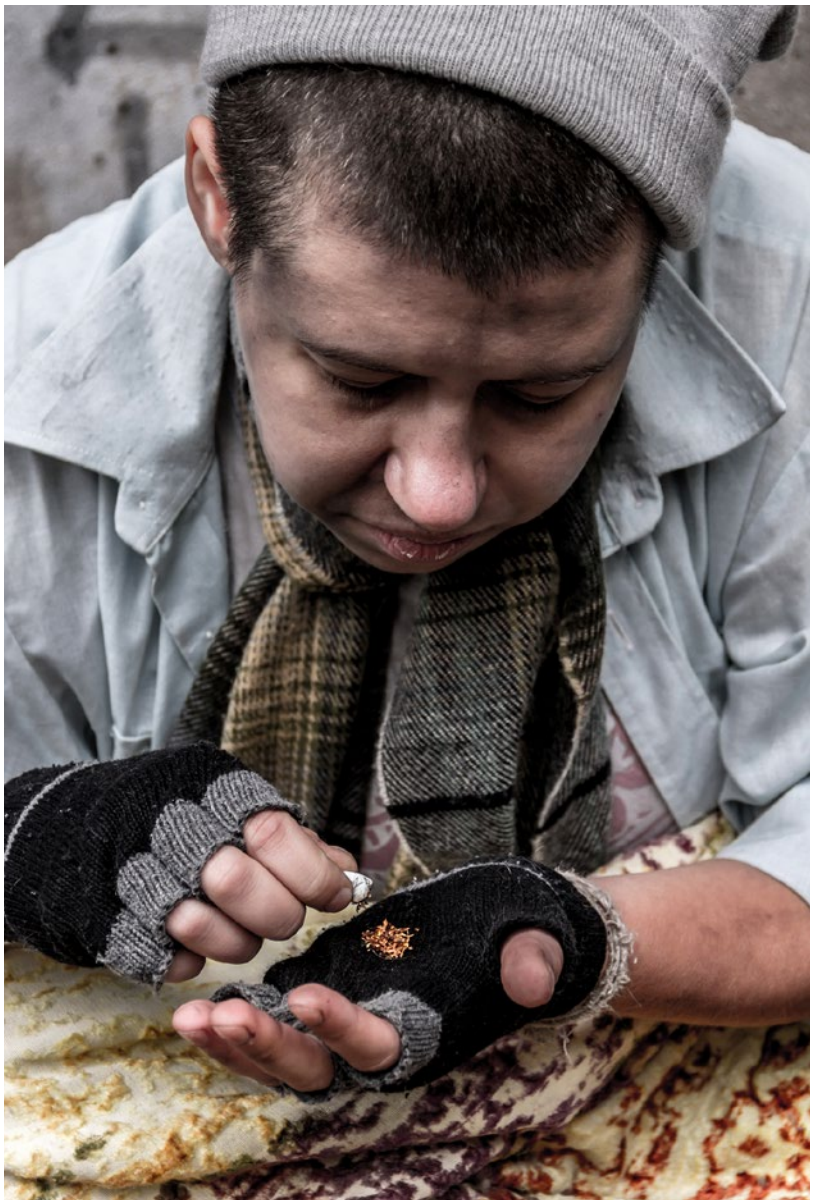
TOBACCO USE AMONG THE HOMELESS POPULATION: FAQ



This publication provides answers to several common questions about tobacco use among members of the homeless population, including those who are chronically, episodically or transitionally homeless, and policies and approaches that state and local organizations, including shelters and related facilities, can take to reduce the use of tobacco in this population.[1]

For more information about tobacco policies in residential settings for vulnerable populations, check out the publications and resources on the Public Health Law Center's website at www.publichealthlawcenter.org.

Q: How does the U.S. government define "homelessness"?

A: The U.S. government does not have a one-size-fits-all definition for the state of homelessness. Different government agencies, such as the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Housing and Urban Development (HUD) define homelessness differently, and this affects how various programs determine eligibility for individuals and families at state and local levels.[2] For example, programs funded by HUD define homelessness as including:

- 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 residences;
- Unaccompanied youth and families with children and youth who meet other 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.[3]

The Health Resources and Services Administration uses a more expansive definition of homelessness, which includes individuals unable to maintain their housing situations, who may be forced to stay with a series of friends or extended family members (sometimes called "coach surfing" or "doubling up").[4]

Q: How many people are homeless in the U.S.?

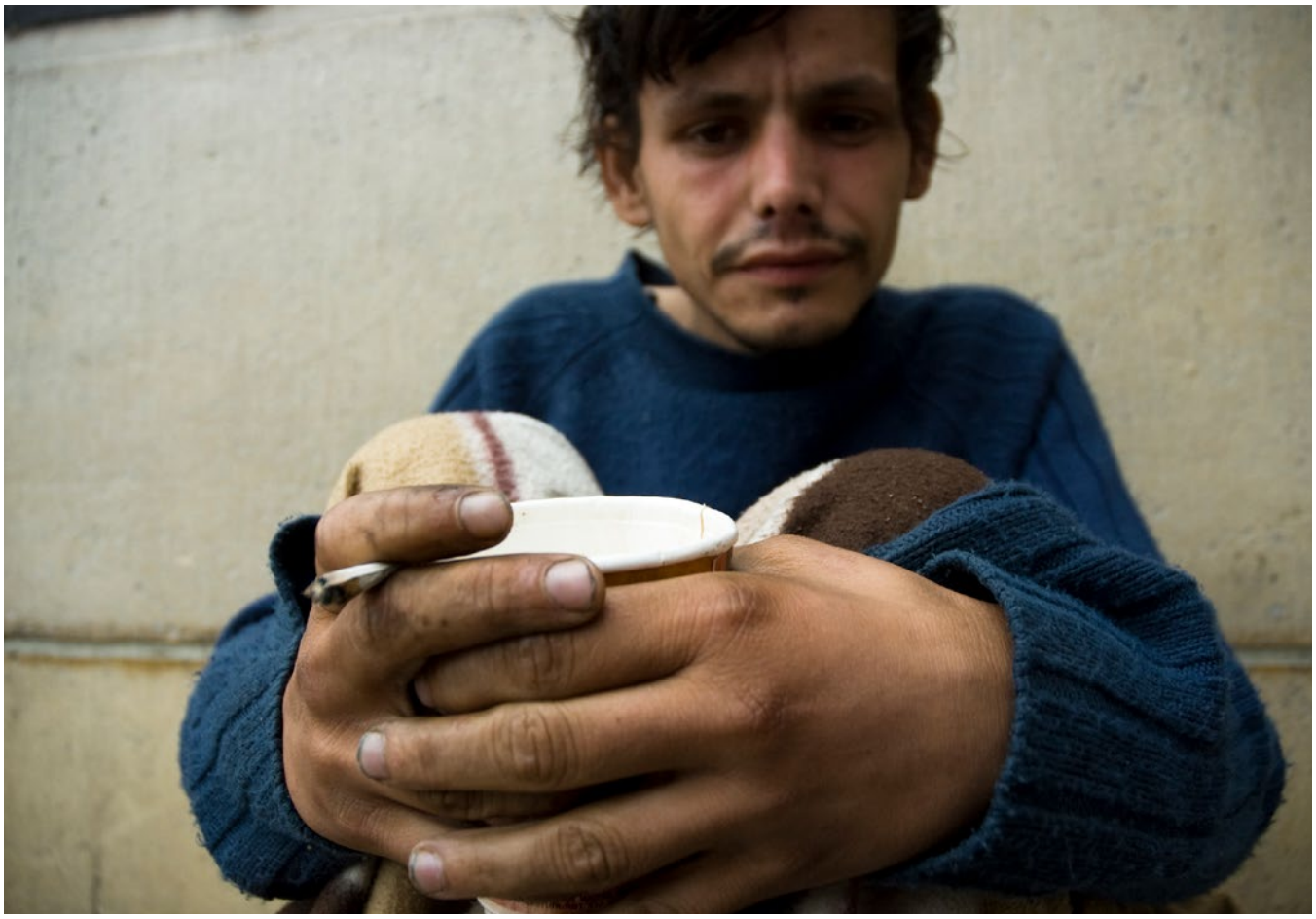
A: The transient lifestyle of homeless individuals makes it challenging to get a clear estimate of the number of homeless individuals in the U.S., and a demographic breakdown. Estimates also vary significantly depending on whether a measurement is taken on a single night or is extrapolated to a given year. Estimates of the number of U.S. homeless range from approximately 565,000 on any given night[5] to 2.3 to 3.5 million in any given year.[6] 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.[7]

Q: How prevalent is tobacco use among the U.S. homeless population?

A: At least 70 percent of all homeless individuals smoke, 4 times that of the general U.S. population and 2.5 times that among impoverished Americans.[8]

Q: What is the health impact of tobacco use on the homeless population?

A: Tobacco-related chronic diseases are among the leading causes of morbidity and mortality among homeless adults.[9] For example, cardiovascular disease is the primary killer of homeless and formerly homeless individuals[10] and obstructive lung disease is more than twice as high in homeless individuals as in the general



population.[11] Homeless individuals suffer higher rates of death due to circulatory and respiratory diseases than domiciled individuals.[12] In addition, homeless individuals are susceptible to a range of chronic and infectious diseases and common health concerns, including HIV, diabetes, cancer, hepatitis C, tuberculosis — conditions that are often exacerbated by tobacco use. Many homeless individuals suffer from medical conditions as a result of exposure to the cold, poor nutrition and hygiene, limitedaccess to health services — as well as risky behaviors, including tobacco use. As a result, homeless people are at least three times more likely to die prematurely than the general population.[13]

Q: In addition to the overall adverse health impact of tobacco use, do the ways socioeconomically disadvantaged people often use tobacco products have any additional health implications?

A: Because of lack of resources, many low income and homeless individuals use tobacco in unconventional ways that increase the likelihood

of ingesting infectious agents and toxins trapped in filters and tobacco remains. For example, they often snipe, which involves digging around in the trash or searching the ground for cigarette butts or filters with enough unsmoked tobacco in them to warrant the time it takes to find, unravel and re-roll them. They also commonly share single cigarettes. As a result, homeless smokers (and smokers in general) often suffer from gum diseases, such as gingivitis and periodontitis. Untreated, these conditions can lead to pain, tooth loss and other health problems.[14] Among people over age 65, only 20 percent of nonsmokers are toothless, while over 41 percent of daily smokers are toothless.[15]

Q: Why is it so hard for many homeless individuals to quit smoking?

A: 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 disorders,[16] along with a 68 percent to 80 percent prevalence of cigarette smoking.[17] 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.[18] Co-existing psychiatric and addiction conditions and the harsh living situation of many homeless individuals complicate tobacco dependency treatment and have led many health professionals to assume a resigned attitude toward addressing tobacco addiction among this population. Homeless individuals smoke for a variety of reasons: often as a way to cope with the stress, boredom and tension of living in survival mode day after day. Some may smoke in combination with alcohol or illicit drugs or as a way to achieve a nicotine buzz or substance high. In addition, homeless smokers tend to begin smoking earlier in life than the general population, smoke more heavily, and are less likely to have health insurance or access to health care.[19] Finally, studies have shown that a culture of tobacco use and permissive shelter policies that result in frequent exposure to smoking also make it significantly more difficult for homeless smokers to maintain smoking abstinence.[20]

Q: Are homeless individuals less motivated to quit than the general population?

A: Despite all the personal, psychological, environmental and systemic barriers faced by homeless individuals, a majority of homeless smokers in a wide number of studies insist they want to quit and are motivated to quit.[21] Nevertheless, their confidence in their ability to quit is low and even though many try repeatedly to quit, fewer succeed than in the general population.[22]

Q: What are some common challenges that shelters and related housing providers face when it comes to providing tobacco cessation resources or options?

A: Shelters, half-way houses, and other housing providers face a host of challenges. A large number of staff in these facilities smoke, which can pose a significant obstacle, not just in the

implementation of smoke-free policies, but in the overall attitude toward cessation. 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 behavioral health and substance use issues. 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. In fact, smoking can complicate the treatment of patients with mental illness.[23] Data suggest that smoking cessation can help reduce mood/anxiety disorders and depression.[24] Also, in many communities, limited coordination among social services, primary care, mental health, substance abuse, and tobacco addiction specialists remains an issue.

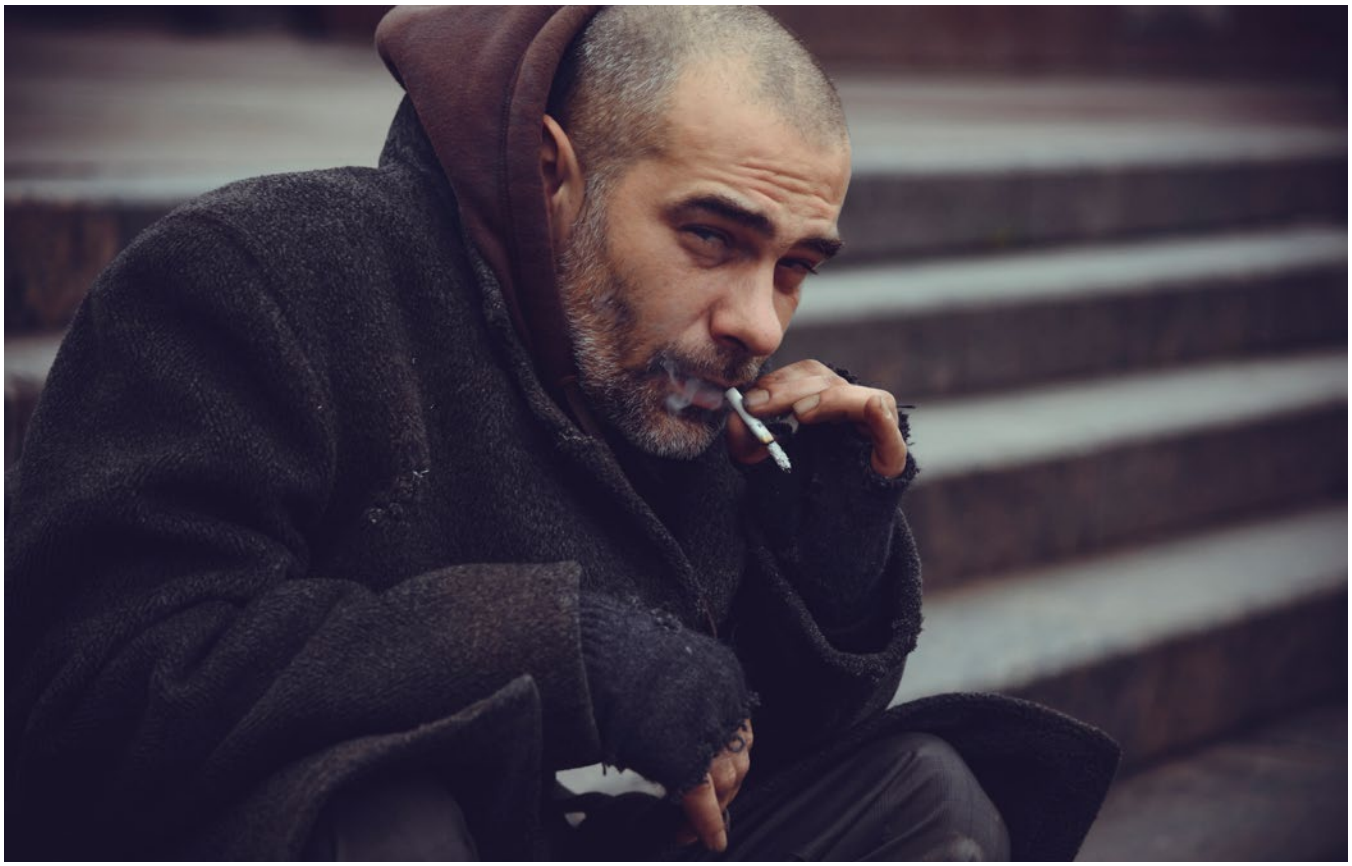
In addition, homeless service providers are generally short of funds for bare necessities, let alone funding for nicotine replacement therapy products and trained counselors or tobacco dependency treatment programs. Some providers are simply not set up to provide on-site cessation service or support. Moreover this is a transient population that may not have ready access to cell phones for quitlines or the ability to travel to tobacco treatment counseling sessions. Finally, a lot of different subgroups make up the homeless population. Research needs to be done on the most effective ways to address smoking in different subgroups of this population, such as the mentally ill, substance users, youth, families with children, and veterans.

Q: Are homeless shelters and related homeless housing facilities typically smoke-free? How well are these policies enforced?

A: Most homeless shelters are smoke-free within the building, 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. Research has shown that a lack of knowledge among staff about nicotine addiction, negative staff attitudes toward a smoke-free policy, and staff smoking often pose significant barriers to establishing a smoke-free culture in some shelters.[25]

Q: How have some researchers recruited homeless individuals to participate in tobacco cessation studies?

A: Researchers are frequently challenged in identifying effective interventions for the homeless population because of the difficulty in recruiting and retaining smokers for studies when the subjects have no permanent address and often are difficult to reach, and where they may be suffering from mental illness, cognitive impairment, or substance abuse. Many potential participants are screened out for various reasons. Methods used to recruit homeless individuals in tobacco cessation studies include the provision of monetary and nonmonetary incentives that meet participant needs, such as personal care



items and hygiene kits, transportation costs (bus tokens or metro cards), gift or debit cards or cash vouchers for food and clothing.[26]

Q: What are some approaches that communities and organizations can take to reach members of the homeless population with tobacco cessation assistance?

A: Communities, working in tandem with housing, social services, health care and other local partners and providers, can 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 church-

es or other faith-based locations), where cessation education efforts and referrals are provided, along with free health care services

- Providing free CT lung screenings and follow-up cessation information at events targeted for low-income and homeless individuals

Q: What are some promising measures that homeless shelters and related providers could adopt to address tobacco use and secondhand smoke exposure on the premises?

A: Adopting and effectively implementing comprehensive (i.e., indoor and outdoor premises) smoke-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. Because a large number of shelter staff smoke, shelters should consider providing tobacco cessation education and resources to staff and residents alike, making sure that concerns that smokers may have about all aspects of their treatment options are addressed. Personnel policies should prohibit staff from smoking with residents or providing residents with tobacco products. In addition to ensuring that a smoke-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).

This publication was prepared by the Public Health Law Center at Mitchell Hamline School of Law, St. Paul, Minnesota, with funds from the American Cancer Society.

Endnotes

1 Please note that the information contained in this publication is not intended to contain or replace legal advice.

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