

**Kumar N (Nim)**

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**From:** Glen J (John)  
**Sent:** 25 May 2005 13:17  
**To:** Kumar N (Nim)  
**Subject:** British Psychological Society FW: smoking consultation response



smoking.doc (119 KB)

-----Original Message-----

**From:** Christina Docchar [mailto:chrdoc@bps.org.uk]  
**Sent:** 25 May 2005 12:16  
**To:** Glen J (John)  
**Subject:** smoking consultation response

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Dear Mr Glen

I have pleasure in attaching a response to the Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005:draft. The response has been prepared by the Scottish Branch of our Division of Clinical Psychology Faculty of Clinical Health Psychology and the Division of Health Psychology - Scotland. The Society welcomes to opportunity to contribute as psychologists have much to offer with regard to smoking cessation.

The British Psychological Society is the learned and professional body, incorporated by Royal Charter, for psychologists in the United Kingdom. It has a total membership of over 42,000 and is a registered charity.

The key Charter object of the Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge".

The Society is authorised under its Royal Charter to maintain the Register of Chartered Psychologists. It has a code of conduct and investigatory and disciplinary systems in place to consider complaints of professional misconduct relating to its members. The Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology. It also has in place quality assurance programmes for accrediting both undergraduate and postgraduate university degree courses.

Please do not hesitate to contact me at chrdoc@bps.org.uk if you would like further information or further input.

Yours sincerely

Dr C M Crawshaw Psychol AFBPsS  
Chair, Professional Practice Board

(See attached file: smoking.doc)

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## The British Psychological Society

### **Response to Consultation On Draft: The Smoking, Health And Social Care (Scotland) Act 2005 (Prohibition Of Smoking In Certain Premises) Regulations 2005**

#### Schedule 1

The Society broadly agrees with the proposals put forward in the Act to implement a ban on smoking in most public places and recognises the health and social benefits for smokers and non-smokers alike.

In addition to the harmful effect of passive smoking the prohibition of smoking in certain premises is likely to be beneficial for those trying to stop smoking. Research evidence indicates that the environment in which quitters are most likely to lapse is in social settings such as bars with other smokers present and that people benefit from social support from others in their attempts to stop smoking. Smoking is a social behaviour, and the social context, social relationships and broader socio-cultural normative influences are very important both for smoking initiation (Bell et al, 1999) and cessation or behaviour change (Pisinger et al, 2005).

We therefore support this policy, which has the twofold effect of helping people who are trying to stop smoking and benefiting non-smokers by providing a smoke free environment in a wide range of social and public settings.

#### Schedule 2: Exemptions

The Society notes that Adult Care Homes (Q7) and Psychiatric Hospitals and Psychiatric Units (Q8) would be considered exempt from the legislation. Where exemptions are made we would stress that it is necessary to protect the health and quality of life of non-smokers in these environments so they are not adversely affected by passive smoking. It is also important to increase provision of smoking cessation assistance for smokers, if this already disadvantaged group of people is not to be further disadvantaged. In addition, targeting health professionals who smoke with cessation advice is also a positive influence on the advice given to patients (Puska et al, 2005).

Q7

The Society welcomes the proposal to exempt Adult Care Homes, while at the same time targeting cessation programmes on this group. We recommend that not only should smoking cessation programmes be targeted at this group, but that further targeting should be made on individuals within this group according to their readiness to adopt non-smoking behaviours. It has more recently been acknowledged that those who are more or less ready to adopt health-beneficial behaviours will respond differentially to group programmes aimed at people presumed to be all at the same stage of readiness (Rollnick, Mason & Butler 2002).

It should also be noted that the elderly suffer disproportionately from health problems in relation to the effects of smoking and that they are also less likely to attempt to quit than younger people, but more likely to be successful in attempts to quit (Burns 2000). Although the benefits of smoking cessation are expected to be less for those in care homes, there is nevertheless evidence from research in the UK that quitting will result in positive health benefits for older people (Peto et al 2000). Promoting a smoking ban in public places has also been associated with more positive attitudes to quitting in elderly smokers in the USA (Honda, 2005). We would therefore strongly support attempts to target smoking cessation services in this group.

Q8

There is evidence that the physical health of people with mental illness is relatively poor. Deaths from respiratory disease were four times higher in people discharged from psychiatric care in Scotland (Stark et al, 2003) and almost ten times higher in people with schizophrenia in another study (Joukamaa et al 2001). This increased risk is attributed to smoking. We therefore welcome the statement that ‘Ministers are committed to ..... implement a programme of targeted cessation across the sector in support of this aim’ (Annex B, p3).

Whereas it is noted with reference to Adult Care Homes and Psychiatric Hospitals and Units, that “guidance will be issued to assist those responsible for running these facilities ... including offering targeted cessation advice and support to those who wish to give up smoking” (Annex C, p22) we would suggest that guidance alone may be insufficient, and resources may need to be committed to increasing provision of such services. Psychologists would be ideally placed to contribute to individually tailored cessation programmes for this group of people and would also have the ability to identify which patients would not be suitable for such interventions owing to severe mental illness or suicide risk.

## **ANNEX C**

### **Draft Regulatory Impact Assessment**

The Society would support **Option 2 – Smoke Free legislation.**

As noted above, evidence suggests this would maximise both reductions in smoking and attempts to quit. Combining increased provision of smoking cessation programmes with such legislation is likely to maximise the health benefits.

The Society is also pleased to see proposals for an increase in funding for smoking cessation interventions over the course of the next few years. It suggests that banning smoking in public places may encourage many current smokers to consider their smoking behaviour in a more critical manner. For these people the provision of targeted, evidence-based smoking cessation advice and intervention programmes may become even more important in helping with the transition from contemplation to action in stopping smoking.

We also recommend that some innovation with regard to the routing of fine monies outlined in the act would be welcome. For instance, it suggests that at least some of the fine monies might be used to “top up” funding for smoking cessation services; this would provide the opportunity for further group, and individual, targeting of such services.

There is generally reasonable evidence to support group interventions for smoking cessation, particularly when such interventions are tailored to suit the individual’s readiness to stop smoking in those with heart problems (Wilson et al 2000; U.S Public Health Service 2000). However, it has also been shown that simple and strong advice from primary health-care professionals can be equally effective in some cases and also less expensive (Law & Tang 1995). It might be hypothesised that the reason some smoking cessation interventions are not as successful as they might be is because participants are not more carefully screened beforehand for their readiness to adopt such behaviour.

Annex C (p6) notes that “introduction of either smoke-free policies or partial restrictions leads to significant numbers of smokers quitting with consequential increasing demand for smoking cessation services” and the Society wishes to emphasise the skills of psychologists with regard to smoking cessation. Psychologists’ skills in communication and treatment may be particularly relevant in those people who may sadly become more entrenched in their smoking behaviour as a result of the ban on smoking in public places as outlined in this very worthy Act. There is sometimes a tendency for us all to ignore or blame those who appear uninterested or unmotivated to engage in healthy behaviours. Some of these individuals may lack confidence to make changes to their lifestyle, even when they perceive how important such a change might be. The Society therefore recommends that the word “targeted” within the bill be used with the realisation that it should apply to individuals, and not just specific populations.

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