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

the **POVERTY ALLIANCE**
WORKING TOGETHER TO COMBAT POVERTY

ash scotland
Taking Action on Smoking and Health

CANCER RESEARCH UK

The **Report**

Report written by:

Fiona McHardy, Research and Information Manager, Poverty Alliance

John Watson, Deputy Chief Executive, ASH Scotland

Linda Bates, Development Officer, ASH Scotland

Peter Kelly, Director, Poverty Alliance

For Further Information

Acknowledgements

Executive **Summary**

This project set out to investigate why there is not more collaboration between public health and anti-poverty interests, given the clear shared aims of improving people's well-being, and to explore changes that might help to address this

The context for the project is the clear health and economic harm caused by smoking, and that this predominantly falls on people in disadvantaged groups who say that they want to quit. Smoking is not a root cause of poverty, but it does exacerbate the harm and disadvantage experienced by people living with poverty.

We started from the observation that 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 therefore focused on exploring 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. To do this 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, following up with two focus groups.

From participant contributions we learned that:

- the relationship between poverty and smoking is complex, and there is no one, generally accepted narrative of how poverty and smoking inter-relate;

- there was general understanding that smoking is commonly used as a coping mechanism, providing a clear explanation of why smoking is more prevalent amongst groups living with poverty and disadvantage, as these people live with greater stresses and pressures and have fewer alternatives available;

- for people living in poverty, immediate needs and services demand precedence over longer term considerations of harm;

- while the financial costs of smoking were appreciated, smoking was not generally seen by organisations as a crucial factor in whether or not people experienced poverty;

- smoking was not a routine part of the conversations services held with clients, partly because it is considered a sensitive issue, with staff keen to avoid any scenario where they could be perceived to be sitting in judgement or control of their clients, and partly because the emphasis was on what were perceived to be the root causes of poverty;

- smoking was not proactively raised by clients, perhaps because of its perception

as a coping mechanism rather than a root cause of poverty, which was a crucial consideration for services seeking to be user-led;

- the way in which different issues were prioritised often meant that smoking was seen as less of a priority, being less likely to present as an immediate crisis and not offering any practical difficulties for engagement (in the way that being under the influence of alcohol or drugs might);

- organisations were increasingly aware of clients using electronic cigarettes, but staff had no shared understanding of their relative risks or benefits and therefore no consistent response;

- while there was generally high awareness of many of public health's "anti-smoking" interventions, there was widespread scepticism as to their effectiveness, and in particular a concern that the "stick" approach (e.g. high taxes) was experienced by clients rather more than the "carrot" (e.g. free support services); and

- organisations understood the harm and were generally open to the idea of greater engagement with the issue, but this would need to be a positive support, centred on the needs and wishes of the individual client.

The focus group discussions, held in the two local authority areas, provided the opportunity to further explore how different perspectives on smoking influence responses. We discussed the different language and assumptions we might see from people following a "health/medical" approach (as public health interests might), "social/community" approach (as anti-poverty interests might) or "recreational/libertarian" approach (as "smokers' rights" campaigners might). Then we sought to explore the overlap between health and social approaches/interests, as a way of identifying the shared ground on which public health and anti-poverty interests might be able to collaborate.

Discussion highlighted good interest in developing this shared approach, with the initial themes identified being that:

- smoking is a harmful addiction, that is nevertheless practiced as a coping mechanism, and hence is more prevalent amongst those most in need of coping mechanisms;

- any activity should focus on positive, supportive interventions, complementing efforts to reduce the underlying root causes of poverty with an emphasis on identifying less harmful coping mechanisms;

- any suggestion of blame should be focused on the commercial interests who drive, and profit from, the problem and never on the individual smoker;

- the harm caused by smoking is such that it should be considered part of the "duty of care" services have to clients.

On this basis the following recommendations are presented:

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.

Introduction

This collaborative research project between Poverty Alliance and ASH Scotland ran from 2017-2018

We set out to explore why there is so little dialogue and partnership working between organisations focusing on poverty and those focusing on public health, despite the potential synergy arising from the harmful effects of smoking in both of these areas. This lack of interaction inhibits joint activity that could help reduce the health, social and economic harms associated with tobacco use.

The research engaged voices at national level and across the Renfrewshire and Fife local authority areas, exploring a range of policy areas. In this report we examine stakeholders' perspectives and perceptions about the relationship and connections between smoking and poverty, and explore how greater collaborative working could be fostered between public health and anti–poverty organisations.

Methodology

This research utilised a two-stage qualitative approach

The targeted local authorities were selected based on recent active anti-poverty work locally, including recent Poverty Commissions in each area.

The project mapped a range of community and voluntary organisations that were working locally on anti-poverty work in the two local authorities sampled for this project.

The project has been developed in response to our observation that public health interests increasingly focus on inequalities, but not in a way that engages anti-poverty audiences. At the same time, it was believed anti-poverty interests do not generally see smoking as a focus for their work. We therefore resolved to explore the hypothesis

that differing worldviews, language and assumptions were creating a divide between public health and anti-poverty interests, leaving each to pursue what were otherwise complementary goals through separate channels that rarely interact. We chose to focus on exploring the current perceptions amongst anti-poverty interests, with a view to understanding why attempts by public health interests to discuss inequality are not effective in engaging those primarily working in this area, and to consider how a new narrative could be developed to appeal to both health and anti-poverty interests and support better collaboration between the two.

Initially, organisations were approached by a letter outlining the project and then followed up by email and phone call outlining the aim of the project. Following this recruitment process, semi-structured one-to-one interviews were conducted with community-based and voluntary organisations across each local authority: nine in Fife and eight in Renfrewshire.

Organisations were drawn from those encompassing a range of populations affected by poverty, including families, single adults and older people. Services delivered a range of interventions and had a range of aims related to supporting people experiencing low income. Research focus group structure was piloted with Glasgow Caledonian University, involving students working with the Scottish Poverty and Inequality Research Unit. This enabled testing of the digital voting and use of Venn diagrams illustrating viewpoints on smoking, as an elicitation tool during discussions.

In addition, four interviews were also conducted with organisations that were involved in national anti-poverty policy work.

Context

What we know about smoking, poverty and health inequality

Scotland has the worst health inequalities in Western Europe[i] and smoking is both a significant cause and effect of that inequality.

An increase in awareness, and a range of government interventions, have led to smoking reducing substantially from its peak in the mid-20th century. This shift has taken decades, however, and the ongoing decline is very slow. The result is that smoking remains far and away the largest preventable cause of ill-health and death in Scotland[ii] . Most people who smoke started as children[iii] , and even now young people in disadvantaged communities are more likely to take up smoking and to do so at an earlier age. 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[iv] – further burdening those already faced with structural inequalities.

There are limitations on the data available to understand the relationship between socio – economic status and smoking. The Scottish

Index of Multiple Deprivation(SIMD)[v] provides insights into area deprivation indicators, but many people affected by poverty will not be living exclusively within SIMD areas.[vi]

As a tool to understand the relationship between poverty and smoking this provides limited analysis as, for example, two out of three people who are income deprived do not live in deprived areas[vi] . Nor does living in deprived area mean that everyone within that data zone is deprived: just under one in three people living in a deprived area are income deprived .

We require more robust evidence and information to understand the complexity of the relationship between poverty and smoking. This needs to incorporate and understand the relationship between smoking rates, household circumstances, broader environment and socio-economic status, as well as other protected characteristics, to better understand the populations most at risk and the circumstances they face. More robust data would enable more effective targeting of smoking as a public health issue, particularly within a context of a fast-evolving and challenging landscape for households experiencing poverty.

Within the data that we currently hold in Scotland there are some important trends to note, despite the limitations in measurement. There is clear analysis within SIMD data that raises concern in terms of the health, social and economic costs of smoking. The smoking rate in SIMD 1 is three times as high as in SIMD 5[vii] , and nearly half amongst those out of work and seeking employment, or living with a long-term disability, are also smokers[viii]. At least one third of tobacco is used by people with mental health conditions[ix]. These intersections point to contributing factors where poverty is well known to have an adverse impact. Overall, financial costs indicate the scale of the issue in disadvantaged communities - with costs

(just to smokers who say they want to quit) equating to nearly half a billion pounds a year[x].

Crucially, across all these groups people are just as likely to say that they want to stop smoking, but they are less likely to succeed in doing so. We need to move beyond narratives that portray smoking as a "lifestyle choice" and instead develop responses that account for social and economic circumstances. As a consequence, policy responses that approach smoking as a freely-entered personal decision will not be fit for purpose.

Poverty is a fundamental cause of health inequality, while smoking is a principal means by which that inequality translates into greater harm to individuals. We need to explore the complex interactions between them. To do so will require us to explore smoking as a social justice issue rather than simply as a health concern.

The data that we currently hold contains some important trends to note. At a national level, in 2013, the Scottish Government set a target to reduce the adult smoking rate to 5% by 2034[xii] (from 18% in 2017[xii]). Setting the target in this way makes it clear that smoking will not be prohibited and can be understood as limiting smoking to the small minority of adults in Scotland (currently just under 6%) who willingly choose to smoke. To do this requires engaging with the great majority of smokers who say that they want to stop, by means they will effectively engage with. Doing so creates the conditions in which health and social goals overlap in supporting people to achieve their own desire to be smoke-free and better off. Supporting smokers experiencing poverty or living on a low income poses many challenges: support needs to be sensitive and informed by the context in which low income households find themselves, and which reflects the barriers and circumstances that households and the services around them are shaped by.

The Relationship between **Poverty** and **Smoking**

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.

Participants recognised a relationship between poverty and smoking, but found it difficult to articulate the nature of this relationship and reported various motivations for smoking amongst people experiencing poverty. and disadvantage. Narratives of poverty shaped and drove participants' views at a local and national level: for example, a mixture of individual and structural factors were articulated as motivation for uptake of smoking.

The diversity of households experiencing poverty meant that different factors emerged across this research as influencing and shaping smoking rates amongst people living on a low income - for example, position in the life course, caring responsibilities, levels of vulnerability, and so on. Generally, though, across this study the intensity of the poverty a household experienced, either through a significant acute shock or experiencing poverty on long-term or persistent basis, was suggested as being a factor in the increased likelihood of smoking within low-income households and to explain higher rates across communities affected by poverty.

Smoking motivations were viewed as being related to household experiences of poverty. A strong attributing factor was the chronic stress and impacts on resilience that living in poverty and experiencing periods of low income had on people's lives – with a common understanding that smoking was used in response to adverse factors such as stress, boredom or poor mental health. People living in poverty are at greater risk of experiencing each of these.

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

Wider evidence around poverty has highlighted that mental health and resilience is shaped by the number of variables, including the social, economic and physical environments in which people live[xiii]. For those living on a low income, risk of experiencing poor mental health is far greater[xiv]. Discussion across focus groups (carried out with representatives of local anti-poverty groups) and interviews outlined that smoking was a coping mechanism people employed to help them deal with trauma and adverse circumstances and mental ill-health, and more fundamentally the feelings of alienation from wider society that poverty induced.

The broader context of social policy impacting and influencing people's lives, as well as macro-level factors such as labour market conditions, were central to creating a changing and difficult context for households affected by poverty. Precarious work and wider structural changes affecting welfare support structures were attributed to having a core impact on the resilience and coping strategies employed by households. The context was seen to have worsened in recent times, with welfare reforms and austerity contributing to a reduction in support for people, as well as levels of household income for different populations experiencing poverty. There are additional questions about the wider context facing low-income communities around the roll-out of Universal Credit, as well as unanswered questions about the potential impact on low-income communities that will emerge from the forthcoming exit of the UK from the European Union.

The nature of the changing landscape for people experiencing low income and poverty, in terms of reduced support services and greater and more precarious financial circumstances, was raised as a difficult context for existing smokers to change their response to stress.

> **"Smoking doesn't actually relieve stress, but the habit of it, the control of it and even control is not the right term, but I guess there's so much more taken away from people…I do not see why we need to keep picking and taking away things"**
> (Local level stakeholder)

Participants discussed that alleviating the determinants of poverty - for example, inadequate benefits or precarious work conditions, or providing support with wider

variables such as mental health conditions - would likely help in reducing smoking rates within disadvantaged communities. So a common view was that reducing poverty was the mechanism by which smoking would be reduced.

Smoking was perceived to promote a feeling of 'psychological safety', whereby people were comforted by the action of having a cigarette and taking an opportunity to remove from the presenting stressor on a temporary basis. Participants discussed that although wider knowledge of smoking was of it being a harmful activity, crisis situations regularly occurred during experiences of poverty and therefore it was often cited as a key activity for dealing with difficult situations. Participants perceived smoking as a short-term approach to managing stress, but that such approaches were a necessary coping strategy in the face of living in poverty. This parallels wider research on the psychology of poverty, which has discussed 'scarcity mindset' as a phenomenon affecting people experiencing poverty on a long-term basis. This would be when people focus on immediate poverty reduction at the expense of other concerns[xv]. Factors pushing people to prioritise short-term needs over long-term well-being would of course support a greater likelihood of smoking.

That there is a relationship between stress and poverty was clearly seen. The stress of living in poverty was viewed by participants as a factor that affected people taking up smoking, as well as continuing to smoke. Stress was also viewed as a barrier to giving up smoking. Agencies involved with the prevention of smoking needed to recognise the number of ways poverty affected and shaped individuals' responses to stress to be effective. Living in poverty was discussed as meaning that people had limited access to other activities which may help reduce stress. Costs of activities, such as a leisure activities, and restrictions

with other barriers, such as travel, caring responsibilities etc., resulted in an increased likelihood of smoking.

Common perceptions (referred to by participants as 'myths') around smoking uptake amongst people experiencing poverty, and areas experiencing poverty, were discussed. It was argued that there was the perception that higher rates of smoking could be attributed to factors such as education and understanding, but participants within this study outlined that contributing factors were more complex, not as easily generalisable, and dependent on a given household's circumstances.

As well as discussion of psychological space, physical space was also critical to understanding the relationship between smoking and poverty. Smoking was viewed as an activity which could fit in a context of a constrained household situation where there may be overcrowding in space which inhibited other forms of leisure, or where opportunities to engage in public leisure spaces were limited. It was cited that living in communities affected by poverty - for example, in poor-quality or overcrowded accommodation - brought pressures to people's lives, affected their wellbeing,

increased the likelihood of smoking and reduced the likelihood of them being able to address their smoking. High-pressure situations, such as insecure housing, were seen as requiring high levels of emotional energy.

People living in low-income communities were viewed to be experiencing higher levels of constraint on their time - for example, through welfare conditionality or other circumstances such as caring responsibilities, as well as less visible barriers such as isolation or low confidence, which affected what leisure activities people engaged in. In situations where there were high caring responsibilities, it was recognised that households may be restricted by time and offered limited opportunities for respite, and were more likely to be adopting smoking as an activity which could be easily accessed and carried out at irregular points, fitting in with household demands.

Peer group and wider feelings of belonging were cited as key reasons why people within specific populations (such as those experiencing homelessness) may be more likely to smoke. Smoking provided a vehicle for social interaction.

Relationship between **Cost** and **Smoking**

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/

poverty, and no matter how high the sums involved.

> **"I think in some instance, the cost, the cost definitely has [a] bearing but then people just go to either cheaper forms, or there's lots and lots of, for example there's more and more people we're finding are rolling their own cigarettes which is a cheaper alternative but you are still smoking"**
> (Local level stakeholder)

Wider evidence has indicated that people who are on low incomes are more price-responsive than wealthier smokers and hence quit (or smoke less) in greater proportions when taxes are higher - thus the health benefits are strongly concentrated in smokers on low incomes who manage to quit[xvi]. Despite this, the perception amongst project respondents was that price had a limited impact on smoking rates, and that price increases on tobacco provided additional challenges for those managing a low income. Experiencing financial hardship adversely impacted households and contributed to people smoking more due to the resulting stress. Increases in the cost of tobacco was perceived to contribute to increasing marginalisation of those on a low income.

In some services within this research study, the cost of smoking came up as part of reviews with service users (for example, around their income or debt). Smoking was routinely dealt with as an 'expense' in the same way that other household expenses were, to ensure continuity in the provision given. This particular area of spending was seen as problematic, in that service users often felt uncomfortable about identifying this as a source of household spending.

More broadly, it was argued that looking at the costs for low-income groups as an approach to reducing smoking could perhaps be contributing to further marginalisation or stigmatisation of low income groups, by specifically targeting low income households. This contributed to a wider impression amongst respondents of lower-income groups being unfairly targeted by public health initiatives.

Wider perceptions also emerged around households remaining in poverty, regardless of whether they smoked or not, and so although reducing smoking could result in less financial pressure it was not perceived as being a significant determinant in people escaping poverty.

Pack sizes of tobacco were also cited as a potential contributing factor. The removal of 'ten packs' of cigarettes, with cigarettes now only being available in packs of twenty, resulted in people paying higher purchase prices and was felt to have the potential risk of increasing consumption rates.

> **"Financial problems have worsened because of cigarettes now only sold in 20's , rather than 10's – people still buy them because they are addicted but will smoke more as a result, meaning they will run out of money more quickly"**
> (Local level stakeholder)

The nature of maintaining an addiction meant that households were also at risk of trying to reduce costs in order to maintain their ability to smoke. People and communities experiencing poverty were therefore at risk of being targeted by those selling illicit cigarettes and bypassing regulations, such as not selling to children. This was cited as a core difference that higher socio-economic groups would not face.

Working with **Low-Income Groups** and **Smoking**

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 indicating that this was not a subject that was raised by either staff or clients. It was generally recognised that smoking has negative impacts, but there were a number of barriers that stood in the way of raising smoking as an issue.

Work around smoking was largely invisible or missing from services interviewed in this study, with some exceptions – for example, for organisations who linked into a specific health concern (e.g. risk of Sudden Infant Death Syndrome (SIDS) for women in pregnancy) or where it was driven by a specific policy initiative (e.g. work across a criminal justice setting was being altered due to the implementation in November 2018 of the smoking ban within prisons in Scotland)[xvii].

Smoking was often viewed as a sensitive subject, and one which participants considered asking about could jeopardise relationships and lead to potential disengagement from services by clients. This was driven by specific perceptions, such as that to do so was infringing on people's rights, or that to ask was insensitive at time of presentation, or that quitting smoking was not a priority for people seeking support. It was not termed as a 'presenting' issue (such as income crisis or supporting immediate emotional wellbeing), so was not something that routinely featured in conversations. Stakeholders outlined that underlying issues

"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)

resulted in people using smoking as a way of managing their emotions – issues that were often complex and required sensitivity to address – so simply offering stop-smoking advice was not straightforward.

For service providers, non-judgemental relationships with service users was viewed as of critical importance - and building relationships was part of day-to-day work for services engaged in this study, particularly where a household was perceived to be experiencing high levels of vulnerability or precariousness. Building relationships enabled services to offer support and to establish detailed pictures of what issues households faced, to enable delivery of tailored inputs and interventions.

The importance of a non-judgemental response was emphasised, and the subject of smoking was perceived to be asking about 'lifestyles' or passing judgment on the choices within a household. The result of this was that even well-intentioned enquiries could be heard as something more intrusive.

> **"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)

Such questioning led to a perceived risk of disengagement, or people being closed to sharing information with service providers. Some services where questions had been posed directly regarding the uptake of smoking (e.g. in money advice provision, where clients were often asked about their financial spend on smoking) reported discomfort from clients around this topic.

Work around smoking was generally related to signposting to NHS smoking cessation services. The uptake of these services was often very low, and discussion highlighted that in some communities the location of smoking cessation groups etc. often created barriers for people, such as poor transport links or being held in a time or location that didn't fit in with caring or work commitments, or other constraints that low-income groups faced.

Project participants emphasised that it was rarely an organisational priority for them to be looking at the issue of smoking. Services were driven by several outcomes and expectations, and had to balance a number of agendas and needs around health, housing etc. with presenting clients. Wider structural factors influenced this - for example, specific funding streams or programmes that agencies were engaged with. Where service users were experiencing chaotic or vulnerable household circumstances, this process often took a long time and required sensitivity.

Including smoking within broader service delivery was, however, seen as important. Services recognised the benefits that could be experienced by their clients – but outlined that this would result in shifts in the way they delivered services and would need to be embedded into existing work to ensure sustainability.

It was also highlighted that some services had a core focus on user participation in terms of how they designed and led different pieces of work. This focus on client-led work (for example, workshop activities) meant that organisations were not asked for smoking cessation information. Organisations expressed reluctance at changing models of service-user participation work, as it was often a draw to engagement and continued retention within their service. The lack of recognition of service users to identify smoking as an issue when engaging with services was cited as a key barrier faced in work around smoking. We understand

that clients will seek to discuss what they perceive to be the root problem, rather than the response or coping mechanism, but the lack of service users identifying smoking as an issue was cited as a key barrier acting to limit work around smoking.

> **"I think people in extreme poverty they've got other stuff going on , whether it's looking at sanctions , whether it's looking at trying to get by ... smoking never really came up as an issue"**
> (Local level stakeholder)

Consequently, due to lack of organisational focus and the perceived sensitivity of the subject, very few examples emerged within this study of provision of stop-smoking support. Work around smoking was generally light-touch and built into work that often included signposting to other agencies. In the few organisations where regular work was ongoing, there were wider challenges about where smoking sat in terms of organisational remit and a need for further tools, resources and advice around the subject. Clarity and strategic focus was seen as essential to embedding smoking cessation within existing work. Greater promotion had to be balanced against staff resources, service-user needs and other core outcomes.

A clear message emerged of the lack of systematic monitoring and recording of levels of smoking amongst service users. Some agencies incorporated it as part of broader evaluative tools such as the Outcomes Star (exploring different categories, e.g. wellbeing), but generally agencies struggled to articulate the number of people accessing their services who smoked. Feedback from signposting to smoking cessation programmes also emerged

as a core gap. Having more systematic feedback structures was identified as potentially helpful for agencies, to think about how referral procedures were working in practice.

Smoking in some circumstances had historically provided an entry point to engagement. Examples ranged from staff smoking alongside service users after group sessions, to smoking having being used as an outreach tool.

> **"If I rewind back to 15 years ago , working in services, it used to be that street teams for example were given cigarettes to walk about with as the first way to approach someone"**
> (Local level stakeholder)

Engagement was cited to be more positive and receptive when smoking was presented and linked to an issue that was important to the service user - for example, being linked to mental health, or post-natal care. This provided an opportunity for dialogue and for talking about harm and risk in a way that seemed relevant and engaging.

> **"We talk about how smoking can have an impact on dementia and if you don't smoke you're less likely to have dementia, and that kind of thing"**
> (Local level stakeholder)

Risk **hierarchy**

The concept of risk and its relationship with smoking was discussed in much depth across the study.

The concept of risk and its relationship with smoking was discussed in much depth across the study. Across both local and national work there was an acknowledgement that smoking was a harmful activity and respondents were able to identify a number of impacts on health, such as the shortening of life expectancy, diseases and long-term conditions like emphysema, Chronic Obstructive Pulmonary Disease and so on. Practitioners cautioned against assumptions around educating people on the physical effects of smoking, and felt that messaging around risk of smoking (for example, though awareness-raising campaigns etc.) were well known.

> **"If you are working with a heroin user who's smoking fags then we are not really going to be focused on the fags bit of it, we are going to be focusing on harm reduction - there's going to be needle exchange"**
> (Local level stakeholder)

Smoking was ranked as being less of a priority issue, although this was dependent on the population being engaged with and the context of the prevalence of smoking. One project engaging with young people discussed how they would engage about smoking where it could be connected with other risks such Child Sexual Exploitation

(CSE), where smoking could be an indicator of grooming of a young person. Others discussed that smoking was ranked as a lower-risk issue in comparison to other substances they may be engaging with.

There was a perception that some of the messages around risks to health had created unintended consequences in terms of making smoking seem a more forbidden activity, and therefore – conversely - seeming to be a more attractive activity to engage in.

Practitioners within this study worked in a diverse range of settings and populations experiencing poverty. This resulted in them addressing a number of different and often competing priorities when delivering services, which were shaped by funding obligations as well as organisational remits and roles. Although practitioners worked in different types of service provision, many were working with vulnerable populations such as those experiencing homelessness, family projects, criminal justice etc. As a result of this, there were a number of outcomes that services would be looking to address, and the area of smoking prevention and support was deemed to be of low or little priority. This was driven by several factors:

Firstly, specific risks were identified that required immediate or ongoing support; this could take the form of providing more immediate crisis support (for example, with poor mental health or assistance with acute income crisis), to dealing with issues such as safeguarding. This, combined with resources and funding targets, and under legislation

to deliver, meant that organisations did not engage on issues beyond those which they were targeted to deliver. Many of the issues services were addressing required immediate action in line with contributing to improving the short-term wellbeing of a household, and smoking was viewed as an issue which was beyond the remit or timescales that organisational support was being provided to a household.

Secondly, a client being a smoker did not prohibit or pose any organisational restrictions generally to working with a client group. When a client was actively using alcohol or drugs, this often prohibited or restricted services from being able to offer support or advice. Smoking was distinguished as being different as it did not prohibit active engagement.

> **"So literally someone could stand outside our offices, have a cigarette and then come in and get an interview, but if somebody stood outside our office and drunk a bottle of whisky , we wouldn't be able to give them advice because they're not competent to take it on board"**
>
> (Local level stakeholder)

Smoking policies were mentioned infrequently across this work. In some cases where there was home working practice within service delivery, service users were expected to abide by non-smoking agreements to allow staff to work within their home settings. This was included with initial paperwork with service users on agreeing to receive support.   Whilst staff reported this was adhered to, it did not reduce the risk of second-hand smoke inhalation to staff - but for staff to challenge behaviours within the home setting was viewed as contentious.

Attitudes towards smoking and risk were also shaped by staff's own experiences and personal smoking status. In some organisations it was unclear if staff were permitted to smoke with service users - for example, during breaks. Boundaries around smoking practices within services were discussed in organisations when there was a lack of organisational policy relating to smoking. Staff also reported feeling hypocritical speaking to service users about reducing smoking or engaging in smoking cessation, if smoking was something they did themselves.

One avenue for discussing smoking and risk differently was the introduction of electronic cigarettes, known as e-cigarettes or vaporisers. These are devices that mimic the action of smoking, offering nicotine (in most cases), but with fewer toxins than found in tobacco smoke[xiii]. Many interviewees reported the rise of 'vaping' across their service user groups, and the promotion of vaping as an alternative to smoking was discussed. Many services reported being unclear about the risks associated with vaping as an activity. The introduction of vaping provided a new mechanism for discussing risk and for thinking about behaviour and coping mechanisms, particularly where smoking had been a long-term addiction for service users. Many services outlined they would like more information on the topic of vaping.

> **"More and more people vape now…. what are the health benefits or disbenefits …. Is it the kinda saviour or does it just create a different health problem?"**
> (Local level stakeholder)

In some services, vaping was being actively promoted - for example, within criminal justice, the ban on smoking in prisons had

been accompanied by the active promotion of vaping as an alternative, and the supply of free kits to prisoners. Services working in the criminal justice field, including within prisons themselves, reported promoting uptake of vaping ahead of the ban and receiving a generally positive response to this from service users.

Assessing and addressing risk was a core part of service delivery across this study; generally, risk was discussed in terms of more immediate short-term harm as opposed to long-term harm. Wider contexts, such as duty of care, were viewed around issues such as immediate safeguarding priorities; however, practitioners reflected that thinking about smoking as part of the wider duty of care might change how this issue is perceived across organisations.

Public Health **Activity**

There was widespread recognition across this research of a number of actions that had been introduced through public health to tackle rates of smoking across Scotland – although there was also significant skepticism as to whether these were appropriate, or effective

Participants were asked to share their views on a number of the larger of these public health actions -this included free stop-smoking support services, the removal of branding and designs from packaging ("plain packaging"), and banning smoking in certain places, such as pubs or cafés.

Participants felt that these policies and interventions had both 'intended' and 'unintended' consequences for low-income communities and people partaking in smoking more generally. On a positive note, it was felt that many of the actions introduced had led to a reduction in rates of smoking, in terms of providing an incentive for people to reduce or stop smoking, and to alter people's behaviors and attitudes to smoking. However, the portrayal of these actions had contributed to providing what was seen as a greater emphasis on punishment and

negativity, as opposed to incentivising or promoting more positive attitudes towards smoking reduction. This was experienced as a focus overall being on framing and addressing people's behaviours in a negative way, with a concern that approaches which do not take into consideration the individual's circumstances could be received as patronising.

> **"In the past we've run smoking cessation alongside the health improvement team and the family nurse partnerships, it wasn't well attended. For me it wasn't the right approach"**
> (Local level stakeholder)

> **"When I hear a smoking cessation worker saying 'have you considered stopping smoking' to somebody who I happen to know has a chaotic lifestyle, I think it must sound like 'because you know, you really could do better, you could be a better person, a better family member, a better community member, a better member of society"**
> (Local level stakeholder)

Smoking interventions and polices were argued to be clustered into two schools of motivation, taking either the "carrot" or "stick" approaches - but that there was a greater focus on the policing of 'behaviour' and less focus on promoting positive actions to encourage and reward quitting smoking.

The least-known intervention discussed within the study was the 'Take It Right Outside' campaign[xix], which focuses on targeting families to make their homes smoke-free. This was largely unknown to participants and there was a need for further promotion of this intervention.

The pricing of tobacco, as a public health intervention, provoked much debate in this research. Increased tax was seen as creating further harm in low-income communities as it would increase household expenditure for anyone continuing to smoke. It as considered a regressive and short-sighted intervention by some, as it placed further pressure on household incomes and did not offer a positive approach to supporting people to reduce their smoking. It was also presented as lacking an understanding of the addictive nature of smoking, and as a tactic that could increase marginalisation through households looking to maintain their addiction. This approach, combined with low-income households looking to reduce costs, increased the likelihood of households turning to forms of illicit tobacco, which they believed, would be putting them at risk of experiencing increasing negative health impacts due to the perceived 'inferior' quality of illicit tobacco. The fact that both the 'legal' and the 'illicit' forms of tobacco convey similar levels of harm was not widely acknowledged in this context.

Smoking was viewed as being tackled and dealt with differently from other public health priorities. The prioritisation and methods employed to tackle smoking were argued to be more draconian than across other substances, such as alcohol. Measures that were applied to cigarettes, such as images of harm on the back on cigarette packaging and covered-up displays of cigarettes in shops, were not applied to other addictive substances such as alcohol, despite recognition of the harm that alcohol use could also cause to low-income communities. This differentiation in how other public health issues were tackled caused confusion about why some substances were targeted differently to others.

Influencing **change**

Across this study, the role of contributing to social change was well understood

Organisations recognised they had an ethical and moral duty to improve society for the better, and this resulted in openness from participants to understanding and addressing how they could be more effective and contribute to wider social change. One core area was around work that drew upon the broader values and beliefs of those working to tackle poverty, in terms of framing smoking as specifically an inequalities issue.

Learning from broader practice was also considered useful. There were examples listed of other difficult social changes and shifts that had been brought about, and the variables and determinants which had resulted in that change. One area suggested was the concept of 'social pioneers' and reformers, whereby key organisations of note or influence across the anti-poverty sector were used as a means of providing leadership and challenge to others in terms of their practice and policies. The role of such 'social pioneers' was viewed as an important one in terms of accountability and transformation. There is wider learning available from other work, in both the public and private sectors, to understand how social change and shifts have been achieved across different contexts, and lessons and practice could be transferred.

Leadership was also articulated to be of importance in terms of providing confidence. Organisations emphasised the importance of a non-judgemental approach within their services and operations. Smoking provided a challenge for organisations in terms of working with their staff and service users, and leadership and strategic focus was required to assist organisations when dealing with the complexity of smoking. Due to the variance in populations experiencing poverty, recognition of differing experiences and drivers towards smoking needed to be embedded within formalised and informal smoking cessation work alike: both within poverty-focused organisations and in wider smoking cessation settings.

Internally in organisations, for staff and volunteers there were suggestions of work that built upon a broader wellbeing agenda - for example, as part of a package of measures that promoted healthy lives both within and outwith their workplace. Examples were given of other areas of practice, such as healthy eating, whereby awareness-raising activities could be harnessed within workplaces. Training was also outlined as a need across this project, to enable staff to think about how to embed conversations about smoking within other conversations that would regularly be occurring as part of their work.

It was felt that a positive approach was required, as giving negative messages to people already dealing with many challenging issues/circumstances would not be effective.

> **"Putting the fear into people doesn't work, as they have heard it all before"**
> (Local level stakeholder)

Availability of funding emerged as a key consideration that would support organisations to consider issues relating to smoking more broadly within the context of their work, and to consider the linkages of their work. Although training was recognised as being a core tool to help organisations with engagement, due to other pressures many service-delivery organisations were concerned about resources and capacity under a number of existing priorities, and additional work would require more time and energy to discuss.

Supporting cultural change within agencies around smoking would require a combination of different measures to be effective. A focus on addressing the underlying determinants of stress, which many low-income households face, was considered to potentially be the most effective way to address reducing the numbers of households smoking.

> **"Awareness campaigns are good, but have to be matched with services/ resources on the ground to back things up"**
>
> (Local level stakeholder interview)

More broadly, the messaging around public health and smoking was recognised as needing change. The current advice was seen as value-laden and contributing to stigma and discrimination of communities. There was a sense of the importance of how the messaging was framed, to ensure that people engaged and could relate to the messages promoted. For populations which may be more vulnerable, there was an emphasis that a focus on negative aspects or deficits, such as risks, increased people's feelings of failure and marginalisation. A greater emphasis on the need for alternatives to smoking was suggested, as well as more positive marketing.

> **"Honesty of young people is a key thing from working from this group, they won't tolerate messages they don't feel is for them or are being delivered by someone they don't click with"**
>
> (Local level stakeholder interview)

Co-production work directly with service users was suggested as a way that could improve the messaging - and effectiveness - of intervention uptake.

Different **perceptions** of **smoking**

To explore the different perspectives on - and approaches to - smoking that we found in our interviews, we proposed three models of smoking that could be used to illustrate the varying ways that people understand or frame the issue. These each represent extremes or stereotypes, and we would expect most individuals or organisations to present some combination or mixture of the models, but these can be considered as tendencies that will help us to analyse how different perspectives

and preconceptions can lead to different interpretations and conclusions.

The "health" (or "medical") model is the framing that - whether fairly or unfairly- many will associate with a hospital or GP visit, or with the traditional "tobacco control" model of action on smoking. This model gives prominence to regulation and restrictions and an emphasis that smoking is a harmful addiction that should be avoided. This is a top-down, interventionist approach, for example in banning smoking in indoor public places.

The "social" (or "community") model is more likely to be associated with a community-based group or support service. 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. This tends to be a bottom-up, non-interventionist approach, such as when anxious services users take a smoking break to calm down.

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 any intervention by governments or other bodies that goes beyond the provision of core information. This is an 'enabling' approach to smoking, for example through calls for smoking rooms in pubs or airports.

The three models were well illustrated in a recent media article on moves to enforce smoke-free hospital grounds.**An NHS spokesperson is quoted as saying *"it's vital we take every possible step to discourage smoking"*, a smokers' rights campaigner describes the moves as "*Orwellian*" and *"targeting smokers using emotive messages"* and the patient interviewed for the piece says *"I know smoking is bad for you but when you are in hospital, it does relieve a lot of stress"*. These three contrasting responses to the same issue illustrate the health, recreational and social approaches respectively.

Given the nature of our study we were particularly keen to explore the common ground that might exist between the health and social models - and this was a key focus of the project's two focus groups. Our concern was in examining the interventions that could take place to support people who wish to stop smoking, and so the recreational model and its proponents were of less interest in this investigation.

In each group we introduced the concept of the three different models of smoking, presenting them as three overlapping circles in a Venn diagram. We then checked the group's understanding of the models through discussing certain phrases that clearly matched one of the frames, and ensuring the group could correctly place these phrases into the Venn diagram in Appendix A. For example:

Health model – *"we need to reduce the smoking rate"*

Social model – *"people smoke because it helps them get through the day"*

Recreational model – "*it's my right to smoke".*

Once confident that the focus groups were comfortable with the three models, we proceeded to explore some more nuanced statements, and then asked participants to explore the views and statements that could populate the shared space/overlap between the health and social models. These suggestions of shared health/social language and ideas are included in the blue box in Appendix 1.

Feedback from the focus groups was that participants found the concept of different models of smoking helped them

to understand how different people, groups and interests would approach the issue of smoking and poverty with different perspectives. In addition, the pictorial representation of the three models acted as a useful focus for discussing the areas where health and social interests could overlap and generate a shared understanding, language and response as the basis for improved collaboration.

One of the core area of consensus emerging from the focus group discussions was the recognition of smoking as an activity that was deployed by low-income groups largely as a coping mechanism. Higher rates of smoking amongst disadvantaged groups was felt to be linked to greater social pressures and anxieties, and hence driven by living on low incomes. This led to a call to shift emphasis to the issues people are dealing with - looking beyond whether someone smokes or not to understanding the circumstances leading them to smoke.

There was a clear understanding in the groups that smoking is an addiction, very often carried out unwillingly. Again this led to an emphasis on supporting people to address their addiction, and significant resistance to any suggestion of attaching blame or stigma to smokers.

These principles led to a strong feeling that approaches should be positive and centre on supporting people to identify alternative coping mechanisms, or to find effective approaches to stopping smoking (should they articulate a desire to quit). The skills and relationships that already exist within services could be utilised to deliver a positive, people-centred conversation on smoking and the associated 'costs' and 'benefits'. It was felt that this could take account of the barriers that households face, and provide a more sensitive and informed approach to addressing and promoting stop-smoking interventions. This was perceived to offer a route beyond traditional public health measures, such as legislation (e.g. around ending smoking in enclosed public places) or through higher taxation and pricing.

Placing the emphasis on commercial interests - as opposed to smokers themselves – was also suggested in terms of shifting the focus of discussions on smoking. Participants felt there was a useful and important conversation to be had around the role of tobacco companies in exploiting vulnerable people, so that the blame for the problem could be laid squarely at the feet of those interests driving it, rather than the people affected by it.

Finally, participants proposed that the harm caused by smoking would justify including consideration of smoking within the 'duty of care' owed to clients and service users.

Overall, discussion at the focus groups identified a widespread disengagement with, and even concern over, public health approaches to smoking. More positively, there was acceptance that there are shared goals between the social and health models, and a willingness to explore the shared areas of interest, language and action. Participants fairly easily identified suggestions to populate the health/social overlap on our Venn diagram, and hence to flesh out the shared territory that might enable health and social interests to work together, although these would require some movement and compromise on either side. Discussion suggested that the health and social models could agree that:

- Given that most people who smoke say they want to stop, then we can focus on smoking amongst low income groups as a coping mechanism and an attempt to respond to circumstances;

- The harm caused by smoking is such that intervening is justified, but this needs to be done with people rather than to them - and focus on helping communities find solutions, rather than imposing them from outside;

- In terms of messaging, it is not enough to say that people shouldn't smoke: instead we need to discuss and explore the factors that lead people to smoke and make it more difficult to stop;

- We should engage people with positive language, try to create new coping mechanisms rather than simply remove existing ones, and emphasise support rather than restrictions;

- We should shift any talk of blame away from people who smoke and towards the commercial interests who profit from the problem.

Much of this could be summarised by the phrase "bottom-up intervention" – so combining the health model's emphasis on smoking being a problem that needs to be tackled, with the social model's insistence that any activity start with the people affected and be led by them.

Conclusions and Recommendations

The research set out to explore the potential synergy between anti-poverty stakeholders and those working in public health.

This study indicated that relationships between smoking and poverty were complex and therefore requires a sensitive and nuanced approach. The project has nevertheless provided an important opportunity to explore the relationships between poverty and smoking, and how more effective cross-sectoral working could be fostered between health and anti-poverty interests.

The research indicated that multiple factors influenced the uptake of smoking amongst those experiencing poverty, and made it more difficult to quit. These included chronic stress and adverse circumstances, barriers such as location of smoking cessation support services, as well as broader society-wide factors such as social policy and precariousness of work.

Working with low-income groups around smoking needs to be framed appropriately,

offering a focus on support while avoiding any approach that could be perceived or experienced as stigmatising or blaming. Anti-poverty stakeholders have to consider and prioritise different needs and issues when working with clients, and smoking was generally not considered a priority and addressed only where deemed appropriate or relevant to the household receiving support. Wider organisational policies and infrastructure, including the role of service user involvement, had a key part to play in an improved approach to stop-smoking work. This study indicated that engagement across anti-poverty stakeholders around smoking was often minimal, and generally only driven by specific legislation or broader outcomes that impacted on the service user group the organisations engaged with, but that service providers were open to discussing how alternative approaches could change this.

Knowledge and uptake of smoking cessation

activities and campaigns varied across this study. Broadly speaking, for anti-poverty organisations, interventions on smoking were usually experienced through 'negative' issues (such as higher taxation) and messaging (such as plain packaging imagery), and were seen to be disengaging for those living on a low income. Wider promotion of support and recognition of the issues low-income communities experience was recommended in terms of the framing of the barriers people faced. Opportunities for change focused on shared areas of consensus, such as support for agreement around alternative coping strategies, and training and resources for anti-poverty organisations to build addressing smoking into their work and organisational practice.

Several recommendations emerged from this research:

1) Better understand the situation:

Given the lack of a shared understanding of the various ways in which poverty and smoking interact there is a need for further investigation of how people living in poverty perceive and experience public health interventions on smoking. A particular priority should be to extend the investigations discussed here to hear directly from people living in poverty themselves, to understand more of their perceptions and experiences and to elicit their views as to how health and anti-poverty support services can better engage with and support them.

2) Frame the message positively:

In order to engage anti-poverty interests, the language and assumptions we use when talking about the links between smoking and poverty should emphasise understanding, compassion and support and take particular care to avoid any misperception that we seek to stigmatise, judge or control smokers. Smoking needs to be framed as part of the challenges facing people in low-income groups, and not as a prop or support to

people in need, so that engagement on smoking is about offering help and benefit rather than about taking something away.

3) Respond to people's needs and experiences:

The consistency with which interviewees reported that their clients use smoking as a coping mechanism highlights how there are real and valid needs that people are trying to address, and which will continue to impact on people and undermine efforts to stop smoking. Consequently we need to do more than just call on people to stop smoking and explore the possible routes to doing so, and the changes and strategies that can support this. This approach has already been recognised in the rebranding of Scotland's stop smoking services as Quit Your Way.

4) Give organisations the support they need to act:

Advice, resources and training are required to help organisations to develop their own approach to engaging clients, with a need both to support anti-poverty organisations in integrating engagement on smoking into their existing service delivery and duty of care, and for health services to adapt and respond to the particular needs and perspectives of people in low-income groups.

5) Take a strategic approach:

To provide the necessary leadership, and in order to support and encourage better collaboration between sectors, the interaction between smoking and poverty needs to be reflected in poverty, health and social care, financial inclusion, parenting, social work and other strategies. This is necessary at both national and local government levels as well as with Public Health Scotland, the Poverty and Inequality Commission and other bodies.

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Puts health outcomes at centre.

Analysis: Smoking is addictive and harmful to health, taken up by the young and carried on by the unwilling

Proponents: Medical interests, government, some smokers, ex-smokers

Action: Make tobacco expensive and restrict smoking, to push people to quit and prevent SHS harm to others

"top-down interventionist"

Puts personal freedom at centre.

Analysis: Smoking is pleasurable activity carried out by adults who know the risks involved

Proponents: Commercial interests, libertarians, some smokers

Action: Provide information but otherwise leave people to it

"bottom-up, non-interventionist"

health/ medical view
(what you might expect your GP to say)

"people don't want to be told what to do"

"the important thing is to give people information and let them decide"

recreational/ libertarian view
(what you might expect a "smokers rights" group to say)

"people enjoy smoking"

"It's my right to smoke"

"It's important to raise the issue of smoking with clients"

"we need to reduce the smoking rate"

"Increasing the price of tobacco encourages people to quit"

"the Government should do more to reduce smoking"

"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"

Puts the needs of the individual at the centre

Analysis: Smoking is largely used as a coping mechanism for stress, boredom, isolation or anxiety and is closely tied to social inequality

Proponents: Potentially inequality organi-sations, some smokers

Action: Support people to quit and to find less harmful ways of coping with stresses

"bottom-up interventionist"

"there are both benefits and costs to smoking"

community/ support view
(what you might expect community-based or third sector advocacy services to say)

"It's the least of their worries"

"for some people smoking is an essential that they rely on

"people smoke because it helps them to get through the day"

"putting the price up takes money from household budgets"