SMOKING CESSATION LEADERSHIP CENTER

HUD Proposed Smoke Free Housing Rule

1. **What barriers that PHAs could encounter in implementing smoke-free housing? What costs could PHAs incur? Are there any specific costs to enforcing such a policy?**

   The PHAs could encounter pushback from residents who say, "*You are taking away my right to smoke*". A similar policy has been put into place regarding smoking in facilities caring for persons with behavioral health issues such as mental illnesses and substance use disorders. Although there were substantial initial concerns that adverse reactions would occur, those fears were not realized [1]. There were also concerns about losing to competitors, that is, persons choosing to patronize centers without smoking restrictions. Again, that latter concern does not seem as relevant for public housing.

   Enforcement issues and possible costs: Expenses could include adding security to ensure compliance, hiring more office/admin staff to handle complaints from residents.

   Other potential costs that PHAs may incur include providing education and resources to residents. PHAs could mitigate those costs by teaming up with state quitlines (1-800-QUIT NOW), using existing campaign materials such as CDC's Tips from Former Smokers, and offering information on nicotine replacement therapy (NRT) coverage from Medicaid via the American Lung Association website.

2. **Does this proposed rule adequately address the adverse effects of smoking and secondhand smoke on PHAs and PHA residents?**

   The proposed rule is a major improvement from the status quo. However, it does not address electronic nicotine delivery systems (ENDS) nor does it address smoked marijuana.

3. **Does this proposed rule create burdens, costs, or confer benefits specific to families, children, persons with disabilities, owners, or the elderly, particularly if any individual or family is evicted as a result of this policy?**

   Given that by definition these families have lower income and have limited housing alternatives, eviction would certainly be a problem. An incident might lead to an unfavorable news story.

   The costs of fighting an eviction and if necessary moving, would be burdensome for these vulnerable populations[2].

4. **For those PHAs that have already implemented a smoke-free policy, what exceptions to the requirements have been granted based on tenants' requests?**

   We have not heard of any.

5. **For those PHAs that have already implemented a smoke-free policy, what experiences, lessons, or advice would you share based on your experiences with implementing and enforcing the policy?**

   That is it doable. With over 600 PHAs that have already implemented smoke-free policy, the potential of best practices and lessons learned abound.

   A specific example is the PHA of Los Angeles County. In 2011, the County Department of Public Health (LADPH) encouraged HACoLA to implement HUD recommendations and offered the County's Tobacco Control and Prevention Program (TCPP) as a resource. The policy was adopted in 2013.

   The smoke-free policy went into effect on July 1, 2014 at 63 HACoLA developments, protecting over 6,500 residents including families and youth, and over 1,100 elderly or the disabled from second hand smoke. The policy was made possible through a systemized process of outreach activities, educational support, surveys, advocacy, collaboration, and campaigns. HACoLA provided residents with a one-year transition period while providing smoke-free education and resources to residents. During the one-year transition phase, over 80% of public housing residents opted to sign an addendum to their lease pledging their unit as smoke-free before the mandatory implementation deadline. During the policy development phase, and the one-year transition phase, public housing residents broadly supported this smoke-free policy.

LADPH also engaged the Housing Authority of City of Los Angeles (HACLA). In December 2015, HACLA approved a smoke-free multi-unit housing policy.

6. **For those PHAs that have already implemented a smoke-free policy, what tobacco cessation services were offered to residents to assist with the change? Did you establish partnerships with external groups to provide or refer residents to these services?**

   See question #5 answer for HACoLA activities.

   Partnerships have been created with state quitlines and coverage for cessation through Medicaid expansion. In addition, the use of online applications like Become An Ex and in-person meeting support through Nicotine Anonymous are also helpful low-cost solutions.

7. **Are there specific areas of support that HUD could provide PHAs that would be particularly helpful in the implementation of the proposed rule?**

   Two services would be helpful: education about the damages from second-hand smoke exposure, especially to young children and to adults with heart disease, and assistance with smoking cessation, such as referral to telephone quitlines along with comprehensive coverage of pharmacotherapy and counseling.

   PHAs should work with state Medicaid Managed Care Organizations (MCOs) or other ACA insurance plans to provide information on cessation services available.

8. **Should the policy extend to electronic nicotine delivery systems, such as e-cigarettes?**
   Yes. Ultimately, but this phased-in strategy makes a lot of sense.

9. **Should the policy extend to waterpipe tobacco smoking? Does such smoking increase the risk of fire or property damage?**

   Yes, including e-hookahs. There would be second hand smoke exposure from waterpipe smoking, but little if any fire damage.

References:

1. NASMHPD toolkit link, http://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Downloads/Toolkits/nasmhpd_toolkit_updated_april_2011.pdf
2. State Participation in the Medicaid Expansion Provision of the Affordable Care Act: Implications for Uninsured Individuals with a Behavioral Health Condition, http://www.samhsa.gov/data/sites/default/files/report_2073/ShortReport-2073.html