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Executive Summary

Studies have shown that those involved with the justice system smoke at up to four times the rate of the general population, with smoking prevalence ranging from 70-80% (Cropsey et al., 2010; Kauffman et al., 2010, Ritter et al., 2011). Inmates and parolees who use 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. These justice-involved (JI) tobacco users cost counties much more than non-tobacco users due to associated medical and psychiatric comorbidities and hospitalizations (Wilper et al., 2009; Fisher et al., 1993; Florida State University, 2017).

County buildings in Maricopa County are tobacco-free. Therefore, tobacco-using adults who are booked into Maricopa County corrections are required to immediately stop using tobacco. This is true across much of the U.S. corrections system. Even so, national research has shown that 90-97% of detained adults who smoked prior to being incarcerated return to smoking within 6 months of release. Since tobacco use is the leading preventable cause of death in the U.S. and many of the most serious medical problems reported by inmates are smoking-related, addressing tobacco cessation among those involved in Maricopa County’s justice system is essential to the health of JI individuals. Moreover, providing cessation services might have positive impacts on Maricopa County overall(?) as healthier JI individuals re-enter its communities.

With support from the Arizona Department of Health Services (ADHS), the Maricopa County Department of Public Health (MCDPH) has contracted with the University of Colorado’s Behavioral Health and Wellness Program (BHWP) to develop both a pilot project plan and a 5-year strategic plan to address tobacco use among adults in Maricopa County’s justice system. Specifically, in the first year of this work, BHWP will do the following:

- Identify best practices in the areas of tobacco cessation that most appropriately can be applied within the Maricopa County justice system and support the justice-involved population.
- Assess the Maricopa County justice system to identify tobacco cessation intervention points within the system and within the larger community that serves this justice-involved population.
- Identify and prioritize opportunities to implement and support tobacco cessation efforts for the Maricopa County justice-involved population both in the justice system and upon community reentry.
- Develop a project plan to implement a tobacco cessation pilot that utilizes a holistic approach to address tobacco use among the justice-involved population. The plan will focus on the justice-involved population that has been identified as most likely to succeed based on the assessment of the justice system, on evidence-based practices, on work in other jurisdictions, and on available resources.
Year 1 of the Justice-Involved Tobacco Cessation Project began in June 2017. At this time, MCDPH worked with BHWP to identify potential pilot sites for the project. The identified sites included the Maricopa County Drug Court, the MOSAIC program, the Veteran Pod at Towers Jail, and Hope Lives. In July-August 2017, BHWP reached out to each site to invite them to complete both the Maricopa County Assessment of Health Services and the Maricopa County Staff Knowledge and Attitudes Survey. Data from the Assessment of Health Services was used to determine potential pilot sites' current engagement in evidence-based health and wellness services. The Assessment of Health Services was completed by a designated point of contact at each site. In comparison, data from the Staff Knowledge and Attitudes Survey was used to assess staff knowledge of and attitudes towards tobacco cessation services at potential pilot sites. The Staff Knowledge and Attitudes Survey was disseminated at each agency by the identified point of contact and voluntarily completed by agency staff.

In August 2017, a project Kick-Off Meeting was held to bring together important project stakeholders and to provide a project overview. At this meeting, attendees were invited to participate in an activity to discuss and document potential strengths, opportunities, and resources (SOaR) for the project. This information has been used as a key planning input for the project pilot design. In addition, BHWP completed site visits and interviews at each of the identified potential pilot sites. These visits and interviews explored the programming offered at each site, tobacco-free policies and enforcement, goals for the pilot, and expected barriers to tobacco cessation programming.

Based on the findings from the various assessments, site visits, and interviews, all identified sites were invited to participate as pilot sites. While Hope Lives is currently unable to be a pilot site, all other sites (Maricopa County Drug Court, MOSAIC, the Veteran Pod) have accepted this offer and plan to move forward with the project pilot.

The following report contains aggregate results from both the Staff Knowledge and Attitudes Survey and the Assessment of Health Services. This report also includes a summary of themes surmised from the qualitative data that was collected during the SOaR activity, potential pilot site visits, and interviews. Based on these inputs, this report details associated conclusions and recommendations for Year 1 of the Justice-Involved Tobacco Cessation Project. These recommendations draw upon the data presented, the evidence base regarding provision of tobacco cessation services in correctional settings, and BHWP’s experience working with other correctional systems to reduce tobacco use inJI populations.
Maricopa County Staff Knowledge and Attitudes Survey: Summary of Findings

Survey Methodology:
The Staff Knowledge and Attitudes Survey is a brief, web-based survey designed to measure staff knowledge and attitudes surrounding tobacco treatment and their willingness to adopt tobacco cessation practices. The knowledge section of the survey asks staff to rate their knowledge of 17 evidence-based cessation strategies on a five-point scale: no knowledge, little knowledge, some knowledge, good knowledge, or extensive knowledge. The attitudes section of the survey asks staff to rate their agreement on six questions related to tobacco use and treatment on a five-point scale: strongly disagree, disagree, neither agree nor disagree, agree, or strongly agree.

The Staff Knowledge and Attitudes Survey was administered electronically from July – August 2017. A link to the survey was sent to identified points of contact at each pilot site, who were asked to share the survey with their staff members. All staff members employed by the pilot sites were eligible and encouraged to participate in the survey.

Survey Data:
Demographics:
Surveys were completed by a total of 46 staff members from across the Maricopa County correctional system and affiliated community agencies. Surveys were completed by employees affiliated with MOSAIC (5 employees; 11%), the Veteran Pod in Towers Jail (1 employee; 2%), Hope Lives (8 employees; 17%), the Drug Court (27 employees; 59%), and other agencies (5 employees; 11%). The majority of the survey respondents were female and the predominant age groups were 25-34 and 45-54.

All staff members reported having direct contact with justice-involved (JI) individuals. The majority of staff members reported that they were not healthcare providers (76%). The most common services provided by respondents included substance use services (67%), mental health services (51%), and other services (27%). These response categories were not mutually exclusive. Within the “other services” category, the most respondents reported providing peer support services or probation services.

Tobacco Use:
Two out of five respondents (40%) reported being ever-tobacco users, defined as having regularly used tobacco products in their lifetime. The majority (88%) had used cigarettes, followed by smokeless tobacco (22%) and e-cigarettes (22%). Of the 18 ever-tobacco users, 9 provided information on their tobacco use in the last three months. Only one-third of these ever-users reported tobacco use in the past three months (3 employees; 33%) and the majority
(6 employees; 67%) reported no tobacco use in the past three months. However, given the relatively low response rate for this question, the rate of current tobacco use among staff may be higher than reported. It is estimated that between 4% and 24% of survey respondents are current tobacco users. Of the respondents who reported tobacco use in the past three months, one reported quitting, one had tried unsuccessfully to quit, and one reported having no interest in quitting.

Knowledge Regarding Tobacco Cessation:
Overall, survey results reveal that staff members have very little knowledge about evidence-based tobacco cessation strategies. Most staff members (82%) reported that they had never received formal training around implementing tobacco cessation services. No staff members reported extensive training around tobacco cessation services, and just 18% reported some training. Similarly, the majority of staff members reported no knowledge of documenting tobacco use in Electronic Health Records (66%), using the 2As-R model (66%), using the 5As Model (68%), referring to other community cessation resources (57%), providing messaging around Electronic Nicotine Delivery Systems (64%), providing culturally competent and tailored interventions to priority populations (52%), and providing specialized cessation treatment for people with behavioral health problems (55%). A significant proportion reported no knowledge of providing individual or group tobacco cessation counseling (50%), referring to the ASHLine (48%), referring to web-based or mobile phone cessation programs (48%). Overall, the categories in which staff reported no knowledge or little knowledge at the highest rates were the 2As-R model (91%) and the 5As model (89%).

However, staff members did report good or extensive knowledge of tobacco cessation strategies pertaining to a few key categories. These categories included asking about tobacco use (30%), advising not to use tobacco (34%), using cognitive behavioral strategies (46%), and using motivational interviewing (57%). Staff report a limited familiarity with Nicotine Replacement Therapy (NRT) and other cessation medications, with 43% of staff members reporting some, good or extensive knowledge of NRT and 41% reporting some, good, or extensive knowledge of other cessation medications.

Attitudes Regarding Tobacco Cessation:
Despite relatively limited knowledge about tobacco cessation strategies, staff members view tobacco cessation as a priority for the JI individuals whom they serve. A majority (59%) of staff members agreed or strongly agreed that it is important for JI individuals to receive tobacco prevention and cessation services. A majority of respondents also agreed or strongly agreed that there is no safe level of exposure to secondhand smoke (73%). Over three-fourths of staff members (80%) agreed or strongly agreed that tobacco cessation was possible for the JI individuals they serve. Moreover, 71% of respondents agreed or strongly agreed that they support (or would support) a tobacco-free policy at their agency.

Although the survey results depict strong support for tobacco cessation among staff members, the results also indicate hesitation regarding the resources and staff time that would be required to implement tobacco cessation strategies. For instance, while 53% of staff members...
agreed or strongly agreed that, given their existing role and responsibilities, it is feasible to also provide brief tobacco prevention and cessation services, 34% of respondents simultaneously disagreed or strongly disagreed that staff at their agency had sufficient time to help a JI individual to quit. Additionally, 43% of respondents agreed or strongly agreed that staff at their agency do not have the resources they need to help a JI individual to quit (including referral sources, materials, and training).

Survey results reveal that negative attitudes towards tobacco cessation are not prevalent. However, staff attitudes are commonly ambivalent. For instance, 57% of staff members neither agreed nor disagreed with the statement, “people are less likely to seek services if an agency is tobacco-free.” Additionally, 61% of staff members neither agreed nor disagreed that their agency did not provide tobacco cessation services because other providers outside of their agency provide these services.

Conclusions:
The Staff Knowledge and Attitudes Survey demonstrates that staff support for providing tobacco cessation assistance to the JI population is strong despite limited knowledge around evidence-based tobacco cessation strategies. The majority of staff members reported that tobacco cessation is possible for the JI individuals that they work with and agreed that it is feasible to provide brief tobacco cessation services within their current roles. This staff support is encouraging, as studies have found that the primary reason given for why providers do not offer tobacco cessation services is the perception that their patients or clients lack the motivation and capability to do so (American Association of Medical Schools, 2007).

The Staff Knowledge and Attitudes Survey revealed that staff hesitation pertaining to tobacco cessation interventions largely revolves around the time and resources required for such interventions. Given that the majority of respondents have never received formal training around tobacco cessation, this hesitation is not surprising. However, research demonstrates that even brief tobacco cessation interventions are effective in many different types of institutional, public health, and healthcare settings. With minimal counseling (defined as less than 3 minutes), low intensity counseling (defined as between 3-10 minutes), and high intensity counseling (defined as greater than 10 minutes), estimated abstinence rates are 13.4%, 16%, and 22.1%, respectively (Bureau of Public Health Service, 2008). Formal training and education around tobacco cessation strategies might increase staff’s confidence in offering proven, low-burden interventions.

Brief, effective tobacco cessation interventions and strategies include the 5As model and the 2As-R model, two of the evidence-based practices for which staff reported the lowest levels of knowledge. The 5As model directs providers and staff to screen for tobacco use (Ask), to recommend reducing or stopping tobacco use (Advise) to evaluate smokers’ willingness to quit and their level of nicotine dependence (Assess), to offer help in their quit attempt (Assist) and to set follow-up visits (Arrange) (Fiore et al., 2008). The 2As-R model directs providers and staff to screen for tobacco use (Ask), to recommend stopping tobacco use (Advise) and to refer
patients or clients to additional services (Refer). For all smokers, advice to quit is typically not followed by assessment, brief treatment, appropriate referrals, or follow-up (Conroy et al., 2005; Morris, Miller, and Mahlik, 2011), and rates of providing counseling or pharmacotherapy are below 20% (DePue et al., 2002; Longo et al., 2006; Park et al., 2015). Both the 5As model and the 2As-R model help to ensure treatment consistency and follow-up. Additionally, utilizing the 5As model is advantageous to the criminal justice system as it can be modified to complement behavioral health and integrated care assessment, screening, and treatment currently being offered.

A large proportion of staff members reported little or no knowledge around making referrals to the ASHLine, which provides telephonic counseling and access to free cessation medications for the state of Arizona. Training around such referrals offers a high-impact, low-cost intervention as quitline counseling can more than double a smoker’s chances of quitting, and quitline counseling combined with medication can more than triple the chances of quitting (Anderson & Zhu, 2007; Stead, Perera & Lancaster, 2007). Quitlines such as the ASHLine also have the potential to overcome common barriers to healthcare access for JI populations such as lack of insurance or transportation, and the cost of cessation medications (Zhu et al., 2000).

Addressing the tobacco cessation needs of employees as well as the JI individuals is a parallel process that can enhance correction staff’s acceptance, prioritization, and provision of tobacco cessation services. It is therefore recommended that the correctional system provides cessation counseling and supports to employees who use tobacco as well as to the JI individuals they serve (Cork, 2012). Historically, a large percentage of criminal justice employees are tobacco users themselves, and one of the best means of supporting staff’s own health and wellness is to encourage smoking cessation. At the same time, studies have demonstrated that provider smoking status affects tobacco treatment (Meshefedjan et al., 2010). Providers who are themselves smokers are less likely ask patients about smoking status or to offer their patients smoking cessation assistance. However, providers who have quit smoking are far more likely to ask their patients about smoking status and to offer their patients tobacco cessation assistance.

Since Maricopa County already offers cessation support for its employees (see https://www.maricopa.gov/1378/Stop-Using-Tobacco), it would be useful to promote this support in association with the Justice-Involved Tobacco Cessation Project. Cessation support for county employees could be highlighted in project updates, within the project newsletter, and on the project webpage. In addition, communication around these supports could be inserted within various mediums of communication throughout the county corrections systems including signage, social media posts, county news segments, and inter/intranet sites.
Maricopa County Staff Knowledge and Attitudes Survey: Data Visualizations

Overview:
This section provides figures and tables that represent aggregate data from the Maricopa County Staff Knowledge and Attitudes Survey. The data represents responses from all pilot site agencies. In total, 46 employees participated in the assessment.

Demographics:

![Age Distribution](image)
n=45

![Gender Distribution](image)
n=45
Other answer category option(s): My gender is not listed
n=45

Race/ethnicity:

- White/Non-Hispanic: 69%
- Hispanic/Latino: 13%
- Black/African American: 7%
- Prefer not to answer: 11%

n=46

Staff Employment:

Where do you work?

- MOSAIC - Estrella Women: 7%
- MOSAIC - Durango Men: 4%
- Veterans Programming - Towers Jail: 2%
- Hope Lives: 17%
- Drug Court: 59%
- Other (please specify): 11%

Qualitative Responses for “Other:”
- Correctional Health Service Mental Health
- Adult Probation Department/Reach Out Program and Assessment Center
- MOSAIC Men and Women
- Estrella Jail
Do you have direct contact with justice-involved individuals at your agency?

- Yes: 100%
- No: 0%

n=46

Are you a healthcare provider?

- Yes: 24%
- No: 76%

n=46
Qualitative Responses for “Other Services:”

- Mental Health Court
- Peer Support Training, Peer Support, Forensics Support, Life Support
- Offender Supervision
- Supervision
- Probation Officer/Supervision
- Office Assistant
**Staff Tobacco Use:**

Have you ever REGULARLY used any tobacco product(s) in your lifetime? ("Regularly" means at least a few times every few days)

- Yes: 40%
- No: 60%

n=45

In your lifetime, which tobacco products have you REGULARLY used? (Check all that apply)

- Cigarettes: 89%
- Smokeless tobacco (e.g. chewing tobacco, snuff, snus): 22%
- E-cigarettes/vaping: 22%

n=9*

Other answer category option(s): Cigars, Hookah/Waterpipe, Pipe Tobacco

*This question was administered only to individuals that identified as ever-smokers (n=18)
n=9*
*This question was administered only to individuals that identified as ever-smokers (n=18)

n=3*
Other answer category option(s): “I would like to try to quit in the next 3 months,” “I would like to try to quit in the next 6 months”
*This question was administered only to individuals that identified as having used tobacco in the past 3 months (n=9)
**Staff Knowledge:**
Which category describes your knowledge of the following interventions for tobacco cessation and prevention (regardless of whether or not you use these services)?

<table>
<thead>
<tr>
<th>Intervention</th>
<th>No Knowledge</th>
<th>Little Knowledge</th>
<th>Some Knowledge</th>
<th>Good Knowledge</th>
<th>Extensive Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking about tobacco use</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>8.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Advising not to use tobacco</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>8.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Documenting tobacco use</td>
<td>34.1%</td>
<td>27.3%</td>
<td>16.2%</td>
<td>8.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>2A’s-RI model</td>
<td>22.7%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>SA’s model</td>
<td>22.7%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>NRT</td>
<td>22.7%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Cessation medications</td>
<td>27.3%</td>
<td>22.7%</td>
<td>16.2%</td>
<td>8.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>CBT</td>
<td>20.5%</td>
<td>20.5%</td>
<td>16.2%</td>
<td>8.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td>MI</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Cessation counseling</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>AshLine referral</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Web-based referral</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Community resources</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>ENDS messaging</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Tailored interventions</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Promote policies</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>BH cessation treatment</td>
<td>27.3%</td>
<td>27.3%</td>
<td>34.1%</td>
<td>16.2%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

n=44
<table>
<thead>
<tr>
<th>Domain</th>
<th>No Knowledge</th>
<th>Little Knowledge</th>
<th>Some Knowledge</th>
<th>Good Knowledge</th>
<th>Extensive Knowledge</th>
<th>Total</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking about tobacco use</td>
<td>15.91%</td>
<td>20.45%</td>
<td>34.09%</td>
<td>27.27%</td>
<td>2.27%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Advising not to use tobacco</td>
<td>15.91%</td>
<td>11.36%</td>
<td>38.64%</td>
<td>34.09%</td>
<td>0.00%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Documenting tobacco use status in electronic health records or other records</td>
<td>65.91%</td>
<td>9.09%</td>
<td>15.91%</td>
<td>9.09%</td>
<td>0.00%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>2A’s-R model (Ask, Advise, Refer)</td>
<td>65.91%</td>
<td>22.73%</td>
<td>9.09%</td>
<td>2.27%</td>
<td>0.00%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>5A’s model (Ask, Advise, Assess, Assist, Arrange)</td>
<td>68.18%</td>
<td>22.73%</td>
<td>6.82%</td>
<td>2.27%</td>
<td>0.00%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Nicotine replacement therapy (e.g., patches, gum, nasal spray)</td>
<td>22.73%</td>
<td>34.09%</td>
<td>27.27%</td>
<td>11.36%</td>
<td>4.55%</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Cessation medications (e.g., Chantix, bupropion)</td>
<td>36.36%</td>
<td>22.73%</td>
<td>25.00%</td>
<td>9.09%</td>
<td>6.82%</td>
<td>3</td>
<td>44</td>
</tr>
<tr>
<td>Cognitive behavioral strategies</td>
<td>18.18%</td>
<td>15.91%</td>
<td>20.45%</td>
<td>27.27%</td>
<td>18.18%</td>
<td>8</td>
<td>44</td>
</tr>
<tr>
<td>Motivational interviewing and enhancement</td>
<td>13.64%</td>
<td>9.09%</td>
<td>20.45%</td>
<td>31.82%</td>
<td>25.00%</td>
<td>11</td>
<td>44</td>
</tr>
<tr>
<td>Individual or group tobacco cessation counseling</td>
<td>50.00%</td>
<td>18.18%</td>
<td>20.45%</td>
<td>9.09%</td>
<td>2.27%</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>Referral to the ASHLine</td>
<td>47.73%</td>
<td>20.45%</td>
<td>13.64%</td>
<td>18.18%</td>
<td>0.00%</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Service Description</td>
<td>Percentage</td>
<td>Count</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------------</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to web-based or mobile phone cessation programs and resources</td>
<td>47.73%</td>
<td>21</td>
<td>1.84</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other community cessation resources</td>
<td>56.82%</td>
<td>25</td>
<td>1.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing messaging around evidence-based messaging around Electronic Nicotine Delivery Systems (ENDS) (e.g., e-cigarettes)</td>
<td>63.64%</td>
<td>28</td>
<td>1.61</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing culturally competent and tailored interventions to priority populations</td>
<td>52.27%</td>
<td>23</td>
<td>2.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting tobacco-free policies</td>
<td>34.09%</td>
<td>15</td>
<td>2.43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing specialized cessation treatment for people with behavioral health problems</td>
<td>54.55%</td>
<td>24</td>
<td>1.82</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Answered: 44
Skipped: 2
Staff Attitudes:
Please check how much you agree or disagree with the statements that follow.

[Bar chart showing attitudes with n=44]
Please check how much you agree or disagree with the statements that follow.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
<th>Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.09%</td>
<td>4</td>
<td>9.09%</td>
<td>13</td>
<td>40.91%</td>
<td>18</td>
<td>11.36%</td>
</tr>
<tr>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>20.45%</td>
<td>9</td>
<td>50.00%</td>
</tr>
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<td>2.27%</td>
<td>1</td>
<td>9.09%</td>
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<tr>
<td>18.18%</td>
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<tr>
<td>6.82%</td>
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<td>18.18%</td>
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<td>4.55%</td>
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<td>18.18%</td>
<td>8</td>
<td>34.09%</td>
<td>15</td>
<td>34.09%</td>
</tr>
</tbody>
</table>

Given my existing role and responsibilities, it is feasible for me to also provide brief tobacco prevention and cessation services. Smoking cessation is possible for the justice-involved individuals my agency works with.

It is important for the justice-involved individuals my agency works with to receive tobacco prevention and cessation services.

Staff at my agency have sufficient time to help a justice-involved individual quit.

Staff at my agency do not provide cessation counseling because other providers outside of my agency provide these services.

Staff at my agency do not have the resources needed to help a justice-involved individual quit (e.g. referral sources, materials, training).
<table>
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<tr>
<th>Statement</th>
<th>Percentage</th>
<th>Count</th>
<th>Answered</th>
<th>Skipped</th>
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</thead>
<tbody>
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<td>There is no safe level of exposure to secondhand smoke.</td>
<td>4.55%</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People are less likely to seek services if an agency is tobacco-free.</td>
<td>9.09%</td>
<td>4</td>
<td></td>
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</tr>
<tr>
<td>I would/do support a tobacco-free policy at this agency.</td>
<td>4.55%</td>
<td>2</td>
<td></td>
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Justice-Involved Tobacco Cessation Project Kick-Off Meeting: Qualitative Input

The Justice-Involved Tobacco Cessation Project held a project Kick-Off Meeting on August 8th, 2017. This meeting featured a presentation from the University of Colorado Behavioral Health and Wellness Program, as well as a facilitated discussion around the strengths, opportunities, and resources (SOaR) that can be leveraged for tobacco cessation interventions. During this discussion, possible threats that could interfere with tobacco cessation efforts were also noted. In total, 21 representatives from Maricopa County Public Health, the Arizona Department of Health Services, Maricopa County Adult Probation, the ASHLine, Maricopa County Correctional Health Services, and all potential pilot sites took part in this meeting.

Themes from the Strengths, Opportunities, and Resources (SOaR) Activity:

Strengths:
Meeting participants highlighted strengths within three main categories: knowledge/experience, community/agency connections, and structure. Regarding knowledge and experience, participants noted strengths at both the individual and systems level. For instance, at the individual level participants emphasized employee experience with counseling methodologies, such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT), as well as with the previous use of incentives programs. At the systems level, participants noted knowledge of comprehensive health models and systems thinking capabilities. This existing knowledge and staff skill will be critical to designing and implementing effective tobacco cessation programming across the county correctional system as well as directly providing engaging, tailored tobacco cessation programming for justice-involved individuals.

Community/agency connections emerged as another common theme within the strengths category. Noted strengths pertaining to community/agency connections included not only the previous collaborations between various Maricopa County agencies, but also encompassed the way in which community organizations have been integrated within the county correctional system. These community organizations have helped develop peer connections throughout the county correctional system and have ensured the sustained development of one-on-one relationships with JI individuals throughout the system. Accordingly, the various ties between Maricopa County agencies and community organizations will strengthen the Patient-Centered Medical Neighborhood (PCMN) and ensure that JI individuals have multiple points of entry to the tobacco cessation services that they require. However, the involvement of many agencies will also require ongoing, strong communication across agencies and consistent messaging around tobacco cessation for the Maricopa County JI population.

Finally, participants frequently noted various aspects of existing county structure as strengths integral to the success of the project. These structural strengths included the existing tobacco-free policy in Maricopa County, current data collection and analysis efforts, upcoming changes to Electronic Health Records, and established group counseling programs. Moreover, the
Arizona quitline, the ASHLine, as well as the quitline for veterans were also included as existing, free resources.

Opportunities:
Participants emphasized four primary categories of opportunity: existing aspects of probation structure, cross-agency messaging, health care, and serving as a model for criminal justice agencies for tobacco cessation. First, participants reinforced the opportunity to leverage and build on existing probation structure, particularly the use of group counseling. It was widely agreed that, given the extensive use of groups in probation, it would be easy to incorporate tobacco cessation into existing curricula. Additionally, probation staff possess the knowledge needed to establish an incentive program that could potentially increase recruitment and retention for tobacco-free groups. This knowledge is critical, particularly given that recruitment and retention are often the most challenging aspects of establishing a group.

Meeting participants also acknowledged an opportunity to create consistent, cross-agency messaging. This messaging could occur across a variety of county and community agencies, including Regional Behavioral Health Authorities, and would be employed to continue building Maricopa County’s continuity of care. Therefore, it will be important that the decision-makers and stakeholders across the project are both educated and informed. Additionally, it was noted that this cross-agency messaging will need to include the various ways that individuals can access tobacco cessation programming.

Healthcare also emerged as a theme in the opportunity category. Participants agreed that the project provided an opportunity to create buy-in among healthcare providers and to further connect with Regional Behavioral Health Authorities. Moreover, participants wanted to ensure that the project reinforced the enrollment of JI individuals within the Arizona Health Care Cost Containment System (AHCCCS) prior to leaving jail. Consequently, participants also hoped to explore the resulting possibility that JI individuals may be able to receive NRT or other cessation medications through their primary care provider.

Finally, participants agree that the Justice-Involved Tobacco Cessation Project offers the opportunity for Maricopa County to serve as a model for other criminal justice agencies. Participants emphasized the innovative nature of the work, and noted that there may also be an opportunity to expand tobacco work to also address legalized marijuana.

Resources:
In addition to strengths and opportunities, meeting participants were also asked to identify resources that were available or would be important for the project. Two main themes emerged within this discussion: collaboration and planning. Participants emphasized not only existing collaborations occurring across agencies, but encouraged seeking additional partnerships. Specifically, participants underscored work with other specialty courts as well as the Arizona ASHLine.
Additionally, planning emerged as another theme. Participants discussed the Community Health Improvement Plan, and contemplated strategies for disseminating tobacco cessation strategies and practices. Additionally, inmate funds were also noted as a resource.

Threats/Problems:
Finally, although threats and problems were not explicitly solicited within the SOaR activity, participants wanted to make sure that these topics were also covered. The major threats that were identified included the current Maricopa County tobacco-free policy, communication, and jail-specific concerns.

First, the current Maricopa County tobacco-free policy may not adequately prevent or inhibit tobacco use on or around county facilities. Areas that are close to, but do not qualify as county property (such as sidewalks near building entrances) are not covered under the policy. Furthermore, the county tobacco-free policy contains an exemption clause that allows for tobacco use in designated areas that have received county permission. Participants also noted confusion or a lack of knowledge around the tobacco cessation assistance that is offered as a benefit to Maricopa County employees.

Concerns around communication included the tricky nature of tobacco cessation messaging. Specifically, participants emphasized the difficulty of communicating an anti-tobacco message when tobacco is a legal substance. Additionally, participants noted that although communication offered an opportunity for constructing consistent messaging and building relationships across agencies, creating and delivering consistent messaging is a difficult task. Moreover, the open-ended group format discussed may result in either repeated or missed information. Participants also contemplated the need to incorporate available VA services within this messaging.

Finally, participants highlighted various jail-specific threats. These threats included the variable length of time that individuals are in jail, particularly in considering when NRT may be most effectively dispensed. Since jail is a revolving door for many, timing tobacco cessation interventions may be challenging. Moreover, the social environment within jail is potentially a threat to tobacco cessation. Since this environment contributes to the association between tobacco use and smoking with freedom and release, addressing the attitudes of JI individuals around tobacco cessation is an anticipated challenge. Similarly, participants expressed concern around the possibility that NRT may be misused or used as contraband within the jails.
Potential Pilot Site Visits and Interviews: Qualitative Themes

Overarching Site Visit Themes:
In early August 2017, the University of Colorado Behavioral Health and Wellness Program visited all potential pilot sites and conducted interviews with identified points of contact. These site visits and interviews explored the programming offered at each site, tobacco-free policies and enforcement, goals for the pilot, and well as expected barriers to tobacco cessation programming. The primary themes that emerged across potential pilot sites during these discussions are reviewed in the next section.

Pilot Sites are Prepared to Implement:
The most important theme to emerge from the pilot site visits was that all sites seemed well prepared to implement tobacco cessation strategies imminently. This preparedness stemmed from a number of factors including the opportunity to leverage existing resources and the prevalence of staff support.

First, it was noted that all sites possess resources or access to resources required to implement tobacco cessation programming – particularly, the DIMENSIONS: Tobacco-Free Group. All sites have access to classrooms or similar spaces to implement groups, as well as the staff knowledge to facilitate group counseling. Moreover, since many of the sites are already running groups for JI individuals, they already have complimentary workflows in place that can be adapted for tobacco cessation.

Additionally, pilot sites were both interested and invested in tobacco cessation. This finding was surprising; tobacco use in criminal justice settings has historically been condoned (MacDonald et al., 2010) and corrections staff commonly possess negative attitudes toward cessation services (MacAskill & Hayton, 2007). However, consistent with findings from the Staff Knowledge and Attitudes Survey, it appears that potential pilot site staff recognize the importance of tobacco cessation and prioritize cessation for the JI.

Tobacco-Free Policy Enforcement:
Although Maricopa County has a tobacco-free policy that covers all buildings owned by the county, it is apparent from the site visits that there is an opportunity to potentially expand this tobacco-free policy and to increase enforcement of the existing policy. Although county-owned buildings are definitively covered by the tobacco-free policy, some of the pilot site agencies work closely with contract agencies. It was unclear at the site visits as to whether the county tobacco-free policy is currently applied or enforced at these agencies. However, pilot sites did highlight opportunities to include and emphasize tobacco-free language within contracts to ensure that the county’s tobacco-free policy extends to contract agencies.
Additionally, Maricopa County allows agencies to obtain exemptions to the tobacco-free policy. While it did not appear that any of the pilot sites possessed such an exemption, moving forward it will be important to identify and address any exemptions that exist throughout the county correctional system.

Finally, despite county policy, there was evidence of frequent tobacco use outdoors at county facilities. These outdoor areas were often immediately outside of building entrances or within a short distance of the building, and did not appear to have exempt status. Accordingly, there is an opportunity to increase tobacco-free policy adherence and enforcement, as well as to review and revise any exemptions that may exist throughout the county correctional system.
Recommendations

Overview:
The following section contains recommendations based on the data presented within this report, the evidence base around tobacco cessation in JI populations, and the Behavioral Health and Wellness Program’s experience implementing tobacco cessation programming in other correctional settings.

The first set of recommendations pertains to possibilities to be explored throughout Year 1 of the project in association with the pilot. These recommendations include:

- Tobacco-Free Groups
- ASHLine Referrals
- Pharmacotherapy/NRT
- Tobacco-Free Policy Enforcement/Expansion
- Peer Programming

Based on the Year 1 recommendations, the second portion of this section provides an overview of related project next-steps such as workflow discussions, opportunities for training and education, evaluation, and the construction of the 5-year strategic plan.

Finally, this section concludes by introducing the Sequential Intercept Model to establish a basis for expanding cessation intervention efforts throughout Maricopa County during Years 2-5 of the project. The Sequential Intercept Model depicts the ways in which people typically move through the criminal justice system and suggests five “points of interception” that provide opportunities for intervention.

Year 1 Pilot:

Tobacco-Free Groups:
Group interventions are an important counseling modality used to help motivate individuals to change. Tobacco-free groups offer an effective intervention to promote and achieve tobacco cessation. Tobacco-free groups have been found to have associated quit rates between 7-13% within the general population (Fiore et al., 2008), and tobacco-free groups are also effective within JI populations. For example, one study found that JI individuals mandated to tobacco cessation treatment received a therapeutic benefit if they attended at least 3 sessions of a 6-session group intervention (Garver-Apgar et al., 2017). Throughout the study, 39% of the entire sample (n=962) reported at least one quit attempt during the intervention. In addition, between session 1 and session 6, the number of tobacco users who reported using tobacco more than 11 times per day decreased. This decrease indicates an increased likelihood that these individuals will be capable of quitting tobacco in the future (Broms, Korhonen & Kaprio, 2008).
All potential pilot sites already offer various forms of group therapy. It is recommended that pilot sites leverage this skillset to institute the DIMENSIONS: Tobacco-Free Group. More information about this group can be found in the discussion below regarding project next-steps.

**ASHLine Referrals:**
Within the general population, quitline counseling can more than double a smoker’s chances of quitting, and quitline counseling combined with medication can more than triple the chances of quitting (Anderson & Zhu, 2007; Stead, Perera, & Lancaster, 2007). Quitlines also have the potential to overcome common barriers to healthcare access like transportation and the cost of both counseling and cessation medications (Zhu et al., 2000). However, far too few smokers avail themselves of this service despite media campaigns targeting socio-economically disadvantaged populations. In fact, less than 1% of all smokers access counseling or medication assistance through quitlines (North American Quitline Consortium, 2015).

In Arizona, the ASHLine provides quitline services for the state, including 12 weeks of free Quit Coaching and, for eligible individuals, 4 weeks of free nicotine gum, patches, or lozenges. The ASHLine can be reached by calling 1-800-556-6222 or by texting “NO SMOKE” to 74079. Referrals to the ASHLine are quick, easy, and free.

Despite the availability of the ASHLine, very few staff at the pilot sites reported knowledge around ASHLine referrals. This is not unique to Arizona. Across the U.S. quitlines have limited reach for the JI population. However, research is beginning to explore the ways that quitline services can provide improved services for this population. For instance, Greenbacker and associates (2017) worked with the quitline in Pennsylvania to tailor services to the JI population. This work included reviewing the quitline intake procedure to eliminate questions that were not applicable to individuals in correctional settings. Additionally, this study found that quitline services for JI individuals could be improved if the JI were assigned to work with a designated quitline coach. A designated coach is important given the limited time and resources for quitline calls within the JI population, whether due to restrictions on call times in correctional settings or a limited number of phone minutes within the community. Additionally, designated coaches can be trained to tailor counseling to the JI population, ensuring that appropriate coping techniques and resources are provided (Greenbacker et al., 2017).

It is recommended that Maricopa County utilize the JI program to strengthen the relationship between corrections agencies and the ASHLine. Corrections staff could be provided with brief training around ASHLine referrals (such as that provided within the DIMENSIONS: Tobacco-Free Advanced Techniques training). Additionally, discussions around integrating tobacco cessation programming into site workflows should specifically incorporate ASHLine referrals.

**Pharmacotherapy/NRT:**
When people stop using tobacco products and the amount of nicotine in their body decreases, they experience withdrawal symptoms. Withdrawal symptoms can make people so uncomfortable that they often relapse and begin to use again. Cessation medications help to alleviate nicotine withdrawal, mimic the effects of nicotine, and block the effects of nicotine.
Therefore, cessation medications help make people more comfortable while they are working to change their smoking behavior or habit.

The use of pharmacotherapy increases the likelihood of tobacco cessation in the general population (Fiore et al., 2018). In addition, the use of pharmacotherapy has been proven to be effective within the JI population. In fact, a recent systemic review of studies involving cessation interventions for incarcerated adults and/or prison staff found that cessation interventions that include a pharmacological component are particularly effective (de Andrade & Kinner, 2017). Moreover, JI individuals in community corrections are interested in pharmacotherapy for tobacco cessation (Cropsey et al., 2010).

However, NRT and other pharmacotherapy for cessation are difficult for the JI to access. For instance, in jails NRT sold in commissaries can cost more than what a prisoner can earn in a single month (Kauffman et al., 2011). Even when NRT is offered at a low, subsidized price within the community, the JI are unlikely to purchase these medications (Puljevic et al., 2017). However, offering cessation medications for free may increase abstinence rates (Turan & Turan, 2016). Therefore, where possible, the Behavioral Health and Wellness Program would recommend providing free NRT to JI individuals or, at a minimum, connecting JI individuals with resources like the ASHLine that provide free NRT.

Often, individuals are unsuccessful with NRT or discontinue its use because they do not know how to dose or administer NRT properly. This is equally true of the JI population and the general population; only 50% of participants were medication adherent in one study where individuals in community corrections received free NRT (Cropsey et al., 2015). Therefore, it is essential not only to provide NRT, but additionally to properly train corrections staff and JI individuals on dosing recommendations and the proper use of NRT. Preliminary research demonstrates that such NRT training in JI populations increases medication adherence, and consequently increases the likelihood of cessation (Cropsey et al., 2017). The Behavioral Health and Wellness Program will work closely with Maricopa County to provide the training and information that correctional staff require to help the JI in properly using NRT and other cessation pharmacotherapy. This training will include the DIMENSIONS: Tobacco-Free Advanced Techniques training, which provides an introduction to the use of NRT and other cessation pharmacotherapy.

**Tobacco-Free Policy Enforcement/Expansion:**
Workplace bans on tobacco products encourage people to reduce the amount of tobacco they use each day and to increase successful quit attempts. A 2010 systematic review concluded that workplace tobacco-free policies were associated with significant decreases in tobacco use and increases in tobacco cessation (Callinan et al., 2010). Moreover, tobacco-free work environments lead to an average 72% reduction in secondhand smoke exposure (Stolz et al., 2014; Ham et al., 2011; Task Force on Community Preventative Services, 2000; Task Force on Community Preventative Services, 2005). Studies have also found that tobacco-free policies significantly reduce secondhand smoke exposure among incarcerated individuals.
However, the success of tobacco-free policies is largely contingent on policy adherence and enforcement. Problems with tobacco-free policies within correctional settings tend to be related to lax or inconsistent enforcement as well as the unequal treatment of staff and inmates (Cork, 2012). Therefore, a tobacco-free policy in a correctional setting may be undermined if exemptions permit smoking in designated areas or, alternatively, if staff members – but not JI individuals – are allowed to continue using tobacco on the agency grounds.

Generally, supervisors are responsible for implementing and enforcing an agency’s tobacco-free policy. However, leadership must make it clear that it is everyone’s job to create a healthy work environment, and a healthy work environment includes policy enforcement. Supervisors as well as staff can be trained to use scripts to provide information regarding the policy in a non-confrontational manner.

It is recommended that Maricopa County and the Behavioral Health and Wellness Program assist corrections sites to craft a tobacco-free policy message for their agency if one does not already exist. For sites that already have policies, messaging should be revisited and redistributed. The policy should emphasize the benefits of a tobacco-free policy for both employees and JI individuals. Sites might contact key partners and neighbors to reinforce the message, and recruit partners to help with policy enforcement. Moreover, agencies can provide their staff ongoing education around effective policies, including progressive consequences in response to policy violations – both for employees and the JI.

Additionally, sites can be urged to consider additional ways to communicate and reinforce their tobacco-free policy. They might add highly visible tobacco-free signage to areas where tobacco products are commonly used. Sites might also consider removing elements that make an environment convenient for tobacco use, like trash cans with ash trays, to make the area less accommodating to tobacco use.

As the Behavioral Health and Wellness Program helps pilot sites to implement tobacco cessation strategies, discussions around tobacco-free policy enforcement and expansion will be an important part of this process. The DIMENSIONS: Tobacco-Free Policy Toolkit is a readily available toolkit containing resources for tobacco-free policies and policy enforcement, including frequently asked questions, sample guidelines for enforcement, and tools to craft a tobacco-free policy message.

Peer Programming:
Peer specialists (e.g. peer recovery coaches, peer navigators, peer community health workers) complement other professional services by providing a unique perspective and skill set. These individuals have a lived experience such as having a behavioral health condition or having a history of homelessness or criminal justice involvement.

According to the Center for Substance Abuse Treatment (2009), “peer recovery support services fill a need long recognized by treatment providers for services to support recovery
after an individual leaves a treatment program. They hold a promise as a vital link between systems that treat substance use disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live.” Therefore, peer specialists are a critical component of a recovery oriented system of care and are an important augmentation to provider-driven strategies. Peers are often able to provide services in a less threatening way, and individuals report high satisfaction with peer delivered services (Davidson & Rowe, 2008; Rowe et al., 2007; SAMHSA, 2012; WHO, 2003).

There is growing evidence that peer-to-peer services are effective. Utilizing peer programming has begun to show significant success in criminal justice populations and many corrections systems are beginning to adopt peer models (Ashcroft & Anthony, 2011). This cost effective and innovative method is currently being used to deliver tobacco cessation services in corrections systems in California and in community-based settings across the nation (Behavioral Health and Wellness Program, 2012).

Maricopa County is already an innovator in its use of peer specialists for the Peer Navigator and Thinking for a Change (T4C) Programs. Using a “warm transfer” model, the JI are paired with a peer navigator to help them settle into the community upon reentry. Findings indicate a reduction in recidivism for people who received a referral to the program. Additionally, organizations within the community - such as Hope Lives - offer a variety of peer supports for the JI.

It is recommended that Maricopa County leverage the peer support services that already exist throughout the county by training peers in evidence-based tobacco cessation strategies and ways in which to integrate tobacco cessation within their current work. The county and corrections agencies might further consider in what locations or settings peer support services may be implemented to bolster tobacco cessation across the correctional system.

**Year 1 Next Steps:**

**Pilot Site Workflow Discussions - November 2017 – Early 2018**

Given pilot site buy-in, their interest in implementing tobacco cessation programming, and the current use of groups across sites, the Behavioral Health and Wellness Program recommends implementing the DIMENSIONS: Tobacco-Free Group at each of the pilot sites. However, prior to conducting training for this program Maricopa County and the Behavioral Health and Wellness Program will hold discussions with each of the pilot sites to discuss the integration of the Tobacco-Free Group within their current workflows, as well as to help to determine which employees should be trained to facilitate tobacco cessation groups. These workflow discussions could take place remotely via conference call or web-based video conferencing. However, in-person discussions are recommended to continue to build buy-in, to continue momentum around the project, and to ensure that a realistic work plan is constructed for each site.
DIMENSIONS: Tobacco-Free Advanced Techniques Training - March 19-20, 2018

DIMENSIONS: Tobacco-Free Advanced Techniques is an innovative 1.5 day program that is designed to train administrators, health professionals, counselors, and peers to assist individuals to envision and to achieve their personal tobacco-free goals. The training consists of education on understanding tobacco addiction, tobacco cessation strategies, motivational interventions for tobacco cessation, and how to facilitate the Tobacco Free Group—a 6-session group for tobacco cessation. The training includes:

- Module 1: Tobacco Use (JII-Specific)
- Module 2: Understanding Tobacco Addiction
- Module 3: Tobacco Cessation Strategies
- Module 4: Motivational Intervention for Tobacco Cessation
- Module 5: Tobacco-Free Group

The Tobacco-Free Group is designed to be an open, rolling group structure. The Tobacco-Free Group builds participant awareness about the importance of a healthy lifestyle and creates positive social networks. Through wellness education, group discussion, and associated activities, the group provides a supportive environment to facilitate quitting among JII individuals. All Tobacco-Free Group materials have been translated into Spanish. The Tobacco-Free Group includes:

- Session A: Creating a Plan
- Session B: Healthy Behaviors
- Session C: The Truth about Tobacco
- Session D: Changing Behaviors
- Session E: Coping with Cravings
- Session F: Maintaining Change

The DIMENSIONS: Tobacco-Free Advanced Techniques training is based on a train-the-trainer model, meaning that participants leave the training with the materials and knowledge to prepare other trainers at their agency to facilitate tobacco cessation groups. Each DIMENSIONS training can accommodate up to 50 individuals. Therefore, Maricopa County Public Health and the Behavioral Health and Wellness Program will work with pilot sites and other project partners to determine which organizations should have prioritization at the March training.

Opportunities for Continuing Education:

Pilot sites are both prepared for and enthusiastic about integrating tobacco cessation into their workflows. It is integral to capitalize on this enthusiasm and momentum to drive the project forward. Therefore, continuing learning opportunities will be offered through mediums such as project webinars and the project newsletter. These learning opportunities will keep the pilot sites engaged with the project and will prime the pilot sites for further planning and program implementation in 2018.
The first Justice-Involved Tobacco Cessation Project webinar was held on October 30, 2017. The webinar, titled “Tobacco Cessation: Opportunities for Maricopa County”, expanded on the evidence base for tobacco cessation in JI populations, reviewed the results of the Staff Knowledge and Attitudes Survey, and provided an overview of recommendations and project next-steps. It is anticipated that the next webinar and/or training will cover the provision of pharmacotherapy for tobacco cessation, particularly NRT, and will review the evidence base for the use of NRT within JI populations. Additionally, the first project newsletter was released in early October 2017. This ongoing newsletter will be used to keep project stakeholders informed of progress, as well as to highlight relevant recent research and resources involving tobacco cessation in the JI population.

Evaluation:
The Behavioral Health and Wellness Program will work with the Maricopa Department of Public Health and pilot sites to develop an evaluation plan for the project. The evaluation framework may be comprised of two primary components. The first component would feature a process evaluation. The evaluative work associated with this component has already begun with the collection of call notes, meeting notes, and qualitative data from interviews and site visits. The second evaluation component could incorporate measures and indicators that are selected based on input from pilot sites, Maricopa County Public Health, and the Justice-Involved Tobacco Cessation Workgroup. These indicators would likely incorporate program participation, health outcomes, and recidivism outcomes.

Most importantly, the goal for any evaluation plan would be to create an evaluation framework that is self-sustaining and low-burden. Such a framework would permit Maricopa County corrections agencies to assume and continue the evaluation work upon the termination of the project.

5-Year Strategic Plan:
Based the various assessments, site visits, workflow discussions, and other inputs, the Behavioral Health and Wellness Program will draft a 5-Year Strategic Plan for tobacco cessation. This plan will include:

• Executive Summary
• Synthesized Findings
• Recommended Intervention Points across the Justice Continuum
• Recommended Interventions and Programming (including a logic model and timeline)
  o Whole Health Framework
  o Staged Interventions Based on Organizational Readiness for Change
  o Evaluation and Outcome Standards
• Pilot Project Recommendations
  o Training
  o Evaluation Plan
  o Sustainability and Scalability Plan
• Suggested Next Steps
The Behavioral Health and Wellness Program is currently working to determine additional information and inputs that will be required to draft the Strategic Plan.

Project Years 2-5:
The Sequential Intercept (SI) Model provides a conceptual framework for collaboration between the criminal justice and other treatment systems to methodically address and reduce criminalization and recidivism. The model depicts the ways in which people typically move through the criminal justice system and suggests a series of "points of interception," or opportunities for intervention. Thus, the SI model can help to identify points of intervention for Maricopa County’s tobacco cessation and whole health programming.

For Year 1, the identified pilot project sites are primarily concentrated within Intercepts 3-5. However, there are opportunities to integrate tobacco cessation programming throughout the county correctional system. Indeed, most people would ideally be intercepted during the early points of interception (Munetz & Griffin, 2006). Therefore, as part of the 5-year strategic planning process, it is recommended that Maricopa County explore options to integrate tobacco cessation across all Intercepts throughout project Years 2-5.
Appendices

Related BHWP Programming:

The Rocky Mountain Tobacco Treatment Specialist (RMTTS) Training Program
The RMTTS Training program provides interdisciplinary healthcare and public health professionals the highest quality tobacco treatment training. Currently, RMTTS is one of 13 national programs accredited by the Association for the Treatment of Tobacco Use and Dependence (ATTUD).

RMTTS consists of an interactive, 4-day course designed for interdisciplinary healthcare professionals, patient navigators, community health workers, and peer specialists who desire a concentrated learning experience. The curriculum focuses on the knowledge, clinical skills, and evidence-based treatment strategies needed to effectively treat tobacco dependence. The curriculum also facilitates trainee mastery of the ATTUD Core Competencies & Skill Sets.

RMTTS is offered twice per year at the University of Colorado Anschutz Medical Campus. RMTTS may also be administered onsite in other states. Each RMTTS training can accommodate up to 50 trainees.

DIMENSIONS: Peer Specialist Trainings
The DIMENSIONS: Peer Support Program Toolkit and related consultation is designed for use by organizations that serve populations who would benefit from a peer support program, such as the JJ population. This training provides evidence-based information to help organizations understand the value of adding peer specialists to their teams, as well as practical tools and step-by-step instructions to plan for, implement, and sustain a successful peer support program.
DIMENSIONS: Well Body

JI individuals often face factors that make wellness difficult to achieve, including movement restriction, limited access to healthy foods, and the general stress of incarceration. A program such as Well Body can therefore help JI individuals strategize ways to maintain a well body and to set wellness goals within a restricted system and during transition into the community. Additionally, studies within correctional settings have found that JI individuals commonly set goals for tobacco cessation that are related to overall health and wellness, and suggest that behavior change like tobacco cessation may be bolstered by also addressing other tangential behaviors (van den Berg et al., 2016). In fact, one study that tracked prisoners’ change in health perceptions throughout a cessation program found that prisoners commonly highlighted an increase in their exercise tolerance, improvements in overall health, the restoration of their ability to taste food, and an acknowledgement of their stress levels (Muir, 2016).

The DIMENSIONS: Well Body Program is intended to provide administrators, healthcare providers, and peer specialists the necessary knowledge and skills to promote physical health and well-being. This innovative program provides training on strategies for healthy eating, healthy activity, healthy sleep, and decreased stress, as well as ways to promote positive behavior change through motivational engagement and behavior change strategies.

In each training module, problems associated with deficits in each of these areas are discussed as well as strategies to improve habits and health behaviors. After establishing the scientific background and providing strategies for improving health in each of these areas, the program focuses on the development and practice of motivational skills to help individuals choose healthy behaviors, using Motivational Interviewing and the DIMENSIONS: Well Body Motivational Intervention. Finally, trainees are instructed on how to facilitate the DIMENSIONS: Well Body Group, applying the evidence-based information taught throughout the program. The 6-session Well Body Group curriculum includes the following group topics: The Whole Well Body, The Mindful Well Body, Well Body Essentials, Well Body Wisdom, The Well Body Journey, and Maintaining a Well Body.

The broader community benefits from the release of individuals with health knowledge, positive health behaviors, fewer communicable diseases, self-efficacy, and a lower probability of recidivism. (Kim et al., 1997; Glaser & Greifinger, 1993; Hammet, Roberts, & Kennedy, 2001; Conklin, Lincoln, & Tuthill, 2000). Rehabilitation of the justice involved population is possible and may be more likely with health education, programming, and services (Andrews & Bonta, 2010).
DIMENSIONS: Motivational Interviewing for Health Behavior Change Levels 1 & 2

MI has been found to be effective within the JI population (Clarke et al., 2011; Jalali et al., 2015; van den Berg et al., 2016). Although many staff members report current knowledge of MI, additional training to hone skills and to train MI for tobacco cessation specifically offers an opportunity to enhance cessation programming throughout the Maricopa County correctional system.

Motivational Interviewing for Behavior Change Level I is a two-day intensive training during which participants learn the fundamentals of MI. Participants are guided through a sequence of learning activities to support the development of proficiency in the application of MI. Through activities designed to facilitate a deep understanding of the core MI concepts, participants have an opportunity to practice and implement basic MI skills and strategies to reinforce their learning.

Motivational Interviewing for Behavior Change – Level II is a two-day intensive training that focuses on advanced application of MI for health care and public health professionals, including methods for:

- Strategically eliciting and strengthening change and commitment talk
- Decreasing and managing discord
- Deepening skills of engagement and evocation

This dynamic and experiential training features didactic material, trainer demonstrations, real-play exercises, and audio (or video) recorded practice, coding, and self-evaluation. Enrollment is limited to 30 people.
References:


Morris, C., Miller, B., & Mahalik, J. (2011). An expanded opportunity to provide tobacco cessation services in primary care. *Translational Behavioral Medicine, 1*(1), 31-34.


