

ETHICAL DECISIONS OF PSYCHIATRIC MENTAL HEALTH NURSES CARING
FOR PATIENTS WHO SMOKE

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DEDICATION

This is dedicated to God, who has been my source of strength throughout this journey, and to my husband, Bill, and our daughters, who lovingly accepted that Mom was always in school and adjusted their lives accordingly.

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I would like to thank all of my family, friends, and professional colleagues who supported me throughout this journey. Thank you so much to my family members who prayed for me and always encouraged me to pursue my education. Thank you to my committee, Drs. Sorrell, Kodadek, and Kreps, who were patient and kind in advising and guiding me through the research process. Thank you to Deborah and my nursing colleagues who went before me on this journey and who believed in me to finish. Thank you, Eric, for sharing your perspective as a friend and person with lived experience. Finally, thank you to Nick and everyone at APNA who encouraged and supported me in so many ways. I could not have done this without all of you.

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ABSTRACT

ETHICAL DECISIONS OF PSYCHIATRIC MENTAL HEALTH NURSES CARING FOR PATIENTS WHO SMOKE

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Tobacco use causes significant morbidity and mortality in persons with mental health conditions and psychiatric mental health nurses are in a position to provide interventions that can help them to quit smoking. Unfortunately, there has been minimal progress made by psychiatric mental health nurses in delivering smoking cessation interventions that have been effective in reducing the number of people who smoke. Given the high rate of tobacco use by persons with mental health issues, it is important to explore how psychiatric mental health nurses make ethical decisions about caring for their patients who smoke. Very few studies have looked at psychiatric mental health nurses' ethical decisions related to patients and smoking.

This study explored the lived experiences of 10 psychiatric mental health nurses and their ethical decisions in caring for patients who smoke. The study focused on how values conflict in the day-to-day experiences of nurses who

provide care in the mental health system to persons who smoke. The study was guided by van Manen's human science approach in order to understand the unique experience of the nurses and to gain insight into their world as they live it. An in-depth interview was conducted with each nurse using an unstructured interview format. Thematic analysis was used to discover meaning and to report the research data. A process of writing, reflecting, and rewriting was used to capture meaning in the experiences and to allow themes to emerge.

Final analysis of the data revealed three major themes: going beyond basic obligations of duty as a nurse, crime and punishment, and double jeopardy. Data revealed that nurses experienced ethical conflicts with patients, staff, and the hospitals related to smoking. Some stories identified inequities in the treatment of patients or staff within the mental health system with respect to smoking. Findings from this study support that psychiatric mental health nurses would benefit from additional education in ethics and in smoking cessation related to caring for patients who smoke.

CHAPTER 1. INTRODUCTION

In 2013, tobacco use continues to be the leading cause of preventable illness and death in the United States (Centers for Disease Control and Prevention [CDC], 2008; U.S. Department of Health and Human Services [USDHHS], 2012). In 2010, the U.S. Department of Health and Human Services established new *Healthy People 2020* objectives with a goal to improve the nation's health. One objective is to reduce tobacco use in the United States through efforts that include increased smoking cessation assessment and intervention.

Tobacco kills more than 400,000 Americans each year, and approximately half of them are people with serious mental illness (CDC, 2008; Schroeder, 2004). Nurses are the largest group of health care professionals in the caregiver role, and psychiatric mental health nurses in particular are in a position to significantly influence the number of people who smoke.

The prevalence of smoking averages 75% among people with mental illness or substance use disorders as opposed to 20.9% in the general population, and smokers with chronic mental illness die of tobacco-related illnesses 25 years earlier than nonsmokers in the general population (American Psychiatric Association, 2006; CDC, 2011; Prochaska, 2011; USDHHS, 2012).

Given the high rate of tobacco use by persons with mental health issues and national initiatives to increase smoking cessation and interventions, it is important to explore how psychiatric mental health nurses make decisions about caring for their patients who smoke. According to Steven Schroeder, director of the Smoking Cessation Leadership Center, understanding the reasons why people with mental illness smoke and helping them quit should be a national research initiative (2007). Hopefully, recent government efforts to increase success in smoking cessation will encourage research that targets persons who use mental health services.

Research in smoking cessation indicates that clinician advice is highly regarded by patients and it motivates them to want to try to quit smoking (Fiore et al., 2008). According to Fiore et al. (2000), only 4% of tobacco users successfully quit without assistance. Uses of tobacco cessation interventions, however, can nearly double the quit rate. In a meta-analysis by Rice and Stead (2008), 42 randomized trials of nurse-led interventions for smoking cessation were examined. Thirty-one of those studies found that when compared with a control or usual care, use of a smoking cessation nursing intervention significantly increased the likelihood of quitting tobacco. The next section explores which factors affect the decisions of psychiatric mental health nurses in planning and implementing these interventions.

Statement of the Problem

Because nurses are the largest group of health care professionals, they are in a position to significantly influence the number of people who receive tobacco cessation interventions. Unfortunately, many nurses have not received adequate training or information to assist their patients who are tobacco dependent. For psychiatric mental health nurses, assisting patients with smoking cessation may present special challenges. Historically, hospitals and mental health facilities have accommodated and even encouraged cigarette smoking for psychiatric patients (Jones & Jones, 2008; Lawn & Condon, 2006; Matthews et al., 2005).

There may be many ethical issues for psychiatric mental health nurses to consider when providing care for their patients; however, there are few articles in the literature related to nurses' ethical decisions and smoking cessation. In a study of ethics and smoking by Lawn and Condon (2006), psychiatric mental health nurses were asked a list of questions that included their own smoking history, their views on patients smoking, their level of involvement in supplying cigarettes to patients, and what informed their decisions and actions related to smoking in the workplace. The authors reported that most nurses in the study condoned patients' smoking and the use of tobacco to promote cooperative behavior with hospitalized mental health patients. Smoking was supported as a central part of the psychiatric milieu, where patients relied on it for socialization and symptom management, and nurses accepted it regardless of personal and

professional values. Nurses in this study cited autonomy and beneficence as ethical reasons for their care decisions.

In a study of 289 mental health nurses in Australia, Dwyer, Bradshaw, and Happell (2009) reported that nurses were less likely to promote smoking cessation with patients if they believed that smoking was a personal choice. The authors noted a concern related to some of their findings that indicated that nurse participants believed that health care facilities should discourage smoking but also should provide a designated place to smoke for those individuals who chose to do so. Findings suggested that understanding smoking behaviors and smoking attitudes of mental health nurses is essential to engaging them with patients to promote smoking cessation. Nursing literature on tobacco dependence and smoking cessation, however, does not provide adequate information to understand the ethical issues and challenges encountered by psychiatric point-of-care nurses.

In 2004, the Tobacco Free Nurses Initiative hosted a nursing leadership conference to address the importance of tobacco control activities in nursing. Leaders from 22 nursing organizations representing more than one-half million nurses attended. According to Sarna and Bialous (2006), participants of the meeting agreed that “tobacco cessation is central to nursing practice and that research in the field was compromised by lack of nursing involvement” (p. S4). Priorities from the meeting included recommendations to mentor new nurse investigators and to collaborate with researchers from other disciplines.

Recommendations highlighted the importance of nurses' involvement on a national level in tobacco control policy and in standardization of smoking cessation programs. Additional priorities included the importance of addressing tobacco cessation in underserved and high-risk populations, including women (especially pre- and postpartum) and persons with mental illness (Sarna & Bialous, 2006).

More recently, the *Healthy People 2020* objective to reduce tobacco use in the United States calls on all health care professionals—including nurses—to reduce the tobacco epidemic in the United States through efforts that include increased smoking cessation assessment and intervention (USDHHS, 2010).

Despite these recommendations and evidence suggesting that nurses should be on the front lines of treating tobacco dependence, nursing education and nursing research have only minimally supported this position. Nursing literature indicates that there is little training on tobacco cessation in nursing education curricula (Sarna, Bialous, Rice, & Wewers, 2009; Wewers, Kidd, Armbruster & Sarna., 2006). Two studies of psychiatric mental health nurses reported that participants had received less than two hours of instruction on tobacco-related education during their nursing programs and minimal teaching on smoking cessation interventions (Price, Jordan, Jeffrey, Stanley, & Price, 2008; Sharp, Blaakman, Cole, & Evinger, 2009). Nursing research is only beginning to encourage nurses to develop studies in the area of tobacco cessation. Although research articles focused on nursing involvement in tobacco cessation increased

eightfold in a 10-year period from 1996 to 2005, only one third of those articles were published in nursing journals (Wells, Sarna, & Bialous, 2006). Since 2005, the number of articles on tobacco cessation published annually in nursing journals has remained approximately the same. Thus, even though health professionals across the nation have received a call to action to help the public stop smoking, tobacco dependence appears to be receiving minimal attention in nursing research. Of 66 articles on smoking cessation published in nursing journals since 2005, only 6 discussed special populations including psychiatric patients, and only 3 articles provided an ethical focus on nursing issues and tobacco cessation (Lawn & Condon, 2006; Matthews et al., 2005; Phillips, 2006).

Current research has documented that nurses can be effective in improving smoking cessation interventions with acute care patients with cardiovascular disease and pneumonia, yet national surveys show that few nurses are aware of tobacco dependence interventions and the U.S. Public Health Service Clinical Practice Guideline for treating tobacco dependence (Heath & Andrews, 2006; Wewers, Sarna, & Rice, 2006). In the general medical population, research supports that smoking cessation programs initiated in the hospital setting are effective for patients who want to quit when follow-up is provided after discharge. This strategy has not yet been established to be effective with special patient populations (Rigotti, Munafo, Murphy, & Stead, 2003). Unfortunately, little has been done to gather information or address nursing interventions around smoking cessation in the psychiatric–mental health

community. Nurses need to investigate strategies that are successful in the general population for their potential use as interventions with patients in the psychiatric mental health population (Sarna & Bialous, 2006; Wells et al., 2006). According to the American Psychiatric Nurses Association (Stein, 2008), the time to act regarding tobacco dependence is now; failure to do so equals harm.

There are more than 91,000 psychiatric mental health nurses in the United States. It is estimated that approximately 86% of those nurses are staff nurses who provide direct care to patients on a day-to-day basis, yet much of the nursing literature that addresses tobacco dependence education and intervention has studied only advanced-practice nurses (USDHHS, 2004). To address that gap, this study explored the ethical decisions of psychiatric mental health nurses who provided direct care to mental health patients who smoke. What we learn from these nurses, who care for the largest percentage of people in America who still smoke, may help increase the use of tobacco cessation interventions, reduce the harm that is occurring from tobacco use, and offer hope to patients who smoke.

Significance of the Study

National initiatives have been established to reduce tobacco use in the United States (USDHHS, 2012). The importance of addressing smoking cessation with persons who have mental health conditions is a priority because persons with mental illness use tobacco at two to three times the rate of the general population, resulting in high rates of smoking-related illness and

premature death (CDC, 2008; Schroeder, 2004). Prochaska (2009) recommended that smoking cessation be addressed with persons who are hospitalized in psychiatric facilities as an effective way to impact the high rate of smoking in persons with mental illness. Nurses have frequent contact with hospitalized patients and are in a position to offer smoking cessation interventions, but little progress has been made in successfully helping patients to quit (Sarna et al., 2009).

Little is known about the experience of psychiatric mental health nurses who address smoking cessation interventions on inpatient and outpatient units. Less is known about nurses' ethical decisions in caring for patients who smoke. A brief search of CINAHL produced seven articles addressing psychiatric nurses, attitudes, and smoking cessation. Only one study addressed ethical decisions of psychiatric nurses with smoking (Lawn & Condon, 2006). This current study will help to better understand the experience of psychiatric mental health nurses and their ethical decisions in working with patients who smoke. Findings from this study can raise the awareness of psychiatric mental health nurses regarding the importance of ethical decisions and how those decisions support ethical nursing practice and patient outcomes.

Purpose of the Study

The purpose of this study was to explore the ethical decisions made by psychiatric mental health nurses who provide direct care to patients who smoke.

Research Question

This study focused on the following research question: What is the experience of psychiatric mental health nurses making ethical decisions regarding the care of patients who smoke?

Methodology

A phenomenological method of inquiry was used to explore the experiences of psychiatric mental health nurses making ethical decisions regarding patients who smoke. Phenomenology is a qualitative research approach that explores human experience as it is lived. This study used the conceptual framework of Max van Manen (1997), who suggests that although some researchers argue that phenomenological knowledge has no practical value, perhaps a more important consideration is: "Can phenomenology, if we concern ourselves deeply with it, do something with us?" (p. 45). Benner (2001) suggests that interpretive phenomenology provides a rich description of nursing practice and allows for understanding the phenomenon within the context of a larger whole. As a research method, phenomenology is a rigorous, systematic approach that is important to the discipline of nursing (Streubert Speziale & Carpenter, 2003).

Maxwell (2005) suggests that a qualitative approach can provide information that is unique to the phenomenon of study, including the following (pp. 22-23):

- Understanding the participant's perspective

- Understanding events, actions, and meanings within the context of the circumstances in which they occur
- Generating discovery of unanticipated phenomena and influences
- Understanding process versus outcomes
- Developing causal relationships and explanations.

Phenomenology, according to van Manen, is a human science approach that provides insight into everyday lived experiences. It studies the way in which persons create the expressions of how human beings exist in the world. This is in contrast to a natural science approach that studies objects and the way they behave (van Manen, 1997, p. 4). According to van Manen (1997), phenomenology questions *what something is really like or the nature of the lived experience*. He suggests that the aim of phenomenology is “to construct an animating, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in the lifeworld” (p. 19). In contrast to an experimental research approach, the human science approach meets human beings in their situation, engaged in their world. Phenomenological research is an exploration of human “lifeworld,” “the lived world as experienced in everyday situations and relations” (p. 101). It can be examined using four categories or existential themes: spatiality, corporeality, temporality, and relationality. Van Manen (1997) refers to these themes of lived space, lived body, lived time, and lived human relationships as “existentials” and suggests that they may be helpful in guiding the research process (p. 101).

Phenomenology is not “inductively empirically” derived, according to van Manen (1997, p. 22). It is also not a science that describes who did what, when, and how. Phenomenology is not a reflective experience apart from the concrete lived experience expressed with language, and it does not problem solve. Instead, it looks for meaning.

Van Manen (1997) uses a descriptive and interpretive approach to phenomenology. He suggests that some researchers make a distinction between phenomenology (description) and hermeneutics (interpretation) of the lived experience; however, he chooses to use the term *descriptive* to mean both interpretive and descriptive elements of phenomenology (p. 26).

Phenomenology looks for meaning in lived experience. For this study, it was implemented to investigate the meaning of being a psychiatric mental health nurse who makes decisions in the care and treatment of patients who smoke. It is about listening to the day-to-day successes and failures of nurses who make decisions with patients around smoking or not smoking, an area of care that is not necessarily recognized for its presentation of ethical situations in mental health. The aim of the study was not a statistical analysis of what decisions are made and how often, but instead was about learning from the experience of nurses who care for the largest group of individuals in the United States who still smoke. This study used a rigorous human science approach to phenomenology that aimed to provide rich interpretive descriptions and to capture the truth of the nurses' experience as they live it (van Manen, 1997).

CHAPTER 2. REVIEW OF THE LITERATURE

The following review of literature provides a basic look at smoking in the U.S. general population and in persons who use mental health services. It also provides a brief background on national efforts to address tobacco cessation in the health care system, including some involvement by nurses. Two articles related to ethics in smoking cessation and psychiatric mental health nursing are addressed. The findings of this current study will be discussed (in Chapter 4) within the context of what is known about the ethical decisions of psychiatric mental health nurses and tobacco cessation.

An article search of CINAHL, Medline, and PsycInfo was conducted through the George Mason Libraries database using the search terms *smoking cessation, tobacco, and mental health. Ethics and nursing* were then added to the search which narrowed the available articles. The Philosophers Index database was also searched for *tobacco, smoking cessation, mental health, and ethics.*

Smoking and the General Population

In 1982, the U.S. Surgeon General's report declared cigarette smoking to be the chief single avoidable cause of death and the most important public health issue in the country (USDHHS, 1982). More than two decades later, tobacco use

remains the leading preventable cause of illness and death in the United States (Agency for Healthcare Research and Quality, 2008). Approximately half of all cancers are due to smoking, and smoking causes more deaths each year than alcohol or illegal drug use, HIV, traffic fatalities, suicides, and murders combined (USDHHS, 2004). The 2004 USDHHS report concluded that more than 400,000 people died each year of tobacco-related illness and that the economic burden equaled more than \$157 billion in annual smoking-related costs, including direct medical costs, indirect costs from lost productivity, and the cost of neonatal care. The report also indicated that three out of four people who smoke expressed an interest in quitting, but fewer than 5% of smokers who quit stayed tobacco-free for 3 to 12 months (USDHHS, 2004).

According to the CDC (2007), smoking rates for adults in the United States declined sharply from 42% in 1965 to 25% in 1990. The rates continued to decline at a steady pace to approximately 21% in 2004; however, the rate remained unchanged through 2006, suggesting a leveling off in the decline of smoking rates. By 2010, the rate of smoking in the U.S. dropped to 19.3% and it is hopeful that it will reduce again by the end of 2013 through government efforts to meet *Healthy People 2020* goals.

Smoking prevalence was highest among male adults, persons who live below the national poverty level, and those who have not completed high school or have only a General Education Diploma (GED). In general, the rate of smoking

in the United States has declined dramatically since 1965; however, that rate has not declined for persons with mental illness (Schroeder & Morris, 2010).

Smoking and Mental Illness

According to the CDC, in 2010 approximately 19.3% of Americans still smoked, and the percentage of persons with mental illness who smoked was at least two times higher than the general population. In fact, nearly 44% of the total cigarettes consumed in the United States are smoked by persons who have a severe mental illness or substance use disorder (Grant, Hasin, Chou, Stinson, & Dawson, 2004; Lasser et al., 2000; Shroeder & Morris, 2010). Smoking prevalence for persons with severe mental illness varies with the type of disorder from approximately 45% to 85%, with people with schizophrenia having the highest rate. Smoking prevalence is also high among persons with substance use disorders, including 77% of participants in drug treatment programs (Kelly et al., 2012). Studies of smokers in the United States support that approximately 70% of people who smoke would like to quit, including people with mental health disorders, in spite of the poor quitting outcomes reported for this population (Prochaska et al., 2004; Prochaska, Fletcher, Hall, & Hall, 2006).

There are several reasons why persons with severe mental illness continue to smoke at higher rates than the general population. According to Ziedonis, Williams, and Smelson, (2003), "It is most likely that biological, psychological and social risk factors contribute to the phenomenon, including neurobiological vulnerability, increased severity of withdrawal symptoms, poor

coping skills, and self-medication for attention, mood and anxiety symptoms” (p. 224).

Smokers with serious mental illness tend to be heavy smokers and are shown to inhale higher levels of the nicotine metabolite cotinine than do other smokers (Olincy, Young, & Freedman, 1997). Nicotine releases dopamine in the brain and achieves a sense of reward and pleasure within 11 seconds after tobacco smoke is inhaled. It is speculated that persons with severe mental illness may experience a greater sense of pleasure because of neurobiological abnormalities in the dopamine system. If so, this would place them at greater risk of addiction to tobacco (Ziedonis et al., 2003). In addition to increasing pleasure, nicotine reduces negative symptoms of some illnesses, such as depression or hallucinations. Therefore, smoking may represent an attempt to self-medicate symptoms of mental illness. Atypical antipsychotic medications also reduce negative symptoms of mental illness. Studies show that during treatment with these atypical medications, smokers tend to reduce the number of cigarettes smoked and have greater success with tobacco cessation (Benowitz, 1992; Ziedonis et al., 2003).

Smokers who are addicted to tobacco may experience nicotine withdrawal symptoms when they quit smoking unless they are treated with medications and nicotine replacement to reduce cravings and possible symptoms of depression, anxiety, insomnia, increased appetite, irritability, and restlessness (American Psychiatric Association, 1994). Studies suggest that some withdrawal symptoms

decrease within weeks after quitting tobacco; however, cravings may persist for months or even years (Williams & Hughes, 2003; Ziedonis et al., 2003).

Social factors of smoking are also important to consider for persons with mental illness. Traditionally, smoking has been part of the inpatient culture in mental health. Until recent years, *smoke breaks* have been viewed as behavioral rewards by most mental health staff and a common social activity for patients on psychiatric units. Persons who are experiencing increased psychiatric symptoms may smoke to cope with boredom and loneliness. It is essential to recognize the importance of social factors as triggers for relapse and failure in quit attempts (Cataldo, 2001; Lawn & Condon, 2006; Schroeder & Morris, 2010; Ziedonis et al., 2003).

Persons with mental illness, their family members, and mental health staff must understand the consequences of smoking and why it is important to quit. They should be educated about physical and psychosocial issues around tobacco dependence, and they need interventions to cope with factors that interfere with successful tobacco cessation. National efforts have been organized to address the issue of tobacco dependence in mental health care settings. In 2003, the Smoking Cessation Leadership Center was established as a Robert Wood Johnson program office aimed at helping clinicians to develop interventions to reduce tobacco use (Schroeder, 2008). The Smoking Cessation Leadership Center has partnered with mental health organizations in an effort to decrease tobacco use in the psychiatric mental health community.

The establishment of smoke-free environments is another national approach to addressing the issue of tobacco use in mental health communities. A 2006 position statement, *Smoking Policy and Treatment in State Mental Health Facilities*, was developed by the Medical Directors Council of the National Association of State Mental Health Program Directors (Parks & Jewell, 2006). The purpose of the report was to demonstrate the urgent need for leadership and support of efforts by individuals and state mental health facilities to promote smoke- and tobacco-free environments.

Most recently, the USDHHS established new *Healthy People 2020* objectives with a goal to improve the nation's health. One objective is to reduce tobacco use in the United States through efforts that include increased smoking cessation assessment and intervention (2010).

Nursing and Tobacco Cessation

In 1993, the Agency for Health Care Policy and Research (later renamed Agency for Healthcare Research and Quality) convened a panel of health care professionals, who developed the U.S. Public Health Service clinical practice guideline *Treating Tobacco Use and Dependence* from research on smoking cessation (Fiore et al., 1996). This practice guideline was updated in 2000 and again in 2008 to include new studies and treatment recommendations for clinicians in specialty practice (Fiore et al., 2000; 2008). The 2008 practice guideline provides nurses with the basic information needed to develop

interventions based on current best practices for working with tobacco-dependent patients.

There are 10 key recommendations from the 2008 guideline. The overall goal suggests that clinicians strongly recommend tobacco dependence counseling and medication treatments to patients who use tobacco. It also recommends that health systems, insurers, and purchasers provide assistance to clinicians in making such treatments available for patients (Fiore et al., 2008).

The 10 key recommendations from the 2008 practice guideline are summarized as follows:

1. Tobacco dependence is a chronic disease that requires repeated interventions with effective treatments that can increase long-term abstinence.
2. It is essential to identify, document, and treat every tobacco user seen in the health care setting.
3. All willing patients (across populations) should be encouraged to use counseling and medication treatments recommended in the guideline to make quit attempts.
4. Practitioners should offer at least a brief intervention to every patient who uses tobacco.
5. Counseling is effective (individual, group, and telephone) and is increasingly so with intensity. Two effective components include:
 - a. Practical counseling (problem solving/skills training)

- b. Social support as part of treatment
6. Clinicians should encourage use of medications effective for tobacco dependence except where contraindicated (pregnant women, smokeless tobacco users, adolescents, or light smokers).
 - a. First-line medications that increase abstinence rates include:
bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, varenicline.
 - b. Consider use of medication combinations recommended in the guideline.
 7. Anyone making a quit attempt should be encouraged to use both counseling and medication for maximum effectiveness.
 8. Clinicians should ensure patient access to telephone quitlines and promote their use across populations.
 9. When a current user is unwilling to make a quit attempt, the clinician should use recommended motivational techniques to increase future quit attempts.
 10. Tobacco dependence treatment is clinically sound and cost-effective, and it increases quit rates. All insurers and purchasers should include insurance coverage for recommended medications and counseling.

This clinical practice guideline has been abbreviated for quick reference into a series of steps known as the five As: Ask, Advise, Assess, Assist, and Arrange (Fiore et al., 2000; 2008). In some cases, this series of steps is

abbreviated further into an intervention process that all nurses can use and can adapt according to their specialty and scope of practice to help patients start a quit program. Once the nurse engages the patient in the ask-advise-refer process, he or she must involve the physician or nurse practitioner and the health care institution for completion of the intervention with follow-up services. Nurses who refer patients for smoking cessation services could provide a catalyst for health care systems to offer adequate resources.

To date, the most visible movement in nursing toward promoting and encouraging the use of these guidelines has been through the Tobacco Free Nurses, an organization initially funded by the Robert Wood Johnson Foundation (Tobacco Free Nurses, 2008). The Tobacco Free Nurses is a national program focused on helping nurses and nursing students to quit smoking. This initiative also provides nurses with tobacco cessation resources for patient care, and it supports nurses as leaders in tobacco cessation efforts (2008). The Tobacco Free Nurses recognize that nurses maintain the highest estimated percentage of smokers among health care professionals (18%) and that this can present a barrier to providing smoking cessation interventions for the public. The Tobacco Free Nurses Initiative collaborates with other nursing organizations and, to date, it is still the largest nursing initiative dedicated to reducing tobacco dependence (2008).

The literature related to tobacco cessation and psychiatric mental health nursing is limited, and few studies focus on nursing care. Three studies of mental

health nurses in Canada addressed nursing practice and tobacco. Green (2010) studied knowledge, attitudes, and practice of mental health nurses related to tobacco use by persons with mental illness. Half of the nurses who participated in the study did not believe that smoking cessation was a priority for psychiatry and indicated that they did not want to take away an enjoyable activity from patients. More than half of participants reported having received no training on tobacco interventions and 90% received little to no training in medications for smoking cessation. The majority of participants did not use the 5 As from the tobacco guidelines and only 30% reported providing medications for smoking cessation.

Scharf (2008) interviewed mental health nurses in Canada on their perceived role with respect to patients' smoking behaviors. The study was conducted soon after government legislation of smoking bans and nurses reported feeling frustrated over additional work related to the smoke-free environment with minimal prior smoking cessation knowledge and no consistent staff practices in place. Nurses continued to provide traditional nursing care with nicotine replacement for patients who smoked. Some exceptions to traditional care were reported by participants who provided teaching and support to patients for smoking cessation.

A study by Berthiaume (2010) assessed factors that potentially influenced the delivery of tobacco cessation interventions by 70 hospital-based mental health nurses in Canada. Data from this study indicated that nurses who reported a higher frequency of advising patients to quit smoking also reported a higher

level of agreement on the effectiveness of providing smoking cessation advice to patients, even if it was not requested.

Lawn and Pols (2005) reviewed 26 studies of smoking bans implemented in psychiatric settings between 1988 and 2002. Although nursing reports were used as evidence to measure the success of the smoking bans, key findings from the studies focused primarily on institutional change and not on nursing care. The studies reported mixed findings regarding the success of the bans; however, 20 of the 26 studies agreed that “there was no increase in aggression, use of seclusion, discharge against medical advice or increased use of as-needed medication” following implementation of a smoking ban (Lawn & Pols, 2005, p. 866).

Nursing and Ethical Decision Making Related to Smoking Cessation

Ethical decision making is part of daily nursing practice for psychiatric mental health nurses. Nurses must advocate for decisions that maintain a patient’s autonomy and balance those decisions with maintaining the person’s safety using least restrictive measures or when treatment is court ordered. Safety concerns for staff and other patients must also be considered. Addressing informed consent and treatment decisions with a person who is experiencing psychosis also presents ethical decisions in psychiatric mental health nursing practice. This current study addressed ethical decisions shared by participants related to caring for their patients who smoked.

Two studies from the United Kingdom discussed registered nurse (RN) smokers versus nonsmokers in psychiatric hospitals and their attitudes toward nonsmoking hospital policies (Bloor, Meeson, & Crome, 2006; Dickens, Stubbs, & Haw, 2004). On the one hand, nursing staff viewed a nonsmoking policy as necessary; on the other hand, they believed that smokers should be able to smoke and that the policy was not effective in helping staff to quit without additional organizational support (Bloor et al., 2006). The second study compared nursing staff with other health care professionals (OHPs) and reported that RNs and nursing assistants shared similar liberal values toward smoking (Dickens et al., 2004). Findings indicated that RNs were more likely than OHPs to support the idea of staff smoking with patients, and they believed that smoking had value in forming therapeutic relationships with patients. Findings suggested that higher stress levels, increased direct patient contact with little opportunity to leave the unit, and a unique relationship with patients might contribute to their attitude (Dickens et al., 2004).

In a study of 289 psychiatric mental health nurses in Australia, Dwyer et al. (2009) reported that nurses who believed that smoking is a personal choice were less likely to promote smoking cessation with patients. Findings indicated that most participants believed that health care facilities should discourage smoking and provide health promotion. Participants also reported that they were adequately prepared with smoking cessation knowledge and skills to fulfill the health promotion role for the facility. In contrast to the findings related to

promoting health, many participants indicated that smoking should be a personal choice and that facilities should provide a designated place to smoke for individuals who chose to do so. The authors suggested that the contradictory findings were influenced by nurses' attitudes and personal smoking habits.

Insight into psychiatric mental health nurses' ethical beliefs and dilemmas in supporting smoking cessation for patients was articulated in a qualitative study (Lawn & Condon, 2006). The findings showed that nurses did not agree on the patients' right to smoke or their informed choice to do so. The authors concluded that most participants were "thoughtful, concerned and very aware of the conflicts inherent in their ethical decisions and subsequent actions and inactions" (p. 117). In addition, they recommended that nurses be given support in clarifying their own values and that a learning environment be promoted to encourage dialogue around dilemmas in the nursing role (p. 117). Matthews et al. (2005) reported that nursing staff shifted their perception of whether a smoking ban was ethical when they were surveyed before and after implementation of the change in institutional policy. Nurses who reported that the ban was ethical doubled from 5 to 10 (of 13 total respondents) following the implementation of the smoking ban. Researchers speculated that the change in attitude might have been related to positive outcomes following the intervention.

This current study extends previous research by exploring ethical decision making of psychiatric mental health nurses regarding the care of their patients who smoke. Based on the ANA's *Code of Ethics for Nurses with Interpretive*

Statements (American Nurses Association, 2001), nurses engage in ethical decisions as they make choices regarding the care and safety of their patients. Nurses frequently advocate for patients and, in doing so, may need to question the policies of the health care system, and at other times they may make decisions based on patient requests that are contrary to their own value system. It is hoped that this study will help psychiatric mental health nurses to better understand the dilemmas that they face and the ethical decisions that they make in providing care to patients who smoke.

Weston (2002) provides a practical approach to ethical decision making that is appropriate to this study. He suggests that ethics must be more than theories and academics, and brings together ethics with practical thinking so that challenges and dilemmas become opportunities for creative thinking and problem solving. Weston's practical view of ethics recognizes that individuals often come to their decisions based on previous values, norms, traditions, and rules that may lead to stereotypes and limited thinking (2002). He suggests that we need to apply the rules, norms, and values but in a way that is creative, moving from the "perfect-but-impossible" to solutions that are possible and realistic (Weston, 2002, p. 39).

Weston's approach to ethics builds around three fundamental "families of moral values" (Weston, 2001, p. 68). Those three families include what he labels goods, rights, and virtues. *Goods* is the ethics of happiness and well-being that moves our focus beyond ourselves toward a concern for others. The values

associated with utilitarianism, the greatest good for the greatest number, is included in this family of values. *Rights* is the ethics of personhood or honoring and respecting persons. This family of values includes fairness, justice, and autonomy. *Virtue* refers to good moral character and living up to being our best as a person. Weston suggests that virtue is the basis for most professional codes of ethics that mandate us to do no harm (2001).

Weston (2001) suggests that practicing ethics involves paying attention to issues that question moral values. Exercise mindfulness and do not ignore those situations that make us feel unsettled. When a situation presents itself, keep questioning until the underlying core value is clear. Once the core issue is identified, make a commitment to working toward gradual change with the understanding that ethical issues may take time to address. Weston (2009) suggests that ethics should not be brought out for occasional decision making, but should be functioning in the background as an assumption that moral values will be considered in all that we do.

It is hoped that this study will bring forth a discussion of ethical decisions that psychiatric mental health nurses make in providing care to patients who smoke. Furthermore, it is hoped that this discussion will lead to possible and realistic solutions to address tobacco cessation with persons who seek mental health services.

Theory of Reasoned Action

The literature on psychiatric mental health nurses and smoking cessation is limited and tends to focus on nurses' attitudes and their inconsistent support for tobacco cessation in mental health. Therefore, it is important to understand the relationship between attitudes and behavior in exploring the psychiatric nurse's experience of making ethical decisions in caring for tobacco-dependent patients. A well-researched theory in psychology is the *theory of reasoned action* (Fishbein & Ajzen, 1975). Ajzen and Fishbein (1980) do not believe that behavior "is controlled by unconscious motives or overpowering desires.... Rather, we argue that people consider the implications of their actions before they decide to engage or not engage in a given behavior" (p. 5).

This theory has been used in research to better understand and predict health behaviors such as smoking (Cohen, Shumate, & Gold, 2007; Noonan, Kulbok & Yan, 2011). The theory of reasoned action (Ajzen & Fishbein, 1980) was used to guide Noonan et al.'s (2011) study of smoking intentions of college students and young adults who smoked tobacco using a water pipe. Their study was designed to highlight the problem of water pipe smoking and to identify predictors of its use with tobacco among college students and young adults. The researchers found that attitudes, behavioral beliefs, and subjective norms were all significantly associated with the intention to smoke. Findings from their study should inform campus health providers that they need to screen students for water pipe smoking as well as provide guidance for interventions to promote

health on campus and to discourage water pipe smoking. Data from Noonan et al. suggest that campus smoking prevention messages need to focus on dispelling the myth that smoking tobacco with a water pipe is safer and decreasing favorable attitudes toward water pipe smoking among college students and young adults (2011).

Cohen et al. (2007) examined the use of health communication theories in 399 television ads designed to decrease smoking in adults and teens. The researchers identified the theory of reasoned action as one of three social influence theories used by advertisers to encourage behavior change. Further, they reported that attitude was the most prevalent persuasive health message used in ads included in the study. Forty-five percent of the antismoking advertisements relied on appeals to attitudes with less emphasis given to social norms, barriers to quitting smoking, or self-efficacy. Cohen et al. suggested that promoting positive change and the benefits of not smoking should be considered in future research for designing antismoking ad campaigns. This might be helpful for psychiatric mental health nurses to consider in promoting smoking cessation and health behavior change with patients.

In this current study of nurses' ethical decisions related to patients who smoke, the theory of reasoned action was not used to predict behaviors, but rather was considered in understanding the nurse's experience in the context of his or her ethical decision making relative to the care of mental health patients who smoke.

The theory suggests that the most important factor in determining a health behavior is the intention to perform that behavior. According to the theory of reasoned action, behavioral intentions motivate the performance of behaviors, and “attitudes only serve to direct behavior to the extent that they influence intentions” (Armitage & Christian, 2004, p. 5). Therefore, nurses who assist tobacco-dependent patients to quit smoking may be *most* influenced to do so by their own intent to provide that care. The theory of reasoned action goes on to explain those factors that influence intention. According to Armitage and Christian (2004), the theory suggests that attitude is one determinant of intention and that perceived social pressure from significant others is also a likely determinant. Furthermore, the theory suggests that attitudes and subjective norms are determined by underlying salient behavioral and normative beliefs (Fishbein & Ajzen, 1975).

According to the theory of reasoned action, an individual’s beliefs about a behavior and its outcomes as well as perception of and motivation to comply with social pressure influence his or her attitudes and subjective norms. In turn, those attitudes and subjective norms influence the individual’s behavioral intention and finally his or her action or behavior. If this is true, then a psychiatric mental health nurse’s beliefs about smoking and smoking outcomes for mental health patients, along with the nurse’s perception of and motivation to comply with the social pressure, influences the nurse’s attitude and intention related to support for smoking cessation interventions.

Summary

There is sufficient literature to show that quitting tobacco use provides benefits that far outweigh the risks of continued smoking. Benefits include better quality of health, increased personal savings, increased productivity, and savings to the health care system. With nearly half of the country's smokers in the mental health system, it seems evident that there could be a profound positive effect by addressing tobacco dependence with mental health patients. It is curious to this researcher that nursing, especially psychiatric mental health nursing, has given minimal attention to this health risk. It is hoped that this current study will help to better understand the nurse's experience of making ethical decisions regarding the care of mental health patients who smoke, and that it will provide insight into understanding key issues related to tackling this complicated health issue.

CHAPTER 3. METHODOLOGY

Chapter 1 introduced information about tobacco dependence in the United States and its prevalence in the mental health community. It also established that limited attention has been given to the development of nursing research and education in tobacco cessation, especially in the area of ethical decisions by psychiatric mental health nurses in the care of patients who smoke. Chapter 2 provided a closer look at tobacco dependence in mental health patients through examining the literature in this area and acknowledging efforts in the health care system to decrease tobacco use on a national level. Only one article, however, was found that focused on ethical issues faced by psychiatric mental health nurses in making decisions about caring for patients who smoke (Lawn & Condon, 2006). This lack of attention to tobacco cessation in the nursing literature, especially concerning the ethical dimensions of the problem, has produced limited knowledge and understanding of the nursing experience with mental health patients who smoke. Thus, ethical decision making of psychiatric mental health nurses providing direct care to tobacco-dependent patients was identified as the phenomenon of interest for this study.

This chapter provides the philosophical framework and methodology for this study. It introduces the method for data collection, criteria for selecting

participants, and a guide for data analysis. This study used Max van Manen's hermeneutic phenomenological approach to human science research (1997).

A Philosophical Framework

Phenomenology is the study of phenomena. According to Heidegger (1962), phenomenology is ontology, a study of being in the world. Husserl described how phenomena present themselves in the everyday lived experience, in the "lifeworld" (Macann, 1993), which is described as what individuals experience prereflectively, without interpretation and apart from culture. According to van Manen (1997), phenomenological research always begins in the lifeworld. It studies persons and how they experience their world. Phenomenology "offers accounts of experienced space, time, body, and human relation as we live them" (van Manen, 1997, p. 184). Van Manen describes four existentials: spatiality, corporeality, temporality, and relationality, that are common to the way all persons experience the world and are categories for questioning, reflecting, and writing in phenomenological research. According to Merleau-Ponty (1962), phenomenology studies the "essence" of a phenomenon (p. vii). It tries to uncover the internal meaning and describe it. In studying the essence of something, one attempts to capture a creative linguistic description of the unique experience, sometimes to capture it in a way that might reveal something that was previously unseen.

Van Manen suggests that the researcher must maintain a balance between objectivity and subjectivity in his or her orientation to the object of

inquiry. The researcher's writing should subjectively disclose the full richness and depth of the object while objectively defending its true nature (van Manen, 1997). Van Manen challenges the researcher to confront one's own assumptions and to approach each unique experience in a manner that is as unbiased as possible.

Hermeneutics is the theory and practice of interpretation. Van Manen's human science approach is hermeneutic, phenomenological, and language oriented. Hermeneutic phenomenology is descriptive as it attends to the facts and how things appear, and it is an interpretive process that captures the meaning of the facts into language (van Manen, 1997).

Methodology, according to van Manen (1997), is "the theory behind the method, including the study of what method one should follow and why" (p. 28). It is derived from the Greek word *hodos*, meaning the "way," and is interpreted as the study of the method or "way" of inquiry. Methodology pursues knowledge as opposed to following rules and procedures that use a fixed research method. In fact, "phenomenological human science is discovery oriented" and the methodology should emerge in response to the question as the research is conducted, avoiding the tendency toward following a predetermined fixed procedure (van Manen, 1997, p. 29).

Van Manen (1997) suggests that his human science research approach is one way to investigate a question using phenomenology and hermeneutics. He further suggests that the use of this method assumes that the researcher comes with a prior interest and is therefore not conducting research merely for the sake

of research. According to van Manen, the human science researcher is a scholar and the method used in hermeneutic phenomenological human science research would best be described as involving “scholarship” (p. 29). He explains the use of phenomenology as follows:

Phenomenology does not offer us the possibility of effective theory with which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world. (van Manen, 1997, p. 9)

This researcher pursued knowledge of the experience of psychiatric mental health staff nurses who make ethical decisions in caring for patients who smoke. Using van Manen’s human science approach allowed the researcher to explore stories with the participants without judgment of their actions and decisions around smoking, and it provided participants the opportunity to reflect on their decisions within a situation that was unique to them. Nurses were given freedom to describe their unique stories and in doing so some nurses appeared to clarify their values around working with persons who smoke and some shared insight into dilemmas that they faced in light of the unique circumstances of their story. Using the lens of phenomenology and van Manen’s human science approach to understand the experience of psychiatric mental health nurses making ethical decisions with persons who smoke provides insight into the world of these nurses as they live it.

Rationale for the Study Design

Because it is essential that the research design must match the research question, it is helpful to consider the history of how this research question came

to be. In 2007, this student researcher began working with an experienced tobacco researcher on a project to address tobacco dependence in the psychiatric mental health nursing community. With the support of the Smoking Cessation Leadership Center and the American Psychiatric Nurses Association (APNA), a task force was formed and a survey was conducted to assess the level of smoking cessation knowledge and activity among members of the APNA (Sharp et al., 2009). When the task force convened and survey findings were discussed, this researcher noted a few important details:

- Approximately two thirds of survey respondents were advanced practice nurses.
- Of the respondents, 21% viewed tobacco dependence intervention as a high organizational priority and only 17% perceived it to be a high priority in their own work.
- Less than 2% of respondents perceived clients to be highly motivated or highly able to quit smoking.
- Although 90% of respondents screened patients for tobacco dependence, only 29% provided interventions.
- The needs and experience of staff-level psychiatric nurses in this area were not clearly known.

It was quickly evident to this researcher that many nurses who responded to this survey did not perceive smoking cessation as a high work priority, nor did they expect favorable outcomes regarding their clients' ability to quit smoking.

According to the theory of reasoned action (Fishbein & Ajzen, 1975), these advanced practice nurses would not be inclined to provide interventions; therefore, it should not be surprising that only 29% of respondents reported doing so. These data provided some insight into the values and beliefs of the survey respondents; however, they did not provide information to explain the experience of respondents and their day-to-day ethical dilemmas in making decisions in the care of their patients who smoked.

It was also evident that staff-level nurses, who represent 86% of psychiatric nurses working with tobacco-dependent patients, were not well represented in the survey data and were therefore not a focus of discussion by this national task force. As a psychiatric mental health nurse and a former staff nurse, this researcher deemed it important to learn the experience of the staff nurses in the current mental health setting. If staff nurses could begin to recognize the ethical decisions that they face with their patients regarding smoking cessation, they could be better equipped to make decisions based on thoughtful and reflective choices.

Thus, the phenomenon of interest was identified, and the search began for how best to investigate this community of psychiatric nurses. This researcher considered using a survey to collect data from staff nurses across the United States. Consideration was given to replicating the APNA survey or developing a new survey for this purpose. A cursory literature search was completed to determine if data were already available, and experts in both tobacco

dependence and research design were consulted to determine how to effectively engage staff nurses in the dialogue about their experience with tobacco-dependent patients. It was determined that a survey built on previous findings might gather a large volume of data; however, it may not ask the right questions to investigate the phenomenon of interest with this group of psychiatric mental health nurses. Because phenomenology explores the human experience as it is lived, this researcher decided that using a phenomenological method of inquiry would provide better insight into the day-to-day experience of the psychiatric nurses of interest for this study.

This study asked the question, “What is the experience of psychiatric mental health nurses making ethical decisions regarding the care of patients who smoke?” It focused on the unique experience of each study participant and aimed to fully describe and interpret participants’ experience and their related perceptions.

Participant Selection

Participants were selected using a purposeful approach for their experience or specific knowledge of the phenomenon of interest (Polit & Hungler, 1999; Streubert Speziale & Carpenter, 2003). An attempt was made to achieve diversity in participants related to geographic location, gender, smokers and nonsmokers, and nurses from inpatient and outpatient settings. The selection criteria for participants in this study included the following: (1) psychiatric mental health nurses, (2) two or more years of psychiatric mental health nursing

experience, (3) working on an inpatient or outpatient unit, and (4) working with mental health patients who are tobacco dependent. The sample was designed to include nurse participants who were smokers, nonsmokers, and former smokers. Participants were recruited through this researcher's personal contact with psychiatric nurses and through members of the APNA Tobacco Dependence Task Force (now a council). Written approval from the APNA was obtained prior to recruitment of participants through their nursing organization. It was estimated that between 10 and 20 participants would need to be interviewed in order to acquire rich data that would reach saturation. Saturation was determined when data began repeating and new participants confirmed findings rather than adding new essences and themes (Streubert Speziale & Carpenter, 2003).

Protection of Human Subjects

Approval to conduct the study was obtained following the guidelines of the Human Subjects Review Board at George Mason University. Informed consent was obtained from each participant prior to the interview (Appendix A). Participation in the study was voluntary, and participants were not compensated for their participation. Demographic information was collected at the beginning of each interview (Appendix B), and data were collected using recorded, unstructured, in-person or telephone interviews (Appendix C). Pseudonyms were used to protect the identity of the participants, and participant names were known only to this researcher. Interview data were transcribed; audio and written data were kept in a locked cabinet in the researcher's home.

Data Collection

Following approval by the Human Subjects Review Board, the researcher began contacting psychiatric mental health nurses as described in the Participant section. All interviews were conducted by the researcher. Each interview was scheduled for a time and place that allowed privacy, facilitated audio recording, and was mutually acceptable to the participant and researcher. Most interviews were conducted by phone; two interviews were conducted in person. Phone interviews allowed nurses from across the country to participate in the study.

Consent forms were signed and demographic information was collected prior to beginning each interview. For in-person interviews, the participant signed the consent form and completed the demographic form at the time of meeting with the researcher, prior to beginning the interview. For interviews conducted by phone, the researcher emailed or faxed consent and demographic forms to the participant. Each participant completed the forms and returned them to the researcher prior to conducting the interview. Permission for follow-up contact with the participant for clarification of interview data and approval of the transcribed interview summary was obtained in the initial consent form.

Each participant was reminded that the interview would be recorded prior to beginning the recording process. All interviews were recorded and later transcribed by the researcher. Recording the data allowed the researcher to listen to the interviews multiple times. Personally transcribing the interviews provided the researcher the opportunity to carefully review and reexperience

each conversation. Notes were kept by the researcher to provide the opportunity to reflect on feelings, challenges, changes, or circumstances that occurred with each interview.

Participants were told at the beginning of the interview that the researcher would use specific questions but that she might ask them to expand on parts of their stories for clarification or for more information. For confidentiality, each person was asked to choose an alternate name. Some participants suggested that it was acceptable to use their real names; however, to maintain privacy of the participants the researcher substituted a pseudonym at the time of transcription. Individuals who did not choose an alternate name for the interview acknowledged the substitution in the interview summary that was later approved by each of them.

Interview questions were pilot tested with three participants. Following the first three interviews, recordings were transcribed and data were examined by content experts to determine if the questions elicited responses in keeping with the research question. It was then determined that adjustment to the data collection process was not needed and that the student researcher could continue to interview participants with the interview protocol. The pilot interviews are included with the others in Chapter 4. The quotations presented have been edited slightly for grammar and conciseness. Additional participants were obtained through referrals from members of the researcher's professional

organization (APNA) and through the researcher's personal contact. Effort was made to interview psychiatric mental health staff nurses across the country.

Prior to addressing the interview question, the researcher established rapport by asking each participant about the graph that was sent to him or her before the interview (Appendix C, Figure C1). The graph addressed smoking as the leading cause of annual deaths in the United States and indicated that 50% percent of the total number of smoking-related deaths is in persons with mental illness (CDC, 2008; Schroeder, 2008). Participants were asked if they had looked at the graph and whether or not they had questions about it. Following a short discussion of the statistics and the importance of the findings, the interviewer asked the following question: "Does it surprise you to see that nearly half of those people in the smoking category are persons with mental illness?" Most participants indicated that this statistic did not surprise them on the basis of their own experience with patients who smoke. However, most of these nurses did not realize that the number of annual smoking-related deaths among people with mental illness equaled 200,000.

Following this short introduction, the researcher reminded each participant that the focus of the study was on the experience of psychiatric mental health nurses making ethical decisions regarding the care of their patients who smoke. She stated that her hope was to capture their unique experiences. Participants were asked to respond to the following: "Think back on your years of caring for patients who smoke. Can you think of an experience that stands out in your mind

where you made a difficult decision about how to care for a patient who smoked? This might be an experience that caused you or the patient distress or one that you felt particularly good about. It might be a situation in which you felt a conflict of values. Can you tell me about that experience? Think of it as if you're telling me a story and include all the details that stand out in your mind."

Once the participant described his or her experience related to caring for patients who smoke, some of the following prompts were used to encourage further detail as appropriate to the individual interview.

- How does this experience reflect ethical issues that you have faced as a psychiatric mental health nurse in caring for patients who smoke?
- In thinking about this experience or others in your practice, did you feel uncertain about making the best decision with your patient? Was there anything specific that helped you to resolve that situation?
- How does this experience relate to other ethical decisions that you face in caring for psychiatric patients who are hospitalized in a nonsmoking environment?
- What kinds of information or support would be helpful to you in making ethical decisions regarding the care of patients who smoke?

The secondary questions were prepared by the researcher to encourage participants in discussion if needed; however, silence and patience were more often used by the interviewer to allow individuals to share their stories (van Manen, 2007). The researcher ended each interview by inviting the nurse to send

additional thoughts, information, or stories if he or she wished to do so. Following each interview, the researcher reflected on the discussion and noted special thoughts, feelings, or circumstances that might be helpful to remember later.

Data Analysis

Van Manen (1997) provides six dynamic research activities to guide the human science researcher through the research process; he invites the researcher to create the methods or techniques appropriate to the question rather than using a predetermined fixed set of procedures. The following six methodological themes or research activities of van Manen (1997) were used to guide this study:

1. turning to a phenomenon that seriously interests us and commits us to the world;
2. investigating the experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes that characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon; and
6. balancing the research context by considering parts and whole. (pp. 30-31)

Following transcription of interviews, an interpretive summary was written by the researcher (Appendix D), and each participant was asked to confirm his or

her own data summary. The interpretive summary was developed through a process of reading the transcribed interview, then writing, revisiting the transcription, and rewriting a summary of the interview data in an effort to capture the essence of the personal stories. Writing, reflecting, and rewriting encouraged the researcher to continue the process of inquiry in order for the nature of the lived experience to show itself. Reading, rewriting, and reflecting also allowed the researcher to recognize and appreciate themes as they emerged from the stories. Van Manen (1997) suggests that through the process of writing, reflection, and rewriting, themes will begin to emerge and the researcher can begin to gain insight and make sense of the data. Thematic analysis was used to discover meaning and as a means to organize and report the research data.

This researcher shares the experience of having been a psychiatric mental health staff nurse who made decisions regarding patients who smoked, so it is from this experience that the researcher oriented to this study. As a staff nurse in the days before antismoking campaigns and legislation, this researcher recognized the ethical implications of many decisions in providing patient care including those involving patient safety, consent for treatment, and medications. However, ethical implications were less evident in making decisions related to patients smoking—even though such decisions sometimes conflicted with personal values and with the nurse's role in promoting health. Perhaps it was less evident at that time because smoking was considered the norm, accommodated by the hospital with a smoking room on the inpatient unit and

scheduled smoking times. As a young nurse with minimal training in ethics, this researcher would also have been less likely at the time to question hospital policies. In spite of the fact that smoking policies were beginning to change outside the hospital, it was expected practice inside the hospital for most mental health patients to smoke. Van Manen (1997) suggests that one cannot reflect on an experience when one is in the middle of living it, but that it is retrospective and can only be reflected on after having lived through it. Now, as a result of personal experience and a review of literature on this problem, this nurse researcher believes that it is time to reflect on the decisions that psychiatric mental health nurses make with patients who smoke and that, in doing so, nurses can develop the best quality care for these patients based on education, ethical standards, and reflective practice.

CHAPTER 4. TELLING THE STORIES

The purpose of this study was to explore the experience of ethical decision making of psychiatric mental health nurses who provide direct care to patients who smoke. A phenomenological approach was used to gather the data, and van Manen's human science research method (1997) was used to analyze and interpret the findings. This chapter will present the analysis and interpretation of the stories of the psychiatric mental health nurses who participated in this study. All participants' names are pseudonyms.

Responding to the Research Question

What is the experience of psychiatric mental health nurses making ethical decisions regarding the care of patients who smoke?

Ten psychiatric mental health nurses shared stories that reflected on a wide range of ethical experiences to inform the research question. Stories included participants' experiences with patients, staff, and personal experiences with smoking. Some stories revealed hospital or system issues that provide evidence of unequal treatment of patients or staff with respect to smoking and the health care system.

Psychiatric mental health nurses who participated in the study were thoughtful and cooperative and seemed anxious to share their stories. Two of the

10 nurses recontacted the researcher after their interviews to share additional information that added to their previous stories. Only 1 nurse who was referred to the researcher did not schedule an interview when she discovered that smoking would be discussed. For others it appeared to help raise the participants' awareness of ethical issues in psychiatric mental health nursing care that may have previously been less apparent to them.

A few participants acted surprised that the researcher referred to their care decisions with patients who smoke as "ethical." Two nurses in this study stated that they did not agree that decisions involving smoking should be considered ethics. Upon further analysis of the interviews this researcher wonders if those two nurses may have interpreted the researcher's question to mean forcing patients to stop smoking since both nurses went on to share stories during their interview that involved care decisions with ethical implications.

Psychiatric mental health nurses who participated in this study suggested that there are ways to assist all nurses in making ethical decisions related to caring for mental health patients who smoke. Many of those suggestions involved education for nurses and were specific to working with persons who use psychiatric mental health services.

One nurse believed that education about smoking cessation is "first and foremost" in helping staff to make ethical decisions regarding their patients who smoke. Another nurse emphasized the need for nurses to get a good education in physiology and chemistry of the brain so that nurses understand what nicotine

does to the brain of a person with schizophrenia. She also suggested that nurse education must be creative and not “boring.” Participants in this study suggested that smoking cessation literature would be helpful for teaching patients or to send home with them in order to support smoking cessation efforts.

Three nurses shared that lack of time was an issue in trying to provide adequate care to psychiatric patients who smoke. Beth felt that nurses were fairly well educated about smoking and could apply their general knowledge to helping their patients. However, at her facility, the time required to complete paperwork reportedly interferes with the nurse–patient partnership and takes away time from working with patients on smoking cessation.

Smoking cessation treatment and education are expected with outpatient services delivered on one nurse’s unit. However, she said it would be more effective if adequate time were allowed to provide needed support for patients. With only 45 minutes allotted for the client appointment and so much education to cover, she said that tobacco cessation counseling “gets put on the back burner.”

Another nurse referred to organizations that believe they support their nursing staff but do not give the nurse time to go to educational programs. Her plea was: “Give them the time!”

Demographics

Ten psychiatric mental health nurses from 9 hospitals across the United States were interviewed for this study. Table 1 shows their demographic characteristics.

Data were collected to learn whether participants' workplace settings offered nurses education about tobacco dependence and whether assistance with smoking cessation was provided to patients or staff members. Eight of the hospitals offered tobacco dependence education to nurses. It was interesting to learn that 7 of the 9 hospitals did not offer smoking cessation assistance to staff members who wanted to quit smoking. Table 2 details the type of assistance provided for smoking cessation.

Table 1

Participants' Demographic Data

Demographic	Number (N = 10)
Gender	
Female	9
Male	1
Age, years (range)	27-64
Psychiatric mental health nursing experience, years (range)	4-30
Smoking history	
Smoker	1
Former smoker	4
Never smoked	5
Type of unit	
Inpatient	8
Outpatient	2
Workplace smoking status	
Smoke free	7
Smoking allowed	3

Table 2

Smoking Cessation Assistance at Participants' Hospitals

Type of Assistance	Number of Hospitals Providing Cessation Assistance for Patients or Staff (N = 10)	
	Patients	Staff
Groups Only	1	2
Medication Only	2	0
Groups and Medication	2	0
Groups, Medication, and Counseling	3	0
Groups and Counseling	0	1
No Assistance	2	7

Introducing the Participants

The following characteristics describe each of the nurses who participated in this study.

- Mark is 36 years old and has been a psychiatric mental health nurse for 10 years. He is a former smoker who works on the inpatient unit in a smoke-free hospital.
- Beth is a 64-year-old former smoker who has been a psychiatric mental health nurse for 30 years. Beth works on the inpatient unit of a smoke-free hospital.
- Annette has never smoked. She is 51 years old and has been a psychiatric mental health nurse for 26 years. She works on an inpatient unit in a smoke-free hospital.
- Lee is 48 years old and has never smoked. She works on the inpatient unit in a hospital that is not smoke free. Lee has been a psychiatric mental health nurse for 15 years.
- Donna is 53 years old and has been a psychiatric mental health nurse for 14 years. She works on the inpatient unit of a hospital that is smoke free. Donna smokes but says that she is trying to quit.
- Ann is 41 years old, has been a psychiatric mental health nurse for 19 years, and has never smoked. Ann works on an inpatient unit and also works with patients who are admitted through the emergency department at a smoke-free hospital.

- Mary is 54 years old and has been a psychiatric mental health nurse for 15 years. She is a former smoker and works in a smoke-free outpatient clinic.
- Angie has never smoked. She is 56 years old and has been a psychiatric mental health nurse for 20 years. Angie works on the outpatient unit of a smoke-free hospital.
- Cindi is 47 years old and has been a psychiatric mental health nurse for 4 years. Cindi is a former smoker who works on an inpatient unit that is not smoke free.
- Karen is 27 years old and has been a psychiatric mental health nurse for 5 years. Karen is a former smoker who works on an inpatient unit that is not smoke free.

The Stories: Experience of Being a Psychiatric Mental Health Nurse Caring for Patients Who Smoke

This section presents the participants' background information and each person's unique experience as a psychiatric mental health nurse who cared for patients who smoked. Participants are presented in the order in which they were interviewed.

The researcher introduces each story with an interpretive paragraph. These paragraphs were written by the researcher in an effort to capture the essence of each story. The interpretive paragraphs are italicized; words from the nurses are either in quotation marks for short quotations or indented for lengthy quotations.

Mark: Offering Choices

I am a nurse. I am a person—thinking, always thinking as a nurse. When can I separate the two? I try, but my patients bring me back to the reality that I exist as a person in a relationship with them [when I am in this environment].

How can I make things better—better for them when they are in this place with me? Maybe there is a way. Maybe I can be better, to make this place better. Can I offer you [the patient] a choice? Can I teach you what you need to know to make a choice? Is this ethics? I think not—not if I am doing my job as a nurse, as a person.

Mark, a former smoker, views making decisions about caring for patients who smoke as part of holistic care rather than as ethical decisions. The event described in Mark's story took place some years before the interview, when he was a fairly new graduate on an inpatient unit in a state psychiatric facility. He remembers doing admissions on the unit with patients who were usually in crisis and were experiencing hallucinations, paranoia, or anxiety that was "through the roof," especially if it was their first admission. In some cases if the patient was agitated, it was difficult to get through the admission process. In those cases, after giving some preliminary information and assessing whether the patient was a smoker, Mark would ask if that person would like to have a cigarette. It was simple to walk a short distance to the smoking room, sit down, and have a cigarette with the patient and finish the admission. It put the patient in a more relaxed state, according to Mark.

"I found [smoking together] to be really helpful in making that connection and building that rapport and also decreasing their anxiety," he says. "I got some pretty robust information...so it was beneficial in some instances." Some might

disagree that this is helpful to the patient but according to the theory of reasoned action, Mark's behavioral intention could justify his action as "beneficial."

Mark was at the facility when it changed to nonsmoking. "That was a different challenge because now it was our job to provide education and nicotine replacement for the patient." Episodes of assault did not increase because of the change, he reports. Providing education to patients "gave them the opportunity to think about that behavior—the nicotine addiction."

Mark took that opportunity to quit smoking. He explains why:

I felt bad going on a break, coming back smelling like an ashtray after having a cigarette, then going to talk with a patient, and they would say, "Oh, we can't smoke, but how come you went and smoked?".... It... gave me some insight to say, "You know what, yeah, it's making their stay a little more difficult if I'm [doing] what they can't do." So, I quit and used [for myself] some of the same education...and teaching materials [intended] to...facilitate educating patients during that time.

Mark's actions to change his own smoking behavior showed respect for his patients and Mark's relationship with them. Using Weston's practical approach to ethics, one might say that Mark used creative thinking to turn this dilemma into an opportunity to problem solve for the good of his patients.

Mark believes that one's level in the organization and one's work environment can influence the decisions that nurses make. This response to organizational pressure is supported by the theory of reasoned action.

If you are working within a smoke-free environment, then you have to provide that education and treatment, and you have to monitor [the patients] for signs of nicotine withdrawal and give opportunities to share their feelings, thoughts, and concerns. If you're working in an outpatient clinic where you may be doing home visits, you can still provide the

education, but that person has the free will and the choice to make that decision to smoke or not.

Mark notes the inequity in the smoking policy of a previous workplace:

“The behavioral health department went smoke free, and the rest of the inpatient organization was not, so patients who were on med-surg or telemetry could get up and walk outside to have a cigarette and come back.” He wonders, “Are we treating the behavioral health patient differently from the medical patient?” Mark remembers the debate over the difference in treatment between medical and mental health inpatients with respect to smoking privileges and he questions whether that inequity drives away prospective patients: “When they sign the consent [form] and when they realize that smoking is not permitted on the behavioral health units...they may choose to go to a different facility.”

Mark recognizes ethical issues in organizational decisions regarding the treatment of persons who smoked but he does not view his decisions with patients and smoking as reflecting ethical issues.

I don't see it as an ethical issue if you care for the whole patient: the physical, the mental, and the spiritual aspects. It follows the harm reduction model, where the individual is given information and is allowed to make choices based on the information, education, and teaching that is provided to them. I don't see it as an ethical dilemma.

Mark believes that education about smoking cessation is “first and foremost” in helping frontline staff to make decisions regarding their patients who smoke.

It's easy to walk into an environment and say, “You know, you shouldn't do that, it's bad for you.” But you also have to assess the needs of the patient.... Who am I sitting in front of, and how am I best going to get my

message across?... It's about making sure the patient is provided with options. In behavioral health I often see the anxiety increase, the assaults increase when options are limited.... The option may not be to smoke, but what other options are available?

And I think it's important to let the staff nurses know what their resources are...prior to going in with the client. Because if you don't go in with the tools for the job, your opportunity for success is less than if you have the tools.

Beth: It's a Disease

Can you call [providing care for smokers] an ethical decision? It's not a crisis or safety decision; it's not a moral issue. [Smoking is] a disease, a nasty disease. I am happy to support you [the patient], coach you, but I won't force my will on you.

I had to make the same decision for myself [to quit smoking], and it's not easy. Find the benefit and keep trying. I will support you, but you will be responsible for making the decision. We have the tools if the hospital will give me the time to use them, to be with the patient, to do my job.

Beth started working with addictions treatment and rehabilitation when that service was combined with a mental health unit. She sees addictions-affected patients who might be interested in quitting smoking, but they often make the choice to deal with their drug or alcohol addiction initially, because it is more challenging to address it concomitantly with smoking.

She notes the high correlation of smoking with alcohol and drug use, and believes that education is the answer. Her personal approach to her job is to supply the information so that the patient can make an informed decision regarding smoking cessation. "I don't tell you what to do, you kind of have to figure that out, and that's your responsibility. I will support you, coach you, listen to what you have to say, those kinds of things." She sees smoking as a direct

analogy to other issues that they are dealing with. “It’s compulsive, very compulsive.”

Beth quit smoking at least 15 years ago. She says she was a stress smoker. She did not smoke on the job, but when she got into the car at the end of a shift, she needed a cigarette. None of her family members smoked. She recalls going on vacation and smelling her clothes when she unpacked the suitcase from a family trip. The smell from the clothes is still a clear memory.

When Beth was away from work, she would try quitting. “The impulsivity and craving for a cigarette...is an addiction.”

She eventually quit with the help of a smoking cessation program. She notes that it has been a long time since then, yet she has the same stress level. Even though smoking was a coping mechanism, she sees quitting somewhat like recovery from other addictions. “When you can get...to the point where you don’t think about it and you want the benefits of not using more than using—to me that’s an integral part of quality sobriety.”

In considering smoking cessation for psychiatric patients, Beth sees working with them on using a nicotine patch or gum as different from working with patients who do not have psychiatric complications. She recalls that it was a much bigger issue when the hospital first became a nonsmoking facility. She says there was initially staff resistance to the change and she wondered if some of the resistance was driven by staff’s own habits and not patients. The staff tended to have the viewpoint of “why you can’t, rather than why you can.” They

also anticipated that the change to nonsmoking “would be much worse than what it ended up turning out to be.”

Beth believes that nurses have a high degree of control. She says:

We want to help people, we want to fix things, we want to make it better and make things right.... A good psychiatric nurse does regular checks of herself, however she does that. [You] look at your boundaries and where you cross over.... I think my big job is to support, promote [patients'] functioning as well as they can possibly function and...[being] as healthy as they can possibly be. Do I feel that not smoking is a much better way of health? Absolutely, positively, but for me to force my will on a person and say, “You have to, you must”...I don't approach things in that way.

Beth's personal and professional experiences greatly influence her attitudes toward smoking cessation. Beth recognizes smoking as an addiction and she emphasizes that personal choice will make the difference in the outcome for each person. Beth's view aligns with the theory of reasoned action, however: She appears to be less influenced by social pressure and bases her actions on her beliefs related to smoking outcomes for the patient.

Beth thinks that the concept of approaching decisions about smoking as ethical is interesting but cites those decisions as very different from safety or crisis situations where there can be no negotiation. “It seems to me that it's not an ethical issue, it's not a moral issue.... It's a disease and much like addiction.... It's a nasty disease that has many, many consequences.”

Beth recognizes that her hospital has made extra effort to do outreach education related to smoking cessation, with respiratory therapists coming once a shift to the unit. She thinks that nurses are fairly well educated about smoking and can apply their general knowledge to helping their patients; however, she

says the nurse–patient partnership can happen only if the nurse is able to get away from the computer. “It seems as though the practice is less time with the patient and more time just getting the paperwork done.... So, just having the time to...sit down and really work with your patients...smoking [cessation] can be part of that.”

She believes smoking is part of a bigger issue in this country and that we must do a better job of teaching our children about preventive health. Beth says:

We have a population in America that is obese. We are cutting back on the time outdoors, the time being active in the name of more technology in their heads. I’m against that. It’s important [to encourage] exercise and coping skills...[and to] try to quit smoking.

Annette: Why Do I Have to Put Up With This?

Why do I have to put up with this? I grew up with smoking and tolerated it in my own home. I am trying to do my job and enforce the rules at work...no smoking! It’s a nasty habit that makes you sick; please don’t make others sick from your smoke. I see that it’s hard to stop. It’s even harder when you are a person who lives with mental illness and have relied on smoking as a social connection.

I’m a nurse, and ethically it’s my job to promote holistic health. Can somebody help us to help our patients? Give us the tools to make this work so that people can be healthy and can have a better life.

Annette has worked as a psychiatric nurse for many years and has always been a nonsmoker. She immediately recalled a story from years before of an incident that happened when she worked in a state hospital in the southern U.S. At that time, nurses were not allowed to smoke on the psychiatric unit, but patients could go outside to smoke. Annette witnessed a nurse on the unit who was smoking in the nurses’ lounge/report room. When she confronted her coworker, he threatened her: “something to the effect of ‘if you report this, I’ll

deny it ever happened'...but he was basically threatening me that he'd get me fired." Her colleague threatened her, Annette believes, to protect his use of cigarettes.

Annette recalls another incident while working on an adolescent unit where smoking was not allowed. She remembers being kicked by an adolescent who was upset because she "busted" him when she searched him and found cigarettes hidden in his pants.

Her current hospital formerly had smoking rooms, and some of the more lenient nurses became upset with her when she would "go by the book" in enforcing the smoking times. "I couldn't stand the smoke room, and the lungs of the staff were not really considered." She notes that the situation is better since the hospitals became smoke free.

Annette reflects on the fact that the danger of secondhand smoke has been recognized for perhaps the last 20 years. She states that she has become more vocal with age about secondhand smoke. "I have five children and with successive pregnancies, I thought, why should I have to put up with this?" Annette grew up with a mother who smoked, and her husband smoked through the first part of their marriage. "As a young nurse and newly married, I think I just ignored it, but as the years went by, I became more militant and confrontational, both where the hospital allowed it and the staff allowed it."

Annette calls smoking "a nasty habit." She remembers confronting patients who continued to smoke even with cancer or a laryngectomy. Some

patients with mental illness use inhalers or nicotine gum and then smoke. “Then we have people who have been at our unit awhile, and it’s, like, ‘Look, you’ve been off cigarettes for one, two weeks, whatever, why don’t you stay off since you’ve gone through the worst of [nicotine withdrawal]?’” She recalls a homeless patient in her hospital who had stopped taking his psychiatric medications. “He said he couldn’t afford them, but he had enough money for a fifth of liquor and two packs of cigarettes.” She told him, “Your priority is the cigarettes.”

According to Annette, people with mental illness “may feel like [smoking is] a reward, it’s a pleasure, it’s a fix...and it’s a social component of a lot of groups, not just the mentally ill.”

Annette thinks that psychiatric care focuses on changing some out-of-control issues and tends to ignore the health problems such as smoking, obesity, and increased risk of diabetes related to use of some antipsychotic medications.

Ignoring the smoking can also limit housing options if a person needs a place to live and only nonsmoking residences are available, she notes.

We’ve come a long way.... They used to give the soldiers cigarettes as part of their rations in World War II.... I don’t know if society as a whole is frowning on [smoking] enough in the social context.... Just like they say you can’t dress a certain way out in public, it needs to be where smoking is considered lower class—“déclassé”—and not cool, because it’s still considered grown up and sophisticated [by some people].

Regarding smoking cessation interventions, Annette believes that health care providers’ efforts for people who have mental illness have not been effective. Despite the availability of medications, such as bupropion, varenicline, and the nicotine patch and gum, they require motivation to use them. She adds,

“We’ve had people smoking while they’re on the gum, smoking while they’re on the patch, so [treatment doesn’t always] work.”

Annette believes that ethically a nurse’s job is to promote holistic health. She thinks that nurses are not really well educated in tobacco cessation and that each nurse approaches it differently. “There has not been training for nurses in smoking cessation with the mentally ill.... That hasn’t been stressed as a priority in the care for our clients.”

Nurses need specific tools for working with psychiatric patients because they tend to not read the printed materials provided on smoking, according to Annette. In addition, the nurses need consensus on how to address tobacco cessation with these patients. Annette suggests that groups on smoking cessation might be helpful, with movies and visual aids.

Most importantly, [education] needs to be *real* and specific to persons with mental illness so that they actually *get* the message.... We need to find a way to reach them...and the general public too, because all the [antismoking] campaigns out there are not reaching them.... We still have our adolescents who are smoking, and those are usually the lifelong smokers. They think they’re invincible—“Well, I can quit anytime”—and *anytime* never comes.

Lee: Can I help you understand?

I’ve been there and taught it; I know what to do and am willing to help. I see the inequity of treatment. Please, can we offer the help that is needed? Can we help all people, including those who live with mental illness? Is there no hope for those people? Who gets to decide? I am high functioning and have not chosen to quit [smoking].

Lee formerly worked in a residential program that transitioned from smoking to smoke free. She participated in a pilot program when the state made

the change to nonsmoking facilities, and she was with a group of staff members who received “great” education about tobacco and addiction. Lee says after all of that, she still smokes, but she is attempting to quit.

Staff members were expected to model behavior at work. “You couldn’t smell of smoke; you couldn’t have paraphernalia like cigarettes or matches or anything in your pocketbook.”

Other residential programs did not agree with the change, which caused a problem in getting the no-smoking change through the courts. Therefore, court-mandated patients were allowed to choose other programs because they wanted to be able to smoke. Also, the state facilities could not change the smoking policy for people with mental illness, rather, only for people with addictions. “We could only change it for people with a higher level of functioning, not for people with schizophrenia and illnesses like that.”

Lee is challenged with patients who have chronic obstructive pulmonary disease (COPD) and other respiratory illnesses. “We try to get them to stop smoking.... That has been the biggest challenge, but I can’t remember one particular case.” She continues:

What sticks out in my mind is taking care of these people in my med-surg rotation who had severe, severe emphysema and COPD, and their whole personality was so fearful. What struck me about them was that they were very nervous all the time, but it was because they couldn’t breathe. It really left an image in my mind, that lack of breath changed a person to be very irritable all the time, very nervous, very panicky. I’m sure they were not always like that.... I’m sure that it’s because if you can’t get a breath and you don’t know when your breath is going to stop, when you’re gonna have to have some kind of treatment or something else just to be able to

give you a breath, you know it really changes a person. That's what sticks out for me.

They were always on the buzzers—the COPD patients...always on the call bell. They would drive you crazy! You're running back and forth, back and forth. And then it occurred to me why...that they were very, very afraid all the time because they couldn't breathe. I think it affects them on a lot of levels, and I think it changes a person.

Lee believes that her observation of these patients helped her to understand them better.

In her residential program the people with drug addiction did not think about their health, she says.

They have so many social problems that their health is the last thing they think about. You have to work really, really hard to get them to try to understand how to take care of themselves even a little bit. So it's a challenge to begin with, but when it comes to smoking, statistics are that [people who] stop their substances of abuse, if they stop their cigarettes at the same time and they continue to stay stopped, they have a greater success rate as far as reaching recovery and long-term recovery. The heroin addicts...they have a 45% greater chance of staying clean if they quit both.

Lee believes that having resources available, such as nicotine replacement therapy (NRT), was a key to not feeling conflicted in making decisions for her patients. "What really helped was we had a lot of NRTs available to us. We had [nicotine] patches, lozenges, Chantix [varenicline]." Lee recalled having psychiatrists "on board" with treatment and additional activity resources for patients. "The patients became involved in making posters and artwork. That was helpful—their buy-in. But...for nursing...you have to have the NRTs available."

That experience differs from her current position. Lee says:

You can't ask these patients 2 days later [after admission] if they want a patch...and that's what I see that happens here. We wait until treatment planning the following day for someone to initiate a patch when the patch should be initiated in the emergency room.... It drives me crazy!... They [Clinical managers] have no value for nonsmoking. This is a new position for me; I'm only here 3 months, and there's not one word about nicotine on this unit. Yep, we just give 'em a patch, leave the patch on.

Just yesterday I did a meeting with [patients]...to see how they're doing, and one girl said, "I just want a cigarette; I'm dying for a cigarette." So, I'm going to put in [a request] for some [smoking cessation] groups, some education, but it's strange to me that nobody thought of it until now.

Moving to this new job has been an interesting transition for Lee, especially in the approach to tobacco dependence treatment.

You can't even believe that there is such a difference...but health care here is very different. Where I was trained we had so much smoking information and education, and here there is such a lack of it. Patients deserve to have education and they deserve to be given their options, not just have a patch put on them.

Donna: I'm Looking for the Magic Wand

In a perfect world I would like for you not to smoke...but it's your right to decide. I would also like for you to stay healthy and to be independent. I will give you all the educated reasons to quit. But, do you see through the smoke to the clearing where the system does not offer you a better place, a better plan, a better life?

I am studying and learning, so work with me on this, and we will figure out a plan for you. What do you really want? How can I get you to want this decision for yourself as much as I want it for you?

Donna is a nonsmoker who works in a hospital that has transitioned to a nonsmoking environment inside the hospital, but the patients are allowed to go out of the building to smoke. Her state has instituted a wellness and recovery program that does address smoking, and because so many of her patients smoke, mental health staff members are trying to get everyone involved in a program to quit.

Donna does not feel conflicted about her decisions with clients, but she faces a few challenges with getting her program off the ground. Of the 50 residential clients (46 smokers) plus participants in the outpatient program, only about 7 people attend the wellness classes. Donna recognizes that participation is not up to what she would like but says “it’s a start.” Another challenge is keeping clients healthy when they go outside to smoke in the winter. In one client, pneumonia developed, so she is vigilant in helping them to stay healthy because she “really wants them to be independent.” Realistically, she knows “my idea of healthy and their idea of healthy obviously are very different, because in a perfect world I would like for them not to smoke.”

One of the positive outcomes is that Donna has been reading articles and doing her own research on smoking and people with mental illness. She is learning about monitoring for medication toxicity in clients who reduce or stop their smoking.

Donna shares some of what clients experience in her group:

We talk about ingredients that are put into cigarettes, how they affect the body, how it all affects them long term, short term, what kind of changes they can see even if they [only] decrease their smoking.... We initially do a test to...measure the carbon [monoxide], and we have seen in a few clients there appears to be a decrease, but it’s really difficult to track because these are not clients who come to every group. We don’t know if this [change] is...going to be long term or if they just say, “Okay, we’re going to try this” and then they decrease their smoking.... We don’t exactly know what the precipitate is prior to them coming into group. Having those decreased [carbon monoxide] numbers...I’d like to hope...that the education piece is helping them to decrease how they are smoking, but then...what are we going to substitute for it? That’s the challenge.

Donna emphasizes the education of her clients and the effect that smoking has on their medications by explaining that smoking interferes with medications so that the dosage of the medications must be increased. She and the psychiatrist provide medication counseling, and they include smoking education. "A lot of [clients] would like to reduce their medications.... We help them understand that if you want to decrease your medication, then you have to decrease your cigarette smoking." Donna shares that they draw pictures to explain how a decrease in smoking affects the nicotine receptors, and that this helps, especially for the clients who are visual learners.

Donna wants to make shared decisions with her clients, and she struggles with that when it comes to cigarette smoking.

They are individuals and they have rights to make those decisions, even though I might not want them to. And just for my spiritual peace...who am I to tell them to stop smoking? How dare I? Gosh, I struggle with that piece. I don't smoke myself and never have...and I understand that it's an addiction, but they're making a choice, and I know that I struggle with that piece.

Donna hopes that the education she provides will allow clients to make informed decisions.

Do they want to decrease their smoking or stop? But then...I also realize that when they smoke, it's part of their socialization, and I'm sure that when they smoke, they feel like they have control. It's not us telling them, "Oh no, you can't smoke; it's bad for you."... It's an addiction, so I'm sure it's also a struggle for them. I still do my part as a nurse in explaining it to them, and ultimately they have to make the decision. I think it reflects in the numbers when I say that I have 50 clients and 7 of them come to group. And all 7 of them aren't coming from my program.... It speaks to how many of them want to stop and...that we don't have anything to offer them if they do.

When asked what type of support might be helpful to her in caring for patients who smoke, Donna replies, “I think we have to come up with some really good incentive that’s going to appeal to them, not to me, but to them.” She further explains:

This is an ongoing project for us and I’m doing my own research because I realize I have to be able to offer them something different if I want them to stop smoking. I’ve been looking at literature over the last month, and while it tells me a lot of statistics and that there needs to be research done, I’m looking for someone to tell me [the solution]... I want the magic wand and for someone to say, “This is what we did, and this is how it worked.”

Ann: Treat Everyone the Same

I adjust to my environment and make decisions accordingly. I respect your right to make decisions about your own life and whether or not to smoke, but when you come to my unit, it’s no smoking, and we treat everyone the same. Treatment should be fair [and] equal, and we all follow the same rules.... It’s always the approach.

Ann, a nonsmoker, appreciates working in a smoke-free facility. Previously she worked in a health care facility that allowed smoking and says she used to come home smelling as if she “had been in a tavern all day.” Her experience as a former home health nurse was also sometimes difficult as a nonsmoker when she visited the homes of four patients, all of whom smoked. “It was their house and their rules, and I couldn’t tell them, ‘You can’t smoke while I’m here.’”

Ann estimates that 50% of her current patients smoke. She says, “It’s just a fact with the mentally ill.”

Hospital employees are not allowed to smoke and will be issued a ticket by hospital security if they smoke on the hospital campus, although she says the policy is not always enforced equally. One of her coworkers received a ticket for

smoking, whereas another witnessed an administrator smoking when the staff member accompanied security to transport a patient from the emergency room (ER) to the psychiatric unit. Security ignored the administrator's smoking and did nothing. Ann prefers fair treatment. "Treat everybody equally; it doesn't matter who's smoking, whether they're a housekeeper or an administrator...a smoker's a smoker."

Ann shared a story from the 1990s of a manipulative patient who was being admitted to her inpatient facility and demanded to have a cigarette upon her arrival. The facility allowed smoking at that time, but the times were based on a set schedule. "She was one of those patients who was very loud, boisterous, threatening, and demanding," yet she said that she respected Ann when she told her, "No, you're going to do the admission first" and "no, you're going to smoke at smoke time." Ann thinks that firm approach could be used with everyone.

Ann has "mixed emotions" around working with people who smoke. She does not believe in smoking, and she knows all the problems that it causes. At the same time, she does have compassion and thinks that we do need to provide some sort of help to quit smoking. Ann's decisions with patients who smoke are related to smoking cessation treatment. Because her facility is smoke free, they offer a choice of nicotine gum or a patch, with the dosage dependent on the number of cigarettes currently smoked per day.

Ann thinks that some kind of literature on smoking cessation might be helpful to nurses in her workplace, especially with caring for the psychiatric

patients who may be delayed in the emergency department. Psychiatric patients must be medically cleared before admission; therefore, they may be delayed in the ER for a few days before being transferred while they wait for an open bed on the unit.

Ann stresses that the staff does have compassion for people who smoke and that some coworkers are smokers.

Everyone at work is pretty compassionate with the smokers. [We say] “I understand, I know it’s tough...we know this is hard for you.”... We’re always on the side of the patient; we’re here to help, even the drunk, belligerent patient.... “We’re always on your side, but we do have to enforce the rules. We have to enforce the law.” It’s always the approach.

Mary: Give Them the Time

I’ve lived on both sides of addiction: as a nurse, as a patient. Driven by my craving, I’ve done dangerous things. Resistant to change, I defended smoking on my unit in the name of safety.... Don’t take away my ability to manipulate the patients!

Now, in the name of safety I defend my patients. I know it’s hard to quit, so we work at it as a team. I know this addiction firsthand. We have to make this meaningful, for the nurses to understand and, for goodness sake, give them the time to learn what is needed to be better partners with their patients, to help those patients heal.

Mary is a former smoker and has been a psychiatric nurse for many years. Her stories spanned her career and began back as an RN working on an inpatient unit. She describes “a very eclectic but standard psychiatric inpatient unit” that included a variety of patients who smoked. She describes her reaction to change as hospitals began to ban smoking.

I remember being in concert with those nurses who said, “What, are you kidding me? What do they want—a riot? It’s not safe now!” You know, what is that going to do for us? [No more being able to tell patients] “If you are a good boy or girl, you will not lose your cigarette break.”

Even then, we couldn't keep that rule because we knew what would happen if [the patients] didn't get a cigarette.... I don't know if I was smoking at that time, but as a former smoker, I thought, you've got to be kidding; I know what that addiction is like.

Mary shares her personal understanding of addiction to cigarettes:

Twenty-one years ago I was smoking, and I developed leukemia—acute myelogenous leukemia.... I was in laminar flow and I was undergoing a bone marrow transplant at the time. And not really understanding the laminar flow, my sister brought in a cigarette, and here we were lighting up behind this huge plastic bubble, and the smoke alarms went off.... So I know what that addiction is about.

And when I was at a hospital getting into remission, they let me smoke in the bed.... I was smoking in the bed coughing up globs of horrible stuff, and my sister said the cigarette was hanging from my mouth. I would go off into this Dilaudid [hydromorphone] sleep, and she thought I was going to burn the hospital down, and the nurses were okay with it.

And I understand—I've been there, I've done that; I've snuck the cigarettes. And when they finally let me go off the bone marrow transplant unit, I was looking through the ash cans for other people's stubs. So with that kind of framework, for me it was real easy to jump on the bandwagon [for smoking regulation].”

Now an ex-smoker who works at an outpatient community mental health clinic, Mary has a patient with chronic schizophrenia and obesity who smoked four packs of cigarettes a day and who requested a prescription for varenicline. Mary recommended that the patient first reduce the number of cigarettes smoked to about 30 a day. Together they developed a behavioral modification plan that included medication for impulse control. “He actually did get down from four to two packs, and his wife validated it because I put her in charge of the money for the cigarettes. I said, ‘Look how much money you're gonna save!’”

Regarding resources for nurses, Mary says, “I think we're not going to have a choice [about smoke-free facilities] so they need to be prepared; they

need to be educated.” Mary emphasizes the need for a good education in physiology and chemistry of the brain, including what nicotine does to the brain of a person with schizophrenia. As to which medium she thinks is most effective to educate nurses, she says, “In my practice, when I get the brochures or a clinical practice guideline, I think, Okay, I don’t even have time to figure this out. I’d much rather have a workshop.”

Mary thinks that some organizations believe that they support their nursing staff but do not give the nurses time to attend educational workshops. To them, she would say, “*Give them the time!* Spend the money to send them to these kinds of workshops so they can better assist our patients in healing!”

Mary went on to talk about former military personnel who were nonsmokers before they went away to war. “How many of them come back smoking? It’s one of the symptoms of PTSD [post-traumatic stress disorder]: increased use of substances. Nicotine is the number one.”

Mary refers any nurse who wants to see a military person with PTSD to the state’s Area Health Education Center. “It is awesome. They have an online learning module, and if you don’t get enough from that, they tell you where to get the live learning.”

She suggests that nurses can develop their own online learning materials.

Create a web-based approach with different populations of people: the chronically mentally ill, a post-deployed service member, pregnant teenager.... Create scenarios, then [apply] evidence-based approaches, and it could be online. It could be through a grant with the American Lung Association or other interested stakeholders. And that way a nurse could

access something that takes one hour...and get credit for it. But it needs to be good! It can't be boring.

An advantage of online education, such as through a state Area Health Education Center is the convenience, according to Mary. "You can do it at any time. If it's late at night or if I have a patient who did not show up, I can take an hour and finally learn how to be with this patient who smokes."

Angie: One More Thing for Us to Do

I have experienced the difficulties of dealing with smoking at home and at work. Not all good outcomes, but let me tell you about my patient who is fighting to be successful. I am so proud of him.

We don't make it easy for you: our patients, our [former military personnel]. We take away your cigarettes, and just when you might have a chance at really quitting, we stress you out, bring back the smoke breaks, and sabotage the good work that you and I started.

I am the outpatient team cheerleader—"keep those patches on; stay strong." I know you need more attention to this...it's frustrating. We do have really good programs for you, but we'll have to squeeze them in.

Angie is a psychiatric mental health nurse and a nonsmoker who works in an outpatient partial hospitalization program. She shares her personal and professional experiences of working with people who smoke.

My mother-in-law was...a heavy smoker, was diagnosed with lung cancer, and smoked until her death.... [She slept with] a down comforter and mattress, and a down blanket over her because she lost so much weight [and was cold].... [She] had oxygen on and would get up in the middle of the night for a cigarette. And our daughter who was in high school at the time [and staying overnight with her grandmother] called us in the middle of the night and asked, "Is Grandma supposed to be smoking with her oxygen on?" So I asked, "Where is she?" and my daughter said, "She's in bed." She was sitting with oxygen on, under feathers, on top of feathers, and smoking a cigarette. Needless to say, my husband and I packed up, moved in with her, and took turns staying up with her every night until she died because we could not get her to stop smoking.... And that was really, really difficult.

Professionally, Angie works with young and old people who previously served in the military, some recently returned from Iraq and some older ones with mental health diagnoses and PTSD. The hospital is smoke free but does have a smoke shack outside the facility that clients in the outpatient program use. The locked inpatient unit is nonsmoking and does not allow patients to go out to smoke. Many of the outpatients come to the partial hospitalization program from the inpatient unit and have been off cigarettes and not smoking for 1 to 3 weeks. The outpatient staff is then challenged with trying to keep those patients off cigarettes.

Angie leads the outpatient team in promoting smoking cessation to the patients.

I just want to be gung ho and say, "Yes, keep on those patches, and you've got a good jump start here. Let's not get back into smoking!"... They think they're going to be really strong... But the problem is that all these people are [under] high stress, and we run a program where we do group after group after group, with breaks in between, and, of course, they all take off for the smoke shack during breaks. More often than not [if they do quit], they return to smoking again.... It's just frustrating.

Angie shares one patient's struggle with smoking:

I have a gentleman right now who is in his early 40s, addicted to cocaine, heroin, and cigarettes.... He was really struggling because he wanted to quit everything at once because he could see the relationship between smoking cigarettes and it being a trigger to marijuana.... He really, really wanted to quit, so we talked about triggers, we did some breathing exercises, and we talked about what else he might be able to do when he was experiencing triggers. We talked about nicotine replacement, and as long as he was trying to stay sober from the drugs as well, he ended up staying at our facility. We have a dorm across the road and, rather than going home to his [family], he stayed there for the first week, and it helped him get a jump start.... We have a state quit plan and we referred him to that.

And for our [former military personnel], we set up an arrangement where instead of them calling the quit plan offices, we have the opposite where the quit plan calls them...without them having to take the initiative. Even though it's good for them to have the initiative, we also recognize that there's stress if you do return to smoking. With this gentleman, he has been back home and, even though he found out how hard it is, he's cut back to 1 cigarette a day. He stays in our room for the breaks, and we just give him a lot of praise for sticking around and for what he's doing. He doesn't hang out in the smoke shack with everybody else, and he has decided to keep going. Instead of returning home when he's done with our program, he's going to enter another 30-day program for dual diagnosis. That's...one of the success stories that...I'm so proud of, because I think he's really worked hard.

Mental health patients too often do not want to do the hard work of quitting smoking, Angie believes.

We hear that there's just no good time.... "I'm dealing with too much right now; this isn't the time to quit." And more often than not, I'll do my tobacco cessation program and...out of 30 people in our program I may have 1 or 2 every 2 weeks who show up for that, maybe 2 to 3. And out of those, more often than not, they say, "It's just too hard right now, too much stress, too overwhelming.... I'll quit when I'm done with the program.... I'll quit later."

However, she says it is possible that some patients quit after leaving the program.

We don't necessarily ask the people to quit smoking right away. We ask them to set a quit date—usually 3 weeks down the road—and then we start working with them to start practicing quitting and identify the triggers. We make a plan, and [they] practice quitting and then practice eliminating some of those triggers' times, and we ask what else they did that was helpful for them. So, oftentimes we don't actually get to see them when they've totally quit, nor do we get to find out that they really did. Sometimes they quit sooner than that but many times not.

In considering other ethical decisions, Angie believes that nurses sometimes find it easier to make decisions *for* patients regarding smoking cessation.

As nurses, we make the decisions for patients. “Okay, just go ahead and smoke; it’s better than going back [to] drinking.” I think that’s a hard one. I know there’s a theory now that if you’re going to quit [substance use], just quit everything at once, but in the past it was...quit one thing at a time.... Sometimes we still struggle with that when they say, “Oh, come on, it’s too stressful,” and we say “oh, okay” and we feel sorry for them and don’t address it.

Angie’s hospital had a smoking cessation program with nurses who did only tobacco cessation counseling, but she says that changed.

Somewhere along the way, they decided that each client area should have a designated nurse to work more one-to-one with the patients. And even though the one-to-one is really a good thing, we were asked to add that onto everything else that we do.... Clients come in for their 45-minute appointment, and there’s so much already to cover. Then add tobacco cessation, [and] it gets put on the back burner. To me, it seems that one of the things that would be most helpful would be to have designated [tobacco cessation staff] people to refer patients to, just for that purpose.

Angie feels fortunate to be able to offer nicotine replacement and ongoing smoking cessation treatment to her patients without the struggle over payment and preauthorization. She appreciates the available resources but wishes that more time was devoted to using them. Even though Angie likes the idea of offering a smoking cessation program to patients, she says, “I wish someone else could do it and do a better job of it and spend more time at it.”

Cindi: Going Against the Flow

I feel pretty powerless in my ability to change things for you here. I see inequities and feel bad after I support behaviors that I don’t believe in. I don’t agree with the crime and punishment mentality when staff uses smoking privileges to control you.... That’s not good.

I hear your complaints. This environment is unhealthy, with a smoking policy that forces you to breathe outside air that is not clean. I should speak with someone who has the power to change this. As a nurse practitioner, I do have the power to ask you about healthier behaviors and to give you support that I do not feel myself. I did it [quit smoking]!

I spoke up for you and for me and found the freedom to teach you better self-care.

Cindi is a nurse and a former smoker who works on an inpatient psychiatric unit. Currently she is attending graduate school to become a psychiatric mental health nurse practitioner. She describes an “incident of conflict of values” regarding supporting patients’ continued use of tobacco. “I really didn’t take the time to think about it before I did it,” she says, “and then later I felt like I probably shouldn’t have...done that.”

We had an older woman on our unit who was psychotic. She was having manic behaviors and she was being kind of taken advantage of by other peers [because] her family had brought her cigarettes. Our facility still allows smoking, not inside the building, but there’s a patio for smoking...at scheduled smoke breaks. And peers—they didn’t really steal her cigarettes but they kept asking to borrow cigarettes—and she would give them whole packs. So, in 2 days’ time she had gone through a whole carton of cigarettes....

My mental health technician felt badly for her and was telling me about it.... He said he was going to buy her a pack, and I donated to him buying a pack of cigarettes, which was only a dollar or two. But, afterward I thought oh, I supported that.... I felt kind of conflicted about it.

Cindi is not at all happy about having a smoking patio for patients:

I would rather that we have a smoke-free environment, just like all of the acute care hospitals in my area, and offer nicotine replacement at the time of admission and at any time that they need it.... The patio area is the only way for the [psychiatric patients] to get outside. It’s a small area and it’s fenced off. They really can’t stand out there and not be affected by secondhand smoke, because it’s really small. They complain [that] they’d like the opportunity to get outside; they just go out there for 15 minutes every 2 hours, but there isn’t anything provided for the people who don’t smoke. The activity therapy department takes patients outside about once a day in a much larger area. [Only certain] patients can do that according to their safety measures.... [Those patients] have the ability to do that, but *all* patients can go out to the patio.... I just don’t like that.

Cindi says smoking is used as a “paternalistic” means of control on her hospital’s psychiatric unit.

When we have patients who don’t do what they’re supposed to, and they smoke, the taking away of smoking privileges is a means of control. That’s not good either.... When that comes up, it’s usually a decision among the staff...like “we need to do something about this behavior” and sometimes that decision can be made without my input. It happens...almost every day.... I won’t say that I never participate. I just say I don’t agree with that. I don’t like the crime and punishment mentality that goes with it.

Cindi thinks about questioning the hospital’s smoking policy and approaching the administration.

I thought about just presenting some evidence to the corporation. It’s my understanding that most of their other facilities do not allow smoking. In our area we’re one of the few psychiatric facilities that still allow smoking on their campus.... Really, I should start within the hospital framework—the smaller management hospital staff—and if I can influence them....

Cindi’s hospital does not have a care plan for smoking. She says:

We have a question on our assessment...about whether they smoke.... I do ask, “Is it possible that while you are here, you might want to quit smoking? Even though you’re here for chemical dependency...studies show that you can quit both.” And I encourage them to ask their psychiatrist about it, and I offer: “If you’d like me to talk with your psychiatrist about it, I’d be more than happy to do that.” It’s not a routine; it’s not something we’re encouraged to ask about.

Education about smoking cessation is limited in Cindi’s facility. She leads a group about twice monthly on healthy lifestyles in which she focuses on smoking along with diet and sleep. There is also a technician-led group that meets twice a month that shows a video about smoking and uses visual teaching tools.

Cindi gets annoyed with the unrestricted use of smokeless tobacco in her hospital.

Smoking is allowed 15 minutes every 2 hours.... You're supposed to use smokeless tobacco during those same smoke breaks, but patients are using [smokeless tobacco] outside the smoke break times.... They are using the smokeless tobacco and going to smoke breaks. They're getting a whopping dose. I don't like it for that reason. I've walked in patient day rooms [and seen] cups sitting around with tobacco juice in them, and that's just a biohazard to me.

Cindi feels that she is lacking supportive resources in working toward a smoke-free environment other than having the *Journal of the American Psychiatric Nurses Association* and support from faculty and peers at school.

There is not a lot of support at my facility because we still have a lot of staff members who smoke, and they don't want to have that taken away from them—having to push toward a tobacco-free environment.... I don't really feel like I have lots of support.

Cindi followed up our interview with a story about one of her nursing colleagues who corrected her as Cindi counseled a patient on smoking cessation. Cindi did not address the behavior at the time but confronted her peer quietly and privately later and offered literature to support her teaching. Cindi's colleague refused the articles and has maintained a collegial relationship, but she no longer interrupts Cindi when she counsels patients about a healthier lifestyle.

Cindi is writing a paper about smoking and mental health, in hopes of educating other nursing colleagues.

I just don't know where to proceed. As a nurse practitioner I will continue to ask [patients] about their readiness to quit, and make available the behavior modification changes as well as the nicotine replacement.... I feel more comfortable about that.... At least that's something I can do individually.

Karen: We're Here to Support You

I just keep trying and hope that some day you will get it and will want to quit smoking. I am ready to support you when you decide that you want to live a healthier life. I will give you whatever you need—[nicotine] gum, patches, medication—because yesterday we taught some of you to smoke, then we used cigarettes to control your behavior. Now we see that you may have lived through wars, but this addiction is killing you. Not all nurses agree that smoking is bad, and some still use it therapeutically. I want you to hear me that I will do a better job. I am here and I am ready to help you quit smoking.

Karen is a nonsmoker who works on an inpatient unit in a government facility in a state that is “mostly smoke free.” Karen says that they “kind of get by with letting their patients smoke” because they maintain a smoke-free environment inside the hospital but allow patients to smoke on a porch attached to the unit. She says, “Our other psych hospital in town doesn’t allow them to smoke at all. They can have chewing tobacco and...[nicotine] gum and the patches, but they won’t let them smoke.”

Karen recalls the days in psychiatric mental health care when the staff rewarded patients by letting them go outside to smoke.

They’d get extra cigarettes if they followed whatever rules or boundaries were set for the day.... There’s kind of a similarity with our older [former military personnel] because it was the Army that got them smoking in the first place. They’d tell them “smoke if you got ’em”...and that’s the only way they’d get a break.”

Karen sees many patients, especially older people who previously served in the military, some with COPD and heart problems and psychiatric diagnoses. She is pleased that they can get consistent and ongoing treatment for free at

government facilities. “It’s awesome because then at least they’re getting all the meds and the follow-up care.”

All patients who come into the hospital for a medical, primary care, or psychiatric visit are asked if they smoke, how long they have smoked, and if they want to quit. Smokers are educated on how to quit and are offered nicotine gum or a patch. Varenicline is not normally offered because of the risk of suicidal ideation that has been correlated with people who are depressed or have mental illness. If a patient wants varenicline, that person is admitted until stabilized on the drug and then sent home.

Karen believes that many of their patients have been able to quit because of this support.

I think they do pretty good once they’ve decided to quit because we give them the meds and we support them...because it’s costing us more in the long run to have them smoke. We talk to them about quitting permanently, and we give them education about how much better it is for your body.... “If you want to quit, we can help you.”

Despite the hospital’s smoking cessation programs, some patients are unreceptive, according to Karen.

They’re just not going to quit smoking, especially the ones [who also] drink and dabble in every kind of drug you can think of. Some patients say, “No, I’ve smoked for 20 years, and I’m not going to change for you or the doctors,” and if you push it, they tell you, “Hell, no!” And sometimes after they’ve been admitted over and over, they get to the point where they can’t walk onto the unit without having to stop to take a breath. And you can use that relationship from all their [prior] admissions to say to them, “You know, you’re getting older.... Maybe it’s time to quit smoking and see how you do with that.”

How they respond varies, Karen says.

We get the ones who hit their 70s, and they've got heart problems and COPD, and sometimes they'll quit then or if they go into assisted living. Most of our assisted-living [facilities are] smoke free and...won't take them if they smoke. So sometimes that's a defining factor; once they can't function independently, they have to quit smoking. But if they have the choice, they'll often smoke.... It's kind of like the revolving-door patients.... We see them almost every month for years and years, and each admission you tell them the same thing. You hope that you give them a little more information and [that] the cumulative effect over multiple admissions will flicker the light in their head [so] they say, "Oh, now I get it."

Karen points out another danger of smoking for mental health patients.

She has seen smokers who receive different medical treatment because of their psychiatric diagnoses.

I've seen them turned down for heart surgery...that they needed because they smoke and...with mental illness...the surgeons will say, "Yes, he needs a CABG [coronary artery bypass graft]...but we're not going to do it until his schizophrenia or depression is stabilized...and then he's got to stop drinking and smoking." So we put him in an adult family home for a while, but I mean getting a [person with schizophrenia] to stop smoking [after] 40 years is a difficult thing.... We know how much worse it is for people with mental illness, just because their brain receptors are wired to fixate on that nicotine, and it's a more difficult addiction to kick [than for a person without mental health complications].

Karen has been trying to discourage staff from smoking with patients from the unit. Staff members who smoke are not allowed to leave the unit, so they smoke with the patients on the porch. Karen thinks that these staff members are sending the wrong message. "You wouldn't drink with the patients even though it's legal, so why are you going out and smoking with them? And in between puffs [the staff members are] saying to them, 'Smoking is bad, and you should probably quit.'" She finds that there is resistance among the nurses who do this

because, she believes, they do not want to lose their smoke breaks and “they don’t really see the harm in smoking with people who already smoke.”

Karen thinks as nurses, we can do better. She is conflicted that during the smoke breaks some patients really start talking.

I think it’s a good thing that they open up, but I think it’s not a therapeutic environment, and to make that connection...with someone around smoking is not the message that we want to be sending. I think we can do better. We can save the therapy, developing connections, and rapport for the unit in a safe environment... We need to be more aware of the message we convey outright or subliminally. We can’t ask them if they want to quit and then go out and smoke with them; that just takes the wind out of the sails of supporting cessation.

Regarding how to help the nurses make good decisions with their patients who smoke, Karen has this to say:

The hospital I worked at [previously] didn’t focus on smoking cessation at all, and we didn’t have a bunch of resources, so working [here] has been really nice. We have flyers, cards for the quit lines, the opportunity to offer the patch or gum anytime and Chantix or whatever if they want to try. And we have the support of the doctors and staff to say, “You need to stop smoking; this is not healthy for you.”

I think it helps to be consistent in that message that we can help you...and have all the staff on the same page rather than have the psychiatrists saying, “Well, we will get your schizophrenia stable first, and then maybe we’ll address [quitting smoking] once you’re stable.” Places I worked at before were like that.... At the [government facilities] you have to sign off that you’ve talked with the patient about [tobacco use] every time you meet with them. For me just having that support, and me not being the only one they hear it from, has made a huge difference.

Themes Within the Lived Experience

Reading the interviews, writing interpretive summaries, rewriting, and reflecting allowed the researcher to recognize and appreciate themes as they emerged from the stories. Van Manen (1997) suggests that through the process

of writing, reflection, and rewriting, themes will begin to emerge and the researcher can begin to gain insight and make sense of the data.

Ethical issues within the data were first identified, highlighted, and placed into categories. Some issues were identified as personal struggles with smoking and some were with family, staff, or patients. Some were categorized as organizational challenges. Each issue was assigned to one or more than one category. Stories were reviewed and data were discussed with content experts to confirm categories and to identify themes. Content experts included nurses with more than 20 years of research experience and with expertise in ethics and mental health.

Nurses who participated in this study were thoughtful in their responses, and in some cases telling the stories appeared to help them reflect on their own feelings around their experiences of caring for patients who smoked. Three themes emerged from participant stories: (a) each nurse's attitudes toward smoking and toward his or her job as a nurse (*going beyond basic obligations of duty as a nurse*), (b) navigating the institution or mental health system regarding smoking (*crime and punishment*), and (c) the patient's combined experience with smoking and having a mental illness (*double jeopardy*). This section presents the findings according to these themes.

Ethical issues within each theme involve values that will be identified and discussed within broad value categories that Weston (2001) refers to as "three families of moral values" (p. 68): goods, rights, and virtues. Goods might be

explained as that which provides well-being or relieves suffering, rights equals justice or fairness, and virtues involve the character of being a good person which manifests in our relationships at home and at work (Weston, 2001).

Theme 1: Going Beyond Basic Obligations of Duty as a Nurse

According to van Manen (2007), persons experience their “lifeworld” through lived time, space, body, and relationships. Stories of the lived experience of several nurse participants provided evidence that the nurses varied in their decisions regarding working with patients who smoke. These decisions varied based on the nurses’ values, their relationships, their personal experiences with smoking, and how they view their job as a nurse. For most study participants, nursing is more than a job, and advocating for their patients to have smoking cessation treatment is an expected part of good nursing care.

One participant, Donna, described how she cares about the well-being and health of her patients. She advocates for them to be actively involved in educational activities on the effects of smoking, and she always includes the benefits of quitting smoking while performing medication counseling. Angie is the unit cheerleader who likes to say, “Yes, keep on those patches, and you’ve got a good jump start here. Let’s not get back into smoking!”

Annette believes that ethically a nurse’s job is to promote holistic health. Karen believes that the nurse–patient relationship established from prior admissions can make a difference in encouraging patients to quit smoking. Karen also thinks that nurses “can do better” when it comes to setting an example with

patients. She said, “We can’t ask them if they want to quit and then go out and smoke with them; that just takes the wind out of the sails of supporting cessation.”

Mark acted out of respect and benevolence toward his patients when he decided to quit smoking because he recognized that his smoking affected his relationship with patients. He felt that smoking on breaks when patients were not allowed to smoke was unfair to them and made their stay somewhat more difficult.

Two nurses, Mary and Lee, spoke of their compassion with patients who smoke based on their own experience with smoking. Lee, a smoker, knows that it is difficult but possible to quit. She feels compassion toward her current patients and gets frustrated over inadequate attention to their need for help with smoking cessation. The delay in starting nicotine patch therapy until treatment planning the following day rather than in the emergency room, she said, “drives me crazy!” She also advocates for better treatment, saying, “Patients deserve to have education and...to be given their options, not just have a patch put on them.”

Cindi felt powerless to change her work environment, which does not support smoking cessation. However, she hopes to make a difference to her patients one-on-one, such as offering cessation counseling and nicotine replacement therapy. “At least that’s something I can do individually,” she stated. Butts and Rich (2008) suggest that what Cindi may be experiencing is moral suffering related to working in an environment that she believes must change for

the health and well-being of the patients. In addition to feeling unhappy about the hospital's smoking policy, Cindi may also experience moral suffering because she has acted in agreement with other staff members who have supported smoking behaviors or used smoking as a coercive means of control on her unit.

Nine nurses shared thoughts and experiences that this researcher would describe as driven by moral values that indicate that their dedication to patients goes beyond basic obligations of duty as a nurse. Nurses' actions provided evidence that even when they did not think in terms of making an ethical decision, they made choices driven by their values for the good of their patients.

Ethical issues within this theme crossed Weston's three families of moral values including decisions based on well-being and avoiding suffering, justice and fairness, and virtues that demonstrated regard for the nurse–patient relationship (2001). Working in an environment where smoking policies conflict with moral values may cause nurses to experience moral suffering (Butts & Rich, 2008) or moral distress (Corley, Minick, Elswick & Jacobs, 2005).

Theme 2: Crime and Punishment

Cindi recognized that smoking is still often used as a “paternalistic” means of control on her unit, by nurses taking away smoking privileges from patients who smoke when they do not do what they are supposed to. “I don't like the crime and punishment mentality that goes with it,” she said.

The lifeworld described by the psychiatric mental health nurses who participated in this study included their lived experiences with navigating their

work environment and the health care system. The theme of crime and punishment emerged as 10 nurses described day-to-day challenges with staff and patients smoking. Examples of coercion, inadequate time with patients, and lack of resources supported this theme as nurses told their stories of caring for patients who smoke.

Smoking has a long history in hospitals that serve persons with mental illnesses, and some nurses have used smoking to manipulate patient behavior. Karen recalled the days when psychiatric and mental health nurses would reward the patients by letting them go out and smoke or get extra cigarettes if they followed the rules and boundaries that were set for them.

Mary remembered years ago being in agreement with nurses who responded negatively to the idea of changing the unit to a smoke-free environment. She and the others thought the patients would riot and the nurses would lose their ability to promise a cigarette break in exchange for good behavior.

Participants also reported negative responses from colleagues with respect to staff or patient smoking. Annette recalled confronting a coworker who was smoking in a staff lounge. She felt threatened by his response: “something to the effect of ‘If you report this, I’ll deny it ever happened,’” which she perceived as him threatening to get her fired. She also remembered that some of the more lenient nurses used to get upset with her when she would “go by the book” in enforcing smoking times on the unit.

Many hospitals have transitioned to nonsmoking facilities; however, according to the nurses in this study, some hospitals still make smoking and smokeless tobacco available to patients, sometimes in hospitals that are considered smoke free. Angie said her smoke-free hospital has a smoke shack outside that clients in the outpatient program use, whereas the locked inpatient unit is nonsmoking and does not allow patients to go out to smoke. Many of the outpatients come to the partial hospitalization program from the inpatient unit, where they have not smoked for 1 to 3 weeks, and the outpatient staff is then challenged with trying to keep those patients from returning to smoking.

Cindi is unhappy that her facility provides a smoking patio for patients, rather than having a smoke-free campus like most other psychiatric facilities in the area. Furthermore, because the patio is small and the only place for patients to spend time outside, even for nonsmokers, everyone is exposed to secondhand smoke.

In addition, Cindi recognizes that the unrestricted use of smokeless tobacco in her hospital causes negative consequences for all patients and staff. She called the cups filled with tobacco juice sitting around the patient day rooms a "biohazard." She also noted that some patients both chew smokeless tobacco and smoke cigarettes, thereby getting a dangerously high dose of nicotine.

Ann shared that her organization changed to a smoke-free environment but that rules about smoking are not equally enforced. According to hospital policy, employees who smoke on the hospital campus are issued a ticket by

hospital security. One administrator was seen smoking but was ignored by security and reportedly received no ticket. Ann prefers fair treatment, saying, "Treat everybody equally...whether they're a housekeeper or an administrator, it doesn't matter who they are, a smoker's a smoker."

Organizational support for nurses to provide smoking cessation treatment and education varied across environments. Stories ranged from little or no support to stories of success and support for patients who want to quit smoking. Cindi believes she lacks support in her organization for moving toward a tobacco-free environment because many staff members smoke.

Lee also does not believe there is support for patients regarding quitting smoking. She finds it strange that nobody before her had proposed smoking cessation education and groups for patients. "They have no value for nonsmoking," she said.

Donna recognizes the outcome from lack of system support. Although she offers wellness classes to patients, including smoking cessation education, few come to the meetings. For those who do want to stop smoking, there are few good treatments or substitutes that staff can offer them, she said.

Karen and Angie shared some positive experiences working in a government-run health care system. Karen said many patients at her facility have been able to quit smoking because the facility offers much support, including assistive medical treatments. She said administrators in her system recognize

the cost-effectiveness of investing in smoking cessation resources and medicines “because it’s costing us more in the long run to have them smoke.”

Angie shared a success story for one of her patients. He was able to quit smoking in part because, as former military personnel, he benefited from an arrangement in which he received timely calls from the state quit plan offices.

Three nurses shared that lack of time was an issue in trying to provide adequate care to psychiatric patients who smoke. Beth felt that nurses were fairly well educated about smoking and could apply their general knowledge to helping their patients. However, at her facility, the time required to complete paperwork reportedly interfered with the nurse–patient partnership and took away time from working with patients on smoking cessation.

Smoking cessation treatment and education are expected with outpatient services delivered on Angie’s unit. However, Angie said it would be more effective if adequate time were allowed to provide needed support for patients. With only 45 minutes allotted for the client appointment and so much education to cover, she said that tobacco cessation counseling “gets put on the back burner.”

Mary referred to organizations that believe they support their nursing staff but do not give the nurse time to go to educational programs. Her plea was: “Give them the time!”

Two nurses shared success stories in helping their patients to quit smoking but most nurses in this study shared organizational challenges that limit

the extent to which they can effectively assist patients with smoking cessation interventions. Many of their experiences suggest that ethical situations cause frustration in attempting to deliver good nursing care. Within this theme of *Crime and Punishment* nurses described a range of ethical issues within Weston's (2001) three families of moral values including goods, rights, and virtues.

Nurses shared their experiences of working in hospitals that are smoke-free inside the hospital, but they either allow smoking on a porch or designated area outside the building, or they allow smokeless tobacco in the hospital in order to accommodate patients who smoke. In some cases, staff smoke with the patients and they are resistant to pressure from nonsmoking colleagues to eliminate smoking in support of smoking cessation treatment and promoting better health.

In his discussion of ethics, Weston (2001) describes many ethical situations that involve two sets of moral values with "pros" on both sides that should be debated to uphold good for both parties by taking a broader view of the situation and finding ways to connect moral values. He also says that there are some situations where moral values clash and negative moral values should not be given equal consideration. The latter is the case for hospitals that still accommodate smoking for their inpatient or outpatient programs.

Smoking cessation treatment must be reflected in policies as the standard of care in any health care environment for the well-being of all persons. Stories from the nurses indicate that tobacco use in the mental health setting does not

promote health for smokers or nonsmokers (goods); it continues a culture of coercion and lack of respect for patients (rights), and it undermines the nurse–patient relationship and the success of persons who would begin smoking cessation treatment during an inpatient or outpatient hospitalization (virtue).

In addition to showing a lack of respect for patients and for their well-being, nurses can experience moral suffering when they recognize that they cannot positively influence or change a situation that causes ethical stress related to the well-being of patients and staff (Butts & Rich, 2008). Corley et al. (2005) studied moral distress with 106 nurses and found that the ethical work environment predicted the level of moral distress experienced by the nurses. Findings from their study suggest that providing an ethical environment is an important factor in reducing ethical stress in the workplace. Hospitals can reduce moral suffering or distress for psychiatric mental health nurses by providing consistent policies that support nurses with time and tools to provide effective smoking cessation interventions for patients.

Theme 3: Double Jeopardy

Smoking for people with mental illness is double jeopardy. Persons with mental illness smoke two to three times more cigarettes than individuals in the general population (CDC, 2007), in part because they experience greater physical pleasure from smoking and in some cases they can control some symptoms of their mental illness with tobacco use (Ziedonis et al., 2003). In addition to the perceived positive effects of smoking, persons with mental illness

experience increased severity of withdrawal symptoms, which discourages them from quitting. Social factors also contribute to their higher rate of smoking (Ziedonis et al., 2003). This dichotomy creates circumstances that make it more difficult for persons with mental illness who smoke to make the choice for smoking cessation treatment and to live a healthier life.

Psychiatric mental health nurses who participated in this study demonstrated awareness that people with mental illness tend to smoke at higher rates than the general population. They acknowledged that environmental factors and sometimes staff behaviors continue to support smoking habits. Karen noted that smoking is a more difficult addiction to quit for persons whose brain receptors are wired to fixate on nicotine.

Donna observed that smoking may provide a sense of control for persons with mental health disorders. Both Donna and Annette reported that smoking is often a social component of groups for people with mental illness.

Another reason why mental health patients may smoke at higher rates could be smoking policies. Lee worked in a state that transitioned its state mental health facilities temporarily to smoke free but because there was resistance from some groups, the nonsmoking policy was only enforced for persons with addictive disorders and did not apply to persons with mental health disorders.

Annette believes that inpatient psychiatric care providers ignore the patients' smoking problem because they are more intent on trying to change patients' antisocial and out-of-control behaviors so they can integrate back into

mainstream society. She said, “Smoking does not affect that, so they don’t really focus on that.”

Karen has seen patients with psychiatric diagnoses treated differently in making decisions regarding their medical treatment. She has observed some psychiatric patients turned down for needed heart surgery on the grounds that they first had to have their mental illness stabilized and then must stop drinking and smoking.

It therefore should not be surprising that persons with mental illness die of tobacco-related causes an average of 25 years earlier than people in the general population if they smoke more, receive less help with smoking cessation, and sometimes do not qualify for life-sustaining medical treatment.

Some nurse participants recognized that they previously accepted smoking as normal behavior for people with mental health issues. They admitted at times they have supported the patients in continuing to smoke, rationalizing that it was otherwise “too stressful” or that they felt sorry for the patients. Cindi remembered feeling conflicted that she had once donated money to buy cigarettes for a patient who had given away all her cigarettes.

Stories shared by psychiatric mental health nurses in this study reflect attitudes and behaviors related to smoking that have supported unequal treatment of persons with mental illness. Some stories support nurses’ understanding of patients’ smoking as a social activity, for pleasure or to abate psychiatric symptoms. Other stories show smoking as a barrier to lifesaving

medical treatment. While it is true that smoking cessation is more difficult for persons with mental health symptoms and it takes them longer to quit smoking, it is also true that many persons with mental illnesses want to quit smoking and they are successful at doing so (Lawrence et al., 2011).

Inconsistent hospital policies and lack of knowledge of current evidence related to smoking and persons with mental illness have perpetuated attitudes that do not encourage smoking cessation and are not consistent with nursing ethics and equal treatment for all people. According to the *ANA Code of Ethics for Nurses With Interpretive Statements* (2001), nurses respect all persons and provide services to promote health and prevent illness. Psychiatric mental health nurses provide these services by establishing treatment priorities with the patient through the nurse–patient relationship. Weston’s (2001, 2002, 2009) approach to ethics would recognize the promotion of wellness and justice for the person as good moral values. It would also suggest that the nurse take responsibility for offering smoking cessation as a treatment priority and support the patient in their own self-discipline and participation in improving their own health.

Summary

Ten psychiatric mental health nurses from across the United States shared stories of their experiences in making ethical decisions regarding the care of patients who smoke. Nurses in this study described successes and failures as they managed their patients’ care within work environments that did not always promote health and well-being or equal treatment for all patients related to

smoking. Some experiences shared by nurses in this study indicated that efforts to promote health related to smoking cessation are diminished and nurses' moral distress or suffering may occur in environments where smoking policies conflict with personal and professional values. Psychiatric mental health nurses in this study suggested that having a smoke-free environment, more nurse and patient education specific to mental health and smoking cessation, as well as support for smoking cessation interventions would be helpful to them in making ethical decisions in working with patients who smoke.

CHAPTER 5. DISCUSSION OF FINDINGS, IMPLICATIONS, AND RECOMMENDATIONS

Chapter 1 provided an introduction and background for this research study: *Ethical Decisions of Psychiatric Mental Health Nurses Who Care for Patients Who Smoke*. Chapter 2 provided a literature review of the topic and Chapter 3 introduced the use of van Manen's method of human science research. Chapter 4, *Telling the Stories*, introduced the reader to the nurses who shared their lived experiences of making ethical decisions in caring for patients who smoke and described three themes that were framed by the research question. Chapter 5 will provide a summary of findings of this research study within van Manen's lifeworld and the theory of reasoned action; implications of the findings for nursing practice, education, and policy; and recommendations for future research.

The purpose of this study was to explore ethical decisions made by psychiatric mental health nurses who provide direct care to patients who smoke. The study focused on the research question "What is the experience of psychiatric mental health nurses making ethical decisions regarding patients who smoke?" The aim of the study was not an analysis of what decisions are made and how often, but instead it was about learning how values conflict in the day-to-day experiences of 10 psychiatric mental health nurses who care for persons

who are treated in the mental health system and are part of the largest group of individuals in the United States who still smoke. Through these experiences, the researcher hoped to gain insight into key issues that psychiatric mental health nurses experience in making ethical decisions in caring for patients who smoke.

A strength of this study was that it provided psychiatric mental health staff nurses a voice in the discussion of ethics and smoking cessation and an opportunity to share experiences that may help to influence better outcomes in mental health care for persons who smoke. A limitation of this qualitative study was the small number of psychiatric mental health nurse participants. Additional research could be done to replicate this study with a larger sample or to collect additional data through quantitative research methods that explore ethical decisions of psychiatric mental health nurses who care for patients who smoke.

Lifeworld: Experienced Body/Time/Space/Relationality

Max van Manen's (1997) human science approach meets human beings as they experience their lifeworld through lived body, time, space, and relationality. Nurses who participated in this study shared experiences related to their lived body, time, space, and relationships as described by van Manen.

Lived Body

Nurses shared their personal struggles with smoking as an addiction and the difficulty that some experienced in their own lives with trying to quit smoking. Lived body was also expressed through supportive caring behavior. Finally,

nurses described ways in which they helped patients to experience new ways of living and experience their own body in a new way without cigarettes.

Lived Time

Lived time was evident as stories spanned years and influenced changes in attitude for some nurses and changes in practice for many because of organizational smoking policies changing over time. Time for Annette changed her response to tolerating secondhand smoke when “she became more assertive” as a mother of five children. Time was an influencing factor for Mary, who told stories that spanned her career as a nurse, and described changes that occurred over time related to the health care system and the social acceptance of smoking. Within that context Mary shared stories of her own tobacco use and how her education, personal commitment, and professional responsibility moved her from cigarette addiction to becoming a champion for change with her patients related to smoking.

Some nurses mentioned inadequate time provided by organizations for training nurses to be effective in treating patients who want to quit smoking and for working with patients on smoking cessation. Time was also a factor in patient care: the time patients spent in groups and treatment, time until they could have another cigarette, time for patients to get fresh air without being subjected to smoke, and ultimately time for change. Nursing staff also needed time away from smoke or, if they were smokers, counted the time until they could have a smoking break.

Lived Space

Nurses spoke of lived space as an influential aspect in their stories. They spoke of their home space, their work environment, their personal space, and the space shared by patients and staff. Space also applied to the porches, patios, smoke shacks, smoking rooms, and other places that represented and invited smoking. Space could provide freedom from smoke or encroach on personal rights to fresh air without smoke. The inpatient unit was a place for treatment and for opportunity to recover from illness and addictions, including smoking.

Some nurses experienced moral conflict related to inpatient or outpatient space when it offered smoking as an option for psychiatric mental health staff or patients. Nurses shared their frustrations and concerns for a lack of attention to patients' health and well-being when the hospital provided space for smoking. This conflict of values caused some nurses to experience moral distress in their diminished ability to help patients achieve good outcomes related to smoking cessation and better health. These findings support previous research of nurses who experienced moral distress related to working in an environment that did not support ethical values (Corley et al., 2005; Corley, 2002).

Lived Relationality

Nurses shared stories of relationships with family, coworkers, and patients. Both positive and negative aspects of relationships were mentioned in this study. Some nurses told stories of their personal experiences with smoking and struggles with family members who smoked. Some relationships involved

conflict with staff members over smoking or using smoking privileges to manipulate patients. Other relationships supported and encouraged positive change and healthy behaviors. Some nurses shared that their own choices in relationships with coworkers and patients sometimes caused them ethical dilemmas related to tobacco use.

Weston (2001) discusses three families of moral values within ethics. The first involves choosing what is best for the well-being of others and/or what will reduce suffering. The second involves interdependence, equality, and respecting one another. The third is good moral character: Virtues that define who we are and what we do. Weston explains that virtues are revealed through our relationships with persons in our families and at work (2001). Stories of conflicting moral values were shared by nurses in this study and they sometimes caused tension in relationships with other nurses who wanted to smoke or to use smoking as coercion with patients. Ethical consideration must be given to others' rights, but in this case, the right to smoke, to use smoking for coercion, or to expose persons to secondhand smoke violates all three families of moral values described by Weston (2001). Smoking with patients and/or using coercive behavior with patients also violates the ANA's (2001) *Code of Ethics for Nurses With Interpretive Statements* which mandates nurses to be compassionate, be respectful of all persons, to do good, and to promote health.

Reasoned Action

According to the theory of reasoned action (Fishbein & Ajzen, 1975), an individual's beliefs about a behavior and its outcomes, as well as his or her perception of and motivation to comply with social pressure, influence that person's attitudes and subjective norms. Therefore, a psychiatric mental health nurse's beliefs about smoking and smoking outcomes for mental health patients, along with the nurse's perception of and motivation to comply with social pressure, influence the nurse's attitude and intention related to support for smoking cessation interventions.

Stories from nurses who participated in this study supported that personal beliefs about smoking, beliefs about smoking cessation outcomes for mental health patients, and the nurse's perception of and motivation to comply with social and organizational pressures did influence nurses' attitudes and intentions to support smoking cessation interventions.

Nurses in this study shared experiences that described smoking as part of the culture of psychiatric mental health inpatient units. They also shared stories of persons with mental illness as being disadvantaged in their efforts to quit smoking. Other nurses in this study shared stories of change and encouragement related to patients who were able to quit or reduce their smoking. Using the theory of reasoned action, psychiatric mental health nurses can change beliefs about smoking outcomes for persons with mental illness and they can influence expectations for psychiatric mental health nursing practice and

patient outcomes. Organizational expectations related to smoking cessation as a treatment priority can also influence nurses to offer smoking cessation to improve patient outcomes. Findings from this study related to the influence of health care professionals' attitudes on patient outcomes supports previous research (Danda, 2012; Howard & Holmshaw, 2010).

Recommendations for Nursing: Education, Practice, Policy, and Research

According to *Healthy People 2020*, tobacco is a leading health indicator that has been targeted to monitor improvement in the nation's overall health (USDHHS, 2012). In an effort to promote a healthier nation, the U.S. Department of Health and Human Services has developed a tobacco control strategic action plan to end the tobacco epidemic in the United States and to reduce the illness and premature death caused by tobacco use (USDHHS, 2012). The Substance Abuse and Mental Health Services Administration (SAMHSA) has joined this national effort and has outlined specific steps to reduce tobacco use among persons with mental health and substance use disorders (2011). Additionally, as of January 1, 2012, The Joint Commission added standardized quality measures to hospital accreditation standards for tobacco screening and intervention for all hospitalized patients (Chassin, Loeb, Schmaltz, & Wachter, 2010; The Joint Commission, 2012).

Knowledge specific to psychiatric mental health nursing practice and smoking cessation is limited in the nursing literature. Nursing research related to ethical conflicts and working with patients who smoke is even more limited.

Findings from this study support efforts to understand ethical conflicts experienced by this group of psychiatric mental health nurses who care for persons who smoke. In keeping with national initiatives and regulations, psychiatric mental health nurses should expect to see organizational support for smoking cessation as hospitals meet national requirements for standards of care. These efforts should result in more institutional support for smoke-free environments and should in turn reduce the level of moral distress for nurses who previously experienced a conflict of values.

Recommendations for Nursing Education

The Institutes of Medicine's Report, *The Future of Nursing: Leading Change Advancing Health* (National Research Council, 2011) recommends that nurses should practice to the full extent of their education and that nursing schools should provide evidence-based nursing education at the undergraduate and graduate level. Data collected in this study add to current evidence related to ethical conflicts experienced by psychiatric mental health nurses who care for patients who smoke. Findings from this study also support the need for more education in ethics for psychiatric mental health nurses. Two nurses in this study did not agree that decisions related to smoking involved ethics. Other nurses in this study shared experiences related to ethical decisions in caring for patients who smoke, but there was no support to improve situations where ethical conflicts occurred.

Psychiatric mental health nurses could benefit from increased knowledge of ethics and how to address moral distress in nursing practice. Pavlish, Brown-Saltzman, Hersh, Shirk, and Rounkle (2011) identified the need for more education related to nursing ethics in a study of nurses' descriptions of ethically difficult situations. Their study analyzed nursing priorities and actions and although some nurses were proactive in their actions, nurses in 21 cases did not pursue ethical concerns beyond providing standard care. Pavlish et al. specifically identified the need to teach nurses to advocate using evidence-based ethical interventions to identify and address moral conflict. Findings from this current study of ethical decisions of psychiatric mental health nurses who care for patients who smoke support current research related to the need for nursing education in ethics.

Nurses in this study identified a need for additional education in tobacco dependence and smoking cessation for psychiatric mental health nurses and for their patients. Psychiatric mental health nurses reported that they need smoking cessation education that is practical, effective, and specific to helping persons with mental health challenges to quit smoking. Undergraduate, graduate, and continuing nursing education on tobacco use and smoking cessation could enhance nurses' knowledge of tobacco dependence, assist nurses in clarifying their beliefs about smoking, and support all psychiatric mental health nurses in making ethical decisions to help patients to quit smoking.

Nursing education on tobacco dependence and cessation should be introduced at the undergraduate level in order to ensure that all nurses will be educated on the effects of tobacco dependence and will have the necessary tools to make evidence-based care decisions and to provide smoking cessation interventions. Nursing students should be introduced to the amplified effects of tobacco on persons who live with psychiatric symptoms and taught that medications and psychiatric mental health nursing interventions can be effective in helping patients to quit smoking (Morris et al., 2011).

Undergraduate nursing students should be introduced to the evidence-based protocol that is outlined for nurses in *Treating Tobacco Use and Dependence: Clinical Practice Guideline* (Fiore et al., 2008; Wewers et al, 2004), the document that has become recognized as the gold standard for smoking cessation assessment and treatment. Undergraduate nursing students should learn to incorporate the ask-advise-refer intervention process in order to improve nursing care decisions and outcomes for mental health patients who smoke.

The current version of the *Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum* (APNA & International Society of Psychiatric Mental Health Nurses Education Council, 2008) did not include tobacco as essential curricular content for nurses studying psychiatric mental health nursing at the prelicensure level. Psychiatric mental health nurse educators should update this document to include tobacco as an essential component of undergraduate psychiatric mental health nursing education. Introducing smoking cessation as a

treatment priority will guide nurses in their ethical decision making with patients who smoke.

Neurobiological implications of tobacco dependence and smoking cessation interventions must be emphasized in graduate content for psychiatric mental health nurses. The document *Treating Tobacco Use and Dependence: Clinical Practice Guideline* (Fiore et al., 2008) should be used by faculty to teach evidence-based protocol to psychiatric mental health nurses for assisting patients with smoking cessation. Psychiatric mental health nurses at all levels can incorporate the ask-advise-refer intervention process that is recommended in the clinical practice guideline. Graduate-level psychiatric mental health nurses will be influenced in making care decisions when they have been educated according to national guidelines for effective prescribing and managing medications and behavioral interventions to assist mental health patients with smoking cessation.

Tobacco dependence and smoking cessation education should be promoted through continuing nursing education for psychiatric mental health nurses. Nurses who are certified in psychiatric mental health must provide evidence of continuing nursing education in their specialty area in order to maintain their certification. Likewise, many states require evidence of continuing nursing education for state license renewal. Professional nursing organizations provide continuing nursing education in order to help nurses meet continuing nursing education requirements for certification and state licensure. This researcher recommends that professional organizations should offer continuing

nursing education in tobacco dependence assessment and smoking cessation treatment to support psychiatric mental health nurses in making care decisions that meet national initiatives to reduce and prevent tobacco use among persons with mental health and substance use disorders. Practical and current information on tobacco use and smoking cessation interventions through continuing nursing education would support previous school-based education on smoking cessation, fill gaps that may have occurred in previous smoking cessation education, and support continuing education needs for psychiatric mental health nurses.

Additionally, professional organizations should educate psychiatric mental health nurses to recognize that ethics is often involved in decisions that are made in the day-to-day care of patients who smoke. Weston (2001) suggests that learning about ethics involves exploring and challenging our own feelings about moral issues that might limit our ability to see another's view or to consider compromise in complex situations. Ethics is interdependent and it asks us not to accept just any change that is proposed but to recognize that we are part of a larger dialogue and to be open to change as we think things through together to determine what is right or good (Weston, 2001). With respect to smoking, nurses might consider several ethical questions: Why do some nurses not consider decisions with smoking related to ethics? Do persons with mental illness have the right to smoke? Should hospitals provide a place to smoke? What obligation does the mental health system have to persons who began smoking while they

were hospitalized? What about the rights of the people on an inpatient unit who do not smoke? Should nurses advocate for policy change in an environment that allows smoking?

Most continuing education in ethics for psychiatric mental health nurses focuses on safety or patient autonomy. Smoking cessation should also be considered an important ethical focus for continuing education considering the high impact of smoking on morbidity and mortality for persons with mental illness as well as the risk for conflict of values when smoking is allowed in the workplace as experienced by nurses in this study (Morris et al., 2011). Situations that cause ethical conflict will continue in nursing; however, teaching early identification and strategies for ethical intervention can benefit nurses, patients, and their families (Pavlish et al., 2011).

Professional nursing organizations provide accredited continuing education to address identified educational gaps based on current best evidence in nursing practice, research, and education. Data from this study support the need for continuing education related to ethics for psychiatric mental health nurses who care for patients who smoke.

Recommendations for Nursing Practice

Psychiatric mental health nursing practice must include the assessment of patients for tobacco use and treatment with smoking cessation interventions. Current standards of practice for psychiatric mental health nursing are outlined in the *Scope and Standards of Practice for Psychiatric Mental Health Nursing* (ANA,

APNA, & International Society of Psychiatric Nurses [ISPN], 2007) which mentions tobacco along with alcohol and other substances as a traditional focus in primary preventive mental health care. It is this researcher's position that psychiatric mental health nurses must approach the assessment of tobacco use and smoking cessation interventions as both a mental health treatment priority and an ethical priority if they hope to improve patient outcomes and reduce smoking in persons who use mental health services. Psychiatric mental health nurses can respect the autonomy of persons by partnering with each patient to set smoking cessation goals and to identify coping skills that will work for each individual who wants to quit smoking.

In 2013, the *Scope and Standards of Practice for Psychiatric Mental Health Nursing* (ANA, APNA, & ISPN, 2007) is being revised. This provides an opportunity for psychiatric mental health nurses to lead change on a national level by emphasizing the importance of smoking cessation interventions and by aligning psychiatric mental health nursing practice with the call to action against tobacco use as outlined by the U.S. Department of Health and Human Services' *Tobacco Control Strategic Action Plan* (2010) and *Healthy People 2020* (USDHHS, 2010).

The *Scope and Standards of Practice for Psychiatric Mental Health Nursing* (ANA, APNA, & ISPN, 2007) includes recommendations for psychiatric mental health nursing practice at the basic and advanced practice levels and it guides decisions that are made by nurses at all levels of practice. Psychiatric

mental health nurses adhere to the *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2001) and they look for additional guidance related to ethics in the specialty practice standards. The *Psychiatric Mental Health Nursing Scope and Standards of Practice* (ANA, APNA, & ISPN, 2007) is often used as a guide by hospitals and health organizations to develop policies and procedures for psychiatric mental health nursing practice within their organizations. Emphasizing ethical aspects of tobacco assessment and intervention provides an opportunity to influence nursing practice and to guide nurses in their practice decisions throughout the mental health system. Most importantly, this offers the potential to increase the success rate of smoking cessation and to produce positive health outcomes for mental health service users and for psychiatric mental health nurses.

Recommendations for Policy

According to the Centers for Disease Control and Prevention (2008), tobacco use remains the leading cause of premature and preventable death in the United States. The U.S. Department of Health and Human Services has responded with a strategic action plan that proposes strategies to meet the *Health People 2020* objective to decrease the adult smoking rate in the United States (USDHHS, 2010). Nearly half of the deaths from tobacco related illness occur in people who receive services in the mental health system. In order to meet the 2020 objective, all providers in the mental health system will need to

work together to support smoking cessation among persons who use mental health services.

Psychiatric mental health nurses who participated in this study indicated that efforts to provide successful smoking cessation interventions were sometimes not supported by facility- or system-level smoking policies. Some hospitals still allowed smoking on the inpatient unit during limited hours while some smoke-free hospitals provided a smoking area outside the facility for patients receiving inpatient or outpatient psychiatric mental health services. Other examples included hospitals that provided nicotine patches to patients who smoke without additional services to promote smoking cessation.

Psychiatric mental health nurses must advocate for change to a smoke-free policy for inpatient and outpatient units in order to align with national initiatives to reduce smoking in persons who receive mental health services. Nurses must also advocate for change toward organizational policy that supports an ethical work environment in which nurses can fully promote health without risk of moral conflict related to smoking. Nurses should also advocate for evidence-based treatments and support services in the hospital and after discharge in order to provide effective treatment for persons who wish to quit smoking.

Recommendations for Nursing Research

This study provides data to support two areas of nursing research: ethics and smoking cessation in psychiatric mental health nursing practice. The study also adds to the body of nursing research by providing findings from 10

psychiatric mental health nurses who shared their experiences with making ethical decisions in caring for patients who smoke. Stories included examples of day-to-day decision making that described ethical conflict with nursing staff, patients, and organizational policy in caring for patients who smoke. Research is needed to further explore ethical conflicts in psychiatric mental health nursing practice and ethical decision making related to smoking. A quantitative nursing study of ethical values in caring for persons who smoke could provide additional data to enhance understanding of the challenges experienced by psychiatric mental health nurses. Additional qualitative studies could explore how nurses respond to conflict of values in providing care with persons who smoke. Research in continuing education related to smoking cessation and ethical decision making could identify knowledge gaps for development of continuing nursing education for psychiatric mental health nurses; it could also support psychiatric mental health nurses in developing skills for ethical thinking and decision making.

Weston (2001) suggests that developing skills for ethical thinking takes work. He also says that many skills that we use for daily decision making can often be applied to ethics and those skills, when improved, will make us better at practicing ethics. Weston's (2001) approach to practicing ethics includes paying attention to and clarifying key moral values, using a questioning approach to consider all sides of an issue, using creativity in considering options, and finally making a decision based on what you have learned. According to Weston (2001),

making the decision to improve one's ethical practice is in and of itself an ethical decision.

Psychiatric mental health nurses need to recognize ethics in their day-to-day decision making in caring for patients who smoke. Incorporating ethics will strengthen nursing practice, improve outcomes for patients, and reduce the risk of moral conflict for psychiatric mental health nurses in making ethical decisions with patients who smoke.

APPENDIX A. INFORMED CONSENT FORM

Exploring Ethical Decisions of Psychiatric Mental Health Nurses Who Care For Patients Who Smoke INFORMED CONSENT FORM

RESEARCH PROCEDURES

In 2008, tobacco use continues to be the leading cause of illness and death in the United States. Tobacco kills more than 400,000 Americans each year and approximately half of them are people with serious mental illness. Nurses are the largest group of health care professionals and psychiatric mental health nurses are in a position to significantly influence the number of people who smoke. The purpose of this study is to explore ethical decisions made by psychiatric mental health nurses who provide direct care to patients who smoke. It is about listening to the day-to-day successes and failures of nurses who make decisions with patients around smoking or not smoking, an area of care that is not necessarily recognized for its presentation of ethical situations in mental health.

If you agree to participate, you will be asked to:

- Sign a consent form prior to being interviewed and return it via fax or email if interviewed by telephone
- Provide demographic information
- Participate in an audiotaped interview estimated to last up to one hour
- Review a summary of the interview and provide clarification of information if needed

To facilitate confidentiality or distance, you may be interviewed via telephone. Interviews will be scheduled at a time agreeable to you and the researcher. The audiotaped interview will be transcribed and you will be asked to confirm a summary of the information collected.

RISKS

The foreseeable risks or discomforts include discussion of ethical decision making and tobacco dependence.

BENEFITS

There are no benefits to you as a participant other than to further research in nursing.

CONFIDENTIALITY

The data in this study will be confidential. Email will be used to collect consent forms and demographic data. Your name will not appear on any data. In order to facilitate confidentiality, you will be asked to choose a name other than your own that will be used (as an identification key) on the demographic form and in the transcription and analysis of interview data. Only the researcher will have access to the identification key and only the researcher will be able to link your information to your identity.

You will have the option to return forms via email or fax. Electronic forms will be downloaded and stored on a removable drive that will be accessed by only the researcher. Consent forms with signatures will be stored in a locked file. Audio taping will be used to collect interviews. Identifiers on tapes will be coded and known only to the researcher. Tapes will be kept in a locked file accessible only to the researcher and once data is transcribed and analyzed, tapes will be destroyed. While it is understood that no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your transmission.

PARTICIPATION

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled.

CONTACT

This research is being conducted by the student investigator, Patricia Black, PhD(c), APRN, BC, College of Health and Human Services at George Mason University. She may be reached at xxx-xxx-xxxx. Jeanne Sorrell, PhD, RN, FAAN, College of Health and Human Services at George Mason University is the faculty advisor for this study. She may be reached at xxx-xxx-xxxx for questions or to report a research-related problem. You may contact the George Mason University Office of Research Subject Protections at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

CONSENT

_____ I agree to audio taping.

_____ I do not agree to audio taping.

I have read this form and agree to participate in this study

Name

Date of Signature

Version date:

APPENDIX B. DEMOGRAPHIC INFORMATION

EXPLORING ETHICAL DECISIONS OF PSYCHIATRIC MENTAL HEALTH NURSES WHO CARE FOR PATIENTS WHO SMOKE

Please complete the following form. For telephone interviews please email to Patricia Black xxxx@xxxx.xxx or you may fax to (xxx) xxx-xxxx.

Participant # _____

DEMOGRAPHIC INFORMATION

Please indicate the following:

Gender Male___ Female ___

Age _____

Highest Level of Nursing Diploma___ Associate___ BSN___ MSN___ PhD___

Number of years in nursing _____ (fill in)

Number of years in psych nursing _____ (fill in)

Practice setting Hospital Inpatient___ Outpatient___ Community Health___
Other_____

Do you work in a tobacco-free setting? Yes___ No___

Do you smoke? Yes___ No___ Former smoker Yes___ No___

Have you been educated to help patients quit smoking? Yes___ No___
If yes, was the training in school___ at work___

Does your workplace offer assistance with smoking cessation?
Yes___ No___

If yes, please complete the following: (mark all that apply)

Assistance for staff to quit smoking is offered in the form of:

Medication___ Individual Counseling___ Groups___

Assistance for patients to quit smoking is offered in the form of:

Medication___ Individual Counseling___ Groups___

Thank you for your participation.

Please contact Patricia Black (xxx) xxx-xxxx or xxxx@xxxx.xxxwith questions.

APPENDIX C. INTERVIEW GUIDE

Interview Guide

Participants will be asked the following:

Think back on your years of caring for patients who smoke. Can you think of an experience that stands out in your mind where you made a difficult decision about how to care for a patient who smoked? This might be an experience which caused you or the patient distress or one that you felt particularly good about. It might be a situation in which you felt a conflict of values. Can you tell me about that experience? Think of it as if you're telling me a story and include all the details of the incident that stand out in your mind.

- Once the participant has described the experience related to caring for patients who smoke, some of the following prompts may be used to encourage further detail:
 - How does this experience reflect ethical issues that you have faced as a psychiatric mental health nurse in caring for patients who smoke?
 - In thinking about this experience, or others in your practice, did you feel uncertain about making the best decision for your patient? Was there anything specific that helped you to resolve that situation?

- How does this experience relate to other ethical decisions that you face in caring for psychiatric patients who are hospitalized in a nonsmoking environment?
- What kinds of information or support would be helpful to you in making ethical decisions regarding the care of psychiatric patients who smoke?

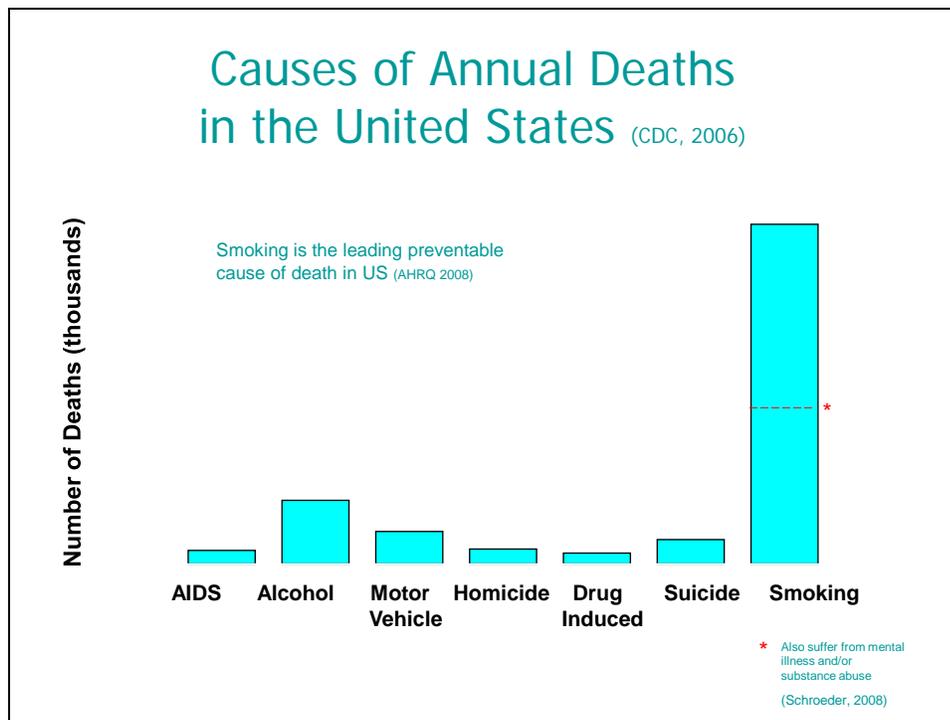


Figure C1. Causes of annual deaths in the United States. Presented at the APNA Smoking Cessation Leadership Summit by Steven Schroeder, MD, February 14, 2008. Used with permission.

APPENDIX D. INTERVIEW SUMMARIES

Summary 1: Mark

Mark is a former smoker who views making decisions about caring for patients who smoke as part of holistic care rather than ethical decisions. Mark's story took place some years before as a fairly new graduate working as evening charge nurse on an inpatient unit in a state psychiatric facility. He remembered doing admissions on the unit with patients who were usually in crisis and experiencing hallucinations, paranoia or anxiety that was "through the roof," especially if it was their first admission. In some cases if the patient was agitated, it was difficult to get through the admission process so after giving some preliminary information and assessing if the patient was a smoker, Mark would ask if they would like to have a cigarette.

Since the facility allowed smoking at that time, it was simple to walk 50 feet to the smoking room, sit down and have a cigarette with the patient and finish the admission. He noted that it put the patient in a more relaxed state. "And at the time I was a smoker and I would continue my assessment. During that time and I found that to be really helpful in kind of making that connection and building that rapport and also decreasing their anxiety and I got some pretty robust information from the patients during that time period...so it was beneficial in some instances."

Mark was also at the facility when it changed to nonsmoking. "...and that was a different challenge because now it was our job to provide education and nicotine replacement for the patient and I found that episodes of assault were no different; they were similar to when it was a smoking facility. I found that providing this person with information gave them the opportunity to kind of think about that behavior—the nicotine addiction."

Mark took that same opportunity himself to quit smoking. "I felt bad going on a break, coming back smelling like an ashtray after having a cigarette then going to talk with a patient and they would say, 'Oh, we can't smoke but how come you went and smoked.' So, I took that opportunity and it kind of gave me some insight to say, 'you know what, yeah, it's making their stay a little more difficult if I'm going against what they can't do.' So, I quit and used some of the same education and went to a training class with the American Lung Association, I

believe it was, and they provided us with education and information and teaching materials to help facilitate educating patients during that time.”

Mark believes that your level in the organization and your work environment can influence the ethical decisions that nurses make. “...if you are working within an organization and the organization is a smoke-free environment, then you have to provide that education and treatment and you have to monitor them for signs of nicotine withdrawal and give opportunities to share their feelings, thoughts and concerns. If you’re working in an outpatient clinic where you may be doing home visits, you can still provide the education, but that person has the free will and the choice to make that decision to smoke or not.”

Mark noted the inequity in the environment of a previous workplace “...the behavioral health department went smoke free and the rest of the inpatient organization was not, so patients who were on med surg or telemetry could get up and walk outside to have a cigarette and come back.” This caused a debate, “Are we treating the behavioral health patient differently than the acute care medical patient because the patient on our inpatient locked unit could not smoke but on the inpatient medical unit they could go out and smoke.” So there needed to be education throughout the organization that previous smoking times in behavioral health no longer existed and that patients needed that information prior to admission. In some cases, “when they sign the consent and when they realize that smoking is not permitted on the behavioral health units,...they may choose to go to a different facility.”

Mark does not view his decisions with patients and smoking as reflecting ethical issues. “I don’t see it as an ethical issue if you care for the whole patient the physical, the mental and the spiritual aspects. It follows the harm reduction model where the individual is given information and is allowed to make choices based on the information, the education and teaching that is provided to them. I don’t see it as an ethical dilemma.”

Mark believes that education on smoking cessation is “first and foremost” in helping front line staff make decisions regarding their patients who smoke. “Education...it’s easy to walk into an environment and say “you know, you shouldn’t do that, it’s bad for you.” But you also have to assess the needs of the patient. Are they a visual learner, a kinesthetic learner, an auditory learner? Who am I sitting in front of and how am I best going to get my message across? What message should I share with them? What message are they going to listen to? What terminology should I use? ...it’s about making sure the patient’s provided with options. In behavioral health I often see the anxiety increase, the assaults increase when options are limited. The option may not be you can go have a cigarette. The option might be that you can pace; what would you like to do? Incorporate that into a treatment plan. What helps you decrease anxiety?”

“...And the option may not be to smoke, but what other options are available? Do you think the patch might work, or gum might work? Would an inhalant work? ‘Well...I’m a coke user so the inhalant would probably trigger other thoughts.’...Okay, so how about a transdermal patch? Yeah, let’s try that...or you give somebody nicorette gum. Sometimes I’ll say to them, ‘there’s plenty of information out there...there’s *Nicotine Anonymous* that some of our addiction folks also go to. AA will give you opportunities to look into *Nicotine Anonymous* and get information and education from that peer support group.’ And I think it’s important to let the staff nurses know what their resources are... prior to going in with the client. Because if you don’t go in with the tools for the job your opportunity for success is less than if you have the tools.”

Summary 2: Beth

Beth started working with addictions treatment and rehabilitation when it was combined with a mental health unit. She sees that the addiction patient might be interested in quitting smoking but often makes the choice to deal with the addiction initially, not that they can’t do it concomitantly but it is more challenging for them to do so.

She noted the high correlation of smoking with alcohol and drug use with education as the answer. Her personal approach to her job is to supply the information so that the person can make an informed decision. “I don’t tell you what to do, you kind of have to figure that out, and that’s your responsibility. I will support you, coach you, listen to what you have to say, those kinds of things.” She sees smoking as a direct analogy to other issues that they are dealing with... “it’s compulsive, very compulsive.”

Beth quit smoking at least 15 years ago. She was a stress smoker; she did not smoke on the job but when she got into the car at the end of a shift, she needed a cigarette. She stopped and started and stopped and started to use a program and eventually did quit. She clearly recalled going on vacation and smelling her clothes when she unpacked the suitcase from a family trip. None of the family smoked and when she was away from work she would try quitting—the smell from the clothes was a clear memory... “the impulsivity and craving for a cigarette...it is an addiction.”

She noted that it’s been a long time and she has the same stress. Even though it was a coping mechanism she sees it somewhat like recovery from other addictions. “When you can get it to the point where you don’t think about it and you want the benefits of not using more than using—to me that’s an integral part of quality sobriety.”

In considering psychiatric patients, Beth sees it as different—working with them on using a nicotine patch or gum. She recalled that it was a much bigger issue when the hospital first went to nonsmoking. She noted the initial staff resistance citing that any kind of change is hard to make and that the staff tends to see “why you can’t rather than why you can” and also that staff anticipated that the change “would be much worse than what it ended up turning out to be.”

Beth believes that “nurses have a very high degree of control. We wanna help people, we wanna fix things, we wanna make it better and make things right and I think a good nurse, a good psychiatric nurse does regular checks of herself however she does that and look at your boundaries and where you cross over...and as I said I think my big job is to support, promote a person functioning as well as they can possibly function and to be as healthy as they can possibly be. Do I feel that not smoking is a much better way of health? Absolutely, positively, but for me to force my will on a person and say you have to, you must...I don’t approach things in that way.”

Beth thought that approaching decisions about smoking as ethical was interesting and cited those decisions as very different from safety or crisis situations where there can be no negotiation. “...it seems to me that it’s not an ethical issue, it’s not a moral issue; it’s a disease. It’s a disease and much like addiction...it’s a nasty disease that has many, many consequences.”

Beth noted that her hospital had really made an effort to do outreach education with respiratory therapy coming once a shift to the unit. She also noted that it’s a team effort in working with the clients since nursing has a different approach. Beth felt that nurses are pretty well educated about smoking and can apply their general knowledge to their patients however she also noted that the nurse patient relationship can only happen if the nurse is able to get away from the computer... “it seems as though the practice is less time with the patient and more time just getting the paperwork done...so, just having the time to really sit down and really work with your patients...and smoking can be part of that.”

She cited this as part of a bigger issue in this country and that we must do a better job of teaching our children. “We have a population in America that is obese. We are cutting back on the time outdoors, the time being active in the name of more technology in their heads. I’m against that. It’s important—exercise and coping skills—it’s important. Physical exercise, try to quit smoking; physical exercise is a good part of that too.

Summary 3: Annette

Annette has worked as a psych nurse for many years and has always been a nonsmoker. She immediately recalled a story from years before of an incident that happened when she worked in a state hospital in the southern U.S. At that time nurses were not allowed to smoke on the psych unit but patients could go outside to smoke. Annette witnessed a male nurse on the unit who was smoking in the nurses' lounge/report room. When she confronted her co-worker he threatened her "something to the effect of 'if you report this, I'll deny it ever happened'...but he was basically threatening me that he'd get me fired." She recalled that nurses at that time in some hospitals did smoke in the report areas but in this hospital it was breaking the rules and he threatened her to protect his use of cigarettes.

Annette recalled another incident while working on an adolescent unit. People were not allowed to smoke on adolescent units and she remembered being kicked by an adolescent who was upset because she "busted" him when she searched him and found cigarettes hidden in his pants.

Her current hospital used to have smoking rooms and some of the more lenient nurses used to get upset with her when she would "go by the book" in enforcing the smoking times. "I couldn't stand the smoke room and the lungs of the staff were not really considered." She noted that it is better since the hospitals are smoke-free but mentioned that one nurse has asthma which she did not have before.

Annette reflected on the fact that second hand smoke has only been recognized as equally as bad as smoking for maybe the last 20 years and she stated that she has gotten more vocal as she has gotten older. "I have 5 children and with successive pregnancies I thought, why should I have to put up with this?" Annette grew up with a mother who smoked and her husband smoked through the first part of their marriage (when company visited and never in her car). "As a young nurse and newly married, I think I just ignored it but as the years went by, I became more militant and confrontational both where the hospital allowed it and the staff allowed it."

Annette calls smoking "a nasty habit" as she recalled confronting patients who continued to smoke even with cancer or a laryngectomy. Some patients with mental illness use inhalers or gum and then smoke. "And then we have people who have been at our unit a while and they've been on the gum with a patch and it's like 'look you've been off cigarettes for one, two weeks, whatever, why don't you stay off since you've gone through the worst of it'." She had one homeless gentleman recently who was in the hospital and off his psych meds. He said he couldn't afford them "but he had enough money for a fifth of liquor and 2 packs of

cigarettes” and she told him “well, your priority is the cigarettes.” Annette thinks that psychiatric care focuses on changing other out-of-control issues and tends to ignore the smoking problem just like obesity from some antipsychotics or increased risk of developing diabetes. But then ignoring the smoking can also cause issues with housing options if a person needs a place to live and the only available places are nonsmoking.

“And the mentally ill may feel like it’s a reward, it’s a pleasure, it’s a fix...it’s not mind-altering like the drugs, but it’s something they can rely on as opposed to a relationship...and it’s a social component of a lot of groups, not just the mentally ill.... We’ve come a long way...but they used to give the soldiers cigarettes as part of their rations in WWII. I talked to one person who said he used to barter his cigarettes for extra food ’cause he wasn’t a smoker...and it’s...I don’t know if society as a whole is frowning on it enough in the social context. I know they’re saying it in restaurants...but just like they say you can’t dress a certain way out in public, it needs to be where smoking is considered lower class—“déclassé” and not cool because it’s still considered grown up and sophisticated.”

Regarding interventions, Annette believes that what we’ve done with people who have mental illness has not been effective. We have welbutrin, chantix, the patch and gum but the person has to be motivated to use them. “We’ve had people smoking while they’re on the gum, smoking while they’re on the patch so it doesn’t work.”

Annette believes that ethically a nurse’s job is to promote holistic health. She thinks that nurses are not really well educated in tobacco cessation and that each nurse approaches it differently. “There has not been training for nurses in smoking cessation with the mentally ill...that hasn’t been stressed as a priority in the care for our clients.” She believes that nurses need specific tools to use with psychiatric patients since they do not tend to read the printed materials provided on smoking and the nurses need to have consensus on how to address tobacco cessation with them. Annette suggested that groups on smoking cessation might be helpful with movies and visual aids. Teaching should be limited to 10-15 minutes to keep their attention and attendance might be better if it is mandatory. Most importantly it needs to be “real” and specific to persons with mental illness so that they actually “get” the message. “...we need to find a way to reach them...and the general public too, because all the campaigns out there are not reaching them ’cause we still have our adolescents who are smoking and those are usually the life-long smokers.” “They think they’re invincible... ‘well I can quit anytime’ and anytime never comes....but I don’t know what that effective plan is...”

Summary 4: Lee

Lee worked in a residential program that transitioned from smoking to smoke free. She participated in a pilot program when the state made the change to nonsmoking so she was with a group of staff members who “went on retreat and got this great education about tobacco and addiction.” Lee says after all that she still smokes, but she’s working on it.

As a staff member, they were not allowed to be identifiable smokers at work. “...you couldn’t smell of smoke, you couldn’t have paraphernalia like cigarettes or matches or anything in your pocketbook. You could not smell like smoke and walk in there.”

Unfortunately, the other residential programs did not buy in to the change which caused a problem in the courts. Many of Lee’s patients were court mandated and they no longer wanted to go to that program because they wanted to be able to smoke. Also, the state could not change policy for people with mental illness. They could only change it for people with addictions. “We could only change it for people with a higher level of functioning not for people with schizophrenia and illnesses like that.”

Lee said that she is challenged with patients who have COPD and respiratory illnesses... “we try to get them to stop smoking...that has been the biggest challenge, but I can’t remember one particular case.”

“What sticks out in my mind is taking care of these people in my med surg rotation that had severe, severe emphysema and COPD and their whole personality was so fearful and what struck me about them was that they were very nervous all the time but it was because they couldn’t breathe. And it really left an image in my mind like that lack of breath changed a person to be like very irritable all the time, very nervous, very panicky and I’m sure they were not always like that.... I’m sure that it’s because if you can’t get a breath and you don’t know when your breath is going to stop when you’re gonna have to have some kind of treatment or something else just to be able to give you a breath, you know it really changes a person—that’s what sticks out for me.”

“They were always on the buzzers; the COPD patients...they were always on the call bell. They would drive you crazy! You’re running back and forth, back and forth and then it occurred to me why...that they were very, very afraid all the time because they can’t breathe. I think it affects them on a lot of levels and I think it changes a person.

Lee believed that her observation of these patients helped her to understand them better.

In her residential program the drug addicts didn't think about their health. "They have so many social problems that their health is the last thing they think about. You have to work really, really hard to get them to try to understand how to take care of themselves even a little bit. So it's a challenge to begin with, but when it comes to smoking, statistics are that a person who puts down cigarettes and they stop their substances of abuse, if they stop their cigarettes at the same time and they continue to stay stopped, they have a greater success rate as far as reaching recovery and long term recovery. The heroin addicts...they have a 45% greater chance of staying clean if they quit both.

Lee felt that having resources available was a key to not feeling conflicted in making decisions for her patients. "I'll tell you what really helped was we had a lot of NRT's available to us. We had patches, lozenges, Chantix. We had psychiatrists on board where they wrote Chantix; we had a lot of resources. We had posters. There was a tremendous push...the patients became involved in making posters and artwork. That was helpful—their buy-in. But I would have to say for nursing it was...you have to have the NRT's available. You can't ask these patients 2 days later if they want a patch...and that's what I see that happens here."

"We wait till treatment planning the following day for someone to initiate a patch when the patch should be initiated in the emergency room. So that's...it drives me crazy! There is no...they have no value for nonsmoking. This is a new position for me; I'm only here 3 months and there's not one word about nicotine on this unit. Yep—we just give 'em a patch, leave the patch on...."

"Just yesterday I did a meeting with them, I do groups with them—I actually like to do morning meetings to see how they're doing and one girl said, I just want a cigarette; I'm dying for a cigarette so I'm going to put in for some groups, some education—but like it's strange to me that nobody thought of it until now."

Moving to this new job has been an interesting transition for Lee especially in the approach to tobacco dependence treatment. "You can't even believe that there is such a difference—there's only a river between us, it's only over a bridge but health care here is very different. Where I was trained we had so much smoking information and education and here there is such a lack of it. Patients deserve to have education and they deserve to be given their options, not just have a patch put on them."

Summary 5: Donna

Donna is a nonsmoker who works in a hospital that has transitioned to a nonsmoking environment inside the hospital but the patients are still allowed to

go out of the building to smoke. Her state has instituted a wellness and recovery program that does address smoking and because so many of her patients smoke they are trying to get everyone involved in a program to quit smoking. She described the classes, 1-2 per week that address smoking cessation and what can be done.

Donna does not feel conflicted about her decisions with clients but there are a few challenges that she faces with the getting the program off the ground. Of the 50 residential clients (46 smokers) plus participants in the outpatient program, only about 7 people attend the classes on average. Donna recognizes that they're not seeing as many people participate as they would like to see but it's a start. Another challenge is keeping clients healthy when they go outside to smoke in the winter time. One client developed pneumonia so she is vigilant in monitoring them so that they stay healthy because she "really wants them to be independent." Realistically she knows "at the same time we want them to be healthy and my idea of healthy and their idea of healthy obviously is very different because in a perfect world I would like for them not to smoke."

One of the positive outcomes is that Donna has been reading articles and doing her own research on smoking and people with mental illness and she has been learning about monitoring for medication toxicity in clients who reduce or stop their smoking.

Donna shared some of what clients experience in her group, "we talk about ingredients that are put into cigarettes, how they affect the body how it all affects them long term, short term, what kind of changes they can see even if they decrease their smoking. When they come in, we initially do a test to kind of measure the carbon and we have seen in a few clients there appears to be a decrease but it's really difficult to track because these are not clients who come to every group." "We don't know if this is something that's going to be long term or if they just say, 'okay we're going to this' and then they decrease their smoking...we don't exactly know what the precipitate is prior to them coming in to group. Having those decreased numbers...I'd like to hope and think that the education piece is helping them to decrease how they are smoking but then it goes back to what are we going to substitute for it—that's the challenge.

Donna emphasizes the education of her clients and the effect that smoking has on their medications. Smoking interferes with medications so the dosage of the medications needs to be increased. She and the psychiatrist do medication counseling and they include smoking education. "We meet with them so that in counseling—we've incorporated the smoking piece. And a lot of them would like to reduce their medications; and they say that to us. But then we help them understand that if you want to decrease your medication then you have to decrease your cigarette smoking." Donna shared that they draw pictures to

explain how the decrease in smoking affects the nicotine receptors and that it helps especially for the clients who are visual learners.

Donna wants to make shared decisions with her clients and she sometimes struggles with that when it comes to cigarette smoking... “they are individuals and they have rights to make those decisions, even though I might not want them to and just for my spiritual peace for me—who am I to tell them to stop smoking, how dare I ? Gosh, I struggle with that piece and I don’t smoke myself and never have...and I understand that it’s an addiction but they’re making a choice and I know that I struggle with that piece.”

Donna hopes that the education that she provides will allow clients to make informed decisions. “Do they want to decrease their smoking or stop? But then there are a couple of things that I realize too. I also realize that when they smoke, it’s part of their socialization and I’m sure that when they smoke they feel like they have control. It’s not us telling them ‘Oh no, you can’t smoke; it’s bad for you’...and it’s an addiction so I’m sure it’s also a struggle for them. I still do my part as a nurse in explaining it to them and ultimately they have to make the decision. I think it reflects in the numbers when I say that I have 50 clients and 7 of them come to group. And all 7 of them aren’t coming from my program; they’re coming from another program as well. But I kind of think that it speaks to how many of them want to stop and the fact that we don’t have anything to offer them if they do stop.

When asked what type of support might be helpful to her in caring for patients who smoke, Donna replied “I’d say I think we have to come up with some really good incentive that’s going to appeal to them—not to me, but to them.” She further explained “This is an ongoing project for us and I’m doing my own research because I realize I have to be able to offer them something different if I want them to stop smoking. I’ve been looking at literature over the last month and while it tells me a lot of statistics and that there needs to be research done, I’m looking for someone to tell me...like you said, I want the magic wand and for someone to say ‘this is what we did and this is how it worked’.”

Summary 6: Ann

Ann is a nonsmoker who currently works in a smoke-free facility and enjoys doing so. She previously worked in a facility that allowed smoking and said that she “used to come home smelling like she had been in a tavern all day.” Her experience as a former home health nurse was also difficult at times as a nonsmoker when she visited homes where people smoked. Currently probably 50% of her patients smoke.

Ann shared a story from “back in the ’90s” of a patient with borderline personality disorder who was being admitted into her inpatient facility and demanded to have a cigarette when she arrived. The facility allowed smoking at that time but the times were based on a set schedule. “She was one of those patients who was very loud, boisterous, threatening and demanding yet she said that she respected Ann when she told her ‘No, you’re going to do the admission first and no, you’re going to smoke at smoke time.’ Ann thinks that approach could be used with everyone.

Ann says she has “mixed emotions” around working with people who smoke. She doesn’t believe in smoking and she knows all the problems that it causes. At the same time she does have compassion and she thinks that we need to provide some treatment. Since her facility is smoke free they offer patients the choice of nicotine gum or a nicotine patch with the dosage dependent on the number of cigarettes currently smoked per day.

Employees are not allowed to smoke and will be issued a ticket by hospital security if they smoke on the hospital campus, although the policy is not always enforced equally. One of her coworkers received a ticket for smoking and another witnessed an administrator smoking when they accompanied security to transport a patient from the ER to the psychiatric unit. The administrator was ignored by security and nothing was done. Ann does not think this is fair treatment. “Treat everybody equally, it doesn’t matter who’s smoking, whether they’re a housekeeper or an administrator, it doesn’t matter who they are, a smoker’s a smoker.”

Ann thought that some kind of literature on smoking cessation might be helpful to nurses in her workplace, especially with the psychiatric patients who may be delayed in the emergency department. Psych patients must be medically cleared before admission so they may be delayed in the ER for a few days before being transferred while they wait for a bed to open on the unit.

Ann stressed that the staff does have compassion for people who smoke and that some co-workers are smokers. “Everyone at work is pretty compassionate with the smokers, you know “I understand, I’m a smoker too, I know it’s tough...we know this is hard for you...” and we know what this is like for you. We’re always on the side of the patient; we’re here to help. Even the drunk belligerent patients...we’re here to help you. Yeah, I know you have to stay here till you get down to a legal level and you’re no longer suicidal. You said that out of a moment of haste...and we’re always on your side but we do have to enforce the rules. We have to enforce the law. It’s always the approach.”

Summary 7: Mary

Mary is a former smoker and has been a psychiatric nurse for many years. Her stories spanned her career and began back as an RN working on an inpatient unit. She described “a very eclectic but standard psychiatric inpatient unit” that included a variety of patients who smoked. She remembered her reaction to change as hospitals began to regulate smoking. “...I remember being in concert with those nurses who said ‘What, are you kidding me? What do they want—a riot? It’s not safe now!’ You know, what is that going to do for us? ‘If you are a good boy or girl, you will not lose your cigarette break.’”

“Even then, we couldn’t keep that rule because we knew what would happen if they didn’t get a cigarette. And the smoking...and I don’t know if I was smoking at that time but as former smoker, I thought, ‘You’ve got to be kidding—I know what that addiction is like.’”

Mary shared her personal understanding of addiction to cigarettes. “Twenty-one years ago I was smoking and I developed leukemia—acute myelogenous leukemia and I have the funniest story.... I was in laminar flow and I was undergoing a bone marrow transplant at the time. And not really understanding the laminar flow, my sister brought in a cigarette and here we were lighting up behind this huge plastic bubble and the smoke alarms went off...so I know what that addiction is about.”

“And when I was at [Named] hospital getting into remission, they let me smoke in the bed; this was 1988. I was smoking in the bed coughing up globs of horrible stuff and my sister said the cigarette was hanging from my mouth. I would go off into this dilaudid sleep and she thought I was going to burn the hospital down and the nurses were okay with it.”

“And I understand—I’ve been there, I’ve done that I’ve snuck the cigarettes. Here I was at risk for aspergillus with a bone marrow transplant and what they did to you back then. I was on methotrexate, cyclosporine, massive doses of any kind of corticosteroid you can think of and I’m out there and I’m all masked up and when they finally let me go off the BMT unit, I was looking through the ash cans for other people’s stubs. So with that kind of framework for me it was real easy to jump on the band wagon.

“Now—ex-smoker...community mental health clinic...I have a patient who’s smoking, chronic schizophrenia, he’s obese—probably 350 lbs., smokes 4 packs a day. He wants to go on Chantix. I said no ‘cause I’m not gonna do it until you cut back to about 30 cigarettes a day. So, we put together a behavioral modification plan; I think I used some lamictal to help with the impulse control. If there was some nuance with a medication that would help with behavior control, I

would use it off label and I think it did help him. He actually did get down from 4 to 2 packs and his wife validated it because I put her in charge of the money for the cigarettes. I said 'look how much money you're gonna save!'"

Regarding resources for nurses, "I think we're not gonna have a choice so they need to be prepared; they need to be educated." Mary emphasized a good education in physiology and chemistry of the brain...to have a good basic understanding of schizophrenia and what nicotine does to the brain for a person with schizophrenia. "Drawing on that, what is going to be most effective to educate the nurses? Is it going to be a power point slide presentation? Is it going to be a workshop? Is it going to be a brochure? I can tell you that in my practice, when I get the brochures or a clinical practice guideline, I think 'okay, I don't even have time to figure this out.' I'd much rather have a workshop."

Mary referred to organizations that believe that they support their nursing staff. "...they don't really give the nurse time to go to these things... **Give them the time!** Spend the money to send them to these kinds of workshops so they can better assist our patients in healing!"

Mary went on to talk about former military persons. "...those who go away to war who never have touched a cigarette... How many of them come back smoking? It's one of the symptoms of PTSD; increased use of substances. Nicotine is the number one."

"If we had a platform where we put educational materials online.... Before I refer a nurse who wants to see a military person for PTSD for an online learning module, I send them to the North Carolina AHEC; it is awesome. If you want to learn prolonged exposure therapy or CPT as opposed to CBT, I'd go to that AHEC. They have an online learning module and if you don't get enough from that they tell you where to get the live learning."

"So you wouldn't even need to go through the expense of pulling people together. Create a web based approach with different populations of people; the chronically mentally ill, a post deployed service member, pregnant teenager.... Create scenarios then put evidence-based approaches and it could be online. It could be through a grant with the American Lung Association or other interested stakeholders. And that way a nurse could access something that takes one hour CEU and you get 1 credit for it."

"But it needs to be good! It can't be boring...I hate it; the post-traumatic stress people.... They put all these videotapes online but it's a bunch of arrogant people and they're talking. Whereas in the other one, there are vignettes, simple.... They go through co-occurring PTSD and TBI; it's just an amazing thing...and you can

do it at any time. If it's late at night or if I have a patient who did not show up, I can take an hour and finally learn how to be with this patient who smokes."

Summary 8: Angie

Angie is a nurse who works in an outpatient partial hospitalization program. She shared her personal and professional experiences of working with people who smoke.

"Actually, this is interesting because my mother-in-law was one like you spoke of. She was a heavy smoker, was diagnosed with lung cancer and smoked till her death with oxygen on, sleeping under a down comforter and mattress, and a down blanket over her because she lost so much weight...*and* had oxygen on and would get up in the middle of the night for a cigarette. And our daughter who was in high school at the time called us in the middle of the night and asked, 'is grandma supposed to be smoking with her oxygen on?' So I asked, 'where is she' and my daughter said 'she's in bed.' So she was sitting with oxygen on, under feathers, on top of feathers and smoking a cigarette. So, needless to say my husband and I packed up, moved in with her and took turns staying up with her every night until she died because we could not get her to stop smoking...and that was really, really difficult."

Professionally, Angie works with young and old veterans, some recently returned from active duty and some older veterans with mental health diagnoses and a lot of PTSD. The hospital is smoke-free but does have a smoke shack outside the facility that is used by clients in the outpatient program. The locked inpatient unit is nonsmoking and does not allow patients to go out to smoke. Many of the outpatients come to the PHP from inpatient and have been off cigarettes and not smoking for 1, 2 or 3 weeks. The outpatient staff is then challenged with trying to keep those patients off cigarettes.

Angie is the person who leads the outpatient team in promoting smoking cessation. "I'm kind of the designated person on our outpatient team to talk with patients about not smoking, so I just want to be gung ho and say 'yes, keep on those patches and you've got a good jump start here. Let's not get back into smoking.' But the problem is that all these people are high stress, and we run a program where we do group after group after group with breaks in between and of course, they all take off for the smoke shack during breaks. More often than not, they return to smoking again eventually, even though the first couple of days they think they're going to be really strong, they have a jump start and they think they're not gonna do it. It's just where they end up and it's just frustrating.

Angie shared one patient's struggle. "I have a gentleman right now who is in his early 40s addicted to cocaine, heroin and cigarettes coming into our program. He's married...and is in a wheel chair. They have multiple children and he came into my tobacco cessation class that I teach every 2 weeks. He was really struggling because he wanted to quit everything at once 'cause he could see the relationship between smoking cigarettes and it being a trigger to marijuana. In any event, he really, really wanted to quit so we talked about triggers, we did some breathing exercises and we talked about what else he might be able to do when he was experiencing triggers. We talked about nicotine replacement and as long as he was trying to stay sober from the drugs as well, he ended up staying at our facility. We have a dorm across the road and rather than going home to his kids and wife, he stayed there for the first week and it helped him get a jump start. We also referred him...we have a state quit plan and we referred him to that. And for our veterans we set up an arrangement where instead of them calling the quit plan offices we have the opposite where the quit plan calls them."

"If they're willing to do it, they can sign a paper to say that it's okay to call them and that's been really a good thing. Then it just follows up without them having to take the initiative. Even though it's good for them to have the initiative, we also recognize that there's stress if you do return to smoking. With this gentleman, he has been back home and even though found out how hard it is, he's cut back to 1 cigarette a day and he stays in our room for the breaks and we just give him a lot of praise for sticking around and for what he's doing. He doesn't hang out in the smoke shack with everybody else and he has decided to keep going. Instead of returning home when he's done with our program, he's going to enter another 30 day program for DD and that's probably one of the success stories that I can think of that I'm so proud of because I think he's really worked hard."

"I think so often we hear the opposite. Especially in the inpatient setting and in outpatient we hear that there's just no time...'I'm dealing with too much right now, this isn't the time to quit.' And more often than not, I'll do my tobacco cessation program and people will come—generally out of 30 people in our program I may have 1 or 2 every 2 weeks who show up for that and maybe 2-3 and out of those, more often than not they say, 'it's just too hard right now, too much stress, too overwhelming...I'll quit when I'm done with the program.' Or 'I'll quit later.'"

"...We don't necessarily ask the people to quit smoking right away. We ask them to set a quit date—usually 3 weeks down the road and then we start working with them to start practicing quitting and identify the triggers. We make a plan and practice quitting and then practice eliminating some of those trigger times and we ask what else they did that was helpful for them. So, often times we don't actually get to see them when they've totally quit or do we get to find out that they really did. Sometimes they quit sooner than that but many times not."

In considering other ethical decisions Angie believes that nurses sometimes find it easier to make decisions for patients regarding smoking cessation... “as nurses we make the decisions for patients—okay, just go ahead and smoke, it’s better than going back and drinking and I think that’s a hard one. I know there’s a theory now that if you’re gonna quit, just quit everything at once but in the past it was which was the priority and quit one thing at a time. And I think that sometimes we still struggle with that when they say ‘Oh, come on, it’s too stressful’ and we say ‘oh, okay’ and we feel sorry for them and don’t address it.”

“...Our hospital used to have a quit smoking program so that when we do get busy with our day trying to lead groups, trying to take care of things, we could refer our people to that program and there were nurses who did just tobacco cessation. Somewhere along the way they decided that each client area should have a designated nurse to work more one-to-one with the patients. And even though the one-to-one is really a good thing, we were asked to add that onto everything else that we do.... Clients come in for their 45 minute appointment and there’s so much already to cover and then add tobacco cessation, it gets put on the back burner. To me, it seems that one of the things that would be most helpful would be to have designated people to refer patients to just for that purpose.”

Angie feels fortunate to be able to offer nicotine replacement and ongoing smoking cessation treatment to her patients without the struggle over payment and pre-authorizations. She also commented on another thing that was helpful for the hospital staff. “We started about a year ago, before we started to do the classes. We had the nurses do a hospital-wide training with books to use and the session outlines to use. Probably if I did not have it (that resource) at my fingertips, I would be saying that that would be really helpful, even though then we have to turn around and try to squeeze it into what we are already doing.” Even though Angie likes the idea of the smoking cessation program...“I wish someone else could do it and do a better job of it and spend more time at it.”

Summary 9: Cindi

Cindi is a nurse and a former smoker who works on an inpatient psych unit. She is currently attending graduate school to become a psychiatric mental health nurse practitioner.

“I have a perfect incident of conflict of values that I really didn’t take the time to think about it before I did it, and then later I felt like I probably shouldn’t have...we support people continuing to use tobacco. I felt ugh...I shouldn’t have done that.”

“We had an older woman on our unit that was psychotic. She was having manic behaviors and she was being kind of taken advantage of by other peers and her family had brought her cigarettes. Our facility still allows smoking, not inside the building but there’s a patio for smoking which I don’t like at all but they can smoke at scheduled smoke breaks. And peers—they didn’t really steal her cigarettes but they kept asking to borrow cigarettes and she would give them whole packs. So, in 2 days time she had gone through a whole carton of cigarettes.... And my mental health technician felt badly for her and was telling me about it. And he was fixing to go out on a break and he said he was going to buy her a pack and I donated to him buying a pack of cigarettes which was only a dollar or two but afterward I thought oh, I supported that. I was working on her too, but we felt really bad that she was being taken advantage of and it wasn’t something that we had thought about but afterward I felt kind of conflicted about it.”

Cindi is not at all happy about having a smoking patio for patients. “I would rather that we have a smoke free environment, just like all of the acute care hospitals in my area and offer nicotine replacement at the time of admission and at any time that they need it...just to be supportive that way; not to mention the smoke and all the health implications...and for all the people who don’t smoke. And the patio area is the only way for them to get outside. It’s a small area and it’s fenced off and they really can’t stand out there and not be affected by secondhand smoke because it’s really small. And they complain and they’d like the opportunity to get outside; they just go out there for 15 min every 2 hours but there isn’t anything provide for the people who don’t smoke. The activity therapy department takes patients outside about once a day in a much larger area. Just the patients can do that according to their safety measures...they have the ability to do that but ALL patients can go out to the patio...I just don’t like that....”

Cindi recognizes that smoking is still used as a “paternalistic” means of control. “When we have pts who don’t do what they’re supposed to and they smoke, the taking away of smoking privileges is a means of control. That’s not good either....” “...When that comes up, it’s usually a decision among the staff...like ‘we need to do something about this behavior’ and sometimes that decision can be made without my input. And it happens on a daily basis, almost every day.... I don’t like to use that. I won’t say that I never participate. I just say I don’t agree with that. I don’t like the crime and punishment mentality that goes with it.”

Cindi has thought about questioning the hospital smoking policy and approaching the administration. “...I thought about just presenting some evidence to the corporation. It’s my understanding that most of their other facilities do not allow smoking. In our area we’re one of the few psychiatric facilities that still allows smoking on their campus...and really I should start within the hospital

framework—the smaller management hospital staff and if I can influence them....”

“I’m working on a paper on smoking and mental health but I don’t know.... I just don’t know where to proceed. As a nurse practitioner I will continue to ask them about their readiness to quit and make available the behavior modification changes as well as the nicotine replacement...I feel more comfortable about that...at least that’s something I can do individually.”

Cindi’s hospital does not have a care plan for smoking. “We have a question on our assessment—like our generalized nursing assessment when a patient is first admitted about whether they smoke or not but there is no follow up to that. Now, I don’t get it done every time but I do ask ‘is it possible that while you are here you might want to quit smoking—even though you’re here for chemical dependency since studies show that you can quit both.’ And I encourage them to ask their psychiatrist about it and I offer ‘if you’d like me to talk with your psychiatrist about it, I’d be more than happy to do that.’ It’s not a routine—it’s not something we’re encouraged to ask about.”

Education on smoking cessation is limited Cindi’s facility. She does a group about twice monthly on healthy lifestyles where she focuses on smoking along with diet and sleep. There is also a technician-led group that meets twice a month that shows a video about smoking and uses visual teaching tools.

“One of the worst things that’s really starting to bug me about our facility is the restriction that they do have on smoking. Smoking is allowed 15 minutes every 2 hours. Smokeless tobacco is allowed also. You’re supposed to use smokeless tobacco during those same smoke breaks but patients are using outside the smoke break times and it seems to me that they are using the smokeless tobacco (which they get a lot more nicotine from it if they’re having it all the time) and going to smoke breaks. They’re getting a whopping dose. I don’t like it for that reason and I’ve walked in patient day rooms with cups sitting around with tobacco juice in them and that’s just a biohazard to me.”

Cindi feels that she is lacking support in working toward a smoke-free environment other than articles in the APNA journal and support from faculty and her peers at school. “...there is not a lot of support at my facility because we still have a lot of staff members who smoke and they don’t want to have that taken away from them – having to push toward a tobacco free environment...I don’t really feel like I have lots of support....”

Summary 10: Karen

Karen is a nonsmoker who works on an inpatient unit. She works in a government facility that is located in a state that is “mostly smoke free.” As a federal facility, Karen says that they “kind of get by with letting their patients smoke” because they maintain a smoke-free environment inside the hospital but allow patients to smoke on a porch attached to the unit. “Our other psych hospital in town doesn’t allow them to smoke at all. They can have chewing tobacco and they can have the gum and the patches but they won’t let them smoke.”

Karen recalled the days in psych when in “you’d reward the patients by letting them go out and smoke...they’d get extra cigarettes if they followed whatever rules or boundaries were set for the day...and there’s kind of a similarity with our older vets ’cause it was the army that got them smoking in the first place. They’d tell them ‘smoke if you got ’em’...and that’s the only way they’d get a break.”

Karen sees a lot of patients, especially older former service members, some with COPD and heart problems and psych diagnoses. She is pleased that they can get consistent and ongoing treatment for free. “You know the vets get all their medical care for free and it’s awesome because then at least they’re getting all the meds and the follow-up care. But some of our patients have schizophrenia or these chronic mental illnesses that are keeping them where they almost need an adult family home to maintain so they’re not in the hospital all the time.”

Everyone who comes into the hospital for a medical, primary care or psych visit is asked if they smoke, how long they’ve smoked and if they want to quit. If they are a smoker they’re educated on how to quit and are offered gum or a patch. Chantix is not normally offered because of suicidality that’s been correlated with people who are depressed or have mental illness. If they do want to take Chantix they are admitted until they stable on it and then sent home. The hospital has a lot in place to help with smoking cessation but some of the vets are completely unreceptive. “They’re just not going to quit smoking, especially the ones that smoke and drink and dabble in every kind of drug you can think of. But...we’ve had a lot of guys who have been able to quit...because there’s the support in the structure. I think they do pretty good once they’ve decided to quit because we give them the meds and we support them to do this because it’s costing us more in the long run to have them smoke.”

“We talk to them about quitting permanently and we give them education about how much better it is for your body if you quit for a week or a month or a year then your body’s regaining and your lungs are getting better. And the nurses do a lot of teaching, tobacco screening and offer them treatment and the doctors also have to do it. So, we both kind of are always talking with them about it. We

assess it when they are admitted, after their admission, when they leave and after, if you wanna quit we can help you.”

“Some patients say no—‘I’ve smoked for 20 years and I’m not going to change for you or the doctors,’ and if you push it they tell you ‘Hell no!’ And sometimes after they’ve been admitted over and over they get to the point where they can’t walk onto the unit without having to stop to take a breath and you can use that relationship from all their admissions to say to them ‘you know, you’re getting older and your body’s not as young as it used to be and maybe it’s time to quit smoking and see how you do with that.’ And sometimes they still don’t care but sometimes they are curious about if it might work and it depends on their level of willingness to make things a little better for themselves.”

“Sometimes we get the ones who hit their 70s and they’ve got heart problems and COPD and sometimes they’ll quit then or if they go into assisted living. Most of our assisted living is smoke free and...they won’t take them if they smoke. So sometimes that’s a defining factor—once they can’t function independently, they have to quit smoking. But if they have the choice they’ll often smoke.... It’s kind of like the revolving door patients...we see them almost every month for years and years and each admission you tell them the same thing and you hope that you give them a little more information and the cumulative effect over multiple admissions will flicker the light in their head and they say ‘oh, now I get it’ ’cause some people just don’t have the insight to put that stuff together.”

Karen has also seen patients with psychiatric diagnoses treated differently in making decisions regarding their medical treatment. “I’ve seen them turned down for heart surgery and stuff that they needed because they smoke and because with the mental illness...the surgeons will say yes, he needs a CABBG or whatever but we’re not going to do it until his schizophrenia or depression is stabilized...and then he’s got to stop drinking and smoking. So we put him in an adult family home for a while but I mean getting a schizophrenic to stop smoking when they’ve been smoking for 40 years is a difficult thing...especially for schizophrenia.... We know how bad smoking is in general but we know how much worse it is for people with mental illness just because their brain receptors are wired to fixate on that nicotine and it’s a more difficult addiction to kick than for a normal person.”

Karen has been working on trying to prevent staff from smoking with patients on the unit. A couple of staff members that smoke are not allowed to leave the unit so they smoke with the patients on the porch. Karen thinks that they are sending the wrong message. “...you wouldn’t drink with the patients even though it’s legal so why are you going out and smoking with them and in between puffs saying to them ‘smoking is bad and you should probably quit.’” She feels that there is resistance because they don’t want to lose their smoke breaks and “they don’t

really see the harm in smoking with people who already smoke.” Karen thinks as nurses, we can do better. “They take them out and sit down with them and they really start talking...I think it’s a good thing that they open up but I think it’s a not a therapeutic environment and to make that connection and to develop that rapport with someone around smoking is not the message that we want to be sending and I think we can do better. We can save the therapy, developing connections and rapport for on the unit in a safe environment.... It’s not the right message that we need to be sending and we need to be more aware of the message we convey outright or subliminally. We can’t ask them if they want to quit and then go out and smoke with them—that just takes the wind out of the sails of supporting cessation.”

Regarding how to help the nurses make good decisions with their patients who smoke... “The hospital I worked at prior to [this one] didn’t focus on smoking cessation at all and we didn’t have a bunch of resources, so working at [this hospital] has been really nice. We have flyers, cards for the quit lines, the opportunity to offer the patch or gum anytime and chantix or whatever if they want to try. And we have the support of the doctors and staff to say ‘you need to stop smoking; this is not healthy for you.’ We have a bunch of resources available and say ‘why is it that you think you need to keep smoking? What’s fulfilling for you and can we maybe get that someplace else?’ ...I think it helps to be consistent in that message that we can help you...and have all the staff on the same page rather than have the psychiatrists saying ‘well, we will get your schizophrenia stable first and then maybe we’ll address it once you’re stable.’ Places I worked at before were like that...[at this hospital] you have to sign off that you’ve talked with the patient about it every time you meet with them. For me just having that support and me not being the only one they hear it from has made a huge difference.”

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