Towards a future without tobacco

The Report of
The Smoking Prevention Working Group

November 2006
The Aim of this Report

More than any other single thing, the cigarette has blighted the health and shortened the lives of people in Scotland for over a century. Tobacco is now known to be a highly addictive substance that seriously damages the health of both smokers and people exposed to tobacco smoke. If the health of people in Scotland is to be improved and inequalities reduced, smoking prevention must be a top priority.

This report makes a comprehensive series of recommendations intended to protect and dissuade all young people in Scotland from starting to smoke and to deter adults, individually and collectively, from encouraging or enabling them to smoke. Their full implementation should take Scotland much further towards a future where smoking tobacco has become a thing of the past.
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Summary and recommendations

Chapter 1 Why do some people become smokers and how can this be prevented?
The active drug in tobacco is nicotine. Nicotine is highly addictive, acting on the same parts of the brain as other psychoactive drugs such as heroin and alcohol. Addiction to nicotine can develop within weeks or months of starting to smoke. However, few young people are aware of nicotine’s addictiveness and many young regular smokers do not think they are addicted. Whilst recognising that smoking is unhealthy, many young people think it has some benefits such as helping to cope with anxiety, controlling weight or creating a positive self-image and identity. Many other factors contribute to encouraging young people to start and continue smoking including: parental attitudes and behaviour; friends who smoke; and the availability, cost and perceived attractiveness of cigarettes. An effective smoking prevention strategy should therefore both reduce the availability of cigarettes and other tobacco products and discourage young people from wanting to smoke.

Chapter 2 Current patterns and trends in smoking by young people in Scotland
In Scotland in 2004, at age 13 about 5% of boys and 7% of girls are regular smokers. At 15, about 14% of boys and 24% of girls are regular smokers. In the last ten years, boys’ smoking rates have fallen much more than girls’. Rates for boys are among the lowest in Europe, for girls among the highest. Smoking rates continue to rise through the late teens and early twenties. Among 16-24 year olds in 2003, 32% of men and 29% of women are regular smokers.
Substantially higher rates of smoking among 15 year olds are associated with: having a parent or elder sibling who smokes; living with a single or step parent; having lower levels of parental supervision and spending more nights out with friends; truanting, being excluded from school and juvenile offending.
Regular smoking is more common among disadvantaged young people, especially girls. The link with disadvantage becomes stronger with age. Smoking is less common among girls of South Asian origin, but data for other ethnic groups are lacking. Regular smoking is strongly associated with the use of alcohol and other drugs, especially cannabis. Among 13 year olds, 48% of smokers had used other drugs in the past month compared with 1% of never smokers. Among current smokers at age 23, the majority have used other drugs in the last year.

Chapter 3 Sources, availability and marketing of cigarettes to young people
Thirteen and 15 year olds in Scotland have little difficulty in buying cigarettes from shops, indicating a widespread disregard for the law of age of purchase at 16. Research shows that vigorous enforcement of age of purchase laws may help reduce youth smoking rates. Given that the harmfulness of tobacco is at least as great as that of alcohol, there is a strong case for raising the age of purchase of tobacco to 18. While raising the age of purchase of tobacco has not been shown to reduce youth smoking rates on its own, it may well do so as part of a comprehensive package of
control measures including vigorous enforcement and a negative licensing scheme for persistent offenders. Raising the price of cigarettes through increasing taxes has been shown consistently to reduce youth smoking rates. This is arguably the most effective measure that can be taken to reduce smoking by young people.

Packets of ten cigarettes are particularly popular with teenage smokers. Smuggling of cigarettes currently accounts for a significant proportion of cigarettes in circulation, particularly in disadvantaged areas. There is good evidence that the marketing of cigarettes has been successful in encouraging young people to smoke. Whilst advertising and sponsorship have now been banned, opportunities still exist for other forms of marketing. Positive images of smoking are still found in the media including the youth media (e.g., magazines and films).

A series of recommendations are made aimed at making cigarettes less affordable, accessible and attractive to children and young people.

Chapter 4 Evidence for the effectiveness of smoking prevention programmes

Several major long-term, comprehensive American state-wide smoking prevention programmes appear to have contributed to declines in teenage smoking rates, although it was several years before the effects were seen. A small number of media campaigns have been shown to contribute to reducing youth smoking rates, as part of a wider smoking control strategy. They were intensive and long-lasting and used strong, carefully designed messages on TV, supported by other media. Some multi-stranded campaigns involving community action have been effective but the contribution of community action and its possibly effective elements have not been clearly identified.

Reviews of the evaluations of large numbers of mainly American school-based smoking and drug prevention programmes show that most are ineffective in reducing smoking rates. Some programmes using social influence methods, including peer-led approaches, reported positive short-term effects on smoking rates but it is unclear why these were effective and other similar programmes were not. A peer-supported preventive programme in South Wales is showing early promise.

Few programmes appear to have addressed the underlying factors associated with higher rates of smoking and other drug use by young people. Although rates of smoking and other drug use continue to rise after leaving school, few preventive programmes have focused on this older age group.

Chapter 5 The current policy context and smoking prevention initiatives in Scotland

The new legislation on smoking in public places has the potential to make a major contribution to smoking prevention by reducing young people’s exposure to second-hand smoke and reinforcing a negative image of smoking. Over the past eight years, there has been a series of anti-smoking adverts on Scottish TV that have achieved high viewer awareness and accurate recognition of the message but an unknown impact on smoking behaviour. Websites and other new technologies are beginning to be used to promote anti-smoking and other health messages but their impact is not known.

A major recent study has shown that most Scottish schools are providing education about drugs including tobacco but there is great inconsistency in the methods and
materials used, the training of staff and the level of coordination within and between the primary and secondary school curricula. An anti-smoking campaign using community development principles did not achieve changes in attitudes or behaviour in the local community. A pilot programme of various different types of smoking cessation services for young people in Scotland did not prove to be effective in helping smokers quit. Both these initiatives offer useful lessons about how to proceed in the future.

By reducing the proportion of parents and other adults who smoke, action to increase smoking cessation among adults (eg cessation services, taxation and smoke-free environments) may in the long term make a major contribution to smoking prevention among young people.

Chapter 6 Implications of the research evidence and recent experience in Scotland for future preventive initiatives

There is good evidence that a comprehensive integrated approach to smoking prevention can reduce smoking rates among young people. A well-designed on-going, intensive, multi-stranded media campaign can contribute by conveying potent messages to large numbers of young people. Target audiences should include girls and young women in disadvantaged circumstances and young people in their late teens.

Given the equivocal research evidence and the inconsistency of drugs education in Scottish schools, there needs to be a careful reappraisal of how it is done. The Ambitious, Excellent Schools agenda and the Health Promoting Schools programme provide a framework within which a comprehensive new approach to drugs education including smoking prevention in schools can be developed. Further detailed work will be required to design its content and integration into the school curriculum as a whole. The message on tobacco should be uncompromising: never smoke. Effective support and management of pupils with behavioural or family problems is highly relevant to smoking prevention. Informing parents about tobacco, alcohol and other drugs and their responsibilities in this regard should also be an integral part of drugs education.

Given the large number of young people who start smoking or become heavier smokers once they leave school, universities and further education institutions should play a bigger part in discouraging young people from smoking (or misusing alcohol or other drugs).

Given the lack of impact of the only Scottish community development based initiative for smoking prevention and of a series of pilot smoking cessation services for young people, any plans for future initiatives of these types should take full account of what has been learned from these studies and should be fully evaluated. There is a need for innovative research studies that aim to identify ways to prevent children and young people in disadvantaged circumstances from starting to smoke.

In the long-term, increasing smoking cessation among adults who are or will be parents is likely to contribute to the prevention of smoking among young people. Where cessation is not attained, stopping smoking in the home may also contribute to the prevention of smoking among young people.
Recommendations

Targets
1. New separate targets should be set for boys and girls at both 13 and 15 as follows (See paragraph 2.24).

<table>
<thead>
<tr>
<th>% regular smokers at these ages</th>
<th>Rate in 2002 SALSUS</th>
<th>Rate in 2004 SALSUS</th>
<th>Target for 2010</th>
<th>Target for 2015</th>
<th>Target for 2020</th>
<th>Target for 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys age 13</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Girls age 13</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Boys age 15</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Girls age 15</td>
<td>24</td>
<td>24</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

2. The following new targets should be set for 16-24 year olds (See paragraph 2.25).

<table>
<thead>
<tr>
<th>Adults age 16-24</th>
<th>Rate in 1998 Scottish Health Survey</th>
<th>Rate in 2003 Scottish Health Survey</th>
<th>Target for 2010</th>
<th>Target for 2015</th>
<th>Target for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults age 16-24</td>
<td>35%</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Research
3. Priority should be given to commissioning research that can provide a clearer understanding of current knowledge, attitudes and behaviour relating to the use of tobacco, alcohol and other drugs among 16-24 year olds. Regular surveys of 13 and 15 year olds should be continued (See paragraph 2.26).

4. All the new measures proposed in this report should, if implemented, be subject to rigorous evaluation to establish their impact and cost-effectiveness (See paragraph 2.27).
Reducing availability
The Scottish Executive should implement an integrated series of measures aimed at substantially reducing the availability, affordability and attractiveness of cigarettes and other tobacco products to young people. It should:

5. ensure that much greater efforts are made to enforce the prevailing legal age of purchase. These should include: the use of proof of age; active test purchasing; prosecution with heavy fines and education of retailers and trading standard officers (See paragraph 3.6).

6. introduce a negative licensing scheme to enable vendors who repeatedly sell cigarettes to under-age customers to be prohibited from selling tobacco products (See paragraph 3.8).

7. amend the current offence of selling tobacco products to anyone under the age of 16 by raising the minimum age to 18. There should be a sufficient delay between amending the legislation and its implementation to prepare both customers and retailers for a smooth transition. Its impact should be carefully evaluated (See paragraph 3.13).

8. urge the UK Government annually to increase the price of tobacco products at a rate faster than inflation (See paragraph 3.16).

9. make representations to the UK Government to urge that health considerations are taken into account in the decision making process of EU policy concerning the taxation of tobacco products, as is required by the Framework Convention on Tobacco Control (See paragraph 3.17).

10. refer the issue of the sale of packs of ten cigarettes to the UK Government for consideration in the light of further research into its likely impact (See paragraph 3.22).

11. commission research to ascertain the extent to which young people in Scotland purchase cigarettes in packs of ten (See paragraph 3.22).

12. commission research to ascertain the current extent of use of smuggled or personally imported tobacco by young people (See paragraph 3.31).

13. ensure that Customs and Excise and the police in Scotland both put a high priority on activities aimed at reducing the influx of smuggled tobacco (See paragraph 3.31).

14. urge the UK Government to maintain and if necessary increase the investment in staff and equipment needed to control the influx of smuggled tobacco (See paragraph 3.31).

15. urge the UK Government to review the appropriateness of the current limits for the importation of cigarettes from other EU countries for personal use and the effectiveness of the controls thereof (See paragraph 3.31).
16. urge the UK Government to work collaboratively with the EC and other Member States to help develop a comprehensive international protocol on illicit tobacco as agreed at the first Conference of the Parties of the Framework Convention on Tobacco Control (See paragraph 3.31).

17. reinforce the UK Government’s intention to require graphic photographs of smoking-related diseases to be displayed on cigarette packets (See paragraph 3.37).

18. together with the UK Government and other devolved administrations, look at ways to reduce positive images of smoking in the media and associated publicity materials, including reviewing any additional measures which might be taken to strengthen the ban on tobacco advertising and promotion introduced in 2002 (See paragraph 3.38).

19. prohibit the display of cigarettes at the point of sale, to be replaced by a simple list of the brands available and their prices (See paragraph 3.39).

Discouraging young people from smoking

The Scottish Executive should also implement an integrated series of measures aimed at discouraging young people from starting to smoke and encouraging and enabling young smokers to stop:

20. Building on previous work by Health Scotland and the Health Education Board for Scotland, an on-going, multi-stranded media campaign should be designed and implemented to discourage the uptake of smoking by young people of any age. One strand should have a strong focus on developing messages and using media that will have resonance with girls and young women in disadvantaged circumstances. Another should target young people in their late teens (See paragraph 6.2).

21. A comprehensive reassessment and reform of education on tobacco, alcohol and other drugs in Scottish schools should be carried out by a working group whose members bring expertise in drugs education research and delivery and in the design, integration and delivery of complex educational programmes across the curriculum. (See paragraph 6.5).

22. Given the importance of parents’ influence upon whether or not their child will smoke, an integral part of drugs education in school should be to inform parents about tobacco, alcohol and other drugs and their responsibilities in this regard. This should mainly be done by sending parents clear, consistent information at regular points during their child’s progress through school (See paragraph 6.6).

23. At the relevant stages, parents should be encouraged by midwives, health visitors, general practitioners and hospital doctors, nursery staff and teachers to create a smoke-free home and not smoke when their children are present. (See paragraph 6.6).
24. Embracing the concept of the Health Promoting School, all schools should develop an holistic approach to the health and well-being of their pupils. The aim should be to ensure that the school’s ethos, policies, services and extra-curricular activities all foster the health and well-being of all the pupils. This should include having and strictly enforcing a school no-smoking policy covering everyone using the school grounds (See paragraph 6.7).

25. Given the association between smoking (and other drug use) and mental health problems, truancy and juvenile offending, all schools should have effective systems for the assessment, support and care for such pupils, including the ability to liaise effectively with social services where necessary (See paragraph 6.8).

26. Given the clear evidence that many young people start to smoke or progress from occasional to regular smoking (and drink heavily or use other drugs) once they leave school, Universities, Colleges of Further Education, student associations, the National Union of Students and other major training providers should be invited to explore how they could better enable students or trainees to avoid starting to smoke or misuse alcohol or other drugs. This could be developed within the framework of “The Health Promoting University” (See paragraph 6.9).

27. Research studies should be commissioned to test innovative, carefully designed ways of protecting and dissuading young people in disadvantaged areas from starting to smoke or becoming regular smokers (See paragraph 6.11).

28. All community-based youth organisations should be encouraged to adopt clear no-smoking policies and to use the opportunities open to them to reinforce the message about the addictiveness and harm to health of smoking (See paragraph 6.11).

29. In the light of the recent poor outcome of the pilot smoking cessation services for young people in Scotland we recommend that active consideration is given to developing other approaches within a carefully designed evaluation framework (See paragraph 6.12).

Making things happen

30. Given that implementation of the recommendations in this report would largely affect young people, a representative sample of young people should be consulted to seek their views on the recommendations (See paragraph 6.14).

31. The recommendations in this report should be used by the Scottish Executive as the basis for developing a fully resourced five year Action Plan, with built in performance measures subject to monitoring by the Scottish Ministerial Group for Tobacco Control (See paragraph 6.15).
Membership of the working group

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Acknowledgments and thanks
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Dr Eleanor Anderson for conducting literature reviews of evidence for effectiveness.
Brian Crook of The Bridge Advertising Agency and Danielle Sharp NHS Health Scotland on approaches to smoking communications.
Martine Stead of Stirling University and Bob Stradling of Edinburgh University on ‘The Nature and Effectiveness of Drug Education Practice in Scottish Schools’.

With respect to raising the age of sale of tobacco, we were aided by a Parliamentary briefing session organised by Duncan McNeil MSP relating to Guernsey's experience of raising the age of sale of tobacco from 16 to 18 and by submissions from ASH Scotland, the Scottish Coalition on Tobacco and the Scottish Parliament's Cross Party Group on Tobacco.
Introduction

Over the past 50 years, tobacco has been unmasked as a wolf in sheep’s clothing: a lethal combination of a highly addictive drug and, when smoked, a host of toxic chemicals capable of causing a wide range of serious diseases. It has been estimated that smoking has caused around 685,000 premature deaths in Scotland in the last 50 years and still results in over 13,000 deaths a year\(^1\).

Given what we now know about tobacco, if it were to be introduced as a new product today, it is inconceivable that it would be allowed onto the market. Arguably, the only justification for its continued legal status in the United Kingdom is that there are already over ten million adult smokers. To deny them legitimate access to cigarettes would create an immense black market with unacceptable social consequences. Nevertheless, there is widespread agreement that we should do all we can to prevent and dissuade young people from starting to smoke. Even sections of the tobacco industry now acknowledge that tobacco is addictive and dangerous, and that children should be protected from it.

In *A Breath of Fresh Air for Scotland*, published in 2004, the Scottish Executive made a commitment to working towards making Scotland “a society in which everyone aspires to live a healthy smoke-free life and has access to the support that can help them realise this ambition”\(^2\). It set out an Action Plan for putting this commitment into action. It has three main aims:

- To help as many smokers as possible to stop smoking if they wish to;
- To protect the public from the effects of second-hand smoke;
- To prevent as many people as possible from starting to smoke.

Since *A Breath of Fresh Air for Scotland* was published, much more progress has been made than most people would have thought possible even five years ago. We now have a nation-wide network of smoking cessation services, helping thousands of people to quit. For those who need it to help give up, nicotine replacement therapy (NRT) is available free on prescription or can be purchased over the counter in pharmacies.

On March 26, 2006, the historic legislation banning smoking in enclosed public places came into effect. It has already been hailed as a huge success, dramatically reducing exposure to tobacco smoke in all enclosed public places.

If smoking is to be made a thing of the past, the third great challenge is to prevent people from becoming smokers. In order to advise the Scottish Executive how this should be done, the Smoking Prevention Working Group (SPWG) was set up as a sub-group of the Scottish Ministerial Working Group on Tobacco Control. It was asked to make recommendations for the development of a new long term smoking prevention strategy to guide future tobacco control prevention activity at national and local levels. This would include reviewing current national communication and education programmes and the development of a long term communication strategy. The SPWG was also asked to advise Ministers on the question of evidence to support...
raising the age of sale of tobacco products from the current age of 16. The group’s formal remit is set out below:

**General**

- to scope current national and local activity aimed at preventing smoking among young people in Scotland since 1999;
- to review the evidence of effectiveness of different approaches to preventing smoking among young people;
- to identify gaps in our knowledge which require to be filled; and
- to make recommendations to assist the development of a new long-term integrated smoking prevention strategy.

**Specific to age of purchase**

- to consider in relation to the age of purchase:
  - the significance of the legal age limit in relation to uptake of smoking;
  - the evidence on this from other countries; and
  - to make recommendations to Ministers.

The group met on six occasions between August 2005 and May 2006. It considered a wide range of evidence from research in this country and abroad. It received presentations on key aspects such as prevention in schools and use of the media.

It is therefore the aim of this report to recommend a comprehensive range of measures designed to prevent people from starting to smoke and becoming regular smokers. Each of our recommendations has its own justification as a contribution to smoking prevention, but we hope that collectively they will have an effect even greater than the sum of the parts. Our intention is to help move Scotland decisively towards a future where smoking is a thing of the past.

**Definitions**

In this report, **young people** refers to the age group 10-25 years although some of our evidence may refer to individuals who were younger or older than this.

**Regular smoking** is defined as smoking at least weekly among under 16s and at least daily among over 16s. These differences reflect the definitions used in the main surveys cited in this report.
1. Why do some people become smokers and how can this be prevented?

Key points

- Nicotine is a highly addictive drug, acting on the same parts of the brain as other drugs such as heroin, cocaine and alcohol.
- Addiction to nicotine can develop within weeks or months of starting to smoke. However, many young smokers do not think they are addicted.
- Whilst recognising the health hazards, many young people see some benefits in smoking such as coping with anxiety, controlling weight or creating a positive self-image and identity.
- Many other factors contribute to encouraging young people to start and continue smoking including: parental attitudes and behaviour; friends who smoke; and the availability, cost and perceived attractiveness of cigarettes.
- An effective smoking prevention strategy should both reduce the availability and affordability of cigarettes and other tobacco products and discourage young people from wanting to smoke. It should be informed by young people’s views through active consultation.

1.1 If we are to be successful in preventing young people from becoming smokers, we need to understand why they start smoking in the first place and why they continue.

1.2 The single most important factor that turns a beginner into a regular smoker is the addictiveness of the nicotine in tobacco. It is now known that nicotine acts on the same parts of the brain as do other drugs such as heroin, cocaine and alcohol. With repeated use, the brain becomes accustomed to the nicotine. Repeated exposure to the nicotine gradually brings about subtle changes in how certain parts of the brain work. As a result, a state is reached where the smoker finds that he or she needs to smoke to feel comfortable. Many other factors reinforce the purely chemical effect of the nicotine – the associations between smoking and other things, such as being with friends, having a drink or reacting to stressful situations. Even the smell of tobacco itself can produce a strong urge to smoke. In addition, the cigarette is a highly efficient nicotine delivery system. The nicotine from inhaled cigarette smoke is rapidly absorbed and carried to the brain almost as quickly as an intravenous injection of heroin. The resultant “hit” enhances the drug’s addictiveness.

1.3 Recent research suggests that addiction to nicotine can develop very quickly - within a few months or sometimes just a few weeks. A study of 12 and 13 year olds in the US found that 40% of new smokers quickly developed signs of addiction – an average of six months in boys but as little as three weeks in girls. The SALSUS survey of 23,000 Scottish 13 and 15 year olds found that 70% of the regular smokers had already tried but failed to give up. By their late teens, most regular smokers do not see themselves as addicted to nicotine, with many believing they are still in control and could stop if they wanted to.
1.4 While nicotine may largely explain why people become and remain regular smokers, it clearly cannot be responsible for the first cigarette. Smoking has to be attractive enough for people to want to start. While most young people know that smoking is a cause of ill-health, the belief remains widespread that it also has its positive side. In a 2004 survey of 11-15 year olds in England, 68% thought it helped people relax if they were nervous and around 20% felt that smokers stayed slimmer than non-smokers, and that it gave people confidence and helped them cope better with life. For some people, therefore, smoking can seem to offer a solution to certain problems. Smoking can also appear to offer the route to acceptance, by friends or colleagues who already smoke. Or it can be legitimised because it is done by people whom you admire – for example, celebrities, elder siblings or parents. Other positive images in the media, including advertising or smoking in films or TV programmes may reinforce its acceptability. Curiosity may also be a strong incentive: “I want to find out what it’s like.” Starting to smoke is also much more likely if you live in a community or society where smoking is common and tolerated and cigarettes are readily available. What may influence the potential smoker not to start is the knowledge that 83% of smokers say they regret having started smoking, and would not smoke if they had their time again.

1.5 If the positive attributes of cigarettes outweigh risks that are seen as minimal, distant or non-existent, trying a first cigarette is highly likely. After the first cigarette, the chances of smoking again are high. In the SALSUS survey, 47% of 13 year olds had tried smoking and 8% were already regular smokers. By 15, 64% had tried smoking at least once and 20% were regular smokers. In a survey of over 2000 15 year olds in the UK, 36% of girls had never smoked, 15% had had one or two cigarettes, 13% between 3 and 9, 11% between 10 and 39 and 24% more than 40.

1.6 If we are to prevent young people from becoming regular addicted smokers, we need to load the balance against the perceived and actual benefits of smoking and in favour of its perceived and actual costs. Figure 1.1 provides a diagrammatic view of a range of factors thought to contribute to whether or not young people become and remain smokers. It divides these factors into three domains: individuals and their knowledge, attitudes and state of mind; their immediate circle of family and friends; and the wider social and cultural environment in which they live. These domains are highly interactive. For example the individual’s attitude to smoking can be shaped by their parents but also influenced by what they see on TV or in magazines. One way of looking at the figure is to see it as the battleground on which the struggle to prevent young people from starting to smoke will be won or lost. Which are the elements that are most amenable to change in favour of smoking prevention in ways that are practical and cost-effective? Table 1 has been adapted from Figure 1.1. It summarises the possible means whereby these factors may make smoking more or less attractive and briefly summarises the evidence for their impact in practice. This evidence will be addressed in succeeding chapters.

1.7 An effective smoking prevention strategy should therefore logically both reduce the availability of cigarettes and other tobacco products and discourage young people from wanting to smoke. In the succeeding chapters we will look in more detail at the relevance of the factors outlined above and at the practical possibilities for modifying them with the aim of preventing smoking.
Figure 1.1 Factors associated with smoking.

**SOCIAL AND CULTURAL ENVIRONMENT**

- Social attitudes and norms
- Culture
- Ethnicity
- Social disadvantage
- Tobacco promotion
- Price
- Availability

**PERSONAL ENVIRONMENT**

- Friends
- School
- Resources
- Social activities
- Relationships
- Knowledge
- Educational attainment
- Self-image
- Skills
- Self-esteem
- Beliefs
- Values
- Nicotine
- Attitudes
- Personality
- Gender

**INDIVIDUAL**

- Social support
- Media
- Family
- Religion
- Tobacco promotion
- Self-image
- Self-esteem
- Educational attainment
- Self-image
- Skills
- Personality
- Gender
<table>
<thead>
<tr>
<th>Factors which may influence uptake of smoking</th>
<th>Potential means of preventing smoking</th>
<th>Evidence for effectiveness of policies or interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge, skills and educational attainment</td>
<td>Lack of awareness of consequences of smoking. Perception of smoking as a good thing. Low intelligence, poor educational attainment and disengagement from school.</td>
<td>Provide clear information about hazards of smoking and develop skills to resist offers of tobacco and other drugs. A supportive school environment.</td>
</tr>
<tr>
<td>Gender</td>
<td>Differing reasons for valuing or rejecting smoking e.g. weight control for girls; self-image, peer relationships, impact on reproduction and fitness.</td>
<td>Provide information about smoking and develop attitudes that address gender specific concerns.</td>
</tr>
<tr>
<td>Self image and self-esteem</td>
<td>Dissatisfaction with self and self-image may lead to use of tobacco and other drugs as a means of problem resolution, coping or creating desirable identity or self-image.</td>
<td>Creating conditions at home, in school etc that build self-confidence, create alternatives for positive self-images and identity and develop positive coping skills.</td>
</tr>
<tr>
<td>Personality &amp; mental health problems</td>
<td>Conduct disorder, truants, impulsive risk-takers more likely to smoke and use other drugs.</td>
<td>Provide support (and treatment) for young people with these problems.</td>
</tr>
<tr>
<td>Attitudes, beliefs and values, ethnicity and religion</td>
<td>Presence or absence of positive or negative attitude to smoking.</td>
<td>Sustaining values and beliefs which reject smoking and challenging positive attitudes to smoking.</td>
</tr>
<tr>
<td><strong>Personal environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and home</td>
<td>Whether parents and/or siblings smoke; parents’ attitudes to smoking; level of parental monitoring.</td>
<td>Support family unit; encourage effective parenting, inform parents about risks of smoking to their children, enable adults to quit; smoke free policies in the home.</td>
</tr>
<tr>
<td>Friends and relationships</td>
<td>Whether friends and/or colleagues smoke.</td>
<td>Reduce opportunities for friends and colleagues to smoke together esp ban on smoking in public and workplaces.</td>
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</tr>
<tr>
<td>School</td>
<td>Young person’s knowledge of potential hazards of smoking.</td>
<td>Provide clear information about hazards of smoking and develop skills to resist offers of tobacco and other drugs.</td>
</tr>
<tr>
<td>School</td>
<td>School ethos and school policies towards smoking</td>
<td>Build supportive school ambiance; clear no-smoking policies.</td>
</tr>
<tr>
<td>Social activities and support</td>
<td>Certain activities may discourage or encourage smoking Eg sport or hanging around with friends.</td>
<td>Provide healthy, fulfilling activities for young people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and cultural environment</th>
<th>Price of tobacco</th>
<th>Decision to buy influenced by price</th>
<th>Increase real price</th>
<th>Strong evidence that raising real price reduces consumption.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Availability of tobacco</td>
<td>Affects ease of obtaining cigarettes</td>
<td>Reduce access by various means eg age of purchase and its enforcement;</td>
<td>Moderate evidence that enforcement of proof of age reduces cigarette purchase by young people and may reduce smoking rates.</td>
</tr>
<tr>
<td></td>
<td>Tobacco promotion</td>
<td>Influences attractiveness of cigarettes and the social image of smoking.</td>
<td>Prohibit all tobacco advertising, promotion and other marketing devices.</td>
<td>Moderate evidence that banning advertising reduces youth smoking.</td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td>Influences perceptions of smoking</td>
<td>Reduce positive images and references to smoking; increase negative references</td>
<td>Strong evidence that some sustained media campaigns have reduced youth smoking.</td>
</tr>
<tr>
<td></td>
<td>Social norms and values</td>
<td>Seeing lots of smokers around may increase acceptability and encourage smoking.</td>
<td>Banning smoking in enclosed public places, media campaigns on passive smoking.</td>
<td>Early evidence that banning smoking in enclosed public places reduces youth smoking.</td>
</tr>
<tr>
<td></td>
<td>Social disadvantage</td>
<td>Smoking a cultural norm in disadvantaged areas; smoking seen as a means of coping with multiple problems.</td>
<td>Enabling upward social mobility; banning smoking in enclosed public places; targeting smoking prevention and cessation programmes in disadvantaged areas.</td>
<td>No evidence as yet that addressing social disadvantage per se reduces youth smoking.</td>
</tr>
</tbody>
</table>
2. Current patterns and trends in smoking by young people in Scotland

Key points

- In Scotland in 2004, at age 13 about 5% of boys and 7% of girls are regular smokers. At 15, about 14% of boys and 24% of girls are regular smokers. In the last ten years, boys’ smoking rates have fallen much more than girls’.
- Rates for boys are among the lowest in Europe, for girls among the highest.
- Smoking rates continue to rise through the late teens and early twenties.
- Among 16-24 year olds in 2003, 32% of men and 29% of women were regular smokers.
- Substantially higher rates of smoking among 15 year olds are associated with:
  - Having a parent or elder sibling who smokes
  - Living with a single or step parent
  - Having lower levels of parental supervision and spending more nights out with friends
  - Truanting, being excluded from school and juvenile offending.
- Regular smoking is more common among disadvantaged young people, especially girls.
- Regular smoking is less common among girls of South Asian origin, but data for other ethnic groups are lacking.
- Regular smoking is strongly associated with use of alcohol and other drugs. In particular, cannabis is typically smoked with tobacco. Among 13 year olds, 48% of smokers had used other drugs in the past month compared with 1% of never smokers. Among current smokers at age 23, the majority have used other drugs in the last year.
- A school’s ethos and policies may have an influence on smoking rates.

2.1 In this chapter, we first look at current patterns and trends in smoking among young people in Scotland. We then consider a range of factors which are strongly associated with higher or lower smoking rates.

2.2 There have been a series of regular, large cross sectional surveys of 13 and 15 year olds in Scotland which give a clear idea of the proportion of young people who smoke regularly at these ages (Figure 1). In these surveys, regular smoking is defined as smoking one or more cigarettes each week.

2.3 Between 1998 and 2004 the prevalence of regular smoking among 13 year olds has decreased from 9% to 5% among boys and from 11% to 7% among girls. Among 15 year old boys, the prevalence of regular smoking has decreased from 30% in 1996 to 15% in 2000 and has since remained around that level. The drop among 15 year old girls over the same period (from 30% in 1996 to 24% in 2000) was smaller and not statistically significant: prevalence has remained at 24% since 2000.
Figure 2.1. Regular smokers among 13 and 15 year olds in Scotland by age group and gender 1982-2004


Comparisons with other countries in Europe.

2.4 The Health Behaviour of School Children (HBSC)\textsuperscript{11} and the European School Survey Project on Alcohol and Drugs (ESPAD)\textsuperscript{12} are two large well-conducted international studies which provide comparisons between Scotland and other European and North American countries. The prevalence of regular smoking in the UK is higher among girls than in most European countries but, among boys, UK smoking rates are among the lowest in Europe (Figures 2.3 and 2.4). Scotland and Wales are two of only four European countries where smoking among boys has declined since 1998. On the other hand, in only Greenland and Scotland is the average onset of both weekly and daily smoking earlier among girls than boys.
**Fig 2.2**: Percentage of 15 year old boys who are weekly smokers\textsuperscript{13}

**Fig 2.3**: Percentage of 15 year old girls who are weekly smokers\textsuperscript{13}
2.5 In Edinburgh, over 4000 children who were 12 in 1998 (the vast majority of 12 year olds in the city at that time) have been followed up every year since then. Figure 2.4 shows the proportion who were smoking at least once a week at each age. As with the cross-sectional studies, it shows that by the age of 15, girls are smoking more than boys. However, the gap has narrowed somewhat by the time they are 17.

![Figure 2.4. Edinburgh study of youth transitions and crime: weekly smoking by sex and age (ref 13)](image)

2.6 In the West of Scotland, a representative sample of almost 1000 young people who were 15 in 1987 has been followed up periodically since then. Figure 2.5 shows that the proportion who smoked at least weekly continued to rise until the mid twenties. The proportion who smoked at least ten cigarettes a day was less than 5% at age 15 but rose rapidly to over 20% by 18 and continued to rise further until the mid 20s. The continuing high prevalence of smoking in this age group is confirmed by the 2003 Scottish Health Survey. In a representative sample of over 900 16-24 year olds, 32% of men and 29% of women were current smokers; 19% of the men and 16% of the women smoked more than ten cigarettes a day.
2.7 The late teens and early twenties is thus a period when many young people start to smoke and many smokers become regular heavy smokers. This is a crucial period of transition from school to higher education or the work environment and greater independence from parents. The role of the cigarette as a perceived reliever of stress, and a tool for socialising and bonding with one’s peers may all have potency for many young people trying to respond to new everyday pressures, establish their own identity and cope with the uncertainties of the future.

2.8 The direction of travel is not always towards smoking. Significant numbers of young people stop smoking, some for good, others for variable periods of time. In the MRC Twenty-07 study, 2% of the sample had been smoking at age 15 but had stopped at age 18; 6% were smokers at 18 but had stopped by 23; and 8% were smokers at 23 but had stopped by age 30\textsuperscript{15}.

Factors strongly associated with smoking by young people

Parents or elder siblings who smoke
2.9 Teenagers are more likely to smoke if their parents or siblings do. SALSUS found that 71% of 13 year old regular smokers and 62% of 15 year old regular smokers had at least one parent who was a daily smoker, compared with only 37% of non-smoking 13 year olds and 36% of non-smoking 15 year olds\textsuperscript{10}. Higher smoking rates were also found among pupils who had at least one sibling who smoked. Having an elder sibling who smoked was found to be strongly and significantly correlated with smoking in all 31 European countries providing data for ESPAD\textsuperscript{12}.

Living with a single parent or a step parent
2.10 The proportion of pupils who smoked is lowest among those living with both natural parents. Among 13 year olds living with both natural parents, 4% of pupils reported smoking regularly compared with 10% of pupils living with one parent and a
step parent and 10% of pupils living with a step parent\textsuperscript{10}. Living with a single parent or a step parent was strongly and significantly correlated with smoking in 25 of 29 reporting countries in Europe\textsuperscript{12}.

**Low levels of parental supervision and more evenings out with friends**

2.11 Both 13 year old and 15 year old regular smokers are less likely to be closely supervised by their parents than non-smokers. In SALSUS, 79% of 13 year olds who were regular smokers reported that their mothers had lower than average levels of knowledge about what they were doing compared with 42% of non-smokers of this age\textsuperscript{10}. Among 15 year olds, 62% of regular smokers and 47% of non-smokers reported lower than average levels of maternal knowledge about their behaviour. At both 13 and 15, boys and girls who were regular smokers were more likely to spend more evenings out than non-smokers and to have less structured leisure time activities\textsuperscript{10}. In 30 of 31 reporting countries in Europe, “adolescents used substantially and significantly more tobacco, alcohol and cannabis when their parents did not know where they spent their Saturday nights”\textsuperscript{12}.

**Friends who smoke**

2.12 SALSUS also found that regular smokers were much more likely than non-smokers to have friends who smoked. Forty-six percent of 15 year olds and 38% of 13 year olds who were regular smokers reported that “all or almost all” of their friends smoked compared with only 4% of 15 year old and 2% of 13 year old non-smokers\textsuperscript{10}. The importance of friends and their wider peer group for smoking has been underlined by studies of the relationships between individuals, for example at school. Scottish research has confirmed work from elsewhere that starting to smoke and moving on to heavier smoking typically involves individuals both selecting and being influenced by the group or groups they associate with\textsuperscript{16, 17}. The popularity of smokers can vary between schools and this in turn can influence the behaviour of others\textsuperscript{18}. Friends who smoke continue to be an important factor in the late teens, by which time parental and sibling influences have waned\textsuperscript{19}. During this time of transition, smoking is often perceived as a means of maintaining and enhancing sociability in new social, educational and occupational spheres\textsuperscript{20}.

**Gender differences**

2.13 As shown above, more girls than boys in Scotland are regular smokers by their mid-teens, although these differences appear to narrow and disappear in the late teens and early twenties. It is increasingly recognised that the factors which influence starting and continuing to smoke are different for boys and girls. A study of Scottish 11 and 13 year olds found that popular or “top” girls were often smokers whereas for boys smoking conflicted with their wish to be fit\textsuperscript{21}. Among 15-16 year olds, some girls saw smoking as part of their rejection of the traditional “good girl” identity\textsuperscript{22}. While both boys and girls who smoke highlight the importance of smoking in their social relationships and dealing with negative feelings, they differ in the way this is expressed. For girls, smoking could be seen as helping when they are upset whereas for boys it is a means of dealing with anger and frustration. Girls are also much more likely to see smoking in relation to their appearance, on the one hand as a means of weight control and enhancing their sexual attractiveness; on the other, a dislike of their bodies and clothes smelling of smoke\textsuperscript{23}. These differences point to the need to design prevention campaigns in ways that address the differing attitudes of males and females.
Truancy and exclusion from school
2.14 SALSUS found that among regular smokers about three-quarters had truanted in the past year compared with 29% of 13 year olds and 39% of 15 year olds who did not smoke\textsuperscript{10}. Regular smokers are also more likely to report they have been excluded since starting secondary school: 28% of 13 year olds and 32% of 15 year olds who were regular smokers had been excluded from school compared with only 6% of 13 year olds and 9% of 15 year olds who were non-smokers\textsuperscript{10}. In every one of 32 reporting countries in Europe there was a strong and significant correlation between truancy and use of tobacco, alcohol and other drugs\textsuperscript{12}.

Juvenile offending
2.15 The Edinburgh transitions study found large and statistically significant correlations between regular smoking and self-reported delinquency (covering a wide range of illegal and anti-social acts) at all ages from 12 to 17. Regular smokers reported on average between three and four times as many delinquent acts as occasional or non-smokers\textsuperscript{14}.

Socio-economic disadvantage
2.16 Among girls, regular smoking is significantly more common in Scotland among those from more disadvantaged areas or whose parents have lower socio-economic status\textsuperscript{10}. The link with family affluence is less clear cut for boys (Figure 2.6). However, both boys and girls whose parents were in manual occupations were about twice as likely to be regular smokers as those whose parents were in non-manual occupations\textsuperscript{9}. Between 2002 and 2004 there was a drop in smoking levels among both 13 and 15 year old boys from “higher affluence” families. During the same period there was no change among boys from lower affluence families or among girls in general\textsuperscript{9}. These differences may at least in part be explained by the much higher proportion of adults and hence parents who smoke in disadvantaged areas. However, there is also evidence that heavier smoking is more likely to develop among the more disadvantaged. Among 15 year olds, the differences between those of higher and lower economic status were more marked among daily than weekly smokers and much more marked among those smoking more than ten cigarettes a day\textsuperscript{24}. This may be part of the explanation why young people from lower socio-economic backgrounds find it harder to quit than their more affluent counterparts.
Ethnic minorities

2.17 Scotland’s population is becoming increasingly diverse, with significant numbers of immigrants having settled here over the last 50 years and a rapid new influx in the last five years of asylum seekers and refugees and, since 2005, of people from the new accession states of the European community. However, each distinct group remains relatively small and there is thus very little reliable information about the smoking behaviour of young people in any one group.

2.18 Even with a sample size of over 23,000, in the SALSUS survey of 2002, South Asians were the only ethnic group large enough to allow comparisons to be made with white pupils. Girls of South Asian ethnicity were significantly less likely to be regular smokers than white girls. Levels of smoking reported by boys of South Asian origin were not significantly different from those of white boys.

2.19 Some useful insights into ethnic differences which may have relevance to Scotland are provided by a large survey of 13 and 15 year olds in England. White and mixed ethnicity pupils were more likely than black or South Asian pupils to report being a regular smoker. Around one in ten white pupils (12% girls and 8% boys) and mixed ethnicity pupils (11% girls and 8% boys) were regular smokers compared with one in twenty black pupils (7% girls and 4% boys). The same proportion of South Asian boys as black boys were regular smokers (4%) although South Asian girls were less likely than other girls to smoke (3%).

The use of tobacco, alcohol and other drugs

2.20 Smoking tobacco is highly correlated with regular use of alcohol and other substances. SALSUS, 2002, found that among regular smokers aged 13, 48% had used drugs in the past month, compared with only 1% of never smokers. At age 15, 61% of regular smokers had used drugs in the past month compared with only 3% of never smokers. At age 13, 59% of regular smokers were already weekly drinkers, compared with only 18% of those who had never smoked. At age 15, 71% of regular smokers were weekly drinkers compared with only 10% of never smokers.
2.21 The Edinburgh transitions study has shown that smoking most commonly starts around the same age as drinking and drug use but there are also many young people who start smoking before they start drinking or taking other drugs and vice-versa.\(^{14}\)

2.22 Cannabis use is particularly linked to smoking tobacco because cannabis is usually smoked mixed with tobacco. Typically, a first time cannabis smoker will already have tried cigarettes but some cannabis users may have their first experience of tobacco this way and may indeed then become addicted to tobacco as a result.\(^{26}\)

2.23 The association between smoking tobacco and the use of other drugs persists into the later teens and early twenties. Using data from the MRC Twenty-07 study Figures 2.7 and 2.8 show that the majority of current smokers at ages 18 and 23 also drank above the recommended limits or used other drugs, with the proportion that do so apparently rising with age.\(^{15}\) By age 23, almost one in ten of the sample were smoking, drinking and using other drugs.

**Influence of the school**

2.24 Studies which have compared secondary schools in the West of Scotland have found that the smoking levels can be very different even when the communities from which the pupils are drawn are apparently similar.\(^{18, 19, 27}\) There is evidence from these studies that a number of factors may contribute to this “low smoking school effect” including:

- The enforcement of a school smoking policy
- The creation of a positive school ethos with good communication, teamwork and pupil involvement
- “More advanced” health education and health promotion policies.

**Figure 2.7 Combination of current smoking, drinking over recommended levels and last year drugs at age 18.**

![Venn Diagram](image.png)
Figure 2.8 Combination of current smoking, drinking over recommended levels and drug use in the last year at age 23 (%s do not add up to 100 due to rounding)\textsuperscript{15}

![Combination of current smoking, drinking over recommended levels and drug use in the last year at age 23](image)

Recommendations for targets, regular surveys and more research

**Children**

2.25 The targets for smoking rates set out in *A Breath of Fresh Air for Scotland* were:

*Reduce smoking among young people (aged 12-15) from 14% to 12% between 1995 and 2005 and to 11% by 2010*\textsuperscript{7}.

The current surveys of school-children sample only those who are around 13 and 15 and consequently an accurate figure for 12-15 year olds cannot be given. In addition, there are big differences in the smoking rates of girls and boys at these ages. We therefore recommend that new separate targets are set for boys and girls at both 13 and 15 as shown below. We suggest a greater proportionate drop for girls as we think the aim should be to reduce smoking rates for girls towards those of boys and that therefore there should be a greater focus on preventing smoking among girls. The targets for 2010 are based on the extrapolation of current trends. Those for 2015 and beyond are aspirational, reflecting the desired direction of travel. They assume that the proposed recommendations in this report will be implemented and effective.

<table>
<thead>
<tr>
<th>% regular smokers at these ages</th>
<th>Rate in 2002 SALSUS</th>
<th>Rate in 2004 SALSUS</th>
<th>Target for 2010</th>
<th>Target for 2015</th>
<th>Target for 2020</th>
<th>Target for 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys age 13</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Girls age 13</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Boys age 15</td>
<td>16</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Girls age 15</td>
<td>24</td>
<td>24</td>
<td>20</td>
<td>15</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>
Adults
2.26 The targets for adults in *A Breath of Fresh Air* were: **Reduce smoking among adults (16-64) from an average of 35% to 33% between 1995 and 2005 and to 31% by 2010. This has since been modified to be 22% of all adults over 16 by 2010.**

This target does not allow for the rates among young adults to be followed. As large numbers of people start to smoke or become regular smokers aged 16-24, we think it is essential that there is a separate target for this age group to concentrate minds on preventing the uptake of smoking in this group. We therefore **recommend** that new targets for 16-24 year olds are created as follows:

<table>
<thead>
<tr>
<th>Rate in 1998 Scottish Health Survey</th>
<th>Rate in 2003 Scottish Health Survey</th>
<th>Target for 2010</th>
<th>Target for 2015</th>
<th>Target for 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults age 16-24</td>
<td>35%</td>
<td>30%</td>
<td>25%</td>
<td>20%</td>
</tr>
</tbody>
</table>

The target for 2010 reflects the current downward trend of adult smokers as a whole. The targets for 2015 onwards are aspirational and assume that the recommendations in this report will be implemented and effective.

2.27 In the light of the relative lack of information about smoking and the misuse of alcohol and other drugs by young people in the 16-24 age group, we **recommend** that this should be a priority area for new research. The aim should be to establish a clearer understanding of the current knowledge, attitudes and behaviour of this group to provide a firmer foundation for prevention initiatives. To enable comparisons to be made between surveys, the same age groups should be surveyed at the same time of year wherever possible. Regular surveys of 13 and 15 year old schoolchildren should continue to provide accurate information about smoking and other related behaviour.

2.28 Later in this report, a series of new measures are proposed. We **recommend** that, if implemented, they are all subject to rigorous evaluation to establish their impact and cost effectiveness.
3. Sources, availability and marketing of cigarettes to young people

Key points
- 13 and 15 year olds have little difficulty buying cigarettes from shops in Scotland, indicating a widespread disregard for the law of age of purchase at 16.
- Research shows that vigorous enforcement of age of purchase laws can help reduce youth smoking rates.
- Raising the age of purchase has not been shown to reduce youth smoking rates as an isolated measure but may contribute as part of a comprehensive package of wider control measures including vigorous enforcement.
- Raising the price of cigarettes through increasing taxes has been shown consistently to reduce youth smoking rates. This is arguably the most effective measure that can be taken to discourage smoking by young people.
- Packets of 10 cigarettes are particularly popular with teenage smokers.
- Smuggling of cigarettes currently accounts for a significant proportion of cigarettes in circulation, particularly in disadvantaged areas.
- There is good evidence that the marketing of cigarettes has been successful in encouraging young people to smoke. Whilst advertising and sponsorship have now been banned, opportunities still exist for other forms of marketing. Positive images of smoking are still found in the media including the youth media (e.g. magazines and films).
- A series of recommendations are made, aimed at making cigarettes less affordable, accessible and attractive to children and young people.

3.1 Young people can only smoke if they are able to buy or otherwise obtain cigarettes. It is currently an offence to sell cigarettes to anyone under the age of 16. Cigarettes have also become increasingly expensive due to a progressive rise in the tax imposed on them. In this Chapter, we look at where young people obtain cigarettes and consider the evidence for various measures designed to make it less easy for young people to obtain them.

Availability and underage sales
3.2 Tobacco is widely available for sale from retail outlets across Scotland. The SALSUS surveys found that 13 and 15 year olds have little difficulty buying cigarettes from a range of shops and from vending machines. Among regular smokers, almost all (86%) 15 year olds and almost two-thirds (62%) of 13 year olds reported buying cigarettes from shops. Newsagents, tobacconists or sweet shops were the most commonly reported type of shop reported by 79% of 15 year olds and 53% of 13 year olds. Supermarkets and garage shops were also a common source, particularly for 15 year olds. It is therefore clear that the law on the age of purchase of cigarettes is widely disregarded.

3.3 Many 13 and 15 year olds also reported buying cigarettes from friends, relatives and other people, with these sources appearing more important for younger children. Thus, 21% of 13 year olds and 14% of 15 year olds reported buying cigarettes from
friends or relatives. Smokers also reported being given cigarettes and the most common source for both regular and occasional smokers was friends. Among regular smokers, 43% of 13 year olds and 38% of 15 year olds reported this source.10

3.4 Evidence from the US suggests that more stringent under-age sales policies are associated with lower youth smoking rates. Reviews also concur that the vigorous enforcement of the minimum legal purchase age combined with high compliance by retailers is more effective in reducing illegal sales than unenforced voluntary agreements or education of retailers.29 However, as shown by intervention studies the impact of vigorous enforcement of minimum legal purchase age on actual smoking behaviour is weaker, probably because young people obtain cigarettes from a variety of different sources.30

3.5 Recently, the Lord Advocate has granted permission for trading standards officers in Scotland to carry out test purchases of cigarettes using underage customers. Vendors who sell cigarettes to these customers are then liable to prosecution. This offers a potentially powerful means of putting pressure on vendors to comply with the existing age of purchase.

3.6 There is good evidence that vigorous enforcement of under-age sales legislation does reduce cigarette sales to minors and can have some impact on smoking rates among minors. We therefore recommend that measures are taken to ensure that much greater efforts are made to enforce the prevailing legal age of purchase. These should include the following:

- active use of test purchasing by underage customers with appropriate action taken against offending vendors, including heavy fines that provide a genuine deterrent.
- encouraging vendors to require proof of age before selling to young customers;
- conducting an information campaign for retailers and trading standard officers, to explain the law on age of purchase, and emphasise the addictiveness of smoking and the consequent need to discourage young people from smoking.

Tobacco licensing schemes
3.7 A number of countries or jurisdictions within countries have established a form of licensing of vendors of tobacco products. There are negative licensing schemes in New Zealand, in Australia (Queensland, Victoria and New South Wales) and in Canada (Ontario). Under these schemes, tobacco retailers can be prohibited by Court Order from selling tobacco products if found guilty of multiple breaches of the relevant legislation, for example, by selling to minors. Over the past six years, four Australian jurisdictions have introduced positive licensing schemes. Tasmania licenses the company or individual selling tobacco. South Australia, the Australian Capital Territory and the Northern Territory license the individual premises at which tobacco is sold. We were unable to obtain any information about the impact of these schemes.

3.8 There is very little published evidence available to demonstrate whether negative or positive licensing schemes are effective as a deterrent. Recent research in New Zealand found that many young people are still accessing tobacco, despite negative licensing being in place, as current legislation and enforcement appear insufficient to
deter tobacco retailers. Establishing and maintaining a positive licensing scheme would require a costly and resource intensive administrative effort. Given the lack of evidence for its effectiveness, such a scheme could not be justified on cost grounds at the present time. On the other hand, a negative licensing scheme would require no new infrastructure but simply the amendment of existing legislation. It would provide an added sanction against retailers who repeatedly flout the law. We therefore recommend the introduction of a negative licensing scheme for the sale of tobacco in Scotland. This would result in retailers found guilty of repeated offences being prohibited from selling tobacco for a specified period. However, it would only be of value if it were linked to the active and widespread enforcement recommended in 3.6.

**Changing the age of legal purchase of tobacco**

3.9 Under the Children and Young Persons (Scotland) Act 1937 and the Children and Young Persons (Protection of Children from Tobacco) Act 1991, it has been illegal to sell tobacco products in Scotland to customers under the age of 16 since 1937. This follows similar legislation passed in England in 1933. In the 1930s, smoking was considered a fairly harmless behaviour. It was not until the 1950s that the link with lung cancer was made. Since then, the list of serious conditions to which both active and passive smokers are at risk has grown enormously. It is also now established that nicotine is a highly addictive drug. In the light of our current knowledge, does it still make sense to maintain the age of legal purchase at 16 and, if not, what evidence is there that raising the age would prevent young people from smoking?

3.10 Many other countries have set the legal age of sale at 18, including most states in the US. Six out of the eight Canadian provinces have set it at 19, as have at least three American states. Jamaica, Japan, Kuwait and the Republic of Korea have a minimum purchase age over 18. There are many potential benefits of raising the age of purchase: reduced uptake of smoking among young people, reduced prevalence of regular smoking, reduced numbers of cigarettes smoked by regular under-age smokers, increased smoking cessation among young smokers, easier refusal of sales by retailers and a change in social norms. The possible harms include further glamorising of smoking in terms of it being viewed as an adult behaviour thereby potentially encouraging some young people to smoke. It may also further alienate young regular smokers.

3.11 Unfortunately, there do not appear to be any adequately conducted studies of whether or not raising the legal age results in a reduction in the prevalence of smoking by people younger than the legal age. In 1997, Guernsey (population 64,000) introduced a series of measures aimed at reducing smoking prevalence among young people, including raising the age of legal sale from 16 to 18. Smoking prevalence among 15 year olds fell from 32% to 18% between 1997 and 2002. However, as a number of measures were introduced simultaneously, the new age limit has not been strictly enforced and no formal evaluation of the impact of the measures was carried out, it is not possible to quantify the contribution of raising the legal age to this reduction.

3.12 Although there is no clear evidence from other countries that raising the age of legal sale in and of itself reduces the prevalence of smoking, we consider that to leave it unchanged would be inconsistent with the range of other tobacco control measures that are now in place or are proposed. Given what is now known about tobacco, it
seems entirely unjustified that such a dangerous and addictive substance, clearly labelled as lethal, should still be sold to minors. We consider that raising the age of purchase, as a part of a range of measures, would reinforce the message to the population in general and young people in particular that tobacco is a highly dangerous substance which should be avoided. If properly enforced, we think it is likely that the measure would contribute to a reduction in consumption of tobacco by young people.

3.13 We therefore recommend that the current offence of selling tobacco products to anyone under the age of 16 should be amended by raising the minimum age to 18. There should be sufficient delay between amending the legislation and its implementation to prepare both customers and retailers for a smooth transition. We also recommend that the impact of this change should be carefully evaluated.

The impact of price
3.14 There is strong evidence that tobacco taxation is a particularly effective way of reducing tobacco consumption among young people. Tax policy is thus one of the main tools for preventing nicotine addiction. The World Bank has calculated that a 10% increase in the price of cigarettes on average reduces demand by 4% in high-income countries such as the UK. The effect of a 10% price increase on the 77 billion cigarettes sold in the UK would be to reduce consumption by about 3 billion cigarettes per year. However, young people may be up to three to four times more price sensitive than older adults. A recent systematic review amongst 13 to 24 year olds also concluded that price affected both the number of young smokers and the amount of tobacco consumed.

3.15 In his 2000 Budget Statement, the Chancellor raised cigarette taxes by 5 per cent above inflation with 25 pence on a packet of 20 cigarettes. He announced that some of the additional money accruing from the duty increases on tobacco would go towards the NHS. The Scottish Executive received £26 million of the extra tobacco taxation money and announced it would invest the money in a major health improvement and public health programme. By the 2004 Budget, tax increases had levelled out, and the Chancellor only raised tobacco duty rates in line with inflation (including VAT), meaning that a typical packet of 20 cigarettes increased in price by 9.2 pence. In 2006, the Chancellor raised the duty on cigarettes by only 9p, an increase lower than the current rate of inflation. As a result, cigarettes will actually be cheaper in real terms for the forthcoming year. This apparent downward trend in budgetary terms is out of step with significant UK tobacco control advances in other areas.

3.16 We recommend that the Scottish Executive urges the UK Government annually to increase the price of tobacco products at a rate faster than inflation.

3.17 We also recommend the Scottish Executive makes representations to the UK Government to urge that health considerations are taken into account in the decision making process of EU policy concerning the taxation of tobacco products, as is required by the Framework Convention on Tobacco Control (WHO).
Packets of ten cigarettes

3.18 Recent research in the Republic of Ireland indicates that 75% of smokers aged under 17 buy packets of ten cigarettes. A recent survey of 11-15 year olds in England found that smokers were more successful in buying packets of ten than packets of twenty. Similar research has not been conducted in Scotland but packets of ten are universally available. Whilst there is apparently no objective evidence to demonstrate the effectiveness of banning packets of ten (also known as ‘kiddie’ packs) as a means of reducing young people’s access to cigarettes, an increasing number of countries are prohibiting the sale of packets of ten as part of wider youth prevention strategies. These include Australia, New Zealand, Canada, France, 14 states in the US and the District of Columbia. The Republic of Ireland’s Public Health (Tobacco) Act 2002 contains a clause making it an offence for a person to sell cigarettes by retail other than in a packet containing not less than 20 cigarettes. However, this section of the Act has not yet been implemented.

3.19 The World Health Organisation have also raised concerns about ‘kiddie packs’, branding them “another strategy of the tobacco industry… It is clear that these packs are made for children, young people and those on low income in an effort to maintain and even enlarge the market for tobacco products”.

3.20 Whilst a case can be made for prohibiting the sale of packs of ten in Scotland, such a step could also have negative consequences.

- It could discourage smokers who are trying to “cut down to quit” by requiring them to buy larger packs.
- It could disproportionately affect smokers on low incomes.
- It could stimulate a cross-border black market in smuggled or counterfeit packs of ten.

3.21 In the absence of good evidence for its effectiveness, we consider that banning the sale of packs of ten in Scotland is unlikely to make a useful contribution to preventing smoking by young people at this stage. We have concluded that raising the cost of cigarettes, raising the minimum age of purchase and vigorously enforcing the age of purchase are together likely to have a much greater impact.

3.22 We therefore recommend that the issue of the sale of packs of ten should be referred to the UK Government for consideration in the light of further research into its likely impact. To inform future decisions, we also recommend that the Scottish Executive commissions research to ascertain the extent to which young people in Scotland purchase cigarettes other than in packs of 20.

Smuggled and personally imported tobacco

3.23 The availability of much cheaper smuggled tobacco products – both cigarettes and loose tobacco, sold from vans, at open-air markets and by other means across the UK, undermines the impact of the pricing and sale controls that are currently in place. As smuggled tobacco products are particularly prevalent in more disadvantaged areas, smuggling may have a disproportionate impact on smoking behaviour by young people in these areas.
3.24 In March 2000, the UK Government announced a package of measures designed to curb smuggling, including the deployment of 1000 additional Customs officers; additional specialist investigators and intelligence staff; additional x-ray scanners; tougher sanctions and penalties; and a public awareness campaign\textsuperscript{57}. In addition, packs of cigarettes and hand-rolling tobacco sold for consumption in the UK are now required to carry a duty-paid mark.

3.25 In 2002-2003, the illicit market in cigarettes fell to 18\%, representing 2.5 billion fewer smuggled cigarettes than the previous financial year\textsuperscript{58}. However, by 2003-04, 54\% of cigarettes seized in the UK were counterfeit, a 2.6 fold increase in only two years. Counterfeit cigarettes are not manufactured by the company they purport to be and their content is not standardised. Recent tests have shown that some samples have higher levels of lead, arsenic and other harmful chemicals than legitimately manufactured cigarettes\textsuperscript{59}. Smuggled packets of 20 cigarettes are around 40\% cheaper than their legal counterparts\textsuperscript{60}. Recent estimates suggest that tobacco smuggling costs over £2.5 billion a year in lost tax revenue\textsuperscript{61}.

3.26 Many people now import large numbers of cigarettes “for their own personal use” when returning from visits to other EU countries (the current guideline upper limit is 3200 cigarettes per person per visit). However, it is not known how many cigarettes are imported in this way or in what proportion of cases individuals successfully bring in more than the upper limit. In addition, a growing number of web sites offer imported cut price cigarettes for sale\textsuperscript{62}.

3.27 Tobacco smuggling constitutes a serious public health risk by undermining initiatives aimed at reducing tobacco consumption. Smuggled tobacco is most likely to be sold in deprived areas and increasingly children are being targeted\textsuperscript{56}. Purchasing from unregulated internet sites accounts for a growing proportion of UK smuggled tobacco. These sites often use child friendly marketing, and fail to carry health warnings\textsuperscript{62}.

3.28 The trade in smuggled cigarettes is dominated by large-scale container fraud: as many as ten million cigarettes can be hidden in a container apparently carrying legitimate products such as food or furniture. This is very different from the popular perception of cigarette smuggling, namely the “white van trade” in which small-scale operators exploit cross-Channel tax differentials but pay duty in another country. Bootlegging – legally buying tobacco in a low tax country and illegally re-selling it in a high tax country – accounts for about 20\% of the cigarettes sold on the UK black market\textsuperscript{63}.

3.29 The tobacco industry benefits from smuggling in several ways. Smuggling stimulates consumption both directly (through the street sale of cheap cigarettes) and indirectly (through pressure to lower or keep down taxes)\textsuperscript{64}. Whilst legitimate retailers lose tobacco sales, the tobacco industry maintains their production and sales. Thus, they have no incentive to reduce smuggling. The industry does not lose out when contraband cigarettes are confiscated and destroyed, as these cigarettes need to be replaced, resulting in yet more sales.
3.30 Although customs activity can reduce smuggled cigarettes’ share of the domestic market, there is no direct evidence regarding the impact of this activity on tobacco consumption by adults or young people. On the other hand, in Canada the downward trend in teenage smoking prevalence was reversed in provinces where there was a substantial cut in tobacco taxes in order to make smuggled tobacco less attractive. This suggests that the availability of smuggled tobacco may not have much influence on tobacco use by young people.

3.31 If, as we believe should happen, the relative price of tobacco should rise and further controls on its availability should be put into place, the incentives to smuggle and deal in illicit tobacco products may increase. This may well have a disproportionate effect in more disadvantaged areas, where the trade in smuggled tobacco is already greater, potentially widening health inequalities. Effective measures are therefore needed to prevent tobacco smuggling and control more effectively importation “for personal use”. We therefore recommend that the Scottish Executive should:

- commission research to ascertain the current extent of use by young people of smuggled or personally imported tobacco;
- ensure that Customs and Excise and the police in Scotland both put a high priority on activities aimed at reducing the influx of smuggled tobacco into Scotland in particular;
- urge the UK Government to maintain and if necessary increase the investment in staff and equipment needed to control the influx of smuggled tobacco;
- urge the UK Government to review the appropriateness of the current limits for the importation of cigarettes from other EU countries for personal use and the effectiveness of the controls thereon;
- urge the UK Government to work collaboratively with the EC and other Member States to help develop a comprehensive international protocol on illicit tobacco as agreed at the first Conference of the Parties of the Framework Convention on Tobacco Control.

**Tobacco advertising and marketing strategies**

3.32 The tobacco industry worldwide invests vast resources on the marketing of their products. In order to maximise their sales, they focus on efficient systems of distribution, competitive pricing, careful product placement and the use of a wide range of techniques to promote their products.

3.33 Tobacco advertising was banned in the UK and the rest of Europe in 2002 and tobacco sponsorship came to an end in 2005. The impact of this development is yet to become clear. However, the marketing of tobacco products in the UK continues through a variety of communications and promotional devices. Cigarettes are still prominently displayed in thousands of supermarkets, newsagents, petrol stations and other points of sale. Images of smokers (often with the allure of celebrity status) continue to be featured in films, TV and magazines.

3.34 There is a growing body of research on the impact of tobacco advertising on youth smoking. Lovato and colleagues conducted a meta-analysis of nine cohort studies and found “a positive, consistent and specific relationship” between exposure to tobacco advertising and the subsequent uptake of smoking among adolescents. In
all the studies, non-smoking adolescents who were more aware of tobacco advertising or receptive to it were more likely to have experimented with cigarettes or become smokers at follow-up. Other studies have found a positive association between smoking and awareness of and appreciation of tobacco advertising.\(^{66, 67, 68, 69, 70, 71, 72}\) Furthermore, adolescents appear to be more receptive to tobacco advertising than adults.\(^{73, 74}\) Although a causal relationship cannot be inferred, the association is consistently in the same direction and tends to support the hypothesis that advertising encourages young people to continue smoking as well as to start.

3.35 Studies of a variety of other tobacco marketing communications and promotional devices including point of sale advertising, packaging, brand stretching, loyalty schemes, free samples and the internet have shown a similar relationship between youth smoking and tobacco advertising. One major study examined young people’s awareness of and involvement with all existing forms of tobacco promotion.\(^{75}\) The authors found that smokers had more involvement with tobacco promotions than non-smokers and the heavier the smoker, the greater the involvement. This cumulative impact suggests that integrated marketing communications are an effective way of influencing adolescent smoking behaviour.

3.36 Whilst tobacco advertising and sponsorship have now been prohibited in the UK, tobacco companies will continue to seek to market their products to young smokers in any way they can. This includes prominent displays of cigarettes behind the counter at the point of sale. We understand that Norway and New Zealand are currently considering a requirement that cigarettes are only sold from under-the-counter\(^ {76}\) (ASH Scotland 2006, personal communication).

3.37 We welcome the moves by the European Union towards requiring graphic photographs of smoking-related diseases to be displayed on cigarette packets as a means of encouraging smokers to give-up and reducing the attractiveness of cigarettes to young people. We recommend that the UK Government fully supports this initiative.

3.38 We recommend that the Scottish Executive continues to work with the UK Government and other devolved administrations to look at ways to reduce the positive and increase the negative images of smoking in the media and associated publicity materials, including reviewing any additional measures which might be taken to strengthen the ban on tobacco advertising and promotion introduced in 2002.

3.39 We recommend that the Scottish Executive prohibits the display of cigarettes at the point of sale, to be replaced by a simple list of the brands available and their prices.
4. Evidence for the effectiveness of smoking prevention programmes

Key points
- Several major long-term comprehensive American state-wide smoking prevention programmes appear to have contributed to declines in teenage smoking rates.
- A small number of media campaigns have been shown to contribute to reducing youth smoking rates, as part of a wider smoking control strategy. They were intensive and long-lasting and used strong, carefully designed messages on TV but supported by other media.
- Some multi-stranded campaigns involving community action have been effective but the contribution of community action and its possibly effective elements have not been clearly identified. A Scottish community-based smoking prevention initiative was not successful.
- Reviews of the evaluations of large numbers of school-based smoking and drug prevention programmes show that most are ineffective in reducing smoking rates. Although there is no clear “best-buy,” a number of peer-led programmes reported positive results and a peer-supported preventive programme in South Wales is showing early promise. Some programmes using social influence methods reported lower short-term effects on smoking rates but why these were effective and other similar programmes were not is unclear.
- Few programmes appear to have addressed the underlying factors associated with higher rates of smoking and other drug use by young people.
- Although rates of smoking and other drug use continue to rise after leaving school, few preventive programmes have focused on this older age group.

4.1 In this chapter, we consider the available published evidence for the effectiveness of interventions that have been specifically designed to discourage young people from smoking. Most of the evaluations have been conducted in the United States and included media campaigns, community-based programmes and schools-based programmes. Several comprehensive programmes involving a wide range of concurrent elements have also been assessed.

Comprehensive programmes
4.2 Wakefield and colleagues described the effects on teenage smoking of five state-wide programmes in the USA. There were no control groups or states. Instead, the smoking prevalence among teenagers and young people was measured and compared with the US prevalence. The programmes were implemented in California (1989-96), Massachusetts (1993-97), Arizona (1994), Oregon (1996) and Florida (1997). The funding of the programmes varied; some had lower than anticipated budgets which is thought to have strongly influenced their effectiveness. Furthermore, the tobacco industry employed lobbying against a number of the programmes. In general, the programmes consisted of mass media campaigns, grants for smoking cessation services, school based programmes, environmental tobacco smoke (ETS) legislation, enforcement and youth and community programmes.
4.2 The apparent effects of the campaigns on reported smoking prevalence among teenagers varied:

- In California there was no change in 12-17 year old prevalence from 1990-93, an increase from 1993-96, and an increase in non-smoker susceptibility. Among 8th graders and 10th graders, relative increases in smoking prevalence from 1993-1996 were less than in other states.

- In Massachusetts the relative increase in 30 day prevalence was less than for the rest of the US for 8th and 10th graders from 1993-1996, and for 9th and 10th graders from 1993-97. There was a relative decline in lifetime use for 8th graders compared to an increase in the rest of the USA.

- In Oregon smoking prevalence was the same as national trends for 8th and 11th graders.

- In Florida the relative declines in 30 day prevalence for middle and high school students were greater than national trends.

4.3 The Californian tobacco programme has been the subject of further evaluation of its long-term impact, covering its first 13 years, from 1989-2002. Downward trends in adolescent ever-smoking rates were first observed among 12-13 year olds in 1993 and carried through in subsequent years among 14-15 year olds and then 16-17 year olds. The prevalence of current smokers among 12-17 year olds actually increased significantly from 1994-1996 and a significant fall was not seen until 1999, ten years after the programme began. Compared with the rest of the US, current smoking rates among 12-17 year olds were substantially lower in California at the outset (18% v 27% in 1991) and the gap had widened by 1999 (20% v 34%), even though an overall increase in smoking rates had occurred across the country. It is thus plausible that the California programme successfully discouraged early teenagers from starting to smoke and prevented the overall rise in teenage smoking across the US during that period from being as large as it might otherwise have been.

4.4 Thus, overall, there appeared to be some slowing or reversal of the upward trend in smoking in states where the interventions took place. However, as with the studies reviewed by the Cochrane Collaboration, the heterogeneity of the programmes makes it very difficult to assess what were the components of the programmes, or indeed other factors, which contributed to their success.

**Mass media campaigns**

**Sources of evidence**

4.5 The main sources of evidence we used were systematic reviews by the Cochrane Collaboration and the US Task Force on Community Preventive Services. A recent Health Development Agency review was based on the Cochrane and US Task Force reviews. The US Task Force review identified 12 studies of sufficient quality. The Cochrane review found only six studies that met their criteria, all of which were included in the US Task Force review. They had the following characteristics:
• All were mass media campaigns carried out in the late 1980s to 1990s either alone or in combination with other primary prevention interventions such as school programmes.

• They targeted children from late primary school to young adults aged 18 in the US (5) or Norway (1).

4.6 The US Task Force found that mass media campaigns either alone or when combined with other interventions such as school-based and community-wide educational activities can be effective in preventing the uptake of smoking. Among the five studies which measured self-reported smoking before and after the campaigns, the decrease in rates varied from 0.02% to 9.5%. It is not known whether these decreases were maintained.

4.7 The Cochrane review found that only two of the six studies were associated with reduced smoking behaviour among children and young people. The review’s authors concluded there was moderate evidence that mass media interventions could be effective.

Characteristics of effective campaigns

4.8 The reviews found that the effective campaigns were sustained for at least two years and were relatively intense. They used a variety of media with brief repeated messages that motivated young people to remain tobacco free. The effective messages were designed to provoke emotional reactions among young people. They were of two types - exposing the strategies of the tobacco industry, and providing information and support to help young people to remain non-smokers. The primary prevention message was either the sole component of the campaign or part of a broader anti-tobacco intervention. Most of the successful interventions and the messages they used were based on initial market research or built on successful components of previous campaigns. The content was adjusted for the age of the target audience. The type of media and times of exposure were adjusted to suit those used by young people. The media used in the campaigns included broadcasts on television and radio and adverts in printed media and on billboards.

Additional non-systematic review level evidence

4.9 A recent evaluation of the “TRUTH” campaign in the US was not included in the review as it was published in 2005. This was a before-and-after evaluation of a national campaign to inform young people of the tobacco industry’s tactics. Changes in estimated smoking prevalence among young people attributed to the campaign were calculated using national annual survey data and correlating this with the degree of exposure to the campaign. Between 1999 and 2002, youth smoking rates declined from 25.3% to 18%. It was estimated that 22% of this decline (a 1.6% fall in the rate) was due to the campaign.

4.10 Further useful information on the nature of effective mass media campaigns for smoking prevention is provided in a literature review and a qualitative study by Devlin and colleagues which identified the following additional requirements for successful media interventions:

• Segmenting “consumers” into target markets and making the campaign relevant to them by tailoring the message to their culture, motivations, attitudes and behaviours. This should recognise that young people’s perceived
benefits of smoking vary according to their personal and social circumstances. Three types of smoker were identified: resigned smokers, (older and of lower socio-economic groups), contented experimenters (younger smokers who do not consider the dangers of smoking) and reluctant experimenters (who view smoking as a “social tool”, and are from higher socio-economic groups)

- Repeating, refreshing and updating the messages throughout the campaign
- Using “branding” to increase recall of key messages.

**Summary of main findings**
4.11 These reviews suggest that media campaigns should:
- Be combined with other interventions
- Be based on successful components of previous campaigns or initial market research, including identifying and understanding the target markets
- Use the full range of media which young people are currently using
- Include adverts which provoke an emotional reaction and/or expose the tobacco industry and are regularly refreshed
- Be intense and sustained over a number of years.

**Community-wide interventions**
4.12 The rationale for community-wide interventions is based on the observation that smoking is a behaviour which is embedded in a social context. Accordingly, manipulation of the wider social environment, to discourage the uptake of smoking, may help young people remain smoke free. In this context, community-wide interventions are either developed and/or supported by the community. The community has “ownership” of the programme which usually involves a number of diverse agencies working in partnership.

4.13 Community-wide interventions have been the subject of a Cochrane Collaboration systematic review upon which a review by the Health Development Agency was recently based. The Cochrane review identified 17 studies of sufficient quality, based in the USA, UK and Finland. The target populations were aged from 8-24 years; some were focused on deprived areas.

**Interventions**
4.14 The interventions were in general multi-component programmes – often including school based interventions as well as mass media campaigns, parental involvement and community action. Some were part of wider campaigns to reduce cardiovascular or cancer risk in the community, others targeted young people, either focussing on drug use in general or specifically on smoking prevention. The extent of community involvement varied, as did the duration and intensity of the intervention. Further, the duration of follow-up varied markedly.

4.15 Nine studies compared community-based interventions with no intervention. Only two (the Minnesota Heart Health Programme and the North Karelia Project) showed reduced smoking prevalence in the intervention group. Both had been primarily designed as a heart disease prevention campaign. The remainder found no significant difference between the groups. The studies in which the interventions were effective used the social learning theory or the social influences approach. Six studies compared community-wide programmes with single component controls. The single
component was most often a school-based programme, but others used, for example, media only. Two studies found a statistically significant reduction in the community group, while three found no difference, and one found no difference but did identify a decline in smoking in both the intervention and control groups.

4.16 The heterogeneity of the interventions, populations, methods and outcomes measured in community interventions, as well as difficulties in selecting appropriate comparison populations make the assessment of whether community interventions are effective problematic. The review authors concluded that there was some limited evidence of effectiveness of community wide interventions for smoking prevention. They identified the following features which may increase the likelihood of programme success:

- Programmes should be built upon the effective elements of existing campaigns
- Programmes need to be flexible to address variability between communities
- Developmental work should be carried out with representative samples of the target audience to implement appropriate messages and activities
- Programme messages and activities should be guided by theoretical constructs
- Community activities need to reach the intended audience.

4.17 *Breathing Space* is the only major anti-smoking community based initiative in Scotland that has been evaluated. *Breathing Space* was an experimental health promotion initiative designed to assess the potential for shifting community attitudes to smoking in a low-income area in Edinburgh (Wester Hailes). The initiative was based on community development principles and practice combined with health education theories and methods. It was thought that a shift towards less tolerance towards smoking in the community would contribute significantly towards reducing smoking in the medium to long term. It focused on four settings – community, primary care, young people (including school) and the workplace. A survey was conducted before the start of the intervention in 1999, in Wester Hailes and three other comparable housing estates and repeated in the same areas about 2.5 years later. It was found that there was little awareness in Wester Hailes of the *Breathing Space* campaign materials and no difference between Wester Hailes and the control areas in awareness of any health promotion activities that were smoking related. Overall, there was no evidence that the initiative had achieved its intended outcome. The study raised questions about the appropriateness of using community development approaches in this context, given the varying and competing understandings of community development methods among multi-agency teams and the structural issues that prevented partnership collaboration from achieving successful outcomes.

**School-based smoking preventive interventions**

4.18 The main sources of evidence were

- A meta-analysis of smoking prevention programmes. A recent HDA review of reviews considered only this analysis.
- A systematic review of schools-based programmes for preventing smoking.
- A systematic review of school based smoking prevention trials with long term follow up.

4.19 Rooney and Murray identified 90, mostly US based, studies undertaken from 1974-91. The study populations aged from 11-18 years old. The interventions,
classified as “social” or “peer-led type” included information on the short health effects of smoking, the factors which encourage young people to start smoking, the training in techniques to resist the offer of cigarettes and pro-smoking influences in the media, as well as making a public declaration of not smoking. The length of follow up varied from 2-20 months. Smoking prevalence was mostly self-reported.

4.20 There was some evidence of effectiveness, with an estimated 5% relative reduction in smoking. Programmes which employed peer-led preventive activities as part of a multifaceted programme delivered to late primary school children with yearly “booster” sessions were recommended. Information on whether the reductions were sustained was not available.

4.21 The authors concluded that the following characteristics would increase the likelihood of success:

- They are delivered early in the school career
- They are delivered by peer leaders
- They are part of a multi-component campaign
- Boosters sessions occur
- Peers are not over-trained.

4.22 Thomas and colleagues\(^{87}\) identified all randomised controlled trials evaluating behavioural interventions in schools to prevent children (5-12) and adolescents (13-18) from starting smoking. They identified 16 studies of sufficient quality; 15 described interventions based on social influences, eight of which showed reduced uptake of smoking in the intervention compared with the control group; however, the largest and most methodologically sound trial found no long term effect. It is unclear which factors contributed to the apparent success of some interventions but not others.

4.23 Wiehe and colleagues\(^{88}\) reviewed all school-based randomized controlled trials with follow-up to age 18 and one year post-intervention which measured smoking prevalence. They identified eight out of 177 studies which met the inclusion criteria, only one of which showed long term reduced smoking prevalence in the intervention group. This was an American school-based drug abuse prevention trial which included smoking prevention in a white middle-class population. The review authors could not ascertain whether the success of this intervention was based on its content, intensity, implementation or other factors.

Other evidence

4.24 The ASSIST trial is a large scale evaluation of a schools-based smoking prevention initiative, currently being conducted in schools in South Wales and the Bristol area of England\(^{89}\). Fifty-nine schools involving 10,730 pupils were randomly allocated either to continue with their normal smoking education programme, or to do so with additional “peer supporter” training. Peer-nominated students in Year 8 (aged 12-13) were recruited as peer supporters and given intensive training off the school premises by professional health promotion staff. The peer supporters were trained to intervene informally with other pupils in their year in everyday situations to discourage them from smoking. Students have then been followed up for two years to see whether smoking prevalence in the intervention schools was lower than that in the schools which did not receive the training. Outcome data at one year indicated that the risk of students who were occasional or experimental smokers at baseline going on to
report weekly smoking at one year follow up was 18.2% lower than in intervention schools. This finding was supported by analysis of salivary cotinine. Qualitative data from the process evaluation indicate that the majority of peer supporters adopted a pragmatic approach, concentrating their attentions on friends and peers whom they felt could be persuaded not to take up smoking, rather than those they considered to be already ‘addicted’ or who were members of smoking ‘cliques’.

Summary of findings
4.25 There is some limited evidence of short-term effectiveness for school-based smoking prevention programmes which use social influences and other approaches based on the social context of smoking. However, only about half of the adequately evaluated programmes using these approaches were effective. There was minimal evidence for the long-term effectiveness of school-based programmes. As most of the published studies were conducted in the US and do not provide sufficient information to be able to reproduce the programme, they do not provide a clear indication of the best way forward. The ASSIST programme has reported promising early results, indicating that the peer supporter approach may be worth pursuing.

School-based drug preventive programmes
4.26 Drug prevention interventions often aim to prevent the use of tobacco and alcohol as well as illegal drugs. The interventions designed to prevent the uptake of illegal drugs can also inform the development of smoking prevention interventions. We thus considered two further systematic reviews.

4.27 A Cochrane Collaboration review of school-based drug preventive programmes was published in 2005. It identified 32 studies which met the inclusion criteria (RCTs, case-controlled trials or controlled prospective studies), 29 of which were RCTs which compared the intervention with usual curricula. Twenty-eight of the 29 studies were undertaken in the USA, mostly during the 80s and 90s. The interventions (often aimed at preventing use of tobacco and alcohol, as well as illicit drugs) were skills based programmes (designed to improve individual pupils’ social skills), programmes designed to influence drug knowledge or those designed to modify psychological factors (affective programmes). The target populations were largely pre-teenage children.

Findings
4.28 Despite drug knowledge improving among the intervention groups exposed to the knowledge-based and affective programmes, there was no evidence of these interventions affecting drug use. In addition to improving drug knowledge, decision making, self esteem and peer pressure resistance, skills based approaches appeared to reduce reported drug use (heroin and cannabis, and in those assessing smoking, tobacco). However, no difference in drug use was found when skills programmes were compared “head to head” with knowledge or affective approaches.

4.29 A Cochrane Collaboration review of non school-based drug prevention interventions identified 17 studies all published within the last ten years. The interventions considered included multi-component community studies, family intervention studies, education and skills training and brief intervention.
4.30 No conclusive evidence of effectiveness was obtained. There was limited evidence of effectiveness of some family interventions and some brief interventions (in primary care or further education college settings).

**Conclusions**

4.31 Of the various types of intervention studied, the comprehensive multi-stranded state-wide American campaigns appear to have been the most successful but took several years to achieve positive results. There are a small number of apparently effective media campaigns, characterised by careful design, targeting, high intensity and long duration. Most community-wide interventions did not lead to reduced smoking rates even when they were large, well-resourced and well-conducted. Of the two that achieved reduced smoking rates, it was unclear which elements made the difference. The results of school-based smoking prevention and drugs education programmes were also generally disappointing. While some studies found social skills-based approaches had short-term effects, particularly those involving peer education, in other comparative evaluations they did not appear to be any more effective than knowledge or affect-based approaches. Studies with follow-up for longer than one year have generally not shown lasting effects. The ASSIST peer support programme in Wales and the Bristol area appears to be showing some promise with results from two years of follow-up awaited.

4.32 There are two further important considerations. First, most if not all the community-based and school-based programmes were run as research studies. As a general rule, such programmes are conducted with a higher degree of quality control, better resourcing and more training and commitment of staff than would be the case in programmes that have been rolled out across the country in the “real world”. Consequently, the impact of the real world interventions is invariably less than that of those conducted as a pilot or research study.

4.33 Second, the findings in chapter 2 show clearly that smoking and other drug use is more common among young people with particular family and social circumstances and especially among those who have shown signs of disturbed or anti-social behaviour. Teenage smoking is also more common among girls than boys. None of the interventions reviewed above appeared to take any of these factors into account. If these underlying issues are not being addressed, it is perhaps not surprising that the interventions are ineffective.

4.34 These conclusions have important implications for future smoking prevention interventions in Scotland which will be considered in Chapter 6.
5. The current policy context and smoking prevention initiatives in Scotland

Key points

- The new legislation on smoking in public places has the potential to make a major contribution to smoking prevention by reducing young people's exposure to second hand smoke and reinforcing a negative image of smoking.
- Over the past eight years, there have been a series of anti-smoking adverts on Scottish TV that have achieved high viewer awareness and accurate recognition of the message. Websites and other new technologies are beginning to be used to promote anti-smoking and other health messages.
- A major recent review has shown that most schools are providing drug education but there is great inconsistency in the methods and materials used, training of staff and coordination within and between the primary and secondary school curricula.
- The Ambitious, Excellent Schools agenda and the Health Promoting Schools programme provide a framework for addressing smoking prevention.
- A pilot programme of smoking cessation services for young people in Scotland did not prove to be effective in helping smokers quit.
- By reducing the proportion of parents and other adults who smoke, action to increase smoking cessation among adults (eg cessation services, taxation and smoke-free environments) may in the long term make a major contribution to smoking prevention among young people.

The wider environment: prohibition of smoking in enclosed public places

5.1 On March 26, 2006 legislation prohibiting smoking in wholly or substantially enclosed public places came into effect in Scotland. The early signs are that the ban is being very largely observed. As a result, deaths due to passive smoking will be prevented. There may be other benefits. The occasions when children and young people will be exposed to second-hand smoke should be greatly reduced. The opportunities for young people to observe other people smoking in leisure or work situations will diminish. Furthermore, there is emerging evidence from New York and Ireland that banning smoking in public places enables substantial numbers of people to stop smoking. As many of these quitters will be parents, and the children of non-smokers are less likely than those of non-smokers to become smokers themselves, the new legislation may well prove to have a powerful preventive effect. Evaluation of the impact of the ban in Scotland should enable some of these issues to be addressed.

Smoking in the home

5.2 The next challenge will be to find ways of reducing children's exposure to smoking in the home. Success in this domain may not only protect children from the physical effects of cigarette smoke but also make it less likely that they will be influenced by their parents’ or other adults’ behaviour in the home. Qualitative research linked to the evaluation of the new legislation is currently taking place and is likely to shed further light on this.
Media

**TV**

5.3 From 1998-2003, the Health Education Board of Scotland and, from 2003 to the present, NHS Health Scotland, have conducted a number of anti-smoking media campaigns centred on TV adverts but supplemented by promotional material such as a CD, a website and posters. They have all involved developmental research with the target audience which has been defined in each case according to gender, age and whether they are non-smokers or smokers. Thus, the targeted viewers for successive adverts are shown in Table 5.1. In the light of our findings that many people only start to smoke in their late teens and twenties, it is notable that this age group has not been targeted.

Table 5.1 TV anti-smoking advertising campaigns in Scotland

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<th>Target age</th>
<th>Target gender</th>
<th>Smoking status</th>
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<th>Viewer awareness</th>
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<td>10-14</td>
<td>Both</td>
<td>Non-smokers</td>
<td>1997</td>
<td>87%</td>
</tr>
<tr>
<td>Stinx</td>
<td>10-14</td>
<td>Female</td>
<td>Non-smokers and occasional smokers</td>
<td>2000</td>
<td>85%</td>
</tr>
<tr>
<td>Alien</td>
<td>10-14</td>
<td>Male</td>
<td>Occasional smokers</td>
<td>2001</td>
<td>66%</td>
</tr>
<tr>
<td>Club smoking</td>
<td>14-17</td>
<td>Both</td>
<td>Non-smokers</td>
<td>2002</td>
<td>57%</td>
</tr>
<tr>
<td>Butts</td>
<td>12-17</td>
<td>Female</td>
<td>Non-smokers and occasional smokers</td>
<td>2005</td>
<td>83%</td>
</tr>
</tbody>
</table>

5.4 All the adverts achieved moderate to very high viewer awareness. When asked prompted questions, a high proportion of the viewer sample appeared to think that the advert would have an effect on viewers’ attitudes towards smoking. However, the research was not designed to be able to demonstrate an effect on smoking behaviour.

**Websites**

5.5 *Young Scot* is an organisation dedicated to providing information and support for 12-26 year olds in Scotland. Its website, [www.youngscot.org.uk](http://www.youngscot.org.uk) has a major section on health - Health: Feeling Good - funded by NHS Health Scotland. This includes a number of entries about the effects of smoking on your health, how much it costs to smoke and how to give up.

5.6 *Healthbits* is a web-based initiative developed by Youth Media and NHS Health Scotland. It is designed for use on University and Further Education networks (see [www.healthbits.co.uk](http://www.healthbits.co.uk)). It uses ten second pop-up adverts to encourage students to click through to related web pages. It has included a number of ads to help smokers quit but has not yet focused on smoking prevention.

**Education**

**Drug education in schools**

5.7 Drug education in schools has been strongly promoted by the Scottish Office and the Scottish Executive since the early 1990s. Tobacco is generally included in the range of drugs covered. Whilst some central guidance has been given, exactly what is taught and how it is taught also depends upon the local authority, the school board,
the head teacher and the teaching staff. Such an arrangement inevitably produces considerable scope for variation in content, mode and timing of delivery and educational value. Typically, however, many schools opt for a staged approach, introducing new concepts, information and skills at appropriate ages (See box).

A staged approach to education on smoking in schools

9-11 yrs - health effects of smoking, what's in tobacco smoke, addiction; why young people choose to smoke, global tobacco - growing and producing;
11-13 yrs - booster sessions covering components covered in primary school, short term and long term health effects - smoking related diseases, peer pressure, glamorisation of smoking, the tobacco industry (controls, taxation, environmental impact, etc),
13-15 yrs - tobacco advertising and the media, role models in the media, peer pressure, stopping smoking support.

5.8 A large and detailed evaluation of the effectiveness of drugs education in Scottish schools has recently been carried out by the Institute for Social Marketing on behalf of the Scottish Executive. It considers how drugs education is currently delivered, assesses the most effective best practice of drug delivery and considers the views of young people on its value and impact on them. The report is due to be published soon.

Health Promoting Schools

5.9 Our National Health: A Plan for Action, A Plan for change 95 included a commitment by the Executive that all Scottish schools would become health promoting schools by 2007. Following this, the Scottish Health Promoting School’s Unit (SHPSU) was established to support schools in achieving this target. The Unit’s main role is to champion, facilitate and support the implementation of the health promoting school concept throughout Scotland. A key focus is to provide strategic and practical support to partner organisations, councils, schools, NHS health boards, community planning partnership integration managers and other stakeholders as they work together to achieve the National Priorities for education and health in schools.

5.10 The SHPSU is supporting a whole school approach to promoting the physical, social, spiritual, mental and emotional well-being of all pupils and staff. This ensures not only that health education is integral to the curriculum but also that the school ethos, policies, services and extra-curricular activities foster mental, physical and social well-being and healthy development. Efforts to prevent smoking and the misuse of alcohol and other drugs should be part of the curriculum but also reflected in the school’s ethos, policies, services and extra-curricular activities.

Future policy

5.11 In 2004, the Scottish Executive launched Ambitious, Excellent Schools (AES) 96, a comprehensive modernisation agenda for Scotland’s schools. This sets out a wide ranging plan for action to ensure that “all our young people are safe, nurtured, healthy, achieving, active, respected, responsible and included”. The aim is to enable all children and young people to have access to positive learning environments and opportunities to develop their knowledge, skills, ambition, confidence and self-esteem.
to the fullest potential. As a part of the agenda, *A Curriculum for Excellence (CfE)* sets out the action for change. The four capacities of CfE encompass aspirations for all children and young people which are that they should be

- successful learners,
- confident individuals,
- responsible citizens and
- effective contributors.

Health education, including drugs education, will be firmly embedded within these four areas. Exactly how this will be done will be the subject of further work.

*Universities, other institutions of further education and training establishments*

5.12 In Chapter 2, we showed that many young people only start using tobacco, alcohol or other drugs in a hazardous way once they have left school. A growing proportion of school-leavers now spend several years at Universities or Further Education Colleges and thousands others receive training in other establishments such as the Armed Forces, the Police and the Civil Service. The combination of new freedoms, greater stresses, peer pressures and more disposable income may all tip the balance for many in favour of smoking, excessive drinking and use of other drugs. To our knowledge, such institutions either provide no information to students or trainees about the potential hazards of tobacco, alcohol and other drugs or it is done in a very low-key way – a few lines in a freshers’ week manual for example, or a leaflet in a student health centre. The National Union of Students actively promotes No Smoking Day but the focus is on helping existing smokers to stop. Advice and support for students who smoke is available from a number of other sources which are readily found on the Internet. However, we think that more attention should be paid to preventing school leavers and students from starting to smoke.

*Community-based initiatives*

See para 4.17

*Smoking cessation services for young people*

5.13 There is increasing interest in providing smoking cessation services for young people, but relatively little research evidence on which to base such services. In 2002 NHS Health Scotland and ASH Scotland funded the first major UK programme of pilot cessation projects for young people. These aimed to engage with young smokers (12-24 years) who wanted to quit smoking, and identify acceptable and potentially effective approaches to help them quit. The eight projects were funded for three years, took place in a range of settings (NHS, community, education, prison, internet) and focused on different groups (pregnant women, students, pupils, offenders).

5.14 The projects all experienced difficulty in attracting and retaining clients, with more time and effort having to be put into recruitment than had been expected. Most participants reported making some change to their smoking. However, from a total of 470 young people using the services, only 11 (2.4%) were confirmed quitters with carbon monoxide validation at both 3 and 12 months.

5.15 Participation in the pilots was seen by the project staff as offering wider benefits to the young people involved, such as increased confidence and self esteem. Key learning points were identified concerning the challenges of engaging and working
with young people on their smoking which would be relevant to smoking prevention as well as cessation interventions and programmes. Indeed given the diversity of participants' understanding of smoking, dependence, addiction and cessation, projects had to provide considerably more information and education on smoking-related issues than is required in adult cessation services.
6. Implications of the research evidence and recent experience in Scotland for future preventive initiatives.

Key points

- There is good evidence to support the implementation of an on-going, intensive, multi-stranded media campaign. Targets should include girls and young women in disadvantaged circumstances and young people in their late teens.
- Given the equivocal research evidence and the inconsistency of current approaches in Scottish schools, a reappraisal of drugs education in schools is needed.
- Drugs education should continue to be an integrated part of the curriculum with clear consistent messages. The message on tobacco should be uncompromising: never smoke.
- Informing parents about tobacco, alcohol and other drugs and their responsibilities in this regard should be an integral part of drugs education.
- The Ambitious, Excellent Schools and the Health Promoting School programmes provide the framework within which a comprehensive approach to tobacco, alcohol and other drugs should be developed.
- Effective support and management of pupils with behavioural problems is relevant to smoking prevention.
- Universities and further education institutions should play a bigger part in discouraging young people from smoking or misusing alcohol or other drugs.
- Any plans for future smoking prevention initiatives based on community development principles should ensure that they take full account of the unsuccessful Breathing Space campaign.
- Further consideration of smoking cessation services for young people is needed in the light of the poor results of the recent pilot programme.
- In the long term, increasing smoking cessation among adults who are or will be parents is likely to contribute to the prevention of smoking among young people.
- Where parental smoking cessation is not attained, stopping smoking in the home may also contribute to the prevention of smoking among young people.

6.1 In Chapter 4, we summarised evidence that comprehensive, campaigns, combining well-enforced regulations, educational programmes and support for individuals and communities can reduce smoking rates if sustained over several years. This is what we recommend for Scotland. In Chapter 3 we set out a comprehensive series of recommendations designed to reduce the availability and affordability of tobacco products for young people. In the light of the further evidence we have gathered and presented in Chapters 4 and 5, we set out in this Chapter what else we think should be done to prevent young people from starting to smoke and becoming addicted smokers?
Media
6.2 There is moderately good evidence from other countries that carefully developed, targeted, intensive and long-lasting media campaigns can discourage some young people from smoking. Successive previous campaigns in Scotland have shown that anti-smoking ads can achieve high levels of viewer awareness. We therefore recommend that an on-going, multi-stranded media campaign, building on the previous work by Health Scotland and the Health Education Board for Scotland, is designed and implemented to discourage smoking by young people of any age. One strand should have a strong focus on developing messages and using media that reach and have credibility with girls in our more disadvantaged communities. Another should target young people in their late teens. The campaign should draw on the evidence for effectiveness in the source literature summarised in this report and should be integrated as far as possible both with other anti-smoking measures and with other media-based health information for young people. This recommendation is consistent with the Final Recommendations of the pan-European meeting on Tobacco, Youth Prevention and Communication in Rome, 2003, agreed by over 200 public health and media experts from 32 countries (see Box).

<table>
<thead>
<tr>
<th>Key conclusions from the Pan-European meeting on Tobacco, Youth Prevention and Communication, 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth prevention campaigns have to be part of a comprehensive tobacco control policy and not be conducted in isolation. Media campaigns play a key role to build knowledge, change attitudes and behaviour in support of a tobacco-free society.</td>
</tr>
<tr>
<td>Pan European youth smoking prevention campaigns should promote the visibility of tobacco control. Campaigns should contribute to change the social norm from smoking to non-smoking in the European Union.</td>
</tr>
<tr>
<td>To reach young people we need to do campaigns which target both adults and youngsters. We need to speak to young people as adults but use the media of their generation.</td>
</tr>
</tbody>
</table>

Education
Schools
6.3 The research evidence does not provide a sound foundation for confidently advocating a particular approach to smoking or drugs education in schools. Furthermore, although the recent review of drugs education in Scottish schools has shown that almost all schools are providing some form of drugs education, it has also revealed a picture of inconsistency in all aspects of its delivery. Given the recent adoption of the Ambitious, Excellent Schools programme, we think this is an ideal time to take stock.

6.4 Despite these disappointing findings, the Working Group was in no doubt that the education system has a vital role to play in helping to prevent children and young people from smoking and the hazardous use of alcohol and other drugs. Drugs education should be a fully integrated part of the curriculum. This conclusion is consistent with that of a recently published authoritative report by the UK Advisory Council on the Misuse of Drugs, Pathways to Problems, which among other things, extensively reviewed the effectiveness of tobacco, alcohol and drugs education in schools. The aim should be to convey clear, consistent messages that are begun in primary school and continued right through secondary school. With respect to
tobacco, given its addictiveness and its harm to smokers, their babies, children and those around them, the message should be uncompromising: never smoke. This should be delivered from an early age and continued right through school.

6.5 We therefore **recommend** that a comprehensive reassessment and reform of education on tobacco, alcohol and other drugs in Scottish schools is carried out by a working group whose members have expertise in drugs education research and delivery and in the design and integration of complex educational programmes across the curriculum.

6.6 Given the importance of parents’ influence upon whether or not their child will smoke, we also **recommend** that an integral part of drugs education in school should be to inform parents about tobacco, alcohol and other drugs and their responsibilities in this regard. This should mainly be done by sending parents clear, consistent information at regular points during their child’s progress through school. In addition, to reduce their children’s exposure to second-hand smoke, we **recommend** that at the relevant stages, parents are encouraged by midwives, health visitors, general practitioners and hospital doctors, nursery staff and teachers to create a smoke-free home and not smoke when their children are present.

6.7 We endorse the concept of the Health Promoting School and **recommend** that schools continue to develop an holistic approach to the health and well-being of their pupils. The aim should be to ensure that the school ethos, policies, services and extra-curricular activities all foster the health and well-being of all the pupils. This should include having and applying a school no smoking policy covering everyone using the school grounds. Staff have an important influence as role models.

6.8 Given the association between smoking (and other drug use) with mental health problems, truancy and juvenile offending, we **recommend** that all schools have effective systems for the assessment, support and care for such pupils, including the ability to liaise effectively with social services where necessary.

**Higher and further education and training**

6.9 Given the clear evidence that many young people start to smoke or progress from occasional to regular smoking (and drink heavily or use other drugs) once they leave school, we **recommend** that Universities, Colleges of Further Education and other major training providers, student associations and the National Union of Students should be invited to explore how they could better enable students or trainees to avoid starting to smoke or misuse alcohol or other drugs while attending their institution. This could be developed within the framework of The Health Promoting University.

**Community-based initiatives**

6.10 Our review of the research found that most community-wide initiatives were not successful and in those that showed some impact it was unclear which elements contributed to the effect. The *Breathing Space* initiative in Wester Hailes, Edinburgh, was not successful. Given the absence of a successful model, we cannot as yet endorse this approach for country-wide action. Future plans for a community-based smoking prevention initiative should fully consider and seek to avoid the reasons behind the lack of success of *Breathing Space*.\(^\text{84, 85}\)
6.11 There remains, nevertheless, an urgent need to find ways of interrupting the drift into nicotine addiction and lifelong smoking by so many young people in Scotland, particularly in disadvantaged circumstances. We therefore recommend further research studies to test innovative, carefully designed ways of protecting and dissuading young people in disadvantaged circumstances from starting to smoke or becoming regular smokers. We also recommend that all community-based youth organisations should adopt clear no-smoking policies and use the opportunities open to them to reinforce the message about the addictiveness and harm to health of smoking.

Smoking cessation services for young people
6.12 In the light of the recent poor outcome of the pilot smoking cessation services for young people in Scotland98 we recommend that active consideration is given to developing other approaches within a carefully designed evaluation framework.

Smoking cessation services for adults
6.13 We have shown that young people are more likely to smoke if their parents smoke and if they live in areas where smoking is more common. We are optimistic that the current policies on the provision of opportunities and support for smoking cessation, against the background of the legislation on smoking in public places will reduce the number of present and future parents who smoke. In the medium to long-term, this should result in fewer children and young people starting to smoke. In addition, if parents who are unable to stop smoking ensure they at least do not smoke in the home, this could also contribute to the prevention of smoking among young people.

Consultation and implementation
6.14 Given that implementation of the recommendations in this report would largely affect young people, we recommend that a representative sample of young people should be consulted to seek their views on the recommendations

6.15 We recommend that the proposals in this report are used by the Scottish Executive as the basis for developing a fully resourced five year Action Plan, with built in performance measures, subject to monitoring by the Scottish Ministerial Group for Tobacco Control.
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