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

Tenovus Cancer Care is Wales' leading cancer charity. Our aims are simple. We want to help prevent, treat and find a cure for cancer.

We do this by offering support, advice and treatment to cancer patients and their loved ones. We also promote healthy lifestyles and fund cancer research to find new ways to prevent it, diagnose it, and treat it.

We welcome the opportunity to respond to this important consultation and would like to note the valued collaboration with ASH Wales on elements of this consultation.

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.

Overall we agree with the 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 each year around one in every six of all 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 Regulations are both workable and proportionate to support a reduction in smoking prevalence.

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.

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.

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.

Although all routes to decrease the prevalence of smoking merit investigation there appears to be no pragmatic mechanism for enforcing this specific proposal.

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))
Disagree.

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."

Tenovus Cancer Care believes the Welsh Government has a duty of care to use the strongest possible measures to protect non-smokers from the harms of tobacco. Healthcare 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 part of their workplace.

---

[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.

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] - while also minimising the potential risk from third-hand smoking (see below).

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)
Disagree.

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 Tenovus Cancer Care 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.

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)
Disagree.

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

[6] 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] BBC News 2017. 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
[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.

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 without significant investment in systems to eliminate the risk. Consequently, Tenovus Cancer Care is strongly in favour of never permitting smoking in an enclosed public space.

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))
Disagree.

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

There are practical considerations that prevent this proposal from achieving its aim, for example, who would help wheelchair-bound residents enter the room and what happens if a resident falls ill while inside the room, or requires emergency extraction by the Ambulance Service? Additionally, as above second-hand tobacco smoke can spread from one room to another within a building, even if doors to the smoking area are closed[14] meaning that a designated room would be unable to sufficiently mitigate the serious harms of SHS without significant investment in systems to eliminate the risk. Consequently, Tenovus Cancer Care is strongly in favour of never permitting smoking in an enclosed public space.

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.

Mental illness affect almost a quarter of the population and there is now evidence that people with mental health conditions die on average 10 to 20 years earlier than the general population[15,16,17], with smoking being

---

[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. 2016. http://www.who.int/tobacco/mpower/2009/c_gtcr_protect_people_tobacco_smoke.pdf
[14] World Health Organisation. Protect people from tobacco smoke. 2016. http://www.who.int/tobacco/mpower/2009/c_gtcr_protect_people_tobacco_smoke.pdf
[15] Odegard O. Mortality in Norwegian mental hospitals 1926-1941. Acta Genet Stat Med 1951; 2: 141-73.
[16] Chesney, E et al. Risks of all-cause and suicide mortality in mental disorders: a meta-review. World Psychiatry. 2014; 3 (2): 153–160
[17] 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.

the single largest contributor to reduced life expectancy.[18] Smoking rates amongst people with a mental health condition are also significantly higher than in the general population[19] and this may be particularly a problem in mental health units, since smoking rates are positively associated with the severity of the mental condition[20], with the highest expectancy levels of smoking found in psychiatric in-patients.[21]

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.[22,23]

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. The impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants.[24]

Smoking also increases the required psychiatric medication dosage for smokers[25], which may cost the UK up to £40 million per annum[26] and increases potential side-effects.[27]

Smoking may also push a large proportion of smokers with a mental illness into poverty.[28] Research has shown that, after adjusting for under-reporting of tobacco smoked, smokers with a mental health condition below the poverty line could be spending over £2,200 a year.[29] Longitudinal evidence also finds that increases in household incomes above the poverty line may lead to improvements in smoking cessation rates.[30]

Despite high rates of smoking and levels of addiction in this population, people with mental health conditions are no less likely to want to quit smoking but they can expect to find it more difficult than the general population.[31] Primary care professionals are less likely to intervene with smokers with a mental health

[18] Smoking and Mental Health. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. 2013
[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] 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
[21] Jochelson, K. & Majrowski W. Clearing the Air: Debating Smoke-free Policies in Psychiatric Units. London, King's Fund, 2006.
[22] 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
[23] 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
[24] Taylor G et al. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ 2014. 348:g1151
[25] 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
[26] https://www.rcplondon.ac.uk/projects/outputs/smoking-and-mental-health
[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] The Stolen Years: The Mental Health and Smoking Action Report. The report is available at www.ash.org.uk/stolenyears
[29] www.ash.org.uk/povmentalhealth
[30] http://journal.cpha.ca/index.php/cjph/article/view/3005
[31] Health Survey for England 2010.

condition than with those without[32] even though prompts from health professionals have been shown to be pivotal in driving quit attempts among all smokers.[33]

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. Tenovus Cancer Care believes the removal of this exemption is imperative to denormalise smoking and encourage quit attempts.

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.[34] 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.[35]

Concerns had been raised that long-stay settings such as mental health trusts should be exempt, yet these exemptions were rejected by NICE[36] 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 services 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.[37]

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.[38]

Several studies, as discussed in a 2018 report by the Royal College of Physicians (RCP)[39], 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]

---

[32] 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.

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

[34] 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].

[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] 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.

[38] 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].

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

An international review[40] 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[41].

Although Tenovus Cancer Care supports a comprehensive smoke-free policy, it considers that other aspects of the NICE guidance relevant to harm reduction are more important, including the provision of quitting support 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.

There is an abundance of evidence indicating that smoke-free policies which are successfully implemented can have significantly 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[42]. There is also evidence from an international review[43] that a smoke-free policy in mental health units: improves staff and patient physical wellbeing[44,45,46,47], leads to a decline in staff smoking rates[48,49,50], increases staff perception of patients'

---

[40] 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

[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] 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

[43] 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

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

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

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

[47] 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.

[48] 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.

[49] 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.

[50] 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.

capacity to quit smoking[51,52], and that patients gain capacity and belief in their own ability to quit or cut down their tobacco consumption.[53,54,55,56,57] Longitudinal studies show smoke-free policies bring about a change in the smoking culture, particularly shifting staff attitudes towards patients' smoking.[58] The international review also found evidence that a smoke-free policy leads to patients being less bored and more engaged in ward activities[59] and evidence for an improvement in mental health and quality of life[60,61], though evidence for this last point comes from studies outside of mental health units.

Finally, given that smoking and ignition sources (matches, lighters) are also a common cause of accidental fire[62], there is also evidence that since national smoke-free legislation was introduced there has been a steady decline in accidental hospital and medical care fires.[63]

After considering the evidence, Tenovus Cancer Care supports the proposals in Regulation 8. Tenovus Cancer Care 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 trusts across Wales.

Question 10 – Do you agree that the proposed transition period of 18 months after the 2018

---

[51] 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.

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

[53] 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.

[54] 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.

[55] 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.

[56] 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.

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

[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] 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.

[60] Do ex-smokers report feeling happier following cessation? Evidence from a cross-sectional survey.
Shahab L, West R
Nicotine Tob Res. 2009 May; 11(5):553-7.

[61] Smoking reduction for persons with mental illnesses: 6-month results from community-based interventions.
Morris CD, Waxmonsky JA, May MG, Tinkelman DG, Dickinson M, Giese AA
Community Ment Health J. 2011 Dec; 47(6):694-702.

[62] Home Office. Detailed analysis of fires attended by the fire and rescue services, England, April 2017 to March 2017, 2017. www.gov.uk/government/uploads/system/uploads/attachment_data/file/650926/detailedanalysis-fires-attended-fire-rescue-england-hosb1617.pdf [Accessed 2 March 2018].

[63] Home Office. Fire statistics data tables, 2016/17. www.gov.uk/government/statistical-datasets/fire-statistics-data-tables - non-dwelling-fires-attended [Accessed 2 March 2018].

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.

Tenovus Cancer Care 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.[64]

Tenovus Cancer Care 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.

Tenovus Cancer Care believes a smoke-free policy will be far more effective if it is implemented in accordance with the NICE PH48 recommendations[65], 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.[66]

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. Tenovus Cancer Care supports the recommendations in the NICE PH45 guidance, 'Smoking: Harm reduction' to be applied for all those with a mental health condition 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.[67] 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.[68] This is supported by CQC guidance[69] and a statement by ASH England's 'Mental Health and Smoking Partnership'.[70] The statement recommends information on the use of e-cigarettes, alongside licensed treatments, should form part of the care package for people with mental health conditions 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

[64] CITE Stolen Years and RCP
[65] 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].
[66] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
[67] Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.
[68] The Stolen Years: The Mental Health and Smoking Action Report. The report is available at www.ash.org.uk/stolenyears
[69] 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].
[70] 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].

deter individuals coping with a mental illness from using e-cigarettes instead of cigarettes.[71] Public Health England have also recommended approaches to e-cigarette use are developed to support smoke-free sites.[72]

Although the settings are very different, lessons can be learned from the fact e-cigarettes have also been found as a useful way to develop a smoke-free policy in prisons. For example, a pilot on the Isle of Man[73] found allowing inmates to use e-cigarettes resulted in a decrease in behaviour warnings (58%), 25% of newly received offenders asking for help to quit smoking and an annual saving of £8,500 on NRT. The report also noted a 2% drop in offender adjudication.

After considering the evidence Tenovus Cancer Care 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?

It is important to note progress in the implementation of the NICE guidance across mental health units since 2013 is variable.[74] 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 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

[71] 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].
[72] 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-of-cigarettes-in-public-places-and-workplaces.PDF [Accessed 4 March 2018].
[73] BBC News February 2018. https://www.bbc.co.uk/news/world-europe-isle-of-man-42909703
[74] 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

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 including initiatives to improve exercise, diet and fun activities to minimise boredom. This is supported by research[75] which found mental health settings are places where many patients experience significant boredom during their hospital stay due to a lack of structured activities. Research has shown a lack of activity (and associated boredom) in mental health settings is associated with high levels of smoking.[76,77,78,79]

The international review of best practice generally supports the findings discussed above[80] 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.[81,82,83]

Given the discrepancy in the variability in the success of a smoke-free policy, Tenovus Cancer Care would support the above facilitators of successful implementation being considered, which the 18-month transition period will enable.

Finally, it is important to note that the majority of individuals with a mental illness will never enter a mental health trust, and so policies supporting smoking cessation outside mental health units will be necessary to fundamentally lower health inequalities.

Discussions within the 2016 WTHN event with 60 health professionals found that specialised smoking

---

[75] 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

[76] 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.

[77] 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]

[78] 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.

[79] 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.

[80] 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

[81] 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

[82] 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.

[83] 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.

cessation support, namely with a treatment period longer than 4 weeks is required to adequately support individuals with a mental illness 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 good relationships already established. It is also essential that once patients are discharged from mental health units, they are automatically referred to these services and the data on smoking prevalence and quit rates is collated and published for these smokers.

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.

Tenovus Cancer Care 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.

Making all enclosed workplaces smoke-free – whether they be 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 2018 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.

Tenovus Cancer Care believes the 12 months transition period is more than sufficient for these premises to install outside designated smoking areas and no-smoking signs and would support consideration of a more compressed transitionary period.

Question 14 – Do you consider the proposed conditions that have to be met before areas can be designated as areas in which smoking is permitted in the grounds of schools with residential accommodation are appropriate? (Regulation 10)
Disagree.

The guidance suggests that '[these] conditions should minimise smoke-drift into other smoke-free areas, prevent large areas being used for smoking and prevent inappropriate use'. Tenovus Cancer Care recognises and values the consideration paid to restricting the space available for smoking as a means of denormalising the practice. However, given that there is no risk-free level of exposure to tobacco smoke, we believe that it is in the public interest to eliminate, rather than minimise, public exposure to SHS in such environments and thus the exclusion zone 10 metres from a non-smoking premises may be inadequate to achieve this aim. We would also be concerned that a 10 metre limit does not go far enough in the denormalisation of smoking by allowing smoking shelters in relative proximity to smoke-free premises. Tenovus Cancer Care urges the Welsh Government to consider this matter again with a view to a suitable distance being established to eradicate, as opposed to minimise, smoke drift and impacts on SHS on smoke-free premises and ensure any smoking shelters are visually discreet and away from areas of high traffic, both footfall and vehicular.

Question 15 – Do you consider the proposed conditions that have to be met before areas can be designated as areas in which smoking is permitted in hospital grounds are appropriate? (Regulation

11)
Disagree - as above.

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?
Disagree.

Exposure to SHS has a major adverse impact on the health of non-smoking bystanders. While Tenovus Cancer Care warmly welcomes the proposed prohibition of smoking in hospital grounds 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 and placing an additional expectation of enforcement upon teachers and clinical staff would be unjustified. While compassion is shown in the proposed provision of smoking shelters, particularly in relation to hospitals, to cater for the needs of smokers suitable enforcement mechanisms must be in place in order to ensure that the rights of non-smokers, and interests of public health, are shown equal consideration. In particular there appears to be no clear rationale for the failure to impose a duty to prevent smoking in public playgrounds.

We appreciate that there is a pressure on the public purse. However many Local Authorities already have a population of warranted officers empowered to enforce regulations related to littering and dog fouling and other Public Spaces Prevention Orders - for example those related to the consumption of alcohol in public - and the addition of a duty to prevent smoking in public playgrounds provides an overlap in service delivery.

While it is accepted that there are barriers to overcome in the practical enforcement of a duty to prevent smoking in hospital grounds, school grounds and public playgrounds - not least the dispersed nature of such grounds - there is concern that a blanket exemption in respect of the duty of managers of said facilities to enforce the ban is too binary. For example, there is a qualitative difference between the ability of a school or hospital manager to enforce the ban 20 metres away from a smoke-free premises as compared to its enforcement at the perimeter of the grounds. Accepting the latter as justification for non-enforcement of the former risks weakening the premise of the ban.

Therefore Tenovus Cancer Care urges the Welsh Government to consider again how suitable enforcement mechanisms might be developed in this environment.

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

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 Tenovus Cancer Care 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)
Neither agree nor disagree.

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

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))
Neither agree nor disagree.

Tenovus Cancer Care 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.

However the consultation guidance also provides examples of a private vehicle being used to transport a colleague to a meeting. Tenovus Cancer Care believes that while these vehicles are being used in the course of employment, the employer's duty to prevent smoking should be extended to the private vehicles being used for work purposes and as a result should fall within 14(3)(a). Its is not clear that this is currently the case.

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))
Disagree.

We also believe that greater consideration should be given to whether 14(3)(a) should apply to activities such as use of private vehicles to transport vulnerable adults, children and in the provision of private contractor taxi services such as Uber. This would both help denormalise smoking as a practice, encourage the uptake of cessation services among the service provider by limiting the opportunities for smoking and safeguard the public from being exposed to SHS in enclosed spaces. Given the potential risks from THS on public health there is also scope for considering whether the above, and similar, categories should reside in 14(2) - and thus be smoke-free all of the time.

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.

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)).
Disagree.

The penalty amount is not line with fixed penalties for other public health matters - for example failure to pick up dog waste which is £100 in many certain 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.[84] While these matters are of great importance there is a risk in diminishing the severity of smoking in a smoke-free premises if the penalty structure is less severe than other such 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)).
Disagree.

In addition to the arguments made above in respect of the severity of penalties for failing to prevent smoking in a smoke-free premises 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, 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 each year.[85] Given the vulnerable nature of minors and their potentially diminished ability to advocate for their rights and interests Tenovus Cancer Care believes that this offence should carry a more severe penalty than that of smoking in a smoke-free vehicle.

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.

Social Housing
Tenovus Cancer Care would also support social housing, Housing of Multiple Occupancy (HMOs) being considered as additional smoke-free premises. This might 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.

In light of the evidence from other countries, Tenovus Cancer Care would support a comprehensive smoke-free policy in social housing, accompanied by smoking cessation support to help the most deprived and addicted smokers to quit, who may struggle the most to comply with the policy.

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.

Tenovus Cancer Care 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

[84] https://www.cardiff.gov.uk/ENG/resident/Parking-roads-and-travel/Parking-fines/Received-a-pcn/Pages/default.aspx [Accessed 08 August 2018]
[85] Cancer Research 2016. https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/smoking-and-cancer/passive-smoking

rooms within such premises - would be in the interest of public health.

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.

Tenovus Cancer Care believes the Welsh Government should go further and additionally include bans on smoking in*, and at the entrances to,* the outdoor, non-enclosed, public places of sports grounds, parks, and beaches. 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, public parks, and beaches. 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.[86] 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[87,88] and when smoking bans are in force.[89]

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 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 school gates, play areas and hospital grounds. For example, not banning smoking on beaches and at sports grounds 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 sports grounds and beaches given the difficulty in getting voluntary smoking bans introduced in these 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, and at the entrances to, sports grounds/leisure centres/playing fields, would likely have a substantial impact on whether smoking is normalised. Almost half of children in Wales participate in 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

[86] NHS Website 2009. https://www.nhs.uk/news/Pages/Newsglossary.aspx#Peerreview

[87] 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

[88] Meier KS. Tobacco truths: the impact of role models on children's attitudes toward smoking. Health Educ Q. 1991 Summer;18(2):173–182

[89] 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.

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 centres 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 could also have a significant impact on denormalising smoking for young people and it may additionally lead to a considerable reduction in cigarette litter on beaches, which research has shown is quite substantial. A report[90] 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.[91]

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 has also been shown to 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,

[90] 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

[91] CIWM Journal online. June 2018. https://ciwm-journal.co.uk/cigarette-litter-the-most-common-litter-on-europes-beaches/

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.[92] Although there currently is 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.

[92] 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