Chartered
Institute of
Environmental
Health

CIEH response to Department of Health consultation on the future of tobacco control

08 September 2008

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1.0   CIEH support for Government's tobacco control work

1.1   We are making our response on behalf of our members in England, Wales and Northern Ireland. However, we have also encouraged environmental health representatives of other jurisdictions of the Isles of Britain to make their own submissions or respond similarly to separate consultations.

1.2   The CIEH was represented as a stakeholder on the Policy Development Groups which helped to produce the following publications:

- NICE public health programme guidance No 10 on *Smoking cessation services* (issued in February 2008). This is concerned with the evidence of effectiveness of smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities.

- NICE public health intervention guidance No 5 on *Workplace health promotion: how to help employees to stop smoking* (issued in April 2007). This guidance is for NHS and non-NHS professionals and employers who have a role in, or responsibility for, supporting and encouraging employees to quit smoking, and includes those working in local authorities and the community, voluntary and private sectors.

1.3   The CIEH has also provided staffing support to the Department of Health Tobacco Control National Support Team and was represented on the Department of Health expert group developing national guidance to reduce smoking prevalence, improve tobacco control and promote smokefree policies and which produced the publication: *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco* (issued in May 2008).

2.0   Introduction

2.1   Smoking is still by far the major cause of preventable death and disease, exacerbating health inequalities and killing more people each year than alcohol, obesity, road accidents and illegal drugs put together. Reducing smoking, especially among the most disadvantaged in society, must continue to be the number one priority for the Government if we are to significantly improve public health.

2.2   We therefore wish to congratulate the Government for launching this ambitious consultation on a comprehensive new strategy so soon after successfully implementing 'smoke free' legislation. This initiative maintains and renews the concern and active involvement of all those who can and need to make their contributions to reducing smoking prevalence.

2.3   We welcome the commitment in the consultation document to developing a new national tobacco control strategy and the CIEH will encourage and actively support our members and all those involved in environmental health practice to make their important contributions. We believe that a well-funded, long-term national strategy is vital to reducing ill health caused by smoking and to ensure that smoking rates do not start increasing after the substantial reductions which have followed from the successful introduction of the smokefree legislation.

2.4   We are making our response on behalf our members in England, Wales and Northern Ireland. However, we have also encouraged environmental health representatives of other jurisdictions of the Isles of Britain to make their own submissions or respond similarly to separate consultations.

2.5   Our responses to this consultation are focussed on those particular aspects of a national tobacco control strategy where environmental health practitioners can be most productively involved. However, we also work in close collaboration with other regulatory officers (eg trading standards officers) and regulatory bodies (e.g. LACORS) and our views on matters of common concern, for example proposals for licensing of tobacco sales, will be of shared interest.

2.6   In addition, the CIEH is a founding member of the Smokefree Action Coalition (www.smokefreeaction.org.uk) and has contributed to the response to this consultation made on the behalf of the Coalition as well as the 10-Point Plan to protect child health and reduce health inequalities.

3.0   Concerns not specifically covered by the consultation

3.1   We are aware of the commitment given by the Health Ministers to undertake a review of smokefree legislation in England in 2010 and that, therefore, this consultation is not concerned with those matters. However there is one singular issue which we wish to raise in order that it can be considered at the highest level.

3.2   The CIEH is greatly concerned that there have been no announcements from the Department of Transport regarding the implementation of the Government proposals for Restrictions on Smoking on Sea Going and Inland Waterway Vessels. The delayed introduction of the necessary legislation will mean that the intended review in 2010 will not be able to address the implementation issues in these areas as comprehensively as in other areas.

3.3   The Government's proposals were first published on 14th February 2007 and we submitted a comprehensive joint response on behalf of both the CIEH and the Association of Port Health Authorities (APHA) in time for the closing date of 11th May 2007. The results of the consultations were published on the Department of Transport website on 19th June 2007 and we understood these to be largely supportive of the Government's proposals.

3.4   The Government will appreciate that the CIEH and its members, including our environmental health colleagues in the port health authorities, have already demonstrated their commitment to supporting the Government's legislation to establish smokefree workplaces and public places and the failure of the Government to complete its introduction of these intended regulatory controls is causing both confusion and dissatisfaction. There are now in existence serious anomalies eg in relation to moored craft operating as restaurants and bars vis-a-vis propelled craft. These anomalies confuse the public and create unfair trading and employment practices for businesses and inconsistencies in approach – the very problems we worked so closely with the Department of Health to successfully avoid.

3.5   Both the CIEH and the APHA have indicated, to the officers at the Department of Transport, our willingness to assist in resolving any outstanding issues to assist the

Government to bring the necessary legislation forward. We would appreciate a positive response to this offer.

CIEH Responses to the questions listed in the consultation document

Part A: Reducing smoking rates and health inequalities caused by smoking.

4.0   Question 1: *What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030 and on what basis do you make these suggestions?*

4.1   The CIEH supports the findings and conclusions of the Smokefree Action Coalition which recommends the following:

- That on the basis of a comprehensive new strategy, which is monitored, evaluated and regularly updated and includes a harm reduction approach, ambitious new targets should be achievable. The aim should be to reduce smoking prevalence rates for England by 2015 to 11% for the general population and 17% amongst routine and manual workers. Such stringent targets are supported by the significant decline in smoking prevalence in England following implementation of smokefree legislation, [1] recent rates of decline in the proportion of children smoking in England [2] and evidence of rates of decline achieved over a number of years in other jurisdictions with comprehensive tobacco control strategies [3] (e.g. Canada, Norway and California). Progress should be reviewed in 2012 to determine whether any revision of the tobacco control strategy is required in order to achieve these targets and again in 2015 to set new targets for 2020 and 2025.

- Eroding the differential in smoking between the classes will be slow but achievable in the longer-term. By 2020 it should be possible to reduce smoking prevalence to around 1 in 20 in the general population, and around 1 in 10 in routine and manual groups. It is too soon to set targets for 2030 but by then smoking should be uncommon right across the classes.

- Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest setting targets for these specific age groups for 2015 of 5% for 14 year olds and 10% for 15 year olds (compared to 9% and 15% in 2007 respectively). This would give a smoking prevalence rate amongst 11-15 year olds of 4% by 2015, compared to 6% in 2007.

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[1] *Smoking ban triggered the biggest fall in smoking ever seen in England.* Cancer Research UK press release, 30 June 2008. Research presented by Prof Robert West at the UK National Smoking Cessation Conference (30 June-1 July 2008).
[2] *Drug use, smoking and drinking among young people in England in 2007.* The Information Centre for Health and Social Care, 2008
[3] *Health Canada. Long-term trends in the prevalence of current smokers.* http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/chart_image_2005-eng.php
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/index-eng.php
Statistics Norway: Smoking prevalence and social surveys http://www.ssb.no/royk_en/main.html
CDC Behavioural Risk Factor Surveillance System http://www.cdc.gov/brfss/

5.0 Question 1 continued: *Moreover, what else should the government and public services do to deliver these rates?*

5.1   From April 2008 each local authority has needed to choose up to 35 targets from the set of national indicators published in October 2007. [4]

5.2   Primary care trusts already have smoking prevalence as one of their key indicators from April 2008. The CIEH has advised all local authorities to also include smoking prevalence as one of their 35 targets for the following reasons:

5.3   Smoking prevalence is a key indicator not just for smoking-related disease but also for health inequalities. Tackling smoking is equally a necessary target for local authorities and primary care trusts, to enable them to determine their effectiveness in tackling health inequalities. Smoking prevalence is a more relevant indicator than increasing life expectancy at birth (which is calculated on the basis of current mortality data) as it will lead to immediate as well as long-term changes in life expectancy. Even local authorities with relatively low overall smoking prevalence compared to national averages will have pockets of deprivation which need addressing, and continuing to drive down smoking prevalence will be a good indicator of their effectiveness in achieving this.

5.4   Reducing smoking prevalence can also have a strongly positive impact on the local economy. Research in the West Midlands found that the total cost of treating smokers and the effects of premature death, ill health and loss of productivity due to smoking amounted to more than £1.25bn in 2001 alone. This economic planning tool is now available to calculate the costs of smoking on any local economy.[5]

5.6   For these reasons the CIEH believe that it is crucial that primary care trusts and local authorities are required to set appropriate local targets for smoking prevalence reductions and that these targets are adopted by Local Strategic Partnerships. The Department of Health should ensure that monitoring of smoking prevalence at primary care trust and local authority level is carried out consistently and comprehensively to enable primary care trusts and local authorities to measure their effectiveness in meeting their targets.

6.0 Question 2: *What more do you think could be done to reduce inequalities caused by tobacco use?*

6.1   The CIEH supports the findings and conclusions of the Smokefree Action Coalition that high tobacco prices due to sustained increases in taxation are the best way of reducing smoking. However we believe that this is undermined by smuggled tobacco, mainly bought by poorer smokers.[6] Tougher action is needed to stop smuggling [see answers to Qs 4 & 5 below.]

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[4] The New Performance Framework for Local Authorities & Local Authority Partnerships. DCLG London, October 2007.

[5] www.smokingcosts.org.uk/

[6] A YouGov poll commissioned by ASH found that 1 in 5 poorer smokers buy smuggled tobacco compared to only 1 in 20 of the most affluent smokers. (Fieldwork undertaken 20-25 Feb 2008. Total sample size was 3,329 adults, weighted to represent all GB adults aged 18+.)

7.0   Question 3: *Do you think the six strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?*

7.1   Yes. There is good evidence that each of the six strands of tobacco control [para 2.23] is effective in reducing smoking rates. The United Kingdom has achieved a great deal, particularly with respect to: helping people who want to quit, banning tobacco advertising and promotion, and reducing exposure to secondhand smoke. However, more could be achieved by: greater investment in sustained mass media education campaigns and investment in social marketing of the stop smoking services; by further reducing tobacco industry promotional opportunities; by greater regulation of tobacco products and by reducing the availability and supply of tobacco products.

7.2   The six strand strategy also demonstrates the value of collaboration and that "Tobacco control - not just Stop Smoking Services or media campaigns in isolation, but an integrated package of interventions – has enormous potential to tackle health inequalities and the ongoing burden of disease caused by smoking".[7]

7.3   The work of the Department of Health Tobacco Control National Support Team has identified that the most successful outcomes are achieved when the there is co-ordination, cooperation and collaboration at local and regional level and that this is the best way to ensure that local authorities and fully engaged and able to make there important contributions.

7.4   Throughout the implementation of the smokefree legislation, local authority officers have been encouraged to promote local stop smoking services, and national telephone lines etc, as facilities to support compliance. This has been to the mutual benefit of both local authority and primary care trust staff and it will now be important to keep those local authority staff 'on-board' and for primary care staff to see the value of working with and through local authority staff and making use of their networks and contacts especially with businesses and interest groups. The continuation and development of the six strand strategy provides these arrangements with formal status and creates the opportunity for greater local partnership working e.g. through local tobacco alliances, and for regional strategic structures, as best exampled by the organisation *fresh Smoke Free North East*.[8]

8.0   Question 4: *How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?*

8.1   An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. The new Borders Agency must work closely with HMRC and the Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the Government.

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[7] *Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control*; Tobacco National Support Team, DH, May 2008.
[8] www.freshne.com

8.2   For these agencies to have the capacity to provide an effective response and take action in 'hot-pursuit' of good intelligence there must be adequate staffing levels and tobacco control must be awarded an appropriate priority. Neither of these expectations is always in evidence and indeed, the location of key officers one hundred or more miles distant from local hotspots and with wide ranging responsibilities, other than tobacco control, does not encourage intelligence gathering and collaboration on enforcement measures or contribute to the deterrent effect that is needed.

8.3   The Government should demonstrate its commitment to this area of work by the allocation of sufficient resources, appropriate priorities and commitment to support local and regional collaboration.

9.0   Licensing of tobacco sales

9.1   The CIEH wishes to make strong representations for the reintroduction of a scheme of positive licensing for all sales of tobacco.

9.2   Any licensing system for the sale of tobacco makes no difference to any member of the public (over the age of 18) who wish to buy tobacco. What a licensing system does do is to provide an effective deterrent to retailers considering selling to those who are underage. Licensing is not a measure to deter over 18s from buying cigarettes but on stopping retailers from selling to under 18s, and if they do, it provides an effective and more easily administered penalty for breaking the law.

9.3   Trading standards officers within each local authority area are responsible for ensuring tobacco sales are compliant with the law. This does not change with the introduction of any licensing scheme although it may be appropriate to involve additional local authority staff in ensuring compliance. The decision to suspend/revoke a licence under a positive system or to stop a retailer selling tobacco under a negative system would be a matter for the local authority's licensing committee (as it is now in relation to liquor licensing).

9.4   There are two types of licensing system in relation to sales of tobacco – positive and negative.

9.5   With a **negative licensing** scheme, when a retailer is caught selling cigarettes they can lose their right to sell tobacco for a set period of time. Under a **positive scheme** the retailer's tobacco licence can be suspended or revoked. If revoked, the retailer would have to reapply for a licence at a later date (after a minimum period which could be fixed). If a licensing system was introduced along with fixed penalty fines, then enforcement officers could also issue an on-the-spot fine. If the offence were particularly serious or had been repeated, then court proceedings could be instituted against the retailer for a criminal offence incurring substantial fines upon conviction.

9.6   There are a number of advantages that a positive licensing system has over a negative scheme:

9.6.1   Education of retailers
        A positive licensing scheme requires that a retailer applies for a licence before he or she can legally sell tobacco products. This active engagement in the licensing process ensures that the retailer is made fully aware of their responsibilities regarding the

sale of an age-restricted product. The retailer's first contact with a negative scheme, in contrast, takes place only when they have been caught making an illegal sale.

9.6.2 Ease of securing compliance
With a positive scheme education and enforcement work can be carried out more easily as there is a comprehensive record of all those selling tobacco in an area, which will include mobile shops and premises with vending machines. With a negative licensing system there is no record of tobacco retailers so awareness and enforcement work is harder to undertake and it is difficult to control the sale of tobacco products that do not occur in fixed premises, eg from mobile shops or car boot sales.

9.6.3 Ease of enforcement
While the ultimate sanction for both positive and negative licensing schemes is the same – suspension or revocation of the right to sell tobacco – there are significant differences in the way that each scheme operates which would result in a positive scheme being considerably more effective than a negative scheme. A positive system gives local authorities the opportunity to suspend or revoke a licence to sell tobacco, thereby taking the system of enforcement for illegal sales out of the busy and costly court system and directly into the hands of local authorities.

A positive licensing scheme has a higher and more effective level of deterrent than a negative system, especially when partnered with a system of fixed penalty notices. A positive licensing scheme was introduced in Tasmania, Australia in the late 1990s and a number of studies have subsequently been carried out to evaluate the effectiveness of this legislation. Compliance varied depending on the level of active enforcement carried out: one study that took place during a period of high enforcement found levels of compliance as high as 90%.

9.6.4 Costs
UK Government figures indicate that the costs of introducing a positive licensing scheme would be far outweighed by the savings to the NHS for treating tobacco-related illnesses.

Positive licensing has been used to control the sale of alcohol in both the on-trade and off-trade sectors for many years in the UK and is increasingly being introduced to control the sale of tobacco in other parts of the world. The last two years have also seen the introduction of licences for the sale of year-round fireworks (2006) and a new system of gambling licensing which is administered by local authorities (2007).

9.6.5 Controlling counterfeit and contraband tobacco
A positive licensing scheme could extend to all premises where tobacco is stored, supplied and offered for sale and include the provision of an offence for a person to offer tobacco for sale otherwise than at or from licensed premises or for a person to be in possession of quantities of tobacco otherwise than in accordance with the terms of a licence.

Enforcement officers could also be given power to seize tobacco in the possession of a person who is storing or supplying it from unlicensed premises, as well as those offering it for sale at unlicensed premises or on the streets. If seized, the items could be taken before a magistrate who will have power to order their destruction. Similar powers already exist in relation to food which is unfit for human consumption (Food

Act 1984). As an alternative to formal seizure and the possibility of a conviction for possession, the person in possession could offer to surrender the tobacco to the officer for proper disposal. This would make it far less attractive for individuals to be involved in the supply and sale of counterfeit and contraband tobacco as they would run the risk of having their stocks seized and destroyed and incurring the financial loss (which could be substantial) that would result.

9.6.6   <u>Advantage to traders</u>
A key aspect of a positive licensing scheme is that it helps to establish and maintain a level trading field which supports legitimate traders. Small businesses especially can benefit as the numbers of 'illegal sales', which undermines the legitimate trade and often involve counterfeit and contraband products, increasingly diminish.

9.7   The CIEH supports the findings and conclusions of the Smokefree Action Coalition which recommends that the UK Government should lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

10.0   Question 5: *What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?*

10.1   There should be more investment in mass media campaigns to encourage the public to report illegal tobacco sales and to show how the availability of cheap smuggled tobacco undermines other tobacco control measures. There should also be greater transparency of information about the scale of smuggling to allow civil society to monitor the anti-smuggling strategy and lobby for change where necessary.

10.2   There should be explicit identification and explanation in media campaigns of the links between tobacco smuggling and organised crime so that people are made aware that they may be funding activities which directly or indirectly damage or threaten those whom they love or care for, or their wider communities.

Part B: Protecting children and young people from smoking.

11.0 Question 6: *What more do you think the Government could do to:*
a. reduce demand for tobacco products among young people?
b. reduce the availability of tobacco products to young people?

11.1 The CIEH supports the findings and conclusion of the Smokefree Action Coalition that there is wide support for measures to reduce youth smoking but there is little evidence to show that measures targeted specifically at young people have much benefit. Indeed, youth smoking prevention campaigns (particularly those initiated by the tobacco industry) can be counter-productive. [9] [10]

11.2 There is good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. In addition to the 'six strands' identified above, there is widespread and growing support for measures to reduce tobacco marketing such as removing tobacco from view at the point of sale and plain packaging [see answers to questions 7,8,10] Banning sales of tobacco from vending machines, increasing price through taxation and stronger measures to curb smuggling to reduce the availability of tobacco products to young people.

11.3 The reintroduction of licensing of the sale of tobacco [see answers to questions 4] with fines and penalties for anyone who sells tobacco illegally, including that they may have their licence removed, would not just strengthen control of underage sales but would also help retailers by enabling unlicensed sales of tobacco to be tackled more effectively eg in street markets and at car boot sales.

12.0 Question 7: *Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?*

12.1 The CIEH supports the findings and conclusions of the Smokefree Action Coalition that the advertising of tobacco accessories such as cigarette papers or lighters can act as a prompt and reminder about smoking.

13.0 Question 8: *Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option?*

13.1 The CIEH supports **Option 3:** Require retailers to remove tobacco products from display.

13.2 The CIEH supports the findings and conclusions of the Smokefree Action Coalition that there is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law which

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[9] Landman, A., Ling, P., & Glantz, S. *Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control.* Am J Public Health 2002; 92 (6): 917-930.
[10] Wakefield, M. et al. *Youth responses to anti-smoking advertisements from tobacco-control agencies, tobacco companies, and pharmaceutical companies.* J Applied Social Psychol 2005; 35 (9): 1894-1911.

banned most forms of tobacco advertising. [11] Tobacco packaging is now the principal means by which tobacco companies promote their brands and point of sale displays are a form of tobacco advertising. Removing tobacco products from public view will not affect adult smokers' ability to buy them but it will remove the temptation of children to try to purchase them. A ban on the display of tobacco products also removes the temptation for adults who are trying to quit to make an impulse purchase.[12]

13.3   The CIEH is aware that there has been considerable speculation in the retail trade press about the cost to the retail trade of this measure. However, the CIEH supports the findings and conclusions of the Smokefree Action Coalition that evidence from Canada shows that the tobacco industry paid for cigarette displays and, once they were banned, the companies continued to pay retailers for the tobacco storage units. [13]   The tobacco industry has the means and resources to assist tobacco retailers in managing similar changes in the UK.

14.0   Question 9: *Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?*

14.1   The CIEH supports **Option 3:** A total ban on the sale of tobacco products from vending machines.

14.2   The CIEH supports the findings and conclusions of the Smokefree Action Coalition that although vending machines account for a small proportion of overall cigarette sales, a disproportionate number of young people under the legal minimum age for the sale of tobacco obtain cigarettes from this source. This is because the machines are not properly supervised and children can access them relatively easily. The latest survey conducted when the legal age for purchasing tobacco was 16, found that 17% of 11-15 year old smokers reported that vending machines are their usual source of cigarettes. [14]   However, following the rise in age of sale to 18, unsupervised vending machines could become a more significant source of under age sales.

14.3   Banning the sale of tobacco products from vending machines would make it harder for children to purchase cigarettes. Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it) and a total ban on tobacco sales from vending machines has been recommended by the World Health Organisation.

15.0   Question 10: *Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?*

15.1   Yes. The CIEH supports the findings and conclusions of the Smokefree Action Coalition that although no jurisdiction has yet implemented a law requiring plain

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[11] Pierce J et al. *Does tobacco advertising target young people to start smoking? Evidence from California.* JAMA 1991; 266(2): 3154-3158
[12] Wakefield, M.   *The effect of retail cigarette pack displays on impulse purchase.* Addiction Nov 2007   http://www.addictionjournal.org/viewpressrelease.asp?pr=69
[13] *Anti-tobacco troopers won't butt in* - The Gazette (Montreal), 19 May 2008
[14] Fuller, E. *Smoking, drinking and drug use among young people in England 2006.* NHS Information Centre, Leeds, 2007.

packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal. [15]

15.2 There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to:
- Target young people
- Maximise display space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).
- Communicate misleading messages (it would be illegal for manufacturers to claim products were "low tar" "light" or less harmful yet all these are communicated by the colour of sub-brand packaging)

15.3 Tobacco companies invest considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its products to new and existing smokers. [16] Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales. [17]

15.4 Plain packaging would also make it far easier to distinguish between legitimate and smuggled or counterfeit tobacco products.

16.0 Question 11: *Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?*

16.1 The CIEH supports the findings and conclusions of the Smokefree Action Coalition that currently there is insufficient evidence to show whether a requirement for minimum pack sizes would have a significant impact on youth smoking. It is recommended that the policy is kept under review and that further research be conducted. The Government may wish to consider taking reserve powers to determine permitted pack sizes by Regulation in future.

17.0 Question 12: *Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.*

17.1 Secondhand smoke as a statutory nuisance

17.1.2 Defra is drafting a Local Authority Guide on Odour as a Statutory Nuisance which aims to provide local authorities and, specifically, environmental health practitioners with practical guidance on odour as a statutory nuisance, as well as defining odour and potential sources. In addition the guide will look at how exposure to odour can lead to a statutory nuisance, the assessment process including assessment tools and

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[15] Cunnigham, R. & Kyle K. *The case for plain packaging.* Tobacco Control 1995; 4: 80-86
[16] Wakefield, M. *The cigarette pack as image: new evidence from tobacco industry documents.* Tobacco Control 2002; 11:i73-i80 http://tobaccocontrol.bmj.com/cgi/content/full/11/suppl_1/i73
[17] *Material new risk appears: UK government suggests plain packaging.* Citigroup, 2 June 2008

investigation techniques, and the control measures (technical solutions) available constituting best practice. The aim is to complete the Guide by Spring 2009.
The CIEH is being made aware, through our local authority contacts, of increasing numbers of complaints of tobacco smoke arising from adjacent premises and outdoor smoking areas and giving rise to complaints from occupants of both commercial and domestic premises.

17.1.3 The highly effective information campaign which accompanied the introduction of the smoke-free legislation has had the effect of sensitising people to the presence of secondhand tobacco smoke. The findings of the SCOTH report that there is no safe level of exposure also supports and justifies people's concerns. These concerns and resulting complaints can be expected to increase with the further campaigning which is intended around secondhand smoke in the home and, in particular, its effects on children.

17.1.4 The Government should require Defra to include within the proposed Local Authority Guide on Odour as a Statutory Nuisance, measures to investigate, prevent and control odour arising from secondhand tobacco smoke either as a specific form of pollution giving rise to odour or to be taken into account in the general considerations and provisions.

17.2   Smoking in motor vehicles

17.2.1 Section 148 of The Highway Code now states, under the heading of 'Safe driving and riding needs concentration'.

Avoid distractions when driving or riding such as
- *loud music (this may mask other sounds)*
- *trying to read maps*
- *inserting a cassette or CD or tuning a radio*
- *arguing with your passengers or other road users*
- *eating and drinking*
- *smoking*

*You **MUST NOT** smoke in public transport vehicles or in vehicles used for work purposes in certain prescribed circumstances. Separate regulations apply to England, Wales and Scotland.*

17.2.2 In addition to the issue of lack of concentration, or distraction, an enclosed motor vehicle must be one of the worst, if not the worst, places to smoke – the polluted air cannot easily escape and the ventilation arrangements can actually recycle the polluted air. The existing provisions of the Highway Code are sufficient to prohibit drivers of motor vehicles from smoking whilst driving and are enforceable by the police. There remains the concern that smoking can still take place by any person in any vehicle in which children are being carried. In addition, we know that the

presence of carcinogens arising from smoking will persist in the upholstery and other fabric of the motor vehicle long after smoking has taken place. Therefore for proper protection of the health of children, there would be justification in discouraging, or even prohibiting smoking in motor vehicles at all times (this same principle is applied under the Health Act 2006 in relation to all public service vehicles ie smoking is prohibited even when the vehicle is not being used for hire and reward, but only for private use.)

17.2.3 The Government should include in its campaigns information about the harmful effects of smoking in motor vehicles and seek to discourage smoking in motor vehicles at all times. The effects of the campaign should be monitored and if smoking in motor vehicles persists then consideration should be given to the need for additional legislation and appropriate enforcement arrangements.

17.3   Protection of children

17.3.1 The CIEH fully supports the position statement on Children & Secondhand Smoke issued by the Faculty of Public Health and ASH. [18]

17.3.2 The CIEH supports the findings and conclusions of the Smokefree Action Coalition that more could be done by both Government and individuals to reduce children's exposure to secondhand smoke. For example, the Government should

- Run further mass media campaigns targeted at parents/carers about the health effects of secondhand smoke, particularly in enclosed places such as the home and motor vehicles.
- Commission research into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents do not stop smoking. (This links to the harm reduction approach outlined in question 17.)
- Ensure that the stop smoking services are adequately funded and continue to be targeted towards disadvantaged smokers and other groups such as parents.
- Consider extending the smokefree regulations to cover private cars.

Part C: Supporting smokers to quit

18.0 Question 13: *What do you believe the Government's priorities for research into smoking should be?*

18.1   The use of tobacco amongst ethnic minority groups, to include the smoking of shisha pipes.

18.2   Monitoring and examination and, where necessary, testing of smoking apparatus purporting to be 'smokefree' including so called 'electronic' cigarettes and cigars.

18.3   The motivation and mechanisms by which most people decide and act upon their decision to stop smoking. Of particular interest are the triggers which may prompt or reinforce the decision.

19.0 Question 14: *What can be done to provide more effective NHS Stop Smoking Services for:*
• *smokers who try to quit but do not access NHS support?*
• *routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?*

19.1   The CIEH supports the findings and conclusions of the Smokefree Action Coalition that stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%. [18] Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

19.2   Hospitals should be required to monitor smoking rates of patients and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored.

19.3   In addition, smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

19.4   The cost of purchasing stop smoking aids can be a barrier to use, as can the limited availability of these products. Although some versions of NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order to help smokers who want to quit without NHS support, stop smoking aids should be accessible in all the places where tobacco products are currently sold. There is widespread public support for such as policy. According to a YouGov poll, 76% of adult smokers in England said they supported making NRT easier to access.

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[18] West, R. *The Smokers Toolkit Study.* www.smokinginengland.info

19.5   Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services.

19.6   Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit.

20.0   Question 15: *How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?*

20.1   Clearly much more needs to be done to make the services attractive to people who want to stop smoking. This could be achieved by improving the selection, training, assessment and supervision of specialists; the implementation of treatment protocols and high quality administrative support for services.

20.2   Mass media health campaigns should be complemented by community-based initiatives to promote local services.

21.0   Question 16: *How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?*

21.1   All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support.

21.2   Smoking cessation should be included as part of the medical training for all healthcare professionals.

21.3   There should be more outreach with services being set up in places where people are likely to see them, such as in workplaces, shopping centres and schools.

21.4   Better use could be made of existing social networks including faith groups to reduce smoking prevalence.

21.5   The NHS smoking quitline should appear on all tobacco packaging.

Part D: Helping those who cannot quit.

22.0 Question 17: *Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?*

22.1 Yes. The CIEH supports the findings and conclusions of the Smokefree Action Coalition that people are free to smoke but it is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT much more needs to be done.

22.2 The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer. [19] Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

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[19] Siahpush M, McNeill A, Hammond D, and Fong GT. *Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey.* Tobacco Control 2006; 15: iii65 - iii70.