AN OVERLOOKED ADDICTION

TOBACCO USE AMONG THE HOMELESS POPULATION
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THE PUBLIC HEALTH LAW CENTER
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FEATURED SPEAKER

Dr. Maya Vijayaraghavan

University of California
San Francisco
FEATURED SPEAKER

Darlene Huang

Staff Attorney
Public Health Law Center
TOBACCO USE AMONG THE HOMELESS
A Public Health Epidemic

Kerry Cork, J.D.
PRESENTATION

- Overview
- Patterns of Tobacco Use
- Barriers & Challenges
- Promising Policy Options
U.S. HOMELESS POPULATION OVERVIEW
DEFINING HOMELESSNESS?

Homelessness = “State of being without a home”

“State of abject poverty, often accompanied by high-risk comorbidities”
HOMELESSNESS

- Individuals and families who do not have a fixed, regular, and adequate night time residence, including those who live in emergency shelters or places not meant for human habitation

- Individuals and families at imminent risk of losing their main night-time residence

- Unaccompanied youth and families with children and youth who meet other definitions of homelessness

- Individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual violence, stalking, or other dangerous or life-threatening conditions

Homeless Emergency Assistance & Rapid Transition to Housing Act of 2009
FACES OF THE HOMELESS

• Chronically homeless
• Episodically homeless
• Transitionally homeless
DEMOGRAPHICS

Approximately 578,424 people homeless on a given night in U.S. (2014)

- Poor, marginalized, vulnerable
- Those experiencing mental health issues / addiction
- Victims of domestic & sexual abuse, etc.
- Veterans (suffering from PTSD, depression, etc.)
- Runaway youth
- Seniors
- Families with children
HOST OF PROBLEMS

- Mental disorders
- Alcoholism
- Substance abuse
- Hunger
- Little or no access to health care
- Lack of social support
- Depression
NICOTINE ADDICTION

• 3 out of 4 homeless people smoke cigarettes, a rate 4 times higher than in general population
• 2 to 5 times more likely to die prematurely
THE LIST GOES ON

• Medical concerns
  – Cardiovascular disease
  – Obstructive lung disease
  – Other chronic / infectious diseases
  – Brain injury
• Cognitive impairment
• Limited education
• Legal / criminal justice challenges
• Displacement (eviction, natural disaster, etc.)
PATTERNS OF TOBACCO USE

• Sniping: Collecting & using discarded cigarette butts or filters
• Rolling own cigarettes
• Blocking filter vents
• Smoking other tobacco or organic substances
• Borrowing, sharing or trading single cigarettes
BARRIERS & CHALLENGES
WHY IT’S HARD FOR THEM TO QUIT

• Many have mental illness or addictions
• Smoking is a way to --
  – Cope with stress, boredom, hunger
  – Self-medicate; regulate their moods
  – Provide instant gratification
  – Socialize; a means of camaraderie
  – Retain control in one area of their lives
“An expression of autonomy in the face of desperation and a source of comfort in the midst of chaos.”

Dr. Travis Baggett
WHY IT’S HARD FOR THEM TO QUIT

• Tobacco industry’s predatory marketing tactics (Project SCUM)
• Pricing discounts, coupons, cheap alternative tobacco products
AND YET . . .

A majority of homeless individuals want to quit smoking.
TYPES OF SHELTER FOR HOMELESS POPULATION

• Day Shelters / Rescue Missions
• Emergency Homeless Shelters
• Halfway Housing
• Permanent Affordable Housing
• Residential Drug and Alcohol Rehab Programs
• Supportive Housing
• Shared Housing
• Transitional Housing
• Rooming House or Boarding House
CHALLENGES FOR HOMELESS SERVICE PROVIDERS #1

• Traditional use of tobacco by providers to build trust
• High percentage of provider staff smoke
• Nicotine addiction “less a priority” than other coexisting issues
• Lack of coordination / collaboration among social services, primary care, behavioral health/substance use experts & tobacco addiction experts
CHALLENGES FOR HOMELESS SERVICE PROVIDERS #2

• Service providers lack –
  – Funding for nicotine replacement products
  – Organized cessation counseling programs and trained counselors

• Challenge in providing service to (and retaining contact w/) transient population

• Challenge in determining the most effective cessation treatments, given diverse needs of (& subgroups in) homeless population
PROMISING POLICY OPTIONS
TOBACCO-FREE SHELTERS

• Most shelters are smoke-free on premises

• Many prohibit smoking on entire grounds; others permit smoking w/in a certain distance of entrances & exits (e.g., 20 – 25 ft.)

• Challenge: Enforcing smoke- or tobacco-free policies. Staff often smoke with residents.
TRAIN PROVIDER STAFF

• Make tobacco cessation a priority among staff
• Train staff on how to assist homeless smokers with tobacco cessation
• Engage staff who are former smokers to provide positive support
• Consider recruiting former homeless clients to serve as peer advisors
ENFORCE SMOKE-FREE POLICIES

• Ensure that all staff, residents comply with smoke-free policies, and that policies are enforced fairly and consistently.
LEVERAGE OUTREACH OPPORTUNITIES

• Cessation information in food distribution packages
• Annual one-day event where services are made available at convention center (e.g., haircuts, HIV/AIDS testing housing, healthcare, dental, tobacco cessation)
• Weekly free lunches provided by local parish, offering cessation info / referrals
• Free CT lung screenings and follow-up cessation information
RECRUIT HOMELESS CLIENTS IN STUDIES

• Set up flexible visit schedules
• Provide incentives that meet their needs:
  – Bus tokens & metro cards
  – Gift cards at each visit
  – Hygiene kits
  – Calendar/planner to record their visit times
• Obtain multiple forms of contact info
• Use outreach staff with experience in homelessness
PROVIDE COUNSELING & NRT

- Behavioral counseling (short in-person sessions) or motivational interviews are often preferred over quit lines.
- Pharmacotherapy (NRT cessation medications) are useful when combined with counseling.
- If possible, make cessation info and resources available, along with access to NRT.
INTERVENTION STRATEGIES AT DIFFERENT LEVELS

• Individual (e.g., NRT and behavioral counseling)
• Interpersonal (e.g., group & peer-based cessation interventions)
• Health care delivery (e.g., consistent smoke-free message during clinical encounters)
• Shelter (e.g., tobacco-free settings; educational messaging, training, resources, referrals for clients & staff)
• Policy (e.g., expanding health insurance that covers comprehensive tobacco treatment; evidence-based tobacco control policies at state & local levels)
HUD’S SMOKE-FREE RULE

Rule requires more than 3,100 public housing agencies across the U.S. to prohibit lit tobacco products in all living units, indoor common areas, administrative offices, and all outdoor areas within 25 feet of housing and administrative office buildings.
“HOUSING FIRST” APPROACH

• Offer permanent, affordable housing as quickly as possible to individuals and families experiencing homelessness,

... and then...

• provide supportive services and connections to the community-based supports people need to keep their housing and avoid returning to homelessness
Tobacco Use Among the Homeless Population: FAQ

This publication provides answers to several common questions about tobacco use among members of the homeless population, including those who are chronically, episodically or transitonally homeless, and policies and approaches that state and local organizations, including shelters and related facilities, can take to reduce the use of tobacco in this population.

For more information about tobacco policies in residential settings for vulnerable populations, check out the publications and resources on the Public Health Law Center’s website at www.publichealthlawcenter.org.
OPPORTUNITIES FOR INTERVENTIONS – TOBACCO USE AMONG POPULATIONS EXPERIENCING HOMELESSNESS

Maya Vijayaraghavan, MD MAS
Division of General Internal Medicine/ Zuckerberg San Francisco General Hospital
Department of Medicine, University of California, San Francisco
EPIDEMIOLOGY OF NON-CIGARETTE TOBACCO AND NICOTINE PRODUCT USE AMONG HOMELESS ADULTS AND YOUTH
NON-CIGARETTE TOBACCO AND NICOTINE PRODUCT USE IS COMMON AMONG HOMELESS ADULTS

- In a sample of sheltered homeless English speaking current smokers in Dallas, Texas (N=178)
  - Data collected in August 2013
  - 51% had used another tobacco products or e-cigarettes in the past month

Kish et al., NTR, 2015
MORE THAN HALF OF CURRENT SMOKERS HAVE USED A NON-CIGARETTE TOBACCO OR NICOTINE PRODUCT

- In a sample of homeless English speaking current smokers in Boston, MA (N=306)
- Data collected in April-July 2014
- 68% had used another tobacco product or e-cigarettes in the past month

Baggett et al., Addictive Behaviors, 2016
REASONS FOR E-CIGARETTE USE

- Perceived to be less harmful than cigarettes
- Used to cut down or quit cigarette smoking
  - Persons who were more ready to quit were more likely to use e-cigarettes
- Curiosity
- Flavors/novelty
- Circumvent indoor smoking restrictions

FACTORS ASSOCIATED WITH DUAL AND POLY-USE OF TOBACCO

- Increased subsistence difficulties
  - Little cigars and cigars are cheaper than cigarettes
- Increased psychiatric symptom severity
- Increased drug use symptom severity

Tucker et al., NTR, 2014; Baggett et al., Addic Behav. 2016
72% had used some other form of tobacco in the past 30 days

- E-cigarettes was more common among those who slept outdoors
- Chewing tobacco or snuff was more common among males
- Little cigars was more common among African Americans

Tucker et al., NTR, 2014
Among 83 youth current smokers who had ever tried e-cigarettes:

- About half viewed e-cigarette as less harmful
- The most common reasons for use:
  - “To avoid having to go out to smoke”
  - “To deal with situations or places when I cannot smoke”
IMPLICATIONS OF NON-CIGARETTE TOBACCO AND NICOTINE PRODUCT USE

- Increased nicotine dependence
- Challenges with tobacco cessation
- Tobacco treatment programs should include:
  - Assessment of non-cigarette tobacco and nicotine products
  - Educate about the harms of dual and poly-tobacco use
  - Capitalize on interest in quitting but direct toward approved medications for cessation

Tucker et al., NTR, 2014; Baggett et al., Addic Behav. 2016
INTERVENTIONS AND POLICIES FOR TOBACCO USE

Research to Practice

A Look at Smoking & Homelessness
TOBACCO CESSTATION TRIALS – CHALLENGES AND RESULTS
TOBACCO DEPENDENCE TREATMENT

- Smoking cessation counseling
- Pharmacotherapy:
  - Nicotine replacement therapy
  - Wellbutrin
  - Varenicline
- Combined counseling and pharmacotherapy more effective than either alone

ENGAGING HOMELESS ADULTS IN CESSATION TRIALS

- 6 studies have demonstrated the feasibility of engaging homeless adults in cessation trials
  - 2 clinical trials in progress
- Recruitment and retention are barriers to conducting studies with this population:
  - Substance use
  - Male gender
  - Irregular use of health services
  - Poor physical and mental health
  - High stress

Richards et al., NTR, 2015; Okuyemi et al., NTR, 2006; Okuyemi et al., Addiction, 2013; Shelley et al., AJHB 2010; Segan et al., NTR 2015; Baggett et al. in progress, Rash et al., in progress
ENGAGING HOMELESS ADULTS IN CESSION TRIALS

- Factors associated with enrollment and retention in a large randomized controlled trial of homeless adults:
  - Older age
  - Having healthcare coverage
  - Lower stress level
  - History of multiple homeless episodes
  - Alcohol and substance use

Richards et al., NTR, 2015; Okuyemi et al., NTR, 2006; Okuyemi et al., Addiction, 2013; Shelley et al., AJHB 2010; Segan et al., NTR 2015
ENGAGING HOMELESS ADULTS IN CESSATION TRIALS

- Recent studies have demonstrated retention rates of 75%-80%:
  - Conducting study visits at community-based sites
  - Flexible visit schedule
  - Use of community mobilizers/peer researchers to assist with recruitment
  - Asking for multiple forms of contact including places that participants spend time
  - Scheduling weekly/monthly check in visits
  - Incentivizing visits: gift cards, transportation, hygiene kits, cash vouchers

Richards et al., NTR, 2015; Okuyemi et al., NTR, 2006; Okuyemi et al., Addiction, 2013; Shelley et al., AJHB 2010; Segan et al., NTR 2015; Pakhale et al., Research Invol and Engagement, 2016
PARTICIPATORY RESEARCH IN OTTAWA, MANAGEMENT AND POINT-OF-CARE OF TOBACCO (PROMPT) STUDY – USE OF COMMUNITY PEERS

- Capitalized on social networks within homeless communities
- Partnered with the largest homeless shelter in Ottawa
- Designed a ten-step Ottawa Citizen Engagement and Action Model (OCEAN)
- Trained peers selected from the target population to conduct all aspects of the study:
  - Formulating study question – tobacco use
  - Designing study and instruments
  - Recruitment and Consenting
  - Administering questionnaires
  - Conducting follow-ups
  - Interpreting findings
  - Disseminating findings
- Honorarium of $15/hour for every hour spent on the project
- Nurse provided counseling and nicotine replacement therapy to clients at a homeless shelter

Pakhale et al., Research Invol and Engagement, 2016
## QUIT RATES FROM CESSATION TRIALS AND INTERVENTIONS

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Intervention</th>
<th>N</th>
<th>Measures</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Okuyemi et al., 2006</td>
<td>Uncontrolled, Randomized to 2 counseling conditions</td>
<td>5 MI session (2 forms)+ 6 group counseling+ NRT (8 weeks)</td>
<td>46</td>
<td>CO-verified 7-day PPA</td>
<td>8 weeks: 13% vs. 17% (ns) 26 weeks: 8 vs. 17% (ns)</td>
</tr>
<tr>
<td>Shelley et al., 2010</td>
<td>Uncontrolled</td>
<td>12 group counseling, NRT, patch or bupropion</td>
<td>58</td>
<td>CO-verified 7-day PPA</td>
<td>12 weeks: 15% 24 weeks: 13%</td>
</tr>
<tr>
<td>Okuyemi et al., 2013</td>
<td>2-group RCT</td>
<td>6 week individual MI+ 8 weeks NRT vs. 1 session of brief advice to quit</td>
<td>430</td>
<td>CO-verified and salivary cotinine, 7-day PPA</td>
<td>26 weeks: 9.3% vs. 5.6% (ns)</td>
</tr>
<tr>
<td>Segan et al., 2015</td>
<td>Uncontrolled</td>
<td>12-week nurse-led counseling, meds., quit line referral</td>
<td>49</td>
<td>CO-verified 24 hr. PPA</td>
<td>12 weeks: 6% 24 weeks: 4%</td>
</tr>
<tr>
<td>Businelle et al., 2014</td>
<td>Uncontrolled but with usual care comparison group</td>
<td>Shelter based smoking cessation counseling + CM vs. shelter counseling</td>
<td>10 vs. 58</td>
<td>CO-verified 7-day PPA</td>
<td>4 weeks: 50% vs. 19% 8 weeks: 30% vs. 1.7%</td>
</tr>
<tr>
<td>Carpenter et al., 2015</td>
<td>Uncontrolled (veterans)</td>
<td>4 week mobile contingency mgmt., NRT+bupropion</td>
<td>20</td>
<td>CO-verified 7-day PPA</td>
<td>4 weeks: 50% 12 weeks: 55% 24 weeks: 45%</td>
</tr>
</tbody>
</table>

Okuyemi et al., NTR, 2006; Okuyemi et al., Addiction, 2013; Shelley et al., AJHB 2010; Segan et al., NTR 2015; Carpenter et al. J Clin Psych, 2015; Businelle et al., Addict Behav, 2014.
# QUIT RATES FROM CESSATION TRIALS AND INTERVENTIONS

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</thead>
<tbody>
<tr>
<td>Rash et al., in progress</td>
<td>Controlled, Randomized to CM vs. usual care</td>
<td>Twice weekly counseling, NRT, with CM vs. Twice weekly counseling +NRT</td>
<td>70</td>
<td>CO-verified 7-day PPA</td>
<td>• 12/24 weeks no differences&lt;br&gt;• CM 17.5 consecutive CO-negative samples vs. 6.3 negative samples in usual care</td>
</tr>
</tbody>
</table>
QUIT RATES – COMPARISON WITH OTHER HIGH RISK POPULATIONS

Cessation trials with behavioral counseling and pharmacotherapy

Quit rates slightly lower than other high risk populations

Adapted from: Hall SM et al., AJPH, 2006; Hickman NJ et al., NTR, 2015; Cropsey et al., AJPH, 2007; Okuyemi et al., Addiction, 2015
INCENTIVES FOR SMOKING CESSATION – FEATURES OF SUCCESSFUL INTERVENTIONS

- Incremental increase in incentive amounts for evidence of longer duration of abstinence
  - $20 gift card for biochemically verified abstinence on quit date
  - $5 increase for each additional week abstinent, up to $150 for 5-weeks
  - Resetting amounts to $20 for non abstinence

- Larger and longer studies are needed for sustainable intervention effects

Businelle et al., Addict Behav, 2014.
Treatment of tobacco and alcohol dependence

- Large trial of ~645 participants
- Randomized to three conditions:
  - Intensive smoking plus alcohol intervention using cognitive behavioral therapy
  - Intensive smoking cessation intervention only
  - Usual care – brief cessation or brief alcohol use counseling
  - 12 weeks of NRT
  - Counseling weekly individual counseling for 3 months followed by monthly groups for another 3 months

Okuyemi et al., Clin trials, 2015
TOBACCO CESSATION CAPACITY BUILDING INTERVENTIONS IN HOMELESS SHELTERS
TOBACCO DEPENDENCE INTERVENTIONS IN HOMELESS SHELTERS

- Little data on the provision of cessation services in shelters
- Among 12 emergency and 40 transitional shelters in San Diego County (62% response rate):
  - One-third offered on-site resources for smoking cessation: classes, wellness initiative, public health nurse
- Among 23 shelters and day centers serving homeless youth in Los Angeles County:
  - Majority did not provide on-site cessation services

Vijayaraghavan et al., Health Promt &Pract, 2015; Shadel et al., J Subst Abuse Treat. 2014
BARRIERS TO CAPACITY BUILDING

- Lack of resources: money and staff to enforce smoke-free policies and implement cessation programs
- Staff training
- Staff smoking
- Perceptions among staff that smoking cessation is not a priority among clients

Vijayaraghavan et al., Health Promt &Pract, 2015; Shadel et al., J Subst Abuse Treat. 2014
**Smoke-free policies**

- Restrict smoking outdoors to designated smoking zones at least 25 feet away from exits/entrances
- Have separate smoking zones for staff and clients.
- Consider broader restrictions on outdoor smoking in the property

**Smoking cessation programs**

- Modifying beliefs and attitudes among staff on the importance of addressing nicotine addiction
- Improving knowledge among staff on clients’ interest in smoking cessation
- Discouraging staff smoking with clients
- Training staff to provide brief cessation counseling
- Incentivizing staff to participate in cessation training and to enforce policies.
- Partnering with local tobacco control organizations to increase capacity to provide cessation services

Vijayaraghavan et al., Health Promt & Pract, 2015; Shadel et al., J Subst Abuse Treat. 2014; Porter et al., Health Promot & Pract, 2010
BUILDING TOBACCO CESSATION CAPACITY IN HOMELESS SHELTERS – A PILOT STUDY

- Setting – 2 transitional homeless shelters
- Trained shelter staff to provide brief cessation counseling
- Assessed provision and receipt of cessation services

**Staff**

<table>
<thead>
<tr>
<th>SKAP Scores</th>
<th>Knowledge</th>
<th>Beliefs</th>
<th>Barriers</th>
<th>Efficacy</th>
<th>Practices</th>
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<tr>
<td>Pre-intervention</td>
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<td>6-weeks post-intervention</td>
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<tr>
<td>12-weeks post-intervention</td>
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**Clients**

<table>
<thead>
<tr>
<th>SKAS Score</th>
<th>Knowledge</th>
<th>Attitudes</th>
<th>Program services</th>
<th>Clinician services</th>
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<tr>
<td>Pre-intervention</td>
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<td>12-weeks post-intervention</td>
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</tbody>
</table>

Vijayaraghavan et al., J Comm Health, 2016
SMOKE-FREE POLICIES
SMOKE-FREE POLICIES IN HOMELESS SHELTERS

- Evolving field, earliest study in 2007
- Homeless shelters in California and Texas
  - Restrict smoking indoors
  - Differ in outdoor restrictions on smoking, with some having campus wide bans and others no outdoor restrictions
- Most homeless adults are supportive of such policies

Arangua et al., NTR, 2006; Businelle et al., Addictive Behav, 2014; Vijayaraghavan et al., Health Promt &Pract, 2015; Vijayaraghavan et al., J Comm Health, 2015; Vijayaraghavan et al., AJHP, 2015
In 2 studies of sheltered homeless smokers in San Diego County, we found that:

- Smoke-free policies were associated with anti-tobacco norms
  - Clients staying in shelters with indoor and outdoor smoke-free policies were more likely to not smoke with staff

- Smoke-free policies were associated with self-reported:
  - Decreases in consumption
  - Interest in short-term quit attempts
  - Interest in smoking cessation

- A minority (< 10%) expressed interest in leaving the facility because of smoke-free policies

Vijayaraghavan et al., J Comm Health, 2015; Vijayaraghavan et al., AJHP, 2015
SMOKE-FREE POLICIES IN PUBLIC HOUSING

• 2009
  • 20% implemented voluntary smoke-free policies

• 2015
  • HUD proposed a new rule for all Public Housing Authority-managed housing to restrict smoking of combustible tobacco in living areas, indoor common areas, and all outdoor areas within 25 feet of the building.

Smoke-free policies in 3100 PHA-housing will impact 1.2 million low-income housing units in the United States

Instituting Smoke-free Public Housing; Department of Housing and Urban Development; 2015
SMOKE-FREE POLICIES IN PUBLIC HOUSING – BENEFITS

- Improve the health of very low-income tenants by reducing secondhand smoke exposure
- Reduce tobacco use among low-income smokers if policies are combined with treatment
- Save over $15 million dollars/year in maintenance costs
- Save about $500 million dollars/year in health care costs
REPERCUSSIONS FOR NOT FOR PROFIT SUPPORTIVE HOUSING FOR HOMELESS ADULTS

- HUD rule does not apply to not for profit supportive housing for formerly homeless adults
  - Unless there is a city wide ordinance to ban smoking
- Smoking is allowed indoors in living units, but not in shared common areas

Comment on HUD’s proposed rule instituting smokefree public housing: A good start but needs to include e-cigarettes and marijuana; UCSF CTCRE, 2016
IMPLEMENTING AND ENFORCING SMOKE-FREE POLICIES IN SUPPORTIVE HOUSING

- Could improve health and well-being of residents and staff
- But could be perceived as contradicting harm reduction framework of supportive housing
- Overly aggressive enforcement can lead to loss of housing
- Lack of enforcement dilutes the positive effects of a policy

Comment on HUD’s proposed rule instituting smokefree public housing: A good start but needs to include e-cigarettes and marijuana; UCSF CTCRE, 2016; Tobacco Control Legal Consortium, 2017
POSSIBLE STRATEGIES FOR IMPLEMENTING SMOKE-FREE POLICIES IN SUPPORTIVE HOUSING

- Policies need to be aligned with a goal of ending homelessness:
  - Obtaining buy-in from residents and staff
  - Policies designed with feedback from residents
  - Supporting the voluntary adoption of smoke-free home
  - Ensuring on-site cessation support: counseling and medications
  - Partnering with public health and health care facilities to increase resources for cessation
  - Providing accommodations to make it easy for residents to follow smoke-free policies
  - Staged enforcement

Comment on HUD’s proposed rule instituting smoke-free public housing: A good start but needs to include e-cigarettes and marijuana; UCSF CTCRE, 2016; Tobacco Control Legal Consortium, 2017
MEDIA CAMPAIGNS
MEDIA AS MOTIVATOR OF CESSATION – ANTI-TOBACCO GRAPHIC WARNING LABELS

- Not approved by the FDA in U.S., but other public health campaigns exist
  - CDC Tips from Former Smokers

- Data from other countries suggest that labels:
  - Raise awareness about harms of tobacco to self and others
  - Motivate cessation behaviors

- In our study among older homeless adults:
  - Perceived as more effective for motivating cessation behaviors

- Media campaigns could serve as effective adjuncts to cessation interventions for older homeless smokers

FDA Proposed graphic warning labels, 2012; Vijayaraghavan et al., Manuscript in preparation
SUMMARY

- It is feasible to engage homeless adults in cessation
- Integrate counseling and pharmacotherapy into other services
  - Incentivizing cessation efforts may be a promising tool
- Policy-level interventions are critical to reducing tobacco use:
  - Smoke-free policies and smoke-free home interventions in shelters and supportive housing
  - Policies that mandate provision of cessation services in homeless services settings
  - Media can motivate cessation behaviors among certain homeless populations
  - Tailor messages to the unique circumstances of homeless adults and youth
CURRENT THINKING in TOBACCO DEPENDENCE TREATMENT

CONTEXT
- Homeless population

INTERVENTION
- Behavioral counseling and pharmacotherapy

OUTCOMES
- Marginal reductions in tobacco use
SHIFT IN PARADIGM

CONTEXT

Populations experiencing homelessness
- Sheltered/Unsheltered
- Mental health/substance use disorders
- LGBT/Youth/Older homeless adults
- Racial/ethnic minorities

INTERVENTIONS

Behavioral counseling and pharmacotherapy
AND
Smoke-free policies

Other adjunctive interventions for subpopulations

OUTCOMES

REDUCTIONS IN TOBACCO USE
MORBIDITY AND MORTALITY
TOBACCO-RELATED HEALTH DISPARITIES

DIVERSE SUBPOPULATIONS
MULTIMODAL INTERVENTIONS
PROMOTING HEALTH EQUITY
MANY UNANSWERED QUESTIONS

- What interventions would benefit homeless subpopulations?
- What interventions would benefit homeless youth?
- What interventions would lead to improved quit rates?
- What are the ways to increase access to smoke-free environments?
- What are the ways to eliminate early childhood exposure to tobacco and nicotine products?
TAKE HOME MESSAGES

- Ask everyone about cigarette and non-cigarette tobacco use
- Advise to quit tobacco use
- Provide access to or refer to cessation services
- Ask about e-cigarette and marijuana use and counsel against use
- Integrate counseling for substance use with counseling for tobacco use
- Ask everyone about exposure to secondhand smoke
- Support interventions to:
  - Increase access to tobacco-free housing and homeless service settings
  - Implement policies to increase delivery of cessation services
THE HOUSING CONTINUUM: HUD’S SMOKE-FREE PUBLIC HOUSING RULE
HOUSING CONTINUUM

- Emergency and Transitional Housing
- Affordable Rental Housing
- Affordable Home Ownership
WHY PUBLIC HOUSING?

• Children
• Older adults
• Tobacco-related disparities
  – African Americans
  – American Indians/Alaska Natives
  – Asian Americans/Pacific Islanders/Native Hawaiians
  – Hispanics/Latinos
  – Lesbian, Gay, Bisexual, and Transgender Persons
  – People of Low Socioeconomic Status
  – Adults with Mental Illness and Substance Use Disorders
Cigarette smoking and adverse health outcomes among adults receiving federal housing assistance

Veronica E. Helms a,*, Brian A. King b, Peter J. Ashley c

b Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, GA, United States
c Office of Lead Hazard Control and Healthy Homes, U.S. Department of Housing and Urban Development, Washington, DC, United States

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Disparities

ABSTRACT

Cigarette smoking is higher among low-income adults and individuals who reside in federally assisted housing and are particularly susceptible to the adverse effects of smoking and secondhand smoke exposure. This study assessed smoking-related behaviors and health outcomes among U.S. adults who received federal housing assistance during 2006–2012. National Health Interview Survey data linked with administrative data from the U.S. Department of Housing and Urban Development were analyzed: 5218 HUD-assisted adults were assessed. Demographic characteristics associated with smoking, including frequency and consumption, were assessed among adult cigarette smokers. Fourteen adverse health outcomes were examined among cigarette smoking and nonsmoking adults. One-third (31.6%) of HUD-assisted adults were current cigarette smokers. Smoking prevalence was highest among adults aged 25–44 (42.5%), non-Hispanic whites (39.5%), and adults who resided in households with children (37.5%). Half attempted to quit in the past year; 82.1% were daily smokers; and 35.8% of daily smokers reported smoking 20+ cigarettes a day. Multivariable analyses revealed that compared to nonsmokers, cigarette smokers had increased likelihood of reporting fair or poor health (95% CI: 1.04–1.52), chronic obstructive pulmonary disease (CI: 1.87–3.06), disability (CI: 1.25–1.83), asthma (CI: 1.02–1.55), serious psychological distress (CI: 1.39–2.52), >1 emergency room visit in the past year (CI: 1.09–1.56), and ≥10 work days in the past year (CI: 1.15–3.06). Adults who receive housing assistance represent an at-risk population for adverse health outcomes associated with smoking and secondhand smoke. Housing assistance programs provide a valuable platform for the implementation of evidence-based tobacco prevention and control measures, including smokefree policies.
HUD FINAL RULE

- Public housing
- “Prohibited tobacco products”: Cigarettes, cigars, pipes, hookah
- All indoor areas and outdoor areas 25 feet from buildings
- No grandfathering
- Minimum requirements
- Amend PHA plans and tenant leases/house rules
- By July 30, 2018
HUD FINAL RULE OVERVIEW
POLICY ADOPTION PROCESS

- Assess
- Partner and Engage
- Plan and Develop
- Educate and Communicate

* Buy-in before adoption *

- Implement and Promote Compliance
- Enforce
COMPLIANCE AND ENFORCEMENT ISSUES

• Buy-in = Compliance
• Set a tone that encourages management and residents to achieve compliance together
• Appropriate timeline
• Clear policy
• Enforcement plan
• Reasonable accommodations

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CLEAR POLICY AND ENFORCEMENT PROCESS

• Promote compliance

• Ensure policy language prohibits smoking and specifies it’s a violation of the lease that can lead to terminating residency

• Identify enforcement steps if not specified elsewhere
  – Graduated enforcement (i.e. first violation, second, third, etc.)
  – Remediation options (e.g. attending a quitting class erases a violation)
  – State what will be evidence of violations (e.g. neighbor complaints, carpet and countertop burns, wall stains, etc.)
EQUAILTY does not mean EQUITY
REASONABLE ACCOMMODATIONS

Smoke-Free Public Housing: Reasonable Accommodations

Safe, quality, affordable housing with the necessary supports is “one of the most basic and powerful social determinants of health.”

Smoke-free multi-unit housing offers many benefits, including better air quality and health, as well as lower fire risk and maintenance costs. While these benefits accrue to all residents of a smoke-free property, certain groups of people with higher rates of tobacco use and secondhand smoke exposure stand to benefit more if policies are implemented equitably. For example, while people with mental health or substance use conditions make up 25 percent of the general population, they smoke 40 percent of all cigarettes. Well-implemented smoke-free policies that reach this population have the potential to reduce health disparities and promote health equity.

In its final rule, “Instituting Smoke-Free Public Housing,” the U.S. Department of Housing and Urban Development (HUD) states that smoke-free public housing helps HUD realize its mission of providing safe, decent, and sanitary housing for vulnerable populations nationwide, including people with disabilities. The rule also reminds public housing agencies (PHAs) that individuals with disabilities have the right to seek a reasonable accommodation. This fact sheet explains the legal framework for and highlights a number of considerations to assist PHAs with smoke-free reasonable accommodation requests.

Interplay Between Fair Housing, Disability Laws, and Smoke-Free Policies

Laws protecting individuals with disabilities help ensure equal access to fair housing. Under these laws, housing providers are prohibited from discriminating on the basis of disability. The Fair Housing Act, Section 504 of the Rehabilitation Act, and Title II of the Americans with Disabilities Act (ADA) require that PHAs provide a reasonable accommodation, when requested, if it is necessary to afford a person with a disability equal opportunity to use and enjoy a dwelling. State and local anti-discrimination and fair housing laws may also provide similar or additional protections to people with disabilities.

These laws are important because treating people with disabilities exactly the same as those without disabilities can sometimes have unequal results. For example, a no-pet policy might deny a visually impaired resident an equal housing opportunity by disallowing a service animal. At the same time, individuals living in federally-assisted housing with people with behavioral health issues and those with disabilities have disproportionately high tobacco use rates. This is concerning because tobacco use remains the leading cause of preventable death and disease in the U.S., and there is no safe level of exposure to secondhand smoke. If these individuals are
REASONABLE ACCOMMODATIONS

- Does someone who smokes qualify as a person with a disability?
- Can a request to smoke indoors be granted?
- What can be done to help residents with disabilities that smoke?
REASONABLE ACCOMMODATIONS

• Qualifying disability?
• Accommodation necessary?
• Accommodation reasonable?
• Other ways to enable compliance?
REASONABLE ACCOMMODATIONS

Q: Qualifying disability?

A: Smoking/nicotine addiction is **NOT** a qualifying disability.
A: An individual’s underlying condition may be a qualifying disability.
Q: Accommodation necessary?

A: Smoking is **NOT** a recommended treatment for any physical or mental condition.

A: Individuals with behavioral health conditions and other disabilities can refrain from smoking. Quitting smoking does not worsen conditions or increase use of other substances.

A: There is **no safe level of exposure** to secondhand smoke.
Q: Accommodation reasonable?

A: “Allowing smoking in areas required to be smoke-free is NOT an accommodation that can be granted.”

A: Accommodations that would impose an undue financial or administrative burden on the housing provider or would fundamentally alter the provider’s operations are NOT required.
Q: Other ways to enable compliance?

A: Move resident to a first floor unit or closer to an elevator or door to get outside.

A: Have a social worker place signs in the home reminding the resident to go outside.

A: Partner with local public health or a community-based organization to help the resident understand the policy, manage cravings, and available quitting resources if interested.
The only way to protect health is for buildings to be completely smokefree.

Residents NEED and WANT smokefree housing.

Only 30% of multi-unit residents live in smokefree buildings, but the majority would prefer their building to be smokefree.

Everyone deserves to breathe smokefree air at home.
QUESTIONS?
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