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Title: Evaluation of a totally smoke-free forensic psychiatry inpatient facility: practice and policy implications

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Competing interest:

The authors declare they have no competing interests.

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Abstract:

Objective: To evaluate the impact of implementing smoke-free policy in an Australian high security forensic psychiatry inpatient hospital.

Methods: Focus groups (N=21) and surveys with patients (N=45) and surveys with staff (N=111, 53.2% nurses) elicited their experience and attitudes towards smoke-free policy. A follow-up survey elicited the impact of the policy on 15 patients' smoking practice post discharge.

Results: Eighty-five percent of patients stated it was easier quitting when no-one else smoked. Over half of discharged patients surveyed (58%) continued to not smoke post-discharge, despite almost half of staff (41%) perceiving that patients were unlikely to quit long-term. Smoking staff were significantly more pessimistic than non-smoking staff. Many patients (69%) perceived that their health had improved as a result of not smoking. Most staff (80%) viewed nicotine dependence treatment as important, but fewer (66%) felt confident to support patients to stop smoking. Increased patient violence and management difficulties expected by staff were not realized.

Conclusions: Smoke-free policy can be successfully implemented in forensic psychiatry inpatient units. Nursing staff are a large and important group who need particular support to implement smoke-free policy into practice effectively, particularly those who are smokers. Continuity of care as part of a coordinated policy and service response is needed.

Key Question Summary

1. What is known about the topic?

Health care settings are increasingly going totally smoke-free, with mental health facilities the slowest to implement these policy changes. This is partly due to the fear of possible increases in violence and aggression among a patient population who have a high prevalence of smoking.

2. What does this paper add?

This paper adds to the evidence base that implementing a smoke-free policy in mental health inpatient hospitals is not only feasible but has substantial benefits for both staff and patients. In particular, it highlights the policy and practice implications which can assist mental health facilities to go smoke-free.

3. What are the implications for practitioners?

Smoke-free policy can be successfully implemented in forensic psychiatry inpatient units; however, more support and education for staff is needed to increase their confidence and capacity to implement the policy consistently across service domains.

Introduction

Forensic psychiatry inpatient facilities are unique settings caring for people found not guilty by reason of mental illness, found unfit to be tried for an offence or found unfit to be tried and subsequently found guilty on a limiting term basis because of their mental illness. They also accommodate patients transferred from correctional or detention centres while serving a sentence of imprisonment, or while on remand, and high risk civilian patients.¹ Rates of smoking by forensic psychiatry populations, prison populations, and mainstream psychiatric populations are disproportionately high, compared with smokers in the general community. A number of reports have claimed that almost half of all cigarettes smoked are smoked by people with mental illness;²⁻³ These rates have been questioned as too broad and fairly contentious largely because of the large range of definitions used.⁴ A more recent national survey by the US Centers for Disease Control and Prevention has determined that 30.9% of all cigarettes smoked are smoked by people with mental illness.⁵ Their rates of physical health comorbidity are also high, with smoking being a leading contributor to their morbidity and mortality, as it is for the general population.⁶ Therefore, a comprehensive and coordinated health policy and service response is needed.

People with mental illness are over-represented in correctional systems, with prisoners in the United Kingdom having increased psychosis (20-fold)⁷ and personality disorder risk (130 fold).⁸ In Australia, Aboriginal and Torres Strait Islander prisoners, in particular, are over-represented in Australian prisons and forensic psychiatry facilities.⁹ In 2009, 76% of NSW prisoners reported being current smokers, and 52% accessed psychiatric treatment.¹⁰ More recent statistics for NSW forensic mental health report 75% of male and 52.4% of female prisoners smoke.¹¹ Others have found smoking rates as high as 85% for Australian prison

populations.¹² In Europe, 64-88% of male prisoners (95% of prison population) are smokers.¹³

Traditionally, smoking has been perceived as important for coping with stress, boredom, and psychiatric symptoms, and part of the cultural fabric of psychiatric settings; used as a management tool, mediating exchanges and relationships between staff and patients, and between patients.¹⁴ Several myths about smoking and mental illness have contributed to widespread acceptance of patients' smoking and opposition to smoke-free policy, including concern that smoking cessation might negatively impact patients' mental health and lead to increased aggression, that they are uninterested in quitting, and that they cannot quit.¹⁵⁻

¹⁷These might act as barriers to staff implementing smoke-free policy and providing patients with cessation support.¹⁸⁻²² There has also been debate about the ethics of smoke-free policy within long-term care settings which could be interpreted as patients' homes, as part of complex debates about patients' rights and choices which are beyond the scope of this study.^{23,24} This culture has been similar for prisons.^{25,26}

Within both correctional and psychiatric settings, there is increased awareness of the physical health harms of second-hand smoke for non-smokers and associated occupational health and safety concerns for staff working in these environments.^{25,27-29} There have therefore been significant efforts, nationally and internationally, to make correctional and psychiatric environments smoke-free.^{13,30-32} However, this has met with some resistance. A survey of English psychiatric hospital staff found 60% believed they should smoke with patients, 54% that smoking played a therapeutic role for patients, and 93% that patients' mental state would deteriorate if denied access to cigarettes whilst hospitalised.³³ An Australian study of psychiatric staff found however that attitudes have shifted over time towards supporting

smoke-free policy,³⁴ although strategies to address staff knowledge and capacity are still needed.³⁵

More evidence is needed to document experiences of implementing smoke-free mental health facilities from the perspective of both patients and staff. This study reports policy and practice implications of an evaluation of a newly opened high security forensic inpatient hospital in Sydney Australia. Detailed papers have been published on patient and staff perspectives related to this evaluation.^{36,37} This paper seeks to add value to these papers by highlighting important findings and identifying policy and practice implications for smoke-free psychiatric units more broadly.

Methods

Setting

The setting is an Australian metropolitan stand-alone 135 bed high security forensic hospital for men and women, providing treatment and forensic rehabilitation in line with national and international best practice. In compliance with NSW Health's Smoke-free Workplace Policy,³⁸ and following extensive consultation with management, clinical experts and staff across facilities, the hospital was opened in 2008 as a totally smoke-free facility where patients and staff are unable to smoke inside buildings or on hospital grounds. During the evaluation period, the hospital had no provisions for patients to access outside leave. Staff pass through secure foyer screening upon leaving and returning to the hospital.

All forensic patients are admitted to the hospital from NSW correctional centres, many where smoking is still allowed in prisoners' cells and outside spaces. Civilian patients are admitted from Local Health Districts where smoking is accessible during outside leave. Existing staff

were transferred to the new facility from a prison hospital where previously they had been able to smoke in designated smoking areas outside. Prior to admission, patients are assessed for nicotine dependence and offered nicotine replacement therapy (NRT- patch, lozenge or inhaler). Inpatient staff monitor patients' nicotine withdrawal and offer smoking cessation support. All clinical staff are offered training in assessment of nicotine withdrawal and use of NRT products, though this is not systematically offered and not mandatory.

The study was approved by the Justice Health Human Research and Ethics Committee.

Study population

Current patients considered able to participate due to stable mental state and ability to speak English were approached by the researchers to inform them about the study and seek their verbal or written consent to participate. Patient study components included a cross-sectional survey of current patients (N=45 participants from a sample of 84 patients, 80% previous smokers, 54% response rate from a total sample of 106 patients, after exclusion of 17 who were too unwell to participate), focus groups (N=21 participants, all previous smokers, 25% of eligible patients, N=84) among current patients and a survey among discharged contactable patients (N=15 participants of 23 discharged patients, 65% response rate; 80% previous smokers). Surveys and focus groups asked participants to describe their smoking history, experiences of being admitted to and living in a totally smoke-free environment and the impact of smoke-free policy on their smoking intentions. 93% of participating patients were male and 62% of staff were female. More detail on the patient survey methodology and its findings have been reported elsewhere.³⁶

All staff (N=222) working at the forensic hospital were invited to complete a short tick-box cross-sectional survey related to their attitudes and experience of smoke-free policy and its

impacts on patients. The survey was distributed via email, staff meeting attendance and provision of hard copies with a return envelope or a return box in nursing stations, Half of staff (50%, N=111) completed the survey. Gender, age and profession reflected current staff populations: 62 (55.9%) were female and 49 (44.1%) were male; most were between 30-39 years (38.7%, N=43) or 50-59 years (26.1%, N=29) with fewer in other age groups; most were nurses (53.2%, N=59) with clinical managers being the second largest group (16.2%, N=18), allied health professionals being the third largest group (12.6%, N=14) and smaller numbers from administration and medical officers/specialists. They identified their smoking status as: current smokers (13%, N=14), former smokers (42%, N=47) and never smokers (45%, N=50). Most staff participants had worked at the hospital for more than two years (54.1%, N=60) or between one and two years (28.8%, N=32), with the remainder being less than one year. More information regarding the characteristics of the staff who participated in the survey and its detailed findings are described elsewhere.³⁷

Data analysis

Data was entered and analysed using IBM SPSS Statistics Version 19. Descriptive statistics were used to analyse demographic data and responses to questions about the policy impacts and implementation. Pearson chi-square (2-tailed) was used to detect significant differences at $P < 0.05$ between staff who identified as smokers compared to non-smokers.

A limitation of the analysis was that investigation of potential specific gender, ethnicity and other differences among patient and staff participant groups was beyond the scope and capacity of this research. In particular, higher rates of smoking and greater health inequalities for indigenous populations might have implications for how smoke-free policy is implemented in these settings, warranting further research that takes account of ethnicity.

Results

The following represent key findings from the evaluation.

Impact of a total ban on patients' current and future smoking cessation

Many patients (42%, N=19) stated that they wanted to quit when they arrived at the forensic hospital. Whilst 40% (N=18) of surveyed patients were angry with being forced to stop smoking, and 76% (N=34) reported difficulty quitting, 85% (N=38) indicated that it was easier when no-one else smoked, and many stated that living in a totally smoke-free environment was the only way they felt they could quit. Over half (58%, N=7) of the 12 patients surveyed who had been smoking prior to admission to the forensic hospital and discharged to medium secure facilities continued to not smoke post discharge (average 305 days). Though promising, this finding cannot be extrapolated without conducting further research with a larger sample. Many patients indicated that support to help them remain non-smoking post-discharge would be valuable. Just under half of staff surveyed (41%, N=46) felt patients were unlikely to quit long-term, with smoking staff significantly more pessimistic than non-smoking staff.

Managing Patient Withdrawal

Most staff (80%, N=88) agreed that providing nicotine dependence treatment was as important as other roles, but fewer (66%, N=73) felt confident to support patients to stop smoking. Just over half (57%, N=63) felt that withdrawal was a significant issue for most patients. Most (76%, N=84) patients reported that withdrawal was hard. In the focus groups, some patients indicated that their withdrawal symptoms might have been confused, by staff, with worsening of their mental illness. Some patients reported stressful incidents triggered by nicotine withdrawal not being addressed. These concerns are not unreasonable, given limited training received by staff and the consequent lack of confidence by many staff to support

patients to stop smoking, as reported above. Most patients (82%, N=91) felt that NRT helped them with nicotine withdrawal, although some patients reported still struggling and using NRT months after admission.

Total smoking bans and patients' health

Many patients (69%, N=76) reported health improvements and improved ability to exercise, as a result of the smoke-free policy, though many (62%, N=69) also felt they had gained weight as a result of not smoking.

Staff support for the policy

Staff who smoked were significantly less likely (15% vs 38%, $p=0.003$) than non-smoking staff to report feeling supported by smoke-free policy. Despite this difference, over a third of the 111 staff surveyed (35%, N=39), regardless of their smoking status, agreed that there was a lack of support for staff smokers and over half (57%, N=63) felt it was difficult for staff smokers to adhere to the policy. Staff overwhelmingly preferred to work in a totally smoke-free environment (88%, N=98), though responses differed significantly for current smokers compared to non-smokers (39% vs 95%, $p<0.001$) and for not forcing patients to stop smoking (64% vs 30%, $p=0.001$).

Patient Care

Increased violence among patients and potential management difficulties expected by staff were not played out in reality. Staff smokers were less likely to find patient care easier (21% vs 64%, $p=0.009$) under the policy and were more likely to report problems with patient aggression (39% vs 17%, $p=0.016$). However, more than half of staff (57%, N=63) felt

patient care was easier with the policy, indicating that loss of smoking-related management tools was not seen as a negative outcome of the policy.

Discussion

Our findings provide clear evidence to debunk a range of myths held about smokers with mental illness in forensic psychiatric units; in particular, that these smokers are uninterested in quitting, that they cannot quit, that their mental health will deteriorate if they attempt to quit or are subjected to nicotine withdrawal, that there will be an increase in patient aggression if inpatient units attempt to be smoke-free, and that their cessation will not be sustained post-release,. These and other related results are discussed below.

Myth 1: Forensic patients who smoke do not want to quit or cannot quit

Many people with mental illness want to quit smoking and can quit.^{39,40} While some forensic patients objected to the smoke-free policy, for many this presented an opportunity they had not had in any other environment. That is, when given the opportunity and supported to do so, patients were interested in quitting and could quit without adverse impacts on their mental health. It suggests that allowing smoking to continue in these settings compromises patients' opportunities to quit, and that smoke-free environments are positive learning environments where patients can learn to quit smoking, and remain quit following discharge, rather than believing that they need to be well before this can occur. However, they are likely to need additional support to quit long-term, although paradoxically, they tend to be offered less support by healthcare providers.⁸ Our research suggests that discharge planning should address smoking post-discharge from smoke-free facilities and consistency of support across the continuum.⁴¹

The results suggest that NRT plays a beneficial role for some patients in clinically managing their nicotine withdrawal. However, policies around its provision, cost to health services, and availability to patients during hospitalization and beyond when they are discharged or transferred, and the extent to which it is used in combination with other quitting aides warrants further consideration. Extended courses of NRT^{42,43} and additional support, rather than different approaches to support or exemptions from existing policies,⁴⁴ have been found to lead to better smoking cessation outcomes for people with mental illness.

The results also suggest more focus on early preventative approaches to patients' health and wellbeing is also needed, ensuring clinicians follow guidelines, and to promote opportunities for health promotion within routine care.¹¹ This also has implications for the types of health workers employed within such settings (for example, whether more health promotion workers, dietitians or exercise physiologists and physiotherapists would be useful), their ratio within clinical teams, and training and role expectations held of all clinical staff in providing holistic care.

Myth 2: The mental health of forensic patients who quit smoking will deteriorate and they will be more aggressive

Our study did not find any increase in aggression or deterioration in patient mental health as a result of the smoke-free policy. Concerns about patient violence and aggression towards staff attempting to enforce the policy are consistent with other research,^{18,20} as are greater reporting of concerns by staff who smoke.^{22,45,46} In the smaller number of cases where there were issues associated with patient aggression, reports suggested these could have been avoided with appropriate planning, patient and staff preparation and training.⁴⁷ Meehan et al's study with

27 patients in a forensic psychiatric unit found that the cause of aggressive behaviour centred around five major themes: the environment; empty days; staff interactions; medication issues; and patient-centred factors.⁴⁸ Provision of meaningful activities to reduce boredom and improve staff attitudes were two strategies identified by patients to reduce their aggressive behaviour. This is particularly important for nurses, given their hands-on role in providing patient care, managing risk and responding to adverse events. With this in mind, our results suggest an even greater imperative for policies and practices that improve care delivery in these environments. This includes effective mentoring and supervision, training and education for all staff, especially those who struggle to untangle smoking from clinical care. The results clearly debunk the myth of increased aggressive incidents in smoke-free psychiatric settings. They go further to suggest the opposite is more likely; that is, increased effective use of staff time due to not managing and monitoring tobacco distribution. This includes perceived increased staff skills in therapeutically engaging and communicating with patients, creating opportunities for more therapeutic encounters with patients that no longer involved cigarettes as the vehicle for engagement.⁴⁹

Myth 3: Forensic patients who quit smoking will return to smoking on release

Though this study only had a small sample of 15 patients followed post-release, over half of these did not return to smoking when released from the forensic hospital. While other studies report rapid returns to smoking,^{50,51} outcomes for the small sample of discharged patients surveyed in this study demonstrated the potential for long term quitting. Patients surveyed in this study may differ from those surveyed elsewhere due to their long period of hospitalisation and duration of NRT provision. Reasons given by patients for not smoking were that they felt better and, having gone through withdrawal, did not want to go through it

again. There were differences between smoking policies and access to cigarettes in the discharge locations which also likely impacted on patient smoking post-release. These differences included whether they were totally smoke-free, or had designated smoking areas, or other opportunities to smoke.

Myth 4: Forensic patients who smoke are easier to manage

Over half of forensic hospital staff indicated that patient care was easier to manage in the smoke-free environment. The results also suggest that staff need education in recognizing nicotine withdrawal, delivering integrated interventions to address the complexity of interactions between patients' psychiatric symptoms and nicotine withdrawal as part of holistic consistent clinical care; a view supported by others.^{35,52,53} With improved staff education and training, patient management strategies can be utilised to address patients who are more distressed by nicotine withdrawal, so that clinical teams do not struggle and resort to escorting such patients to areas away from other patients where they can provide them with a cigarette. This has implications for perpetuating a culture in which the various myths about smoking by these populations remain unchallenged. It also has implications for the security of the person, staff and premises, creating the potential to incite other patients, and staff then relying on this opt-out approach more routinely, or patients then complaining about inequity of this approach; all of which can undermine the policy.⁵⁴ This requires consistently applied leave arrangements for patients, given they can trigger potential conflicts between patients and staff, and staff and other staff, especially between nurses and doctors.^{19,54}

Further reasons exist for supporting staff through education and training. A UK study of 135 forensic healthcare professionals (58 nurses) found high levels of burnout were associated

with higher reports of unhealthy coping strategies such as smoking.⁵⁵ Smoking staff were more likely to use depersonalization as a defense mechanism to reduce emotional energy needed to work with patients, with detrimental implications for patient care (eg. cynical attitudes and poor therapeutic relationships). Promoting staff wellbeing through improved access to effective training, clinical supervision and support are recommended. With regard to promoting patient wellbeing, Happell et al's systematic review of the most common forms of physical healthcare by nurses found that health education and monitoring were prominent activities, but how nurses take action to support sustainable patient behaviour change was less clear. Significant barriers to enhancing nurses' capacity included role ambiguity, unclear responsibility structures, and lack of preparation of psychiatric nurses for physical health tasks.⁵⁶ Our study found potential barriers included confidence in providing withdrawal advice and treatment, limited belief in long-term quitting potential of patients and expectations of patient management issues. Smoking staff tended to identify and emphasize such barriers more than non-smoking staff. These barriers may be similar for other disciplines.

A related issue is how staff are supported to quit smoking. The results show clear support by staff for smoke-free work environments in these settings; however, more attention needs to be given to understanding and shifting the views of smoking staff and supporting staff smoking cessation, at least while they are on duty. In this study site, support provided to staff smokers was tailored to quitting and did not provide support options while on duty for those staff who did not want to quit. Policy implementation should acknowledge support for such staff to manage their smoking and withdrawal while at work especially given staff smokers returning to smoke-free units following breaks smelling of cigarettes has been shown to undermine success of smoke-free policy.^{19,54}

A consistent policy approach

Overall, this study showed clear support for smoke-free policy by both mental health patients and staff. However, in order to work, such policy needs to be unambiguous and consistently implemented. This involves providing support to all staff, particularly those who smoke, preparing patients prior to admission and providing them with NRT and other withdrawal support during their admission and discharge as part of transition to other settings.^{19,20,22} A ‘whole prison approach’ is recommended,^{11,13} with clear communication between all stakeholders (patients, staff, carer givers, service managers and policy makers) is important, to ensure the views and needs of each are heard and to build uniform support for practice in implementing the policy and to avoid tensions that might undermine implementation efforts. At a broader system and community level, Banfield et al’s continuity and service coordination framework would be useful as it involves: informational (eg. using information about past tobacco dependence to make current care more appropriate to individual needs); relational (eg. fostering an ongoing therapeutic relationship to support smoking cessation); and management (eg. consistent and coherent approach training for staff and to the management of nicotine withdrawal based on individual patients’ needs) requirements from services, to enhance their care provision and communication with each other and with patients.^{41,57}

Conclusions

Few studies have focused on smoke-free policy in forensic psychiatric facilities. High smoking prevalence among this vulnerable population underlines the need for a comprehensive approach to smoke-free policy within all settings where people with mental illness receive treatment. Integrated mental and physical health programs need to support a

long-term, person-centered perspective to improve patients' overall health and wellbeing. People with mental illness are likely to need additional support to quit long-term, although paradoxically, they tend to be offered less holistic support by healthcare providers⁵⁸. More education and training is needed that provides staff with the capacity to support and respond to patients' smoking cessation needs effectively, and challenges the many myths that abound in relation to this population. Discharge policies and practice protocols which provide for ongoing mental and physical health support, community links and access to NRT on discharge from psychiatric facilities are critical to patients' long-term smoking cessation. Clear protocols on how to implement smoke-free policy in forensic psychiatric inpatient units are needed, as are procedures for dealing with patients and staff who experience more significant nicotine withdrawal despite the availability of NRT. Non-smoking patients need to be supported in not starting smoking inside these facilities, and those who have successfully quit need a continuum of care that effectively supports them to remain non-smokers. Inpatient facilities, even forensic ones, can lessen harmful physical, social and economic impacts of smoking on this population. This includes identifying, acknowledging and responding to the needs of staff who smoke.⁵⁹ The consequences for patients and staff, should there be a failure to act on the policy and practice implications identified in the paper, are that an entrenched smoking culture will prevail, one in which health inequalities in life expectancy, increased risk of physical health conditions, exacerbated poverty and social stigma will continue for people with mental illness.

References

1. NSW Ministry of Health. Forensic mental health services. Policy Directive PD 2012_0505. NSW Health: Sydney; 2012. Available at: http://www.nslhd.health.nsw.gov.au/ppg/PD2012_050.pdf http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_050.html (verified 22 September 2013).

2. Access Economics. Smoking and mental illness: costs. SANE Australia: Melbourne; 2007.
Available
at: http://www.sane.org/images/stories/information/research/0712_info_smokecosts.pdf (verified 22 September 2013).
3. McManus S, Meltzer H, Campion J. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research; 2010.
Available at: <http://www.natcen.ac.uk/study/cigarette-smoking--mental-health> (verified 22 September 2013).
4. Chapman S. Access Economics talking up mental illness? Crikey, 12 December 2007.
Available at: http://www.crikey.com.au/2007/12/12/access-economics-talking-up-mental-illness/?wmp_switcher=mobile (verified 16 January 2014).
5. Gfroerer J, Dube SR, King BA, Garrett BE, Babb S, McAfee T. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥ 18 Years with Mental Illness — United States, 2009–2011. Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report* 2013; 62: 1-7. Available
at: http://smokingcessationleadership.ucsf.edu/mmwr_vital_signs_mental_illness_2-5-2013_cdc.pdf (verified 22 September 2013).
6. Aubin HJ, Rollema H, Svensson TH, Winterer G. Smoking, quitting and psychiatric disease: a review. *Neurosci Biobehav R* 2012; 36: 271–84. Available
at: <http://dx.doi.org/10.1016/j.neubiorev.2011.06.007> (verified 22 September 2013).
7. Stewart D. The problems and needs of newly sentenced prisoners: results from a national survey, Ministry of Justice Research Series 16/08; 2008. Available
at: <http://217.35.77.12/CB/england/research/pdfs/2008/research-problems-needs-prisoners.pdf> (verified 22 September 2013).

8. NICE. Antisocial personality disorder, treatment, management and prevention CG77; 2009. Available at: <http://guidance.nice.org.uk/CG77> (verified 22 September 2013).
9. Heffernan EB, Andersen KC, Dev A, Kinner S. Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. *MJA* 2012; 197:37-41. DOI: 10.5694/mja11.11352
10. Indig D, Topp L, Ross B, Mamoon H, Border B, Kumar S, McNamara M. The 2009 NSW Inmate Health Survey: key findings report. Justice Health: Sydney; 2010. Available at: <http://www.justicehealth.nsw.gov.au/about-us/publications/2009-ihs-report.pdf> (verified 22 September 2013).
11. Justice and Forensic Mental Health Network. Strategic Plan 2013-2017. Justice and Forensic Mental Health Network: Matraville, NSW, 2013. Available at: <http://www.justicehealth.nsw.gov.au/about-us/publications/jfmhn-strat-plan-2013-17> (verified 16 January 2014).
12. Butler T. & Papanastasiou C. National prison entrants' bloodborne virus and risk behaviour survey report 2004-2007. National Drug Research Institute (Curtin University) and National Centre in HIV Epidemiology and Clinical Research (University of NSW); 2008. ISBN: 1 74067 582 72008 Available at: <http://ndri.curtin.edu.au/local/docs/pdf/publications/R223.pdf> (verified 22 September 2013).
13. Hartwig C., Stöver H. & Weilandt C. Report on tobacco smoking in prison: Final Report Work Package 7. Directorate-General for Health and Consumers. Drug policy and harm reduction SANCO/2006/C4/02. Bremen University/Scientific Institute of the German Medical Association/ Centre for Interdisciplinary Addiction Research (CIAR); 2008. Available at: http://www.gesundinhaft.eu/wp-content/uploads/2008/11/drug_frep21.pdf (verified 22 September 2013).

14. Lawn S. Systemic barriers to quitting smoking among institutionalised public mental health service populations: a comparison of two Australian sites. *Int J Soc Psychiatr* 2004; 50: 204-215. DOI: 10.1177/0020764004043129
15. Ragg M, Ahmed T. Smoke and Mirrors: a review of the literature on smoking and mental illness. Tackling Tobacco Program Research Series No. 1. Cancer Council NSW: Sydney; 2008. Available at: <http://askthequestion.com.au/wp-content/uploads/2011/05/CAN-1021-Smoke-and-Mirrors.pdf> (verified 16 January 2014).
16. Allan J. Smoking: time for the mental health system to confront its own ambivalence. *Australas Psychiatr* 2013; 21(3):203-205. DOI: 10.1177/1039856213486212
17. Lawn S, Champion J. Achieving smoke-free mental health services: lessons from the past decade of implementation research. *Int J Environ Res Pub Health* 2013; 10: 4224-4244. DOI: 10.3390/ijerph10094224
18. Lawn S, Pols RG. Smoking bans in psychiatric inpatient settings? A review of the research. *Aust NZ J Psychiat* 2005; 39: 866-85. DOI: 10.1111/j.1440-1614.2005.01697.x
19. Lawn S, Champion J. Factors associated with success of smoke-free initiatives in Australian psychiatric inpatient units. *Psychiatr Serv* 2010; 61: 300-5. Available at: <http://www.ap.psychiatryonline.org/article.aspx?articleid=101263&RelatedWidgetArticles=true> (accessed 4 April 2013).
20. Voci S, Bondy S, Zawertailo L, Walker L, George TP, Selby P. Impact of a smoke free policy in a large psychiatric hospital on staff attitudes and patient behaviour. *Gen Hosp Psychiat* 2010; 32: 623-30. Available at: <http://dx.doi.org/10.1016/j.genhosppsy.2010.08.005> (accessed 22 September 2013).
21. Prochaska JJ. Smoking and mental illness: breaking the link. *New Engl J Med* 2011; 365: 196-8. DOI: 10.1056/NEJMp1105248

22. Eadie D, MacDonald L, Angus K, Murray R, O'Mara-Eves A, Stansfield C, Leonardi-Bee J. Review 7: A review of the barriers to and facilitators for implementing smokefree strategies and interventions in secondary care settings. NICE Evidence Reviews: Smoking cessation acute, maternity and mental health services. Draft 3, 25th October, 2012.
<http://guidance.nice.org.uk/PHG/51/Consultation/Latest> (accessed 10 October 2013).
23. Shattell M, Andes M. Smoking Bans in Acute Care Settings: A Machiavellian Smoke Screen? *Issues Ment Health Nurs* 2008; 29(2): 201-203.
24. Warner J. Smoking, Stigma and Human Rights in Mental Health: Going up in Smoke? *Soc Pol Society* 2009; 8(2): 275–286. DOI: [10.1017/S1474746408004788](https://doi.org/10.1017/S1474746408004788)
25. Global Smokefree Partnership. FCTC Article 8-plus Series: Reducing Tobacco Smoke Exposure in Prisons. Global Smokefree Partnership; 2009. Available at: http://www.globalsmokefreepartnership.org/resources/ficheiros/1_SF_Prisons.pdf (accessed 22 September 2013).
26. Richmond R, Butler T, Wilhelm K, Wodak A, Cunningham M, Anderson I. Tobacco in prisons: a focus group study. *Tob Control* 2009; 18: 176-82. DOI:10.1136/tc.2008.026393
27. Lawn S. Cigarette smoking in psychiatric settings: occupational health, safety, welfare and legal concerns. *Aust NZ J Psychiat* 2005; 39: 886-91. DOI: 10.1080/j.1440-1614.2005.01698.x
28. Lasnier B, Cantinotti M, Guyon L, Royer A, Brochu S, Chayer L. Implementing an indoor smoking ban in prison: enforcement issues and effects on tobacco use, exposure to second-hand smoke and health of inmates. *Can J Pub Health* 2011; 102: 249-53. Available at: <http://journal.cpha.ca/index.php/cjph/article/view/2350/2452> (accessed 4 April 2013).
29. [World Health Organization. Guidelines on protection from exposure to tobacco smoke. Geneva: WHO; 2007. Available at:](#)

http://www.who.int/fctc/cop/art%208%20guidelines_english.pdf (accessed 22 September 2013).

30. Foley KL, Proescholdbell S, Herndon Malek S, Johnson J. Implementation and enforcement of tobacco bans in two prisons in North Carolina: a qualitative inquiry. *J Correct Health Care* 2010; 16: 98-105. DOI: 10.1177/1078345809356522
31. Kauffman RM, Ferketich AK, Wewers ME. Tobacco policy in American prisons, 2007. *Tob Control* 2008; 17: 357-60. DOI:10.1136/tc.2007.024448
32. Collinson L, Wilson N, Edwards R, Thomson G, Thornley S. New Zealand's smokefree prison policy appears to be working well: one year on. *New Zeal Med J* 2012; 125: 1-5. Available at: <http://journal.nzma.org.nz/journal/125-1357/5247/> (accessed 4 April 2013).
33. Dickens G, Stubbs J, Popham R, Haw C. Smoking in a forensic psychiatric service: a survey of inpatients' views. *J Psychiat Ment Health Nurs* 2005; 12: 672-78. DOI: 10.1111/j.1365-2850.2005.00892.x
34. [Ashton M, Lawn S, Hosking JR. Mental health workers' views on addressing patients' tobacco use. *Aust NZ J Psychiat* 2010; 44: 846-51. DOI: 10.3109/00048674.2010.488637](#)
35. [Wye P, Bowman J, Wiggers J, Baker A, Carr V, Terry M, Knight J, Clancy R. Providing nicotine dependence treatment to psychiatric inpatients: the views of Australian nurse managers. *J Psychiat Ment Health Nurs* 2010; 17: 319-27. DOI: 10.1111/j.1365-2850.2009.01524.x](#)
36. Blinded.
37. Blinded.
38. NSW Department of Health. NSW Health Smoke-Free Workplace Policy. NSW Department of Health: Sydney: NSW Health; 1999. Available at: http://www0.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_375.pdf (verified 22 September 2013).

39. Champion J, Checinski K, Nurse J, McNeill A. Smoking by people with mental illness and benefits of smoke-free mental health services. *Adv Psychiat Treat* 2008; 14: 217–28. DOI: 10.1192/apt.bp.108.005710
40. [Ashton M, Miller CL, Bowden JA, Bertossa S. People with mental illness can tackle tobacco.](#) *Aust NZ J Psychiat* 2010; 44: 1021-8. DOI: 10.3109/00048674.2010.497753
41. Banfield MA, Gardner KL, Yen LE, McRae IS, Gillespie JA, Wells RW. Coordination of care in Australian mental health policy. *Aust Health Rev* 2012; 36(2): 153-157.
42. Horst W, Klein MW, Williams D, Werder SF. Extended use of nicotine replacement therapy to maintain smoking cessation for people with schizophrenia. *Neuropsychiat Dis Treat* 2005; 1: 349-55. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2424122/> (accessed 4 April 2013).
43. Schnoll RA, Patterson F, Wileyto EP, Heitjan D, Shields AE, Asch D, Lerman C. Effectiveness of extended duration transdermal nicotine therapy: a randomized trial. *Ann Intern Med* 2010; 152: 144-51. Available at: <https://annals.org/article.aspx?articleid=745558> (accessed 4 April 2013).
44. Thornton L, Baker AL, Lewin T, Kay-Lambkin FJ, Kavanagh DJ, Richmond R, Kelly B, Johnson MP. Reasons for substance use among people with mental disorders. *Addict Behav* 2012; 37: 427-34. Available at: <http://dx.doi.org/10.1016/j.addbeh.2011.11.039> (accessed 22 September 2013).
45. Dwyer T, Bradshaw J, Happell B. Comparison of mental health nurses' attitudes towards smoking and smoking behaviour. *Int J Mental Health Nursing* 2009; 18: 424-33. DOI: 10.1111/j.1447-0349.2009.00628.x
46. Garg S, Shenoy S, Badee M, Varghese J, Quinn P, Kent J. Survey of staff attitudes to the smoking ban in a medium secure unit. *J Forensic Legal Med* 2009; 16, 378-380. Available at: <http://dx.doi.org/10.1016/j.jflm.2009.04.009> (accessed 22 September 2013).

47. Shetty A, Alex R, Bloye D. The experience of a smoke free policy in a medium secure hospital. *The Psychiatrist* 2010; 34: 287-89. DOI: [10.1192/pb.bp.109.027425](https://doi.org/10.1192/pb.bp.109.027425)
48. Meehan T, McIntosh W, Bergen H. Aggressive behaviour in the high-secure forensic setting: the perceptions of patients. *J Psychiat Ment Health Nurs* 2006; 13: 19-25.
DOI: 10.1111/j.1365-2850.2006.00906.x
49. Prochaska JJ. Ten critical reasons for treating tobacco dependence in inpatient psychiatry. *J Am Psychiat Nurses Assoc* 2009; 15: 404-9. DOI: 10.1177/1078390309355318
50. Prochaska JJ, Fletcher L, Hall SE, Hall SM. Return to smoking following a smoke free psychiatric hospitalization. *Am J Addict* 2006; 15: 15-22. DOI: 10.1080/10550490500419011
51. Lincoln T, Tuthill RW, Roberts CA, Kennedy S, Hammett TM, Langmore-Avila E, Conklin TJ. Resumption of smoking after release from a tobacco-free correctional facility. *J Correct Health Care* 2009; 15: 190-6. DOI: 10.1177/1078345809333388
52. Lawn S, Pols RG. Nicotine withdrawal: pathway to aggression and assault in the locked psychiatric ward. *Australas Psychiat* 2003; 11: 199-203. Available at: <http://informahealthcare.com/doi/abs/10.1046/j.1039-8562.2003.00548.x> (accessed 22 September 2013).
53. Williams JM, Steinberg ML, Hanos Zimmermann M, Gandhi KK, Lucas GE, Gonsalves DA, Pearlstein I, McCabe P, Galazyn M, Salsberg E. Training Psychiatrists and Advanced Practice Nurses to Treat Tobacco Dependence. *J Am Psychiat Nurses Assoc* 2009; 15(9): 50-8.
DOI: 10.1177/1078390308330458
54. Champion J, Lawn S, Brownlie A, Hunter E, Gynther B, Pols R. Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. *Australas Psychiat* 2008; 16: 92-7. DOI: 10.1080/10398560701851976

55. Elliot KA, Daley D. Stress, coping, and psychological well-being among forensic health care professionals. *Legal Criminol Psych* 2013; 18(2): 187-204. DOI: 10.1111/j.2044-8333.2012.02045.x
56. Happell B, Platania-Phung C, Scott D. A systematic review of nurse physical healthcare for consumers utilizing mental health services. *J Psychiat Ment Health Nurs* 2013; (early view) DOI: 10.1111/jpm.12041
57. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair DE, McKendry R. Continuity of care: a multidisciplinary review. *BMJ* 2003; 327(7425): 1219–1221.
Doi: 10.1136/bmj.327.7425.1219
58. Royal College of Physicians and Royal College of Psychiatrists (2013) *Smoking and mental health: a joint report*. eISBN: 978-1-86016-375-3. London, UK: Royal College of Physicians and Royal College of Psychiatrists.