The Samaritan Women
INSTITUTE for SHELTER CARE

Smoking Policies Report

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Introduction

In 2022, a group of seasoned shelter leaders convened to discuss the issues facing this field and strategies for being proactive towards changes in society, law, and the landscape of sexual exploitation. One of the topics that emerged was the barriers to placement that seem common among residential programs, and the question was raised whether the Institute for Shelter Care could help this field reduce some of those barriers so more survivors would accept placement. One of the barriers noted from referring agencies was the restriction on smoking. This study intended to identify the prevalence of smoking restrictions as well as the policies and advice from agencies that allow smoking.

The goal is not that all agencies would permit or support smoking. We know that cigarette smoking is the leading preventable cause of death in the United States, and 21 million deaths in the United States were related to smoking over the past 50 years.[1] The U.S. adult smoking prevalence has declined over the last 30 years to 13.7% in 2018; [2] however, this same decrease is not seen among those with disorders such as post-traumatic stress disorder (PTSD). According to one study, persons with a PTSD diagnosis were almost one and a half times more likely to smoke on a daily basis than those without a PTSD diagnosis.[3] Compared to smokers without PTSD, smokers with PTSD smoke more heavily and are less successful in quitting smoking.[4] Farris et al., (2014) concluded that the more severe the trauma symptoms, the more individuals reported looking to smoking to reduce the negative effects of trauma.[5]

Therefore, we know smoking is an unhealthy, if not lethal, habit that is keenly present among those who are suffering the effects of traumatic experiences. We also know that many survivors depend on smoking as a coping mechanism for symptoms of greater distress. This study endeavors to report on the stance and policies shelter agencies have taken in light of this conflict.

Methodology

Respondents

An email invitation to participate in this survey was sent to 213 agencies nationwide that were identified as providing residential care to survivors of sexual exploitation/sex trafficking. Fifty-eight responses were received of which three responses were omitted from the analysis due to those agencies only serving minors. This sample of fifty-five responses therefore reflects 26 percent of the trafficking shelter agency population in the United States, according to the Institute for Shelter Care's national landscape map (thesamaritanwomen.org/shelter-map).

1 U.S. Department of Health and Human Services. (2020). *Smoking cessation: A report of the Surgeon General.* U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

2 Creamer, M. R., Wang, T. W., Babb, S., Cullen, K. A., Day, H., Willis, G., Jamal, A., & Neff, L. (2019). Tobacco product use and cessation indicators among adults—United States, 2018. *Morbidity and Mortality Weekly Report, 68*(45), 1013.

3 Estey, D., Platt, J., Goodwin, R. D., & Weinberger, A. H. (2021). Relationship of trauma exposure and PTSD to cigarette smoking prevalence, frequency, and quantity: Data from a nationally representative sample of U.S. adults. *Psychological Trauma, 13*(2), 231-239. https://doi.org/10.1037/tra0000991

4 M.T. Feldner, K.A. Babson, M.J. Zvolensky. (2007). Smoking, traumatic event exposure, and post-traumatic stress: A critical review of the empirical literature. *Clinical Psychology Review, 27*(1), 14-45

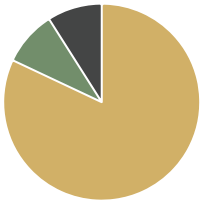
5 Farris, S. G., Zvolensky, M. J., Beckham, J. C., Vujanovic, A. A., & Schmidt, N. B. (2014). Trauma exposure and cigarette smoking: The impact of negative affect and affect-regulatory smoking motives. *Journal of Addictive Diseases, 33*(4), 354–365.

Program Type and Duration

18%	Emergency Shelter – 1-30 day holding, usually in coordination with law enforcement
20%	Stabilization Program – usually 3-6 months of residential care, goal is to determine long-term course of action
87%	Restorative Program – usually 12 months or more, long-term care with goal of social re-entry
25%	Independent Housing – independent housing with support and accountability

Several agencies (N=21) operate more than one type of program and were invited to respond reflecting all of their program areas; therefore, the total number of responses exceeds 100.

Resident Smoking Allowed



- Allowed
- Only in certain phases
- Not allowed

Smoking Policies

Throughout this study, "smoking" will apply to both cigarettes and vape products.

Residents

Eighty-two percent of respondents indicated that they allow residents to smoke while in their programs; 9 percent only allow residents to smoke in certain phases of the program and; 9 percent do not allow smoking at all.

Staff

Staff smoking policies followed a somewhat different pattern:

- 14 programs allow staff/volunteers to smoke whenever they want.
- 25 allow staff to smoke but they have to follow the same rules as the residents.
- 16 do not allow staff or volunteers to smoke at any time.

Ten agencies allow their residents to smoke in some capacity while disallowing staff and volunteers to smoke at all. Only one shelter agency allows residents to smoke in certain phases of the program but allows staff/volunteers to smoke whenever they want. All agencies who do not allow residents to smoke, also do not allow staff/volunteers to smoke.

Decline of Placement

Of the 13 respondents who restrict smoking, 46 percent of those have experienced survivor referrals who declined placement because the agency did not allow smoking. In balance, however, the remaining agencies reported that they were unaware of any referrals who declined placement because of their smoking policy.

Policy Reasoning

Of the agencies that do not allow smoking, the consensus reason was due to health-related concerns. One agency that allows smoking for residents (but not staff) wants to see residents work toward cessation, mainly for financial and dependence reasons. Another program shares a campus with a partner program that does not allow smoking, which forced them to adopt the same policy.

"The survivors have enough to deal with, quitting smoking is the least of them and provides them with a suitable coping tool until they can develop better, healthier coping tools/ skills through therapy. Asking a survivor to give up everything she knows to ease her anxiety is a lot. Whereas meeting a survivor where she is at provides the survivor with the autonomy, she needs to make the executive and ultimately smart decision to quit. After she has the information and resources she needs to live without that coping tool."

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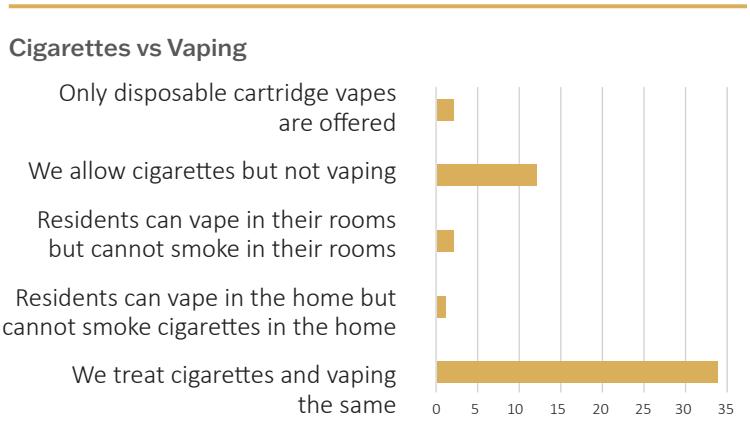
An agency that allows smoking for residents but not staff, commented that there is not a lot of time for smoke breaks, in addition to promoting a healthy lifestyle for residents. One respondent commented, "We found that residents automatically would stop smoking before coming to our program expecting that they would have to." Another said, "The physical space is shared and some of the residents have medical problems such as asthma or respiratory problems. Another reason was that the facilities are rented, and the landlord will not allow it. Residents may smoke outside the premises if they wish on the designated areas."

The agencies that do allow smoking offered several contributing factors that led to that decision. Nearly half (47%) gave the reasoning that residents are already giving up so much (drugs, alcohol, etc.), they did not find it reasonable or worth it, to ask them to quit smoking as well. Thirty-nine percent made the decision to allow smoking to reduce the number of barriers of entry into their program. Twenty-eight percent cited that smoking is a coping mechanism for residents that they don't want to take away and nineteen percent mentioned they felt it was the resident's choice to quit and did not want to take away that autonomy.

Cigarettes vs Vaping

While over half of the respondents treat cigarettes and vaping the same in terms of policy, a large portion (23%) do not allow vaping at all, whereas they do allow cigarettes.



Rules

Allowing residents to smoke can come with perimeters. The table below shows commonly held practices by agencies who allow smoking. None of the respondents allow smoking in personal rooms.

Rules for Smokers in the Program

Residents can smoke only in designated smoking areas	75%
Residents may not buy or share their tobacco/vape products with other residents	48%
Residents can smoke whenever they are not in a scheduled group or appointment	46%
Residents can smoke anywhere as long as it's outside of the house	27%
Residents can only smoke during scheduled smoke breaks during the day	21%
Residents who smoke when not allowed or where not allowed may lose smoking privileges	21%
Residents can buy tobacco/vape products for other residents	13%
Residents can smoke at any time	10%
Only one resident may smoke at a time	4%
Residents are allowed to smoke during certain hours, with lighters being turned in at night	2%
Residents who do not follow smoking rules receive consequences including possible delay of graduation to next phase	2%
Residents are limited to a certain number of smoke breaks per day	2%

Cessation

Research shows that individuals diagnosed with PTSD exhibited more intense smoking behaviors and those with higher nicotine dependence experience greater craving to smoke and are less likely to engage in quit attempts in comparison to those with lower nicotine dependence.[6]

Most of the responding agencies in this study offer some form of support for cessation, while some are interested in the idea, though they do not currently offer any resources.

Smoking Cessation Options Offered

Nicotine patch and/or gum	75%
No services offered	15%
A behavioral modification program to stop smoking	11%
Cover the cost for a resident to switch to non-nicotine vaping	11%
Work with other agencies who provide cessation options	4%
No services offered but interested	4%

These shelters reported making multiple options for cessation available. What is missing in our toolkit, however, is an approach that combines smoking cessation with a recognition of trauma. When compared to specialized smoking cessation treatment alone, integrated treatment for smoking and PTSD resulted in greater prolonged abstinence from smoking.[7]

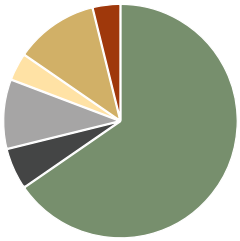
Supply Cost

Residents' smoking supplies are most often paid for by the residents themselves, but a common trend among responding agencies was that supplies were provided by the agency until the resident secures a source of income to cover his/her own supplies.

The average expense per resident among shelters who cover the cost of smoking supplies (N=4) is $49.65 per month. $70 is the highest amount paid per resident each month (N=2) and $25 per resident is the lowest amount.

Seven agencies gave a lump sum spent per month on smoking supplies, not per resident. $139.43 was the average amount spent per month by these seven shelters with $300 being the highest amount and $40 (n=2) being the lowest.

Smoking Supply Financial Responsibility



- The resident has to pay for his/her own supplies
- Our agency covers the cost of smoking supplies
- Our agency provides a weekly allotment of cigarettes to residents who smoke
- The resident has to work/volunteer in our agency to earn funds for smoking supplies
- Supplies are provided for the resident until he/she has a paying job
- Only tobacco and papers to roll cigarettes are provided

6 Messer, K., Vijayaraghavan, M., White, M. M., Shi, Y., Chang, C., Conway, K. P., . . .Pierce, J. P. (2015). Cigarette smoking cessation attempts among current U.S. smokers who also use smokeless tobacco. *Addictive Behaviors, 51,* 113–119. 10.1016/j.addbeh.2015.06.045

7 McFall, M., Saxon, A. J., Malte, C. A., Chow, B., Bailey, S., Baker, D. G., Beckham, J. C., Boardman, K. D., Carmody, T. P., Joseph, A. M., Smith, M. W., Shih, M-C., Lu, Y., Holodniy, M., & Lavori, P. W. (2010). Integrating tobacco cessation into mental health care for posttraumatic stress disorder: A randomized controlled trial. *JAMA: Journal of the American Medical Association, 304*(22), 2485–2493.

Advice

Respondents offered the following advice to shelter agencies struggling to find a workable solution to smoking.

Manage Expectations:

- Consider how lack of smoking parameters would interfere with programming activities.
- Don't try to force survivors to conquer too many addictions all at once.
- Offer a compromise. The more you try to regulate the more battles you will face. Compromise over Control. Recognize that to them smoking is the very least of their issues, and you focus on it being a larger issue seems like you don't actually care about what they are going through, especially when they are in crisis.
- We've seen residents who were unsuccessful at other programs find success at ours because they were able to continue smoking. Changing too much of their lives too quickly doesn't produce the results that our agencies are looking for.

Acknowledge the Need:

- Recognize that they may not have any other way to cope and that to them, smoking is healthy compared to the other ways they may have used in the past. Managed smoking really is better than banned smoking.
- For them smoking has been a coping skill. We will continue to allow that. We want them to focus on staying sober and trauma therapies. Quitting smoking can come later on in their healing journey.
- We think that allowing residents to smoke is relatively low-risk way to allow for a coping skill that can be helpful to survivors. We recognize the difficulty of quitting and encourage survivors to consider quitting on their own time.

Logistics:

- We've found that giving them 4 smoke breaks a day helps and they are more likely to quit if they are able.
- We've found smoking to be a non-issue with the parameters of keeping all forms of smoking/vaping outside the house and asking clients to manage their own habit in this regard.
- Stay consistent in your decision. For those who smoke, we provide 4 packs per week until (they) receive the first paycheck and then they pay for their own. If they are not smoking that many, we replace the packs that were smoked.

Smoking Alternatives:

- We offer healthy options such as gym memberships or vitamin protein shakes, etc. as a replacement for these items if they choose to stop and we front the cost but put a stipulation in place to ensure they sustain from cigarette use.
- It is the resident's decision to quit smoking or not and we support their decisions. In our experience, smoking is generally associated with anxiety issues, we offer individual and group counseling and therapy. Depending on the residents' needs, smoking cessation may be a goal of therapy.

"Consider how difficult it is to change a habit… when you want to change. And now consider how hard that would be if someone is requiring you to do it. We see it as a retraumatization of women, invoking control. Place boundaries on it, like you would anything else, and then do everything you can to help them quit if they choose that for themselves."

RESPONDENT

Pick Your Battles:

- They come with so much more critical issues, tackle the more important first and not make quitting smoking "cold turkey" a hardship for their healing process.
- It is important to differentiate major vs minor issues and really focus on the major issues.
- It really hasn't been a big issue for us vs. what I would imagine would be the challenges of not allowing smoking. If we didn't allow smoking, I think we would have missed out on serving many of the survivors we've had the privilege of walking alongside.
- With our children we often say, "choose your battles", so this is what I would offer. Is it really a battle that is meaningful or worthy of denying admission?

Promote Autonomy:

- Let survivors make choices for themselves.
- Our program operates from a housing first lens and serves clients from the least restrictive approach. It is always my suggestion to provide clients as much freedom as possible while also considering safety.
- We strongly believe that clients achieve the best long-term success when they define their own goals and work towards them. When we create rules that are difficult to enforce, we create power struggles and barriers to recovery.

Reality of Cost:

- DO NOT allow other residents /volunteers to buy tobacco products for other residents. This becomes a problem with "paying back, favoritism, etc."
- We hold residents responsible for purchasing their own cigarettes and draw firm boundaries against "bumming" as it creates transactional relationships between residents.
- We find that when it is getting near to them moving out and on their own with many more expenses, they desire to cut back or quit that habit as it is expensive to maintain.
- They often end up quitting themselves just because of the cost but even if they don't, we decided the small inconvenience is worth them getting help.

"I suggest we allow God to work on the client in this area while they heal. Healing is stressful enough, many used drugs to cope with their pain, give the option of a cigarette/vape to help with the anxiety and stress. Personally, God delivered me from drugs and a year LATER from cigarettes."

RESPONDENT

Postlude

The Samaritan Women-Institute for Shelter Care has been conducting studies on the field of residential care for victims of exploitation/trafficking since 2017. It is our mission to equip agencies with contemporary and qualified research so they can make the best possible decisions about their agency policies and for the survivors they serve.

If you have suggestions for a topic of research that would benefit your shelter program, please email research@thesamaritanwomen.org.