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# Healing Hands

# Supporting People Experiencing Homelessness in Smoking Cessation

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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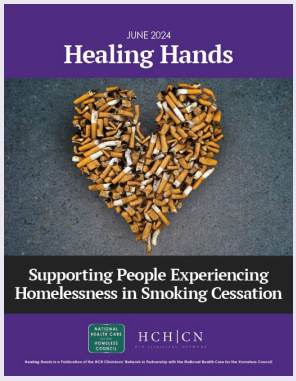


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# I. Introduction

Dr. Maya Vijayaraghavan, Associate Professor of Medicine and Director of the Smoking Cessation Leadership Center at the University of California (San Francisco), writes that:

> **About 70% of people experiencing homelessness report current tobacco use. Some of the earliest studies — dating back to the 1980s — that characterize the health of people experiencing homelessness in the U.S. report a similar percentage of tobacco use. Few statistics have remained the same in 50 years. In contrast, cigarette smoking in the general U.S. population has declined from 50%-60% in the 1950s-1960s to around 11% today.** [1]

Nationwide decreases of cigarette smoking have represented a key public health victory, but the negative impacts of smoking have become concentrated amongst marginalized populations, including people experiencing homelessness. To understand why this is the case, it is crucial to note that the rate of tobacco use among people experiencing homelessness is a structural issue and social justice issue, not just an individual health decision. Commercial tobacco is an easily accessible and heavily-marketed substance, often used to cope with structural injustices such as racism, discrimination, economic injustice, and multi-generational trauma. This is perhaps one possible explanation for why cigarette smoking has not declined nearly as much amongst people experiencing homelessness as it has in the general population: Because experiences of structural injustice drive and sustain tobacco use, just as they do other forms of substance use.

Despite the overall declining rates of smoking over the past few decades, the American Academy of Pediatrics notes in a 2023 technical report that:

> **Tobacco use remains one of the leading preventable causes of disease and death in the United States. Cigarette smoking causes about 1 of every 5 deaths in the United States each year, or more than 480,000 deaths annually (including deaths from secondhand smoke [SHS] exposure). Cigarette smoking causes premature death, with the average person who smokes dying 10 years earlier than their nonsmoking peers.** [2]

These health risks appear to be magnified for people experiencing homelessness. Dr. Vijayaraghavan notes that in her primary care practice at the San Francisco General Hospital, patients who smoke present with heart or lung disease 10 to 20 years earlier, if they are unhoused, than housed patients. They are also more likely to experience more severe forms of tobacco-related chronic disease. Research indicates that people experiencing homelessness are three to five times more likely to die prematurely and that "tobacco-caused chronic diseases are the leading

"Smoke" by Mark, PhotoVoice Digital Exhibit

causes of morbidity and mortality among those aged 45 and older… Among younger homeless-experienced adults (aged less than 45 years), the incidence of tobacco-caused chronic diseases is three times higher than the incidence in age-matched non-homeless adults." [3]

In this issue of *Healing Hands*, we will look at the impact of cigarette smoking, vaping, and other tobacco use among people experiencing homelessness, including children, teens, families, Indigenous communities with cultural experiences of medicinal tobacco use, and people who experience other forms of social marginalization. We will also consider key aspects of communication and intervention in the realm of smoking cessation, including motivational interviewing, harm reduction, trauma-informed care, and the five stages of change model. We will end with one individual's story about quitting smoking that illustrates both the challenges and benefits of engaging in tobacco cessation.

# II. Harms of Smoking Through the Lifespan

**Dr. Brian Jenssen** is a practicing pediatrician, researcher, and medical director with a focus on value-based care at the Children's Hospital of Philadelphia (CHOP). He works in a clinic in West Philadelphia, where 85 percent of the children he sees have Medicaid insurance. While "children in general are the age cohort at greatest risk of being in poverty," families in this cohort are also at risk of moving in and out of homelessness. Dr. Jenssen thinks about smoking through a family systems lens, both because the physical health risks of smoking are spread across households—with both first- and second-hand smoke posing serious health risks—and because a smoking habit is often passed down from generation to generation. Pediatric clinicians are in a unique position to help break these cycles.

"We've made great strides in helping push back against tobacco use across the country and tobacco companies, themselves," says Dr. Jenssen. "About 55% of adult men used to smoke, and now we're down to 12 to 14%. But it's more clustered in our most vulnerable populations—including the fact that 40% of children aged 3 to 11 have a documented smoke exposure. It's a huge problem among children. It's not just the modeling—it's also that when you're exposed to the secondhand smoke and nicotine, it actually primes your brain toward nicotine addiction." For people and families experiencing homelessness, this chemical component interacts with social and economic stresses and instabilities, creating conditions for addiction to arise.

Understanding these family cycles is an important part of understanding the roots of smoking. "The vast majority of tobacco use starts when people are teenagers or even younger," says Dr. Jenssen. "About 90% of tobacco users in their 20s and beyond started smoking in their teenage years." This is partly because of early chemical exposure combined with modeling and access, but it is also because "tobacco companies intentionally target kids. You now have to be 21 to purchase tobacco, but there is evidence that kids typically start before the age of 18. [Teens] are targeted by tobacco companies, and the adolescent brain is uniquely vulnerable to addiction, including to nicotine… It's technically illegal for them to target kids, but they do it in a couple of ways: by marketing products in a way that makes them enticing to youth—and by using flavors…. Flavors in products lead to experimentation, regular use, and addiction."

Tobacco companies utilize targeted ads that market flavored products as well as vaping and electronic nicotine delivery systems. Perhaps partly for this reason, there has been "a steady decline in cigarette use among teens, and e-cigarettes are now their number one product," says Dr. Jenssen. "Also, there's emerging data that teens use multiple different products. We hit a peak where 1/5 to 1/4 of teens were using on a regular basis; the numbers are now down into the teens, but with an increase in intensity of use." Dr. Jenssen also notes that teens who use e-cigarettes have a four-fold risk of using

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*— Dr. Brian Jenssen*

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cigarettes, and because the data is conflicted on what helps a teen quit (and whether or not e-cigarettes function as a form of harm reduction in different populations), the best medicine is, as ever, education and prevention. [4]

At CHOP, Dr. Jenssen uses his experience as a physician and researcher in two broad efforts: first, helping parents quit smoking in pediatric settings, and second, doing clinical work to identify teens who use a range of tobacco products and help them cut down and/or quit. He and other physicians are working to develop evidence-based protocols that can be used to screen care networks to find children, teens, and adults who may be experiencing harm from first-hand or second-hand smoke, and offer them support. They offer ways to directly connect to evidence-based treatment, including medications (such as nicotine replacement therapy) and counseling services, including free services available via phone or text.

Dr. Jenssen explains that the majority of smoke exposure in children—approximately 2/3 of it, in fact—is from a person who does not attend medical appointments with the children (e.g., another parent, a grandparent, or another caregiver or relative). At CHOP, thanks to an NIH grant, they have begun testing an initiative where they ask parents if they would like the clinicians to reach out to the other person in the household to discuss cigarettes with them. About 1/10 to 1/4 of the parents say yes—and of the people contacted by clinicians, 25 to 40% of them agree to be connected to more services. Clinicians mail them nicotine replacement therapy and connect them to counseling. The child's health and well-being helps clinicians "reach into the home and family to help anyone who wants to quit… and most adults who are around kids want to do the right thing for the kids."

In fact, data from CDC surveys suggests that 60 to 70% of adult smokers want to quit [5], but nicotine is incredibly addictive and quitting smoking poses a challenge for most people. For this reason, Dr. Jenssen emphasizes the importance of taking the time to understand the systems operating around the person who smokes, and of taking a non-judgmental stance in conversations: "A non-judgmental approach to treatment says, 'I understand why you got here, and I'm here to help you find a different path."

# III. Developing Culturally Inclusive Interventions

**Bridie Johnson** (two-spirit/she/they) is an Indigenous smoking cessation specialist trained by Indian Health Service (IHS) on cultural adaptations that honor the tobacco plant and discourage the abuse of commercial tobacco used in mainstream society today. Bridie is the current Clinical Director at ABODE services, a permanent supportive housing program in San Francisco, California, the first of its kind that just opened in collaboration with the city and county of San Francisco in October 2023. They are a direct descendent of the "now so-called

Canada," Chippewa of the Garden River, First Nations, also known as Ketegaunzeebee in the Ojibwe language. As a social worker and behavioral health specialist with over 20 years' experience, Bridie feels that focusing on increasing the visibility and awareness of issues facing Native and Indigenous communities—including the fact that Native Americans are overrepresented amongst people experiencing homelessness—is essential.

This continued need for increased cultural awareness is especially important for smoking cessation initiatives: "I just want to make sure that we're decolonizing and re-indigenizing cessation spaces to include the importance and sacredness of traditional tobacco." says Bridie. "We must continue to parse out or separate the white colonized commercial tobacco products (with tons of chemicals) from our Indigenous traditionally grown 'asemaa' in my language or tobacco that Indigenous peoples have used for tens of thousands of years and still use today." For example: "Ojibwe people of the Americas use tobacco daily as ritualistic thank you or 'miigwech' in prayer, as well as in medicinal and other ceremonial usage and a lack of awareness when treating Indigenous peoples around this important lesson may turn indigenous people off from quitting smoking for the important chemical nicotine reasons needed for survival."

A 2023 study on smoking cessation among North American Indigenous people (including American Indians and Alaska Natives) noted that the smoking rate among Native people "is the highest of any race or ethnicity in the United States, estimated to be as a high as 42.1% nationally by the Centers for Disease Control," and that smoking contributes to higher rates of cancer, cardiovascular disease, and all-cause mortality amongst Indigenous populations. The study explains:

> **There are over five million Indigenous North Americans in the United States represented by 574 federally recognized Tribal communities, with roughly 54% of the population residing in rural areas. The cause of prominent smoking prevalence in this population is complex and multifactorial with variability among the diverse Tribal communities in the United States and Canada. In addition to social factors influencing smoking behaviors in the general population such as social determinants of health, stable housing, transportation, medical literacy, and healthcare access, there are multiple unique factors contributing to smoking behaviors in Indigenous North Americans. Tobacco is viewed by many Tribes as a traditional plant with spiritual, medicinal, and cultural significance. The important role of traditional tobacco remains important for many communities today. Historical trauma due to colonization remains a contributor to adverse health outcomes in modern Indigenous people.** [6]

The study also notes that "cessation interventions created for the general public not only do not acknowledge the traditional role of tobacco in Indigenous communities, but also create a negative image of tobacco that is incongruent with honorable traditional views of tobacco for many Indigenous people." [7] For this reason, recent years have seen an expansion in available training programs for health care professionals that combine smoking cessation knowledge with cultural understanding, often tailored to specific cultural groups. As Bridie explains, "cultural beliefs must be included in order for the health education to land with the peoples, and for a feeling of belonging to occur."

Bridie notes that people of other global/cultural backgrounds may also have traditional or medicinal uses for tobacco in their cultural contexts, and so it is important to develop "culturally appropriate ways to reach out to people by making sure advertising and interventions are culturally sensitive and inclusive rather than sparse and left out or separated." Depending on the Indigenous population, a culturally relevant cessation intervention may include participation of Indigenous or culturally aware staff members, in collaboration with Indigenous communities, and clear acknowledgment of the traditional role of tobacco as "held high and (prayed around) or spoken about first as it is in our oral traditions."

It can be extremely helpful and important to differentiate between traditional tobacco and commercial tobacco. This understanding of how these products are produced and used traditionally can help to explain the different health impacts of the products as well. Bridie emphasizes that traditional tobacco usage has to do with growing, sharing, cultivation, and other important processes of laying down tobacco as a way of thanking mother earth and does not just including smoking it: "I use it every morning to thank Creator… I lay tobacco to thank Mother Earth for receiving me here and guiding my path… I might even smudge you with tobacco while I'm telling you about the concerns related to commercial tobacco use."

The booklet *Walking Toward the Sacred: Our Great Lakes Tobacco Story* is a collection of information compiled by Isaiah Brokenleg and Elizabeth Tornes about traditional tobacco use in a variety of cultural groups. This booklet, and other resources created by Indigenous authors and communities, are important tools for helping people respect and recover cultural relationships with tobacco while also supporting them in avoiding the harms caused by commercial tobacco, nicotine, and smoking:

> **As we lost our culture, we lost our knowledge of traditional tobacco because of government policies that prohibited our practice of Native religion, and many of us shifted toward using commercial tobacco, both ceremonially and recreationally. As a result, we are losing our health, suffering, and dying much earlier from commercial tobacco-related illnesses.** [8]

# IV. Interventions and Communication

**Jim Winkle** is the Project Director of the SBIRT Oregon Residency Initiative. He recommends that clinicians follow the SBIRT Model when working with clients who use tobacco delivery products. SBIRT stands for Screening, Brief Intervention, and Referral to Treatment, and is described by SAMHSA as "a public health approach to the delivery of early intervention and treatment for substance use disorders and those at risk of developing disorders." [9]

## Screening

The first step in the SBIRT process is to use an assessment tool to screen the patient. One frequently used validated screening tool for tobacco use/smoking is TAPS: Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool. This well-tested tool also screens for co-occurrence with other substance use, which is common among people experiencing homelessness. Using a validated screening tool can help a clinician see whether a client's pattern of tobacco use qualifies as Tobacco Use Disorder as defined by the DSM-V, and can also enable a clinician to make sure they are asking the right follow-up questions about the landscape of a client's tobacco use.

## Brief Intervention

Once the screening has been completed, clinicians can introduce a brief intervention. "Even three minutes of intervention can make a difference," says Mr. Winkle, who recommends that clinicians utilize motivational interviewing techniques in developing brief interventions. Clinicians can seek certification from organizations like MINT (Motivational Interview Network of Training). "Even 2 hours of training plus some practice can make a difference," says Mr. Winkle. "It can be done by anyone with some training."

There are various models of brief interventions. Mr. Winkle recommends this four-step process:

**1. Raise the subject.** Ask permission to discuss the subject of tobacco use. If it is granted, convey transparency about your role, then ask the client to describe their use.
**2. Share information.** Share the client's score on the screening tool and explain the associations between usage and health. Share relevant health facts and remember to ask the client for their reaction to the information you have shared.
**3. Enhance motivation.** Ask the client what they like and don't like about their use, which helps them assess whether the cons are beginning to outweigh the pros. From this discussion, you can begin to discuss the client's personal goals or intentions, as well as helping clients translate abstract goals into more concrete steps.
**4. Identify plan.** If a client is ready, you could ask "What would a plan of reaching your goal look like?" Support them in coming up with a plan for themselves, then ask whether they are open to a follow-up conversation later.

It is important that the plan and goals be client-centered—sensitive to the needs of the client, and generated by the client themselves. Some examples of client-centered goals could include practices like:

- Using nicotine gum or another treatment method
- Meeting with a substance use professional
- Abstaining from the substance for a certain period of time

Mr. Winkle emphasizes that the clinician will be more effective if they are operating in a supportive, guiding context—helping the client clarify their goals—rather than being directive. ***Directive communication*** may look like telling the client why they should change, pressuring them to change, or even using guilt and shame as methods to attempt to induce change. People on the receiving end of directive communication from care providers may feel judged or embarrassed, or may shut down. Directive communication is professional-centered and may reflect an attempt to meet clinical goals, whereas a guiding style of communication is client-centered. ***A guiding style of communication*** respects the client's autonomy and goals, is comfortable with ambivalence, recognizes the client's expertise in their own lives, gauges readiness to change, and emphasizes empathy, non-judgment, and respect.

## Referral to Treatment

In some cases, a client may be immediately ready to access treatment in the form of replacement medications or products or substance use counseling. This is a cause for celebration when it happens! However, clients are often not ready for change on their first conversation. There are many reasons why clients decline treatment: lack of desire and interest, lack of transportation, disinterest in excessive paperwork or logistics, stigma, fear of relapse, time conflicts, fear of losing job while in treatment, etc. In these cases, clinicians can meet the client where they are at and take a harm reduction approach. Maybe the client is not ready for treatment, but they are willing to try using replacement gum for a month. Or maybe they are willing to speak to a substance use counselor once.

"Harm reduction is pragmatism plus compassion," says Mr. Winkle, and "it helps improve people's quality of life at the same time as it may create a pathway toward accessing more comprehensive treatment in the future." Mr. Winkle emphasizes that the variable most associated with substance use is stigma, so it is essential that clinicians avoid reinforcing or entrenching stigma in their communication with clients. If a client feels stigma in an interaction with a care provider, it can interrupt treatment or result in loss of contact and follow-up with the client.

# V. Harm Reduction and Trauma-Informed Care

Harm reduction in the realm of cigarette smoking is difficult territory, because what constitutes harm reduction varies widely depending on individual circumstances. For example, some people may smoke cigarettes to help themselves avoid other substances and their life-threatening complications, and for these people cigarettes might already be a form of harm reduction. For some people, e-cigarettes might help them avoid some of the dangerous aspects of smoke from cigarettes—but for other people, especially youth, e-cigarettes might actually be an entry point into regular usage of tobacco/nicotine.

"I use this analogy around harm reduction," says Dr. Jenssen. "Tobacco use in any form is a highway toward disease, disability, and death. It's the only legal product on the marketplace that will kill you at this rate. Policy levers are on- and off-ramps. E-cigarettes may be an off-ramp for some adult users but they are also an on-ramp for vulnerable users like children and teens. We have to ask ourselves: Is that on-ramp bigger?" In this area, as in all addiction studies, harm reduction must incorporate a trauma-informed lens and attentiveness to individual circumstances. [10] It is also important for providers and policy-makers to think carefully about whether and how anti-smoking policies—ranging from shelter policies disallowing smoking on the premises to pre-surgical limitations that may deny care to people who smoke—fit into a harm reduction framework.

**Dr. Shelby H. Davies** is an attending physician in the Division of Adolescent Medicine at the Children's Hospital of Philadelphia. As a pediatrician who specializes in adolescent health, Dr. Davies also provides medical care at Covenant House, a youth shelter in Philadelphia. All new and returning residents of the shelter are asked to complete a medical intake with the clinic, which is similar to a well visit at a primary care site. Full psychosocial histories are a critical part of the medical intake and include substance use screening. The clinic can also be accessed for follow-up needs, including behavioral health support.

Dr. Davies' area of expertise within adolescent health includes incorporating strength-based and trauma-sensitive approaches to care, particularly as applied to working with an unhoused population. [11] Smoking cessation work comes up frequently at Covenant House. According to Dr. Davies, many young people experiencing homelessness use tobacco products as a coping mechanism for trauma: "Most, if not all, of our youth have experienced some form of trauma. When a youth shares with me that they are using tobacco products, I often ask myself: Is this youth trying to self-medicate? And in taking away smoking, is a support lost? How can we help them in other ways? What are healthier and more sustainable ways of coping with trauma?"

**"When a youth shares with me that they are using tobacco products, I often ask myself: 'Is this youth trying to self-medicate?' And in taking away smoking, is a support lost? How can we help them in other ways? What are healthier and more sustainable ways of coping with trauma?"**

*— Dr. Shelby H. Davies*

To get at the answers to these questions, Dr. Davies frequently uses motivational interviewing. "What is absolutely critical," says Dr. Davies, "is creating a non-judgmental space:

> **I have worked closely with one youth in shelter who expressed interest in cutting back their cigarette use. They asked me to prescribe replacement therapy in the form of gum, as it had previously worked for them during a prior attempt. Despite using the gum, the youth has shared with me that they have 'slipped up and had a cigarette' a couple of times. During these interactions, I try to create a safe environment, where youth feel comfortable coming to me and asking for help. This is true when they are achieving their goals but it is especially true when there is a setback. I never want them to feel like they are going to disappoint me or get in trouble. For this population in particular, where the road to recovery is not always linear, this is very important. There will be highs and lows and ups and downs during their stay at the shelter, and sometimes residents may backtrack a bit in terms of goals. I know I did something right when someone comes to me and says 'I need help.' That tells me they see the clinic as a safe, non-judgmental space, not a place where they will feel scared or embarrassed.**
>
> **When working with young people in this setting, I try my best to praise the process, the effort, and not necessarily the outcome. Even for a youth that 'slipped up,' I can still praise their effort or the fact that they want to try again, and not necessarily focus on the slip up…** ***if I'm praising the outcome and they don't get the desired outcome then they might be embarrassed to come back and tell me, but if I'm praising the effort then they know they can still come back and ask for help when they need it.***

Dr. Davies also acknowledges the difficulty of setting up long-term behavioral supports with a population that tends to be more transient, and notes that interventions often focus on nicotine replacement therapy (such as the use of gum or patches), which has been shown to be more effective when combined with counseling that focuses on the trauma and behavioral health components that lead to smoking. Though there are difficulties in creating holistic support structures for clients experiencing homelessness, an important first step is taking the time to understand each individual's personal context:

> **In my experience, a lot of my patients do understand the risks associated with smoking and they know that it does lead to negative health outcomes. Saying 'you should quit for health' falls flat. They don't necessarily need to be told that or reminded of that. With this population, addressing the underlying drivers of why they're smoking and what are the barriers to stopping is much more effective.**

When basic needs like housing, food, employment, and a reliable income are not met, long-term health may seem like an abstract consideration. "I think it is important to provide a space for residents to prioritize their long-term health," says Dr. Davies, "For a lot of youth who are struggling to get basic needs met, they tend to focus on: What's today going to look like? How do I get through the next day or two? It is challenging to talk about health outcomes in 10 or 20 years." Clinicians can take this opportunity to use health as an entry point into thinking more long-term—"by giving them the confidence and empowering them to start designing the life they want to lead, and helping them piece their health into that." Dr. Davies wonders: "Maybe this is part of why smoking is now concentrated in marginalized populations [with intense immediate concerns]—because they may not have the luxury or the time to think as much about the future."

# VI. Paul's Story: Quitting Smoking After 35 Years

Paul Tunison is a Housing and Community Program Specialist with Shasta County's Health and Human Services department. He smoked for 35 years and quit in 2016, and is now able to speak to the difficulties of quitting smoking both from the perspective of an ex-smoker and a health care advocate.

Mr. Tunison says that he started smoking cigarettes in 4th grade, because his parents and older brother smoked. His grandma died at 49 of emphysema, his mom died of lung cancer, and his uncle was also diagnosed with lung cancer. Mr. Tunison became an avid bicyclist as an adult, and noticed he would lose his breath frequently on long 50-mile rides. Some of his fellow bike riders were doctors, and shared information with him about the health impacts of smoking. "One day I felt something shift in my chest," says Mr. Tunison, "and I decided to quit."

As he began to work on quitting smoking, Mr. Tunison tried different approaches. First he moved from cigarettes to snuff pouches, then to Nicorette gum and patches. He views these other methods as harm reduction: "Nicotine does restrict blood vessels and tax the heart. But with the gum, I'm avoiding other chemicals and smoke." He explains that there were many health care professionals involved in helping him access the alternative nicotine-delivery systems and get them covered by insurance. Mr. Tunison was also helped by some counseling and having a good relationship with doctors who shared information and helped him stay motivated.

Mr. Tunison says the most important impact of quitting smoking has been a visible change in his health: "When I get sick, I remember being congested while smoking as ten times worse than now. Now I'm not as congested, and I can ride my bicycle without coughing." He wants clinicians to know that their role as educators is essential to helping people move through the five stages of change (see text box):

> **We can't tell people how to live, but we can educate. Depending on the type of clinical setting (whether it's backpack medicine or a walk-in clinic), we can offer clients education about the relationship between smoking and things like diabetes and high blood pressure. We can offer information to folks that are suffering from their relationship with cigarettes… and we can ask them: Are they ready to take action?**

Noticing when a person has moved into contemplation and preparation stages, and providing them with the supports they need to move into action—and eventually maintenance — requires attentiveness, listening, and patience. But the application of these skills can be life-changing (and life-saving) for a person who is ready to quit smoking.

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# VII. Conclusion

This issue of Healing Hands has looked at the importance and challenge of supporting smoking cessation—in a culturally-aware, trauma-informed, realistic, and respectful way—for people experiencing homelessness. According to Dr. Brian Jenssen,

> **Smoking is the leading preventable cause of death in the U.S. and clusters around poverty and people struggling with homelessness. Evidence shows us that even though people have a lot going on, most adults who smoke want to quit. Offering services in a non-judgmental way to parents helps improve their physical health and their financial health—and the health of children and families.**

Beyond clinical intervention, though, Dr. Jenssen also emphasizes the importance of advocacy and policy change when it comes to the availability and marketing of commercial tobacco products—particularly when that marketing is targeted at young people and other marginalized populations: "When it comes to teenagers, the best treatment is prevention. If you can prevent them from starting in the first place, that's how to help make sure they don't get pulled into products that will kill them 10 years earlier."

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