Addressing Tobacco Use in Homeless Populations : Recommendations of an Expert Panel

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Addressing Tobacco Use in Homeless Populations: Recommendations of an Expert Panel

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A diverse group of panelists met for one day on October 21, 2009, in Washington, DC, for the purpose of addressing the high tobacco use prevalence rates in homeless populations; identifying appropriate policy, cessation practices and models for implementation in this population; and providing targeted recommendations for researchers, homeless service providers, tobacco control advocates, and policy makers. The panel was convened by Break Free Alliance, one of six national networks funded by the Centers for Disease Control and Prevention, Office on Smoking and Health. The panelists worked through a process of problem identification, generation of responses, analysis and prioritization, development of recommendations, and arrival of final decisions reached by consensus. The resulting recommendations for addressing tobacco use in homeless populations focused on tobacco non-use policy implementation, cessation programming, and expansion of partnerships and collaborations between tobacco control advocates and social service providers. The panel also identified unanswered research questions that can serve to develop a framework for future initiatives to reduce tobacco use among homeless persons. The expert panel model serves as one approach for engaging nontraditional partners and building consensus among leaders from a variety of sectors to address tobacco use in special populations.

Keywords: *community intervention; health disparities; health promotion; community-based participatory research; health research; mental health; partnerships/coalitions; social determinants of health; substance abuse; tobacco prevention and control; cessation*

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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. The Alliance partners 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 is 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. With their support, Break Free Alliance convened a group of 22 stakeholders to develop recommendations for

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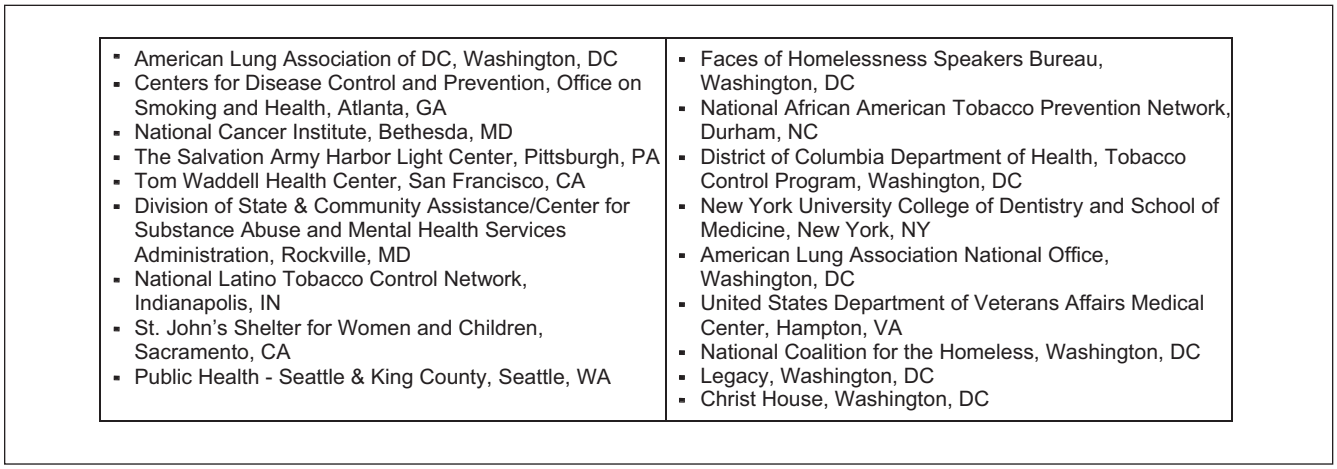

FIGURE 1 Organizations Represented by Expert Panel Participants

researchers, policy makers, tobacco control program personnel, social service providers, and community advocates for implementing comprehensive tobacco policy and programming initiatives to reduce tobacco use rates among homeless persons.

The resulting document outlines strategies for sustaining and institutionalizing policies and cessation programs This work was also supported in part by WVU's Prevention Research Center Cooperative Agreement Number U48 DP001921 from the Centers for Disease Control and Prevention. to prioritize addressing tobacco related behavior among homeless persons and the agencies that serve them. The Expert Panel approach outlined in this article serves as one example of a technical assistance practice that can engage nontraditional partners from a variety of settings to discuss and develop key strategies to further reduce tobacco use prevalence rates in the United States.

BACKGROUND/LITERATURE REVIEW

Recent data indicate that the prevalence of smoking among homeless people is 73%—more than three times that of the general population (Baggett & Rigotti, 2010; Connor, Cook, Herbert, Neal, & Williams, 2002). Many diseases common among the homeless, such as tuberculosis, pneumonia, chronic obstructive pulmonary disease, respiratory disease, and cardiovascular disease (Goss et al., 2003; Haddad, Wilson, Ijaz, Marks, & Moore, 2005; Jones et al., 2009; Mandelberg, Kuhn, & Kohn, 2000; Snyder & Eisner, 2004) are known to be caused and/or exacerbated by tobacco use (Bates et al., 2007; Lee et al., 2005; Sachs-Ericsson, Wise, Debrody, & Paniucki, 1999, Szerlip & Szerlip, 2009; U. S. Department of Health and Human Services, 2004). At the same time, homeless adults struggle with mental illness, substance abuse, alcohol abuse, and victimization (Heffron, Skipper, & Lambert, 1997; Hwang, 2001), which have all been linked to higher smoking prevalence (Baggett & Rigotti, 2010).

Homeless adults have been found to be sensitive to the health, appearance, and cost disadvantages associated with tobacco use and would like to quit (Arnsten, Reid, Bierer, & Rigotti, 2004; Butler et al., 2002; Connor et al., 2002; Okuyemi, Thomas, et al., 2006). However, the barriers to quitting are complex, including lack of cessation support from homeless shelter staff, high prevalence of smoking in homeless settings, stress from unpredictable social and physical circumstances, and limited access to health care (Okuyemi, Caldwell, et al., 2006).

Some progress has been made in identifying how to address smoking in homeless populations. Several studies have shown that enrolling and retaining sheltered homeless adults in a smoking cessation program is feasible, and that a combination of motivational interviewing, pharmacotherapy, and cognitive behavioral therapy can produce promising results (Okuyemi, Cladwell, et al., 2006; Okuyemi, Thomas, et al., 2006; Shelley, Cantrell, Wong, & Warn, 2010). One study of long-term transitional shelters in Los Angeles found that the majority were both receptive to tobacco control efforts and had an indoor smoke-free policy (Arangua, McCarthy, Moskowitz, Gelberg, & Kuo, 2007). Most studies point to the need for a highly tailored approach to address tobacco use among the homeless (Baggett & Rigotti, 2010; Butler et al., 2002; Connor et al., 2002; Okuyemi, Caldwell, et al., 2006; Okuyemi, Thomas, et al., 2006; Shelley et al., 2010), but no best practices have been established.

CASE STUDY

An Expert Panel (Figure 1) was convened for the purpose of addressing three goals: (a) identify the successes and challenges to addressing tobacco use in homeless

populations; (b) identify current tobacco cessation practices and models for homeless populations; and (c) develop targeted recommendations for dissemination among researchers, policy makers, funding agencies, state tobacco control programs, and service providers. The panel was selected from Break Free Alliance partners, recommendations from colleagues, and the literature. The *nominal group process* was used to frame this panel. It is a well-established technique for helping groups to reach consensus. In brief, it is a "structured meeting which seeks to provide an orderly procedure for obtaining qualitative information" from participants (Van de Ven & Delbecq, 1972).

Phase I: Problem Identification

The process started with opening presentations intended to provide both an overview of homelessness in general and background on what is known specifically about homelessness and tobacco use. A 45-minute problem identification session followed in which all panelists discussed the following questions to gain consensus on the definition of the problem:

1. Why do homeless persons have a national smoking prevalence of more than 70%?
2. What stressors and issues do homeless persons have outside of tobacco use that are important to know in terms of addressing this issue?
3. Why does the issue of tobacco use among homeless persons need to be addressed more strongly?
4. What are the key health-related and other consequences of not addressing this issue?

Phase II: Generating Responses

Panelists were then placed into one of four groups according to expertise: health and tobacco control, funding/research, community advocacy, and policy. Each of these groups was given 1.5 hours to identify challenges and promising strategies for addressing tobacco use among homeless persons while using the following questions as a guide:

1. From your experience and perspective as a (fill in profession), what have been some successes related to reducing tobacco use among homeless persons?
2. What factors were most critical to achieving these successes?
3. What are some challenges, barriers, or concerns in terms of reducing tobacco use among homeless persons?
4. What is needed or how can we creatively and most effectively address these challenges, barriers, or concerns?
5. What are some of the promising practices related to reducing tobacco use among homeless persons?
6. What makes them promising practices—what are the factors, elements, or characteristics? What are your criteria used for the selection of best or promising practices or models?
7. What else do we wish or hope existed? What would it take to address these wishes or hopes, or what is needed to get them in place?

Phase III: Analyzing and Prioritizing

In this phase, four new groups were formed composed of one to two people from each of the previous groups. The four groups were dedicated respectively to successes, challenges, best practices, and additional needs. The purpose of this new formation was to create dialogue between panelists with different areas of expertise and thereby enhance the richness of the discussion and data. These new groups were given 1 hour to consolidate, integrate, and categorize responses from Phase II. After each group presented their consolidated data to the rest of the groups, all groups voted on the items in each topic that they deemed most important.

Phase IV: Recommendations

Panelists remained in the same groups as Phase II and were given 45 minutes to develop recommendations based on prioritized responses.

Phase V: Final Decisions

Finally, panelists convened in one large group for 35 minutes to both review and object to any of the recommendations generated from Phase IV. The final recommendations were reached by consensus.

The meeting objectives, goals, and invitees were determined by a planning committee composed of tobacco control advocates and researchers with expertise on tobacco use among homeless persons. External facilitators created and directed the process design and guided the four concurrent workgroups along with Break Free Alliance staff and partners.

Survey Monkey, an online survey tool, was used to survey panelists 1 week after the event to obtain their feedback. In all, 14 out of 22 panelists responded and all felt that the objectives for the event had been met, although a few had felt rushed. The majority expressed that the opening presentation, process design, facilitator competence, and number of participants were good whereas the packet materials and time frame were satisfactory to good. Strengths included the diversity and expertise of the panelists, the level of group involvement

and the facilitation; areas in which to improve were including more experts from the field and increasing the meeting room size.

DISCUSSION/CONCLUSION

Before determining the final recommendations, there was discussion about balancing the issue of lack of housing with high rates of tobacco use. Ultimately, all panelists agreed that the following preamble should be included:

> *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.*

Including a cross-section of expertise in the prioritization process increases the likelihood that these recommendations will be valid from a variety of perspectives. When categorizing recommendations, the four main themes that emerged were policy, cessation programming, social service settings, and research.

Critical Factors for Achieving Policy Success

Traditionally, population-based policy interventions in tobacco control such as clean indoor air laws have had a great impact on reducing overall tobacco use rates among the general population. However, panelists believe that they have had less of an impact on curbing tobacco use among homeless persons.

Community mobilization and partnership. 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. In part this can be accomplished through educating community champions dedicated to the issue of tobacco control about the problem of tobacco use among homeless persons and empowering homeless persons and those who serve them to advocate for policy change. In addition, educating 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. Evidence of staff support for these issues is mixed: On surveying long-term transitional centers, Arangua et al. (2007) found that staff acknowledged the importance of reducing the prevalence of tobacco use among their clients and were supportive of tobacco control interventions; Okuyemi, Caldwell, et al.'s (2006) focus groups with homeless persons indicated that support for quitting tobacco use was lacking among service providers. Adequate funding to gain public support for such policies is also needed.

Research. Research by and with the homeless community is essential to gaining knowledge about tobacco control policies that affect homeless persons. 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.

Social service settings. There are mandatory and voluntary policy options for social service settings. On the whole, treatment for nicotine addiction among homeless persons should be integrated into broader standards of care for shelters and health and social service providers. One option is for public health and accrediting agencies that oversee and license service providers to partner on implementing 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. Enforcing such tobacco non-use policies may be easier in smaller facilities or in facilities that have experience in treating substance abuse (Arangua et al., 2007). In addition, 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.

In reviewing the presented data, members of the panel identified the following interventions as a priority:

1. State Medicaid coverage should include tobacco cessation treatment, nicotine replacement therapy (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 services 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.

Critical Factors to Achieving Success in Cessation Programming

The panelists were in agreement that best practices for addressing tobacco use among homeless persons do not exist. The Centers for Disease Control and Prevention's (2007) *Best Practices for Comprehensive Tobacco Control Programs—2007* includes information both on implementing cessation interventions and addressing tobacco-related disparities, but does not contain instructions for addressing the unique needs of homeless individuals. As such, the tobacco control expert members of the panel agree that promising interventions aimed at reducing tobacco use among this population should be considered by state tobacco control programs, community-based organizations, and funders.

Resources. Public health entities must build relationships with homeless service providers and link them to cessation resources. Tobacco control advocates in particular should assist in (a) connecting social service staff to trainings on providing brief cessation counseling interventions, (b) working with staff to explore ways to provide free or low-cost NRT, and (c) helping service agencies identify cessation assistance for staff who want to quit. These steps are critical to the success of integrating resources into service delivery systems for homeless individuals.

Programming. Implementing cessation programming and tracking its effectiveness are both important measures in identifying best practices. Cessation programming for clients with substance abuse disorders and mental illnesses should include more intense and tailored tobacco cessation interventions and should be easily accessible. A successful tobacco cessation program will also need a site champion or dedicated staff person to "oversee" a tobacco cessation program. To gauge a program's effectiveness, tobacco control advocates and public health programs should collaborate with homeless and social service providers to adapt existing intake and discharge procedures 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.

Tobacco cessation experts on the panel identified the following interventions as a priority for cessation programming:

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 struggling with homelessness to create capacity for promoting and supporting tobacco cessation.
4. State and local health departments should also 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 agency leadership to integrate cessation programming services for clients and staff. Invite these individuals to join state and local tobacco control coalitions and workgroups.

Critical Factors for Achieving Success in Social Service Settings

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 faced by homeless individuals.

Facility readiness and motivation. 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. Also, having all facility staff committed to tobacco cessation and decreasing tobacco use among their clients is imperative in a service delivery system. A safe and smoke-free environment, access to NRT, and keeping clients busy with activities will increase the chances that a client can quit tobacco successfully.

Integrating cessation. Treatment for nicotine addiction should be incorporated into a comprehensive approach to improving the overall health of clients. If possible, integrate cessation services into facilities that serve homeless persons as opposed to looking to outside agencies to provide them. 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 (Hwang, 2001).

One promising approach is New York University's "bundle" model. The model draws from the substance abuse literature (Foulds et al., 2006; Richter & Arnsten,

"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. (From: National Alliance to End Homelessness).

FIGURE 2 "Housing First" Model

- Facilities must adopt a tobacco-free policy
- 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 are 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)

FIGURE 3 New York University's "Bundle" Model for Tobacco Cessation Programming in Homeless Service Agencies

2006; Ziedonis, Guydish, Williams, Steinburg, & Foulds, 2006) on barriers and solutions to integrating smoking cessation services in addiction treatment settings and systematic reviews from the Centers for Disease Control and Prevention's Task Force on Community Preventive Services (2001). There is additional evidence that making medications available increases cessation rates (Curry, Keller, Orleans, & Fiore, 2008).

Similar to studies in substance abuse treatment settings, smoking by homeless shelter staff creates barriers to program implementation and undermines clients' cessation efforts (Shelley et al., 2010; Ziedonis et al., 2006). Thus, the bundle model incorporates several evidence-based approaches to smoking cessation while acknowledging the difficulty that continued smoking among staff poses to integrating these services and policies into sites that serve homeless clients.

Local community centers and churches can also be engaged to offer family education and support programs for homeless persons attempting to quit, and free community center space could be used to provide childcare and cessation services for clients.

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:

1. Integrate tobacco cessation services into the "Housing First" process (see Figure 2), adding a training component for staff to address tobacco cessation.
2. Implement the New York University "bundle" model (see Figure 3) to address tobacco use among clients receiving services.
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 *Treating Tobacco Use and Dependence: 2008 Update, Clinical Practice Guideline* (Fiore et al., 2008) into the existing continuum of care.
5. Integrate tobacco cessation into a broader service delivery system for improving the overall health of homeless persons.

Critical Factors for Raising Awareness in the Research Community

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 from federal agencies or through the solicitation of Special Interest Projects.

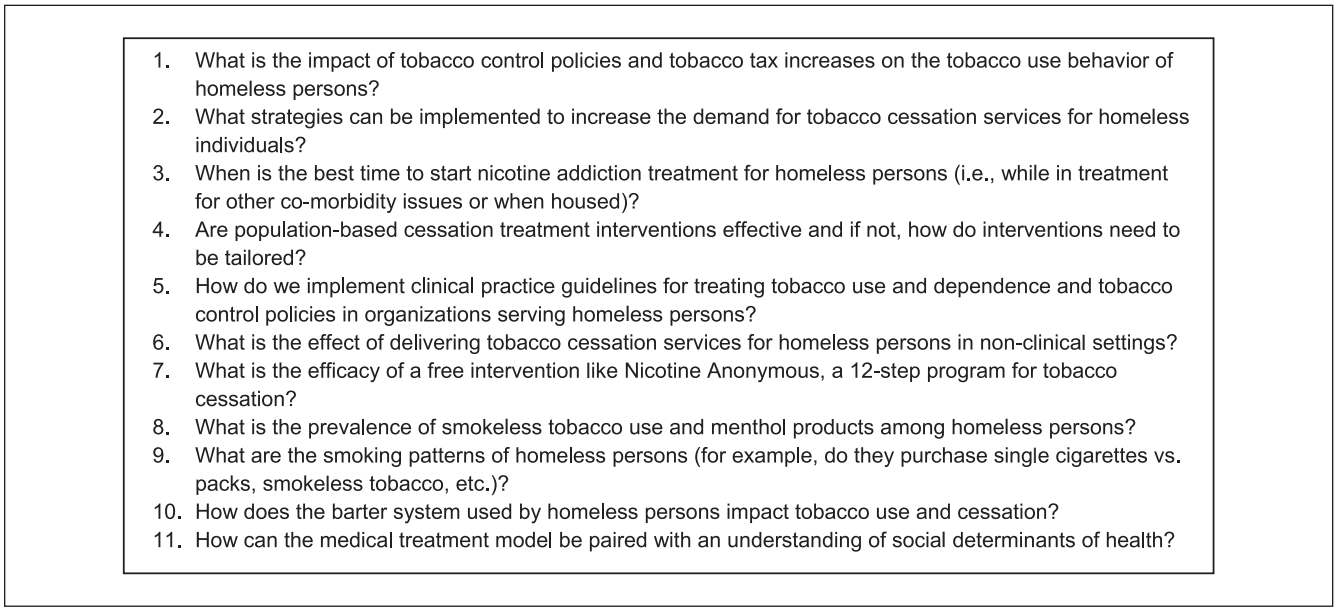

FIGURE 4 Questions Identified by the Panel to Be Addressed by Future Research Initiatives

Correspondingly, tobacco cessation is a low priority for funders who provide financial support for homeless services and 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 on health care costs and social service systems.

Research design. Researchers need to think broadly in studying the problem of tobacco use among homeless persons; particularly, 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. Community-based participatory research should involve partners who serve homeless individuals and families as well as formerly homeless individuals. Also, process evaluation measures will help better understand and document the successes and challenges of working with homeless individuals.

Funding. 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. In summation, from a research perspective there are many unanswered questions that impede progress in reducing tobacco use among homeless persons (see Figure 4).In conclusion, the partnership, education and mobilization of all organizations represented by this expert panel could make great strides in reducing the tobacco use prevalence among homeless persons. A strength of this process was the building of consensus among nontraditional partners and leaders from sectors integral to achieving success in this area. Although the resulting recommendations will require time and no small amount of effort to implement, they also provide a comprehensive framework for the development of future initiatives that was previously lacking.

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