Building the Case for Smoke-Free Public Outdoor Spaces

Technical Report

November, 2011

MIDDLESEX-LONDON HEALTH UNIT

PLAY, LIVE, BE TOBACCO-FREE

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Public Health Ontario's Smoke-Free Ontario Scientific Advisory Committee's report "Evidence to Guide Action: Comprehensive Tobacco Control in Ontario".

Physicians for a Smoke-Free Canada is a national health organization, founded in 1985 as a registered charity. It is a unique organization of Canadian physicians who share one goal: the reduction of tobacco-caused illness through reduced smoking and reduced exposure to second-hand smoke.

Smoking and Health Action Foundation is a national, non-profit health organization formed in 1974 to conduct public policy research and education designed to reduce tobacco-related disease and death. SHAF is the sister organization of the Non-Smokers' Rights Association, and acts as a policy think-tank for governments and NGOs in Canada and abroad.

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Introduction

In September 2011, the Board of Health for Middlesex-London passed the following motion:

> 1. **That the Board of Health endorse the Smoke-Free Outdoor Public Spaces Position Statement attached as Appendix A to Report No. 081-11; and further**
> 2. **That the Board of Health direct staff to prepare a report summarizing existing municipal bylaw amendment options for establishing smoke-free outdoor public spaces.**

In addition, Health Unit tobacco control staff members were directed to include information on waterpipe use (hookah and shisha use), the reasons for its increasing popularity, and the health effects of waterpipe use and policy options to address this growing public health issue within the City of London and across Ontario.

This report has been prepared as directed by the Board of Health.

Background

Smoking and other forms of tobacco use remain the leading cause of preventable death and disease in Ontario. Currently, tobacco use costs the Ontario economy an estimated $7.73 billion annually. For 2009, the use of tobacco products cost Ontario $1.93 billion in direct health care costs. These costs include specialized inpatient and outpatient treatment, ambulatory care, and prescribed drugs. When you factor in lost productivity from illness, hospitalization and death, these costs become much higher. In 2002, tobacco use cost the Ontario economy $4.4 billion in lost productivity, and accounted for 2.2 million acute care hospitalization days.[i]

Despite the significant achievements that have been made in tobacco control, the public health community still faces many challenges, including

- Elimination of the remaining exposure to tobacco smoke
- Absence of an ongoing media campaign to denormalize the tobacco industry and promote protection, prevention and cessation
- Persistent inequities with regard to reaching sub-populations
- Low prices of tobacco products and low tobacco taxes
- Widespread availability of contraband tobacco products
- Innovative marketing and other activities of the tobacco industry
- The lack of a federal tobacco control strategy to address some of the broader, national tobacco issues that burden our communities.

The Ontario Public Health Agency's Evidence to Guide Action Report, prepared by leading tobacco researchers, calls for policy changes to provide further protection from second-hand smoke. The evidence indicates that as part of the next phase of tobacco control across Ontario, policy changes that would eliminate exposure to outdoor tobacco smoke and limit youth's exposure to tobacco use are required.

Ontario has a history of progressive legislation providing protection from second-hand smoke. Numerous municipalities, including the City of London and the County of Middlesex in 2003, have enacted bylaws to ensure that all enclosed public places and workplaces are smoke-free. The *Smoke-Free Ontario Act* (*SFOA*) came into effect May 31, 2006, prohibiting smoking in enclosed workplaces and public places. The law includes a ban on smoking within nine metres of entrances and exits to healthcare facilities. In addition, the law prohibits smoking in common areas of multi-unit dwellings and partially enclosed restaurant and bar patios. Effective January 21, 2009, an amendment to the *SFOA* prohibits smoking in motor vehicles when children under the age of 16 years are present. The provincial legislation helped create a more level playing field for proprietors across Ontario, and a standard level of protection from second-hand smoke exposure. Emerging evidence and results from public opinion surveys has demonstrated that the current provincial standard of second-hand smoke protection is not high enough, and that bylaws that extend protection beyond that covered by the *SFOA* are required.

A provision of the *SFOA* permits municipalities to pass smoking bylaws which exceed the requirements of the *Act* and where such bylaws are in place, "the provision that is more restrictive of smoking prevails". Under Section 115 of the Municipal Act, municipalities have the authority to enact bylaws to prohibit or regulate the smoking of tobacco in public places and workplaces. Under this section, a bylaw shall not apply to a highway but may apply to public transportation vehicles and taxicabs on a highway. This legislative authority and public health's experience in the tobacco control policy domain positions the Health Unit, the City of London and the County of Middlesex nicely to work together to respond to the community's demand for greater prohibitions on smoking and social exposure to tobacco use.

Emerging Issues and New Evidence

Hookah: Increasing Use of Waterpipe Smoking in Ontario

Described as a global epidemic[ii], waterpipe smoking (hookah) has been growing in popularity since the 1990s. No longer is waterpipe-use just the domain of older Middle Eastern men; it has become a chic and popular social activity among young people. Hookah lounges or cafes are popping up across North America, with many of them being situated in university or college towns, like the City of London. There are at least 400 hookah lounges or bars in the United States, likely many more, representing a 400% increase since 1999[iii]. At last count, there are over 130 hookah bars in Ontario alone, with another 500+ retailers selling combustible waterpipe preparations, also commonly known as shisha[iv]. Currently, we have five establishments within the City of London offering hookah smoking to its patrons. There are no legal age restrictions in place for who smokes shisha at these establishments.

Hookah is known by many different names, including shisha, hubble-bubble and goza. The waterpipes are made in a variety of designs, but essentially, the smoke of the substance is passed through water ("bubbled") before inhalation. A typical modern hookah comprises of a head (with holes in the bottom), a metal body, a water bowl and a flexible hose with a mouthpiece. The substance being smoked is

placed in a small bowl with holes in the bottom, to which is attached a tube that allows the smoke to be drawn to the bottom of the water container. The tobacco or herbal shisha does not burn independently, but is heated and partially burned by the addition of a hot coal or burning ember to the bowl. One or more tubes are attached to the top of the water container to allow multiple user(s) to inhale and thereby draw smoke out of the bowl, through the water and into the lungs. Groups of young people can be seen passing the tube around from person to person, often using the same mouthpiece.

It is difficult to know what ingredients are in shisha because at retail there is poor labeling of both manufactured tobacco shisha and manufactured "herbal" shisha. This lack of clarity regarding the ingredients in shisha is further compounded by the practice of many hookah cafes whereby they manually prepare non-standardized shisha mixtures on-site. Tobacco shisha is a moist mixture of tobacco, preservatives and flavourings held together with molasses or honey. Anecdotally, tobacco shisha seems to be comprised of a mixture of 5% to 30% tobacco and 70% to 95% honey or molasses, but this is not reflected on the packaging or on manufacturers' websites. There are varying amounts of nicotine, but it does appear that washed shisha has lower amounts of nicotine (0.05%) than unwashed shisha (0.5%); however, the tobacco shisha manufacturers do not provide reliable consumer information.

The contents of "herbal" shisha are even less clear, however, honey and molasses seems to be the binders used in the preparation. Product information labels on packages use non-descriptive terms like "herbs", "flavours", and "preservatives".

Hookah use is a public health issue for many reasons. Waterpipe smoking is a new "hip" trend among young adults worldwide, including Canada, due to flavourings, exotic appeal and the misperceptions about the health effects of its use. Recent survey data indicates 23% of young Canadians aged 18-24yrs reported smoking a waterpipe in the previous year.[v] According to the Canadian Youth Smoking Survey, almost 7% of Canadian youth in grades 7 – 12 reported ever using a waterpipe, and 3% of them claim to have done so in the past 30 days[vi]. The Canadian Tobacco Use Monitoring Survey (2006) reported that 4% of Canadians aged 15 years and older reported ever trying a waterpipe and 1% reported waterpipe use in the last month[vii].

While many hookah smokers consider this practice less harmful than smoking cigarettes, it carries many of the same health risks as smoking cigarettes. Using hookah to smoke tobacco shisha delivers the addictive drug nicotine and is at least as toxic as cigarette smoke. Due to the mode of smoking (including frequency of puffing, depth of inhalation and the length of the smoking session) hookah smokers may absorb higher concentrations of the toxins found in cigarette smoke. A typical 1hr long hookah smoking session involves inhaling 100-200 times the volume of smoke inhaled from a single cigarette. This deeper, more frequent inhalation means that a typical 20-80 minute hookah session is equivalent to smoking 100 cigarettes, exposes you to up to 200 times the volume of smoke compared to a single cigarette and can triple your nicotine exposure. Hookah smokers are at risk for the same kinds of diseases that are caused by cigarette smoking, including oral cancer, lung cancer, stomach cancer, cancer of the esophagus, reduced lung function and decreased fertility.

Hookah smoking emits second-hand smoke, just like cigarette smoking. The charcoal used to heat tobacco in the hookah increases the health risks by producing high levels of carbon monoxide, metals and cancer-causing chemicals, even after it passes through water. Second-hand smoke from hookahs poses a serious risk for non-smokers, particularly because it contains smoke not only from the tobacco but also from the heat source (i.e. the charcoal) used in the hookah. The prolonged duration of a hookah smoking session increases the level of exposure. The health impacts of smoking 'herbal" shisha and the exposure to second-hand smoke from burning "herbal" shisha have been less rigorously studied; however, users are breathing in a combustible product and bystanders are breathing in the by-

products from combustion. Many of the cancer-causing chemicals and negative health effects from cigarette smoking and cigarette second-hand smoke are a result of the combustion, not from the specific product being burned.

The *SFOA* only applies to smoking or holding lighted tobacco; the smoking of other substances is beyond jurisdiction. Some hookah establishments have been found to remove tobacco shisha from its original packaging and store it in unlabelled containers, claiming the product to be “herbal”, circumventing the *SFOA* and allowing customers to smoke indoors. The combustion of any vegetable matter produces byproducts, including particulate matter and carbon monoxide that are harmful to human health. By allowing smoking in enclosed public places, these allowances are confusing to the public and it undermines our efforts to enforce the *SFOA* and to protect people from harmful second-hand smoke exposure.

It is common practice for two of more people to share a hookah pipe, which may have one or two hoses for the whole group. There are no public health requirements in Ontario for hookah lounges to properly clean and disinfect hoses between smoking sessions. Sharing hoses and mouthpieces pose risks for the transmission of communicable diseases such as tuberculosis, hepatitis, influenza and mononucleosis.

Numerous types of shisha on the market (tobacco and herbal) do not meet various federal and provincial regulations. Violations include lack of information for consumers regarding ingredients and nicotine content, improper health warnings, if any at all, and failures to pay federal and provincial tobacco taxes. There are no age restrictions on the sale or supply of ‘herbal” shisha to persons under the age of nineteen, but given the practice of mixing herbal and tobacco shisha, or the uncertainty that ‘herbal’ shisha is in fact free of tobacco or nicotine, we have young people being sold a product that is harmful for indoor consumption.

Urgent action is required to halt the rapid spread of waterpipe smoking to protect the health of our young people and to limit people’s exposure to second-hand smoke. There may be an opportunity for single-tier municipalities to enact legislation under Section 10.2(6) and upper-tier municipalities under Section 11.2(6) to regulate hookah bars to ensure the health, safety and well-being of persons; however, given that this has not yet been explored in Ontario, the Health Unit has secured legal assistance to explore authority and jurisdiction under the Municipal Act.

Smokeless Tobacco: Smokeless Does Not Mean Harmless

Chewing tobacco, also called spit tobacco, chew or plug, comes in two forms, snuff and chewing tobacco. Snuff is a fine-grain tobacco that often comes in teabag-like pouches, which users "pinch" or "dip" between their lower lip and gum. Chewing tobacco comes in shredded, twisted, or "bricked" tobacco leaves that users put between their cheek and gum. Whether it's snuff or chewing tobacco, users let it sit in their mouths and suck on the tobacco juices, spitting often to get rid of the saliva that builds up. This sucking and chewing allows nicotine to be absorbed into the bloodstream through the tissues in the mouth.

Smokeless tobacco contains nicotine, over 28 carcinogens, sweeteners, flavourings (such as mint, cherry, strawberry daiquiri), salt and other chemicals that contribute to health problems. Smokeless tobacco also contains abrasives which wear down the surfaces of teeth, and scratch the soft tissues in the mouth to ensure more rapid absorption of the nicotine and other chemicals into the blood system.

One dip equals out to more than one cigarette in terms of the amount of nicotine absorbed into the body, allowing for even more nicotine to get to the brain with one “use”

The use of chewing tobacco has always been a public health issue; however, historically, a small percentage of the population used these forms of tobacco products. Unfortunately, we have reports that the use of smokeless tobacco is rising across Ontario. There is a misperception that smokeless tobacco is a safe alternative to smoking cigarettes. Despite federal and provincial legislation banning the addition of flavours to cigarillos and small cigars, and stricter packaging requirements for cigarillos, youth and young adults are still being targeted by the tobacco industry. The industry is adding delicious, candy-flavours to smokeless tobacco and is changing the packaging to appeal to the youth and young adult market. Evidence indicates that Canadian youth and young adults, aged 15-24 years, are the highest users of smokeless tobacco compared to other age categories. More young men than young women use smokeless tobacco products, and surprisingly, use is highest in young men who are involved in athletics. The more youth witness tobacco use, the more likely they are to try it themselves; when they see leaders within their cohort or role models using smokeless tobacco, the more likely they are to have positive associations to smokeless tobacco use, and then as a result, be more likely to initiate using these harmful products.

The short-term health effects of using smokeless tobacco includes increased heart rate, decrease in appetite, addiction to nicotine, increased chances of sores forming in the mouth where chewing tobacco is held and cracking and bleeding of lips and gums. Continued use of smokeless tobacco can result in irregular heart beats, high blood pressure, leading to a greater risk of heart attack and brain damage, tooth and gum disease, bad breath, mouth sores, sensitive teeth and receding gums. Long-term health consequences of using smokeless tobacco include increased risk of heart disease and many cancers, including oral cancer and cancer of the stomach, throat and oesophagus.

The *SFOA* only applies to smoking or holding lighted tobacco; therefore, there are no provincial regulations in place which limit where smokeless tobacco can be used. Smokeless tobacco can be used anywhere outdoors and even indoors at arenas, concert venues, work or even at school, unless policies banning smokeless tobacco are put into place. When children and youth observe family, friends and role models like their coaches or local athletes using smokeless tobacco, they are more likely to begin using smokeless tobacco as a means to be just like their heroes.

Policy options which address smokeless tobacco, as well as smoked tobacco, provides consistent messages about how both are harmful and that a healthy community is one that is free from exposure to tobacco use and second-hand smoke. There may be an opportunity for single-tier municipalities to enact legislation under Section 10.2(6) and upper-tier municipalities under Section 11.2(6) to regulate smokeless tobacco use to ensure the health, safety and well-being of persons; however, given that this has not yet been explored in Ontario, the Health Unit has secured legal assistance to explore authority and jurisdiction under the Municipal Act.

Tobacco Smoke and Social Exposure to Tobacco Use

Second-hand smoke (also referred to as environmental tobacco smoke or passive smoking) is a mix of smoke that is exhaled and smoke that is emitted when a tobacco product is burned such as in cigarettes, cigars, cigarillos, or water pipes. Second-hand smoke contains over 4000 chemicals of which more that 50 are known carcinogens. Some of the chemicals that can be found in cigarettes are: carbon monoxide (found in car exhaust), ammonia (found in window cleaners), cadmium (found in

batteries), arsenic (rat poison), benzene, acetone and formaldehyde[viii]. According to the World Health Organization there is no safe level of second-hand smoke and all exposure to tobacco smoke should be eliminated.

Table 1. Adverse Long-Term Health Effects of Second-Hand Smoke Exposure

SHS Exposure and Adults	SHS Exposure and Children	SHS Exposure and Pregnant Women
▪ Acute respiratory illness ▪ Heart disease ▪ Cancer (including breast) ▪ Premature death ▪ COPD ▪ Stroke	▪ Exacerbations of asthma ▪ Decreased lung function ▪ Lower respiratory illness ▪ Middle ear infections ▪ Sudden Infant Death (SIDS) ▪ Low birth weight ▪ Adverse impact on cognition and behaviour	▪ Spontaneous abortion/miscarriage ▪ Premature birth ▪ Congenital anomalies and smaller head circumference

In addition to the above health concerns, second-hand smoke can have immediate affects such as asthma attacks, headaches, nausea, vomiting and irritation of the nasal passage way[ix].

Some of the adverse health effects are more severe for infants and young children because their bodies, lungs and brains are still in development and they have higher respiratory rates than adults. Children and youth are especially vulnerable to the poisons in secondhand smoke and when compounded with the fact that exposure to second-hand smoke in childhood can persist into adulthood (longer duration of exposure), only emphasizes the severity of exposure to second-hand smoke[x]. It is estimated that for every eight smokers who die from smoking, one non-smoker will die from second-hand smoke.

Second-hand smoke can be found wherever a tobacco product is burned such as in the entrance to doorways of buildings and workplaces, at local transit stops, at sports events, and basically in any public outdoor space where there is a smoker. When looking at outdoor places there is a common belief that it is safe to smoke outdoors because the smoke will drift away, or individuals can move out of the way of the second-hand smoke. However, children are less likely to leave a smoke filled place or even complain about the level of smoke, given the difference in power between an adult and a child. In addition, there are places that are nearly impossible to avoid exposure to second-hand smoke, including entrance-ways or restaurant patios, and there is often repeated exposure if that place is visited frequently, like the door way to a workplace.

In 2009, it was estimated that 54% of individuals were exposed to second-hand smoke at an entrance in the last month[xi]. Recent research indicates that outdoor levels of tobacco smoke within one to two metres of a lit cigarette can be as high as indoors[xii]. If there is no wind, tobacco smoke will rise and fall and will saturate the local area with second-hand smoke; if there is a breeze, tobacco smoke will spread in various directions, and will expose non-smokers down-wind[xiii]. Depending upon weather conditions and air flow, tobacco smoke can be detected at distances between 25-30 feet away[xiv]. The closer an individual is to tobacco smoke, and the greater the number of lit cigarettes, the greater the amount of tobacco smoke, and consequently, the greater the harm. For example, if the number of lit cigarettes increases, the concentration of tobacco smoke can increase 2.5-3 times and be detected 9m away[xv].

In addition to emerging evidence on outdoor exposure to second-hand smoke, it has been identified that the application of Social Norms Theory is invaluable to explain tobacco initiation in young people. Tobacco use is increasingly influenced by social norms and what is seen as acceptable or normal

behaviour [xvi]. Therefore, in order for young people to see smoking as less common, tobacco use needs to be removed from our cultural landscape and made less visible. It is important for youth to receive the same tobacco-free messages in their wider community as they experience at school.

In addition, a person's behaviour is influenced by the perception of how others behave in society, meaning that an individual is more likely to engage in harmful behaviour if that behaviour is seen as typical behaviour[xvii]. The large crowd of smokers standing at the entrance way to the local library normalizes tobacco use; tobacco use is an addiction and policies which restrict where people can smoke will send a strong, consistent message to young people that a healthy life is one that is free from tobacco use.

Worldwide over 4.5 trillion cigarettes are littered each year and cigarettes have been considered the most littered item in the world. Cigarette butts are non-biodegradable and can take up to 12 years to break down into smaller particles. This is mostly due to the cellulose acetate, a form of plastic, which is found in the cigarette butt filter[xviii]. Discarded cigarette butts leach chemicals and toxins into the soil and into water systems. In parks and playgrounds, discarded cigarette butts are picked up and eaten by children and pets. It only takes two to three cigarette butts to harm or kill a small animal[xix].

Furthermore, there is the concern of discarded cigarette butts and our homeless population. It has been found that due to the strength of the addiction, many homeless individuals will resort to borrowing, sharing, selling cigarettes and even "sniping", the smoking of discarded cigarette butts or rerolling of discarded cigarette butts. The latter not only makes these individuals more susceptible to tobacco related disparities but also potentially exposes them to infectious diseases[xx]. Cessation supports, along with greater restrictions on where tobacco is smoked will provide greater protection for our most vulnerable populations.

Stronger restrictions on smoking in outdoor public places can have a protective effect on smoking uptake among youth and young adults, supports those who are currently addicted to tobacco trying to quit, and improves the health of our environment.

Strong Public Support for Smoke-Free Outdoor Spaces

Public support is an important factor to consider when implementing smoking restrictions, such as those commonly found in smoke-free outdoor public places bylaws. Often there is concern that increased smoking restrictions will negatively impact business or the public's use of facilities where smoking restrictions have been put into place. However, when reviewing the many municipal smoke-free outdoor public places bylaws that have been enacted since 2000 and their impact, this has not been the case. In many jurisdictions where public support for the smoking restrictions had been high, once the bylaw came into effect, support for the smoking restrictions increased even more, in both non-smokers and smokers[xxi]. Generally support was highest in places where children play and congregate such as parks and recreational fields.

The City of Woodstock's Smoke-Free Outdoor Public Places Bylaw has been in effect since September 2009 and their evaluation showed that there has been no negative impact on the use of facilities such as parks or recreational fields, and 84% of smokers in Woodstock stated that their outdoor smoke-free bylaw was good for their children's health. In Ottawa, there was an Ipsos Reid telephone survey conducted of 400 Ottawa residents and it showed that 73% were in favour of smoking bans on patios, 77% for parks and playgrounds and 68% for beaches. The highest support that they found was for entrances to doorways to public places (84%). In Sarnia-Lambton, who is currently looking going

through a similar process, their support has ranged from 68% - 89%, with doorways to public places (89.1%) and doorways to workplaces (87.8%) being the highest support followed by public playgrounds (79.1%) and sports fields (76.1%).

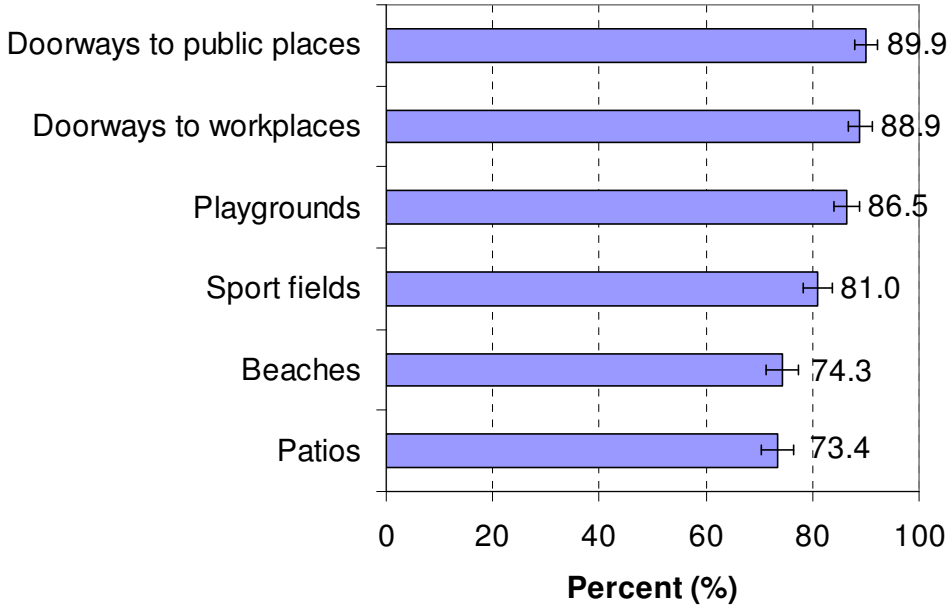
Internationally, in Upper Hutt Council, New Zealand, 83% of park users thought that it was a good idea. Minnesota has been an international leader, and when their park directors were interviewed, ninety percent (90%) of park directors in parks with tobacco-free policies would recommend a tobacco free-park to other communities, and 83% said it was not difficult at all to establish such parks[xxii].

Strong Public Support for Middlesex-London

When looking locally at the Middlesex-London area, the support continues both in the City of London and Middlesex County. Between May and December of 2009 data was collected from the Rapid Risk Factor Surveillance System (RRFSS).

Figure 1. Support for local by-laws for smoke-free public places.

Adults (18+) in Middlesex-London May – Dec 2009.



Source: RRFSS May – Dec 2009.

* It is important to note that only 5.3% (± 1.6%) of the respondents did not support any suggested by-laws.

The highest level of support was observed for doorways to public places (89.9% ± 2.1%), doorways to workplaces (88.9% ± 2.2%), and playgrounds (86.5% ± 2.4%). Support for smoke-free sport fields was found among 81.0% (± 2.7%) of adults, and among three-quarters for smoke-free beaches and patios (74.3% ± 3.1% and 73.4% ± 3.1%, respectively).

In addition, the Middlesex-London Health Unit's Tobacco Control Program receives a number of inquiries and complaints from concerned citizens about smoking in outdoor spaces, including doorways to public places and workplaces. When looking at the above data and drawing upon the experiences of other municipalities who have enacted outdoor smoking restrictions, it can be anticipated that public

support will continue to increase once the residents of the City of London and Middlesex County see the benefits that can come from such bylaws.

Relationship to Public Health Mandate

The mandate of the Middlesex-London Health Unit, as defined by the Ontario Ministry of Health and Long-Term Care, Ontario Public Health Standards (2008) is to promote and protect the health of Middlesex-London residents by providing public health programs and services that contribute to residents' physical, mental and emotional health and well-being. Under the Chronic Disease and Injuries Program Standards, the Health Unit's goal is to reduce the burden of preventable chronic diseases of public health importance, which include cardiovascular disease, cancer, respiratory diseases and type II diabetes. The reduction or elimination of exposure to tobacco smoke and the adoption of tobacco-free living through bylaw amendments is grounded in evidence as a best practice, and will significantly reduce the burden of disease and death from tobacco use.

Scan of Ontario Bylaws

Almost 60 Ontario municipalities have enacted bylaws regulating smoking in outdoor public spaces[xxiii]. In addition, dozens of other municipalities including the City of Ottawa, City of Kingston, Grey-Bruce County and Region of Waterloo are in the development/consultation phase of smoke-free public outdoor spaces bylaws.

These bylaws and the restrictions they entail generally fall under 6 categories. Some smoke-free outdoor places policies also prohibit smoking on City / municipally-owned property, and community/special events which may or may not fall under one of the 6 categories mentioned below.

These 6 categories are:

1. Smoke-free parks, playgrounds and recreational fields (27)
2. 100% smoke-free patios (8)
3. Hospitals or LTC grounds (4)
4. 100% smoke-free hotels (1)
5. Smoke-free beaches (6)
6. Buffer zones around doorways, air intakes, transit shelters (32)[xxiv]

The following chart provides an overview of outdoor smoking restrictions in public places. A complete listing of all municipal bylaws which currently exceed provincial or federal regulations is available online at http://www.nsra-adnf.ca/cms/file/Compendium_Winter_2011.pdf.

Table 2. Overview of Outdoor Smoking Restrictions in Ontario Municipalities

Municipality	Year Implemented	Restrictions / Policy
Barrie	2010	Prohibits smoking in any public place within the city whether or not a No Smoking sign is posted
Clearview	July 2009	Smoking prohibited in public places defined as: municipal building, playground area, playing field and municipal property. With a 9 meter rule for the entrance to any municipal building, playground area, and playing fields. Municipal property means any outdoor area owned or operated by the city
Collingwood	2000 Amended June 2005	Smoking was prohibited within 25 metres of any playground equipment defined as: swings, slides, climbing apparatus, facilities expressly designed for rollerblades, and municipally-owned swimming pools. The definition does not include facilities for hockey, baseball or walking and biking trails. As of June 2005 the bylaw was amended to include 25 metres from playing fields
Hamilton	May 2011 (in effect May 2012)	A complete smoking ban on any city-owned recreational property (excludes golf courses).
Orillia	Feb 2010	No person shall smoke in any place, including but not limited to, those designated under section 9253.2.1 which includes within 10 metres from a playground area, 10 metres from a beach area, 10 metres of a sport activity area, 10 meters from an entrance to a municipally owned or managed building
Sault Ste. Marie	2003 amended 2005, 2007, 2009 and 2011	No person shall smoke any public place within the City or in a City building whether or not a sign is posted; no person shall smoke at any City entranceway; 15 metres of a playground area and recreational field; no person shall smoke on the Sault Area Hospital site; no person shall smoke on the Algoma Public Health site.
Thunder Bay	2004 amended in 2010	10 metres radius of the entrance to a recreational Facility; 10 metres of any playground equipment that it located on land owned by the corporation, 10 metres from the edge of the beach (water's edge), 3 metres from the entrance to a workplace. Smoking is also prohibited on a patio.
Woodstock	September 2008	No one shall smoke or hold lighted tobacco in any downtown sidewalk café, within 30 meters of any playground equipment or 15 metres from any baseball diamond, soccer pitch or tennis court, within 4 metres of any bus stop, and within 9 metres of the entrance to any municipal owned building.
Niagara Falls	May 2010 (in effect May 2011)	Complete smoking ban on any city owned park (included playgrounds, sport & recreation fields, skate parks, sport and recreation seating and community events)
City of Peterborough	December 2007 (last revision May 2011)	Parks (9 m) Playgrounds, skate parks, splash pads (9 m) Beaches (9 m) Sport & recreation playing fields includes seating (9 m) Municipal entrances (9 m)
Ottawa	August 2004 (currently undergoing community consultation to go 100% smoke-free.	Municipal parks (9 m) Playgrounds (9 m) Beaches (9 m) Sport & recreation playing fields (9 m) Municipal entrances (9 m)

Smoke-Free Public Outdoor Spaces Policy Options

The list below reflects four available options presented in order from least restrictive to most restrictive of smoking in public outdoor spaces.

The authors would like to acknowledge and thank Lambton County Community Health Services Department, the City of Ottawa's Public Health Department and the City of Woodstock for their assistance.

Table 3. Options for the Regulation of Outdoor Smoking

OPTION 1	PROS	CONS
No smoking within nine (9) metres of: a) All public playgrounds and arenas, including but not limited to swimming pools, splash pads, sports and recreation playing fields, outdoor areas used for public enjoyment and recreation areas for children such as petting zoos, trails, and public gardens. b) All public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation.	• Moves exposure to ETS out of danger zone for the listed settings. • Most people believe existing law requires a buffer of 9 m from all entrances.	• Several public settings not included. • A defined distance (9 m) creates confusion with a setting since the property boundary may be unclear. • Creates confusion re: "How far is 9 metres?" • Places increased demands on enforcement staff. • Does not address role modelling or social norms concerns. Children still view the smokers. • Not reflective of trends for outdoor bylaw development in other communities. Bad image for our communities. • Safety concerns - adults attempting to smoke 9 m from child/setting can no longer actively supervise.

OPTION 2	PROS	CONS
A complete smoking ban in: a) All outdoor areas used for public enjoyment and recreation areas for children, including but not limited to parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals, etc.) b) All municipally-owned and/or operated recreational properties* ❑ No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation). ❑ Application process required for Designated Smoking Areas at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult. * Exemptions for long-term care homes, campgrounds, beaches, and golf courses - current legislation to apply.	• Increased protection from ETS. • Complete ban is easier to understand and obey; easier to enforce. • Festival option for designated smoking area addresses concerns of organizers of events whose audience is adult. Requires consultation with Enforcement Officers which provides an opportunity to explain the Smoke-Free Ontario Act and ensure increased compliance. • Less litter. • Attempts to address role modelling and social norms related to child focused settings. • Reflects recent trend for outdoor bylaw development.	• Does not include beaches, or golf courses. • While exemptions may increase perception of co-operation with festival and event organizers, residents and workers/volunteers would potentially be exposed to environmental tobacco smoke. • Festival organizers required to apply for a designated smoking area.

OPTION 3	PROS	CONS
A complete smoking ban in: a. All outdoor areas used for public enjoyment and recreation areas (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals and public beaches) b. Municipally-owned and/or operated recreational properties* c. All outdoor seating areas - bar and restaurant patios ❑ No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation). ❑ Application process required for Designated Smoking Areas (DSAs) at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult. ❑ Application process enabled for hospital campuses, university campuses and college campuses to be named within a schedule of the bylaw for designated smoking areas (DSAs) or for 100% smoke-free campuses. * Exemptions for long-term care homes and campgrounds - current legislation to apply.	• As above and: • Enforcement simplified with a clearer message on restrictions. • Protects staff and patrons who work/dine outdoors on patios equally with those who work/dine indoors. • Protects children who frequent outdoor patios. • Simplifies compliance requirements for restaurant and bar proprietors. Equitable for all restaurants and bar operators – level playing field for all proprietors • Includes beaches and golf courses – consistent message that tobacco, sports and recreation don't mix.	• Does not fully respond to social norms and role modelling issues. • Increased cost in reviewing and processing applications for DSAs.

OPTION 4	PROS	CONS
4) A complete smoking ban in: a. All areas used for public enjoyment and recreation (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, beaches, public gardens, golf courses, etc.). b. Municipally-owned and operated recreational properties c. All outdoor areas and venues d. Outdoor seating areas - restaurant and bar patios e. Outdoor public events and community festivals f. All areas of hospital campuses g. All areas of university and college campuses h. All hotels, motels and bed and breakfasts	• As in Option 2 and 3 and: • Best for the health of Middlesex-London; protecting everyone from ETS. • Fully addresses role modelling and social norms issues. • Includes full property of all golf courses. • Potential for an increase in attendance and visitor satisfaction at festivals similar to the experience of restaurants and bars.	• Imposes on private living spaces at campgrounds, hotels, motels and bed and breakfasts. • Imposes on those who are patients, visiting or working in hospitals – could put patients in risky situations if not supported with withdrawal management treatment in hospital. • Large university campus – difficult for addicted staff on campus. • The expectation is that you smoke only outside at home, which could be unrealistic, creating enforcement challenges which exceed capacity.

Definitions*:

Outdoor areas

Includes but not limited to - parks, playgrounds, wading or swimming pools, splash pads, sports fields, (e.g. but not limited to, soccer fields, football fields, baseball/softball diamonds, basketball courts, skateboard parks, tennis courts, lawn bowling greens, golf courses, horseshoe pits, ice surfaces, toboggan hills).

Outdoor venues:

Includes but not limited to - stadiums, grandstands, public areas adjacent to water, beaches, horticultural display areas or ornamental gardens, walking/hiking trails, campgrounds, bike paths.

Outdoor seating areas:

Includes but not limited to - restaurant and bar patios, buffer zone of a specific number of meters around the perimeter of the patio, entranceways and air intakes; buffer zone makes patios truly smoke-free.

Outdoor public events

- Includes but not limited to - festivals, fairs and spectator events – including tents that may be erected on the grounds – such as concerts, sporting events and parades.
- Specific streets, e.g., in a main shopping area or within a school zone, including the sidewalk, street, lane, thoroughfare, curb, retaining wall, boulevard, etc.

***These definitions are for reference only and to help illustrate the four options available. Specific language and definitions would need to be reviewed by legal counsel before adoption into bylaws or corresponding regulations.**

Preferred Option

A complete smoking ban in:

a) All outdoor areas used for public enjoyment and children recreation areas (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals and public beaches)
b) Municipally-owned and/or operated recreational properties*
c) All outdoor seating areas - bar and restaurant patios

 No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation).

 Application process required for Designated Smoking Areas (DSAs) at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult.

 Application process enabled for hospital campuses, university campuses and college campuses to be named within a schedule of the bylaw for designated smoking areas (DSAs) or for 100% smoke-free campuses.

* Exemptions for long-term care homes and campgrounds - current legislation to apply.

Why this Option?

- This policy option aligns the closest with the RRFSS results and matches current levels of public support for smoke-free playgrounds, recreational playing fields, entrances and patios.
- This policy option achieves the goal of protecting children from exposure to second-hand smoke, enhances role modelling of tobacco-free choices, and addresses the need to role model tobacco-free living, while acknowledging the addiction at adult-focused events.
- Enables hospital, university and college partners who have been increasing smoking restrictions on campus with the opportunity to be named within the bylaw and receive additional enforcement support than what can currently be offered.
- Increased compliance with the bylaw given that the restrictions match closest to public readiness.
- Enforcement less complex and increased public comprehension with a complete ban than with bylaws with set-backs from play structures and splash pads.
- Reflects current bylaws in development or recently enacted (Hamilton, Niagara).

Enforcement

Middlesex-London Health Unit currently employs five (a total of 3.6 FTE) Tobacco Enforcement Officers (TEOs) who are trained, experienced and are responsible for enforcement of the City of London and County of Middlesex 2003 Smoke-free Public Places and Workplaces bylaws and the 2006 *Smoke-Free Ontario Act*. No additional funding is required for enforcement; TEOs are 100% funded through the Ministry of Health Promotion and Sport's Smoke-Free Ontario strategy. The Tobacco Enforcement Team would be responsible to assist with the smooth introduction and implementation of the proposed bylaw. Police Services would also be empowered to enforce the proposed bylaw. If University, College and Hospital Campuses applied to be named within a schedule of the Bylaw, Campus and Hospital Security would also be empowered to assist with enforcement of the proposed bylaw.

Proposed Approach for Moving Forward

The issues of hookah smoking and smokeless tobacco products are significant, emerging issues in tobacco control; however, given the specificity of wording of Section 115 of the *Municipal* Act, there may be some limitations on how municipalities can regulate their use. There may be an opportunity for single-tier municipalities to enact legislation under Section 10.2(6) and upper-tier municipalities under Section 11.2(6) to regulate smokeless tobacco use to ensure the health, safety and well-being of persons; however, given that this has not yet been explored in Ontario, the Health Unit has secured legal assistance to explore authority and jurisdiction under the *Municipal Act*; and/or, there may be other opportunities under licensing of which legal counsel may be aware. Once this advice has been received, Health Unit staff will report back to the Board of Health.

Jurisdictions across Canada and most notably in Ontario, including some of our neighbouring communities, have successfully regulated outdoor smoking. While not all bylaws have been formally evaluated, studies of some existing bylaws demonstrate that enforcement has not been difficult and compliance is not a significant issue[xxv, xxvi, xxvii]. Municipalities reported either no increase in complaints, or minimal complaints/inquiries that required a response. Municipalities also reported no impact on the use of city recreational facilities[xxviii]. The Health Unit's Tobacco Control Team anticipates a similar situation for our communities.

With the Board of Health's support and approval, Middlesex-London Health Unit Tobacco Control staff will prepare a community engagement plan, based on Policy Option #3 to enable the Health Unit to approach key community stakeholders and representatives from the City of London and the County of Middlesex in early 2012 to begin working together on this important policy initiative. With involvement and input from community leaders and the development of a community consultation, communication and education plan, these steps will help to ensure that proposed amendments to local bylaws are met with strong public and political support.

A bylaw is only effective if it has a high compliance rate, is easily understood by the public and is enforceable. Policy Option #3 provides strong direction on how the City of London and the County of Middlesex can provide greater protection from second-hand smoke and begin to role model a culture free from tobacco use to our children and youth.

Conclusion and Recommendation

Tobacco-free environments provide the greatest level of protection from second-hand smoke, help to prevent young people from starting to use tobacco products and assist smokers to quit smoking.

Public Health Ontario recommends that tobacco use be eliminated in selected outdoor public spaces, and local data suggests that our community is prepared and ready for greater restrictions on smoking in outdoor public spaces. It is recommended that the Middlesex-London Board of Health support Policy Option #3 and direct staff to prepare a community engagement plan, and begin approaching key community stakeholders and representatives from the City of London and the County of Middlesex to begin working together on this important healthy, public policy initiative. Once information from legal counsel is obtained on how municipalities can regulate hookah smoking and the use of smokeless tobacco products in public places and workplaces, this information will be presented to the Board of Health for consideration.

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