Smoking, Stigma and Human Rights in Mental Health: Going up in Smoke?

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Debates about the ban on smoking in public places have centred on the right to self-determination and privacy versus the right to health. This paper addresses the issue of smoking in relation to mental health and focuses on the right to dignity and respect. The public health agenda on smoking has involved the mobilisation of stigma to persuade people to give up. The paper argues that this strategy risks adding to the stigma and process of 'othering' that many mental health service users already experience and is also likely to be ineffective in reducing smoking rates, particularly among heavy smokers.

Introduction

Cigarette smoking is a major public health problem worldwide. It is thought that 1.3 billion people around the world smoke cigarettes and that smoking has resulted in the deaths of approximately 100 million people in the last century (Sweanor *et al.*, 2007). In the UK as of 2001, 27 per cent of adults smoke (28 per cent of men and 25 per cent of women) and 9 per cent of the population smoke heavily (i.e. smoke more than 20 cigarettes a day). Smoking remains the main preventable cause of premature death among adults with one in five (120,000) deaths in 1995 caused by smoking (DoH Statistical Bulletin, 2003). There is a sharp differential in prevalence of smoking by social class, with 32 per cent of people in manual occupations who are smokers compared to 21 per cent in the non-manual occupational groups (ibid.). The proportion of people with mental health needs who are cigarette smokers far exceeds that in the general population. Up to 70 per cent of mental health service users in hospital smoke, and 50 per cent are classed as 'heavy smokers' (Jochelson and Majrowski, 2006). The smoking rates among mental health service users in the community are lower than those among in-patients, but still much higher than those in the general population, with 40 per cent smoking and almost 30 per cent smoking heavily (ibid.). People with a diagnosis of a psychotic illness such as schizophrenia or bipolar affective disorder are more likely than those in the general population and other mental health service users to smoke and to smoke heavily (McNeill, 2004). The risks associated with cigarette smoking are therefore unevenly distributed amongst the population, with mental health service users at the 'sharp-end' of risk.

Concerns on the part of UK policy makers about the extent of the public health problem posed by smoking has informed the implementation of a number of policies designed to lead to the maximum numbers of people giving up. Strategies such as the ban on smoking in public places have specifically focused on cessation as a goal, which is consistent with the approach to the problem internationally. There has been a national

ban on smoking in public places in the United States since 1992. Across the EU, smoking policies are increasingly undergoing a process of harmonisation, although there is still variation in terms of the measures that are imposed to stop people from smoking (Louka *et al.*, 2006). That such measures lead to reduced rates of smoking is incontrovertible. Advertising bans in countries such as Finland, Norway and Iceland have been found to reduce smoking rates, while the ban on smoking in public places in Ireland in 2004 was quickly followed by a 7.5 per cent reduction in levels of smoking (Louka *et al.*, 2006). However, there is evidence that the reduction in levels of smoking is uneven across different socio-economic groups (Farrimond and Joffe, 2006) and this of great significance for the arguments developed in this paper.

The implementation of the Health Act 2006 means that a total ban on smoking in enclosed public spaces has been effective across Wales from 2 April 2007 and England from 1 July 2007. Underpinning this policy has been the explicit goal of reducing the numbers of people who smoke as quickly and dramatically as possible. The policy in England included National Health Service sites with the exception of mental health units, where implementation of the ban was postponed to 1 July 2008. It is important to emphasise in this regard the distinction between smoke-free buildings or enclosed spaces within the meaning of the smoking legislation and smoke-free hospital *grounds*, which includes outdoor areas on-site. While the legislation does not *require* Health Trusts to adopt a smoke-free policy for their outdoor areas, they do have the freedom to extend the ban in such a way (DoH, 2008). In its guidance in 2005, the Health Development Agency emphasised the desirability of a complete ban in all health Trusts, with the inclusion of grounds as the 'ultimate standard' (McNeill and Owen, 2005: 3). According to this guidance, exemptions should only be considered for individual patients on a case-by-case basis. The implications of the smoking ban for mental health service users who wish to smoke but are compulsorily detained under Mental Health legislation are significant because people in this position will not be able to smoke unless they are allowed leave or are accompanied off-site or to the designated smoking area to smoke. Going out for a cigarette therefore depends on there being adequate staff numbers available. Evidence at the time of writing suggests that mental health Trusts are less likely than acute Trusts to incorporate grounds into the ban, and are more likely to allow blanket exemptions to the ban, including for mental health in-patients (Ratschen *et al.*, 2008). However, policies appear to be very variable and abuses of the ban in National Health Service settings by both staff and patients are widespread and frequent, often occurring on a daily basis (ibid.)

Unsurprisingly, banning smoking in mental health units has been the subject of a great deal of debate (see, for example, Jochelson, 2006; Arnone and Simmons, 2007; Williams, 2007), with competing rights at the centre of the controversy. Three main rights issues have been identified as most relevant: the right of staff to be protected from the second-hand smoke of others in their workplace; the right of mental health service users to exercise choice in their lifestyle by choosing to smoke; and, finally, the right of non-smoking mental health service users to a safe environment (Jochelson and Majrowski, 2006). The present paper seeks to shift the terms of the debate around smoking and rights towards a critical focus on the right to dignity and respect, as outlined in the health and human rights perspective (Mann *et al.*, 1994) and reflected in the Department of Health's *Human Rights in Healthcare Framework* (2007). In so doing, the present paper addresses the issues in a way that has relevance for mental

health service users in the community as well as those who are in-patients at any given time.

The paper begins by summarising evidence on the relationship between smoking and mental health, including consideration of the symbolic role that smoking appears to have. The paper then examines human rights in relation to smoking and mental health, and provides a brief account of the health and human rights perspective as it applies here. I then critically analyse the contrasting health promotion strategies of 'harm reduction' and those which advocate total cessation and which mobilise stigma as part of their strategy. The final section explains the significance of the relationship between social deprivation and mental health, and the implications of the stigmatising character of health policies for the effectiveness of health promotion strategies and also the right to dignity and respect of mental health service users who smoke.

Central to the arguments I develop in this paper is the idea that smoking policies in the UK and elsewhere have mobilised stigma in order to create a climate of antipathy towards smoking. This paper argues that in so doing, the campaigns have created a climate of antipathy and even hostility towards smokers themselves, with mental health service users who smoke being particularly vulnerable to this negative agenda by virtue of being 'multiply stigmatised'. From a human rights perspective, the strategy of shaming smokers into giving up is at odds with the basic principles of dignity and respect which should underpin all health promotion campaigns. Furthermore, I will argue that strategies based on processes of stigmatisation are highly unlikely to prove effective with those populations most at risk from heavy smoking, including those who experience social deprivation and many mental health service users. Such campaigns are instead likely to prove counterproductive to the overall goal of reducing smoking rates and are therefore unlikely to significantly affect the high mortality and morbidity levels arising from smoking in these groups. In conclusion the paper advocates a pragmatic focus on harm reduction strategies in smoking policies as opposed to the current emphasis on cessation.

Smoking and mental health

It is difficult to overstate the possible physical health benefits of stopping smoking for mental health service users. Mental health service users in general are more at risk of a range of smoking-related illnesses such as cardiovascular and coronary heart disease, chronic bronchitis and emphysema (Joukamaa *et al.*, 2001; Jochelson and Majrowski, 2006). People who have a diagnosis of schizophrenia are many times more likely to die from respiratory diseases than those with other diagnoses and this can be attributed to the particularly high rates of heavy smoking in this population (Joukamaa *et al.*, 2001). However, there is a confusing array of evidence about the relationship between smoking and *mental* health, supporting both the view that smoking may contribute to serious mental health problems *and* that it is symptomatic of or associated with them. The idea that smoking can be regarded as a form of 'self-medication' may be contentious, but the *perception* that this is so remains powerful. While the evidence is complex, smoking appears to reduce the effects of positive and negative symptoms and increase concentration levels, at least in the short term (McNeill, 2004; Mental Health Act Commission, 2005). However, there is also evidence that smoking might intensify some forms of mental disorder such as anxiety and panic disorders (Jochelson and Majrowski, 2006), and at least one study of suicidality among adolescents appears to demonstrate

that smoking may be a risk factor (Bronisch *et al.*, 2008). Interactions between smoking and medication add an important dimension to the issue. Higher doses of anti-psychotic drugs are required by people who smoke and some drugs appear to encourage smoking (McNeill, 2004; Jochelson and Majrowski, 2006). Such evidence suggests that the effects of sudden and enforced tobacco withdrawal might be physiologically harmful for patients who smoke, particularly in terms of the possible effects on psychotic symptoms and/or the absorption of antipsychotic medication. Whatever the direction of the relationship – cause, effect and/or close association – it is clear that smoking is a fundamental health concern in mental health.

A number of theories to explain the higher prevalence of smoking among mental health service users have been suggested (McNeill, 2004). A particularly useful summary of the main issues as they relate to mental health service users who are detained under the Mental Health Act 1983 is provided by the Mental Health Commission (2005: 250–1). That nicotine in the form of smoking is regarded as a readily available form of self-medication by many service users is undoubtedly true. Once addicted, the difficulties involved in stopping smoking and dealing with negative side-effects mean that giving up smoking poses a greater challenge for people who experience mental health problems than those who do not (ibid.). According to their review of the evidence, the Mental Health Act Commission (2005) suggests that there are a number of reasons for this. The physiological effects of withdrawal might well be magnified by the experience of mental illness such that giving up is more difficult. People with mental illness may be less inclined to health promotion generally and therefore less likely to be able to take advantage of smoking cessation programmes; this might be especially true of people at what might be their 'lowest point', on admission to hospital. Furthermore, smoking cessation programmes do not generally take account of cannabis use which is widespread amongst some groups of mental health service users, particularly younger people. While stress reduction appears to be a major motivation, this again is a complex area, as smoking addiction creates a 'new' stress, that of craving nicotine.

Aside from the serious health implications of smoking for mental health service users, it is clear that smoking also fulfils a powerful *symbolic* role for smokers and non-smokers alike. Up until the ban, smoking was unwittingly encouraged in psychiatric units because the spaces and places that smokers congregated in meant that '"going for a cigarette" becomes a legitimate means of respite from the general ward environment that is not otherwise available' (Mental Health Act Commission, 2005: 250). The symbolic meaning of smoking means that efforts to mitigate the effects of any ban can also have perverse and unforeseen consequences. The national ban on smoking that has been effective in the United States since 1992 also encompasses psychiatric units, but it incorporates exemptions through the use of 'smoking passes'. This effectively recreates the use of cigarettes as reward tokens in a reward/punishment system. Ironically, as Prochaska *et al.* (2004) point out, this is the form of reinforcement that in older institutions meant hospital was the very place where some mental health service users were first introduced to cigarettes.

Smoking can therefore be used in struggles for control, both symbolic and real, particularly where people have been compulsorily detained. The smoking ban in the UK may prove anti-therapeutic because of the effects of confiscating cigarettes on patients' experience of the care regime (Mental Health Act Commission, 2005: 249). This might explain why the idea of a complete ban on smoking in mental health units appears to have

very limited support from the users of such facilities, including non-smokers. Research carried out immediately prior to the implementation of the smoking ban on the attitudes of people who were currently in-patients in mental health facilities indicated that the majority (71.1 per cent) were in favour of retaining the current smoking policy (Smith and O'Callaghan, 2008). Only 3 per cent of respondents in this study favoured a total ban on smoking, which the authors concluded might reflect the view that smoking policies should be less stringent in psychiatric units. Accounting for the symbolic importance of cigarettes should therefore be an important element in health promotion strategies which target mental health service users.

A further dimension, which is of central importance for understanding the relationship between mental health and smoking, is social deprivation. This is because of the strong association between mental health and socio-economic position, and the importance of social deprivation in accounting for differential rates of smoking. The rates of smoking among people from deprived socio-economic groups are consistently higher than those in other socio-economic groups (Layte and Whelan, 2008) and mental illness is also more prevalent in deprived populations (Rogers and Pilgrim, 2003). Whilst it is not possible to argue that poverty *causes* mental illness, 'it is safe to say that poverty contains causal influences which both create and exacerbate mental health problems' (Pilgrim and Rogers, 2005: 60). Perhaps most importantly for the arguments I am developing about smoking in this paper, there is evidence that it is the reduced likelihood of *cessation* among socio-economically deprived groups that is a key factor in the inequalities in smoking behaviour, as well as the increased likelihood of starting in the first place (Layte and Whelan, 2008). The reasons for the differentials in giving up smoking appear to be closely related to 'the lived experience of socio-economic deprivation' (ibid.: 10). If this is the case, it should not be surprising that cessation rates are also low among many mental health service users, for whom the lived experience of extreme forms of mental distress as well as deprivation are a fact of everyday life. Before examining the importance of low cessation rates, the paper sets the context for the discussion on human rights as it relates to smoking policies and mental health.

Human rights, health and the right to dignity and respect

The Department of Health has explicitly identified human rights as lying at the heart of healthcare in general. In its publication entitled *Human Rights in Healthcare – A Framework for Local Action* (DoH, 2007), it states that human rights should be seen as 'a vehicle for making principles such as dignity, equality, respect, fairness and autonomy central to our lived experience as human beings' (p. 13). Core principles such as dignity and respect are therefore seen as underpinning the rights that are explicitly stated in human rights legislation. Under the 'Right to respect for private and family life', the document lists the following as examples of relevant issues in healthcare settings: privacy on wards and in care homes; family visits; sexual and other relationships; participation in social and recreational activities; and independent living (p. 39). The emphasis is thereby on making human rights 'real' in the experience of people receiving health care.

A key moment in the emphasis on human rights for mental health service users was the embedding of a human rights-based approach in the activities of the Mental Health Act Commission. This project began in February 2005 and set out its objectives in the

form of making the promotion of equality and human rights of people detained under the Mental Health Act (1983) a 'core and central function' of the organisation (Mental Health Act Commission, 2006: 1). In the context of this development, the direct link between the ban on smoking and the human rights of mental health service users was highlighted by the Mental Health Act Commission in its Eleventh Biennial Report (Mental Health Act Commission, 2005), again in response to the consultation on the implementation of the Health Act 2006 (Mental Health Act Commission, 2006), and then reiterated in its Twelfth Biennial Report in 2008:

> We stated *[in our response to the consultation]* that we do not believe that patients who are deprived of their liberty through use of the Mental Health Act to detain them in hospital for psychiatric treatment should, as consequence, be forced to abstain from smoking. Having suggested in our last report that enforcing a smoking ban on patients whose detention in hospital is justified for the purposes of psychiatric treatment could be found to be an unjustifiable interference in their human rights if this were subject to legal challenge ... we therefore suggested that hospitals where detained patients are resident should have the same exemption from the smoking ban as was being considered for prisons. (Mental Health Act Commission, 2008: 70)

The human rights emphasised by the Mental Health Act Commission in this context were the rights to respect for home and private life under Article 8. However, the application for judicial review of the smoking ban bought by patients of Rampton Hospital in 2008 under this article failed. The grounds given in the High Court judgement related firstly to health, including the rights of others to be protected from the effects of smoke pollution, and, secondly, security, in the sense that making arrangements for smoking by providing outdoor facilities would not be feasible in a high security environment such as Rampton (England and Wales High Court, 2008). The terms of this debate highlights what has been the central focus in relation to the smoking ban: the competing rights of smokers versus those of non-smokers and confusion about what can be defined as 'home'. This paper shifts the debate away from these competing rights towards a focus on the nature of the smoking policies themselves, and the implications they have for the right to dignity and respect. This requires a focus on the complex nature of the relationship between health promotion and human rights.

The core argument of the health and human rights perspective as first advocated by Mann *et al.* (1994) is that health promotion and protection and the promotion and protection of human rights are intrinsically linked and both are prerequisites for human well-being. The most relevant feature of the relationship between health and human rights emphasised for our purposes concerns recognition of the potential that public health campaigns have for *burdening* human rights and the desirability of 'an approach to realizing health objectives that simultaneously promotes – or at least respects – rights and dignity' (Mann *et al.*, 1994: 17). The emphasis placed on the state's responsibility for recognising the differential effects of particular health problems for 'a marginalised or stigmatized group' (ibid.: 13) is also relevant to my argument because of the particular issues that smoking represents for many mental health service users, as already outlined.

A central argument of the present paper is that the current orientation of smoking policies and the nature of the strategies pursued encompass a moral agenda that potentially contradicts the core principles of dignity and respect in healthcare. This is

because the cessation strategies that underpin smoking policies are strongly identified with moralistic forms of intervention that may have more to do with creating 'better moral souls' than making people healthier (Sweanor *et al.*, 2007: 70). In contrast, harm reduction strategies may offer a more pragmatic solution for some of the most 'high-risk' groups of smokers, including mental health service users.

Harm reduction vs smoking cessation

The sheer scale of the health problem that smoking represents has understandably encouraged an attitude that any strategy that works should be adopted. However, approaches that increasingly involve 'heavy-handed moral opprobrium' (Bayer and Stuber, 2006: 48) have implications, not only in terms of the human rights of those who smoke but also, just as significantly, the likely effectiveness of the strategies. This is particularly true in relation to those who are *most at risk* from the morbidity and mortality resulting from heavy smoking, including people from socially disadvantaged groups and consequently a large number of mental health service users. People in disadvantaged groups are likely to find it harder to give up in general (Layte and Whelan, 2008) and campaigns that stigmatise smokers are likely to prove especially ineffective with such groups (Farrimond and Joffe, 2006).

It is the difficulties in giving up for some groups that forms the main rationale behind harm reduction strategies:

> The rationale behind harm reduction is that although the best option would be to avoid the harmful behaviour completely, the next best option, if the behaviour is likely to continue, is to ensure that the harm caused is kept to a minimum. (Britton and Edwards, 2008: 442).

Harm reduction strategies on smoking stress that cigarette tobacco is the vehicle for a less harmful substance, nicotine, and it is therefore nicotine addiction which is the primary cause of tobacco consumption (Britton and Edwards, 2008). In simple terms: 'people smoke for the nicotine but die from the smoke' (Sweanor *et al.*, 2007: 74). Harm reduction strategies involve advocating smokeless nicotine replacement products such as patches and gum, or Swedish 'snus' as less harmful alternatives to cigarettes. Whilst such products do cause disease, they do so at significantly lower rates than cigarettes, and modern products of this kind are estimated to be as much as 90–99 per cent less deadly. However, harm reduction strategies are significantly hindered by an 'irrational' pattern of regulation of products in which the most harmful products – cigarettes – are freely available and barely regulated, whilst the less harmful smoke-free medicinal nicotine products are treated as drugs and as such are tightly regulated (Britton and Edwards, 2008). This regulatory anomaly means that medicinal nicotine is characterised by 'low-addiction, low-dose, low-effectiveness' (ibid.: 444).

Furthermore, the fact that cessation strategies demonise nicotine means that lower risk alternatives to cigarettes tend to be underutilised and users tend to use a lower dosage than required, thus increasing the likelihood of relapse into smoking. It is the binary choice between either smoking nicotine or not having it all which ensures the continued dominance of smoking as opposed to other forms of nicotine consumption (Sweanor *et al.*, 2007: 72). From the perspective of risk analysis, this is irrational:

> Alternative nicotine delivery devices will still entail risks. But as nothing in life is devoid of risks it is nonsensical to dismiss an alternative to a tremendously harmful activity by claiming the alternative is not absolutely 'safe', or to claim that the pursuit of a less hazardous alternative implies that the alternative is 'virtually harmless' (Gray and Henningfield, 2006). (Sweanor *et al.*, 2007: 72)

In any event, whatever the 'true' levels of harm that may be caused by smokeless nicotine products, they are without question significantly less harmful than smoking cigarettes (Britton and Edwards, 2008).

The simplification of the message in smoking policies about the risks involved in consuming tobacco to the single statement that 'it isn't safe' has been defended on the grounds that to present detailed information will cause confusion that might result in some people continuing or resuming smoking. This blanket approach has been criticised from a rights perspective on the grounds that, 'the right to health information is not contingent upon how an individual makes use of that information' (Kozlowski and Edwards, 2005: ii6). For Kozlowski and Edwards (2005), the right to accurate health information about the risks involved in smoking and the use of smokeless nicotine products as a possible alternative to smoking is a human right based on the principles of autonomy and self-determination.

Whilst the practical issues relating to the strategies that are currently being deployed to reduce smoking in the general population are of concern, there is a more specific issue which has a special bearing on the experience of mental health service users who smoke, and that is the way smoking campaigns have mobilised stigma to achieve their objectives. It is to this issue the paper now turns.

Smoking, structural stigma and social disadvantage

The mobilisation of stigma in public health campaigns aimed at affecting collective behaviour has a long history, particularly in terms of their focus on the behaviour of people who are disadvantaged (Bayer and Stuber, 2006). In this sense, the process of stigmatisation can be regarded as both ideological and moral, and is inextricably linked to structural disadvantage (Farrimond and Joffe, 2006). Poverty and smoking are strongly correlated, with smoking rates for both men and women from lower socio-economic groups more than twice those of their middle-class counterparts, and smoking among unemployed people even more prevalent (Farrimond and Joffe, 2006). This means that through smoking alone, it is the most socio-economically disadvantaged who are 'bearing a vast burden of avoidable morbidity and mortality' (Britton and Edwards, 2008: 441). The fact that there is also a close relationship between lower socio-economic status and certain diagnostic categories in mental health, particularly schizophrenia, may go some way towards explaining the extremely high smoking rates among mental health service users (Mental Health Act Commission, 2005).

Studies on stigma and smoking suggest that health promotion campaigns and smoking policies which use stigma as the main motivating factor for giving up may have a differential impact according to socio-economic status (Farrimond and Joffe, 2006). While people from higher socio-economic groups appear likely to change their behaviour in response to the increasingly stigmatised climate for smoking, people from lower socio-economic groups do not:

> Unlike higher *[socio-economic status]* smokers, the study has shown that lower *[socio-economic status]* smokers tend to internalise stigmatisation rather than challenge it or change behaviour to avoid it. Current health promotion campaigns that focus on the 'peril' smokers represent, and the disgust they engender, may push higher *[socio-economic status]* smokers into quitting, but fail to engage the already stigmatised (often multiply) disadvantaged smoker. They are thus more likely to perpetuate smoking inequalities than remove them. (Farrimond and Joffe, 2006: 489)

The literature on HIV/AIDS would also suggest that stigma is a highly ineffective process through which to influence health behaviour (Bayer and Stuber, 2006). Those with experience in this field have been led to conclude that stigma is itself a major public health concern because of its deleterious effects on the effectiveness of health campaigns, particularly among the socially disadvantaged.

The 'smoking discourse' which is created through health promotion campaigns certainly appears to be important in terms of the attitudes of smokers towards their capacity to give up, and there is evidence for significant cultural differences in this respect. In a comparative study of representations of smoking in Greece and the UK, two countries with a very different level of restriction on smoking, Louka *et al.* (2006) found an apparent paradox. UK smokers experienced themselves as inhabiting a highly moralised climate with regard to smoking, in which smokers are regarded as 'immoral'. Giving up was perceived by them as being extremely difficult and this perception was clearly linked to the notion of smoking as highly addictive, a discourse that is strongly represented in UK health promotion discourse. Greek smokers, in contrast, appeared to regard giving up as relatively unproblematic. While the translation of these perceptions into actual smoking behaviour is not explored, it is clear from such studies that the cultural narratives around smoking created by health campaigns have an important impact on the way smokers perceive their smoking behaviour. These perceptions of smoking behaviour may also in part explain some of the difficulties that some groups experience in giving up.

The emotion of shame is central to understanding the way stigma operates in relation to health behaviour such as smoking in groups where social disadvantage is a key factor. Shame is both a profoundly social but also an intensely private emotion (Sayer, 2005). It is an important mechanism in the production of social order through which norms, values and expectations about behaviour and how to live are internalised, particularly in relation to social class:

> Shame is evoked by failure of an individual or group to live according to their values or commitments, especially ones concerning their relation to others and goods which others also value. It is commonly a response to the real or imagined contempt, derision or avoidance of real or imagined others. (Sayer, 2005: 954)

The more these norms and expectations are assumed to be valuable, the greater the risk of shame for the individual who cannot live up to them. Importantly for the argument presented in this paper, shame may remain unarticulated and beyond immediate awareness, 'yet still capable of blighting one's life' (ibid.: 954).

In socio-cultural terms, the metaphorical notion of pollution is a powerful element in mechanisms of stigmatisation and shame that can be considered common to both smoking and 'madness'. Non-smokers associate smokers with 'embodied dirt and decay',

with strong unpleasant smells and negative appearance, and conceive of passive smoking as a form of contamination (Farrimond and Joffe, 2006: 484). Sociologists have long observed that 'odors do indeed bear social meaning' (Largey and Watson, 1972: 1027) and the meaning associated with the smell of smoking has undergone a transformation from its early association with almost therapeutic qualities to the present association with toxicity. The moral judgement of smokers is especially vigorous and emotional where the 'contamination' of children is concerned, and a particularly intense form of social disapproval and disgust is directed at those who smoke in restaurants or around food (Farrimond and Joffe, 2006). It is argued that 'madness' in the socio-cultural sense is also symbolically identified with waste and pollution, and such images have been constructed in powerful ways through media representations of people with a mental illness (Wilkinson, 1998).

Most significantly from the viewpoint of this paper, smokers are increasingly identified with the 'Other' and with specific 'out-groups' such as the old and disadvantaged. The 'poor young single mother who smokes' is identified by Farrimond and Joffe (2006: 487) as an example in which the link between smokers and several stigmatised 'out-groups' (the poor, the young, single parents) appears to compound the strength of the negative response on the part of non-smokers. Mental health service users may also represent an 'out-group' for whom smoking may have important symbolic connotations, since: 'The stigmatisation of "the unhealthy" is an active social process; risky behaviour is associated with and projected onto "Other" already stigmatised out-groups' (Farrimond and Joffe, 2006: 482). The notion of 'peril' which underpins stigma (Farrimond and Joffe, 2006) can be understood in both symbolic and real terms in relation both to smoking and mental illness. The 'smoking world' (Louka *et al.*, 2006) inhabited by people with mental health problems is therefore increasingly characterised by exclusion, isolation and a further dimension to being 'Other'. Just as mental health service users are multiply disadvantaged, they may also experience a multiplier effect of stigmatisation which in part arises from the unintended consequences of the health campaign against smoking.

Conclusion

In this paper I have argued that the differential burden of stigma upon smokers who are already disadvantaged has implications in terms both of their human right to dignity *and* the likely effectiveness of health campaigns. For many in public health who are concerned with reducing smoking rates, there is a crucial distinction between the act of smoking – which they say is what is stigmatised through health campaigns – and smokers themselves. However, it is difficult to refute the idea that it is the 'social transformation of the smoker' (Bayer and Stuber, 2006: 49) rather than just the act of smoking that we have witnessed in the US and in most European countries in the past 20 years or so. I have emphasised the way in which shame and stigma operate in the lived experience of deprivation and mental distress. The effects of these mechanisms are magnified further by the orientation of a health campaign against smoking which emphasises the personal failings and moral weakness of individuals who continue to smoke.

The powerful symbolic and complex role that smoking has played in mental health services has been ignored in health promotion in favour of a purely rationalist approach to the problem. This approach is epitomised by the emphasis on cessation rather than harm reduction. Although the latter approach is likely to prove more effective with some

groups of 'high-risk' heavy smokers, including mental health service users, such harm reduction strategies are hampered by the demonization of nicotine as a substance and by a distorted regulatory regime. Given the disproportionately high mortality and morbidity rates suffered by those in deprived socio-economic groups, particularly the many mental health service users who smoke, serious thought needs to be given to refocusing health campaign strategies to reduce their more stigmatising effects. This is not only warranted from a rights perspective, but also in terms of the likely effectiveness of such strategies. Total cessation need not be seen as the only objective and the advancement of a strategy which targets more achievable goals through harm reduction is likely to benefit the heaviest smokers who are most at risk.

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