential. Please contact me if you have any concerns you may wish to discuss further about this study.

Thank you for your assistance.

Sharon Lawn
Social Worker / Southern Mental Health - Marion
Ph. 8375 6000 (Monday - Friday)
Appendix C:

Interview Guide: Clients Who Smoke:

Basic details:
Diagnosis
Years Smoked
Amount smoked per day
Cigarette Strength
Highest Educational level reached
Source of Income
Accommodation status
Marital Status
Cigarettes Smoked in Interview
Interview Length

Belief in level of control over smoking and quitting

If you could quit painlessly

Quit Attempts and what happened

Quitting methods tried

What it is like being a smoker

Who is responsible for smoking and quitting

Response of doctor and key worker to their smoking

Hospital experience as a smoker

If there were further bans / restrictions on smoking-View of smoking policies

Reasons for commencing smoking

Reasons for continuing smoking

What is it like having a mental illness

Determine whether the person sees any link between illness and

Smoking and reasons why or why not.

What happens to their smoking when they become unwell

Role of families re smoking
Appendix D:

The Fagerstrom Dependence Scale

Please mark either A, B, or C in the box at the end of each question.

<table>
<thead>
<tr>
<th>Questions</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>How soon after you wake up do you smoke your first cigarette?</td>
<td>After 30 min.</td>
<td>Within 30 min.</td>
<td>[ ]</td>
</tr>
<tr>
<td>Do you find it difficult to refrain from smoking in places where it is</td>
<td>No</td>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>forbidden, such as in a shopping centre, or doctor’s office?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which, of all the cigarettes you smoke in a day, is the most satisfying</td>
<td>Any other than the first</td>
<td>First one in the morning.</td>
<td>[ ]</td>
</tr>
<tr>
<td>one?</td>
<td>one in the morning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many cigarettes per day do you smoke?</td>
<td>1 to 15</td>
<td>16 to 25</td>
<td>&gt; 25</td>
</tr>
<tr>
<td>Do you smoke more during the morning than during the rest of the day?</td>
<td>No</td>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>Do you smoke when you are so ill that you are in bed most of the day?</td>
<td>No</td>
<td>Yes</td>
<td>[ ]</td>
</tr>
<tr>
<td>Does the brand you smoke have a low, medium, or high nicotine content?</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
<tr>
<td>How often do you inhale the smoke from your cigarette?</td>
<td>Never</td>
<td>Sometimes</td>
<td>Always</td>
</tr>
</tbody>
</table>

A = 0 points  
B = 1 point  
C = 2 points

Total points = [ ]  
(Researcher will complete. However, you may like to work out your score)

0 - 6 = Low dependency  
7 - 11 = high dependency
Appendix E:

Examples of Transcribed Interviews and Data Analysis Sheets – Clients:

Mark

1. (When started?) When 16, at school due to peer pressure, used to hide them from parents, and after school friends used to give me smokes. Other people bought them and I put money towards them. We’d all put in a get a packet between us.
2. I started buying my own when I left school when I was about 18, and I haven’t stopped since.
3. (So what was being a teenager like for you?) Awful, I used to get picked on at school, and alot of the time I was a loner, spent alot of time on my own, it was pretty tough times. I don’t think I’d like to go back to them.
4. (Why did people pick on you do you think?) Well I was big at school, a real fat kid, and people used to call me names, call me fatty.
5. (Did that have anything to do with smoking?) (Immediately answered with no hesitation) So that I could fit in with other kids. I found out at that age that if I smoked I could have friends.
6. From 18 I was a heavy smoker. I smoke 12mg now but used to smoke 16mg. If friends offer me a 16mg I’ll only have one because they’re too strong for me. I’ve tried to reduce them more but I just smoke more.
7. (How often do you smoke now?) Every hour an hour, I’ve got the clock there to time myself. If I’m home I watch the clock to time myself and if I’m out I just keep asking people ‘what’s the time, what’s the time, what’s the time’ and they tell me.
8. (Why do you think you do that?) I need them that often. It makes me feel safer to know that I can watch the clock and see when the next one is coming. It’s predicable, which is more that I can say for most other things.
9. I tried making it every hour but I just had this weird feeling in me, it was too long, I was getting the shakes, and anxious and nervy. That’s why I smoke half the time because I’m anxious, I’m bored, it’s something to do with my hands and fingers, you know the movement helps.
10. Tomorrow night friends are coming over and I’m going to buy 2 packets, just to have for tomorrow night. (we talked about how people usually smoke more when they’re at the pub or out with friends)
11. (Mark talked about a brother who gave up smoking ‘just like that’) I wish I could do that. Imagine all the money you’d be saving. I’ll try to do it one day.
12. (How many do you smoke in a usual day?) I don’t know really. I start smoking from when I wake up right up to midnight. I smoke in bed which is something my mother says I shouldn’t do. I have my first smoke as soon as I wake up. They’re by my bed, so I can stay in bed and have it. Then I get out and make a cup of coffee and have another one with that. and then I have one every half and hour from then on. It would be easy to have more, especially first thing. If I wake up in the middle of the night I have another one. it relaxs me. I reckon I go through a packet a day (35 escort red) I used to go through 2 packets a day, a chain smoker I think they call it. (Mark drinks 6-8 coffees per day)
13. I got unwell in the mid 80’s. My smoking was more then than it is now. I know I inhale differently when I’m more unwell, deeper. Most of the time now I don’t inhale that deeply. I do have lots of puffs on the smoke and smoke it right to the end though, more puffs that way. That’s where they reckon all the bad stuff is, all the poisonous chemicals or whatever.
14. (What do you think of smoking this bit?) I don’t really care at the moment. I might as well mightn’t I? There’s not much else is there?
15. (Doesn’t remember much about when he first went to hospital) There’s not much to do, I remember that. Just waiting to get out and getting bored. Some people liked it in there, I didn’t.
16. (What didn’t you like about it?) I just wanted to get back to my house and freedom. Like they let me out there and let me go to town, but it wasn’t the same.
17. (What do you mean by freedom?) They used to get you up about 7 am and have breakfast, then have a shower, and then what do you do for the rest of the day. Watch telly, or play pool or something. (pause) Every day the same. set meals, medication. A routine that I had no say in. At home you can smoke when you want and as often as you want. 18. (So what was it like when they lock the doors at night as just say no more?) They had a room at the back that you could go to, It was very cold at night though so you didn’t get many people going there. Only if you needed one. As soon as I’d get up in the morning I’d get up and have a smoke. I wasn’t the only one either. I saw lots of people start smoking in hospital. I think it was like what happened to me at school, just to fit in.
19. (Said out of the blue) I think if I really wanted to I could give up but I don’t think I want to. It relaxes me, it calms my nerves. It’s something you have to really want to do. I’ve heard it on the TV and the radio that you can ring the quit line.
20. It’s the money that makes the difference.(Have you ever been in the situation where you’ve run out of money and pension day is a day or two off?) Yes, Yes (Said strongly several times as I spoke as if this has happened several times)
I’m lucky I can get credit at the deli. (laughs with relief) They know I’m reliable and that I’ll pay. (The deli is also the agent for Mark’s bank where he withdraws his money weekly) But in January they’re getting new people in there so I don’t know how I’ll go then. (Concerned)

21. (So have you always been able to get credit there?) No, the first few times I wanted credit they wouldn’t give it to me so I borrowed money from my mother. I didn’t tell her it was for smoke because if she knew she wouldn’t give it to me. When she did find out, she wouldn’t give it to me so I had to tell her lies which I didn’t like doing very much. It doesn’t do the self-esteem very much good.

22. You’ve got to have a reason for stopping smoking and I don’t at the moment. It costs alot of money and like it’s bad for your health they say but I don’t know if that’s true or not. I know people who smoke who are eighty and then you get younger ones who are unlucky and die of a heart attack or something.

23. (What’s it like having an illness for you?) I became unwell when I was in my twenties. I used to smoke dope, nearly every day, 2 or 3 a day, every day. The doctor thinks that I might of got unwell earlier if I’d started smoking dope in my teens. The last time I had a smoke of dope I only had one puff and had to go to hospital. I went crazy, I went mad, I smashed everything in my place and I lost the place I was in. Before that I had a part-time job as a storeman that paid abit more than the dole. But even then I didn’t have many friends. I used to get into the wrong crowd, drinking alot, smoking alot. I did alot of those things just to feel wanted and accepted. I’m not the only one though, there’s plenty of others.

24. (Now have a number of regular friends - talks about how 4 of them are coming over for new years eve the next day) We all drink alot but I’m the only one who smokes regularly, That’s pretty unusual from what I’ve heard from other people at the clinic. Most of them smoke and a couple smoke OP (laugh- other people’s). I’m a bit weird I suppose. (Most of his friends also have mental illness, in particular BPAD)

25. I’ve got one friend who will go outside whenever I smoke, he doesn’t like it. He doesn’t say anything, he just can’t stand it so either he goes outside or I’ll go outside, and I wont because it’s my place. I can do what I want in my own place. Sometimes he says Peter you smoke too much and imagine the money you’d save if you gave up’. It goes in one ear and out the other with me. I can hear him and I know what he says but I put it down do feeling that I just don’t want to stop at the moment. Tomorrow night I’ve got 2 packets. How am I going to gauge how many I smoke. I’ll probably smoke the lot.

26. I get the bills paid and I pay the rent; all that’s pretty important. It keeps things more in control. (Mark is very organised in this) I’d rather go without food than go without smokes. The bills always come first. I’ve always been like that, when I was in boarding houses and everything. I wasn’t going to live on the street. (recounted experience of a friend who this happened to)

27. (Do you ever have times when you light a smoke and can’t remember lighting it?) OH yeah, definitely, lots of the time, especially when I’m having a bad head day (this is his early warning for illness) that’s why I try to time myself with the smokes. I think about it before I’ll think about other things. Like I said I’d rather have smokes than food. I’ve done that alot of times before.

28. I drink alcohol every day, usually just one or two when I’m have lunch (goes to the pub each day for a meal as he doesn’t cook) But I can’t promise anything for tomorrow night (laughs) and when you drink, you just smoke one smoke after the other don’t you. Cause smokes and booze go together for me, for lots of people doesn’t it.

29. (Talked about changes in policies) If they banned smoking in the pub then I just wouldn’t go to the pub. I’d buy takeaway and bring it home, and smoke at home, and drink at home. (Getting out is pretty important to you Isn’t it though) Yes, it’s better to get out, not stay at home like I used to and just get bored and feel more unwell being on my own all the time.

30. (Mark very regularly goes out to the city, pub, cinema, market, etc) People tell me it’s good for me to be with other people so that’s what I do and it keeps me well. Sometimes I can’t go out because of my illness. (talked about recent bout of illness) I stayed inside and smoked my head off. I found it hard to even go to the letterbox, let alone the front door. If a car was coming I’d jump back inside and wait for it to go and then go out to the letterbox, and run back inside and lock the door straight away. I smoked differently, inhaled more and smoked it right down so that I didn’t even realise it until I looked.

31. (Which smoke do you enjoy the best?) The first one. it gets you going. I enjoy smoking cause it gives me something to do with my hands. I suppose it’s boredom with me.

32. (What would you be doing if you didn’t smoke? What would you want to be doing?) I just don’t know. I’d probably put the money in the bank, at the end of the week I’d probably put the money in the bank, and that would be about it. (Mark quite lost looking when thinking and talking about this as if it just didn’t apply to him.) I suppose I could buy more things for the house. I don’t know if I stopped smoking whether I’d drink as much, they go together don’t they. I’d still have my drink a day even if I didn’t smoke I might even drink more and that’s even worse than smoking isn’t it. (Pauses) I’ve got the basics really in the house. I could go on a holiday, but I’m not sure how I’d cope with my illness. I’d have to go with someone. I don’t think I could go by myself. I might as well smoke mightn’t I? I’m just not sure what else there is. What would I do with myself?

33. (Have you ever tried patches or gum?) No, but I’ve tried cutting down. In the new year I’ll try going back down to every hour. I don’t know I was just getting too uptight, I just couldn’t do it every hour.
34. I’ve thought about whether I’d get unwell if I tried to quit. I know I don’t want to end up in hospital again, I know that.
35. The first time when I had no money and I couldn’t get credit at the deli, I used to go around the streets looking for butts, (despondent echoes) looking for butts (shaking his head) (So did you find some?) A few. I don’t know where or who they come from but I’d unroll them and join them all up again into one. It was just a smoke wasn’t it. I’ve been that bad. when you can’t have smokes you just go round knocking on people’s doors asking for smokes and some I didn’t even know the people, and they’d say ‘who are you and what do you want?’ (Did you have some who would give you a smoke?) Yeah, some would and some wouldn’t. Some just used to swear at me and push the door in my face, bang the door. (So how did that make you feel. At the time you must have just wanted a smoke real bad, Yes?) I would have done anything for one at the time. I hope it never gets like that again, but no, now I’ve got my own smokes. (relieved) At that point it was just ruining my life.
36. Now I keep my finances under control so that I never have to get into that situation. I pay my bills first and then smokes and entertainment and then food money.
37. (talking about family) My parents ring me every day. Mum rings twice a day, or I rind her. They all help me out. My brother says if I feel down or if I feel like I’m getting sick again just to ring him. If I felt like I was getting sick again, I don’t think I’d ring my parents, I’d rather talk to my brother. Sometimes it’s hard to ask for help. In the other place I used to just lock myself away, with all the doors shut and the window blinds down, didn’t eat for a week and just sat there. It’s not much of a life is it? It’s bright in here and I can have the door open.
38. It’s different on Olanzepine. I know I get a good night’s rest. Occasionally I get panic attacks, but that’s normal I suppose, everyone gets them. I just got nervous. (Mark talked about how panic attacks might be due to more stimulation and different thinking with new meds, not so blunt Ie. not necessarily a sign of being unwell, just adjusting) I’m addicted to the nicotine though aren’t I, so I’d probably get the shakes and cold sweats. It would be really difficult.
39. (Do you ever see yourself as a non-smoker?) Truthfully, no. Not at the moment, I don’t know. I’d like too, but..... You have to want to don’t you. If I rang up the quit line now it would be a waste of time. They can’t help me. I have to help myself first. You have to want to give up. Like I watch those adds on the TV where they squeeze the stuff out (Grimaces) and I wonder, am I like that inside, and I have a smoke while I’m watching.
40. None of other family members smoke or ever did smoke. I’m different I suppose aren’t I. I’ve got schizophrenia, they haven’t.
41. Having schizophrenia takes away alot of your motivation for doing things. Sometimes when I wake up in the mornings I just don’t want to get out, I just want to stay there. The smokes help to get you going. When you’re not sure what’s ahead in the day, you have a smoke and think about it. It gets you going. Sometimes it helps me think clearer. It’s just something to do with my hands to stop them from shaking.
42. (talking about what he means by boredom) Well, sometimes I just don’t know what to do with the day do I. Every day is the same. (Has it always been like that?) When I was a storeman I used to live day by day also but now it’s even more so. I just live for right now. I don’t plan or look into the future. I don’t plan it but I do worry about it; that’s why I don’t want to look at it too much.
43. (Talked about last year being the first year when he didn’t have relapse of illness which usually has happened every year at a particular time for several years and how he was surprised by this, and now has just made it past year two) We’ve done it again haven’t we. It makes me feel better, more confident. To give up smoking, I’ll have to look beyond day to day won’t I. You just don’t know when the illness is going to hit again, it’s pretty unpredictable. I know the warning signs now and to let other people know earlier to avoid hospital.
44. (What do family think of illness?) My mother does. She rings me in the morning and at night and asks ‘are you alright, are you alright?’
45. (Do you like her doing that?) I don’t mind it. I’ve gotten into the habit of it now. I don’t expect it to be any different. I’ve organised my life to live within my capacity. That way you don’t get sad about missing things. Sometimes I do get sad and ask ‘why me, why did I get this illness, my brothers and sisters are alright, they’ve got no illness, why me, it’s not fair.’ You can’t do all the time, feeling sorry for yourself.
46. (So what do you do to keep your spirits up?) (immediately responds) Smoke (Laughs loudly) It relaxes me and I can control it. I can say I’m going to have a smoke ever half an hour whereas I can’t always say ‘well no, I’m not going to get unwell this year, I’m not too sure on that one. It could happen anytime, you don’t know. I can do all the right things; have my tablets, see my doctor, and all that hooah, but you still don’t know don’t you. I’ve got control of paying my bills. And even when I don’t feel like going out I do because I know it keeps me from feeling unsettled. It’s pretty to be around people. It’s pretty important. But not all the time. I like to be by myself sometimes.
47. (Do you smoke more when you’re at home?) No, that’s when I can time myself more. I think I smoke more when I go into town because I feel stressed sometimes when I’m around other people and it relaxes me and calms me down, especially when I think they’re looking at me. It makes me feel good because it makes me feel normal like everyone else.
48. A big part of my day is going down to the deli to buy a packet of smokes. It gets me out, even if I don’t want to, it gets me out of the house, and they have a chat to me, they know me, they say hello. If I didn’t have the reason to go out
I’d probably stay in bed all day. So at the moment it’s good isn’t it. I suppose if I was working, I’d see people more and have more people to talk to, and I’d have less reason to smoke.

49. (Issue of control) I sort of control it and it sort of controls me. It’s like, when I’ve got smokes, then everything else seems to be more manageable, more in my control. When I haven’t got smokes then everything else goes out of wake. It’s like the marker that keeps everything in control.

50. (Is being able to smoke in hospital important to you?) Yeah, well when everything else is so regimented then being able to choose and have the freedom to smoke, of course it’s important. Sometimes I never used to smoke. It was just good being around other people, but they all used to smoke so I just joined in; it was a real social thing. Sometimes it was better than the treatment. Some of the nurses used to come out and have a smoke and that was better because they’d have a smoke and talk to you. They’d be talking to you just as a friend, not like when you were talking to the doctor. I sort of got held back abit. Seeing them smoking there and talking seemed less intimidating, it helped step over the barrier between us and them.

51. I’m responsible for my smoking, no one else.

52. (If you could give up painlessly, would you?) (Without any hesitation) Oh yeah. Who wouldn’t, I would for sure. If it was that easy I would.

53. Smoking used to be much more acceptable than it is now. Like now it as if you’ve committed a crime or something. Sometimes when I’m out people come up to me as ask me for a smoke and others give me strange looks. I try to ignore them. I know there will always be smokers but it worries me what people will think of them.

54. (What would you need to help you quit if you wanted to?) Probably patches or nicorettes. Someone to support me and encourage me I suppose. (Half-hearted feeling as if not much faith in these)

55. (Re doctors) The psychiatrist doesn’t cause she’s a smoker herself. I bring it up sometimes; she says there’s nothing wrong with it (laughs) I know it’s bad for you but it does help with the voices. It distracts me somehow off the illness.

56. I’ve heard that when people give up smoking, they eat more. I’m big enough. I don’t want to be bigger than I am.

57. At the moment I’ve got enough money, but one day I might have to stop or cut down. I don’t even know even if I went to the doctor and he told me I had to give up smoking, whether I would or not, even if it come to that, if I had cancer or something. Seems I’ve got an illness, like, it would be good to go (to die) wouldn’t it (small laugh to himself) I wouldn’t have the illness no more. I wouldn’t have to worry about it. If you’re going to die of cancer you’re going to die of cancer. It’s better than having the illness. (we both took a long pause and felt like bursting into tears) Even if I did give up smoking, I’ve still got schizophrenia haven’t I? How much pain is enough before you draw the line?

58. (We talked about Mark’s experience of having a panic attack yesterday and how the unpredictability of this really frightened him. Reiterated how the new medication might be causing some new and strange sensations as part of recovery)

59. (We talked about how Mark gets out and tries to push himself and how that’s special) It’s pretty damn good for me. Smoking keeps me stable enough so that I can do that. It must be really different for people who don’t have schizophrenia. I couldn’t cope if I had no family around, couldn’t cope, wouldn’t cope. My parents are getting older. (in their eighties) I know they won’t always be there. When they go how am I going to cope.

60. I really worry about the future sometimes. It doesn’t seem to have much hope in it for me.

61. (Impressions of being interviewed) It’s good. I was abit nervous when I knew you were coming. I was looking at the clock thinking Sharon’s going to be here soon. What am I going to say. I thought you’d try to convince me to quit but that’s not what we did at all. It’s still my choice.
<table>
<thead>
<tr>
<th>Code</th>
<th>Transcript</th>
<th>Issues/Theoretical Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why Quit, I’ve Still Got Schizophrenia?</td>
<td>Mark[13][14](On smoking cigarettes right down to the end of the butts.)</td>
<td>Self-destructiveness as response to powerlessness.</td>
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<tr>
<td></td>
<td>That’s where they reckon all the bad stuff is, all the poisonous chemicals. (When asked what he thought of smoking this bit)</td>
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<td></td>
<td>I don’t really care at the moment, I might as well sake</td>
<td>Lack of purpose with illness</td>
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<td>Fear of becoming unwell Effect of stigma on self-efficacy Lack of purpose / QOL Helplessness Hopelessness Powerlessness</td>
<td>I just don’t know …I could go on a holiday, but I’m not sure how I’d cope with my illness. I’d have to go with someone. I don’t think I could go my self. I might as well smoke, mightn’t I?</td>
<td>Lack of autonomy</td>
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<td>I’m just not sure what else there is. What would I do with my self? Mark[47][Re his current situation]</td>
<td>Lack of control over illness</td>
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<td></td>
<td>I don’t expect it to be any different</td>
<td>Sense of powerlessness</td>
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<td></td>
<td>I’ve organised my life to live within my capacity</td>
<td>Limiting options for change</td>
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<td>That way you don’t get sad about missing things</td>
<td>Sense of hopelessness</td>
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<td>Sometimes I do get sad and ask “why me, why did I get this illness. My brothers and sisters are alright, they’ve got no illness. Why me. It’s not fair</td>
<td>Self-protection</td>
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<td>I don’t even know if I went to the doctor and he told me I had to give up smoking, whether I would or not, even if it came to that, if I had cancer or something</td>
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<td></td>
<td>Seems I’ve got an illness, like, it would be good to go to die wouldn’t it? I wouldn’t have the illness no more. I wouldn’t have to worry about it any more: (On having cancer) It’s better than having the illness. Even if I did give up smoking, I’ve still got schizophrenia haven’t I?</td>
<td>Smoking as form of dying quicker</td>
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<td></td>
<td>How much pain is enough before you draw the line?</td>
<td>Smoking as relief from pain</td>
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<td></td>
<td>Jenny[23]</td>
<td>Depth of despair re illness</td>
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<tr>
<td></td>
<td>I wonder sometimes, like if I got cancer, would I just give up or not?</td>
<td>Despair and pain</td>
</tr>
<tr>
<td></td>
<td>I just give up or not?</td>
<td>Choice between two evils?</td>
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<td></td>
<td>Jenny (24)</td>
<td>Priority of smoking</td>
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<td></td>
<td>I’ve heard people say that it’s not even worth helping them (people with a mental illness)</td>
<td>Despair, sense of hopelessness</td>
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<td>There’s the whole issue ‘why bother’ which you get assumed about you by others, especially because you’ve got an illness that’s ging to stay with you as a label for ever.</td>
<td>Dominant stories about illness and smoking</td>
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<td></td>
<td>Jenny (39) (re illness label) That’s a prejudice I have to live with forever.</td>
<td>Sense of powerlessness</td>
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<td></td>
<td>Jenny (40)</td>
<td>Irreversible</td>
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<td></td>
<td>I can’t change the way somebody thinks and feels and acts. So in a sense there’s a bit of a helpless feeling there, and you just wish that some people would just grow up.</td>
<td>Sense of powerlessness</td>
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<td></td>
<td>Jenny (54)</td>
<td>Stigma</td>
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<td></td>
<td>It’s a real resignation about what you can’t change. Like, life’s shit anyway so you might as well smoke.</td>
<td>Despair re illness</td>
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<tr>
<td>Jenny (54)</td>
<td><strong>Dominant stories</strong></td>
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<td>It’s like a real big message from a lot of people saying that they accept that they’re killing themselves. Like, it’s a really really slow form of suicide that’s not conscious...it’s to do with some deeper feelings they have about themselves.</td>
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<td>Why do I smoke when all the other messages I give to myself are that I want to live?</td>
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<tr>
<td>Rod (26)</td>
<td>Sense of Powerlessness</td>
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<tr>
<td>It’s a shit life, a shit life. It’s harder to give up smoking when you’re part of a mental health service because they deprive you of everything.</td>
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<td>Sense of Hopelessness</td>
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<td>Rod (26)</td>
<td>Sense of Hopelessness</td>
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<td>(requested to turn lines off) I strongly emphasised the problems with labels, pigeon-holing, stigma, and judgements made by others. He felt totally powerless to be able to change these things</td>
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<td>Mark (53)</td>
<td>Sense of hopelessness</td>
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<td>I really worry about the future sometimes. It doesn’t seem to have much hope in it for me.</td>
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<td>Margaret (24)</td>
<td>A choice due to perceived lack of other purposes?</td>
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<td>There doesn’t seem much point sometimes.</td>
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<td>Jean (31) (32)</td>
<td>Effect of Stigma on self-efficacy</td>
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<td>I think it would be harder for people with a mental illness to give up because I think they worry a lot more, and worry about having a mental illness...Some people are terribly cruel. They don’t understand it. I had one neighbour who said to the man next door, ‘Don’t have anything to do with the crazy lady on the corner.’ Social isolation effect of stigma</td>
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<td>When I’m at the shops I feel like people are looking at me and saying, ‘she’s got schizophrenia.’</td>
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<td>Jean (34)</td>
<td>Stigma</td>
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<td>I feel like I’m not able to follow through with anything. I just think why bother?</td>
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<td>Sense of Hopelessness</td>
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<td>Illness affects motivation</td>
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<td>It started when I was young I suppose, lacked shit of confidence, felt I was not good enough. Historical development of sense of hopelessness and powerlessness.</td>
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<td>At first I used to hit back, but then I just gave up.</td>
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<td>Reinforced learning through abuse and coercion. Link systematic reinforcement of hospital setting - reward/punishment</td>
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<td>Jean (35)</td>
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<td>I learned not to say anything, (punishment if I did) I remember them (the nurses) saying, ‘you’re no good, you’re family’s no good.’</td>
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<td>It’s like trying to quit smoking. I think, why bother, I’ve still got schizophrenia and I think that’s what’s stopping me.</td>
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<td>John (26)</td>
<td>Illness effects self-efficacy</td>
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<td>I really couldn’t quit. I just think I’m not mentally capable of quitting.</td>
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<td>Fear</td>
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<td>I really worry that I would become unwell, and that’s the last thing [I] want to happen.</td>
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<td>John (35)</td>
<td>Depth of despair V’s mainstream reasons</td>
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<td>Use as heading</td>
<td>Gut wrenching stuff</td>
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<td>The first smoke of my day is just to get through the terrible shock of being awake again.</td>
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Appendix F:

Interview Guide: Staff:

Mental health service experience

Their own smoking history, why they smoking, and smoking while at work

Being a non-smoker while at work – what this is like

What occurs in their work setting re smoking

Their views on clients smoking and staff smoking while at work

What informs their decisions about how they act re smoking in the workplace

What do they think would happen if there was a smoking ban

Mental illness and smoking – any links perceived and why/why not

View of their own and other professions’ response to smoking issue

Level of involvement in supply of cigarettes to clients, and how they decide

How do they respond to clients who demand help to get cigarettes, what determines their decision

Determine their ethical stance on smoking
Appendix G:

Examples of Transcribed Interviews and Data Analysis Sheets – Staff:

Staff / Psychiatric Nurse
Inpatient Locked 12 years (only in community briefly)
Ex-smoker (one year as a teenager)

1. I smoked out of curiosity. I stopped because I didn’t like it.
2. (smoking and your work) Well, here in the locked ward they’ve got very set rules about smoking. They’ve just cut down on ward smokes to just after meal times, and if they’ve got their own, then they’re allowed one every half an hour. (What do you think of all that?) From the patients’ point of view I don’t think it’s very good because I think with smoking you should be allowed to smoke when you want. But from a practical point of view, it’s the time factor. With patients like we’ve got here, you really can’t be out there supervising all day long which is what it would be. So you’ve got to have some kind of balance, and I think that fits the balance fairly reasonably.
3. When people are banging on the glass, I personally go out and ask them, you know, what the problem is and try to explain the reasons and stuff. I suppose it depends how disturbed they are. Nine times out of ten, they listen, and they know and go away.
4. I think if I was a smoker, I would sit and smoke with the patients, if that was appropriate for the time and place and what have you. It’s different here, because it is so strict, I suppose.
5. (What informs your decisions about how you act with their smoking?) I just think they’ve got a right as much as anyone else to have a cigarette when they want a cigarette. I mean, you just take so much, like when they’re in here they’ve just got so little anyway, that’s one of the pleasures that they’ve got.
6. And if it stops them from getting aggressive or agitated, then why should we be so like prison wardens and so, “No you can’t have one.” I think a lot of the time, it’s power games with some nurses. (clarification?) I think with the nurses when some of them say, “You can’t have a cigarette,” it’s a power game, like, “I’m the nurse and I’m looking after you and I can tell you what to do,” kind of thing. That’s the feeling I get from a lot of the nurses.
7. (what do you see happening here, your daily experience?) Well the patients pretty much know the routine. I thought there’d be a lot more problems for patients who don’t have their own cigarettes, but they seem to manage and understand; not all the time; it’s depends how disturbed they are. Once they’re settled down a bit, you just say, “well, you haven’t got any cigarettes and this is it,” and they seem to be OK with that. (Depth of sense of powerlessness?) They seem to be resigned to it, I suppose.
8. I think, if they’ve got their own, but then also that can be a problem if they want to smoke all the time when they’ve only got $6 or whatever to last them another 3 days, and you know that if they keep smoking then they’re going to run out and you know it’s going to be difficult ‘cause they can’t go without them. I suppose then you’ve got to get a good balance to make them last for them.
9. (her stance on ward cigarettes?) That’s a hard one. I just think everyone has got the right to choose to do what they want to do. If they want to smoke, that’s fine by me.
10. I haven’t really thought about it that much. I just never think about it.
11. They were smoking before they were detained so what right have we to stop them from smoking once they’re detained. It’s something they were doing before.
12. (what do you think would happen if there was a smoking ban in the ward?) I don’t think anything would happen. I think that people would be upset for a while and then they would just accept it like any changes. Eventually you just come to accept that that’s how it is. I can remember when they suddenly decided to ban smoking in the locked ward. It was like 10 years ago you couldn’t walk through here without going through a thick wall of smoke. And you can imagine the outroar, you know, and then people just accepted it. So if that was to happen, then it would just be accepted over time.
13. (Re comments on community staff being firm about supply of smokes) I think that because, in an inpatient setting, you’ve got so many patients in close proximity to one another that if one gets agitated because they haven’t go their cigarettes, then it could just upset all the other people around them, or they could just go around pestering or being a nuisance to other patients, saying, “Can I have a cigarette? Can I have a cigarette?” So in the inpatient setting we try to ensure that they have cigarettes to keep them settled. And I think the consequences of not giving them a cigarette can be a lot worse than not giving them. Like, I’ve seen patients hit because they’ve been pestering other patients for a cigarette because they haven’t got any.
14. (What informs this?) I’m using the safety factor when I’m thinking about how they’re going to react to other people and how other people are going to react to them. But I really must admit, I never think of the safety of their health with smoking. I don’t consider that at all. Maybe because it’s something that you can’t that’s happening inside of them, you don’t think about it, and if you’re addicted, you just don’t care anyway. They’re just going to do it, whatever.
15. (re doctors and what they do/say re smoking) They ask routinely on admission, whether they use drugs, how much they smoke, that kind of thing. They tend to lump everything onto the nursing staff, rather than buy into it themselves. I really don’t think it’s an issue for them, and everyone here. No-one says, “I think we have to do something about the smoking.” And also, on admission, it’s often used, like, “See the doctor, calm down, and we’ll take you out for a cigarette.” It’s like a reward thing.

16. I think the smokes are definitely used as a reward and punishment thing. I remember an incident once when we had some exams here for the doctors and they were bribing patients to agree to sit in and be used in the exam, like, “We’ll give you 20 extra cigarettes if you agree to do this.” (What did you think about this?) I just thought it was amusing. (Laughs) And, I don’t know, I suppose it’s just like payment for everything. If they’re going to do something, then they should get some benefit from it, if that the reward they want.

17. I think they need their smokes and if it’s going to help their mental health, if it stops them from getting agitated and anxious, then I think the benefits in the short term are worth it. Who knows what the long term difficulties are going to be because of it.

18. (Your observation of links between illness and smoking?) I really don’t think I’ve noticed any difference in their symptoms with smoking, just their agitation. (blank moments)

19. It’s a good way of establishing rapport with a patient and getting good relationships so that you can get a working relationship with them. When they first come in and they really don’t want to be there, it’s a good opportunity to sit there and they’re more relaxed so they’re more likely to talk to you, so you’ve got a better idea of what’s going on.

20. (What would the nursing staff do if they didn’t have cigarettes to use for this purpose?) I think there’d be more medication given. I definitely think a greater amount of prn medication would be given, especially for agitation and things like that.
Social Worker / community
8yrs – community and inpatient experience
Ex-Smoker
1. (what informs your attitudes about smoking -re social work?) I think that’s an incredibly fluid question to ask me and I think my attitudes have changed over time and according to the areas I’ve worked in, where I am in my career and certainly whether I’m smoking or not. When I smoked I was probably more clear that it was a client right, or not even that, but that it was something they should be allowed to do what they want.

2. And when I was working in the long term wards, my ability to empathise and almost openly to model smoking behaviour at different points in time in my career when I didn’t have different tools. And, realistically, by the nature of the clients that I worked with in extended care, who were really hard to work with and really hard to engage with. And part of working with really difficult clients is trying to find an entry point where you can develop rapport with them. And what was more easy than sitting around with them and having a smoke. It was easy to do this in the community also, but even more so in the hospital ward where you would be sitting down with a group of clients on a sunny day, so that you weren’t just interacting with your client. You were almost conducting group work over an informal cigarette. And there’s something very connecting about that and very levelling about sitting down with a group of people smoking.

3. When I was working in extended care there’s such a clear power differential. Being able to smoke with clients and to be able to be an equal smoker was something incredibly joining and connecting.

4. And I think that part of me at that time was that I saw smoking with clients as incredibly respectful. I was smoking as being a choice. And when people were ready to give up they could speak to me about that. I had very few clients who chose to give up smoking, and I think that also entrenched my beliefs that it’s just something I had to put up with.

5. Sure you had discussions with clients about money. When ever the cigarette prices increased and there was no increase in pocket money, there were always tussles with that and at different points in time it was a major task to get people to smoke different types of cigarettes, and looking at how cost effectively people could smoke. At different points we had to cut down people’s cigarettes, but we also had to explain to clients that this was a consequence of their smoking.

6. There were times in the community when, if a client of mine ran out of smokes and he had 4 or 5 days to go before he got his money, I was more likely to cross boundaries and even dip into my own pocket on 2 or 3 occasions to buy the client smokes, because I knew that the rules were so difficult.

7. I think that staff... I don’t think that people give enough credence...I think that most people nominally know that smoking is addictive but to actually admit that we have all these clients who are so heavily addicted is a really different mindset. Even the closed wards, in the past 18 months, have really love /hate relationships with cigarettes in that I have given up, although I still have 2 or 3 a week which I consider not smoking, and we had incredible pressures, as social workers my responsibility was to organise these things. The nursing staff wouldn’t go to the canteen. The nursing staff wouldn’t buy cigarettes. The hospital was supplying cigarettes through the canteen fund but you have clients that were, on several occasions, violent because they didn’t have cigarettes, clients who had to be restrained and given medication because they couldn’t have a cigarette. And the nurses certainly said they have no hesitation in giving people cigarettes, because they just don’t want to go home clobbered.

8. And similarly, you don’t want a client at that level of personal distress that they are risking their own personal safety for a cigarette, and people’s judgements are so impaired and when you’re prioritising what you’re there to do, you don’t give a rats about their addiction at that time. The addiction is by far the lesser of the addictions that you’re dealing with at the time. It’s just so low on the list of priorities, when you’ve got stuffed family dynamics; they’ve lost their house, their psychotic, etc. It’s strange though when you dealt with, like I know I had a lot of clients who weren’t smokers before they came into the locked ward and started smoking. It was freaky.

9. But because I was working in a situation where the staff wouldn’t buy cigarettes, that role fell on me. I had this strange... I ’d moved from the shop, on the one hand, of hating the fact that, as a paid clinician, I was spending my time going to the shop and buying fucking smokes for people and often that would take an hour and a half every day with the bank run for a number of people. And I was developing a relationship with the woman at the bloody smokes shop because I was there so often. I was often there 3 or 4 times per week and found that very degrading but then I’d combat that ethnically by saying this is seen as a client need and this is what I’m called upon for, that’s great, you know, who am I to be sanctimonious about that should only be a clinician.

10. On the flip side of the coin, you had clients who were so disempowered and had had so much removed from them, that to be able to go to the shop and get them a bloody chocolate bar and a packet of smokes that they wanted was so enabling, and allowed me to work with them in such a different way from what the doctors and nursing staff did because I didn’t have that same power kick, and again, the power differentials are immediately reinforced by your work environment.

11. and I found clients regularly, and often wouldn’t want their normal brand of cigarettes. They would go for something more luxurious, a more indulgent brand of smokes, or something special. And for me to act as the facilitator of that was really important. But I actually resented the time I had to spend doing that.

Social Worker / Community
8yrs –community and inpatient experience
Current Smoker
1. Most of the boarding houses dole out cigarettes as certain times as well, and everyone lines up and they follow that hospital system of packaging them up and having people’s names on them. It’s like an extension of the hospital ward. And I used to get quite frustrated with the way people used to learn to smoke while they were in hospital and came out smokers and couldn’t give it up. And if we’re going to use that function of cigarettes as a reward system while people re inpatients then we need to also provide them with the means and needs to give up smoking once they go home because the loss financially is just so huge. It so constrains them once their money is gone on cigarettes that they can’t even go out for a coffee because they have no money left.

2. (re her own smoking and how she incorporates that into her role as a worker) It’s really difficult to know, only that I understand what they’re going through. I’ve just seen so much of it. I sometimes joke when people have no money and say, “well, give up smoking,” and they say “well, you should talk,” and I say “I can afford to smoke on my salary. That’s not a consequence for me. I’ve still got money, you haven’t.” Other times I’ll commiserate and say, “well, yes it’s a really difficult thing.” One lady I’ve got who I saw this morning, and I was coughing with my flu, and she’s got this suspect lung and she said to me, “you know you shouldn’t smoke.” And I said I agreed, and said “Well, what are we going to talk about (laughs)” She said, “the trouble is I like smoking.” and I said,” that my trouble too,” and we’re both aware that we’re probably killing ourselves and we ended up just laughing about it.

3. (So what does that do as far as your relationship is concerned?) It probably improves it; that’s what it seems. Like, people are certainly very comfortable about the fact that I’m a smoker like them, and they prefer that, and they often ask if, once they’re transferred out, whether their new worker will also be a smoker. It’s one of the very first questions they ask me and I almost always say invariably no, that their odds of getting a smoker are pretty slim because most of them don’t smoke.

4. They like knowing that the worker has something in common with them.

5. (quick look at her case load - 80% smokers, the majority have schizophrenia also) And all fairly heavy smokers to the point where it impacts on their lives financially. And it’s a problem because the younger clients in particular would benefit greatly from more social activity.

6. We talk a lot about smoking, it’s very common in all my interaction with my clients.

7. Like, I remember this one client I had who was the worst smoker I’ve ever seen in my life, the heaviest smoker, and she could smoke 3 or 4 large packets of rollies from Wednesday morning at about 10am to about 6pm on Friday afternoon. And I said to her, “you couldn’t have gone to sleep.” And she said “I didn’t.” No-one could have smoked that many. So I worked really hard with her to cut down her smoking, and I was very blunt about it, and I said, “you will die, you will die, you will just fall down dead. Your body will just not cope with this.” We started off all sorts of things. Eventually what worked was that the whole team got involved and what we did was we actually parcelled up tobacco into enough to make up about 10 cigarettes and we made two trips a day, and twice a day we dropped off this package. And she didn’t have access to funds, so that was all the smokes she was getting. She was really excited because she wanted to see if she could get by without that many cigarettes for a week, so that’s what we did. What happened was that she got so used to it and she didn’t want to run out of tobacco that she made her tobacco last so that she still had one left when the next package came. That was a turning point for her realising that she didn’t really need to smoke all of her pension. She wanted us to do it forever, and we said no, that we just wanted to prove that she could do it, and that “now you know that, you can package up your own and mark it for the days of the week”, and every time she felt that she was smoking too much, that’s what she’d do. She actually learnt what to do, because before that it had been feast or famine, and she smoke them all and go for three days with this horrendous withdrawing, and it would happen all over again, and her behaviour was so bad that she was going to be evicted when she was uptight from having no smokes.
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<td>John (42)</td>
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<td>Robyn (1)</td>
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<td>Bob (3)</td>
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<td>One of the beautiful anehcdotes recently</td>
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<td>Bob (4) (descriptions of each extended care ward re level of ability and disability, and focus of care and goals. Became a description based on the level of smoking)**</td>
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<td>The currency of cigs is the other fascination thing that exists in the hosp. It definitely happens in extended care, and occasionally we have entrepreneurial people who exploit the situation by charging considerably more than the cost of the cigs, or they'll - //Terry comments actually use cigs in order to get sexual favour...But it's a case of knowing that it's happening because a lot of these people are reticent to tell staff about other patients' behaviour because it's part of the culture that exists that you don't tell. It has its own social rules.</td>
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<td>Grace (41)(Hospital)</td>
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Appendix H:

Audit Report – Client and Staff Interviews, Ms Shaun Byrne
Aims of the Audit:

To verify that the 10 criteria formulated as requirements of the audit process have been reasonably achieved.

(1) Fully informed consent

The auditor met with the researcher and discussed the process of recruitment of participants, preparation and organisation of interview appointments, distribution and explanation of information sheets for clients and staff, and signing of consent forms by clients. In addition, the auditor randomly checked 8 of the 24 case notes of client participants to check that consent forms were present and completed correctly, as assured was the case by the researcher. This was confirmed. The auditor also informally spoke with a number of client participants to glean their impressions of the interview process. No coercion or incongruence in what was said to have occurred by the researcher was noted. The criteria for fully informed consent is found to have been met.

(2) Freedom from bias in the inquiry process - freedom from bias, interests, motives on the part of the researcher which may threaten neutrality and objectivity.

An extensive review of data collected, including interview transcripts, reflective notes, memos of interviews and data analysis sheets confirmed freedom from bias, interests, and motives. Neutrality and objectivity by the researcher was established. As a consequence, the unique significance of client participants' words and meanings was particularly noted. The poignancy of the effects of being within a mental health system for both clients and staff was also of particular significance. The researcher clearly and openly briefed the auditor on research goals, subjective experience of the research and interview process, personal and professional motivations for the research, as part of regular meetings and discussions with the auditor. At times it was noted that the researcher was emotionally close to the data, particularly that dealing with client distress and with staff professional rivalries and burnout comments. Discussion of this counter-transference with the auditor allowed the researcher to place this data in a productive context in order to enrich the meaning of the data and enhance theoretical development.

(3) Fairness by tapping perspectives of all stakeholders.

The researcher's planning notes, journal entries, and discussions with the auditor suggest that the perspectives of several types of stakeholder were sought and gained. Clients with varying categories of mental illness, level of functioning, and complexity of issues were involved, as were staff with varying levels of experience and training, workplace setting, and professional discipline. The views of Quit advisors and educators, and specialists in the fields of research methodology, addictions, psychiatry, psychology, philosophy, anthropology, and sociology were sought via consultation with prominent individuals in these areas of expertise. The perspectives of policy makers and other administrative staff, particularly non
medical staff would have possibly given the findings a further interesting dimension. Overall, this aspect, required to establish authenticity as suggested by Rodwell and Byers, was met. The researcher clearly aimed and achieved the establishment of equal power in their relationship with interviewees, thus empowering all to have a voice. A review of written results also confirms that all perspectives sought were given due consideration.

(4) Evidence of increased insight as a result of interviews.

This was clearly established with the complexity of discussions at the initial stages of the project being markedly less than discussions as the research progressed. The quality of memos, questioning by the researcher, ideas demanding further exploration, as noted in the researcher's interview notes and analysis sheets, verify that interviews stimulated further theoretical exploration of the findings. Several interviews were randomly selected by the auditor and read as part of assessment of this point, together with impressions gained from discussions with the auditor and written results from the research in conference papers. Ontological authenticity, via consciousness raising, was established by a review of transcripts in which increased insight by participants was noted. Clients were clearly more aware of the complexity of their smoking and staff were more aware of the ethical and legal implications of smoking by staff and clients. Educative authenticity was demonstrated by evidence of increased respect for the views of others by client and staff participants, with each showing empathy for the other's position while maintaining their own stance. Catalytic authenticity was evident with the auditor observing the growth in interest in this research project by various interest groups, as the research progressed and news of it spread with the mental health system. Invitations for the researcher to speak at various forums, including the schizophrenia fellowship and medical staff training sessions, was noted. Tactical authenticity was demonstrated through effective change actions noted by the researcher as part of the interview process. The empowering effect of being heard was evident in the progress of a number of interviews with both clients and staff. One client and one inpatient staff participant directly attributed their decision to attempt to quit smoking to interest raised by this research and following interviews with them.

(5) Assessment of the structure of questions and quality of responses.

Transcribed interviews were selected at random with congruency and flow checked with regard to interviewer and participant interactions. Interview questions were found to confirm that generous allowance was made for individual participant meanings and interests to be explored, while also allowing the researcher to return to the main areas identified in order to provide consistency. The depth and intensity of many participant responses demonstrates that they felt comfortable and safe with disclosure in the interview process, thus allowing for unique experiences and comments on taboo areas to emerge more readily. This enhanced the quality of responses.
(6) Encoder reliability scores between the researcher and a second coder have a high percentage of matching, i.e. more than 85%.

Interview transcripts were checked for degree of encoder reliability following a description sought by the auditor from the researcher on the process of how the second coder, Dr Pols, was briefed and how the coding process occurred between the two parties. This included information on how they resolved discrepancies and disagreements regarding the formulation and assignment of codes to the data. Each coder began their task of coding with transcripts free of any added codes or notes by either party. The auditor is satisfied that the researcher and Dr Pols coded interviews independently once initial discussions between them to discuss the framework took place. The final codes are therefore deemed to be based on the strength of the data itself in being self-evident. Of the 24 client interviews, 6 were selected at random by the auditor. A manual cross-checking and counting of matching of codes assigned by the researcher and Dr Pols confirmed 85% or more encoder reliability was established. Where coding differed substantially once the two copies of transcripts were reunited, extensive memos and questioning by the researcher was evident. This was followed by supervision sessions with Dr Pols and Prot. Jim Barber (Primary Supervisor) to discuss this, with supervision notes outlining the conclusions reached. This further stimulated the development of questioning and theorising by all concerned. In general, there is much evidence that codes were examined thoroughly to ensure exclusive mutuality and correct assignment of ideas and interviewee statements to codes.

(7) The logic of the researcher’s thought processes and decision-making is apparent in notes.

A review of descriptive notes and axial coding notes attached to data analysis sheets show clear and extensive questioning and theorising about ideas expressed by participants. An accompanying rationale for the assignment of codes is evident, as demonstrated by cross-referencing and linking of ideas in several sections of interview transcripts. At several points, links have been made and noted by the researcher to existing theory on nicotine dependence and mental illness.

(8) Existence of ‘thick’ descriptions is evident

A review of all support materials, in particular the reflective journal revealed that the researcher had consistently made notes about each interview soon after it was performed. This included a general description of the context and setting of interviews, the culture of the environment, descriptions of non-verbal behaviours observed by the researcher, and subjective feelings about each interview. These notes supported the transcripts and memos made. The ability of the researcher to vividly recall these features of each interview, and her familiarity with the data received, suggests and supports the trustworthiness of the process of data collection in general as an accurate depiction of what actually occurred. Interpretability of the data was therefore enhanced. Tranfererability, or external validity, was also enhanced by the researcher’s careful and extensive descriptions
of place, context, and culture in which interviews with clients and staff occurred. This was particularly so for interviews with staff who worked in locked wards and for clients who were hostel residents.

(9) Check findings and interpretations with various data sources to establish credibility (internal validity) of data.

The researcher contacted most client and staff participants more than once during the course of the study. This prolonged engagement and persistent observation of the cultural milieu in which smoking occurred provided the potential for greater depth and scope of data and ideas to emerge, and for a greater understanding of the essential characteristics of the interactions being observed. Credibility of the data was further enhanced with the researcher performing peer debriefing in order to test ideas and to detach themselves from time to time from the immediacy of the data. Debriefing with the auditor and with supervisors was noted here. Presentations to peers at staff meetings, conferences, later visits to client participants to provide them with feedback, and other presentations provided the researcher with opportunities for questions, challenges, and confirming feedback to occur. Reflections made about these occasions show that the researcher incorporated this feedback into later development of conclusions. Triangulation of data sources and theories to support credibility was evident, the former by interviews and consultations with various groups and individuals during the course of the study, and the latter by extensive literature review encompassing the ideas from several different paradigms.

(10) The audit trail was clearly established, i.e. explaining how data was collected, analysed, and interpreted in order to demonstrate consistency, reliability and replicability.

The draft methodology chapter for the thesis provided a clear and understandable explanation of the process of data collection and analysis, step by step. Descriptive and axial coding notes and reflective journal notes explain how the researcher interpreted the data. The auditor is satisfied that the audit trail was clearly established so that this research could be carried out by others if necessary. The four document types necessary for an audit trail to be established, as outlined by Rodgers and Cowles (1993), were present in the materials provided to the auditor by the researcher.

Suggestions and Issues Raised during the Audit:

(1) Potential effect of staff participant volunteers on the generalisability of data from staff interviews, including their relationship to the researcher, both personally and professionally.

(2) Repercussions of the reporting of findings on staff, clients, and the researcher needs to be considered carefully, with implications for the acceptance of the findings by the system of care. This includes the political implications for all concerned.
Audit’s Report

Aims:

To verify that the following ten points have been reasonably achieved:

- fully informed consent

- check for bias in inquiry process i.e. freedom from bias, self-interest, motives on the part of the researcher which threaten neutrality and objectivity of findings

- fairness by tapping into the perspectives of all stakeholders

- evidence of increased insight as a result of interviews

- assess structure of questions and quality of responses, as well as congruency in the process

- encoder reliability scores for the researcher and supervisor have high percentage of matching, i.e. 85% or more

- logic or researcher thought processes and decision-making is apparent in notes and memos

- existence of ‘thick’ description, i.e. memos, interviews, reflections (Applicability)

- check findings and interpretations with various data sources (Credibility)

- the audit trail was clearly established, i.e. it explained how data was collected, analysed, interpreted, together with triangulation of sources (Consistency, Reliability, Replicability)

As part of this process, the auditor will make notes about:

- content
- issues raised
- questions needing clarification
- specific claims made as part of the work plan for the audit

These are then to be raised, discussed, and negotiated with the researcher as part of regular meetings with the auditor.
Support Notes
(Provided to the auditor with reference articles and list of aims of the auditor’s report)

The four basic types of documentation for a comprehensive audit trail to be established:
(as per Rodgers and Cowles (1993) p.220ff)

1. Contextual Documentation

Observations, events and other factors related to the context of the data collection and
the actual data collection process.
E.g. fieldnotes, description of non-verbal behaviours, summary notes of interviews

Aim - thick descriptions, interpretability, transferability, trustworthiness

2. Methodological Documentation

Recording of all methodological documentation made throughout the study to reflect
the emergent nature of the qualitative study.
E.g. - questions to include in interviews and follow-up interviews with others and
quitters
- supervision feedback and reflection

Aim - demonstrate rigour, dependability

3. Analytic Documentation

Note the researcher’s thought processes in sorting, categorising and comparing data and
in conceptualising matters that emerge as the data are examined and coded.
E.g. memos, theoretical notes, descriptive /axial memos, reflective notes, identification
of negative cases and questioning around this.

Aim - consistent and clear documentation regarding all phases / stages of data analysis
- questioning ‘fit’ of the data through constant re-examination

4. Personal Response Documentation

The investigator’s conceptualisation of the original study problem. Also, the knowledge,
philosophical approach, professional background, emotional response to participants,
data and analysis procedures, and end product.
E.g. reflective journal, auditor discussions in meetings, and debriefs

Aim - to establish credibility, explain rationale for various decisions, and identify
personal biases and idiosyncrasies relevant to the study.
5th May 2000

Ms. S. Byrne
Senior Social Worker
Southern Mental Health Services

Dear Shaun,

Re: Auditor’s Report on Ms. S. Lawn’s thesis methodology
and research process

May I thank and congratulate you on what I consider to be, an objective, thorough and high quality report.

I should first note that there has been no contact between you as auditor or myself as a supervisor throughout the time that Sharon has been engaged in this work. I am impressed with the rigour that Sharon has applied to the whole research methodology and process: both the fieldwork and the analyses.

Your report is also an indicator of this. It is clearly an in depth look at the quality of the data and the validity of its collection and analysis. It reads well and I agree fully with what I perceive to be a fair and objective conclusion.

Yours sincerely,

Dr. R.G. Pols MB,BS,FRANZCP,FAFPHM
Senior Lecturer – Flinders University of South Australia – School of Medicine
Appendix I:

Audit Report – Participant Observation of the Settings, Ms Judith Condon
Auditor's Report

Research Project: Cigarette Smoking and Mental Illness: Barriers to Quitting

Researcher: Ms Sharon Lawn
Auditor: Ms Judith Condon
Lecturer
School of Nursing & Midwifery
Flinders University
Bedford Park, South Australia

Date: February, 2001

Preamble: I conducted an audit of the ethnographic component of Ms Lawn's research, in which she was engaged from August 2000 to January 2001. During this period we met approximately monthly to discuss progress, the extent to which the audit criteria were being met and any difficulties or concerns with the data collection process.

The first meeting in August was used to establish the criteria for the audit and familiarise me with the research aims and methods of data collection. Subsequent meetings involved examination of the process and context of data and its collection.

Supporting Documents: The articles were helpful in describing the audit process. The research documents became part of the audit and were able to be cross referenced with the data


Extract from Method Chp: Participant observation of the in-patient and community psychiatric settings

Information sheet on participant observation research: Smoking and Mental Illness (for distribution to staff and parents)
Observation checklists

Copy of auditor’s report for Part 1 of research (client interviews).

Extracts from reflective journal

Summary themes from reflective journal/participant observation

Summary observation of sites “A day in the life of...”

Criteria for Audit: After discussion with the researcher, the following criteria were decided on, to monitor the ethnographic observation.

a) Evidence of increased insight as a result of observations. This included:
   • Ability to suspend preconceived ideas and notice unexpected data
   • Alert to categories of behaviour not on the checklists
   • Observation process subject to revision if necessary
   • Transparancy of interpretation and decision making
   • Thick description
b) Appropriateness of consent process
c) Maintenance of confidentiality in process and reporting
d) Inclusion of all stakeholders
e) Sensitivity in entering and leaving field
f) Audit trail clearly established

1. Evidence of Increased Insight as a Result of Observation

There were numerous examples of new insights developing as a result of the observations. In particular the reflective journal was used by Ms Lawn to record her responses to what she was observing.

Insights ranged from making theoretical links or raising theoretical questions to noting the impact on herself of what she was observing:

Struck by the sociability of the ward and peer smoking to meet others, initiate conversation

Ms Lawn used both check lists and thick description to record behaviours, coming to depend more on the latter than the former.

Some categories were dropped from the check lists as being impractical to measure. Once familiarity with patterns of behaviour
had been gained, the thick descriptions provided more a more useful record of observations.

An example of recognition of unexpected data was the ambivalence of nurses towards their role in patients’ smoking and the lack of support they perceived they received from management, when they questioned policies or tried to change things. This insight was supported by a number of different observations of different nurses, wards and occasions. Early data showed "staff keen for support to fix the problem but don’t see it as their role/duty or having put into play," (1/8/00). Later data recognized the structural components of the issue “Staff despondent about loss of ideals of their nursing roles due to the realities of control and force in their environment" (20/10/00).

Interpretation of data and decision making was transparent. The reflective journal recorded decisions e.g. to continue data collection because new data were continuing to merge. Tentative themes were developed as data was collected. By the end of the observation period 4 themes had emerged

- Smoking as a tool
- Smoking as social currency
- Attitudes of staff
- Us and them

Origins of these themes could be seen in earlier developments, in the data and reflective journal.

2. Appropriateness of Consent Process

The draft methodology chapter lists the consent process and the large number of consents required and obtained. The reflective journal notes numerous occasions on which Ms Lawn explained her presence to clients, who checked her out to make sure she wasn’t staff, before being willing to converse.

3. Maintenance of Confidentiality

The observation data and reflective journal are meticulous in their absence of names. Where wards are named, titles of staff have been changed. In our discussions, no names were mentioned.

4. Inclusion of Stakeholders
The number of consents sought and obtained give some indication of the inclusiveness of the process. Another example is Ms Lawn's willingness to talk with clients about a smoking quit program on the request of a staff member. There was a clear responsiveness to staff concerns although necessarily limited by constraints of the research.

5. Sensitivity in Entering and Learning the Field

The reflective journal is a good source of Ms Lawn's efforts to maintain positive relationships with staff. An example of the success of these efforts is in the running of a meeting for senior nurses on the issues arising from the research. Senior nurses were also comfortably present at a conference at which some initial data were presented.

6. Audit Trail Clearly Established

I believe a clear audit trail has been established such that it is clear how themes have been arrived at and data collected. There are clear links between the methodology chapter, the data, reflective journal and the emerging themes. The monthly discussions showed Ms Lawn to be open and responsive to her observations and data. She maintained an open ended approach to the observation process, constantly monitoring the extent to which new data were continuing to emerge and being willing to continue the observation visits as long as necessary.

Conclusion

I find this research to be conducted ethically, according to clearly described and justified methods. There is clear evidence of the derivation of insights and themes from the various sources of data. This research has established a clear audit trail.

Judith Condon
Lecturer
School of Nursing & Midwifery
Flinders University
Appendix J:

Examples of Observation Sheets
## Smoking Area Observation Sheet

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## Individual Cigarette Consumption Patterns – Staff

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### Cigarette Sequence
**Staff Reasons for Smoking – Definitions:**

**Addiction**
Relief from physical withdrawal symptoms of smoking and psychological craving for cigarettes.

**Response to Stress**
To calm or pacify oneself by smoking in response to stress directly related to the performance of work duties.

**Time Out**
Smoking once removing oneself from direct contact with others in order to avoid the direct contact environment with patients and/or other staff.

**Boredom / Slow Period**
In the absence of other activity, to fill in time, to relieve monotony of the setting.

**Break Time**
Smoking during designated breaks from being on duty with patients.

**Between Tasks**
Purposeful pause between two work-related activities

**Socialising with Patients**
Casual conversation while smoking with patients, without pressure on nursing role or motivation being to administer care or intervention to patients.

**Socialisation with Staff**
Casual conversation with staff not work related and not involving or directly including patients.

**Debrief**
Smoking with another staff member in order to talk about a work-related incident and to seek support in managing feeling pertaining to the incident.

**Rapport Building**
Shared smoking with patients in order to gain their trust.

**Assessment**
Smoking with a patient in order to gain information from them related to their mental illness.

**Management of Patient**
Smoking with a patient to pacify them, quieten them and minimise their distress or adverse behaviour in order to get them to comply with staff wishes and/or ward rules.

**Other**
Any reason not elsewhere defined by the other reasons.

**Smoking Sequence**
Pertaining to smoking by locked ward staff only. Taking the opportunity to smoke with patients as part of the designated times for performing their role in supervising these detained patients’ smoking.
## Smoking Area Interaction Sheet – Clients and Staff

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<td>- non-smoking</td>
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<th>Other Activity: (person 1)</th>
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<td>- offers smoke/light (1&gt;2)</td>
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<td>- offers smoke/light (2&gt;1)</td>
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<td>- 2 ignores 1</td>
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<td>- 1 moves away</td>
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Archived at Flinders University: dspace.flinders.edu.au
Appendix K:

Participant Observation Information Sheets:

Information Sheet on Participant Observation Research:
Smoking and Mental Illness

For distribution to staff and patients:

This information is provided to you to clarify the reasons for my presence on your ward. My name is Sharon Lawn and I am currently employed as a Key Worker at Marion Community Care Team. I am also currently completing a PhD, looking at smoking and mental illness, barriers to quitting, based on the perceptions of community mental health clients and staff in community and inpatient settings. As a key worker in the community, I share your concerns for the high level of addiction and consumption of cigarettes by people with a mental illness, as well as the degree of poverty and other social problems caused by this expensive habit. The aim of this study is to better understand the process of smoking and quitting for people with a mental illness in order to help them to quit, and to help guide agencies and workers who are assisting them to quit.

The component of the study that has brought me to your ward is known as ‘participant observation’. For this, I will visit the ward for periods of time, usually mornings, afternoons, or whole days so that staff and patients become familiar and comfortable with my presence. My aim is to observe interactions between staff and patients, patients and patients, and staff and staff, regarding their smoking behaviours, and to record this using notes and a checklist of themes. Examples of these themes are:
- peer smoking, smoking to establish rapport, smoking to pacify, smoking for stress relief

To ensure the genuineness of results, staff and patients will not be aware of exactly when I will be recording data and when I will be merely present on the ward. There may be times when I appear to be recording data but am not. As part of the methodological requirements of the study, these times will be predetermined randomly, to ensure the absence of any bias by the researcher. For example, I may be on your ward for two or three times without recording data, and using results from days five, seven, and nine. I propose to be part of your ward environment for not more than two weeks and hope to cause you as little inconvenience as possible in the day to day activity on the ward.

I would like to stress that your participation in this study is completely voluntary. Please feel free to ask me any questions about the study or to ask to be excluded from it if you wish. Your non-participation will be respected and will in no way influence your status as either patient or staff member, as applicable. Should you decide to withdraw from the study, you may do this freely and without prejudice, and you can do this at any stage. As no personal details of names, wards, etc will be included in the study, confidentiality and anonymity is assured.

If you have any further questions or concerns please contact me on the ward or at Marion CCT Ph. 8375 6000. Alternatively, my supervisors are Prof. Jim Barber (Ph. 8201 2216) and Dr Rene Pols (Ph. 8204 4916). This study has been reviewed by the Flinders Medical Centre and Flinders University Social Sciences Ethics Committees, (contact - Carol Hakof Ph. 8204 4507) and the Royal Adelaide Hospital Ethics Committee, (contact - Toni Pietrafesa Ph. 8222 4139), should you wish to discuss the study with someone not directly involved with the study. Your participation is greatly appreciated.

Yours Sincerely
Sharon Lawn
Information Letter – Community Staff and Clients

Dear Hostel Manager, Staff, and Residents

I am currently undertaking a study of the smoking culture of environments in which mental health service clients live and interact, as part of my research towards a PhD on “Smoking and Mental Illness: Barriers to Quitting”. I have interviewed several clients of the community team, and staff from the community and inpatients settings.

To finalise the project, I plan to conduct a participant observation of the various settings mentioned by these people. This would involve me coming to the hostel over a period of time and on a number of occasions to observe the smoking behaviours of residents and staff, and observe the interactions regarding smoking between resident and resident, resident and staff, and staff and staff, where applicable. I envisage visiting approximately ten times for periods of between two to three hours at a time. The main area I would hope to spend time in would be the outside smoking area and the reception area where some residents come to receive their cigarettes from staff at the office.

Participation would be completely voluntary and confidentiality for residents and staff would be assured. For example, no details of staff status or position would be distinguished that would identify them or the particular hostel. Participants would be named only as either “staff” or “resident” for the purposes of this project. I would in no way interfere with the day to day running of the hostel or the activities of residents, except where I may, for example, be ethically bound to report any abuse or intimidation of residents to the hostel manager. I would aim to keep as low key as possible in order that people interact as they normally would, regardless of my presence, hence the need to visit on a number of occasions so that the participants become accustomed to my presence. I feel confident that my experience and sensitivity to mental health client needs would allow me to fit comfortably into the setting without disturbing residents also. I have consulted with the Southern Consumer Advisory Group and the Schizophrenia Fellowship to gain their impressions regarding the voluntariness of participation by clients who may be disturbed or who may suffer from memory loss. These consumer advocates feel assured that the nature of this project would not pose ethical problems or jeopardise the welfare of residents.

I would be using specific observation schedules while visiting in order to record my observations, and would show these to you prior to commencing the participant observation. If you have any concerns as the time frame progresses and you do not wish me to continue visiting and undertaking this part of the study, that would be accepted without question. I would welcome your feedback during that time in order that any problems may be prevented. I do not envisage problems and am keen to come to visit you and meet with you all again.

I would welcome further discussion with you about any concerns or questions you may have regarding this project and I look forward to hearing your response to this request. You may also like to direct any concerns to my supervisors Prof. Jim Barber (8201 2216 / Flinders University) or Dr Rene Pols (8204 4916 / FMC Dept Psychiatry), or to Ms Carol Hakof, Executive Secretary for the Committee on Clinical Investigation (8204 4507 / FMC). I look forward to visiting you at the hostel at Daw Park soon to discuss the project further,

Yours Sincerely

Sharon Lawn
Key Worker / Southern Mental Health - Marion
Appendix L:

Examples of Journal Notes
11/10 5 - 8pm.

Late afternoon at the Hotel. It's a warm night & the residents are enjoying the smoking area in the garden. I asked a man to rekindle my fire in his corner. He & another man are sitting in a corner with books on a table. He is reading a book & the other man is smoking. He says he is reading a book about the war & history. He says it's about a war & history. He is reading a book about the war & history.

It's a warm night & the residents are enjoying the smoking area in the garden. I asked a man to rekindle my fire in his corner. He & another man are sitting in a corner with books on a table. He is reading a book & the other man is smoking. He says he is reading a book about the war & history. He says it's about a war & history. He is reading a book about the war & history.

It's a warm night & the residents are enjoying the smoking area in the garden. I asked a man to rekindle my fire in his corner. He & another man are sitting in a corner with books on a table. He is reading a book & the other man is smoking. He says he is reading a book about the war & history. He says it's about a war & history. He is reading a book about the war & history.
12/10 Canteen Working 10 - 11.30am.

The line up at the Revenue desk was a queue of 2-3 at 11am smoking or waiting in line for those that have some left - got and completed for their important tasks.

Much activity at Canteen today - many people are seated.

Workmen group of 8-10 have taken over their usual spot.

1st casually take out my note pad to write to people on side of the seats. They eye me up down. Lady asks if I am a police officer, I say no, I am from Canteen.

1st completely convince 2 people to sit at adjoining table across from me, relax & find out about today.

"M: How do you spend 35 yrs here living from day to day, what would that feel endurance consequence to soul and human spirit"

A then the man A approaches & I greet and answer his question. We share stories, I relate & give good humour and blurred 3. I ask A's name (I am not afraid). We learn to be from more the 15 men to avoid confusion/identifying.

My deficiencies (as an outsider/badgered by 12) add to them.

We take at length, others & then & draw near & begin to join in > 45 people either directly, indirectly or timidly listening. M's mind: I have a dream for the future. She says don't do anything! I asume she is not in the mood to speak.

I ask our questions when I leave the canteen we decide to give me an application for my journey. All I speak to them well & good progress."
Appendix M:

Diagnostic Differences Between Clients Who Smoke:

(1) Schizophrenia and Smoking
A good deal is now known about the pharmacological interaction of smoking with the symptoms of psychosis and with the medications used to treat it. These interactions have already been discussed in the literature review section.

Holmberg and Kane (1994) view the high rate of smoking and paucity of health promoting behaviours by people with schizophrenia as an expression of their perceived poor locus of control. The current research does not refute this proposition, however, it takes an alternative view by asking why these people may have developed a poor locus of control and what are the forces that perpetuate this. There appear to be complex reasons for this phenomenon for people with schizophrenia. Locus of control is expressed uniquely for this group when positive and negative symptom management, and sociological factors are taken into account. In fact, participants with schizophrenia demonstrated a significant desire to have control over their lives. It was these participants, from all of the diagnostic groups, who could best articulate the reasons for their smoking and describe their smoking habits and behaviours. They knew why they smoked. As commented in the results, they described their smoking routine as if they were titrating the dose of nicotine.

The subjective experience of smoking and quitting appears to be significant for people with a diagnosis of schizophrenia. McEvoy and Brown (1999) found that more than 80% of people with schizophrenia were established smokers by the time of their first episode of psychosis. This was not suggested for other diagnostic groups. There appear to be features unique to this diagnosis that make smoking more likely, even prior to any influence by systems of care and treatment. Such systems may merely serve to reinforce the already established process. Pharmacological interactions in the brain may account for this, or it may be related to the experience of psychosis itself and the consequences it brings for the person’s psychological responses, social interactions and relationships with others. Schizophrenia is arguably the most stigmatising of mental illnesses. Therefore, people with this diagnosis may feel the effects of alienation and isolation more profoundly than other diagnostic groups. Hence the existential barriers to quitting, identified by the current research, may be more substantial for smokers with schizophrenia.
The pharmacological influence of particular types of neuroleptic medication on the person’s desire to smoke has been reviewed already (McEvoy, et al., 1993a; McEvoy, et al., 1995b). The positive role of clozapine in reducing the desire to smoke is noted by Waserman and Criollo (2000). Their study participants all reported improved quality of life, satisfaction, and compliance with treatment following commencement on clozapine, despite significant negative side effects of the medication also being reported. Another study involving 58 clozapine users with alcohol, marijuana and cocaine use found that their use of these substances decreased once clozapine commenced. The reasons for this were unclear (Zimmet, et al., 2000). Of the successful quitters interviewed for the current study, three were taking clozapine. They described its effect on their lives as miraculous and transforming, especially its effective treatment of positive and negative symptoms of their schizophrenia. Successful quitters suffering from schizophrenia perceived benefits of taking clozapine that far outweighed any negative side effects of taking this medication. The researcher believes that it was no coincidence that, of the few successful quitters found for the current study, half of them were on clozapine. The pharmacological benefits of this drug appear to have flow on positive consequences for many other aspects of the person’s live and relationships with others. Successful quitters described how clozapine removed these barriers to quitting.

(2) Bipolar Affective Disorder and Smoking

The perceptions of these participants support the evidence for cigarettes being used to self-medicate the symptoms of BPAD. What is not clear is the degree to which this is a biological, psychological, or social process. Nicotine use to avoid illness relapse is supported by the findings of Glassman’s study (1993) of patients with BPAD and depression. He found that they were more likely to become depressed when they ceased smoking, although the reasons for this were not clear. Labbate’s (1992) account of two people who became manic and depressed, given no prior history of BPAD or depression, suggests that nicotine withdrawal and cessation invokes a physiological response leading to BPAD for some people. This needs further investigation. Benezzi’s (1989) case study of a man with severe mania following abrupt nicotine withdrawal is also noted, due to its suggestion of a causal link between the two phenomena. Strakowski and DelBello (2000) reviewed studies of BPAD and found that substance abuse by this group is state dependent, that is, more of the substance is used when the person with BPAD is manic. This was confirmed by the current study participants who said they ‘smoked their heads off’ when unwell.
The findings of this research also clearly identify specific patterns of smoking behaviour by people with BPAD. Their black and white view of their own ability and their situation has significant implications for the way they see their ability to plan, perform, and achieve the process of quitting. The perceived lack of a middle ground, where it is assumed control and constructive learning takes place, is noted as a significant barrier to quitting. Robertson and Taylor’s (1985) research found significant problems with spatial and holistic tasks for people with BPAD and depression. Bulbena and Berrios (1993) found that mania and depression have detrimental effects on attention, memory, and visio-spatial function. A later study by van Gorp et al. (1998) found significant long-term cognitive impairment in people with long-standing BPAD, especially if they had a history of alcohol abuse. The implications of these findings for the person’s ability to fulfil the cognitive planning and processing necessary to quit smoking are apparent. They are supported by the participants demonstrating little insight into the quitting process. All participants of this study commenced smoking prior to the onset of their BPAD. Therefore, energy needs to also be directed at preventing smoking initiation and the development of nicotine dependence in the first instance for this group.

Merely advising the person to wait until they become very well before attempting to quit smoking is not seen as an adequate solution either, as we would expect them to relapse quickly to smoking as soon as their mood deteriorated. This problem is confirmed by the participants’ comments about their attempts to quit and their relapse experiences. Weiss et al. (1997) have devised specific, targeted interventions that fit well with the findings of this study. Their innovative study proposed useful guidelines for running a relapse prevention group for those suffering from BPAD and concurrent substance abuse. They take into account the meaning the person gives to their illness and their ambivalence to treatment. In particular, their suggest that interventions acknowledge the important issue of control by challenging the person’s black and white view of their illness and their drug use and challenging the “may as well” attitude found to be prevalent in this group. Working to increase the person’s self-awareness of the processes involved is also advocated.

(3) Depression and Smoking

The evidence for links between depression and both smoking and problems with smoking cessation has been noted by several research studies over several years. While the focus of such research has continued to be on psychopathology, the current research has also demonstrated the important role of existential variables. These include perceived stigma, loss and hopelessness and lack of
autonomy and control. Smoking to reinforce identity and to provide companionship in the face of social isolation and stigma was also noted by these participants.

Of particular relevance for smoking cessation programs involving people with depression, is the significant negative beliefs held by these smokers about their ability to overcome their depression and to take control of their illness management and their cigarette consumption. Keeping this control aspect in mind, Abramson (1988) asserts that the internalisation of self-blame for negative events, imposes an order or structure in which the individual’s perception of personal control is diminished. The extension of this process is that, “Inappropriate guilt can sometimes be preferable to a sense of randomness or chaos” (pp.10-11). This idea adds another dimension to the control theme discussed in this paper, in particular, that the person’s diagnosis and cognitions may be important to consider when devising interventions. More generally, the current research suggests that people with depression are likely to be less aware of the habits around their smoking and more susceptible to visual cues to smoke. Particular attention should also be paid to their tendency to rely on external sources of control and to internalise blame. This has implications for relapse prevention strategies and the need to assertively address the abstinence violation effect noted as common during relapse to smoking by these participants. Cognitive behavioural therapy to promote greater control over the process of quitting and to challenge their negative perceptions of themselves may be useful. This intervention has been found to enhance treatment outcomes for people with a history of depression, especially when used to target mood related problems (Hall, et. al., 1992, 1994).

The perceptions of these participants support the evidence for cigarettes being used to self-medicate the symptoms of depression. They describe their smoking continuance in the context of mood management, asserting that it is predominantly an activity over which they have little control and little hope of successfully overcoming. Joffe and Levitt (1988) found that smoking causes changes to thyroid functions, especially the reduction of levels of T4 which is specifically important for the regulation of mood. Research by Robertson and Taylor (1985) found that people suffering from depression have difficulty with spatial and holistic tasks, and have other neuropsychological deficits that may effect cognitive functions. More recently, the benefits of nicotine for memory and concentration have been established (Heishman, 1998). These findings suggest that there may be some interference with the ability to think through, plan, and perform the quitting process when depression is also present, based on neuropsychological features of the illness. Others have more recently speculated whether this is a direct relationship or due to indirect effects mediated by nicotine effects on mood and arousal (Waters & Sutton, 2000).
All client participants with a diagnosis of depression described adolescent depression or psychological and social problems prior to their smoking initiation. Pre-existing problems with depressed mood have been noted as a major risk factor for smoking initiation, with clearly understood links with self-medication established (see Kandel & Davies, 1986; Stefanis & Kokkevi, 1986). However, there may be some question about the validity of retrospective studies like this one, especially where the person’s current depressed mood may foster a more negative bias towards recounting of past events and experiences unfavourably. A recent study of 92 depressed smokers compared to a matched control group concluded that depression and smoking are more likely to be linked by shared deprivation variables, rather than smoking causing depression or the converse (Roy, et al., 2001).

These participants’ focus on the oral functions of their smoking and their descriptions of smoking for physical and emotional comfort is supported by the literature on smoking for sensation-seeking in the presence of anhedonia (Carton, et. al., 1994). Interestingly, each participant with depression displayed a degree of internalised hostility in response to unresolved conflict with others in their past or present life. This was especially so for Jack and Mick. Research has shown hostility measures to be predictive of smoking initiation and smoking continuance (Barefoot, et. al., 1990).

(4) Borderline Personality Disorder and Smoking

Borderline Personality Disorder (BPD) is characterised by 3 relatively distinct clusters of challenging behaviours centred around problems with identity, affect management, and impulse control, as mentioned in the introduction. Extroversion, rebelliousness, risk-taking and self-harming behaviours are prominent in their presentation (Milton & McMahon, 1999, p.1).

By far the most significant theme to emerge from interviews with participants diagnosed with BPD centred around control. This incorporated rebelliousness and protest against control by others, signifying the central role of power and powerlessness for these participants. The need to feel control in relationships with significant others, the need for self-control over feelings and situations, and control of supply and consumption of cigarettes were variations on this theme. Power and trust in relationships formed the central and fundamental platforms for the responses given by these participants. They perceived hostility from treatment providers and were hostile in return. All such dynamics are clearly described and understood to form the central components of BPD (American
Psychiatric Association, 1994; Psychiatric Clinics of North America, 1994; Milton & McMahon, 1999). Of all the diagnostic groups, those people with a personality disorder have had the most difficulty accessing support and treatment within mental health settings. They are perceived to be difficult and disruptive merely by the nature of their perpetual crisis contact with service providers and chronic self-harming behaviours. The treatment of BPD within mental health settings has been marked by much fierce debate as to whether BPD should be regarded as a mental illness at all. An informative example of this is the debate: “Do Personality Disorders belong within Contemporary Psychiatry?” Contemporary Clinical Challenges in Psychiatry Conference, Sydney (1999). The participants of this study clearly described their experiences of being criticised, ostracised and unwelcomed by mental health service providers. Under these circumstances, their smoking gave them power. The descriptions of cigarettes as a compliant and passive friend can be clearly understood as part of these smokers’ feeling of being judged by others, their lack of trust in others and their problems with forming healthy relationships and interactions with others.

There exists a substantial literature on personality traits as predictors of smoking initiation, continuance and cessation. Patton et al. (1997) highlighted the role of high neuroticism, lower self-esteem and ego strength and higher psychoticism in predicting the person’s likelihood of becoming a smoker. Waldeck and Miller (1997) collected self-report data on licit substance use and impulsivity using a multi-scale questionnaire with 332 young adults. Their findings confirmed those of earlier research (Grunberg, Winders & Wewers, 1991; Simon, et al. 1995), that smoking is positively related to personality factors such as, “extroversion, rebelliousness, anti-social tendencies, risk-taking, and social deviance” (p.270). The current qualitative study did not consider possible gender influences on tobacco consumption due to the low sample size. There is, however, extensive research indicating that women with high impulsivity scores are more likely to use nicotine (Beckwith, 1986). Also, Waldeck and Miller’s (1997) study of licit substance use found that the use of alcohol and caffeine but not nicotine was positively related to high impulsivity in men but not low impulsivity. Alternatively, for women, the use of alcohol and nicotine but not caffeine was positively related to high impulsivity but not low impulsivity. Of note, most of the current participants demonstrated heavy use of nicotine, caffeine, and alcohol.

In another study, Barry et al. (1997) surveyed 1893 patients of 64 primary care physicians in Southern Wisconsin, US, all with a diagnosis of conduct disorder or anti-social personality disorder. Using the Health Habits Questionnaire, these researchers concluded that smoking is strongly associated with these personality disorders, with implications for all personality disorders. A large
US prospective study by Lipkus et al. (1994) of 3810 men and 836 women (smokers, ex-smokers, and non-smokers), involving a 20 year follow-up period, looked at personality predictors of smoking initiation and cessation. The participants were enrolled in the University of North Carolina Alumni Heart Study 1987-1991 and had previously completed the Minnesota Multiphasic Personality Inventory as part of the college enrolment 1964-1967. Their study confirmed that indicators such as impulsiveness, rebelliousness, sensation-seeking, and hostility were the best predictors of smoking initiation, and that, “people who continued to smoke were more hostile and engaged more often in sensation-seeking behaviours” (p.152). Earlier research by Eysenck (1980) found similar personality patterns. However, as Lipkus et al. (1994) suggest, “it remains uncertain whether personality differences are the precursors or the products of smoking behaviour” (p.149). In the current qualitative study, it can only be inferred that the participants’ personality disorders preceded their smoking initiation rather than the other way around. Of note here is that 4 of the 6 participants with BPD did not appear to initiate their smoking in the context of teenage peer pressure, as was the case with many of the participants in other diagnostic groups. Also of note is that all participants with BPD reported being abused as children, with 4 of the 6 participants reporting sexual and physical abuse. A history of abusive relationships in childhood, often in the context of poor parenting and bonding problems, is considered to be a significant contributor to problems with personality development into adulthood (Tyrer, 1988; Weston, Ludolph & Misle, 1990; van der Kolk, et al.,1996; Milton &McMahon, 1999). An understanding of these central features of BPD provide clear links to understanding their vulnerability to drug use and abuse and their choices regarding health behaviours. Susan’s comments on the inconsistency of parenting she received as a child, the lack of safety and security, and the abuse she experienced, is an illustration of this phenomenon and its significance to her current poor coping abilities.

A US study of 110 children aged 10 to 13 years looked at smoking and other health-related behaviours. It found that smoking positively correlated to greater exposure to violence and that growing up in a violent environment has a negative effect on the development of healthy behaviours and intentions in general. Exposure to community and/or family violence was also found to impact health locus of control, that is, lowering the person’s belief in their ability to take charge of their health in positive ways and diminishing their belief in others such as service providers and health professionals to assist them in improving their health (Fick & Thomas, 1995). These finding are consistent with previous researchers (Hawkins, Catalano & Miller, 1993; Lewis & Lewis, 1982). The self-harming behaviours reported by the participants of the current study and their opposition to treatment providers is noted in support of the ideas highlighted here. In particular, Kathy’s
Other points arise from the data and require comment and further investigation. Given the apparent importance of trust, relationships and locus of control for these smokers, the relationships that are offered by service providers such as mental health professionals and quitline advisers becomes significant for these people. They indicate that relationship building is an important consideration to any interventions to assist these people to change their smoking behaviour. The role of the community key worker providing consistency and continuity would appear to be essential here.

Smoking as a form of self-harm in the context of coping skills and locus of control needs also requires further consideration. These participants clearly described how they use cigarettes to medicate their feelings of stress and pressure and their mood. Of unique significance is their emphasis on euphoria-seeking by smoking, through deliberate nicotine withdrawal followed by smoking. This demonstrates that smoking is a complex activity for these smokers and closely linked to how they manage their illness and their environment. The role of substance use for self-medication of illness symptoms has been reviewed and debated (Khantzian, 1985) and doubted by several researchers. Castaneda (1994), for example, surveyed 83 inpatients with drug dependence and personality disorder, using scales to measure symptoms and cognitive measures and concluded that there was, “no evidence in support of the self-medication hypothesis as a necessary reinforcer of continued drug use with”(p.180). These conclusions related to alcohol, heroin and cocaine use with no mention of nicotine. Arguably, nicotine is used more insidiously and involves more habitual processes than other drug use. This could account for its entrenched role and use in self-medication in multi-faceted ways by the smoker with BPD.

The role of boredom for smokers with personality disorders is also interesting. Using Eysenck’s typology of personality (1967), Patton et al. (1997) found that, for people with high extroversion, neuroticism and psychoticism dimensions of their personality, smoking is more attractive in boring situations because it meets their need for increased stimulation (p.270). The participants with BPD clearly described their smoking in this context. However, their responses indicate further depth in the meaning of boredom for them, especially its connection to control and fear of being out of control, as well as its mundane purpose for filling in time. Their responses demonstrate that smoking is a complex activity requiring complex interventions to assist people to change their smoking behaviour.
Overall, an understanding of why smokers with BPD continue to smoke and don’t quit requires an understanding of the central features of their diagnosis as well as the social context in which they receive treatment for their mental illness symptoms. Their experience of mental health services has been less than favourable, with frustration and hostility often shown by service providers towards them. The results of a study by Fisher and Bentley (1996) indicate that smoking cessation interventions with people with can be successful. They randomly assigned 19 inpatients and 19 outpatients with personality disorders to 2 different groups. The first group used cognitive behavioural therapy (CBT) techniques to challenge the person’s locus of control and relationship interactions with the drug and with others. The second group used a disease and recovery model whereby the substance abuse was accepted as a disease with an underlying biological vulnerability. The study found that outpatients fared better with the CBT approach, while the inpatients found either was better than no intervention. Their intervention was based on the premise that, “substance abuse is a set of learned, maladaptive behaviours that have led to distorted beliefs about the power of the abused substance and a general reliance on substance use as a coping behaviour” (p.1245). Given the descriptions of smoking by the current study’s participants, CBT interventions may indicate a way forward.

(5) Nicotine and Other Licit Drugs
Smokers with schizophrenia have been found to be 2 to 3 times more likely to have another substance use disorder than smokers without a mental illness (Ziedonis, et al., 1994). In the current study, client participants from all of the diagnostic groups studied had high rates of use of other substances. Of note was the high consumption of caffeine by client participants, verging on toxicity levels for those with a diagnosis of depression or BPAD. Two participants with BPD reported previous hospital admissions for caffeine toxicity and most participants with this diagnosis consumed more than 15 cups of coffee per day, always pairing it with a cigarette. Both nicotine and caffeine have stimulant (US Dept of Health and Human Services, 1988; Benowitz, 1990) and withdrawal effects (US Dept of Health and Human Services, 1988; Simmons, 1996; Swanson, et.al., 1994; Swanson, et.al., 1997). It is also clear that cigarette smoke induces hepatic enzymes to metabolise a wide variety of psychotrophic drugs much more rapidly (Goff, et.al., 1992; Lohr & Flynn, 1992). As such smoking may be an important factor in the pharmacological management of these people also. The potential for caffeine to interact with psychiatric medications also needs to be considered (Simmons, 1996). These smokers appear to be using caffeine in similar ways to their
smoking and for similar purposes. Subjective, psychological and physiological interactions of caffeine, nicotine and mental illness require further investigation.

The prevalence of current alcohol use and history of alcohol abuse was also noted for these participants. Paired consumption of nicotine and alcohol has been established as a major hurdle for people attempting to quit smoking. Likewise, the links between alcohol abuse and depression have been established, especially with regard to self-medication of depressed mood (Abraham & Fava, 1999). The implications of these results were not explored further for this study. However, they are consistent with all other data that show a high correlation between depression, negative mood states and substance abuse. The findings clearly identify significant barriers to quitting for people with affective disorders and suggest that any interventions should consider the compounding factors such as paired learning with other substances such as alcohol and caffeine.

Sonne et al. (1994) found that 96% of regular drug users with BPAD used drugs to help their mood while only 7.6% of non-users with BPAD used drugs for this purpose. While not including nicotine dependence, their findings suggest that the mood management role had been learned through a process of dependence and withdrawal that may be similar to the physiological and psychological dependence known to occur with nicotine use. Ultimately, the advice given by Brady and Sonne (1995) in their review of the literature, is supported here, that is, that “All patients with bipolar disorder are at risk of developing substance use disorders and, consequently, should be informed about the risks...In particular, patients should be warned about the dangers of self-medicating with substances of abuse (p.23).”

Muesler et al. (1992) set out to test the hypothesis that patients abuse specific classes of drugs or alcohol as a function of their diagnosis in an attempt to self-medicate their symptoms. They studied 263 patients with various mental illnesses and concluded that social learning factors and demographic characteristics such as gender, age and education level are primarily responsible for determining which patients abuse which types of drugs. They found a weak trend for alcohol use and BPAD. It is unfortunate that arguably the most insidious drug use for this group, nicotine, was not included in their study, as is the case for caffeine use. Currently it is not clear how these reported effects of smoking may be causally attributed. A greater understanding is needed of the context in which mental illness occurs and how it is experienced as a complex predicament.
In conclusion, these findings indicate the need to ask further questions about the complex phenomenology of mental illness and drug use. This involves the need to desegregate mental illness from nicotine and caffeine withdrawal and intoxication and to take into account the effects of smoking on psychotrophic drug metabolism. It also raises several questions about the meaning of the person’s experience, how and why they seek and relinquish control and about the reinforcing barriers to quitting within the person’s environment.

(6) Summary

The most striking feature of these findings is the perceived centrality of smoking to participants’ overall well-being and the clarity of links made between their smoking and their mental illness. There is a growing literature emphasising links between nicotine withdrawal and illness relapse (Glassman, 1993; Glynn & Sussman, 1990; Greeman & McClellan, 1991; Hall, et al., 1996; Stage, Glassman & Covey, 1996). The most recent pharmacological research is attempting to unlock the riddle of interaction between nicotine and brain neurotransmission to help explain nicotine dependence and biological barriers to quitting (Laakso et al., 2000; Salokangas, et al., 2000). This is particularly relevant for future studies of smoking and mental illness, given that the central pathways are thought to be shared by the two phenomena (Ziedonis & George, 1997).

The current study acknowledges the biological research and confirms it. However, according to these smokers, the main barriers to their quitting, appear to be existential, to do with their sense of despair about having a mental illness, their lack of hope for recovery and need for control. Causes and consequences must therefore be interpreted through multiple lenses. Davis reminds us that, “Physical symptoms are not the sole basis for dependence; it is only when they are set in the context of psychological and social factors that the meaning of dependence can be appreciated” (1996, p.8). This broad view of the phenomenon is also taken by others (Black, 1991; Drew, 1987a; Drew, 1987b; Drew, 1990; Miller, 1990; O’Hagan, 1987). Liazos (1972) argues that the medical model has been dominated by labelling theorists who have focused on the person as ‘problem’ while the larger social, historical, political and economic contexts for smoking by particular groups of people need also to be acknowledged. Kaplan and Weiler (1997), researching in the United States, found social and economic disadvantage to be the strongest predictor of smoking. Peoples’ experiences of grief and loss as a consequence of their mental illness needs further exploration (Lafond, 1994, 1998). Earlier recognition of the signs of stress and distress in people’s lives is essential to prevent later dependence on cigarettes for social, physical and psychological comfort. Studies of
adolescents have confirmed the links between smoking onset and depressive symptoms (Escobedo, Kirch & Anda, 1996; Escobedo, Reddy & Giovino, 1998; Killen, et al., 1997). Add to this the entrenched processes of reinforcement and acceptance by treatment providers and carers in the caring environments and it is not surprising that the statistics for smoking and quitting for people with a mental illness remain abysmal (Hughes, et al., 1986; Watt & Hocking, 1996; Ziedonis & George, 1997).
Appendix N:

Department of Human Services-

November, 2001

Writing by: Sharon Lawn
Division of Mental Health, FMC, Marion CCT for
The Smoking and Mental Illness Project

Introduction:

This paper forms part of a study undertaken by the author as part of her PhD thesis. It is based on a series of studies of smoking within mental health settings. The first and second study involved indepth interviews with clients and staff of public mental health services in metropolitan South Australia between 1998 and 2001. The third study involved an extensive participant observation of inpatient and community mental health settings to validate, triangulate and better understand the interview results. The systemic culture of smoking was observed to dominate interactions within the mental health settings. This raises several occupational health, safety and welfare concerns as well as legal implications for mental health services in this state. The author wishes to acknowledge Mr John Harley (Public Advocate, South Australia) and Mr Owen Ames (Legal Services Commission, Adelaide) who provided advice on ethical and legal aspects of the research findings.

The Issues:

Psychiatric institutions and prisons share similar dilemmas when attempting to address concerns about smoking and occupational health and safety for staff. They are, “the workplace of some people and the living space of others” (Biggins & Wares, 1993, p.327), therefore dilemmas exist in balancing rights and interests which exist for both parties, especially where they exist in conflict with each other. Balancing any rights of clients to smoke in their living space with the rights of staff to a smoke-free work environment becomes difficult, especially in the locked settings where staff have designated roles in supervising clients while they are in the smokers’ ‘cage’. By looking at how the law has dealt with the topic, through the interpretation of ethics into practice via legal claims, a greater understanding and resolution of the dilemmas may be achieved.

Appelbaum (1995) noted the first lawsuit in the United States was a class action by patients of Fallsview Psychiatric Hospital in Ohio. These patients’ claims regarding smoking bans as a violation of rights was over-turned by the court on the basis that all rights granted by the law are subject to the limitation that they be consistent with health and safety; in this case fire risk. There were continued challenges on the grounds that patients suffer significant morbidity from nicotine withdrawal and, where people are long stay patients, some relaxing of these restrictions has occurred (Foderato, 1995). Appelbaum (1995) also noted the dilemmas involved by allowing written authorisations by physicians allowing smoking by some patients in circumstances where smoking was generally banned for other patients. The implications are that doctors could be seen to be prescribing smoking for some patients, with further legal implications involving the potential to...
be sued for contributing to subsequent morbidity and mortality. In these circumstances, Appelbaum questions the legal effect of consent forms waiving the subsequent right to sue hospitals. He questions this on the grounds that the person’s capacity to understand may not have been established as part of this process, especially where they are detained patients in locked wards at the time.

According to the Australian Occupational Health Safety and Welfare Act 1986, there exists a “legal obligation of the employer to provide a safe working environment free of foreseeable and avoidable risks to health and safety for employees and others who may enter it” (Winstanley, et al., 1995, pp.107-8). Further to these developments, the Australian Federal Court decision of 1991, known as the Morley Decision, found that employers have the onus to take a positive role in protecting non-smokers. This legal obligation has been tested in the courts on a number of occasions in the past, with several successful claims against employers in a variety of work settings.

In this study neglect is apparent through systematic reinforcement of smoking where there is overwhelming knowledge of smoking problems with little or no acknowledgement of responsibility for addressing it within the setting (Bidmeade, 1994). System reinforcement was evident in this study. Pressure to become smokers, in the absence of other meaningful activity, was clearly shown. Staff also said they felt left out and lacked a clinical edge once they become non-smokers. Absence of administrative support and training to recognise nicotine withdrawal, as well as no use of NRT, was noted. However, breach of duty must be shown to be the cause of the damage. The current study demonstrates that breach of duty is a complex notion. Staff argued that harm-minimisation by restricting the supply of cigarettes to clients in some wards and in hostels meant that they were meeting their legal and duty of care requirements.

Negligent misstatement may exist for doctors, whose authority is trusted, where clients have said that their doctors have advised them to keep smoking. The duty to warn clients of the harms of smoking or to take action to treat their nicotine dependence and withdrawal is part of this (Bidmeade, 1994). Inpatient doctors observed in the current study failed to diagnose and treat nicotine withdrawal. Some of the consequences of this were assault, intimidation for cigarettes and sexual abuse in order to get cigarettes. An Australian study found that approximately half of smokers were given advice by their GP (Mullins & Borland, 1993).

The issue of negligence is complex. It involves decisions about what an ordinary, reasonable person or ordinary, reasonable professional would regard as acceptable standards of care. Where there is reduced capacity, such as in the care of children, a higher standard of care is assumed (Bidmeade, 1994). Section 27C of the Wrongs Act speaks of vicarious liability whereby, if an employee is sued for negligence in the course of employment, then the employer must indemnify the employee, except in cases of wilful misconduct. In this instance, negligence may equate to not informing people of the harms of smoking when there are known risks. A hierarchy of accountability and neglect exists under these circumstances. Neither does the existence of a smoking policy by an organisation necessarily protect it from litigation. If the employer is aware of the day-to-day activities involving acceptance and reinforcement of smoking, despite contrary policy guidelines, then this overrides any smoking policy document presented to court (Bidmeade, 1994). In the case of this study, standover, barter and sex for cigarettes were described as activities known by all levels of employees and representatives of employers at the inpatient and community settings. The production line of smoking routines in the locked settings in the absence of commitment to NRT options is also noted.
With informed consent, the courts have held that there is no duty to provide information in every case. A South Australian case involving Battersby V Tottman (1985) SASR 524, held that full disclosure of risks was not appropriate where it was judged on reasonable grounds that health, physical or mental, might be seriously harmed with full disclosure and where the person would be unable to make the information a basis for rational decision-making at the time (Bidmeade, 1994). From this determination, clear parallels can be drawn with smokers with mental illness in situations of extreme un-wellness. Staff spoke at length about how they gave action against smoking lesser priority while patients are acutely unwell, therefore supporting their need to smoke as the lesser of harms in the short-term.

Recognition of the harms of environmental tobacco smoke (ETS) has been noted in the literature (National Cancer Institute, 1999; NH&MRC, 1997; Office of Environmental Health Hazard Assessment, 1997). Wares and Biggins’ (1993) Western Australian study of prison environments and ETS found that 79% of the 225 staff and 135 prisoners surveyed were annoyed by ETS, with 47% reporting ill effects of ETS. That study noted several examples of successful litigation in prison settings. It suggests implications for the mental health settings where passive smoking by staff and clients was found to be part of the daily experience of work and care in the settings. Where passive smoking concerns are addressed as part of occupational health, safety and welfare requirements in the workplace, patients do not currently enjoy the same protections available to staff. Concern for their needs are part of duty of care within the settings. To breach duty of care, one must be proved to reasonably comprehend that duty of care. This may not be so for patients towards other patients, or for patients towards staff, however, it may apply to staff. In situations where patients are detained and acutely unwell, patients are deemed to have diminished responsibility with limited decision-making capacity, similar to that afforded to children. In such situations the hospital has a duty of care. The example of a detained patient who left the grounds of a Queensland hospital in 1996 and stepped into the path of a small bus in an attempt to commit suicide, demonstrates this principle. The court found that the state of Queensland, as the operator of the psychiatric facility, owed a duty to take reasonable care in this situation (Malloch, 2001).

In conclusion, there are a number of legal implications for continued smoking by staff and patients within mental health settings. These include initiation of smoking while the person is unwell and duty of care held by the staff and hospital administration in recognising the person’s vulnerability to smoking. Staff roles and duties in dispensing cigarettes, supervising clients’ smoking and purchasing cigarettes for clients, needs to be considered. The pressure on social workers to find funds to purchase cigarettes for indigent patients also needs to be considered. The use of cigarettes by nurses to clinically management patients and the failure of doctors to diagnose and treat nicotine withdrawal is likely to be considered negligent. The possible impact of a likely future decline in the rate of staff smoking, may lead to increased problems as more staff refuse to perform duties involving the monitoring of clients smoking during inpatient stays. Alternatively, there may be more concern for passive smoking and more likelihood of legal action as more non-smoking staff are forced into performing roles involving cigarettes because of the decline in staff smokers. The grounds for compensation claims by staff who develop smoking related illnesses who clearly commenced smoking in the context of performing their role of dispensing cigarettes to patients is of concern. Such staff said that they were directed by management to dispense and light cigarettes for patients where the patients were unable or unsafe to do so themselves.
References:


Appendix O:

Department of Human Services - Issues Paper:
Research on Smoking Bans in Psychiatric Settings.

Writing By: Sharon Lawn, Senior Social Worker
Southern Mental Health, Marion Community Care Team

Introduction:
This survey of research on smoking bans was performed in response to a request by the Glenside Campus working party on smoking in the inpatient setting. The working party was formed in response to a directive received from Margaret Tobin, Director of Mental Health Services, South Australia in the first half of 2001 in which she directed the hospital to cease its tobacco licence. The author of this briefing paper was undertaking research on this topic as part of her PhD thesis on the topic of smoking and mental illness at the time and offered support to the working party.

A number of US studies from the late 1980’s and early 1990’s have documented the experiences of psychiatric settings where smoking bans were introduced. Their findings are mixed, with some researchers stating that few transition problems were experienced by patients and staff, while other studies clearly present some concerning findings. In particular, there were concerns about the level of patient distress and assault towards others. All of these studies are useful for their articulation of the processes they followed in order to achieve smoking bans and the lessons they learned along the way. Their overall findings suggest that a smoking ban in inpatient psychiatric settings is possible, given sufficient support and planning.

The Studies:
(1) Resnick & Bosworth (1989a) performed the first known study on this topic when they looked at the effects of a smoking ban on an acute 12 bed locked unit in Oregon in 1986. They surveyed patients (N= 165) and multi-disciplinary staff (N=25) about their attitudes to a ban, before and after the ban was imposed with favourable results. However, the positive result may have been skewed given that, at that time, Oregon had an adult smoking rate of 19% when the national average was 30%. In addition, 60 patients admitted consecutively (30 prior to the ban and 30 after the ban) were reviewed to determine the incidence of need for prn medication, seclusions, restraint orders, calls from security backup, and discharge against medical advice. Resnick & Associates (1989b) performed a second study in 1987 involving a phone poll of 49 Oregon psychiatric facilities. They spoke with either the head nurse or the program director from each site (N=18), representing a participation rate of 100%, with each having participating in the initial study (1989a). Results showed a significant increase in positive attitudes towards smoking bans and their successful implementation, with half of the state’s psychiatric ward becoming smoke free within one year of the initial ban.

(2) Thorward & Associates (1989) studied the effects of a smoking ban on a Washington17 bed locked unit at time of implementation and 12 months later (1987-1988). Patients and staff were asked to fill in the Moos Ward Atmosphere Scale 6 months prior to the ban and 6 months after the ban was implemented. Records were also kept, documenting use of prn medications pre and post-ban, and staff recorded incidents of note related to the smoking ban and its effects. As with other studies, these researchers found the uptake of NRT gum as an alternative to smoking was low. Admission rates did not drop after the implementation of the smoking ban, however, violations of the smoking ban were significantly noted by staff. No change in patients’ post-admission smoking behaviour was observed as a result of the ban; they continued to smoke.
(3) Smith & Grant (1989) looked at 3 psychiatric units (42 beds) within a private (not-for-profit) general hospital psychiatric service in Seattle in 1987. Pre and post-ban questionnaires to staff provided the main data in conjunction with patient interviews just prior to discharge. With the settings, doctors expressed less concerns than nurses. They saw a smoking ban as an opportunity for new skills to be learned by patients, such as improved self-control and relaxation. Nurses anticipated many more adverse smoking-related events, such as elopement, verbal threats, inappropriate attention-seeking, and injury to self and others. However, this was not matched by actual incidents, which were markedly less than expected. Events related to nursing tasks were, however, significantly noted to have become more problematic after the ban. These included gaining patient co-operation, calming patients, discussing treatment. Staff smokers were noted to be more concerned than staff non-smokers. Several patients acknowledged violating the ban while at the hospital. 54% of patients interviewed expected to reduce their smoking significantly after discharge. Overall, the positive effects of the ban, such as increased self-esteem and self-control by patients, outweighed negative ones. Staff anticipated more smoking-related problems than actually occurred. Higher functioning patients who were given more autonomy were observed to tolerate the bans better than more severely disturbed patients, thought to be due to their greater ability to participate in out-of-hospital activities. Preparation for the ban included several staff meetings to provide opportunities for staff to verbalize their concerns and to problem-solve. Staff education about use of NRT and techniques for handling nicotine withdrawal was also provided.

(4) Greeman & McClellan (1991) studied a 60 bed psychiatric unit within a 600 bed Veterans Affairs Medical Centre in Minnesota over a 2 year period following the implementation of a smoking ban. Although fewer negative incidents occurred than were initially feared, these researchers found that, 2 years later, 20-25% of patients still had adjustments problems and 10% still had significant problems coping with a ban. They illustrated their findings by the use of 4 case studies which showed significant disruption, treatment problems, greater use of seclusion, increased demands on staff, and increased vulnerability to standover occurring between patients. 3 or the 4 cases refused NRT, with the 4th finding it to be ineffective. Prior to the ban the hospital had sold cigarettes and had donated cigarettes to indigent patients, however, after the ban patients left the grounds without authorization and bartered their possessions at higher rates than before the ban. Other problems experienced were that off-unit privileges favoured smokers versus non-smokers. There was also a system whereby less able patients were escorted off the grounds by willing patients in order to smoke or to purchase cigarettes. This created the dilemma of making a fellow patient responsible. No administrative process for enforcement of the ban existed and it was unclear what sanctions to impose. This study recommended a special unit that allowed smoking for involuntary disturbed patients.

(5) Erwin & Biordi (1991) studied 2 acute care wards (42 beds) at a Veterans’ Affairs hospital in Illinois in 1990. Nursing staff completed questionnaires based on Levine’s Four Conservation Principles of Nursing as it relates to addressing the needs of patients who have the urge to smoke – patient energy, structural integrity, personal integrity, and social integrity. Their attitudes pre and post-ban were also recorded. One month after the ban’s implementation, approximately 75% of nursing staff reported that the non-smoking policy was a success. Collaboration at all levels of nursing care was noted as part of this positive result with a number of administrative implications outlined – extensive consultation and collaboration, co-ordination of efforts across the disciplines, provision of alternative activities and dietary changes, a clear and agreed protocol to address non-compliance, enlisting family support for the ban, provision of unit-based smoking cessation groups, and review of fire safety procedures.
(6) Taylor & Associates (1992) performed a prospective study by analysing responses on the feasibility of a smoking ban from 50 multi-disciplinary staff of a 934 bed New York psychiatric setting in 1989-1990 pre and post the imposition of a smoking ban for patients. Staff had already experienced a 2 year staff ban at that stage and only 8 of the 50 staff involved in the study identified themselves as smokers. The experiences of 232 patients was also monitored by keeping a log of prn medication use, seclusion, restraint, elopement, incident reports, and smoking-related discharges. These researchers found staff attitudes to a ban were more positive after it was put in place. They also found no significant difference in demographic or diagnostic variables, and no significant difference in the level of disruptive incidents during smoking and non-smoking conditions, despite 60% of patient participants being involuntarily hospitalised, and despite the rates of patient smoking remaining at 53% for both periods suggesting that the policy change did not deter smokers from admission or from smoking. Geriatric units were not included in the study. A two month preparation period prior to the ban involved community and staff meetings and advertising of the impending ban to patients. NRT gum and candy was made available to patients after the ban, however they were not taken up substantially as alternatives by patients.

(7) Velasco and Associates (1996) studied the effects of a smoking ban on a Kentucky 25 bed locked unit at implementation and at 2 year follow-up (1991-1993). The initial study was reported by Ryabik & Associates (1994). The first period involved observations for a 6 week period just prior to implementation of the ban and 6 weeks immediately after with staff daily documenting number of security calls, application of seclusion and restraint, verbal assaults and physical assaults per shift, use of prn, number of patients receiving NRT, and number of discharges against medical advice per day. They found a significant increase in verbal assaults and prescribing of prn medication for anxiety immediately after the ban, but not 2 years later. No significant increase in physical assaults, use of seclusion, or discharge against medical advice was observed, as was expected at either stage. It was observed in the first week of the ban but quickly declined the following week. The use of NRT was greater immediately after the ban and at 2 year follow-up, gum being available in the first period and both gum and patches available in the second period. Patients struggled with using gum effectively. The application of ‘soft’ restraints (cloth posey vests) was significant at 2 year follow-up. These researchers concluded by suggesting education of staff about nicotine withdrawal to help them differentiate between nicotine craving and psychiatric symptoms. Alternative activities and NRT were also recommended.

**Discussion:**

Overall, their findings are mixed. Unintended negative consequences of change are evident in each study presented. Staff anticipated more smoking-related problems than actually occurred. Some researchers stating that few transition problems were experienced by patients and staff (Resnick & Bosworth, 1989), while other studies clearly present some concerning findings. Overall, the following concerns were noted:

- The levels of patient distress and assault towards others did increase as a result of the bans (Greeman & McClellan, 1991; Velasco, et al., 1996).
- Leaving the grounds without authorization, smuggling and bartering problems and fire risks did increased as a result of the bans (Greeman & McClellan, 1991).
- Significant violations of the bans (Smith & Grant, 1989; Thorward, et al., 1989; Taylor, et al., 1992) may have accounted for some studies claiming that disruptive incidents did not increase after the ban (Taylor, et al., 1992).
- Raised animosity was noted between detained and voluntary patients who could leave the hospital grounds and smokers and non-smokers was noted (Smith & Grant, 1989; Greeman & McClellan, 1991; Bromaugh & Frances, 1990).
- Enforcing smoking bans was a significant problem as no administrative process for enforcement of the ban existed and it was unclear what sanctions to impose (Greeman & McClellan, 1991).
- The system whereby less able patients were escorted off the grounds by willing patients in order to smoke or to purchase cigarettes created the dilemma of making a fellow patient responsible (Greeman & McClellan, 1991).
- Nursing tasks such as gaining patient co-operation, calming patients, and discussing treatment were noted to have become more problematic after the ban. Staff smokers were noted to be more concerned about this than staff non-smokers (Smith & Grant, 1989).
- Positive consequences of the ban were noted. Resnick and Bosworth (1989) found that few patients required NRT for more than a limited time. They suggested that, “This may be because smoking cues are missing in the smoke free environment” (p. 526). Smith and Grant (1989) found that 54% of patients interviewed expected to reduce their smoking significantly after discharge. Overall, the positive effects of the ban, such as increased self-esteem with temporary mastery and self-control by patients, was seen to outweigh negative ones.
- The usefulness of NRT immediately after the ban was recognised. Velasco et al. (1996) suggested the need to educate staff about nicotine withdrawal to help them differentiate between nicotine craving and psychiatric symptoms. However, other studies noted that NRT options were problematic and not readily taken up by patients (Taylor, et al., 1992; Thorward, et al., 1989; Greeman & McClellan, 1991).

Conclusions:
This review has demonstrated that a number of measures would need to be considered in order to introduce effective smoking bans.

- The over-reliance of nursing staff on smoking to assist with the clinical management of clients would need to be addressed. Helping nursing staff to find alternative options is seen as essential.
- Extensive consultation and collaboration, co-ordination of efforts across the disciplines, provision of alternative activities, dietary changes, clear protocols and family support for the bans would need to occur.
- More effective measures to accommodate patients who are unable to tolerate abrupt abstinence would be needed.
- Greater awareness of the ban prior to admission would be useful.
- Greater support for and education of direct-care staff on distinguishing mental illness symptoms from nicotine withdrawal symptoms is seen as vital. This would require support at all levels, from direct care to administration.
- A preparation period prior to the ban involved community and staff meetings and advertising of the impending ban to patients was also proposed.
- The role of nursing staff in monitoring safe use of cigarettes in ‘the smokers cage’ would need to be reviewed.
- In the absence of staff smoking while at work, alternative means of stress relief, clinical management of clients and other forms of support for staff would need to be developed.
- Patients may interpret restrictions as a further source of powerlessness and control by others, with implications for staff morale as agents of further social control. This would need to be addressed with open and equitable consultation with all parties.
- Trade and standover for cigarettes within the grounds of the hospital may increase,
with potential for such activities to increasing spreading beyond the grounds to nearby shops and houses.
- Black market use and sale of tobacco within mental health settings may increase.
  Use of other drugs may increase.
- The absence of nicotine interaction with anti-psychotic drug metabolism while client smokers are inpatients, where smoking bans exist, may confuse the clinical picture upon discharge from hospital, given the expectation that many clients would return to smoking on discharge. Community mental health teams would need to be aware of this as part of improved co-ordination of follow-up.
- More co-ordinated efforts between hospital and community staff to help clients who wish to stay quit as part of discharge planning.

These points indicate that the introduction of smoking bans would need to be a clearly and carefully planned process involving all the relevant parties.

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