The Smoke-free Premises and Vehicles (Wales) Regulations 2018

Consultation response form

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Responses should be returned by **17 August 2018** to:

Risk Behaviours (Tobacco, Alcohol, Gambling)
Public Health Division
Directorate of Health Policy
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

or completed electronically and sent to: tobaccopolicy@gov.wales

Category of respondent	**Primary school**	☐
	Secondary school	☐
	Special school	☐
	Maintained school	☐
	Independent school	☐
	Higher education sector	☐
	Further education sector	☐
	Pre-school organisation	☐
	Other childcare setting	☐
	Registered child-minder	☐
	NHS hospital	☐
	Private hospital	☐
	Public health professional	☐
	Local government	☐
	Mental health unit	☐
	Hospitality sector	☐
	Enforcement officer	☐
	Police	☐
	Representative group	☐
	Other public sector organisation	☐
	Third sector organisation	✓
	Private individual	☐

	Other	☐

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐

ASH Wales is the only public health charity in Wales working exclusively to tackling the harm tobacco causes to Welsh communities. Further information about our work can be found at www.ash.wales

We welcome the opportunity to respond to this consultation and would like to note the valued collaboration with Tenovus Cancer Care in elements of this response.

This consultation response has been endorsed by the following members of the Wales Tobacco Control Alliance (WTCA), a network of third sector organisations and health professionals in Wales that have an interest in tobacco control: The British Heart Foundation, The British Lung Foundation, Tenovus Cancer Care, The British Medical Association, The Royal College of Paediatrics and Child Health, The Royal College of Nursing, RNIB Cymru and Kate Evans, Specialist Public Health Midwife at Abertawe Bro Morgannwg University Health board.

Questions

The Smoke-free Premises and Vehicles (Wales) Regulations 2018

Question 1 – Do you agree with the overall approach that has been taken to implementing the smoke-free provisions in the Public Health (Wales) Act 2017?

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

We agree with the overall approach taken to implement the smoke-free provisions in the Public Health (Wales) Act 2017.

Tobacco is the leading single cause of premature death in Wales and a major contributor to health inequalities. Smoking-attributable mortality still accounts for over 5,000 deaths in Wales each year and around one in every six deaths in people aged 35 and over. It is estimated 11,000 young people a year take up smoking in Wales and therefore it is imperative we concentrate on measures which will reduce this number and thereby reduce the amount of smoking-attributable morbidity and mortality among the Welsh population.

We believe the provisions contained in the Act are both workable and proportionate to support a reduction in smoking prevalence.

Definition of substantially enclosed and not enclosed or substantially enclosed

Question 2 – Do you think the proposed amendment to the meaning of 'substantially enclosed' provides clarity as to whether other structures that form part of the perimeter of the premises should be included when assessing whether the premises is 'substantially enclosed'? (Regulation 3(2))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

Question 3 – Do you consider the proposed meaning of 'not enclosed or substantially enclosed' provides clarity to the types of premises that such a meaning would relate to? (For example, hospital grounds, school grounds, or public playgrounds.) (Regulation 3(5))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

Exemptions: dwellings

Question 4 – Do you agree with the proposal to exempt dwellings that are workplaces when all of the people who work there are members of the household and when no members of the public might attend the dwelling to receive goods and services? (Regulation 4(1)-(5))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

There are no sustainable arguments to support the prohibition of smoking in an environment when all of those who work there are members of a household with no public attendance.

Question 5 – Do you agree that the following activities should be excluded from the assessment of work when considering whether a dwelling is a workplace under Section 7(2) of the 2017 Act? Please provide evidence to support your response. (Regulation 4(7))

- Providing personal or health care for a person living in the dwelling.
- Assisting with the domestic work of the household in the dwelling.
- Maintaining the structure or fabric of the dwelling.
- Installing, inspecting, maintaining or removing any service provided to the dwelling for the benefit of persons living in it.

Agree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐

Supporting comments

Legislation should seek to ensure all employees are treated equally, including those working in private spaces. A private space used as a workplace should be regulated like other workplaces.

Every person should be able to breathe air free from tobacco smoke whilst they are working. Smoke-free laws protecting the health of non-smokers are popular, do not harm businesses and encourage smokers to quit.

Exposure to second-hand smoke (SHS) has a major adverse impact on the health of non-smoking bystanders[1], increasing the risk of developing lung cancer by 20-30%[2] and coronary heart disease by approximately 25-30%[3]. Increased risk of these diseases occurs for both short-term and long-term exposure to SHS[4]. It has been estimated domestic exposure to SHS in the UK causes around 2,700 deaths in people aged 20-63 and a further 8,000 deaths a year among people aged 65 years and older. The 2006 US Surgeon General report[5] states there is no safe level of exposure to SHS and furthermore concludes that "the scientific evidence is now indisputable: SHS is not a mere annoyance. It is a serious health hazard that leads to disease and premature death in children and non-smoking adults."

ASH Wales believes the Welsh Government has a moral and legal obligation to use the strongest possible measures to protect non-smokers from the harms of tobacco. Healthcare

[1] Llewellyn DJ, Lang IA, Langa KM, Naughton F, Matthews FE. Exposure to secondhand smoke and cognitive impairment in non-smokers: national cross sectional study with cotinine measurement, BMJ , 2009, vol. 338 pg. b462

[2] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

[3] ITC Project, World Health Organization, and World Heart Federation (April 2012). Cardiovascular harms from tobacco use and secondhand smoke: Global gaps in awareness and implications for action. Waterloo, Ontario, Canada and Geneva, Switzerland.

[4] Flouris AD, Metsios GS, Carrillo AE, Jamurtas AZ, Gourgoulianis K, Kiropoulos T, Tzatzarakis MN, Tsatsakis AM, Koutedakis Y. Acute and short-term effects of secondhand smoke on lung function and cytokine production. Am J Respir Crit Care Med 2009;179:1029–103

[5] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

workers, police officers, social workers, domestic staff etc have the right to receive the same level of protection as their co-workers. Community midwives, nurses, social and domestic workers can be regularly exposed to second and third-hand smoke and for extensive periods of time whilst visiting dwellings which are considered their workplace.

Making all enclosed workplaces, whether permanent or temporary, smoke-free spaces, will also serve to minimise the risk of legal challenges by non-smoking staff or other residents who are exposed to SHS, as occurred in 2015, when a prisoner went to court over SHS related health issues he developed whilst in prison[6].

Exemptions: holiday or temporary accommodation

Question 6 – Do you agree that self-contained holiday or temporary accommodation should **never** be smoke-free? If not, please describe the scenario(s) in which you consider such accommodation should be smoke-free. (Regulation 5)

Agree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐

Supporting comments

There is some evidence that third-hand smoke (THS) can be harmful as smoke can linger on furniture and surfaces, causing harm to other people who use the property especially babies and toddlers who are more likely to come into contact with objects, furniture etc. with their hands and transfer THS residue.

A 2010 study[7] indicated third-hand smoke accumulates in smokers' homes and persists even after homes have been vacant for two months and are cleaned and prepared for new residents. The study suggested non-smokers living in former smokers' homes are exposed to THS in dust and on surfaces.

Furthermore, a WHO report on SHS[8] states that toxic chemicals from second-hand tobacco smoke contamination persist well beyond the period of active smoking, clinging to rugs, curtains, clothes, food, furniture and other materials. These toxins can remain in a room for weeks and months after someone has smoked there.

While the evidence on the harms of third-hand smoke is less established than SHS it is likely to exist and be particularly harmful to children and babies.[9] Therefore ASH Wales believes that, while the evidence on this issue must continue to be regularly reviewed, a precautionary principle must be applied to THS until such a time arrives that the nature and extent of its effects are definitively and conclusively known.

As a result, the weight of argument favours a ban on smoking in self-contained holiday and temporary accommodation, including short-term lettings.

[6] BBC News. December 2017. https://www.bbc.co.uk/news/uk-england-lancashire-42394342

[7] Matt, George E et al. When smokers move out and non-smokers move in: residential thirdhand smoke pollution and exposure. Tobacco Control, 2011;20:e1. http://tobaccocontrol.bmj.com [Accessed 06 May 2011]

[8] World Health Organisation. Protect people from tobacco smoke. 2009. http://www.who.int/tobacco/mpower/2009/c_gtcr_protect_people_tobacco_smoke.pdf

[9] ASH Scotland. Third-hand Smoke. June 2011. https://www.ashscotland.org.uk/media/3942/Thirdhandsmoke.pdf

Exemptions: adult care homes and adult hospices

Question 7 – Do you agree with the exemption that permits the managers of adult care homes or adult hospices to designate a room in the premises for smoking? (Regulation 6)

Agree	☐	Disagree	✓	Neither agree nor disagree	☐

Supporting comments

Care homes and adult hospices are places where people live and work. Patients and staff have as much right as the general population to be protected from toxic tobacco smoke in their home and workplace.

Exposure to SHS has a major adverse impact on the health of non-smoking bystanders.[10][11] The Scientific Committee on Tobacco and Health also reported in November 2004 that exposure to SHS was a "substantial public health hazard" and found that exposure to SHS increased a non-smoker's risk of contracting lung cancer and heart disease by around 25%[12]. Second-hand tobacco smoke can spread from one room to another within a building, even if doors to the smoking area are closed[13] meaning that a designated room would be unable to sufficiently mitigate the serious harms of SHS. Consequently, ASH Wales is strongly in favour of never permitting smoking in an enclosed public space.

The adult hospices we have sought views from have a voluntary smoking ban in place already with designated areas for smokers outside. We would suggest a review of the current position to ensure that the legislation supports these voluntary bans, which are often difficult to enforce without the backing of relevant legislation.

Question 8 – Do you agree that a room designated for smoking within an adult care home or adult hospice should be used by residents only? (Regulation 6(2)(a))

Agree	☐	Disagree	✓	Neither agree nor disagree	☐

Supporting comments

[10] ITC Project, World Health Organization, and World Heart Federation (April 2012). Cardiovascular harms from tobacco use and secondhand smoke: Global gaps in awareness and implications for action. Waterloo, Ontario, Canada and Geneva, Switzerland.
[11] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
[12] Secondhand smoke: Review of evidence since 1998. Scientific Committee on Tobacco and Health (SCOTH), November 2004: pg 4.
[13] World Health Organisation. Protect people from tobacco smoke. 2009. http://www.who.int/tobacco/mpower/2009/c_gtcr_protect_people_tobacco_smoke.pdf

ASH Wales believes staff and visitors should never be permitted to smoke in an enclosed public space, given the comprehensive evidence of the harms of SHS discussed in the responses to questions 5 and 7.

Exemptions: mental health units

Question 9 – Do you agree with the proposal to remove the exemption that permits the designation of smoking rooms in mental health units? (Regulation 8) (Please note that the removal of the exemption would not prevent the person in charge of the premises from designating outdoor areas as places where patients can smoke).

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

Mental health problems affect almost a quarter of the population and there is now evidence that people with mental health problems die on average 10 to 20 years earlier than the general population, [14][15][16] with smoking being the single largest contributor to reduced life expectancy [17]. Smoking rates amongst people with mental health problems are also significantly higher than in the general population[18] and this may be particularly problematic in mental health units, since smoking rates are positively associated with the severity of the mental problem[19], with the highest expectancy levels of smoking found in psychiatric in-patients.[20]

In Wales, this issue of higher rates of smoking prevalence among individuals coping with a mental illness is particularly problematic since this inequality in smoking prevalence is failing to fall. The gap in smoking prevalence between adults dealing with a mental illness and the population average has failed to sustainably decrease; from 14% in 2004/05 and in fact rose to 17% in 2016/17 and 2017/18. The smoking prevalence for males for adults who report that

[14] Odegard O. Mortality in Norwegian mental hospitals 1926-1941. Acta Genet Stat Med 1951; 2: 141-73.
[15] Chesney, E et al. Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry. 2014; 3 (2): 153–160
[16] Chang CK et al. Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. PLoS One. 2011; 6(5): e19590.
[17] Smoking and Mental Health. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 2013
[18] McManus S, Meltzer H & Campion J, 2010. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research. 4
[19] McManus S, Meltzer H & Campion J, 2010. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research. 4
[20] Jochelson, K. & Majrowski W. Clearing the Air: Debating Smoke-free Policies in Psychiatric Units. London, King's Fund, 2006.

they have a long-standing mental health problem also increased from 36% in 2016-17 to 41% in 2017-18.[21][22][23][24].

Smoking cessation not only improves physical health, it also is associated with improved mental health. A review of numerous studies finds that cessation is associated with reduced depression, anxiety and stress as well as improved positive mood and quality of life compared with continuing to smoke.[25]

Smoking also increases the required psychiatric medication dosage for smokers,[26] and may increase potential side-effects.[27]A 2013 report finds that the required increase in medication may cost the UK up to £40 million per annum[28]

Smoking may also push a large proportion of smokers with a mental illness into poverty.[29] Research has shown that, after adjusting for under-reporting of tobacco smoked, smokers with a mental health problem below the poverty line could be spending over £2200 a year.[30] Longitudinal evidence also finds that increases in household incomes above the poverty line may lead to improvements in smoking cessation rates[31].

Despite high rates of smoking and levels of addiction in this population, people with mental health problems are no less likely to want to quit smoking but they can expect to find it more difficult than the general population[32]. Primary care professionals are less likely to intervene with smokers with a mental health problem than with those without[33] even though prompts from health professionals have been shown to be pivotal in driving quit attempts among all smokers[34].

Allowing smoking rooms in mental health settings encourages smoking and facilitates the continuation of this deadly and highly addictive habit amongst the most vulnerable in our society. ASH Wales believes the removal of this exemption is imperative to de-normalise smoking and encourage quit attempts.

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[21] National Survey for Wales 2017-18 date will be published here as an ad-hoc request: https://gov.wales/statistics-and-research/ad-hoc-statistical-requests/?lang=en

[22] It is important to note that a different survey was used in 2016-17 relative to all years prior to this, meaning the results are not directly comparable.

[23] National Survey for Wales. https://gov.wales/docs/statistics/adhocrequests/2017/170821-reported-smoking-prevalence-adults-report-have-long-standing-mental-health-condition-2016-17-en.ods

[24] Welsh Health Survey. https://gov.wales/docs/statistics/adhocrequests/2016/161017-reported-smoking-prevalence-adults-currently-treated-mental-illness-2003-04-to-2015-en.ods

[25] Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 2014. 348:g1151

[26] Oquendo MA, Galfalvy H, Russo S, Ellis SP, Grunebaum MF, et al. 2004. Prospective study of clinical predictors of suicidal acts after a major depressive episode in patients with major depressive disorder or bipolar disorder. Am. J. Psychiatry 161: 1433–41

[27] Oquendo MA, Galfalvy H, Russo S, Ellis SP, Grunebaum MF, et al. 2004. Prospective study of clinical predictors of suicidal acts after a major depressive episode in patients with major depressive disorder or bipolar disorder. Am. J. Psychiatry 161: 1433–41

[28] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.

[29] The Stolen Years: The Mental Health and Smoking Action Report. 2016. www.ash.org.uk/stolenyears

[30] Mental health, smoking and poverty in the UK. University of Nottingham. 2016. A report commissioned by Action on Smoking and Health and Public Health England www.ash.org.uk/povmentalhealth

[31] Young-Hoon KN. A longitudinal study on the impact of income change and poverty on smoking cessation. Can J Public Health 2012; 103(3): 189-194

[32] Health Survey for England 2010.

[33] Szatkowski L, McNeill A. The delivery of smoking cessation interventions to primary care patients with mental health problems. Addiction. 2013 Aug;108(8):1487-94.

[34] Stead LF et al. Physician advice for smoking cessation. The Cochrane Collaboration. 2013; 5:CD000165.

NICE guidance on smoking in secondary care settings issued in 2013 concluded that a smoke-free NHS estate, including all mental health trusts, is essential to providing a healthy environment and promote non-smoking as the norm for people using NHS services[35].The guidance justifies this for a number of reasons including; there is no risk-free level of exposure to tobacco smoke and so there is a need to protect people from exposure to SHS, to limit fire-risks, to promote smoking cessation and to remove triggers that may cause relapse[36].

Concerns had been raised that long-stay settings such as mental health trusts should be exempt, yet these exemptions were rejected by NICE[37] on the grounds they are likely to perpetuate smoking in disadvantaged groups and contravene the NHS's duty of care.
There were concerns that smoke-free policies in mental health settings may increase the number of violent incidents, yet evidence from mental health settings in the UK and abroad which adopted comprehensive smoke-free policies suggests there is no evidence for this and in many cases violence levels have decreased following the introduction of smoking bans[38].

The 2013 NICE guidance also stresses supporting patients to quit smoking requires hospital grounds as well as buildings to be smoke-free, with no exemptions, and therefore shelters or other designated outdoor smoking areas should be removed. NICE guidance rejected calls to permit smoke-free shelters by arguing it consumes staff time and financial resources which would be better used providing effective cessation support and in other aspects of patient care[39].

Several studies, as discussed in a 2018 report by the Royal College of Physicians (RCP)[40], support the notion that the implementation of smoke-free policies is often undermined in mental health settings by regular institutionalised smoking breaks which often became a fixation for patients and reduced their motivation to try to quit smoking.[34]

An international review[41] found that partial smoke-free policies are less successful than total smoke-free policies and can create additional problems, mainly because partial smoke-free policies are found to have a limited impact on the culture of smoking and can create conflict if inconsistently implemented. Yet the review also conceded it may be effective to provide a stepped approach from partial to complete smoke-free policy in some contexts*[42].*

Although ASH Wales supports a comprehensive smoke-free policy, it considers that other aspects of the NICE guidance are more important, including the provision of quitting support

[35] National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services (PH48). London: NICE, 2013. nice.org.uk/guidance/ph48 [Accessed 26 February 2018].
[36] National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services (PH48). London: NICE, 2013. nice.org.uk/guidance/ph48 [Accessed 26 February 2018].
[37] National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services (PH48). London: NICE, 2013. nice.org.uk/guidance/ph48 [Accessed 26 February 2018].
[38] Smoking bans in psychiatric inpatient settings? A review of the research Lawn S, Pols R. Aust N Z J Psychiatry. 2005 Oct; 39(10):866-85.
[39] National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services (PH48). London: NICE, 2013. nice.org.uk/guidance/ph48 [Accessed 26 February 2018].
[40] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
[41] Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research Sharon Lawn, Jonathan Campion Int J Environ Res Public Health. 2013 Sep; 10(9): 4224–4244. Published online 2013 Sep 10. doi:10.3390/ijerph10094224 PMCID: PMC3799524
[42] Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research Sharon Lawn, Jonathan Campion Int J Environ Res Public Health. 2013 Sep; 10(9): 4224–4244. Published online 2013 Sep 10. doi:10.3390/ijerph10094224 PMCID: PMC3799524

to patients, and alternative nicotine products to be made readily available for patients. Therefore, it may be preferable to aim towards a comprehensive smoke-free policy in future, once these aspects of the NICE guidance have been implemented.

Finally, there is an abundance of evidence indicating that smoke-free polices that are successfully implemented can generate significant positive outcomes. A review of the evidence on the impact of smoke-free policies in 4 mental health units found a smoke-free psychiatric hospitalisation may also have a positive impact on patients' smoking-related behaviours, motivation, and beliefs, both during admission and up to 3-months post discharge, although more research would be needed to verify this[43]. There is also evidence from an international review[44] that a smoke-free policy in mental health units: improves staff and patient physical wellbeing[45][46][47][48], leads to a decline in staff smoking rates,[49][50][51] increases staff perception of patients' capacity to quit smoking[52][53], and that patients gain capacity and belief in their own ability to quit or cut down their tobacco consumption[54][55][56][57][58]. Longitudinal studies additionally show that smoke-free policies bring about a change in the smoking culture, particularly shifting staff attitudes towards patients' smoking[59]. The international

[43] Stockings EA. et al (2014) The impact of a smoke-free psychiatric hospitalization on patient smoking outcomes: a systematic review. Aust NZ J Psychiatry 2014 May 12;48(7):617-633

[44] Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research Sharon Lawn, Jonathan Campion Int J Environ Res Public Health. 2013 Sep; 10(9): 4224–4244. Published online 2013 Sep 10. doi:10.3390/ijerph10094224 PMCID: PMC3799524

[45] Draft Final Report for the Department of Health, CIEH; London, UK: 2010.

[46] Extended use of nicotine replacement therapy to maintain smoking cessation in persons with schizophrenia. Dale Horst W, Klein MW, Williams D, Werder SF
Neuropsychiatry Treat. 2005 Dec; 1(4):349-55.

[47] Impact of a smoke-free policy in a large psychiatric hospital on staff attitudes and patient behaviour. Voci S, Bondy S, Zawertailo L, Walker L, George TP, Selby P
Gen Hosp Psychiatry. 2010 Nov-Dec; 32(6):623-30.

[48] Review Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Olivier D, Lubman DI, Fraser R
Aust N Z J Psychiatry. 2007 Jul; 41(7):572-80.

[49] Review Smoking bans in psychiatric inpatient settings? A review of the research. Lawn S, Pols R
Aust N Z J Psychiatry. 2005 Oct; 39(10):866-85.

[50] Factors associated with success of smoke-free initiatives in Australian psychiatric inpatient units. Lawn S, Campion J. Psychiatry Serv. 2010 Mar; 61(3):300-5.

[51] Readiness to quit smoking and quit attempts among Australian mental health inpatients. Stockings E, Bowman J, Mc Elwaine K, Baker A, Terry M, Clancy R, Bartlem K, Wye P, Bridge P, Knight J, Wiggers J. Nicotine Tob Res. 2013 May; 15(5):942-9.

[52] Evaluation of a smoke-free forensic hospital: patients' perspectives on issues and benefits. Hehir AM, Indig D, Prosser S, Archer VA
Drug Alcohol Rev. 2012 Jul; 31(5):672-7.

[53] Impact of a smoke-free policy in a large psychiatric hospital on staff attitudes and patient behaviour. Voci S, Bondy S, Zawertailo L, Walker L, George TP, Selby P Gen Hosp Psychiatry. 2010 Nov-Dec; 32(6):623-30.

[54] Effect of a total smoking ban in a maximum security psychiatric hospital. Hempel AG, Kownacki R, Malin DH, Ozone SJ, Cormack TS, Sandoval BG 3rd, Leinbach AE. Behav Sci Law. 2002; 20(5):507-22.

[55] Impact of smoking cessation on psychiatric inpatients treated with clozapine or olanzapine. Cole ML, Trigoboff E, Demler TL, Opler LA.
J Psychiatr Pract. 2010 Mar; 16(2):75-81.

[56] People with mental illness can tackle tobacco. Ashton M, Miller CL, Bowden JA, Bertossa S. Aust N Z J Psychiatry. 2010 Nov; 44(11):1021-8.

[57] What do 1000 smokers with mental illness say about their tobacco use? Ashton M, Rigby A, Galletly C Aust N Z J Psychiatry. 2013 Jul; 47(7):631-6.

[58] Ashton M., Lawn S., Hosking J.R. Mental health workers' views on addressing tobacco use. Aust. N. Z. J. Psychiatr. 2010;44:846–851

[59] Ashton M., Lawn S., Hosking J.R. Mental health workers' views on addressing tobacco use. Aust. N. Z. J. Psychiatr. 2010;44:846–851

review also found evidence that a smoke-free policy leads to patients being more engaged in ward activities.[60]

After considering the evidence, ASH Wales supports the proposals in regulation 8. ASH Wales would also support mental health settings aiming towards a comprehensive smoke-free policy in future, (where an outdoor smoking shelter is not permitted) after key aspects of the NICE guidance are implemented, such as smoking cessation support and alternative methods of nicotine delivery being made available within mental health units across Wales.

Question 10 – Do you agree that the proposed transition period of 18 months after the Regulations come into force is sufficient time to allow mental health units to implement indoor smoke-free conditions in a safe and secure way? (Regulation 8(6))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

ASH Wales supports the 18-month proposed transition period, especially given evidence suggests a sufficiently long transition period of at least 12 months enables units to enact a smoke-free policy successfully[6162].

ASH Wales is particularly supportive of a time-limited exemption as it would enable patients and residents to adjust to policy changes and seek support to give up smoking if they wish or to seek alternative methods of nicotine delivery such as NRT or e-cigarettes for those who are unable to stop smoking.

ASH Wales believes a smoke-free policy will be far more effective if it is implemented in accordance with the NICE PH48 recommendations,[63] which the transition period will enable. A 2018 RCP report found it is cost effective to make NHS settings, including mental health units, smoke-free, as recommended in the NICE guidance, and savings to the NHS would be achieved within the first year of implementation[64].

Interestingly the guidance first recommends the importance of providing support for secondary care followed by stop smoking support. This indicates that to create a smoke-free NHS the provision of cessation support, pharmacotherapies, among other factors, are pivotal to developing a smoke-free policy.

Recommendation 8 specifically mentions abstaining from smoking as an inpatient or a visitor to a hospital can be challenging for smokers and therefore that it is essential patients and their visitors have access to therapies and products to relieve withdrawal symptoms and to support quit attempts. ASH Wales supports the recommendations in the NICE PH45

[60] Jochelson K. Smoke-free legislation and mental health units: The challenges ahead. Brit. J. Psychiatr. 2006; 189:479–480. doi: 10.1192/bjp.bp.106.029942.
[61] The Stolen Years: The Mental Health and Smoking Action Report. 2016. www.ash.org.uk/stolenyears
[62] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
[63] National Institute for Health and Care Excellence (NICE). Smoking: acute, maternity and mental health services (PH48). London: NICE, 2013. nice.org.uk/guidance/ph48 [Accessed 26 February 2018].
[64] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.

guidance, 'Smoking: Harm reduction' to be applied for all those with a mental health problem who are unwilling or unable to stop smoking completely.
E-cigarettes may be an important method to deal with nicotine withdrawal symptoms and support the effectiveness of a smoke-free policy, as is considered in a 2018 RCP report[65]. E-cigarettes have been found to be useful sources of nicotine for mental health patients dealing with nicotine withdrawal symptoms and support the effectiveness of a comprehensive smoke-free policy [66]. This is supported by CQC guidance[67] and a statement by ASH England's 'Mental Health and Smoking Partnership'[68]. The statement recommends that information on the use of e-cigarettes, alongside licensed treatments, should form part of the care package for people with mental health problems who smoke. This advice should include information explaining that e-cigarettes are significantly less harmful than tobacco cigarettes, to counter false beliefs which are found to deter individuals coping with a mental illness from using e-cigarettes instead of cigarettes[69]. Public Health England have also recommended approaches to e-cigarette use are developed to support smoke-free sites[70].

After considering the evidence ASH Wales would be supportive of the proposed transition period, to allow for the policy to be enacted broadly in line with the PH48 NICE guidance, including the provision of smoking cessation support and alternative methods of nicotine delivery.

Question 11 – Is there anything else that should be taken into account in relation to smoking in residential mental health treatment establishments?

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

It is important to note progress in the implementation of the NICE guidance across mental health units since 2013 is variable[71]. The same NICE PH48 evidence review identified barriers to implementation as well as facilitators of smoke-free policy in mental health units, of which lessons can be learned.[57]
Key barriers include; resistance among staff, a belief that smoking is a right, a lack of clarity among staff about how to implement the policy and what to do when it was violated - leading to calls for better management support and greater guidance and training on how to deal with

[65] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
[66] The Stolen Years: The Mental Health and Smoking Action Report. 2016. The report is available at www.ash.org.uk/stolenyears
[67] Care Quality Commission. Brief guide: smoke-free policies in mental health inpatient services. London: CQC, 2017. www.cqc.org.uk/sites/default/files/20170109_briefguide-smokefree.pdf [Accessed 1 March 2018].
[68] Action on Smoking and Health (ASH). The stolen years: the mental health and smoking action report. ASH, 2016. http://ash.org.uk/information-and-resources/reportssubmissions/reports/the-stolen-years/ [Accessed 25 February 2018].
[69] Action on Smoking and Health (ASH). The stolen years: the mental health and smoking action report. ASH, 2016. http://ash.org.uk/information-and-resources/reportssubmissions/reports/the-stolen-years/ [Accessed 25 February 2018].
[70] Public Health England. Use of e-cigarettes in public places and workplaces. Advice to inform evidenced-based policy making. London: Public Health England, 2016. www.gov.uk/government/uploads/system/uploads/attachment_data/file/534586/PHE-advice-on-use-ofe-cigarettes-in-public-places-and-workplaces.PDF [Accessed 4 March 2018].
[71] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.file:///C:/Users/sophia/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/Hiding%20in%20plain%20sight%20(2).pdf

violations. Other barriers include insufficient staff resources and the belief a smoke-free policy would adversely affect psychiatric patients' mental health. There is some evidence these beliefs can diminish after exposure to the policy. Other barriers include (incorrect) beliefs on the impact of quitting smoking on psychiatric drug use and on patient's commitment to treatment.

The NICE evidence review [57] also found a number of factors which could enhance the uptake and value of cessation support as part of a smoke-free policy: improved provision of information materials, pharmacotherapies, trained staff and diversionary activities; better continuity with stop smoking services provided in the community, including advanced warning of smoke-free rules and provision of comparable services for staff who wish to stop smoking.

The review also found strong leadership, committed management and robust systems for monitoring implementation and responding to problems as they emerge are also important. It also notes a smoke-free policy is most likely to succeed if support is framed as an initiative designed to improve patient health more generally and provisions are made for those inpatients seeking temporary abstinence while attending for treatment.

Lessons learnt from the Wales Tobacco or Health Network (WTHN) event which ASH Wales held in 2016 with 60 mental health professionals supports that the most successful trusts often implemented a smoke-free policy which had a wide-reaching objective to increase the general health and well-being of their patients. This includes initiatives to improve exercise, diet and fun activities to encourage patients to engage in a positive health environment. This is also supported by research, which shows fewer activities in mental health settings is associated with higher levels of smoking.[72][73][74][75]

The international review of best practice generally supports the findings discussed above[76] and also adds the importance of; clear audit and reporting of all patients' smoking status, adequate resourcing of policy implementation, close follow-up of patients after discharge, support across the continuum of care transitions, and consistent implementation practices in mental health inpatient units.[77] [78][79]
Given the discrepancy in the variability in the success of a smoke-free policy, ASH Wales would support the above facilitators of successful implementation being considered, which the 18-month transition period will enable.

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[72] Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective. Olivier D, Lubman DI, Fraser R. Aust N Z J Psychiatry. 2007 Jul; 41(7):572-80.
[73] Long C.G., Jones K. Issues in running smoking cessation groups with forensic psychiatric inpatients: Results of a pilot study and lessons learnt. Brit. J. Forensic Pract. 2005;7:22–28. doi: 10.1108/14636646200500011. [Cross Ref] [Ref list]
[74] Smoking and quitting: a qualitative study with community-living psychiatric clients. Lawn SJ, Pols RG, Barber JG Soc Sci Med. 2002 Jan; 54(1):93-104.
[75] Determining the effectiveness of mental health services from a consumer perspective: part 1: enhancing recovery. Happell B. Int J Mental Health Nurse. 2008 Apr; 17(2):116-22.
[76] Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research Sharon Lawn, Jonathan Campion Int J Environ Res Public Health. 2013 Sep; 10(9): 4224–4244. Published online 2013 Sep 10. doi:10.3390/ijerph10094224 PMCID: PMC3799524
[77] Achieving Smoke-Free Mental Health Services: Lessons from the Past Decade of Implementation Research Sharon Lawn, Jonathan Campion Int J Environ Res Public Health. 2013 Sep; 10(9): 4224–4244. Published online 2013 Sep 10. doi:10.3390/ijerph10094224 PMCID: PMC3799524
[78] Smoking bans in psychiatric inpatient settings? A review of the research. Lawn S, Pols R Aust N Z J Psychiatry. 2005 Oct; 39(10):866-85.
[79] Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. Campion J, Lawn S, Brownlie A, Hunter E, Gynther B, Pols R
Australas Psychiatry. 2008 Apr; 16(2):92-7.

Finally, it is important to note the majority of individuals with mental health problems will never enter a mental health unit therefore policies supporting smoking cessation outside mental health units will be necessary to address health inequalities.

Discussions within the 2016 WTHN event found specialised smoking cessation support, namely with a treatment period longer than 4 weeks is required to adequately support individuals with mental health problems to quit smoking. This could be achieved either within Help Me Quit services or could involve the training of mental health employees to deliver treatment, making use of established relationships. It is also essential that once patients are discharged, they are automatically referred to these services and the data on smoking prevalence and quit rates is collated and published for these smokers.

Exemptions: hotels, guesthouses, inns, hostels and members' clubs

Question 12 – Do you agree with the proposal to remove the exemption that permits the designation of smoking bedrooms in hotels, guesthouses, inns, hostels and members' clubs? (Regulation 9)

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

ASH Wales strongly believes there should be no exemptions when it comes to the banning of smoking in enclosed spaces given the fact there is no safe level of exposure to SHS from cigarettes, as discussed earlier (please see evidence discussed in Question 5).

Making all enclosed workplaces smoke-free - whether permanent or temporary - will serve to minimise the risk of legal challenges by non-smoking staff who are exposed to SHS.

Question 13 – Do you agree that the proposed transition period of 12 months after the Regulations come into force is sufficient transition time for hotels, guesthouses, inns, hostels and members' clubs to remove their smoking bedrooms? (Regulation 9(5))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

ASH Wales believes the 12 months transition period is sufficient for these premises to install outside designated smoking areas and no smoking signs. Please see supporting evidence on transition periods in Question 10.

Smoke-free hospital grounds, school grounds and public playgrounds

Question 14 – Do you consider the proposed conditions for areas designated for smoking in the grounds of schools with residential accommodation are appropriate? (Regulation 10)

Agree	✓	Disagree	☐	Neither agree nor disagree	☐

Supporting comments

Question 15 – Do you consider the proposed conditions for areas designated for smoking in hospital grounds are appropriate? (Regulation 11)

Agree	✓	Disagree	☐	Neither agree nor disagree	☐

Supporting comments

Question 16 – Do you agree that the duty to prevent smoking should **not** be applied by these Regulations to hospital grounds, school grounds and public playgrounds?

Agree	☐	Disagree	✓	Neither agree nor disagree	☐

Supporting comments

ASH Wales supports the fact that, since the previous smoke-free legislation has been enforced quite effectively, each local authority is authorised to act as an enforcement authority in relation to the smoke-free premises, places and vehicles in their area and that the enforcement provisions contained in the 2007 Regulations will be retained.

However, ASH Wales disagrees with the lack of duty on the managers of hospital grounds, school grounds and public playgrounds to prevent smoking there due to their extensive and dispersed nature. ASH Wales believes either the managers of these areas, or local authorities should be named as having a duty to prevent smoking and recommends this be clarified.

Exposure to SHS has a major adverse impact on the health of non-smoking bystanders. While ASH Wales warmly welcomes the proposed prohibition of smoking in hospital grounds, school grounds and public playgrounds, it considers that without adequate enforcement the proposals risk being undermined. There is little evidence to suggest that self-enforcement or peer pressure works as an effective deterrent in such circumstances, particularly in the often-emotional environment of a hospital setting or public playground.

While compassion is shown in the proposed provision of smoking shelters, particularly in relation to hospitals, to cater for the needs of smoker's suitable enforcement mechanisms must be in place to ensure the rights of non-smokers, and interests of public health, are shown equal consideration. There appears to be no clear rationale for the lack of clarity around the duty to prevent smoking in these outdoor spaces. ASH Wales also believes that placing an additional expectation of enforcement upon teachers and clinical staff would be unjustified.

Many Local Authorities have warranted officers to enforce regulations related to littering and dog fouling and other Public Spaces Prevention Orders. The addition of a duty to prevent smoking in public playgrounds could provide an overlap in service delivery.

ASH Wales is calling for clarification and consideration of suitable mechanisms for the duty to prevent smoking in the smoke-free areas, or at least on part of these areas to ensure they are effectively enforced.

ASH Wales also disagrees with the way compliance with the smoking ban in these smoke-free areas will be monitored, with a review four years after the regulations come into force to assess their effectiveness. We believe assessments should be more regular with specific detail on how the impact of the legislation will be monitored.

ASH Wales believes there should be clarification on plans for evaluating these regulations, as there is limited detail so far both in terms of timetables and methodology. We also recommend a baseline assessment of how prevalent smoking currently is across these areas, covering levels of second hand smoke and visual exposure.

There should be a timetable of evaluation check points, to measure progress and make changes where necessary. This may be important since a good evaluation framework can:

o Ensure the regulations are being properly implemented
o Support the case for further legislation in Wales (should the evaluation prove the legislation is effective)
o Provide evidence from Wales for other countries with aspirations for smoke-free legislation

No-smoking signs

Question 17 – Do you agree with the proposed reduced requirements for no-smoking signs for enclosed and substantially enclosed premises? (Regulation 12)

Agree	☐	**Disagree**	✓	**Neither agree nor disagree**	☐

Supporting comments

The consultation document to these proposal outlines that '[the] current smoke-free law has high levels of compliance' - yet no rationale is provided for seeking to relax the requirements for no-smoking signs. Similarly, no risk-based analysis accompanies the proposal that takes into account possible reduced levels of awareness and/or compliance with the regulations as a result of the reduced requirements for signage and there is no suggestion that the amended requirements will increase compliance.

Consequently, ASH Wales is concerned that the proposals risk reducing compliance with the regulations and thus represents a risk to public health.

Question 18 – Do you agree with the proposed requirements for no-smoking signs in hospital grounds, school grounds and public playgrounds? (Regulation 13)

Agree	☐	**Disagree**	☐	**Neither agree nor disagree**	✓

Supporting comments

Although we support the general principles of the proposals, ASH Wales is concerned at the prospect of relaxing the requirements for signage, in line with the response provided to Question 17.

We also believe, as reflected in our response to Question 16, enforcement will be necessary, as well as the proposed no-smoking signs, to ensure this legislation is enacted in practice.

Smoke-free vehicles

Question 19 – Do you agree that vehicles should be smoke-free when being used by only one person for paid or voluntary work purposes whilst carrying a person who is receiving goods or services from another person also in the vehicle? (Regulation 14(3)(a))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

ASH Wales also believes, that even in the event that goods and services are not being delivered, that while these vehicles are being used in the course of employment, the vehicle should be smoke-free, due to the substantial harms of SHS, discussed in the response to Question 5.

Question 20 – Do you agree that vehicles being used by only one person for paid or voluntary work purposes whilst carrying a person who is receiving goods or services from another person also in the vehicle should be smoke-free only when being so used? (Regulation 14(5))

Agree	☐	**Disagree**	☐	**Neither agree nor disagree**	✓

Supporting comments

Neither agree nor disagree.

Fixed penalty amounts

Question 21 – Do you agree that the fixed penalty amount (£200) and discounted amount (£150) for the offence of failing to provide smoke-free signage that meets the specified requirements are appropriate and proportionate? (Regulations 19(a) and 20(a))

Agree	✓	**Disagree**	☐	**Neither agree nor disagree**	☐

Supporting comments

Question 22 – Do you agree that the fixed penalty (£50) and discounted amounts (£30) for the offence of smoking in smoke-free premises are appropriate and proportionate? (Regulations 19(b) and 20(b)).

Agree	☐	Disagree	✓	Neither agree nor disagree	☐

Supporting comments

The penalty amount is not in line with fixed penalties for other public health matters. For example, failure to pick up dog waste, is £100 in many Local Authorities in Wales such as Bridgend, Rhondda Cynon Taff. Furthermore, fines are more severe for many non-public health matters such as illegal parking[80] or for dropping a cigarette but, for which the default fine in Wales is £75 and for England it is £100 (the range is £50-£150 depending on the council).

While these matters are of great importance, there is a risk in diminishing the severity of smoking in a smoke-free area if the penalty structure is less severe than other public health and non-public health matters.

Question 23 – Do you agree that the fixed penalty (£50) and discounted amounts (£30) for the offence of failing to prevent smoking in smoke-free private vehicle carrying a person(s) under the age of 18 are appropriate and proportionate? (Regulations 19(c) and 20(c)).

Agree	☐	Disagree	✓	Neither agree nor disagree	☐

Supporting comments

In addition to the arguments made above in respect of the severity of penalties for failing to prevent smoking in a smoke-free area it does not appear proportionate that the same penalties should apply to the scenario of failing to prevent smoking in a smoke-free private vehicle carrying a minor. According to Cancer Research UK, SHS has been linked to around 165,000 new cases of disease among children in the UK each year[81].

Given the vulnerable nature of minors and their potentially diminished ability to advocate for their rights and interests ASH Wales believes that this offence should carry a more severe penalty than that of failing to pick up dog waste or parking illegally.

Additional smoke-free premises

Question 24 – There are no current proposals for additional smoke-free premises; however, we welcome your views on the types of premises that could be considered in future consultations on moving towards the ambition of a smoke-free Wales.

Comments

Social Housing

[80] Cardiff Gov 2018. https://www.cardiff.gov.uk/ENG/resident/Parking-roads-and-travel/Parking-fines/Received-a-pcn/Pages/default.aspx [Accessed 08 August 2018]

[81] Cancer Research UK 2016. https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/smoking-and-cancer/passive-smoking

ASH Wales would support a future consultation to investigate the most effective policies to reduce significantly higher rates of exposure to second-hand smoking in social housing relative to other forms of housing tenure. This impacts on non-smokers and perpetuates persistent health inequalities. Responses to the consultation may include a change in tenancy rules to make rented accommodation smoke-free.

Given that smoke-free tenancy rules are far more common in private rented accommodation relative to social housing, such a policy would reduce health inequalities arising from SHS across rented accommodation. Other measures, which could also be considered, include tailored cessation support and incentives to encourage more social housing tenants who smoke to access NHS behavioural support. A national consultation will therefore enable all relevant stakeholders to identify the most effective and acceptable measures to address these problems.

Our latest YouGov survey (March 2018), which surveys a representative sample of 1079 adults (aged 18+) in Wales finds that 45%[82] of respondents living in housing association/local authority accommodation are exposed to SHS in their home from someone smoking elsewhere, e.g. a neighbour. This is more than double the average figure across all respondents (21%) and nearly double the average figures for all other types of housing tenure. 31% of tenants also reported that they are exposed to SHS in the communal areas of the building they reside in.

This may be explained by the fact that the survey also found that when respondents that rent were asked if their tenancy agreement includes a rule that you must not smoke in your home, the proportion that answered no was over twice as high for those that rent from a housing association/local authority (81%) compared to those that rent privately (30%). Ensuring the tenants of private accommodation and social housing in Wales have equal opportunities to live in a smoke-free premise may be pivotal in reducing inequalities in SHS exposure across these social tenures.

The health harms of SHS have been firmly established. The Scientific Committee on Tobacco and Health reported in November 2004 that exposure to SHS was a “substantial public health hazard” and found exposure to SHS increased a non-smoker’s risk of developing lung cancer and heart disease by around 25%[83]. Homes are a major source of SHS, especially for children[8485] and this is particularly relevant in multi-unit housing (e.g., apartment buildings and townhouses) where tobacco smoke can travel between living units.[8687]

According to Cancer Research UK, the majority of exposure to SHS happens in the home and SHS has been linked to around 165,000 new cases of disease among children in the UK

[82] Excluding respondents that are not applicable.
[83] Secondhand smoke: Review of evidence since 1998. Scientific Committee on Tobacco and Health (SCOTH), November 2004: pg 4.
[84] Mbulo L., Palipudi K.M., Andes L. Secondhand smoke exposure at home among one billion children in 21 countries: findings from the Global Adult Tobacco Survey (GATS) Tob. Control. 2016;25:e95–e100. (doi: 10.1136)
[85] Wilson K., Klein J., Blumkin A., Gottlieb J.D., Winickoff J. Tobacco-smoke exposure in children who live in multiunit housing. Pediatrics. 2011;127:85–92.
[86] Kraev T.A., Adamkiewicz S., Hammond S.K., Spengler J.D. Indoor concentrations of nicotine in low-income, multi-unit housing: associations with smoking behaviours and housing characteristics. Tob. Control. 2009;18:438–444
[87] King B., Travers M., Cummings K.M., Mahoney M.C., Hyland A.J. Secondhand smoke transfer in multiunit housing. Nicotine Tob. Res. 2010;12:1133–1141.

each year.[88] SHS exposure to children within the home has been found to increase young infants' risk of lower respiratory tract infections (including flu, bronchitis and pneumonia) by around 50%. [89] SHS causes over 300,000 GP consultations and 9,500 hospital admissions among children each year in the UK, at a cost of £23.3 million to the NHS[90].

Since tenants of social housing have less freedom to move accommodation in order to lower their exposure to SHS, due to limited social housing, addressing this issue may be especially important to ensure social housing tenants have equal access to a smoke-free living environment.

Survey data also finds that smoking prevalence is highest for social housing and rented private accommodation, relative to other housing tenures. The YouGov results find that smoking prevalence is highest for respondents who rent from a housing association/local authority (24%), followed by rented accommodation (18%), which compares to the survey average of 13%. Evidence from the US [91]finds a similar pattern. The ONS[92] using 2017 data finds that 28% of individuals that rent from a local authority/housing association in Wales currently smoke, compared to 19.5%, which is the figure across all housing tenures. Yet the figure is slightly higher for private rented accommodation, where 32% reportedly smoke.
Higher rates of smoking in rented accommodation is also likely to influence the smoking habits of children born in these living environments. One paper finds children whose parents smoke are three times more likely to take up smoking[93].

Given the average smoking prevalence for the most deprived quintile has remained more than double the prevalence for the least deprived quintile in Wales since 2005, where the gap stood at 18 % points[9495], it is vital that more attention is devoted to helping reduce these stagnant inequalities and such high rates of smoking in social housing.

[88] Cancer Research UK 2016. https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/smoking-and-cancer/passive-smoking

[89] Parental and household smoking and the increased risk of bronchitis, bronchiolitis and other lower respiratory infections in infancy : systematic review and meta-analysis. Jones, Laura L; Hashim, Ahmed; McKeever, Tricia; Cook, Derek G; Britton, John; Leonardi-Bee, Jo.In: Respiratory research, Vol. 12, 5, 2011. 90 Royal College of Physicians (2010). Passive smoking and children.

[91]Cigarette smoking and adverse health outcomes among adults receiving federal housing assistance. Prev Med. Helms VE, King BA, Ashley PJ. 2017 Jun;99:171-177. doi: 10.1016/j.ypmed.2017.02.001. Epub 2017 Feb 10.

[92] Office for National Statistics. Ad hoc request. Smoking status and housing tenure, Wales, 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/adhocs/008871smokingstatusandhousingtenurewales2017

[93] Leonardi-Bee J, Jere ML, Britton J. (2011). Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax; 66(10): 847-55.

[94] Welsh Health Survey. https://gov.wales/statistics-and-research/welsh-health-survey/?tab=previous&lang=en https://gov.wales/docs/statistics/2016/160601-welsh-health-survey-2015-health-related-lifestyle-trends-2003-04-2015-en.xlsx

[95] National survey for Wales. https://gov.wales/statistics-and-research/national-survey/?slideId=2&topic=population_health&tab=el_home&lang=en https://gov.wales/docs/statistics/2018/180627-national-survey-2017-18-population-health-lifestyle-en.pdf https://gov.wales/docs/statistics/2018/180627-national-survey-2017-18-health-related-lifestyle-adults-en.xlsx

A 2018 ONS report[96] for the first-time investigated inequality in avoidable mortality,[97] measuring deaths of people under the age of 75 which would be avoidable in the presence of timely and effective healthcare or public health interventions. It found that relative inequalities have increased from 2001 to 2016, despite an overall fall in avoidable mortality for all levels of deprivation. Interestingly, the report also found that mortality rates for respiratory diseases increased since 2001 in England and Wales for those living in the most deprived areas. The largest increases were observed in Wales.

The report, when discussing the inequality in respiratory deaths, although not the increase itself, states that the 'substantially higher rates observed in the most deprived areas compared with the least deprived areas are likely to be a consequence of persistently higher smoking prevalence among disadvantaged populations'. Given the strong relationship between smoking and respiratory diseases[98], ASH Wales believes that more research is urgently needed to understand if changes to smoking prevalence/SHS in the most deprived areas have played a part in this increase in avoidable deaths by respiratory diseases.

Smoking may also push a large proportion of smokers, that are living close to the poverty line, into poverty.[99] Research has shown that smokers in poverty may spend an average of around £1200 a year on smoking.[100] A 2015 Landman economic study commissioned by ASH found that the inclusion of tobacco costs moves an extra half a million UK households into poverty and pushes 370,000 children into poverty[101]. Longitudinal evidence also finds that increases in household incomes above the poverty line may lead to improvements in smoking cessation rates[102].

Finally, smoking has been found to significantly increase fire risks in social housing dwellings. Freedom of Information Act requests to every stock-retaining local authority in the UK revealed 27 tenant deaths in fires were recorded between 2010/11 and 2016/17, of which cigarette lighters accounted for 12 of the deaths –the most frequent cause of fatality[103].

In light of these issues, ASH Wales would support a consultation investigating effective ways to decrease the exposure of social housing tenants to SHS and support smokers in social

[96] Office for National Statistics. Socioeconomic inequalities in avoidable mortality, England and Wales: 2001 to 2016. July 2018.
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/measuringsocioeconomicinequalitiesinavoidablemortalityinenglandandwales/2001to2016

[97] Avoidable mortality, as defined by the ONS, refers to deaths from causes that are considered avoidable in the presence of timely and effective healthcare or public health interventions. For most of the causes of death included in our definition there is an upper age limit of 74 years

[98] Smoking cessation in patients with respiratory diseases: a high priority, integral component of therapy
P. Tønnesen, L. Carrozzi, K. O. Fagerström, C. Gratziou, C. Jimenez-Ruiz, S. Nardini, G. Viegi, C. Lazzaro, I. A. Campell, E. Dagli, R. West
European Respiratory Journal Feb 2007, 29 (2) 390-417; DOI: 10.1183/09031936.00060806

[99] The Stolen Years, 2016: The Mental Health and Smoking Action Report. The report is available at www.ash.org.uk/stolenyears

[100] Mental health, smoking and poverty in the UK. Langley Tessa. 2016. www.ash.org.uk/povmentalhealth

[101] Estimates of poverty in the UK adjusted for expenditure on tobacco. Howard Reed, Landman Economics, May 2015.
file:///C:/Users/sophia/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/ASH_964-1%20(1).pdf – this file is a download to someone else's PC so won't open

[102] Young-Hoon KN. A longitudinal study on the impact of income change and poverty on smoking cessation. Can J Public Health 2012; 103(3): 189-194

[103] Inside Housing. September 2017. Cigarettes cause majority of deadly council housing fires
https://www.insidehousing.co.uk/home/cigarettes-cause-majority-of-deadly-council-housing-fires-52198

housing to quit smoking. This would decrease health inequalities in accordance with the 'Well-being and Future Generations Act'[104].

In recent years, changing tenancy rules to include a smoke-free agreement has been encouraged by the U.S. Department of Housing and Urban Development on a voluntary basis since 2009 and was recently legislated for in July 2018 for all public housing. Surveys in the US find that the majority of Multi-Unit Housing residents have been found to prefer to rent in smoke-free communities[105][106]. Many studies have also found that a smoke-free housing policy led to moderate positive changes in tenants smoking behaviour such as a decrease in cigarette consumption and an increase in quit attempts.[107][108][109][110][111][112][113]

However, there may be issues concerning the practicality of enforcing a smoke-free policy in social housing premises more generally. It may also be important to ensure that smokers are supported in a positive way to comply with the policy and create a healthy living environment for all tenants and are not penalised disproportionately for non-compliance.

Although social housing tenancy agreements currently lag behind private rented agreements in requiring a smoke-free policy in Wales, it could be argued that if a smoke-free policy were considered, it should also be extended to all rented accommodation, to guarantee all tenants are protected from SHS, (especially given the high smoking prevalence in private rented accommodation) and ensure that social housing tenants are not singled out.

Although ASH Wales is clear that the issues discussed are problems that need to be addressed, the most effective measures remain uncertain. We therefore recommend a national consultation to bring all stakeholders together to identify effective and acceptable measures that could support rapid change.

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[104] Well-being of Future Generations Act projections 2017
http://www.publichealthwalesobservatory.wales.nhs.uk/wbfgaprojections

[105] Licht AS, King BA, Travers MJ, et al. Attitudes, experiences, and acceptance of smoke-free policies among US multiunit housing residents. Am J Public Health 2012;102:1868–71.

[106] Andrea S. Licht, Brian A. King, Mark J. Travers, Cheryl Rivard, and Andrew J. Hyland. Attitudes, Experiences, and Acceptance of Smoke-Free Policies Among US Multiunit Housing Residents. American Journal of Public Health: October 2012, Vol. 102, No. 10, pp. 1868-1871. doi: 10.2105/AJPH.2012.300717.

[107] J.P. Winickoff, M. Gottlieb, M. Mello. Regulation of smoking in public housing.New Engl. J. Med., 362 (2010), pp. 2319-2325

[108] A.L. Mills, K. Messer, E.A. Gilpin, J.P. Pierce. The effect of smoke-free homes on adult smoking behavior: a review. Nicotine Tob. Res., 11 (2009), pp. 1131-1141

[109] A. Kernoghan, I. Lambraki, K. Pieters, J.M. Garcia. Smoke-free housing: A review of the evidence Program Training and Consultation Centre and the Propel Centre for Population Health Impact, Toronto, ON (2014).

[110] R.D. Kennedy, S. Ellens-Clark, L. Nagge, O. Douglas, C. Madill, P. Kaufman. A smoke-free community housing policy: changes in reported smoking behaviour-findings from Waterloo Region, Canada. J. Community Health, 40 (2015), pp. 1207-1215

[111] M. Shields Smoking bans: influence on smoking prevalence Health Rep., 18 (2007), pp. 9-24

[112] E. Gilpin, M. White, A. Farkas, J. Pierce
Home smoking restrictions: which smokers have them and how they are associated with smoking behaviour? Nicotine Tob. Res., 1 (1999), pp. 153-162

[113] Impact of smoke-free housing policy lease exemptions on compliance, enforcement and smoking behaviour: A qualitative study
Pamela Kaufman, Julie Kang, Ryan David Kennedy, Pippa Beck, Roberta Ferrence. Preventive medicine reports 2018

Childminding Premises
Although the 2018 Regulations make clear that smoking would be prohibited in the parts of a childminders home being used to provide child minding services for the duration that the children are present, this prohibition is limited solely to the period in which children are present. This is particularly concerning as it raises the prospect of a childminder being able to smoke up to the second that a third party, a child for example, entering the premises and thence being exposed to SHS and THS.

ASH Wales believes that this is unacceptable and either a period of time needs to be established to allow the effects of SHS disperse and to be eliminated, or an absolute prohibition on smoking in all parts of a childminding premises that a third party might be in, or transit through for the duration that the premises is used for such purposes - and in such a fashion as to eliminate the risk of SHS emanating from not smoke-free rooms within such premises - would be in the interest of public health.

Any other comments

Question 25 – We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them.

ASH Wales believes the Welsh Government should go further and additionally include bans on smoking in the outdoor, non-enclosed, public places of sports grounds, beaches and public parks. As with school gates and public playgrounds these are all places frequented on a regular basis by children and young people meaning the rationale behind banning smoking in school grounds and public playgrounds equally applies to banning smoking at sports grounds, beaches and public parks. Legislated bans on smoking in these areas will also serve to denormalise smoking as an activity and reduce potential exposure to SHS.

Research studies have found that children are far more likely to try a cigarette or be current smokers if they see 'role models' smoke, such as actors in movies[114]. Smokers have also been found to be more likely to attempt or successfully quit when tobacco use is de-normalised, seen as less socially acceptable[115][116] and when smoking bans are in force[117].
An additional reason why it is necessary for this Public Health (Wales) Act to extend the smoke-free legislation to additionally include the outdoor, non-enclosed, public places of sports grounds, public parks and beaches concerns the fact that, should smoking continue to be allowed in these areas, it will serve to diminish the impact of the new smoking bans set to be introduced in schools, play areas and hospital grounds. For example, not banning smoking on beaches, sports grounds and public parks will potentially reduce the positive impact of denormalisation and exposure to SHS which banning smoking in public playgrounds will bring.

Legislated smoking bans are also further required in places such as beaches, sports grounds and public parks given the difficulty in getting voluntary smoking bans introduced in these

[114] NHS Website 2009. https://www.nhs.uk/news/Pages/Newsglossary.aspx#Peerreview
[115] Hammond, D., Fong, G.T., Zanna, M.P., Thrasher, J.F., and Borland, R. Tobacco denormalisation and industry beliefs among smokers from four countries. American Journal of Preventive Medicine. 2006; 31: 225–232
[116] Meier KS. Tobacco truths: the impact of role models on children's attitudes toward smoking. Health Educ Q. 1991 Summer;18(2):173–182
[117] Denormalization, smoke-free air policy, and tobacco use among young adults. Brian C. Kelly, Mike Vuolo, Laura C. Frizzell, Elaine M. Hernandez. Social Science & Medicine Volume 211, August 2018, Pages 70-77.

areas. For instance, we have been in discussions with all Local Authorities in Wales with regards to the introduction of smoke-free beaches in their jurisdictions. Whilst some areas - namely Swansea and Pembrokeshire County Councils - have implemented voluntary restrictions others have not yet done so, often citing a lack of resources or confusion as to whether they have sufficient power to introduce such changes.

A smoking ban in sports grounds/leisure centers/playing fields, would likely have a substantial impact on whether smoking is normalized. Almost half of children in Wales participate in a sporting activity three or more times a week according to research by Sport Wales. A survey of over 116,000 Welsh school children showed more than half of all boys and a third of girls play sport.

When given the choice young people would like to participate and enjoy sport in a clean, healthy, smoke-free environment. ASH Wales recently surveyed 125 children and 99% said they didn't want adults smoking around them when playing sport. The survey results also found that 88% of children thought smoking was common. When asked what percentage of people smoke in Wales the average answer was over half the population, at 56%.
Children and young people are found to be highly influenced by what they see around them and the influential people in their lives. Ensuring sports grounds, leisure centers and playing fields are smoke-free will help to denormalise smoking and change young people's perceptions that smoking is a common activity.

The extension of smoking bans to include non-enclosed public places such as beaches, sports grounds and public parks could also have a significant impact on denormalising smoking for young people and it may additionally lead to a considerable reduction in cigarette litter, which research has shown is quite substantial. A report[118] published by Keep Wales Tidy in 2018 revealed the prevalence of smoking-related litter and the far-reaching impacts on our health, wildlife and environment. During recent street cleanliness surveys, smoking-related litter was found on 80.3% of our streets - making it the most common type of litter in Wales.

Across the UK, it is estimated 122 tonnes of smoking-related litter are dropped every day. This is predominantly in the form of cigarette ends which are difficult and time-consuming to clean up and cost the taxpayer millions of pounds each year. Contrary to popular belief, cigarette filters are not biodegradable but are made of a type of plastic which means they can stay in the environment for up to 15 years. Also, because of their small size cigarette ends are easily transported to our waterways and coastline.

Cigarette ends can also have deadly consequences for wildlife and have been found in the guts of whales, dolphins, turtles and seabirds who have mistaken them for food. In addition, recent data from the European Environment Agency (EEA) also shows that cigarette butts and filters are most commonly found individual items littering Europe's beaches[119].

In many parts of the world, smoke-free beaches have been successfully implemented with public support: Canada (Vancouver), United States (California, Maine, Massachusetts, and New York), Mexico, Japan, Hawaii, Puerto Rico and Australia. The extension of smoking bans to include non-enclosed public places such as beaches and parks has also been shown to

[118] Smoking-related litter. Keep Wales Tidy 2018. Jones, H. Keep Wales Tidy, July 2018.https://www.keepwalestidy.cymru/Handlers/Download.ashx?IDMF=873fcec1-d268-4901-8f92-5a139d2ec502
[119] CIWM Journal online. June 2018. https://ciwm-journal.co.uk/cigarette-litter-the-most-common-litter-on-europes-beaches/

be effective. For instance, following the parks and beaches in New York City (NYC) becoming smoke-free in 2011, Johns et al found the trend in the frequency of NYC residents noticing people smoking in local parks and beaches decreasing significantly over the six quarters after the law took effect, leading the authors to conclude their results provided population-level evidence suggesting the law had reduced smoking in parks and on beaches.[9]

Furthermore, there is also strong public support in Wales for an extension of the smoking ban to include additional non-enclosed spaces. According to a 2015 YouGov survey commissioned by ASH Wales, 54% of respondents agreed that smoking should be banned in communal recreational spaces such as parks and beaches.

One key argument against legislating on banning smoking in enclosed outdoor spaces is that it may encourage smokers to smoke at home and therefore increase SHS exposure to non-smoking family members and children. Given that the home environment is typically the main source of SHS, an increase in SHS-related diseases would be expected as an unintended detrimental consequence of smoke-free legislation.

However, studies investigating the impact of smoking bans in enclosed public places have found such legislation does not lead to more smoking in smokers' homes. On the contrary, numerous studies have found smoke-free legislation led to a significant decrease in smoking in the home, as many householders subsequently imposed voluntary home smoking restrictions[120]. Although there is currently no clear evidence on the impact of smoking bans in enclosed outdoor public places on smoking levels in the home, it is likely to have a similar impact, though the evidence on this issue should be continuously monitored.

Impact Assessment

We have published a number of impact assessments alongside this consultation and would welcome your views on these.

Question 26 – Are you aware of any challenges or positive effects as a result of the proposed regulations that you believe to be missing from the Regulatory Impact Assessment, particular to your field of interest?

Supporting comments

Question 27 - Do you have any comments on the draft impact assessments for Welsh Language, Children's Rights, or Equality and Human Rights? The Equality Act 2010 prescribes protected characteristics that include gender; age; religion; race; sexual orientation; transgender; marriage or civil partnership; pregnancy and maternity; and disability.

[120] Mons U, Nagelhout GE, Allwright S, Guignard R, van den Putte B, Willemsen MC, Fong GT, Brenner H, Potschke-Langer M, Breitling LP. Impact of national smoke-free legislation on home smoking bans: findings from the international tobacco control policy evaluation project Europe surveys. Tob Control. 2013;22(e1):e2–e9. doi: 10.1136/tobaccocontrol-2011-050131

Supporting comments

Question 28 – We would like to know your views on the effects the changes and the amendments to regulations would have on the Welsh language, specifically on:

i) opportunities for people to use Welsh
ii) treating the Welsh language no less favourably than the English language.

What effects do you think there would be? How could the positive effects be increased, or negative effects be mitigated?

Supporting comments

Question 29 – Please also explain how you believe the proposed policy could be formulated or changed so as to have:

i) positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language
ii) no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Supporting comments