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Tobacco Use among Homeless People — Addressing the Neglected Addiction

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Although the prevalence of smoking in the United States has declined, vulnerable and marginalized groups continue to use tobacco at high rates. One such group is the 2.3 to 3.5 million people nationwide who are homeless in any given year. Approximately three quarters of homeless adults are cigarette smokers[1] — a prevalence 4 times that in the U.S. adult population and 2.5 times that among impoverished Americans in general. The coexisting psychiatric and addictive conditions and life circumstances of homeless smokers have long fueled a fatalistic attitude among health care professionals toward addressing tobacco use in this population. We believe that this approach should change.

Smoking-related deaths among homeless and marginally housed people occur at double the rate seen among more stably housed people and account for a considerable fraction of the absolute mortality disparities between these groups.[2] In our study of more than 28,000 adults seen at the Boston Health Care for the Homeless Program in 2003 through 2008, cancer was the second-leading cause of death overall and the leading killer among adults 45 years of age or older. Malignant neoplasms of the trachea, bronchus, and lung caused more than one third of these deaths, a finding that underscores the excess burden of lung-cancer mortality in this population that has been documented elsewhere.[2] Studies have also shown higher rates of death due to circulatory and respiratory diseases among homeless people than among people with homes.

A number of factors create challenges for reducing tobacco use and its consequences in this population. Homeless smokers have a high burden of nicotine dependence, psychiatric symptoms, and coexisting substance-use disorders.[3] They are more likely than homeless nonsmokers to have experienced physical or sexual trauma.[1] Many homeless people lack health insurance and a usual source of care, which limits their access to smoking-cessation therapies.

The circumstances of homelessness add to these barriers. Whereas most homeless shelters no longer permit smoking indoors, smoking around shelters is com-

monplace and contributes to a culture of tobacco use that makes quitting more difficult and relapse more likely. The psychological stress of fulfilling survival needs, the physical hazards of daily living, and the attendant expectation of premature death diminish the perceived benefits of smoking cessation in this population. Indeed, homeless people may view smoking as one of the few life domains over which they have control. Tobacco use thus becomes an expression of autonomy in the face of desperation and a source of comfort in the midst of chaos.

Some providers of services for homeless people have reinforced smoking as the norm among their clients. In a 1992 letter, the director of a homeless shelter for women and children requested cigarette donations from R.J. Reynolds Tobacco Company, stating that cigarettes would be a comfort to clients and that this would not be an appropriate time for them to quit smoking.[4] A 2010 survey of a national network of clinicians who work with homeless persons found more progressive attitudes toward addressing tobacco use, but these attitudes varied by clinical discipline.[5] In addition, 15% of respondents reported having given patients tobacco to build trust or promote adherence, and one third knew of colleagues who had done so.[5]

The tobacco industry has cultivated and capitalized on the culture of smoking among homeless people. In 1995, R.J. Reynolds launched Project SCUM, a "Sub-Culture Urban Marketing" plan targeting vulnerable groups in the San Francisco area, including "street people" in the Tenderloin.[4] Tobacco-industry documents also reveal these companies' efforts at building a consumer base in the homeless community through the distribution of branded blankets to homeless people, volunteerism at homeless service sites, and the provision of cigarettes to homeless shelters.[4]

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Despite the common expectation that homeless smokers may not consider cessation a priority, evidence suggests that many are interested in quitting.[3] However, confidence in the ability to quit is low,[3] and few succeed in quitting,[1] which indicates that interventions to support smoking cessation are needed in this population. Few such interventions have been scientifically tested. Most have involved combinations of multisession psychosocial counseling and pharmacotherapy — and have had modest results in comparison with the cessation rates achieved in the general population. Consequently, more research is needed to clarify the optimal intervention strategy for homeless smokers. We believe that addressing this complex issue will require intervention strategies at multiple levels (see table).

At the individual level, tobacco-cessation interventions should be tailored to the unique characteristics of homeless smokers while incorporating evidence from related populations, such as smokers with mental illness and substance-use disorders. Interventions should be delivered at or near shelters and drop-in facilities to enhance participation and lessen the burden of competing life priorities. The daily stressors of homelessness foster a present-oriented outlook that values immediacy over delay. Overcoming the immediate rewards of smoking will require intervention strategies that emphasize the short-term benefits of quitting, such as fewer smoking-related symptoms and saving money from not buying tobacco. Contingent monetary rewards for quitting might bolster this approach and have shown promise in other vulnerable groups of smokers. Adding pharmacotherapy to relieve nicotine withdrawal symptoms would complement these behavioral strategies.

For homeless smokers who are unable or unwilling to quit, we suggest consideration of pharmacotherapy and counseling to reduce cigarette consumption. Although there is limited evidence supporting this approach, it acknowledges the challenges faced by this population and may facilitate future quit attempts.

At the interpersonal level, smoking is a ubiquitous social phenomenon among homeless people that is strongly influenced by peer interactions. Homeless smokers with greater social support for quitting report greater readiness to quit,[3] a finding that suggests that group-oriented or peer-based strategies may hold promise.

Challenges and Opportunities in Addressing Tobacco Use among Homeless People.

Challenges	Opportunities
Individual level	
High level of nicotine dependence	Pair pharmacotherapy with behavioral counseling
High prevalence of psychiatric and substance-use disorders	Bundle cessation services with other behavioral health treatments
Immediacy valued more than delay	Emphasize immediate symptomatic and financial benefits of cessation
Competing life priorities	Locate interventions at or near shelters and drop-in centers
Interpersonal level	
Ubiquitous social reinforcers of smoking, little support for quitting	Develop group and peer-based cessation interventions
Health care delivery level	
Ambivalence about addressing tobacco use	Routinely screen for tobacco use
Mixed messages about relative importance of smoking cessation	Present consistent antismoking message during clinical encounters
Giving out cigarettes to build rapport or promote adherence to care	Use alternative methods for engagement
Shelter level	
Variable policies regarding permitting smoking	Adopt and enforce smoke-free policies
Client reluctance to accept smoking restrictions	Offer nicotine-replacement therapy to help compliance with smoking bans
Pervasive culture of tobacco use	Partner with shelters to develop educational messaging for clients and staff
Policy level	
Use of alternative tobacco products	Broaden excise taxes to include all tobacco products
Inadequate funding of cessation resources	Direct excise-tax revenues toward cessation programs for impoverished smokers
Limited access to health care and tobacco treatment	Expand health insurance, ensure coverage of comprehensive tobacco treatment

At the health care delivery level, screening and brief interventions for tobacco use are guideline-supported measures that should be part of a comprehensive care model for homeless patients. Multidisciplinary teams who work with this population should convey a clear and consistent antismoking message. Although giving tobacco to patients may stem from well-intentioned efforts to forge a treatment alliance, this practice should be avoided in favor of alternative strategies for building rapport.

At the shelter level, smoke-free policies are imperative but should be coupled with efforts to assess their unintended consequences, including determining whether smoking restrictions may prompt some homeless smokers to avoid shelters and sleep outside. Making nicotine-replacement therapy available at shelters for overnight craving relief might enhance the acceptability of these measures and promote interest in quitting. Shelters are also a potential target for educational messaging to change the culture of tobacco use among clients and the staff who serve them.

At the policy level, our experience suggests that homeless smokers reduce their cigarette consumption when tobacco excise taxes increase. However, we have witnessed a concomitant increase in the use of more affordable cigarette-like cigars and other alternative tobacco products, which are often taxed at lower rates. Taxing all tobacco products similarly may mitigate this problem, and the revenue should be directed toward cessation programming for impoverished smokers. Health insurance expansion and coverage of comprehensive tobacco treatment might further reduce the barriers to quitting.

Underlying all these strategies is the need to change the culture of complacency that has enabled our acceptance of smoking as an inextricable aspect of homelessness. Though the challenges of addressing tobacco use in this population are many, we believe that ignoring this issue is no longer justifiable — and that the conversation should shift away from the question of *whether* to address smoking among homeless people and toward the question of *how*.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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The FDA's Graphic Tobacco Warnings and the First Amendment

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In the past, constitutional principle gave the government broad authority to regulate tobacco or pharmaceutical advertising. The state's power to safeguard the public health was strong, and companies' freedom to plug their products was weak.

But the Supreme Court has changed course. Whereas it once did not view "commercial" speech as the kind of speech the First Amendment protects, it now gives businesses nearly the same rights to market their goods as it does individuals to speak their minds. And as the Court has broadened corporate freedom to advertise, it has narrowed governmental power to preserve the public's health. Whereas the Court once gave the government more leeway when invoking its interests in public health than when asserting other state interests, it now tends to hold health-related rules to the same constitutional standards as other types of rules.[1]

As a result, government today is much more susceptible to challenge when it tries to regulate the promotional activities of the tobacco or pharmaceutical industry. In 2011, the Supreme Court rejected Vermont's effort to restrict the use of prescription data by drug companies' sales representatives.[2] And last year, the U.S. Court of Appeals for the D.C. Circuit vetoed the new graphic warnings for cigarette packages that had been issued by the Food and Drug Administration (FDA).[3] The Supreme Court's increasing sympathy for corporate speech and decreasing deference to public health authorities makes it more difficult for government to protect the public's health. The fate of the graphic cigarette warnings is illustrative.

Congress authorized the graphic warnings when it passed the Family Smoking Prevention and Tobacco Control Act in 2009. The Act requires the use of nine new textual warnings for cigarette packages and directs the Department of Health and Human Services to select color graphics to accompany the warnings. The images have to depict the "negative health consequences" of smoking, with text and graphic taking up the top halves of each pack's front and back panels.

In June 2011, the FDA unveiled the nine images, including some that were quite explicit. One image showed a man smoking through a tracheostomy (see image). Another showed the corpse of a man with staples in his chest on an autopsy table. Several tobacco companies promptly sued, alleging that the graphic-warning requirements violated their First Amendment rights. The companies prevailed in both the district court and the D.C. Circuit.

In one sense, the result was not surprising, given the Supreme Court's increased sympathy toward corporations and their First Amendment rights. Regulations of commercial speech often succumb to judicial scrutiny.

However, there was good reason to think that the D.C. Circuit would uphold the graphic warnings. Even as the Supreme Court has narrowed the power of government to regulate corporate speech, it has preserved an important authority to regulate. The graphic warnings seemed to fall within that authority.

The preserved authority reflects the distinction the Supreme Court makes between the regulation of corporate speech that informs and the regulation of corporate speech that misinforms. On the one hand, the Court usually objects when the government tries to block truthful speech by businesses. In the prescription-data case, the Vermont law would have restricted the free flow of information about physicians' prescribing practices. On the other hand, the Court typically approves when the government tries