Smoking in the home: attitudes and perceptions and the impact of the 2004 Irish smoking ban / David S. Evans, Colm Byrne, Maurice Mulcahy

SMOKING in the HOME

attitudes and perceptions and the impact of the 2004 Irish Smoking Ban

SMOKING IN THE HOME:

ATTITUDES AND PERCEPTIONS AND THE IMPACT OF THE 2004 IRISH SMOKING BAN

By

Health Promotion Services and the Department of Public Health, Health Service Executive West

Authors: Dr. David S. Evans
Mr. Colm Byrne
Mr. Maurice Mulcahy

December 2006

Published by Health Service Executive West

ISBN: 1898098123

ACKNOWLEDGEMENTS

The authors are grateful to MORIMRC who undertook the fieldwork and inputted data. To Helena Morkan for further assistance entering and recoding data. To Josie Waters for typing and layout and Fiona Healy for proof reading and printing. Finally, we are indebted to Ms Jacky Jones (Functional Manager, Health Promotion Services) and our colleagues in the Health Service Executive West for their generous support and assistance throughout this project. The research was supported by funding from Health Promotion Services, Health Service Executive West.

EXECUTIVE SUMMARY

The Irish indoor workplace smoking ban was introduced in March 2004. The ban aimed to protect the Irish workforce from the adverse health effects of secondhand smoke. The ban has had a significant impact on exposure to secondhand smoke in the workplace. However, it is unclear whether the ban has had an impact on other places such as the home. The study aimed to assess the impact on smoking in the home and attitudes towards smoking generally.

Face to face interviews were undertaken with a statistically representative sample of 512 respondents in their own homes two years prior to the introduction of the workplace smoking ban (April 2002). Twenty one months after the introduction of the smoking ban (December 2005) a second statistically representative household survey was undertaken of 425 respondents in the same region (Galway, Mayo, and Roscommon). The surveys assessed the extent of smoking in the home, and attitudes towards smoking in the home, the workplace smoking ban, and smoking generally.

The key findings of the study can be summarised as follows:

- The proportion of households allowing smoking reduced from 58% before to 50% after the ban. Those allowing smoking in selected areas in the house reduced from 29% to 25%.

- Significantly more respondents from households from lower socioeconomic groups (SEG's) than higher SEG's allowed smoking in the home both before (66% compared to 46%) and after (56% compared to 44%) the introduction of the workplace smoking ban.

- The main changes in the proportion of households allowing smoking in the home were among lower SEG's. This has had the effect of reducing SEG differences in the proportion allowing smoking between higher and lower SEG's from 20% to 12%.

- Over a third before (37%) and 40% after the ban would prefer if people did not smoke in their homes.

- After the ban, cigarettes were smoked in 39% of households with children under 15.

- Three quarters (76%) of respondents interviewed after the introduction of the workplace smoking ban stated that they agreed with it.

- Almost a quarter (22%) of respondents reported that their attitude to where people were allowed to smoke in their home had changed since the ban. For these, the main changes were that they did not allow people to smoke (25%), they were less tolerant of smoking (14%) and that they were more aware of the dangers of passive smoking (16%).

- Half of the respondents interviewed after the ban believed that the health risk of smoking in the home to themselves (52%) and other adults (53%) was high, with three quarters (72%) perceiving that the risk to children was high.

- After the ban, over a third of respondents allowed people to smoke in their home but would prefer if they didn't. The main reason these respondents gave for allowing people to smoke (85%) indicated a lack of assertiveness skills.

The study has shown the success of Ireland's workplace smoking ban in terms of having an impact on the home, an area not covered by the legislation. However, smoking in the home remains a significant public health issue with half the households in the study allowing smoking in the home after the ban. The following recommendations have been made:

1. The merits of introducing further legislation covering smoking in the home warrant further investigation (e.g. banning smoking in multi-occupied buildings).

2. A comprehensive review of initiatives that encourage 'no smoking' in the home should be undertaken. Following the

review, initiatives should be developed to promote ‘no smoking’ in the Irish home setting.

3. Assertiveness skills should be developed to facilitate people who do not want others to smoke in their home. Assertiveness training programmes for adults and children (through programmes such as the Department of Education’s Social, Personal, and Health Education Programme), and media campaigns designed to build assertiveness skills should be considered.

4. There is a need to raise awareness of the risks of passive smoking. This should be achieved by employing ‘best practice’ techniques.

5. The dangers of smoke migration from room to room should be highlighted to help reduce the proportion of households allowing smoking in selected areas.

6. Health inequalities should be addressed adopting a population health approach to smoking.

7. Current initiatives and strategies aimed at reducing inequalities at a local and national level should be supported.

CONTENTS

1. INTRODUCTION

1.1 Introduction

The Irish indoor workplace smoking ban was introduced in March 2004. It banned smoking in all bars, restaurants, cafes and hotels (excluding bedrooms, outdoor areas and properly designed smoking shelters; Office of Tobacco Control, 2004). The ban aimed to protect the Irish workforce from the adverse health effects of secondhand smoking such as an increased risk of lung cancer, coronary heart disease, and asthma (Allwright, 2005a, UK Department of Health, 2004, WHO, 2004, Californian Environmental Protection Agency, 2005).

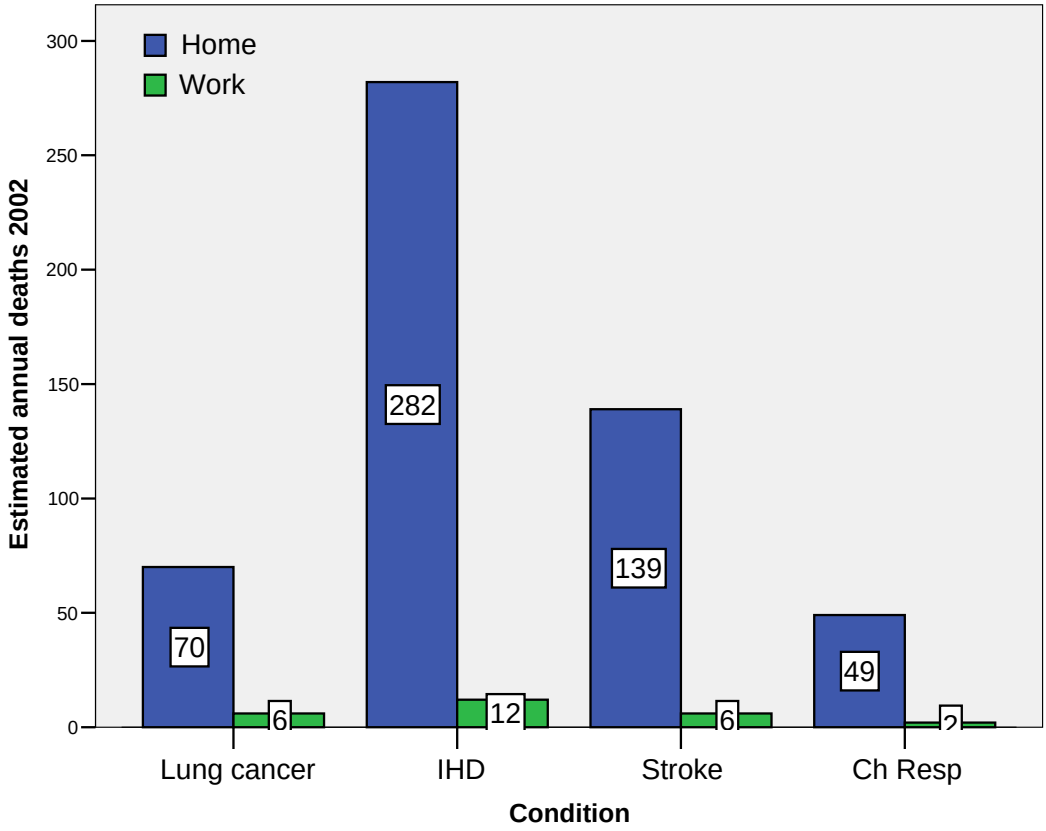
The evidence to date on the impact of the Irish workplace smoking ban has been very positive. Compliance with the legislation is very high, with 94% of all workplaces inspected by the National Tobacco Control Inspection Programme being smoke free (Office of tobacco Control, 2006). A study of Galway city (Mulcahy et al, 2005) reported an 83% reduction in air nicotine levels in bars and a 69% reduction in saliva cotinine concentrations of hospitality workers three months after the ban. A study of bar workers in three areas of Ireland (Allwright et al, 2005b) reported an 80% reduction in salivary cotinine concentrations and a 17% reduction in reported respiratory symptoms one year after the ban. Whilst smoking outside buildings remains an area of concern due to the potential for smoke infiltration[8]), the smoking ban has to be heralded as a major success story.

However, it has been suggested that smoking bans can lead to greater levels of smoking in private venues exempt from legislation such as the home. Adda and Cornaglia (2005) in a study of smoking bans in the USA found that parents smoke more at home if prevented from smoking in bars and restaurants. A review of research into passive smoking by the Royal College of Physicians

(cited by O' Dowd, 2005) found that smoking bans encourage smokers to cut down or quit, rather than smoke more at home.

Given the debate concerning smoking in the home and smoking bans, the 'knock on' effect of smoking bans on other settings such as the home clearly needs to be established to ensure that any impact on one location does not have a counteracting impact on another. This is particularly important as SHS in the home is a significant public health issue. It has been estimated that in 2002 there were 16,443 deaths in the European Union among non smokers attributable to passive smoking at home compared to 2799 at work. This translates to one death every 32 minutes from passive smoking at home compared to one non smoking employee every 3.5 working days for the hospitality industry (Jamrozik, 2006). Figure 1.1 shows deaths in Ireland in 2002 due to passive smoking in home and work. For each condition, significantly more people are dying due to smoking at home. For example 282 people in 2002 died of heart disease due to passive smoking at home compared to 12 for exposure at work. This demonstrates the importance of establishing what the 'knock on' effect of the workplace smoking ban has been. At the time of the study it was unclear whether the ban has had any impact on smoking in the home and attitudes towards smoking in the home. Knowing the extent of the problem is critical if strategies are to be developed to combat it. It was against this background that the study was undertaken.

Figure 1.1: Estimated Deaths in Ireland due to Passive Smoking at Home and Work



Source: Jamrozrik, 2006

1.2. Aims and Objectives

The study aimed to establish the impact of the 2004 Irish workplace smoking ban on smoking in the home.

Its specific objectives were to:

- determine the impact of the smoking ban on the extent of and attitudes towards smoking in the home.
- the perceptions of health risks of smoking in the home.
- the extent to which children are exposed to SHS in the home.
- the extent to which children are exposed to SHS in cars.
- attitudes of smokers to people smoking in cars.

2. METHODOLOGY

Face to face interviews were undertaken with a statistically representative sample of 512 respondents in their own homes two years prior to the introduction of the workplace smoking ban (April 2002). This survey formed part of a comprehensive study of the home as a setting for health promotion (Jones et al, 2003). In relation to smoking in the home, the study assessed:

- Where smoking was allowed in the home.
- Whether respondents objected to/disapproved of other members of the household smoking.

Twenty one months after the introduction of the smoking ban (December 2005) a second statistically representative household survey was undertaken of 425 respondents in the same region. The survey assessed:

- Where smoking was allowed in the home.
- Whether respondents objected to/disapproved of other members of the household smoking.
- The amount of cigarettes smoked in the home.
- Smoking status and number of smokers in household.
- Attitudes towards smoking.
- Attitudes towards the workplace smoking ban.
- Changes in attitudes towards smoking in the home since the introduction of the workplace smoking ban.

- Perceptions of the health risk in terms of smoking in the home.

- Smoking in cars.

Both surveys employed quota sampling to ensure the sample was representative by age, gender, and socioeconomic group. A total of 29 sampling points were selected (15 in Galway, 9 in Mayo, and 5 in Roscommon) to represent both the urban and rural districts of each county in proportion to the number of interviews to be completed using a computer programme based on district electoral divisions. From each sampling point, trained interviewers set out on a 'random route' following instructions to call at every n^{th} household to try to complete an interview. A maximum of 12 interviews were undertaken at each sampling point to eliminate any possible 'clustering effect'. The fieldwork for both surveys were undertaken by MORI MRC, Dublin, Ireland.

A copy of the relevant section of the 2002 questionnaire is attached as Appendix 1 (full copy available on request) and a copy of the 2005 questionnaire is attached as Appendix 2.

3. THE IMPACT OF THE SMOKINGBAN ON SMOKING IN THE HOME

3.1 Introduction

In this section, questions asked about smoking in the home to representative samples of respondents from HSE West (Galway, Mayo, and Roscommon) both before and after the introduction of the indoor workplace smoking ban are compared.

3.2 Profile

A profile of respondents is given in Table 3.1. There were no significant differences in sample composition between the 2002 and 2005 surveys in terms of age, gender, socioeconomic group, region, and area type ($p>0.05$).

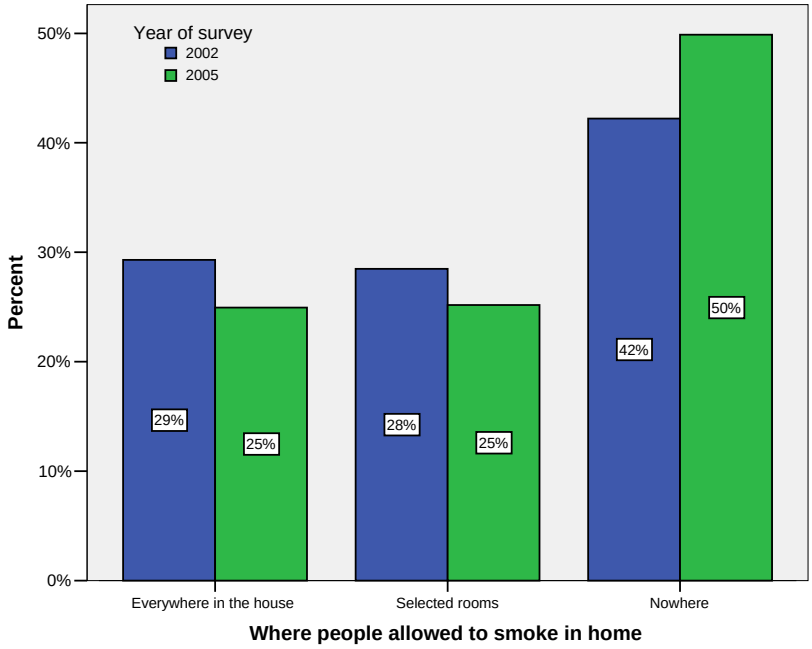
Table 3.1: Profile of Respondents

Profile of respondent	Year of survey				Total		Chi square comparison between 2002 and 2005
	2002		2005				
	No.	%	No.	%	No.	%	
Age							
16-34	200	39	169	40	369	40	$\chi^2 = 0.067$
35-54	181	35	149	35	330	35	df = 2
55+	132	26	107	25	239	26	p = 0.967
Gender							$\chi^2 = 0.002$
Male	248	48	206	48	454	48	df = 1
Female	265	52	219	52	484	52	p = 0.969
Socio economic group							$\chi^2 = 2.233$
A-C1	226	44	208	49	434	46	df = 1
C2-E	287	56	217	51	504	54	p = 0.135
Region							
Galway	264	52	229	54	493	53	$\chi^2 = 2.187$
Mayo	157	31	135	32	292	31	df = 2
Roscommon	92	18	61	14	153	16	p = 0.335
Area type							$\chi^2 = 0.146$
Urban	158	31	126	30	284	30	df = 1
Rural	355	69	299	70	654	70	p = 0.702

3.3 Allowing Smoking in the Home

Figure 3.1 shows the proportion of households allowing smoking in the home in 2002 and 2005. The proportion of households where smoking is allowed everywhere and in selected areas have decreased (29%-25% and 28%-25% respectively), whilst the proportion not allowing smoking anywhere in the home has increased (42%-50%). Overall, between 2002 and 2005 the proportion of homes that allow smoking has decreased from 58% to 50% and the proportion of homes that do not allow smoking has increased from 42% to 50%. These changes are statistically significant (p = 0.000).

Figure 3.1: Proportion of Households Allowing Smoking in the Home in 2002 and 2005



3.4 Allowing Smoking in the Home by Socioeconomic Group

Table 3.2 shows that significantly more respondents from households from lower socioeconomic groups (SEG's) allowed smoking in the home both in 2002 (66% for SEG C2-E compared to 46% for SEG A-C1, p = 0.000) and 2005 (56% for SEG C2-E compared to 44% for SEG A-C1, p = 0.017). Changes in the proportion not allowing smoking between 2002 and 2005 are statistically significant for respondents from lower SEG's (34-44%, p = 0.021) but not for respondents from higher SEG's (56%-54%, p = 0.669). There are only small changes in the proportion of

respondents allowing smoking in selected areas by SEG between 2002 and 2005 (26%-22% for SEG A-C1 and 30%-28% for SEG C2-E, p = 0.755).

Table 3.2: Where Smoking is Allowed in Home by Year of Survey and Socioeconomic Group (SEG)

Year of survey by SEG	Where people are allowed to smoke in house					
	Everywhere		Selected rooms		Nowhere	
	No.	%	No.	%	No.	%
SEG A-C1						
2002	43	20	57	26	116	54
2005	46	22	46	22	116	56
SEG C2-E						
2002	100	36	82	30	94	34
2005	60	28	61	28	96	44

3.5 Objecting to Household Members Smoking

Respondents were asked whether they objected/disapproved of other members of the household smoking (table 3.3). It can be seen that the proportion of respondents that objected to household members smoking increased from 37% in 2002 to 44% in 2005. This change was not statistically significant (p = 0.064). A larger proportion of respondents from higher SEG's objected/disapproved of other members of the household smoking both in 2002 (45% for SEG A-C1 compared to 31% for SEG C2-E) and 2005 (44% for SEG A-C1 compared to 40% fir SEG C2-E). Differences between SEG's were significant in 2002 (p = 0.004) but not in 2005 (p = 0.156). Changes in the proportion of respondents that objected/disapproved of other members of the household smoking between 2002 and 2005 are greater but not statistically significant for respondents from lower SEG's (31-40%, p = 0.072) than for respondents from higher SEG's (45-48%, p = 0.526).

Table 3.3: Objecting / Disapproving of Other Members of the Household Smoking by SEG

	Object / disapprove of other household members smoking			
	Yes		No	
	No.	%	No.	%
ALL RESPONDENTS				
2002	163	37	276	63
2005	136	44	174	56
SEG A-C1				
2002	86	45	107	55
2005	72	48	78	52
SEG C2-E				
2002	77	31	169	69
2005	64	40	96	60

4. ATTITUDES AND PERCEPTIONS TOWARDS SMOKING SINCE THE BAN

4.1 Introduction

In this section, attitudes towards smoking, smoking at home, and the impact on the workplace smoking ban on attitudes are analysed. In addition, information on smoking status and the amount of cigarettes smoked was also obtained. The results are based on the household survey of 425 respondents undertaken in December 2005.

4.2 Smoking Status and Exposure at Home

A total of 31% of respondents were current smokers. Table 4.1 shows that 47% of these smoked up to 10 cigarettes a day and 44% smoked between 11 and 20 cigarettes a day. The average number smoked was 14.39 cigarettes a day. Overall 49% of households had at least one person who smoked. The average number of smokers per household was 0.76.

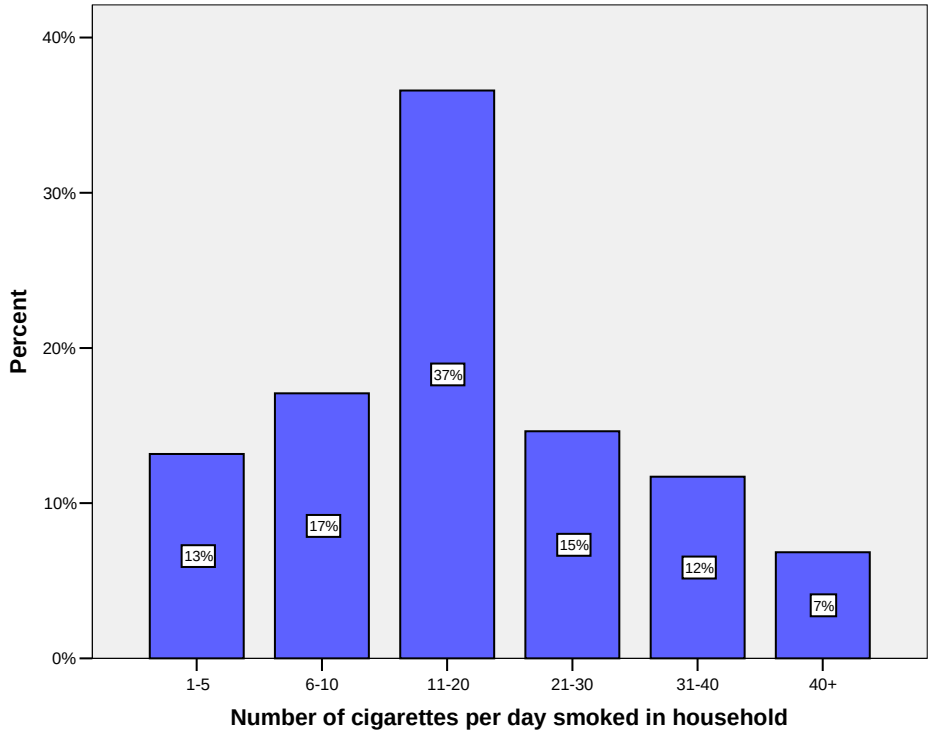
Table 4.1: Number of Cigarettes Smoked

	No.	%
Number of cigarettes smoked by smoker		
1-2	12	9
3-5	10	8
6-10	38	30
11-15	24	19
16-20	32	25
Over 20	13	10
Number of smokers within household		
None	218	51
1	124	29
2	62	15
3	12	3
4	4	1
5	5	1

Cigarettes were smoked in 48% of households. A larger proportion of respondents from lower SEG's stated that cigarettes were smoked in their household (52% for SEG C2-E compared to 44% for SEG A-C1) although these differences were not statistically significant (p = 0.106). In addition, a larger proportion of households with no children stated that cigarettes were smoked in their household (54% compared to 39% for households with children under 15). These differences were statistically significant (p = 0.002).

Figure 4.1 shows that in households where cigarettes were smoked, over 20 cigarettes a day were smoked in 34% of households with 11-20 cigarettes being smoked in 37% of households. On average, 21.61 cigarettes were smoked a day. There were no significant differences in the average amount of cigarettes smoked by SEG (p = 0.180) or whether there were children under 16 residing in the household (p = 0.635).

Figure 4.1: Number of Cigarettes Smoked per Household Where Cigarettes were Smoked



4.3 The 2004 Workplace Smoking Ban

Three quarters of respondents (76%) agreed with the introduction of the 2004 workplace smoking ban. Significantly more non smokers

agreed with the introduction of the ban (92% compared to 68% for smokers, p = 0.000). There were no significant differences in the level of agreement/disagreement with the smoking ban by SEG (p = 0.079) or whether there were children under 16 residing in the household (p = 0.078). Almost a quarter of respondents (22%) stated that their attitude to where people are allowed to smoke in their home had changed since the introduction of the workplace smoking ban. This pattern was similar for smokers and non smokers (p= 0.165) and for different SEG's (p = 0.727) and whether there were children residing in the household (p = 0.889). Table 4.2 shows that the main ways that their attitude had changed was that they did not allow people to smoke (25%), they were less tolerant of smoking (14%) and that they were more aware of the dangers of passive smoking (16%).

Table 4.2: Main Ways Attitudes have Changed Since the Workplace Smoking ban

Main ways attitudes have changed	No.	% *
Don't allow people to smoke in the home anymore/ask to smoke outside	23	25
More aware of passive smoking/dangers of passive smoking/health risk	15	16
Less tolerant of people smoking in the home less acceptable	13	14
Prefer if people smoked outside	12	13
Gave me the confidence to ask people not to smoke/am now more forceful	9	10
Don't like the smell/less used to the smell of smoke	8	9
More conscious of non smokers	6	6
Smokers now go outside to smoke/don't smoke in the home now	2	2
Ask permission before start smoking	2	2
Gave up smoking/person in the house gave up smoking with the introduction of the smoking ban	2	2
Smoking now only allowed in certain rooms/allow certain rooms to be smoke free	1	1

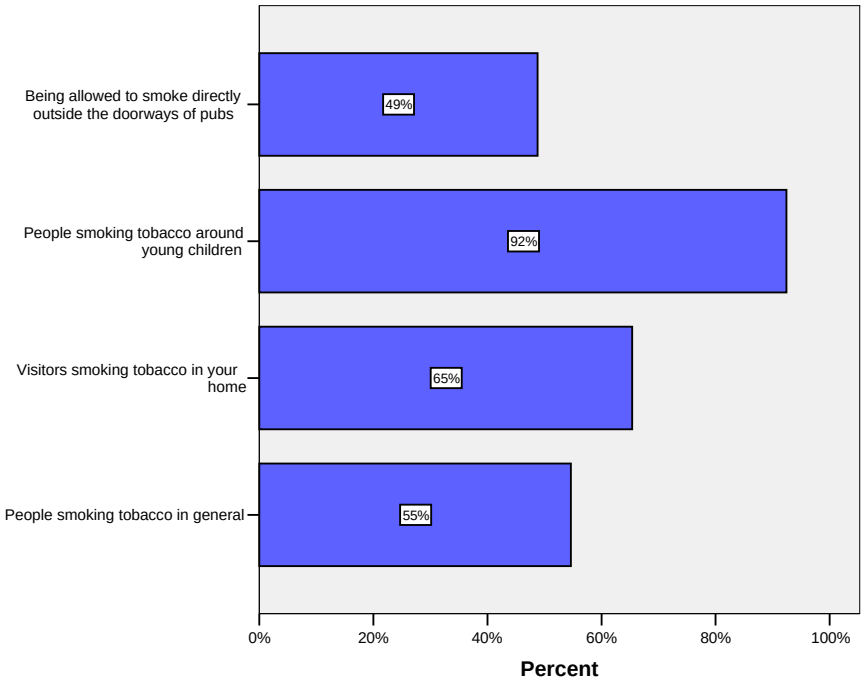
* multiple response, therefore percentages do not add to 100%

4.3 Approval or Disapproval of Smoking

Respondents were given a list of four smoking behaviours and asked whether they approved or disapproved of each behaviour (figure 4.2). Almost half (49%) disapproved of each of the behaviours listed. The behaviour that received the highest level of disapproval was for people smoking tobacco around young children (91% disapproving and 2% approving), with the lowest level of

disapproval being for allowing people to smoke directly outside the doorways of pubs (49% disapproving and 28% approving). Significantly more non smokers disapproved of three of the four behaviours listed ($p < 0.01$). In addition, significantly more households with children under 16 disapproved of visitors smoking in their home ($p = 0.001$). There were no significant differences in approval or disapproval by SEG ($p > 0.05$).

Figure 4.2: Proportion of Respondents That Disapprove of Smoking Behaviours



4.4 Prefer if People did not Smoke in the Home

After the introduction of the workplace smoking ban 37% of respondents who allowed smoking in their home would prefer if people did not smoke in their home. The main reasons why these respondents allowed smoking (table 4.3) were out of courtesy/to be friendly/polite/sociable (20%), because it was their home as well (18%), and not wanting to appear awkward (13%).

Table 4.3: Why Respondents (who Would Prefer if People did not Smoke in the Home) Allow People to Smoke in their Home

Why allow people to smoke in home	No.	% *
Out of courtesy/to be friendly/politeness/sociable	16	20
They live in the house/it's their home as well	14	18
Don't want to appear awkward/pushy/rude to tell them not to	10	13
Difficult to ask people/less hassle/easier option	7	9
Because I smoke myself	6	8
Don't want to fall out with people/offend them	5	6
Their choice/their right	5	6
It's my parent(s) that smoke	4	5
Family/relative/personal friends	3	4
Not too bothered by it/not a big issue	3	4
Rarely happens	2	3
No say/choice in matter/not my home	1	1
Other answers	1	1

* multiple response, therefore percentages do not add to 100%

Respondents who allowed smoking in their home but would prefer if people did not were also asked what would help them to ask people not to smoke in their home. Table 4.4 shows that the main responses were that they did not know what would help (38%), nothing would help (25%), and to highlight/make people more aware of the dangers of passive smoking (10%).

Table 4.4: What would help Respondents (who Would Prefer if People did not Smoke in the Home) ask People not to Smoke in their Home

What would help to ask people not to smoke	No.	%
Highlight the dangers/make people more aware of the dangers/advertising campaign	8	10
If I was to stop smoking	4	5
Smoking ban has helped	2	3
If young child or baby in house/if children at home	2	3
If house member with health problem (asthma)	2	3
Provide no smoking signs	2	3
Don't feel strong enough about it/just tell them if it became an issue	2	3
Ban smoking/ban on smoking in the home	1	1
Don't have the courage/if I was more assertive/too embarrassed	1	1
Just let them/I wouldn't ask them not to smoke	1	1
Don't know	30	38
Nothing	20	25
Other answers	4	5

4.5 Perceived Health Risks of Smoking in the Home

Table 4.5 shows respondent's perceptions of the health risks smoking in the home has on themselves, other adults, and on children (after the introduction of the workplace smoking ban). Half of the respondents believed that the risk to themselves (52%) and other adults (53%) was high, with three quarters (72%) perceiving that the risk to children was high. Risk was rated significantly lower in households that allowed smoking (p= 0.000 for respondents, p = 0.000 for other adults, p = 0.001 for children). There were no significant differences in the rating of risk by SEG or whether there were children residing in the household (p > 0.05).

Table 4.5: Respondents Perceived Health risk of Smoking in the Home to Themselves, to Other Adults, and to Children Living in Their Home

Perceived health risk	Respondent		Other adults		Children	
	No.	%	No.	%	No.	%
No risk	19	5	13	4	6	3
Low risk	64	16	57	16	14	7
Medium risk	109	28	100	28	34	18
High risk	205	52	193	53	136	72

4.6 Smoking in Cars

Table 4.6 shows that a quarter of respondents (25%) that owned cars allowed people to smoke in their car. Significantly more smokers allowed people to smoke in their car than non smokers (58% compared to 13%, p = 0.000). Differences were not significant by SEG (p = 0.154). It can also be seen from table 4.6 that 79% of those who allow smoking in their car would not allow people to smoke in their car if children were present. Significantly more smokers who allow smoking in their car don't allow it if children are present (91% compared to 63%, p = 0.001). As with smoking in cars generally, differences were not significant by SEG (p = 0.543).

Table 4.6: Allowing Smoking in Respondents Car by Smoking Status

Smoking in car	Smoker		Non Smoker		Total	
	No.	%	No.	%	No.	%
Allowing smoking						
Yes	58	57	33	13	91	25
No	44	43	224	87	268	75
Allowing smoking if children present *						
Yes	5	9	11	37	16	18
No	53	91	19	63	72	79
Don't know	0	0	3	9	3	3

* Those who allow smoking in their car

5. DISCUSSION

5.1 Introduction

The study aimed to establish the impact of the 2004 Irish workplace smoking ban on smoking in the home. It involved two representative surveys of respondents residing in HSE West (Galway, Mayo, and Roscommon). The key issues arising from the study will now be discussed.

5.2 'Knock on Effect' on Smoking in the Home

The study findings suggest that the introduction of the Irish workplace smoking ban has had a significant 'knock on' effect on smoking in the home. The proportion of households where smoking was allowed significantly reduced from 58% to 50%. This finding is supported by two other Irish studies of the workplace ban. Allwright et al[8] in a study of Irish bar workers reported that although they did not specifically ask about smoking in the home, their data suggested that exposure in the home may have declined after the introduction of the ban. Fong et al (2006) in a study of adult smokers in Ireland and the United Kingdom (UK) reported a significant decrease in the proportion of Irish homes where smoking was allowed from 85% to 80%. It is clear that the Irish workplace smoking ban has had a significant impact on smoking behaviour and attitudes towards smoking. Indeed the main ways a quarter reported that their attitude had changed was that they no longer allowed people to smoke at home, that they were less tolerant of smoking, and that they were more aware of the dangers of passive smoking. After the ban, the majority of respondents also perceived that smoking in the home had a high health risk both on themselves and others in the home. This demonstrates the effectiveness of public policy in reducing smoking in the home and supports a review of policy options (Thomson et al, 2006) which concluded that comprehensive tobacco control programmes are likely to be the most effective option to reduce smoking in the home.

5.3 Addressing Health Inequalities

Addressing health inequalities remains a significant challenge for policy makers and health service providers. SEG differences in mortality and morbidity have been found in Ireland and elsewhere (Kunst et al, 1998). This study found that significantly more respondents from households from lower SEG's allowed smoking in the home both before and after the introduction of the workplace smoking ban. This finding is similar to Okah et al (2002) who found that households with lower incomes reported lower rates of homes where smoking was not allowed compared to higher income households. In addition, Whitlock et al (1998) found that secondhand smoke exposure was inversely associated with socioeconomic status. This finding demonstrates that despite the success of the ban, there remains a need to address the socioeconomic determinants of health. A review of tobacco, alcohol, and drug policies (Anderson, 2000) concluded that such policies will not succeed in the long term if the social factors determining their use remain unchanged. Being poor can reduce the opportunities and the motivation to adopt a healthy lifestyle. If tobacco control policies are to succeed, it is very important that the socioeconomic determinants of health are addressed. It is suggested that this could be achieved by adopting a population health approach. This focuses on improving the health status of whole populations and/or subgroups of the population to reduce inequalities (Health Canada, 2006). This approach is a key component of health policy in Ireland (Department of Health and Children, 2001, p62). In addition, current initiatives and strategies aimed at reducing inequalities at a local and national level should be supported.

However, whilst recognising that SEG variations remain, it must be stressed that the main changes in the proportion of households allowing smoking in the home were among lower SEG's. This has had the effect of reducing SEG differences in the proportion allowing smoking between higher and lower SEG's from 20% to 12%. In addition, after the ban, there were no significant differences by SEG in perceptions of risk associated with smoking in the home nor in attitudes towards the introduction of the smoking ban and smoking generally. This suggests that the Irish workplace smoking ban may be having an effect on reducing health inequalities. As the

proportion of smokers in Ireland is higher among lower SEG's (Office of Tobacco Control, 2006) then it is likely that the workplace smoking ban would have had a greater impact in terms of curtailing smoking behaviour among lower SEG's. This, combined with a media campaign leading up to the introduction of the new legislation (highlighting the dangers of passive smoking and offering support for those wanting to give up) may have contributed to the significant reduction in the proportion of households from lower SEG's that allow smoking. This finding is particularly important due to the fact that generic health promotion initiatives aimed at improving health behaviour have been found to have been less effective among lower SEG's (Whitehead, 1989).

5.4 The Dangers of Passive Smoking

Exposure to passive smoking does have an adverse health effect on health (Allwright, 2005a, UK Department of Health, 2004, WHO, 2004, Californian Environmental Protection Agency, 2005). A report by the US Surgeon General (US Department of Health and Human Services, 2006) states that there is no risk free exposure to secondhand smoking. It highlights that even brief exposure to secondhand smoke has immediate adverse effects on the cardiovascular system and increases the risk of heart disease and cancer. In addition, because the bodies of infants and children are still developing, they are particularly vulnerable. Whilst the dangers of passive smoking are well documented in the scientific literature, there is evidence to suggest from the study that despite media campaigns designed to promote awareness of this issue, the dangers have not been fully realised by the population of the study area (Galway, Mayo, and Roscommon). Although over half perceived the risk of passive smoking in the home to themselves and others as high (after the introduction of the workplace ban), there does remain significant scope for improvement. There is a need to raise awareness of the risks of passive smoking. This should be achieved by employing 'best practice' techniques.

5.5 Smoke Migration

The dangers of smoke migration should be highlighted as the workplace smoking ban had no significant impact on the proportion of households allowing smoking in selected areas. Matt et al (2004) has found that smoking in different rooms, outdoors, or when non smokers are absent does not completely protect non smokers from tobacco smoke in the home. In Ireland, an air nicotine experiment conducted by Mulcahy (2005) as part of a television series on environmental health issues found that in the home of a ten cigarette a day smoker a sixth of air nicotine concentrations in the smoking room were detected in the bedroom of a child where no smoking took place.

5.6 Developing Initiatives to Address Smoking in the Home

Despite the evidence of a positive 'knock on' effect, smoking in the home remains a significant issue that may have a negative impact on population health. Half the households in the study allowed smoking after the introduction of the workplace smoking ban. This compares to 34% in USA (US Department of Health and Human Services, 2006). In addition, after the ban, 39% of households with children under 15 allowed smoking in the home. Based on the study findings and the number of households in the study area (Central Statistics Office, 2002) it is estimated that there are 61,901 Households in the HSE Western Area that allow smoking in the home, with 21 cigarettes a day smoked on average in these homes. Whilst extending current legislation to also cover smoking in the home could be problematic and may not be acceptable to the general public, the merits of introducing some additional legislation warrants further investigation. For example, legislation banning smoking in multi occupied buildings by families could be considered. In USA these have been the subject of a number of private litigation cases (Sweda, 2004). Initiatives should also be developed to encourage 'no smoking' in the home setting. Private households that have smoking rules adopted by household members can significantly reduce SHS exposure among children, reduce the risk of adolescents being smokers, and also help smokers to quit (US Department of Health and Human Services, 2006). Any initiatives that are developed should be based on 'best practice' and should be evaluated to ensure they are effective. At present, it is unclear

whether there are any interventions available that effectively reduce exposure at home. This suggests that there is a need for a detailed review to facilitate the development of home based initiatives in Irish homes. A review by the Surgeon General (US Department of Health and Human Services, 2006) in USA found that many studies were not systematically evaluated. Reporting on a review of 19 studies they concluded that home based interventions that tended to be more intensive in terms of frequency and duration are more effective than physician based interventions which tended to be less intensive. In addition, interventions based on behaviour change theory appeared to be more likely to be effective. They concluded that the optimum solution was to have a combination of physician and home based interventions. This review should be examined in further detail as part of a more extensive review.

Over a third of respondents allowed people to smoke in their home but would prefer if they didn't. The main reason these respondents gave for allowing people to smoke (85%) indicated a lack of assertiveness skills (e.g. to be sociable). The development of assertiveness skills appears to be an important component of any initiative targeting smoking in the home. This is supported by a study showing that assertiveness techniques are effective when used by non smokers for achieving compliance with a request to refrain from smoking (Leedom, 1986). This could be achieved through assertiveness training programmes for adults and for children. In children for example, the SPHE (Social, Personal, and Health Education) programme in schools does aim to develop assertiveness skills. In addition, a media campaign focusing on a concept that "it's ok for you to ask me not to smoke in your house" could also be considered.

6. CONCLUSIONS AND RECOMMENDATIONS

In conclusion, this study has shown the success of Ireland's workplace smoking ban in terms of having an impact on the home, an area not covered by the legislation. It also appears to be having a positive effect on reducing health inequalities. However, smoking in the home remains a significant public health issue which is continuing to have a negative impact on the health of the Irish nation. Half the households in the study allowing smoking in the home after the introduction of the indoor workplace ban. This places a significant challenge in terms of building a tobacco free society for policy makers and health practitioners. The following recommendations have been made to help facilitate this process:

1. The merits of introducing further legislation covering smoking in the home warrant further investigation (e.g. banning smoking in multi-occupied buildings).

2. A comprehensive review of initiatives that encourage 'no smoking' in the home should be undertaken. Following the review, initiatives should be developed to promote 'no smoking' in the Irish home setting.

3. Assertiveness skills should be developed to facilitate people who do not want others to smoke in their home. Assertiveness training programmes for adults and children (through programmes such as the Department of Education's Social, Personal, and Health Education Programme), and media campaigns designed to build assertiveness skills should be considered.

4. There is a need to raise awareness of the risks of passive smoking. This should be achieved by employing 'best practice' techniques.

5. The dangers of smoke migration from room to room should be highlighted to help reduce the proportion of households allowing smoking in selected areas.

6. Health inequalities should be addressed adopting a population health approach to smoking.

7. Current initiatives and strategies aimed at reducing inequalities at a local and national level should be supported.

7. REFERENCES

Adda, J, Cornaglia, F. The effect of taxes and bans on passive smoking, CEMAP working paper CWP20/05, Institute for Fiscal Studies, Department of Economics, University College London, 2005. Available at: http://cemmap.ifs.org.uk/publications.php?publication_id=3523. Accessed 14 June 2006.

Allwright S, McLaughlin P, Murphy D, Pratt I, Ryan M, Smith A, *A Report on the Health Effects of Environmental Tobacco Smoke (ETS) in the Workplace*. Health and Safety Authority, Office of Tobacco Control, Ireland 2002. Available at: http://www.otc.ie/article.asp?article=29. Accessed 25th January 2005a.

Allwright, S, Paul G, Greiner B, Mullally, BJ, Purcell, L, Kelly, A et al. Legislation for smoke-free workplaces and health of bar workers in Ireland: before and after study. BMJ 2005b; 331:1117. Available at: http://bmj.bmjjournals.com/cgi/content/full/331/7525/1117?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=allwright&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT. Accessed 14 June 2006.

Anderson, P. The Smoking Gun, In: I*nternational Union for Health Promotion and Education, The Evidence for Health Promotion Effectiveness, Shaping Public Health in a New Europe, European Commission, Brussels, 2000, p69-79.*

California Environmental Protection Agency: Air Resources Board, *Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant*. June 24 2005. TOBACCO Control. Surveys and program evaluations from outside UCSF, Paper CALEPA2005. Available at: http://repositories.cdlib.org/tc/surveys/CALEPA2005/. Accessed 19 December 2006.

Central Statistics Office, Census 2002, Volume 3 Household Composition and Family Units, The Stationary Office, Dublin, Ireland, August 2003. Available at: http://www.cso.ie/census/Vol3.htm. Accessed 18 December 2006.

Department of Health and Children. Quality and Fairness: A Health System for You, Government Publications, Ireland, 2001. Available at: http://www.healthreform.ie/publications/reports.html. Accessed 18 December 2006.

Fong, GT, Hyland, A, Borland, R, et al. Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK Survey. Tob Control 2006; 15: 51-58. Available at: http://tc.bmjjournals.com/cgi/reprint/15/suppl_3/iii51?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=fong&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT. Accessed 7 December 2006.

Health Canada, Population Health Approach, 2006. Available at: http://www.phac-aspc.gc.ca/ph-sp/phdd/. Accessed 7 December 2006.

Jamrozik, K. An estimate of deaths attributable to passive smoking in Europe, In The Smoke Free Partnership, Lifting the smokescreen, 10 reasons for a smoke free Europe, 2006, ERSJ Ltd, Brussels. Available at: http://www.ersnet.org/ers/show/default.aspx?id_attach=13509 Accessed 11 August 2006.

Jones, J, Evans, D.S, Donovan, F, Larkin, N., Promoting health in the west, A survey of the home as a setting for health promotion in the Western Health Board area, Health promotion Services, Western Health Board, Galway, 2003. Available at: http://213.94.192.203/uhtbin/cgisirsi.exe/bj4HFMTSx7/ADMINLIB/216730048/523/1494. Accessed 15 June 2006.

Kunst, AE, Groenhof, F, Mackenbach, JP, and the EU Working Group on Socioeconomic Inequalities in Health, Occupational class and cause specific mortality in middle aged men in 11 European countries: comparison of population based studies. BMJ 1998; 316:1636. Available at: http://bmj.bmjjournals.com/cgi/reprint/316/7145/1636?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=kunst&fulltext=occupational&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT. Accessed 7th July 2006.

Leedom, C. Persaud, D, Shovein, J. The effect on smoking behaviour of an assertive request to refrain from smoking, Int J Addict 1986, 21: p1113-1117.

Matt, GE, Quintana, JE, Hovell, MF et al. Households contaminated by environmental tobacco smoke: sources of infant exposures. Tob Control 2004; 13: 29-37. Available at: http://tc.bmjjournals.com/cgi/reprint/13/1/29. Accessed 11th July 2006.

Mulcahy, M. Passive smoking experiment, In Eco- eye series three, .A seven part series on the environment, 2004, Earth Horizon Productions, Dublin.

Mulcahy M, Evans DS, Hammond SK, Repace, JL, Byrne, M. Secondhand smoke exposure and risk following the Irish smoking ban: an assessment of salivary cotinine concentrations in hotel workers and air nicotine levels in bars. Tob Control 2005; 14: 384-8. Available at: http://tc.bmjjournals.com/cgi/content/full/14/6/34#BIBL. Accessed 14 June 2006.

O'Dowd, A. Smoking ban in public places also cuts smoking at home. BMJ 2005, 331:129. Available at: http://bmj.bmjjournals.com/cgi/reprint_abr/331/7509/129-b?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=o%27dowd&fulltext=smoking+ban&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT Accessed 11 August 2006.

Office of Tobacco Control. Ireland: Current trends in cigarette smoking, Clane, Kildare, Ireland, 2002. Available at: http://www.otc.ie/research_reports.asp. Accessed 11 July 2006.

Office of Tobacco Control, Ireland. National Law. Available at: http://www.otc.ie/legislation.asp. Accessed 19th January 2004.

Office of Tobacco Control. Smoke-free workplaces in Ireland, a one year review, Clane, Kildare, Ireland, 2005. Available at: http://www.otc.ie/Uploads/1_Year_Report_FA.pdf. Accessed 11 July 2006.

Office of Tobacco Control. Ireland: Current trends in cigarette smoking, Clane, Kildare, Ireland, 2002. Available at: http://www.otc.ie/research_reports.asp. Accessed 11 July 2006.

Okah, FA, Choi, WS, Okuyemi, KS et al. Effect of children on home smoking restriction by inner city smokers. Paediatrics 2002; 109:2 244-249.

Repace, JL ,Jinot J. Bayard S et al. Air nicotine and saliva cotinine as indicators of workplace passive smoking exposure and risk. Risk Analysis 1998: 18 (1), p71-83.

Repace JL, Al–Delaimy WK, Bernert, JT. Correlating atmospheric and biological markers in studies of secondhand tobacco smoke exposure and dose in children and adults. JOEM 2006: 48 (2), p181-194.

Sweda, EL. Lawsuits and secondhand smoke. Tob Control 2004; 13: 61-66. Available at:

http://tc.bmjjournals.com/cgi/reprint/13/suppl_1/i61?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=sweda&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT. Accessed 11 Sept 2006.

Thomson, G, Wilson, N, Howden-Chapman, P. Population level policy options for increasing the prevalence of smoke free homes, Journal of Epidemiology and Community Health 2006, 60: 298-304. Available at: http://jech.bmjjournals.com/cgi/content/abstract/60/4/298. Accessed 11th July 2006.

U.K. Department of Health. Scientific Committee on Tobacco and Health (SCOTH). *Second-hand Smoke: Review of evidence since 1998*. Department of Health. November 2004. DH Publications, London. Available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4101474&chk=%2BB7p/V. Accessed 18th December 2006.

U.S. Department of Health and Human Services, The health consequences of involuntary exposure to tobacco smoke, A report of the Surgeon General, Rockville, MD, 2006. Available at: http://www.surgeongeneral.gov/library/secondhandsmoke/report/fullreport.pdf. Accessed 18th December 2006.

Whitehead, M. Swimming Upstream, trends and Prospects in Education for Health, King's Fund Institute, London, 1989.

Whitlock, G, MacMahon, S, Vander Hoorn, S, et al, Association of environmental tobacco smoke exposure with socioeconomic status in a population of 7725 New Zealanders. Tob Control 1998; 7: 276-280. Available at: http://tc.bmjjournals.com/cgi/reprint/7/3/276?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=whitlock&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT. Accessed 7th July 2006.

WHO International Agency for Research on Cancer (IARC). Tobacco Smoke and Involuntary Smoking *Monograph on the Evaluation of Carcinogenic Risks to Humans* 2004.Vol 83.WHO IARC: Lyon. Summary available at:
http://monographs.iarc.fr/ENG/Monographs/index.php.
Accessed 18th December 2006.

APPENDIX 1

Q13a In relation to smoking where are people allowed to smoke in the house …

Everywhere in the house	1
Selected rooms	2
Nowhere	3
No one in the house smokes	4
Other (please specify)	5
Don't know	6
Not Applicable	7

Q13b Do you object / disapprove of other members of the household smoking?

Yes	1
No	2
Don't know	3
Not Applicable	4

Q14a How important or unimportant do you think it is, to change the alcohol use patterns and drink culture in this country, on a scale of 1 to 5,where 1 is very unimportant and 5 is very important?

Very unimportant	Fairly unimportant	Neither important or unimportant	Fairly important	Very important
1	2	3	4	5

SHOW CARD 'D'

Q14 b In which of the following should the Western Health Board be focussing on?

(Even in the role of persuading the relevant authorities i.e. Government Departments / Policing)

MULTICODE POSSIBLE

	Q14b	Q14c
Increase legal drinking age	1	1
Server liability (if serve underage)	2	2
ID cards for customers to prove age	3	3
Reduce licensing hours	4	4
Random breathalyser testing for drivers	5	5
Lower legal blood alcohol levels for drivers	6	6
Set blood alcohol levels for young drivers to zero	7	7
Increase tax on alcohol	8	8
Ban alcohol advertising	9	9
Ban alcohol sponsorship of sporting events	10	10
Warning on alcohol labels	11	11
Alcohol education in schools	12	12
Promote alternatives – alcohol-free activities	13	13
Other (please specify)	14	14
Don't know	15	15
None	16	16

Q14c Of the above, which in your opinion, are the 3 most important things that the Western Health Board should be focusing on?
(PLEASE CODE THREE ONLY ON GRID ABOVE)

APPENDIX 2

O.U.O		JOB NO:	50717

CLASSIFICATION

TO BE COMPLETED BY THE INTERVIEWER

MORI IRELAND

24 Windsor Place, Lower Pembroke St, Dublin 2

92-96 Lisburn Road, Belfast BT9 6AG

NAME: Mr/Mrs/Miss/Ms							
ADDRESS:							
POSTCODE							

TEL. NUMBER:		
	(STD Code)	(Tel. Number)

In household	1	Refused to say	3
None	2	Yes, but ex-directory	4

C.1 What was your age last birthday?

STATE EXACT AND CODE:

16 – 34	1
35 – 54	2
55+	3

SHOW CARD C1

C.2 Which of these describes you?

Single	1
Married / living as a couple	2
Widowed	3
Divorced / Separated	4

C.3 Please circle one of the following:

Male	1
Female	2

C.4 Status in Household:

Head of Household	1
Partner of Head of Household	2
Other Adult	3

C.5 Is your home owned or rented? PROBE

Owned outright	1
Being bought on mortgage	2
Rented Council	3
Rented privately	4
Other (***Specify***) _____	5

SHOW CARD C2

C.6 Which of these best describes you?

In Paid Job	
Working full-time 30 hrs+/week	1
Working 8-29 hrs/week	2
Working less than 8 hrs/week	3
No Paid Job	
Retired from full-time job	4
Unemployed	5
Housewife	6
Student	7
Other (***Specify***)_____	8

C.7 Which member of your household is the main shopper?

Self	1	Other (***Specify***) _____	2

Assignment Number:

Intv. Sign:			
Date of Intv:			
Intv. No:			

OFFICE USE ONLY			**Social Grade:**
A	1	C2	4
B	2	D	5
C1	3	E	6

Intervr. Checked	Supervisor Checked	Supervisor Accomp.	Back-checked	
			Tel	1
			Visit	2
			Post	3
			Date:	Initials:

C.8 Which member of your household would you say is the CHIEF INCOME EARNER, that is the person with the largest income, whether from employment, pensions, state benefits, investments or any other sources? **(If equal income is claimed for two people, classify the elder as the C.I.E.)**

Self	**A**	Go to Q.12
Other (**WRITE IN**)	B	Go to Q.11

C.9 Is ..... related to you?

Yes	A	Go to Q.12
No	B	Go to Q.12 (Respondent is C.I.E)

ASK ALL

C.10 Employment Status of C.I.E:

Does the C.I.E. have a paid job full-time or part-time?

Yes	*A*	Go to Q.14
No	B	Go to Q.13

SHOW CARD C3

C.11 Looking at this card, please tell me the statement that best describes the C.I.E. Just read out the letter of one that best applies.

A-Retired, gets pension from previous job	A	**Ask occ. details of previous job-Q.14**
B-Unemployed, less than 2 months	B	
C-Sick, still receiving pay or statutory pay from job	C	
D-Widow, receiving pension from husband's previous job	D	**Ask occ. details of husband's prev. Job**
E-Divorced/separated, receiving maintenance from ex-husband	E	
F-Full-time student	F	**Code SG C1 at Q.15**
G-Not working, private means	G	**Assess SG at Q.15**
H-Unemployed longer than 2 mths	H	**Code SG**
I-Sick - only receiving Income Support or Invalidity Benefit	I	**E at Q.15**
J-Receiving State Pension only	J	

C.12 Employment Status of C.I.E.:

- What type of firm/organistion does/did (C.I.E.) work for?
  WRITE IN:

_____

- What job does ..... do?
  WRITE IN:

_____

- Does ..... have any position/rank/grade in the organisation (ie., responsible for the work of other people)?

Yes	A	**No**	B

PROMPT AS APPROPRIATE (*Foreman, Sergeant, Office Manager, Executive, Officer etc.)*
IF YES,WRITE IN:

_____

AND ASK: How many people is ..... responsible for ? ☐

- Does ..... have any qualifications?

Yes	A	No	B

PROMPT AS APPROPRIATE:
Apprenticeship, professional qualifications, University degree)
WRITE IN:

_____

- **IF FARMER ASK**: How many acres do you farm? ☐

C.13 Assess Social Grade:

A	1	*D*	5
B	2	E	6
C1	3	F1 (50+ acres)	7
C2	4	F2	8

C.14 Interview Location

Galway	1
Mayo	2
Roscommon	3

C.15 Is this an ... area

Urban	1
Rural	2

C.16 How long have you lived in this area

One year or less	1
Between 1 and 2 years	2
Between 3 and 5 years	3
Between 5 and 10 years	4
More than 10 years	5

C.17 Do you have a general medical services card?

Yes	1
No	2

C.18 What is the highest level of education that you have completed, was it ...? READ OUT

Primary	1	Third level	3
Secondary	2	Still studying (Third Level)	4

Health Service Executive Western Area (50717)

Good morning/afternoon/evening, my name is ... from MORI Ireland, a market research company. We are conducting a very short piece of research on smoking in the home for the Health Service Executive and I'd like to ask you some questions.

Q1 How many people are there in the household, including yourself?

Q2a Are there any children under the age of 16 in the household?

Yes	1
No	2

Q2b If yes, can I please have their ages?

	Age	
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		
Child 6		

(if more than six children, ask for the ages of the youngest six children)

Q3 Do you currently smoke tobacco, such as cigarettes, cigars or a pipe?

Yes	1
No	2

Q4 If yes, how many do you smoke per day?

Q5a How many people in your household smoke tobacco, including yourself? Please push for best estimate

Q5b How many cigarettes per day are smoked in your household? Please push for best estimate

Q6 Can you please rate on a scale of 1 to 5 your level of agreement or disagreement with the introduction of the total smoking ban in public places, where 1 is disagree strongly and 5 is agree strongly.

1	2	3	4	5

Q7 **In relation to smoking where are people allowed to smoke in the house …**

PROBE TO PRECODES SINGLE CODE

Everywhere in the house	1
Selected rooms	2
Nowhere	3
Other (please specify)	4
Don't know	5

Q8a **Has your attitude to where people are allowed to smoke in your home, changed since the introduction of the smoking ban?**

Yes	1
No	2

If "Yes"

Q8b **In what way has your attitude changed?**
PROBE FULLY AND RECORD VERBATIM

Ask Q9 if code " Everywhere in House" / "selected rooms" at Q7

Q9 **Would you prefer if people did not smoke in your home?**

Yes	1
No	2 Go to Q12

If "Yes" at Q9

Q10 **Why do you allow people to smoke in your home?**
PROBE FULLY AND RECORD VERBATIM

If "Yes" at Q9

Q11 What would help you to ask people not to smoke in your home?
PROBE FULLY AND RECORD VERBATIM

ASK ALL

Q12 Do you object / disapprove of other members of the household smoking?

Yes	1
No	2
Don't know	3
Not Applicable	4

Q13 Can you tell me if - you approve / disapprove / neither approve nor disapprove with the following?

ROTATE AND TICK START		Approve	Disapprove	Neither Approve / Disapprove	Don't know
☐	**People smoking tobacco in general**	1	2	3	4
☐	**Visitors smoking tobacco in your home**	1	2	3	4
☐	**People smoking tobacco around young children**	1	2	3	4
☐	**People being allowed to smoke directly outside the doorways of pubs?**	1	2	3	4

Q14 What health risk do you believe smoking in your home has on the health of ...

	No risk	Low risk	Medium risk	High risk	N/A
Yourself	**1**	**2**	**3**	**4**	**5**
Your Children	**1**	**2**	**3**	**4**	**5**
Other adults living in your home	**1**	**2**	**3**	**4**	**5**

Q15 Do you allow people to smoke in your car?

Yes	1
No	2
Do not have a car	3

If "YES" at Q15

Q16 Do you allow people to smoke in your car if there are children present?

Yes	1
No	2

ASK ALL

Q17 The Health Service Executive is conducting research in 2006, to evaluate the air quality of homes in the region – would you be willing to participate in this study?
All participants will receive a free confidential report detailing the air quality of their home.

Yes	1
No	2

Q18 If yes, have we your permission to pass your contact details to the Health Service Executive to enable it to conduct this research?

Yes	1
No	2

THANK RESPONDENT AND COLLECT CLASSIFICATION DETAILS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Health Promotion Services, HSE West, St Mary's Headquarters, Westport Road, Castlebar, Co. Mayo
Phone: 094 9042266 Fax: 094 9022716 Email: healthpromotion@mailn.hse.ie

Front cover designed by Frank O'Reilly, Westport, Co. Mayo