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Research paper

Content analysis of homeless smokers' perspectives on established and alternative smoking interventions☆

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ABSTRACT

Background: Cigarette smoking is 5 times more prevalent among homeless individuals than in the general population, and homeless individuals are disproportionately affected by smoking-related morbidity and mortality. Homeless smokers report interest in changing their smoking behavior; however, established smoking cessation interventions are neither desirable to nor highly effective for most members of this population. The aim of this study was to document homeless smokers' perceptions of established smoking interventions as well as self-generated, alternative smoking interventions to elucidate points for intervention enhancement.

Methods: Participants ($N = 25$) were homeless smokers who responded to semistructured interviews regarding smoking and nicotine use as well as experiences with established and alternative smoking interventions. Conventional content analysis was used to organize data and identify themes.

Results: Participants appreciated providers' initiation of conversations about smoking. They did not, however, feel simple advice to quit was a helpful approach. Instead, they suggested providers use a nonjudgmental, compassionate style, offer more support, and discuss a broader menu of options, including nonabstinence-based ways to reduce smoking-related harm and improve health-related quality of life. Most participants preferred engaging in their own self-defined, alternative smoking interventions, including obtaining nicotine more safely (e.g., vaping, using smokeless tobacco) and using behavioral (e.g., engaging in creative activities and hobbies) and cognitive strategies (e.g., reminding themselves about the positive aspects of not smoking and the negative consequences of smoking). Abrupt, unaided quit attempts were largely unsuccessful.

Conclusions: The vast majority of participants with the lived experience of homelessness and smoking were uninterested in established smoking cessation approaches. They did, however, have creative ideas about alternative smoking interventions that providers may support to reduce smoking-related harm and enhance quality of life. These ideas included providing information about the relative risks of smoking and the relative benefits of alternative strategies to obtaining nicotine and avoiding smoking.

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Introduction

Smoking prevalence in the US has decreased precipitously over the past 50 years, from 42% at its peak in the 1960s to 15% in 2015 (Jamal et al., 2016; Office of the Surgeon General, 2014). This trend has not, however, been observed in marginalized populations such as homeless individuals. In fact, population-based surveys have indicated that between 73 and 80% of homeless individuals are current smokers (Baggett & Rigotti, 2010; Tsai & Rosenheck, 2012), a prevalence approximately 5 times that of the general US population. Greater smoking prevalence paired with other comorbidities translates into an experience of smoking-related mortality for homeless individuals that is 3–5 times higher than in the general US population (Baggett et al., 2015).

Despite a self-reported readiness to quit or limit smoking (Arnsten, Reid, Bierer, & Rigotti, 2004; Okuyemi, Caldwell et al., 2006; Tsai & Rosenheck, 2012), the lifetime quit ratio in the homeless population is 6 times lower (9%) than in the general US population (55%; Baggett & Rigotti, 2010; Jamal et al., 2016). Further, when compared to smokers who are also economically disadvantaged but housed, homeless smokers have lower self-efficacy to quit and are exposed to more stressors, which may contribute to their high smoking prevalence and low smoking cessation success rates (Businelle, Cuate, Kesh, Poonawalla, & Kendzor, 2013). Likewise, other barriers such as psychiatric symptoms and limited access to healthcare make this already vulnerable and marginalized group especially susceptible to continued smoking (Baggett, Lebrun-Harris, & Rigotti, 2013; Baggett & Rigotti, 2010).

Although they have cited cigarettes as a helpful coping mechanism, homeless smokers have also reported motives for quitting, including fear of health consequences, the rising prices of cigarettes, and concerns about compromised physical appearance (Arnsten et al., 2004; Okuyemi, Caldwell et al., 2006). Homeless smokers have also indicated interest in support for smoking cessation, including pharmacotherapy and behavioral treatments (Okuyemi, Caldwell et al., 2006), tailored programs (Bryant, Bonevski, Paul, O'Brien, & Oakes, 2011), and financial incentives (Bonevski, Bryant, & Paul, 2011; Okuyemi, Caldwell et al., 2006).

Qualitative studies have explored potential facilitators and barriers to smoking cessation. The most commonly reported barrier is the desire to maintain the stress relief smoking provides (Bryant et al., 2011; Okuyemi, Caldwell et al., 2006). Homeless smokers have also reported that smoking helps regulate mood, cope with mental illness, alleviate boredom, and provide means of social interaction within a population in which smoking is highly accepted and widespread (Okuyemi, Caldwell et al., 2006). Perceived lack of instrumental support for smoking cessation by practitioners and lack of awareness of available cessation support are other barriers (Bryant et al., 2011; Garner & Ratschen, 2013).

Given their self-reported interest in changing their smoking behaviors and the abundance of research on barriers to and motives for smoking cessation, one solution has been to tailor smoking cessation treatment to homeless smokers' unique needs (Borrelli, 2010). Researchers have accomplished this in various ways: using a community-based participatory research framework to involve homeless smokers in smoking cessation treatment design (Okuyemi, Thomas et al., 2006), recruiting participants in community-based settings (Richards et al., 2015), and providing rewards and incentives (Bonevski et al., 2011). Despite these adaptations, however, smoking cessation treatment studies to date have yielded low long-term point-prevalence abstinence in the homeless population, ranging from 4% to 16% (Okuyemi et al., 2013; Segan, Maddox, & Borland, 2015; Shelley, Cantrell, Wong, & Warn, 2010).

These suboptimal outcomes underscore the need to reevaluate the usefulness of smoking cessation as the primary goal and established smoking cessation interventions as the primary treatment pathway for homeless smokers. Instead, a focus on more realistic and patient-driven treatment goals that may include but are not limited to smoking cessation may be more engaging and effective. There are, however, no research studies to date that have asked homeless smokers what goals and strategies are desirable, feasible and effective based on their own lived experience. These insights could be helpful in re-envisioning how the field defines and measures positive treatment outcomes—prioritizing, for example, participants' self-defined outcomes—as well as pathways to achieving them. Treatments that draw on homeless smokers' lived experience and are codesigned by the population may have a better chance of engaging and effectively treating this traditionally 'hard-to-reach' population.

In the present study, we sought to document homeless smokers' perspectives on currently available, established smoking cessation interventions as well as their ideas for alternative smoking intervention strategies. This study aim was accomplished using conventional content analysis, a method of interpreting qualitative data through a systematic process of coding and classification (Hsieh & Shannon, 2005). These findings will be used to better tailor smoking interventions to homeless smokers' needs and goals.

Method

Participants

Participants were 25 homeless smokers (20% female) who received services from an emergency shelter in a large city in the Pacific Northwest. The shelter serves 4000 people a year, many of whom are multiply affected by psychiatric, medical and substance use disorders. The shelter has 198 beds, a daytime drop-in center, and toilet and shower facilities. Services provided onsite include nursing, case management, and chemical dependency counseling. Clothing, mail pick-up, phone access, and meal services are also available.

The average age of participants was 47.88 ($SD = 10.82$) years. Of the overall sample, 64% ($n = 16$) self-identified as White/European American, 24% ($n = 6$) as Black/African American, and 12% ($n = 3$) as Multiracial (American Indian/White, $n = 2$; African American/White, $n = 1$). No participants identified as Hispanic/Latino(a). All but 4 participants were daily smokers ($M = 28.15$ smoking days in the past 30 days, $SD = 4.48$), and the sample's mean smoking intensity was 17.40 ($SD = 13.88$) cigarettes a day.

Measures

One-on-one, semistructured interviews included prompts assessing sociodemographic characteristics, smoking histories, participants' perceptions of smoking and the role of smoking in their lives, past experiences with smoking treatment, and suggestions about alternative intervention strategies or means of reducing smoking-related harm.

Open-ended interview prompts included: "Thinking about your current smoking: How would you describe the role that smoking plays in your life?" "What are some of the good things/things you like about your smoking?" "What are some of the not-so-good things/things you don't like as much about your smoking?" "What other kinds of nicotine products do you use/have used? What has been your experience with each of them?" "Some people have tried to quit smoking. Have you ever tried this before?" "(If yes) How did that go for you?" "Did you use any particular aids to help you? Which ones?" "What do you think were the most helpful thing(s)