IMPLEMENTING SMOKING CESSATION INTERVENTIONS IN COMMUNITY MENTAL HEALTH SETTINGS: EXPLORING NURSES’ READINESS TO CHANGE, PERCEIVED BARRIERS AND OVERALL PERCEPTIONS USING A MIXED METHODS DESIGN

by

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ABSTRACT

Tobacco use is deeply entrenched in the culture of psychiatry. Historically, nurses condoned smoking and at times even encouraged it. Despite the vast research examining smoking cessation interventions for the general public, little is known about the barriers health care professionals face while working in community mental health settings and their ‘readiness’ to change in regards to implementing smoking cessation interventions into their practice.

This study is part of a growing body of research examining tobacco in the context of mental illness. A mixed methods research design was utilized for this project. The first phase of the study consisted of the analysis of a self-report questionnaire completed by 282 health care providers working within the community mental health field in the Greater Vancouver area. The Transtheoretical Model: Stages of Change Method was applied to this largely untapped source of health providers to determine their ‘readiness’ to a) talk to clients about their smoking habits, and b) provide smoking cessation support to their clients. The second phase consisted of a focused ethnographic design in which semi-structured in-depth interviews were conducted with 13 community mental health nurses.

This first Canadian investigation of community mental health nurses’ ‘readiness’ to implement smoking cessation interventions into their practice revealed that the majority of nurses were in the preparation stage for both a) talking to clients about their smoking and b) providing smoking cessation support to their clients. Barriers to providing smoking cessation included lack of knowledge, time and appropriate resources. The ethnographic profile of the sociocultural and organizational context of community mental health nursing revealed the structure of the nursing subculture within the mental health teams (Brokers, Conductors, and Connectors) and highlighted the impact of these roles on nurses’ readiness to change. Findings
from both phases of the study were synthesized and results indicate a need for 1) the development of smoking cessation interventions specifically tailored to community mental health nurses’ roles, 2) the incorporation of smoking cessation intervention education into the community mental health workplace, and 3) placing equal emphasis on the role and value of mental health nursing in undergraduate nursing programs.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER 1: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Overview of the Thesis Presentation</td>
<td>1</td>
</tr>
<tr>
<td>The Research Project</td>
<td>1</td>
</tr>
<tr>
<td>Background Information about Tobacco Use and Mental Illness</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>3</td>
</tr>
<tr>
<td>Research Project Theoretical Framework</td>
<td>4</td>
</tr>
<tr>
<td>Summary of Research Method</td>
<td>6</td>
</tr>
<tr>
<td>CHAPTER 2: LITERATURE REVIEW</td>
<td>8</td>
</tr>
<tr>
<td>Background</td>
<td>8</td>
</tr>
<tr>
<td>Tobacco Use and Mental Illness</td>
<td>9</td>
</tr>
<tr>
<td>Evolution of Psychiatric Care: From Hospital to Community</td>
<td>11</td>
</tr>
<tr>
<td>Defining Smoking Cessation and the Nurse’s Role</td>
<td>12</td>
</tr>
<tr>
<td>Focused Literature Review</td>
<td>14</td>
</tr>
<tr>
<td>Results</td>
<td>15</td>
</tr>
<tr>
<td>Personal Barriers: Attitudes and Beliefs</td>
<td>15</td>
</tr>
<tr>
<td>Perceived lack of client interest and client resistance to smoking cessation</td>
<td>15</td>
</tr>
<tr>
<td>Ethical decision making</td>
<td>15</td>
</tr>
<tr>
<td>Smoking as a therapeutic tool</td>
<td>18</td>
</tr>
<tr>
<td>Smoking as self-medication</td>
<td>19</td>
</tr>
<tr>
<td>Nurses’ Smoking Behaviour</td>
<td>19</td>
</tr>
<tr>
<td>Systemic Barriers</td>
<td>20</td>
</tr>
<tr>
<td>The culture of tobacco use</td>
<td>20</td>
</tr>
<tr>
<td>Cigarettes to manage mental illness</td>
<td>21</td>
</tr>
<tr>
<td>Insufficient time and prioritizing of care</td>
<td>22</td>
</tr>
<tr>
<td>Lack of smoking cessation skills and knowledge</td>
<td>23</td>
</tr>
<tr>
<td>Limitations of the Literature</td>
<td>25</td>
</tr>
<tr>
<td>Summary</td>
<td>27</td>
</tr>
<tr>
<td>CHAPTER 3: QUANTITATIVE RESEARCH COMPONENT</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Study Protocol ..................................</td>
<td></td>
</tr>
<tr>
<td>Study Sites ......................................</td>
<td></td>
</tr>
<tr>
<td>Sample ..........................................</td>
<td></td>
</tr>
<tr>
<td>Instrumentation ..................................</td>
<td></td>
</tr>
<tr>
<td>Readiness to change ................................</td>
<td></td>
</tr>
<tr>
<td>Smoking status and demographic variables ........</td>
<td></td>
</tr>
<tr>
<td>Workplace policies ................................</td>
<td></td>
</tr>
<tr>
<td>Environmental tobacco smoke (ETS) exposure ....</td>
<td></td>
</tr>
<tr>
<td>Personal barriers ..................................</td>
<td></td>
</tr>
<tr>
<td>Systemic barriers ..................................</td>
<td></td>
</tr>
<tr>
<td>Data Analysis ......................................</td>
<td></td>
</tr>
<tr>
<td>Results ...........................................</td>
<td></td>
</tr>
<tr>
<td>Efficiency of Sampling .........................</td>
<td></td>
</tr>
<tr>
<td>Participant Demographics .......................</td>
<td></td>
</tr>
<tr>
<td>Nurses' Readiness to Change .....................</td>
<td></td>
</tr>
<tr>
<td>Talking to clients about their smoking ...........</td>
<td></td>
</tr>
<tr>
<td>Providing smoking cessation support to clients that smoke .....................................</td>
<td></td>
</tr>
<tr>
<td>Workplace Policies ................................</td>
<td></td>
</tr>
<tr>
<td>Environmental Tobacco Smoke (ETS) Exposure ....</td>
<td></td>
</tr>
<tr>
<td>Personal Barriers ..................................</td>
<td></td>
</tr>
<tr>
<td>Organizational Barriers ...........................</td>
<td></td>
</tr>
<tr>
<td>Summary .........................................</td>
<td></td>
</tr>
<tr>
<td>Stage of change ....................................</td>
<td></td>
</tr>
<tr>
<td>Smoking status and length of mental health career</td>
<td></td>
</tr>
<tr>
<td>Environmental tobacco smoke (ETS) exposure and workplace policies ....................</td>
<td></td>
</tr>
<tr>
<td>Personal and organizational barriers .............</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER 4: QUALITATIVE RESEARCH COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methods .........................................</td>
</tr>
<tr>
<td>Setting .........................................</td>
</tr>
<tr>
<td>Gaining Access ...................................</td>
</tr>
<tr>
<td>Sample ..........................................</td>
</tr>
<tr>
<td>Data Collection ..................................</td>
</tr>
<tr>
<td>Analysis .........................................</td>
</tr>
<tr>
<td>Context: Policies and Place .....................</td>
</tr>
<tr>
<td>Results .........................................</td>
</tr>
<tr>
<td>Sociocultural and Organizational Context .....</td>
</tr>
<tr>
<td>External Environment ............................</td>
</tr>
<tr>
<td>De-skilled and de-valued by their peers and the public ........................................</td>
</tr>
<tr>
<td>Organizational Environment ....................</td>
</tr>
<tr>
<td>Intake nurses: The Brokers .....................</td>
</tr>
<tr>
<td>Case managers (nurses): The Conductors ........</td>
</tr>
<tr>
<td>Outreach nurses: The Connectors ...............</td>
</tr>
<tr>
<td>Topic</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nurse-client relationship: A partnership</td>
</tr>
<tr>
<td>Teamwork: A misnomer</td>
</tr>
<tr>
<td>Tobacco Use and Smoking Cessation</td>
</tr>
<tr>
<td>The embeddedness of tobacco use</td>
</tr>
<tr>
<td>Tobacco: Choosing our battles</td>
</tr>
<tr>
<td>Endemic Barriers to Implementing Smoking Cessation Support</td>
</tr>
<tr>
<td>Time: A precious commodity</td>
</tr>
<tr>
<td>Lack of knowledge</td>
</tr>
<tr>
<td>Lack of training and resources</td>
</tr>
<tr>
<td>Readiness to Provide Clients with Smoking Cessation Support</td>
</tr>
<tr>
<td>Changing attitudes: Asking and referring</td>
</tr>
<tr>
<td>Summary</td>
</tr>
<tr>
<td>Sociocultural and Organizational Context</td>
</tr>
<tr>
<td>Tobacco Use and Smoking Cessation</td>
</tr>
<tr>
<td>CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS</td>
</tr>
<tr>
<td>Synthesis of Findings</td>
</tr>
<tr>
<td>Stage of Readiness: Preparation</td>
</tr>
<tr>
<td>Barriers to Providing Smoking Cessation Support</td>
</tr>
<tr>
<td>Benefits and Challenges of Mixed Methods Designs</td>
</tr>
<tr>
<td>Implications for Practice</td>
</tr>
<tr>
<td>Nurses as Role Models</td>
</tr>
<tr>
<td>Time and Tools</td>
</tr>
<tr>
<td>Implications for Further Research</td>
</tr>
<tr>
<td>Implications for Nursing Education</td>
</tr>
<tr>
<td>Conclusion</td>
</tr>
<tr>
<td>REFERENCES</td>
</tr>
<tr>
<td>APPENDIX A: CACTUS Provider Survey</td>
</tr>
<tr>
<td>APPENDIX B: Community Mental Health Nurse Interview Guide</td>
</tr>
<tr>
<td>APPENDIX C: Interview Form</td>
</tr>
<tr>
<td>APPENDIX D: Consent Form</td>
</tr>
<tr>
<td>APPENDIX E: UBC Ethics Approval Form</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1. Response Rates for Questionnaire Participants .................................................. 37
Table 2. Demographic Characteristics of Survey Respondents ........................................ 38
Table 3. Comparing Survey Respondents’ Demographic Means ..................................... 39
Table 4. Talking with Clients about their Smoking (n=254) ........................................... 40
Table 5. Providing Smoking Cessation Support to Clients that Smoke (n=243) ................. 41
Table 6. Cross Tabulations for Community Mental Health Nurses’ Stage of Change ......... 45
LIST OF FIGURES

Figure 1. Structure of Community Mental Health Teams and Nursing Subculture ........................ 59
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CHAPTER 1: INTRODUCTION

Overview of the Thesis Presentation

The central issue addressed in this master’s thesis is community mental health nurses’ readiness to change in relation to implementing smoking cessation interventions into their practice. This issue was investigated using a mixed methods design that consisted of two components: the first utilized a quantitative research design and the second utilized a qualitative research design. This thesis consists of five chapters. The first chapter presents background information on the topic of tobacco use and mental illness and introduces the research project. Chapter two presents the findings of a focused literature review pertaining to smoking cessation in psychiatric settings, while chapter three and four describe the methods and findings for the quantitative and qualitative components. Finally, chapter five provides a synthesis of research findings, offers a concluding discussion, and addresses implications for nursing practice, research and education.

The Research Project

Background Information about Tobacco Use and Mental Illness

Despite a decline in smoking among the general population, individuals with severe and persistent mental illness continue to smoke at increased rates. The subject of tobacco control is currently a priority topic for provincial, national and international health organizations due to the fact that tobacco is presently the single most preventable cause of morbidity and mortality in most developed nations (BC Ministry of Health Services, 2004). To address this growing concern of what the World Health Organization calls a worldwide epidemic, tobacco control strategies have been designed and implemented by numerous governing bodies across Canada and internationally. In 1999 the Provincial/Territorial Conference of Ministers of Health released
a new national tobacco control strategy entitled *New Directions for Tobacco Control in Canada*—*A National Strategy* that has since been supported by all provinces and territories and contains the following goals for Canada as a whole: 1) prevention, 2) cessation, 3) protection and 4) denormalization (BCMHS, 2004).

British Columbia (BC) is a leader in tobacco control with the lowest smoking prevalence rate of any Canadian province and the second lowest in North America; BC’s rate of smoking is 16%, which is well below the Canadian average of 21%. Despite these impressive statistics, research indicates that smoking rates among psychiatric patients range from two to four times that of the general population (Prochaska, Gill, & Hall, 2004). Due to mental health care reform over the past four decades, many individuals living with mental illness are now being followed by health professionals in a community mental health setting. Community mental health nurses play a key role within the multidisciplinary team and are considered to be in a prime position to facilitate smoking cessation among their clients (Canadian Nurses Association, 2001). Despite the potential for positive input by nurses, research shows that psychiatric mental health nurses have not been as influential as expected in supporting smoking cessation within psychiatric settings (Lawn & Condon, 2006; Stubbs, Haw & Garner, 2004).

A consistent public health message is aimed at increasing awareness about the harmful effects of tobacco products. Moreover, health care providers are expected to educate their clients about this issue, as well as encourage behaviours that lead to the reduction or quitting of tobacco. The public health message about the harmful effects of tobacco use, however, does not seem to be affecting the smoking rates associated with individuals with severe and persistent mental illness.
Smoking has long been an accepted part of the culture of psychiatric settings. Historically, smoking has been used as a behavioural reward in psychiatric inpatient units and continues to serve as a shared social activity for many psychiatric patients. Patients coping with persistent symptoms and reduced social and occupational functioning often resort to smoking to fill the voids of boredom and loneliness (Williams & Ziedonis, 2004). However, for individuals already challenged with the stigma of living with a mental illness, tobacco use can be an additional barrier to achieving relationships, employment, adequate nutrition, housing, and an acceptable standard of health. The evidence supports the argument that there are many barriers mental health nurses’ face in the delivery of smoking cessation interventions with clients.

**Purpose of the Study**

There have been a limited number of studies that have examined perceived barriers among nurses implementing smoking cessation interventions to individuals with mental illness with even fewer examining the perceived barriers among community mental health nurses. In order to achieve effective implementation of smoking cessation guidelines in community mental health settings, we must first understand how ready nurses are to implement these interventions into their practice and how the workplace culture affects nurses’ readiness to change and their perceptions regarding implementing tobacco cessation interventions into their practice. The purpose of this study was to answer the following questions:

1. What is the stage of ‘readiness’ of community mental health nurses in relation to implementing smoking cessation interventions into their practice? Is their stage of readiness significantly different from other professionals working in community mental health? Do smoking status of the health care provider, number of years working in the
mental health system, and environmental factors affect community mental health nurses’ readiness to change?

2. What are the barriers encountered (personal and systemic) in the uptake of smoking cessation interventions among community mental health nurses? Do these barriers affect readiness to change?

3. What are community mental health nurses’ perceptions regarding implementing smoking cessation interventions into their practice and how does workplace culture affect nurses’ readiness to change?

Research Project Theoretical Framework

Further research is required to explore community mental health nurses’ readiness to implement smoking cessation interventions into their practice. Specifically, there is a need to understand how complex factors such as personal and systemic barriers affect community mental health nurses’ stage of readiness. Personal barriers include factors which are internal to the individual such as smoking history and attitudes towards smoking among this specific population. Systemic barriers include factors external to the individual such as the community mental health environment, culture, workplace policies and exposure to second hand smoke. It is well documented that tobacco dependence treatment is considered the single most important preventative strategy for decreasing premature morbidity and mortality (Wewers, Sarna, & Rice, 2006). Furthermore, a recent Cochrane review of nurses’ smoking cessation interventions has shown that nurses are effective in motivating smokers to quit (Hall, Vogt, & Marteau, 2005).

The embeddedness of tobacco in psychiatry has significantly affected how mental health care providers view the high prevalence rates of smoking among this specific population. Smoking has been an accepted part of psychiatry for decades and is only now being seen as a
problem as the physical, psychological and economical harms of smoking for mental health populations are becoming more apparent (Lawn & Condon, 2006). An important step in addressing this pressing issue is understanding how ready community mental health nurses are to implement smoking cessation interventions into their practice, what the barriers are that impede the execution of these interventions, and the intricate relationship between community mental health workplace culture and readiness to change. This would be useful information for community mental health nurses, other health care providers, nurse managers, and policy makers working towards the common goal of decreasing the morbidity and mortality of individuals who are smoking as well as living with a severe and persistent mental illness.

The theoretical background guiding this study is based on Prochaska and DiClemente’s (1984) Transtheoretical Theory: Stages of Change Model. This model conceives of behavioural change as a process involving movement through five stages (Prochaska, Redding, & Evers, 1997). These five stages are: 1) precontemplation- no intention to take action, 2) contemplation-intention to change within the next 6 months, 3) preparation-intention to change in the immediate future, 4) action-overt modifications in behaviours within the last 6 months, and 5) maintenance-behaviour change is consistently maintained.

In the context of this research, the behaviour under study was the provision of smoking cessation support to clients by community mental health nurses. The aim of determining the stage of change of community mental health nurses is valuable in developing stage-matched interventions that will ultimately promote movement of community mental health nurses who are in the precontemplation, contemplation or preparation stage to the action or maintenance stage. The stage construct is important here as it represents a temporal dimension. The model is also based on critical assumptions such as a) behavioural change is a process that unfolds over time
through a sequence of stages, b) stages are both stable and open to change, c) without planned interventions, populations will remain in the early stages, and d) specific processes and principles of change need to be applied at specific stages if progress through the stages is to occur (Prochaska, Redding, & Evers, 1997).

The stages of change theory has been applied in a variety of behavioural contexts. Because little is known about nurses' smoking cessation behaviour, it was thought the stage model would facilitate an understanding of nurses' readiness to implement smoking cessation interventions into their practice. Stage-matched approaches reduce the risk of interventions being deemed irrelevant or inappropriate. In studying readiness to change, it is important to recognize how change is supported by workplace sociocultural and organizational contexts. Change takes place in a cultural context (Wilson, McCormack & Ives, 2005; Yamaguchi, 2004), making it necessary to explore the sociocultural factors and organizational arrangements that influence community mental health nurses' readiness to change and tobacco control behaviours in regards to providing smoking cessation interventions to their clients.

Summary of Research Method

This study examined the readiness of community mental health nurses in relation to implementing smoking cessation interventions into their practice. A sequential mixed methods design was used to meet the challenge of understanding community mental health nurses' readiness to implement smoking cessation interventions into their practice. Mixed method designs include the collection and analysis of both quantitative and qualitative data in a single study or a series of related studies (Creswell, 1994; Tashakkori & Teddlie, 1998). Mixed methods in research designs continue to gain popularity among health scientists due to the belief that multiple forms of knowledge are useful for understanding the complexity of human
existence and that by blending research methods a more comprehensive understanding of the phenomenon being studied can be achieved (Howe, 2004; Johnstone, 2004).

Tashakkori and Teddlie (1998) stated that the main purpose for conducting mixed method research is data triangulation; to seek convergence, corroboration and correspondence of results of the phenomenon of interest. The strength of data triangulation lies in the fact that it results in a "thick description" of the phenomenon of interest which would otherwise not be possible if fewer data collection strategies had been employed (Creswell, 1994). In this study the quantitative and qualitative data were collected and analyzed separately, with the qualitative component complementing the initial quantitative analysis, adding further depth and scope to the research findings.

There were two phases to this study; phase one consisted of an analysis of data from a self-administered confidential questionnaire that was administered to health care providers working within the community mental health setting and phase two employed a focused-ethnographic design in which semi-structured in-depth interviews were conducted with a purposive sample of 13 community mental health nurses.
CHAPTER 2: LITERATURE REVIEW

The following chapter provides background information on the issue of smoking cessation and mental illness and presents the results of a focused literature review on the barriers to implementing smoking cessation interventions in clinical settings.

Background

Tobacco is considered the world’s deadliest product. It kills more people than AIDS, legal and illegal drugs, road accidents, murder and suicide combined (World Health Organization [WHO], 2004). Tobacco is considered a global epidemic with an estimated 1.1 billion people smoking worldwide (WHO, 1999). Due to increasing awareness and acknowledgment of the severity of this global health concern, initiatives to eradicate tobacco use are being developed and implemented in primary, secondary, and tertiary levels of care. Despite this massive movement towards implementing smoking cessation interventions into all areas of health care, the field of mental health has been largely ignored on an international scale (Ziedonis, Williams, & Smelson, 2003). This is extremely problematic, because in Canada, for example, an estimated 60%- 95% of individuals with mental illness use tobacco (Canadian Health Services Research Foundation, 2002).

Due to the alarmingly high rates of smoking in the psychiatric population, nicotine dependence has been described as “the most prevalent, most deadly, most costly, yet most treatable of all psychotic disorders” (Hughes, 1999, p. 57). As our understanding of the health effects of tobacco use and the effectiveness of tobacco cessation methods mature, an increasing amount of smoking cessation practice guidelines are being implemented in clinical settings. These guidelines are used as a set of suggestions that guide or direct health care providers in the implementation of smoking cessation intervention strategies in their daily practice. Guidelines
are clear suggestions on how to implement interventions but despite the presence of these documents in inpatient and outpatient clinical settings, research shows that existing guidelines are under-utilized, or worse, not utilized at all in psychiatric settings (Cataldo, 2001).

Psychiatry proves to be an especially challenging area for nurses to incorporate smoking cessation interventions into their practice. Many factors contribute to this including a heavily entrenched smoking culture within psychiatry, the nature of mental health clients' diagnoses, tobacco's purported therapeutic effects for certain mental illnesses, and lastly, mental health services are well known for being the most under-resourced sector of health care systems both nationally and internationally (Canadian Nurses Association [CNA], 2003). Furthermore, due to the significant changes in mental health over the last 40 years, the focal point of care has moved from the institution to the community (CNA). Mental health care reform is decreasing the number of psychiatric hospital beds available, and increasing the number of clients served in the community, thus shifting the onus of implementing smoking cessation strategies from nurses working within the hospital to nurses working within the community mental health sector.

**Tobacco Use and Mental Illness**

It is estimated that tobacco is the cause of four million deaths worldwide every year (World Health Organization, 1999). The financial burden of tobacco use is staggering, as the cost to society of tobacco death and disease surpasses 100 billion dollars (U.S Department of Health and Human Services, 2000). Due to the devastating impact of tobacco on the health of individuals worldwide, health care providers are increasingly encouraged to begin incorporating smoking cessation interventions into their daily practice. Agreement around the globe regarding the severity of the tobacco epidemic has prompted international nursing organizations, health agencies and policy makers to draft and develop smoking cessation guidelines specifically
designed for health care providers to use in their daily practices. These guidelines are numerous, but they are all similar in that they are 1) based on rigorous meta-analysis of empirical evidence, 2) conducted by experts, and 3) contain key components that make up smoking cessation best practice (International Council of Nurses 2003; Registered Nurses Association of Ontario [RNAO], 2003; Royal College of Nursing, 2001; US Department of Health and Human Services, 2000.). The interventions described in these documents include health care personnel providing brief advice, behavioural counseling, and pharmaceutical treatment, with the ‘Five A’ (ask, assess, assist, advise, arrange) method providing the framework which health professionals are encouraged to follow when developing appropriate smoking cessation interventions for their clients (WHO, 2000). The complex issue of smoking cessation interventions for specific populations such as those persons with mental illness has been addressed in a few of these guidelines; however, only superficially at best.

Despite the repeated demonstration of the efficacy and cost-effectiveness of smoking cessation delivery systems, recent literature demonstrates that these interventions have not received the priority they deserve from health care providers (Erwin & Biordi, 1991; Gould, Pearce, & James, 2000; Ziedonis, Williams & Smelson, 2003). This is especially true in the field of psychiatry where the relationship between smoking and mental illness is extremely complex. Research consistently shows that rates of smoking are significantly greater in populations where mental illness is also present (Carosella et al., 1999; McNeill, 2001) and that smoking rates may be as high as 80%-90% compared to 20%-30% in the general population (McCloughen, 2003). Despite increasing global efforts to eradicate tobacco use by international governing health organizations, the issue of smoking prevalence rates and the promotion of smoking cessation have been largely ignored within the psychiatric population.
Many explanations that account for the relationship between mental illness and smoking have been proposed: 1) shared neurobiology of mental illness and nicotine addiction, 2) self-medication of symptoms, 3) psychological coping responses, 4) environmental factors, 5) psychological factors and 6) systemic factors (Lawn, 2004; Lawn, Pols & Barber, 2002; Ziedonis, Williams & Smelson, 2003). The association between smoking and mental illness makes implementing smoking cessation interventions more complex, further discouraging health care providers from providing this essential health promotion and prevention service to their psychiatric clients.

**Evolution of Psychiatric Care: From Hospital to Community**

The introduction of community mental health nursing in the late 1950s took place during a troubled period in mental health care (Hannigan & Coffey, 2003). The asylum system, a highly ambitious attempt to manage mentally ill people founded almost one hundred years earlier, was close to collapse. By the 1950s, attitudes were changing and there was a shift in thinking regarding the treatment of mental illness. New policies and innovative care were being introduced such as the implementation of part-time hospitalization; provision of easily accessible outpatient care; psychiatric units in general hospitals; and mental health staff carrying out home visits (Hannigan & Coffey, 2003). A catalyst in the shift from hospital to community care was the discovery of powerful new psychotropic medications (White, Roy & Hamilton, 1997). These medications enabled clients to control the symptoms of major mental illness which ultimately allowed them to live independently in their own communities.

During the 1950s, the role of the nurse began to evolve as well. It was recognized that nursing care in itself was therapeutic and that nurses could take on more functions than simply subduing and controlling patients (Worley, 1996). Therapeutic relationships were encouraged
and there was an attempt to move away from the original beliefs of custodial care and social control that were so often implemented in the asylums (Hannigan & Coffey, 2003). Since this time, nurses have continued to be instrumental in the provision of care in both acute and community psychiatric settings. However, despite their important role in providing health promotion interventions of patients with mental illness, there is evidence that nurses are not fully embracing this role and providing appropriate and effective smoking cessation interventions to this patient population.

**Defining Smoking Cessation and the Nurse's Role**

Similar to the general population, individuals with mental illness use tobacco primarily in the form of a cigarette. A cigarette, as described by the Royal College of Physicians (2000) is a “skillfully engineered product designed to deliver a sufficient dose of nicotine to maintain dependence” (p. 68). Smoking cigarettes is a known or probable cause of at least 25 diseases, including lung and other cancers, heart disease, stroke, emphysema and other chronic lung diseases (El-Guebaly et al., 2002; WHO, 2000; Williams & Ziedonis, 2004).

The World Health Organization (2004) states that smoking cessation is one of the most important components of a comprehensive tobacco control policy that strongly contributes to a decrease in smoking prevalence. Smoking cessation practice guidelines are systematically developed statements used to help health care providers make decisions about appropriate cessation strategies for clients who smoke. Smokers often turn to nurses and other health professionals for help in quitting smoking as they are a highly credible source of health information; thus, nurses are well positioned to combat the tobacco epidemic and promote a tobacco-free lifestyle (International Council of Nurses, 2003). Nurses working within community psychiatric settings are in a particularly optimal position to provide smoking
cessation support to their clients as they; 1) represent the largest group of care providers among
the various disciplines, 2) yield the highest amount of client contact in inpatient settings, 3) often
assume the position of case manager or coordinator due to their holistic perspective on the health
of the patient, and 4) their broad skill set and their broad knowledge of community resources

Nurses have been targeted as prime candidates to promote smoking cessation amongst
their clients. The Canadian Nurses Association (2001) states “registered nurses are the largest
group of health professionals in Canada, and are therefore in a powerful and primary position to
help reduce tobacco use at the clinical, community, and administrative levels” (para. 4). Nurses
are essential allies in the fight to eradicate tobacco use amongst individuals living with mental
illness. Cataldo (2001) asserts that the ability of the mental health nurse to deliver broad based
care while addressing psychotherapeutic needs positions them in the forefront of treating tobacco
use and dependence. Paradoxically, the research shows that while most nurses view smoking as a
severe health risk, few actually take action in providing smoking cessation counseling to their
clients (Buchanan, Huffman & Barbour, 1994; Dickens, Stubbs & Haw, 2004; Haller, McNiel &
Binder, 1996). Furthermore, nurses have not been as influential as expected in smoking cessation
within psychiatric settings and studies show that nurses are especially reluctant to address
nicotine addiction amongst this particular population (Jenkins & Elliot, 2004).

Smoking cessation counseling is widely recognized as an effective clinical practice
(CNA, 2003). Even a brief intervention by a health professional significantly increases the
cessation rate (Bialous & Sarna, 2004; Cataldo, & Tally, 2001; El-Guebaly et al., 2002). Brief
opportunistic advice from a nurse involves asking clients about their current smoking habits,
advising them to stop, offering assistance by way of referral to a specialist service, offering
advice about pharmacotherapy options, and lastly, arranging follow-up where appropriate (West, McNeill, & Raw, 2000). Although brief interventions, self-help, and supportive therapy have proven effective with general medical patients, such minimal therapies may not be sufficient for patients with psychiatric problems. This poses further cessation challenges for nurses working within the psychiatric setting (American Psychiatric Association, 1996).

**Focused Literature Review**

The literature was searched for studies that reported nurses’ beliefs and attitudes towards discussing smoking cessation in psychiatric settings. Due to the limited literature available on this specific topic, the review included studies that examined a broader range of health care providers’ attitudes and beliefs towards smoking cessation in both inpatient and outpatient psychiatric settings. A core search strategy was developed using the PubMed and PsychInfo electronic databases, with CINAHL and the Cochrane Database of Systematic Reviews used to glean further relevant studies. Among others, the main key words included: ‘exp Smoking Cessation/ (MeSH)’, ‘exp attitude of health personnel/(MeSH)’, ‘exp psychiatric nursing/(MeSH)’, ‘exp Attitude/(MeSH)’, ‘views’, ‘beliefs’, and ‘opinions’.

There is limited research examining why nurses working in psychiatric settings have not been as influential as expected in smoking cessation. Twelve studies addressing the barriers health care providers face when confronted with providing smoking cessation to individuals with mental illness were reviewed. Ten of these studies focused primarily on nurses with six of them specifically examining nurses working within inpatient psychiatric settings. There was only one study that examined barriers experienced by community mental health nurses.
Results

Personal Barriers: Attitudes and Beliefs

Perceived lack of client interest and client resistance to smoking cessation. The barrier most frequently identified by nurses to providing smoking cessation to their clients in the literature review related to client attitudes including perceived lack of interest and resistance to smoking cessation (Buchanan, Huffman, & Barbour, 1994; Dickens, Stubbs, & Haw, 2004; McCarty et al, 2001). All of the nurses working within an adult inpatient unit surveyed by Buchanan, Huffman, and Barbour (1994) ranked clients’ attitudes towards smoking cessation as the number one barrier to planning and implementing cessation interventions. This was further confirmed by the study by McCarty et al. (2001), whose findings demonstrated that nurses most frequently mentioned that they were fearful of alienating clients because clients were generally not receptive to receiving advice. Despite this belief, Buchanan et al. found that 88% of clients reported they wanted to stop smoking, and 62% said they would use assistance from a nurse if it were available. Another barrier consistently described throughout the literature reviewed was nurses’ concern about the effectiveness of giving cessation advice to clients. It is a widely held attitude that cessation advice from a nurse would not do any good, because health risk counseling was not effective in changing patient behaviour (Buchanan, Huffman, & Barbour, 1994; Dickens, Stubbs, & Haw, 2004).

Ethical decision making. A qualitative study performed with inpatient and community nursing staff in Australia showed that the decision to provide smoking cessation to clients was an individual process, in which all seven nurses interviewed perceived smoking cessation interventions as leading to a loss of autonomy for their clients (Lawn & Condon, 2006). Nurses interviewed in this study reported they were mindful of imposing their own value judgments on
clients, as they were acutely aware of the potential power imbalance. They felt that because
clients already had many of their choices taken away in inpatient psychiatric settings, they
wanted to give clients the choice of being able to smoke.

The principles of beneficience and non-maleficence were also addressed by nurses in
Lawn and Condon’s (2006) study. Most participants in this study perceived smoking as ethically
causing less damage than the more immediate problems faced by clients. This form of reasoning
was echoed throughout the relevant studies as leading to one of the top barriers cited by nurses
working in psychiatric settings due to the potential for increased aggression if clients did not
receive their cigarettes (Lawn & Condon, 2006; McEwan & West, 2001; Stubbs, Haw & Garner,
2004). This was of particular concern for nurses working on locked psychiatric wards where
smoking bans were taking place. However, it should be noted that studies included in this review
that examined rates of aggression with the implementation of smoking bans showed that these
fears were unfounded as rates of aggression did not increase once smoking bans were
implemented (Buchanan, Huffman & Barbour, 1994; Dickens, Stubbs & Haw, 2004; Haller,
McNeil & Binder, 1996; Ryabik, Lippmann & Mount, 1994; Stubbs, Haw & Garner, 2000). For
inpatient nurses, the longer-term physical effects and risks of smoking were seen as the “lesser
evil” when compared with the immediate effects of mental illness symptoms, level of distress
and the consequences of relapse for the person (Lawn & Condon, 2006). One nurse even went as
far as to claim that “letting them smoke is the easy option” (p.115).

The belief that clients become less calm or deteriorate if they are encouraged to stop
smoking was pervasive throughout the reviewed literature. Stubbs, Haw, and Garner (2004),
found that 92% of the nurses they surveyed believed that this would be the case, as did 88% of
psychiatrists. Interestingly, 87.9% of nurses in the same study believed that clients who smoke
should be encouraged to stop or cut back, compared to 100% of psychiatrists. This further highlights the significant discrepancies and contradictions found in the results of these studies as once again the reviewed studies show that while some nurses realize the detrimental health effects of tobacco on their clients, they are unwilling to provide smoking cessation to clients for fear of further deterioration.

Lawn and Condon (2006) also found that nurses working in inpatient psychiatric settings worried that restricting clients’ smoking at times when they were unwell would only hinder their recovery. Encouraging smoking cessation during these times was therefore seen as unfair and unnecessary. This perceived emotional instability was consequently a significant barrier to nurses providing smoking cessation advice and support to their clients. In contrast, most nurses working within the general hospital setting believed that hospitalization was an appropriate time to deliver smoking cessation advice (McCarty et al., 2001). The majority of nurses in a study conducted by McCarty et al. endorsed the belief that advice should be offered selectively and that the decision to provide cessation advice reflected their clients “openness to education”, expressing reluctance to give advice if a client was hostile or defensive about their smoking (p.86).

The issue of accountability was also a barrier that was reported in the literature. There is strong agreement in the research literature that nurses believe it is not appropriate to raise the topic of smoking cessation when a client was acutely unwell (Gould, Pearce & James, 2000; Erwin & Biordi, 1991; McCarty et al., 2001; Willaing & Ladelund, 2004). Inpatient nurses often saw the role of assisting people to quit smoking as a community role that should be directed at the client once they have been discharged from the hospital, are in their own environment, and have recovered from the acute phase of their illness. While inpatient nursing staff are reported to
have expressed attitudes that reflected the belief that smoking is one of their client’s few pleasures, community mental health nurses tended to give the patient more responsibility for their choices (Lawn & Condon, 2006).

Smoking as a therapeutic tool. Health care professionals, specifically nurses, have long perceived cigarettes to be an effective therapeutic tool in psychiatric settings. This belief proves to be a significant barrier for nurses providing smoking cessation counseling to their mentally ill clients, as smoking has been reported to aid therapeutic relationships between nurse and client and clients and their peers. This was exemplified in the study conducted by Buchanan, Huffman, and Barbour (1994) where findings indicated that smoking was not necessarily seen as a nursing problem and thus nurses did not see the need for initiating plans for implementing nursing interventions. Mester et al. (1993), suggest that nurses believe that smoking has a calming effect on clients and that they use cigarettes as a tool to achieve therapeutic goals. Stubbs, Haw and Garner (2004) sent questionnaires to 1,471 health care professionals in the US with nurses having the lowest response rate at 37.5% (n=476). Interestingly enough, no psychiatrists believed that cigarettes should be given to clients to achieve therapeutic goals, whereas 22% (n=126) of nurses agreed that they should.

Smoking has been touted as a therapeutic tool to aid in promoting interpersonal contact with patients, establishing rapport, and facilitating assessment (Lawn & Condon, 2006). Deeply entrenched in the culture of psychiatry is the belief that cigarettes help nurses facilitate the achievement of therapeutic goals with their clients (El-Guebaly et al., 2002; Stubbs, & Haw, 2004; Lawn & Condon, 2006). However, the term ‘therapeutic goals’ was explicitly defined in only one of the studies reviewed; indicating the need for further exploration into what this term means and how nurses currently go about achieving these goals.
Smoking as self-medication. As our understanding of the therapeutic uses of tobacco for psychiatric disorders matures, the concept of smoking cessation seems to become increasingly complicated. Nicotine has long been known for its anxiolitic and sedative qualities, making it a desirable agent for those suffering from mental illness, especially those with schizophrenia as there is growing evidence that nicotine can normalize two different dysfunctions in schizophrenia, auditory sensory gating and negative symptoms (Houexcé, 1998). Lawn (2004) reported that over half of the nurses surveyed stated that they condoned clients’ smoking because they believed it helped clients manage their mental illness symptoms. It has also been suggested that smoking reduces social inhibition and isolation for those with acute and chronic mental illness (Ziedonis, Williams & Smelson, 2003). Research evidence suggests that both neurobiological and psychosocial factors reinforce the use of nicotine in psychiatric populations (El-Guebaly et al., 2002).

Nurses’ Smoking Behaviour.

A formidable barrier to the lack of widespread involvement of nurses in smoking cessation efforts is their own smoking habits. It is clear from the existing research that despite efforts to promote cessation among health care professionals, nurses still smoke at relatively high rates (Sarna et al., 2004). Smoking among nurses limits their ability to provide effective smoking cessation interventions to their clients (Froelicher & Kohlman, 2005). A UK based study focused on mental health nurses’ attitudes towards smoking and found that nurses who smoked were more likely to report the positive value of smoking in the formation of therapeutic relationships, and less likely to report believing that patients who smoke should be encouraged to quit or cut back (Dickens et al., 2004). Studies by both Lawn and Condon (2006) and McCarty et al. (2001)
found that nurses who smoked perceived they were not credible role models as smoking cessation interventionists.

The high rate of smoking amongst psychiatric nurses, compared to nurses in other areas and other health care professionals is of concern (Griffith, 1999; Plant, Plant & Foster, 1991; Rowe & Clark, 2000; Trinkoff & Storr, 1998). Further findings from the Williang and Ladelund (2004) study indicate that physical and occupational therapists and medical doctors were significantly less likely to be smokers than nurses. Additionally, Willaing and Ladelund examined how smoking behaviour among hospital staff influenced their attitudes and counseling on smoking and found that staff working on the psychiatric wards were significantly more likely to be current smokers than staff in the medical departments. The reasons for this discrepancy remains unclear, however, some authors have attributed the higher rates to the accepted smoking culture in psychiatry, accessibility of cigarettes, emphasis on medication use, and work-related stress (Jenkins & Elliot, 2004; Prochaska, Gill, & Hall, 2004; Brown, 2004).

Lastly, both earlier and recent studies have found that current smokers systematically underestimate the health consequences of smoking. The findings of these studies consistently suggest that nonsmokers give counseling on the health consequences of smoking and on smoking cessation significantly more often than do current smokers (Dickens, Stubbs & Haw, 2004; McCarty et al., 2001; Hall, Vogt, & Marteau, 2005).

**Systemic Barriers**

The culture of tobacco use. Smoking is an entrenched part of the culture of psychiatric settings and has been central to the foundation of mental institutions over the past century (Lawn, 2006). Multiple studies have shown how the culture of smoking is a primary barrier to the effective implementation of smoking cessation interventions to individuals with mental illness.
(Buchanan et al., 1994; Dickens, Stubbs & Haw, 2004; Lawn, 2004; Lawn & Condon, 2006). A study conducted by Dickens, Stubbs, and Haw in the United States examined the prevalence of smoking in mental health nurses, as well as their beliefs and attitudes about smoking at work. They reported that registered nurses working in acute psychiatric settings had a more liberal attitude towards smoking and attributed this to environmental and cultural factors such as higher stress levels, and more time in direct patient contact with fewer opportunities to leave the ward.

In their qualitative studies with nurses and clients in mental health settings in Australia, Lawn and Pols (2004) found that smoking was a significant part of the hospital culture. Cigarettes were described as the currency within a token economy. An explicit example of this was reported in a qualitative study conducted by Lawn and Condon in 2006 in which a nurse stated, “...each inpatient was given a tobacco ration for personal use or barter, regardless of whether they were a smoker [or not].” (p. 113).

Cigarettes to manage mental illness. Many nurses have been trained within a mental health care system that accepted the use of cigarettes to assist patients with their mental illness management. A powerful example used to describe the entrenched culture of smoking in psychiatric settings is described in the study by Lawn and Condon (2006) in which a nurse is reported to state:

"Back in the days the tobacco was supplied by the hospital in bulk in big brown paper bags, and nurses, especially in the (locked) ward, ...because of the patients inability to roll their own cigarettes, used to spend hours just sitting there rolling up cigarettes in bulk, and because these patients were incapable of lighting their own or handling matches safely, quite often it was expected that nurses would light the cigarettes for them and then hand them the lit cigarette" (p. 113).

Cigarettes were also used to establish rapport with clients and to ensure the safety and harmony of the ward environment (Ryabik, Lippman & Mount, 1994; Haller, McNiel & Binder, 1996;
Lawn, 2004; Lawn & Condon, 2006). Nurses in a number of studies, conducted in various countries, have been reported to accept cigarettes as a part of their interaction with patients and use them as a tool to reinforce behaviours (Lawn & Condon, 2006; McCarty, 2001; Stubbs, Haw, & Garner, 2004). Another example of this is articulated by a community mental health nurse interviewed by Lawn and Condon (2006); “If you wanted the patients to do something, you could give them a cigarette and they’d probably do it. In fact, I remember the charge sister saying, ‘Go and run this errand and I’ll give you a cigarette. Go and make your bed and I’ll give you a cigarette...’ It was how you got things done” (p.113).

Insufficient time and prioritizing of care. Due to the severity of their conditions, a significant number of individuals with mental illness receive most of their treatment and rehabilitation in the hospital setting; some even consider it their home (White, Roy, & Hamilton, 1997). Buchanan, Huffman and Barbour (1994) conducted a study in an acute psychiatric setting and found that 58% (n=7) of nurses working in the adult program reported that a short patient stay was a significant barrier to implementing smoking cessation interventions to their clients. Due to overwhelming patient workloads, 58% (n=7) of those surveyed reported that other priorities took precedence over providing smoking cessation education. The issue of inadequate time in a nurse’s schedule to provide smoking cessation interventions was also a common theme throughout the reviewed literature, and was reported numerous times in the studies conducted by Buchanan, Huffman and Barbour, Gould, Pearce and James (2000), Jenkins and Elliot (2004), McCarty et al., (2001) and McEwan and West (2001).

Lawn and Condon (2006) studied the ethical stance which nurses take in regards to individuals with mental illness and smoking. They examined the nurse’s role in supporting smoking cessation and found that the due to the limited time nurses had with their clients, and
the severity of their clients’ illness, the ethical principles of beneficence and nonmaleficence
became significant, as they believed that smoking caused less damage than the more immediate
problems faced by the client. This claim was also supported by studies conducted by both
Buchanan et al. (1994) and Gould, Pearce and James (2000) in the UK and Australia
respectively, as both reported that nurses believed they had other individual patient priorities
compared to smoking cessation and the need for more time with clients in order to provide
smoking cessation advice was a substantial barrier to the implementation of such interventions.

Lack of smoking cessation skills and knowledge. The lack of nurses’ smoking cessation
skills and knowledge has proven to be a significant barrier to the provision of smoking cessation
advice to clients with mental illness. A Cochrane Review titled ‘Training Health Professionals in
Smoking Cessation’ reported that staff training-of shorter or longer duration-leads to
significantly more frequent, and for some professional groups, more effective counseling
(Lancaster et al., 1999). In terms of amount of training required Buchanan, Huffman, and
Barbour (1994) reported that the less qualified that staff members feel about providing
counseling and smoking cessation support, the less they will ultimately counsel. Moreover, a
study conducted by Sarna et al. in 2004 concluded that 97% (n=57) of the participating nurses
reported never having seen the *Treating Tobacco Use and Dependence. Clinical Practice
Guidelines* developed by the US Department of Heath and Human Services, which was a pivotal
and extremely influential document in regards to targeting tobacco reduction in North America
and abroad. In terms of cost effectiveness, even minimal training that encourages health
professionals to be sensitive to and prepared to address client’s concerns about quitting have
been demonstrated to be a cost-effective investment (Bialous & Sarna, 2004; El-Guebaly et al.,
2002; Lancaster et al., 2005).
As the number of empirical studies about mental illness and tobacco use increase, new associations between tobacco smoking and psychiatric disorders are being discovered. These associations include smoking as a form of self-medication as well as the complex interactions of cigarettes with antipsychotic medications. Many nurses believe that the cigarettes provide some beneficial therapeutic effects to their clients and are therefore reluctant to encourage their clients to quit. Knowledge of these associations have the potential to provide further barriers to health care professionals' in provision smoking cessation interventions to their clients as they may be considered further 'beneficial' aspects of tobacco for this particular population.

Buchanan, Huffman, and Barbour (1994) found that 17% of nurses stated that their lack of cessation knowledge hindered the ability to provide effective counseling to their clients. This barrier appears to permeate not just psychiatry, but all areas of nursing, as evidenced by McCarty et al.'s (2001a) study which found that the barrier most frequently mentioned by nurses working on medical/surgical, orthopedic, oncology, and cardiology units was a lack of information about smoking cessation methods and referral options or self-help cessation materials. Similar findings were reported in studies conducted since the late 1990s (McCarty et al., 2001b; Pelkonen & Kankkunen, 2001). Earlier studies do not mention lack of information as a primary barrier, if at all, which is interesting to note as it brings attention to the shift in thinking regarding the increased complexity of delivering smoking cessation to clients. With the advent of pharmaceutical aids for cessation and a deeper understanding of the psychology and physiology of nicotine addiction, providing cessation advice is now viewed as more complex than once thought.

McEwan and West (2001) interviewed 33 nurses and found that nurses who reported having received training in the delivery of smoking cessation advice were significantly more
likely than those who had not to report that they provided cessation assistance for smokers. Nurses with cessation training were also more likely to recommend nicotine replacement therapy (NRT) as well as believe that NRT is effective enough to justify its cost (McEwan & West). McEwan and West concluded that there was a positive association between training and activity, attitudes, and knowledge towards implementing smoking cessation to clients.

Williang and Ladelund (2004) reported that the most educated staff members, such as medical doctors often had more of an active attitude toward smoking cessation counseling and more often provided counseling compared to those with less education. Their study found that "medical doctors were over twice as likely to offer smoking cessation counseling to their clients as nurses; OR= 2.2" (p. 372). Furthermore, the authors concluded that the less staff felt qualified, the less likely they were to provide counseling. Those with post qualification training gave counseling and smoking cessation advice significantly more often compared with other health professionals (p=0.0001).

Limitations of the Literature

It is difficult to compare studies on tobacco use and mental illness as many authors use the terms ‘education, advice, support, and counseling’ interchangeably, without explicit definitions as to what each entails. This is troublesome, as these terms are not equivalent and potentially require different levels of resources, training, time and effort. Also, the majority of studies included in this literature review have relatively small sample sizes in regards to nurses surveyed or interviewed, thus making it difficult to generalize the findings to the overall mental health nursing population. In addition, studies where multiple health care providers’ attitudes and beliefs were examined, nurses consistently had the lowest response rates compared to other
health care professionals. This poses a problem not only in terms of representation of findings, but also in determining the overall clinical significance of the findings.

Another major limitation of the research literature is that it is not clear what factors influence smoking by nurses in the workplace or support nurses' efforts to quit. Furthermore, the concerns for staff morale and anxiety levels as part of a change process and the destructive effects of not having a consistent approach to implementing smoking cessation programs does not appear to be addressed in the reviewed literature. There is also no mention of staff education regarding the ability to differentiate between psychotic symptoms of distress and nicotine withdrawal symptoms.

There is no research that has examined community mental health nurses' stage of readiness in relation to implementing smoking cessation interventions into their practice. Furthermore, there is an absence of empirical evidence about how personal and systemic barriers affect nurses' stage of readiness to 1) talk with clients about their smoking and 2) provide smoking cessation support to clients. Lastly, there is a lack of current research on the barriers nurses face when providing smoking cessation counseling in the community mental health setting. As the mental health system shifts its paradigm of care from the hospital to community, it is imperative that the barriers faced by nurses working in this unique sector be studied to ensure effective and optimal continuation of care. It is also apparent from the literature reviewed, that Canada is sorely under-represented in the evidence base that has examined the three inter-related components of barriers, smoking cessation, and nurses, working with mentally ill clients. All of the studies reviewed were conducted in a country other than Canada, which is problematic, as barriers nurses' face in other countries may not be the same as those encountered by nurses working in Canada. Despite studies being conducted in countries such as the UK,
Australia and the US, it is apparent that there remains an overall lack of international research in this specific area.

Summary

Tobacco use has played a significant role in the lives of mentally ill clients in inpatient psychiatric settings. As the treatment for the mentally ill moves away from custodial care and to a more health promotion and self-efficacy model and the health risks of smoking become increasingly apparent, nurses have an obligation to provide equal and optimal smoking cessation counseling to their clients as they would in any other nursing context. However, personal and systemic barriers continue to impede nurses working in psychiatric settings from providing effective cessation counseling to their clients on a global scale.

Despite the development of smoking policies and cessation guidelines formulated to assist nurses and other health care professionals incorporate smoking cessation interventions into their practice, barriers such as personal smoking behaviour, nurses attitudes and beliefs, lack of skills and knowledge, and the culture of tobacco use in psychiatry continue to impede individuals with mental illness from receiving the cessation support they deserve.

As global health initiatives aim to eradicate tobacco use worldwide, it is imperative that nurses working in psychiatric settings overcome these barriers, and ultimately address a critical problem that has been largely ignored by the health care system. By acknowledging and addressing both personal and systemic barriers that are currently impeding the delivery of smoking cessation interventions to the mental health population, clients who are smokers and living with mental illness are closer to receiving the optimal nursing care they deserve. Despite the barriers nurses face when implementing smoking cessation interventions for this population, it is imperative that nurses move beyond the highly ingrained stigmas and reinforced smoking
culture that remain implicit within psychiatric settings. Systemic patterns of learning and reinforcement need to be challenged and replaced within psychiatric treatment environments.

The few studies undertaken to explore the perceptions and barriers psychiatric nurses' confront when addressing tobacco use among their clients have been limited by low response rates, small sample sizes and outdated data, and focused almost exclusively on nurses working within in-patient settings. Studies exploring community mental health nurses’ perceptions regarding tobacco use among their clientele were not found. It is therefore important that further study of this phenomenon is conducted in order to develop a better understanding of nurses’ readiness to implement smoking cessation interventions into their practice.
CHAPTER 3: QUANTITATIVE RESEARCH COMPONENT

The purpose of the first phase of this research projects was to describe the stage of readiness of community mental health nurses in relation to implementing smoking cessation interventions into their practice as well as describe how their stage of readiness compares to that of other mental health care professionals. Factors such as smoking status of the health care provider, number of years working within the mental health system, and environmental factors were explored to determine if, and how they affected health care providers’ readiness to change. Personal and systemic barriers were also analyzed to determine whether they affected health care providers’ readiness to change.

This research was embedded in a larger research project conducted by Johnson et al. (2005) entitled the ‘CACTUS Project: Cultivating Awareness of the Context of Tobacco’. The research encompassed three components (Survey of Persons Providing Services to Individuals with severe and persistent mental illness [SPMI], Survey of Persons with SPMI, and Research Synthesis and Intervention Planning) that addressed the relationships between individual, professional, and environmental factors that affect tobacco use by individuals with SPMI. For this research project, questions measuring stage of change were added to the Health Care Provider Survey, developed by Johnson et al. (2005). The provider survey was aimed at examining health care providers’ thoughts, feelings, and behaviours regarding tobacco use in the context of community mental health settings. Data were collected via a self-report questionnaire. The questionnaire contained items pertaining to: a) attitudes and beliefs regarding smoking and tobacco use within the mental health system, b) workplace practice and policies related to tobacco use, c) provider practices regarding tobacco, d) knowledge, training, and skills regarding tobacco dependence, e) personal smoking history, and f) participant demographics.
This cross-sectional survey design was appropriate for the quantitative component of this study because: 1) it was exploratory in nature and relationships among variables could be examined, 2) large amounts of data were collected over a short period of time and, 3) due to flexibility and broadness of scope, self-report questionnaires are a primary source of information in a wide range of clinical and research settings (Polit & Beck, 2004). Despite the strengths of this design, information obtained from surveys can be relatively superficial; rarely do items probe deeply into complexities such as human behaviour and feelings (Polit & Beck). Phase two of this study complements the survey findings by employing a qualitative approach that aims to probe deeper into nurses’ overall perceptions relating to implementing smoking cessation interventions into their community mental health practice.

The setting for this study was eight community mental health teams and 12 contracted mental health agencies in the City of Vancouver. Within the City of Vancouver, Vancouver Coastal Health (VCH) oversees the provision of mental health services to non-institutionalized individuals living with a SPMI who live in the community. Non-institutionalized individuals diagnosed with a SPMI are followed by one of the eight community mental health teams and are also eligible to receive additional support in the form of rehabilitation or housing through a number of contracted agencies.

**Study Protocol**

Four research assistants (RAs) along with the investigator were hired and trained by the CACTUS project’s principal investigator and project director to deliver study presentations to the mental health teams, recruit participants, and ensure all health care providers received a questionnaire. Completion of the questionnaire indicated the participants’ consent to participate. Incentive draws were employed at each participating site on a one-time basis to encourage
participation. Completed questionnaires were collected weekly by both the investigator and RAs and the accrued data was professionally entered into a secure database. Each questionnaire was coded to indicate the geographic sector of the agency and anonymity of the participants was maintained throughout the research process. Data collection commenced in February 2006 and was completed by the end of April 2006. Once data collection was complete, “Thank You” posters were placed in the staff rooms of participating sites and preliminary findings were shared with staff and clients.

Study Sites

The eight mental health teams and 12 contracted agencies within the City of Vancouver were the study sites for phase one of this research. The mental health teams provide psychiatric services to residents who have a SPMI and live in defined catchment areas. These services include outreach, clinical assessment, comprehensive case management, medication management, basic support services, advocacy for income assistance and housing, and coordination of community services (Vancouver Coastal Health, 2005). Front-line health care providers working in this area are therefore involved in one or more of the following: diagnosis, treatment, individual and group therapy, rehabilitation, consultation, emergency and urgent services, and residential services. Clients utilizing these services have a diagnosis of SPMI such as schizophrenia, bipolar disorder, severe depression, behavioural disorders and severe dementia (Vancouver Coastal Health, 2005). Each mental health team is uniquely tailored to the needs and multicultural mix of the neighborhood in which it works, and consists of nurses, psychiatrists, physicians, occupational therapists, rehabilitation workers, social workers, health care workers and peer support workers.
Sample

The population for this study included health care professionals who worked with either one of the eight community mental health teams, or with one of the 12 agencies contracted by Vancouver Coastal Health to provide government funded services to persons with mental illness. Team and agency directors were first approached by the CACTUS project director to assess their interest in participation in this study. Once rapport was established with the directors and they expressed interest in the study, an RA visited the site, explained the study and proceeded with distributing questionnaires to staff. The study population was defined as all community mental health care providers who directly provided front-line care to adults diagnosed with a severe mental illness. Inclusion criteria for this study included: a) being a health care provider, b) providing direct front-line care to clients, and c) providing services to the adult clientele. Exclusion criteria included clerical support staff and other support workers such as cooks or custodians and staff who provided mental health services to a population other than adults, such as adolescents or the elderly. Eligible health care providers were identified with the help of the director of mental health services. The study population included 320 staff members from the mental health teams and approximately 400 additional professional and paraprofessionals who work for the contracted agencies. To minimize sampling biases, efforts were made to ensure all health care providers were given a questionnaire. Non-response of some individuals was expected but was not anticipated to interfere with the study unless a particularly large number of non-responses accrued.

Instrumentation

In the CACTUS project Johnson et al. (2005) examined tobacco control techniques and practices, workplace policies, skills and self-efficacy, barriers to smoking cessation advice,
personal smoking status and demographics of health care providers. Items for the questionnaire were generated from the literature. Many items were listed as attitudinal scales (strongly agree, agree, disagree, etc.) while other scales used frequency measurements (never, often, always, etc) to determine practices and policies. To strengthen content validity, three nurse researchers who are experts in the field of tobacco and survey construction reviewed the questionnaire for completeness and relevance to the mental health care field in Vancouver. The survey instrument was then reviewed by an expert panel and pilot tested in two mental health settings outside Vancouver. A 29 page survey booklet titled ‘CACTUS Health Care Provider Survey’ was distributed to the participating study sites and on average it took participants 20 minutes to complete (see Appendix A). It is important to note that the tool for data collection represents items drawn from other established tools as well as items developed to answer the research questions posed by this study. The items used in this analysis are described below.

Readiness to change. Health care providers’ readiness to change was assessed by asking respondents to select the response that best represented their approach to ‘talking with clients about their smoking’. The responses available included the following: “I have not given it much thought”, “I have decided that I do not need to provide smoking cessation support to my clients”, “I am planning on providing smoking cessation support to my clients within the next 6 months”, “I sometimes provide smoking cessation support to my clients”, “I often provide smoking cessation support to my clients”, “I always provide smoking cessation support to my clients”. A similar item asked participants to select the response that best represented their approach to ‘providing smoking cessation support for your clients who smoke’. Responses included “I have not given it much thought”, “I have decided that I do not need to provide smoking cessation support to my clients”, “I am planning on providing smoking cessation support to my clients”, “I always provide smoking cessation support to my clients”, “I often provide smoking cessation support to my clients”, “I sometimes provide smoking cessation support to my clients”, “I always provide smoking cessation support to my clients”. A
within the next 6 months”, “I sometimes provide smoking cessation support to my clients”, “I often provide smoking cessation support to my clients”, “I always provide smoking cessation support to my clients”. The two variables were then collapsed and recoded into one of the five stages of change based on Prochaska and DiClemente’s Transtheoretical Model and Stages of Change Theory. The response “I have not given it much thought” was recoded into the “precontemplation” stage, “I have decided that I do not need to provide smoking cessation support to my clients” and “I am planning on providing smoking cessation support to my clients within the next 6 months” were recoded into the “contemplation” stage, “I sometimes provide smoking cessation support to my clients” was recoded into the “preparation” stage, “I often provide smoking cessation support to my clients” was recoded into the “action” stage, and “I always provide smoking cessation support to my clients” were recoded into the “maintenance” stage. All items were modeled on items used to measure self-change behaviour as described by Prochaska and DiClemente’s (1982) Transtheoretical Model of behaviour change.

**Smoking status and demographic variables.** Personal smoking status was assessed by asking respondents whether they were a current smoker (yes/no), a former smoker, or a non-smoker. Length of time working in the mental health field was measured using an open-ended question asking “How long have you worked in the mental health field?; the response was provided in months and then later recoded in years. Age of the respondent was also measured by an open-ended question asking “What is your age?”

**Workplace policies.** Items were developed to assess community mental health workplace practices and policies related to tobacco use. For the purpose of this study ‘workplace policies’ was operationalized using the three variables: “Are there designated smoking areas outside your workplace?”, “Have you read any written material regarding smoking policies at your
workplace?”, and “Are written smoking policies mentioned to clients during the intake process?” Each respondent answered these questions by choosing “yes” or “no.”

Environmental tobacco smoke (ETS) exposure. Respondents were asked questions pertaining to the amount of exposure to second hand smoke from their clients. The two variables used in the analysis were ordinal level (never, rarely, sometimes, often, never). These items asked if the respondents were “exposed to second hand smoke from clients” and “exposed to second hand smoke from co-workers”.

Personal barriers. Personal barriers are obstacles perceived by individuals (health care providers) to impede the implementation of smoking cessation interventions into their workplace. For the purpose of this study, items used to operationalize this concept included “I lack adequate knowledge about smoking cessation and tobacco reduction” and “I avoid mentioning tobacco use so that I won’t seem judgmental”. Participants responded on a four-point ordinal scale from “strongly agree” to “strongly disagree”.

Systemic barriers. Systemic barriers were measured with two items. Systemic barriers pertain to barriers outside an individual, rather to a system in its entirety (Oxford Canadian Dictionary of Current English, 2005) and therefore this concept was operationalized using the items “I do not have enough time, as a health care provider, to deal with tobacco use” and “Tobacco cessation/reduction support is not an expected part of my role”. Once again participants responded on a four-point ordinal scale ranging from “strongly agree” to “strongly disagree”.

Data Analysis

Questionnaires were reviewed for completeness, entered into an electronic file and verified for accuracy. All analyses were performed using SPSS statistical software. Univariate
Descriptive statistics were examined to ensure accuracy of the data, determine the extent of missing data and outliers, and assess the distributional properties of the variables. Bivariate analyses were then performed to assess the effect smoking status, workplace policies, exposure to ETS, and personal and systemic barriers had on nurses' stage of change. Descriptive statistics were employed to determine how many nurses were in each of the five stages of change. The frequencies were then compared to the other health care professionals using a Pearson chi-square test to determine whether there were any significant differences between the two groups. To handle a contingency table with a zero cell, the dependent variable (stage of change) was collapsed into three categories (precontemplation/contemplation, preparation, and action/maintenance) based on the frequency of the data and theoretical evidence. The precontemplation/contemplation phase was the stage where health care providers were not actively engaged in either talking with clients about their smoking or providing any smoking cessation support. The preparation category remained separate, as it represented health care providers beginning to engage in talking with clients about their smoking and provide smoking cessation support. There were also a significant number of health care providers in this stage. The third category, the action/maintenance stage, represented respondents who were actively engaged in tobacco control with their clients on a regular basis. Overall, the action and maintenance stages had the lowest responses.

**Results**

**Efficiency of Sampling**

The questionnaire was completed by 282 health care providers (response rate 39%). See Table 1 for the breakdown of respondents by professional status. Out of this sample 5 questionnaires were omitted from the analysis; 3 because there was a substantial amount of
information missing on the questionnaires and 2 because they were completed by mental health care workers who did not meet the eligibility criteria for this study. To avoid misrepresentation of the findings it was also necessary to omit the group of 'prescribers' (n=7) from the analysis due to their small sample size and statistically different responses from the other 3 health care provider groups. The final sample size for the statistical analyses was therefore 270.

Table 1. Response Rates for Questionnaire Participants

<table>
<thead>
<tr>
<th>Respondent</th>
<th>N (N=282)</th>
<th>% (100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses(^a)</td>
<td>62</td>
<td>22.0</td>
</tr>
<tr>
<td>Other Professionals(^b)</td>
<td>66</td>
<td>23.4</td>
</tr>
<tr>
<td>Paraprofessionals(^c)</td>
<td>142</td>
<td>50.5</td>
</tr>
<tr>
<td>Prescribers(^d)</td>
<td>7</td>
<td>2.4</td>
</tr>
<tr>
<td>Other(^e)</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Missing/Refused</td>
<td>3</td>
<td>1.0</td>
</tr>
</tbody>
</table>

\(^a\)Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs)
\(^b\)Social Workers, Occupational Therapists, Recreational Therapists, Psychologists, Counselors
\(^c\)Mental Health Workers, Community Living Support Workers, Outreach Workers, Peer Support Workers, Tenancy/Housing Workers
\(^d\)Psychiatrists and Physicians
\(^e\)Custodian, Cook

For the purpose of benchmarking, the responses of other mental health care providers were compared with community mental health nurses.

Participant Demographics

The personal and professional characteristics of the respondents such as their education, smoking status and number of years worked in the mental health field were markedly different between nurses, paraprofessionals and other professionals (Table 2). Age and hours worked per week did not differ significantly between the groups and most responders across all three groups...
were female. Due to the ethnic/cultural diversity in Vancouver participants were asked what ethnicity/cultural background they most identified with. Over 91.3% of all the participants reported they identified most with a Canadian/European background, and 94% of all participants reported their primary language was English. The majority of the participants (86%) worked the day shift, which is not surprising as participants primarily worked in agencies that were open Monday to Friday from 9:00am to 5:00pm. Nurses were primarily female and were most likely to have a community college diploma or university degree. Over half (53.2%) of the nurses reported they were former smokers.

Table 2. Demographic Characteristics of Survey Respondents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Nurses</th>
<th>Paraprofessionals</th>
<th>Other Professionals</th>
<th>df</th>
<th>( \chi^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (n=269)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>49 (79.0)</td>
<td>86 (61.0)</td>
<td>47 (71.2)</td>
<td>4</td>
<td>8.0*</td>
</tr>
<tr>
<td>Male</td>
<td>13 (21.0)</td>
<td>53 (37.6)</td>
<td>19 (28.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0 (0.0)</td>
<td>2 (1.4)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education (n=270)</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>32.6*</td>
</tr>
<tr>
<td>High School/Trades</td>
<td>2 (3.2)</td>
<td>18 (12.7)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certification</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community College</td>
<td>23 (37.1)</td>
<td>48 (33.8)</td>
<td>11 (18.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University Undergraduate Degree</td>
<td>24 (38.7)</td>
<td>52 (36.6)</td>
<td>25 (37.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master’s Degree/Post Graduate/Professional Degree</td>
<td>13 (21.0)</td>
<td>24 (16.9)</td>
<td>30 (45.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Status (n=268)</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>13.7*</td>
</tr>
<tr>
<td>Current</td>
<td>8 (12.9)</td>
<td>43 (30.9)</td>
<td>10 (17.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former</td>
<td>33 (53.2)</td>
<td>55 (39.6)</td>
<td>22 (37.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>21 (33.9)</td>
<td>41 (29.5)</td>
<td>26 (44.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p ≤ 0.01

Table 3 compares the results of age, months worked in the mental health field, and hours worked per week between nurses, paraprofessionals and other professionals. Results revealed a statistically significant difference among group means for months worked in the mental health
field. Post-hoc pair wise comparison of means by Scheffe test revealed a statistically significant difference between nurses and paraprofessionals and nurses and other professionals. The means in the table indicate that nurses had worked significantly longer in the mental health field than paraprofessionals and other professionals. Age and hours worked per week did not differ significantly between the groups.

Table 3. Comparing Survey Respondents' Demographic Means

<table>
<thead>
<tr>
<th>Variable</th>
<th>Nurses (M (SD))</th>
<th>Paraprofessionals (M (SD))</th>
<th>Other Professionals (M (SD))</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months worked in the mental health field (n=268)</td>
<td>193.27 (137.8)</td>
<td>113.30 (82.1)</td>
<td>148.12 (91.0)</td>
<td>2</td>
<td>13.9*</td>
</tr>
<tr>
<td>Hours worked per week (n=267)</td>
<td>37.06 (6.4)</td>
<td>34.40 (12.8)</td>
<td>34.92 (5.9)</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>Age (n=266)</td>
<td>45.08 (11.4)</td>
<td>44.00 (10.8)</td>
<td>44.25 (9.3)</td>
<td>2</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*p ≤ 0.001

Nurses' Readiness to Change

Talking to clients about their smoking. Descriptive statistics were used to determine the frequency of nurses in each of the stages of change. To determine whether the nurses' stage of readiness differed significantly from other professionals working in the community mental health setting a Pearson chi-square test was employed. The analysis showed that significantly more nurses were in the preparation stage (sometimes talking to their clients about their smoking habits) compared to 'other professionals' (social workers, occupational therapists, recreational therapists, psychologists and counselors) and 'paraprofessionals' (mental health workers, community living support workers, outreach workers, tenancy housing workers and peer support workers), and that nurses were significantly less likely to be in the precontemplation or
contemplation phase (not actively talking to clients about their smoking) than their counterparts. Over one quarter of paraprofessionals has not given much thought to talking with their clients about their smoking. Table 4 highlights these findings.

Table 4. Talking with Clients about their Smoking (n=254)

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Nurses N (%)</th>
<th>Paraprofessionals N (%)</th>
<th>Other Professionals N (%)</th>
<th>df</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precont/Contemp</td>
<td>2 (3.4)</td>
<td>36 (27.1)</td>
<td>7 (11.1)</td>
<td>4</td>
<td>18.6*</td>
</tr>
<tr>
<td>Preparation</td>
<td>40 (69.0)</td>
<td>73 (54.9)</td>
<td>39 (61.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action/Maintenance</td>
<td>16 (27.6)</td>
<td>24 (18.0)</td>
<td>17 (27.0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p ≤ 0.001

Providing smoking cessation support to clients that smoke. There was a significant difference between the three groups in regards to providing smoking cessation support to clients (Table 5). Nurses were twice as likely to report that they provide their clients with smoking cessation support as paraprofessionals. Paraprofessionals and other professionals were much more likely to engage in talking with a client about their smoking than to provide smoking cessation support. Over half of the paraprofessionals were not actively providing smoking cessation support to their clients. Nurses however, were providing smoking cessation support to their clients at close to the same rate as they are speaking with clients about their smoking.
Table 5. Providing Smoking Cessation Support to Clients that Smoke (n=243)

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Nurses N (%)</th>
<th>Paraprofessionals N (%)</th>
<th>Other Professionals N (%)</th>
<th>df</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precont/Contemp</td>
<td>6 (10.3)</td>
<td>64 (52.5)</td>
<td>22 (34.9)</td>
<td>4</td>
<td>30.6*</td>
</tr>
<tr>
<td>Preparation</td>
<td>39 (67.2)</td>
<td>46 (37.7)</td>
<td>33 (52.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action/Maintenance</td>
<td>13 (22.4)</td>
<td>12 (9.8)</td>
<td>8 (12.7)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p ≤ 0.001

In what follows we considered in more detail the responses of the community health nurses. Due to the small sample size of nurses it was not possible to conduct a valid chi-square analysis with the independent variables. Below, results related to workplace policies, environmental tobacco smoke exposure and personal and organizational barriers are reported first, and second, key findings from the cross tabulations employed between the dependent variables and smoking status, years working in the mental health system, workplace policies, ETS exposure, and personal and organizational barriers are then reported (Table 6).

**Workplace Policies**

Almost 10% of nurses said there were designated smoking areas *inside* their workplace while over half of the nurses (56%) reported there were designated smoking areas *outside* their workplace. Over half (58%) of the nurses had not read any written materials regarding smoking policies at their workplaces while 72.6% of nurses indicated that smoking policies were not mentioned to clients during the intake process. Nurses were divided as to whether they thought smoke-free policies would discourage clients from utilizing their services; 45.1% believed such policies would discourage clients from utilizing their services and 54.9 disagreed that smoke-free policies would discourage clients from utilizing their services.
Environmental Tobacco Smoke (ETS) Exposure.

Over 60% of nurses reported being exposed to second hand smoke from clients and over half of these nurses (58%) reported they were not bothered by it. Close to 80% of nurses reported allowing clients to smoke when accompanying them from point A to B (for example, from their house to an appointment) while 90% of nurses reported their clients smoked in their presence when accompanying them in public spaces. Over half (58%) of the nurses reported clients smoked in their presence during home visits.

Personal Barriers

Lacking adequate knowledge about smoking cessation support was a common barrier for health care providers mentioned throughout the literature. In this study, 67.7% of nurses reported they did not lack knowledge about smoking cessation and smoking reduction, but almost 80% of nurses thought they needed additional training/skills to assist clients in reducing/ quitting tobacco. Furthermore, 85% of nurses disagreed with the statement “I avoid mentioning tobacco so I don’t seem judgmental”.

Organizational Barriers

Over half of the nurses (58%) surveyed reported they had enough time as a health care worker to deal with tobacco use. Most nurses (64%) also believed that tobacco cessation/reduction support was an expected part of their role. Almost a third (32%) of nurses reported that smoking cessation was not their role; however 0% believed that it was no one’s role. The majority of nurses believed that it was the case manager’s role (79%) or psychiatrist’s role (76%), while over half (58%) of the nurses believed it was the occupational therapist’s role.
Table 6 focuses on community mental health nurses and presents cross tabulation results concerning the relationship between the two dependent variables: a) talking with clients about their tobacco use and b) providing smoking cessation support, and independent variables: smoking status, years in mental health service, workplace policies, environmental tobacco smoke exposure and personal and organizational barriers. The most prominent finding from this table is that it did not matter whether nurses were current, former, or non-smokers, if they worked more or less than ten years in the mental health service, whether they answered yes or no to the workplace policy and environmental tobacco smoke exposure items, or agreed or disagreed with the personal and organizational barrier questions; the majority of nurses reported they were in the preparation phase for each response. Further key findings include: 1) former smokers were more likely to talk with their clients about their tobacco use and providing smoking cessation support to their clients more often than current and non-smokers, 2) nurses who worked in the mental health system for > ten years reported talking with clients about their tobacco use and providing smoking cessation support more often than nurses who had worked less than 10 years in the system, 3) Nurses who responded yes to there being designated smoking areas outside of their workplace were less likely to often/always talk to their clients and provide smoking cessation support than nurses who reported there were no designated smoking areas outside of their workplace, 4) Nurses were divided as to whether they had read any written material regarding smoking policies, but for those who indicated they had, almost 40% reported often/always talking to clients about their tobacco use, 5) nurses who reported they were exposed to second hand smoke from clients were twice as likely to provide smoking cessation support to their clients compared to nurses who were not exposed to second hand smoke from their clients, 6) nurses who disagreed with the personal barrier items were more likely to be actively engaged in
talking with clients about their smoking and providing smoking cessation support than those who agreed, and 7) nurses who believed they had enough time to deal with tobacco use and believed tobacco cessation/reduction was an expected part of their role were more actively engaged in often/always talking to their clients about their tobacco use. The findings suggest that the majority of nurses have sometimes taken significant action towards engaging their clients in a dialogue about their tobacco use, as well as provided smoking cessation support to them no matter what their smoking status, years in the mental health field, the presence/absence of workplace policies, if they had been exposed to environmental tobacco smoke, and whether they believe the personal and organizational barriers have affected their ability to address tobacco use among their clients.
<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Talking With Clients About Their Smoking N (%)</th>
<th>Providing Smoking Cessation Support N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre/Cont</td>
<td>Prep</td>
</tr>
<tr>
<td>Smoking Status (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>1 (12.5)</td>
<td>6 (75.0)</td>
</tr>
<tr>
<td>Former</td>
<td>0</td>
<td>19 (65.5)</td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>1 (4.7)</td>
<td>15 (71.4)</td>
</tr>
<tr>
<td>Years in Service (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>2 (9.5)</td>
<td>15 (71.5)</td>
</tr>
<tr>
<td>&gt;10</td>
<td>0</td>
<td>25 (67.5)</td>
</tr>
<tr>
<td>Workplace Policies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there designated smoking areas outside your workspace (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (3.1)</td>
<td>25 (78.2)</td>
</tr>
<tr>
<td>No</td>
<td>1 (3.8)</td>
<td>15 (57.6)</td>
</tr>
<tr>
<td>Have you read any written material regarding smoking policies (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (3.8)</td>
<td>15 (57.8)</td>
</tr>
<tr>
<td>No</td>
<td>1 (3.1)</td>
<td>25 (78.1)</td>
</tr>
<tr>
<td>Are written smoking policies mentioned to clients during the intake process (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (11.7)</td>
<td>11 (64.7)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>29 (70.7)</td>
</tr>
<tr>
<td>Environmental Tobacco Smoke Exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed to second hand smoke from co-workers (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1 (7.7)</td>
<td>11 (84.6)</td>
</tr>
<tr>
<td>No</td>
<td>1 (2.2)</td>
<td>29 (64.5)</td>
</tr>
<tr>
<td>Exposed to second hand smoke from clients (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (4.9)</td>
<td>27 (65.8)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>13 (76.5)</td>
</tr>
</tbody>
</table>
Table 6. Continued.

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Talking With Clients About Their Smoking N (%)</th>
<th>Providing Smoking Cessation Support N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre/Cont  Prep  Action / Main</td>
<td>Pre/Cont  Prep  Action / Main</td>
</tr>
<tr>
<td><strong>Personal Barriers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I lack adequate knowledge about smoking cessation and tobacco reduction (n=58)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>2 (10.5)  15 (79.0)  2 (10.5)</td>
<td>13 (65.0)  2 (10.0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0        25 (64.1)  14 (35.9)</td>
<td>26 (68.4)  11 (28.9)</td>
</tr>
<tr>
<td>I avoid mentioning tobacco use so that I won’t seem judgemental (n=57)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>1 (12.5)  6 (75.0)  1 (12.5)</td>
<td>5 (62.5)  1 (12.5)</td>
</tr>
<tr>
<td>Disagree</td>
<td>0        34 (69.3)  15 (30.7)</td>
<td>24 (61.5)  12 (30.9)</td>
</tr>
<tr>
<td><strong>Organizational Barriers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t have enough time as a health care provider to deal with tobacco use (n=57)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>0        19 (79.2)  5 (20.8)</td>
<td>15 (60.0)  6 (24.0)</td>
</tr>
<tr>
<td>Disagree</td>
<td>2 (6.0)  21 (63.7)  10 (30.3)</td>
<td>24 (75.0)  6 (18.8)</td>
</tr>
<tr>
<td>Tobacco cessation/reduction is not an expected part of my role (n=52)</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>15 (68.1)  3 (13.8)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (3.4)  17 (58.7)  11 (37.9)</td>
<td>20 (66.7)  8 (26.7)</td>
</tr>
</tbody>
</table>
Summary

This is one of the first attempts to describe the stage of readiness of community mental health nurses in relation to implementing smoking cessation interventions into their practice. The summary below presents a brief overview of each of the primary findings from the quantitative research component. Further implications and conclusions will be addressed in the ‘Discussion’ chapter.

Stage of change. Nurses are at the forefront of taking significant action towards implementing smoking cessation interventions into their practice. They have surpassed their community mental health colleagues in regards to not only broaching the subject of their client’s smoking habits, but also have taken it one step further and are taking a more active role in providing smoking cessation support to their clients than both paraprofessionals and other professionals.

Smoking status and length of mental health career. The majority of nurses were former smokers. Nurses had the smallest percentage of current smokers (12.9%) compared to the other two groups. Paraprofessionals had the highest percentage of current smokers (30.9%) while other professionals’ had the highest percentage of non-smokers (44.8%) out of the three groups. Nurses reported working an average of 16 years in the mental health field. This was almost twice as long as paraprofessionals (9 years) and an average of 4 years longer than ‘other professionals’.

Environmental tobacco smoke (ETS) exposure and workplace policies. The majority of community mental health nurses reported being exposed to second hand smoke from clients, however over half of the nurses reported not being bothered by this. Almost one quarter of nurses reported that they were exposed to second hand smoke from their colleagues. Nurses who were not exposed to co-workers’ second hand smoke were more likely to be in the
action/maintenance phase (i.e., sometimes talking to their clients about smoking and providing them with cessation support). Conversely, nurses exposed to clients’ second hand smoke were more likely to be actively engaging clients about their smoking and providing cessation support.

**Personal and organizational barriers.** Whether nurses agreed or disagreed with the personal barriers, the majority reported that they sometimes talk to their clients about their tobacco use or provide smoking cessation support to their clients. The majority of nurses who agreed that tobacco cessation/reduction was not an expected part of their role were not often/always engaging in tobacco control with their clients, while almost 40% of nurses who believed that it was an expected part of their role were often/always engaging in tobacco control with their clients. Nurses who did not avoid mentioning tobacco out of fear of seeming judgmental were more likely to ‘sometimes’ or ‘often’ engage in tobacco control with their clients. Nurses who believed they had adequate knowledge about smoking cessation were more likely to ‘sometimes’ speak with clients about their tobacco use.
CHAPTER 4: QUALITATIVE RESEARCH COMPONENT

Phase two of this study utilized a focused ethnography qualitative design aimed at examining community mental health nurses’ workplace culture and their perceptions regarding implementing smoking cessation interventions into their practice. This qualitative approach fits the study well, as focused ethnography seeks to interpret the meanings of beliefs and behaviours in the context of social/cultural worlds in which individuals are immersed (Bassett, 2004). Most ethnographies today focus on a distinct problem within a specific context among a small group of people (Roper & Shapira, 2000). In this study the issue of implementing smoking cessation interventions into mental health practice constitutes the problem, community mental health settings constitute the context, and community mental health nurses comprise the subculture under study. Focused ethnography retains the characteristics of traditional ethnographic inquiries, while being an economical and efficient alternative to its traditional counterpart. This method was especially suited to this project, as the intent of focused ethnographies is to concentrate efforts on specific questions, thereby accruing large amounts of data within a short amount of time (Bassett, 2004; Roper & Shapira, 2000).

Another reason focused ethnography was a highly appropriate research design for the qualitative component of this study is because careful attention is given to the participant’s ‘emic’ view of the world; that is, the ethnographer discovers the insider’s view of the phenomenon being studied (Bassett, 2004). By utilizing this qualitative method, valuable information could be gathered about nurses’ views on smoking cessation in the context of community mental health culture. Furthermore, using focused ethnography enabled the cultural beliefs and practices of community mental nurses to be uncovered.
Methods

Setting

The setting for this study included five mental health teams out of the total of eight within the City of Vancouver. Over the course of working on the CACTUS project, the primary investigator had spent several hours at each team and had been able to learn about the ways in which mental health care is organized. This entree into the setting provided valuable background information. The teams were widely dispersed across the city with each one representing a different catchment area. Despite the different geographic locations, each team operated under the mandate of providing free treatment to individuals living in the community with serious thought disorders such as schizophrenia, or a severe mood disorder. Each mental health team consisted of nurses, doctors, social workers, occupational therapists, recreation therapists, other mental health professionals and peer support workers. This study received formal ethical approval by the Behavioural Research Ethics Board at the University of British Columbia in February 2007 while the Vancouver Coastal Health Research Institute (VCHRI) granted ethical approval of the larger study in January 2006.

The target population for the semi-structured, in-depth interviews was community mental health nurses working within one of the eight mental health teams in the city of Vancouver. In order to be eligible for participating in phase two of the study, nurses had to: 1) be a registered psychiatric nurse, or a registered nurse, 2) have previously responded to the provider survey, 3) have indicated they are interested in participating in further tobacco and mental health research, and 4) be willing to participate in the interviews as indicated by informed written consent. Purposeful sampling was used to select 13 nurses from the varying mental health teams.
Deliberate attempts to include nurses from different mental health teams were made, but nurses from three of the eight mental health teams did not participate in the interviews.

Gaining Access

Access for this project was facilitated by the directors at each of the five mental health teams. Contact was previously made with the directors and other staff through the investigator’s work as a graduate research assistant on the CACTUS Project. Informal contact was made initially with nurses who had indicated on the Health Provider Survey they would be interested in participating in further research focused on mental health and tobacco. Three directors endorsed the study during one of their morning meetings. Throughout the five weeks of recruiting nurses, there was no response from three of the eight mental health teams, despite initial contact e-mails and follow-up phone calls. For nurses who did respond to the e-mails and phone calls, responses were mixed. A few of the nurses stated they were too understaffed or busy to participate in research, while others were happy to participate. One enthusiastic nurse disappointed to hear there were not many participants, recruited 3 colleagues who had participated in the CACTUS Provider Survey and with their permission supplied the investigator with their names and telephone numbers. Nurses were interviewed according to their availability. For example, one nurse stated that she had to be interviewed right away or else she would not participate. She believed participating in research was not a priority for her or her staff due to their excessive workloads. Attempts to recruit male nurses were also difficult, as there were a limited number of male community mental health nurses working at the teams. E-mail and telephone messages were left with the male nurses, but only one male responded.
Sample

There were a total of 13 participants; 12 female and one male. Seven of the participants were registered psychiatric nurses (RPNs) and the other six were registered nurses (RNs). Five of the participants classified themselves as case managers, four as intake workers, two as primarily outreach nurses, and one was the director of one of the participating mental health teams. Participants ranged from 26 to 60 years old. Nine of the nurses were former smokers, three were non-smokers and one was a current smoker. There was a wide range of clinical expertise among the participants, with years working in the mental health field ranging from one to 37.

Data Collection

Data was collected using semi-structured in-depth interviews. At the beginning of each session, the investigator reviewed the purpose of the study, obtained written consent (Appendix D) and collected participant demographics and a brief smoking history (Appendix C). A semi-structured interview guide was then used to gently direct the discussion (Appendix B). The interviews commenced by asking the nurses to describe a typical day for them at the team, what their goals were with clients and tobacco control related questions. Participants were also encouraged to speak in detail about what it meant to them to be a community mental health nurse and how they perceived the culture of community mental health teams and how others perceived them. The nurses were then asked a series of questions about the ways in which clients’ tobacco use was dealt with by themselves and team members.

Each interview was conducted in the participant’s office which was located at their respective mental health team location. Interviews were tape recorded and lasted from 25-45 minutes. The interviews were transcribed verbatim and each was reviewed with the recording device to ensure accuracy. Field notes were recorded following the interviews and included a
brief description of the participants' work environment, areas where clients and staff smoked, what type of brochures were available to the client in the waiting room, and participants' feelings and non-verbal reactions to interview questions. The researcher was also familiar with the general layout and environment of each team from conducting presentations on the Health Provider Survey from February-April 2006. In addition to taking notes before and after the interviews, spending time at the teams for those three months helped inform the work on this project.

Data collection took place over a two month period. This is a relatively short amount of time, but conducting a focused ethnography allowed for the collection of a large amount of data over a short period of time (Roper & Shapira, 2000). Ideally, data collection continues until data saturation is reached, or no new data, patterns, themes, dimensions, or insights are revealed (Polit & Beck, 2004). Several themes were revealed throughout the course of the interviews and were validated by the participants.

Analysis

Ethnographic analysis is a non-linear inductive process that includes coding, sorting, theorizing, and reflecting upon the analytic process (Roper & Shapira, 2000). In this study the data set included field notes and tape recorded interviews. All data was entered manually into electronic files using Microsoft Word; no qualitative data analysis software was used for this study. Data sets were reviewed numerous times in the initial analysis stage to gain a sense of: a) the organizational culture of the community mental health teams, b) nurses' perceptions regarding tobacco use among their clients and c) barriers to implementing smoking cessation interventions. Data from the transcribed interviews were constantly compared to identify similarities and differences, leading to the formation of categories. Categories were then
compared with each other, strengthened when supported by frequent observations in the data and refined with each new transcription. My supervisor (J. Johnson) was consulted to examine the emerging themes, derived from collapsing the categories, to enhance content validity.

The context of nurses’ work on smoking cessation is shaped by the broader British Columbia (BC) policy on tobacco control. Therefore, the recent developments in BC’s smoking reduction policy will be briefly discussed before addressing study results.

**Context: Policies and Place**

British Columbia has long been recognized as a leader in tobacco control efforts in Canada (Vancouver Coastal Health, 2004). Many tobacco control projects have been implemented by the BC Ministry of Health and its Tobacco Control Community. Tobacco control initiatives implemented in BC are reported to be available to all British Columbians free of charge (British Columbia Ministry of Health, 2004). British Columbia currently has the lowest smoking rate in the country at 16% of the population; as compared to the national average of 21%. In March 2007 the province of British Columbia passed an amendment that would ban: 1) smoking in all indoor public spaces (to take effect in 2008), 2) smoking in public doorways, near public doors, windows and air intakes and 3) tobacco sales in public hospital and health facilities, public universities and colleges, public athletic and recreational facilities and provincial buildings (Ministry of Health, 2007). Furthermore, the City of Vancouver’s health authority, Vancouver Coastal Health, has implemented a tobacco reduction strategy aimed at changing social norms around tobacco through a balanced set of initiatives across the areas of prevention, protection, cessation and education (VCH, 2004). The three main goals of the VCH Tobacco Reduction Strategy (2004) are:

1) to prevent the initiation of tobacco use in the Vancouver Coastal Health Region
2) To protect the health of people living, working and playing in the VCH region from the effects of second hand smoke

3) To build capacity within individuals in the VCH to quit smoking or reduce the amount smoked

The mission statement of the VCH Tobacco Reduction Strategy is:

"By 2007, all VCH residents will understand the dangers of tobacco use and exposure to second hand smoke and will have enhanced capacity to achieve healthier lifestyles through the reduction of tobacco use and exposure to second hand smoke, moving toward tobacco use no longer being regarded as a social norm" (VCH, 2004).

British Columbia’s leading tobacco control document BC’s Tobacco Control Strategy: Targeting Our Efforts (2004) reports tobacco control strategies place more emphasis on cessation and reduction measures, while focusing on three main groups that have been identified as having the highest rates of tobacco use. These three groups are: 1) young adults aged 20-24 years, 2) adults 25-44 years and 3) aboriginal populations (BC Ministry of Health Services, 2004). However, since the release of this document 3 years ago, there has been a growing recognition that individuals with mental illness have a significantly higher smoking prevalence rate than the general population (Carosella et al., 1999, McNeill, 2001 & Ziedonis, Williams, & Smelson, 2003).

**Results**

The findings from this study illuminate the complexities that surround the issue of nurses implementing smoking cessation support for clients utilizing community mental health services. The section opens with the themes that pertain to the sociocultural and organizational context of the community mental health teams studied. By exploring social and organizational factors of community mental health nursing culture, factors involved in shaping both group and individual
smoking cessation behaviour may be uncovered (Peterson & Wilson, 1998). This approach to examining a specific culture has been successfully utilized in the nursing literature. For example, Yamaguchi (2004) examined sociocultural and organizational factors when studying the nursing culture of an operating theater in Italy.

In this first section I illustrate the context in which community mental health nurses are working and highlight the core beliefs, values and nursing practices they share. Due to the lack of accessible literature describing the community mental health framework in Vancouver, this section includes a description of the organizational context in which community mental health nurses are working. The second section focuses on nurses’ perceptions regarding tobacco use and smoking cessation among their clients. Four categories were identified: the embeddedness of tobacco, choosing our battles, endemic barriers to smoking cessation, and readiness to provide clients with smoking cessation support. Direct quotes from participants are used throughout to demonstrate key findings. Nurses are differentiated by role (case manager, intake, or outreach). No further identifiers are used to ensure participants’ anonymity.

**Sociocultural and Organizational Context**

How nurses think and feel about their work is critically important to their effectiveness in addressing clients’ changes in smoking behaviour. One of the main purposes of the interviews was to explore the sociocultural factors and organizational structures that influence nurses’ readiness to integrate smoking cessation practices in their community mental health practice. For this component of the study, sociocultural factors were defined as elements in the external environment such as public attitudes and how community mental health was viewed by health care providers working within the broader health care system. Organizational factors were defined as all formal systems designed to regulate the actions of community mental health nurses.
including job design, the reporting hierarchy and the team structure (Yamaguchi, 2004). Culture was defined as core norms, values and beliefs shared by community mental health nurses.

**External Environment**

De-skilled and de-valued by their peers and the public. Working within the community mental health system is demanding. Working with clients who may be challenging, in great distress, often reluctant to seek help or adhere to their treatment regimen, can be wearing and stressful on staff (Henderson, 2001). There may be constant rejection of help or support and reluctance to become involved in the community among clients utilizing these services. The nurses interviewed did not believe that their peers or the public understood how challenging their jobs were. It was perceived that registered nurses working in areas other than psychiatry did not look upon nurses working in mental health as equals. When asked how others perceive community mental health nurses a number of participants reported feeling de-skilled and devalued. They believed other nurses and health professionals considered their nursing abilities less adequate than those working in other areas of health care. This perceived inadequacy led community mental health nurses to report that they were at the bottom of the nursing hierarchy. One nurse stated that devaluation of her nursing skills began when she was training to be an RN, specializing in psychiatry, in the late 1960s. She later went to work in an acute care setting where she experienced being on the bottom of the medical hierarchy.

I worked in a busy downtown emergency room for several years...psych nurses were new in emergency at that time; I mean, I was next to the cleaning lady in the hierarchy. [Intake]

Nurses also reported that for a lot of people, including friends and family members, mental health care provision/nursing was considered a poor career choice.
I’ve had people say it, including my own family, ‘what a waste, what a waste of training, education and time’ [Intake]

There was also consensus among the nurses interviewed that the general public tended to identify community mental health nurses as less skilled than nurses working in acute-care hospitals. This was in stark contrast to how the nurses perceived themselves. Nurses working within community mental health valued their job and skills very highly. Participants mentioned needing a wide variety of skills; everything from knowing how to give immediate crash cart service to giving back-up support to colleagues during a difficult psychiatric certification of a client.

I think you have to be more skilled in the community because you have less immediate resources that you can draw on or people to bail you out. I [also] think you need more confidence probably. I don’t think the community views it that way; I’ve had friends say ‘why don’t you go back to working in the hospital?’ [Intake nurse]

Organizational Environment

The organizational arrangements including job design, reporting hierarchy, and team structure in community mental health settings are internal organizational factors. Depending on the size of the team there was anywhere from four to eight nurses at each of the five sites. Each nurse operated under the mandate of a case manager, intake worker or outreach nurse, however these roles were blurred at times, as some of the case managers would also perform outreach and intake workers would case manage a small number of short term clients. The work day began at 8:15am with the nurses attending a half hour to hour long team meeting where new referrals, overnight crises, and client issues were discussed among all of the health care providers. The nurses worked within a team environment (see Figure 2), yet maintained their autonomy and independence by having the ability to be the primary coordinator of care for their clients.
Intake nurses: The Brokers. Intake nurses are the first point of contact for a client who has been referred to a community mental health team. Intake nurses assess whether a client fits the mandate of the team, through a primary diagnosis of schizophrenia, bipolar or major depression. Intake nurses also case manage a small number of short-term, high acuity clients. The clients they keep for a short period of time include those who do not meet the mandate for case managers; people with a serious depression but no psychosis or individuals who are too mentally ill to wait to get connected with somebody in the community. They bridge the clients with other outpatient services in the community and also may have clients seen and assessed by a psychiatrist for the interim. One intake nurse described her role as a 'broker'; determining what the client sees as the problem and what they want in terms of treatment and what services are
available. Intake nurses divide their day between ‘fielding’ emergency and inquiry calls and assessing new referrals as they come before the team.

**Case managers (nurses): The Conductors.** Nurses who were employed as case managers have up to 70 clients on their caseload. Case managers are the principal care providers for clients utilizing services from the community mental health teams. Services provided by case managers include medication management, basic support services, advocacy for income assistance and housing and coordination of community resources. Case managers also work closely with family members, housing personnel and dual diagnosis resource centres to address all aspects of care.

One nurse spoke about the case manager role:

Nurses manage client’s signs and symptoms; ensure they have access to medication and access to someone that will prescribe it and provide supportive counseling. Once they are over the acute phase of their illness, they’re on their medication, they’re back to their certain normal life; what they are looking at is getting extra money for food, looking at their housing and wanting to get into social relationships. [Case manager]

**Outreach nurses: The Connectors.** Outreach nurses engage people who are resistant to treatment. Their clients include individuals who have been referred to the team but are either too mentally ‘disorganized’ to come in or are resistant to coming in and having treatments. Outreach nurses see 5-10 clients a day with most of their clients living in single room occupancy hotels (SROs). They see their clients once or twice a week. One of the five teams from which nurses were recruited for this study hired nurses exclusively for outreach. These nurses had a smaller caseload, usually around 12, as their clients were difficult to engage and had a mental illness of high acuity. Once a client was engaged with the outreach nurse and willing to be seen at the team by a psychiatrist, the client would be referred to a case manager. Adding to the blurring of roles
for nurses was the fact that case managers were not only nurses but also social workers or individuals with a master’s degree in education or counseling psychology.

People know their individual contributions within the team, but at the same time there’s case managers that are generic, regardless of what their discipline is. [Case Manager]

The role of the case manager was therefore perceived to be quite generic by both nurses and staff, with the only difference being that nurses could give injections. This was seen by the nurses interviewed as an added responsibility, as not only did they have to give injections to their own clients but they also had to give injections to clients who did not have a nurse as their case manager. One nurse also noted that the role of the nurse is changing, as there is added responsibility, due to their medical background, to ask clients about medications and their side effects because of emerging medical conditions induced by atypical antipsychotics, such as metabolic syndrome.

I’m more aware to ask things like ‘how are you doing’...noticing if they are stiff, pacing more...and asking ‘are you having any problems with your medication’ even if I don’t know them...I think I’m more likely to do that than [other staff] who don’t have a nursing background. [Case Manager]

Nurses believed they had more autonomy working in community mental health settings than they did at in-patient settings. However, with this autonomy came increased responsibility. One nurse described the added emotional challenges that resulted for her around increased autonomy and responsibility when working with clients:

Community mental health nursing is a double-edged sword because you have this relationship with clients and there is a lot of responsibility that goes with that...it doesn’t end in community mental health...that’s part of it, sometimes on weekends you wonder if they are okay because when you saw them on Friday they weren’t doing so well .... the disadvantage with it is that you carry much more individual responsibility...there is nobody assuming care when you leave [Case Manager]
When asked what nurses' main goal was with their clients, the common thread throughout the interviews was maintaining clients' stability. Nurses, whether they were a case manager, intake nurse or outreach nurse, indicated that they wanted to help clients maintain housing, control their mental status, help them develop social skills and connect them to other resources in the community.

Nurse-client relationship: A partnership. Community mental health nurses reported that they were highly involved with clients in many areas of their life and were in the unique position to build long standing therapeutic relationships with their clients. Case managers were more likely to see clients over a longer period of time, as intake and outreach nurses referred their clients to case managers once it was determined they would be followed indefinitely by the team. One nurse stated that she had the same 50 clients on her caseload for over two years; highlighting the fact that she knew her clients 'quite closely':

It's not just the mental illness anymore, it extends into the relationships with people, what they are doing in the community, what their housing is like, whether or not there is anything meaningful going on in their life...we definitely get more involved with their lives than nurses do in the hospital.” [Case manager]

A number of nurses also commented that they viewed the nurse-client relationship as a partnership; where clients are active members of the treatment team. Psychiatrists were also part of this ‘partnership’ but only on a consultation basis. Psychiatrists were used as consultants for medication review (clients must have this done once every three months), emergency calls, appointments and new assessments. Otherwise, case managers were considered to be the primary health care providers for clients in the community.

Teamwork: A misnomer. A strong sense of teamwork was implied in the community mental health worksites, job descriptions and information pamphlets. The team environment
involved individuals working towards the same goal; helping clients maintain the best possible level of mental health. Despite working in a team environment, nurses reported that ‘teamwork’ was confined to collaborating on new intakes at the morning meeting. It was believed that for the most part community mental health nurses worked independently and by using the word ‘team’ when referring to community mental health, clients were being misled.

The word ‘team’ is a wee bit of a misnomer because the actual team is you and the psychiatrist. We refer clients to the occupational therapist so you could say we have mutual clients and if I am on vacation or if I am sick I share my caseload with my ‘buddy’. We don’t work together as far as providing treatment other than when one is away and then you step in...it’s not like the client comes in and they’ve got the whole team.[Case manager]

It’s not a private practice where you’ve only got psychiatrists; you’ve just got one person; one nurse and you’ve got the OT and when we hear “he needs the team approach”, when we hear that [it means] somebody’s going to look after the medication; somebody’s going to do the psycho-social stuff; and somebody’s going to look after the occupation stuff...and that’s why when we get referrals from the hospital we like to go up and I will introduce myself ‘I’m from the team...I am a nurse and you will be meeting with me, you’ll also be meeting the psychiatrist and it’s the two of us’. If you don’t do that and they meet the doctor straight away, they think they are going to meet the doctor every time and that is not the philosophy of the teams. [Case manager]

Paradoxically, cooperation among nurses was the norm and considered essential to ensure improved patient outcomes. The nurses reported strong bonds of reliance and trust in one another and this was exemplified by the ‘buddy system’ employed at each site. Participants also consistently mentioned that members of the team knew each other’s jobs fairly well and if a crisis arose there was always a team member to assist. All participants reported that they felt that there was always a staff member around to consult if they had any questions regarding their client. It was also apparent that nurses were considered a valuable resource among the team
members and were used as consultants for nursing related issues such as questions about medications or medical enquiries by other staff not medically trained.

**Tobacco Use and Smoking Cessation**

*The embeddedness of tobacco use.* Many of the nurses interviewed spoke of how smoking has been historically reinforced within psychiatric institutions and acute care settings. Eight of the thirteen nurses interviewed had trained within a system that condoned smoking by staff and patients and accepted the clinical use of cigarettes to assist patients with their mental illness management. A nurse recounted how cigarettes were incorporated into her past psychiatric nursing practice:

Each night shift you had to make, I don’t know, 200 cigarettes... each staff had to, that was part of your night shift duty... and then they would be used, ‘okay, if you have a bath you can have three cigarettes, if you take your morning meds you can have one’. It was used a lot in those days as a reinforcing tool. [Intake]

Nurses also spoke about the large role managing clients’ cigarettes had played in their daily inpatient psychiatric practice. The monitoring of clients’ cigarette intake was an unwritten responsibility that nurses were in charge of and eventually began to spurn. Cigarettes and candy were often locked away together and regarded as ‘treats’ that nurses were in charge of handing out to clients as a reward or a treat at the appropriate time. One nurse voiced her opinion regarding how this duty compromised both nurses’ personal and work ethics:

Nurses hated making cigarettes on night shift and I think they hated doling out cigarettes... I think it got to be such an issue of control and it was so time consuming... and [nurses] didn’t really agree with it because they were handing out something that wasn’t healthy. [Intake]

Another participant echoed the sentiment about tobacco control:

We would have to monitor cigarettes, hand out cigarettes, you know one per hour. We didn’t like it as nurses, being the smoking police. [Intake]
When asked if cigarettes were currently used as a form of behavioural reinforcement in the community mental health teams 11 of the 13 nurses reported ‘no’. These nurses reiterated ‘we used to do that’ but agreed that over the last 10 years the use of cigarettes by nurses to reinforce behaviour had significantly decreased due the fact that it was now considered ‘too politically incorrect’. One participant mentioned that she knew of a client who was given cigarettes every time he came to the team for his injection, however, recently this had changed and the nurses were now giving him two dollars instead. Two other outreach nurses suggested that cigarettes provided a way to encourage clients to come into the mental health team. One nurse talked specifically about how they used cigarettes as a way of connecting with difficult to engage clients:

We have a budget down here that we are allowed to spend on them...coffee, smokes and anything like chocolate bars or treats...anything that they like we can pretty much get them. We have a [cigarette] budget because we sometimes have to use [cigarettes] to entice people to come into the team. [Outreach]

Tobacco: Choosing our battles. A common theme throughout the interviews in regards to addressing tobacco use was that tobacco was generally not seen as the top priority for nurses to address, especially by intake and outreach nurses. Intake nurses reported being more concerned with issues such as mental status, housing, substance abuse and whether the clients were suitable for the team in general. Outreach nurses reported their main concern was for illicit drug use, safe housing, and any acute medical concerns the client may have. For these nurses in particular, addressing crack cocaine and crystal meth use took precedence over tobacco use:

I would hate for them to feel bad about smoking in front of me. Part of my job is building a rapport and I don’t want them to feel bad about anything. I mean these people use hard drugs, so it is kind of like smoking versus
crack and crystal meth. I would rather stay more focused on the crack and crystal meth and minimizing that use than say smoking with them.

[Outreach]

For case managers the priority was ensuring clients were mentally stable and that they had secure housing and adequate finances. Nurses reported inadvertently addressing tobacco use when discussing client’s financial status. One nurse spoke about how tobacco was addressed only when a client’s mental health status and primary needs had been stabilized:

If everything in their life is stable then we can discuss maybe trying to cut back on smoking, but if they have lots of other stuff going on its not usually what I aim for. I usually go for ‘try to cut back on your crystal meth use’ or ‘let’s work on helping you out with your housing issue or your mental stability’. [Smoking] is one of the last priorities.” [Case manager]

We’re looking at medication management for the symptoms...the first two or three appointments are usually weekly...it’s always with the doctors so we can get them on the right medication...so in between times I can certainly suggest they meet with the OT. We do have a few drop-in groups, I direct them to what support there is, but it is voluntary, but unless their symptoms; usually delusions and hallucinations are controlled, they are not going to get involved in anything. [Case manager]

The majority of nurses interviewed went into clients’ homes, mainly to give injections or perform clinical assessments on clients unwilling to come into the team. A few of the nurses spoke about having to ‘juggle’ their own health risks around second hand smoke in order to treat and support clients. Nurses would often visit their clients in ‘smoke filled’ apartments with nicotine stained walls. One nurse recounted how she was repeatedly exposed to second hand smoke while providing essential services to her client:

You know, I’ve got my head down because he’s usually in bed and he’s blowing all this smoke in my face...occasionally I’ll ask him to put it down and he will usually put it down, but there are other times it’s just more important to get in and give him his injection and get out [Intake]
Endemic Barriers to Implementing Smoking Cessation Support

Time: A precious commodity. Participants repeatedly referred to the limited length of time they had with clients during an appointment. On average, case managers would see around ten clients a day allotting 30 minutes for each appointment. The majority of case managers believed that this was too brief of a time to address smoking cessation in any detail with clients. Moreover, the frequency of a client’s appointments was also considered a barrier, as once the client was stable they would only be seen by their case manager on a bimonthly or monthly basis. Time as a significant barrier to discussing tobacco use was articulated by one nurse in the following way:

I can spend a little bit of time, I’ll take five or ten minutes, but I’m certainly not going to have somebody come in once a week or once every two weeks for twenty minutes to talk with them about smoking [Case manager]

Intake and outreach nurses both talked about the difficulty in offering smoking cessation because their length of time case managing a client was always brief. Nine out of the 13 nurses interviewed were former smokers and identified with the lengthy and difficult process of quitting smoking. One nurse spoke about the practicality of providing smoking cessation support to her clients through the quitting process:

The repeat barrier for me is that my contact with clients is brief; and quitting smoking is a lengthy process. [Intake]

Lack of knowledge. Throughout the interviews it was apparent that the nurses lacked knowledge about why clients were smoking, the current tobacco and mental health research and smoking cessation interventions for health care providers. A few nurses had not heard of the ‘Five A Model’ (ask, assess, assist, advise, arrange) and acknowledged they were not up to date on current smoking cessation support information. One nurse genuinely wanted to engage a
client in a conversation about the effects of tobacco use but was uncertain about his level of expertise on the subject matter:

There is supposedly some research about nicotine hurting brain cells and medication absorption. I don’t know what fact that is, but you kind of throw it out there. [Case manager]

Lack of training and resources. The nurses expressed uncertainty about whether there had been any seminars targeting smoking cessation at some of the teams. Overall, there was a general consensus that no one had been to any smoking cessation seminars, in-services or workshops. Smoking tended to be combined with seminars aimed at helping people with drug and alcohol addictions. There was no education specifically targeting smoking. It was apparent throughout the interviews that there was confusion about whether there were smoking cessation resources for their clients, and if there were resources, how to access them. A few of the nurses thought there may have been an in-service on smoking, but they could not remember when it had taken place or who had presented it. All 13 participants reported that they referred their clients to the occupational therapist (OT) when a client expressed interest in quitting smoking. The nurses believed that the OT had more knowledge, resources and training regarding smoking cessation than they did. However, one nurse described how referring clients to the OT was seen as an extra step that could be eliminated if the nurses themselves had the smoking cessation information readily available. The nurses repeatedly spoke about the need for easily accessible smoking cessation resources such as pamphlets and telephone numbers that would be available to them at their ‘fingertips’.

The nurses also expressed frustration about the fact that there were limited appropriate smoking cessation resources available to their clients. Four of the participants highlighted the fact that clients were not getting the smoking cessation support they needed from programs that
targeted the general public. One nurse recounted a conversation she had with a client who was trying to quit smoking:

My client was telling me that she called this quit smoking help line run by the government and said 'I'm having a hard time and I can't sleep and I'm restless' and the woman said 'oh well, isn't it good to have that much energy?'... they don't know that for our clients who have psychotic histories or bipolar, you don't say to them 'isn't it good to have a lot of energy' because she was scared to death that she was going psychotic again. [Case manager]

Another nurse spoke about the fact that her clients would not go to regular stop smoking groups due to group dynamics and potentially unrealistic stop smoking goals:

You know a lot of our people won't go to those regular groups. They'll go to Coast because Coast is a place for people who have mental illness and it's presented more as “try; try the best you can. [Intake]

Participants reported that another barrier to providing smoking cessation support to their clients was the inability for clients to pay for nicotine replacement therapy [NRT]. This was seen as an enormous deterrent because broaching the subject of quitting smoking seemed futile if the supports in place were not financially feasible. One nurse emphasized the challenge they face in suggesting NRT to their clients:

Their medications are covered. They are not going to pay out of their pocket for more medication and patches that are expensive. [Case manager]

Readiness to Provide Clients with Smoking Cessation Support

Changing attitudes: Asking and referring. When asked if they were ready to talk to clients about their tobacco use, participants agreed that smoking was not healthy for their clients and that they would all like them to quit. It was further acknowledged that none of the participants discouraged their clients from quitting smoking; however, three nurses did not encourage their clients to stop, as cigarettes were considered the most effective bridge for building rapport. Since
many of the clients in the community had been through psychiatric institutions, some nurses saw
smoking as something clients ‘just did’ and were therefore more reluctant to address the issue.
Overall, nurses, at the very least, were asking clients about their smoking status and readiness to
quit. If the client then indicated they were interested in quitting the nurse would take it a step
further and refer the client either to the OT or a community mental health service stop smoking
group. Many nurses also talked about providing their clients with ongoing verbal encouragement
and support, including conversations regarding their own struggle with smoking cessation. Two
nurses reported talking to all of their clients about smoking cessation. This is exemplified by the
quote from a nurse whose attitude towards smoking had changed dramatically over the last few
years:

I’ve gone from really supporting clients who smoke to telling them that it is
killing them. I mean, I’m right there as far as smoking. I’ve got clients that are
spending out of a $500.00 cheque $300.00 on cigarettes… I think it is just
criminal. But they say it’s only a pack a day and I say ’30 times’, I’m very
hard on them now, absolutely. [Case manager]

Nurses further spoke of the fact that they did not see it as their role to provide in-depth smoking
cessation support to their clients. However, the majority of nurses felt that it was their role to
provide some level of smoking cessation support to their clients.

I think we have a role as nurses just on a general healthy aspect, but once
you get down to specifics, I mean within the team I think our OT runs
those [smoking cessation] groups… I would say it is her role [Case
manager]

The majority of nurses tended to see the implementation of smoking cessation interventions as
being part of their daily assessments. They spoke of their readiness to address tobacco in a non-
threatening and nonconfrontational manner; most often when talking about finances or health
with clients. Nurses were acutely aware of the financial and physical burden tobacco placed on
their clients and over half of the nurses reported knowing a client who would relinquish food for
cigarettes. One nurse also reported seeing the side effects of smoking on her clients first hand, which in turn prompted her to begin addressing smoking cessation on a regular basis with all of her clients that smoked:

You know, it’s terrible. You listen to people in the waiting room and they are just hacking. They can be waiting for half an hour sometimes and they hack and they cough and they gurgle and you think ‘that can’t be good’. [Case manager]

A few nurses believed that clients were getting the stop smoking message ‘loud and clear’ from professionals and staff, as it was not considered a ‘taboo’ subject anymore. Case managers were more likely to make addressing smoking a priority with their clients, while some of the nurses continued to view smoking as a habit or personal choice making them less likely to provide smoking cessation support to their clients.

Summary

Nurses play an integral role among the community mental health teams in the City of Vancouver, yet little is known about the unique culture of community mental health nurses and its effect on the successful implementation of smoking cessation interventions into community mental health practice. The findings from this component of the study therefore help to illuminate the sociocultural and organizational context of community mental health culture, as well as describe the embedded acceptance of tobacco in community mental health settings.

Sociocultural and Organizational Context

Nurses perceived themselves to be undervalued by peers in areas of healthcare other than mental health, as well as by family and friends; working with individuals with severe and persistent mental illness in the community was often considered futile by peers and the public. Community mental health nurses were seen to have inferior nursing skills compared to nurses
working in hospitals, however, community mental health nurses believed their work required a higher skill set than those working in the hospital.

The organizational environment of the mental health teams was conducive to allowing a high degree of autonomy for the nurses. However, participants remarked on how an increase in autonomy also means an increase in responsibility for their clients. The role ‘community mental health nurse’ was considered an umbrella term with three subgroups; intake worker (Brokers), case manager (Conductors) and outreach nurse (Connectors), highlighting the diversity of roles among nurses working at the teams. Nurses who did primarily intake or outreach were more concerned with dealing with acute issues such as mental status, housing, and illicit drug use, while case managers had larger case loads and were considered the primary care coordinators. Clients are considered active members of the treatment team, where ‘team’ consists of the nurse and the psychiatrist. Psychiatrists are consulted on an as-needed basis (up to three months) and the nurse can also refer his/her patient to the occupational or recreational therapist.

**Tobacco Use and Smoking Cessation**

Tobacco was seen as an accepted part of psychiatric culture. Many of the nurses had worked in the mental health system for over 15 years and had used cigarettes as a form of behavioural reinforcement or as a ‘treat’ when working in in-patient settings. However, participants reported that the use of cigarettes in this way had not been an accepted part of nursing care in community mental health settings for ten years. The exception was that outreach nurses working with particularly difficult to engage clients continued to use cigarettes as a means to connect with them.

All 13 participants agreed that smoking was harmful to their clients. However, tobacco use was addressed only when a client’s mental health status and other primary needs had been
stabilized. When tobacco use was addressed it was usually when discussing financial matters. Nurses reported the major barriers to providing smoking cessation to their clients was lack of time and appropriate rapport, lack of knowledge, and insufficient training and suitable resources. Nurses were divided as to whether they were ready to provide smoking cessation support to clients. Many of them were broaching the subject with their clients, but then referring them on to a colleague (usually the OT) who had more training in the area of smoking cessation.
CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This chapter provides a synthesis of the quantitative and qualitative key findings. The key findings pertain to four issues: community mental health nurses' stage of readiness in regards to implementing smoking cessation interventions into their practice, personal and systemic barriers encountered in the uptake of smoking cessation interventions, the organizational culture of community mental health nursing and the embedded acceptance of tobacco use in community mental health. An overview of the benefits and challenges of conducting a mixed methods research design, and a commentary on the conclusions and implications that these findings may have for clinical practice, research and education is also included.

Synthesis of Findings

This study followed the lead of earlier descriptive work concerning in-patient psychiatric nurses' attitudes and behaviours around tobacco control by employing a mixed methods design. The analysis of survey data resulted in descriptions of 1) community mental health nurses' stage of readiness in regards to talking with clients about their tobacco use and providing smoking cessation support to their clients, and 2) barriers encountered in the uptake of smoking cessation interventions. A focused ethnographic investigation in five mental health teams revealed a profile of community mental health nursing culture and tobacco control in community mental health settings. Findings from both research components were synthesized and are reported in relation to two main themes: stage of readiness and barriers to providing smoking cessation support. These two themes are in turn described and areas of strong convergence or contradiction in the qualitative and quantitative findings are noted.
Stage of Readiness: Preparation

The majority of community mental health nurses reported they were in the preparation phase on the Health Provider Survey. This was further confirmed by the in-depth interviews, as a majority of the nurses stated they were beginning to take significant action towards providing smoking cessation support to their clients. The in-depth interviews added depth to the survey findings by providing insight as to how some of the nurses had moved from precontemplation to the preparation stage through the course of their mental health career. Many of the nurses had worked in psychiatric settings where cigarettes were an accepted part of care and therefore did not see tobacco use as something they should be discouraging until recently. According to the quantitative findings nurses were actively engaging in talking with their clients about their tobacco use and providing smoking cessation support more so than paraprofessionals and their professional colleagues.

Overall, health care providers reported talking with their clients about tobacco use more often than they were providing smoking cessation support. Nurses were providing smoking cessation to their clients more often than paraprofessionals and other professionals, however, there remained a higher percentage of nurses in the precontemplation/contemplation stage for ‘providing smoking cessation support’ than ‘talking with clients about their smoking’.

Barriers to Providing Smoking Cessation Support

There was incongruence between nurses’ responses regarding having adequate knowledge about smoking cessation and reduction. In the survey, 67.7% of nurses reported they did not lack knowledge about smoking, yet all 13 nurses interviewed stated they felt they did not have enough knowledge to provide their clients with adequate smoking cessation support. Almost all (85%) of the nurses surveyed indicated they did not avoid mentioning tobacco use to
their clients for fear of seeming judgmental, however in the interviews a few nurses mentioned they would avoid mentioning tobacco use to their clients if there were more pressing concerns such as illicit drug use and if they were wanting to build rapport with clients who were unstable and difficult to engage. For organizational barriers such as lack of time, over half of the nurses reported they had enough time to address tobacco use, but upon deeper exploration, the role of the community mental health nurse (intake, case manager, outreach) seemed to dictate whether nurses believed they had enough time to address tobacco. Almost a third of nurses reported that smoking cessation was not their role, however, case managers were more likely to address smoking cessation but due to lack of time, resources and knowledge, stated they would refer them on to the smoking cessation ‘specialist’ at the team, which was the OT.

Smoking status did not seem to influence what stage of readiness nurses were at in regards to providing smoking cessation support to their clients, however, the majority of the nurses in the interviews were former smokers (consistent with the quantitative findings), and every one of them thought that that was an advantage in providing smoking cessation support to clients, as they were then able to empathize and offer practical support and suggestions that had worked for them.

Another barrier uncovered in the ethnographic component was how community mental health nurses felt devalued and deskilled by their peers and the public. By studying the sociocultural and organizational context of community mental health nurses it was apparent that external barriers played a significant role in the extent of their ability and desire to address tobacco control with their clients. An example of this is when a nurse stated her family thought that community mental health nursing was ‘a waste of training, education and time’. Not having one’s work appreciated or valued is a critical barrier to smoking cessation that needs further
exploration. The embededness of tobacco use in psychiatric settings was prevalent throughout both study components. Examples of this included nurses’ being exposed to second hand smoke from their clients on a regular basis with this being viewed as part of the job as well as tobacco use continuing to be an acceptable way of connecting with difficult to engage clients.

**Benefits and Challenges of Mixed Methods Designs**

This study utilized a mixed method design, which brings its own unique benefits and challenges. Obtaining data on a topic where little is known about community mental health nursing culture and readiness to change in regards to smoking cessation behaviour calls for a multifaceted methodological approach. A combination of quantitative and qualitative techniques was needed to understand nurses’ readiness to change in culturally-appropriate terms, to obtain accurate information on behaviour and to interpret the meanings behind the behaviours. The uniqueness of this mixed methods design is that a large amount of quantitative data was initially collected and then followed up with in-depth interviews to provide a deeper understanding of the context in which the initial findings were answered, thereby expanding the contribution of a single approach (Gilbert, 2006). The mixed model design adds complexity to a design and uses the advantages of both paradigms.

For this study triangulation of methods was used to 1) improve the validity of the research study and 2) explain more fully the richness and complexity of human behaviour (Creswell, 1994; Tashakkori & Teddlie, 1998). The main strengths of this study lie in the breadth and scope of the findings. Findings provide a deeper understanding of nurses’ readiness to change in regards to implementing smoking cessation interventions in their practice than a quantitative or qualitative study would have alone. Utilizing both a survey design and focused ethnography provided the opportunity to take multiple stances to investigate nurses’ readiness to
change and the barriers encountered in the uptake of tobacco control in community mental health settings. The in-depth interviews were used to supplement the survey findings which then synergistically generated evidence that provided a comprehensive understanding of the context of tobacco control among community mental health nurses.

Incorporating the qualitative component into the study became important due to the low response rate of nurses on the initial Health Care Provider Survey. For example, the in-depth interviews provided a means to explore the potential reasons for a low response rate among nurses through the examination of the organizational culture of community mental health nursing and level of embedded acceptance of tobacco in community mental health settings. By focusing on organizational culture it was also possible to understand the factors that influence community mental health nurses’ stage of readiness to provide smoking cessation interventions to their clients.

The findings from this study portray a vivid profile of nurses’ readiness to change in regards to implementing smoking cessation interventions into their practice, by providing a unique look at contextual features that influence their stage of readiness. In addition, this study clarifies traditional barriers to providing smoking cessation support to individuals living with mental illness, and illuminates the subject with some new findings. While the findings offer insight as to how to overcome implementation barriers, they must be examined in light of study limitations.

The study focused only on community mental health teams in the City of Vancouver, thus generalizing the findings to all community mental health settings is not possible. Additionally, both the quantitative and qualitative components employed a small sample size of nurses, limiting the generalizability of findings. Further limitations include those inherent in self-
reporting, social desirability, and self selection of stage membership, as there was a need to assign stage membership using objective measurements (McKenna, Naylor & McDowell, 1998). The Transtheoretical Model/Stages of Change offered a theoretically derived approach for the study and made it possible to get a timely and preliminary idea as to how ‘ready’ community mental health nurses were at in regards to implementing smoking cessation interventions into their practice, however, it does not inform us how change is initiated, maintained or relapsed.

It must also be kept in mind that accounts of one’s behaviour do not always coincide exactly with one’s actual behaviour. When discussing contentious issues, such as tobacco use among individuals with mental illness, there may be the potential for ‘idealizing’ one’s readiness to implement smoking cessation behaviour into their practice. This type of ‘impression management’ is, however, not limited to health care providers, but rather is seen as a factor affecting the data collected by an ethnographer in any context (Roper & Shapira, 2000).

This study provides an initial analysis of community mental health nurses’ readiness to implement smoking cessation interventions into their practice. Some of the most interesting findings of the study were the ‘barriers to change’ uncovered when studying the sociocultural and organizational context of community mental health nursing. It was here that very powerful barriers affecting community mental health nurses’ self-esteem were uncovered.

Evidence shows that there is a high rate of smoking among nurses working in psychiatric settings (Griffith 1999, Rowe & Clark, 2000, Trinkoff & Storr, 1998); however, this study demonstrated that in community mental health settings, nurses are smoking at a much lower rate than their colleagues, as well as the Canadian general population. It also became clear through this study that nurses understood that smoking was harmful to their clients and that they might be willing to take on more of a role regarding smoking cessation if some of the barriers were
addressed and they were given the appropriate resources. Many of the nurses had worked in psychiatric settings where tobacco use was condoned by both staff and clients, so the movement from precontemplation to preparation was apparent. Given all the barriers, nurses have come a long way in changing their behaviours towards providing smoking cessation interventions to their clients; there are indicators that some of them would be open to going even further if given the resources.

The issue of nurses having to prioritize care is an ongoing issue in the mental health literature (Buchanan, Huffman & Barbour, 1994; Gould, Pearce & James, 2000; Jenkins & Elliot, 2004, McCarty et al., 2001; McEwan & West, 2001). This was further confirmed by community mental health nurses stating they had to ‘choose their battles’ when working with clients. Providing smoking cessation support was not seen as a priority when nurses had limited time with their clients, and only saw them on a bimonthly or monthly basis. More pressing issues such as maintaining mental stability, securing housing, or addressing illicit drug or alcohol abuse took precedence over tobacco use.

This study also added the element of the community mental health nurses’ role, highlighting the fact that not all community mental health nurses had the same client outcome goals. For example, an intake nurse’s primary role was to see if a client was appropriate for the team and attend to emergency calls, while case managers had longstanding clients and outreach nurses worked with only very difficult to engage individuals. Each of the three nursing roles had to contend with unique barriers to providing smoking cessation interventions, suggesting this fact should be taken into consideration when developing smoking cessation guidelines for community mental health nurses.
Evidence shows that smoking has historically been an entrenched part of psychiatric culture (Lawn, 2006). This embeddedness of smoking was evident throughout this study, however to a seemingly less degree as it once was. Nurses reported cigarettes had not been used as a form of behavioural reinforcement in the community mental health teams ‘for years’ as it was now seen as ‘too politically incorrect’. Nurses mentioned that there was very few staff that currently smoked at the teams, compared to the 1980s where it was not unusual for staff to smoke with their clients during an assessment. However, tobacco continues to be used by outreach nurses as a way to connect with particularly difficult to engage mentally ill clients, making it still an accepted part of nursing care for community mental health teams working in extremely impoverished catchment areas.

Community mental health nurses face similar barriers to implementing smoking cessation interventions, such as lack of time, knowledge and skills, as their peers working in acute-care settings. Due to the longstanding therapeutic relationships community mental health nurses form with their clients, it would seem that this would be a good time for nurses to address smoking cessation with their clients. This study, however, illuminates how frequency and length of appointment make it difficult for community mental health nurses to engage in any significant amount of smoking cessation interventions with their clients. Furthermore, the cost of nicotine replacement therapy and lack of appropriate resources (i.e., support groups specifically tailored to individuals with mental illness) were additional barriers community mental health nurses were challenged by in the uptake of smoking cessation provisions to their clients.

In conclusion, the study findings highlight the fact that community mental health nurses face similar barriers in regards to implementing smoking cessation interventions as nurses working in hospital –based psychiatric settings. This study highlights the claim that systemic
barriers such as lack of time and resources and personal barriers such as lack of smoking cessation skills and knowledge affect the rate at which nurses implement smoking cessation interventions in psychiatric settings. This study also revealed evidence about the ethical dilemmas that permeate community mental health nurses’ practice. The principles of beneficence and nonmaleficence were addressed by the nurses in this study, as nurses perceived smoking to cause less damage to the client than their more immediate problems such as illicit drug use, acute mental health state, and absence of housing. This study further confirmed the use of cigarettes as a therapeutic tool, however, on a much smaller scale than previously reported in the literature review. This study revealed that cigarettes were only used as a therapeutic tool by outreach nurses working with clients deemed extremely difficult to engage due to their impoverished living conditions coupled with acute mental health issues.

The findings of this study demonstrate the complexity surrounding smoking cessation and mental illness. While nurses are expected to engage in smoking cessation interventions in their practice they are also accountable for prioritization of care and required to respect a client’s choice to use tobacco and promote autonomy (Registered Nurses Association of British Columbia, 2004). This study confirms the culture of tobacco use continues to permeate community mental health settings. Some significant examples of this include the majority of mental health teams continuing to have designated smoking areas outside of their workplace, nurses reporting being exposed to second hand smoke from their clients and not being bothered by it, the absence of appropriate smoking cessation resources and training and lastly, the confusion over whose role it is to address client’s tobacco use. This study also confirms that although nurses have a general knowledge about the harmful health effects of tobacco use, they also believe that cigarettes provide some beneficial therapeutic effects to their clients.
In regards to the literature, this study further broadens our understanding of the complexities faced by community mental health nurses, not only in the uptake of smoking cessation interventions, but also around the challenges they face in regards to gaining recognition from their peers and the public.

**Implications for Practice**

The central research issue, community mental health nurses’ readiness to implement smoking cessation interventions into their practice, focused on community mental health nurses’ smoking cessation intervention behaviour. Most nurses were in the preparation phase. This means that it is now possible to develop stage-matched interventions conducive to helping nurses progress to the action stage, where they are consistently providing smoking cessation support to their clients. According to Prochaska and DiClemente (1984) the process of change that is conducive to progressing through the preparation stage is self-liberation. This is the belief that one can change one’s behaviour and then make a firm commitment to change. Self-efficacy (confidence) and decisional balance (weighing the pros and cons) also comes into play. For community mental health nurses to make the commitment to consistently provide smoking cessation interventions to their clients, it is imperative that the barriers (cons) to self-liberation are minimized or eliminated. In this instance the most prominent ‘cons’ are: 1) lack of time (having to prioritize care), 2) lack of smoking cessation knowledge and skills, 3) lack of appropriate and affordable resources and 4) lack of recognition of the value of their work from health care providers working in areas other than mental health and the general public.
Nurses as Role Models

Nurses are often seen as valuable resources in the health care field (Canadian Nurses Association, 2002; International Council of Nurses, 2003). Among their colleagues it appears that they are well respected in the community mental health field. Nurses were talking to clients about their tobacco use and providing smoking cessation support generally more often than their colleagues, making them potential role models for other community mental health care providers in the area of tobacco control. For example, almost one third of other health professionals, and over 50% of paraprofessionals were in the precontemplation/contemplation phase for ‘providing smoking cessation support’, while only 10% of nurses were in the same stage. The majority of nurses in this study were also former smokers. This makes them a valuable resource to not only clients wanting to quit smoking, but also to their current and non-smoking colleagues who may want to quit themselves or require insight into the smoking cessation process.

Time and Tools

It appears what community mental health nurses need are time and tools to accomplish the objective of providing smoking cessation interventions to their clients. Nurses have said that if they had more time with their clients they would be able to talk with clients about their tobacco use. Nurses have also said if they had useful tools at their fingertips (i.e. brochures etc.) they would utilize them.

In smoking cessation behaviour change efforts, it is important for community mental health team leaders and policy makers to attend to nurses’ attitudes and beliefs about adopting new approaches to tobacco control.
Implications for Further Research

There continues to be a lack of research on community mental health, especially in the area of tobacco control. Further research is needed to explore ways of building collaboration and respect with other health disciplines. Further research is needed to understand how lack of job recognition influences community mental health nurses’ ability and motivation to provide health promoting activities to their clients. It would be interesting to delve further into why community mental health, and mental health in general, continues to be regarded as the bottom of the medical hierarchy. There is the need to find ways, other than tobacco, of connecting with difficult to engage mentally ill clients. Due to the fact that the majority of the nurses studied in both components of the research were women, it is necessary to do further research involving male community mental health nurses to see if there are gender differences regarding readiness to change and perceived barriers in relation to implementing smoking cessation interventions into their practice. Further research could involve the use of focus groups to bring community mental health nurses and clients together to discuss appropriate and feasible smoking cessation interventions.

Due to the issue of community mental health nurses being exposed to second hand smoke from their clients, especially nurses providing outreach services, there needs to be further research conducted on the effect of occupational health hazards on community mental health care providers. The research could explore whether stricter rules around clients’ smoking in the presence of nurses influenced the rate at which nurses provided smoking cessation to their clients, as well as how often clients pursued smoking cessation with their nurses.

The low response rate of healthcare providers overall for this study also supports the possibility of conducting further research on readiness to change based on a larger sample.
Additional models should also be utilized so that results can be compared and validated against each other; rather than relying on the single Transtheoretical Model.

**Implications for Nursing Education**

In terms of ensuring nurses going into mental health are respected by their peers, it is important to strive for equal emphasis on the role and value of mental health nursing in undergraduate nursing programs. In terms of tobacco control, it is also essential that undergraduate nursing programs provide comprehensive smoking cessation education. Exploration of ways to incorporate smoking cessation education into the undergraduate curriculum would help build a strong foundation of smoking cessation knowledge for nurses embarking on a career in the healthcare field.

If one were to use these findings to identify the top three recommendations for bringing about change in how community mental health nurses approach smoking cessation with their clients they might be:

1) Develop smoking cessation guidelines and resources that are specific to community mental health nurses and specific to their individual roles (i.e. intake, case manager, outreach).

2) Ensure undergraduate nursing programs contain comprehensive smoking cessation interventions and teach the value of community mental health/psychiatric nursing.

3) Reduce the tobacco culture in psychiatric settings; find alternative methods to connect with difficult to engage clients.
Conclusion

This study builds on research examining smoking cessation barriers experienced by nurses working in psychiatric settings. Much of the research completed in the area of providing smoking cessation to individuals with mental illness has been conducted in acute-care psychiatric settings. This study was the first to provide an analysis of community mental health nurses' readiness to change in regards to implementing smoking cessation interventions into their practice, the barriers encountered in the uptake of smoking cessation interventions, and the effect of organizational culture on readiness to change. The mixed method design of this study allowed for the in-depth interviews to build upon the quantitative findings. The quantitative phase revealed majority of community mental health nurses were in the preparation phase in regards to implementing smoking cessation interventions into their practice and personal and organizational barriers affecting community mental health nurses' readiness to change were uncovered as well.

The qualitative analyses illuminated the sociocultural and organizational context of community mental health nursing and provided insight into how the personal and organizational barriers were affecting their ability to provide smoking cessation interventions to their clients. Further analyses of the interview data uncovered barriers to providing smoking cessation not previously discovered in the quantitative data. By listening to the participant’s voice, this mixed methods analysis offers nurses and policy makers important information regarding the barriers affecting community mental health nurses readiness to implement smoking cessation interventions into their practice, and portrays the nurses’ actual experience in ways that the quantitative component could not. By making the quantitative findings ‘real’, it empowers community mental health nurses, their colleagues and policy makers to address these barriers and then take the necessary steps to overcome them.
This study highlights the fact that nurses working within community mental health face similar barriers regarding providing smoking cessation as nurses working within in-patient settings. However, unique to community mental health settings is that nurses have different roles to play, whether it is intake, case management or exclusively outreach. Barriers affect community mental health nurses differently depending on their position. Furthermore, this study illuminated that community mental health nurses feel there is a lack of appropriate and affordable smoking cessation resources available to their clients.

In conclusion, this study illustrates the role of traditional personal and systemic barriers affecting the implementation of smoking cessation interventions in community mental health settings by nurses. It shows the potential for nurses’ leadership in this area. As the acceptance of tobacco use declines on a provincial and national scale, it is imperative that nurse managers, policy makers, and the public support community mental health nurses in playing the most effective role possible within their sphere of influence. Nurses are moving in the direction toward delivering smoking cessation support to their clients. Certain barriers still exist that are impeding them from making further progress, but these barriers are not insurmountable. This study points out some ways forward in helping community mental health nurses deliver consistent and affective smoking cessation interventions into their practice.
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APPENDIX B

Community Mental Health Nurse Interview Guide

As you know the focus of this study is to gain a rich understanding of health care providers' attitudes, beliefs, and practices around tobacco use in community mental health settings. There are no wrong answers here and the purpose of this study is not to get individuals to stop smoking! The intention of this study is purely descriptive and I hope you will see this as a valuable opportunity to have your voice heard on this particular topic of interest. The interview will take approximately 30-60 minutes and I assure you that everything you say in this interview will be kept strictly confidential and that all identifying information will be removed.

Warm up-grand tour question

- Can you describe a typical day for you here at the team

Tobacco Use Among Clients

- Can you tell me why you think your clients are using tobacco [Prompt: how many, addiction, self-medicating, boredom, social activity, psychiatric culture, anything else]
- Can you tell me about a time when you talked to a client about their tobacco use
- In your opinion, do you think clients are interested in quitting/reducing their tobacco use? Please explain.

Nurses’ Role

- Do you see yourself playing a role in smoking cessation for your clients [Prompt: If not, why? If so, what does this look like-talking to clients about smoking status, providing NRT, counseling, referring, do you think someone else is better suited to provide smoking cessation interventions than you? Why is this?]
- Have you ever heard of any guidelines specific to smoking cessation? [Prompt: If not, are there any workplace policies related to smoking here? If so, do you think they are appropriate and feasible to implement in the community mental health setting. Please explain.]
- Can you describe any barriers you may think of that make it difficult for you to offer smoking cessation support to your clients [Prompt: personal, organizational, environmental, systemic]
- In your opinion, what do you think the best smoking cessation interventions for your clients would be? Whose role do you think it is to provide these smoking cessation
interventions to clients [Prompt: nurses, physicians, psychiatrists, mental health workers, social worker, everyone’s role, anyone else]

• Can you describe any formal smoking cessation training you may have had in the past [Prompt: Seminars, In-services]

Readiness to Change

• Findings from the CACTUS survey show that providers are at different stages in relation to talking with clients about their smoking. Can you tell me how you feel about talking to clients about their tobacco use [Prompt: have you thought about it, decided it is not something you want to do, or do you talk to clients sometimes or even often about their tobacco use, can you tell me how you decide “when” to talk to clients about their tobacco use, or when not to]

• What about providing smoking cessation support to clients? [Probe: have you thought about it, decided it is not something you want to do, or do you talk to clients sometimes or even often about their tobacco use, can you tell me how you decide “when” to provide smoking cessation interventions to a client, or when not to]

• What do you do if a client wants to quit smoking? What do other nurses do?

Personal Smoking Status

• Do you think your smoking status affects how you feel about implementing smoking cessation interventions into your practice? Please explain.
  
  • Smoker- Can you tell me your thoughts on providing smoking cessation to clients when you are a smoker yourself [Prompt: Is it difficult, easier?]
  
  • Former Smoker- Can you tell me about being a former smoker and how that may impact your thoughts and actions around providing smoking cessation to this client population
  
  • Non-Smoker-What are your thoughts around providing smoking cessation to this client population?

Is there anything else that you would like to add?
APPENDIX C

Interview Form

Implementing Smoking Cessation Interventions in Community Mental Health Settings: Exploring Nurses’ Readiness to Change, Perceived Barriers and Overall Perceptions Using a Mixed Methods Design

Name/Initials: ____________________________________________

ID# _______

Mental Health Team _________________________________________

Number of years worked in Mental Health Field ________________

Smoking Status _____________________________________________

Age ________________

Interview Start Time: __________

Interview End Time: __________

Date: ________________
Consent Form

Implementing Smoking Cessation Interventions in Community Mental Health Settings: Exploring Nurses’ Readiness to Change, Perceived Barriers and Overall Perceptions Using a Mixed Methods Design

Principal Investigator: Dr. Joy Johnson, PhD, RN Professor, School of Nursing
Co-Investigator: Rosanna Holehouse, RN, BSN, MSN student, School of Nursing

Purpose:
The purpose of this study is to learn about nurses’ perceptions regarding implementing smoking cessation interventions into community mental health settings in the City of Vancouver.

Study Procedures:
The information you share with the researcher may be used in this research study. There is a possibility that the information will be published. The researcher will request a one-time interview that may last up to 60 minutes. The researcher will tape record the interviews and the information from the tape recording will be typed. The interview can be conducted at a location of your choice.

This study is Rosanna Holehouse's master's thesis work and therefore is part of her masters education requirements.

Risks and Benefits:
There could be minimal to no risks to you if you participate in this study. Any information gathered for this study will be held in the strictest confidence, and will not be directly shared with mental health team staff, managers, or anyone within the team or elsewhere. There will be no way to identify participants or any person, place or setting mentioned in any public documentation related to this study. Please note that choosing to speak with Rosanna in a non-private setting would expose your ideas about tobacco use among individuals with mental illness to others; however, Rosanna will be available to have a conversation in private at your request.

Data will NOT be used to evaluate nursing practice or to make any inferences regarding the quality of care provided at the mental health team. Rather, the data will be used to discuss broader issues related to providing smoking cessation care to individuals with mental illness. The data may be used at a later date for educational purposes. No identifying information will be revealed during any such future use.
CERTIFICATE OF APPROVAL - MINIMAL RISK

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<th>PRINCIPAL INVESTIGATOR:</th>
<th>INSTITUTION / DEPARTMENT:</th>
<th>UBC BREB NUMBER:</th>
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<tr>
<td>Joy L. Johnson</td>
<td>UBC/Applied Science/Nursing</td>
<td>H07-00046</td>
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**INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:**

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<th>Institution</th>
<th>Site</th>
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<tr>
<td>Vancouver Coastal Health (VCHRI/VCHA)</td>
<td>Vancouver Community</td>
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**Other locations where the research will be conducted:**

The research will be conducted in a place that is mutually agreeable to the subject and the researcher.

**SPONSORING AGENCIES:**

N/A

**PROJECT TITLE:**

Implementing Smoking Cessation Interventions in Community Mental Health Settings: Exploring Nurses' Readiness to Change, Perceived Barriers and Overall Perceptions Using a Mixed Methods Design

**CERTIFICATE EXPIRY DATE:** February 27, 2008

**DOCUMENTS INCLUDED IN THIS APPROVAL:**

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<td>TCPS Certificate</td>
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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.