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Tobacco harm reduction and people experiencing homelessness – a UK perspective

Smoking is recognised as one of the leading causes of health inequalities or disparities, broadly defined as avoidable, unfair and systemic differences in health between different groups of people. While in many high-income countries average smoking rates have fallen significantly over recent decades, rates of combustible tobacco use remain very high in certain populations, who are often among the most vulnerable and marginalised communities.

In the UK, for example, average smoking rates have been falling for decades. After widespread uptake of vaping products among consumers switching away from smoking, and the subsequent government acceptance of vaping as an effective quit aid,[i] the decline in UK smoking rates has accelerated. This has not been mirrored across all groups in society, however, and smoking rates among people experiencing homelessness or rough sleeping remain extremely high.[ii]

In this Briefing Paper, we will explore: the impact of high rates of smoking among people who are homeless or sleeping rough; the barriers they face to smoking cessation; and ways in which support services could use tobacco harm reduction strategies to improve health outcomes for this group, including recent evidence drawn from initiatives that emerged in the response to the COVID-19 pandemic.

What proportion of people who experience rough sleeping smoke?

Smoking rates among people who experience homelessness or rough sleeping are much higher than in the general UK population. Average smoking rates have been falling in the UK since 1974, the year government surveys began, when 45% of UK adults smoked.[iii] By 2011, this had fallen to 20.2%, reaching the historic low of 12.9% by 2022.[iv] By comparison, surveys consistently estimate that smoking rates among people experiencing homelessness or rough sleeping are between 76% and 85%, around six times higher than the general population.[v vi]

There is also evidence that this group frequently smoke in ways which increase the level of health risk. Room to Breathe, an in-depth peer-research study from homelessness charity Groundswell, found that people were extremely heavy smokers, with the majority of respondents smoking more than 20 cigarettes (or rolled tobacco equating to 20 cigarettes) per day. Furthermore, the researchers found evidence that people were smoking in high-risk ways that were more likely to increase their exposure to toxins in cigarette filters and infectious diseases. 75% of survey respondents reported sharing cigarettes, 64% remaking cigarettes from discarded cigarettes and 45.5% smoking discarded cigarettes.[vii]

Homelessness, smoking and health

A striking example of the real impact of health inequalities, and how vulnerable groups can be 'left behind', can be found in the average age of death among people who are homeless in the UK. Men who

are homeless die on average at 44 years of age, compared to 76 in the general population, and women die aged 42, compared to 81 in the general population.[viii] The findings of the Dying Homeless project by the Museum of Homelessness found that 1,313 people died while homeless in the UK in 2022.[ix]

Unsurprisingly, people who are homeless report substantially worse physical and mental health than people who are living in stable housing.[x] Poor health can be both a cause and a consequence of homelessness. Homeless Link's Health Needs Audit 2022 found that 78% of homeless people had a physical health condition, and most of those (80%) more than one; 45% had a mental health diagnosis, compared to 12% in the general population.[xi] Whether it predates or develops while someone is homeless, drug and alcohol use is very common (with rates up to 60%); rates of hepatitis C are 50 times higher and tuberculosis 34 times higher than the general population.[xii xiii]

Of particular note, when considering high smoking rates in this group, is the poor respiratory health among people experiencing homelessness; chest infections, pneumonia and breathlessness requiring hospital admission are all frequently reported.[xiv] Smoking is one of several factors that can contribute to acute respiratory distress or longer-term illness; many people are exposed to very high levels of toxic compounds from vehicle emissions when living in the open, for example. And among people who use drugs such as heroin or crack cocaine, inhalation may be seen as a safer administration route than injecting but brings with it attendant risks to the respiratory system.

Homeless people are three times more likely than those in stable housing to report a chronic disease, in particular asthma, COPD and cardiovascular disease.[xv] All of these conditions can be either worsened or caused by tobacco smoking. Difficulties accessing primary care often lead to poor management of chronic health conditions, in part explaining the high rate of emergency department attendance among this population, which one study estimated at 60 times the rate seen among the general population.[xvi]

What support is available to people who are homeless and want to quit smoking?

Many who experience rough sleeping are keen to improve their health by stopping smoking. The most recent Homeless Link Health Needs Audit found that 50% of those surveyed said they would like to give up; this is not dissimilar to rates in the general adult smoking population, currently estimated at 60%.[xvii xviii] However, there is a significant lack of appropriate services to support people experiencing homelessness or rough sleeping to quit. Even during periods of more generous funding in the UK for smoking cessation services, few have specifically focussed on the needs of people who are rough sleeping.

Meanwhile, within the homelessness sector, work to address the health needs of people sleeping rough often includes a focus on the use of alcohol and drugs, but appropriate interventions to reduce smoking-related harm within homelessness services are currently underdeveloped. A recent survey of UK homelessness services found that while the majority accounted for smoking within their policies in some form, only half (52%) screened and recorded clients' smoking status. Although 58% of centres referred clients to smoking cessation services, established links with these services were low (12%) and most centres did not train staff on how to support smoking cessation. At 23%, rates of smoking among homeless centre staff were significantly higher than among the general population (12.9%); 62% of centres reported that staff smoked with clients.[xix xx]

Does smoking act as a barrier to other services?

The lack of support for smoking cessation among this population is frustrating given that high smoking rates within this group can act as a barrier to accessing support services, particularly those offering short-term or emergency accommodation to get people off the streets. Violating rules or restrictions on smoking is a common reason for people being asked to leave hostels or other accommodation. Many people know that they may fall foul of these rules and so see little point in engaging with services.

Conversely, in some services, while smokefree policies may exist, staff may find them difficult or impossible to enforce, concluding that doing so would reduce opportunities to support clients in need. There are perhaps additional challenges posed by high smoking rates among staff; some staff may, for example, value the client engagement that results from time spent smoking together.

Unfortunately, the conflation of smokefree policies with rules against vaping can act as a barrier to harm reduction. This was exemplified during the course of a study, led by K•A•C Tobacco Harm Reduction Scholarship Programme graduate, Florian Scheibein, that provided vaping products to homeless people in temporary accommodation in Ireland. A client who had described the vape as "a fantastic aid" to smoking cessation had to move during the research; at the new service, he had to vape outdoors with people who were smoking and returned to smoking cigarettes.[xxi]

COVID-19: how and why was tobacco harm reduction integrated into the UK homeless response?

Before the pandemic, there had been a number of small-scale and local initiatives which sought to help rough sleepers address their smoking. A 2019 study showed that at least two thirds of rough sleepers who smoked would be willing to try a vaping device if freely available, would access smoking cessation support if available at their homelessness service and were aware of the benefits of switching to vaping from smoking. The same study also noted barriers to vaping for smoking cessation for this client group, identifying cost, high nicotine dependence, lack of product knowledge, availability of charging facilities and no vaping policies at homeless services as issues.[xxii]

The commencement of the COVID-19 pandemic and the urgent need to bring people indoors to safe accommodation provided a stimulus for further action in this area. The 'Everyone In' initiative began in March 2020 and provided temporary and emergency accommodation for people who were sleeping rough throughout the UK during the pandemic; by July 2021, 37,000 people had been supported by Everyone In.[xxiii] Several UK locations saw the delivery of direct tobacco harm reduction interventions for people living in this short-term accommodation, predominantly through the provision of free vaping devices. Whether the result of formal commissioning or more informal support from vaping consumer advocates and vendors, this work has helped demonstrate the potential of tobacco harm reduction for an extremely vulnerable client group.

In London, some 5,000 people were moved into temporary accommodation, mostly hotels. The Pan-London Homeless Hotel Drug and Alcohol Service (HDAS) was commissioned to meet the substance use support needs of this population. Harm reduction for tobacco was recognised as a priority alongside the provision of support for alcohol and drug use, as HDAS was alert to existing high-risk smoking behaviours (sharing cigarettes, picking up cigarette butts, remaking cigarettes from discarded cigarettes or lighting cigarettes with someone else's), all of which were made riskier by the spread of COVID-19. HDAS also identified opportunities to prevent former smokers from relapsing, encourage current

smokers to quit, while minimising fire risks from smoking in hotel bedrooms, and reduce the likelihood of client evictions due to hotel rules on non-smoking in bedrooms.[xxiv]

Alongside drug and alcohol treatment, HDAS therefore offered tobacco harm reduction resources, supplying more than 3,000 vape starter kits, 20,000 vape refill pods and nicotine replacement products (gum and oral spray). Hotel and healthcare staff received supporting information in the form of leaflets and a training video; HDAS also produced a leaflet for hotel residents signposting them to London's free smoking cessation support line and website.[xxv]

Manchester also saw homeless people housed in hotels. A local provider offered a free source of closed-pod vaping devices for residents, and staff from the Greater Manchester Health and Social Care Partnership (GMHSCP) handed these directly to clients, as well as delivering on-site training to support worker teams based at the hotels. Residents were also given access to a smoking cessation app, enabling them to log and manage cravings and monitor health improvements.[xxvi]

Meanwhile, homeless people in Edinburgh were able to access a range of substance misuse interventions in temporary accommodation during the pandemic. Alongside prescriptions for opiate substitution therapies and support for safer alcohol consumption, tobacco harm reduction options in the form of vaping devices were offered to those clients who smoked.[xxvii]

COVID-19: what was the impact of tobacco harm reduction interventions for homeless people while in temporary accommodation?

Hotel residents in London who were supplied with vaping devices and replacement pods reported feeling grateful for the resources, according to a qualitative evaluation specifically addressing HDAS' work on tobacco harm reduction. People reported satisfaction with the nicotine strengths provided (18mgs), found the devices easy to use and only required staff support to access supplies. As well as physical health improvements, the resources offered other important benefits to those who made the switch:

> *"I would always feel embarrassed and ashamed, that doesn't happen anymore because I have the vapes." (HDAS service user).*
>
> *"I don't need to worry anymore about the raining days because obviously, when it rains you don't get dog ends [discarded cigarettes] from the floor… I almost don't cough at all anymore. I used to cough pretty much all the day. I'm less nervous, when you smoke a lot of cigarettes during the day you can go like in a tense position." (HDAS service user).*[xxviii]

HDAS reports that all London hotels regularly requested further tobacco harm reduction supplies, with feedback from hotel and healthcare staff suggesting that as well as reducing smoking, they successfully reduced incidences of residents picking up cigarette stubs off the street, breaking lockdown to buy cigarettes and being evicted from their rooms for smoking.[xxix]

Reflecting on the successes of smoking cessation and tobacco harm reduction work delivered during Everyone In, GMHSCP public health specialists have expressed ambitions to continue the initiatives with Manchester's homeless population beyond the pandemic.[xxx] And Rankin Barr, manager for the Edinburgh COVID-19 response for the homeless, describes an "astonishing uptake" of vaping products among tobacco users.

"The normalisation of all-round healthcare in our daily routine empowered people to develop a culture of wellness, supported by organic community- and peer-led support," Barr reports. In his estimation, "vaping contributed significantly, providing positive social interactions and smoking reduction on a scale not thought possible. The evidence showed this approach led to systemic health improvements and a reduction in tobacco smoking impacts, helping to prevent substance misuse deaths in this most vulnerable population. Over the six months of this project, all clients survived to move onto alternative housing options".[xxxi]

Conclusion

More research is needed, but it is clear this is an area of great potential which can and should be pursued. A world-first study, funded by the National Institute for Health Research and led by teams from University College London and London South Bank University, is currently trialling the provision of vape starter kits in homelessness services and will provide a direct comparison with usual smoking cessation care pathways.[xxxii] Experience from the drug and alcohol treatment sector suggests there may be great value in pursuing peer-led models, as well as the opportunities offered by potential 'quit communities' formed within hostels and services.

For service providers wishing to integrate tobacco harm reduction into their practice now, the National Centre for Smoking Cessation and Training provides training on Very Brief Advice (VBA) for Homelessness Services, as well as guidance on the procurement of vaping products.[xxxiii xxxiv]

While initially delivered in a time of crisis, the smoking cessation and tobacco harm reduction work that took place with homeless people during COVID-19 offers commissioners and service providers valuable real-life examples of what could be achieved for this population over the longer term.

For further information about the Global State of Tobacco Harm Reduction's work, or the points raised in this GSTHR Briefing Paper, please contact info@gsthr.org

About us: Knowledge•Action•Change (K•A•C) promotes harm reduction as a key public health strategy grounded in human rights. The team has over forty years of experience of harm reduction work in drug use, HIV, smoking, sexual health, and prisons. K•A•C runs the Global State of Tobacco Harm Reduction (GSTHR) which maps the development of tobacco harm reduction and the use, availability and regulatory responses to safer nicotine products, as well as smoking prevalence and related mortality, in over 200 countries and regions around the world. For all publications and live data, visit https://gsthr.org

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[i] *The UK and tobacco: Successful elements of a harm reduction strategy and the chance to influence the international response to smoking* (GSTHR Briefing Papers). (2021). Global State of Tobacco Harm Reduction. https://gsthr.org/briefing-papers/august-2021/.

[ii] In this Briefing Paper, we are following generally accepted UK definitions of homelessness or rough sleeping. This includes: people sleeping in the open air (such as on the street, in tents, doorways, parks, bus shelters or encampments), or in buildings or other places not designed for habitation (such as stairwells, barns, sheds, car parks, cars, derelict boats, stations, or makeshift shelters). It does not include people in hostels or shelters, people in campsites or other sites used for recreational purposes or organised protest, squatters or travellers.
Source: Public Health England. (2020, February 11). *Health matters: Rough sleeping* [Guidance]. GOV.UK. https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping.

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