Tackling half the difference

Reducing Health Inequalities: A
Smokefree Action Coalition briefing
for local authorities

Smokefree Action Coalition Briefing
Tackling half the difference

Tobacco is to blame for half the difference in life expectancy between rich and poor

Medical professionals, politicians and the general public are all rightly concerned about health inequalities. In poorer communities, there is a higher rate of illness and a lower average length of life. What is not so widely understood is the relationship between health inequalities and the consumption of tobacco. Smoking rates are higher in poorer communities than elsewhere, and this is by far the most important single factor in the difference in life expectancies between social classes.

This briefing for local authority members and officers sets out five steps that every Council should consider taking to help tackle this difference. This includes;

1. **Targeted quit support for the most disadvantaged communities**
2. **Innovation to tackle high levels of addiction in those with mental health problems**
3. **Tackling indoor smoking in disadvantaged homes and families**
4. **Identifying and supporting pregnant women to stop smoking**
5. **Taking regional action to tackle the sale of illicit tobacco in local communities**

Tackling tobacco provides one of the great opportunities to transform public health and local authorities can and do play a central role in this. There are numerous steps they can take to address the smoking epidemic. As well as signing the Local Government Declaration on Tobacco Control, which is a public commitment to tackle smoking, and taking part in a CLeaR assessment which provides councils with the opportunity to reflect upon their approach to local tobacco control, local authorities need to address health inequalities.

Although stop smoking services reach a large number of disadvantaged smokers who want to quit, many will be heavily addicted to nicotine, and will therefore find it harder to remain smokefree. Some particularly disadvantaged groups, such as those with long term mental health problems, have smoking rates that are far higher than the average, and they need particular consideration when considering what to do about the health damage caused by tobacco.

The transfer of responsibility for public health to local authorities means that it is particularly important that both councillors and officers understand the reality of smoking and health inequality, and that they put into action a co-ordinated local plan for dealing with the problem. This briefing provides a clear set of steps to tackle health inequalities caused by smoking.
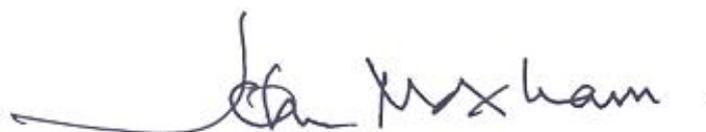
Prof John Moxham, Professor of Respiratory Medicine at King's College London School of Medicine, Director of Clinical Strategy for King's Health Partners, Chair of Action on Smoking and Health.

NCSCT

Targeted quit support for the most disadvantaged communities

Smoking is highest in the poorest communities
Poorer, more disadvantaged people are significantly more likely to smoke. Whilst stop smoking services reach a significant number of disadvantaged smokers who are motivated to quit, these individuals are often more heavily addicted to nicotine and therefore find it more difficult to remain smokefree.

What does an effective approach look like?
We know poorer, more disadvantaged smokers find it harder to quit, we should therefore ensure they are offered more support. An enhanced level of support to disadvantaged communities could include:

- Offering evidence-based behavioural support programmes via different forms (drop-in, groups, individual or family sessions) and in multiple community settings
- Ensure that these smokers have first line access to the most effective medications: varenicline (Champix) and combination NRT (patch + an acute acting form)
- Establishing mechanisms for providing additional support, such as written support materials, telephone support and text messaging

Further benefits may also be achieved by maintaining contact with those who are not initially successful to ensure they can re-engage with treatment programmes when they are ready to try quitting again in the future.

It's also important to maximise the opportunities to communicate with disadvantaged communities. All health and social care professionals should be trained to raise the issue of smoking and know how to refer into treatment services. A short online training module if freely available to all health and social care professionals via the NCSCT website: ncsct.co.uk

How can you measure impact?
Monitoring both the uptake of services from priority groups and the outcomes achieved to ensure services are both equitable and appropriate is essential. Quitting, like taking up smoking, can be a contagious behaviour. Supporting more people to quit smoking in communities where smoking is commonplace can improve the health and wellbeing not just of smokers but of those around them.

Further information
- Brose, L.S., West, R., McDermott, M.S., Fidler, J.A. & McEwen, A. (2011). What makes for an effective Stop-Smoking Service? *Thorax*, 66(10):924-6. doi:10.1136/thoraxjnl-2011-200251
- NCSCT. Stop Smoking Services and Health Inequalities. 2013
- UKCTCS. Tobacco Control Health Inequalities Pilot Programme (reports from 6 pilot projects)
- ASH. Beyond smoking kills. 2008

ash.
action on smoking and health

Innovation to tackle high levels of addiction amongst those with mental health disorders

If you have a mental health problem why are you more likely to smoke?

People with mental health disorders are significantly more likely to smoke, and be more heavily addicted to nicotine. A 2010 report carried out by the National Centre for Social Research estimated that a third of all cigarettes smoked are smoked by people with a mental health disorder. People with a severe mental illness die 16 to 25 years earlier and the Royal College of Physicians (RCP) attributes much of this substantially lower life expectancy to smoking.

What does an effective approach look like?
To date conventional prevention and treatment strategies have made little if any impact on smoking in this population. This is not as a result of less motivation to stop smoking. Those with mental health problems are just as likely to want to quit, but have often not been given the support and encouragement they need. In addition smoking is often accepted as a norm and prevention is not addressed as a high priority. Given the levels of dependency and the severe impact that smoking has on life expectancy it is important to consider innovative approaches.

This group may need longer to quit and need more support to do so. They may also benefit from reducing the amount they smoke before they quit and being given ongoing access to alternative forms of nicotine. This is acknowledged by NICE in their new guidance on tobacco harm reduction, which states that using these approaches could offer a more effective way of working with people with high dependency.

In mental health settings the application of the guidance could offer a real step forward in work with highly dependent smokers.
- Secondary care settings: Secondary care should be smokefree and use a harm reduction approach to provide smokers with licenced nicotine containing products as an alternative to smoking. This could move them closer to quitting by giving them a positive experience of not smoking.
- Community settings: The provision of targeted services which help people to cut down and support them to use licenced nicotine containing products long term would provide an innovative alternative to current services.

How can you measure impact?
Track success between secondary and community settings. Set targets based on longer term and track the conversion of temporary abstinence to total abstinence.

Further information
- NatCen. Cigarette smoking and mental health in England. 2010
- RCP and RCPsych. Smoking and mental health. 2013
- NICE. Smoking cessation in secondary care: acute, maternity and mental health service. 2013
- NICE. Tobacco harm reduction. 2013
- NASMHPD. Morbidity and mortality in people with serious mental illness. 2006

Tackling indoor smoking in disadvantaged homes and families

Why smoking in the home contributes to health inequalities
The RCP estimates that exposure to secondhand smoke results in as many as 300,000 visits to GPs by children each year. Although smoking has declined significantly even in homes containing smokers in recent years, children from disadvantaged backgrounds are still more likely to be exposed to secondhand smoke. A 2014 YouGov survey commissioned by ASH found that 88% of people in professional and managerial occupations (social grades

ABC1) did not allow smoking in their home or only in places that are not enclosed, compared with 77% of people in casual or low grade work, pensioners and unemployed on state benefits (social grade E).

What does an effective approach look like?
The Take 7 Steps Out campaign, developed by Tobacco Free Futures, is an example of an effective approach to tackle exposure to secondhand smoke in the home amongst disadvantaged communities. It provides a clear message to take smoking *'right outside'* and marries public-facing campaigns and social marketing activity with brief intervention guidance to support frontline professionals, delivering community and system change.

Work with deprived communities established that encouraging those smoking around children to take their smoking right outside was an effective approach. The approach aimed to create social norm change within communities by targeting audiences who might be influential in driving change in their families and communities. The initiative achieved notable success.

How can you measure impact?
It is important to evaluate impact and this can be done by considering attitudes and behavioural changes amongst different groups. Evaluation carried out by 2CV Research revealed that 61% of female smokers were encouraged to 'take 7 steps out' after seeing the campaign, 19% of smokers said they now go right outside the house to smoke. Moreover 6% of smokers who saw the campaign indicated that after seeing the advertising they had quit or tried to quit smoking. 44% said that it had made them think of cutting down.

Further information
- Journal of Public Health. Socioeconomic inequalities in childhood exposure to secondhand smoke before and after smoke-free legislation in three UK countries. 2012
- RCP. Passive smoking and children. 2010
- 2CV Research. Take 7 Steps Out evaluation. 2010

Smoking is the single most modifiable risk factor in pregnancy

Why does smoking in pregnancy contribute to health inequalities?
The RCP recently reported that maternal smoking causes up to 5,000 miscarriages, 300 perinatal deaths and 2,200 premature births in the UK each year. Maternal smoking causes around 19,000 babies to be born with low birth weight. It is also associated with an increased risk of sudden infant death syndrome.

These adverse effects are entirely avoidable and disproportionately affect younger women and those who are poorer.

What does an effective approach look like?
It is essential that women who smoke are identified early in pregnancy to ensure they have an opportunity to discuss the harm caused by smoking in pregnancy and be offered support to stop. A 2013 report found that self-reported smoking status underestimates the number of women smoking as some women, when asked, do not admit they smoke.
To ensure all women can be offered appropriate advice and support carbon monoxide screening should be offered by midwives at the first booking visit. For further information see NICE guidance on Quitting smoking in pregnancy and following childbirth.

How can you measure impact?
The impact of screening can be measured by:
- The percentage of pregnant women screened
- The number of women identified as a smoker who are referred to the Stop Smoking Service
- The number of women referred to the Stop Smoking Services
- The number of women who engage with the Stop Smoking Service
- The number of pregnant women who quit with the support of the Stop Smoking Services
- The number of women recorded as smoking at the time of delivery.

Further Information
- RCP. Passive smoking and children. 2010
- NICE guidance. Quitting smoking in pregnancy and following childbirth. 2010
- Prenatal Diagnosis. Accuracy of self-reported smoking status in first trimester aneuploidy screening. 2013

Regional action to tackle the sale of illicit tobacco in local communities

Why does illicit tobacco increase health inequalities?
The illicit tobacco market is in long-term decline but it still remains a problem in some local communities. It undermines tobacco control measures, including taxation and age of sale regulations. This gives children easier access to tobacco at lower prices which makes it more likely they will get addicted. It also encourages established smokers to smoke more than if they were paying full price and makes it less likely they will quit. Poorer smokers are also more likely to purchase illicit tobacco. This exposes communities to organised crime.

What does an effective approach to tackle illicit tobacco look like?
Effective approaches are co-ordinated across large geographical areas where health and enforcement partners collaborate to reduce both the demand for, and the supply of, illicit tobacco. Supra-local working in the North East, North West and South West has changed social norms around illicit tobacco as part of broader regional tobacco control strategies. ASH data from 2014 suggests that illicit purchases make up only a minority of total tobacco purchases. Only 12%, 9% and 8% of respondents from the North East, North West and the South West respectively, bought their tobacco exclusively from illicit sources.

How can you measure impact?
Evaluation surveys can measure the impact of activity, and HM Revenue & Customs statistics provide a national picture. But additional, local measures can be used, including information received from the public, seizures and enforcement activity, and increased partnership working between agencies.

Further information
- UKCTCS. www.ukctcs.org/ukctcs/research/featuredprojects/illicittobacco.aspx
- www.illegal-tobacco.co.uk
- www.stop-illegal-tobacco.co.uk
- www.keep-it-out.co.uk

Contributors

The National Centre for Smoking Cessation and Training (NCSCT) is a social enterprise committed to support the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions provided by local stop smoking services.

Action on Smoking and Health (ASH) is a public health charity that works to eliminate the harm caused by tobacco by campaigning for workable and evidence-based policies.

Tobacco Free Futures (TFF) is a social enterprise which tackles tobacco use in the North West of England. It aims to change the way children, young people and adults think about tobacco and drive down smoking rates.

The Tobacco Control Collaborating Centre (TCCC) was established in 2004 to examine the most effective ways to increase knowledge and skills for tobacco control policy implementation and practice development among public health workers.

Fresh Smoke free North East was the UK's first dedicated regional tobacco control programme. It was set up in the North East in 2005 to tackle the worst rates of smoking-related illness and death in England. Since then the North East has seen adult smoking fall at twice the national average.

For further information contact admin@smokefreeaction.org.uk