Results from the 2017 Vermont Local Opinion Leaders Survey

Opinions Regarding Tobacco, Alcohol, and non-Medical Marijuana Prevention and Control Policy Options

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Vermont Tobacco Control Program &
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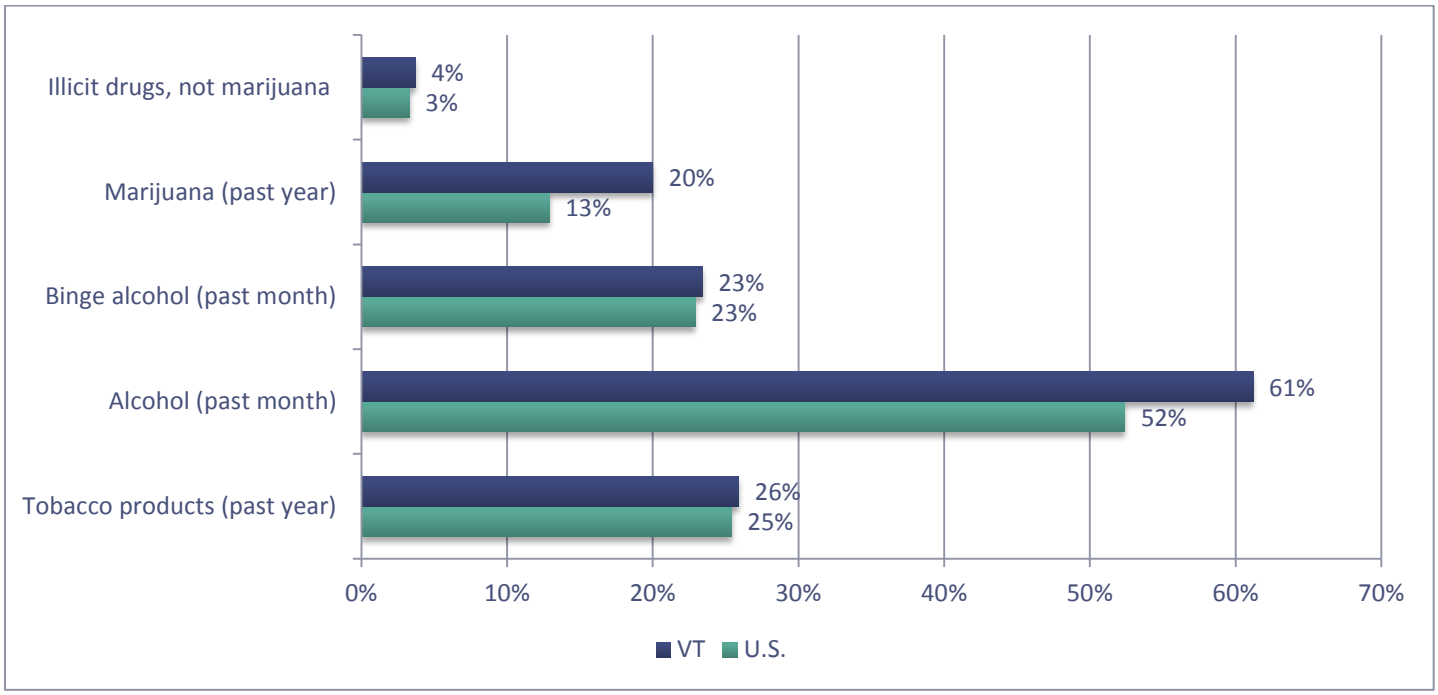
Introduction

Substance use and misuse are prevalent in the United States and in Vermont[i] (Figure 1). The health effects of tobacco use[ii], secondhand smoke[iii], illicit drugs, such as non-medically indicated use of prescription drugs[iv], and misuse of alcohol[v] are well documented. Experimentation with these highly addictive substances often begins during adolescence and young adulthood.

Figure 1: Substance Use Prevalence among Persons aged 12 years and older, United States and Vermont, 2013-2014



Effective tobacco prevention and control efforts involve population-wide, multicomponent best practice strategies at multiple levels (individual, organizational, community, state, environment, etc.) [vi]. The Vermont Tobacco Control Program (VTCP) and the Vermont Alcohol and Drug Programs (ADAP) employ these types of practices, aiming to reduce tobacco and substance use burden in Vermont. Policy interventions that restrict access to, or increase the cost of tobacco or substances, also effectively reduce their use. For example, several studies have shown that smoke-free policies and tobacco tax increases reduce smoking[vii]. A recent British study, using econometric modeling and survey data, estimated that establishing a minimum unit pricing for alcohol would reduce consumption, primarily for heavy drinkers[viii]. Both the VTCP and ADAP work closely with strategic partners and community grantees to promote prevention and control policy strategies at the state and local levels. Thus, assessing knowledge, attitudes, and support for potential policy options among municipal government and other local opinion leaders is useful to inform strategic planning and policy priorities.

In 2014, VTCP sponsored a survey of local opinion leaders in Vermont, conducted by RTI International. The survey sample consisted of mayors, regional planning council chairs, select board chairs, and town managers. The primarily interview-based survey ascertained opinions on a series of possible tobacco control policies. In

2017, VTCP and ADAP co-sponsored a second local opinion leader survey, conducted by JSI Research & Training Institute, Inc. (JSI). The 2017 survey expands on the 2014 survey by including additional local opinion leaders (local planning council chairs, chamber of commerce members and staff) and additional policies (for alcohol and recreational marijuana use). The goals of the study were to:

- Compare level of support for selected tobacco prevention and control policies over time;
- Describe local opinion leaders' top of mind concerns about the health of their community and on the relative importance of tobacco, alcohol, marijuana, and opiate use in their community.
- Ascertain level of support for new potential prevention and control policies for tobacco, alcohol, and recreational marijuana use;
- Examine whether level of support for policies varies by local opinion leader role, perceived influence, and county population size;
- Describe the reasons local opinion leaders provided for their policy stances.

Methods

Sample development

The sample frame used in the administration of the 2014 Local Opinion Leader Survey (LOLS) was provided and updated with current contact information for the 2017 LOLS. The sample was also expanded with additional opinion leaders—local planning commission chairs and chamber of commerce staff or members. This approach was used to allow for comparative analysis between the 2014 and 2017 results, while also adding new voices to the data. The total sample for the 2017 LOLS was 460 local opinion leaders.

The total 2017 LOLS sample had two distinct parts: an updated list of the original contacts from 2014, referred to as the "core sample" (n = 310) and additional leaders identified as the "expanded sample" (n = 150) inclusive of the local planning commission chairs and chamber of commerce contacts. The Vermont League of Cities and Towns list of municipal leaders and the Vermont Chamber of Commerce list of employees and board members were used to create the sampling frame, supplemented with online queries of local and regional websites to add and correct contact information.

Data Collection

The survey for the core sample was fielded initially by telephone interviews, with an on-line option made available later in the process. A pre-notification letter signed by the Commissioner of Health was mailed on August 22, 2017 and telephone outreach began on August 29, 2017. JSI's trained telephone interviewers made up to 10 attempts to reach core sample members over the next 60 days. Non-responders with email addresses were invited to complete an on-line survey on their own on October 30, 2017 (8 weeks after calling began). Non-responders received periodic mailed, emailed and telephone reminders through November 30, 2017.

Pre-notification of leaders in the expanded sample started on September 29, 2017 with a letter in the mail and an email, both of which included a live link to the on-line survey. Participants in the expanded sample received two email reminders in the later part of October, two reminder phone calls in November, and a final email reminder on November 30, 2017. Data collection closed for both the core and expanded samples on December 18, 2017.

Although leaders in the core sample were sent the Commissioner's letter, in part to garner trust in the survey process, many of those contacted expressed concerns. Concerns were primarily with regard to how their contact information was acquired and whether/how their information would be made public. JSI assured respondents their individual data would be kept confidential and only reported in the aggregate.

Response Rate

The overall response rate for the combined samples was 65% (Tables 1-4). The response for the core sample was higher (68.1%) compared to the expanded sample (58.7%).

Table 1: Core Sample Response Rate

TITLE	Survey Sample	Completed Interviews	Completed Online	Refusals	Ineligible*	Response Rate
Mayors	8	5	0	0	0	**62.5%**
REGIONAL Planning Commission	11	7	2	0	0	**81.8%**
Town Managers	54	35	3	9	0	**70.4%**
Selectboard Chairs	237	117	42	25	2	**67.1%**
TOTAL	**310**	**164**	**47**	**34**	**2**	**68.1%**

Table 2: Expanded Sample Response Rate

TITLE	Survey Sample	Completed Online	Response Rate
LOCAL Planning Commission	114	69	**60.5%**
Chambers of Commerce	36	19	**52.8%**
TOTAL	**150**	**88**	**58.7%**

Table 3: Combined Response Rates

SAMPLE	Survey Sample	Completed	Response Rate
Core Sample	310	211	**68.1%**
Expanded Sample	150	88	**58.7%**
TOTAL	**460**	**299**	**65.0%**

Table 4: Combined Response Rates by Role

	Survey Sample	Completed Interviews	Completed Online	Response Rate
Mayors	8	5	0	63%
REGIONAL Planning Commission	11	7	2	82%
Town Managers	54	35	3	70%
Select board Chairs	237	117	42	67%
LOCAL Planning Commission	114		69	61%
Chambers of Commerce	36		19	53%
TOTAL	**460**	**164**	**135**	**65%**

*Ineligible indicates the position was either vacant or the individual was new to the position and not prepared to take the survey.

Respondents were distributed throughout the state, ranging from 5 from Grand Isle to 35 from Windsor County. The median number of respondents per county was 22.5 leaders (Table 5). Except for Grand Isle and Franklin Counties, all other counties had at least one respondent who was from the business community (chamber of commerce), at least one who represented a planning commission (local or regional), and at least one who was a municipal official (mayor, select board chair, or town manager).

Table 5: Response Rates by County

COUNTY	Survey Sample	Completed	Response Rate
Addison	38	29	76%
Bennington	31	21	68%
Calendonia	32	24	74%
Chittenden	35	24	69%
Essex	16	9	56%
Franklin	28	19	67%
Grand Isle	6	5	83%
Lamoille	20	14	70%
Orange	31	19	61%
Orleans	31	15	48%
Rutland	54	28	52%
Washington	45	32	70%
Windham	43	24	56%
Windsor	50	35	69%

Survey Development

The 2014 LOLS questions were used as a model for the 2017 LOLS to support comparative analysis over time, to the extent possible. During the summer of 2017, JSI engaged the VTCP, ADAP and their evaluator, PIRE, to provide input on policy priorities and related questions for the 2017 LOLS, considering potential state and local policy initiatives for tobacco, alcohol, and non-medical marijuana prevention and control. A final set of questions and related survey was developed and approved by the Vermont Department of Health and Governor in August 2017.

The surveys ascertained the following elements:

- How local opinion leaders rated the importance of tobacco, alcohol, marijuana, and opiate use in their community and what they considered the most important health problem in their community.
- How local opinion leaders rated the extent they would favor 5 tobacco control policies, 4 alcohol control policies, and 1 recreational marijuana policy. All but one were rated on the same 5-point scale: strongly against, somewhat against, neither in favor or against, somewhat in favor, and strongly in favor. For 7 of these policies, respondents were asked a follow-up question to explain why they rated the policy in this way.

- Local opinion leaders' perception of their own influence, at the community level, and among state legislators.

The final draft survey was pilot tested by JSI internally; it took from 10-15 minutes to complete. A copy of the interview version of the survey can be found in the Appendix. There were only minor grammatical differences between the interview and online versions of the survey (an example instruction: "now I'd like to ask you…" versus "the next question asks about..").

Effect of Mode of Survey Administration on Response Quality

The 2017 core sample was primarily collected via telephone interview (about 78%) in order to be consistent with the mode of administration of the 2014 LOLS. Since the survey elicited opinions about policies, it was thought that trained interviewers would help elicit these types of "open-ended" responses. However, in order to be efficient, the expanded sample was fielded solely via self-report online survey. We examined whether the response to open-ended questions varied by mode of administration.

For 7 of the 9 policies covered on the survey, respondents were asked the open-ended question "could you tell me why you felt this way?" On average, the interview surveys had 5.8 open-ended responses per survey (95% confidence interval 5.7 to 5.9), significantly higher than the average of 4.5 for the online surveys (95% confidence interval 4.2 to 4.8).

Statistical/Analytic Methods

Questions regarding the importance of substance use in the community, degree of agreement with specific policies, and perceived level of personal influence all had Likert-scaled response options. The results for these questions are presented in the form of frequency distributions. For the policy opinion questions, 95% confidence intervals are presented (Clopper-Pearson Exact method for binomial proportions) on the proportion who "strongly agree" with the policy.

Per the project analysis plan, results for the policy questions are also stratified by respondent role, level of influence, and geography. The strata are defined so that each subgroup was large enough to ensure respondent confidentiality, while maintaining analytic rigor. These strata are defined as follows:

- **Role.** This stratification variable has three levels: Municipal Official (mayors, select board chairs, town managers); Planner (local or regional planning commission chairs); Business (chamber of commerce staff or member). Since there were substantial numbers of select board chairs, we provide results for that group separately, when there is a difference in opinions across roles.
- **Influence.** There are two strata of influence: Local (medium or high perceived level of influence in their community) and State (medium or high perceived level of influence with their state legislators).
- **Geography.** This stratification variable has three levels based on the size of the population of Vermont cities and towns. This aggregation was selected because substantial commentary regarding policies revolved in terms of whether it applied "to my small town" or that a policy might be more relevant in "larger/tourist towns". The categories are[ix]: counties with at least one city or town of 10,000 or more residents (Bennington, Chittenden, Rutland, Windham), counties with at least one medium city or

town of 5,000-9,999 residents (Addison, Caledonia, Franklin, Lamoille, Washington, Windsor), and counties with all towns with <5,000 residents (Essex, Grand Isle, Orange, Orleans).

The Chi-square test of association (p-value < .05) was used to determine whether the distribution of opinions for each policy varied by the levels of each strata. Because of the small number of chamber of commerce members/staff, in order for the Chi-square test to be accurate, we collapsed the response categories down to two (strongly favor/somewhat favor and neither in favor or against/somewhat against/strongly against).

Respondents had seven opportunities to provide a rationale for their opinions for eight specific policies. To help reduce redundancy toward the end of the survey, the survey asked for the opinions about an increase in the state excise tax on beer or wine and about creating a 1% local option tax on alcohol in one, rather than two, questions. The concepts, or themes, embedded in these opinions were derived using an inductive coding process (i.e., thematic categories were developed per the data versus creating a list of preconceived thematic categories).

- The first 20 core responses were reviewed by one coder to develop a preliminary set of themes for each policy question;
- The entire sample was split in thirds and assigned to the three coders;
- After a preliminary review of their data, the coding team met again to refine and expand the set of themes;
- Each coder assigned themes to their set of responses.
- Once coded, the split samples were re-assigned so a second coder could double check coding. The first coder then resolved any differences between the two coders.

Results

Respondents

Given the greater number of towns than cities in Vermont, it makes sense that most respondents were select board chairs (159, or 53%) and local planners (69, or 23%; Figure 2a). When grouped by role, 67% of the sample consisted of municipal officials, 26% planners, and 6% business people (Figure 2b).

Figure 2a: Respondents by Role

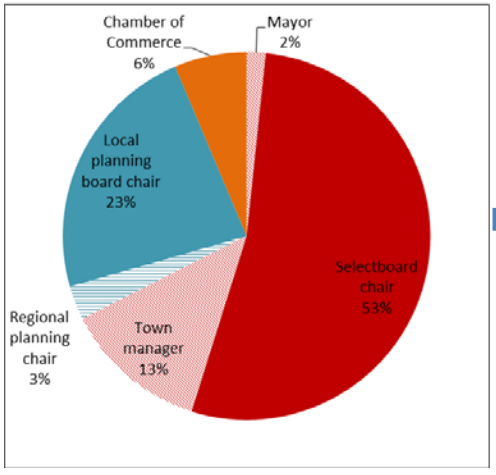
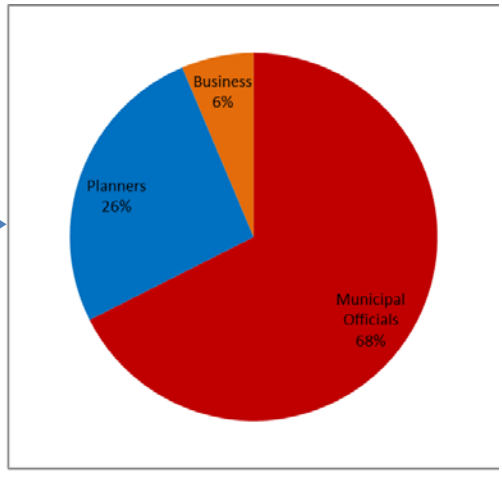


Figure 2b: Respondents by Role Category



The majority of leaders thought they were moderately or highly influential in their communities (Table 6). Municipal officials were more likely to consider themselves moderately or highly influential than planners or business people. Leaders generally perceived their influence to be greater at the local level than with state legislators. With the exception of mayors, the majority of other leaders perceived they had little or no influence with their state legislators.

Table 6: Perceived Level of Influence as "Medium" or "High"

Role	Influence in local Community %	Influence with State Legislators %
Mayor (n=5)	100%	80%
Selectboard chair (n=159)	71%	44%
Planners (n=78)	45%	33%
Town manager (n=38)	84%	45%
Chamber of Commerce (n=19)	63%	47%

Very few respondents considered themselves highly influential at either the local (76, or 25%) or state (19, or 6%) levels. In fact, only 13 leaders considered themselves highly influential at both levels; they were a mix of select board chairs (7), town managers (2), local planners (2), mayors (1), and business people (1). They were evenly split among counties with larger cities (Chittenden, 4; Rutland, 2) and counties with no cities (Windsor, 2; Lamoille, 2; Orange, 1; Franklin, 1).

Relative Importance of Public Health Issues

Tobacco Use. In 2014, leaders were asked to rate how important addressing tobacco use was in their community; the question was repeated in 2017. Comparing the 2017 core sample responses to the 2014 sample (same type of leaders), there was a slight but not statistically significant decline in the percent who perceived tobacco use as an equally or more important issue than other health problems (82.4% in 2014 and 76.5% in 2017; Table 7). The majority of the full 2017 sample considered this an important issue (77.6%).

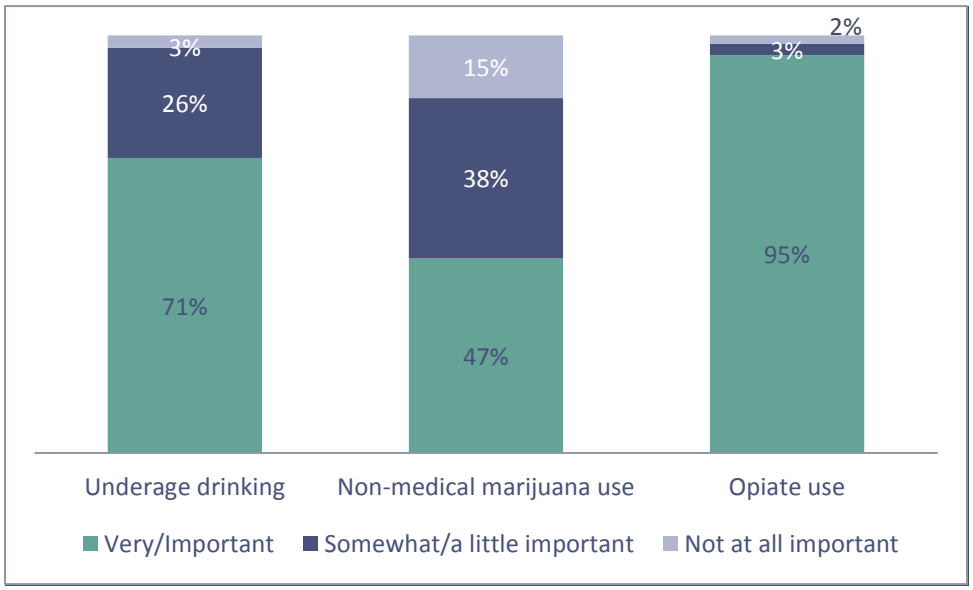
Table 7: Perceived Importance of Tobacco Use in the Community

	2014 sample	2017 core sample	2017 full sample
Among the most important health problems	11.5%	12.5%	13.7%
Equally important as other health problems	70.9%	64.0%	63.9%
Among the least important health problems	17.5%	23.5%	22.5%
Among the most and equally important, combined	82.4%	76.5%	77.6%

95% confidence interval (most & equal combined)	77.6% to 87.2%	70.6% to 82.3%	72.8% to 82.4%
Somewhat or strongly favor two tobacco control policies (95% CI)			
Increase minimum age to 21 years	47% 40.7% to 53.3%	42.1% 35.4% to 48.8%	47.0% 41.3% to 52.7%
Prevent retailers from accepting coupons	56.2% 49.9% to 62.5%	46.6% 39.8% to 53.4%	51.8% 45.9% to 57.5%

Substance Use. In 2017, nearly everyone (93.6%) thought opiate use was important or very important to address (Figure 3). Underage drinking was rated important or very important by a similar majority as for tobacco control (69.9%). Just under half thought non-medical marijuana use was an important or very important issue (45.5%). Of note is that the question on importance of alcohol control focused on underage drinking, while the alcohol control policies option questions were not specifically tied to age.

Figure 3: Perceived importance of Substance Use ("how important do you think it should be for your community to address…")



For reference, **76.5%** considered tobacco use *"among the most important or equally important issues".*

Note: The question about importance of tobacco control was asked differently than the questions about other substances. The tobacco control question was asked in the same manner as in 2014. The questions about the importance of other substances were new to the 2017 survey. While the tobacco question asked about the issue in relation to other health issues on a 3-point scale, the other substance questions simply asked about the importance of each issue on a 5-point scale; thus the results are not directly comparable.

Most Important Health Issues for Communities. When local opinion leaders were asked to describe in their own words what the most important health problem their community needs to address, addiction in some form was most often mentioned at 174 times (51% out of 338 mentions[x]). Of these, opioids (115 mentions) or heroin (7) predominated; other substances were mentioned less frequently: alcohol (9), cannabis (1), crime-related to addiction (4), or drugs generally (38). The next highest set of issues mentioned were related to metabolic health (70 mentions): obesity (39), nutrition (16), and physical activity (15). Other topics mentioned 10-20 times were: access to health care or insurance (24), aging (16), mental health (13), poverty and its effect on health (15).

The vast majority of leaders also support including health promotion language in their town or regional plan (n=203, 69%) or already have such language in their plan (n=50, 17%).

Level of Support for Tobacco Prevention and Control Policies

Opinions concerning two tobacco prevention and control policies were ascertained in both the 2014 and 2017 LOLS. Recall that JSI's "core" sample consisted of the same types of respondents (mayors, town managers, select board chairs and regional planners) as the 2014 sample. For consistency sake we compared 2014 results to those for the 2017 **core** sample (Table 7). Comparing 2014 results to those for the 2017 core sample, support for both policies has declined somewhat, but not statistically significantly so. In 2014, 47% of respondents were in favor of increasing the minimum age to 21 years to purchase tobacco products, which declined to 42.1% in 2017. In 2014, 56.2% favored preventing retailers from accepting tobacco coupons, which declined to 46.6% in 2017.

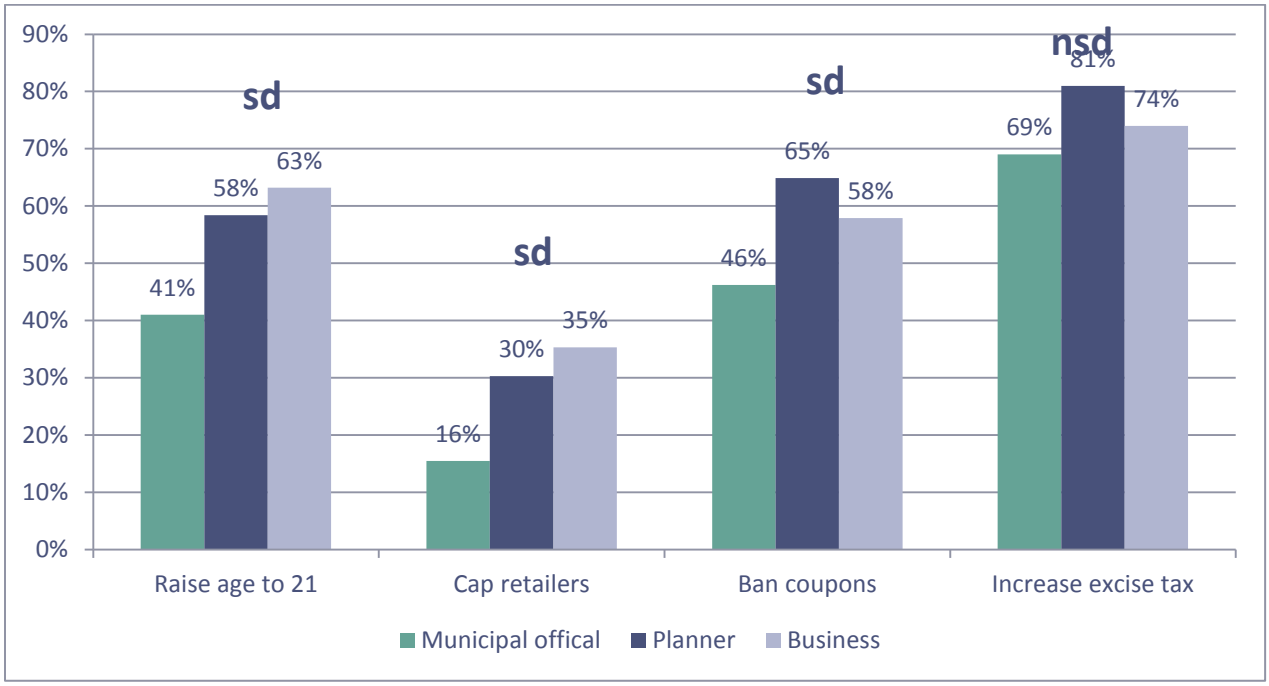
For the full sample in 2017, support varied by specific policy (Table 8). The policies with the strongest support were for increasing the tobacco excise tax, with 44% strongly in favor (72.7% strongly or somewhat in favor) and making flavored tobacco products illegal (46.2% said "yes") - although the different scale makes it difficult to know the gradations of actual support. There was little support for restricting the number of retailers; only 9.3% strongly favor this policy (20.7% strongly or somewhat favor).

Table 8: 2017 Opinions Regarding Tobacco Control Policies

Policy	Yes (95% CI)		No		Don't know
Make flavored tobacco illegal	46.2% (40.4 - 52.1%)		38.1%		15.6%
	Strongly Favor (95% CI)	**Somewhat Favor**	**Neither For or Against**	**Some-what Against**	**Strongly Against**
Increase tobacco excise tax	44.0% (38.3% -49.9%)	28.7%	11.3%	8.2%	7.9%
Prevent retailers from accepting coupons	38.9% (33.2% - 44.8%	12.9%	14.6%	13.9%	19.8%
Increase minimum age to 21 years	29.4% (24.3% - 34.9%)	17.6%	0.0%	35.5%	17.6%
Restrict # of tobacco retailers	9.3% (6.2% - 13.3%	11.4%	31.1%	19.6%	28.6%

For several tobacco control policies, opinions varied significantly by role (Figure 9). Municipal officials were less likely to favor: raising the legal age to 21, restricting the number of retailers, or preventing retailers from accepting coupons. Within the municipal officials group, select board chairs' percent favorability on these three policies was within a percentage point of the full group. There were no significant differences by county grouping (based on city/town population size), nor by level of influence (neither local nor state).

Figure 9: Tobacco Policy Support by Role (% somewhat or strongly favor)



"sd" means opinions vary significantly across the three roles; "nsd" means opinions do not vary significantly across roles. Statistical significance determined by the chi-square test of association.

Level of Support for Alcohol Control Policies

There was very little strong support for any of the proposed alcohol control policies (Table 9). One-quarter of leaders strongly favored restricting alcohol consumption in public places, although 50.7% strongly or somewhat favored this policy. Less than half favored a 1% local option tax on alcohol sales (46.6% strongly or somewhat favored). There was little support for increasing the state excise tax and particularly restricting the number of alcohol retailers.

Table 9: Opinions Regarding Alcohol Control Policies

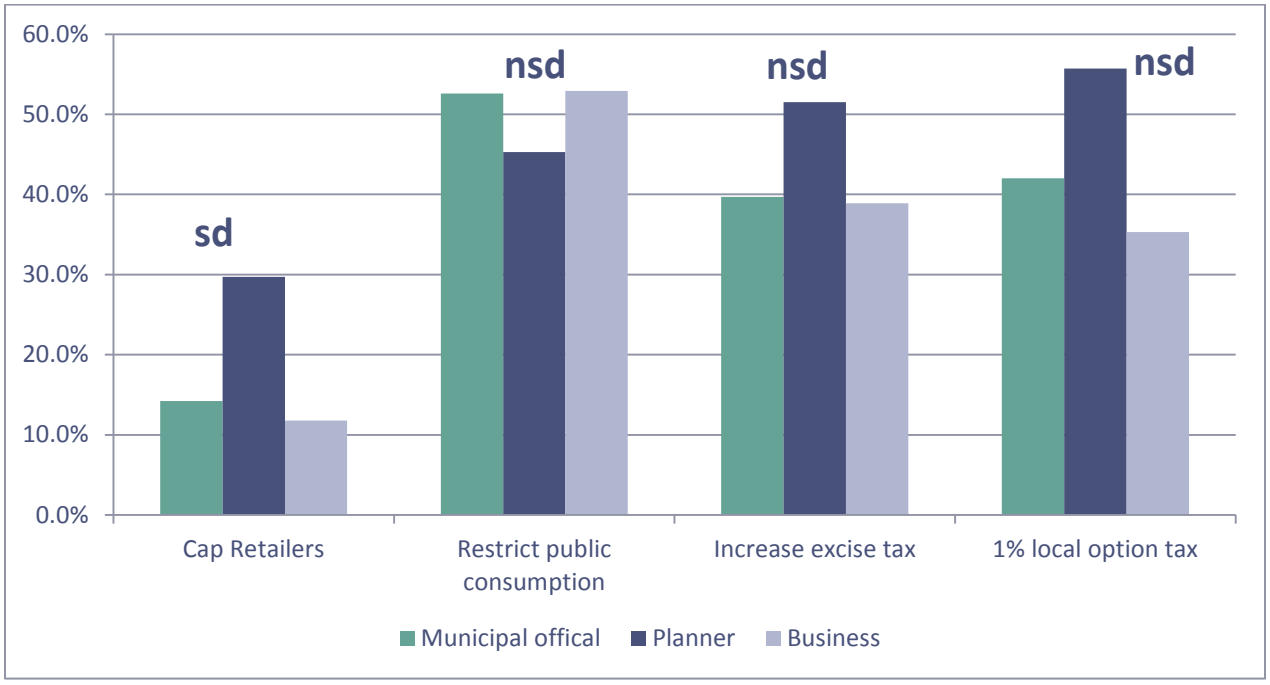
Policy	Strongly Favor (95% CI)	Somewhat Favor	Neither For or Against	Some-what Against	Strongly Against
Restrict alcohol consumption in public places	25.0% (20.1% - 30.4%)	25.7%	16.0%	18.1%	15.3%
Create a 1% local option tax	25.3% (20.3% - 30.8%)	21.3%	15.2%	13.0%	25.3%
Increase alcohol excise tax	14.8% (10.9% - 19.4%)	27.8%	17.2%	17.5%	22.7%
Restrict # of alcohol retailers	7.8% (5.0% - 11.6%)	10.3%	18.8%	23.4%	39.7%

Just over one-third of the sample declined to answer the question about the enforceability of restricting alcohol consumption in public places. Of those who responded, leaders were nearly evenly split with 48% thinking it would be very or somewhat unlikely (or didn't know) and 52% thinking it would be very or somewhat likely to be enforced.

One alcohol control policy varied significantly by role (Figure 10), which was restricting or capping the number of alcohol retailers. Planners favored this policy (29.3%) more than municipal officials (14.2%; select board chairs 16.3%) or business people (11.8%). There was little variation in opinion by county grouping. Only one borderline statistically significant finding was that leaders from counties with larger cities or towns were somewhat more likely to favor the 1% local option tax (60% favor if from a county with at least one large city/town, 43% favor if from a county with at least one medium sized city/town, 46% favor if from a county with all small towns).

There was a nominal amount of variation (borderline significant) by level of influence. Those who perceived they had medium to high influence in the community were more strongly against capping the number of retailers (67%) than those with low or no influence (55%) and more strongly against the 1% local option tax (43% vs. 30%).

Figure 10: Alcohol Policy Support by Role (% somewhat or strongly favor)



Level of Support for both Alcohol and Tobacco Excise Taxes

There were 117 leaders who somewhat or strongly favored both the beer/wine and tobacco taxes; only 36 strongly favored both. Nearly all who favored the alcohol excise tax also favored the tobacco tax (117/123 or 95%), but not so the other way - only just over half who favored the tobacco tax also favored the alcohol excise tax (117/209, or 56%).

Level of Support for a Non-Medical Marijuana Control Policy

Just over 40% of leaders favored restricting advertising for non-medical marijuana and related paraphernalia, should marijuana be legalized (60.8% strongly or somewhat favor). There were no differences in opinion across roles, geography, or perceived influence.

Table 10: Opinions Regarding Restricting Advertising for Non-Medical Marijuana and Paraphernalia

Policy	Strongly Favor (95% CI)	Somewhat Favor	Neither For or Against	Some-what Against	Strongly Against
Restrict advertising for non-medical marijuana and related paraphernalia	41.1% (35.3% - 47.0%)	19.7%	13.7%	8.8%	16.8%

Qualitative Thematic Analysis

The thematic groups and associated frequencies of occurrence are presented for responses to open-ended questions on reasons for support/non-support for eight policies (Tables 10-16). Mirroring the policy ratings, increasing the tobacco excise tax, restricting alcohol consumption in public places, and restricting advertising for non-medical marijuana garnered the relatively greatest positive commentary.

With regards to increasing the legal age to acquire tobacco to 21 years (Table 10), the primary reasons cited against this policy related to the legal age of adulthood being 18 years (i.e., if it is legal to vote or be in the military, buying legal tobacco products should also be OK for those 18 years and older). Also there was a somewhat common belief that such a restriction would not effectively stop young adults from acquiring tobacco products. There were nearly equal numbers, however, who did believe increasing the age would delay access to or use of tobacco products.

Commentary was similar regarding capping or restricting the number of tobacco retailers (Table 11) and alcohol retailers (Table 13). While there were those that believed that such restrictions would reduce consumption, more believed that businesses have the right to sell legal products. Often that was qualified with the idea of "responsibly selling", presumably supporting existing regulations (e.g., age requirements). Related themes were the negative economic impact on the retailers or the community and the need support local business (for alcohol, tourism was an issue). The question of how to select retailers to constrain was often noted, particularly if a community only has 2 or a few retailers - how could this be done without implying favoritism.

With regards to increasing the tobacco excise tax (Table 12), the most frequent comments were positive or neutral. There was good recognition that increasing the tax would reduce demand/discourage use. A common concern was the lack of control how the additional revenue would be used; favorability for many is conditional on the money being used to offset the societal cost of tobacco use (use revenue for health care costs or insurance or substance abuse education).

Opinions regarding increasing the state beer/wine tax or creating a local option tax (Table 14) were fairly similar to those for the tobacco excise tax, with some exceptions. Belief in taxation reducing consumption was

still true, but noted by fewer people; more noted their conditional favor based on how the revenue was raised. Far more people noted a general opposition to increased alcohol taxes - too much taxation already, pushback from residents, unfair to those of lesser means, negative economic impact. For all tax questions, around 10% consistently said these policies won't work - people will go elsewhere (other VT towns with lower taxes, or notably, New Hampshire). On the positive side, many noted they already had implemented a local 1% tax, and those in favor noted the need for local revenue sources.

Restrictions on consumption of alcohol in public places generally garnered positive comments. Commentary was nuanced: some phrased their opinion as allowing public drinking with restrictions based on place or situation (e.g., not where children play, not in the parks; events that get local permission are OK, etc.), while others phrased their opinions as being against restrictions as long as people are of age and abide by norms. Across the board, there was sense that control should be local, based on each community's situation, not mandated by the state.

Opinions regarding restricting advertising for non-medical marijuana and related paraphernalia tended to be positive, in the sense many thought that such use of marijuana should not be promoted or its use encouraged, and that those who want to use it will find it anyway. There was a smaller group who favored advertising - once it is a legal product, businesses should be able to sell it and thus advertise.

Table 10: Policy of increasing the legal age for purchasing tobacco to 21 years

# Mentions	*Tone toward policy*	*Theme*
102 (35%)	Neg	Age 18 is considered adulthood; the age for serving in the military and voting. Adults should be able to purchase legal goods.
49 (17%)	Pos	Increasing the age will help delay access to, or discourage use of, tobacco products.
37 (13%)	Neg	Increasing the age will have no effect on tobacco use and young people's ability to acquire it.
29 (10%)	Pos	Increasing the age will reduce the negative health and environmental consequences of tobacco use.
24 (8%)	Pos	18 year olds are not yet mature enough to choose to smoke; 21 year olds are more mature... yet some noted prohibition can make tobacco more attractive.
20 (7%)	Pos	The same guideline should apply to tobacco as alcohol.
19 (7%)	Neg	There are better ways to limit tobacco access/use (education, ads, personal experiences).
9 (3%)	Neg	Difficult to enforce such a policy.
5 (2%)	Neutral	Need more information/examples of such a policy to decide.

Table 11: Policy of restricting the number of tobacco retailers

# Mentions	*Tone toward policy*	*Theme*
95 (35%)	Neg	Businesses have a right to sell legal products; we are free market society. Too harsh of a measure.
54 (20%)	Neg	We should support small business, it will have negative economic impact, we only have 1-2 retailers.
35 (13%)	Pos	It will reduce access to, and use of tobacco. Having fewer retailers will make tobacco easier to regulate.

34 (13%)	Neg	It will have no effect on tobacco use/ability to acquire it - go elsewhere (or no retailers in town anyway).
17 (6%)	Neutral	Need more information/examples on the process to decide for or against.
15 (6%)	Neg	Hard or unclear how to enforce. Which retailer do you pick? (issue of fairness, perceived favoritism).
11 (4%)	Neg	There are other ways to limit tobacco use (education).
7 (3%)	Pos	Regulate tobacco and alcohol uniformly.
3 (1%)	Neg	People who are of age should be able to acquire tobacco.

Table 12: Policy of increasing the tobacco excise tax

# Mentions	*Tone toward policy*	*Theme*
136 (45%)	Pos	Increasing tax works by discouraging use so do it. [some noted that it provides motivation to quit, send a message tobacco use is not healthy behavior]
49 (16%)	Neutral	Conditional on the money going toward health care/health insurance - opportunity cost of tobacco.
33 (11%)	Neg	It will have no or limited effect; people will go elsewhere to buy tobacco (NH)
26 (9%)	Neg	Disproportionate impact on certain people (lower SES, addicts)
18 (6%)	Neg	Negative economic impact - tax is high enough.
16 (5%)	Neutral	Need more information/examples about the process to decide for or against.
10 (3%)	Neg	Too many regulations already (legal product that adults should be able to buy; state should not do social engineering)
6 (2%)	Pos	Additional tax revenue would be beneficial (generally)
6 (2%)	Neg	We won't/not sure we'll use the tax revenue effectively, so no point in doing it.

Table 13: Policy of restricting the number of alcohol retailers

# Mentions	*Tone toward policy*	*Theme*
88 (32%)	Neg	Businesses have a right to sell legal products; we are a free market society. Too harsh a measure.
56 (20%)	Neg	We should support small business, it will have negative economic impact, we only have 1-2 retailers - we need more retailers.
37 (13%)	Neg	It will have no effect on alcohol use and ability to acquire it; will go else where
30 (11%)	Pos	It works by discouraging use so, do it.
27 (10%)	Neg	Establishments are already regulated/controlled - establishments abide by rules. [number of establishments is OK as is; no state interference]
13 (5%)	Neutral	Need more information/examples about the process to decide for or against.
13 (5%)	Neg	There are other ways to limit alcohol - need activities for young people, education, training retailers on underage buyers.
12 (4%)	Neg	Difficult to enforce such a policy.

Table 14: Policy of restricting consumption of alcohol in public places

# Mentions	Tone toward policy	Theme
69 (27%)	Pos	Allow public drinking with restrictions (e.g., at certain public events/with permits, not where children play - not the parks)
50 (19%)	Pos	Public drinking does not set a good example (illegal behavior, safety concerns)
40 (15%)	Pos	Already regulated in my city/town; communities should establish local policies appropriate to them.
36 (14%)	Neg	Against restrictions as long as people are of age and abide by norms (adults can set good example, let adults relax/enjoy)
27 (10%)	Neg	Too much restriction on freed of choice (no conditions set; we can't ban everything)
12 (5%)	Neutral	Need more information/examples about the process to decide for or against
10 (4%)	Pos	It works by discouraging use, so do it.
7 (3%)	Neg	Difficult to enforce such a policy.
5 (2%)	Neg	Prohibition is useless or counterproductive.
3 (1%)	Neg	Economic implications - impact on tourism, need the revenue

Table 15: Policy of increasing the state beer/wine excise tax; creating a 1% local option tax

# Mentions	Tone toward policy	Theme
69 (22%)	Pos	Additional revenue is beneficial to offset health costs; towns need it for education, infrastructure (9 specified state tax)
77 (25%)	Neg	Opposed to increased taxes - too much taxation already; pushback from residents, unfair to segments of population; negative economic impact (15 specified state tax; 11 specified local tax)
39 (13%)	Pos	Taxation works by discouraging use, so we should do it (4 specified state tax, 3 specified local tax).
34 (11%)	Neg	Raising taxes won't be effective - people will go elsewhere (towns with lower tax or NH; 4 specified state tax, 3 specified local tax)
26 (8%)	Neg	Support for tax increase is dependent upon how the revenue is used - want to be able to specify for health or education, not general coffer (4 specified local tax; 2 specified state tax)
17 (6%)	Neg	Local 1% tax is not cost effective; so few retailers and/or population, won't generate enough revenue to offset admin costs.
17 (6%)	Neutral	Need more information about tax options to decide (7 specified local taxes, 4 specified state taxes)
10 (3%)	Neg	Taxes are effective at current levels, so don't change them.
9 (3%)	Pos	State tax is fairer (no price differential across towns)
5 (2%)	Pos	Local tax is fairer (local control).
5 (2%)	Neutral	Local tax already implemented.

Table 16: Policy of restricting advertising for non-medical marijuana and related paraphernalia

# Mentions	Tone toward policy	Theme
101 (41%)	Pos	Use of non-medical marijuana should not be promoted; restrict advertising to discourage use.
48 (20%)	Neg	Allow advertising without restrictions (mirror rules for alcohol, tobacco)
34 (14%)	Pos	Against legalization in general (expected harms - crime, addiction, health)
20 (8%)	Neg	Allow advertising once legalized; free market/free speech for legal product
18 (7%)	Neg	Restricting advertising will have no effect - people who really want it will find it
12 (5%)	Neutral	Too soon to tell if regulation necessary; hypothetical situation.
12 (5%)	Neutral	Need more information (research on the effects of marijuana, advertising); unsure of implementation

Conclusion

The 2017 LOLS garnered 299 responses from municipal officials (n=202), planners (n=78), and business people (n=19) from across the state. These leaders agree that substance use - including underage drinking (71%) and tobacco use (68%) are important health issues in their community; opiate use was universally acknowledged as important (95%). The vast majority of leaders also support including health promotion language in their town or regional plan (n=203, 69%) or already have such language in their plan (n=50, 17%).

Since 2014, support in the core sample for increasing the legal age to 21 years for tobacco purchase declined somewhat but not significantly so (47% in 2014; 42% in 2017). A similar trend existed for preventing retailers from accepting tobacco coupons (56% in 2014; 47% in 2017).

Overall, in 2017 for the full sample, the policies that garnered at least 50% favorable support were:

- Increasing the tobacco excise tax (44% strong, 29% somewhat support);
- Restricting advertising for non-medical marijuana and related paraphernalia (41% strong, 20% somewhat support);
- Preventing retailers from accepting tobacco coupons (39% strong, 13% somewhat support) or selling flavored tobacco (46% “yes”);
- Restricting alcohol consumption in public places (25% strong, 26% somewhat support).

With regards to the tobacco excise tax and public alcohol consumption policies, there was strong commentary that support for the tax was dependent on how the revenue would be used (e.g., it should be used to offset the health costs of tobacco) and that local communities should play a primary role in regulating public alcohol consumption. We did not ascertain reasons for support regarding flavored tobacco or tobacco coupons.

The number of alcohol and tobacco retailers and the nature of the local economy vary by the size of communities. However policy ratings did not vary significantly by geography, when leaders were grouped as being from counties with larger cities, a small city (<5,000 population), nor no cities.

In some instances opinions did vary by the role of the leader. Municipal leaders (mayors, select board chairs, and town managers) were somewhat less likely to favor raising the tobacco purchase age to 21, restrict the number of tobacco retailers, restrict the use of tobacco coupons, and restrict alcohol retailers (business people also had less favorability for this latter policy). Another way to put it is that planners were somewhat more amenable to these specific policies. Information from the business perspective is limited to just a few people, so it is difficult to draw conclusions for that subgroup.

Local leaders are balancing public health concerns, economic concerns and personal freedoms; this is particularly clear for policies that would cap or restrict the number of beer/wine or tobacco retailers, and to some extent raising the legal age to 21 for acquiring tobacco-- policies which have less support . With regards to advertising regarding non-medical marijuana use and paraphernalia, there is relatively strong support, which is timely given that the legislature recently passed a bill and the governor signed into law legalization of possession of marijuana effective July 1, 2018.

While most leaders felt they had some degree of influence in their local community, the vast majority felt they had no influence with their state legislators. Through this survey, they provided support for public health, offered varied perspectives, and raised practical questions. Considering ways to bridge this communications gap could prove worthwhile for policy making.

[i] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014. Model-based Prevalence Estimates (50 States and the District of Columbia).

[ii] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm

[iii] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm

[iv] https://www.cdc.gov/drugoverdose/data/overdose.html

[v] https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

[vi] Dolina S, Khanchandani H, Schmitt C, Durocher B, Goode S. (2015) *Vermont Local Opinion Leader Survey, Technical Report*. Research Triangle Park, NC: RTI International.

[vii] Centers for Disease Control and Prevention. Smokefree Policies Improve Health. Accessed January 23, 2018. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/improve_health/index.htm

[viii] Effects of Minimum Unit Pricing for Alcohol on Different Income and Socioeconomic Groups: A Modelling Study. Holmes J, Meng Y, Meier PS, Brennan A, Angus C, Cambell-Burton A, Gou Y, Hill-McManus D, Purshouse RC. Lancet. 2014;383:1655-64.

[ix] Results based on 2010 Census population data, as posted on Wikipedia https://en.wikipedia.org/wiki/List_of_cities_in_Vermont

[x] Some leaders provided 2-3 issues and some did not answer the question; there were a total of 338 issues mentioned.