THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO

Generating knowledge for public health

Smoke-Free Ontario Strategy Monitoring Report:

Youth Prevention

Table of Contents

List of Tables

List of Figures

Prevention: Smoke-Free Ontario Strategy Components

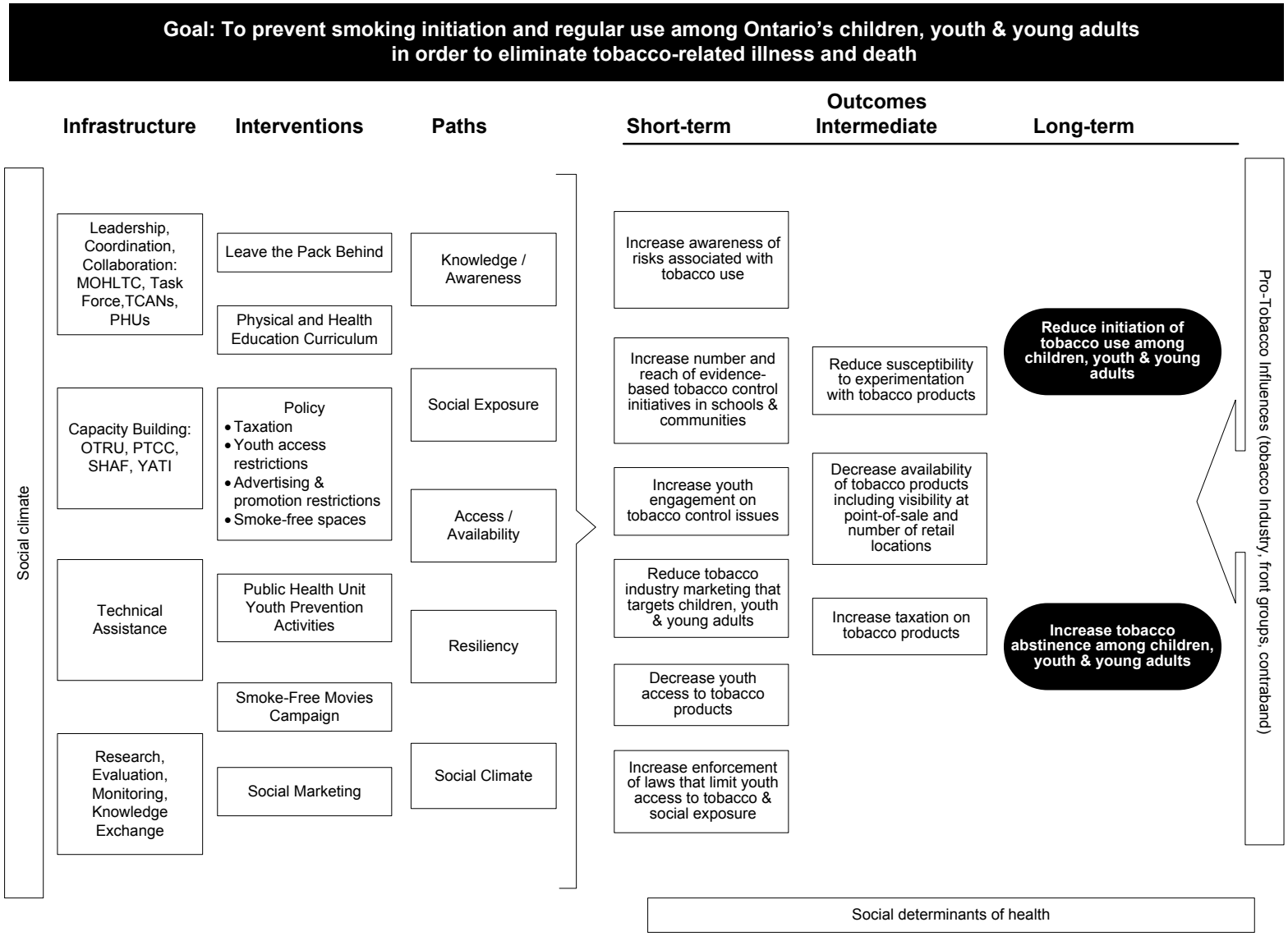
A comprehensive approach is required to prevent and reduce the prevalence of tobacco use among youth because of the complexity of factors that determine smoking initiation in this population.[1] Such an approach includes building capacity for the implementation of various interventions, such as federal and provincial policies, as well as provincial and regional public health programming. These interventions seek to prevent use through a number of pathways such as:

- Limiting social exposure to tobacco use among youth
- Decreasing access and availability of tobacco products
- Increasing knowledge of the harmful effects of tobacco use
- Increasing youth resiliency to make healthy choices and resist tobacco use initiation

In Ontario, the prevention component of the Smoke-Free Ontario Strategy is the main avenue by which progress toward these pathways/desired goals is expected to be achieved (Figure 3-1).

In this chapter, we provide an overview of current infrastructure, policy measures and prevention-related interventions in Ontario, which seek to prevent tobacco use among youth. We follow with an examination of progress toward prevention objectives at the population level.

Figure 3-1: Prevention Path Logic Model



Prevention Infrastructure

To ensure success, the prevention system has been designed to build capacity, provide technical assistance and offer research and evaluation support to key stakeholders—including public health unit staff, educators and service providers—and to deliver evidence-based programs, services and policies to the public. This infrastructure function is delivered by several key organizations with funding from the Ministry of Health and Long-Term Care (MOHLTC) including the Ontario Tobacco Research Unit (OTRU), the Program Training and Consultation Centre (PTCC), public health units (PHUs), Tobacco Control Area Networks (TCANs), Smoking and Health Action Foundation (SHAF) and the Youth Advocacy Training Institute (YATI).

Ontario Tobacco Research Unit

The Ontario Tobacco Research Unit (OTRU) provides research, monitoring, evaluation and teaching / training resources to the prevention component of the Strategy. Over the 2015/16 fiscal year (April to March), prevention initiatives conducted by OTRU included:

- Rapid scientific consulting to the Ministry and SFO partners on a variety of prevention topics.
- Knowledge and evaluation support—including consultation, design, ethics' protocols, data collection, analysis/interpretation, and reporting—to SFO partners working on 29 prevention projects.
- Prevention module of OTRU's online course (Tobacco and Public Health: From Theory to Practice) in which 1052 public-health personnel across the province enrolled.
- Evaluation of the ban on flavoured tobacco

Program Training and Consultation Centre

Within the prevention pillar, the Program Training and Consultation Centre (PTCC) provides a multi-day training course on the foundations of enforcing the *Smoke-Free Ontario Act* that includes regulations prohibiting tobacco sales to minors. This course is offered in collaboration with the Ministry of Health and Long-Term Care and is required training for any PHU employee enforcing the *Smoke-Free Ontario Act*. PTCC also supported two province-wide communities of

practice addressing practice areas relevant to tobacco use prevention (i.e., Tobacco Use Reduction for Young Adults and Tobacco-free Policy). PTCC Health Promotion Specialists and Media and Communications Specialists also provided consultation to local PHUs, TCANs and tobacco control coalitions working on community education and policy development initiatives (e.g., smoke-free multi-unit dwellings (MUDs), smoke-free movies, e-cigarettes).

In 2015/16[i], PTCC was involved in the following prevention initiatives:

- Delivered 43 training events reaching over 1284 clients. Training events included 21 workshops, 12 webinars and 10 special request workshops. Only a few of these were relevant to prevention. PTCC's training programs were attended by staff of Ontario's 36 PHUs, Community Health Centres, the health care sector (e.g., hospitals), non-governmental organizations and government.
- A total of 462 consultations were delivered by PTCC health Promotion Specialists and Media and Communication Specialist in 2015/16.
- A total of 226 public health practitioners and researchers were actively engaged across three provincial Communities of Practice.

Public Health Units

In Ontario, 36 local boards of health are responsible for delivering public health programs and services within their communities (henceforth referred to as Public Health Units, or PHUs). PHUs are critical stakeholders in the implementation of tobacco use prevention programming and policies in the Province and have a sizable infrastructure including program staff and enforcement personnel.

PHUs are responsible for the following prevention outcomes of the Ontario Public Health Standards:

- Youth have reduced access to tobacco products
- Priority populations adopt tobacco-free living

[i] Steven Savvaidis, Personal communication, September 19, 2016.

- To influence the development and implementation of a comprehensive tobacco control approach, PHUs are to work with school boards and/or staff of elementary, secondary, and post-secondary educational settings
- Tobacco vendors are in compliance with the *Smoke-Free Ontario Act*

The Ministry of Health and Long-Term Care has provided funding for youth tobacco use prevention at each of the Province's 36 PHUs. Although not mandated by the MOHLTC, many PHUs have chosen to hire a Youth Engagement Coordinator. These coordinators work collaboratively across risk factor-related programs within the PHU and externally through community partnerships with youth organizations. They also work with Youth Development Specialists and other regional stakeholders within the TCANs to establish regional plans and priorities for tobacco use prevention programming.[2] Youth Engagement Coordinators focus their work on a number of activities including: training on the principles of youth engagement across PHU programs, funding of youth-led health promotional activities, ongoing engagement of youth in tobacco control and creating opportunities for peer networking and learning.

Specific PHU level initiatives related to the *Smoke-Free Ontario Act* are discussed later in this chapter (Interventions).

Smoke-Free Ontario Advisory Groups, Committees and Task Forces

SFO Provincial Young Adult Prevention Advisory Group

The purpose of this Advisory Group is to provide a forum for provincial partners to collaborate, develop, implement and evaluate a comprehensive, coordinated, evidence-informed approach to reduce tobacco use among Ontario young adults including:

- Review evidence related to young adult tobacco use
- Move components of the SFO Strategy forward by supporting the work of any SFO working group

In 2016, two working groups were set: a) Tobacco/smoke free campus working group, and Workplace policy/programming working group. The latter group was placed on hold in early 2017.

SFO Prevention Task Force

The SFO Prevention Task Force was comprised of representatives of the tobacco control community who have an expertise in youth tobacco use prevention and organizations with expertise in youth development and youth engagement strategies. It was struck in 2011 to provide input on implementation of the renewed Strategy prevention programming and to identify areas for collaboration across programs. As of the release of this report, this committee was on hold.

SFO Scientific Advisory Committee

In 2010, the SFO Scientific Advisory Committee (SAC) identified a) the prevention of tobacco use among youth and young adults and b) the pervasive availability of tobacco products in the retail environment as major issues for tobacco control in Ontario. An update to their 2010 report is currently underway and is expected to be released in 2017. This report will include updated evidence reviews and consensus statements across numerous topics of relevance to this chapter including those related to prevention and pro-tobacco influences.

Smoking and Health Action Foundation

The Smoking and Health Action Foundation (SHAF) engaged in a number of prevention-related activities in 2015/16 to support, educate and build capacity in the Ontario public health community including PHUs and TCANs. SHAF provided training, technical assistance and knowledge exchange to Strategy partners on a number of current and emerging prevention topics such as contraband, e-cigarettes, plain and standardized packaging, tobacco taxation, tobacco industry activity, tobacco retailing, waterpipes, smoke-free movies (SHAF co-chairs the Ontario Coalition for Smoke-Free Movies) and, more generally, policy options to address young adult use and prevention.

Tobacco Control Area Networks

Tobacco Control Area Network (TCAN) Coordinators and Youth Development Specialists from each of the seven TCANs (representing the 36 PHUs) provide leadership, coordination and

collaborative opportunities centred on the prevention goal of the SFO Strategy. These efforts seek to engage youth and promote a tobacco-free lifestyle. TCANs assist in assessing local PHU training and technical assistance needs around youth prevention, and they help communicate Ministry policies and activities including local media and public relations initiatives.[3] One of the more important roles TCANs play is to plan and execute large regional projects and coordinate regional media activities (please see the Intervention section below for an overview of these projects).

Youth Advocacy Training Institute

The Ontario Lung Association's Youth Advocacy Training Institute (YATI) is a program that engages Ontario youth (and adults) by creating partnerships with provincial, regional and local organizations. YATI provides youth and adults with training in skill building, resources, and tools to empower these groups to positively affect change in their communities by promoting tobacco-free and healthy lifestyles.

In 2015/16, YATI delivered 78 trainings and events across Ontario, attended by 1628 youth and 1017 adults. This included 35 general trainings (435 youth and 317 adults). For youth, these trainings focused on knowledge and skills required to engage participants in health promotion and advocacy-oriented activities in support of tobacco prevention and other related health initiatives. For adults, these trainings focused on building the capacity of adults who work with youth across public health and the youth-serving sector by helping them learn the necessary skills to support youth engagement practice, in terms of tobacco prevention and health promotion and advocacy-oriented activities. Other training included 13 custom trainings (436 youth and 234 adults); 11 partnership trainings, which supported priority populations (111 youth and 289 adults); 13 special events (90 youth and 102 adults) and 6 summits (556 youth and 75 adults).

The YATI website was active in 2015/16, with the English site having 11,353 visits (8,328 unique visitors) and 42,484 page views and the French site having 855 unique visitors and 1,412 page views. The YATI Facebook account had 503 friends; their Twitter feed had 1,564 followers and 3,945 tweets; and the YATI YouTube channel had 18 subscribers and 16,233 views.

Prevention Interventions

The SFO Strategy includes a number of programs, services and policies focused on prevention and reduction of tobacco use among youth and young adults. These initiatives are centred on increasing knowledge of the harmful effects of tobacco use; increasing youth resiliency to make healthy choices and resist tobacco use initiation; limiting social exposure to tobacco use; and decreasing access and availability of tobacco products.

Where possible we have provided evaluative data for each intervention listed below. Given the nature of some of these interventions— and challenges in attributing changes in prevention-related outcomes at the population level to particular interventions—evaluative data are not currently available for many of the interventions discussed in this chapter.

Province-Wide Interventions

Freeze the Industry—Plain and Standardized Packaging Steering Committee

One of the main objectives of the Freeze the Industry—Plain and Standardized Packaging (FTI-PSP) Steering Committee is to develop a coordinated provincial social marketing campaign, which mobilizes youth in tobacco industry denormalization efforts to educate the public and elected officials on the need for plain and standardized packaging legislation and to build support for Federal legislation.

In 2015/16, this Committee has worked toward establishing training and capacity building, as well as the development of communication and social media tools including a public awareness campaign. Future reports will update progress.

Leave The Pack Behind

To address prevention goals, Leave The Pack Behind (LTPB) uses several tobacco control interventions including a) social marketing campaigns that use social media, mass media and interpersonal communication in print, electronic and face-to-face formats; and b) peer-to-peer

programs and services that actively discourage uptake/escalation of tobacco use, address social norms, support campus polices and provide general tobacco control education.

LTPB's Party *Without The Smoke* prevention campaign encouraged young adults to refrain from using any form of tobacco/nicotine products while partying. In a survey of 1,688 young adult students, two thirds (66%) were aware of the campaign and over half (54%) were able to identify at least one campaign message.[4]

LTPB's annual *wouldurather... contest* challenged post-secondary students and community-dwelling young adults to quit, reduce or stay smoke-free. In 2015/16, the prevention component of the contest attracted 5,285 young adult nonsmokers who pledged to be smoke-free for the duration of the contest.

Ontario's Health and Physical Education Curriculum

In September 2010, Ontario public schools began implementing the Ministry of Education's revised interim health and physical education curriculum for grades 1 to 8. This was the first revision since 1998. In 2014, the Ministry of Education published its Foundations for a Healthy School resource.[5] Using an integrated approach, this resource focuses on curriculum, teaching and learning; school and classroom leadership; student engagement; social and physical environments; and home, school and community partnerships. Under the health-related topic of *Substances Use, Addictions and Related Behaviours*, students begin to learn about tobacco during the junior grades (specifically grades 4 to 7). Learning focuses on understanding what tobacco is, what influences its uptake (i.e., peer pressure, industry advertising) and the effects and consequences of its use (i.e., health effects, social implications). This knowledge is integrated with the development of a variety of living skills (e.g., decision making and refusal skills) that help students make and maintain healthy choices.

The Ontario Physical and Health Education Association (Ophea) has developed online elementary and secondary school resources to support the implementation of the Health and Physical Education curriculum including substance use.[6] Each resource includes ready-to-use lesson plans and other supports such as student templates, assessment tools and daily physical activity ideas.

Smoke-Free Movies

Health organizations internationally, including the US Surgeon General, have drawn a causal link between smoking that is seen on screen and youth smoking initiation. In response, the Ontario Coalition for Smoke-Free Movies has endorsed the five actions recommended by the World Health Organization to limit exposure of smoking in youth-rated movies. Specifically, the Coalition endorses that a change be made to the current rating system in Ontario to ensure that any future movies released in Ontario rated for children and teens (G, PG, 14A) are free from smoking images and tobacco products.

The Ontario Coalition for Smoke-Free Movies formed in May 2010 to take collective action to counter the harmful impact of smoking in youth-rated movies released in Ontario. The Coalition is an alliance of health organizations including the Canadian Cancer Society (Ontario Division), Heart and Stroke Foundation of Ontario, NSRA/SHAF, Ontario Lung Association, OTRU, Physicians for a Smoke-Free Canada, PHUs, TCANs and YATI.

Between 2004 and 2014, 56% (877/1,564) of the top-grossing movies released in Ontario featured onscreen tobacco. Of the movies with tobacco content, 86% were rated for youth by the Ontario Film Review Board (G, PG, 14A).[7] Over this same period, these top-grossing movies contained a total of 29,620 tobacco incidents, with 85% of these incidents occurring in youth-rated movies. In 2014, 2,770 tobacco incidents occurred, up from 2,498 in 2013.

Exposure to onscreen smoking at current levels is expected to recruit more than 185,000 children and teens aged 0 to 17 living in Ontario today to become smokers. Eventually, more than 59,000 of those recruited to smoking as a result of this exposure will die prematurely from tobacco-induced diseases. It is projected that if an adult rating (18A) for smoking in movies was required in Ontario, it would avert at least 95,000 Ontario children and teens from becoming smokers and prevent more than 30,000 future tobacco deaths.

In 2016, a provincial monitoring survey administered by OTRU collected data from across 28 of 36 PHUs and 7 TCANs working toward raising public awareness on the issue of smoking in youth-rated movies. Results indicate that there were 165 Smoke-Free Movies initiatives reaching 41,300 people. These initiatives generated the following outputs: 44,627 promotional items and

information materials distributed; 3,390 signatures collected to support an 18A rating change; and 52 million (8 million earned, 44 million paid) media impressions generated resulting in 110,000 actions (30,000 earned actions; 80,000 paid actions). (Note: This survey may not have captured all paid and earned media impression and actions due to underreporting by some PHUs). Based on google analytics, there were 46,579 visits to SmokeFreeMovies.ca in 2016. The launch of the provincial Hey Parents Campaign in August 2016 appeared to be responsible for a significant increase in reach and actions over the previous year (for more information, go to the Hey Parents Campaign section under Select Regional Interventions, below).

In 2016, a second provincial monitoring survey involving 18 PHUs and 7 TCANs collected information from participants of local events. Of the 2,202 people completing the survey, there was a 32 percentage point relative increase after the event in those reported being 'very' or 'extremely' aware of the impact of smoking in movies on youth starting to smoke (51% pre-event vs. 83% post-event); 79% reported post-event an intent to take action on the issue; 93% reported post-event that they 'strongly' or 'somewhat' supported a rating of 18A for movies showing onscreen smoking (Note. Interpret with caution. Only 18 or 36 health units participated, and data collection was based on a convenience sample methodology).

Product Restrictions

On May 28, 2015, the *Making Healthier Choices Act* (Bill 45) received Royal Assent. This *Act* prohibited the sale of flavoured tobacco at retail stores in the Province, with exceptions. Specifically, regulations consolidated on November 13, 2015 (and in effect as of January 2016) mandated that the *Act* does not apply to flavouring agents in cigars that impart a flavour or aroma of wine, port, whiskey or rum (at the time, it did not apply to the flavour or aroma of menthol, but this regulation was revoked as of January 1, 2017 thus prohibiting menthol as a flavouring agent[8]). Likewise, an order amending the Schedule to the federal *Tobacco Act* came into force December 15, 2015 that prohibited the manufacture and sale of certain types of cigars that contain targeted additives (flavours). Cigarillos and cigars weighing less than or more than 1.4 g, but not more than 6 g, were captured in the amended Schedule.

Contribution: In 2015, Ontario wholesale sales of the total cigar category (little cigars, cigarillos

and cigars) fell 4.6% over 2011 sales (146,853,259 sticks in 2011 vs. 140,090,699 sticks in 2015).[ii] (Note. Annual sales data may be influenced by wholesale shipment dates). In 2015, little cigars/cigarillos comprised 8.7% of all cigar sales. In 2015, 82.6% of the Ontario cigar market was flavoured cigars, with menthol comprising 4.15% of all cigar sales.

Tobacco Taxation

There is strong evidence that an increase in cigarette taxes is an effective policy measure to drive down cigarette consumption, encourage current smokers to quit and prevent youth from becoming regular smokers.[9,10,11,12,13,14] On average, a 10% increase in price results in a 3 to 5% reduction in demand in higher income countries.[15,16,17] Contrary to the myth promoted by the Tobacco Industry, a recent OTRU study found no correlation between increasing tobacco taxes and the use of contraband tobacco.[18]

Youth are very sensitive to the cost of tobacco products.[19,20,21] Specifically, higher cigarette prices have been shown to prevent youth initiation,[20] prevent adolescents from becoming daily, addicted smokers and can impact the smoking behaviour of youth who are further along the smoking uptake continuum.[22] Increases in the price of tobacco through taxation are central to any preventive approach.

In Ontario, the provincial tobacco tax for a carton of 200 cigarettes was increased by $3.00 on February 25, 2016, resulting in an increase from $27.95 to $30.95 in total provincial tobacco tax. This increase is similar to the last provincial tobacco tax increase in May 2014 (provincial tobacco tax accounted for 32% of the overall retail price of 200 cigarettes in both May 2014 and February 2016). Both tobacco tax increases were simply adjustments for inflation in the price of cigarettes. The Ontario government plans to continue to increase the provincial tobacco tax annually at the rate of inflation for the next five years starting June 1, 2017.[23] Overall, federal and provincial tobacco and sales taxes account for 65.1% of the retail price of a carton of cigarettes in Ontario. The tobacco tax increase was not sufficient to place Ontario in the highest scoring category for taxation in the MPOWER model (75% of the retail price). Ontario continues to have the second lowest total taxes on tobacco ($63.14) of any Canadian province or territory (Table 3-1).

[ii] Health Canada, Personal Communication, December 7, 2016.

Table 3-1: Federal/Provincial/Territorial Tobacco Tax Rates (per 200 Cigarettes, February 2016)

Jurisdiction	Average Pre-Tax Price[a] (2015 Figure)	Federal Excise Duty	Provincial/ Territorial Excise Tax	Provincial/ Territorial Sales Tax or Harmonized Sales Tax[b]	Federal GST[c] 5%	Total Tobacco Taxes	Total Retail Price
Quebec	$29.18	$21.03	$29.80	No PST	$4.00	$54.83	$84.01
Ontario	$33.90	$21.03	$30.95[d]	HST: 13% = $11.16	See HST	$63.14	$97.04
British Columbia	$25.90	$21.03	$47.80	No PST	$4.74	$73.57	$99.46
Yukon	$35.37	$21.03	$42.00	No PST	$4.92	$67.95	$103.32
Alberta	$28.70	$21.03	$50.00[e]	No PST	$4.99	$76.22	$104.92
Nunavut	$39.32	$21.03	$50.00	No PST	$5.52	$76.55	$115.87
Saskatchewan	$36.06	$21.03	$50.00	PST: 5% = $5.35	$5.35	$81.73	$117.79
Newfoundland	$35.25	$21.03	$47.00	HST:15% =$15.49	See HST	$83.52	$118.77
Prince Edward Island	$33.16	$21.03	$50.00[f]	HST: 14% =$14.59	See HST	$85.62	$118.78
Nova Scotia	$35.41	$21.03	$51.04	HST: 15%=$16.12	See HST	$88.19	$123.60
New Brunswick	$44.37	$21.03	$44.52[g]	HST:13% =$14.29	See HST	$79.34	$124.21
Northwest Territories	43.16	$21.03	$57.20	No PST	$6.08	$84.31	$127.46
Manitoba	$37.89	$21.03	$59.00[h]	PST:7%= $9.43	$5.90	$95.36	$133.25

Note: Ordered by total retail price, from lowest to highest.
[a] This average estimate of "pre-tax price" for each province is calculated by using the Consumer Price Index and the CPI Intercity Index from Statistics Canada for a carton of 200 cigarettes available in 2015. The full methodology for the calculations is available upon request
[b] PST/HST is calculated on the total of pre-tax price + federal excise duty + provincial excise tax.
[c] GST is calculated on the total of pre-tax price + federal excise duty + provincial excise tax.
[d] Ontario tobacco tax increase effective February 25, 2016.
[e] Alberta tobacco tax increase effective October 28, 2015.
[f] Prince Edward Island tobacco tax increase effective June 20, 2015.
[g] New-Brunswick tobacco tax increase effective February 3, 2016.
[h] Manitoba tobacco tax increase effective April 20, 2015.
Source: Non-Smokers Rights Association (NSRA). Cigarette prices in Canada. A map comparing the average price of a carton of 200 cigarettes in Canada's provinces and territories, as of February 25, 2016.

Youth Access Laws and Vendor Compliance

PHUs are mandated to enforce the *Smoke-Free Ontario Act* in accordance with provincial protocols (e.g., the *Tobacco Compliance Protocol*, 2008). Likewise, PHUs are mandated to enforce the *Electronic Cigarettes Act* in accordance with provincial protocols (e.g., the *Electronic Cigarettes Compliance Protocol*, 2016).

In Ontario, it is illegal to sell tobacco products to anybody under the age of 19. MOHLTC funds PHUs to conduct two youth access checks of each tobacco vendor in their jurisdiction. In 2015, there were 20,956 youth access checks (compliance or enforcement) conducted in Ontario, in which a test shopper entered a store and attempted to purchase tobacco products. The test shopper was sold a tobacco product 1,005 times. Using the store as the unit of analysis, 97% of Ontario tobacco vendors were found to be in compliance with youth access legislation at the time of their last inspection (10,046 checks, with 315 sales).

Vendor Licensing

One opportunity to reduce tobacco retail outlet density is to require vendor licenses, annual fees or both. Licensing fees, especially if they are expensive, may deter would-be retailers or prompt current retailers to stop selling tobacco.[24,25] Most provinces in Canada have not established tobacco retailer license fees, but there are a few exceptions. For example, New Brunswick has a one-time fee of $100, with an annual renewal fee of $50.[26] Nova Scotia has a tobacco retailer licence fee of $124.60, renewable every three years.[27] In Ontario, the provincial government requires all retailers wishing to sell tobacco to have a valid Retail Sales Tax (RST) vendor's permit or, as of July 1, 2010, a tobacco retail dealer's permit issued under the *Tobacco Tax Act*. However, this system is free and requires only a one-time application, with no renewal required. As of 2015, a growing number of Ontario municipalities have had an annual tobacco retailer licence fee (Table 3-2).

Table 3-2: Annual Tobacco Retailer Licence Fees, Ontario

Municipality	Licence Fee
Ottawa	$806
Hamilton	$649
Sudbury	$440
Markham	$330
Vaughan	$298
Richmond Hill	$285
Mississauga	$277
Oakville	$267
Kingston	$251
Brampton	$215
Windsor	$188

Municipality	Licence Fee
Waterloo	$172
Burlington	$170
Wasaga Beach	$150
Halton Hills (Georgetown)	$131
Hawkesbury	$100
Chatham-Kent	$85
North Bay	$50
Cornwall	$40
Brockville	$36

Source: Canadian Cancer Society, December 10, 2015

Vendor Locations

Tobacco retail availability refers to the accessibility of tobacco products at the retail level. In essence, "availability" describes the level of convenience associated with obtaining tobacco in Ontario. Restricting the retail distribution and availability of tobacco products is considered an important mechanism to limit consumption and subsequent negative health effects.[28,29] In Ontario, legislation prohibits tobacco from being sold by vending machines, at pharmacies, hospitals and other health care and residential care facilities and, as of January 1, 2015, college and university campuses.[30]

Despite these advances, tobacco products continue to be available across the province through a large number of retail outlets (10,044 in 2015),[31] primarily convenience, gas and grocery stores. This is down from 10,620 in 2014, 11,581 in 2013, 12,455 in 2012 and a further decrease from the approximate 14,000 tobacco vendors that were operating in 2006 (Note: The reason for these decreases is unclear. It could be due to more accurate recording of vendors by Ministry, fewer vendors selling tobacco or both). Sixty-five per cent of Ontario tobacco retail outlets are located within 500 metres of a school.[32] Tobacco retailers are also more likely to be located in lower socioeconomic status neighbourhoods.

Higher tobacco retail outlet density has been associated with higher rates of youth smoking and increased likelihood of young smokers purchasing their own tobacco. According to the 2015 Ontario Student Drug Use and Health Survey, approximately 18% of underage students in grades 7 to 12 who had smoked a whole cigarette in the last 12 months reported purchasing their last

cigarette from a corner store, grocery store, supermarket, gas station or bar. Just over half of all underage students (62%) reported getting their last cigarette from social sources such as a friend or family member.[33] In a 2005 study prepared for Health Canada, young adult smokers report that they would smoke less if they had to travel farther to buy cigarettes.[34]

There is growing interest in policies to regulate the number and location of tobacco vendors. Provinces, such as Nova Scotia and Quebec have prohibited tobacco sales in a wide number of types of locations such as colleges and universities, theatres and bars and restaurants. As previously mentioned, Ontario legislation prohibits tobacco from being sold by vending machines and at pharmacies, hospitals, other health care and residential care facilities and college and university campuses.

Vendor Point-of-Sale Display Ban

Social exposure to tobacco products may promote the normalization of tobacco use, trigger initiation in youth and young adults through processes of social influence and modeling and may encourage the continued use of tobacco among smokers and relapse among quitters.[35,36] On May 31, 2008, a complete ban on the retail and wholesale display of tobacco products was implemented in Ontario in order to discourage youth from starting to smoke.[37] Those exempted from this ban include tobacconists, duty free retailers and manufacturers.

Select Regional Interventions

Youth prevention activities are running at the local and regional level across the Province. This work varies widely in funding, scope and available evaluative evidence, with some projects ongoing and other projects being one-time events. Numerous PHU/TCAN prevention projects that build knowledge and resiliency have reached out to OTRU's Knowledge and Evaluation Support initiative. Below is a brief summary of select prevention initiatives from across the province.

Bad Ways 2 Be Nice

Bad Ways 2 Be Nice (BW2BN) is an initiative that began with the Central East TCAN and is designed to raise awareness among young adults about the issue of supplying cigarettes to teenagers and encourage young adults to think twice before giving cigarettes to youth. In 2015,

Central East TCAN, Southwest TCAN and the Aboriginal Tobacco Program ran a number of events—such as a polaroid frame booth, post-it note activity, wheel spin-to-win "nice" or "not so nice" prizes—at various settings including colleges/universities, fairs/exhibitions and in the general community. In 2015, Southwest TCAN piloted BW2BN campaign videos.

Hey Parents Campaign

The Hey Parent Campaign is a provincial public education initiative in support of smoke-free movies. In 2013, the Central East TCAN formed a subcommittee to develop a communication campaign targeted at parents to raise awareness on the impact that tobacco imagery in film has on youth smoking behaviour. This subcommittee later expanded to include representatives from across most TCANs in Ontario.

As an initial step to guide the campaign development, an audience analysis was conducted within the Central East TCAN (excluding Kawartha) in 2014 to better understand parents' beliefs and opinions about the issue. In 2015, a vendor was hired to conduct focus groups within the Central East TCAN to further delve into results of the audience analysis. Based on the findings, the vendor created 3 campaign concepts and messages for consideration for the campaign. A second vendor was hired to test the messages and concepts via focus groups. Once the creatives and messages were developed they were pre-tested with the targeted audience and fine-tuned prior to the campaign launch, resulting in two final creatives. In late summer and early fall of 2016, all 7 TCANS and 36 PHUs across Ontario implemented *Hey Parents* in their local communicates using a variety of paid and earned communication channels. Survey results following this fall campaign revealed that the *Hey Parents Campaign* had very good reach, with almost half of all parents surveyed (47%) exposed to the campaign in the past 2 months (Note. Survey collection was centred in three PHUs and employed a convenience sample.)

Love My Life

An initiative of the East TCAN, Love My Life's (LML) goal is to meaningfully engage youth aged 10 to 24 around increasing tobacco-free environments, with the expectation that these will enhance supportive social and physical environments and influence policies that support healthy living. For instance, tobacco-free environments are expected to support the process of normalizing

tobacco-free living by removing tobacco use role-modeling.[38]

LML project-based activities take place within partner organizations and often include tobacco-free policy development and implementation (e.g., community arts project with a tobacco free theme, tobacco-free school project). OTRU is currently collecting administrative and participant-based surveys on this project, and annual results are anticipated in 2017.

Youth Social Identities and Tobacco Use Prevention Project: Uprise

In 2013, a Functional Analysis for Cultural Interventions was conducted by Rescue (The Behavior Change Agency), with teenagers in Central West and South West Ontario, to better understand the relationship between youth sub-cultures and tobacco use. Findings from this study showed that teens that are influenced by the Hip Hop and Alternative peer crowd are at the highest risk for tobacco use. In July 2015, a campaign called UPRISE was launched to address tobacco use among youth who identify with the Alternative peer crowd. UPRISE is designed based on Rescue's proprietary Social Branding® model. The objective of the campaign is to eliminate the pro-tobacco perceived norms of Alternative youth while simultaneously increasing the belief that being tobacco-free is an important component of being part of the Alternative peer crowd.

The following components are part of UPRISE's Social Branding® strategy:

- Attending events, such as rock music concerts, to build the brand's social influence within the Alternative culture
- Recruiting and training influencers within the Alternative culture, such as bands, to support UPRISE's key messages
- Aligning anti-tobacco messages with the peer crowd's values and interests, delivered through social media channels that alt youth are actively using

Data from UPRISE's social media content in 2015 (July – December) and 2016 (January – December) are highlighted in Table 3-3.

Table 3-3: UPRISE's Social Media Results, 2015 and 2016

Social Media Channel	2015 (July-December)	2016
Facebook		
Impressions (number of times a post from your page is displayed/seen)	961,980	5,521,055
Video Views	55,146	169,476
Engagements (any action that is performed on a piece of content)	10,261	41,737
Page Likes (number of fans that have liked the Facebook page)	824	1297
Instagram		
Reach (number of times people were exposed to our content)	Not available	185,442 (Q3/Q4 only)
Engagements	426	6625
Page Likes	138	231
Youtube		
Video Views	17,290	62,915

Youth Tobacco Prevention with Dental Professionals Project

The Youth Tobacco Prevention with Dental Professionals Project ran as a pilot project in the South West TCAN in 2015. Local PHUs partnered with dental professionals to test the usefulness of using prevention and cessation resources with high school-age youth (age 14-18) in dental settings.

Dental professionals were asked to: a) show a laminated infographic to each youth patient aged 14 to 18 who visited an office that described reasons to be tobacco free as well as the negative effects of using tobacco; b) provide all youth with a magnet associated with an Instagram account named "91 Reasons," that reflected the 91% of Ontario youth who don't smoke; and c) offer a youth cessation booklet to youth patients aged 14 to 18 who identified as tobacco users or who were identified as a tobacco user by the dental professional.

Of 153 dental professionals approached, 87 (or 57%) responded to an online survey (run by OTRU in partnership with the South West TCAN). Among respondents, one in five *always* shared the two main project resources: an infographic and magnet. Approximately 60% of dental professionals *often* or *sometimes* shared, whereas 20% *rarely* showed these resources to youth patients. About 8 in 10 dental professionals (79%) provided cessation booklets to their patients who smoked. No data are available about the effects of this intervention on youth initiation and cessation. However, the intervention is based on published research that demonstrated that face-to-face interaction with a health-care provider and providing print materials to youth can reduce the risk of smoking initiation among youth.[39]

Prevention Outcomes: Population Level

The prevention goal of the Strategy is to prevent smoking initiation and regular use among Ontario's children, youth and young adults in order to eliminate tobacco-related illness and death. The long-term goals of prevention are to reduce initiation of tobacco use and to increase tobacco abstinence among children, youth and young adults (Figure 3-1). In working toward these desired outcomes, the more immediate objectives of the Strategy are to increase awareness and adoption of school and community tobacco prevention initiatives.

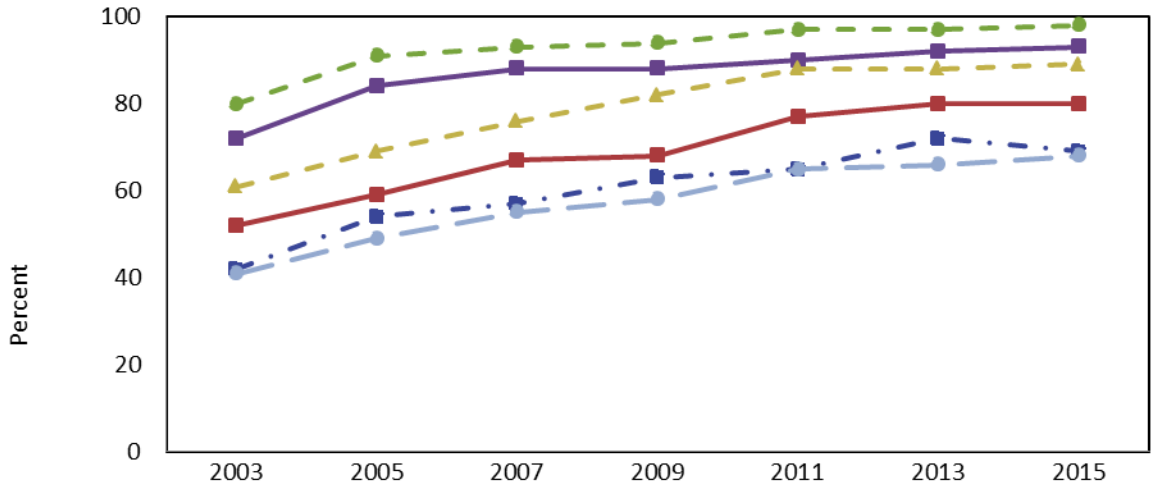
Long-Term Outcomes: Cigarettes

Comprehensive tobacco control programs, such as the SFO Strategy, focus on reducing the initiation and prevalence of tobacco use among children, youth and young adults. Indicators related to the progression to smoking include lifetime abstinence, past-year initiation, past-year smoking and past 30-day current smoking.

Lifetime Abstinence: Students in Grades 7 to 12

- Among students, lifetime abstinence from cigarettes ranged from 98% of students in grade 7 to 68% of students in grade 12 (OSDUHS 2015 data; Figure 3-2), with overall lifetime abstinence among all grades combined at 81%.
- From the 2005 pre-SFO baseline year, there was a significant increase in lifetime abstinence among all grades except grade 8 (Figure 3-2).

Figure 3-2: Lifetime Abstinence, by Grades 7 to 12, Ontario, 2003 to 2015



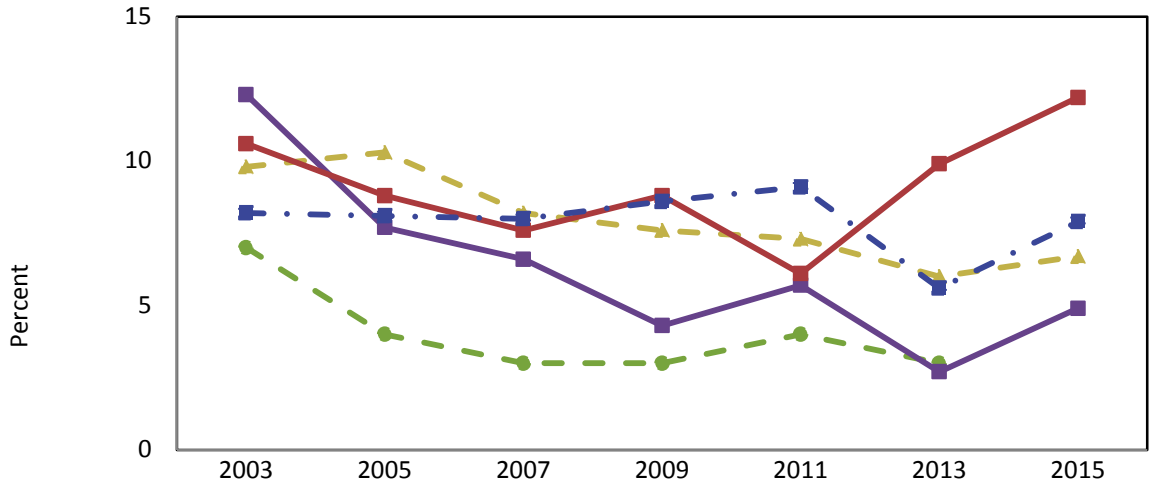
	2003	2005	2007	2009	2011	2013	2015
Grade 7	80	91	93	94	97	97	98
Grade 8	72	84	88	88	90	92	93
Grade 9	61	69	76	82	88	88	89
Grade 10	52	59	67	68	77	80	80
Grade 11	42	54	57	63	65	72	69
Grade 12	41	49	55	58	65	66	68

Note: Full data table for this graph provided in the Appendix (Table 3A-1).
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Past-Year Initiation: Students in Grades 7 to 12

- In 2015, first use of cigarettes at any time in the previous 12 months ranged from 5% for grade 9 students to 12% for grade 11 students (Figure 3-3). (Grade 7/8 student data suppressed due to small sample size.)
- There were no significant changes in 2015 from our pre-SFO baseline year of 2005.

Figure 3-3: Use of Cigarettes for the First Time in the Past Year, by Grades 7 to 12, Ontario, 2003 to 2015



	2003	2005	2007	2009	2011	2013	2015
Grade 7-8	7	4	3	3	4	3	S
Grade 9	12	8	7	4	6	3	5
Grade 10	10	10	8	8	7	6	7
Grade 11	11	9	8	9	6	10	12
Grade 12	8	8	8	9	9	6	8
Total	9	7	6	6	6	5	6

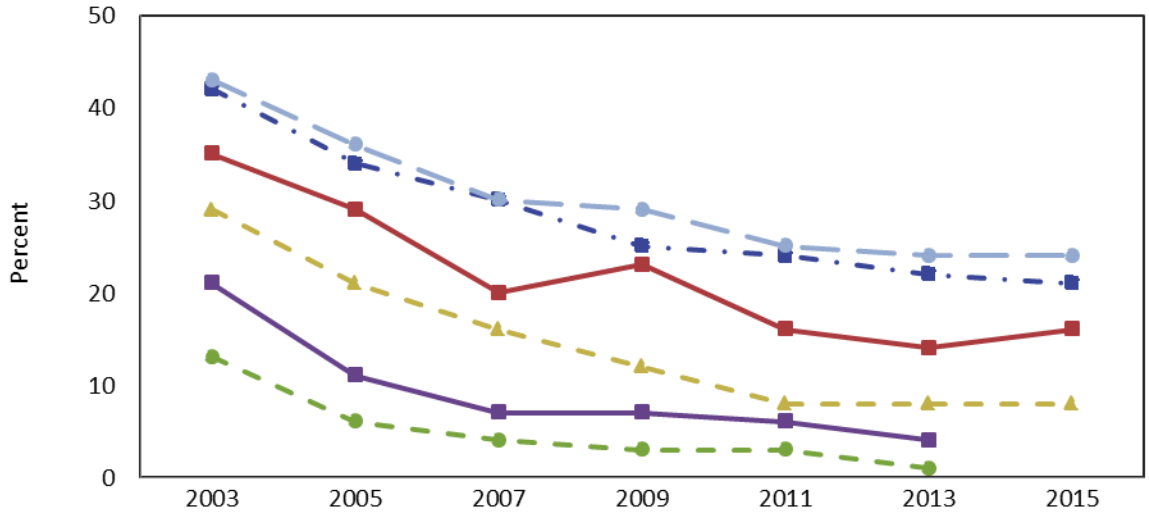
S = data suppressed due to small sample sizes.
Note: Full data table for this graph provided in the Appendix (Table 3A-2).
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Past-Year Smoking: Students in Grades 7 to 12

- Among students in grades 7 to 12, the 2015 overall prevalence of smoking in the past year, even a few puffs, was 14% (representing 134,700 students; data not shown). (Note. Respondents in any given grade reported about their smoking behaviour over the previous year.)

- In 2015, past-year smoking significantly declined among all students in grades 7 to 12 (combined) compared to the pre-SFO baseline year of 2005 (14% vs. 23%). However, declines have been stagnant since 2011.
- Over the period 2005 to 2015, there were significant declines in past-year smoking among students in grades 9, 10, 11 and 12 (Figure 3-4); over the period 2005 to 2013, there were significant declines in past-year smoking among students in both grade 7 and grade 8 (Figure 3-4; Note: In 2015, data for grades 7 and 8 were suppressed due to small sample sizes).
- In 2015 the prevalence of past-year smoking was 8% in grade 9, significantly lower than all higher grades (Figure 3-4). Grade 10 past-year smoking was significantly lower than grade 12 past-year smoking (16% vs. 24%, respectively).

Figure 3-4: Past-Year Smoking, by Grades 7 to 12, Ontario, 2003 to 2015



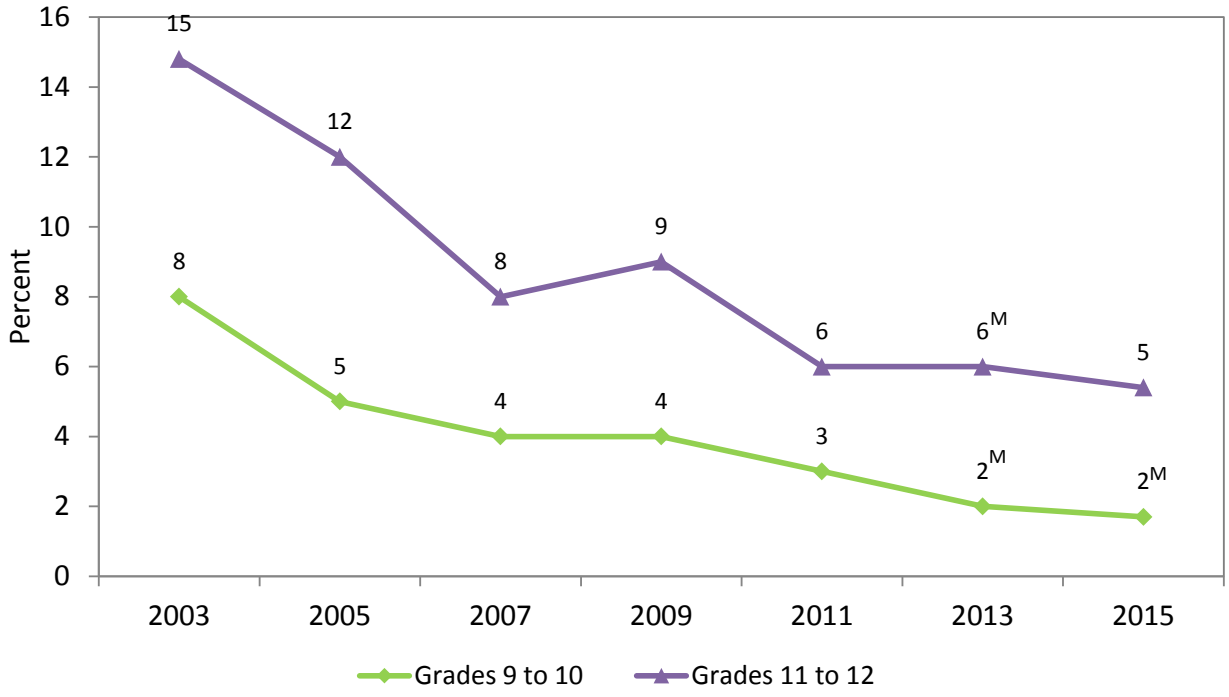
	2003	2005	2007	2009	2011	2013	2015
Grade 7	13	6	4	3	3	1	S
Grade 8	21	11	7	7	6	4	S
Grade 9	29	21	16	12	8	8	8
Grade 10	35	29	20	23	16	14	16
Grade 11	42	34	30	25	24	22	21
Grade 12	43	36	30	29	25	24	24

Note: Data collection for grades 8, 10 and 12 started in 1999. S = data suppressed due to small sample sizes. Full data table for this graph provided in the Appendix (Table 3A-3).
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Current Smoking (Past-30 Days): Students in Grades 9 to 12

- In 2015, past-30 day current smoking was significantly higher among students in grades 11 to 12 (combined) compared to students in grades 9 to 10 (5% vs. 2%; Figure 3-5).
- From 2011 to 2015, there has not been significant change in the prevalence of current smoking among students in grades 9 to 10 and grades 11 to 12.
- Over the period 2005 to 2015, the prevalence of past 30-day smoking was cut by about 60% for students in grades 9 to 10 and in grades 11 to 12 (Figure 3-5).

Figure 3-5: Current Smoking (Past-30 Days), by Grade, Ontario, 2003 to 2015



M= Marginal. Interpret with caution.
Note: Full data table for this graph provided in the Appendix (Table 3A-4).
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

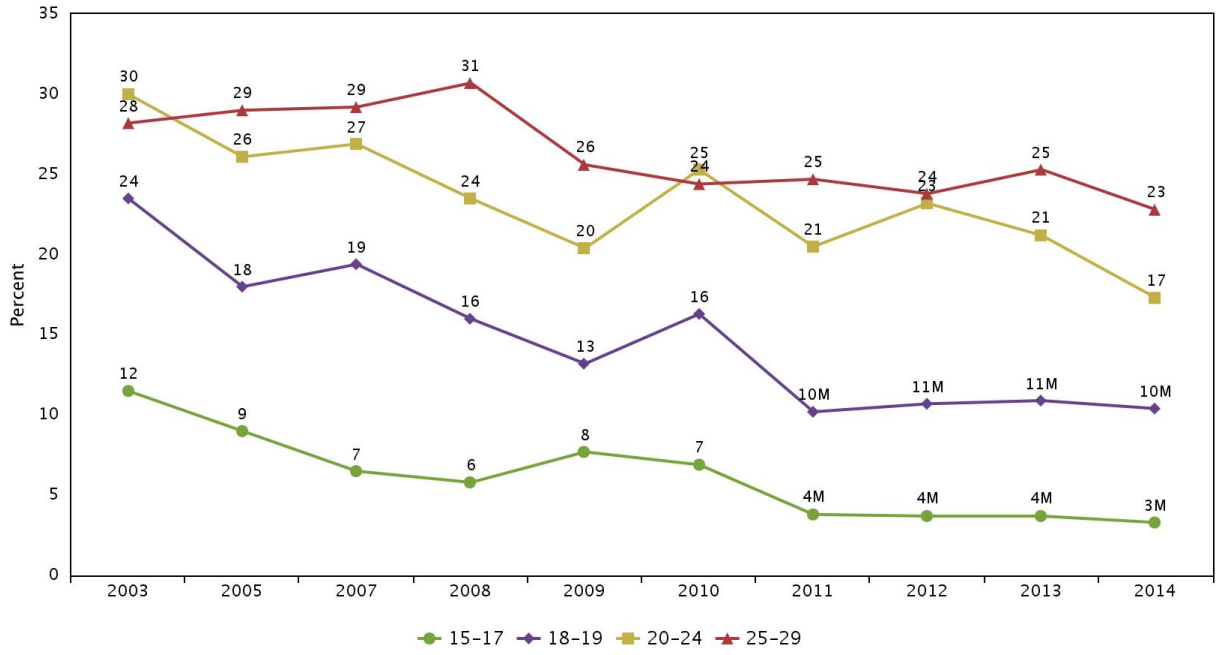
Current Smoking (Past-30 Days): Youth and Young Adults Aged 15 to 29

- In 2014, 23% of young adults aged 25-29 were current smokers and there has not been a significant change in this rate over the five-year period from 2010. Notably, 29% of males aged 25-29 were current smokers in 2014.
- The rate of current smoking for young adults aged 20 to 24 significantly decreased over

the past five years from 24% in 2010 to 17% in 2014.

- Over the period 2005 to 2014, there has been a significant decline in past-30 day current smoking by age including 15 to 17, 18 to 19, 20 to 24 and 25 to 29.
- According to the Canadian Community Health Survey[iii] (CCHS), youth aged 15 to 17 have a significantly lower rate of current smoking than young adults, with their level stable in recent years (3% in 2014;[iv] Figure 3-6).
- Among 18 to 19 year olds, the rate of current smoking was 10% in 2014, significantly lower than that of young adults aged 25 to 29 years (Figure 3-6).
- In 2014, males aged 18 to 19, 20 to 24 and 25 to 29 were significantly more likely to smoke in the past-30 days compared to females of the same age (Figure 3-7). (Data for males 15 to 17 was suppressed due to small sample sizes).

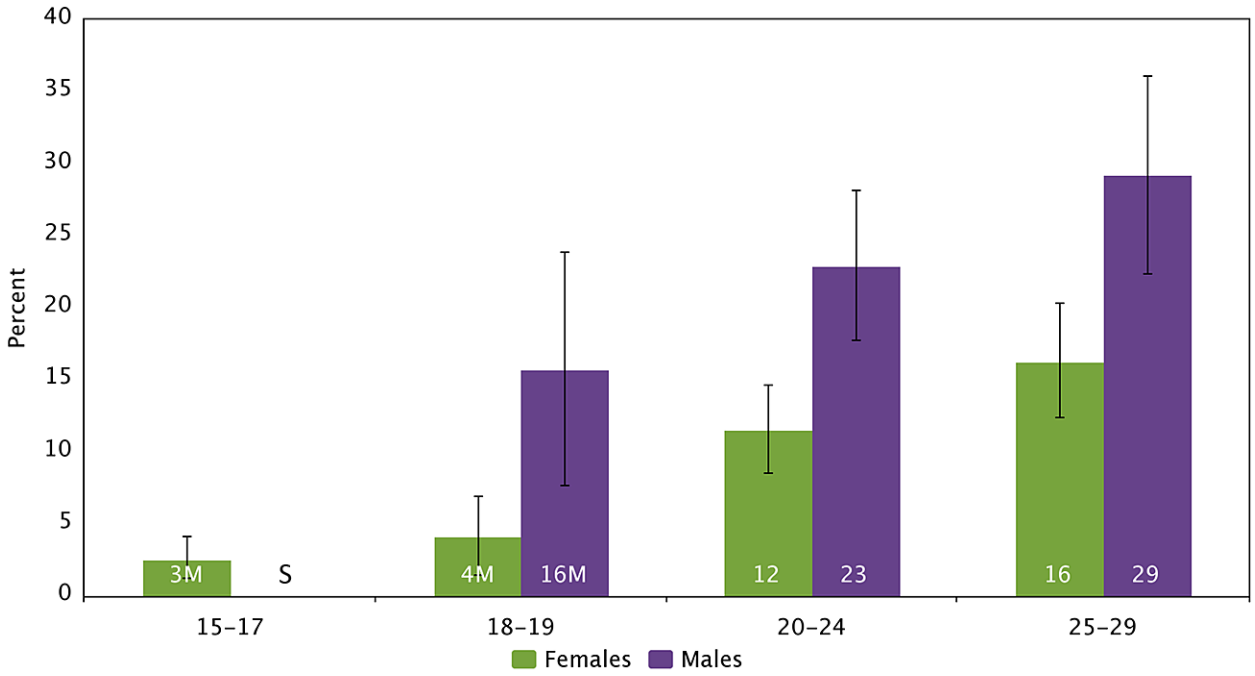
Figure 3-6: Current Smokers (Past-30 Days), Youth and Young Adults, Ontario, 2003 to 2014



Note: M= Marginal. Interpret with caution. X-axis scale (year) not uniform—interpret with caution. Full data table for this graph provided in the Appendix (Table 3A-5).
Source: Canadian Community Health Survey 2003, 2005, 2007-2014.

[iii] Note: The Canadian Community Health Survey, on which this section is based, considers both in-school and out-of-school respondents.
[iv] The 2015 Canadian Community Health Survey was unexpectedly delayed and was not available when this report was released.

Figure 3-7: Current Smokers (Past-30 Days), Youth and Young Adults, by Sex, Ontario, 2014



Note: Vertical lines represent 95% confidence intervals. M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes. Full data table for this graph provided in the Appendix (Table 3A-6).
Source: Canadian Community Health Survey 2014.

Long-Term Outcomes: Use of Alternative Products

Cigars

- According to the 2014 CCHS, past-month use of cigars was 3.3% among 12 to 18 year olds, significantly unchanged from 2009/10 at 5%.

Smokeless Tobacco Products

- In 2015, among Ontario students in grades 7 to 12, 6.3% used smokeless tobacco products (chewing tobacco or snuff) in the past year, significantly unchanged since 2011 (4.6%). Among these past-year users in 2015, 78% tried these products only a few times (OSDUHS, 2015).

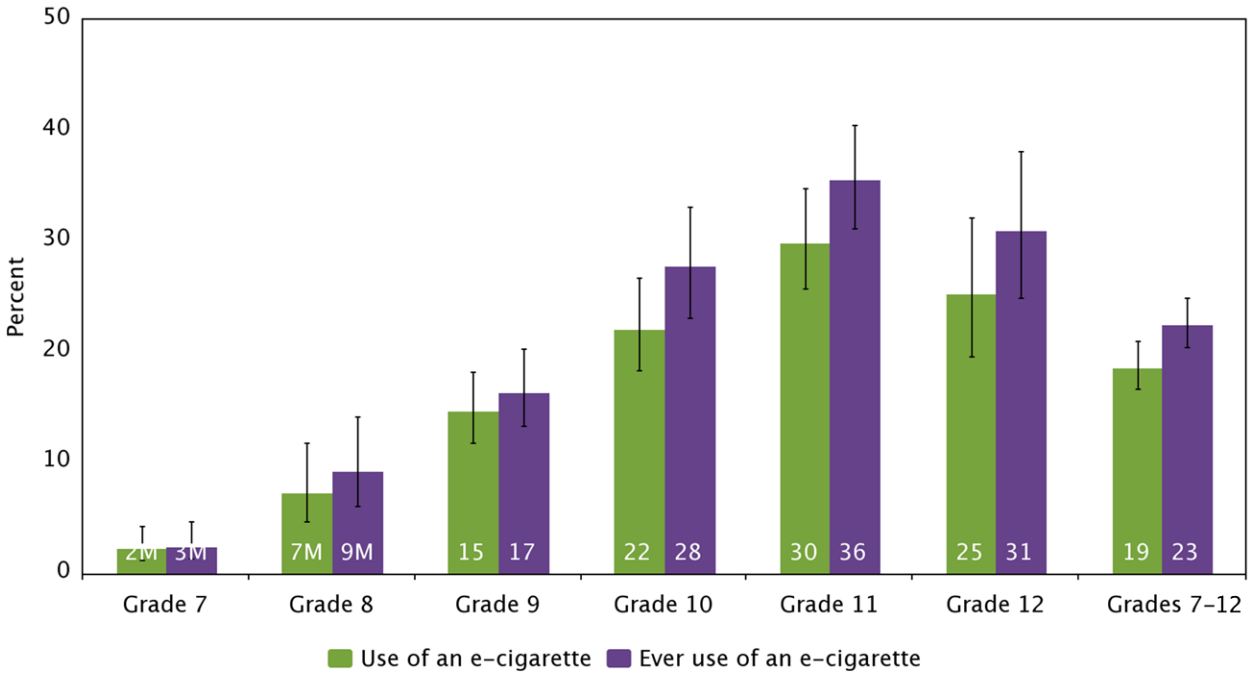
Electronic Cigarettes

- Among students in grades 7 to 12 in 2015, 23% (208,400) had ever used an e-cigarette. Prevalence of ever use varied by grade (Figure 3-8), with rates in grades 7 (3%), 8 (9%) and

9 (17%) significantly lower than that reported in grades 10 (28%), 11 (36%) and 12 (31%).

- Among students in grades 7 to 12, 19% (172,500 students) had used an e-cigarette in the past year (including only a few puffs; Figure 3-8), with rates in grades 7 (2%), 8 (7%) and 9 (15%) significantly lower than that reported in grades 10 (22%), 11 (30%) and 12 (25%).
- Significantly more male than female students in grades 7 to 12 had ever used an e-cigarette a) in their lifetime (27% vs. 18%) or b) in the past year (22% vs.16%; OSDUHS 2015, data not shown).
- Among all past-year users (19%), 6% had used e-cigarettes every day, and 19% had used e-cigarettes in the past month (OSDUHS, 2015; data not shown).
- In Canada, e-cigarettes are not permitted to contain nicotine, yet available evidence suggests that a number of users obtain nicotine juice for their e-cigarettes. Of students in grades 7 to 12 using an e-cigarette in the past year, 14% reported using nicotine-based e-cigarettes, 50% reported using non-nicotine e-cigarettes and 9% used both kinds (a further 26% were not sure what kind of e-cigarette they used; OSDUHS 2015, data not shown).
- Among grade 9 to 12 students who used an e-cigarette in the past year, 19% said they tried smoking it with marijuana, hash oil or wax (OSDUHS, data not shown).

Figure 3-8: E-Cigarette Use, Past Year and Ever Use, by Grade, Ontario, 2015

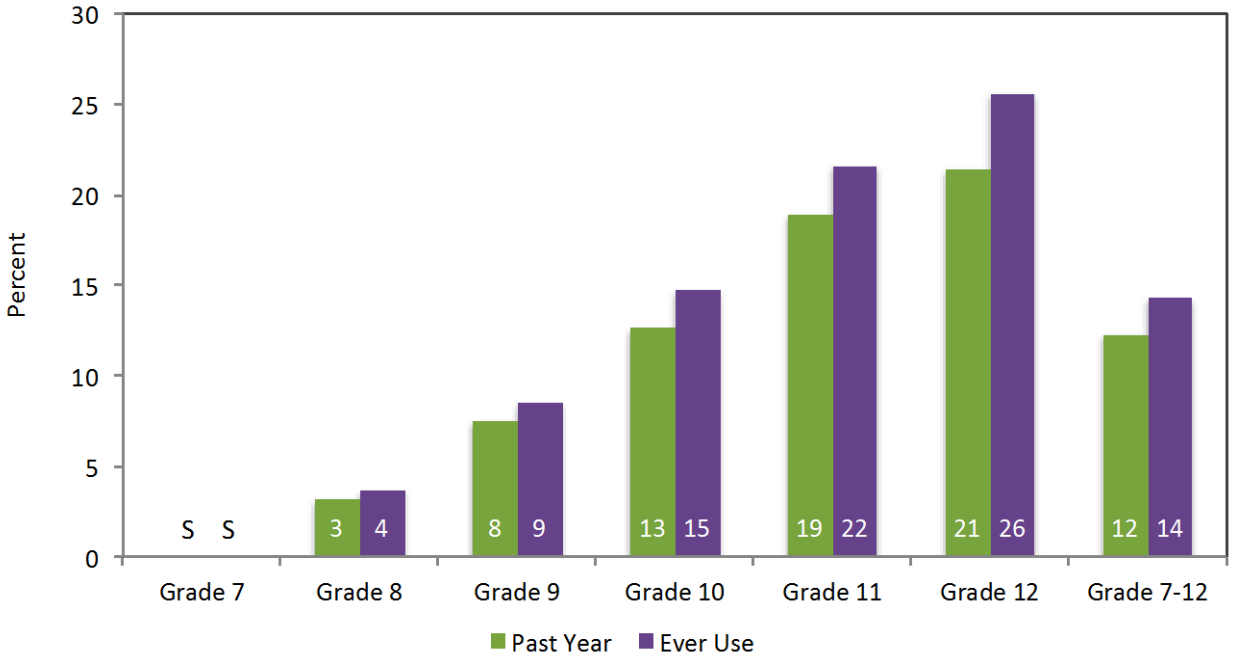


Note: Full data table for this graph provided in the Appendix (Table 3A-7).
Source: Ontario Student Drug Use and Health Survey 2015.

Waterpipes

- Among students in grades 7 to 12 in 2015, 14% (132,400 students) had ever used a waterpipe. Prevalence of ever use varied by grade (Figure 3-9), with rates in grades 8 and 9 significantly lower than those reported in grades 10, 11 and 12.
- Among students in grades 7 to 12, 12% (113,100 students) had used a waterpipe in the past year (including only a few puffs; Figure 3-9), with rates in grades 8 and 9 significantly lower than those reported in grades 11 and 12; and grade 10 lower than that reported for grade 12.
- Past-year use of waterpipe did not differ between 2013 and 2015 (12% vs. 12%).

Figure 3-9: Waterpipe Use, Past Year and Ever Use, by Grade, Ontario, 2015



S = data suppressed due to small sample sizes.
Note: Full data table for this graph provided in the Appendix (Table 3A-8).
Source: Ontario Student Drug Use and Health Survey 2015.

Cannabis Use

The use of Cannabis—which is also known as marijuana, weed, pot, grass, hashish, hash and hash oil—has led to widespread interest in recent years amongst health practitioners, in part, given talk about its possible legalization by the current federal government.

- Among students in grades 7 to 12, lifetime abstinence from cannabis was 76% in 2015 (among students in grades 9 to 12, it was 68%). Abstinence differed by grade: 99% in grade 7, 95% in grade 8, 88% in grade 9, 73% in grade 10, 61% in grade 11 and 58% in grade 12 (OSDUHS 2015). Only 15.5% of past-year cigarette smokers had a lifetime abstinence from cannabis compared to 86% of non-cigarette smokers.
- Among students in grades 7 to 12, 21% used cannabis in the past year (among students in grades 9 to 12, it was 28%; OSDUHS 2015). Reportable levels by grade include: 10% in grade 9, 25% in grade 10, 35% in grade 11 and 37% in grade 12.
- Among students in grades 7 to 12, 14% used cannabis during the past month (among grades 9 to 12, 18% used cannabis). Specifically, past month use of cannabis was 7% in grade 9, 15% in grade 10, 24% in grade 11 and 24% in grade 12 (OSDUHS 2015).

Short and Intermediate-Term Outcomes

Awareness of School and Community Prevention Initiatives

- In 2015, very few students (3%) had participated in an event sponsored by youth groups who were raising awareness of smoking and tobacco issues, although 27% had heard of such groups, unchanged from 2013 (OSDUHS 2013, 2015, data not shown).

Social Climate

Social climate refers to societal norms, practices and beliefs and to patterns of human actions and interactions. Evidence suggests that creating a healthy social climate is a key path for achieving and sustaining the desired outcomes of a comprehensive tobacco control program. One important indicator of the social climate around tobacco use is the social acceptability of smoking.

Social Acceptability

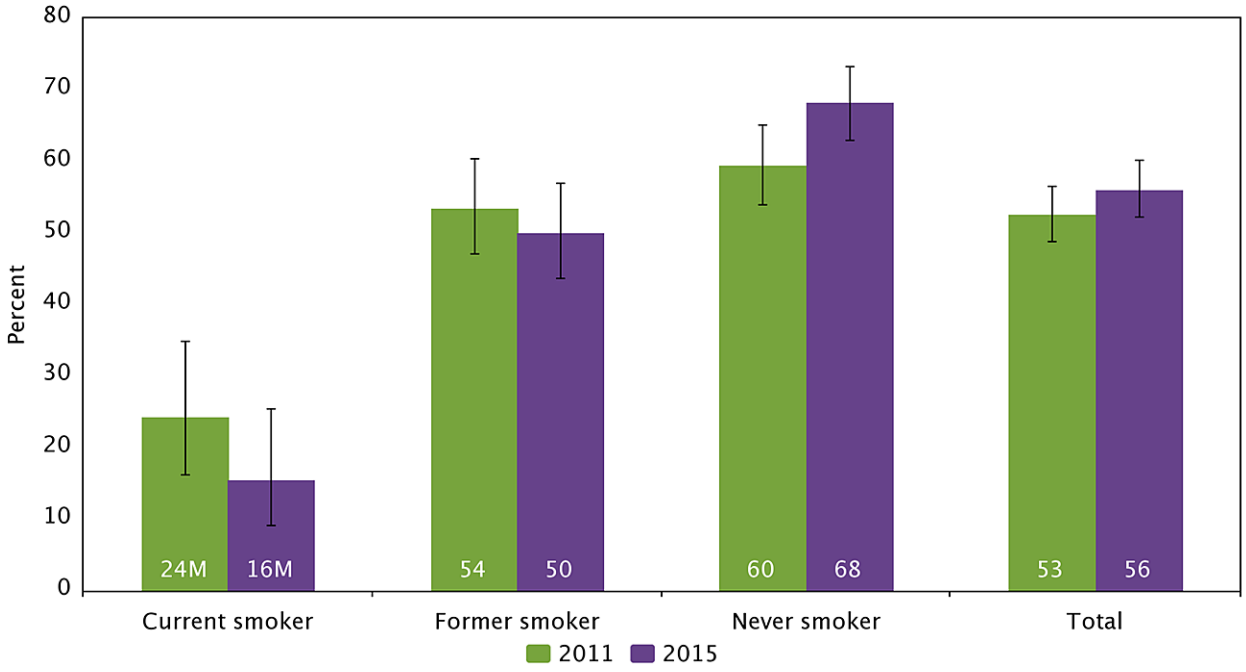
- In 2015, 68% of never smokers, 50% of former smokers and 16% of current smokers aged 18 years and over reported that it was unacceptable for adults to smoke (CAMH Monitor 2015; Figure 3-10), unchanged from 2011.
- In 2015, smoking by teenagers was viewed as highly unacceptable among all adults regardless of the respondent's smoking status (Figure 3-11). Never smokers and former smokers reported a significantly higher level of disapproval of smoking by teenagers, than did current smokers (93% and 92% vs. 71%; Figure 3-11).

- Adult views on the unacceptability of teenagers smoking remained stable from 2011 to 2015 (Figure 3-11).
- In 2015, 41% of adults viewed it as unacceptable for adults to use e-cigarettes whereas 77% viewed it as unacceptable for teenagers to use an e-cigarette (CAMH Monitor 2015, data not shown).

Smoking in Movies

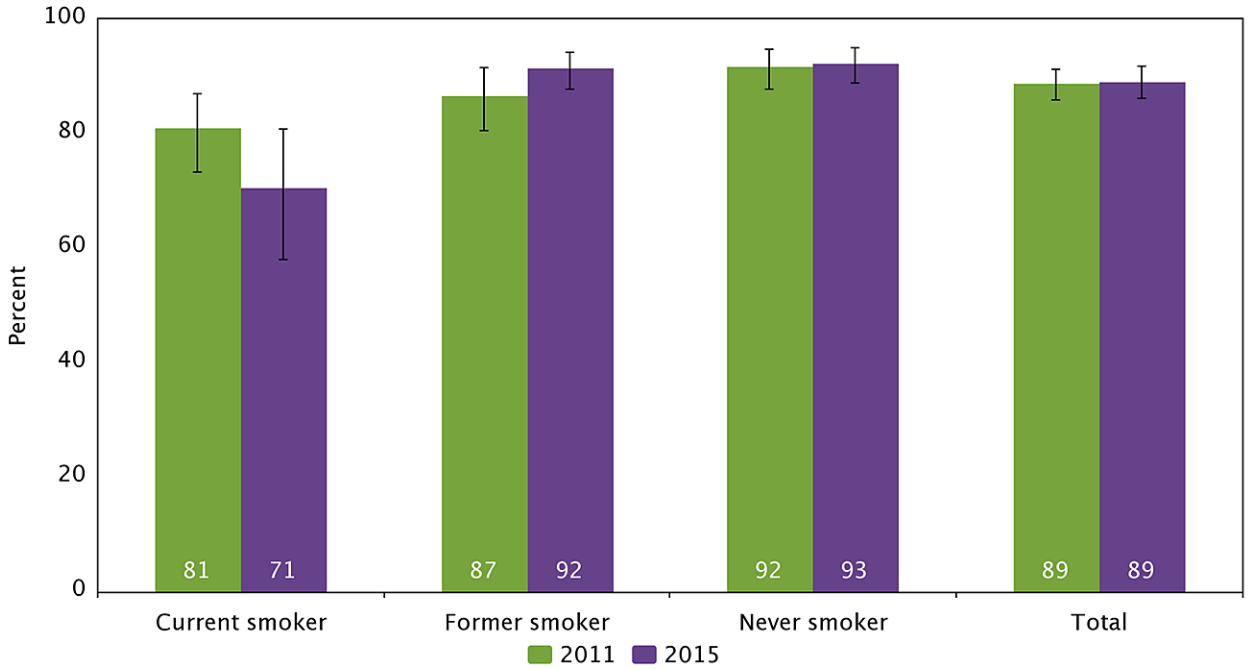
- Three in 10 students who were nonsmokers (30%) were in agreement that movies showing characters smoking should be rated 18A compared to 14% of students who were past-year smokers (OSDUHS 2015, data not shown; 14% is a marginal estimate. Interpret with caution).
- Over half of all adults (54%) agreed that movies showing characters smoking should be rated 18A. One in three (33%) current smokers were also in agreement (CAMH Monitor 2015, data not shown).

Figure 3-10: Adult Views on the Social Unacceptability of Adults Smoking Cigarettes, by Smoking Status, Ontario, 18+, 2011 and 2015



Note: Vertical lines represent 95% confidence intervals. M=Marginal. Interpret with caution: subject to moderate sampling variability. Full data table for this graph provided in the Appendix (Table 3A-9).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Figure 3-11: Adult Views on the Social Unacceptability of Teenagers Smoking Cigarettes, by Smoking Status, Ontario, 18+, 2011 and 2015



Note: Vertical lines represent 95% confidence intervals. Full data table for this graph provided in the Appendix (Table 3A-10).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Ease of Obtaining Cigarettes

In 2015, 53% of students in grades 7 to 12 under the age of 19 believed it was fairly easy or very easy to obtain cigarettes, a significant decrease from 61% reported in 2013 (OSDUHS, data not shown). Students in grades 9 to 12 were much more likely to report it was fairly easy or very easy to obtain cigarettes compared to students in grades 7 to 8 (64% vs. 21%).

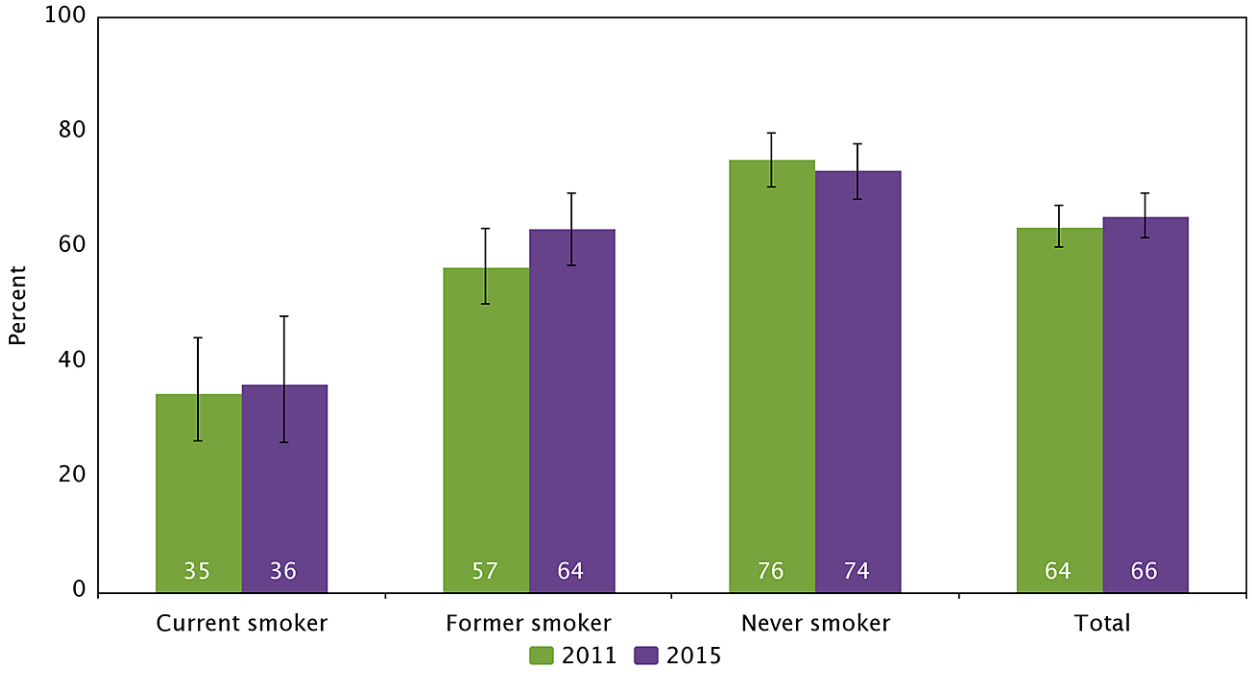
Support for Measures Related to Product Availability

Retail Sales

- In 2015, 63% of Ontario students in grades 7 to 12 under 19 years of age indicated their support for further restrictions on tobacco sales. That is, 35% agreed that tobacco products should not be sold at all and 28% responded that tobacco products should be sold in government-owned stores, similar to the way alcohol is sold in liquor stores. Only 17% responded that tobacco products should be sold in a number of places as they are now (OSDUHS 2015, data not shown).

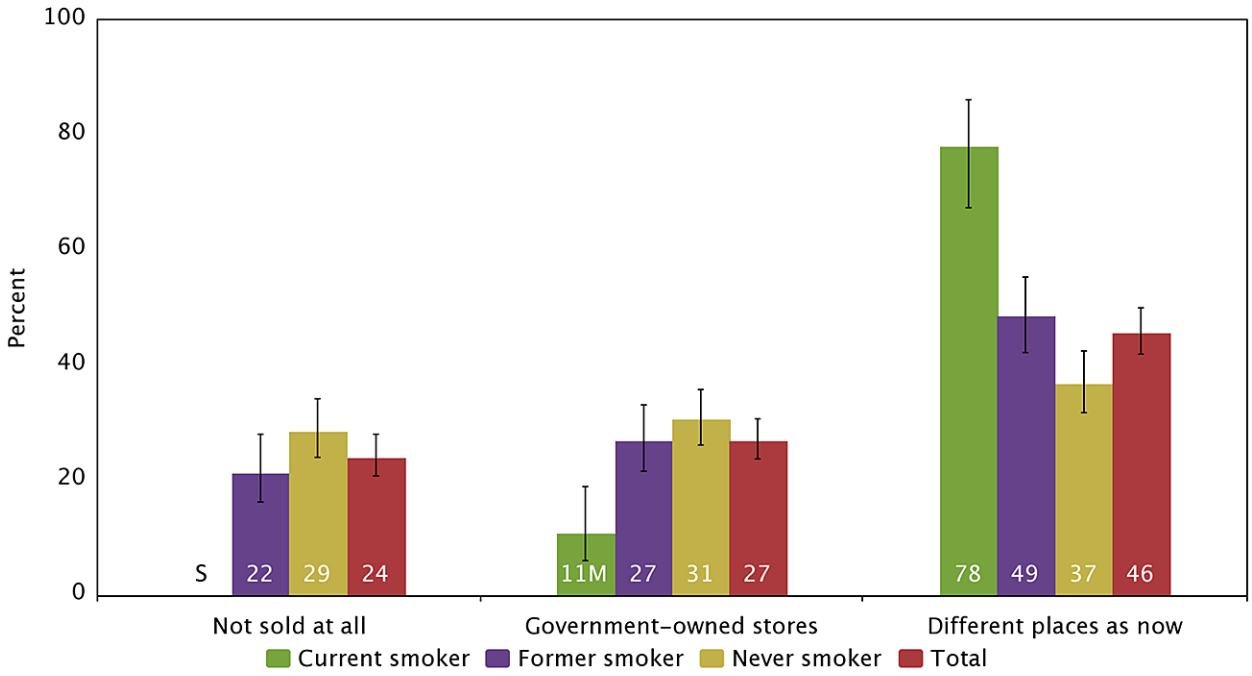
- In 2015, 66% of all Ontario adults agreed that the number of retail outlets that sell cigarettes should be greatly reduced, a rate unchanged in recent years (Figure 3-12, CAMH Monitor 2015). Significantly more never smokers and former smokers agreed with this policy option (74% and 64%, respectively) compared to 36% of current smokers (Figure 3-12).
- In 2015, 51% of adults in Ontario indicated their support for further restrictions on tobacco retail location. Specifically, almost one quarter (24%) responded that tobacco products should not be sold at all, 27% responded tobacco should be sold in government-owned stores similar to the way alcohol is sold in Liquor Control Board of Ontario stores, and 46% agreed that tobacco should be sold in a number of different places as they are now (Figure 3-13; no change over a 5-year reference period, 2011 to 2015, data not shown).
- Opinion about how tobacco products should be sold differed by grade (for kids under 19 years of age), with 48% of grade 7 and 8 students indicating that tobacco products should not be sold at all but only 31% of students in grades 9 to 12 sharing this view.

Figure 3-12: Agreement that the Number of Retail Outlets Selling Cigarettes Should Be Reduced, by Smoking Status, Ages 18+, Ontario, 2011 and 2015



Note: Vertical lines represent 95% confidence intervals. Full data table for this graph provided in the Appendix (Table 3A-11).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Figure 3-13: Views on How Tobacco Should Be Sold, Ages 18+, Ontario, 2015



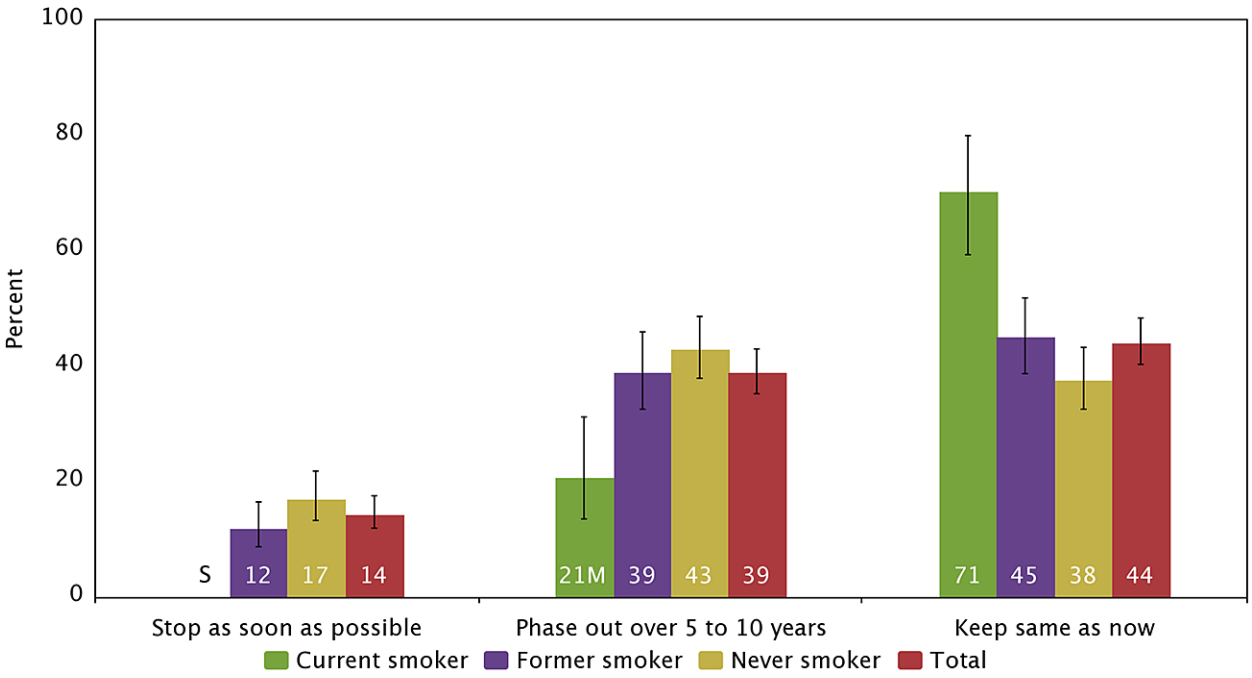
Note: S = data suppressed due to small sample sizes. Survey wording as follows: Which of the following comes closest to your view of how we should treat tobacco products in Ontario? Tobacco products should be sold in a number of different places, AS THEY ARE NOW; Tobacco products should be sold in government-owned stores similar to the way alcohol is sold in LCBO stores; Tobacco products should not be sold at all. Vertical lines represent 95% confidence intervals. Full data table for this graph provided in the Appendix (Table 3A-12).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Support for the Prohibition of Tobacco Products

- In 2015, 14% of Ontario adults responded that the sale of cigarettes should be stopped as soon as possible, 39% felt cigarettes should be phased out over the next five to 10 years and 44% felt that the sale of cigarettes should be kept as it is now (Figure 3-14), unchanged from the reference year of 2011 (data not shown).
- Two out of every ten smokers (21%) felt that cigarettes should be phased out in five to 10 years, whereas, 71% of smokers responded that the sale of cigarettes should be kept the same (Figure 3-14).
- Over half of all Ontario adults are in agreement that tobacco products should forever not be sold to youth who are now teenagers even when they reach adulthood (Figure 3-15); 28% of current smokers are likewise in agreement (Note. Marginal estimate. Interpret with caution).
- Adults in Ontario had varied beliefs about where e-cigarettes should be sold including

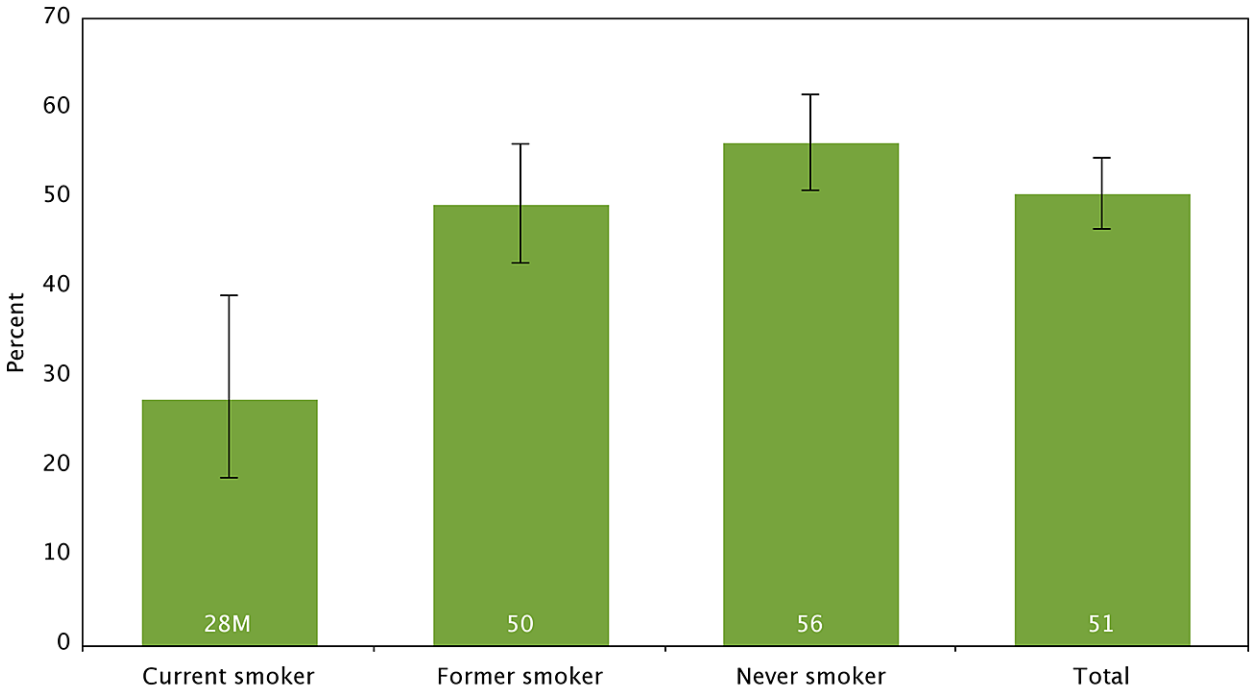
not at all (21%), different place as is the case now (31%), government-owned stores (13%), pharmacies (12%), vape shop (12%), with 12% responding that they did not know where it should be sold (Figure 3-16). Among past-year e-cigarette users, 63% believed e-cigarettes should be sold in different places as is the case now (CAMH Monitor 2015, data not shown).

Figure 3-14: Views on the Sale of Cigarettes, by Smoking Status, Ages 18+, Ontario, 2015



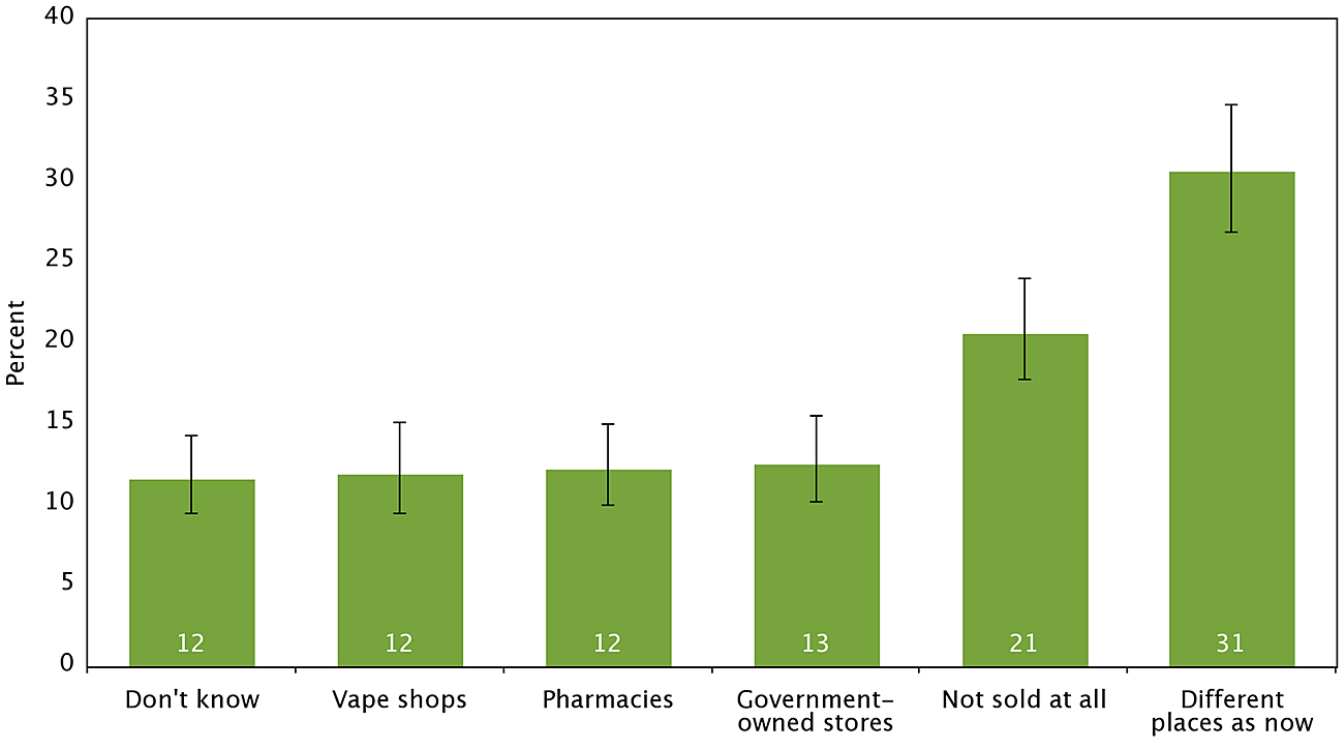
Note: S = data suppressed due to small sample sizes. Vertical lines represent 95% confidence intervals. Full data table for this graph provided in the Appendix (Table 3A-13).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Figure 3-15: Agreement that Tobacco Products Should Forever Not Be Sold to Youth Who Are Now Teenagers Even When They Reach Adulthood, Ontario, 2015



Note: Vertical lines represent 95% confidence intervals. M=Marginal. Interpret with caution: subject to moderate sampling variability. Full data table for this graph provided in the Appendix (Table 3A-14).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Figure 3-16: Opinion About Where E-Cigarettes Should Be Sold, Ontario, 2015



Note: Vertical lines represent 95% confidence intervals. Full data table for this graph provided in the Appendix (Table 3A-15).
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

MPOWER Comparison with Ontario: Prevention

Six MPOWER indicators relate to prevention: Monitoring, Health Warning Labels, Mass Media Campaigns, Tobacco Advertising Bans, Advertising Ban Compliance and Taxation (Table 3-4).

Table 3-4: Assessing Prevention: MPOWER Indicators Applied to Ontario

MPOWER Indicator	Highest MPOWER Requirement	Situation in Ontario
Monitoring	Recent, representative and periodic data for both adults and youth).	Meets the requirement for the highest score.
Health warning labels on cigarette packages	Large health warning labels (i.e., over 50% of package panel, graphic, rotate, specific health warnings).	Meets the requirement for the highest score.
Mass media campaigns	Research to gain a thorough understanding of the target audience, air time (radio and television) and placement (billboards, print ad); effectively and efficiently reach a target audience; gain publicity or news coverage for the campaign; evaluation of the campaign reach and impact.	Since January 2011, no sustained and intensive provincial prevention campaigns have been conducted in Ontario with duration longer than three weeks. There have been varied online and local campaigns and the Ontario Ministry of Health and Long-Term Care created a new campaign in March 2013 called Quit the Denial (a campaign targeting young adults aged 18 to 29 years old who are social smokers but don't view themselves as smokers).
Tobacco advertising bans	Ban on all forms of direct and indirect advertising.	Direct mail to adult readership, non-tobacco goods and services with tobacco brand names and appearance of tobacco products in TV and/or films are allowed in Ontario (and Canada).
Advertising ban compliance	Complete compliance.	Meets the requirement for the highest score.
Taxation	Tobacco tax > 75% of the retail price.	Tobacco tax at 65.1% of the retail price in Ontario in 2015.

Scientific Advisory Committee: Overview of Prevention Goals and Recommendations

The Scientific Advisory Committee[v] (SAC) goal for prevention is: "To prevent the uptake of tobacco use among youth and young adults in Ontario, where uptake encompasses all stages of smoking, initiation and progression." The SAC report includes several recommendations on media and social marketing, movies and video games, policy enforcement, program alignment, high-risk youth and young adults, evaluation and monitoring, retail access and compliance and cessation assessment and early intervention. As related in earlier parts of this chapter, progress has been made in many of these areas, but more work remains to address several shortcomings (e.g., movies and video game ads to denormalize tobacco industry and change social norms) and to increase intensity (e.g., media and social marketing, assessment of smoking status and provision of cessation services to youth and young adults).

2010 Scientific Advisory Committee Recommendations

Media and Social Marketing

SAC Recommendation 5.1: Implement media and social marketing strategies using traditional and non-traditional media (e.g., viral and interactive media channels) that denormalize the tobacco industry, highlight the social unacceptability of tobacco use, identify resources available to youth and young adults who want to quit and encourage youth and young adults to refrain from tobacco use.

Current Status: Since January 2011, no sustained and intensive campaigns have been conducted in Ontario with duration longer than three weeks. There have been varied online and local campaigns and the MOHLTC created a campaign in March 2013 called Quit the Denial (a campaign targeting young adults aged 18 to 29 years old who are social smokers but don't view themselves as smokers).

[v] Upon request of the Ministry of Health Promotion and Sport, a committee of lead tobacco control researchers in Ontario was convened to provide scientific and technical advice and recommendations to the Government of Ontario to inform the comprehensive tobacco control strategy renewal for 2010-2015.

Movies and Video Games

SAC Recommendation 5.2: Require adult ratings for movies (18A) and video games (Mature) with any tobacco imagery.

Current Status: The Ontario Film Review Board (OFRB) provides a 'tobacco use' content advisory for movies released in Ontario. Of the 879 top-grossing movies released over the period 2008 to 2014, 438 featured tobacco imagery, yet the OFRB posted tobacco use observations for only two thirds of these (288/438).

Current Status: Tobacco use continues to be shown in movies that are rated for youth viewing.

SAC Recommendation 5.3: Require ads that aim to denormalize tobacco companies and change social norms related to tobacco products and their use preceding movies and video games that contain tobacco imagery, as well as warnings on movie and video game packaging.

Current Status: No requirements for ads preceding movies and video games that contain tobacco imagery.

Policy Enforcement

SAC Recommendation 5.4: Develop, implement and enforce comprehensive tobacco control policies within and across settings (e.g., schools, colleges, universities and communities).

Current Status: Comprehensive legislation on sales to minors enforced; legislation enacted to: a) prohibit the sale of tobacco on college and university campuses, as of January 1, 2015, and b) prohibit flavoured tobacco ("adult" flavours excepted such as wine, port, whiskey or rum), with a delayed implementation date of January 1, 2017 for menthol-flavoured tobacco products.

The Ministry of Finance strengthened oversight of raw leaf tobacco, effective January 1, 2015, to enable comprehensive coverage of the tobacco supply chain and provides greater opportunity to

disrupt the diversion of raw leaf tobacco to contraband manufacturers.[vi]

The Ontario government also introduced legislation that amended the *Tobacco Tax Act* to: increase fines for offences related to marked tobacco products and allow for the impoundment of vehicles used to transport contraband tobacco.

Program Alignment

SAC Recommendation 5.5: Align cessation and prevention programs in schools, colleges, universities and communities with other activities (e.g., media and social marketing, policy interventions), within the provincial Tobacco Control Strategy.

Current Status: TCANs, health units, YATI and LTPB have variously worked in these settings, leveraging prevention programs and other activities.

High-Risk Youth and Young Adults

SAC Recommendation 5.6: Target program interventions to the schools, colleges, universities and workplaces where youth and young adults are at greatest risk for tobacco use.

Current Status: TCANs, health units, YATI and LTPB have variously targeted prevention programs in these settings. The extent to which high-risk youth and young adults are targeted is unknown at this time.

Evaluation and Monitoring

SAC Recommendation 5.7: Further develop and implement an integrated system of intervention development, evaluation and surveillance that is applicable province-wide and at the local level, to: A) Identify high-risk environments and at-risk sub-populations. B) Guide the implementation of evidence-based prevention initiatives (programs and policies). C) Evaluate the impact that changes in programs and policies have on youth and young adult smoking behaviour over time.

[vi] Ontario Ministry of Finance. *Contraband Tobacco: Recent Action Taken*. Queen's Printer of Ontario, 2010. Accessed on February 27, 2017.

Current Status: OTRU, in partnership with SFO partners, have a strong provincial-level surveillance system in place. Additional surveillance work remains at the local level and in the identification of high-risk environments and sub-populations. OTRU provides SFO partners knowledge and evaluation support.

Retail Access and Compliance

SAC Recommendation 5.8: Implement revised and more rigorous (realistic) compliance protocols with tobacco retailers regarding sales to underage consumers.

Current Status: No change to existing protocol.

Cessation Assessment and Early Intervention

SAC Recommendation 5.9: Ensure smoking status is assessed and cessation services are provided in all settings (e.g., social, school and health care) providing services to youth and young adults.

Current Status: Not consistently implemented.

Chapter Summary

Policies and programs to prevent initiation—including taxation, restrictions on youth access, smoking bans, advertising bans, youth engagement initiatives and school-based programming—have had some success in the general youth population. Reporting of past 30-day current smoking is too small in the lower grades to adequately measure in 2015, but it is 2% in grades 9 and 10 combined and 5% for grade 11 and 12, which is significantly lower from that reported for the pre-SFO baseline year of 2005 (5% and 12%, respectively; Figure 3-5).

Despite improvements in recent years, past 30-day current smoking is firmly established among 18- to 19-year olds (10%), young adults aged 20 to 24 (17%) and young adults aged 25 to 29 (23%; Figure 3-6). However, rates of past-30 day current smoking are much higher for young adult males (12% for females and 23% for males aged 20 to 24; Figure 3-7). Efforts to prevent initiation in this young adult age group include expansion of LTPB to community colleges and targeted social marketing campaigns. Overall, more research may be needed to support interventions that will more quickly and effectively prevent initiation among young adults.

Among youth, emerging products, including e-cigarettes and waterpipes, are a growing concern. According to the Ontario Student Drug Use and Health Survey, e-cigarettes have a particularly high rate of ever and past-year use (Table 3-5), albeit cigarettes may be used more frequently. Cannabis has the highest ever use and past-year use compared to these other products.

Table 3-5: Ever Use and Past-Year Use of Cigarettes, E-Cigarettes, Waterpipe and Cannabis, Grades 7 to 12, 2015

Product	Ever use, %	Past year, %
Cigarettes	19	14
E-Cigarettes	23	19
Waterpipe	14	12
Cannabis	24	21

Source: Ontario Student Drug Use and Health Survey 2015.

Although Ontario does well on most of the MPOWER indicators related to prevention, there are still noticeable gaps in meeting these minimum requirements. Despite a small increase again

this past year, tobacco tax is still lower than the 75% of retail price minimum; mass media campaigns, though improved, are still inadequate in target, duration and intensity; and gaps remain in banning advertising of tobacco products.

Ontario continues to fall short on several of the Scientific Advisory Committee recommendations for preventing tobacco use among youth and young adults. Notably, tobacco use continues to be shown in movies that are rated for youth viewing; there are no requirements to run ads denormalizing tobacco preceding movies and video games that contain tobacco imagery; and the protocols for compliance of tobacco retailers with restrictions on sales to minors have not improved. Moreover, SAC noted that beyond basic information about tobacco being provided in all schools, prevention efforts need to focus on high-risk schools, colleges and workplaces where youth and young adults are at greatest risk for tobacco use. Our analyses of 2015 data indicate that a significant number of students in grades 9 to 12 who are current smokers also have a drug use problem (80%), a hazardous drinking problem (71%), and engage in delinquent behaviour (38%; See Figure 2-13 in Tobacco Use chapter). It is unclear whether sufficient effort is being directed to targeting youth and young adults who are most at risk of becoming established tobacco users.

The progress in decreasing cigarette initiation among school-aged youth has held course. At the same time, there is stagnation in decreasing cigarette use among young adults indicating a need for more focus on policies and programs for those at high risk. Moreover, alternative tobacco products, including e-cigarettes and waterpipes, are being used by a significant number of youth and young adults. Cannabis use is particularly high compared to these other products. Prevention infrastructure, programming, policies and surveillance need to keep pace not only with existing patterns of tobacco use but new and emerging patterns as well.

Visual Summary of Key Prevention Indicators

Past Year Use

14% of grade 7 to 12 students used cigarettes

24% of grade 12 students used cigarettes (peak)

6% of grade 7 to 12 students used cigarettes for the first time

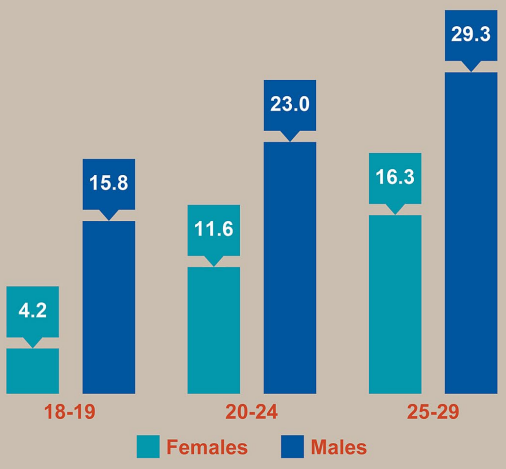
12% of grade 11 students used cigarettes for the first time (peak)

19% of grade 9 to 12 students tried smoking marijuana, hash oil or wax with e-cigarettes (among those who used e-cigarettes)

19% of grade 7 to 12 students used e-cigs

30% of grade 11 students used e-cigs (peak)

Past 30 Day Use



12% of grade 7 to 12 students used waterpipe

21% of grade 12 students alone used waterpipe

Male youth and young adults were significantly more likely to smoke than females of the same age

Appendix: Data Tables

Table 3A-1: Lifetime Abstinence, by Grades 7 to 12, Ontario, 2003 to 2015

Grade	2003	2005	2007	2009	2011	2013	2015
Grade 7	80	91	93	94	97	97	98
Grade 8	72	84	88	88	90	92	93
Grade 9	61	69	76	82	88	88	89
Grade 10	52	59	67	68	77	80	80
Grade 11	42	54	57	63	65	72	69
Grade 12	41	49	55	58	65	66	68
Grade 7-12	57	67	72	74	78	80	81

Note: Data table is for Figure 3-2.
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Table 3A-2: Use of Cigarettes for the First Time in the Past Year, by Grades 7 to 12, Ontario, 2003 to 2015

Year	Grade	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2003	Grade 7	5.8	4.3	7.8
	Grade 8	8.1	5.2	12.3
	Grade 9	12.3	10.1	14.8
	Grade 10	9.8	7.9	12.1
	Grade 11	10.6	9	12.5
	Grade 12	8.2	6.6	10.1
	Grades 7-12	9.3	8.4	10.3
2005	Grade 7	2.9	1.7	5
	Grade 8	5.3	3.2	8.6
	Grade 9	7.7	5.7	10.2
	Grade 10	10.3	8	13.2
	Grade 11	8.8	6.5	11.8
	Grade 12	8.1	5.9	11.1
	Grades 7-12	7.3	6.4	8.3
2007	Grade 7	S		
	Grade 8	5.2	2.7	9.8
	Grade 9	6.6	4.6	9.3
	Grade 10	8.2	5.8	11.6
	Grade 11	7.6	5.4	10.6
	Grade 12	8	5.5	11.3
	Grades 7-12	6.3	5.2	7.7
2009	Grade 7	S		
	Grade 8	3.6	2	6.5
	Grade 9	4.3	2.6	6.9
	Grade 10	7.6	5.5	10.5
	Grade 11	8.8	6.3	12.2
	Grade 12	8.6	5.6	13
	Grades 7-12	6.1	5.1	7.4
2011	Grade 7	S		
	Grade 8	4.5	2.6	7.7
	Grade 9	5.7	3.7	8.6
	Grade 10	7.3	4.5	11.5
	Grade 11	6.1	3.9	9.5
	Grade 12	9.1	5.6	14.6
	Grades 7-12	6.3	5.1	7.6

Year	Grade	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2013	Grade 7	S		
	Grade 8	S		
	Grade 9	2.7	1.4	5
	Grade 10	6	3.8	9.4
	Grade 11	9.9	6.5	14.8
	Grade 12	5.6	3.9	8
	Grades 7-12	5.3	4.3	6.5
2015	Grade 7	S		
	Grade 8	S		
	Grade 9	4.9 [M]	3.3	7.2
	Grade 10	6.7	5	9
	Grade 11	12.2	9.2	16
	Grade 12	7.9 [M]	5.6	11
	Grades 7-12	6.3	5.4	7.4

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes. Data table is for Figure 3-3.
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Table 3A-3: Past-Year Smoking, by Grades 7 to 12, Ontario, 2003 to 2015

Grade	2003	2005	2007	2009	2011	2013	2015
Grade 7	13	6	4	3	3	1	S
Grade 8	21	11	7	7	6	4	S
Grade 9	29	21	16	12	8	8	8
Grade 10	35	29	20	23	16	14	16
Grade 11	42	34	30	25	24	22	21
Grade 12	43	36	30	29	25	24	24
Grade 7-12	31	23	18	18	15	14	14

Note: S = data suppressed due to small sample sizes. Data table is for Figure 3-4.
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Table 3A-4: Current Smoking (Past-30 Days), by Grade, Ontario, 2003 to 2015

Year	Grades 9 to 10	Grades 11 to 12
2005	5	12
2007	4	8
2009	4	9
2011	3	6
2013	2	6
2015	2	5

Note: Data table is for Figure 3-5.
Source: Ontario Student Drug Use and Health Survey 2003–2015 (Biennial).

Table 3A-5: Current Smokers (Past-30 Days), Youth and Young Adults, Ontario, 2003 to 2014

Year	Age	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2003	15-17	54,700	11.5	9.7	13.2
	18-19	75,600	23.5	20.4	26.6
	20-24	256,400	30	27.2	32.7
	25-29	214,900	28.2	25.7	30.8
2005	15-17	47,600	9	7.3	10.8
	18-19	58,800	18	15.4	20.5
	20-24	231,900	26.1	23.8	28.3
	25-29	228,800	29	26.8	31.3
2007	15-17	35,500	6.5	4.8	8.2
	18-19	63,100	19.4	13.7	25
	20-24	226,400	26.9	23.3	30.4
	25-29	255,300	29.2	25.9	32.6
2008	15-17	28,900	5.8	4.2	7.5
	18-19	54,600	16	12.1	19.8
	20-24	208,700	23.5	19.6	27.5
	25-29	260,700	30.7	27.2	34.2
2009	15-17	40,100	7.7	5.4	9.9
	18-19	44,500	13.2	9.6	16.8
	20-24	179,600	20.4	17	23.8
	25-29	224,900	25.6	21.9	29.2
2010	15-17	37,000	6.9	5	8.9
	18-19	55,300	16.3	12.1	20.5
	20-24	238,500	25.3	21.2	29.3
	25-29	212,100	24.4	21.3	27.6
2011	15-17	19,600	3.8 [M]	2.3	5.2
	18-19	35,000	10.2 [M]	6.9	13.5
	20-24	199,800	20.5	17.1	24
	25-29	214,500	24.7	21.1	28.4
2012	15-17	20,400	3.7 [M]	1.9	5.5
	18-19	31,000	10.7 [M]	7	14.5
	20-24	228,900	23.2	19.2	27.2
	25-29	211,200	23.8	19.9	27.7
2013	15-17	18,700	3.7 [M]	2.2	5.1
	18-19	37,800	10.9 [M]	7.2	14.6
	20-24	197,700	21.2	17.8	24.6
	25-29	242,700	25.3	21.6	29
2014	15-17	17,800	3.3 [M]	1.7	4.9
	18-19	33,700	10.4 [M]	5.8	15
	20-24	171,000	17.3	14.3	20.4
	25-29	202,900	22.8	18.8	26.7

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. Data table is for Figure 3-6.
Source: Canadian Community Health Survey 2003-2014.

Table 3A-6: Current Smokers (Past-30 Days), Youth and Young Adults, by Sex, Ontario, 2014

Age	Sex	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
15-17	Females	6,700	2.6 [M]	1.2	4.1
15-17	Males		S		
18-19	Females	6,400	4.2 [M]	1.5	6.9
18-19	Males	27,400	15.8 [M]	7.7	23.9
20-24	Females	56,700	11.6	8.5	14.6
20-24	Males	114,200	23	17.8	28.2
25-29	Females	73,300	16.3	12.4	20.3
25-29	Males	129,500	29.3	22.4	36.1

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes. Data table is for Figure 3-7.
Source: Canadian Community Health Survey 2014.

Table 3A-7: E-Cigarette Use, Past Year and Ever Use, by Grade, Ontario, 2015

Use of an E-Cigarette	Group	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Past Year	Grade 7	2,600	2.3 [M]	1.2	4.2
	Grade 8	8,900	7.4 [M]	4.6	11.8
	Grade 9	22,000	14.7	11.7	18.2
	Grade 10	34,500	22.2	18.3	26.7
	Grade 11	48,700	30	25.7	34.7
	Grade 12	55,900	25.3	19.5	32.1
	Grades 7-12	172,500	18.7	16.7	20.9
Ever Use	Grade 7	2,800	2.5 [M]	1.3	4.6
	Grade 8	11,300	9.4 [M]	6.1	14.1
	Grade 9	24,700	16.5	13.3	20.3
	Grade 10	43,200	27.8	23.1	33.1
	Grade 11	57,700	35.6	31.1	40.4
	Grade 12	68,800	31.1	24.9	38.1
	Grades 7-12	208,400	22.6	20.4	24.9

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. Data table is for Figure 3-8.
Source: Ontario Student Drug Use and Health Survey 2015.

Table 3A-8: Waterpipe Use, Past Year and Ever Use, by Grade, Ontario, 2015

Any Use of a Waterpipe	Group	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Past Year	Grade 7		S		
	Grade 8	3,800	3.2 [M]	1.7	5.9
	Grade 9	11,200	7.5	5.5	10
	Grade 10	19,500	12.6	9.5	16.4
	Grade 11	30,700	18.9	15.2	23.4
	Grade 12	47,300	21.4	18	25.3
	Grades 7-12	113,100	12.3	10.8	13.9
Ever use of waterpipe	Grade 7		S		
	Grade 8	4,500	3.7 [M]	2.1	6.6
	Grade 9	12,700	8.5	6.4	11.2
	Grade 10	22,800	14.7	11.5	18.6
	Grade 11	35,000	21.6	17.3	26.5
	Grade 12	56,500	25.6	20.5	31.3
	Grades 7-12	132,400	14.3	12.6	16.2

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes. Data table is for Figure 3-9.
Source: Ontario Student Drug Use and Health Survey 2015.

Table 3A-9: Adult Views on the Social Unacceptability of Adults Smoking Cigarettes, by Smoking Status, Ontario, 18+, 2011 and 2015

Year	Smoking Status	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2011	Current smoker		24.4 [M]	16.3	34.9
	Former smoker		53.7	47	60.3
	Never smoker		59.6	53.9	65.1
	Total		52.7	48.8	56.6
2015	Current smoker	218,600	15.7 [M]	9.1	25.5
	Former smoker	1,409,700	50.2	43.6	56.9
	Never smoker	4,139,600	68.4	63	73.3
	Total	5,767,900	56.2	52.2	60.2

Note. M=Marginal. Interpret with caution: subject to moderate sampling variability. Data table is for Figure 3-10.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Table 3A-10: Adult Views on the Social Unacceptability of Teenagers Smoking Cigarettes, by Smoking Status, Ontario, 18+, 2011 and 2015

Year	Group	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2011	Current smoker		81.2	73.3	87.1
	Former smoker		86.9	80.6	91.5
	Never smoker		92	87.7	94.9
	Total		88.9	85.9	91.3
2015	Current smoker	987,600	70.8	58	80.9
	Former smoker	2,554,400	91.6	87.9	94.2
	Never smoker	5,608,000	92.5	88.9	95
	Total	9,150,000	89.3	86.3	91.7

Note: Data table is for Figure 3-11.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Table 3A-11: Agreement that the Number of Retail Outlets Selling Cigarettes Should Be Reduced, by Smoking Status, Ages 18+, Ontario, 2011 and 2015

Year	Group	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
2011	Current smoker		34.8	26.3	44.4
	Former smoker		56.9	50.2	63.4
	Never smoker		75.6	70.7	80
	Total		63.9	60.1	67.5
2015	Current smoker	507,500	36.4	26.1	48.1
	Former smoker	1,782,200	63.6	57	69.7
	Never smoker	4,451,900	73.7	68.5	78.2
	Total	6,741,600	65.8	61.9	69.6

Note: Data table is for Figure 3-12.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2011 and 2015.

Table 3A-12: Views on How Tobacco Should Be Sold, Ages 18+, Ontario, 2015

Policy Option	Smoking Status	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Different places as now	Current smoker	1,091,100	78.2	67.5	86.1
	Former smoker	1,367,300	48.7	42.1	55.4
	Never smoker	2,244,000	37.1	31.9	42.5
	Total	4,702,400	45.8	41.9	49.9
Government-owned stores	Current smoker	152,600	10.9 [M]	6.1	18.8
	Former smoker	757,400	27	21.6	33.1
	Never smoker	1,858,600	30.7	26.1	35.8
	Total	2,768,600	27	23.7	30.6
Not sold at all	Current smoker		S		
	Former smoker	604,200	21.5	16.2	28.1
	Never smoker	1,746,100	28.8	24.1	34.1
	Total	2,485,400	24.2	20.9	28

Note: S = data suppressed due to small sample sizes. Survey wording as follows: Which of the following comes closest to your view of how we should treat tobacco products in Ontario? Tobacco products should be sold in a number of different places, AS THEY ARE NOW; Tobacco products should be sold in government-owned stores similar to the way alcohol is sold in LCBO stores; Tobacco products should not be sold at all. Data table is for Figure 3-13.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Table 3A-13: Views on the Sale of Cigarettes, by Smoking Status, Ages 18+, Ontario, 2015

Policy Option	Smoking Status	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Stop as soon as possible	Current smoker		S		
Phase out over 5 to 10 years	Current smoker	291,900	21 [M]	13.5	31.1
Keep same as now	Current smoker	982,700	70.6	59.3	79.9
Stop as soon as possible	Former smoker	335,500	12	8.6	16.4
Phase out over 5 to 10 years	Former smoker	1,094,700	39.1	32.6	45.9
Keep same as now	Former smoker	1,268,100	45.3	38.8	51.9
Stop as soon as possible	Never smoker	1,039,700	17.2	13.4	21.8
Keep same as now	Never smoker	2,284,700	37.7	32.6	43.2
Phase out over 5 to 10 years	Never smoker	2,617,900	43.2	38	48.7
Stop as soon as possible	Total	1,477,500	14.4	11.8	17.5
Phase out over 5 to 10 years	Total	4,004,600	39.1	35.2	43
Keep same as now	Total	4,535,600	44.3	40.3	48.3

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. S = data suppressed due to small sample sizes. Data table is for Figure 3-14.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Table 3A-14: Agreement that Tobacco Products Should Forever Not Be Sold to Youth Who Are Now Teenagers Even When They Reach Adulthood, Ontario, 2015

Smoking Status	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Total	5,189,700	50.6	46.6	54.6
Never smoker	3,416,700	56.4	50.9	61.7
Former smoker	1,388,500	49.5	42.8	56.1
Current smoker	384,500	27.7 [M]	18.7	39.1

Note: M=Marginal. Interpret with caution: subject to moderate sampling variability. Data table is for Figure 3-15.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

Table 3A-15: Opinion About Where E-Cigarettes Should Be Sold, Ontario, 2015

Location	Population Estimate	Value (%)	Lower 95% Confidence Limit	Upper 95% Confidence Limit
Don't know	1,197,400	11.7	9.5	14.3
Only vape shops	1,230,200	12	9.5	15.1
Only pharmacies	1,257,900	12.3	10	15
Government-owned stores	1,291,300	12.6	10.2	15.5
Not sold at all	2,115,200	20.7	17.7	24
Different places as now	3,137,100	30.7	26.9	34.7

Note: Data table is for Figure 3-16.
Source: Centre for Addiction and Mental Health Monitor (Full Year) 2015.

References

[1] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, October 2007.

[2] Ministry of Health Promotion and Sport. *Youth Engagement Principles.* Toronto, ON: Ontario Ministry of Health Promotion and Sport, December 2010.

[3] Ontario Ministry of Health Promotion. *Comprehensive Tobacco Control: Guidance Document*. Queen's Printer for Ontario, 2010. Accessed on February 17, 2017.

[4] Leave the Pack Behind. *Final Report/Program Activity: April 1st 2015—March 31st 2016.* St. Catharines, ON: Brock University, 2016.

[5] Ontario Ministry of Education. *Foundations for a Healthy School: Promoting Well-Being is Part of Ontario's Achieving Excellence Vision.* Queen's Printer for Ontario, 2014. Accessed on December 17, 2016.

[6] Ontario Physical and Health Education Association (Ophea). *Teaching Tools: The Tools You Need for Teaching Healthy Active Living*. Accessed January 19, 2017.

[7] Luk R, Schwartz R. Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2014. OTRU Special Report. Toronto, ON: Ontario Tobacco Research Unit, September 2015.

[8] The Ontario Gazette. *Ontario Regulation 336/15 made under the Smoke-Free Ontario Act.* Printed in The Ontario Gazette: November 28, 2015. Accessed on February 17, 2017.

[9] Bader P, Boisclair D, Ferrence R. Effects of tobacco taxation and pricing on smoking behavior in high

risk populations: A knowledge synthesis. *International Journal of Environmental Research and Public Health* 2011 Nov;8(11);4118-4139.

[10] Chaloupka FJ, Cummings KM, Morley CP, Horan JK. Tax, price and cigarette smoking: Evidence from the tobacco documents and implications for tobacco company strategies. *Tobacco Control* 2002 Mar;11 (Suppl 1):i62-i72.

[11] Chaloupka FJ, Grossman M. Price, tobacco control policies and smoking among young adults. *Journal of Health Economics* 1997 Jun;16(3):359-373.

[12] Gruber J, Sen A, Stabile M. Estimating price elasticities when there is smuggling: The sensitivity of smoking to price in Canada. *Journal of Health Economics* 2003 Sep;22(5):821-842.

[13] International Agency for Research on Cancer. *Effectiveness of Tax and Price Policies for Tobacco Control.* IARC Handbooks of Cancer Prevention, Volume 14. Lyon, FR: IARC, 2011.

[14] Cavazos-Rehg PA, Krauss MJ, Spitznagel EL, Chaloupka FJ, Luke DA, Waterman B., et al. Differential effects of cigarette price changes on adult smoking behaviours. *Tobacco Control* 2014 Mar;23(2):113-118.

[15] Chaloupka FJ, Pacula RL. The impact of price on youth tobacco use. In: National Cancer Institute. *Changing Adolescent Smoking Prevalence.* Smoking and Tobacco Control Monograph No. 14. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2001:pp.193-199.

[16] Tauras JA. Public policy and smoking cessation among young adults in the United States. *Health Policy* 2004;68(3):321-332.

[17] United States. Dept. of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: U.S. Department of health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

[18] Schwartz R, Zhang B. Debunking the taxation–contraband tobacco myth. *Canadian Medical Association Journal* 2016 April; 188(6):401-402.

[19] Carpenter C, Cook PJ. Cigarette taxes and youth smoking: New evidence from national, state and local Youth Risk Behaviour Surveys. *Journal of Health Economics* 2008 Mar;27(2):287-299.

[20] Gruber J. *Youth Smoking in the U.S.: Prices and Policies.* NBER Working Paper No. 7506. Cambridge, MA: National Bureau of Economic Research, January 2000. Accessed on February 17, 2017.

[21] Chaloupka FJ, Wechsler H. Price, tobacco control policies and smoking among young adults. *Journal of Health Economics* 1997 Jun;16(3):359-373.

[22] Ross H, Chaloupka FJ, Wakefield MA. Youth smoking uptake progress: Price and public policy effects. *Eastern Economic Journal* 2006 Spring;32(2):355-367.

[23] Ontario. Ministry of Finance. *Tobacco Tax Rate Increases.* Ottawa: Queen's Printer for Ontario,

February 2016. Accessed December 8, 2016.

[24] Satterland TD, Treiber J, Haun S, Cassady D. Evaluating local policy adoption campaigns in California: Tobacco retail license (TRL) adoption. *Journal of Community Health* 2014 Jun;39(3):584-591.

[25] Tilson M. *Reducing the Availability of Tobacco Products at Retail: Policy Analysis.* Toronto, ON: Non-Smokers' Rights Association, April 2011. Assessed February 17, 2017.

[26] New Brunswick. Department of Finance. *Tobacco Retailer's Guide*. Revised: February, 2016. Accessed on January 27, 2017.

[27] Service Nova Scotia - Provincial Tax Commission. *Retail Vendor's Permit (Designated Tobacco Retailer)*. Accessed on January 27, 2017.

[28] Chuang YC, Cubbin C, Ahn D, Winkleby MA: Effects of neighbourhood socioeconomic status and convenience store concentration on individual level smoking. *Journal of Epidemiology and Community Health* 2005 Jul;59(7): 568–573.

[29] Cohen JE, Anglin L. Outlet density: a new frontier for tobacco control. *Addiction* 2009 Jan;104(1):2-3.

[30] Ontario Government (Service Ontario e-Laws). *Smoke-Free Ontario Act (July 1, 2010)*. Accessed February 27, 2017.

[31] Ontario Ministry of Health and Long Term Care. *Tobacco Inspection System*. Toronto, ON: Ontario Ministry of Health and Long Term Care, 2016.

[32] Chaiton MO, Mercredy GC, Cohen JE, Tilson ML. Tobacco retail outlets and vulnerable populations in Ontario, Canada. *International Journal of Environmental Research and Public Health* 2013 Dec 17;10(12), 7299-7309. Accessed on February 27, 2017.

[33] Boak A, Hamilton HA, Adlaf EM, Mann RE. *Drug Use among Ontario Students, 1977-2015: Detailed OSDUHS Findings.* CAMH Research Document Series No. 41. Toronto, ON: Centre for Addiction and Mental Health, December, 2015.

[34] Health Canada. *2005 National Baseline Survey on the Tobacco Retail Environment.* Final Report POR-04-48. Prepared for Health Canada by Corporate Research Associates Inc., March 2005. Accessed on February 27, 2017.

[35] O'Loughlin J, Karp I, Koulis T, Paradis G, DiFranza JR. Determinants of first puff and daily cigarette smoking in adolescents. *American Journal of Epidemiology* 2009 Sep 1;170(5):585-597.

[36] Alesci N, Forster J, Blaine T. Smoking visibility, perceived acceptability, and frequency in various locations among youth and adults. *Preventive Medicine* 2003 Mar;36(3):272-281.

[37] Ontario Tobacco Research Unit. The Tobacco Control Environment: Ontario and Beyond. Monitoring and Evaluation Series (Vol. 16). *Retail Display of Tobacco Products: Monitoring Update*. Toronto, Canada: OTRU, April 27, 2010. Accessed February 27, 2017.

[38] Chisholm J. *Evaluation of East TCAN Regional Project: Love My Life…Tobacco Free! (2016-2018)*

[Draft LML Evaluation Framework]. Eastern Ontario Health Unit, 2015.

[39] Moyer V; U.S. Preventive Services Task Force. Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine* 2013 Oct 15;159(8):552-557.