



# A BREATH OF FRESH AIR FOR SCOTLAND

IMPROVING SCOTLAND'S HEALTH: THE CHALLENGE  
TOBACCO CONTROL ACTION PLAN

# A BREATH OF FRESH AIR FOR SCOTLAND

IMPROVING SCOTLAND'S HEALTH: THE CHALLENGE  
TOBACCO CONTROL ACTION PLAN



© Crown copyright 2004

ISBN 0-7559-0981-X

Published by  
Scottish Executive  
St Andrew's House  
Edinburgh  
EH1 3DG

Produced for the Scottish Executive by Astron B32533 1-04

Further copies are available from  
The Stationery Office Bookshop  
71 Lothian Road  
Edinburgh EH3 9AZ  
Tel: 0870 606 55 66

The text pages of this document are produced from 100% elemental chlorine-free,  
environmentally-preferred material and are 100% recyclable.

# CONTENTS

	Page
<b>Ministerial Foreword</b>	1
<b>Summary of action points</b>	2
<b>Chapter 1: Introduction</b>	6
<b>Chapter 2: The approach</b>	10
<b>Chapter 3: Prevention and education</b>	14
<b>Chapter 4: Provision of smoking cessation support services</b>	18
<b>Chapter 5: Second-hand smoke (passive smoking)</b>	22
<b>Chapter 6: Protection and controls</b>	28
<b>Chapter 7: Measuring progress</b>	32
<b>Appendix 1: Summary of recommendations made in <i>Reducing Smoking and Tobacco-related Harm</i> and action to address them</b>	37
<b>Appendix 2: Membership of Scottish Tobacco Control Strategy Group</b>	41



## MINISTERIAL FOREWORD

Smoking is deeply rooted within our society, particularly in some of our most deprived communities and we all know that many smokers find it very difficult to quit a habit which may well have gripped them for most of their adult lives.

This document is the first ever action plan on tobacco control designed specifically for Scotland. It builds upon and responds to an excellent report by NHS Health Scotland and ASH Scotland and offers a programme of action covering prevention and education, protection and controls and the expansion of high quality cessation services. It also addresses the issue of passive smoking and offers everybody the opportunity to learn more about the risks involved and contribute to a national debate about the steps we might take to reduce such risks.

There is no question of forcing people to stop smoking. This is a matter for persuasion not coercion. However, the impact of smoking in places where it can impact on others is a source of legitimate concern. We want smokers to listen and act upon clear evidence about the harm that their habit can do to themselves and the people around them. We want young people to see that smoking is as 'uncool' as it is harmful. We want to see a society in which everybody aspires to live a healthy, smoke-free life and has access to the support that can help them realise this ambition.

*A Breath of Fresh Air for Scotland* represents a huge opportunity to improve the health of the people of Scotland and I hope that it strikes a chord with everybody who reads it.

**Tom McCabe**  
**Deputy Minister for Health and Community Care**

## SUMMARY OF ACTION POINTS

### Chapter 2: The approach

1. In order to undertake or commission work on tobacco-related health issues of specific relevance to Scotland, the existing Tobacco Control Strategy Group will be strengthened and upgraded to a Ministerial Working Group chaired by the Deputy Minister for Health and Community Care. This Group will provide expert advice on the health impact of tobacco and provide a forum for the dissemination of best practice to health and other professionals throughout Scotland.

### Chapter 3: Prevention and education

2. In consultation with the new Ministerial Working Group, we will commission a review of current national communication and education programmes and build any learning into the development of a coherent, integrated long-term communications strategy to guide future prevention activity at national and local levels.
3. In partnership with NHS Health Scotland, we will commission further research with young people to provide a clearer picture of the factors that lead them to start or resist smoking and track awareness of the dangers of smoking and passive smoking amongst key target groups.

### Chapter 4: Provision of smoking cessation services

4. We will allocate additional funding to smoking cessation services of £1 million in 2003/04, £1 million in 2004/05 and £5 million in 2005/06. Using the *Revised Smoking Cessation Guidelines* and the *Smoking Atlas of Scotland*, which are due to be published by the end of March 2004, NHS Boards should assess local needs, identify gaps and develop plans to fill these gaps.
5. We will take steps to further develop the evidence base for effective cessation services through increased investment in the Partnership Action on Tobacco and Health (PATH). The findings of the review report should be used to inform the priorities for this increased investment.
6. We will negotiate and agree cessation targets with each NHS Board by the end of July 2004. As part of this process we will work with NHS Boards, ISD and PATH to introduce reliable baseline measures and develop outcome based measures for future use.

## Chapter 5: Second-hand smoke (passive smoking)

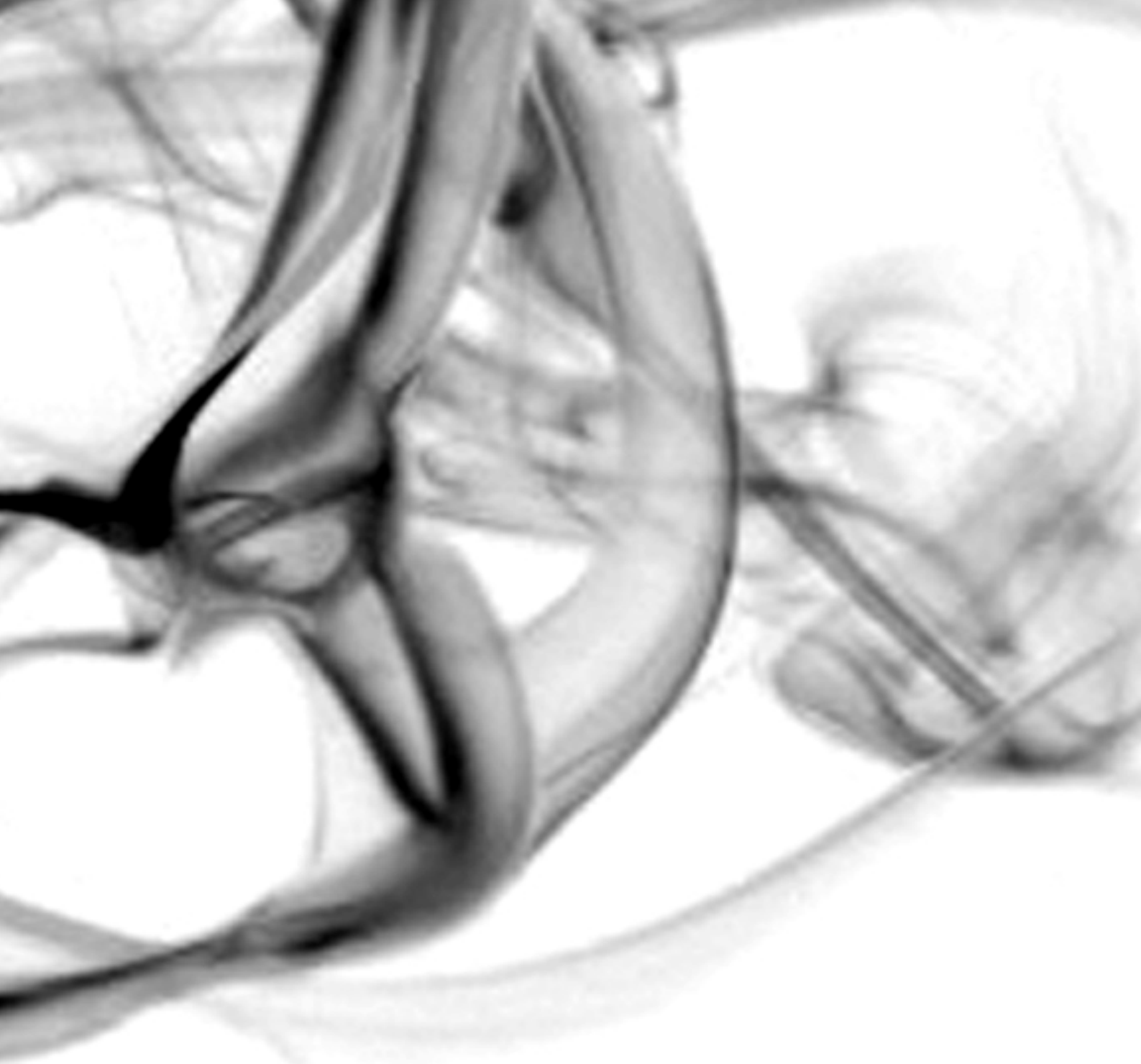
7. In 2004, we will sponsor a major public debate on actions to minimise the impact of second-hand smoke. This will involve a range of conventional and innovative opportunities to contribute to the dialogue, including a major conference to provide acknowledged experts with the opportunity to put their messages across to the people of Scotland.
8. We will work with partners including NHS Health Scotland to develop and deploy a national advertising and communications campaign about the dangers of second-hand smoke.
9. We will review our own current staff smoking policy, which permits smoking only in designated smoking areas, with staff representative bodies, with a view to introducing a complete smoking ban by the end of July 2004.
10. As part of efforts to facilitate 'healthy working lives', we will challenge employers, trade unions, voluntary groups and representative organisations to encourage and support the introduction of effective smoking policies by all Scottish employers.
11. NHS Boards and local authorities will be encouraged to review their smoking policies by the end of 2004 in the light of guidance available from Health Scotland, ASH Scotland and CoSLA.

## Chapter 6: Protection and controls

12. The results of the test purchasing pilot scheme will be carefully considered by the Lord Advocate in order to assess whether the test purchasing arrangements are sufficiently safe, effective and fair to allow the revised prosecution policy adopted for the pilot to remain in place or be extended.
13. In light of the decision on test purchasing, we will agree an enforcement protocol with our local authority partners to guide more effective enforcement of the Children and Young Persons (Protection from Tobacco) Act 1991. We will also look for ways to raise awareness about illegal sales and to encourage the public to report retailers who sell cigarettes to under-16s.
14. We will continue to support the roll out across Scotland of the Dialogue Youth project and associated Young Scot card which provides amongst other things proof of age and to work with Young Scot, the Scottish Retail Consortium, CoSLA and the Society of Chief Officers of Trading Standards in Scotland to encourage support of the card, including by retailers.
15. We will make subordinate legislation in the Scottish Parliament to deploy the Tobacco Advertising and Promotion Act 2002.
16. We will establish, in partnership with the UK Government, appropriate arrangements to monitor the Tobacco Advertising and Promotion Act 2002 and act to close any loopholes which are identified. This will include monitoring of remaining marketing activity, including point-of-sale publicity, distribution strategies, pack design, new product development and corporate social responsibility campaigns.
17. We will continue to work closely with the UK Government to promote tobacco control policies at UK and international level.

## Chapter 7: Measuring progress

18. NHS Boards should have a broad-based programme of tobacco control action which will be monitored through the Performance Assessment Framework.
19. To reflect the action in this plan, the Scottish Executive will increase its existing target for smoking rates amongst adults (aged 16-64) to 29% by 2010. We confirm our commitment to reducing smoking amongst young people (aged 13-15) to 12% in 2005 and 11% by 2010 and reducing the proportion of women who smoke in pregnancy to 23% in 2005 and 20% in 2010.
20. The new Ministerial Working Group will review these targets in 2004 following the publication of the *Smoking Atlas of Scotland* and the latest results from the Scottish Health Survey, Scottish Household Survey and surveys of Scottish school children. This will allow us to consider the potential for targets based on specific areas or demographic groups. In the meantime, NHS Boards and their health improvement partners should set local milestones as a stepped process towards meeting national targets.



CHAPTER 1  
INTRODUCTION

# INTRODUCTION

## The Health Challenge

**1.1** In February 2003 the Scottish Executive published *Improving Health in Scotland: the Challenge*<sup>1</sup> to bring about a more rapid rate of health improvement in Scotland and narrow the gap between the health of our poorer and better off communities. *The Challenge* described a series of actions to tackle the key risk factors to health, along with a commitment to focus specifically on the early years, teenage transition, the workplace and communities.

## Purpose of this document

**1.2** This paper takes forward the commitment made within *the Challenge* document to review national tobacco control policy in conjunction with key interests and to set out a new plan for action which will build on achievements to date. It also takes forward the commitment made within *A Partnership for a Better Scotland*<sup>2</sup> to consult on how to achieve considerably more smoke-free bars and restaurants and to consult transport operators on further measures to improve enforcement of restrictions on smoking in public transport.

**1.3** Since 1999, the Scottish Executive has been driving forward implementation in a Scottish context of the comprehensive tobacco control programme set out in the UK White Paper *Smoking Kills*.<sup>3</sup> Working with our partners, we have delivered new and expanding cessation services, high quality communications campaigns, Nicotine Replacement Therapy on prescription, a ban on tobacco advertising, enhanced health warnings on cigarette packets and tobacco test purchasing pilots.

**1.4** **Whilst these are substantial achievements, the Scottish Executive believes that the time is right to step up the pace of advance and come forward with a new action plan which can take us even further.** We therefore invited NHS Health Scotland and ASH Scotland to undertake a review of national tobacco control policy which would:

- 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; and
- make recommendations about what further action should be taken in Scotland.

---

<sup>1</sup> *Improving Health in Scotland: The Challenge*. Scottish Executive 2003 ISBN 0-7559-0607-1

<sup>2</sup> *A Partnership for a Better Scotland*: the Scottish Executive 15 May 2003

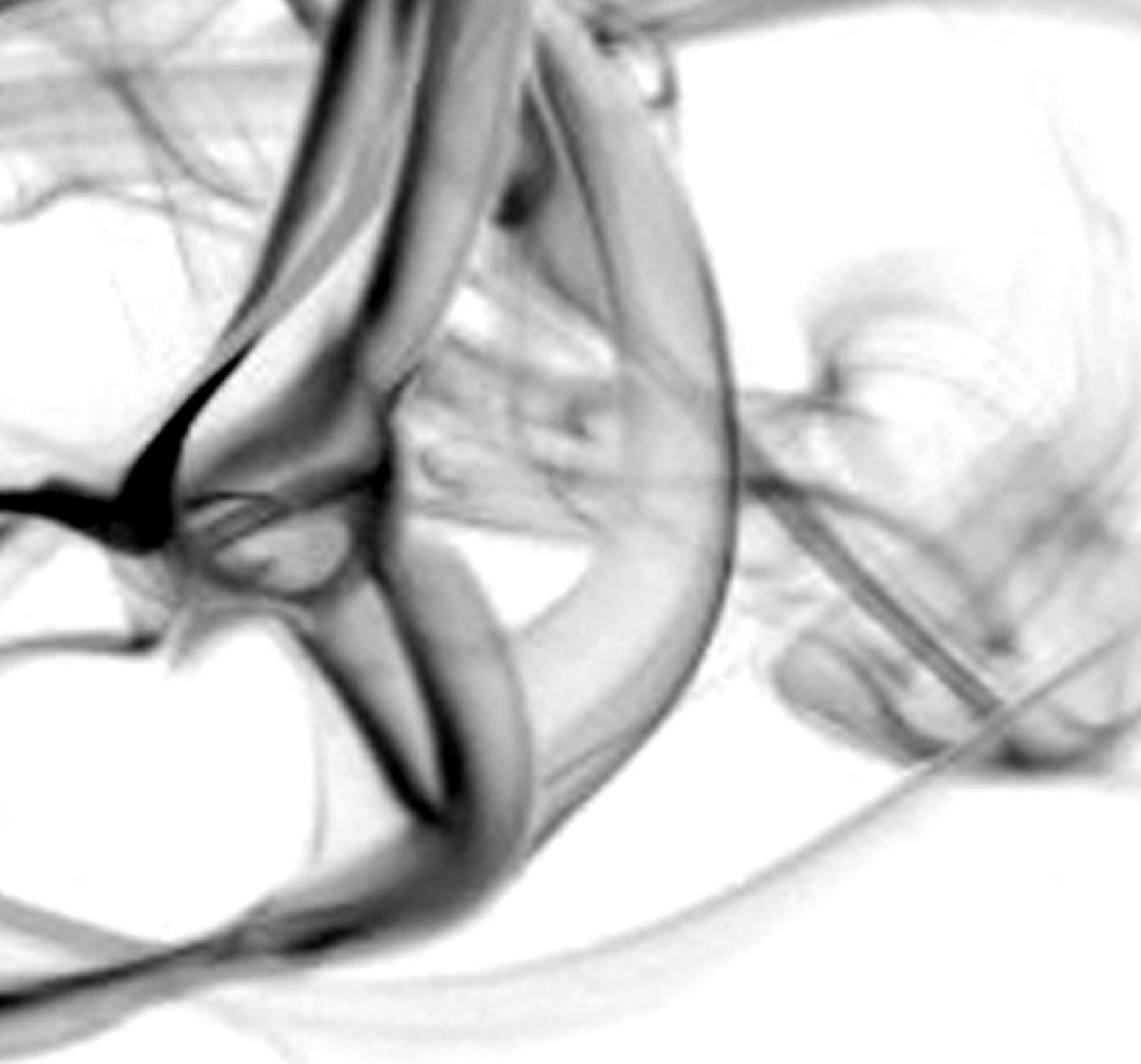
<sup>3</sup> *Smoking Kills*: HMSO 1998 ISBN 0-10-141772-1

- 
- 1.5** The resultant report, *Reducing Smoking and Tobacco Related Harm: A Key to Transforming Scotland's Health*,<sup>4</sup> provides the platform for this action plan. We would like to thank the authors for the quality of their research and for identifying a set of recommendations (Appendix 1) which, taken together, provide new impetus for our efforts to minimise the harm that smoking causes to the people of Scotland.
- 1.6** This action plan sets out the Executive's response to ASH Scotland and NHS Health Scotland's review report. It sets out the direction we will take and a series of actions which underline our commitment to robust action to tackle smoking, particularly within our deprived communities. We are grateful to the members of the Executive's Scottish Tobacco Control Strategy Group (see Appendix 2) who helped advise on its content and determined it represents a significant step along the road towards a non-smoking Scotland.

---

<sup>4</sup> *Reducing Smoking and Tobacco Related Harm: A Key to Transforming Scotland's Health*. NHS Health Scotland/ASH Scotland 2003





CHAPTER 2  
THE APPROACH

## THE APPROACH

- 2.1 Smoking has long been recognised as the most important preventable cause of ill-health and premature death in Scotland, accounting for more than 13,000 smoking-related deaths every year. We know that it is linked to diseases of the heart and blood vessels, the lungs, stomach, kidneys and other organs and that as a result, it has been estimated the NHS in Scotland spends **up to £140 million<sup>5</sup> every year** on treating smoking-related disease – at current prices this would amount to over £200 million. We also know that it is not just smokers themselves that are at risk.
- 2.2 This plan is based on the vision of a non-smoking Scotland; a country in which everyone is aware of the health risks associated with smoking, the health of our children is protected and where people can go out and enjoy themselves free from the dangers of second-hand smoke.
- 2.3 The Scottish Executive does not believe that it is right to force people to stop smoking. However, nicotine is highly addictive and we need to bring home to Scots the harm smoking is doing to their own health and that of others. Our long-term aim is for no Scot to be exposed involuntarily to second-hand smoke at work or anywhere else and for them to choose, to reject smoking as being an outdated and unfashionable practice which doesn't have a place within a healthy, forward-looking nation.

### Social Inclusion

- 2.4 *Improving Health in Scotland: the Challenge* makes it clear that efforts to improve health are inextricably linked to the pursuit of social justice.
- 2.5 We know that some of the highest rates of smoking are to be found amongst our most disadvantaged communities. This plan sets out to close that gap by describing actions which give most help to those communities, be that through the provision of services or access to communication and education material.

### Integration

- 2.6 A reduction in smoking levels in Scotland requires clear priorities and targets backed by action across a wide range of health and non health related fields. Actions in this plan are therefore set out in four broad categories:
  - **Prevention:** action to accelerate reductions in smoking prevalence including a major review of prevention, education and communications efforts.
  - **Provision of services:** action to further extend and improve cessation services with new funding for the Executive to support this.

---

<sup>5</sup> The Scottish Office (1999): *Towards a Healthier Scotland* (HMSO)

- **Second-hand smoke (passive smoking):** action to reduce the health risks from second-hand smoke and reinforce efforts to 'de-normalise' smoking in Scotland.
- **Protection and controls:** legislative and other action to reduce the attractiveness and availability of cigarettes.

2.7 Evidence to support policy development in each area is taken from the NHS Health Scotland/ASH Scotland review of tobacco control policies.

### Long-term commitment

2.8 We are, of course, describing a vision and a programme that cannot be achieved overnight. Although this document describes a number of short-term actions, these are merely first steps. We need to commit ourselves to a long-term strategy and design processes and support structures which are capable of delivering results, monitoring progress and identifying new and subsequent actions based on the evidence of what has delivered results both within Scotland and elsewhere in the world.

### Partnership working

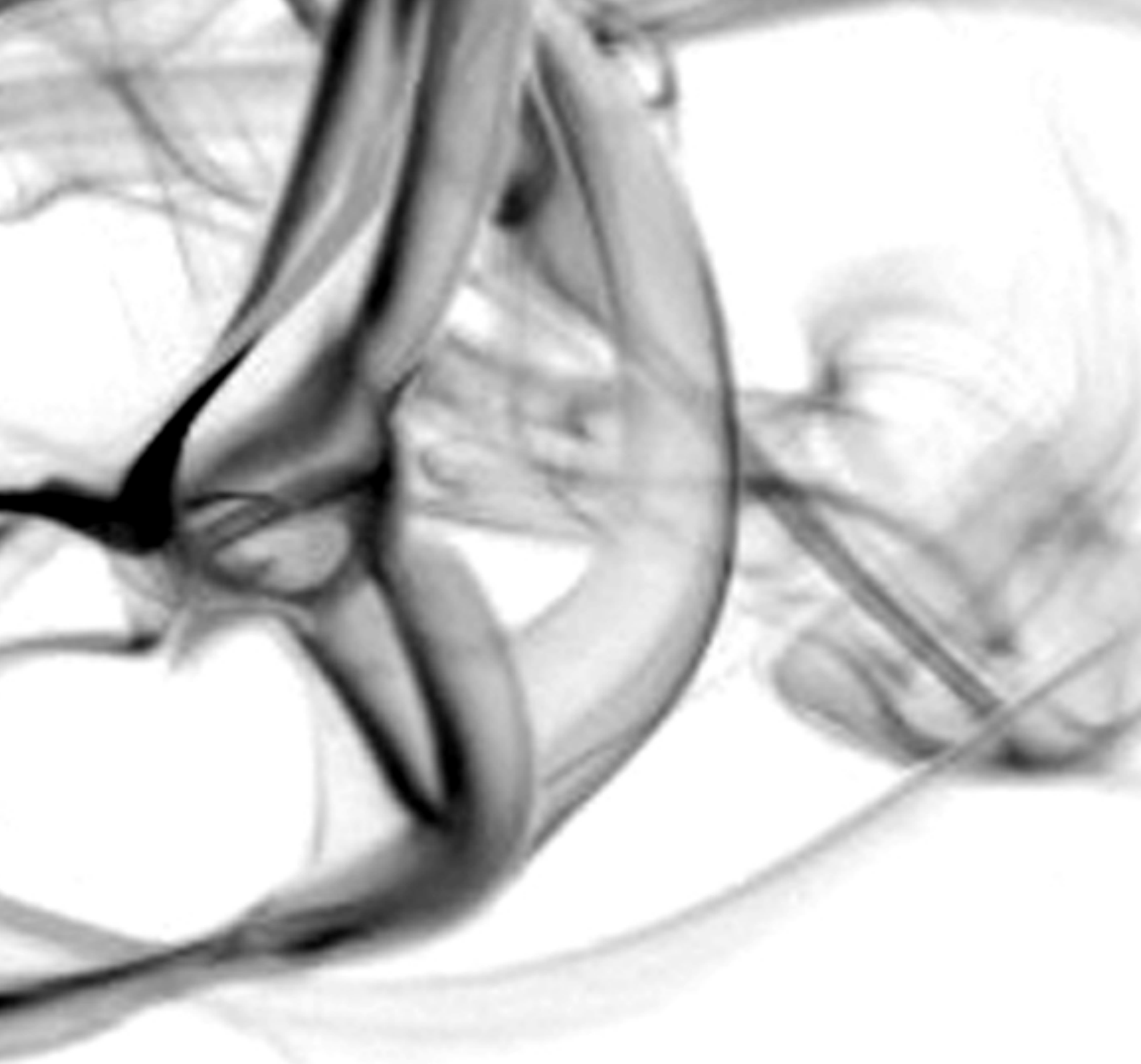
2.9 A successful strategy will require partnership working at both local and national level. Individuals hold the key to effective culture change so we need to engage communities, employers, trade unions and other employee representative bodies, government, the NHS and the voluntary sector in our plans. Crucially, we need to see broad-based action on tobacco control featuring strongly in the community planning process, joint health improvement plans and NHS Board local health plans. We also need action on smoking to form a core part of employers' workplace health and welfare policies for their employees.

2.10 Scottish Ministers and officials play a full part in debating, discussing and developing UK and international tobacco control policy. In Scotland, the Health Improvement Directorate co-ordinates action across Scottish Executive departments and works closely with national organisations and forums – such as ASH Scotland, Health Scotland, the Scottish Tobacco Control Alliance and Partnership Action on Tobacco and Health – in delivering tobacco control policies. The Scottish Executive Health Department's Public Health Division also has a close relationship with the HSE in Scotland.

**2.11** The Scottish Tobacco Control Strategy Group, set up by the Scottish Executive to guide the implementation of *Smoking Kills* in a Scottish context has proved extremely valuable over the past few years and has played a leading role in the development of this Plan. However, in order to generate momentum behind this plan, we agree with the review report that this Group should be upgraded to a Ministerial Working Group chaired by a Minister. The new Working Group will have a Scotland-wide remit to gather and analyse national and international information and provide advice to Ministers, in order to ensure that tobacco control policy continues to reflect the best available evidence about the effects of tobacco on our nation's health. The core membership will include authoritative figures in the tobacco control and related areas in Scotland, including health professionals, academics, young people's representatives, public relations experts, retailing interests and others with recognised expertise and experience in the tobacco control field.

### **Actions**

- 1. In order to undertake or commission work on tobacco-related health issues of specific relevance to Scotland, the existing Tobacco Control Strategy Group will be strengthened and upgraded to a Ministerial Working Group chaired by the Deputy Minister for Health and Community Care. This Group will provide expert advice on the health impact of tobacco and provide a forum for the dissemination of best practice to health and other professionals throughout Scotland.**



CHAPTER 3  
PREVENTION AND EDUCATION

## PREVENTION AND EDUCATION

### The Challenge


- 3.1 A reduction in smoking levels in Scotland requires us to take action to minimise the number of 'new recruits' to the smoking habit. The *Improving Health in Scotland: the Challenge*<sup>6</sup> announced our determination to focus action on what it called teenage transition, the vitally important move from childhood to adulthood during which attitudes, opinions and habits can be formed for life.
- 3.2 The decision to start smoking can be influenced by a variety of social and cultural factors. Inevitably, our choices are influenced by what we see around us, the behaviour and views of our families, friends and members of our community as well as the addictive nature of nicotine itself. We are influenced also by the access that we have to cigarettes and the images that we see in the media, be that through direct advertising or subtle association with a particular lifestyle or role model.
- 3.3 The review report points to new evidence about the speed with which young people, particularly young girls, can develop nicotine dependence. More than 80% of adult smokers start smoking in their teens and most are addicted before they are 20. Some will manage to kick the habit early, but many will continue to smoke for decades, unable to give up and increasingly at risk of serious illness and early death. There is also a strong correlation between poverty, social exclusion and other risk factors such as poor diet and the misuse of drugs and alcohol, and early smoking.

### Current activity

- 3.4 Smoking prevention is a key priority for NHS Health Scotland and it currently devotes some £1.5 million per annum across a range of programmes to it. The review report examines in detail prevention efforts to date, including mass media campaigns, school-based initiatives and community-based programmes. It notes the contribution of the Scottish Health Promoting Schools, that 96% of schools in Scotland now provide education on tobacco and highlights the high levels of awareness amongst young people of recent advertising campaigns developed by NHS Health Scotland.
- 3.5 The marketing and promotion of tobacco products has, in the past, done much to counteract public health messages. For this reason, the ban on tobacco advertising, steps to increase smoke-free provision in the workplace and public places and the new health warnings on cigarette packets are significant. However, as described in Chapter 6, we will continue to work – including at UK level where necessary – to see how much further we can push the boundaries.

---

<sup>6</sup> *Improving Health in Scotland: The Challenge*. Scottish Executive 2003 ISBN 0-7559-0607-1

- 
- 3.6** In spite of the advances made, we are concerned at the lack of real progress in recent years particularly in closing the inequalities gap and in reducing smoking levels in young people, particularly girls. For this reason, we believe that a radical re-think of traditional approaches to prevention and education activity is necessary. We need to maximise the benefits from the limited resources available for health education and prevention and do more to challenge influences which promote smoking and smoking behaviour. In particular, discouraging young people from starting to smoke needs to be given the utmost priority.

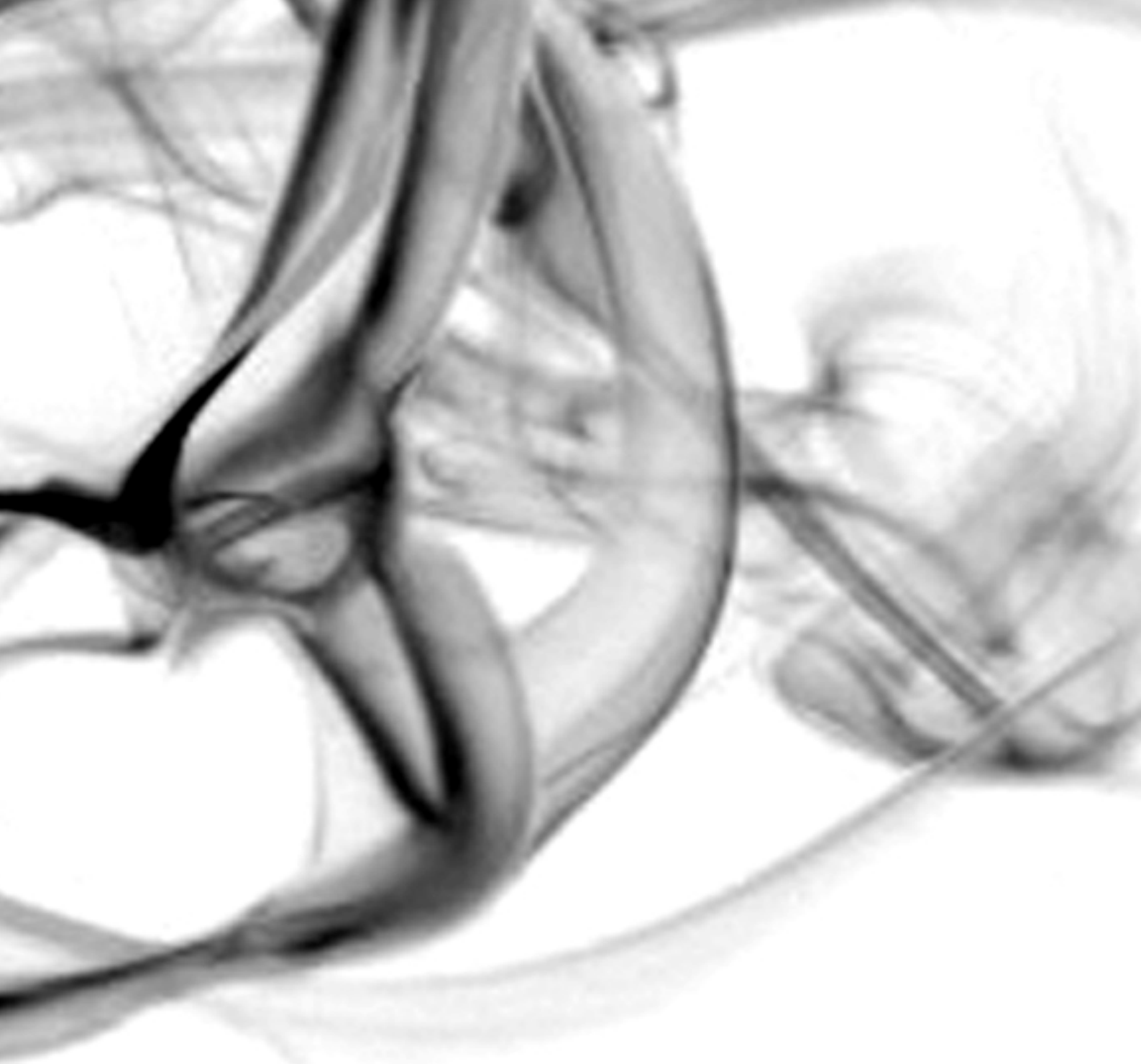
### **Future direction**

- 3.7** We believe a national communications strategy is needed. A multi-faceted approach is necessary in order to influence both the general public and specific target groups. Young people must remain our principle target and they themselves hold the key to the success of any prevention messages. We need to understand more about the way in which they make choices about their lifestyle and involve them in shaping the strategies and messages we need to put across in order to make a difference.
- 3.8** Clearly we recognise the continuing importance of raising awareness of both the immediate and longer-term dangers of smoking. We need to ensure that these messages continue to get across, particularly to those who still believe that it is always easy to stop. However, despite the power and importance of such messages, the Executive believes that warnings alone will not be sufficient to make the kind of impact we need. We do need to track awareness of the dangers of smoking amongst young people and ensure that these don't decline but the reality is that awareness of the risks does not always translate into a decision to avoid developing a smoking habit.
- 3.9** Our approach to prevention and education will be founded on the commitment to involve young people and develop messages that relate to their lives. We will conduct further research into the pressures that young people are under to start smoking and work with them to design programmes which help them to recognise and resist these pressures. We will also involve young people directly in the development of a strategy which demonstrates that smoking isn't the norm amongst the people they aspire to be and that the decision to adopt a smoke-free lifestyle will be more rewarding in both the short and longer term.
- 3.10** These messages will carry the greatest weight if they are integrated across a variety of different channels and settings. Schools programmes, community education and media advertising must work together over a long period of time. We will explore a range of channels and options for getting our messages across and be prepared to experiment with electronic and direct marketing where young people judge this to be appropriate. We also believe that interventions are likely to be most effective when they are linked to other supportive action rather than being delivered in isolation. For example, in socially deprived communities, prevention can be coupled with support and advice given in other settings such as debt counselling.

**3.11** Of course, we also need to ensure that our commitment to integration doesn't start and finish with our approach to education and communication. However sophisticated our message, it will not deliver change unless we also act to restrict availability, provide cessation services where they are most needed and provide a route out of poverty and social exclusion for our most disadvantaged members of society.

### **Actions**

- 2. In consultation with the new Ministerial Working Group, we will commission a review of current national communication and education programmes and build any learning into the development of a coherent, integrated long-term communications strategy to guide future prevention activity at national and local levels.**
- 3. In partnership with NHS Health Scotland, we will commission further research with young people to provide a clearer picture of the factors that lead them to start or resist smoking and track awareness of the dangers of smoking and passive smoking amongst key target groups.**



**CHAPTER 4**  
**PROVISION OF SMOKING CESSATION  
SUPPORT SERVICES**

# PROVISION OF SMOKING CESSATION SUPPORT SERVICES

## The Challenge

- 4.1** A reduction in smoking levels in Scotland will require us to increase and tailor the provision of services across a wide range of settings. Smoking affects every social group. We do know, however, that the highest smoking rates are found within the areas of highest socio-economic deprivation and that prevalence is particularly high amongst socially excluded groups such as heavy drinkers, homeless people, prisoners and people with serious mental health problems. Services need to be sensitive to the particular needs of such individuals who may be difficult to engage in services and not necessarily catered for by traditional health or workplace settings.
- 4.2** In providing services, we also need to be mindful of the effects that smoking can have on young and unborn children. The review report points out that 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. Around 27%<sup>7</sup> of Scottish pregnant women currently smoke in pregnancy, meaning that about 13,500 babies born in Scotland have been put at risk from the effects of tobacco.

## Current activity

- 4.3** The review report acknowledges the major expansion in cessation services across the UK since publication of *Smoking Kills*. It looks at the effectiveness of a range of interventions – from low intensity support such as self-help materials and telephone helplines to more intensive interventions, including individual and group counselling – which assist increased quit rates. It also refers to the value of national activity such as ‘Smokeline’ and ‘No Smoking Day’ in encouraging people to quit and offering support and advice to enable them to do so.
- 4.4** In Scotland, substantial resources are made available to NHS Boards through the following funding streams:
- Smoking Kills*: £1 million in each of 3 years (1999/00, 2000/01 and 2001/02) was provided as part of NHS Boards’ revenue allocations specifically for smoking cessation services and NRT which was to be targeted particularly at areas of deprivation. This funding, which the majority of Boards have indicated has been used for smoking cessation activity, is now included in NHS Boards’ unified budgets and continues to be available.
- Health Improvement Fund (HIF)*: smoking prevention and cessation was identified as a priority for investment from the £26 million per annum fund which has been available since 2000/01. Information supplied by NHS Boards about HIF expenditure suggests that over £750 thousand per annum is allocated to smoking-cessation developments.

---

<sup>7</sup> ISD National Health Service in Scotland 2002

*Revenue allocations:* £5 billion has been allocated for 2003/04. NHS Boards have a standard increase of 7.4%, with an average increase of 7.8%. Indicative revenue allocations totalling £5.4 billion for 2004/05, a standard increase of 6.5% and £5.8 billion for 2005/06, a standard increase of 7% were notified to Boards in August 2003.

- 4.5 Within HIF resources and revenue allocations, Health Boards have flexibility to direct the appropriate level of funding required to meet smoking cessation and prevention needs within their areas. As a result, all areas now have one or more smoking cessation service, although their extent varies greatly according to what is made available on the basis of local decisions. NHS Board Health Promotion Departments are sources of expertise, training, information and resources for smoking cessation and can assist with the development and evaluation of prevention and cessation services. Most NHS Boards have appointed a smoking cessation co-ordinator and a variety of service delivery models are being developed and evaluated.
- 4.6 The ASH Scotland/Health Scotland's *Smoking Cessation Guidelines for Scotland*<sup>8</sup> were sent to all NHS Boards in 2001 to provide evidence-based information on the most effective smoking cessation services. Further pieces of guidance – a patient's guide and a health professional's guide – were also circulated. The Scottish Executive funded initiative Partnership Action on Tobacco and Health (PATH), launched in June 2002, was specifically set up to support tobacco control activity through gathering and disseminating evidence of best practice, the development of training standards and recommendations on information management and data collection.

#### **Future direction**

- 4.7 There remains an untapped demand for smoking cessation services and the Scottish Executive is committed to making further funds available to support the expansion of such services in Scotland. We aim to agree annual cessation targets with individual NHS Boards and take a proactive role in ensuring that local providers are indeed translating additional resources into additional cessation capacity.
- 4.8 However, the expansion of cessation services should not just be seen as a matter of numbers. We need to ensure that the services we offer are of high quality and produce long-term results. GPs, practice nurses, midwives, dentists, pharmacists, health visitors, and other health professionals, all potentially have a role to play in giving smoking cessation advice. Such advice need not take long but the messages need to be consistent. Moreover, it needs to take account of the conclusion within the review report that, in general, the more intensive the intervention, the greater probability of success. Also that some individuals find it more difficult than others to give up and, therefore, need longer-term and more intensive support. It also notes that quit rates double, irrespective of the interventions, when combined with the use of NRT or bupropion.

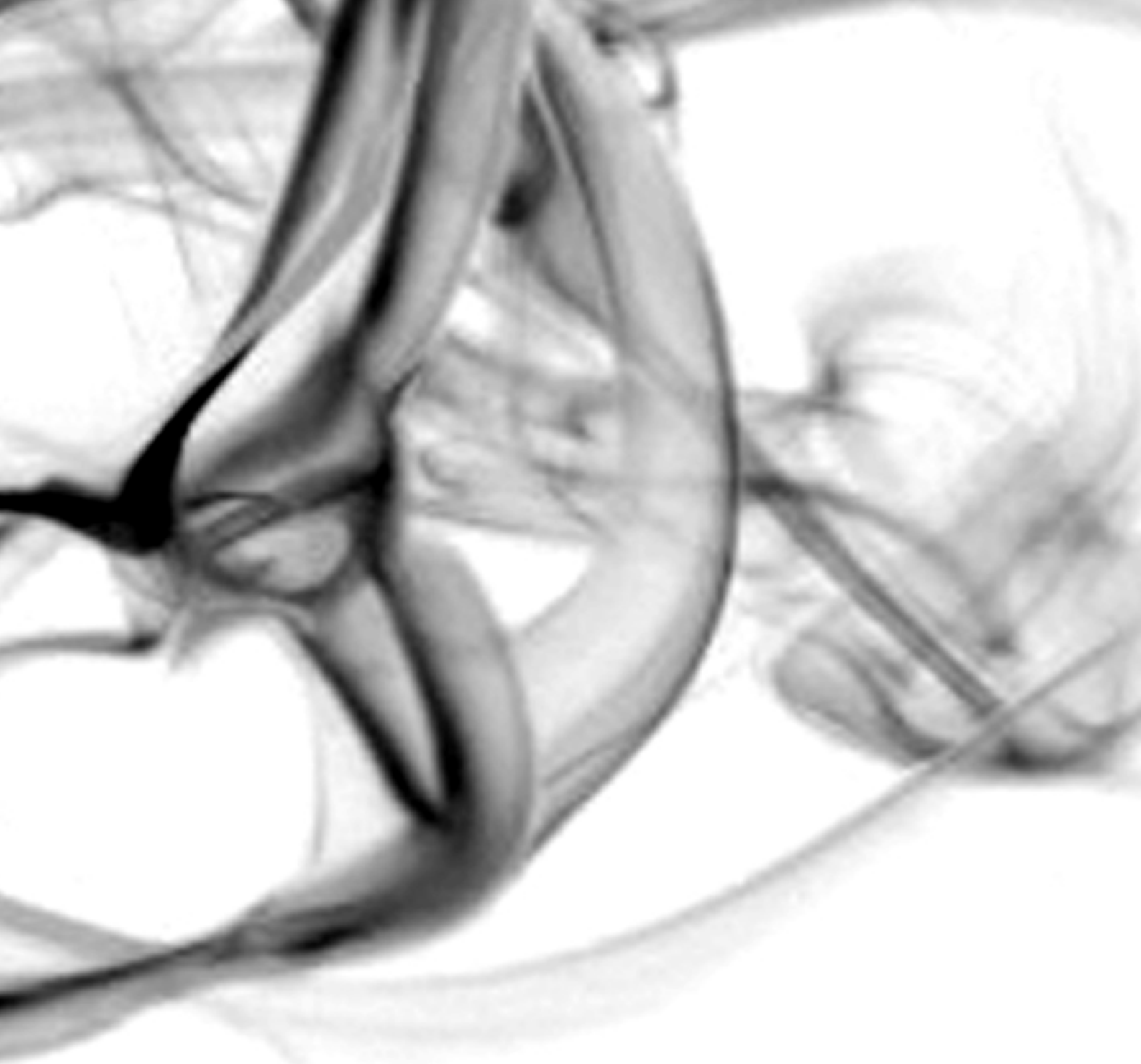
---

<sup>8</sup> *Smoking Cessation Guidelines for Scotland*: ASH Scotland: ISBN 1902030 06 0

- 4.9** Our approach to the provision of services must continue to be based squarely on the evidence of their effectiveness. PATH has a central role to play in identifying this evidence from around the world, and then distilling and disseminating best practice guidance through publications, and the development of training standards for service providers in Scotland. This work includes the management of a £900 thousand fund over 3 years – 2003/04 to 2005/06 – which is supporting 11 innovative projects aimed at improving understanding of how to help different types of people to quit. The work being undertaken by ASH Scotland and Health Scotland to identify acceptable and effective approaches to smoking cessation for young people, through a programme of eight pilot smoking-cessation interventions, will also help to strengthen the knowledge base.
- 4.10** We will also work with partners to encourage the development of services that are accessible to those in the most deprived areas of our country and sympathetic to those groups who have proved to be hard to engage in conventional approaches. We will continue to pay special attention to smoking during pregnancy. All this will require efforts to embed smoking cessation within services (e.g. debt counselling, housing, social work, etc.) which tackle the broader social issues that can contribute to smoking behaviour and create barriers to smoking cessation. We need to help professionals working within both the statutory and the voluntary sector to take advantage of opportunities to raise the subject of tobacco use with clients and patients, assess smokers' readiness to make an attempt to quit and ensure appropriate motivation and support is provided to help them to stop. This requires us to find ways of equipping workers with the necessary skills to empower them to do so.

## Actions

4. We will allocate additional funding to smoking cessation services of £1 million in 2003/04, £1 million in 2004/05 and £5 million in 2005/06. Using the *Revised Smoking Cessation Guidelines for Scotland* and the *Smoking Atlas of Scotland*, which are due to be published by the end of March 2004, NHS Boards should assess local needs, identify gaps and develop plans to fill these gaps.
5. We will take steps to further develop the evidence base for effective cessation services through increased investment in the Partnership Action on Tobacco and Health (PATH). The findings of the review report should be used to inform the priorities for this increased investment.
6. We will negotiate and agree cessation targets with each NHS Board by the end of July 2004. As part of this process we will work with NHS Boards, ISD and PATH to introduce reliable baseline measures and develop outcome based measures for future use.



**CHAPTER 5**  
**SECOND-HAND SMOKE**  
**(PASSIVE SMOKING)**

## SECOND-HAND SMOKE (PASSIVE SMOKING)

### The Challenge

- 5.1 The health risks posed to non-smokers by exposure to second-hand smoke – also known as ‘environmental tobacco smoke’ (ETS) or passive smoking – are clear. The review report highlights these dangers and calls for firm action to increase smoke-free zones in all enclosed public places and the workplace.
- 5.2 The review report highlights the dangers second-hand smoke presents. It also identifies a body of evidence on the links between passive smoking and lung cancer, ischaemic heart disease and the aggravation of conditions such as asthma and chronic bronchitis.
- 5.3 Despite this clear medical evidence, the review report also notes that a recent study in Scotland found a poor understanding of the risks amongst the public. It highlights the need for more public education and calls for firm action to extend smoke-free zones in enclosed public places and workplaces. In doing so it challenges leading public sector employers, such as the Scottish Executive, local authorities, and NHS Scotland, to show leadership in the creation of smoke-free environments.

### Current activity

- 5.4 Whilst not ruling out statutory restrictions in smoking in public places, the Executive's approach to date has been to work in partnership with business interests to achieve continuous improvement in the provision of smoke-free places through voluntary action. A central plank of the policy has been an industry initiative, the ‘Scottish Voluntary Charter on Smoking in Public Places’, to drive improvements in non-smoking facilities in the licensed, tourism and hospitality sector by encouraging venue operators to set a formal smoking policy and to highlight this through external signage. Operators could adopt one of five levels of policy:
  - *Smoking*: no special segregation or special ventilation equipment;
  - *Ventilated*: non-defined areas but special ventilation equipment used to improve comfort for non-smokers;
  - *Designated areas*: with spaces clearly defined for smoking and non-smoking;
  - *Separated*: smoking and non-smoking areas separated by walls; and
  - *Non-smoking*: no smoking allowed at any time.

- 5.5 Supported by the four main industry bodies – the Scottish Beer and Pub Association, the Scottish Licensed Trade Association, the Scottish Tourism Forum and the British Hospitality Association – the Charter was launched in May 2000. Targets were set to achieve – by the end of 2002 – 10% increases in the number of places with smoking policies, written smoking policies, signs indicating smoking policy near entrances, and non-smoking provision.
- 5.6 An independent evaluation, published on 23 September 2003,<sup>9</sup> of smoking policies in the Leisure Industry would suggest the industry had met three out of the four targets set under the Charter, including the key target of availability of smoke-free provision. We welcome the progress made under the Charter and believe that it demonstrates the progress which can be made through partnership with the business community in this most challenging of sectors. We now intend to work with partners to step up these efforts in order to accelerate progress in smoke-free provision across all sectors of business in Scotland.
- 5.7 The annual cost of employee smoking in Scotland is estimated to be more than £500 million – £450 million for lost productivity (smoking breaks), £40 million from higher absenteeism among smokers and £4 million as a result of fire damage.<sup>10</sup> A number of studies show smoking restrictions in workplaces reduce smoking rates and tobacco consumption.<sup>11</sup> The Executive has supported Scotland's Health at Work (SHAW) and NHS Health Scotland in efforts to encourage employers to introduce smoking policies in their workplaces. However, legislation covering health and safety at work is reserved to Westminster. *Smoking Kills* announced the intention to push this agenda forward through the publication by HSE of an Approved Code of Practice and the Executive is disappointed by the lack of progress in this document, believing it to be a missed opportunity for culture change in the workplace.

### Way forward

- 5.8 The review report suggests that an increase in smoke-free provision is unlikely to be achieved without legislation. We acknowledge that legislation can form as well as follow public opinion and understand both the growing strength of opinion and increasing weight of evidence behind such a move. We will continue to pay close attention to the evidence emerging from Australia and the US states such as California and New York about the effectiveness of legal prohibition. In particular, we will monitor the situation in Ireland where a ban on smoking in the workplace, including bars and restaurants, is due to be introduced in early 2004.

---

<sup>9</sup> *Smoking in Public Places: A follow up survey of the Scottish Leisure Industry: prepared for ASH Scotland/Health Scotland by MVA: September 2003*

<sup>10</sup> Parrot S, Godfrey C, Raw M, *Costs of employee smoking in the workplace in Scotland: tobacco control 2000:9: 187-192:*

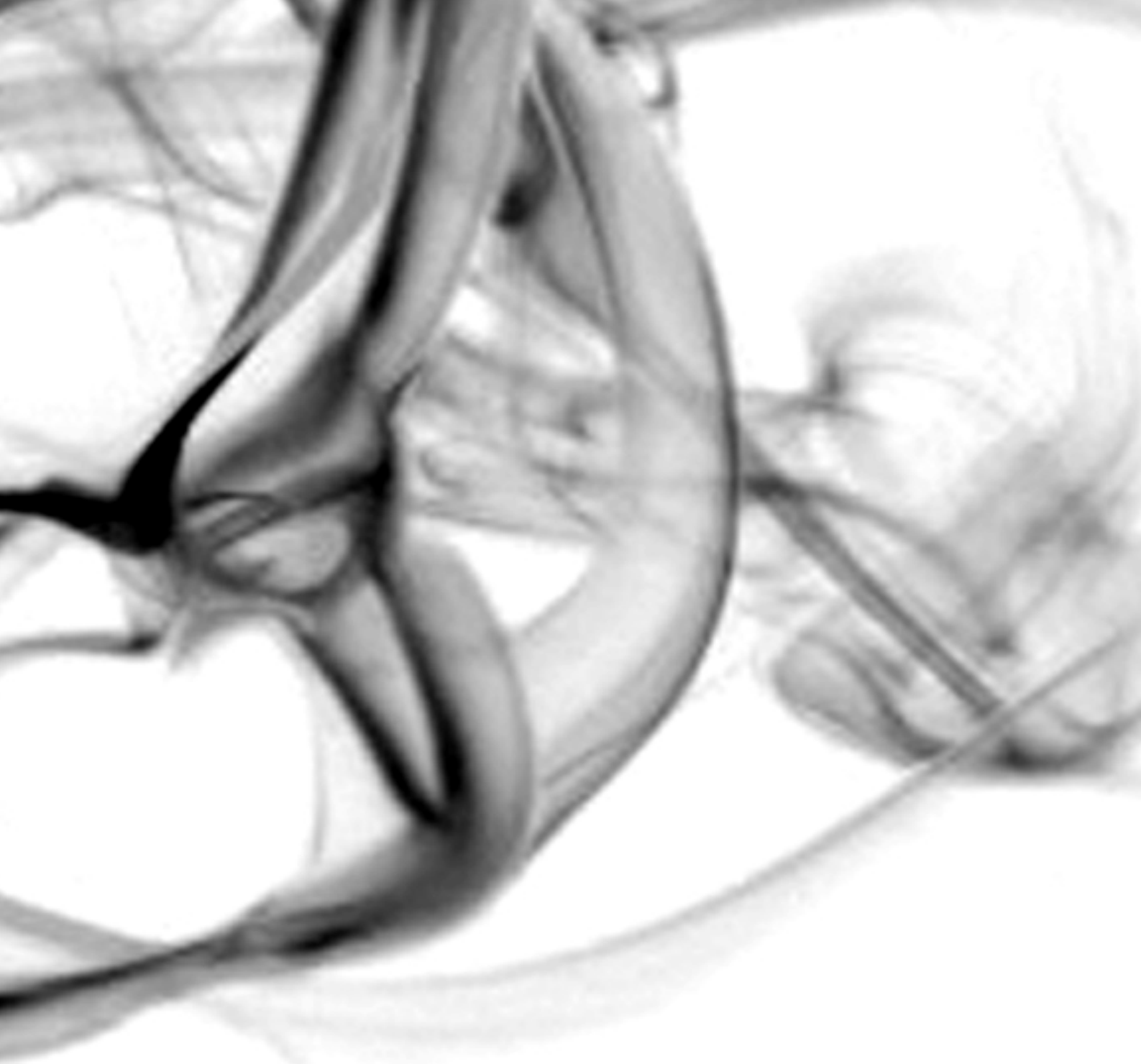
<sup>11</sup> Health Education Board for Scotland (1997) *Scotland's Health at Work-Baseline Survey Report*, Edinburgh.

- 5.9** Clearly legislation is one option but, equally, an extension of the voluntary approach remains an option also. Much progress has been made in smoke-free environments in public places in Scotland through voluntary action. Smoke-filled buses, trains and cinemas are a thing of the past and an increasing number of shopping and sports centres, restaurants and other public places have adopted sound smoking policies. Nevertheless, in spite of the inroads made through initiatives such as the Scottish Voluntary Charter, progress has been much slower in the licensed hospitality sector, particularly in pubs, leading many to believe that statutory controls are the only way to make real progress.
- 5.10** However, in our view statutory controls would only be truly effective – and ultimately enforceable – if they take place in an environment in which the legislation reflects rather than attempts to force public opinion on what remains essentially an issue of personal behaviour. We have to prepare the ground by working to ‘de-normalise’ smoking within our society. In particular we need to raise awareness of the harm that can be caused to unborn and young children and raise awareness amongst employees of the damage that smoking at work can have upon employees and the potential risks that this poses in terms of possible future litigation. In this way, we need to reverse the traditional paradigm within which young people are tempted to start smoking by the desire to ‘fit in’ to one in which smoking is not considered to be a normal ‘social’ behaviour. This will require long-term and sustained communication programmes which raise public awareness of the dangers of passive smoking.
- 5.11** Advertising needs to be supported and reinforced by an open public debate on the issues involved in passive smoking. As indicated in Chapter 1, our own commitment to a public debate specifically on issues around second-hand smoke is clear. We need to be prepared to hear all shades of opinions so that the issues can be surfaced and properly debated. We need to convince people not to smoke and convince people that if they do continue with the habit then they need to do so away from others so that they do not affect the health of those around them. This will be easier and more capable of being sustained if people can arrive at their own informed decisions rather than feeling as though this is being imposed upon them in some way.
- 5.12** Whilst smoking in the workplace remains a reserved area, we believe that there is a clear leadership role for the Executive. We must be prepared to take action to protect the health of our own staff and to ensure that help and advice is available for all those who wish to follow suit. The Health Improvement Challenge identified the workplace as one of the special focus areas for action and we will encourage employers across all sectors to review their health and safety arrangements with regard to tobacco smoke, and increase the number of employees that can enjoy the benefits of a smoke-free environment at work.

## Actions

7. In 2004, we will sponsor a major public debate on actions to minimise the impact of second-hand smoke. This will involve a range of conventional and innovative opportunities to contribute to the dialogue, including a major conference to provide acknowledged experts with the opportunity to put their messages across to the people of Scotland.
8. We will work with partners including NHS Health Scotland to develop and deploy a national advertising and communications campaign about the dangers of second-hand smoke.
9. We will review our own current staff smoking policy, which permits smoking only in designated smoking areas, with staff representative bodies, with a view to introducing a complete smoking ban by the end of July 2004.
10. As part of efforts to facilitate 'healthy working lives', we will challenge employers, trade unions, voluntary groups and representative organisations to encourage and support the introduction of effective smoking policies by all Scottish employers.
11. NHS Boards and local authorities will be encouraged to review their smoking policies by the end of 2004 in the light of guidance available from Health Scotland, ASH Scotland and CoSLA.





CHAPTER 6  
PROTECTION AND CONTROLS

# PROTECTION AND CONTROLS

## The Challenge

**6.1** Measures to protect individuals and society from the impact of tobacco, through legislative and other forms of regulation/control, are a vital component of any tobacco control strategy. Some of the levers, such as laws governing the sale of tobacco products to under-16s, tobacco advertising and action to address smoking in public places, are within the scope of the Scottish Parliament. Others, such as fiscal policy, tobacco smuggling and controls on the tobacco industry are reserved to Westminster. Given the global nature of the tobacco industry, international action to control tobacco consumption also has a contribution to make. The challenge is, therefore, to do as much as we can within the powers, partnerships and routes of influence available to us, and to ensure that Scotland's voice is heard at UK and international level.

## Current activity

### *i. Scotland*

**6.2** The Children and Young Persons (Protection from Tobacco) Act 1991 prohibits the sale of tobacco products to under-16s. However, the review report highlights the fact that sales to children and young people under 16 remain a problem and calls for the law to be enforced more effectively. We agree that major steps need to be taken to improve enforcement and recognise the value of a constructive approach by enforcement officers helping retailers to meet their responsibilities while targeting those who flout the law. We have been working closely with CoSLA, the Society of Chief Officers of Trading Standards in Scotland, the Scottish Retail Consortium and others on steps to improve enforcement. Two resultant ongoing initiatives, the test purchasing pilot scheme taking place in four sites across Scotland and the roll out of the Young Scot Youth Dialogue Card – in which proof of age is an integral part – are of particular importance in this respect.

**6.3** The Tobacco Advertising and Promotion Act 2002, which extends to Scotland, received Royal Assent on 7 November 2002. Through UK-wide action it has been possible to deliver a more effective and comprehensive ban. The Act bans press, billboard and most Internet advertising of tobacco products and the promotion of smoking through free distribution of tobacco products, coupons and mailshots in the UK. The Scottish Ministers have some regulation making powers under the Act. Having already made regulations bringing to an end the promotion of tobacco products through sponsorship of sporting and other events, Scottish regulations will be made to place restrictions on point-of-sale advertising.

## *ii. UK*

- 6.4** Taxation is one important means of reducing consumption and we support the UK Government's approach to tobacco duties. We also welcome the tough line they are taking on tobacco smuggling. As the review report points out, access to cheap tobacco and cigarettes makes it harder for addicted smokers – particularly those on low incomes – to quit. Tobacco smugglers are estimated to be responsible for £2.5 billion in lost revenue. The Scottish Executive welcomes the investment by the UK Government of £209 million to fight tobacco smugglers.
- 6.5** New UK regulations, the Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002, came into force on 31 December 2002. These regulations transpose the EU Directive on Manufacture, Presentation and Sale of Tobacco Products (the Labelling Directive) which was published in July 2001. We welcome the measures introduced by this legislation including larger and starker health warnings on tobacco products, new maximum yields for tar, nicotine and carbon monoxide in cigarettes and the end to 'misleading descriptors' such as 'low-tar' and 'light'. The Labelling Directive also allows for pictures to be added to pack warnings, a move which has already proved to be a success in Canada and which we would support in the UK.

## *iii. International action*

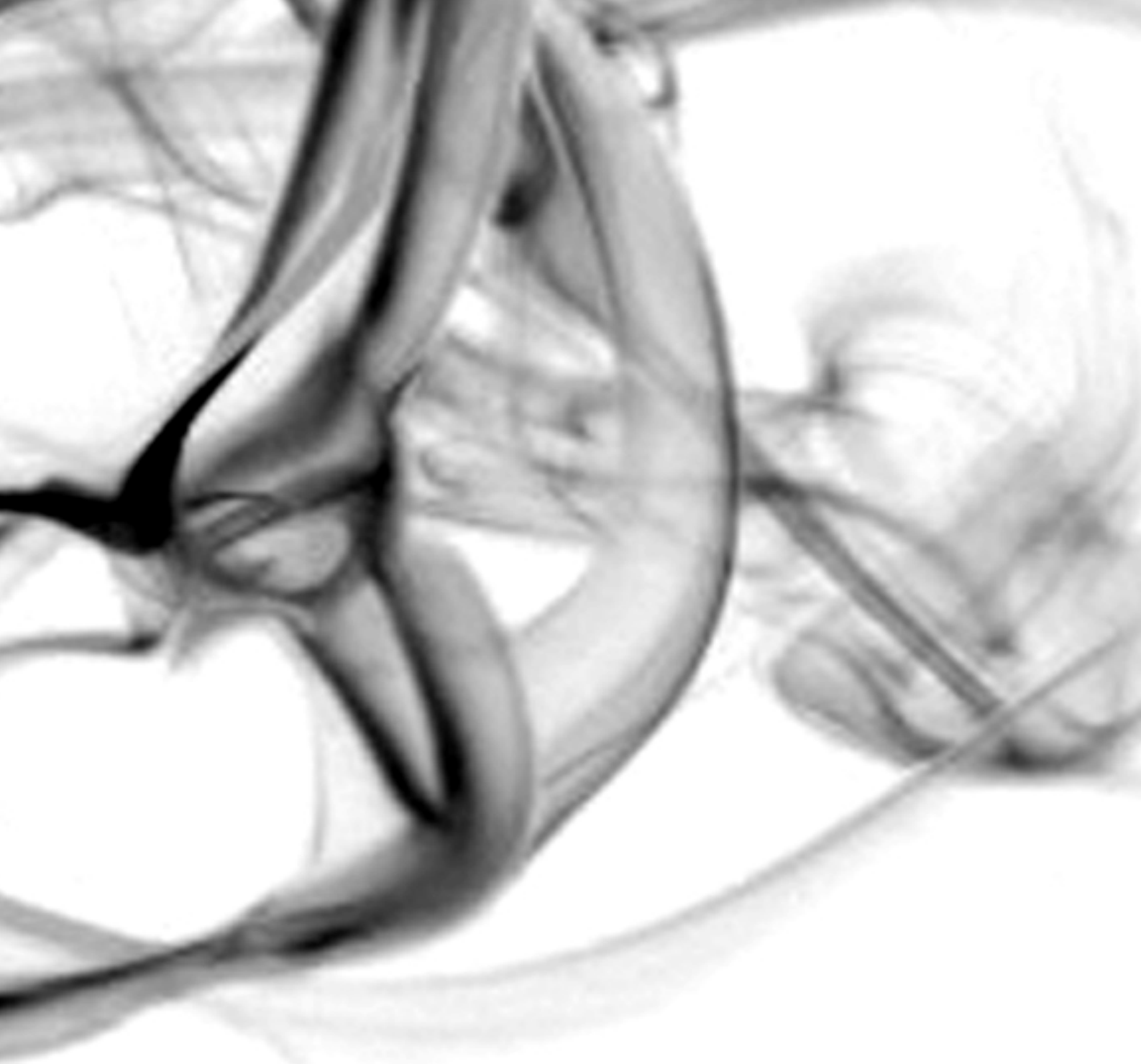
- 6.6** Action to control the supply and distribution of tobacco is being taken at an international as well as a national level. As indicated above, EU action has already resulted in enhanced firmer controls on the manufacture, presentation and sale of tobacco products and the ban on tobacco advertising, promotion and sponsorship. The broader the reach of controls the greater the impact and we particularly welcome the UK Government's support for the Framework Convention on Tobacco Control (FCTC), an international treaty developed under the auspices of the World Health Organisation (WHO), which binds its signatories to the process of regulating the tobacco industry throughout the globe. The FCTC covers a whole range of issues such as introducing a comprehensive ban on tobacco advertising and sponsorship, controls on labelling of products, education about the health effects of tobacco, tackling smuggling, protection from the public of second-hand smoke and measures to reduce availability and promotion of tobacco to young people. These measures are very much in line with our own domestic policies.

## Way forward

- 6.7 We believe that a continuing commitment to partnership working with UK and EU colleagues will allow us to build upon the progress made to date. We will welcome further moves to increase the price of cigarettes and will support the efforts of HM Customs and Excise to crack down on illegal smuggling operations. We aim to use the planned public consultation exercise around passive smoking to build the international profile of Scotland's approach to tobacco control and engage in a positive exchange of best practice with experts throughout the world.
- 6.8 Within Scotland our main challenge is now one of monitoring and enforcement. We will support the roll out of proof-of-age cards and work closely with our partners in monitoring the effectiveness of the ban on tobacco advertising and identifying those who continue to sell tobacco to young people under the age of 16.

## Actions

12. The results of the test purchasing pilot scheme will be carefully considered by the Lord Advocate in order to assess whether the test purchasing arrangements are sufficiently safe, effective and fair to allow the revised prosecution policy adopted for the pilot to remain in place or be extended.
13. In light of the decision on test purchasing, we will agree an enforcement protocol with our local authority partners to guide more effective enforcement of the Children and Young Persons (Protection from Tobacco) Act 1991. We will also look for ways to raise awareness about illegal sales and to encourage the public to report retailers who sell cigarettes to under-16s.
14. We will continue to support the roll out across Scotland of the Dialogue Youth project and associated Young Scot card which provides amongst other things proof of age, and to work with Young Scot, the Scottish Retail Consortium, CoSLA and the Society of Chief Officers of Trading Standards in Scotland to encourage support of the card, including by retailers.
15. We will make subordinate legislation in the Scottish Parliament to deploy the Tobacco Advertising and Promotion Act 2002.
16. We will establish, in partnership with the UK Government, appropriate arrangements to monitor the Tobacco Advertising and Promotion Act 2002 and act to close any loopholes which are identified. This will include monitoring remaining marketing activity, including point-of-sale publicity, distribution strategies, pack design, new product development and corporate social responsibility campaigns.
17. We will continue to work closely with the UK Government to promote tobacco control policies at UK and international level.



CHAPTER 7  
MEASURING PROGRESS

## MEASURING PROGRESS

### The Challenge

**7.1** Earlier chapters of this Plan have said how a number of different organisations and interests will take action to contribute towards our desire for a non-smoking Scotland. At national level, the Executive will play a major role in delivery as will other national bodies such as ASH Scotland, NHS Scotland, PATH and the Scottish Tobacco Control Alliance. For our part we will disseminate and promote the Plan widely; ensure appropriate systems are in place to measure its success; and identify resources as in Chapter 4. At local level, NHS Boards and their community planning partners will be responsible for ensuring delivery.

### Current activity

**7.2** The current tobacco targets were set in the White Paper *Towards a Healthier Scotland*<sup>12</sup> in 1999: These are:

#### Headline target

- Reduce smoking among young people (aged 12-15) from 14% to 12% between 1995 and 2005 and to 11% by 2010.
- Reduce the proportion of women who smoke in pregnancy from 29% to 23% between 1995 and 2005 and to 20% by 2010.

#### Second rank target

- Reduce smoking among adults (16-64) from an average of 35% to 33% between 1995 and 2005 and to 31% by 2010.

**7.3** Until 2002, young people's smoking targets were monitored through a UK biennial survey. The last such survey, *Smoking, drinking and drug use among young people in Scotland in 2000*<sup>13</sup> reported 10% of pupils who were regular smokers – the lowest prevalence since measurements were first taken in 1982. Partly because of the need for disaggregated local data to inform service planning, a new survey, *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)*,<sup>14</sup> designed to monitor substance misuse prevalence among 13 and 15 year olds was introduced in 2002. SALSUS continues the biennial series of surveys used to monitor national trends in Scotland since 1982 for these two age groups and also incorporates items of health, lifestyle and social factors for the first time. SALSUS 2002 reported that 8% of 13 year olds and 20% 15 year olds were regular smokers. In both age groups girls were more likely to be regular smokers than boys.

<sup>12</sup> *Towards a Healthier Scotland*. The Scottish Office 1999

<sup>13</sup> *Smoking, drinking and drug use among young people in Scotland in 2000*: NCSR and NFER: Scottish Executive

<sup>14</sup> *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report*: National Statistics publication ISBN 011-497314-8

Although there is an apparent decrease in smoking among 13 year olds since 1998, these changes were not statistically significant. Smoking prevalence in 15 year olds has also decreased since its peak in 1996 (30%) but it is only among boys that the change was statistically significant.

- 7.4** Maternal smoking is monitored through data from Maternity Inpatient and Day Case records (SMR02). Latest figures from Information Services Division (ISD) report that in 2002 27% of Scottish pregnant women smoked in early pregnancy.
- 7.5** Adult smoking rates are monitored through several data sources. Latest available figures from the 2002 Scottish Household Survey<sup>15</sup> show 31% of men (aged 16-64) were current smokers which is a small decrease from the 1995 figure of 34% from the Scottish Health Survey. The percentage of women (aged 16-64) smokers decreased from 36% in 1995 Scottish Health Survey<sup>16</sup> to 32% in the 2002 Scottish Household Survey. However, in 2001, people living in most deprived areas (Carstairs Quintile 5) were twice as likely to smoke as people living in most affluent areas (Carstairs Quintile 1) in Scotland, ie 41% and 18% respectively. However, a percentage of smokers – 70% overall – were in the lower socio-economic groups.

#### **Future direction**

- 7.6** While these figures suggest we are moving in the right direction in terms of these targets, it needs to be borne in mind that the decline in smoking rates over the past 30 years has been mainly among more affluent people. The trend in young girls smoking is also disappointing.
- 7.7** We will judge success of this Plan by continuing to measure performance against the three targets, on children smoking, adults smoking and smoking in pregnancy. However, to reflect action in this Plan, we now propose to adjust the adult target to 29% by 2010. Moreover, primarily in order to drive progress in reducing smoking levels among more disadvantaged groups, we propose to revisit all the national targets in light of the results of SALSUS 2002, the latest Scottish Household Survey and the Scottish Health Survey 2003. We will also require NHS Boards and their partners in health improvement to set and monitor local targets to underpin achievement of the national targets set. This process will be informed by the *Smoking Atlas of Scotland*, to be published by the end of March 2004, which is a source of guidance to NHS Boards, local authorities and MSPs on the level of smoking and related harm in their area and the consequent scale of the challenge they face in reducing it.

---

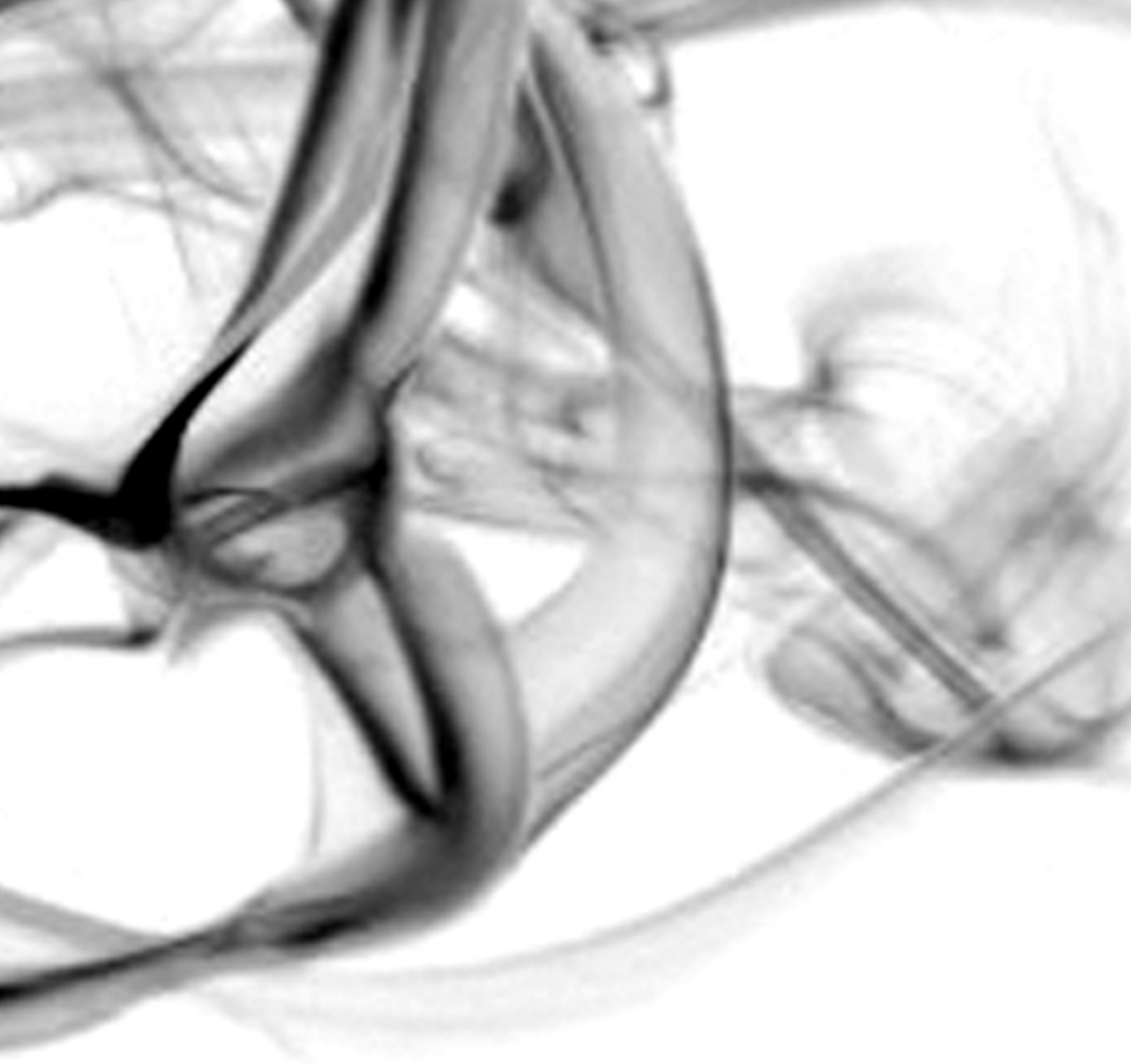
<sup>15</sup> Scottish Household Survey 2002

<sup>16</sup> Scottish Health Survey 1995

- 7.8** At local level, Joint Health Improvement Plans will be the focus for tobacco control activity. Local action will continue to be monitored through the Performance Assessment Framework which contained four smoking indicators relating to pregnant women and adult smoking rates. However, we will also continue to explore other possible means to monitor smoking rates and other proxy indicators which might be used also to measure progress.

### **Actions**

18. NHS Boards should have broad-based programme of tobacco control action which will be monitored through the Performance Assessment Framework.
19. To reflect the action in this plan, the Scottish Executive will increase its existing target for smoking rates amongst adults (aged 16-64) to 29% by 2010. We reconfirm our commitment to reducing smoking amongst young people (aged 13-15) to 12% in 2005 and 11% by 2010 and reducing the proportion of women who smoke in pregnancy to 23% in 2005 and 20% in 2010.
20. The new Ministerial Working Group will review these targets in 2004 following the publication of the *Smoking Atlas of Scotland* and the latest results from the Scottish Health Survey, Scottish Household Survey and surveys of Scottish school children. This will allow us to consider the potential for targets based on specific areas or demographic groups. In the meantime, NHS Boards and their health improvement partners should set local milestones as a stepped process towards meeting national targets.



## APPENDICES

## APPENDICES

### Summary of recommendations made in *Reducing Smoking and Tobacco-related Harm* and action to address them

#### Appendix 1

Recommendations	Action Points
<p>1. The implementation of the UK ban on tobacco advertising in Scotland should be rigorously enforced, systematically and carefully monitored and the legislation amended if necessary to minimise circumventions.</p>	<p>Chapter 6: Protection and controls</p> <p>Action 16</p>
<p>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 <i>Improving Health in Scotland: the Challenge</i>. The plan should set realistic priorities, outcome targets and timescales.</p>	<p>Tobacco Control Action Plan: <i>A Breath of Fresh Air for Scotland</i></p>
<p>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.</p>	<p>Chapter 2: The approach</p> <p>Action 1</p>
<p>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.</p>	<p>Reduction of poverty and social inclusion are key components of the Partnership Agreement</p>
<p>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.</p>	<p>Chapter 3: Prevention and education</p> <p>Actions 2 and 3</p>

Recommendations	Action Points
<p><b>6.</b> 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.</p>	<p>Chapter 3: Prevention and education</p> <p>Actions 2 and 3</p>
<p><b>7.</b> 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.</p>	<p>Chapter 3: Prevention and education</p> <p>Actions 2 and 3</p>
<p><b>8.</b> 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.</p>	<p>Chapter 3: Prevention and education</p> <p>Actions 2 and 3</p>
<p><b>9.</b> The Scottish Executive and all NHS Boards should ensure that effective smoking cessation services of sufficient size and variety to meet local needs are available in every area. To achieve this, adequate long-term funding is essential. The assessment of need for services should be based on estimates of the number and profiles of smokers. The type of smoking cessation services provided should reflect the best available evidence for effectiveness and value for money and should be delivered in a number of different settings by appropriately trained staff.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Actions 4-6</p>
<p><b>10.</b> 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.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Actions 4-6</p>

Recommendations	Action Points
<p><b>11.</b> 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 in providing smoking cessation support themselves or in referring patients to appropriate services.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Actions 4-6</p>
<p><b>12.</b> 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.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Action 5</p>
<p><b>13.</b> 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.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Actions 4-6</p>
<p><b>14.</b> 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.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Key role of PATH</p>
<p><b>15.</b> 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.</p>	<p>Chapter 4: Provision of smoking cessation services</p> <p>Key role for PATH which is funded by the Executive</p>
<p><b>16.</b> All schools in Scotland should be smoke-free zones for everyone as part of the Health Promoting School concept.</p>	<p>Chapter 5: Second-hand smoke</p> <p>Action 11</p>

Recommendations	Action Points
<p><b>17.</b> 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. The need for legislation to achieve these objectives should be carefully considered.</p>	<p>Chapter 5: Second-hand smoke (passive smoking)</p> <p>Actions 7-11</p>
<p><b>18.</b> Efforts to enforce the law on the sale of cigarettes to under-16s should be intensified.</p>	<p>Chapter 6: Protection and controls</p> <p>Actions 12-14</p>

## **Appendix 2:**

### **Membership of the Scottish Tobacco Control Strategy Group**

#### Scottish Executive

Colin Cook, Substance Misuse Division, Health Department (HD)  
Joyce Whytock (Secretary), Substance Misuse Division, HD  
Mary Cuthbert, Substance Misuse Division, HD  
Joyce Edwards, Health Improvement Division, HD  
David Pattison, Health Improvement Division, HD  
Hugh Purves, Pharmacy Division, HD  
Linda Miller, Pupil Support and Inclusion Division, Education Department (ED)  
Dr Elizabeth Stewart, Medical Services, HD

#### External

Lindsay MacHardy, Director of Programmes, NHS Health Scotland  
Sally Haw, Research Specialist, NHS Health Scotland  
Dr Laurence Gruer, Public Health Specialist, NHS Health Scotland  
Professor Gerard Hastings, Director, Centre for Tobacco Control Research  
Maureen Moore, ASH Scotland  
Graham Lyell, Lothian NHS Board  
Brian Pringle, Scottish Tobacco Control Alliance  
Dr Sinead Jones, Director, Tobacco Control Resource Centre, BMA  
Paul Ballard, Health Promotion Managers Group  
Rohini Kharbanda, CoSLA

© Crown copyright 2004

Astron B32533 1-04

ISBN 0-7559-0981-X



9 780755 909810