SMOKEFREE MULTI-UNIT HOUSING POLICY IN MONTGOMERY COUNTY, MARYLAND: INTEGRATING INPUT FROM RESIDENTS AND MANAGERS TO ADVANCE CLEAN AIR FOR ALL

by
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Abstract

Objective: To assess attitudes and beliefs of residents and managers of multi-unit housing (MUH) regarding developing and implementing policy to reduce secondhand smoke (SHS) in MUH in Montgomery County, Maryland.

Design: Semi-structured interviews with managers of multi-unit housing and focus group discussions with residents.

Setting: Montgomery County, Maryland.

Participants: Residents and managers of MUH in Montgomery County (MoCo).

Phenomenon of Interest: Implementation of a policy to reduce SHS in MUH in MoCo.

Analysis: The researchers transcribed and analyzed audio-recorded interviews and focus groups using thematic analysis.

Results: Residents and managers of MUH in Montgomery County broadly agreed regarding the benefits of a comprehensive policy to restrict all smoking in MUH, and opinions expressed did not differ significantly based on residents' smoking status. Participants emphasized carefully structured implementation of the policy to increase likelihood of success. Managers suggested requiring all leases to include language outlining the new policy and requiring all new and returning tenants to sign. They also suggested specifying a structure of fines for violations but advised against using the court system, which can be costly and time-consuming. Fair and consistent enforcement of the policy across the county and in all residential environments is crucial to success. Smokers asked that outdoor smoking areas be clearly marked and appealing to use. All urged that

clear, simple language about the new policy be disseminated broadly, via multiple channels to all residents, and that an adequate phase-in time for the policy be included. Both smoking and nonsmoking residents and the managers emphasized the importance of building resident support and providing ample cessation services and support for residents and staff who wish to stop smoking.

Conclusions and Implications: The ultimate audience for this research is policymakers in Montgomery County who are concerned about the health and well-being of their constituents and have a reputation for progressive policymaking. These policymakers work to be recognized as leaders with a progressive agenda in Maryland and around the United States. Because this policy could have broad impact for other state and local policymakers it is important that it be implemented well. Extensive research indicates that policymakers want local data from their own constituents on which to make important policy decisions. This research provides Montgomery County policymakers with important evidence from critical constituents that many of their constituents support such a policy. This research also offers useful suggestions to improve implementation of a comprehensive no smoking policy in MUH in Montgomery County, Maryland.

Key Words: secondhand smoke, policy, multi-unit housing, implementation, high risk populations, qualitative research.

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Acknowledgments

Where do I begin? There are so many people to thank for helping me get through this tremendous ordeal! All the hackneyed aphorisms about the importance of team work probably apply here, at least in so far as it really took a great deal of effort from many people to help me make it across the finish line to complete this dissertation and this Doctor of Public Health degree. I believe it was during our first doctoral seminar that our cohort began to discuss the theory of social support and to delve into the importance of social support for so many positive aspects of our lives. Although I have always placed tremendous value in my own social network and the stellar people in my life who are so crucial to my well-being, I really had not begun to fully appreciate the depth of that support or how grateful I would become for having nurtured these relationships for years, and all the many gifts they have brought to my life. I did quickly cherish the relationships that I built with each member of my cohort with whom I started the program and the subsequent cohort who also adopted me.

The most important person for me to thank is my advisor, **Dr. Katherine Clegg Smith**, who walked this entire journey with me, providing exactly the right balance of sound academic advice, patient and motivational encouragement, a stiff foot in the ass when needed, and a refreshing sense of humor throughout it all. Only Kate truly knows all the challenges I encountered from the tumultuous first year of the program including fun with statistics, to computer crashes in Logan Airport a few days before proposal defense, to negotiating meeting times with a key committee member as he prepared for his Senate confirmation hearing. Through all this, Kate made sure I did not wander away

or get lost in pot holes along Wolfe Street and helped me maintain some minor semblance of sanity through the darkest moments.

Kate has always fostered in me, and so many others at Hopkins, a personal commitment to sound qualitative research methods and showed me how important it is to help others develop a greater appreciation for the essential role of qualitative research in the broader scientific enterprise. I'm so glad that I hitched my star to the premier guru of qualitative research at JHSPH. I really did find myself getting excited at times in the midst of an interview when I was probing to get a better understanding of why the person held the views she or he did, and what the underlying issues were emerging from a focus group discussion. I found myself connecting with some research participants and enjoying the process as well as the content of what I was learning. Kate also emphasized the importance of a balanced life through good times and not so good times. She encouraged me to apply to the program when the time was right for me and did not give up as I worked my way through each of the many steps of the process. Truly, there are not words adequate enough to express my most sincere gratitude for everything you have done to guide me along this path, and around the many landmines! Thanks for always offering a huge smile when I needed it most.

My dissertation committee was also beyond compare in their support and guidance for me throughout our journey together. **Drs. Janice Bowie, Ryan D. Kennedy, Paul Locke (Chair) and Beth Resnick**, along with my essential "alternates" **Drs. Tom Burke, Connie Hoe and Vanya Jones**, each proved to be incredible resources to me in many ways, both personal and professional. I am so grateful for your patient guidance and unceasing support throughout this process. I selected each of you very

carefully after my academic interactions with you, most often during stimulating classroom conversations, but also after learning more of your own research interests and unique public health practice experiences. Your approaches to the pursuit of positive behavioral change and improved public health policies and practices often helped me to see things in a new light and continued to drive my eternal curiosity.

The support, camaraderie and friendships I developed with other students really was crucial to my survival in the program. This group is far too numerous to mention them all by name, but it begins with the **12 amazing women** who started the program with me, and who fully shared the experience along the way, refusing to leave me behind as I struggled through stats or whatever the challenge of the moment was. We had lots of exciting times from solving the health problems of the world in doc seminar, to exploring restaurants and bars throughout Baltimore, to climbing the peak of Old Rag. It has been a wonderful team, and I'm so glad to have been a part of it. After all, we needed some gender diversity, right? The great experiences were also shared with the **next cohort** who adopted me as we learned proposal writing together and explored haunts in Fells Point. Finally, I want to give a special shout out to my friends **Nasreen Jessani** and **Rohit Ramchandani** who were DrPH classmates, but so much more. Rohit was one of the first people I met when I arrived in Baltimore—at the new student happy hour, of course. He happily introduced me to his International Health friends and brought me into the fold—the only other DrPHers I knew then. We bonded quickly and I felt as excited as a first-grader on the first day of school. Of course, the late nights cramming for epi exams might not have fit into the "fun" category, but we helped each other learn "what we came here for," and they both exposed me to so many new cultural experiences that I have felt truly

blessed, and even a bit more like a global citizen having experienced slices of the public health world through their eyes.

I am also truly grateful for the support of all of my family from the moment that I told them I had been accepted into the program and they in unison wondered what a DrPH was, and why in the world I would ever want to go "back to school" at my age and station in life! For now, let's chalk it up to "I needed a new challenge" to distract me at that point (boy, I had no idea what I was getting myself into then!) and I have an insatiable curiosity for learning in general and certainly in anything related to public health or improving the world for all! My parents, **Bob and Karen**, have always been great guides for me in many aspects of life, and I feel very fortunate to have had their support through all of life's biggest challenges. My brothers, **Mark and Steve**, and their wives, **Kim and Sandy**, have remained engaged and supportive through this long, winding journey, even when they kept asking, aren't you done with that yet? And what are you going to do when you're finally finished? I know their questions come from a place of love, support, and yet again, wondering what's wrong with me!

I also would like to thank my very broad circle of friends and supporters en masse because I am really blessed to have such a large and wonderful group of friends who've helped motivate and carry me through this entire process. I'm sure some have been a bit incredulous about how it would all work out, or if I'd ever finish. I assure you all, what I lack in stats or epi knowledge, I make up for in grit, perseverance and a steadfast commitment to finishing what I start. Perhaps those are the only characteristics that got me through. I thank all my friends who were so patient when I told them I wasn't available to do whatever they wanted me to do. I really hope we get to make up for lost

time very soon—there are so many exciting things I want to do with all of you, and to relax and enjoy your company more than anything else—whether it's listening to jazz, watching a baseball game, or taking a long bike ride! Though this list is too long to itemize, several people have been so significant in the depth of your support, as well as your wisdom and ceaseless inspiration—you all know how important you are to me—that I cannot fail to thank you personally. To **Allison Rose**, for kicking my butt all the way to the testing center to take the damn GRE to get the ball rolling; I'd avoided it too long and you gave me just the brief moment of confidence that I needed to consider that I might actually be able to do this thing. To **Gustavo Matheus**, for being my regular sounding board on so many things, helping me through life's many challenges and keeping your deep faith in front of you in a way that always serves as a model for me. To **Gary Gardner**, for having the incredible vision and clear-thinking of a serious researcher and successful author, matched with a peerless personal commitment to social justice that truly helps me stay on track and whose compass serves as a guiding star for me too. To **Bob Devlin**, for always being curious about what I was doing and how I was caring for my soul, even in the depths of my struggles through this process. You, My Good Man, are a true life-friend—and I'm particularly grateful for your keen insights months ago to challenge me to visualize the joy I will be able to see and feel when this is all done. All those I love will be around to smile and cheer with me. I am deeply grateful for that important piece—it really has been what's gotten me to the finish line!

The approach I took to identifying study participants was a relentless and winding one. And it happened exactly the way it was supposed to. For countless months all I did is try to think about and identify potential connections to people in multi-unit housing—

from friends who lived in large apartment or condominium buildings and were willing to share key contacts, to a former co-worker who was a member of her condo association board, to networking at parties and being so excited to meet someone who worked at Fannie Mae and dealt with Multifamily Affordable Housing. (How's that for celebrating the holiday season?!) I was reminded of another friend I'd met many years ago through other social justice work who continued to work locally with low income housing and social support programs and who had many great contacts she eagerly shared. As I rode my bike around Montgomery County, every large apartment building I saw became a possible research site and I wondered whether they might participate and how to contact the manager. All of these people played an important part in my work. I'm grateful to each of them, and to all the **research participants** who shared so freely with their opinions and perspectives on these potentially sensitive topics about policies that might influence their own living environments.

I'm also grateful to my many professional colleagues, nearly all of whom have survived this ordeal of doctoral training and who each in their own way knew some of the challenges I would encounter. My many friends in the **Tobacco Control Research Branch** at NCI have been supportive cheerleaders at times, willing to cover me when needed, understanding when I strolled into work late after an extremely late night pouring over transcripts or writing a couple paragraphs, great colleagues throughout, and willing to commiserate when that was most helpful. A special shout to **Dr. Erik Augustson** who went above and beyond in coaching me through biostats formulas that were all Greek to me, riding many miles with me to reduce tons of stress, and being a great moral support and true friend. Another special thanks to my friend and colleague from CDC, **Dr. Brian**

King, who is an international expert on my topic and who offered guidance and feedback at key steps throughout the process. From the time I read his dissertation on a related topic, to the late-night sessions kicking around key questions to pursue and potential recruitment strategies, and sharing comments on related smokefree housing documents, I always benefitted from his wisdom and experience. I'm grateful for your generosity and patience as I worked my way through my own process and for the outstanding example you set.

Thanks to the larger-than-life **Jesus statue** who so serenely watches over all who pass by his feet under the Dome of the historic hospital. I traversed this path so many times between the Wolfe Street Building and Hampton House, and there were many times when I'd rub his foot for the inspiration I needed in the moment, especially if I were passing on my way to a biostats exam.

I want to close with an appropriate quote that I encountered over the last few months as I approached conclusion of this dissertation. I stumbled onto it in a book I read as one of the few distractions I enjoyed while juggling work and dissertation. The book will provide some insights into the broader context or chaotic environment in which I write, however the quote struck me because it expresses so well how I feel. "Friendship, connections, family ties, trust, loyalty, obedience—this was the glue that held us together." Mafia Boss Joseph Bonanno, in his autobiography, *A Man of Honor* as quoted by **James Comey** in *A Higher Loyalty: Truth, Lies, and Leadership*, to begin Chapter 13, "Tests of Loyalty" (Comey, 2018).

Yes, I've taken the liberty of **bolding** a few names here because I acknowledge how very few people will read this entire document. If you actually see your name, you might read a few key words to know how truly grateful I am to all of you! Thank you from the bottom of my heart!

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Acronyms and Abbreviations

CBPR	Community Based Participatory Research
CDC	U.S. Centers for Disease Control and Prevention
CE	Community Engagement
DHCA	Department of Housing and Community Affairs
DHMH	Maryland Department of Health and Mental Hygiene
FGD	Focus Group Discussion(s)
MoCo	Montgomery County, Maryland
MUH	Multi-unit housing -- any residence that shares a common wall or ceiling with another unit
NCI	U.S. National Cancer Institute
NIH	U.S. National Institutes of Health
SHS	Secondhand Smoke
SHSe	Secondhand Smoke Exposure
SSI	Semi-Structured Interviews
USDHHS	U.S. Department of Health and Human Services
USDHUD	U.S. Department of Housing and Urban Development

Introduction

The topic of secondhand smoke exposure in multi-unit housing (MUH) has become increasingly important over the last decade for several reasons. The knowledge of the health risks of secondhand smoke (SHS) has continued to grow since seminal reports were issued beginning in 1986 (USDHHS, 1986) and another major Surgeon General's report on the topic was published in 2006. The Surgeon General concluded that there is no safe level of exposure to SHS and that the negative health effects begin to occur immediately upon exposure (USDHHS 2006; 2014). Also, as policies to restrict smoking in public places such as workplaces, restaurants and bars have been successfully adopted and implemented across the nation, now covering over half the population, a greater proportion of exposure is occurring in multi-unit housing. This is a major health concern since Americans spend about 69% of their time in personal living spaces (Klepeis, 2001).

Brian King and colleagues from the Office on Smoking and Health at the Centers for Disease Control and Prevention (CDC) reported that in 2009 25.8% of the total U.S. population lived in MUH representing over 79 million Americans, and that 40.0% of Maryland residents live in MUH (King et al., 2013). Multi-unit housing is most often defined as two or more housing units that share a wall or ceiling with another living unit. Clearly the risk of exposure to SHS in MUH is a major public health risk based on the substantial proportion of the population who is exposed to this deadly environmental threat in their homes. In addition, the U.S. Department of Housing and Urban Development has a mandate to provide a safe and healthy living environment for all residents residing in HUD housing. HUD staff have been working to protect all residents of public housing from the risks of exposure to SHS (SHSe). In July 2018 HUD

implemented a policy prohibiting all smoking in public housing, including in all residential units (USDHUD, 2016). Thus the urgency and timeliness of this dissertation research has continued to increase while I have been conducting this study.

This dissertation begins with an explanation of community engagement (CE) and community based participatory research (CBPR) and why this CE approach was utilized to frame and conduct my dissertation work. I describe a case study of a Community Engagement Workgroup (CEW) that I created and led at the National Cancer Institute (NCI) as a means to build stronger relationships between National Institutes of Health (NIH) funded researchers and tobacco control practitioners at the state, local and national levels with the shared goal of improving the dissemination and implementation (D and I) of research findings from NCI's State and Community Tobacco Control research initiative. This CEW has continued to grow in size and expand in scope since it was created in 2012 and has taken on a broader role in building research to practice partnerships while expanding D and I efforts in tobacco control research. The workgroup has served numerous important roles since its inception in 2012, while also providing a vehicle for me to learn more about community engagement and CBPR approaches to research. This work has only deepened my personal commitment to a community engagement approach as I have learned more about it.

The community engagement chapter elaborates more on these issues and has created the foundation for my approach to this dissertation research. My community engagement work has emphasized that to successfully adopt and implement a smokefree MUH policy in Montgomery County, Maryland, policymakers must have access to data from their constituents regarding their views about this policy, and that residents and

managers must have ample opportunity to engage with and inform the policymaking process. As the saying goes, all politics is local. And thus the most effective policy making also occurs at the local or state level. This dissertation work offers crucial insights from Montgomery County residents who will be most directly affected by the policy and who have the greatest stake in ensuring the success of the policy. I also describe the demographics of Montgomery County while attempting to make the case that this is a community ready to consider a policy to prohibit all smoking in MUH. The very low smoking rates, high educational levels, high incomes and progressive political views create an environment in Montgomery County that is committed to values that support an ethic of protecting the health and well-being of all its residents.

The dissertation then proceeds to describe the qualitative methods used to conduct this study and reports findings from interviews with managers of MUH buildings in the county and focus groups with residents including both smokers and nonsmokers to better understand their views about a smokefree MUH policy and gather their insights about how to effectively implement such a policy. While conducting this research it became quite clear that many residents were concerned about high risk populations in their midst and how this policy would particularly affect children, senior citizens or people with disabilities. The research takes a careful look at these vulnerable populations and how a policy could be implemented to incorporate their specific concerns.

The Specific Aims of the study are as follows:

Aim 1: To assess the beliefs and attitudes of residents of MUH regarding a policy to reduce secondhand smoke exposure (SHSe) by eliminating smoking in and around

multi-unit housing in Montgomery County, and identify perceived barriers and facilitators to implementing such a policy.

Aim 2: To explore the beliefs and attitudes of owners and managers of MUH regarding a policy to reduce SHSe by eliminating smoking in and around multi-unit housing in Montgomery County, and to identify perceived barriers and opportunities related to implementing such a policy.

Integrating a community engagement approach was crucial to guiding and structuring the conduct of this dissertation research. I believe that this approach holds great potential to achieve the mutual goals of this researcher and the community members who will be most affected by the research. Principles of collaboration and fairness dictate that those most affected by any public health policy be fully involved from the outset in guiding policy development and any research that is intended to inform or shape that policy agenda. A personal commitment to social justice has always guided my public health work throughout my career, and this dissertation research provided a direct opportunity to put these beliefs into practice and allow me to learn from the participants of the study.

A Community Engagement Approach to Disseminating and Implementing Research Findings to Reduce Tobacco Use

Purpose

The purpose of this chapter is threefold. First, the chapter describes the project I conducted to fulfill the requirements for the practicum experience for the DrPH degree and briefly outlines the work I did to organize and lead a Community Engagement Workgroup at the National Cancer Institute. I will describe how a community engagement approach was, and is currently, being used to proactively disseminate and implement research findings from large federal tobacco control research initiatives and build partnerships to facilitate these goals in order to maximize the public health impact of the research. The second purpose is to provide important underlying background information about community based participatory research and community engagement to help readers understand more about these approaches to conducting health research as an insight to my view of this work and to provide some context for decisions that were made throughout this study. Finally, this paper will explain why my dissertation research was structured in the way that it was and why I believe so strongly that it is essential to fully engage community members in research that may have direct implications for their health and well-being. The collaborative nature of this study and the deliberate, structured attempt to gather input from residents and managers of multi-unit housing will be instrumental in shaping any future policy that may require all multi-unit housing in Montgomery County, Maryland to be smokefree.

Background to the Community Engagement Approach

In this chapter I provide an example of how a community engagement (CE) approach has been used to facilitate the broad dissemination and implementation of

research findings from a national tobacco control research initiative by building strong partnerships among relevant research and public health practice communities with the shared goal of reducing tobacco use. First I will provide a brief description of community engagement theory and why this approach was utilized as a central component of the National Cancer Institute's (NCI) State and Community Tobacco Control (SCTC) research initiative, describe some of the activities of the Community Engagement Workgroup (CEW), and how this experience helped to form the foundation for subsequent qualitative research on a policy regarding secondhand smoke (SHS) in multi-unit housing (MUH) in Montgomery County, Maryland. The results of the research have guided tobacco control programs across the nation, to increase program effectiveness and produce real reductions in the prevalence of tobacco use. This CEW was created to facilitate the achievement of this goal by involving as many key partner organizations as possible who also have an interest in reducing death and disease from tobacco consumption or exposure to SHS, and who were committed to helping realize the goal.

Rationale for Community Engagement Approach

The literature on community engagement (CE) is quite compelling and expansive. One important summary resource is the *Principles of Community Engagement, Second Edition,* developed by several federal health agencies including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry in collaboration with an extensive group of experts on this topic (Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 2011). This publication was developed as part of the work of the Clinical and Translational Science Awards Consortium's Community Engagement Key Function Committee and updated the first edition that had been issued

in 1997. The report identifies the underlying goals of community engagement: 1) to build trust, 2) enlist new resources and allies, 3) create better communication, and 4) improve health outcomes while building successful projects into lasting collaborations (Alinsky, 1962; Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 2011; Chávez et al., 2010; Freire, 2010; Wallerstein and Duran, 2006).

There are many definitions of community, community engagement and community-based participatory research (CBPR), some of which share common elements, and depend on the context in which they are employed. In fact, McLeroy and his colleagues in a seminal article on the ecological perspective on health promotion programs in 1988 suggest that "community" has been defined in so many ways that it has lost much of its meaning (McLeroy et al., 1988). A community can represent a geographic area with shared interactions, a group who are affected by health or other issues of concern, or a group that shares a particular culture or set of norms (Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 2011; Tindana et al., 2007). Perhaps a defining characteristic of a community is the common identity that its members share. Communities are often defined by their shared traditions or values; however, these can change over time and may even accommodate multiple or conflicting interpretations of these values or cultural norms within the group (Tindana et al., 2007).

The concept of community engagement is complex and tends to defy a commonly accepted definition, but the one put forward by the *Principles* group encompasses most of the key principles: "…the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address

issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs and practices" (Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 2011, p. 7). The group also provides a useful continuum to think about the processes of community engagement (Figure 1) (Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry, 2011). Other definitions also stress the themes of collaboration, building authentic partnerships around mutual respect, with the goal of mutually beneficial outcomes (D'Alonzo, 2010; Tindana et al., 2007).

The concepts of CE and CBPR are closely related, although distinct. Sometimes the terms are used interchangeably, although many would argue that is not precise. A widely cited definition by Israel and colleagues emphasizes a collaborative approach to research that involves community members, organizational representatives, and researchers equitably in all aspects of the research process. "The partners contribute unique strengths and shared responsibilities to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained with action to improve the health and well-being of community members" (Israel et al., 1998, p. 177).

Tandon and colleagues use this definition and offer a vision for future health partnership research by providing recommendations on issues that they believe CBPR research should focus on (Tandon et al., 2007). These authors used a Delphi Process to

elicit the perspectives of the editors and external advisory board of the journal *Progress in Community Health Partnerships: Research, Education and Action (PCHP),* and their efforts generated a list of specific recommendations in eight scholarly domains. They obtained responses from all the editors and 71% of the editorial board members and the first stage generated 318 unique recommendations across all eight domains. Stage 2 was a priority setting process that organized the topics into the most important ones for publication. Highlights included the commonly rated priority for Original Research was "translation of research into policy and practice" (92%). In the Work-in-Progress/Lessons Learned domain "building community partnerships" (58%) and "challenges in conducting CBPR" (58%) were most often selected. In the Policy and Practice domain "engaging community members in policy/practice" (92%) was most commonly selected and in the Practical Tools domain, the commonly selected topics were "resources to develop community partners' skills" (75%) and to "evaluate projects" (75%). In the Community Perspectives domain, the most common priorities noted were "community members' perspectives on research usefulness" (92%) (Tandon et al., 2007).

Figure 1: Community Engagement Continuum

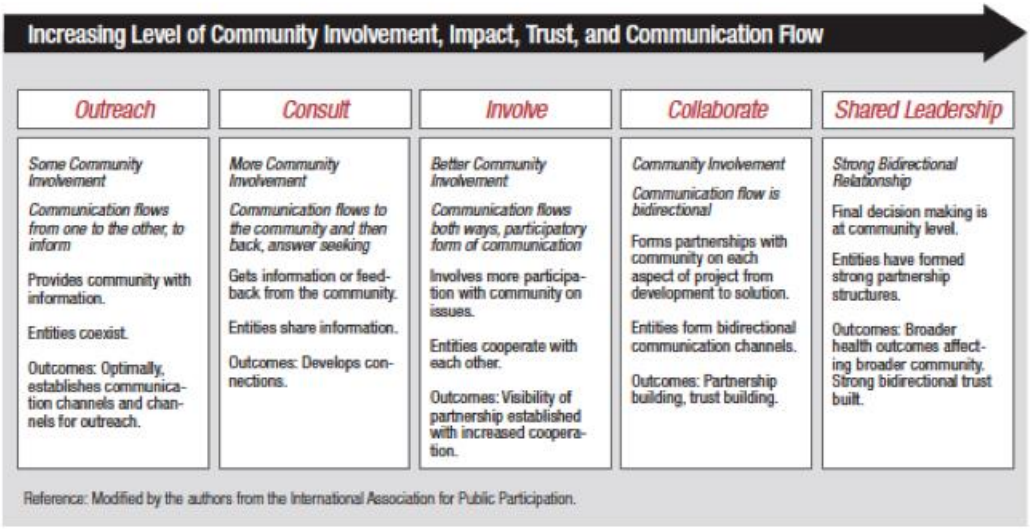

Figure 1.1. Community Engagement Continuum

Source: CDC/ATSDR, 2011. Principles of Community Engagement, 2nd Edition.

SCTC Community Engagement Workgroup (CEW) and Its Purpose

The SCTC research initiative addresses high-priority gaps in state and community tobacco control research in the following areas: secondhand smoke policies, tax and pricing policies, mass media countermeasures, community and social norms, and tobacco industry marketing and promotion (Ginexi and Vollinger, 2016). An explicit goal of the initiative was to encourage collaborations between scientists and practice-based partners. This Community Engagement Workgroup (CEW) was originally created in 2012 and was comprised of SCTC grantees and their representatives, tobacco control partners and NCI staff who are committed to actively engaging community members in disseminating and implementing research findings throughout the initiative in ways that will expand and strengthen partnerships and the overall public health impact of the initiative. The workgroup is an essential component of this research initiative which launched in 2010

and is the largest workgroup of the initiative. A social network analysis by Ginexi and colleagues found very substantial increases in the numbers of scientist-partner network linkages that were developed over time (Ginexi et al., 2017). Details about the funded research projects, research topics, major publications and research products and other relevant information is available at: https://cancercontrol.cancer.gov/brp/tcrb/sctc.html (NCI, 2017). The Request for Applications (RFA) that funded these cooperative agreement research projects may be found here: http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-10-008.html (National Institutes of Health, 2009).

The purpose of this workgroup as originally constituted in 2012 was threefold, and these goals (see Appendix 1) remain relevant as the workgroup as evolved since its inception:

1) To broaden the group of partners involved in the SCTC initiative to include others who can help actively disseminate research findings and ensure that results are being fully utilized to advance policies and media interventions that will reduce or eliminate tobacco use.
2) To serve as facilitators or liaisons between community partners and scientific leaders on the Research Projects (RPs), particularly the collaborative developmental projects, and ensure that the perspective of public health practitioners and community members are included in efforts to disseminate findings in ways that will maximize the public health impact of the SCTC initiative.
3) To identify and promote partnerships between community stakeholders and Research Projects to ensure that community and practitioner partners' needs are

incorporated into the research projects and collaborative developmental projects in ways that will enhance mutual credibility and maximize the potential for broad impact of the initiative.

Although the SCTC initiative which served as the organizational home of the workgroup has ended, the Community Engagement Workgroup has continued and expanded because the goals remain crucial to NCI's broader policy research portfolio that I manage. We seek to ensure that current research in the field is directly relevant to state and community tobacco control programs, and that the research is utilized to advance public health goals across the U.S. The intended outcomes of the workgroup remain to:

- increase membership in the Community Engagement Workgroup to include other tobacco control partners;
- promote cross-site collaborations (abstracts, manuscripts, projects) related to community engagement;
- review and disseminate key literature on community engagement efforts in public health;
- identify and distribute examples of successful community engagement efforts with other public health research interventions; and
- develop resources to improve and expand engaging community partners in the SCTC initiative.

The workgroup includes a diverse array of tobacco control researchers, practitioners and policy makers from state and local health departments, voluntary health

organizations and federal health agencies, among others, who are all committed to actively disseminating and implementing research findings from the funded projects. The group began in November 2012 with twenty members and has conducted targeted outreach over its existence and has actively recruited selected partners and stakeholders to include more than 60 members currently (see Appendix 2). When the SCTC initiative ended the Community Engagement Workgroup had continue to grow and was serving an important function for NCI's Tobacco Control Research Branch as a vehicle for disseminating policy and media-related research findings and providing a forum to continue to strengthen partnerships between the research and public health practice communities. As the SCTC initiative sunsetted (when a program expires automatically at the end of fixed time period according to original plans), we conducted a self-assessment to gauge the level of interest from workgroup members in continuing to interact and hold meetings on a regular basis. The group was widely supportive of continuing their mission and being open to adding new members who shared their interest and vision. In the interim NCI had approved a new research initiative on U.S. Tobacco Control Policies to reduce Health Disparities which I lead. See PAR's 18-674 and 18-675 for additional details at https://grants.nih.gov/grants/guide/pa-files/PAR-18-674.html (NIH 2018, R21) and https://grants.nih.gov/grants/guide/pa-files/PAR-18-675.html (NIH 2018, R01).

The workgroup has continued to expand its scope and membership now with over 60 members who participate in regular conference calls. The group now includes other scientists who have been funded under these new research mechanisms as well as other researchers conducting tobacco control policy or media research and other public health organizations who work to advance tobacco control policy at the state and local level throughout the United States. In addition, several representatives of state tobacco control

programs are involved in the group, along with numerous federal partners including the Centers for Tobacco Control and Prevention, the Food and Drug Administration, the Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Environmental Protection Agency.

The value of this workgroup has been in building partnerships across most of the key organizations involved in tobacco prevention and control efforts in the U.S. to facilitate the proactive dissemination and implementation of scientific findings from this large federal investment in research. The primary emphasis has been on policy and media related research, with a particular focus on state and community interventions. Although many members of this workgroup have collaborated in various ways over several decades, this workgroup provides an opportunity to strengthen ties and build new collaborative relationships while focusing on a clearly articulated agenda. The idea from the outset was to bring together scientists who were conducting this research with a broad array of partners who could help ensure that their findings are widely disseminated and used to advance a policy agenda that would have the greatest likelihood of reducing tobacco use and exposure to SHS. Originally the workgroup focused on the research topics of the initial seven grantees that were part of the SCTC initiative, however the scope has also broadened more recently to include key topics in the tobacco control policy landscape with recent meetings focused on Tobacco 21 research and policy advances and the July 2018 meeting focusing on smokefree multi-unit housing in anticipation of the HUD rule which will be fully implemented this month. Representatives of HUD's Office of Public and Indian Housing and the Office of Lead

Hazard Control and Healthy Homes participated along with presentations from researchers in New York City and Boston shared some of their recent research.

These partners are crucial in expanding the efforts to disseminate and implement tobacco control policy and media research findings beyond the traditional channels of journal publication or presentations at professional conferences to engage the ultimate consumers of this evidence base. Examples include engaging state attorneys general responsible for enforcing relevant provisions; facilitating joint discussions between researchers, practitioners and policy makers; sharing findings with front line public health advocates who use the evidence to advance comprehensive tobacco control policies at the state and local level; providing training and technical assistance; translating scientific findings into lay language so that they can be used more broadly with many audiences; and ensuring the results reach those most motivated to change public health policy. With the evolution of NCI's tobacco control research agenda, the focus has also shifted more explicitly to research that can be used to reduce tobacco-related health disparities.

Discussion

This deliberately collaborative effort has created multiple opportunities for the researchers and practitioners to engage regularly, listen to one another's concerns, and work together to ensure the broadest possible reach of this evidence. Practitioners have been involved with these research projects from the very outset to ensure they were attempting to answer questions that could inform the policy environment at the state or local levels, or with specific priority populations. These collaborative activities woven together with this CE approach have resulted in a synergistic impact much greater than is likely to have been achieved by NCI, the individual research projects, or any of these partner organizations alone. By involving these diverse partner organizations, NCI has

been able to: enhance and strengthen federal research efforts, expand the impact of research findings, and more fully integrate dissemination and implementation efforts.

In addition to the benefits directly to the SCTC initiative, this Community Engagement Workgroup has also strengthened the relationships among all those involved and the organizations they represent. In fact, I believe the primary reason that the workgroup has outlasted the research initiative under which it was created is because the members have seen the value-added of their regular interaction, have appreciated the opportunities to collaborate and brainstorm around future research questions, and understand the benefits of partnerships in disseminating and implementing their research findings as broadly as possible, and to audiences who are most likely able to help them achieve true public health gains. This work will yield dividends that may enhance a wide array of related tobacco prevention and control work at the state and community levels, but also among many federal agencies, including research, policy development, programmatic activities and regulatory efforts. The trust and personal relationships built and strengthened through this work may yield positive outcomes far into the future.

One specific example of this is the work led by a team of investigators at Emory University that focused on smokefree home policies in low-income households. This cooperative agreement was funded by the SCTC initiative and the investigators participated actively with the CEW efforts and helped to inform activities at many levels. The team engaged colleagues from multiple state health departments who were also working on smokefree MUH activities and their findings guided these activities as well as the efforts of an Interagency Workgroup on Smokefree Multi-Unit Housing convened by the U.S. Department of Housing and Urban Development and CDC, but that also

included other federal agencies involved in efforts to support the development and implementation of HUD's smokefree public housing policy. This interagency workgroup on smokefree MUH has proven to be a useful vehicle to share information across several organizations with a vested interest in ensuring that the rule is implemented well and minimizes any potential backlash so that the rule will be able to achieve the goal of reducing exposure to deadly SHS, consistent with HUD's broader purpose of providing a safe housing environment for its residents across the United States.

The success of these community engagement efforts as part of the SCTC initiative has resulted in many benefits for the initiative and extended the impact of this research. However, this workgroup and its activities have also expanded the scope of NCI's efforts to disseminate and implement research findings and has made important contributions to the collaborative activities of these organizations who share a mission and values to reduce death and disease from the use of tobacco and nicotine and exposure to SHS. This CEW has provided a foundation for other collaborations across these organizations that have worked together in the past, either frequently or somewhat more sporadically. One example is another collaborative effort on state and community research and policy that has recently been formed between NCI's Tobacco Control Research Branch and CDC's Office on Smoking and Health to interact more closely with each other as they advance a common agenda to share information to support state and local tobacco prevention and control programs. This is an explicit attempt to build an infrastructure to improve communication between these organizations that have many reasons to work closely with one another and have a shared constituent base who will benefit from these strengthened interactions.

These community engagement efforts at NCI, and the CEW in particular, have proven particularly useful in informing the direction and structure of a local qualitative research study on attitudes and beliefs about a policy to reduce SHS in MUH in Montgomery County, Maryland. In order to increase the likelihood of success for adopting and implementing such a ground-breaking policy, it is essential to engage residents and managers of multi-unit housing from the outset and obtain their advice about how best to successfully implement such a policy. My dissertation research was designed to engage community members who are residents, owners or managers of MUH in Montgomery County on the topic of SHS exposure with the goal of learning from them and using their insights to craft and implement the most effective policy possible. D'Alonzo notes that the most effective CBPR efforts often are a natural outgrowth of an evolutionary process of engaging community members (D'Alonzo, 2010). Importantly, Minkler and Hancock indicate that the best CBPR projects build upon existing relationships and past projects within the community (Minkler and Hancock, 2008). Leeman and colleagues also reported important information regarding what public health practitioners hope to get from these collaborations. They report that practitioners are more likely to adopt and implement evidence-based interventions when they address the needs and aspirations of the practitioners, are integrated into their social and professional contexts and also include comprehensive guidance regarding implementation (Leeman et al., 2015). This team also emphasized that in order to be effective, practitioners must have flexibility to develop policy and environmental change interventions integrate stakeholder priorities and resources and that they accommodate the policies and environments that already exist locally (Leeman et al., 2015).

In considering how to best organize and frame this study I intended to utilize my historic knowledge of Montgomery County as a long-time resident and build on existing relationships with key partners, as well as involvement with previous successful public health efforts, to enlist participation in this project. A community engagement approach is essential to this type of research that seeks to ultimately shape policies affecting how people live, as well as health outcomes for themselves and other neighbors or community members. This community engagement approach, with its commitment to building trust; enlisting new resources and allies; creating better communication; and improving health outcomes while building successful projects into lasting collaborations, is consistent with my personal public health philosophy and my views about how to ensure positive impact of the work we do in public health.

Background

Secondhand Smoke Remains a Deadly Problem

Exposure to secondhand smoke remains a critical public health problem in the United States, causing 41,280 deaths each year (USDHHS, 2014). In 2006 the Surgeon General reiterated that there is no risk-free level of exposure to SHS and that the adverse health effects occur immediately upon exposure (USDHHS, 2006). SHS causes premature death in children and adults who do not smoke. Children who are exposed to SHS are at increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma (USDHHS, 2006). Parents' smoking causes respiratory problems and slows lung development in their children (USDHHS, 2006). Furthermore, research has identified an association between secondhand smoke exposure (SHSe) and mental health problems including major depressive disorder, generalized anxiety disorder, attention-deficit/hyperactivity disorder, and conduct disorder among children and adolescents between ages 8 and 15 (Bandiera et.al., 2011; Samet, 2011). According to the Centers for Disease Control and Prevention (CDC) and the California Environmental Protection Agency, in Maryland alone, 6,800 adults die from their own smoking each year, and 670 adult nonsmokers will die from being exposed to other people's smoke (CDC, 2012).

The dangers of SHS have been outlined in numerous major reports over more than 30 years, including the 1986 Surgeon General's Report, a seminal report in 1992 from the Environmental Protection Agency that identified secondhand smoke as a "Class A Carcinogen," and the 2006 Surgeon General's Report that updated and expanded upon these findings (USDHHS, 1986; 2006; USEPA, 1992). This mounting evidence was used to change policies and norms throughout the United States and beyond, and provided the

basis for restrictions on where people could smoke that were first imposed in California in the late 1970s. As knowledge of the deadly effects of SHS has increased, the breadth and scope of these restrictions have also expanded in attempt to provide greater protection to nonsmokers and to increase motivation to stop smoking for the majority of smokers who want to quit.

The health risks from home exposure to SHS have been documented in several studies, including one which found that children who live in homes where no one smokes inside have a 45% increase in cotinine levels (a biomarker for exposure to tobacco smoke) if they live in an apartment compared to a detached home. The authors conclude that multi-unit housing may be a significant source of SHSe for children at levels that are associated with morbidity (Wilson et.al., 2011).

Although numerous studies have noted the public health problems caused by SHSe in multi-unit housing (MUH), it is important to view these findings on health effects in combination with work by King and colleagues that focused specifically on the extent of the problem and pointed toward a need for greater policy action to reduce exposure to SHS in the home (King et al., 2013). These authors reported on two national surveys indicating that 25.8% of U.S. residents (79.2 million) live in MUH, ranging from 10.1% in West Virginia to 51.7% in New York (King et al., 2013). They also provide data from self-reported surveys indicating that 44%–53% of MUH residents with smokefree home rules experienced an SHS infiltration in their living unit that originated from elsewhere in or around their building (King et al., 2013). In Maryland, 40.0% of the state's population lives in MUH, representing approximately 2.3 million people who could be exposed to SHS in their homes from others in the building (King et al., 2013).

The issue of SHS exposure in MUH is a significant public health concern that warrants further study for at least two reasons: (1) SHSe in MUH causes disease and death among nonsmokers in their homes, and (2) the large proportion of people in the United States who live in multi-unit housing makes the overall magnitude of the problem significant from a population perspective. This is particularly true in Maryland, which ranks 9th nationally in total number of residents living in MUH (King et al., 2013).

Policies restricting smoking in workplaces, restaurants, and bars have been the precursors to attempts to provide protection from the dangers of SHS in the home. Many tobacco prevention and control and public health advocates, along with like-minded policymakers, have considered exposure to health risks in public places a higher priority for taking policy action, at least in part based on the perspective that people should be free from risks to their health in public places that they frequent often and that individuals should not be put at risk when conducting their daily activities. As awareness of the deadly effects of SHS has grown, along with the knowledge that even small doses of exposure increase health risks, and that risk increases soon after exposure, some residents and policymakers have begun to consider how to reduce the risk of SHSe in the home as well. The building evidence base was greatly expanded by the 2006 Surgeon General's Report *The Health Consequences of Involuntary Exposure to Tobacco Smoke* (USDHHS, 2006), which received broad media coverage. Some owners and managers of MUH began to adopt their own voluntary policies to prohibit smoking in MUH as they became aware of these risks. Policymakers, however, were initially slow to enact legislation addressing smoking in the home because of a social taboo against telling people what they can and cannot do in their own homes, and many public practitioners were concerned about

"slippery slope" arguments or accusations of being "neo-prohibitionists" (Gostin, 2013; Jacobson and Warner, 1999).

An important point to note here is that these policies are being considered for multi-unit housing, not individual private homes, because of the potential risk of SHSe to *other people* living in close proximity who do not share their homes with a smoker, and whose units share a wall. The most commonly accepted definition of multi-unit housing is two or more units that share a wall or ceiling, including townhomes or duplexes.

In October 2007 the City of Belmont, California approved an ordinance making them the first jurisdiction to prohibit smoking in multi-family residential units or multi-unit dwellings (MUD) (Tippens, 2009). Until that time, most of the attempts to limit exposure to SHS in the home involved voluntary policies adopted on a somewhat ad hoc basis by landlords, tenant associations, real estate companies or others interested in the safety of people's home environments.

Support for Smokefree Multi-Unit Housing

Over the last decade a growing body of literature has assessed residents' and owners' attitudes and support for smokefree housing policies. These studies have surveyed views in specific jurisdictions within California, Minnesota, New York, Ohio, Oregon, and Washington, among others, using a variety of methods (Drach et al., 2010; Hennrikus et al., 2003; Hewett, Ortland, et al., 2012; Hood et al., 2013; King, Cummings, et al., 2010; Pizacani et al., 2012; Satterlund et al., 2014). A 2001 study that surveyed residents of large apartment complexes in a Minneapolis suburb found that 79% of nonsmokers preferred that their building be smokefree, and 75% thought that enforcing a smokefree policy for guests would not be difficult. Of those in nonsmoking households,

53% reported smelling smoke in their units, and most of these were bothered by it (Hennrikus et al., 2003). Generally, these studies found broad support for smokefree MUH policies, with higher levels of support among nonsmokers than smokers. In a survey of multi-unit public housing residents in Tacoma, Washington, 82% of nonsmokers supported a policy to ban smoking in their homes, compared to 42% of smokers; 82% of nonsmokers agreed with a ban in common areas, compared to 74% of smokers; and 68% of nonsmokers and 38% of smokers agreed or strongly agreed with a ban on smoking in outdoor areas (Ballor et al., 2013). The differences in support for the policy between smokers and nonsmokers depended on the specific details of the particular policy. In this study, 53% of smokers and 90% of nonsmokers currently do not allow smoking in their homes.

The following studies are important for several reasons. Not only will results from this research drive the policymaking agenda, but the fact that this research is being conducted indicates that there is growing interest in this topic in the United States. These studies found that many people continue to be exposed to SHS infiltration into their homes and that they support smokefree policies in their MUH. The research also demonstrates increased quit rates and reduced exposure to SHS from smokefree policies and shows that interventions are warranted to promote cessation and smokefree policies to protect all MUH residents, employees, and visitors from SHSe. These research findings and the growing demand for smokefree policies in MUH provided the background and incentives to frame my current research.

Research from several regions of the United States has found that many MUH residents do not want to be exposed to SHS in their homes and prefer smokefree housing.

Pizacani and colleagues' study found that indoor smoking decreased significantly, from 59% to 17%; almost half of continuing smokers reduced their cigarette consumption; and frequent exposure of nonsmokers to indoor SHS decreased dramatically, from 41% pre-policy to 17% post-policy, resulting in a 58% decrease in SHSe after the policy (Pizacani et al., 2012). They also found that implementation of a comprehensive smokefree policy in low-income multi-unit housing was associated with reductions in SHS exposure among nonsmokers and with cessation-related behaviors among smokers.

Brian King and colleagues reported that a majority of MUH residents who responded (55.6%) supported a policy prohibiting smoking in all areas of their building, including residential units, balconies, and patios. Support was significantly higher among ethnic minorities and people who live with children (King, Cummings, et al., 2010). In another study, King and colleagues reported that 75% of respondents who were owners or building managers without a smokefree policy indicated interest in restricting smoking in at least one of their units, with much greater interest among participants with government-subsidized units (King, Travers, et al., 2010). The primary barriers to policy implementation included concerns over increased vacancy rates (27%), potential decrease in the market size of potential tenants (21%), or the federal, state, or local legality of such a policy (18%). Among owners and managers with no smoking restrictions in their buildings, the most commonly reported motivators for policy implementation were evidence of high demand for smokefree units and knowledge that a policy would reduce turnover rates or insurance cost. All 17 of the respondents who did have smoking restrictions in at least one of their buildings responded that it was "likely" they would retain their smokefree policy.

Licht and colleagues evaluated attitudes, experiences, and acceptance of smokefree home rules and building policies among a nationally representative sample of U.S. MUH residents. They found that 79% of MUH residents reported having smokefree home rules and 29% reported living in a smokefree building. About 56% of participants would support the implementation of smokefree building policies (Licht et al., 2012).

As of 2011-2012, data show that approximately 58 million U.S. nonsmokers (25.3%), including 15 million children ages 3–11 years, were exposed to SHS (Homa at al., 2015; Nguyen et al., 2016). The analysis indicated that the percentage of adults who used tobacco products was higher in MUH than in single-family housing for any type of tobacco use (24.7% vs. 18.9%) and combustible-only product use (19.8% vs. 13.6%) (Nguyen et al., 2016). Key findings from this study indicate that U.S. MUH residents have a higher prevalence of tobacco use, particularly combustible products, and lower prevalence of smokefree home rules than single-family home inhabitants, particularly among combustible tobacco users. This research emphasizes the need to implement comprehensive smokefree building policies in MUH to protect all residents, staff, and visitors from the dangers of SHS exposure, including those who may have implemented their own smokefree home policies, because they remain susceptible to smoke from neighbors who may not have implemented a smokefree home.

Why Approach Policy Change at the Local Level and the Importance of Preemption

The most innovative tobacco control policies have tended to emerge at the local level (Mowery et al., 2012; National Cancer Institute, 2000). Smokefree MUH policy is an example of this trend of beginning innovative policy change at the local level, as noted previously with the early adoption of these policies in cities and counties in California. In addition to serving as a source of innovation and advances in tobacco control

policymaking, local clean indoor air laws offer several advantages over state or federal legislation. Local laws are easier to enact and strengthen because local officials are highly responsive and more directly accountable to constituents, and the tobacco industry generally has less influence at the local level than at the state or national levels. Local laws typically provide more comprehensive and stronger protections from secondhand smoke and establish more accessible and accountable enforcement mechanisms, and they involve public education and grassroots organizing aimed at changing attitudes and social norms (National Cancer Institute, 2000).

Why Montgomery County, Maryland

This dissertation study focuses on the readiness for smokefree multi-unit housing among both residents and managers of MUH within one U.S. county. In attempting to adopt and implement a policy that some may view as controversial or lacking unanimous support, it is important to understand the full range of opinions and concerns that motivate key constituents in the public debate, specifically regarding a policy to prohibit smoking and eliminate exposure to SHS in MUH. To better understand these concerns and issues surrounding a policy to eliminate SHS in MUH, I want to give voice to a wide range of perspectives that will prove useful to policymakers and public health practitioners who could ultimately be tasked with implementing smokefree MUH policy.

Montgomery County is a large county in Maryland with over a million residents who tend to be affluent and well educated. The median household income in the county is approximately $96,000 with only approximately 6% of county residents living below the federal poverty level. According to the U.S. Census Bureau (2013), 57% of residents over age 25 have at least a bachelor's degree. It is also notable that 33% of housing units in the county are in multi-unit structures (U.S. Census Bureau, 2013). The population of the

county is racially, ethnically, and demographically diverse and relatively progressive in their political views, with a strong commitment to protecting public health. For example, a comprehensive clean indoor air law in public places was adopted in 2003, and Montgomery was the first county in the country to pass legislation restricting trans fats. The county has been a leader on many other health, education, and welfare policies (Spivak, 2007; Delaney and Daniels, 2013). The demographics of the county suggest that it is a prime place to implement a policy to reduce exposure to secondhand smoke in multi-unit housing.

Montgomery County also has a high proportion of nonsmokers—about 92% of adults, making nonsmokers by far the largest segment of the county's population in terms of tobacco use (Maryland Department of Health and Mental Hygiene, 2009). Adult smoking rates in the county are estimated to range from 8.1%, based on a report by the Maryland Department of Health and Mental Hygiene in conjunction with the CDC (MDMH, 2009), to 11.9% based on 2006 data from the U.S. Behavioral Risk Factor Surveillance System (BRFSS) (CDC, 2006). The Maryland Department of Health and Mental Hygiene report also notes that the statewide adult smoking prevalence rate is 14.9%, much lower than the national average, ranking Maryland 4th lowest among the states in smoking prevalence (CDC, 2012; MDMH, 2009). Among young people in Montgomery County the smoking rate is 3.1% for middle school students and 6.0% for high school students; statewide, the percentages are 5.2% and 7.0% respectively (MDMH, 2009).

Why This Study

Literature cited in this dissertation demonstrates increasing demand for smokefree multi-unit housing across the country. This work offers insights into the opinions and

attitudes of residents, both smokers and nonsmokers, and managers regarding a policy to prohibit smoking in multi-unit housing in Montgomery County, Maryland. The primary purpose of this research is twofold: (1) to provide local Montgomery County policymakers with evidence about attitudes and beliefs about a smokefree MUH policy from their constituents who would be most directly affected by the policy—residents and managers of MUH, and (2) to increase the likelihood of successful implementation of such a policy by guiding policy development so that implementation issues can be addressed early in the process, and to identify steps that can be taken to ensure that policy can be implemented smoothly, with limited backlash from those who may not be supportive.

This dissertation focuses on suggestions from study participants regarding what steps can be taken to implement the policy in ways that will make it more successful in reducing SHS exposure, increase the likelihood that it will be accepted by smokers, and reduce potential backlash upon adoption. Results are organized according to six main implementation themes that emerged from the research. Many of these issues relating to implementation apply directly to building managers who will have primary responsibility for implementing the policy, but some steps can be taken during the drafting of a policy and included from the outset that will likely facilitate transition to completely smokefree MUH in Montgomery County.

Important information came to light during the research about common perceptions of the reputation of Montgomery County and stereotypes that many people hold. Among other things, these stereotypes included the view that county residents are affluent, highly educated, and often very progressive in their political views and attitudes

about policy, and that Montgomery County is generally a clean, beautiful, desirable place to live. Some of these findings are significant enough to warrant being included in this analysis so they can be shared with county policymakers.

Important preliminary findings on this topic of smokefree MUH have emerged from research studies on issues such as the degree to which residents are currently exposed to deadly SHS in their homes, and attitudes of residents and managers toward smokefree MUH policies. This literature helped to guide the structure of my research study. Key findings from existing studies include:

- The level of residents' support for smokefree MUH housing rules.
- Among managers and owners, the commonly reported motivation for implementing a smokefree policy was evidence of high demand for smokefree units and the knowledge that a smokefree policy would reduce turnover costs, insurance rates, maintenance, and other costs.
- MUH residents who have already voluntarily adopted smokefree rules in their own homes continue to be exposed to SHS.
- Primary barriers to implementation include manager concerns about vacancy rates, a perceived reduction in the market size of potential tenants, and legal concerns regarding a policy that would prohibit all smoking in the home.

Some of these possible barriers to implementation may or may not be important considerations in Montgomery County at this time. As previously mentioned, smoking rates are very low—below 10% of the adult population. Also, the legal foundation for these policies is well established, and there is no legal right to smoke in one's home. The U.S. Department of Housing and Urban Development (HUD) is proceeding with the

implementation of a smokefree public housing policy at a national level (USDHUD, 2016; Navarro, 2016). Therefore, I focused my research on what specific challenges to implementation might present concerns for residents or managers in Montgomery County, and whether the county's MUH population replicated the broad support for smokefree MUH that has been previously demonstrated in other areas of the United States over the past decade.

Wilson and colleagues conducted a study that attempted to describe the prevalence of SHS incursions that were reported by MUH residents using a nationally representative sample from the 2011 Social Climate Survey of Tobacco Control (Wilson et al., 2014). Their research reinforced previous studies in which residents expressed a strong preference for the option to live in smokefree MUH and provided additional support for efforts to create completely smokefree living options for MUH residents. These findings were also consistent with the results from my research with Montgomery County residents of MUH. Their work found that partial smokefree policies might actually increase the risk of exposure for nonsmokers in their own homes. This led them to conclude the most effective solution for minimizing or eliminating SHS incursions in MUH was a comprehensive smokefree policy that prohibits smoking in all areas of MUH, including the public spaces and residential units (Wilson et al., 2014). Given growing support for smokefree environments as people become more aware of the risks of exposure to SHS, potential resistance may continue to decline as social norms continue to support more smokefree places.

This research by Wilson and her colleagues cited extensive evidence of the negative consequences of SHSe for adults and children including that even brief

exposures to SHS result in sustained vascular injury and changes in endothelial function, and that very low levels of SHSe are associated with cognitive deficits and decreased antioxidant levels in children (Wilson et al., 2014). It is this type of research that led the Surgeon General to conclude that there is no safe level of exposure to SHS. Further, residents of subsidized housing reported high exposure to SHS (88%) as measured by cotinine assessments (Levy et al., 2013). Also, a study cited by Brian King and colleagues emphasized how smoke incursions can negatively affect quality of life; 77% of MUH residents who experienced an incursion in their unit reported that they were bothered by it (King, Cummings, et al., 2010). This mounting evidence over the last decade about the dangerous effects of even small doses of SHS and the high levels of support for MUH residents being protected from SHSe in their homes created the rationale for the present study.

Methods

Study Design

The qualitative work conducted for this dissertation was designed to gather insights about smokefree housing policies from residents, owners, and managers of MUH in Montgomery County. For purposes of this study, "owners" refers to the individual owners of condominium units in MUH buildings and does not refer to owners of entire apartment buildings. The primary mode of data collection was focus group discussions with MUH residents, both smokers and nonsmokers. These groups were designed to gather wide-ranging input on policies to eliminate exposure to SHS in the home. The focus groups explored residents' concerns and thoughts on how the policy might improve their health or that of other family members, how it would impact their ability to smoke and whether it would influence their decisions about attempting to quit. Additionally, the focus groups addressed participants' suggestions regarding the implementation and enforcement of a smokefree policy, and whether they intend to comply with such a policy. Additionally, I interviewed building managers, and one individual smoker (from a building where it was not possible to conduct a focus group with smokers), to inquire about their views on similar issues, as well as how they expect that a smokefree MUH policy would impact their costs of doing business and any potential economic savings they may anticipate, as well as potential challenges to implementation and enforcement. This study was reviewed and approved by the Johns Hopkins Bloomberg School of Public Health IRB-X on February 19, 2015 and assigned IRB study number 6258.

Participants and Recruitment

The first step was to identify large apartment or condominium buildings in MoCo with 49 or more units whose managers were willing to conduct an interview regarding

their attitudes and beliefs about a policy to reduce exposure to secondhand smoke. Originally, I had intended to recruit from buildings with 50 or more units in order to ensure enough residents to participate in focus groups, ideally of nine members each. Duplexes or other small buildings were not considered because of the possible difficulty of recruiting enough focus group discussion (FGD) participants. Another consideration was that large buildings were more likely to yield some diversity of opinions on the discussion topics, which might not be possible if the residents all knew each other. It was later decided to include one building that had only 49 units to expedite recruitment and because the size was close to what had been anticipated and the building manager was willing to allow focus groups in her building. A total of five buildings were included in this study. Managers of four of these buildings were interviewed. Because the fifth building was a large condominium, the focus group and resident interview were arranged through the leaders of the condo association. Of these buildings, two had already voluntarily adopted a comprehensive smokefree policy, the two condominium buildings were considering enacting changes to their by-laws that would allow them to become smokefree but had not taken action at the time of the research study, and the other large apartment building had no plans to become completely smokefree when I interviewed the manager.

Manager interviews were conducted between August 2015 and February 2016, and resident focus groups were conducted between October 2015 and March 2016. During the manager interviews I obtained their approval to conduct focus group discussions in their buildings and to recruit their residents for this study. I conducted four manager interviews, one individual smoker interview and six focus group discussions with a total of 50 participants (see Tables 1 and 2). One manager ran a large market-rate

apartment building with 891 units, and another ran a market-rate condo building with 422 units. The other two managers each ran affordable senior housing apartment buildings, one with 187 units and the other with 49 units.

In attempting to identify managers and MUH buildings of affordable housing in MoCo from which to recruit FGD participants, I used a broad approach of contacting many types of people who might be able to provide access, then applied a snowball sampling approach to my list of contacts. I contacted affordable housing organizations in the county, county health officials, managers of low-income housing, and an employee who worked in Multifamily Affordable Housing for Fannie Mae, among others. Many of these produced further contacts though few yielded managers who were willing to conduct an interview for my research. Eventually I was referred by a friend who leads a local community development organization to someone who was an executive for a nonprofit housing development company who was willing to help with my recruitment. He seemed interested in the topic of my research so was willing to help and referred me to a company that had already voluntarily converted several of their properties to completely smokefree buildings. This executive also produced a referral to the manager of a large property management company with many apartment communities in the region which included affordable housing, senior housing, and market-rate communities. This manager provided introductions to several building managers in affordable housing, and with her personal referral, two of these managers agreed to conduct interviews with me. These were managers of affordable housing buildings that were identified as senior housing, where the residents were age 62 or older. These senior buildings provided access to participants of limited incomes who had flexible schedules and were eager to share their views in focus groups to receive a modest incentive. In the end, three of my

focus groups were conducted in these two buildings. These two senior buildings had already voluntarily adopted a smokefree policy, while the other buildings in the study had not yet established comprehensive smokefree policies for their residents at the time the study was conducted. I did not conduct a group with smokers in one of the buildings because the manager indicated that there were not enough smoking residents to conduct a focus group.

The U.S. Department of Housing and Urban Development defines affordable housing as "housing for which the occupant(s) is/are paying no more than 30 percent of his or her income for gross housing costs, including utilities" (USDHUD, 2018). HUD also notes that some jurisdictions may base definitions of affordable housing on locally determined criteria. The Housing Opportunities Commission of Montgomery County indicates that some affordable housing programs offer below-market rents, and others base their rent on 30% of the household income (Housing Opportunities Commission of Montgomery County, 2018). Typically, affordable housing is available to families earning 60% or less of the area median income (AMI). Market-rate housing is housing that is available at the prevailing local market price to anyone without any subsidy and without respect to income.

After obtaining permission to recruit from the building managers or condo association, I posted flyers throughout the buildings to recruit focus group participants. Criteria for inclusion in the focus groups were: age 18 or over, English speaking, and full-time residence in the building for at least 2 months. Smoking status was defined as follows: Smokers are adults (18 years or older) who live in a particular building and report that they have used traditional cigarettes within the last 30 days. Nonsmokers are

adults (age 18 or older) who are not currently smoking, have not used any traditional cigarettes within the last 6 months, and have not used any type of electronic cigarette or electronic nicotine delivery system (ENDS) within the last 6 months, based on self-report. Residents' smoking status was assessed during the recruitment process based on self-reported data.

I conducted six focus group discussions as follows: two groups of smokers and four groups of non-smokers. In addition, one individual interview was conducted with a smoker from a building in which I was unable to recruit enough participants to conduct an entire group. In the six focus groups, there were a total of 11 smokers and 34 nonsmokers, plus the one additional smoker interview. The original plan had been to conduct an equal number of focus groups with smokers and nonsmokers, but given the low smoking rates in MoCo, it was not possible to recruit additional groups of smokers. Three focus groups were conducted in market-priced housing, and three groups in affordable senior housing buildings.

Table 1: Number of Focus Groups

	Affordable housing	Market-priced housing	Total
Smokers	1	1	2
Nonsmokers	2	2	4
Total	3	3	6

Table 2: Individual Focus Group Participants Enrolled

	Affordable housing	Market-priced housing	Total
Smokers	8	3*	11
Nonsmokers	16	18	34

Total	24	21	45

* One additional individual smoker interview was conducted from a market-priced building because there was an insufficient number of participants to conduct a focus group discussion.

Data Collection

The interviews were conducted in the manager's offices in their residential buildings in Montgomery County, and the individual smoker interview was conducted in his residence in a market-rate condo building. The focus groups were also conducted in private rooms within the residential buildings. The intent was to make participation in these FGD as convenient as possible for the residents in hopes of increasing participation levels. In each case, after obtaining permission to conduct the group, a private room in the building was identified and advertised as the location for the discussion. Each room had a door and was secured during the FGD to provide maximum privacy to group participants. The individual interviews lasted between 60 to 90 minutes, and the FGD were each approximately 90 minutes in duration.

I used an interview guide for the manager interviews (see Appendix 3) and a focus group discussion guide (see Appendix 4) that was open-ended and allowed for probing follow-up questions. Topics addressed in these guides included: exposure to SHS in building and unit, effects of secondhand smoke, attitudes toward a policy to prohibit smoking in the building, and suggestions for implementing a clean indoor air policy in multi-unit housing. Managers' interviews addressed these topics as well as their knowledge of potential cost savings that might be achieved by implementing a comprehensive smokefree policy, and other economic considerations that might be a concern. Significant attention was devoted during the interviews and FGD to participants'

views regarding implementation of a smokefree policy. Participants were provided a $50 cash incentive as a thank you gift for their participation in the study.

Data Analysis

An iterative process was used to analyze these qualitative data. Immediately following the completion of each FGD or interview, audio recordings were transcribed by a professional transcriptionist. Once transcripts were received, I checked the transcripts for accuracy and the text was re-read to get a sense of the whole. Two coders (myself and Krystal Lynch, Ph.D.) read the transcripts and made notes regarding ideas and categories that sum up and describe what is said in the text. I compiled categories and themes into a codebook, which was based on inductive themes raised in the transcripts and from the a priori concepts built into the discussion guides. The codebook was then applied to a subset of transcripts and revised as needed to uniquely capture concepts relevant to the research aims, and later applied to all the transcripts. Throughout this process, the research questions and proposed design were reassessed and attention was given to what, if any, additional questions emerged.

The intent of this approach was to build conceptual and descriptive analysis based on the data, and to explore how concepts of interest are related. After the transcripts were coded individually, the two coders reviewed their responses, and any discrepancies were discussed until consensus was reached on final codes and themes. We drew comparison within and across participants and groups to summarize emerging themes. The themes were primarily developed through the codebook and focused on the topic of policy implementation and related sub-themes for this analysis. We used text-based data analysis software (MAXQDA version 12.1.4, VERBI Software GmbH, Berlin, Germany) to manage and organize the data by codes and themes.

The following codes were developed after extensive reading of the relevant literature on these topics, many presentations and conversations with national experts on smokefree MUH, and this research with participants in MoCo. The broad topic of implementation was frequently discussed, and the following codes emerged as some of the most frequently mentioned sub-themes. After careful review of the transcripts, these codes were identified as most important to providing context and framing for this research study and likely to provide insights into the attitudes and beliefs of this audience that would be the most valuable for Montgomery County policymakers (see Appendix 5).

Table 3: Implementation Codes

No.	Title	Full Description of Code
8.0	Implementation	Discussion of suggestions for how to implement the policy and what their best recommendations are for implementation, including any specific suggestions they offered. Includes views from residents and managers.
8.1	Transition, phase in period	How long should the county take to make a new policy effective?
8.2	"Grandfathering"	Some say this is necessary for implementation. Others say will take too long and allow too much additional exposure and risk.
8.3	Challenges to implementation	Any reference to how difficult it will be to implement such a policy. Also include challenges to adoption of policy.
8.4	Consequence of policy	Any reference to something that is a result or consequence of implementing the policy, e.g., references to aid in quitting or smoking cessation.
8.5	Enforcement	Any issues related to enforcing the policy, either from manager or resident perspective.

An additional code for higher risk residents was also included as it emerged as a major theme in reviewing the data. Upon review and analysis of all the data, it became apparent that this additional higher risk resident code was also essential to fully reflect the nature of the discussion in the focus groups. Although the primary focus of this research is on the implementation of a smokefree MUH policy in Montgomery County,

the data also reflected crucial unique challenges confronting senior citizens, children, and disabled people. The data analysis was framed to also consider how, if a smokefree MUH policy is to be truly comprehensive, the policy must explicitly address the unique challenges of these vulnerable populations.

Higher Risk Residents

The code for higher risk residents was referenced any time that participants expressed concern for senior citizens, children, disabled people and others who they believe are at higher risk from SHSe. Any references to "seniors" or senior housing or related issues was included. This was particularly relevant in my research given that three of the six focus groups were conducted in senior affordable housing; as previously noted, senior housing is housing where residents are 62 or older.

I therefore decided to structure the dissertation analysis to include an in-depth consideration of discussion related to the key topics that emerged regarding higher risk populations. These included: concern for others, the inability of children to make decisions for themselves, mobility issues and potential hardships for people who are physically disabled, health consequences of SHSe, smokers' objections to being harassed for their behavior, smokers who do not object to going outside to smoke, and community members' active involvement and engagement regarding policies that affect their well-being.

These vulnerable residents are a primary concern for many reasons and efforts should be made to address the health concerns of residents of federally assisted housing and particularly MUH. Colleagues from HUD and CDC with whom I have been working on an interagency workgroup of smokefree public housing have published research

clearly articulating why these residents of HUD-assisted housing are a priority population in which to intervene. Helms and colleagues report that over 20% of HUD-assisted persons are disabled and that 33% of HUD-assisted households are headed by elderly adults (Helms et al., 2017). Further, they note that residents of assisted housing have a higher burden of disease than the general population, including chronic conditions that could be exacerbated by exposure to SHS (Helms et al., 2017). These colleagues conclude that "housing assistance programs provide a valuable platform for the implementation of evidence-based tobacco prevention and control measures, including smokefree policies" (Helms et al., 2017, p. 171).

Results

This section is organized around the six primary implementation codes delineated in Table 3 above, which were the major themes emerging from the data. An additional code for higher risk residents is also included because it was needed to fully reflect the nature of the discussion in the focus groups and capture key points raised by residents in these groups. Although the preliminary review of the implementation codes captured many main points raised by study participants, it quickly became apparent that the study would not be complete without thorough analysis of these higher risk residents, also referred to as vulnerable populations. In considering how to most effectively implement a smokefree MUH policy in Montgomery County, the data also reflected crucial unique challenges that confront elderly, children, and disabled people as they would attempt to comply with the policy. In order to consider how to implement a comprehensive smokefree MUH policy, the policy must explicitly address the unique challenges of this vulnerable segment of the local population and offer solutions that will consider their concerns directly.

Implementation

The implementation theme referred to suggestions for how to implement this policy and recommendations from residents and managers about policy implementation, including any specific suggestions offered, particularly those that did not fit into other categories. The major findings that emerged from the implementation code pertain to the following topics and were provided by both managers and residents:

- Avoid the court system and ensuring that enforcement is simple
- Ensure that enforcement is fair and consistent
- Allow use of fines

- Provide clearly marked outdoor smoking areas
- Make smoking areas comfortable, safe, convenient, and appealing
- Build in adequate transition time to a new policy (4–6 months to a year or more) to allow sufficient education and preparation for smokers (will be addressed under phase-in section)
- Provide sufficient cessation services and support for smokers
- Work collectively with all involved (smokers, nonsmokers, residents, managers, owners, and staff) to build buy-in and support for adoption and implementation of new policy
- Write the policy and implementation guidelines clearly so that all can understand
- Communicate the new policy through multiple channels to residents, including in-person, via email, meetings, and signage that is clear, pervasive, and obvious.

Building managers stated numerous times that making implementation and enforcement of the policy as simple and straightforward as possible is a priority for them. They do not want policy implementation to take significantly more time or energy from them or their staff. One manager indicated that she and her staff already spend a great deal of time responding to complaints of smoking in the building, investigating them, and attempting to move residents around in the building to accommodate requests to reduce exposure to SHS.

A manager of a large market-rate apartment building was explicit that maintaining very high occupancy rates was a clear priority for her, and that she wanted to avoid interacting with the legal system as much as possible, noting that it creates extensive delays and incurs additional unnecessary costs. A clear fine structure that could be shared

in writing with all involved, and assessed automatically, was strongly supported by managers and residents alike, including both smokers and nonsmokers.

> *"But if they did the financial impact, where it's fines and would allow us to do the fines, that'd be great. If it has anything to do with the court, I don't support it. That costs me lawyer fees, and there's no good result ever to that."*
> (Manager, market-rate apartment, 8-12-2015)

> *"I think that that's going to be the big thing, is just giving us some kind of financial outlet to – you know, a fine to slap. It's quick, we put it on their account, it's done. They don't pay it, it accrues late charges. It's a deterrent. Sending them a violation letter does not…."*
> (Manager, market-rate apartment, 8-12-2015)

Another important theme raised consistently by all parties was the need for a clearly designated outdoor smoking area that would be sufficiently far away from the building and all air intakes, comfortable for smokers, and marked with explicit signage. There was broad agreement that participants did not want to ostracize smokers or make them feel as if they are second-class citizens, and that the smoking area should be clearly marked so that others would not harass them for smoking in this area. The smoking area could include some amenities such as seating, ashtrays, ideally a roof for bad weather, and some even suggested providing Wi-Fi access so that smokers could utilize their time well while smoking.

> *"Well, we've talked about several different things related to making it more comfortable for people to transition their smoking to outdoors if they insist on doing it. We've talked about not only … an ongoing educational process to kind of keep reminding people that we're moving toward a truly smokefree environment, but also … where can folks go on the property that's comfortable for them and safer for everyone else? … there are lovely benches out, directly out in front of the building in the grassy area, but that's great if it's not raining or beating down sunshine. … do we move towards creating a protective structure for them that they can…?"*
> (Manager, market-rate condo, 8-28-2015)

RESPONDENT: *"Because they knew the rules coming in here. And actually, we didn't even have a designated smoking area until I got here and put one up."*

MODERATOR: *"Oh, really?"*
R: *"Mm-hmm. It was always smokefree, but they just didn't have a designated spot for it."*
R: *"Well, when I had this designated smoking area put up—because like I said, when I got here, it wasn't there—I got good feedback from the smokers that were here. You know, `It's about time,' this and that. Because what I would hear is … they weren't far enough away from the building as we would've liked them to be, and residents could still, who had their windows open, could still smell the smoke come in. Yeah."*

MODERATOR: *"Right. They could still smell it. So why did you decide to put the smoking area there?"*

R: *"Because at the time, we had four smokers in the building, and I – even though four is not a lot compared to 49 units, I still think it was necessary, because whether it be one smoker or two, I still think we should have an area for them to do that, not only for the residents, but for the visitors as well."*
(Manager, affordable senior housing, 2-22-2016)

"Yeah. Well, whatever they do, they smoke tobacco…. And the people who smoke cigarettes, instead of sending them outside, because I really don't like that where you got to go outside and smoke in front of everybody in the cold winter, I think that's very inhumane…. So they should have a building outside for people who want to go and smoke and set up this nice lounge, it's comfortable, and all the smokers can just go right over there and smoke all they want to."
(FG6 Nonsmoking resident, affordable senior housing, 3-30-2016)

From a conversation between smoking residents of market-rate housing (FG2, 10-26-2015):

RESIDENT 1: *"I guess like an area … if they put the ashtray there, and maybe a bench or something. Kind of like how we have it out front here. We have the wooden bench and the ashtray right next to it. Something where it clearly states that this is the smoking area."*
R2: *"Yeah. As long as they have a smoking section where smokers can smoke, and I'd be okay with that."*
R1: *"As long as it's clearly marked as a smoking section."*
R2: *"And so a whole, like, hell-bent-on-nonsmoking people won't come over and say, 'You can't smoke there, you can't smoke there.' Because there are people that are like that."*
(FG2 smoking residents, market-rate housing 10-26-2015)

Several participants addressed the importance of providing access to cessation services for smokers interested in quitting, as well as providing a supportive environment to encourage them to quit. One of the managers referenced her experience with this as she had been involved in helping her building become smokefree. Even nonsmoking residents, some of whom were former smokers, acknowledged the need for help in trying to quit and referenced the power of addiction to nicotine. Some also described the cultural shift they had observed in which smoking has become more socially unacceptable as the public has become more aware of the risks of SHS. One resident, however, also noted that he and others are resistant to any government intervention in the home.

> *"Well, they could offer training. They could look at things that you can do that – persons who are trying to give up smoking, things that they could do to help them. They can offer counseling…. We work with Washington Adventist Hospital, and they have – we have a counselor that comes out once a month. She was coming a couple times a month and just working with residents for various issues. Smoking could be one of those issues. … Counseling, training, cessation programs—things like that are really helpful for someone when they're trying to either – when they're trying to make a change in their lifestyle."*
> (Manager, affordable housing, 2-19-2016)

> "*Now, if the building suddenly went to nonsmoking, and let's say, they gave everyone a deadline—the end of this year, December 31st, the building was going to be nonsmoking… it might be nice maybe if the building offered some kind of smoking cessation program where people would pay for it and – but the building could offer something like that if – you know, not that it was mandatory for them to take, but understanding it could be difficult for them…"*
> (FG3 Nonsmoking resident, market-rate housing, 2-15-2016)

> *"Well, it's a culture shift. So it would take a lot of time until it becomes really part of the culture. And I think it's going to take a really good marketing campaign. You know, if it's something that the county wants and believes in and can get enough support for, you've got to really sell it to the public…. People don't want the government telling them what they can and cannot do in their spaces. So even though it's a condominium and I'm*

supposed to abide by the bylaws, but I paid for that unit, it's mine, and I should be able to do what I want in there. You know, I'm in support of this, but I'm just saying…."
(FG3 Nonsmoking resident A, market-rate housing, 2-15-2016)

Another resident alluded to a contagion effect of this policy. As they move toward making their building smokefree and learn lessons from that experience, she wanted others to benefit from their experience. She stressed the importance of this change to a smokefree environment being initiated by residents and homeowners who are demanding it and indicated that policymakers might benefit from knowing that she and her neighbors want this type of policy.

"Well, the first thing I would want them [policymakers] to do is to support us in our efforts and use us as a pilot building so that they can say … I understand new buildings, new construction, that's sort of an easy sell. I think you would need a piece of that, but to say we … worked with some older buildings and through a series of board groups, focus groups, etc., that there was community buy-in in those places for it, so that it's not sort of – it doesn't look like it's a top-down issue. I think that when it's a grassroots, it comes that way from – the community is asking for this. So maybe they would need to get other communities like ours, other buildings that are around our age to be involved in that and be presenting it."
(FG3 Nonsmoking resident A, market-rate housing, 2-15-2016)

Several residents, including former smokers who were not currently smoking, attempted to convey how difficult it was to stop smoking, even when they wanted to. They empathized with smokers facing the challenges a policy like this might present. Providing support to smokers through education and cessation resources was deemed crucial to successful policy implementation.

"Well, I would volunteer to speak out as an ex-smoker, because I think people have to understand … that it is an addiction. People … say … nicotine is more addictive than cocaine, I might add. And if I smoke one cigarette now, and then smoke another, I would be addicted again. But I

think people need to understand that side of it, what it is to be addicted, and it's [not] a moral thing and it's not will power. It's a damn addiction."
(FG6 Nonsmoking resident J, affordable senior housing, 3-30-2016)

Many residents, both smokers and nonsmokers, mentioned the importance of communicating clearly, in simple language, about the new policy, and providing this information frequently, through multiple channels. They wanted to ensure that residents have ample opportunity to learn about the policy and ask unlimited questions, and that they have sufficient time to get adjusted to the changes in their behavior the policy may require. Residents were concerned that people would be confused or distracted by legalistic language, and that it can be easy to miss important information even when one is paying attention. Residents wanted opportunities to benefit from all the many formats through which information about the smokefree policy could be communicated.

"I'm wondering how many of the actual residents are really informed. I know that [the building manager] is trying to send emails and inform people, but because we do have such a high percentage of renters, I'm really wondering if we need more signage in the lobby sort of promoting this, or maybe in some of those common areas, letting people know that there's now no smoking there. I'm a very long-time resident. I've lived in this building for 40 years. I'm in my second apartment in the building, that I've owned. So I just feel there's a core group of people that are informed and active, but I think we have a high percentage of renters now, and I really feel like they are not informed, and feel 'if I go out on my balcony, that's okay'…"

"… periodically we get these emails about please do not drop cigarette butts off the balcony, things like that. … I feel like maybe we need to do a better job … of reinforcing this and letting people know that there have been changes. I know that the board tries really hard to do that."

"So if there was a sign posted that would remind people in the garage, … there is no smoking here, then at least I could point to that and feel I had some backup with that, rather than kind of having to knock on their car window and say…"
(FG3 Nonsmoking resident A, market-rate housing, 2-15-2016)

From a conversation between smoking residents of market-rate housing (FG2, 10-26-2015):

> MODERATOR: *"Do you feel like you know the policies?"*
>
> R1: *"Not completely, I know it was made up a long time ago. But also if they were to redo it, I'd want them to put it in not – using all the big legal terms. Because I know a lot of the rules, they do that. Just try to make it easy for everyone to understand."*
>
> R1: *"I'd still go [to an informational meeting] even if they weren't giving out pens and mugs. I'd still go to get the pamphlets and maybe have them explain it to me in non-legal form. Like in a non-legal way, or have them dumb it down. A lot of the things, it's all in legal words. I'm like, 'What's that mean?' Because I get confused and I stop reading it."*
>
> R1: *"Yeah. Because I get confused. Just like when I go look at NIH's website about studies, I get confused with all the medical words. I'm like, 'Oh, next one.' Wait until I find one that I understand what the whole line says, and then I'm like 'Oh, click that one.'"*
>
> MODERATOR: *"If they had meetings to explain this, would you go to those?"*
>
> R2: *"Yeah."*
>
> R1: *"Yeah. I would."*
>
> R3: *"I would assume, like most other important notices. I get something slid under my door every week in some capacity."*
>
> R2: *"They just would talk to you about it..... I would like somebody to talk to me and tell me."*
>
> R3: *"I'd appreciate a warning before getting fined."*
>
> R1: *"Preferably a verbal warning. If I got a written warning slid under my door, put in my box, I'd go down and discuss it. I'd rather just skip that whole few steps of someone typing something up, having someone slide it under my door, put it in my box or whatever."*
> (FG2 smoking residents, market rate housing, 10-26-2015)

Transition, Phase-In Period

This theme refers to residents' and managers' opinions about the optimal amount of time the county should take to make a new policy fully effective—as indicated by

study data. Participants typically said they wanted enough time to get adjusted to the policy and called for enough time for broad dissemination of information about the upcoming policy so that all would be aware that it was coming soon and have the opportunity to quit smoking or make alternative plans before they were prohibited from smoking in their homes.

Everyone who addressed the topic of implementing a new smokefree MUH policy specifically acknowledged the importance of including phase-in or transition time to increase the likelihood of success of the policy. This included all the building managers interviewed, as well as smokers and nonsmoking residents in both affordable and market-priced housing, though some of the comments and rationale offered may appear counter-intuitive.

The longest time period for policy implementation was recommended by the manager of a market-rate apartment building, who also emphasized the importance of explicitly describing the new smokefree policy in a lease addendum which all tenants would be required to sign.

> *"Because what we need to do is we need to do is get everyone … that leases an apartment today, just so you know, 1 year from now or 13 months from now, this is what the policy is going to be.… And have that addendum for all the people coming in for the next year. But the big thing is, on renewals, you would have to also give them that heads' up. So it would take that long to say before you choose to renew, this is what the policy is going to be. And then the other sticky thing is, because only Montgomery County does this, we have to offer a 2-year lease."*
> (Manager, market-rate apartment, 8-12-2015)

The other building managers in affordable housing properties that had already successfully adopted comprehensive smokefree policies suggested a shorter phase-in time

of several months, with emphasis on providing information to residents and support and services for residents who wanted to quit smoking.

> *"… they began like 6 months' out, letting them know that at a certain point in time, the buildings would go to nonsmoking, and then notices or meetings were done … to remind them that this is what's coming down the pike, so you want to start getting prepared. And for those of you who smoke or – and are thinking about stopping smoking, let's see what kinds of information or kinds of help we can get to you. But we definitely gave them a lot of notice as well as tried to give them information to help them."*
> (Manager, affordable senior housing, 2-19-2016)

> *"Maybe instead of saying, 'Okay, next week we're going to start this,' maybe give them some time. For the ones that aren't already smokefree, maybe give them a period of time, and in that period, they can decide whether they want to move out or stay here, but rules are rules…. I guess giving time for them to accept it and figure out what they want to do, I think, would be a good approach to it."*
> (Manager, affordable senior housing, 2-22-2016)

> *"Holding these seminars … probably wouldn't hurt. My main key is just giving them time for people to accept it, because I think people will react better if they know they have time to either think about it or take action on it than if "Oh, next week or the beginning of next month it's starting, the new policy," and they don't have time to do anything."*
> (Manager, affordable senior housing, 2-22-2016)

> *"I just think, like I said before, just if you're going to do a policy like this, just give people time. I think time is a very important key in this whole thing."*
> (Manager, affordable senior housing, 2-22-2016)

The focus groups with residents yielded interesting findings regarding how long the phase-in time should be for a new policy. Three of the groups included nonsmokers, and two of these groups generally came to agreement within their respective groups, one suggesting approximately 6 months, and the other generally agreeing on a 1-year phase-in when they considered that the policy being discussed would be countywide rather than just in their own building. The third group of nonsmokers did not arrive at such a clear consensus about phase-in time but did agree that time for transition should be adequate.

This third group often discussed a policy that would apply to their building because they were actively discussing implementing their own policy ahead of any change in county law.

From a conversation with nonsmoking residents in affordable senior housing (3-30-2016):

> *"So maybe if you did 6 months to a year and, okay, tell them it's going to happen in 6 months and this is going to happen."*
>
> MODERATOR: *"So 6 months to a year until they can get ready for it."*
>
> R1: *"They got time. If they don't want to do it, they can leave."*
>
> R2: *"Or quit smoking or get ready to walk out."*
>
> MODERATOR: *"What do the rest of you think about that idea? Anybody else have thoughts about that?"*
>
> R3: *"It takes time. Yeah. It takes time."*
>
> MODERATOR: *"Is that the right amount of time—6 months to a year?"*
>
> R3: *"Maybe more. Depends on the person."*
>
> R4: *"Six months is enough, I think."*
>
> *R5: "Well, 6 months seems like a good amount of time. What happened here, a couple of people that I personally know, they were very upset and almost to the point of really being angry by having to go outside and smoke. And so you got to – especially with older people. You have to sit down with them and help them make that transition in a more calm way without them feeling like it's personal."*
> (FG6 Nonsmoking residents, affordable senior housing, 3-30-2016)

Nonsmoking residents in market-rate housing (FG3, 2-15-2016):

> MODERATOR: *"What do you think is the optimal time to phase in something like this?"*
>
> R1: *"I think 6 months."*
>
> R2: *"I think minimum 6 months."*

R1: *"I think if you made it a year, then people are going to wait until the last month anyway. So why not make it 6 months?"*

R2: *"Good point. That makes sense."*

R3: *"Why not make it 3 months then?"*

R1: *"Yeah. Why not make it 3 months?"*

R4: *"Yeah. Three months."*

MODERATOR: *"Now, again, I'm not talking about a building policy, I'm talking about a county one."*

R3: *"Oh, a county."*

R5: *"Yeah. County policy, it's got to be a year for …"*

R3: *"You have to do a campaign, you have to let people know."*

R5: *"Nine to 12 months is my opinion, but that's just me."*

R2: *"I don't know, I think maybe a year."*

R6: *"I agree with that."*

R7: *"A year."*

Then, this from a nonsmoking resident in market-rate housing (FG3, 2-15-2016):

> *"But I think for a building, I think we have a right to make a policy, or a plan, but just think about what is going to be the best way to implement it, by taking into account – because if people are addicted, it's going to be a very, very difficult rule to enforce. But if there's some flexibility in how you're going to implement a no-smoking rule, I think it's going to be a lot easier to accomplish what you want to accomplish in the end, which eventually means that nobody in the building smokes. But there's got to be some kind of transition period."*

The smokers indicated a preference for a much shorter phase-in time as long as they were adequately informed and had time to adjust to the change (FG2, 10-26-2015):

MODERATOR: "So what do you think is the right amount of implementation time?"

R1: "I'd say minimum 6 to 8 weeks, minimum."

MODERATOR: "Minimum?"

R1: "The way I see it, the more advance warning, the better. But I'd say as long as there's 6 to 8 weeks I'd be sufficiently happy with that."

MODERATOR: "What about the rest of you guys?"

R2: "Same."

R3: "Yeah. I agree, as long as it's longer than a month."

R1: "I would say at least 6 to 8 weeks, if not more. I always say, the more time the better. For the people who smoke in their unit a lot more, they might need more time to get acclimated to the change."

Contrary to what might be expected, groups of smokers suggested the shortest phase-in time—6 to 8 weeks. These smokers also made comments indicating they were looking for help in quitting or reducing their smoking levels, so perhaps they saw the implementation of this smokefree housing policy as a possible source of support for their efforts. Others explicitly discussed how the policy could help them reduce their smoking.

"As long as they give enough advance notice. Like they did when they said no smoking in bars. This was—what, 12, 13, years ago when they did that? Anybody who's from Maryland—I don't remember exactly when it was, but I know they gave like 6 weeks or 8 weeks advance notice to when they were going to stop doing smoking inside. And I know, it was like all over the TV and the paper and everything, and then the weekend before, they're like, 'effective midnight Sunday, no smoking inside restaurants and bars.'"
(FG2 Smoking resident, market-rate housing, 10-26-2015)

"Grandfathering"

The question of whether to allow existing residents to continue to smoke after the adoption of a comprehensive housing smokefree policy—referred to as "grandfathering"— is often raised in discussions of these policies. Most public health discussions of smokefree housing policies do not seriously consider this option, however,

because it would defeat the intention of enacting a comprehensive policy. For purposes of this study, I wanted to raise the issue to identify whether participants had strong opinions on the topic. The underlying question attempted to understand whether participants believed that current smokers should be allowed to continue smoking in the building and that the new policy should only apply to new residents. The codebook describes the theme this way: "Some say this is necessary for implementation. Others say will take too long and allow too much additional exposure and risk."

In fact, in this study, the topic was rarely raised by participants themselves and did not appear to be a major concern, perhaps because they recognized that allowing some people to continue to smoke after policy implementation would create confusion and would not ensure the smokefree environment they are seeking.

> *"Now, if you're going to grandfather in an existing multi-unit building, there are people there who are smoking and who will have the valid arguments of [two residents] that there are individual rights. One, I have the right to smoke. Of course, the state is not going to take away your right to smoke. They're just taking away the right of you to smoke in this particular building."*
> (FG4 Smoking resident, affordable senior housing, 3-7-2016)

> *"…the problem with grandfathering is that other people in the building may be injured by the grandfathered owner or resident. And there needs to be some way of accommodating so that people are not harmed by other people. That's the basic principle. You don't harm someone else."*
> (FG1 Nonsmoking resident, market-rate housing, 10-15-2015)

Also, see another crucial quote in the following section regarding challenges to implementation from a resident who supported a smokefree environment but opposed any government intervention. He did not object to "grandfathering" current condo owners who smoke so that a policy would only become effective after they left the building. He acknowledged that this could significantly delay the full implementation of the policy but

felt that it was not fair to change the rules on residents after they had moved into the building.

Challenges to Implementation

This theme refers to any reference to how difficult it would be to implement such smokefree housing a policy. It also includes challenges to adoption of policy. Several important challenges to implementation were noted by study participants, particularly by a manager in a market-rate apartment building who explicitly mentioned her desire to keep occupancy rates as high as possible and who initially seemed to think that this policy might interfere with that goal, at least if she were competing with other properties that did allow smoking in the building. She was clear that she did not want the policy to involve the court system and was concerned that this would slow enforcement and create complications for her as a building manager. She mentioned a clear, simple fine structure which could be written into lease agreements would be very helpful.

> *"…I'm going to have the other residents that say, `I'm not allowed to smoke, why is he allowed to smoke?' You know, so give me a tool. Don't do this so over-the-top tenant friendly. If you're going to implement it, say I can put in the lease a fine. Money is where it is."*
>
> *"Not the court system. Not bogging it down. So if I could say, 'All right, your first violation for smoking in the building is $250. Your second violation is $500. Your third violation is a 30-day notice for you to move out.' It will never happen, but in a perfect world, if you're going to create this policy, that's the type of back-up we need."*
> (Manager, market-rate rental housing, 8-12-2015)

Some residents, including smokers and former smokers, acknowledged how difficult it is to stop smoking and that nicotine is so addictive that not smoking in their units would be very difficult for some smokers. One resident mentioned the challenges of adjusting to change, particularly as people grow older, and the satisfaction they get from

smoking. Another resident suggested that enforcing this policy would be very difficult, but some others in the conversation disagreed.

> *"As an ex-smoker … it's really, really hard to quit. Really hard. You've got to be very motivated. And tobacco—or nicotine, I should say—is the most … worse than heroin … the most addictive substance that we know about. Anyway, knowing that, I would support a policy that, like you were saying, if Montgomery County … or maybe there'd be a federal policy, etc., would support a stop smoking program that would incentivize people."*
> (FG6 Nonsmoking female resident, affordable housing, 3-30-2016)

> *"…and people been smoking for 40, 50 years, and now they been living in their apartment for how many years … it's like taking something away from them. And as we mature and get older, we don't have a whole lot more left. So they try to hold on to whatever they can that brought them joy and brought them pleasure."*
> (FG6 Nonsmoking female resident, affordable housing, 3-30-2016)

> *"I think the nonsmoking … I think it's unenforceable. Now, every month that I can remember, smoking problem is on the agenda. Management has a meeting with us. And smoking in the building is more than likely on the agenda."*
> (FG5 Nonsmoking female resident, affordable housing, 3-7-2016)

Another important challenge to implementing a smokefree MUH policy is the dilemma raised by adopting a policy that affects individual behavior in one's own home. Two residents who supported a smokefree environment in their building had reservations about a law that would direct their behavior at home. Opposition to smokefree MUH policies is often based on opposition to attempts to change people's behavior in their own homes. One participant expressed it this way:

"*I believe your own property is your – a man's home is his castle. I have no objection to people smoking within their own unit. This building is nonsmoking in common areas but allows people to smoke in their own homes. If the building had been originally built as a no-smoking building, then I could see that…. Now having said that, if a – the majority of the residents want to change it, I would have no objection to grandfathering in those who are smokers and not unfairly punish them because the rules have changed since they move[d] in, and that would take a fairly long time before the building would become completely nonsmoking, but eventually it would be…. We don't need any level of government telling us how we're going to conduct ourselves. The decision should be made by the owners within this building, not by fiat from Montgomery County or the state*

of Maryland, or the federal government or the United Nations, or whatever level of government you want to name."
(FG1 Nonsmoking male resident, market-rate housing, 1-15-2015)

Consequence of Policy

This theme includes any reference to something that is a result or consequence of implementing the policy, e.g., references to aid in quitting or smoking cessation.

In regard to policy consequences, the previously mentioned manager repeated her concerns about maintaining maximum occupancy of her large market-rate apartment building, saying that financial concerns were a top priority for her and her company. She described the challenge of operating in the county's competitive rental market, which would also be a concern for many managers of market-rate housing, though she was not aware of smoking rates in the county or how low they are. This manager also discussed the possibility of providing incentives for her residents to comply with a smokefree policy rather than acting solely in a punitive enforcement role.

> *"And the problem is that in a building this size, when [occupancy] drop[s], our landscaping doesn't drop 3 percent and our pool contract doesn't..... It's really difficult. And ... what would probably happen is, ... if it was put into place where everyone had to abide by a no-smoking policy, it would just be people either going – I mean, we're so close to the DC border, they're going to fly over there, or they're just going to find those properties that don't enforce it."*
>
> *"...we'll lose occupancy. And that's really big. So the trickle down to that is we're going to lose occupancy, so other buildings will as well."*
>
> *"So it doesn't feel like we're just saying no, ..., if you quit smoking and you have no issues for whatever, there's no way to prove that somebody quit smoking, but make it a reward system. ... we'll give you five free yoga classes because now you're getting healthier. Or we'll give you a month at a fitness center. Or just something."*
> (Manager, market-rate rental housing, 8-12-2015)

Another manager of a large condo building, where a high proportion of units were rentals, shared a different perspective. His resident board had already been studying this issue extensively and was considering adopting a voluntary smokefree policy, so he seemed informed on more specific issues than managers from all-rental properties might be.

> *"I think the advantages would be better marketability of the building, less complaints from nonsmokers, less time responding to the complaints, less clean-up for the porter staff, better general health."*
> (Manager, market-rate condo building, 8-28-2015)

Two managers from affordable housing buildings also saw these advantages and were generally supportive. These managers had already transitioned their buildings to a comprehensive smokefree policy which was well-received, and they had experienced generally positive results. One manager described the benefits of the policy for her residents and stated that it would help the few smokers in her building reduce their tobacco consumption. Both managers mentioned that the policy would make their jobs easier by reducing the number of complaints they would have to deal with from residents.

> *"I think it would make things a lot smoother, a lot easier. Number one, the air would be cleaner. So I definitely think that for those people who are smokers and who are maybe trying to stop smoking, it would be a good thing for them as well, because you may think twice about getting up and going outside to smoke, as opposed to 'I can sit right here in my apartment and smoke,' because now [they] have to figure out 'Do I want to really get up and go outside? Or maybe I'll just put off and I won't smoke that cigarette.' So that's one less cigarette, and one less could fall into another less…. The amount of cigarettes you smoke goes down, till at some point and time, you'll say 'Hey, I'm not smoking that much,' and not to mention the cost of it. Cigarettes are extremely expensive."*
> (Manager, affordable senior housing, 2-19-2016)

> *"[I] don't have to deal with the headache too much about resident complaints and things like that… even though we could have a policy like this, I'm sure people would still violate it. You're going to have at least one wherever you go, but it would lessen the amount of complaints that we would probably get from*

smoking."
(Manager, affordable senior housing, 2-22-2016)

The input from the focus groups, comprised of both smokers and non-smokers, was quite similar in the views they shared regarding the consequences of this comprehensive smokefree MUH policy. As noted, a number of study participants stated that the policy could help smokers quit smoking or reduce the number of cigarettes they smoke per day, and one respondent mentioned the benefits that would accrue to families with children and the positive economic impact of the policy.

"Or if it's the law. I think a lot of people will pay attention to the law."
(FG6 Nonsmoking female resident, affordable housing, 3-30-2016)

"And then people have said to me … that they're smoking less…. They're down to like three cigarettes a day instead of 10 or 25."
(FG5 Nonsmoking female resident, affordable housing, 3-7-2016)

"A lot of the benefits to the county would be that families with children would feel more free to move into these buildings. They're safer for children. So economically there's an impact there."
(FG5 Nonsmoking female resident, affordable housing, 3-7-2016)

"I prefer going outside. I smell like it right now. But my apartment would really be a stench of just odor."
(FG4 Smoking female resident, affordable housing, 3-7-2016)

"I also prefer going outside…. But I'm not a nonsmoker as yet. The reason I prefer going outside at this stage of my process of stopping to smoke is that it's an added disincentive to smoke…. I have to think, do I really need this? I got to wait for an elevator that takes a half an hour to come up and a half an hour to get it to go back up. And that's an hour. And then a half an hour for a cigarette…. I got something else to do."
(FG4 Smoking male resident, affordable housing, 3-7-2016)

"It'd have a great impact on me, because you would know what areas you could smoke at and what areas not to smoke at. And see, the residents, they only talk to only certain people sometimes...."
(FG2 Smoking male resident, market-rate housing, 10-26-2015)

"I think it would have a good impact because it would get people not smoking inside. And it would be healthier for everyone else—nonsmokers and asthmatics and people who are allergic to smoke, or whatever, would feel better. They'd feel like things would be better for them…. Only for all the nonsmokers. And it might

even help get some smokers to quit."
(FG2 Smoking male resident, market-rate housing, 10-26-2015)

"I could see myself smoking less due to that. Spending my time doing something else."
(FG2 Smoking male resident, market-rate housing, 10-26-2015)

"I'm not saying I'm going to completely quit, but I'm saying, you know, I might smoke one or two less cigarettes a day, by constantly having to go out. Because I have to walk all the way down the hallway, take the elevator the whole way down, and walk out to the smoking section. Even more so on days where it's like pouring rain, or we have a blizzard, or a tornado…. And I know for me, having a designated spot outside, and having it set up to not smoke inside, me smoking inside would basically drop to zero…. And the nonsmokers would know where the smokers smoke at. If someone [is] not abiding by the rules, then a nonsmoker or the smoker will be like, well look, this is where you need to smoke at. These are the areas that you can smoke in."
(FG2 Smoking male resident, market-rate housing, 10-26-2015)

Enforcement

Many of the issues raised regarding enforcement issues were similar to or overlapped with the results regarding implementation. The theme of enforcement encompassed any issues related to achieving adherence to the policy, either from manager or resident perspective; however, many participants did not distinguish between enforcement and implementation. Both managers and residents provided insights into specific steps that could be taken to fairly enforce the policy, particularly regarding warning notices, uniform application of fines, and conduct of inspections when needed. One smoking resident asserted that fines could quickly increase to the point of having substantial impact on residents' behavior. Managers and residents commenting about enforcing the policy often did not distinguish between enforcement and implementation.

"Someone smelled it…. we do routine inspections, or let's say we have to go into your apartment to make a repair or something … our guys are trained when they go into the apartment to kind of look for signs of misuse or violations or things like that, and that was another reason."
(Manager, affordable senior housing, 2-19-2016)

"I'd have a cigarette and I'd put the cigarette butt inside the bottle of water because I didn't want to start flicking them all in the front yard. Then when I moved out I didn't want, like, oh, you had all these cigarette butts in the front yard that we had to clean up. And then subtract whatever from the deposit."
(FG2 Smoking resident, market-rate housing, 10-26-2015)

"Preferably a verbal warning. If I got a written warning slid under my door, put in my box, I'd go down and discuss it. I'd rather just skip that whole few steps of someone typing something up, having someone slide it under my door, put it in my box or whatever."
(FG2 Smoking resident, market-rate housing, 10-26-2015)

"Yeah. If I knew I was going to be fined, I would definitely be more mindful of smoking at home period."
(FG2 Smoking resident, market-rate housing, 10-26-2015)

"I'd say double it each time…. Twenty-five, up to 50, to 100 and so on and so on and so on. Because when it gets up there, when they're paying a fine that's like four times the amount of their condo fee, they're going to think about…"
(FG2 Smoking resident, market-rate housing, 10-26-2015)

"And the way you can enforce that is … raise rents, or you tell people they have to vacate. I know someone who owns apartments and condos, and … when he rents them out, people have to sign in the lease that it'll be nonsmoking, and that's how he does it. Raises the rents, then ultimately says good-bye."
(FG1 nonsmoking resident, market-rate housing, 10-15-2015)

"You receive a couple of letters from the office first. After about three or four letters from us, … I reach out to our attorneys, and then the attorneys will send a letter. If it doesn't stop, then in their correspondence with them, it will let them know that we can file for an eviction if you fail to abide by your lease. And the smoking policy is a product of our lease."
(Manager, affordable senior housing, 2-19-2016)

Managers and residents offered many suggestions for how a smokefree MUH policy could be enforced in a manner that would increase the likelihood of its success in reducing smoking in the buildings. In particular, the residents emphasized the importance of a graduated series of warnings followed by increasing fines associated with multiple violations. One resident indicated a preference for the first notice to be a verbal warning from the building manager about a violation so he could discuss the policy and have an opportunity to ask clarifying questions, and that this warning should be followed by

written notices or violation letters. Residents and managers agreed that a graduated set of fines that increased with each successive violation would get their attention and was likely to change the behavior of smokers. A written legal notice about the possibility of eviction with continued violations was also important, though managers and residents concurred that this was a last resort and not an option that they wanted to employ unless necessary.

Higher Risk Residents

As previously mentioned, the code for higher risk residents referenced any time that participants expressed concern for elderly, children, disabled people and others who they believe are at higher risk from SHSe. Any references to "seniors" or senior housing or related issues was included. These results are particularly relevant in this study given that three of the six focus groups were conducted in senior affordable housing where residents are 62 or older. The key topics that emerged regarding these higher risk populations include: concern for others, the inability of children to make decisions for themselves, mobility issues and potential hardships for people who are physically disabled, health consequences of SHSe, smokers who do not object to going outside to smoke, and community members' active involvement and engagement regarding policies that affect their well-being.

Concern for others

One of the most frequently occurring discussion points that was raised in various ways in the group discussion by both smoking and nonsmoking residents, as well as building managers, was a concern about their neighbors and how exposure to others' smoke might affect their health or ability to be safe and enjoy their homes. Much of this discussion focused on general concern for neighbors' health or well-being and seemed to

be motivated at least in part based on their knowledge of the health risks of SHS. Many comments specifically referenced susceptibility of children, elderly people or pregnant women. One of the results of the way the conversations flowed was that the comments often fell into more than one or several of these categories noted above. It seems appropriate to acknowledge the degree to which these concerns were blended and note that they often were framed in a broader context referring to several populations of higher risk residents rather than just one group.

The FG moderator asked a group of smoking residents whether they thought it was acceptable to smoke in the building.

PARTICIPANT 1: *"No."*

MODERATOR: *"Why not?"*

P1: *"Because that's one of the rules for us to be staying here. Smokers here are a minority."*

P2: *"And especially since it's a senior building."*

P1: *"... smokers here are a minority. As [de-identified] said, there are a lot of seniors. Some have breathing issues [inaudible] and stuff, health issues. So sure. I don't have a problem with going outside and having a cigarette."*

P3: *"It doesn't matter whether it's a senior building. I believe I should not smoke around children."*

P2: *"Healthy people don't get bothered by the smoke like a senior will when his -- they have breathing problems sometime anyway."*

P4: *"Especially if in a wheelchair -- can't get outside. Where you going to go? We ought to have a particular place in the building -- like in the basement with fan and everything else -- inside the building so we don't smoke in the snow."*

P2: *"Well, I think people with diseases -- like I have a friend who has asthma. And every time she goes to the bus stop, she's bombarded by smokers ... waiting for a bus, she's bombarded by people who have been waiting around. So she would be extremely happy to have that* [smokefree MUH policy adopted]*."*

(FG4 smoking residents, affordable senior housing, 3-7-2016)

These smokers were quite conscious of their minority status as smokers in their building and expressed willingness to comply with the no smoking policy that had already been implemented in their building. One person cited the policy itself as reason not to smoke in the building and seemed willing to comply. This is an affordable housing building which seemed relevant to residents' sense of their power in decision-making: many or all residents described being grateful to be eligible for these reduced rents and expressed a desire not to jeopardize their eligibility to live in the building. Participant 1 quoted above was willing to smoke outside so he could maintain access to his affordable housing. Others cited seniors and some of their health issues, including frequent respiratory problems, as a reason not to smoke in the building. Another participant addressed her intention not to expose children to SHS and her view that others should not expose children.

One alternative view expressed in this group was a resident who thought that a person who used a wheelchair should not have to go outside to smoke, particularly in bad weather. He suggested that some accommodation be made so that people with limited mobility could have an indoor place to smoke that was well ventilated. Although the issue of accommodating people with mobility issues was mentioned a few times in other groups, except in this one instance, both smokers and nonsmokers suggested that it was not too great a hardship for such people to smoke outdoors if it would protect the much larger group of people who did not want to be exposed to SHS.

Another FG of male smoking residents in market rate housing expressed similar concerns about the risks to children or pregnant women from exposure to others' smoke.

This group was comprised of younger male smokers in their 20's or early 30's and one participant observed that he thought it was older smokers who would be most likely to violate a policy to prohibit smoking indoors.

PARTICIPANT 1: *"Like for the young kids, their body hasn't fully developed. And I know like when pregnant women smoke, there's risk of things. I don't know if that goes with secondhand smoke or whatever, but I know they're at risk."*

P2: *"I was going to say the same thing, but it's not really the people our age. These are older people."*

MODERATOR: *"What do you mean?"*

P2: *"Like in their 60's, that smoke in their units."*

MODERATOR: *"So you think it's generally older people who are smoking in their units?"*

P2: *"Yeah."*

P2: *"Like I was saying, it's older people here that smoke, and they smoke in their units and they smoke them on their balconies and everything. A lot of people around our age, since [de-identified building manager] sent the email out not to smoke on your balcony or not to smoke in your unit, the younger people come out and smoke in the smoking areas and everything."*

MODERATOR: *"So you're saying, you think older people would be more likely to stay in their units and smoke there, but people who are younger and more mobile would go out and use the smoking area. Is that what you're saying?"*

P2: *"Right."*

(FG2 smoking residents, market rate housing, 10-26-2015)

However, this perspective was only raised by this one younger person, based on his own observation, and he offered no reasons for why he thought this might be true or evidence to support his observation. His perspective contrasted views of older participants in other groups who made comments indicating that younger people might be more likely to smoke in general.

A third group of nonsmokers in a market rate building comprised mostly of older residents also expressed concerns about the effects of SHS on both seniors and children. They were concerned about how residents might be affected by SHS exposure, but one woman provided an emotional story detailing how exposure to another resident's smoke made it difficult for her to have visits from her grandson.

PARTICIPANT 7: *"… the majority people are senior people. We need to protect their health."*

P 5: *"I certainly understand ... what [de-identified] and others have said about – this is your home, you bought it, and you should be able to do whatever you want to in it. I really feel very strongly that you shouldn't do something that is hurting someone else, as [de-identified] mentioned. And I think if you haven't experienced smoke in your apartment, you don't know what it is and how awful it is."*

P 6: *"It is. It is. Your whole apartment smells."*

P 5: *"I mean, it ruined my existence there. My daughter wouldn't come who lives in Silver Spring, because she is allergic to smoke. She gets a terrible migraine. She wouldn't bring my grandson because she didn't want him exposed to the smoke. So, whenever she came we had to go down to the lobby, and play in the lobby, but not in my own home. ... I just had terrible cough, too, and my asthma [was] aggravated by the smoke. My life is so much better now that they have moved."*

P 9: *"And also it depends upon the age. The older folks are more…"*

P 2: *"Susceptible."*

P 2: *"…and babies."*

P 9: *"…endangered."*

P 5: *"And I'll have to add to that one. Your risk is higher, even at a low level of – if you are older, or a child."*

P 8: *"Or if you have a respiratory problem."*

P 6: *"I'm thinking of the five-month-old baby next door to me who is getting the same smoke from the ventilation that I'm getting. I'm sure the parents would be very happy with a change."*

(FG1 nonsmoking residents, market rate housing, 10-15-2015)

Often conversations about whether people should be allowed to smoke in public places quickly devolve into debates about personal freedom, individual liberty and the right to smoke. Even here in these discussions about smoking in private places, there were times when smokers addressed their individual rights; however, the majority of the comments referenced concern for other neighbors and avoiding placing them at risk of exposure to SHS. Respondents emphasized particular concerns for these higher risk residents—children, disabled people, and elderly residents—who may be at increased risk from SHSe in their homes. Indeed, concern for these vulnerable populations seemed to override a more traditional dialog about individual freedom. Extensive legal precedents have established that there is no legal right to smoke, and the focus of the comments from this research seemed to emphasize an overriding concern for these vulnerable populations. Advocacy efforts in support of other clean air policies have often emphasized the social desire or value to protect vulnerable people, particularly those who may not be able to protect themselves. This is one of the reasons that children and young adults are often involved in working for tobacco control policies at the state and local level. Indeed, this dissertation research supports that public health strategy and many participants expressed similar views.

The inability of children to make decisions for themselves and their well-being

Another aspect of vulnerability that was referenced by many participants was their concern for children. These sentiments were expressed in many different ways by different participants, across smoking status, what type of MUH they lived in, or whether they were residents or managers. Virtually all participants made some reference to children being at particular risk, and expressed support for a policy on the basis that it would be a good way to help protect children's developing bodies.

When one of the building managers was pressed for why she thought this would be a good policy, she responded:

"Because – health reasons more than anything. I think people who don't smoke are healthier. … it definitely makes you save money, and it wouldn't affect those people who are nonsmokers as much. And especially where you have kids involved, wherever there are children as well, because they don't get an opportunity to say, "Hey, don't smoke," or "I wish you wouldn't smoke." They can, but most adults may not respond to them as they would if there's a law in place, you can't smoke here, and we can just all live where it's nice and free and clear."

(Manager, affordable senior housing, 2-19-2016)

There was broad recognition among participants that the policy would promote a healthier environment in the buildings and that it would contribute to improving individuals' health. These comments pertained to several different populations, and these adults acknowledged that it would help protect adult residents, but they seemed to be more highly motivated by the opportunity, or duty, to protect those who they believed were more vulnerable. Often this referred to children who were not positioned well to protect themselves, or seniors who were more susceptible to health problems in general that might be exacerbated by SHSe. One manager also noted that the consequences of exposure were also likely to occur sooner in children whose lungs and bodies were still developing so this led her to support a smokefree policy that could reduce the health risks for children. She expressed the view that protecting a child's health and development should supersede someone else's interest in smoking and that it was not too much to require smokers to smoke outside away from other residents or staff.

"I think it would be a lot healthier environment, number one. You don't have to worry about walking in and someone smoking either inside or outside, especially for – I always go back to the children. When children are in an area, I just think that folks shouldn't smoke at any – you know, whether it be outside or what have you, because their bodies

are still developing, and we don't fully know what all of the problems are that have developed from, say, secondhand smoke. So we shouldn't deprive a child because `I want to light up.'"

(Manager, affordable senior housing, 2-19-2016)

When asked how long she thought it would take for health consequences from exposure to SHS to appear, one manager responded:

"I believe it's probably over a period of time. I think it could take a number of years before you start to see something. However, in babies and little children, I think science could show a little bit earlier since they're more susceptible of getting sick than we are."

(Manager, affordable senior housing, 2-22-2016)

Similar views were also expressed by two groups of nonsmokers, indicating a feeling they had a responsibility to protect the health of children, whether the children are residents, or guests of residents. Group 6 was conducted in affordable senior housing and Group 3 was conducted in a market rate condominium building, but the comments from participants in both groups expressed very similar sentiments.

PARTICIPANT 1: *"My grandchildren also were affected by it (SHS)."*

MODERATOR: *"How were they affected?"*

P 1: *"They were affected by it -- sometimes they would stay with me, …. And they would come over here with nothing, but they would leave with something, like runny nose."*

(FG6 nonsmoking residents, affordable senior housing, 3-30-2016)

PARTICIPANT 1: *"I think that it's especially bad for children. They're still developing…. I would not be okay with little kids inhaling secondhand smoke. It's just my opinion."*

P 2: *"And that's the thing about this building too, is you have a lot of brand new families with little babies before they move out. It's an important time in their development."*

P 3: *"Lots, I think, has been brought up here. We have a lot of small children here, infants…"*

P 4: *"There should be no exposure at all."*

P 3: *"...that are getting, yeah, exposed."*

P 5: *"I would imagine that a young child would develop symptoms quicker than an adult because of their developmental cycle."*

P 6: *"Coughing or asthma or something in a young child."*

(FG3 nonsmoking residents, market rate housing, 2-15-2016)

Seniors' attitudes toward smoking

Many of the participants in this study were seniors and maintained strong views on these topics and expressed a preference for a healthy environment free from exposure to SHS. These views were based in part in wanting to protect their own health, but also that of their neighbors, or family members and friends who visited the participants in their homes. Some of these sentiments are categorized under the previous headings noting their interest in protecting children or other vulnerable populations. In addition to broader concerns about health, one manager and a resident also directly noted how strongly senior residents objected to being exposed to SHS. These specific comments about seniors' attitudes opposing SHS only served to reinforce other comments they made that have been grouped under the other headings in this section.

"Most seniors, I believe, ... they don't smoke, they don't like smokers, they don't want smoking, as where you have the younger group that probably smoke more often than seniors."
"Well, like I said, most seniors – and I've worked at another senior property before this one, and most seniors don't like smoking. They don't smoke; they don't want anything to do with smoke. You still have your seniors that hold onto their smoking from a younger age. Working in multifamily communities, that opens up a whole other door of issues, and I think implementing something like this, you'd get good reviews from it and you'd get bad reviews from it."

(Manager, affordable senior housing, 2-22-2016)

Several comments from managers referenced to how competitive the marketplace is for rental housing and even in affordable housing where spaces were highly cherished, the managers seemed very interested in maintaining high standards in their buildings and doing all they could to maintain resident satisfaction. In addition, focus group participants acknowledged that they carefully reviewed ads for properties as they were deciding where to live, and several mentioned searching for smokefree status and having some difficulty finding specific reference to this in online advertisements.

One senior resident expressed a point that was shared by several focus group participants about how important it would be to allow residents sufficient time to adapt to a new smokefree policy.

PARTICIPANT: *"Well, six months seems like a good amount of time* [for policy implementation]. *What happened here, a couple of people that I personally know, they were very upset and almost to the point of really being angry by having to go outside and smoke. And so you got to -- especially with older people. You have to sit down with them and help them make that transition in a more calm way without them feeling like it's personal."*

(FG6 nonsmoking residents, affordable senior housing, 3-30-2016)

Mobility issues and potential hardships for physically disabled residents

Another theme that arose in several of the focus groups related to people who have physical disabilities and how mobility issues may influence residents' ability to comply with the policy. Although the topic came up several times, there was not a clear consensus emerging from participants' views and how they thought it could be resolved. In fact, comments seemed to suggest that a physical disability might make it more difficult for a few people to get out of the building to smoke, but it did not appear to be a major problem for most of those who addressed the issue. One noteworthy exception was

the smoker in affordable senior housing previously mentioned in FG4 who thought that any policy should include a provision to allow smokers who used wheelchairs to be allowed to smoke in some common area inside the building, however he was the only person who advocated for this position. Some of the other comments that addressed disability issues follow.

One cited a conversation she had had with a neighbor in their nonsmoking building who thought that the person was exempt from compliance with the policy because of the person's disability.

PARTICIPANT 1: *"I smell cigarette smoke on the 6th floor and I know who it is. I smell it on the 5th floor. I know who it is. But the person on the 6th floor, I had a conversation with that person. And they are convinced that smoking in their unit is allowed because of their physical disability, like getting down here to go outside in their mobile chair."*

(FG4 smoking residents, affordable senior housing, 3-7-2016)

Another disabled resident in the group explained how she had been treated rudely by another resident simply because she was a smoker.

PARTICIPANT 2: *"I can't stand it. It's like when I first moved here -- I have a disability. People will walk up to me -- the nonsmokers. I don't give a crap who smokes it or don't smoke it. They didn't say, how you doing, nothing. You know what? You shouldn't be smoking. I was like, you don't even know me, miss. Please take your finger out of my face. Literally stand and point right in my face. Nice, sweet people. But it wasn't too sweet to me to point in my face standing and point."*

(FG4 smoking residents, affordable senior housing, 3-7-2016)

The following participant is a nonsmoking woman who expressed a perspective that was raised by several people and seemed to represent the view held by numerous residents. She indicated that she was concerned about the challenges the policy might

raise for others with mobility issues, but that it was more important to her to protect the health and well-being of children or other vulnerable people from SHS.

PARTICIPANT: *"You know, I didn't think about maybe people with personal mobility issues that smoke. I feel bad making them go all the way outside. But then at the same time, you have little kids living in the same low-income housing. They shouldn't have to be exposed to that smoke…"*

(FG3 nonsmoking residents, market rate housing, 2-15-2016)

This comment represented views that were expressed by numerous participants and seemed to address the underlying tension that many people felt. Smokers and nonsmokers were sympathetic to the challenges that confronted many of their neighbors; on the one hand they recognized that it is difficult for people with mobility issues to leave their units to go outside to smoke, and on the other hand they did not want anyone to have to be involuntarily exposed to the smoke of others. They recognized that many smokers were addicted and could not, or would not, choose to quit smoking; however, they did not feel it was fair for people to suffer health consequences from being exposed to others' SHS. This is a common tension that arises when different perspectives are in conflict with one another, and in recent years trends have been shifting towards protecting people who are put at risk by others' behavioral choices. This concern for others seems to be amplified when protecting the rights of children are involved because many are sympathetic to the notion that children often are unable to protect themselves from health risks in their environment. This is particularly true when the risk exposure occurs in one's home. Furthermore, this sympathetic view also often translates to elderly people as well, perhaps because some experience mobility challenges themselves, or they have chronic health conditions that are exacerbated by exposure to SHS.

This tension was expressed by one of the managers of an affordable senior housing building. When asked what she thought about a policy that would prohibit all smoking in MUH, one manager responded:

"I think it would be good. My only concern would be if the policy says that they can't smoke within so many feet of the building, then it may create an issue for our residents, because they're mostly seniors, 62 years of age and older, so I don't foresee them going … to the park to smoke."

(Manager, affordable senior housing, 2-19-2016)

Health consequences of SHS exposure

The topic of health concerns was raised often in the discussions, and many of these issues have previously been addressed as they related to other topics delineated earlier. Here are some of the other important comments offered by nonsmokers that were representative of the views expressed throughout the discussions in several groups. One participant acknowledged the point that people with particular health conditions may be more severely affected by exposure to SHS than others who do not have respiratory or other health problems and suggested that a policy be written to protect those at highest risk.

PARTICIPANT: *"But I was raised disliking the smell of it, but it makes me nauseous quite quickly. And it used to be when people smoked in restaurants and they had no smoking section, my eyes would just swell almost shut, … I was miserable in those circumstances. … and I know about the harm it causes. And I hate it when I see people smoking around children, or I've seen pregnant women smoke, and I have to bite my tongue because I want to go up and snatch it right out, but that's a grandmother attitude."*

(FG5 nonsmoking residents, affordable senior housing, 3-7-2016)

PARTICIPANT: *"I'm asthmatic, so if I have exposure to secondhand smoke, I might have a different reaction than somebody who doesn't have asthma as an issue. … how do you try and structure a House rule, or whatever we're going to call this, so that we can*

accommodate those people who are more fragile, as you mentioned—the elderly and infants as well as some of us who have asthma and allergy problems."

(FG1 nonsmoking residents, market rate housing, 10-15-2015)

Virtually all participants were aware of some health risks associated with exposure to SHS and expressed concerns about the health of other people, including children, senior citizens and people who were disabled. Many of the comments focused on the health of other people and how a policy to prohibit all smoking in and around MUH had significant potential to benefit others' health. In addition, these last two comments were examples of ways the participants expressed how such a policy might benefit their own health, either because of particular increased risks they had or a personal aversion to exposure to SHS because of its impact on them.

Most smokers do not object to going outside to smoke

Smokers spoke openly about their awareness that they were in the minority in their buildings, outnumbered by many more people who did not smoke and preferred not to be exposed to SHS. This comment was indicative of views expressed by others who said they did not object to going outside to smoke and appeared to accept the policy in their buildings that had already become smokefree. Three of the groups, including one with smokers, were conducted in affordable housing buildings that had already voluntarily become smokefree.

P1: *"... smokers here are a minority. As [de-identified] said, there are a lot of seniors. Some have breathing issues [inaudible] and stuff, health issues. So sure. I don't have a problem with going outside and having a cigarette."*

(FG4 smoking residents, affordable senior housing, 3-7-2016)

Community members' active involvement and engagement regarding policies that affect their well-being

One manager in an affordable housing building in MoCo emphasized how politically active her residents are and that they are very organized and engaged around issues that are important to them.

"...we have a community that's really involved in what's going on in Montgomery County and Takoma Park. Our residents, they organize – we have what's called the [identifier deleted] Senior Association. So when there are things that they would like to see come about in the community or in Montgomery County as a whole, they know who to contact to try and get their issues out there."

(Manager, affordable senior housing, 2-19-2016)

This was an interesting point for the manager to raise voluntarily without prompting from the interviewer. She highlighted how engaged her residents were on a broad range of issues that affected them and suggested they were quite comfortable interacting with local policymakers, and had invited them to address their group on numerous occasions. This inclination to stand up for their views on issues they care deeply about, their comfort with local advocacy, and familiarity with local policymakers may prove to be very helpful traits if they decide to become more involved on the issue of smokefree MUH in the county. Senior citizens are often outspoken on wide-ranging issues and in this case it may serve to advance this local public health agenda.

"They're very vocal. They ... invite politicians to come in and speak on a regular basis, whether it'd be election year or non-election year. Whenever there are issues that come up that affect Takoma Park as a whole, they will organize together to find out what those issues are and they let their opinions be heard. They wanted a bus stop out here, ... they wanted the bus to change its route, and they organized, they did petitions, they went to meetings. So our community is a very vocal community. They're not the 'I'm just going to just sit here and rock myself away because I'm a senior.' No."

(Manager, affordable senior housing, 2-19-2016)

Discussion

Managers and residents of multi-unit housing in Montgomery County broadly agreed on the benefits of a comprehensive policy to restrict all smoking in MUH in the county, and it was perhaps somewhat surprising to note that opinions did not differ significantly based on residents' smoking status. Both smokers and nonsmokers noted the potential of this policy to help smokers reduce the amount and frequency of their smoking, and both groups described this in positive terms. Nonsmoking and smoking residents acknowledged that this smokefree MUH policy would create a safer, healthier, more pleasant living environment for everyone, and they did not anticipate significant objections from smokers, mostly because smokers are a very small proportion of the residents of these buildings. One seeming advantage to introducing this policy at this juncture is that most smokers seem already well-adjusted to smoking outside, far away from others who may be exposed to their SHS or bothered by the effects or the smell.

This is in part a result of a strong health conscious social norm in Montgomery County and broad awareness of the risks of SHS, as well as a sensitivity to the well-being of others. One difference between smokers and nonsmokers was that smokers wanted implementation to be accompanied by clear, easy-to-understand, repeated communications about the new policy, via multiple channels and formats. Smokers frequently raised this issue in focus groups, whereas nonsmokers did not highlight communication as a major concern suggesting perhaps a potential source of conflict in relation to implementation, if not handled carefully (given that smokers are in the minority but will be most impacted by this policy). Smokers' expressions of strong support for a smokefree policy were consistent with findings from earlier research

previously cited, but the current study found more interest in and support on the part of smokers than had previously been reported.

Managers and residents agreed that careful implementation of this policy, with specific attention to fair and consistent enforcement in all MUH residential settings, is perhaps the most crucial element to ensure that such a policy is successful in Montgomery County. There was little to no perceptible resistance to the policy, with a couple noteworthy exceptions which will be addressed below. The major concerns that emerged from interviews and focus groups are organized into the following categories: managers' concerns, smokers' concerns, owners' concerns, transition time and support for cessation services, and clear communication of the new policy.

One manager of a market-rate apartment building was primarily concerned with ensuring that her occupancy rates would not be negatively affected by such a policy, a concern one might expect from any business manager focused on maximizing revenues and profits in a competitive real estate market. She had specific recommendations for how to implement the policy and what steps policymakers could take to ensure that she had tools available to her to enforce the policy without spending excessive time bogged down in legal proceedings. She also wished to avoid adjudicating disputes through the court system because of the significant delays and unnecessary costs this could involve, preferring to set up positive incentives for residents' compliance with the policy whenever possible. This manager strongly supported a graduated fine structure for violations of the policy, which would be spelled out in all leases or lease addendums for returning tenants. Previous research has reported similar views about the importance of including information about fines in revised leases, and this Montgomery County

building manager reinforced this perspective. The details about how such a fine structure could most effectively be supported, as well as the benefits and challenges of various approaches, would be a helpful subject for further research to inform the implementation of such policies across the nation. For this study, it is important to report findings from constituents for Montgomery County policymakers.

A different manager of a market-rate condominium building had already been contemplating these policy issues for some time and was being motivated, at least in part, by an active and outspoken group of his condominium owners who were eager to adopt a comprehensive smokefree policy for their building. The condominium owners also supported efforts to enact a similar policy at the county level so that their aging building did not suffer market consequences, because they realized their building had much competition in its immediate vicinity. The manager wanted to learn what steps he might take to facilitate smooth implementation of this policy because his owners' association appeared to be moving toward adopting it ahead of any action by the Montgomery County Council. My research brought to the fore specific ideas about how building managers or condo associations can use smokefree policies to make their buildings more appealing in a highly competitive real estate market. I did not find this in previous literature and it might be a function of a more recent increasing trend toward smokefree environments, especially in an area with very low smoking rates.

One focus group participant noted that advertising for apartments in his building did not mention smoking status or policies. He suggested that marketing materials promote the building as smokefree. Future research could provide useful insights into the reactions of prospective and current residents to marketing information that promoted the

smokefree status of a particular MUH property. Various messages could be tested with this population to assess salience and potential reactions. Given the population demographics and low smoking prevalence rates in MoCo, apartment owners and managers might find that promoting their smokefree status in this environment could provide competitive advantages and highlight desirable qualities of their properties.

Managers of the affordable housing buildings were also well-versed in the issues related to implementing this policy because they were responsible for buildings that had already become smokefree and were working with their residents to ensure fair, uniform enforcement of the policy. One manager had been actively involved in taking her building and its residents through the process of becoming smokefree, and she had seen firsthand the benefits to her and her residents of adopting and implementing the policy. The managers of both the affordable housing buildings were quite supportive of the policy, largely because they had already experienced its benefits: (1) a cleaner and safer environment for residents, including reduced risk of fire; (2) fewer complaints and disputes among residents when tenant support is strong; and (3) lower costs, such as reduced turnover costs, reduced cleaning and maintenance costs, and lower insurance rates. These managers' views supported previous research findings that the potential cost savings are a primary motivating factor for many managers and owners who have voluntarily made their buildings smokefree; these are often stronger motivating factors than concerns about health consequences of secondhand smoke exposure. Thus, the experience of these managers provides local data about perceptions of policy benefits that could sway policymakers in their deliberations. The current study's reports of lessons learned firsthand by managers involved in transitioning their buildings to being

smokefree is unique in the literature; no other studies have been found to report on managers' experiences and insights arising from this process.

Smokers are the group who will be most directly impacted by a smokefree MUH policy. The strongest concern from smokers was their desire for clearly marked outdoor smoking areas where they could smoke when they wanted to without feeling harassed by other residents or visitors for choosing to smoke. Several smokers indicated their willingness to comply with a smokefree MUH policy if there is a clearly marked outdoor smoking area. Their primary objective was to avoid harassment from nonsmokers or others who did not want to be exposed to their smoke while in the building, or while coming or going, and who did not want to be confronted by smokers lingering around the building entrances. Smokers also wanted a comfortable space that is protected from rain or direct sun and, ideally, has seating and a Wi-Fi connection for working or internet browsing while they smoke.

This is an important finding from smokers that I did not find expressed in previous literature I reviewed. Several possible factors may explain this finding. Perhaps the most important is the changing social norm that has made exposing others to the risks of SHS less acceptable than it has been previously, and this attitudinal shift may be the result of increased awareness of the dangers of secondhand smoke, which were widely known among the study population in Montgomery County. Further, study participants made numerous comments that they were aware of the risks to their neighbors of exposure to SHS and their interest in reducing these risks, and that they did not object to being required to smoke outdoors. They expressed broad acceptance of this public

expectation which has now become common as a result of other worksite and public policies that prohibit smoking in many public places.

The broad awareness of the risks of SHS among both smokers and nonsmokers, and the stated willingness of smokers to go outdoors to smoke raises the obvious question of the merits of designated outdoor smoking areas. This seems like the appropriate next step in advancing a policy that will protect everyone from exposure to SHS in their homes and the concept of designated outdoor smoking areas may be an intermediary step to facilitate the adoption of smokefree home policies. One lesson that has been learned throughout the field of tobacco prevention and control policy since the 1964 Surgeon General's report is that policy change often occurs incrementally. This is also true with other public health interventions. The public must come to accept the idea and the change that it represents so that they can ultimately experience the change as a normal way of life. An often-cited example is the notion of smokefree air travel. At one point, the traveling public accepted smoking on airlines as a normal way of life, until it became enough of a health problem that it was prohibited. Now virtually no one would argue that it is a good idea to allow smoking on airline flights and they accept this policy as the widely accepted norm.

It is not hard to imagine that after residents of MUH have come to accept the idea that they cannot smoke in their homes and have grown accustomed to smoking outdoors, that some will raise the question of whether of whether the entire campus of their residential environment should be entirely smoke- or tobacco-free as many hospitals and universities have already done. Many people believe that a tobacco-free campus would encourage more smokers to quit, would protect more people from SHSe, and that the

absence of any cues of seeing people smoking, or even the reminders of ashtrays, would further reinforce a nonsmoking social norm. However, others believe this smokefree MUH policy and other policies should be adopted incrementally and that is important to allow smokers to have some refuge where they can smoke without feeling stigmatized or further ostracized from society. It is important to adopt and implement this and other tobacco-free policies in a way that will ensure their greatest success and avoid significant challenges to their implementation. Public health practitioners understand the crucial nature of careful policy implementation to ensure that the policies meet or exceed their stated goals. In this case, by allowing a safe, sheltered space to smoke outdoors, the policy is likely to increase the acceptance from smokers who are not ready to quit and may allow smokers and others to eventually be open to the idea of tobacco-free campuses. Successful policy advocates understand the importance of moving toward progress in a way that does not advance so quickly that it risks turning away potential supporters. This is another topic that warrants further research to better understand the circumstances under which the public may be open to tobacco-free campuses in their living environments and steps that might be taken to facilitate these next policy changes.

The three focus groups conducted in market-rate condominiums, and the one additional individual interview from one of these buildings, consisted of 22 residents including four who were smokers. One of the focus groups of nonsmokers was quite committed to a goal of making their building smokefree, and they were already studying this issue and preparing to pass a by-laws amendment to prohibit all smoking in their building. Two residents in this group supported a nonsmoking policy for the building but were quite vocal in their opposition to a government policy that would prohibit all smoking in MUH in Montgomery County. Although they supported a nonsmoking policy

for the building, they did not want to have the policy legislated by the government. Their view was clear in opposing government intervention in their homes, rather than an objection to a nonsmoking policy in their building. In fact, the participants of this group strongly favored a comprehensive smokefree policy for their building, but these two people specifically stated that they wanted implementing a smokefree policy to be their decision, and not the result of government intervention in their homes. Although I did not find this opinion expressed among other study participants as strongly as these two people did, this view is often expressed by those opposed to smokefree MUH policies. See the "a man's home is his castle" quote included under the "Challenges to Implementation" section in the results. This single quote represents a view that seems to be virtually a prerequisite for any qualitative research on a topic such as this addressing policy change in private settings, and particularly in one's own home.

Although very few participants, either smokers or nonsmokers, in my research expressed this view, it is important to consider carefully nonetheless because this will likely be one of the arguments made most often in opposition to the policy proposal. By way of context, this discussion occurred in an expensive condominium building, where participants might have had stronger views about property rights and the personal freedom home ownership affords them than residents of rental housing, and especially those in affordable housing, who are pleased to have access to housing at below-market costs and therefore are willing to endure additional conditions for their residency as a consequence of their reduced rents. Although it is difficult to draw any broad conclusions from this small sample, it is important to note that none of the other focus groups of residents raised this issue as explicitly or clearly as this one participant did, and this building included the most expensive housing in my sample. Even this one person, who

might be characterized as one of the most outspoken critics of a law to prevent all smoking in MUH, was well aware of the risks of SHSe and seemed to support the policy if the residents adopted it themselves. In addition, the comment above drew an immediate response from another group member who cited a Surgeon General's Report that said there was "no right to smoke." In the ensuing discussion, several people expressed opposition to grandfathering smokers into a new policy. According to one participant, *"That's the basic principle. You don't harm someone else."* (FG1 Nonsmoking male resident, market-rate housing, 1-15-2015).

Another important theme to many of the participants—residents and managers, and smokers and nonsmokers—was the importance of adequate transition time. Participants cited the need for residents and staff to adjust to a new nonsmoking policy, to consider what the policy would mean for their specific circumstances, to prepare for personal behavior change, to decide whether they want to quit smoking, or possibly to consider moving to a jurisdiction that had no such policy. Interestingly, the closest alternative jurisdiction for most of the study participants is Washington, D.C., which is also currently considering a comprehensive smokefree MUH policy, though no action had been taken at the time of this study. Most residents preferred 4–6 months of phase-in time to allow for necessary adjustments, though a few indicated a preference for one year. It was the smokers who indicated that they thought 4–6 weeks would probably be enough transition time as long as they were adequately notified of the upcoming policy change. Previous studies did not appear to report such specific views about appropriate phase-in times or that smokers opted for shorter times than nonsmokers.

Another issue raised by many participants, particularly younger smoking residents, was a desire to have extensive educational materials about the new policy and a preference for receiving the information through multiple channels. Participants wanted information about the policy to be written in very clear, easy-to-understand language so they could be certain to understand the policy's terms and conditions and potential consequences for violations. They wanted clear signage in the building, written notices distributed to their units, and information sessions where they could have all their questions answered. Participants urged policymakers to write the countywide policy and implementation guidelines in clear terms that would be easy to understand for everyone.

Several managers and residents also brought up the need for evidence-based cessation services and social supports for smokers motivated by the new policy to stop smoking. Evidence-based cessation services will be crucial to support those who choose to stop smoking and their availability and utilization may play an important role in smokers' success in quitting.

Despite this study's important findings, some limitations should also be acknowledged. Perhaps the most important limitation is that this research represents a single case study example of the attitudes of residents from Montgomery County, Maryland towards a hypothetical smokefree MUH policy. It may not be appropriate to extrapolate their views to other jurisdictions, either in the surrounding Washington, D.C., Maryland or Virginia region, or in other regions of the country. For reasons previously described, this research was conducted in southern Montgomery County, the most densely populated part of the county, which is located adjacent to Washington, D.C. Views of residents and managers from this part of the county may vary from those in

northern areas, which are less densely populated and more rural. However, the more densely populated areas may also be more appropriate to this study's focus on multi-unit housing MUH policy, given that a greater proportion of residents live in MUH in the south county than in areas further north. Also, three of the six focus groups were conducted in two affordable senior housing buildings that had already voluntarily adopted smokefree policies (a decision made by the management company which owns both buildings). Because the managers and residents of these buildings had already transitioned to smokefree environments, they might have viewed the hurdles of this process as less difficult than those who had not yet survived such a policy change or experienced its benefits; thus, living in already smokefree buildings could have influenced these participants to be more supportive of a smokefree MUH policy.

Participants in this research indicated broad understanding of the risks of SHS exposure, and particularly how it affects several key high-risk populations who reside in MUH, such as children, seniors and people who are disabled. The over-riding conclusion to emerge from my research is that managers and residents, both smokers and nonsmokers, in MUH expressed concern about the risks of SHS and were committed to protecting themselves and their neighbors from these increased risks. This underlying awareness of the health risks of SHS and a humanitarian value of protecting neighbors and themselves from these risks led to strong overall support for a smokefree MUH policy. In addition to a commitment to protecting residents' health, managers were also concerned about economic implications of this policy and wanted to ensure that the policy did not interfere with their ability to maintain high occupancy rates. However, these concerns were both somewhat suppressed in findings from this study because of the low smoking rates in Montgomery County, and because two managers who participated

in this study were operating in affordable housing for which there is always a very high demand, and one other manager worked in a building that was already considering voluntarily adopting a smokefree policy. The market pressures to focus on occupancy rates was primarily expressed by the one manager who operated a large apartment building located relatively close to the border with the District of Columbia.

Participants were particularly vocal about their concerns for children and often referenced children's inability to protect themselves or the difficulty they have in making decisions that affect their well-being. These respondents, who were disproportionately senior citizens, were well aware of the increased health risks for people who are exposed to SHS—both themselves and their neighbors. Particular concern was expressed for people who have asthma or other respiratory health conditions. Further, some acknowledged the unique challenges confronting people who have mobility problems in being able to get themselves outside the building. However, the most common view expressed indicated that protecting babies, children and others at high risk of SHS related health problems was more important than allowing people to smoke in their multi-unit homes.

Given these concerns expressed by many research participants about the well-being of others whom they deemed particularly vulnerable, this seems to provide some insight into how such a policy could be framed to produce the broadest level of support. Government policies are often designed to protect the marginalized people in society and ensure a basic level of public safety for all. Clean air policies in workplaces, restaurants and public places; safe drinking water standards; water fluoridation; elimination of lead from the environment; sanitation and food safety regulations; and many other public

policies all share this common goal. Smokefree MUH policies are consistent with this broader view and will protect vulnerable members of society. These policies are becoming more acceptable to broader populations as awareness of the risks of SHSe continues to grow, with greater attention to the risks of even low-dose exposure and while people spend the majority of their time in individual homes, either their own or others'. Policymakers and public health advocates might consider framing their support for smokefree MUH policy in the context of these particularly vulnerable populations who stand to gain the most from these additional protections in their homes. This framing also provides the additional benefit of support from voters who may be particularly sympathetic to these vulnerable neighbors.

A similar study in both purpose and design was a qualitative study to examine residents' reactions to a smokefree policy enacted in summer 2014 in public housing in Minneapolis with the goal of informing the development of an enhanced and improved implementation strategy for smoke-free housing policies (Hennrikus et al., 2017). These authors drew an insightful conclusion from their research that it is "particularly important that the policy be implemented in a way that fosters resident support and promotes resident self-enforcement" (Hennrikus et al., 2017, p. 480). My research reinforced this previous work and contributes to the principal conclusion that emanates from the current research. The potential success of a smokefree MUH policy in Montgomery County will largely be determined by how well it is implemented, which will be significantly influenced by the degree to which it incorporates the views and experiences of those who will be most directly affected by the policy—residents and managers of multi-unit housing in the county.

Smokers who participated in this research recognized that they were in the minority in Montgomery County and did not seem to make a strong case for being allowed to smoke in their homes. Based on comments expressed in one FGD, some smokers indicated that it was acceptable to them to go outside to smoke. One male smoker in affordable senior housing acknowledged that he and other smokers were in the minority and explicitly noted that he did not mind going outside to smoke by saying, *"I don't have a problem with going outside and having a cigarette."*

Another smoker shared her perspective that was not raised frequently in the discussions; however, it is a very important point to include because it addressed a basic notion of civility. This person (who described having had a finger waived in her face by a neighbor because she was smoking) expressed an opinion that seems so obviously true that it should not require a policy to be written in order for people to adhere to basic civility and manners in their interactions with their neighbors. She had experienced harassment from a neighbor apparently only because she was smoking and she had been offended, perhaps because she had felt isolated or stigmatized by her neighbor. In fact, many policies of this nature are often self-enforcing and depend on neighbors being able to talk with one another and resolve concerns amicably. Being able to resolve disagreements or conflicts civilly is an important societal value, that is even more indispensable in situations among neighbors or others who live in close proximity to one another. Most of the discussion in these groups indicated broad understanding of this notion and a general willingness to resolve any disagreements politely and respectfully.

Although the smokers were in the minority in this research, their attitudes, opinions and suggestions were crucial to the findings of the study, for many reasons, but

perhaps most because observers might expect them to be most likely to object to a policy that would prohibit them from smoking in their own homes. As previously noted, some expressed reservations about the policy, but for the most part even smokers accepted the idea of smokefree MUH. Part of this support was a direct result of their acknowledgement that they are significantly in the minority in Montgomery County, but more particularly also in the buildings in which they live. Further, they seemed to be quite well aware of the health risks of exposure to SHS and virtually all expressed sincere concern about protecting the well-being of family members, neighbors and others who visited their MUH buildings.

Participants conceptualized of both health and economic benefits of the policy and this contributed to an underlying openness to the idea of a new policy prohibiting all smoking in MUH or a willingness to consider adopting and implementing the policy. Many managers and residents spoke directly to the healthier environment that would exist if smoking were not allowed in MUH and specifically mentioned the impact on children. One manager in affordable senior housing noted that the policy would create a much healthier environment and went on to say that she always focuses on the children. She indicated that she thought when children were present that people should not smoke around them because their bodies are still developing. Protecting these higher risk populations generally led to support for a comprehensive policy to prohibit smoking in MUH, among all groups of participants including smokers and nonsmokers, residents and managers. Kaufman and colleagues also reported similar findings and listed among the motivations of participants to quit were the economic benefits, concerns about smoking around children and the potential for improved health (Kaufman et al., 2018).

Previously cited research by Karen Wilson and colleagues drew on findings from the 2011 Social Climate Survey of Tobacco Control and emphasized that many earlier studies have reported that residents expressed a strong preference for the option to live in smokefree MUH (Wilson et al., 2014). This team concluded that a partial smokefree policy might actually increase the risk of SHSe among nonsmokers in their own homes and that the most effective solution for minimizing SHS incursions was to prohibit smoking in all areas of MUH, including residential units.

The foundation for this dissertation research is to attempt to verify whether these findings from other areas of the U.S. also hold true in Montgomery County and if local residents did hold these or similar views, what steps policymakers could take to implement a local SF MUH policy that will be most effective and meet with the least possible resistance. This study was designed to ascertain residents' and managers' views about a comprehensive SF MUH policy as the evidence base is building that this is the best solution to eliminate exposure to this deadly carcinogen. Would local residents, particularly smokers, support such a comprehensive policy? What steps did they believe could be taken that would facilitate implementation in ways that are least disruptive and most likely to gain the acceptance of managers who would deal directly with violations or unhappy residents?

Another research team with extensive experience on the topic of reducing SHS in MUH is Geller, Rees and Brooks from Boston. Their work has often emphasized the need to engage residents in the process of policy implementation (Geller et al., 2016). In a *JAMA* commentary they report that "...reducing secondhand smoke exposure for children, seniors, and residents with disabilities, and anticipated progress toward denormalization

of tobacco use among public housing communities, may help to address long-standing disparities in tobacco-related health burdens. Further, implementation of the (HUD) rule may contribute to more quit attempts and sustained cessation among residents who might not otherwise engage with those services" (Geller et al., 2016, p. 1105). My research in Montgomery County yielded very similar findings and generated similar conclusions that this team has researched based on their work over the last several years, with a particular emphasis on public housing authorities (PHAs). They have interacted with HUD and shared their research with HUD staff and others working to implement the HUD smokefree public housing rule.

One concern with smokefree MUH policy that emerged as potentially important is the issue of whether or not, and how, to accommodate smokers with mobility disabilities. Although there was broad support for smokefree housing, there was a sentiment expressed in some groups that some steps can or should be taken to facilitate people with disabilities' compliance with the policy, rather than a sense that they should not be expected to comply. Even though some residents expressed concerns about how difficult or inconvenient it might be for disabled people to exit their homes if they wanted to smoke, it became clear that a majority of participants placed a higher priority on protecting vulnerable people including children, seniors, pregnant women and disabled people who did not want to be exposed to SHS. This judgement they made and expressed in the FGDs indicated that minimizing the risks from SHSe seemed to be a more compelling consideration in shaping their ultimate support for a policy. Residents and managers were concerned about their own health, but even more so about the health of those who they believed either could not protect themselves, or who might benefit from the support provided by a policy that applied to everyone. These views were consistent

with findings from Kaufman and colleagues who conducted a qualitative study in Ontario, Canada on the impact of smokefree housing policy lease exemptions on compliance, enforcement and smoking behaviors (Kaufman et al., 2018). These researchers also concluded that "policy approaches should be designed to prevent the marginalization of groups who are most vulnerable to smoking and SHS exposure while maximizing the effect and impact of policies" (Kaufman et al., 2018, p. 34). This research reinforced findings from my study by noting that tenants in their focus groups and interviews indicated that the policy helped them decrease their cigarette consumption and quit smoking.

Another theme that emerged from these discussions was the importance of any new policy being uniformly applied and enforced. The concepts of fairness and civility were important to residents who did not want to be discriminated against because of their smoking status and indicated that all neighbors deserved respect from one another. Geller and colleagues also noted views that the success of the new HUD rule will depend on resident engagement and support, and "the perception that policies are implemented fairly and with sensitivity" (Geller et al., 2016, p. 1106).

Similar points had also previously been raised in the earlier discussion about key implementation issues. One smoking resident indicated how she had been treated rudely because of her smoking status and how greatly this offended her. The importance of preserving good relationships was also raised in the Kaufman study. These researchers found that in the Waterloo Region Housing in Ontario that tenants did not want to jeopardize relationships by asking guests to smoke outside and researchers attributed this behavior to tenants' concerns about etiquette, appearing ungracious, being embarrassed

or afraid of offending visitors (Kaufman et al., 2018). Geller and colleagues attempted to reiterate this point by suggesting that PHAs should frame their messages to residents by focusing on the smoke rather than on the smoker themselves (Geller et al., 2016).

Many health behavior theories contributed to my thinking about how to organize this research, which research questions to pose, and who to recruit to participate in the research. Two perspectives that are particularly relevant to framing the research I have conducted and that shaped the formation of this study are community based participatory research (CBPR) and the concept of an ecological perspective. Since CBPR has previously been addressed in the discussion of my practicum experience and how it guided the design of this study, I will elaborate briefly on the importance of an ecological perspective because of the seminal role it has played for decades in guiding health promotion programs and public health policy development (Sallis et al., 2008). Kenneth McLeroy and colleagues acknowledge the challenges of defining "community" because it has been used in so many different contexts; however, they ultimately describe three distinct meanings of community: mediating structures, the relationships between organizations in a defined area, and the power structures (McLeroy et al., 1988). They describe the purpose of an ecological model to focus attention on the environmental causes of behavior and to identify environmental interventions. They also note that an essential component of ecological strategies is to involve the "target population" in defining the problem as well identifying appropriate interventions, implementation and evaluation (McLeroy et al., 1988).

These key principles of this model undergird this study and contributed to my efforts to enroll MUH residents and managers so that they could be engaged in shaping a

policy that would directly affect them. All three aspects of community are essential to advancing a smokefree MUH policy. The mediating structures of families, social networks, homeowners' associations, civic groups, public health organizations and others can play vital roles in building support for the policy. The relationships among the organizations in the community will be important and the likelihood of adopting and implementing the policy will be enhanced if many of these structural organizations coalesce around the policy and work collaboratively to achieve its goals. If, for instance, health and housing organizations took opposite views about the value of advancing this policy, this disagreement could significantly interfere with its ultimate success. Finally, the power structure within Montgomery County will play a crucial role in determining the future of this policy. In the end, a decision will be made by the County Council and County Executive, but if the business community aligns with health and housing organizations, along with the residents, the chances for success will be greatly enhanced. The pursuit of consensus building espoused by McLeroy and colleagues as integral to this model make it a useful lens through which to view the pursuit of smokefree MUH policy in Montgomery County.

The importance of adequate phase in time for a new policy was also explicitly addressed in these discussions regarding higher risk populations. This same point had been raised during discussions relating to the implementation of the policy more broadly by residents and managers of MUH, but the issue seemed to have special urgency for these higher risk residents. One nonsmoking resident in affordable senior housing expressed the view particularly well on behalf of many others. When asked how long it should take for this new policy to be implemented, she indicated that six months was a good amount of time. She noted in particular that transitions can be particularly difficult

for older people and that it often helps if new ideas or policies are explained in a calm manor and that people patiently explain the changes to them, while providing ample opportunity to ask questions. This resident addressed a point that might be more broadly relevant for other seniors who are attempting to adapt to a new policy in their homes. The idea that new policies must be carefully explained to people in simple language that they can understand and allow them sufficient time to adapt their behaviors to the new policy certainly applies to seniors, however this may also be relevant to other residents as well. This transition time that can be used to allow residents and staff to become more comfortable with the policy, understand more fully how it will affect them, and identify ways to alter their behavior patterns may also prove instrumental to the eventual success of the policy.

Public Health Policy and Practice Implications

The ultimate audience for this research is policymakers in Montgomery County who are concerned about the health and well-being of their constituents, have a widely recognized reputation for their progressive policymaking actions, and are interested in being perceived as progressive leaders across Maryland; the D.C., Maryland, and Virginia (DMV) region; and the country as a whole. Smokefree multi-unit housing policy in Montgomery County could have broad impact on policy in other state and local jurisdictions, thus it is important that it be implemented well if it is adopted. Many others will be studying the impact of the policy and will want to ensure that it does not create undue hardship for landlords, MUH owners, or residents, or damage the county's ability to compete with adjacent jurisdictions. One manager who placed high priority on maintaining high occupancy rates in her building expressed concern about the possibility that potential renters who smoke could take their business to a nearby jurisdiction that does not have a similar policy. Although this remains a concern in a competitive real estate market, the closest alternate jurisdiction, Washington, D.C., is also actively considering a similar smokefree policy for their MUH buildings.

As of this writing, all the local jurisdictions in the United States that have enacted laws prohibiting smoking in MUH are in California, and the trend has continued to spread there. Many public housing authorities in other jurisdictions have voluntarily adopted smokefree policies for their public housing units, and the U.S. Department of Housing and Urban Development's policy prohibiting smoking in all public housing will become effective in July 2018 (USDHUD, 2016). Increased awareness of the health consequences of SHS and the increased financial burden to managers and owners of continuing to allow smoking in multi-unit housing are accelerating the adoption of

comprehensive smokefree policies. States and localities, beginning with California, have adopted comprehensive clean indoor air laws covering workplaces, restaurants, and bars, and this trend has spread eastward. The diffusion of smokefree MUH policies may follow a similar pattern. The groundwork that has occurred at the local level in California and the recently implemented HUD policy making all public housing smokefree are providing evidence and serving as models for other jurisdictions considering implementation of smokefree MUH policy. Montgomery County policymakers already have a strong track record of enacting many tobacco prevention and control policies to protect the health of their residents, and my research indicates that they appear open to considering this policy change to prohibit all smoking in and around MUH in the county.

Extensive research indicates that policymakers want to base important policy decisions on local data from their own constituents, particularly when views on a particular issue may diverge. My research provides them with evidence indicating that many of their constituents support smokefree multi-unit housing policy, as well as suggestions for ways to implement such a policy that will increase the likelihood of success. The categories of participants for this research were carefully selected because they are people who were most likely to be directly affected by this policy and would have the strongest opinions relevant to it. The most important lesson from this research is that smokefree MUH policy could be successful in Montgomery County if it is enacted with careful attention to the implementation issues and concerns expressed by residents and managers of multi-unit housing in the county.

This research with residents and managers of MUH in Montgomery County, Maryland points to several ideas that may be helpful in attempting to implement a

comprehensive smokefree MUH policy in the county, particularly as it relates to these higher risk populations. Several comments from FGD participants indicated that most people are willing to follow the rules and tend to be law abiding. These participants indicated that they would adhere to the policy, though one might expect participants who would not adhere to refrain from making those views known in the context of this research. This also suggests that the existence of a local ordinance prohibiting all smoking in MUH could have a significant impact on reducing exposure to SHS in MUH and thereby improving the health status of residents and staff.

One of the biggest challenges to successfully implementing this policy is identifying ways to deal with people with mobility issues, and to find pragmatic ways to help disabled people comply with the policy so that they do not attempt to circumvent the policy because of the unique challenges they face. Of course, as with all residents of MUH, the adoption of this policy will provide opportunities to encourage all smoking residents to attempt to quit and this will especially important for those with disabilities for whom it may be difficult to exit the building. Extensive resources, materials, and training will be provided for everyone who wants to quit. However, it will also be important to provide additional assistance and customized planning and resources to help people with disabilities.

For those who are unwilling or able to stop smoking when the policy is implemented, one possibility is to develop a buddy system by voluntarily identifying friends and neighbors who will help the person get in and out of the building as needed. Also, building managers could identify residents or staff throughout their buildings who may require additional assistance and assign floor monitors, either residents or staff, who

could assist these residents if they request it. It would be important to be sensitive to the particular needs and preferences of disabled people, and any such assistance would be voluntary. Most people already manage to get around as they do their activities of daily living including shopping, visiting friends or family, or participating in other activities outside the building so they can plan to smoke while they are already outside.

The importance of having a plan and being prepared with a support network has been identified in the disability literature as a useful tool for the survival, independence, safety and health of people with mobility impairments (Rooney and White, 2007). Rooney and White with the Research and Training Center on Independent Living conducted a qualitative study to gain better understanding of disaster preparedness for and challenges of people with mobility impairments. They found that both general and disability-related disaster preparedness efforts were useful for the survival, independence, safety and health of people with mobility impairments. They also found that coworkers, family, friends, neighbors, and strangers often formed spontaneous networks both during and after disasters to provide essential assistance. They found that problems arose when there was a lack of community and workplace evacuation plans, or someone was left behind during an evacuation. They concluded that "Preestablished and spontaneously formed networks to provide assistance are also important for persons with mobility limitations to survive disasters and emergencies" (Rooney and White, 2007, p. 212).

Earlier in this dissertation I provided an explanation for why I utilized a community-based participatory research frame for this study and why I believe this approach is important to the success of adopting and implementing this public health policy. The importance of community engagement cannot be overstated and is reinforced

by another relevant study of Hispanics/Latinos on the topic of SHS exposure in MUH. Baezconde-Garbanati and colleagues emphasized the importance of engaging MUH residents when developing the recommendations from their research conducted in southern California (Baezconde-Garbanati et al., 2011). Their work focused on a Hispanic/Latino population and was motivated by a concern that disproportionate exposure to SHS among minority groups could exacerbate well-documented health disparities. Their data were collected between 2005-2007 and the researchers acknowledged that even though some MUH residents may have felt powerless to avoid exposure to SHS, that they could become empowered nonetheless. These researchers recommended that MUH residents form partnerships with community-based housing organizations; health organizations; and city, county or state agencies responsible for promoting smokefree housing. Coalitions of residents can educate landlords and policymakers about the hazards of SHS as well as the health, safety and economic benefits of smokefree housing (Baezconde-Garbanati et al., 2011).

One important point that was reiterated in the findings from this research is how crucial it is to allow sufficient transition time to the new policy so that residents, managers, staff and guests all have enough time to get adjusted to new policy and make decisions about how they're going to change behavior patterns to accommodate the policy. During the transition time to this new policy it will be essential for the county officials to prepare and distribute educational materials to help ensure everyone knows the risks of exposure to SHS, and particularly how it affects infants, children, pregnant women, people with asthma or respiratory health problems, and seniors with or without health problems. This study has helped to identify some of the specific steps that local public health officials and policymakers can take to ease the transition to this new policy.

These officials would benefit tremendously from engaging local MUH residents and managers in designing the details of any new policy. This transition time will allow for extensive discussions of all interested parties to consider implementation issues that have been identified through this research. Ideally policymakers will design an interactive process through which they can solicit input from community members and work collaboratively with residents and managers as well as public health officials, housing organizations, firefighters and public safety officials, and other community members who are invested in ensuring that this policy is successful and is implemented in a way that increases the probability of that success.

Another central point generated from these focus groups is that it will also be important to provide multiple channels and many opportunities for residents to learn about the new policy, how they can easily comply with it, and what the consequences will be for failure to comply. Again, participants of this study could provide specific feedback or recommendations about which communication channels and messages may be most effective in reaching the intended audiences. Also, it is important to recall that one market rate building manager strongly emphasized her desire to avoid adjudicating violations of this policy through the court system. She felt strongly that the policy would be more effective, and much easier to implement, if she could circumvent the expense, delays and overall hassles of having to work through the judicial system to resolve potential problems with residents.

In addition, broad availability of comprehensive evidence-based cessation support will be crucial to successful policy implementation. Research by Geller and colleagues reinforced what I learned from my study participants and has been frequently

documented that providing smoking cessation services that are tailored to meet the challenges of these most vulnerable populations in MUH such as children, elderly and disabled residents and staff are critical to maximizing the success of this policy (Geller et al., 2016). Helms and colleagues also reiterated this point noting that given the interest in cessation among this population, assisted housing residents who are current smokers should be provided access to proven cessation resources and support (Helms et al., 2017).

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Appendices

Appendix 1: NCI Community Engagement Workgroup Founding Proposal

Workgroup Name: Community Engagement Workgroup

Workgroup Proposed Duration (Month, Year, Years): Years 1 -5 and as needed.

Workgroup Description: This workgroup is comprised of State and Community Tobacco Control (SCTC) grantees and their representatives, tobacco control partners and NCI staff who are committed to actively engaging community members in disseminating and implementing research findings throughout the initiative in ways that will expand and strengthen partnerships and the overall public health impact of the initiative.

Workgroup Purpose:

1) To broaden the group of partners involved in the SCTC to include others who can help actively disseminate research findings and ensure that results are being fully utilized to advance policies and media interventions that will reduce or eliminate tobacco use. This will include actively identifying and recruiting stakeholders who may currently be under-represented in the Research Projects (RPs). Examples include state and local health department staff, public health and tobacco prevention and control practitioners, voluntary health organizations, community foundations working in tobacco control, community members and other stakeholders working in states and communities not usually included in research projects. Community partners working in rural or poor regions of the country may be a priority group to engage given their important role in tobacco use and unique perspectives in reducing consumption.
2) To serve as facilitators or liaisons between community partners and scientific leaders on the RPs, particularly the collaborative developmental projects, and ensure that the perspective of public health practitioners and community members are included in efforts to disseminate findings in ways that will maximize the public health impact of the SCTC initiative.
3) To identify and promote partnerships between community stakeholders and RPs to ensure that community and practitioner partners' needs are incorporated into the research projects and collaborative developmental projects in ways that will enhance mutual credibility and maximize the potential for broad impact of the initiative.

Workgroup Measurable Outcomes:

- Increased membership in the Community Engagement Workgroup to include other tobacco control partners mentioned above.
- Cross-site collaborations (abstracts, manuscripts, projects) related to community engagement.
- Review and dissemination of key literature on community engagement efforts in public health.
- Identification and distribution of examples of successful community engagement efforts with other public health research interventions.
- Resources to improve and expand engaging community partners in the SCTC initiative.

Chair Name and Contact Information:

Bob Vollinger, NCI, TCRB

301-496-0275

Bob.Vollinger@nih.gov

Last updated: November 8, 2012.

Appendix 2: NCI Community Engagement Workgroup Roster as of July 30, 2018

Name	Organization
Kari Appler	Center for Tobacco Products, Food and Drug Administration
Peter Ashley	Office of Lead Hazard Control and Healthy Homes, HUD
Carla Berg	Rollins School of Public Health, Emory University
Dawn Berkowitz	Maryland Department of Health and Mental Hygiene
Dan Brooks	Boston University School of Public Health
Lucja Bundy	Rollins School of Public Health, Emory University
Dee Calhoun	SelfMade Health Network
Ralph Caraballo	Office on Smoking and Health, Centers for Disease Control and Prevention
Ginny Chadwick	University of Missouri and Preventing Tobacco Addiction Foundation
Frank Chaloupka	University of Illinois at Chicago
Stan Cowan	Missouri Tobacco Control Research Center
Johnetta Davis-Joyce	National Association fo County and City Health Officials (NACCHO)
Pebbles Fagan	Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences
Margaret Farrell	Implementation Science Team, DCCPS, National Cancer Institute
LeRoy Ferguson	Office of Public and Indian Housing, HUD
Alison Freeman	Retired, formerly EPA Office of Air and Radiation
Bronson Frick	Americans for Nonsmokers' Rights

Name	Organization
Alan Geller	Harvard T.H. Chan School of Public Health
Stan Glantz	Center for Tobacco Control Research and Education, University of California, San Francisco
Susan Marsiglia Gray	Maternal and Child Health Bureau, Health Resources and Services Administration
Regine Haardoerfer	Rollins School of Public Health, Emory University
Clark Hagen	Center for Substance Abuse Prevention, SAMHSA
Cynthia Hallett	Americans for Nonsmokers' Rights
Bonnie Halpern-Felsher	Stanford University
Patricia Henderson	Black Hills Center for American Indian Health
Amy Henes	RTI International
Sally Herndon	North Carolina Tobacco Prevention and Control Branch
Robin Hobart	ICF International with Oficce on Smoking and Health, Centers for Disease Control and Prevention
Annette Kaufman	Tobacco Control Research Branch, National Cancer Institute
Michelle Kegler	Rollins School of Public Health, Emory University
Dannielle Kelley	Tobacco Control Research Branch, National Cancer Institute
Fritz Laux	Northeastern State University
Scott Leischow	College of Health Solutions, Arizona State University
Joelle Lester	Tobacco Control Legal Consortium, William Mitchell College of Law
Pam Ling	School of Medicine, University of California, San Francisco
Doug Luke	Washington University in St. Louis

Name	Organization
Whitney Magendie	National Network of Public Health Institutes (NNPHI)
Maggie Mahoney	Office on Smoking and Health, Centers for Disease Control and Prevention
Erika Mansur	Arizona Attorney General's Office
Mark Meaney	Tobacco Control Legal Consortium, William Mitchell College of Law
Sarah Moreland-Russell	Washington University in St. Louis
Lexie Perreras	BLH Technologies, Inc.
Vaughn Rees	Harvard T.H. Chan School of Public Health
Meg Riordan	Campaign for Tobacco Free Kids
Megan Roberts	The Ohio State University
April Roeseler	California Tobacco Control Program, California Department of Public Health
Ashley Ross	Center for Tobacco Products, Food and Drug Administration
Carol Schmitt	RTI International
Randy Schwartz	Independent consultant (formerly at ACS)
Donna Shelley	New York University School of Medicine
Kara Skahen	Association for Nonsmokers-Minnesota
Sandy Slater	University of Illinois at Chicago
Karla Sneegas	Office on Smoking and Health, Centers for Disease Control and Prevention
Tracey Strader	Oklahoma Tobacco Research Center
Lorna Thorpe	New York University School of Medicine

Name	Organization
Jim Thrasher	University of South Carolina - Arnold School of Public Health
Michael Tynan	Office on Smoking and Health, Centers for Disease Control and Prevention
Bob Vollinger	Tobacco Control Research Branch, National Cancer Institute
Jennifer Wagner	Office of the Inspector General, Department of Health and Human Services
Nicholas Wellington	Department of Justice, State of California

Appendix 3: Interview Guide

Approved: 19Feb15 **IRB No.**: 00006258

Interview Guide for Multi-unit Housing Owners and Managers

Study Title: Assessing Attitudes and Beliefs regarding Developing and Implementing Policy to Reduce Secondhand Smoke in Multi-Unit Housing in Montgomery County, Maryland
Principal Investigator: Katherine Clegg Smith, Ph.D.

IRB No.: 6258

PI Version/Date: V1; February 5, 2015

Interviewee Guide

Thank you for speaking with me today. The questions I am going to ask do not have right or wrong answers. First, I will ask basic questions about the health effects of secondhand smoke (SHS), then about your awareness of SHS in your building and the economic implications of prohibiting smoking. Then I will ask about your attitude toward adopting a policy to prohibit all smoking in or around the building. Finally, I will ask for your suggestions regarding how to effectively and smoothly implement such a policy. I am planning to record these discussions so that I do not miss any key points you share.

Heath Effects of Secondhand Smoke

1. From what you know, what are the health effects of secondhand smoke exposure?
    a. Diseases?
    b. Respiratory issues?
2. What do you think are the consequences of low-level exposure to SHS?
    a. What are they?
    b. Has anyone in your building experienced these consequences?
3. How quickly do you think the health consequences occur, if there are health consequences?
    a. Have your residents ever been treated for a condition related to SHS exposure?
    b. Have your staff ever been treated for a condition related to SHS exposure?
4. What other consequences are you aware of from SHS exposure, besides health effects?
    a. Signs of smoke in the building such as cigarette butts, discoloration, carpet holes, etc.?
    b. Unpleasant odors?
    c. Additional cleaning costs?
    d. Effects on your personal belongings, e.g., clothes, furniture, window treatments, carpets, electronics, etc.?
    e. Impact on your insurance rates, e.g., health insurance, renters' or homeowners' insurance? Other?

Exposure to SHS in Building and Unit

1. Do you see any signs of smoking inside your building?
    a. What signs, e.g., cigarette butts, people smoking, lingering smoke?
    b. Where in the building?
    c. How often?
2. Are your staff exposed to secondhand smoke in or around the building?
    a. From someone smoking inside their unit?
    b. Outside the unit, but inside the building?
    c. How often, if ever, do you get complaints?
    d. Do you know how smoke may enter individual units?
        i. Through the HVAC system?
        ii. Under the door?
        iii. Through a window?
        iv. Through the walls, i.e., electrical outlets, cracks, etc.
        v. Through the ceiling?
        vi. Some other way?
    e. Do you (or your staff) experience the smoke? How?
        i. Smell it?
        ii. See it?
        iii. Effects on breathing?
        iv. Effects on property?
        v. Effect you or other household members?
3. Do residents complain about being exposed to secondhand smoke?
    a. Do you know where the smoke is coming from?
    b. Who the source is?
    c. Have you asked the person not to smoke?
    d. Had any other conversations with the resident or staff member about her/his smoking?
    e. Describe one or more scenarios where this has happened.
4. Describe the effect of smoke exposure on residents or staff.
    a. Have you done anything in the past to protect residents or staff from exposure to smoke in the building?
    b. Are there any policies that you have considered but not actually done yet?
    c. Do you have any plans to implement a policy about smoking in the building?

Attitudes about a Policy to Prohibit Smoking in the Building

Some places have adopted policies that prohibit all smoking inside the building or within a specific distance from entrances, windows or air intakes. Now we will consider the possibility of adopting a policy that would prohibit all smoking inside the building, including in individual living units, and within 25 feet of the building.

1. What do you think about such a policy?
2. What impact would this policy have on you?
3. How do you think such a policy would affect the residents of your building?
4. The staff (maintenance, front desk or others)?
5. Do you expect residents to be supportive of such a policy?
6. Do you expect staff to be supportive of such a policy?
7. Do you think that such a policy would have an impact on people's well-being?
8. What are the business implications of this policy?

9. Would you support such a policy? Why or why not?

Suggestions for Implementing a Clean Indoor Air Policy in Multi-unit Housing

If such a policy were adopted, it would most likely come with a phase-in time to allow people to adjust. This would allow some people time to quit smoking. Smoking cessation services and support would be made available to those smokers who want to quit. Or to move to other locations where the policy did not apply if they want to continue to smoke in their homes. It is important to note that the policy would prohibit smoking inside the building (or within 25 feet) but it would not prohibit smokers from living in the building. They could continue to smoke if they wished—just not inside the building.

1. What do you think it would be like to implement this policy in Montgomery County?
2. Do you know what proportion of adults smoke in Montgomery County?
3. What challenges to implementing such a policy do you envision?
4. What steps could be taken to overcome challenges in implementing this policy? Some possible issues to probe further, depending on responses:
    a. How could you implement this policy to minimize any potential hardship for your residents?
    b. Specifically for any smoking residents of the building?
    c. What would be an ideal phase-in time for this policy? Why?
    d. What steps can be taken to minimize the difficulty for smokers or others who live with smokers?
5. What would the advantages be of such a policy? Some optional topics to discuss, depending on responses:
    a. How would you benefit directly?
    b. The owner, or manager, of the building?
    c. Residents of the building?
    d. Staff in your building?
    e. Others in the community?
    f. The public at large?
    g. Health?
    h. Economic?
    i. Social?
    j. Other?
6. Would you support a policy to prohibit all smoking in or around your building?
7. What do you think other residents and staff might think of such a policy?
    a. Visitors?

Remind participants:

- Please maintain confidentiality of all that was said in this interview. Do not repeat any questions or comments that were spoken in this interview to anyone. You may share the general content of the discussion and the topics addressed, but do not repeat any individual comments that were shared.
- Do you have any questions for me?
- If you would like to be involved in the adoption or implementation of such a policy at a later time, please contact me separately.
- THANK YOU VERY MUCH for your participation!

Last updated: February 5, 2015.

Appendix 4: Focus Group Guide

Approved: 19Feb15 **IRB No.**: 00006258

Focus Group Guide for Multi-unit Housing Residents

Study Title: Assessing Attitudes and Beliefs regarding Developing and Implementing Policy to Reduce Secondhand Smoke in Multi-Unit Housing in Montgomery County, Maryland Principal

Investigator: Katherine Clegg Smith, Ph.D.
IRB No.: 6258

PI Version/Date: V1; February 5, 2015

Focus Group Guide

Thank you for speaking with me today. The questions I am going to ask do not have right or wrong answers. I will ask basic questions about the health effects of secondhand smoke (SHS), and about your exposure to SHS in your building and your home. I will also ask about your attitude toward adopting a policy to prohibit all smoking in or around the building, and I will ask for your suggestions regarding how to effectively and smoothly implement such a policy. Just as a reminder, I am planning to record these discussions so that I do not miss any key points you share.

Exposure to SHS in Building and Unit

1. Do you see any signs of smoking inside your building? (Where? How often?)
2. Are you exposed to secondhand smoke in your apartment?
    a. Do you know where it's coming from?
    b. How do you experience the smoke? (Optional follow-ups if needed:)
        i. Smell?
        ii. Sight?
        iii. Effects on breathing?
        iv. Effects on property?
        v. How does it affect you or other household members?
3. Do you think that people think it is acceptable to smoke in your building? (Are people bothered?)
    a. Do you or your neighbors talk about smoking or are you aware of any problems that smoking has caused within the building?
    b. Have the building managers or owners raised the issue with residents?

Effects of Secondhand Smoke

1. What do you think are the health effects of secondhand smoke exposure?
2. Do you think there are risks to low-levels of exposure to SHS?
3. How quickly do you think that the health consequences might show up for a person who has been exposed?
4. Are you aware of any other consequences of SHS exposure besides the health effects?

Attitudes about a Policy to Prohibit Smoking in the Building

Some places have adopted policies that prohibit all smoking inside the building or within a specific distance from entrances, windows or air intakes. Now we will consider the possibility of adopting a policy that would prohibit all smoking inside the building, including in individual living units, and within 25 feet of the building.

1. What do you think about such a policy? Why?
2. What impact would this policy have on you or your smoking habits?
3. Would you support such a policy? Why or why not?
4. How do you think your neighbors would react to such a policy? What reason(s) do you have for these views?
5. How do you think such a policy would affect the managers, owners or staff of your building? Do you expect them to support such a policy? Why or why not?

Suggestions for Implementing a Clean Indoor Air Policy in Multi-unit Housing

If such a policy were adopted, it would most likely come with a phase-in time to allow people to adjust. It would allow some people time to quit smoking if they wanted to. Smoking cessations services and support would be made available to those smokers who want to quit. Or to move to other locations where the policy did not apply if they want to continue to smoke in their homes. It is important to note that the policy would prohibit smoking inside the building (or within 25 feet) but it would not prohibit smokers from living in the building. They could continue to smoke if they wished—just not inside the building.

1. Do you think it would be difficult to implement this policy in Montgomery County? Why or why not?
2. Would this policy have a big impact in Montgomery County?
3. What challenges to implementing such a policy do you envision?
4. What steps could be taken to ensure smooth implementation?
    a. What could the landlord do to minimize any potential hardships?
    b. For smoking residents?
    c. What is the ideal phase-in time for this policy and why?
5. What are the advantages of such a policy? (Optional follow-ups if needed:)
    a. How would you benefit directly?
    b. Others?
6. Would you support a policy to prohibit all smoking in or around your building? Why or why not?
7. How do you think others would feel about such a policy?

Remind participants:

- Please maintain confidentiality of all that was said in this group. Do not repeat any questions or comments that were spoken in this group to anyone outside the group. You may share the general content of the discussion and the topics addressed, but do not repeat anything about who participated in the discussion, or any individual comments that you or others shared.
- Do you have any questions for me?
- If you would like to be involved in the adoption or implementation of such a policy at a later time, please contact me separately.
- THANK YOU VERY MUCH for your participation in this discussion!

Last updated: February 5, 2015.

Appendix 5: Codebook

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
1	Fresh air	Descriptions of how they want their homes to smell and feel.		
2.0	Source of exposure in unit	Sources of in home exposure to secondhand smoke (SHS). How residents and visitors experience infiltration of SHS in their homes.		
2.1	Exposure source	Vent location, window, balcony, under door, etc.		
2.2	Exposure in communal areas	Exposure in or around the building, outside an individual living area, e.g., pool, parking area, sidewalk or entrance way		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
2.3	Outside smoking area(s)	Designated smoking area outside the building 25 feet or more from entrances, air intake, or windows.		
3	Morality police	This term is used as a value statement by residents who do not want government intervention or to explain why they do not want others telling them what they can and cannot do in their own homes.	Replace w "government interference"? See also "no govt intervention", #9	
4.0	"No right to smoke"	Residents frequently used this term or something similar to indicate why they thought people should not be allowed to smoke in their homes.		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
4.1	"Right to smoke"	Residents discussing their right to smoke in their own home, or others' rights to do so.	Also would include references to "freedom" here.	
5	Desirability of non-smoking (NS) building	This term was used broadly to indicate why they wanted to live in a smokefree (SF) building, or why they thought the market preferred SF buildings over those that allow smoking. It includes issues from cleanliness and smell to faster sales of SF condos and higher selling prices.		
6.0	Health effects of SHS	A broad term to include any personal health effects of SHS either that participants experience themselves, or that they are aware affect others. This term includes reference to both personal knowledge or experience, research that participants were familiar with,	Frequency of exposure. This also includes comments indicating respondents not being aware of any SHS health effects.	

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
		or general knowledge they expressed without any specific references.		
6.1	Harms to others	This term reflects residents and managers concern about other neighbors or residents, including health effects of SHS, but also more generally their concern and compassion for risks to others.		
7	Property effects	Effects other than health resulting from exposure to SHS, including damaged carpet, furniture, artwork, clothing, etc. as well as the effect of property damaged by fires or smoke. Could also include reference to thirdhand smoke.		
8.0	Implementation	Discussion of suggestions for how to implement the policy and what their best recommendations		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
		are for implementation, including any specific suggestions they offered. Includes views from residents and managers.		
8.1	Transition, phase in period	How long should the county take to make a new policy effective?		
8.2	"Grandfathering"	Some say this is necessary for implementation. Others say will take too long and allow too much additional exposure and risk.		
8.3	Challenges to implementation	Any reference to how difficult it will be to implement such a policy.		
8.4	Consequence of policy	Any reference to something that is a result or consequence of implementing the policy.		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
8.5	Enforcement	Any issues related to enforcing the policy, either from manager or resident perspective.		
9	No government intervention	Some residents expressed concerns about the government being involved in their private lives and not wanting the government to tell them what they could do in their own homes, regardless of their views on consequences of exposure to SHS.		
10	Legal issues	Fear of being sued. Other considerations expressed, particularly by condo board officers, property managers or others in a potential position to be legally vulnerable.		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
11	Higher risk residents	Participants expressed concern for elderly, children, disabled people and others who they believe are at higher risk from SHSe.	Any references to "seniors" or senior housing or issues would be included.	
12	Increased knowledge	"must live in the present and the future" not in the past. Some expressed a desire to factor in knowledge that has been generated over the last several decades regarding the risk of SHS and that it does not make sense to continue policies that were developed when much less was known about the risks of SHS. (They talked about making decisions based on current knowledge, not what was commonly known (about SHS or tobacco use) many years ago. Particularly relevant w elderly residents.)		
13	Educate public	Many expressed a need for greater education as a first step to changing policy. This term refers to any mention of doing more		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
		education, need more education, etc. of building residents, neighbors, and the general public so people are more aware of the health risks of SHS and how quickly they are experienced, and how easily SHS moves within and around MUH buildings.		
14.0	Economic impacts	For building managers—addresses how a SF policy might save the building management money, and other consequences (besides health) of allowing smoking in their buildings.	Reference to maintenance fees, clean up, insurance costs, unit turnover costs, etc. Also includes economic impact for the county or broader community—beyond building residents, owners or managers.	
14.1	Economic impacts—managers	Any of the economic consequences of SHS influencing MUH, including for building owners and managers such as maintenance,		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
		enforcement, turnover, insurance.		
14.2	Economic impacts—residents and condo owners	For unit owners—specifically how residents experience the economic consequences of living in a building that allows smoking.		
15.0	Support for policy	Any response to questions or explicit indication that the respondent was supportive of a comprehensive SF MUH policy for MoCo.	This question code does not necessarily correspond to the person's views about their own building adopting a smokefree policy, or not.	
15.1	Opposition to policy	Any response to questions or explicit indication that the respondent opposed or was not supportive of a comprehensive SF MUH policy for MoCo.	This question code does not necessarily correspond to the person's views about their own building adopting a smokefree policy, or not.	

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
16.0	Lack of resistance--residents	Indicates some specific or explicit reference to the respondents' lack of opposition to a policy. Potentially distinct from "support" for a policy—just that they do not resist the adoption or implementation of a county policy.		
16.1	Lack of resistance--managers	Indicates some specific or explicit reference to the respondents' lack of opposition to a policy. Potentially distinct from "support" for a policy—just that they do not resist the adoption or implementation of a county policy.		
17	Risk of fires	And other physical or property damage that is caused by fires resulting from the use of cigarettes on site.		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
18	Affordable housing	Includes any reference to the type of housing and whether it is "affordable", "subsidized" or other reference to income status of the residents related to their housing status.		
19	Leases	Includes mentions of leases, lease violations, lease terms, etc.		
20	MoCo reputation	Any reference to the reputation of Montgomery County, or individual or community perceptions of the county, its residents, or stereotypes of the social, policy, or political environment of the county.	Makes no judgement about whether this "reputation" is accurate or fact-based, but rather is based on respondent's perceptions.	
21	Self-interest	Whether a respondent's comments reference his or her own self-interest, or whether they believe their comment refers to individual self-interest, rather		

No.	Mnemonic code/Title	Full description of code	When to use and when not to use the code.	Example of use of the code
		than the good of the community, neighbors, or others in the building or local environment.		
22	Respect for others	Any explicit reference to issues or comments the respondent attributes to his or her respect for others, or to neighbors or the broader community.		

Assessing Attitudes and Beliefs regarding Developing and Implementing Policy to Reduce Secondhand Smoke in Multi-Unit Housing in Montgomery County, Maryland

Research Questions:

Comparison of affordable and market-priced housing:

What differences in attitudes and beliefs are observed between residents and managers of affordable housing and market-priced housing in Montgomery County, Maryland regarding a policy to eliminate smoking in and around multi-unit housing in Montgomery County?

Observations regarding implementation of a comprehensive smokefree multi-unit (MUH) housing policy:

What steps can residents, owners and managers of multi-unit housing take to facilitate the effective implementation of a comprehensive smokefree MUH policy in Montgomery County? What steps can policymakers take to increase the likelihood of successfully implementing a comprehensive smokefree MUH policy in Montgomery County?

Study Aims:

Aim 1: To assess the beliefs and attitudes of residents of MUH regarding a policy to reduce secondhand smoke exposure (SHSe) by eliminating smoking in and around multi-unit housing in Montgomery County, and identify perceived barriers and facilitators to implementing such a policy.

Aim 2: To explore the beliefs and attitudes of owners and managers of MUH regarding a policy to reduce SHSe by eliminating smoking in and around multi-unit housing in Montgomery County, and to identify perceived barriers and opportunities related to implementing such a policy.

Version 4. Last revised: January 4, 2017

CURRICULUM VITAE

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EDUCATION:

2018 **Johns Hopkins Bloomberg School of Public Health, Department of Health, Behavior and Society.** Baltimore, Maryland. DrPH Candidate.

2008 **The Human Element® Program.** NCI, Office of Workforce Development, Shepherdstown, West Virginia. This leadership training program is internationally recognized as one of the most effective and complete self-mastery and team building programs available. The intensive 5-day seminar was designed to enable participants to experience increased self-awareness and self-esteem. The Human Element Program offers an integrated four-quadrant approach for building an exceptional organization. These quadrants include: personal meaning and integrity, surface behavior and interaction, interpersonal connection and trust, and systems and processes.

2007 **Johns Hopkins Bloomberg School of Public Health.** Washington, D.C. Health Policy and Management Winter Institute. "The Role of Non-Governmental and Community-Based Organizations in Improving Global Public Health".

2006 **Knowledge Management Mentoring Program.** NCI, Office of Workforce Development, Rockville, Maryland. This is a year-long structured facilitated mentoring program designed to meet the needs of NCI employees, at all levels, interested in tapping into the knowledge of established leaders and subject matter experts. This program allows participants to work closely with senior mentors and through tailored skill building sessions to establish career goals, develop and hone leadership skills, improve knowledge management and communication skills, understand and foster emotional intelligence, and enhance group processing skills to enable them to be outstanding team members and leaders in a wide variety of work settings. Developed year-long mentoring relationship with Mitchell R. Zeller.

2000 **Johns Hopkins Bloomberg School of Public Health.** Baltimore, Maryland. Graduate Summer Institute of Epidemiology and Biostatistics. "Epidemiology in Evidence-Based Research" and "Tobacco Control: National and International Approaches".

1996 **USDA Graduate School, Executive Potential Program.** Washington, D.C. This is a year-long management development program focusing on individual development, team building, negotiation skills, managing conflict and change, managing a culturally diverse workforce, leadership styles, reinvention processes, total quality management and effectively utilizing work teams.

1994 **Johns Hopkins Bloomberg School of Public Health.** Rockville, Maryland. Health Communications course "Persuasive Communication Theory and Practice".

1990 **U.S. Office of Personnel Management, Presidential Management Intern Program (PMI).** Washington, D.C. The PMI program is a two-year management training program that includes numerous rotational assignments in the following areas: budget and financial management; program and management analysis; procurements; grants; and legislative analysis.

1988 **University of North Carolina at Chapel Hill, Gillings School of Global Public Health.** Chapel Hill, North Carolina. Master of Science in Public Health. Department of Health Policy and Administration.

1985 **Duke University, Sanford School of Public Policy.** Durham, North Carolina. Bachelor of Arts in Public Policy Studies and Religion, with concentrations in health policy and ethics.

WORK HISTORY:

1996 - Present **National Cancer Institute**, National Institutes of Health, Department of Health and Human Services, Bethesda, Maryland. Public Health Advisor

and Program Director with the Tobacco Control Research Branch (TCRB), Division of Cancer Control and Population Sciences. Program Director for State and Community Tobacco Control Policy and Media Research. Previously the Program Director for the Tobacco Research Initiative for State and Community Interventions (TRISCI). That initiative was the largest tobacco control research initiative at NCI and supported research on innovative tobacco prevention and control interventions at the community, State, or multi state-level, particularly policy or media-based interventions. The results have guided tobacco control programs across the Nation to increase program effectiveness and produce real reductions in the prevalence of tobacco use. Currently leads a research initiative on U.S. Tobacco Control Policies to reduce health disparities, manages a large portfolio of other grants, leads a Community Engagement Workgroup, plans the National Conference on Tobacco Or Health, and participates on an Interagency Workgroup on Smokefree Multi-unit Housing.

Served as the co-Senior Scientific Editor of *National Cancer Institute Tobacco Control Monograph No. 16, ASSIST: Shaping the Future of Tobacco Prevention and Control*. Writes research concepts and requests for applications, guides them through an extensive review and clearance process, responds to inquiries from grantees and applicants, plans relevant meetings, produces grant reports, and represents NCI at numerous national tobacco control meetings. Leads policy and media research initiatives for TCRB, manages contracts, coordinates diffusion and dissemination efforts, assists in budget development and priority setting, serves as liaison to numerous national tobacco control organizations and as the NCI representative to National Tobacco Control Partner initiatives and meetings.

Project Officer for the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) Coordinating Center contract and managed numerous multi-million dollar contracts with State Health Departments, working closely with the American Cancer Society and other major voluntary health organizations. Provided technical assistance and training to State and local public health agencies, and prominent voluntary organizations regarding comprehensive tobacco prevention and control.

1996 **Center for Substance Abuse Prevention**, Substance Abuse and Mental Health Services Administration, U.S. Public Health Service, Department of Health and Human Services, Rockville, Maryland. See below. Successfully completed the Executive Potential Program, a year-long management development program focusing on individual development, team building, negotiation skills, managing conflict and change, managing a culturally diverse workforce, reinvention processes, total quality management and effectively utilizing work teams.

1995-1996 **Food and Drug Administration**, Office of the Commissioner, Department of Health and Human Services, Rockville, Maryland. Participated on a special team in the Office of the Commissioner preparing background work products and drafting final FDA regulations on restricting the sale and distribution of cigarettes and smokeless tobacco products to protect children and adolescents.

1992-1995 **Center for Substance Abuse Prevention**, Substance Abuse and Mental Health Services Administration, U.S. Public Health Service, Department of Health and Human Services, Rockville, Maryland. Public Health Advisor in the Public Education Branch of the Division of Public Education and Dissemination. Managed Communications Cooperative Agreement Program to demonstrate the effectiveness of communications strategies in reducing alcohol, tobacco and other drug (ATOD) problems and lead the work team to implement this program. Planned, developed, coordinated, implemented, and evaluated CSAP's communication initiatives, programs and campaigns.

1990-1992 **Office for Substance Abuse Prevention**, Alcohol, Drug Abuse, and Mental Health Administration, U.S. Public Health Service, Department of Health and Human Services, Rockville, Maryland. Health Policy Analyst in the Policy and Planning Branch of the Office of Budget, Policy and Evaluation.

1990 **United States Senate Committee on Labor and Human Resources**, Washington, DC. Served in the Health Office of the Committee Chairman, Senator Edward M. Kennedy, as a Health Policy Fellow and provided staff support to the Tobacco Product Education and Health Protection Act of 1990. Organized hearings on this legislation, recruited witnesses to testify, drafted statements for Senator Kennedy, prepared briefing materials, recruited Senate Co-sponsors for the legislation, and briefed Congressional staff on the legislation.

1989-1990 **National Cancer Institute**, Smoking, Tobacco and Cancer Program, U.S. Public Health Service, Department of Health and Human Services, Bethesda, Maryland. Helped prepare the ASSIST Request for Proposals and supporting documents for contracts to conduct comprehensive smoking prevention and control programs. Wrote background materials on policy and media interventions as a component of the *NCI Standards for Smoking Prevention and Control*, explored ways to effectively use media and mass marketing strategies for changing personal health behaviors, studied Federal procurement process and helped prepare justifications.

1989 **Office of the Surgeon General**, U.S. Public Health Service, Department of Health and Human Services, Rockville, Maryland. Conducted follow-up activities from the Surgeon General's Workshop on Drunk Driving,

including compiling and editing the *Proceedings* and *Background Papers*, planning and arranging press conferences and drafting and editing Congressional testimony for Dr. C. Everett Koop.

1988-1989 **Office for Substance Abuse Prevention**, Alcohol, Drug Abuse and Mental Health Administration, Department of Health and Human Services, Rockville, Maryland. Presidential Management Internship. Assignments with the Associate Director for Policy and Planning including budget formulation and with the Division of Prevention Implementation.

1987 **Office of Disease Prevention and Health Promotion**, U.S. Public Health Service, Department of Health and Human Services, Washington, DC.

1984 **National Highway Traffic Safety Administration**, U.S. Department of Transportation, Washington, DC. Analyzed various impaired driving prevention systems, including ignition interlock devices and assisted editor of special issue of *Health Education Quarterly* and edited manuscripts.

AREAS OF INTEREST:

- Tobacco control research, especially State and community policy, media-based and population-based interventions;
- Dissemination and implementation of public health research;
- Health policy research and practice;
- Health communications, social marketing, and knowledge transfer;
- Organizational development, team building, community organizing and social justice approaches to public health.

EDITORIAL BOARDS:

2017 - present **Associate Editor, *Tobacco Regulatory Science.***

1991-1993 **American Public Health Association (APHA)**, Co-Editor of the *Alcohol, Tobacco and Other Drugs Section Newsletter*.

COMMITTEES AND OTHER OFFICES:

2016 – present Interagency Smokefree Multi-Unit Housing Workgroup with HUD, CDC, NCI, EPA.

2012 - present Co-Chair then Chair of NCI Community Engagement Workgroup.

2006 -- 2010	Member of D.C. Tobacco Free Families 2006-2007 Campaign Steering Committee through the American Lung Association of the District of Columbia. 2008-2010 served as Chair of the Program Committee of D.C. Tobacco Free Coalition.
2006 -- 2007	Invited member of CDC Office on Smoking or Health's *Best Practices for Comprehensive Tobacco Control Programs—2007* Expert Panel.
2004 -- present	Active member of APHA since 1987 and served in numerous elected and volunteer leadership positions with the Alcohol, Tobacco and Other Drugs (ATOD) Section since its inception, including a 6-year term as the Section Chair, including Chair-Elect and Immediate Past Chair. Previously served several terms as Section Councilor and Governing Councilor. Currently beginning third term as elected Governing Councilor representing ATOD Section. Since 2016 also a member of APHA Environment Section.
2004 - present	NCI Health Communications Internship Program. Served as TCRB program liaison and mentor to numerous Health Communications Interns and Fellows, including several outstanding students from Johns Hopkins Bloomberg School of Public Health. Also mentored Presidential Management Fellows and Cancer Research Training Award Fellows.
2000 - 2003	National Advisory Committee for The Robert Wood Johnson Foundation's SmokeLess States: Statewide Tobacco Prevention and Control Initiatives Program.
1997 - 2000	Alumni Mentor for Masters students in Health Policy and Administration at UNC School of Public Health through the Health Policy and Administration Alumni Liaisons (HPALS) program. Participated in pilot project and served as mentor for several years.
1999	NCI DCCPS Web Steering Committee.
1998	NCI Quality Improvement Initiative Travel Committee.
1996-1998	Department of Health and Human Services delegate to the Japan America Leadership Exchange Committee, a bi-lateral exchange of civil servants from each of the cabinet level ministries in their respective national governments.
1993-1995	Co-Chair of the Resolutions Committee of the Alcohol, Tobacco and Other Drugs Section of APHA.

PROFESSIONAL SOCIETIES:

American Public Health Association, member, 1987 to present.

Society for Research on Nicotine and Tobacco, member, 1999 to present.

SELECTED HONORS AND AWARDS:

2016	**Johns Hopkins Bloomberg School of Public Health**, Center for Qualitative Studies in Health and Medicine Dissertation Enhancement Award.
2015 - 2016	**Johns Hopkins Bloomberg School of Public Health**, Department of Health, Behavior and Society, Doctoral Distinguished Research Award. $2,000 awarded to support thesis research.
2010	**Alcohol, Tobacco and Other Drugs Section Leadership Award** from APHA's ATOD Section.
2007	**NIH Group Award of Merit "**For outstanding leadership in translating science into practice by developing the NCI smoke-free meeting policy to help protect the public from secondhand smoke exposure" from NCI Director Dr. John Niederhuber.
2000 - present	Numerous **NCI On-The-Spot Awards** and **Incentive Awards** and **Performance Awards** for outstanding performance on key projects and sustained superior performance.
2000	**NCI On-The-Spot Award** for quickly learning the full range of Program Director responsibilities and resolving programmatic issues with a large RFA "Research in State and Community Tobacco Control Interventions" while handling "new responsibilities with professionalism and addressing issues in a timely manner."
2000	**NCI Sustained Superior Performance Award** "For sustained superior performance as project director for several ASSIST project site contracts, and Project Director for the State and Community RFA."
1999	**NCI On-The-Spot Award** "For outstanding work and dedicated effort in the successful transition of the ASSIST program to the Centers for Disease Control and Prevention at the end of FY99."

1999	**NCI On-The-Spot Award** for his participation in "The NCI Quality Improvement Initiative Working Group for Travel…and was a work group member confronting this formidable challenge, and its success was a direct result of his input and dedication to improving operations at the NCI."
1999	**NCI Recognition for Exemplary Performance** "For taking on and managing a substantial increase in workload during a co-worker's absence, including overall direction of the ASSIST program and related meetings and communications, additional state contracts, program director responsibilities for the State/Community RFA, and proactive participation in a variety of time-sensitive and important tobacco-related policy and program-related issues."
1998	**NCI Sustained Superior Performance Award** "For sustained superior performance as project director for several ASSIST site contracts."
1989 - 1998	**Outstanding Performance Awards** consistent throughout government career at the National Cancer Institute and the Center for Substance Abuse Prevention.
1997	**Secretary's Award for Distinguished Service** "For Outstanding performance in the development of regulations to protect the nation's children from cigarette smoking" from Department of Health and Human Services Secretary Donna E. Shalala.
1993	**Administrator's Award for Meritorious Achievement** "For sustained leadership in communicating about the prevention of alcohol, tobacco and other drug problems" from Substance Abuse and Mental Health Services Administration's Administrator Dr. Elaine M. Johnson.
1993	**Administrator's Award for Meritorious Achievement** "For superb performance and teamwork in the efficient operation of a highly responsive correspondence system, which is a model of quality and timeliness of control correspondence" from Substance Abuse and Mental Health Services Administration's Administrator Dr. Elaine M. Johnson.
1993	**Certificate of Appreciation from the American Public Health Association** "For outstanding service to the Alcohol, Tobacco and Other Drugs Section" from Dr. Kathryn Magruder and Dr. Lorraine Midanik.
1989	**The Surgeon General's Certificate of Appreciation** "In recognition of exceptional performance in the implementation of follow-up

activities related to the Surgeon General's Workshop on Drunk Driving" presented on June 29, 1989 by Dr. C. Everett Koop.

PEER-REVIEWED PUBLICATIONS:

Ginexi EM and **Vollinger RE Jr**. National Cancer Institute's leadership role in promoting state and community tobacco control research. *Tob Control*. 2016;25:i4-i5. doi:10.1136/tobaccocontrol-2016-053153.

Allem JP, Ayers JW, Unger JB, **Vollinger RE Jr**, Latkin C, Juon HS, Park HR, Paik HY, Hofstetter CR, Hovell MF. The Environment Modifies the Relationship Between Social Networks and Secondhand Smoke Exposure Among Korean Nonsmokers in Seoul and California. *Asia-Pacific Journal of Public Health.* (first published 2012) 2015, Vol. 27(2) NP437–NP447. doi:10.1177/1010539512459750.

Pebbles Fagan, Erik Augustson, Cathy L. Backinger, Mary E. O'Connell, **Robert E. Vollinger, Jr.,** Annette Kaufman, and James T. Gibson. Quit Attempts and Intention to Quit Cigarette Smoking Among Young Adults in the United States. Am J Public Health. 2007. doi:10.2105/AJPH.2006.103697. http://www.ajph.org/cgi/content/abstract/AJPH.2006.103697v1?papetoc

Motsinger BM and **Vollinger RE Jr** (Eds.) ASSIST: Shaping the Future of Tobacco Prevention and Control. Tobacco Control Monograph No. 16. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 05-5645, May 2005.

Vollinger RE Jr, Moon RW, Greenwald P. Historical Context. In: ASSIST: Shaping the Future of Tobacco Prevention and Control. Tobacco Control Monograph No. 16. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 05-5645, May 2005.

Moon RW, Havlicek D, Garcia JM, **Vollinger RE Jr**, Motsinger BM. The conceptual framework. In: ASSIST: Shaping the Future of Tobacco Prevention and Control. Tobacco Control Monograph No. 16. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 05-5645, May 2005.

Malek SH, **Vollinger RE Jr**, Babb S, Sneegas KS, Shopland DR. Public and Private Policy Interventions. In: ASSIST: Shaping the Future of Tobacco Prevention and Control. Tobacco Control Monograph No. 16. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 05-5645, May 2005.

Motsinger BM, **Vollinger RE Jr**, Niemeyer D. The Promise of ASSIST. In: ASSIST: Shaping the Future of Tobacco Prevention and Control. Tobacco Control Monograph No.

16. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 05-5645, May 2005.

Convissor RB, **Vollinger RE Jr**, Wilbur P. Using national news events to stimulate local awareness of public policy issues. Public Health Rep. 1990 May-Jun;105(3):257-60.

OTHER PUBLICATIONS:

Bob Vollinger "High Blood Pressure Screening Programs: The Most Bang for the Buck?" *FOCUS on Hypertension*, Atlanta: International Society on Hypertension in Blacks, 1989.

SELECTED PRESENTATIONS AT STATE, NATIONAL OR INTERNATIONAL CONFERENCES:

Society for Research on Nicotine and Tobacco Annual Conference, "Higher Risk Residents and Implementing a Smokefree Multi-Unit Housing Policy" Baltimore, Maryland, February 23, 2018.

State and Community Tobacco Control Research Initiative Steering Committee Webinar, "Peering into the Future and Engaging our Partners: Tobacco Policy Research at NCI to Inform State and Community Programs" July 14, 2017.

Maryland Tobacco Control Conference, "A Community Engagement Approach to Implementing Smokefree Multi-unit Housing Policies" Towson, Maryland, May 11, 2017.

CDC 2015 Kickoff Meeting: Retooling and Recommitting, "National Cancer Institute, Tobacco Control Research Branch Update: What's Research Done for Me Lately?" Atlanta, Georgia, August 19, 2015.

13th National Synar Workshop, "Collaborating with Diverse Partners: A Community Engagement Approach to Disseminate and Implement Tobacco Control Research to Improve the Public's Health" Rockville, Maryland, May 7, 2014.

Centers of Excellence in Cancer Communication Research Grantee Meeting, "NIH NCI Funding Mechanisms and Grant Writing Tips" Philadelphia, Pennsylvania, April 30, 2010.

The University of Oklahoma Health Sciences Center, College of Public Health Grand Rounds, "NCI's Tobacco Control Research Agenda: Where Science Meets Practice to Improve the Public's Health" Oklahoma City, Oklahoma, February 16, 2010.

APHA 137th Annual Meeting, "FDA Regulation of Tobacco Products: What it Means for Policy, Practice and Research" Session Organizer and Moderator, with Mitch Zeller, Robin Appleberry, Douglas Blanke, Karla S. Sneegas, K. Michael Cummings, Lawrence R. Deyton, Joshua M. Sharfstein, Philadelphia, Pennsylvania, November 9, 2009.

DC Tobacco Free Families Annual Conference, "Tobacco Control in Our Nation's Capitol: HOPE for Our Future by Building on the Evidence & Our Past Success" Washington, DC, September 15, 2009.

Tobacco Research Network on Disparities Meeting (TReND) Meeting, "State and Community Tobacco Control Policy and Media Research" Bethesda, Maryland, June 16, 2009.

National Conference on Tobacco Or Health Closing Plenary, Moderator, Phoenix, Arizona, June 12, 2009.

National Conference on Tobacco Or Health, "Motivating Underserved Smokers to take Action: An Evidence-based Approach" with Debra Annand, Phoenix, Arizona, June 11, 2009.

10th National Synar Workshop, *Raising the Bar: Integrating Youth Access into Comprehensive Tobacco Control*, Keynote Address "Tobacco Control Research Highlights and Funding Opportunities" Phoenix, Arizona, June 8, 2009.

Society for Prevention Research Annual Conference, "Global Tobacco Control Symposium" Discussant, Washington, DC, May 28, 2009.

World Conference on Tobacco Or Health, Poster: "Implementing the U.S. National Cancer Institute Smoke-free Meeting Policy" with Michele Bloch, Sarah Evans, Mary O'Connell, Mumbai, India, March 10, 2009.

National Tobacco Control Partners Meeting, "NCI Smoke-Free Meeting Policy" Atlanta, Georgia, December 3, 2008.

George Washington University School of Public Health and Health Services Guest Lecture, "Tobacco Control Policy Advocacy" Washington, DC, November 10, 2008.

APHA 136th Annual Meeting, "State and Local Regulation of Tobacco Products: Lessons Learned from NCI Research" San Diego, California, October 27, 2008.

Society for Research on Nicotine and Tobacco, Europe, "NCI Smoke-Free Meeting Policy" Rome, Italy, September 24, 2008.

Society for Prevention Research Annual Conference "Tobacco Control Research Priorities at the National Cancer Institute" San Francisco, California, May 29, 2008.

APHA 135th Annual Meeting, "Clean Air Policies Sweep the Nation Improving Public Health Every Step of the Way!" Moderator, Washington DC, November 6, 2007.

APHA 135th Annual Meeting, "Generating Science to Drive Comprehensive Tobacco Regulatory Policy: Creating the Research Blueprint" Moderator, Washington, DC, November 5, 2007.

National Conference on Tobacco Or Health Closing Plenary, Moderator, Minneapolis, Minnesota, October 26, 2007.

Best of the West: Educating, Training and Collaborating on Tobacco Control Regional Conference, Plenary Address: "National Recommendations for State and Local Tobacco Control and Future Possibilities" Phoenix, Arizona, September 5, 2007.

Arizona Cancer Center Behavioral Oncology Seminar "NCI's Tobacco Control Research Agenda: Where Science Meets Practice to Improve the Public's Health" Tucson, Arizona, September 4, 2007.

APHA 134th Annual Meeting, "Building the Evidence Base for Tobacco Control Policy: The Interventions in the Era of the Framework Convention on Tobacco Control and Beyond: The International Tobacco Control Policy Evaluation Project" Moderator, Boston, Massachusetts, November 7, 2006.

APHA 134th Annual Meeting, "NIH State-of-the-Science on Tobacco Control Policies: The Real Deal" Boston, Massachusetts, November 6, 2006.

Oklahoma Tobacco Settlement Endowment Trust Research Study Group Meeting, "Tobacco Control Research Funding: Maximizing the Public Health Impact" Oklahoma City, Oklahoma, September 5, 2006.

APHA 133rd Annual Meeting, "What Do Alcohol, Tobacco, Other Drugs, Physical Inactivity, and Mental Health Disorders Have in Common?" Moderator, Philadelphia, Pennsylvania, December 12, 2005.

Society for Research on Nicotine and Tobacco, Poster, "ASSIST Results: A Comprehensive Tobacco Control Demonstration Program Based on Policy and Media Interventions" with Brenda Motsinger, Frances Stillman. Prague, Czech Republic, March 23, 2005.

Society for Research on Nicotine and Tobacco, "Evaluating Tobacco Control Policies of the Framework Convention on Tobacco Control: Findings from the International Tobacco Control Policy Evaluation Project Symposium" Symposium Chair, with Gerard Hastings, Ron Borland, David Hammond, K. Michael Cummings, Geoffrey T. Fong, Derek Yach. Prague, Czech Republic, March 22, 2005.

Virginia Youth Tobacco Project Research Conference, "Tobacco Control Research Priorities at the National Cancer Institute" Richmond, Virginia, March 24, 2004.

National Tobacco Control Partners Meeting, "Funding Opportunities in Tobacco Control: Current Research in Tobacco-Related Disparities" Atlanta, Georgia, July 14-15, 2003.

National Conference on Tobacco Or Health, "ASSIST: Shifting the Paradigm for Tobacco Control in the U.S.: A Policy and Media Approach with Results" with Jerie Jordan, Phil Wilbur, Sally Malek, Jane Pritzl, Fran Stillman, Richard Peck, and Brenda Motsinger. San Francisco, California, November 20, 2002.

National Conference on Tobacco Or Health, "Translating Research to Practice: Creating Collaboration Between Researchers, Public Health Practitioners and Private Enterprise" San Francisco, California, November 19, 2002.

APHA 130th Annual Meeting, "NCI's State and Community Tobacco Control Interventions Research" Philadelphia, Pennsylvania, November 12, 2002.

APHA 129th Annual Meeting, "NCI's State and Community Tobacco Control Interventions Research" Atlanta, Georgia, October 22, 2001.

Center for Disease Control and Prevention, Office on Smoking and Health's Tobacco Use Prevention Training Institute, Denver, Colorado, September 18-19, 2000. Presented on NCI's tobacco control research agenda and budget planning for State programs in the "Creativity in Leadership: Managing State and Local Programs" class.

Robert Wood Johnson Foundation SmokeLess States Annual Meeting, "Building Bridges Between Research and Application" Honolulu, HI, May 26, 2000. Presented on NCI's "Research in State and Community Tobacco Control Interventions" RFA and the implications for the future of tobacco control and types of research that would be most useful to educate the public and policy makers on the need for policy interventions.

U.S. Environmental Protection Agency Annual Conference of Regional Staff on Indoor Environments Issues, Presentation on NCI's tobacco control research agenda and the role

on national partners in establishing successful comprehensive tobacco control programs. Alexandria, Virginia, March 21, 2000.

ASSIST Celebration at the National Conference on Tobacco and Health, Historical successes of the ASSIST program, highlighted accomplishments of State and local staff, and their role in advancing a national tobacco control agenda, Orlando, Florida, August 24, 1999.

Center for Disease Control and Prevention, Office on Smoking and Health's Tobacco Use Prevention Training Institute, NCI's tobacco control research agenda and evaluating state programs in the "Creativity in Leadership: Managing State and Local Programs" class. Atlanta, Georgia, July 26, 1999.

Maine Statewide Tobacco Control Conference, Keynote speech on national tobacco control activities and progress in the ASSIST project. Orono, Maine, June 15, 1999.

The Fourth National Synar Technical Assistance Workshop, "The Next Step: A Sustainable Youth Tobacco Control Program" At this national conference sponsored by the Center for Substance Abuse Prevention, provided an overview of the ASSIST program, its highlights and effectiveness, as well as a briefing on NCI's research initiatives on State and Community Tobacco Control Interventions. Arlington, Virginia, March 30, 1999.

ASSIST Coordinating Committee Meeting, Present NCI's research initiatives on State and Community Tobacco Control Interventions that will follow up on ASSIST to the major policy making board of the ASSIST Program. Bethesda, Maryland, March 19, 1999.

ASSIST Annual Information Exchange, "ASSIST Success: A Foundation for the Future" Provide closing plenary remarks at the national ASSIST information exchange training sponsored by the National Cancer Institute. Bethesda, Maryland, March 17, 1999.

The 2nd European Conference on Tobacco or Health, "Capacity Building for Tobacco Use Prevention: The Success of the ASSIST Model" Poster session on the success of community-based tobacco control interventions at this European and Ibero-American Conference. Las Palmas de Gran Canaria, February 23-27, 1999.

ASSIST Scientific Advisory Committee Meeting, Overview of major ASSIST intervention activities including progress report on State activities, an update on the investigation by the DHHS Inspector General, an update on lobbying restrictions, progress on youth access issues with the Synar Amendment and FDA enforcement efforts, and a briefing on Attorneys General law suits. Rockville, Maryland, February 11, 1998.

ASSIST Orientation at the National Conference on Tobacco and Health, "Highlights of the ASSIST Project: Goals, Infrastructure and Successes" Houston, Texas, September 21, 1997.

National Partners State Technical Assistance Meeting, "Overview and Progress Report on ASSIST and NCI Tobacco Control Activities" Atlanta, Georgia, July 29, 1997.

Robert Wood Johnson Foundation SmokeLess States Program Annual Meeting, "Future Directions of the ASSIST Project at the National Cancer Institute" Portland, Oregon, April 9, 1997.

National Dental Tobacco-Free Steering Committee Meeting, "Annual Progress Report on State and local tobacco control activities in the ASSIST Project" Bethesda, Maryland, July 28, 1997.

ASSIST Scientific Advisory Committee Meeting, "A Current Progress Report on State and local tobacco control activities in the ASSIST Project" Rockville, Maryland, January 13, 1997.

USDA Graduate School Executive Management Training Seminar, "Total Quality Management and the Effectiveness of Self-Directed Work Teams" a national Executive Potential Program final group presentation with Jim Barrett, Laurie Hermies, Gerain Perry, Margaret Litteras, et. al. Williamsburg, VA, December 1995.

U.S. Center for Substance Abuse Prevention's/Prevention, Intervention, Treatment Coalition for Health Funding Workshop, San Diego, California, December 13, 1994. "CSAP's Knowledge Dissemination Conference Grant Program and Division of Public Education and Dissemination activities."

National Cancer Institute's ASSIST Coordinating Committee Meeting, Review of the U.S. Center for Substance Abuse Prevention's tobacco control activities with Barbara Anderson Kosogof. Washington, D.C., May 14, 1993.

Interagency Committee on Smoking or Health, The Synar Amendment and the Substance Abuse and Mental Health Services Administration's Tobacco Control Activities chaired by Surgeon General Antonia Novello. Washington, DC, December 1992.

Regional Alcohol and Drug Awareness Resource Network Conference, U.S. Office for Substance Abuse Prevention's Conference Grant Program, Plenary Session. Kansas City, Missouri, July 1991.

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