



Addressing Tobacco Use in Homeless Populations

Recommendations of the Expert Panel

Convened October 21, 2009, Washington, DC



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PREAMBLE

In the United States, every person should have the right to be healthy and every life should be valued. The high prevalence of tobacco use in homeless populations is a national health issue. The panel convened recognizes that the likelihood of success for any of the following recommendations begins with the eradication of homelessness.

BACKGROUND

The Health Education Council

The Health Education Council is a private, nonprofit organization whose mission is to promote healthy communities around the world. The Council is dedicated to providing access, education, advocacy and training to empower individuals towards a healthy life.

Break Free Alliance

Break Free Alliance is a national network of organizations, state tobacco programs, regional partners and researchers working to end the cycle of tobacco use and poverty. We partner with a variety of stakeholders to develop Alliance initiatives, programs and services and disseminate promising strategies and recommendations nationally. The Alliance is funded by the Centers for Disease Control and Prevention, Office on Smoking and Health and administered by the Health Education Council.

The work of Break Free Alliance is accomplished through the leadership of the Alliance's Coordinating Council and through partnerships with stakeholders nationwide. Both the National Health Care for the Homeless Council (NHCHC) and the National Coalition for the Homeless (NCH) serve as members of the Coordinating Council and stakeholder body respectively. This panel was convened with their support, both organizations having recognized the need to develop comprehensive tobacco policy and programming initiatives to reduce tobacco use rates among homeless persons.

Tobacco Use and Homelessness

The panel estimates that between 70-80% of homeless persons use tobacco, compared to 19% of adults in the general population (Connor, 2002; Heffron, 1997; Sachs-Ericsson, 1999). Homeless persons face unique barriers when it comes to quitting and few service providers offer adequate tobacco cessation programs to meet the needs of this particular population of tobacco users. Tobacco use among homeless persons needs to be addressed much more strongly by policy makers, the academic community, funders and homeless service providers in order to mitigate the consequences of tobacco use in this population and to reduce overall prevalence rates.

Meeting Goals

This panel convened for the purpose of addressing the following goals:

1. Identify the successes and challenges to addressing tobacco use in homeless populations.
2. Identify current tobacco cessation practices and models for homeless populations.
3. Develop targeted recommendations for dissemination among researchers, policy makers, funding agencies, state tobacco control programs and service providers.

Panel members were asked to share specific knowledge of the problem as it related to their discipline, participate in a facilitated workgroup of 10-15 other panelists to set priorities, and work collaboratively with other panelists to concur on specific recommendations for national dissemination.

Process

Invitations to participate in the meeting were sent to tobacco control advocates, formerly homeless individuals, researchers, social service providers and clinicians working with homeless persons, and funders from the private and public sectors. The intent was to limit the panel to no more than 30 individuals in order to generate dialogue and debate.

Panelists were convened on October 21, 2009, in Washington, DC. The following presentations were made to frame the discussion:

Overview of Homelessness in the U.S., Michael Stoops, Director of Community Organizing, National Coalition for the Homeless

Tobacco Use among the Homeless: Challenges and Opportunities, Donna Shelley, MD, MPH, Clinical Associate Professor, NYU College of Dentistry and School of Medicine

Panelists were asked as a group to provide a general overview of the problem of tobacco use among homeless persons. They were then divided into groups of four depending on their area of expertise (health and tobacco control, funding/research, community advocates, policy). Each of these groups were asked to generate responses specific to 1) the successes and challenges to addressing tobacco use in homeless populations, and 2) promising strategies, program models and approaches to address challenges and barriers. The groups later merged together to consolidate, integrate and categorize their responses, expand their dialogue, and prioritize the importance

of the responses. The panel then developed decision criteria and recommendation categories.

This document contains a summary of the problem as identified by the panel and promising interventions as they relate to policy, tobacco control programs, social service programs, and future research. For each topic area, the panel identified critical factors to achieving success, challenges and barriers, what is needed to overcome the challenges and barriers, and the top five recommended interventions/strategies.

PROBLEM IDENTIFICATION

The reasons for the high rate of tobacco use among homeless persons are varied and complex. Homeless service providers have been slow to recognize tobacco use as a serious addiction that warrants the same attention as illicit drug and alcohol addiction, just as public health and tobacco control workers have been slow to partner with social service providers to address the issue. Tobacco control among homeless persons needs to be approached as both a health crisis and social justice issue.

Why do homeless persons have a national smoking prevalence rate of over 70%? Why is this happening? What is going on?

Among homeless persons, depression, anxiety and other mental health disorders contribute to tobacco use. Cigarettes are easily available and are a cheap way for homeless individuals to self-medicate. Other contributors to tobacco use include exposure to violence/trauma, hunger, boredom, the need for companionship and socialization (cigarettes provide this), nicotine addiction and tobacco industry marketing of tobacco products to homeless populations. There is a belief among many homeless individuals that they cannot change or influence their environment. Some homeless individuals do not accept services and many have cognitive deficiencies that make cessation outreach and success more difficult. Many do not see the benefits of quitting tobacco use.

According to panelists, tobacco cessation is a low priority among homeless service providers. Many of them smoke and nicotine addiction is not being addressed in most clinical settings where homeless individuals receive services. While more 12-step meetings (Alcoholics Anonymous; Nicotine Anonymous) are now smoke-free, there are still few successful programs for referrals, inadequate professional practice standards around treating tobacco addiction for homeless persons and little professional accountability. As a result, tobacco quit rates are extremely low in homeless populations. There is a need to train service

providers to address tobacco use in clinical encounters with homeless patients and to encourage them to treat nicotine addiction as they would other "more urgent" medical and social concerns.

What stressors and issues do the homeless have outside of tobacco use that is important to know in terms of addressing the issue?

Homeless individuals experience stressors that contribute to tobacco use and make tobacco cessation more difficult. These include substance abuse issues, lack of shelter, lack of social support, low self esteem, unemployment, lack of care from society, lack of social empathy, lack of education, hunger and starvation, little or no access to healthcare, tobacco use among peers, lack of private living conditions, and the stress of caring for family and children while homeless.

Why does the issue of tobacco use among homeless persons need to be addressed more strongly? What are the key health related and other consequences of not addressing the issue?

Cardiovascular disease is the primary killer of homeless and formerly homeless individuals. While data is limited, the national health care costs associated with tobacco use among homeless persons is estimated to be extremely high. The prevalence of obstructive lung disease and the rates of death from obstructive lung disease are higher among homeless persons than in the general population (Snyder, 2004; Hwang, 1997). Additionally, tobacco use in this community contributes to a higher rate of communicable disease as many homeless individuals share cigarettes and salvage discarded cigarette butts off the streets.

GENERAL RECOMMENDATIONS OF THE EXPERT PANEL

- Homeless service providers should integrate tobacco cessation interventions into all points of access to homeless persons - from street outreach to housing placement.
- Medical and social service providers should ensure access for homeless persons to all treatment modalities for nicotine replacement therapy (NRT), other cessation medications/aids and counseling regardless of insurance and citizenship status.
- Homeless service providers should adopt tobacco non-use policies for clients and staff at facilities treating and providing services to homeless persons.

- Tobacco control professionals should strive to increase the use of existing cessation resources by promoting services to agencies serving homeless persons.
- State Medicaid programs should cover tobacco dependence treatment, including counseling and NRT.
- Medical and social service agencies serving homeless persons should integrate the U.S. Public Health Service-sponsored, *Clinical Practice Guideline: Treating Tobacco Use and Dependence* into current practice and systems.
- Agencies serving homeless persons should integrate tobacco cessation programming as a part of behavioral health care and substance abuse services.
- Tobacco control advocates and state/community tobacco programs should work to build capacity within homeless provider networks to address tobacco use.
- Tobacco control advocates and state/community tobacco programs should invite formerly homeless individuals and advocates to join existing tobacco control networks and coalitions.
- More public funding and research is needed to investigate the effectiveness of existing tobacco cessation strategies for the general population and their impact on homeless persons to determine promising practices.
- Tobacco cessation intervention models that are specifically tailored to homeless persons are needed.
- Advocates should encourage state quitline service providers to develop treatment protocols specifically for homeless persons.
- Outreach workers and service providers should utilize strategies other than the provision of tobacco in engaging homeless persons in care.

POLICY INTERVENTIONS

Traditionally, tobacco control policy initiatives have had a great impact on reducing overall tobacco use rates among the general population. An example of a population-based policy intervention would include a clean indoor air law (for example, ordinances prohibiting tobacco use in restaurants, bars, public places, worksites, etc.). Other policy strategies have included increasing tobacco excise taxes, limiting the way retailers can display and sell tobacco products

and prohibiting smoking in vehicles with young children present. While these policies have had an impact on the general population, panelists believe that they have had less of an impact on curbing tobacco use among homeless persons.

According to the policy expert members of the panel, the following are considered promising policy-related strategies to reducing tobacco use among homeless persons:

- Passage of city/county ordinances requiring homeless shelters to be tobacco-free and limit smoking within 20 feet of building entrances and exits.
- Enactment of voluntary policies by homeless service providers that require intake personnel to ask a client about his/her tobacco use.
- Requirement of all evaluation tools such as the Government Performance and Results Act (GPRA) used by Substance Abuse and Mental Health Services Administration (SAMHSA)-funded projects targeting homeless persons to include questions about tobacco use at intake and throughout treatment.
- Passage of statewide, clean indoor air laws that DO NOT exempt homeless shelters, food banks, alcohol/drug treatment centers and bars.
- Adoption of public housing policies that prohibit tenants from smoking inside of units, thus reducing exposure of other occupants to secondhand smoke.
- Enforcement of local ordinances that prohibit retailers from selling single cigarettes (loosies).
- Enforcement of Food and Drug Administration (FDA) regulation of tobacco products, which limits how tobacco companies and retailers can advertise and market tobacco products.
- Voluntary adoption of tobacco-free grounds policies by homeless service agencies including mental health and substance abuse service providers.
- Passage of city and statewide universal healthcare coverage policies (see City of San Francisco example listed in the Resource section of this document).
- Passage of legislation requiring state Medicaid coverage for NRT.

Critical Factors for Achieving Policy Success

Treatment for nicotine addiction among homeless persons should be integrated into broader standards of care for shelters and health and social service providers. Partnerships between state/local tobacco control programs and homeless service organizations/advocates can lead to community mobilization to gain support for policy enactment and legislation. Research by and with the homeless community is essential to gaining knowledge about tobacco control policies that impact homeless persons, especially women and children. Policy adoption

takes perseverance, patience and the involvement of political and community champions dedicated to the issue of tobacco control. There is a continual need for adequate funding to address the problem and garner support for the passage of policies. Local, state and national organizations should work together to support a culture for policy change.

Challenges and Barriers Identified

There is a lack of solid prevalence, economic and health care expenditure data on tobacco use among homeless persons. Incorporation by agencies of voluntary policies to prohibit tobacco use often takes a back seat to incorporating policies that curb illegal drug and alcohol use. Additionally, agencies serving homeless persons often receive tobacco industry grants/sponsorships (including money for direct food distribution), making it difficult for them to adopt voluntary tobacco use policies. Similarly, many policy makers still accept tobacco industry funds for their election campaigns, which can affect their votes on tobacco control legislation such as clean indoor air.

What Is Needed to Address the Challenges and Barriers?

Funding is needed for community-based participatory research and data collection related to tobacco use among homeless adults/families as well as for evidence-based cessation programming and assessments of service providers' level of readiness to adopt tobacco use policies. Such data will help convince policy makers that this is an important issue that needs to be addressed. Education for policy makers and service agency directors on social justice issues, tobacco-related health disparities and the cost effectiveness of cessation services for homeless persons will help garner support for the passage of policies that impact homeless persons. Education about the problem of tobacco use among homeless persons for community advocates is also a must. Homeless persons, and those who serve them, need to be empowered to advocate for policy change.

Partnerships between public health and accrediting agencies that oversee and license service providers could also result in the implementation of tobacco use policies as part of the standards of care, and agencies receiving federal homeless dollars could be required to adopt tobacco non-use policies. Homeless service providers and policy makers should be encouraged to enact voluntary policies that prohibit them from accepting tobacco industry monies and/or in-kind contributions from tobacco companies.

Top Five Policy Interventions Identified by the Panel

1. State Medicaid coverage should include tobacco cessation treatment, NRT and counseling services.
2. 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.
3. Faith-based organizations, social service organizations, public health agencies and others should partner to adopt or strengthen agency policies and local clean indoor air laws to further change community norms around tobacco use.
4. Providers serving homeless persons should enact policies that integrate tobacco cessation treatment into the continuum of care.
5. Communities should adopt clean indoor air policies that do not exempt homeless shelters and transitional housing facilities.

TOBACCO CESSATION INTERVENTIONS IDENTIFIED BY THE PANEL

CDC's *Best Practices for Comprehensive Tobacco Control Programs—2007* is an evidence-based guide to help states plan and establish effective tobacco control programs to prevent and reduce tobacco use. The goal of comprehensive programming is to reduce exposure to environmental tobacco smoke, prevent initiation in youth, promote cessation in adults and youth and identify and eliminate health disparities among populations.

While it is not clear if the best practices outlined in the CDC document are effective among homeless persons, tobacco control expert members of the panel agree that the following promising interventions aimed at reducing tobacco use among this population should be considered by state tobacco control programs, community-based organizations and others who fund and implement tobacco control programming:

- Integrate motivational interviewing techniques into service delivery systems that serve homeless individuals.
- Integrate tobacco cessation counseling into drop-in visits at clinics, shelters and other service centers. Staff should be trained in brief intervention counseling techniques to ask clients if they use tobacco, if they want to quit, and provide them with tobacco cessation resources.

- Provide cessation classes, state quitline referral information and other resources for staff who work with homeless populations. Likewise, train staff who have one-on-one interactions with clients to provide tobacco cessation counseling for them.
- Develop cessation curricula specifically tailored to homeless individuals and service delivery systems. (e.g. Adaptation of the Matrix Model - see Rawson, 1995; <http://www.drugabuse.gov/BTDP/Effective/Rawson.html>)
- Engage the support of existing tobacco control experts to develop or adapt tobacco education and self-help materials for homeless populations (e.g. adapt *Pathways to Freedom* and/or *40 Days to Freedom* to make them more applicable to homeless persons).
- Train case managers in social service settings on the 5 A's (Ask, Advise, Assess, Assist and Arrange) and/or the 2A's + R (Ask, Advise and Refer for cessation treatment) model (Fiore, 2000).
- Health departments should develop partnerships with homeless shelters and provide free or reduced-cost NRT and other cessation medications/aids to residents willing to quit.

Critical Factors for Achieving Success

Public health entities must build relationships with homeless service providers and link them to free training resources in tobacco cessation. This is critical to the success of integrating cessation programs and resources into service delivery systems for homeless individuals. Identifying a site champion or dedicated staff person to "oversee" a tobacco cessation program is a key component to a successful program as well. Tobacco control advocates should work with homeless service providers to explore ways to provide free or low-cost NRT, and all staff working in agencies serving homeless individuals should be trained to provide brief cessation counseling interventions. More intense

interventions should be easily accessible and tailored to clients with substance abuse disorders and mental illnesses. Cessation assistance must also be given to staff who want to quit.

Challenges and Barriers Identified

Homeless individuals are a hard population to reach and maintain contact with due to their transient nature, and although many individuals have cell phones, the cost of minutes used creates a challenge for service providers to stay in contact. Service agency staff's attitudes towards addressing tobacco use are often negative and many staff are tobacco users themselves. Historically, tobacco has been used by outreach workers and health care providers as an incentive for engaging difficult-to-reach clients in care, sending a negative message about the health effects of tobacco use. NRT options are often non-existent and many sites cannot afford to purchase this effective medication for clients. Veterans are of special concern as many are both tobacco users and homeless and few cessation programs exist that are specifically tailored for veterans recently returning from war. Most state tobacco cessation quitlines are not set up to address the needs of homeless persons, and nicotine addiction treatment policies and programs in facilities vary from agency to agency. Collaboration between social service providers, public health and tobacco control programs to address this issue is a rarity.

What is Needed to Address the Challenges and Barriers?

Tobacco control advocates and public health programs should collaborate with homeless and social service providers to adapt existing intake and discharge procedures used when providing services for homeless persons and develop tracking mechanisms to assess and monitor tobacco use as individuals move through the housing continuum. By building partnerships between tobacco cessation experts and emergency shelters, transitional housing facilities, rescue missions and others, it may be possible to track individuals and offer continued cessation support services for this transient population.

Training models on social justice issues have been developed by public health entities to help address negative staff attitudes about the importance of cessation services. One such model was developed

by Public Health Seattle & King County through its Community Tobacco Cessation Partnership program – a systems-change approach that integrates brief tobacco intervention into the daily work of community agencies. More information about this program can be found in the resource section of this document. State and local health departments can take advantage of the Medicaid Match program to generate dollars for purchasing NRT for community agencies who cannot afford it. (Medicaid Match is a program that reimburses local government health programs for work they do that promotes Medicaid services.)

Note: This is different than Medicaid coverage that an individual client would use to get NRT as they need it and if their state Medicaid program covers it. Some states require Medicaid coverage for NRT – these existing models can be a resource to other state programs struggling with this issue. Refer to the resource section of this document for a list of states that provide Medicaid coverage for NRT.

There are also successful nicotine addiction treatment models that have been proven to be successful in the general population and are showing promise in non-traditional settings. These include motivational interviewing, cognitive behavioral therapy, 5A's, and the Matrix Model for treating drug addictions. The panel agreed that integrating nicotine addiction treatment into the substance abuse treatment model is very feasible.

MATRIX MODEL

The Matrix Model is a comprehensive, multi-format program that covers six key clinical areas:

- Individual/conjoint therapy
- Early recovery
- Relapse prevention
- Family education
- Social support
- Urine Testing

This integrated therapeutic model also incorporates the following components:

- Cognitive behavioral
- Motivational enhancement
- Couples and family therapy
- Individual supportive/expressive psychotherapy and psycho-education
- Twelve-step facilitation
- Group therapy and social support

From Rawson, 1995. See <http://www.drugabuse.gov/BTDP/Effective/Rawson.html>

It is also important to note that many homeless service providers employ the "Housing First" model. "Housing First" assumes that individuals who have safe shelter will be more successful with cessation attempts (see below), but training is needed for service providers in tobacco cessation. Peer-to-peer counseling has been shown to be an effective model for assisting individuals with a number of issues, and therefore formerly homeless individuals should be engaged to provide outreach and counseling to help those trying to quit. The National Alliance for the Mentally Ill (NAMI) provides training for service providers in treating nicotine addiction. States and community-based organizations should partner with local NAMI chapters (to find your local NAMI, visit http://www.nami.org/template.cfm?section=your_local_nami). Cessation services can also be integrated as part of the Veteran Administration's (VA) "Stand Down" program (see below).

"HOUSING FIRST" MODEL

Housing First is an approach to ending homelessness that centers on providing homeless people with housing quickly and then providing services as needed. What differentiates a Housing First approach from traditional emergency shelter or transitional housing approaches is that it is "housing-based," with an immediate and primary focus on helping individuals and families quickly access and sustain permanent housing. This approach has the benefit of being consistent with what most people experiencing homelessness want and seek help to achieve.

From the National Alliance to End Homelessness www.endhomelessness.org

STAND DOWNS

Stand Downs are one part of the Department of Veterans Affairs' (VA) efforts to provide services to homeless veterans. Stand Downs are typically one to three day events providing services to homeless Veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VAs, other government agencies, and community agencies who serve the homeless.

From the United States Department of Veterans Affairs (VA). To find a Stand Down in your state, visit: www1.va.gov/homeless

NEW YORK UNIVERSITY'S "BUNDLE" MODEL FOR TOBACCO CESSATION PROGRAMMING IN HOMELESS SERVICE AGENCIES:

- Facilities must be smoke-free
- At least one staff is identified as a site champion to oversee cessation programming
- All staff are trained and competent in providing brief cessation counseling
- Intensive interventions easily accessible/tailored for clients with substance abuse disorders and mental illness
- Clients have access to sufficient supplies of pharmacotherapy (e.g. NRT)
- Staff who are tobacco dependent are given assistance to quit

From Donna Shelley, MD, MPH, New York University, College of Dentistry, School of Medicine

Top Five Cessation Interventions Identified by the Panel

1. State and local health departments should provide funding for free or reduced-cost NRT for homeless persons by making cessation-specific funds available to homeless service providers.
2. State and local health departments should partner with homeless service providers and other community agencies to provide basic health care services for homeless persons.
3. Tobacco control advocates should develop relationships with agencies that serve people who are currently or recently homeless to create capacity for promoting and supporting tobacco cessation.
4. State and local health departments should work with state quitline service providers to pilot test counseling protocols and outreach strategies specifically tailored to homeless persons.
5. Identify "site champions" within the homeless service community who can motivate and convince agency leadership to integrate cessation programming services for clients and staff. Invite these individuals to join state and local tobacco control coalitions and workgroups.

RECOMMENDED INTERVENTIONS FOR SOCIAL SERVICE PROVIDERS

Social service providers who serve homeless individuals can play an important role in reducing tobacco use prevalence among homeless persons. Even though many are not tobacco cessation or policy experts, they understand the issues of homelessness, the stressors homeless individuals face and the barriers they experience to receiving services. As stated previously, partnerships between public health and social service providers are essential to reducing tobacco use among homeless persons. From the perspective of community advocates and social service providers, the following were identified as promising interventions related to reducing tobacco use among the homeless intended specifically for consideration by social service agencies:

- Regulate and/or prohibit tobacco use within your facility.
- Provide more opportunities for homeless individuals to access tobacco-free, affordable housing.
- Integrate tobacco cessation counseling into the existing service structure where homeless individuals receive services.

- Train service staff to provide positive reinforcement and feedback to those making a quit attempt or contemplating a quit attempt.
- Provide a safe environment for individuals as this will encourage cessation attempts.
- Integrate a comprehensive approach to health into existing services that includes nicotine addiction treatment.
- Provide a variety of pharmacotherapy options (NRT) if possible and not just the nicotine patch exclusively.
- Establish support groups within your agency for those making a quit attempt.
- Hire non-smoking staff.
- Make tobacco cessation a priority within your agency and increase the number of case managers who are trained in treating nicotine addiction.
- Provide basic tobacco and health education classes for clients that include tobacco education information and information about the dangers of secondhand smoke.
- Seek out and identify local tobacco control coalitions to join and partner with them to identify collaborative opportunities and resources.

Critical Factors for Achieving Success

Having all facility staff committed to tobacco cessation and decreasing tobacco use among their clients is imperative in a service delivery system. Providing access to NRT and a safe and smoke-free environment will increase the chances that a client can quit tobacco successfully. Treatment for nicotine addiction should be integrated into a comprehensive approach to improving the overall health of clients.

Challenges and Barriers Identified

The lack of cessation integration into social service networks, behavioral health services, faith-based agencies, food banks, correctional facilities and transitional housing agencies remains a barrier to reducing tobacco use prevalence among the homeless. Homeless individuals are under extreme stress because they lack basic needs (i.e., shelter, adequate food, jobs, resources, etc.). Lack of childcare and transportation to cessation services contribute to continued tobacco use. Facilities that serve the homeless often lack the expertise and physical space to provide cessation classes or needed services. Mental illness among the homeless also makes it more difficult for them to access appropriate cessation help. Often, there is also a lack of community and family education and support.

What Is Needed to Address the Challenges and Barriers?

Clearly, more funding is needed to provide homeless services and basic needs including clothing, shelter,

food, job skills and job placement. By providing basic services it is more likely that homeless individuals will attempt cessation. Keeping clients busy with activities while they are receiving shelter services will also increase their chances of quitting successfully. If possible, integrate cessation services into facilities that serve homeless persons as opposed to looking to outside agencies to provide them. In particular, the integration of cessation services into other addiction services may be particularly useful since homeless smokers have very high rates of concomitant alcohol and drug use. Utilize free community center space to provide childcare and cessation services for clients and engage local community centers and churches to offer family education and support programs for homeless persons attempting to quit. Engage providers who are behavioral health specialists, integrate tobacco education/cessation into behavioral health specialists' job responsibilities and implement the use of the *Clinical Practice Guideline: Treating Tobacco Use and Dependence* (US Department of Health and Human Services, Public Health Service). If onsite cessation classes are not possible, consider providing tobacco cessation information via satellite. State quitline services may be an option but coordinate with your local state tobacco control program office to discuss the feasibility of providing phones at clinics and shelters for quitline access.

Both the "Housing First" model and the New York University "bundle" model are addressed again below as these models are at the heart of a framework to address tobacco among homeless persons and the panel supports these.

Top Five Interventions for Social Service Providers Identified by the Panel

1. Integrate tobacco cessation services into the "Housing First" process, adding a training component for staff to address tobacco cessation.
2. Implement the New York University "bundle" model to address tobacco use among clients receiving services (see box on page 13).
3. Employ treatment strategies used in alcohol and drug recovery and treatment program models (e.g. 12-step programs such as Alcoholics Anonymous and Nicotine Anonymous may already be in many shelters).
4. Integrate the *Clinical Practice Guideline: Treating Tobacco Use and Dependence* (U.S. Department of Health and Human Services, Public Health Service, June 2000).
5. Integrate tobacco cessation into a broader service delivery system for improving the overall health of homeless persons.

RESEARCH PRIORITIES IDENTIFIED BY THE PANEL

Tobacco cessation is a low priority for funders who provide financial support for homeless services. Likewise, homeless persons are a low priority for funders of tobacco control programs. Therefore, there is a need to raise awareness among all funders (public and private) about the impact of the homeless population's tobacco use and poor health behaviors on health care costs and social service systems. There is a lack of reliable tobacco use prevalence data on this population because homeless individuals are traditionally not included in smoking cessation studies or state data collection and surveillance systems. Few categorical funding opportunities to address tobacco use among homeless persons are available through special Funding Opportunity Announcements (FOAs) from federal agencies or through the solicitation of Special Interest Projects. Therefore, there are many unanswered questions that impede progress in reducing tobacco use among homeless persons.

Research Questions

The panel identified the following questions and recommended they be addressed by future research initiatives:

- What is the impact of tobacco control policies and tobacco tax increases on the tobacco use behavior of homeless persons?
- What strategies can be implemented to increase the demand for tobacco cessation services for homeless individuals?
- When is the best time to start nicotine addiction treatment for homeless persons (i.e., while in treatment for other co-morbidity issues or when housed)?
- Are population-based cessation treatment interventions effective and if not, how do interventions need to be tailored?
- How do we implement clinical practice guidelines for treating tobacco use and dependence and tobacco control policies in organizations serving homeless persons?
- What is the effect of delivering tobacco cessation services for homeless persons in non-clinical settings?
- What is the efficacy of a free intervention like Nicotine Anonymous, a 12-step program for tobacco cessation?
- What is the prevalence of smokeless tobacco use and menthol products among homeless persons?

- What are the smoking patterns of homeless persons (for example, do they purchase single cigarettes vs. packs, smokeless tobacco, etc.)?
- How does the barter system used by homeless persons impact tobacco use and cessation?
- How can the medical treatment model be paired with an understanding of social determinants of health?

Critical Factors for Achieving Success

Funders and researchers need to think broadly in studying the problem of tobacco use among homeless persons. Community-based participatory research should involve non-traditional partners who serve homeless individuals and families. There is a need for flexibility in research design and the ability of researchers to take novel approaches that adapt to the needs of this population. Process evaluation measures should be the priority in research design in order to better understand and document the successes and challenges of working with homeless individuals. Funders should think beyond tobacco to research the impact of providing basic needs on individual health behavior change and the prevention of chronic diseases among homeless persons. Providing incentives for health systems, providers and individual clients involved in research is important. In general, much has been learned about what strategies work to reduce tobacco use in the general population but more funding is needed to test the tailoring of these strategies for homeless persons.

RESOURCES AND LINKS

40 Days to Freedom (A cessation curricula for the African American Church). Available at: www.healthedcouncil.org

Best Practices for Comprehensive Tobacco Control Programs – 2007: http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf

Centers for Disease Control, Office on Smoking and Health: www.cdc.gov

City of San Francisco Health Access Program: <http://www.healthysanfrancisco.org/>

Government Performance and Results Act of 1993 (GPRA): http://www.whitehouse.gov/omb/mgmt-gpra_gplaw2m/

HUD Office of Public & Indian Housing Memo, "Non-Smoking Policies in Public Housing": <http://www.hud.gov/offices/pih/publications/notices/09/pih2009-21.pdf>

Health Education Council – Break Free Alliance and National African American Tobacco Education Network (NAATEN): www.healthedcouncil.org/breakfreealliance

National Alliance on Mental Illness (NAMI): www.nami.org

National Coalition for the Homeless: www.nationalhomeless.org

National Healthcare for the Homeless Council (NHCHC): www.nhchc.org

National Tobacco Control Networks: www.tobaccocontrolnetworks.org

Nicotine Anonymous website: <http://www.nicotine-anonymous.org/>

Pathways to Freedom: Winning the Fight Against Tobacco (A cessation guide for African Americans). See: http://www.cdc.gov/TOBACCO/quit_smoking/how_to_quit/pathways/index.htm

Public Health Seattle King County, Community Tobacco Cessation Partnership Program: <http://www.kingcounty.gov/healthservices/health/drugs/tobacco/ctcp.aspx>

Quick Reference Guide for Clinicians: <http://www.surgeongeneral.gov/tobacco/tobaqrg.htm>

Smoking Cessation Leadership Center: <http://smokingcessationleadership.ucsf.edu/>

State Medicaid Coverage for NRT: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5843a1.htm>

United States Department of Veterans Affairs - Stand Down program: www.va.gov/homeless

US Department of Health and Human Service, Public Health Service. Clinical Practice Guideline: Treating Tobacco Use and Dependence. June, 2000.

DOCUMENTS REVIEWED BY THE PANEL

Arangua, L., McCarthy, W.J., Moskowitz, R., Gelberg, L. & Kuo, T. (2007). Are homeless transitional shelters receptive to environmental tobacco control interventions? *Tob Control*, 16(2), 143-44.

Apollonio, D.E. & Malone, R.E. (2005). Marketing to the marginalised: tobacco industry targeting of the homeless and mentally ill. *Tob Control*, 14(6), 409-15.

Arnsten, J.H., Reid, K., Bierer, M. & Rigotti, N. (2004). Smoking behavior and interest in quitting among homeless smokers. *Addict Behav*, 29(6), 1155-61.

Benson & Hedges tobacco documents: "Special Kings Event Marketing Combined Plan" outlining efforts to penetrate minority communities, including plans for concerts benefitting homeless people and making contributions to local homeless organizations.

Baggett, T.P. & Rigotti, N.A. Cigarette Smoking and Advice to Quit in a National Sample of Homeless Adults. Abstract presented at 2009 Society of General Internal Medicine national meeting.

Butler, J., Okuyemi, K.S., Jean, S., Nazir, N., Ahluwalia, J.S. & Resnicow, K. (2002). Smoking characteristics of a homeless population. *Subst Abuse*, 23(4), 223-31.

Connor, S.E., Cook, R.L., Herbert, M.I., Neal, S.M. & Williams, J.T. (2002). Smoking cessation in a homeless population. There is a will, but is there a way? *J Gen Intern Med*, 17(5), 369-72.

DC Tobacco Free Families (American Lung Association of DC, American Cancer Society, DC Department of Health). (2009). Focus Group Final Report: Developing Strategies for Tobacco Addiction Treatment for the Homeless.

"Engagement Incentives." From: Homeless Link, London. Available at: <http://handbooks.homeless.org.uk/streetoutreach/positiveservice/waysOfWorking>

Erickson, S & Page, J. (1999). "To Dance with Grace: Outreach & Engagement to Persons on the Street." In: The 1998 National Symposium on Homelessness Research. U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services. Available at: <http://aspe.hhs.gov/homeless/symposium/6-Outreach.htm>

Falk, N. (2006). General Concepts of Outreach and Engagement. In P.M. Gillig and H.L. McQuiston (Eds.), *Clinical Guide to the Treatment of the Mentally Ill Homeless Person* (pp. 9-19). Arlington, VA: American Psychiatric Publishing, Inc.

National Coalition for the Homeless. (2009). Tobacco Use and Homelessness Fact Sheet. Available at: <http://www.nationalhomeless.org/factsheets/tobacco.html>

Okuyemi, K.S., Thomas, J.L., Hall, S., Nollen, N.L., Richter, K.P., Jeffries, S.K., Caldwell, A.R. & Ahluwalia, J.S. (2006). Smoking cessation in homeless populations: A pilot clinical trial. *Nicotine & Tob Res*, 8(5), 689-99.

Okuyemi, K.S., Caldwell, A.R., Thomas, J.L., Born, W., Richter, K.P., Nollen, N., Katherine Braunstein, K. & Ahluwalia, J.S. (2006). Homelessness and smoking cessation: Insights from focus groups. *Nicotine & Tob Res*, 8(2), 287-96.

Ross-Viles, S., Leon-Gurerrero, M. & Louch, J. CTCP: Partnering to support cessation for people who are homeless. Public Health & Seattle King County. Poster Abstract.

RJ Reynolds tobacco documents: "Project SCUM" (Sub-culture Urban Market) was a plan to penetrate alternative and marginalized communities, including "street people" in the Tenderloin. Available at: http://tobaccodocuments.org/landman/518021121.html?ocr_position=hide_ocr

Ohio Department of Health, Ohio Cross Cultural Tobacco Control Alliance. (2008). Tobacco Use Survey Report, YMCA Homeless Residence, Columbus, Ohio.

Spector, A., Alpert, H. & Karam-Hage, M. (2007). Smoking cessation delivered by medical students is helpful to homeless population. *Acad Psychiatry*, 31(5), 402-5.

Zerger, S. R2P: A Look at Smoking and Homelessness. Available at: <http://homelessness.samhsa.gov/Resource/R2P-A-Look-at-Smoking-and-Homelessness-37730.aspx?search=smoking&orgSearchString=smoking>

REFERENCES

Aloot, C.B., Vredevoe, D.L., Brecht, M.L. (1993). Evaluation of high-risk smoking practices used by the homeless. *Cancer Nurs* 16(2), 123-30.

Cohen, D.C. & Krating, M.A. (1993). Characteristics of homeless alcohol and drug abusers identified through an assertive outreach program. *J Soc Distress Homeless*, 2(3), 193-206.

Connor, S.E., Cook, R.L., Herbert, M.I., Neal, S.M. & Williams, J.T. (2002). Smoking cessation in a homeless population. There is a will, but is there a way? *J Gen Intern Med*, 17(5), 369-72.

Fiore, M.C., Bailey, W.C., Cohen, S.J, et al. (2000). *Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. Available at: <http://www.surgeongeneral.gov/tobacco/tobaqrg.htm>

Heffron, W.A., Skipper, B.J. & Lambert, L. (1997). Health and lifestyle issues as risk factors for homelessness. *J Am Board Fam Pract*, 10(1), 6-12.

Hwang, S.W., Orav, E.J., O'Connell, J.J., Lebow, J.M. & Brennan, T.A. (1997). Causes of death in homeless adults in Boston. *Ann Intern Med*, 126(8), 625-28.

Kim, D.H., Daskalakis, C., Plumb, J.D., Adams, S., Brawer, R., Orr, N., et al. (2008). Modifiable cardiovascular risk factors among individuals in low socioeconomic community and homeless shelters. *Fam Community Health*, 31(4), 269-80.

Lee, T.C., Hanlon, J.G., Ben-David, J., Booth, G.L., Cantor, W.J., Connelly, P.W., et al. (2005). Risk factors for cardiovascular disease in homeless adults. *Circulation*, 111(20), 2629-35.

Osborne, R.E., Karlin, J.E., Baumann, D., Osborne, M. & Nelms, D. (1993). A social comparison perspective of treatment seeking by the homeless. *J Soc Distress Homeless*, 2(2), 135-53.

Rawson, R., Shoptaw, S., Obert, J.L., McCann, M., Hasson, A., Marinelli-Casey, P., Brethen, P. & Ling, W. (1995). An intensive outpatient approach for cocaine abuse: the Matrix model. *J Subst Abuse Treat*, 12(2), 117-27.

Sachs-Ericsson, N., Wise, E., Debrody, C.P. & Paniucki, H.B. (1999). Health problems and service utilization in the homeless. *J Health Care Poor Underserved*, 10(4):443-52.

Snyder, L.D. & Eisner, MD. (2004). Obstructive lung disease among the urban homeless. *Chest*, 125(5), 1719-25

Stack, K.M., Goalder, J.S., Calhoun, P.S., Bradshaw, E.J., & Samples, C.P. (2009). Anti-smoking interventions in residential substance abuse treatment. *J Addict Med*, 3(2): 103-7.

Vredevoe, D.L., Brecht, M.L., Shuler, P. & Woo, M. (1992). Risk factors for disease in a homeless population. *Public Health Nurs*, 9(4), 263-69.

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