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Tobacco Policies and On-Premise Smoking in Bars and Clubs that Cater to Young African Americans following the Maryland Clean Indoor Air Act of 2007

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Abstract

African American young adults age 18–25 smoke less than their white peers, yet the burden of tobacco-related illness is significantly higher in African Americans than whites across the lifespan. Little is known about how clean indoor air laws impact tobacco smoking among African American young adults. We conducted a systematic observation of bars and clubs with events targeted to African American adults 18–25 in Baltimore City at two time points (October and November of 2008 and 2010) after enforcement of the Maryland Clean Indoor Air Act (CIAA). Twenty venues—selected based on youth reports of popular venues—were rated during peak hours. All surveillance checklist items were restricted to what was observable in the public domain. There was a significant decrease in observed indoor smoking after CIAA enforcement. Observed outdoor smoking also decreased, but this change was not significant. Facilities for smoking outdoors increased significantly. The statewide smoking ban became effective February 1, 2008, yet measurable changes in smoking behavior in bars were not evident until the City engaged in stringent enforcement of the ban several months later.

Keywords

Tobacco; African Americans; Young Adults; Smoking Ban

INTRODUCTION

While policy initiatives such as excise taxes and workplace smoking bans have helped to decrease tobacco use in the past decade, the benefit of legislation and interventions to curtail

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smoking have not been fully realized for African American young adults (Lorenc et al., 2013). African American young adults who initiate smoking are more likely to stay smokers than their white peers (Center for Behavioral Health Statistics and Quality, 2015; Siahpush et al., 2010). While African American young adults are less likely to be smokers than their white peers (Arrazola et al., 2015; Center for Behavioral Health Statistics and Quality, 2015), the burden of tobacco-related illness is significantly higher in African Americans than whites across the lifespan. African American young adults have a greater risk of developing long-term illnesses including lung cancer (Haiman et al., 2006) as a result of smoking, and they tend to experience negative health consequences earlier in life than other racial/ethnic groups (Delva et al., 2005; Kamil et al., 2013). The mechanisms by which smoking results in greater disease burden in this population are unclear, though evidence points to type of cigarette smoked (Alexander et al., 2016), daily nicotine exposure (Ross et al., 2016), and fewer quit attempts (Holford et al., 2016) as possible sources. The extent to which these disparities stem from inequitable access to health care and other social and economic factors and not from biological differences is also an active area of inquiry (DeSantis et al., 2016).

Furthermore, African Americans young adults are more likely to use alternative tobacco products such as little cigars and cigarillos (small cigars); e-cigarettes and hookah are also increasing in popularity (Arrazola et al., 2015). Increased cigarette taxes have been associated with product switching from cigarettes to little cigars (Stillman et al., 2007); increasing cigarette cost has also produced an informal economy in which loose cigarettes or “loosies” are readily available, undermining efforts to curtail consumption (Lee et al., 2015; Smith et al., 2007; Stillman et al., 2014). This is especially troubling as small cigars and cigarillos are often inhaled, have higher levels of nicotine, and are sold overwhelmingly in predominately minority and underserved communities (Cantrell et al., 2013; Page & Evans, 2003). Little cigars also tend to be flavored, and flavored tobacco products have been associated with earlier smoking initiation and inhibited smoking cessation (Farley et al., 2014). The use of highly addictive tobacco products in this population is particularly troubling as African Americans are less likely to use nicotine replacement therapy or successfully quit smoking, and they are less likely to be advised to quit smoking by a medical provider compared to whites (Trinidad et al., 2011).

Targeted preventive interventions are needed to reduce and prevent youth tobacco use, and policy-level changes offer great promise to reduce smoking at a population level (Fichtenberg & Glantz, 2002; Guide to Community Preventive Services, 2014). We have seen great success in place-based prevention strategies targeting locales where people live, work, and play (Hopkins et al., 2010). Findings from two recent systematic reviews of studies of clean indoor air laws found that the enactment of such policies were accompanied by decreased cigarette consumption among continuing smokers, increased quit attempts, and increased successful quit attempts, in addition to decreased passive smoke exposure (Callinan et al., 2010; Hopkins et al., 2010). For example, in 2003, New York City implemented legislation that called for a ban on smoking in bars, restaurants, and nightclubs. Reports of indoor smoking among restaurant and bar patrons in New York City decreased significantly after the law took effect (Farrelly et al., 2005). Data gathered in Boston after enactment of its smoke-free bar ordinance reveal similar results; furthermore, this ban did

not cause declines in bar patronage or displacement of smoking to the home (Biener et al., 2007). Clean air laws enjoy popular support nationally, even among smokers (Eriksen & Chaloupka, 2007).

The impact of clean indoor air laws on youth and young adult smoking is less consistent. Research on the New York City ban found a positive relationship between attitudes of club-going youth towards the ban and a self-reported reduction in cigarette smoking (Kelly, 2009). One study in Massachusetts found that youth living in towns with comprehensive bans on smoking in restaurants were significantly less likely to progress to regular smokers than youth living in towns with weak smoking restrictions (Siegel et al., 2005). However, a study in Minnesota found no relationship between clean indoor air laws and youth smoking rates (Klein et al., 2009).

There is scant research investigating tobacco control policies' impact on African American smoking in general and African American youth smoking in particular (Hill et al., 2013). Most research on tobacco control policies has focused on the general population's smoking patterns post-intervention and not on specific, vulnerable subgroups (Main et al., 2008); the unintended consequence of this oversight could be increased health disparities in populations where tobacco control measures have not been fully realized (Frohlich & Potvin, 2008; Lorenc et al., 2013). There is some indication that African Americans have not experienced the same levels of reduction in second-hand smoke exposure as the general population (Eriksen & Cerak, 2008; Pickett et al., 2006). There is also weak evidence that smoking bans in bars and restaurants are less likely to be enforced in low SES areas, further exacerbating health disparities in these populations (Hill et al., 2013).

The Maryland Clean Indoor Air Act of 2007 (CIAA), while not designed specifically to reduce smoking by African American young adult, should reduce tobacco smoking in high-risk drinking and smoking environments among this vulnerable population. Since 1992, state law prohibited smoking in most public places and workplaces. In 2007, the Maryland General Assembly expanded these restrictions to include bars and restaurants, with limited exceptions. The provisions relating to smoking in bars and restaurants took effect February 1, 2008.

The goal of this research was to estimate the pervasiveness of smoking in bars and clubs with events targeted to African American young adults ages 18 to 25 in Baltimore City and evaluate these venues' adherence to and the City's enforcement of the CIAA. Targeted smoking prevention and cessation interventions in this age group may be particularly relevant as African Americans tend to initiate smoking at an older age compared to other racial/ethnic groups (Dube et al., 2010). Our original goal was to test one time point after the legislation went into effect. Evidence of on-site tobacco use was so high (85%) at the first assessment nine months after the ban went into effect that we conducted a second assessment two years later. The City had implemented an enforcement strategy, and we assess the efficacy of that enforcement in reducing onsite smoking of tobacco.

Methods

Quantitative and qualitative data were collected from a sample of African American young adults about their smoking and bar and club attendance, as well as recommendations for bars and clubs frequented by this group. Observational data were collected at a sample of 20 venues on nights that cater to African Americans at both eight months (October-November 2008) and two years (October-November 2010) after the ban went into effect.

Interview data and focus group data

Participants for focus group data were recruited from the Baltimore Youth Opportunity (YO!) Centers. The YO! Centers provide education, life skills, and employment training and internships to young adults (18 to 24 years old) not enrolled in remedial or undergraduate study. The YO! Center is funded by the Baltimore Mayor's Office of Employment Development. The focus groups were conducted to 1) identify bars and clubs that African American young adults frequented; and 2) better understand tobacco use in this population, specifically at bars and clubs. These focus groups were conducted within a larger tobacco project that aimed to understand tobacco use and acquisition, factors associated with cessation, and community norms around smoking (Milam et al., 2012; Stillman et al., 2007).

Four focus groups were conducted, each with eight consenting YO! Center members for a total of 32 participants, using a semi-structured leader guide. Focus groups were transcribed, and the data were coded and tagged for thematic similarities using ATLAS.TI. All focus group participants were smokers. This research was approved by the Institutional Review Board at the Johns Hopkins Bloomberg School of Public Health.

Venue Identification

Bars and clubs were assessed pre- and post-enforcement of the CIAA in 2008. Popular venues for African American young adults were identified through three sources: 1) young adults' self-report of the venues that they and their peers frequent; 2) venues that advertised or were promoted in the Baltimore City Paper; and 3) venues identified by the Principal Investigator from previous research on bars and clubs that catered to all young adults (Furr-Holden et al., 2006; Miller et al., 2005). Venues and events were scouted in advance of data collection. Project staff called all candidate venues and identified venues that catered to African Americans or that promoted specific nights where at least 50% of the clientele were African American. Direct observations were made during data collection to confirm the race and gender composition of the clientele.

Twenty venues were chosen from a list of possible venues identified before CIAA implementation. Of these 20 venues, 55% (n = 11) still met the inclusion criteria of promoting events targeted to African Americans ages 18 to 24 post-enforcement. Thirty percent (n=6) of the venues that were not included for post-enforcement observation had been shut down permanently. The remaining three venues were not included because two had a minimum age policy that prohibited entry for patrons under age 25, and one venue no longer held events on a regular basis. Replacement venues (n=9) for post-enforcement

observations were selected from the remaining list of venues generated from the focus groups and the Baltimore City Paper.

Observational Data Collection

The Tobacco Observation Checklist consisted of 138 items divided into four primary domains: 1) patron characteristics (e.g., predominant age, race, and gender of patrons); 2) venue characteristics (e.g., size, cover charge, outdoor seating/space, attendee density); 3) evidence of tobacco use inside (e.g., seeing people smoking, cigarette butts); 4) evidence of tobacco use outside. The Tobacco Checklist was developed from prior research completed in bars and clubs that specifically held electronic music dance events that combined portal surveys with systematic assessments completed by an observational research team (Miller et al., 2005). The items from the tobacco portion of the original observational assessment were retained and additional observational items related to the CIAA were added for this research.

Independent observations were conducted in the 20 venues by a pair of trained observers during peak hours of 10 p.m. to 4 a.m. (although most clubs closed at 2 a.m.). The observers did not engage human subjects; project staff did not interview or question venue patrons or staff. All 138 checklist items were restricted to observations available in the public domain—activities observable by any lay person who entered the venue. Using the tobacco observational checklist, the observers recorded observations from both immediately outside the venue and inside the venue.

Data were collected by a pair of data collectors, one man and one woman from the target age group. In order to conduct the observational study without attracting attention to data collection, all data collectors were African American. The data collectors were trained to make a lap around the venue together, observing behaviors related to tobacco use in publicly-accessible areas, including the exterior of the venue, bathrooms, hallways, and music room(s). After observing the behaviors, the observers entered data into personal digital assistant (PDA) devices, either in a private area such as a bathroom or in their vehicle as soon as they left the venue. In addition to completing the observational checklist, data collectors made field notes regarding information not captured by the checklist. The data were uploaded from the PDA via an internet-enabled PC to the office server using a secured uplink. A simultaneous testing approach was used, and any discrepancies in observations were reconciled in favor of the presence of an observed indicator; in other words, if one observer noted an indicator, it was deemed as present.

All data collectors were required to attend a training session. The training session included policies and procedures for data collection, review of the items in the Tobacco Observation Checklist and their definitions, and use of the PDA. Additional training and quality control was provided through a weekly teleconference.

Enforcement Strategy

The CIAA is enforced by the Maryland Department of Health and Mental Hygiene (DHMH), local health departments, and the Maryland Department of Labor, Licensing and Regulation (DLLR). The state and local health departments conduct enforcement at places of public accommodation, like bars and restaurants, and DLLR conducts enforcement in

other workplaces. Baltimore City also passed a local clean indoor air act (Health Code, Title 12, Subtitle 1) that is enforced by the Baltimore City Health Department (BCHD). The Division of Environmental Health (DEH) within BCHD conducts enforcement of the state and local clean indoor air laws.

The Environmental Inspection Services program under DEH investigates all CIAA complaints received via the City's 311 service request system. At the time of CIAA's enactment, the Food Control section of DEH investigated indoor smoking complaints; because of their heavy inspection schedule, this section was unable to investigate complaints in a timely manner. The duty of investigating these infractions then shifted to the Ecology section, which conducts complaint investigations for nuisances such as mosquitoes, odors, and noise. DEH conducts surprise inspections, most of which occur between 8:30 a.m. to 4:30 p.m. DEH also conducts late-night inspections at random and on a case-by-case basis: When DEH receives a complaint for late-night indoor smoking, these complaints are investigated at night. Complaint inspections for smoking are conducted when the complaint is received. Regulatory inspections are conducted from once every two years to three times a year depending on the designated risk level of the facility (risk level is based on health risk associated with food preparation, the same criteria used for food safety inspections). Inspectors do not wear uniforms but are required to wear identification, and inspectors are also required to make their presence known to business owners before conducting an inspection. Sometimes inspectors will quickly walk through an establishment before letting management know they are there; for example, the inspector may enter a bar and walk through the facility, visit the restroom, and then alert management.

Violations of the City law are heard by an administrative tribunal, the Environmental Control Board. All businesses are required to prohibit smoking within their facilities and must post signs stating that smoking is prohibited in all bars and restaurants. If a DEH inspector observes evidence of smoking, such as cigarettes butts, ashes, or smoke, facility management receives a violation notice if it is the first offense. If it is the second offense, the business receives a \$500 citation. If the inspector observes someone smoking on premise, then the business receives a \$500 citation. In an employee or management of the bar knowingly allows smoking in the facility, the business receives a \$750 citation. Each day a violation continues is considered a separate offense.

Data Analysis

We used Pearson Chi-square Test of Independence to investigate differences in observed smoking characteristics in venues for Wave 1 and 2. Analyses were performed using SPSS 20.

Results

Characteristics of Venues and Associated Tobacco Use and Promotion: Wave 1

All (100%, n=20) of the clubs had staff or security people visible on the floor. Security staff were recognizable by uniform, shirt or hat 70% of the time (n=14) or by headset 20% of the time (n=4). Seventy percent (n=14) of the venues had three or more club personnel visible

on the floor. One (5%) of the venues was an exotic dancer club. One (5%) of the clubs had to be visited twice because a fight occurred inside the club and police ordered all patrons to leave. The second visit to this club went smoothly.

Tobacco use in and around venues—Of the 20 venues assessed, 20% (n=4) offered either areas dedicated to smoking outside of the club entrance, designated outdoor smoking area courtyards available upon entry to the venue, or both. One club (5%) had a basement area designated for smoking that was not well ventilated. Seventy percent (n=16) of venues provided no segregated place for their patrons to smoke. Our raters observed people smoking in informal groupings in 75% (n=15) of the venues. These groupings contained between two and 20 people and assembled between one and 15 feet away from the venue entrance. Ashtrays were provided outside of one club (5%), and one club (5%) had a stocked cigarette vending machine.

Our raters saw evidence of recent indoor smoking in the general dance floor area of 15% (n=3) of the venues in the form of cigarette butts. There was physical evidence of tobacco use in the bathrooms at 30% (n=6) of venues. Raters also observed people actually smoking in bathrooms at two venues. None of the people smoking inside the venues were confronted by club staff.

Tobacco products and tobacco sharing—Our raters observed tobacco use at 85% (n=17) of venues. Cigarettes were the most common tobacco product; cigarette smoking was observed at all locations where tobacco use was observed. Little cigars were used at just under half of the venues where tobacco use was observed (47%, n=8). Tobacco sharing was observed outside of venues at under half of the clubs (40%, n=8) and exchanges of tobacco products inside at 20% (n=4) of the clubs. Data collectors also observed marijuana sharing at 10% (n=2) of the clubs. They observed sharing or “bumming” tobacco products outside of 20% (n=4) clubs and “bumming” marijuana at 5% (n=1) of clubs. The person-to-person sale of cigarettes was observed outside at a single club (5%).

Tobacco messaging in and around venues—Warning signs about smoking were posted outside at 15% (n=3) and inside at 65% (n=13) of venues. Two examples of tobacco messaging recorded in the data collectors’ field notes included, “1 small sign in corner warning folks not to smoke,” and “No smoking after Feb 2008 or be removed.” Tobacco-promoting print ads were posted inside the venues but were not observed outside of the venues. One club posted a print ad promoting the “Kool” cigarette brand.

In addition to print ads, various tobacco promotional items were visible in 30% (n=6) of venues. These included coasters, napkin holders, neon table top signs, and bar mats. All items in these venues were in promotion of the “Kool” cigarette brand.

Characteristics of Venues and Associated Tobacco Use and Promotion: Wave 2

The characteristics of the venues were similar between Wave 1 and Wave 2. The majority of the facilities had an even split of male and female patrons (Wave 1: 65%; Wave 2: 70%) and were predominately African American. The only statistically significant difference in characteristics of the facilities between waves was the cost of admission ($p = 0.037$); the

majority of venues in Wave 2 had a higher admission price compared to venues in wave 1 and charged \$10–20 for admission ($n = 15$; 75%).

During Wave 1, 75% ($n=15$) of venues had people concentrated outside smoking; there was a marginally significant reduction in Wave 2 (45%; $n=9$; $p = 0.053$). During both data collection waves, there were outdoor smoking areas and tobacco products being sold or bummed. There was a statistically significant increase in availability of ashtrays outside venues from Wave 1 to Wave 2 ($p = 0.028$). There was no observed change in the number of people purchasing tobacco products outside of venues, but there was a slight, non-significant decrease in observed outdoor tobacco bumming ($p=0.376$). There was, however, a significant change in the types of tobacco products used outside: Observed use of cigarettes ($p=0.008$) and little cigars ($p=0.002$) both significantly decreased, with no observed use of little cigars outside venues in Wave 2.

While there was physical evidence of tobacco use in the bathrooms at six venues (30%) during Wave 1, there was no evidence of tobacco use during the later tobacco assessment ($p = 0.08$). Raters also observed people smoking in two clubs in bathrooms during Wave 1 (10%); although raters did not observe patrons smoking during the second wave of data collection, the difference was not significant ($p = 0.147$). Observed bumming ($p= 0.376$) and exchanging ($p=0.548$) of tobacco products indoors also decreased, but these changes were not significant.

More venues posted smoking warning signs outside their venues in Wave 2 compared to Wave 1, but this increase was not significant ($p=0.429$). Surprisingly, observed indoor smoking warning signs decreased in Wave 2 compared to Wave 1, and this change was marginally significant ($p=0.058$). Tobacco print ads posted inside also decreased ($p=0.311$), but the presence of tobacco promotional items inside did not change.

Discussion

Overall there were substantial reductions in indoor smoking from Wave 1 to Wave 2 and clear indications that club owner/operators were implementing strategies to operate consistent with the CIAA after increased enforcement. In comparison to Boston, where indoor smoking ban compliance and self-enforcement among bar and club owners was found to be widespread within three months of the ban's enactment (Skeer et al., 2004), Baltimore's indoor smoking ban required more vigilance on the part of enforcement authorities, mainly the BCHD Division of Environmental Health. While both waves of data collection were conducted after the CIAA went into effect, there was a significant decrease in observed indoor smoking after implementation of a CIAA enforcement program. In facilities where smoking is considered normal or socially acceptable, self-enforcement of smoking bans is less likely (Levy & Friend, 2003); consequently, rigorous enforcement strategies may be necessary to promote compliance with indoor smoking bans in bars, clubs and other social and entertainment venues where smoking is commonplace. The importance of stringent enforcement is supported by discrepancies in indoor smoking compliance in Los Angeles, which mounted a rigorous enforcement strategy, compared to other California

cities, which relied more on media communication and self-enforcement strategies (Weber et al., 2003).

The decline in indoor smoking was accompanied by decreased smoking outside of venues. Unlike Boston, where indoor smoking bans were accompanied by a significant increase in outdoor smoking (Skeer et al., 2004), the observed decrease in outdoor smoking suggests that the CIAA may change social norms around the acceptability of smoking. Previous research on stringent smoking bans in restaurants and bars has been associated with increased quit attempts among smokers and reinforced anti-smoking social norms (Albers et al., 2004, 2007; Tang et al., 2003). Increased outdoor signage reminding patrons not to smoke may also reinforce anti-smoking messages and lead to decreased smoking. The observed reduction in outdoor smoking is a promising development in the support of comprehensive clean indoor air laws for young adult smoking prevention and cessation.

At the same time that observed indoor and outdoor smoking decreased, accommodations to facilitate outdoor smoking increased. This may be problematic as the CIAA's provisions have relocated where young adults smoke. Moving smoking outdoors may be detrimental to smoking cessation efforts as it normalizes smoking behavior by making it more public and visible and, consequently, socially acceptable (Alesci et al., 2003). Young adults are significantly influenced by peer smokers, and African American young adult smokers are significantly more likely to have friends who smoke than their non-smoking peers (Stillman et al., 2007). One study found that having even one close friend who smoked increased the odds of past-month smoking by 67%; the odds of smoking increased significantly with each peer smoker (Klein et al., 2009). Furthermore, increased outdoor smoking may undermine efforts to protect bar staff and patrons from secondhand smoke exposure as outdoor smoking areas adjacent to smoke-free indoor areas negatively impact indoor air quality (Brennan et al., 2010).

Policies and interventions aimed towards young adults who identify as “social smokers”—a subset of nondaily smokers who tend to restrict their tobacco use to social situations such as parties, bars, or clubs (Schane et al., 2009; Song & Ling, 2011)—may be particularly relevant for bars and clubs as these smokers tend to be less nicotine dependent and less inclined to quit but still at high risk for smoking-related health problems (Song & Ling, 2011). Consequently, positioning anti-smoking messaging at the point of consumption may be motivating for young adult African American “social smokers.” These policies may also be particularly successful in social settings as young adults are more likely to obtain tobacco from social sources than commercial outlets (Harrison et al., 2000; Pokorny et al., 2006).

A few limitations of this research merit discussion. This study was cross-sectional and does not allow for exploration of temporal shifts in tobacco use. While we attempted to visit each venue more than once, these data do not provide a continuous picture of ongoing tobacco use in bars and clubs. We also did not observe smoking behavior prior to CIAA enactment; conclusions about the overall impact of CIAA on young adult smoking are not possible. While the non-intrusive nature of this observational study is a strength, it is possible that observer recall underestimated certain behaviors or features of venues as some data recording occurred off-site. Furthermore, researchers did not observe CIAA enforcement

activity on site; therefore, the observed decreases in smoking may be attributable to other, unmeasured factors such as shifting social norms around smoking or growing popularity of other recreational substances (e.g., e-cigarettes, marijuana, synthetic cannabinoids). Because the population observed is not necessarily representative of all young adult African Americans in Baltimore, conclusions about the impact of CIAA on overall smoking rates among this population compared to other racial and ethnic groups are not possible. Despite these limitations, this study provides strong support for the impact of CIAA on African American young adult smoking.

While CIAA implementation and compliance in bars and clubs did not occur immediately, rigorous enforcement produced a significant change in African American young adult smoking behavior both in and outside of venues. This study provides essential evidence in support of clean indoor air policies' positive impact on African American smoking behavior and may provide a policy model for curbing use of other combustible tobacco products such as hookah (Morris et al., 2012; Primack et al., 2012). Considering the disproportionate health burden suffered by African American smokers, wide-reaching strategies to decrease and prevent smoking in this population are vital to addressing ongoing health disparities (Frohlich & Potvin, 2008; Lorenc et al., 2013).

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Table 1

Tobacco Observation Outcomes

	Number of Locations Where Behavior was Observed		
	Wave 1 Oct-Nov 2008	Wave 2 Oct-Nov 2010	
	<i>n</i> (%)	<i>n</i> (%)	<i>p</i> -value
Patron Characteristics			
Gender Ratio			.680
Even Men/Women	13 (65)	14 (70)	
Predominately Women	1 (5)	2 (10)	
Predominately Men	6 (30)	4 (20)	
Predominate Race			1.000
African American	15 (75)	15 (75)	
Caucasian	3 (15)	3 (15)	
Mixed Crowd	2 (10)	2 (10)	
Predominate Age			.128
Under 18	1 (5)	0 (0)	
18–25	8 (40)	14 (70)	
26+	11 (55)	6 (30)	
Attendee Density			.528
Empty	4 (20)	2 (10)	
Small	5 (25)	5 (25)	
Moderate	7 (35)	11 (55)	
Full/Packed	4 (20)	2 (10)	
Club Characteristics			
Cover Charge			.037
Free	4 (20)	2 (10)	
\$5-\$9	9 (45)	3 (15)	
\$10-\$20	7 (35)	15 (75)	
ID Check	15 (75)	15 (75)	1.000
Tobacco Use Outside			
Outdoor Smoking Area	4 (20)	9 (45)	.091
People Smoking in Aggregation Outside	15 (75)	9 (45)	.053
Tobacco Products Purchased Outside	1 (5)	1 (5)	1.000
Tobacco Products Bummed Outside	4 (20)	2 (10)	.376
Ashtrays Outside	2 (10)	8 (40)	.028
Types of Products Used Outside			
Cigarettes	17 (85)	9 (45)	.008
Little Cigars	8 (40)	0 (0)	.002

	Number of Locations Where Behavior was Observed		
	Wave 1 Oct-Nov 2008	Wave 2 Oct-Nov 2010	
	<i>n</i> (%)	<i>n</i> (%)	<i>p</i> -value
Hand-Rolled Cigarettes	1 (5)	1 (5)	1.000
Other Tobacco Products	2 (10)	0 (0)	.147
Tobacco Use Inside			
Evidence of Indoor Smoking	6 (30)	0 (0)	.008
Tobacco Products Purchased Inside	0 (0)	0 (0)	1.000
Tobacco Products Bummed Inside	4 (20)	2 (10)	.376
Tobacco Products Exchanged Inside	2 (10)	1 (5)	.548
Attendees Smoking	2 (10)	0 (0)	.147
Cigarette Butts Visible	3 (15)	0 (0)	.072
Little Cigar Tips Visible	0 (0)	0 (0)	1.000
Ashtrays Provided Inside	0 (0)	0 (0)	1.000
Types of Products Used Inside			
Cigarettes	2 (10)	0 (0)	.147
Little Cigars	0 (0)	0 (0)	1.000
Hand-Rolled Cigarettes	0 (0)	0 (0)	1.000
Other Tobacco Products	0 (0)	0 (0)	1.000
Tobacco Messaging			
Smoking Signs Inside	13 (65)	7 (35)	.058
Smoking Signs Outside	3 (15)	5 (25)	.429
Tobacco Print Ads Inside	1 (5)	0 (0)	.311
Tobacco Print Ads Outside	0 (0)	0 (0)	1.000
Tobacco Promotional Items	6 (30)	6 (30)	1.000