UNDERSERVED & OVERLOOKED
Tobacco Addiction Among the Homeless Population
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Introduction

The public health community is committed to addressing issues of health equity and social justice that often impact marginalized populations. Few examples of health disparities are more compelling than the stunning prevalence of tobacco-related illness and death in the world of the homeless. Tobacco use among the homeless population is at a crisis stage: between 60 and 80 percent of people who are homeless use tobacco products. In addition to wrestling with a host of economic, systemic, and logistical barriers, many homeless individuals suffer from physical, psychological, and substance use challenges exacerbated by their nicotine addiction. To a large extent and for a variety of reasons, the rate of tobacco use among the homeless population has remained discouragingly and disproportionately high, even while the prevalence of smoking in other segments of the population has declined. This policy brief explores the challenges and barriers in addressing tobacco use among homeless individuals, as well as a few promising tobacco control policies and cessation interventions that the public health community, shelters, and other providers and organizations that serve the homeless could consider for this vulnerable population.
Background

Each year over 2 million people experience homelessness in the United States. What constitutes “homelessness” is not as straightforward as it would seem. The phrase itself suggests a homogeneity that “belies the remarkable diversity of this population.” Homeless people “range from those who have spent their entire lives in poverty to those with advanced degrees and once-successful careers cut short by mental illness, addiction, personal tragedy, or bad luck.” They include veterans, runaway youth, domestic abuse victims, substance users and individuals with a host of behavioral health issues, whose lives have been sidelined by unemployment, skyrocketing housing costs, disabilities, and countless other mishaps.

Who are the “Homeless”?

Federal agencies use different “official” definitions of homelessness. These definitions affect how different programs determine eligibility for individuals and families. For example, according to the U.S. Department of Health and Human Services, a homeless individual lacks housing (regardless of whether the individual is a member of a family), and may include someone whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, or an individual who resides in transitional housing. A homeless individual without permanent housing may live on the streets; stay in a shelter, mission, single room occupancy facility, abandoned building or vehicle; or reside in any other unstable or non-permanent situation. The Health Resources and Services Administration also considers an individual to be homeless if that person is “doubled up,” which refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends or extended family members (sometimes called “coach surfing”). Moreover, previously homeless individuals about to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return.

On the other hand, programs funded by the Department of Housing and Urban Development have a less expansive definition of homelessness. These programs comply with the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009, which defines “homelessness” as:

- Individuals and families who do not have a fixed, regular and adequate night time residence, including those who live in emergency shelters or places not meant for human habitation;
- Individuals and families at imminent risk of losing their main nighttime residence;
- Unaccompanied youth and families with children and youth who meet other federal definitions of homelessness;
• Individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual violence, stalking, or other dangerous or life-threatening conditions.8

Experts often use different typologies to describe this population, distinguishing (for example) among individuals who are “chronically homeless” (e.g., hard core unemployed often suffering from disabilities and substance use); “episodically homeless” (often experiencing intermittent medical, mental health and substance use problems and cycling in and out of institutions and homelessness); or “transitionally homeless” (typically entering the shelter system for only a short time due to a major event or unforeseen situation).9 This is just one of many ways to categorize what is an extremely fluid and disparate population.10 Regardless of the source or typology, each of these definitions describes individuals whose living arrangements are unstable and uncertain. The range of definitions reflects the heterogeneity of this population — a broad diversity that presents challenges in developing targeted cessation interventions.

Demographics

The transient lifestyle of homeless individuals also makes it challenging to get a clear demographic breakdown of the number of homeless individuals in the U.S. Numbers vary significantly depending on whether a measurement is taken on a single night or is extrapolated to a given year. Estimates of the number of U.S. homeless individuals range from approximately 565,000 on any given night11 to 2.3 to 3.5 million in any given year.12 More than one in five homeless people live in New York City or Los Angeles alone, although many live in smaller communities around the country.13 Despite a recent decrease in overall unsheltered homelessness nationally, only 18 states recently reported decreases in the number of people living in unsheltered locations, including the street, cars, and abandoned buildings.14 In 2014-15, for example, the homeless population in New York City increased by 11 percent and in Los Angeles by 20 percent.15 These cities, and many other communities across the U.S., are struggling in light of the widespread housing affordability crisis, budget shortages, the removal of institutional supports for people with severe mental illness, and related challenges.16 As a result, the number of homeless individuals in the U.S. continues to have a major impact on our social, environmental, economic, and community services.

In addition, the adverse health of homeless individuals has a significant financial effect on our clinical and public health systems. Compared with the general U.S. population, homeless individuals are three to six times more likely to become ill and their hospitalization rates are four times higher.17 Approximately 37 percent of the estimated 1.6 million homeless individuals living in shelters have a disability, compared with 25 percent of those in poverty and 15.3 percent of the general population.18 Moreover, as chronicled below, homeless adults are particularly
susceptible to chronic illnesses and are frequently wrestling with behavioral health issues and substance use disorders, along with risky lifestyle situations. Tobacco use is often just one of many addictive behaviors in their lives, but one with the most deadly consequences.

Common Providers

States and local communities across the U.S. respond to the many challenges facing the homeless with a variety of housing and services programs. Service providers that work most directly with the homeless population include day shelters/rescue missions, emergency homeless shelters, halfway housing, permanent affordable housing, residential drug and alcohol rehab programs, supportive housing, shared housing, transitional housing, and rooming houses or board houses. These providers commonly have funding and resource challenges and vary in the way they are organized or administered — all of which affects their capacity and may have implications for their ability to provide tobacco cessation services.
### Common Providers

<table>
<thead>
<tr>
<th>Type of Housing</th>
<th>Overview</th>
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</thead>
<tbody>
<tr>
<td>Day shelters/rescue missions</td>
<td>Provide housing in the daytime hours, generally providing showers, toilets, soup kitchens, telephone banks, and often case management.</td>
</tr>
<tr>
<td>Emergency homeless shelters</td>
<td>Typically overnight short-term relief housing, where individuals are only permitted to stay for 3 months or less.</td>
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<tr>
<td>Halfway housing</td>
<td>Helps transition individuals from homelessness or shelters to permanent housing, with a stay of roughly 6 months to 2 years.</td>
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<tr>
<td>Permanent affordable housing</td>
<td>Long-term solution for housing, where residents generally pay a small percentage of their income toward rent.</td>
</tr>
<tr>
<td>Residential drug and alcohol rehab programs</td>
<td>Residential programs intended to treat alcohol and drug dependency; costs and treatment methods range widely.</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>Provides living arrangements for those unable to live independently without care, supervision and/or support to help them in the activities of daily living or for those who need access to case management, housing support, vocational, employment and other services to transition to independent living.</td>
</tr>
<tr>
<td>Shared housing</td>
<td>Option for low income families, disabled persons and others wanting companionship.</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>Affordable supportive housing that also provides appropriate services such as substance abuse treatment, psychological assistance, job training, domestic violence assistance.</td>
</tr>
<tr>
<td>Rooming houses or board houses</td>
<td>Buildings (such as converted single family homes, converted hotels, or purpose built structures) where renters occupy single rooms and share kitchens, bathrooms, and common areas.</td>
</tr>
</tbody>
</table>
Tobacco Use Among The Homeless

Tobacco Use Health Effects

The prevalence of smoking among the homeless population is roughly 4 times that of the general U.S. population and 2.5 times that among impoverished Americans. At least 70 percent of unaccompanied homeless youth smoke cigarettes, a rate several times higher than the national average for adolescents and young adults. It is hardly surprising then that tobacco-related chronic diseases are among the leading causes of morbidity and mortality among homeless persons. Cancer and cardiovascular disease are the primary killers of homeless individuals and obstructive lung disease is more than twice as high in those experiencing homelessness as in the general population. Homeless individuals also suffer higher rates of death due to circulatory and respiratory diseases than domiciled individuals.

In addition, homeless individuals are susceptible to a range of chronic and infectious diseases and common health concerns, including HIV, diabetes, hepatitis C, and tuberculosis — conditions that are often exacerbated by tobacco use. These health conditions often require long-term, consistent care, and not receiving this care can lead to dangerous situations and more costly treatment than for persons with ready access to health care and insurance.

Many homeless individuals also suffer from medical conditions as a result of long-term exposure to weather extremes, poor nutrition and hygiene, disease agents, overcrowding, sleep deprivation, violence, limited access to health services — as well as risky behaviors, including nicotine addiction. As a result, homeless adults are two to five times more likely to die prematurely than nonsmoking adults and their average life expectancy is estimated to be 12 years less than the general U.S. population (66.5 vs. 78.8 years).

Related Health Implications

The way in which the homeless smokers often use tobacco also has other deleterious health effects. Given their limited income and the high cost of cigarettes and other tobacco products, many of these individuals use tobacco in unconventional ways that increase the likelihood of ingesting infectious agents and toxins trapped in filters and tobacco remains. One study that examined the prevalence of high-risk smoking behaviors in a Los Angeles homeless population reported that sharing cigarettes with strangers (86%), smoking cigarettes remade from discarded cigarette butts (71%), and smoking discarded cigarette butts (63%) were the most commonly used alternative smoking behaviors. This last practice, called “sniping,” involves...
digging around in the trash or searching the ground for discarded cigarette butts or filters with enough unsmoked tobacco in them to warrant the time it takes to find, unravel and re-roll them.

Other high-risk behaviors include bartering and smoking cigarettes remade by others, blocking filter vents, and using unsafe and unsanitary ingredients other than tobacco in remaking cigarettes. As a result, smokers engaging in many these practices often suffer from gum disease, such as gingivitis and periodontitis. Untreated, these conditions can lead to pain, tooth loss and other health problems. Among people over age 65, only 20 percent of nonsmokers are toothless, while over 41 percent of daily smokers are toothless.

Barriers and Challenges

Individual Challenges

Homeless individuals often face clinical, psycho-social and logistical challenges that make them particularly susceptible to tobacco use and complicate treatment of tobacco dependency.

Behavioral Health & Substance Use Disorders

Approximately 20 to 30 percent of homeless adults have a serious mental illness and roughly 30 to 50 percent either have substance use or dual mental illness and substance use disorders. Members of the behavioral health population are not only two to four times more likely to smoke, but have lower rates of quit attempts and higher rates of relapses than the general population.

Smoking often plays a central role in social interactions and the use of other substances by this population. For example, some homeless individuals smoke in combination with alcohol or illicit drugs or as a way to achieve a nicotine buzz or substance high. Unfortunately, traumatic brain injury, learning disabilities, co-existing psychiatric and addiction conditions, and the harsh living situations of many homeless individuals complicate tobacco dependency treatment and have led many health professionals to prioritize other clinical conditions and behaviors over the treatment of tobacco addiction among this population.

Stress and Related Issues

In addition to a host of medical challenges, many of these people are struggling with hunger, the stress of needing to find shelter and feed themselves and their families, and little or no access to medical care or social support networks. Crowded living conditions and lack of privacy...
and security compound problems, and medications to manage health conditions may be stolen, lost, or compromised due to rain, heat, or other factors.

Smoking is often seen as a way to cope with the stress, boredom and tension of living in survival mode day after day. This stress cannot be overestimated. For instance, homeless individuals may find themselves unable to get a job due to cognitive deficiencies, illiteracy, or limited skills or education; an existing criminal record; or a precarious immigration status. They may be displaced because of changes in the housing market, eviction, foreclosure, bankruptcy, divorce, or natural disaster. They also may be struggling with past physical or emotional trauma, sexual or domestic abuse, post-traumatic stress syndrome — any number of complex life circumstances. Given these many stressors and the social reinforcement provided by tobacco use, homeless smokers not only smoke more heavily but typically begin smoking earlier in life than the general population. One expert in homelessness describes tobacco use by these individuals as “an expression of autonomy in the face of desperation and a source of comfort in the midst of chaos.”

Susceptibility to Tobacco Marketing

Individuals with behavioral health or chemical dependency issues that impair judgment may be particularly susceptible to marketing that portrays cigarettes as a method to reduce stress. The tobacco industry has a long history of targeting vulnerable and marginalized individuals, including those who are homeless and suffering from mental illness. Tobacco companies distributed free cigarette samples to shelters and homeless service organizations, gave blankets with cigarette brand logos to homeless people, and used their relationships with, and contributions to, homeless service providers to further their political goals. As one infamous example, R. J. Reynolds launched its so-called Project SCUM (SubCulture Urban Marketing) campaign in 1995, which focused on selling Camel cigarettes to marginalized groups in the San Francisco Bay area, including “street people” in the Tenderloin District.

In addition, although the tobacco industry uses price discounts and point-of-sale strategies to target all consumers, certain populations — including low-income individuals — are particularly susceptible to these tactics. Tobacco product discounts such as multi-pack offers, coupons, and buy-one-get-one-free offers target price-sensitive individuals. Moreover, low-income predominantly minority neighborhoods often have more tobacco retailers and advertising than other neighborhoods. Many homeless shelters are located in urban areas where corner convenience stores, gas stations, and other retailers that sell tobacco products are hard to avoid.

Despite all these challenges, studies have found that a majority of homeless smokers insist they want to quit using tobacco products. For example, in a survey of 236 homeless adults at nine homeless service sites, researchers found a smoking prevalence of 69 percent; and of
these smokers, 72 percent attempted to quit at least once and 37 percent reported readiness to quit smoking within the next six months.45 Their motivation to take such a preventive health measure is significant, particularly in light of their other pressing needs. Nevertheless, even though many try repeatedly to quit, their success rates are lower than in the general population.46 The critical ongoing public health challenge is to identify the most effective ways to help members of the homeless population address their nicotine addiction.

Provider Challenges

Shelters, half-way houses, and other housing providers face a host of challenges in addressing tobacco use among the homeless, as do health care and behavioral health providers and other social service organizations working with this population.

Lack of Resources & Expertise

Homeless service providers are perennially short of funds for bare necessities, let alone funding for trained tobacco addiction counselors, cessation programs, or nicotine reduction therapy products and pharmaceutical support. Some providers are simply not set up to provide on-site cessation service or support, and may not be reimbursed sufficiently to cover the cost of these interventions. Homeless individuals usually have limited or no insurance.

In addition to monetary constraints, at least one study of homeless shelters flagged a concern of administrators about the need for additional resources to “police” compliance with a tobacco-free policy and to develop strategies for addressing violations of smoking restrictions.47 For instance, determining whether violations should result in ejection from a shelter led to disagreements among staff and clients. Administrators also flagged constraints on staff time and lack of appropriate expertise to offer smoking cessation support as significant barriers to addressing tobacco dependence in shelters.48

Logistical Issues

Moreover this is a transient population that may not have cell phones for scheduling appointments or accessing quitlines, or the ability to travel to tobacco treatment counseling sessions. For example, in one study of smoking cessation interventions for homeless individuals, clients needed to wait in long lines to see a clinic physician and then take a shuttle to a pharmacy to fill their smoking cessation medication prescriptions — barriers that reduced the interest of many individuals in obtaining the medications.49 In addition, even if individuals procure nicotine replacement therapy (NRT) products, many of them need long-term treatment, therapy or some type of regular follow-up, which is often difficult given their displaced and itinerant life styles.
Smoking Culture

Studies have also shown that the culture of tobacco use in homeless shelters creates environments that often make it difficult for smokers to quit tobacco use.\textsuperscript{50} A large number of staff in these facilities smoke, which can pose a significant obstacle, not only in the implementation of smoke-free policies, but in the overall attitude toward cessation.\textsuperscript{51} According to one study, homeless smokers in shelters can be routinely exposed to over 40 smokers per day.\textsuperscript{52} Research on barriers to smoking cessation among the homeless has found that the “ubiquity and acceptance of smoking in homeless settings,”\textsuperscript{53} the “permissive attitude” toward smoking in shelters,\textsuperscript{54} and the “social goads and other cues”\textsuperscript{55} of smoking in the shelter environment, can be directly related to the high rate of tobacco use among shelter staff. For instance, a recent study of homeless shelters in San Diego found that lack of knowledge among staff about nicotine addiction, negative staff attitudes toward the smoke-free policy, and staff smoking posed significant barriers to establishing a smoke-free culture in the shelters.\textsuperscript{56}

Competing Needs

In addition to this culture of tolerance, a triage mentality continues to exist where many health care and social service providers who work with homeless individuals view the treatment of nicotine addiction as less a priority than the need to address other urgent clinical, behavioral health, and substance use issues.\textsuperscript{57} Moreover, some providers and homeless individuals still believe that tobacco cessation treatment could dangerously interfere with other medical treatments or could jeopardize or compromise recovery or stability.\textsuperscript{58} In fact, smoking can complicate the treatment of patients with mental illness.\textsuperscript{59} Data suggest that smoking cessation can help reduce mood/anxiety disorders and depression.\textsuperscript{60} Also, research has found that standard smoking cessation interventions — such as individual and/or group therapy, nicotine replacement therapy, bupropion — generally work as well in behavioral health populations as in the general population.\textsuperscript{61} Despite this, mental health providers, aware of the high social and biological predispositions to smoking in this population, have traditionally been lenient about tobacco use by their patients, often mistakenly assuming their patients were uninterested in quitting.\textsuperscript{62}

Researcher Challenges

Limited Targeted Research

Although a few researchers have begun to explore the issue of tobacco use among homeless individuals, traditionally this population has not been included in studies or state data collection and surveillance systems.\textsuperscript{63} Nor is it often included in funding opportunities to address to-
bacco use offered by federal agencies or other public or private funders. Moreover, the homeless population is made up of many different subgroups, including the mentally ill, substance users, youth, families with children, and veterans, creating challenges for targeted research. As a result, only a handful of studies to date have evaluated the efficacy of smoking cessation interventions in homeless smokers, and of these studies most had small samples (e.g., 10 to 58 participants) and quit rates were discouraging. Research needs to be done on innovative and effective cessation approaches for specific target groups, since the incentives to use tobacco and motivations to quit vary, particularly among these distinct populations.

Recruitment Difficulties

One reason researchers struggle to identify effective interventions for the homeless population is the lack of reliable tobacco use prevalence data. Also, studies are limited because of the difficulty in recruiting and retaining smokers when the subjects have no permanent address, are often difficult to reach, and may be suffering from mental illness, cognitive impairment, or substance abuse. Many potential participants are screened out for a variety of other reasons, such as suicide ideation or their unwillingness to use nicotine replacement therapy.

Another challenge in recruiting subjects for these studies is the prevalence of alcohol abuse/dependence among homeless adults, which varies across study samples, but has been reported as high as 86 percent. It can be hard to recruit smokers who are also co-dependent on alcohol, particularly when they are struggling with limited forms of available communication and transportation. Coincidentally, the prevalence of cigarette smoking among alcohol-dependent persons is nearly 80 percent, more than three times the smoking rate of the general population. As a result, one promising intervention being studied is the integration of smoking cessation with alcohol abuse treatment for homeless smokers.

Promising Policies & Intervention Options

Tobacco-free Environment

Adopting and effectively implementing and enforcing comprehensive (i.e., indoor and outdoor premises) tobacco-free policies in shelters and other transitional housing helps denormalize smoking in this setting and reduce continued exposure to secondhand smoke, but such policies are not enough. Most homeless shelters are smoke-free indoors, but restrictions vary regarding smoking on the outdoor grounds or in close proximity to the facility. Although some shelters prohibit smoking on the entire grounds, others permit smoking within a certain distance of the entrances or exits (for example, 20 to 25 feet). Compliance also varies within the shelters.
Organizational Readiness, Planning & Commitment

Before implementing a tobacco-free policy, administrators and staff should assess the organization's readiness to change and, as much as possible, engage the community and service providers in discussions about the rationale for the policy and the implementation and enforcement process.71

Equitable Enforcement

Smoke- and tobacco-free environments denormalize smoking and promote cessation. Providers should ensure that all staff and residents comply with tobacco-free policies and that
the policies are enforced fairly and consistently. Personnel policies should prohibit staff from smoking with residents or providing residents with tobacco products. Penalties for violating a shelter’s tobacco policy should be sufficiently severe to discourage attempts at circumvention by other residents, including staff. Shelters should make every effort to prevent the use and trafficking of tobacco contraband by visitors.

Staff Involvement & Training

To help defeat the cultural norm of smoking in shelters and to achieve buy-in throughout the organization, administrators and staff need to be trained on the health impact of tobacco use and the many benefits of quitting. Front-line shelter staff — employees who work most directly with residents, who are generally responsible for policy enforcement, and who often smoke themselves — have an opportunity to build rapport and trust among the residents. It is critical that they model the behavior they are promoting.

Tobacco Cessation Resources & Services

In addition to ensuring that a tobacco-free culture is the norm, shelters should consider ways to integrate health care and related social services with tobacco cessation resources and referrals, and tailor services and approaches as much as possible to subgroups within the homeless populations (e.g., adults, young adults, veterans, substance users, and those suffering from behavior health challenges). Some smoking cessation programs have specifically targeted homeless smokers: on-site smoking cessation services; smoking cessation counseling using cognitive behavioral therapy; providers offering integrated cessation services; accessible and tailored tobacco dependence treatment programs; nurse-led smoking cessation programs; intensive counseling with pharmacotherapy; and smoking cessation interventions integrated with alcohol and drug treatment.72

State and local health departments should consider partnering with homeless service providers and other community agencies to provide funding for free or reduced-cost NRT products and work with state quitline service providers on programs specifically focused on homeless persons.73 If at all possible, shelters should make tobacco dependence information, referrals and resources available to staff and residents, along with quitline information and nicotine replacement therapy products. Making nicotine replacement resources available in shelters may help reduce cravings at night in smoke-free settings. Another way to integrate cessation services into daily shelter life might be to offer cessation classes in the evening.
Several recent studies have highlighted cessation treatment approaches for different subgroups of homeless smokers. Homeless vets, for example, can be referred to Veterans Administration facilities where they have access to tobacco cessation treatment, including evidence-based products and counseling. Cessation preferences vary by individual. Many homeless individuals prefer short one-on-one counseling sessions; others prefer cessation intervention practices that combine motivational interviewing and counseling with pharmacotherapy. Yet other individuals express concern about losing or having their NRT products stolen or misplaced while they are living in transit.

Health care providers serving homeless patients should be prepared to address concerns they may have about their treatment options. Providers serving patients with behavioral health issues might want to consider, in particular, the patient’s coping skills and stress level; the timing of tobacco dependency treatment; the choice among various therapies and counseling; and the most effective NRT products for an individual on psychiatric medication. Because tobacco interacts with many antipsychotic, antidepressant, anxiolytic and mood stabilizer medications, providers need to monitor cessation efforts carefully and adjust medication levels regularly as an individual quits tobacco use.

Peer-Driven Models

Peer interventions, which are now common in behavioral health, are also beginning to be used for tobacco cessation in shelters. In addition to involving staff who were former smokers, shelters could consider retaining formerly homeless clients and advocates to work at the shelter as peer advisors. By focusing on ways to obtain tobacco policy buy-in and compliance by shelter staff and on methods to engage staff in supporting and promoting tobacco cessation, shelters can address one of the most challenging obstacles to reducing tobacco use among the homeless: the engrained tobacco culture in shelters.

Finally, shelter, social service, and health care staff all need to keep in mind that many individuals experiencing homelessness may mistrust health care, behavioral health, or social service systems due to past negative experiences, cognitive impairment, behavioral health concerns, or other reasons. At a minimum, staff should understand how to communicate clearly the positive health effects (on both users and those exposed to secondhand smoke) and the financial benefits of quitting tobacco use.
Leveraging Outreach Opportunities

Communities, working in tandem with housing, social services, health care and other providers, local partners, and faith organizations, provide tobacco cessation services to the homeless population in a variety of ways. For example, some state and local organizations target tobacco addiction in the homeless population by:

- Providing tobacco dependency treatment information in food distribution packages in homeless facilities
- Holding events where services are made available at a convention center (e.g., free haircuts, free HIV/AIDS testing, free housing resources, free primary/behavioral health care and referrals, free dental services, free tobacco cessation assistance)
- Offering weekly free lunches in community halls or other public areas (including churches or other faith-based locations), where cessation education efforts and referrals are provided, along with free health care services
- Providing free low-dose computed tomography (CT) lung screenings and follow-up cessation information at events targeted for low-income and homeless individuals

Engaging Homeless Clients in Studies

A few recent studies have explored ways to engage homeless individuals in tobacco cessation trials and interventions. Methods used to recruit homeless individuals in tobacco cessation studies include the provision of monetary and nonmonetary incentives that meet participant needs, such as hygiene kits, transportation costs (bus tokens or metro cards), gift or debit cards or cash vouchers for food and clothing. One Minneapolis study, for instance, showed the value in setting up flexible visit schedules at convenient locations that could be completed within a 20-week window. Incentives were designed to meet participant needs, such as personal care items (e.g., a water bottle or a T-shirt), a calendar/planner to record visit times, and transportation costs to the site. At the final visit, participants received a Visa gift card and a sweatshirt. Researchers obtained multiple forms of contact information from each participant, set up interviews as informal conversations, and made every effort to show participants that their time was valued and appreciated, and their input respected.
Offering Intervention Strategies at Different Levels

Although housing providers are often in the front lines in addressing the problem of nicotine addiction among the homeless, this is not a problem that providers can address without the support and collaboration of the stakeholders in the community. Social service workers, case workers, primary, behavioral health and addiction experts, and state and local policymakers, all need to work together to address nicotine addiction among the homeless at different levels and through different means and agencies.86

<table>
<thead>
<tr>
<th>Level</th>
<th>Intervention Strategies</th>
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<tbody>
<tr>
<td>Individual</td>
<td>Nicotine reduction therapy products and behavioral counseling.</td>
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<tr>
<td>Interpersonal</td>
<td>Group and peer-based cessation interventions.</td>
</tr>
<tr>
<td>Health care delivery</td>
<td>Consistent smoke-free messages during clinical encounters; cross-training of health care providers to deliver integrated tobacco cessation, substance use, and behavioral health care.87</td>
</tr>
<tr>
<td>Shelter</td>
<td>Tobacco-free settings; education messaging, training, resources and referrals for clients and staff.</td>
</tr>
<tr>
<td>Policy</td>
<td>Health insurance that covers comprehensive tobacco cessation treatment and products; evidence-based tobacco control policies at the state and local levels, such as pricing policies that make tobacco less affordable; restrictive point-of-sale policies that help prevent initiation and encourage people to quit; effective package warning labels and counter-tobacco advertising to warn about the dangers of tobacco use; and tobacco-free environments that help change social norms around tobacco use and exposure.88</td>
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Looking Ahead

Smoke-free Public Housing

The near future holds promising opportunities to address the problem of tobacco use among the homeless population. Many formerly homeless individuals and families, including those who require supportive or assisted living services and may be struggling with behavioral health issues or physical disabilities, reside in affordable or public housing. In addition, a recent study con-
firmed that one-third of all adults living in public housing are current cigarette smokers, which is approximately double the prevalence of current cigarette smoking among all U.S. adults.89

On February 3, 2017, a Department of Housing & Urban Development rule took effect requiring that more than 3,100 public housing agencies across the U.S. prohibit lit tobacco products in all living units, indoor common areas, administrative offices, and all outdoor area within 25 feet of housing and administrative office buildings.90 Since the rule will impact many vulnerable and formerly homeless members, this federal initiative is providing local communities, tobacco control and cessation professionals, and public housing authorities with opportunities to work together to help make this transition to smoke-free living as smooth as possible for the residents.

In addition, HUD is encouraging public housing authorities to engage residents early in developing smoke-free policies, and to partner with outside organizations for cessation support.91 Medicaid recipients, depending on the state, may be eligible to receive financial assistance for tobacco dependency services and prescription cessation medicines.92

“Housing First” Approach

The “Housing First” approach offers permanent affordable housing as quickly as possible to individuals and families experiencing homelessness and then provides supportive services and connections to the community-based supports people need to keep their housing and avoid returning to homelessness. This popular program has begun to encourage the integration of tobacco cessation services with other services provided to individuals as soon as they have received some type of housing.93

Integrated Housing & Health Care Approaches

Some communities are beginning to consider multi-pronged approaches to provide a variety of services to homeless clients, including treatment for nicotine addiction and other interpersonal and health care needs, including substance abuse such as alcoholism.94
**EXAMPLE: Colorado Coalition for the Homeless**

The Colorado Coalition for the Homeless provides housing and integrated health care to homeless and at-risk families, children, and adults throughout Colorado. The Coalition combines aggressive street outreach with integrated systems of primary care, mental health care, substance treatment services, tobacco use screening and counseling, dental care, vision care, case management, patient advocacy, and linkages to essential services such as housing, benefits and other critical supports.95 These health services, located in high need locations, are provided without regard to the patient’s ability to pay and are governed with involvement from the homeless community.96

**EXAMPLE: Good Samaritan Homeless Shelters**

In 2015, eleven Good Samaritan homeless shelters in Santa Maria and Lompoc, California, implemented tobacco-free policies at their sites, while also providing tobacco cessation services for clients — making the organization the first multisite behavioral health agency in Santa Barbara County to include comprehensive tobacco treatment programs. The shelters offer clinical evaluations for tobacco dependency, nicotine replacement therapy, support groups, and educational materials, as well as support from Santa Barbara Public Health Department and a helpline. The Good Samaritan clinical staff receives 26 hours of training for treating smoking cessation.97

**A Collaborative Future**

A growing number of states and local communities are beginning to focus attention on health equity issues and the need for multi-disciplinary collaboration at different levels to reduce health disparities such as the disproportionate impact of tobacco use on vulnerable individuals. Organizations such as the Smoking Cessation Leadership Center, the Substance Abuse and Mental Health Services Administration, the American Cancer Society, and the American Lung Association, have conducted Leadership Academies for Wellness and Smoking Cessation in Behavioral Health to help states, and the nation, develop plans and targeted interventions to reduce tobacco use prevalence among individuals with behavioral health and substance use issues, including homeless individuals. By raising awareness of the huge toll tobacco takes on homeless individuals, and on our society as a whole, states and local communities can pool their resources and expertise in researching and implementing promising measures to address tobacco use among different segments of this population.
Conclusion

Tobacco use among the U.S. homeless population is at epidemic levels. With their health already compromised by high rates of mental illness, substance use disorders, and chronic and communicable diseases and with limited access to health care and related services, homeless individuals experience far greater health disparities than the general U.S. population. The disturbing prevalence of smoking among homeless persons — at least 70 percent or three times the national average among U.S. adults — is the main reason for the higher rates of disease, shorter life expectancies and steeper health care costs of these individuals. Unfortunately, homeless shelters and related housing, health care and social service providers, while often restricting smoking on shelter premises, generally offer little or no tobacco cessation services for residents in their facilities. Given emerging recognition of the disproportionate impact of tobacco use on the homeless population, state and local communities and service providers have an obligation to work together to address this alarming public health crisis.

Endnotes


4 Id.

5 Section 330 of the Public Health Service Act (42 U.S.C. 254b).


7 Id.


15 Id.

16 See, e.g., Martha Burt et al., *How Many Homeless People Are There?*, supra note 2.


19 In addition, several federal departments, such as the U.S. Department of Health and Human Services (through the Substance Abuse and Mental Health Services Administration), as well as the Departments of Justice, Education, and Veterans Affairs, offer homeless assistance services or programs targeted at people experiencing or at risk of homelessness. Moreover, a number of private foundations and for-profit organizations contribute to homeless assistance programs, such as the United Way and the John D. and Catherine T. MacArthur Foundation.


27 Erin Taylor et al., Health Risk Factors and Desire to Change among Homeless Adults, 40 AM. J. HEALTH BEHAVIOR 455-60 (2016); Stephen Hwang et al., Mortality Among Residents of Shelters, Rooming Houses, and Hotels in Canada: 11 Year Follow-Up Study, 26 BRIT. MED. J., 339 (2009).

28 See Erin Taylor et al., supra note 27; Stephen Hwang et al. supra note 27.


31 Cynthia Aloot et al., supra note 30.


37 Randall Cohn, What We Talk About When We Talk About Homelessness, Streets.Mb (April 7, 2015).


39 Travis Baggett et al., Tobacco Use Among Homeless People — Addressing the Neglected Addiction, supra note 12.

40 Dorie Appollonio & Ruth Malone, Marketing to the Marginalized: Tobacco Industry Targeting of the Homeless and Mentally Ill, 14 TOBACCO CONTROL 409-15 (2005), http://tobaccocontrol.bmj.com/content/14/6/409.full.

41 Id.


46 See, e.g., Kolawole Okuyemi et al., supra note 1.


48 Id.


51 See, e.g., Michael Businelle et al., *Smoking Policy Change at a Homeless Shelter: Attitudes and Effects*, supra note 50.


55 Michael Businelle et al., *Smoking Policy Change at a Homeless Shelter*, supra note 50.

56 Maya Vijayaraghavan et al., supra note 47.

57 Baggett & Rigotti, supra note 1 at 164.


60 Gemma Taylor et al., *Change in Mental Health After Smoking Cessation: Systematic Review and Meta-Analysis*, 348 BRIT. MED. J. 1151 (2014).


62 Aniyizhai Annamalai et al., supra note 36.

63 Janet Porter et al., supra note 25.

64 Id.

65 Michael Businelle et al., *Small Financial Incentives Increase Smoking Cessation in Homeless Smokers*, supra note 49.


68 Carolyn Warner et al., supra note 66.


70 Id.


73 Janet Porter et al., supra note 25.

74 See, e.g., Surendra Bir Adhikari et al., supra note 72; Minh-Anh Nguyen et al., supra note 72.


76 Surendra Bir Adhikari et al., supra note 72.


79 Id.

80 Id. at 14; see also Surendra Bir Adhikari et al., supra note 72.


82 See, e.g., Kolawole Okuyemi, supra note 1; Michael Businelle et al., Small Financial Incentives Increase Smoking Cessation in Homeless Smokers, supra note 49.

83 Minh-Anh Nguyen et al., supra note 53; Okuyemi et al., supra note 1.

84 Okuyemi et al., supra note 1.

85 Id.


89 Veronica Helms et al., Cigarette Smoking and Adverse Health Outcomes Among Adults Receiving Federal Housing Assistance, 99 PREVENTIVE MEDICINE 171-77 (2017).


Janet Porter et al., supra note 25.


Id.

Appendices

Appendix A. Select Resources

Organizations Working with the Homeless Population

- National Alliance to End Homelessness. A nonprofit membership organization dedicated to solving the problems of homelessness and to preventing its continued growth. The Alliance web page contains information on programs, practices, and legislation related to homelessness.

- National Coalition for the Homeless. A national advocacy network of homeless persons, activities, service providers and others committed to ending homelessness through public education, policy advocacy, grassroots organizing, and technical assistance. The site includes a searchable bibliographic database of research on homelessness, housing, and poverty; calendar of events; legislative alerts; and links to local state and national homeless/housing organizations.

- National Coalition for Homeless Veterans. A national network that provides legislative advocacy, public education and technical assistance for service providers of homeless veterans.

- National Health Care for the Homeless Council. A network of more than 10,000 doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness.

- National Law Center on Homelessness & Poverty. A private nonprofit organization that advocates to protect the rights of homeless people and to implement solutions to end homelessness in America. To achieve this mission, the Law Center pursues three main strategies: impact litigation, policy advocacy, and public education.

- National Network for Youth. A public education and policy advocacy organization dedicated to protecting key legislation and funding for community-based youth programs, including those for homeless and runaway youth.

- Smoking Cessation Leadership Center. A nonprofit Center, funded by the Robert Wood Johnson Foundation and the Truth Initiative, that works with leaders of more than 80 American health professional organizations and health care institutions to increase the cessation rate for smokers. Its current work is focused on how to reduce the huge health burden from smoking that falls upon those with mental illnesses and/or substance abuse disorders.
• Tobacco Control Legal Consortium. A program of the Public Health Law Center, the Consortium is a nonprofit national network of law and policy specialists that provides legal technical assistance, such as legislative drafting and policy development, to tobacco control advocates, public health professionals, local and state health departments, coalitions, government and private attorneys and individuals. The Consortium’s website offers a wealth of tobacco law and public health law-related publications and resources, including material on addressing tobacco-related health disparities among vulnerable populations.

Federal Agencies Working with the Homeless Population

• U.S. Centers for Disease Control and Prevention (CDC). An agency of the Department of Health and Human Services, the CDC is the leading national public health institute in the U.S. The CDC’s website includes health data standards, scientific and surveillance data, health statistics, and other health information, as well as data about smoking and tobacco use and tobacco-related health disparities. It also includes resources on tobacco use among people of low socioeconomic status and those suffering from mental illness and substance use disorders.

• U.S. Interagency Council on Homelessness (USICH). An independent federal agency within the U.S. executive branch that leads the implementation of the federal strategic plan to prevent and end homelessness.

• U.S. Department of Housing and Urban Development (HUD). HUD is one of a number of federal agencies working toward remedying homelessness in the nation through emergency, transitional, and permanent housing programs each year.

• U.S. Substance Abuse & Mental Health Services Administration. SAMHSA supports programs that prevent homelessness and increase access to permanent housing for people with mental and/or substance use disorders. Its website includes resources on tobacco use and behavioral health.

• U.S. Department of Veterans Affairs (VA). Federal agency that provides information about veterans’ benefits and services. Its website includes resources on homeless and tobacco use among veterans.
Appendix B. Common Terms

**Continuum of Care (CoC):** A local planning body responsible for coordinating a full range of homelessness services in a geographic area, which can cover a city, county, metropolitan area, or an entire state.

**Chronically homeless:** Individual, often suffering from disabilities or substance use, who has either been continuously homeless for a year or more or has had several episodes of homelessness in the past few years.

**Emergency shelter:** A facility with the primary purpose of providing temporary shelter for people experiencing homelessness.

**Episodically homeless:** Individual, often with disabling conditions, who often experiences intermittent medical, mental health or substance use problems and cycles in and out of institutions and homelessness.

**Housing First:** A proven approach in which people experiencing homelessness are offered permanent housing with few to no treatment preconditions, behavioral contingencies, or barriers. It is based on evidence that all people experiencing homelessness can achieve stability in permanent housing if provided with the appropriate levels of services.

**Rapid rehousing:** A housing model designed to provide temporary housing assistance to people experiencing homelessness by moving them quickly out of homelessness and into permanent housing.

**Permanent supportive housing:** A program designed to provide housing (project- and tenant-based) and supportive services on a long-term basis to formerly homeless people, the majority of whom have disabilities.

**Safe Havens:** Projects that provide private or semi-private long-term housing for people with severe mental illness.

**Sniping:** Slang term for the practice of scavenging cigarette butts and filters in public ashtrays or on the streets and then smoking the castoffs or using the contents to make a “new” cigarette.

**Transitionally homeless:** Individuals typically experiencing homelessness for only a short time due to a major event or unforeseen situation.

**Transitional housing:** Provides people experiencing homelessness with a place to stay, combined with supportive services, for generally up to 24 months.
Appendix C. Checklist of Evidence-based Strategies

The following checklist contains several common evidence-based tobacco control and cessation strategies for states, local communities and homeless service and housing providers considering ways to address tobacco use among the homeless population. These strategies are dependent on whether the governing body or organization has the regulatory authority, resources and capacity to adopt, implement and enforce these measures.

Checklist of Tobacco Control & Cessation Strategies

<table>
<thead>
<tr>
<th>Strategic Options</th>
<th>Regulatory Authority</th>
<th>Notes</th>
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<tbody>
<tr>
<td><strong>Tobacco-free Environment</strong></td>
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<tr>
<td>Prohibit tobacco use inside multi-unit residential properties and other designated housing (such as shelters)</td>
<td>Homeless service provider</td>
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<tr>
<td>Prohibit tobacco use on outdoor premises and within [20–25 feet] of any building’s entrance, window or air intake</td>
<td>Homeless service provider</td>
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<tr>
<td>Train staff on rationale for policy and procedures</td>
<td>Homeless service provider</td>
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<tr>
<td>Ensure compliance by residents and staff alike</td>
<td>Homeless service provider</td>
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<tr>
<td>Other options?</td>
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<tr>
<td><strong>Access to Tobacco Cessation Services</strong></td>
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<tr>
<td>Provide tobacco cessation resources, NRT products, quitline referral information, &amp; related services</td>
<td>Homeless service provider and others</td>
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<tr>
<td>Use peer advisors for cessation interventions</td>
<td>Homeless service provider</td>
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<tr>
<td>Integrate tobacco cessation treatment with other health care treatment</td>
<td>Health care and behavioral health providers; specialists in substance use &amp; tobacco cessation</td>
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<tr>
<td>Other options?</td>
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# Checklist of Tobacco Control & Cessation Strategies

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<tr>
<th>Strategic Options</th>
<th>Regulatory Authority</th>
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<tbody>
<tr>
<td><strong>Retailer Licensing</strong></td>
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<tr>
<td>Restrict the number of tobacco retail establishments in neighborhoods</td>
<td>State or local community</td>
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<tr>
<td>Require a minimum distance between tobacco retail establishments</td>
<td>State or local community</td>
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<tr>
<td>Set up safeguards, such as photo ID checks, to ensure compliance with minimum legal sales age requirements</td>
<td>State or local community</td>
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<td>Other options?</td>
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<tr>
<td><strong>Youth Access</strong></td>
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<tr>
<td>Raise to 21 the minimum legal sale age to purchase tobacco products.</td>
<td>State or local community</td>
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<tr>
<td>Other options?</td>
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<tr>
<td><strong>Pricing</strong></td>
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<tr>
<td>Set minimum price laws</td>
<td>State or local community</td>
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<tr>
<td>Prohibit price discounting (e.g., cents-off or dollars-off discounts, coupon redemption, buy-one-get-one-free deals, and/or multi-pack discounts)</td>
<td>State or local community</td>
<td></td>
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<tr>
<td>Raise tobacco taxes</td>
<td>Typically state</td>
<td></td>
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<tr>
<td>Restrict sale based on pack size for non-cigarette tobacco products</td>
<td>State or local community</td>
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<tr>
<td>Other options?</td>
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<tr>
<th>Strategic Options</th>
<th>Regulatory Authority</th>
<th>Notes</th>
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<tbody>
<tr>
<td><strong>Marketing and Advertising</strong></td>
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<tr>
<td>Restrict point-of-sale advertising</td>
<td>State or local community</td>
<td></td>
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<tr>
<td>Require posting of quitline information in retail stores</td>
<td>State or local community</td>
<td></td>
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<tr>
<td>Restrict product placement</td>
<td>State or local community</td>
<td></td>
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<tr>
<td><strong>Other options?</strong></td>
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<tr>
<td><strong>Outreach Opportunities</strong></td>
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<tr>
<td>Provide cessation information at local events where services are provided for low-income and homeless individuals</td>
<td>Communities, social service, health care &amp; faith organizations, etc.</td>
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<tr>
<td>Offer cessation information in conjunction with free CT lung screenings</td>
<td>Health care &amp; social service organizations</td>
<td></td>
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<tr>
<td>Recruit homeless individuals to participate in cessation studies</td>
<td>Communities and tobacco control researchers</td>
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<tr>
<td><strong>Other options?</strong></td>
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