Smoking and vulnerable populations: supporting smoking cessation and tobacco harm reduction in social work

Introduction

Smoking and the use of other high-risk tobacco products are often disproportionately high among marginalised or vulnerable communities. As part of their role, social work professionals build relationships with individuals who will often be from these communities. When appropriately trained and resourced, social workers could therefore play an important part in supporting smoking cessation and tobacco harm reduction with many of the people who need it most.

Tobacco harm reduction is a potentially life-saving intervention for millions of people across the world. To those who currently use high-risk tobacco products, like cigarettes and some oral tobaccos, it offers the chance to switch to a range of safer nicotine products that pose fewer risks to their health. These include nicotine vapes (e-cigarettes), snus, heated tobacco products and nicotine pouches.

What do social workers do?

The responsibilities of social workers differ around the globe, however their main focus is to serve individuals, groups and communities by helping people address the problems they face in their everyday lives. Social workers interact with a wide range of clients, including, but not limited to: individuals and families experiencing poverty and homelessness, people with mental health problems; young offenders; adults with learning disabilities or physical disabilities; people with alcohol, drug or other substance use problems; families at risk of breaking down; and children who are at risk of abuse or neglect. In some of these groups, the prevalence of smoking is much higher than the general population, therefore social workers are often in contact with groups whose smoking rates are high.

Equipping social workers with the knowledge and tools needed to help their clients reduce or quit smoking offers a chance to improve people's health and save many lives. At the time of writing, however, few social workers are being trained or supported to address client smoking. Among many competing needs, tobacco use is not often identified as a priority issue. But smoking cessation and/or support to switch to safer nicotine products could bring multiple benefits to their client groups.

Vulnerable populations and smoking: what does the evidence show?

Evidence from a range of studies shows that smoking disproportionately affects the vulnerable and marginalised populations with whom social workers are likely to work. One such group is people who have faced childhood adversity or trauma such as abuse or neglect, which may be described under the term 'Adverse Childhood Experiences (ACEs)'. In adulthood, they are more likely to have poor mental health, be a high-risk drinker or drug user, be a victim or perpetrator of violence, or have long-term health conditions such as obesity, diabetes, heart or respiratory disease. They are also more likely to smoke. A 2020 population-wide survey in Scotland found that people with four or more ACEs smoked at almost three times the rate of people who had experienced none (27% compared to 10%).[i]

Adults facing mental health issues are another key group whose smoking rates are higher than the general population. In England, in 2016/17, while the prevalence of smoking in all adults aged 18 or over was 15.1%, the prevalence of smoking among adults living with anxiety or depression was 25.88%.[ii] For those with a long-term mental health condition it was 34% and for those with a serious mental illness it was 40.5%. In 2021, according to the World Health Organization (WHO), two-thirds of people with severe mental health conditions were current smokers.[iii] This has a significant impact on people's physical health; those with severe mental health conditions die on average 15–20 years prematurely,[iv] and tobacco is cited as one of the main causes of death. The prevalence of smoking in those experiencing schizophrenia is especially high, with rates reaching as high as 70-80%.[v]

Research has found that people who use illicit drugs are three times more likely to smoke cigarettes compared to non-users.[vi] People who use drugs often die not because of drug-related illnesses, but rather due to cardiovascular and lung-related diseases caused by smoking. One study in California found that smoking-related conditions comprised around 40% of total deaths among people hospitalised with cocaine, opioid and methamphetamine disorders.[vii] But while social workers regularly screen, assess, and treat mental health and substance dependency issues, smoking has not to date been prioritised as part of the approach.

A number of studies have also shown that smoking rates are higher among socioeconomically disadvantaged groups than within the general population.[viii] [ix] [x] Lower socioeconomic status correlates with higher cigarette and tobacco product use, alongside a decreased likelihood of quitting tobacco. Disadvantaged populations, when compared to higher income groups, also have a higher tobacco initiation rate, a lower rate of quit attempts and less success on a given attempt to quit.[xi]

The negative impacts of smoking do not only affect the person who smokes, but those around them too, particularly children and young people. A study in Quebec, Canada, found that second-hand smoke exposure in the home was nearly five times more common among youths in the lowest versus the highest income quintiles.[xii] Research has also found that early teens whose main caregiver smoked were more than twice as likely to have tried cigarettes (26% versus 11%) and four times as likely to be regular smokers (4.9% versus 1.2%).[xiii]

Smoking also has a significant impact on household income. In the UK, in 2012, around 1.1 million children, or nearly half of all those children living in relative poverty, had at least one parent who smoked.[xiv] Over 1.5 million people in England need social care support as a result of illness or disability caused by smoking, and spending on smoking-caused social care takes a significant toll on already overstretched budgets.[xv]

Why do people smoke?

Individuals smoke for a huge variety of reasons. Even though people know smoking is bad for them, it can be difficult to prioritise long-term health over a short-term desire to smoke. Nicotine can cause dependency – meaning people feel they have to continue using it – but in isolation from tobacco smoke, nicotine itself is a low-risk substance.[xvi] It should be acknowledged that many people experience pleasure from using nicotine, just as people enjoy using caffeine or alcohol. Many feel they get positive effects from their nicotine intake – for example, to relax or focus, or to cope with sadness, boredom or the stresses of their daily lives.

Others may find that nicotine use is associated with a reduction in specific symptoms, for example of post-traumatic stress disorder (PTSD) or attention deficit hyperactivity disorder (ADHD). For some people with schizophrenia, using nicotine can be a form of self-medication, which they feel allows them to treat cognitive symptoms or reduce the side effects of psychiatric medicines.[xvii] Until the emergence of safer nicotine products, few people were able to use nicotine without also smoking tobacco, causing significant damage to their health.

When considering the vulnerable and marginalised populations with whom social workers are likely to interact, it is also useful to consider why people smoke from a wider perspective – to ask why some groups of people are more likely to smoke, smoke more heavily or find it more difficult to quit than others, for example. Research led by Sir Michael Marmot and published in a major UK policy review stated that "health inequalities result from social inequalities [and that] action on health inequalities requires action across all the social determinants of health".[xviii] The 'social determinants of health' are the economic and social conditions that influence the health of individuals and groups.

For example, a child or young adult is more likely to start smoking if they are growing up in a family with parents who smoke, in an area with lots of shops selling tobacco products and with friends and peers their own age who smoke. All of these factors normalise smoking. These circumstances are also all more likely to arise in areas of social deprivation. And when people begin smoking in childhood or adolescence, they often end up smoking heavily, and so find it more difficult to give up. Many will continue smoking into adulthood and then parenthood – meaning the cycle can begin again.

Quitting smoking completely is the most beneficial outcome for health. But for those who cannot or do not want to quit, tobacco harm reduction provides a choice of safer alternatives for nicotine intake, without exposure to the thousands of toxic chemical compounds present in cigarette smoke. It is a crucial public health intervention.

How could social workers help clients reduce the harms associated with smoking?

Only a few countries currently train social workers to support those who want to quit smoking. This is a real missed opportunity for the public health system. Like doctors, community nurses, midwives, psychologists, and psychotherapists, social workers can have a significant influence, both over people's decisions and their overall wellbeing. Serving as the initial – and in some cases only – point of contact with marginalised communities, social workers could therefore play an important role in reducing the prevalence of smoking.

Social workers should be equipped to signpost their clients to local or national smoking cessation support where available. Unfortunately, in many parts of the world, smoking cessation services are rare, non-existent or expensive to access. A 2021 WHO report found that 70% of smokers globally had no access to stop-smoking services.[xix] Where safer nicotine products are accessible and affordable, social workers should also be supported to raise awareness of tobacco harm reduction as another tool to help people reduce the impact of their smoking or use of risky tobacco products.

Social workers could be trained in the delivery of Very Brief Advice (VBA) for smoking cessation, an evidence-based, 30-second intervention, designed to be used opportunistically with people in health or social care settings. With a non-judgemental approach, VBA aims to identify people who smoke ('Ask'), advise them on the best method of quitting ('Advise'), and support subsequent quit attempts ('Act').[xx]

Many social workers are already skilled in the use of different psychological methods to support their clients, including motivational interviewing or brief cognitive behavioural therapy. These tools have also been shown to be effective in smoking cessation. With support and adequate resourcing, social workers could be encouraged to develop and promote individualised programmes for particular populations to quit or reduce smoking. A study published in 2013 showed that brief consultations of 20 minutes or less, delivered by physicians and other healthcare workers, increased quit rates among patients who smoked when compared to those who received no advice.[xxi]

Integrating tobacco harm reduction into a social work approach to smoking resonates with the aims and motivations of many in the profession. Through harm reduction, people who smoke can be empowered to make a positive difference to their health for themselves. Therefore, in countries where safer nicotine products are available and affordable, social workers should be equipped to provide trusted information and advice on tobacco harm reduction options, as part of all-round smoking cessation support.

For further information about the Global State of Tobacco Harm Reduction's work, or the points raised in this GSTHR Briefing Paper, please contact info@gsthr.org

About us: Knowledge•Action•Change (K•A•C) promotes harm reduction as a key public health strategy grounded in human rights. The team has over forty years of experience of harm reduction work in drug use, HIV, smoking, sexual health, and prisons. K•A•C runs the Global State of Tobacco Harm Reduction (GSTHR) which maps the development of tobacco harm reduction and the use, availability and regulatory responses to safer nicotine products, as well as smoking prevalence and related mortality, in over 200 countries and regions around the world. For all publications and live data, visit https://gsthr.org

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