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Smokefree Northern Ireland Coalition

Response to

The Draft Smoking (Northern Ireland) Order 2006
Public Consultation

April 2006

The Smokefree Northern Ireland Coalition was established in January 2005. Facilitated and chaired by the Health Promotion Agency, the aim of the coalition was to promote a coordinated response to the Department of Health, Social Services and Public Safety's consultation on smokefree legislation, issued as part of a wider consultation on A Healthier Future: A Twenty Year Vision for Health and Wellbeing, and to encourage the many organisations who believed that Option C "legislation to ban smoking in all enclosed public places and workplaces" was the only way to protect the health of workers, to work collaboratively for maximum effect. By February 2005, 41 organisations had signed up to Smokefree Northern Ireland.

A website, www.smokefreenorthernireland.com was developed to provide information on the risks of second-hand smoke, to encourage the public to vote for Option C, and to highlight the work of the Smokefree Northern Ireland partners.

Since October 2005, when the Minister for Health announced that legislation to ban smoking in all enclosed public places and workplaces would be forthcoming, the role of the Smokefree Northern Ireland Coalition has evolved, and this has been reflected by increased membership, most notably with the four Environmental Health Committees and Belfast City Council becoming active members.

The following response to *The Draft Smoking (Northern Ireland) Order 2006 Public Consultation* was written using feedback from 25 members of the Coalition[1] who came together on 10 April 2006 to develop a coordinated response.

Smokefree Northern Ireland's Response

The Smokefree Northern Ireland Coalition would like to welcome *The Draft Smoking (Northern Ireland) Order 2006* and would also like to make the following comments in response to the questionnaire.

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[1] A list of participating Coalition members can be found in Annex 1

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QUESTIONNAIRE

Q1. Do you agree with the definition of smoking as set out in the draft Order?

Yes

If you wish to comment, please do so here.

The Coalition welcomes the inclusion of herbal cigarettes in the definition. While the precise health risks of herbal preparations are uncertain, the presence of smoke causes discomfort and can provoke illness in susceptible individuals, such as those with asthma.

Q2. Do you agree with the definition of smoke–free premises as set out in the draft Order?

Yes

If you wish to comment, please do so here.

N/A

Q3. Do you think that hotel bedrooms, designated rooms, or areas within the following premises should be exempt?

Hotel Bedrooms	No**.** The Coalition firmly believes that hotel rooms present no convincing argument for exemption
Care Homes	
Psychiatric Units	
Prisons	

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

The Coalition does not wish to suggest any other exemption but would like to make the following comments:

The Coalition agrees that, as stated within the Order, any premises which are exempt should be no-smoking premises with exempt status allowing only for a restricted area for smoking. In premises which are exempt, exemption should apply only to those living there and never to staff or visitors.

The Coalition believes that, rather than giving examples of possible exemptions, there is a need to establish fundamental principles under which any premises should be exempt. It suggests that, in so far as is possible, criteria are established which a premise must meet in order to be exempt.

The Coalition recommends a fundamental criterion is the mobility which people within the premise have to smoke outside. Criteria may also include humane

issues (such as might apply to palliative care homes) and the extent to which staff are placed at risk (i.e. a premise could not be exempt if staff would be expected to work for significant periods of time in close proximity to second-hand smoke, such as may be the case in prisons)The Coalition notes the difficulties inherent in establishing such criteria.

Any guidance which the DHSSPS provides prior to legislation taking effect should also emphasise and remind that the key issue is eliminating risk for staff and others, and that a strong message around supporting smokers who want to quit should be given.

If the regulations are to list specific places to which exemptions may apply, and these are based on whether or not a premise is someone' s home then hostels for homeless people may be a premise which needs to be considered.

The Coalition believes that any provision for exemptions should be kept under constant review.

Psychiatric units - additional comments

The Coalition noted that the Consultation document makes references to psychiatri*c hospitals*, psychiatric *facilities* and psychiatric *units* and provides no clear definition of the kind of premise it intends to be exempt.

There is no reason why psychiatric inpatients should be treated differently to non-psychiatric inpatients. Current research[2] suggests that the introduction of smoking bans in psychiatric inpatient settings is possible but would need to be a clearly and carefully planned process involving all parties affected by the ban. Under the criteria suggested the issue would not be the duration of stay on the premises but whether or not they are free to go outside without posing a security risk.

It is important to remember the need to protect psychiatric patients who do not smoke. The Coalition believes that exemptions on psychiatric settings could run the risk of failing to protect psychiatric patients who already experience many inequalities in health. This may contradict the Government's public health strategy *Investing for Health* which focuses on tackling inequalities.

Prisons – additional comments

In considering whether or not prisons should be exempt, the Coalition would advise that the DHSSPS consider evidence from prisons elsewhere which have successfully gone smokefree, for example, Ashfield Young Offenders Institute, a prison in South Gloucestershire which accepts remand and sentenced young people between the ages of 15 and 18, introduced a smoke-free policy on 1st

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[2] Lawn, S and R, Pols. "Smoking bans in psychiatric inpatient settings? A review of the research." Australian and New Zealand Journal of psychiatry 2005; 39:866-885.

February 2005. Smoking is not permitted within the prison by young offenders or staff and all tobacco related products are banned[3].

It is also worth noting that a letter to the editor was published in the British Medical Journal in 2005 on the experience of smoke-free prisons in the United States which states 'On admission to a smoke-free jail our patients have repeatedly reported very little difficulty with stopping tobacco use…'[4]

Q4. 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.

The Coalition agrees that that the largest penalty should be for whoever owns or is responsible for the management of the smokefree premise, but has some concerns that the suggested offences shift responsibility to managers not owners. The Coalition believes that owners should take responsibility. By making the owner responsible we believe that there is much greater likelihood that the full range of measures necessary to ensure the success of this intervention will be implemented prior to the legislation coming into force, including staff training and smoking policies. This in turn would be likely to increase compliance and reduce the need for significant enforcement effort.

The Coalition notes that not all premises will have an individual owner, for example healthcare services, in which case, the most senior manager or Chief Executive should have overall responsibility.

The Coalition does not believe that Articles 7(7), 8(4), 9(5) are necessary and believes that the onus should be on the defendant to establish the defence and not for the prosecution to disprove it if an issue is raised.

The Coalition is also concerned at the level of penalties as the level cited is the maximum level and there is no obligation on a court to impose the maximum level.

Q5. Do you agree with the fixed penalty notice procedures as set out in the draft Order?

No

If you wish to comment, please do so here.

The Coalition does not agree there should be fixed penalties. We believe that it risks undermining the legislative message as people may feel it is worth taking the risk and paying the fine and that a stronger deterrent is required.

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[3] Personal communication with Ashfield
[4] BMJ 2005; 331:1473 Lincoln et al

Furthermore, there is evidence elsewhere, ie from British Columbia, that fixed penalty notices for this type of offence have not been effective[5].

Fixed penalties have not been used in the Republic of Ireland, instead offences lead to prosecution and a fine. Compliance rates have been very high in the Republic of Ireland, with very low prosecution rates. The Coalition strongly recommends a similar policy.

The use of fixed penalty notices in Northern Ireland may also in practice create different regimes in cross-border areas.

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?

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.

If not, please state your reasons below.

N/A

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

If you wish to comment, please do so here.

The Coalition agrees with this proposal that the DHSSPS take the power to raise the age limit from 16. We would also recommend that the DHSSPS proceed with this issue as soon as possible.

The Coalition would respond positively to any future consultation around this issue. It believes that changing the age to 18 would mean we are giving out a message consistent with alcohol legislation and butane gas and emphasising the serious risk which tobacco smoking poses to health, as well as potentially

[5] Tobacco Control 2003:12:264-268

facilitating an integrated approach to enforcement. It would also align NI legislation with Republic of Ireland legislation and therefore reduce the potential for inconsistencies in approaches to tobacco sales amongst border counties.

The Coalition would also like to make the following comments:

In a paper on the proposal to raise the age to 18 in Scotland, ASH Scotland emphasised as a stand alone measure this may not make a difference. There are also concerns that it may make smoking appear more adult and therefore more desirable as a mechanism for rebelling. This change in legislation would therefore need to be part of a wider package of measures including, for example, the forthcoming smokefree 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 those under 16 to pass themselves off as the legal age.

Enforcement is a real issue which still needs to be considered.

INTEGRATED IMPACT ASSESSMENT OVERVIEW

General

Q8. Do you have any views on the conclusions reached by the Department to screen out from further assessment the implications of the draft Order in respect of:

- **(a) Social Impact Assessment (New TSN, Homelessness etc);**
- **(b) Rural (see Q21 –Q23);**
- **(c) Environmental;**
- **(d) Human Rights;**
- **(e) Victims;**
- **(f) Community Safety & Other Areas?**

Is there any other evidence which you consider should have been taken into account in these assessments?

Equality

Q9. Do you agree with the decision that the draft Order does not require a full equality assessment? (see Annex 1 and Annex 2 of the IIA Overview). If not, please explain why?

Yes

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Q10. Is there any other qualitative or quantitative information which you consider should have been taken into account in performing this exercise?

No

Q11. Are you aware of any evidence – qualitative or quantitative that the draft Order may have an adverse impact on equality of opportunity or on good relations? If so, please provide details. Can you suggest any ways of avoiding or minimising such adverse impact?

No

Q12. Are you aware of any other equality implications likely to arise from the draft Order?

There will be benefits to staff in workplaces which have traditionally employed staff from lower socio-economic groups and where staff may currently be exposed to high levels of second hand smoke, for example, factories, bars and working clubs.

The equality section does not refer to the Partial Regulatory Impact Assessment, and the Coalition believes that there is a need to acknowledge in the equality section the potential unequal impact on employment of Protestants in the Ballymena area if the existing tobacco factory there were to close.

Partial Regulatory Impact Assessment (RIA)

Q13. Do you have any views on the assessment of health impacts?

The Coalition supports the work done on the health impact assessment of the proposed legislation.

Q14. Are there any other potential health impacts that you consider should have been addressed?

Some other positive impacts might be included, for example, the educational benefits of smokefree schools and the benefits of smokefree workplaces to workers who are pregnant.

The predicted impact of a 2% reduction in smoking prevalence may also have been underestimated; the Coalition notes that the Wanless Report[6] refers to studies estimating a workplaces smoking ban in England might reduce smoking

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[6] Wanless, Derek "Securing Good Health for the Whole Population" Department of Health 2004.

prevalence by around 4%, and acknowledges that although this may be an overestimate, it might also be an underestimate if the legislation triggers a move to wider cessation.

Q15. Is there any other material evidence which you consider should have been taken into account in this assessment of health impacts?
The Coalition recommends including some of the more recent research which hasn't been considered, most notably "How Smoke-free Laws improve air quality: A global study of Irish pubs".[7]

Economic

Q16. Do you have any general comments on the overall approach that was taken in completing the RIA?

We welcome and support the IIA.

Q17. Do you consider that there are other issues which need to be taken into account in the assessment of the impact on business?

No

Q18. Do you agree with the analysis of the sectors and business/organisations which might be particularly affected by the introduction of this policy?

We support what has been done but believe that, based on the research commissioned by the Scottish Executive[8], the main benefit may be from a reduction in smoking breaks. This is an important point which may be worth highlighting to businesses as part of the DHSSPS smokefree legislation communications strategy.

Q19. What are your views on the identification and assessment of the costs and benefits?

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

Public Expenditure and Public Service

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[7] Harvard School of Public Health, March 16 2006.
[8] HERU, International review of the health and economic impact of the regulation of smoking in public places, NHS Scotland 2004

Q20. Do you agree with the Department's view that a separate Economic Appraisal is not required?

Yes

Rural Proofing

Q21. Do you agree that the draft Order will not have a disproportionate adverse impact on rural business?

No rural impact

Q22. Are there any rural impacts that you consider should have been addressed?

No

Q23. Is there any other material evidence which you consider should have been taken into account in this assessment of rural impacts?

No

Additional Comments

Q24. Do you have any other comments or suggestions on the draft Order and/or the Integrated Impact Assessment Overview?

The Northern Ireland Human Rights Commission (NIHRC) has stated that it recognizes as a human right the right of all bar workers in Northern Ireland to protection from exposure to smoke and that Government is therefore obliged to adopt and implement legislative or other measures providing effective protection. The Coalition suggests that this is referred to in the integrated impact assessment. We attach a key document produced by the NIHRC for the Health Promotion Agency on the Commission's views on the existence of a human right to health and on the possibility that a partial smoking ban in bars could lead to bar workers denied protection from second-hand smoke taking their case to the European Court of Human Rights.

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Appendix One

Smokefree Northern Ireland Coalition Members who contributed to developing the Coalition response to the Draft Smoking (Northern Ireland) Order 2006

Action Mental Health	Mr Ian Walters
Armagh & Dungannon Health Action Zone	Ms Tracey O'Neill
Belfast City Council	Mr Tom Crossan
British Medical Association	Ms Anona Robertston
Chartered Institute of Environmental Health	Mr Gary McFarlane
Down & Lisburn H&SSPS Trust	Ms Lynda Vladeanu
Eastern Group Environmental Health	Mr David Knox
EHSSB	Dr David Stewart
EHSSB	Ms Gerry Bleakney
Health Promotion Agency	Ms Victoria Creasy
Health Promotion Agency	Ms Sarah Bothwell
Health Promotion Agency	Dr Brian Gaffney
Institute of Public Health	Ms Arlene McKay
Macmillan Cancer Relief	Ms Heather Monteverde
NHSSB	Ms Madeline Heaney
NI Ambulance Service	Ms Marie Mullan
NI Chest Heart & Stroke Association	Ms Sara Morrow
Northern Group Systems	Mr Sean Martin
Royal College of Nursing	Ms Lisa Holden
SHSSB	Mrs Siobhan O'Brien
SHSSB	Ms Lyn Donnelly
Southern Group Environmental Health Committee	Mr Sam Knox
Ulster Cancer Foundation	Ms Anne Devlin
Western Group Environmental Health Service	Mr Larry Dargan
WHSSB	Ms Cathy Mullan
Western Tobacco Control Group	Mr Mark McBride