

Breathe Easy – lifting the burden of smoking



A partnership between the Mental Health Coordinating Council and the Cancer Council NSW aimed at reducing levels of smoking in people with mental health problems who are one of the most disadvantaged groups in the community.

The Mental Health Coordinating Council

The Mental Health Coordinating Council (MHCC) is the peak body for community mental health organisations in New South Wales.

Our membership is primarily comprised of not-for-profit Non-Government Organisations (NGOs) whose business or activity is wholly or in part, related to the promotion or delivery of services for the wellbeing and recovery of people with mental health problems and organisations that support carers and families of people with a mental health problem. Membership also includes Associate Members such as Area Health Services, legal or medical organisations, disability, housing, employment and education who have an interest in mental health education, promotion and recovery oriented service delivery. Individuals not representing a specific organisation may become subscription members.

MHCC aims to:

- Advocate for policy development and legislative reform;
- Represent sector views to government and the broader community and health sector through consultation with member organisations, consumers, carers, and other stakeholders;
- Build sector capacity through partnerships, collaboration, and workforce development;
- Facilitate change through policy initiatives and projects;
- Inform the sector on strategic directions in community mental health and disseminate information;
- Research, publish and report on current directions in community mental health and wider mental health and related areas;
- Provide accredited training in recovery oriented practice, traineeships and a range of educational products; and,
- Support and nurture its member organisations to deliver recovery oriented services and work in collaboration with consumers, carers, other organisations and the community.

MHCC established the Learning and Development Unit (LDU) in 2007 in recognition of the need for mental health specific training and other workforce development products and services to member organisations and others interested in improving their responsiveness to mental health issues. The LDU is an accredited Registered Training Organisation which delivers nationally recognised qualifications and courses specifically designed to meet the needs of the Community Mental Health workforce.

Executive Summary

The Breathe Easy project was a partnership between the Mental Health Coordinating Council and the Cancer Council NSW. The project was primarily targeted at reducing levels of smoking in people with mental health problems who are one of the most disadvantaged groups in the community.

Although rates of smoking have significantly declined over the last three decades in the general Australian population, smoking is still a significant issue for a number of marginalised population groups. Smoking has a profound impact on people's lives that goes beyond the physical impacts of smoking; smoking reinforces cycles of poverty and social exclusion because of the combined health, financial and social burdens it causes.

People with mental health problems are more likely to be exposed to a number of risk factors for smoking – they tried it in adolescence, lower education, low income, and being around friends and family who smoke. Environment has also been a risk factor for smoking.

In the community sector and the public health sector there has been a failure to address or a culture of neglect around the damage caused by smoking. This culture is founded on strong beliefs and assumptions that consumers are not interested in addressing their smoking, that smoking is a form of medication for a range of mental health problems, that a person's mental health will worsen if they quit smoking, that smoking relieves stress and that smoking is the only vice left for consumers who have had so much taken away from them.

To change this culture the project employed a change management or organisational change approach that focussed on three levels of community mental health services – consumers, staff and the organisational culture. Three key strategies were used:

- Training for staff in tobacco cessation and mental health;
- Policy development; and
- Providing support structured to consumers to address their smoking.

Five MHCC member organisations participated as demonstration sites in the project. They participated in training, policy development workshops and they provided consumers with structured and regular support to address smoking using a group program format in smoking cessation.

The project achieved a number of positive results and was able to discredit a number of the prevailing myths about smoking and mental health. One of the key findings of the project was that staff and organisations discovered that consumers were very interested to reduce or quit smoking and that assisting them to do this had positive results. A number of consumers made attempts to quit smoking during the project and did so without any detrimental effects to their smoking.

Providing consumers with better opportunities to quit smoking had multifaceted benefits. Confidence to quit smoking increased and consumers developed new skills for coping with stressors in their lives that don't involve smoking. Some consumers were able to reduce their psychiatric medication. With increased self-confidence and self-esteem consumers felt more empowered to address other issues in their lives.

Organisations also found that delivering a group program was a meaningful way to address smoking and provided benefits beyond quitting smoking. Consumers used the group program as an opportunity for socialising and developing peer support.

Addressing smoking had benefits for staff and the organisation. Staff who were smokers were encouraged by the project to address their own smoking. Staff were able to increase their skills and knowledge and expand their understanding of the issues that are important in consumers' lives. Organisations were perceived to be more supportive of addressing smoking; staff and consumers felt they had more support and understanding from their peers in trying to quit smoking.

Leadership from the organisations and from key staff members were vital to successful implementation of the project strategies to address smoking. Identifying champions can greatly assist the process of change. Time was highlighted as the biggest barrier to being able to address smoking. Because smoking cessation has not been a priority and has not been part of core practices of services staff need to be given ample time to incorporate new skills into their normal practice. Time is required for planning group programs if offered, time required for developing partnerships and time for assisting consumers.

Staff and organisations need to appreciate that just as quitting smoking is a journey and a process that requires time and planning, comprehensively addressing smoking in the sector is also a process that takes time and consideration. Organisations need to allow for changes to take place over time and not expect immediate changes. Any changes in policy and practice should be made in consultation with consumers and staff in a collaborative manner.

This report recommends that organisations provide staff opportunities with opportunities to become skilled and increase their knowledge in smoking cessation and mental health; organisational policies should be developed or updated to include greater detail around recording consumer smoking status, staff not smoking with consumers and providing consumers with structured support to address their smoking. Organisations should also, as a minimum, ask consumers if they want to address their smoking and if deliver smoking cessation group program facilitated by staff.

Having a mental health problem should not be seen as an obstacle to quitting smoking. Nor should smoking be considered an acceptable activity for consumers in lieu of more meaningful and affordable activities. And smoking should not be considered a form of medication or a method for managing mental health problems; the risks of smoking far outweigh any perceived benefits smoking provides.

Smoking is an important issue for services to address. It sits firmly within a recovery framework where self-determination and social inclusion are encouraged; where compassion and understanding are promoted. By looking at the organisation as a whole and making changes to the systems and practices, organisations that address smoking will expand the choices and opportunities for consumers to increase their overall health and well being and better support their recovery journey.

Acknowledgements

MHCC acknowledges and gives sincere thanks to the consumers and staff at demonstration sites, Steering Committee and Reference Group for their commitment of time, expertise and knowledge to the project.

MHCC is particularly grateful to the five member organisations who participated as the demonstration sites in the project in addition to their normal workloads; their energy and willingness and contribution of time were invaluable to the project.

Thank you to:

- Billabong Clubhouse, Robyn Lane, Michael and Collette
- PHaMs Shoalhaven of The Schizophrenia Fellowship of NSW and Judith Simons
- Neami South East Sydney, Julie Payne, James Kim and Lea Robertson
- Hunter Joblink Inc and Amy Radford
- Irene Luth Supported Accommodation of UnitingCare Mental Health and Lainy Samperi.

A special thank you to all the consumers at each of these organisations for their willingness to share sharing their experiences for the project.

MHCC would also like to thank Tracey Greenberg, NSW Health Tobacco Cessation Trainer, Wendy Oakes and Phil Hull from the Cancer Council NSW.

Steering Committee

Jenna Bateman
CEO, MHCC

Sue Sacker
Deputy CEO, The Schizophrenia Fellowship of NSW

Jon O'Brien
Senior Program Coordinator for the Tackling Tobacco Program, Cancer Council NSW

Peter Schaecken
Area Coordinator, Community Consultative Committee SSWAMHS

Arthur Papakotsias
CEO, Neami Ltd

Reference Group

Kathy Duggan
Samaritans Foundation

Peter Schaecken
Consumer Consultative Committee, SSWAMHS

Anne Easterbrook

Nichole Sullivan
Triple Care Farm, Mission Australia

Andrew Hamilton
Formerly with New Horizons Enterprises Ltd.

Contents

- The Mental Health Coordinating Council1
- Executive Summary.....2
- Acknowledgements4
- 1. Smoking and Mental Health.....7
- 2. The Breathe Easy project8
 - 2.1 The demonstration sites8
 - 2.2 Evaluation of the project12
 - 2.3 Methodology of the project.....13
 - 2.3.1 Working with the demonstration sites13
 - 2.3.2 Project strategies.....14
 - 2.3.3 Other project activities.....17
- 3. Findings of the project18
 - 3.1 Surveys of the demonstration sites.....19
 - 3.1.1 Surveys of consumers19
 - 3.1.2 Findings from the group program23
 - 3.1.3 Focus groups with consumers24
 - 3.1.4 Surveys of staff27
 - 3.1.5 Interviews with staff.....31
 - 3.2 Surveys of MHCC members.....34
- 4. Program sustainability.....37
- 5. Discussion of the project findings38
- 6. Recommendations43
- References45

Figures

Figure 1: percentage of consumers interested to address their smoking	19
Figure 2: Timeframe for interest in quitting.....	20
Figure 3: Self-rated confidence by consumers to quit smoking in the next 6months	20
Figure 4: Time since quit smoking	21
Figure 5: Time since last quit attempt	21
Figure 6: Average number of cigarettes per day and CO levels of group program participants per session (n=9).....	24
Figure 7: Percentage of staff who agreed that quitting smoking will cause consumers to have a relapse in their mental health problem.....	28
Figure 8: Comparison of baseline and final survey of percentage of MHCC members who agreed quitting smoking will cause a relapse in a person's mental health.....	35

Tables

Table 1: Description of demonstration sites and summary of participation	9
Table 2: Outline and description of SANE Smoke SmokeFree Kit group program sessions.....	16
Table 3: Policy areas reviewed by demonstration sites	28
Table 4: Percentage of staff and usefulness of project strategies to address smoking (n=12).....	30
Table 5: Percentage of staff and the benefits of the project (n=12)	30

1. Smoking and Mental Health

The rate of smoking in Australia continues to decline and is no longer considered the norm. Yet for many population groups, such as for people with mental health problems the rate of smoking is still unacceptably high. Within the mental health sector there has existed a culture of smoking long supported by a number of enduring myths about the 'benefits' of smoking as well as a lack of responsibility taken by mental health workers around the physical health of consumers. Smoking not only occurs at a higher rate amongst people with mental health problems compared to the general Australian population, but has also been considered and accepted as a normal activity for consumers. Hopefully it can now be said that the myths around mental illness and smoking are increasingly being exposed and the culture of smoking is beginning to change.

The most recent data available from the Australian Bureau of Statistics (ABS) indicates that approximately 32% of people with mental health problems smoke whereas the rate of smoking in the Australian population is about 20%.ⁱ Research indicates that people with mental health problems have poorer health outcomes and lower life expectancy, one of the main causal factors being smoking.ⁱⁱ Many people with mental health problems receive a pension and studies have shown that up to 30% of this income is spent on smoking.^{iii, iv} After housing and food costs there is little money left for anything else, let alone money for leisure or recreation. And smoking is often given greater importance than food.^v This all adds up to fewer opportunities to participate in the community through work or leisure and greater reinforcement of social disadvantage and isolation for a group of people who already experience stigma as a result of their mental health problems.

So why do people with mental health problems smoke more? The reasons for smoking are essentially the same as for any smoker, that is, they tried it in adolescence and became addicted. However, people with mental health problems are also more likely to experience other risk factors related to smoking such as lower levels of education, low-income and unemployment.

There are a number of key prevailing myths, beliefs and assumptions about the relationship between smoking and mental health that have played a large part in how smoking is addressed in the mental health sector. It is widely believed that:

- Smoking is needed as a form of self-medication to manage mental health problems;
- Quitting smoking will cause a worsening of a person's mental health;
- Smoking relieves stress;
- People with mental health problems are not interested and can not give up smoking; and,
- Smoking is their only last pleasure in life.

A literature review recently commissioned by the Cancer Council NSW (CCNSW), found that these beliefs and others were either untrue or the available evidence was not strong enough to draw any firm conclusions.^{vi}

Such beliefs have limited the access and development of tobacco treatment programs for people with mental health problems and have only served to undermine peoples' recovery process. They have aided the creation of a culture of smoking in the mental health sector where smoking is normalised and accepted and where it has even been encouraged and reinforced.^{vii, viii}

It is for these reasons people with mental health problems smoke at a higher rate than the general population and therefore experience a disproportionate burden of tobacco related harm.

2. The Breathe Easy project

The Breathe Easy project began in February 2008 as a partnership between the Mental Health Coordinating Council (MHCC) and the Cancer Council NSW (CCNSW). The project is part of the CCNSW's broader project Tackling Tobacco which aims to reduce the harm caused by tobacco use amongst socially disadvantaged population groups.

The purpose of the Breathe Easy project has been to reduce tobacco related harm in people with mental health problems accessing organisations within the community mental health sector. Organisations within the sector deliver a range of support programs and services such as supported accommodation, employment, self-help and mutual support groups, and centre-based support, education and leisure.

Because smoking cessation is not traditionally considered a core service or priority of community mental health organisations, the sector requires a culture change and service reorientation to address smoking. Culture is dynamic and constantly changing and community mental health organisations working within a recovery-oriented framework should regularly evaluate and clarify the core values and mission of the organisation. Thus for smoking to be addressed alongside other issues in consumers lives, the project has principally focussed on a culture change of the sector so that it can better address smoking and genuinely support consumers in a recovery-oriented framework.

Due to the complex nature of the issue and the challenge of culture change it was recognised early on in the project that a multi-pronged approach would be needed to address the enduring beliefs and assumptions around smoking and mental health that seem to impede the ability of the sector to address smoking. A change management or organisational change approach was adopted for the project to reorient the sector and initiate a culture change in the way smoking is addressed. A number of strategies were employed that looked at organisations as a whole. The model developed for the project is described below in the methodology section.

Addressing smoking through change management or organisational change is not a novel concept. The Addressing Tobacco Use Through Organizational Change (ATTOC) intervention model is one such model that was developed on the basis that staff training alone is not enough to address smoking in settings where it is an established part of the organisational culture such as in drug and alcohol and mental health settings. It involves six core strategies that are implemented in a 12 step process. This model informed the development of the strategies adopted for this project.^{ix}

2.1 The demonstration sites

Five MHCC member organisations participated as demonstration sites for the project. The following table provides a description of each service and a summary of their involvement in the project. The process of selecting and working with the demonstration sites is described in section 2.3.

Table 1: Description of demonstration sites and summary of participation

DEMONSTRATION SITE	DESCRIPTION OF SERVICE	SUMMARY OF PARTICIPATION
Billabong Clubhouse, Tamworth	<p>Billabong Clubhouse is a psychosocial rehabilitation service for adults with mental health problems. The Clubhouse is relationship and work centred where members and staff work together to achieve positive vocational and social outcomes for members and the whole Clubhouse.</p> <p>During the period of the project the Clubhouse had a total of five staff with up to 25 members attending each day and a total of approximately 253 members attending the Clubhouse.</p>	<ul style="list-style-type: none"> • All staff, ten consumers and two occupational therapists from the local hospital attended the training day; • The policy workshop was attended by four staff and two consumers; • Billabong Clubhouse was the only site provided with a carbon monoxide monitor or a Smokerlyzer that measures the level of expired carbon monoxide. Carbon monoxide decreases with a reduction in smoking. • The site began weekly sessions of the group every Monday from early February 2009 for ten weeks and was facilitated by two clubhouse staff and a community mental health worker; • The management council of Billabong Clubhouse provided any member who wanted to use NRT to help them quit with \$50 per fortnight to help with the purchase of NRT; • ‘Showbags’ were put together for participants that contained a stress ball, quit diary, Quit pack from the Quitline, money box, pen, bookmark, NSW Health DVD on NRT and a calendar. • Guest speakers were organised from a bank and travel agency; • Healthy snacks were provided to consumers for free as part of the group; • A buddy system to increase support for people trying to quit was encouraged; • The site advertised their involvement in the project through a clubhouse newsletter and generated a lot of interest about the project in the local area with health professionals and clubhouse in other areas of Australia and the USA; • The site was also featured in a number of articles in local media.
Hunter Joblink, Newcastle	<p>Hunter Joblink is a community service supported by Hunter New England Area Health Service that provides participants with the opportunity to establish a sound work history in conjunction with nationally recognised training that is delivered in a supported environment. Specialising in helping those with a psychiatric disability, Hunter Joblink has assisted participants in workplace rehabilitation training and supported employment since 1998, offering qualifications in the hospitality and lawn care industries.</p>	<ul style="list-style-type: none"> • All staff attended the training day as well as one staff member from another service and Occupational Therapist from Morisset Hospital; • The policy workshop was attended by three of the staff members as it was difficult for the service to close the restaurant and cancel mowing crews;

DEMONSTRATION SITE	DESCRIPTION OF SERVICE	SUMMARY OF PARTICIPATION
Neami South East Sydney	<p>During the period of the project Hunter Joblink had four staff members and approximately about 30 consumers accessing the service.</p> <p>Neami South East Sydney (Neami SES), based in Hurstville, is one of eight Neami services in NSW. Neami is a community managed organisation that provides a range of mental health rehabilitation services to consumers in Victoria, NSW and South Australia. Neami provides a range of services including supported housing, outreach support, group rehabilitation programs as well as an art studio in Melbourne.</p> <p>In NSW Neami provides support to over 140 consumers with high to low support needs under the Housing and Accommodation Support Initiatives HASI 1 and HASI 2 and now. The staff provide support to consumers 7 days per week, working am and pm shifts. The support may include assistance with socialisation, education, employment, living skills, health and resourcing consumers to access their community of choice. Accommodation is arranged in the community for each consumer and they live independently with access to the 7 day support.</p> <p>At the beginning of the project Neami SES had twelve staff members and approximately 72 consumers accessed the service.</p>	<ul style="list-style-type: none"> • Due to staffing changes early in 2009 only baseline data and partial interim data was collected from this site and a focus group was not conducted with consumers. • Five staff members attended the training day; • Seven staff members and three consumers attended the policy workshop; • The site teamed up with community mental health to facilitate the group program – two Neami staff and one community mental health worker facilitated the group; • The site began the group program in late May 2009 on a twice weekly basis, every Monday and Friday; • Healthy snacks were provided to consumers for free as part of the group; • The site developed a partnership with a local pharmacist that provided NRT at below cost price to Neami SES; and, • NRT was offered for free to consumers; • Due to staffing changes in 2009 only baseline data and interim data was collected from this site.
Personal Helpers and Mentors Shoalhaven, Schizophrenia Fellowship	<p>The Personal Helpers and Mentors (PHaMs) Shoalhaven outreach service of The Schizophrenia Fellowship of NSW. The service is a split site that provides support in the Nowra and Ulladulla areas of the Shoalhaven region.</p> <p>The Schizophrenia Fellowship of NSW works to improve the quality of life for people living with mental illness, especially schizophrenia, by:</p>	<ul style="list-style-type: none"> • All staff attended the training day as well as a staff member from another Schizophrenia Fellowship service, an AOD counsellor, and two staff from another local service; • All staff and ten consumers attended the policy workshop; • PHaMs began running two groups, one in each of it's service delivery areas, in mid April on a weekly basis (every Tuesday) for ten weeks; • Two staff members facilitated each of the groups; • On attendance to the group consumers were provided with information packs that included CCNSW information sheets, NSW Health Pamphlets, Quit Program & Quit Line referrals, pamphlets

DEMONSTRATION SITE	DESCRIPTION OF SERVICE	SUMMARY OF PARTICIPATION
	<ul style="list-style-type: none"> Initiating and undertaking programs which support consumers, carers and clinicians; Raising community awareness regarding the implications of schizophrenia in order to reduce stigma; Advocating on behalf of consumers and carers to state and federal governments; and Supporting research into schizophrenia. <p>The Fellowship has many services that include support groups throughout the state; rehabilitation programs, including Clubhouse; Carer Assist Service; state-wide consumer outreach programs; and, housing.</p> <p>During the project PHaMs Shoalhaven had a total of seven staff members and about 55 consumers who accessed the service.</p>	<p>on pharmacotherapies (NRT, champix and zyban) and NSW Health Smart NRT DVD;</p> <ul style="list-style-type: none"> Healthy snacks were provided to consumers for free as part of the group; Guest speakers were organised for different sessions that included a representative from local chemists, an optometrist, a yoga/meditation instructor and a Health Education Officer; A partnership was developed with a pharmacy in Ulladulla which has agreed to provide an on-going 10% discount on NRT products for consumers attending the Ulladulla group; Staff transported most consumers to and from the group each week; Consumers were offered a one-off amount of \$100 to assist with the purchase of NRT.
Irene Luth Supported Accommodation, Uniting Care Mental Health	<p>Irene Luth Supported Accommodation (Irene Luth) is one of many services of UnitingCare Mental Health (UCMH).</p> <p>UnitingCare Mental Health provides a diverse range of community based psychosocial rehabilitation, counselling, support and accommodation services and is a specialised division of Parramatta Mission.</p> <p>The main functions of the UCMH is to provide psychosocial rehabilitation services from a recovery based and social inclusion philosophy, and family and carer services that increase resilience and coping skills. Through collaborative recovery planning and community inclusion modelling, UCMH endeavours to partner with consumers and families and carers to increase wellbeing and quality of life.</p> <p>During the project Irene Luth had three staff members and 25 residents at the service.</p>	<ul style="list-style-type: none"> All staff from Irene Luth and an additional three staff members from other UCMH services attended the training day; All staff from Irene Luth, an additional five UCMH staff members (this included the Director of UCMH) and 3 consumers attended the policy development workshop; The group program began late February and ran on a weekly basis for ten weeks; The group ran every Tuesday during after work hours to accommodate for residents who worked or were studying; One staff member facilitated the group and was a later assisted by an intern with the service; Healthy snacks were provided to consumers for free as part of the group.

2.2 Evaluation of the project

The Breathe Easy project was evaluated in terms of the effectiveness of the activities undertaken throughout the project and the impact of these activities based on the following ultimate goals of the project:

- A reduction in smoking rate by consumers & staff;
- An increase in the percentage of consumers who quit during and by the end of project;
- An increase in the number of quit attempts by consumers;
- An increase in consumer interest in quitting, and,
- An increase in consumer confidence in their ability to quit.

The main objectives of the project were to:

- Create a better awareness of the need to address smoking – to affect changes in smoking behaviour and attitudes; and,
- Enhance the capacity of the participating organisations to address smoking – by changes in organisational policy & practice.

In evaluating the above goals and objectives a combination of evaluation methods were used to gather largely quantitative but also qualitative data. The following table provides a timeline and a description of the evaluation methods and the target group of each method.

Date	Activity and Purpose
May 2008	Baseline survey of MHCC member organisations to measure the attitudes, policies and practices around smoking.
November 2008	Baseline surveys of demonstration sites to: <ul style="list-style-type: none"> • Measure consumer smoking behaviour and attitudes; • Measure staff and management smoking rates, attitudes, policies and practices.
March 2009	<ul style="list-style-type: none"> • Interim surveys of demonstration sites as per baseline survey.
May-June 2009	<ul style="list-style-type: none"> • Final survey of demonstration sites as per baseline survey and to evaluate project activities; • Focus groups with consumers to measure smoking behaviour and attitudes and evaluate support provided.
June 2009	Final survey of MHCC member organisations to measure the attitudes, policies and practices around smoking and to measure promotion of project.

Each demonstration site was also asked to:

- Keep a project diary;
- Record the nicotine dependence score at the beginning and end of the group program;
- Record the number of cigarettes smoked per day of each participant in the group program;
- Record if anybody made a quit attempt and if they used a quit smoking product
- Record carbon monoxide (CO) levels using a CO monitor (this only applied to Billabong Clubhouse, see section 2.1).

These were not mandatory requirements of the project and not all. However this was not a mandatory requirement and not all sites had to time to provide this.

2.3 Methodology of the project

2.3.1 Working with the demonstration sites

Selecting the demonstration sites

MHCC worked with and supported five member organisations (as described in section 2.1) in strategies to address smoking for approximately nine months beginning October 2008 to June 2009.

A baseline survey was sent to MHCC members in May 2008. The survey was used to select organisations who were interested in participating as a demonstration site for the project. Thirty-eight surveys were returned and sixteen organisations registered an interest in participating in the project. The following five organisations were then selected to ensure a range of service types and geographical spread in NSW.

Initial meeting with the demonstrations sites

Each organisation was contacted to confirm their interest in participating in the project. On-site meetings were organised throughout October with each organisation to discuss what participating in the project involved; what was expected from the organisation and how the organisation would be supported by MHCC. All staff and consumers were encouraged to attend the initial meeting to highlight awareness that their service was participating in the project.

This initial meeting was an opportunity for questions and issues to be raised and addressed about participating. It was also an opportunity to identify staff and consumer champions for the project who would help drive the project within their organisation.

A guide on participating in the project was also developed and provided to each organisation as a reference document for the project. The guide included the purpose of the project, expected outcomes, timeframes, project strategies and activities, evaluation of the project and what was expected from the organisations.

Expected contributions from the participating organisations

To assist with the implementation of the project each organisation was asked to:

- Start talking to all staff and consumers about the project and what their involvement would entail;
- Sign a 'Project Agreement' as a pledge of commitment to the project;
- Identify consumer, staff and management champions to help drive the project within their organisation;
- Participate in all planned evaluation activities;
- Try to create partnerships and networks with the relevant Area Health Service, local GPs, local pharmacists and any other relevant stakeholders to increase their support and advice network, but to also increase the profile of the need to address smoking;
- Keep a project diary to record the positive and negative experiences, lessons learnt, ideas, consumer and staff views, etc during the project rather than trying to capture these details at the end of the project. Although this was not a compulsory requirement, organisations were asked to submit the diary at the end of the project to help with evaluating the project.

2.3.2 Project strategies

Three main strategies were devised for the project:

1. Training and education for staff in tobacco cessation and mental health;
2. Policy development workshops; and
3. Support for consumers to address their smoking.

The order of the implementation of the strategies was deliberate. Although senior management of the organisations agreed to participate in the project the next step was to bring staff of each of the selected services on-side as there is always initially reluctance with any proposed changes within an organisation. Often this is because the change can be perceived as extra work but also because staff may have preconceived notions about a particular issue and require more knowledge.

Therefore providing training was considered a frontline action to increase knowledge and help to change attitudes. With increased knowledge the organisation would then be better placed to understand the importance of enhancing and creating more comprehensive smoking policies. Once these two strategies were implemented staff would be more skilled to provide support to consumers and the organisational environment would be more accommodating for staff to address smoking with consumers.

It was expected that all staff from each organisation, where possible, would attend the training days and policy workshops provided.

Training and education

The first strategy was to provide staff with the skills and knowledge in tobacco cessation and mental health. One day training was delivered by Tracey Greenberg, the Tobacco Cessation trainer for NSW Health.

The learning outcomes for the training were:

- Provide background information relating to smoke-free policy and effects of environmental tobacco smoke;
- Discuss a range of issues specific to smoking in the mental health community;
- Outline the management of nicotine dependence, toxicity and withdrawal;
- Describe the assessment process;
- Define a brief intervention on smoking cessation;
- Outline treatment options, including behavioural strategies and nicotine replacement therapy; and,
- Outline a range of relapse prevention measures.

A resource kit was provided to each participant who attended the training; the resources are listed in Appendix xx.

Because the training is targeted at people in a position to provide assistance and support to quit smoking, only staff were invited to attend the training days. However at one site interested consumers also attended the training.

Policy development workshop

A 2-3 hour policy workshop was conducted at each site by the Breathe Easy project officer. With any proposed changes to policies all those who will be affected by a proposed change should be consulted. Based on this all staff and consumers at each site were invited to attend the workshops.

The purpose of the workshops was to stimulate ideas of policy changes they could make and to provide each organisation with the tools and information on how to make and implement policy changes.

The workshop was based on the CCNSW's publication *Addressing smoking in community service organisations: A Policy Toolkit*. The toolkit was specifically developed for the community services sector and provides a step by step guide on what issues need to be considered when developing a new or existing policy and how to develop and implement the policy.

There were two components to the workshop. During the first half of the workshop a presentation based on the aforementioned toolkit was delivered. In the second half participants were asked to break up into groups to work on two exercises, one based on two case studies detailed in the toolkit, and the second exercise required the participants to look at their own organisations.

Support for consumers to address their smoking

To comprehensively address smoking each organisation was asked to conduct smoking cessation using the SANE SmokeFree Kit, a program based on a group format. At the time of writing SANE were reviewing the kit; the new edition may have changed from what is described here.

Group programs for smoking cessation typically involve coping and social skills training, contingency management, self control, and cognitive-behavioural interventions and use six to eight sessions.^x

The SANE SmokeFree Kit is designed to be run for 10 weeks for people at all stages of readiness to address their smoking and has been specifically designed to assist people with mental health problems address their smoking. It uses a combination of motivational interviewing and cognitive based therapy methods to assist consumers to look at their smoking behaviour. The kit provides workers in the drug and alcohol, smoking cessation or mental health fields with information on smoking and mental health and a manual on how to run each weekly session and the handouts and materials required. Table 2 provides an outline and description of each of the sessions in the SANE group program.

Table 2: Outline and description of SANE Smoke SmokeFree Kit group program sessions^{xi}

SESSION	DESCRIPTION OF SESSION
Session 1 – Introduction to the Program	In this first session participants will be given more information about what to expect from the program, they will be able to discuss their own experience with smoking and talk about the positive and negatives of smoking
Session 2 – Working with the Positives	Review of the previous week’s activities and emphasising the positives about quitting.
Session 3 – How Smoking Affects Your Body	This session examines the effects of smoking on the body and how to build motivation by acknowledging these effects.
Session 4 – Self-liberation	Participants have an opportunity to learn new skills, planning for the future and to make a strong commitment to some goals.
Session 5 – Dealing with Stress and Helping Relationships	Follow-up on participants smoke-free goals and a discussion and opportunity to learn new skills in dealing with stress.
Session 6 – Healthy Ways of Dealing with Feeling Down	This session looks at ways participants can cope with negative feelings.
Session 7 – Dealing with Strong Negative Feelings	Follows on from the previous week but explore strong negative feelings a little more.
Session 8 – Fit and Wel	Participants will look at how they can make changes to have a healthier lifestyle and be more active.
Session 9 – Planning for High-Risk Situations	This session looks at how to prevent a smoking relapse and building the skills and strategies to cope with situations where they might be tempted to smoke. This session also provides the facilitators to work with participants who still need a bit more attention.
Session 10 – Celebrating the Journey	Last session of the group program. Participants review the past ten weeks, talk about what their smoke-free goals and plan for how they will work on their goals when the program finishes.

Based on consultations conducted with another organisation that used the kit, it was recommended that each of the sites hold an information session one week before the commencement of the program. The purpose of the information session was to speak to participants about the program, discuss what to expect, the benefits of participating, and emphasising that it is a support group with no pressure to quit smoking. The information session was also an opportunity for participants to invite their friends, family and carers, anybody who may be a support for them, so that would have an understanding of the program and be aware that the participant was thinking about addressing their smoking.

During the information session each site was also encouraged to record the nicotine dependence score at the beginning and end of the group program, the number of cigarettes smoked per day, and if anybody made a quit attempt and if they used a quit smoking product.

Nicotine dependence can help to predict if a smoker is likely to experience nicotine withdrawal on stopping smoking and is measured using the *Fagerstrom Test for Nicotine Dependence*.^{xii}

One site, Billabong Clubhouse, was provided with a piCO Smokerlyser machine which measures the level of CO expired and asked to record the CO levels each week of each participant. Carbon monoxide is one the major toxins in cigarettes that robs the body of oxygen and decreases dramatically within twelve hours of quitting smoking. Therefore monitoring CO levels can provide smokers with tangible and immediate results if they make an attempt to quit smoking.

The rationale for supplying only one site with a Smokerlyser was to evaluate whether it was an essential motivational tool for smoking cessation that community mental health organisations required to address smoking.

2.3.3 Other project activities

Smoking & mental health seminar

An important component of the project was to raise awareness of the need to address smoking. In late 2008 MHCC held a sector-wide to examine and discuss some of the beliefs and evidence around smoking and mental illness. The purpose of the seminar was to inform and encourage individuals and organisations on what they can do to address smoking.

The seminar generated a high level of interest in the sector and was well attended; 90 people were registered to attend the seminar. In the final survey of MHCC members (see section 3.2) 37.5% said they learnt of the project by attending the seminar.

A range of speakers presented at the project to provide attendees with different perspectives of smoking and mental health.

The keynote speaker was Mark Ragg who presented findings from the literature review 'Smoke & Mirrors: a review of the literature on smoking and mental illness' conducted with Dr Tanya Ahmed's for the Cancer Council NSW.

Other speakers included:

- Carla Cowles discussing the Breathe Easy project;
- Jon O'Brien, Program Coordinator for CCNSW's Tackling Tobacco, discussing an organisational approach to addressing smoking;
- Peter Schaecken, Area Coordinator for the Consumer Consultative Committee SSWAMHS, discussing his personal quitting experience.

The presentation from Peter Schaecken was considered one of the highlights of the seminar because it provided attendees with an insight in to the process of quitting smoking and helped to dispel the idea that mental health problems are an obstacle to quitting smoking. Smoking and mental health resources were also available for attendees at the seminar.

Smoking & mental health resources

Three information sheets were developed as part of the project:

- Smoking and your mental health;
- Supporting someone with a mental health problem to address their smoking; and,
- Information for health professionals: Smoking & Mental Health.

The purpose of the information sheets was to increase awareness, dispel the myths around smoking and mental health, and to provide better information to consumers and people supporting consumers to quit smoking. All three information sheets have been made available for download on the MHCC and CCNSW websites.

Smoking Cessation Resources and Training Collaboration working group

In 2008 the Smoking Cessation Resources and Training Collaboration (SCRATC) working group was formed to examine and identify the most useful and relevant smoking cessation resources currently available to the community sector. Members of the group were Jon O'Brien (CCNSW, Senior Program Coordinator of Tackling Tobacco), Jill Morris (CCNSW, Program Officer with Tackling Tobacco), Tracey Greenberg (NSW Health, Tobacco Cessation Trainer), Arya Geike (ACWA, Project Coordinator of Smoking Matters) and Carla Cowles (MHCC, Project Officer of Breathe Easy).

SCRATC identified a list of resources to be recommended for community organisations to use when addressing smoking. Many of these were given to participants who attended the training for this project.

Two other information sheets were also developed as a result of an informal gap analysis conducted by SCRATC:

- The impacts of smoking and the benefits of quitting – by CCNSW; and
- The relationship between smoking and disadvantage and what community services can do – by ACWA and CCNSW.

A new resource, Smoking Care Assessment Pack, was also developed to assist workers in community sector organisations address smoking with consumers/clients in a non-confrontational way. The structure of the resource is based on the brief intervention framework, known as the 5As (ask, advise, assess, assist and arrange follow up),¹³ used in smoking cessation to assist health professionals provide quitting smoking advice. Design and content of the resource was based on SmokeCheck, a NSW Health resource for smoking cessation with Indigenous clients.

The Pack comprises a desktool with guidelines and prompt questions for workers, and four booklets to be given to consumers/clients depending on which stage of readiness they are at to quit smoking. It is available to community sector organisations from the CCNSW.

3. Findings of the project

As outlined in section 2.2 the evaluation of the project was conducted using a combination of quantitative and qualitative methods which included: surveys of consumers and staff; focus groups with consumers; exit interviews with staff; project diaries from each participating organisation; and surveys of MHCC members.

It should be noted that there are some limitations to the data collected throughout the project.

The five organisations that participated in the project were asked to be involved in addition to their normal workloads and practice. The project was subject to real-world constraints that could not always be controlled such as time, resources, staff changes or changing circumstances of consumers that access the service. These constraints help to explain why there are significant differences in the number of responses received for the surveys.

Every effort was made to accommodate any problems or changes that arose that would affect the organisations' participation in the project activities and evaluation, however, this was not always possible because of various project deadlines.

Therefore the findings presented here are not necessarily definitive of the sector or the organisations and the project strategies involved but they do provide a useful tool to gauge what does and what doesn't work to address smoking.

3.1 Surveys of the demonstration sites

The following sections describe the results from evaluation activities undertaken with the five demonstration sites only. A baseline, interim and end survey was conducted with consumers, staff and managers at each site. Consumers also participated in focus groups at the end of the project and exit interviews were conducted with staff at four of the sites.

3.1.1 Surveys of consumers

Consumers at each site were surveyed at the beginning (November 2008), middle (March 2009) and end (May – June 2009) of the project.

A total of 83 consumers responded to the baseline survey, 53 responded to the interim survey and 34 responded to the final survey.

The profile of the consumers surveyed show just over half of respondents were female and the average age was in the early 40's.

The findings of the consumer surveys are presented in terms of the goals of the project described in section 2.2.

An increase in consumer interest in quitting

Consumer interest to quit smoking was measured in two ways.

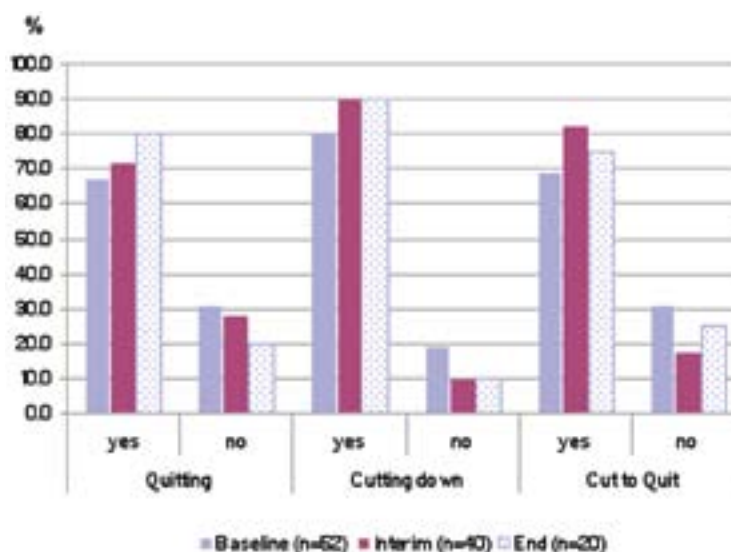


Figure 1: percentage of consumers interested to address their smoking

(i) Those who were smokers were asked whether they were interested to quit smoking, just cut down smoking, or cut down smoking to quit.

Figure 1 shows that consumer interest to do something to address smoking was high at the beginning of the project and continued to increase by the end of the project; the percentage of consumers who wanted to do something to address their smoking never fell below 60%. Most consumers, at each stage of the project, were thinking about cutting down smoking and by the end of the project 80% were interested in quitting smoking altogether and 75% were interested to cut down smoking to quit.

(ii) The second method of measuring interest to quit was by assessing how soon consumers were interested to quit smoking. Consumers were asked if they would like to quit smoking in the next 30 days, the next six months, or another period of time. Figure 2 shows that at the beginning over 60% of consumers were interested in quitting in the next six months, but by the end of the project almost 80% of smokers said they were interested in quitting in the next 30 days.

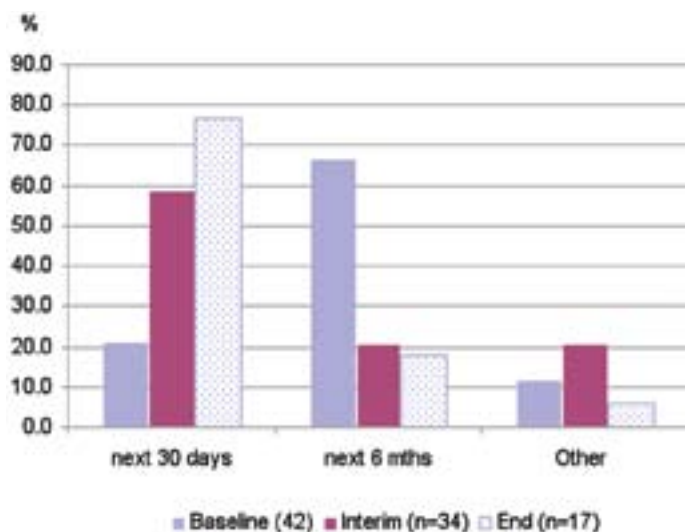


Figure 2: Timeframe for interest in quitting

An increase in consumer confidence in their ability to quit.

Measuring smokers' confidence to quit smoking is another way of looking at the process of quitting smoking and helps to assess their readiness to make an attempt to quit smoking. The results generally indicate that consumers' confidence to quit smoking increased by the end of the project.

Consumers were asked to rate how confident they felt on a scale of 0 to 10, where 0 was 'not at all confident' and 10 was 'extremely confident', in quitting smoking in the next 6 months. Figure 3 shows that at the baseline most consumers rated themselves between not at all confident and fairly confident. By the end of the project confidence to quit smoking tended toward extremely confident.

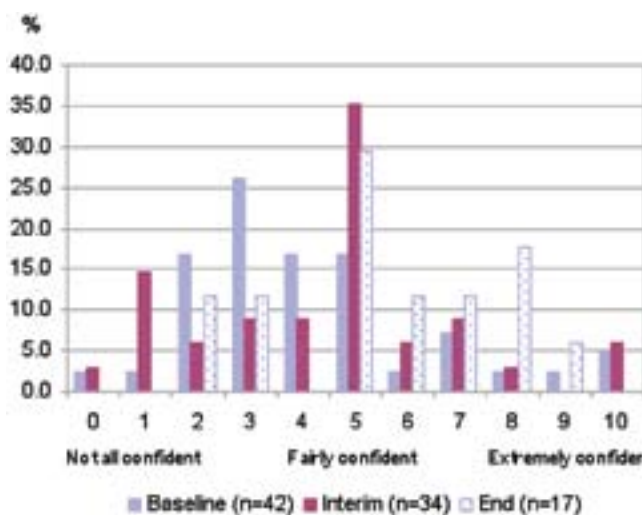


Figure 3: Self-rated confidence by consumers to quit smoking in the next 6 months

An increase in the percentage of consumers who quit during and by the end of the project

This project goal was measured in two ways: (i) asking ex-smoker consumers how long since they quit smoking (stopped regular smoking), and (ii) asking consumers who are smokers how long since their last quit attempt.

(i) Figure 4 shows there was an increase in the number of consumers who quit smoking during and by the end of the project. By the end of the project more consumers said they quit 'less than 1 month ago' and 'less than 3 months ago', which is during the period of the project.

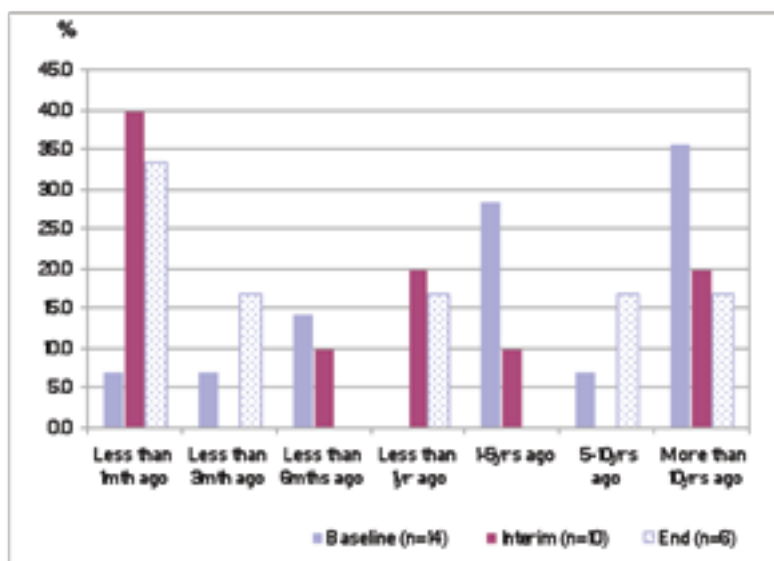


Figure 4: Time since quit smoking

(ii) By the end of the project there was an overall increase in the percentage of consumers who said they made a quit attempt during the period of the project. Figure 5 shows more consumers made a quit attempt 'less than 3 months ago' and 'less than 1 week ago' by the end of the project.

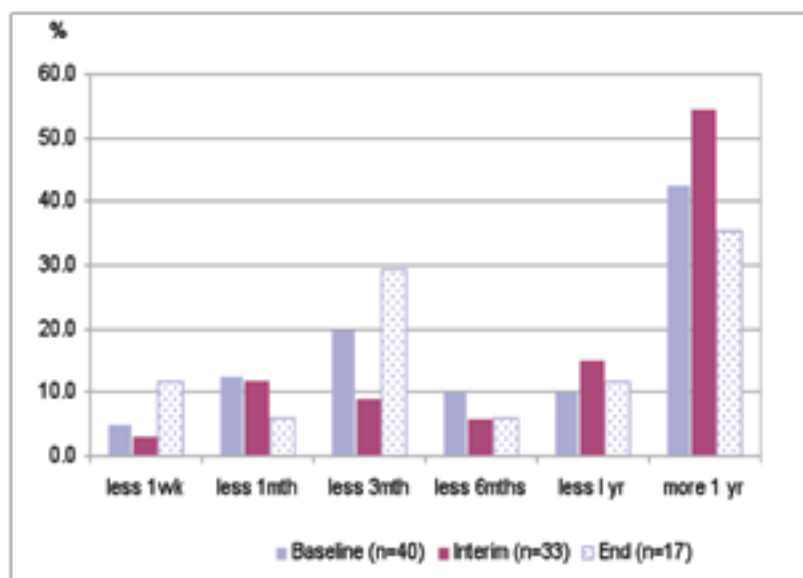


Figure 5: Time since last quit attempt

An increase in the number of quit attempts by consumers

Measuring an increase in the number of quit attempts by consumers looks more closely at the process of quitting smoking rather than quantifying quitting as a one-off event.

Overall there was an increase in the number of quit attempts made by consumers by the end of the project. At the beginning of the project most smokers had only ever made one or more previous quit attempts. By the end of the project there was an increase in the percentage of consumers who said they had made '5 or more' and '10 or more' attempts at quitting smoking.

A reduction in smoking rate by consumers

A reduction in the rate of smoking was measured in two ways.

(i) The smoking status of consumers was recorded at each survey and results showed no significant reduction in the smoking rate by consumers. The rate of smoking at the beginning of the project was 62.7%, 73.2% at the interim and 58.8% by the end of the project.

Most smokers had been smokers for 20 or more years and tailor-made cigarettes were the most common type of tobacco smoked.

(ii) The number of cigarettes smoked per day by consumers was also recorded. At the first survey most consumers said they smoked 11 to 20 cigarettes per day and at the final survey most consumers said they smoked 21 to 30 cigarettes.

Other survey data

In the surveys consumers were also asked if they were aware of the health risks from smoking and if they felt that smoking was in anyway beneficial to their physical or mental health. This was to get an insight in to whether smoking was considered to be a form of medication for managing mental health problems, which is strongly believed to be true by many people.

Results indicated:

- Almost all consumers were aware of the risks to physical health from smoking;
- The most common health risks noted were cancer and emphysema, which have been reported in various public health campaigns;
- By the end of the project 65.5% of consumers did not feel that smoking was helpful for their mental health; and,
- Those that said smoking helped their mental health said it helped with stress relief, relaxation, anxiety and feeling calm.

In the last survey consumers were asked the following additional questions:

- If they attended the group program;
- What they liked about the group program;
- What they didn't like about the group program;
- What was strategies were most helpful to quit or cut down smoking;
- What the main reasons were for quitting or cutting down smoking; and,
- What have been the main barriers to quitting or cutting down.

It is important to note that only a total of 34 consumers from three of the five sites participated in the last survey; reasons for this are described in section 2.1.

Consumers were asked to choose from a selection of ten characteristics about the support group that they liked which included:

Information	Staff were supportive
Support to quit or cut down smoking	The number of sessions
Socialising	Opportunity to talk about my smoking
Support from other participants	The activities
Other	Nothing, I did not like the group

Of these choices, the top three characteristics of the program that consumers liked were information, the staff and socialising. An opportunity to talk about their smoking and quit support also rated highly.

When asked what they didn't like about the support group almost all responded to 'none of the above, I enjoyed the group', however two people said they felt the pressure to quit smoking.

Consumers were also given a range of choices when asked:

- What they found most helpful to quit or cut down smoking;
- What were the main reasons for quitting or cutting down; and,
- What have been the main barriers to quitting or cutting down smoking.

Consumers were asked to rate each choice on a scale of zero to ten, or to tick 'not applicable'.

The results to these questions are as follows:

- Staff at the service, attending the support group and talking to a health professional were the top three most helpful methods given a rating of 10 (very helpful) by consumers;
- Physical health, finances and family were the top three main reasons for quitting or cutting down smoking. It should be noted that all reasons, which included mental health, self improvement, sick of smoking, more knowledge of the effects of smoking, options to quit, and friends, were all rated as 'very important' by over 30% of consumers;
- Peer pressure from friends, the cost of NRT and problems with using champix were the main barriers to quitting or cutting down highlighted by consumers.

3.1.2 Findings from the group program

As described in section 2.1 four of the participating sites ran the 10 week group program for consumers who were interested to address their smoking.

Billabong Clubhouse

- Attendance fluctuated between 12-22 people;
- Three people had quit smoking at the start of the program;
- Eight people quit smoking over the course of the group program and remained quit by the end of the program. This included one staff member who joined the group program with consumers. All were using NRT in addition to attending the group program;
- Other consumers were cutting down their smoking;
- One consumer was able to dramatically decrease their medication by half;
- A Smokelyser was provided to this site and it was found to be a good motivational tool, particularly for people who had a lapse.

Looking at CO levels, number of cigarettes per day, and nicotine dependence score (NDS) provided by Billabong Clubhouse also provides information on the quit rates of consumers. This was the only site to provide this data.

Because attendance fluctuated each week, figure 6 below shows the averages of nine consumers who attended at least half of the ten week group program. Cigarette consumption and CO levels high at the beginning of the program but decreased throughout the project. By the end of the group program six of the nine had quit smoking and the average cigarettes per day was 2.4 and the average CO level was six parts per million. A CO reading of greater than 6ppm is generally taken to indicate that a person is a smoker.^{xiii}

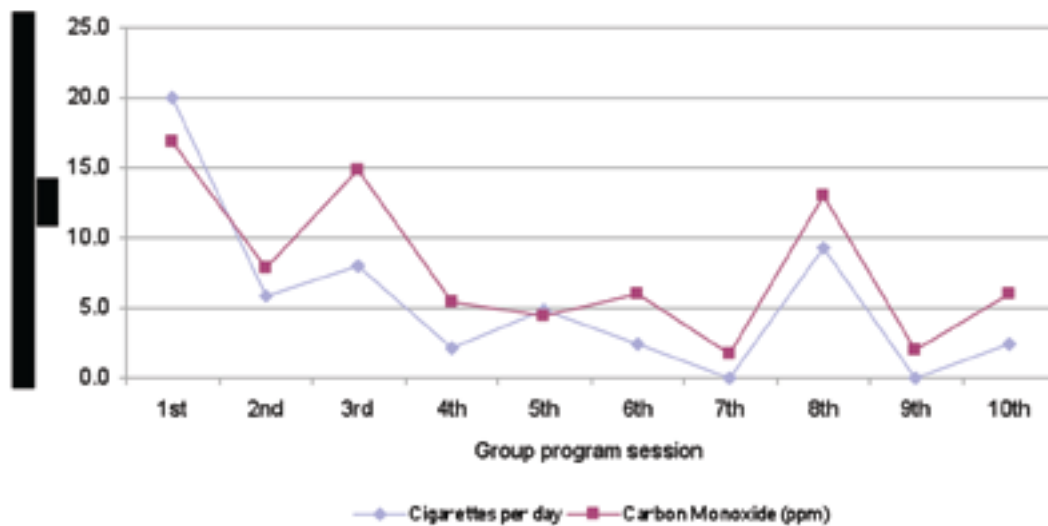


Figure 6: Average number of cigarettes per day and CO levels of group program participants per session (n=9)

The average NDS also correlates with the number of people who quit smoking – at the first session the average NDS was 6.9 and at the last session the average was 1.9. A score of 1-2 is considered to mean low nicotine dependence and 8 or more is very high dependence.¹²

PHaMs

- Attendance fluctuated between 10-15 people at each session at each group.
- At least four people quit smoking for at least three weeks, including a staff member facilitating the group. All used NRT in addition to attending the group;
- Other consumers were cutting down their smoking.

Irene Luth

- Eight people consistently attended the group each week;
- Three people made a quit attempt during the program.

Neami

- Attendance fluctuated between five to ten consumers at each session.
- No consumers made a quit attempt by the end of the program.

3.1.3 Focus groups with consumers

One focus group was conducted at each of the sites (with the exception of Hunter Joblink, see section 2.1) with consumers to gain a deeper understanding of how they felt about smoking and quitting, what they thought of the group program, and their understanding of the relationship between their smoking and their mental health. A total of 24 consumers participated in the focus groups.

Consumers were asked nine questions. These were:

1. What do you think are the good things about smoking?
2. What are the not so good things about smoking?
3. How interested are you in quitting? What are the main reasons you want to quit?
4. What have been the barriers to quitting and getting help to quit? Do you have any concerns that quitting will make your life harder in some way?
5. What would be more helpful to help you quit smoking?
6. Was the support you received during the Breathe Easy project appropriate?

7. What are your thoughts on staff smoking with you?
8. Do you feel medication has an effect on how or how much you smoke?
9. Do you think quitting will cause a relapse in your mental illness?

Nine participants had recently quit smoking, five were actively trying to quit or had cut down smoking, and the remaining ten were all smokers.

Responses to the above questions are presented in the five following sections.

Likes and dislikes about smoking

Stress and anxiety relief, relief from boredom, an opportunity for time out and socialising were the most common themes that consumers liked about smoking. When asked about the not so good things about smoking worries about health, finances, stigma, and the stress caused by having the addiction were recurrent themes that were not good about smoking.

While health and finances are obvious concerns for any smoker the stigma of being a smoker as well as the stigma of having a mental health problem was felt and discussed at length by a number of participants. A number of participants talked about the guilt they felt when smoking in public, smoking in front of their children, the impact on their relationships with friends who didn't smoke, and also the shame of what people thought of them as a smoker and the impact on their physical appearance. One participant, stated,

"if you're a smoker and you're single, you may not necessarily attract someone who might be a better potential partner if they're a non-smoker."

Another participant keenly felt the double stigma of being a smoker and having a mental health problem:

"I feel like an outcast and if you've got a mental disorder, that's quite damaging because you take it more personally than you're average person, if that makes sense, and one simple comment might affect you for a whole year."

The stress of the addiction was also talked about at length. A number of participants talked about the dislike of the actual addiction and not being able to beat it, but the stress of running out of cigarettes and not having money to pay for them was also an issue for many.

Quitting

All but seven participants were very interested to quit smoking. The main reasons for quitting were health, finances and the impact on family, particularly their children. Some participants talked about wanting to start a family and so the health risks of smoking on their fertility were of high concern.

A number of barriers to quitting were identified by participants which included being around other smokers, stressful circumstances, affordability of NRT, boredom, loneliness and isolation and lack of face-to-face support to quit smoking.

Being exposed to other smokers was problematic for many participants, one participant stated,

"...finding a non-smoking environment when you've got a mental illness is difficult because most people with a mental illness smoke."

A number of participants clearly recognised the connection between using smoking as a method of support in times of stress or when they felt bored and lonely and openly talked about a cigarette as a friend.

“...the isolation of living alone and having nothing to do at home except watch TV, listen to music, and I’m not allowed to have pets at my place so I don’t have them to keep me company or have affection.”

Face-to-face support and the affordability of NRT were identified as being things that would be more helpful to quit smoking.

No participants felt that their life would be made harder in any way if they quit smoking.

The group program

All participants agreed that attending the group was useful for them regardless of whether they were interested in quitting smoking or not. At one focus group all but one person was interested in quitting smoking yet they all still enjoyed going to the support group each week.

The most common things participants liked about the group program demonstration sites ran were:

- that it provided an outlet for smokers;
- they had access to face-to-face quit support;
- they were given an opportunity to discuss their problems and socialise;
- they were given personalised support;
- there was mateship through other commonalities with participants;
- it was additional support to what the service provides; they could get information about smoking and quitting; and,
- they were able to learn new coping strategies for stressful times in their lives.

Many of the participants said the availability and access to the group program came at a good time for them and they saw it as an important support that should be continued. One participant described the extra support as follows,

“It’s kind of like walking on a tightrope; you’re happier knowing there’s a net on the bottom, someone there to catch you when you fall.”

Staff smoking with consumers

Most consumers were not concerned about the issue of staff smoking with consumers or had not thought about it. Those who did have an opinion were generally opposed to it as being unprofessional and poor role modelling. Some participants also highlighted that it could be detrimental to a consumer if they were trying to quit smoking and could also stop somebody from approaching staff if they knew they were a smoker. One participant equated it with a parent smoking with their 15 year old child.

Smoking & mental health

Most participants saw no connection between the type of psychiatric medication they were taking and how much or how little they smoked. However a handful of participants could clearly recall times when they were on particular medications where they chain-smoked and other medications that made them so drowsy they were unable to smoke.

Two participants stated that their medication levels were being adjusted specifically because they quit smoking.

About half of the participants did not feel quitting would have a negative impact on their mental health. A number said they did think it could be a possibility but talked about just remaining positive because quitting smoking was something they wanted to do. Others felt that they've had some issues with their stress levels and problems with their mental health since quitting.

3.1.4 Surveys of staff

Staff and managers at each of the sites were asked to complete a survey at the beginning (November 2008), middle (March 2009) and end (May – June 2009) of the project. A total of 28 staff and managers responded to the baseline survey, 23 responded to the interim survey and 11 responded to the final survey. This drop in numbers is accounted for in section 2.1.

The surveys asked questions about the attitudes, policies and practices around smoking to ascertain how smoking was addressed within the organisations as a whole and measure whether the two objectives of the project were achieved. These were:

- Create a better awareness of the need to address smoking – to affect changes in smoking behaviour and attitudes; and,
- Enhance the capacity of the participating organisations to address smoking – by changes in organisational policy & practice.

Although managers and other staff were surveyed separately the following results are presented as combined data from the staff and manager surveys, unless otherwise stated.

Attitudes to smoking

Overall the results indicate that there was a positive change in attitudes to smoking.

By the end of the project there was stronger agreement from staff that all smokers should be encouraged to quit smoking. Staff also more strongly agreed that consumers should receive support to address their smoking and that that support should be offered as part of the routine care and support provided by the service.

The link between smoking and disadvantage appeared to be better understood with stronger agreement that smoking is a contributing factor. Throughout the project there was generally consistent agreement from staff that consumers were interested in addressing their smoking.

In terms of smoking and mental health more staff felt that quitting smoking was not too hard for people with mental health problems. There was also more agreement that smoking has a negative effect on a person's mental health, and more importantly, figure 7 shows that staff disagreed that quitting smoking will cause a relapse in mental health problems.

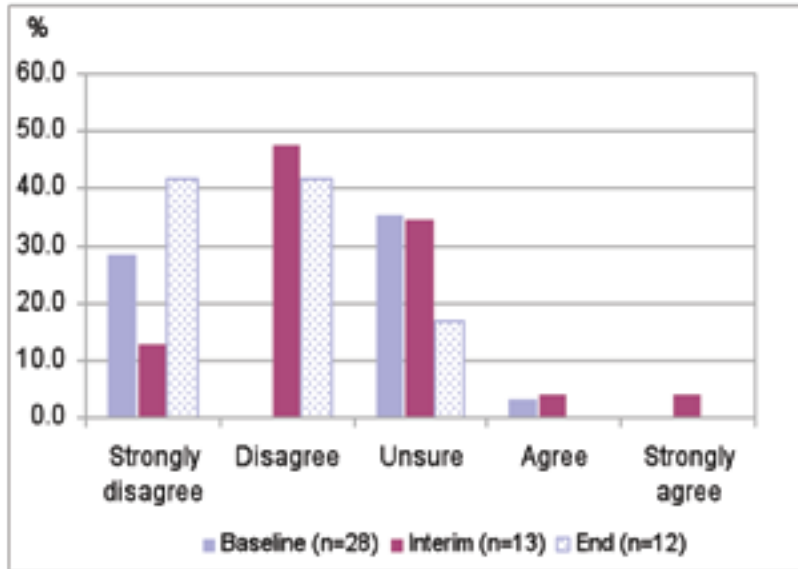


Figure 7: Percentage of staff who agreed that quitting smoking will cause consumers to have a relapse in their mental health problem

By the end of the project staff were also less inclined to agree that smoking with consumers is a good method to build trust and rapport or to help de-escalate a tense situation.

Policies to address smoking

At the beginning of the project, most staff at all of the sites were aware that there was a smoking policy in place at their service, but the policies did not include much detail beyond designated smoking areas and smoking within agency cars.

By the end of the project policies were more comprehensive. In the last survey only managers were asked if the smoking policy had been reviewed or if there were plans to review the policy and which elements of the policy were up for review. The following table provides details of the policy changes that were planned or had been made by the three organisations who participated in the last stage of evaluation.

Table 3: Policy areas reviewed by demonstration sites

DEMONSTRATION SITES			
POLICY AREA	Billabong Clubhouse	PHaMs Shoalhaven (SFNSW)	Irene Luth (UCMH)
Smoking Areas	Area already provided	Policy permits smoking only in outdoor designated areas, which are clearly signposted.	Smoking areas have been moved away from social outdoor areas.
Staff smoking with Consumers	Aim for nil	Staff are role models and are not to use cigarette as an engagement tool, give cigarettes to participants, go for breaks with participants or use cigarettes as a control mechanism.	No staff smokers will be written in as an expectation of position descriptions.

Smoking breaks	Staff are to smoke in a suitable area - not with consumers	Limited to morning tea, lunch and afternoon tea breaks.	
Smoking by staff and consumers on home visits & other settings	Not to be permitted	Staff have the right to request that a person refrain from smoking during visit. Staff are not to engage in smoking with participants and are to leave building or encourage smokers to smoke outside.	
Recording consumer smoking status	New intake forms will include recoding smoking status.	PHaMs will incorporate consumer smoking status on their intake assessment records.	Already occurs
Assistance for consumers to quit smoking	Program to be offered annually, one-to-one throughout year, and subsidised NRT	Support in reducing to smoke will be available. Provision of specific reduction activities and or referral to relevant courses or organisations.	Clearer support availability.
Assistance for staff to quit smoking	Program to be offered annually, one-to-one throughout year, and subsidised NRT	Support in reducing to smoke will be available. Provision of specific reduction activities and or referral to relevant courses or organisations.	
Other	Include guidelines for smoking during clubhouse social activities		

During the project some of the larger participating organisations were in the process of reviewing their smoking policies for the whole organisation. Schizophrenia Fellowship reviewed and implemented a new smoking policy, Neami's smoking policy was under review, and by the end of the project UnitingCare Mental Health were beginning the process of reviewing and updating their smoking policy.

Practice in addressing smoking

By the end of the project staff were more active in addressing smoking with consumers in their routine practice.

More staff were recording the smoking status of consumers, more consumers were being referred to external support to address their smoking and by the final stage of the project four of the sites were running support groups, thereby offering more structured support for consumers to address their smoking.

By the end of the project results showed that staff were increasingly more confident, believed they had sufficient resources, and felt they had the skills and knowledge to address smoking with consumers. Some staff members who were smokers stated they still did not feel comfortable talking to consumers about smoking because they felt hypocritical or it was an uneasy topic because they could 'talk the talk' but not 'walk the walk'.

Other survey data

Survey results show that there was a reduction in the rate of smoking by staff by the end of the project. This was one of the goals of the project. At the baseline survey the rate of staff smoking was 28.6% and this dropped to 16.7% at the end survey.

In the last survey managers and staff were also asked additional questions about the strategies implemented in the project and whether they felt they had been beneficial and useful to address smoking and the culture of the service as a whole. The table below shows that all staff surveyed either agreed or strongly agreed that the training and policy workshops had been useful strategies, and, although one person was unsure, most staff felt the group program was useful for consumers to address their smoking.

Table 4: Percentage of staff and usefulness of project strategies to address smoking (n=12)

Project Strategy	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
Training provided useful information and skills	0.0	0.0	0.0	50.0	41.7
Policy workshop was useful to review our smoking policy	0.0	0.0	0.0	58.3	33.3
The smoker support group was useful for consumers to address their smoking	0.0	0.0	8.3	41.7	50.0

Staff were also asked three questions about the perceived benefits of the project. Table 5 shows that staff mostly agreed that the project had been beneficial for staff capacity to address smoking, for consumers to address their smoking and for the organisational culture.

Table 5: Percentage of staff and the benefits of the project (n=12)

Who benefited	Strongly disagree	Disagree	Unsure	Agree	Strongly agree
Beneficial for staff to address consumer smoking	0.0	0.0	16.7	33.3	50.0
The project has been beneficial for consumers to address their smoking	0.0	0.0	8.3	33.3	58.3
The project has been beneficial for the culture of the organisation	0.0	0.0	16.7	25.0	58.3

They were also asked to rate the overall benefits of the project on a scale of 0 to 10 (0 being poor, 10 being excellent). Just over 70% staff rated the project as being very good to excellent in terms of the benefits from the project.

3.1.5 Interviews with staff

Informal exit interviews were conducted with staff at each of the sites (with the exception of Hunter Joblink, see section 2.1) at the end of the project. Staff were asked four questions:

1. What are some of the barriers to working with consumers on smoking cessation?
2. What have been the pros and cons of participating in the project?
3. What did you think of the group program?
4. What other supports do you think could be useful for your service and other services to address smoking?

The main themes from each of the interviews with staff are presented in terms of these four questions.

Barriers to working with consumers on smoking cessation

Time was identified as one of the biggest barriers to being able to address smoking with consumers. Previous to participating in the project it had not been considered a priority or it was not recognised that there was even a need to support consumers to address smoking because services lacked the time and energy. As one staff member stated,

"It was easier for us to leave the status quo – we had no time or energy and didn't know where to send people for help."

Attitudes to address smoking were also identified as a barrier. At one site staff realised that because they saw smoking as a personal choice, as a normal activity for people to do, and thought it was too hard for people with mental health problems to quit smoking, they didn't do anything about smoking.

Some staff also felt that smoking policies, or lack thereof, impeded their ability to address smoking. Without any clear directions of how consumers should be supported or what would be tolerated within the service, staff were previously at a loss to know how to address smoking overall.

Pros and cons of participating in the project

There were a number benefits noted in participating in the project, the most common being staff, for the first time, were able to get an insight into how consumers really felt about smoking. Other benefits included:

- Addressing smoking with consumers lead to other benefits in their lives. Self-esteem and self-confidence grew throughout participation in the group program and staff saw that confidence in being able to quit went through to other aspects in consumers' lives.
- Consumers became more respectful of each other and less selfish. At one site staff noted that the work ethic and efficiency of consumers who participated in employment programs changed; they were happier to wait for allocated break times to smoke rather than insist on regular breaks throughout the working day.

Staff also felt more skilled and better equipped in being able to provide support to consumers who had previously identified that smoking was an issue for them and to also provide better information, particularly around some of the myths of smoking.

Overall staff felt that participating in the project was a positive step forward for the service and consumers. For the service it meant there was another area they could better support consumers. Addressing smoking had multifaceted benefits and could be combined with other programs. As one staff member commented,

“Once our ideas had been challenged, we just felt, how could you not do it!”

Time was appeared to be the only negative element about participating in the project. Although all of the sites felt that it was worthwhile doing, all staff felt that the time required to prepare each session of the group program was the main that needed to be considered and properly allocated for.

Each site ran the group program, attended the training and policy workshops in addition to their normal workloads. At one site, the time for transportation of consumers in a rural area to attend the support group each week was also an issue that needed to be considered.

The project also provided an opportunity for some staff members to quit smoking. Staff at two of the sites were in the process of quitting and this was found to have a positive impact in terms of role modelling for consumers and also encouraging other staff members who were considering quitting smoking.

The group program

As described in section 2.3.2 the smoking cessation group program used for the project was the SANE Smoke Free Kit.

Overall, all staff felt that the kit was good; that it was well laid out and easy to follow and that they would use it again and recommend for others to use. Although ambivalent to begin with, the kit provided them with a good framework to address smoking with consumers. One staff member said,

“As facilitators we were nervous to start with because we didn’t want to do any harm but now we would recommend it to anybody who has not run a group before because it gives you a different perspective of how consumers feel.”

An important aspect that emerged about the group program was that the purpose of the group became more than just about quitting smoking.

Staff recognised in a number of ways that the group also became:

- An opportunity for peer support to occur naturally;
- An opportunity for consumers to raise other issues that they don’t get a chance to discuss, e.g. one week one of the groups started talking about medication and wanted to have a forum about medication;
- An opportunity to socialise and develop friendships – many consumers are bored so attending the group served two aims;
- An opportunity for shy people to come out of themselves and increase their self-confidence because they felt safe in the group;
- An opportunity to learn to cope with other stressors in their lives. The strategies learnt were not just useful for quitting or cutting down smoking, they were also strategies for handling stress in

their everyday lives; and,

- A place where people learnt to articulate their needs, helping them to learn how to speak up and be honest with each other, so they could think of different areas of their lives they wanted to address.

Other common factors that arose about the group program included:

- It can be hard to attract consumers to attend at first, however each site found that attendance to the group remained constant throughout the 10 weeks and many people cut down and were more interested in quitting altogether in the long term;
- Free healthy snacks at each session worked as a good way to attract consumers to the group, although this can be costly It was important to set the ground rules from the beginning of the program, e.g. starting times, breaks, not allowing one person to dominate the group
- Having some structure to each session was important but there was still room to facilitate in an informal way. The groups were largely guided by discussion of the participants – being flexible is very important;
- Group facilitators need to be very keen and motivated and they should have some background knowledge to smoking cessation, i.e. training:
- Each site felt that the group worked well because there was already established trust and rapport with consumers, therefore it may not be suitable for an unknown facilitator to run;
- Having participants at different stages of readiness to quit worked because there were different levels of support and encouragement for everyone, but this may also depend on different personalities;
- The number of weeks in the group program is just right because there is a process to it, however the end can become repetitive – this is helpful when people are in the maintenance stage but for people who are not at this stage it is irrelevant;
- It was important to address the slip-ups every week. This is not included in the kit and would be helpful to state that this needs to be addressed every week;
- Guest speakers and other health professionals such as community mental health workers, GPs and psychiatrists, being involved in the delivery of the program added more support for staff and consumers; and,
- Staff felt that the group was also beneficial for people who were not attending the group because consumers felt they could approach staff to talk about quitting smoking.

Other support

Staff identified that the most useful tools of support to address smoking are:

- Access to ongoing training in smoking cessation;
- Being able to allocate time and resources to working with consumers to address smoking;
- Low cost NRT for consumers; and,
- Developing partnerships within and outside of the organisation – partnerships with local pharmacists was found to be vital by three of the sites.

Three of the sites offered consumers attending the group program free or subsidised NRT. Staff felt that being able to offer at least a subsidy for NRT allowed consumers to try different NRT products to find which suited them best and that it was an important motivational tool for consumers to address their smoking. Yet staff were surprised that not as many consumers took up the offer of the subsidised NRT as expected. It was suggested that subsidised NRT should only be offered in the initial stages of quitting as it should start to become cheaper for consumers.

3.2 Surveys of MHCC members

MHCC members were surveyed at the beginning of the project in May 2008 to gain an insight into how smoking was being addressed in the sector and to select organisations interested in participating in the project. The results for this baseline survey are available in a separate report.^{xiv}

This section describes the results from the final survey sent to MHCC members on completion of the project in June 2009 to measure what changes had occurred since the baseline survey and the impact of the project on attitudes, policies and practices of organisations around smoking.

The final survey was based on the baseline survey and included four additional questions.

Both surveys were used to measure whether the two project objectives stated in section 2.2 were achieved.

The baseline survey conducted in May 2008 attracted a response rate of 19% (38 responses from a membership of 200); the final survey received a response rate of 13% (30 responses from a membership of 230). The results therefore can only provide an insight and are not definitive of how smoking is addressed in the sector.

The results from the final member survey are presented in four sections.

Attitudes to smoking

Overall there was a positive shift in attitudes around smoking since the baseline survey 12 months ago. There was more agreement that smokers should be encouraged to quit smoking, that consumers who smoke should receive support to quit smoking, and that support to quit smoking should be provided by organisations as part of the support and care they already provide.

More respondents agreed that smoking contributes to consumers' socioeconomic disadvantage and more respondents also agreed that consumers who smoke are interested in addressing their smoking.

Figure 8 shows that one of the most significant shifts in attitude was in regard to the statement 'Quitting smoking will cause consumers to have a relapse in their mental health problem'. At the baseline survey 55.2% of respondents agreed or strongly agreed that quitting smoking would result in a relapse in a mental health problem. At the final survey more respondents disagreed with this statement; 68.9% of respondents did not agree that quitting smoking will cause a relapse in a mental health problem.

Results from the final survey also indicated that more respondents did not agree that smoking with consumers was a good way to build trust and a good rapport or to help de-escalate a tense situation.

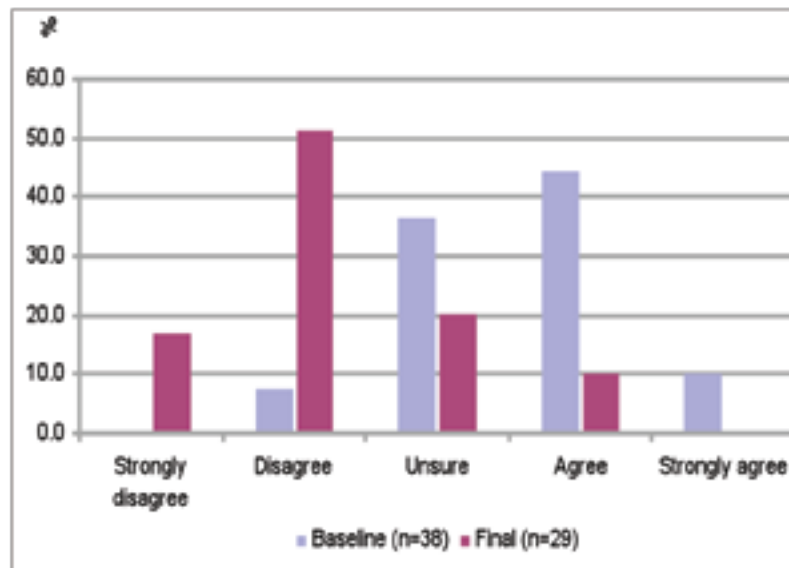


Figure 8: Comparison of baseline and final survey of percentage of MHCC members who agreed quitting smoking will cause a relapse in a person's mental health

Policies to address smoking

Approximately 77% of respondents said their organisation had a smoking policy; this result was similar to the baseline survey. However it appears that smoking policies have become more comprehensive – more policies address smoking during home visits by consumers or workers, and more policies included support for consumers and staff to quit smoking.

In the final survey members were also asked if their organisation had reviewed or developed a new or existing smoking policy in the last 12 months; 40% of respondents said they had reviewed or developed a policy and 20% said they planned to review or develop a smoking policy.

Practices in addressing smoking

The final survey showed that there were also positive changes in the way organisations responded to addressing smoking and supporting consumers to be smoke-free.

More organisations are providing consumers with information about the risks of smoking and more organisations refer consumers to external support to quit smoking.

There were two important areas of change in terms of practice – significantly more organisations said they always record the smoking status of consumers and more organisations are providing consumers with support to quit smoking.

The Breathe Easy project and doing more to address smoking

In the final survey members were asked questions about their awareness of the project and how they had addressed smoking in the last 12 months.

70% of respondents said they had heard of the project. Most respondents had heard about the project through:

- MHCC's weekly e-newsletter – 69%;
- The smoking and mental health information sheets developed for the project – 50%;
- The smoking and mental health seminar held in 2008 – 37.5%; and,
- MHCC's quarterly newsletter 'View from the Peak' – 37.5%.

Over 60% of respondents indicated they had done more in the last 12 months to address smoking and 39% said that the project 'somewhat' influenced this decision while 22% said the project 'extremely' influenced this decision.

Most respondents, 47%, said that staff had not undergone training in tobacco cessation, and 43% said staff had undergone training. Interest to do more to address smoking was still high in the final survey, yet however interest did not appear to be as strong as 12 months previous.

4. Program sustainability

Sustainability of the efforts of the project and the efforts of the demonstration sites is an important factor to consider if addressing smoking is to continue in the sector.

Each site was offered the opportunity to apply for \$1000 funding if they submitted sustainability proposals that detailed how they would continue to address smoking once the project finished. This included how they would acquire additional funds from other funding bodies to assist with supporting consumers to address smoking.

Three sites applied for and received funding. Their proposals included the following elements:

- Continuation of the group program;
- Providing subsidised NRT for consumers;
- Developing partnerships with pharmacists, GPs, or other community mental health organisations through Interagency Forums;
- Applying for funding from local community organisations, NIB Foundation Community Grants Program, etc; and
- Internal evaluation of addressing smoking.

A six months post evaluation of the demonstration sites will be conducted by MHCC to investigate how the sites have continued addressing smoking. A short survey will also be sent out to MHCC members to measure whether the sector has also continued to address smoking. Information collected will be available on the MHCC website.

There were also other elements for sustainability that were identified during the course of the project. These included:

- Allocating time within normal workloads to address smoking;
- Partnerships with local GPs, organisations, pharmacists, local communities are vital to address smoking to increase the support available to community mental health organisations and consumers. It is helpful to develop these partnerships before addressing smoking more comprehensively;
- The cost of delivering a group program needs to be planned; organisations need to consider buying healthy snacks, printing costs, etc;
- Offering subsidised NRT can help in motivating consumers to join a group program;
- CO monitors can be helpful but expensive (approximately \$500). One site suggested a local pharmacist could purchase a monitor that can be used by people trying to quit to monitor their success;
- CO monitors can be purchased in partnership with other organisations;
- A staff member dedicated to the coordination of smoking cessation activities.

5. Discussion of the project findings

The results from the evaluation of the project give a clear indication that addressing smoking is a worthwhile endeavour for the community mental health sector to undertake. They show that the culture of sector is in the midst of change in how smoking is addressed. While the goals of the project were not completely achieved it can be said that the project has been able to:

- Create a better awareness of the need to address smoking – to affect changes in smoking behaviour and attitudes; and,
- Enhance the capacity of the participating organisations to address smoking – by changes in organisational policy & practice.

The project has achieved a number of positive results, one of the most important being that a number of myths around smoking and mental health have been discredited. The project has shown that generalisations and assumptions about smoking and mental health can no longer be used as grounds for not supporting people to make an informed choice to quit smoking.

Consumers can and want to do something about their smoking – busting myths

Consumers are interested in doing something about their smoking. The survey results strongly indicate that it can not be assumed that consumers are not interested in quitting smoking or that they are not concerned about the impact of smoking in their lives. The impact of smoking on physical health, finances and passive smoking on family, especially children, were the biggest concerns highlighted by consumers. This finding is no different from other research of smokers.^{xv} An added concern found in this project was that consumers experience a double stigma – they felt the stigma of being a smoker in a society where smoking is now frowned up on and they felt the stigma as a result of their mental health problems. Therefore quitting smoking is something many consumers want to achieve.

This project has also been able to show that quitting smoking is not too hard for people with mental health problems to quit smoking. While overall there was no significant reduction in the rate of smoking by consumers, at one site eight consumers quit smoking while attending the group program and they did so without any reported negative outcomes in mental health, which is a finding analogous with other studies.^{xvi} In fact, one consumer was able to halve their psychiatric medication. This is because nicotine can affect the dosage of a number of medications where some may need to be increased or others decreased.⁶

There were also other benefits for consumers resulting from this project. Each site found that in running the group program for consumers to address their smoking there were benefits for consumers beyond just being able to quit smoking. They were able to gain confidence in other areas of their lives and were empowered in being able to make a positive change in their lives, whether they quit smoking or not. The group program provided opportunities to socialise and more importantly it provided an opportunity for consumers to learn new coping strategies that don't involve smoking. Previous studies in the US have also found that a group program approach for people with schizophrenia is an effective method for smoking cessation.^{xvii}

Stress and anxiety relief was highlighted as a reason for smoking; however the focus groups and surveys with consumers revealed that consumers did not feel that quitting smoking would make life harder and most did not see smoking as beneficial to their mental health. Thus they did not see smoking as a way to manage their mental health problems.

The theory of smoking for self-medication was examined at length in the literature review commissioned by the CCNSW.⁶ The theory suggests that people with a range of mental health problems smoke to ease the symptoms of the mental health problems, however this suggests that all mental health problems have a biological commonality which, if it exists, has not yet been found. The review also examined the body of evidence that has looked at the effect of nicotine on the neurobiological functioning of people with schizophrenia. While there is evidence to suggest that nicotine can improve the neurobiological functioning because of nicotinic receptors in the brain, such as improved memory or concentration and correcting for abnormalities in a deficit in sensory auditory gating and smooth eye pursuit movements, the authors concluded that the evidence was conflicting and unclear and the methodology for many of the studies were questionable.

If nicotine is beneficial for people with mental health problems, the method of delivery should then be reconsidered. The risks and harms of smoking have been well established and therefore outweigh any perceived benefits that nicotine provides.

Staff and organisations benefit from addressing smoking

Staff and organisations also benefited from this project. In two instances staff were able to use this project as an opportunity to address their own smoking. At the beginning of the project the rate of smoking by staff was 28.6%. This figure is similar to findings from the National Health Survey conducted between 2004 and 2005 that looked at tobacco smoking by occupation in Australia; the survey revealed 30.3% of females and 32% of males who worked as health and welfare associate professionals were smokers. These figures are higher than the current rate of smoking of 20% in the Australian population, thus staff in this sector also have much to gain in terms of health and wellbeing if services address smoking.

Staff who are smokers are also less likely to address smoking with consumers; some staff surveyed for this project revealed they felt hypocritical talking to consumers about smoking because they themselves were smokers. Other studies have suggested that staff in the drug and alcohol field who smoke may be a significant barrier to addressing smoking with clients.^{xix}

“...finding a non-smoking environment when you’ve got a mental illness is difficult because most people with a mental illness smoke.”

A important outcome of the project was that attitudes to addressing smoking were challenged and were changed. Mental health workers are ideally placed to address smoking with consumers as part of their mental health recovery, yet attitudes and beliefs often get in the way of workers being able to promote smoking cessation. This correlation has been examined and established in a number of studies.^{19, xx} By the end of this project staff and MHCC member organisations saw smoking cessation as part of their core services, they gained a better understanding in to how consumers felt about smoking and quitting, they did not see having a mental health problem as an obstacle to quitting smoking, and they did not believe that smoking with consumers to build trust and rapport was good practice. This shift in attitude is an important step for the sector to more comprehensively address smoking with consumers.

Training in tobacco cessation that was provided as part of the project was one way that helped to change attitudes. Lack of training is often one of the core barriers to whether smoking cessation is promoted. In a survey of general practitioners in Germany a major finding was that the more training

in smoking cessation they received the more active they were in smoking cessation with patients.^{xxi} Another study of female paediatricians in the US found that those who received training were more likely to believe that counselling in smoking cessation was highly relevant to their practice.^{xxii}

However training in smoking cessation alone is not the only determinant as to whether workers will be more active in promoting smoking cessation. The environments in which staff work needs to allow for new skills and knowledge to be put in to practice. This is achieved by implementing new or updated smoking policies that go beyond including basic legislative requirements for smoke free areas. The demonstration sites in this project made changes to their policies by making clear statements about staff not smoking with consumers, repositioning designated smoking areas, information of how consumers and staff will be supported to quit smoking, and being more systematic in recording the smoking status of consumers so that smoking is addressed as part of holistic care and support provided by services.

Most people who try to quit smoking will relapse, that is, return to regular smoking, in the first week.^{xxiii} The chance of relapse is increased if people are exposed to triggers like being exposed to other smokers. Household and workplace restrictions on smoking have been found to increase the likelihood of quitting smoking and decrease the rate of relapse.^{xxiv, xxv} This is important information for the sector where rates of smoking by consumers and staff are high and people are frequently exposed to smoking.

Leadership is important

It can not go unsaid that leadership has been vital to the success of this project. Changes to any system, organisation or social system will always be met with some opposition.^{xxvi} People may believe the change is not necessary, that that change will translate to increased workloads, or perhaps that the change does not align with their values. Therefore it is important that any proposed changes focus on the people who will be affected by the change and not just the system or procedures that will change, and that adequate time is taken to promote and advertise the proposed change.^{xxvii}

The ATTOC model⁹ has been a useful guide for this project to address these change factors. Consumers, staff and management were consulted about the project from the beginning and each service was encouraged to continue discussing the project and the planned activities at opportunities like staff meetings. The project activities took place over a period of nine months, the group program was promoted at each site for a minimum of 4 weeks and each site identified champions who would take responsibility as leaders to drive the project.

The demonstration sites volunteered to participate in this project and can therefore be perceived as leaders in the sector. Managers and a number of key staff members at each of the sites were extremely keen and willing from the initial meeting in October 2008 to undertake the project even though it would mean initially taking on extra work to incorporate the project in to their normal workload and challenging their attitudes. Three of the sites were also strongly supported by senior management in their parent organisation who saw addressing smoking as necessary to consumers' recovery and to the advancement of their organisational practices.

The demonstration sites that went above and beyond what was expected of them and committed time and resources to incorporate the project in to their everyday practice were the sites that saw the greatest benefits for consumers. They were also the sites that developed solid plans for continuing smoking cessation support within their services.

“Once our ideas had been challenged, we just felt, how could you not do it!”

How should consumers be supported in smoking cessation?

The findings from this project have highlighted some important factors about what works to help consumers quit smoking. In formulating this answer one needs to be mindful that ultimately how a consumer addresses their smoking should be defined collaboratively with consumers within a recovery framework. One size does not fit all, but there are some distinct approaches that can be provided to consumers to quit smoking.

These are:

- Where possible, offering some counselling one-to-one or in a group format for consumers to address their smoking;
- At the very least, asking consumers who smoke if they want to address their smoking and including this in Individual Service Plans or the like;
- Staff should be accessible for consumers to talk to them about smoking;
- Support to staff who smoke to quit smoking;
- Consider offering subsidised NRT to staff and consumers.

Consumers surveyed in this project identified that attending the group program was the first time they had received such support to quit smoking. Regardless of whether they made an attempt to quit smoking or not they found attending the group program beneficial because it was face-to-face support, the support was personalised and it provided them with an outlet to discuss their smoking in addition to other issues. However the group format, for various reasons, will not be suitable or appealing to all consumers and staff should be prepared to provide more one-to-one support with some individuals.

In providing more intensive support for consumers to quit smoking staff and organisations should bear in mind how people give up smoking and how long it can take to give up smoking; they need to be compassionate, understanding and patient. Consumers identified that they were interested in quitting smoking that is, just abstaining from smoking. But most were interested in just cutting down smoking or cutting down their smoking to eventually quit. This is important to recognise when providing support for smoking cessation. Without acknowledging the preferred method of addressing smoking, that support is set up to fail. This finding is analogous with two other studies that found that most consumers who smoked were interested to cut down their smoking.^{xxviii, xxix} This desire to quit gradually is also recognised by the availability of commercial programs through pharmacies that assist smokers to quit over a six to nine month period.

Staff and organisations should also appreciate that the process of quitting can take an extended period of time and may involve several attempts of quitting. Smoking is an addiction that may require a number of interventions^{xxx} and a number of attempts; the more attempts a person makes the more likely they will stay quit.^{xxxi} There is some research that indicates quitting smoking may take a longer amount of time for people with mental health problems.⁶ Time is required to build up the confidence to quit smoking. Most consumers in this project started with low levels of confidence to quit smoking and were interested to quit in the next six months; six months later confidence in quitting had increased and more people wanted to quit within in the next 30 days.

And services should not look at quit rates as the only measure of success. Any type of smoking cessation interventions should also measure success as being:

- An increase in confidence to quit smoking;
- An increase in the number of quit attempts; and,
- An increase in interest to quit smoking.

=====

The findings from this project give the sector a clear directive that smoking should be addressed to increase the overall health and wellbeing of consumers and staff, and should be part of the holistic care and support that services provide. They also show that smoking can be addressed with positive results for consumers, staff and organisations. Any attempt to address smoking will be more successful using an organisational change approach – a combination of training and education for staff, organisational policy changes and development, and providing support for consumers to address their smoking.

Consumers are interested, willing and able to quit smoking and ignoring this means that there will be missed opportunities to better support consumers in their recovery journeys. The community mental health sector is well placed to address smoking systematically, rather than in an ad hoc manner, by increasing the opportunities for consumers to quit smoking.

Direct and indirect reinforcement of negative messages, that quitting is too hard for people with mental health problems or that smoking is their last vice or pleasure in life, undersells and denies consumers the right to hope and self-determination. It leaves consumers in cycles of poverty and social exclusion. Addressing smoking is not about taking something away, it is about offering increased support and expanding the choices for consumers to achieve better life outcomes as determined and directed by them.

6. Recommendations

For the sector

1. Organisations should provide or offer staff smoking cessation and mental health training opportunities. Staff need the skills and knowledge to feel confident to consistently address smoking with consumers without the fear they will do more harm than good. Providing up-to-date information on smoking cessation and mental health will help to dispel the many myths that have hindered the sector to address smoking.
2. Organisations need to review and update their smoking policies to change the environments in which staff and consumers interact. Policies need to include more than basic legislative requirements and address the key issues of:
 - zero tolerance of staff smoking with consumers;
 - smoking status of consumers should be consistently recorded as part of a holistic approach to support; and,
 - support for consumers and staff to address their smoking should be considered.
3. Organisations need to look at how they can provide more intensive support for consumers to quit smoking if they want to and how to include this in everyday practice. The community sector is well placed to address smoking with consumers as a continuation of the care and support that is already provided because of the established relationships and trust with consumers. Depending on the type of service provided organisations should offer ongoing group programs, subsidised nicotine replacement therapy, providing information and referral to quit smoking support such as the Quitline, GPs and local pharmacists.
4. All consumers who smoke should always be asked, in a non-confrontational and non-judgemental manner, if they would like to address their smoking. Staff should never assume that consumers are not interested in quitting smoking and should continue to offer support and encouragement even if support is not taken up on the first offer. This should be recorded and continually followed up so that consumers know staff are approachable if they need help to quit when they are ready.

For MHCC

1. Develop a training course in smoking and mental health specifically for the sector and delivered through the Learning and Development Unit as part of calendar training. The course would be open to any workers from the sector who would like to know more about smoking and mental health and how to incorporate smoking cessation in their service. It should be offered as an accredited course so that students undertaking the Certificate IV in Mental Health can choose this course as an elective stream that will contribute to their qualification. The course should also include a component on policy development and organisational change strategies to provide workers with the skills and knowledge required to reorient service environments to address smoking.
2. Continue to communicate and promote the need to address smoking in the sector via a webpage on the MHCC website. The webpage should include basic steps of what organisations can do to address smoking and should provide access to the following documents and publications:
 - a. Information sheet: smoking and your mental health
 - b. Information sheet: supporting someone with a mental health problem to address their smoking
 - c. Information sheet: The relationship between smoking and disadvantage and community services can do

- d. Smoke & Mirrors: a review of the literature on smoking and mental illness
- e. Addressing Smoking in Community Service Organisations: a Policy Toolkit
- f. Smoke Free Guidelines for the Community Mental Health Sector.

The webpage should also provide links to useful resources and organisations such as the Cancer Council NSW and SANE.

- 3. The findings of the Breathe Easy project be distributed in hardcopy to MHCC members and made available for download on the MHCC website.
- 4. Information sheets are disseminated through MHCC events such as 'Meet Your Neighbour' and provided as part of training resources.
- 5. Six month follow up evaluation of the participating organisations should be conducted and the information shared with MHCC members via an article in View from the Peak and the MHCC website.
- 6. MHCC to develop a process for how it will continue the efforts of the project and the interest from the sector to do more to address smoking and help with driving the above recommendations.

The Cancer Council NSW

- 1. Continue to make available information and resources to the community sector to address smoking via the CCNSW website.
- 2. Work with MHCC to provide bodies of health professionals such as the divisions of General Practitioners and the Royal Australian & New Zealand College of Psychiatrists, Australian college of Mental Health Nurses and allied health peak bodies with information on smoking and mental health.
- 3. Assist MHCC with the development of a smoking cessation and mental health training course by providing relevant resources for participants.

The Quitline

- 1. Staff should continue to update knowledge and skills in smoking and mental health to better assist consumers.
- 2. Although considered a generic service for smokers, the Quitline should be better resourced to support people with complex needs, such allowing for extended duration of phone counselling.
- 3. Better promotion of the service as a viable support option for mental health consumers.

References

- ⁱ Australian Bureau of Statistics. (2006) *Mental Health in Australia: A Snapshot, 2004-05*. cat. no. 4824.0.55.001. Canberra: ABS.
- ⁱⁱ Brown, S., Inskip, H. and Barraclough, B. (2000). Causes of excess mortality of schizophrenia. *British Journal of Psychiatry*, 177:212-217.
- ⁱⁱⁱ Lawn, S. (2001). Australians with a mental illness who smoke. *British Journal of Psychiatry*, 178(1): 85.
- ^{iv} Steinberg, M.L., Williams, J.M. and Ziedonis, D.M. (2004). Financial implications cigarette smoking among individuals with schizophrenia. *Tobacco Control*, 13: 206.
- ^v Lawn, S.J., Pols, R.G. and Barber, J.G. (2002). Smoking and quitting: a qualitative study with community-living psychiatric clients. *Social Science and Medicine*, 54:93-104.
- ^{vi} Ragg, M. and Ahmed, T. (2008). *Smoke and Mirrors: A review of the literature on smoking and mental illness*. Tackling Tobacco Program Research Series No. 1. Sydney: Cancer Council NSW.
- ^{vii} Lawn, S. (2005). Cigarette smoking in psychiatric settings: occupational health, safety, welfare and legal concerns. *Australian and New Zealand Journal of Psychiatry*, 39(10): 886 – 891.
- ^{viii} Williams, J.M. and Ziedonis, D. (2004). Addressing tobacco among individuals with a mental illness or an addiction. *Addictive Behaviours*, 29: 1067-1083.
- ^{ix} Ziedonis, D.M., Zammarelli, L., Seward, G., Oliver, K., Guydish, J., Hobart, M. and Meltzer, B. (2007). Addressing tobacco use through organizational change: A case study of an addiction treatment organization. *Journal of Psychoactive Drugs*, 39(4): 451-459.
- ^x Stead LF, Lancaster T. (2005). Group behaviour therapy programmes for smoking cessation. *Cochrane Database of Systematic Reviews*. Issue 2. Art. No.: CD001007. DOI: 10.1002/14651858.CD001007.pub2.
- ^{xi} SANE Australia (2004). *The SANE SmokeFree Kit, Second, revised edition*, Melbourne: SANE Australia.
- ^{xii} NSW Department of Health (2005). *Let's take a moment – quit smoking brief intervention: a guide for health professionals*, North Sydney: NSW Department of Health.
- ^{xiii} Middleton, E.T & Morice, A.H. (2000). Breath carbon monoxide as an indication of smoking habit, *CHEST*, 117:758-763.
- ^{xiv} Report title
- ^{xv} Carter, S., Borland, R., & Chapman, S. (2001). Finding the strength to kill your best friend: smokers talk about smoking and quitting. Sydney: Australian Smoking Cessation Consortium and GlaxoSmithKline Consumer Healthcare.
- ^{xvi} Currie, S.R., Karltyrn, J., Lussier, D., de Denus, E., Brown, D. & el-Guebaly, N. (2008). Outcome from a community-based smoking cessation program for persons with serious mental illness. *Community Mental Health Journal*. 44:187-194.
- ^{xvii} Addington, J., el-Guebaly, N., Campbell, W., Hodgins, D.C. & Addington, D. (1998). Smoking cessation treatment for patients with schizophrenia. *American Journal of Psychiatry*. 155(7): 974-975.
- ^{xviii} Smith, D.R. and Leggat, P.A. (2007). Tobacco Smoking by Occupation in Australia: Results from

the 2004 to 2005 National Health Survey. *Journal of Occupational and Environmental Medicine*. 49:437–445.

^{xix} Walsh, R.A., Bowman, J.A., Tzelepis, F. & Lecathelinais, C. (2005). Smoking cessation interventions in Australian drug treatment agencies: a national survey of attitudes and practices. *Drug and Alcohol Review*. 24: 235 – 244.

^{xx} Lawn, S. & Condon, J. (2006). Psychiatric nurses ethical stance on cigarettes smoking by patients: determinants and dilemmas in their role in supporting cessation. *International Journal of Mental Health Nursing*. 15: 111-118.

^{xxi} Twardella, D. & Brenner, H. (2005). Lack of training as a central barrier to the promotion of smoking cessation: a survey among general practitioners in Germany. *European Journal of Public Health*. 15(2):140–145.

^{xxii} Malarcher, A., Easton, A., Husten, C. and Frank, E. (2002). Smoking cessation counseling: Training and practice among women pediatricians. *Clinical Pediatrics*. 41(5): 341-349.

^{xxiii} Zwar N, Richmond R, Borland R, Stillman S, Cunningham M, Litt J. (2004) *Smoking cessation guidelines for Australian general practice: practice handbook*. Canberra: Commonwealth Dept of Health and Ageing.

^{xxiv} Farkas, A.J., Gilpin, E.A., Distefan, J.M. & Pierce, J.P. (1999). The effects of household and workplace smoking restrictions on quitting behaviours. *BMJ*, 8:261-265.

^{xxv} Fichtenberg, C.M. & Stanton, A.G. (2002). Effect of smoke-free workplaces on smoking behaviour: systematic review. *BMJ*, 325:1-7.

^{xxvi} Pascaris, A., Shields, L.R. and Wolf, J. (2008). The work and recovery project: changing organizational culture and practice in New York City outpatient services. *Psychiatric Rehabilitation Journal*, 32(1) 47-54.

^{xxvii} Yeager, J. & Saggese, M.L. (2008). Making your agency outcome informed: a guide to overcoming human resistance to change. *Families in Society: the Journal of Contemporary Social Services*. 89(1): 9-18.

^{xxviii} Moeller-Saxone, K., Tobias, G., Helyer, K. (2005) Expanding choices for smokers with a mental illness: smoking rates, desire to change and program implementation. *New Paradigm Press*. Psychiatric Disability Services of Victoria: Melbourne.

^{xxix} Moeller-Saxone, K. (2008). Cigarette smoking and interest in quitting among consumers at a Psychaitric Diasability Rehabilitation and Support Service in Victoria. *Australian and New Zealand Journal of Public Health*. 32(5): 479-481.

^{xxx} Fiore MC, Bailey WC, Cohen SJ, et al. (2000). *Treating Tobacco Use and Dependence*. Clinical Practice guideline. Rockville, MD: US Department of Health and Human Services. Public Health Service.

^{xxxi} Zhu, SH., Wong, S., Tang, H., Shi, CW. & Chen, M.S. (2007). High quit ratio among Asian immigrants in California: Implications for population tobacco cessation. *Nicotine and Tobacco Research*. 9:1, S505-14.

Further project information and data from the various surveys is available from the MHCC website www.mhcc.org.au/projects-and-research/breathe-easy-project.aspx