

2014 Report of the Director of Public Health

Smoke-Free Montréal

For a Tobacco-Free Generation

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“ Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. ”

Sir Michael Marmot, 2010

A message from the Director

Concerned about the significant impacts of smoking on chronic illnesses and on associated social inequalities in health, Montréal's public health department has made tobacco control a regional priority.

Le point sur le tabagisme, a publication released in February 2013, looked at the evolution of tobacco use in Montréal while a document entitled *Montréal sans tabac – Plan de lutte contre le tabagisme 2012–2015* set objectives to lower smoking prevalence and identified initiatives to reach those objectives. Since 2013, the regional public health team has worked actively to support its partners as they fulfil their mandates. For instance, local profiles of tobacco use were prepared for each Health and Social Service Centre. Our partners implemented a number of projects and activities, and my report highlights several examples that are likely to inspire other stakeholders.

In light of the tobacco industry's efforts to develop new products and market e-cigarettes, the current legislative framework is insufficient to adequately protect the population against the harmful effects of tobacco. The report reasserts our position regarding current provisions of the *Tobacco Act* that must be revised.

I hope this report will be a catalyst to mobilize partners for the next stages and to share common commitments so that Montréal can be one of the most dynamic Canadian cities in the field of tobacco control.

It is important to reiterate our objective: Ensure that future generations of Montrealers can live in a tobacco-free society.

Director of public health

A handwritten signature in black ink, appearing to read 'Richard Massé', written in a cursive style.

Richard Massé, M.D.

Table of Contents

1 Introduction	1
2 Smoking in Montréal	3
Update	3
Health impacts of smoking on the population and the health system	7
3 Social Inequalities in Health and Smoking	9
Some data	9
Effects of tobacco control on social inequalities in health	11
Shared commitments to focus on SIH	13
4 Prevention: Young People Who Choose Not to Smoke	14
Some data	14
Almost 30% of students initiate smoking in high school	14
About 10% of high school students smoke cigarettes	14
Students also smoke other tobacco products	14
Students at greater risk	15
About one in five young people aged 15 to 24 smokes	16
Model initiatives	16
Engagement project for young people: Operation Say It Loud!	16
Community project on smoking prevention: Zéro nico pour mon Ado	17
Findings	17
Tobacco products that target youth	17
Tobacco products accessible to youth	18
Educational institutions and the latest tobacco-related issues	19
Young people aged 15 to 24: Investing in additional efforts	20
Shared commitments to prevent youth smoking	20
5 Protection: A Smoke-Free Environment	22
Some data	22
Exposure at home: An ongoing decline	23
Exposure in public places: Expected downward trend not observed	23
Exposure in cars: Little change since 2003	24

Model initiatives	24
Le Centre jeunesse de Montréal – Institut universitaire: Better protection for vulnerable youth.	24
Exemplary health institutions.	24
Smoke-free terraces and patios of bars and restaurants.	25
Proactive municipalities	25
Smoke-free homes	25
Findings	26
Children and adolescents: The group most exposed to tobacco smoke	26
Post-secondary education institutions: Current and future measures	27
Shared commitments to protect non-smokers from secondhand smoke	27
6 Cessation: Adapting Support to Smokers	29
Some data.	30
Fewer than 10% of smokers have quit smoking in the past 12 months	30
One in four smokers is ready to quit	30
Successful quitting: Health benefits unequally distributed	30
Characteristics of persons least likely to quit smoking.	30
Pregnancy and smoking	30
Model initiatives	30
Smoking cessation services in hospitals	30
Hôpital du Sacré-Cœur – Position created	31
CHUM – Systemized process	31
MUHC – IMPACT program	31
Smoking cessation services and perinatal care	32
CSSS de la Pointe-de-l'Île – Zéro nico pour mon Coco.	32
CSSS de l'Ouest-de-l'Île and Lakeshore General Hospital.	32
Pharmacists: Essential partners	33
Collective prescription for smoking cessation – A success story	33
Initiatives for groups with vulnerability factors	34
Findings	34
Cessation support services seldom used.	34
Successful cessation support services.	34
Shared commitments to adapt cessation counselling	35

7 E-cigarettes: Controls Needed.	36
Concept and composition	36
Risks and effectiveness	36
Health risks to users and non-users	36
Effectiveness and health risk reduction	37
Some data.	38
An expanding international market	38
Canada.	38
Québec	38
Montréal	38
Model initiatives	39
Health and education institutions prohibit e-cigarettes	39
Public health and Montréal's fire department recommend vigilance	40
Municipalities take a stand.	40
Impact of e-cigarettes on tobacco control measures	40
Shared commitments to control e-cigarettes	41
8 Monitoring and Evaluation: Tracking Consumption and Policies	43
9 A Network of Stakeholders with Shared Commitments	45
References	49

List of Figures

Figure 1	Proportion (%) of smokers, major Canadian urban centres, 2011–2012	3
Figure 2	Proportion (%) of current smokers, Montréal, Québec and Canada.	4
Figure 3	Proportion (%) of current smokers, by personal characteristics, Island of Montréal, 2012.	6
Figure 4	Number of deaths due to smoking, 2007–2011, Island of Montréal	7
Figure 5	Proportion of the population with at least one of three tobacco-related chronic diseases, Island of Montréal.	8
Figure 6	Proportion of individuals aged 35 and over with at least one of three tobacco-related chronic diseases	10
Figure 7	Prevalence of cigarette, and cigar or cigarillo use among Québec students, 2010–2011	15
Figure 8	Proportion (%) of smokers, by sex and age group, Montréal 2012.	16
Figure 9	Proportion (%) of non-smokers exposed to secondhand smoke, by location of exposure, Island of Montréal 2003 to 2011–2012	23
Figure 10	Proportion (%) of non-smokers exposed to secondhand smoke in public places by age group, Island of Montréal 2003 to 2011–2012	23
Figure 11	Proportion (%) of respondents who have ever used EC, by certain personal characteristics	39

List of Maps

Map 1	Number and proportion (%) of current smokers aged 15 and over, by CSSS district, Island of Montréal	5
Map 2	Density of tobacco retail outlets by CSSS, Island of Montréal, 2014	18

List of Tables

Table 1	Impacts of tobacco control policies on inequities and actions for more equitable implementation.	12
Table 2	Summary of Commitments – Montréal sans tabac network partners.	45



Introduction

About 25 years ago, close to 40% of Montrealers aged 15 and over smoked. In 2012, this figure fell to 21%,^[1] or about 311 400 smokers. Social perceptions of smoking have utterly changed within the space of one generation. In the past, smoking cigarettes was socially acceptable; now it is increasingly less so. Those changes are due to the ongoing efforts of stakeholders involved in tobacco control, which have engendered numerous communications campaigns, programs, innovations, policies and legislation such as the *Tobacco Act*.^[2]

Given that the decline in smoking prevalence has slowed since 2009, stakeholders must pursue their work since smoking is still the leading cause of avoidable premature death, chronic disease and increased poverty of the most disadvantaged groups.^[3, 4]

A smoker's life expectancy is 10 years shorter, on average.^[5] Tobacco kills up to half of its users^[5, 6] and 2 400 Montrealers every year,^[7] which represents on average about 16% of all deaths.

Smoking causes health problems at all stages of life: low birthweight and sudden infant death syndrome, asthma in children and adolescents, and chronic respiratory diseases, heart diseases and cancer in adulthood.^[4] In Québec, the annual direct and indirect costs of smoking average 3.96 billion dollars.^[8] It is also estimated that for each 1% decrease in the rate of smoking in Québec, the province saves \$41 million in health care and \$73 million in indirect costs.^[9] The health impacts of smoking and the economic burden for the health system cannot be denied.

In Montréal, gaps still persist among certain population groups. Among people aged 15 and over, smoking prevalence doubles (from 13% to 26%) according to Health and Social Service Centre (CSSS) district.^[10] Territorial variations are even more pronounced among young adults between the ages of 15 and 24, ranging from 10% to 32%. Differences in prevalence can also double between populations living in disadvantaged areas and those in advantaged neighbourhoods (12% compared to 25%). Economically and socially disadvantaged individuals are more likely to start smoking, smoke longer, fail more often when they try to quit, be exposed to secondhand smoke and die prematurely.^[11]

These observations support the conclusions of the director's 2011 report on social inequalities in health^[12], which outlined persisting gaps in health between the poor and the wealthy despite an increase in Montrealers' life expectancy and a reduction in their mortality rate.

The plan, entitled *Montréal sans tabac – Plan de lutte contre le tabagisme 2012–2015* ^[13], clearly states that the priority is to step up initiatives designed for the most vulnerable groups living in poor socioeconomic conditions, such as youth aged 15 to 24, and people with chronic diseases or mental health disorders. Recent data on tobacco use in Montréal (TOPO 2012)^[10] have helped us better define districts where smoking prevalence is highest and people are most affected by tobacco use. The challenge is to undertake sustained actions that will target those populations without stigmatizing them, and to implement optimal conditions that will reduce gaps between advantaged and disadvantaged groups.

A key initiative is to support stronger public policies recognized around the world for their effectiveness in decreasing tobacco use,^[14-15] including among disadvantaged groups. More specifically, those policies involve raising the price of cigarettes and related taxes.

In Québec, the *Tobacco Act* has not been revised since it was passed in 2005. As set out in section 77, a report on its implementation was produced in 2010. In 2013, the Committee on Health and Social Services examined the report and recommended that the National Assembly revise the *Tobacco Act*.^[16] During Committee hearings, the director of public health asked that the *Tobacco Act* be revised as quickly as possible so that Montrealers could be better protected against the harms caused by tobacco; ten recommendations were drawn up and presented.^[17] In Montréal, a CSSS followed suit and presented a brief to the Committee. Other partners, including most CSSS, Centre jeunesse de Montréal and Québec's Order of Pharmacists, expressed their support for the recommendations in the director's brief that involved their field of expertise. The Order of Pharmacists also submitted a document that put forward recommendations on e-cigarettes.

It should be pointed out that public policies must include actions specific to local contexts. Consequently, it is up to the various stakeholders to join together and take the necessary measures to reduce the gaps associated with social inequalities in health in Montréal.

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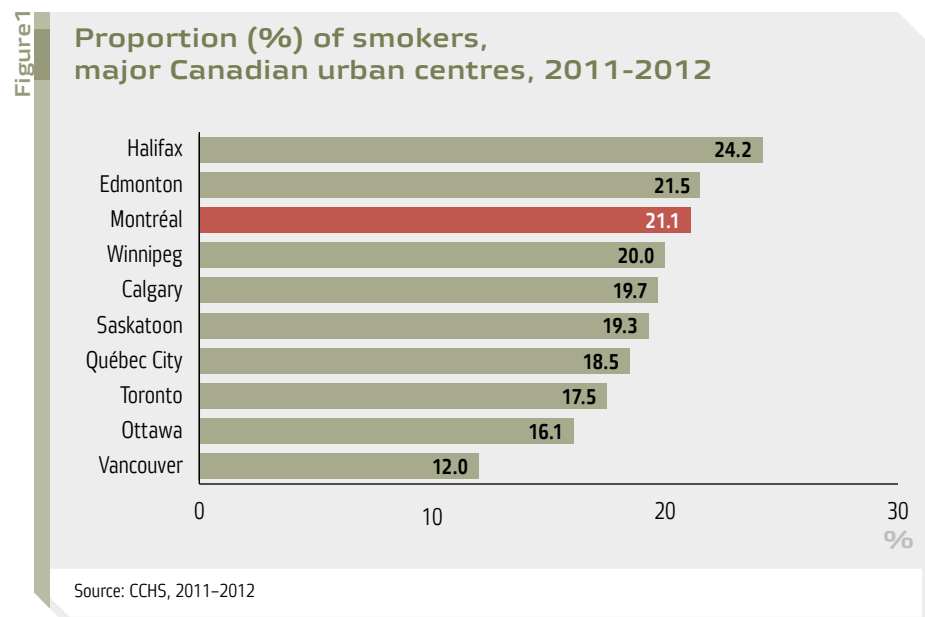
Smoking in Montréal

Update

The TOPO population survey conducted in Montréal in 2012, which focused on chronic diseases and their determinants, has helped better define the groups most affected by tobacco use. The main findings are presented in this section. Data from other sources (e.g. the Canadian Community Health Survey [CCHS])^[1] are also presented for comparison or as additional information.^A

Montréal, one of Canada's major urban centres with high prevalence

In 2011–2012, smoking prevalence in Montréal (21.1%) was significantly higher than in Ottawa (16.1%) and Vancouver (12.0%), but similar to that in other big Canadian cities (Figure 1).

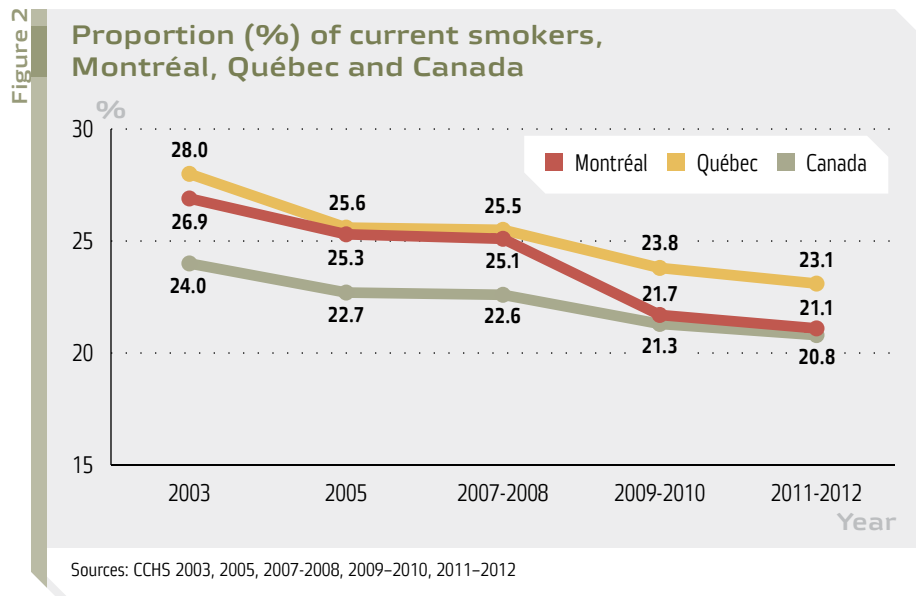


A Two data sources from two different 2012 surveys were used for this report. The difference in smoking prevalence in Montreal, estimated at 18.9% in the 2012 TOPO survey and at 21.1% in the 2011–2012 CCHS survey is not statistically significant.

The 2012 TOPO survey documented Montrealers' health status across the 12 CSSS. The study sample consisted of almost 11 000 Montrealers aged 15 and over. The CCHS survey collected data across Canada and is used to monitor tobacco use and compare big Canadian cities.

Same downward trend in Montréal as in the rest of Québec

Over the past 10 years, there has been a decreasing trend in prevalence in Montréal and in the rest of Québec (Figure 2). Although the prevalence observed in 2011–2012 in Montréal was lower than in the province, the difference is not statistically significant.



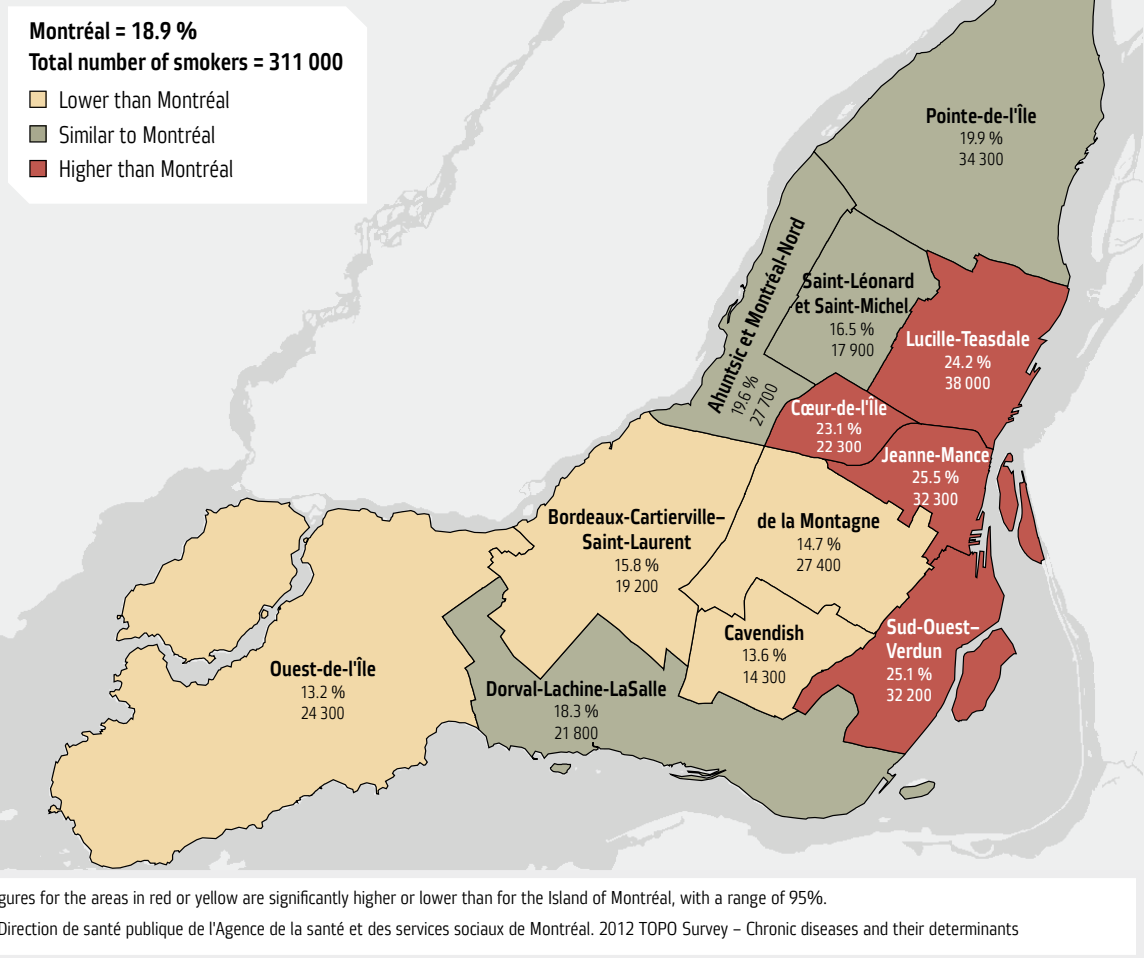
Differences among districts on the Island of Montréal

According to the TOPO survey, the overall smoking prevalence in Montréal is 18.9% (Map 1). However, it varies from 13.2% to 25.5% according to CSSS district. Because other tobacco products (e.g. waterpipes, small cigars) are not included in this estimate, it is clear that the results underestimate the true prevalence of smoking.

In four CSSS districts, the proportions of smokers are significantly higher than for the region; in four other districts, the proportions are significantly lower.

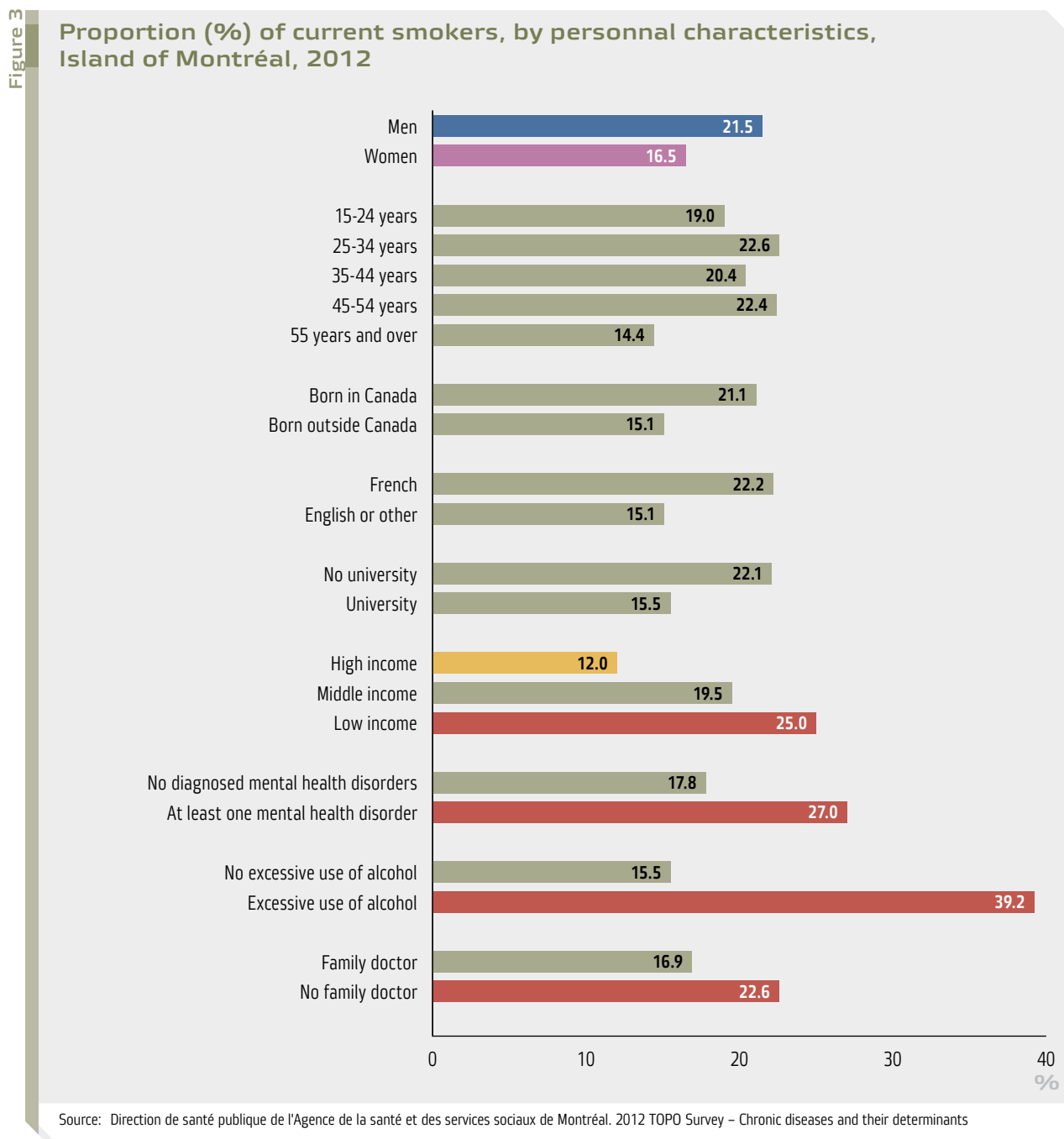
Map 1

Number and proportion (%) of current smokers aged 15 and over, by CSSS district, Island of Montréal



Some groups more affected by smoking

Although there are smokers in all segments of the population, some groups are more likely to smoke than others, as shown in Figure 3. Moreover, we can see that the proportion of current smokers varies significantly according to certain individual characteristics.



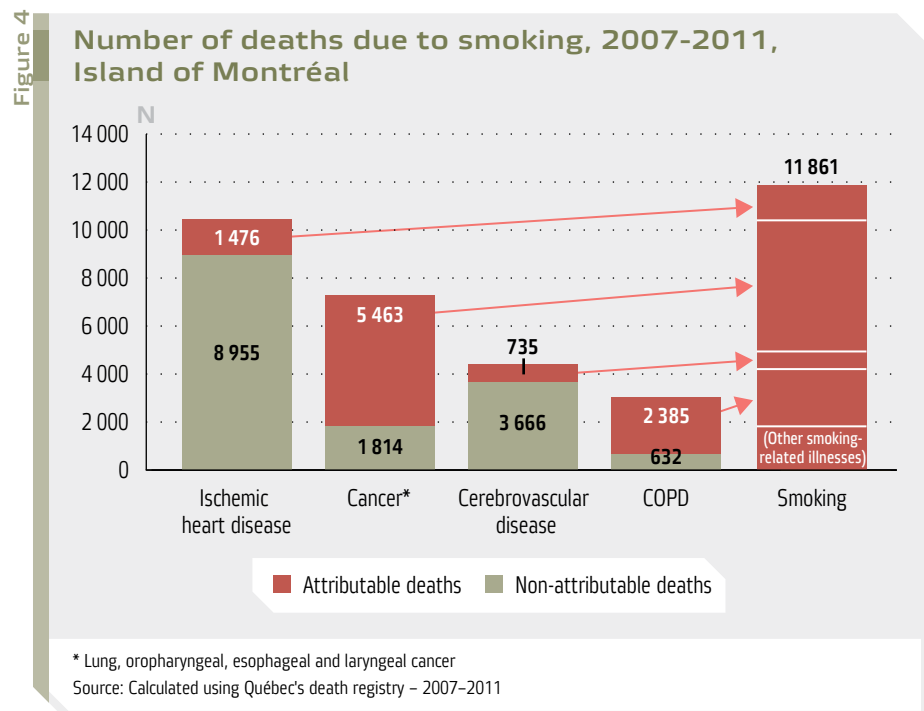
More daily smokers in some groups

A person is considered a smoker if he or she smokes cigarettes every day or occasionally. Recent data indicate that a majority of smokers smoke every day. Two-thirds (66.9%) smoke cigarettes every day, and their proportions rise significantly with age.^[18]

Health impacts of smoking on the population and the health system

Mortality: Almost one in five deaths due to smoking

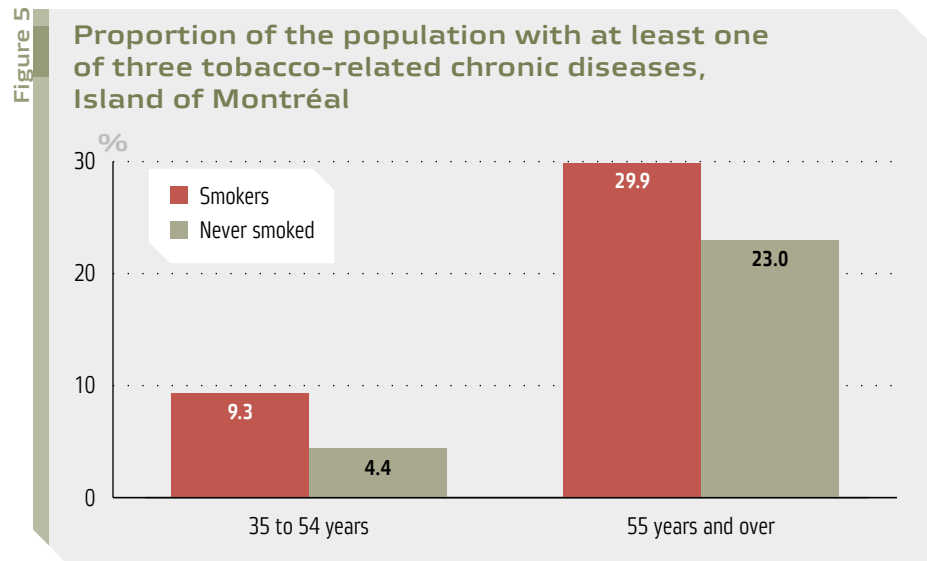
In Montréal between 2007 and 2011, 11 861 deaths were attributed to smoking, that is, 16% of all deaths during the period— 21% for men and 12% for women. Figure 4 illustrates percentages attributable to smoking for various causes of mortality: 75% (5 463 deaths) for lung, oropharyngeal, esophageal, and laryngeal cancers, 79% (2 385 deaths) for chronic obstructive pulmonary diseases (COPD), and 15% (2 211 deaths) for cardiovascular and cerebrovascular diseases.^[7]



Morbidity: Tobacco-related diseases appear at a young age

In 2012, 16% of people aged 35 and over were diagnosed with at least one of the following three diseases: COPD, cardiovascular disease or cancer. Prevalence was even higher among daily and occasional smokers (17%) and long-term smokers (22%) compared to people who had never smoked (13%).^[18]

Tobacco-related diseases also appear at a young age. Among 35- to 54-year-olds, prevalence of those three chronic diseases is twice as high among smokers than among people who have never smoked (9.3% and 4.4 %, respectively)^[18] (Figure 5).



Hospitalizations and use of health services

Over two-thirds (70%) of Montrealers with COPD are smokers or ex-smokers. Their use of health services is a good marker of the effects of smoking on the health network.^[18]

In 2010, 70 000 Montrealers aged 35 and over had COPD, which resulted in over 27 000 visits to emergency departments and more than 12 000 hospitalizations. In 2009–2010, compared to all users, Montrealers with COPD accessed outpatient services (5 visits on average versus 3) and emergency departments more often (39% versus 23%). They were also hospitalized more often (17% versus 5.8%).^[19]

3

Social Inequalities in Health and Smoking

A gradient of health observed in most countries indicates that the lower the socioeconomic status, the greater the risks of chronic diseases and reduced life expectancy. In Canada, a 10-year study (1991 to 2001) showed that mortality rates for all causes increase as socioeconomic status goes down, whether defined by income, level of education or occupation.^[12, 20]

Among all causes of death, smoking and excessive alcohol consumption are most closely associated with income level.^[21] The mortality rate for smoking-related diseases is 27% higher for men in the lowest income quintile compared to those in the highest quintile.^[21] Smoking combined with an unfavourable socioeconomic situation has greater health impacts. Moreover, high morbidity among smokers results in lost household earnings.^[3, 22]

Some data

Recent data on smoking in Montréal confirm data in the literature.^[18]

Higher smoking prevalence among some groups

- Twice as many people living in disadvantaged districts smoke than those living in wealthier neighbourhoods.
- The proportion of daily smokers is higher among people who live in disadvantaged neighbourhoods compared with those in wealthier areas (72.3% versus 58%).
- Smoking prevalence among young people aged 15 to 24 varies considerably from one CSSS district to another, ranging between 10% and 32.4%. It also fluctuates according to the level of deprivation^B of residential district. The proportion of smokers among young people living in disadvantaged neighbourhoods is almost twice that in wealthier districts (24.4% versus 13.3%).
- Smoking prevalence among individuals who have not attended university is higher than for those who have (22.1% versus 15.2%).
- These discrepancies are even more pronounced when level of education is taken into consideration. The proportion of daily smokers among those who did not attend university is 79.5% and 57% among university graduates.
- Having a mental health diagnosis increases the probability of smoking by 50%.

Greater exposure to second-hand smoke at home

- Among people aged 15 and over, those most likely to be exposed to tobacco smoke are youth aged 15 to 24, people living in disadvantaged neighbourhoods, people who have not attended university and ex-smokers who have quit smoking for less than 12 months.

^B A provincial material and social deprivation index is used to analyze data on service utilization. The index is broken down into quintiles for the reference area, the Island of Montréal, and people living in the most privileged districts (quintile 1) are compared to people living in disadvantaged districts (quintile 5).

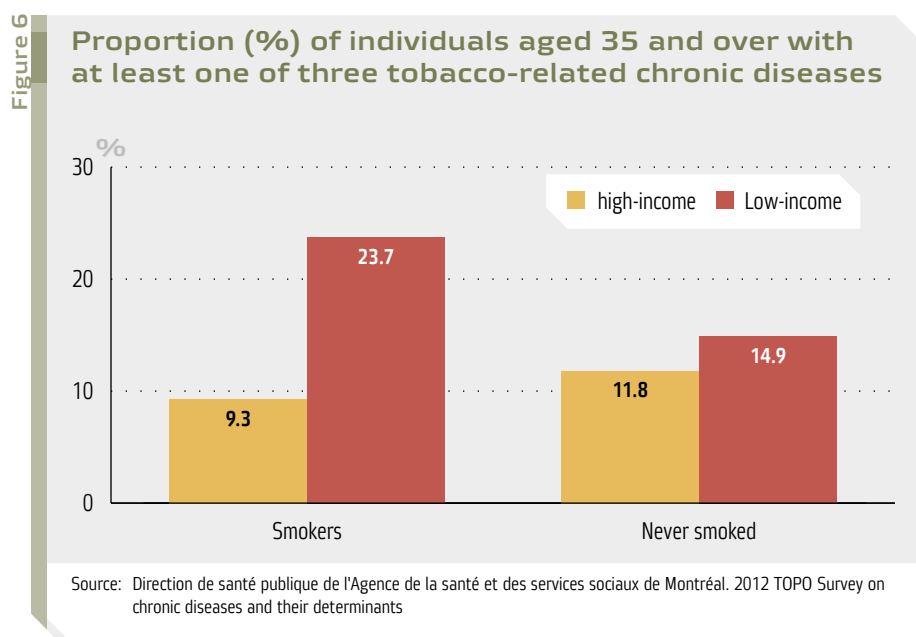
Lower quit rate

People living in disadvantaged neighbourhoods, those with lower levels of education, individuals with mental health problems and people with no family doctor have the lowest quit rates.

The proportions of people in the most disadvantaged neighbourhoods who quit smoking in the past year were lower than in the wealthiest areas (5.4% versus 13.1%).

Higher prevalence of chronic diseases

Among individuals 35 years old and over, almost a quarter of current smokers (24%) who live in disadvantaged neighbourhoods report having at least one of three smoking-related diseases^C, compared with 9% among those living in high-income neighbourhoods^[23] (Figure 6).



Greater use of health services

The proportion of individuals with COPD who used emergency services varies according to level of deprivation of area of residence. The figure is 43.7% among people living in low-income areas and 32.7% among those living in high-income neighbourhoods.

Among people with COPD, the proportion of hospitalizations is higher (19.1%) for people living in low-income areas, compared with those living in high-income neighbourhoods (14 %).^[19]

C Three chronic diseases were selected for analysis in this study: COPD, cardiovascular diseases and cancer.

Effects of tobacco control on social inequalities in health

Public tobacco control policies have led to lower smoking prevalences in all groups. However, this decrease was limited in the lowest-income areas and among some vulnerable groups, such as people with low levels of education or with mental health problems, even though it is in those areas and groups that we find the heaviest smokers.^[14]

Montréal's public health department has been involved in tobacco control and reduction of social inequalities in health for a number of years.^[12, 24] The department now plans on putting tobacco control at the heart of its strategy to reduce social inequalities in health (SIH), as recommended by Marmot^[25] and the World Health Organization.^[12, 14] They recommend implementing strategies that go beyond measures for the population as a whole and aim to act specifically on gaps between low and high income groups (see Table on the following page).



Table 1

Impacts of tobacco control policies on inequities and actions for more equitable implementation

Measures	Impacts on inequities	Initiatives for a more equitable application
Monitor tobacco use and prevention policies	Evidence of decreasing overall tobacco use, but of widening inequities. Impact of tobacco control policies on different subgroups is not often evaluated.	Evaluate impact of policies on different socioeconomic groups. Include measures of socioeconomic status in all routine tobacco prevalence surveys.
Increase price of tobacco through taxation	Greater impact on smoking cessation and decreased initiation in poor and young individuals, with a higher tax burden on higher socioeconomic groups.	Alongside any price increase, ensure nicotine replacement therapy and smoking cessation support are affordable and accessible to low-income groups.
Introduce smoke-free places	Some evidence of greater compliance with, and impact and acceptability of workplace bans in higher socioeconomic groups.	Ensure enforcement in low-income workplaces. Target campaigns to build support for the ban among disadvantaged groups.
Introduce mass media campaigns warning of tobacco harms	Some evidence of greater impact in higher socioeconomic groups.	Less likely to widen inequities if the campaign <ul style="list-style-type: none"> • uses TV rather than print; • is intensive in exposure; • uses messages targeting disadvantaged groups; • uses emotive personal stories.
Restrict sale of tobacco to minors	Some evidence of greater effectiveness in girls than boys. Inadequate evidence to assess socioeconomic gradient.	Strict enforcement of laws, especially in deprived neighbourhoods.
Ban tobacco advertising	No evidence of a gradient in impact, but inadequate evidence to assess. Evidence of the tobacco industry targeting marketing at more vulnerable groups.	Universal comprehensive bans on tobacco advertising.
Place warning labels on tobacco products	No evidence of a gradient in impact, but inadequate evidence to assess. Pictorial warnings reach a larger audience than text warnings (including vulnerable groups with low literacy levels).	Include warnings tailored to certain groups and in certain languages. Opt for large, pictorial warnings to be placed on packaging.
Provide support for smokers to stop smoking	Evidence that some smoking cessation services fail to reach the most disadvantaged groups, and that those who do access services have lower cessation success rates.	<ul style="list-style-type: none"> • Remove financial barriers, including free or subsidized NRT. • Deliver services in broader range of settings (including non-health care). • Offer specific services tailored to needs of particular groups (e.g. ethnic groups, prisoners, pregnant women). • Introduce mandatory training for all front-line health care staff. • Use smoking cessation telephone lines and SMS (text messaging) to reach young people and disadvantaged groups.

Source: World Health Organization. *Tobacco and inequities: Guidance for addressing inequities in tobacco-related harm*, 2014.

Shared commitments to focus on SIH

To implement effective conditions for tobacco control with a view to reducing SIH, stakeholders already engaged in collaborative partnerships support the following commitments:

- **Vision**

1. Acknowledge that smoking is an aggravating factor of social inequalities in health.
2. Refocus tobacco control efforts on the most vulnerable groups.

- **Funding**

3. Shore up and protect current funding and resources dedicated to tobacco control.
4. Set aside part of the tobacco control budget for actions that target the most vulnerable groups.

4

Prevention: Young People Who Choose Not to Smoke

In Montréal over the past 20 years, provincial, regional and local stakeholders have put in place plans and communications campaigns designed to prevent youth smoking. The initiatives have targeted grade 6 elementary school children to students in their final year of high school.

Canada and Québec have introduced legislation related to the use, sale and promotion of tobacco products. This has helped bring about change to social norms so that use, desirability and access to tobacco products are increasingly less acceptable. Those measures have had a positive impact on preventing youth smoking.^[26]

In Québec, changes to the *Tobacco Act* adopted in 2005^[2] led to the implementation of restrictive measures related to smoking initiation: a ban on smoking on school grounds, displays of tobacco products in retail outlets and sales of packages containing fewer than 20 cigarettes; and increased sanctions for retailers who sell tobacco products to minors. Canadian law prohibits adding flavours to cigarettes and small cigarillos, with the exception of menthol.

Some data

Almost 30% of students initiate smoking in high school

In general, smoking initiation occurs at 12.7 years of age. Among Montréal high school students, almost 30%—28 600 students—claim to have tried^D cigarettes^[27] The figure rises as students progress through school, going from 17% in secondary 1 and 2 to 40% in secondary 4 and 5.

About 10% of high school students smoke cigarettes

For some youth, experimentation leads to regular or occasional use of cigarettes. Overall prevalence in Montréal is 8%, compared with 11% for the province. The proportion of young smokers increases with grade level, rising from 4% to 13% between secondary 1 and 5.^[27]

Students also smoke other tobacco products

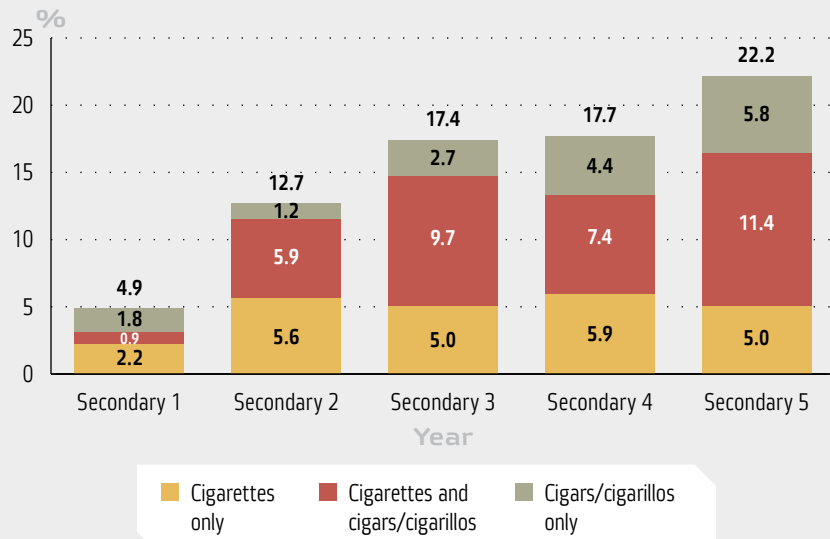
Smoking prevalence is underestimated when only cigarettes are considered. Young people also use other tobacco products such as small cigars, smokeless tobacco and waterpipes.^[28]

In Québec in 2010–2011, overall prevalence of cigarette and small cigar use ranged from 4.9% in secondary 1 to 22.2% in secondary 5 (Figure 7). In secondary 5, prevalence of combined use of cigarettes and small cigars is twice as high as cigarette use only. E-cigarettes must now be added to the mix. This product may be attractive to children in higher levels of elementary school as well as high school students and lead to nicotine addiction.^[28]

D Having smoked a cigarette in their lifetime, even if only a few puffs.

Figure 7

Prevalence of cigarette, and cigar or cigarillo use among Québec students, 2010-2011



Source: Lasnier B. (2013). Enquête sur le tabagisme chez les jeunes. Prévalence de l'usage de cigarettes et de cigares ou cigarillos chez les élèves québécois : 2010-2011. Institut national de santé publique du Québec

Students at greater risk

- Three times more students who attend technical or vocational schools^E smoke cigarettes than students in general education schools (24% versus 7%).^[29]
- The proportion of smokers among students at high risk of dropping out of school^F is three times higher than among those who are at no risk, low risk or moderate risk of dropping out (18% versus 6%).^[27]
- Among students with major alcohol and drug use problems, 64% are smokers^G.^[27]

E Education paths other than general education, such as training for semi-skilled trades or prework training.

F The dropout risk index is an assessment of the risk that students drop out of high school without graduating. It takes into consideration students' learning delays, results in French and mathematics, and commitment. There are three categories of risk: low, intermediate and high.

G The DEP-ADO index adapted for the Québec Health Survey of High School Students is used to measure young people's problematic or risky alcohol and drug use. With the index, young people's scores can be classified according to three levels of substance use:

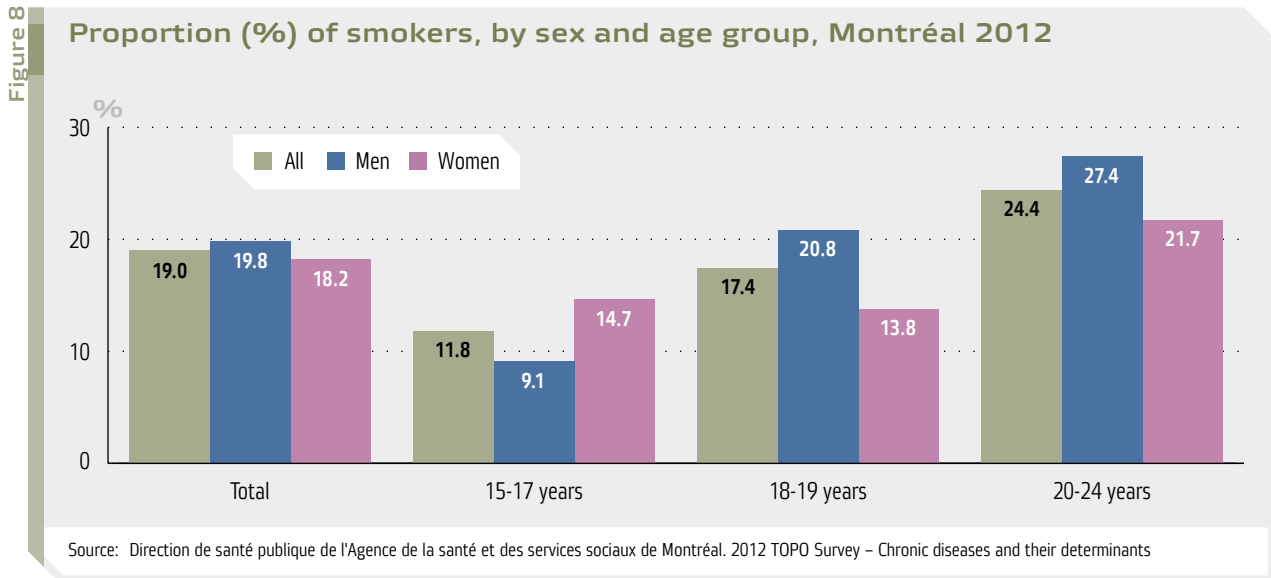
Green light: Students with no obvious problem of substance use currently but merit periodic screening and preventive counselling (information, awareness raising)

Yellow light: Students with possible emerging substance use problems for whom primary care interventions are needed (e.g. information about risks, brief intervention)

Red light: Students with obvious substance use problems and who require specialized interventions delivered by a specialist in problematic substance use

About one in five young people aged 15 to 24 smokes

- In Montréal, 42 900 young people aged 15 to 24 smoke cigarettes, that is, 19% of youth in this age group. No statistically significant difference is observed between the sexes.^[10, 18]
- The proportion of smokers increases with age, rising from 11.8% among 15- to 17-year-olds to 24.4% among people aged 20 to 24. The difference is significant between these two age groups only (Figure 8).



Model initiatives

Engagement project for young people: Operation Say It Loud!

For over five years now, Montréal's public health department has deemed it important to give young people an opportunity to get involved in policy, program and service development, linked to issues of concern to them. With this in mind and in collaboration with the Québec Council on Tobacco and Health, young people, and partners from the health, education, municipal and community sectors, the public health department developed an innovative affirmation, mobilization and engagement project for and by young people: Operation Say It Loud!

The project's goal is to give youth aged 14 to 18 and the adults who coach and support them the skills to carry out a social action. This enables young people to take part in public debate and think critically about issues linked to tobacco control, such as advertising that targets youth, access to tobacco products and tobacco-related social standards.^H

In 2013–2014, 13 schools from all five Montréal school boards participated in the project.

H For more information, go to <http://sayitloud.ca>.

Community project on smoking prevention: *Zéro nico pour mon Ado*

In Montréal, prevalence among youth aged 15 to 24 is highest in the CSSS de la Pointe-de-l'Île district (32.4%).^[18] To provide support and create conditions conducive to youth engagement in tobacco control, CSSS administrators and professionals developed an innovative project, launched in the fall of 2014: *Zéro nico pour mon Ado*. They want to understand how young people perceive the problem and how they can better support and mobilize youth around smoking cessation. The project complements actions carried out by various partners whose participation is key: Commission scolaire de la Pointe-de-l'Île, Commission scolaire de Montréal and youth community centres. The project uses best practices in tobacco control in youth.

Findings

Tobacco products that target youth

Flavoured products

Despite the ban on flavours in cigarillos and cigarettes set out in Bill C-32, which amended the federal *Tobacco Act* and was implemented in 2010, many flavoured tobacco products remain on the market in Québec and specifically target young people. Flavours added to tobacco products encourage youth tobacco initiation. In Canada, although menthol is recognized as a popular flavour that fosters initiation, it is excluded from the list of banned flavourings. In Québec, among secondary 3 to 5 students who have smoked cigarillos or small cigars, 68% smoked the flavoured ones.

New tobacco products: Small cigars

New products and the strategies deployed to make them attractive foster youth initiation to smoking. Small cigars, for instance, are almost exclusively used by young people.^[30]

Hookah bars

Use of hookahs, or waterpipes, is increasingly popular, especially among youth.^[31] In 2007, 23% of young Montrealers had used hookahs during the previous year.^[32] Waterpipes are perceived as being less dangerous than cigarettes, but the nicotine absorption rate of smokers who use hookahs is equivalent to smoking 10 cigarettes a day.^[33] Although young people under 18 are prohibited from using hookahs, they can go to tea rooms where waterpipe smoking is allowed. Most businesses who sell waterpipes or allow their use are operating illegally.

Attractive packaging

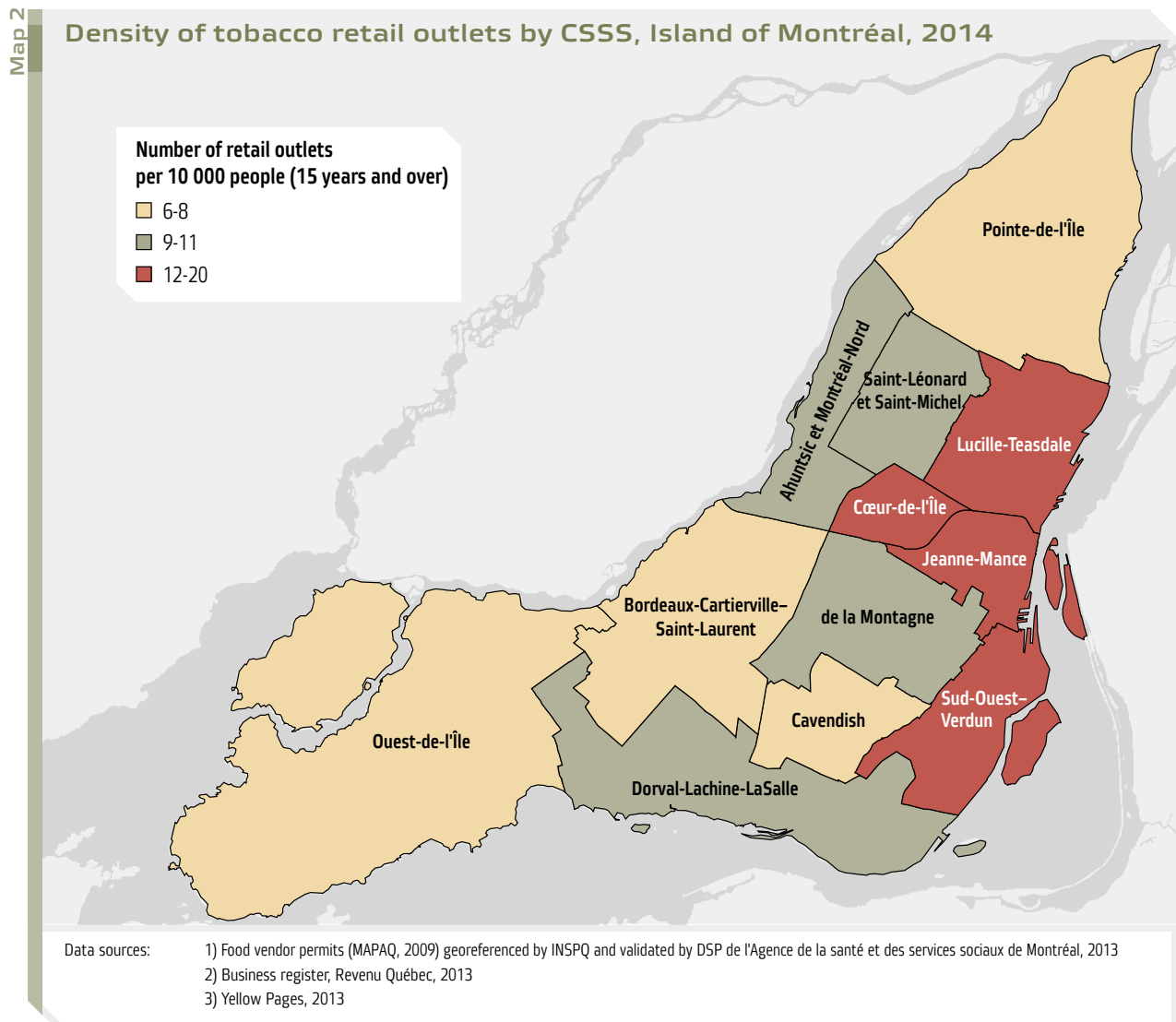
Tobacco product packaging, a tool the tobacco industry uses to attract young people, comes in a variety of formats, each more attractive than the next: lipstick, BlackBerry, iPhone, etc. However, according to Australian researchers, plain packaging decreases the appeal of tobacco and increases adult smokers' urgency to quit.^[34] The WHO Framework Convention on Tobacco Control, ratified by Canada, recommends "to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging)".^[15]

Tobacco products accessible to youth

Density of retail outlets

Some studies have shown that there is an association between density of tobacco retail outlets and smoking prevalence, especially in lower socioeconomic neighbourhoods.^[35] A high density of tobacco retailers near schools is associated with increased smoking initiation rates^[36-39] and higher prevalence among youth,^[40-41] as is the number of cigarettes students smoke.^[42-43]

Data collected by Direction de l'inspection and MSSS surveys do not enable accurate georeferencing of tobacco retail outlets in Montréal; therefore, Montréal's public health department cross-matched three data sources¹ to map out the situation. With that information, tobacco retail outlet density by CSSS district



1 To come up with this estimate, the public health department combined data from three sources: 2009 Ministère de l'Agriculture, des Pêcheries et de l'Alimentation du Québec food vendor permits; 2013 Revenu Québec business register; and 2013 Yellow Pages.

was computed. A map based on those data traces a correlation between geographical areas with high densities of tobacco outlets (number of tobacco retail outlets per 10 000 inhabitants) and those where smoking prevalence is high (Map 2).^[44] These observations confirm data in the literature and support the pertinence of implementing public policies to regulate retail outlets in general, and those near schools, in particular.^[45]

Affordability of Tobacco Products

Sale of packages containing fewer than ten small cigars

The *Regulation under the Tobacco Act* sets a minimum price for tobacco products other than cigarettes.^[46] It also permits consumers to purchase small cigars by the unit, as long as the total purchase amount is over \$10. This measure means that for young people, tobacco products are relatively affordable.

Prices and taxes applicable to tobacco products

Raising taxes on tobacco products is the most effective measure to reduce smoking.^[14, 15, 47] It has a greater impact on tobacco use in low-income individuals and young people than in the general population.^[14]

In Montréal, the average cost of a carton of 200 cigarettes is \$85.39. This is the lowest price among all large Canadian cities. It is much lower than the Canadian average (\$102.81) and current prices in Vancouver (\$104.96), Winnipeg (\$125.80) and Toronto (\$88.64).^[48]

Contrary to the tobacco industry's assertions, higher taxes do not automatically result in an upsurge in contraband.^[47] For example, despite an increase in taxes after seeing a sharp escalation in contraband between 2005 and 2009, Québec succeeded in curbing the market share of contraband tobacco products, mostly thanks to ACCESS Tabac (concerted actions to counter the underground economy – Tobacco). The market share of contraband tobacco, thought to be about 30% in 2009, declined to 14% in 2013; this figure has been stable since 2011 and similar to that observed in the early 2000s.^[49] From 2008–2009 to 2013–2014, income from the special tax rose more than \$370 million, from \$654 million to \$1026 million. Consumption of contraband products has been well documented in Québec, as indicated in the 2012 report of the Commission des finances publiques sur l'étude des mesures pour contrer la consommation du tabac de contrebande.^[50]

Educational institutions and the latest tobacco-related issues

Educational institutions, particularly school boards and elementary and high schools, have been engaged in tobacco control for over 20 years. They have been especially focused on communications campaigns, program and project implementation (e.g. Youth Coalition Against Smoking, Operation Say It Loud!), and enforcing smoking bans on school grounds.

Representatives from Montréal's five school boards have reported difficulties in applying legislation that prohibits smoking on school grounds, especially in high schools in low-income neighbourhoods, trade schools and schools offering adult education courses. In addition, because of the growth in new products, the introduction of e-cigarettes and the proximity of tobacco retailers to schools, educational institutions feel they are ill-equipped to supervise young people and enforce existing measures, both inside and outside their buildings.

Smoking prevalence in specific groups—students at high risk of dropping out, who have severe alcohol and drug problems or are developing such problems, those who attend technical and vocational schools—induces administrators and educators to concentrate their efforts on these groups. An approach integrating preventive and protection measures as well as measures adapted to those groups should be chosen to optimize its impacts on the reduction of social inequalities in health. Given how difficult it is to reach those populations and the scientific data showing that nicotine acts as a gateway to problematic alcohol and drug use, we advocate focusing prevention efforts in schools on both tobacco and addictions. ^[109] This is why we must also persevere in our fight against school dropout, an approach that acknowledges links between education and health inequalities.

Young people aged 15 to 24: Investing in additional efforts

Although the high-school years are key to deterring smoking initiation, data show that a significant number of young people start smoking once they have finished high school.^[18] There are, however, few measures to prevent initiation, particularly for youth aged 15 to 24. Additional efforts are needed in schools, especially in adult education facilities. Colleges and universities could combine their efforts with those of other schools, since people in this age group attend those institutions. This would result in concerted action and standardize smoking prevention messages targeting youth, regardless of educational orientations.

Shared commitments to prevent youth smoking

A drop in smoking rates among young people is due to two factors: laws and regulations governing use and marketing of tobacco products; and the participation and support of institutional and community partners. However, despite the progress made over the past decade, smoking prevalence among young people is still of concern, especially in certain vulnerable groups or residential districts.

The preceding observations indicate the degree to which the approach outlined in the *Plan de lutte contre le tabagisme* is justified, as regards smoking prevention. Stakeholders, in particular CSSS, school boards, youth centres and youth community centres, must recognize the need to combine their efforts to influence legislative, economic and population-based tobacco control measures.

To achieve the results fixed in the Montréal plan and move toward tobacco-free generations, partners have committed to recommend to the government that it strengthen legislation, reduce access to tobacco products, and support prevention projects and initiatives in schools and in the community.

Strengthen legislation

- **Flavours**

5. Prohibit the marketing of flavoured tobacco products—including menthol and those smoked with waterpipes, or hookahs, and flavoured e-cigarettes.

- **Packaging**

6. Impose plain packaging for all tobacco products sold in Québec.

- **Hookahs (waterpipes)**

7. Ban hookah bars and revoke the permits of bars exempted under the law.

- **New products**

8. Declare a moratorium on the sale of new tobacco products and related items to discourage the development of new products.

Reducing access to tobacco products

- **Minimum price**

9. Increase the minimum consumer price to at least \$20 for one or several tobacco products other than cigarettes.

- **Price**

10. Increase the tax on tobacco products until it reaches the Canadian average, taking into account the price of cigarettes in neighbouring provinces and states.

- **Retail outlets**

11. Put in place an effective system to monitor and oversee retail outlets, using reliable data.

Encourage and support prevention projects and initiatives in schools and the community (11 to 24 years)

Creating conditions conducive to supporting young people's commitment and choice to remain non-smokers requires coherent messages delivered in a variety of environments, such as youth community centres, schools and youth job banks (Carrefours jeunesse-emploi). Implementation of collaborative, complementary actions is essential, particularly in districts where prevalence is high. Those actions should target access to tobacco products, encourage protection of children against second-hand smoke and enhance access to cessation tools and services.

- **School dropout**

12. Maintain efforts to prevent school dropout that target school retention and educational success.

- **Prevention programs**

13. Integrate tobacco control within addiction prevention programs in schools.

- **Technical and vocational schools**

14. Urge technical and vocational schools to review their tobacco-related practices, particularly in the application of legislation on smoke-free school grounds.

- **Community projects**

15. Increase the number of community projects that mobilize partners and urge them to work together on the most effective measures to reduce smoking prevalence among youth, especially in neighbourhoods where prevalence is high.

- **Social engagement projects**

16. Support young people's social engagement projects pertaining to tobacco control (e.g. Operation Say It Loud!, Youth Coalition Against Smoking), in collaboration with local stakeholders and partners, especially in neighbourhoods where smoking prevalence is high, in schools in disadvantaged areas, and in technical and vocational schools.

5

Protection: A Smoke-Free Environment

Non-smokers exposed to secondhand smoke—also called passive smoke or environmental tobacco smoke—are also at risk of developing tobacco-related diseases.

In Montréal, passive smoking causes about 50 deaths a year due to lung cancer or heart disease.^[7] Tobacco smoke contains over 7 000 chemicals, more than 70 of which are known to cause cancer.^[51-54] Secondhand smoke increases the risk of cardiovascular disease 25% to 30% and the risk of lung cancer 20% to 30%, to name but two.^[51] It can also cause sudden infant death. In pregnant women, it can lead to low birthweight infants. Young people exposed to secondhand smoke at home are 1.5 to 2 times more at risk of taking up smoking than children who are not exposed.^[51] Since there is no threshold below which exposure to secondhand smoke is safe, the only way to protect the health of non-smokers is to prohibit smoking in public places, workplaces, cars and homes.^[47]

For the past 20 years, regional and local stakeholders have been working relentlessly to protect the health of the population, especially of children and pregnant women, against the dangers of secondhand smoke. Changes brought to the *Tobacco Act* in 2005 that restricted the use of tobacco have been in force since 31 May 2006^J. The Act includes exemptions for some institutions such as psychiatric hospitals and residential and long-term care centres. It allows these institutions to have smoking areas and to reserve 40% of its rooms for smokers.

Growing knowledge about the health risks of secondhand smoke for non-smokers as well as the population's awareness of these risks and its greater appreciation of the benefits of smoke-free spaces have spurred some institutions to put in place measures that go beyond what is required by law. For instance, most psychiatry services in Montréal no longer provide places to smoke. Centre jeunesse de Montréal – Institut universitaire has adopted a policy that will gradually introduce a total ban on smoking, both indoors and outdoors.

Public health clarified its approach regarding the protection of non-smokers in its 2010–2015 regional public health plan^[55] and in *Montréal sans tabac – Plan de lutte contre le tabagisme 2012–2015*.^[13] It intends to focus its actions on public policy and support for local stakeholders to reduce harm cause by secondhand smoke, notably among vulnerable individuals: children in general, children in youth centres and people with mental health problems.

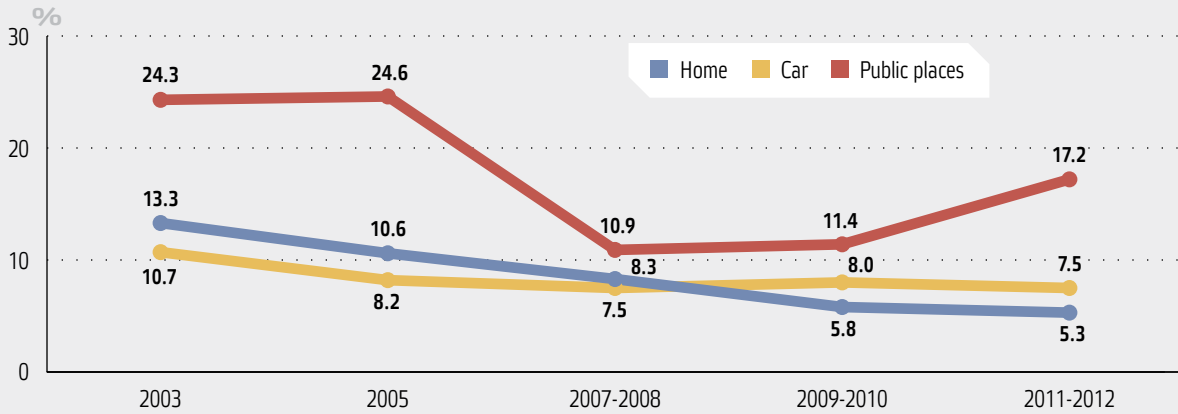
Some data

Figure 9 shows the change in the proportion of non-smokers exposed to tobacco smoke in public places, at home and in cars from 2003 to 2012. It is interesting to note that in 2011–2012, exposure of non-smokers was greatest in public places

J The Act prohibits smoking in enclosed spaces such as workplaces, restaurants and bars, childcare centres, health institutions, schools, colleges and universities. It also prohibits smoking outdoors on school grounds and the grounds of childcare centres, as well as within a perimeter of nine metres from health institutions.

Figure 9

Proportion (%) of non-smokers exposed to secondhand smoke, by location of exposure, Island of Montréal 2003 to 2011-2012



Sources: CCHS 2003, 2005, 2007-2008, 2009-2010, 2011-2012
 Note: CCHS data for individuals aged 12 and over

Exposure at home: An ongoing decline

The proportion of non-smokers exposed to tobacco smoke at home has declined substantially since 2003 and the figure is significantly lower than that observed for the rest of the province since 2005. In 2011–2012, young Montrealers aged 12 to 19 formed the group that was most exposed (14%) compared with those aged 25 and over (3.8%).^[1]

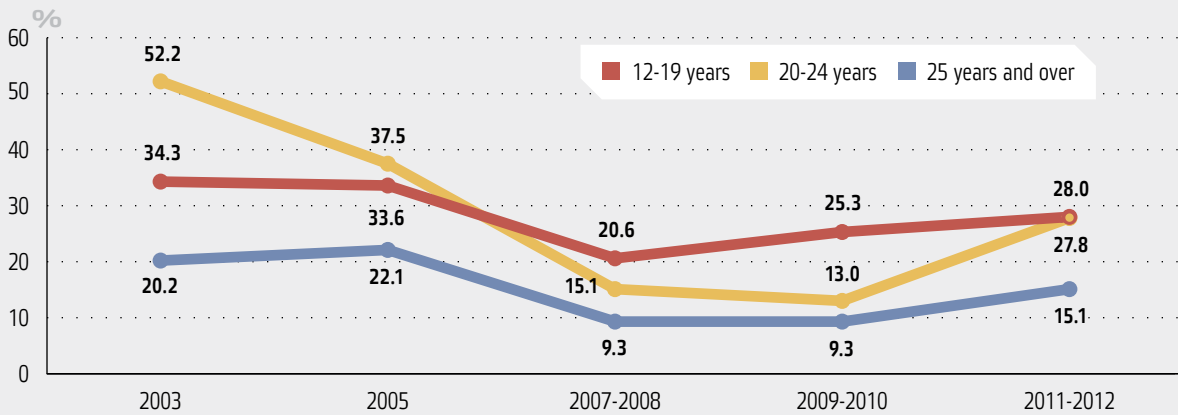
Results of the TOPO survey^[10] reveal that among people aged 15 and over, the groups most likely to be exposed to tobacco smoke were 15- to 24-year-olds, people without high school diplomas, people living in disadvantaged neighbourhoods and ex-smokers who have quit smoking for less than 12 months.

Exposure in public places: Expected downward trend not observed

A downward trend in non-smokers' exposure to tobacco smoke in public places was observed between 2005 and 2007–2008. This is probably largely attributable to changes to the *Tobacco Act* that came into force in 2006. However, that downward trend did not continue after 2007–2008 in any age group (Figure 10).^[1]

Figure 10

Proportion (%) of non-smokers exposed to secondhand smoke in public places by age group, Island of Montréal 2003 to 2011-2012



Sources: CCHS 2003, 2005, 2007-2008, 2009-2010, 2011-2012

Exposure in cars: Little change since 2003

The proportion of non-smokers exposed to tobacco smoke in cars has not changed since 2003. This is not different from what has been noted in the rest of the province. In 2011–2012, young people aged 12 to 19 formed the group that was most exposed in cars (16.1%)—almost three times more than adults aged 25 and over (6.3%).^[1]

Model initiatives

The *Tobacco Act* governs tobacco use in many places, but not in parks, beaches and places where sport or cultural activities are held, or on open terraces and patios of bars and restaurants.

The Act allows psychiatric institutions, residential and long-term care centres (CHSLD) and rehabilitation centres to have a designated smoking room and to set aside up to 40% of their rooms for smokers. However the exemption provided in the Act causes enforcement problems related to the safety of service users, visitors and staff. Public health has worked with health institutions wishing to adopt approaches that are more coherent with their missions.

Le Centre jeunesse de Montréal – Institut universitaire: Better protection for vulnerable youth

Each year, Centre jeunesse de Montréal – Institut universitaire works with 13 000 children and families and provides housing to more than 2 000 children and minors. The Centre plays a pivotal role with Montréal's most vulnerable children, young people and families. Smoking prevalence in Québec youth centres is very high: two-thirds of youth aged 14 and over are daily smokers.^[56] Centre jeunesse de Montréal has adopted a policy to become a smoke-free institution, following a long period of reflection and in accordance with its mission to protect and give a sense of responsibility to the children and young people entrusted to its care.^[57] The policy prohibits smoking at its facilities, both indoors and outdoors. It will be progressively implemented from September 2014 to January 2016, and will include training and smoking cessation services adapted to the needs of the youth and its employees. Support services will be determined in cooperation with stakeholders from the districts concerned.

Exemplary health institutions

Institut Philippe-Pinel de Montréal has been a smoke-free hospital since 2005: smoking is prohibited both inside and outside the institution. It is the first smoke-free psychiatric hospital in Montréal. Health and social services authorities have recognized the excellence of this initiative.^[58]

Several institutions with psychiatric pavilions or units have also closed their smoking rooms. This is the case at the **Douglas Mental Health University Institute, St. Mary's Hospital Centre, Albert-Prévost pavilion at Hôpital du Sacré-Cœur, and McGill University Health Centre**. The Douglas is moving towards becoming completely smoke-free.

Other institutions such as **Agence de la santé et des services sociaux de Montréal** and many CSSS have smoke-free policies that are also applied outdoors on the grounds.

In October 2014, the **Quebec Network of Health Promoting Institutions**, in collaboration with the regional tobacco team, launched a guide on how to become a smoke-free institution. The tool, available on the Web, puts forward a process for network institutions that is based on best practices and that aims to integrate tobacco-related activities, guided by an official policy.^k In addition, the guide contains tools to facilitate communication and assist in change management, key elements in this process.

A profile of the tobacco control practices in force in mental health and addiction institutions, put together by public health in 2013, indicates that most had chosen to ban the use of cigarettes inside their buildings even though they could have taken advantage of the exemption in the Act.

The initiatives taken by some health and social services institutions, restaurants and the City of Côte Saint-Luc show that it is possible to respond proactively to provide smoke-free environments, especially to vulnerable groups struggling with tobacco addiction.

Smoke-free terraces and patios of bars and restaurants

Canadian researchers have found conclusive evidence regarding the need to keep restaurant terraces smoke-free to protect workers and the public against secondhand smoke.^[59] A number of provinces (Newfoundland–and–Labrador, Nova Scotia, Alberta, Yukon and, more recently, Ontario) and municipalities (Vancouver, Saskatoon and Ottawa) have adopted laws or regulations to protect staff and patrons of terraces of bars and restaurants against secondhand smoke. With the recent adoption of a smoke-free law in Ontario, Montréal is now the only big Canadian city that does not provide smoke-free environments on all terraces and patios.^[60] In Montréal, and elsewhere in Québec, the smoking ban in force since 2006 in restaurants and bars does not apply to terraces and patios. As a result, restaurant workers (often young people aged 20 to 24) as well as clients and their children are still exposed to tobacco smoke.

Nonetheless, measures taken by some businesses should be mentioned. For example, the coffee chain **Starbucks** has offered its clients totally smoke-free terraces since 2013.^[61]

Proactive municipalities

Municipalities have the power to adopt regulations that restrict smoking in some public places not covered under the law. Most big Canadian cities have measures that regulate tobacco use in parks, playgrounds, swimming pools and other public spaces.

In Montréal, the only municipality to adopt a by-law is the **City of Côte-Saint-Luc**. In 2012, the City adopted a regulation that prohibits smoking within a 20-metre perimeter of a number of public places:

1. Playgrounds, splash pools or any other place where there are sport activities
2. Municipal parks during special events
3. Municipal outdoor pools^[62]

Smoke-free homes

Smoke-Free Family project

The Smoke-Free Family communications campaign developed by Capsana is a tool designed to inform the public about the risks associated with secondhand smoke^K. The campaign, supported by a website, urges current and future parents to take concrete actions for their children's health by eliminating secondhand smoke from their homes and cars.

K www.famillesansfume.ca/en

Habitations sans fumée au Québec – An indispensable website

In response to the growing number of requests for information about smoke-free homes, apartments and condos, the Association pour les droits des non-fumeurs has developed a website: Les habitations sans fumée au Québec^L. Visitors to the website will find tools, examples and legal notices to encourage the creation of a movement to promote smoke-free dwellings. One objective is to foster the availability of a housing supply that meets the needs of tenants who want to raise their children in smoke-free environments.

Smoke-free prisons

In prisons, where 70% to 80% of inmates are smokers, smoking is now prohibited both inside and outside the facilities. The ban applies to inmates and employees. In Montréal, this measure has been in force throughout the provincial prison system since spring 2014, as directed by the ministry of public security.^[63] Québec was the last province in the country to completely ban smoking in prisons.

Findings

Children and adolescents: The group most exposed to tobacco smoke

Exposure to smoke in cars

Little has changed since 2003 in terms of adolescents' exposure to tobacco smoke in cars. In 2011–2012, prevalence declined only 2%, from 18% to 16%. Those results indicate that the objective set in the tobacco control plan (11% by 2015) can only be attained if supported by legislation that prohibits smoking in cars in the presence of minors.^[13]

Montréal children's exposure to secondhand smoke in cars is higher than for children in other big Canadian cities, where provincial laws ban smoking in cars when children are present.^[60] It is essential to ban smoking in cars with children, given that concentrations of toxic substances in tobacco smoke in cars are very high, even with good ventilation, that young children's lungs are more vulnerable to cigarette smoke and that exposure to secondhand smoke can result in nicotine dependence among young people.^[64-67] Such a ban is effective since it has contributed to a 33% decline in exposure to secondhand smoke in children in the nine other Canadian provinces.^[68]

Exposure at home

Although exposure of adolescents aged 12 to 19 to secondhand smoke at home is clearly declining (the rate was 14% in 2011–2012), it is three times higher than for adults aged 25 and over (4%). Efforts made over the next few years should aim at ensuring that children and adolescents are at least as well protected as adults.

Exposure in public places

While legislation that bans smoking specifically targets public places, this is where the numbers of non-smokers exposed to tobacco smoke is highest, compared with homes and cars. This finding indicates the urgency of strengthening laws and regulations so that all non-smokers can be better protected, especially young people aged 20 to 24.

L www.habitationsansfumee.qc.ca

Post-secondary education institutions: Current and future measures

In Montréal, few measures have been put in place to protect 15- to 24-year-olds, an age group for which prevalence is particularly high. Universities and colleges offer some smoking cessation activities, but none has adopted a policy that would make their institution totally smoke-free. However, many of them have voiced an intention to contribute to tobacco control by asking public health or a CSSS for support in helping them become smoke-free and improving their smoking cessation services. Given their mission and their proximity to young adults, it is clear that post-secondary education institutions^M can play leading roles in tobacco control.

Shared commitments to protect non-smokers from secondhand smoke

Given that legislative means are essential to bolster efforts of local stakeholders, a number of public policy actions have been implemented, and should be kept up in the future. During the revision process of the *2005–2010 Tobacco Act*, public health participated in the public dialogue with support from its partners and produced a brief for the government.^[17] Its main recommendations were aimed at reducing harm caused by secondhand smoke and increasing the number of smoke-free places. Essentially, it recommended banning smoking in cars with children, inside buildings and on the grounds of health and social services institutions, including youth centres, mental health institutes and the Centre de réadaptation en dépendance. Together with Québec's directors of public health, the Montréal public health department recommended that the Minister of Health and Social Services include, in the new bill, measures to prohibit smoking on the terraces and patios of bars and restaurants.

Last year, public health undertook the task to produce a portrait of measures taken by some partners to counter exposure to secondhand smoke, especially those pertaining to perinatal and mental health. Moreover, public health provided support to partners who wanted to adopt and implement policies that go beyond what is in the law; those partners include prisons, youth centres, CSSS, the Montréal Agency and Douglas Mental Health University Institute.

To achieve the desired results for tobacco control and make Montréal smoke-free, partners must commit to the following:

- **Motor vehicles**

- 17.** Recommend to the government that it revise the *Tobacco Act* to prohibit smoking in cars where there are children under 16.

- **Vulnerable children and adolescents**

- 18.** Recommend to the government that it revise the *Tobacco Act* to ban smoking inside and on the grounds of youth centre buildings, while systematically providing smoking cessation support.
- 19.** Offer completely smoke-free environments inside and on the grounds of Montréal's two youth centres, while systematically providing smoking cessation support adapted to young people's needs.

M Post-secondary education institution refers to vocational training centres, colleges, CEGEPs and universities.

- **Health and social services institutions**

- 20. Recommend to the government that it revise the *Tobacco Act* to ban smoking inside and on the grounds of health and social services institutions, while systematically providing smoking cessation support.
- 21. Develop and implement a comprehensive, integrated anti-smoking policy to become totally smoke-free environments, both indoors and on facility grounds. A smoke-free institution is one that has adopted a vision and an integrated strategic plan to protect the health of users, visitors and employees. The policy should contain measures to systematically identify patients who smoke and to support cessation; the latter measures can be adjusted to the needs of individuals living in those institutions.

- **Youth aged 15 to 24**

- 22. Provide smoke-free environments in all post-secondary institutions (vocational training centres, and Cegeps, colleges and universities, including student residences) as well as systematic smoking cessation services adapted to young people aged 15 to 24.

- **Terraces and patios**

- 23. Recommend to the government that it revise the *Tobacco Act* to prohibit smoking on the terraces and patios of bars and restaurants.
- 24. Encourage municipalities to adopt regulations to restrict the use of tobacco on the terraces and patios of bars and restaurants.

- **Children's playgrounds, pools, beaches and public places not covered in the law.**

- 25. Encourage municipalities to adopt regulations to restrict the use of tobacco in places not covered in the law, such as playgrounds, pools and wading areas, beaches and outdoor facilities during sport activities or special events.

- **Homes**

- 26. Ensure that interventions and tools to reduce harm caused by exposure to secondhand smoke in people's homes are integrated into cessation services and across the continuum of mother-child services in neighbourhoods with high prevalence rates.

6

Cessation: Adapting Support to Smokers

Smokers develop tobacco-related diseases at a young age.^[23] It has been demonstrated that cessation before age 40 reduces tobacco-related risks by 90%.^[69] Improved health is also observed soon after cessation and most harmful effects can decrease over time, even for the heaviest smokers.^[69]

Using the guidelines outlined in Québec's smoking-cessation plan (PQAT)^[70-71], Montréal has made significant efforts over the past 10 years to improve cessation support services and set up a network of complementary services.

Quit-Smoking Centres accessible in Montréal's 12 CSSS

- Intensive individual interventions: minimum of three face-to-face meetings with a health professional

Smoking cessation groups

- Respirer la santé, an 8-session program with groups of 8 to 10 people led by professionals from Quit-Smoking Centres; developed in cooperation with various partners including the CHUM, Jewish General Hospital and the Montréal Agency, and uses group practices known to be effective

Canadian Cancer Society's iQuitnow help line

- Dissemination of information on existing PQAT services, including cooperation in special projects
- Intensive individual telephone interventions, with follow-up frequency determined according to smokers' needs

Canadian Cancer Society's Short Messages Against Tobacco (SMAT)

- Cessation support text messages for people who are registered

Capsana's annual Quit to Win! Challenge

- Smokers register and commit to quitting smoking for six weeks, from March 1 to April 11
- Support through different means (e.g. kits, emails, website) and information on existing PQAT services

Regional Quit-Smoking Centre promotional campaigns

- Promotional Web pages, including georeferencing of services and online appointment booking, as well as banners for partners' sites
- Use of social media (Facebook, YouTube, Google Ads) to target young people aged 25 to 34

Regional NRT collective prescription

- Regional collective prescription signed by the director of public health that allows community pharmacists to provide nicotine replacement therapy, the cost of which is refunded by RAMQ
- Pharmacist referrals to the iQuitnow help line

Some data

Fewer than 10% of smokers have quit smoking in the past 12 months

In Montréal, in the 12 months preceding the TOPO survey, 8.8% of smokers had quit smoking and 44% had quit at least once for a period of at least 24 hours.^[10] Since 2005, the quit rate has been about 8% and appears to have remained stable.^[72]

One in four smokers ready to quit

In Montréal, there are an estimated 311 400 smokers. At the time of the TOPO survey,^[10, 18] one in four smokers (24.5%) had tried to quit at least once in the past year and was considered to be ready to quit within the next 30 days.

Successful quitting: Health benefits unequally distributed

Smokers living in the wealthiest areas have markedly higher cessation rates than those in the most disadvantaged districts (13% versus 5.4%).

Characteristics of persons least likely to quit smoking

To better define the characteristics of smokers who have not quit, the latter were compared with people who have quit smoking for less than two years as well as those who have not smoked for two years or more. Results show the following:

- The younger the individuals, the less likely they are to quit smoking.
- People with no high school diploma are less likely to quit than those who have graduated from high school or college, and the latter are less likely to give up smoking than people who have attended university.
- People with mood or anxiety disorders are less likely to quit smoking than individuals who do not have such health problems.

Pregnancy and smoking

From 2000 to 2005, 10.4% of pregnant Montrealers smoked during their pregnancies, a rate that varied from 3.1% to 18.4% by CSSS district.^[73] A recent Canadian study established that smoking prevalence is highest among adolescents aged 15 to 19, and prevalence is seven times higher in mothers in this age group (40%) than in those aged 35 and over (5%).^[74]

The proportion of pregnant women exposed to tobacco smoke decreased from 6.5% in 2000 to 2.5% in 2005.^[73] During this same period, pregnant women who had finished elementary school only were proportionately more exposed to tobacco smoke (14.4%) than those with university degrees (3.9%).

Model initiatives

Smoking cessation services in hospitals

Smoking is one of the main causes of a number of diseases that require outpatient medical consultations or hospitalizations. This is why hospitals can play important roles in smoking cessation, especially since over 35% of Montrealers don't have family doctors (TOPO 2012). It is clear that smoking cessation support delivered in hospitals reaches smokers and is effective with patients who are open to such interventions. There is a 26% success rate after six months of cessation,^[75] which is five times higher than for smokers who try to quit on their

own. Moreover, there is also an opportunity to act outside acute care episodes, as illustrated by CSSS Cavendish's implementation of systematic interventions for smoker patients in its two rehabilitation hospitals

Since 2004, Montréal's public health department has provided funding and support to facilitate smoking cessation projects in mother–child care units and cardiology departments at several hospitals. These projects often aim to put in place measures that systematically identify hospitalized smokers and offer them brief interventions to support abstinence during hospitalization. Such interventions can include use of pharmacological aids to manage withdrawal symptoms, but always involve referral to smoking cessation services (Quit-Smoking Centres or iQuitnow help line) upon a patient's discharge. Hospitals have also trained health professionals on brief interventions and on motivational interviewing to enable them to intervene more effectively with patients in various departments.

An evaluation of eight facilities^N conducted in 2007–2008^[76] showed that 6 314 smokers were exposed to at least one intervention during periods ranging from 8 to 44 months. It highlighted issues linked to the sustainability of smoking cessation interventions as well as the need to use those interventions across an institution rather than only in targeted departments. It is important to acknowledge that smoking cessation is integral to each institution's mandate and should be a mandatory activity, just like infection prevention or complaints management are.

Hôpital du Sacré-Cœur – Position created

Montréal's Sacré-Coeur hospital has always made sure that its professionals integrated smoking cessation into their practices and has taken steps to enhance the sustainability of this intervention. It initially designated a position in smoking cessation and then put in place mechanisms to systematically identify hospitalized smokers. This is a first in Montréal.

CHUM – Systemized process

The Centre hospitalier de l'Université de Montréal (CHUM) has created a training session on the brief smoking cessation intervention for health professionals in all units and departments at its three sites. With support from the public health department, CHUM has produced information sheets for smoking patients adapted to each department (cardiology and oncology, for example) and smokers' stages of change.^[77]

MUHC – IMPACT program

The McGill University Health Centre (MUHC) has developed an intervention project based on the Ottawa Model for Smoking Cessation. The Model, which has been highly successful across Canada, involves systematic, automated phone calls to smoker patients after discharge from hospital. The MUHC has also worked with key partners, including a CSSS and the Canadian Cancer Society (iQuitnow help line) to ensure appropriate follow-up. The pilot project will be documented and evaluated to determine if the project, or some of its elements, can be useful in other districts or across the Island.

N Lakeshore General Hospital, Hôpital du Sacré-Cœur de Montréal, Hôpital Maisonneuve-Rosemont, Hôpital de LaSalle, St. Mary's Hospital, Jewish General Hospital, Hôpital Saint-Luc du CHUM, and the MUHC's Royal Victoria Hospital.

Some institutions have successfully argued for the importance of maintaining smoking cessation interventions and have been able to hold on to their resource person. The Montréal Heart Institute has managed to keep its smoking cessation nurse since 2004, when it first conducted its projects. The Jewish General has integrated a service offering intensive individual and group counselling for its outpatients. Those resources have contributed to greater use and visibility of hospital smoking cessation services. Since the end of these hospital-based initiatives, other key projects have been carried out.

Smoking cessation services and perinatal care

Smoking during pregnancy increases the risks of prematurity, stillbirth and neonatal death. It can also have harmful effects on the baby's health: higher risks of sudden infant death, respiratory diseases, attention deficit disorders and hyperactivity.^[4]

Since 2005, the Montréal public health department has supported initiatives in hospitals and CSSS to foster smoking cessation in pregnant women and their spouses and reduce exposure to secondhand smoke in the home. Nearly all hospitals with obstetrics departments or mother–child programs offer cessation support services and counselling on secondhand smoke, using tools from the Smoke-Free Family campaign. This is also true for the 12 CSSS, which offer Integrated Perinatal and Early Childhood Services, and for Montréal's three midwifery services.

CSSS de la Pointe-de-l'Île – *Zéro nico pour mon Coco*

Some CSSS have prioritized smoking cessation in their local action plans. As part of its *Zéro nico pour mon Coco* project, CSSS de la Pointe-de-l'Île and its local services network have set up, in various points of service, smoking cessation interventions for pregnant or breastfeeding women and their spouses. *Zéro nico* recognizes that smoking is a significant determinant of young children's respiratory health in Pointe-de-l'Île. It is part of the clinical project and aims to provide better-quality air to babies and children through concerted actions for pregnant women and new mothers as well as their social networks. The intervention maximizes the strengths and skills of professionals and of their partners serving families in this CSSS district. It enables them to work together on issues affecting these families throughout the consultation process, during pregnancy and after childbirth. Whether in pharmacies or test centres, during prenatal courses or thematic meetings with vulnerable women, in community groups or people's homes, partners help spread *Zéro nico pour mon Coco's* message.

CSSS de l'Ouest-de-l'Île and Lakeshore General Hospital

CSSS de l'Ouest-de-l'Île and Lakeshore General Hospital have developed a smoking cessation intervention model for smokers living in this district. First used by the perinatal team, the model systematically identifies the smoking status of a pregnant woman and her spouse at all pregnancy points of service. It includes brief counselling by a health professional and referral to a Quit-Smoking Centre in the district or to the iQuitnow help line. With support from public health, local teams have developed intervention tools, and professionals from different units and departments have been trained to use them (e.g. decision making tools, nursing protocol) so they can, in turn, train their peers. The intervention model has also been implemented in the surgery, cardiology, geriatrics and mental health units.

Pharmacists: Essential partners

Proximity and frequent contacts with the population make community pharmacists ideal partners to connect with and support smokers as they try to quit. Public health has worked with pharmacists to develop a collaborative strategy for tobacco control. The collective prescription is central to this strategy, which aims to facilitate geographical and financial access to nicotine replacement therapy. Furthermore, it is a lever to achieve various objectives:

- Encourage knowledge transfer among pharmacists
- Support pharmacists' smoking cessation and prevention efforts
- Stimulate collaboration between pharmacists and various cessation resources^[78]

Most pharmacists (84%) practising in Montréal and surrounding areas believe smoking cessation is an area of promotion and prevention in which they should participate.^[79] They want to get more involved in smoking cessation, and their counselling practices with smokers have improved.^[80-83]

Montréal has over 1 600 pharmacists practising in the city's 443 pharmacies.^[84] Pharmacies are considered as primary care points of service that can deliver personalized smoking cessation services to smokers.

Access to pharmacological aids in pharmacies is known to be an effective and efficient measure.^[85-87] Since 2007, Montréal's public health department has issued a regional collective prescription allowing pharmacists to initiate nicotine replacement therapy (NRT).

Collective prescription for smoking cessation – A success story

As is the case for individual prescriptions written by doctors, RAMQ reimburses 80% of the costs of NRT, including Zyban and Champix, for one 12-week treatment per year.

Implementing a collective prescription has a significant impact on the abstinence rate.

- Data indicate that implementing a collective prescription in community pharmacies shows promise. Pharmacist involvement and use of the collective prescription enhance efforts to reduce smoking in Montréal, especially among young adults and in districts where smoking prevalences are highest.^[88]
- Between 2010 and 2013, the number of people who accessed NRT through the collective prescription rose from 3 008 to 5 970, an increase of over 50%.
- The collective prescription makes it possible to reach a greater number of young smokers. It has been used by 31.7% of smokers aged 18 to 34, 23.5% of smokers aged 45 to 54, and 18% of smokers aged 55 and over.
- The collective prescription significantly enhances use of NRT. In 2013, 36.5% of smokers who had access to the collective prescription were given a combination of NRT (patches and another product), in accordance with Canadian guidelines, compared with 11.5% for smokers who asked for individual prescriptions.
- In 2012–2013, pharmacists referred an average of 115 smokers a month to PQAT counselling services using the NRT collective prescription referral form.^[89]

Initiatives for groups with vulnerability factors

As noted in the section on protection, measures aimed at tobacco use reduction in some Montréal institutions have been put in place over the past few years or are currently being implemented. Those institutions—Albert-Prévost psychiatric wing at Hôpital du Sacré-Cœur, Institut Philippe-Pinel (2005), Centre jeunesse de Montréal – Institut universitaire, and provincial prisons (2014)—worked in partnership with public health and their local CSSS. More recently, Institut universitaire en santé mentale de Montréal decided to follow suit and is taking steps towards becoming a smoke-free institution.

Thanks to their outreach services, community groups can reach clientele with vulnerability factors who are unlikely to use services in institutions.

One thing is certain: whether these are health institutions or community groups, they all serve populations with very high smoking prevalences who are generally unlikely to stop smoking. There is a preconceived notion that, for these individuals, smoking has a calming affect or could even be part of a treatment plan. The *Tobacco Act* even includes exemptions that allow institutions to set aside rooms where smoking is permitted. Nonetheless, some institutions have successfully created smoke-free environments and have demonstrated that tobacco control interventions with these clientele can work.

Findings

Cessation support services seldom used

Although cessation services are free and widely promoted, fewer than 2% of Montrealers who smoke used them in 2011–2012. Their effectiveness is obvious: the quit rate after six months is 27%, a result that equals those of the best interventions.^[71, 90]

In 2009–2010, only 9% of smokers were exposed to medical counselling for smoking cessation^[71]; in 2011, about 5% received a collective prescription for NRT. Even so, although these exposure rates go from single to double digits in some CSSS districts, they remain low in all districts.^[91]

Successful cessation support services

The annual Quit to Win! Challenge

Since the first edition of the Challenge in 2000, 50 260 Montrealers have signed up. Among respondents to the 2013 survey, 68.3% had quit smoking during the six-week Challenge period; the quit rate was 34% after six months and 20% after a year.

Intervention by health professionals

A smoking cessation intervention delivered by health care professionals (doctors, nurses, pharmacists, dentists, etc.) is considered to be one of the most effective preventive clinical practices.^[90] An evaluation of the use of services available at Quit-Smoking Centres in Montréal has determined that more than half of respondents (57%) quit smoking during the cessation process and that the rate of abstinence after six months was 27%.^[71] When counselling and NRT were combined, chances of succeeding were at least three times higher than with use of NRT alone.^[92]

Shared commitments to adapt cessation counselling

Montréal's tobacco control plan aims to increase the overall annual cessation rate to over 10%.^[13] Given the high variability in cessation rates among CSSS districts,^[10] cessation support services should be innovative and adapted to the clientele previously identified, who are less likely to quit smoking. Moreover, the partners concerned should commit to the following:

- **Funding**

27. Review the financial framework for smoking cessation services according to prevalence, reduction of social inequalities in health and the new composition of Montréal's health network (as of April 2015).

- **Continuum of care and services**

28. Systematically provide smoking cessation interventions in health and social services institutions at all points of the continuum of care and services (e.g. admission to hospital, during hospital stay, in out-patient services, upon discharge). Act as liaison with community services.
29. Include systematic provision of cessation services in a policy for smoke-free institutions to safeguard sustainability.
30. Ensure that smoking cessation services and protection against secondhand smoke are integrated across the continuum of mother-child services.

- **Collective prescription**

31. Encourage pharmacists to offer nicotine replacement therapy (NRT), especially in neighbourhoods where smoking prevalence is high and among clientele such as young adults aged 18 to 34 and the most vulnerable individuals.
32. Inform young adults (18 to 34) about the collective prescription, which allows for reimbursement of NRT.

- **Vulnerable clientele**

33. Recommend to the government that it revise the *Tobacco Act* to ban smoking inside and on the grounds of the two mental health institutes and Centre de réadaptation en dépendance, while systematically providing smoking cessation support.
34. Offer completely smoke-free environments inside and on the grounds of the two mental health institutes and Centre de réadaptation en dépendance de Montréal, while systematically providing smoking cessation counselling adapted to the needs of these clientele.

7

E-cigarettes: Controls Needed

Concept and composition

E-cigarettes are currently the most common electronic nicotine delivery systems used. Shaped to look like conventional tobacco products (cigarettes, cigars, pipes and waterpipes), they also take the form of larger cylindrical or rectangular devices.^[93-95] They deliver an aerosol by heating a solution (juice or e-liquid) that contains propylene glycol, as well as glycerol, flavouring agents, nicotine and other psychoactive substances. Concentrations of nicotine and toxic substances in e-cigarette emissions can vary depending on battery voltage, unit circuitry of the atomizer or cartomizer, and on a user's (also called "vaper") decision to place the liquid directly onto the atomizer—a practice called "dripping".

Levels of carcinogens and toxicants in vapour from e-cigarettes are much lower than in cigarette smoke.^[96-99] In some brands, levels of some cancer causing agents, such as formaldehyde and other toxicants like acrolein, could be as high as in the smoke produced by some cigarettes. The potential cytotoxicity of the chemical components of e-cigarette liquids is correlated with the number and concentration of chemicals used in the flavours.^[100] An analysis of nicotine content of the cartridges of five popular e-cigarette brands in the United Kingdom showed variations in nicotine concentrations that are considered acceptable. However, the study authors were unable to establish a relationship between nicotine levels in e-liquids and nicotine concentration in the vapour. They concluded that product characteristics and how it is used affects nicotine levels in the vapour.^[101] Vapers are exposed to lower levels of nicotine and toxic substances than smokers of conventional cigarettes, but to much higher levels than people who use medicinal nicotine inhalers.^[98]

Unlike conventional cigarettes, e-cigarettes do not emit sidestream smoke; however, exhaled aerosol increases concentrations of particles in the air. Levels of toxicants and nicotine emitted are lower than those in conventional cigarette emissions. Ultrafine particles are composed of propylene glycol, glycerol, water and nicotine, but lack combustion products like carbon monoxide and various organic compounds.^[102-103] Vapour vanishes more quickly and contains less nicotine than secondhand smoke. However, it does not prevent eventual nicotine absorption from passive vaping.^[104-107]

Risks and effectiveness

Health risks to users and non-users

Chemical and nicotine levels in e-cigarette vapour pose fewer health risks for most vapers, whether they are active or passive e-smokers, than the 7 000 chemicals in tobacco smoke, which include 70 carcinogens as well as carbon monoxide. Nonetheless, foetal and adolescent exposure to nicotine has lasting adverse consequences for brain development and could act as a gateway drug for cigarette smoking and use of other drugs.^[108-109]

There is enough evidence to caution children and adolescents, pregnant women and women of reproductive age about the use of electronic nicotine delivery systems (ENDS) and, of course, of all tobacco products. The risk of children

being exposed to liquid nicotine by ingestion or absorption through the skin is of particular concern. The number of reported incidents involving nicotine poisoning in the United States and the United Kingdom has risen substantially since electronic inhalers have been introduced.^[93] A few fires and explosions involving the device have also been reported.

Unfortunately, it will take decades before evidence concerning possible associations between e-cigarettes and illnesses such as cancer and cardiovascular diseases is available. In the short term, eye and respiratory irritations caused by exposure to propylene glycol are the only reported risks.^[93]

Effectiveness and health risk reduction

To date, the effectiveness of e-cigarettes and nicotine inhalers for quitting smoking has not been systematically evaluated. The only randomized trial, which involved smokers who wanted to quit, assessed smoking cessation over a 13-week period using three different methods: 16 mg nicotine e-cigarettes, 21 mg nicotine patches and no-nicotine placebo e-cigarettes. The study did not find significant differences among the three cessation treatments. Cessation rates at 6 months were 7.3%, 5.8% and 4.1%, three times lower than those observed in clinical trials combining nicotine patches and behavioural counselling. The study could not demonstrate variations between the three groups. Moreover, e-cigarettes contained and delivered less nicotine than labelled. However, some 30% of participants continued to use e-cigarettes following the trial, which demonstrates acceptability of the product among smokers.⁽¹¹⁰⁾

An English population study found that, from 2009 to 2014, smokers who used e-cigarettes were more likely to report abstinence than those who used NRT bought over-the-counter.^[111] In addition, an American population-based study showed that intensive users (used e-cigarettes daily for at least one month) were six times more likely than non-users or individuals who tried e-cigarettes at most once or twice to report that they were still not smoking conventional cigarettes 2 to 3 years later.^[112]

For some smokers, use of electronic nicotine inhalers completely replaces cigarette use; however, the most common effect is to reduce conventional cigarette use. Reduction in consumption leads to fewer health risks, which rise with persistent exposure to tobacco combustion products.^[113-115]

WHO considers that exposure of established adult smokers to toxic substances generated by electronic nicotine inhalers is likely to be less toxic than conventional cigarettes if inhalers are well regulated and used as substitutes for cigarettes. According to WHO, "in some smokers who have failed treatment, have been intolerant to it or who refuse to use conventional smoking cessation medication, the use of appropriately-regulated ENDS may have a role to play in supporting attempts to quit".^[95, 116]

In the United Kingdom, the Medicines and Healthcare Products Regulatory Agency has announced that from 2016, e-cigarettes will be regulated as medicinal products and required to meet the same standards for quality and availability as pharmaceutical products. All authorized forms of ENDS advertising will be monitored to prevent potential marketing abuses.^[93]

For its part, the European Union has announced that beginning in 2017, e-cigarettes will be considered a tobacco product and subject to the same rules as conventional cigarettes (e.g. health warnings on the product, ban on advertising, increased taxes).

They will also be considered a medication and prescribed by doctors as smoking cessation or smoking-related harm reduction aids. If the need arises, e-cigarettes will be subject to the same standardization regulations as medications.

In the United States in 2014, the Food and Drug Administration put forward regulations that were submitted for consultation. The FDA has given itself two years to establish safety and quality standards for e-cigarettes.^[117] However, nothing has been done to ensure that bottles of liquid be equipped with safety devices to prevent children from coming into contact with the liquid.

Some data

An expanding international market

In 2014, there were 466 brands of electronic inhalers; in 2013, it was assessed that US\$3 billion had been spent on these products worldwide. Data mainly from North America, the European Union and South Korea indicate that, from 2008 to 2012, use of nicotine inhalers at least doubled among both adults and adolescents.^[95] In 2012, 7% of European citizens aged 15 years and over had tried electronic cigarettes, but only 1% of them vaped regularly.^[93] In 2013, 47% of smokers and ex-smokers in the United States had tried e-cigarettes, but prevalence of regular vaping was 4% in this group.^[118] The most common reasons given for using these products are to cut down on smoking, to help with quitting smoking and to use in spaces where smoking is prohibited.^[95]

Canada

A 2012 cross-sectional survey of an online panel revealed that 16.1% of young people aged 16 to 30 (5.2% of non-smokers and 34.5% of smokers) had tried e-cigarettes. Smokers were 15 times more likely than former smokers to be current users of e-cigarettes at the time of the study. Smokers reported trying e-cigarettes to help them quit smoking (80.4%), as a long-term replacement for cigarettes (77.8%), and to have the option of using it in places where smoking is prohibited (80.9%).^[119]

Québec

In 2013, around 28% of high school students had already tried e-cigarettes, 4% of them had used it in the past 30 days, and about 20% who had never smoked cigarettes had tried e-cigarettes. In Montréal, 31.9% of secondary 5 students have tried e-cigarette and 4.3% had used it in the past 30 days.^[119a]

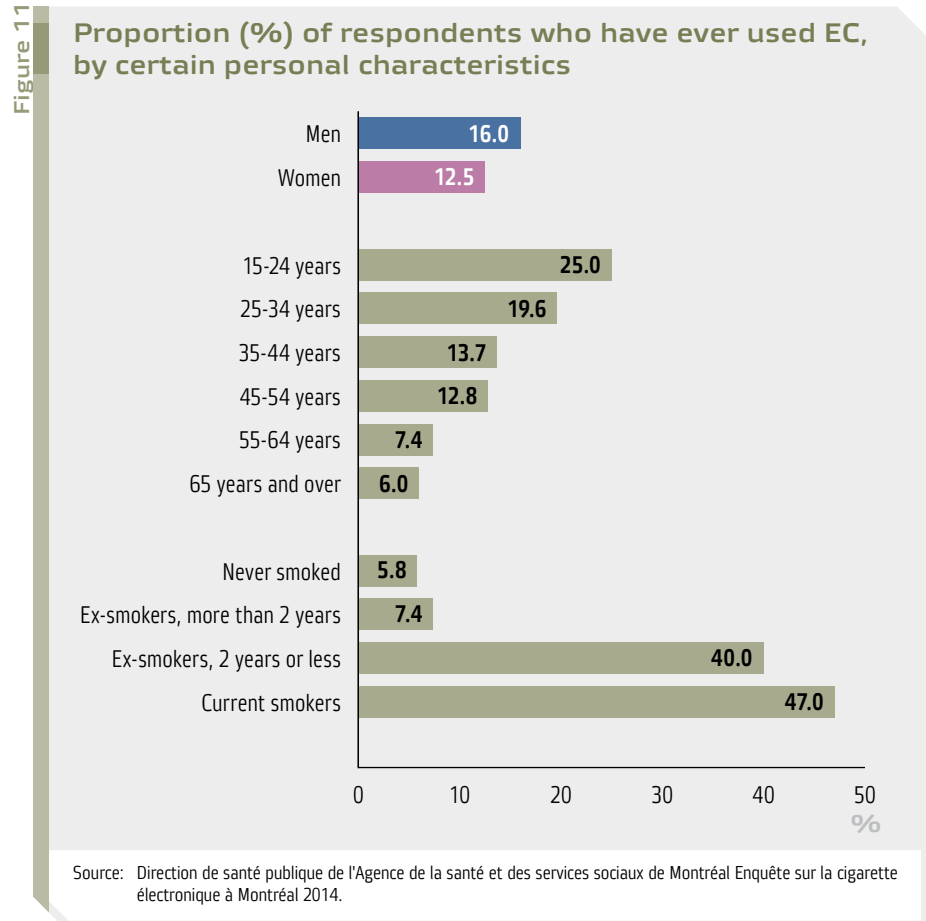
Montréal

In August 2014 the public health department conducted a telephone survey of 2501 people aged 15 and over. Findings revealed that almost 90% of respondents were familiar with e-cigarettes. For many of them, use of e-cigarettes was motivated by a desire to reduce tobacco consumption or a will to quit smoking, both of which are ways to improve their health.^[120] The characteristics of respondents who have tried e-cigarettes are presented in Figure 11.

Just under 15% of survey participants had used e-cigarettes: about 5% had used it in the past 30 days and slightly under 2% were using it daily. Those figures are significantly higher for current smokers. Indeed, 47% had used it at least once, 20.3% had done so in the past 30 days and 7.9% were using it every day. E-cigarette utilization is a behaviour that is seemingly associated with smoking. Among recent users, more than a third (69.6%) had also smoked conventional cigarettes.^[120]

Among lifetime non-smokers who had tried e-cigarettes, 6% had used it at least once, 1% in the past 30 days and 0% had used it every day.

Although this recent survey on e-cigarettes does not describe developments in e-cigarette use, it does show that daily use is not widespread.



Model initiatives

Québec's director of public health urges e-cigarette users not to vape in places listed in the *Tobacco Act*, and owners or operators of these places not to tolerate vaping on their premises. Increasingly, stakeholders in Montréal are taking initiatives to control e-cigarette use in places where smoking is prohibited and to inform the population that e-cigarettes can cause fires.

Health and education institutions prohibit e-cigarettes

In the past year, a number of institutions have included e-cigarettes in their tobacco policies or issued memorandums to that effect. For example, the Montréal Agency, CSSS Cavendish, Ahuntsic et Montréal-Nord, and de la Pointe-de-l'Île, the CHUM, the Montréal Heart Institute, Institut universitaire en santé mentale de Montréal, Centre jeunesse de Montréal – Institut universitaire and Université de Montréal have all taken a stand and banned the use of e-cigarettes in their institutions.

Public health and Montréal's fire department recommend vigilance

In November 2014, Montréal's public health department was notified of an incident involving an e-cigarette that occurred in the home of a person on oxygen therapy. The investigation showed that the use of e-cigarettes by and around people receiving oxygen therapy can be associated with a risk of fire and explosion. It is the first case of this kind in Canada.^[121-122]

Public health informed Montréal physicians that, when being used or charged, e-cigarettes may create a spark and start a fire. It recommends three safety measures for handling or using home or portable oxygen therapy equipment:

- 1) Not using e-cigarettes at the same time as oxygen therapy
- 2) Staying at least three metres away from anyone using an e-cigarette
- 3) When charging an e-cigarette, keeping the charger at least three metres away from the oxygen equipment^[123]

Public health and the Montréal fire department held a joint press conference on this matter.

Municipalities take a stand

Last September, the Montréal City Council asked the Government of Québec to include e-cigarettes in the *Tobacco Act*. It also enjoined Health Canada to determine the conditions under which e-cigarettes could be used. The City of Côte-Saint-Luc also passed a resolution asking the National Assembly to prohibit the use of e-cigarettes in public places.

Impact of e-cigarettes on tobacco control measures

Although not approved by Health Canada, nicotine e-cigarettes are nonetheless available on the market. At this time, there is a risk that e-cigarettes redefine the norm that smoking is harmful to health by encouraging non-smokers—especially young people—to initiate nicotine use with e-cigarettes before switching to conventional cigarettes. It is also possible that the use of flavours entices young people. A recent study indicates that electronic nicotine inhalers are marketed in 7,764 unique flavours.^[124-125]

The number of adolescents who try e-cigarettes is growing rapidly, but most of these young people already smoke. A pattern of dual use predominates among adults and results in a reduction in number of smoked cigarettes. In addition, fewer than 1% of people who have never smoked are starting to use e-cigarettes.^[126-131] In the United Kingdom, where e-cigarette use is increasingly popular, smoking prevalence continues to decrease gradually without a concurrent renormalization effect.^[132] Two cross-sectional studies conducted in Poland among students aged 15 to 19 showed that current use of e-cigarettes rose from 6% in 2010–2011 to 30% in 2013–2014; dual use increased from 4% to 22%; and use of conventional cigarettes grew from 24% to 38%.^[133]

Promoters of e-cigarettes claim that ENDS are relatively safe and that they can be used in places where smoking is prohibited. This message is likely to dissuade some smokers from trying to quit and from using effective cessation methods. Anti-smoking policies are designed to protect non-smokers from passive smoking, motivate smokers to quit and uphold the current social norm that

tobacco use is harmful to health. The possibility of using e-cigarettes in places where smoking is prohibited makes enforcing those policies more difficult and diminishes their impact.

However, e-cigarettes can have a positive effect on smokers who try to quit and succeed in doing so. There is the potential for a reduction in health risks for vapers who still use conventional cigarettes, but the health benefits are difficult to assess based on current knowledge.

In a recent position statement, WHO suggested that when designing a regulatory strategy for ENDS, governments should bear in mind the following general objectives:

- Impede ENDS promotion to and uptake by non-smokers, pregnant women and youth
- Minimize potential health risks to ENDS users and non-users
- Prohibit unproven health claims from being made about ENDS
- Protect existing tobacco-control efforts from the tobacco industry's commercial and other vested interests

WHO also recommends that electronic nicotine inhalers be regulated to

- minimize content and emissions of toxicants;
- ensure use of nicotine of pharmacological quality, when nicotine use is intended;
- standardize nicotine delivery at levels known to the consumers;
- minimize acute nicotine toxicity;
- impede product alteration for use with other drugs.^[93]

Shared commitments to control e-cigarettes

Although their sale has not been authorized in Canada, e-cigarettes, even nicotine e-cigarettes, are commercially available. Just over a year ago, the number of speciality shops selling e-cigarettes in Montréal was limited, but since then they have been growing in numbers and the products are more and more varied. Electronic cigarettes and waterpipes are increasingly being marketed as alternatives to tobacco. Both products are more frequently used in places where tobacco is banned: restaurants, bars and public transit.

To control the use of e-cigarettes, all partners can sign on to the following commitments:

- 35.** That Health Canada set maximum concentrations of nicotine and toxic products, including nitrosamines possibly found in EC, to ensure product quality and minimize associated risks.
- 36.** That e-cigarettes be marketed as a tobacco product in Canada.
- 37.** Recommend to the Québec government that it revise the *Tobacco Act* over the next six months to cover e-cigarettes and include the following provisions: prohibit sales to minors; ban all advertising, promotion and sponsorship, including ads that promote EC as smoking cessation or harm reduction tools; and ban flavoured tobacco. Recommend that the use of e-cigarettes be permitted in sites exempted by the *Tobacco Act*, such as residential and long-term care centres, mental health institutes and Centre de réadaptation en dépendance.

38. That EC be made available under therapeutic supervision to smokers who are unable to quit, before the product is approved for sale in Canada.
39. That EC not be authorized for use as pharmacological aids until they have been evaluated for their efficacy as smoking cessation devices and harm reduction tools.
40. That Montréal stakeholders—health and social services institutions, school boards, post-secondary education institutions, municipalities, City of Montréal, Société de transport, Board of Trade, and associations of hotel, restaurant and bar owners—immediately add e-cigarettes to their smoking policies.

8

Monitoring and Evaluation: Tracking Consumption and Policies

The World Health Organization considers that monitoring tobacco use and public policies is one of six key components required to reverse the tobacco epidemic.^[47] Monitoring informs stakeholders of the scope of the problem in their facilities, districts, cities and towns, and helps them allocate appropriate resources when they are lacking and where they will be most effective. Monitoring can also evaluate the success of policies and projects and provide guidance on how to adjust them to the needs of different groups and districts.

Montréal's public health department has made significant efforts^[134-136] to monitor regional^[134] and local^[135] tobacco use in adults and adolescents^[27], use of smoking cessation services and exposure to secondhand smoke. Recent data^[10] have been used to develop a more accurate portrait of tobacco-related social inequalities in health.

Public health has also tracked health institutions' current policies and practices regarding measures to control exposure to secondhand smoke and smoking cessation services, in particular those providing mental health, addiction and perinatal (pregnant women and their spouses) care. It has also identified tobacco retailers located close to schools in Montréal.^[44] The department's recent survey on e-cigarettes supplements existing data.^[120]

Public health has developed a tool that is available to all CSSS and that enables them to track all tobacco control activities carried out in their districts. It will be updated periodically to ensure administrators and partners are supported and to deliver a common vision of the issues. Public health's support to institutions' various projects also results in knowledge production and transfer among partners.

The public health department is committed to the following:

- 41.** Continue monitoring and evaluation activities linked to all aspects of tobacco control, such as prevention, protection, cessation, EC and policy, in order to properly document the outcomes of interventions for different groups and in various districts, as well as on reduction of social inequalities in health.

9

A Network of Stakeholders with Shared Commitments

As outlined in the present report, close collaborations between regional and local partners have given rise to a number of initiatives and projects since 2013. This collective effort had helped deliver several activities included in Montréal's 2012–2015 tobacco control plan.

A consultation and mobilization process was needed during the fall of 2014 to put together this report. There were meetings with the partners listed in the Table below to discuss the commitments that concern them. All groups expressed their adherence to those commitments. At the same time, a preliminary version of the report was sent to more than 150 people in the health and social services network, education, municipal and correctional settings, and to partners working for tobacco control. The consultation enhanced the contents of this report.

The progress made over the past year shows that innovation in this area is still possible, and underlines the importance of uniting our strengths to go further. It is imperative that mobilization of the Montréal sans tabac network continue: the health and well-being of all Montrealers is at stake. It is essential if we are to reduce social inequalities in health and smoking prevalence.

Partners must work together to enable the Montréal sans tabac network to meet its commitments and ensure that the city take its place among Canada's major cities, known for their enthusiasm and exemplary actions.

Table 2

Summary of Commitments – Montréal sans tabac network partners

No.	Categories	Commitments	Partners
Implementation of core conditions for tobacco control, from a social inequalities in health perspective			
1	Vision	Acknowledge that smoking is an aggravating factor of social inequalities in health.	All
2	Vision	Refocus tobacco control efforts on the most vulnerable groups.	All
3	Funding	Shore up and protect current funding and resources dedicated to tobacco control.	Direction de santé publique (DSP); ministère de la Santé et des Services sociaux (MSSS)
4	Funding	Set aside part of the tobacco control budget for actions that target the most vulnerable groups.	DSP

No.	Categories	Commitments	Partners
Prevention			
	Tobacco products	Recommend to the government that it revise the <i>Tobacco Act</i> :	
5	Flavours	<ul style="list-style-type: none"> Prohibit the marketing of flavoured tobacco products—including menthol and those smoked with waterpipes or hookahs, and flavoured e-cigarettes. 	DSP
6	Packaging	<ul style="list-style-type: none"> Impose plain packaging for all tobacco products sold in Québec. 	DSP
7	Hookahs (waterpipes)	<ul style="list-style-type: none"> Ban hookah bars and revoke the permits of bars exempted under the law. 	DSP
8	New products	<ul style="list-style-type: none"> Declare a moratorium on the sale of new tobacco products and related items to discourage the development of new products. 	DSP
9	Minimum price	<ul style="list-style-type: none"> Increase the minimum consumer price to at least \$20 for one or several tobacco products other than cigarettes. 	DSP
10	Price	Recommend to the government that it gradually increase the tax on tobacco products until it reaches the Canadian average, taking into account the price of cigarettes in neighbouring provinces and states.	DSP
11	Retail outlets	Recommend to the Ministère de la Santé et des Services sociaux du Québec that it put in place an effective system to monitor and oversee retail outlets, using reliable data.	DSP
12	Youth aged 11 to 24	Maintain efforts to prevent school dropout that target school retention and success.	School boards (SB); Health and social services institutions
13	Youth aged 11 to 24	Integrate tobacco control within addiction prevention programs in schools.	School boards (SB); Health and social services institutions
14	Youth aged 11 to 24	Urge technical and vocational schools to review their practices related to tobacco, particularly in the application of legislation on smoke-free school grounds.	SB
15	Youth aged 11 to 24	Increase the number of community projects that mobilize partners and urge them to work together on the most effective measures to reduce smoking prevalence among youth, especially in neighbourhoods where prevalence is high.	Établissements de santé et de services sociaux ; CS
16	Youth aged 11 to 24	Support young people's social engagement projects pertaining to tobacco control (e.g. Operation Say It Loud!, Youth Coalition Against Smoking), in collaboration with local stakeholders and partners, especially in neighbourhoods where smoking prevalence is high, in schools in disadvantaged areas, and in technical and vocational schools.	Conseil québécois sur le tabac et la santé (CQTS) ; DSP ; CS
Protection			
17	Motor vehicles	Recommend to the government that it revise the <i>Tobacco Act</i> to prohibit smoking in cars where there are children under 16.	DSP
18	Vulnerable children and adolescents	Recommend to the government that it revise the <i>Tobacco Act</i> to ban smoking inside and on the grounds of youth centre buildings, while systematically providing smoking cessation support.	DSP
19	Vulnerable children and adolescents	Offer completely smoke-free environments inside and on the grounds of Montréal's two youth centres, while systematically providing smoking cessation support adapted to young people's needs.	Youth centres
20	Health and social services institutions	Recommend to the government that it revise the <i>Tobacco Act</i> to ban smoking inside and on the grounds of health and social services institutions, while systematically providing smoking cessation support.	DSP

No.	Categories	Commitments	Partners
21	Health and social services institutions	Develop and implement a comprehensive, integrated anti-smoking policy to become totally smoke-free environments, both indoors and on facility grounds. The policy should contain measures to systematically identify patients who smoke and to support cessation; the latter measures can be adjusted to the needs of individuals living in those institutions.	All health and social services institutions
22	Youth aged 15 to 24	Provide smoke-free environments in all post-secondary institutions (vocational training centres, and Cegeps, colleges and universities, including student residences) as well as systematic smoking cessation services adapted to young people aged 15 to 24.	Post-secondary educational institutions
23	Terraces and patios	Recommend to the government that it revise the <i>Tobacco Act</i> to prohibit smoking on the terraces and patios of bars and restaurants.	DSP
24	Terraces and patios	Encourage municipalities to adopt regulations to restrict the use of tobacco on the terraces and patios of bars and restaurants.	DSP; Municipalities
25	Children's playgrounds, pools, beaches and public places not covered in the law.	Encourage municipalities to adopt regulations to restrict the use of tobacco in places not covered in the law, such as playgrounds, pools and wading areas, beaches and outdoor facilities during sport activities or special events.	DSP; Municipalities
26	Homes	Ensure that interventions and tools to reduce harm caused by exposure to secondhand smoke in people's homes are integrated into cessation services and across the continuum of mother-child services in neighbourhoods with high prevalence rates.	Health and social services institutions
Smoking cessation			
27	Funding	Review the financial framework for smoking cessation services according to prevalence, reduction of social inequalities in health and the new composition of Montréal's health network (as of April 2015).	DSP
28	Continuum of care and services	Systematically provide smoking cessation interventions in health and social services institutions at all points of the continuum of care and services (e.g. admission to hospital, during hospital stay, in out-patient services, upon discharge). Act as liaison with community services.	Health and social services institutions; Canadian Cancer Society; pharmacies
29	Continuum of care and services	Include systematic provision of cessation services in a policy for smoke-free institutions to safeguard sustainability.	Health and social services institutions
30	Continuum of care and services	Ensure that smoking cessation services and protection against secondhand smoke are integrated across the continuum of mother-child services.	Health and social services institutions – Perinatal services
31	Collective prescription	Encourage pharmacists to offer nicotine replacement therapy (NRT), especially in neighbourhoods where smoking prevalence is high and among clientele such as young adults aged 18 to 34 and the most vulnerable individuals.	Pharmacies
32	Collective prescription	Inform young adults (18 to 34) about the collective prescription, which allows for reimbursement of NRT.	Pharmacies
33	Vulnerable clientele	Recommend to the government that it revise the <i>Tobacco Act</i> to ban smoking inside and on the grounds of the two mental health institutes and Centre de réadaptation en dépendance, while systematically providing smoking cessation support.	DSP
34	Vulnerable clientele	Offer completely smoke-free environments inside and on the grounds of the two mental health institutes and Centre de réadaptation en dépendance, while systematically providing smoking cessation support adapted to the needs of these clientele.	Mental health institutes; Centre de réadaptation en dépendance de Montréal

No.	Categories	Commitments	Partners
E-cigarettes			
		Recommend to Health Canada	
35	E-cigarettes	<ul style="list-style-type: none"> That it set maximum concentrations of nicotine and toxic products, including nitrosamines possibly found in EC, to ensure product quality and minimize associated risks. 	DSP
36	E-cigarettes	<ul style="list-style-type: none"> That e-cigarettes be marketed as a tobacco product in Canada. 	DSP
37	E-cigarettes	Recommend to the Québec government that it revise the <i>Tobacco Act</i> over the next six months to cover e-cigarettes and include the following provisions: prohibit sales to minors; ban all advertising, promotion and sponsorship, including ads that promote EC as smoking cessation or harm reduction tools; and ban flavoured tobacco. Recommend that the use of e-cigarettes be permitted in sites exempted by the <i>Tobacco Act</i> , such as residential and long-term care centres, mental health institutes and Centre de réadaptation en dépendance.	DSP
38	E-cigarettes	That EC be made available under therapeutic supervision to smokers who are unable to quit, before the product is approved for sale in Canada.	DSP Health professionals
39	E-cigarettes	That EC not be authorized for use as pharmacological aids until they have been evaluated for their efficacy as smoking cessation devices and harm reduction tools.	Health professionals
40	E-cigarettes	Encourage stakeholders to immediately add e-cigarettes to their smoking policies.	School boards; Post-secondary educational institutions; Municipalities; City of Montréal: Health and social services institutions; Transit board; Board of Trade; Associations of hotel, restaurant and bar owners
Monitoring and evaluation			
41	Monitoring and evaluation	Continue monitoring and evaluation activities linked to all aspects of tobacco control, such as prevention, protection, cessation, EC and policy, in order to properly document the effects of interventions on different groups and in various districts, as well as on reduction of social inequalities in health.	DSP

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