

## TOOELE CITY CORPORATION

### ORDINANCE 2011-19

#### AN ORDINANCE OF THE TOOELE CITY COUNCIL AMENDING TOOELE CITY CODE §7-16-3 AND §7-16-6 REGARDING LAND USE REGULATIONS FOR TOBACCO SPECIALTY STORES.

WHEREAS, decades of medical research, in addition to government-sponsored tobacco litigation, have clearly established that the use of tobacco products accompanies *negative primary effects among adult and youth populations*, such as, addiction, disease, and death.<sup>1</sup> These effects are in addition to a drain on the public purse and the fact that some tobacco product advertizing is known to target children; and,

WHEREAS, the Tooele City Council and City Administration believe it to be at least reasonably debatable that the sale of tobacco products from retail establishments specializing in the sale of tobacco products ("Tobacco Specialty Stores") would be shown to be associated with *negative secondary effects*, such as, increased crime, increased juvenile delinquency, increased truancy, increased marketing of tobacco products to children, increased tobacco usage by children, increased vandalism/graffiti, increased use of illegal drugs, and increased marketing to and use by children of *mind-altering substances that are currently unregulated by the State of Utah (e.g., designer drugs, bath salts, spice, and incense containing certain chemical formulations constituting or resembling cannabinoids, amphetamines, and hallucinogens)*<sup>2</sup>; and,

WHEREAS, the article "The Effect of Tobacco Outlet Density and Proximity on Smoking Cessation," Vol. 101, No. 2, *American Journal of Public Health* (February 2011) (article attached as Exhibit B), sites the conclusions of recent research, and reaches its own complementary conclusions, regarding the effects of tobacco outlet density and proximity on smoking initiation and smoking cessation:

1. "the density of tobacco retail outlets around schools has been linked to adolescent smoking initiation and purchasing habits";
2. "the density of tobacco outlets [to and around] the home . . . has been associated with the number of cigarettes consumed per day among adult smokers";
3. "greater smoker sensitivity to point-of-sale advertising at tobacco outlets predicted a reduced likelihood of having quit smoking 18 months later"; and,
4. "close residential proximity (e.g., 500 meters) to a tobacco outlet [i]s associated with lower odds of maintaining smoking abstinence during a smoking quit attempt" (Exhibit B, at pp. 315, 319); and,

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<sup>1</sup> Reference, for example, the 33 U.S. Surgeon General Reports on the subject from 1964-2010, a listing of which is attached as Exhibit A. Also, see Exhibit B, at p. 315: ". . . smoking remains the leading cause of preventable death and disease among adults in the United States."

<sup>2</sup> See Exhibit D for information and materials on the history, properties, negative health effects, addictive nature, and pervasiveness of new designer drugs such as bath salts, incense, and spice.

WHEREAS, the article "Regulating Tobacco Retailers: Options for State and Local Governments" by the Tobacco Control Legal Consortium (2010) (article attached as Exhibit C), states that the 2009 federal Family Smoking Prevention and Tobacco Control Act "does not preempt or in any way lessen the ability of local governments to create tobacco-free zones around schools and playgrounds" by way of land use ordinances (Exhibit C, at 8); and,

WHEREAS, Utah Code §10-9a-501, *et seq.*, authorizes the enactment of municipal "land use [i.e., zoning] ordinances" like the present Ordinance, that constitute a portion of the City's regulations (hereinafter "Zoning") for land use and development, establishing order and standards under which land may be developed and used in Tooele City; and,

WHEREAS, Exhibit B (at 315, 319) and Exhibit C (at 1, 7-9) recommend local land use regulations that establish tobacco-free zones and/or minimum distances (e.g., 500 meters) between tobacco retail stores and schools, playgrounds, homes, and other public places<sup>3</sup>; and,

WHEREAS, it is commonly known among law enforcement officials that Tobacco Specialty Stores sell drug paraphernalia, such as, bowls and bongs (the possession of which is not currently illegal in Utah unless combined with evidence of the intent of the possessor to use the paraphernalia to consume illegal drugs<sup>4</sup>) and mind-altering substances that are currently unregulated by the State of Utah (see Exhibit D); and,

WHEREAS, based on the above, the City Council believes that, in furtherance of the legitimate governmental interest to reduce the negative primary and secondary effects caused by Tobacco Specialty Stores, Tobacco Specialty Stores should not be permitted in locations near schools, public parks, public recreational facilities, libraries, churches, and youth centers, in close proximity to each other, in close proximity to residential neighborhoods, or on Vine Street (a principal pedestrian route for Tooele High School and Tooele Junior High School students); and,

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<sup>3</sup> Research on tobacco outlet density and proximity is beginning to proliferate. In addition to the articles referenced in the Recitals to this Ordinance, other recent studies establish a link between tobacco outlet density and proximity with increased youth smoking, and suggest zoning and land use ordinances to regulate density and proximity to reduce negative primary and secondary effects. See, for example: Schneider et al., "Tobacco outlet density and demographics at the tract level of analysis in Iowa: implications for environmentally based prevention initiatives," Prev. Sci. (Dec. 2005); Hyland et al., "Demographics and tobacco outlet density," Am. J. Public Health (Nov. 2003); Novak et al., "Retail tobacco outlet density and youth smoking: a propensity modeling approach," Am. J. Public Health (Apr. 2006); Peterson et al., "Tobacco outlet density and demographics: analyzing the relationship with a spatial regression approach," Public Health (Jul. 2010); "UI researchers examine effect of race on smoking, tobacco outlet density," UI Health Care News (Dec. 2005); Lipperman-Kreda et al., "Local tobacco policy and tobacco outlet density: associations with youth smoking," J. Adolescent Health (Oct. 2011), copies or abstracts of which are incorporated into Exhibit C.

<sup>4</sup> Reference the definition of "drug paraphernalia" in U.C.A. §58-37A-3.

WHEREAS, the present Ordinance is limited to Tobacco Specialty Stores because of their concentration of tobacco, designer drug, and drug paraphernalia products; and,

WHEREAS, Tooele City has a legitimate governmental interest in eliminating, or at least reducing, the negative primary and secondary effects enumerated above and in the Exhibits attached hereto; and,

WHEREAS, the City Administration recommends the enactment of a Tobacco Specialty Store regulation within Chapter 7-16 of the City Code (see the proposed revisions attached as Exhibit E); and,

WHEREAS, at least one other Utah municipality has enacted similar regulations for Tobacco Specialty Stores<sup>5</sup>; and,

WHEREAS, the Planning Commission convened a duly-noticed public hearing on this Ordinance on December 14, 2011, and voted 6-1 to recommend approval of this Ordinance to the City Council (see the Planning Commission minutes attached as Exhibit F); and,

WHEREAS, the City Council convened a duly-noticed public hearing on this Ordinance on January 18, 2012:

NOW, THEREFORE, BE IT ORDAINED BY THE TOOELE CITY COUNCIL that Tooele Code §7-16-3 and §7-16-6 are hereby amended as shown in Exhibit E for the regulation of Tobacco Specialty Stores, and that the definitions in §7-16-6 be appropriately renumbered.

This Ordinance is necessary for the immediate preservation of the peace, health, safety, or welfare of Tooele City and shall become effective upon passage, without further publication, by authority of the Tooele City Charter, and shall have no retroactive effect upon existing licensed Tobacco Specialty Stores at their current licensed locations.

IN WITNESS WHEREOF, this Ordinance is passed by the Tooele City Council this 18<sup>th</sup> day of January, 2012.

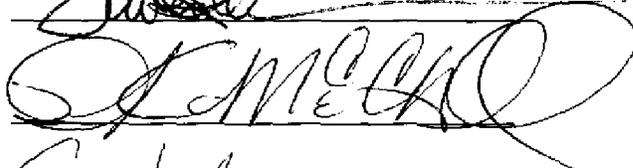
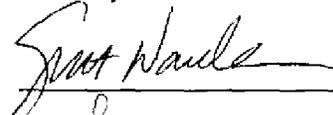
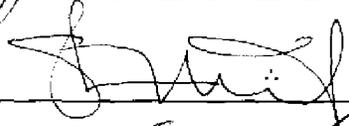
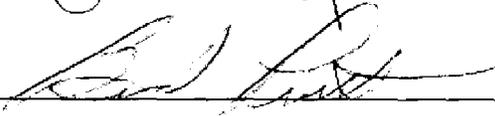
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<sup>5</sup> Reference Sandy City Ordinance 2010-03.

TOOELE CITY COUNCIL

(For)

(Against)

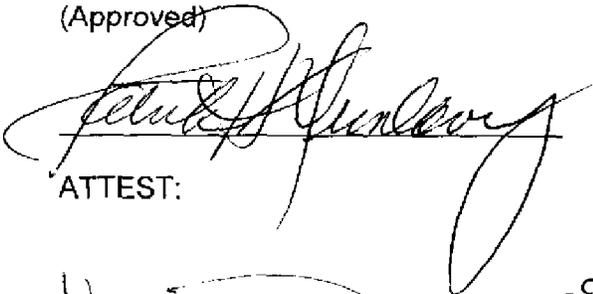
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ABSTAINING: \_\_\_\_\_

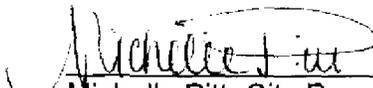
MAYOR OF TOOELE CITY

(Approved)

(Disapproved)

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ATTEST:

  
 Michelle Pitt, City Recorder



SEAL

Approved as to Form:

  
 Roger Baker, City Attorney

## Exhibit A

### Listing of U.S. Surgeon General Reports Concerning Tobacco

[Skip Navigation](#)



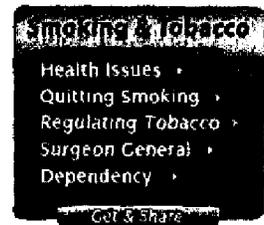
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## Reports of the Surgeon General, U.S. Public Health Service

The Surgeon General of the Public Health Service has focused the Nation's attention on important public health issues. Reports of the Surgeon General on the adverse health consequences of smoking triggered nationwide efforts to prevent tobacco use. Reports on nutrition, violence, and HIV/AIDS—to name but a few—have heightened America's awareness of important public health issues and generated major public health initiatives.

Smoking & Tobacco



2010

→ [How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease](#)

2007

→ [Children and Secondhand Smoke Exposure Excerpts from The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General](#)

2006

→ [The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General](#)

2004

→ [Bone Health and Osteoporosis: A Surgeon General's Report](#)

→ [The Health Consequences of Smoking: A Report of the Surgeon General](#)

2001

→ [Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General](#)

→ [Women and Smoking: A Report of the Surgeon General](#)

→ [Youth Violence: A Report of the Surgeon General](#)

2000

→ [Reducing Tobacco Use: A Report of the Surgeon General](#)

→ [Oral Health in America: A Report of the Surgeon General](#)

1999

→ [Mental Health: A Report of the Surgeon General](#)

1998

→ [Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General](#)

1996

→ [Physical Activity and Health: A Report of the Surgeon General](#)

1994

→ [Preventing Tobacco Use Among Young People: A Report of the Surgeon General](#)

→ [Surgeon General's Report for Kids about Smoking](#)

1992

→ [Surgeon General's Report to the American Public on HIV Infection and AIDS](#)

→ [Smoking and Health in the Americas: A Report of the Surgeon General](#)

1990

→ [The Health Benefits of Smoking Cessation: A Report of the Surgeon General](#)

1989

→ [Reducing the Health Consequences of Smoking - 25 Years of Progress: A Report of the Surgeon General](#)

→ [Reducing the Health Consequences of Smoking: 25 Years of Progress: A Report of the Surgeon General: 1989 Executive Summary](#)

1988

→ [The Surgeon General's Report on Nutrition and Health](#)

→ [Understanding AIDS: America Responds to AIDS](#) (brochure)

→ [The Health Consequences of Smoking - Nicotine Addiction: A Report of the Surgeon General](#)

→ [The Surgeon General's Letter on Child Sexual Abuse](#)

1987

→ [The Surgeon General's Report on Acquired Immune Deficiency](#)

*Children with Special Health Care Needs: Surgeon General's Report: Campaign '87*

**1986**

→ [Smoking and Health, A National Status Report: A Report to Congress](#)

→ [The Health Consequences of Involuntary Smoking: A Report of the Surgeon General](#)

[The Health Consequences of Using Smokeless Tobacco](#)

**1985**

→ [The Health Consequences of Smoking - Cancer and Chronic Lung Disease in the Workplace: A Report of the Surgeon General](#)

**1984**

→ [Summary of the Health Consequences of Smoking - Chronic Obstructive Lung Disease: A Report of the Surgeon General](#)

→ [The Health Consequences of Smoking - Chronic Obstructive Lung Disease: A Report of the Surgeon General](#)

**1983**

→ [The Health Consequences of Smoking - Cardiovascular Disease: A Report of the Surgeon General](#)

**1982**

→ [The Health Consequences of Smoking - Cancer: A Report of the Surgeon General](#)

**1981**

→ [The Health Consequences of Smoking - The Changing Cigarette: A Report of the Surgeon General](#)

**1980**

→ [The Health Consequences of Smoking for Women: A Report of the Surgeon General](#)

**1979**

[Healthy People - The Surgeon General's Report on Health Promotion and Disease Prevention](#)

→ [Smoking and Health: A Report of the Surgeon General](#)

→ [The Health Consequences of Smoking, 1977-1978](#)

**1976**

→ [The Health Consequences of Smoking: A Reference Edition](#)

**1975**

→ [The Health Consequences of Smoking 1975](#)

**1974**

→ [The Health Consequences of Smoking 1974](#)

**1973**

→ [The Health Consequences of Smoking 1973](#)

**1972**

→ [The Health Consequences of Smoking 1972](#)

[Television and Growing Up: The Impact of Televised Violence, Report to the Surgeon General](#)

**1971**

→ [The Health Consequences of Smoking: A Report of the Surgeon General, 1971](#)

**1969**

→ [The Health Consequences of Smoking: 1969 Supplement to the 1967 Public Health Service Review](#)

**1968**

→ [The Health Consequences of Smoking: 1968 Supplement to the 1967 Public Health Service Review](#)

**1967**

→ [The Health Consequences of Smoking: A Public Health Service Review](#)

[Securing Health in Our Urban Future: A Report to the Surgeon General](#)

[Report on Regional Medical Programs to the President and the Congress](#)

[Kidney Disease Program Analysis: A Report to the Surgeon General](#)

**1966**

[Protecting and Improving Health through the Radiological Sciences: A Report of the Surgeon General prepared by the National Advisory Committee on Radiation](#)

**1964**

→ [Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service](#)

[top of page](#)

## Exhibit B

“The Effect of Tobacco Outlet Density and Proximity  
on Smoking Cessation”

# The Effect of Tobacco Outlet Density and Proximity on Smoking Cessation

Lorraine R. Reitzel, PhD, Ellen K. Cromley, PhD, Yisheng Li, PhD, Yumei Cao, MS, Richard Dela Mater, BS, Carlos A. Mazas, PhD, Ludmila Cofta-Woerpel, PhD, Paul M. Cinciripini, PhD, and David W. Wetter, PhD

Although the prevalence of smoking has decreased substantially over the past few decades, smoking remains the leading cause of preventable death and disability among adults in the United States.<sup>1</sup> A key public health strategy to reduce the deleterious health effects of tobacco use is to decrease the prevalence of smoking by increasing smoking cessation rates.<sup>2</sup> Previous public health and policy approaches to affect smoking prevalence have included restrictions on tobacco advertising, counter-advertising campaigns, bans on smoking in public places, increases in federal and state cigarette excise taxes, and increases in the availability of treatment programs. The effectiveness of these approaches in increasing smoking cessation rates has been supported by the literature.<sup>3–5</sup> However, additional tobacco control strategies are needed to achieve national public health goals.<sup>2</sup>

One potential area of expansion for tobacco control policies is the regulation of tobacco retail outlets. Regulation strategies are designed to facilitate behavior change by altering structural aspects of the community context in which problematic behavior occurs.<sup>6</sup> An analogous area in which regulation strategies have been applied is alcohol beverage retail outlets. In this case, regulation strategies have included the implementation of zoning restrictions to reduce the density of alcohol outlets and the proximity of alcohol outlets to residential areas. It was hypothesized that such regulations would affect problematic alcohol use at a community level by decreasing residents' access to alcohol, reducing exposure to on-site product marketing, and changing social norms about alcohol use.<sup>7</sup> Ultimately, research supported the success of these policies in reducing problematic alcohol use and alcohol-related injury, crimes, and violence.<sup>7–9</sup> In contrast to the alcohol arena, little attention has been paid thus far to the potential utility of tobacco outlet

*Objectives.* We examined the influence of tobacco outlet density and residential proximity to tobacco outlets on continuous smoking abstinence 6 months after a quit attempt.

*Methods.* We used continuation ratio logit models to examine the relationships of tobacco outlet density and tobacco outlet proximity with biochemically verified continuous abstinence across weeks 1, 2, 4, and 26 after quitting among 414 adult smokers from Houston, Texas (33% non-Latino White, 34% non-Latino Black, and 33% Latino). Analyses controlled for age, race/ethnicity, partner status, education, gender, employment status, prequit smoking rate, and the number of years smoked.

*Results.* Residential proximity to tobacco outlets, but not tobacco outlet density, provided unique information in the prediction of long-term, continuous abstinence from smoking during a specific quit attempt. Participants residing less than 250 meters ( $P=.01$ ) or less than 500 meters ( $P=.04$ ) from the closest tobacco outlet were less likely to be abstinent than were those living 250 meters or farther or 500 meters or farther, respectively, from outlets.

*Conclusions.* Because residential proximity to tobacco outlets influences smoking cessation, zoning restrictions to limit tobacco sales in residential areas may complement existing efforts to reduce tobacco use. (*Am J Public Health*. 2011;101:315–320. doi:10.2105/AJPH.2010.191676)

regulation strategies as a supplement to existing tobacco control policies.

The Family Smoking Prevention and Tobacco Control Act, signed into law in June 2009, greatly expands the federal government's ability to enact new public health policies related to tobacco sales in the United States. If one considers the success of alcohol outlet regulation strategies on curbing alcohol use, an increased understanding of the effects of tobacco retail outlets on smoking behaviors may provide direction to emerging tobacco control policies. Thus far, studies largely support associations between tobacco retail outlets and smoking behaviors. For example, the density of tobacco retail outlets around schools has been linked to adolescent smoking initiation<sup>10</sup> and purchasing habits.<sup>11</sup> Similarly, the density of tobacco outlets around the home, as well as the proximity of tobacco outlets to the home, has been associated with the number of cigarettes consumed per day among adult smokers.<sup>12</sup> In another study, greater smoker sensitivity to point-of-sale advertising at

tobacco outlets predicted a reduced likelihood of having quit smoking 18 months later.<sup>13</sup> However, no previous studies have directly examined the effects of tobacco outlet density and proximity on smoking cessation during a specific quit attempt.

The purpose of our study was to examine the effect of tobacco retail outlet density and proximity on smoking cessation among a racially/ethnically diverse group of smokers undergoing a specific quit attempt. We had two hypotheses. The first was that greater density of tobacco outlets around participants' homes would be associated with lower odds of cessation. The second was that close residential proximity to a tobacco retail outlet would be associated with lower odds of cessation. All analyses controlled for participant demographics and tobacco-related variables. To our knowledge, this is the first study to examine the effects of tobacco retail outlets on a smoking quit attempt using a prospective, longitudinal design and biochemically verified smoking abstinence.

## METHODS

We collected data as part of a longitudinal cohort study, conducted in the Houston, Texas, metropolitan area, designed to examine social disparities in smoking cessation.<sup>14</sup> Participants were recruited via local print and radio advertisements and were required to be aged at least 21 years, to have smoked at least 5 cigarettes per day for the past year, to have a home address and functioning telephone number, to demonstrate proficiency in English at a 6th grade level or higher, and to be motivated to quit smoking in the next 30 days. Potential participants were excluded if the nicotine patch was contraindicated, if they reported use of tobacco products other than cigarettes, or if they reported participation in a smoking cessation program within the past 90 days. The original cohort sample consisted of 424 adult smokers who were enrolled from April 2005 through April 2007. All participants received standard smoking cessation treatment as part of the larger cohort study, which consisted of 6 weeks of nicotine patch therapy, 6 brief smoking cessation counseling sessions based on the *Treating Tobacco Use and Dependence Clinical Practice Guideline*,<sup>15</sup> and self-help materials.

### Measures

**Participant demographics and tobacco-related variables.** We collected demographic and tobacco-related variables at baseline and included these as covariates in the analysis. These variables included age, race/ethnicity, partner status, education, gender, employment status, prequit smoking rate, and the number of years smoked. Although we collected income data, we did not use income as a covariate in the current study because 47 participants declined to provide this information.

**Participant smoking abstinence outcomes.** Continuous abstinence from smoking through 26 weeks after quitting was the outcome of interest. We defined continuous abstinence as a self-report of no cigarettes smoked since the quit date (not even a puff) and an expired carbon monoxide level of 10 ppm or less. Smoking status was assessed at weeks 1, 2, 4, and 26 after quitting. Because the focus was on continuous abstinence, relapse at any postquit week resulted in classification as relapsed from that point forward. An intention-to-treat

procedure was followed, whereby participants with missing abstinence outcomes were considered not abstinent (i.e., relapsed). The percentage of participants with missing smoking status at these timepoints ranged from 15% (week 26) to 18% (week 1).

**Participant residential locations.** We geocoded participants' residential addresses so that the density of tobacco outlets and the distance to closest tobacco outlet could be measured. We obtained participants' (N=424) residential addresses from baseline data. Using Environmental Systems Research Institute's ArcGIS software version 9.3.1 (ESRI, Redlands CA), we created an address locator to set parameters for batch geocoding of the participant addresses using address points from Centerpoint Energy's Houston metropolitan area address database. The majority of the participants' residential addresses were successfully geocoded using the address locator, but about one quarter required manual geocoding. Only 10 participants from the original cohort could not be geocoded (6 participants gave a PO box as their address and 4 participants gave addresses that could not be found). Therefore, the current study included 414 adult smokers from the original cohort.

**Tobacco outlet locations.** We obtained tobacco outlet addresses from the Texas Comptroller of Public Accounts, who keeps a record of all the facilities licensed to sell tobacco in Houston and surrounding areas. We used tobacco outlet records from 2006 (the midpoint of our enrollment) in the current study. We geocoded tobacco outlet locations (N=7183) using the same procedures used for geocoding participant residential locations. The majority of tobacco outlets were geocoded with the address locator, but 7% required manual geocoding.

**Tobacco outlet density.** The measurement of tobacco outlet density was a 3-step process. First, 3 road network buffers were created around each participant's home by using the New Service Area tool in the ArcGIS Network Analyst based on travel distances of 500 meters, 1 kilometer, and 3 kilometers, respectively. These distances are commonly used in accessibility studies.<sup>16-18</sup> Defining a neighborhood based on distance traveled along the street network is preferable to defining a neighborhood with a circular buffer based on straight-line distance from the home, as distance traveled

along the street network more closely approximates the actual travel effort required to access goods and services.<sup>16</sup> Second, the geocoded tobacco outlets were overlaid with the road network neighborhood buffer areas, and a count of outlets within each buffer was obtained using the Spatial Join tool within ArcGIS, which joins the polygons (buffers) to points (outlets). Finally, the count of outlets was divided by the actual geographic coverage area of each buffer area to obtain the tobacco outlet density variables. This procedure resulted in 3 predictor variables that were unique to each participant: the density of tobacco outlets within 500 meters, 1 kilometer, and 3 kilometers of the participant's residence.

**Tobacco outlet proximity.** To measure the proximity of each participant's home to the closest tobacco outlet we used the New Closest Facility tool in ArcGIS Network Analyst, which calculates the shortest travel distance in meters along the street network from the home to the closest outlet. We dichotomized tobacco outlet proximity based on the 25th and 50th percentile values, respectively, for analyses. This procedure resulted in 2 binary predictor variables: the closest tobacco outlet was less than 250 meters from the home (yes or no) and the closest tobacco outlet was less than 500 meters from the home (yes or no).

### Data Analysis

Because continuous abstinence was the outcome of interest, we used continuation ratio (CR) logit models (PROC GENMOD<sup>19-21</sup>) to examine the influence of tobacco outlets on abstinence across weeks 1, 2, 4, and 26 after quitting. Continuation ratio logit models are appropriate when ordered categories (e.g., relapsed at week 1, abstinent at week 1 but relapsed at week 2, abstinent at week 2 but relapsed at week 4, abstinent at week 4 but relapsed at week 26, and abstinent through week 26) represent a progression through stages.<sup>19-21</sup> The CR logit models operate by modeling the conditional probability of being abstinent at the current assessment point given that a participant has been abstinent through the most recent assessment point. Because all data in this study were compiled at the individual level, error related to the modifiable areal unit problem was minimized and no statistical adjustment for nesting

structures was necessary. We performed all analyses with SAS version 9.1 (SAS Institute, Cary, NC).

First, we ran respective CR logit models to assess the relationship of tobacco outlet density within (1) 500 meters, (2) 1 kilometer, and (3) 3 kilometers of the participant's residence with continuous abstinence. Next, we ran respective CR logit models to assess the relationship of tobacco outlet proximity within: (1) 250 meters and (2) 500 meters of the participant's residence with continuous abstinence. We adjusted all analyses for time and age, race/ethnicity, partner status, education, gender, employment status, prequit smoking rate, and the number of years smoked to isolate the effect of tobacco outlet density and proximity on abstinence.

## RESULTS

Participants were 414 racially/ethnically diverse adult smokers (approximately 33% were non-Latino White, 34% non-Latino Black, and 33% Latino. Forty-seven percent of participants were male. As a group, they were primarily low income (37% of responders reported less than \$20,000 yearly household income). See Table 1 for participant characteristics. Participants were spread throughout the Houston metropolitan area, with at least 1 participant in each of 337 Census block group areas and 280 Census tracts. Figure 1 shows the mean center of participants' residences (average longitude, average latitude), which was slightly east of downtown, and indicates the number of participants in each quadrant of a grid superimposed on this origin. Of the 7183 tobacco outlets geocoded, 6614 outlets were located within the 4-quadrant grid and were relevant to the generation of the outlet density and proximity variables. Figure 1 shows the number of tobacco outlets in each quadrant. On average, there were 1.5 ( $\pm 2.1$ ) tobacco outlets within the 500-meter buffers (range=0–14), 6.6 ( $\pm 6.6$ ) outlets within the 1-kilometer buffers (range=0–38), and 50.5 ( $\pm 38.5$ ) outlets within the 3-kilometer buffers (range=0–244) around participants' residences. The proximity of the closest cigarette outlet to participants' homes ranged from 16 meters to 5315 meters, with a median distance of 492 meters and an average distance of

**TABLE 1—Participant Characteristics (n=414): Adult Smokers in Houston, TX, April 2005–April 2007**

Demographics and Tobacco-Related Variables	% or Mean (SD)
Age, y	41.4 (11.2)
Race/ethnicity, %	
Non-Latino White	32.9
Non-Latino Black	34.3
Latino	32.9
Gender, % male	47.0
Married or living with partner, %	34.8
Annual household income <\$20,000, %	37.0
Education, %	
<High school/GED	13.8
High school/GED	28.3
Some college	30.4
College degree	26.6
Not employed, %	41.3
Prequit smoking rate <sup>a</sup>	21.2 (10.3)
No. of y smoked	21.6 (11.1)

Note. GED = general equivalency diploma.

<sup>a</sup>The prequit smoking rate was defined as the number of cigarettes per day smoked before the participant began their latest quit attempt.

654.7 meters ( $\pm 606.8$ ). Participants living in areas with higher tobacco outlet densities were more likely to be unemployed and without a partner than were those living in areas with lower tobacco outlet densities (both  $P \leq .05$ ). Participants living in closer proximity to a tobacco outlet (<250 m) were more likely to be without a partner and to have smoked for more years than were those living farther from the closest outlet ( $\geq 250$  m; both  $P < .001$ ).

### Tobacco Outlet Density

The density of tobacco outlets around participants' residences was not a significant predictor of smoking abstinence in any analysis (for 500 m:  $b = -0.03$ ;  $SE = 0.02$ ;  $\chi^2 [1] = 2.40$ ;  $P = .12$ ; for 1 km:  $b = -0.01$ ;  $SE = 0.02$ ;  $\chi^2 [1] = 0.28$ ;  $P = .6$ ; for 3 km:  $b = -0.03$ ;  $SE = 0.04$ ;  $\chi^2 [1] = 0.49$ ;  $P = .48$ ).

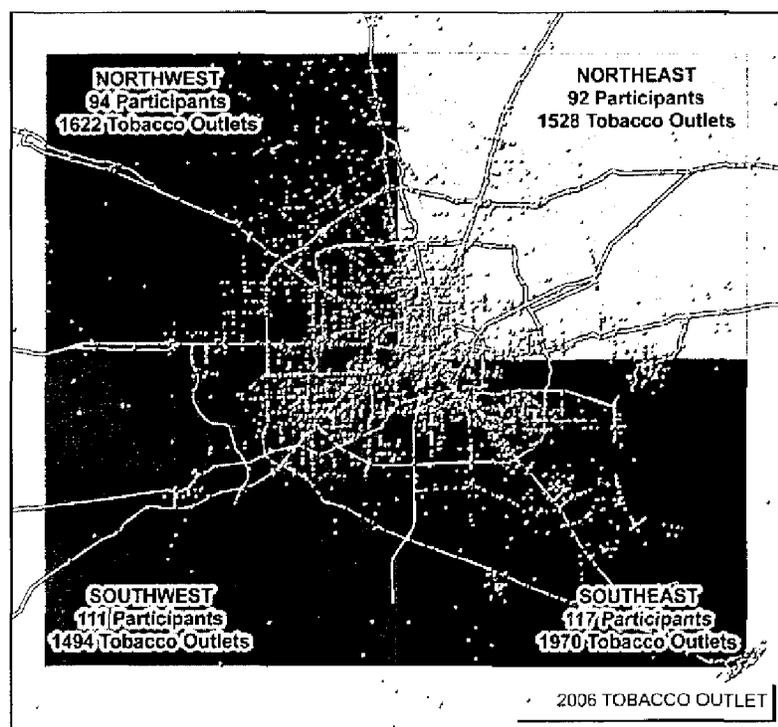
### Tobacco Outlet Proximity

The proximity of residence to the closest tobacco outlet was a significant predictor of smoking abstinence in both analyses (for <250 m vs  $\geq 250$  m:  $b = -0.62$ ;  $SE = 0.25$ ;  $\chi^2 [1] = 6.46$ ; odds ratio [OR] = 0.54; 95% confidence interval [CI] = 0.33, 0.87;  $P = .01$ ; for <500 m vs  $\geq 500$  m:  $b = -0.39$ ;  $SE = 0.20$ ;

$\chi^2 [1] = 4.04$ ; OR = 0.68; 95% CI = 0.46, 0.99;  $P = .04$ ). The tobacco outlet proximity by time interaction was not significant in either analysis, indicating that the effect of outlet proximity on smoking abstinence did not vary across postquit weeks (for <250 m vs  $\geq 250$  m:  $\chi^2 [3] = 2.70$ ;  $P = .44$ ; for <500 m vs  $\geq 500$  m:  $\chi^2 [3] = 0.21$ ;  $P = .98$ ).

## DISCUSSION

To our knowledge, this is the first longitudinal study assessing the influence of tobacco retail outlet density and proximity on smoking abstinence during a specific quit attempt. Results indicated that residential proximity to the closest tobacco retail outlet predicted smoking cessation among racially/ethnically diverse, adult daily smokers. In this sample, participants living within a short walking distance (<500 m) of the closest tobacco retail outlet were less likely to maintain continuous abstinence from smoking 6 months following a quit attempt than were those who lived farther from the closest tobacco retail outlet. The strength of this relationship increased with decreased distance (i.e., <250 m) to the closest outlet. These results add to a growing body of literature



Note. Census tracts and major highways displayed.

FIGURE 1—Tobacco outlet locations in the Houston, TX, metropolitan area, 2006.

supporting the influence of tobacco outlets on smoking behavior<sup>10–12</sup> and extend that literature to smoking cessation.

This study had a number of strengths, including the longitudinal design, biochemical verification of smoking status, and adjustment for a number of covariates known to affect smoking cessation (e.g., age, race/ethnicity, partner status, education, gender, employment status, prequit smoking rate, and the number of years smoked). However, other potential confounders might exist that were not accounted for in our analyses. For example, income was not among the covariates in the models because these data were not provided by 11% of participants. Posthoc analyses conducted among those providing income data, however, indicated that the inclusion of income as an additional covariate did not change the pattern of results. It is also possible that the relationship between tobacco outlet proximity and smoking cessation might be attenuated when one is

adjusting for relevant neighborhood-level characteristics. For example, a previous study found that smokers living in more economically deprived areas were less likely to quit smoking over a 6-year period than were those residing in areas with greater economic resources.<sup>22</sup> Posthoc analyses of our data indicated that further adjusting models for neighborhood (i.e., Census tract) unemployment, poverty, and low levels of education, respectively, did not alter our pattern of results.

Close residential proximity to tobacco outlets could reduce the likelihood of maintaining smoking abstinence during a quit attempt in several ways. For example, a large body of evidence supports that smoking cues can provoke subjective and autonomic responses among smokers, including increases in self-reported cravings to smoke.<sup>23</sup> It may be that a tobacco outlet close to the home represents a cue for smoking that is difficult to avoid when one is walking or driving in the neighborhood,

which might increase the risk of relapse. Previous research also supports that the ready availability of cigarettes is a risk factor for relapse.<sup>24</sup> Thus, the close proximity of a tobacco retail outlet may increase the likelihood of relapse by offering easy access to cigarettes when an urge to smoke strikes. Another study found that greater smoker sensitivity to point-of-sale advertising at tobacco outlets predicted a reduced likelihood of having quit smoking 18 months later.<sup>13</sup> Thus, it may be that the closer proximity of retail outlets results in greater exposure to point-of-sale tobacco advertising, which may derail a quit attempt. These ideas are speculative, however, and require additional research.

The passage of the Family Smoking Prevention and Tobacco Control Act represents an unprecedented legislative opportunity to affect smoking prevalence and smoking cessation rates in the United States. Results suggest that if tobacco outlets were less accessible to quitting smokers (i.e., located farther from their homes) the likelihood of maintaining abstinence during a quit attempt might increase. Therefore, exerting greater control over the locations of tobacco outlets through zoning regulations may reduce access to cigarettes, and ultimately decrease smoking prevalence.<sup>25</sup> Similar regulation policies have been applied to alcohol beverage retail outlets and have been successful in reducing problematic alcohol use and alcohol-related injury, crimes, and violence.<sup>7–9</sup> Zoning restrictions on tobacco licensing have been implemented around school zones in some areas<sup>10</sup> to prevent adolescent smoking, and such restrictions might also be helpful in promoting cessation among established adult smokers undergoing a quit attempt.

In this study, the density of tobacco retail outlets around the home was not associated with smoking abstinence during a quit attempt. Previous studies have established an association between tobacco outlet density and smoking rate among adult smokers,<sup>12</sup> smoking initiation among adolescents,<sup>10</sup> and cigarette purchasing behavior among underage smokers.<sup>11</sup> These, and other studies on tobacco outlet density,<sup>26–28</sup> have engendered recommendations to limit the availability of tobacco retail sale licenses within prescribed areas or require a certain distance between retail outlets to better restrict the sale of tobacco.<sup>29</sup> Results of this study, however, indicate that the presence of even

a single tobacco outlet in close proximity to the home was enough to affect smoking abstinence during a quit attempt. This may be because only a single retail outlet is needed to purchase cigarettes, and the closer that cigarette outlet is to home, the lower the cost in effort (time and distance traveled) expended to obtain the product. It may also be that having to travel farther to obtain cigarettes may result in the natural dissipation of cravings, or may allow participants greater opportunity to employ other strategies to cope with the urge to smoke. These suppositions require more research. Although the density of tobacco outlets did not affect smoking cessation in this sample, results might be sample- or area-specific and should be replicated in future research. Moreover, the absence of significant effects in this study does not preclude the importance of tobacco outlet density on smoking initiation<sup>10</sup> or other smoking behaviors.<sup>12</sup>

### Limitations

Participants in this study were self-selected, treatment-seeking smokers who may differ from smokers who attempt to quit without treatment in important ways, and the influence of tobacco outlets on cessation among the latter group remains unknown. This study did not assess car ownership, the density or proximity of tobacco outlets around participants' workplaces, their usual travel routes, or proportion of time spent in the neighborhood to determine the effect of these factors on smoking cessation. Future studies might explore these areas.

Another limitation includes the use of tobacco outlet data from a single point in time (i.e., 2006), despite a rolling enrollment period for participants that spanned 2005 through 2007. However, although opening or closing of tobacco outlets may have occurred before or after we obtained tobacco licensing data, it is unlikely that substantial changes would have taken place if one considers the absence of major external economic factors during this time span (e.g., a local or national economic crisis). Also, because analyses were conducted in 2009, tobacco outlet locations in 2006 could not be confirmed by direct observation. Instead, we relied on the accuracy of licensing data provided by the comptroller. Results may not generalize to other metropolitan areas in the United States, and studies like this should be replicated in other cities. More research is

needed to assess relationships between tobacco retail outlets and smoking cessation in rural areas, which may differ from metropolitan areas in important ways. Finally, although analyses adjusted for several potential confounders, the presence of unknown and unmeasured confounders might have influenced these results.

### Conclusions

Results indicated that close residential proximity to a tobacco outlet was associated with lower odds of maintaining smoking abstinence during a smoking quit attempt, even after controlling for participant age, race/ethnicity, partner status, education, gender, employment status, proquit smoking rate, and the number of years smoked. Because residential proximity to tobacco outlets affects smoking cessation, results suggest that zoning laws restricting the licensing of tobacco retail outlets around residential areas might be an important complement to existing policy efforts to reduce tobacco use. ■

### About the Authors

At the time of this study, Lorraine R. Reitzel, Yumei Cao, Richard Dela Mater, Carlos A. Mazas, and David W. Wetter were with the Department of Health Disparities Research; Yisheng Li was with the Department of Biostatistics; and Ludmila Cofta-Woerpel and Paul M. Cinciripini were with the Department of Behavioral Science, The University of Texas MD Anderson Cancer Center, Houston. Ellen K. Cronley was with the Institute for Community Research, Hartford, CT.

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### Contributors

L.R. Reitzel, E.K. Cronley, and D.W. Wetter conceptualized the research question and wrote the article. E.K. Cronley also provided senior guidance over the ArcGIS analyses and contributed to their interpretation, reviewed and edited article drafts, and is a mentor on the Centers for Disease Control and Prevention grant supporting L.R. Reitzel. Y. Li and Y. Cao conducted the statistical data analysis, interpreted results, and reviewed the data analysis and results sections. R. Dela Mater conducted the geocoding and all ArcGIS analyses, and contributed to the authorship of the Methods section. C.A. Mazas, L. Cofta-Woerpel, and P.M. Cinciripini helped with the conceptualization of the overall cohort project and methodology, and reviewed and edited article drafts. P.M. Cinciripini also is a coinvestigator on the National Institute of Drug Abuse (NIDA) supporting

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### Human Participant Protection

The University of Texas MD Anderson Cancer Center institutional review board approved this study.

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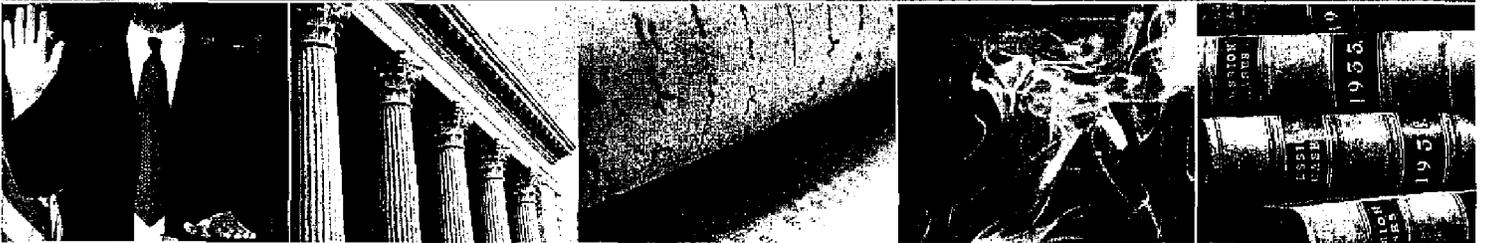
## Exhibit C

**“Regulating Tobacco Retailers:  
Options for State and Local Governments”**

# Regulating Tobacco Retailers: Options for State and Local Governments



Tobacco Control  
Legal Consortium



*Law. Health. Justice.*

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# Regulating Tobacco Retailers: Options for State and Local Governments

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On June 22, 2009, President Barack Obama signed into law the Family Smoking Prevention and Tobacco Control Act, giving the U.S. Food and Drug Administration (FDA) comprehensive authority to regulate the manufacturing, marketing, and sale of tobacco products. The Act represents the most sweeping action taken to date to reduce what remains the leading preventable cause of death in the United States.

In addition to granting the FDA power to establish tobacco product standards, the new law gives the agency wide-ranging authority to regulate tobacco product marketing and advertising. The Act leaves state and local governments free to restrict the sale, distribution and possession of tobacco products. State and local governments are considering appropriate measures they can take to regulate the retail sale of tobacco products. The Tobacco Control Legal Consortium, a collaborative network of legal centers, has prepared this summary of guidelines and drafting tips to help governments identify strategies for regulating tobacco retailers and potential ways these strategies might be limited by federal law.

## Introduction

Tobacco products are sold at nearly every gas station, convenience store, grocery store or pharmacy in the United States. The prevalence of these retailers and their placement of tobacco products at every turn exacerbates the health crisis brought on by tobacco use in this country, with tobacco use continuing to be the leading preventable cause of death in the United States.<sup>1</sup> When people approach or enter tobacco retail establishments, they invariably encounter a wide array of vivid and compelling tobacco advertisements designed to persuade them to purchase these products.<sup>2</sup>

While anti-tobacco education and legislation have contributed to a decline in smoking in recent years, more can be done to reduce the impact tobacco products have on public health. This publication looks at reducing tobacco use by regulating the retail sale of tobacco products. The Family Smoking Prevention and Tobacco Control Act (“the 2009 FDA law”) provides state and local governments with the freedom to engage in a wide range of tobacco control policy options.<sup>3</sup> At the same time, state and local governments need to be aware of federal restrictions that might apply to measures they take to regulate tobacco retailers.

This publication examines three of the many legally and politically viable strategies that state and local governments might consider using to regulate the retail sale of tobacco products: (1) limiting the sale of tobacco products to face-to-face transactions only;

(2) requiring retailers to keep tobacco products out of sight from customers; and (3) reducing or eliminating the number of tobacco retailers within 1,000 feet of schools and playgrounds. By understanding the way courts might view these three regulatory strategies, state and local governments will be better prepared to draft laws that stand a good chance of surviving legal challenges.

## Barriers to Public Health Laws

As we explore these regulatory approaches, it is important to keep in mind a few barriers state and local governments will want to consider when drafting new public health laws.

### Lack of State and Local Public Health Authority

Opponents to public health laws often claim that state and local governments lack the legal authority to pass such legislation. This claim is almost always rejected by the courts, which recognize that state and local governments have broad legal authority to pass laws to protect the public’s health.

Historically, public health protection resides within the stewardship of states.<sup>4</sup> Courts recognize that states have the authority to regulate conditions related to the *general health and welfare of their community*—often referred to as their “police power.”<sup>5</sup> Most states, in turn, delegate public health authority to lower levels of government through a statute<sup>6</sup> or a Home Rule

Amendment to the state constitution.<sup>7</sup> The scope of these grants of authority vary by state.<sup>8</sup>

**Drafting Tips:** When drafting a tobacco control law, consider referencing the authority under which the governmental body is operating. A formal citation to the granting law may assist in defending the law against allegations that the government lacks the authority to pass the law.

### Preemption

The doctrine of federal preemption, derived from Article VI, Section 2 of the U.S. Constitution (known as the Supremacy Clause), essentially means that a hierarchy of laws exists where, in certain circumstances, federal law trumps (or preempts) state law. Similarly, in some circumstances, state law trumps (preempts) local law. For example, a federal law might expressly state that it is preemptive, thereby prohibiting state and local governments from regulating the same area of the law. Absent express preemption language in the law, preemption can also exist. In this scenario, if both federal and state laws exist in the same area of the law and if those laws are in conflict, the federal law preempts the state law.<sup>9</sup> The difficulty is knowing exactly when two or more laws conflict.

To help determine whether a conflict exists and preemption can occur, courts follow a few basic rules. First, they rely largely on a plain reading of the laws.<sup>10</sup> If a federal statute states that it “does not preempt state or local law,” courts will respect that limitation on the preemptive scope of the federal law. Second, courts generally interpret laws in a manner designed to read them in concert as opposed to finding a conflict.<sup>11</sup> However, if the federal law appears comprehensive in nature, the courts may conclude that any state or local law on the issue is preempted.<sup>12</sup> This is known as “field preemption.”<sup>13</sup>

Courts can also look at the law’s legislative history to interpret ambiguous terms and phrases when deciding whether a law is preemptive.<sup>14</sup> Records of committee hearings, floor debates, and congressional testimony may provide the judge with insights as to whether the legislative body intended for the law to be preemptive.<sup>15</sup>

**Drafting Tips:** State and local governments should review other related laws to determine whether any of them impact the proposed tobacco control law being

considered. Special attention should be paid to the preemptive effect of the other laws. If higher levels of government have passed similar laws that are not expressly preemptive, the lower levels of government should ensure that their proposed laws do not conflict with the other law. Finally, to avoid preemption problems in the future, public health practitioners drafting new state-level public health laws should strive to include language that expressly states that the law is not preemptive, so that local governments may later implement stronger regulations.

### Other Federal Constraints

State and local public health laws may be constrained by federal laws, in addition to those that might be preemptive. Numerous provisions in the U.S. Constitution prevent governments from intruding too far into individual behavior. Complex constitutional issues of due process, equal protection, and freedom of speech, for example, may occasionally arise. The First Amendment in particular provides protection to a broad range of spoken and written communication, including expressions of political, religious or other fundamental opinions (fully protected “core speech”). Over the years, the Supreme Court has established a less robust level of “intermediate” protection for what the Court calls commercial speech, or speech related to the economic interests of the speaker.<sup>16</sup> Some opponents to laws that curb the retail sale of tobacco products may claim these laws violate the First Amendment’s commercial speech provision.

**Drafting Tips:** Tobacco manufacturers have successfully argued in court that their tobacco product advertisements are protected commercial speech.<sup>17</sup> Thus, drafters of laws restricting tobacco marketing need to pay close attention to First Amendment cases, as well as cases interpreting other constitutional provisions. Knowing how courts might analyze a law restricting tobacco retailers will help in drafting it so it will be likely to survive a First Amendment review if it is challenged in court. A law that restricts commercial speech should restrict the least amount of speech possible, while still achieving the law’s goal.<sup>18</sup> For more information about First Amendment issues related to restrictions placed on tobacco marketing, and drafting tips, see our companion publication, *Regulating Tobacco Marketing: “Commercial Speech” Guidelines for State and Local Governments*, at [www.publichealthlawcenter.org](http://www.publichealthlawcenter.org).

## Regulatory Strategy: Limiting Sales to Face-to-Face Only Transactions

### Defining and Describing a Face-To-Face Only Sales Law

One regulatory approach that states and localities might consider is to restrict tobacco sales to *face-to-face transactions only*. With this strategy, vending machines and self-service displays would be prohibited. Tobacco products would only be accessible to store personnel, thereby requiring customers to ask for tobacco products, and ideally, to have their identification checked to ensure compliance with the minimum age sales law.

Twenty-six states have adopted this face-to-face sales requirement for cigarettes and some have enacted a face-to-face requirement for other tobacco products.<sup>19</sup> Massachusetts law, for example, states:

[I]t shall be an unfair or deceptive act or practice for any person who sells or distributes cigarettes or smokeless tobacco products through a retail outlet located within Massachusetts to engage in any of the following retail outlet sales practices:

Selling cigarettes or smokeless tobacco products in any manner other than in a direct, face-to-face exchange [;]

Using self-service displays of cigarettes or smokeless tobacco products ... [except in adult only facilities; and]

Failing to place cigarettes and smokeless tobacco products out of the reach of all consumers, and in a location accessible only to outlet personnel.<sup>20</sup>

While the new 2009 FDA law includes a face-to-face sales requirement by prohibiting the sale of certain tobacco products through vending machines and self-service displays except in adult-only facilities,<sup>21</sup> state and local governments should consider passing their own similar prohibition. With the passage of a state or local law, state or local enforcement officials, who likely have a better knowledge of their own jurisdiction's laws than other agencies, will have unquestionable authority to enforce these laws.<sup>22</sup> Also, any monetary fines imposed by a state or local law would be revenue for the state or local government.

Furthermore, state and local governments may also impose stricter retail sales regulations. For example, the FDA ban on self-service displays and vending machines only applies to cigarettes and smokeless tobacco products and does not cover adult-only establishments. State and local governments may want to expand this ban and impose more restrictive controls. In Massachusetts, for instance, even in adult-only facilities, vending machines include a lock that an employee needs to open for each tobacco product purchase.<sup>23</sup> Governments might consider limiting self-service or vending machine sales of all tobacco products to adult-only facilities or prohibiting vending machines altogether, given that youth frequently gain entrance to adult-only facilities despite the proprietor's efforts to impose stricter regulations.

**Drafting Tips:** Drafters should consider writing face-to-face transaction requirements into their laws. They should also consider ways to make their local laws more effective in reducing tobacco use within their local community. For instance, in some communities, small cigars and other tobacco products are gaining popularity with youth because such products are relatively inexpensive.<sup>24</sup> It is unclear how many states have adopted face-to-face sales requirements for cigars and other tobacco products. State and local governments could consider requiring those products to be included in any such law and could also consider requiring face-to-face transactions in adult-only facilities.

### Legal Considerations

Face-to-face sales laws have been tested and upheld in the federal courts, including the 2001 case *Lorillard Tobacco Co. v. Reilly*. This landmark case involved a challenge to a series of tobacco control regulations promulgated by the Massachusetts Attorney General.<sup>25</sup> In *Lorillard*, the U.S. Supreme Court concluded that prohibiting self-service displays and vending machines is a *legally appropriate means* for preventing minors from obtaining tobacco products.<sup>26</sup> The Court upheld those regulations that restricted access to tobacco products by consumers by requiring face-to-face direct contact with a salesperson, finding that such sales practices regulated conduct rather than speech, and were thus valid under the First Amendment.<sup>27</sup> The Court found that even though the regulated conduct had a communicative component, the reason for the regulation was unrelated to the communication of

ideas or expression. Thus the Court did not apply the First Amendment test in *United States v. O'Brien* related to the restriction of expressive conduct.<sup>28</sup> (See the “Sample Tobacco Retailer Regulations and Legal Tests Applied by Court” chart at the end of this document.)

### *Federal Law Does Not Preempt State and Local Laws that Limit Tobacco Sales to Face-to-Face Transactions*

The 2009 FDA law does not in any way diminish the legal validity of bans on self-service displays and vending machines addressed in the *Lorillard* case.<sup>29</sup> If anything, the FDA law affirms that no federal law impedes state and local governments from enacting such bans. The FDA law states:

[n]othing in this [Act] ... or rules promulgated under this subchapter, shall be construed to limit the authority of ... a State or political subdivision of a State ... to enact, adopt, promulgate, and enforce any law, rule, regulation, or other measure with respect to tobacco products that is in addition to, or more stringent than, requirements established under this [Act], including a law, rule, regulation, or other measure relating to or prohibiting *the sale, distribution, possession, exposure to, access to, advertising and promotion of, or use of tobacco products* . . . .<sup>30</sup> (Emphasis added.)

The legality of this language was upheld in *Commonwealth Brands Inc. v. FDA*.<sup>31</sup> In *Commonwealth Brands*, tobacco manufacturers claimed that the language from the 2009 FDA law, quoted above, amounts to an unconstitutional delegation of authority to state and local governments.<sup>32</sup> The Court rejected this argument and concluded that the language instead articulates the very limited preemptive scope of the 2009 FDA law.<sup>33</sup> In other words, the anti-preemption language within the 2009 FDA law instructs state and local governments that they may continue to exercise their public health law authority to enact and enforce laws regulating the manner in which tobacco products are sold.

### *State and Local Laws that Limit Tobacco Sales to Face-to-Face Transactions Do Not Violate Commercial Speech Protections*

Bans on self-service displays and vending machines comport with commercial speech protections under the

First Amendment. In *Lorillard*, the Court concluded that bans on self-service displays are “unrelated to expression” of product information.<sup>34</sup> To understand why the Court reached this conclusion, it is helpful to look at a recent case from California that upheld the City and County of San Francisco’s ban on the sale of tobacco products in pharmacies.<sup>35</sup> In that case, the largest domestic manufacturer of cigarettes, Philip Morris, argued that the San Francisco law violated the company’s right to communicate product information to customers.<sup>36</sup> The Court disagreed and pointed out that a cigarette manufacturer’s “advertising is protected expressive activity [but] . . . [s]elling cigarettes isn’t because it doesn’t involve conduct with a significant expressive element.”<sup>37</sup>

**Drafting Tips:** Keep in mind that state and local governments continue to have broad authority to regulate the manner in which tobacco products are sold. The new FDA oversight of tobacco products is intended to complement this authority. Regulation of the manner in which tobacco products are sold does not trigger commercial speech protections under the First Amendment.

Drafters should consider writing face-to-face transaction requirements into their laws. They should also consider ways to make their local laws more effective in reducing tobacco use within their local community. For instance, in some communities, small cigars and other tobacco products are gaining popularity with youth because such products are relatively inexpensive.<sup>38</sup> It is unclear how many states have adopted face-to-face sales requirements for cigars and other tobacco products. State and local governments could consider requiring those products to be included in any such law and could also consider requiring face-to-face transactions in adult-only facilities.

## **Regulatory Strategy: Keeping All Tobacco Products Out of Sight**

### **Defining and Describing an Out-of-Sight Requirement for Tobacco Products**

A regulatory strategy requiring retailers to keep all tobacco products out of sight means just that: all products must be kept out of the public view. It is well documented that tobacco manufacturers pay retailers to display promotional materials.<sup>39</sup> One of the most

powerful pieces of promotional materials currently used by the tobacco industry is the so-called “power wall.”<sup>40</sup> A power wall consists of substantial product shelving located behind the retail sales counter.<sup>41</sup> Power walls can be very large, from ceiling to counter height and several feet in width.<sup>42</sup>

## Legal Considerations

### *Federal Law Would Not Preempt a Requirement that All Tobacco Products Be Kept Out of Sight*

The 2009 FDA law does not preempt or lessen the ability of state or local governments to prohibit power walls.<sup>43</sup> Rather, the FDA law clarifies that it will not preempt any state or local law that regulates the “advertising and promotion of” tobacco products.<sup>44</sup> The 2009 FDA law also states that “a State or locality may enact statutes and promulgate regulations . . . [that impose] specific bans or restrictions on the time, place and manner, but not content, of the advertising or promotion of any cigarettes.”<sup>45</sup> This language specifically instructs courts not to interpret the 2009 FDA law in a way that preempts state or local governments from regulating the time and placement of tobacco advertising.

### *A Requirement that All Tobacco Products Be Kept Out of Sight May Result in Claims that the Law Violates the First Amendment*

Although federal law would not appear to preempt a state or local requirement that retailers keep tobacco products out of sight, such a measure would likely trigger legal claims reviewed under the First Amendment. The issue was discussed briefly by the U.S. Supreme Court in the *Lorillard* case, which dealt with self-service displays along with a series of tobacco advertising and sales restrictions established by the Massachusetts Attorney General.<sup>46</sup> The tobacco manufacturers claimed that self-service displays were protected commercial speech.<sup>47</sup> Although the Court disagreed, it stated that the ban on self-service displays left “open ample channels of communication” within the store.<sup>48</sup> As an example of one such channel of communication, the Court suggested that the display of packaging itself had promotional value. The Court stated:

Moreover, retailers have other means of exercising any cognizable speech interest in the presentation of their products. We presume that

vendors may place empty tobacco packaging on open display, and display actual tobacco products so long as that display is only accessible to sales personnel.<sup>49</sup>

The court reached a similar conclusion in the ongoing case *Commonwealth Brands, Inc. v. FDA* regarding a legal challenge brought by tobacco manufacturers against numerous aspects of the 2009 FDA law.<sup>50</sup> The trial court in the *Commonwealth Brands* case struck down the FDA law’s ban on color and graphics in tobacco advertising, based in part on the argument that the ban would prohibit manufacturers from “depicting their own packaging in their advertising.”<sup>51</sup> The court stated that tobacco manufacturers “are clearly right when they say that images of packages of their products, simple brand symbols, and some uses of color communicate important commercial information about their products, i.e., what the product is and who makes it.”<sup>52</sup> Whether the tobacco package appears in advertising or behind the store clerk on a shelf, the court’s reasoning would seem to apply. Thus, a law that requires cigarette packages (or other tobacco product packages) to be stored where customers cannot see them would be subject to a heightened level of judicial scrutiny.

When analyzing an out-of-sight law challenged on First Amendment grounds, the courts would likely apply a four part (prong) test first developed in *Central Hudson Gas & Electric Corp. v. Public Service Commission of New York*:<sup>53</sup> –

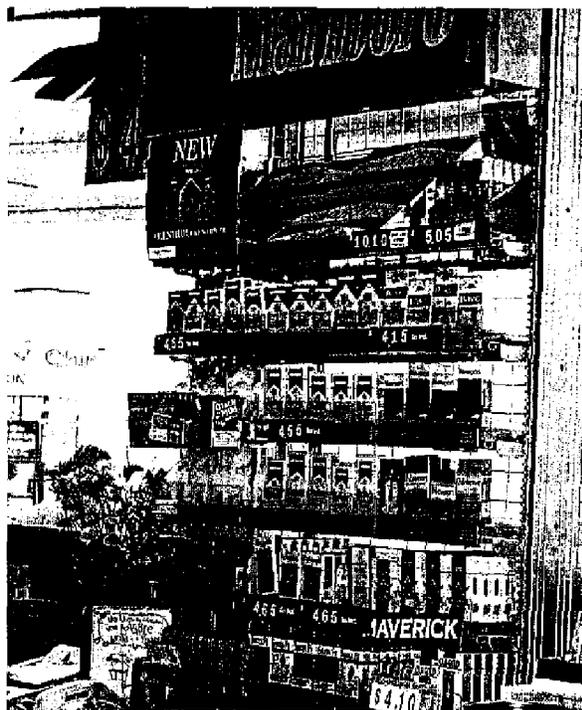
1. Is the required statement false, deceptive or concerning illegal activities?
2. Is the law justified by a substantial government interest?
3. Does the law directly advance the governmental interest?
4. Is there a reasonable fit between the goal and the means chosen to accomplish the goal?

Given the *Lorillard* Court’s application of this test, we can be relatively confident of the answer to at least the first two questions. The *Lorillard* Court found that the advertising of tobacco products in and around stores is not false, deceptive or illegal because tobacco is a legal product used by adults.<sup>54</sup> The Court also found that governments have a substantial interest in reducing youth smoking rates.<sup>55</sup>

However, the answers to the second two questions are less apparent. The *Lorillard* Court, for example, concluded that a ban on advertising of tobacco products within five feet of the floor did not directly advance a governmental interest.<sup>56</sup> Massachusetts argued that the five-foot limit would reduce tobacco advertising directed at children.<sup>57</sup> The Court disagreed and concluded that children could simply look up and that some children were taller than five feet.<sup>58</sup>

Nevertheless, research conducted since the *Lorillard* decision in 2001 demonstrates the dramatic effect of tobacco advertising in stores on enticing children to try to buy or use tobacco products.<sup>59</sup> These studies may “provide evidence that young people respond to cigarette marketing even when it is aimed at adults, showing that new restrictions are needed to curb illegal, as well as highly addictive and harmful, underage smoking.”<sup>60</sup> This recent empirical evidence linking youth smoking to advertising targeting adults may be pivotal to any future First Amendment legal challenges to tobacco advertising regulations.<sup>61</sup>

A court considering a First Amendment challenge to an out-of-sight regulation will also need to consider the fourth and final prong in *Central Hudson*: whether a reasonable fit exists between the goal and the means



chosen to accomplish the goal. In *Lorillard*, the Court evaluated the legality of a ban on billboard advertising near schools as well as the five-foot limitation discussed above, and the Court held that the restriction on billboards failed this fourth prong. Although the ban was designed to prevent tobacco billboard ads from being viewed by children, the ban was overly broad because it restricted too much speech that was suitable for adults.<sup>62</sup> The Court reached this conclusion even though it agreed that the billboard ban would directly advance the state’s interests in protecting children.<sup>63</sup> Opponents to an out-of-sight requirement would likely argue that the Court’s reasoning in the *Lorillard* case applies to the display of packages, because the display communicates the range of tobacco products available for sale in the store. In response, proponents of the law would need to identify an alternative means for retailers (and manufacturers) to communicate such information. Thus, a law that requires retailers to keep products out of sight from customers will need to be drafted carefully to withstand a legal challenge under the First Amendment.

**Drafting Tips:** Lawmakers should proceed with caution when considering direct restrictions of tobacco marketing. One option would be to require health warnings of a type and size sufficient to compete with tobacco marketing in stores. For example, the New York City Department of Health and Mental Hygiene implemented a requirement that retailers post point-of-sale health warnings that contain graphic images and strong language.<sup>64</sup> Another regulatory option would be to prohibit tobacco retailers in certain locations as discussed below, which would have a side effect of decreasing tobacco promotions in these locations. Yet another option might be to require the products to be out of sight, but to respect the tobacco industry’s First Amendment rights, by allowing items to be advertised in a menu of products that adults could view upon request or to allow limited signage to communicate the existence of tobacco products in the stores.

As mentioned earlier, a law that restricts commercial speech should restrict the least amount of speech possible, while still accomplishing the law’s goal. Drafters should document the extent of the problem the law is intended to solve, why the law’s approach must be taken, and why other approaches to solving the problem that have a lesser impact on commercial

speech would not work (or why they did not work in the past). This documentation can be included in the law's findings (often included as "whereas" clauses at the beginning of the law's text).

## **Regulatory Strategy: Prohibiting the Sale of Tobacco Products Within 1,000 Feet of Playgrounds and Schools**

### **Defining and Describing the 1,000-Foot Buffer Zone Around Schools and Playgrounds**

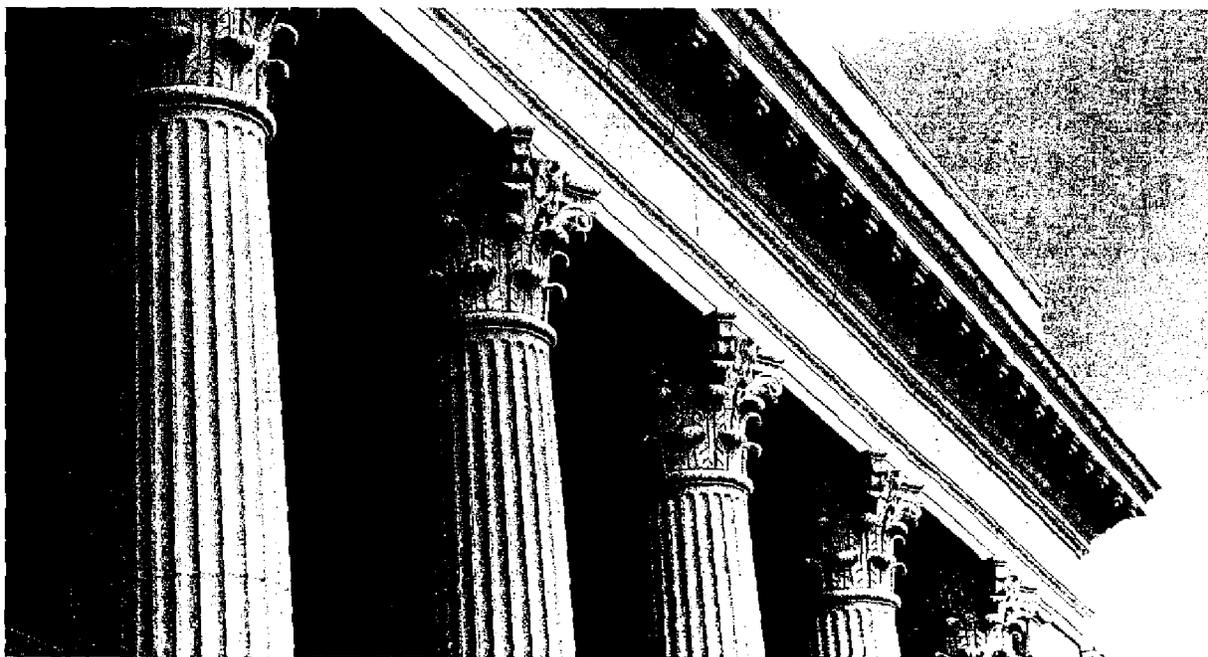
The regulatory strategy of creating tobacco-free zones around schools and playgrounds was also addressed, to some extent, in the *Lorillard* case, when the U.S. Supreme Court struck down a Massachusetts regulation that prohibited most tobacco advertising within 1,000 feet of schools and playgrounds.<sup>65</sup> The *Lorillard* Court made two important findings regarding the 1,000-foot buffer zone. The Court concluded that tobacco advertising is protected commercial speech and that Massachusetts' interests in protecting minors from tobacco advertising was not sufficient to justify the 1,000 foot buffer zones.<sup>66</sup>

The *Lorillard* decision, however, does not foreclose all options for creating buffer zones around schools.

The ruling applies to the advertising and promotion of tobacco products. It does not include the actual sale of tobacco. In an effort to create tobacco-free zones for children, state and local governments could consider prohibiting the sale of tobacco products near schools, playgrounds and other similar areas. The buffer zones could extend even further than 1,000 feet if doing so was adequately supported by the findings included within the law.

This strategy of tobacco-free zones has support within the public health community. For example, the Centers for Disease Control and Prevention recommends "the use of regulatory authority (e.g., through licensing and zoning) to limit alcohol outlet density on the basis of sufficient evidence of a positive association between outlet density and excessive alcohol consumption and related harms."<sup>67</sup> According to research reported in the *American Journal of Public Health*, experimental smoking among high school-aged minors increases when tobacco retailers are closer to schools and densely populate those locations.<sup>68</sup>

As a practical matter, state or local governments can establish tobacco-free buffer zones in at least two ways. The first option is to require tobacco retailers to obtain a tobacco retailer license, and make the issuance of licenses conditional on the retailers not operating within a certain distance, such as 1,000



feet, of schools or playgrounds. A second option is to amend the local zoning code to prohibit the sale of tobacco products within a certain distance, such as 1,000 feet, of schools and playgrounds. Under either option, the law should clearly and comprehensively define what constitutes a school or playground. The law should also define whether the 1,000 feet is measured by the distance pedestrians travel or the shortest straight line.<sup>69</sup> For example, the law might read as follows:

No Tobacco Retailer shall be located within one thousand (1,000) feet, as measured by a straight line, of the boundary of a property occupied by (i) a public or private kindergarten, elementary, middle, junior high or high school; (ii) a licensed child-care facility or preschool; (iii) playground; (iv) youth center; (v) recreational facility; (vi) arcade; (vi) park; or (vii) library.<sup>70</sup>

### Legal Considerations

Courts would likely evaluate either type of tobacco-free buffer zone law (licensure or zoning) as a type of land use regulation. Local governments have the legal authority to establish permissible uses of land.<sup>71</sup> Although state governments have commensurate legal authority for establishing land use laws, the responsibility has historically been left to local governments.<sup>72</sup>

The legal validity of zoning was established in the landmark case *Village of Euclid v. Ambler Realty*, in which the U.S. Supreme Court stated that a zoning ordinance violates due process protections only if it is “clearly arbitrary and unreasonable, having no substantial relation to the public health, safety, morals, or general welfare.”<sup>73</sup> Courts will “refrain from reviewing the merits of [such] decisions, absent a showing of arbitrariness or irrationality.”<sup>74</sup>

State and local governments interested in creating tobacco-free zones around playgrounds and schools should consider the well established laws prohibiting the sale of alcoholic beverages within certain distances of schools, playgrounds and the like. States can (and frequently do) require that alcohol retailers obtain a license and be located away from schools and similar locations.<sup>75</sup> These laws are generally regarded as constitutional.<sup>76</sup> Local governments could establish comparable restrictions for tobacco retailers.

### *Federal Law Does Not Preempt State and Local Governments from Prohibiting Tobacco Sales within 1,000 Feet of Schools and Playgrounds*

The 2009 FDA law does not preempt or in any way lessen the ability of local governments to create tobacco-free zones around schools and playgrounds. Rather, the 2009 FDA law clarifies that it will not preempt any state or local law that regulates the “sale, distribution, possession, exposure to, [or] access to” tobacco products.

### *Tobacco-Free Buffer Zones Can Be Established but Careful Implementation is Critical*

While laws prohibiting tobacco sales licenses to retailers located within 1,000 feet of schools and playgrounds are constitutional,<sup>77</sup> some difficulty can arise during implementation. The Fifth Amendment of the U.S. Constitution states that “private property [shall not] be taken for public use, without just compensation.”<sup>78</sup> Although this provision traditionally is applied to the physical taking of property, courts have extended this constitutional protection to regulatory takings as well. To determine whether a regulatory taking has occurred, the court considers (1) the character of the governmental action (for example, whether it is a licensing or land use regulation or a response to a public health problem); (2) the economic impact of the action on the property owner; and (3) the extent to which the action interferes with the property owner’s reasonable “investment-backed expectations.”<sup>79</sup>

A licensing or land use regulation is more likely to inspire a takings challenge when it prohibits a use that was previously permitted. Prospective regulations are less likely to raise constitutional concerns than regulations that are retroactive. A primary issue with the implementation of tobacco-free zones is that tobacco retailers may claim that prohibiting existing businesses from continuing amounts to an unconstitutional regulatory taking.

The case of *City of Antonio v. El Dorado Amusement Co.* illustrates problems that can arise with rezoning.<sup>80</sup> This case focused on whether rezoning that excluded the sale of alcoholic beverages constituted an unconstitutional taking of property that was leased to a licensed retailer of alcoholic beverages. The appellate court found that although the property was not physically taken from the retailer, the rezoning had

a “severe economic impact” on the retailer’s business and “unreasonably interfered with [the owner’s] investment-backed expectations.”<sup>81</sup>

Given that gas stations, convenience stores and other retailers that sell tobacco products derive substantial profits from tobacco, the immediate implementation of a tobacco-free buffer zone would likely trigger takings claims. As such, state and local governments should carefully consider how they will deal with retailers who were in operation before tobacco-free sales zones are to be implemented, and whether such businesses should be grandfathered in or be deemed nonconforming uses and allowed to continue.

Nevertheless, the law recognizes the importance of not perpetuating businesses that do not conform to existing land uses.<sup>82</sup> Depending on the jurisdiction, it may be possible to limit the transferability of a tobacco retailer license or to limit the period in which businesses are grandfathered in or can operate as nonconforming uses.<sup>83</sup>

One important regulatory tip to consider is that licensees who violate their license requirements could be deemed to have waived their nonconforming use status. In *Kertsetter v. City of Bridgeport*, for example, the operator of a used car lot repeatedly violated its license requirements.<sup>84</sup> When the city pulled the license, the zoning board pulled the nonconforming use status.<sup>85</sup> The court concluded that the licensee’s noncompliance demonstrated intent to abandon the lawful operation of a business, which amounted to a waiver of the licensee’s right to the nonconforming use status.<sup>86</sup> Similarly, a tobacco retailer located in a 1,000-foot zone that continually sells to minors arguably waives its right to nonconforming use status.

Another option for eliminating nonconforming uses is to establish an amortization schedule, where retailers are given a reasonable period of time to recover the full value of their business.<sup>87</sup> Calculating amortization is a complex and fact-specific process.<sup>88</sup>

**Drafting Tips:** State and local governments that use land use regulation or licensing as strategies to control the tobacco retail environment should be familiar with the zoning and licensing law in their jurisdictions. Because the implementation of these regulations can pose problems, policymakers might find it helpful to research how similar laws (both for tobacco and other products such as alcohol) have been enforced

in other localities, and the way legal or policy issues or challenges were addressed.

## Conclusion

The Family Smoking Prevention and Tobacco Control Act leaves state and local governments free to adopt a wide range of tobacco control policy options, including more restrictive retail sales regulations. Many legally and politically viable regulatory options are available, including laws that require face-to-face only sales of tobacco products, laws that keep all tobacco products out of sight in retail establishments, and laws that prohibit the sale of tobacco products within 1,000 feet of playgrounds and schools. In drafting any of these regulatory measures, policymakers will want to be aware of conflicts with existing state or federal law, and other possible federal or state constraints or limitations. They will also want to focus on what they are regulating (for example, speech or conduct), where the law applies, and how the law will be enforced, so they will be better able to anticipate legal tests the courts may apply if the law is challenged. By using tips outlined in this publication and by including factual findings that support the legislation, state and local governments will be able to draft strong tobacco retailer laws likely to withstand legal challenge.

The following chart may be helpful when state and local governments consider strategies for regulating tobacco retailers in their jurisdictions. Because it provides an overview of tests that might be applied to new tobacco laws challenged in court, it can be used to draft the strongest laws possible. For more information on Commerce Clause considerations when drafting state and local regulations that restrict tobacco advertising and promotion, see the Tobacco Control Legal Consortium’s *Regulating Tobacco Advertising and Promotion: A “Commerce Clause” Overview for State & Local Governments* and *Regulating Tobacco Product Pricing: Guidelines for State and Local Governments* (2010). For information on related Commercial Speech considerations, see the Tobacco Control Legal Consortium’s *Regulating Tobacco Marketing: “Commercial Speech” Guidelines for State and Local Governments* (2010); *Regulating Tobacco Marketing: A “Commercial Speech” Factsheet for State and Local Governments* (2010); and *Regulating Tobacco Marketing: A “Commercial Speech” Flowchart for State and Local Governments* (2010).

## Select Tobacco Retailer Regulations and Legal Tests Applied by Courts

Type of regulation	Possible legal challenge*	Test applied by courts	Notes and drafting tips
<p><b>"Face-to-face" requirement for all tobacco sales</b></p>	<p>No federal preemption concerns</p>	<p>N/A.</p>	<ul style="list-style-type: none"> <li>When drafting a tobacco control law, consider referencing the authority under which the governmental body is operating. A formal citation to the granting law may assist in defending the law against allegations that the government lacks the authority to pass the law.</li> </ul>
	<p>No first Amendment restriction on expressive conduct concerns</p>	<p>See <i>Lorillard Tobacco Co. v. Reilly</i>, 533 U.S. 525 (2001), where the Supreme Court analyzed the requirement that tobacco be kept behind the counter or in a locked case. The Court declined to apply the expressive conduct test set out in <i>United States v. O'Brien</i>, 391 U.S. 367 (1968).</p> <p>4 prongs:</p> <ol style="list-style-type: none"> <li>Does the government have the authority to pass the law?</li> <li>Does the restriction further a substantial governmental interest?</li> <li>Is the restriction unrelated to the suppression of free expression?</li> <li>Is the incidental restriction on First Amendment freedoms no greater than is essential to achieve the government's interest?</li> </ol>	<ul style="list-style-type: none"> <li>Document the problem the law was drafted to solve, the government's interest in solving the problem, the way the law advances the government's interest, and way the government's goal fits with the means chosen to accomplish it.</li> <li>The law's purpose must not be to limit communication. Any suppression or restriction of commercial speech must be incidental to the law's goal in keeping tobacco from minors.</li> </ul>

\*Other possible legal challenges, such as claims based on Equal Protection, are not discussed here.

## Select Tobacco Retailer Regulations and Legal Tests Applied by Courts

Type of regulation	Possible legal challenge	Test applied by courts	Notes and drafting tips
<b>"Out-of-sight" requirement for all tobacco products</b>	No federal preemption concerns	N/A.	<ul style="list-style-type: none"> <li>When drafting a tobacco control law, consider referencing the authority under which the governmental body is operating. A formal citation to the granting law may assist in defending the law against allegations that the government lacks the authority to pass the law.</li> </ul>
	First Amendment restriction on speech <i>Burden: high hurdle</i>	<p><i>Central Hudson Gas v. Public Services Commission</i>, 447 U.S. 557 (1980).</p> <p>4 prongs:</p> <ol style="list-style-type: none"> <li>1) Is the restricted speech false, deceptive, or advertising illegal activities?</li> <li>2) Is the law justified by a substantial governmental interest?</li> <li>3) Does the law directly advance the governmental interest?</li> <li>4) Is there a reasonable fit between the goal (the government's interest) and the means chosen to accomplish the goal?</li> </ol> <p>OR</p> <ol style="list-style-type: none"> <li>4) Does the law restrict the least possible amount of speech necessary to achieve its goal?</li> </ol>	<ul style="list-style-type: none"> <li>Fully document the extent of the problem the law was drafted to solve, and include a careful, thorough analysis of how the law would impact commercial speech in the law's "findings" (sometimes included as "whereas" clauses preceding the text of the law that document, through statistical data or other means, the problem the law was drafted to solve and how the law would solve it).</li> <li>Clearly state the government's goal in enacting the law, because doing so helps to show the law satisfied prong two: that the government has a substantial interest in solving the problem, and prong three: that the law as written will achieve the goal it seeks.</li> <li>The law must clearly advance the objective the government enacted the law to achieve.</li> <li>The findings should also indicate why the law's approach must be taken and why other approaches to solving the problem that have a lesser impact on commercial speech would not work or, if they were tried before, have not worked in the past.</li> <li>Be sure that the new law restricts the least amount of speech possible, while still achieving the law's goal.</li> </ul>
	First Amendment restriction on expressive conduct (incidental) <i>Burden: moderate hurdle</i>	<p><i>United States v. O'Brien</i>, 391 U.S. 367 (1968).</p> <p>4 prongs:</p> <ol style="list-style-type: none"> <li>1) Does the government have the authority to pass the law?</li> <li>2) Does the restriction further a substantial governmental interest?</li> <li>3) Is the restriction unrelated to the suppression of free expression?</li> <li>4) Is the incidental restriction on First Amendment freedoms no greater than is essential to achieve the government's interest?</li> </ol>	<ul style="list-style-type: none"> <li>The findings must clearly state the reason for the law and include as much research as possible showing the need for the law.</li> <li>The law's purpose must not be to limit communication; any effect on speech must be a side-effect of a conduct regulation.</li> <li>Drafters should show that the law's goal is being met without a wider than necessary impact on expressive conduct.</li> <li>The findings must not suggest that the law's real purpose is to suppress speech, because that will undermine the argument that any impact on commercial speech is incidental and not the purpose of the law.</li> </ul>

## Select Tobacco Retailer Regulations and Legal Tests Applied by Courts

Type of regulation	Possible legal challenge	Test applied by courts	Notes and drafting tips
<p><b>Prohibition of the sale of tobacco products within 1,000 feet of playgrounds and schools</b></p>	<p>No federal preemption concerns</p>	<p>N/A.</p>	<ul style="list-style-type: none"> <li>When drafting a tobacco control law, consider referencing the authority under which the governmental body is operating. A formal citation to the granting law may assist in defending the law against allegations that the government lacks the authority to pass the law.</li> </ul>
	<p>First Amendment restriction on commercial speech Burden: Moderate hurdle</p>	<p>See <i>Lorillard Tobacco Co. v. Reilly</i>, 533 U.S. 525 (2001), where the Supreme Court analyzed the requirement that tobacco billboards be located at least 1,000 feet away from schools and playgrounds and found the restriction on speech unconstitutional under the test set out in <i>Central Hudson Gas v. Public Services Commission</i>, 447 U.S. 557 (1980).</p> <p>4 prongs:</p> <ol style="list-style-type: none"> <li>1) Is the restricted speech false, deceptive, or advertising illegal activities?</li> <li>2) Is the law justified by a substantial governmental interest?</li> <li>3) Does the law directly advance the governmental interest?</li> <li>4) Is there a reasonable fit between the goal (the government's interest) and the means chosen to accomplish the goal?</li> </ol> <p>OR</p> <ol style="list-style-type: none"> <li>4) Does the law restrict the least possible amount of speech necessary to achieve its goal?</li> </ol>	<ul style="list-style-type: none"> <li>Fully document the extent of the problem the law was drafted to solve, and include a careful, thorough analysis of how the law would impact commercial speech in the law's "findings" (sometimes included as "whereas" clauses preceding the text of the law that document, through statistical data or other means, the problem the law was drafted to solve and how the law would solve it).</li> <li>Clearly state the government's goal in enacting the law, because doing so helps to show the law satisfied prong two: that the government has a substantial interest in solving the problem, and prong three: that the law as written will achieve the goal it seeks.</li> <li>The law must clearly advance the objective the government enacted the law to achieve.</li> <li>The findings should also indicate why the law's approach must be taken and why other approaches to solving the problem that have a lesser impact on commercial speech would not work or, if they were tried before, have not worked in the past.</li> <li>Be sure that the new law restricts the least amount of speech possible, while still achieving the law's goal.</li> </ul>
	<p>Fifth (&amp; Fourteenth) Amendment taking (partial regulatory) Burden: Moderate hurdle</p>	<p>See <i>D.A.B.E. Inc. v. City of Toledo</i>, 292 F.Supp. 2d 968 (N.D. Ohio 2003), aff'd 393 F.3d 692 (6th Cir. 2005).</p> <p>3 prongs:</p> <ol style="list-style-type: none"> <li>1) What is the character of the governmental action (for example, is it a land use regulation or a response to a public health problem?)</li> <li>2) What is the economic impact of the action on the property owner?</li> <li>3) To what extent does the action interfere with the property owner's reasonable "investment-backed expectations"?</li> </ol>	<ul style="list-style-type: none"> <li>Drafters must clearly identify the state interest at stake, the level of government intrusion, and the impact this intrusion has in preventing the property owner from realizing the property's economic use.</li> <li>Drafters might consider –             <ul style="list-style-type: none"> <li>o Exempting or "grandfathering" preexisting uses of land that become nonconforming when local zoning ordinances are amended, or</li> <li>o Requiring that any new land use regulation not apply to existing business concerns for a particular period of time.</li> </ul> </li> </ul>

## Endnotes

- 1 Centers for Disease Control and Prevention, *Tobacco Use: Targeting the Nation's Leading Killer – At a Glance 2010*, 1 (2010).
- 2 See Lisa Henriksen et al., *Effects of Youth Exposure to Retail Tobacco Advertising*, 32(9) *J. APPLIED SOC. PSYCHOL.*, 1771 (2002); See also Ellen Feighery et al., *An Examination of Trends in Amount and Type of Cigarette Advertising and Sales Promotions in California Stores, 2002-2005*, 17 *TOBACCO CONTROL* 93 (2008) (describing cigarette promotions and trends in retail environments); Sandy Slater et al., *The Impact of Retail Cigarette Marketing Practices on Youth Smoking Uptake*, 161 *ARCHIVES OF PEDIATRICS & ADOLESCENT MED.* 440 (2007) (noting that point-of-sale cigarette promotions correspond to an increase in tobacco use among youth).
- 3 Family Smoking Prevention and Tobacco Control Act, Pub. L. No. 111-31, 123 Stat. 1776 (West 2010) (codified, in relevant part, at 15 U.S.C.A. §§ 1333-34 and 21 U.S.C.A. § 301 et seq.) The Act has been challenged in court (*Commonwealth Brands, Inc. v. United States*, No. 1:09-CV-117-M, 2010 WL 65013 (W.D. Ky. Jan. 5, 2010)), but this publication assumes that all provisions of the Act are being enforced.
- 4 See James Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 *J. CONTEMP. HEALTH L. & POL'Y*, 93, 94 (1997).
- 5 See *Gibbons v. Ogden*, 22 U.S. 1, 203 (1824); Wendy Parmet, *After September 11: Rethinking Public Health Federalism*, 30 *J.L. MED. & ETHICS* 201, 202-03 (2002).
- 6 See, e.g., MASS. GEN. LAWS ch. 111, § 31 (2009) (noting that “Boards of health may make reasonable health regulations”).
- 7 See 56 Am. Jur. 2d *Municipal Corporations* § 107 (2009).
- 8 See 56 Am. Jur. 2d *Municipal Corporations* § 110 (2009).
- 9 See *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374 (1992).
- 10 See *id.*
- 11 See *Bates v. Dow Agrosciences, LLC*, 544 U.S. 431 (2005).
- 12 See *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293 (1988).
- 13 See *id.*
- 14 See *Bank of New York v. Hoyt*, 617 F. Supp. 1304 (D.R.I. 1985).
- 15 See *id.* at 1311.
- 16 *Central Hudson Gas & Electric Corp. v. Pub. Serv. Comm'n of New York*, 447 U.S. 557 (1980).
- 17 See, e.g., *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001).
- 18 See Elisa P. Laird-Metke, Tobacco Control Legal Consortium, *Regulating Tobacco Marketing: A “Commercial Speech” Factsheet for State and Local Governments* (2010), available at <http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-fs-speech-2010.pdf>.
- 19 AMERICAN LUNG ASS'N, STATE OF TOBACCO CONTROL 2009 29 (2009), available at [http://sotc2009.pub30.convio.net/2009/ALA\\_SOTC\\_09.pdf](http://sotc2009.pub30.convio.net/2009/ALA_SOTC_09.pdf) (last visited June 15, 2010).
- 20 940 MASS. CODE REGS. 21.04 (2000).
- 21 Family Smoking Prevention and Tobacco Control Act, *supra* note 3. Section 102 of the Act revives federal rules previously passed on August 28, 1996 by the FDA. §102(a)(2) (requiring the FDA to promulgate rules identical to 61 Fed. Reg. 44615-18).
- 22 See *Thompson v. Thompson*, 484 U.S. 174, 179 (1988) (stating that congressional intent on whether state and local authorities can enforce federal law is to be considered when determining enforcement authority).
- 23 See 940 MASS. CODE REGS. 21.04(4)(b).
- 24 See MASSACHUSETTS DEP'T OF PUB. HEALTH, TRENDS IN YOUTH TOBACCO USE IN MASSACHUSETTS, 1993-2007, 5-6 (2008), available at [http://www.mass.gov/Eeohhs2/docs/dph/tobacco\\_control/adolescent\\_tobacco\\_use\\_youth\\_trends\\_1993\\_2007.pdf](http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/adolescent_tobacco_use_youth_trends_1993_2007.pdf) (last visited June 15, 2010).
- 25 See *Lorillard*, 533 U.S. at 570. The Massachusetts law does not actually prohibit vending machines but it places many restrictions on their use. Under the Massachusetts law, vending machines can only be in adult-only facilities, within sight of workers and locked at all times, except during actual sales transactions. In other words, anyone who wants to use a vending machine to purchase cigarettes must first get an employee to unlock it..
- 26 See *id.* at 532-37 (citing 940 MASS. CODE REGS. 21.04 (2000)).
- 27 See *id.* at 570.
- 28 391 U.S. 367 (1968).

- 29 Family Smoking Prevention and Tobacco Control Act, *supra* note 3.
- 30 21 U.S.C. § 387p (2009).
- 31 678 F. Supp. 2d 512 (W.D. Ky. 2010).
- 32 See *id.* at 528.
- 33 See *id.*
- 34 See *Lorillard*, 533 U.S. at 570.
- 35 Philip Morris USA v. City and County of San Francisco, No. C 08-04482 CW, 2008 WL 5130460 (N.D. Cal. 2008), *aff'd*, No. 08-17649, 2009 WL 2873765 (9th Cir. 2009).
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- 45 15 U.S.C. §1334.
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- 47 See *id.*
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- 51 *Id.*
- 52 *Id.* at \*6.
- 53 *Central Hudson Gas & Electric Corp.*, 447 U.S. 557 (1980).
- 54 *Lorillard*, 533 U.S. at 578-79. Note that the regulation at issue in this case applied to all tobacco advertising. This decision leaves room open for restriction of certain types of advertising: namely advertising that is shown to be targeted at youth. An easy example of this type of youth targeted advertising is the use of cartoons, which is already prohibited among signatories to the 1998 Master Settlement Agreement. (All major U.S. tobacco product manufacturers are signatories to the Master Settlement Agreement.) Less obvious examples of youth targeted tobacco advertising would need to be identified either through an admission by a manufacturer or rigorous scientific evaluation of the advertising.
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- 56 See *id.* at 566.
- 57 See *id.*
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- 88 See *Art Neon Co. v. Denver*, 488 F.2d 118, 122 (10th Cir. 1973).

## **About the Tobacco Control Legal Consortium**

The Tobacco Control Legal Consortium is a network of legal programs supporting tobacco control policy change throughout the United States. Drawing on the expertise of its collaborating legal centers, the Consortium works to assist communities with urgent legal needs and to increase the legal resources available to the tobacco control movement. The Consortium's coordinating office, located at William Mitchell College of Law in St. Paul, Minnesota, fields requests for legal technical assistance and coordinates the delivery of services by the collaborating legal resource centers. Our legal technical assistance includes help with legislative drafting; legal research, analysis and strategy; training and presentations; preparation of friend-of-the-court legal briefs; and litigation support.



Tobacco Control  
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*Prev Sci.* 2005 Dec;6(4):319-25

## **Tobacco outlet density and demographics at the tract level of analysis in Iowa: implications for environmentally based prevention initiatives.**

Schneider JE, Reid RJ, Peterson NA, Lowe JB, Hughey J.

Department of Health Management & Policy, University of Iowa College of Public Health, 200 Hawkins Drive, E204 GH, Iowa City, Iowa 52242, USA. john-schneider@uiowa.edu

### **Abstract**

This study assessed the geographic association between tobacco outlet density and three demographic correlates—*income, race, and ethnicity*—at the tract level of analysis for one county in the Midwestern United States. Data for residential census tracts in a Midwestern U.S. county were derived from year 2003 licenses for 474 tobacco outlets. Demographic variables were based on 2000 census data. Census tracts with lower median household income, higher percent of African American residents, and higher percent of Latinos residents had greater density of tobacco selling retail outlets. Areas characterized by lower income and disproportionately more African Americans and Latinos have greater physical access to tobacco products. Physical access to tobacco is a critical public-health issue because, given that smokers have been shown to be price sensitive, lowering access costs (e.g., reduced travel time) is likely to increase consumption. Findings also suggest the need for structural or environmental interventions, i.e., tobacco outlet zoning laws, to mitigate the health consequences associated with tobacco use in certain populations and geographic regions.

PMID:16163568[PubMed - indexed for MEDLINE]

**Publication Types, MeSH Terms**

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## DEMOGRAPHICS AND TOBACCO OUTLET DENSITY

Andrew Hyland, PhD, Mark J. Travers, BS, K. Michael Cummings, PhD, MPH, Joseph Bauer, PhD, Terry Alford, BS, and William F. Wieczorek, PhD

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In our recent report associating community demographics and tobacco outlet density in Erie County, New York,<sup>1</sup> we stated that no other studies had been performed examining this topic. After our original submission date, work was published by Laws et al,<sup>2</sup> who found that the percentage of all businesses that sold tobacco in 10 Massachusetts neighborhoods was strongly inversely correlated with the average per capita income of those neighborhoods and that the resident populations of the lower-income neighborhoods were predominantly African American or Latino. Therefore, by the publication date of our report, our statement was no longer correct, and the work of Laws et al should be recognized.

The important point is not whose paper was published first, but rather that 2 independent studies found similar results. There seems to be little dispute over the observation that tobacco-selling retail outlets are disproportionately located in poor neighborhoods. The implication for public health is that zoning rules to limit the proliferation of tobacco outlets to eliminate this disparity should be seriously considered.

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## Retail tobacco outlet density and youth smoking: A propensity modeling approach

**Authors:** Scott P. Novak, [Sean F. Reardon](#), Stephen W. Raudenbush, Stephen L. Buka,

**Publication Type:** Journal Article

**Year of Publication:** 2006

**Published Date:** 04/2006

**Journal:** American Journal of Public Health

Full Text Sources: <http://ajph.aphapublications.org/cgi/content/short/AJPH.2004.061622v1>

### Abstract

**OBJECTIVES:** We examined whether retail tobacco outlet density was related to youth cigarette smoking after control for a diverse range of neighborhood characteristics.

**METHODS:** Data were gathered from 2116 respondents (aged 11 to 23 years) residing in 178 census tracts in Chicago, Ill. Propensity score stratification methods for continuous exposures were used to adjust for potentially confounding neighborhood characteristics, thus strengthening causal inferences.

**RESULTS:** Retail tobacco outlets were disproportionately located in neighborhoods characterized by social and economic disadvantage. In a model that excluded neighborhood confounders, a marginally significant effect was found. Youths in areas at the highest 75th percentile in retail tobacco outlet density were 13% more likely (odds ratio [OR]=1.13; 95% confidence interval [CI]=0.99, 1.28) to have smoked in the past month compared with those living at the lowest 25th percentile. However, the relation became stronger and significant (OR=0.21; 95% CI=1.04, 1.41) after introduction of tract-level confounders and was statistically significant in the propensity score-adjusted model (OR = 1.20; 95% CI = 1.001, 1.44). Results did not differ significantly between minors and those legally permitted to smoke.

**CONCLUSIONS:** Reductions in retail tobacco outlet density may reduce rates of youth smoking.

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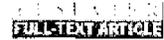
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Public Health. 2010 Jul;124(7):412-6. Epub 2010 Jun 11.



## Tobacco outlet density and demographics: analysing the relationships with a spatial regression approach.

Yu D, Peterson NA, Sheffer MA, Reid RJ, Schnieder JE.

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### Abstract

**OBJECTIVE:** Studies of relationships between tobacco sales and socio-economic/sociodemographic characteristics are well documented. However, when analysing the data that are collected on geographic areas, the spatial effects are seldom considered, which could lead to potential misleading analytical results. This study addresses this concern by applying the spatial analysis method in studying how socio-economic factors and tobacco outlet density are related in New Jersey, USA.

**STUDY DESIGN:** A spatial regression method applied to tobacco outlet and socio-economic data obtained in 2004 in New Jersey, USA.

**METHOD:** This study assessed the association between tobacco outlet density and three demographic correlates - income, race and ethnicity - at the tract level of analysis for one state in the north-eastern USA. Data for 1938 residential census tracts in the state of New Jersey were derived from 2004 licences for 13,984 tobacco-selling retail outlets. Demographic variables were based on 2000 census data. When applying a regression model, the residuals of an ordinary least squared (OLS) estimation were found to exhibit strong spatial autocorrelation, which indicates that the estimates from the OLS model are biased and inferences based on the estimates might be misleading. A spatial lag model was employed to incorporate the potential spatial effects explicitly.

**RESULTS:** Agreeing with the OLS residual autocorrelation test, the spatial lag model yields a significant coefficient of the added spatial effect, and fits the data better than the OLS model. In addition, the residuals of the spatial regression model are no longer autocorrelated, which indicates that the analysis produces more reliable results. More importantly, the spatial regression results indicate that tobacco companies attempt to promote physical availability of tobacco products to geographic areas with disadvantageous socio-economic status. In New Jersey, the percentage of Hispanics seems to be the dominant demographic factor associated with tobacco outlet distribution, followed by median household income and percentage of African Americans.

**CONCLUSION:** This research applied a spatial analytical approach to assess the association between tobacco outlet density and sociodemographic characteristics in New Jersey at the census tract level. The findings support the common wisdom in the public health research domain that tobacco outlets are more densely distributed in socio-economically disadvantaged areas. However, incorporating the spatial effects explicitly in the analysis provides less biased and more reliable results than traditional methods.

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MeSH Terms

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UI Health Care News: Week of December 5, 2005

## UI Researchers Examine Effect of Race on Smoking, Tobacco Outlet Density

The relationship between tobacco outlet density and smoking prevalence is greater in Iowa counties with a higher percentage of African Americans, according to three studies co-authored by University of Iowa researchers. The studies are among the first to examine the effect of race on the geographic association between tobacco outlet density and cigarette smoking prevalence.



Tobacco use kills more than 440,000 Americans each year, according to the Centers for Disease Control and Prevention (CDC), and has a significant impact on the health of African Americans. Of the three leading causes of death in African Americans--heart disease, cancer, and stroke--smoking and other tobacco use are major contributors. More than one in five African American adults is a smoker, the CDC reports.

"An important public health and policy question is whether tobacco companies are increasing their presence in disadvantaged, racially diverse communities to increase sales of their product," said John Lowe, Dr.P.H., UI professor and head of community and behavioral health and a co-author of the studies. "The aim of these studies was to determine whether an area's high disadvantaged concentration is a factor in the link between the density of tobacco-selling retail outlets and the prevalence of smoking."

In two of the studies, the investigators used U.S. census and state data to determine the tobacco outlet density, percentage of African American residents, and adult cigarette-smoking prevalence rates in each of Iowa's 99 counties. Data analysis revealed that the statistical association between tobacco outlet density and smoking prevalence was stronger in Iowa counties with higher percentages of African Americans.

The researchers also conducted a third, related tobacco outlet study that focused exclusively on Polk County, Iowa. The investigators found that census tracts with the lowest household incomes and highest proportions of African American and Latino residents had more than twice as many tobacco outlets per 10 kilometers of roadway compared to wealthier, less diverse tracts.

"Our findings have important implications for future tobacco

control initiatives, particularly land-use policies," said co-author N. Andrew Peterson, Ph.D., UI assistant professor of community and behavioral health. "One such control initiative is to enact zoning laws that decrease the density of tobacco outlets in a given area. The idea is that smokers will have to travel farther, and in effect spend more, to obtain cigarettes, which will discourage the smoking habit."

The first study appeared in the June 2005 issue of the journal *Drugs: Education, Prevention and Policy*, and included co-investigators Robert J. Reid, Ph.D., of Rutgers University and Joseph Hughey, Ph.D., of the University of Missouri-Kansas City. The second study was published in the October 2005 issue of *Substance Use & Misuse*. The third study, authored with John Schneider, Ph.D., UI assistant professor of health management and policy, appeared in the September 2005 online issue of *Prevention Science*.

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## Journal ToCs

### **Local Tobacco Policy and Tobacco Outlet Density: Associations With Youth Smoking**

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Publication year: 2011

**Source:** Journal of Adolescent Health, Available online 26 October 2011

Sharon Lipperman-Kreda, Joel W. Grube, Karen B. Friend

**Purpose**This study investigates the associations between local tobacco policy, tobacco outlet density, and youth smoking. A primary focus is on whether local tobacco policy moderates the relation between outlet density and youth smoking.  
**Methods**In all, 1,491 youth (51.9% male, mean age = 14.7 years, standard deviation = 1.05) in 50 midsized California cities were surveyed through a computer-assisted telephone interview. Measures of local clean air policy and youth access policy were created based on a review of tobacco policies in these cities. Outlet density was calculated as the number of retail tobacco outlets per 10,000 persons, and city characteristics were obtained from 2000 U.S. Census data.  
**Results**Using multilevel regression analyses and controlling for city characteristics, tobacco outlet density was positively associated with youth smoking. No significant main effects were found for the two tobacco policy types on any of the smoking outcomes after controlling for interactions and covariates. However, statistically significant interactions were found between local clean air policy and tobacco outlet density for ever smoked and past 12-month cigarette smoking. Comparisons of simple slopes indicated that the positive associations between tobacco outlet density and youth smoking behaviors were stronger at the lowest level of local clean air policy compared with the moderate and high levels.  
**Conclusions**Our results suggest that tobacco outlet density is related to youth smoking. In addition, local clean air policy may act as a moderator of relationship between tobacco outlet density and youth smoking, such that density is less important at moderate and high levels of this tobacco policy.

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## Exhibit D

Information regarding designer drugs, such as,  
Bath Salts, Incense, and Spice.



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July 16, 2011

## **An Alarming New Stimulant, Legal in Many States**

By **ABBY GOODNOUGH** and **KATIE ZEZIMA**

Dr. Jeffrey J. Narmi could not believe what he was seeing this spring in the emergency room at Schuylkill Medical Center in Pottsville, Pa.: people arriving so agitated, violent and psychotic that a small army of medical workers was needed to hold them down.

They had taken new stimulant drugs that people are calling “bath salts,” and sometimes even large doses of sedatives failed to quiet them.

“There were some who were admitted overnight for treatment and subsequently admitted to the psych floor upstairs,” Dr. Narmi said. “These people were completely disconnected from reality and in a very bad place.”

Similar reports are emerging from hospitals around the country, as doctors scramble to figure out the best treatment for people high on bath salts. The drugs started turning up regularly in the United States last year and have proliferated in recent months, alarming doctors, who say they have unusually dangerous and long-lasting effects.

Though they come in powder and crystal form like traditional bath salts — hence their name — they differ in one crucial way: they are used as recreational drugs. People typically snort, inject or smoke them.

Poison control centers around the country received 3,470 calls about bath salts from January through June, according to the American Association of Poison Control Centers, up from 303 in all of 2010.

“Some of these folks aren’t right for a long time,” said Karen E. Simone, director of the Northern New England Poison Center. “If you gave me a list of drugs that I wouldn’t want to touch, this would be at the top.”

At least 28 states have banned bath salts, which are typically sold for \$25 to \$50 per 50-milligram packet at convenience stores and head shops under names like Aura, Ivory Wave, Loco-Motion and Vanilla Sky. Most of the bans are in the South and the Midwest, where the drugs have grown quickly in popularity. But states like Maine, New Jersey and New York have also outlawed them after seeing evidence that their use was spreading.

The cases are jarring and similar to those involving PCP in the 1970s. Some of the recent incidents include a man in Indiana who climbed a roadside flagpole and jumped into traffic, a man in Pennsylvania who broke into a monastery and stabbed a priest, and a woman in West Virginia who scratched herself “to pieces” over several days because she thought there was something under her skin.

“She looked like she had been dragged through a briar bush for several miles,” said Dr. Owen M. Lander, an emergency room doctor at Ruby Memorial Hospital in Morgantown, W.Va.

Bath salts contain manmade chemicals like mephedrone and methylenedioxypropylvalerone, or MDPV, also known as substituted cathinones. Both drugs are related to khat, an organic stimulant found in Arab and East African countries that is illegal in the United States.

They are similar to so-called synthetic marijuana, which has also caused a surge in medical emergencies and been banned in a number of states. In March, the Drug Enforcement Administration used emergency powers to temporarily ban five chemicals used in synthetic marijuana, which is sold in the same types of shops as bath salts.

Shortly afterward, Senator Bob Casey, Democrat of Pennsylvania, asked the agency to enact a similar ban on the chemicals in bath salts. It has not done so, although Gary Boggs, a special agent at D.E.A. headquarters in Washington, said the agency had started looking into whether to make MDPV and mephedrone controlled Schedule I drugs like heroin and ecstasy.

Mr. Casey said in a recent interview that he was frustrated by the lack of a temporary ban. “There has to be some authority that is not being exercised,” he said. “I’m not fully convinced

they can't take action in a way that's commensurate with the action taken at the state level."

Senator Charles E. Schumer, Democrat of New York, introduced federal legislation in February to classify bath salts as controlled Schedule I substances, but it remains in committee.

Meanwhile, the drugs remain widely available on the Internet, and experts say the state bans can be thwarted by chemists who need change only one molecule in salts to make them legal again.

And while some states with bans have seen fewer episodes involving bath salts, others where they remain fully legal, like Arizona, are starting to see a surge of cases.

Dr. Frank LoVecchio, an emergency room doctor at Banner Good Samaritan Medical Center in Phoenix, said he had to administer general anesthesia in recent weeks to bath salt users so agitated that they did not respond to large doses of sedatives.

Dr. Justin Strittmatter, an emergency room doctor at the Gulf Coast Medical Center in Panama City, Fla., said he had treated one man whose temperature had shot up to 107.5 degrees after snorting bath salts. "You could fry an egg on his forehead," Dr. Strittmatter said.

Other doctors described dangerously elevated blood pressure and heart rates and people so agitated that their muscles started to break down, releasing chemicals that led to kidney failure.

Mark Ryan, the director of the Louisiana Poison Center, said some doctors had turned to powerful antipsychotics to calm users after sedatives failed. "If you take the worst attributes of meth, coke, PCP, LSD and ecstasy and put them together," he said, "that's what we're seeing sometimes."

Dr. Ryan added, "Some people who used it back in November or December, their family members say they're still experiencing noticeable paranoid tendencies that they did not have prior."

Before hitting this country, bath salts swept Britain, which banned them in April 2010. Experts say much of the supply is coming from China and India, where chemical manufacturers have less government oversight.

They are labeled "not for human consumption," which helps them skirt the federal Analog Act,

under which any substance “substantially similar” to a banned drug is deemed illegal if it is intended for consumption.

Last month, the drug agency made its first arrests involving bath salts under the Analog Act through a special task force in New York. Undercover agents bought bath salts from stores in Manhattan and Brooklyn, where clerks discussed how to ingest them and boasted that they would not show up on a drug test.

“We were sending out a message that if you’re going to sell these bath salts, it’s a violation and we will be looking at you,” said John P. Gilbride, special agent in charge of the New York field division of the D.E.A.

The authorities in Alton, Ill., are looking at the Analog Act as they prepare to file criminal charges in the death of a woman who overdosed on bath salts bought at a liquor store in April.

“We think we can prove that these folks were selling it across the counter for the purposes of humans getting high,” said Chief David Hayes of the Alton police.

Chief Hayes and other law enforcement officials said they had been shocked by how quickly bath salts turned into a major problem. “I have never seen a drug that took off as fast as this one,” Chief Hayes said. Others said some people on the drugs could not be subdued with pepper spray or even Tasers.

Chief Joseph H. Murton of the Pottsville police said the number of bath salt cases had dropped significantly since the city banned the drugs last month. But before the ban, he said, the episodes were overwhelming the police and two local hospitals.

“We had two instances in particular where they were acting out in a very violent manner and they were Tasered and it had no effect,” he said. “One was only a small female, but it took four officers to hold her down, along with two orderlies. That’s how out of control she was.”

*This article has been revised to reflect the following correction:*

***Correction: July 24, 2011***

*An article last Sunday about a new stimulant known as “bath salts” erroneously included, in some editions, a drug among those that are Schedule I, a governmental classification that the Drug*

*Enforcement Administration is considering for mephedrone and methylenedioxypropylone, the manmade chemicals found in bath salts. Cocaine is a Schedule II drug, which can be prescribed for medicinal purposes. (Schedule I drugs cannot be prescribed.)*

## **'Bath Salts' Drug Trend: Expert Q&A**

### **Why 'bath salts' are dangerous, though not illegal in all states.**

(From [www.webmd.com](http://www.webmd.com))

*Editor's note: On Sept. 7, 2011, the U.S. Drug Enforcement Administration (DEA) invoked its "emergency scheduling authority" to control three synthetic stimulants -- mephedrone, MDPV, and methylene -- commonly called "bath salts" or "plant food" and marketed under such names as "Ivory Wave," "Purple Wave," "Vanilla Sky," and "Bliss." The DEA plans to make possessing and selling these chemicals, or products that contain them, illegal in the United States. The emergency action will remain in effect for at least a year, during which time the government is expected to call for permanent control of the drugs.*

A new designer drug known as "bath salts" has become increasingly popular and increasingly scary. Poison centers across the U.S. have reported growing numbers of calls about the synthetic stimulant, and more and more states are banning the drug. But as of now, there is no federal law prohibiting their sale.

Make no mistake: These are not bath salts like those you would use in your bath.

WebMD talked to Zane Horowitz, MD, an emergency room physician and medical director of the Oregon Poison Center, about what they are and why you should avoid them.

#### **First of all, what are bath salts?**

"The presumption is that most bath salts are MDPV, or methylenedioxypropylvalerone, although newer pyrovalerone derivatives are being made by illegal street chemists. Nobody really knows, because there is no way to test for these substances," Horowitz says.

#### **Why are they called bath salts?**

"It's confusing. Is this what we put in our bathtubs, like Epsom salts? No. But by marketing them as bath salts and labeling them 'not for human consumption,' they have been able to avoid them being specifically enumerated as illegal," Horowitz says.

#### **Are bath salts illegal?**

"You can find them in mini-marts and smoke shops sold as Ivory Wave, Bolivian Bath, and other names," Horowitz says. "The people who make these things have skirted the laws that make these types of things illegal. While several states have banned the sale of bath salts, ultimately it will have to be a federal law that labels these as a schedule 1 drug, which means it has no medicinal value but a high potential for abuse, and declare them illegal."

#### **What do you experience when you take bath salts?**

"Agitation, paranoia, hallucinations, chest pain, suicidality. It's a very scary stimulant that is out there. We get high blood pressure and increased pulse, but there's something more, something different that's causing these other extreme effects. But right now, there's no test to pick up this drug. The only way we know if someone has taken them is if they tell you they have.

The clinical presentation is similar to mephedrone [a chemical found in other designer drugs], with agitation, psychosis, and stimulatory effects. Both of these agents should be of concern, as severe agitated behavior, like an amphetamine overdose, has occurred.

A second concern is the ongoing suicidality in these patients, even after the stimulatory effects of the drugs have worn off. At least for MDPV, there have been a few highly publicized suicides a few days after their use," Horowitz says.

**Are bath salts addictive? How are they taken?**

"We don't know if they are addictive. We have not had enough long-term experience with it. Acute toxicity is the main problem. But many stimulants do cause a craving. The people who take them are very creative. They snort it, shoot it, mix it with food and drink," Horowitz says.

**Bath salts are the latest example of designer drugs. Where do you see this trend going?**

"That's right. They are part of a long line of other pills and substances that we call designer drugs. And drug makers will keep creating new combinations at home and in illicit labs," Horowitz says. "It's almost impossible to keep up. And the motivation for buying them is always the same: Drugs like these are new and below the radar, unlike named illegal drugs."

## **FAQ: K2, Spice Gold, and Herbal 'Incense'**

### **Legal Herbal Products Laced With Designer Drugs: Not Your Father's Marijuana**

(From [www.webmd.com](http://www.webmd.com))

*Editor's note: On March 1, 2011, the U.S. Drug Enforcement Administration invoked its "emergency scheduling authority" to make most "legal high" products illegal. The relatively inactive herbs used in these products are spiked with potent designer drugs. The DEA action applies to five of these drugs: JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol. The drugs are now on the DEA's Schedule I, meaning they have no accepted medical use and high potential for abuse. The emergency action will remain in effect for a year, during which time the government is expected to call for permanent control of the drugs.*

March 5, 2010 -- K2, Spice Gold, and dozens of other currently legal "herbal incense" products are spiked with powerful designer drugs -- and they don't show up in drug tests.

As early as 2004, this type of product began appearing for sale on the Internet and in head shops in Europe. By 2008, sales throughout Europe soared; U.S. and Canada sales took off in 2009.

"I believe it is everywhere in the United States," Marilyn Huestis, PhD, chief of chemistry and drug metabolism at the National Institute for Drug Abuse, tells WebMD.

Package labels feature psychedelic art and claim that the contents are a mixture of various herbs. But unlike smoking the herbs listed on the label, smoking the products produces effects similar to those of marijuana, hashish, and other forms of cannabis.

"Hospitals in Europe began to report instances where a person appeared with all the symptoms of cannabis intoxication, but their drug screen was negative," Huestis says.

Users, parents, public health officers, and enforcement agencies all want to know: What really is in these products? How safe are they? Are they addictive?

Here are WebMD's answers to these and other FAQs.

#### **What drugs are in K2, Spice Gold, and other herbal incense products?**

Initial tests of Spice Gold and similar products found no illegal substances and were not able to detect active ingredients that could explain the "high" they produced in users. The tests also were unable to detect most of the herbs the products were supposed to contain.

Finally, in late 2008, Volker Auwarter, ScD, and colleagues in the forensic toxicology lab at the University Hospital Freiburg, Germany, found that the products contained at least two different designer drugs known as synthetic cannabinoids.

The drugs detected by Auwarter had the same chemical signal as drugs detected -- but not identified -- in samples of Spice brand product tested privately by the user-oriented Erowid drug information web site in 2007.

Like THC, the active ingredient in marijuana and other forms of cannabis, these synthetic cannabinoids turn on the cannabinoid receptors found on many cells in the body. The brain is particularly rich in the CB1 cannabinoid receptor.

But most synthetic cannabinoids are quite different chemical structures from THC. And unlike cannabis, the new drugs have never been tested in humans.

One of these synthetic cannabinoids, JWH-018, was first made in 1995 for experimental purposes in the lab of Clemson University researcher John W. Huffman, PhD.

"In terms of biological activity, these things are similar to THC, the active compound in cannabis," Huffman tells WebMD. "Now the thing is, nobody knows anything about how these new compounds act in the human body. Anecdotal reports say they stick around in the body for quite a long time."

More than 100 different synthetic cannabinoids have been created. In his 2008 study, Auwarter tested seven of the herbal products and found they contained different levels of JWH-018, a synthetic cannabinoid created by Pfizer called CP-47,497, or both.

Since then, Auwarter has found five different synthetic cannabinoids in the products. Huestis estimates that about 10 different synthetic cannabinoids have been detected in the products, usually in some combination.

#### **Are K2, Spice Gold, and other herbal incense products safe?**

No. Until a drug is tested, it cannot be considered safe. Not only have synthetic cannabinoids not been tested, nearly all were created for experimental use in animals and cell cultures -- not in humans.

And there are good reasons to believe that some if not all of these drugs are unsafe. JWH-018 and its many cousins, for example, have a chemical structure shared with known cancer-causing agents.

JWH-018 inventor John W. Huffman, PhD, puts it bluntly.

"It is like Russian roulette to use these drugs. We don't know a darn thing about them for real," he tells WebMD.

Most of these drugs were created because they bind much more tightly to the body's cannabinoid receptors than THC does. THC, in fact, only partially binds to these important regulators of body function. Many of the synthetic cannabinoids fully activate the receptors.

"When you take these drugs, you are hijacking the part of the brain important for many functions: temperature control, food intake, perception, memory, and problem solving," Huestis says. "And people taking these high-potency drugs are affecting other important functions throughout their bodies -- hormone functions, for example."

Moreover, cannabinoids also bind CB2, the cannabinoid receptor that helps regulate the immune system.

Finally, all of the effects of these drugs may not become apparent for a long time. That's because they are stored in the body for a long period of time.

"The fact is these drugs have not been tested in humans, and we don't know what they could do," Huestis says. "There may be acute toxicity; there may be long-term toxicity. We don't know any of that."

And here's another alarming thing that isn't known. Tests show that even the same brand of one of these products may have different drugs -- in different amounts -- at different times. Since the synthetic cannabinoids are very powerful, even a small increase in dose can have much more powerful side effects.

And since these products are not regulated drugs, there's no way to know how big a dose you're getting. No drug is safe if you don't know what it is and how much of it you're taking.

### **What happens when a person smokes K2, Spice Gold, or other herbal incense products?**

Before trying to find out what was in the herbal incense products, Auwarter wanted to know whether the products really had any activity.

So he took what is these days a very unusual step: He and a colleague tested the products on themselves.

They took a packet of a product called Spice Diamond and rolled 300 milligrams -- a tenth of the package -- into a cigarette paper. The two men shared the cigarette, so each consumed only a small dose of about 150 milligrams.

"Nothing happened in the first five minutes. I was just about to roll the next one and suddenly the effects came quite quickly," Auwarter tells WebMD. "I had massive reddening of the eyes, and a very dry mouth. My heart rate doubled, from 60 to 120 beats per minute. And the feeling of intoxication was like the experience reported by cannabis users."

Auwarer's heart pounded away for the six hours it took for the drug's acute effects to wear off. He did not sleep well that night and felt a slight hangover the next day.

Huffman tells a much scarier story. He says he'd never take the drugs himself, but he recently received an email from a worried parent whose daughter was given something to smoke at a party.

"She thought it was pot, but it was K2," Huffman says. "She was still having effects a week later. And a toxicologist at St. Louis University came by a week ago and said there are all kinds of reports of people having heart rates like 150 and blood pressure shooting up to 200 over 100. That is dangerous."

### **Are K2, Spice Gold, and other herbal incense products addictive?**

Apparently so. Last year, German researchers reported the case of a 20-year-old man who had been using the Spice Gold product daily for eight months.

Not long after starting the product, the man found that he needed larger and larger doses to feel an effect. He quickly increased his use to 3 grams per day -- 10 times the dose that produced the effects described by Auwarter.

The man felt a continuous need for the product. He was unable to get it for a period of time and experienced unrest, drug craving, nightmares, sweating, nausea, tremor, headache, high blood pressure, and racing heartbeat. This went away when he again began using the product.

Finally, the man was persuaded to stop using the product. But fearing a repeat of his earlier experience, he checked into a hospital. Sure enough, he again went through classic withdrawal symptoms that lasted a week.

This clinical description fits with reports that Auwarter has received. He says that while classic drug dependence is rare among cannabis users, it may be much more common among users of synthetic cannabinoids.

**Do drug tests detect K2, Spice Gold, and other herbal incense products?**

Not yet. Huffman says he heard from the director of a very strict boys' school that gives weekly drug tests to pupils. Despite finding that some of the boys were smoking K2, none of them tested positive on the drug screens.

Auwarter says his team is close to developing a urine test for some of the synthetic cannabinoids. But today, the only way to identify the compounds is via a blood test -- and that has to be performed before the effects of the drug wear off.

**Are K2, Spice Gold, and other herbal incense products legal?**

Because the synthetic cannabinoids found in these products are new, they remain legal in many states. Many European nations already have banned some or all of the products.

Kansas was the first state to pass a law banning sale of the products; similar laws have been proposed in Missouri, Tennessee, and several other states.

However, dozens of web sites continue to offer the products for sale.

## **Bath Salts** (from [www.abovetheinfluence.com](http://www.abovetheinfluence.com))

Though the name may sound harmless, bath salts are a dangerous synthetic stimulant that carry the risk of easy overdose, hallucinations and even death.

### **AKA**

Brand names include Blizzard, Blue Silk, Charge+, Ivory Snow, Ivory Wave, Ocean Burst, Pure Ivory, Purple Wave, Snow Leopard, Stardust, Vanilla Sky, White Dove, White Knight and White Lightning.

### **What is it?**

A synthetic, stimulant powder product that contains amphetamine-like chemicals, including mephedrone, which may have a high risk for overdose. Because the drug is new and some of the contents unknown, using it in any way is highly dangerous. Right now, bath salts are illegal in a growing number of U.S. states, as well as foreign countries like Canada, Australia and Great Britain.

### **The Risks**

Between January and February 2011, there were over 250 calls to U.S. poison centers related to bath salts. This is well over the 236 calls received for all of 2010. Bath salts are a dangerous drug whose full risks and effects are still unknown. What doctors at poison centers have reported is that bath salts can cause rapid heartbeat, high blood pressure, chest pains, agitation, hallucinations, extreme paranoia and delusions.

### **Long-Term Effects**

Bath salts are a relatively new drug, so it's hard to know the full long-term effects, but they seem to have many similarities to methamphetamine (meth). Taking a lot of it for a long time can lead to emotional and physical "crash-like" feelings of depression, anxiety and intense cravings for more of the drug.

### **The Bottom Line**

Since it contains amphetamine-like chemicals, bath salts will always carry the risk of stroke, heart attack and sudden death. It may be legal in some states, but so is rat poison, and you probably wouldn't want to ingest that either.

## Community Anti-Drug Coalitions of America (CADCA)

**Summary of Article Abstract.** New research by scientists at the National Institute on Drug Abuse indicates that, just like MDMA (Ecstasy), the active compounds in “bath salts” — mephedrone and methylone — bind to monoamine transporters on the surface of some neurons. This, in turn, leads to an increase in the brain chemicals serotonin, and, to a lesser extent dopamine, suggesting a mechanism that could underlie the addictive potential of these compounds. The study was published last week in *Neuropsychopharmacology*.

The Designer Methcathinone Analogs, Mephedrone and Methylone, are Substrates for Monoamine Transporters in Brain Tissue. In *Neuropsychopharmacology*, (14 December 2011)

Authors: Michael H Baumann, Mario A Ayestas, John S Partilla, Jacqueline R Sink, Alexander T Shulgin, Paul F Daley, Simon D Brandt, Richard B Rothman, Arnold E Ruoho and Nicholas V Cozzi

**Abstract.** The nonmedical use of ‘designer’ cathinone analogs, such as 4-methylmethcathinone (mephedrone) and 3,4-methylenedioxymethcathinone (methylone), is increasing worldwide, yet little information is available regarding the mechanism of action for these drugs. Here, we employed *in vitro* and *in vivo* methods to compare neurobiological effects of mephedrone and methylone with those produced by the structurally related compounds, 3,4-methylenedioxymethamphetamine (MDMA) and methamphetamine. *In vitro* release assays using rat brain synaptosomes revealed that mephedrone and methylone are nonselective substrates for plasma membrane monoamine transporters, similar to MDMA in potency and selectivity. *In vivo* microdialysis in rat nucleus accumbens showed that *i.v.* administration of 0.3 and 1.0mg/kg of mephedrone or methylone produces dose-related increases in extracellular dopamine and serotonin (5-HT), with the magnitude of effect on 5-HT being greater. Both methcathinone analogs were weak motor stimulants when compared with methamphetamine. Repeated administrations of mephedrone or methylone (3.0 and 10.0mg/kg, *s.c.*, 3 doses) caused hyperthermia but no long-term change in cortical or striatal amines, whereas similar treatment with MDMA (2.5 and 7.5mg/kg, *s.c.*, 3 doses) evoked robust hyperthermia and persistent depletion of cortical and striatal 5-HT. Our data demonstrate that designer methcathinone analogs are substrates for monoamine transporters, with a profile of transmitter-releasing activity comparable to MDMA. Dopaminergic effects of mephedrone and methylone may contribute to their addictive potential, but this hypothesis awaits confirmation. Given the widespread use of mephedrone and methylone, determining the consequences of repeated drug exposure warrants further study.

## **National Institute on Drug Abuse**

### **Message from the Director on "Bath Salts" - Emerging and Dangerous Products**

"Bath Salts", the newest fad to hit the shelves (virtual and real), is the latest addition to a growing list of items that young people can obtain to get high. The synthetic powder is sold legally online and in drug paraphernalia stores under a variety of names, such as "Ivory Wave," "Purple Wave," "Red Dove," "Blue Silk," "Zoom," "Bloom," "Cloud Nine," "Ocean Snow," "Lunar Wave," "Vanilla Sky," "White Lightning," "Scarface," and "Hurricane Charlie." Because these products are relatively new to the drug abuse scene, our knowledge about their precise chemical composition and short- and long-term effects is limited, yet the information we do have is worrisome and warrants a proactive stance to understand and minimize any potential dangers to the health of the public.

We know, for example, that these products often contain various amphetamine-like chemicals, such as methylenedioxypropylamphetamine (MDPV), mephedrone and pyrovalerone. These drugs are typically administered orally, by inhalation, or by injection, with the worst outcomes apparently associated with snorting or intravenous administration. Mephedrone is of particular concern because, according to the United Kingdom experience, it presents a high risk for overdose. These chemicals act in the brain like stimulant drugs (indeed they are sometimes touted as cocaine substitutes); thus they present a high abuse and addiction liability. Consistent with this notion, these products have been reported to trigger intense cravings not unlike those experienced by methamphetamine users, and clinical reports from other countries appear to corroborate their addictiveness. They can also confer a high risk for other medical adverse effects. Some of these may be linked to the fact that, beyond their known psychoactive ingredients, the contents of "bath salts" are largely unknown, which makes the practice of abusing them, by any route, that much more dangerous.

Unfortunately, "bath salts" have already been linked to an alarming number of ER visits across the country. Doctors and clinicians at U.S. poison centers have indicated that ingesting or snorting "bath salts" containing synthetic stimulants can cause chest pains, increased blood pressure, increased heart rate, agitation, hallucinations, extreme paranoia, and delusions. It is noteworthy that, even though we are barely two months into 2011, there have been 251 calls related to "bath salts" to poison control centers so far this year. This number already exceeds the 236 calls received by poison control centers for all of 2010. In response to this emerging threat, several states, including Hawaii, Michigan, Louisiana, Kentucky, and North Dakota, have introduced legislation to ban these products, which are incidentally labeled as "not fit for human consumption." In addition, several counties, cities, and local municipalities have also taken action to ban these products.

We will continue to monitor the situation and promote research on the extent, pharmacology, and consequences of "bath salts" abuse. In the meantime, I would like to urge parents, teachers, and the public at large to be aware of the potential dangers associated with the use of these drugs and to exercise a judicious level of vigilance that will help us deal with this problem most effectively.

Sincerely,

***Nora D. Volkow, M.D., Director***  
National Institute on Drug Abuse  
March 2011

## **Bath Salts Abuse and Use** (from [www.burningtree.com](http://www.burningtree.com))

### **Use and Availability of “Bath Salts”**

A new, highly addictive designer drug labeled “Bath Salts” contains Mephedrone and MDPV (Methylenedioxypropylvalerone). Mephedrone and MDPV are stimulants that act much like Methamphetamine and Cocaine, but produce the added effect of hallucinations. “Bath Salts” are known by many names such as Ivory Wave, Bliss, White Lightning, Hurricane Charlie, Vanilla Sky, Charge, and White Knight. “Bath Salts” are snorted, injected, or smoked primarily by teens and young adults due to their widespread availability on the Internet, local convenience stores, and smoke shops. The product is carefully labeled as not for human consumption, but that is precisely why drug manufacturers have placed this extremely toxic substance on the market.

### **Major Side Effects of Using “Bath Salts” for Drug Use**

“Bath Salts” are known to produce side effects similar to Meth and Cocaine such as elevated heart rate, hypertension, irritability, extreme paranoia, delusions of super-human strength and invincibility, hallucinations, suicide, aggressive and violent behavior, and possibly even murder.

### **Addictive Properties of Bath Salts**

“Bath Salts” are so addicting that users crave the drug even after experiencing a trip to the Emergency Room with psychotic episodes brought on by hallucinations and delusions of super-human strength. Unlike Meth and Cocaine, however, standard Emergency Room procedures for treating Meth and Cocaine overdose do not work well with “Bath Salts.” Administering Valium to patients suffering from the toxic effects of “Bath Salts” does not result in positive responses to treatment.

### **Dangers of Using “Bath Salts” for Drug Use**

Standard hospital treatment for drug overdose does not work effectively on “Bath Salts.” Even when patients come off of sedation, behavior has been shown to revert back to the uncontrollable state of psychosis. As a warning to young people experimenting with this drug, the effects of “Bath Salts” may be permanent. Cases of violent suicide are numerous and growing fatalities are reported to Poison Control authorities. For all intents and purposes, this drug is extremely toxic and may result in permanent brain damage. The chemical ingredients found in “Bath Salts” are also found in various forms of insecticide, as well as chemical treatment programs designed to kill aqueous algae and fungus. Further research is required in order to determine the long-term effects of using this drug and how to effectively sedate patients suffering from toxic psychotic states.

Article rank 15 Dec 2011 USA TODAY US Edition By Donna Leinwand Leger USA TODAY

# More teens using synthetic drugs

## Survey also finds tobacco, alcohol use takes big dip

Large numbers of high school seniors are getting high on synthetic forms of marijuana, which remain easy to get even after federal officials banned them this year.

About one in nine high school seniors, 11.4%, used synthetic drugs such as "K2" or "Spice" in the past year, second only to the number who used marijuana, according to "Monitoring the Future," the nation's most comprehensive survey of teen drug use.

The survey, out Wednesday, also found that tobacco and alcohol use are at their lowest levels since it began in 1975. "Kids consider smoking to be dangerous. They aren't even trying it," says Lloyd Johnston, the survey's principal investigator.

Much of the survey was done before March, when the Drug Enforcement Administration issued an emergency ban of the chemicals used to make synthetic marijuana, but the drugs remain popular. The American Association of Poison Control Centers reports 6,348 calls about synthetic drugs in the first 11 months of 2011, more than double the 2,915 calls received in all of 2010.

"You can get them right off the Internet," says Mark Ryan of the Louisiana Poison Center.

The chemical-coated herbs, often marketed as potpourri or herbal incense, are stamped with a warning against human consumption to avoid running afoul of the law. When police crack down, suppliers change the labels and the ingredients, Ryan says.

People who smoke the herbs may experience euphoria, but dangerous reactions are common, including convulsions, anxiety attacks, elevated heart rates and suicidal thoughts.

Teens may gravitate toward synthetic drugs because they are cheaper than marijuana, Johnston says. Most teens who smoke Spice or K2 report using other illicit drugs, he says. Researchers asked about the synthetic drugs for the first time this year.

Marijuana remains the most popular drug among teens. Nearly 7% of seniors report smoking it almost daily. "It's the highest rate we've seen in 30 years," Johnston says.

Gil Kerlikowske, director of the White House Office on National Drug Policy, blames legalization by some states of marijuana for medical use. "We're sending young people the wrong message when we call it medicine," he says.

Proponents of legalizing marijuana say decreases in smoking and drinking show that regulation and education are the best ways to combat teen drug abuse. "It's hard to get beer because it's regulated and licensed, where marijuana is not," says Bill Piper of the Drug Policy Alliance.

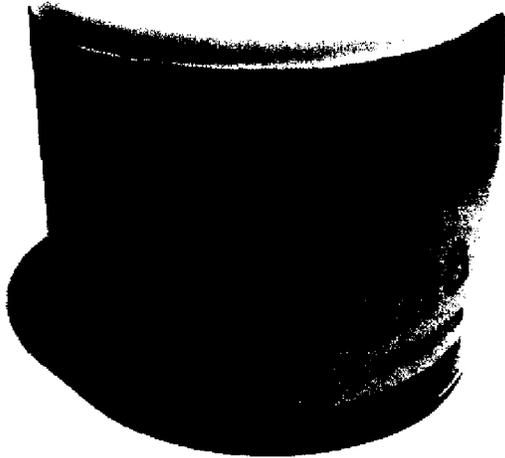
The survey, sponsored by the federal government and conducted by the University of Michigan, is of 47,000 eighth-, 10th- and 12th-graders.

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## Ads from Commercial Purveyors of Bath Salts

Bath Salt Of The Week: Fine China  
October 8th, 2011

### **50 STATE LEGAL**



This is a new personal favorite of mine; Fine China. With all the recent federal and state bans on the common ingredients, it has become harder and harder to find an ENJOYABLE 50 state legal salt.

After vigorously searching different websites for new blends that actually packed a punch, I made an order for this stuff on [k2incenseonline.com](http://k2incenseonline.com) and was amazed when my package arrived in only a few days! I tried Fine China and a few others, but this stuff blew the others out of the water. Minimal burn which goes away almost instantly, which is always an absolute selling point for me.

Fine China delivers a perfect blend of euphoria and energy, with even the smallest amount! I bought the 500mg size and still have almost half left after extensive testing.

This is by far one of the most superior 50 state legal blends on the internet, so if you are in a state with strict laws, get some 50 state legal Fine China!



If you have tried any of the previous Drone blends, then you know that it is one of the best brands out there. But now they have come out with their newest 50 state legal blend, Drone IV Plus.

This stuff knocks the socks off of any of the other new 50 state legal blends – Drone IV Plus is the best, hands down! The old Drone and Drone IV blends are great if you can still get them in your state. If not, then I highly recommend that you try Drone IV Plus!

Currently legal in EVERY state – and in my opinion is more powerful than Drone IV! Try some today.

## Exhibit E

Revisions to Tooele City Code  
§7-16-3 and §7-16-6

USE	DISTRICT							RD Research / Development
	MU-B Mixed Use- Broadway	MU-G Mixed Use- General	NC Neighborhood Commercial (Maximum individual lot Size 15,000 square feet)	GC General Commercial	RC Regional Commercial	LI Light Industrial	I Industrial	
Retail sales accessory to an allowed use				P	P	P	P	P
Retail Store (located within an existing structure)	C	C	C	P	P			
Retail Store (Total maximum 3,000 square footage)	C	C	C	P		P		P
Retail Store or Commercial Center				C				
Retail Store or Commercial Center (Minimum 120,000 building square foot and planned and phased by approval of a Master Development Site Plan)					C			
Retirement Center	C	C						
Rock, Sand and Gravel Storage and Distribution							P	
Sexually Oriented Business							P	
Shooting Range, Indoor				C		C	C	C
Social Detoxification Facility and Program	C	C		C	C			
Telecommunications Site/Facility						C	C	C
Temporary Construction Office	C	C	C	P	P	P	P	P
Temporary Use	C	C	C	P	P	P	P	
Tobacco Specialty Store (see Note #5)				C	C	P	P	C
Utility Service Facility (major)				C	C	C	C	C
Utility Service Facility (minor)			C	C	C	C	C	

USE	DISTRICT							RD Research / Development
	MU-B Mixed Use- Broadway	MU-G Mixed Use- General	NC Neighborhood Commercial (Maximum individual lot Size 15,000 square feet)	GC General Commercial 1	RC Regional Commercial	LI Light Industrial	I Industrial	
Veterinary Clinic / Animal Hospital						P	P	
Veterinary Clinic/ Animal Hospital operating entirely within an enclosed building	C	C		P		P	P	P
Warehouse						C	P	

P = PERMITTED USE

C = CONDITIONAL USE

ANY USE NOT IDENTIFIED AS EITHER A PERMITTED (P) OR CONDITIONAL (C) USE IS USE THAT IS A PROHIBITED USE WITHIN THE ZONING DISTRICT

ANY USE NOT IDENTIFIED IN THE TABLE OF USES IS A PROHIBITED USE IN TOOELE CITY.

**NOTES:**

1. With the exception of detached single family dwellings, all dwellings in the MU (Mixed Use) zoning district must comply with the regulations and requirements, as amended, of the HDR (High Density Residential) zoning district, or its equivalent replacement, contained in Chapter 7-14, Tables 2, 3, and 4.
2. Any Use allowed in a District and proposing, or requiring any area for Accessory Outside Storage, for any purpose, such use and outside storage area shall be considered as a Conditional Use. All Accessory Outside Storage is prohibited in the Mixed Use (MU) District and the Neighborhood Commercial (NC) District.
3. Any Use allowed in a District and proposing, or requiring a "Accessory Drive Through Facility" such Drive through Facility shall be considered as a Conditional Use. All Accessory Drive Through Facilities are prohibited in the Mixed Use (MU) District and the Neighborhood Commercial (NC) District.
4. Any Use allowed in a District and proposing any Accessory Outside display and sales area, such Accessory Outside Display and Sales use and area shall be considered as a Conditional Use for any Uses allowed in the District. Accessory Outside Display and Storage is prohibited in the Mixed Use (MU) District, Neighborhood Commercial (NC) District and the Research and Development (RD) District.
5. This use is not permitted if any part of the proposed or existing building containing the use is located within 1,500 feet from (a) any school (public or private kindergarten, elementary, middle, charter, junior high, or high school), public park, public recreational facility, youth center, library, or church; (b) any other Tobacco Specialty Store; (c) any residential use or residential zoning boundary, including mixed-use zones; or (d) on Vine Street. Distances shall be measured in a straight line, without regard to intervening structures or zoning districts, from a Tobacco Specialty Store structure to the property line of a school, public park, library, church, youth center, cultural activity, residential use, zoning district boundary, or other Tobacco Specialty Store.

(Ord. 2010-16, 10-06-10); (Ord. 2008-09, 11-05-08); (Ord. 2006-18, 09-13-06); (Ord. 2006-16, 07-19-06); (Ord. 2006-10, 06-21-06); (Ord. 2003-08, 03-19-03); (Ord. 2003-02, 01-08-03); (Ord. 2003-01, 01-08-03); (Ord. 2002-21, 09-18-2002); (Ord. 99-08, 04-06-99); (Ord. 99-06, 04-06-99); (Ord. 99-05, 04-06-99); (Ord. 98-40, 12-16-98)

research and development work.

(87) Residential Facility for Elderly Persons - A single-family dwelling unit or multi-family dwelling unit which does not operate as a business provided, however, that a facility shall not be considered a business solely because a fee is charged for food or for actual and necessary cost of operation and maintenance of the facility; and

(a) is owned by one of the residents or by an immediate family member of one of the residents or be a facility in which the title has been placed in trust for a resident;

(b) is consistent with all the requirements as contained herein and the requirements of the Utah Code, (§10-9 et.seq. (U.C.A.), and

(c) is occupied on a 24-hour-per-day basis by eight (8) or fewer elderly person in a family type arrangement.

(88) The term "residential facility for the elderly" does not include a health care facility.:

(a) A Residential facility for Elderly Persons shall not be considered a business because a fee is charged for food or for actual and necessary costs of operation and maintenance of the facility.

(89) Residential Facility for Persons with Disability - A single-family dwelling unit or multi-family dwelling unit:

(a) in which more than one (1) person with a disability resides; and

(b) is occupied on a 24-hour-per-day basis by eight (8) or fewer persons with a disability in a family type arrangement.

(c) is licensed or certified by the State of Utah Department of Human Services under Title 62A, Chapter 2, Licensure of Programs and Facilities, and conforms to all applicable standards and requirements of the Department of Human Service and the requirements of the Utah Code, (§10-9 et.seq. (U.C.A.).

(90) Restaurant - A building in which food is prepared and served for consumption within the premises. Typical uses include buffets; cafes; cafeterias; coffee shops; diners; dining rooms; dinner theaters and snack shops.

(91) Retail Store - An establishment for the retail sale of merchandise. Retail store includes but is not limited to antique or art shops, clothing, department, drug, dry good, florist, furniture, gift, grocery, hardware, hobby, office supply, paint, pet, shoe, sporting, or toy stores.

(92) Retirement Center - Any age-restricted development, developed, designed for, and marketed to adults at or near retirement age, which may be in any housing form including detached and attached dwelling units, apartments, and residences, offering private and semi-private rooms. Retirement Center dwelling units are limited to a minimum size of 590 square feet for a one-bedroom dwelling unit, 700 square feet for a two-bedroom dwelling unit, and 850 square feet for a three-bedroom dwelling unit. Buildings fully constructed prior to the effective date of Tooele City Ordinance 2002-21 shall be exempt from the regular height restriction.

(93) Rock, Sand and Gravel Storage and Distribution - The outdoor storage and sale of rock, sand and gravel in bulk quantities and the storage on-site of necessary loading equipment, facilities and vehicles.

(94) Shooting Range, Indoor - A structure used for archery and/or the discharging of any firearm for the purposes of target practice or temporary competitions.

(95) Social Detoxification program - a short term non medical treatment service for individuals unrelated to the owner or provider. A treatment program that provides psycho-social services and non-medical detoxification.

(96) Telecommunications Site/Facility - A facility used for the transmission or reception of electromagnetic or electro-optic information, which is placed on a structure. This use does not include radio frequency equipment which have an effective radiated power of 100 watts or less. This use is not required to be located on a building lot, or comply with the minimum lot size requirement for the district in which it is located.

(97) Temporary Construction or Sales Office - A facility temporarily used for a period, not to exceed 12 months, as a construction or sales office.

(98) Temporary Use - Fireworks stands, Christmas tree sale lots, and similar activities which are open to the public and scheduled to occur over a period not to exceed 40 days in any calendar year and including uses incidental to construction.

(99) Tobacco Specialty Store - An establishment providing retail sales and services which exclusively or primarily involve the sale of tobacco or tobacco-related products.

(100~~0~~) Utility Service Facility (major) - Any electric transmission lines (greater than 115,000 volts), power plants, or substations of electric utilities; gas regulator stations, transmission and gathering pipelines, and storage areas of utilities providing natural gas or petroleum derivatives; and their appurtenant facilities

(101~~0~~) Utility Service Facility (minor) - Any electrical distribution lines, natural gas distribution lines, cable television lines, telegraph and telephone lines, and gathering lines, or other minor service facilities. No buildings are allowed and the use is limited to the following sizes: (i) gas lines less than 12"; and (ii) electric lines of less than 115,000 volts.

(102~~0~~) Veterinary Clinic/Animal Hospital - A facility for the diagnosis, treatment, hospitalization, and boarding of animals, which does not include outdoor holding facilities.

(103~~0~~) Warehouse - A building used primarily for the inside storage of nonhazardous goods and materials and including accessory office facilities.

(Ord. 2011-17, 09-21-11); (Ord. 2010-16, 10-06-10); (Ord. 2008-09, 11-05-08); (Ord. 2006-10, 06-21-2006); (Ord. 2003-02, 01-08-03); (Ord. 2002-21, 09-18-2002); (Ord. 2001-31, 12-05-2001); (Ord. 2000-14, 08-02-2000); (Ord. 98-40, 12-16-98)

## Exhibit F

### Planning Commission Minutes

**DRAFT TOOELE CITY PLANNING COMMISSION MINUTES**  
**December 14, 2011**

Place: Tooele City Hall Council Chambers  
90 North Main Street, Tooele Utah

**Commission Members Present:**

John Curwen, Chair  
Melanie Hammer  
Bob Gowans  
Ken Spence  
Phil Montano  
Matt Robinson  
Steve Dale  
Fran Garcia  
Chris Sloan

**City Employees Present:**

Rachelle Custer, City Planner  
Cary Campbell, Public Works Director  
Roger Baker, City Attorney

Chairman Curwen called the meeting to order at 7:00 p.m.

1. **Pledge of Allegiance**

The Pledge of Allegiance was led by Commissioner Spence.

2. **PUBLIC HEARING and MOTION on conditional use permit to construct a 1,405 sq. ft., 19 ft. tall detached garage to be located at 144 N 4<sup>th</sup> St by Roger Grimsley.**

Rachelle Custer

Ms. Custer explained that Mr. Grimsley is requesting a conditional use permit (CUP) for a 1,405 sq. ft. garage which is under the 35% total lot coverage. However, in the code today there is still a 25% rear lot coverage allowance which the staff is proposing to possibly change so they are asking that this garage be approved up to 13% lot coverage. Mr. Grimsley will decrease the garage to 1,240 sq. ft. to be in compliance if the 25% rear lot coverage does not change. Mrs. Custer also stated that anything over 15' in height on an accessory structure requires a conditional use permit. Mr. Grimsley has a lift and an RV that he would like to put in the garage and is requesting a 19' tall garage. Staff recommends approval of this conditional use permit with the following conditions: 1) the building is to be for personal use only; not to be used for any business purposes, and 2) any lighting placed on the building be directed down onto site.

Ms. Custer said that the applicant asked for 8:00 a.m. to 6:00 p.m. The City's standard hours for daycare is 6:00 a.m. to 6:30 p.m. Staff left it at the standard if she chooses to expand her hours.

**Commissioner Spence moved to approve the conditional use permit for an in home daycare to be located at 782 Valley View Drive with the following conditions:**

- 1. No more than 8 children at one time.**
- 2. Hours of operation to be between 6:00 a.m. and 6:30 p.m. Monday through Friday.**
- 3. Fenced rear yard be provided for the children.**
- 4. State residential child care certificate be obtained.**
- 5. Tooele County health Department approval.**
- 6. Building inspection approval.**
- 7. Fire inspection approval**

Commissioner Robinson seconded the motion. All members present voted "Aye

- 7. PUBLIC HEARING and RECOMMENDATION on ordinance 2011-19. An ordinance of the Tooele City Council, amending Tooele City code 7-16-3 and 7-16-6 regarding land use regulation for tobacco specialty stores.**

Presented by Mr. Baker

Mr. Baker explained that the City Council has spoken with him regarding their concerns about mixing residential uses and public uses in close proximity with retail establishments that exclusively deal with tobacco and tobacco related products. They asked him to explore whether a zoning regulation could be crafted that would create a separation of those types of uses. He has drafted an ordinance regarding this issue. He has done research and found the negative effects of these types of concentrated establishments on vulnerable populations which include youth populations, and people that have intentions to quit. There is very recent research showing a link of negative secondary adverse effects created by having "Tobacco Specialty Stores" in close proximity to public uses and residential uses. Several of the academic institutions that are doing these studies are recommending precisely what the Council has asked him to look at which are zoning ordinances establishing minimum distance requirements for separating these uses. One of the studies recommended the 1,500 ft. distance. For a zoning ordinance to be legal, it has to have a legitimate public interest. The City Council will decide if it is legitimate or not. The Courts defer to local legislators on these types of issues. If it were to involve free speech and things like that it would be a much higher standard. He has attempted in the draft ordinance to lay out all the research so the City has a clear and legally defensible ordinance. The Planning Commission makes policy recommendations to the City Council so they can make the policy decisions.

Commissioner Gowans asked how this ordinance affects the new tobacco specialty store that just opened on Vine Street or the Vine Street Market and stores of that nature.

Mr. Baker said that this ordinance would not affect any existing specialty store or a general convenience store that has some tobacco products. In the future it would not affect retail establishments that sell a range of retail products including tobacco. This ordinance would only affect retail establishments that sell exclusively or almost exclusively tobacco related products.

Commissioner Gowans verified that a retail establishment like Vine Street Market or one like that would not be affected because they sell a range of products.

Mr. Baker said that this ordinance does not pertain to general retail establishments. This ordinance focuses on stores that emphasize these products because that is what the research focuses on (i.e., density). He was asked to look at establishments that deal only with this small sector or retail products.

Commissioner Spence asked what other municipalities have an ordinance of this nature.

Mr. Baker said that Sandy City is referenced in the ordinance. He hasn't done a lot of research on what other cities have ordinances. What is legally important isn't what other cities have done but how the City drafts their ordinance. He said that the Sandy ordinance is two pages and Tooele's is thirty. It is his job is to make sure that it will withstand court challenges.

Commissioner Montano asked Mr. Baker to explain the restrictions.

Mr. Baker referred the Commission to page 7-64.2 to footnote #5 which is the new foot note. The footnote reads: "*This use is not permitted if any part of the proposed or existing building containing the use is located within 1,500 feet from (a) any school (public or private kindergarten, elementary, middle, charter, junior high, or high school), public park, public recreational facility, youth center, library, or church, (b) any other tobacco Specialty Store, or (c) any residential use or residential zoning boundary, including mixed-use zones, or (d) on Vine Street.*" Mr. Baker said that it is unusual to call out a specific street in a zoning ordinance. He explains in the ordinance why he did that: because Vine Street is probably the most heavily walked street by school youth. That is precisely the population that they are most concerned about protecting from marketing. They have already seen marketing by the new smoke shop on Vine Street by people holding signs and walking against the youth traffic. (Which is illegal as well but that is another issue.) The 1,500 ft. measurement is a straight line.

Commissioner Dale asked if the smoke shops that exist today came in after this ordinance passed they would probably not be able to be located where they are now.

Mr. Baker said he has not done an analysis on that. He thinks that the Smoke-4-Less on the north end of town might be the appropriate distance away. The one on Vine Street and the one next to Little Ceasers would not be.

Commissioner Dale asked if any residential use would mean even one residential house.

Mr. Baker said yes, but most of the homes are in residential zones.

Commissioner Dale was wondering about the two homes on the north side of 1000 North.

Mr. Baker said they might be within 1,500 ft.

Commissioner Gowans questioned the smoke shop by Little Ceasers would not be 1,500 ft. away because of the residential homes behind it?

Mr. Baker said that is correct. It would not be allowed under this ordinance. They would be allowed in any industrial, light industrial, commercial zoning district that is 1,500 ft. away from residential neighborhoods.

Commissioner Robinson asked how Mr. Baker came up with the 1,500 ft.

Mr. Baker stated that 1,500 ft. was one of the controlled distances used in one of the studies. It was coincidental that the City Council asked him to look at 1,500 ft.

Commissioner Montano noted that Broadway is zoned commercial, but there are homes behind it and that would mean smoke shops would not be allowed?

Mr. Baker said that yes, smoke shops would not be allowed on Broadway. Broadway is a mixed use so even if they were 1,500 ft. away smoke shops would still not be allowed.

Commissioner Gowans asked what the area is zoned by the Community Learning Center?

Mr. Baker said that is a Research and Development zone.

Commissioner Dale said they would not be allowed there anyway because they are schools.

Commissioner Montano asked if a person came into Tooele and wanted to open a smoke shop where they could locate it.

Commissioner Hammer said you don't have to tell them. She has been in training meetings where they have said it is not the City's job to find a place for them.

Commissioner Montano said if someone wanted to open a smoke shop in Tooele they would have to go to the Depot or the northern end of Main Street.

Mr. Baker said that he has not done research on that issue. It is possible that you could open one on the northern end of Main Street and 1000 North area. You have to be far enough away from the mobile home park and the two homes on 1000 North. You could go anywhere north of the viaduct. You could go in an industrial or light industrial area.

He stated that this is a restrictive ordinance. He has not measured 1,500 ft. from any number of points to see where it would be possible or not possible to locate a smoke shop.

Chairman Curwen stated that this is a public hearing if anyone would like to come forward and address this issue.

Curtis Beckstrom, 443 East 700 North, addressed the Commission. He said that he has been concerned since the smoke shop opened on Vine Street. He asked about how many homes would be 1,500 ft. away? He was also concerned about the people out with signs.

Mr. Campbell said it would be about 20-22 lots.

Mr. Baker said that it is not legal to hold signs in front of the shops. The City has also talked to Little Ceasers about holding signs. They are treating everyone the same.

Mr. Beckstrom asked if there are any other limitations to what businesses can do in front of their stores.

Mr. Baker also said that businesses can't sell merchandise from the sidewalk.

**Commissioner Dale moved to close the public hearing.** Commissioner Gowans seconded the motion. All members present voted "Aye". The public hearing closed at 8:09 p.m.

**Commissioner Dale moved to make a positive recommendation to the City Council on ordinance 2011-19. An Ordinance of the Tooele City Council, amending Tooele City code 7-16-3 and 7-16-6 regarding land use regulations for tobacco specialty stores.** Commissioner Spence seconded the motion. All members except Commissioner Montano voted, "Aye".

Commissioner Dale thanked Mr. Baker for his research on this ordinance.

8. **Review and Approval of Planning Commission minutes for meeting held October 12, 2011.**

**Commissioner Robinson moved to approve the minutes as presented.** Commissioner Gowans seconded the motion. All members present voted "Aye".

9. **Adjourn**

**Commissioner Dale moved to adjourn the meeting.** Commissioner Spence seconded the motion. All members present voted "Aye". The meeting adjourned at 8:11 p.m.

Chairman Curwen thanked Commissioners Spence, Garcia and Gowans for their service; they are at the end of their terms.