This powerful and authoritative report should be essential reading for everyone interested in Scotland’s health. It looks at the latest smoking trends and levels of tobacco-related harm to health in Scotland. It reviews current prevention, treatment and control policies and services. While there has been considerable progress in recent years, it concludes that much more needs to be done.

SEVEN IMPORTANT FACTS ABOUT SMOKING IN SCOTLAND

- Around 1.2 million people smoke — 30% of the adult population.
- About 25% of girls and 16% of boys are regular smokers by the time they are 16.
- A quarter of women smoke during pregnancy, with serious consequences for their children’s health.
- Smoking causes at least 20-25% of all deaths and is one of the main reasons why disadvantaged people are more likely to have poorer health and die younger.
- Breathing second-hand smoke increases the risk of heart disease, lung cancer and other conditions.
- Many young people become addicted to cigarettes within weeks of starting to smoke and find it very difficult to stop.
- Around 70% of smokers say they want to give up but only around 2% a year succeed without help.

THREE KEY RECOMMENDATIONS

- We need to take a much more intensive approach to discouraging children and young people from ever smoking.
- A huge expansion in smoking cessation services is needed to help many more people to stop smoking.
- Further steps should be taken towards making all enclosed public places and workplaces smoke-free zones.

This report is also available at www.healthscotland.com
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Working Group

This report was prepared on behalf of NHS Health Scotland* and ASH Scotland by:

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Acknowledgements

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* NHS Health Scotland was established on 1st April 2003 from the merger of HEBS and PHIS. Drs Gruer and Parkinson were formerly of PHIS and Sally Haw of HEBS.
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Abbreviations

ASH Action on Smoking and Health
COSLA Convention of Scottish Local Authorities
ETS Environmental tobacco smoke
EU European Union
FCTC Framework Convention on Tobacco Control
GPs General Practitioners
HEBS Health Education Board for Scotland
HSC Health and Safety Commission
HTBS Health Technology Board for Scotland
LST Life Skills Training
NHS National Health Service
NICE National Institute for Clinical Excellence
NRT Nicotine replacement therapy
PATH Partnership Action on Tobacco and Health
PHIS Public Health Institute of Scotland
SALSUS Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCSs Smoking cessation services
STCA Scottish Tobacco Control Alliance
UK United Kingdom
US United States
WHO World Health Organisation
Smoking remains the biggest single cause of preventable illness and premature death in Scotland. Despite all the warnings, 30% of adults continue to smoke, lowering their life expectancy and reducing their quality of life through heart disease, respiratory problems and a variety of other conditions. In our most deprived communities, smoking rates are twice the national average. Scotland has the highest death rates from lung cancer amongst both men and women in Western Europe. We live in a country where smoking kills.

I welcome this report as a powerful and stimulating contribution to our efforts to improve the health of the people of Scotland. It reviews recent trends and sets out the very latest, robust evidence about the harm caused by smoking and the ways in which it might be possible to reduce that harm. The report goes on to consider the impact of current prevention, control and treatment programmes in Scotland and makes a series of recommendations for future action. In doing so, it helps us consider the role that all of us, whether we are medical professionals, employers, trade union representatives, smokers or non-smokers, can play in transforming health in Scotland.

Whilst acknowledging the progress we have made since the publication of the UK Government’s White Paper Smoking Kills, the report challenges the Scottish Executive to go further in its efforts to reduce tobacco-related harm. I am pleased to say that the Executive has responded to this Challenge and will publish a new action plan, Tobacco Control Action Plan alongside this report. This provides the kind of integrated, national programme of action envisaged by the authors of this study and demonstrates the importance that the Executive attaches to tobacco control.

Action to reduce smoking and minimise tobacco-related harm is the key to transforming the health of the people of Scotland. This report provides a firm basis for such action and I commend it to you.

Dr Mac Armstrong
Chief Medical Officer for Scotland
The aims of this report are to:
● examine current smoking trends in Scotland;
● summarise the most up-to-date evidence about smoking and tobacco-related harm and how it can be reduced;
● consider current prevention, control and treatment policies and services in Scotland;
● make recommendations about what further action should be taken in Scotland.

Smoking Rates in Scotland

About 30% of adults in Scotland currently smoke — around 1.2 million people. There is, however, considerable variation in smoking rates across the population. Despite a marked decline in the prevalence of smoking among the more affluent over the past 30 years, rates among the least well-off have scarcely changed. As such, rates are more than five times higher among women and three times higher among men in the most disadvantaged groups than in the most affluent. Smoking rates are also extremely high among socially excluded groups such as the homeless and people with mental health problems, and may be increasing among some ethnic minorities. Smoking among females is now a major concern: more than a quarter of women still smoke during pregnancy; smoking rates for boys have dropped somewhat in the past 20 years whilst those for girls have not.

Smoking and Tobacco-related Harm in Scotland

Smoking causes a wide range of serious illnesses, reducing the average life expectancy of those who continue to smoke by many years and frequently causing long-term disability. It is estimated that smoking currently causes at least 20-25% of all deaths in Scotland. Specifically, Scotland has the highest lung cancer rates in Europe for both men and women, with most cases caused by smoking. Around two-thirds of the social class difference in death rates in middle age are due to smoking. Although, the risks of smoking-related diseases increase with the duration and frequency of smoking, these risks diminish substantially and progressively if smoking stops.

Smoking also impacts on non-smokers. Regular exposure to environmental tobacco smoke (passive or second-hand smoking) increases the risk to non-smokers of lung cancer and heart disease by 20-25%. Furthermore, maternal smoking during pregnancy is the commonest preventable cause of death and illness in the foetus and infants in Scotland. It is also associated with both physical and behavioural disorders in the child’s later life. Exposure to tobacco smoke in the home increases children’s risk of asthma, as well as ear and lung infections.

The financial implications of smoking are also significant. The average smoker currently spends about £1,500 per year on cigarettes and the cost of parental smoking can increase child poverty in already disadvantaged homes. To society as a whole, smoking results in an estimated annual loss of productivity in Scotland of about £450 million and NHS hospital costs of £200 million.
Reducing Harm — The Barriers

The main cause of dependence on tobacco is nicotine, a drug which is as addictive as heroin or cocaine and is delivered rapidly to the brain by smoking cigarettes. Many people start smoking when young. They can quickly become dependent and carry this dependence into later life. Dependence varies greatly from person to person and tends to increase with increased socio-economic disadvantage or reduced mental health.

Over 70% of smokers want to stop but only 2% succeed in the long term each year. Personal problems and social pressures reinforce continued smoking. Stress and social situations associated with smoking increase the risk of relapse for those who have stopped. In addition, the tobacco industry has long sought to deny the addictiveness of cigarettes and has used advertising and marketing to encourage and sustain smoking behaviour. The availability of cheaper cigarettes through smuggling, now accounting for about 20% of all cigarettes in the UK, also undermines the public health benefits of tobacco taxation and contributes to continued smoking.

Reducing Harm — Current and Future Action

Comprehensive, intensive and sustained tobacco control programmes in the United States and Finland have reduced smoking rates, but only among men. The Scottish anti-smoking strategy includes many of the required elements of such programmes, several of which are part of a range of new initiatives in Scotland as a result of the UK Tobacco White Paper, *Smoking Kills* (1999). These include mass media preventive programmes aimed at young people; new smoking cessation services across the country; and efforts to extend smoke-free areas and deter under-age tobacco sales. However, their current reach, intensity and duration appear insufficient, given the number of smokers in Scotland and the difficulty in preventing initiation and enabling cessation of smoking.

Prevention

Mass media anti-smoking campaigns in Scotland consistently achieve a high level of awareness among young people. The research evidence, however, indicates that successful campaigns are multi-stranded and of higher intensity and duration. In addition, the type of messages used may require reconsideration if attitudes and behaviour are to change. There is also a lack of evidence for the effectiveness of tobacco education as currently delivered in Scottish schools.

Cessation

A range of psycho-social approaches, including individual and group counselling and support techniques, have been shown to achieve modest increases in quit rates compared to will-power alone. Smoking cessation services have been shown to be cost-effective, especially when nicotine replacement therapy or bupropion is used in conjunction with other forms of support. However, relapse rates remain relatively high, particularly for highly dependent smokers. There is scope for exploring the potential of more intensive use of nicotine replacement
therapy among highly dependent smokers and the place of nicotine replacement therapy in the treatment of pregnant smokers requires urgent research. Among other cessation techniques, there is little published evidence that acupuncture, hypnotherapy or laser therapy are effective. A dedicated telephone helpline can play a useful supportive role.

Although there has been rapid development of smoking cessation services in Scotland since 2000, considerable expansion will be needed if a measurable impact on smoking rates is to be achieved. The implementation of systems for evaluating these services and the development of training standards and programmes are being taken forward by PATH (Partnership Action on Tobacco and Health). Eight pilot smoking cessation interventions for young people are also underway and are being rigorously evaluated. A major intervention in a disadvantaged area of Scotland, based on the community development approach, failed to achieve a measurable impact on attitudes or smoking behaviour.

Control Measures
Progressive increase in the taxation of tobacco products is an effective control measure, determined at UK government level. There is a strong public health case for restricting smoking in public places, yet public awareness of the hazards of environmental tobacco smoke is limited. The Voluntary Charter on Smoking in Public Places provides an opportunity for extending smoke-free areas but its actual impact remains doubtful. Most leisure industry companies in Scotland still permit smoking in their public access areas, and public houses and bars are the least likely to have smoking restrictions. Restrictions on smoking have been introduced in many workplaces in recent years but about a quarter of Scottish employees are still exposed to environmental tobacco smoke and have little protection under current legislation. By 2001, less than 40% of Scottish local authorities had created any smoke-free zones on their premises. In contrast, although recent data are lacking, most NHS premises prohibit smoking or have designated smoking areas. All schools ban smoking by pupils but only a minority prohibit smoking by staff. Public transport restrictions also vary: smoking is prohibited on domestic flights; prohibited or restricted on trains; and restrictions on buses and taxis depend very much on the operator. Enforcement on, for example, buses can be a problem.

A large proportion of smokers under 16 still buy their cigarettes from shops. To address this important issue, the Crown Office has recently instituted four pilot schemes of child-assisted test purchasing. This will provide evidence for prosecution of vendors of tobacco products to minors. Restricting the influx of smuggled cigarettes is a major ongoing challenge for Customs and Excise and the police.

Conclusions
Reducing smoking and tobacco-related harm is indeed a key to improving Scotland’s health.

A well-resourced, long-term, multi-stranded national programme is needed on a scale that truly matches the size and intractability of the challenge.
1. The implementation of the UK ban on tobacco advertising and promotion in Scotland should be rigorously enforced, systematically and carefully monitored and the legislation amended if necessary to minimise circumventions.

2. The Scottish Executive should develop a comprehensive action plan that sets out an adequately resourced programme of initiatives designed substantially to reduce smoking and tobacco-related harm in Scotland over the next ten years. This should build on the findings and recommendations of the present report and should be integrated with the recently published document *Improving Health in Scotland: The challenge*. The plan should set realistic priorities, outcome targets and timescales.

3. The Scottish Executive should establish a standing Advisory Committee on Smoking and Tobacco Control to ensure it has a constant source of expert advice on its Tobacco Control Strategy. This should be organised on the same lines as the Scottish Advisory Committees on Drug Misuse and Alcohol Misuse.

4. There should be explicit recognition at national and local government levels of the importance of action to reduce poverty and social exclusion if tobacco-related harm is to be reduced in the long term.

5. The development of future prevention initiatives for young people should be supported by further research designed to provide a clearer view of the factors that influence whether or not young people smoke and of their understanding of the addictiveness of tobacco and other issues such as smoking during pregnancy, passive smoking and the marketing techniques of the tobacco industry.

6. Consideration should be given to developing, piloting and evaluating a more intensive, phased approach to smoking prevention at school, starting before the onset of smoking. Smoking prevention should be part of a wider programme that addresses tobacco, alcohol and other drugs within the personal and social education curriculum and should be linked to other tobacco control initiatives within the school and the community.

7. Smoking prevention programmes should be designed to ensure they are in tune with the needs and aspirations of both girls and boys, especially those in circumstances of social exclusion and vulnerability.

8. The way in which the media are used to influence smoking and tobacco-related knowledge and behaviour should be reassessed to take account of the latest research findings and to exploit the opportunities provided by formats such as reality TV, TV documentaries, chat shows and soaps and teen magazines.

9. The Scottish Executive and all NHS Boards should ensure that effective
10. Smoking cessation services should be designed particularly to help men and women on middle and low incomes of all ages who are moderately or heavily dependent on nicotine and who want to give up. They need to address the particular difficulties faced by people living in areas or circumstances of socio-economic disadvantage.

11. Health professionals in both community and hospital based services should be encouraged and enabled as far as possible to play a key role in smoking cessation — either by referring patients to specialist services or, if suitably trained, providing smoking cessation support themselves.

12. As a matter of urgency, the Scottish Executive should fund the development and evaluation of initiatives designed to help pregnant women, their partners and parents of young children to stop smoking. This should include qualitative research into the attitudes towards

13. Smoking cessation services should specifically address the needs of young smokers, and other groups such as people with mental health problems and members of ethnic minorities.

14. All smoking cessation services should be subject to careful evaluation so that the most effective approaches and models of service delivery can be identified and reproduced across the country. This should be coordinated centrally on a national basis to ensure a consistent approach.

15. PATH should take the lead in coordinating a consistent approach, based on agreed Scottish training standards, to training smoking cessation service staff in the management and provision of smoking cessation services, drawing on developments in England and Wales where appropriate.

16. All schools in Scotland should be smoke-free zones for everyone as part of the Health Promoting School concept.

17. Further steps should be taken to extend smoke-free zones in all enclosed public places, including public transport, shopping centres and premises where food or drink is served. The value of...
smoke-free environments should be explained in media campaigns. Employers should be encouraged to create smoke-free work environments and provide staff who smoke with the opportunity to attend smoking cessation services and obtain other appropriate support. It is most unlikely these objectives will be fully and consistently achieved without new legislation to restrict smoking in public places.

18. Efforts to enforce the law on the sale of cigarettes to the under 16s should be intensified.
1 INTRODUCTION AND AIMS

1.1 Smoking tobacco is by far the most important preventable cause of ill health and early death in both Scotland and the United Kingdom (UK) as a whole. Over the past five years, this understanding has stimulated a much stronger policy focus on the need to tackle smoking both as a health problem and as a broader social issue. Reducing smoking and the harm it causes are now major Government priorities, confirmed by the recent publication of four policy documents which have provided a strong impetus for much of the current work:

- *Smoking Kills: A white paper on tobacco* (1998);¹
- *Towards a Healthier Scotland: A white paper on health* (1999);²
- *Our National Health: A plan for action, a plan for change* (2000);³

Smoking has also been identified as a special focus programme in *Improving Health in Scotland: The challenge*, published by the Scottish Executive in March 2003.⁵

In the light of these important developments, the aims of this report are to:

- examine current smoking trends in Scotland;
- summarise the most up-to-date evidence about smoking and tobacco-related harm and how it can be reduced;
- consider current prevention, control and treatment policies and services in Scotland;
- make recommendations about what more should be done in Scotland.

1.2 Additionally, in November 2002 the *Tobacco Advertising and Promotion Act* (2002) was given Royal Assent, heralding an end to most forms of advertising of cigarettes and other tobacco products in the UK, with the majority of measures taking effect from 14th February 2003.⁶

1.3 This report is the product of close collaboration between NHS Health Scotland and ASH Scotland. It is envisaged that it will be of value to the Scottish Executive and Scottish Parliament, and all agencies, professionals and other individuals who have an interest in improving Scotland’s health.
2 SMOKING RATES IN SCOTLAND

Adult Smoking Rates

2.1 Although adult smoking rates in Scotland fell steadily for over 20 years until the mid 1990s, they have since levelled off (Figure 1). They remain consistently higher than in the UK as a whole for both genders — 30% v 29% for males and 30% v 25% for females in 2000.\(^7\)\(^8\) This means that about 1.2 million Scots are current smokers. Recent figures from 48 European countries for 1997-2001 show that fewer Scottish males (33% v 38%) but more females (29% v 23%) smoke than in Europe as a whole.\(^9\)

FIGURE 1
Prevalence of smoking in Scotland for people aged 16 and over by sex, 1972-2000
(Source: General Household Survey, ONS\(^7\))

[Graph showing smoking rates by sex and year]
Smoking by Socio-economic Group

2.2 The decline in smoking rates in Scotland over the past 30 years has mainly been among more affluent people. People in skilled manual and non-manual occupations are as likely to smoke as professionals were 30 years ago and the unskilled and unemployed continue to smoke as much as ever. In the late 1990s, 16% of Scottish men in social class I* were current cigarette smokers compared with 50% in social class IV and 55% in social class V. Among women, 11% in social class I were smokers rising to 52% in social class V (Figure 2).[10]

2.3 Although smoking rates are highest among the unskilled and unemployed, given the number of people in each social class in Scotland and the proportion who smoke, almost half of all smokers are in the skilled manual and skilled non-manual social classes (Figure 3). Because neighbourhoods tend to consist of people of broadly similar socio-economic status, particularly in towns and cities, there are also large variations in smoking rates by locality. For example, estimated smoking rates vary between Scottish local authority areas from 24% to 45% and between postcode sectors from 15% to 71%.[11] The highest smoking rates are found in the areas of highest socio-economic deprivation.

FIGURE 2
Prevalence of smoking in Scotland by social class and sex among 16 to 64 year olds
(Source: Scottish Health Surveys 1995 and 1998 combined data for individual respondents[10])
Children and Adolescents

2.4 More girls have been smoking than boys in Scotland throughout most of the last 20 years. Whilst fewer boys are smoking now than in the mid-1990s, there has been no real change among girls (Figure 4). In the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2002, 9% of 13 year old girls and 6% of boys reported smoking one or more cigarettes per week (regular smoking) as did 24% of 15 year olds girls and 16% of boys. Regular smokers spent on average £8 per week on cigarettes. Other studies have found smokers to be more likely to report poor academic performance and more pessimism about the future, to dislike school and have an unhealthy diet.

2.5 Smoking is strongly associated with the use of alcohol and illegal drugs. Reports have shown that boys and girls who smoked daily were 3.6 and 5.7 times more likely, respectively, than non-smokers to have been drunk more than ten times and that among 13 and 15 year olds who smoked at least once a week, 60% had used illegal drugs (usually cannabis) in the past month, compared with only 2% of those who had never smoked. Smoking usually begins before first use of illegal drugs, with the average ages of initiation being 12 and 14 years, respectively.

FIGURE 3
Percentage of all Scottish smokers aged 16 to 64 year by social class
(Source: Scottish Health Surveys 1995 and 1998 combined data for individual respondents)

Professional
Managerial/technical occupations
Skilled occupations non-manual
Skilled occupations manual
Partly-skilled occupations
Unskilled occupations and unemployed

(Social class based on Registrar General’s Standard Occupational Classification for individual respondent)
FIGURE 4
Proportions of children smoking at least one cigarette per week
(Source: SALSUS report 200212)

FIGURE 5
Percentage of women smoking in early pregnancy
(Source: Scottish Health Statistics 2001, 2000 data14)
Women Smoking During Pregnancy

2.6 Around 27% of Scottish women currently smoke in early pregnancy. This means that about 13,500 babies born in Scotland each year have been exposed to many of the toxic chemicals in cigarette smoke with potentially damaging consequences for their health (See Section 3). Pregnant teenagers are the most likely to smoke (Figure 5). This is partly because teenage pregnancies are most common in disadvantaged areas where smoking rates are also highest. Smoking in pregnancy is also associated with early school-leaving, being unmarried, living with other smokers and unemployment.

2.7 Up to a quarter of women stop smoking during pregnancy, while a further quarter or more try to cut down. However, most who stop during pregnancy restart after their baby is born. Many say they give up for the baby's sake rather than their own well-being. Furthermore, about 7% more fathers than mothers smoke, and women who stop smoking during pregnancy are much more likely to start again if their partner smokes. Therefore, successful quitting by pregnant women may be more likely if a joint effort is made with their partner.

Socially Excluded Groups

2.8 Smoking rates are particularly high among heavy drinkers, homeless people, prisoners and people with serious mental health problems. For example, 82% of 225 homeless people in Glasgow and 98% of 266 female problem drug users in Glasgow were found to be smokers.

Ethnic Minorities

2.9 There have been no scientifically reliable surveys of the prevalence of smoking among ethnic minorities in Scotland. However, a recent series of interviews with 85 representatives of the four main ethnic minority groups in Glasgow (Pakistani, Indian, Chinese and Black) suggested that smoking prevalence may be higher than previously recognised, particularly among women. Respondents felt significant amounts of covert smoking may be a consequence of prevailing negative attitudes about smoking by women. The survey revealed a low level of awareness regarding anti-tobacco agencies, pharmacological aids (nicotine replacement therapy (NRT)) and prevention materials. Whilst almost all the interviewees were aware of the adverse effects of smoking, many felt the perceived beneficial effects — relaxation, socialising and managing stress — outweighed the disadvantages.
3 SMOKING AND TOBACCO-RELATED HARM

Smokers

3.1 Smoking is a major cause of illness and death from diseases of the heart and blood vessels, the lungs, stomach, kidney and other organs.\textsuperscript{23,24} The list of serious diseases caused by smoking is much longer than most people realise (Table 1). Many smokers will develop more than one tobacco-related illness and face years of discomfort and disability. On average, a 35 year old male smoker who continues to smoke can expect to live seven years less than a non-smoker and a female smoker six years less.\textsuperscript{25} As these are averages, many smokers will lose far more than six or seven years. Overall, the more cigarettes smoked, the more likely is poor health to result. Other harmful effects of smoking include reduced fertility among women, higher rates of male impotence, dental problems and brittle bones especially among women.\textsuperscript{26}

3.2 Smoking disproportionately affects those already disadvantaged by poverty and is a major contributor to health inequalities.\textsuperscript{27} Rates of all smoking attributable diseases in Scotland are lowest in the most affluent and highest in the most disadvantaged areas. It has been estimated that around two-thirds of the difference in risk of death across social class groups in middle age is attributable to tobacco.\textsuperscript{18}

TABLE 1
Percentage of deaths from diseases attributable to smoking
(Source: Nicotine Addiction in Britain, RCP\textsuperscript{25})

<table>
<thead>
<tr>
<th>Cancer</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Lung</td>
<td>84</td>
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<tr>
<td>Upper respiratory tract</td>
<td>66</td>
</tr>
<tr>
<td>Oesophagus</td>
<td>68</td>
</tr>
<tr>
<td>Bladder</td>
<td>37</td>
</tr>
<tr>
<td>Kidney</td>
<td>27</td>
</tr>
<tr>
<td>Stomach</td>
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<tr>
<td>Pancreas</td>
<td>23</td>
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<tr>
<td>Unspecified site</td>
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</tr>
<tr>
<td>Myeloid leukaemia</td>
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<table>
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<tr>
<td>Chronic obstructive airway disease</td>
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</tr>
<tr>
<td>Pneumonia</td>
<td>17</td>
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</table>

<table>
<thead>
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<th>Circulatory disease</th>
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<tbody>
<tr>
<td>Heart attack</td>
<td>7</td>
</tr>
<tr>
<td>Stroke</td>
<td>10</td>
</tr>
<tr>
<td>Aortic aneurysm</td>
<td>57</td>
</tr>
<tr>
<td>Heart muscle degeneration</td>
<td>15</td>
</tr>
<tr>
<td>Hardening of the arteries</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Digestive</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcer of stomach and duodenum</td>
<td>45</td>
</tr>
</tbody>
</table>
3.3 The Registrar General of Scotland has estimated that at least 20-25% of all deaths in Scotland are due to smoking: 11,600 to 14,500 deaths in 2002. 28 This far outweighs any other single cause and is a higher proportion than in any other country. 29 A recent analysis suggests that an even higher proportion of deaths in Scotland may be tobacco-related. 30 Scotland has had the highest death rate from lung cancer in Western Europe for both men and women since the 1950s, probably reflecting the very high rates and intensity of smoking in Scotland throughout the twentieth century. Lung cancer rates among men have been declining in Scotland since 1975 reflecting the steady decline in the number of men who smoke. However, rates among women rose steadily from 1955 to 1995 and only recently show signs of levelling off. 30

3.4 Less easy to measure than death, but nevertheless of huge importance, is the impact of tobacco-related diseases on quality of life. Chronic lung disease, angina and narrowing of the arteries to the legs are all common tobacco-related diseases that can result in years of discomfort and disability, early retirement or lengthy absences from work and a heavy burden on the health and social services. As these conditions often occur among people who are already of modest means, the net effect for many is increased poverty and social isolation. The risks of smoking-related diseases increase progressively the longer smoking continues and the more cigarettes are smoked. 31 They diminish substantially if smoking is stopped, resulting in improvements in health even among long-standing smokers. 32

The Foetus, Infants and Children

3.5 Smoking during pregnancy is the single largest preventable cause of disease and death to the foetus and infants and accounts for a third of perinatal deaths. 25; 33; 34 The main problems are highlighted in Table 2. Of these it is estimated that 10% of spontaneous abortions and 10% of low birth weight babies are due to smoking during pregnancy. Whilst most of the harmful effects of smoking in pregnancy are thought to be due to the over 4,000 chemicals in tobacco smoke, nicotine itself may also have some adverse effects on the developing foetus. 25; 33

3.6 Recent evidence has shown that cigarette smoking during pregnancy can also increase the risk of diseases such as diabetes later in the child’s life. 35 There is also a growing body of evidence linking maternal smoking during pregnancy with future conduct disorder and delinquency in children 36 and various behavioural and cognitive problems in childhood. 33

TABLE 2
Health problems among children of smokers

<table>
<thead>
<tr>
<th>Exposure during pregnancy</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous abortion</td>
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</tr>
<tr>
<td>Premature birth</td>
<td></td>
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<tr>
<td>Low birth weight</td>
<td></td>
</tr>
<tr>
<td>Stillbirth</td>
<td></td>
</tr>
<tr>
<td>Foetal hypoxia</td>
<td></td>
</tr>
<tr>
<td>Structural abnormalities in the foetal brain</td>
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<td>Cognitive behavioural abnormalities in the newborn</td>
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<td>Sudden infant death syndrome after birth</td>
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<td>Attention deficit disorder</td>
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<td>Impaired physical growth</td>
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<td>Impaired academic attainment</td>
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<table>
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<tr>
<th>Exposure during infancy and beyond</th>
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<tr>
<td>Middle ear infections</td>
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<tr>
<td>Lower respiratory tract infections</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Wheezing</td>
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<tr>
<td>Sudden infant death syndrome</td>
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</table>
3.7 After birth, children whose parents smoke are more likely to suffer from middle ear disease, asthma and other respiratory diseases\(^\text{37}\) and are at higher risk of sudden infant death syndrome (cot death).\(^\text{38}\) Of these it is estimated that exposure to smoking during infancy and beyond accounts for 10% of middle ear infections, 15% of lower respiratory tract infections, 25% of wheezing and 20-50% of sudden infant death syndrome. These children may also experience impaired physical growth and academic attainment compared to children of non-smoking mothers.\(^\text{39}\) Children of parents who smoke are also more likely to become smokers themselves than children of non-smoking parents.

Non-smokers

3.8 In recent years, awareness has grown of the health risks associated with inhaling environmental tobacco smoke (ETS), also known as passive or second-hand smoking. A new report has estimated the annual number of deaths from passive smoking in the UK to be over 12,000, equating to about 1,200 in Scotland.\(^\text{40}\) Among the 4,000 and more chemicals in tobacco smoke there are around 60 known or suspected carcinogens such as arsenic and benzene.\(^\text{41}\) ETS contains many of the carcinogenic and toxic agents inhaled by active smokers. Long-term exposure to ETS, through passive smoking, increases the risk of lung cancer by 20-30%,\(^\text{42}\) and of ischaemic heart disease by 23%,\(^\text{43}\) accounting for hundreds of deaths per year in Britain.\(^\text{37}\) A large follow-up study from California reports a lower risk from passive smoking than other studies but has serious methodological weaknesses.\(^\text{44}\) Passive smoking can also aggravate respiratory conditions such as asthma and chronic bronchitis. Even brief exposure can affect the coronary circulation in non-smokers\(^\text{45}\) and non-smokers exposed to ETS in the workplace may have their lung function reduced by up to 10%.\(^\text{46}\) Exposure to parental smoking can reduce lung function in children.\(^\text{37}\) The 1998 Scottish Health Survey indicated that the majority of children aged 8 to 15 are exposed to ETS from some source. This includes 4 in 10 children who report being exposed at home.\(^\text{47}\)

3.9 Despite increased awareness of the risks of ETS, recent surveys in Scotland found that the public’s understanding of the true risk is poor, particularly among smokers.\(^\text{48,49}\) This highlights the need to further inform and educate people about the effects of passive smoking on everyone, especially children.

Economic Costs

3.10 The economic cost of smoking is huge and is borne both by the individual smoker and the wider community. A 20-a-day smoker will smoke 7,300 cigarettes a year and will currently spend about £1,500 doing so.\(^\text{50}\) For the less well-off, this can be a large proportion of their total income, even if cheaper smuggled cigarettes are available. For example, over 70% of two-parent households on income support smoke, spending on average about 15% of their disposable income on tobacco.\(^\text{27}\) Children of low income smokers are three times more likely to go without essential items than similar children of non-smokers with a comparable income.\(^\text{51}\) Smoking therefore deepens economic inequalities with further potential negative consequences for health.

3.11 The cost of smoking to society as a whole is incurred through the use of scarce health service resources, lower productivity in the workplace (including the effects of ETS) and the payment of welfare benefits to those unable to work due to smoking-related illnesses.
3.12 The estimated annual cost of smoking-related time off work in Scotland is £40 million and total productivity losses are put at £450 million. Based on Buck et al., smoking costs NHS Scotland an estimated £200 million a year in hospital care, and the costs of treating smoking-related conditions in primary care must be added to this. Further costs include higher insurance rates for smokers, the more frequent need to redecorate and damage from smoking-related fires.

3.13 It is often argued by the tobacco industry, that tobacco brings major benefits to the economy, through revenue raised via taxation and jobs supported — directly and indirectly — by the tobacco industry. Taxation of tobacco products raises substantial revenues for the UK Government — £9,510 million in revenue from tobacco tax for the financial year 2000-2001: £7,648 million in excise duty and £1,860 million in VAT. However, duty on tobacco should not be seen primarily as a source of revenue, but as a public health measure, designed to control tobacco consumption. If tobacco duty were reduced, replacement revenue would be raised from elsewhere in the economy. Young people are particularly sensitive to tobacco prices, and high tobacco prices reduce youth consumption of tobacco. Studies show that a 1% rise in relative cigarette price results in about 0.55% fall in the amount smoked.

3.14 The tobacco industry is not a major employer in the UK. According to an industry report, 62,855 full-time jobs are supported by the tobacco industry in the UK of which only 9,620 are directly employed in tobacco manufacturing and none of these are based in Scotland. The World Bank has concluded that in a country like the UK, which imports all its tobacco, reductions in tobacco consumption would result in an increase in jobs due to spending on other things, likely to generate more employment than tobacco. A recent review of studies on the economic impact of smoking restrictions in different countries indicated that businesses in the hospitality industry had not suffered after smoking restrictions were introduced.
4 REDUCING HARM — THE BARRIERS

Dependence on Nicotine and Smoking

4.1 ‘Cigarette smoking should be understood as a manifestation of nicotine addiction... comparable with addiction to “hard” drugs such as heroin and cocaine.’

Cigarettes are efficient nicotine delivery systems and smoking cigarettes rapidly delivers nicotine to the brain. Nicotine acts upon many different parts of the brain but exactly how it causes dependence is unknown. If brain cells are repeatedly exposed to nicotine, they gradually alter the way they respond. This appears largely to explain why a smoker experiences pleasant sensations when smoking but unpleasant symptoms when the supply of nicotine to the brain runs out. The latter include headaches, anxiety, depression, sleeplessness and a craving for cigarettes. A detailed review of the evidence that nicotine is addictive is given in a report by the Royal College of Physicians: Nicotine Addiction in Britain. The full text of this report is available on-line at Royal College of Physicians website www.rcplondon.ac.uk

4.2 Smokers usually have their first cigarette as children or teenagers and most are already addicted before they are 20. Recent research from Scotland and the United States (US) shows how quickly dependence can develop. A survey of 23,000 13 and 15 year old Scottish school children found that 73% of those who had been smoking for more than a year wanted to give up. Seventy percent of regular smokers reported that they had already tried to give up, almost a third felt it would be ‘very difficult’ to stop smoking altogether and a further 36% thought it would be ‘quite difficult’. A study of US 12 and 13 year olds found that 40% of new smokers quickly develop symptoms of dependence – after an average of six months in boys but only three weeks in girls. A recent major American review has also highlighted the much higher rates of early smoking dependence and misuse of alcohol and other drugs among vulnerable young people in general and girls in particular.

4.3 Surveys of adult smokers have shown that around 70% say they want to quit. Despite this, only about 2% of smokers each year who try without help will succeed in stopping for at least a year.

When poverty, unemployment or other major difficulties dominate life and cigarettes seem to help make life bearable, there may be little incentive to try to quit. For those who do try, the severity of withdrawal symptoms varies enormously from person to person. For some, stopping can be relatively easy. But for many, it can take weeks or months of abstinence before all symptoms disappear. Whilst overcoming nicotine withdrawal symptoms may be the first hurdle, many people start again at times of stress or at those moments of the day or week normally associated with smoking: at lunch with colleagues; relaxing with friends in the pub.
Stopping is particularly difficult if most of the people in one's circle of family, friends, colleagues or neighbours smoke and if smoking has been part of life from childhood. The resolve not to smoke is thus tested on a daily basis: is it worth putting up with these symptoms (often adding to other major problems) when the easiest thing in the world is to have another cigarette? Many ex-smokers continue to experience for years an intermittent but intense desire to smoke at times of stress or in social situations they previously associated with smoking. The combination of heavy addiction, many other problems in life and an environment full of other smokers can thus create a situation from which it is very hard to escape.  

The Tobacco Industry and Tobacco Marketing

4.4 The tobacco industry has long refused to acknowledge publicly that nicotine is addictive and that smoking damages health. Indeed, even in today's climate, when the facts are inescapable, tobacco companies have sought to minimise the proven health impacts and addictiveness of their products.  

4.5 Tobacco companies have manipulated public and political opinion through misleading advertising, promotional strategies and both overt and covert lobbying. These strategies have played a part in ensuring that current smokers continue to smoke and new ones are recruited. Internal documents have revealed the extent of the tobacco industry's knowledge of the harm caused by smoking.  

4.6 The tobacco industry is now trying to portray itself as reformed, offering to play a useful role in funding youth prevention and scientific research. However, behind the scenes it continues to pursue a very different agenda, with internal documents showing how the companies aim to use the appearance of philanthropy to further their aims of circumventing regulation, promoting consumption, and distorting the debate towards the industry's conclusions. Tobacco smuggling provides another example of the industry's behaviour. Tobacco companies in the UK and elsewhere argue that high taxes on tobacco encourage smuggling. However, lawsuits and investigations have been launched against tobacco multinationals by Governments and fraud investigators in the UK, the European Union (EU), North and South America, accusing them of complicity in smuggling. In January 2003, the Public Accounts Committee of the House of Commons published the findings of its investigation into tobacco smuggling in the UK. This included Customs and Excise data showing that just two brands made by one manufacturer account for half the entire smuggled market in the UK. The illicit — smuggled — market for these two brands was greater than the legitimate market.  

4.7 The industry has sought to give the impression that 'low tar' and 'mild' cigarettes deliver less tar to the lungs of smokers and hence are safer. However, the reduced tar and nicotine yields claimed for these cigarettes are based on measurements by machines. These do not reproduce the deeper and more prolonged inhalation by smokers that ensure sufficient nicotine intake from these cigarettes. This behaviour means that both nicotine and tar intakes are increased. The tobacco industry has manufactured cigarettes that give low machine readings but a high yield when smoked.
4.8 The House of Commons select committee enquiry into the UK tobacco industry and the health risks of smoking stated in 2000 that ‘the dangerous nature of the product being marketed means that tobacco companies cannot expect to operate in the same commercial environment as most other industries.’ They concluded that more regulation is needed to control the manufacture, presentation and sale of tobacco products and recommended that a Tobacco Regulatory Authority be established, following a recommendation made by the Royal College of Physicians. This body, which would be independent of the tobacco industry, could be established at UK or EU level. More recently, the Royal College of Physicians published another more detailed report in December 2002 which repeated its earlier calls for a Tobacco and Nicotine Regulatory Authority to be established.

4.9 In June 2001 the EU adopted a Directive on the manufacture, presentation and sale of tobacco products. It aims to strengthen controls over tar and nicotine yields of cigarettes, introduce larger health warnings and removing the misleading terms ‘low tar’ and ‘mild’. The Directive was incorporated into UK law on 10th December 2002 and will be introduced in stages, with full compliance required by 30th September 2004.

4.10 The World Health Organisation (WHO) recognises the threat tobacco poses to health throughout the world and believes that international legislation is needed to ensure the industry is better controlled. In May 2003, WHO member states adopted a legally binding treaty, the Framework Convention on Tobacco Control (FCTC), to regulate the tobacco industry at a global level. The treaty is now open for signature and ratification by member states and may enter into force as soon as 2004.

4.11 Tobacco advertising counteracts public health messages, undermines a proper understanding of the real size of the hazard, promotes the social acceptability of cigarette smoking and influences the uptake of smoking by young people. The tobacco industry has until recently spent approximately ten times as much money on tobacco advertising and promotion as the UK Government does on anti-tobacco advertising: £135m by the tobacco industry in UK compared to £13m by the UK Government.

4.12 Although the tobacco industry argues that advertising is used to encourage brand switching, in reality it is to encourage people to start and continue smoking. Voluntary regulations on tobacco advertising have been deliberately undermined by tobacco companies who have targeted women, the disadvantaged and children by a variety of techniques and have placed special emphasis on aspirational/lifestyle marketing. The techniques used include: sponsorship of arts and sports, point of sale advertising, direct mailing and brand-sharing.

4.13 The Tobacco Advertising and Promotion Act prohibits virtually all tobacco advertising and promotion in the UK. It was given Royal Assent in November 2002 and took effect on February 14th 2003.

4.14 Cigarette smuggling is undermining the UK Government’s policy of increasing the tax on tobacco to reduce consumption. Smuggled cigarettes are currently around 40% cheaper than legal ones and are most likely to be sold in deprived areas and increasingly to children. It is estimated by Customs and Excise that in the years 2000-2002 around 21% of
cigarettes consumed in the UK were smuggled. Of these, about 75% were due to large-scale organised ‘container smuggling’ of cigarettes on which duty had not been paid. Most illicit imports are manufactured in the UK, exported and then smuggled back into Britain. Most of the remaining smuggled tobacco is legally purchased in countries with lower tax and then illegally sold in the UK. Internet purchasing from unregulated sites accounts for a small but growing proportion. It poses a threat to a comprehensive advertising ban and tobacco control strategy by increasing the likelihood of sales to minors; increasing the availability of cheap cigarettes; permitting unfettered advertising, marketing and promotion of tobacco; and maintaining the normalisation of the tobacco industry and its products.

4.15 Smuggling is estimated to have cost the Exchequer around £3.5 billion in lost revenues in 2000-2001. In contrast, in the year to March 2000, Scottish Customs and Excise seized over 29 million cigarettes with a value of £4.8 million. The UK Government also estimates that there would have been around a further 8% decrease in cigarette consumption since 1997 had it not been for smuggled cigarettes.

**Recommendation 1**

The implementation of the UK ban on tobacco advertising and promotion in Scotland should be rigorously enforced, systematically and carefully monitored and the legislation amended if necessary to minimise circumventions.
5 REDUCING HARM – CURRENT AND FUTURE ACTION

The Need for a Comprehensive Approach

5.1 Impressive evidence that smoking rates can be substantially reduced by public health interventions comes from the US where a number of states – notably Florida, California and Massachusetts – developed comprehensive tobacco control programmes in the 1990s. These typically included a range of interventions as shown in Table 3. The aim of these programmes is to change the social climate around smoking, discouraging people from starting to smoke, helping smokers to stop and creating an environment that is increasingly free of tobacco smoke.

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Initiatives in the Massachusetts Tobacco Control Programme</th>
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<tbody>
<tr>
<td>Type of intervention</td>
<td>Actions</td>
</tr>
<tr>
<td>Public education</td>
<td>Media, schools, one-to-one education, workshops</td>
</tr>
<tr>
<td>Professional education</td>
<td>Learn to assess and treat nicotine dependence, counsel and refer smokers, organise and manage the service</td>
</tr>
<tr>
<td>Services/interventions</td>
<td>Group facilitation, one-to-one interventions, nicotine replacement, referral</td>
</tr>
<tr>
<td>Regulations</td>
<td>Workplace policies, smoke-free buildings</td>
</tr>
<tr>
<td>Economic strategies</td>
<td>Increase taxes, limit advertising</td>
</tr>
</tbody>
</table>
5.2 Trends in smoking prevalence for Massachusetts were compared with those for 41 other states that did not have a tobacco control programme. It was found that smoking rates fell by an average of 1.8% per year among men in Massachusetts between 1990 and 1999 compared with an average 1% increase in the other states. Among women there was a slight decrease in Massachusetts and a slight increase elsewhere but the difference was not statistically significant. The decline in smoking prevalence was greatest in the early years of the programme.\(^\text{89}\)

Greater reductions in the use of cigarettes, cigars and smokeless tobacco by 13 to 18 year olds in Massachusetts were also seen than in other states without a control programme.\(^\text{90}\)

5.3 Similar evidence of effectiveness among men but not women comes from Finland where an intensive anti-smoking campaign in North Karelia province was associated with an average annual decrease of 1% in smoking prevalence among men over a period of 20 years compared with 0.65% in a province where no such campaign took place. However, during the same period, the prevalence of smoking among women increased by 10% in both provinces and was greatest among women aged 30 to 49.\(^\text{91}\) The campaigns were heavily targeted at men as, in the 1970s when they were implemented, smoking among women was comparatively rare.

Current Government Policy and Action

5.4 Smoking Kills, the UK Tobacco White Paper (1998),\(^\text{1}\) sets out a range of measures at individual, national and international levels, to reduce smoking-related deaths in the UK. These included:

- raising the profile of NRT, encouraging its use and research into use during pregnancy;
- consulting on a Health and Safety Commission (HSC) Approved Code of Practice on workplace smoking;
- agreeing a voluntary charter with the hospitality industry to extend smoke-free areas;
- setting targets to reduce smoking among children, adults and pregnant women.

5.5 New resources were made available, including £8 million in Scotland enabling many new smoking-related interventions to be developed. Of this money in Scotland, £5m was made available over three years for health education on smoking and £3m over three years to NHS Boards to set up specialist NHS smoking cessation services (SCSs) offering NRT. Whilst a similar amount per capita was allocated for health education, twice as much per capita was invested in smoking-related services in England. This ring-fenced funding has now come to an end with no undertaking that the new interventions can continue.

5.6 Following the UK Tobacco White Paper, the Scottish Executive confirmed in the Public Health White Paper Towards a Healthier Scotland (1999) that action to tackle smoking would be a priority and set specific targets for the reduction of smoking prevalence in Scotland (Table 4).\(^\text{2}\) A commitment was also given to:

- working to reduce the harmful impact of tobacco – especially on the young;
- banning tobacco advertising;
- strengthening health education measures; and helping smokers stop, including the use of NRT. The Scottish Executive would also review the availability of support services, and work with HEBS and ASH Scotland to extend best practice in the provision of smoking cessation services across the country.
5.7 The Scottish Executive also created a Health Improvement Fund, providing £100 million over four years from tobacco tax revenues for measures to improve Scotland’s health. Although these measures include support for people who want to stop smoking none of the funding was specifically ring-fenced for this purpose. In practice, only about 3% of the fund is being spent directly by NHS Boards on SCSs.

5.8 More recently, Cancer in Scotland: Action for change (2001) highlighted smoking as one of the main causes of cancer, and the importance of helping people to stop smoking, particularly those in low income groups. The Coronary Heart Disease and Stroke Strategy for Scotland (2002) also indicated that smoking is a major preventable cause of coronary heart disease and stroke and a lifestyle risk factor which can be addressed.

5.9 The strong links between smoking and socio-economic disadvantage underline the importance of the Scottish Executive’s social justice agenda and its commitment to sustained action at both national and local level designed to reduce poverty and social exclusion.

5.10 It is clear that many of the elements of the successful US programmes have at least been initiated here. These include media campaigns, SCSs, workplace policies and smoke-free areas. Tax increases have been a strong feature of successive Government policies and a ban on advertising has recently come into effect. There has also been an emphasis in Scotland on targeting people in socially disadvantaged groups and some attempt to reduce tobacco sales to the under 16s. Whilst all these initiatives are logical and welcome, our main concern is that they are not yet being implemented on the required scale. In particular, the ease with which young people, and perhaps especially girls — become addicted to smoking and the difficulty many established smokers have in stopping, require a much more intensive and focused approach. In addition, the much higher prevalence of smoking in areas of socio-economic disadvantage makes it imperative that the targeting of preventive initiatives and SCSs in these areas continues to develop.

Coordination by the Scottish Executive

5.11 Development and coordination of the implementation of government strategy in Scotland is the responsibility of the Substance Misuse Team in the Health Department of the Scottish Executive. In early 2003, the Scottish Executive re-established a Tobacco Control Strategy Group to consider future Scottish Executive policy on smoking. Smoking is a Special Focus Programme in Improving Health in Scotland: The challenge, launched in March 2003. In it the Scottish Executive makes a commitment ‘to take stock of progress and outline a plan for

### TABLE 4
Towards a Healthier Scotland targets for the reduction of smoking prevalence in Scotland

<table>
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<tr>
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<th>2010 Target</th>
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<tr>
<td>Children (aged 12-15)</td>
<td>14%</td>
<td>12%</td>
<td>11%</td>
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<tr>
<td>Adults (aged 16-64)</td>
<td>35%</td>
<td>33%</td>
<td>31%</td>
</tr>
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<td>29%</td>
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action that builds upon the established base of successful activity’. This is a welcome initiative and provides the opportunity to implement the approaches recommended in this report. Given the pre-eminence of smoking as a cause of ill-health in Scotland and the complexities of the issues involved, we suggest that the Scottish Executive also establishes a multi-disciplinary Advisory Committee for smoking and tobacco along the lines of those for Alcohol and Drug Misuse. This would provide a means for ensuring that the Executive had a constant source of expert advice and a means of monitoring the effectiveness of its Tobacco Control Strategy.

**Recommendation 2**
The Scottish Executive should develop a comprehensive action plan that sets out an adequately resourced programme of initiatives designed substantially to reduce smoking and tobacco-related harm in Scotland over the next ten years. This should build on the findings and recommendations of the present report and should be integrated with the recently published document *Improving Health in Scotland: The challenge*. The plan should set realistic priorities, outcome targets and timescales.

**Recommendation 3**
The Scottish Executive should establish a standing Advisory Committee on Smoking and Tobacco Control to ensure it has a constant source of expert advice on its Tobacco Control Strategy. This should be organised on the same lines as the Scottish Advisory Committees on Drug Misuse and Alcohol Misuse.

**Recommendation 4**
There should be explicit recognition at national and local government levels of the importance of action to reduce poverty and social exclusion if tobacco-related harm is to be reduced in the long term.

5.12 An important initiative by the Scottish Executive has been to provide three years funding for PATH (Partnership Action on Tobacco and Health). Established in 2002 and managed by ASH Scotland, PATH is funded and designed to support the implementation of the UK tobacco white paper *Smoking Kills* and subsequent policy documents. Its remit includes developing evidence-based national tobacco training standards and advising on the development of data management systems which will permit comprehensive monitoring and evaluation of smoking cessation services in Scotland. It also manages a national support fund of £300,000 per year, for three years, to support local smoking cessation and prevention initiatives, to contribute to the evaluation of smoking-related initiatives and to the design and implementation of training for staff involved in SCSs and prevention initiatives.

**ASH Scotland**

5.13 ASH Scotland is the leading voluntary organisation informing and influencing tobacco control policies in Scotland. It works to raise awareness about the impacts of tobacco and the activities of the tobacco industry. In 2001, it established the Scottish Tobacco Control Alliance (STCA), a multi-disciplinary, multi-sectoral body of over 130 organisations concerned with the impact of tobacco in Scotland. It provides ongoing opportunities for information exchange on tobacco in Scotland and a voice for those working in the tobacco field to influence policy development. It has established a number of subgroups including a Smoking Cessation Coordinators Group and a Researchers Group (the current composition of the subgroups can be found at http://www.ashscotland.org.uk/stca/groups.htm).
Local Forums
5.14 In a number of areas, local forums have been started to address smoking-related issues such as prevention and tobacco policies and to support people trying to give up. These include Burning Issues in Lanarkshire, Magic Wand in East Renfrewshire, West Lothian Tobacco Issues Group, Shetland Tobacco Forum, and Argyll and Clyde Tobacco Steering Group. Other projects include smoking cessation and prevention issues as part of a wider remit. These include the Corner and the Web Project in Dundee and the Have a Heart Paisley National Demonstration Project in Paisley.

Prevention
Media Campaigns
5.15 A recent review of mass media campaigns aimed at reducing smoking prevalence reached a number of conclusions. Campaigns of longer duration and higher intensity seemed to be more successful. Advertisements evoking strong emotions were the most effective and those using humour the least, as judged both by recall by young and adult smokers and non-smokers, and their impact on cessation. The most cost-effective youth campaigns were thought to be those that gave a single, clear, validated messages and used youth spokespersons. Another review of controlled studies of mass media campaigns found some evidence that the mass media can be effective in preventing the uptake of smoking in young people, but overall the evidence was not strong. It also found that the most effective were multi-stranded, had a strong theoretical basis, were based on developmental research with the target group and were of greater intensity and duration.

5.16 Tobacco prevention initiatives designed to discourage children and young people in Scotland from starting to smoke have been developed through mass media campaigns, health education in schools and community-based initiatives. A large proportion of the £5 million made available through the UK Tobacco White Paper has been invested in campaigns by HEBS. These have been set within the teens ‘Think about It’ series which encourages young people to think about their own health. Three TV adverts have been developed or broadcast since 1998 and all have involved developmental research with the target audience. The two most recent adverts entitled ‘Stinx’ and ‘Alien’ have been accompanied by promotional activity including a CD of the ‘Stinx’ advert (which reached No 8 in the Scottish charts and No 49 in the UK charts) and a HEBSWEB subsite for ‘Alien’. Data from the HEBS Communications Tracking Survey indicate very high levels of awareness among young people aged 12 to 17 years but no data on smoking behaviour outcomes are available.

School-based Initiatives
5.17 Research reviews indicate that providing information alone is not effective in preventing initiation into smoking. A recent systematic review of school-based programmes for preventing smoking found that the effects of information given about smoking have not been rigorously tested. Well-conducted randomised controlled trials to test the effects of social influence based interventions showed mixed results. There is a lack of high-quality evidence about the effectiveness of combinations of social influences and social competence interventions or of multi-modal programmes that include community interventions. The Life Skills Training (LST) school-based programme developed in the US by G. Botvin aims to prevent use of alcohol, tobacco and illicit drugs by enhancing life skills: to increase resistance to substance misuse; and improve self-management and general social
perceptions towards smoking change on entry to secondary school. Most NHS Boards are phasing them out in favour of other approaches.

Conclusion

5.21 Discouraging young people from starting to smoke needs to be given the utmost priority. It is important to reassess the approach taken to prevention of smoking in the light of the evidence that young people, and perhaps especially girls, can develop nicotine dependence within a few weeks or months of starting to smoke. There is thus a strong case for emphasising how easy it is to get hooked on cigarettes and how difficult it can be to stop. It is important that girls are made fully aware that smoking during pregnancy will harm their baby. That young people living in circumstances of social exclusion or vulnerability are at greater risk also needs to be reflected in the design of preventive programmes. Given the strong links between smoking tobacco and the misuse of other drugs, smoking needs to be part of a wider preventive programme. Young people should also be made aware of the way in which they are being encouraged by tobacco companies to become dependent on cigarettes so that they will become long-term consumers. These ideas may have more impact than the more distant prospect of harm to health later in life. We think that schools can and should be doing more to get these ideas across effectively. Whilst smoking is arguably only one of numerous health-related topics children should ideally know about, the consequences of becoming a smoker are so serious that it needs to be made a top priority. We also think that the full potential of the media has yet to be realised, for example through collaboration on anti-smoking themes with TV programme makers or journalists on teenage magazines.

Community-based Programmes

5.18 According to a 2000-2001 survey of both local authority and other schools in Scotland, 96% of schools provide education on tobacco.99 However, little is known about what this means in practice and nothing about whether it has any influence on smoking behaviour.

5.19 Community-based programmes typically have several components including smoke-free public places, mass media campaigns, school-based programmes and interventions designed to restrict underage sales. A review of 13 interventions which were diverse in approach, population characteristics and focus, found that the most successful were targeted at multiple sites and settings, used diverse media, and were of longer duration.100

5.20 Smokebusters is a community-based smoking prevention initiative for young children undertaken by NHS Boards with schools and other agencies. Some studies have suggested that Smokebusters may delay initiation into smoking among 11-13 year olds by a few years,101 but there is no evidence of sustained change in smoking behaviour. Although these initiatives proved popular among younger children, their
Recommendation 5
The development of future prevention initiatives for young people should be supported by further research designed to provide a clearer view of the factors that influence whether or not young people smoke and of their understanding of the addictiveness of tobacco and other issues such as smoking during pregnancy, passive smoking and the marketing techniques of the tobacco industry.

Recommendation 6
Consideration should be given to developing, piloting and evaluating a more intensive, phased approach to smoking prevention at school starting before the onset of smoking. Smoking prevention should be part of a wider programme that addresses tobacco, alcohol and other drugs within the personal and social education curriculum and should be linked to other tobacco control initiatives within the school and the community.

Recommendation 7
Smoking prevention programmes should be designed to ensure they are in tune with the needs and aspirations of both girls and boys, especially those in circumstances of social exclusion and vulnerability.

Recommendation 8
The way in which the media are used to influence smoking and tobacco-related knowledge and behaviour should be reassessed to take account of the latest research findings and to exploit the opportunities provided by formats such as reality TV, TV documentaries, chat shows and soaps and teen magazines.
Smoking Cessation

5.22 Although most adult smokers say they would like to give up smoking, each year only 2% of smokers who try manage by will-power alone. There are a number of interventions that increase quit rates. These range from low intensity support such as self-help materials and telephone helplines to more intensive interventions including individual and group counselling. In general, the more intensive the intervention, the greater is the increase in quit rate over will-power. When combined with pharmacological aids — NRT or bupropion — quit rates double irrespective of the intervention. Table 5 provides a summary of the effectiveness of different interventions compared with will-power alone or a placebo. It can be seen that even the most intensive interventions result in modest quit rates. Nevertheless, compared with other medical interventions, smoking cessation interventions are cost-effective and if widely available and properly applied, will contribute to reduction in smoking prevalence.

Psychosocial Approaches

5.23 Several behavioural approaches exist to help smokers quit, ranging from brief opportunistic advice to more intensive programs by trained counsellors. Cessation rates clearly increase with the intensity of the intervention (Table 5). Cochrane systematic reviews on smoking cessation interventions have indicated that:

- group behaviour therapy programmes are better than self-help and other less intensive interventions but there is insufficient evidence on their effectiveness compared to intensive individual counselling; \(^{103}\)
- individual behavioural counselling from a smoking cessation specialist assists smoking cessation although intensive does not seem to be more effective than brief counselling; \(^{104}\)
- high intensity behavioural interventions including at least one month of follow-up contact are effective in promoting smoking cessation in hospitalised patients; \(^{105}\)

TABLE 5

Rates of abstinence for six months or longer compared with will-power or placebo alone

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written self-help materials</td>
<td>1%</td>
</tr>
<tr>
<td>Telephone counselling</td>
<td>2%</td>
</tr>
<tr>
<td>Brief opportunistic advice from a GP or outpatient doctor to stop</td>
<td>2%</td>
</tr>
<tr>
<td>Face to face intensive behavioural support from a specialist</td>
<td>4.7%</td>
</tr>
<tr>
<td>Various forms of NRT with limited or intensive behavioural support</td>
<td>5.12%</td>
</tr>
<tr>
<td>Bupropion (300 mg/day sustained release) with intensive behavioural support</td>
<td>9%</td>
</tr>
</tbody>
</table>

Adapted from Smoking Cessation Guidelines for Health Professionals: An update. \(^{102}\) The effect size is the difference in >6 month abstinence rate between intervention and control/placebo in the studies. Studies were mainly Cochrane meta-analyses. 95% confidence intervals for effect size can be obtained from the guidelines.
simple advice by physicians has a small effect on cessation rates and intensive interventions are marginally more effective;\textsuperscript{106}  
smoking cessation advice and counselling by nurses to their patients is effective;\textsuperscript{107}  
self-help materials, especially tailored material, have a minor effect on quit rates above no intervention;\textsuperscript{108}  
proactive telephone counselling is effective compared to an intervention without personal contact.\textsuperscript{109}

Pharmacological Aids

\textbf{5.24} In 2002, the National Institute for Clinical Excellence (NICE) in England published guidance for England and Wales on the use of all forms of NRT and bupropion for smoking cessation.\textsuperscript{110} The Health Technology Board for Scotland (HTBS) (now part of NHS Quality Improvement Scotland) has advised that this guidance is equally valid for Scotland. This guidance concluded that both NRT and bupropion are highly cost-effective and recommended that they are available to NHS patients.

\textbf{5.25} Nicotine Replacement Therapy (NRT) in the form of gum, patches, spray, inhaler and lozenges can increase cessation rates by 5-12\% more than control/placebo when combined with smoking cessation support (Table 5). In April 2001, all forms of NRT were made available on prescription under the NHS.\textsuperscript{111} Most are now also available on general retail sale or over-the-counter in community pharmacies. The NICE guidance recommends that smokers under 18 years, or who are pregnant, breastfeeding or have unstable cardiovascular disorders should consult a relevant health care professional before NRT is prescribed.

\textbf{5.26} The present NRT regimes all require a fairly rapid reduction in the amount of nicotine used over a period of two or three months, typically using doses of nicotine that are well below what the individual would have used when smoking. Research on treatment of heroin addiction with methadone has shown conclusively that this approach, i.e. low dose and rapid reduction, has a high failure rate and has little to offer more severely dependent individuals, for whom higher doses given over a much longer period of time are much more helpful in reducing dependence on the more dangerous form of the drug.\textsuperscript{112} Currently, NRT regimens have little to offer most highly dependent smokers. Studies have demonstrated the successful use of NRT for continued abstinence by smokers for a year or longer and US Clinical Practice Guidelines state that ‘continued use of [smoking cessation medication] is clearly preferable to a return to smoking with respect to health consequences.’\textsuperscript{113} There thus is a very strong case for exploring ways of enabling highly dependent smokers to reduce their cigarette consumption by the use of higher doses of nicotine for longer periods.\textsuperscript{114}

\textbf{5.27} Strategies that require further evaluation include: longer term maintenance on NRT for those for whom reduction has failed; combinations of different forms of NRT; use of NRT for temporary abstinence, for example in the workplace or when travelling in non-smoking services; use of higher doses of NRT, in appropriate circumstances, than is currently permitted; and use of NRT for relapse prevention in abstinent smokers who still experiences craving.\textsuperscript{114} There is also a need to establish more consistent and practical criteria for the use of NRT among the under 18s and, especially, among pregnant women.\textsuperscript{33}
5.28 Bupropion (Amfebutamone or Zyban) was licensed for use as an aid to smoking cessation in June 2000. Cessation rates average at 9% above control/placebo after six months abstinence (Table 5). Patients should have previously tried other forms of cessation, be highly motivated to quit and willing to participate in an intensive cessation counselling programme. The NICE guidance states that bupropion is not recommended for smokers under 18 years, or who are pregnant or breastfeeding and that there is currently not enough evidence to recommend the use of NRT and bupropion together. There is, however, some emerging evidence that in combination with nicotine patches, bupropion is more effective than either alone although the difference was not statistically significant. Some questions remain over the safety of bupropion. The Medicines Control Agency recently stated that up to April 2002 there have been 58 reports of deaths in patients taking bupropion. However, the link between bupropion and the deaths is unproven and the recent NICE guidance reaffirmed the regulators’ confidence in the drug. The European Medicine Evaluation Agency has reviewed the safety of bupropion, reporting in July 2002 that ‘the balance of risks and benefits of bupropion remains favourable’ when used for smoking cessation.

Possible Future Interventions — Anti-nicotine Addiction Vaccine

5.30 Novel therapeutic anti-nicotine addiction vaccines are being developed and tested in clinical trials and may prove to be an aid to relapse prevention. They work by either binding with nicotine receptors in the brain, thus preventing nicotine acting on the pleasure centre or by stimulating the immune system to produce antibodies that will bind to nicotine and stop it from crossing the blood/brain barrier. Smokers would still experience nicotine withdrawal symptoms but would not be able to relieve them by smoking.

Smoking Cessation Services (SCSs)

5.31 With the impetus of additional funding to implement the recommendations of the UK Tobacco White Paper, there has been a huge expansion of SCSs throughout the UK since 1999. In Scotland, £1m per annum for three years was allocated to NHS Boards from 1999/2000 for the development of specialist SCSs and NRT provision, particularly targeted at areas of deprivation, with further investment from the Health Improvement Fund. All areas now have one or more SCSs, although their extent varies greatly depending on the funding available. Most have appointed smoking cessation coordinators. A variety of service delivery models are being developed and evaluated.

5.32 Early indications are that a range of health professionals and others can contribute to SCSs. These include specialist cessation service staff, general practitioners (GPs), nurses, community pharmacists, midwives, health promotion...
officers and community workers. Factors that may increase success include: accessibility; a non-judgemental, empathetic approach; work on developing self-confidence and motivation at individual, group and community levels; use of NRT and/or bupropion as required; and longer-term support for relapse prevention. These more innovative, flexible and sensitive approaches may be particularly important in attracting those on low income and with additional problems, and in ensuring their on-going engagement.

5.33 An unpublished survey for the Scottish Executive in early 2001 showed that about 7,000-10,000 people used the new services in 2000. The availability and type of services vary widely across Scotland although most NHS Boards had services aimed at the UK Tobacco White Paper priority groups. They also indicated an intention to extend their current services. An evaluation of English services found they are popular and highly cost-effective. The establishment in 2002 of PATH (Section 5.12) should now ensure that systematic evaluation of SCSs in Scotland is developed.

5.34 To support the delivery of smoking cessation advice by health professionals across the NHS in Scotland, HEBS and ASH Scotland have published and distributed smoking cessation guidelines for Scotland and a guide for health professionals Helping Smokers to Stop — and Stay Stopped. The guide advocates the provision of brief advice, augmented where appropriate with NRT or bupropion, relapse prevention and referral to intensive cessation support. An update of the guidelines and guide and evaluation of the implementation of smoking cessation across the NHS in Scotland will be completed early 2004. It is likely that these will emphasise the vital role in smoking cessation played by GPs and other primary care staff, general dental practitioners, community pharmacists and clinical staff in hospital based services — either in referring patients to appropriate services or, if suitably trained and resourced, providing smoking cessation support themselves.

5.35 A significant number of SCSs in Scotland are oversubscribed. There is clearly considerable scope for expansion in SCSs in Scotland: even if only 1 in 20 of Scottish smokers who say they want to give up were to attend an SCSs each year that would involve about 45,000 people, or about five times as many as attended in 2000. As an illustration of the financial implications of expanding SCSs, the community pharmacy service in Glasgow costs about £120 per person per course, of which £100 for is NRT and £20 for professional fees and support services. Annually, £5 million would purchase a similar service for 45,000 people or 3% of all current smokers. A 10-20% success rate would thus help 0.3-0.6% of smokers in Scotland to give up each year at a cost of about £600-1,200 per success.

5.36 Smokeline is a free telephone helpline that was set up by HEBS in 1992. The female-to-male caller ratio is 2:1 and between its launch and the end of March 2002, it received almost 500,000 calls. An evaluation of the service conducted in 1992/1993 found that at one year follow-up, 24% of callers reported that they were not smoking. However, of these only just over a third had not smoked for 80% or more of the previous year (equivalent to 8% of the total sample). Although set up as an adult helpline, in recent years, 60% of contacts have been from callers under 16 years. More recently, use of the helpline has declined and it is to be refocused to act more in a referral capacity to direct callers to the most accessible appropriate services. The proportion of young callers has also declined and in 2002/2003 only 28%
of calls were from young people. An electronic helpline version, e-Smokeline, has been created (http://www.hebs.scot.nhs.uk/topics/smoking/e-smoke.cfm).

5.37 National No Smoking Day raises general awareness and provides an additional incentive to smokers to quit UK-wide. Each year around a million smokers become involved and 40,000 quit as a result of this cost-effective intervention. In 2001, 80% of smokers and 71% of the Scottish public were aware of No Smoking Day, women more so than men, and 4% of smokers made a quit attempt with a further 10% cutting down (note, these figures are based on small sample size). The day had an impact on young smokers: 13% of men and 9% of women aged 16-24 made a quit attempt and a further 18% of the young men and 17% of the women smoked less.

Training for smoking cessation staff and others
5.38 PATH has been charged by the Scottish Executive to develop National Training Standards for staff working on smoking prevention and cessation in Scotland. This will include enhancing existing training and development opportunities and providing appropriate training materials for smoking cessation specialists and other staff whose duties include smoking prevention and cessation or related work. Adequate resources will be required to facilitate ongoing training in both urban and rural areas.

5.39 The UK Department of Health has recently commissioned the Health Development Agency to explore the feasibility of developing a national standard for training in smoking cessation. This followed an audit of existing training arrangements which identified 24 different courses, most of which were very short, with no exam, no accreditation and little or no follow up. It would be useful for PATH to link in with this initiative, to avoid duplication of effort.

Smoking Cessation and Young People
5.40 Most young smokers are aware of the health risks associated with smoking but do not believe it will do them any harm in the short term. The majority intend to quit eventually but most greatly underestimate the addictiveness of nicotine. Currently there is very little evidence from research on cessation services for young people although there is evidence of demand for cessation support, particularly among young women. A 1998 survey of Scottish school children found that more than one in four girls who smoked had called Smokeline at some time. Although prank calls and requests for advice about parental smoking were common, older girls were likely to call for advice in connection with their own smoking.

An attitude survey has found that young smokers rate cost and convenience of smoking cessation interventions as the most important factors determining whether or not they would use them. The location and confidentiality of services for young people is also important.

5.41 Following a recommendation of the document Smoking Cessation Policy for Scotland that smoking cessation initiatives aimed at young people should be piloted and evaluated, HEBS and ASH Scotland have initiated a national programme of eight pilot smoking cessation interventions, targeted at young smokers who want to give up. A major aim is to identify acceptable and effective approaches to smoking cessation for young people. The programme and pilot initiatives will be fully evaluated and will help inform the development of a national smoking cessation strategy for young people. The following eight projects have received funding for three years (Table 6):
TABLE 6
Pilot smoking cessation intervention funded by HEBS and ASH Scotland

<table>
<thead>
<tr>
<th>Project</th>
<th>Target group</th>
<th>Setting</th>
<th>Main approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vulnerable young people, 12-18 years</td>
<td>Youth and community</td>
<td>Alternatives to smoking; relapse prevention</td>
</tr>
<tr>
<td>2</td>
<td>Pregnant women, under 25 years and partners</td>
<td>Primary care; hospital; community</td>
<td>Smoking cessation clinic; professional training</td>
</tr>
<tr>
<td>3</td>
<td>Socially excluded young people, 11-15 years</td>
<td>Informal youth; community</td>
<td>Smoking cessation support</td>
</tr>
<tr>
<td>4</td>
<td>Young people in island communities</td>
<td>Further education; informal youth</td>
<td>Smoking cessation support</td>
</tr>
<tr>
<td>5</td>
<td>Rural youth, 13-17 years</td>
<td>School; community</td>
<td>Web-based chat room</td>
</tr>
<tr>
<td>6</td>
<td>Young people, 15-24 years in diverse geographical areas</td>
<td>Community; informal youth</td>
<td>Mobile bus; peer workers</td>
</tr>
<tr>
<td>7</td>
<td>Further Education Students</td>
<td>Further Education college</td>
<td>Smoking cessation groups; individual counselling</td>
</tr>
<tr>
<td>8</td>
<td>Young Offenders, 12-21 years</td>
<td>Young Offenders Institute</td>
<td>Creating a supportive smoke-free environment</td>
</tr>
</tbody>
</table>

Community Development and other Community Approaches

5.42 This involves work in communities where smoking rates are high, smoking is normalised, and health promotion messages have had little effect. In these communities, smoking dependence cannot be divorced from the social context of people's lives where barriers to cessation are created that may not exist for more affluent smokers. The aim is to enable people to better understand the role of smoking and its impact on health in their community and to consider what can be done to reduce the harm to individuals and the community as a whole in the context of competing priorities.

5.43 Projects may encourage or support cessation attempts, or may help smokers to move towards considering quitting or the impact of smoking on others. They are typically local and community driven with many agencies involved within communities and partnership working is important. Community development activities are not necessarily targeted directly at smoking behaviour but address other issues that can contribute to the incidence of smoking behaviour and create barriers to cessation.
5.44 Such a community-based intervention was carried out in a low income community in Edinburgh in 1999-2002 (The Breathing Space Project). The aim was to produce a significant shift towards non-smoking in community attitudes and behaviour by creating a health promoting environment across the wider community. The intervention was focused on four settings — the community, primary care, young people (including school) and the workplace. It was carefully evaluated by comparing trends in awareness and behaviour in the intervention community with those in three other low income communities in Edinburgh over a two-and-a-half year period. Unfortunately, there was little evidence that the intervention had any positive effect on attitudes towards smoking or actual smoking behaviour in the study community. A number of difficulties in implementing the intervention may have contributed to its lack of impact.\[141\]

5.45 ASH Scotland’s Women, Low Income and Smoking Project (1996-1999) aimed to explore new ways of working with the community to address smoking reduction among women living on low income.\[142\] The conclusions, recommendations and learning from this project have informed The Tobacco and Inequalities Project, and the Minority Ethnic Project, two further pieces of work by ASH Scotland. The latter aims to investigate the perceptions and experiences of adults from ethnic minorities in relationship to tobacco use.

Conclusion

5.46 The great majority of smokers say they want to give up. The main reason why so many try and fail repeatedly is because they are dependent on nicotine and trapped in a way of life within which smoking seems integral. If the harm to health from smoking is to be reduced in the long term, we must substantially reduce the number of smokers in Scotland. As well as discouraging young people from starting, far more people need to be enabled to stop smoking.
Reducing Harm — Current and Future Action

Control Measures

Taxation

5.47 The progressive increase in the taxation of tobacco products has been a central and effective element of current tobacco control policy by successive Governments and is a measure we strongly support. However, as this is a power reserved to the UK Government, it is not considered further here.

Passive or Second-hand Smoking

5.48 Given the evidence of harm to health from ETS, restrictions on smoking in public places and workplaces are an important harm reduction measure. However, many people, especially smokers, appear to be unaware of the hazards of ETS. A recent report into smoking in public places found that smokers in Scotland had a lower awareness of the health risks of passive smoking than non-smokers (42% compared to 74%).

5.49 The 1988 Froggatt Report on passive smoking, by the Independent Scientific Committee on Smoking and Health (a government advisory group and predecessor of the Scientific Committee on Tobacco and Health), concluded: ‘non-smoking should be regarded as the norm in enclosed areas frequented by the public or employees, with special provision being made for smokers, rather than vice versa.’ Subsequently, the Report of the Scientific Committee on Tobacco and Health recommended that ‘Smoking in public places should be restricted on the grounds of public health. They concluded that the level of restriction should vary according to the different categories of public place but smoking should not be allowed in public service buildings or on public transport, other than in specially designated and isolated areas. Wherever possible, smoking should not be allowed in the workplace.’

Recommendation 12

As a matter of urgency, the Scottish Executive should fund the development and evaluation of initiatives designed to help pregnant women, their partners and parents of young children to stop smoking. This should include qualitative research into the attitudes towards cessation of women who smoke during pregnancy and their partners and research to evaluate the effectiveness, safety and acceptability to women of nicotine replacement therapy in pregnancy.

Recommendation 13

Smoking cessation services should specifically address the needs of young smokers, and other groups such as people with mental health problems and members of ethnic minorities.

Recommendation 14

All smoking cessation services should be subject to careful evaluation so that the most effective approaches and models of service delivery can be identified and reproduced across the country. This should be coordinated centrally on a national basis to ensure a consistent approach.

Recommendation 15

PATH should take the lead in coordinating a consistent approach, based on agreed Scottish training standards, to training smoking cessation service staff in the management and provision of smoking cessation services, drawing on developments in England and Wales where appropriate.
Public Places

5.50 A survey of 1,007 businesses in the leisure industry across Scotland found that 58% allowed members of the public to smoke in all public places, 31% restricted smoking and 8% banned smoking completely. Only 47% of businesses had a smoking policy for areas used by the general public. Almost twice as many shopping centres and supermarkets had a smoking policy in place compared with businesses in the food and entertainment industry and the sport and recreation sectors. Public houses and bars, particularly those located in more deprived communities, were least likely to have smoking policies and most likely to permit smoking throughout their premises.

5.51 Until now, smoking restrictions in public places have been largely left to individual organisations. The Scottish Executive and UK Government have taken some steps to address smoking in the workplace and hospitality industry. However, there are no statutory regulations restricting smoking in other public places, including public transport, schools, hospitals and other government buildings, to leisure spaces like shopping centres and pubs and bars. The Scottish Executive has promoted a voluntary approach to smoking restrictions in public places and in 2000 developed a Voluntary Charter on Smoking in Public Places in Scotland in conjunction with the hospitality industry, with trade associations, representing the hospitality industry, as signatories. This has set targets for successful compliance, including the development of policies on smoking, smoke-free provision and signage. However, simply providing signage indicating whether or not smoking is allowed is sufficient to meet the minimum requirements of the charter. In addition, the charter encourages improved ventilation which has been shown to be ineffective in removing the health risks of passive smoking. There are thus serious doubts that the charter will result in a significant extension of smoke-free areas. In 2002, the Scottish Executive committed a further £175,000, part-funded by the signatories to the voluntary charter, for more premises to have smoke-free areas. This will be focused on smaller hotels, restaurants, licensed premises and coffee chains.

Workplaces

5.52 In the most recent Scottish Health Survey, among non-smokers 23% of men and 14% of women had been exposed to other people's smoke at work in the week preceding the survey. Health and Safety Regulations, derived from European Directives, came into force in 1993 for new workplaces and in 1996 for existing workplaces. Under this legislation, employers must provide rest rooms and rest areas which include suitable arrangements to 'protect non-smokers from discomfort caused by tobacco smoke'. However, in practice, there is little protection in law for those affected by passive smoking at work, particularly employees on low income and working in small businesses.

Local Authorities

5.53 A recent audit of the smoking policies of the 32 Scottish local authorities scored these against a set of criteria with a best possible overall score of 100. It found the range of scores was 0 to 82 with an average of 33. Twelve were found to operate indoor smoke-free zones, two allowed employees to decide whether smoking was permitted and the...
remainder had designated smoking rooms. Most authorities offered some support to smokers who wish to quit. Overall, the audit concluded that in most cases smoking policies had a low priority compared to other personnel policies. Guidelines developed from the audit, by HEBs, ASH Scotland and COSLA (Convention of Scottish Local Authorities), for implementing effective tobacco policies for local authorities are due to be published in late 2003.

**National Health Service**

5.54 When smoking policies in the NHS in Scotland were monitored in 1994, it was concluded that:

- about half the NHS Boards and NHS service providers allowed staff to smoke in designated areas only;
- about 1 in 5 of NHS service providers did not allow patients to smoke; of the rest, most provided designated smoking areas;
- 86% of GP fundholder practices reported they had smoke-free premises;
- there were widespread problems with monitoring and enforcing policies: some areas of the NHS – eg psychiatric facilities – had little or no smoke-free provision.

Since then, guidelines for the development of effective tobacco policies in the NHS have been drawn up. However, no more recent evaluation of NHS smoking policies and practice has been conducted.

**Schools**

5.55 There is evidence that school smoking policies can help reduce smoking by young people. A Welsh study of 55 secondary schools found that in schools with a written policy banning smoking by both pupils and staff, the self-reported daily smoking prevalence among pupils was 9.5% compared with 30% among pupils from schools lacking a smoking policy.

5.56 Virtually all schools in Scotland now have a smoking policy. A survey of 77 Scottish schools in 1998 found that smoking policies vary from written to informal policies for both pupils and teachers. Although all the schools banned smoking by pupils on the premises, smoking by teachers was only banned in 20. In the remainder, smoking by teachers was restricted to designated areas. A survey in 2000-2001 of Scottish local authority-controlled and other schools found that 37% had written procedures for managing incidents of tobacco smoking by pupils and 64% by other school users (eg teachers and visitors). Local authority schools were less likely than independent schools to have such procedures. We conclude that the desirability of creating a non-smoking ethos at school within the Health Promoting School concept and the evidence for the effectiveness of clear non-smoking policies at school mean that all schools in Scotland should be smoke-free zones for everyone – pupils, staff and visitors.

**Public Transport**

5.57 Smoking restrictions on public transport are dependent on the individual operator. Air travel is now largely smoke-free, particularly on domestic and short-haul flights. Most train companies in the UK restrict smoking to one carriage per train. All Virgin services are non-smoking, Scotrail operates a no-smoking policy on most services, though there is limited provision aboard the Caledonian sleeper services. GNER has designated smoking areas in first and standard class. Most larger bus companies in Scotland also have a smoking policy, in
many cases involving a complete ban. Smaller operators have patchier provision and cover and often do not ban smoking. Many taxis are now smoke-free and display signage. For public transport agencies in Scotland, particularly buses, the main concern is that smoking policies are not being monitored or effectively enforced.

**Recommendation 17**

Further steps should be taken to extend smoke-free zones in all enclosed public places, including public transport, shopping centres and premises where food or drink is served. The value of smoke-free environments should be explained in media campaigns. Employers should be encouraged to create smoke-free work environments and provide staff who smoke with the opportunity to attend smoking cessation services and obtain other appropriate support. It is most unlikely these objectives will be fully and consistently achieved without new legislation to restrict smoking in public places.

**Tobacco Sales to under-16s**

5.58 The ease of access to tobacco is an important factor in adolescent smoking uptake.\(^{151}\) Despite the measures introduced through Smoking Kills to tackle illegal sales, sales to children under 16 remain a problem in Scotland. A recent Scottish Executive survey into smoking among young people in Scotland found that the proportion of regular under 16 smokers buying their cigarettes from shops has fallen over the last few years. However, more than eight out of ten regular underage smokers still buy their cigarettes from shops and only 21% said they found it difficult to purchase cigarettes from shops.\(^{152}\)

5.59 The Scottish Executive is working with COSLA and Scottish Trading Standards towards the development of a Scottish Tobacco Enforcement Protocol for use by local authorities in carrying out their duty in relation to the Children and Young Persons (Protection from Tobacco) Act 1991. Until recently, the Crown Office has ruled out the use by the prosecution of evidence obtained by children in test purchasing exercises against retailers charged with selling tobacco to underage children. In contrast, evidence from test purchasing exercises was permitted to be used in England. As a result, Scotland has had a very low rate of prosecutions for underage tobacco sales in comparison with England. However, in 2001, the Lord Advocate announced a change in Crown Office policy and four pilot schemes were established in 2003 over a period of three years which will allow evidence obtained through child-assisted test purchasing to be used in prosecutions for selling tobacco to children under 16. The pilots have been set up in contrasting areas, Edinburgh, Moray, South Ayrshire and Stirling, and are a collaboration between the Scottish Executive and Trading Standards Departments. The scheme is being evaluated.

**Recommendation 18**

Efforts to enforce the law on the sale of cigarettes to the under 16s should be intensified.
Smuggling

5.60 Access to cheap tobacco and cigarettes makes it harder for addicted smokers to quit, particularly those on low incomes. The Government rightly perceives smuggled tobacco as a law and order issue. Following the launch of the UK Government’s policy, *Tackling Tobacco Smuggling*, in March 2000, there has been an increase in Customs Officers in Scotland to combat tobacco smuggling and an increase in x-ray scanners at ports. Most of Scotland’s smuggled tobacco comes into the UK through ports in Southern England.

5.61 The Government’s strategy is to focus on disrupting the supply of smuggled tobacco, and prosecuting major criminals, rather than small scale smugglers. This approach has stemmed the flow of smuggled tobacco into the UK. In October 2002, the UK Government announced an increase in the guideline levels for tobacco that can be brought into the UK from other EU member states, from 800 to 3,200 cigarettes and from one to three kilograms for hand-rolled tobacco. These guideline levels are indicative of the threshold above which Customs may establish that tobacco is bootlegged. The main planks of the Government’s Tobacco Smuggling strategy are unaffected.

Conclusion

5.62 With the growing evidence for the harmful effects of ETS, there are strong public health grounds for doing much more to reduce the exposure of non-smokers to tobacco smoke. Extending smoke-free zones also provides further incentives for smokers to stop. If real progress cannot be achieved in the near future through existing legislation, new legislation should be considered. Efforts to enforce restrictions on the sale of cigarettes to minors and to minimise smuggling are also important parts of a comprehensive tobacco control strategy.
6 CONCLUSIONS

6.1 In this report we have set out the case that smoking remains the single greatest cause of avoidable ill-health among adults in Scotland; the main reason for the huge gulf in health experience and life expectancy between rich and poor; and a major source of future ill-health and disadvantage for many children of mothers who smoke during pregnancy. We have also focused attention on how easy it is for young people to slide casually and unknowingly into dependence on nicotine and the rituals of smoking, and how difficult many find it to stop.

6.2 Against this background, we have highlighted the progress that has been made in recent years to enable many smokers to escape the tyranny of tobacco. Progress has been made in extending smoke-free environments in public places, to the benefit of both non-smokers and smokers. However, we have concluded that if further significant progress is to be made, a much more concerted and sustained effort will be needed. We thus advocate tough but imaginative new approaches that can effectively communicate to youngsters the extreme danger of even the first cigarette — because it so often starts a process of unconscious seduction that effortlessly creates a committed smoker. We also think that much more needs to be done to enable people to quit smoking. This means building up a much stronger infrastructure of smoking cessation services, fit for purpose in both method and scale. It means making the most of the available therapies, particularly for the many who feel it is too difficult to stop. This will require staff who are well-trained and resourced, backed up by information and evaluation systems that can help create a climate that encourages improvement. There is also huge scope for extending smoke-free environments in public places to ensure that people are not unwillingly exposed to tobacco smoke. This is unlikely to be achieved without further legislation.

6.3 In short, what is now needed is a well-resourced, long-term, multi-stranded national programme on a scale that truly matches the size and intractability of the challenge. Reducing smoking and tobacco-related harm is indeed a key to improving Scotland’s health.
7 REFERENCES


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<table>
<thead>
<tr>
<th>Reference</th>
<th>Details</th>
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<tr>
<td>110</td>
<td>NICE. Guidance on the <em>Use of Nicotine Replacement Therapy (NRT) and Bupropion for Smoking Cessation</em>. Technology Appraisal Guidance, No. 39. 2002. London, NICE.</td>
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</table>


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This powerful and authoritative report should be essential reading for everyone interested in Scotland’s health. It looks at the latest smoking trends and levels of tobacco-related harm to health in Scotland. It reviews current prevention, treatment and control policies and services. While there has been considerable progress in recent years, it concludes that much more needs to be done.

SEVEN IMPORTANT FACTS ABOUT SMOKING IN SCOTLAND

- Around 1.2 million people smoke — 30% of the adult population.
- About 25% of girls and 16% of boys are regular smokers by the time they are 16.
- A quarter of women smoke during pregnancy, with serious consequences for their children’s health.
- Smoking causes at least 20-25% of all deaths and is one of the main reasons why disadvantaged people are more likely to have poorer health and die younger.
- Breathing second-hand smoke increases the risk of heart disease, lung cancer and other conditions.
- Many young people become addicted to cigarettes within weeks of starting to smoke and find it very difficult to stop.
- Around 70% of smokers say they want to give up but only around 2% a year succeed without help.

THREE KEY RECOMMENDATIONS

- We need to take a much more intensive approach to discouraging children and young people from ever smoking.
- A huge expansion in smoking cessation services is needed to help many more people to stop smoking.
- Further steps should be taken towards making all enclosed public places and workplaces smoke-free zones.

This report is also available at www.healthscotland.com