CANCER RESEARCH
N. Ireland

Dear Sir/Madam

Cancer Research N. Ireland welcomes the consultation on *The Draft Smoking (Northern Ireland) Order 2006* and the opportunity to submit comments to the Department via the Questionnaire. We believe that the legislation has the potential to significantly improve the health of the Northern Irish population and we support it being as comprehensive in scope as possible with very limited exceptions (if any). These exceptions should be further investigated to ensure that they are justified on the basis of current research and consultation with the relevant stakeholders.

In summary, we would like to draw your attention to our opinions in three key areas: exemptions, enforcement and periodic review.

1. Smokefree public places should be the norm, with smokefree buildings with designated smoking premises being the exception. Exceptions should only be allowed in places that are both workplaces and temporary/permanent homes, where there are mental/ physical/ emotional/ custodial reasons that render it impossible for a 'resident' to leave. Staff and visitors (for example in the case of residential homes) should not be permitted to smoke.

   Excepted premises must develop best practice smoking policies to protect workers' and visitors' health as much as possible and ensure that smoke does not migrate. Appropriate stop smoking services for 'residents' should be available wherever possible and staff should be able to opt-out of working in smoky environments.

2. We believe that the following pre-requisites for successful enforcement must be adhered to: clear and consistent definitions that cannot be misinterpreted or avoided; an ability for the regulations to be applied in a practical and consistent way across N. Ireland; and clear understanding of duties by those responsible for enforcement.

3. We encourage the Department to commit to periodically review the legislation once implemented. We believe that this is particularly important in relation to effective enforcement. Where enforcement issues do arise, these must be addressed and should not be used as a reason to exclude additional premises.

Please see our response to the Questionnaire for our detailed comments on the draft Order. If you have any other queries, please do not hesitate to contact me.

Yours sincerely,

Mr Richard Davidson
Director of Policy and Public Affairs

CANCER RESEARCH
N. Ireland

Cancer Research N. Ireland Response to
THE DRAFT SMOKING (NORTHERN IRELAND) ORDER 2006

QUESTIONNAIRE

May 2006

QUESTIONNAIRE

Q1. *Article 2 (a) and (b)* of the draft Order defines “smoking” as covering all lit tobacco or any other lit substance in a form which could be smoked, for example, herbal cigarettes. This is to avoid enforcement difficulties in cases where smokers claim their cigarettes do not contain tobacco.

Do you agree with the definition of smoking as set out in the draft Order?

Yes x

If you wish to comment, please do so here.

Yes, we agree with the definition of smoking as set out in the draft Order.

We support the inclusion of non-tobacco cigarettes in the definition of “smoking” as there is evidence that secondhand smoke from non-tobacco cigarettes poses a health hazard. Whilst there is a dearth of peer-reviewed published studies in this area, primarily because such products are smoked by a small minority of people, Cancer Research N. Ireland believes that the existing evidence[1] [2] warrants a wider definition of “smoking” to include such products.

In addition, we believe the current definition offers prospects for the best enforcement. It is often difficult to establish whether a lit smoking product contains tobacco and this could be a matter of dispute in enforcement situations. This could necessitate sampling procedures and laboratory analysis, which would have a significant cost implication. Omitting non-tobacco cigarettes from the legislation would leave a loophole that could be exploited.

We are, however, keen to ensure that any adopted definition of “smoking” should not capture nicotine substitutes/ nicotine replacement therapy products being used for medicinal purposes to aid a smoker’s quit attempt/ nicotine maintenance.

Q2. *Article 3* of the draft Order defines “smoke–free premises”.

Do you agree with the definition of smoke–free premises as set out in the draft Order?

Yes X

If you wish to comment, please do so here.

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[1] Correspondence from Professor Robert West to inform Cancer Research UK consultation response, 29th July 2005.

[2] Gourlay SG and McNeill JJ. 1990. Anti-smoking products. Medical Journal of Australia. 153:pp 699-707.

We broadly support the definition of smokefree premises as set out in the draft Order, though it is difficult to fully endorse the proposals until more detailed definitions are published.

We support clause 4 (3) stipulating that licensed premises and registered clubs will not be permitted to be exempt from the legislation. Wherever secondhand smoke in a public place is a significant danger to health it should not be permitted, including in pubs, bars and private members' clubs.

We welcome the proposal to designate places that are both "enclosed" and "substantially enclosed" as smokefree.

Defining a "substantially enclosed" place

We support the principle of using a percentage area to aid definition of a place that is "substantially enclosed", and think that the notional percentage area employed should be 50%. We believe this would offer a clear definition to all those responsible for implementing and enforcing the legislation on the ground.

Defining premises that are 50% or more enclosed as "substantially enclosed" would further minimise public exposure to secondhand smoke by capturing a far greater number of oft-frequented public places in the legislation. Adopting this definition of enclosed would follow the example set by the Irish[3] and Scottish[4] legislation.

We urge that the definition is sufficiently robust to ensure that the spirit of the legislation is upheld.

Other places to be designated smokefree

We believe that secondhand smoke can also be harmful in non-enclosed places where people congregate closely and support the inclusion of other public places where people congregate closely in the smokefree legislation. This structure is currently being proposed in England. We therefore support the inclusion of sports stadia, bus shelters and railway stations for example, within the scope of the legislation.

We would recommend regular review of a list of 'other public places' to be captured, in order that the legislation is appropriate and operates effectively. In addition, we hope that where necessary, the legislation will provide clear definitions of 'outside areas' to be smokefree. For example, it may be necessary to offer a definition of a bus shelter that would not fulfil the definition of a totally "enclosed" area or a "substantially enclosed" area, but nevertheless would be considered to be a smokefree area in the legislation.

We are concerned about the possible erection of external structures very close to enclosed public places, specifically constructed for the purposes of accommodating smokers. We urge that the definition adopted be sufficiently rigorous, and the accompanying regulations sufficiently thorough, to ensure that such temporary external structures do not allow the inevitable drift of smoke into smokefree premises. For example, we would not wish to see permitted temporary structures within

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[3] The Republic of Ireland Public Health (Tobacco) Act 2002. Full text available online at: http://www.otc.ie/Uploads/Public%20Health%20(Tobacco)%20%202002.pdf

[4] Amendment to The Smoking, Health and Social Care (Scotland) Bill 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005 suggested and accepted at Stage 2 of the parliamentary process. The Bill as passed by the Parliament is available online at: http://www.scottish.parliament.uk/business/bills/pdfs/b33bs2-aspassed.pdf.

courtyards and lighting wells, where natural ventilation is restricted, as this would reduce the potential health gains.

Where possible we urge that the definitions developed in the smokefree legislation for Northern Ireland are consistent with those in operation in the Republic. This will help aid clear understanding of the legislation and enforcement efforts.

Q3. *Article 4* of the draft Order provides for the Department to make regulations to specify premises or parts of premises not to be smoke-free. In accordance with the Minister's announcement, the intention is that these exemptions will be limited and *Article 4(3)* specifically precludes exemptions in respect of licensed premises. ***The regulations will be the subject of a separate consultation later in the year.*** However, the Department is taking this opportunity to seek views. There are premises which act as a person's home, either on a permanent or temporary basis, but which are also another person's workplace, for example, residential accommodation, hotel bedrooms, prisons and psychiatric facilities. Different approaches to this issue have been adopted by other jurisdictions. In the Republic of Ireland psychiatric hospitals are exempt. In Scotland designated rooms in psychiatric hospitals are exempt while in New York it is necessary to apply for a waiver.

Set out below are examples of premises that serve as a person's home, either on a temporary or permanent basis.

Do you think that hotel bedrooms, designated rooms, or areas within the following premises should be exempt?

Do you wish to suggest any other exemptions? If yes, please specify below.

We believe the question of designated exceptions to the smokefree legislation to be a complex one and do not believe the structure of the question will elicit the most useful responses. We have answered the question in a different way.

General comments that relate to any exempt premises

We understand the sensitivity and complexity around the smoking status of places that are both residences and workplaces. Whilst human rights must certainly be respected, individual rights to smoke in such places have to be balanced against the health risks posed by secondhand smoke to staff or other people. Indeed the Human Rights Act 1998, Schedule 1, recognises that the right to respect for private and family life (Article 8) should not be interfered with except as is necessary for the protection of health.

We strongly believe that wherever possible, all enclosed premises should be smokefree. "Residential exceptions" and more general exceptions should therefore be kept to a minimum. Staff should not be allowed to smoke while on duty in their workplace. In addition, there is still a duty of care on the employer to protect workers from workplace hazards and a growing acceptance that the Health and Safety at Work etc. Act 1974 will apply.

If exceptions are allowed, it might also be worth the Department considering whether staff should have the right to opt out of working in places where they might be exposed to secondhand smoke. In addition, there must be an agreed process for reviewing such exceptions, and in some circumstances to reducing provision over a set time period. The proposed legislation should therefore be written flexibly enough to make this possible.

Individual premises must also take appropriate measures to minimise secondhand smoke exposure and minimum standards must be clearly outlined. For example:

- Exceptions where they are agreed should not be granted for communal areas;
- If care is being provided, patients should not be able to smoke when particular treatment or care is being administered by a member of staff;
- All precautions must be taken to limit the migration of smoke from a smoking room to the rest of the non-smoking environment;
- The status of rooms as smoking or non-smoking should not change, except to add more non-smoking rooms, or enhance overall non-smoking provision;
- Members of the public, when visiting such places, should be given adequate protection; and
- There should be readily accessible and appropriate smoking cessation services that are part of individuals'/patients' care plans. Senior members of staff should regularly review these.

In addition to the above:

Long stay voluntary and involuntary places (including long stay psychiatric hospitals and units, prisons, hospices, adult residential care homes).

We recognise that there are some places which are workplaces and long-term residences and where people are not being housed on a voluntary basis e.g. prisons and some psychiatric institutions. Particular sensitivity and due care is needed in assessing smokefree status in relation to some of these places and we urge that further research is undertaken, particularly in relation to possibilities for smokefree provision in psychiatric hospitals and units (both short and long-stay).

In the Scottish legislation, the initially proposed exemptions for adult care homes and psychiatric facilities were amended to apply to 'designated rooms' within these facilities only, and in these areas there must be ventilation systems that do not ventilate into any other parts of the premises.

It is possible to go further. Smokefree policies have been successfully introduced in various long stay institutional establishments and have been supported by readily accessible smoking cessation services.[5] It has been suggested that the only people who should be allowed to continue smoking are those who are being held involuntarily or those who have mental health problems and are in an acute psychiatric state. [6] If this were the case, smoking should be heavily restricted to, for example, a secure outdoor courtyard or, less preferably, a room with restricted amenities and access. Willingness to abide by a smokefree policy has also been

[5] el_Guebaly N, Cathcart, J, Currie S et al. Public health and therapeutic aspects of smoking bans in mental health and addiction settings. Psychiatric Service[s] Dec 2002; 53: 1617- 22.
[6] Chapter 14. Special cases: smoke-free policies in long-stay institutions. From Going smoke-free. The medical case for clean air in the home, at work and in public places. A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians. July 2005.

suggested as a condition of acceptance into other long-term but voluntary places e.g. nursing homes and hospices.[7]

We support the idea of 'designated rooms' in a premise being exempted as opposed to an entire premise. This helps to restrict the exceptions within residential premises. We encourage the Department to consider this approach when drafting the regulations.

Any place occupied as residential premises or as living accommodation

Some of these places (hotels, hostels and B&Bs) also pose a conflict of interest since they are workplaces offering residency but usually only on a short-term basis. Proprietors of hotels have stated that complete bans will be unworkable for them to enforce because this would interfere with privacy and would require warrants. It is likely that the same is true for other establishments.

If there are multiple smoking rooms (potentially for example in the case of hotel bedrooms), all smoking rooms on the same floor should be contiguous.

We recommend that the Department looks into what is possible in the case of hotel rooms. In New York, no more than 20% of hotel bedrooms in any one establishment may be designated as smoking rooms.

Q4. *Articles 7, 8, 9 and 12* of the draft Order sets out the following four offences and penalties:

(i) a person failing to display the prescribed no-smoking signs in smoke-free premises commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000);

(ii) a person who knowingly smokes in smoke-free premises commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000);

(iii) a person who controls or is concerned in the management of smoke-free premises and fails to prevent a person smoking in a smoke-free place commits an offence and is liable on summary conviction to a fine not exceeding level 4 on the standard scale (£2,500); and

(iv) a person who intentionally obstructs an authorised officer of a district council acting in exercise of his duties under the Order commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000).

[7] Ibid.

Do you agree with the offences and level of penalties set out in the draft Order?

If you wish to comment, please do so here.

We believe that other organisations, such as those involved with enforcement, will be best placed to comment on the detail of the penalty levels and designated offences.

However, we do believe there to be a number of guiding principles that should be considered when setting types of offences and penalty levels, to ensure that the legislation is workable.

We urge that the public communication campaign that will precede implementation of the legislation be designed to ensure messages about the four types of offence are clearly conveyed, as well as the levels of penalties and information about how penalties will be collected.

In order to encourage high compliance levels, we would support clear guidelines relating to the treatment of repeat offenders.

We suggest that for pub, bar and membership club managers and owners who fail to prevent smoking on their premises on a regular basis, there should be an ascending scale of fines together with the ultimate deterrent of withdrawal of a licence to sell alcohol. This could prove important in discouraging a small minority of publicans, for example, from attempting to defy the legislation and hence undermine it more widely.

It is crucial that flexibility is built into the legislation in order that there can be regular review of the level of penalties, to ensure continued appropriateness. We therefore support the proposal to provide the power in the Bill to make regulations under which the amount of penalties may be prescribed.

Similarly, we are keen to ensure that the level of penalties is considered appropriate in relation to comparable enforcement measures (for example, food safety regulations). Regular review and monitoring of offence penalties is necessary and will aid enforcement efforts.

Q5. *Article 10* of the draft Order provides for an authorised officer of a district council to issue a fixed penalty notice where he believes an offence has been committed under Articles 7, 8 or 9. Schedule 1 makes further provision about fixed penalties. The levels of fixed penalties will be specified in regulations which will be the subject of consultation this year.

Do you agree with the fixed penalty notice procedures as set out in the draft Order?

We believe that other organisations, such as those involved with enforcement, will be best placed to comment on the detail of the penalty procedures.

Q6. Tobacco control measures are currently enforced by Environmental Health Officers of district councils.

Do you agree that smoke-free legislation should also be enforced by district councils?

Yes X

We believe that this will allow links to be made to wider public health issues. District councils already have links with the four Tobacco Control Groups, and will have a community planning role in the future which will enable them to take a strategic view of smoking and related health issues.

However, further discussion around enforcement roles of the Health and Safety Executive for Northern Ireland and the Environmental Health within District Councils is required to ensure a coordinated approach to enforcement.

Q7. At present *Articles 3 and 4* of the Health & Personal Social Services (Northern Ireland) Order 1978 make it an offence to sell tobacco products to young people under 16. In the Republic of Ireland, the Health (Miscellaneous Provisions) Act 2001 increased the age limit from 16 to 18 and in Scotland the Smoking, Health & Social Care (Scotland) Act 2005 provides the power to raise the age limit there. The draft Order provides the power *(Article 14)* for the Department to raise the age limit from 16. Any proposal to raise the age limit would be the subject of further consultation.

Do you agree that the Department should take this power?

Yes X

If you wish to comment, please do so here.

Smoking in children and adolescents is a serious problem and we support any move that reduces smoking rates in these age groups. Increasing the age of purchase to 18 is unlikely to be harmful and would ensure consistency with alcohol sales. However, there is little evidence at present that this would dramatically alter the availability of cigarettes to under-age young people. Is it difficult for retailers to enforce the policy and under age smokers often get cigarettes from older friends and family.

We do not know how increasing the age of sale would change young people's perceptions and behaviour towards smoking. It could, for example, reinforce the perception of smoking as an adult activity, or conversely, it could help progress the 'denormalisation' of smoking. We also do not know what measures could practically be introduced that would help retailers establish a young person's age. Measures such as introducing age ID cards are flawed because the cards can be faked. ID cards are also strongly promoted by the tobacco industry- a sure sign that they are ineffective.

If the age of cigarette purchase was increased, it would be a much more effective measure to introduce this change as part of a comprehensive strategy that regulated many aspects of tobacco products –product availability, composition, packaging, disclosure of contents and promotion.

Integrated Impact Assessment Overview

We welcome the publication of the Impact Assessment Overview. We have no detailed comment to make on the Assessment at this time.

For further information or clarification on any point raised in this response, please contact the Cancer Research UK Public Affairs Department on publicaffairs@cancer.org.uk or on 0207 061 8360.