CITY OF MARLBOROUGH
BOARD OF HEALTH POSTING

Meeting Name: Marlborough Board of Health

Date: February 17, 2015

Time: 6:30 PM

Location: 140 Main Street, City Hall, Council Committee Room, First Floor
Marlborough, MA 01752

Agenda Items to be addressed:

Call to Order

Administrative:

1. Review February 3, 2015 Public Hearing Minutes

New Business:

2A. Sully's First Edition Pub (Hearing)

2B. Board Appointments

2C. Fee Schedule Review

2D. Tobacco Regulation Testimony Review

2E. Sam Wong and Alex DePaolo update

a. Prevention & Wellness Trust Fund project
b. MetroWest Moves project

Old Business

ADJOURNMENT

THE LISTING OF TOPICS THAT THE CHAIR REASONABLY ANTICIPATES WILL BE DISCUSSED AT THE MEETING IS NOT INTENDED AS A GUARANTEE OF THE TOPICS THAT WILL HAVE BEEN DISCUSSED. NOT ALL TOPICS LISTED MAY IN FACT BE DISCUSSED, AND OTHER TOPICS NOT LISTED MAY ALSO BE BROUGHT UP FOR DISCUSSION TO THE EXTENT PERMITTED BY LAW.

Marlborough Board of Health Meeting Minutes February 3, 2015
City Hall, 3rd Floor, Memorial Hall

CALL TO ORDER: James Griffin, Chairman called the meeting to order at 6:44

PRESENT: James Griffin, Chairman (JG); John Curran, M.D., Vice Chair (JC); Robin Williams, Member (RW); Steven Ward Interim Public Health Director; Tina Nolin, Senior Clerk.

Administrative:

1: **Minutes Review: The board reviewed the minutes of the December 2, 2014 meeting.** RW made a motion to approve the minutes of the January 6 meeting and place on file. JC seconded. Motion carried 3-0

New Business:

2: **Public Testimony related to proposed Tobacco Regulations**
JG read aloud meeting protocol
15 were in the attendance / 9 gave oral testimony

Craig Hunt, Hunt's Mobil (100 Crosby Road) – Doing business in Marlborough for 31 years. Raised opposition to the proposed regulations as it will hurt business/profits by causing customers to go to other towns to buy the products and they will buy their other products at the other stores as well. These products are legal and we should be able to sell them. If the current rules and regulations are enforced and education is expanded both businesses and public will be better served. Please consider the economic impact of the regulations including jobs.

Ken Forbstein – on behalf of Drs. Hartman and Winickoff
Submitted MGH letter along with samples of Kid friendly tobacco products (flavors and e-cig)
Pro adopting the regulations. AMA, American pediatric, American Lung Assoc. favor adopting the regulations. Well within the mission of the BOH. No evidence of convenience stores going out of business due to these new 21 age laws, other towns already adopting so won't lose business this way. Listed variety of other things we do not allow 18 year olds to do: drink, gamble etc.).

Anna Bettencourt – Verc Enterprises/Gulf Station
Opposed to regulations. Retailers know it is most important not to sell to minors – whether the law says they are under 18 or under 21. However, we graduate kids at 18 and we consider them adults. The Federal age is 21 – ask you to leave it there. More regulations are not needed. Education is more important than more regulations. If you take away single cigars at $2.50 they will then buy a pack. Single cigars are for occasional smokers.

Public Testimony related to proposed Tobacco Regulations cont'd

DJ Wilson – Mass. Municipal Association Tobacco Control Director
Pro regulations. Kids are attracted to the flavored products and have been shown to smoke more of the flavored cigars than cigarettes. These products are shown to be highly addictive and geared toward youth. No data of retail stores going out of business in towns that have adopted these policies. Submitted policies showing 148 municipalities have banned e-cigarette usage. Worcester is entertaining same "draft" minimizing pricing for cigars.

Sue Reno – Compliance Officer for Honey Farms
Opposed to regulations. Responsible retailers purchase licenses that say we will only sell to legal adults. We have had no compliance issues in years. Rather than restricting an age group, you need to put the onus on retailers to do their job. These are legal products, the government says they're legal and retailers should be able to sell them.

Matt Le Lacheur – NESSARA – New England Service Station & Auto Repair Association
Opposed to Regulations. NESSRA and local sellers take seriously the age restriction of the current regulations and laws seriously – they live in the community, their kids go to school with the local kids. To institute the proposed age related regulations suggest we don't trust them to do their jobs and accept their responsibilities. Sellers are losing business when you take away the single cigar purchases @ the ~$2 rate and leave only the packs which may go for as high as $10. People will go to other retailers in other towns to buy singles – and other products they but at the same time.

Steve Ryan – NECSA, Executive at New England Convenience Store Association
Expressed opposition to proposed age regulation. Real issue is no one wants kids to be buying these products, but this is an unregulated matter, rest of regulations are not about product, but about responsible retailing – thus an issue of compliance. Make consequences very serious for those who break the current age regulations and are not compliant, don't change the regulation itself. Adopting them opens the opportunity for current customers to go to other towns to buy the products and ancillary purchases. The latter of which are important income to retailers.

Peter Frattarda – Alliance Energy
Expressed opposition to proposed regulation related to raising retail prices on cigars, by getting rid of single sales of cigars, raising the legal age to 21. 25% - 50% of sales are from tobacco products. Adopting these regulations will lead to double digit declines in sales – especially since there are towns nearby who do not have these same restriction. This loss of income ultimately effects jobs, store upkeep, etc. Suggested we need more education re: responsible leadership among retailers, not more or stricter regulation.

Matt Elder – Marlborough City Councilor (Ward 3)
Told about his Mom currently dying of lung cancer related to smoking – but expressed opposition to the proposed legislation. Pointed out we allow 18 year olds to vote, go to war, etc... Suggested that these regulations may not actually lead to the desired results – ending smoking among those 18-21, end use and popularity of flavored smokes. Expressed that these regulations will serve to hurt the retailers via loss of sales and profits. Reported overall not a fan of regulation.

3: Assistant Sanitarian Monthly Report – January, 2015
Motion made to accept and place on file. Motion carried 3-0

4: Public Health Nurse Monthly Report – January, 2015
Motion made to accept and place on file. Motion carried 3-0

OLD BUSINESS

5: Update on Sully's First Edition Pub
SW gave update on Sully's First Edition Pub's Richard Sullivan of First Edition Pub – a consultant, Eric Nusbaum of Wheelwright Consultants, has been hired to help with getting to compliance. The 3-bay sink is in with hot and cold running water. Walk-in is not yet up to compliance. Consultant is looking at reducing the menu to be in line with the physical limitations of the kitchen. Mr. Ward (SW) and Ms. Lee will be meeting again with Mr. Nusbaum and Mr. Sullivan on Friday (2/6). RW asked about the progress of the education piece. SW reported that did not appear to be completed. SW suggested, based on findings in next Fridays meeting, that a suspension letter be drafted that requires Mr. Sullivan to appear before the board to defend what has and has not been done regarding the issues of compliance and determine if suspension is warranted due to a failure to meet expectations.

6: Prospector (Status Update)
Hand sink has been installed.

Next BOH meeting will be held on Tuesday, February 17th at 6:30 pm.

RW motioned to adjourn; seconded by JG at 8:40 pm (Motion carried 3-0)

Respectfully submitted,

James Griffin, Chairman

CITY OF MARLBOROUGH
BOARD OF HEALTH
140 Main Street, Lower Level
Marlborough, Massachusetts 01752
Facsimile (508) 460-3625 TDD (508) 460-3610

James Griffin, Chairman
John Curran, MD, Member
Robin Williams, Member
Tel (508) 460-3751

2/6/15

Mr. Richard Sullivan
Sully's First Edition Pub
11-b Florence Street
Marlborough, MA 01752

Delivered by:_____

Date: _____

Re: Board of Health Show Cause Administrative Hearing

Dear Mr. Sullivan,

As a result of documented history of non-compliance with the Massachusetts State Sanitary Code, 105 CMR 590.000, and the 1999 Federal Food Code an administrative show cause hearing was held on December 2, 2014 and January 6, 2015 at 7:45 PM in Memorial Hall located in Marlborough City Hall. The purpose of these hearings is to show cause as to why the Board of Health should not suspend or revoke your Permit to Operate a Food Establishment for serious and repeated violations and failure to comply with the requirements of Massachusetts State Sanitary Code, 105 CMR 590.000 and the 1999 Federal Food Code. Interim Director of Public Health, Steven J. Ward and Food Service Consultant Maureen Lee outlined the documented history of non-compliance with the above referenced food code.

DECISION OF THE BOARD OF HEALTH

After much discussion, it was the unanimous decision of the Board of Health that you must complete required tasks within a specified time specified time (*see attached Board of Health decision letter dated January 9, 2015*). On January 30, 2015 and February 6, 2015 the Board of Health determined, via onsite inspections/meeting with you and your consultant Eric Nusbaum that you are in non-compliance with the BOH decision letter dated January 9, 2015.

Under 105 CMR 590.014 (B) (1) (a-h) the board of health or its authorized agent, as determined by the board of health, may issue a notice to suspend a permit to operate a facility under 105 CMR 590.000 or one or more particular operations of the facility for failure to comply with the requirements of 105 CMR 590.000 and the 1999 Federal Food Code and the requirements of this this decision order.

As a result of non-compliance with the BOH Decision letter dated January 9, 2015 and failure to comply with the requirements of 105 CMR 590.000 and the 1999 Federal Food Code **you are required to attend a show cause administrative hearing on Tuesday, February 17, 2015 at 7:00 PM in the Council Committee Room located on the first floor of City Hall, 140 Main Street.** At this hearing you will be given an opportunity to show cause as to why your permit to Operate a Food Establishment should

not be suspended for failure to comply with the requirements of 105 CMR 590.000 and the Board of Health Decision Letter dated January 9, 2015.

Should you have any questions concerning this matter you may contact this office at 508-460-3751.

Sincerely,

Steven J. Ward, MPH, CHO
Interim Director of Public Health

CC: File
BOH Members
Eric Nusbaum

CITY OF MARLBOROUGH

BOARD OF HEALTH

140 Main Street, Lower Level
Marlborough, Massachusetts 01752
Facsimile (508) 460-3625 TDD (508) 460-3610

James Griffin, Chairman
John Curran, MD, Member
Robin Williams, Member
Tel (508) 460-3751

In accordance with the authority granted by the General Laws of the Commonwealth of Massachusetts, Chapter 111, Section 31 and provisions of the State Sanitary and Environmental Codes, the Board of Health of the City of Marlborough hereby establishes the following regulation pertaining to permit requirements and fees relating thereto:

CITY OF MARLBOROUGH
FEE SCHEDULE FOR LICENSES AND PERMITS

PERMIT	CURRENT FEE	AVERAGE FEE**	EXPIRATION DATE
Food Service Establishments			
Food Service (Seats 0 - 49 seats)	$100	$192	December 31st
Food Service (Seats 50 & Over)	$175	$369	December 31st
Temporary	$25	--	December 31st
Non-Profit	N/C	$61	December 31st
Schools	N/C	N/C	December 31st
Schools (Outside)	$50	--	
Theater/Concessions	$50	--	December 31st
Churches	N/C	$61	
Bakeries (under 3,000 Sq. ft.)	$100	--	December 31st
Bakeries (over 3,000 Sq. ft.)	$150	--	December 31st
			(Consider November 30th for all food service permit renewals)
Review of Plans New/Renovations	$50	--	
New establishment	--	$133	
Renovation/Remodel	--	$63	
Variance	--	$50	
Retail Food Establishments			
Under 1,500 sq. ft.	$100	$257+	December 31st
1500-4000 sq. ft.	$125	$213+	December 31st
4000 – 5000 Sq. ft.	200	$370+	December 31st
			(Consider May 31st)
Residential Kitchen	$75	--	May 31st??
Catering Establishment (Annual)	$100	--	Dec 31st
Mobile Food Canteen (Per Truck fee)	$50	--	
Milk License (Consider removing)	$25	--	Include in Retail Food Permit
			(Consider May 31st)
Frozen Dessert Manufacturing	$25	--	December 31st
Permitted Establishments Late Fee *(per day fee – 14 day assessment followed by administrative hearing)*	$5	--	

** New Fee *Consider Amendment
+ 5,000 sq ft or less/ 5,001 sq ft – 9,999 sq ft/10,000 sq ft or more

CITY OF MARLBOROUGH

BOARD OF HEALTH

140 Main Street, Lower Level
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Facsimile (508) 460-3625 TDD (508) 460-3610

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Tel (508) 460-3751

PERMIT	CURRENT FEE	AVERAGE FEE**	EXPIRATION DATE
Permitted Establishment Surcharge Fee (*Fee assessed for additional inspections as a result of non-compliance*)	$75.00 per additional inspection	$75	
			Consider May 31st
Onsite Wastewater			
Percolation Test/Deep Hole (Per Lot)	$100	--	
Disposal Works Installers	$50/Yr	--	Consider May 31st
Permit to Install New Septic System	$150	--	
Permit to Repair or Replace	$100	--	
Septage Hauler (Per Truck Fee)	$100	--	
Well Permit	$100	--	
Swimming Pools & Whirlpools			
Semi-Public (*annual*)	$100	$192	December 31st
Semi-Public (*seasonal*)	$100	$161	May 31st
Special Purpose	$75	$244	December 31st
Wading Pool (*seasonal*)	$75	$75	May 31st
Review of Plans New/Repairs	$50	$50	
Miscellaneous			
Abrasive Blasting (Annual Registration of Company)	$25	--	May 31st (Assigned)
Abrasive Blasting (Per day fee)	$75	--	?????
Bed and Breakfast	???	--	December 31st ?
Motel Permit/Mobile Home	$50	$100++	December 31st
Tobacco Permit	$100	$114	(Remove – City Clerk)
Burial Permit	$10	--	Consider May 31st
Rubbish Contractors (Per Truck Fee)	$100	--	December 31st
Wells/Plan Review	$100	--	
Tanning Establishment Plan Review	$200	$50	
Funeral Directors	$25	$85	April 30th?
Tanning Establishment Permit	$100	$211	Consider May 31st
Day/Recreational Camp	$100	$100++	Upon Permit Application

*** Consider Amendment**

**** New Fee**

++ Broke out camps < 50 campers / 51 – 50 campers / over 151 campers

	Braintree	Billerica	Framingham	Hudson	Leominster	Natick	Shrewsbury	Wellesley	Marlborough
FOOD ESTABLISHMENTS / RESTAURANTS									
50 seats or less	150	150	150	150	50	475	250	250	100
51 - 100 seats	200	250	225	150	75	600	250	500	175
101 +	300	250	225	175	100	725	400	500	175
150+	300	350	N/A	175	100	850	400	600	175
250 +	450	350	400	225	100	1,125	400	600	175
500 +	450	500	400	225	100	1,350	400	600	175
Nonprofits/Charitable/Churches	N/A	100	N/A	0	N/A	20	25	100	N/A
Private schools	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A
Take-Out only (no seating)	N/A	N/A	N/A	100	N/A	N/A	N/A	N/A	N/A
Mobile Food Permits	125	100	100	75	150	100	200	140	50
PLAN REVIEWS									
0 - 25 seats	N/A	N/A	50	N/A	N/A	300	N/A	200	N/A
50 seats or less	N/A	N/A	50	N/A	N/A	300-500	N/A	200	N/A
51 - 200 seats	N/A	N/A	100	N/A	N/A	500-750	N/A	400-600	N/A
201 + seats	N/A	N/A	150	N/A	N/A	750	N/A	600	N/A
New establishment	100	150	N/A	150	N/A	N/A	N/A	N/A	N/A
Renovation / Remodel	50	75	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Variance	50		N/A	N/A	N/A	N/A	N/A	N/A	N/A
RETAIL FOOD ESTABLISHMENTS WITH FOOD SERVICE									
5,000 square feet or less	150	150	225	150	N/A	200-1,250	250	N/A	100-200
5,001 square feet or more	150	300	225	175	N/A	N/A	N/A	N/A	N/A
10,000 square feet or more	300	500	400	250	N/A	N/A	400	N/A	N/A
BODY ART / PIERCING ESTABLISHMENT									
Body Art Establishment	200	200	100	100	200	1,000	200	500	N/A
Body Art Practitioner	100	200	50	100	200	100	100	350	N/A

FUNERAL	Braintree	Billerica	Framingham	Hudson	Leominster	Natick	Shrewsbury	Wellesley	Marlborough
Funeral Director	100	50	N/A	N/A	100	100	75	N/A	25
Permit: Removal/burial of bodies	N/A	10	N/A	N/A	10	N/A	10	N/A	N/A
TANNING									
Tanning Facility Permit	100	N/A	100	75	100	300	100	100	100
Each additional tanning device	25	N/A	N/A	N/A	N/A	N/A	N/A	50	N/A
POOLS									
Annual	100	150	250	100	50	525	150	300	100
Seasonal	75	100	150	100	50	525	150	200	100
Saunas & Vapor Baths	75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Special Purpose Pools	100	75	300	N/A	N/A	500	N/A	N/A	75
Wading Pools	N/A	75	N/A	N/A	N/A	N/A	N/A	N/A	75
TOBACCO									
Sales Permit	100	125	100	75	50	75	150	250	100
CAMP									
Less than 50 campers	50	N/A	100	75	50	50	100	200	100
51-150 campers	75	N/A	150	75	50	50	100	200	100
Over 151 Campers	100	N/A	200	75	50	50	100	200	100
INSPECTIONAL SERVICES / INVESTIGATIONS									
Reinspection (Food)	N/A	N/A	N/A	75	N/A	75	100	50	N/A
Reinspection (Occupancy)	N/A	N/A	N/A	N/A	75	75	N/A	50	N/A
Reinspection (Non-Food)	N/A	N/A	N/A	50	N/A	N/A	N/A	50	N/A
SEPTAGE / TITLE V									
Title V System Inspector Annual Perm	125	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Disposal Works Construction Permit	200	N/A	100	100	100	325	325	200	50
Septage haulers permit	N/A	200	100	100	100	325	100	50	100
Percolation Test	200	N/A	N/A	N/A	100	N/A	325	N/A	100

TOWN OF WATERTOWN
Board of Health

Administration Building
149 Main Street
Watertown, MA 02472
Phone: 617-972-6446
Fax: 617-972-6499
www.watertown-ma.gov

Steven J. Ward, M.P.H., C.H.O.
Director of Public Health

Under Massachusetts General Laws Chapter 111, Section 31, the Watertown Board of Health at its regularly scheduled meeting on August 15, 2012 unanimously voted to amend "Fee Schedule for Licenses and Permits"

TOWN OF WATERTOWN
FEE SCHEDULE FOR LICENSES AND PERMITS

TYPE EXP. DATE	FEE
FOOD SERVICE	
Places of Worship and Function Halls	$ 75.00
Food Service Establishment with 0-99 seats	$175.00
Food Service Establishment with greater than 100 seats	$325.00
Food Service (coffee only)	$ 20.00
Expires November 30th	
RETAIL FOOD	
Less than 10,000 SF	$175.00
Greater than 10,000 SF	$450.00
Expires November 30th	
CATERERS	
Watertown Business	$175.00
Expires November 30th	
Outside Caterer.....Each Function	$ 25.00
MOBILE FOOD **Expires May 31st**	$ 100.00
BAKERY **Expires November 30th**	$175.00
FOOD SERVICE/RETAIL FOOD REINSPECTION FEE Reinspection Subsequent to an Order Letter	$ 75.00

True Copy Attest
Steven J. Ward, Director of Public Health

TOBACCO PRODUCTS	$ 100.00
Expires November 30th	

Surcharge:

Administrative hearing before the Board of Health for non-compliance results in a surcharge of double the permit fee for the next calendar year (only). Revert back to original permit fee after one (1) year, if compliance is achieved.

Temporary License for Concessions, etc... (one to three days)	$ 5.00
Temporary Seasonal (greater than 14 day)	$ 75.00
MOTEL/HOTEL	
Basic Fee	$125.00
Additional Fee Per Room	$ 2.00
Expires December 31st	
LODGING HOUSE	$ 125.00
RECREATIONAL CAMPS	$ 50.00
Expires May 31st	
TANNING FACILITIES/ESTABLISHMENT	
Establishment	$150.00
Additional Machine/Bed	$ 20.00
Greater than one (1)	
Expires May 31st	
SWIMMING POOLS	
Seasonal	$150.00
Annual (Indoor)	$250.00
Annual with Whirlpool	$300.00
Wading Pool	$100.00
Expires December 31st ANNUAL	
Expires September 30th SEASONAL	
JACUZZI WHIRLPOOL (ONLY)	$175.00
Expires May 31st	
SAUNA, VAPOR BATHS	$125.00
Expires May 31st	

True Copy Attest

Steven J. Warth, Director of Public Health

SEWAGE HAULER	$125.00
DISPOSAL TRUCKS	$125.00
GREASE AND BONES (OFFAL)	$100.00
FUNERAL DIRECTOR Expires April 30th	$ 50.00
BURIAL PERMITS	$ 10.00
INSTALLERS	
Basic Fee	$ 50.00
Per Connection	$ 5.00
Expires December 31st	
PERC TEST	
Filing Fee	$100.00
Perc Test	$ 75.00
Each Additional Perc Test/Site	$ 50.00
Deep Observation Hole	$ 15.00
WELL CONSTRUCTION APPLICATION	$125.00
Registration (One Time Fee)	$ 20.00
KEEPING OF ANIMALS	
Horses, Pony, Mule or like Animal	$ 50.00
Cows, Goats, Sheep, Pig or Like Animal	$ 50.00
Chickens, Ducks, Geese	$ 50.00
Expires April 30th	
Temporary One Day Event	$ 20.00
ABRASIVE BLASTING PERMIT Expires 30 Days from Date of Application	$ 75.00
21 E Search (Per Site)	$ 50.00
ASBESTOS REMOVAL PERMIT	
Commercial	$125.00
Residential	$ 75.00
HAZARDOUS MATERIAL PERMIT (Initial Permit Fee)	$ 75.00
LATE FILING FEE (Permit Renewal)....PER DAY Not To Exceed 100% of Permit Fee	$ 5.00

True Copy Attest

Steven J. Ward, Director of Public Healt

PLAN REVIEWS

FOOD SERVICE

New Establishment

Places of Worship and Function Halls	$ 50.00
Food Service Establishment with 0-99 seats	$175.00
Food Service Establishment with greater than 100 seats	$325.00

Retail Food

Less than 10,000 SF	$175.00
Greater than 10,000 SF	$450.00

Renovation

Simple	$ 50.00
Complex	$ 125.00

Department Mandated Seminar (Food, Pools, Hazmat, Tanning)

Individual Training	$100.00
Each Additional Employee	$ 50.00

SWIMMING POOLS

New Establishment or Complex Renovation	$125.00
Simple Renovation (i.e., Change in Filter-type or Sanitation System)	$ 50.00

BODY ART ESTABLISHMENT/PRACTITIONER

Initial Plan Review	$250.00
Annual Permit to Operate a Body Art Establishment	$200.00
Annual Body Art Practitioners Permit	$100.00

Expires May 31st

OTHER FEES (UNRELATED TO REVIEW OF SUBMITTED PLANS)

Establishment Name Change	$ 15.00

* Non-Criminal Disposition – **Fining Fee**..... Set by Ordinance

**Copies of applicable regulation for review at the Watertown Health Department, 149 Main Street, Watertown, MA 02472

August 20, 2012

True Copy Attest
Steven J. Ward, Director of Public Health

MASSACHUSETTS FOOD ASSOCIATION

President
CHRISTOPHER FLYNN

31 MILK STREET, SUITE 518 BOSTON, MASSACHUSETTS 02109

(617) 542-3085
FAX: (617) 542-3505
Email: mafood@mafood.com

January 29, 2015

Board of Health
City of Marlborough
140 Main Street – Lower Level
Marlborough, MA 01752

Introduction

The Massachusetts Food Association (MFA) submits the following comments in response to consideration of the City of Marlborough Board of Health's proposed regulations for its February 3, 2015 meeting which may prohibit the sale of tobacco products in establishments with pharmacies, along with other restrictions.

Comments

Foremost I would like to thank you for the opportunity to file comments.

My name is Brian Houghton and I am the Vice President of the Massachusetts Food Association. On behalf of our retail food store members that operate in the City of Marlborough with a pharmaceutical establishment such as Hannaford, the Association respectfully requests to be recorded in opposition to any proposed regulations that would restrict the sale of tobacco products at this establishment within the City of Marlborough for the following reasons:

- This proposal unfairly targets a small percentage of outlets where legal (tobacco) products are sold. It does not do justice towards protecting, promoting and preserving the health and well-being of those citizens, but rather does an injustice to a small percentage of the city's retail and food outlets with a pharmacy that sell a legal product by simply denying their sale of a legal product while forcing those sales to another establishment;

- Food retailers with pharmacies that presently sell legal tobacco products must adhere to some of the nation's most restrictive requirements with regards to the legal sale of these products. There are already strict limitations placed upon businesses for the sale of legal tobacco products in many cities and towns through local regulations to curtail access of tobacco products to minors, such as those presently in effect in Marlborough;

- The MA Attorney General's Office also enforces 940 CMR 21.00 and 940 CMR 22.00 with regards to the Sales and Distribution of Cigarettes, Smokeless Tobacco and Cigars in Massachusetts;

- The Massachusetts General Laws Chapter 270 Sections 6 & 7 also restrict the sale of legal tobacco products.

The Massachusetts Food Association has worked cooperatively to provide materials to its members to educate them on these restrictions and ensure compliance. We have worked with local Tobacco Control Programs and the MA Attorney General's office to distribute Retailer Resource Kits for Merchants and annually provide information from the Coalition for Responsible Tobacco Retailing, Inc. on their *"We Card"* Program. This material is used to educate consumers *who enter supermarkets that have pharmacies* on the harmful effects of using legal tobacco products.

This regulation, if proposed, merely blocks legal trade of a legal product from a tiny proportion of all retail outlets that sell these products, and would only force consumers who wish to continue to purchase them to merely take their business elsewhere, perhaps in some instances simply across the street.

I thank you for the opportunity to provide comment and would be happy to answer any questions you or members of the Board may have on this proposal.

Respectfully,

Brian Houghton

necsa
New England Convenience Store Association

NESSARA
NEW ENGLAND SERVICE STATION & AUTO REPAIR ASSOCIATION, INC.
574 Boston Road, Suite #12
Billerica, MA | 01821 | (978) 667-7706

Retailers Association of Massachusetts
The Voice of Retailing

NATO

February 3, 2015

VIA email: citycouncil@marlborough-ma.gov
Hon. Arthur Vigeant, Mayor
Hon. Mark A. Oram, Councilor
Hon. Patricia Pope, Councilor
Hon. Michael Ossing, Councilor
Hon. Kathleen D. Robey, Councilor
Hon. Joseph F. Delanao, Jr. , Councilor
Hon. Robert Page, Councilor
Hon. Matt Elder, Councilor
Hon. Robert J. Tunnera, Councilor
Hon. John Irish, Councilor
Hon. Edward Clancy, Councilor
Hon. Donald R. Landers, Councilor
City Hall
140 Main Street
Marlborough, Massachusetts 01752

Subject: Comments and Recommendations on Tobacco Regulations

Dear Mayor and Councilors:

In advance of the public hearing to be conducted by the Board of Health on February 3, we are sending this letter with comments and suggested changes to the proposed amendments to your existing smoking and tobacco regulations. We are basing these comments on the draft regulations that accompanied the Board's January 6 agenda packet.

Massachusetts retailers are committed to keeping tobacco out of the hands of underage youth and want to partner with cities, towns and boards of health to expand effective regulations that would substantively address the goal of reducing youth access to tobacco without resulting in a severe negative impact on local retailer. The set of regulations currently being promoted by some statewide organizations to boards of health fail to address the key issues surrounding legal youth access to, and possession of, tobacco products that extend beyond the control of retailers and the reach of current laws and regulations.

Failure to address the deficiencies and loopholes of the proposed regulations, current laws and regulations will compound the harm to communities by damaging the local economy and putting local retailers at a distinct disadvantage to their counterparts in surrounding communities. The deficiencies that exist include the following:

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New England Convenience Store Association

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1. Under Massachusetts state law, parents and guardians can legally provide tobacco products to their children who are under the age of 18 and minors are not legally prohibited from purchasing and possessing tobacco. A 2011 Youth Risk CDC report found that 86% of underage smokers get access to tobacco products from sources other than purchase at retail stores.[1] In fact, Section D(1) of the proposed tobacco regulations contains this same exemption for parents or legal guardians to give tobacco products to an underage youth. We ask the City Council to take a bold step and remove this exception language from Section (D)(1) so that parents and legal guardians are not allowed to give tobacco products to an underage child.

2. The FDA reports that Massachusetts retailers have a 91 % compliance rate with laws preventing youth tobacco access based on FDA retail compliance checks of Massachusetts stores that sell tobacco products.[2]

3. A 2007 study from DePaul University assessed the smoking status of juveniles fined for violating tobacco purchase, use and possession laws. The study surveyed youth in 24 towns once a year for three years.[3] Of those youth who were issued a ticket for a law violation, 39% reported not smoking again during the first year after the violation. For the two follow-up years, 45% and 41% reported not smoking. Assuming that those who quit were more frequent smokers, it is possible that about 15% to 24% of the original sample of underage youth cited actually quit smoking over the follow-up period, according to the study.[3]

4. A 2006 DePaul University Study found that over time, youth exposed to increased enforcement of laws prohibiting purchase, use and possession (PUP) resulted in reduced youth tobacco use at school and in their towns and perceived lower rates of tobacco use among their peers than youth in the control group.[4] This study tested for any differences across four environments, including (1) with friends, (2) in school, (3) on school grounds, (4) around town.

   In all four of these environments, the use of PUP laws were significantly associated with lower likelihood of students observing use of tobacco in the town. Overall, the study found that "PUP laws can result in important changes in the amount of publicly visible youth tobacco use in a community, perceptions of youth tobacco use, and self-reported tobacco use."

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[1] Center for Disease Control and Prevention. "Youth Risk Behavior Surveillance – United States, 2011" Morbidity and Mortality Weekly Report, Volume 61. Issue No. 4 (2012): Pg. 17.
[2] Food and Drug Administration. "Compliance And Enforcement Report" (2013): Pg. 27.
[3] Jason, Leonard A. PhD, Steven B. Pokorny PhD, Monica Adams MPH, Yvonne Hunt PhD., Praveena Gadiraju, Michael Schoeny. "Do Fines for Violating Possession-Use-Purchase Laws Reduce Youth Tobacco Use?" Journal of Drug Education Volume 37, Issue #4 (2007): Pgs. 393-400.
[4] Jason, Leonard A. PhD, Steven B. Pokorny PhD, Monica Adams MPH, Annie Topliff MA, Courtney Harris BA, Yvonne Hunt PhD. " Youth Tobacco Access and Possession Policy Interventions: Effects on Observed and Perceived Tobacco Use" American Journal on Addictions Volume 18, Issue #5, (2009): Pgs. 6-8.

5. A 2012 Surgeon General study found that "Social influences are among the most robust and consistent predictors of adolescent smoking. Peer influences seem to be especially salient, perhaps because adolescence is a time during which school and peer group affiliations take on particular importance. Adolescents tend to overestimate the prevalence of smoking among their peers, and perceptions that one's peers smoke consistently predict use of tobacco." [5]

In light of these facts, retailers and industry members recognize that cities and towns can play a critical role in bringing more effective youth tobacco and nicotine programs to bear. Based on these facts, we are asking that the Marlborough Board of Health give serious consideration to passing a compromise set of regulations that would more directly and substantively address underage youth tobacco use by focusing regulations on the access and possession of tobacco while limiting harm to the local economy and responsible retailers. Our proposal includes the following provisions:

1. Increase the legal age to purchase, use and possess tobacco and nicotine products, including electronic cigarettes, to age 19 instead of age 21, effectively removing the ability of purchase, use and possess tobacco products from high school age and younger children. The U.S. Food and Drug Administration is currently conducting a study to determine if there is any public health benefit to raising the legal age to purchase tobacco. The results of the study are scheduled to be released early this year. Also, remove the exception for parents and legal guardians to give tobacco products to their children who are under the legal age.

2. Impose a fine on those adults that provide tobacco products to persons under the minimum legal sales age.

3. Collaborate with retailers and the industry to publicly request the State of Massachusetts remove provisions from Massachusetts General Laws Chapter 270 that allow parents or other complicit adults to legally provide tobacco products to underage children and to make such an action punishable by a civil fine.

4. Add language to the state statute that specifically makes it illegal for minors to purchase tobacco products.

5. Implement civil fines for underage minors in possession of tobacco or nicotine products.

In addition, we are requesting that the Marlborough Board of Health make the following specific amendments to the proposed changes to your existing tobacco regulations as identified in the public notice:

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[5] U.S. Department of Health and Human Services. "Social, Environmental, Cognitive, and Genetic Influences on the Use of Tobacco Among Youth" Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. (2012) Pg. 458

As to the Smoking Regulations, remove Section 4(a)(a) of the Smoking Regulations so as to not extend the smoking ban to include e-cigarette use.

As to the Tobacco Regulations:

1. Amend Section D(1) by making the minimum legal age to purchase, use and possess tobacco products to 19, not 21.

2. Remove Section F which would regulate cigar sales.

We have a serious legal concern with dictating cigar package sizes in the absence of any evidence or support doing so will achieve a health-related goal either for underage youth or for adults who buy and smoke cigars. This lack of evidentiary support undermines the justification for proposing a minimum package size. We would be pleased to review any purported authority for the City to set packing requirements.

3. Remove Section G which would ban the sale of flavored tobacco products.

A ban on flavored tobacco products, except in retail tobacco stores and smoking/hookah bars, will cause irreparable financial harm to those other Worcester retailers because the ordinance prohibits the sale of literally hundreds of legal flavored tobacco products. The sale of flavored tobacco products is a very important revenue source for retailers; Worcester retailers will lose customers and sales if they are required to remove several hundred different kinds of flavored cigars, pipe tobacco and smokeless tobacco products from their store shelves.

Such a ban will only cause adults to travel to nearby cities and towns to purchase their preferred flavored tobacco products. In addition, since virtually all pipe tobacco is flavored, a blanket flavor ban provision will effectively eliminate the sale of pipe tobacco by most Marlborough retailers. Moreover, there is no scientific data or other evidence that minors buy and use pipe tobacco, so no justification for banning such flavored tobacco products.

a. Insert the following Sections:

Section Q. Purchase for or providing tobacco products to minors.

(1) Civil Violation. It shall be unlawful for any individual to purchase any tobacco product on behalf of, or to give any tobacco product to, any person under the minimum legal sales age. The terms of this section shall not apply to an employee who, in the course of their employment and as a part of their employment duties, sells tobacco products.

(2) Civil Penalty. Any individual who violates subsection (A) shall be liable for a civil penalty of:

a. [$_____] for the first violation of such subsection by such individual;

b. [$_____] for the second violation of such subsection by such individual within [time period]; or
c. [$_____] for the third or a subsequent violation of such subsection by such individual within [time period].

Section R. Purchase or possession of tobacco products by persons under the minimum legal sales age; use of false identification.

(1) Civil Violation. It shall be unlawful for any person under the minimum legal sales age to purchase a tobacco product, possess a tobacco product, or to attempt to purchase or possess a tobacco product. This subdivision shall not apply to any person under the minimum legal sales age engaged in law enforcement activity in accordance with enforcement of minimum age laws, or to any person under the minimum legal sales age who is handling or transporting a tobacco product under the terms of his or her employment.

(2) Civil Violation. It shall be unlawful for any minor to present or offer to another individual a purported proof of age which is false, fraudulent or not actually his or her own proof of age, for the purpose of attempting to purchase or possess a tobacco product.

(3) Civil Penalty. An individual who violates subsection (1) and/or (2) shall forfeit any tobacco products and/or forfeit such proof of age in his or her possession to any law enforcement officer upon request, and/or and such individual also shall be liable for a civil penalty of:

a. [$_____] and/or [#] hours of community service work for the first violation of such subsection by such individual;
b. [$_____] and/or [#] hours of community service work for the second violation of such subsection by such individual; or

c. [$_____] and/or [#] hours of community service work for the third or any subsequent violation of such subsection by such individual.

Section S. Tobacco Awareness Program.

(1) In General. On a finding of liability of an individual for a violation under Section R, the court shall require such individual to attend a tobacco awareness and cessation program approved by the Marlborough Board of Health. The court may require the parent or guardian of such individual to attend the tobacco awareness and

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cessation program with that individual. On request, such program may be taught in languages other than English. If such individual resides in an area of this state in which access to a tobacco awareness

(2) and cessation program is not readily available, the court shall require such individual to perform [#] hours
(3) of community service in lieu of attending the tobacco awareness and cessation program.

(2) Violation Expunged From Record. Not later than [#] days after the date of a finding of liability under Section R, the individual found liable shall present to the court, in the manner required by the court, evidence of satisfactory completion of the tobacco awareness and cessation program, and/or evidence of the performance of any community service required under this section or Section R. On receipt of the evidence required under this section, the court shall waive any fine imposed under Section R and shall expunge such individual's record of liability for the violation, whereupon such individual shall be released from all penalties and disabilities resulting from the violation, except if, after the date of such release, such individual is subsequently found liable for a violation under Section R, any preceding violation of such sections shall be reinstated in such individual's record.

We also request that the Marlborough Board of Health partner with us to appeal to state lawmakers to close the loophole in Massachusetts General Law that permits parents and guardians to distribute tobacco products to children. We welcome your thoughts on how we might collaboratively approach state leaders, including the new Governor, to make this a priority for the 2015 legislative session.
Sincerely,

Stephen Ryan
Executive Director
New England Convenience Store Association

Jon Hurst
President
Retailers Association of Massachusetts

Thomas Briant
Executive Director
National Association of Tobacco Outlets

John Howell
Executive Director
New England Service Station and Auto Repair Assoc.

City of Marlborough
Marlborough Public Library
35 West Main Street
Marlborough, MA 01752
Phone 508-624-6900 FAX 508-485-1494
TDD 508-460-3610

Margaret Cardello
Director

January 6, 2015

City of Marlborough
Board of Health
140 Main Street
Marlborough, MA 01752

Dear Marlborough Board of Health,

The Trustees of the Marlborough Public Library would like to state our support for the adoption of regulations related to "Smoking in Workplaces and Public Places."

The Library has a policy in place that requires people who wish to smoke to leave library property and smoke only on public sidewalks. This action was taken after we received many complaints from people entering and exiting the Library who had to walk through cigarette smoke to do so. Many complaints came from parents who wanted to shield their children from the second hand smoke.

While this has reduced the amount of smoking, action to strengthen the regulations would help our cause significantly. Not only would it help eliminate the smoke it would remove the smell and litter that accompany smokers.

We strongly support the expansion of the existing smoke-free buffer zone to include banning "smoking on library property".

Presuming the changes are made what is the process that we would go through to have signs made alerting the public to these changes? We also would like to know what enforcement provisions will be included in the revised regulations.

Thank you for your attention to this important health and safety matter.

Sincerely,

Rustin Kyle

Rustin Kyle, Chairman, Board of Library Trustees

MASSACHUSETTS GENERAL HOSPITAL

MassGeneral Hospital for Children™

Harvard Medical School

MGH Center for Child and Adolescent Health Research and Policy
15-1542A, 100 Cambridge Street, Boston, MA 02114
Tel: 617-724-1062
Fax: 617-726-1886
Email: jwinickoff@mgh.harvard.org

Jonathan P. Winickoff, M.D., M.P.H.
Associate Professor of Pediatrics

Dec. 15, 2014

To the Board of Health,

We are writing to express our strongest support for raising the minimum legal age for the sale of tobacco products to 21 as part of comprehensive tobacco regulations. Indeed, the American Academy of Pediatrics, the American Medical Association, and the Massachusetts Health Officers Association endorse raising the legal age to 21.

We are both pediatricians with long experience in the field of tobacco cessation and control. We have been encouraging communities to safeguard their youths against tobacco for many years and currently have 41 cities and towns that have taken this life-saving action. Neither of us receive any funds whatsoever for this effort.

It is imperative for the health of the youths of our communities that Boards of Health use their legal authority to raise the age of sale to 21. Individuals who begin smoking at a young age are more likely to become addicted, progress to daily smoking, become heavier tobacco users as adults, and have difficulty quitting, according to the 2012 Surgeon General's Report. Ninety percent of smokers start smoking before age 21. Many people who purchase for distribution to minors are still in high school and are between the ages of 18 and 20.

It is also imperative that we ban flavor-enhanced tobacco products as these are the sweet entry-level starter products that are designed to appeal to new users of any age.

Please feel free to contact us with any questions.

Sincerely,

Jonathan P. Winickoff

Jonathan P. Winickoff, MD, MPH
Division of General Academic Pediatrics

Lester J. Hartman MD MPH

Lester Hartman, MD, MPH
Medical Director for the Patient-Centered
Medical Home
Westwood-Mansfield Pediatrics
Lester.Hartman@childrens.harvard.edu

TOBACCO21

"HEALTHY TOWNS, HEALTHY KIDS."™

T21

IT'S SIMPLE MATH:

Raising the minimum tobacco sales age to 21 will dramatically reduce tobacco use.

Just 2% of tobacco sales help produce 90% of new smokers.

Cigarette sales to those under 21 account for only 2.12% of total sales. But, because 90% of smokers start by the age of 21, these are the very sales that help lead to 9 out of every 10 new smokers. This means that the impact on store owners will be minimal and will only affect a very small percentage of their tobacco sales in the short term.[1]

Raising the minimum tobacco sales age to 21 can reduce smoking rates to single digits.

Only 10% of smokers start at the age of 21 or older.[2] If the current smoking rate is about 20%,[3] then by simple math, if someone reaches the age of 21 as a non-smoker, that individual has only a 2% chance of becoming a smoker (.1 X.2 = .02=2%).

This strategy is already working.

In 2005, Needham, MA voted to raise and enforce theminimum tobacco sales age of 21. In 2006, before full enforcement, the town had a youth smoking rate of 13% compared with 15% in the surrounding communities. By 2010, the youth smoking rate in Needham was down to 6.7% while the surrounding communities' rate only decreased to 12.4%. The percent decline in youth smoking in Needham was nearly triple that of its neighbors.[4]

Many people who purchase for distribution to minors are between the ages of 18 and 20.[5]

Since most students do not reach twenty-one years of age while still enrolled in high school, increasing the legal age of sale would greatly reduce the number of students who could purchase tobacco products. By decreasing the number of eligible buyers in high school, this action will help reduce youth smoking by decreasing the access of students to tobacco products.

A similar strategy was highly successful in addressing alcohol sales.

A national age 21 law for alcohol sales resulted in reduced alcohol consumption among youth, decreased alcohol dependence, and has led to dramatic reductions in drunk driving fatalities.[6,7] At the time, some critics of the policy argued that because 18 year-olds can vote and enlist in the military, they should be allowed to be sold alcohol. Despite these arguments, the increase in the minimum sales age for alcoholic beverages has saved tens of thousands of lives of young drivers, their passengers, and others on the road. [8]

[1] Winickoff JP, Hartman L, Chen ML, Gottlieb M, Nabi-Burza E, DiFranza JR. Minimal Retail Impact of Raising Tobacco Sales Age to 21. American Journal of Public Health. 2014. In Press.
[2] This is a conservative estimate. Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2008. Analysis by the American Lung Association, Research and Program Services Division using SPSS software.
[3] CDC. Morbidity and Mortality Weekly Report. "Current Cigarette Smoking. Among Adults — United States, 2011." November 9, 2012. 61(44);889-894.
[4] Analysis of 2011 Youth Risk Behavior Surveillance System (YRBSS) data by Jonathan P. Winickoff, MD, MPH, Associate Professor of Pediatrics, Harvard Medical School.
[5] Difranza JR, Wellman RJ, Mermelstein R, et al. The natural history and diagnosis of nicotine addiction. Current Reviews in Pediatrics. 2011;7(2):88-96.
[6] Wagenaar AC. Minimum drinking age and alcohol availability to youth: Issues and research needs. In: Hilton ME, Bloss G, eds. Economics and the Prevention of Alcohol-Related Problems. National Institute on Alcohol Abuse and Alcoholism (NIAAA) Research Monograph No. 25, NIH Pub. No. 93-3513. Bethesda, MD: NIAAA; 1993:175-200.
[7] DeJong W, Blanchette J. "Case Closed: Research Evidence on the Positive Public Health Impact of the Age 21 Minimum Legal Drinking Age in the United States." J. Stud. Alcohol Drugs, Supplement 17, 108-115, 2014.
[8] NHTSA's National Center for Statistics and Analysis, March 2005. "Calculating Lives Saved Due to Minimum Drinking Age Laws." Washington, DC, U.S., DOT.

T21

THE VULNERABLE TEEN/YOUNG ADULT BRAIN

Nearly 90% of smokers started smoking by age 20.[1]

Scientific study of the brain is increasingly showing a distinct gap between when we are physiologically mature and neurobiologically mature.[2]

In fact, there could be as much as a 4-7 year difference. During this period the brain continues to be highly vulnerable.[2]

The minimum age of military service does not equal readiness to enlist in a lifetime of smoking.

THE SCIENCE OF BRAIN WIRING

From neuroscience experiments, we know that the frontal lobe - the seat of human judgment - is not fully wired until age 25. [3] This is why some describe the period from 18-25 years as emerging into adulthood.[2] During this critical period, the brain remains especially vulnerable to tobacco addiction.[4]

Delaying the age of initiation of nicotine significantly prevents a lifetime of addiction.

99% of lifetime smokers started smoking before the age of 26.[2]

Tobacco affects the development of the brain in areas of addiction during this vulnerable period.[4,5]

The tobacco industry knew all of this as early as 1982:

"If a man has never smoked by age 18, the odds are three-to-one he never will. By age 21, the odds are twenty-to-one." -RjReynolds, 1982[6]

Brain health is public health

[1] SAMHSA. Calculated based on the data in the 2011 National Survey on Drug Use and Health.
[2] The Surgeon General Report. 2012. "Preventing Youth Tobacco Use." http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/factsheet.html.
[3] Crews et al, Adolescent Cortical Development: A Critical Period of vulnerability for addiction; Pharmacol Biochem Beh, 2007, pages 189-199.
[4] Morales et al, Cigarette Exposure, Dependence & Craving are Related to Insula Thickness in Young Adult Smokers; Nature/Neuropsychopharmacology, 2014, pages 1-7
[5] U.S. Department of Health and Human Services. "The Health Consequences of Smoking —50 Years of Progress: A Report of the Surgeon General." Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[6] RJ Reynolds. Estimated Change in Industry Trend Following Federal Excise Tax Increase .; 1982. Available at: http://legacy.library.ucsf.edu/tid/tib23d00;jsessionid=211D4CCF0DBD25F9DC2C9BB025239484.tobacco03

T21

RESPONSES TO CONVENIENCE STORE OWNERS' CONCERNS

Big tobacco (RJR and Philip Morris USA) have been working through the retailers.

The arguments you may hear:

We will go out of business.

When Needham increased the sales age to 21 in 2005 not a single convenience store went out of business.

Restaurant and bar owners had the same fear when smoking was banned, and this did not happen.[1]

Tobacco sales to 18-20 year olds are only 2% of retail tobacco sales.[2]

CVS and Target have decided to stop selling all tobacco products, leaving more tobacco business for convenience stores.

We make our profits from the ancillary purchases (milk and bread) when people come in to buy cigarettes.

98% of tobacco sales and all associated ancillary purchases will be unaffected.[2]

18-20 year olds will have more money for other in-store purchases that are not tobacco.

They will just go to other towns and we will lose business.

Lower smoking rates are better for business.
A city or town that creates fewer smokers will have higher socioeconomic status, better health status, better jobs, and better quality of life for all residents.[3]

Research has shown a minimal retail impact of raising the sales age to 21.[2]
In fact, since 2005 in Needham, there is no evidence for youth traveling to other towns to purchase tobacco.

Each town that goes to 21 increases the likelihood that the surrounding towns will also to go to 21.

Small decreases in youth access to retail tobacco are strongly associated with lower tobacco use.
The key point is that youth will quit or use less tobacco, and those who don't smoke are less likely to start.[4,5]

We want this to go to the state legislature to make it a level playing field.

The banning of tobacco in bars and restaurants was won on the local level first before it went to the state.

This is a ploy by the Tobacco Industry.
When Utah's Senator Reid was asked why Tobacco21 didn't pass at the state level, he explained it to us in three words: "The Tobacco Lobby."

[1] Hahn, EJ, "Smokefree Legislation: A Review of Health and Economic Outcomes Research," American Journal of Preventive Medicine 39(6S1):S66-S76, 2010.
[2] Winickoff JP, Hartman L, Chen ML, Gottlieb M, Nabi-Burza E, DiFranza JR. Minimal Retail Impact of Raising Tobacco Sales Age to 21. American Journal of Public Health. 2014. In Press.3 [2]
[3] U.S. Department of Health and Human Services. "The Health Consequences of Smoking —50 Years of Progress: A Report of the Surgeon General." Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
[4] Scully M, Mcarthy M, Zacher M, Warne C, Wakefield M, White V. Density of tobacco retail outlets near schools and smoking behavior among secondary school students. Aust New Zealand J Pub Health. 2013;37(6):574-78.
[5] Henriksen L, Feighery EC, Schleicher NC, Cowling DW, Kline RS, Fortmann SP. Is adolescent smoking related to the density and proximity of tobacco outlets and retail cigarette advertising near schools? Prev Med. 2008 Aug;47(2):210-4.

[redacted]

T21

THE MILITARY/AGE RESTRICTION ARGUMENT

What you can't do until you are 21 years or older:

- Buy alcohol
  During the Vietnam era, 29 states lowered the alcohol purchase age to 18 and highway death rates made a significant climb. Raising the sales age back to 21 caused the death rate to drop significantly.[1]
- Casino gambling
- Get a 'license to carry' gun permit.
- Rent a car (must be age 25 - crash rates don't drop significantly until then)
- Rent a hotel room in some hotels.

The argument: If you can go to war and bear arms at 18 you should have the right to smoke.

Response: The minimum age of military service does not equal readiness to enlist in a lifetime of smoking.

IN FACT:

The U.S. Army Surgeon General says soldiers who smoke are less combat ready and take longer to heal.[2]

The U.S. Military is taking steps to ban all tobacco sales on military bases. Easy access to cigarettes has led to a 33.6% smoking rate among active duty military. [2]

Years of studies, including a comprehensive study on 9.3 million military beneficiaries, have revealed lung cancer mortality rates are double among Veterans.[3]

Veterans who served to protect our freedom but contracted emphysema from addiction to the discounted cigarettes in the military have lost **their** freedom.[4]

[1] DeJong et Blanchette: Case Closed: Research Evidence on the Positive Public health Impact of Age 21 MLDA in the US, Journal of Studies On Alcohol and Drugs/ Supplement No17.2014 pg108-115
[2] http://www.army.mil/standto/archive/issue.php?issue=2012-11-20
[3] A Study of Cancer in the Military Beneficiary Population, Guarantor: Raymond Shelton Crawford III, MD MBA, Contributors: Raymond Shelton Crawford III, MD MBA; Julian Wu, MD MPH; Dae Park, MD; Galen Lane Barbour, MD; Military Medicine, Vol. 172, October 2007
[4] http://www.iom.edu/~/media/Files/Report%20Files/2009/MilitarySmokingCessation/Combating%20Tobacco%20Military%20for%20web.pdf

NOTES

Contact Us

Jonathan P. Winickoff, MD, MPH

jwinickoff@mgh.harvard.edu

Lester Hartman, MD, MPH

lester.hartman@childrens.harvard.edu

compare favorably to nicotine-replacement therapies in terms of the likelihood of having returned to smoking 6 months after a cessation attempt.[5]

Given the near unanimity of the public health community in pressing for harm reduction for injection-drug users in the face of relentless political opposition, some harm-reduction advocates find it stunning that their allies in that struggle have embraced an abstinence-only position on smoking. These advocates claim that a strategy of reducing, though not eliminating, risk is a moral imperative, given the certainty of harm associated with continued tobacco smoking.

The debate's stakes are heightened by the current discussion of the tobacco endgame, which aims to eliminate smoking or reduce it to very low levels. Most endgame strategists have advanced prohibitionist policies, from complete bans on traditional cigarettes, to regulatory strategies that would reduce and eventually eliminate nicotine, to efforts to manipulate pH levels in tobacco to make inhaling unpleasant.

This debate compels us to address the fundamental issue posed by Kenneth Warner in a recent issue of *Tobacco Control* devoted to endgame strategies: "What would constitute a final victory in tobacco control?" Warner's question raises several others: Must victory entail complete abstinence from e-cigarettes as well as tobacco? To what levels must we reduce the prevalence of smoking? What lessons should be drawn from the histories of alcohol and narcotic-drug prohibition?

From the glowing tip to the smokelike vapor, e-cigarettes seek to mimic the personal experience and public performance of smoking. But ironically, the attraction of the device is predicated on the continued stigmatization of tobacco cigarettes. Although abstinence-only and strict denormalization strategies may be incompatible with e-cigarette use, the goal of eliminating smoking-related risks is not. We may not be able to rid the public sphere of "vaping," but given the magnitude of tobacco-related deaths — some 6 million globally every year and 400,000 in the United States, disproportionately among people at the lower end of the socioeconomic spectrum — an unwillingness to consider e-cigarette use until all risks or uncertainties are eliminated strays dangerously close to dogmatism. We believe that states should ban the sale of e-cigarettes to minors and the FDA should move swiftly to regulate them so that their potential harms are better understood — and so that they can contribute to the goal of harm reduction.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Center for the History and Ethics of Public Health, Department of Sociomedical Sciences, Columbia University Mailman School of Public Health, New York.

This article was published on December 18, 2013, at NEJM.org.

1. Grana RA, Glantz SA, Ling PM. Electronic nicotine delivery systems in the hands of Hollywood. Tob Control 2011;20:425-6.
2. Henningfield JE, Zaatari GS. Electronic nicotine delivery systems: emerging science foundation for policy. Tob Control 2010;19:89-90.
3. Chapman S, Wakefield MA. Large-scale unassisted smoking cessation over 50 years: lessons from history for endgame planning in tobacco control. Tob Control 2013;22:Suppl 1:i33-i35.
4. Sweanor D, Alcabes P, Drucker E. Tobacco harm reduction: how rational public policy could transform a pandemic. Int J Drug Policy 2007;18:70-4.
5. Siegel MB, Tanwar KL, Wood KS. Electronic cigarettes as a smoking-cessation: tool results from an online survey. Am J Prev Med 2011;40:472-5.

DOI: 10.1056/NEJMp1313940

Tobacco 21 — An Idea Whose Time Has Come

Jonathan P. Winickoff, M.D., M.P.H., Mark Gottlieb, J.D., and Michelle M. Mello, J.D., Ph.D.

On November 19, 2013, New York City Mayor Michael Bloomberg signed into law the "Tobacco 21" bill, imposing the strictest age restriction on tobacco sales of any major U.S. city.[1] Beginning in May 2014, it will be illegal to sell tobacco products and electronic cigarettes to persons younger than 21 years of age. The law stops short of making possession of tobacco products by persons under 21 a crime, placing the responsibility on retailers under penalty of civil fines.

Regulations issued by the Food and Drug Administration (FDA) set the national minimum tobacco-sales age at 18 but allow states and localities to enact laws setting a higher minimum age. In 2013, seven Massachusetts towns and one Hawaiian county adopted Tobacco 21 laws. Similar legislation has been introduced in a growing number of communities and at least three states: New Jersey, New York, and Utah. Further dissemination of Tobacco 21 laws represents a critical opportunity for public health law to reduce one of the most important health risks facing the U.S. population.

A generation ago, a similar strategy proved successful in curbing alcohol use by young

people and its social harms. The national minimum drinking age of 21, adopted universally by the states after Congress made it a condition of receiving federal highway funds in 1984, is credited with decreasing alcohol consumption, drunk driving, and motor vehicle accidents among young people.[2] These laws have withstood the test of time, against objections that find echoes in those raised to Tobacco 21 laws.

Chief among these objections are protests against "nanny state" interference with the decisions of young adults. If these people are old enough to vote and enlist in the military, it is argued, they are old enough to make decisions that affect their own health. There is also initial skepticism about the effectiveness of restrictions on access for young people, who may make purchases in surrounding jurisdictions with lower minimum ages or may buy tobacco or alcohol from friends. Finally, critics worry about the cost to small businesses.

Tobacco 21 laws are too new to have generated rigorous evidence concerning their effectiveness, but early data are provocative. Consider the case of Needham, Massachusetts, which in 2005 became the first town in the country to adopt such a law. Before fully implementing the measure, the town had a smoking rate among high school students of 12.9%, as compared with 14.9% in surrounding towns, according to the Youth Risk Behavior Surveillance System. By 2010, the youth smoking rate in Needham had fallen by nearly half, to 6.7%, while the rate in surrounding communities decreased to 12.4%. The percentage decline in Needham was nearly triple that of its neighbors — contradicting the hypothesis that young people will simply shift their purchases to surrounding towns.

The most compelling case for Tobacco 21 laws comes not from experience, however, but from the epidemiology and science of smoking addiction. Eighty percent of adult smokers began smoking daily before 20 years of age,[3] and 90% of persons who purchase cigarettes for distribution to minors are under 21.[4] Increasing the minimum tobacco-sales age to 21 could virtually eliminate minors' ability to buy from other local high school students, substantially raising barriers to access. It therefore addresses a major reason why — as critics hasten to point out — existing age restrictions have not successfully eliminated smoking among children.

There remains the prospect of shopping across jurisdictional lines, but minors are not a highly mobile population that can easily cross borders for regular purchases. Although those who are already addicted may be sufficiently motivated to do so, increasing the transaction costs associated with obtaining tobacco products may reduce daily consumption among regular users and discourage others from starting to smoke. Protecting younger adolescents is a key goal, but often overlooked is the fact that 31% of smokers progress to daily smoking in early adulthood.[3] For this group, the practical costs of increasing tobacco use shift from negligible to considerable under Tobacco 21 laws.

Erecting further barriers to tobacco use among adolescents is especially crucial in light of evolving neuroscientific evidence that the adolescent brain has a heightened susceptibility to the addictive qualities of nicotine.[3] While people are still experimenting with tobacco use and before they're aware of their own addiction, they go through a process in which they first want, then crave, then need nicotine. Once they reach the point of need, they are often unable to quit. Research suggests that adolescents can become dependent on nicotine very rapidly, at lower levels of consumption than adults; that they are undergoing alterations in the structure and function of the brain that make them more vulnerable to addiction to nicotine and other substances over the long term; and that they may be less responsive than adults to nicotine-replacement therapy.[3] Adolescents' greater impulsivity and risk taking also leads them to discount the potential consequences of tobacco experimentation and use. These tendencies place young people at high risk for addiction, which is a strong counterpunch to objections related to paternalistic interference with free choice.

The burdens associated with any new regulation should be carefully considered, but Tobacco 21 laws would not impose major new compliance costs. FDA regulations already require tobacco retailers to check the identification of anyone seeking to purchase tobacco products who appears to be younger than 27. Convenience stores and other outlets that sell alcoholic beverages also already enforce the minimum purchase age of 21 for alcohol. Tobacco retailers and producers fear, with reason, that Tobacco 21 laws will mean lost sales revenue, but that has never been a strong argument for permitting the sale of a lethal product to young people. Finally, enforcement costs to the government

are offset to a degree by revenue generated through fines.

One barrier to successful implementation of Tobacco 21 laws is the prospect of incomplete compliance by retailers. Compliance with the 18-year minimum has been variable, and interventions to boost compliance have had mixed success.[5] Some retailers may prove even more reluctant to comply with Tobacco 21 laws, particularly in challenging economic times, because they further undercut already-reduced sales revenue and lack the perceived moral force of laws that more explicitly aim to protect children.

Studies show that the extent to which such access restrictions reduce the prevalence of smoking among young people depends on the vigor with which authorities enforce them.[5] Strong incentives for enforcement activities can be provided through mechanisms such as the Synar Amendment, which made a portion of federal block grants from the Substance Abuse and Mental Health Services Administration conditional on states' willingness to adopt policies to restrict tobacco sales to minors and demonstrate high levels of compliance with these laws.

A forthcoming FDA report to Congress on the public health impact of raising the minimum tobacco-sales age could soon place Tobacco 21 legislation on the federal agenda. In the interim, further state and local policy leadership can help to generate effectiveness data to determine whether the policy merits nationwide adoption and what implementation problems should be anticipated.

According to a recent Gallup poll, nearly 90% of U.S. adults who smoke report that if they had it to do over again, they would not have started. Helping today's adolescents avoid that regret requires a comprehensive strategy that includes strong supply-side interventions. We believe that Tobacco 21 laws are a logical next step.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Department of Pediatrics, Harvard Medical School and Mass General Hospital for Children (J.P.W.), the Public Health Advocacy Institute at Northeastern University School of Law (M.G.), and the Department of Health Policy and Management, Harvard School of Public Health (M.M.M.) — all in Boston; and the Edmond J. Safra Center for Ethics, Harvard University, Cambridge, MA (M.M.M.).

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Smoke, the Chief Killer — Strategies for Targeting Combustible Tobacco Use

Michael C. Fiore, M.D., M.P.H., M.B.A., Steven A. Schroeder, M.D., and Timothy B. Baker, Ph.D.

January 2014 marks the 50th anniversary of the landmark *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service* — an important moment to take stock of efforts to eliminate the harms of tobacco use. Smoking rates in the United States have decreased dramatically over the past 50 years. The prevalence of smoking among adults fell from about 43% in 1965 to about 18% in 2012, meaningfully reducing rates of smoking-caused disease and death. These outcomes are a testament to the policy, legal, and clinical strategies begun 50 years ago that have reduced tobacco use and mitigated its harms.

The current landscape of tobacco use presents new challenges and opportunities. Nearly 50 million Americans continue to use some form of tobacco, with much higher rates among the poor, the mentally ill, illicit-substance and alcohol abusers, Native Americans, and lesbian, gay, bisexual, and transgender persons. But research now quite clearly highlights the specific harms of combustible tobacco use (cigarette, pipe, and cigar smoking): given that up to 98% of tobacco-related deaths are attributable to combustible

MetroWest Prevention & Wellness Partnership

The MetroWest Prevention & Wellness Partnership is one of nine innovative projects in Massachusetts working to improve health outcomes and reduce healthcare costs. Our work is focused on four health conditions, identified by the Massachusetts Department of Public Health as having the most potential for improving health and reducing costs. They include:

1. Pediatric Asthma
2. Hypertension
3. Tobacco Use
4. Fall Prevention Among Older Adults

The Town of Hudson is the lead municipality for this project. Our partnership is cross-sector collaboration among municipal, clinical and community based organizations. Each member of our partnership has a clearly identified role to play. These roles were outlined in the application phase of the project (September 2013). Partners include:

Municipal Partners	Town of Hudson
	Town of Framingham
	City of Marlborough
	Town of Northborough
Clinical Partners	Charles River Medical Associates
	EMK Framingham Community Health Center
	MetroWest Medical Center
Community Partners	MetroWest YMCA
	YMCA of Central MA
	Latino Health Insurance Program
Training & Technical Assistance	Metropolitan Area Planning Council
	Central MA Area Health Education Center

Role of municipal health departments:

Local health departments play a critical role in this project. They will provide referral services, direct services, and advance public health policies. Specifically, health departments will work on the following health conditions:

Falls Prevention:	Provide home safety assessments and modification
Tobacco Use:	Refer patients to tobacco cessation counseling programs
	Expand smoke-free housing policies

Grant funds are available to each municipality to hire a Community Health Worker who can carry out these activities. The City of Marlborough is included in our partnership and eligible for these funds provided they participate fully in the project and provide appropriate supervision and support for the Community Health Worker.

Framingham ★ Hudson ★ Marlborough ★ Northborough

MetroWest Moves

Mass in Motion ©

2014-2015 Work Plan

MetroWest Moves was awarded a $165,000 grant over the next three years as part of the Mass in Motion Municipal Wellness and Leadership Program. With this new funding, which began in October 2014, MetroWest Moves selected the following three work plan strategies for 2014-2015:

Healthy Dining Initiative:

Restaurants are a vital part of these four communities' economic bases and draw visitors from across MetroWest. A unified, healthy dining initiative will improve nutrition for residents and visitors and draw attention to healthy eating. Restaurant inspectors can play an important role in communicating with restaurants currently participating in the MetroWest Moves Healthy Dining Initiative and ensuring that they comply with the requirements of the Initiative. Under the new work plan, MetroWest Moves will:

- Develop a standardized protocol to embed healthy dining in local restaurant inspections
- Train restaurant inspectors to conduct compliance checks of current participating restaurants
- Promote participating restaurants regularly on websites, social media, and through distribution of brochures
- Partner with local community based organizations or community leaders to develop and disseminate healthy nutrition messages that are linguistically and culturally appropriate
- Continue to provide materials to restaurants as needed to feature their approved healthier menu items

Complete Streets:

Benefits of community design standards such as Complete Streets include increased transportation choices, economic revitalization, creation of vibrant and livable communities, improved safety, and increased opportunities for daily physical activity. Framingham passed a Complete Streets policy on January 6, 2015. Using Framingham's experience as a model, MetroWest Moves is working towards the development of Complete Streets guidelines in the other three communities. The following action steps will be taken to achieve these goals:

- Supplement the work of the Community Innovation Challenge grant
- Support the development of Framingham's Bike Plan to expand the Town's network of bicycle paths
- Engage key stakeholders and inform municipal leadership about Complete Streets progress in the MetroWest including holding meetings and distributing an Active Living Newsletter
- Collaborate with MAPC to assist communities with site plan and subdivision regulation review

Safe Routes to School:

MA Safe Routes to School (SRTS), a federally funded program of MassDOT, partners with public elementary and middle schools throughout the Commonwealth to help plan and implement programs that encourage student walking and bicycling activities. MetroWest Moves aims to add one new school and increase SRTS activities in schools currently participating in SRTS. Action steps to achieve these goals include:

- Establish a SRTS taskforce in Hudson
- Continue surveying parents to determine child travel behaviors and barriers to walking and biking using the statewide MassDOT My School Commute Survey
- Analyze survey data and develop an implementation plan to increase SRTS participation with MassDOT support

About Us: MetroWest Moves is a quad-community Mass in Motion initiative to facilitate opportunities for people who live, work and play in Framingham, Hudson, Marlborough, and Northborough to engage in healthy eating and active, smoke-free living.

Learn more at: www.metrowestmoves.org facebook.com/MetroWestMoves @metrowestmoves