Why alcohol and drug treatment workers smoke cigarettes.

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the degree Master of Nursing (Research)

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Signed:

Ray Stephens

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ABSTRACT

A grounded theory approach was used to explore the reasons why staff who work in alcohol and drug treatment services smoke cigarettes.

Eleven in-depth interviews were conducted with staff in Victoria across a variety of service types and roles. Data gathered from the interviews were analysed and grouped into categories. From analysis of the interviews it appeared that cigarette smoking is given legitimacy in the alcohol and drug treatment field that reinforces its place in these services. Legitimacy was evident in three main ways – Permission, a Therapeutic Tool and Rewards.

Permission to smoke was communicated by means that included the opportunity to smoke at work, the provision of smoking areas, the absence of no-smoking rules and policies, and an acceptance of smoking.

Smoking was seen as a therapeutic tool that enhanced the treatment provided to clients. Some smokers saw cigarettes as a tool to convey empathy, develop rapport, promote a feeling of engagement and manage difficult clients.

Smokers also received some rewards to reinforce their behaviour. There was a benefit of feeling an increased acceptance by other staff, increased socialising, work breaks, a reduction in perceived stress levels and the opportunity to readily satisfy cravings for nicotine that reinforced the smoking behaviour.

Punishments, or negative rewards, for smoking were also described. These included being recipients of harassment or pressure from non-smoking staff and concerns about the impact of smoking on their health.

These three categories of permission, therapeutic tool and rewards contribute to the legitimacy of smoking in this field and support the continued presence of this behaviour.
CHAPTER 1.

Introduction to the Study

1.1 Introduction
This introductory chapter provides the background to how this study came into being. It describes this researcher’s history of smoking since commencing nursing and his observations of smoking practices in the different fields in which he has worked. Discussions of why it is necessary to research smoking, particularly in the field of alcohol and drug treatment, are presented.
1.2 Background to the study

The idea for this study emerged from the growing discontent that this researcher felt about the phenomenon of cigarette smoking among nurses and, in particular, those in alcohol and drug treatment services.

This researcher has been nursing for sixteen years during which time he has become aware that smoking levels among nurses seem to be very high, considering the nature of their work as health professionals. Having worked across a variety of nursing roles during that time awareness had also been raised that smoking levels among the nurses appeared to vary either according to the type of work that they do, or the agency at which they worked.

Exposure to this phenomenon commenced during nurse training. This took place in a large teaching hospital in Melbourne where most student nurses lived at the nurses’ residence. This was a very social time and much alcohol and many cigarettes were consumed by students during these years. After graduating, working on the wards also did not seem to effect the numbers of nurses who would, at each break, huddle together in any weather to gossip and enjoy their cigarettes. This researcher made many attempts to try and stop smoking during these years but was unsuccessful. Smoking was a big part of the social interaction of nurses at this time.

After four years of working at the teaching hospital a career move prompted leaving the wards and commencing a position in the field of alcohol and drug treatment. The experience of working in a residential withdrawal unit (‘detox’) was at times very challenging and quite stressful at times. Most of the staff in this unit spent much of their day outside either smoking with each other in a ‘staff only’ area or smoking with the clients in casual counselling-type sessions. Cigarettes appeared to be entrenched in the field of alcohol and drug work.
Residential withdrawal units are deliberately designed to be low-stimulus environments in that there were few organised activities, and clients and staff seemed to spend much of their day either drinking coffee or smoking cigarettes. Being a smoker in this field was advantageous as cigarettes were a useful tool to both engage with clients when it was needed as well as to distance oneself from clients when this need arose. In other words cigarettes provided an advantage for staff working in the field of drug and alcohol that would not otherwise have been obtained.

It was only after again changing career paths and moving into district nursing that this researcher noticed for the first time an area of nursing where almost none of the nurses employed were smokers. Smoking was not permitted in the work vehicles or in patient’s houses making it difficult to find opportunities to have a cigarette during the day. During this period of work the smoking rate of this researcher decreased to the point of being able to easily giving up smoking altogether.

However, after five years of working with the Royal District Nursing Service the search for new challenges prompted a move back into the alcohol and drug field. It was immediately apparent that in this field there remained a high number of workers who were smoking cigarettes. Staff there made comments that “all alcohol and drug workers smoke”. Being an ex-smoker, accustomed to low rates of smoking at work, it was now very worrying to move to a field that was almost surrounded by smokers. After only two weeks working in this field this researcher found it impossible to resist the temptation and relapsed into a pattern of smoking which, was for him disappointing.

Discussions with staff about their smoking revealed that smoking was a large part of their day in this field, whether it was during breaks, counselling sessions with clients, or even during home visits. No-one was able to inform this researcher why smoking appeared to play such a pivotal function in the professional lives of these clinicians but many thought that ‘someone
needs to research this’. A decision was made to explore why smoking was so entrenched in the alcohol and drug field. The aim was to discover why so many workers were smoking by posing the research question: What were the reasons why nurses who work in alcohol and drug treatment smoke cigarettes?

1.3 Purpose of the study

1.3.1 Why is it pertinent to research smoking?

Smoking is the single largest preventable cause of death and disease in Australia. Cigarettes kill 52 Australians daily, 360 each week, and around 19,000 every year (Australian Government Department of Health and Ageing, 2005). Tobacco smoking is the single risk factor responsible for the greatest disease burden in Australia, causing around 12% of the total burden in Australian males and 7% of the disease burden of females (Mathers, Theo Vos, Stevenson, & Begg, 2001). Smoking causes 30% of all cancers, 25% of all heart disease and costs $12.7 billion a year in health care, lost productivity and other costs (Collins & Lapsley, 1996). In people less than 65 years of age, cigarette smoking causes 40% of deaths in men and 20% of deaths in women (English et al., 1995).

Smoking in workplaces also incurs specific health, economic and legal costs. Employees who choose to smoke are likely to suffer a greater variety of illnesses and more ill health than non-smokers (Action on Smoking and Health, 1999). As well as major illnesses, such as cancer, bronchitis, emphysema, stroke and heart disease, smokers experience increased susceptibility to coughs, colds and flu (Action on Smoking and Health, 2000). The ‘cost’ to the employer is not just sick pay, but also lost productivity and output which translates to additional burden on their non-smoking colleagues (Action on Smoking and Health, 1999).

Smoking in the workplace also creates legal risks for the agency (Lawn, 2005a). The harmful effects of passive smoking are now established beyond reasonable doubt and have been
widely publicised (National Drug Strategy, 2001; Victorian Government Department of Human Services, 2005). In response to this identified risk, from March 1st 2006 new tobacco laws were imposed to reduce the risk of passive cigarette smoke effecting employees of workplaces. Under the Tobacco Act 1987 it is now illegal to allow smoking in any enclosed area (Victorian Government Department of Human Services, 2005). However, there are a few exceptions to this law, where smoking indoors is permitted. Initially these exceptions included licensed premises, however smoking in licensed premises was made illegal from July 1st 2007 (Victorian Government Department of Human Services, 2007). Other indoor areas that remain exempted from the smoke-free legislation are prisons, parts of the casino and “an area in an approved mental health service (within the meaning of the Mental Health Act 1986) declared by the Secretary” (Victorian Government Department of Human Services, 2005, p.2). This means that even though we know the risks of second-hand smoke for staff and patients of mental health services (under the Act, this includes residential alcohol and drug treatment services) include a 50-60% increased likelihood of heart disease (Victorian Government Department of Human Services, 2005), the legislation continues to allow this practice to take place.

The Tobacco Act 1987 seems to be in conflict with The Occupational Health and Safety Act 2004 (Workcover Victoria, 2005), which requires that employers protect their staff from harmful substances in the workplace and to take reasonable and practicable measures to secure the health, safety and welfare of their employees (Workcover Victoria, 2005). Employers who do not protect their employees from tobacco smoke may be guilty of negligence or a criminal offence (Howard, 1990). Employment tribunals have found in favour of employees forced to leave their jobs on account of exposure to passive smoking, while smokers who have argued in the courts their right to smoke have not been successful (Action on Smoking and Health, 1999).
1.3.2 Why research smoking by nurses in the field of alcohol and drug treatment?

With the overwhelming evidence that cigarette smoking is a major cause of death and disease, it might be expected that nurses would be keenly aware of such a health issue and therefore, make all attempts to reduce their rate of smoking. Studies of nurses and smoking have shown that nurses are not only smoking in large numbers but at some of the highest rates in the health care field (Bartscherer et al., 2005). Estimates of smoking rates among nurses vary from 20-40% (Rowe & Clark, 2000) with some fields of nursing at higher rates, notably, mental health (Beverly, 2000; Griffith, 1999; Plant, Plant, & Foster, 1991; Tarbuck, 1996; Trinkoff & Storr, 1998). Despite their aim to treat addiction to substances including tobacco, alcohol and drug nurses are smoking in large numbers and cigarette smoking is almost always permitted by their agencies (MacCalman, 2000).

Other studies also show that, as health practitioners, nurses are failing to address smoking practices with their patients (Bartscherer et al., 2005; Hughes & Rissel, 1999). One report on smoking studies states that “the ultimate health promotion challenge centres around nurses and smoking” (Rowe & Clark, 2000, p.1052). In light of the findings of recent research on the effects of smoking, it would seem that it is important to know why nurses aren’t promoting the ‘anti-smoking’ message. A review of literature on the incidence of smoking amongst nurses by Rowe and Clark (2000) concluded that there is a lack of information available on smoking rates and patterns among nurses and that many of the studies have been methodologically flawed. They noted that research has mainly taken place in the United Kingdom, Canada and the U.S.A., and little is known about the smoking practices of nurses elsewhere (Rowe & Clark, 2000).

Nurses are in a strong position to affect the smoking behaviours of their patients. In alcohol and drug treatment settings nurses and counsellors typically explore issues of addiction with clients. It is known that clients of these centres have smoking rates around three times that of
the general population (Story & Stark, 1991). A common perception in this field is that it is asking too much of clients to stop smoking when they are attempting to address more ‘urgent’ drug issues. This perception is evident anecdotally in advice to clients such as “Don’t worry about your smoking, concentrate on your heroin first”, the practice of supplying residents of withdrawal units with staff-bought cigarettes to encourage them to stay and complete the program, as well as staff smoking with clients (MacCalman, 2000). This perception of concentrating on ‘one drug at a time’ is contradicted by evidence that shows that alcohol and drug clients have a higher success rate of ‘staying off’ any drugs if they also stop smoking (Hatcher, 1989).

The practice of smoking with clients may even be harming treatment outcomes as one identified barrier to patients giving up drugs of dependence is the negative modelling behaviour of nurses who smoke (Stillman, Hantula & Swank, 1993). The nurses appear to be sending the contradictory message, that addiction can be overcome, while they are demonstrating their own smoking addiction. Reports published on smoking by health workers have highlighted the “glaring inconsistency of allowing smoking in medical facilities in the face of the known health hazards of smoking” (Hurt, 1990, p.1027). It might seem an obvious contradiction that a service devoted to the treatment of addictions appears to condone tobacco consumption.
1.4 Summary

The negative health effects of smoking are well documented, yet smoking seems to be a common practice in alcohol and drug treatment services. After being troubled by this seemingly high rate of smoking within the field of alcohol and drug treatment this researcher chose to investigate the reasons why nurses and others who work in this field continue to smoke.

The next chapter describes the grounded theory approach used to conduct this study.
CHAPTER 2.

Theoretical Framework

2.1 Introduction

This chapter will describe the reasons for choosing to develop a Grounded Theory and the underpinnings of the Grounded Theory methodology used in this research. The theory of Symbolic Interactionism will be traced and related to the formation of the Grounded Theory methodology. The subsequent divergent streams of the Grounded Theory methodology will also be acknowledged with an argument stated to support the methodology chosen by the researcher.
2.2 Choosing to build a grounded theory

2.2.1 Qualitative research

Initially it was tempting to undertake some quantitative research to investigate rates and patterns of cigarette smoking amongst the population of nurses working in the area of alcohol and drug. However, being less concerned with whether this was happening (observations confirmed it was) and more with why this was happening, the selection of a qualitative research approach was made as “qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, gathering rich, descriptive data that help us to understand their experiences” (Boyd, 1990, p.183). The chance to unearth the meaning behind the phenomenon was more attractive.

The researcher was also most interested in uncovering explanations of a phenomenon of human behaviour that had been observed. Strauss & Corbin describe qualitative research as “…research that attempts to uncover the nature of a person’s experiences with a phenomenon. It is used to uncover and understand what lies behind a phenomenon about which little is yet known” (1990, p.19). Such a statement was useful to this researcher in assisting him to choose an appropriate approach to inquiry as he was at a loss to explain a phenomenon of which he was a contributor, and therefore, was keen to allow the words generated from the data collection, rather than his own words, to describe the phenomenon.

2.2.2 Why grounded theory?

Once a decision was made to use a qualitative research approach, consideration was given to a range of methodologies as to which would lend itself to provide the most satisfactory answer to the questions in mind, while providing clear guidelines for a novice researcher, and seemed to align itself with the researcher’s own philosophies and logic. Streubert and Carpenter’s
Barney Glaser and Anselm Strauss (1967) first published grounded theory techniques with the aim to promote the status of qualitative methods of research, especially in sociological practice (Richardson, 1996). The primary aim of generating a grounded theory was to discover theories from data that actually work, withstand the scrutiny of scientific rigour, and can be applied to local settings. Glaser and Strauss (1967) felt that too often qualitative research techniques were aimed at verifying existing or hypothetical theories. They offered as an alternative a methodology that focuses itself on “discovering what concepts and hypotheses are relevant for the area one wishes to research” (Glaser & Strauss, 1967, p.2). “One does not begin with a theory and then test it, one begins with an area of study and what is relevant to that specific area is allowed to emerge” (Strauss & Corbin, 1990, p.23).

The notion that one allows a theory to emerge from an area of study, rather than test a theory, matched the desires of undertaking research in this field. Ensuring that theories emerged from the data was also important, as this was a phenomenon surrounding the researcher. The
grounded theory method, therefore, was particularly suited to this study as it is especially useful when no existing theories are available or when a “fresh perspective in a familiar situation” (Stern, 1994, p. 116) is needed.

2.3 Symbolic Interactionism

Grounded Theory derived its main theoretical underpinning from Symbolic Interactionism (Strauss & Corbin, 1990). Symbolic Interactionism, in turn, has its roots in the thoughts and writings of John Dewey and George Herbert Mead. Dewey (1922) suggested that philosophy is best practiced when human beings are studied in their relationship with the natural world. The individual conducts this relationship by the use of language to interact with those around them. It is this relationship between an individual and the world around them that will lead to shared meanings, the individual's thoughts and hence ‘mind’ (Charon, 1979; Dewey, 1922).

Mead (1934) expounded on this notion of interaction by developing an approach to the study of humans, known as ‘social behaviourism’. She saw the ‘self’, or the meaning that people give to themselves, as arising from the internalisation of the feedback and interaction they receive from others. Mead thought that what we see as true is what we have defined for ourselves based on our involvement with and interpretation of the world (Charon, 1979).

Herbert Blumer (1969) built on the ideas of Dewey and Mead and proposed the theory of ‘Symbolic Interactionism’. Blumer noted that “human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions” (1969, p.180).

Symbolic Interactionism is defined as “a philosophical belief system based on the assumption that humans learn about and define their world through interaction with others” (Streubert & Carpenter, 1999, p.317). By interacting with others in a community, humans share language, ideas and interpretations. Meanings must be shared in a common language to allow social
interactions and communication to take place (Strauss & Corbin, 1990). This interaction with others gives meaning to the world for the individual and can be reflected in a person’s behaviour.

Blumer (1969) proposed that Symbolic Interactionism rests on three primary premises. These primary premises can be summarised as the three core principles of meaning, language, and thought:

- **Meaning**: Humans act towards people or things according to the meaning they give to those people or things.
- **Language**: Such meanings have arisen out of the act of using language with others or ‘symbolic interaction’
- **Thought**: Interactions, words and names used are interpreted by individual’s thoughts for each situation, and determine how that individual will perceive their reality.

(Griffin, 1997)

These three premises can be described in more detail.

### 2.3.1 Meaning

In the study of symbolic interactionism meaning is based on the use of symbols. Symbols are a class of social objects that are used by people to represent whatever is agreed upon by those people (Charon, 1979). Shibutani (1961) states that whatever it is agreed the symbol stands for constitutes its meaning. Symbols may take the form of words, gestures or objects and their meaning is defined by the people who use them and negotiate their meaning via communication or interaction.
2.3.2 Language

The use of a common language to communicate with others is essential in establishing the meaning of symbols. “Symbols – acts, objects, words – have meaning to us only because they can be described through using words” (Charon, 1979, p.43). Language is a dynamic process, constantly changing over time and in different situations. As language changes, so too does the meaning of symbols. Language, and therefore symbols, are dynamic by nature and change over time through interaction, to constantly re-evaluate their meaning.

2.3.3 Thought

Our thoughts are the mechanism via which we ascribe meaning. Thoughts are “anything the individual indicates to himself” (Blumer, 1962, p.181). We process symbols around us via conversations to determine the meaning of those symbols. These conversations occur with others and with ourselves. Meaning, therefore, is determined through interaction - interaction with others (via language) and interaction with ourselves (via thoughts) (Charon, 1979). Thus, thoughts and language are intrinsically linked and depend on each other. Charon (1979) goes so far as to say that thoughts will diminish and even disappear until interaction, or conversation, is resumed. The interaction of these premises to determine meaning can be illustrated via an example from the study.

The symbol of holding a cigarette in one’s hand can convey, in one instance, a common act used to engage or break down some barriers with clients in a way of sharing a common action. The symbol conveys the shared meaning that ‘I am like you’. In another instance, the same symbol can infer a very different meaning. It may communicate that the holder of the cigarette is taking a break from work and does not want to engage with clients at this time. The meaning of the symbol, holding a cigarette, changes according to the location, the organisation of the furniture, allocated areas for staff only, and more subtle rules of
conformity that are quickly established with new residents of the service. The meaning of the symbol is communicated via language and interaction. Thus the holding of a cigarette has different meanings depending on the situation, but those meanings are communicated and quickly established. The new resident that does not yet know these meanings may find themselves breaking convention and will be told through language and gestures the true meaning of the symbol at that time.

Another example is the meaning attributed to the words used. In the context of cigarette smoking a person may comment that they are going for a ‘smoko’. The meaning this term may have for that person is that ‘smoko’ is having a break or rest from work, or removing themselves from the work area for a short time. The term will have arisen from the symbolic interaction that person has had with other persons and the language they have used over time in the workplace. This person uses the language of ‘smoko’ as conveying the meaning of ‘having a break’. The person will also have made a mental interpretation of their comment, put themselves in the shoes of those around them, and thought that the term ‘smoko’ would accurately convey the intended meaning to those around them.

These underpinnings of Symbolic Interactionism lend themselves very well to the aims of this study. The research question considers, in the alcohol and drug treatment workplace, the reasons behind/underpinning the smoking behaviour of staff. One way to unearth these reasons is to study the interaction between these staff, these clients and in these environments. The researcher was not looking to describe the phenomenon of smoking, the personalities of smokers, or the nature of the work, rather the aim is to investigate the thoughts that nurses who work in alcohol and drug treatment have about their smoking and through analysis of these thoughts describe the way smoking was represented in the interaction between staff, as well as staff and clients, the language (words) they use to describe this interaction, and the thoughts they have used to ascribe meaning to this action (or symbol).
Investigating the symbolic interaction in this environment focuses the researcher on the
dynamic social activities taking place between persons (Charon, 1979). Using the techniques
of building a grounded theory, analysis of the interview data would unearth the thoughts,
language, and meaning embedded in the data. These aspects are inextricably linked to the
reasons for the interaction and the behaviour therein. Further conceptualisation of the
description of the interaction will contribute to a theory of the reasons why nurses who work
in alcohol and drug treatment smoke cigarettes.

2.4 A grounded theory

The methodology of Grounded Theory was developed from these principles of Symbolic
Interactionism. Glaser and Strauss took the principles of Blumer, and others, of unearthing
meaning from observing interaction, and proposed techniques to further the analysis of this
qualitative data to generate a theory, a theory that is grounded in the data.

Grounded Theory methods provide a way to study human behaviour and interaction to try and
unearth the common meanings. The focus of a grounded theory study on interaction, with a
view to unearthing meaning, allows us to understand behaviour in new and different ways and
is therefore particularly useful in areas in which little previous research has been done
(Strauss & Corbin, 1990).

Grounded theory methods are also useful as ‘a grounded theory is faithful to and illuminates
the area under study’ (Strauss & Corbin, 1990, p.24). This was important in this study
because the aim was not merely to investigate why people smoke as this had been researched
many times before (Rowe & Clark, 2000). Instead, the aim was to know what were the
reasons peculiar to drug and alcohol work that contributed to the smoking levels of its staff.
Grounded Theory techniques allow theories to emerge from the particular perspective of the
nurses of the drug and alcohol agencies interviewed, so that they may be compared and contrasted with existing knowledge.

### 2.4.1 Different streams of Grounded Theory methodology

Since the publication of ‘The Discovery of Grounded Theory’, Glaser, Strauss and other researchers (Glaser & Strauss, 1967; Schatzman, 1991; Strauss & Corbin, 1990) have shown emergent differences in how the Grounded Theory methodology has been interpreted and adapted. These differences in approaches can be roughly divided into three camps, differentiated by the extent to which the researcher follows a prescribed structure in analysis. Basically there is the “emerging approach” of Glaser (1992), the “systematic approach” of Strauss and Corbin (1990), and other approaches including the constructivist approach of Charmaz (2000) and dimensional analysis proposed by Schatzman (1991). The two most common and well-known approaches used, and therefore the two considered by this researcher, are those of Glaser, and Strauss and Corbin.

In the first approach, Glaser (1992) advocates the need to take a less rigid approach, more intent on allowing the data to guide the researcher. Glaser recommends allowing categories to emerge from the data without forcing them and stresses the need for the research question itself to be developed after collection and analysis of the data. Strauss, on the other hand, has refined the process of developing a grounded theory in a different direction. Writing later with Corbin, Strauss recommends a more rigid approach to developing a theory (Strauss & Corbin, 1990). The methods are more prescriptive, stressing the importance of research requirements such as ‘canons’. These canons include:

- **Replicability**: where a different researcher with the same perspective, using the same rules under similar conditions should produce the same theory. Any difference in
theories developed would require a re-examination of the data for evidence of a different situation.

Verification: requires that a researcher can look to the data to verify statements made of relationships within that data.

Precision: the greater the scope of the study, the more data that is collected, then a more accurate and hence precise representation of the situation will be produced.

(Strauss & Corbin, 1990).

In contrast to Glaser’s more secondary development of a research question, Strauss and Corbin suggest, “the research question in a grounded theory study is a statement that identifies the phenomenon to be studied” (1990, p.38).

The development of different models of conducting Grounded Theory research presents difficulties for the novice researcher attempting to differentiate and choose between the variants of the methods. Dunican (2006) also described these difficulties and suggested that researchers consider their own personality and modes of working, the nature of the research question and the context of the research when choosing a model to follow. In this case, the research question needed to be identified in the research proposal as part of the requirements for a Higher Degree Candidature, and although it was permissible to change this question, these requirements would immediately lend the research project more to Strauss and Corbin’s methods. As this was the researcher’s first use of Grounded Theory analysis techniques, Strauss and Corbin’s more prescriptive and step-by-step approach also provided a path to follow that seemed more suitable and safe. Following the methods described in their book (Strauss & Corbin, 1990) the researcher was able to feel well guided in the research techniques and the construction of a theory grounded in the data. While providing many rules, Strauss and Corbin acknowledge that these are not set in stone and “while we set these
procedures and techniques before you, we do not wish to imply rigid adherence to them” (1990, p.59).

2.4.2 Constant Comparative Analysis

Another key underpinning of generating a grounded theory is the means by which the data is analysed. Data collected from interviews and observations is initially coded, then grouped into categories according to common properties and dimensions of the data. Categories are compared to each other and redefined as subsequent data is collected. This simultaneous collection and analysis of data is referred to as constant comparative analysis (Glaser & Strauss, 1967). The techniques of constant comparative analysis used in this study will be described in more detail in the next chapter.

2.4.3 Theoretical Sampling

One benefit of constant comparative analysis is the ability to theoretically sample the data. As data is analysed during the gathering process, the researcher is able to strategically target specific sites, participants or situations that will maximise the likelihood of incoming data comparing or contrasting with existing dimensions and properties. The researcher used the process of theoretical sampling in this study when choosing to conduct interviews in rural as well as metropolitan settings and with staff that worked in inpatient as well as outpatient services. An example of this method is that early data described the behaviour of staff giving cigarettes to clients. The researcher wanted to investigate whether this behaviour continued to exist in staff that worked with clients under the age of eighteen and if so, what were the descriptions of this behaviour and how did it compare. Therefore participants from youth alcohol and drug treatment services were ‘theoretically sampled’ to be included in the study. The use of theoretical sampling allows the researcher to “densify categories, to differentiate among them, and to specify their range of variability” (Strauss & Corbin, 1998, p.201).
2.5 Summary

This chapter has described the reasons for choosing the Grounded Theory methodology in this research and has traced the underpinnings of this methodology. Armed with the methodology guidelines the researcher commenced gathering data. The next chapter outlines the methods used to conduct the study.
CHAPTER 3.

The Research Process

3.1 Introduction

This chapter provides a descriptive account of the research process employed for this study. The chapter includes a description of the underlying principles guiding the study, the context, and descriptions of methods used to address ethical considerations, the process of recruitment, conducting interviews and the recording of observations. The chapter also includes brief descriptions of the participants and the role of the researcher. The chapter concludes with a discussion of processes adopted by the researcher to address rigour.
3.2 Study context

This study was undertaken using participants who work in the field of alcohol and drug treatment in Victoria. This section will describe a brief orientation to the structure of alcohol and drug treatment in Victoria.

Within Victoria there is a range of treatments and other interventions for people with alcohol and other drug (AOD) related issues. Some are provided in general health settings, such as a GP’s clinic or a hospital, but most are provided within the AOD service system of specialist services, where these interviews took place.

Specialist services are offered in a range of settings, by workers from many professional backgrounds, with varying goals. These services together make up the service system. They form a co-ordinated network of services that provide a range of options for clients.

3.2.1 Dimensions of the service system

The three main approaches to drug treatment in Victoria are withdrawal services, behaviour change and substitution pharmacotherapies.

Most services are provided on a regional basis, with services available in each of the nine Department of Human Services regions. Regional services are provided separately for adults and young people. Some services are also provided on a statewide basis, where one or more agencies provide the service for the state. Participants for this study were recruited from both regional and statewide services.

The main types of services in the Victorian AOD service system are:

- withdrawal (residential, home-based, outpatient, rural)
- counselling and support
- residential rehabilitation
• self-help groups (not part of the funded system)
• substitute pharmacotherapies (methadone, buprenorphine, naltrexone)
• supported accommodation
• Koori services
• outreach
• needle and syringe programs
• forensic (corrections) programs

Workers who provide treatment and other interventions come from a range of professional backgrounds in the social and health areas. These include:

• specialist AOD workers
• welfare workers
• youth workers
• social workers
• nurses
• pharmacists
• doctors
• psychologists
• peer workers (people with personal experience of AOD issues)

The goals of interventions that services provide also cover a wide range, including:

• reduce harmful use and risk behaviour (including risk of infectious diseases)
• reduced or controlled use
• stopping drug use
There are also services that cater to the needs of specific groups of people. There are separate services for young people and adults. Some services also target more specific groups, for example pregnant women, Koori peoples, homeless people, people who inject drugs, and people involved in the criminal justice system.

Participants for this study were recruited from specialist AOD treatment services within Victoria. The profession and type of service of these participants is outlined in the table below.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Type of service</th>
<th>Adult/youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses x 2</td>
<td>Statewide</td>
<td>Adult</td>
</tr>
<tr>
<td>Registered nurses x 3</td>
<td>Regional</td>
<td>Adult</td>
</tr>
<tr>
<td>Registered nurses x 2</td>
<td>Regional</td>
<td>Youth</td>
</tr>
<tr>
<td>Youth workers x 2</td>
<td>Regional</td>
<td>Youth</td>
</tr>
<tr>
<td>Medical officer x 1</td>
<td>Statewide</td>
<td>Adult</td>
</tr>
<tr>
<td>Social worker x 1</td>
<td>Statewide</td>
<td>Adult</td>
</tr>
</tbody>
</table>

Table 1: Distribution of study participants

The above discussion has located the context for the study; the next section will outline the ethical considerations given for this research.
3.3 Ethical considerations

Approval was obtained to conduct the research from the RMIT University Human Research Ethics Committee (HREC) and the Higher Degrees Committee. The HREC deemed this research to be ‘minimal risk’ as the researcher was not in a dependant relationship with the participants and the nature of the research process was unlikely to elicit any strong emotional or physical reactions in the participants.

3.3.1 Informed consent

All participants were informed initially of the study via phone and emails and followed up by the researcher in person. All participants were given a verbal description of how the study was to be conducted as well as being sent a consent form (see Appendix 1) and plain language statement (see Appendix 2) prior to the commencement of the study.

All participants were assured that their involvement in the research was voluntary and they could withdraw from the study at any time, prior to analysis of their interview. They were also informed that they could decline to answer any questions or request to cease the interview at any time. Should they become distressed, or wish to stop, the interview would be ceased, assistance sought, and the interview would only recommence if the participant so desired.

As an experienced counsellor, the researcher felt that he could provide any immediate support required. An arrangement had been made with the counselling team at Turning Point Alcohol and Drug Centre to offer and provide free of charge counselling to any research participants, should the need arise.

3.3.2 Confidentiality and anonymity

Interviews were transcribed verbatim and participants were informed that a process of deindentification would be used. Participants were not addressed personally during the
interview and any identifying information such as names and workplaces were removed in the transcribing process of the interviews.

Interview audio-tapes, transcripts and identifying information were stored in a locked cupboard in the researcher's supervisor’s office during the course of the study. On completion of the study all information will be archived at the University for a period of five (5) years after which time it will be destroyed in accordance with RMIT University's policy for destruction of confidential information.

### 3.4 Recruitment

A total of eleven participants were recruited for this study. Inclusion criteria at the commencement of the study were:

Registered nurses who currently smoke cigarettes at work and had resumed, or commenced, smoking since commencing work in alcohol and drug treatment.

Seven interviews were conducted with participants who met these inclusion criteria. As the researcher is currently employed by an alcohol and drug treatment service, the first two participants were recruited as work colleagues. The researcher is also a member of the Victorian Drug and Alcohol Nurses Network and sent an email with an attached plain language statement informing the network of the study and seeking participants that met the inclusion criteria. Those who responded with interest were contacted by phone to discuss the study and, if willing to participate, schedule a suitable time and venue for the interview. Two more participants were successfully recruited by this method. The recruitment method of “network sampling”, sometimes called “snowballing” (LoBiondo-Wood & Haber, 1994, p.302), was then used to recruit additional participants. Each participant was asked at the end of the interview if they knew of any other staff who were smokers and whether they may wish to participate in the study. Two additional participants were recruited in this manner.
Part of the researcher’s current work role is the provision of training workshops across Victoria and these opportunities were utilised to advertise the study prior to the workshop commencing. This method of “convenience sampling” (LoBiondo-Wood & Haber, 1994, p.291) led to the recruitment of one further participant.

After the seven interviews were completed and the data analysed, the researcher’s supervisors suggested the need for interviewing workers in the alcohol and drug treatment system who were not registered nurses. It was recognised that alcohol and drug treatment differs in some ways to other health care services in that although it is a multi-disciplinary workplace, staff, whether they be nurses or welfare workers, predominately fulfil the same functions when working with clients. This only differs slightly in residential withdrawal units where registered nurses are also called upon to dispense medication. It was agreed to expand the inclusion criteria to include workers in the alcohol and drug field other than registered nurses. This expansion of inclusion criteria is consistent with the principle of theoretical sampling in developing a Grounded Theory. “Theoretical sampling is sampling on the basis of concepts that have proven theoretical relevance to the evolving theory” (Strauss & Corbin, 1990, p.176). Four interviews were conducted with participants from these expanded inclusion criteria. These participants were recruited via direct approach with workers known to the researcher in the field of alcohol and drug treatment.

At the end of the data gathering stage, eleven interviews had been completed. The participants comprised seven registered nurses, one youth worker, a generic alcohol and drug worker, a social worker and a manager of a treatment service. Comparisons of the difference in work role versus findings of the study will be discussed in more detail later.
3.5 The interviews

To minimise inconvenience to the participants, nine of the eleven interviews were conducted at their respective workplaces. A location for the interview was chosen by the participant that maximised privacy, comfort, quiet, and reduced the likelihood of interruptions. Permission to enter the service and conduct the interview was obtained from the manager of the service prior to any visit. Two participants chose to be interviewed at the researcher’s workplace as they felt this would be more convenient and would be less likely to be interrupted.

All interviews were conducted in private rooms. A tape recorder and a microphone were used to record the interviews. Each participant was given a fresh copy of the plain language statement for them to keep, the consent form was read through and questions answered prior to the participant giving written consent.

The researcher began each interview with an introduction to the research and followed this up with open ended questions to allow the participant to explore the topic as it applied to them. In later interviews, where participants had been theoretically sampled to explore emerging information, the researcher combined open ended questions with more targeted questions aimed at validating current themes and categories of knowledge.

Interviews lasted between 30 and 60 minutes; ending when the researcher felt the topic had been thoroughly explored and no further relevant information was able to be elicited. At this time each participant was given the opportunity to provide “any additional information that they thought was relevant”. Most participants stated that they were happy to conclude the interview however, two participants used this opportunity to provide clarification of statements that they had made during the interview process. All participants were given the researcher's contact details and reminded that they could withdraw their interview from the
study at any time prior to analysis of the data. None of the participants withdrew from the study.

3.5.1 The participants

As previously mentioned, a total of eleven participants, comprising seven registered nurses and four other workers, were interviewed for this study.

The first participant was a recently graduated registered nurse. She was employed in a counselling position at a metropolitan adult outpatient treatment service. She gained this position after completing a placement at the service as part of her undergraduate degree and had been working in drug and alcohol treatment for less than a year. Most of her smoking was with colleagues in a laneway outside her work building.

The second participant had been a registered nurse for twenty seven years, with the last three having been in drug and alcohol settings. She was currently employed in an adult outreach programme, working from an office base during business hours. She had been smoking for four years and most of her current smoking was undertaken with colleagues on a balcony visible from her desk.

The third participant had been a registered nurse for five years after a longer career in an alternative profession. He was currently employed in a metropolitan adult residential withdrawal unit. He had been smoking for sixteen years and spent much of his work time either smoking with clients in the common courtyard or with staff in a different area of the courtyard. He has had many attempts at quitting.

The fourth participant was also a registered nurse employed by a metropolitan adult residential withdrawal unit. She had been nursing and smoking for more than twenty years with almost all of her employment in that time being in drug and alcohol settings. She
smokes at work, with clients, and sometimes purchases cigarettes for clients. She had never
had a desire to quit smoking.

The fifth participant had been a registered nurse for twenty three years and had been smoking
for thirty three years. She was currently employed in an adult residential withdrawal unit in a
rural setting. This involved working business hours. Her smoking was usually performed
alone, out of view of staff and clients.

The sixth participant was a registered nurse working as a youth outreach and withdrawal
nurse in an outer metropolitan setting. He had been a nurse for eighteen years and had been
smoking for twenty eight years. Most of his smoking was performed either alone or with
colleagues outside his office. He occasionally smoked with clients but not as much as he used
to.

The seventh participant and last registered nurse to be interviewed was working as a nurse in
a metropolitan youth residential withdrawal unit. She was involved in shift work and usually
smoked in the courtyard with clients and staff.

The eighth interview was conducted with a youth worker employed in a rural youth outreach
service. She had been smoking for thirty years and was currently trying to stop. She was
relatively new to the drug and alcohol field with three years experience. She smokes with
clients although she would rather not.

The ninth interview was also conducted with an employee of a rural youth outreach service.
His background was naturopathy. He is currently employed as a primary health and outreach
worker. He had been working in drug and alcohol settings for over fifteen years and smoked
with clients in the past. He has recently decided to stop smoking with clients and was one
week into trying to quit smoking altogether.
The tenth interview was conducted with a senior staff member of a metropolitan alcohol and drug treatment service. He was a medical officer with many years in community health settings. He had been in this position for only six months and usually smoked with staff outside the building.

The eleventh and final interview was conducted with a social worker employed in a counselling position at a metropolitan adult outpatient alcohol and drug service. She had been working in the alcohol and drug field for one year and had been smoking for two years. She smoked with colleagues at work but chose not to smoke with clients.

### 3.5.2 Data Saturation

Data saturation occurs when participants believe they have exhausted their descriptions and no new knowledge is emerging from the interviews (Streubert & Carpenter, 1999). Recruitment of participants was ceased after 11 interviews as it was agreed that data saturation had been reached after 10 interviews and was confirmed with the eleventh.

### 3.5.3 Recording of observations

A journal was maintained by the researcher throughout this study to record details of the study particulars, the researcher’s thoughts as they emerged, as well as additional notes made outside the interviews. Two important aspects of these additional notes were the field observations and off-the-record comments.

Field observations included observations of the participant, details of the layout of the service, where staff and clients smoked, where counselling opportunities appeared to take place, and whether staff and/or clients were visibly smoking during the visit. An example of a field observation is:

…dressed a bit hippy, crazy hair, large bag of (?) weed on the desk. Relaxed, confident, sure in themselves, saw things objectively…
Off-the-record comments included remarks made by the participant when the tape recorder was turned off, that the participant agreed to have included in the study. These remarks usually occurred after the interview and were usually noted when the researcher had left the service. For example:

“When working in Community Health there was a shame attached to smoking; guilt, hypocrisy, when the patients or the community saw you smoking. In the alcohol and drug field it doesn’t matter, clients don’t judge this, it’s seen as the least of the problems, so you’re more likely to relapse”.

Off-the-record comments also included notes made by the researcher to record other people’s comments on the research topic, which were deemed interesting or applicable to the research.

“People get into D and A [alcohol and drug treatment] because they have some degree of perversity; they’re risk-takers, excited by antisocial behaviour”.

Field notes and off-the-record comments were used by the researcher to assist in validating the themes that emerged from the interviews, by verifying that these notes supported the categories of data and themes as they emerged.

3.6 The role of the researcher

The researcher is currently a teacher in the field of alcohol and drug treatment, where he also worked as a registered nurse for four years prior to the research commencing. This familiarity with the nature of the profession, services and participants provided advantages for the researcher in terms of access to the participants and an understanding of the context of practice and language used by them. Indeed, this familiarity served to increase the level of theoretical sensitivity for the researcher.
Theoretical sensitivity refers to the attribute of [the researcher] having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t.

(Strauss & Corbin, 1990, p.42)

Previous professional experience is a source of theoretical sensitivity, helping to understand thoughts, language and actions more quickly than if there were no previous experience (Strauss & Corbin, 1990).

This familiarity also provided cause for caution when interpreting and analysing the data. Although the acceptance that researchers frequently select topics that are personally meaningful is well documented in the qualitative research literature (Berg, 1995), the researcher was keenly aware of his own assumptions and experience with the research topic and was very mindful of the effect these may have on the participants’ content direction in the interviews, or analysis of the data. As investigator, the researcher followed the guidelines of Strauss and Corbin (1990) who suggest that in order to obtain valid and reliable information in qualitative research, the researcher should periodically ‘step back’ from the research and critically evaluate what is emerging from the research process. This was achieved through the use of the steps of constant comparative analysis (described earlier) and by taking a “fresh look” at the data from time to time to check for any introduced bias or leading of the participants.

Other attempts to minimise these concerns included the researcher exploring and outlining his initial thoughts on the research question so that these could be recognised by the researcher and therefore not introduced as part of the interview process. The researcher also provided a transcript after each interview to his two supervisors to independently corroborate codes, categories and themes used to describe the data. When utilising this process, the researcher
was periodically instructed to revisit elements of the transcripts to question the choice of
codes or categories used and refine them to more accurately reflect the words used by the
participants.

3.7 Rigour of the study

Qualitative methods have traditionally been viewed with some scepticism and debate around
their ability to achieve reliability, validity and objectivity (Sandelowski, 1986). Although this
debate seems to have decreased, critics of qualitative research still often reflect concerns
about the rigour of the findings. Judging qualitative research using empirical (or scientific)
criteria misses the point that these are two different approaches to conducting research, with
different philosophical aims.

Guba and Lincoln (1989) and Sandelowski (1986) suggest four criteria for rigour in
qualitative research that are designed to more accurately assess rigour than the traditional
criteria used in scientific or quantitative research. Table 2 outlines these criteria.

<table>
<thead>
<tr>
<th>Question area</th>
<th>Conventional (empirical) paradigm criteria</th>
<th>Qualitative (Constructivist) paradigm criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truth value</td>
<td>Internal validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>Generalisability</td>
<td>External validity</td>
<td>Transferability</td>
</tr>
<tr>
<td>Consistency</td>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Objectivity</td>
<td>Confirmability</td>
</tr>
</tbody>
</table>

Table 2: Qualitative paradigm criteria

Adapted from Guba and Lincoln (1989).
3.7.1 Credibility

A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own.

(Sandelowski, 1986, p.30)

Sandelowski (1986) goes on to suggest some strategies to ensure credibility. These include:

- Checking for representativeness of data, categories and examples used
- Comparing across data sources to determine congruence
- Ensuring descriptions, explanations or theories contain elements of the data
- Deliberate attempts to discount or disprove conclusions
- Independent analysis of data and conclusions by another researcher

The researcher employed methods to promote credibility and reduce bias throughout this study. These methods included verification and revisiting of data categories, themes and theories with his supervisors throughout the study, presentation of the methods and findings of the study at a Drug and Alcohol Nurses Association Conference and in a Seminar to other workers, where comments and questions reflected that these staff recognised these experiences.

3.7.2 Transferability

Transferability is related to the question of generalisability of the findings, that is, whether another researcher would find the same results when conducting the same research. There is a clear distinction here in the aim of qualitative versus quantitative research. Sandelowski (1993) describes qualitative research as art rather than science, and uses a useful analogy that two artists drawing the same object will both produce an image that is recognisable to those who are familiar with the object, even though the images will have differences in their
portrayal. “Creativity is … a vital component of the grounded theory method” (Strauss & Corbin, 1990, p.27). Where quantitative analysis uses statistical techniques to generalise the findings from the sample to the population, qualitative methodologies aim to reflect the findings of “…a particular researcher in interaction with a particular subject in a particular context” (Sandelowski, 1986, p.31).

However, Grounded Theory still has aims of generalisability.

Given the same theoretical perspective of the researcher and following the same general rules for data gathering and analysis, plus a similar set of conditions, another investigator should be able to come up with the same theoretical explanation about the given phenomenon.

(Strauss & Corbin, 1990, p.251)

Any differences that arise in the theory generated will be able to be traced back and reconciled with differences in the data gathered.

In contrast with quantitative research, sample sizes are not predetermined in qualitative research, but are dependent on the emerging themes/theories from the study. In particular, the use of theoretical, or discriminate sampling (Guba & Lincoln, 1989), means that inclusion criteria may be varied during the study, as the researcher aims to investigate emerging theories. Using grounded theory methods, the number of participants in the study is determined by the requirement of theoretical (or data) saturation (Strauss & Corbin, 1990).

As this study aims to contribute to a generalisable theory on smoking in this population, without describing the theory in totality, the concerns of transferability are addressed as the findings are intended to relate only to similar participants, in similar situations, under a similar set of conditions.
3.7.3 Dependability

This is concerned with stability of the data and findings over time. Guba and Lincoln (1989) propose that auditability be used as the criterion for assessing dependability. As qualitative research allows for the researcher to alter hypotheses, methods, or theories as the study progresses, Sandelowski (1986, p.34) suggests that

Auditability is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end...Any reader or another researcher can follow the progression of events in the study and understand their logic.

This researcher has attempted to satisfy this criterion by articulating a clear progression of events that detail the logic behind the decisions made and eventual theory generated.

3.7.4 Confirmability

“Confirmability requires one to show the way in which interpretations have been arrived at via the inquiry” (Koch, 1994, p.978). Guba and Lincoln (1989) suggest that confirmability will be achieved when the elements of credibility, transferability and dependability are achieved. That is, the study should be amenable to an audit procedure reviewing decisions made, lines of inquiry and conclusions drawn. The researcher has attempted to provide signposts of all decisions made and conclusions reached throughout the study in order to satisfy this criterion.

It should also be said that the methods of generating a grounded theory, are designed to address the question of rigour (Strauss & Corbin, 1998). The use of the constant comparative method of analysis ensures that themes and theory emerge from the data itself. These are constantly compared to previous data and field notes to ensure their accuracy.

The main objective to promote rigour in this type of study is the need for a clear description of events, a decision trail, to allow the reader to follow the method and agree with the method.
and the conclusions reached. Strauss and Corbin (1990) reassure that grounded theory procedures are “designed that, if they are carefully carried out, the method meets the criteria for doing ‘good’ science: significance, theory-observation compatibility, generalisability, reproducibility, precision, rigour, and verification” (p.27).

3.8 Summary

This chapter provided a description of the various research processes used in the information collection phase of the study. The following chapter will provide the findings of the study as explicated through the process of grounded theory.
CHAPTER 4.

Analysis of interviews

4.1 Introduction

This chapter will describe the methods used to analyse the data from the interviews. Summaries of data from each of the interviews will be presented and the process used to organise and conceptualise the data will be presented. The final relationship between the chosen core theme of legitimacy, its categories and concepts will be proposed to describe the data.
4.2 Data analysis

The methods of theory development described by Glaser and Strauss (1967) and Strauss and Corbin (1990; 1998) were used to guide the analysis of data. These methods include techniques of open, axial and selective coding.

Open coding is the process of ‘breaking down, examining, comparing, conceptualising, and categorizing data’ (Strauss & Corbin, 1990, p.61). The interviews were transcribed verbatim and then each line of data was analysed and assigned one or more descriptive terms (or ‘codes’). For example the statement that “it’s [smoking] good to just go outside, get away from everyone, and just talk” was coded as:

- Socialising
- Time-out
- Environment (outside)

It could also have easily been coded in other ways (e.g. escaping clients) but through conceptualising the statement, these were codes that seemed to fit.

The selection of the words used as codes would sometimes change as the study progressed, in the process of constant comparative analysis. For example, considering the statement:

A lot of the guys smoked, there wasn’t any smoking legislation, so you could smoke in the place and sit down with the guys, have a smoke and a chat

In early interviews this statement would have included a code of ‘rules’. In later interviews, as the theory began to crystallise, this statement was revisited and the code of ‘legitimacy’ applied. Strauss and Corbin (1990) reassure this process stating that “an investigator can legitimately return to the old materials, and recode them in light of additional knowledge” (p.181).
Later in the study, as concepts began to accumulate and this researcher was better able to understand what was going on for participants and codes that were developed from each interview were then grouped together into concepts of similar codes. For example, the codes of:

- Stress management
- Work breaks
- Time-out
- Taking a break
- Stress

were combined to form a concept of “Stress reduction”. This concept or phenomenon has all the properties and dimensions of all the lines of data that have been included in its codes.

The lists of these concepts were then compared with one another for similarities and differences to identify emerging categories from the data (axial coding). Axial coding is “a set of procedures whereby data are put back together in new ways after open coding, by making connections between categories” (Strauss & Corbin, 1990, p.96). Axial coding refers to the process of relating categories to their concepts, then linking categories by their properties and dimensions. Categories of legitimacy, rewards, permission, and therapeutic tool all emerged during this process to describe clusters of concepts.

In the first interview this researcher identified some key concepts that emerged from the participant’s description of their reasons for smoking. These concepts led to the development of further questions in subsequent interviews.

Later in the study, the concepts of knowledge were related to each other in a way that explained the phenomenon for these participants. As these concepts emerged, further literature reviews were undertaken to compare the emerging concepts and their categories with existing research knowledge. Interviews and data analysis occurred side by side.
Questions were generated from the concepts, and were tested and elaborated on in further interviews. Concepts initially identified changed and grew over the time of the interviews and eventually repeated. This was a signal that a level of data saturation had been reached.

The technique of selective coding was used to re-integrate and converge the emergent categories of data to contribute to a central or grounded theory (Strauss & Corbin, 1990). This is the process of

selecting the core category, systematically relating it to other categories, validating these relationships, and filling in categories that need further refinement and development.

(Strauss & Corbin, 1990, p.116)

The core theme of “Legitimacy” was selected as it explained and encompassed all the categories of data. Other categories were related to this, such as:

- Providing a smoking space, gives permission for a legitimate activity
- Smoking improves rapport with clients, and therefore is legitimised as a therapeutic tool
- Socialising with other staff while having a cigarette provides a reward of acceptance amongst the team and is therefore legitimised by the group

The process of formulating a grounded theory to explain a phenomenon can be represented by the following flowchart:
Figure 1: Flowchart representing the process of developing a grounded theory

The next section will describe the formation of categories of data from the interviews.
4.3 The interviews

4.3.1 Interview 1

Data analysis and category formation from the first interview revealed the following categories of data: [Note: For Interview 1 the researcher has included a short explanation of the categories. This will not be included in subsequent interviews.]

- Professional behaviour – what is expected of your position
- Modelling – setting an example
- Blurring boundaries – what are the rules of the relationship with the client
- Socialising with other staff
- Location – where does smoking take place, and what does this mean?
- Taking a break
- Guilt - the feelings associated with smoking
- Hypocrisy – treatment of others’ addictions when you are unable to stop smoking yourself
- Personalising – reflecting the client’s problems in your own
- Level of addiction – does it depend on how much you smoke?
- Prevalence – does it depend on how many people are smoking?
- Culture, acceptance – the feeling or pressure at work from staff about smoking
- Enjoyment – smoking is enjoyable
- Stress management
- Exposure – does being exposed to others’ smoking influence your choices?

The core category or theme of ‘Culture’ was chosen as being central to a description of what was going on in the first interview. The participant described a culture of smoking at the workplace that encouraged staff to smoke.

The researcher decided to attempt to represent these categories graphically in a depiction of the participant’s workplace and the corresponding influence that these categories had on whether the participant was more (✓) or less (X) inclined to smoke. This picture looked like:
After settling on these descriptions of the categories of data from the first interview, these categories were noted and checked in the course of the second interview. This was done by having a list of these categories in front of the researcher during the second interview and, in a manner that was not obvious to the participant and did not upset the flow of the interview; the researcher verified that these categories had been covered during the interview.

**Figure 2:** Map of categories of data from Interview 1
4.3.2 Interview 2

Concepts that emerged from the second interview were:

- The hypocrisy of smoking as a health professional, professional role
- Disappointment about relapsing
- Peer group pressures
- Socialising with peers
- Exposure to other smokers
- Stress management
- Work breaks
- Addiction
- The culture of smoking
- Smoking levels increasing
- Management, rules, guidelines
- The location of smoking
- The prevalence of smoking
- Guilt
- Concerns about health
- Effecting situations outside work
- Keeping busy
- Being accepted by others
- Strength in resisting
- Time-out
- Distractions
- Relapse time, window of opportunity, inevitability (of relapse)
- Determination, mind-made-up
- Identifying with clients
- Drug talk
- Personalising
- Loss of control
- Shame
- Secrecy, hiding
- Feeling judged
• Planning to stop
• Sharing with clients
• Associating with clients, developing rapport
• Empathy
• Modelling addictive behaviours

These concepts were then grouped into categories in keeping with the recommendations of Strauss & Corbin (1998) who suggest “once concepts begin to accumulate, the analyst should begin the process of grouping them under … categories” (p.114).

This process of category construction is useful as it allows the researcher to reduce the size of the list with which he is working. The researcher attempted when possible to use participant’s words in the formation of the category titles to reduce the possibility of bias in the labelling process.

Categories of data that were chosen for these concepts were:

• Acceptance by other smokers
• Exposure to smoking
• Identifying with clients
• Inevitability, determination, mind-made-up
• Hypocrisy of role
• Shame/guilt
• Stress management
• Addiction
• Relapse prevention
• Health concerns
• Enjoyment of smoking

The categories were also placed under headings of whether they were involved in increasing the likelihood or prevalence of smoking, or decreasing it. This was done so that the
researcher could begin to conceptualise possible theoretical explanations to try and answer the research question.

The categories of data were listed as:

**Increase the likelihood of smoking**

- Acceptance by other smokers
- Exposure to smoking
- Identifying with clients
- Inevitability, determination, mind-made-up
- Stress management
- Addiction
- Enjoyment of smoking

**Decrease the likelihood of smoking**

- Hypocrisy of role
- Shame/guilt
- Relapse prevention
- Health concerns

In comparison with the first interview, this participant did not describe as much a ‘culture of smoking’ but rather feeling like part of ‘the gang’ when smoking with others in the workplace. As a result, the use of constant comparative analysis with the first interview led to a renaming of the category of ‘culture’ to ‘acceptance’. Acceptance was now a central category or theme with other categories of data also impacting.

It was at this time the paradox of smoking was noticed. On the one hand, smoking gave you benefits such as acceptance and breaks, while at the same time it gave negatives such as guilt and health effects. The updated graphic representation of these themes was now:
Figure 3: Map of categories of data from Interview 2
4.3.3 Interview 3

A strong theme that developed from this interview was one of being a prisoner. This emerged from the participant’s descriptions of the difficulties in leaving the clients or the workplace during shifts and from observations of the building, staff and client space. Smoking was an integral part of working in this service and was used as a tool in many ways including facilitating access to clients as well as time away from clients. For this reason, the central category of acceptance was changed to ‘permission’, in other words, permission to access people, social groups, locations, or privileges such as a break.

Categories of data after this interview were:

**Increase the likelihood of smoking**

- Acceptance
- Exposure (increased)
- Location
- Rules (lack of)
- Stress Management
- High Risk Situations
- Client contact

**Decrease the likelihood of smoking**

- Rules (management guidelines)
- Location
- Exposure (decreased)
- Hypocrisy of role
- Relapse Prevention
Once again, categories that had been developed from the second and first interviews were compared through constant comparative analysis with data generated in the third.

The new graphic representation follows:

**Figure 4:** Map of categories of data from Interview 3
4.3.4 Interview 4

This interview took place in a similar service to interview three. New information from this interview included the idea that smoking has many rewards and these rewards deliver primary and secondary gains to those who smoke. This was the first time that the category of rewards had stood out during the interviews. The category of rewards was to become a central category of data in future interviews.

Another theme to emerge from the interview was one of legitimacy. The category emerged out of the idea that smoking has a legitimate place in this type of work setting. Smoking at work in drug and alcohol treatment services is justifiable and even seen as beneficial for the clients by some staff. Smoking is therefore given a legitimate place within the context of the work environment.

The categories of data chosen after interview four were: Rewards, Permission and Legitimacy.

The concepts contributing to these categories after this interview were:

- Socialising
- Peer group
- Exposure
- Building
- Location
- Rules
- Culture
- Enjoy smoking
- Health
- Breaks
- Stress management
- Tool with clients
- Keep busy
• Addiction
• Identifying with clients
• Hypocrisy of the role
• Pressure to stop

No further graphical representations were made as it was felt that this was no longer necessary to conceptualise the data.

4.3.5 Interview 5

The fifth participant had recently stopped smoking and spoke mainly of the feelings of separation and alienation they now felt from their colleagues. Concepts were very similar to previous interviews and the participant spoke of the need to somehow reward non-smoking rather than providing rewards for smoking at work.

Categories of data continued as: Rewards, Permission and Legitimacy

Concepts of data that supported these categories after this interview were:

• Acceptance
• Exposure
• Environment
• Stress Management
• Hypocrisy of role
• Relapse
• Prevalence
• Rules
• Health

4.3.6 Interview 6

New information from the sixth interview involved the concept of smoking as an identity. This participant felt that being a smoker had made them a little different to other nurses and helped him to identify and socialise with those who were considered to be on the margins.
Being a smoker had also often led to this nurse being called upon to de-escalate aggressive or threatening patients as they were able to take them outside and offer them a cigarette as a means of calming them down. For this nurse, the thought of not smoking at work would mean a reduction in who they were and how they were received by clients as well as a reduction in the methods that they used to engage with clients.

It was after this interview that the category of permission was collapsed into legitimacy in that smoking provided a legitimate reason for accessing people and places as well as taking breaks, and providing a tool that was felt to be helping clients.

Categories of data were now: Rewards and Legitimacy

Concepts contributing to these categories from this interview were:

- Acceptance
- Peers
- Identity and alternative behaviour
- Rules
- Culture
- Prevalence
- Exposure
- Location
- Professional role
- Therapeutic tool
- Taking a break
- Trying to quit
- Relapse
4.3.7 Interview 7

This participant described very similar concepts to previous interviews but also seemed to clearly, although not deliberately, describe the contradictions associated with smoking in a health treatment service. Statements such as smoking helps workers to engage with clients, while later emphasising the importance of maintaining a professional role by not smoking with clients, provided contradictions that the worker was not able to resolve. This contradiction reflected the previous conceptualisation of smoking as a paradox.

Categories of Rewards and Legitimacy continued to surface in this interview.

Concepts contributing to these categories from this interview were:

- Peers
- Therapeutic tool
- Trying to quit
- Socialise
- Rules
- Culture
- Prevalence
- Location
- Opportunity
- Taking a break
- Trying to quit
- Professional role


4.3.8 Interview 8

The eighth participant spoke of similar concepts to the previous interviews but also focussed on how smoking helped them to overcome nervousness and feelings of inadequacy in working with a perceived difficult client population. This participant spoke of how smoking helped to overcome fear; fear of saying or doing the wrong thing as well as fear for one’s own safety when trying to manage clients that were felt to be difficult or potentially aggressive.

This participant was also keen to point out that once other skills had been acquired to improve the therapeutic nature of the relationship with clients, a process of ceasing smoking commenced as it was felt to be no longer necessary and was not a professional behaviour to be modelling. This was the first time that the notion that smoking with clients may be reduced by improving the skills of staff had been so clearly expressed.

Categories continued to be Legitimacy and Rewards. Concepts contributing to these categories from this interview were:

- Therapeutic tool
- Trauma
- Trying to quit
- Source of identity
- Prevalence
- Alcohol
- Taking a break
- Stress relief
- Risk
- Trying to quit
- Lesser of two evils
- Relapse prevention
- Rules
- Professional role
- Health
4.3.9 Interview 9

The ninth participant provided descriptions of smoking in this field that seemed to synthesise the data analysis so far.

This participant spoke of the difference in smoking when working in different professions. When employed in a previous health related role the participant felt it was unprofessional and hypocritical to smoke and therefore, did not smoke at work. When working in welfare and later in alcohol and drug treatment, the participant noticed that the emphasis changed from being a ‘health worker’ to developing rapport with clients. Smoking was an accepted means to working with clients and a way of ‘fitting in’ with staff and the organisation. Smoking was also a way to debrief and cope with the stresses associated with this field of work.

The participant also felt that having now worked for many years in the alcohol and drug treatment field, they had gained the necessary skills and supports to no longer feel the need to rely on smoking as a tool. Due in part to this reduction in the perceived need for smoking at work, the participant was currently in the process of trying to quit smoking.

After analysis of this interview, and comparison with previous interviews, a new category of data emerged; that of smoking being used as a therapeutic tool. Participants had been using many descriptions to explain how smoking was used to provide therapy and enhance the relationship with clients.

With this further data analysis and comparison with previous interviews, the categories were again integrated and the core theme of Legitimacy was chosen. By describing the various ways smoking is permitted, how it is used as a therapeutic tool, and the rewards on offer to those who smoke, participants had been describing how smoking is legitimised in the field of alcohol and drug treatment.
The core theme was now Legitimacy which contained the categories of Permission, Therapeutic Tool, and Rewards.

Concepts within these categories were

- Source of identity
- Prevalence
- Socialising
- Acceptance
- Peer support
- Taking a break
- Rules
- Permission
- Stress relief
- Trying to quit
- Triggers
- Professional role
- Health concerns

4.3.10 Interview 10

This participant provided data during the interview that, on analysis, was not related to smoking amongst alcohol and drug nurses. Frequent attempts were made by the researcher to re-focus the interview onto the research question without success. After analysis of the interview data and in-depth discussion with the researcher’s two supervisors, it was agreed to exclude the interview transcript from the research.
4.3.11 Interview 11

The eleventh and final participant provided a discussion that once again summarised concepts from previous interviews. The participant spoke of a culture of non-judgemental attitudes and alternative behaviours around such notions as dress, socialising and smoking, which had attracted them to the profession and were part of why they enjoyed their job.

The researcher was satisfied following analysis of this interview, and discussion with his supervisors, that data saturation had been reached.

The core theme of Legitimacy continued, with categories of Permission, Therapeutic tool and Reward.

The final relationship between the core theme, categories and concepts are depicted in the following table. The concepts that contribute to each category and the dimensions of each concept are presented showing the range of data collected that contributed to each of these concepts.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Concept</th>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legitimacy</td>
<td>Permission</td>
<td>Opportunity</td>
<td>Tea breaks – anytime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Space</td>
<td>&gt;150m outside – staff smoking area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of rules</td>
<td>No smoking policy – no rules</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Freedom of breaks</td>
<td>Designated breaks – freedom (anytime)</td>
</tr>
<tr>
<td></td>
<td>Therapeutic</td>
<td>Expressing empathy</td>
<td>Never had an addiction – currently addicted</td>
</tr>
<tr>
<td></td>
<td>Tool</td>
<td>Engagement</td>
<td>Client approaches worker – worker approaches client</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managing difficult clients</td>
<td>Limited options-can distract with a cigarette</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rapport building</td>
<td>Staff vs. client – ‘we are the same’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional role</td>
<td>Clear difference – blurred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modelling</td>
<td>Not modelling an addiction – modelling addiction behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypocrisy of role</td>
<td>Do as I do – do as I say</td>
</tr>
<tr>
<td>Rewards</td>
<td>Reinforcement</td>
<td>Acceptance</td>
<td>Exclusion from peers – part of the gang</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Socialising</td>
<td>Rarely speak to others – frequently chat with staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taking a break</td>
<td>Designated times – anytime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stress reduction</td>
<td>Limited options – use of cigarettes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addiction</td>
<td>Cravings – satisfy cravings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeling pressure from others</td>
<td>Constant pressure – no pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health concerns</td>
<td>Very concerned – no concerns</td>
</tr>
</tbody>
</table>

Table 3 – The relationship of the Core theme, categories, concepts and dimensions
4.4 Summary

This chapter described the process of data analysis - how the analysis led to the development of a core theme, categories and concepts to describe the phenomenon under study. The next chapter describes further the explicated categories and provides examples from the interviews to illustrate how these categories were conceptualised.
CHAPTER 5.

The Emergent Categories

5.1 Introduction

This chapter provides descriptions of each of the three categories of data supported by extracts from participant interviews. The three categories are:

- Permission
- Therapeutic tool
- Rewards

A summary of the content of each category will be provided, as will extracts from interviews that illustrate these categories.
5.2 Permission

The first category of ‘Permission’ describes the impact on smoking of the environment and policies of the organisation, as well as the culture and perceived norms of the staff working there. A number of the participants described the influence of the manager or supervisor’s personal views about smoking and how their personal views impacted on whether staff felt a personal sense of guilt or whether the sense of guilt was distributed between staff who smoked.

- She wouldn’t say you weren’t allowed to, and she’d make a joke of it sometimes and wave her finger and say “put that cigarette out” and carry on but, I think that sort of stopped us smoking a lot

  Interview 2

Participants also commented on the physical layout of the service; where interactions with clients took place, the positioning of courtyards, and tea rooms and client space, as having an influence on smoking behaviours. If they could actually see other staff smoking, or there was a lack of client-free staff space, participants were more likely to smoke.

- There is a difference, here most people smoke with the clients, and most, the majority of staff, smoke. And in the adult unit, yeah they smoke out there with the clients as well

  Interview 7

Other participants also described the nature of alcohol and other drug work as being based on non-judgemental attitudes, reliant on engaging with clients, and pervaded by a culture of alternative behaviour which seemingly promotes the level of, and acceptance of, smoking in this field.
• …working in this kind of environment fosters a kind of leniency with that stuff where people are more comfortable with doing it. …it would seem really ironic if someone came up to you and shook their finger at you about your smoking when it’s all about starting where the client’s at.

Interview 11

The clearest elucidation of the category of Permission was in the 2\textsuperscript{nd} and 3\textsuperscript{rd} interviews, with staff members of small inner-city residential withdrawal units. In these work environments staff seemed cramped and lacking options with regard to where they could situate themselves and cigarettes gave permission to perform almost all daily activities. Smoking allowed staff to engage clients and enter a therapeutic space, approach an angry client or de-escalate them, and engage in debriefing and socialisation. Smoking also gave permission to resist interruptions by providing a barrier to clients; allowing staff to take breaks, a walk, or sit in the tearoom.

• As well as sitting down with them, having a smoke with them, it can also be a protective barrier

Interview 3

The selected data below also demonstrate contributions to the category coded as Permission:

5.2.1 Extracts from transcripts that contribute to the category of Permission.

• I can recall people who started work here wanting to quit or even in the process of stopping smoking, but would then resume smoking because of the culture

Interview 1

• It was just a really different feel to work at a hospital to, say, this place. You sort of felt like you shouldn’t be smoking [in a hospital].
• The manager didn’t smoke and she absolutely put her foot down about people going down stairs for smoke breaks. So, if you did smoke it was only at lunchtime.

  Interview 2

• Let’s face it, if there’s nothing happening you should be out with your clients. There’s always little problems arising with them.

• And that’s what it is to go out there, an excuse

• It’s more of a fact that it just gets me out of the office for five minutes. I can walk outside, have a cigarette in my hand and I know no-one’s going to bother me. If a client comes out I can say, “I’m having a smoke”. I can actually get away with that.

• As well as sitting down with them, having a smoke with them, it can also be a protective barrier

  Interview 3

• There’s always been provision made in most of the hospitals that I’ve worked at for smoking. Cause I’ve always worked in the psych field or alcohol and drug, and it might be that perhaps those streams of nursing smoke a lot.

  Interview 4

• Yeah, another senior member and the acting co-ordinator were smoking and then a group of other people from the team that were very close. There was a sense of alienation it involved when they’d duck out for a smoke, and they’d go off for lunch, this group.

• …and any cultural thing is always going to come from the top down.

  Interview 5

• That very much opened the culture of you’ve got an 8 hour shift, I’m more than likely spending 6 hours of it in the courtyard. And most of the time was smoking.

  Interview 6

• I think it’s probably in this field more accepted, and I probably smoke more because I’ve got more opportunities

• I’m possibly smoking more because I can smoke in my area. You know it’s not recommended that when you work in the hospital you smoke on your breaks, you
don’t leave the ward and that sort of thing. I’m probably smoking more because of that.

Interview 7

- I don’t smoke with the clients, because it’s policy not too.

Interview 8

- A lot of the guys smoked, there wasn’t any smoking legislation, so you could smoke in the place and sit down with the guys, have a smoke and a chat.

Interview 9

- [Name] will often come and say “Oh do you want to come and have a smoke?” It’s a good opportunity to catch up because [Name] was my supervisor when I did my placement, so quite a good rapport there.

Interview 11

See Appendix 3 for further extracts that demonstrate the category of Permission.

5.3 Therapeutic Tool

The second category Therapeutic Tool describes how smoking is used as an intervention with clients. Those who described cigarette smoking as a therapeutic tool told of the remarkably wide range of uses. Cigarettes were used to ‘break the ice’ with new or isolated clients, de-escalate angry or anxious clients, and as an incentive to encourage clients to stay in treatment. Cigarette smoking was also described in terms of a ‘leveller’ to help clients feel more relaxed and as a means to reduce the perceived power imbalance in the client-therapist relationship.

In describing their role, participants stated that one of their main aims was to develop rapport and engage with clients.

A lot if it’s about engaging, because if you can’t engage with someone then that’s pretty much it.

Interview 11
The majority of participants described a reliance on smoking cigarettes as a ‘tool in their kit’ that could be used as a means of engaging clients and establishing a therapeutic relationship.

That’s one of the tools in my bag, and that’s the one you seem most familiar with and it’s comfortable when you pull it out …and it’s positive reinforced because it works most of the time.

Interview 6

More experienced nurses also expressed that the use of smoking as a tool could be replaced by other skills that had since been developed. They had come to rely less on cigarettes and more on other skills of engagement.

- I felt of it as therapeutic and what was therapeutic was the engagement rather than the actual smoking with them.

Interview 9

The implications of this underlying need to develop rapport and engage with clients at an early stage are discussed further in Chapter 6.

Other selected extracts from the interviews that contribute to the category of Therapeutic Tool follow:

5.3.1 Extracts from transcripts that contribute to the category of Therapeutic Tool (positive).

- You do get some appreciation for how difficult it can be

Interview 1

- An advantage to smoking with a client is that your engagement skills can be hastened because you’re doing something socially together

- It just gives you that familiar ground to start with. So, it may relax clients more. It may make them feel not so client–worker orientated.

Interview 2
• You need it because people will leave because of it. Someone will leave detox because they haven’t got cigarettes.

• If someone’s really anxious, having a bit of an outburst, about to hit someone, quite often, “come out the back mate, have a smoke”. So we’ll stand away from the other clients and have a smoke together, it brings us down so we have something in common, rather than being nurse or welfare worker, junkie, you know. I smoke too, we both smoke, so it gives us something in common as a starting point where I can help deal with them at the time.

• It works better, as a one on one, sit down together having a fag.

• It’s something about it that brings you a little bit closer together. Same thing as a therapeutic touch on the shoulder. That connection brings you a bit closer. The same thing with a cigarette as the therapeutic touch.

• It brings us down so we have something in common, rather than being nurse or welfare worker, junkie, you know. I smoke too, we both smoke, so it gives us something in common as a starting point.

• So we’ll worry about that one later on, we’ll concentrate on one substance at a time. So I give away a lot of cigarettes

Interview 3

• I’d often sit out the back with a client, and I’d talk over a cigarette, or two or three or whatever. But you’d often get more out of them and find out what’s going on if you could sit down and have a cigarette with them.

• It’s also a really good thing to have if you want to break the ice with someone who’s being really difficult, and who is a smoker and most of our people are, offer them a cigarette, “let’s go outside for a smoke” and you find they’ll open up and tell you more outside having a cigarette than they will like say in an interview room, because they feel uncomfortable in there.

• Especially if they’re separated from the group and they’re sitting on their own it’s a really good thing, well it works for me a lot of the time.

• They think that’s good because then you’ve got something that they’ve got
• I just think gee, that would be a shocking thing for me, so I quite often give a packet away.

Interview 4

• I think sometimes I’ll sit out and have a ciggie with them and it becomes a therapeutic intervention as far as their other drugs go.

Interview 5

• I was often picked to go with the big bikie out the front and go have a ciggie and calm him down or the mad bugger who wants to smash up the place, I’d take them out. And I sort of ended up with this role of taking out people for a ciggie out the front.

• And I think I sort of learnt early on that that was a good equaliser, or I can help you by lighting your cigarette or you can feel better with yourself by offering me a cigarette.

• I had to justify it because I had all these wonderful interactive moments over cigarettes.

• And my missus would be always on my case about giving up and I was like “Oh no, no I use it so much in my work”

• In some ways I use it as a tool to say I’m human as well, I’m much the same as you are, yes I have had different issues in my past and got through stuff, so I have a smoke.

• I hope that people see me as a health professional, but a little bit of a non-conventional health professional, and maybe a little bit more approachable. So I don’t think of it as a negative…

• You’ve got to use what’s available and what the person is going to relate to easier.

Interview 6

• Sometimes the kids don’t have cigarettes or something like that, they’ll come in or run out or something like that, I’ll offer them a cigarette, and then I’ll have a cigarette with them

• It’s friendly and, you know like you’re somebody that they can talk to or relate to.

• It’s just part of making them feel more relaxed and that’s the reason why we’re here. I’m not saying that that’s the reason why I have a cigarette with them, um, but, I don’t know, it may be, maybe that is the reason.
• You, know, making them feel more relaxed, making them feel you’re someone they can relate to and feel comfortable with, because you smoke too.

    Interview 7

• Smoking is a good tool to engage ‘here have a smoke’ and have a cigarette and you just stand there

• It can be really, not just with this work but socially it can be a really good tool. I’ve met some lovely people having a cigarette. With work too share a smoke it sort of breaks down some sort of barrier or something

• It takes away a bit of the power imbalance. ‘I’m human, I’m real, I struggle in my own way’

• If they go into detox and they haven’t got any we’ll get them a packet and we’ll doctor it and we’ll say it was something else.

    Interview 8

• It was quite a good thing seemed like an okay thing to do because it just helped you fit in and connect and they felt that you were more on the level if you had that.

• It was that way of sitting down with the old guys and the younger guys, having a chat, having a fag. Talking about issues that were going on for them.

• …feeling that I need to mirror with them

    Interview 9

The category of Therapeutic Tool also seemed to encapsulate an interesting aspect of the phenomenon; the notion of 'smoking as a paradox'. On the one hand, smoking promotes empathy for clients battling substance use and abuse, in facilitating personal engagement. There seemed to be a double-standard; smoking was seen to be useful in some cases as a therapeutic tool, but was also seen to be unprofessional behaviour for a health worker. Some participants felt guilty at being seen smoking with clients, while others stated that they would never smoke with clients as they felt it was ‘unprofessional’.
Participants also discussed concerns about the negative modelling behaviour of substance abuse counsellors. Concerns were raised that they may be promoting the use of addictive substances by smoking in view of clients.

Selected extracts from the interviews that also contribute to the Category of Therapeutic Tool but were coded as ‘negative’ now follow:

5.3.2 Extracts from transcripts that contribute to the category of Therapeutic Tool (negative).

- I think that it’s really irresponsible to be doing it in the workplace with clients because if they see you smoking then you are setting an example for them

- Well your relationship with them, my relationship with them is a professional relationship, and I think it’s overstepping when you’re out having cigarettes with clients in not being professional

- I think it contradicts it when you can’t really control your cigarette smoking.

  Interview 1

- It’s like how can I be teaching or helping clients understand this behavioural change stuff if I’ve got this antisocial negative behaviour myself?

- I felt uncomfortable even just thinking about smoking with clients.

  Interview 2

- It gives a bad impression like, you know, modelling.

  Interview 5

- But I mean you have a certain role in that situation. And I’ve seen clients today and I could have had a cigarette with them but I suppose it’s about keeping that little bit of professional business or something, which I suppose I’ll have to break down that barrier I mean when you get into that culture of doing that, you don’t think much more about it. So, um, you get into a habit I suppose.

  Interview 7

- I was always uncomfortable and felt like a hypocrite smoking in front of the clients.
• Here I am like a drug and alcohol worker and I’m saying to you ‘I don’t give a sh*t about my health and my body, and I’ve got an addiction’.

• Yeah, it’s not on I don’t reckon – you give them the wrong message

Interview 8

• Over time I’ve come to the position that it’s not a great thing to encourage so … about a year or so ago I stopped smoking at work.

• To actually engage with them that’s what engagement is about but I’ve come to the opinion ‘no’ that this is not what engagement is about and being a drug and alcohol worker I think ‘no’ we do have a responsibility to actually mirror good ways of not necessarily, its difficult that one but it’s not like I want to preach an AA sort of model but with tobacco it’s either all or nothing.

• This is not the thing to promote.

Interview 9

• If I’m having counselling with a client about some sort of substance addiction that they have and I’m smoking, it kind of discredits you a little bit

Interview 11

See Appendix 4 for further extracts that demonstrate the category of Therapeutic tool.

5.4 Reward

The third category of Reward describes the benefits derived for those staff who smoke cigarettes in alcohol and drug treatment services.

Rewards were classified as either reinforcements or punishments, where reinforcements provided a benefit or gain for the smoker and punishments provided a disincentive for the behaviour. Reinforcements included those that either made the worker feel better about themselves and their ability to do their job well, or those that made them feel more accepted by those around them.
Being a smoker in an alcohol and drug treatment service often helped the participants to feel accepted by the group. For new staff in particular, it was an easy way to join in with peers. Participants who had periods of not smoking described feelings of isolation from others, and even felt they were left out of important decision-making processes.

- It tied you in with particular people

Interview 5

Feeling accepted by others is a primary gain of smoking. Other gains included the feeling of working better with clients, by being able to spend more time with them, even if that time was unrelated to therapeutical contact. Significantly, even the opportunity to satisfy the craving for nicotine by having a cigarette at work reduces anxiety related to nicotine withdrawal and was seen as a benefit.

- It’s a habit that I have and I enjoy it.

Interview 4

Other types of reinforcements pertained to external or secondary benefits derived from smoking at work. These included the concepts of socialising, taking a break, and at times protecting yourself from clients. Being a smoker entitled you to opportunities that in some settings were not available to non-smoking staff. Participants described that having a cigarette was a way to justify a break from work whenever this was desired.

- Unofficial break is easier to take than an official break

Interview 4

Punishments were related to the pressure smokers received from other staff and concerns participants felt about the effect smoking was having on their health. Smokers were sometimes verbally harassed by non-smokers, or given ‘quit-smoking’ literature. This led to feelings of guilt associated with their smoking.
The following selected interview extracts demonstrate examples that contributed to the category of Reward for positive and negative rewards.

5.4.1 **Extracts that contribute to the category of Reward (reinforcements)**

- It’s still a quick way to fit in with a few individuals
- ‘Cause it’s really hard to stop, ‘cause half the time it’s mighty fine. It’s enjoyable
- As a new employee, you know, it’s so hard starting a new job, you know if you smoke, you've automatically got something in common with someone. And you’re automatically going to spend a lot more time with that person than you will with anyone else, get to know them better
- It gives you a chance to talk about stuff, talk about what has happened at work, and outside, um, it gives you a chance to catch up socially, like talk about personal stuff. Um, it’s good to just go outside, get away from everyone and just talk
- I wouldn’t step outside for a chat. There are other people who have quit or…they come outside just to have a chat, but I don’t do that unless I’m smoking
- Yep, and it gives you a break too, like a five-minute break from work

**Interview 1**

- When I gave up in January it, it almost felt like you weren’t a part of the gang anymore.
- I wasn’t with anyone in particular at lunch time or whatever because I was the agency nurse, so you just don’t make friends or whatever
- We used to have our morning tea, lunch, afternoon tea breaks together, we were pretty good friends, and I guess I began smoking
- Go out regularly for a smoke, even to talk about clients or whatever, not on allocated time, just whenever, and starting to smoke more.
- We were having smoke breaks and the rest of the staff were cracking up about it because why should we go down stairs for smoke breaks when they didn’t go downstairs for fresh air breaks.

**Interview 2**
• It’s just to reassess I suppose, about where I am and what’s next

• I find that dealing with clients in the office and out the back, they all have their own problems and they can be quite stressful, and as part of my own addiction I use my smoking as part of an anxiety relief myself, a stress relief for myself.

Interview 3

• I think you’d feel very out of it then if you didn’t smoke and I think that’s possibly why I started smoking.

• I found that I smoke more in a social situation. You know, I hate going outside having a smoke by myself because there’s no-one to chat with and I talk too much anyway. It’s a social thing.

• But one thing I know I’ve noticed is that the non-smokers tend to stay inside more than the smokers do

• The more tired I get the shorter the space between the cigarette and coffee.

Interview 4

• There were a group of core smokers who would go outside and smoke and my sense was that there was a lot of decision making and programme discussion going on informal which was very powerful and I wasn’t part of that – I wasn’t smoking.

• And I can remember feeling quite resentful of how often that occurred

• There was always a social content or ‘feel’ to smoking

Interview 5

• It was the pub stuff and the dance stuff and the club stuff that combined, well the pub stuff, the group of people who were opening more doors, and the smoking was perhaps just one of those things.

• So I did say that it’s a social occasion some times and yes it’s not work related, that’s when you’re with your group of colleagues

• …the quiet time out there is really almost meditative to some degree, and, um, it’s good to sit out and de-stress now and again

Interview 6
• I know one worker and he’s fine, he still goes out there, even though he wasn’t smoking. He’s probably wasn’t going outside as much, and yeah, he ended up getting back on them. But yeah, when he wasn’t smoking he definitely wasn’t coming outside as much.

• I mean there have been occasions, it’s been a bit full-on in here and I’ve been feeling a bit stressed and I’ve wanted to be on my own.

Interview 7

• Reflection time and if I don’t smoke I don’t do it.

• It gives me time to reflect. Mainly the cigarette smoking apart from my chest screaming out for the drug it’s reflection you’ve got to have a smoke to get that reflection which I need to have sort of look at what went down – what was said.

• That was the only time I sat down and just relaxed and thought and I really like that thought time

• Yeah extremely comforting

Interview 8

• [It] was wanting to be in with the core kids and that was the done thing and was worth doing that to get in there.

Interview 9

• I’d often go out and [name] will often come and say “Oh do you want to come and have a smoke?” It’s a good opportunity to catch up … I don’t see so much of her now … so it’s a good opportunity to catch up with her and have a chat.

Interview 10

5.4.2 Extracts that contribute to the category of Reward (punishments)

• you’d have to walk past and they’d all yell stuff out at you and say, you know, “disgusting habit, you’ll come back smelling, and blah, blah, blah”. So, it did make you feel uncomfortable

• …[you] get ridiculed on the way
• That apart from work or people it’s just your health. You just generally feel better not smoking.

• Apart from the smelly clothes and taste in your mouth … The first cigarette in the morning, you think you really want it and then when you’ve had it, it’s like the life drains out of you. You feel lethargic… and yet it’s meant to make you feel better. You think it does.

Interview 2

• It’s costing me physically

• It’s getting more and more things on the email “Do you want help quitting?” No, go away!! But they are appearing more and more.

• Yeah, I’ve tried to give up, because I’ve been told I had to by a doctor, so eventually I’ll have to. Cause I had throat surgery. I’ve got the beginning of COAD and I get bronchitis and I’m a skinny old I get the flu. It’s taken its toll.

Interview 4

• We were often abused each morning because people had been smoking on night duty on the balcony or in the cleaner’s room or something like that

• We were given some very ugly stupid comments from coming in and out from smart-ass accountants and stuff that just thought it was insane that nurses smoked. And there is this perception from non-nursing people that “Oh, I’m a bit surprised that a nurse smokes”.

• I think that hopefully one day I will be in a mood where I’m annoyed enough at cigarettes or I’m concerned about my health or about being around for my children or that sort of thing that hopefully I’ll do a bit more of this patch stuff.

Interview 6

• I’m hanging out for one and when I have one I’ll feel guilt for having it

• What sort of time out is it actually when you’re making your teeth yellow, your fingers yellow, giving yourself emphysema and possibly cancer? Where’s the time out?
• It’s not in that Allan Carr book because your best friend doesn’t try to kill you.

• I just don’t like the effect it has on me with the yoga. I hate the smell, the taste

Interview 8

• She’s been hassling me about it and I’ve been resistant but now I’ve come to that myself. It’s taken, like she’s been hassling me for maybe a year and a half and I know her position on it.

• This has been more about ‘I’d like to get healthier’, my partner and I want to have kids.

Interview 9

See Appendix 5 for further extracts that demonstrate the category of Reward.

5.5 Summary

Throughout the interviews the participants described the legitimate place that smoking is given in alcohol and drug treatment work. They also described the influence of variables that both increase and decrease the likelihood of smoking in their work. In some instances a category of concepts seemed to both increase and decrease the likelihood of smoking. For example, as a therapeutic tool, workers stated that smoking was useful to engage with clients, but they also were concerned about the negative modelling of smoking in front of clients. Rewards offered were mostly reinforcing but some punishments were also described.

Prior to conceptual analysis of the emergent theory for this study, a preliminary model was developed to describe the data analysis from the interviews. This is shown in Figure 5 below.
Figure 5: A Preliminary Model of the relationship between the core category – Legitimacy, and the concepts contributing to that category.

The core theme that emerged from analysis of the data was that of Legitimacy. Smoking has been legitimised in this field of work. Impacting on that core theme are variables or concepts that influence to either increase the likelihood of smoking or decrease the likelihood of smoking. There are three categories of concepts that can be said to increase the likelihood of smoking; Permission, Therapeutic Tool, and Rewards.

This emerging theory will be further discussed and conceptualised in Chapter 6 Theory Development.
CHAPTER 6.

Theory Development

6.1 Introduction

This chapter provides a discussion of the emergent theory generated by analysis of the data from the interviews. A description of the proposed theory will be provided that states the core theme ‘Legitimacy’ as well as the relationships of the categories of data to the core theme. The dimensions of the categories will also be discussed to clarify the range of the data collected.
6.2 Conceptual analysis

From analysis of the data it became clear that smoking was a behaviour that was given a legitimate place in the field of alcohol and drug treatment. The legitimacy of the practice was underpinned in three ways.

1. Permission to smoke was communicated by policies or by the behaviour of senior staff, either tacitly or explicitly, and smoking also gave permission to access various aspects of the work.

2. Smoking was accepted as a therapeutic tool which justified the behaviour as benefiting the treatment of clients.

3. There were also rewards for the staff who smoked that reinforced the behaviour.

The legitimacy of smoking also had concepts that both positively and negatively affected the behaviour. For example, smoking with a client was positively reinforced when the staff member felt it was serving as a therapeutic tool or negatively reinforced when the same staff member felt concerns for the negative modelling of this behaviour. In this model the core theme of Legitimacy was influenced by positive and negative aspects contained within the categories. This can be represented in the figure below:
Figure 6: A diagram indicating the core theme of Legitimacy and the three layers of this theme; Permission, Therapeutic Tool and Rewards.

These three underpinning categories of legitimacy are now discussed in detail. This discussion will include further exploration of the concepts contributing to these categories as well as their location within the literature.
6.3 Permission

The first of the categories that describe how smoking is given legitimacy in alcohol and drug treatment services is that smoking is permitted.

Permission was communicated by both tacit and explicit means. Tacit permission was given by way of the layout of the services that resulted in staff needing to spend much time in common courtyards, where smoking was often taking place, in order to be with their clients. Explicit permission was provided by way of an absence of no-smoking policies, smoking of other staff, especially supervisors, and the perceived need for staff to convey a non-judgemental attitude to substance use generally, and smoking in particular.

In a review of smoking in mental health settings Lawn (2005a) showed very similar themes:

The studies that informed this review found that systematic reinforcement of smoking existed by means of a series of entrenched institutional and clinical practices, beliefs and attitudes held by patients and particularly by staff. ... It was also noted that institutionalised smoking and higher percentages of staff-smoking were found in wards where the Clinical Nurse Consultant in charge was also a smoker. The converse was noted when that person was a non-smoker. (p.887)

Alcohol and drug treatment services appear to be one of the last workplace bastions where permission for staff to smoke usually continues and is supported in a variety of ways. The means of permission described by participants were grouped into concepts of Opportunity, Space, and Lack of Rules.
6.3.1 Opportunity

Opportunity encapsulates descriptions of the availability of options to have a cigarette. Participants reported having the freedom to smoke virtually whenever they chose to. One participant suggested that being free to smoke may be the main reason for their smoking; that is they smoke because they can.

Staff frequently invited others to join them for a cigarette. Supervision sessions sometimes took place over a cigarette and informal meetings were held outside while staff smoked. Participants who had previously worked in hospitals reflected on the difference in opportunities to smoke, describing the imposition of restrictions in hospitals on the time and place for staff to smoke. This was in contrast to alcohol and drug treatment services in which staff had the freedom to smoke throughout the day.

The nature of working with clients in alcohol and drug treatment services typically also provided such opportunities. Staff felt that they should always be seen to be working, which could be achieved if they were sitting with clients in the courtyard while they smoked.

6.3.2 Space

Without exception all facilities in which the participants worked provided smoking areas. Although there is a small trend at present to reduce available smoking areas in alcohol and drug treatment services (Major, 1995; Patten, Martin, & Owen, 1996), this remains by far a minority and common smoking areas were universally available for these participants. Space was also usually provided (or commandeered) for ‘staff only’ smoking areas.

Participants described an ‘unwritten rule’ that if they were smoking in the courtyard they were able to be approached by clients, whereas, if they were smoking in a staff only area they were not to be approached as the staff member was taking a break. Permission to smoke, conveyed by the provision of a smoking space, tacitly legitimised and supported the level of staff smoking.
6.3.3 Lack of rules

The presence of, or conversely the lack of rules or policy regarding smoking by staff and clients seemed to have a significant impact on both the number of staff who smoked and how often they smoked. Rules could be articulated in smoking-related policies, or, just as effectively, by comments and examples of managers and supervisors.

These rules may be implied by whether or not the manager of the service smoked, and whether they smoked with staff. One service noted a significant increase in smoking levels, without any change in smoking policy, when the manager of the service changed from one who did not smoke to one who smoked with staff. This ‘filter-down’ effect of the influence of key staff was noticed by all participants and may provide a strategy to impact upon the smoking levels of staff without the need for the changing of policy.

Staff who had worked at services with different rules about smoking described the impact of rules on their smoking behaviour most clearly. Generally, in hospital-based services and those services where staff believed managers were opposed to smoking, staff smoked less often and were less likely to smoke with clients.

The impact of rules governing smoking will now be compared to the research of the experiences of other alcohol and drug treatment services.

6.3.3.1 Attempts to introduce smoke-free policies

The literature reveals that a number of alcohol and drug treatment services have made attempts to introduce smoke-free policies, with varying success (Capretto, 1993; Kotz, 1993; Major, 1995). Sydney’s Langton Centre attempted in 1994 to introduce a complete ban on smoking in the centre’s buildings and grounds (Major, 1995). Reasons cited for this ban included concerns that smoking is a major health problem (Major, 1995). In view of the fact that their staff were in contact with a population of heavy smokers they felt they were ideally
positioned to address this issue with their clients. It was also felt that giving up smoking would help clients to give up other addictions, while allowing smoking may be sending a message to clients that nicotine is not a drug (Major, 1995). A similar change in smoking policy was undertaken by a treatment service in the United States as it was felt that the creation of a smoke-free policy tended to promote the integrity of a drug-free treatment and recovery program (Fishman & Earley, 1993).

The Langton Centre received much criticism at the time from outside parties regarding their new policy, particularly claiming a perceived discrimination against clients who wished to smoke (Major, 1995). The service has since reversed this ban. The reason provided by one of the staff of the facility for the reversal of policy was primarily due to staff rather than client difficulties with the ban. Discussions with the Langton Centre in November 2007 verified that this situation has continued to date, however staff were considering re-introducing a no-smoking policy in 2008.

In 1993, the *Journal of Substance Abuse Treatment* reported on five different chemical dependency units that had introduced smoking bans in their services (Capretto, 1993; Fishman & Earley, 1993; Karan, 1993; Kotz, 1993; Pletcher, 1993). Of these five cases, only one reported the ban was continuing (Pletcher, 1993).

A review of these attempts at changing smoking policies suggested that, in order to be successful, chemical dependency units may need to delay the implementation of these policies until their staff are entirely smoke free (Hoffman & Slade, 1993). The recommendation that all staff be smoke-free before rules can effectively be changed would seem to disqualify all treatment services in this study from making those changes.

Two reviews (Fishman & Earley, 1993; Karan, 1993) also reported a related problem to be the continued smoking of treatment staff when it is often visible to patients who, conversely, are
prohibited from smoking. When this is the case, patients and staff tended to focus more on smoking-related issues than on treatment issues. Capretto (1993) also reported that the rate of patients leaving against medical advice increased from approximately 14% before the smokefree policy to about 30% after the ban was implemented. These types of difficulties led some administrators to reinstate a smoking lounge on their units or to allow patients to smoke outside (Capretto, 1993; Karan, 1993; Kotz, 1993). The availability of a smoking lounge or outdoor smoking room, however, was felt to reduce the likelihood of smoking cessation attempts among patients (Patten et al., 1996). The focus of treatment likewise included a change from mandatory smoking abstinence to a motivational enhancement approach in which smoking cessation was optional but encouraged.

It was also noted that health care professionals who smoke may tend to undermine the treatment of nicotine dependence and the enforcement of a smoke-free policy (Capretto, 1993; Fishman & Earley, 1993; Goldsmith & Knapp, 1993). Thus, it was recommended that smoking cessation should be encouraged among staff, and resources should be provided to facilitate this (Patten et al., 1996).

Despite these obstacles, some studies reported short-term reductions in smoking rates associated with these policy changes, and highlighted the importance of the implementation of complementary policies to help facilitate changes in smoking behaviours (Fishman & Earley, 1993; Joseph et al., 1993; Karan, 1993).

Campbell et al. (1998) indicated that complementary factors that enhanced the success of such policies included strong commitment from the organisation’s leadership, gradual implementation that included staff participation and education, and a clinical emphasis on nicotine-dependence treatment instead of a disciplinary focus on policy violations.
These experiences show that although a lack of rules seems to encourage smoking levels among staff, simply changing the rules without considering other measures to support these rule changes has usually created other complications for staff and clients. Staff and clients therefore need to be involved in developing recommendations for addressing smoking in treatment services.

6.4 Therapeutic Tool

Smoking with clients was also given legitimacy as a therapeutic intervention. Smoking was often described in terms of a therapeutic tool that achieved better outcomes for the client and assisted workers by means of improving their therapeutic relationship with clients.

The legitimacy of smoking as a therapeutic tool was supported by providing a number of perceived benefits for the work with clients. These benefits were grouped into concepts of expressing empathy, rapport building, engagement, managing difficult situations, professional role, modelling, and hypocrisy of role.

6.4.1 Expressing empathy

Smoking with clients was described as a useful way to express empathy for the client’s situation. Participants in this study stated that by smoking with clients they were communicating acceptance of the client and reflecting an understanding of the problems of having an addiction.

It is useful here to compare this need to express empathy with some of the guiding principles of alcohol and drug treatment. One of the fundamental methods of providing treatment in addictions is the use of Motivational Interviewing (MI). MI is an integral concept to understand and practise when working with people who are attempting to undergo change and has been demonstrated to improve outcomes for clients and retain them in treatment (Dunn, Deroo, & Rivara, 2001), (Mullins, Suarez, Ondersma, & Page, 2004).
MI was most notably developed by Miller and Rollnick (1991) who give the definition:

Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence

(Miller & Rollnick, 1995, p.325)

The first of their (now) five principles for MI is to express empathy. In expressing empathy the worker seeks to develop and reflect an understanding of the client’s situation. Miller and Rollnick (2002) defined empathy as displaying acceptance. Smoking was seen to be a useful way to display acceptance.

6.4.2 Rapport building

In a similar aim to that of expressing empathy, there is also the need to develop rapport early with clients. Developing rapport is achieved by assisting the client to feel comfortable with the worker, that they are understood and have been heard, and that they have now started to develop a relationship.

Participants alluded to this aim of establishing a relationship by describing smoking as being a leveller. The aim was to move from a worker-client relationship to one where ‘we are just the same’.

Miller and Rollnick (2002) advise that this relationship is to be more like a partnership or companionship where

the counsellor avoids an authoritarian one-up stance, instead communicating a partner-like relationship (p.34)

Smoking was described in terms of enhancing this relationship.
6.4.3 Engagement

Another use of smoking as a therapeutic tool is the ability to use it as a tool of engagement. Engagement builds on the work of establishing rapport and communicating empathy, and extends this relationship to one where the client now feels they have been welcomed and are ‘part of the service’. Engaging clients in a service or therapy is crucial to the effectiveness of the service (Ashton & Witton, 2004).

When the aim of a worker is primarily to engage with the client, the worker will draw on their learned skills of engagement. If the repertoire of skills is limited, as it may be for those newer to the field, the worker may draw on previous life skills learned for engaging with new people. This may include smoking with others. Smoking was also described by the participants as an icebreaker to start a conversation or commence the process of engagement.

The legitimisation of smoking as a therapeutic tool is mainly described by the participants in these early stages of attempting to commence a relationship with clients or enter a social situation with them. Using smoking to develop relationships with clients, especially early in a contact, may be in response to this perceived need to follow the guiding principles and ‘be a good worker’.

Indeed, the Clinical Treatment Guidelines for Alcohol and Drug Clinicians (Addy, Ritter, Lang, Swan, & Engelander, 2000) state that the first of three phases in the case management of clients is the initiation phase which “focuses on the process of engagement with the client” (p.25). Alcohol and drug clinicians are also told that “the formation of a quality relationship with the client has a significant impact on the outcome of therapeutic treatment interventions” (Addy et al., 2000, p.28).
A survey of nurses in a psychiatric setting (Dickens, Stubbs, & Haw, 2004) found that RN smokers were more likely to report a value of smoking in the formation of therapeutic relationships and less likely to believe that patients who smoke should be encouraged to quit or cut back. (p.449)

The perceived use of smoking to enhance relationships is in contrast to Tarbuck’s (1996) findings that 72% of mental health nurses in that sample felt that smoking had no role in creating therapeutic relationships. Some respondents reported that smoking was a “potential distracter from other ways of therapeutic relationship building” (p.227). These respondents were all ‘senior nurses’ and this researcher suggests that experienced clinicians may move away from smoking as a therapeutic tool when other tools are learned.

One lesson that stuck in this researcher’s mind throughout his work in the alcohol and drug treatment field was picked up during a seminar presented at a service providers’ conference. The research being reported had compared the outcomes of the different types of alcohol and drug treatment being provided in Victoria. The speaker summarised the findings with the observation that in providing successful outcomes (or treatment methods) the type of treatment provided did not matter, but rather how well that treatment had engaged the client.

Smoking cigarettes has historically been used as a tool for socialisation or facilitating entering new social arenas (Georg, 2003). In a comment piece titled ‘A (Reluctant) Defense of Smoking’, McEnery (1999) observed that

…because all smokers are, in essence, addicts … they feel understood by each other. They have something in common with each other, and over time this develops into a kind of camaraderie …smoking seems to be one of the last bastions of camaraderie among strangers (p.2).
The perceived use of smoking as an icebreaker in the development of relationships, especially for young people, is well reported in the literature (Baillie, Lovato, Johnson, & Kalaw, 2005; Georg, 2003).

Smoking is a good icebreaker; they bum a smoke or a lighter, or begin a conversation with, ‘Oh, you smoke too.’ It’s a social lubricant.” (Georg, 2003, p.2)

6.4.4 Managing difficult situations

Another way that engaging with clients was described was in the context of managing difficult or aggressive clients. Smoking was viewed by two participants as a useful therapeutic tool to deescalate aggressive or stressful situations. A staff member who smoked may be called upon as the person to take the aggressive client outside for a cigarette in an attempt to defuse the situation.

Turning Point’s Clinical Treatment Guidelines for Managing Difficult and Complex Behaviours in alcohol and drug treatment services recommends that aggressive clients be removed from public areas to a quieter area if possible (Lee, Hocking, Smith H, & Richards, 2003). An offer of a cigarette may be one method used by participants to entice these clients to that quieter area. A search of the literature found that smoking also seems to be a traditional method used by staff in an attempt to manage agitated patients in mental health settings (Lawn, 2005a, 2005b). In these settings it was also felt by staff and patients that a lack of access to cigarettes would result in an increase in agitation and aggression (Lawn & Pols, 2003). Interestingly, in a review of 26 international studies that reported on the effectiveness of smoking bans in inpatient psychiatric settings, Lawn (2005b) found that there was no increase in patient aggression after bans on smoking were introduced.

The use of smoking as a therapeutic tool also raised some concerns for the participants. As discussed in Chapter 5 there seemed to be a paradox of smoking in this situation. The same
participants who felt that smoking provided benefits to working with clients also had misgivings about smoking with them. These concerns were categorised as the concepts of Professional role, Modelling and Hypocrisy.

6.4.5 Professional Role

Some participants were concerned as to how their professional role as a health worker may be perceived by clients and others when they are observed to be smoking. These participants compared this behaviour to how they saw themselves as a professional. In some cases the workers continued to smoke with clients despite their concerns about a lack of professionalism, while for others, this concern was enough to cause them to refrain from smoking with clients.

This perceived reduction in the professional role of staff who smoke may also contribute to the reluctance in these workers to explore the smoking concerns of their clients. Participants also described thoughts that clients had enough issues to contend with at the time without needing to address smoking as well. This feeling is also reported by the Clinical Treatment Guidelines aimed at working with clients to quit tobacco use (Lee, Coonan, Dunlop, Stephens, & Ritter, 2005) that state

Many [alcohol and drug clinicians] believe that it [smoking cessation] is not what clients want or that it is too difficult for their clients to address smoking while in other drug treatment (p.39).

Other studies have also found that nurses who smoke are less likely to address smoking with their clients (Bartscherer et al., 2005; Becker et al., 1986; Bowman & Walsh, 2003; Lawn, 2005a; McKenna et al., 2001; Mundt, Glass, & Michaels, 1995; Padula, 1992). This lack of health intervention has been cited as occurring for a number of reasons. These include workers’ beliefs that clients are not interested in addressing their smoking, they should address one substance at a time and nicotine is not a priority, reducing smoking may
negatively impact on their drug treatment outcomes, and the staff who smoke may find it personally uncomfortable to consider smoking reduction with their clients (Bowman & Walsh, 2003).

Despite these concerns, multiple studies have now found that clients are interested in addressing their nicotine use, do as well as non-clients in responding to tobacco interventions, and actually have improved drug treatment outcomes when addressing tobacco use at the same time (el Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Friend & Levy, 2004; Hatcher, 1989).

These concerns about perceptions of a lack of professionalism are given some basis by an early study that found treatment workers who smoked created negative impressions with their clients including being untrustworthy and incompetent (Schneider, 1992). Mundt et al (1995) suggest that the standard of practice for these nurses must be addressed so that “nurse smokers will be encouraged to deal with the inconsistencies of their personal and professional behaviour” (p.140).

6.4.6 Modelling

Concerns of the negative modelling behaviour of smoking were also described by some participants. These concerns of modelling differ to professional behaviour as a health worker in that these concerns were related to potential for staff smoking to influence the behaviour of their clients. It could be argued that modelling the use of an addictive substance, while working with clients to address the issues of addiction, may have an impact on the success for the clients in making changes to their patterns of substance use. Some participants alluded to this idea that treatment service clinicians need to be some sort of a role model for their clients in how to lead a healthy life and that smoking undermined this modelling.
There is evidence that modelling behaviour of staff smoking in front of clients or with clients does have a negative impact on the smoking behaviour of clients themselves (Dawley, Cortel, & Morrison, 1981; Meikeljohn, Sanders, & Butler, 2003; Strobl & Latter, 1998). Dickens et al. (2004) found that 29% of patients in a study believed that smoking by staff encouraged them to smoke. El Guebaly et al. (2002) also point out that staff of drug treatment services who quit smoking provide a positive role model for clients.

In it’s Position Statement on Smoking and Health, The Royal College of Nursing, Australia (2000) has called on all members of the college to help to reduce smoking levels and harms in the community by “act[ing] as positive role models for clients and community members”.

6.4.7 Hypocrisy of role

The third area of concern for participants in using smoking as a therapeutic tool was a slightly different concept which was labelled as ‘hypocrisy of role’. This concept grouped responses that indicated that what participants were saying to clients about addiction was the opposite of what they were displaying to clients.

This concern even extended to some participants questioning their ability to provide useful treatment services to clients when this advice was obviously not working for the staff member. The feeling that your words are not backed up by your actions with regards to smoking may be a commonality for all health workers who smoke (Bartscherer et al., 2005). This seems to be especially the case for health workers who are engaged in providing addiction related therapies (Capretto, 1993).

Suggestions have been made for health workers to overcome this contradiction in their role and increase the likelihood of them providing effective smoking related health care. Of these, the most common suggestions seem to be to provide cessation programs for staff to reduce
smoking rates (Puska, Barrueco, Roussos, Hider, & Hogue, 2005), provide education for staff to improve skills in addressing smoking related issues with clients (Hurt, Croghan, Offord, Eberman, & Morse, 1995) and to remove the visibility of staff smoking by creating policies of staff not smoking in view of clients (Fichtenberg & Glantz, 2002; Mac Calman, 2000).

Smoking as a therapeutic tool seems to provide justification for these participants to smoke while at work. The idea that the behaviour is necessary to benefit the clients gives smoking a legitimate platform for it to remain a tool for some staff while engaged in therapeutic intervention. Despite some concerns expressed about this behaviour, smoking with clients continues be given legitimacy as a therapeutic tool by some alcohol and drug clinicians.

6.5 Rewards

The third category that supports the legitimate place smoking is given in alcohol and drug treatment settings is that of rewards. Staff who choose to smoke at work received benefits that may not have been available to non-smoking staff.

Reward theory essentially states that when somebody does something (e.g. smokes with a client), the consequences of that behaviour are reinforcing (they receive a positive response), and therefore that person is more likely to repeat that behaviour. This phenomenon was most notably described by Skinner as ‘Operant Conditioning’ (1956).

In an earlier work Skinner stated that

> The strengthening of behavior which results from reinforcement is appropriately called "conditioning". In operant conditioning we "strengthen" an operant in the sense of making a response more probable or, in actual fact, more frequent (1953, p.65).

The concepts that make up the category of rewards are divided into reinforcements and punishments. Punishments were included in this category as they are one aspect of the philosophies of operant conditioning (Skinner, n.d.).
For conceptual analysis, rewards in this study were also notionally categorised according to the psychiatric terms used to denote the benefits patients may derive from an illness. Although smoking is by no means intended to be conveyed as an illness, the labels are a useful way to conceptualise the benefits (rewards) one may derive from certain behaviour.

In this case rewards were categorised as either primary gain or secondary gain.

**Primary gain:** The relief from emotional conflict and the freedom from anxiety achieved by a defence mechanism.

**Secondary gain:** The external gain derived from any illness, such as personal attention and service, monetary gains, disability benefits, and release from unpleasant responsibilities. (Abess, 2002)

Primary gain is an internal motivator achieving relief from emotional conflict and anxiety. If one achieves a primary gain then one feels better about themself. In this study participants described how smoking enabled them to feel more accepted by their peers. This is an example of a primary gain from smoking. Secondary gain is an external motivator achieving additional benefits that contribute to reinforcing the behaviour. Participants described how smoking enabled them to take additional breaks from work. The extra time-off is a secondary gain. Whether the reward received by the participant for smoking was a primary or a secondary gain, operant conditioning states that the behaviour will be reinforced and the person will be more likely to repeat that behaviour in the future (Skinner, n.d.).

In researching the phenomenon of nicotine related rewards this researcher was also confronted with an array of studies identifying nicotine’s stimulation of reward pathways in the brain (Glautier, 2004; Jarvis, 2004; Mameli-Engvall et al., 2006; Tomkins & Sellers, 2001). Researchers have found that nicotine triggers the same neural pathways that give opiates such as heroin their addictively rewarding properties, including associating an environment with the drug's reward (Walters, Cleck, Yuo-chen, & Blendy, 2005).
Nicotine … activates nicotinic acetylcholine receptors (nAchRs), which are widely distributed in the brain, and induces the release of dopamine in the nucleus accumbens. This effect is the same as that produced by other drugs of misuse (such as amphetamines and cocaine) and is thought to be a critical feature of brain addiction mechanisms (Jarvis, 2004, p.1).

Although neurological reward pathways are becoming well researched in studies exploring the addictive nature of chemical substances including nicotine (Laviolette & Van der Kooy, 2004; W. Schultz, 1998), and although the researcher intuitively feels that these pathways are related in some way to the behaviour of the participants in this study, the complex links between chemical reward pathways and human behaviour are beyond the reporting scope of this study and the researcher feels are better left as a marker for further research.

Concepts that are reinforcing rewards are:

- acceptance
- socialising
- taking a break
- stress reduction
- addiction

Concepts that are punishments are:

- pressure from others
- health concerns

**Reinforcing rewards**

**6.5.1 Acceptance**

The first area of reward described by the participants was that smoking was a means that gained acceptance with some staff. Some described it as useful when commencing at an
organisation to find something in common with the staff there. Smoking seemed to be one commonality that, if taken up, provided a fast means to establish a connection and acceptance by those staff. In some cases, the perception was that the majority of staff were smokers and non-smokers were in the minority. To join the smokers was a way to feel part of the group.

In addition to feeling part of the staff group, there were also descriptions of smoking being used to gain acceptance by specific members of staff, who had positions of responsibility or influence within the group. This was similarly described by those who had given up smoking and then felt that they had become outsiders or were no longer accepted by key players in the group.

This need for acceptance is commonly reported in studies of adolescent uptake of substance use and smoking in particular (MacDonald & Patel, 2002). Adolescents have a strong need to find commonality in their group and sharing the use of a substance is also a way to feel accepted with their peers. Studies exploring risk factors for substance use among adolescents have shown that a “high need for acceptance from others” is a strong driving force (MacDonald & Patel, 2002, p.5)

The need for acceptance and the desire to be a part of the group exert strong influence on young people to experiment with drugs.

(PRIDE, 2007, p.1)

6.5.2 Socialising

Another reward for participants who were smokers was the increased ability to socialise with colleagues while at work. Participants described informal chats over cigarettes with other staff, sometimes about clients, but often just to ‘catch up’ that they enjoyed and which they considered to be a valuable part of their work time. This process was often instigated by one staff member deciding to go outside for a smoke and asking others to join them as they didn’t want to smoke alone. One participant resented this notion of staff members encouraging
others to smoke, however they usually joined in on the requests. The need to socialise encouraged staff to smoke more which also contributed to the alienation of staff who did not smoke.

Participants also described how this was one aspect of smoking that crossed the boundaries between work and outside work. Some described the aspect of socialising outside work as contributing to their smoking and then taking that habit with them to work, while others described continuing to socialise outside work with those that they had formed a bond with while smoking at work.

Studies describing the reasons for smoking usually include a desire to socialise as an incentive to smoke (Georg, 2003; MacDonald & Patel, 2002). Smoking as a means of attempting to increase social networks is also well reported in the literature, particularly among disadvantaged or isolated groups (Edwards & Sims-Jones, 1998; Jackson, Prebble, & Rose, 2002; Jarvis, 2004). There is also evidence of existing social networks influencing the behaviour of individuals, encouraging non-smokers to smoke when those in the network or social group are predominately smokers (Holt, 2007; MacDonald & Patel, 2002).

If one lives or works together with other smoking individuals, one will more or less automatically adopt these individuals’ smoking habits. If one then tries to break out of the social structure, one will feel anxiety for not being accepted any more by the social group one is a part of (Holt, 2007, p.1).

Once these social groups had been established, the risk of the loss of socialisation then became a disincentive to give up smoking. Other studies have also commented on this disincentive (Rowe & Clark, 1999) and found that:

…nurses who wanted to quit viewed the fear of the loss of relationships (with previous smoking buddies) as a significant barrier. (Sarna, Bialous, Wewers, Froelicher, & Danao, 2005, p.87)
This aspect of participant’s working life needs to be considered and addressed in any attempts to reduce smoking rates in organisations.

6.5.3 Taking a break

A key reinforcing reward for smoking described by participants in this study was the opportunity which smoking provided to take breaks from work. Smoking was described earlier in this chapter as a tool to be with clients, but in this case smoking is now a tool to justifiably take breaks and be away from clients or other work. Participants who previously worked in hospital settings contrasted the strict scheduling of break times in hospitals with the ability to take breaks whenever it suited in alcohol and drug work. This led some participants to smoke more in alcohol and drug work than they did in previous work settings.

The idea that smoking allows you to take a justified break also became clear. Participants noted that when they weren’t smoking or in the case of other staff that didn’t smoke, it was not justifiable to just take a break and sit outside or go for a walk. Being a smoker afforded you more opportunities to take breaks without feeling like you were avoiding your work. One participant also noted that the opportunity to take more breaks at chosen times allowed her to reflect on her work and process the interactions that had taken place. When trying to give up smoking, and hence, not taking these unofficial breaks, the participant found less reflection time and increased stress about her work. This was also supported by qualitative analysis of other nurses smoking (Sarna et al., 2005). In this study a smoker had rationalised:

> If I’m not smoking, it’s probably unhealthier for me in some ways because I’m not taking breaks. (p.85)

Although participants pointed out the benefits or rewards to them of being able to use smoking as a justification for extra work breaks, studies have also reported on the negative impact of cigarette smoking on productivity of employees (Bush & Wooden, 1995; Parrott,
Godfrey, & Raw, 2000). In reviewing the economic costs of alcohol and other drugs in the workplace, Collins and Lapsley (2001) stated that:

The economic impact of tobacco in the workplace includes the diminished health status of workers, lost productivity due to smoking breaks and premature retirement and death (, p.111).

They also infer that these economic costs are then borne by the workers themselves as well as their industry. One would conclude that rewards to staff that smoke are not always rewards to non-smoking staff or their industry as a whole. Indeed, many non-smokers feel that they are disadvantaged with the relative number of breaks they can take in their work (Pucci & Haglund, 1993; Sarna et al., 2005) and that “smokers get more breaks” (Pucci & Haglund, 1993, p.122). It has also been argued, however, that simply reducing opportunities for smokers to take smoking breaks at work does not necessarily reduce this lost productivity as smokers will travel further and take longer to have a cigarette (Borland, Cappiello, & Owen, 1997). This was supported by the participants.

The relationship between smoking and taking ‘justified’ breaks from work is a debatable one that may reflect more on the nature of the work than the individual smoker.

6.5.4 Stress reduction

In a similar way to taking a break, cigarettes were also seen to provide a reinforcing reward to smokers of reducing their stress. Participants often spoke of particular incidents that were stressful and difficult to manage, or of the general stresses or anxiety related to their work. Having a cigarette was seen as a way of coping with these stresses.

Using cigarettes as a means of coping with anxiety or stress is a common finding in reviews of why people smoke (Jarvis, 2004). Many nurses who smoke state that one of the main reasons they smoke is to deal with stress or control anxiety (McKenna et al., 2001; Plant, Plant, & Foster, 1992; Strobl & Latter, 1998; Tselebis, Panaghiotou, Theotoka, & Ilias, 2001).
Given that nicotine is a stimulant and actually raises heart rate and blood pressure, this would appear to be contradictory to the belief that it has a calming effect. It may be that one of the reasons that nicotine is associated with a calming effect is that for dependent smokers, other than being able to merely take a break, having a cigarette enables the person to remove the anxiety associated with nicotine withdrawal (Jarvis, 2004). This leads us to another reward described by participants, that of addiction.

6.5.5 Addiction

The reward of ‘addiction’ encompasses participant responses that described the reason for having a cigarette as merely because they were addicted to them. By having a cigarette, the participant was rewarded with being able to satisfy cravings or reduce withdrawal symptoms and the behaviour was then reinforced.

One aspect related to addiction that did emerge from this study, was that participants described how the nature of alcohol and drug work allowed them to satisfy their cravings for nicotine more often than when they had worked in other circumstances. This added freedom to take a break when needed and have a cigarette whether you are with clients or not was described as increasing the level of smoking by participants and therefore increasing their level of dependence or addiction to cigarettes. It is interesting that working in the field of addiction treatment may, in some cases, seem to increase addiction to nicotine for those who smoke.

This category of describing why these participants smoke is consistent with most research into why people smoke (Benowitz, 1992). “Smokers smoke in large part because of the addictive effects of nicotine” (Benowitz, 1992, p.415). That is; they smoke because they are addicted. We know that nicotine is a very addictive substance and dependent users will feel discomfort if they have to go without nicotine for a period of time (Jarvis, 2004; Laviolette & Van der
Kooy, 2004). Nurses have stated that ‘addiction’ was one of the main reason they smoked (McKenna et al., 2001; A. Schultz, 2003), while mental health nurses said it was their main reason for smoking (McKenna et al., 2001). With the powerful addictive properties of nicotine, these results reflect that even though most nurses would like to quit, they find it very difficult to do so (A. Schultz, 2003; Strobl & Latter, 1998).

Along with these reinforcing rewards received by those who smoke, there were also some negative rewards or punishments for smoking.

**Punishments**

**6.5.6 Feeling pressure from others**

Smokers are sometimes ridiculed or made to feel guilty when they smoke. Participants described being pressured by non-smoking staff to quit or harassed for their smoking. Pressures included taunts about the smell, tallies of number of breaks, and receiving unwelcome emails or literature on quitting smoking. These pressures led to participants feeling guilty or uncomfortable and avoiding smoking in view of some staff or in certain places. Pressures seemed to be more prevalent in services with apparent lower rates of smoking although there was no indication that these pressures, taunts or literature reduced the smoking rates.

As societies progress to increase rules limiting smoking areas and situations, smokers are increasingly exposed to workplace and social pressures to stop smoking and often feel on the outer in these situations (Jackson et al., 2002; Nuttall, 2006). It is not clear whether this negative pressure put upon smokers is generally effective in influencing smoking habits and in some cases it has been shown to contribute to the stress that increases smoking (Williams et al., 2002).
6.5.7 Health

Smokers also received the punishment of an increased concern about the health implications of their smoking. Generally those participants who described health concerns had been smoking for longer and were older. Concerns were expressed both for the negative health effects felt from smoking and that they had felt healthier during times when they were not smoking.

Health concerns are commonly reported as reasons for why nurses want to quit smoking (McKenna et al., 2001). Concerns about health generally increase as smokers get older and have smoked longer (Suranovic, Goldfarb, & Leonard, 1999). This may be due to the delayed cumulative health effects of smoking and natural concerns of health due to age (Suranovic et al., 1999). In younger smokers, health concerns are usually not reported as reasons for stopping smoking (Georg, 2003). The research on the attitudes of nurses who smoke has shown that they are well aware of the health implications of smoking, that quitting is beneficial and achievable, but this is usually not enough of a driving force for them to give up smoking (Nagle, Schofield, & Redman, 1999).

6.6 Summary

This chapter has provided a discussion of the ways in which smoking is given legitimacy in alcohol and drug treatment services. The three categories of permission, therapeutic tool and reward that contribute to this legitimacy were discussed and the concepts that form these categories were explored. Each concept was also compared to relevant literature.

The final chapter will provide a conclusion regarding the proposed theory and make some recommendations to possibly address this issue.
CHAPTER 7.

Conclusion and recommendations

7.1 Conclusion

In summary it appeared that the legitimate place smoking is given by staff in alcohol and drug treatment services contributes to the prevalence of smoking in these services. This legitimate standing was achieved by the different ways that smoking was supported by some staff and their services. These three ways of supporting the legitimacy of smoking were that: permission to smoke was given, smoking was seen as a therapeutic tool for clients, and staff who smoke were reinforced in this behaviour by rewards.

Permission to smoke was communicated by the opportunity to smoke at work, either with clients or without, at any time during the day, the provision of staff-only as well as common smoking areas, the absence of no-smoking rules and policies, the encouragement of senior
staff to smoke with them, and a perception that the service should be seen as non-judgmental about drug use and conveys this through an acceptance of smoking.

Smoking was seen as a therapeutic tool that enhanced the treatment provided to clients. Some smokers saw cigarettes as a tool to convey empathy, develop rapport, promote a feeling of engagement and manage difficult clients. Alongside these benefits, smokers also described some concerns of negative impacts for clients of staff smoking. These included concerns about the professional role of a health worker, the impacts of modelling smoking for clients, and the hypocrisy conveyed of workers in the field of addiction treatment using an addictive substance.

Smokers also received some rewards to reinforce their behaviour. There was a benefit of feeling an increased acceptance by other staff of the service. This was particularly felt by new staff attempting to find a place in the service. Those who gave up smoking felt that they lost some acceptance by other staff. Smokers also received rewards of increased socialising, work breaks, a reduction in perceived stress levels and the opportunity to readily satisfy cravings for nicotine that reinforced the smoking behaviour.

Punishments, or negative rewards, for smoking were also described. These included being recipients of harassment or pressure from non-smoking staff and concerns about the impact of smoking on their health.

These three categories of permission, therapeutic tool and rewards contribute to the legitimacy of smoking in this field and support the continued presence of this behaviour. Each category had both positive and negative influences on this legitimacy but the positive influences seemed to outweigh the negative influences and maintain its presence.
7.1.1 Proposing a Substantive Theory

Consistent with the principles of generating a Grounded Theory, the theory proposed to describe the data gathered in this investigation is the basis of a “substantive theory” (Strauss & Corbin, 1990, p.174) for this area of inquiry. A substantive theory provides a *contribution* to a more formal theory of this phenomenon (Strauss & Corbin, 1990). The emergent theory proposed in this study is therefore not intended to be an overall explanation of ‘The reasons why nurses and others who work in the field of alcohol and drug treatment smoke cigarettes?’ for all alcohol and drug workers. Rather, the findings of this study propose to describe the reasons why nurses and others who work in the field of alcohol and drug treatment smoke cigarettes *for the participants included in this study*. It is intended that these reasons may then contribute to a more formal theory that may describe this phenomenon in a larger context.

7.2 Implications and Recommendations:

Given the proposed theory above it would follow that to reduce smoking levels in these services we need to reduce the legitimacy of smoking. Reducing legitimacy should include measures that reduce permission to smoke at work, the perceived therapeutic nature of smoking and the rewards for smokers.

7.2.1 Recommendations to reduce permission

Reducing permission to smoke may be achieved firstly by reducing the tacit and explicit ways in which it is communicated. Permission to smoke is communicated by the provision of opportunity and space, and by a lack of rules about smoking at some services. To reduce permission services may consider developing policies that clearly communicate a position on smoking at the service. Aspects of the policy may include factors that limit opportunities, smoking areas or places or occasions where smoking is permitted. Previous policies have included ‘no-smoking on or near the premises’, not in view of clients or visitors, only at meal
breaks, and other restrictions. By reducing permission, services would reduce the perceived culture of smoking at their organisations, which has been shown to reduce rates of smoking by staff (Fishman & Earley, 1993; Joseph et al., 1993; Karan, 1993).

Previous successful attempts to introduce smoke-free policies at alcohol and drug treatment services have relied on staff involvement and input into the development of the policies and a graduated, extended process of introduction. Success would be dependent on staff feeling that they have introduced the policy rather than it being forced upon them.

7.2.2 Recommendations to reduce the perceived therapeutic tool

Smoking was described as a therapeutic tool in this field. Staff, therefore may benefit from training in techniques of engagement, expressing empathy, and managing difficult clients that do not involve the use of cigarettes. Participants who had developed these increased skills over time in the field, and were once using smoking to aid interventions, were now employing skills other than smoking to achieve therapeutic interactions. Providing means for staff of alcohol and drug treatment services to gain these skills sooner may reduce the current reliance on smoking as a therapeutic tool.

7.2.3 Recommendations to reduce the rewards for smoking

Finally there may need to be methods developed to counter some of the reinforcing rewards for staff who smoke. The introduction of measures to reduce permission to smoke, as stated above, would counter some contributors to what is perceived to be a culture of smoking at services. This would also assist in reducing the number of rewards that reinforce the smoking behaviour of some staff. Rewards such as taking breaks, increased socialisation, and acceptance by other staff would be reduced if services moved towards becoming more smoke-free.
Other strategies to reduce the reinforcement of smoking may include measures that reward those staff who are not smoking or trying to reduce their smoking. These may include the setting up and encouragement of quit-smoking support groups that can meet during working hours. Support groups provide acceptance, socialisation, stress reduction and a break from work that may reinforce the change in smoking behaviour.

It must be reiterated that staff need to be consulted and involved in the planning and implementation of any of these changes prior to them being introduced to increase the likelihood of them being effective.
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Appendix 1 Consent Form

RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

FACULTY OF Life Sciences
DEPARTMENT OF Nursing and Midwifery

Name of participant: ____________________________
Project Title: The reasons prompting nurses who work in the field of alcohol and drug treatment to smoke cigarettes.

Name(s) of investigators: (1) Ray Stephens  Phone: *** ****
(2) Phone: ____________________________

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The confidentiality of the information I provide will be safeguarded. However should information of a confidential nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to me. Any information which will identify me will not be used.

Participant’s Consent

Name: ____________________________ Date: ____________________________
     (Participant)

Name: ____________________________ Date: ____________________________
     (Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.
Appendix 2 Plain Language Statement

ROYAL MELBOURNE INSTITUTE OF TECHNOLOGY
FACULTY OF LIFE SCIENCES

Information for Participants

Project: The reasons prompting nurses who work in the field of drug and alcohol treatment to smoke cigarettes.

Investigator: Mr. Ray Stephens
Master of Nursing by Research Student
Royal Melbourne Institute of Technology (RMIT)
Faculty of Life Sciences
Department of Nursing and Midwifery

I am a registered nurse working in the Education and Training Unit at Turning Point Drug and Alcohol Centre. I am currently researching smoking amongst drug and alcohol nurses as part of the requirements towards a Master of Nursing by Research at RMIT.

You are invited to participate in a qualitative research project to address the question:
"Why do drug and alcohol nurses smoke cigarettes?"

Study Aim

The aim of this project is to identify those factors that contribute to smoking for nurses in the drug and alcohol field.

A qualitative study will be undertaken to explore the question:

What are the reasons prompting nurses who work in the field of alcohol and drug treatment to smoke cigarettes?

The objectives of the research are:

- To generate knowledge regarding factors affecting smoking amongst nurses working in the drug and alcohol field
- To allow this knowledge to guide future policies aimed at helping to reduce smoking rates for nurses in this population.

Participants

The inclusion criteria for the participants will be:

- Registered nurses who currently smoke cigarettes at work and;
- Those nurses who commenced, or resumed smoking, since commencing work in drug and alcohol treatment.
Information will be gathered through the process of interviews. The interviews will be conducted at a mutually agreed time and place that promotes comfort and confidentiality. Interviews will be audio taped and later transcribed by me.

The interview will begin with broad open-ended questions to explore your thoughts about the process of commencing or resuming smoking and what may be the reasons for this. Subsequent questions will explore the issues that develop during the interview. It is expected that interviews will take one to one and a half hours to complete.

At the conclusion of the interview you may be asked if you are able to suggest any colleagues that satisfy the inclusion criteria for the study and may be approached to participate in the study.

**Anonymity and Confidentiality**

To ensure your anonymity and confidentiality all information collected in the study, including the taped interviews, will be stored and locked in a cupboard in my supervisor’s office for at least seven years after completion of the study. All data and tapes will be destroyed after that time. The only people able to access the data will be my research supervisor and myself.

The interviews and their transcripts will remain anonymous to you and your agency, and any identifying data for you or your agency will be changed to ensure anonymity.

You are able to refuse to answer questions or withdraw from the interview at any time without prejudice. You may contact me later to clarify or change your responses, or have the interview removed from the study at any time prior to analysis of the data.

If it is required after the interview you will be offered access to debriefing facilities at Turning Point Drug and Alcohol Centre. This process is anonymous and confidential. You may also be given resources for follow-up information regarding smoking and quitting smoking if you request it.

The results of the research will be published as a minor thesis and will be made available to you if requested. These results may be passed on to your agency.

Should you require further details about the study, either before, during, or after the study, you may contact me by telephone on *** *** or by email at [email address]

*This study has been reviewed by the Faculty of Life Science's (i) Higher Degrees Committee, and (ii) Human Research Ethics Committee. Should you wish to discuss the study with someone not directly involved, in particular in relation to matters concerning policies, information about the conduct of the study or your rights as a participant, or should you wish to make a confidential complaint, you may contact the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745.*
Appendix 3 Extracts from interviews that contribute to the category of Permission

Interview 1

- You said it's handy being outside. Yeah that’s right. I wouldn’t step outside for a chat. There are other people who have quit or… they come outside just to have a chat, but I don’t do that unless I’m smoking
- it’s not so ‘in your face’ so much. No, you don’t. I don’t notice people, only when I go out the door and see them there. Yeah! Oh, that’s good. So maybe having people go outside to have a smoke, somewhere out of sight, maybe that reduces the culture Mm! And it doesn’t encourage people to smoke as much?: Yeah, and makes the number of people who actually smoke feel a lot less Because nobody... people just disappear. Yeah! That’s right! Yeah

Interview 2

- Go out regularly for a smoke, even to talk about clients or whatever, not on allocated time, just whenever, and starting to smoke more.
- we’d have to come down stairs and smoke outside with them, because you weren’t allowed to smoke inside
- You had to physically walk down the stairs and leave.
- It was just a really different feel to work at a hospital to, say, this place. You sort of felt like you shouldn’t be smoking.
- I’m not really sure it was because of the manager or whether it was because it was a hospital and there were all quite ill people around.
- I don’t like smoking in public. I don’t smoke in my car where I used to smoke in my car the first time. I don’t smoke in the house, although I’ve never really smoked in the house. If there’s particular family and friends around I don’t smoke at all. And it’s sometimes not even a choice it’s just that I don’t think of it. Because they’re non-smokers. So yeah, it’s sort of like I do pick times when I think about it and places where I’m comfortable smoking.
- The other balcony that we used to smoke on, one of the anti-smokers won’t let us go out there because she says it filters in through the door and she can smell it. AH, I felt uncomfortable on that balcony because we had to go past the research people to actually open the door up and get out on the balcony and I felt really I was intruding on their space and um, I felt uncomfortable out there because yeah I knew they were anti-smoking. They were standing there; it was like a judgement was being made. Probably wasn’t it was just my perception of it
- The other balcony that we are on now you have to walk past two offices. One of the offices the person smokes and the other one we don’t see anyone. So this is more like you can sneak out.
- I think initially, I would have smoked more. Everyone smokes, not everyone, but a lot of people smoke here.
• I didn’t smoke as much at work because only one of the girls smoked and it was frowned upon.
• There were less smokers. They had, it was a majority rules sort of thing.

• I didn’t smoke as much at work because only one of the girls smoked and it was frowned upon.
• The manager didn’t smoke and she absolutely put her foot down about people going down stairs for smoke breaks. So, if you did smoke it was only at lunchtime.
• we weren’t out the front we weren’t allowed to be seen smoking. We weren’t allowed to drop butts. The manager was just anti-smoking, hated it
• She wouldn’t say you weren’t allowed to, and she’d make a joke of it sometimes and wave her finger and say “put that cigarette out” and carry on but, I think that sort of stopped us smoking a lot
• we were having smoke breaks and the rest of the staff were cracking up about it because why should we go down stairs for smoke breaks when they didn’t go downstairs for fresh air breaks.

R: Yep. Were they serious about that?
K: Yes. So she made it a rule that we weren’t allowed to go down for smoke breaks. You could smoke in your breaks, like your morning tea, lunchtime, afternoon tea.
• I assume she was with them because she was anti-smoking anyway
• In the end you just got used to not doing it. And you just didn’t go down willy-nilly.
• the manager, who was anti-smoking, she was very much ‘you never’ she really preached it, ‘you never smoke with clients’. There was a detox unit over the road, the withdrawal unit, and a few workers were caught smoking with clients over there and she reprimanded. You know, she threatened all sorts of stuff and it was just forbidden. You weren’t to smoke with clients. So, I think because I learnt that early or something was taught to me early, I just never picked up on doing that.
• It was just a really different feel to work at a hospital to, say, this place. You sort of felt like you shouldn’t be smoking.
• the new manager that we got at Box Hill, the manager that hated smoking, she left. And the new manager came on, he didn’t hate smoking, he wasn’t a smoker but he wasn’t anti either. But we still continued the same practice.
• we were having smoke breaks and the rest of the staff were cracking up about it because why should we go down stairs for smoke breaks when they didn’t go downstairs for fresh air breaks.

R: Yep. Were they serious about that?
K: Yes. So she made it a rule that we weren’t allowed to go down for smoke breaks. You could smoke in your breaks, like your morning tea, lunchtime, afternoon tea.
• you go out for lots of breaks, or you go out to talk about a client and it would be outside having a smoke. So my smoking increased, um, and I’d be going home smoking more.

Interview 3

• You just walked off the kitchen into the staff dining room there, and it was just one haze of smoke. We used to smoke in there all the time, we used to play cards in there and puff away. After that I just kept on smoking
• You were allowed to smoke in the, it was in a Hospital in Heidelberg, we were allowed to smoke in the kitchen/dining room
• There’s two areas, there’s actually no staff smoking area at [organisation]. There’s two courtyards. There’s the back courtyard, which is the general courtyard and everybody uses that, that’s where there’s a shelter, and 90% of the time, there’s at least five or six people out there smoking, cause they tend to chain smoke, you’d be very surprised how much they smoke in there. Then there’s the little courtyard, which is the girl’s courtyard which goes off one of the girl’s bedrooms, and there’s a little shelter there, but that’s strictly for the girls. But I suppose half the time they’re out in the general courtyard anyway, so that’s where we tend to go and have our lunch and our smoke, and escape. [Name] doesn’t like us using that because it does go through to the girl’s area, and I’m always conscious of that because if there is a girl in there that’s not well, I tend to go and smoke more out the back. The only other place to smoke is out the front near the front door and that doesn’t look appropriate either. There is an ash tray out there close to the door.
• [Name] banned it but then, I agree with her that it looks inappropriate standing out there smoking if you’re on night duty
• It’s more of a fact that it just gets me out of the office for five minutes. I can walk outside, have a cigarette in my hand and I know no-one’s going to bother me. If a client comes out I can say, “I’m having a smoke”. I can actually get away with that.
• You’re free game. If you walk out the back without a cigarette in your hand then there’s four or five people around you, saying “I want to see the doctor” or “I need some medication or I’m going to kill her”. That’s just because you’re free game, you’re a staff member, they see your keys there, especially because you’re the nurse who gives the medications. You’re out there, they want you. You walk out and you’re having a cigarette, it’s “O.K. I’ll see you in a couple of minutes”. So that’s sort of like a protective barrier when you go out the back sometimes. As well as sitting down with them, having a smoke with them, it can also be a protective barrier. Then you can go to the girl’s courtyard where there isn’t any clients, basically I suppose it’s an escapism where you say I’m going out the back can you look after the place for a few minutes? Same thing, to get away from them for five minutes, you need that little bit of a break, but also it’s your own time just to reassess your thoughts. When I’m out there I’m usually still thinking about what’s happening in the unit, how the dynamics are going, who’s interacting how, so I’m still thinking about work when I’m having it. It just gives me that space to step back and think about what’s happening during the day, and what to do next.
• I feel like I should be doing something, because I should be doing something. There’s always things to do, that you’re supposed to look like that. It’s just to reassess I suppose, about where I am and what’s next.
• I was still going out there, occasionally, you need to, just to get away from everything. Every half hour lunch break you need to get around and walk around the block rather than being stuck inside all the time
• You sort of have that in the staff room which is not overly accessible as you have to go right up the stairs, so we can do that if we want to, but no-one hardly ever uses it. To go up there you really have to take an official break. Even though there’s a phone up there, you’re totally separated. Sometimes that’s not appropriate, you need to be able to be on hand.

Interview 4
• Then I went onto psych nursing, and the same thing happened, you smoke in the courtyard with the clients, patients, whatever, and in D&A you know you never even think about giving up. It’s a habit that I have and I enjoy it. It’s costing me physically
but then it causes me to having forced breaks. Whenever things get stroppy at work, and you’re flat out and need a break – “coffee and a fag” – that’s probably how I use it in D and A.

- You tend to do more smoking with them while you’re talking. And I find too with D&A when I was in Brisbane working in D & A, I’d often sit out the back with a client, and I’d talk over a cigarette, or two or three or whatever.

- Especially if they’re separated from the group and they’re sitting on their own it’s a really good thing, well it works for me a lot of the time, you know, there sitting there, there’s obviously something going on in their head, they’re not feeling comfortable or whatever. I just say “do you mind if I have a cigarette with you?” and they say “no”, and you might just sit there and have silence, but you also might find out that they’re feeling really bad and they need medication, they’re withdrawing really badly or you might find out something about their history, it could be anything.

- But I always thought, no, I’d just keep a spare packet in my bag, in case someone ran out and needed them, you know what it’s like working in D and A.

- They could say, “no, you’re not going to smoke in the building” But they couldn’t stop me going around there. It sort of makes you more rebellious, although I probably, I think if they did it, I’d find a way. And I think somebody else would too. It’s an informed choice thing, and informed consent, and if you don’t want to stop smoking fine but, but if they tried to push that on to you then all hell would break loose because a lot of the public nurses smoke too, and they haven’t even got the time that we have to, cos they have to go down the lift, go down to the ground floor go out the front, and their work load is just as heavy, so I don’t know. If they say, “well you’ve got to go”, okay, so I’d have to find a job somewhere else where I can smoke.

- Because when I started nursing, everyone smoked. Everyone full stop. Even the cooks smoked, and they smoked while they cooked. I think you’d feel very out of it if you didn’t smoke and I think that’s possibly why I started smoking. But I don’t think you can just say that drug and alcohol nurses smoke.

- There’s always been provision made in most of the hospitals that I’ve worked at for smoking. Cause I’ve always worked in psych field or alcohol and drug, and it might be that perhaps those streams of nursing smoke a lot.

- And I know a lot of them drink more, and whether it’s got anything to do with the nature of the job. I think probably it has. See I’ve always been in those areas, so always had areas where we can smoke. And it’s only lately that people have started saying, well if you want to stop, we can help you, and making it sound like a threat. “You all stop and we will help you”.

Interview 5

- also the handovers, everybody smoked so you’d have maybe eight nurses in a room everybody’s chuffing away in a small cubicle type room…

- I think it’s very difficult when you’ve got somebody that’s a reasonably heavy smoker and they go on an outing, like generally they do an outing an all day outing on Thursday and they leave here at say 0930, 10 o’clock and get back here at two or three. And they’re expected not to smoke the entire time. I think that’s very difficult.

- Yes, and there were a couple of ex-smokers long term ex smokers one being the manager, well acting manager at that time, who was part of that group who was quite happy to stand out there.

- Yeah, another senior member and the acting co-ordinator was smoking and then a group of other people from the team that were very close – yeah. So it was, I’m not
sure whether it was, well from my perspective there was a sense of alienation it involved when they’d duck out for a smoke, and they’d go off for lunch, this group.

- …and any cultural thing is always going to come from the top down.

**Interview 6**

- and it stimulates a bit of a culture in here which I don’t like that much, but um, if someone goes for a cigarette they sort of grab 3 people with them as well, cause they don’t like to be out there by themselves.
- But you almost haven’t quite got the same choice and I know you have, but I don’t like people coming to have a cigarette with me because if you want a cigarette go and have one on your own bloody volition. But you only need a little whiff of a suggestion and you’re happy to have another cigarette even if you’ve only just had one.
- So I did say that it’s a social occasion some times and yes it’s not work related, that’s when you’re with your group of colleagues
- I’ve worked in hospitals where you can’t smoke and you’ve found ways around that. It was annoying but it wasn’t the be-all and end-all. Um, there’s a policy that you’re not meant to smoke in the cars and stuff like that, obviously. Most of those things are ignored by most people.
- It’s such an entrenched culture
- So, I don’t know if you’ve ever been in one of those rooms but they generally tend to have a little fan or something blowing and I’d prefer to just have one of my own than smoke everybody else’s. I don’t work in that area obviously anymore but that was huge actually. Psych nurses, their environment is probably even more full-on than drug and alcohol stuff.
- And I haven’t really thought about it like that but for some people it’s an enormous issue for them. So I suppose you either get used to it or you don’t work.
- That very much opened the culture of you’ve got an 8 hour shift, I’m more than likely spending 6 hours of it in the courtyard. And most of the time was smoking.
- In those sort of unstructured jobs where you can really have a smoke break any time of day that you wish, as opposed to that 15 minutes of rush down the stairs in your regulated break, you do smoke more often.
- I mean it wouldn’t matter on the ward if you were busy or not busy, you couldn’t leave the place. You only had that time anyway

**Interview 7**

- I know one worker and he’s fine, he still goes out there, even though he wasn’t smoking. He’s probably wasn’t going outside as much, and yeah, he ended up getting back on them. But yeah, when he wasn’t smoking he definitely wasn’t coming outside as much.
- There is a difference, here most people smoke with the clients, and most, the majority of staff smoke. And in the adult unit, yeah they smoke out there with the clients as well
- I mean I think its part our fault too, I mean, it’s, you know, more accepted I think. And if you do, well you have to so there has to be an area, and I mean we all know the health risks and all that sort of thing, but when you’re working with a client group where people are using substances and things like that, I think it’s just more acceptable I mean you’re not going to say anything about people smoking…
• There is that culture as I said before, you know most staff here smoke, it would be difficult.
• I’m possibly smoking more because I can smoke in my area, you know it’s not recommended that when you work in the hospital you smoke on your breaks, you don’t leave the ward and that sort of thing. I’m probably smoking more because of that.
• I think it’s probably in this field more accepted, and I probably smoke more because I’ve got more opportunities

Interview 8

• And the majority of clients smoke and you’re in their houses and it’s full on and you sort of you’ll stop and you’re outside and have a smoke
• Reflection time and if I don’t smoke I don’t do it.
• People smoke to get remove themselves from their work. That’s how they get through their day ‘oh ten o’clock, I’ll go and have my smoke, twelve o’clock I’ll go and have my lunch and have another smoke, oh two o’clock I can get out’
• It is a stressful job. It’s high risk
• It’s stressful.
• Yeah, it depends what’s going on but if they’ve got a knife and is about to pull an armed robbery I’d say ‘I really do think you should have a cigarette’. They’ve got a knife up against my throat I think a cigarette’s a good option. I think one cigarette
• So stress and alcohol are my big triggers
• But I really think it’s very difficult for someone to give up smoking – me anyway, if they’re in the middle of a stressful situation. They need to have a bit of peace.

Interview 9

• A lot of the guys smoked there wasn’t any smoking legislation so you could smoke in the place and sit down with the guys have a smoke and a chat.
• part of my justification for experimenting with every drug that there was, was around ‘I want to be a drug and alcohol worker some day so I want to experience that so I’ve got understanding’ to impart
• The only reason I would smoke with clients was because they were having a fag too. So it was just appropriate like that…

Interview 11

• [Name] will often come and say “Oh do you want to come and have a smoke?” It’s a good opportunity to catch up because [Name] was my supervisor when I did my placement so quite a good rapport there.
• I think the first thing I noticed in this place when I switched over from where I was working was that we’re a pretty non-conservative environment. In terms of presentation, like how we dress, and how we are with each other, and people’s sense of humour, and there seems to be, and I think probably for all the reasons that you mentioned, the dynamics here seem to be different to where I worked before and that’s part of what I really like about […] is that it is kind of laid back and I think all that stuff, not that I’m saying that conservative people don’t have any fun and don’t smoke, they do, but I think you’re right, working in this kind of environment fosters a kind of leniency with that stuff where people are more comfortable with doing it. …it would seem really ironic if someone came up to you and shook their finger at you
about your smoking when it’s all about starting where the client’s at. You know, like when you’re working with clients.

- Yeah, my smoking increased when I was on placement here. I wasn’t smoking as much when I was at uni and I’d often have periods of non smoking it wasn’t a big deal. When I started my placement here it actually increased and I would go and smoke on the balcony. When I started my placement. Most of the girls upstairs were smoking so yeah, it kind of increased.

- I was here for 8 hours everyday in an office with the same fixed set of people and the people pretty much collectively would get up and go for a smoke together. And I get along pretty well with the people here so it was a good opportunity to stop and have a chat and have a laugh and even get away from the room, away from the same 4 light blue coloured walls for a period of time. It was a good excuse to get out of the building really, for a moment or two.

- If I’ve had a session or I’ve been running around doing something that takes a bit of time, or it feels like I’ve been running around for a while, then I’ll go back to my desk and feel like one. And that’d be like taking some time-out.

- It’s not uncommon to hear of people that are abused or whatever, so your tolerance in general goes up. So there’s less shock value and I suppose with that comes a kind of relaxing with ‘yeah, you smoke, that’s cool’.
Appendix 4 Extracts from interviews that contribute to the category of Therapeutic Tool

Interview 1

- I try not to smoke with clients. I always do that. I never, hardly ever smoke with clients
- it’s setting a bad example
- I think that it’s really irresponsible to be doing it in the workplace with clients because if they see you smoking then you are setting an example for them
- Because, I mean, it’s hard for me to give up smoking and, um, I struggle with that all the time, [Mmm], and you see people who struggle with other drugs and, you know, you go through strategies with them, etc, etc, and they’re strategies that I have trouble doing myself
- you do get some appreciation for how difficult it can be
- it’s setting a bad example
- I don’t think it’s a very good look. I don’t think it’s very responsible for a professional
- Well your relationship with them, my relationship with them is a professional relationship, and I think it’s overstepping when you’re out having cigarettes with clients in not being professional
- Your role somehow is altered in some way
- I felt uncomfortable even just thinking about smoking with clients.
- It makes my job more complicated
- *So it’s not comfortable smoking in the courtyard?* Oh, it’s, if my client is there, no. (GUILT?)But if there are other clients I don’t really worry as much. So *you prefer to go outside the building?* Mmm  *So why is that better than the courtyard?* Because you’re not observed smoking by the clients
- Because every time you go through those strategies you wonder ‘are they effective?’ and here I am as a drug and alcohol worker encouraging people to think about what strategies might work and, you know, giving them encouragement to do these things, at least in part, and, well, it doesn’t work (laughs)
- I’ve become a health professional in some ways and, um, you know that the danger is just around the corner and yet you continue to smoke. So that’s why I think the topic is sensitive
- I think it contradicts it when you can’t really control your cigarette smoking. Not if you’re just smoking occasionally or…
- I feel a bit guilty or, um, I don’t know, but it doesn’t effect my ability to work with clients
- I’m surprised working in drug and alcohol, how many people smoke. I think there would be less, because they should know of the dangers *And they should give up?* Yeah and all that stuff, yeah.

Interview 2

- I was planning this, ‘where am I going to get a cigarette’ from and, um, all the stuff you teach your clients. That’s what I felt like a bit, like a client.
- It got to the stage where there was no return. I was just hell-bent on ‘scoring’. So I did
• the stopping is easy, this is another client thing, the stopping is easy going through the withdrawals and all that sort of stuff, being motivated to stay stopped. It’s down the track when you think you’re O.K., that you can have one more, and you start again.
• It makes me understand more about what they do go through. Um, it’s really funny though, because a lot of the clients knew that I’d stopped smoking, most of my long-term clients knew that I’d stopped smoking.
• well, when we were talking about cigarettes or using it as a comparison about quitting, I’d self disclose a bit and they were really ‘Oh that’s great’ and it would be a talking point initially when we would first come to a session they’d say ‘oh, have you still stopped smoking?’ and it was like they were really proud.
• It was like switching roles for a bit. I thought oh, not that I’d ever say I was disappointed to them but I just thought ‘gees, I’m under the microscope here’.
• An advantage to smoking with a client is that your engagement skills can be hastened because you’re doing something socially together
• So once I do manage the relapse and get myself into the position of not smoking again I can talk to them about that as well.
• You know, a relapse is O.K. It’s starting the whole cycle of change again. So you can incorporate it into your sessions. If you know your clients well enough and these ones I do. These are long term ones. So it gives you an association with them.
• An advantage to smoking with a client is that your engagement skills can be hastened because you’re doing something socially together
• it just gives you that familiar ground to start with. So, it may relax clients more. It may make them feel not so client – worker orientated.
• The smokers at Wellington House where I was or at the detox unit where I was, um, the workers there who did smoke, they would always go for the argument that it helps the clients relax, helps them engage
• the stopping is easy, this is another client thing, the stopping is easy going through the withdrawals and all that sort of stuff, being motivated to stay stopped. It’s down the track when you think you’re O.K., that you can have one more, and you start again.
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• It was like switching roles for a bit. I thought oh, not that I’d ever say I was disappointed to them but I just thought ‘gees, I’m under the microscope here’.
• It gives you an understanding, an empathy of what they go through. So I suppose if can you look at it that way it’s a learning thing, for me and for them.
• all the stuff that you tell clients about um, maintenance stage and you can get through it and relapse prevention stuff that, like I was preaching a whole lot of bullsh*t.

**Interview 3**

• I don’t set out to instigate it, sometimes I do
• So I’m using it as an excuse to get away from them for a few minutes and using it as an excuse to sit down with them as well.
• You need it because people will leave because of it. Someone will leave detox because they haven’t got cigarettes.
• So we’ll worry about that one later on, we’ll concentrate on one substance at a time. So I give away a lot of cigarettes.
• If someone’s really anxious, having a bit of an outburst, about to hit someone, quite often, “come out the back mate, have a smoke”. So we’ll stand away from the other clients and have a smoke together, it brings us down so we have something in common, rather than being nurse or welfare worker, junkie, you know. I smoke too, we both smoke, so it gives us something in common as a starting point where I can help deal with them at the time.
• I find I need something that helps with them to bring to a more level, feel, not being, not using drugs apart from nicotine, caffeine and alcohol.
• Just by offering that cigarette, it’s like “thanks mate”, and taking it, and sitting down together while you’re having that cigarette, they’re far more open, rather than having someone who’s having a really agitated experience to come and sit nicely in the office with you and explain their feelings to you, it very rarely happens.
• It works better, as a one on one, sit down together having a fag.
• Quite often at a weekend I’ll just buy a packet of 50 Horizons to have on hand in case people do run out. I don’t make a big issue of it or anything like that, that’s just my charity. It’s probably not very appropriate when you think about it, my charity is buying cigarettes for people.
• You need it because people will leave because of it. Someone will leave detox because they haven’t got cigarettes.
• I don’t know what it is but it’s something about it that brings you a little bit closer together. Same thing as a therapeutic touch on the shoulder. That connection brings you a bit closer. The same thing with a cigarette as the therapeutic touch.
• When I was giving up last year at [my work], I wasn’t using any interventions at all, and I went out the back courtyard where I do quite a lot of my usual, I was avoiding it like the plague, but when I was sitting in the kitchen with people, it’s more public, I suppose in the courtyard, you’re sitting in the area where it’s public, but you can always go around the corner where it’s private and have a chat. So I wasn’t doing that as much all the time when I was giving up last time.

Interview 4

• I find too with D&A when I was in Brisbane working in D & A, I’d often sit out the back with a client, and I’d talk over a cigarette, or two or three or whatever. But you’d often get more out of them and find out what’s going on if you could sit down and have a cigarette with them.
• it’s also a really good thing to have if you want to break the ice with someone who’s being really difficult, and who is a smoker and most of our people are, offer them a cigarette, “let’s go outside for a smoke” and you find they’ll open up and tell you more outside having a cigarette than they will like say in an interview room, because they feel uncomfortable in there.
• I’d say “Oh well come and have one with me anyway”. And often they’ll come with you and they don’t smoke but you do, and it’s just, I don’t know, maybe it just seems to be a situation, maybe they see you as being more relaxed, and it’s more like a one to one thing, and they’re more prepared to tell you whatever they want to tell you and get it off their chest.
• Oh, probably the same way, except I’d say “come out and have a pretend smoke?”
• I don’t know, because I’ve never ever done it. Never ever been in that situation where I’m not smoking. I don’t know. But yeah I’d probably say something like that. Say “I used to smoke, let’s have a pretend one” or something like that. I can make fun of myself like that.
• Especially if they’re separated from the group and they’re sitting on their own it’s a really good thing, well it works for me a lot of the time, you know, they’re sitting there, there’s obviously something going on in their head, they’re not feeling comfortable or whatever. I just say “do you mind if I have a cigarette with you?” and they say “no”, and you might just sit there and have silence, but you also might find out that they’re feeling really bad and they need medication, they’re withdrawing really badly or you might find out something about their history, it could be anything. It goes from that silence, right up to that full blown blah blah blah.
• It might even keep them from leaving, it might keep them from becoming aggressive.
• I still think that people get comfort from a cigarette. It’s a paradox because it’s hyping you up but it’s also depressing you, but for the guys that we get in this state they, it’s almost like they need a cigarette.
• I don’t know whether I do it on a compassionate level, or whether I do it because it’s going to make them feel better or whether I do it to avert a hissy fit. I think it could be a bit of that in there, you know, let’s keep things cool, you know.
• And quite often I think it’s sort of like a, you can’t call it intimacy because it’s not intimacy, but it’s a shared behaviour
• You know, I’m addicted to cigarettes, and if there was a detox centre for cigarettes I’d probably be at it, and they think that’s good because then you’ve got something that they’ve got, and someone actually asked me if I’d tried to give up and I said yes I had, by various means, and I reverted back to my two year old self, chucked tantrums on the floor, so it’s a sharing of probably that addiction state……
• if you’ve been a smoker and you give up and you go through all that horror, it does, it gives you some idea of how they’re feeling I suppose, and they realise that they’ve got to give up but they can’t.
• Oh they might be down on themselves and say “I’m just a bloody junkie I can’t get off this stuff”, and I say “look at me, I can’t give up cigarettes. So what can we do about it?” And we might come up with some idea of how to make the detox easier. Even given me a few hints on how to give up smoking, and I always take them on board, and yeah it’s just that levelling thing again. I’m stuck with this habit, and how do we get rid of it? And it’s all, it doesn’t matter what you think, it’s all addiction.
• it’s also a really good thing to have if you want to break the ice with someone who’s being really difficult
• I’d say “come out and have a pretend smoke?”
• I just say “do you mind if I have a cigarette with you?”
• I mean we’re not going to go the smoking bit when you’re coming off alcohol, smack or whatever, perhaps they can be told later on you should give up smoking but we all know we should give up smoking, so I think that’s a given. It might even keep them from leaving, it might keep them from becoming aggressive.
• I just think gee, that would be a shocking thing for me, so I quite often give a packet away.
• I suppose I would hate to be in that situation, and I just say when you see me down the road in twenty years, you can give me a smoke. So, yeah I do.
• I don’t like seeing anybody go without a cigarette because I know what it would be like.
• I could put myself in their place and I’d be in a hissy fit on the floor.
• why am I doing it? I just think it’s too hard. Probably I’m just projecting, probably it’s too hard for me to contemplate at this stage. So if I’m not going to, you don’t have to. It’s part of that. Does that sound alright? I think that’s what it probably is, a bit of that.
• I think that’s the slightest of the worries. A lot of them are coming in off alcohol, heroin and whatever, and although smoking will kill you eventually, so will all the others, it’s probably more likely to be an overdose of heroin and they’ll drop, or they’re going to get cirrhosis of the liver or go into a seizure.
• I don’t get regimental about smoking. I think “They smoke, okay”. Let’s keep them comfortable in one area. And it is, it’s paradoxical for them. I’m getting them off one drug and I’m probably encouraging the other.

**Interview 5**

• Sometimes, when they don’t get regular breaks or structured breaks, and they’re working with clients, like sitting, there’s a smoking area for clients, they I think sometimes will sit out and have a ciggie with them and it becomes a therapeutic intervention as far as their other drugs go. There’s probably only one staff member that does that.
• I can see that, that person has a fairly heavy smoking habit and they don’t get the opportunity for breaks some times and they’ll have a ciggie and do, or they’ll have somebody that’s a bit distressed and, the client and they’ll have a cigarette at the same time.
• Self respect I think probably at the time. Mmm. Yeah and not being readily identified as a smoker or a smoking nurse.
• No, no I don’t smoke and chat with clients. Cos I don’t think it’s okay. It gives a bad impression like, you know, modelling.
• I didn’t think it was appropriate. Erm, because of the role model thing and, containment as well. You know like ‘limits’ on myself – yeah.
• I’m glad that the staff, there’s only one, none of the other nurses smoke or yes, one of them does but she would never do that with clients.
• as a result I think the one nurse that smokes would only ever do that in the staff area at a time when they’re on a break but wouldn’t sit out and smoke with clients; wouldn’t see that as appropriate
• When working in community health shame attached to smoking, guilt, hypocrisy when patients or the community saw you smoking.
• In A & D field, it doesn’t matter. Clients don’t judge this, it’s seen as the least of the problems so you are more likely to relapse.

**Interview 6**

• I was often picked to go with the big bikie out the front and go have a ciggie and calm him down or the mad bugger who wants to smash up the place, I’d take them out. And I sort of ended up with this role of taking out people for a ciggie out the front.
• And I think I sort of learnt early on that that was a good equaliser, or I can help you by lighting your cigarette or you can feel better with yourself by offering me a cigarette.
• It was sort of like a ritual, you know with people who are highly agitated and all of a sudden you’re the only one who understands, and it personalises the contact with the hospital system by having a one-on-one. (personalising)
• At the same time my skills weren’t that good so I did what I usually do just sort of get through it with luck.
• all I could rely on then was that instant I suppose and part of that instant was give them a cigarette if that helps give them a bottle if that’s what’s required in the normal aggressive situation to try and defuse that.
• And I’ve worked in a lot of mental health areas where people are banging their head against the wall or really frustrated with the moment, screaming out names, “you’re a f*cking bitch, rah rah rah, - car’n mate let’s head out the back and have a ciggie”. And as you say, it would change the direction, the focus is completely different, and yeah they’d just get to stop to smell the roses and just completely stop that thought pattern and yeah, it is a good tool in that regard.
• I sort of get into the routine now of walking into someone’s life that I haven’t met much before and I’ll offer them a ciggie or they’ll offer me one and we may go out the back and talk about stuff. It’ll be like “oh, how’re you going, you smoke Winnie Reds do you, I haven’t smoked them for a while…
• Obviously if the cigarettes weren’t there, I’d look at the poster on the wall and say “Oh, do you like that bag?” Or whatever, but yeah you use what you’ve got and cigarettes are, well, one of the constant things in my pocket.
• I had to justify it because I had all these wonderful interactive moments over cigarettes.
• And my missus would be always on my case about giving up and I was like “Oh no, no I use it so much in my work” and then she’d say (my friend Paul works there as well) “Well Paul doesn’t smoke and he’s a good worker and doesn’t he interact with the patients as well?” Well alright he does, that’s just a bit too logical.
• And that sort of made me aware that Paul is a good worker, he doesn’t smoke and he can have the same interaction and the same rapport building skills, so that’s obviouslybullsh*t. But for me in my mind, as you say, that’s one of the tools in my bag, and that’s the one you seem most familiar with and it’s comfortable when you pull it out so, …and it’s positive reinforced because it works most of the time and … yeah …
• And yet I don’t remember thinking that I was slacking off; I was still doing my job. Whereas if you went and stood anywhere else and stared at the roof, you’d hardly be doing any good at all.
• If there are a couple of people arcing up or something we’ll take them out there.
• in some ways I use it as a tool to say I’m human as well, I’m much the same as you are, yes I have had different issues in my past and got through stuff, so I have a smoke.
• I don’t eat any vegetables and I like fast food too. I’m not trying to promote that stuff, but I’m saying I’ll be honest and this is what you get. I hope that people see me as a health professional, but a little bit of a non-conventional health professional, and maybe a little bit more approachable. So I don’t think of it as a negative…
• I do use it as a positive tool: “When you want to go and bash your mother, go out and have a ciggie mate, and have a walk around the block”. “If things are getting to the stage where your children are screaming and you’re going to do something you’re not too happy with, go out and have a ciggie, or go for a walk around the block”. And I use it myself, if I’m feeling shitty or I’m having a blue with the missus, I made up my mind a long time ago, remove yourself from the situation. Well I use cigarettes, but you just take 5 minutes from whatever’s going on and you can come back in with
hopefully a bit more rational look at what’s going on. So if people use smoking as a tool of relaxing anyway, then using a tool that they’re already used to, then they might be able to use it more efficiently and in that regard it’s a positive.

- I should point out cigarettes isn’t my only tool, we will talk about slowing the wheels in the head, slowing the heart rate down, slowing the breathing rate down, or thinking of the pleasant past thoughts or the pleasant beach or the camping spot or any of that sh#t that we do. You’ve gotta use what’s available and what the person is going to relate to easier.

- And if you want to go and talk to any of these people, they’re in the smoking room at the end of the psych unit. They’re not anywhere else.

- Before I worked here, I worked at the ….. community health centre where there was just me and the receptionist and maybe 120 people. And we were given some very ugly stupid comments from coming in and out from smart-ass accountants and stuff that just thought it was insane that nurses smoked. And there is this perception from non-nursing people that “Oh, I’m a bit surprised that a nurse smokes”. Gees you don’t know me well... But there is that perception.

- I’ve always had motley beards or an alternative appearance I suppose so I was often picked to go with the big bikie out the front and go have a ciggie and calm him down or the mad bugger who wants to smash up the place, I’d take them out. And I sort of ended up with this role of taking out people for a ciggie out the front.

**Interview 7**

- And the situation here too, I don’t know why that is, but sometimes the kids don’t have cigarettes or something like that, they’ll come in or run out or something like that, I’ll offer them a cigarette, and then I’ll have a cigarette with them, but I wouldn’t necessarily do that, have a cigarette with them when I was at [Name], but I do that out here. I don’t know why that is. I’ll have a cigarette with them. But, you know, there I wouldn’t.

- I don’t know whether it’s more of a tool of engagement with young people, you know, come and have lets have a cigarette and talk about why you’re feeling stressed and stuff like that. Yeah, yeah. Which I’ve been made aware of with young people. I’m just a bit more aware of that. It’s friendly and, you know like you’re somebody that they can talk to or relate to.

- It’s just part of making them feel more relaxed and that’s the reason why we’re here. I’m not saying that that’s the reason why I have a cigarette with them, um, but, I don’t know, it may be, maybe that is the reason, I don’t know

- You, know, making them feel more relaxed, making them feel you’re someone they can relate to and feel comfortable with, because you smoke too. Do you know what I mean? Whereas, maybe I haven’t, maybe I didn’t think about that with adults.

- I just don’t remember ever smoking with clients

- I’ve had a lot of kids say that “You’re smoking?” And I say “Yeah, it’s my choice and I know what the risks are and that sort of thing, but it’s a choice”. Yeah, I have always felt that someone in my position...

- But I mean you have a certain role in that situation. And I’ve seen clients today and I could have had a cigarette with them but I suppose it’s about keeping that little bit of professional business or something, which I suppose I’ll have to break down that barrier I mean when you get into that culture of doing that, you don’t think much more about it. So, um, you get into a habit I suppose.
Interview 8

- smoking is a good tool to engage ‘here have a smoke’ and have a cigarette and you just stand there
- Even when I’ve gone out on functions you go out for a smoke and you meet some really lovely people. If you sit at the table and stare at a bottle of water – this is just an observation – you don’t meet anyone! It can be really, not just with this work but socially it can be a really good tool. I’ve met some lovely people having a cigarette. With work too share a smoke it sort of breaks down some sort of barrier or something but you don’t have to do that
- I said it and it’s been said to me and it’s there and on a scale from one to ten it’s there on a two
- Can we take that out its bullshit? Take it out. Serious it is. I think that was one of my justifications. When I first started it wasn’t a tool for engagement it was probably a tool for mainly calming my nerves and they smoke too and they were my first client and I didn’t want to say anything wrong ‘now remember your body language’ and all this stuff?
- I’m not responsible for the client’s wins or losses but I do my best and I continually do my best.
- it takes away a bit of the power imbalance. ‘I’m human I’m real I struggle in my own way’
- I reckon that’s great ‘cos it’s the biggest killer but if they go into detox and they haven’t got any we’ll get them a packet and we’ll doctor it and we’ll say it was something else.
- I said I don’t know I’m sorry but I don’t know anything about youth. The thought of dealing with adolescent males like flipped me. But they’re the ones I connect with so quickly and we’re going to have so many wins with them. A thing that might have been a bit of a concern on me I worry about whether I like a power imbalance, there is a power imbalance and yet they see you as having the answer. I continually say I’m okay – [Name] is providing this, they pay me, my life experience is really the most beneficial thing. I’ve learnt skills on how to better communicate
- If they say ‘I want a cigarette, I want a f*cking cigarette’. Come on let’s go find a cigarette shop. You know, weigh up what’s going down they’re going to beat the sh*t out of me their partner, are they going to go to jail are they going to sell ….. like depends, like ‘Hello’
- Yeah, it depends what’s going on but if they’ve got a knife and is about to pull an armed robbery I’d say ‘I really do think you should have a cigarette’. They’ve got a knife up against my throat I think a cigarette’s a good option. I think one cigarette
- Well, I’d be rapt if someone comes to the door they’re dressed, they’re not carrying a weapon, you know, the smoke things on the bottom of the list. There’s not a domestic dispute going on, no-ones to attack me, rape me. Have a smoke yeah that’s okay
- I’m a yoga instructor it was affecting my breath I felt like a big hypocrite when I teach class
- And the yoga. I just don’t like the affect it has on me with the yoga
- The implication that I don’t care about myself
- But I say to people ‘hey I’m an Aussie Yogi, Yoga chose me and I drank and smoked when it chose me and I’m just doing my best’
- I was always uncomfortable and felt like a hypocrite smoking in front of the clients.
• Here I am like a drug and alcohol worker and I’m saying to you ‘I don’t give a sh*t about my health and my body, and I’ve got an addiction’.
• Yeah, it’s not on I don’t reckon – you give them the wrong message and you know smoking is the biggest killer. That’s what I say when I did the drug thing ‘which drug do you use rah di rah di ra h di ra h’ Candidates always laugh and I always say and that’s the one that’ll most likely kill you. 80% of people that smoke end up with a smoking related illness. 7% who use heroin die – hello? Can you see a bit of a .... But I’m not saying too much about that because I love my job
• And they’re responsible for their health. I’m responsible for mine and others and me on theirs but them sucking cigarette into their lungs isn’t my fault.
• Isn’t this job a bit like that anyway? Yeah. On every level. There’s a risk element on every level. Realistically.
• Well, working with people with dual diagnosis high risk, erratic, irrational at times behaviour, drug addicted there’s a risk element there.

Interview 9

• We’d go to the pub after work, have a beer, talk about the day, stuff like that and there was a lot of stuff going down it was a really difficult time sorting out where I actually fitted in to [Name] and it was all a bit overwhelming the whole thing and the whole thing about being a free agent out there in the field trying to work out what Outreach means. Although you are guided its like at the end of the day you’ve got to work out where it fits in for you, you can only get so many models if you know what I mean.
• part of my justification for experimenting with every drug that there was, was around ‘I want to be a drug and alcohol worker some day so I want to experience that so I’ve got understanding’ to impart
• A lot of the guys smoked there wasn’t any smoking legislation so you could smoke in the place and sit down with the guys have a smoke and a chat.
• It was quite a good thing seemed like an okay thing to do because it just helped you fit in and connect and they felt that you were more on the level if you had that.
• it was that way of sitting down with the old guys and the younger guys, having a chat, having a fag. Talking about issues that were going on for them.
• Stopping? No. It’s probably been better, not initially but now I’m actually levelling out.
• The only reason I would smoke with clients was because they were having a fag too. So it was just appropriate like that
• But no I wouldn’t I don’t see that as necessarily any more as being a necessity if they are towy, if I feel they are escalating I can be there more for them. I feel it’s more of something in the past that may be it’s been my own inadequacy feeling that I need to mirror with them. To actually engage with them that’s what engagement is about but I’ve come to the opinion ‘no’ that this is not what engagement is about
• I felt of it as therapeutic and what was therapeutic was the engagement rather than the actual smoking with them. That’s a good point. I think it’s possible.
• Yes. It is very much so. Part of it too is that not smoking I feel a more emotional edge, so in that way it actually improves or sharpens that being there of being focussed whereas smoking it sort of numbing senses a bit. You’re there but people say that they feel sharper with it I think just on reflection that it actually sedates a bit – it does stimulate but it does take the edge away from me being connected to the
environment. It’s about me being connected to me and not being connected to my environment so much. So in that regard I think yes, I had more of an external focus.

- part of my justification for experimenting with every drug that there was, was around ‘I want to be a drug and alcohol worker some day so I want to experience that so I’ve got understanding’ to impart
- there was another significant time when I stopped smoking too which was when I was a Naturopath at a Health Food store in Sydney called [Name] and that was for a year as well and I stopped smoking in that time. That was more around feeling that I was working there full time so of course I wouldn’t smoke at all during that time and it just made more sense that I just be consistent with my approach and just not smoke.
- working in a health food store where people are coming in there with chronic diseases stuff like that, we’d assist them to stop smoking, really wanting to clean up.
- I wake up more vibrant in the morning and I’ve got more focus around work in between it’s like doing things on the computer before going out to see a client and then trying to fit in a cigarette between doing that then going out to do the client stuff. Instead there’s more fluid movement just going through my day with that focus without having to fit in the cigarettes.
- The only reason I would smoke with clients was because they were having a fag too. So it was just appropriate like that and over time I’ve come to the position that it’s not a great thing to encourage so I stopped smoking maybe I don’t know about a year or so ago I stopped smoking at work.
- To actually engage with them that’s what engagement is about but I’ve come to the opinion ‘no’ that this is not what engagement is about and being a drug and alcohol worker I think ‘no’ we do have a responsibility to actually mirror good ways of not necessarily, its difficult that one but it’s not like I want to preach an AA sort of model but with tobacco it’s either all or nothing.
- This is not the thing to promote. Again it stimulates that neuro-transmitter of connection with dependency and so therefore it wasn’t really a good thing to do and that’s the number one thing saying talking about improving my skill base in engagement that’s a sort of maybe a reflective

**Interview 11**

- I mean it’s interesting that we do counselling around addictions and then kind of go out and smoke and enjoy having a drink?
- I’d often go out and M will often come and say “Oh do you want to come and have a smoke?” It’s a good opportunity to catch up because M was my supervisor when I did my placement so quite a good rapport there. But I don’t see so much of her now because she’s in forensic so it’s a good opportunity to catch up with her and have a chat.
- I think the first thing I noticed in this place when I switched over from where I was working was that we’re a pretty non-conservative environment. In terms of presentation, like how we dress, and how we are with each other, and people’s sense of humour, and there seems to be, and I think probably for all the reasons that you mentioned, the dynamics here seem to be different to where I worked before and that’s part of what I really like about […] is that it is kind of laid back and I think all that stuff, not that I’m saying that conservative people don’t have any fun and don’t smoke, they do, but I think you’re right, working in this kind of environment fosters a kind of leniency with that stuff where people are more comfortable with doing it
Appendix 5 Extracts from interviews that contribute to the category of Rewards

Interview 1

- I usually smoke with other people
- It gives you a chance to talk about stuff, talk about what has happened at work, and outside, um, it gives you a chance to catch up socially, like talk about personal stuff. Um, it’s good to just go outside, get away from everyone and just talk
- But when you’re going for a five-minute walk around the block you’re not doing those other things?
  - No, no, not those other things, you’re not, that’s true, you’re removing yourself as you walk
- The socialisation
- Do you get those things any other time at work? Um, no, not really. Oh, I can think of some instances, there are certain people you can have a chat with, but it’s not the same
- You said it’s handy being outside. Yeah that’s right. I wouldn’t step outside for a chat. There are other people who have quit or… they come outside just to have a chat, but I don’t do that unless I’m smoking
- as a new employee, you know, it’s so hard starting a new job and being, you know, especially in a big organisation like this, you know if you smoke, you’ve automatically got something in common with someone. And you’re automatically going to spend a lot more time with that person than you will with anyone else, get to know them better
- it’s still a quick way to fit in with a few individuals
- Or people wanting to quit finding it really difficult and keep lapsing and relapsing back to the same thing so it would seem like it was harder for those people, working here?
  - Mmm! Because what everyone did
- Yep, and it gives you a break too, like a five-minute break from work
- Do you often get five-minute breaks from work other times? I could but I won’t
- But when I tried to quit I was having to step out and go for a five-minute brisk walk around the block and then come back… it’s just like also getting out and getting some fresh air which is nice

Interview 2

- I went out with a guy who smoked, umm a few friends that I was associating with at the time, they’re still friends now but I was seeing more of them then, who smoked, and I picked up smoking.
- So yeah, that’s when I started, you know, associating with people, that I smoked. It was probably due to that peer group pressure (laughs).
- being around someone all day when I was working and I picked it up
- if it was sort of one on one it wasn’t too bad, but if it was a group and say they were out in the courtyard smoking and you went out with them and you were chatting away, you sort of felt a bit like the odd one out. It was just a really strange feeling.
I did feel uncomfortable and I questioned myself as to why. Why I was doing it and why I felt uncomfortable. And it was enough, I felt uncomfortable enough, not to do it again. So I wouldn’t go out in the courtyard to have a smoke. But yet upstairs, and I’m still in view of people because it faces the street, it doesn’t worry me. They’d say, “Are you coming now?” “No I’ve given up remember.” “That’s right, yeah, I forgot.” when I gave up in January it, it almost felt like you weren’t a part of the gang anymore. I felt like a bit of a, how can I put it, just felt like not part of the gang anymore. I don’t know if it was a coincidence that there were just so many people that worked there that were just anti-smoking. But they really were anti-smoking. They would even put literature on your desk. You know, the quit program stuff. One of the guys in the home-based team was actually a teacher of the quit programs or whatever, he did those courses, ran those courses. But in the end it was really funny because before I started smoking it was almost like I’m the strong one and you are all the ones that should be feeling different because I’ve done something that you haven’t been able to achieve when I did start smoking again so many people said, “oh, I’m so disappointed, you were doing so well.” Even Sandra said, “You were my hero.” Um, so it sort of switched at the end, it’s to me feeling like I was the one that was achieving things and I’d still go out with them and feel different but it was different for a good reason. Not different because I wasn’t fitting in with them. But now I’m just sort of one of the gang again (laughs). Initially it was probably a bit of a novelty, felt part of the gang again, I don’t want that feeling anymore. I want the old feeling back of being still going out and having a chat with them while they’re smoking, but being the one that doesn’t smoke. we used to have our morning tea, lunch, afternoon tea breaks together, we were pretty good friends, and I guess I began smoking we’d go out, have a few drinks, and smoke. And I think it just started from there, you know, maybe one a day, initially, to smoking every break, after work, when we went out Go out regularly for a smoke, even to talk about clients or whatever, not on allocated time, just whenever, and starting to smoke more. there’s four of us in the one room that smoke. So that when we go out on the balcony for a cigarette, generally the four of us go out. I don’t know if it was a coincidence that there were just so many people that worked there that were just anti-smoking. But they really were anti-smoking. They would even put literature on your desk. You know, the quit program stuff. One of the guys in the home-based team was actually a teacher of the quit programs or whatever, he did those courses, ran those courses. They’d say, “Are you coming now?” “No I’ve given up remember.” “That’s right, yeah, I forgot.” I felt like a bit of a, how can I put it, just felt like not part of the gang anymore. But in the end it was really funny because before I started smoking it was almost like I’m the strong one and you are all the ones that should be feeling different because I’ve done something that you haven’t been able to achieve when I did start smoking again so many people said, “oh, I’m so disappointed, you were doing so well.” Even Sandra said, “You were my hero.” Um, so it sort of switched at the end, it’s to me feeling like I was the one that was achieving things and
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- Initially it was probably a bit of a novelty, felt part of the gang again, I don’t want that feeling anymore. I want the old feeling back of being still going out and having a chat with them while they’re smoking, but being the one that doesn’t smoke.
- get ridiculed on the way
- you’d have to walk past and they’d all yell stuff out at you and say, you know, “disgusting habit, you’ll come back smelling, and blah, blah, blah”. So, it did make you feel uncomfortable
- the other balcony that we used to smoke on, one of the anti-smokers won’t let us go out there because she says it filters in through the door and she can smell it. AH, I felt uncomfortable on that balcony because we had to go past the research people to actually open the door up and get out on the balcony and I felt really I was intruding on their space and um, I felt uncomfortable out there because yeah I knew they were anti-smoking. They were standing there; it was like a judgement was being made. Probably wasn’t it was just my perception of it
- The other balcony that we are on now you have to walk past two offices. One of the offices the person smokes and the other one we don’t see anyone. So this is more like you can sneak out.
- I went out on the balcony and sat out there and had a smoke. It was, no one was around and, um, it was comfortable and more enjoyable than having to go past people or smoke in public or whatever.

Interview 3

- Everyone else was doing it, that was the only reason I did it. Peer group pressure. Everyone else was puffing around the front of the RSL in Ararat, and I thought, “well why not?”
- We always say that we don’t mind people smoking cigarettes in a detox at this stage, although cigarettes might kill you in thirty years time, you could die tomorrow from an overdose
- I find that dealing with clients in the office and out the back, they all have their own problems and they can be quite stressful, and as part of my own addiction I use my smoking as part of an anxiety relief myself, a stress relief for myself.
- Unofficial break is easier to take than an official break (which is harder to justify)
- Researcher: What I’m wondering is, if you didn’t have the cigarette as an excuse would you get a break?

Participant: It would be a bit harder because cigarettes are so accessible. They’re sitting there, I go to work they’re sitting on the bench, lighter on top of them.
- So I’m using it as an excuse to get away from them for a few minutes and using it as an excuse to sit down with them as well.
- It’s more of a fact that it just gets me out of the office for five minutes. I can walk outside, have a cigarette in my hand and I know no-one’s going to bother me. If a client comes out I can say, “I’m having a smoke”. I can actually get away with that.
- If you walk out the back without a cigarette in your hand then there’s four or five people around you, saying “I want to see the doctor” or “I need some medication or I’m going to kill her”. That’s just because you’re free game, you’re a staff member, they see your keys there, especially because you’re the nurse who gives the
medications. You’re out there, they want you. You walk out and you’re having a cigarette, it’s “O.K. I’ll see you in a couple of minutes

- So that’s sort of like a protective barrier when you go out the back sometimes.
- I find that dealing with clients in the office and out the back, they all have their own problems and they can be quite stressful, and as part of my own addiction I use my smoking as part of an anxiety relief myself, a stress relief for myself.
- As well as sitting down with them, having a smoke with them, it can also be a protective barrier (paradox)
- Same thing, to get away from them for five minutes, you need that little bit of a break, but also it’s your own time just to reassess your thoughts. When I’m out there I’m usually still thinking about what’s happening in the unit, how the dynamics are going, who’s interacting how, so I’m still thinking about work when I’m having it. It just gives me that space to step back and think about what’s happening during the day, and what to do next.
- Sometimes you still need that total escape. I’d have a cup of coffee in my hands or something, just to give me that five minutes.
- I don’t smoke as much on night duty cause, once your work’s done, you’re babysitting for the night.

Researcher: So why don’t you smoke as much on night duty?
Participant: I’m doing other things. I’m not chatting with the clients so much, so I’m not needing the escapism.

“Yeah, I’m not dealing with the clients as much so I’m getting that time anyway, my works done.

- Sometimes at the end of a night I’ll find myself saying “I don’t need another cigarette”, but I’ll have one. Or I’ve gone out the front before with a cigarette in my hand, and put it back in the packet and go back in.

**Interview 4**

- I found that I smoke more in a social situation. You know, I hate going outside having a smoke by myself because there’s no-one to chat with and I talk too much anyway. It’s a social thing
- I started when I was 16, cause all the other nurses I worked with smoked
- It hasn’t really hit us that it is not socially acceptable. It makes you smelly and your voice and stuff…
- How long you’ve been smoking has got a lot to do with it, and how long you’ve been a nurse probably. Because when I started nursing, everyone smoked. Everyone full stop. Even the cooks smoked, and they smoked while they cooked. I think you’d feel very out of it then if you didn’t smoke and I think that’s possibly why I started smoking.
- It’s a habit that I have and I enjoy it.
- It’s costing me physically
- Yeah, I’ve tried to give up, because I’ve been told I had to by a doctor, so eventually I’ll have to. Cause I had throat surgery. I’ve got the beginning of COAD and I get bronchitis and I’m a skinny old I get the flu. It’s taken its toll, but it’s just not one of those things that I want to look at yet. I will when I’m 65 years old and dying.
- it causes me to have forced breaks
- Whenever things get stroppy at work, and you’re flat out and need a break –“coffee and a fag” -that’s probably how I use it in D and A
The more tired I get the shorter the space between the cigarette and coffee.
Whenever things get stroppy at work, and you’re flat out and need a break—“coffee and a fag”—that’s probably how I use it in D and A.
You know, I’m addicted to cigarettes, and if there was a detox centre for cigarettes I’d probably be at it
if you’ve been a smoker and you give up and you go through all that horror, it does, it gives you some idea of how they’re feeling I suppose, and they realise that they’ve got to give up but they can’t.
Oh they might be down on themselves and say “I’m just a bloody junkie I can’t get off this stuff”, and I say “look at me, I can’t give up cigarettes. So what can we do about it?” And we might come up with some idea of how to make the detox easier. Even given me a few hints on how to give up smoking, and I always take them on board, and yeah it’s just that levelling thing again. I’m stuck with this habit, and how do we get rid of it? And it’s all, it doesn’t matter what you think, it’s all addiction
It’s certainly addictive behaviour. And that’s what my doctor said to me he told me I had to stop. He said “you’ve got to stop smoking Jen”, “have you got the patches?” and I said “Yeah” and he said “why aren’t you using them?” and I said “well I’m scared they might work”.
he said “bullshit, you’re an addict” and I thought yeah I am
But I always thought, no, I’d just keep a spare packet in my bag, in case someone ran out and needed them, you know what it’s like working in D and A.
So I’m colluding with their addiction, what the hell.
And I know a lot of them drink more, and whether it’s got anything to do with the nature of the job. I think probably it has
to me, because it’s so much part of my life, I do it without thinking.

Interview 5

And it was really part of the whole scene of being a student nurse
there was camaraderie around it, especially when you worked evenings really late at night because the evenings at the Royal Melbourne went until something like quarter past eleven at night, so you’d be with another student nurse and you’d sneak off to some of the toilets and sit up on the big old building, you know? And sit up in there and chuff away.
also the handovers, everybody smoked so you’d have maybe eight nurses in a room everybody’s chuffing away in a small cubicle type room…
Yeah, yeah, sneaking off for a smoke together feeling like you’ve achieved something and the other thing with that is that is was compulsory to actually live in still so…
It tied you in with particular people
I wouldn’t say closer but it was a contact point – yeah
Point of recognition – yeah
Yeah, and we both do this – (laughs) yeah.
Really good, I had good support from the other withdrawal nurses in the team
And also I had erm a very close friend, well two close friends, but one who quit with me – a psychologist.
It just turned out that way, I was doing it she did it too. So we’d both became non-smokers together.
• And another friend who she and her husband both stopped and that was really good too.
• No I knew that erm that it wouldn’t matter what they were doing or major crisis was happening, cigarettes wouldn’t be come a part of it.
• Yeah we were all committed
• And I really liked their place it would be a smoke free environment too and they knew that with mine mmm.
• Oh I’d have a cigarette with them but I’d worked through a whole lot of other issues in terms of team functions by that point where I’d been in survival mode as well at work.
• I did tend to try to just keep going out for a cigarette when I felt like it not because other people were going and calling me to come out.
• I don’t, I mean there’s probably only one, oh there’s a couple of staff members that smoke but I don’t line up to duck out and have a ciggie with or doing it like that
• I go on my own
• there was always a social content or ‘feel’ to smoking
• you’d only duck off like that with someone else that smoked who had a vested interest in it
• the non smoking nurses, there weren’t very many erm, I don’t know what they did.
• Erm, there were a group of core smokers who would go outside and smoke and my sense was that there was a lot of decision making and programme discussion going on informal which was very powerful and I wasn’t part of that – I wasn’t smoking.
• And I can remember feeling quite resentful of how often that occurred
• Oh ten to fifteen [times a day] maybe, but I was, yeah. There was also, yeah, there was problems in that team and I can see that that was around that time developing
• Yes, and there were a couple of ex-smokers long term ex smokers one being the manager, well acting manager at that time, who was part of that group who was quite happy to stand out there.
• Yeah, another senior member and the acting co-ordinator was smoking and then a group of other people from the team that were very close – yeah. So it was, I’m not sure whether it was, well from my perspective there was a sense of alienation it involved when they’d duck out for a smoke, and they’d go off for lunch, this group.
• Well, like I said there were problems in the team and there was splitting so it just turned out that the smokers mainly were part of the group.
• Yeah its, it was more about erm. In some ways going out and standing there because I wanted to know what the agenda was. ‘Cos of problems and of course the conversation would be stopped and they’d go on to general chitchat so I wouldn’t stay long
• Yet there were a couple of smokers who just used to go and and have a ciggie on their own and were never part of anything
• And I’d be probably inclined to go and stand with them if they smoked
• Yes, on the ward and you’d open the door and the smoke’d billow out (laughs) so it was really quite a – how you got your breaks.
• those that didn’t they would take formal breaks, you’d go to formal breaks with them in their time but I mean, if I was working with someone that didn’t smoke I might not go off and have that break if there was time.
• Occasionally, I mean I used to find sometimes that my concentration would go and I’d feel really fatigued. Obviously because of the stimulants
• Yeah, usually about two o’clock in the afternoon and then I’d just, I only struggled for that little while or go and have a glass of water or something and just keep on track
Interview 6

- And it’s also I’ve been looking at people and thinking, I must grab a moment to talk to you and make sure you’re alright and she seems a bit troubled or she seems a bit tired so I make a point of thinking she’s going out so I might take a bit of time or it might be a quiet time to talk.
- When I say that I mean my crew, I was with the type of people that would be going out to the pub and doing a bit more.
- As you know there’s generally two sorts of groups and one is usually a bit more adventurous than the other one. And at that stage I was certainly exploring lots of different things.
- I was dating a long term smoker at that stage so I doubt if we ever reflected on it as anything other than harmless.
- I’ve often wondered if it’s particular people in life who’ve experienced different things or who have wanted to take on different things, either negative or positive, is it a defiance of some type or trying to beat the odds of some type, and I’ve certainly done a lot of my contemplation of why are you smoking, you know, you’re coughing so why are you still smoking, and yeah, you get a bit of that attitude of don’t give a f*ck or a little bit of that type of rule book so therefore I’m happy to be doing that sort of thing. Nothing has been conventional I suppose.
- When I say that I mean my crew, I was with the type of people that would be going out to the pub and doing a bit more.
- As you know there’s generally two sorts of groups and one is usually a bit more adventurous than the other one. And at that stage I was certainly exploring lots of different things.
- It was the pub stuff and the dance stuff and the club stuff that combined, well the pub stuff, the group of people who were opening more doors, and the smoking was perhaps just one of those things.
- When I was older, 15, 16, 17, definitely all of my social engagements involved cigarettes as well
- the ones I hung around with in my neighbourhood, after school and on the weekends, or the guys I caught the train with, we’d stop off somewhere on the way home and have a ciggie that sort of thing
- my support worker arrived 6 months ago smoking and then within the first few weeks stopped smoking and she felt a bit left out so she’d follow us out the front. And a couple of them who were between smoking and not smoking would come and stand under the tree and enjoy not having to be in the office and stuff.
- and it stimulates a bit of a culture in here which I don’t like that much, but um, if someone goes for a cigarette they sort of grab 3 people with them as well, cause they don’t like to be out there by themselves.
- But you almost haven’t quite got the same choice and I know you have, but I don’t like people coming to have a cigarette with me because if you want a cigarette go and have one on your own bloody volition. But you only need a little whiff of a suggestion and you’re happy to have another cigarette even if you’ve only just had one.
- So I did say that it’s a social occasion some times and yes it’s not work related, that’s when you’re with your group of colleagues
- I hear the door. That sometimes happens. And I do sometimes think, bloody hell, Sarah’s gone out, although I say I don’t like people encouraging me and I don’t
encourage other people, but yeah, it doesn’t take much to think, oh god this paperwork, and think nup, someone’s going out and…yeah.

- I’d been living with the same guy for about 5 years. He was an old cigarette smoker and was completely tolerant of overflowing ashtrays and bongs and that sort of paraphernalia so, smoked inside
- A lot of the young women were smoking I suppose, and the pub scene was fairly good at the end of the day and I suppose that was fairly normal
- I met my current partner then too and she didn’t smoke then and never has smoked so…. And yeah, one of my best nursing mates that I ended up living with years later he never smoked, come to think of it. But yeah, most of the other people I remember were pretty heavy smokers.
- and it stimulates a bit of a culture in here which I don’t like that much, but um, if someone goes for a cigarette they sort of grab 3 people with them as well, cause they don’t like to be out there by themselves.
- So I’m trying to think I won’t have a joint I’ll just have a ciggie and then that’s a common conversation between myself and some of my peers.
- my support worker arrived 6 months ago smoking and then within the first few weeks stopped smoking and she felt a bit left out so she’d follow us out the front. And a couple of them who were between smoking and not smoking would come and stand under the tree and enjoy not having to be in the office and stuff.
- In those sort of unstructured jobs where you can really have a smoke break any time of day that you wish, as opposed to that 15 minutes of rush down the stairs in your regulated break, you do smoke more often.
- I mean it wouldn’t matter on the ward if you were busy or not busy, you couldn’t leave the place. You only had that time anyway
- So I find on my busy days here I go home and I find f*ck I’ve only got 2 cigarettes left. Because if the paperwork sh*ts me or whatever, I could be out there 4 times an hour if I really want to walk out for that time. So, depending on the dynamics here too, if I’m having a hard time I could be out there more often and therefore…
- And I’ve had this argument with lots of different people but, um, the phones are going, everything’s going, I think ‘f*ck this I’m going for a cigarette’. That 5 minutes does work out to process things. That’s going good, I should have done that, it helps to keep the head going. Definitely part of the day, part of the processing of what needs to be done now, or looking after the other staff, so yeah, you do all that.
- the quiet time out there is really almost meditative to some degree, and, um, it’s good to sit out and de-stress now and again, back to smelling the roses again. Sometimes it’s just to notice that the beetles are back on the bushes outside.
- It sort of worked out that most of time people were sort of going out for a cigarette once an hour and farting quite happily out there. And then there was a couple of people not going because they were giving up and yeah, there were quite a few pretty annoyed people screaming that “Oh, will you stop bloody farting, people can’t sit in the office anymore”.
- This is one thing that I did think about, you know hang on; you’ve got to go outside. And you haven’t got an excuse to go outside. And you can’t just go out and fart every hour. So at least the cigarettes are a good prompt to…
Interview 7

- Most of the nurses in my group all smoked
- No, no it’s not even a sociable thing really, you know, that’s just where you go to smoke
- Or sometimes Robyn might come in and Robyn’s the part-time manager and she’s pretty stressed or might want to have a conversation then we might go out there
- I’m picturing the person who doesn’t smoke and they’ll still be outside and everybody will be sitting around them smoking, clients and staff, and she gets included just as much, except she’s not smoking cigarettes
- I know one worker and he’s fine, he still goes out there, even though he wasn’t smoking. He’s probably wasn’t going outside as much, and yeah, he ended up getting back on them. But yeah, when he wasn’t smoking he definitely wasn’t coming outside as much.
- No, I never smoked on the wards. Just at meal-break times. Yeah, looking back on that, I probably didn’t smoke then as much as I do now. You know, I could only smoke on meal breaks and I’d sometimes nick outside for a couple but, so probably that was better, I probably smoke more now, than what I did then
- Yeah, I’d sometimes be able to duck out with someone on night shift but never during the day.
- I went back to a bit more like my first placement again, you know, like morning tea, lunch time, afternoon tea. There was more of a routine there I think. And I wasn’t missing them as much as I was at the doctor’s surgery because I had more time and could do my own thing and that (at the doctor’s practice), so I was probably smoking more at the doctor’s surgery than I was…
- You can, but I, I didn’t do that. I liked that thing that you could get away from the clients and go out and have my break without the clients in tow, so to speak.
- No, no that’s not right. Sometimes, you can go out the back, clients can go there, but they don’t unless they’re doing their laundry or washing up. If I want to have a bit of time, get away from them and have a quiet cigarette I can go out the back. I don’t do that very often. I mean there have been occasions, it’s been a bit full-on in here and I’ve been feeling a bit stressed and I’ve wanted to be on my own.
- The only time I might think about not going there, it may be one of our busy times and I might want have a minute to myself and, say something’s happened and I might be a bit stressed and I’ll look out there and see a few kids or staff or someone and I’ll think “No, I don’t want to talk to anybody, I just want to go out there and have a cigarette to myself”. But I mean to say that might happen probably not even once a week.
- I’d probably be more stressed though. I don’t want to be more stressed. I don’t know if I’d be more stressed, I probably would be. You couldn’t just go when you needed to; you’d have to wait a couple of hours until you had your break or whatever.

Interview 8

- it gives me time to reflect. Mainly the cigarette smoking apart from my chest screaming out for the drug it’s reflection you’ve got to have a smoke to get that reflection which I need to have sort of look at what went down – what was said. I’m an analyser. I’m sort of there at the time but I go away and think about everything. Body language, conversation, environment. It all computes and it all comes up after.
- Reflection time and if I don’t smoke I don’t do it.
• That’s why it’s coming up at home at night I’m in bed. I’ve just given up for five days and my work stuff is coming up at home when I’m in bed which it hasn’t done for ages and I’ve realised it’s because I’m not doing the reflection thing during the day.
• Yeah, just having five minutes quiet space to reflect. Only when I meditate, like when I practice meditation that’s the only time I do it but it’s about my life stuff really not work stuff. I need to do something about that or I’ll go back smoking.
• Yeah, that reflection time. Because I don’t set the time aside.
• I haven’t realised it was in relation to work but I have realised this before at home that that was the only time I sat down and just relaxed and thought and I really like that thought time
• I just follow on with something else or the ‘phone will ring or the children need you, or the next door neighbour…. It just doesn’t happen same as at work you just don’t set that time aside. But if I was hanging out for a smoke I’d say to my neighbour ‘come out with me’. I would think ‘oh let the answer machine answer that I’m going outside for a smoke’
• She’s probably not as good a worker as me because I do the reflection thing
• I meditate daily, that’s time out
• what sort of time out is it actually when you’re making your teeth yellow, your fingers yellow, giving yourself emphysema and possibly cancer? Where’s the time out?
• People smoke to get remove themselves from their work. That’s how they get through their day ‘oh ten o’clock, I’ll go and have my smoke, twelve o’clock I’ll go and have my lunch and have another smoke, oh two o’clock I can get out’
• You bet! Smoked more there than what I do here… Just to get out of the building
• I’ve predominantly lived alone it’s been my best friend ever since I started when I was a kid. Upset, stress? smoke. Happy – smoke. Celebrate. It was my wins and losses my best friend
• working with the client creates stress
• It is a stressful job. It’s high risk
• most of them have had trauma. I would have thought that most of them would have resolved it by the time they got here but not that I can walk on water myself but a lot of them can resolve it – it’s been trauma
• I think a possibility one of the underlying factors is the worker comes from the same trauma – they’ve had trauma and they smoke anyway.
• It’s stressful, can be stressful you know? – we’re dealing with kids at risk. Concern over them; whether they’re going to be alive on Monday. Concern with three young guys in a car one of them is aggressive you know it’s you’re sort of on your wits all the time and you have to sound caring and it takes a lot of energy. Projected in your voice, listen, body language, empathetic. Thinking about everything you do and everything you say before you put it out there – it’s draining
• It’s stressful. Yes. Me it does.
• So stress and alcohol are my big triggers
• Yes, stress is a trigger for me. I gave up for seven months and it’s no excuse but I found out that one of my best friends has died. Massive heart attack at fifty and she was a smoker and someone come around just after with smokes gave me one after the seven months and I had one, and I read at the funeral and I had about four that day and then that was it I was back on the wagon
• That is stressful – you go to someone’s house to make an assessment and they say ‘get out now’ someone’s pulled up it’s not exactly – it is a stress but I sort of kind of enjoy that stress. I enjoy using my mind.
• Yes. They’re my two triggers. Stress and alcohol
• We’ll put down stuff – materials support – because it can be a very stressful time when they work through their trauma and get off the sh*t that’s holding their lives back they focus on the smoking
• Well it’s about their needs it’s not about my needs. If they say ‘I want a cigarette, I want a f*cking cigarette’. Come on let’s go find a cigarette shop. You know, weigh up what’s going down they’re going to beat the sh*t out of me their partner, are they going to go to jail are they going to sell ….. like depends, like ‘Hello’
• Yeah, it depends what’s going on but if they’ve got a knife and is about to pull an armed robbery I’d say ‘I really do think you should have a cigarette’. They’ve got a knife up against my throat I think a cigarette’s a good option. I think one cigarette
• Yeah extremely comforting
• I had a couple of things there that had been ongoing and I’d been more assertive and said like to myself ‘I want some focus for me – I want this last thing to not be here’ but when you’re going through emotional stress like I said, that’s my biggest trigger
• But I really think it’s very difficult for someone to give up smoking – me anyway, if they’re in the middle of a stressful situation. They need to have a bit of peace.

Interview 9

• I might have a fag in the afternoon as the day was finishing with some other workers stuff like that.
• Probably started at the age of 12 actually and that was peer group pressure was wanting to be in with the core kids and that was the done thing and was worth doing that to get in there.
• We’d go to the pub after work, have a beer, talk about the day, stuff like that and there was a lot of stuff going down it was a really difficult time sorting out where I actually fitted in to YSAS and it was all a bit overwhelming the whole thing and the whole thing about being a free agent out there in the field trying to work out what Outreach means. Although you are guided its like at the end of the day you’ve got to work out where it fits in for you, you can only get so many models if you know what I mean.
• That was interesting it was more around the people I was living with – my flatmates, we all gave up stopped at the same time.
• And so stopped for a year or something like that then I moved out of there – out of that house that we were sharing and moved to a place of my own on Nicholson Street, Fitzroy. Pretty seedy part of town and got back into it again
• In the past it’s like whenever I have it’s been around because there have been external forces which perhaps have supported that change and there’s been the job that I’ve been doing that has supported that change too. So those combined it makes a good containment for me and when I do stop I feel great. I feel fantastic
• Don’t ask me how I relapse I don’t know but the thing is that that goes along again with how I feel supported with my work environment and with my outside work environment too.
• I suppose it could and the thing is until now my partner who doesn’t smoke cigarettes. She’s been hassling me about it and I’ve been resistant but now I’ve come to that myself. It’s taken, like she’s been hassling me for maybe a year and a half and I know her position on it.
• you were trying to do the best you can because you had a duty of care but at the end of the day it’s their lives, you can’t save them from what they actually do. I understand
that but at the same time it impacts upon you and then it’s like I suppose, not that your organisation has to know but at the time I didn’t feel supported by my co-ordinator as well. That was part of the thing of going to the pub with my workmates after work having them to debrief with around what was going on rather than with the co-ordinator

- I’m in a team now where I feel really supported and I feel very connected to the others at my work the co-ordinator’s fantastic she listens to everything it’s really safe with her and stuff like that so quite different atmosphere and she values my skill base.
- I might have a fag in the afternoon as the day was finishing with some other workers stuff like that.
- I reckon probably the place where I smoked a lot was when I started work in the crisis men’s accommodation units….. you were the only worker on….. you’d also get guys who were in crisis who were really schizing out
- So that was quite a stressful time so it was around that, it was around. There were a few changes happening in my life it was quite a stressful time. So the stresses actually kept me relapsing.
- you were trying to do the best you can because you had a duty of care but at the end of the day it’s their lives, you can’t save them from what they actually do. I understand that but at the same time it impacts upon you and then it’s like I suppose, not that your organisation has to know but at the time I didn’t feel supported by my co-ordinator as well. That was part of the thing of going to the pub with my workmates after work having them to debrief with around what was going on rather than with the co-ordinator

Interview 11

- I’d often go out and M will often come and say “Oh do you want to come and have a smoke?” It’s a good opportunity to catch up because M was my supervisor when I did my placement so quite a good rapport there. But I don’t see so much of her now because she’s in forensic so it’s a good opportunity to catch up with her and have a chat.
- I guess I enjoy smoking, and I suppose it’s a social thing as well. And you get a break.