Smoking Health Risk Counseling of Psychiatric Patients by Nurses

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CHAPTER I

INTRODUCTION

Cigarette smoking has been identified as the single most important source of preventable morbidity and premature mortality in the United States for each of the past 25 years (Fielding, 1985). Mortality directly attributable to cigarette smoking is estimated at 350,000 per year or nearly 40% of total U.S. mortality. Extensive research has affirmed the link between cigarette smoking and numerous chronic and acute diseases. The smoking rates for the total U.S. population has declined to about 28% with men composing the most rapidly declining group (U.S. Department of Health and Human Services, 1984).

Health care providing professionals and organizations and entrepreneurs have developed numerous treatment strategies to assist individuals with smoking cessation. These strategies include aversive therapy, behavior modification, support groups, and basic health risk education. Success for most treatment approaches is approximately 20 - 25%, a rate equivalent to most chemical dependency treatment (Fagerstrom, 1984). Studies have demonstrated that brief advice from a physician to stop smoking with information about health risks is equally effective as more structured, more intensive programs in assisting patients to stop smoking (Li, Kim, Ewart, Terry, Guthie, Wood, Emmette, & Permutt, 1984).

Much of the smoking cessation treatment effort has been directed toward individuals who already have an acute or chronic smoking related illness. Despite a smoking rate of 50 - 84%, persons with psychiatric illness have not been the target of any major smoking cessation treatment strategy. These persons are often viewed as being too fragile to cope with smoking cessation or as being unable to benefit from treatment for nicotine dependence (Dingman, Resnick, Bosworth & Kamanda, 1988; Feldman, 1984; Hughes, Hatsukami, Mitchell, & Dahlgren, 1986). Resnick and Bosworth (1989) found these theories are unsubstantiated and that persons with major psychiatric illness were able to tolerate a complete nonsmoking policy while hospitalized on an acute psychiatric unit without measurable ill effects.

The current trend in smoking policies in hospitals is of increasing restrictiveness, often consisting of a total ban of cigarette smoking on hospital premises. The exception to this trend is in psychiatric hospitals and on psychiatric wards in general hospitals where smoking is largely unrestricted (Resnick, Gordon, & Bosworth, 1989). This exception provides a strong environmental reinforcer to patients that smoking is a behavior acceptable to their health care providers. Antonuccio and Lichenstein (1980) confirmed that patients smoke more when in a smoking environment and when in the presence of smoking nurses. Nurses have been identified as being capable of influencing

patient behavior both by role modeling and by providing information (Wilson & Petruska, 1984). Unfortunately the rate of smoking for nurses is equal to or higher than the rate for the general population at 28 - 38%. The rate is even higher among psychiatric nurses at 50% (Wagner, 1985; Feldman, 1984). Most nurses view smoking health risk education as a nursing function but few actually provide this care for patients (Sander, Stone, Fowler, Marquillier, 1986). Reasons cited for not providing this care include perceived ineffectiveness of health risk education, belief that smoking is not a health risk, and lack of knowledge base to provide the care (Faulkner & Ward, 1983; Wagner, 1985).

Given the statistics confirming the significant risk to health associated with smoking, nurses must provide education on the health risks of smoking to their patients. This education can take many different forms including direct methods such as discussion, use of audio-visual aids, and indirect methods such as enforcing environmental nonsmoking policies and role modeling nonsmoking behavior. Research has demonstrated that both methods are effective to varying degrees and combining both direct and indirect methods increases the overall effectiveness.

In many areas of practice, nurses are aggressively educating patients about health risks; especially about health risks which can be minimized by changes in behavior

and lifestyle. Advising patients about the health risks associated with tobacco smoking has become a more common practice with nurses providing care to patients with chronic medical problems. Unfortunately patients with psychiatric illness seldom receive this education from nurses. They also receive a strong indirect message condoning smoking from psychiatric nurses who smoke at a rate higher than any other specialty group of nurses. As a result, psychiatric patients smoke at a rate higher than any other subgroup (about 80% of patients). They continue to do so without the benefit of adequate information with which to make a decision about continuing their smoking habits.

Statement of the Problem

Adequate evidence exists to support the potential impact of nurses actively engaging in smoking health risk counseling of persons with psychiatric illness. Providing this counseling is an important challenge for all nurses. The challenge to accomplish this same task in the population of persons with mental illness is especially difficult due to stereotyping and lack of policy support for encouraging smoking cessation in this group. The limited research currently published indicates that smoking behavior in the mentally ill can be severely curtailed without adverse effect on the individual. This indicates that nurses in all settings who come in contact with the mentally ill should include smoking health risk information and

cessation recommendations as a portion of the care they provide. At the present time it appears that nurses are not consistently performing this care, despite the high rate of smoking among these patients. This study will describe the current status of nursing practice related to smoking health risk counseling of psychiatric patients in one state facility. For the facility, the study is timely as their is discussion of the possibility of change to the current smoking policies.

Review of the Literature

The review of the literature to support this study includes an overview of the health risks of smoking, smoking cessation strategies, and the role of nurses as educators. Special attention is directed to hospital smoking policies, smoking among psychiatric patients, and current studies on no-smoking policies on psychiatric wards.

Health Risks of Smoking

Cigarette smoking is a significant factor in the development of numerous acute and chronic diseases. Smokers have a reduction in longevity between five to eight years when compared to an equivalent nonsmoking population. Prior to the Surgeon General's report in 1964, most people who smoked were unaware of the health risks associated with cigarette smoking. Since that time some efforts to educate the public about the detrimental effects of smoking on health have been made. Cigarette packages are labeled with

a warning about health hazards and numerous Surgeon General Reports have been published outlining the risks. Over 30,000 scientific studies have been published exploring the various interrelationships between aspects of smoking, exposure to tobacco, and health. This research provides a good base of information from which to discuss the health risks of cigarette smoking.

Numerous acute and chronic diseases are directly attributable to cigarette smoking. Most significant of these in number is coronary heart disease with approximately 200,000 deaths annually or about 35% of the total mortality from this disease (U.S. Department of Health and Human Services, 1984). The 1983 Surgeon General's report states that "cigarette smoking should be considered the most important of the known modifiable risk factors for coronary heart disease (CHD) in the United States" (U.S. Department of Health and Human Services, 1984). Additionally smoking appears to have a synergistic effect together with other risk factors for mortality from the disease (U.S. Department of Health and Human Services, 1984).

The reduction of risk for CHD that occurs when individuals stop smoking is very significant. Within one year of smoking cessation the increased risk of CHD has decreased by 50% and at 10 years has returned to equal the risk of a nonsmoker (U.S. Department of Health and Human Services, 1983). Persons who have experienced myocardial

infarctions (MI) and subsequently stop smoking have a significantly lower risk of experiencing additional MI and a better survival rate if another MI occurs (The Pooling Project Research Group, 1978).

The disease process most closely associated with cigarette smoking in the minds of the public is lung cancer. Cancer mortality is highest for both men and women from lung cancer. Eighty to 85% of all lung cancer deaths are attributable to smoking, making smoking the leading cause of cancer deaths in the US (U.S. Department of Health and Human Services, 1982). Lung cancer mortality in the U.S. has increased dramatically from 18,300 in 1950 to 131,000 in 1984 (Silverberg, 1984). Lung cancer accounts for 25% of all cancer mortality. In 1986 lung cancer replaced breast cancer as the leading cause of cancer death for women. Several studies have demonstrated that lung cancer risk decreases with smoking cessation to 40% greater risk after 5 years, and to nearly equivalent risk of a nonsmoker after 15 years.

The most significant non-carcinoma pulmonary disease strongly associated with cigarette smoking is chronic obstructive pulmonary disease (COPD). Over 80% of 60,000 deaths from COPD in 1983 were attributable to smoking and were therefore preventable. The risk for smokers of COPD morbidity ranges as high as 30 times that of nonsmokers (U.S. Department of Health and Human Services, 1984).

Smoking cessation after the onset of COPD related respiratory symptoms leads to a decrease in the risk of mortality from COPD and can reverse small airway inflammation and improved pulmonary function. Smokers with fixed reductions in expiratory volume may either slow or halt the destructive process but are unable to regain lost lung capacity (U.S. Department of Health and Human Services, 1984).

Laryngeal cancer accounts for about 4,000 cancer deaths annually. Numerous studies have established a strong association between smoking and the development of laryngeal cancer with some studies attributing up to 84% of cases to smoking. Men have continued to outnumber women as victims of laryngeal cancer with the synergistic effect of alcohol with smoking as the explanatory factor (McCoy, Heeht, & Wynder, 1980). Reduction in risk to the level of a nonsmoker requires about 10 to 15 years (McCoy et al, 1980).

Peripheral arterial occlusive disease (PAOD) has been strongly associated with cigarette smoking in numerous studies. It has been shown that 98.8% of aortoiliac disease victims are cigarette smokers (Kannel & Shurtleff, 1973). Nearly 80% of abdominal aortic aneurysms occur in smokers, and there is a two to threefold greater chance of mortality than for nonsmokers (U.S. Department of Health and Human Services, 1984). Symptoms associated with PAOD decrease measurably with smoking cessation.

The incidence of cerebrovascular disease (CVD) and cerebrovascular accidents (CVA) has decreased with improved treatment of hyperlipidemia and hypertension. The risk of CVD and CVA remains 1.2 to 1.5 times higher for smokers. For women who smoke and use oral contraceptives risk of CVA is 21.9% higher than for nonsmokers. Two studies have shown that the increased risk of CVA diminishes rapidly after smoking cessation (Rogot, 1974).

Mortality from all types of oral cancer demonstrates a smoker to nonsmoker ratio of 13:1. Again alcohol appears to be a multiplicative factor in the formation of this disease in smokers. Sixteen years of smoking abstinence is required before the smokers' risk of oral cancer equals that of the nonsmoker (Fielding, 1985).

The percentage of bladder cancer which can be attributed to smoking is estimated at 40 - 60% for women and men. A smoker maintains a risk of bladder cancer morbidity two to three times higher than a nonsmoker. The time period required for the smokers' risk of bladder cancer to decrease to that of a nonsmoker is similar to the other cancers discussed at about 15 years.

Both cancer of the pancreas and cancer of the esophagus demonstrate an association between morbidity and smoking. Rates for smokers are about double that of nonsmokers. Risk reduction also occurs at about 15 to 16 years (U.S. Department of Health and Human Services, 1982).

Cancer of: stomach, kidney, and cervix show a less definitive link to smoking but mild association has been demonstrated. Continuing research in this area is examining the role of smoking in the development of numerous other types of carcinoma (U.S. Department of Health and Human Services, 1982).

Peptic ulcer disease has been convincingly associated with smoking in a large number of studies. Mortality rates for smokers with this disease are approximately 2.5 times that of nonsmokers. No definitive results have been reported on the reduction of risk with smoking cessation (U.S. Department of Health, Education, and Welfare, 1979).

In addition to the increased risk of disease and death in those individuals who actively engage in cigarette smoking, a significant risk exists for the victims of passive cigarette smoke exposure. Blood levels of carboxyhemoglobin and urine levels of cotinine in persons exposed to an environment contaminated with cigarette smoke were equivalent to those found in persons who actively smoked 1 to 10 cigarettes per day (Fielding, 1985). Individuals exposed to passive smoke also experience a variety of other detrimental health effects including exacerbation of allergy symptoms, headaches, and increase in angina symptoms (Fielding, 1985).

Smoking Cessation Strategies

Clearly, cigarette smoking is a major threat to health. As a result numerous strategies have been developed to assist people in smoking cessation efforts. Surveys indicate that over 90% of smokers wish to quit and that most have attempted to quit one or more times (U.S. Department of Health and Human Services, 1979). Of those individuals who stopped smoking and remained abstinent for more than one year the majority did so without the assistance of a formal program or guidance from a clinical professional (U.S. Department of Health and Human Services, 1979). Reasons cited for quitting are varied and include health problems, pressure from family and friends, cost, fear of adverse health effects, cleanliness, and a desire for social acceptability.

Smoking cessation can be accomplished in a variety of ways. Among these are the unassisted "cold turkey" approach, formal classes, indirect environmental measures, and simple, brief advice and information from a health care provider. The average success rate of an individual remaining abstinent for one year for any approach is about 25% (Grunberg & Bowen, 1985). Studies indicate that patients who receive advice from a health care professional to stop smoking and are given written information on how to cope with withdrawal symptoms have nearly equal success to patients who participate in structured behavior modification

groups (Grunberg & Bowen, 1985). Modeling by the health care provider is also an important element of the smoking cessation message transmitted to patients. If providers do not smoke and require abstinence from cigarettes while in the providers' work setting, strong reinforcement of the verbal smoking cessation message occurs (Alexander, 1988).

The process of assisting an individual to stop smoking begins by the health care provider identifying and documenting smoking history and prior failed cessation attempts. Information gathering about a subject reinforces to the patient that smoking is a issue of health concern (Alexander, 1988). Most smokers would prefer to be nonsmokers but they are fearful of failure at cessation attempts and withdrawal symptoms (Alexander, 1988). The health care provider can allay these fears and increase the likelihood of successful cessation by providing accurate information about health risks, benefits of cessation, withdrawal symptoms and management of them and smoking cessation resources.

Role of Nurses as Educators

It has been widely shown that nurses believe that smoking health risk education is part of their role as nurses (Department of Health and Human Services, 1977; Elkind, 1980). In a large study (N=222 nurses from 3 hospitals) with 100% response rate, Faulkner and Ward (1983) found that the majority of nurses appear to believe in the

concept of their role as health educators, yet do not appear to act upon this belief as far as the smoking patient is concerned. Questions raised from this study, which focused on the general hospital nurse, found that nurses may not have an adequate knowledge base to take on the role of health educator. An underlying assumption was that it is not possible to teach without the relevant knowledge.

A certain amount of role conflict was also noted among nurses in the study performed by Faulkner and Ward (1983). Sixty-one percent were aware of the need to model nonsmoking behavior. Forty-nine percent did not agree that their smoking made it harder for them to give advice to their patients. Other studies have shown that nurses who smoke view the health risks to be less severe than nurses who do not smoke (Dalton & Swenson, 1986; Sanders et al, 1986; Feldman, 1984). In a study done by Antonuccio and Lichenstein (1980) on peer influence on smoking habits, role modeling influenced both smoking frequency and intercigarette interval. Patients in their study smoked more cigarettes when exposed to a high rate model than when exposed to a low rate model.

Dalton and Swenson (1986) polled 601 (46% of 1,300 randomly selected nurses) in North Carolina through a mailed questionnaire to explore the role modeling beliefs and behaviors of smoking and nonsmoking nurses in relation to patients, families, and the general public whom they counsel

about smoking. The sample included 322 nurses (54%) who identified themselves as having never smoked, 191 (32%) who had smoked during the last year, and 87 (31%) who were former smokers and had not smoked for at least one year. Fifty-four percent of the respondents thought nurses are very important role models of health behaviors for their patients. However, less than half of the respondents (43%) thought that nurses are very important role models for the general public. It was interesting to note that nurses who smoked felt that nurses are not favorable role models to the general public. Former smokers, when compared to current smokers and nonsmokers, felt that nurses have limited or negligible importance as role models for patients. All of the respondents were asked if nurses had to exhibit certain behaviors in order to be effective role models. Almost all (94%) of the respondents thought that in order to be good role models for patients nurses must be able to teach health behaviors effectively.

Few studies have been published that describe the frequency of nurse counseling of patients regarding the health risks of smoking. The information that is available suggests that the majority of nurses do not provide this counseling for patients (Goldstein, Hellier, Fitzgerald, Stegall, & Fischer, 1987). Dalton & Swenson (1986) found that 35% of the 601 nurses in their sample regularly counsel patients about the health effects of smoking. Twenty-five

percent of those counseling were never or former smokers and 10% were current smokers. The largest proportion of the respondents (52%) occasionally or rarely counsel patients about health effects of smoking.

Sanders et al (1986) study on the practice of nurses and anti-smoking education produced similar results. Anti-smoking activities were not occurring regularly despite the interest of the nurses in smoking education. Nurses reported that advice on smoking was given only occasionally (41%) rather than regularly (16%), although there was more discussion with smokers with smoking related disorders.

From the 1960s to 1975 the percent of nurses smoking increased from 35% to 39% (Smoking and Health Reports, 1979). It is interesting to note physicians, dentists, women and men have decreased smoking during this time frame (Garfinkel & Stellman, 1986). Wagner (1985) took a 5% random sample of RNs in western New York (a total of 800 nurses, with a return of 63%) and found that 28% of the 504 respondents were smokers. Of the 137 former smokers (27%), 118 (86%) had quit smoking for longer than one year. Younger nurses (21-30) had a higher incidence of never smoking (38%).

Nurses working in the psychiatric area reported a higher incidence of smoking (50%) when compared to other areas of nursing and were exposed to excessive tobacco smoke on the job (Feldman, 1984). In some settings, one of the

job responsibilities of the psychiatric nurse is to light patients' cigarettes. The nurse may also be called upon to provide patient care in an atmosphere of lingering smoke.

Knudsen, Schulman, Van Den Hoek, & Fowler (1985) surveyed 57 patients with lung cancer in order to identify ways to assist lung cancer patients and their families to quit smoking. Implications for nursing practice were derived from the survey. These implications included: (a) Nurses should be assertive in asking about patient's smoking habits and plans to stop smoking; (b) a nurse could be a major influence in helping a patient make the decision to quit; (c) nurses can be instrumental in providing a smoke-free environment for the patients; (d) nurses can help patients manage withdrawal symptoms; and (e) nurses can provide patient teaching about risks of smoking, benefits of quitting, and programs available to help patients quit smoking.

Hospital Smoking Policies

Many hospitals in the Western world have guidelines to control smoking, and meaningful results have been achieved. There has been a trend to restrict or eliminate smoking in both private and government sectors (Resnick & Bosworth, 1989). General hospitals have begun to be more active in health promotion. Many have stopped the sale of cigarettes, have established nonsmoking areas, and offer programs to help people stop smoking.

Efforts to limit smoking in hospitals have been hampered by the concern for the rights of smokers, often with less than due regard for those who want and need to breathe clean air (Ho, 1985), or the effects of passive smoking. Strict antismoking regulations have frequently been criticized as too harsh or difficult to enforce, as if disease and premature death brought on by smoking were any easier to accept and control. Restrictions reduce the opportunity for smokers to smoke and may thus limit cigarette consumption. They can act as a positive reinforcement to those who have already given up smoking.

Dawley, Fleischer, and Dawley (1985) concluded that hospitals send a strong anti-smoking message to the public by implementing firm hospital smoking policies. They also note that there is a disparity between the seriousness of the smoking problem and the scant attention directed by hospitals toward actively discouraging smoking. This lack of serious smoking discouragement efforts is particularly disappointing because hospitalization may be a period in which individual smokers are likely to be more receptive to stopping (Dawley et al, 1985). Hospitalized smokers are removed from many of the cues that elicit smoking, are presumably more aware of the health hazards of smoking, and would thus most probably be more susceptible to smoking discouragement efforts.

In the era where competitive medical marketing is

common-place, it is reasonable to ask about the effect of a no-smoking policy on the ward census. Admittedly involuntary and indigent patients have few choices about where to be hospitalized. In one study in a 359 bed private hospital (Smith & Grant, 1989) ward census, number of admissions, and percent occupancy remained the same after a smoking ban. The patient advocate's office confirmed that the policy created no serious problems.

Psychiatric wards and hospitals have few restrictions on smoking (Catford & Nutbeam, 1983); and smoking is a major concern in psychiatric settings. Cigarettes and lighters have been used by psychiatric patients to inflict self-injury. Smoking is a leading cause of fire-related deaths and the leading cause of hospital fires. Patients focused on smoking or the pursuit of smoking materials often disrupt the ward milieu and group and occupational therapy meetings. Aggression toward other patients and staff sometimes revolves around smoking. The use of tobacco as a reinforcer to exact desired changes in behavior is a common, ethically troubling practice. Cigarettes are often sold in psychiatric facilities.

Smoking Among Psychiatric Patients

Studies have reported a higher prevalence of smoking among psychiatric patients (50 - 84%, depending on diagnosis) than among nonpsychiatric control subjects (27% - 58%) (Hall, 1980; Dawley et al, 1985; Masterson & O'Shea,

1984; Mathew, Weinman, & Mirabi, 1981; McNeil, Kaij, & Malmquist-Larsson, 1983; and O'Farrell, Connors & Upper, 1983). The validity and generalizability of these prevalence figures may be limited because the studies failed to eliminate the possibility that factors other than a psychiatric disorder were responsible for the higher prevalence of smoking. For example, psychiatric patients are more likely than nonpsychiatric subjects to be of low socioeconomic status and unmarried (Hollingshead & Redlich, 1958) and to use alcohol (Solomon, 1982), all of which have been associated with a higher prevalence of smoking (Kozlowski, 1979). The studies also examined very select populations, e.g., institutionalized schizophrenic patients (Masterson & O'Shea, 1984), veterans (O'Farrell et al, 1983; Dawley et al, 1985), and pregnant women (McNeil et al, 1983).

A stronger design was used by Hughes et al (1986) in their study of the prevalence of smoking among psychiatric outpatients in comparison to other populations. The study consisted of a heterogeneous group of outpatients (N=277) seen in a general psychiatry clinic. Eligible subjects were patients who participated in an intake evaluation in the clinic during a two year period of time who filled out an intake questionnaire, were 18 years of age or older, and had a single diagnosis. Subjects had either an adjustment, affective, anxiety, psychotic, or personality disorder. The

two control groups consisted of random, population-based samples. The state figures were obtained by the state department of health (N=1,440) and the national sample (N=17,000) was collected by the National Health Interview Survey. Smokers were identified as those who answered yes to the question "Do you smoke cigarettes now?" Information on the two control groups was obtained from a brief telephone survey. Psychiatric diagnosis was based on DSM-III criteria and was obtained by agreement between a psychiatry resident and faculty after a 1-2 hour interview.

The prevalence of smoking among psychiatric outpatients (N=277) was significantly higher (52%) than among either local (30%) or national population-based samples (33%). The higher prevalence was not associated with the age, sex, marital status, alcohol use, socioeconomic status, institutionalization of the psychiatric patients, or coffee use. Smoking was especially prevalent among patients with schizophrenia (88%) or mania (70%) and among more severely ill patients. Patients who had been hospitalized previously for psychiatric symptoms had a higher prevalence of smoking than patients who had not been hospitalized. Similarly, patients who had ever been on prescribed psychotropic medications had a higher prevalence of smoking than those who had not. The smoking of one or more packs of cigarettes a day was similar for psychiatric patients (66%) and the state (68%) and national control subjects (66%).

There are several hypotheses as to why psychiatric patients are more likely to smoke (Hughes et al, 1986, p. 995). They (a) have neurotransmitter (noradrenalin) deficiencies that are increased by smoking; (b) are more often bored and use smoking as a behavioral "filler"; (c) have problems with aggression, concentration, or relaxation, all of which can be improved by smoking; (d) have higher levels of extroversion, impulsivity, or other personality traits associated with smoking; (e) use smoking to offset the sedative effects of drugs; or (f) are more likely to become dependent on drugs. None of these hypotheses has been directly tested.

Psychiatric patients have been viewed as too fragile to cope with a nonsmoking policy (Dingman et al, 1988; Feldman, 1984) or unable to benefit from education programs (Hughes et al, 1986). In part this is because of the complexity of cigarette dependence. Smoking is a dependency that has physiological, behavioral, and psychological aspects (Smith & Grant, 1989). These combine to bestow on the smoker a powerful set of meanings and motivations, which become particularly apparent when the smoker changes the pattern of tobacco use. For instance, a smoker who attempts to cut down may experience a significant loss, similar to the loss of a reliable friend, and may feel increasingly vulnerable to distress.

Issues of dependency, vulnerability, and loss are often

raised during a psychiatric illness. For a smoker with a psychiatric illness, cigarettes may take on a unique or sometimes magical and ritualistic significance. Since psychiatric patients use relatively more tobacco compared to the population at large (Hughes et al, 1986) it is easy to see how the restrictions of psychiatric patients' smoking could raise numerous concerns, both real and fantasized, among members of the psychiatric treatment team. Only since 1980 has tobacco abuse and dependence been acknowledged as a psychiatric diagnosis.

Studies of No Smoking Policies on Psychiatric Wards

Smoking policies in Oregon psychiatric settings changed radically between 1986 and 1987 (Resnick et al, 1988). More stringent policies were implemented in response to increased concerns about the health risks of smoking and ensuring a safe work environment, the rising costs of accommodating smoking practices, and a national movement to limit smoking in hospitals.

However, the implementation of smoking restriction policies in psychiatric wards of Oregon's general hospitals has been less than for other hospital divisions. One study done in 1986 (Resnick et al, 1988) found no smoke-free psychiatric wards, although all wards restricted smoking to specific areas and times. One year later a follow-up study (Resnick & Bosworth, 1989) found that 24 (49%) of the state's psychiatric wards were smoke-free. Eleven of the 25

wards (44%) that still allowed smoking had further restricted patient smoking areas, smoking hours, or availability of cigarettes. Smoking in staff areas had also become more restricted. Twenty-eight percent of facilities allowed smoking in staff lounges, and less than 7% allowed staff to smoke in day rooms, in an enclosed porch, or outdoors. (One respondent stated that a new common smoking area had improved patient-staff interaction.) Forty-five percent of the respondents stated the model and experience of the no-smoking policy at a university hospital (Resnick & Bosworth, 1989, described later) positively influenced their own facility's decision to become smoke-free.

A pilot project was designed to test the feasibility of creating a nonsmoking psychiatric ward in an Oregon university hospital (Resnick & Bosworth, 1989). The psychiatric crisis unit is a 12-bed acute care locked unit which serves predominately a medically indigent population. Forty percent of the patients are admitted under the state's civil commitment statute, and patients are predominately psychotic or suicidal and often have complicating drug or alcohol problems. Involuntary patients average a four-day stay and voluntary patients a seven-day stay. Very few patients have off-ward privileges.

Before the study began in November 1986, smoking was allowed in the day room from 8 a.m. to 11 p.m. Patients in security room were limited to one cigarette per hour.

Nursing staff dispensed and lit all cigarettes and observed patients while they smoked.

A plan was developed to stop smoking on the psychiatric crisis unit and study the results. Questionnaires were distributed to staff (physicians, resident physicians, nurses, occupational therapists, and social workers) and patients during the month preceding the implementation of the no-smoking policy and again during the period when smoking was prohibited. The staff questionnaire asked about staff attitudes toward the unit's smoking policy and whether the staff member currently smoked and the amount of time nurses spent monitoring patient smoking. A separate questionnaire asked patients about past and current smoking habits and their attitudes toward the unit's smoking policy.

A total of 165 patients completed the smoking questionnaire, 116 during the control period preceding the smoking ban and 49 in the month after its implementation. Seventy-one percent of the patients reported that they currently smoked cigarettes. During the control period, 7% of all patients favored a smoking ban. After it was implemented, 22% endorsed the ban. The majority thought smoking areas should be designated.

During the control period, 60% of the patients who smoked said they would attend a stop-smoking program. The percentage declined to 32% after the ban was implemented. During the control period, 29% of the patients reported that

restricted smoking would lead them to try to quit. Thirty percent said they would try to reduce the amount they smoked, and 38% said it would not affect their level of smoking.

Staff attitudes toward a smoke-free ward changed considerably after implementation of the ban. Twenty-four percent of the 25 staff members who completed the questionnaire during the control period favored a complete smoking ban, compared with 95% of the 20 staff members who completed the questionnaire after the change to a smoke-free ward. The nurses reported spending less time per shift dealing with cigarette issues--15.1 minutes during the control period, compared with 6.4 minutes spent after the smoking ban answering questions about the new policy and the use of nicotine gum. Eighty-three percent of the staff rated the no-smoking policy as very successful and 17% as successful.

A review of the charts (30 charts from the control period and 30 from the smoke-free period) showed no readily discernible changes in antipsychotic drug dose, PRN psychotropic medications dispensed, episodes of seclusion or restraint, and discharges against medical advice. The only change was an increase in the use of nicotine gum, from seven PRN doses for one month prior to the ban and 176 for the month after the ban. The number of court holds initiated decreased from four (all smokers) to two

(nonsmokers). Campus security reported 67 calls for backup for the month prior to and 70 calls for the month following the ban.

The study showed that it is possible to ban smoking on an inpatient psychiatric unit. The problems that staff expected did not occur. The staff were uniformly in favor of continuing to have a smoke-free ward. The results of the study were disseminated in the hospital and were used to persuade the hospital board to vote to make the hospital smoke-free.

Another study (Smith & Grant, 1989) in a neighboring state in a 42 bed private general hospital psychiatric unit was implemented to identify anticipated and actual patient-related problems associated with a smoking ban and to assess staff and patient attitudes toward the ban. Methods similar to the Resnick & Bosworth study (1989) were used including collecting data through a pre- and post-ban survey of medical and nursing staff. One change was the use of patient interviews prior to discharge instead of a questionnaire. This study also showed that staff anticipated more smoking-related problems than actually occurred and patients who smoked were able to reduce their tobacco use during their hospital stay.

Prior to implementing the ban, information on smoking cessation was provided to staff along with inservice education. The physicians responded to two questionnaires,

the first one week prior to implementing the ban, and the second six weeks after the ban was instituted. The nursing staff responded to questionnaires on six occasions, ranging from two weeks before to 12 weeks after the ban. Each nurse on duty on the designated observation day was asked to complete a questionnaire. Nurses and physicians again found fewer adverse smoking-related events than they anticipated.

Thirty-two patients were assessed just before their discharge by means of a structured interview in the third through the fifth weeks after the ban was implemented. The first eight patients discharged each week were interviewed; none refused. Patients were asked whether the no-smoking policy had influenced their choice of hospitals and how the policy had affected their treatment. They were also asked about their smoking behavior history. Thirteen of the patients (41%) interviewed were smokers. Several reported smoking, violating the ban by smoking out of the staff's view.

Summary

Smoking is a risk to health. Numerous treatment strategies have been developed to assist individuals with smoking cessation. Hospital policies are increasingly more restrictive, except for psychiatric units. Psychiatric patients are excluded from smoking health risk counseling.

Given the statistics confirming the significant risk to health associated with smoking, nurses should provide

education on the health risks of smoking to their patients. In many areas of practice, nurses are aggressively educating patients about health risks. Unfortunately patients with psychiatric illness seldom receive this education from nurses. Psychiatric patients smoke at a rate higher than any other subgroup. They continue to do so without the benefit of adequate information with which to make a decision about continuing their smoking habits.

Conceptual Framework

This descriptive research project focused on the following variable: the hospital as the environment viewed as the interaction between administration, nursing staff, and patients (See Figure 1). The research was predicted on the following propositions derived from the literature: smoking is a risk to health, nurses are health educators and role models and have a responsibility to educate/counsel patients, and patients have a right to information and assistance to help them stop smoking. Sustained behavior change was viewed as a consequence of the interaction of counseling by nurses, patients having individual strategies to stop smoking, and these being realized in an environment that discourages smoking (see Figure 2). The discussion that follows further describes these propositions.

Smoking is one of the major health and economic issues of our century. It is clearly a detrimental health behavior that costs millions of dollars annually. There is a growing

Figure 1

Interactive Model Describing the Environment of a Psychiatric Facility as it Relates to Smoking

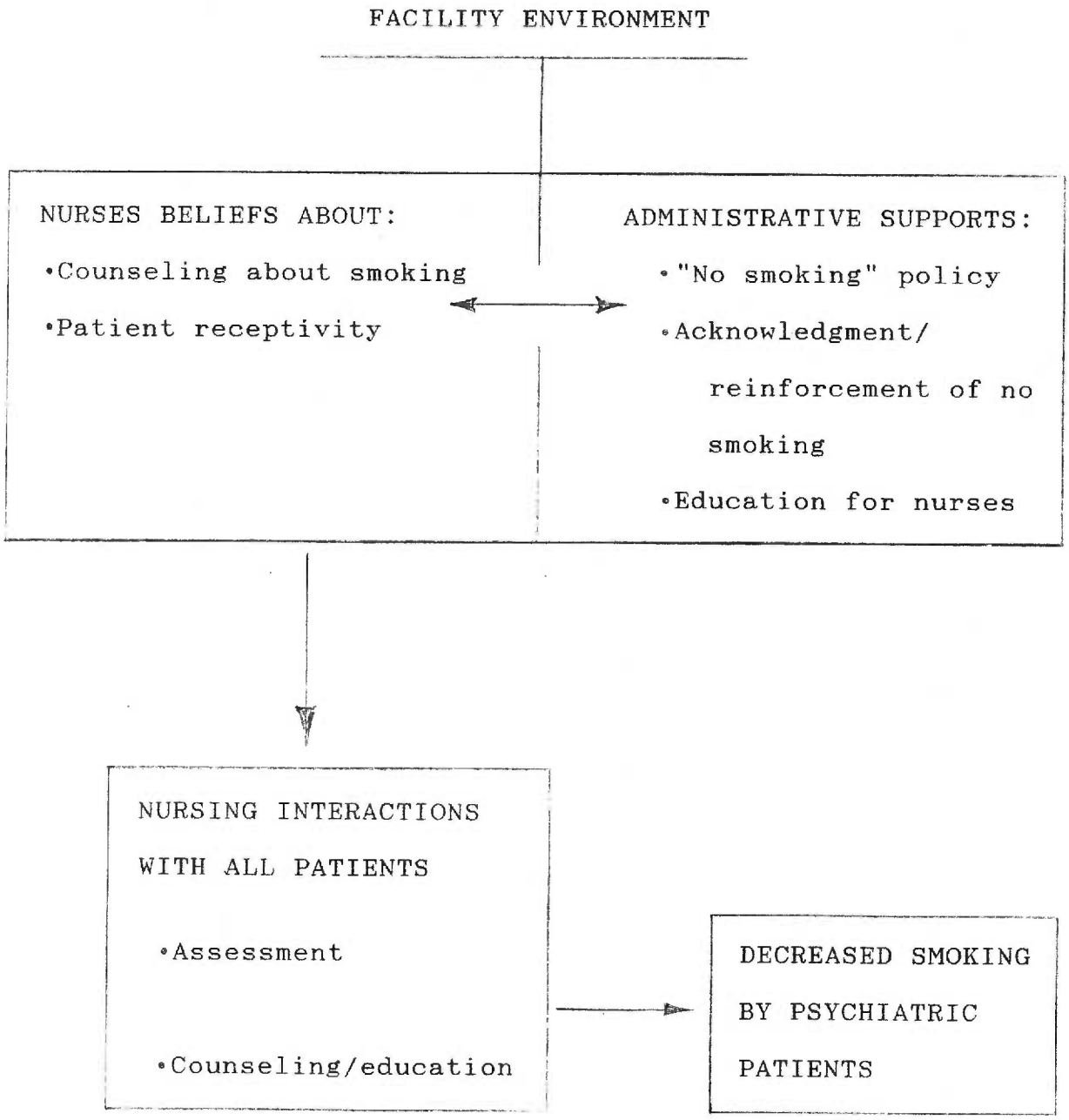
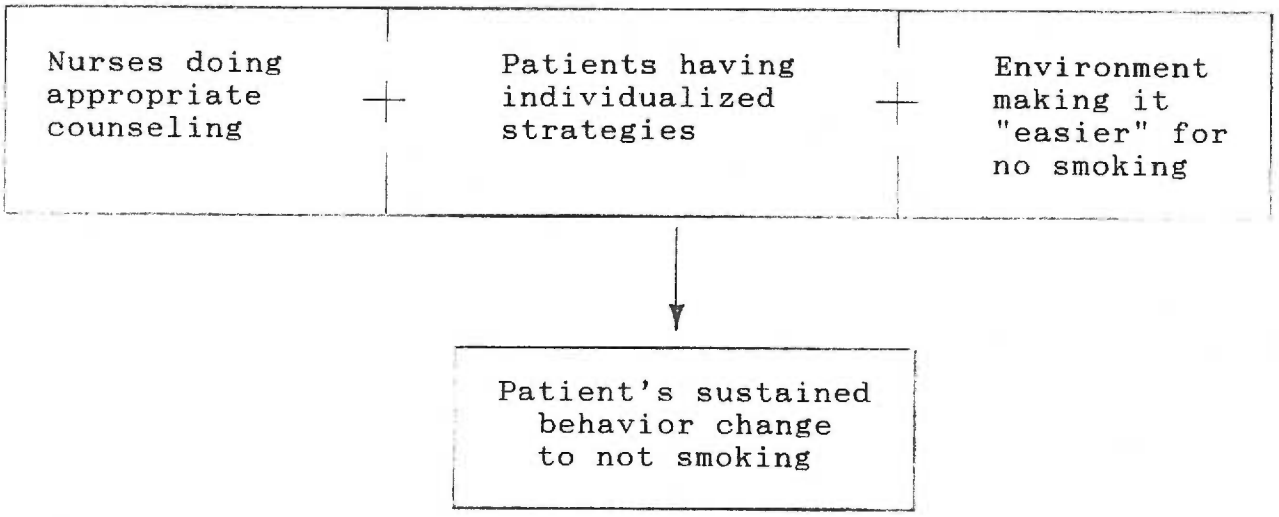


Figure 2

Model Describing Factors Influencing Development of Sustained Behavior Change Toward Not Smoking in a Psychiatric Facility



interest among health care providers to assist smokers in the cessation of this destructive personal habit. Smoking cessation represents one of the most significant health education challenges to nurses (Alexander, 1988). Nurses are the largest body of health care providers and they have frequent, direct, and prolonged contact with patients and their families. Nurses are therefore in a unique position of informing patients, as well as the community, about the health risks of smoking.

Our society believes that human beings have the right to know, to be informed, and to be taught. These rights are demonstrated daily in our school systems, news media, informed consent procedures, and patient-teaching interactions. The right to know requires access to accurate information. Nursing has a strong health education and health promotion emphasis and nursing care focuses around these activities. Nurses are legally and ethically bound to engage in health teaching which is appropriate to the health problems and concerns of patients.

Psychiatric patients, as consumers of health care, have a right to information concerning their diagnosis, prognosis, and treatment options provided in terms they can understand. Unfortunately, psychiatric patients have been viewed as too fragile to cope with a nonsmoking policy (Dingman, Resnick, Bosworth, & Kamanda, 1988, & Feldman, 1984), unable to benefit from education programs (Hughes,

Hatsukami, Mitchell & Dahlgren, 1986), resistent to stop smoking or prone to more anxiety, disruptive behavior or violence if they are not permitted to smoke. Our observations indicate that nurses often avoid engaging in smoking cessation education because of a perception that psychiatric patients are incapable of learning or understanding new information or are not interested in their own health or changing harmful behaviors. This perception is not shared by the investigators. It has been our experience that many psychiatric patients want to stop smoking and appreciate the information and support to help them do so.

It is important for nurses to do an adequate assessment of each patient's health status, including the patient in the process as much as possible. Even patients who are actively psychotic can have some input into their current needs and care. The patient should be a part of the team making decisions about his/her care, especially if the decision involves changing an integral part of the patients daily activities or behaviors.

To accomplish changes in the patient's smoking behaviors, nurses must first endorse the beliefs that: (a) smoking is detrimental to health, (b) nurses can have an impact by providing education and support to patients, and (c) nurses should include smoking education as part of their already busy schedules. In order to do this, nurses need to

have education about the health risks of smoking, smoking cessation techniques, and resources available to help patients quit. Education for nurses will increase their knowledge base and help to decrease their anxieties about teaching this content.

Administrative and policy support for restriction of smoking in health care settings assists nurses efforts to help patients accomplish smoking cessation. This support is crucial in transmitting a clear message to patients that smoking is an unhealthy behavior. Smoking policies on psychiatric units are less restrictive than those in other hospital units. Nurses have the opportunity to have impact on facility policy decisions regarding restrictions on smoking through participation on nursing and hospital committees and interdisciplinary treatment teams.

Due to the high incidence of smoking among psychiatric patients, more time and energy should be aimed at educating this patient population. By establishing personalized health goals which are mutually generated, patient interest and participation will be increased. Nurses actions that convey optimistic expectations and praise can create an environment in which the patient feels capable of success, free to take risks, and motivated to explore new learning experiences. As Alexander (1988) pointed out, failure of the nurse to send an antismoking message can serve to reinforce the patients denial mechanisms of the problem's

true severity and actually indirectly reinforce continued smoking behavior.

Research Questions

The purpose of our research project is to identify the interactions between the nursing staff, patients and administration in relation to smoking health risk counseling. Specifically, this study will attempt to answer the following questions:

1. Do psychiatric nurses view smoking as a health risk?
2. Do nurses counsel psychiatric patients about these health risks?
3. What barriers exist that prevent nurses from providing smoking health risk counseling?
4. What factors would facilitate nurses in providing health risk counseling?
5. Do psychiatric patients report receiving health risk information from nurses?
6. What interventions do patients report would assist them in smoking cessation?
7. Are smoking health risk assessments documented in patients' medical records?

Definitions

The following definitions are provided to clarify terms used in this paper. The definitions are adapted from

Comprehensive Psychiatric Nursing by Habor, Leach, Schudy, & Sideleau (1978). The diagnoses are consistent with those listed in DSM-III-R (1987).

Adjustment disorder: A maladaptive reaction to an identifiable psychosocial stressor or stressors which impair functioning within society (relationships, job, social or activities).

Affective disorder: An emotional feeling tone attached to an object, idea, or thought; including inner feelings and their external manifestations (euphoria, anger, sadness).

Anxiety disorder: A state of tension associated with apprehension, worry, feelings of guilt, sense of insecurity, and need for reassurance.

Barriers: Factors that act to hinder or restrict goal-directed behavior.

Confusion: A state of mental perplexity or bewilderment resulting from disorientation.

Counseling/education: Advice, guidance or information sharing by a knowledgeable person.

Health risks: Behaviors and exposure to environmental factors which subject individuals to potential negative alterations in health status (smoking contributing to lung cancer).

Mental illness: Maladaptation to the life process manifested as a behavioral, psychological, or biological

dysfunction in a person.

Passive smoking: Tobacco smoke present in the environment which causes respiratory exposure to those in the environment.

Personality disorder: A marked difference in behavior from what is considered acceptable or normal in society.

Psychiatric patient: Any person who has a documented diagnosis of adjustment, affective, anxiety, personality, or psychotic disorder.

Psychotic disorder: A state in which a person's mental capacity to recognize reality, communicate, and relate to others is impaired, thus interfering with the person's capacity to deal with the demands of life.

CHAPTER II

METHODS

Design of the Study

This is a descriptive study to identify the current nursing practice related to smoking health risk counseling of patients with a psychiatric illness in one facility. In order to describe smoking orientation and knowledge, and their counseling behaviors, the non-administrative registered nurse staff at a state psychiatric hospital were asked to complete a questionnaire developed by the investigators. In order to determine patients' perception of counseling and what would help them, a stratified random sample of patients at the same facility were interviewed by the investigators using a structured format. Medical records of interviewed patients were reviewed for documentation of smoking related information in order to assess emphasis given to smoking by nurses.

Setting

This study was conducted at a public psychiatric treatment facility. It is located in an urban community in the northwestern part of the state. In the past decade, the role of the facility has changed from that of a regional general psychiatric hospital to a specialty hospital serving the entire state. Innovative programs were developed to serve specific patient populations. These populations include forensic patients, correctional inmates, geriatric

patients, and children and adolescents.

This facility employs about 900 staff, including 125 registered nurses (RNs), and has a bed capacity of 725, which is divided among five different programs. Treatment is provided by multidisciplinary teams within each program. This study will involve staff and patients in the five programs: the adult admission program, the child and adolescent program, the geropsychiatric program, the forensic program and the correctional treatment program.

The adult admission program has 80 beds, with a staff of 15 RNs. This program treats mentally ill adults over 18 years of age and less than 65 years of age. This program has a large turnover of patients with over half of the admissions staying less than two weeks.

The child/adolescent treatment program (CATP) has a capacity of 50 beds, with 40 beds designated for patients between the ages of 14-17. This program is staffed by 17 RNs. Two secure sections provide treatment for seriously disturbed individuals considered to be at high risk to injure themselves or others. Another section is an open adolescent unit that serves individuals with severe mental illness.

The geropsychiatric (gero) program has 146 beds and 25 RNs. Mentally ill adults who have nursing care needs and cannot be managed in a nursing home or community care facility and persons 65 years of age or older are treated in

this program.

The forensic program has 340 beds and 42 RNs. Patients are adult mentally ill offenders who are directed by the court for psychiatric evaluation or treatment.

The correctional treatment program has 120 beds and a staff of 3 RNs. Patients are inmates from the state correctional facilities who participate in this residential treatment program prior to their parole release date. There are four focus areas within the program including drug and alcohol abuse, social skills, sexual deviance and aggression, and mental and emotional disturbances. Patients participate in those programs which are designated by their treatment teams.

The RNs in each program are responsible for all phases of the nursing process including assessing, planning, implementing, and evaluating nursing care. An RN performs a nursing assessment of each new patient within 8 hours of admission to the unit. This evaluation is recorded on the nursing assessment form which includes information related to smoking history and patient knowledge of smoking health risks. This ongoing nursing assessment of each patient is used to determine the nursing diagnosis/problem, to complete the initial Nursing Plan of Care, and to update the plan of care as needed.

The nursing care plan is integrated into the Interdisciplinary Team (IDT) Treatment and Care Plan (TCP).

At least one intervention/method in the integrated Nursing Plan of Care must focus on strategies for patient education. The educational strategies will be consistent with the overall plan of care for each patient. RNs are responsible for monitoring patient safety, patient care, and milieu activities via quality assurance activities. Patient teaching and staff training are educational functions of RNs. RNs are members of nursing and hospital committees and interdisciplinary treatment teams; therefore, they have input into policy decisions.

The administration of this facility is currently revising the smoking policy. The present smoking policy of the facility states that smoking is permitted only in designated smoking areas. No smoking is allowed in public areas. Each program designates the area for patients to smoke, and establishes the guidelines for smoking. These guidelines are posted on all the units in each program and all newly admitted patients are informed verbally and in writing of each program's policy regarding smoking. Patients are allowed to keep their own smoking materials unless there is a problem which precludes possession of smoking material. Staff who occupy private offices may designate whether it is a smoking or nonsmoking area. Staff may smoke in the break room if no one present objects. Smoking is not allowed in the nursing station or at any meeting.

This study focused on three sources of data: questionnaires completed by nurses, interviews with patients, and medical records. A description of each sample, and respective instrument for data collection, procedure and analysis plan will follow.

Sample One: Registered Nurses

This sample encompassed the population of all non-administrative registered nurses who work in this facility. All 90 nurses in this category were approached to participate in the study. The sample consisted of nurses who were working on all three shifts on the days we visited the facility and were willing to participate in this study. Non-administrative staff RNs were chosen because they do the initial patient interviews, develop nursing care plans, do patient teaching, are responsible for nursing care provided in the programs, and have input into policy decisions. They also serve as role models for other staff and patients. It is recognized, however, that other staff in the program can reinforce or sabotage the efforts of the RN.

Instrument

The questionnaire contained 23 open and closed-ended questions (Appendix A). Many answers could be simply checked with no other response necessary. This decreased the amount of time necessary to complete the questionnaire, provided consistency in the data collected, allowed more privacy for the respondent, and was easier to analyze.

Open-ended questions were included to allow nurses to give their own opinions, describe their attitudes and values, and share personal knowledge. Open-ended questions also allowed participants to provide additional information which the investigators may not have included and to explain answers if necessary.

Besides demographic information concerning the participants, information was gathered about the nurses' smoking history, and their opinions about smoking as a health risk and knowledge about the effects of smoking. Another set of questions dealt with the opinions about whether nurses have a responsibility to inform patients about smoking issues. If they currently inform patients about health risks of smoking, they were asked what information they provide patients. They were requested to identify any barriers they see to providing health risk and smoking cessation education, and whether or not they have had any education in health risk and smoking cessation techniques.

A pilot study was conducted to test the questionnaire. Changes were made in the format, wording of questions, and the order in which questions were presented. A second pilot study was conducted on the revised questionnaire. Minor revisions were incorporated based on recommendations from participants.

Procedure

The investigators attended a program managers meeting to describe the objectives of the study and the importance of the nursing staff participation and to negotiate the procedure for accessing the sample. The conclusion was that the investigators would meet with each individual program manager along with the charge nurses from each unit in that program. Questionnaires were handed out at this meeting for these nurses to complete. And, the charge nurses were asked to be responsible for distributing the questionnaires to all the nurses in their unit and to return the completed questionnaires to the nurse manager of that program. The questionnaires were color coded for each program.

Nurses were informed in writing (Appendix B) that participation in this study was voluntary and would not affect their employment at this facility. Assurance was given in writing to each nurse that answers would be confidential and that only aggregate data would be used. Written instructions (Appendix B) and the consent form (Appendix C) were included with the questionnaire. The participants could keep the written instruction sheet and were given a copy of the consent form if requested. Envelopes were provided for each person to insert their questionnaire into once it is completed. A volunteer from each group collected the envelopes and the consent forms separately and returned them to the investigators. The

investigators returned to all the units at the end of the patient interviews to encourage participation and pick up completed questionnaires.

Analysis

The purpose of the analysis was to portray the characteristics of nurses and to describe their practice concerning smoking health risk counseling of psychiatric patients in the facility. The information gathered was summarized and categorized. Frequency distributions describe the range of responses, similar responses, recurring themes, and the presence or absence of phenomena.

Sample Two: Patients

Our second sample was selected from the patient population using a stratified random sampling procedure. Patients were stratified according to program. One out of every 15 patients (8%) was to be chosen from each program for a total of 50 patients. The sample size was determined by time constraints and the heterogeneity of the patients in each program. Sample selection criteria included: (a) person has had a nursing assessment, (b) person is a current smoker or former smoker, (c) person is able to understand and participate in the interview process, (d) person has a psychiatric diagnosis of an adjustment, affective, anxiety, psychotic, or personality disorder, (e) person is over 14 years of age, and (f) person is not currently violent.

The investigators met with the head nurse on each unit

to review the patient census and list those patients who met the inclusion criteria. The patient selection flow sheet (Appendix D) was then completed and the patient sample was selected utilizing a random number table. In each instance of patient refusal or unavailability, the next name on the list was selected to maintain a sample size of 50. Only six patients in the gero unit met the inclusion criteria and two of these refused to participate. The samples from three of the programs were increased to replace the six who were not available from the Gero unit. One additional patient was obtained from the adult admissions and forensic program and four from the corrections treatment program.

Instrument

The patient interview guide contained ten questions (Appendix E). Most of them were yes or no choice answers; some required elaboration if the specific response was positive. There were open-ended questions which allowed the patients the freedom to provide specific information if they chose to do so.

The patients were asked questions about their smoking history, previous health risk education by nurses, and ways nurses could be helpful to them in any smoking cessation efforts. Much of the information was worded in a similar manner to the nursing questionnaire to increase the continuity of data and facilitate comparison of the data for the two groups.

A pilot study was conducted using the patient interview questions with psychiatric patients in another facility. Changes were made in the content and ordering of questions to improve flow of information.

Procedure

Patients were interviewed by the investigators using the structured format. The personal interview was chosen because patients may be unable to read or write responses to a questionnaire. Many psychiatric medications interfere with vision causing blurring or double-vision making it difficult to read. These medications may also decrease the ability to concentrate making it difficult to complete a task requiring sustained attention.

Equal numbers of selected patients were interviewed by the three investigators on an individual basis, in a private office on or near the unit. Each patient either read the consent form (Appendix F) or it was read to them. Questions were asked by the investigators to make sure the person understood this information. Patients were told that participation was voluntary and they could refuse to participate or stop the interview at any time, and this would not affect their continued stay or treatment in this facility. A copy of the consent form was given to the patient upon request. The study was explained to them and assurance was given that their responses would be confidential. They each signed a consent form which was

witnessed by the investigators.

The actual interview took between 10 and 20 minutes. Answers were written on a separate interview schedule form for each participant, quoting verbatim as much as possible the answers to the open-ended questions. The interview sheets were color coded for each program to coincide with the color coding the nurses questionnaires from the same program. To avoid undue stress for the participants, audio recordings were not used during the interview process.

Analysis

The purpose of the analysis was to describe the amount of smoking health risk education that patients have received. The information gathered was summarized and categorized. Frequency distributions describe the range of responses, similar responses, recurring themes, and the presence or absence of phenomena.

Sample Three: Medical Records

Medical records of the 50 interviewed patients composed the third sample. Hospital nursing care standards of this facility require a complete assessment of each patient within the first eight hours after admission. Nursing assessments are updated annually on long-term patients. Smoking history information is found on page 4, question 14, of the nursing assessment form used in these programs (Appendix G). The assessment format is a checklist including the following questions: never smoked; ex-smoker,

date stopped; length of time smoked; amount smoked per day; and knowledge regarding effects of smoking. The nursing diagnosis/problems are included on page 5 of the nursing assessment form.

Nurses initiate an initial treatment plan and problem list which includes nursing diagnoses and short-term goals. They also complete an ongoing problem/strength list which indicates whether or not the problems are being addressed, not considered the focus of current treatment, or resolved.

Instrument

The medical record review form (Appendix H) is a nine item checklist including information on: the patient's smoking history, nursing care plan, nursing education plan, and the treatment and care plan. The presence of smoking health risk information in the specified sections of the medical record was noted on the checklist.

Procedure

Fifty medical records of those patients interviewed by the investigators were reviewed. Each investigator reviewed the records in each program after the patient was interviewed. Information was collected utilizing the checklist system on the medical record review form.

Analysis

The purpose of the analysis was to describe the level of documentation by nurses in the medical records related to smoking health risk counseling of psychiatric patients. The

information gathered was summarized and categorized. Frequency distributions described the presence or absence of phenomena. The results of the medical record review assisted with validation of the information obtained in the self-reports of nurses and patients.

Summary of the Methods

Data were collected from the three samples during one week using a questionnaire for nurses, patient interviews, and a medical record review. In addition to using the data to describe the variables relevant to each sample, results were compared across samples. These analyses provided the basis for suggestions for nursing practice and future research.

CHAPTER III

RESULTS AND DISCUSSION

The data analysis will be presented in narrative and table format. The demographic description of each sample will be presented first as this will form the context with which to better understand the findings. These will be presented using the research questions as headings. Discussion is integrated into each section.

Sample One: Registered Nurses

Nurses in all five programs participated in this study (see Table 1). The overall response rate was 56% (n=50). The low return rate is partly explained by the very low rate of response from the nurses in the forensic program, which employed the greatest number of nurses. The investigators sensed less interest in participation during the initial meeting with the forensic program compared to the other program meetings which may have contributed to a lower participation level. In addition, lack of a designated collection point for completed questionnaires may have contributed to a lower return rate from the forensic program.

Respondents included 47 females and 3 males; they ranged in age from 20 to 60 plus years. Forty two RNs (84%) had either a Diploma (13 -26%) or an Associate Degree (29 - 58%), and 5 (10%) had a Bachelor of Science in Nursing Degree. Forty nine of the nurses worked full-time and all

Table 1

Nurse Participation Rate by Program

Program		Nurses		
Name	Beds	Eligible	Participants	% Participating
AA	70	14	12	86%
A	50	14	8	57%
G	146	23	17	74%
F	340	36	11	31%
CTP	120	3	2	67%
TOTALS	726	90	50	56

Note. AA = Adult Admissions: A = Adolescent: G = Geropsychiatric: F = Forensic: CTP = Correctional Treatment Program.

shifts were represented (10 -20% nights, 29 - 58% days, 14 - 28% evenings). The majority of nurses (31 - 62%) had more than ten years in active nursing practice and many (17 - 34%) have worked one to five years at this facility, followed closely by those who have worked here over 10 years (16 - 32%).

Eleven (22%) of the nurses polled currently smoke cigarettes, 15 (30%) have smoked in the past, and 24 (48%) have never smoked. Of those who quit (15), 10 (67%) stopped more than five years ago. The nurses comprising our sample smoked at a lower rate (22%) than the 50% reported for psychiatric nurses in the studies by Wagner (1985) and Feldman (1984).

Sample Two: Patients

The patient sample (n=50) represented all the hospital programs and comprised an 8% random sample of the hospital population. This sample was composed of 40 men and 10 women ranging in age from 17 to 72 years. Six patients refused or were unable to participate in the study. No specific information was gathered about them. The number of psychiatric diagnoses per patient ranged from one to six, with most having two diagnoses (17 - 34%). All the patients were taking three or less medications daily with 13 (26%) taking no medication at all, 16 (32%) taking only one medication, 10 (20%) taking two, and 11 (22%) taking three medications. Twenty patients (40%) had been in this

Table 2

Patient Sample by Program

Program	Patients		
	Census	Proposed sample size	Actual size
Adult Admissions	82	6	7
Adolescent	35	3	3
Geropsychiatric	144	10	4
Forensic	305	23	24
Correction Treatment	94	8	12
TOTALS	660	50	50

Note. Patient Census includes the patient population at the facility over 14 years of age.

facility for more than one year, 8 (16%) between six months and one year, 14 (28%) between one and six months, and 6 (12%) between one week and one month; for 2 the information was not noted.

Forty five (90%) of the patients in this sample were current smokers and five were former smokers. Three of the five former smokers had quit within the past year. The reasons cited for smoking cessation were current health problems, fear of adverse health effects, cost, and the non-smoking policy of the hospital unit they lived on. Thirty one (62%) of the sample had smoked for more than ten years.

The investigators felt the patients who were interviewed answered questions clearly and without difficulty or distress.

Do psychiatric nurses view smoking as a health risk? Data collected from the nurses indicated that 49 of the nurses (98%) reported that smoking is a risk to health. One person did not answer this question. When asked about specific illnesses to which smoking is an etiologic factor, none of the nurses correctly identified smoking with all fourteen of the diseases listed. Twenty two (44%) incorrectly reported smoking contributed to the development of tuberculosis, 5 (10%) to parkinson's disease and 5 (10%) to multiple sclerosis. Only 13 (26%) correctly identified abdominal aortic aneurysms, 15 (30%) Buergers disease and 20 (40%) identified cancer of the bladder as having smoking as

an etiologic factor. Nurses who have been in practice for more than 10 years correctly identified more of the health related illnesses than nurses who have been in practice for a shorter period of time.

Do nurses counsel psychiatric patients about these health risks? Forty-three (86%) reported it was the nurse's responsibility to inform/counsel patients about the health risks of smoking even if the patient did not have a smoking related illness (42 - 84%). Forty-one nurses (82%) indicated they provide information about smoking to some patients. However, 42% counsel fewer than 25% of their patients. In comparison to nurses who smoke, fewer nurses who are currently non-smokers report they never counsel patients about smoking. However, there is little difference in the percent who report counseling 50% or more of their patients (41% versus 36%) (See Table 3). The most common methods utilized were verbal factual information (36 - 88%), emotional support (35 - 85%), and role modeling non-smoking behavior at work (31 - 76%).

These findings are consistent with other studies. Dalton & Swenson (1986) found 35% of the nurses regularly counsel patients about health risks of smoking; the counseling is more often reported by the former smoker or never smoked group (25%) than the current smoker group (10%). Goldstein et al (1987) also found the majority of nurses do not counsel patients who smoke, and the nurses

Table 3

Percentage of Patients Counseled by Smoking and Non-Smoking Nurses

Percentage of patients counseled	Percentage reporting counseling: Smoking nurses n=11	Non-smoking nurses n=39
Unknown	9%	0%
0% of patients	27%	13%
25% of patients	27%	46%
50% of patients	18%	15%
75% of patients	9%	8%
100% of patients	9%	18%

counseling practices vary with the smoking status of the nurse.

What barriers exist that prevent nurses from providing smoking health risk counseling? Nurses were asked to indicate which of 11 listed barriers were relevant in their situations and to write in any additional ones. The mean was 3.6 barriers reported per nurse. The barrier most frequently identified by nurses to providing health risk/smoking cessation counseling was a perceived lack of patient interest/resistance (44 - 88%) which was also noted by Hughes, et al (1986). (See Table 4) Inadequate time in nurse's schedule ranked second (24 - 48%) followed by other individual patient priorities (22 - 44%). Twenty of the nurses (40%) believed that providing smoking health risk counseling is not effective in changing patient behavior which is consistent with the findings of Hughes et al (1986). Some of the programs have patients who are mentally retarded or who have significant organic impairment which would make teaching more difficult if not impossible.

It was anticipated that differences might be noted in the barriers identified by nurses in the individual programs. Two of the programs are completely non-smoking. There is significant diversity in the nurse/patient ratio on the units, and the role of the nurse varies with each program. Individual programs were reviewed to see if the barriers identified by nurses were consistent with the total

sample population. The data gathered from the nurses questionnaires did not support this theory. Table 4 tabulates the barriers which were identified by the nurses; comparing each program, the smoking and non-smoking programs, and the totals for all the nurses responses combined. The items are presented using percentages. The barriers are listed in rank order from most to least responses generated.

Patient lack of interest/resistance continued to be the number one barrier in all five programs. Inadequate time in nurse's schedule was the second most cited barrier in providing education in the gero program followed by other individual nursing priorities. Patients in the gero program require more bedside nursing care than the other four programs which may explain why this program ranked the barriers in the order they did. This program also has patients who are mentally retarded or who have significant organic impairment which would make teaching more difficult if not impossible.

The second most cited barrier noted in the adolescent program was tied between other individual patient priorities and other nursing priorities on the unit (4 - 50%). Short patient stay was then identified as this unit's third cited barrier.

Inadequate time in nurse's schedule and not effective in changing patient behavior was the forensic program's

Table 4
Percentage of Nurses Identifying Barriers Which Precent Smoking Cessation Counseling

	PROGRAMS					
	Smoking			Non-Smoking		
BARRIERS	AA n=12	F n=11	CTP n=2	A n=8	G n=17	Totals n=50
Patient lack of interest/resistance	100	100	50	63	88	88%
Inadequate time in nurse's schedule	42	55	0	25	65	48%
Other individual patient priorities	58	27	50	50	53	48%
Other nursing priorities on unit	25	36	50	50	59	44%
Not effective in changing patient behavior	75	36	0	25	29	40%
Short patient stay	58	0	0	38	6	22%
Facility policies support smoking	42	18	0	13	18	22%
Other	33	0	0	25	18	18%
Lack of support of administration	25	18	0	0	12	14%
Nurse's lack of knowledge	17	9	0	0	6	8%
Not a nursing function	8	0	0	13	6	6%
Nurse doesn't view smoking a problem	8	0	0	0	0	2%
No barriers	0	0	0	13	0	2%

Note. AA = Adult Admissions Program: F = Forensic Program: CTP = Correctional Treatment Program: A = Adolescent Program: G = Geropsychiatic.

second and third cited barrier. The high patient-nurse ratio and all patients serving criminal sentences might explain the reasons these barriers were cited. These patients are adult mentally ill offenders from the entire state who are directed by the court for psychiatric evaluation or treatment. The majority of patients have been found "Guilty except for Insanity" and are under the jurisdiction of the Psychiatric Security Review Board.

The adult admission unit listed the barrier "not effective in changing patient behavior" as the second ranked barrier. Half of the patients in this program stay less than two weeks which may "explain" their third listed barrier, "short patient stay."

The fifth program, correctional treatment, also has a high patient-nurse ratio which makes it difficult to do patient education; there are only three nurses to 120 patients. Three barriers were indicated one time each as a hindrance to providing smoking health risk education: patient lack of interest/resistance, other individual patient priorities, and other nursing priorities on the unit.

Institutional barriers were identified, but at a proportionately lower rate than those of patient interest and staff workload. Institutional policies that support smoking were cited by 26% (13 of the nurses) and lack of administrative support by 14% (7 nurses).

In response to the question, 11 nurses (22%) reported cigarettes were used as a reward for patients on two of the three smoking units (adult admission and forensic) and on one of the two non-smoking units (gero). Free tobacco is available to indigent patients on some units. This tobacco is purchased with patient community funds generated from patient canteen purchases.

What factors would facilitate nurses in providing health risk counseling? Nurses were asked about two factors that might contribute to their counseling of patients: their own education about risks of smoking and smoking cessation techniques and current smoking policies of the facility. The majority of nurses (35 - 70%) indicated they had received education about smoking. This education was obtained from nursing school (29 - 83%), journals (22 - 63%), and books (18 - 51%). Only 11 (31%) reported receiving their education about smoking from inservices or conferences.

Twenty five (50%) of the nurses reported the current smoking policy was inadequate and needed changes. Seventy six percent of the written responses on the smoking policy indicated this institution should be totally non-smoking and the policy should be enforced. Twenty (40%) of the nurses reported the current policy was fine and no changes were needed; fifteen of them worked on a non-smoking unit. Of the 11 nurses (22%) who currently smoked,

5 (45%) reported the smoking policy is fine, 4 (36%) reported a need for an update or a change in the policy, and 2 (18%) were unfamiliar with the current smoking policy.

One program specific difference was noted in the nurse responses related to hospital smoking policy. The two non-smoking programs (gero and adolescent/child) had a significantly larger number of responses indicating that the current policy was fine (gero - 47% and adolescent/child - 87%) than the other programs (adult admission - 33%, forensic - 9%, and correctional treatment program - 0%).

Questions which were not asked, but would have been helpful were; (a) "Would you be in favor of a total ban on smoking in this facility?" (b) "Would you be in favor of a ban on smoking for patients in this facility?" and (c) "Would you be in favor of a ban on smoking for staff as well in this facility?" These questions would help determine the support or resistance of the nursing staff to make a change to a nonsmoking hospital.

Do psychiatric patients report receiving health risk information from nurses? Twenty five of the patient sample (50%) noted that a nurse had talked to them about smoking during their current hospitalization. Sixteen of the 24 patients stated that nurses had asked about their smoking history and 15 had received information on the health risks of smoking; eleven patients reported receiving direct advice to stop smoking from a nurse. Patients on one of the

forensic units reported attending a smoking cessation program on the unit conducted by the psychologist. Fifteen patients stated nurses in other hospitals or health care settings had discussed their smoking habit with them. Thirty one (62%) patients stated they would use health risk and smoking cessation information provided by a nurse in an attempt to quit smoking.

What interventions do patients report would assist them in smoking cessation? Four responses were most frequently obtained when patients were queried about what interventions by nurses would be most helpful to them in quitting smoking. These were: help in dealing with withdrawal symptoms (23 - 46%), teaching new ways of coping with stress (23 - 46%), providing a smoke free environment (21 - 42%), and providing more opportunities for exercise and activities to decrease stress and combat boredom (17 - 34%). Two of the programs, correctional treatment and forensic, are locked units and the patients are limited in their choices of activities; 36 patients (72%) came from those units.

Forty of the patients (80%) stated they have, at some time, wanted to stop smoking and thirty five (70%) had already made at least one attempt to do so. The most frequently identified problems encountered with smoking cessation were craving for nicotine, stress and irritation, weight gain, and boredom. Relief from these symptoms were the primary motivations for people to return to smoking.

Are smoking health risk assessments documented in the patient's medical records? Medical records on all 50 of the patients who participated in this research project were reviewed. The smoking history section on the nursing assessment form was completed on 46 (92%). Patients awareness of the health effects of smoking was documented on 26 (54%). Two records (4%) had nicotine dependence documented on the treatment care plan, no records listed nicotine dependence on the nursing care plans or the patient educational plan. Nicotine dependence as a psychiatric diagnosis was not listed on any of the records although it is a diagnostic category in DSM-III and DSM-III-R.

Comparison of Relevant Findings Across Samples

All three samples reflect that nurses are providing smoking health risk information to less than 50% of the patients. (See Table 5) Nurses are not identifying nicotine dependence as a nursing problem and therefore are making no plans to provide nursing interventions to resolve the problem. Nurses indicate that they do serve as role models of healthy behavior and they provide support and factual information to patients. Patients verify that they received information from nurses but not support.

The most significant discrepancy between the samples was related to patient resistance to nursing interventions related to smoking behavior. Eighty eight percent of the nurses perceived this to be the major barrier to them

Table 5

Factors Related to Smoking as Described by Nurses, Patients, and Medical Records

Factors	Nurses (n=50)		Patients (n=50)		Records (n=50)	
Smoking history	current smokers	11	current smokers	45	smoking history documented	46
	former smokers	15	former smokers	5	nicotine dependence	2
	never smoked	24				
Reports nurses provide smoking information to patients	% of patients counseled:		nurse at this facility counseled patients about smoking	24	nicotine dependence:	
	0%	8			on education plan	0
	25%	21			on nursing care plan	0
	50%	8				
	75%	4				
	100%	8				
Type of interventions provided to patients	41 nurses report providing:		24 patients report exposure to:		patient awareness of health risks documented on nursing assessment	26
	written information	8	written information	4		
	audiovisuals	4				
	nicorette gum	7	nicorette gum	2		
	medications	5				
	emotional support	35				
	verbal facts	36	health risk information	15		
			advised to quit	11		
			smoking history	16		
	resources	12	resources	1		
	reinforce policy	24				
	role model non-smoking behavior	31				

(continued)

Table 5 (continued)

Factor	Nurses (n=50)	Patients (n=50)	Records (n=50)
Patient interest/ resistence	patient lack of interest 44 not effective in changing behavior 20	of 45 smokers: want to quit 40 tried to quit 35 of 24 patients who received information: information helped 14 information not helpful 11 of 50 patients: would use information of nurse 31 would not use information of nurse 16 uncertain 3	
Barriers to providing counseling and wanted help	barriers: short patient stay 11 nurses lack of information 4 inadequate time 24 other patient care priorities 24 other unit priorities 22 institution supports smoking 11 lack of administrative support 7	want help with: withdrawal symptoms 23 ways to cope with stress 23 emotional support 18 ways to quit 19 information on: benefits of not smoking 18 long-term health risks 18 risks of second hand smoke 12 provide smoke free environment 21	nicotine dependence listed as a psychiatric diagnosis 0

treating a patient's nicotine addiction. The patients did not support this belief with 88% reporting that they wanted to stop smoking and 62% would use assistance from a nurse to do this if that was available. Patients identify coping skills and assistance with withdrawal as the primary nursing interventions they desire to help with smoking cessation. Nurses identify these interventions as appropriate for nurses to perform but encounter sufficient barriers that prevent them from changing their practice.

CHAPTER IV

SUMMARY

Smoking is one of the major health and economic issues of our century. It is clearly a detrimental health behavior that costs millions of dollars annually. There is a growing interest among health care providers to assist smokers in the cessation of this destructive personal habit. Smoking cessation represents one of the most significant health education challenges to nurses (Alexander, 1988). Nurses are the largest body of health care providers and they have frequent and direct contact with patients. Nurses are therefore in a unique position of informing patients about the health risks of smoking.

Much of the smoking cessation treatment effort has been directed toward individuals who already have an acute or chronic smoking related illness. Despite a smoking rate of 50 - 84%, persons with psychiatric illness have not been the target of any major smoking cessation treatment strategy. These persons are often viewed as being too fragile to cope with smoking cessation or as being unable to benefit from treatment for nicotine dependence (Dingman, Resnick, Bosworth & Kamanda, 1988; Feldman, 1984; Hughes, Hatsukami, Mitchell, & Dahlgren, 1986). Resnick and Bosworth (1989) found these theories are unsubstantiated and that persons with major psychiatric illness were able to tolerate a complete nonsmoking policy while hospitalized on an acute

psychiatric unit without measurable ill effects.

The current trend in smoking policies in hospitals is of increasing restrictiveness, often consisting of a total ban of cigarette smoking on hospital premises. The exception to this trend is in psychiatric hospitals and on psychiatric wards in general hospitals where smoking is largely unrestricted (Resnick, Gordon, & Bosworth, 1989). This exception provides a strong environmental reinforcer to patients that smoking is a behavior acceptable to their health care providers.

Conceptual Framework

The environment of a facility includes interactions between nurses, patients and administration and policies of the institution. The variables which were examined in this project include: smoking as a health risk, nurses as educators and role models, patients as receivers of information, circumstances which enhance changing smoking behaviors, the hospital smoking policy, and administrative support.

Methods

This descriptive study was conducted at a public psychiatric facility. The purpose of the study was to identify current nursing practice regarding counseling of patients about the health risks of smoking and cessation techniques. Data were collected from three samples: nurses completed questionnaires, patients were interviewed, and

medical records were reviewed (N=50 for each sample). Fifty of the 90 eligible nurses participated in the study (56% response rate), 50 of the 672 patients were interviewed (7%) and the records of those patients were reviewed. There were six patients who refused or were unable to participate in this study but they were replaced to maintain the sample size.

Findings and Discussions

Forty-five (90%) of the patient sample smoked and 40 (80%) stated they wanted to quit smoking. This study reflects nurses are providing smoking health risk counseling to a minority of patients and that they perceive barriers to changing this practice including patient receptivity and their own workload. The perception that patients were uninterested and resistant to nurses efforts to inform them about smoking health risks was not reflected in the patient responses. More than half of the patients indicated that they would use information provided by nurses and 80% of them have wanted to stop smoking at some time. Seventy percent had already made at least one attempt in the past which reflects at least some level of interest in behavior change.

It is noteworthy that only 11 (22%) nurses identified inservices or conferences as a source of smoking health risk/cessation information. This may be an area for nursing management to focus some attention in planning future

educational offerings in the hospital.

The data related to the hospital smoking policy reflected an interest on the part of both nurses and patients to further restrict or eliminate smoking in the hospital. The patients interest in the change was related to their view that they would be able to stop smoking if they were not allowed to smoke in the hospital and had no access to cigarettes. They reported this would be easier for them than attempting to quit on their own. Some nurses noted that the current smoking policy actually encourages patients to smoke.

The medical records documentation showed that nicotine dependence is not being used as a psychiatric diagnosis at this facility. Forty four patients (88%) had a diagnosis of alcohol abuse or polysubstance abuse which indicates that treatment teams readily utilize substance abuse diagnoses but they do not identify nicotine dependence as a treatment issue.

Strengths and Limitations of the Study

The primary strength of this study was three separate data sources and three investigators performing the study. This provided for triangulation of data and a broader assessment of the research questions.

From our observations and information, this facility is similar to other large psychiatric hospitals, and as such, many of our findings would apply to other facilities. The

exception to the similarities include the forensic program and the correctional treatment program when the patients are sentenced criminals.

A higher return rate of nurse questionnaires likely would have been obtained if the investigators had been able to contact more nurses directly to obtain the completed questionnaires.

The 8% patient sample may have been sufficient to reflect the variety of patients in the facility, but the sampling fraction (15%) yielded a patient sample comprised of only 5% former smokers which limited the responses obtained about the most useful smoking cessation aids. This information may have been different from what current smokers think might help them to quit in the future. Nurses on some units wanted to be helpful and pick out patients for the investigators to interview. We were able, however, to continue with the random selection process on each unit.

The data about desirable smoking cessation aids may be biased due to false agreement by patients who were offered a list of options if they did not generate any spontaneously. A few patients answered yes to all items, while other patients were better able to discriminate and answer only a few.

Patients were receptive and cooperative during the interview process and they contributed information we had not considered during the open-ended questions such as the

need for outdoor and physical activities, especially in the correctional and forensic programs where time and activities are highly structured. The patients who participated were able to answer all questions asked without prompting and gave appropriate responses.

Interviews were conducted with patients prior to doing the medical record review to prevent interviewer bias due to information contained in the record such as diagnosis, medications, mental functioning, or criminal history.

Having all of the patient and medical record data and most of the nursing questionnaires prior to our leaving the facility was a positive feature as we did not have to rely on anyone to return the information to us.

Implications for Nursing Practice

The data gathered in this study reflect that nurses are providing smoking health risk counseling to a minority of patients and that they perceive barriers to changing this practice including patient receptivity and their own workload. The perception that patients were uninterested and resistant to nurses efforts to inform them about smoking health risks was not reflected in the patient responses. More than half of the patients indicated that they would use information provided by nurses and 80% of them have wanted to stop smoking at some time. Seventy percent had already made at least one attempt in the past which reflects at least some level of interest in behavior change.

The hospital utilized in our research currently has two programs containing 186 beds designated as non-smoking. There is interest from nursing administration and staff in expanding reduction of smoking in the hospital. We did not assess the climate for change among the other decision makers in the hospital, but we received comments from nurses that some physicians opposed changes in the smoking policy. Nursing can continue to actively advocate for more smoking restriction and work on educating other professionals about the need for change.

It is noteworthy that only 11 nurses identified inservices or conferences as a source of education related to health risk of smoking and smoking cessation techniques. These may be areas for nursing management to focus some attention in planning future educational offerings in the hospital.

The data related to the hospital smoking policy reflected an interest on the part of both nurses and patients to further restrict or eliminate smoking in the hospital. There appeared to be a climate receptive to change. The patients interest in the change was related to their view that they would be able to stop smoking if they were not allowed to smoke in the hospital and had no access to cigarettes. They reported this would be easier for them than attempting to quit on their own. Some nurses noted that the current smoking policy actually encourages

patients to smoke. Other institutions have moved to a smoking ban on their psychiatric wards with good success (Resnick & Bosworth, 1989 and Smith & Grant, 1989). In the hospitals studied, the staffs anticipated more problems and concerns than actually occurred when the smoking ban was implemented. By implementing a firm policy, a strong message is sent to staff, patients, and the public that smoking is unhealthy.

The medical records documentation showed that nicotine dependence is not being used as a psychiatric diagnosis at this facility. Forty four patients (88%) had a diagnosis of alcohol or polysubstance abuse which indicates treatment teams readily utilize substance abuse diagnoses but they do not identify nicotine dependence as a treatment issue.

A potentially beneficial project would be the development of a new smoking cessation program including health risk information, exercise and structured activity, and coping skills building.

Recommendations for Future Research

A possible next step for this or similar psychiatric settings would be a research project examining specific nursing interventions to assist patients in their efforts to stop smoking. They should be interventions which require a minimal amount of nurses time and may involve groups of patients. The study should include feedback from nurses and patients. Some possible interventions are the American Lung

Association In Control program or a self-help type manual which is augmented by a periodic nurse facilitated support group.

A study using the nursing questionnaires and patient interview format on a medical unit in a general hospital would provide the basis for comparison of nurses who work in a psychiatric hospital and nurses in a medical setting as well as patients' perspectives. Another relevant study, given that so much treatment is outpatient, and that continuity in teaching/counseling is important, would be to survey nurses in doctor's offices, clinics, and mental health centers.

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Abstract

Title: Smoking Health Risk Counseling of Psychiatric Patients by Nurses

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Approved: [redacted]
Caroline M. White, RN, Dr.P.H.

Cigarette smoking is a major cause of preventable morbidity and mortality. Extensive research has correlated smoking with a host of acute and chronic illnesses. Approximately 27% of the US population currently smokes, down over 10% since 1964.

One subgroup which smokes at a higher rate is persons with psychiatric illness. These individuals smoke at a rate two to three times higher than the general population at 60 to 80%. These patients have not received much attention from smoking cessation efforts.

Health education is viewed as an important role for nurses in all practice settings. Research indicated that health behavior can be altered by education, especially if education is provided by an individual regarded as a health expert. Studies have shown that nurses are providing minimal smoking health risk education to patients with medical illnesses, but there are no reports describing the extent to which this component of the care is provided to psychiatric patients.

This study examined the status of smoking health risk counseling of psychiatric patients in one state psychiatric facility with a registered nursing staff of 125 and a patient population of 672. This was accomplished by gathering data from nurses, patients, and medical records at this facility. Fifty-six percent of non-administrative staff nurses (n=50) completed a questionnaire, a stratified sample of 15% of patients (n=50) were interviewed by the investigators, and their medical records were reviewed. The data gathered in this study reflect that nurses are providing smoking health risk counseling to less than 50% of patients and that they perceive barriers to changing this practice. The most frequently identified barriers were lack of patient receptivity/interest (88%) and nurses time constraints; inadequate time in the nurses schedule, other individual patient priorities on the unit, and other nursing priorities on the unit (48%, 48%, and 44% respectively). Nurses from different programs identified different priorities in the barriers due to differences in the programs and the patients on each program.

The perception that patients were uninterested and resistant to nurses efforts to inform them about smoking health risks was not reflected in the patient responses. More than half of the patients indicated that they would use information provided by nurses and 80% of them have wanted to stop smoking at some time. Seventy percent had already

made at least one attempt in the past which reflects at least some level of interest in behavior change.

The data related to the hospital smoking policy reflected an interest on the part of both patients and nurses to further restrict or eliminate smoking in the hospital. Twenty (40%) of the patients indicated that a smoking ban would help them to stop smoking and help prevent them from returning to smoking once they had stopped. Fifteen (30%) of the nurses supported a total ban on smoking. Eleven nurses (22%) noted that the current smoking policy actually encourages patients to smoke.

The medical records documentation shows that nicotine dependence is not being used as a psychiatric diagnosis at this facility. Forty four patients (88%) had a diagnosis of alcohol abuse or polysubstance abuse which indicates that treatment teams readily utilize substance abuse diagnoses but they do not identify nicotine dependence as a treatment issue.

Appendix A
Smoking Health Risk Counseling of Psychiatric Patients by Nurses

Do you think that tobacco smoking is a risk to health?
Yes(1)_____ No(2)_____

Smoking contributes to the development of which of the following diseases? Check as many as apply.

(3)_____Arteriosclerotic vascular disease
(4)_____Chronic obstructive pulmonary disease
(5)_____Parkinson's disease
(6)_____Abdominal aortic aneurysms
(7)_____Peptic ulcer disease
(8)_____Buerger's disease
(9)_____Coronary artery disease
(10)_____Tuberculosis
(11)_____Multiple sclerosis
(12)_____Cancer of bladder
(13)_____Cancer of the lung
(14)_____Cancer of the larynx
(15)_____Cancer of lip, mouth
(16)_____Cancer of esophagus

Do you think it is the responsibility of a nurse to counsel/inform patients who smoke about health risks related to smoking?
Yes(17)_____ No(18)_____ Uncertain(19)_____

Do you think it is the responsibility of a nurse to counsel/inform patients who smoke about health risks related to smoking only if they have a smoking related illness? Yes(20)_____ No(21)_____

What proportion of the patients who smoke do you currently counsel/inform about the health risks related to smoking?
(22)_____None (0%)
(23)_____Very few (25%)
(24)_____Some (50%)
(25)_____Most (75%)
(26)_____All (100%)

If smoking cessation or health risk counseling were ordered by a patient's physician, would you provide it?
Yes(27)_____ No(28)_____

If you provide information about smoking health risks/ cessation techniques to patients who smoke, which methods do you use? Check all that apply.

(29)_____ Written material
(30)_____ Audiovisual material
(31)_____ Nicorette gum
(32)_____ Medications
(33)_____ Emotional support
(34)_____ Verbal factual information
(35)_____ Community or other resources available
(36)_____ Reinforce existing nonsmoking policies
(37)_____ Role model nonsmoking behavior at work
(38)_____ Other, please specify:

Have you ever received education related to the health risks of smoking and smoking cessation techniques?

Yes(39)_____ No(40)_____

If yes, health risks of smoking and smoking cessation education/information came from which of the following sources? Check all that apply.

(41)_____Nursing school
(42)_____Inservice
(43)_____Conference
(44)_____Journals
(45)_____Books
(46)_____Other (please specify):

The literature identifies the following barriers to providing health risk and smoking cessation counseling to patients. Do you encounter any of these barriers? Check all that apply. Use space on back of the paper if further explanation is needed.

(47)_____ None
(48)_____ Patient lack of interest/resistance
(49)_____ Feel that it is not effective in changing patient behavior
(50)_____ Short length of patient stay
(51)_____ Nurse doesn't view smoking as a health problem
(52)_____ Nurse's lack of knowledge about the subject
(53)_____ Inadequate time in nurse's schedule
(54)_____ Feel it is not a nursing function
(55)_____ Other priorities in individual patient's care
(56)_____ Other nursing priorities on the unit
(57)_____ Institutional policies that support smoking
(58)_____ Lack of administrative support
(59)_____ Other, please specify, use back of paper:

Are cigarettes used as a reward on your unit?
Yes(60)_____ No(61)_____

Are you satisfied with the current smoking policy in your facility?
(62)_____I'm not familiar with the current policy.
(63)_____Policy is fine, no need to change.
(64)_____Policy has been fine, but it is time to review and update it.
(65)_____Current policy is inadequate and needs changes.

If changes are needed: please explain what you would include in a new policy. Use the back of the paper if needed. (66)

Do you currently smoke cigarettes?
Yes(67)_____ No(68)_____

If yes, number of cigarettes per day (69)_____

Number of years you have been a daily smoker:
(70)_____Less than one year
(71)_____More than one year and less than five
(72)_____More than five years and less than ten
(73)_____More than ten years and less than twenty
(74)_____More than twenty years

If no, have you been a smoker in the past?
No(75)_____ Yes(76)_____

If yes, how long ago did you quit?
(77)_____Less than a year
(78)_____More than a year and less than five
(79)_____More than five and less than ten
(80)_____More than ten and less than twenty
(81)_____More than twenty

Number of years spent in psychiatric nursing:
(82)_____Less than one year
(83)_____More than one year and less than five
(84)_____More than five years and less than ten
(85)_____More than ten years

Number of years spent in active nursing practice:
(86)_____Less than one year
(87)_____More than one year and less than five
(88)_____More than five years and less than ten
(89)_____More than ten years

What shift do you currently work:
Nights(90)_____ Days(91)_____ PMs(92)_____

Do you currently work:
Full-time(93)_____ Part-time(94)_____

How long have you worked at this facility:
(95)_____Less than 6 months
(96)_____Over 6 months and less than 1 year
(97)_____Over 1 year and less than 5 years
(98)_____Over 5 years and less than 10 years
(99)_____Over 10 years

Male(100)_____ Female(101)_____

Marital Status: Single(102)_____ Married(103)_____
Divorced(104)_____ Separated(105)_____ Widowed(106)_____

If married, does your spouse smoke?
Yes(107)_____ No(108)_____

Age: (109)_____Less than 20 years old
(110)_____More than 20 and less than 30
(111)_____More than 30 and less than 40
(112)_____More than 40 and less than 50
(113)_____More than 50 and less than 60
(114)_____Over 60

Highest educational level achieved:

Diploma(115)_____ A.D.(116)_____ B.S.N.(117)_____

M.S.N.(118)_____ M.S.(119)_____
Other (please specify):(120)_____

Appendix B

Written Instructions for Nurses

Dear Colleague,

Attached is a four page questionnaire seeking information about smoking health risk education/counseling provided for patients with psychiatric disorders. This information is being collected by three graduate nursing students from Oregon Health Sciences University in Portland for a Masters Research Project.

The purpose of the project is to accurately describe the current status of nursing practice related to smoking health risk counseling of psychiatric patients. We will also be interviewing patients and conducting a review of medical records.

Research unequivocally correlates smoking with a host of chronic diseases which are largely preventable if the smoking habit is discontinued. Persons with psychiatric disorders have been found to have a significantly higher proportion of smokers than the average population. Studies have also found many individuals who smoke will stop smoking if advised to do so by a person viewed as a health care expert.

Your participation in this study is voluntary. Your investment of a small amount of time to assist with our research project would be most appreciated. Please fill out the questionnaire as completely as possible and return the completed form in the envelope provided.

A copy of the completed study results will be provided to your institution.

Thank you for your assistance in our project.

Connie Buchanan Carol Huffman Victoria Montgomery

Appendix C

January 24, 1990

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form For Nurses

TITLE OF RESEARCH PROJECT:

Smoking Health Risk Counseling of Psychiatric Patients by Nurses

PRINCIPAL INVESTIGATORS:

Buchanan, Connie; Huffman, Carol; Montgomery, Victoria 826-2111 ext. 3417. Investigators are Masters' students at Oregon Health Sciences University, School of Nursing, Department of Community Health Care Systems, (503) 279-7709.

PURPOSE:

The principal objective of the study is to determine current level of nursing practice related to smoking health risk counseling of psychiatric patients. This study will be a descriptive research project involving gathering data from registered nurses, patients and patient records at Oregon State Hospital.

PROCEDURE:

The nurses/participants will be contacted by the researchers in person once for approximately twenty minutes. Each participant will be asked to complete a 23 item questionnaire about smoking health risk counseling of psychiatric patients currently being provided at Oregon State Hospital, nurses knowledge level about smoking, and information about individual nurse's smoking history and professional status. The questionnaires will be returned to the researchers in a sealed envelope.

RISKS & DISCOMFORTS:

No physical discomfort will be experienced by participants during their participation in the study. Some nurses may experience mild distress when reminded of their own smoking and counseling behaviors.

BENEFITS:

There may not be any personal benefit from participating in this study, but by serving as a

subject, the nurse may help in the development of new information which may benefit nursing practice in the future.

CONFIDENTIALITY:

No identifying information about participants will be transmitted outside of OHSU. All information about participants will be kept strictly confidential. Neither names or other identity will be used for publication or publicity purposes.

COSTS:

There is no monetary cost to any nurse participating in this study.

LIABILITY:

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If any person suffers any injury from the research project, compensation would be available to them only if they establish that the injury occurred through the fault of the university, its officers or employees. If anyone has any further questions, please call Dr. Michael Baird at (503)279-8014.

OTHER:

Victoria Montgomery has offered to answer any questions any participant might have. Please call her at (503) 826-2111 ext. 3417.

Participation in the study is voluntary. Nurses may refuse to participate, or withdraw from this study at anytime without affecting their relationship with the Oregon Health Sciences University, or their employment at Oregon State Hospital.

The person signing the consent form will receive a copy of the form if requested.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

_____ _____

Nurse/Participant Date

Appendix D

Patient Selection Flow Sheet
(Place a check in each column that applies.)

Patient names

Criteria for patient selection:

Has had a nursing assessment

Smoker or former smoker

Able to understand &
participate in interview
process

Psychiatric diagnosis of:
- Adjustment disorder
- Affective disorder
- Anxiety disorder
- Psychotic disorder
- Personality disorder

Over the age of 14 years

Not violent

Criteria \ PATIENTS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Had Nursing Assessment																									
Smoker/former smoker																									
Able to understand																									
& participate																									
Psychiatric disorder																									
Adjustment																									
Affective																									
Anxiety																									
Psychotic																									
Personality																									
Over 14 years of age																									
Not violent																									

Appendix E

Smoking Health Risk Counseling of Psychiatric Patients by Nurses

Information to be collected from head nurse and medical record with the investigators:

Male(1)_____ Female(2)_____

Age _____

(3)_____Under 18 years
(4)_____Over 18 and under 25
(5)_____Over 25 and under 35
(6)_____Over 35 and under 45
(7)_____Over 45 and under 55
(8)_____Over 55 and under 65
(9)_____Over 65

Psychiatric diagnosis/diagnoses:

(10)

(11)

(12)

(13)

(14)

Current psychiatric medications:

(15)

(16)

(17)

(18)

(19)

How long has patient been in the hospital this admission?

Admission date:_____

(20)_____Less than one week
(21)_____More than one week and less than one month
(22)_____More than one month and less than six
(23)_____More than six months and less than one year
(24)_____More than one year

Patient interview schedule.

Have you ever been a patient here or in any other psychiatric hospital before? Yes(25)_____ No(26)_____

Do you currently smoke? Yes(27)_____ No(28)_____
(If yes, skip down)

If no, have you ever smoked? Yes(29)_____ No(30)_____

If yes, when did you quit?
(31)_____Within the last week
(32)_____Within the last month
(33)_____Within the last year
(34)_____More than a year ago

How long did you smoke? (35)_____

What influenced you to quit smoking?
(36)_____Health problems
(37)_____Pressure from family or friends
(38)_____Cost
(39)_____Fear of adverse health effects
(40)_____Cleanliness
(41)_____Desire for social acceptability
(42)_____Other: please specify:

What helped you to quit?
(43)_____Quit "cold turkey"
(44)_____Gradually cut down amount
(45)_____Written material
(46)_____Audiovisual materials
(47)_____Nicorette gum
(48)_____Medications:_____
(49)_____Emotional support:_____
(50)_____Verbal factual information
(51)_____Community resources or programs
(52)_____Other, please specify:

If yes, how long have you smoked?
(53)_____Less than one year
(54)_____More than one year and less than five years
(55)_____More than five year and less than 10 years
(56)_____More than 10 and less than 20 years
(57)_____More than 20 years

Have you ever wanted to quit smoking?
(58)_____Yes (59)_____No

Have you ever tried to quit smoking?
(60)_____Yes (61)_____No

If yes, what happened? (62)

Why did you return to smoking? (63)

Has any nurse talked to you about smoking since you have been here?
(64)_____Yes (65)_____No

Has any nurse any where else talked to you about smoking?
(66)_____Yes (67)_____No

If so, in what setting?
(68)_____Another hospital
(69)_____Doctor's office
(70)_____Mental health center
(71)_____Clinic
(72)_____Other, please specify:

If yes to either of above:

Here:	Other:	
(73)_____	(81)_____	Asked about your smoking history
(74)_____	(82)_____	Talked to you about health risks associated with smoking
(75)_____	(83)_____	Gave you written material
(76)_____	(84)_____	Showed you films or slides
(77)_____	(85)_____	Discussed the use of nicorette gum
(78)_____	(86)_____	Discussed community or other resources available to help you quit smoking
(79)_____	(87)_____	Advised you to quit smoking
(80)_____	(88)_____	Other, please specify:

Was this information helpful to you?
(89)_____Yes (90)_____No (91)_____Other reply:

Would you use advice given to you by a nurse about the health risks of smoking and ways to stop smoking?

(92)____Yes (93)_____No (94)_____Other reply:

In what ways could the nurses caring for you be most helpful to you in quitting smoking? Prompts:

(95)_____ I don't want to quit smoking.

(96)_____ Inquire about current smoking habits.

(97)_____ Provide a smoke-free environment.

(98)_____ Discuss ways to quit smoking.

(99)_____ Help in dealing with withdrawal symptoms.

(100)_____ Emotional support:_____

(101)_____ Explain immediate benefits of smoking cessation.

(102)_____ Explain long term health risks of smoking.

(103)_____ Discuss the risks of second hand smoke.

(104)_____ Teach new ways of coping with stress.

(105)_____ Refer to a treatment program in the community.

(106)_____ Other, please specify:

Appendix F

January 24, 1990

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form For Patients

TITLE OF RESEARCH PROJECT:

Smoking Health Risk Counseling of Psychiatric Patients by Nurses

PRINCIPAL INVESTIGATORS:

Buchanan, Connie; Huffman, Carol; Montgomery, Victoria 826-2111 ext. 3417. The principal investigators are Master's students at Oregon Health Sciences University, School of Nursing, Department of Community Health Care Systems, 279-7709.

PURPOSE:

The principal objective of the study is to determine current level of nursing practice related to smoking health risk counseling of psychiatric patients. This study will be a descriptive research project involving gathering data from registered nurses, patients and patients records at Oregon State Hospital.

PROCEDURE:

The patients/participants in the study will be contacted by the researchers in person once for approximately twenty minutes. Each participant will be interviewed by a nurse researcher and asked to answer questions related to their own smoking history and counseling they have received from nurses about smoking. The medical records for these patients will also be reviewed.

RISKS & DISCOMFORTS:

No physical discomfort will be experienced by patients during their participation in the study. Some patients may experience mild distress when reminded of their smoking behaviors.

BENEFITS:

There will be no immediate benefit to participants in this study, but the information gained from this study may benefit other patients in the future.

CONFIDENTIALITY:

No identifying information about patients will be transmitted outside of OHSU. All information about subjects will be kept strictly confidential. Neither patient's name or identity will be used for publication or publicity purposes.

COSTS:

There is no monetary cost to any patient participating in this study.

LIABILITY:

The Oregon Health Sciences University, as an agency of the State, is covered by the State Liability Fund. If any person suffers any injury from the research project, compensation would be available to them only if they establish that the injury occurred through the fault of the university, its officers or employees. If any participant has any further questions, please call Dr. Michael Baird at (503) 279-8014.

OTHER:

Victoria Montgomery has offered to answer any questions any participant might have. Please call her at 826-2111 ext. 3417. An additional briefing is available upon request.

Participation in the study is voluntary. Patients may refuse to participate, or withdraw from this study at anytime without affecting their relationship with or treatment at the Oregon State Hospital.

The person signing the consent form will receive a copy of the form if requested.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

_____ _____

Patient/Participant Date

_____

Witness

State of Oregon
Oregon State Hospital

Appendix G
NURSING ASSESSMENT

Dept. of Human Resources
Mental Health Division

DATE: TIME: TYPE OF COMMITMENT: COUNTY:

PRECIPITANT TO HOSPITALIZATION (sequence of events, functional level prior to hospitalization, situational crises, other contributing factors):

MEDICAL/NURSING PROBLEMS AND TREATMENTS IDENTIFIED FROM TRANSFERRING FACILITY OR FROM SIGNIFICANT OTHER:

HOSPITALIZATION PREVENTION INTERVENTIONS: Perceptions (Patient and RN) of what interventions, if utilized, might have prevented this hospitalization (e.g., education, medications, psychotherapy, vocational skills/ job, interpersonal support, problem-solving, networking).

ATTITUDE ABOUT HOSPITALIZATION:

ALLERGIES (List substances and describe reactions):

___ NKA

MEDICATIONS: Brought to Hospital ___ Yes ___ No If yes, ___ Sent Home / ___ Pharmacy

DRUG/DOSE	Times Taken	Patient's Knowledge of Purpose, Risks, Benefits	Patient Report of SE/AE

PHYSICAL ASSESSMENT: DOB_____ COLOR OF EYES _____ HAIR COLOR _____

Wt_____ Ht_____ BP____/____ T_____ P_____ R_____

ADL:	Independent	Part. Assist	Total Assistance
Bathes			
Dresses			
Toilets			
Eats			
Transfers			
Walks			
Wheels			

Comments: _____

NAME: _____

OSH#: _____

WARD: _____

(OSH-SIK-00000)

State of Oregon
Oregon State Hospital

Dept. of Human Resources
Mental Health Division

****

8. HEARING (Check only those which apply):

With Hearing Aid:	Without Hearing Aid:
___ Normal Voice	___ Normal Voice
___ Loud Voice	___ Loud Voice
___ Only Loud Noises	___ Only Loud Noises
___ Does Not Hear	___ Does Not Hear

Last Hearing Evaluation Date: _____
Comments: _____

Hearing Aid in Patient's Possession:
___ Yes ___ No _____ Disposition

9. SLEEP PATTERN:
Regular Sleep Hours: _____ to _____
Total Hours Slept in 24 Hours _____
Number of Hours During Day _____
Sleeping Difficulties? ____ Yes ____ No
If Yes:
____ Difficulty Staying Awake in Daytime
____ Difficulty Falling Asleep
____ Difficulty Staying Asleep
____ Early AM Awakening/Time _____
____ Frequent Awakening at Night
____ Length of Time of Difficulty _____
____ No Sleep Since _____
____ Needs Sedation
What Type _____
How Long Used _____
Comments: _____

10. ALCOHOL INTAKE: ___ None
___ Intermittent/Frequency, Type, Amount: _____
___ Daily/Type, Amount: _____
___ Time/Date of Last Drink: _____
___ No History of Withdrawal Symptoms
___ History of Withdrawal Symptoms:
Dates: _____
___ "Shakes"
___ Delirium Tremens
___ Seizures
___ Other _____
Comments: _____

11. APPETITE: Description of Current Eating Pattern
Recent Weight Gain/Loss ___ Yes ___ No
How Many Pounds _____
Current/Prescribed Diet _____
Food Preferences/Dislikes _____
Food Allergies _____
Religious Needs of Diet _____

12. DENTITION: ___ Orthodontia
___ All/Most Teeth
___ Some Opposing Teeth
___ Few/No Opposing Teeth
Dentures: ___ Yes ___ No
___ Complete Upper
___ Complete Lower
___ Partial _____
Dentures Brought to Hospital ___ Yes ___ No
In Patient's Possession ___ Yes ___ No
_____ Disposition

13. DRUG USE ("street, recreational, misuse of prescribed medications)
___ None
___ Intermittant (frequency, type, amount)
___ Date, Time, Amount of Last Use _____
___ History of Withdrawal _____
___ History of Overdose/Adverse Reaction _____
Comments: _____

NAME: _____
OSH#: _____
WARD: _____

State of Oregon
Oregon State Hospital

Dept. of Human Resources
Mental Health Division

****

MENTAL STATUS:

Orientation: _____

_____

Appearance: _____

_____

Affect: _____

_____

Behavior: _____

_____

_____

Thought Content/Process: _____

_____

Memory: _____

_____

Insight: _____

_____

Judgement: _____

_____

****

VOCATIONAL/EDUCATIONAL SKILLS:

Current Vocational Skills: _____

Date(s) of Last Employment: _____

Educational Level: _____

Source of Income: _____

****

STRENGTHS/ASSETS/INTERESTS (e.g., communication skills, interpersonal style, behaviors, hobbies, family/system support, problem solving):

****

NURSING DIAGNOSIS/NURSING PROBLEM STATEMENTS:

****

RECOMMENDATIONS (Optional):

NAME: _____

OSH#: _____

Signature: _____, R.N.

WARD: _____

Date: _____

108

OREGON STATE HOSPITAL

Initial Treatment Plan

(Problem List — Treatment Plan)

_____ Patient Name

_____ Patient Number

REASON FOR ADMISSION/PRELIMINARY PLAN OF CARE (Include major psychiatric and medical problems or target symptoms and recommendations for treatment):

_____, M.D. Date: _____

____ Admission is necessary to provide treatment expected to improve the patient's condition.

Nursing Care Plan

Date	Immediate Problem Nursing Diagnoses	Immediate Goals (short-term only)	Methods and Frequency	Person Responsible

IDT TREATMENT AND CARE PLAN (TCP)
(Diagnoses, Discharge and Signature Section)

Page ___ of ___

Patient Name _____ OSH# | | | | | | |

CURRENT DIAGNOSES (MD): Date: _____ Enter DSM III-R Code

DSM III-R Axis I _____ _____

_____ _____

Axis II _____ _____

_____ _____

Axis III _____

_____

Axis IV Psychosocial Stressor(s): _____
Severity: _____

Axis V Current GAF: _____
Highest GAF Past Year: _____

☐ Note: See reverse side of this form for current diagnoses if box at left is checked.

CRITERIA FOR DISCHARGE:

PLAN FOR DISCHARGE:

PATIENT PARTICIPATION IN TCP:

Patient Comments: _____

_____

I understand this plan. Yes___ No___ I agree with this plan. Yes___ No___

PATIENT SIGNATURE: _____ DATE: _____

If patient is unwilling or unable to participate in TCP or refuses to sign, provide comment and sign below: _____

Staff Signature, Title _____ Date: _____

IDT SIGNATURES: MD _____ Date_____ P _____ Date_____

N _____ Date_____ SW _____ Date_____

TAD _____ Date_____ CM _____ Date_____

OTHERS _____ Date_____

Appendix H

Medical Record Review Form
(Place a check in each column that applies.)

Page 4, Item 14 of Nursing Assessment

Never Smoked

Ex-Smoker, Date Stopped

Length of Time Smoked

Amount Smoked/Day

Knowledge Regarding Effects of Smoking

Page 5 of Nursing Assessment: Nursing Diagnosis/Problem

Smoking noted on Nursing Care Plan

Smoking noted on IDT Treatment and Care Plan

Criteria / PATIENTS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Nsg. Assess. Page 4, 14																									
Never smoked																									
Ex-smoker, date																									
Time smoked																									
Amount smoked/day																									
Knowledge of effects																									
Page 5, Nsg. Assess.																									
Smoking of NCP																									
Smoking on Educ. Plan																									
Smoking on TCP																									

Appendix I
Smoking Health Risk Counseling of Psychiatric Patients by Nurses
N= 50

Do you think that tobacco smoking is a risk to health?
Yes(1)__49_ No(2)_0___ 1=missing

Smoking contributes to the development of which of the following diseases? Check as many as apply.

(3)_47__Arteriosclerotic vascular disease
(4)_49__Chronic obstructive pulmonary disease
(5)__5__Parkinson's disease
(6)_13__Abdominal aortic aneurysms
(7)_37__Peptic ulcer disease
(8)_13__Buerger's disease
(9)_47__Coronary artery disease
(10)_22__Tuberculosis
(11)__5__Multiple sclerosis
(12)_20__Cancer of bladder
(13)_50__Cancer of the lung
(14)_50__Cancer of the larynx
(15)_48__Cancer of lip, mouth
(16)_48__Cancer of esophagus

Do you think it is the responsibility of a nurse to counsel/inform patients who smoke about health risks related to smoking?
Yes(17)__43_ No(18)__4__ Uncertain(19)__4__

Do you think it is the responsibility of a nurse to counsel/inform patients who smoke about health risks related to smoking only if they have a smoking related illness? Yes(20)__8_ No(21)__42_

What proportion of the patients who smoke do you currently counsel/inform about the health risks related to smoking?
(22)___8_None (0%)
(23)__21_Very few (25%)
(24)___8_Some (50%)
(25)___4_Most (75%)
(26)___8_All (100%)

If smoking cessation or health risk counseling were ordered by a patient's physician, would you provide it?
Yes(27)_48__ No(28)__4__

If you provide information about smoking health risks/ cessation techniques to patients who smoke, which methods do you use? Check all that apply.

n=41
(29)___8_ Written material
(30)___4_ Audiovisual material
(31)___7_ Nicorette gum
(32)___5_ Medications
(33)__35_ Emotional support
(34)__36_ Verbal factual information
(35)__12_ Community or other resources available
(36)__24_ Reinforce existing nonsmoking policies
(37)__31_ Role model nonsmoking behavior at work
(38)___3_ Other, please specify:

Have you ever received education related to the health risks of smoking and smoking cessation techniques?

Yes(39)__35_ No(40)__17_ 2=both answers

If yes, health risks of smoking and smoking cessation education/information came from which of the following sources? Check all that apply.

n=35
(41)__29_Nursing school
(42)___7_Inservice
(43)___4_Conference
(44)__22_Journals
(45)__18_Books
(46)__10_Other (please specify):

The literature identifies the following barriers to providing health risk and smoking cessation counseling to patients. Do you encounter any of these barriers? Check all that apply. Use space on back of the paper if further explanation is needed.

(47)___1_ None
(48)__44_ Patient lack of interest/resistance
(49)__20_ Feel that it is not effective in changing patient behavior
(50)__11_ Short length of patient stay
(51)___1_ Nurse doesn't view smoking as a health problem
(52)___4_ Nurse's lack of knowledge about the subject
(53)__24_ Inadequate time in nurse's schedule
(54)___3_ Feel it is not a nursing function
(55)__24_ Other priorities in individual patient's care
(56)__22_ Other nursing priorities on the unit
(57)__11_ Institutional policies that support smoking
(58)__7__ Lack of administrative support
(59)__9__ Other, please specify, use back of paper:

Are cigarettes used as a reward on your unit?
Yes(60)__11_ No(61)__38_

Are you satisfied with the current smoking policy in your facility?
(62)___3_I'm not familiar with the current policy.
(63)__20_Policy is fine, no need to change.
(64)___9_Policy has been fine, but it is time to review and update it.
(65)__16_Current policy is inadequate and needs changes.

If changes are needed: please explain what you would include in a new policy. Use the back of the paper if needed. (66)

16

Do you currently smoke cigarettes?
Yes(67)__11_ No(68)__39___ 15 quit
24 never smoked

If yes, number of cigarettes per day (69)__10___

Number of years you have been a daily smoker:
n=11 (70)__0__Less than one year
(71)__1__More than one year and less than five
(72)__0__More than five years and less than ten
(73)__4__More than ten years and less than twenty
(74)__5__More than twenty years

If no, have you been a smoker in the past?
No(75)__24__ Yes(76)__15__

If yes, how long ago did you quit?
n=15 (77)__2__Less than a year
(78)__3__More than a year and less than five
(79)__4__More than five and less than ten
(80)__2__More than ten and less than twenty
(81)__4__More than twenty

Number of years spent in psychiatric nursing:
(82)___5_Less than one year
(83)__19_More than one year and less than five
(84)__10_More than five years and less than ten
(85)__16_More than ten years

Number of years spent in active nursing practice:
(86)__0__Less than one year
(87)_10__More than one year and less than five
(88)__8__More than five years and less than ten
(89)_31__More than ten years
1=missing

What shift do you currently work:
Nights(90)__10_ Days(91)_29__ PMs(92)_14__
2=more than one shift
Do you currently work:
Full-time(93)__49__ Part-time(94)__1__

How long have you worked at this facility:
(95)__9__Less than 6 months
(96)__6__Over 6 months and less than 1 year
(97)_16__Over 1 year and less than 5 years
(98)__8__Over 5 years and less than 10 years
(99)_11__Over 10 years

Male(100)__3__ Female(101)_47__

Marital Status: Single(102)__3__ Married(103)_24__
Divorced(104)__17_ Separated(105)__2_ Widowed(106)__3__

If married, does your spouse smoke?
Yes(107)__9__ No(108)_14__

Age: (109)__1__Less than 20 years old
(110)__5__More than 20 and less than 30
(111)_12__More than 30 and less than 40
(112)_16__More than 40 and less than 50
(113)_11__More than 50 and less than 60
(114)__5__Over 60
1=missing

Highest educational level achieved:

Diploma(115)__13_ A.D.(116)__29_ B.S.N.(117)__5__

M.S.N.(118)__0__ M.S.(119)__0___

Other (please specify):(120)__7_____

Appendix J

Smoking Health Risk Counseling of Psychiatric Patients by Nurses

N=50

Information to be collected from head nurse and medical record with the investigators:

Male(1)__40_ Female(2)__10_

Age _____

(3)__3__Under 18 years
(4)__9__Over 18 years and under 25
(5)_19__Over 25 and under 35
(6)_11__Over 35 and under 45
(7)__4__Over 45 and under 55
(8)__1__Over 55 and under 65
(9)__3__Over 65

Psychiatric diagnosis/diagnoses:

(10) One diagnosis: 13

(11) Two diagnoses: 17

(12) Three diagnoses: 10

(13) Four diagnoses: 11

(14) Five or more diagnoses: 7

Current psychiatric medications:

(15) No psychiatric meds: 13

(16) One psychiatric med: 16

(17) Two psychiatric meds: 10

(18) Three psychiatric meds: 11

(19) Four or more psychiatric meds: 0

How long has patient been in the hospital this admission?
Admission date:_____

(20)__0__Less than one week
(21)__6__More than one week and less than one month
(22)_14__More than one month and less than six
(23)__8_More than six months and less than one year
(24)_20__More than one year
2=missing

Patient interview schedule.

Have you ever been a patient here or in any other psychiatric hospital before? Yes(25)__39_ No(26)_11__

Do you currently smoke? Yes(27)__45_ No(28)__5__
(If yes, skip down)

If no, have you ever smoked? Yes(29)__5__ No(30)__0__

If yes, when did you quit?
n=5
(31)__0__Within the last week
(32)__1__Within the last month
(33)__2__Within the last year
(34)__2__More than a year ago

How long did you smoke? (35)___5_____

What influenced you to quit smoking?
(36)__2__Health problems
(37)__0__Pressure from family or friends
(38)__2__Cost
(39)__2__Fear of adverse health effects
(40)__0__Cleanliness
(41)__0__Desire for social acceptability
(42)__3__Other: please specify:

What helped you to quit?
(43)__3__Quit "cold turkey"
(44)__2__Gradually cut down amount
(45)__0__Written material
(46)__0__Audiovisual materials
(47)__0__Nicorette gum
(48)__0__Medications:_____
(49)__0__Emotional support:_____
(50)__1__Verbal factual information
(51)__0__Community resources or programs
(52)__0__Other, please specify:

If yes, how long have you smoked?_____
n=45
(53)__0__Less than one year
(54)__6__More than one year and less than five years
(55)__8__More than five year and less than 10 years
(56)_14__More than 10 and less than 20 years
(57)_17__More than 20 years

Have you ever wanted to quit smoking?
n=45 (58)__40__Yes (59)___6__No

Have you ever tried to quit smoking?
(60)__35_Yes (61)__11_No

If yes, what happened? (62)
33

Why did you return to smoking? (63)
32

Has any nurse talked to you about smoking since you have been here?
n=50 (64)__24_Yes (65)__25_No 1=missing

Has any nurse any where else talked to you about smoking?
(66)__15_Yes (67)__34_No

If so, in what setting?
n=15 (68)__4__Another hospital
(69)__3__Doctor's office
(70)__0__Mental health center
(71)__3__Clinic
(72)__5__Other, please specify:

If yes to either of above:

	Here:	Other:	
n=24	(73)__16_	(81)__9__	Asked about your smoking history
	(74)__15_	(82)__9__	Talked to you about health risks associated with smoking
	(75)___4_	(83)__2__	Gave you written material
	(76)___0_	(84)__2__	Showed you films or slides
	(77)___2_	(85)__3__	Discussed the use of nicorette gum
	(78)___1_	(86)__0__	Discussed community or other resources available to help you quit smoking
	(79)__11_	(87)__8__	Advised you to quit smoking
	(80)___2_	(88)__1__	Other, please specify:

Was this information helpful to you?
n=26 (89)__14_Yes (90)__11_No (91)__1__Other reply:

Would you use advise given to you by a nurse about the health risks of smoking and ways to stop smoking?
(92)_26_Yes (93)__12_No (94)__14_Other reply:

In what ways could the nurses caring for you be most helpful to you in quitting smoking? Prompts:

(95)__14_ I don't want to quit smoking.

(96)__13_ Inquire about current smoking habits.

(97)__21_ Provide a smoke-free environment.

(98)__19_ Discuss ways to quit smoking.

(99)__23_ Help in dealing with withdrawal symptoms.

(100)__18_ Emotional support:_____

(101)__18_ Explain immediate benefits of smoking cessation.

(102)__18_ Explain long term health risks of smoking.

(103)__12_ Discuss the risks of second hand smoke.

(104)__23_ Teach new ways of coping with stress.

(105)__15_ Refer to a treatment program in the community.

(106)__28_ Other, please specify: