Helping LGBT Smokers Break Free From Tobacco  By Brian Davis

Quitting tobacco use is tough, even compared to highly addictive illegal drugs like heroin. In fact, many people who have been able to quit using both heroin and tobacco have said that both substances were equally difficult to stop using. Since quitting tobacco is so difficult, it is very important for medical providers to recognize that there are some segments of the population that face higher levels of stress than others. People who face additional stress, especially during the teen years, are more likely to use tobacco and to have a more difficult time breaking free from nicotine products. Members of these populations may require additional support.

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**Doctor’s Page: How to Protect Patients from Jeopardizing Their Housing—When They Can’t Adhere to No Smoking Guidelines**

By Cathy McDonald, MD, MPH, FAAP, ATOD NETWORK Project Director

As smoke free housing becomes more common, those who continue to smoke may be in jeopardy of losing their housing for non-compliance. This is particularly true with clients we serve, many of whom have co-occurring conditions, and may be experiencing great difficulty following smoking restrictions. In an incredibly tight housing market, this can lead to unstable housing situations for these clients. It also increases exposure of the client and others to second hand smoke, and the risk of fires. Here are several ways that providers can work together as a team to support clients/patients caught in this situation.

Teams working with housing providers, on behalf of patients with co-occurring conditions, should be on the lookout for potential trouble. Knowing the problems in advance can help these teams and housing providers develop strategies to assist clients to be compliant with the non-smoking rules, and reduce problems.

Here is a list of things to look for that ‘red flags’ the risk of difficulty abiding by smoking guidelines:

- Smoking ½ pack a day, 10 cigarettes or more per day (cpd)
- Smoking in the middle of the night
- Smoking within 5-30 minutes of getting out of bed in the morning
- History of difficulty following smoking guidelines in prior living situations

Just one of these patterns can lead to difficulty with compliance, and more than one increases the likelihood that problems will occur. By making sure a detailed smoking history is a routine part of every client’s evaluation and reviewing this when a client is about to move from a facility to a housing setting (or from one housing setting to another) can help. All of these patterns are connected with very real physiologic brain mediated signals to smoke that are best dealt with by tobacco treatment medication and counseling. These methods can be used EVEN IF THE CLIENT IS NOT MOTIVATED TO QUIT. Making sure the person knows the non-smoking rules in advance, and helping them apply strategies to comply, can actually lay the groundwork for eventually quitting. Plus this will help build patient confidence that he/she is working both toward quitting and compliance.

Keep in mind that if the patient has lived in a treatment setting where smoking is not allowed, or is limited, and is now moving to more independent housing, this is a great time to support and encourage the client in STAYING QUIT by making sure that he/she continues tobacco treatment medication if it is being used, and has support to stay quit. Ideally he/she should be provided with a supply of short-acting nicotine replacement therapy (NRT) such as gum or lozenge to treat overwhelming cravings during the transition period to the new facility.

Other strategies may include: Help the patient start to experience success by using pack tracks (Example pasted below) and coping tools that include ‘reduce to quit’ strategies. Consider encouraging the patient to try to delay smoking when he has the urge for 3-5 minutes and to log cigarettes on a pack track, example shown below. Have them identify coping tools that work for them and record them or possibly report them daily to staff at the housing site if writing is a barrier.

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Success in delaying cigarettes can help a patient to feel more confident in his ability to regulate his smoking. Using the pack track in written form or verbally can help break down the process of cutting down. The person may discover several cigarettes that he or she smokes each day that are not that important and may be able to drop them. This process trains the patient in using coping tools like music, deep breathing, puzzles, games, walking, socialization like talking on the phone etc. when he has the urge to smoke.

The pack track technique can be paired with “reduce to quit” to be even more effective. “Reduce to quit” (Moore D et al., 2009) is a method that has been scientifically studied that involves using (NRT) in patients who are not planning to quit. This automatically results in decreased smoking since the body seeks homeostasis in nicotine levels and if you have nicotine coming in from a patch the body will not seek as much nicotine from cigarettes and the client will smoke less.

A person smoking 20 cigarettes a day can be prescribed a 21 mg nicotine patch by their provider, which will be covered on Medi-Cal formularies in Alameda County. This medication will help the client reduce his/her smoking. Gradually decreasing smoking is a known stepping stone to quitting completely and works almost as well as setting a quit date for people who want to quit (Lindson-Hawley et al. 2012 Cochrane review). In the case mentioned the individual will probably reduce to 3-9 cigarettes a day and be more likely to be able to adhere to not smoking where smoking is prohibited. We are not trying to MAKE the person quit, but we are trying to help him regulate his high risk smoking. Research demonstrates that when this happens, not only will the person smoke less, but he will be more likely to actually quit.

See prescription insurance flyer at http://www.acbhcs.org/tobacco/docs/presc_insur_nicotine_replacement.pdf for a guide to prescribing tobacco treatment medication for each of the Alameda County Medi-Cal health plans. This can be used as a guide to how much NRT to use for reduce to quit. A common myth is that it is not safe to smoke a cigarette if you have a patch on. This used to be thought to be the case, but studies of cardiac function in individuals who are smoking cigarettes while wearing a patch have disproved this notion. Clients need to be educated that it is not going to harm them to have a patch and smoke. If the client decides he wants to quit it is best to stop smoking altogether and supplemental short acting NRT (gum or lozenge) for break through cravings and cessation counseling can help the person be successful in quitting. Of course quitting will be much better for his health than just cutting down. A Tips from the Experts Handout pertaining to smoking with a patch on can be found at http://www.acbhcs.org/tobacco/docs/tips.pdf.

To protect patients from breaking no-smoking rules, it is best to get started before the patient moves into the agency/residence, or at the time of admission. Explaining that supporting clients struggling with the rules with nicotine replacement and coping tools is part of the ‘house’ policy is a good thing to mention during the application process. It might be that the patient does not want to try these strategies, but if he is struggling with the rules later, he can be given the option at that time as a condition of remaining in the housing.

Stable housing is an important part of mental health recovery. Quitting smoking is as well. Helping clients quit smoking, or ‘reduce to quit,’ will definitely help that client retain housing in a scarce market.
Important New Tobacco Regulation Bills await Gov. Brown’s Signature—Tobacco Industry Threatens to Derail them.

By Judy Gerard, ATOD Network Project Manager (Continue from Page 1)

For a few years now, New York has also led the nation in tobacco taxes, with the highest tax in the country – $4.35 a pack tax for cigarettes and little cigars. In New York City these tobacco products cost $10.50 a pack. The youth smoking rate in New York as of 2001 was 17.6%; by 2007, it had dropped by half to 8.5%, but then leveled off. This still concerned NY officials, and they sought ways to keep the momentum going in the direction of lower rates. Higher taxes and raising the age of purchase to 21 were determined to be good policy initiatives to keep youth smoking rates trending downward. Officials figured that making it harder for kids to start smoking will reduce the percentage of lifetime smokers, thus lowering the negative impact of tobacco use on themselves, families, the community, as well as the medical system. New York City now has some of the toughest anti-smoking laws in the world. With these precedents in place, this year CA legislators decided it was time to follow suit. The new 21 age to purchase law is waiting the governor’s signature (SBX2-7/ABX2-8).

And speaking of tobacco taxes, petitions for a state ballot initiative are currently circulating in CA by Save Lives California, intended to raise the tobacco tax (which is currently the 34th lowest in the country at $.87 per pack), to an additional $2.00 a pack. The tax would be used for health care expenses, cessation programs, tobacco prevention and research for tobacco-related diseases. Advocates include associations for heart, lung, cancer, physicians, hospitals and unions. And San Francisco billionaire, Tom Steyer, one of the nations largest donors to causes like this, is also behind getting the tax on the Nov. ballot and passed. The tobacco industry is closely watching this process as well, and has threatened to derail the tax increase.

Other tobacco prevention bills waiting in line for Gov. Brown’s signature, include one sponsored by Sen. Mark Leno, which would treat e-cigarettes the same as tobacco products, and regulate e-cigarette use in places where smoking is already prohibited, such as workplaces and public buildings. And this bill would include e-cigarettes in local retail licensing fees. (SBX2-5/ABX2-6) One more bill would finally close the loopholes in smoke-free workplace laws, which have been on the books for years, largely not in general practice in most places, but that technically have allowed smoking in some workplace environments. These include prohibiting smoking in certain areas of hotel lobbies, meeting and banquet rooms in hotels/motels, warehouses, break rooms, and owner-operated businesses. Under SBX2-6/ABX2-7, these last bastions of smoking areas would be eliminated.

One other bill that has the potential to cause tobacco taxes to go up in local jurisdictions (SBX2-9/ABX2-10) was also passed. This bill would allow county Boards of Supervisors to place tobacco tax initiatives on local ballots. More than 600 local jurisdictions nationwide have their own tobacco tax rates, including New York City mentioned above. This bill would allow local CA Boards of Supervisors to utilize this same tax measure. These tax initiatives would require a two-thirds majority vote to pass.

As you can tell, the Democratic majority CA legislature, really took on tobacco prevention this past year, something advocates have been working on for years. These important bills successfully made it through legislative commit-tees, and passed both the state Legislature and Senate on their way to become law. Currently the bills are ‘waiting in the wings’ withheld from presentation to Gov. Brown for signature – held hostage by tobacco industry threats.

The tobacco industry spends billions of dollars a year in CA in campaign contributions to legislators, lobbyist groups, and other special interest organizations that will do their bidding. They also try all sorts of backroom ‘blackmailing’ to derail pending legislation that frequently kill bills before they ever get out of legislative committees. Failing to keep these important bills from passing during this legislative session, the industry is now threatening to start a ballot referendum to repeal the newly passed laws by paying $10 for each petition signer. It’s the game they play in CA and elsewhere. But the stakes are always higher in CA where tax and legislative trends often play out in the rest of the nation.

Bravo for the Legislature for doing the right thing this last session! We hope they can get these new bills signed, and keep them from repeal. Let’s set anti-tobacco trends once again in CA – Set a model for the nation.

If someone presents you with a Tobacco Tax Initiative petition to sign, and you want to help push back the Tobacco Industry, this is a way to do it. If you want more information on the bills mentioned above, go to http://www.nosmoke.org/pdf/CA-Extra-Session-Bill-Facts-Final.pdf
One population group that faces greater stress is the Lesbian, Gay, Bisexual and Transgender (LGBT) Community. LGBT youth growing up in our society may not face the same degree of stress due to fear of rejection from family and friends, or be subjected to the same danger of physical and psychological abuse than in the past, but these stresses still exist, even in more accepting areas like Alameda County.

As a result of this stress, LGBT people smoke about twice as much as the general population. California data averaged from 2005-2010 demonstrated that the LGB smoking rate was 27.4% compared to the heterosexual smoking rate of 12.9%. (While Transgender data is generally harder to find, one study of 241 Caucasian and African American Transgender women in San Francisco and Oakland revealed a smoking rate of 83%. A survey of San Francisco middle school students showed that 76% of Transgender students had tried tobacco, compared to 13% of the heterosexual youth.)

There is more to it than stress, however. Historically, LGBT people have not had the same range of social opportunities as the straight population. Bars and clubs catering to the queer community have been one of the few places where LGBT people feel safe to be themselves, and those places often allow tobacco use on fenced patios or semi-enclosed smoking rooms. (Of the three gay bars in Oakland, for example, two have semi-enclosed smoking rooms and the other has a smoking patio.)

Combining increased stress and the availability of safe smoking spaces where young queer adults can gather can result in a social environment that encourages smoking. This can turn high school queer youth who experimented with tobacco into everyday smokers by their early twenties. Tobacco companies are aware of this. For many years (until a law was passed that stopped it last year) tobacco company representatives made regular visits to a gay bar in San Jose, where they distributed “One Pack for One Buck” coupons that could only be redeemed at the bar that night and other discounted offers.

Tobacco companies have also targeted the LGBT community with niche marketed advertising which plays upon the hopes and fears of this population. One ad features two women appearing to be caught in the act of kissing. The ad copy reads, “I Choose.” The message is that “choosing” applies to both being a lesbian and smoking the advertised brand.

Author Bio: Brian Davis runs the Just for Us: LGBT Tobacco Prevention Project at Tri-City Health Center in Fremont. He wrote this article for this publication.”
IT'S TIME FOR SMOKING TO COME OUT OF THE CLOSET

1960
1970
1980
1990
2000
2010

1964
FIRST SURGEON GENERAL REPORT:
Smoking & Health establishes that smoking
causes higher death rates
from lung cancer, chronic bronchitis,
emphysema, and cardiovascular diseases

1960s–1990s
24 additional Surgeon General’s reports on
smoking are released,
ZERO MENTION LGBT

2001
Surgeon General report
Women & Smoking mentions
LGB SMOKING DISPARITY
for the first time

2014
LGBT CLEARLY DELINEATED
as a population experiencing
tobacco disparities in the
50th Anniversary Surgeon
General’s report

32 TOTAL SURGEON GENERAL’S REPORTS ON SMOKING

3 MENTION LGB AND/OR T

SMOKING IS THE LGBT COMMUNITY’S BIGGEST HEALTH BURDEN

$7.9 billion
Estimated annual LGBT money spent on cigarettes

33% LGBT Population

20% U.S. Population

LGBT people smoke cigarettes at rates
that are 68% HIGHER
than the rest of the population.

12.3 vs 5.1
LIFE-YEARS LOST
from smoking
from HIV

For citations and references, please visit http://lgbthealthequity.wordpress.com/2014/01/16/tobacco-infograph-citations/
Another ad, which ran in a national LGBT magazine during Pride month in 2005 features a laundry list of “freedoms.” The list is fairly conventional for the most part (“to speak”, etc.), but the list also includes “to marry” and “to inhale.” Once again, the idea is that smoking and being gay go together.

This last ad also feeds into a tobacco industry narrative that they support LGBT rights that has been reinforced by donations to some LGBT rights and AIDS groups over the years. The reality is actually very different. Tobacco companies are major donors to right wing politicians who work to keep the LGBT community in a second class status. (The tobacco industry was the fourth largest corporate donor to the Republican Party in 2010, for example.)

E-cigarette marketing has also taken aim at the LGBT Community. One e-cigarette company, NJOY, hired a gay man who had served on the Board of Directors of a nonprofit that provides housing to homeless LGBT youth and who had consulted with numerous LGBT-serving nonprofits to sell these toxic products to that population.

Clinicians might benefit from knowledge of this background when working with LGBT patients. Sharing this information with them might increase their willingness to address the issue of smoking as well as potentially other areas of health related to their sexual orientation or gender identity.

Another available option, which may be practical for some patients, is an LGBT Community tobacco cessation group program based in San Francisco called The Last Drag (www.lastdrag.org). Some LGBT patients may prefer to quit smoking with the support of others who can relate to the challenges they face in many areas of their lives. The Last Drag has served the community since 1991 using the American Lung Association’s Freedom From Smoking program. Evaluations of the program have demonstrated its effectiveness.

The Last Drag has also developed cessation materials designed specifically for the LGBT Community. These materials can be ordered from the Tobacco Education Clearinghouse of California (www.tobaccofreecatalog.org), which also has a variety of materials in multiple languages designed for many ethnic and cultural communities.

For those who may wish to join the fight against Big Tobacco, the Just for Us: LGBT Tobacco Prevention Program based at Tri-City Health Center in Fremont offers an opportunity to engage in local education and advocacy work that will help to reduce smoking rates among LGBT and other at risk youth. Another valuable program at Tri-City is TransVision, which provides support services to the Transgender community in southern Alameda County. For information on either of these programs, contact Brian Davis at bdb@hotmail.com.
ATOD NETWORK UPCOMING TOBACCO TRAININGS

May 3, 2016 - ATOD Network Cessation Conference Call
   ♦ 12:30 to 1:00 pm
   ♦ Just call: (712) 775-7031
   ♦ and then dial Mtg.ID: 194-388-309 #

June 7, 2016 - ATOD Network Cessation Conference Call
   ♦ 12:30 to 1:00 pm
   ♦ Just call: (712) 775-7031
   ♦ and then dial Mtg.ID: 194-388-309 #

Email: atodnetjudy@aol.com for training flyers

**ON-SITE STAFF TRAININGS AVAILABLE**
Alameda County AOD, Mental Health, and Primary Care Providers can schedule an on-site staff tobacco training at your agency by calling Judy Gerard at (510) 653-5040 X 349 OR email atodnetjudy@aol.com.

For the latest information on tobacco treatment and resources, go to www.acbhcs.org click on the Tobacco Tab.

Free Cessation Services

The California Smoker's Helpline
For one-on-one cessation counseling call 1-800-NO-BUTTS
Check out their new and improved website: www.nobutts.org

♦ Free patches and incentives for qualified callers
♦ Free texting program for tobacco users
♦ Online initiatives including the new and improved Helpline website, online catalog, and web-based referral service
♦ Future projects including smartphone application, online chat for tobacco users, and e-referral for health care providers with electronic health records