

**Draft Smoking NI Order 2006 econsultation on-line response**

**Homefirst Community Trust Response No.2**

Q1: YES

Q1a: Agree that all lit substances must be included to avoid any confusion or difficulties for those individuals trying to enforce the legislation e.g. managers in a workplace or employees in a bar or restaurant

Q2: NO

Q2a: should not be exceptions made if premises are the place of work of only one person, as this would create inequalities. All areas of work and premises open to the public should have equal smoke-free status.

Any private members clubs should be included as smoke free as these can also be classed as workplaces for some individuals. Again we must maintain an equal status across the Board.

Q3a: NO

Q3b: YES

Q3c: YES

Q3d: YES

Q3e: Bedrooms of a hotel do not provide any convincing argument to be included as an exemption.

Only in certain designated areas of a Care Home, Psychiatric Unit or Prison should smoking be allowed. These areas should not be seen as inviting or in any way promoting smoking. They should be in addition to any rest or comfort areas where residents may relax.

There has been no reference within the legislative documentation to the issue of members of staff entering a person's home as part of their daily work activities to provide care to a person. This may involve up to 4 members of staff having to enter a person's home at any one time. Homefirst Community Trust sought legal advice on issues surrounding the introduction of a Smoke-Free Policy in certain areas and were advised that the Trust does not have legal authority to impose a smoke-free policy in a privately owned home and with regards to nursing and residential homes or supported housing it is up to the home owner to institute a policy in respect of smoking. Obviously staff working in these areas will not have the benefit of working in a smoke-free environment

Q4: NO

Q4a: The offence of smoking and not displaying appropriate signage should get a lesser penalty than the owner of a premises. However, the suggested offences shift the responsibility to managers, not the owners of establishments. We believe that the owner should be ultimately responsible although we are aware that not all premises will have an individual owner e.g. healthcare services. The fines that have been cited are for successful prosecution and we would advise that the burden of proof be on the defendant rather than the prosecution. We are also concerned that there is no obligation on the court to impose the maximum penalty as cited in the documentation.

Q5: NO

Q5a: We do not agree that there should be fixed penalties as this risks undermining the legislative message that it is simply enough to pay a £50 fine whenever caught smoking.

Fixed penalties have not been used on the Republic of Ireland but rather offences lead to prosecutions and a fixed fine. Compliance rates have been very high in the Republic with low rates of prosecution. We would recommend a similar policy.

Q6: YES

Q6a: This will mean that the links may be maintained with the wider public health agenda and other 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.

Further discussion necessary around enforcement roles of Health and Safety Executive for Northern Ireland and the Environmental Health within District Councils to ensure a co-ordinated approach to enforcement.

Q7: YES

Q7a: Changing the age limit to 18 will mean that we are giving out a message consistent with alcohol legislation and butane gas and emphasises the serious risk which tobacco smoking poses to health as well as potentially facilitating an integrated approach to enforcement. It will also align Northern Ireland with the Republic legislation and therefore reduce the potential for inconsistencies in approaches to tobacco sales amongst border countries.

There is potential to create an increased desire to smoke amongst young people - if they feel that smoking is deemed to be an adult activity they may then see it as more attractive. This change in legislation would therefore need to be part of a wider package of measures including e.g. smoke-free legislation, smoking cessation activities aimed at young people, enforcement and education.

Although underage smokers are sometimes able to purchase cigarettes, raising the legal age to 18 should make it harder for an under 16 year old to pass themselves off as the legal age.

Enforcement is a major issue, which needs to be looked at along with child protection issues around test purchasing.

Q8: If you wish to comment, please do so here

Q9: The implementation of section 75 requires that all policies must be screened and if adverse impact is identified they must then go through an Equality Impact Assessment. Screening of policies includes consultation with affected groups. If this consultation process involves those who may be affected by the draft Order, and there is not feedback identifying negative impact, then an EQIA is not required. From the Trust's perspective, those who may be affected by this Order -

depending on where exemptions will actually apply - will be those in inpatient mental health units, people with disabilities who are unable to go outside a building or to a designated area and those who are provided services in residential accommodation or in their own home.

Q10: The Trust's main concerns with regard to the draft Order relate to imposing a smoke free environment in the private home of the smoker, residential accommodation and inpatient mental health units. Decisions on whether or where smoking is allowed must involve those affected. It is vital that information is gathered on the most effective way to support mental health service users in reducing or stopping smoking both in inpatient environments and in community settings.

Q11: The Trust feels that people and organisations representing the 9 equality categories, as defined in Section 75, are best placed to comment directly on how to avoid or minimise adverse impact.

Q12: If you wish to comment, please do so here

Q13: Homefirst support the work done on the health impact assessment of the proposed legislation.

Q14: Other positive health impacts that might be included are the educational benefits of smoke-free schools and the benefits of smoke-free workplaces to workers that are pregnant.

Q15: It may be useful to look to some more recent research that has been carried out e.g. 'How Smoke-Free Laws improve air quality: A global study of Irish Pubs.' (Harvard School of Public Health March 2006)

Q16: Homefirst support this response

Q17: Perhaps further assistance or guidance to aid employers in educating their staff on how best to adhere and enforce new legislation

Q18: Yes

Q19: DHSSPS has assumed signage costs will be met by businesses but we feel it may help compliance if there was central production of all signage.

Q20: ?Yes

Q21: No disproportionate impact on rural businesses

Q22: Unaware of any.

Q23: Unaware of any.

Q24: If you wish to comment, please do so here

