



REPORT ON THE SMOKING SURVEY OF MHCC MEMBER ORGANISATIONS

*Current attitudes, policies and practices
in addressing the issue of tobacco smoking*

NOVEMBER 2008



*A Partnership Project between the
Mental Health Coordinating Council
and The Cancer Council NSW
for the Tackling Tobacco Program*



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 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 now an accredited Registered Training Organisation which delivers nationally recognised qualifications including the Certificate IV in Mental Health Work, and courses specifically to meet the needs of the Community Mental Health workforce.

EXECUTIVE SUMMARY

The aim of the breathe easy project is to reduce the rate of smoking by people with a mental health problem. The project aims to assist participating organisations provide a more supportive environment where mental health consumers are offered the same opportunity to address their smoking as the general population. This survey report is the first stage in the project's development providing a baseline understanding of the rates of smoking and attitudes to smoking in MHCC member organisations.

A strong culture of smoking exists within the mental health sector where smoking has been accepted, encouraged, reinforced, or simply considered a benign problem compared to managing a persons mental health.^{1,2,3} Smoking is normalised and has not been systematically addressed due to a perception that people with a mental health problem are not interested in quitting smoking, or find it too hard to quit smoking. If we are to see a decrease in the prevalence of smoking by people with a mental health in the future, this smoking culture needs to change.

Any process of culture change requires strong leadership and commitment, consultation and inclusion of consumers and staff and other relevant stakeholders affected by the change, monitoring and assessment of the change process, training and education of staff and an awareness of external forces that can affect the success of change.⁴

That a culture change is needed around smoking and mental health is evident from the survey results detailed in this report. The results clearly indicate that MHCC's member organisations are willing and interested in assisting consumers to be free of smoking tobacco, but do not feel they are necessarily able to do so because of gaps in knowledge, skills and resources.

Thus the breathe easy project should be seen as a change management project. It should be seen as one of many steps needed to initiate a process of culture change where addressing smoking is considered as an important component of the recovery-based support provided by services.

It is the intent of the project to dispel myths around the impossibility and unwillingness of people with a mental health problem to quit smoking and to increase the awareness and understanding of the complex relationship between smoking and mental health. The role of the project is to guide and assist MHCC member organisations with policy development around smoking, and staff training opportunities to support consumers to reduce smoke-related harm.

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BACKGROUND

THE BREATHE EASY PROJECT

The breathe easy project is a pilot project between the Cancer Council NSW (CCNSW) and The Mental Health Coordinating Council (MHCC) running for 18 months, beginning February 2008 and ending in July 2009, as part of the CCNSW's five year program Tackling Tobacco.

With a focus on MHCC's member organisations and people with a mental health problem the aim of the project is to reduce smoke-related harm.

The project is a result of increasing awareness of the strong correlation between smoking and disadvantaged populations, such as people with a mental health problem for who the rate of smoking is more prevalent when compared to the general Australian population. More and more evidence has come to light demonstrating how smoking reinforces and increases disadvantage. In Australia a person on a pension smoking 40 cigarettes a day will spend approximately 30% of their income on cigarettes⁵ meaning less money to spend on essential items like food, housing and clothing exacerbating their disadvantage.

The ultimate goal of the project is to see if there has been an increase in the number of clients who quit smoking during and by the end of the project; if there is a reduction in smoking by clients and staff, if there is an increase in the number of quit attempts by clients; if there is an increase in clients interest in quitting and if there has been an increase in client confidence in their ability to quit.

To quantify the above goals the objectives of the project are to:

- Create a better awareness of the need to address smoking;
- Enhance the capacity of organisations to address smoking; and
- Reduce the rate of smoking.

Change Management

This pilot project has employed a change management approach to address smoking. A number of change management approaches to address smoking have been developed for drug and alcohol treatment settings, such as the Addressing Tobacco Use Through Organizational Change (ATTOC) intervention model which was developed on the basis that staff training alone is not enough to address smoking in settings where it is a normal part of the culture.⁶ One-off interventions like staff training will have modest or negligible impact and are unlikely to change clinician behaviours or healthcare outcomes.⁷ Instead, for settings like the mental health sector, multiple interventions are required to address smoking.

As with the ATTOC model the multiple interventions that will be central to the change management approach for this project are: staff development, assistance for clients and staff to quit smoking, consideration of organisational structures and process, and policy development.

Other elements of change that will be applied in this project are leadership, commitment of time and resources, consultation and inclusion of consumers, staff and management, assessment of the process of change and an awareness of external forces that can help or hinder change. These are all elements required for successful change and to challenge attitudes and values⁴ around smoking in this project.

THE SURVEY

The purpose of the survey was primarily to provide baseline data for the project and to gain an insight in to the current attitudes, policies and practices around smoking within MHCC's member organisations. The survey was also used to identify organisations interested in participating in the project.

Further surveys and focus groups will be conducted to measure the aforementioned goals and objectives of the project with the organisations that have registered an interest in participating in the pilot project and to evaluate the strategies used in working with those organisations.

This survey will be repeated at the close of the project to assess if this pilot project has had an impact on MHCC's member organisations overall in regard to attitudes, policies and practices around smoking, thus, to measure if a culture change around smoking and mental health has transpired in the sector.

METHODOLOGY

The survey (Appendix 1) used for this project was developed with the assistance of the CCN and the breathe easy project steering committee.

The survey was distributed in May 2008 to MHCC's 200 members with instructions on how to complete and information about the project. It was distributed electronically using Adobe LiveCycle Designer 8.0.

Members were asked for the survey to be completed by senior staff or the executive officer of each organisation. Each organisation only needed to complete one survey and organisations that provided different service types in multiple regions were asked to complete one survey for each major service type or region. Members were given two weeks to complete and return the survey which could be returned electronically, by post or by fax.

Raw data was collated using Adobe LiveCycle Designer 8.0 and analysed for frequency distribution using Microsoft Office Excel 2003.

Survey Instrument (see Appendix 1)

The survey consisted of thirty four questions divided in to six parts:

1. Eight questions about the organisation;
2. Ten questions dealt with attitudes in regard to smoking;
3. Six questions asked about the details of organisations' smoking policies and guidelines;
4. Five questions addressed what the current practices are in dealing with smoking;
5. Three questions asked about the level of interest in providing more support for clients to quit or reduce smoking; and,
6. Two questions asked organisations if they were interested in participating in the breathe easy project.

RESULTS

The survey was distributed to MHCC's 200 members and a total of 38 completed surveys were returned, representing a response rate of 19%. The following are the results obtained from all 38 completed and returned surveys.

PROFILE OF ORGANISATIONS (PART A, QUESTIONS 1 TO 8)

Organisations were asked to provide details about the position of the person completing the form, the type of services provided, the service region, the number of full time equivalent (FTE) staff and volunteers and the proportion of this workforce who smoked.

The positions of the survey respondents were Chief Executive Officer (15.8%), Senior Manager or Director (13.2%), Program Manager or Coordinator (34.2%) and Other (36.8%).

Most organisations generally provide more than one type of service. The service types described by respondents were then categorised into the groups found in Table 1.

As can be seen from table 1 the main type of service provided by the survey respondents was 'Centre-based support, work, education and leisure'.

Table 1: The types of services provided by survey respondent organisations'

Service Type ⁸	Percentage
Accommodation support & outreach	19.7
Employment & supported employment	11.5
Self-Help and Mutual Support Groups	18.0
Help lines, Information Services and Websites	11.5
Attitude Change and Awareness Campaigns	4.9
Centre-based support, work, education and leisure	26.2
Policy Advocacy and Consumer Networks	8.2
Total	100.0

The service regions were categorised by NSW Area Health Service (AHS). Based on 37 responses for this question figure 1 shows that 48.9% of survey respondents said their organisation provide services in the Sydney area and overall most services are provided in the eastern part of NSW. The highest proportion of services were provided in the South East Sydney AHS (18.9%), the Hunter/New England AHS (18.9%) and many also provide services state-wide (16.2%) and only 2 (5.4%) respondents provide services on a national level.

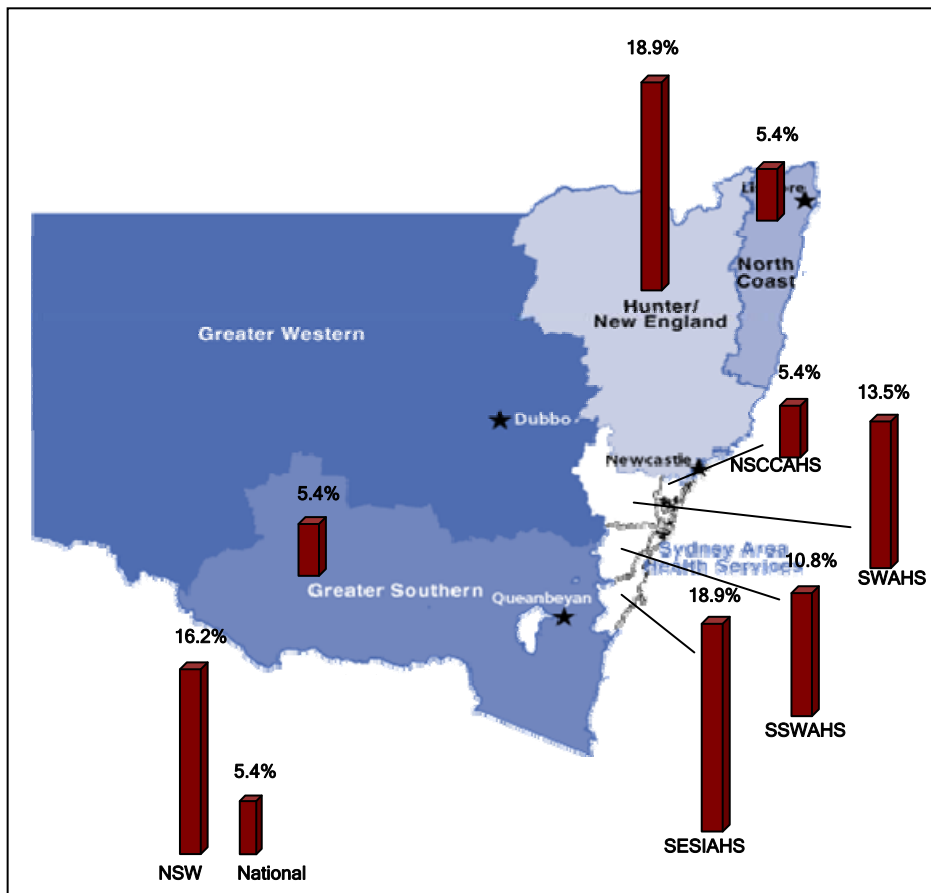


Figure 1: Organisation service regions by NSW Area Health Services

Staff & Volunteers

Most organisations (76.3%) had between 1 and 50 FTE staff with the remaining organisations employing anywhere within 51 to 3000 staff. Not all respondents have volunteers within their organisation; 26 respondents said that they have volunteers and most of these organisations (68.4%) have less than fifty volunteers and a few have anywhere from 51 to over 3000 volunteers.

Looking at the smoking patterns of this workforce figure 2 shows that smokers made up less than 40% of both groups of staff and volunteers. Almost one third (28.9%) of respondents indicated that 21% to 40% of their employed staff members smoked tobacco and the majority of organisations who had volunteers (34.6%) indicated that 20% or less of their volunteers were smokers.

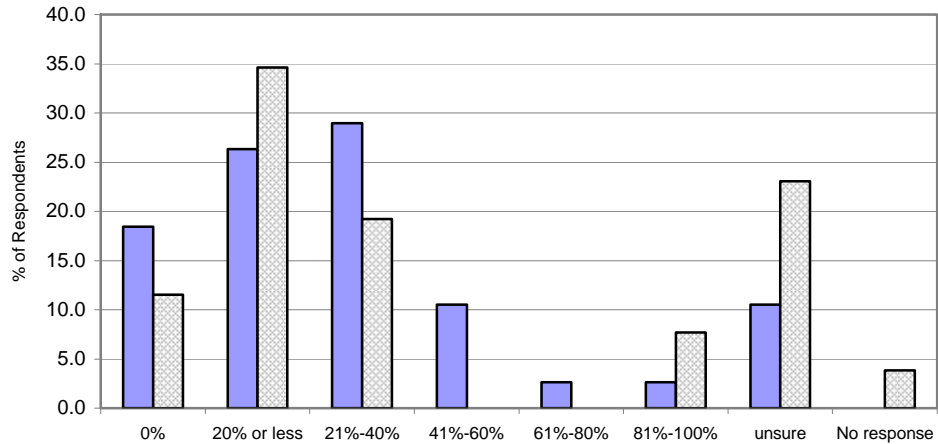


Figure 2: Percentage of staff and volunteers who smoke

ATTITUDES TO SMOKING (PART B, QUESTIONS 9 TO 18)

Part B of the survey was comprised of ten statements around attitudes to smoking and support that is provided for people to quit or reduce smoking. Respondents were asked to indicate their level of agreement with each statement using a scale of 'strongly disagree' to strongly agree'. The statements could generally be divided into positive statements around supporting people to quit or reduce smoking and negative statements that were less supportive. Every statement attracted a response from each respondent.

Figure 3 shows that respondents were generally in agreement with the positive statements. While most agreed that people with a mental health problem should be urged to quit or reduce smoking, there was not a great difference in response to this statement with 21.1% disagreeing, 23.7% unsure, 34.2% agreed and 21.1% strongly agreed. A combined total of 94.7% of respondents were in agreement that people should receive support to quit or reduce smoking if they wish to. Only two respondents strongly disagreed with this statement.

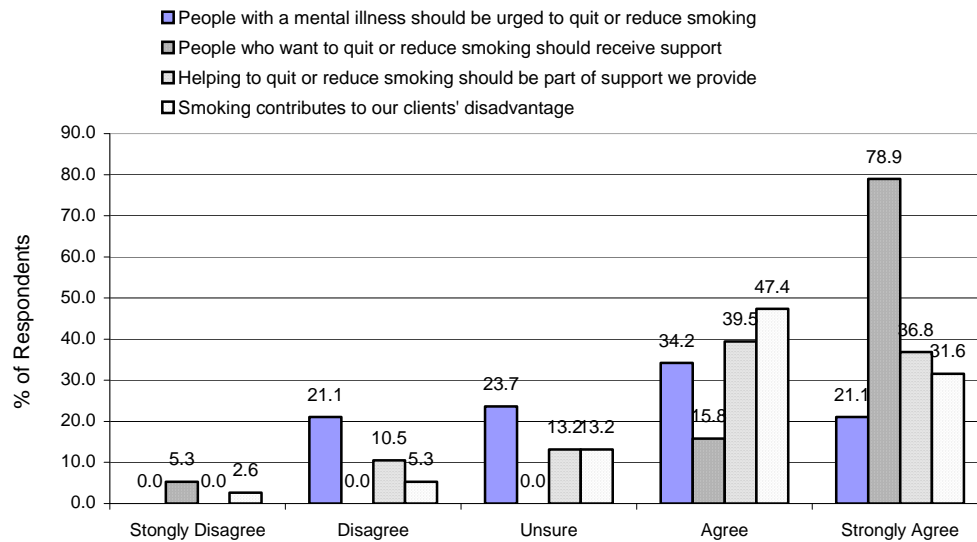


Figure 3: Comparison of responses for four positive statements

There was less agreement that organisations should help clients quit or reduce smoking as part of the care and support they provide. Figure 3 above shows that this statement attracts a drop of 20% in agreement when compared with whether people should be given support. Most respondents also agreed (39.5%) and strongly agreed (36.8%) that smoking contributes to a person's disadvantage.

For the six negative statements most responses were centred around 'unsure' with no great number of respondents either strongly agreeing or disagreeing (Figure 4) and 2 respondents did not provide a response for 'clients have a right to smoke and we shouldn't interfere with that decision'.

Looking more closely at the results for the negative statements, the two statements that received the most disagreement were 'staff smoking with a client is good way to build trust and rapport' (total of 71.1%), and 'staff smoking with a client can be a useful way to help de-escalate a tense situation' (total of 52.6%).

Most respondents agreed (39.5%) that their clients quitting or reducing smoking was not a priority for clients, however most were unsure (36.8%) whether clients were interested in quitting or reducing smoking. And the majority of respondents agreed (42.1%) that 'Clients have a right to smoke and we shouldn't interfere with that decision'.

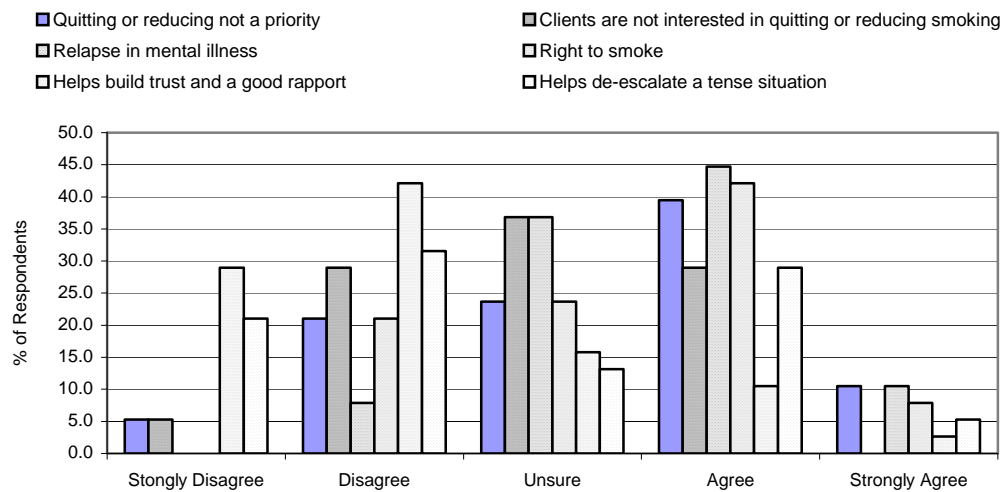


Figure 4: Comparison of responses for negative statements

SMOKING POLICIES & GUIDELINES (PART C, QUESTIONS 19 TO 24)

This section of the survey asked respondents if their organisations had policies on smoking, what these policies included, how much staff and clients observed the policies and whether organisations had existing guidelines on assisting clients who want to quit or reduce smoking.

More than three quarters of respondents (76.3%) said that their organisation had a policy on smoking and of the remaining respondents 13.2% said they did not have a policy and 10.5% were unsure if one existed. Respondents who said their organisation did not have a policy on smoking or, were unsure if one existed were asked to proceed to the last question of Part C.

The 76.3% respondents whose organisations had a policy on smoking were then asked what this policy included. Respondents could choose one or more items from a list of eight policy issues provided in the survey, which included a choice of 'None of the above'. Figure 5 shows that most respondents said that their organisations' policies included 'smoking in or near agency premises/grounds' (73.7%) and 'smoking in agency cars' (50%). Less than 30% indicated that policies included providing support for staff or clients who want to quit or reduce smoking. Smoking by staff or clients on home visits (13.2%) does not feature highly in policies, and few respondents indicated that smoking with clients under 18 (7.9%) or smoking with adult clients (18.4%) was included in their policy. Only one respondent selected said their policy included 'none of the above'.

Following this question respondents were asked to list anything else their policy covered but may not have been listed. Six people responded to this question and responses included time taken for cigarette breaks, designated smoking areas for clients only and no smoking by staff.

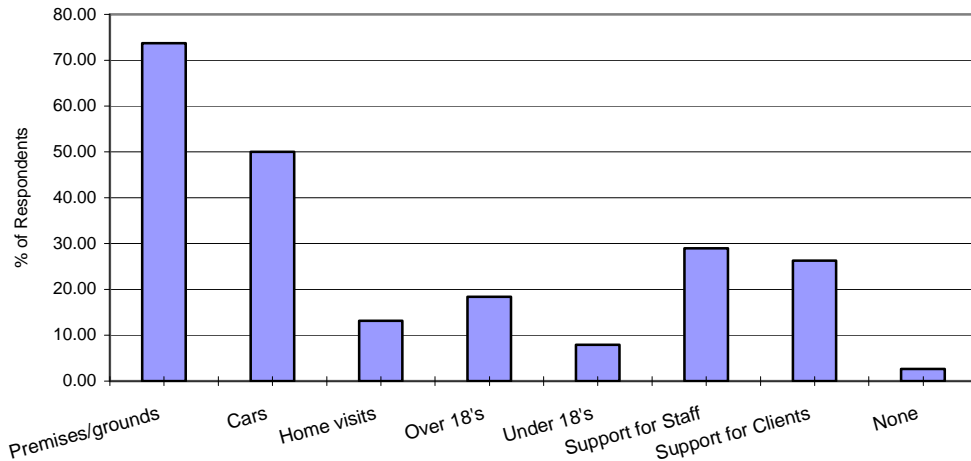


Figure 5: Issues covered in member organisation's policies (n=29)

Based on 28 and 27 responses respectively, 82.1% of respondents said that staff always observed the organisation's policies and 62.1% said that clients always observed the policies. Very few said that staff (3.6%) or clients (3.4%) never complied with the organisations policies.

When it comes to providing formal guidelines on assisting clients who want to quit or reduce smoking the majority, 50%, of all respondents said their organisation does not have guidelines, 34.2% said they do, and 15.8% were unsure. All respondents were asked to answer this question regardless of whether their organisation had policy on smoking and all respondents provided an answer.

PRACTICES AROUND SMOKING AND SUPPORT FOR CLIENTS (PART D, QUESTIONS 25 TO 29)

Part D of the survey asked respondents to describe, on scale of 0% to 100%, their organisation's current practices around smoking. This section had a total of five questions that were divided into two parts 'Your Clients' and 'Your Clients who Smoke'. Two respondents did not answer any questions in this section so the results are based on 36 responses.

Your Clients

Only 11.1% of organisations record the smoking status of all of their clients. The majority (58.3%) indicated that none of their clients have their smoking status recorded; 11.1% said it was less than 50% of clients, 2.8% said 50% of clients, 5.6% said it was more than 50% of clients and 11.1% said they were unsure of how many clients had their smoking status recorded. Two respondents did not answer this question.

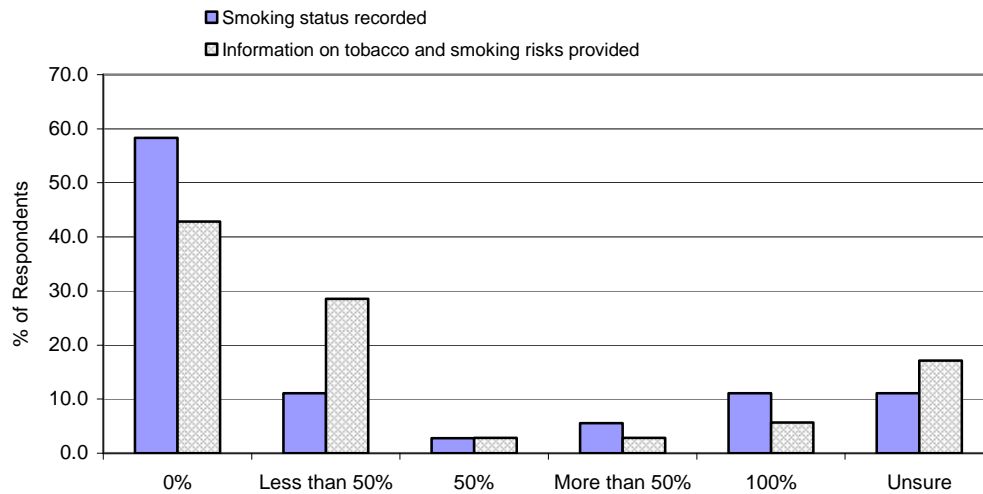


Figure 6: Proportion of clients who have their smoking status recorded and who are provided with information about tobacco and risks of smoking

Figure 6 shows that similar results were found for whether clients were provided with information about tobacco and the risks of smoking. Based on 35 responses (3 respondents did not answer) 42.9% do not provide information to any clients, 28.6% inform less than 50% of their clients, 2.9% said 50% of their clients, 2.9% said more than 50%, 5.7% said all their clients, and 17.1% said they were unsure of what proportion of their clients are provided with information about tobacco and the risks of smoking.

Your Clients who Smoke

Figure 7 shows a similar pattern of results for whether clients are referred to external support to address their smoking or if organisations provide support themselves.

One third of respondents said that none of their clients who are smokers were referred to external support to address their smoking; however the majority (36.1%) were unsure what proportion if any were referred. Of the remainder, 22.2% said that less than 50% of clients were referred, 5.6% indicated 50% were referred, 2.8% said more than 50% are referred, and no respondents indicated that 100% of their clients who are smokers are referred to external support to address their smoking.

Based on 35 responses (one respondent answered incorrectly) 31.4% said that none of their clients who smoke are offered support from the organisation to quit or reduce smoking and 31.4% said less than 50% of clients are offered support from the organisation. A further 22.9% were unsure if support was offered by the organisation to clients who smoke.

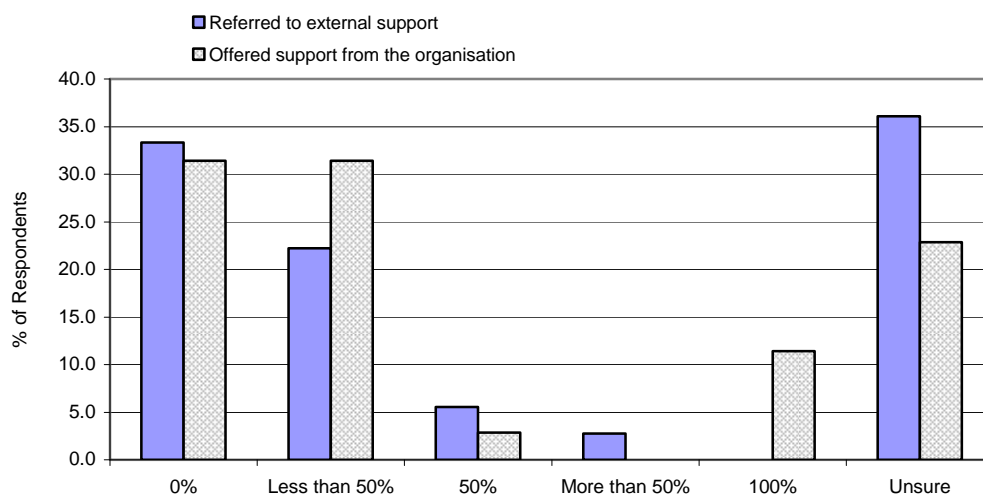


Figure 7: Proportion of clients who are referred to external support to quit or reduce smoking or provided with support from the organisation

The last question in this section asked respondents to describe the type of support offered by organisations, if any, to clients to quit or reduce smoking. Based on the responses supplied the type of support provided by organisations were sorted in to the nine categories shown in table 2.

Table 2: Types of support offered by organisation to assist clients quit or reduce smoking

Client asks	Staff do not address smoking unless it is raised by the client
Brief intervention ⁹	Staff asks client if they smoke and briefly discusses options
Staff training	Staff have been trained in smoking cessation
Nicotine Replacement Therapy (NRT)	NRT is offered for free or at a subsidised rate
Support groups	Quit smoking support groups run by the organisation
Individual support	Smoking addressed as part of individual casework or if client wants to discuss one-on-one
Referral	Clients are referred to the Quitline, GP or pharmacist.
Information	Clients are provided with information if they indicate they are interested in addressing their smoking
SANE Kit	Organisation uses the SANE SmokeFree Kit which is a program specifically developed to support people with a mental health problem to quit smoking.

Those who responded describe one or a combination of these types of support. Based on a total of 28 responses to this question, figure 8 shows that the most common types of support offered by

⁹ NSW Health defines brief intervention as taking anywhere between three minutes and 20 minutes to identify smoking status and provide brief advice.

organisations is 'Client Asks' (21.1%), 'Support Group' (23.7%), 'Referral' (21.1%), and 'Information' (21.1%). Some organisations (13.2%) are able to offer free or subsidised NRT or Individual support (13.2%) to their clients. Two (5.3%) respondents indicated that they use the SANE SmokeFree Kit to run groups and provide information. Only one (2.6%) respondent said that staff had undergone any training to support people who want to quit or reduce smoking.

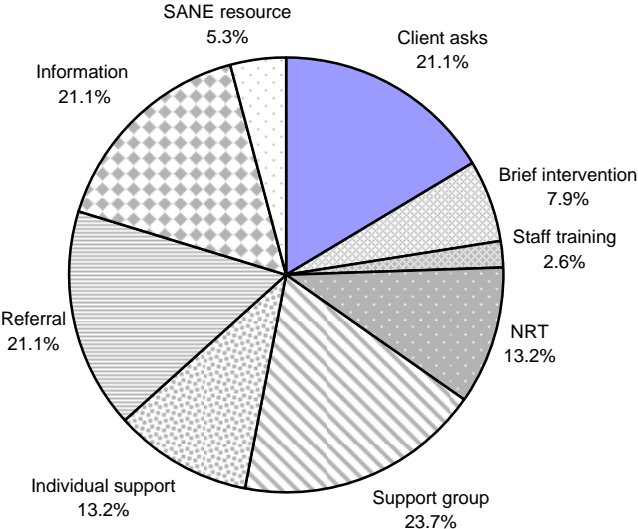


Figure 8: Types of support provided by member organisations to clients to quit or reduce smoking

INTEREST IN DOING MORE ABOUT TOBACCO (PART E, QUESTIONS 30 TO 32)

Respondents were asked in this section of the survey to rate their organisation's interest in doing more about tobacco and what type of strategies would be useful for organisations to adequately address smoking. All respondents answered all three questions in this section.

On a scale of 0 to 10, 0 being 'Not Interested' and 10 being 'Very Interested', almost three quarters (73.7%) of respondents were very interested in doing more about smoking in their organisation. The remainder were either 'Not Interested' (10.5%), 'Somewhat Interested' (13.2%), or 'Unsure' (2.6%). Respondents were then asked to choose one or more options from a selection of seven strategies that would be most useful in assisting organisations to support clients who want to quit or reduce smoking.

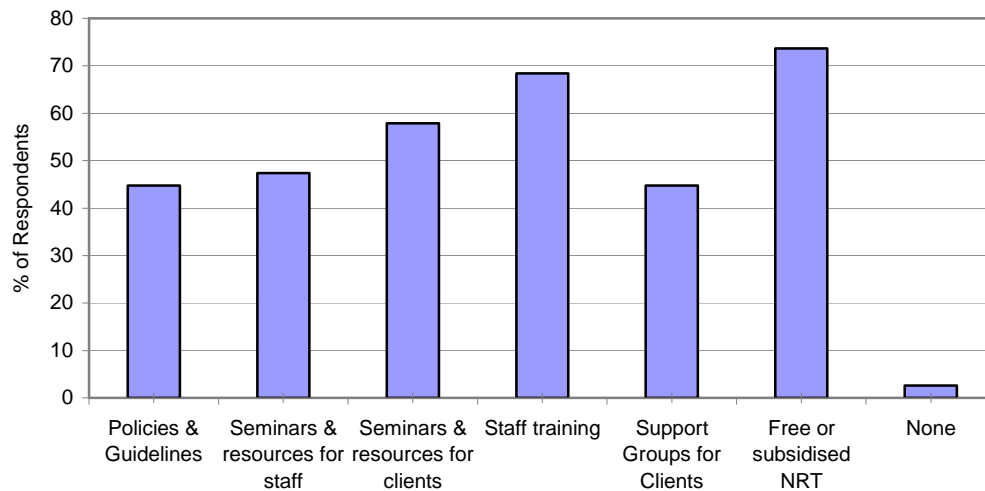


Figure 9: Strategies that would be useful in assisting organisations help clients who want to quit or reduce smoking

Figure 9 shows that in general all of the options provided were seen as useful strategies for organisations to address smoking. The most useful strategy for 73.7% of respondents was being able to provide free or subsidised NRT. Staff training was considered to be the next useful strategy by 68.4% of respondents, which was followed by seminars and resources for clients (57.9%), for staff (47.4%), policies and guidelines (44.7%), and support groups for clients (44.7%). Only one respondent (2.6%) felt that none of the strategies would be useful.

Other suggestions that people provided included financial modelling and client involvement in developing policies and procedures.

INVOLVEMENT IN THE BREATHE EASY PROJECT (PART F, QUESTIONS 33 & 34)

This last section of the survey was used as a means to gauge how interested organisations may be in participating as demonstration site with the breathe easy project. Two questions were asked: level of interest and who would be the best person to contact.

Figure 10 shows that, on a scale of 1 to 10 (1 being 'Most interested' and 10 being 'Least Interested'), 42.1% of respondents indicated they were most interested in participating as a demonstration site. At the other end of the scale 31.6% were not interested at all in participating with the project.

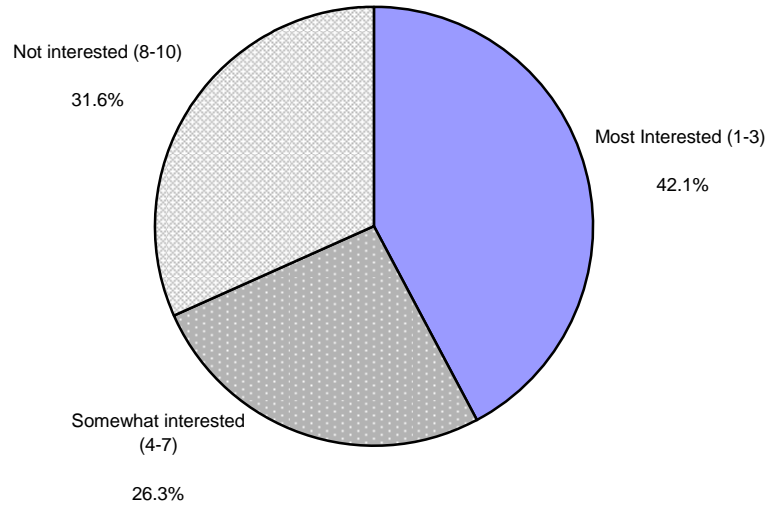


Figure 10: Organisations' interest in participating in the breathe easy project

CONCLUSION

In general the results from the survey indicate that MHCC's member organisations' attitude to addressing smoking is positive and supportive. The general Australian population is well aware of the harms caused by smoking tobacco and this is evident in the continual drop in smoking rates. The current rate of smoking for the general Australian population is just less than 17%¹⁰ compared to approximately 72% of males who smoked in 1945.¹¹ However the rate for many disadvantaged populations is much higher than 17% such as for people with a mental health problem for who the rate of smoking is about 32%.¹² It is on this point that some of the survey results present a basis for this higher rate and provides some indication that there is less clarity in addressing smoking in association with mental health.

Attitudes, policies and practices are strongly connected to level of awareness and education on smoking and mental health. This is apparent in the high proportion of 'Unsure' responses that many statements attracted. The result for the statement 'quitting smoking will cause our clients to have a relapse in their mental illness' would be a good starting point for education as over 50% of respondents agreed with this statement and 36.8% were still unsure if this was true.

The result is not surprising given that this is a concern commonly expressed. A good reason for this is that nicotine withdrawal symptoms experienced by any person giving up smoking vary from person to person and include experiencing changes in mood, stress, anxiety and depression.¹³ Thus these nicotine withdrawal symptoms can sometimes be mistaken for symptoms of mental health problems¹⁴ leading people to assume that a person with a history of a mental health problem will have a relapse if they try to quit smoking tobacco.

The perception of a client's desire and willingness to quit or reduce smoking is another area where education may also be useful. Although almost 80% of respondents agree that smoking does contribute to a person's disadvantage, most either agreed or were unsure that quitting or reducing smoking was not a priority for clients and that they were not interested in quitting or reducing. However there are numerous studies that indicate people with a mental health problem do have an interest in quitting smoking. A survey of clients conducted at Neami** in Darebin, Victoria showed that over half of all respondents wanted to reduce their smoking as a way to quit and a third of respondents were interested in quitting smoking altogether.¹⁵ A study conducted by Baker et al (2007)¹⁶ looking at smoking interventions for people with a psychotic disorder also found that people were very interested in giving up smoking attracting 298 participants to the study.

These results can be explained by looking at the results for two other questions, in Part B and Part D respectively, where most respondents were either unsure or mostly agreed that 'clients have the right to smoke and we shouldn't interfere with that decision' and that almost 60% said that none of their clients have their smoking status recorded. Thus it would seem that clients are not interested in quitting smoking if staff feel it is not their place, or perhaps find it difficult, to raise the issue and the

** Neami is a not for profit non-government organisation providing psychosocial health and rehabilitation support in Victoria, New South Wales, South Australia and Western Australia.

smoking status of clients is not being recorded. In essence, environments that are more conducive to staff or clients being able to discuss smoking are required, emphasising the need for policies and practices to change.

Education also ties in with the capacity of staff and the organisation to address smoking. That respondents generally felt that they shouldn't interfere with their clients decision to smoke supports the notion of self efficacy in the NGO mental health sector but it may also be a reflection that staff don't feel they have the skills and knowledge to address the complex issue of smoking in people with a mental health problem. This is strongly highlighted in the survey findings for Part D with only one respondent indicating that staff had been trained in smoking cessation and that almost 70% of respondents in Part E said that staff training would be useful in assisting their organisation to help clients who want to quit or reduce smoking.

Staff training alone is not enough to change staff practices around smoking, but rather a more organisational approach is needed.¹⁷ The survey results strongly suggest that there are many inconsistencies between smoking policies and practices. Although almost 80% of respondents said a smoking policy existed it seems that what the policies actually include does not correspond with the organisation's practice in terms of providing support for addressing smoking. This is suggested in the high proportion of respondents answering 'Unsure' to questions about the organisation's current practice around smoking. Thus it would appear that policies may need to be more explicit and comprehensive in what the organisation will do in terms of smoking. Clearer and more detailed policies have the potential to generate more consistent practice within an organisation. Workplace and household restrictions alone have been shown to encourage smokers to quit smoking.^{18,19}

Regardless of the lack of consistency in policy and practice, there are a number of very encouraging results in regard to what organisations are currently doing on the issue of smoking. It is commonly reported that smoking is often used as a way for staff to build a therapeutic relationship with clients.²⁰ Surprisingly this view was not well supported by respondents with 71% disagreeing with the statement 'staff smoking with a client is a good way to help build trust and a good rapport'. Although almost one third of respondents agreed with the next statement 'staff smoking with a client can be a useful way to help de-escalate a tense situation' over 50% still disagreed.

And most organisations are clearly interested in doing more about smoking within their services. This is obvious from the 73.7% who indicated they were 'Very Interested' in doing more about smoking and the 42.1% who were 'Most Interested' in participating in the breathe easy project. Respondents have also been able to clearly articulate what strategies would assist organisations to help clients. That free or subsidised NRT was considered to be the most useful strategy by over 70% of respondents raises the need to find a way to make NRT more affordable. This is particularly important if NRT in combination with individual or group behavioural support is considered the gold standard for successfully quitting smoking not only for the general population but also for people with a mental health problem.²¹ And it becomes even more important if highly addicted smokers need a combination of NRT products, as recommended by the Royal Australian College of General Practitioners.²²

There were of course some limitations in administering this survey. That only a 19% response rate was received limits the significance of the findings. There is some in-built bias where those who completed and returned the surveys already have an interest in smoking and mental health. This is highlighted by the 28 (73.7%) respondents who indicated they are doing something about addressing smoking within their service, albeit the minimum of waiting until a client raises the issue before acting, and so the survey results may not necessarily account for those services where smoking is not being considered at all. And there is always the in-built bias that respondents may give the response that is the most socially desirable or acceptable. Regardless of these issues the findings are a useful tool to provide an insight in to the NGO mental health sector.

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SURVEY OF SMOKING RATES AND ATTITUDES

The Mental Health Coordinating Council in partnership with The Cancer Council NSW is running the *breathe easy* project that aims to reduce smoke-related harm in people with a mental illness.

The purpose of this survey is to investigate how MHCC member organisations address the issue of tobacco smoking.

We want to understand:

- the current attitudes of services to smoking;
- the current smoking policies of services;
- the current practices of services in regard to smoking;
- if services want to do more to address smoking, and
- what resources and training would be helpful to address smoking.

We would also like to know if your organisation is interested in participating in the *breathe easy* project.

This survey needs to be completed by senior staff or the executive officer of each organisation.

Small or medium sized organisation need only complete one survey. For large organisations that provide different service types in multiple regions, please complete one survey for each major service type or region, if possible.

All information provided by you will remain anonymous and any contact details provided will not be disclosed outside of MHCC without your permission.

HOW TO COMPLETE THIS SURVEY

3 quick and easy steps –

1. open the document
2. type or click your responses in the pdf file
3. hit the 'Submit by Email' button and follow the prompts once

you've finished.

Note: If you are having trouble completing and sending the survey you can print the file and complete by hand or you may need an updated version of Adobe Reader - click on this link if you wish to update to Adobe Reader 8.1.2 for free <http://www.adobe.com/products/acrobat/readstep2.html> and follow the prompts.



For more information please contact:

Carla Cowles
Project Officer
02 9555 8388, ext 112
E: carla@mhcc.org.au

PART A: YOUR ORGANISATION

1. What is the name of your organisation or service?

2. What is your position within the organisation or service?
 - Chief Executive/Executive Officer
 - Program Manager/Coordinator
 - Senior Manager/Director
 - Other _____

3. What type of service/s does your organisation provide?

4. In which region does your organisation provide these services?

5. Approximately how many employed staff (full time equivalent) does your organisation have?

6. Please approximate how many of these staff are smokers?

7. Approximately how many volunteers does your organisation have?

8. Please approximate how many of these volunteers are smokers?

PART B: YOUR ORGANISATION'S ATTITUDES TO SMOKING

Please tick the most appropriate response for each statement that best describes your organisations view.

9. People with a mental illness who smoke should be urged to quit or reduce smoking

Strongly disagree Disagree Unsure Agree Strongly agree

10. People who want to quit or reduce smoking should receive support if that is what they want to do

Strongly disagree Disagree Unsure Agree Strongly agree

11. Helping clients to quit or reduce smoking should be part of the care and support we provide

Strongly disagree Disagree Unsure Agree Strongly agree

12. Quitting or reducing smoking is not a priority for our clients who have other things to worry about

Strongly disagree Disagree Unsure Agree Strongly agree

13. Smoking contributes to our clients' disadvantage

Strongly disagree Disagree Unsure Agree Strongly agree

14. Our clients who smoke are not interested in quitting or reducing smoking

Strongly disagree Disagree Unsure Agree Strongly agree

15. Quitting smoking will cause clients to have a relapse in their mental illness

Strongly disagree Disagree Unsure Agree Strongly agree

16. Clients have a right to smoke and we shouldn't interfere with that decision

Strongly disagree Disagree Unsure Agree Strongly agree

17. Staff smoking with a client is a good way to help build trust and a good rapport

Strongly disagree Disagree Unsure Agree Strongly agree

18. Staff smoking with a client can be a useful way to help de-escalate a tense situation

Strongly disagree Disagree Unsure Agree Strongly agree

PART C: YOUR ORGANISATION'S SMOKING POLICIES AND GUIDELINES

19. Does your organisation have a policy on smoking?

Yes No Unsure

If you answered YES to question 19 please respond to questions 20, 21, 22 and 23.

If you answered NO or UNSURE to question 19 please proceed to question 24.

20. Does this policy cover any of the following cases? (please tick one or more)

- | | |
|--|---|
| Smoking in or near agency premises/grounds? <input type="checkbox"/> | Staff smoking with clients under 18? <input type="checkbox"/> |
| Smoking in agency cars <input type="checkbox"/> | Providing support for staff who want to quit or reduce smoking? <input type="checkbox"/> |
| Smoking by staff or clients on home visits? <input type="checkbox"/> | Providing support for clients who want to quit or reduce smoking? <input type="checkbox"/> |
| Staff smoking with clients 18 and over? <input type="checkbox"/> | None of the above <input type="checkbox"/> |

21. Does the policy cover anything else not listed above?

22. Overall, how much do you think **staff** comply with your organisation's smoking policies?

All or most of the time Sometimes Very little or never

23. Overall, how much do you think **clients** comply with your organisation's smoking policies?
- All or most of the time Sometimes Very little or never
24. Does your organisation provide guidelines for assisting clients who want to quit or reduce smoking?
- Yes No Unsure

PART D: YOUR ORGANISATION'S CURRENT PRACTICE TOWARDS SMOKING

Please tick the best estimate (between 0% and 100%) that describes your organisations current smoking practices

Your Clients

25. What percentage of clients have their smoking status recorded (e.g. as part of their intake)?
- 0 10 20 30 40 50 60 70 80 90 100 Unsure
26. What percentage of clients are provided with information about tobacco and the risks of smoking?
- 0 10 20 30 40 50 60 70 80 90 100 Unsure

Your Clients who Smoke

27. What percentage of clients who are smokers are referred to external support to quit or reduce smoking (e.g. GP, smoking Quitline)?
- 0 10 20 30 40 50 60 70 80 90 100 Unsure
28. What percentage of clients who are smokers are offered support from your organisation to quit or reduce smoking?
- 0 10 20 30 40 50 60 70 80 90 100 Unsure
29. Please describe the type of quit smoking support your organisation provides.

PART E: YOUR ORGANISATION'S INTEREST IN DOING MORE ABOUT TOBACCO

The following questions are about your organisation's level of interest in learning more and doing more to help clients quit or reduce smoking.

30. Overall, how would you rate your organisation's interest in doing more about smoking? Please tick the appropriate number that best describes your organisation where 0 is the least interested and 10 is the most interested.

Not Interested

Somewhat Interested

Very Interested

0 1 2 3 4 5 6 7 8 9 10 Unsure

31. Which of the following strategies would be useful in assisting your organisation to help clients who want to quit or reduce smoking? (please tick one or more)

Assistance with developing organisational policy and guidelines around tobacco and smoking?

Staff training in smoking cessation and providing support

Smoking information seminars/forums and resources for **staff**?

Providing a support groups to assist clients quit or reduce smoking?

Smoking information seminars/forums and resources for **clients**?

Access to free or subsidised Nicotine Replacement Therapy (NRT)?

None of the above

32. Are there any other strategies you think would be useful for your organisation?

PART F: MHCC BREATHE EASY PROJECT

33. How interested is your organisation in participating as a demonstration site in the MHCC *breathe easy* project? Please tick the appropriate number that best describes your organisation where 1 is the most interested and 10 is the least interested.

Most Interested

Somewhat Interested

Least Interested

1 2 3 4 5 6 7 8 9 10

34. If interested, who is the best person to contact?

Name &
Position:

Phone:

Mobile:

Email:

Thank you for taking the time to complete this survey.

Please return your completed survey by **Monday 19th May**.

To return this survey:

<u>Option 1</u>	<u>Option 2</u>	<u>Option 3</u>
Click 'Submit by Email' and follow the prompts.	Post your printed survey to: Carla Cowles breathe easy MHCC PO Box 668 Rozelle NSW 2039	Fax your printed survey to: 02 9810 8145 Attn: Carla Cowles