See article by Carpenter et al

Smoking Cessation in Homeless Veterans

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Smoking is likely much higher in the homeless than in the general population. It is likely higher still in the mentally ill homeless. The effect of veteran status on smoking in the homeless is unclear. However, there is no reason to think that smoking rates would be different as a function of veteran status in this population. For example, homeless veterans are much more likely to have nicotine dependence than veterans who are not homeless.[1] Few studies have investigated the treatment of smoking in the homeless, despite the fact that the majority of smokers seem to want to quit.

In this issue of the *Journal*, Carpenter and colleagues[2] report an open trial of a multicomponent smoking cessation program for 20 homeless veterans. A novel feature of the study was the development of a smartphone application to facilitate mobile contingency management (mCM) therapy. The smoking cessation program utilized in the study included 4 weeks of using mCM, 4 counseling sessions, nicotine replacement therapy, and bupropion if medically appropriate. Participants could earn up to $815 ($480 for mCM, $100 for verified abstinence at 3 follow-up visits, and $35 for equipment return). This approach was a success in this pilot study. Abstinence as verified by carbon monoxide concentrations ≤6 ppm was 50% at the 4-week endpoint. Follow-up bioverified abstinence was 55% at 3 months and 45% at 6 months. Not surprisingly, there was a high rate of psychiatric comorbidity in this sample including posttraumatic stress disorder, major depressive disorder, and lifetime alcohol or substance dependence. This study further suggests that the intervention may be effective despite other psychiatric conditions that are thought to limit successful abstinence. The interpretation of this study, as the authors note appropriately, is limited by the small sample size and the lack of a control group. Nonetheless, the results are promising and should be further explored using a randomized controlled trial design.

Broader Social and Ethical Issues

This study brings to mind several broader issues than the promising efficacy of the authors' proposed intervention in this sample of homeless veteran smokers. These include practical clinical as well as research issues. That there are homeless people at all in the United States is tragic. Moreover, that there are homeless veterans is unconscionable. Yet attention to the health, including psychiatric, needs for homeless veterans has been increasing, albeit gradually. With this background, the current study is even more admirable. Smoking is more prevalent in lower income and educational status groups.[3] The homeless may be seen as one end of a continuum of poverty. Therefore it is not surprising that the homeless population is much more likely to smoke and less likely to quit.[4] As such, smoking in the homeless is not only a biological and psychological dependence problem, but also a social problem. In fact, the homeless person's perception of social status alone may influence abstinence from smoking.[5] Moreover, there may be even more unique issues in the homeless involving barriers to care that include stigma and lack of emphasis on smoking cessation by service providers. There has been much discussion regarding the overt as well as unique or hidden health needs in the homeless.[6] As such, smoking is one of many health concerns that are largely neglected in the homeless.[7] As Baggett and colleagues note, "Underlying all these strategies is the need to change the culture of complacency that has enabled our acceptance of smoking as an inextricable aspect of homelessness. Though the challenges of addressing tobacco use in this population are many, we believe that ignoring this issue is no longer justifiable—and that the conversation should shift away from the question of *whether* to address smoking among homeless people and toward the question of *how*."[4(p203)] So included in the question of *how* are not only social but also ethical issues. These issues raise even more questions.

This path—the social as well as ethical issues involved in research for substance dependence in an impoverished, even homeless, population—might be seen as tangential but it is a relevant path to venture down. There are many examples of community outreach to the homeless for research, eg, AIDS research in certain inner city populations that included advocacy by activist groups. But who are the stakeholders for the homeless? Who are the community leaders? What are the boundaries of the community? Who exactly is engaged when research is conducted in this population? How does one determine the appropriate compensation in this population in order to avoid coercion?[8] Should we have nicotine replacement therapy available at every shelter and free clinic regardless of research or as a follow-up after research is completed? Should the relevant studies be conducted only in other populations that may not be as vulnerable and then applied on a clinical basis for homeless individuals? The authors of this study[2] appear to have been reasonable in applying the ethical principles of respect, beneficence, and justice

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in conducting the research. They expend more than is customary on their local institutional review board review. For this care they deserve kudos. At the same time, we should continue to discuss whether treatment research in the homeless is in some way a replacement for the appropriate application of proven clinical interventions from other populations.

In summary, the authors thoughtfully note a couple of take-home clinical points: *Veterans who are homeless can quit smoking but will most likely need more intensive interventions* and *Use of mobile technology may be feasible to facilitate the treatment intervention in the homeless veteran population*. This is a critical step in the direction of answering the question of how to address smoking in the homeless.

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