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Letter to the Editor
Smoking Habits of the Homeless

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To the editor:

The homeless population in the United States remains high, with over 600,000 homeless on any given night, and surveys in multiple homeless communities have found smoking rates to range from 68 to 80%, 3–4 times the national average (Baggett, Tobey, & Rigotti, 2013). This high rate is of grave concern to this vulnerable population, as cigarette smoking is the leading preventable cause of premature death in the United States, and cardiovascular disease and cancers of the lung and airway secondary to smoking are the leading causes of death within the homeless population (Porter, Houston, Anderson & Maryman, 2011). Over the last two decades, moves to curb smoking in New York City through taxation and bans on indoor smoking resulted in significantly lower smoking rates throughout the city (Coady et al., 2012). However, as primary care providers to the homeless, we have noted continued high rates of smoking among our patients despite the citywide success of cessation programs, and whether the changes over the last two decades have affected smoking rates in this vulnerable population has not been assessed in the literature. We conducted a survey of 224 homeless adults in New York City shelter walk-in clinics in the 2013 calendar year to assess the current prevalence of smoking in this population, and assess the impact of restrictions, specifically precipitous elevation in prices.

Roughly 80% of the respondents were male, and 75% of respondents reported they were current smokers, in line with previous studies of homeless populations in other cities (Figure 1a). Given the high price of cigarettes in New York City, we asked about the personal expense of smoking, and found a high rate of buying non-taxed cigarettes. Often imported cigarettes from states with lower taxes are sold on the street, and unsurprisingly, our patients reported paying much less for a pack of cigarettes on the street compared to in a store (Black vs. grey bars, Figure 1b). 58% of respondents reported buying cigarettes in a store, however they also reported buying "generic" cigarettes "under the counter"—presumably untaxed—at convenience stores for significantly less than normally taxed name-brand cigarettes (Figure 1c). A majority also reported buying single cigarettes, or "loosies," from convenience stores, and a large number also reported a culture of sharing cigarettes or smoking discarded cigarettes found on the street.

One goal of collecting this data is to inform cessation campaigns, so we further inquired about desire to quit among active smokers. Encouragingly, while most of the homeless adults questioned do not have a regular primary care physician (data not shown), nearly all reported that they had discussed their smoking habits with a medical doctor. Despite this, only 60% of smokers reported that they had ever tried to quit, primarily on their own ("cold turkey") or using the nicotine replacement methods gums or patches offered by the city (Figure 1d).

Despite New York City having one of the lowest rates of smoking in the country, 15.5% in 2012, our data confirm that New York City homeless continue to smoke at 5× this rate. It is well documented they have higher rates of smoking related morbidity and mortality (NYCDOH, 2012). Overall, nationwide rates of smoking have been dropping in response to the increasing financial burden of smoking. Our data suggests that the increased financial burden has not impacted rates of smoking in this poor population (Frieden et al., 2005). Government programs to drive cessation, specifically increased taxation may have simply increased tobacco sales and trade in untaxed and

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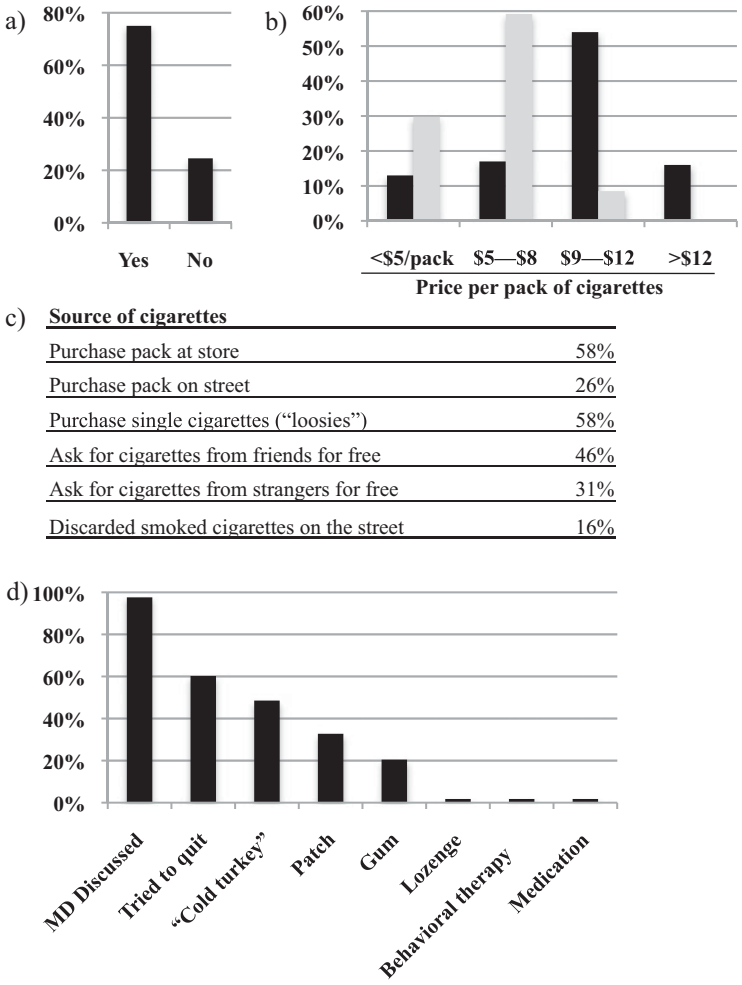

Figure 1

Current smoking status of respondents (a), and price paid for a pack of cigarettes on the street (grey) and in the store (black) (b), source of cigarettes (c), and percent of active smokers who have tried different cessation techniques (d).

unregulated markets, though it is difficult to quantify the exact impact of this trade.

The government needs to tailor smoking cessation campaigns to the homeless population. Our data indicate that increasing cigarette prices is not affecting smoking rates in this population, so a different approach is warranted. Public health campaigns should be aimed at behavioural and awareness interventions. Most respondents that we interviewed had never heard of pharmacologic interventions such as bupropion, and furthermore were not aware of a popular free nicotine replacement offered by New York State via a telephone service called the Smoker's Quitline. To raise awareness, New York City shelters should be better equipped to address smoking cessation and have nicotine replacement options available to homeless patients that have marginal access to healthcare. Governmental focus needs to be shifted from cigarette price increases that appear to promote an illegal marketplace, to health education and narrowing the disparity of access to smoking cessation aides.

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