

The Third Phase of ASH Scotland's Tobacco and Inequalities Project 2003 – 2006



Older Adults Briefing Paper

Background

ASH Scotland is the leading voluntary organisation in Scotland tackling tobacco use. Established in 1973, the organisation holds a wealth of experience and knowledge on tobacco issues. We campaign to raise awareness of nicotine as an addictive drug, for the introduction of effective stop smoking support services, regulation of the tobacco industry and to reduce the number of young people taking up smoking.

The ASH Scotland's Tobacco and Inequalities (T&I) project is a national community development project that aims to develop capacity and sustainability, as well as challenging and changing practice and policy. To facilitate this, a project fund of around £175,000 will be available, spread over two years, for community groups to apply to. The project fund will be launched nationally in late 2004, following a mapping exercise and needs assessment to uncover the important issues and identify priorities for action. Regional seminars will be held to promote the uptake of the fund and partnership working across Scotland.

The three initial target areas are:

- Older Adults
- Mental Health and Well-being
- Minority Ethnic Communities

The current T&I project was developed following the conclusions and recommendations of ASH Scotland's previous Tobacco and Inequalities work. The first phase of this was the Women, Low Income and Smoking Project (WLISP), which operated between 1996 and 1999 and aimed to explore new ways of working to address smoking reduction among women living on low income. The second phase of work ran from 1999 to 2002 and built on the recommendations of the WLSIP.

Both projects stimulated significant interest in developing new approaches to tackling smoking and raised positive expectations and aspirations in the community about future work. Reports on the work so far are available from ASH Scotland and on-line at www.ashscotland.org.uk, inequalities section.

Time scale	Name of Project	Target groups / Objectives
1996-1999	WLISP (phase 1)	<ul style="list-style-type: none"> - funding and supporting community based initiatives to address smoking reduction among women on low income - exploration of different approaches and methods of evaluation
1999-2002	T&I (phase 2)	<ul style="list-style-type: none"> - funding and supporting work that would support smoking reduction among people living on low income - developing evaluation approaches relevant to those working at community level undertaking smoking based work
2003-2006	T&I (phase 3)	<ul style="list-style-type: none"> - work in relation to Older Adults, Mental health and Well-being and Minority Ethnic Communities - funding and evaluation of community based work - support and training - capacity building and sustainability

Significant areas for future work have been identified, to be taken forward in close collaboration with appropriate individuals, staff, community groups and organisations who have an interest and/or expertise in the respective fields.

Aims of ASH Scotland Tobacco and Inequalities Project 2003-06

With specific reference to Older Adults, Mental Health and Well-being and Minority Ethnic Communities:

- To raise awareness of the issues and inequalities some communities across Scotland face in relation to tobacco and health
- To establish good practice that can be disseminated and implemented across Scotland
- To raise awareness, challenge preconceptions, and stimulate positive change in policy and practice
- To form partnerships that will increase capacity, maximise sustainability and keep tobacco and inequalities issues high on local and national agendas

Defining Older Age

There is no legal definition of old age and several characterisations are used by different people and in different contexts. In the UK the conventional definition of older people is age 65, the state pension age for men. However, age 60 is sometimes also used, as this is current pensionable age for women.

Aims and Objectives for Future Older Adults and Tobacco Work

- To ascertain the current needs of those working in the field of Older Adults in relation to information and resources, cessation support, and tobacco training.
- To involve older adults in the design of tobacco interventions and services relevant to their needs.
- To explore and develop tobacco education and training opportunities for older adult groups and organisations which work with them.
- To involve service users and staff in reviewing relevant tobacco policies which affect them.

Older Adults and Tobacco Use - Research

Tobacco, health and inequalities

Tobacco use is the single biggest preventable cause of ill-health and premature death in Scotland and a major cause of health inequalities. Scotland has an estimated 1.4 million smokers, representing more than one third of the adult population¹. In Scotland around 13,000 people die every year from tobacco-related diseases, including heart disease and many cancers². There are also serious health risks associated with passive smoking³. Smoking-related illnesses cost the NHS in Scotland an estimated £200 million per annum⁴.

Scotland's older population

Scotland's population is growing older. In the late 1990s the average life expectancy in Scotland was 72.6 years for men and 78.0 years for women⁵. At the 2001 census there were 804,900 people aged over-65 in Scotland, representing nearly 16% of the population. By 2031 the number of over-65s is expected to rise to 1.2 million people, accounting for nearly one quarter of the total population.

Tobacco use prevalence

Overall, smoking prevalence declines after the age of 65¹ - either because smokers are more likely to die young, leaving a higher proportion of non-smokers in older age groups, or because former smokers quit smoking. Nonetheless, older smokers are an increasingly significant group:

- The 1998 Scottish Health Survey found that 19% of men and 25% of women aged over-65 smoked tobacco⁶.
- These figures include some older adults (notably men) who smoke pipes or cigars, which have been shown to carry significant risk of smoking related ill-health⁶.
- The Scottish Health Survey showed that 4% of men in Scotland smoked cigars or pipes only. Of men over the age of 65, 6% smoked a cigar or pipe, compared with 2% of men under the age of 35¹.
- Older smokers have often smoked for many years. Many are habituated to smoking and highly addicted to nicotine.
- In an English study, 30% of smokers surveyed over the age of 65 were heavy smokers (smoking 20 or more cigarettes per day)⁷.

- The number of older smokers is increasing steadily as the proportion of older adults in the population rises ⁸.

The effects of smoking

The health of older adults is at significant risk from tobacco use. Tobacco use is not only responsible for a large number of premature deaths from smoking-related diseases, but also an increased risk of illness and a reduction in quality of life:

- Research from the USA suggests that one in three smokers die prematurely, losing on average 12-15 years of life from their projected normal life expectancy⁹.
- Smoking is known to aggravate existing health problems and increase the time needed to recover from many illnesses and major surgery^{10, 11}.
- Tobacco use is associated with circulatory and respiratory disorders (including asthma and pneumonia), with viral infections (such as influenza), a number of other health complaints (such as breathing difficulties, coughing and sinus congestion) and with conditions generally associated with ageing (like osteoporosis, oral health problems, hearing loss, cataracts, impotence and wrinkles)^{12, 13}.
- Many health problems associated with smoking can cause functional impairment and disability, which can have a detrimental effect on a person's quality of life, (for example by making personal care, housework and/or socialising difficult).
- Smoking interacts with and impairs the effectiveness of many medications commonly prescribed for illnesses prevalent in older adults, (such as hypertension, arthritis, diabetes and angina)^{14, 15}.
- Although many regard smoking pipes and cigars as less hazardous than cigarettes, recent research confirms that pipe and cigar smoking carries significant risks of smoking related ill-health⁶.
- There are particular risks associated with cigars relating to the nature of the product and the way it is consumed. For example, the nicotine in cigars is absorbed through the lining of the mouth. Cigar smoke also has very high concentrations of carbon monoxide and high tar content. Cigar smoking is associated with damage to teeth and gums and carries high risks of oral cancers (e.g. cancer of the mouth, throat, larynx and oesophagus)¹⁶.
- When compared to non-smokers, pipe smokers have a greater risk of cancer of the lung, throat, oesophagus, colon and pancreas. They are also at greater risk of other tobacco-related diseases, such as stroke, heart disease and chronic obstructive pulmonary disease^{6, 17}.
- Other problems associated with smoking include the financial costs (which are proportionately greater to those on low incomes) and the risk of burns or fires¹⁸.
- There is some evidence to suggest that smoking speeds up mental decline. Smokers may lose their cognitive abilities, such as remembering, thinking or perceiving more rapidly than elderly non-smokers¹⁹.

The benefits of stopping smoking

Stopping smoking can provide increased quality and quantity of life in older adults – by adding both *years to life* and *life to years*. Smoking cessation interventions are cost effective in improving health and reducing the risk of mortality from smoking related diseases²⁰:

- Studies have demonstrated that mortality is reduced among those who stop smoking even after the age of 65^{14,21,22}.
- Research suggests that the risk of diseases such as coronary heart disease, chronic obstructive pulmonary disease and lung cancer for ex-smokers who stay off cigarettes for over 5 years, are similar to the risks for non-smokers²³.
- Stopping smoking improves general health and well-being, can reduce disability caused by chronic illness, protects against loss of physical function, has benefits for conditions including heart disease and stroke, and is advantageous before surgery.

The challenges of smoking cessation

An estimated 70% of smokers want to quit²⁴, yet cessation in older adults is often neglected. (Indeed, the 1999 Scottish Public Health White Paper set targets for smoking reduction in adult smokers aged 16-64, but did not mention smoking in older adults²⁵). Older smokers' and health professionals' beliefs and attitudes in relation to their tobacco use, health promotion and smoking cessation can be a barrier to quitting:

- Older smokers tend to underestimate the risks of smoking and overestimate the benefits. Older smokers are less likely to accept that smoking harms their health or that of others around them than non-smokers or younger smokers^{7, 22,26}.
- Many older smokers believe that the damage has already been done and that little can be done to reverse the adverse effects of disease or symptoms relating to smoking^{7, 13}. Some are apathetic about health promoting behaviour and do not see the point in depriving themselves of 'treats'²⁷.
- Health professionals often fail to target older smokers. One study in Ireland found that doctors were significantly less likely to advise patients over 65 years to quit smoking²⁸. Nurses and other care staff can also be reluctant to broach the subject of stopping, for similar reasons to those discussed above^{8, 14}.

Recommendations

The Scottish Executive has stressed its commitment to promoting healthy lifestyles and has acknowledged a need to develop policies and services that are responsive to the needs of older people. This includes encouraging older smokers to quit and targeting high-risk groups, such as those with heart disease²⁹.

- Health and related professionals should provide accurate information and advice about the risks of smoking and benefits of cessation, and provide support to help people quit.
- Health and related professionals should be trained in tobacco education and cessation.

Given that people aged over-65 are in contact with members of the primary care team on average seven times per year¹², GPs have an important role to

- play. Nurses also make a significant contribution to the health of older people, in primary care, acute hospital care and within nursing homes.
- Age sensitive recruitment strategies, promotional messages, programme content and modes of delivery are important if older adults are to be targeted effectively. Strategies should be tailored to the unique health beliefs and cultural history of older smokers, and older adults should be involved in their development.
 - In addition to specialist clinics and support groups, self help materials, telephone support and buddy support may be suitable for some older people.

Overview of Strategy

The Scottish Executive has given ASH Scotland agreement to continue funding the Tobacco and Inequalities work. The project commenced November 2003. Areas to be covered include awareness raising, support and training, funding and evaluation of community based work, capacity building and sustainability. Funding will be available in years two and three of the project, to undertake project work that involves the target groups. The T&I Project will link in closely with the work of the ASH Scotland led Partnership Action on Tobacco and Health (PATH) initiative, which focuses on tobacco training, cessation evaluation and best practice. It will also draw upon the specialist information support available from the ASH Scotland Information Service.

The project has completed a literature review phase and these will be available shortly on-line at www.ashscotland.org.uk.

A needs assessment and mapping exercise are currently being undertaken relating to community based tobacco work within the three target areas. The needs assessment aims to cover the important issues and to identify priorities for action. The mapping exercise aims to find out what services and resources already exist in relation to the three target areas. It is anticipated that these will be completed and reported on-line by Autumn 2004.

The funded projects will be supported by the Community Development Manager and it is hoped they will commence in 2005.

For further information or application forms please contact

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REFERENCES

- ¹ The Scottish Executive (2000) *The Scottish Health Survey 1998* Edinburgh: TSO
<http://www.show.scot.nhs.uk/scottishhealthsurvey/>
- ² Callum C (1998) *The UK Smoking Epidemic: Deaths in 1995* London: HEA
- ³ ASH Scotland *Briefing on Passive Smoking* www.ashscotland.org.uk
- ⁴ Scottish Executive (2004) *Health in Scotland* Edinburgh: Scottish Executive
<http://www.scotland.gov.uk/library5/health/his03-03.asp>
- ⁵ NHS Scotland Information and Statistics Division (2001) *The Health and Well-being of Older People in Scotland: Insights from national data* http://www.show.scot.nhs.uk/isdonline/Scottish_Health_Statistics/subject/older_people/2001/
- ⁶ Shaper A, Wannamethee S and Walker M (2003) 'Pipe and cigar smoking and major cardiovascular events, cancer incidence and all-cause mortality in middle-aged British Men' *International Journal of Epidemiology* Vol. 32, pp802-808
- ⁷ Jarvis M, Wardle J, Waller J and Omenn L (2003) Prevalence of hardcore smoking in England, and associated attitudes and beliefs: Cross sectional study *British Medical Journal* Vol. 326, pp 1061-1065.
- ⁸ Kerr M, Watson H and Tolson D (2002) 'Older people who smoke: why nurses should help them to stop' *British Journal of Nursing* 2002, Vol. 11, No. 1
- ⁹ Cataldo J (2003) 'Smoking and Aging, Clinical Implications Part 1: Health and Consequence' *Journal of Gerontological Nursing* Vol. 29 (9) pp15-20
- ¹⁰ Appel D and Aldrich T (2003) 'Smoking cessation in the elderly' *Clinics in Geriatric Medicine* Vol.19, No.1
- ¹¹ Raw M, McNeill A and West R (1998) 'Smoking cessation guidelines for health professionals' *Thorax* Vol.53 (Supplement 5), ppS1-S19
- ¹² Health Education Authority (1999) *Older Smokers: A Practical Resource for Health Professionals* London: HEA
- ¹³ Center for Social Gerontology (date unknown) Factsheet on *Tobacco and Older Persons*, Leaflet entitled *It's never too late to quit smoking* from www.tcsg.org
- ¹⁴ Rimer B, Orleans T, Keintz M, Cristinzio S and Fleisher L (1990) 'The older smoker – status, challenges and opportunities for intervention' *Chest* Vol.97, pp547-453
- ¹⁵ Molander L, Hansson A and Lunell E (2001) 'Pharmacokinetics of nicotine in healthy elderly people' *Clinical Pharmacological Therapy* Vol.69, pp57-65
- ¹⁶ GASP (2002) *Cigars and Health: The Facts* (leaflet) Bristol: GASP
- ¹⁷ Henley SJ, Thun MJ, Chao A and Calle EE (2004) 'Association between exclusive pipe smoking and mortality from cancer and other diseases' *Journal of the National Cancer Institute* Vol. 96, pp853-861
- ¹⁸ Office of the Deputy Prime Minister (2004) *Fire Statistics – United Kingdom, 2002* London
- ¹⁹ Cervilla J, Prince M and Mann A (2000) 'Smoking, drinking, and incident cognitive impairment: A cohort community based study included in the Gospel Oak project'. *Journal of Neurology, Neurosurgery and Psychiatry*. Vol. 68, No.5; pp622-626
- ²⁰ Buck D, Godfrey C, Parrott S and Raw M (1997) *Cost effectiveness of smoking cessation interventions* London: HEA
- ²¹ LaCroix A and Omenn G (1992) 'Older adults and smoking' *Clinical Geriatric Medicine* Vol.8 pp69-87
- ²² Taylor J, Hasselblad V, Henley S, Thun M and Sloan F (2002) 'Benefits of smoking cessation for longevity, *American Journal of Public Health* Vol. 92 pp990-996
- ²³ Orleans C, Jepsen C, Resch N and Rimer B (1994) 'Quitting motives and barriers among older smokers – the 1986 adult use of tobacco survey revisited' *Cancer* Vol.74 (7 SS) pp2055-2061
- ²⁴ Office for National Statistics (2003) *Smoking Related Behaviour and Attitudes 2002* London: Stationery Office
- ²⁵ The Scottish Office (1999) *Towards a healthier Scotland - The Public Health White Paper* Edinburgh: The Stationery Office
<http://www.scotland.gov.uk/library/documents-w7/tahs-00.htm>
- ²⁶ Carosella A, Ossip-Klein D, Watt C, Podgorski C (2002) 'Smoking history, knowledge and attitudes among older residents of a long-term care facility' *Nicotine and Tobacco Research* Vol. 4, pp161-169
- ²⁷ Fee L, Cronin A, Simmons R and Choudry S (1999) *Assessing older people's health and social needs: Qualitative Research Investigating health beliefs and social factors relevant to older people's health* London: Health Education Authority
http://www.hda-online.org.uk/documents/assess_older_health.pdf
- ²⁸ Maguire C, Ryan J, Kelly A, O'Neill D, Coakley D and Walsh J (2000) 'Do patient age and medical condition influence medical advice to stop smoking?' *Age and Ageing* Vol.29, pp264-266
- ²⁹ Scottish Executive (2002b) *Adding Life to Years: Report of the Expert Group on Healthcare of Older People*
<http://www.scotland.gov.uk/library3/health/alty-00.asp>