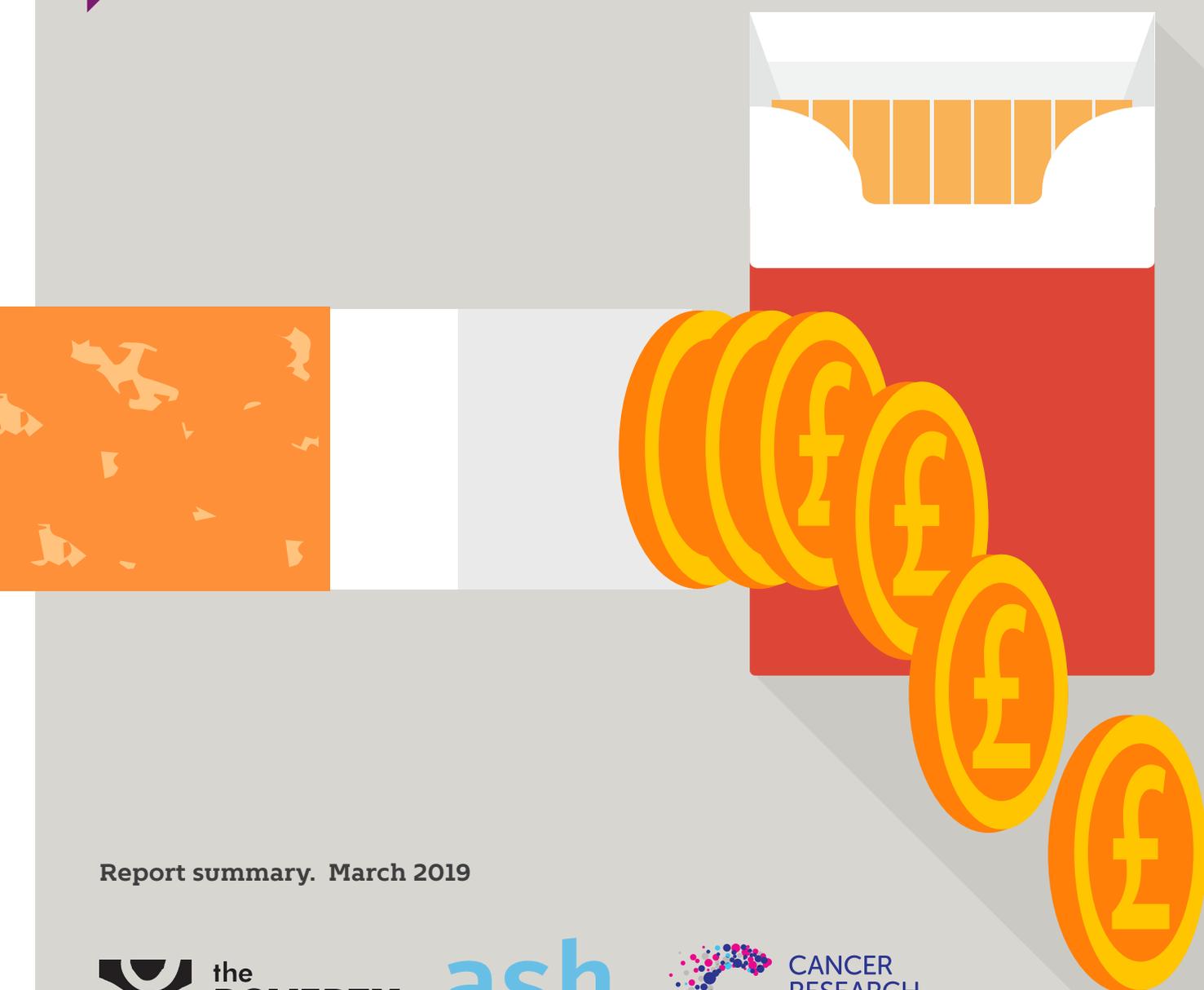


We need to talk about smoking and poverty

Why we need a positive, people-centred approach to improving health and reducing poverty by supporting people who want to stop smoking



Report summary. March 2019

The Smoking and Poverty project is a partnership between the Poverty Alliance and ASH Scotland. With public health and anti-poverty interests sharing the goal of improving people's well-being, we are investigating why there is a lack of collaboration between these sectors, and exploring changes that might help to address this.

There are both health and economic costs to smoking, and this harm largely falls on people in disadvantaged groups who say that they want to quit. Smoking undermines the goals of both public health and anti-poverty groups, so that they have a shared interest in reducing the impact of smoking in Scotland.

Scotland has the worst health inequalities in Western Europe, and smoking is both a cause and an effect of that inequality. Smoking is not a root cause of poverty, but smoking does exacerbate the harm and disadvantage experienced by people living with poverty.

Smoking is the largest preventable cause of ill-health and death in Scotland. Today over 450,000 people in Scotland's disadvantaged areas (SIMD 1 and 2) are living with a greatly increased risk of cancer, heart disease, stroke, diabetes and dementia because of smoking - further burdening those already faced with structural inequalities. The financial costs (just to smokers in these groups who say they want to quit) are nearly half a billion pounds a year.

Public health discussions on smoking increasingly focus on poverty and inequality, but rarely manage to engage organisations working specifically in those areas. Anti-poverty interests, meanwhile, are often focused on the structural causes of poverty and may not see smoking as a priority.

We have therefore explored how anti-poverty organisations perceive smoking as an issue that impacts on their clients, how they view existing health interventions, how they relate these to their own activities and whether they felt that more collaborative efforts between the two sectors were possible or desirable.

We conducted semi-structured interviews with local anti-poverty organisations in

Fife and Renfrewshire, complemented by discussions with several organisations working at a national level, and followed up by two focus groups to further explore the issues raised.

"Smoking is just a wee comfort people will use"
(Local level stakeholder)

- Across this study, participants viewed the relationship between poverty and smoking as complex and one that was shaped by a number of different characteristics. These include household circumstances, demographics, and the nature of poverty that households were experiencing (such as 'persistent poverty'). Beyond this it was noticeable that there was no one shared or commonly accepted narrative or understanding as to how smoking and poverty interconnect.

"I think before you can look at stopping smoking, you've got to deal with the issues that cause you to smoke, especially if you are using it for a crutch, because you've got to deal with what the reason is before you can even think about stopping smoking or even have that conversation"
(Local level stakeholder)

- The cost of smoking was generally understood as a negative expense on household incomes and caused further issues for those living on a low income. However, the cost of tobacco was

viewed as not being a barrier to uptake of smoking, as people would manage their income in order to continue or prioritise smoking. The addictive nature of smoking was considered to make this a key cost people that would sustain, even if they were experiencing periods of financial hardship.

- Project participants were asked to discuss how they engaged with clients around the subject of smoking and how smoking impacted on the work of their service. Most indicated that this was not a subject that was raised by either staff or clients. While it was generally recognised that smoking has negative impacts, there were a number of barriers that stood in the way of raising smoking as an issue.
- There was a widespread acknowledgement that smoking is a harmful activity, but while smoking was understood to be an important issue it was generally not considered a priority for services to deal with. This was partly because it did not require an immediate response, or prevent people from engaging with services, but also because clients tended to raise what they felt were their core problems, rather than the smoking they were using as a coping mechanism.

“I have to admit as part of the list of that I go through I am supposed to bring it up, I’m finding now that it is something that with a homeless risk or whatever, I’d feel personally insulted if I were coming into get some advice about destitution for my smoking habits to be investigated”

(Local level stakeholder)

- There was widespread recognition of a number of public health actions that had been introduced to reduce smoking - although there was also significant scepticism as to whether these were appropriate, or effective. In

particular there was a perception that smokers experienced the negative “stick” approaches (such as tax) more than the supportive “carrot” initiatives (such as free support services).

- Despite the concerns raised, and the recognition that they have found it difficult to engage with smoking, participants understood smoking as being harmful to their clients and were open to building a better understanding and discussion on smoking and poverty.

“Putting the fear into people doesn’t work, as they have heard it all before”

(Local level stakeholder)

The focus groups explored how attitudes and perceptions colour our views and conclusions on smoking and poverty, through considering three different ways of understanding smoking:

- The “health” (or “medical”) model is the framing that might be associated with a hospital or GP visit, or with regulation and restrictions and an emphasis that smoking is a harmful addiction that should be avoided.
- The “social” (or “community”) model is more likely to be associated with community-based support services. Here smoking is framed from the viewpoint of the individual, largely as a coping mechanism used to respond to stress, boredom, isolation or anxiety - one which brings both costs and benefits that must be weighed against each other.
- The “recreational” (or “libertarian”) model puts personal freedom at the centre and presents smoking as a pleasurable activity that adults choose to engage in, knowing the associated health risks. This model is promoted by “smokers’ rights” interests, who will tend to advocate against intervention by governments or other bodies.

Potential ground for collaboration between public health and anti-poverty interests was explored through discussing areas where the health and social models would overlap.

Reassuringly, the focus group participants were quickly able to identify statements, assumptions and language that they felt

could form the basis of a shared conversation between public health and anti-poverty interests, including:

“smoking is an addiction” / “most people who smoke say that they want to stop” / “people need other coping mechanisms” / “let people say what other coping mechanisms might be” / “explore the issues that are leading people to smoke” / “frame support as part of the duty of care” / “be non-judgemental, don’t tell people off” / “most people regret starting” / “create situations where people don’t want to smoke” / “the tobacco companies are exploiting people” / “train and support staff to help people” / “plant the seed and build up to the goal at people’s own pace” / “give staff the courage to engage with smoking” / “honey not vinegar, use positive rather than negative approaches” / “address the underlying problems and people will stop smoking” / “do things with people rather than to them” / “start with the person, so a bottom-up intervention”

Recommendations

- 1) Improve understanding of the situation by further exploring the role and impact of smoking in the lives of people living in poverty, including the participation of people with lived experience.
- 2) In order to engage anti-poverty interests, messaging around smoking must be framed positively, with the emphasis on supporting people rather than on taking something away.
- 3) With smoking so often used as a coping mechanism, we must do more than just call on people to stop smoking and need to support them in finding alternative coping strategies.
- 4) Offer organisations the advice, resources and training they need in order to engage clients who smoke in an empathetic and supportive manner.
- 5) Provide the necessary leadership, and encourage better collaboration between health and anti-poverty interests, by integrating smoking and poverty in local and national strategies.

For Further Information, or to request a copy of the full report:

www.povertyalliance.org

0141 353 0440

admin@povertyalliance.org

www.ashscotland.org.uk

0131 225 4725

enquiries@ashscotland.org.uk

“Awareness campaigns are good, but have to be matched with services/resources on the ground to back things up”

(Local level stakeholder interview)

The Poverty Alliance is recognised as a charity by the Inland Revenue. Reference No: SCO19926.

Action on Smoking & Health (Scotland) (ASH Scotland) is a registered Scottish charity (SC 010412) and a company limited by guarantee (Scottish company no 141711).