
Tobacco Use and Homelessness

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Smoking disproportionately affects the economically disadvantaged and the uneducated in America. In fact, people living below the poverty line are both more likely to smoke and less likely to quit than wealthier Americans (Healton and Nelson, 2004). Because of these discrepancies, tobacco control needs to be approached not simply as a health problem, but also as a social justice issue. Although the prevalence of smoking is more than three times higher among the homeless than in the general population, very few service providers offer adequate programs to reduce tobacco use. Tobacco advocates defend smoking as a matter of personal choice, but many addicts cannot simply choose to quit. Homeless people encounter unique barriers to quitting, even though many people wish to stop smoking. Tobacco use needs to be addressed much more strongly by homeless service providers in order to mitigate the consequences of smoking for such a vulnerable population.

PREVALENCE

Between 70% and 80% of homeless adults in the United States smoke tobacco (Lee et al., 2005; Szerlip and Szerlip, 2002). By comparison, only 19.8% of adults in the general population are smokers (World Health Organization, 2008). According to a study by the World Bank, tobacco use is responsible for up to half of the discrepancy in mortality between adult males in the highest and lowest socioeconomic groups (Healton and Nelson, 2004). In one study of homeless smokers, participants smoked an average of 18.3 cigarettes per day (Okuyemi et al., 2006). Rates of smoking are also very high in the mentally ill population. Since 26% of homeless people have mental illnesses, this subgroup may be particularly at risk (Apollonio and Malone, 2005). Although many homeless service providers have insufficient tobacco prevention, education, and cessation programs, the National Survey on Tobacco Prevention at Homeless Service Providers found that 85% of organizations considered tobacco an important issue to address with their clients (National Coalition for the Homeless, 2007).

RELATIONSHIP TO HOMELESSNESS

The reasons that homeless people begin smoking or continue to smoke are complex and deep-seated. Although some people start smoking while living on the streets or in homeless shelters, the majority of homeless smokers picked up the habit before losing their housing. Okuyemi et al. (2006) found that most homeless smokers were exposed to smoking by family members at an early age or began smoking as a result of peer pressure. Some began while in jail, in the military, or in a substance abuse treatment program. Other people sought the buzz effect of smoking as a replacement or addition to drug and alcohol use. Due to lack of money to pay for cigarettes, many homeless people use alternative smoking behaviors such as borrowing, sharing, and selling cigarettes; purchasing single cigarettes; and “sniping” (searching for partially-smoked cigarettes on the ground or in ashtrays). Many people also switched to cheap or generic cigarettes or smoked other types of tobacco (Okuyemi et al., 2006). Most people continued to smoke because of nicotine addiction and cited alcohol and drug use as behavioral triggers for smoking.

Others enjoyed the social interaction offered by smoking. Many homeless people also continued to smoke as a way to reduce stress and boredom and to cope with depression and other mental illnesses. However, research shows that tobacco use and nicotine addictions actually increase anxiety and exacerbate existing mental health conditions (Apollonio and Malone, 2005). Finally, some homeless smokers said that being able to obtain cigarettes gave them a sense of hope and self-worth (Okuyemi et al., 2006).

In addition to these factors, homeless people are directly targeted by tobacco companies, placing them at higher risk of developing nicotine addictions (Apollonio and Malone, 2005). Once information became available about the health effects of smoking, better educated, wealthier people were the most likely to quit. The tobacco industry identified a need to market to “downscale” customers in order to increase their sales (Apollonio and Malone, 2005; Heaton and Nelson, 2004). The homeless population was specifically targeted starting in the 1990s; it is unclear whether this targeting continues today. Their methods included distributing free cigarette samples to shelters and homeless service organizations and distributing blankets with cigarette brand logos to homeless people. Tobacco companies also developed relationships with homeless service organizations through charitable contributions, service work, and marketing targeted at service workers (Apollonio and Malone, 2005). This often results in positive media coverage of the tobacco industry and lenient smoking regulations in shelters. On many occasions, the tobacco industry has given homeless organizations financial support, only to later seek political support.

Furthermore, current shelter policies are often indulgent and not aimed to reduce tobacco use. Only 40.8% of homeless service organizations that participated in the National Survey on Tobacco Prevention at Homeless Service Providers offer programs to help people stop using tobacco, and only 27.2% provide nicotine replacement therapies (NRTs) for those who are attempting to quit (National Coalition for the Homeless, 2007). Many shelter employees wrongly believe that quitting tobacco would simply increase their clients’ suffering, and will buy cigarettes for clients or solicit cigarette donations from tobacco companies (Apollonio and Malone, 2005). Although many shelters do regulate smoking inside, they often do not place limits on smoking directly outside the building. In a 2005 survey of LA shelters, 75% had an indoor “no smoking” policy and 78% had designated smoking areas (Arangua et al., 2007). However, research has found that some homeless people would prefer completely smoke-free shelters (Apollonio and Malone, 2005).

The health effects of smoking are even more detrimental for homeless people than for the general public, which makes the increased prevalence of tobacco use extremely alarming. Studies have found that tobacco use is the single largest preventable cause of death in the United States (Heaton and Nelson, 2004). Many homeless people already suffer from medical conditions as a result of exposure to the cold, poor nutrition and hygiene, and risky behaviors. Smoking exacerbates many of these conditions, and most homeless people do not have health insurance to cover their care. Additionally, homeless people are more likely to smoke discarded cigarette butts or used filters or to share cigarettes in order to save money. These behaviors put them at greater risk for infectious diseases, cancer, respiratory illness, and cardiovascular disease (Okuyemi et al., 2006).

Many homeless people are more concerned about short-term effects such as shortness of breath or recurrent bronchitis than serious long-term consequences (Okuyemi et al., 2006). Regardless, health is one of numerous issues that motivate homeless people to quit smoking. In fact, Okuyemi et al. (2006) found that 76% of homeless people interviewed intended to quit smoking within the next 6 months. Besides health consequences, the most common reasons for wanting to quit are personal appearance and presentation (similar to non-homeless smokers) and lack of ability to pay for health care. Other reasons

include the effects of second-hand smoke on children or others around them, the price of cigarettes, and the concern that smoking could revive previous substance abuse problems.

Although the majority of homeless smokers interviewed had high motivation to quit, many did not believe that they were capable of doing so (Okuyemi et al., 2006). Many people have trouble quitting because they are unable to pay for treatment. The experience of being homeless creates many other, unique barriers to smoking cessation. Instead of spending their time at work or participating in scheduled activities, many homeless people have unstructured days and often encounter boredom and temptation to smoke. The stress of trying to find a job and a place to stay also make it hard to quit smoking; people often have to focus on their immediate survival needs instead of smoking cessation. Because smoking is so socially acceptable in homeless settings, many people do not receive support for quitting from their peers and service providers. Few shelters restrict smoking outside the facilities, so people staying in shelters have easy access. Finally, many people fear that quitting smoking would have strong emotional impacts and could disrupt relationships or trigger a relapse to previous substance abuse habits. However, research shows that quitting smoking does not compromise people's ability to quit other substances (Okuyemi et al., 2006).

POLICY ISSUES

Tobacco control advocates need to make the homeless a priority in order to reduce smoking and mitigate the harmful effects of tobacco within such a vulnerable population. To begin with, they should challenge the attitude common among service providers that homeless people have too many stressors to quit smoking and offer incentives for homeless service providers to decline support from tobacco companies. Additionally, tobacco control advocates should form partnerships with homeless service providers and should present educational programs about tobacco use in shelters (Apollonio and Malone, 2005). Smoking restrictions at shelters and soup kitchens and funding for smoking cessation programs specifically for the homeless would help reduce tobacco use. Many homeless providers offer treatment for drug and alcohol addictions, but not for smoking; however, tobacco-specific programs must be created (Okuyemi et al., 2006). Enforcing a smoke-free environment may be more difficult in large shelters and shelters without pre-existing substance abuse treatment programs (Arangua et al., 2007). However, 66.1% of organizations surveyed in the National Survey on Tobacco Prevention at Homeless Service Providers expressed interest in training for staff to help clients quit smoking (National Coalition for the Homeless, 2007).

In 1998, 46 states and the tobacco industry signed the Master Settlement Agreement (MSA), which provides states with funding for tobacco control and treatment. In past years, however, states have only used approximately 5% of these funds for the intended purpose (Healton and Nelson, 2004). The money has already been allocated; states simply need to begin using the funds to pay for smoking cessation programs. Many states prefer to intervene by raising taxes on cigarettes. Despite decreasing cigarette consumption, however, this is not the best method. Many people with nicotine addictions will not quit smoking even if the price increases, but the habit will be an even larger financial burden. Smoking cessation programs are a better approach to tobacco control (Healton and Nelson, 2004).

Smoking cessation programs should include behavioral treatments as well as nicotine replacement therapy (NRT) or medication (such as bupropion). Furthermore, the behavioral interventions should involve both individual and group components. Individual interventions provide personalized attention, but many people surveyed were afraid that counselors would not be able to relate to homeless people. On the other hand, group interventions allow people to share a common experience and gain helpful insight from

others, but may lead to competition and lack of privacy (Okuyemi et al., 2006). Unfortunately, many physicians are not adequately prepared to help their patients quit smoking (Healton and Nelson, 2004). To combat this, smoking cessation must be a standard component of physicians' training.

Many factors must be considered in order for a homeless smoking cessation program to succeed. Most importantly, programs must be flexible and account for the unique needs of homeless people. For example, most people surveyed were interested in trying NRT or bupropion, but were worried about taste, convenience, the risk of losing their supply, side effects, and the possibility of becoming addicted to the treatment itself. Many people were also concerned about effects of NRT on pre-existing health conditions and interactions with prescription medications. These concerns must be addressed by treatment providers, and participants should be educated about treatment options and allowed to decide for themselves which to use. Additionally, many people surveyed were concerned about keeping scheduled treatment appointments. To combat this obstacle, meetings should be weekly, at the same time and place, and last an hour at most (Okuyemi et al., 2006). Finally, smoking cessation programs should be culturally tailored to the population they serve, even to subgroups within the homeless (Healton and Nelson, 2004).

Partnering with case managers, existing programs, and transitional shelters may increase retention. Also, incentives such as cash or vouchers for food, transportation, or entertainment would motivate individuals to continue with the program and attend meetings, especially if there was a substantial incentive for completing the program and an award or certificate of achievement at the end of the program (Okuyemi et al., 2006). Finally, alcohol, drug, and tobacco rehabilitation programs are more effective when administered in a "supportive, stable environment", which implies that long-term transitional housing would be an ideal setting for a tobacco intervention program for the homeless (Arangua et al., 2007). Although these cessation programs may be costly, they save the government money in the long run by eliminating the medical costs associated with treating tobacco-related disease (Healton and Nelson, 2004).

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