Behavioral Health & Wellness Program

University of Colorado Anschutz Medical Campus
School of Medicine

DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

SUPPLEMENT
Priority Populations: Justice Involved

Behavioral Health & Wellness Program

University of Colorado Anschutz Medical Campus • School of Medicine

The DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers was developed by the University of Colorado Anschutz Medical Campus, School of Medicine, Behavioral Health and Wellness Program

December 2016

Cynthia W. Morris, PsyD

Catherine J. Greisch, PsyD

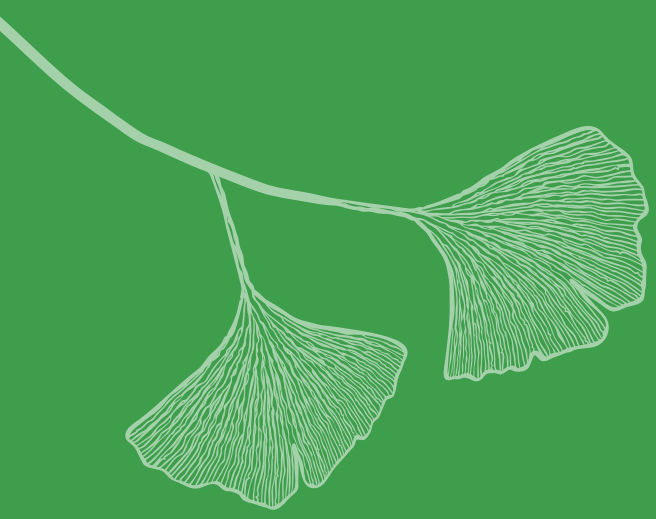
Sara J. Mumby, BA

Chad D. Morris, PhD

For further information about this toolkit, please contact:

Behavioral Health and Wellness Program
University of Colorado Anschutz Medical Campus
School of Medicine
1784 Racine Street
Mail Stop F478
Aurora, Colorado 80045

Phone: 303.724.3713
Fax: 303.724.3717
Email: bh.wellness@ucdenver.edu
Website: www.bhwellness.org



Priority Populations: Justice Involved

1. Why Focus on the Justice Involved Population?
2. Contributing Factors
3. Assessment and Prevention
4. Tobacco Cessation Treatment
5. Maintaining a Tobacco-Free Life
6. Resources

Why Focus on the Justice Involved Population?

The United States has more justice involved individuals per capita than any other nation in the world. In 2013, roughly 1 in 35 adult U.S. residents were on probation, parole, or incarcerated.[1]

Although tobacco use is harmful for all users, individuals under correctional supervision experience higher rates of tobacco use and poorer health outcomes than the general population. Justice involved individuals are also more likely to exhibit demographic characteristics that exacerbate these risks. These include mental health conditions, substance abuse, low income, and less formal education, all of which are associated with higher risk of tobacco use and resultant chronic illness. However, the justice involved population also tends to be younger, which creates an opportunity to achieve greater long-term benefits from early tobacco interventions.

As of 2014, more than 6.8 million individuals, or 2.8% of the adult population, were under some form of correctional supervision within the United States. Roughly one third of these individuals were incarcerated in correctional facilities. The remaining two thirds of this population were under some form of community supervision, meaning they lived in a community setting while under the control, supervision, or care of a correctional agency.[2]

The justice involved population tends to be younger, creating an opportunity to achieve greater long-term benefits from early tobacco interventions.

About This Toolkit

This supplemental toolkit provides guidance for healthcare professionals as well as correctional administrators and staff who want to improve health outcomes for incarcerated individuals through evidence-based interventions. Tobacco cessation interventions for this population are very similar to evidence-based strategies for the general population. However, there are factors unique to this population that are important to consider.

Since there are many different kinds of correctional settings all with unique needs and availability of resources, this toolkit focuses on the health of incarcerated individuals as well as those individuals preparing for release into the community. Many of the assessment and treatment recommendations are applicable to individuals in community corrections, diversion, and re-entry programs.

This toolkit contains information about this population and ways to partner with individuals to help them reach their health goals. It is designed to be used in conjunction with the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers, which contains evidence-based information about assessment, skills building, and interventions to provide support and resources around tobacco cessation.

A Unique Opportunity to Intervene

Correctional and community corrections facilities offer unique access points to deliver smoking interventions to vulnerable and underserved individuals.[3] Tobacco use rates among the justice involved population substantially exceed those of the general population. While 16.8% of the adult population in the U.S. smokes cigarettes,[4] smoking rates for justice involved populations are estimated at 70-80%.[5] An estimated 12% of all U.S. smokers are released annually from jails and prisons.[6] Not only is the rate of tobacco use extraordinarily high in the justice involved population, this population consists of demographic groups that have limited access to healthcare and other public services. Some of the reasons correctional settings are well positioned to intervene include:

- Research indicates that addressing poor physical health conditions and working to decrease the likelihood of developing further conditions while incarcerated can help reduce health disparities and facilitate successful reintegration into the community.[7]
- In the general population, quitting smoking before the age of 40 years reduces the risk of death associated with continued smoking by about 90%.[8] The majority of individuals in the criminal justice system are young adults who have the potential to substantially improve their long-term health outcomes through tobacco cessation. More than 58% of sentenced prisoners under state and federal jurisdictions are under 40 years of age,[9] while more than two thirds of U.S. adults on probation are under age 35.[10] The relative youth of the majority of individuals in the criminal justice system provides an opportunity to affect the health behavior choices of those individuals in a way that will positively impact their health across the lifespan and help to reduce recidivism.
- Individuals in the corrections system are predominantly uninsured or underinsured and often rely on access to community-based health and preventative services. In addition to providing health benefits on an individual level, improving access to cessation services for this population serves to reduce society's burden of healthcare costs in the long-term.
- In 2011, the average cost per offender in Colorado was $32,344.[11] Inmates and parolees who utilize tobacco products are more likely to develop chronic health conditions that are expensive to manage and put undue strain on taxpayer-funded criminal justice and healthcare programs. The return on investment (ROI) for tobacco cessation programming in the general population has been extensively documented; due to higher smoking rates, this ROI is even greater for persons who have been incarcerated.
- Communities benefit when justice involved individuals re-enter their communities with increased health literacy, healthy habits, and greater self-efficacy.[12-16]

Not only is the rate of tobacco use extraordinarily high in the justice involved population, this population consists of demographic groups that have limited access to healthcare and other public services.

Contributing Factors

Tobacco use rates within the justice involved population are among the highest for any subset of the U.S. population. Several factors contribute to these unusually high rates. Tobacco use has historically been endemic to prison culture. Additionally, involvement with the criminal justice system presents a life stressor that may contribute to increased tobacco use. Furthermore, the justice involved population is composed largely of members of other priority populations that have high tobacco use rates.

Demographics

The jail, prison, and community supervision populations are comprised of individuals from many overlapping demographic groups that are disproportionately affected by tobacco usage.

Socioeconomic Disadvantages

Poor economic circumstances are linked to an increased risk for morbidity, mortality, unhealthy behaviors, reduced access to healthcare, and poor quality of care,[17] and there is a link between pre-incarceration poverty and involvement in the justice system. Individuals from low socio-economic backgrounds are disproportionately represented in justice involved populations, and tobacco use is also far more prevalent in this population. One aspect of low socio-economic status involves limited access to preventative healthcare interventions prior to incarceration.[18] Of U.S. adults living below the federal poverty line, 29.2% use tobacco, compared to 16.2% of those living at or above the poverty line.[19]

Education

With respect to educational attainment, tobacco use is highest among individuals who have not graduated high school or who have earned a graduate equivalent degree (GED). Correctional populations, which include state and federal prison inmates, inmates in local jails, and individuals on probation, report lower educational attainment than the general population. While 18% of the general population fails to attain high school graduation, 40% of state prison inmates, 47% of local jail inmates, and 31% of probationers have not completed high school or an equivalent.[20]

DEFINTION: The term "justice involved" will substitute for the customary terms (e.g., inmate, prisoner, parolee, etc.) to describe individuals who have been incarcerated or those participating in community corrections programs. The ways in which individuals or larger groups are labeled can have a profound impact on a reader's subjective experience of objective data. This term makes an attempt to remove some of the inherent stigma associated with this population.

Environmental Factors

Availability of Cessation Services

Although the U.S. spends more on healthcare than any other country, correctional systems often have limited budgets and short supplies of human and other resources to devote to healthcare. In recent decades, there has been unprecedented growth in the U.S. penal system, which makes it challenging for correctional institutions to operate efficiently and to provide comprehensive, quality healthcare services.[21] At the same time, tobacco use in criminal justice settings has been largely condoned historically.[22] While many prisons and jails now have tobacco-free policies, there is a long history of cigarettes, and even nicotine replacement patches, being used as currency among incarcerated individuals.[23, 24]

Imprisoned smokers are typically not offered cessation medications or counseling. Corrections staff may have negative attitudes toward cessation services.[25] They may feel such services fall outside of their public safety mandates. Additionally, staff may think that inmates aren't deserving of such services. Resistence is also based on the belief that smoking restrictions would lead to increased stress on inmates and an upswing of behavioral incidents.[26] Overall, correctional staff have many competing demands and often insufficient budgets that make it difficult to add cessation treatment to daily regimens.[27] Even when correctional setting staff demonstrate openness to integrating tobacco cessation into healthcare services and substance use programming, they often do not possess the training necessary to offer effective cessation services.

Even when correctional setting staff demonstrate openness to integrating tobacco cessation into healthcare services and substance use programming, they often do not possess the training necessary to offer effective cessation services.

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Psychological Factors

Stress of Incarceration

There are obvious stressors that come with being in the criminal justice system, such as confinement, judicial proceedings, transfers, overcrowding, behavioral health issues, violence and victimization, and isolation from family, friends, and social supports.[28, 29] Other less overt stress-inducing factors may be at play as well. For example, fear of other inmates or prison staff, stigma, lack of control over one's environment, uncertainty about the future, and identity issues can all affect one's overall psychological health.[30-32]

People who use tobacco often associate their tobacco use with their ability to manage life stressors and associated anxieties. Incarcerated individuals have identified stress and boredom as primary reasons they continue to use tobacco.[33,34] Tobacco is used as a coping mechanism, but unfortunately, it is also an addiction with often life-threatening health repurcussions.[35-38]

Hopelessness

Learned helplessness, or the perceived absence of control over a situation and subsequent lack of effort, often affects individuals who are incarcerated.[39] Correctional settings have many features that can foster hopelessness, desperation, and depression. Some of these environmental conditions include long hours in cells, lockdown, seclusion, and sensory deprivation.[40]

An individual's perception of being helpless to change their future can affect their motivation to change their behaviors.

Even if signs of severe or chronic depression or suicidal ideation are absent, a justice involved individual may feel disempowered and unable to positively influence their future. An individual's perception of being helpless to change their future can in turn affect their motivation to change their addictive behaviors.[41] This creates additional challenges to improving one's health by stopping tobacco use.

Special Populations:
Mental Illness in the Criminal Justice System

"Prisons and jails have become America's new asylums." [42]

Justice involved individuals disproportionately suffer from higher rates of mental health and substance use conditions compared to the general population.[43] Individuals with behavioral health conditions, including serious mental illness and/or substance abuse, make up more than half of the incarcerated population in the U.S.[44] In 2012, there were estimated to be over 350,000 people with serious mental illness incarcerated in prisons and jails.[45] And, in fact, there are 10 times more people with serious mental illness incarcerated in correctional institutions than in state psychiatric hospitals.[46]

Serious mental illness, which includes bipolar disorder, schizophrenia, and major depression, affects an estimated 15% of men and 31% of women in jails—rates that are four to six times higher than in the general population. People with serious mental illness generally have poorer physical health than people without a mental health diagnosis,[47] and it often worsens with incarceration. Smoking causes or exacerbates many of the diseases that are the leading causes of death among imprisoned individuals.[48]

Individuals with mental health and substance use disorders are also between two to three times as likely to smoke as those without these conditions.[49, 50] This puts justice involved smokers with mental illnesses and addictions at multiplicative risk for smoking and smoking-related health disparities.

See the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers Supplement, Priority Populations: Behavioral Health for more specific information on treating the tobacco cessation needs of the behavioral health population.

In 44 of the 50 states and the District of Columbia, prisons or jails hold more individuals with serious mental illness than the largest remaining state psychiatric hospital.[51]

Social Factors

Social Determinants of Health

Justice involved individuals in general demonstrate poorer health than the general population.[52, 53] Circumstances leading to poor medical outcomes include:

- Disadvantaged socioeconomic backgrounds;
- Low levels of education with an estimated 40% of individuals in state prisons having less than a high school diploma;
- High levels of smoking, drinking, and illicit drug use before incarceration;
- Poor nutrition and limited physical activity in jail or prison;
- High rates of reported psychiatric and neurological disorders, such as schizophrenia, depression, and epilepsy;
- Increased exposure to infectious disease through risky drug injection or sexual practices;
- Elevated levels of stress, anxiety, depression, and sleep deprivation;
- Lower levels of self-efficacy as a result of the stigma of a criminal record and loss of social ties.[54-60]

Jail and prison inmates have a higher burden of chronic illnesses, even after adjusting for confounding factors such as age.[61] Furthermore, many of the most serious medical problems reported by prisoners are smoking-related, including cardiovascular, circulatory, respiratory, kidney, and liver problems.[62] Heart disease and lung cancer—both linked to tobacco use—account for the majority of inmate deaths.[63-65] These health disparities follow justice involved individuals from incarceration back into their communities after release.

Social Environment

Social environments play a critical role in the onset and maintenance of tobacco use. Research shows that substantial numbers of justice involved individuals begin smoking after entering jails and prisons, and among those who use tobacco prior to arrest, tobacco use increases during incarceration.[66] Similar to other institutional settings, such as psychiatric hospitals, individuals are more likely to pick up smoking if their peers smoke, and this also makes it more difficult to stop.[67] As justice involved individuals leave jails and prisons, engaging in other addictive behavior will increase smoking relapses. Alcohol use, for example, decreases the chances that recently released smokers will make a quit attempt.[68]

Research shows justice involved individuals often begin smoking upon entering jails and prisons, will likely increase their use during incarceration,[66] and are more likely to pick up smoking if their peers smoke.[67] These factors contribute to their high rates of tobacco use.

Special Populations:
African Americans in the Criminal Justice System

It is well known that race/ethnicity is an important social determinant of health. African Americans are much more likely to be involved with the criminal justice system and are also generally more at risk for tobacco-related disorders. Nearly 40% of individuals currently incarcerated in the U.S. are African American, despite the fact that African Americans only constitute approximately 12-13% of the general population.[69] Additionally, African Americans as a group generally score lower on many indicators of population health. This includes life expectancy, infant mortality, and other chronic diseases or conditions that lead to lower quality of life or premature death.[70]

- Like other populations, African Americans with less education smoke at much higher rates. For example, African Americans over age 25 with less than a high school education smoke at 2-3 times the rate of African Americans with a college education.[71]
- Over 45,000 African Americans die from tobacco-related diseases each year.[72] These deaths are often related to cancer, cardiovascular disease, stroke, and infant deaths – many diseases which are known to be caused by smoking.[73-77]
- More than 70% of African American smokers prefer menthol cigarettes compared with 30% of White smokers.[78] In part, this is due to the tobacco industry specifically targeting African Americans for menthol cigarette brands.[79-80] Studies have found that menthol in cigarettes causes respiratory depression and longer inhalations, resulting in greater exposure to particulates and harmful chemicals in tobacco smoke.[81-82]
- African Americans are less likely to receive advice to stop smoking from their healthcare providers, to use effective tobacco dependence treatments, or to achieve abstinence.[83-90]

Nearly 40% of individuals currently incarcerated in the U.S. are African American, despite the fact that African Americans only constitute approximately 12-13% of the general population.

Stigma

There is a very real and often damaging stigma associated with having a criminal record. An enduring belief held by many people is that justice involved individuals do not deserve the same rights and privileges as those in the broader community. This perception can affect access to healthcare, policy decisions, and the allocation of resources.[91] Upon release, stigma can also negatively affect a person's ability to secure housing and employment, which may exacerbate stress, affect healthy decision-making, and increase the risk of recidivism—all of which may increase an individual's tobacco use.[92]

LINK: For more information about the unique challenges of the justice involved population in attaining health equity, read "A Continuity of Care Model for the Justice-Involved Population." The paper details an innovative continuity of care model that serves as the foundation for addressing these individuals' specific health concerns.

http://www.bhwellness.org/fact-sheets-reports/Continuity-of-Care-Model-for-JI-Population.pdf

Recidivism

As incarceration is often a "revolving door," it can feed into a cycle of economic disadvantage, social stigma, and emotional stress that can all contribute to negative health outcomes.[93, 94] One study found that after release, nearly 77% of former inmates were rearrested within a 5-year period.[95]

Moreover, those in the criminal justice system go through a number of transitions within the healthcare system, seeing many different providers and making it difficult for these individuals to receive needed healthcare.[96] Important health information and data can be lost during transitions, as can any established rapport and trust between provider and patient. As a result, treatment plans and patient progress may not be maintained.

Assessment and Prevention

Whether in prisons, jails, or community corrections, most justice involved smokers (50-70%) want to and have tried to quit smoking.[97-100] This rate is similar to the general population of smokers, debunking the widely held myth that justice involved individuals have no interest in quitting. In community corrections programs, 50% of tobacco users reported that they would be interested in tobacco cessation treatment if it were available.[101]

The Role of the Healthcare Provider

Having a clear understanding of the overall health needs of the justice involved population, as well as an individuals' unique needs, will help healthcare providers to offer support in a culturally competent and effective manner. Because justice involved individuals often enter the criminal justice system with limited prior access to healthcare, it is important to keep in mind that these individuals may need even more education and information about prevention, the effects of tobacco, and why their health behaviors and choices matter. Your knowledge, experience, and skills are invaluable resources for this population. Justice involved individuals often are not in a position to advocate for their health needs nor have the freedom to make varied health behavior choices due to their incarceration. As a result, it is important for healthcare providers to advocate for education, interventions, and policies within the justice system on their behalf.

Brief interventions matter

Research shows that the influence of healthcare providers' advice to quit smoking may **double** the likelihood of quitting.[102]

Begin the process of addressing an individual's tobacco cessation needs by using some key approaches:

- Be open to exploring an individual's motivation to quit;
- Listen for what matters most to them;
- Guide them towards contemplating a change;
- Approach them with genuine respect, interest, and empathy;
- Listen for statements that suggest readiness to change;
- Strategize ways to maintain cessation and health within restricted settings;
- Explore new policies and programs to support cessation;
- Plan for transition to the community;
- Include tobacco cessation and continued abstinence in transition treatment planning.

Review the Assessment and Planning for Change section of the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers for additional information and strategies to support change.

Tips for Talking about Tobacco Cessation—The 5A's

The best way for providers to discuss tobacco cessation in correctional settings is to use the 5A's model. It is an effective, evidence-based model familiar to many providers and can help to start the conversation.

- Start by ASKing about their interest in quitting tobacco
- ADVISE them to commit to making positive changes in their tobacco use
- ASSESS their readiness to quit and potential barriers to making a change
- ASSIST by providing education and information about tobacco use and the benefits of quitting
- ARRANGE follow-up as needed, including access to resources and support

Strategies to Support Tobacco Cessation in Correctional Settings

Educate yourself. Though research has outlined several chronic health conditions that are vastly overrepresented in the criminal justice population, it will be helpful to familiarize yourself with the tobacco-related illnesses that are present in your population. Many correctional systems collect health data on individuals at intake. Understanding the specific health needs of your population can help tailor cessation interventions and obtain buy-in from other professionals and the individuals you treat.

Educate others. Whether providing education to a justice involved individual or to colleagues in your correctional setting, it is important to help others understand the effects that tobacco use and second-hand smoke can have on an individual, the correctional system, and the broader community.

Build a case for cessation programming. Research indicates that healthcare costs in correctional settings are skyrocketing while the population's health is declining. Find data and resources specific to your state or county to help staff and administrators understand the need for tobacco cessation interventions. It is also possible to directly tie tobacco use to criminogenic risk factors, such as antisocial peers, substance abuse, and employment.

Understand federal, state, and county policies. Many correctional institutions nationwide have adopted partial or full smoking bans. It is vital to understand the tobacco-related policies that affect your correctional system, as well as those that impact the communities to which justice involved individuals will return after incarceration.

Engage leadership. With any health-related initiative or program, individuals in leadership positions are necessary champions. This may include wardens, state agency representatives (e.g., state department of corrections), medical or psychiatric directors, or other leaders that can assist with getting a cessation program up and running. It is important for leadership to secure a realistic level of protected staff time to provide tobacco education and treatment.

Be innovative. When implementing a cessation program within a correctional setting, time and other resource constraints should be considered. Within many facilities, there may be limited space (e.g., rooms to hold groups), and incarcerated individuals may already by required to attend multiple groups or classes per day. Work with other professionals, correctional staff, and individuals within the correctional population to determine the most efficient and effective way to implement programming. For example, tobacco cessation treatment and education might be wrapped into existing addictions programming and workflows. Tobacco use education is also an integral component of any whole health education provided in correctional settings.

Empower. Justice involved individuals may feel that they have little control over their health choices and behaviors, which makes it easier to give up on cessation efforts. Assist these individuals to consider the control they do have over their behaviors, even while incarcerated. For example, individuals can use distraction skills to increase their tolerance of nicotine cravings, and/or become mindful of each decision to use or abstain from tobacco. Support the individual and empower them to make the choice to stop using tobacco.

Plan for re-entry and identify support services in your community. Healthy behaviors and coping strategies developed within the correctional setting can translate and support successful reintegration into communities. By advocating for and providing cessation support resources in communities, you can increase justice involved individuals' chances of staying quit. Correctional healthcare providers can utilize local resources (e.g., local public health departments, federally qualified health centers, state quitlines) to identify community programming and connect individuals to re-entry services.

Pre-release planning. All treatment plans for individuals who use tobacco or who are attempting to maintain abstinence from tobacco should include community support, counseling, and cessation medication goals created collaboratively with individuals being released.

Tobacco Cessation Treatment

Effective tobacco cessation programming will need to address the unique needs of the justice involved population in order to impart lasting cessation benefits for participants both during and after justice involvement.[103] Evidence-based cessation support includes the provision of free or low-cost cessation medications, supportive services, and behavioral counseling interventions.

Key qualities of tobacco cessation treatment for the justice involved populations include:

Early Intervention. Transitions into and out of incarceration and community supervision offer unique opportunities to engage in tobacco education, prevention strategies, and treatment. Early interventions are easier to implement and, if successful, are likely to improve long-term health. When an individual is incarcerated, there is a chance to provide healthcare, education, and treatment that many justice involved individuals may not have had access to before. As individuals develop and practice health behaviors in a correctional setting, they are more likely to translate these behaviors into their post-release lifestyles.

Motivational Assessment. Explore an individual's readiness to change their tobacco use behaviors. Identify their unique motivations for change as well as any ambivalence to change. Examine their perceived benefits of continuing their current tobacco use behaviors and reasons they may want to make different choices. Justice involved smokers, like the general population, are more receptive to potential behavior change when asked to share their perspectives and opinions regarding tobacco use and how tobacco use relates to their values and life goals.

Education. Since many justice involved individuals may not have had adequate access to health education and tobacco-related information, many are open and interested to learn. Helping individuals to understand the relationship between tobacco use and chronic health conditions, as well as increase their awareness of the social justice issues involved in health disparities, inprpving motivation and engagement. For instance, justice involved individuals may be very interested in how the tobacco industry has targeted specific smokers, such as youth, African Americans, the homeless, and individuals with mental illnesses and other addictions. Education can facilitate a sense of empowerment and growing self-efficacy in settings where people may otherwise believe they have little control over their experience.

Skills Building. Assist individuals to develop the skills they need to make healthy decisions about tobacco use. Some of these skills may include impulse control, stress management, boundary setting, and alternative healthy habits. Developing positive coping skills and practicing healthy decision-making support an individual's ability to handle stressful situations, mediate the effects of negative moods, and facilitate prosocial relationships.

Review the Treatment section of the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers for additional strategies and interventions.

Benefits Acquisition. Imprisoned individuals should apply for benefits, such as Medicaid, as a core component of pre-release planning. It is helpful to not only assist individuals to obtain benefits but also educate them how to use benefits wisely to address their whole health needs. As a salient example, many individuals are unaware that in almost all states, Medicaid covers cessation medications. Typically, Medicaid covers medications for several quit attempts each year. Please contact your Medicaid office directly for up-to-date information regarding your state's coverage.

Continuity of Care. The tranisition from incarceration to community is an incredibly chaotic and stressful time for justice involved persons. For all types of substance use, targeted relapse prevention interventions are needed for people reentering the community. Effective and continuous treatment and support are essential to sustain major behavior change. Since justice involved individuals often undergo many care transitions, it can be difficult for these individuals to receive the evidence-based treatment they need. Provider communication, treatment plan transfer, referrals, and follow-up all improve the cessation outcomes for justice involved individuals transitioning back to communities. Often a short supply of nicotine replacement therapy (NRT) will help individuals bridge the gap to renewing prescriptions in the community. Tailored health navigation programs will further insure that former inmates not only have access to needed tobacco cessation, behavioral health, and primary care services, but will also remove barriers to actually being seen by community providers.

See the DIMENSIONS: Well Body Toolkit for Healthcare Providers Supplement, Priority Populations: Justice Involved for more specific information on nutrition and weight management issues for the justice involved population.

Quitlines. Telephonic tobacco counseling is a proven intervention that all states offer through state quitlines. All tobacco users being released from correctional settings should be encouraged to enroll in quitline services. Most state quitlines offer limited NRT or other cessation medications to enrolled clients through the mail. The NRT provided by quitlines may be instrumental to maintain abstinence until newly released individuals are able to engage with other community tobacco cessation supports. Quitlines may be able to work directly with community corrections agencies to insure that mailed medications are appropriately used in congregate living settings.

TIP: Quitline Referrals

For information on making referrals to the state quitlines, see the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers.

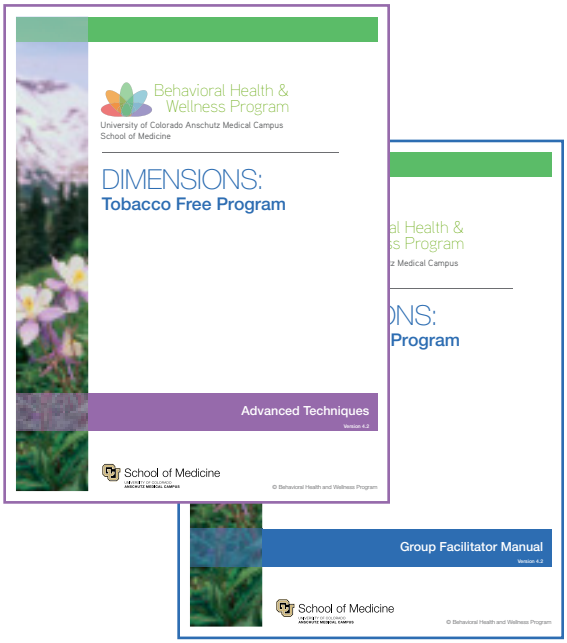
Tobacco-Free Policies. Tobacco-free policies have become increasingly common in correctional facilities over the last few decades. Tobacco use is banned in all federal prisons and at least 38 of 50 state correctional departments report that they are either smoke-free or have partial smoking bans. Overall, approximately 60% of U.S. correctional facilities have total tobacco bans.[104] When smoking bans are enforced, inmates experience the beneficial effects of reduced nicotine use, reduced exposure to second-hand smoke, and reduced threat of tobacco-related health effects.

Evidence-based cessation supports include:

- free or low-cost cessation medications;
- supportive services;
- behavioral counseling interventions.

Peer Programs. Peer-to-peer interventions are an important augmentation to provider-driven strategies. Peers are often able to provide services in a less threatening way, and clients report high satisfaction with peer delivered services. Pro-social, healthy interactions between justice involved individuals is a critical means of increasing self-responsibility and relapse prevention. Many individuals began or increased smoking because it was a privilege and peer norm. To counter this, fostering a supportive atmosphere that involves shared experience, rather than sharing an addiction together, encourages healthy behavior change. Peer-driven services also help to combat the boredom inherent in correctional settings which is a common trigger for addictive behaviors. Several studies have shown peer programming to be successful in improving health for this population. The peer support role can also be beneficial for the individual providing the support. This includes improved self-esteem, knowledge, relationships, self-awareness, perspective, sense of purpose, skills to support good health, and healthy decision-making.

Strategies to Support Tobacco Cessation in Correctional Settings



Offering tobacco cessation services to individuals who are currently supervised within community corrections systems has the potential to reach a large high-prevalence and vulnerable population of smokers who desire to quit, but lack the resources to achieve successful cessation. In response to a critical need for cessation services in the justice involved population, the Arkansas Department of Health, Tobacco Prevention and Cessation Program partnered with the Arkansas Department of Community Corrections (ACC) and the University of Colorado's Behavioral Health & Wellness Program to implement the first statewide tobacco cessation program within all probation, parole, and drug court units.

Starting in 2013, Arkansas implemented the University of Colorado's DIMENSIONS: Tobacco Free Program. The goal of the DIMENSIONS program is to promote recovery through tailored holistic services for tobacco dependence. The curriculum was designed specifically for persons with behavioral health disorders, and it is based on extensive review of the knowledge base and expert opinion for how best to intervene with at-risk populations, such as justice involved individuals. This program offers emotional and informational support for tobacco dependence recovery through motivational engagement strategies, provider-led support groups, community referrals, and educational activities. Lesson plans incorporate educational handouts, group discussion, role play, and activities. The support group provides wellness education, stress management skills, behavior change techniques, and emotional support around tobacco dependence recovery, and it allows clients to build tobacco-free social networks.

The group has six cycling sessions: 1) Healthy Behaviors provides general health and wellness education; 2) The Truth about Tobacco is devoted to exploring a person's motivations to continue tobacco use and reasons to quit tobacco; 3) Changing Behaviors aims to help a person recognize patterns of tobacco use and discover ways to change behaviors; 4) Coping with Cravings provides education about nicotine addiction and support to identify methods of coping with cravings; 5) Managing Stress gives people additional stress management tools, other than tobacco use; and 6) Planning Ahead is geared toward preparing for potential future relapse situations and discussing the importance of planning ahead for high risk situations.

Arkansas demonstrated that a train-the-trainer model for tobacco cessation groups could be scaled up across a state community corrections system. Sustainability is suggested by the fact that since the program's inception, current corrections staff have continuously administered groups within 33 existing substance use programs. In the first two years of this statewide, evidence-based program, over 1,100 individuals from 33 ACC Area Office locations attended tobacco free groups and provided data that tracked tobacco use and readiness to quit. Results demonstrated a significant reduction in tobacco use among participants, as well as increased knowledge, confidence, and intent to quit.[105]

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Maintaining a Tobacco-Free Life

With adequate provider, programmatic, peer, and policy support, many justice involved individuals can make the choice to change their health behaviors and stay quit. However, if they are housed within a correctional setting or are released into a parole or probationary setting that does not provide this support, the individual may struggle to maintain a tobacco-free lifestyle. As such, it is important for the invididual to possess the knowledge, skills, and motivation they can take with them wherever they go.

LEARN Offer opportunities for justice involved individuals to be informed. Provide education about the health consequences of tobacco use and second-hand smoke as well as information on prevention, treatment, and management. Educate individuals about healthy habits that can facilitate wellness and staying tobacco-free. Whether or not the individual is able to practice these behaviors in their current setting, this knowledge will be useful to them in the future.

EMPOWER Inspire individuals to take an active role in their health. While they may feel a lack of control in certain areas of their life, there are many choices that are available to them. Switching focus from things they cannot change to things they can change can be empowering. Support them in making positive choices about tobacco use.

ACT Support the practice of healthy behaviors until they become a habit. When faced with a decision, the easiest choice is the behavior that feels most familiar, almost automatic. The more healthy behaviors justice involved individuals can practice, the greater their skill set when facing a challenge.

ENVISION Help individuals develop an identity separate from their tobacco use. Support justice involved individuals to develop a sense of self that includes health and well-being. Explore their values and goals, highlighting any discrepancies between using tobacco and the life they want to live.

LISTEN Encourage individuals to listen to their physical and emotional responses to tobacco cravings and use. As they become aware, they have the opportunity to take steps to engage in alternative coping strategies and healthy choices.

CONNECT Assist individuals in accessing resources available within their correctional and/or community setting. The more individuals can be made aware of the cessation resources available to them, the more likely they will benefit from these services. Remove barriers to access by facilitating transitions pre-release. Connect individuals with re-entry programming. Encourage the use of peer support in correctional and community settings.

Resources

The following chart outlines some key resources available to healthcare providers and correctional staff who want to improve health outcomes for justice involved individuals.

Program	Description and Resources
Tobacco Behind Bars	A policy brief provided by the Public Health Law Center that provides an overview of tobacco problems in correctional facilities, correctional smoke-free and tobacco-free policies by state, and policy considerations for correctional populations. http://publichealthlawcenter.org/resources/tobacco-behind-bars-policy-options-adult-correctional-population-policy-options-brief-2012
Motivating Offenders to Change	Created by the National Institute of Corrections, this guide provides probation and parole officers and other corrections professionals an introduction in how to apply Motivational Interviewing skills to facilitate justive involved individuals' healthy changes. http://static.nicic.gov/Library/022253.pdf
Involving Peers in Criminal Justice & Problem-Solving Collaboratives	A brief from the GAINS Center for Behavioral Health and Justice Transformation defines the roles peers might play in the criminal justice system and guidance in how best to involve peers, including providing wellness coaching. https://www.yumpu.com/en/document/view/49994762/involving-peers-in-criminal-justice-amp-problem-solving-collaboratives
Wellness Recovery Action Plan (WRAP)	WRAP is used in mental health settings and is now being successfully implemented in the criminal justice setting. A WRAP is a self-designed plan to help individuals feel better when they are not feeling well, to increase personal responsibility, and to improve overall quality of life. http://www.mentalhealthrecovery.com/WRAPintheCriminalJusticeSystem.php
National Commission on Correctional Health Care	This website offers best practices for correctional healthcare and provides recommended healthcare standards, position statements, guidance on disease management, and other resources. http://www.ncchc.org/standards-guidelines

Program	Description and Resources
Behavioral Health & Wellness Program DIMENSIONS Toolkits	Designed for a broad range of healthcare providers, these toolkits provide education on tobacco use, skills for engaging in tobacco cessation discussions, efficient methods for assessing an individual's readiness to quit, and information and research on treatments. http://www.bhwellness.org/resources/toolkits/tobacco/
Health in Prisons: A WHO Guide to the Essentials in Prison Health	The health of prisoners is a worldwide concern. The World Health Organization partners with multiple countries, systems, and organizations to design innovative approaches to reduce public health risks in correctional institutions. This guide provides the steps prisons systems should take to promote the health of prisoners and staff. http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf
Health Promoting Prisons: A Shared Approach	The United Kingdom Department of Health published a report aimed at those working with justice involved individuals and who have a role in promoting health education in prisons. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006230
Health Coverage and Care for the Adult Criminal Justice-Involved Population	This website provides an overview of how the Affordable Care Act coverage expansions provide new opportunities to increase health coverage for this population. http://kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/
Washington State Department of Corrections	The policy "Recreation Program for Offenders" can serve as an example of how to incorporate wellness programming into a correctional setting. Search: Washington State Department of Corrections Recreation Program for Offenders

End Notes

[1] Glaze, L. E., & Kaeble, D. (2014). *Correctional Populations in the United States, 2013.* (NCJ 248479.) Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[2] Kaeble, D., Glaze, L., Tsoutis, A., & Minton, T. (2015). *Correctional populations in the United States, 2014* (NCJ 249513). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[3] Donahue, J. J. (2009). Tobacco smoking among incarcerated individuals: A review of the nature of the problem and what is being done in response. *Journal of Offender Rehabilitation, 48,* 589-604.

[4] Center for Disease Control and Prevention [CDC]. (2015). Current cigarette smoking among adults – United States, 2005-2014. *Morbidity and Mortality Weekly Report, 64*(44), 1233-1240.

[5] Cropsey, K. L., Jones-Whaley, S., Jackson, D. O. & Hale, G. J. (2010). Smoking characteristics of community corrections clients. *Nicotine & Tobacco Research, 12*(1), 53-58.

[6] Lincoln, T., Tuthill, R. W., Roberts, C. A., Kennedy, S., Hammett, T. M., Langmore-Avila, E., & Conklin, T. J. (2009). Resumption of smoking after release from a tobacco-free correctional facility. *Journal of Correctional Health Care, 15*(3), 190–196.

[7] Donahue, J. J. (2009). Tobacco smoking among incarcerated individuals: A review of the nature of the problem and what is being done in response. *Journal of Offender Rehabilitation, 48,* 589-604.

[8] Jha, P., Ramasundarahettige, C., Landsman, V., Rostron, B., Thun, M., Anderson, R. N...& Peto, R. (2013). 21st-Century hazards of smoking and benefits of cessation in the United States. *New England Journal of Medicine, 368,* 341-350.

[9] Carson, E. A. (2015). *Prisoners in 2014* (NCJ 248955). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[10] Bonczar, T.P. (1997). *Characteristics of adults on probation, 1995* (NCJ 164267). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[11] Colorado Department of Corrections. (2012). *Statistical report: Fiscal year 2011.* Prepared by Barr, B., Gilbert, C., & O'Keefe, O.

[12] Kim, J. Y., Rich, J., Zierler, S., Lourie, K., Vigilante, K., Normandie, L., ... & Flanigan, T. P. (1997). Successful community follow-up and reduced recidivism in HIV positive women prisoners. *Journal of Correctional Health Care, 4*(1), 5-17.

[13] Glaser, J. B., & Greifinger, R. B. (1993). Correctional health care: A public health opportunity. *Annals of Internal Medicine, 118*(2), 139-145.

[14] Hammett, T. M., Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime & Delinquency, 47*(3), 390-409.

[15] Conklin, T. J., Lincoln, T., & Tuthill, R. W. (2000). Self-reported health and prior health behaviors of newly admitted correctional inmates. *American Journal of Public Health, 90*(12), 1939.

[16] Freudenberg, N. (2001). Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. *Journal of Urban Health, 78*(2), 214-235.

[17] Centers for Disease Control and Prevention [CDC]. (2011). CDC health disparities and inequalities report – United States, 2011. Morbidity and Mortality Weekly Report, 60. Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

[18] Tobacco Control Legal Consortium. (2012). *Tobacco in adult correctional facilities: A policy overview.* Retrieved from http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-fs-tobacco-adultcorrections-2012.pdf

[19] Center for Disease Control and Prevention [CDC]. (2015). Current cigarette smoking among adults – United States, 2005-2014. *Morbidity and Mortality Weekly Report, 64*(44), 1233-1240.

[20] Harlow, C. W. (2003). *Education and Correctional Populations* (NCJ 195670). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[21] Hammett, T. M. (2006). HIV/AIDS and other infectious diseases among correctional inmates: Transmission, burden, and an appropriate response. *American Journal of Public Health, 96*(6), 974-978.

[22] MacDonald, L., Angus, K., MacAskill, S., & Eadie, D. (2010). *Rapid literature review of smoking cessation and tobacco control issues across criminal justice system settings.* Stirling, Scotland: University of Stirling & The Open University. Retrieved from https://www.uclan.ac.uk/research/explore/projects/assets/tobacco_control_cjs_lit_review_aug_2010.pdf

[23] Lankenau, S. E. (2001). Smoke 'em if you got 'em: Cigarette black markets in U.S. prisons and jails. *The Prison Journal, 81*(2), 142-161.

[24] Kauffman, R. M., Ferketich, A. K., Murray, D. M., Bellair, P. E. & Wewers, M. E. (2011). Tobacco use by male prisoners under an indoor smoking ban. *Nicotine & Tobacco Research, 13*(6), 449-456.

[25] MacAskill, S. & Hayton, P. (2007). *Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy. Executive Summary and Best Practice Checklist.* Stirling, Scotland: University of Stirling, The Open University, & Centre for Tobacco Control Research.

[26] Douglas, N. & Plugge, E. (2006). *A Health Needs Assessment for Women in Young Offender Institutions.* London: Youth Justice Board for England and Wales. Retrieved from http://www.youthmetro.org/uploads/4/7/6/5/47654969/england_and_wales_a_health_needs_assessment_for_young_women.pdf

[27] MacAskill, S. & Hayton, P. (2007). *Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy. Executive Summary and Best Practice Checklist.* Stirling, Scotland: University of Stirling, The Open University, & Centre for Tobacco Control Research.

[28] Choudhry, K., & Evans, N. (2014). Beyond equivalence of care in prison pharmacy. *International Journal of Pharmacy Practice, 22*(5), 363-365.

[29] Richmond, R., Butler, T., Wilhelm, K., Wodak, A., Cunningham, M., & Anderson, I. (2009). Tobacco in prisons: A focus group study. *Tobacco Control, 18*(3), 176-182.

[30] Liebling, A., & Maruna, S. (Eds.). (2013). *The effects of imprisonment.* Devon, UK: Willan Publishing.

[31] Chapman, A. L., Specht, M. W., & Cellucci, T. (2005). Factors associated with suicide attempts in female inmates: The hegemony of hopelessness. *Suicide and Life-Threatening Behavior, 35*(5), 558-569

[32] Hammett, T. M., Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime & Delinquency, 47*(3), 390-409.

[33] Richmond, R. L., Butler, T., Belcher, J., Wodak, A., Wilhelm, K. A., & Baxter, E. (2006). Promoting smoking cessation among prisoners: Feasibility of a multi-component intervention. *Australian and New Zealand Journal of Public Health, 30*(5), 474-478

[34] Sieminska, A., Jassem, E., & Konopa, K. (2006). Prisoners' attitudes towards cigarette smoking and smoking cessation: A questionnaire study in Poland. *BMC Public Health, 6*(1).

[35] Condon, L., Hek, G., & Harris, F. (2008). Choosing health in prison: Prisoners' views on making healthy choices in English prisons. *Health Education Journal, 67*(3), 155-166.

[36] MacAskill, S. & Hayton, P. (2007). *Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy. Executive Summary and Best Practice Checklist.* Stirling, Scotland: University of Stirling, The Open University, & Centre for Tobacco Control Research.

[37] Richmond, R., Butler, T., Wilhelm, K., Wodak, A., Cunningham, M., & Anderson, I. (2009). Tobacco in prisons: A focus group study. *Tobacco Control, 18*(3), 176-182.

[38] Douglas, N. & Plugge, E. (2006). *A Health Needs Assessment for Women in Young Offender Institutions.* London: Youth Justice Board for England and Wales.

[39] Seligman, M. E. (1975). *Helplessness: On depression, development, and death.* San Francisco: W. H. Freeman.

[40] Bonner, R. L. (2006). Stressful segregation housing and psychosocial vulnerability in prison suicide ideators. *Suicide and Life-Threatening Behavior, 36*(2), 250-254.

[41] Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*(1), 39.

[42] Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Treatment Advocacy Center. Retrieved from http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars-abridged.pdf

[43] Fellner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights – Civil Liberties Law Review, 41,* 391 – 412.

[44] Doris, J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (NCJ 213600). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[45] Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Treatment Advocacy Center. Retrieved from http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars-abridged.pdf

[46] Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Treatment Advocacy Center. Retrieved from http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars-abridged.pdf

[47] Phelan, M., Stradins, L., & Morrison, S. (2001). Physical health of people with severe mental illness: Can be improved if primary care and mental health professionals pay attention to it. *British Medical Journal, 322*(7284), 443.

[48] Binswanger, I. A., Nowels, C., Corsi, K. F., Glanz, J., Long, J., Booth, R. E., & Steiner, J. F. (2012). Return to drug use and overdose after release from prison: A qualitative study of risk and protective factors. *Addiction Science & Clinical Practice, 7*(1), 1.

[49] Annamalai, A., Singh, N., & O'Malley, S. S. (2015). Smoking use and cessation among people with serious mental illness. *The Yale Journal of Biology and Medicine, 88*(3), 271-277.

[50] Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association, 284*(20), 2606 -2610.

[51] Torrey, E. F., Zdanowicz, M. T., Kennard, A. D., Lamb, H. R., Eslinger, D. F., Biasotti, M. C., & Fuller, D. A. (2014). *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Treatment Advocacy Center. Retrieved from http://www.tacreports.org/storage/documents/treatment-behind-bars/treatment-behind-bars-abridged.pdf

[52] Binswanger, I. A., Krueger, P. M. & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health, 63,* 912-919.

[53] Donahue, J. J. (2009). Tobacco smoking among incarcerated individuals: A review of the nature of the problem and what is being done in response. *Journal of Offender Rehabilitation, 48,* 589-604.

[54] Condon, L., Gill, H., & Harris, F. (2007). A review of prison health and its implications for primary care nursing in England and Wales: The research evidence. *Journal of Clinical Nursing, 16*(7), 1201-1209.

[55] Mumola C. (1999). *Bureau of Justice Statistics special report: Substance abuse and treatment state and federal prisoners, 1997.* Washington, DC: Department of Justice.

[56] Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. *Journal of Health and Social Behavior, 49*(1), 56-71.

[57] Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *Lancet, 359,* 545-50.

[58] Baillargeon, J., Giordano, T. P., Rich, J. D., Wu, Z. H., Wells, K., Pollock, B. H., & Paar, D. P. (2009). Accessing antiretroviral therapy following release from prison. *Journal of the American Medical Association, 301*(8), 848-857.

[59] Harris, F., Hek, G., & Condon, L. (2007). Health needs of prisoners in England and Wales: The implications for prison healthcare of gender, age and ethnicity. *Health & Social Care in the Community, 15*(1), 56-66.

[60] Schnittker, J., & John, A. (2007). Enduring stigma: the long-term effects of incarceration on health. *Journal of Health and Social Behavior, 48*(2), 115-130.

[61] Binswanger, I. A., Nowels, C., Corsi, K. F., Long, J., Booth, R. E., Kutner, J., & Steiner, J. F. (2011). "From the prison door right to the sidewalk, everything went downhill," A qualitative study of the health experiences of recently released inmates. *International Journal of Law and Psychiatry, 34*(4), 249-255.

[62] Maruschak, L. M., & Beck, A. J. (2001). *Medical problems of inmates, 1997.* Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[63] Binswanger, I. A., Krueger, P. M. & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health, 63,* 912-919.

[64] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison—A high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157-165.

[65] US Department of Health and Human Services. (2006). *The health consequences of involuntary exposure to tobacco smoke: A report of the surgeon general.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, Office on Smoking and Health.

[66] Kauffman, R. M., Ferketich, A. K., Murray, D. M., Bellair, P. E. & Wewers, M. E. (2011). Tobacco use by male prisoners under an indoor smoking ban. *Nicotine & Tobacco Research, 13*(6), 449-456.

[67] Dickens, G., Stubbs, J., Popham, R., & Haw, C. (2005). Smoking in a forensic psychiatric service: A survey of inpatients' views. *Journal of Psychiatric and Mental Health Nursing, 12*(6), 672-678.

[68] Frank. M. R., Blumhagen, R., Wietzenkamp, D., Mueller, S. R., Beaty, B., Sung-Joon, M., & Binswanger, I. A. (2016). Tobacco use among people who have been in prison. Relapse and factors associated with trying to quit. *Journal of Smoking Cessation (First View).*

[69] Federal Bureau of Prisons. (2016). *Inmate statistics: Race.* Retrieved on November 14, 2016 from http://www.bop.gov/news/quick.jsp

[70] Centers for Disease Control and Prevention [CDC]. (2011). CDC health disparities and inequalities report – United States, 2011. *Morbidity and Mortality Weekly Report, 60.* Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

[71] Centers for Disease Control and Prevention [CDC]. (2008). Summary health statistics for U.S. Adults: National Health Interview Survey, 2008. *Vital and Health Statistics, 10*(242). Retrieved from https://www.cdc.gov/nchs/data/series/sr_10/sr10_242.pdf

[72] Centers for Disease Control and Prevention [CDC]. (2008b). Surveillance for cancers associated with tobacco use – United States, 1999-2004. *Morbidity and Mortality Weekly, 57*(SS08), 1-33.

[73] Abidoye, O., Ferguson, M. K., Salgia, R. (2007). Lung carcinoma in African Americans. N*ature Clinical Practice Oncology, 4,* 118-29.

[74] Headley, A. J. (2004). Generations of loss: Contemporary perspectives on black infant mortality. *Journal of the National Medical Association, 96*(7), 987.

[75] Kurian, A. K., & Cardarelli, K. M. (2007). Racial and ethnic differences in cardiovascular disease risk factors: A systematic review. *Ethnicity and Disease, 17*(1), 143.

[76] Unger, B., Kemp, J. S., Wilkins, D., Psara, R., Ledbetter, T., Graham, M., ... & Thach, B. T. (2003). Racial disparity and modifiable risk factors among infants dying suddenly and unexpectedly. *Pediatrics, 111*(2), e127-e131.

[77] Yancy, C. W. (2007). Executive summary of the African-American initiative. *Medscape General Medicine, 9*(1), 28.

[78] Gardiner, P.S. (2004). The African Americanization of menthol cigarette use in the United States. *Nicotine & Tobacco Research, 6,* S55-S65.

[79] Castro, F. G. (2004). Physiological, psychological, social, and cultural influences on the use of menthol cigarettes among Blacks and Hispanics. *Nicotine & Tobacco Research, 6*(supplement 1), S29-S41.

[80] Rising, J., & Alexander, L. (2011). Marketing of menthol cigarettes and consumer perceptions. *Tobacco Induced Diseases, 9*(Suppl 1), S2.

[81] Ahijevych, K., & Garrett, B.E. (2004). Menthol pharmacology and its potential impact on cigarette smoking behavior. *Nicotine & Tobacco Research, 6,* S17-S28.

[82] Garten, S. Falker, R.V. (2004). Role of mentholated cigarettes in increased nicotine dependence and greater risk of tobacco attributable disease. *Preventive Medicine, 38,* 793-798.

[83] Fu, S. S., Kodl, M. M., Joseph, A. M., Hatsukami, D. K., Johnson, E. O., Breslau, N., ... & Bierut, L. (2008). Racial/ethnic disparities in the use of nicotine replacement therapy and quit ratios in lifetime smokers ages 25 to 44 years. *Cancer Epidemiology Biomarkers & Prevention, 17*(7), 1640-1647.

[84] Fagan, P., Moolchan, E. T., Lawrence, D., Fernander, A., & Ponder, P. K. (2007). Identifying health disparities across the tobacco continuum. *Addiction, 102*(suppl 2), 5-29.

[85] Lurie, N., & Dubowitz, T. (2007). Health disparities and access to health. *JAMA, 297*(10), 1118-1121.

[86] Murphy, J. M., Mahoney, M. C., Hyland, A. J., Higbee, C., & Cummings, K. M. (2005). Disparity in the use of smoking cessation pharmacotherapy among Medicaid and general population smokers. *Journal of Public Health Management and Practice, 11*(4), 341-345.

[87] McMenamin, S. B., Halpin, H. A., & Bellows, N. M. (2006). Knowledge of Medicaid coverage and effectiveness of smoking treatments. *American Journal of Preventive Medicine, 31*(5), 369-374.

[88] Bansal, M. A., Cummings, K. M., Hyland, A., & Giovino, G. A. (2004). Stop-smoking medications: Who uses them, who misuses them, and who is misinformed about them? *Nicotine & Tobacco Research, 6*(Suppl 3), S303-S310.

[89] Houston, T. K., Scarinci, I. C., Person, S. D., & Greene, P. G. (2005). Patient smoking cessation advice by health care providers: The role of ethnicity, socioeconomic status, and health. *American Journal of Public Health, 95*(6), 1056-1061.

[90] Lopez-Quintero, C., Crum, R. M., & Neumark, Y. D. (2006). Racial/ethnic disparities in report of physician-provided smoking cessation advice: Analysis of the 2000 National Health Interview Survey. *American Journal of Public Health, 96*(12), 2235-2239.

[91] Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law, 16*(1), 39.

[92] Hammett, T. M., Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime & Delinquency, 47*(3), 390-409.

[93] Massoglia, M. (2008). Incarceration as exposure: The prison, infectious disease, and other stress-related illnesses. *Journal of Health and Social Behavior, 49*(1), 56-71.

[94] Freudenberg, N. (2001). Jails, prisons, and the health of urban populations: A review of the impact of the correctional system on community health. *Journal of Urban Health, 78*(2), 214-235.

[95] Durose, M. R., Cooper, A. D., & Snyder, H. N. (2014). *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010* (NCJ 244205). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[96] Binswanger, I. A., Nowels, C., Corsi, K. F., Glanz, J., Long, J., Booth, R. E., & Steiner, J. F. (2012). Return to drug use and overdose after release from prison: A qualitative study of risk and protective factors. *Addiction Science & Clinical Practice, 7*(1), 1.

[97] Cropsey, K. L., Jones-Whaley, S., Jackson, D. O. & Hale, G. J. (2010). Smoking characteristics of community corrections clients. *Nicotine & Tobacco Research, 12*(1), 53-58.

[98] Kauffman, R. M., Ferketich, A. K., Murray, D. M., Bellair, P. E. & Wewers, M. E. (2011). Tobacco use by male prisoners under an indoor smoking ban. *Nicotine & Tobacco Research, 13*(6), 449-456.

[99] Lincoln, T., Tuthill, R. W., Roberts, C. A., Kennedy, S., Hammett, T. M., Langmore-Avila, E., & Conklin, T. J. (2009). Resumption of smoking after release from a tobacco-free correctional facility. *Journal of Correctional Health Care, 15*(3), 190–196.

[100] May, J. P. (2006). *Preventive health issues for individuals in jails and prisons.* In M. Puisis (Ed.), Clinical practice in correctional medicine. Philadelphia: Mosby Elsevier.

[101] Cropsey, K. L., Jones-Whaley, S., Jackson, D. O. & Hale, G. J. (2010). Smoking characteristics of community corrections clients. *Nicotine & Tobacco Research, 12*(1), 53-58.

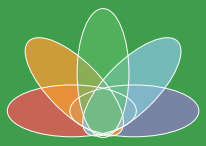
[102] Ong, M. K., Zhou, Q., & Sung, H. Y. (2011). Primary care providers advising smokers to quit: Comparing effectiveness between those with and without alcohol, drug, or mental disorders. *Nicotine & Tobacco Research, 13*(12), 1193-1201.

[103] Donahue, J. J. (2009). Tobacco smoking among incarcerated individuals: A review of the nature of the problem and what is being done in response. *Journal of Offender Rehabilitation, 48,* 589-604.

[104] Clarke, J. G., Martin, S. A., Martin, R. A., Stein, L. A. R., van den Berg, J. J., Parker, D. R.,...Bock, B.C. (2015). Changes in smoking-related symptoms during enforced abstinence of incarceration. *Journal of Health Care for the Poor and Underserved, 26,* 106-118.

[105] Garver-Apgar, C. E., Young, S., Howard, B., Udochi, B., & Morris, C. (in press). Effects of a statewide tobacco cessation program among individuals involved with Arkansas Community Correction. *Journal of Correctional Healthcare.*

The Behavioral Health and Wellness Program's DIMENSIONS: Tobacco Free Program is designed to train peers and providers to assist people to live a tobacco-free life. The DIMENSIONS: Tobacco Free Program Advanced Techniques training supports tobacco cessation through motivational engagement strategies, group process, community referrals, and educational activities. Contact the Behavioral Health and Wellness Program at bh.wellness@ucdenver.edu for more information.



Behavioral Health & Wellness Program

University of Colorado Anschutz Medical Campus
School of Medicine