Smoking Cessation Leadership Center

UCSF

University of California San Francisco

Part Two of the Justice Involved Webinar Series: Access to Tobacco Treatment for the Justice-Involved: The Intersection of Policy, Practice, and Research

Kerry Cork, JD, Managing Legal Editor and Lead Senior Staff Attorney, Public Health Law Center

Allison Gorrilla, MPH, Outreach Specialist, University of Wisconsin's-Center for Tobacco Research and Intervention

Christine Ullstrup, LCSW, CSAC, Special Projects Advisor, Meta House

Pamela Valera, PhD, MSW, NCTTP, Assistant Professor, Department of Urban-Global Public Health and Ph.D. Director, School of Public Health, Rutgers University, the State University of New Jersey

July 20, 2023

Moderator

Brian Clark

Senior Data and Project Analyst

Smoking Cessation Leadership Center
University of California, San Francisco

A National Center of Excellence for Tobacco-Free Recovery

Brian.Clark@ucsf.edu

Disclosures

This UCSF CME activity was planned and developed to uphold academic standards to ensure balance, independence, objectivity, and scientific rigor; adhere to requirements to protect health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and include a mechanism to inform learners when unapproved or unlabeled uses of therapeutic products or agents are discussed or referenced.

All speakers, planning committee members and reviewers have disclosed they have no relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Catherine Bonniot, Anita Browning, Christine Cheng, Brian Clark, Allison Gorrilla, MPH, Kerry Cork, JD, MA, Jennifer Matekuare, Chad Morris, PhD, Ma Krisanta Pamatmat, MPH, CHES, Jessica Safier, MA, Christine Ullstrup, LCSW, Pamela Valera, PhD, and Maya Vijayaraghavan, MD, MAS.

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- **Free CME/CEUs** will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Prevention Program (CTPP)
- For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.
- For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.

- CDC Tips Campaign 2023
- Find resources at:

  https://www.cdc.gov/tobacco/campaign/tips/index.html

Today's Presenter

Allison Gorrilla, MPH

Outreach Specialist,

University of Wisconsin's Center for Tobacco Research and Intervention

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Assistant Professor, Department of Urban-Global Public Health and Ph.D. Director, School of Public Health

Rutgers University, the State University of New Jersey

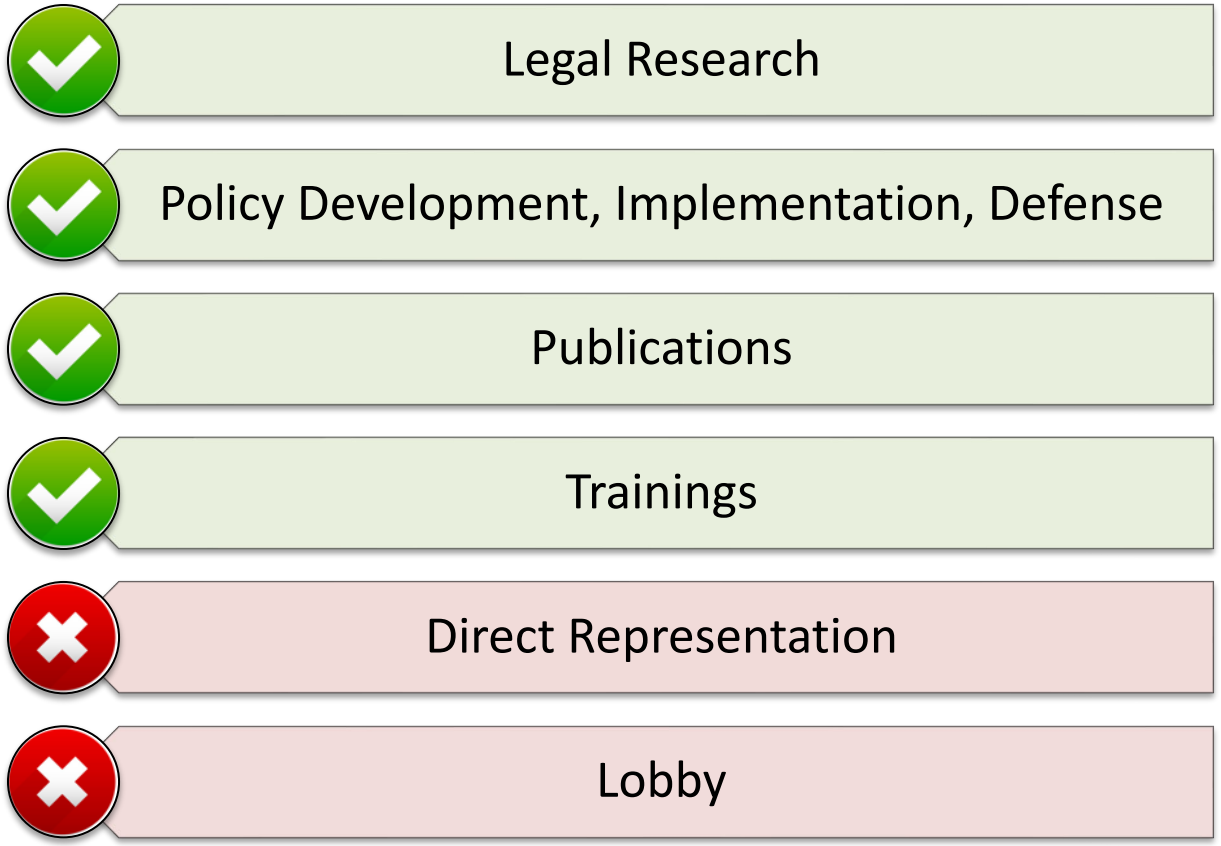
TREATING TOBACCO USE IN THE JUSTICE-INVOLVED POPULATION

Legal Rights and Policy Implications

PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

THE PUBLIC HEALTH LAW CENTER

LEGAL TECHNICAL ASSISTANCE



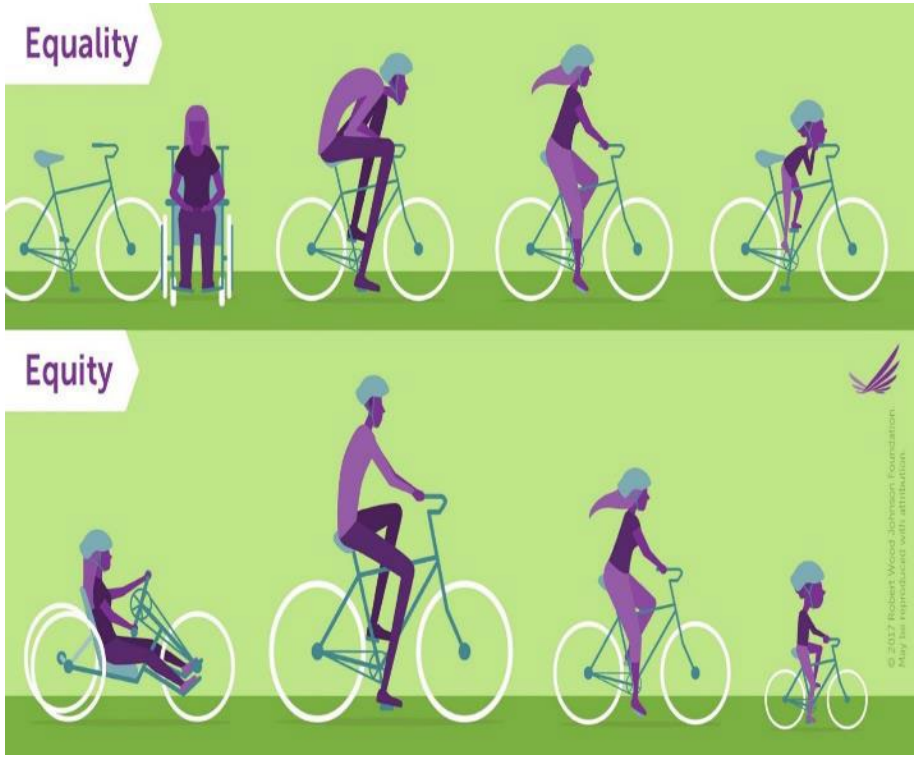


Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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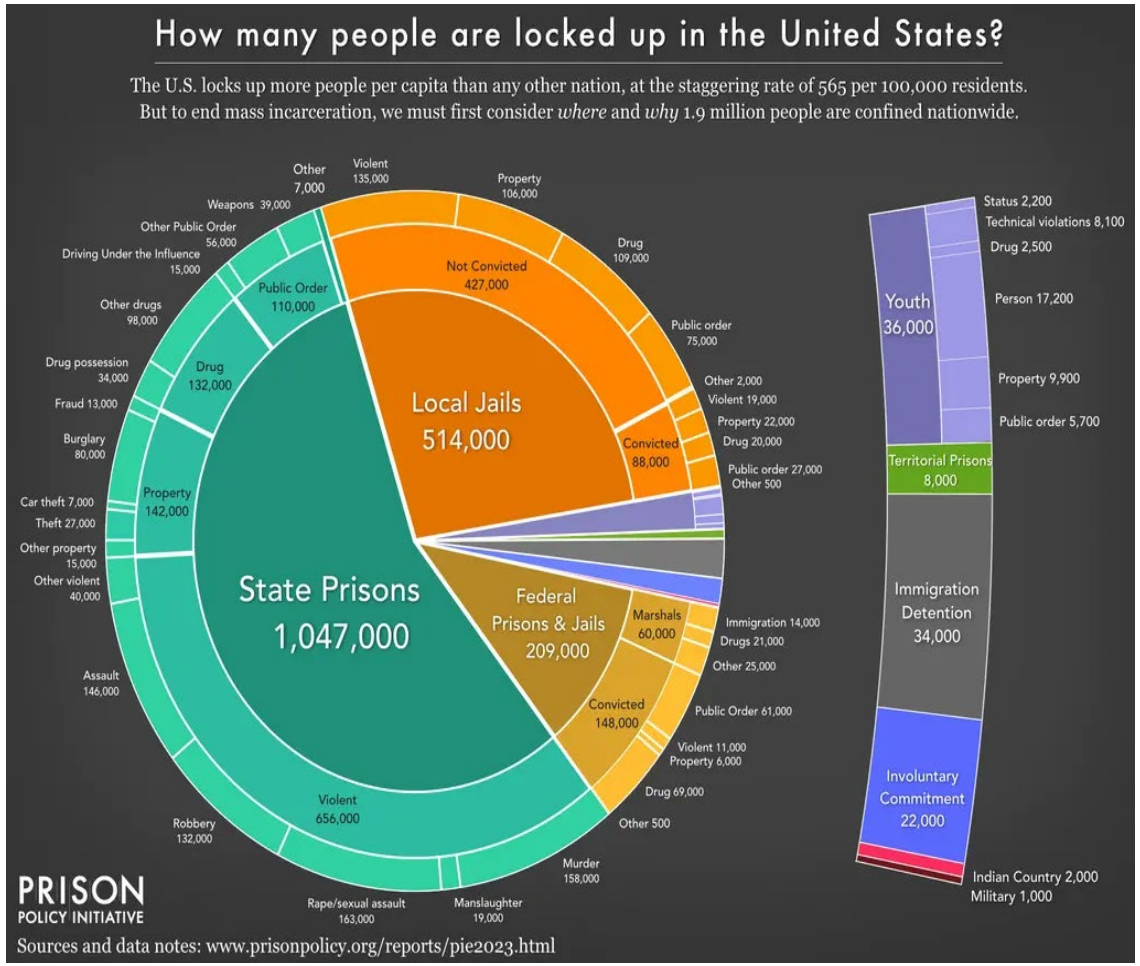
AGENDA

- Overview
- Legal Framework
  - Legal rights
  - Legal duties
- Treatment Implications
  - Treatment barriers
  - Treatment considerations
- Key Takeaways

OVER 2 MILLION PEOPLE INCARCERATED IN U.S.



Prison Policy Initiative, Mass Incarceration: The Whole Pie (March 2023)

PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law

HEALTH EQUITY ISSUE

- Majority of those incarcerated are of low socio-economic status
- Ethnic/racial populations starkly overrepresented
- Over 70% of the US correctional population has an addiction and/or mental illness.
- High number of individuals with chronic and infectious diseases (primarily heart disease, respiratory disease, and cancer)
- **Studies estimate between 70 and 80 percent of all individuals in the U.S. justice system smoke or use tobacco products – up to 4 times the national average.**

CHRONIC ILLNESS & CAUSE OF DEATH

TABLE 2
Number of deaths of state and federal prisoners, by cause of death, 2001–2019

Cause of death	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total	3,170	3,270	3,498	3,456	3,556	3,561	3,757	3,851	3,793	3,620	3,738	3,707	3,878	3,928	4,163	4,122	4,335	4,515	4,234
Federal[a]	301	335	346	333	388	328	368	399	376	387	387	350	400	444	455	388	381	378	381
State[b]	2,869	2,935	3,152	3,123	3,168	3,233	3,389	3,452	3,417	3,233	3,351	3,357	3,478	3,484	3,708	3,734	3,954	4,137	3,853
Illness	2,567	2,616	2,830	2,783	2,817	2,830	2,980	3,036	3,027	2,865	2,979	2,959	3,081	3,032	3,251	3,202	3,273	3,282	3,044
Heart disease	743	803	801	842	835	854	840	845	850	830	854	804	897	896	994	1,029	1,101	1,055	1,038
Cancer	691	681	811	733	805	806	772	907	978	927	1,028	1,024	1,065	1,050	1,125	1,130	1,112	1,139	1,082
Liver disease	307	296	306	283	318	303	316	318	332	288	339	304	355	313	304	261	245	214	141
AIDS-related[c]	275	241	209	147	156	132	120	99	98	73	57	74	52	64	45	31	37	22	17
Respiratory disease	147	163	200	199	213	196	207	251	200	212	205	223	198	238	243	222	253	290	235
All other illnesses[d]	404	432	503	579	490	539	725	616	569	535	496	530	514	471	540	529	525	562	531
Suicide	168	168	199	199	213	219	215	197	202	215	185	205	192	249	219	254	261	312	311
Drug/alcohol intoxication	35	37	23	22	37	56	41	58	51	41	58	33	56	50	81	105	203	253	253
Accident	22	29	26	34	28	32	28	26	32	32	38	50	34	39	41	41	44	43	32
Homicide[e]	39	48	49	49	56	55	57	40	54	70	70	85	90	83	83	96	114	124	143
Other causes	0	0	25	36	17	41	16	95	17	7	12	14	18	10	20	23	28	38	28
Missing/unknown	38	37	0	0	0	0	52	0	34	3	9	11	7	21	13	13	31	85	42

Note: Data may have been revised from previously published statistics. Excludes executions. For execution data, see *Capital Punishment, 2019 – Statistical Tables* (NCJ 300381, BJS, June 2021). See *Methodology*.
[a]Until 2015, federal deaths were submitted as an aggregate count by the Federal Bureau of Prisons (BOP), with limited details regarding cause of death, and excluded deaths in private federal facilities. See table 10 for deaths from 2015 to 2019 in federal prison facilities operated by the BOP or operated privately under a BOP contract.
[b]Includes deaths in private state facilities.
[c]Includes persons who died of illness and were identified as HIV-positive or having AIDS at the time of death.
[d]Includes other specified illnesses (such as cerebrovascular disease, influenza, and other nonleading natural causes of death) and unspecified illnesses.
[e]Includes homicides committed by other prisoners, incidental to the use of force by staff, and resulting from assaults sustained prior to incarceration.
Source: Bureau of Justice Statistics, Mortality in Correctional Institutions, 2001–2019; and Federal Bureau of Prisons, 2001–2019.

LEGAL RIGHTS ISSUE

- Constitutional protection under 8th Amendment against "Cruel and Unusual Punishment"
- Claims can be filed in federal court and are applicable to states through the due process clause of the 14th Amendment

KEY SUPREME COURT CASE - 1

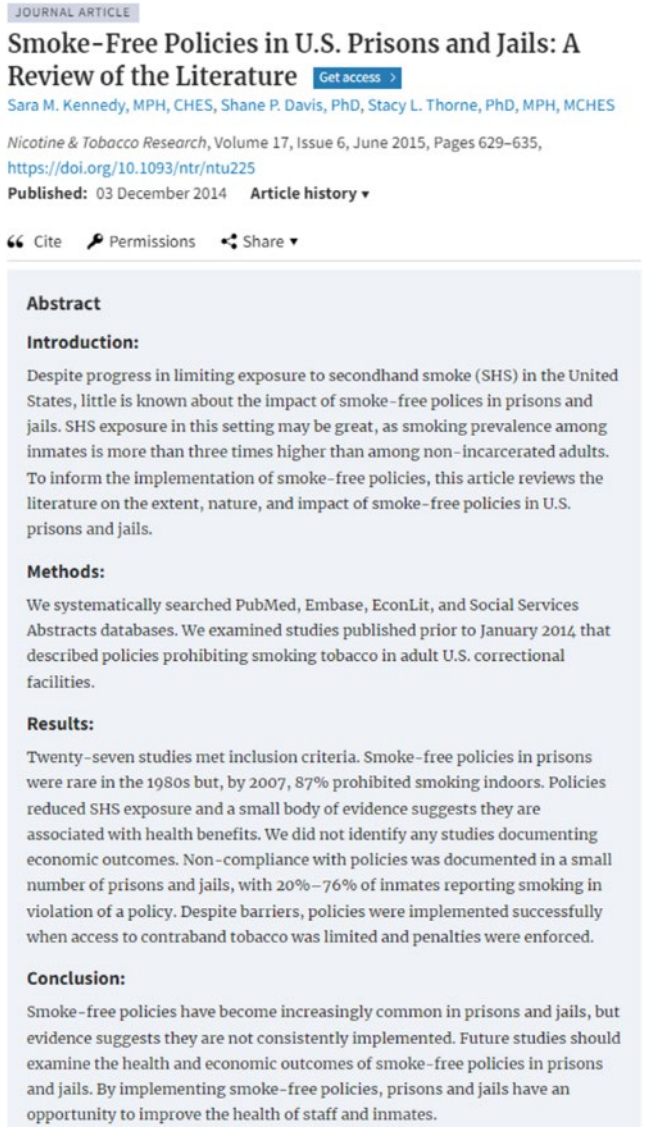
Estelle v. Gamble, 429 U.S. 97 (1976)

- Deliberate indifference to the serious illness or injury of individuals who are incarcerated
- Constitutes **cruel and unusual punishment** contravening the 8th Amendment
  - "Unnecessary and wanton infliction of pain"
  - Evolving standards of decency; punishment must be exercised "within the limits of civilized standards"
- Affirmative duty to provide medical care & protect health and safety of those incarcerated

KEY SUPREME COURT CASE - 2

Helling v. McKinney, 509 U.S. 25 (1993)

- Involuntary exposure to second-hand smoke in prison
- Supports a valid cruel & unusual punishment claim if the risk to one's health is unreasonable and prison officials are indifferent to that risk



JOURNAL ARTICLE

Smoke-Free Policies in U.S. Prisons and Jails: A Review of the Literature Get access

Sara M. Kennedy, MPH, CHES, Shane P. Davis, PhD, Stacy L. Thorne, PhD, MPH, MCHES

Nicotine & Tobacco Research, Volume 17, Issue 6, June 2015, Pages 629–635,
https://doi.org/10.1093/ntr/ntu225
Published: 03 December 2014 **Article history**

Cite Permissions Share

Abstract

Introduction:

Despite progress in limiting exposure to secondhand smoke (SHS) in the United States, little is known about the impact of smoke-free polices in prisons and jails. SHS exposure in this setting may be great, as smoking prevalence among inmates is more than three times higher than among non-incarcerated adults. To inform the implementation of smoke-free policies, this article reviews the literature on the extent, nature, and impact of smoke-free policies in U.S. prisons and jails.

Methods:

We systematically searched PubMed, Embase, EconLit, and Social Services Abstracts databases. We examined studies published prior to January 2014 that described policies prohibiting smoking tobacco in adult U.S. correctional facilities.

Results:

Twenty-seven studies met inclusion criteria. Smoke-free policies in prisons were rare in the 1980s but, by 2007, 87% prohibited smoking indoors. Policies reduced SHS exposure and a small body of evidence suggests they are associated with health benefits. We did not identify any studies documenting economic outcomes. Non-compliance with policies was documented in a small number of prisons and jails, with 20%–76% of inmates reporting smoking in violation of a policy. Despite barriers, policies were implemented successfully when access to contraband tobacco was limited and penalties were enforced.

Conclusion:

Smoke-free policies have become increasingly common in prisons and jails, but evidence suggests they are not consistently implemented. Future studies should examine the health and economic outcomes of smoke-free policies in prisons and jails. By implementing smoke-free policies, prisons and jails have an opportunity to improve the health of staff and inmates.

SMOKING BAN IN ALL FEDERAL & STATE PRISONS

Missouri Prisoner Awarded $111,000 in Second-Hand Smoke Case, DOC Bans Smoking

Loaded on MARCH 5, 2019 by Derek Gilna published in Prison Legal News March, 2019, page 20
Filed under: Smoking. Location: Missouri.

by Derek Gilna

Share:

Ecclesiastical Denzel Washington, a former death row prisoner who is now serving a life sentence, won a jury verdict against the Missouri Department of Corrections (DOC) and various prison officials totaling $111,000. Following the April 2017 verdict, Washington negotiated a settlement banning the sale and consumption of tobacco and tobacco products in state prisons.

His lawsuit alleged that Missouri DOC officials subjected him to cruel and unusual punishment in violation of the Eighth Amendment by ignoring his individual medical management plan, which "required that he be placed in [a] smoke-free environment." Washington claimed that being housed with smokers exacerbated his asthma and bronchitis.

He attached to his *pro se* complaint an article from the *St. Louis Post-Dispatch*, which referenced a study by the U.S. Surgeon General entitled, "There is no safe level of secondhand smoke." Washington meticulously recorded every time prison staff failed to provide him the living environment that his health and their own policies required, and informed DOC officials that the smoking policies at the Crossroads Correctional Center – which prohibited prisoners from smoking inside their housing units – were not being followed. His complaints were ignored and he was repeatedly celled with other prisoners who smoked. As a result, the jury ruled in his favor at trial.

However, not only did he win a substantial monentary judgment, consisting of $40,000 in compensatory damages and $71,000 in punitive damages, he also followed through on his complaint with the assistance of appointed counsel to ensure that no other prisoners would suffer as a result of second-hand smoke. Given that there are over 30,000 prisoners in Missouri DOC facilities, this will result in major health benefits as well as reduced medical costs for smoking-related illnesses.

Pursuant to the settlement the district court entered an order stating, "the Missouri Department of Corrections shall, on or before April 1, 2018, amend its smoking policy to prohibit the sale, possession, and consumption of all tobacco products, except for authorized religious purposes, inside correctional buildings and on the grounds inside the correctional perimeter at all Department correctional centers ... and enforce such policy thereafter."

Further, the court awarded $152,276.51 in attorney fees, $4,911.81 in expenses and $4,492.70 in taxable costs. Washington was ordered to pay $11,100 toward the fees, representing 10 percent of his jury award, pursuant to the Prison Litigation Reform Act. See: *Washington v. Denney*, U.S.D.C. (W.D. Mo.), Case No. 2:14-cv-06118-NKL.

According to Washington's court-appointed counsel, Phillip Zeeck with the Polsinelli law firm, "This is a win ultimately for the people who work and live in Missouri's correctional facilities."

The smoking ban went into effect at all state prisons in April 2018, and prohibits smoking by prisoners, staff, contractors and visitors within the secure perimeter. DOC employees were provided free smoking-cessation products, such as nicotine patches, while prisoners could purchase such products from the commissary. Washington has since been transferred to an out-of-state prison for his own safety.

On August 12, 2018, the Eighth Circuit upheld the jury verdict and compensatory damages award but reversed the punitive damages, finding the defendants' conduct was not "outrageous, intentional, or malicious." The case was remanded for further proceedings. See: *Washington v. Denney*, 900 F.3d 549 (8th Cir. 2018).

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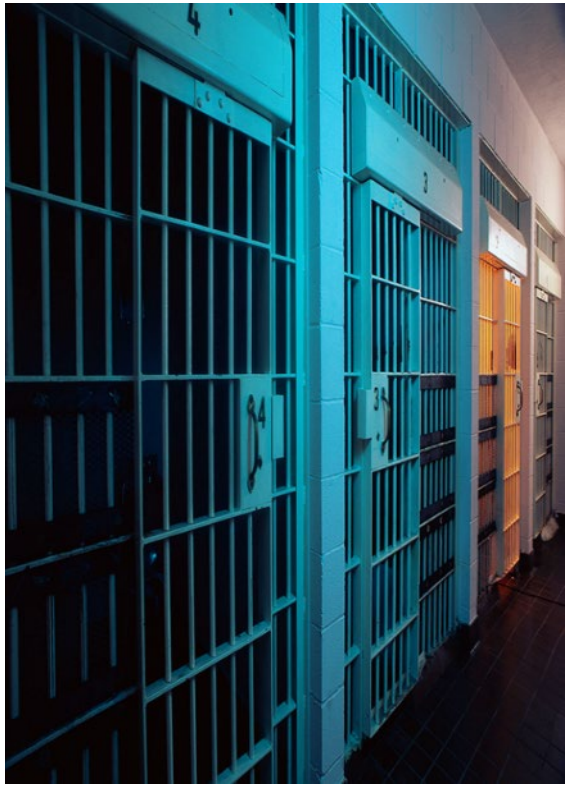
LEGAL CHALLENGES AGAINST TOBACCO POLICIES IN CARCERAL FACILITIES

- Constitutes cruel & unusual punishment
- Violation of due process
- Violation of equal protection
- Violation of right to free expression
- Unconstitutional taking of property

MOST CHALLENGES UNSUCCESSFUL



TRIBAL CHALLENGES

- Violation of right to exercise religion
  - Religious Land Use and Institutionalized Persons Act
  - 1st and 14th Amendments of U.S. Constitution
- Exemptions allow access to ceremonial tobacco

See *Federal Bureau of Prison, Program Statement: Religious Beliefs and Practices* (2004), https://www.bop.gov/policy/progstat/5360_009.pdf

BASIS FOR WITHDRAWAL MANAGEMENT CLAIMS

- Americans with Disabilities Act of 1990
- Rehabilitation Act of 1973
- State tort claims (e.g., medical malpractice, intentional infliction of emotional distress, wrongful death)

PROBLEM WITH LEGAL REMEDIES

- Focus on supportive treatment for specific withdrawal symptoms; little to no post-release support
- Jails / prisons often cite:
  - Preference for “drug-free” withdrawal
  - Concerns over diversion of medications
  - Lack of knowledge about treatment efficacy
  - Stigma against drug users

29 ANNALS HEALTH L. ADVANCE DIRECTIVE 231 (2020)

ABRUPT NICOTINE CESSATION: CRUEL & UNUSUAL PUNISHMENT?

- Nicotine withdrawal is a physical and psychiatric condition caused by substance dependence and merits treatment.
- Common Withdrawal Symptoms
  - Smoking urges/cravings; irritation, grouchiness
  - Jumpiness/restlessness; insomnia; hunger, weight gain;
  - Anxiety; sadness, depression

CDC, *Seven Withdrawal Symptoms*, https://www.cdc.gov/tobacco/campaign/tips/quit-smoking/7-common-withdrawal-symptoms/index.html; *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (2013)

FORMER DRUG ADDICT TESTIMONIAL

"I used to do a lot of different drugs and I did a lot of hard drugs. I did coke, crank, uppers and downers. Any illegal pharmaceutical I did. . . And ***I had a heroin addiction*** *one time and I had to go in rehab for three months to get over that, and then I did the opposite end of the spectrum and* ***I had stimulants, cocaine, and crank, methamphetamines, and that was easier for me to kick than smoking****."*

Cited in Public Health Law Center, *Tobacco Behind Bars: Policy Options for the Adult Correctional Population* (2012)

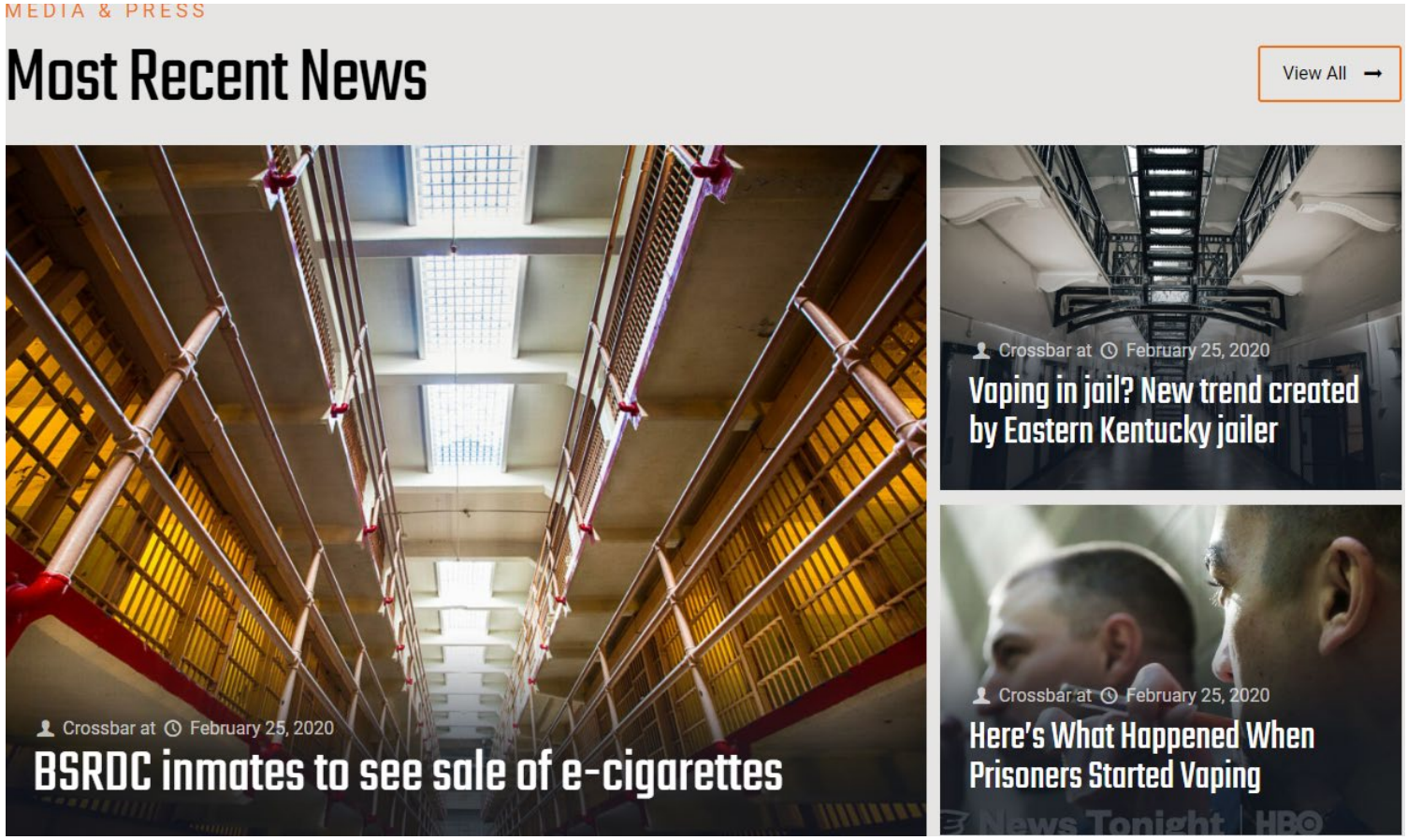
TREATMENT RATIONALE

Carceral environment = unique opportunity to address tobacco dependence among segment of population with disproportionately high health risks and tobacco use

TREATMENT CONSIDERATIONS / BARRIERS

- Released or discharged individuals at high risk of relapse shortly after incarceration ends
- Need for pre-release planning (e.g., referrals, post-treatment plans, follow-up with primary care providers; tobacco dependence treatment providers; quitline resources)
- Proven treatment (behavioral and pharmacological support) must begin in facilities and continue after release (e.g., participation in community treatment programs)

HOW SOME JAILS ADDRESS NICOTINE ADDICTION



BEST WAY TO TREAT NICOTINE ADDICTION?

PUBLIC HEALTH LAW CENTER
at Mitchell Hamline School of Law / E-CIGARETTES / August 2022

E-CIGARETTES IN STATE PRISONS & JAILS

Frequently Asked Questions

People who become incarcerated have higher commercial tobacco[1] use than the general public. Fifty eight percent of people entering prison use tobacco products, and 90 percent of them continue to use tobacco after their release.[2]

Prisons and jails can contribute to public health efforts to reduce tobacco use by providing smoking cessation services and maintaining and enforcing comprehensive tobacco-free policies.[3] This factsheet focuses on the current phenomenon of e-cigarette sales to people incarcerated[4] in state prisons and jails.[5] It describes how correctional institutions regulate and sell e-cigarettes, the types of e-cigarettes that prisons and jails market for sale to incarcerated people, and health concerns related to e-cigarette use.

www.publichealthlawcenter.org

ELECTRONIC CROSSBAR FOR CORRECTIONS CIGARETTES

KEY TAKEAWAYS

- Established legal right for those incarcerated to receive medical care and treatment
- Forced nicotine withdrawal in jails and prisons without corresponding cessation treatment and services unlikely to result in long-term abstinence post-release
  - Affirmative duty of care?
  - Analogous to opioid/other drug withdrawal treatment?
- Significant barriers in carceral setting and post-release (cost, standards, implementation, training, etc.)

AT THE SAME TIME . . .

- Jails and prisons have responsibility to provide nicotine addiction treatment and services to help justice-involved adults with nicotine withdrawal
- Studies have shown that integrating nicotine treatment with substance use and mental health treatment improved likelihood of long-term tobacco abstinence
- Tobacco/nicotine use treatment & services saves current & future health care costs, improves lives, and prevents deaths

CONTACT US


651.290.7506


kerry.cork@mitchellhamline.edu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META HOUSE
RECLAIMING WOMEN'S LIVES

META HOUSE

Ending the generational cycle of addiction by healing women & strengthening families

Who we serve

In 2022, Meta House served 317 women, 79 of whom were pregnant or postpartum, and 190 children.

At admission in 2022:

- 23% did not graduate high school
- 71% were unemployed
- 95% had an annual income of less than $20,000
- 57% were homeless or unstably housed

Who we serve …

- 82% had experienced abuse in their lifetime
- 86% had co-occurring mental health

- 84% had criminal justice in their lifetime
  - 42 %Currently on probation or parole

- 66% are mothers
  - 31% were involved with child welfare

Specialized Services for Pregnant Women

Meta House served 79 women who were either pregnant or had a baby under the age of one in 2022

- Nutrition
- Infant Mental Health, Parent/Child Relationship services
- Connection to prenatal care and MAT
- Transportation to medical appointments
- Parenting classes
- Connection to community resources

Full Continuum of Care

Residential

Treatment settings

Outpatient

→ Tiered outpatient program designed to meet each woman's specific needs

→ Treatment includes one-on-one and group therapies, vocation and education services, child and family services and case management

Recovery
Housing
Community

META HOUSE
RECLAIMING WOMEN'S LIVES

Smoking cessation program

→ In 2012, Meta House added nicotine to its list of addictive substances

→ All Meta House buildings went smoke-free

→ We maintain a smoke free campus

Outcomes

- For women who stayed in residential program for over 60 days
  - 95% of the women who smoked reduced their tobacco use or quit smoking

- For the women who stayed in outpatient treatment more than 90 days
  - **47%** of women who smoked reduced their tobacco use or quit smoking.

At admission

- In 2021, 72% of clients admitted were using nicotine in the 30 days before admission

- In 2022, 56% of clients were using nicotine in the 30 days before admission.

META HOUSE

RECLAIMING WOMEN'S LIVES

In Wisconsin

- As of October 2022
  - Administrative Code DHS 75.24 Requires substance use disorder treatment facilities to assess and treat tobacco use and have a policy about smoke-free environments.

how did we do it …

- Letter to staff
- Timeline in reduction at programs
- Start date and week
- Policies and Procedures that developed overtime
- Treatment planning

Questions?

Christine Ullstrup, LCSW, CSAC
Meta House
cullstrup@metahouse.org
www.metahouse.org

RUTGERS
BIOMEDICAL AND HEALTH SCIENCES

Tobacco Smoking and Smoking Cessation Treatment for People who are Incarcerated in State Prisons

Pamela Valera, PhD, MSW, NCTTP
Rutgers School of Public Health
Community Health Justice Lab
(www.chjl.org)

RUTGERS

Outline of Presentation

- Aim of the Study
- Methods
- Findings
- Discussion

RUTGERS

Aim of Study

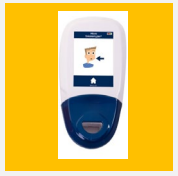
The purpose of this study was to describe the feasibility and acceptability of conducting a single arm 6-week group-based smoking cessation treatment (NRT and CO monitoring) with 1-month follow-up. A multi-site parallel study in 8-prison sites from May 2019 – September 2019.

RUTGERS

Methods

In person Group-based tobacco treatment counseling

Webex Group-Based tobacco treatment counseling



Carbon Monoxide Monitoring

1-month Follow Up

RUTGERS

Methods

- Used as an instrument to measure CO levels (ppm) in bloodstream
- Collected measurements every week prior to beginning sessions
- Reading of 0-4 ppm indicated that participant was a non-smoker
- Reading of 7-11 ppm suggested participant was a regular smoker

RUTGERS

Methods

NRT Patch Tapering Process [6-week (daily transdermal patch, approved by DOC)]

RUTGERS

Data Analysis

The primary outcome of tobacco abstinence is confirmed by expired CO in ppm at 7-day point prevalence abstinence (no smoking for 7 days), at 1-month follow-up, post-group treatment, using CO biochemical–verified abstinence, with <6 ppm.

When participants did not attend a treatment session, they were considered as continuing to smoke for data purposes.

The analysis of this study was undertaken in multiple steps to assure the integrity of variables and statistical models.

SAS version 9.4 was used to calculate descriptive statistics to summarize baseline characteristics of the total sample, those enrolled, and those who completed the program.

Chi-square tests were used to test for differences between those who completed the program and those who did not complete the program.

Findings – Demographics Characteristics

Variable	Total sample (n=177)	Completed Program (n=102)	Not Complete Program (n=75)	p-value
Current age	42.97 (10.29)	42.61 (10.64)	43.43 (9.88)	0.607
Gender				0.909
Male	167 (94.4)	96 (94.2)	71 (94.7)	
Transgender female	9 (5.1)	5 (4.9)	4 (5.3)	
Sexual orientation				0.224
Gay/homosexual/bisexual	8 (4.5)	3 (2.9)	5 (6.7)	
Heterosexual/straight	162 (91.5)	97 (95.1)	65 (86.7)	
Other	1 (0.6)	0 (0)	1 (1.3)	
State residence prior to incarceration				0.202
Northeast	156 (88.1)	87 (85.3)	69 (92.0)	
Midwest	1 (0.6)	1 (1.0)	0 (0)	
South	8 (4.5)	7 (6.9)	1 (1.3)	
West	1 (0.6)	1 (1.0)	0 (0)	
Current marital status				0.655
Single, never married	98 (55.4)	56 (54.9)	42 (56.0)	
Married	31 (17.5)	20 (19.6)	11 (14.7)	
Divorced/separated/ widowed	48 (27.1)	26 (25.5)	22 (29.3)	
Race/Ethnicity				0.552
Caucasian/White	111 (62.7)	66 (64.7)	45 (60.0)	
African American/Black	49 (27.7)	27 (26.5)	22 (29.3)	
Hispanic/Latinx	10 (5.6)	4 (3.9)	6 (8.0)	
Other	7 (4.0)	5 (4.9)	2 (2.7)	
Primary language spoken at home				0.127
English	167 (94.4)	99 (97.1)	68 (90.7)	
Spanish	2 (1.1)	0 (0)	2 (2.7)	
Both English and Spanish	6 (3.4)	2 (2.0)	4 (5.3)	
Other	1 (0.6)	0 (0)	1 (1.3)	
Highest level of education achieved				0.346
High school/GED or less	97 (54.8)	57 (55.9)	40 (53.3)	
Some college/technical school	62 (35.0)	31 (30.4)	31 (41.3)	
College degree	12 (6.8)	8 (7.8)	4 (5.3)	
Graduate degree	2 (1.1)	2 (2.0)	0 (0)	
Body Mass Index (BMI)				0.736
Normal	38 (21.5)	23 (22.5)	15 (20.0)	
Overweight	64 (36.2)	38 (37.3)	26 (34.7)	
Obese	29 (16.4)	14 (13.7)	15 (20.0)	

Findings – Incarceration Experience

Variable	Total sample (n=177)	Completed Program (n=102)	Not Complete Program (n=75)	p-value
Age of first incarceration	21.46 (8.76)	21.68 (8.57)	21.19 (9.04)	0.720
Months in prison for current incarceration	95.62 (109.19)	105.87 (126.27)	81.54 (78.69)	0.123
Charges for first time incarceration*				
Drug distribution offense	26 (14.7)	14 (13.7)	12 (16.0)	
Drug possession offense	25 (14.1)	13 (12.7)	12 (16.0)	
Property offense (e.g. theft, burglary, car theft, etc.)	50 (28.2)	33 (32.4)	17 (22.7)	
Fraud, embezzlement, or identify theft	3 (1.7)	2 (2.0)	1 (1.3)	
Rape, sexual assault	10 (5.6)	5 (4.9)	5 (6.7)	
Molestation	4 (2.3)	2 (2.0)	2 (2.7)	
Violence offense (e.g. battery, murder, manslaughter)	39 (22.0)	21 (20.6)	18 (24.0)	
Other	38 (21.3)	16 (15.7)	22 (28.9)	
Current employment in prison				0.404
Working	118 (66.7)	70 (68.6)	48 (64.0)	
Student	21 (11.9)	8 (7.8)	13 (17.3)	
Unemployed, but looking	20 (11.3)	13 (12.7)	7 (9.3)	
Disability	3 (1.7)	2 (2.0)	1 (1.3)	
Other	13 (7.3)	7 (6.9)	6 (8.0)	

Findings – Smoking Behaviors of incarcerated smokers

Table 4. Smoking behaviors of incarcerated smokers (n=177)

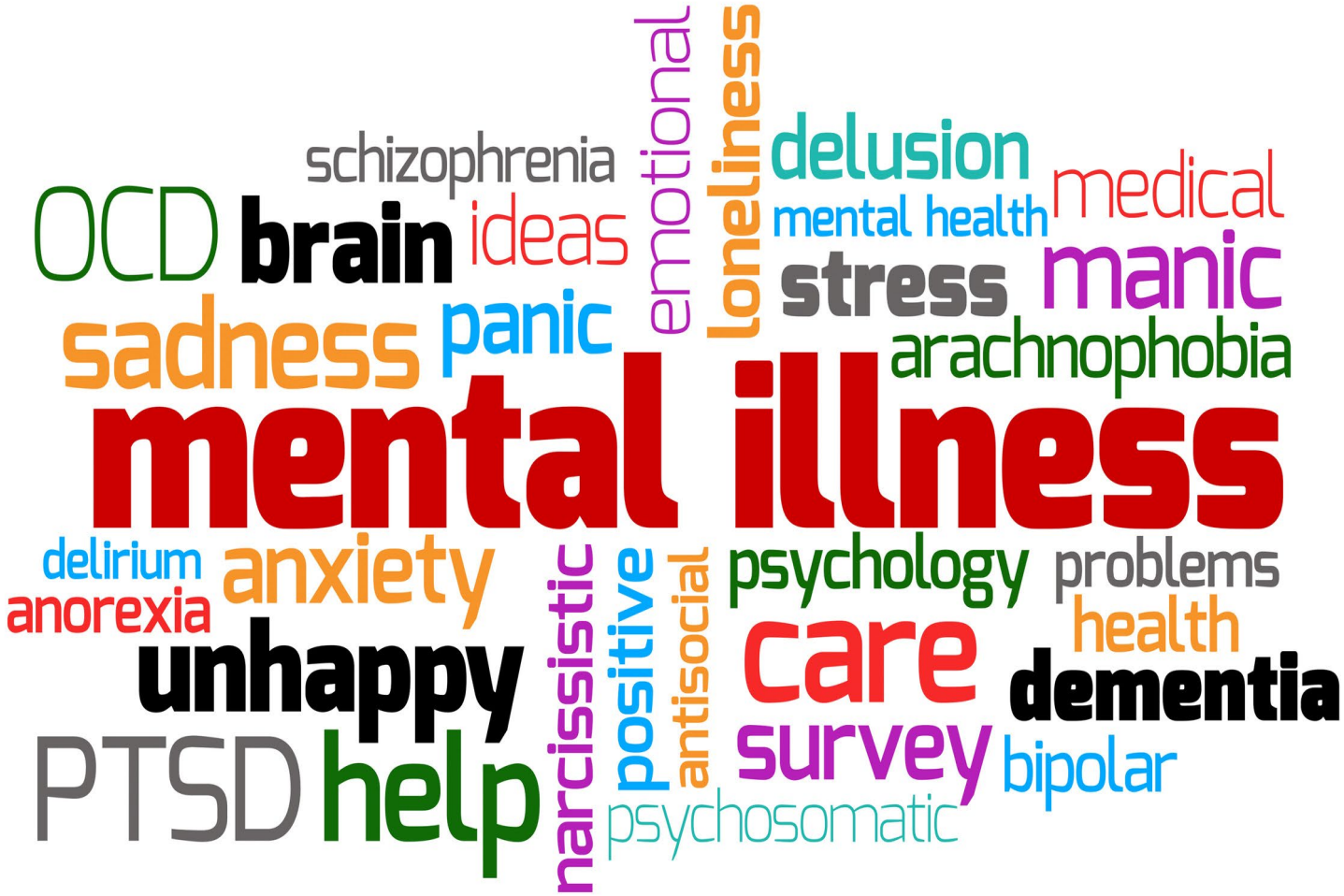
Variable	N(%) or Mean (SD)
Age first became a daily smoker	
Under 10	3 (1.7)
10-14 years old	68 (38.4)
15-19 years old	80 (45.2)
Over 20 years old	20 (11.3)
Number of years smoked cigarettes	26.65 (11.26)
Cigarettes smoked per day	
None	4 (2.3)
Fewer than 10	6 (3.4)
10-19 cigarettes	56 (31.6)
20 or more cigarettes	103 (58.2)
Butt out or relight cigarette	
Yes	118 (66.7)
No	55 (31.1)
Smoke menthol cigarettes	
Yes	149 (84.2)
No	27 (15.3)
Fagerstrom Test for Nicotine Dependence	
Low dependence	5 (2.8)
Low to moderate dependence	14 (7.9)
Moderate dependence	67 (37.9)
High dependence	81 (45.8)
Attempted quitting tobacco smoking for more than 24 hours	
Yes	98 (55.4)
No	56 (31.6)
Electronic cigarette ever use	
Yes	37 (20.9)
No	140 (79.1)
Smoking behavior since incarceration	
Started to smoke	15 (8.5)
Smoke more	99 (55.9)
Smoke less	17 (9.6)
Quit smoking	4 (2.3)
No change	37 (20.9)
Medical professional talk about quitting smoking	
Yes	110 (62.1)
No	60 (33.9)
Don't know	3 (1.7)

Findings – Withdrawals and Triggers

Variable	N(%)
Withdrawal Symptoms	
Agitation/irritability	119 (67.2)
Anger/hostility	78 (44.1)
Anxiety/nervousness	90 (50.8)
Craving	138 (78.0)
Difficulty concentrating	43 (24.3)
Fatigue	15 (8.5)
Disorientation	14 (7.9)
Frustration	104 (58.8)
Increased appetite/weight gain	84 (47.5)
Depressed mood	67 (37.9)
Impatience/restlessness	93 (52.5)
Insomnia	28 (15.8)
Triggers for tobacco use	
At work	53 (29.9)
Attending meetings	29 (16.4)
Anxiousness	116 (65.5)
Under stress	136 (76.8)
Needing to concentrate	37 (20.9)
Drinking coffee, tea, or soda	127 (71.8)
Talking on the phone	19 (10.7)
To keep busy	59 (33.3)
Around other smokers (chewers)	134 (75.7)
Before going to bed	131 (74.0)
Alone and bored	131 (74.0)
Children present	12 (6.8)
After meals	157 (88.7)
Relaxing	79 (44.6)
Wanting to cheer up	31 (17.5)
Hunger	65 (36.7)
Pain	46 (26.0)

Findings – Medical Diagnoses and Substance Use

- The most frequent mental health problems reported were depression (*n* = 39, 22.0%), anxiety (*n* = 31, 17.5%), and insomnia (*n* = 19, 10.7%).
- Heart disease was the highest reported physical health condition among inmates (*n* = 33, 18.6%).
- In terms of substance use, inmates reported using marijuana (*n* = 70, 39.5%), alcohol (*n* = 60, 33.9%), cocaine (*n* = 53, 29.9%), heroin (*n* = 35, 19.8%), caffeine in excess (*n* = 43, 24.3%), and dietary supplements (*n* = 5, 2.8%).



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Findings

Participants were not familiar with smoking cessation treatment

Side effects from the use of the nicotine patch were vivid dreams and irritation to the nicotine patch

There were a few hurdles in dispensing the nicotine patches to the participants across the prison sites

Findings – CO Monitoring Results: Biochemical Verification of Self-Reported Smoking Levels

Session	N	Median Carbon Monoxide Level (Range)
1	115	18.0 (1.0-52.0)
2	60	17.0 (0-45.0)
3	43	12.0 (0-41.0)
4	69	6.0 (0-44.0)
5	63	8.0 (0-37.0)
6	80	5.5 (0-38.0)
One-month follow-up	43	5.0 (0-35.0)

Findings – Exhaled Carbon Monoxide of Those who Did Complete the Program and Those Who Did Not Complete the Program

Session	Completed Program Mean (SD)	Not Complete Program Mean (SD)	p-value
1	18.18 (10.71)	18.59 (12.55)	0.860
6	9.80 (8.97)	10.20 (12.83)	0.925

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Discussion

- This study provided evidence in which a 6-week group-based smoking cessation treatment with NRT patches showed improvement in cessation efforts
- Incarcerated smokers have minimal experience participating in tobacco dependence treatment and using NRT as a form of smoking cessation
- Prison-based group-based smoking cessations ought to be tailored to meet the needs of transgender individuals as they not only experience chronic and daily stress, but some might be undergoing hormone therapy or other necessary treatment, experiencing frequent harassment or abuse, and physical and sexual assault from other inmates and prison staff or correctional officers

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Discussion

Feasibility & Acceptability of Program

- Study facilitators were able to work smoothly with the prison's pharmacy to dispatch NRT patches.
- Group treatment did not appear burdensome to participants or prison staff, in terms of users' time and effort.
- Facilitators maintained confidentiality in creating Target Quit Dates plans with participants and group cohesion and provided social and emotional support throughout therapy

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Implications for Prison –based Smoking Cessation Treatment Programs

The “5” A’s model (Ask, Advise, Assess, Assist, Arrange) should be used during inmate admission to discuss with inmates their readiness or motivation to quit

When the inmate discloses interest in quitting during incarceration, the prison facility should facilitate the quitting process

There is an urgent need to increase prison-based certified tobacco treatment specialists

Tobacco bans without the appropriate smoking cessation resources do not eliminate smoking, vaping, and tobacco use in state prisons

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