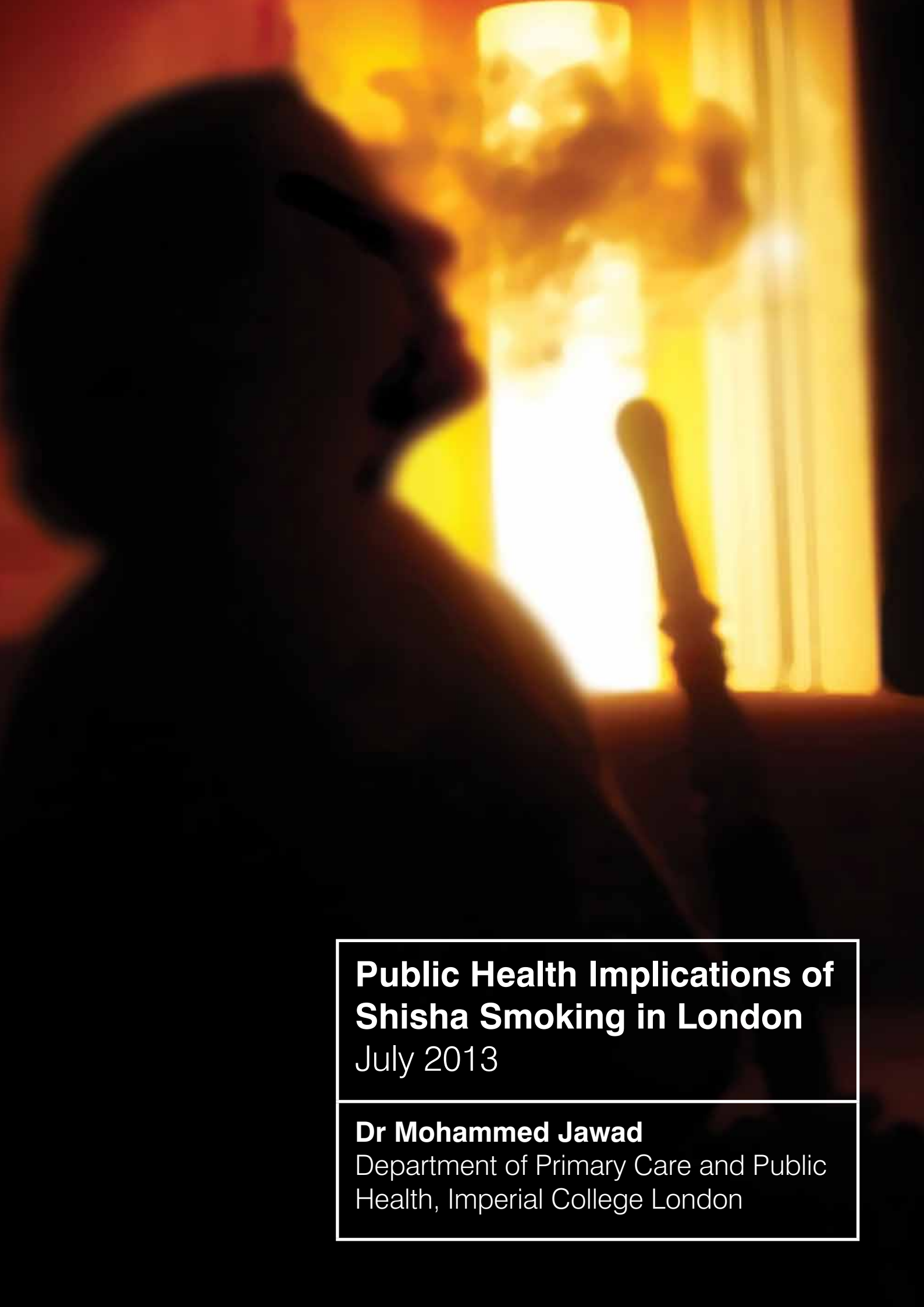

Public Health Implications of Shisha Smoking in London

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Contents

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1. Executive Summary

Shisha smoking is a growing concern in urban areas of Western countries across the globe. In the UK, there has been a 210% rise in the number of shisha cafes in recent years, but little research has been conducted on the public health implications of this smoking practice. This report summarises the current known health effects associated with shisha smoking, whilst presenting data from other countries where such health effects have stimulated the development of shisha-specific legislation. Key London-based studies identify a growing shisha prevalence, especially among young people, university students and those of ethnic backgrounds typically associated with shisha smoking. Finally, local authority responses identified that shisha premises are particularly attractive for young people who smoke under the allure that shisha is safer than cigarettes, and are hubs for antisocial behaviour in certain areas of the city. Most shisha tobacco appears illicit by virtue of being non-duty paid and lacking appropriate health warnings, and many premises remain non-compliant with the Smokefree law. Public health intervention has been minimal thus far, and this report identifies a need for collaborative work and further understanding of the shisha industry before significant strides can be made to control its proliferation. Several peer-reviewed recommendations are detailed which aim to initiate future discussion, justify future action and instigate change in current practice to reduce the public health implications of shisha smoking in London.

2. Introduction

Waterpipe tobacco smoking is a general term given to an apparatus where tobacco is inhaled after passing through water [1]. Although its origins are largely uncertain, it is thought to derive from India several centuries ago [2]. Since its inception and spread across multiple regions, subtle cultural variations have been applied to the waterpipe. This is reflected in its wide variety of names such as hookah, shisha, (n)arghile, goza, qalyan, boory and hubble-bubble to mention but a few.

Appreciating cultural names given to waterpipe tobacco smoking enables a greater understanding of the types of tobacco used in the apparatus: each type contains different proportions of tobacco and nicotine and considerable variations in subsequent health implications are therefore highly conceivable. In the East, the *Ajami* and *Tumbak* types are dark pastes of unflavoured tobacco, whereas the *Jurak* type may contain fruit and oils but also treacle and flavours [3]. In the West, the type of tobacco used is known as *Mo'assel*, a mixture thought to contain 30% tobacco and 70% honey, humectants and fruit-flavours [3]. There are also forms of non-tobacco *Mo'assel*, known as 'herbal'.

In the United Kingdom (UK), waterpipe tobacco smoking is commonly known as shisha, however certain ethnicities may continue to use other cultural names ascribed to it. Shisha's inauguration into British café scene reaches back to the mid-nineties, where large scale industrialisation of *Mo'assel* tobacco coincided with increased global immigration [4]. Evidence suggests that only tobacco and non-tobacco ('herbal') *Mo'assel* types are consumed in the UK, where there has been a witnessed increase in use. A recent report by the British Heart Foundation (BHF) identified a 210% rise in the number of UK commercial shisha venues five years on from the implementation of the Smokefree law on 1st July 2007 [5], and this likely reflects increasing use in the British population.

Other countries have also witnessed a rise in shisha smoking. The Global Youth Tobacco Survey concluded that, whilst cigarette smoking prevalence was decreasing among 13-15 year olds, 33 out of 97 global regions showed an increase in other tobacco use which was mostly attributed to shisha [6]. Several other longitudinal studies confirm these findings. A recent, two year follow up study among American and Syrian high school students found an 18% and 42% increase in shisha use, respectively [7, 8]. Lebanese university students reported a 43% increase over four years [9], and American adults reported a 40% increase over three years [10]. Other countries have also reported alarmingly high prevalence of use [11]. It is therefore of little surprise that shisha's public health status has been described by the American Lung Association as "a growing deadly trend" [12], by other international experts as "the second global tobacco epidemic since the cigarette" [13] and by leading UK tobacco control academics as a "public health priority" [14]. In November 2012, a major shisha manufacturer was bought by a leading tobacco company [15], which adds further concern to future direction of the shisha industry especially in light of existing aggressive and misleading shisha marketing strategies [16].

Several factors can explain this popularity. Shisha emanates a cool, aromatic smoke that provides a sensory appeal to its users contributing to a falsely reduced harm perception [17, 18]. Near-exclusive focus of tobacco control efforts on cigarettes may have contributed to tacit approval of shisha's safety and may have resulted in a lack of surveillance and regulation on the shisha industry [19]. Despite this, UK-based shisha research is severely lacking and much is unknown about the epidemiology of this phenomenon. The Department of Health has recognised that shisha is a health risk warranting attention and identified a need to monitor the changing epidemiology of tobacco use in young people [20].

3. Aims and Objectives

The aims of this report are:

1. To review the health effects associated with shisha smoking
2. To review international legislation, and associated justification, enforced against the shisha industry
3. To review the prevalence of shisha smoking in London
4. To review the knowledge, attitudes and beliefs towards shisha smoking among regular shisha smokers in London
5. To explore the level of crime, disorder and antisocial behaviour associated with shisha premises across London
6. To explore current London local authority responses to the presence of the shisha industry, including difficulties associated therewith

The objectives of this report are:

1. To conduct literature reviews of peer-reviewed papers, conference proceedings and the grey literature to identify the health effects of shisha smoking and international legislation enforced against the shisha industry
2. To summarise results of recent, peer-reviewed, London studies that have identified the prevalence of shisha smoking in certain communities and attitudes, beliefs and knowledge towards shisha smoking among university students
3. To conduct semi-structured interviews with key staff members of several London local authorities to explore the level of crime, disorder and antisocial behaviour associated with shisha premises and their enforcement responses to the presence of the shisha industry

4. Health Effects of Shisha Smoking

4.1 Background

There is a paucity of high-quality evidence pertaining to the health effects of shisha smoking despite its growing public health threat. Western studies are still very much in their infancy, owing only to the recent surge in shisha prevalence, so to this extent long-term cohort studies are not available. Studies from elsewhere are confounded by the fact that many shisha smokers also smoke cigarettes, and that distinctions are not made regarding the different types of shisha tobacco used (*Mo'assel, Tumbak, Jurak, Ajami*). However, it is reasonable to hypothesise that, broadly speaking, smoking tobacco through a waterpipe is likely to have similar effects to cigarettes. Yet key differences exist between shisha smoking and cigarette smoking that may result in a different health effect profile for shisha smokers.

Firstly, the shisha apparatus contains water at its base, through which the smoke passes prior to inhalation by the user (Figure 1). Whilst many smokers incorrectly perceive this water to act as a safe filter for the smoke [21], the smoke produced by shisha is at a much lower temperature than cigarette smoke. Not only is this likely to produce a different type and quantity of toxicants, it also means users are able to inhale the smoke more deeply as it is less irritant on throat, trachea and bronchi [22].

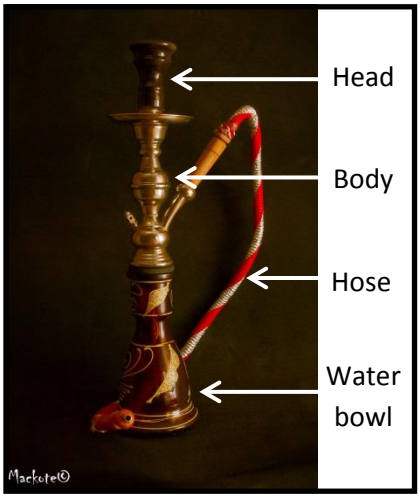

Figure 1: Parts of a waterpipe. *Image reproduced with permission from 'Mackote' under the Creative Commons License, www.flickr.com*

Secondly, a key aspect of shisha that will be explored further in this report, is the social nature of its use. Smokers commonly smoke with family and friends, passing the pipe to one another. This has led to the hypothesis that the shisha apparatus can be responsible for the transmission of infectious disease such as tuberculosis and hepatitis C [3].

Finally, shisha puff characteristics vary greatly between users and this makes it difficult to gauge the amount of harm exposure. Ten grams of shisha tobacco are usually packed into the head of the apparatus prior to each session (Figure 1), but the amount of subsequent tobacco consumption is dependent on the number and depth of each puff, as well as the total session length [22]. Most smokers only consume between 1.5-5.0g per session [22], however they will be unable to tell how much tobacco they have consumed as it is hidden within the apparatus, out of sight. Matters are further complicated by the fact that shisha is an unregulated product and so tobacco content is unstandardized across shisha

brands [23]. Considering these limitations, the aim of this report is therefore to conduct a literature review to determine the currently accepted health effects of shisha smoking.

4.2 Methods

In June 2013, a literature search was conducted using the Cochrane Database of Systematic Reviews and the following electronic databases: Medline (1950 to 06/2013), Embase (1980 to 06/2013), CINAHL (1981 to 06/2013), PsycINFO (1806 to 06/2013), ISI Web of Knowledge and Google Scholar. Search terms included derivate spellings of waterpipe, shisha, hookah, (n)arghile, hubble bubble, goza and boory. Articles were included if they were in English and included data on toxicant exposure, addiction, physical and environmental health.

4.3 Results

4.3.1 Toxicant Exposure

Two methods have been devised to assess the toxicant exposure from one session of shisha smoking. The first method uses smoking machines to replicate human puff behaviour in a standardised fashion and artificially measures the shisha smoke composition; similar to how smoking machines are used to measure cigarette smoke composition [22]. However this has come under much scrutiny as it may not provide a realistic picture of the shisha smoker's puff behaviour, which is largely unpredictable and influenced by social circumstances (eating, drinking, conversation etc.) [24]. The second method uses real-time blood plasma measurements of shisha smokers to identify peak levels of nicotine, carbon monoxide and 'tar' [25]. This has been deemed more accurate as shisha smokers are left to smoke at their own pace. However, a recent study suggested a good correlation between values obtained from smoking machines and blood plasma, indicating that both sets of studies can be used with relative confidence [26].

A summary of several studies enables the following estimates to be made: one shisha session, smoked alone for approximately 45 minutes, may produce 22-50 times more 'tar' [25, 27], 6-13 times more carbon monoxide (CO) [27, 28] and 1-10 times more nicotine [27, 29] than a single cigarette. Shisha is also known to produce significant levels of cancer-causing chemicals (carcinogens), including 3-39 times more benzo[a]pyrene [30, 31]. The volume of smoke produced by one waterpipe session may equal 50-250 times the volume of smoke produced by one cigarette [25, 32], but shisha smoke appears to be more 'dilute' than cigarette smoke per cm^3 of smoke. Shisha tobacco is heated by burning coal placed on top of the head of the apparatus (Figure 1). Considering that burning coal is a major source of CO and carcinogen emissions [33, 34], this poses concerns if it is used in herbal shisha, which is generally marketed and perceived as a 'healthier alternative' to shisha tobacco. In fact, closer analysis of herbal shisha has identified similar levels of CO and 'tar' as ordinary shisha tobacco; the only difference is a lack of nicotine [27].

Despite this, caution must be exercised when comparing shisha to cigarettes. It is likely that direct comparisons may cause confusion. For example, a recent study of over 1,000 online, English news articles about shisha's health effects, revealed that nearly one in five articles incorrectly stated that '100 times more smoke' meant '100 times more harmful' [35], whereas this review has identified that this is not the case. Whilst estimates of shisha-to-cigarette comparisons lie around the 10-cigarette mark [36], the long smoking periods and intermittent use of shisha make comparisons inherently difficult and a

more consistent message of 'at least as harmful as cigarettes' appears more reasonable for health promotion purposes.

4.3.2 Addiction and Cessation

Whilst shisha contains nicotine and is likely to induce addiction in frequent smokers [29, 37, 38], those who smoke less than weekly do not appear to have as many features of nicotine addiction [39]. Single sessions of shisha may contain the same amount of nicotine as 1-5 cigarettes [22, 25, 27, 28], though a review of the literature concluded that daily shisha smokers, due to a cumulated rise in nicotine over time, were exposed to approximately 10 cigarettes' worth of nicotine per shisha session [29].

Nicotine addiction in shisha smokers may be constructed by social and sensory cues such as the ambient atmosphere of shisha cafes, aromatic smell and flavoured taste of the shisha tobacco, as well as the decorative sight of the shisha pipe itself [40]. Thus traditional cigarette addiction measures may not be applicable to shisha smokers. As a result, a shisha-tailored addiction measure has been developed and validated to gauge addiction levels in shisha smokers [39]. In one study, from 180 smokers in shisha cafes in the Edgware Road area (London), nearly half displayed like waterpipe addiction features [41]. Elsewhere, shisha smokers have exhibited nicotine-modulated behaviour as is seen in cigarette smokers: failed quit attempts, cravings and withdrawal symptoms [42-45] despite claims that quitting shisha is "not at all hard" [43].

Some studies have identified that while social pressure is the main barrier to cessation, motivating factors for cessation include concern over shisha's health effects [43] and, rather worryingly, the desire to move onto cigarettes instead [46]. Indeed, several reports have now identified that shisha may be a precursor to future cigarette use [8, 47] and thus has the ability to undermine cigarette cessation programs. However proving this 'gateway hypothesis' is an academically challenging exercise. A recent review of the literature identified no cessation interventions that have been tested on shisha smoking, with only one report suggesting that minimal intervention health promotion may significantly alter smokers' attitudes towards shisha, and promote cessation likelihood [48].

4.3.3 Physical Health

A recent systematic review of the literature, updated to June 2008, summarised the documented long term health effects linked to shisha smoking [49]. Significant associations included lung cancer, respiratory illness, periodontal disease and low birth weight. This included a significant link between the exposure of second-hand shisha smoke to the development of childhood respiratory conditions and possible asthma. Due to limitations in studies, the review could also not rule out associations with bladder cancer, nasopharyngeal cancer, oesophageal cancer or infertility [49]. Since this review, other published studies show that shisha appears to have effects similar to cigarettes on lung function [50] and has been associated with chronic obstructive pulmonary disease (COPD) [51]. Data from case-controlled studies in India have suggested oesophageal cancer is significantly linked to shisha use [52, 53].

Long term studies on the extent to which shisha affects the cardiovascular system are severely lacking. However, in the short term there is a notable rise in heart rate and blood pressure [54, 55]. Herbal shisha too has been shown to have acute effects on the heart [56]. Other concerning acute effects includes the threat of carbon monoxide (CO) poisoning, which has been documented in several

countries including the UK [57, 58]. Long term exposure to CO is a risk factor for cardiovascular disease [59]. Another acute health threat is the potential for infection transmission between users, particularly tuberculosis, due to the close proximity within which shisha smokers sit [60]. However this evidence is not substantial and more research is needed to identify the risk of infection transmission from sharing mouthpieces.

4.4 Conclusion

Despite major limitations in study designs, emerging evidence shows that health effects of shisha may be analogous to those caused by cigarettes. Of particular concern is the harm exhibited by herbal shisha. Despite lower nicotine content, herbal shisha appears to have a similar smoke composition as cigarettes. These findings should reflect the content of health awareness campaigns and health labelling of shisha tobacco. Herbal shisha should also be prohibited for under eighteen consumption and contain health warnings, although this is currently not a legal requirement as it is not a tobacco product. In summary, this review provides evidence that, based on harm exposure alone, there is enough justification to commence health awareness campaigns and incorporate shisha into existing tobacco control efforts. Other UK tobacco control experts agree that, on the balance of this available evidence, shisha smoking should be deemed a public health priority or at a minimum, a preventive approach should be installed [14].

5. International Legislation Enforced Against the Shisha Industry

5.1 Background

In 2005 the World Health Organisation (WHO) produced an advisory note on shisha's growing public health concern, including suggested actions for regulators [61]. Due to the idea that shisha is associated with many of the same risks as cigarette smoking, legislatively the WHO recommended that shisha should be subject to the same regulation as cigarettes and other tobacco products, including the implementation of strong health warnings, prohibition of any safety claims and prohibition of use in public places consistent with bans on cigarettes and other tobacco products [61]. It is currently unknown whether these recommendations, which are based on the WHO Framework Convention on Tobacco Control [62], have been implemented internationally.

Rather, many instances are seen in the literature where there is a lack of legislation enforcement on the shisha industry. Of 74 shisha tobacco products identified in Lebanon, no packaging was compliant under the WHO FCTC (health warnings of adequate size, position and description) and many contained misleading descriptors such as stating there was 0.0% tar and 0.5% or 0.05% nicotine [19], contrary to scientific findings [22]. It is likely that this poor labelling practice occurs elsewhere, including in the United Kingdom. In the USA, 73 out of their 100 largest cities have laws that prohibit indoor cigarette smoking, but 69 of these have exemptions that allow indoor shisha use [63]. This poses concerns considering the indoor air quality of 17 sampled shisha cafes in the USA was over three times worse than cigarette smoking-permitted restaurants and almost five times worse than smoke-free restaurants [64]. Similar studies measuring indoor air quality of shisha cafes in Syria [65], Lebanon [66] and India [67] have shown consistent findings to this, yet legislation does not seem to address this aspect to shisha.

Of further worry is the rapid evolutionary rate of the shisha industry. Whilst legislation is lacking for the *Mo'assel* shisha tobacco, a product that has been internationally present for approximately 15-20 years [68], there have been recent popularity surges of electronic shisha pipes [69] and other herbal variants [27] that have received no legislative attention whatsoever.

5.2 Methods

In June 2013, a literature search was conducted using the Cochrane Database of Systematic Reviews and the following electronic databases: Medline (1950 to 06/2013), Embase (1980 to 06/2013), CINAHL (1981 to 06/2013), PsycINFO (1806 to 06/2013), ISI Web of Knowledge and Google Scholar. Search terms included derivate spellings of waterpipe, shisha, hookah, (n)arghile, hubble bubble, goza and boory. Articles were included if they were in English and included information on law/legislation enforcement, or healthcare policy towards shisha smoking in any country except England. Information on English legislation will be covered later in this report. A grey literature search was also conducted online to explore tobacco control websites and their significance to the shisha industry. Results were themed by country and summarised accordingly.

5.3 Results

Whilst most countries did not have shisha-specific legislation or direct mention of shisha in their legislative documents, there was a universal conformity that tobacco legislation was not limited to cigarettes only. All legislation applied to 'smoking products' or 'tobacco products', leading to theoretical reasoning that shisha is indeed included under their laws. There were specific mentions in the academic

and grey literature regarding the legislative state of shisha in some countries, and these have been outlined below.

5.3.1 The United States

The United States does not appear to have any enforced legislation against the shisha industry, though the concern regarding this has been extensively described in the academic literature. The Family Smoking Prevention and Tobacco Control Act (TCA) was enforced in 2009, however this came under much scrutiny due to its focus on cigarettes (including roll-your-own tobacco) and smokeless tobacco only, while neglecting other tobacco products including shisha [70]. Currently, shisha premises are exempt from any smoke-free law if at least 10-15% of their sales come directly from the sale of shisha, when they are then known as tobacco retail shops [71]. This has been met with much resistance from the scientific community, and calls for legislative improvement include removing these smoke-free exemptions, extending the prohibition of flavoured cigarettes (where only menthol-flavoured tobacco is allowed) to the shisha industry, extending health warnings to the shisha pipe and its accessories [70] and subjecting shisha to the same level of taxation of cigarettes [72]. One example in the state of Oregon showed that, due to the 'badly-worded' smoke-free law which failed to directly account for the shisha is heated by charcoal (i.e. it does not come under a 'directly lit product'), a proliferation of shisha cafés ensued costing the local council an average $5,000 per application for the 52 shisha café applications submitted in a few short months, and consumed 75% of the time of policy specialists [73]. Norman Edelman, chief medical officer at the American Lung Association, says his organisation is working with states to pass laws to ban shisha smoking. "People realise more and more that this is a dangerous practice," Edelman says [74].

5.3.2 Pakistan

Shisha not only falls under smoke-free legislation in Pakistan, but in August 2012 it was verified by the Lahore High Court that it is to be categorically banned in all public places as part of the Prohibition of Smoking and Protection of Nonsmokers' Health Ordinance of 2002. Contrary to places such as England, prohibition in Pakistan includes smoking both inside and outside shisha cafes, effectively ending the commercial shisha industry and limiting shisha smokers to private use only [75]. This was appealed against by shisha premises owners, however the petition was dismissed and premises remained closed. Justification was based on a review of the health effects of shisha, using similar evidence to the one conducted in this report, as well as anecdotal reports that these premises were frequented by young people and worked against the country's aims of becoming a drug-free region [76]. Indeed, shisha cafes are described as "a hub of narcotics and immoral activities" by city officials [77].

5.3.3 India

In India, law enforcement against the shisha industry is similar to that seen in Pakistan. Under the Prohibition of Smoking in Public Places Rules, India's third most populous city, Bangalore, has made headlines regarding the legislative state of shisha. As an industry, shisha cafes are unable to obtain licenses to trade (unlike the food or alcohol industry) due to their omission from the Karnataka Municipal Corporations Act 1976. This classes them as an illegal trading activity by default. Yediyur councillor N.R. Ramesh, who has been leading the case against the shisha industry, stated that "many centres [shisha cafes] mix narcotic drugs such as marijuana and opium to hook youngsters, who eventually get addicted", and following these allegations the major of the city passed a resolution stating that all shisha cafes in the city will be banned [78]. Furthermore a fine of 200 rupees (£2.17) is in

place as a fixed penalty notice for customers smoking shisha in public, and "the owner of the cafe will be fined an amount equivalent to the number of people in the group that is caught" [79]. Similar action has been undertaken in Delhi, India's capital and second most populous city [80].

5.3.4 Turkey

In February 2013, Turkey passed shisha-specific legislation which addressed several key issues. Article 4 states that shisha cafes must be located at least 200 metres away from educational establishments (including preschools, primary, secondary and high schools), that shisha must not be consumed in public buildings, and must not be smoked in an enclosed environment. In Article 5 it also enforces an under 18 sales law for both tobacco shisha and herbal shisha, prohibits the use of substances other than water to be used in the base of the apparatus (such as alcohol, caffeine-based drinks etc.), enforces a cleaning protocol after every use including the use of disposable mouth pieces, and generally prohibits the use of herbal shisha. Health warnings are also to be placed on the apparatus itself, but no details are described of these practicalities [81].

5.3.5 Qatar

Whilst shisha is not specifically mentioned in Qatar's tobacco legislation, it contains similar legislation to Turkey that has been actively enforced against the shisha industry. Article 5 states that "no cigarettes, tobacco or any of their derivatives shall be sold at a distance less than 500 metres from any school or other educational or training institution." Fixed penalty notices, issued by the legislation enforcers that also have powers of tobacco seizure, are enforced with a minimum fine of Qrs. 200 (£35), and a maximum fine of Qrs. 500 (£87.50) [82].

5.3.6 Lebanon

Decree 8991 contains shisha-specific legislation with regards to tailored health warnings on shisha tobacco packaging. It has been argued that current tobacco health warnings are too generic and may not be applicable to the shisha industry due to unique differences in the way it is smoked [13]. Article 4 mentions several options, some of which include 'smoking water pipe leads to a slow and painful death', 'water used in water pipes does not prevent poisons from reaching your body' and 'the tobacco of water pipes contains toxic substances that lead to dangerous and fatal diseases' [83]. The recently passed, controversial Law 174 prohibits indoor smoking at shisha premises.

5.3.7 Scotland

Scotland benefits from unique legislation that is not seen in England. Firstly, all shisha premises must be registered on the Scottish Tobacco Retailers Register. Secondly, under the Tobacco and Primary Medical Services (Scotland) Act 2010, trading standards officers have the power to issue fixed penalty notices to shisha premises if they are caught selling shisha tobacco to those aged under eighteen years or to those who do not register on the Scottish Tobacco Retailers Register. If found non-compliant with the Scottish Tobacco Retailers Register, a fine of £20,000 and a prison sentence for up to six months may be issued if convicted. Similarly to England, according to Part One, Section Four of the Smoking, Health and Social Care (Scotland) Act 2005, both tobacco and herbal shisha are covered by Smokefree legislation.

5.4 Conclusion

Despite theoretical inclusion of shisha under many countries' existing tobacco laws, few have built on these to adapt for the added risks of shisha smoking. Shisha is not an inherently illegal product in most countries and illegality stems from lack of compliance with existing tobacco control legislation. Shisha-

specific legislation widely varies across countries which specify a need for further guidance from organisations such as the World Health Organisation. This issue has been raised with Dr Haik Nikogosian, Head of the Convention Secretariat, and shisha-specific guidance is being prepared in the next WHO FCTC publication. In the meantime, parties seeking to build shisha-specific legislation can use this review to justify recommendations. However it must be noted that legislation enforcement must be conducted sensitively towards ethnicities that view shisha as a traditional, cultural product, and they must engaged with to arrive a sustainable tobacco control strategy.

6. The Prevalence of Shisha Smoking in London

6.1 Background

The epidemiology of shisha smoking is poorly understood in many countries, including the UK. Routine UK national surveys have yet to include shisha smoking questions despite calls from the Department of Health to monitor the changing epidemiology of tobacco use in young people whilst specifically identifying shisha use as a growing health risk [20]. Matters are further worsened by the fact that, traditionally, shisha smokers do not consider themselves as "smokers" [84] and it may be difficult to elicit shisha use in health consultations using ordinary "do you smoke?" questions [36].

As described in the introduction to this report, shisha smoking is on the rise internationally and this has been shown in all age groups. Whilst a high youth prevalence is almost expected in studies from the Middle East due to its traditional association with shisha [8, 85], this has been reciprocated in Western countries. In Estonia, 34.9% of 15 year old students and in Denmark, 60% of boys aged 14-18 years had tried shisha [47, 86]. In Canada, a large study across grades 7-12 reported a current (past-30 day) prevalence of 0.5-5.0% [87], whereas in the US current (past 30-day) prevalence among high school students has reached as high as 9.7-10.9%, similar to the prevalence of cigarettes [46, 88].

University students appear to have the highest documented current (past 30-day) prevalence so far, estimated to be around the 15-20% mark in the US [89, 90]. However in one American institution nearly 60% of students had tried shisha at least once [91]. Until recently the only prevalence data from the UK was from Birmingham university, where in 2007 the current (past 30-day) prevalence of shisha was 8.0% and ever prevalence was 37.9% [92]. Whilst these findings play an important role in identifying the scale of the problem, they are not nationally generalizable both in terms of age group and geography. Thus the aim of this section is to outline key studies to date that have specifically measured shisha prevalence amongst different community groups in London.

6.2 Prevalence among secondary school students, London Borough of Brent

6.2.1 Title

Prevalence and predictors of waterpipe and cigarette smoking among secondary school students in London [93]

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6.2.4 Methodology overview

An anonymous survey of secondary school students in the London Borough of Brent was conducted between October 2011 and March 2012 among Year 8, Year 10 and Year 12/13 (sixth form/college) students. All schools in the borough were contacted by email, letter and telephone inviting them to

participate with an option of a paper or online survey. Out of 23 schools, 15 agreed to participate, six refused and two did not respond. Schools were asked to survey as many students as possible in each of the three year groups. The response rate was 89.9% and 2399 surveys were included in the final analysis. The survey was adapted from the WHO Global Youth Tobacco Survey, amongst others, and all cigarette questions were mirrored with shisha questions. A total of 96 questions were asked: 27 on prevalence, 10 on cessation, 53 on beliefs, attitudes and knowledge, and 6 on socioeconomic data. The definition of a current smoker was a regular (at least weekly) or occasional (less than weekly) smoker, and the definition of an ever smoker was at least one puff of tobacco.

6.2.5 Results overview

Half of the respondents were male, there was a proportional response across all three year groups and the average age was 14.5 years. 43.3% of students described themselves as South Asian, 20.8% as Black, 18.3% as White, 7.0% as Middle Eastern and 10.6% as Other. 19.5% were eligible for Free School Meals (an indicator of lower socioeconomic status).

Current shisha prevalence was over double current cigarette prevalence (7.6% vs. 3.4%). 24.0% had tried shisha but only 15.8% had tried cigarettes. Eighteen per cent of shisha smokers also smoked cigarettes. Shisha smoking was even across genders, higher in older year groups and highest among Middle Eastern and South Asian ethnicities. The graphs on page 16 (Figure 2) present shisha prevalence against different variables, showing for example that 39.9% of Year 12/13 students had tried shisha and one in five White students had tried shisha. Whilst 30.9% of current cigarette smokers smoked daily, only 2.7% of current waterpipe smokers smoked daily.

After mapping known shisha cafés in the borough alongside secondary schools enrolled in our study, we calculated that students from schools that had more than one café within a half-mile radius (a 10 minute walk) were 2.5 times more likely to be current shisha smokers than students from schools that had no cafes within a half-mile radius.

On average, secondary school students started using shisha slightly later than cigarettes (13.5 vs. 12.8 years). Additionally, 36.2% of those who had tried shisha (ever smokers) took their first puff illegally in a café (whilst under the age of 18), and 39.0% of current shisha smokers continue to smoke shisha regularly in shisha cafes. Worryingly, 36.2% of ever shisha smokers were introduced to it by family, but more (40.0%) were introduced to it by a friend. Current shisha smokers were less interested in quitting than current cigarette smokers (10.4% vs. 33.3%), made less attempts to do so (16.9% vs. 50.6%), and received less help to do so (22.0% vs. 30.9%). 41.8% of the total sample felt shisha was safer than cigarettes.

6.2.6 Discussion and conclusion

Shisha prevalence in this ethnically diverse population group was worryingly high. In this demographic age group there appeared to be little dual use between shisha and cigarettes, indicating that shisha may be appealing to young people who may not be considered high risk for cigarette use. Indeed, shisha showed slightly more popularity amongst females than it does for cigarettes, however this finding was not statistically significant and may need more research. Shisha use was also twice as popular across all year groups, which justifies adding shisha to existing cigarette-based health promotion lesson plans. Whilst shisha was most popular amongst young people from the Middle Eastern and South Asian

ethnicities, it is important to note that the White ethnicity showed similar levels of cigarette and shisha smoking. To check this was not due to the eastern European White students (who may smoke shisha endemically) we sub-analysed shisha prevalence into 'White British' and 'White Other' but again no differences in prevalence were found. This indicates a cross-cultural spread of shisha smoking among young people in London.

This is the first UK study to show that proximity between shisha premises and educational establishments may influence shisha prevalence in specific schools. Other local authorities should map their known shisha premises to educational establishments in a similar fashion, because by doing so this justifies targeting specific schools for shisha health promotion activities. Whilst very few shisha smokers smoked on a daily basis, this was expected and is seen across the academic literature. However, the concern is that they may become more regular in the future or use it as a gateway to other forms of substance misuse. Further longitudinal prevalence data is needed to assess the potential for increased frequency.

Many shisha smokers took their first puff in a shisha cafe whilst underage. This occurred in an area which is actively enforcing against the shisha industry and undertaking several prosecutions, showing that the shisha industry is renowned to cater for young people despite resource-intensive efforts. This poses a huge public health concern and should encourage further educational campaigns across the borough. This study also reiterates the social acceptance surrounding the concept of shisha smoking considering over a third of shisha smokers were introduced to it by family members. Further awareness among young people's families should be considered to break down the network of social acceptance associated with shisha.

Finally, young people smoking shisha seemed less interested in quitting shisha than young cigarette smokers were interested in quitting cigarettes. Barriers for this should be explored and contrasted to barriers for young people to quit cigarettes. This should form the basis of evidence-based intervention to curb the growing threat of shisha among young people.

Figure 2.1: Smoking prevalence by gender

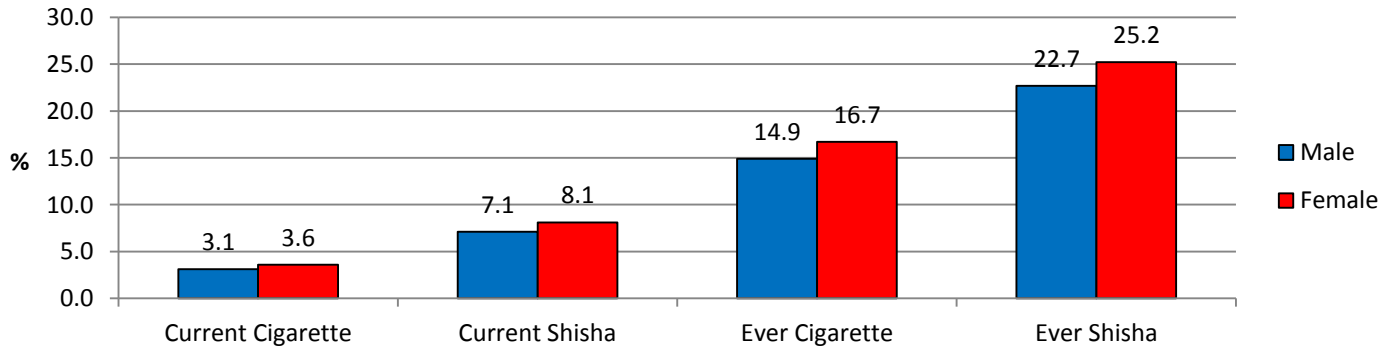


Figure 2.2: Smoking prevalence by year group

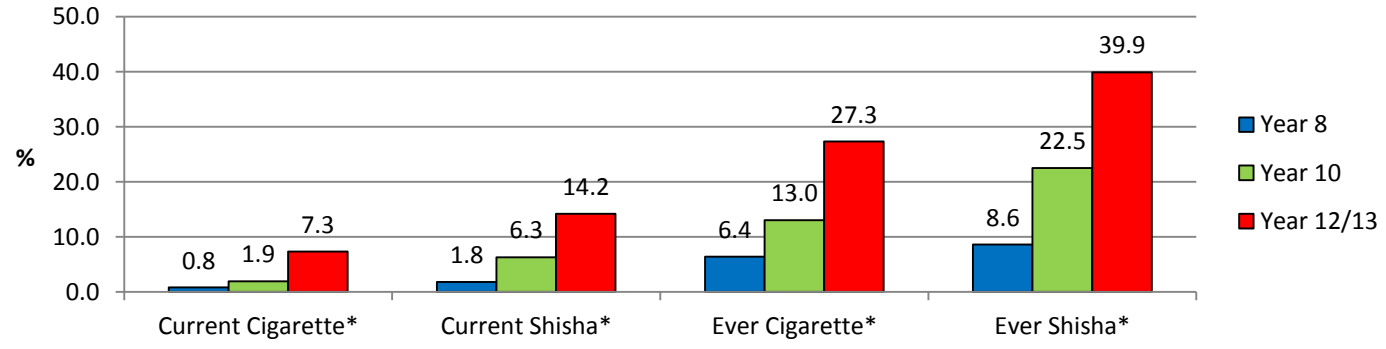


Figure 2.3: Smoking prevalence by ethnicity

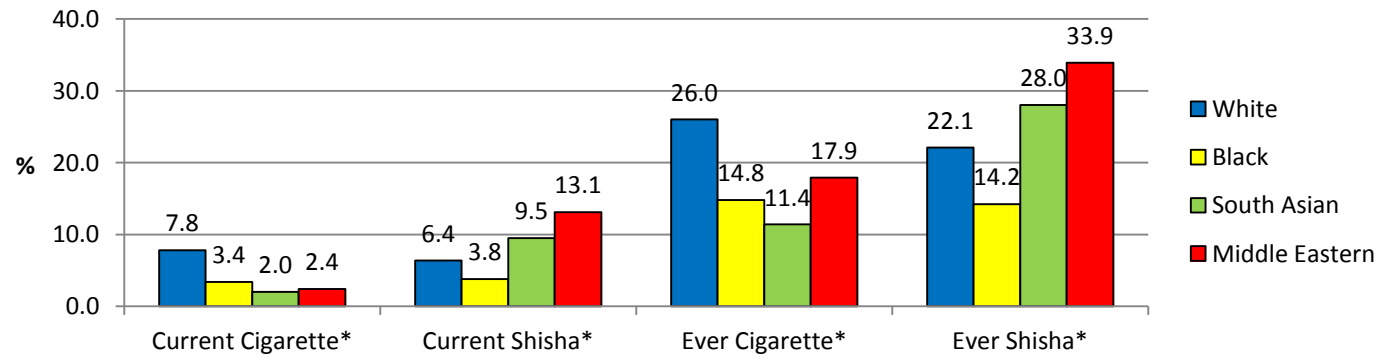
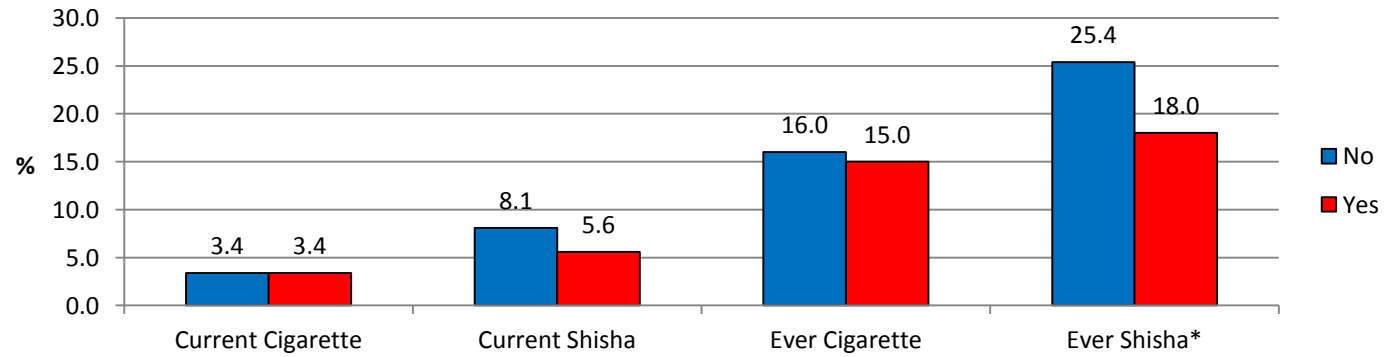


Figure 2.4: Smoking prevalence by free school meals



6.3 Prevalence among university students, London Borough of Hammersmith and Fulham

6.3.1 Title

Waterpipe smoking prevalence and attitudes among medical students in London [94]

6.3.2 Authors

Mohammed Jawad[1,], Jooman Abass[2], Ahmad Hariri[1], Krishna Gayathri Rajasooriar[1], Huda Salmasi[3], Christopher Millett[4], Fiona L Hamilton[4]

6.3.3 Author affiliations

[1]Faculty of Medicine, Imperial College London; [2]Independent researcher; [3]General Practice Vocational Training Scheme, Ealing Hospital, [4]School of Public Health, Imperial College London

6.3.4 Methodology overview

An anonymous survey in the London Borough of Hammersmith and Fulham was conducted in March 2011 among Year 1, Year 2 and Year 5 medical students in Imperial College London. All students in a randomly selected lecture theatre were eligible to participate. The response rate was not determined and 489 surveys were included in the final analysis. The survey was adapted from a previously standardised shisha questionnaire. A total of 18 questions were asked: 8 on prevalence, 5 on attitudes, and 5 on socioeconomic data. The definition of a current smoker was somebody who had smoked at least once in the past 30 days, and the definition of an ever smoker was at least one puff of tobacco.

6.3.5 Results overview

Under half (45.4%) of the respondents were male, there was not a proportional response across all three year groups (Year 1 38.7%, Year 2 34.4%, Year 5 27.0%) and the average age was 20.4 years. 38.0% of students described themselves as White, 36.6% as South Asian, 10.6% as Chinese and 14.7% as Other. 42.0% reported a total household income of between £40,000-£100,000.

Current shisha prevalence was nearly double current cigarette prevalence (11.0% vs. 6.3%). 51.7% had tried shisha but 16.8% had tried cigarettes. Among current shisha smokers, 13.0% reported daily use, 11.1% weekly use and 46.3% monthly use. The average initiation age was 16.1 years. The graphs on page 19 (Figure 3) present shisha prevalence against different variables, showing for example the low variation in shisha use across both genders and all ethnicities. Among ever users, 91.9% shared shisha in a group and 60.0% had no intention of quitting. 45.2% of the total sample thought shisha was less harmful than cigarettes or not harmful at all. 32.7% intended to smoke shisha in the future and 18.8% would encourage their peers to smoke shisha in the future.

Current cigarette smokers were nearly 15 times more likely to have tried shisha than those who had never tried a cigarette. There were no significant differences in shisha use between gender, ethnicity or household income groups.

6.2.6 Discussion and conclusion

This is a small study amongst an educated student group, however shisha smoking was extremely prevalent compared to cigarettes and was associated with a reduced harm perception. A greater proportion of current shisha smokers smoked daily compared to what was measured for young people in Brent (see 6.2.5), giving weight to the theory that young people smoke shisha intermittently at first and then gradually move onto more frequent use. Another noticeable trend between the two studies is

the reduced variation in shisha prevalence between ethnicities. Indeed, whilst Middle Eastern and South Asian young people were more likely to smoke shisha compared to peers from other ethnicities (Figure 2.3), an even prevalence across ethnicities was witnessed in this study. This indicates the multicultural use of shisha and should be observed more closely for frequency and intensity of sessions. As was seen in the Brent study (Figure 2.4), there was no difference in shisha smoking prevalence between sociodemographic variables (Figure 3.4).

This study also gave insights into smoking habits. Nearly all shisha smokers reported smoking in groups and sharing the mouthpiece, and this poses public health concerns regarding infection transmission. Cleaning protocols should be issues to shisha premises to combat this, including issuing the provision of disposable mouthpieces for each customer. Other results were similar to those noted by the survey among young people in Brent, namely the reluctance to quit shisha and reduced harm perception compared to cigarettes. Stop smoking services should identify barriers to overcome these by starting with well-informed educational campaigns to at risk groups.

Figure 3.1: Smoking prevalence by gender

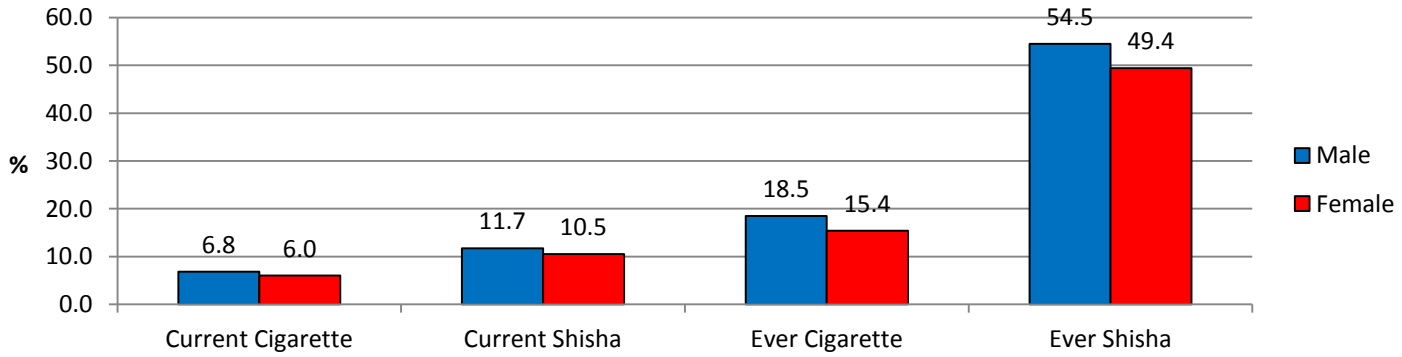


Figure 3.2: Smoking prevalence by year group

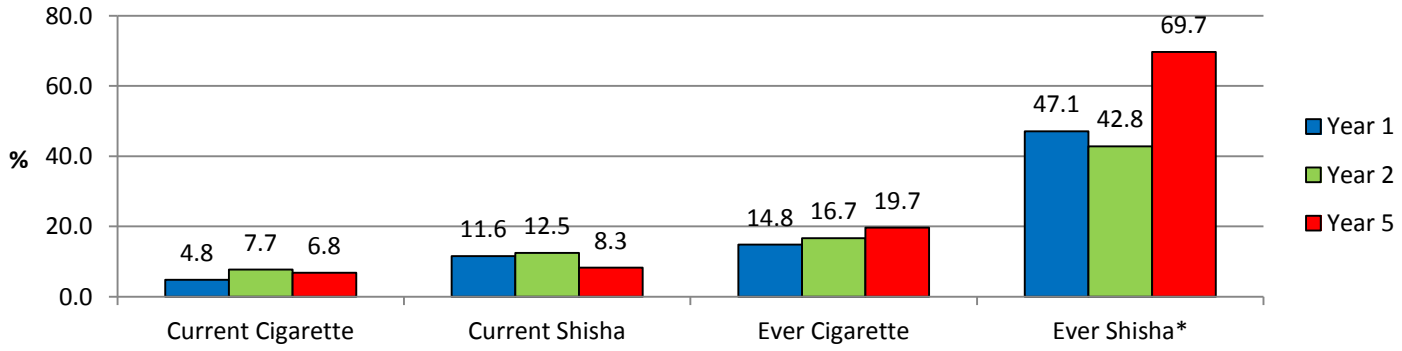


Figure 3.3: Smoking prevalence by ethnicity

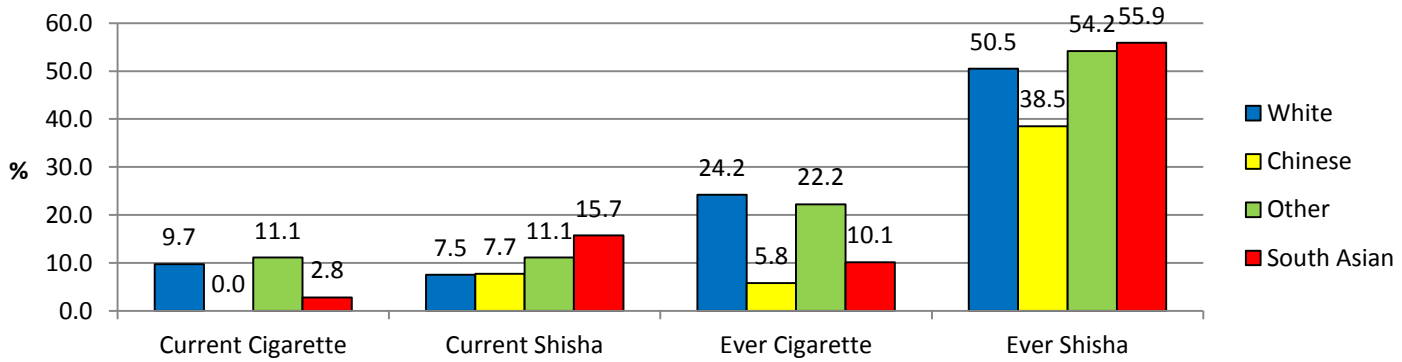
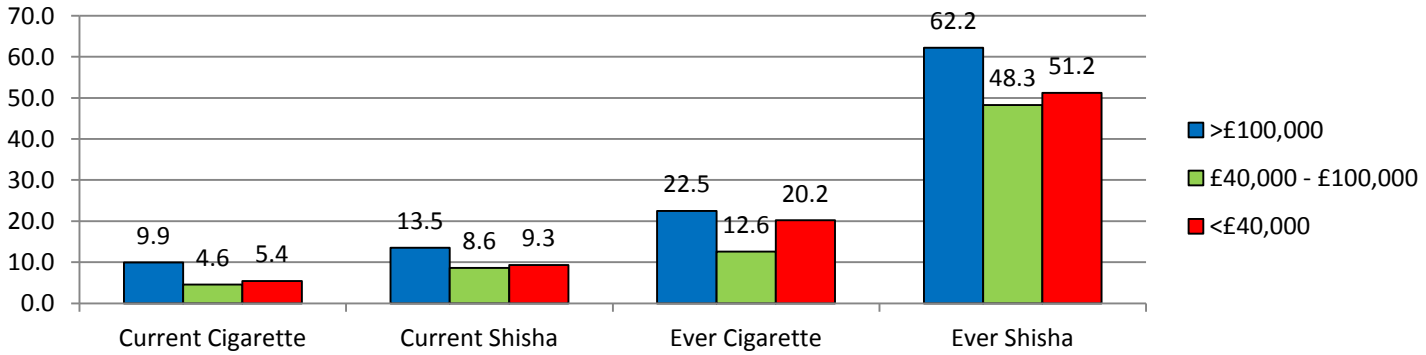


Figure 3.4: Smoking prevalence by household income



6.4 Prevalence among an ethnic community, London Borough of Lambeth

6.4.1 Title

Shisha smoking prevalence, predictors and attitudes amongst a British Asian community in London [95]

6.4.2 Authors

Mohammed Jawad[1,2], Mohsin Asharia[2,3], Fiona L Hamilton[1], Christopher Millett[1]

6.4.3 Author affiliations

[1]School of Public Health, Imperial College London; [2]Faculty of Medicine, Imperial College London; [3]The Council of European Jamaats

6.4.4 Methodology overview

An anonymous, paper survey of a British Asian community attending a mosque in the London Borough of Lambeth was conducted in March 2011 during an annual health screening initiative. All attendees were eligible to participate. The response rate was 100.0% and 92 surveys were included in the final analysis. The survey was adapted from a previously standardised shisha questionnaire. A total of 12 questions were asked: 6 on prevalence, 3 on attitudes, and 3 on socioeconomic data. The definition of a current smoker was somebody who had smoked at least once in the past 30 days, and the definition of an ever smoker was at least one puff.

6.4.5 Results overview

Nearly two thirds (64.1%) of the respondents were male. 9.8% were aged under 22 years, 33.7% were aged 22-29 years, 23.9% were aged 30-49 years and 32.6% were aged over 49 years. Current shisha prevalence was slightly higher than current cigarette prevalence (19.6% vs. 15.2%). The graphs on the page 21 (Figure 4) outline smoking prevalence by demographic variables, and shows that for example, while cigarette smoking was non-existent amongst females, they were not averse to shisha smoking.

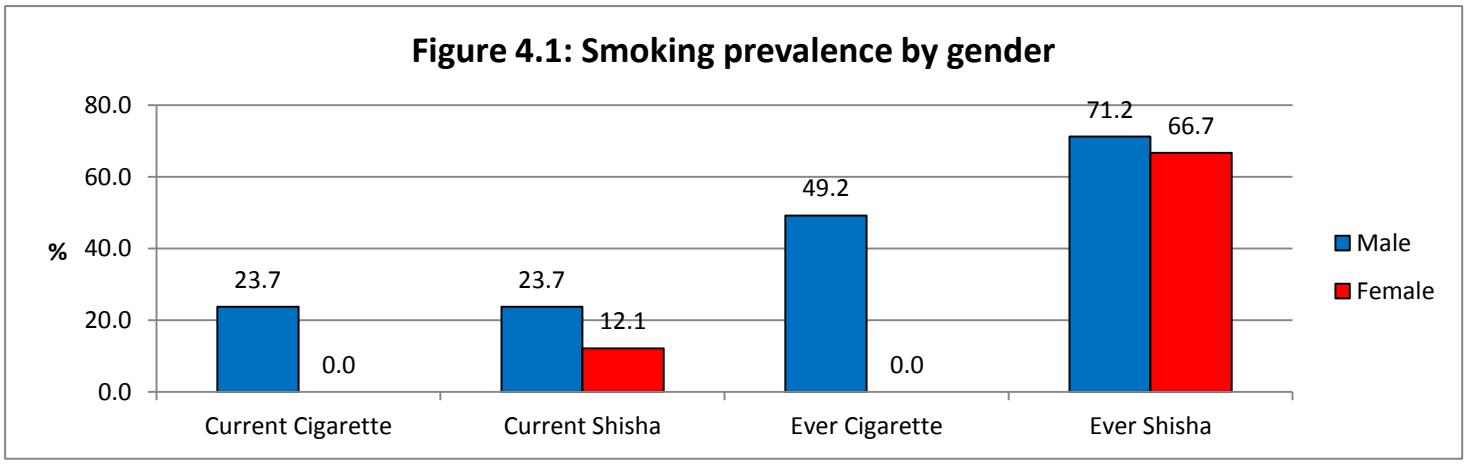
A large proportion of this population (69.6%) had tried shisha but only 31.5% had tried cigarettes. Among current shisha smokers, 5.6% reported daily use, 50.0% weekly use and 44.4% monthly use. Among current shisha smokers, 50.0% started smoking aged 12-16 years, 27.8% aged 17-23 years and 22.2% aged over 23 years. 50.0% of current shisha smokers usually smoke at home, and 50.0% smoke at shisha cafes. Figure 4 shows smoking prevalence by sociodemographic variables.

31.5% of all respondents believed shisha was less harmful than cigarettes, but among current shisha smokers this reached 50.0%. 41.3% of all respondents intend to smoke shisha in the future but only 13.0% of all respondents would encourage others to do so.

6.4.6 Discussion and conclusion

This is a small study in an ethnic community which shows shisha is most popular among young males but less popular among females or older members of the community. It was interesting to note that, whilst females of all ages had never smoked cigarettes, shisha appeared to be more acceptable for them. This was shown by the two thirds of females who had tried shisha (Figure 4.1). Another interesting note is the fact that, among both genders, nobody under the age of 22 had tried cigarettes but most (77.8%) had already tried shisha at this point (Figure 4.2). This again adds weight to a 'gateway' hypothesis, as older age groups became established cigarette smokers. Interventions to curb the high shisha prevalence should be targeted at specific communities most at risk, and involve community leaders in

order to create a culturally-sensitive approach. Health screening events, such as the one where this study was conducted, should be identified by local authorities as an avenue for targeted health promotion activities.



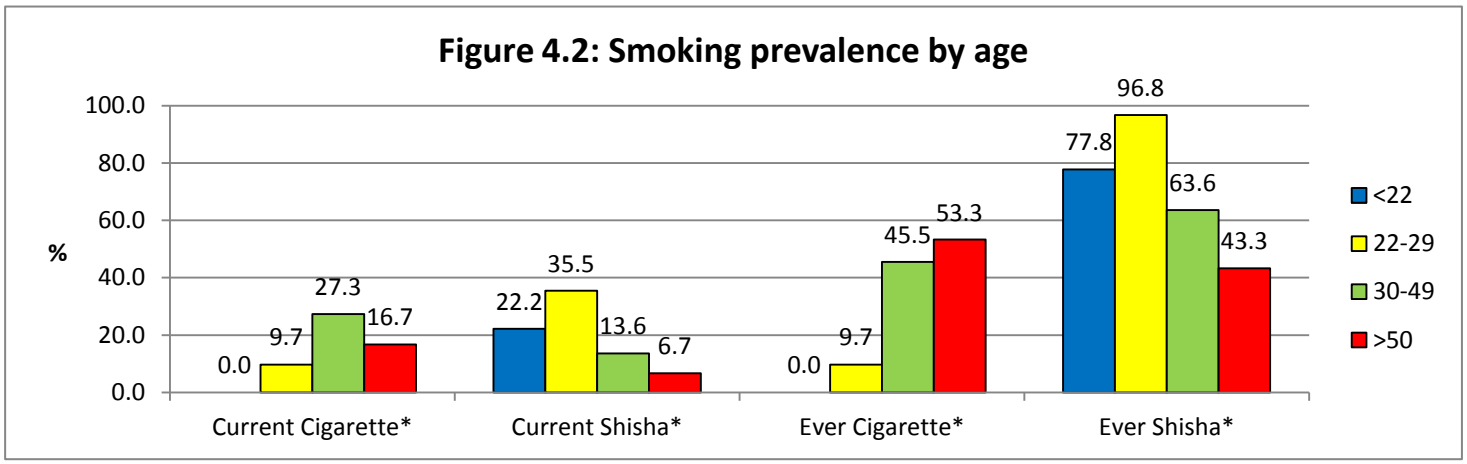


Figure 4: Smoking prevalence among a British Asian community in the London Borough of Lambeth, by different demographic variables

**these differences are statistically significant*

7. Knowledge, Attitudes and Beliefs of Shisha Smokers in London

7.1 Background

Despite the presence of several shisha prevalence studies in London, as with all survey data these have limitations in the number and type of questions asked to the target population. Many questions remain answered regarding the knowledge, attitudes and beliefs of shisha smokers – important information which can guide health promotion practice and evidence-based intervention. The most prevalent shisha smoking group in this series of London studies, and as is identified in the existing literature, were university students. Consequently, focus group discussions were arranged with this population group. This report summarises the findings of a recent, peer-reviewed study on focus groups conducted among regular shisha smokers in London universities.

7.1.1 Title

A qualitative analysis among regular waterpipe tobacco smokers in London universities [96]

7.1.2 Authors

Mohammed Jawad[1], Sarah Jawad[2], Aia Mehdi[2], Abbas Sardar[3], Ali M. Jawad[2], Fiona L Hamilton[1]

7.1.3 Author affiliations

[1] School of Public Health, Imperial College London; [2]Faculty of Medicine, Imperial College London; [3]School of Medicine, King's College London

7.2 Methods

After an earlier prevalence study was conducted on amongst London medical students (see section 6.3) [94], researchers were approached by shisha smokers who were interested in finding out more about shisha research. They volunteered themselves to partake in focus group discussions, and a snowball sampling method ensued where they helped recruit other shisha smokers. Focus groups were also advertised by use of social media, emails and telephone calls. The inclusion criterion included at least monthly shisha smoking. Seven focus groups were undertaken among 32 university students between January to April 2012 in a shisha café or safe university location (e.g. meeting room). They lasted between 30-90 minutes and followed a semi-structured list of open questions that included questions on the shisha smoking initiation, habits, attitudes, addiction, and cessation. The coding and concept-constructing analysis was conducted using established qualitative methods, and is described in detail elsewhere [96].

7.3 Results

Three quarters of the sample were male, and nearly all were either of South Asian or Middle Eastern ethnicity apart from in one focus group where three participants were of White ethnicity. One third of the sample were also concurrent cigarette smokers.

7.3.1 Initiation of shisha smoking

The average age that university students started smoking shisha was 16.7 years, and the vast majority were introduced to it by other peers. Interestingly, one in five students were introduced to shisha by family members and this may allude towards the social acceptance surrounding this type of smoking. Many students had their first of experience of shisha in a foreign country and half of them had visited their country of origin and brought a pipe back to the UK with them. This started an initially intermittent

smoking habit before evolving into a regular practice. Practicing Muslims in the group described the religiously-acceptable stance of shisha in their lives, enabling them to socialise outside of alcohol-centred venues. For them and others, they were able to experience shisha cafes whilst underage due to a lack of underage purchasing enforcement at these premises.

One daily smoker described her initiation experience: "On holiday…I looked at my mum and said "Can I try it?" Then I used to do it with my friends every once in a while, very rarely. When I got to university I started smoking it a little bit more. Then we got one in the flat and we started to do it a lot more."

7.3.2 Current shisha smoking habits

One hour of smoking was the most acceptable length of time attributed to shisha use, but no student claimed this was consistent across sessions. Some sessions lasted several hours, and among Muslim students Ramadan was a time of year this occurred most often. One reason for long smoking sessions was the fact that shisha smoking was accompanied by other activities, such as playing games or watching TV. Several participants also used shisha for meaningful conversation: "I think shisha is brilliant for discussions. We usually have discussion about Palestine, Bahrain and other controversial topics, lasting hours". One daily smoker explains his habits: "In the summer I might go [to a shisha café] four times a week, and each session could last 5 or 6 hours, because we don't just smoke shisha, we also play cards, play dominos – so sessions can last up to 6 hours."

Importantly, home smoking was significantly cheaper than café smoking in the long run. A one-off (£15-20) payment for a shisha pipe was usual, whereas shisha tobacco and accessories were cheaply bought online. Half of the sample smoked at home, and home smokers appeared to use shisha more often than café smokers. More regular smokers described the care needed to prepare their shisha pipe, almost in a ritualistic fashion. Some of these preparations were quite detailed and specific, such as preferring a certain number, density and size of holes in the aluminium foil which 'cooked' the shisha tobacco in a certain way.

A daily male smoker explains: "I've developed this certain quality with how my shisha is made; I can't just smoke anything. If you do it quite regularly I think you develop not a need but a want for that certain quality of shisha; it would help you relax."

Alongside customisation of the shisha tobacco, experimentation with the shisha pipe was seen. Whilst few mixed the water in the base of the apparatus with alcohol or other liquids, all students had heard and/or seen such practice. Shisha tobacco was also subject to being mixed with recreational drugs but no students admitted to this. Cleaning practices varied between students, as one daily male smoker describes:

"I've added a bit of milk, but I couldn't be bothered to change it. I left it for a few weeks and it was disgusting because I don't change the water often anyway. I had to bleach it, which is probably dangerous as well!"

7.3.3 Appeal of shisha smoking

There were many reasons which contributed to the appeal of shisha smoking. Sensory cues such as taste, smell and sight were important, exacerbated by the wide variety of flavours available and fun associated with exhaling smoke rings. Furthermore, the presence of peers during shisha sessions was a

recurrent theme contributing to the appeal of shisha smoking. Interestingly, there were several parallels drawn with the way shisha smoking mimicked alcohol use. Students thought it functioned as a social lubricant that mirrored social drinking. For example, a regular female smoker describes her habits: "We go on shisha crawls instead of pub crawls. We'll just go down Edgware Road and go to every shisha joint – that's what we enjoy doing."

A common misconception towards shisha included the belief inhaled smoke was filtered by water. Whilst this may help explain why it is socially acceptable amongst families, there were instances of disapproval towards shisha by family members and friends. This, though, was not as antagonistic as the disapproval towards cigarettes. One female smoker describes her family's stance: "My parents used to buy shishas as decorations. I have two older sisters and when they reached their teens they started experimenting, then smoking shisha a lot and my parents thought it was alright. They weren't against it, so it became this habitual thing; this thing we did together. They preferred that to cigarettes."

7.3.4 Addiction and cessation

The term 'addiction' was not endorsed by students. They thought that addiction was only possible if they smoked frequently (more than a few times a week), and this was reinforced by the fact that they believed shisha contained little nicotine. All students believed quitting shisha was an easy task, despite failed quit attempts amongst all those who had tried. The number of quit attempts ranged from one to twelve. The main causes of their 'relapse' into shisha was peer pressure. Nicotine addiction could have been masked by several references to a social addiction, described "a craving for hanging out" satisfied only when in the environment of shisha smokers.

Despite this strong, anti-addiction perception towards shisha, a regular female smoker mentioned: "I don't know if I was craving the actual shisha or the habit of it…I know it's not addictive, but I think it's habitual. Now it's got to the stage where I can't tell 'do I need it, or do I just want it?'" A weekly male smoker explains his encounter with addiction: "Sometimes it bothers me - if I want it [waterpipe], I don't just forget about it – I'll do anything just to have it…I don't know why."

Nobody had used professional cessation services (such as the NHS Stop Smoking Service) to help quit shisha. Most had been told about shisha's health effects but carried on smoking either because they felt the evidence was "not very convincing" or because they were willing to overlook the risks, described by one as a "cost-benefit analysis". A less than weekly male smoker gives his opinion on cessation: "I don't see enough advertising to tell me the real effects of shisha, so I don't really know them. Until then I'm not gonna stop."

7.3.5 Perceptions and experiences of health effects

Many shisha smokers had experienced health effects at some point during their smoking history. The most common health effects were non-specific neurological signs such as headache, nausea and light-headedness. This is likely to reflect increased levels of carbon monoxide exposure during long sessions.

Other symptoms included coughs, chest tightness and a head rush. A daily male smoker describes his health effects: "I can't smoke before I play sports because I'm out of breath. If I smoke less than 4 hours before playing, then it really affects me. I can carry on playing but I'm breathing heavily." Another describes: "I feel like my lungs go weaker after I've smoked shisha. If I go exercising the day after I've had shisha I feel a lot weaker, like my lungs can't take that much." A third male smoker had similar

experiences: “If I’ve been sitting for a while smoking shisha and I want to immediately get up and go somewhere upstairs, it’s exhausting.”

Despite this, some participants had not experienced any health effects as a result of shisha use, and among dual cigarette/shisha smokers, believed that shisha felt less harsh on their throat and therefore less likely to cause health problems. Nearly all participants agreed that developing a severe illness would make them reconsider their shisha use. A male dual smoker shares his thoughts: “When I smoke cigarettes I know straight away ‘This is bad for me’ but when I smoke shisha, I don’t feel it’s bad for me and that’s because it’s cold and it’s been through the filter, and you don’t see direct tobacco being burnt – when you’re smoking cigarettes you can see it burning and you can feel the heat.”

7.3.6 Knowledge of shisha smoking

Shisha knowledge was the only elicited theme that varied between different focus groups. Whilst some smokers (mainly home smokers) had acceptable knowledge of the toxicants produced by shisha, others had very little idea. Of those who had used the internet to search for health information, they found contrasting information that was deemed unreliable so knowledge was sought from peers. One weekly male smoker reinforces this: “The thing with research on shisha is that you’re always hearing different things. I’ve not seen some fixed, valuable, viable research. Initially, I heard people say that it’s better for you than cigarette smoking because the water acts like a filter but then I heard people saying ‘no it’s 50 times worse’. I’ve heard all these figures and it’s never consistent. So you don’t really know what to believe.”

7.3.7 Comparison between waterpipe smoking and other tobacco smoking

There was a general consensus that shisha felt less harmful and was less addictive than a cigarette due to its pleasant taste. Adjectives to describe the smoke produced from the waterpipe included “lighter”, “cooler”, and “milder” than cigarette smoke. Whilst shisha had a clearly defined social role, cigarette smoking filled a more personal need. Dual smokers were adamant that the two smoking methods were not freely interchangeable, and each served a different purpose. This was explained by detailing how cigarettes were smoked during a shisha session, indicating each one had a different effect on the smoker. Most dual smokers had sampled shisha before moving onto cigarettes, but this was not quantified in detail.

One smoker’s take on comparing shisha to cigarettes: “I don’t believe all this rubbish about it being 400 times as harmful as smoking one cigarette; it would probably be harmful, because of all the nicotine and tobacco but I don’t think it’s as harmful as cigarettes.” This was in response to news articles numerically comparing shisha to a number of cigarettes, and causing much confusion over the health messages (see final paragraph, 4.3.1).

Dual smokers also described how they felt the inhalation method of shisha was different to the inhalation method of cigarettes: “When you smoke a cigarette, you inhale and then take another breath on top of it. You take it in, so the smoke travels deeper into your lungs. I never do that with shisha. I don’t understand the science behind it. When you say you ‘don’t inhale’, that’s what you mean. You take a deep breath but then you just blow it back out again.” Another explains: “I inhale cigarettes into my lungs but I don’t think I do that with shisha. I take it into my mouth and blow it out, I don’t think I inhale it into my lungs.”

7.4 Conclusion

This is a moderately sized set of focus group discussions among mainly ethnic university students gives insight into their knowledge, behaviour and attitudes towards shisha smoking. Of particular interest is the difference between café and home smokers: home smokers smoked cheaply, appeared to be more addicted but were more knowledgeable about shisha than café smokers. This study shows similarities between shisha and cigarettes, but at the same time highlights key differences such as the social way in which shisha is used, the universally reduced harm perception and strong peer and family network of social acceptance. Inaccurate claims that a single waterpipe session equates to several hundred cigarettes may result in reduced credibility towards researchers and public health specialists. Indeed, this project can form the basis of health education campaigns and can start evidence-based interventions.

8. Local Authority Responses against Shisha Use in London

8.1 Background

Local authorities (LAs) are the frontline enforcers of the law that play a crucial role in controlling the tobacco industry and reducing smoking prevalence. As the number of London shisha premises has grown since the implementation of the Smokefree law [5], so has the extent of LA action in response, but this has not been explored in detail. The aim of this study is to gauge the level of LA response to shisha use in the community, and explore the legislative difficulties exhibited with current enforcement action, if applicable.

8.2 Methods

8.2.1 Participant recruitment

Between 24th May 2013 and 21st June 2013, staff from London LAs were recruited to participate in an anonymous telephone interview using a two stage process. The aim was to speak to anyone actively involved in LA responses against the shisha industry, including those working in environmental health, trading standards, noise and licensing, planning enforcement and public health. Firstly, a snowball sampling technique started with nine LA staff members from six unique London boroughs, who were known to the researcher as being actively responding to the shisha industry. Interviewees were asked to recommend colleagues if not all questions were adequately answered or if they knew suitable interviewees from neighbouring boroughs. This recruitment process resulted in twenty two interviews of key informants from nine unique London boroughs, however several LA staff members were not contactable or a suitably timed interview could not arranged with them within the time frame of the study.

Secondly, recruitment emails outlining this study were sent to the trading standards and environmental health departments of any other London borough that was known to contain greater than ten shisha premises, or if less than ten shisha premises, had experienced a reduction in the number of cafes over the last few years. This was identified from the January 2012 British Heart Foundation Freedom of Information project where number of shisha premises were longitudinally measured across the UK [5]. This purposive sampling method was aimed at targeting boroughs with the most premises, considering phase one of the recruitment process identified that boroughs with less shisha premises seemed to have few problems relating to the shisha industry (as will be described in the results). It also targeted boroughs that had had successes in controlling the shisha industry. Six recruitment emails were sent, from which six interviews were conducted from a further five unique London boroughs. One LA staff member could not arrange a suitable time to talk in the time frame for this study. Therefore in total, this study interviewed twenty six LA staff members from fourteen unique London boroughs.

8.2.2 Interview and transcript analyses

Interviews were conducted by one researcher in a semi-structured format using a mixture of open and closed questions. These explored antisocial behaviour associated with shisha premises as well as their compliance with health warning labelling, underage sales, purchase of duty paid tobacco, the smoke-free law, health and safety and planning issues. Several questions were also posed about the level of public health intervention in each borough, especially health promotion and education. Recommendations for future change, if applicable, were sought from interviewees. Considering the

multi-agency approach towards LA responses to the shisha industry, participants were asked to speak on behalf of other agents in their borough if they felt they were competent at doing so. If not, suitable colleagues were recommended for further information.

Interviews lasted between 15-45 minutes, were audio recorded, transcribed and analysed for recurrent concepts. A framework approach was used to derive concepts deductively, and cross-index concept coding occurred manually. All participants consented to anonymous use of their transcript, a copy of which was sent to them for reference and to check for accuracy. This section of the report was also sent to all interviewees for further review and comments and to help build practical recommendations based on the evidence presented.

8.2.3 Other evidence

Interviewees were asked to provide written evidence to complement their interview transcripts. This could be in the form of reports, presentations or public documents relating to LA responses to shisha use. Each LA website was searched for press releases relating to shisha. In total, 47 pieces of written evidence were provided or found, and they were synthesised into the interview analyses.

8.3 Results

8.3.1 English legislation relating to shisha use

As a tobacco product, shisha is covered by English legislation. For example, The Children and Young Persons (Sale of Tobacco etc.) Order 2007 is not specific to cigarettes and ensures that any form of tobacco cannot be sold to those under the age of eighteen years, and this is similarly seen across other legislative documents. For shisha tobacco, there is however one area which remains unclear and that is in The Tobacco Products (Manufacture, Presentation and Sale) (Amendment) Regulations 2007, where there is no mention of the practical application of health warnings to the shisha pipe apparatus and/or its accessories, only 'the tobacco packet'.

Additionally, another main concern is the legislative inattention given to tobacco substitutes, which is important when defining the legal state of herbal (non-tobacco) shisha, a substance which is known to be consumed in shisha premises. The only legislation that appears to apply to herbal shisha enforcement is the Health Act 2006, where 'smoking' is defined as 'smoking tobacco' or 'smoking any other substance'. This means herbal shisha is not exempt from the Smokefree law in England. In terms of underage sales, the Children and Young Persons (Protection from Tobacco) Act 1991 and The Children and Young Persons (Sale of Tobacco etc.) Order 2007 appear exclusive to tobacco only and do not mention tobacco substitutes or other forms of smoking. This indicates that those aged under eighteen years customers can smoke herbal shisha legally if not sitting in an enclosed environment. There is also no mention of tobacco substitutes concerning the topic of health warnings. Herbal shisha is also exempt from duty payment.

Matters are further complicated by anecdotal reports that LA staff members, shisha smokers, shisha premises owners and the general public may not know what is meant by 'herbal' shisha. Ordinary shisha tobacco is renowned for poor labelling practices [19], and contains misleading descriptors such as '0.05% nicotine', '0.5% nicotine', '0% tar', '100% natural flavours' etc. Whilst these same products are known to contain toxicants and induce cigarette-like disease, the labelling practices may give a false impression that they are herbal in nature, and not *Mo'assel* tobacco where tobacco is mixed with

flavours, honey and humectants. This can confuse LA staff members, shisha premises owners, smokers and the general public and undermine tobacco control efforts. LA response to herbal shisha will be explored in forthcoming themes.

8.3.2 General overview

Shisha-serving businesses were broadly divided into three categories: 1) shisha cafes (where shisha was the primary product sold), 2) restaurants/bars serving shisha (where shisha was not the primary product sold) and 3) retail outlets that sold shisha pipes/tobacco (where no tobacco consumption took place on site). These three categories are listed in order of decreasing problems associated with them (i.e. shisha cafes generally posed the most problems of the three). This report only focuses on the first two categories (shisha cafes and restaurants/bars serving shisha), which will collectively be known as 'shisha premises' unless otherwise stated.

Generally speaking, the number of shisha-related problems in each borough appeared to be proportional to the number of shisha premises in that borough. Table 1 presents the approximate number of shisha premises in each borough as of June 2013, compared to data from the British Heart Foundation (BHF) which collected the number of shisha premises in 2007 and 2011 [5]. Numbers are approximate as it was difficult to monitor the number of premises in each borough; described as a "sand shifting industry." Interviewees were asked to subjectively identify the extent of problems caused by shisha premises in their borough as either 'mild', 'moderate' or 'severe', and this is also shown in Table 1 and graphically represented in Figure 5. If interviewees could not give a subjective perception, this was inferred from their transcript in relation to other boroughs. Combining these results, Table 2 presents the average and range of number of shisha premises in each of these three subjective measures, leading to the conclusion that problems caused by shisha premises in each borough are proportional to the number of shisha premises in each borough.

Table 1 has limitations in the sense that premises numbers are only estimates, data from the BHF (2007 and 2011 data) asked about numbers of 'shisha bars' whereas this project asked about 'shisha premises' (shisha cafes and bars/restaurants serving shisha) and the LoTSA shisha survey asked about 'shisha cafes'. These terms to describe premises serving shisha are usually freely interchangeable and this may impact on total numbers documented. Additionally, subjective perceptions may be influenced by the level of priority given to shisha premises according to the LA resource allocation (i.e. LAs with more resources may be more likely to devote time to the shisha industry, experience difficulties and report 'moderate' or 'severe' subjective responses compared to LAs with a similar shisha problem who do not devote much time to it and report 'mild' subjective responses). Despite this it is a rough estimation of mapping shisha premises across the city.

Table 1. Longitudinal data on the approximate number of shisha premises in each borough, including the subjective perception of shisha-related problems as identified by each LA interviewee in June 2013. (**Bold: interviewed**)

Borough	Number of shisha premises			Subjective perception of shisha-related problems
	2007	2011	2013	
Barking and Dagenham	0	0	0°	No shisha premises
Barnet	2	15	16	Moderate
Bexley	0	0	1-5°	No data
Brent	12*	45	30	Severe
Bromley	0	1	1-5°	No data
Camden	N/A	12	16	Moderate
Croydon	N/A	N/A	3□	No data
City of London	0	0	0°	No shisha premises
Ealing	10	31	33	Moderate
Enfield	0	2	1-5°	No data
Greenwich	0	3	4	Moderate‡
Hackney	0	1	1-5°	No data
Hammersmith and Fulham	17	10	11	Moderate
Haringey	2	7	11-20°	No data
Harrow	3	7	7¥	Moderate‡
Havering	0	0	0°	No shisha premises
Hillingdon	0	9	10	Moderate
Hounslow	9*	3	6-10°	No data
Islington	2	17	12	Moderate
Kensington and Chelsea	8	8	10	Mild
Kingston upon Thames	1	12	7	Mild
Lambeth	11†	19	10	Mild
Lewisham	0	0	0¥	Mild‡
Merton	0	0	1-5°	No data
Newham	21§	5	6	Moderate
Redbridge	0	5	11-20°	Moderate
Richmond upon Thames	N/A	3	1-5	No data
Southwark	0	1	2	Mild
Sutton	0	1	0°	No shisha premises
Tower Hamlets	32*	9	11-20°	Moderate
Waltham Forest	2	11	11¥	No data
Wandsworth	0	10	11	Mild
Westminster	66	103	110	Severe
Total	198	350	354-409	

Key: *BHF data for 2008; †BHF data for 2010; §BHF data for 2009; ‡LA not directly interviewed - answered on behalf of a neighbouring LA; °Data kindly provided by the London Trading Standards Authorities 2013 shisha survey, where LAs were asked to estimate the number of shisha cafes their borough; ¥Unknown number of cafes for 2013 – BHF data for 2011 used; □Data for Croydon taken from www.shishaspot.com

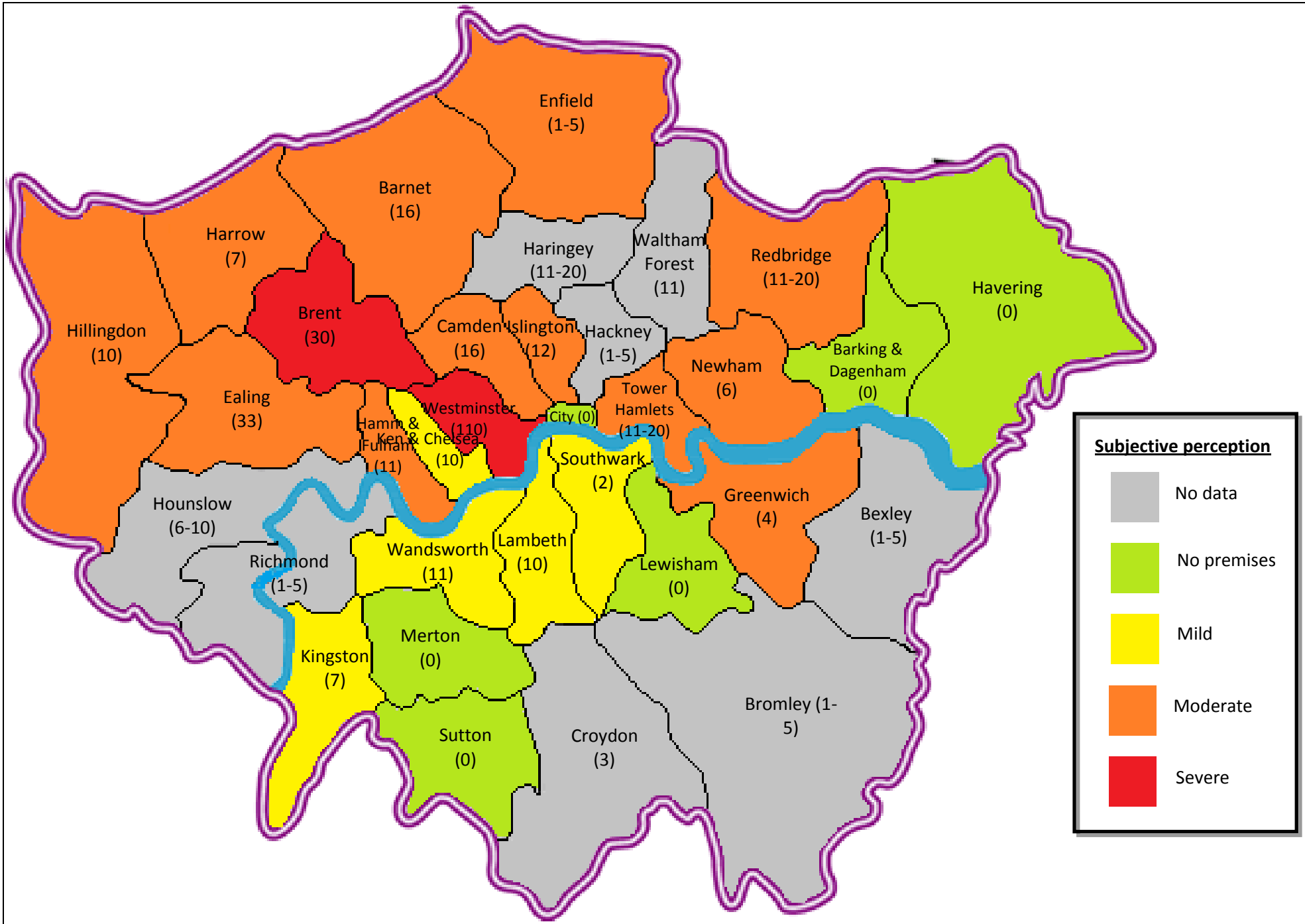


Figure 5: Subjective perception of shisha-related problems across London, including number of shisha premises in 2013 (in brackets)

Table 2. The average number and range of shisha premises (June 2013) among fourteen London boroughs for each subjective perception of shisha-related problems

Subjective perception of shisha-related problems	Average number of shisha premises	Range of shisha premises
Mild	8	2-11
Moderate	13	1-33
Severe	70	30-110

Figure 5 shows subjective perceptions of shisha-related problems across London. Data was only available for 25 boroughs. Shisha premises appear more prevalent and more problematic in boroughs north of the river compared to those south of the river, and more precisely in the northwest rather than the northeast. In general, outer London boroughs had less shisha premises than inner London boroughs, except for those outer boroughs in northwest London. This pattern of shisha premises distribution is likely to coincide with the ethnic demographic of London, but this was not fully explored within the timeframe of the study.

Additionally, shisha premises that were non-compliant in one area of the law were generally non-compliant in other areas as well. This resulted in a LA strategy of stratifying the number of shisha premises in their area and targeting only the most non-compliant cafes using a multi-agency approach. Indeed, whilst all boroughs used a multi-agency approach to respond to the shisha industry, there was a lack of consistency in the extent to which multiple agents were used, and a lack of consistency enforcing the law across boroughs which will be detailed further in these results.

> *"The ones that were more compliant tended to be the better premises with the higher ratings of food safety, and the alcohol license conditions were complied with."*

8.3.3 Antisocial behaviour, crime and disorder

Shisha premises have large potential in being subject to noise-centred antisocial behaviour. Typical opening times extend into the late night and early morning hours, drawing residential complaints and a reactive LA response. One borough described weekly residential complaints however others were generally monthly or less frequent. It seems that shisha premises have two groups of customer characteristics: "the afterschool and early evening crowd", attracting young men and women, some of whom are underage, as well as the "more hard-core group of customers" that stay late into the night and who are responsible for most of the antisocial behaviour associated with shisha premises.

Worryingly, antisocial behaviour was also seen towards enforcement officers, in some cases compromising security. There was a general awareness that shisha premises could be hostile environments, and could even be designed in a way that would be antagonistic to the inspections of enforcement officers. This included obstructing enforcers, owners refusing to identify themselves, and hiding equipment when enforcers arrive. There appeared to be isolated extremes of antisocial behaviour mimicking the problems found in the alcohol industry, but the general consensus was noise-related issues.

"If there's one thing you do not want to be doing, that's walking into one of these places at nine o'clock at night without the police, because there's a lot of hot coals around, there's a lot of glass around, there's a lot of weapons – well, objects that could be turned into weapons – and the crowd are not amenable to our presence. Without the police none of this could have gone ahead, really."

"If you looked at the front of it, it wasn't a regular catering premises, it looked like an empty building. But as soon as you went in there it was a shisha bar, and they were advertising on Facebook and trying to get youngsters involved…And in one particular occasion, I couldn't get through to the back room because the proprietor of the business actually got hold of me to prevent me from seeing what was going on in the backroom. And he physically restrained me so I couldn't see what was going on. And by the time the police arrived, they'd hidden all the pipes at the back."

"The type of problems that we have with licensed premises aren't the same type of problems we get with shisha. I've never heard of – well I've heard of maybe one sexual assault at a shisha bar – but there don't tend to be fights or punch-ups or people getting thrown into the street. The problems we get are people leaving, being noisy...cars turning up...we've had a couple of robberies, we've had a young woman had her phone stolen – stuff like that."

"We've had premises where there have been fights, where they have been smoking in the basement of venues, where there have been allegations or prostitution."

There was an established underground culture associated with shisha premises. LA staff predicted they had an extra 5-30% of shisha premises that they were unaware of, and were made aware of them by members of the public or other agents in the LA. In particularly antisocial premises, enforcement officers had difficulty identifying the person in charge, which posed practical difficulties over subsequent prosecutions. One borough had a particular problem with the underground culture associated with these premises.

"Increasingly you'll find false doors, false walls, hidden trapdoors into the basements. Doors are locked, windows are obscured, the lights are kept off, there's a guy at the front with a mobile phone called something or other, and you have to know his name and speak his language in order to get in. By the time we get in, you go down to the basement and the smell of air freshener is killing and the fans are blowing a gale, but there are forty people there. We've had incidents where, after 20 minutes delay trying to get into the basement, were faced with thirty people. We asked 'what are these people doing here?', and we were told they're having a birthday party, and at that point everybody in the room starting singing 'Happy Birthday'!"

"The other thing is when we talk with some of the young people we work with about shisha, I mean they'll tell you that the places that you see on the high street, the really prominent ones with shisha in the window, are the exception not the rule. Typically what's happening, it's going on in the back of cafes, in the evening, late at night, in an upstairs room or in a basement."

In boroughs populated by Muslim communities, shisha premises rarely sold alcohol and were generally non-hostile atmospheres. Cultural sensitivities had to be taken into consideration when regularly inspecting these premises. However in other boroughs, alcohol was sometimes sold in premises. In rare circumstances, alcohol may have been served within the pipe itself. One borough had a shisha premise apply for an alcohol license purely to sell shisha pipes with alcohol contained within it. In another borough, the only shisha premise with an alcohol license was one that served alcohol in the pipe, and this premise had issues with antisocial behaviour. Whilst university students had all heard or seen alcohol being served inside the pipe (see section 7.3.2), this was a surprise for most LA staff members. Whether this is due to ignorance among LA staff members or due to a true low prevalence of shisha/alcohol mixes, remains uncertain. So far, evidence points to the latter as premises serving alcohol in shisha pipes are likely to stock alcohol on site, and this was not commonly seen during routine inspections. However, it remains an important aspect for the future as it appears a fashionable trend.

> *"There's also quite a strong argument from the Muslim community that they're being quite victimised by police and trading standards in these areas where their young people want to share a shisha pipe on a Friday or a Saturday evening in a basement or in a bar ...and they're continuously being harassed. Whereas you've got their peers downtown who are drunk out of their heads and taking all sorts of drugs, who are left alone by the police."*

> *"We have seen some shisha cafes offering shisha pipes that are filled with spirits or champagne or whatever, which gives a new dimension to the whole thing. I don't think that people realise they'll get completely drunk if they smoke through a spirit, for example. And obviously there's even more health implications for that."*

There was no LA intelligence that recreational drugs had ever seeped into shisha pipes, or that shisha premises may have been a hub for recreational drug activity. There have been a handful of allegations, but very few, if any, had solid evidence of recreational drug activity. Interestingly, one borough noted a problem between shisha smoking and the chewing of qat, a mild hallucinogen used extensively by the East African population, but this appears to be culturally confined and general recreational drug use remains anecdotal.

> *"Anecdotally, we've heard of what they call 'shisha plus'. When we asked what the 'plus' meant, the guy first said 'marijuana', and then decided he couldn't speak English."*

> *"I think there might be an overlap between drug use and shisha use, but then there's an overlap between drug use and being a teenager."*

> *"The guy who ran it [the shisha premise] was stopped by the police and he had nine k's of cannabis in the back of his car. So that one was a bit towards the end of the spectrum, but I have to say that generally speaking, no we don't get the same sort of problems we get with licensed premises. We get noise disturbance mainly."*

Recommendations:

- LAs with a low number of shisha premises and mildly perceived problem related to the shisha industry should develop a preventive approach to ensure uncontrolled proliferation of shisha premises does not occur.
- Managers of shisha premises should be encouraged to learn management techniques and attend workshops in an attempt to prevent their customers from creating antisocial behaviour.
- Shisha premises should be monitored for alcohol use inside the pipe. While this is currently legal, LA staff should be aware of this practice and report it.
- Shisha premises should be monitored for recreational drug use and use of other illicit substances.
- As is seen in Turkish law, legal consideration should be given to limiting what liquids can be used in the base of the shisha pipe apparatus, including a prohibition on the use of alcohol. Although this is a non-researched area of shisha's health effects, it is likely to induce intoxication, contribute to antisocial behaviour and be a major fire hazard if flammable spirits are used. Shisha premises that have an alcohol license should be monitored for this.
- LAs should ensure they have adequate out of hours support for enforcing legislation on shisha premises, as non-compliance is likely to increase at unsociable hours of trading.

8.3.4 Health warning labels

Enforcement of health warning labels was disputatious between LAs. Whilst all LAs agreed that shisha tobacco packets should comply with labelling requirements, extending the enforcement to the shisha pipe apparatus was inconsistently noted. Some believed that health warnings on order menus were sufficient, whereas others were content with health warnings on wall posters or table posters. There were several instances of lanyards displaying health warnings being used over the shisha pipe apparatus. Much frustration was displayed over the lack of legislative guidance on what constituted adequate health warning labelling practices.

> *"If you read the legislation the way we're reading it, the hookah [shisha] pipe in itself is a packet or a receptacle in which tobacco is provided to consumers. And in doing so, needs to be labelled in conformance as if it were a traditional packet of cigarettes i.e. it needs picture warnings on it and it needs one of the two text warnings. So that's where we came from, and that was the advice we started to give all the shisha shops."*

> *"I would be prepared to accept display posters, maybe around the premises, a label stuck to each table. I haven't actually seen that done yet but I know our guidance says that might be acceptable within the spirit of the law, if not quite to the letter."*

> *"We just wish the Department of Health and the government would actually give some parliamentary time for bringing the legislation up to date for what is actually out in the marketplace, because it's inadequate at the moment and it's overly complicated"*

There was one borough in particular that had good compliance with shisha tobacco packets that had health warnings on them and were duty paid (issued by the company Al-Fakher), and why this was not the case in other boroughs remains unknown.

A regular practice seen by shisha premises was storing their tobacco in large tubs, some of them plain and unlabelled, others labelled in foreign languages. It was sometimes difficult for LA staff members to know exactly what was being served to customers. There were general difficulties in performing test purchasing of these products to see whether or not they contained tobacco. Anecdotal reports suggest that premises may be using tubs labelled as herbal shisha, but serving tobacco shisha. Only one borough seemed to have the adequate resources to have their samples tested for tobacco and nicotine content, but the extent to which this was utilised is unknown.

Recommendations:

- Considering shisha premises smokers may only be presented with the shisha pipe and not see the original shisha tobacco packet, existing legislation needs to clarify how the shisha industry should comply with health warning labels.
- If health warning labels need to be applied to the shisha pipe, consideration should be given to the fact that the shisha pipe has multiple detachable parts (head/body/bowl/hose), and thus each may need its own health warning.
- Another consideration is whether these labels need to be fixed to the shisha pipe or whether they can be removable, especially in the light of needing to regularly wash the pipes which could inadvertently wear away health warning labels.
- Given the reduced harm perception towards shisha and distinct features of the apparatus compared to cigarettes, health warnings should be shisha-specific in order to effectively educate shisha smokers e.g. ‘shisha is not a safe alternative to cigarettes’, ‘water in the base of the shisha pipe does not filter out harmful chemicals’, ‘non-tobacco (herbal) shisha contains similar harmful chemicals to tobacco shisha and cigarettes’.
- LAs should collectively contact shisha tobacco companies and encourage them to comply with labelling requirements on their packets to avoid future seizures, whilst teams should work with the UK Border Agency to control the supply of illicit shisha tobacco into the country.
- General enforcement guidance should be sought from the Department of Health, and LAs should work together to lobby for this. This should include targets for each LA to guide enforcement activities.

8.3.3 Underage sales

Described by one as "something that is of specific attraction to young people", all interviewees had come across, or heard of, young people smoking in shisha premises. The suspicion is that they are likely to be found smoking during the weekend. They were also more likely to be of an ethnic background typically associated with shisha smoking (Middle Eastern or South Asian), but these could not be confirmed. In boroughs with more of an ethnic mix, there appeared to be young people from other ethnicities also present in these premises. Many LA staff members noted the presence of young females as well. Where underage problems were not experienced in a few isolated cases, this may have been due to inspection timings that were not typical for young people to be present.

> *"The youngest person we ever found smoking in a shisha premises was a thirteen year old, and we have routinely found under eighteens in shisha businesses."*

Whilst LA staff members did witness young people being present in cafes, many had difficulties proving that they had been smoking or, if they were smoking, whether they were intending to pay for the shisha or whether an adult sitting beside them would pay. It was unclear whether this was a prosecutable offence.

Despite this, statutory signs for the prohibition of sales to those under eighteen years appeared to be the most compliant aspect to shisha premises, albeit some cafes using signs smaller than required A3 format. Some LA staff members were confused about the legal state of herbal shisha and underage use. Two boroughs described how they gave guidance to stop underage herbal use even though premises were under the impression they could supply and sell it to young people.

Underage test purchasing was a particular difficulty in shisha premises, described by one as "a risk assessment too far". Here, applying existing legislation to the shisha industry proved impractical and unethical. As many premises remain non-compliant with the Smokefree law, second-hand smoke inside these premises proved a deterrent for most LAs to pursue underage test purchasing. One recurrent argument was the fact that the point of sale in a shisha premises was only after the product was consumed. One trading standards officer explains:

> *"It's bad enough we send a child volunteer into a Smokefree non-compliant premises most of the time – but then we're asking them to sit there for a period of time...the underage test purchasing part of shisha is sometimes unenforceable, because we cannot get the children to actually formulate a sale. We can get the supply, no problem, but the sale is the problem bit…and we have a backlog of shisha complaints at the moment because it's so hard to actually enforce the underage TP [test purchasing] side of shisha."*

There were a few trials of underage test purchasing in shisha premises, one of which was described by one trading standards officer as having a positive outcome. The merit of conducting underage test purchases appeared to be in the size of the prosecution fine, but in one case this was only due to the coincidental finding of other young people already smoking inside. In one borough, underage test purchasing was simply not considered as trading standards officers had prioritised other enforcement activities ahead of it.

"We sent in our child volunteers to a particular shisha premise and as we sent them in, we actually realised there were children in school uniform in there [smoking] at the same time. So we got statements from the children that were there, and they [the shisha premise] were prosecuted, eventually, and quite harshly as well."

There seem to have been two described methods to combat the practical problems associated with underage test purchasing. The first was to undertake identification checks with the police, but in boroughs with minimal police co-operation this was not feasible. The second method was to identify whether shisha premises had policies in place to check the age of their customers.

Recommendations:

- The concept of underage test purchasing in the shisha industry needs to be revisited. Considering the second-hand smoke harm exposure from premises non-compliant with the Smokefree law, it may be unethical to subject a young person to such an environment. However, a rewording of the legislation from 'point of supply' to 'point of sale' may partly overcome this. There appears to be no issues with performing underage test purchasing at retail shops rather than shisha premises.
- Despite problems associated with underage test purchasing, prevalence studies from this report as well as anecdotal evidence from LA staff members highlight the attractive nature of shisha premises to young people. Community groups and youth clubs should aim to provide suitable alternatives to young people that may emulate the ambient environment created by shisha premises, but in a safer manner.
- Guidance and advice provided to shisha premises owners should include an emphasis on the current legal state of herbal (non-tobacco) shisha – that is, it is covered by the Smokefree law, it can be sold to under eighteens, it is not liable for duty payments nor is it a requirement to display health warnings.
- While herbal shisha is exempt from duty payments, it should not be exempt from underage sales and health warning labels considering the product is unstandardized and contains many of the same harmful chemicals as regular shisha tobacco (see *section 4* of this report). Herbal shisha needs not include statements on addiction as it does not contain nicotine.
- As is seen in Scottish law (*see section 5.3.7*), fixed penalty notices for underage sales should be issued by trading standards officers. This will reduce the burden on the police force and enhance efficacy of the LA response to shisha use.

8.3.5 Duty paid tobacco

Very little shisha tobacco appeared to be duty paid. Several trading standards officers mentioned that one particular shisha company (Al-Fakher) had started to provide duty paid and adequately labelled shisha tobacco, however the extent to which this had reached the mainstream market was minimal and uncertain. Only one LA noted compliance with this brand across their shisha premises. Very few officers knew about a second shisha tobacco company (Habibi) that also had duty paid and adequately labelled shisha tobacco, and this is likely to be due to the fact that is not a routinely popular brand.

"The problem we've got from a trading standards point of view in the local authority is that apart from one product, Al-Fakher, which now has Department of Health authorisation, no other product on the marketplace should even exist. By that fact, all trading standards should be seizing all these products."

"To actually provide unpackaged tobacco, without warnings, without any indication of the constituents of that tobacco, supply that, make it in a pipe and then light it for the customer, is wholly illegal. It's akin to someone taking a pipe into a tobacconists, getting it filled, the tobacconist lighting it for them and then leaving the shop. My understanding of that is it's illegal."

One LA described how, despite seizing hundreds of kilograms of shisha tobacco for lacking health warnings and duty payment, compliance across all premises was still inadequate. This was put down to a lack of resources that meant they could only seize tobacco from the most non-compliant shisha premises only.

Non-duty paid shisha tobacco appears to cost approximately £40/kg. With duty payment (£96.64) and VAT, this legal cost should be tripled to £115/kg. Whilst LA staff members knew approximately how much shisha pipe sessions cost in their premises, they were unaware of how much weight of tobacco was packed into a shisha pipe per session. Indeed, the usual amount of shisha tobacco used per session is 10g (sometimes up to 20g) which, if sold for £10 per session (maximum mentioned price was £20 per session), means that shisha premises are buying their shisha tobacco at £40-115/kg and selling it at £1,000/kg. This makes seizures for non-duty paid tobacco an extremely effective enforcement method should the premises stock a large amount of tobacco.

"We recovered half a million pounds worth of what we believe to be smuggled tobacco, and that was only a quarter of the original confinement. Because if you look at the paperwork and the boxes, there were originally 200 boxes and we only seized 52. There was no indication on any of the packaging or boxes that they had passed legitimately through British customs. The shipping details suggest they came from the Middle East, into Europe, then into the UK."

"Recently we have targeted two premises that have alcohol licenses. One of those premises surrendered the alcohol license so they could continue to do what they were doing from a shisha perspective, without the alcohol – or at least, we believe – without the alcohol. For a premises to voluntarily offer up its alcohol license to continue to operate as a shisha bar, that in itself will tell you much money there is to be made."

Despite the large potential in affecting a shisha premises' profits through seizure of illegal tobacco and shisha pipes, there is good indication that many shisha premises are bypassing this potential loss by only stocking a night or two nights' worth of shisha tobacco in their premise. This equates to only several hundred grams of each main flavour, meaning that seizures for duty non-paid tobacco have become less effective in many boroughs.

"The one thing that is very evident at shisha cafes is that they only stock enough on the premises for even that night or for two days, really…now whether that's because of any previous experience in the other boroughs where all of those products were initially being seized quite significantly."

One particular officer highlighted the fact that, whilst shisha premises could easily absorb the added duty payment and VAT cost on their tobacco through their already-existing high profit margins, retail outlets could not. It was therefore hypothesised that retail outlets would be more likely to hold illicit shisha tobacco and, if they held a concurrent alcohol license, would be breaking the terms of their license due to the presence of a 'smuggled good' on site. Further insight is needed into the supply chain of the shisha industry.

"It's been our experience that most of the traders do adhoc online orders that come through the mail delivery or get delivered direct."

"There's also recently been an incident where we found a shisha production premises where they were producing their own shisha having bought their tobacco…and they were using food colourings and dyes, and creating what they were claiming to be a proper shisha product."

Recommendation:

- Considering there are approximately 500 shisha premises in the London and this figure is likely to increase, Her Majesty's Revenue &Customs (HMRC) should place shisha duty evasion as a priority alongside alcohol, cigarettes and hand-rolling tobacco.
- If shisha premises do not store more than a few nights' worth of tobacco and LAs are not impacting business profitability through recurrent seizures, further investigation should sought into the supply chain to identify warehouses/suppliers that deliver to these premises.

8.3.6 Health Act 2006 and the Smokefree law

The introduction of the 2006 Health Act and subsequent Smokefree law resulted in little extra work for enforcers from a cigarette perspective. However, it considerably increased the workload when it came to the shisha industry who, after adequate industry representation in the build-up to passing the Health Act, were included in the law. This was an unforeseen consequence of the Health Act, which aimed to be enforced without needing extra monetary or human resources. One environmental health officer spends 30% of his time dealing with shisha premises, even though shisha premises comprise of less than 1.5% of food businesses in the borough that he is also partly responsible for.

Although this research project was not a quantitative exercise, environmental health officers were asked what percentage of their shisha premises were compliant with the Smokefree law. This ranged from 5% to 38% although compliance was extremely transient and intermittent. LA staff members were asked to explore reasons for this particular lack of compliance. With specific regards to the Smokefree law, it was felt that it was a cigarette-specific law in the sense that it did not appreciate the long smoking times associated with the shisha smoking. Thus, while a five minute cigarette could be tolerated outside in the poor British weather, long periods of shisha smoking were incompatible with this and this was a main

reason for breaching the Smokefree law. Indeed, there appeared to be a good correlation between the level of Smokefree compliance and the time of year (i.e. more compliance in the summer). Additionally, the Smokefree law appeared to encourage smoking on pavements and did not take into consideration the large plumes of tobacco smoke emitted from shisha pipes compared to the small volume emitted from a cigarette. Smoking on pavements could have inadvertently contributed to shisha's popularity due to unintentional advertising of the product to the general public who would inhale sweet smelling, fruit flavoured, aromatic smoke.

> *"I think a lot of EHOs [environmental health officers] are quite scared of it [enforcing the Health Act] because it's fairly confrontational. It's not something where you can really offer a solution to the people doing it because the law was brought in to stop them doing it."*

However, another important and recurrent reason for regular flouting of the Smokefree law was the fact that prosecution fines were too small for shisha premises to be a deterrent. In one borough where several prosecutions had been undertaken, the smallest fine was £300 and the largest was £1500. This aspect of the LA response will be explored further in section *8.3.9 Successful methods of controlling the industry*. Whilst a small proportion may have simply been ignorant of the law, the vast majority were given clear and regular advice and warnings, and thus any breaches were intentional. Whether enforcers felt uncomfortable enforcing a law they knew had little solution needs further research.

> *"Our enforcement policy basically says to give guidance, then send them a warning letter, then enforce. So they all know what they're doing is wrong and illegal, but they carry on doing it because a) they think they're going to get away with it or b) they'd rather take the fine and carry on with their business. I mean, I have one business which is right across the road, who says "What do you want me to do? Without shisha I can't survive". Basically he has to break the law for his business to survive…that's what he says."*

> *"I think people are trying sometimes to get round the Health Act requirements by having very odd structures which they try to tell me aren't a roof, or not enclosed or whatever."*

Another cited reason was the lack of security associated with long periods of outdoor smoking should shisha premises provide their customers with television entertainment, for example. Managers of shisha premises preferred to have such equipment secured indoors, thus drawing their customers inside. One enforcer describes an innovative use of his powers as an environmental health officer as a result of shisha premises breaching the Smokefree law:

> *"We took a carbon monoxide monitor in…I felt the levels were so high that it warranted a service of a prohibition notice. That closed there and then – I've done that twice."*

Recommendation:

- Environmental health officers should maximise communication lines via Health & Safety Liaison Groups and Health & Safety Quadrants to raise shisha issues with colleagues across London and encourage a more consistent enforcement approach.
- A useful adjunct to evidence gathering is the use of carbon monoxide monitors. Whilst these should be used to ascertain the level of harm exposure in enclosed smoking venues, they can also be used to assess the quality of air outside shisha premises considering the large volumes of smoke (usually greater than one hundred litres per pipe per hour) produced by shisha smoking.
- Environmental health officers may consider using Health and Safety Prohibition Notices if prosecutions for breaching the Smokefree law are too labour intensive.

8.3.7 Health and Safety Act 1974, 1990

Only one borough had a serious accident that had occurred at a shisha premise from a health and safety perspective. This was a case of carbon monoxide poisoning of six customers, induced after lengthy smoking in a concealed basement, which is mentioned in detail in the academic literature [58]. There were certainly other 'accidents in waiting' that resulted in the closure of several premises across different boroughs, although the culture of the industry was such that they did not report health and safety issues. Indeed, nearly all boroughs had reported shisha premises operating a "basement business."

> *"You've got situations whereby these premises are being run covertly, so they want to control precisely who's going in and who's leaving…to make sure people pay. And so what I've found in a few of these places is that these backrooms are basically fire and safety death-traps with locked fire exits. I've had a situation whereby the rear door had physically been boarded up just to control who's entering and leaving. And obviously, then you have situations where you have lit charcoal on top of shisha pipes that could be knocked over by people – often they provide exotic situations with flammable drapes, flammable sofas and no means of escape. So we've had the fire brigade involved. In one of the places they've actually officially prohibited, using their powers, a part of the commercial premises which had a very poor means of escape."*

> *"You have charcoal next to propane glass bottles, which are used as heaters so that people are not too cold. So the health and safety is usually a nightmare. They have electrical equipment which is unsafe, badly installed, so in terms of health and safety the shisha places are usually not great at all."*

> *"These aren't sort of places that report accidents. And I think the clientele aren't the sort of people who would notify us anyway. But I'm not aware of any issues with burns and fires."*

One borough innovatively looked at cleaning practices of shisha pipes at shisha premises, which were anecdotally believed to be inadequate [97]. As described in *Section 4: Health effects of shisha smoking*,

there exists a risk of infection transmission from sharing the shisha pipe hose between peers. Twenty ready-to-be-served shisha pipe hoses were swabbed for microbiology from the first and last 11cm of the hose. A cleaning protocols questionnaire was also distributed to each shisha premise owner. All twenty hoses were lined with a thick, sticky, dark substance but bacterial isolates were undetected. Shisha pipes were cleaned using unstandardised and diverse methods, including two shisha premises that cleaned their hoses by 'blowing through them' to rid of debris, and two that used bleach-based cleaning fluids. No shisha premises had cleaning guidelines for their staff, and some shisha premises claimed to clean pipes after every customer but did not have cleaning equipment on site. Only one LA appeared to give shisha premises guidance on suggested cleaning practices for their pipes.

> *"There are issues over and above the tobacco, such as sharing pipes and risks of communicable diseases being transferred, how they're heating the charcoal – you know, all of those sorts of things…and the fact that it's seen as a safe option by quite young people sometimes."*

> *"It's worth noting the issue of 'net harm' when looking at control strategies. Evidence from many communities is that heavy policing of shisha results in locked premises and potentially creates both fire traps and havens for other illegal activity. The long term harm of shisha needs to be balanced with the harm caused by the response to it, including exposure to other risks and the potential breakdown in trust between the community and police or public health services."*

Recommendations:

- Shisha premises should be provided with case examples of dangerous health and safety scenarios from other premises in order to educate and emphasise the need to comply.
- All LAs should include a suggested shisha pipe cleaning protocol as part of general advice and guidance to shisha premises.
- Consideration should be given to extending the Smokefree law to pavements considering the large volumes of smoke emitted by shisha smokers per session.

8.3.8 Planning Enforcement

Shisha premises do not fall in any of the use classes specified in *The Town & Country Planning (Use Classes) Order 1987* (as amended) and as such constitutes a sui-generis use. Planning enforcement has been described as an effective member of the multi-agency approach to controlling the shisha industry, described by one as "whirring away in the background." Whilst planning enforcement action can be protracted due to legislative constraints, effective action often results in resolution of the breach of planning control (cessation of the unauthorised shisha smoking activity). In certain circumstances, environmental health and trading standards officers are able to expedite enforcement of their respective legislation on a quicker basis. One borough had never lost a planning appeal, such was the strength of their planning policies and effectiveness of the enforcement action pursued.

Breaches of planning control arose when premises changed from a restaurant with ancillary shisha use (where there would only be a few tables and chairs for serving shisha, described at the start of this chapter as 'restaurants serving shisha') to a composite use (where the primary use of the premises

would comprise a mixture of shisha and restaurant uses, described at the start of this chapter as 'shisha cafes'). This change in use is likely to constitute a material change of use for which planning permission may be required, and should such a use commence in advance of planning permission being granted, the use would be unlawful. Furthermore, structures are often erected to facilitate shisha smoking e.g. decking, canopies, wall-mounted heaters, shelters. These generally require planning permission and it is unusual for shisha premises to apply for planning permission despite advice and guidance provided at the start of their trade.

When pursuing planning enforcement action, many local planning authorities elect to serve a Planning Contravention Notice (a formal questionnaire) which is sent to everyone having a material interest in the land of business to establish precisely how the business is operating and whether the use of the premises for shisha smoking constitutes a material change of use. Providing false or misleading information in response to a Planning Contravention Notice can result in a prosecution and a £5000 fine if convicted. This planning enforcement tool has been employed effectively by local planning authorities and the information contained in the response is often relied upon when issuing an enforcement notice or when dealing with the ensuing appeal.

Other members of the multi-agency LA staff were not fully aware of the full extent of planning enforcement action, such as issuing a 'Stop Notice' which, if served alongside a Planning Contravention Notice, can target problematic shisha premises and cease all trading within 72 hours. Non-compliance with this notice is a prosecution where the maximum fine is £20,000 if convicted, which far outweighs the fines given for breach of the Smokefree law.

Recommendation:

- All LA staff members involved in enforcement against the shisha industry should be made aware of the full extent of powers currently held by planning enforcement officers, including the use of Planning Contravention Notices and Stop Notices, and employ these powers where necessary.
- Planning enforcement appears to have the requisite tools to effectively deal with shisha premises and many inspectors on appeal recognise that shisha smoking constitutes a sui-generis use. However, consideration should be given to recognising shisha premises use class in its own right thereby recognising the land use planning characteristics often associated with such a use.

8.3.9 Public Health Intervention

There were recurrent calls for more health promotion towards the general public, however very few LAs had implemented an educational campaign. Shisha has certainly reached the agenda of most LA meetings and many are on the brink of starting a health promotion campaign, especially targeted at young people and ethnic groups.

As with most areas of public health intervention, one particular difficulty was reaching young people in schools. One LA had conducted outreach work where there was good indication young people had heard of shisha, and some, typically those from Middle Eastern or South Asian backgrounds, had tried it. However, there were many students who had never heard of shisha. A good public health promotion

avenue appeared to be the use of social media, and specifically involving young people in the content of such material. A large, unpublished study several years ago involved a series of focus group discussions and school-based workshops, which identified a need for widespread education.

> *"It was as much girls and boys from that kind of ethnicity, that kind of culture, that had tried it. So it wasn't that only the boys were doing it because their uncles were doing it – the girls had tried it as well."*

> *"We even had people talking to us about how they wouldn't want their daughter to grow up smoking [cigarettes], but they wouldn't mind her smoking a shisha pipe at home."*

> *"Now these [adolescents/young adults] had their own flats. And they became almost sort of like…social centres. They'd be meeting up, around twenty to twenty five people coming round to these houses to smoke shisha on an evening. People were smoking incredible amounts. A fourteen year old boy smoking up to four pipes a night. If you think about the amount of intake of CO [carbon monoxide] in four pipes, is huge."*

> *"They knew about tobaccos, they know about the best brands to go for, you know, they can tell you where to get it, they can tell you how to get the cheapest, what sort of pipe was the best, definitely tell you about the experience of it – but really poor knowledge about the effects of it."*

There had been instances where LAs had liaised with local ethnic community groups to instigate a health awareness campaign in a targeted community.

> *"I did a presentation to the cultural heritage centre in the north of the borough. It was to the women's group there and it was talking about public health topics, and one of the ones I spoke about was smoking cessation. And they kept asking about the men in their family and about shisha. And I didn't have a lot of information about shisha at that time because it was several years ago, but there was definitely an appetite there for somebody to go in and speak to them."*

There were also calls for all LA staff members that were actively enforcing against shisha, to be aware of the health effects associated with shisha and contribute to health promotion whilst on their visits. This includes speaking to premises owners and customers where necessary. This had been implemented in one borough as one environmental health officer describes:

> *"Whenever I visit [shisha premises], I tend to dish out a basic little card, which I've had done, to people there about the potential health risks [of shisha smoking]."*

Some LAs had started to advertise shisha cessation as part of the Stop Smoking Service's marketing campaigns. One borough in particular had shisha-specific training for all their smoking cessation advisors, focussing on the differences in addiction between shisha and cigarettes, which occurred prior to their campaign. This training need was identified after advisors were receiving increasing requests for advice on quitting shisha, but felt that information was lacking.

One LA had provided educational material to all secondary schools, including a DVD and presentation on the harms associated with shisha smoking. However this was not evaluated both in terms of uptake nor in terms of impact. Two regions of London were also undertaking prevalence studies in their population to gauge the scale of the problem in each LA.

Recommendations:

- LAs should identify and collaborate with ethnic community groups to provide a well-targeted, multi-lingual approach to shisha educational campaigns. To avoid widening of inequalities, LAs should also run a general campaign in schools or at events. One particularly effective avenue could be through the existing activities of the Stop Smoking Services. These campaigns should be evaluated for impact.
- Each enforcement officer should be trained on the health effects of shisha, especially areas surrounding herbal shisha, and contribute to health promotion activities whilst inspecting shisha premises. This underlies a need for public health staff and legislation enforcers to work closely.
- Secondary schools and colleges should be encouraged to incorporate shisha smoking into existing tobacco awareness lesson plans.
- All Stop Smoking Services should have their staff trained on providing cessation advice for shisha smokers, especially in regions where shisha premises are particularly prevalent. At the moment, there is no evidence base on nicotine replacement therapy so intervention should include behavioural support only.
- Shisha smoking prevalence should be incorporated on local and national health survey questions, including frequency and intensity of use, to gain better insight into smoking habits of the general population. Young people should also be asked about electronic shisha pipes as these appear popular in this age group.
- Further recommendations for public health intervention are mentioned in the conclusions and discussions of each prevalence study described in S*ection 6: The Prevalence of Shisha Smoking in London.*

8.3.10 Successful methods to control the shisha industry

Many boroughs had employed a multi-agency strategy in tackling the shisha industry, but not all had been successful in controlling its proliferation. Whilst trading standards officers and environmental health officers tended to work closely, success appears to have been better achieved when synchronised visits were arranged between the two. Furthermore, those who had additionally synchronised their visits with those from HMRC, the police, fire brigade and/or planning enforcers had further successes and reported a decline in the number of shisha premises. One borough with a particularly successful track record had the UK border agency accompany them on occasional visits. A structured, proactive approach to visiting shisha premises (i.e. routine visits) in addition to a reactive approach (i.e. visits in response to complaints) seemed to be an effective combination for control. Where the police were not readily available, trading standards and environmental health officers did seek adequate alternatives where possible. However, these were limited by resource and the co-operation of the police appears

imperative to the control of the shisha industry. Regardless, one important driving force behind success was the general culture and attitudes of LA staff members, and determination to enforce the law.

> *"One of them particularly, which was a big troublesome place [shisha premise] – planners, in the end, decided to go for them and they actually took planning enforcement action which took several months and was very tortuous. With me [environmental health officer] hammering on the side as well threatening legal proceedings, they finally went. In fact the guy ran off, he didn't close the business formally."*

> *"Following quite a bit of pressure and visits, I think we made the place look bad in front of his more respectable customers. Now, he was found to be compliant."*

> *"We found success approaching the special constables' teams [as police officers were not available]...they were more than happy to get any experience, enforcement-wise, as special constables. But they couldn't sustain it…they wouldn't be able to commit to 'yes we'll do this every three weeks for the rest of the year' – it's not going to happen."*

Another useful adjunct to monitoring the shisha industry was using the internet and social media to gain insight into shisha premises' marketing strategies. By logging onto shisha premises' websites and social media pages, enforcers were able to identify which ones were using misleading advertising or advertising to young people. Due to the transient nature of shisha premises, this method could also identify new shisha premises in the area that had yet to be made known to the LA. In certain cases, advertising to young people resulted in an increased enforcement response against premises, and so this appeared to be a cost-effective way of monitoring the industry.

Inspection timings may also be a factor in successful control of the shisha industry. Where inspections routinely occurred on Tuesday or Wednesday early evening, young people were generally not found smoking despite identification checks by police. This resulted in less enforcement action. However, when inspections occurred during the weekend, young people were more commonly found smoking and a more stringent response was implicated. Decisions over weekend visits had to be offset by the risk posed by busy, bustling shisha premises.

> *"We had to risk assess where we were going to go and on what days we were going to go in. So we never went to these places, for our own health and safety, on Friday or Saturday nights, because we didn't want to be confronted by a hundred people all smoking shisha pipes with hot coals. We just wanted to be confronted with a manageable amount of people, so we only went on Wednesday and Thursday nights, quite early in the evening, where we knew we'd still get some non-compliance, but not non-compliance that we couldn't manage."*

Very few LAs had an active, close working relationship to planning enforcers, despite the legal extent of their powers proving extremely useful in boroughs that had witnessed a decline in the number of shisha premises. Alongside the police, planning enforcers appeared to be particularly active in LAs where shisha industry was adequately controlled. This was in addition to the usual enforcement practice of trading standards and environmental health officers.

Prosecutions of shisha premises regularly non-compliant with the Smokefree law appeared to be a strain on LA resources. It was extremely time-consuming for officers to gather evidence and attend court as part of the prosecution process. Most LA staff members agreed that more prosecutions would have occurred if they had more resources, such was the recurrent, non-compliant nature of many shisha premises. Matters were further compromised by the fact that fines were small and not impacting on business profitability, unlike the aim financial penalties against the cigarette industry. Furthermore, there appeared to be inconsistency in the way magistrates treated prosecutions. Identical breaches of the law from two different premises may result a conviction ranging from a conditional discharge to a maximum fine. Alternatives to prosecutions included issuing Health and Safety Prohibition Notices on shisha premises due to enclosed smoking areas measuring high CO levels and increasing the risk of CO poisoning. This technique was successfully employed in one borough.

> *"I would say at the moment, I'm in court at least three times a month. Then if they plead 'not guilty' you have to prepare for the trial. You have to go back to court if sometimes they don't turn up…so it takes a lot of my time. It's difficult to put into hours or days, but at the moment I would say about 30% of what I'm doing is to do with shisha."*

> *"I'd like to throw some resource at it [the shisha industry] to break its back a bit. We've got a list and we try to prioritise them in order of how bad they are, and tick them off from the top of the list."*

> *"I know from previous experience of talking to shisha owners that they said it costs them about eighty pence for a pipe and they sell it for a tenner. So obviously the profit margin is much greater than food or anything else."*

> *"They charge in the region of eight pounds as a minimum price for a pipe, up to about fifteen pounds. So if they can get all those twenty pipes going in an evening, they can make a reasonable amount of money. And of course, they think that the council is never actually going to bite the bullet, so to speak, and take them to court. And I would also say that when parliament set up the legislation, when it looked at the level of the fines, it wasn't thinking of deliberate and blatant breach of the law."*

> *"A premises has forty people in there, if twenty of those are smoking and they paid fifteen pounds per shisha pipe – if they then get a fine of a hundred and fifty pounds, there's no deterrent for the premises because they can cover that in half a day."*

However, there were very clear cases where prosecutions led to convictions and closures of premises or induced compliance, albeit temporarily. Prosecutions appeared to be behaviour changing among shisha premises across one particular borough, and press coverage on these prosecutions serve as educational and legislative guidance to local communities.

> *"There's also a knock-on effect, because if you prosecute and it becomes known that the council is taking quite a robust line, then other potential shisha businesses know that we're not to be messed around with."*

Recommendations:

- The most effective method to tackle the shisha industry is via a well-synchronised, multi-agency approach including the police, HMRC, fire brigade and planning enforcers which should be timed at peak industry operating hours in both a proactive and reactive fashion. This may only be possible with increasing resources to LAs. However, not all LAs have access to these agents.
- Prosecution fines are currently too small and they should be increased to impact business profitability, or at least be made proportional to the size of the business or the number of repeat offences.
- Magistrates should show consistency in the prosecution process and case examples should be sought from other boroughs to ameliorate this process.
- In boroughs where resources are strained, prosecution should be a last resort and officers should liaise with other agents to maximise legislative powers including powers of closure. Focus should therefore be a reactive response with monitoring of high risk shisha premises.
- Shisha tobacco and shisha pipe seizure appear to be a more cost-effective method of enforcement, and in larger premises the impact of this may surpass the maximum prosecutable fine.
- If the co-operation of the police is available, an effective enforcement tactic may be fixed penalty notices. Not only will this reduce loyalty to a particular premise, but will help change public attitudes that shisha is a safe alternative to cigarettes and therefore exempt from current tobacco legislation.
- LAs should form a London-wide regional network specifically for shisha premises enforcement to reduce fragmentation between them. This should promote information and data sharing between LAs to encourage consistency in shisha enforcement. This should also be used as a platform to lobby for further guidance regarding the legislative difficulties in enforcing the shisha industry and funding, for instance, for a regional sample testing unit.
- LAs should seek to establish a positive and close relationship with shisha premises to encourage co-operation and compliance.
- Powers of closure and seizure should extend to environmental health officers if resources do not permit for a synchronised, multi-agency approach.
- Press releases of LA enforcement activity may help stimulate behaviour change across the shisha culture. They can also serve as health promotion messages to the local community.
- On their visits to shisha premises local authorities should note any advertising to websites and social media, and periodically but regularly monitor such sites for breaches of legislation, including advertising to young people, pictures suggestive of indoor smoking, and misleading advertising such as claiming that shisha is a harmless form of smoking. This could be a cost-effective way of monitoring the industry and evidence gathering for any future prosecutions.

8.3.11 Further insight into the shisha industry

One important aspect to the shisha industry was the transient presence of shisha premises. Described as a "shifting sand industry", these premises could appear and disappear in short spaces of time making it extremely difficult for LAs to monitor them and adequately enforce legislation against them. It also meant that considerable time was spent prosecuting premises for breaches of the Smokefree legislation that would suddenly cease to exist. Such interruptions during the prosecution process was an additional drain on LA resources.

> *"There are other, clandestine ones [shisha cafes] now that move around through vacant premises, particularly at weekends."*

The main customers of shisha premises primarily appear to be those of ethnicities where shisha is endemic, that is the Middle Eastern and South Asian ethnicities. LA staff members observations indicate that premises are also frequented by young people and university students, which corroborate with the earlier findings reported in section *6 The Prevalence of Shisha Smoking in London.* Whether these young people and university students will continue to frequent these premises after graduation, or whether it will continue to be dominated by certain ethnicities, is difficult to say as the industry is only at the start of its cycle.

> *"I don't know if they target young people – I think it's probably more likely young people are attracted to it."*

> *"The worst we had was one where we did two visits there. And I've got the figures somewhere, but it was somewhere like 15 or 16 out of 34 people were under 18 [years old]."*

> *"Again, no formal assessment of this has been made, but it does seem to be very popular among young women. I mean it's probably a fairly even gender balance, but I've definitely been to places where there were probably more young women smoking than men."*

> *"We had the Bangladeshi culture, we had the Arabic culture – they all had the hubs they would go to, and it even became slightly territorial, the way they were talking about it."*

> *"One of the shisha cafes is quite close to a local hospital, and I've been told by the owner there that the main customers are the medical students."*

Business models of shisha premises were poorly planned despite purulent advice and guidance provided by LAs. It was presumed by some LA staff members that neighbouring boroughs that had focussed clampdowns on the shisha industry caused a rebound, mushrooming effect on their borough due to their lack of existing shisha enforcement. This is also shown by Figure 5 (Page 30), where boroughs will have neighbours with very few shisha premises

> *"The situation isn't really helped by some of the neighbouring boroughs. You know, people will say to me 'why can't I run a business in [this borough] when I can run it in [another borough]?' And then our colleagues in [the other borough] are not taking a similar line to us, presenting an*

inconsistency in enforcement. That may give operators some slight credibility to their line of argument that they were confused by the law, because they see things being done differently."

One borough describes how, at the start of their shisha industry growth, they devoted a significant proportion of their time helping shisha premises comply with legislation, which was part in due to the fact that many of the owners had only just arrived into the country or starting up their business from relatively afresh. Very few boroughs did not have any specific guidance or advice to provide to shisha premises at the start of trading.

"We spent an awful amount of time and energy producing leaflets and sending out advice letters, visiting these people and giving them very comprehensive advice on what needed to be done, how it needed to be done and time periods we expected it to be done. Even to the extent where we provided them with labels to comply, lots of documentation…we gave them free labels, laminated labels [to hang over the shisha pipe]."

"We tend to go through a structured approach of advice and warnings, and final warnings. I mean, we bend over backwards to get them to comply because we don't want to prosecute."

Some LA staff members struggled to keep up with the evolution of the shisha industry. Only two mentioned the craze surrounding electronic shisha pipes, with one officer saying "This summer seems to be the summer of e-shisha." Several LAs were receiving enquiries from schools regarding 'shisha pens', which are small devices emulating the electronic cigarette. LAs should maintain close relationships with schools to provide evidence based on advice on these new industry developments.

"Well the only other thing that might be of interest…is 'electronic cigarettes shisha.' And that's a much younger age group that are talking about that. We're talking, Year 6, Year 7, Year 8 are well aware of it. Yeah e-cigarettes are definitely becoming a bigger issue and e-shisha has only come to light in the last six months."

Recommendation:

- All boroughs should have an advisory document which outlines all legislative aspects related to opening and operating a shisha premises. These should be standardised across London boroughs to promote a consistent message to shisha premises owners.
- Due to the recurrent lack of compliance with legislation, LAs should consider periodical educational sessions/workshops/Q&A sessions for premises managers and staff. This could serve as an efficient way of educating shisha premises.
- LAs should liaise with their neighbouring LAs prior to initiating shisha enforcement campaigns to ensure rebound mushrooming of the industry does not occur in neighbouring boroughs.
- LAs should be encourage to collect mapping and longitudinal data on the number and type of shisha premises, as well as enforcement statistics such as number of prosecutions, prohibition orders, closure notices, size of tobacco/pipe seizures and rates of non-compliance. Such evidence may justify further resource allocation to LAs.

8.3.12 Licensing the shisha industry

Several parallels were drawn between the shisha industry and alcohol industry: antisocial behaviour, late night openings, underage sales and an illicit trade. Smokers have even described attending 'shisha crawls' instead of 'pub crawls' (see section 7.3.3). Some LA staff members felt that licensing the shisha industry similar to the alcohol industry would seriously help combat the problems associated with shisha premises, especially in resource-strained boroughs. Indeed, this idea has already been posed by tobacco control experts in the north west of England. Licensing would help LAs to instigate reviews on a registered premise without needing to undertake time-consuming evidence gathering as is seen today.

> *"There's no regulation. Premises don't have to tell us that they're opening a shisha cafe. We've no way of controlling the activity. If, in some way or other, the activity was licensed…we could then, in granting that license, grant with it certain conditions which would allow us to give local residents protection from noise, from smells, from early morning congregations, from early morning deliveries. Because if they have to have a license in order to do that work, they stand to lose something if they don't do it properly."*

> *"I think in the view of potential for harm and the general ignorance of it, then the answer's yes [to licensing shisha premises]. There's no reason why tobacco retailers or tobacco premises can't come under another category under the licensing act…certainly in relation to where tobacco is consumed on the premises, which of course is very different to retail premises…then the licensing act would be perfect. It's an immediate offence without having to go into the ins and outs, for example, like labelling or more technical offences. It simply would be an unlicensed premise."*

The main argument against licensing of shisha premises is that it falls under existing tobacco legislation and thus any attempts to license may be easily dismissed. Furthermore, licensing shisha premises may create a degree of normalisation or regularisation towards smoking, which functions against the philosophy of the Health Act.

> *"They haven't been complying with existing rules and probably won't be compliant with the licensing requirements anyway."*

> *"Even though on the face of it the four licensing objectives would appear to be equally applicable to premises selling tobacco, the actual process of reviewing a licensed premises can become quite fraught with difficulties in terms of appeals and challenges. Shisha businesses would undoubtedly exploit this."*

> *"I think what the [Health] Act lacks is indeed a closure power for those businesses that deliberately and intentionally flout the law. I am unable to say how this would be drafted but I don't think the Licensing Act is the way to do it."*

> *"On licencing I feel there needs to be an element of realism, both in the ability to draft law, the ability to enforce that law and the appetite for the government to give up parliamentary time to it. For the foreseeable future we will need to use the legislation we have."*

Recommendation:

- Licensing shisha premises should be considered but a full evaluation of its potential impact on the shisha industry should be explored prior to any implementation.
- Discussions over licensing should unequivocally include reference to herbal shisha, which is a non-tobacco product.

8.4 Conclusion

This is large study among local authorities in different disciplines across London which highlights responses to the growing problem of shisha consumption, as well as legislative difficulties associated with it. It provides a platform from which evidence-based change can complement existing tobacco control strategies, and informs other members of local authorities about enforcement issues surrounding the shisha industry. Local authorities should use these recommendations to stimulate effective change management and enhance the quality of their tobacco control enforcement. These experiences and recommendations should also be communicated to Public Health England (PHE), especially in light of a lack of resources for most LAs. Whilst London LAs should aim to form a regional network, in doing so the support of PHE should be sought to champion key recommendations and lobby other tobacco control initiatives. PHE should also be interested in shisha from an infectious diseases perspective, in light of shisha smokers sharing the pipes and increasing their risk of oral infection transmission.

Despite these recommendations, any large-scale proposals should be preceded by a full enquiry into the shisha industry. If enforcers are seen to be heavy handed, it may force the shisha industry further underground and expose smokers to potential fatalities (such as CO poisoning from smoking in poorly-ventilated basements, or fires caused by poor coal management). It is important to engage communities in these recommendations to promote support and identify pragmatic ways of responding to the growing threat of shisha. All decisions should aim to reduce the public health implications of shisha.

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