Providing Cessation in Smoke-Free Buildings & Adopting Smoke-Free Policies for Supportive Housing

Stages of Smoke-Free Multi-Housing Program Development:
A series for public health professionals

Part Seven of Nine | January 26, 2012

Welcome!

- Please be sure to turn up the volume on your computer speakers – **No need to call in**
- If you have questions, please type them into the chat box at the bottom of your screen and we will answer them during or after the presentation
- The presentation will be recorded and archived on our web site at www.mnsmokefreehousing.org/webinar
- Print a handout of the presentation

Live Smoke Free

- Program of the Association for Nonsmokers—Minnesota
  - Working on smoke-free housing since late 1990's
  - Three full-time staff dedicated to project
  - Assisted hundreds of property managers in policy adoption, including public housing authorities; private owners; suburban, urban, and rural properties
- Recipient of MN Mentoring Supplement to provide technical assistance to Communities Putting Prevention to Work (CPPW) grantees
- Partnering with the Public Health Law Center
- Made possible by funding from the Centers for Disease Control and Prevention. Sponsored by the Minnesota Department of Health

Technical Assistance Team

Brittany McFadden

Program Director,
Live Smoke Free

Warren Ortland

Staff Attorney,
Public Health Law Center

Carissa Larsen

Assistant Program Director,
Live Smoke Free

Technical Assistance Scope of Work

- Webinar series on the stages of developing a smoke-free housing program
- Development of a comprehensive "how-to" training manual for smoke-free housing advocates
- Individual consultations, including site visits, strategy development, legal issues, and materials

Stages of Smoke-Free Multi-Housing Program Development

Phase 1: Understanding the Need for Smoke-Free Multi-Unit Housing

Stages of Smoke-Free Multi-Unit Housing Program Development			
The Case for Smoke-Free MUH	Getting to Know the MUH Industry	Building Your Smoke-Free MUH Program	Understanding Legal Issues
The importance of adopting smoke-free MUH policies	Assessing the MUH stock and learning what's important to the industry	Creating goals, materials, and procedures to sustain a program	Learning the local, state, and federal laws pertaining to MUH

Phase 2: Working Toward Smoke-Free Multi-Unit Housing Policy Adoption

Continued Stages of Smoke-Free Multi-Unit Housing Program Development				
Strategies to Reach the Housing Industry	Working with MUH to Adopt a Policy	Providing Cessation in Smoke-Free Buildings	Working with Renters Exposed to Smoke	Program Sustainability
Getting your message to landlords	The policy adoption process	Helping current residents make the transition to a smoke-free environment	Empowering renters suffering from secondhand smoke drift	Partnering with other smoke-free MUH programs

Print a pdf of the Smoke-Free Multi-Housing Program Continuum

Webinar Series

Based on the Smoke-Free Multi-Unit Housing Program Continuum

- *The Case for Smoke-Free Housing*
- *Getting to Know the Multi-Housing Industry*
- *Building Your Smoke-Free Housing Program*
- *Understanding Legal Issues*
- *Strategies to Reach the Housing Industry*
- *Working with Property Owners/Managers to Adopt a Smoke-Free Policy*
- **Providing Cessation in Smoke-Free Buildings – January 26th**
- Working with Renters Exposed to Secondhand Smoke – February 9th
- Program Sustainability – February 23rd

Learn more and register at
www.mnsmokefreehousing.org/cppw

Providing Cessation

Topics Covered Today:

- Cessation myths & facts
  - Focus on specialty populations
- Overview of publications and resources
- Helping managers of supportive housing decide to adopt a smoke-free policy
- Examples from Minnesota
- Case study from Maine
- Example cessation resources from other states

Today's Speakers

Brittany McFadden
Program Director,
Live Smoke Free (Minnesota)

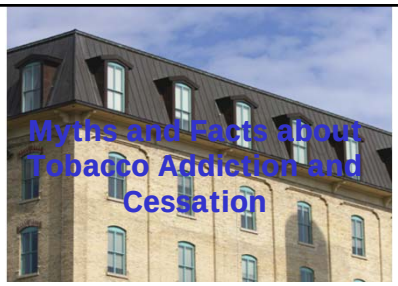
Carissa Larsen
Assistant Program Director,
Live Smoke Free (Minnesota)

Sarah Mayberry
Program Coordinator/Director,
Smoke-Free Housing Coalition of Maine

Dr. Kolawole Okuyemi, M.D., M.P.H.
Director, Program in Health Disparities Research,
University of Minnesota

Why is Cessation Important?

- Knowing about tobacco addition is key to understanding potential opposition and the lives that you may be affecting
- Providing cessation resources can help you alleviate fears of residents and managers
  - Residents will not be kicked out of their housing; they will just have to abide by the policy
  - Managers will be able to enforce a policy
  - Everyone will be treated with respect and be able to live in a healthy environment



Myths and Facts about Tobacco Addiction and Cessation

Presentation by Dr. Kolawole Okuyemi, MD, MPH
University of Minnesota

Read Dr. Okuemyi's full biography
Download Dr. Okuemyi's presentation
Full page slides
3 slides per page with space for taking notes

Cessation Facts and Myths about Smokers with Chemical Dependency, Mental Health Conditions, and Homelessness

Kolawole S. Okuyemi, MD, MPH,
Professor of Family Medicine
Director, Program in Health Disparities Research, Director, Minnesota Center for Cancer Collaborations
University of Minnesota Medical School
Minneapolis, Minnesota, USA

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Disclosure

- Funding Sources in last 5 years
  - National Heart, Lung, and Blood Institute
  - National Cancer Institute
  - National Institute on Drug Abuse
  - National Institute on Minority Health and Health Disparities
  - ClearWay Minnesota
- Industry funding
  - Pfizer for FDA-approved research project involving use of nicotine patch, bupropion, and varenicline
  - No speaker bureau
- Off label medication uses discussed
  - None

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Overview

- Defining the Problem
- Myths
- Facts
- Unknowns
- Publications and Resources

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Defining the problem

- Although the prevalence of smoking has declined overall in the US in the last few decades, tobacco use remains endemic among certain underserved "special" populations including (for the purpose of current presentation)
  - Chemical dependent population
  - Persons with mental health conditions
  - Homeless

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Substance Abuse Populations

Misconceptions or myths about nicotine dependence and substance abusers?

- Smoking cessation may act as a stressor to jeopardize sobriety
- Smoking cessation may precipitate relapse
- Nicotine dependence viewed as a minor problem
- Substance abuse patients are not interested in quitting smoking

Facts about cigarette smoking and chemical dependency

- Prevalence of smoking range 70%-95% [Burling and Ziff, 1998]
- They tend to be heavy smokers
- More dependent on nicotine
- Have lower quit rates [Marks et al. 1997; Lasser et al. 2000; Novy et al. 2001
- The combined use of tobacco and other drugs is a significant and preventable risk for disease and premature deaths. The risk of combined use are multiplicative rather than just additive [Talami et al. 2002; Lee et al. 2005; Marrero et al. 2005]
- Persons with AUD are more likely to die from tobacco-related conditions such as lung cancer and cardiovascular disease than alcohol-related conditions [Hurt et al. 1996]

Possible theories abound for the high degree of overlap

- Similar genetic predisposition
- Using one substance to enhance reinforcing effects of the other
- Capacity of one substance to reduce unpleasant effects of the other

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What are the attitudes of substance abuse users about smoking cessation?

- Consistent evidence refute the misconception that recovering substance abusers are not interested in quitting smoking at some point during their recovery [Sees and Clark, 1993]
  - A survey [n=272] of patients entering substance abuse treatment in a VA hospital reported that
    - All alcoholics
    - 72% of cocaine addicts
    - 70% of heroin addicts expressed interest in quitting smoking [Sees et al. 1993]
    - 52% of alcoholics and 42% of heroin addicts were interested in quitting smoking at the time they started treatment for other addictions.
  - Several studies have found that relatively few [5%-30%] believe that attempting to quit smoking has had or will have negative impact on their sobriety [Bobo et al. 1987; Irving et al. 1994; Joseph et al. 1990; Orleans & Hutchinson, 1993]
  - Some studies have found that a high proportion [>60%] of substance users are interested in concurrently quitting smoking and other drugs in programs where both are offered [Irving et al. 1994; Joseph et al. 1990]

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When should Tobacco Cessation Treatment Occur?

- Concurrent cessation vs. one substance at a time
  - *Concurrent*--Continued use of one addictive substance could provoke relapse to the other due to the brain's cross-sensitivity to both drugs
  - *One substance at a time*--due to the demands of withdrawal from quitting tobacco or alcohol
  - The vast majority of studies suggest that concurrent treatment does not increase the probability of relapse [Burling et al. 1991; Hurt et al. 1994;Martin et al. 1997; Bobo et al. 1998; Patten et al. 1998; Burling et al. 2001; Kalman et al. 2001; Gariti et al. 2002; Rohsenow et al. 2002; Haug et al. 2004]
  - Two studies involving timing of intervention showed that smokers were more likely to participate when tobacco cessation was offered concurrently with treatment for alcohol dependence compared to when it was delayed [Kalman et al. 2001; Joseph et al. 2004]
  - In the two studies that found evidence of greater relapse for concurrent treatment for tobacco and alcohol treatment, the differences between treatment and control groups were not observed consistently at all time points and all measures[Grant et al. 2003; Joseph et al. 2004]

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What smoking cessation methods work for substance abuse populations?

- Efficacy of bupropion and nicotine replacement therapy (gum and patch) have been shown to be similar for smokers with and without a past history of alcoholism [Cooney et al. 2009; Hayford et al. 1999; Humfleet et al. 1999]; Participants who were alcoholics at baseline were less likely to be abstinent at all time points [Humfleet, 1999]
- One study showed lower tobacco abstinence rates with nicotine patch for smokers with past or active alcoholism compared with those without such as history [Hays et al 1999].
- Another study [n=240 subjects] showed that smoking cessation rates at the end of nicotine patch therapy were similar in recovering alcoholics (46%) and non-alcoholics (47%) receiving active 22 mg patches but higher than the respective placebo groups (17% and 19%). The 1-year rate was higher in the non-alcoholic group assigned to an active patch (31%) compared to placebo (14%). For recovering alcoholics, the rates were lower and not significantly different versus placebo [Hurt et al. 1995]. The study concluded that recovering alcoholic smokers can achieve comparable short-term cessation rates with nicotine patch therapy.
- Cognitive behavioral therapy has been found to be helpful for alcoholic smokers [Patten et al. 1998; Patten 2001].
- A study examined smoking intervention for newly recovering drug and alcohol-dependent smokers in a residential rehabilitation program.
  - Participants were randomly assigned to treatment conditions (n = 50 each) including multicomponent smoking treatment (MST), MST plus generalization training of smoking cessation to drug and alcohol cessation (MST+G), or usual care (UC).
  - Both conditions consisted of 5 weeks of prequit treatment and 4 weeks of postquit supportive counseling plus nicotine patch.
  - Both treatment conditions achieved continuous smoking abstinence rates (MST: 12%, MST+G: 10%, at 12-month follow-up) that were significantly higher than in the UC condition (0%). The MST condition had a continuous drug and alcohol abstinence rate that was significantly higher than that of the MST+G condition (40% vs. 20% at 12-month follow-up) although neither differed significantly from that of the UC condition (33%). [Burling et al. 2001]
- In a recent study, 162 alcohol-dependent smokers were randomized to either intensive intervention for smoking cessation or usual care.
  - The intensive intervention consisted of 16 sessions of individual cognitive behavior therapy (CBT) and combination nicotine replacement therapy that lasted 26 weeks.
  - At 12 and 26 weeks, the verified 7-day point-prevalence quit rate was significantly higher for the intensive intervention group than for the usual care group.
  - Verified 30-day alcohol abstinence rates were not significantly different for the two treatment groups at any of the follow-up assessments.
  - Authors concluded that the intensive smoking cessation intervention yielded a higher short-term smoking quit rate without jeopardizing sobriety and recommended use of a chronic care model to facilitate maintenance of smoking cessation during the first year of alcohol treatment and perhaps for longer periods of time. [Carmody et al. 2011]

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Psychiatric Population

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Tobacco Cessation and Severe Mental Illness [SMI]

- Tobacco use and dependence are disproportionately higher among persons with SMI mental illness compared with the general population [Ziedonis et al. 2008]
- Up to 70% of people with SMI smoke cigarettes and approximately half are heavy smokers [Babham & Gilbody]
- Tobacco-related illnesses are a major contributor to excess morbidity and mortality experience by people with severe mental illness [Banham & Gilbody 2010].
- **Depression**
  - Cross-sectional studies show that >30% of patients with current depression are daily smokers [Grant et al. 2004; Waxmonsky et al. 2005; Ziedonis et al. 2008]
  - Lifetime prevalence of major depression is as high as 64% among clinic-based smoking treatment programs [Hitsman et al. 2003]
- **Schizophrenia**
  - ~75%-85% of people with schizophrenia use tobacco [Hughes & Hatsukami 1986]
  - and ~50% are heavy smokers [> 25 cigarettes per day; Lasser et al. 2000]
  - Topography studies have found higher total puffs per cigarette and greater carbon monoxide boost in smokers with schizophrenia compared to controls [Hitsman et al. 2005; Tidey et al. 2005; Williams et al. 2006

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Facts about Tobacco Cessation and SMI

- **PTSD**
  - For patients with military-related PTSD, integrating smoking cessation treatment into mental health care resulted in greater prolonged abstinence compared to referral to specialized cessation treatment [McFall et al. 2010].
- **Depression**
  - Smokers with a history of depression are as likely as those without a depression history to achieve either short-term (≤3 months) or long-term (≥ 6 months) tobacco abstinence [Hitsman et al. 2003; Covey et al. 2006]
  - A recent meta-analysis found similar short-term tobacco abstinence among smokers with or without history of depression. However, smokers with a history of depression had 34% lower odds of long-term abstinence
- **Schizophrenia**
  - People with schizophrenia are able to quit with
    - Psychosocial treatment
    - Nicotine dependence treatment medications
    - Social support [Ziedonis et al. 2008]

What smoking cessation treatments work for people with SMI?

- Depression
  - Antidepressant pharmacological and psychological treatments have been combined with standard smoking cessation
    - One study compared standard CBT for smoking cessation with CBT for depression combined with standard CBT. [Brown et al. 2001]. Adding CBT for depression did not improve cessation compared with standard CBT for cessation. Smokers with history of depression did well with standard CBT [24.7% abstinence rate at 1 year]
    - Another study showed that smokers with recurrent major depression who received cognitive behavioral depression skills training were more than 2.43 times more likely to be abstinent at 12 months compared with smokers in the control conditions [Haas et al. 2004].
    - Three published studies have targeted smokers with current depression. Results from all three randomized clinical trials show that currently depressed smokers can achieve abstinence rates similar to those of non-depressed smokers [Hall et al. 2006; Munoz et al 1997; Thorsteinsson et all 2001]
- Schizophrenia
  - Motivational interviewing with personalized feedback was effective in motivating 32% of smokers with schizophrenia to seek smoking cessation treatment within one month of the single session compared with 11% for educational intervention, and 0% for those given information only [Steinberg, Ziedonis et al. 2004]
  - Bupropion is well tolerated and reduces smoking and carbon monoxide [Evins et al. 2001; Gorge et al 2002; Weiner et al. 2001]
  - Nicotine patch is safe and well tolerated
  - Nicotine nasal spray also helpful and may produce short-term reduction in schizophrenic symptoms [Smith et al. 2002 & 2006]
  - Treatment mediators and moderators [similar to those in the general population]
    - Greater baseline motivation to quit
    - Lower levels of tobacco dependence [Addington et al. 1998; Addington & el-Guebaly, 1998; George et al. 2000; Sacco et al. 2004]
    - Combination of psychosocial and medication treatments [Addington et al. 1998; Addington & el-Guebaly, 1998]
    - Using the optimal dose of nicotine replacement or bupropion [Evins et al. 2001; George et al. 2002; Kalman et al. 2005; Williams & Hughes 2003; Ziedonis, Smelson et al. 2005]
    - Atypical antipsychotics [Dudas, Sacco, & George 2003; George et al. 1995 & 2000; McEvoy et al. et al. 1999x2; Procyshyn et al. 2001; Sacco et al 2004]

Homeless Populations

Tobacco Use in Homeless Populations

- What should homeless persons worry about?
  - Shelter
  - Food
  - Drugs
  - Survival issues

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Actual causes of death

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Facts about Tobacco Use in Homeless Populations

- The prevalence of smoking is estimated to be up to 70% in homeless populations
- Homeless persons are heavier smokers (>20 cpd), start younger, and smoke for a longer duration than their non-homeless counterparts
- Although equally interested in quitting as other persons, homeless individuals have limited awareness of and access to smoking cessation programs
- Homeless individuals are generally excluded from tobacco research studies
- Little is known about smoking cessation within this population.

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Why do Homeless Persons Smoke Cigarettes? [Okuyemi et al. 2006]

- Boredom and lack access to alternative activities
- Mood regulation and stress reduction
- Lack of daily structure and routine
- Social activity and camaraderie
- Appetite suppression for weight/hunger control
- Viewed as a habit associated with behavioral triggers or simply done to satisfy physical and psychological cravings and regulate withdrawal symptoms

Reasons for smoking

- *"I think it is more of a lot to do with boredom...If I'm just sitting there and there's nothing to do, it's like, oh - I need to go smoke. I got to do something!"*
- *"With all the pressures of being homeless and all the situations you have to deal with, the cigarettes seem to be kind of a way out."*
- *"I'm bi-polar and so…it soothes me out."*
- *"No matter where you go, there's always a group of smokers you can walk up to, you know, start a conversation with."*

Past Quit & Relapse Experiences

- <u>Quit Methods</u>
  - Cold turkey
  - Mandatory cessation during incarcerations
  - Substitutes
  - Pharmacologic aids
  - During pregnancy
- <u>Reasons for Relapse</u>
  - Emotional or traumatic event
  - Associated with alcohol
  - Release from hospital, jail/prison or end of military service
  - Loss/change of job
  - After delivery of baby

Reasons for Wanting to Quit

- Personal appearance
- Financial benefits and high cost of cigarettes
- Reduced health risks for self and children
- Psychological and emotional benefits
- Concerns about secondhand smoke
- Inconvenient due to indoor smoking policies and limited places where permitted
- Wanting to be good role model for children
- Physical fitness

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Reasons for Wanting to Quit

- *"Your breath stinks, your clothes stink, your car stinks…and you've got the physical appearance of nicotine on your hands or on your teeth."*
- *"I feel guilty…I'm in a homeless shelter. I've got children and I buy cigarettes… $2.00 a day adds up."*

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Inhibitors/Barriers to Quitting

- Lack of daily structure & fewer restrictions
- Pervasive, socially accepted behavior within the homeless population
- Limited access to medical care & other support services
- More stressful, unstable life situations
- Unsanitary, crowded living conditions
- Competing priorities, such as job/housing search, recovery program, or other appointments
- Smoking associated with polysubstance use, chosen lifestyle, and self-medication for mental illness

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Preferred Smoking Cessation Program

- Retention
  - Partner with existing programs, transitional shelters, case managers
  - Obtain multiple contact information, including frequented service sites
  - Time & place – same every week, once per week, convenient/central sites
  - Incentives - provided every session, bigger reward at end, tangible goals
- Incentives and Compensation
  - Transportation assistance
  - Smoke-free entertainment opportunities
  - Merchandise or restaurant vouchers, gift cards/certificates
  - Accommodate personal needs and interests through choices
- Individual Counseling
  - More focused & private with personalized attention and fewer distractions
  - Counselor may be a non-smoker or not able to relate to homeless situation
- Support Groups
  - Supportive environment with opportunity to learn from & share with others
  - Accountability and competition may result in dishonesty and disagreement

Pharmacotherapy

Preferences by 1st choice

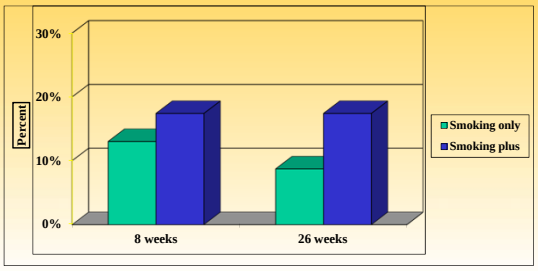
Zyban (29.3%)
Inhaler (28.8%)
Patch (20.7%)
Gum (13.8%)
Lozenge (10.3%)
Spray (0%)

- Consensus that Zyban would have the most "street value"

Smoking Cessation in Homeless Populations [Okuyemi et al. 2006]

- 8-week treatment with either 21 mg Nicotine patch or 4 mg Nicotine lozenge (participants' choice). Sample size=46
- Random assignment to one of 2 MI groups
  - Smoking only (5 MI sessions addressing smoking only)
  - Smoking Plus (5 MI sessions Addressing smoking along with other substance abuse/life events that impact their ability to quit smoking.
- 6 groups sessions to provide educational information and social support
- Main outcome was verified 7-day point prevalence abstinence from cigarettes at 8-weeks and at 6-months from randomization.
- Verification was by expired carbon monoxide (CO) $\leq$ 10 ppm. Salivary cotinine $\leq$ 20 ng/ml was used when there was discrepancy between self-report and CO

7-day verified Abstinence*



*Intent to treat and missing classified as smokers

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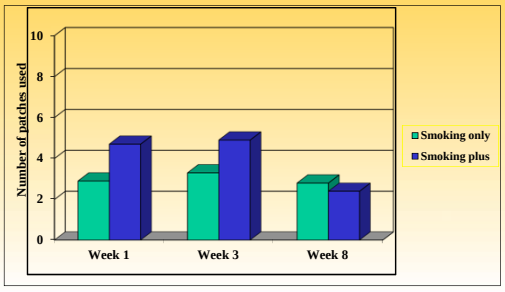
Number of Patches used in the past 7 days



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Another pilot study [Shelley et al. 2010]

- Another study which had no control group (n=58) tested the effects of a 12-week group therapy that used both motivational interviewing and Cognitive Behavioral Therapy principles plus choice of pharmacotherapy [nicotine patch, gum, lozenge or inhaler; bupropion, varenicline]
  - Most participants used at least one type of medication [67%]
  - 75% completed 12-week end of treatment surveys
  - CO-verified quit rates were 15.5% at 12 weeks and 13.6% at 24 weeks

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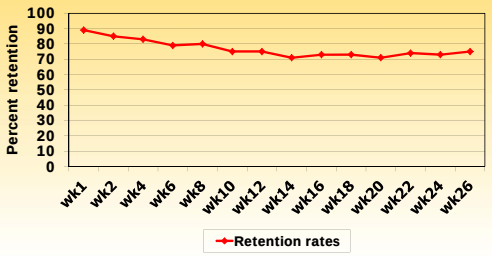
Recently completed large clinical trial [Goldade and Okuyemi et al 2011]

- A community-based randomized trial of 430 homeless smokers that assessed the effectiveness of adherence-focused MI to for smoking cessation.
- Participants were randomized to either
  - the intervention group (nicotine patch + MI): six individual MI counseling sessions each lasting 15 to 20 minutes
  - control arm (nicotine patch + standard care): a one-time brief (10-15 minutes) advice to quit smoking.
- At baseline participants in both groups received a two-week supply of 21-mg nicotine patches and an additional two-week supply of 21 mg nicotine patch every two weeks.
- Primary outcome was verified (CO and salivary cotinine] 7-day abstinence from cigarette smoking at week 26.

Recently completed large clinical trial [Goldade and Okuyemi et al 2011]

- 839 individuals screened for study eligibility
  - 568 were eligible
  - 430 were randomized
    - 216 to the MI intervention
    - 214 to the control group.
    - 76.1% completed their week 8 visit
    - 75.4% completed the final week 26 visit.
- Outcomes data promising [under review]

High Retention Rates!!



Summary

- Persons with chemical dependency, severe mental conditions or experiencing homelessness
  - Have strikingly high smoking rates
  - Are heavy smokers
  - Highly nicotine dependent
  - Are more likely to die from tobacco-related problems than from mental or other substance use disorders
  - Are interested in quitting smoking
  - Will participate in formal smoking cessation programs if given the opportunity
  - Cognitive behavioral therapy and motivational interviewing have been shown to work
  - Nicotine replacement therapies, bupropion, [and probably varenicline] are safe and effective
  - Quitting smoking does not jeopardize recovery from abuse of other substances
  - The national PHS 2008 *Clinical Practice Guideline* recommends that, **"Smokers with psychiatric and substance use disorders should be offered tobacco dependence treatment, and clinicians must overcome their reluctance to treat this population"**. Not providing evidence-based tobacco cessation treatment to these patients is less than standard care.

Publications and Resources

Resources

- American Cancer Society:1-800-227-2345; www.cancer.org
- American Lung Association Freedom From Smoking Online www.lungusa.org . : (maintains profiles of state tobacco control activities)
- American Legacy Foundation: www.americanlegacy.org
- Center for Disease Control: www.cdc.gov/tobacco
- Agency for Healthcare Research and Quality: www.ahrq.gov
- American Academy of Family Physicians: *www.aafp.org*
- American College of Chest Physicians: *www.chestnet.org*
- American Psychological Association: *www.apa.org*
- Association for the Treatment of Tobacco Use and Dependence: *www.attud.org*
- Medicare and Medicaid: *www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=130* and *www.cms.hhs.gov/Smoking Cessation*
- North American Quitline Consortium (NAQC): *www.Naquitline.org*
- National Cancer Institute: Call 1-877-44U-QUIT (1-877-448-7848); Text Message Experts on *LiveHelp:* www.smokefree.gov
- National Heart, Lung, and Blood Institute: *www.nhlbi.nih.gov*
- National Institute on Drug Abuse: *www.nida.nih.gov*
- National Quitplan: 1-800-QUIT-NOW (1-800-784-8669)
- Office on Smoking and Health at the Centers for Disease Control and Prevention: *www.cdc.gov/tobacco*
- Robert Wood Johnson Foundation: *www.rwjf.org*
- Society for Research on Nicotine and Tobacco: *www.srnt.org*
- TobaccoFree Nurses: *www.tobaccofreenurses.org*

Publications

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UNIVERSITY OF MINNESOTA
Driven to Discover

Kola Okuyemi, MD, MPH,
University of Minnesota Medical School
Minneapolis, Minnesota, USA
kokuyemi@umn.edu
612-625-1654

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Live Smoke Free

Public Health Law Center

Some Available Cessation Publications and Resources

Links to Resources

- The Help to Quit Program from beBetter Health, Inc. (www.help-to-quit.com)
  - Addressing Effective Treatment for Tobacco Users with Mental Illness and/or Substance Use Disorders
  - "Quitting tobacco is part of recovery from a mental illness or substance use disorder. Quitting tobacco won't hinder progress and might even be beneficial in ways beyond health improvement."

Links to Resources

- The Break Free Alliance (http://healthedcouncil.org/breakfreealliance)
  - Addressing Tobacco Use in Homeless Populations: Recommendations of the Expert Panel
  - #2 Top Policy Intervention Identified by the Panel: "Agencies serving homeless persons should voluntarily adopt tobacco non-use policies that prohibit tobacco use in the facility and on the grounds. These policies should apply to both clients and staff."

Links to Resources

- National Coalition for the Homeless (www.nationalhomeless.org)
  - Tobacco Use and Homelessness
  - "Some homeless smokers said that being able to obtain cigarettes gave them a sense of hope and self worth." (Okuyemi, et all., 2006)
  - "Tobacco control advocates need to make the homeless a priority in order to reduce smoking and mitigate the harmful effects of tobacco within such a vulnerable population."

Links to Resources

- Association for the Treatment of Tobacco Use and Dependence (ATTUD) (www.attud.org)
  - A National Call to Integrate Tobacco-Free Policy and Tobacco Cessation Services into Behavioral Healthcare
  - "Behavioral health providers can and must have an integral role in implementing tobacco-free policies, offering tobacco education, and integrating tobacco treatment within existing service settings across the lifespan and at every level of care."

Links to Resources

- Centers for Disease Control and Prevention: Preventing Chronic Disease (www.cdc.gov/pcd), Volume 9, 2012
  - Promoting Smoke-Free Environments and Tobacco Cessation in Residential Treatment Facilities for Mental Health and Substance Addictions, Oregon, 2010
  - While currently, few facilities have smoke-free policies and only half mandated cessation into discharge planning, "fewer than 10% of administrators objected to these future tobacco policies, and about equal numbers welcomed such statewide policy changes."

Links to Resources

- Journal of Consulting and Clinical Psychology, 2004, Volume 72, Number 6
  - A Meta-Analysis of Smoking Cessation Interventions With Individuals in Substance Abuse Treatment or Recovery
  - "Smoking cessation interventions provided during addictions treatment were associated with a 25% increased likelihood of long-term abstinence from alcohol and illicit drugs."

Links to Resources

- Annual Review of Public Health, April 2010, Volume 31
  - Confronting a Neglected Epidemic: Tobacco Cessation for Persons with Mental Illnesses and Substance Abuse Problems
  - "This review explains why tobacco use is such an important public health problem among those with mental illnesses and/or substance abuse disorders, with the intention of stimulating interest in reducing tobacco-related health disparities. No other public health field contains such potential gains in preventable death and disability."

Links to Resources

- Loretta Worthington: Worthington Consultants; 2002 Developing Leadership in Substance Abuse Fellow; Certified Addiction Specialist
  - Presentation: Addressing Nicotine in Dependence Treatment "The Elephant in the Living Room"
    - Presentation with author's notes (1 slide per page)
    - Presentation with 3 slides per page
  - "Addicts in recovery are extremely strong individuals. It is through challenging their character defects that they are empowered. That is part of a recovery process. It is unfair to limit them with expectations of weakness."

Links to Resources

- University of Colorado Denver, Department of Psychiatry, Behavioral Health and Wellness Program
  - Smoking Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers
- "Individuals with mental illnesses deserve accurate information regarding tobacco use and options for quitting."

How to Help Managers of Supportive Housing Decide to Adopt a Policy

Challenges/Concerns from Managers

- "Our population smokes at a high rate; we won't be able to enforce this."
- "Our population won't be able to quit smoking."
- "I don't want our residents to be kicked out of their housing."
- "We operate under the 'Housing First' model, and we don't want anything getting in the way of that."

Will the Typical Talking Points Work?

- Secondhand smoke exposure, fire, legal liabilities are likely to be relevant
- Cost savings may work; profits likely will not work
- Market demand will not be relevant
- Recognize that they are providing housing for very different reasons than other companies

Messages to Managers

- Cessation is not required
  - People can continue to live in the building and smoke; they just cannot smoke in smoke-free areas, including their unit
- There are many appropriate cessation resources available for the particular resident population
- Cessation can be a benefit to residents with mental health and addiction issues
  - Cannot be our responsibility to educate on every aspect of this, but we can begin the dialogue

Messages to Managers

- This is a social justice issue
  - Just because a population may smoke at a higher rate, it doesn't mean that the non-smokers deserve to be exposed to smoke
- The transition to becoming a smoke-free building can be customized to ensure that all residents feel comfortable
- Enforcement is up to the manager; multiple warnings are ok. Eventually eviction could be necessary, but it's not inevitable

"Housing First" Model

- Also known as "rapid re-housing"
- Rather than moving through levels of care, residents are moved directly from the streets or shelters to an apartment
- Based on the concept that a person's first and primary need is to obtain stable housing, and that other issues that may affect the household can and should be addressed once housing is obtained
- Opposing model: "housing readiness" — a person must address other issues that may have led to the episode of homelessness prior to entering housing

Why Does "Housing First" Matter?

- Many managers interpret it as "housing only" and believe that they should only be concerned with providing a roof and that residents should not be expected to have to worry about "unnecessary" rules/policies
- A smoke-free policy may be perceived as conflicting with "housing first" because residents may choose not to join their program or will be kicked out
- Refer back to social justice talking points to avoid the debate on "any housing is better than smoke-free housing"
  - Realize that you may never change their mind

The Policy Adoption Process

- The basic process is no different than in any other building

- However, the timeline may need to be a little longer in order to do more community education
- A survey can go a long way; there's no reason for the manager to have to guess what residents want

Process: Work with Social Services Staff

- Some properties may contract with professionals to provide on-site chemical or mental health services
- Even though these professionals work to improve the health of their clients, they may not believe that cessation is appropriate
- Work with management to educate these professionals on the importance of a smoke-free policy and the availability of cessation resources so that they can become messengers in the policy adoption process

How Live Smoke Free Provides Cessation Information

Resources Offered

To Managers

- Information on ordering cessation brochures from state quit line
- Information on Freedom from Smoking (ALA)
- On-site presentation when building goes smoke free on the benefits of the policy and basic cessation information

To Residents

- State quit line brochure
- On-site presentation when building goes smoke free on the benefits of the policy and basic cessation information
- Rarely: on-site cessation class taught by staff member

Communicating with Renters

- Most LSF staff are not trained cessation counselors, but we are the ones with the most interaction with residents
- Offer basic knowledge/suggestions
  - NRTs are available
  - State quit line and health insurance lines are available and often free
  - Find a quit buddy and call upon each other
  - Save the money normally spent on tobacco for a special treat

Cessation Classes: Lessons Learned

- Suburban HRA; 76 units; senior building
- Board was very concerned about going smoke free because they wanted to be fair to the smokers
- In order to alleviate fears, we offered a cessation class put on by an LSF staff member (cost was subsidized by us)
- Class was offered a few months before policy passed

The Results…

- Residents did not show up; even those who said they would be interested in a class
- When asked, the general opinion was that the smoke-free date was still too far in the future for cessation to be considered a priority
- When asked if they would have preferred for the class to be held after the smoke-free date, many weren't sure they would have attended
- A lot of our staff time and money for very little return

Other Lessons Learned

- MN state quit line offers classes for worksites, but they will not conduct classes for apartment residents
  - Perhaps in a special case if there are a lot of employees in the class
- We have answers on cessation in disparate populations, but we don't always know what will resonate with a manager
  - More practical knowledge is needed now that we have the academic knowledge

- We use "smoke free" as a positive message rather than "smoking ban" or "no smoking"; the universal "no smoking" symbol may be a trigger or seem harsh, so we try to use other images or change the color of the symbol

Maine Lessons Learned: SF Transitional Housing

Stay true to core SFH messages, emphasis on:
- It's about the smoke, not the smoker
- NOT about targeting and evicting smokers

Aligns with facilities goals to create safe and healthy living environments!

"Housing first" – don't want to create more evictions and homelessness

Tenant population has high smoking rates – not sure they can quit or that its the right time to tackle that.

Key Smoke-Free Transitional Housing Messages

Key Transitional Housing Professional Concerns

smokefree

Maine Lessons Learned: SF Transitional Housing

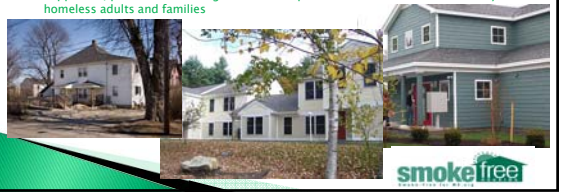
Communication and understanding what smoke-free housing is (and isn't) are key to making transitional properties smoke-free.

To combat fears, focus on facts:
- People with behavioral health issues want to live in smoke-free environments
- Transitional housing residents deserve a healthy living environment free from secondhand smoke
- Smoke-free environments are a daily norm

smokefree

A Maine Example: Tedford Housing

- **Adopted 100% smoke-free policy in 2008**
- **Mission:** Tedford Housing works to end homelessness in Maine by providing, in collaboration with others, shelter, housing and services to those in need. We work to help people become more self-sufficient and advocate for change so that no one faces the prospect of being without a home.
- **Provide**:
  - Homeless Shelters
  - Supportive, permanent housing units in multiple Maine communities for formerly homeless adults and families



A Maine Example: Tedford Housing

Reasons for going smoke-free:

- Create a smoke-free environment for employees
- Don't want non-smoking tenants exposed to secondhand smoke
- Concerns for children in housing being exposed to secondhand smoke
- Significantly decreased maintenance costs from going smoke-free
- Adopting a policy reducing cigarette-related fire risk

It's about the smoke, not the smoker BUT…

Providing good cessation support for residents:

Provided tenants with extended notice of policy change to allow for behavior change

Access Health provided onsite tobacco cessation support and provides community support

Additional cessation support provided to Tedford Residents:

TOBACCO Intervention BASIC Skills Training

Call To Quit 1-800-207-1230 THE MAINE TOBACCO HELPLINE

Healthy Maine Partnerships

Training Housing Staff to do Brief Tobacco Interventions

Maine Tobacco Helpline (including NRT support)

smokefree

Live Smoke Free

Public Health Law Center

What Advocates Say About Cessation

- "I always provide cessation materials when working on any kind of no-smoking policy work. To me, they go hand-in-hand."
- "I have left quit kits with apartment managers, but it does not seem that they are utilized well."
- "25% of our clinic clients from the year were from city subsidized housing, and the great things was they sort of formed their own support group to help each other quit."

Resources Offered

- State quit line brochures/cards
- Lists of local quit classes offered through clinics or other web-based services
- Posters/brochures about cessation classes and NRT availability
- American Lung Association resources
  - Lung Help Line
  - Freedom from Smoking program
- Quit kits
- On-site cessation classes

Quit Kits

- Made available to individual residents or to managers (may be a charge depending on how many are ordered)
- Includes items such as
  - Information on NRT
  - Trinket (magnet, window cling, etc.)
  - Quit line contact information
  - Lung Help Line/Freedom from Smoking
  - Mints, gum, other goodies

Quit Kits

Courtesy of the American Lung Association in Minnesota

Door Hangers

- Respiratory Health Association of Metropolitan Chicago
- Effective in larger complexes where residents may not normally visit a central bulletin board/management desk
- When a workshop or cessation group is offered at the complex, a flyer is stapled to the door hanger

Door Hangers

Courtesy of the Respiratory Health Association of Metropolitan Chicago

Closing Thoughts

- Transitional and supportive housing can be smoke-free environments
- Research indicates that special populations can and should quit smoking
- Housing providers often do not understand that cessation is possible for their residents
- Advocates should take time to educate and work with housing providers to help them understand the importance of smoke-free policies

Webinar Series

Based on the Smoke-Free Multi-Unit Housing Program Continuum

- *The Case for Smoke-Free Housing*
- *Getting to Know the Multi-Housing Industry*
- *Building Your Smoke-Free Housing Program*
- *Understanding Legal Issues*
- *Strategies to Reach the Housing Industry*
- *Working with Property Owners/Managers to Adopt a Smoke-Free Policy*
- *Providing Cessation in Smoke-Free Buildings*
- Working with Renters Exposed to Secondhand Smoke – February 9th
- Program Sustainability – February 23rd

Learn more and register at
www.mnsmokefreehousing.org/cppw

Coming in 2012…

- Policy manual with step-by-step guides on building a smoke-free housing program
- Research paper on Live Smoke Free's successes and lessons learned
- Guides on working with disparate populations and cessation as it relates to multi-housing
- Smoke-free lease addendums in multiple languages and other legal resources

Contact Information

Live Smoke Free

Carissa Larsen
Assistant Program Director
carissa@ansrmn.org
651-646-3005

Brittany McFadden
Program Director
brittany@ansrmn.org
651-646-3005

Public Health Law Center

Warren Ortland
Staff Attorney
warren.ortland@wmitchell.edu
651-290-7539

www.mnsmokefreehousing.org