



# Addressing Dual Tobacco Use in West Virginia

Report and Recommendations of the Expert Panel

Convened December 13, 2011 in Charleston, West Virginia



A Collaboration of Break Free Alliance, the West Virginia Division of Tobacco Prevention, and the West Virginia Prevention Research Center's Translational Tobacco Reduction Research Program.



Mary Babb Randolph  
Cancer Center





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*NOTE: The contents of this document are solely the responsibility of the authors, panel participants and do not necessarily represent the official views of the Centers for Disease Control and Prevention, the West Virginia Prevention Research Center, and/or the West Virginia Department of Health and Human Resources.*

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“The marketing of oral snuff in Sweden and the United States may undermine proven public health measures to curb smoking and promote youth initiation into smoking, as well as adults, combining [dual] use of snuff and cigarettes, resulting in a negative impact on the public health.”

- Dr. Greg Connolly, Harvard School of Public Health

## BACKGROUND

Despite the fact that the consequences of tobacco use are well-known to West Virginians, they continue to use tobacco in alarming numbers. Tobacco use is the number one preventable cause of premature death and disease in West Virginia (WV).

The WV Bureau for Public Health's Division of Tobacco Prevention (WV-DTP) is aggressively addressing this problem by implementing evidence-based, comprehensive tobacco control programs. Surveillance of tobacco use in WV over the past decade shows the adult prevalence of cigarette smoking, currently at 26.8%, to be among the highest of any of the 50 states (West Virginia Health Statistics Center [WV HSC], 2010). Smokeless tobacco (SLT) use also remains high among young and adult males in the state: 24.8% among high school males (WV HSC, 2011) and 15.5% among adult males (WV HSC, 2010).

An alarming development noticed by WV-DTP and through enrollment data from the WV Tobacco Cessation Quitline over the past six to eight years is that dual tobacco user enrollment is on the rise, from just a few dual users registered in calendar year 2007 to 126 dual tobacco user enrollees in 2011. Dual tobacco use is defined as the regular use of cigarettes and SLT. Dual use of cigarettes along with other tobacco products could not only result in delays in sustained smoking cessation but may also increase the risk of chronic diseases more than cigarette smoking alone.

WV-DTP leaders have continued to keep this emerging public health issue in the forefront for both state and national discussion. Working with key partners, plans and funding were approved in late 2010 to further investigate dual tobacco use in West Virginia.

Partnering with the WV Prevention Research Center (WV-PRC), WV University's Translational Tobacco Reduction Research Program, and Break Free Alliance, the WV-DTP set out to gain further information on dual tobacco use in WV. After vital planning, review and research, Break Free Alliance convened an expert panel on December 13, 2011.

The meeting objectives were to explore the prevalence of dual tobacco use in WV, identify successes and challenges to addressing dual tobacco use in the state, and develop targeted recommendations to address dual tobacco use.

## KEY ORGANIZATIONS INVOLVED IN THE ORGANIZATION AND PLANNING OF THE EXPERT PANEL

### West Virginia Division of Tobacco Prevention

The mission of the West Virginia Division of Tobacco Prevention is to reduce disease, disability and death related to tobacco use. The Division funds prevention and cessation interventions and activities through three best practices, science-based programs: Youth Tobacco Prevention, Clean Indoor Air and Tobacco Cessation. The Division's administration also supports special population-based strategies and program evaluation. Annual federal and state funding for the WV-DTP totaled just over seven million dollars in the fiscal year of 2012. Similar funding levels have been sustained the past nine years. The Centers for Disease Control and Prevention (CDC), recommends that WV's tobacco control efforts be funded at \$28 million annually, four times the current total funding amount.

### Break Free Alliance

Break Free Alliance is a program of the Health Education Council (HEC). HEC is a private, nonprofit organization whose mission is to promote healthy communities around the world. HEC is dedicated to providing access, education, advocacy and training to empower individuals towards a healthy life. HEC focuses its work in underserved communities to eliminate preventable causes of death resulting from the use of tobacco, poor nutrition, and lack of physical activity. Break Free Alliance is a national network of organizations, state tobacco programs, regional partners and researchers working to end the cycle of tobacco use and poverty. The Alliance partners with a variety of stakeholders to develop initiatives, programs and services and disseminate promising strategies and recommendations nationally. The Alliance is funded by the CDC's Office on Smoking and Health (OSH).

The work of the Alliance is accomplished through the leadership of the Alliance's Coordinating Council and through partnerships with stakeholders nationwide. Representatives from both the WV-DTP and the WV-PRC serve as members of the Coordinating Council.

These organizations and the Alliance recognized the need to better understand the issue of dual tobacco use in WV, and to develop comprehensive tobacco policy and programming initiatives. It was agreed to come together with a diverse planning committee to do just that.

### West Virginia Prevention Research Center's (WV-PRC) Translational Tobacco Reduction Research Program (T<sup>2</sup>R<sup>2</sup>)

The T<sup>2</sup>R<sup>2</sup> is a joint program of WV-PRC and the Mary Babb Randolph Cancer Center. The purpose of this program is to bring together a multi-disciplinary group of scientists who are conducting cutting edge research related to tobacco control. Collaboration and communication across disciplines is envisioned to advance development of effective tools, services, policies and knowledge into the community.

The WV-DTP contracts with the WV-PRC to provide technical assistance and assessment of the effectiveness of program efforts. Since 2001, the WV-PRC has provided technical assistance and tailored, autonomous feedback and independent evaluation monitoring for WV-DTP programs and administration. This partnership helps to ensure that WV's tobacco prevention and cessation efforts are founded in science, responsive to communities, and accountable to policy makers.

## EXPERT PANEL DELIBERATION PROCESS

A diverse group of panelists met for one day on December 13, 2011, in Charleston, WV, for the purpose of addressing the rising prevalence of dual tobacco use among WV residents; identifying appropriate policy, cessation practices and models for implementation in WV; and providing targeted recommendations for researchers, service providers, tobacco control advocates, and policy makers. The panelists worked through a process of problem identification, analysis, prioritization, development of recommendations, and final decisions were reached by consensus. The panel was selected from Break Free Alliance partners, recommendations from colleagues, and a review of the literature to glean some professional experts in the field.

The nominal group technique process (NGT) was used to frame this panel. NGT is a structured variation of a small-group discussion to reach consensus. NGT gathers information by asking individuals to respond to questions posed by a moderator, and then asking participants to prioritize the ideas or suggestions of all group members. The process prevents the domination of the discussion by a single person, encourages all group members to participate, and results in a set of prioritized solutions or recommendations that represent the group's preferences.

## MEETING GOALS

The goals of the Expert Panel to Address Dual Tobacco Use in West Virginia were to:

- Explore the prevalence of dual tobacco use in WV.
- Identify successes in and challenges to addressing dual tobacco use in WV.
- Identify current tobacco cessation practices and models specific to addressing dual tobacco use.
- Develop targeted recommendations for addressing dual tobacco use for dissemination to policy makers, local health departments, clinicians/practitioners, healthcare providers, researchers, and community-based agencies serving residents of WV.

To provide additional resources and expertise for the Expert Panel members, two reports were presented and were included as part of the Expert Panel process:

### **Dual Use of Smokeless Tobacco and Cigarettes: A Public Health Warning Sign**

*Ralph Caraballo, PhD, Chief, Epidemiology Branch, Centers for Disease Control and Prevention, Office on Smoking and Health*

### **Dual Tobacco Use in West Virginia: An Analysis of In-Depth Interviews with Dual Tobacco Users.**

*Robert H. Anderson, MA, CHES, Translational Tobacco Reduction Research Program, West Virginia University and Lisa N. Houston, MPH, Break Free Alliance, Health Education Council.*

*\*These reports are included in full as Appendix items 1 and 2*

## PROBLEM IDENTIFICATION

### **Why is dual tobacco use increasing among residents of West Virginia? Why is this happening? What is going on?**

Reasons for the increasing dual tobacco use in WV are varied and complex. Tobacco use is passed down through generations and smokeless tobacco (SLT) use, in particular, is normative behavior in WV. According to the 2010 WV BRFSS:

- The adult smoking prevalence in WV is 26.8%.
- The prevalence of adult male SLT use in WV is 15.5%.
- Dual tobacco use prevalence of all adult male smokers who were also SLT users is 9.6%.

WV has one of the lowest cigarette tobacco taxes in the nation at 55 cents/pack. This compares to WV's neighboring states as follows:

- Kentucky: \$0.60 per pack
- Maryland: \$2.00 per pack
- Ohio: \$1.25 per pack
- Pennsylvania: \$1.60 per pack
- Virginia: \$0.30 per pack\*

*\*Note: VA also allows for local excise taxes (thus average tax per pack is around \$0.70)*

Additionally:

- Smokeless products and cigarettes are not equally taxed in WV— the tax remains higher on cigarettes than on SLT ( 7% of wholesale price).
- Passage of successful and comprehensive clean indoor air (CIA) policies contribute to smokeless and snus tobacco use, as some WV smokers are using these products when seeking an alternate nicotine delivery method.
- SLT use is being heavily promoted in WV by the tobacco industry as an alternative to smoking or in situations where one cannot smoke.
- Dual tobacco use in WV is becoming more prevalent among blue collar workers including coal miners, state and local public works employees, etc. (WV-DTP, regional partner and local tobacco coalition interviews, discussion findings).
- Tobacco manufacturers, retailers and wholesalers give substantial support to state-level candidates, committees and ballot measures, especially for opposition of measures seeking public smoking bans or to increase tobacco prices (National Institute on Money in State Politics, 2010). Future funding for tobacco prevention programs, and any other tobacco-related legislation or regulation, remain highly influenced by corporate practices of the tobacco industry. These tobacco industry practices actually promote chronic disease (Malone & Tesler, 2010).
- While there is in place a WV Department of Education policy declaring all schools and school grounds to be tobacco-free (W.Va. §126CSR66, WV Board of Education Policy 2422.5A, Tobacco-Free Schools), there is a known lack of enforcement in many schools and areas across the state.

### **What stressors and issues do residents of WV have (external to dual tobacco use) that are important to know when addressing this issue?**

Residents of WV experience stressors that contribute to tobacco use and make tobacco cessation more difficult. West Virginia ranks among the top five states with the highest high school dropout rates and according to the WV Department of Education almost 7,000 students dropped out of high school in 2010. The state also experiences high rates of substance abuse. The WV Bureau for Behavioral Health and Health Facilities reports that illicit drug dependence among 18 to 25 year-olds is higher than the national average.

West Virginia ranks 33rd in the nation in adults attaining Level 1 literacy, which is defined as reading and comprehension skills below the fifth grade level (U.S. Department of Transportation). The report estimates that 20% of WV adults function at Level 1, compared to the national average of 22%. Level 1 literacy rates for all 50 states ranged from 11% in Alaska, Utah and Wyoming to 37% in the District of Columbia (US Department of Education, 1998). There is a lack of access to public health messaging in more remote areas of the state. There may also be a lack of understanding among West Virginians that tobacco use is considered "substance" use.

Much of the rural area in WV is reflective of a culture of poverty and poor health. Consequently, many West Virginians lack access to health care and harbor a fatalistic outlook. According to the recent 2010 U.S. Census, WV's percentage of persons below the poverty level is 18.4% compared to the U.S. percentage of 13.8% (U.S. Census Bureau, 2010).

Cigarette consumption is associated with increased food insecurity – not always being able to put enough food on the table. According to researchers, low income families who were food insecure were more likely to have a head of household or spouse who smoked cigarettes than low-income families who were food secure (43.6% vs. 31.9%, respectively) (Armour, Pitts, & Lee, 2007). On average, WV's low-income families with one adult smoker spend \$29.75 per week - or \$1,551 annually - on cigarettes assuming an average price of \$4.25 per pack and a 1-pack per day smoker (Adkins, 2011).

Focus group work and statewide survey results reveal that physicians and healthcare providers are challenged when addressing patient need for tobacco cessation. Time and resources are limited for the primary care provider, and more knowledge about cessation counseling and treatment must be made more readily available.

“Yea because snuff gives you throat cancer, but cigarettes can give you throat cancer too, and it gives you lip cancer, but I think cigarettes are a little bit more deadlier because well they give you cancer period.”

- Quote from a West Virginia dual tobacco user on the health difference between smoking and snuff

Further research and economic analysis on dual tobacco use could help inform WV programming and policy makers regarding enrichment of tobacco prevention and cessation efforts. State-specific research is vital to tobacco cessation efforts in WV.

### **Why does the issue of dual tobacco use among WV residents need to be addressed more strongly? What are the key health related and other consequences of not addressing this issue?**

Tobacco use remains the leading preventable cause of disease and death in the United States and in West Virginia. The financial costs of tobacco use are high to both the tobacco user and the state. Every smoker costs WV approximately \$6,300/year. No economic projections are available for SLT or dual tobacco users (WV Bureau for Public Health, 2009).

WV consistently ranks in the top three states for SLT use (of those states reporting on SLT) and typically ranks among the highest in cigarette use among all 50 states (from BRFSS). New products continue to hit the market and the public health community has been slow to respond to the tobacco industry's promotion of these products. New smokeless products have been heavily marketed throughout WV. Dual tobacco use is increasing not only because of the industry's marketing, but especially in smokers who want to continue their nicotine addiction in situations where they cannot or prefer not to smoke.

Little is known about the long term health effects of dual tobacco use, especially in regard to the new U.S.-made snus and dissolvable tobacco products. There is an absence of research and scientific data specific to dual tobacco use and its harm on an individual or population. Initiation and dual use of cigarettes and SLT, snus and dissolvables should be closely studied for any potential level of adverse health outcomes in both youth and adults.

“ [My partner and I] smoke the same cigarettes and we both use the same Camel snus, and we get coupons for the cigarettes, the snus is in there, you buy a Camel product you get snus for free. If it’s free why not use it, you know what I mean?”

-Quote from a West Virginia dual tobacco user

## FROM THE EXPERIENCE AND OBSERVATION OF THE PANELISTS, BELOW ARE SOME SUCCESSES RELATED TO REDUCING DUAL TOBACCO USE AMONG RESIDENTS OF WV FROM THE TITLED PERSPECTIVES

### Research:

Researchers in WV are beginning to engage in dialogue about dual use as an issue and are starting to collect limited data on dual use. Well-researched best practices are already in place in West Virginia for addressing cigarette use and SLT use, especially in alignment with regard to WV’s Quitline protocols. Statewide data indicate that a significant percentage of WV smokers have quit for a period of time (53.4%) (WV HSC 2010) – a finding that can be further leveraged to reduce dual use rates.

### State and Community Programming:

Many WV employers are providing cessation incentives while implementing voluntary tobacco non-use policies (i.e., they form these policies independent of any government law, regulation, or ordinance).

WV-DTP currently funds a healthcare provider education program utilizing clinicians from the Marshall University School of Medicine to increase providers’ interest and skills in addressing tobacco cessation. The training which targets physicians, dentists and dental hygienists, allied health and service providers emphasizes brief intervention counseling techniques to increase patients’ quit attempts. The WV-DTP also provides “Fax-To-Quit” referral forms to providers to more readily provide for patient cessation classes and programs. The Quitline provides timely “fax back” information to the referring provider for patient follow-

up. Additionally, screening for tobacco use is included as a part of patient vital signs and screening tools in many clinics and physician’s offices.

WV has implemented the Save Face counter-marketing campaign specific to SLT which includes print ads, specifically-targeted television ads, stop spit barns, and other media. The WV-DTP is implementing a tobacco-free family approach that incorporates SLT cessation support through Women, Infant, and Children (WIC) programs, a Tobacco-Free Homes Campaign, and specific initiatives in the African American and LGBT (Lesbian, Gay, Bisexual and Transgender) communities. WV has actively engaged youth and has placed a strong emphasis on reaching youth with prevention messages. Targeted media, counter-marketing, and age-specific campaigns such as the RAZE Campaign (a youth-led tobacco prevention program), have been implemented statewide.

WV’s Regional Tobacco Prevention Coordinator Network has been successful in partnering with many at the community level to address tobacco use. Additionally, a regional approach is being implemented in West Virginia around tobacco prevention and education. The Southern Coalfields Regional Tobacco Prevention Program addresses blue-collar workers (coal miners’) tobacco use.

### Cessation/Quitline:

WV’s Quitline, operated by beBetter Health, Inc. in Charleston, WV, continues to closely track dual users. The Quitline has had documented success with counseling dual tobacco users although the numbers for the past two years remain fairly small (125 dual user enrollees in both 2010 and 2011). Additionally, the Quitline has developed and disseminates “Quit Spit Kits.” Educational tools such as pictures of the health impact of tobacco use have been developed to promote calls to the Quitline.

One of the greatest assets of WV-DTP’s on-going cessation efforts is a locally-operated Quitline and state-based vendor, with many of the telephone coaches being WV residents. Many states rely on quitline services provided by large, out-of-state companies that manage quitlines for multiple states which may impair their ability to fully grasp local community and culture.

A positive impact has been that 34% of all those who enroll in WV Quitline services remain successfully quit after 12 months. Quitline reports show that in 2009 – 2010 there was no relapse among enrollees who quit / remained quit between six and 12 months (WV Bureau

for Public Health, 2009). In contrast, dual tobacco users have more difficulty in quitting:\*

- The dual tobacco users quit rate is 25.0%.
- Cigarette smoker quit rate is 34.4%.
- SLT only user quit rate is 31.3%.

\*Data from WV Quitline enrollees

### Policy

Local CIA regulations have been proven to improve the health of West Virginians residing in those areas where policies have been implemented. One such study was done after implementation of the Kanawha-Charleston Health Department's 2004 comprehensive CIA regulation banning smoking in all public places including bars and restaurants. This report showed heart attack rates dropped 37% after the strong CIA regulation was implemented (Gupta, Luo, Anderson, & Ray, 2011).

Currently 20 of 55 WV counties have comprehensive, locally promulgated and enforced CIA regulations that prohibit smoking in most public places, including bars and restaurants. WV does not have a statewide CIA law. Proposed legislation for a statewide smoking ban has been proposed in the past few legislative sessions, but there has not been significant support to date.

The WV-DTP is working with medical professions to require continuing education in tobacco cessation. Current policy in WV requires dental professionals to take a continuing education course on tobacco cessation every two years. WV Quitline Annual Reports show that dentists and dental hygienists remain a key referral source for Quitline enrollees.

“ I smoke when I wake up and the whole time traveling to the mine, I smoke. Then as soon as I get on the mine site, I start chewing. Then when I’m off the property, I start smoking again. ”

- Quote from a West Virginia coal miner and dual tobacco user

## SUCCESSSES TO BUILD ON IN WEST VIRGINIA AS IDENTIFIED BY THE EXPERT PANEL

### Worksites

Some employers in WV are encouraging cessation (i.e.: premium differentials, incentives, and insurance coverage) along with implementing tobacco non-use policies that are comprehensive. Existing partnerships with employers in WV can be expanded to encourage worksite wellness strategies that address dual tobacco use. Employer education and incentives have been important in encouraging cessation attempts. Increased efforts of employers to encourage demand for cessation/Quitline coverage will ensure they become advocates and will help influence legislators. WV-DTP funds the Wellness Council of WV to conduct a Worksite Wellness Tobacco Cessation and Policy Project that can support the inclusion of dual tobacco use issues.

### Surveillance

The WV Tobacco Quitline, national and state-specific surveys, and other surveillance programs in WV are tracking dual users. Expansion of and coordination among these surveillance systems, as well as programs that have the ability to track dual users, can further inform tobacco policy initiatives and cessation and education programming strategies for the state.

### Media

Tailored media to special populations, counter-marketing, and age-specific campaigns (e.g. social media ads targeting the 18-34 age group, the RAZE [Youth] Campaign) have been implemented statewide and could easily be adapted to include a dual use message/component. The WV-DTP reports that widespread media campaigns with specific messaging to populations with high tobacco use prevalence are working in WV. The two-year American Recovery and Reinvestment Act (ARRA) funded media campaign in WV targeting 18-34 year-olds resulted in a quadrupling of Quitline enrollment among this age group. WV tobacco cessation data and Quitline enrollment and reporting data verify that targeted population campaigns are indeed successful and are shown to increase enrollment, and whenever new ads are disseminated, enrollments increase.

### Cessation

WV-DTP offers science-based tobacco cessation training to all healthcare providers by utilizing the School of Medicine faculty at Marshall University. This training can be augmented to include a dual use component (e.g., providers would ask every patient if they use tobacco, what types they use, and if they

would like to quit; utilize the United States Public Health Service 5As, and incorporate motivational interviewing).

The WV Tobacco Quitline provider should continue to be responsive to WV's language patterns and culture. Most of the cessation coaches who are employed by the Quitline are WV residents. The individualized quit protocols for dual users should be further evaluated and formalized. Partnerships between employers and the Quitline are important for addressing dual use.

A statewide, online cessation program that addresses dual tobacco use should be considered along with a 24-hour Quitline for residents that integrate emerging technologies (text messaging, social media, and instant messaging) with existing Quitline protocols and service offerings. All WV Quitline coaches should be trained in dual use treatment. The WV Quitline should continue to be aware of the need to customize both coaching and nicotine replacement therapy treatment to address the varying levels of nicotine dependence for all tobacco users, especially including dual users.

### Community-Based Programs

West Virginia's Regional Tobacco Prevention Coordinator Network has been successful in fostering local tobacco prevention coalitions, promoting the passage of local CIA regulations, and partnering with other community programs to educate and address tobacco use at the grassroots, community, regional, legislative, and state levels. This Network can be instrumental in disseminating a dual use educational message. College coalitions exist that can also be leveraged to address dual tobacco use issues. The currently existing strong partnerships between the WV-DTP, the WV Tobacco Quitline and other cessation service groups can bolster these efforts.

### Policy

Local CIA regulations in WV are working. According to the 2008 WV Adult Tobacco Survey, 72% of adults reported that smoking was prohibited in their homes. A study of hospital admission rates in Kanawha County found a reduction in heart attack admissions in the presence of a strong smoking regulation by the Kanawha-Charleston Health Department. Policy efforts to change the social norms around tobacco use are being enacted but there is still work to be done to further change the culture around dual tobacco use. Continued education of policy makers in WV about the dual tobacco use issue is needed.

### How Did You Become a Dual User?

Quote from a WV dual user interview:

“The cooler kids were smoking so I smoked with them, and then . . . some of them dipped so if I didn't have cigarettes they gave me dip. So . . . usually when I can't smoke I dip to keep the nicotine in me.”

## BELOW ARE CHALLENGES, BARRIERS OR CONCERNS RELATED TO THE REDUCTION OF DUAL TOBACCO USE AMONG WEST VIRGINIANS NOTED BY THE EXPERT PANEL.

### Research

Data from the 2008 WV Adult Tobacco Survey reveal that there are a large percentage of tobacco users in WV who do not want to quit; and many who want to quit don't think they can. Low self-efficacy needs to be considered when conducting research with dual users. Dual users may see tobacco use as a way to deal with stress. This should be considered when conducting research with dual users. Research design should take into account the strong culture and long history of tobacco use and dual use in WV. New research efforts addressing the dual user must acknowledge the hard-core WV tobacco user (who doesn't want to quit) and take stock of existing successes. Research also should look into engaging those who have already quit successfully.

Some people felt that SLT was less harmful than smoking; some felt it was the same risk; none felt SLT was more harmful than smoking (Anderson & Houston, 2011). These findings show users are confused about risks, and show that more research is needed on attitudes and perceptions of dual tobacco users. Additionally, there continues to be a lack of understanding and many misperceptions about the health risks of nicotine/tobacco among the general public, causing a lack of support for research on this issue. Research initiatives should effectively make an economic case for the consequences of tobacco use, a message that is currently lacking. There is a lack of

supportive, trended data and research on “tobacco harm reduction” nationally and WV’s Adult Tobacco Survey also does not have enough trend data at this point.

In WV it is difficult to secure research funding for and recruit rural residents into research projects. Many young adults in WV go to health care providers infrequently and are therefore difficult to locate and hesitant to participate in interventions/research, even if provided financial incentives. In addition, there is a need to link research on dual tobacco use to patient outcomes.

### Policy

The last tax increase on tobacco in WV was enacted in 2003. Tobacco taxes in WV as of January, 2012 remain well below the national average: cigarettes are taxed at 55 cents per pack, ranking WV 44th in U.S. tax rate (Campaign for Tobacco Free Kids [CTFK], 2012), and other tobacco products are taxed at seven percent of the wholesale price. This disproportionate level of taxation, coupled with industry promotions and product discounting, make SLT and other tobacco products significantly cheaper than cigarettes.

There is no retailer licensure policy in place for WV retailers who sell tobacco products.

WV currently has no statewide CIA policy or law. While there are strong local policies in place, this can mean that a statewide ban could be weaker than those policies at the local level, creating an uneven playing field. Unfortunately, there is no political will among WV policy makers to make tobacco policy enactment a priority. Community support for policy enactment exists in WV but it is not being harnessed in a way it could influence policy decisions at the statewide level. Additionally, many local CIA regulations are not comprehensive.

Statewide, there is a need to expand local coalitions and grassroots support for policies to address dual tobacco use.

WV smokers have often mentioned initiating SLT use (thus becoming dual users) after passage of a stronger local smoking ban (Anderson & Houston, 2011). That should be recognized as an unintended consequence of CIA policies in that dual use prevalence is increased. Thus it is important to enact comprehensive tobacco-free policies that prohibit smoking, the use of SLT, or any other form of tobacco use.

In 2007, WV securitized its remaining Master Tobacco Settlement Agreement (MSA) Funds to reduce

indebtedness of the WV Teachers Retirement System. MSA receipts from FY 2008 – FY 2010 were directed to payment of debt service as were all future MSA payments. Tobacco Prevention Program funding, which had been supported by MSA payments, was replaced with General Revenue funds (The Finance Project, 2011).

### State and Community Programming

Currently, no funding is allocated in the WV-DTP budget to specifically conduct educational campaigns around dual tobacco use. There remains a lack of information and research on new tobacco products, making it difficult to develop educational campaigns for the general public. In WV, the tobacco industry continues to conduct manipulation and marketing campaigns directed at youth, and dual tobacco users remain hard to identify. The exact number of dual tobacco users in WV is yet unknown, but WV BRFSS and Adult Tobacco Surveys provide good estimates.

### Cessation/Quitlines

WV has many remote areas with hard-to-reach communities that lack technology to utilize the Quitline or other online cessation services. While many West Virginians want to quit, it remains a low priority in many of the state’s underserved communities. A culture of acceptance of tobacco use contributes to overall tobacco use among the general population in WV, and some health care providers do not see tobacco cessation as a priority. There remains a lack of evidence-based guidelines for providing cessation services specifically for dual tobacco users.

It is known that WV’s dual users have more difficulty in quitting, and the tobacco industry has factored dual use into some of its marketing tactics. Several of the dual users interviewed by Anderson and Houston (2011) were

“ I don’t have to worry about my daughter, and I’d rather smoke than chew because I’m worried about my mouth, but at the same time it’s nicotine. So I mean it’s keeping me calm at home. ”

- Quote from a West Virginia dual tobacco user

first introduced to snus by being offered free samples when they bought cigarettes. To the extent smokers begin and maintain oral tobacco use, they are less likely to successfully quit smoking, and dual users are less likely to be able to quit tobacco completely than those who use one product or the other exclusively (Tomar, Alpert, & Connolly, 2010).

## WHAT IS NEEDED TO EFFECTIVELY ADDRESS THESE CHALLENGES AS IDENTIFIED BY THE EXPERT PANEL:

### A New Focus on Research

- The development of a permanent, statewide research working group to focus on dual tobacco use issues in WV should be considered.
- More research with dual users in WV is needed to further understand clinical and behavioral issues, including when, where and why they are using each type of tobacco. Translational research is needed. Specifically, further work is needed to understand the types of dual users and how to engage the dual user in treatment. Common language should be incorporated in the research community to define the term “dual use” and incorporate it into subsequent messaging and education. To further expand the science base, partnering with neighboring states on the development of metrics/tools that are the same in order to combine efforts on dual use should be considered.
- At the request of the State of WV, it should be strongly emphasized and recommended to include dual tobacco use in the national tobacco use study being conducted by the U.S. Food and Drug Administration (FDA) and the National Institutes of Health.
- A case should be made in WV for using revenue generated from tobacco taxes to fund research on dual tobacco use. WV could examine models from other states that established dedicated tobacco research programs from tax revenues. Additionally, universities and corporations should be approached to look for creative sources, beyond tobacco taxes, for funding research.
- There are very committed groups of local advocates in WV and strong community-based coalitions that are addressing tobacco use, and could become engaged in research efforts. Additionally, the N-O-T (Not on Tobacco) Program, a successful teen cessation program, could be a resource for future research on dual tobacco use in WV.

### A Continued Focus on Policy Enactment

The following recommendations apply generally to tobacco control in the state of WV, but would also benefit efforts to address dual use and were discussed at great length by the panel:

- Make the health of West Virginians a political concern of all elected officials and have it included as part of a social justice and economic framework. WV has a core group of legislative champions that support tobacco policy initiatives. There is a critical need to educate policy makers, and that future efforts place increasing emphasis on the health-occupational cost of tobacco use to the state's taxpayers and private employers.
- Mobilize further the grassroots organizations in WV to increase awareness among policy makers of evidence-based tobacco control interventions and policies.
- Effectively leverage WV's strong partnerships with national entities including the CDC-funded National Networks for Tobacco Control and Prevention and other national tobacco control partners to provide support for future policy enactment initiatives (i.e. statewide CIA regulations or tobacco price increases).
- Consider strong tobacco policy enforcement by a single agency to address illegal sales to youth (currently both the Alcohol Beverage Control and Bureau of Behavioral Health Facilities, have enforcement responsibilities). Passage of tobacco retailer licensure in WV State Code should be considered a crucial policy requirement.

### A Continued Focus on State and Community Programming

- Statewide educational campaigns can help West Virginians better understand the scope of dual tobacco use. Small-scale media campaigns can specifically target the dual user with the addition of social media and text messaging.
- The WV Bureau for Public Health, WV-DTP can add funding and deliverables around addressing dual tobacco use in grantee contracts and work plans; and partner with other state agencies (Medicaid, Obesity, Diabetes, Asthma, Cardiovascular Health, Cancer, Maternal/Child/Family Health, Women's Infants & Children, and others) within the state of West Virginia to address dual tobacco use.
- Within all WV state government agencies, standard language and understanding around “tobacco harm reduction” should be developed.

### Continued Support for Cessation Programs

- Addressing tobacco use is a high priority for public health and health professionals in the state. WV has an existing, statewide cessation infrastructure that can support addressing dual tobacco use. Additionally, the existing infrastructure of the WV Quitline can be further augmented to study existing data on dual tobacco use. To better assist the Quitline and other cessation programs, statewide survey data should include questions on dual use and SLT use.
- WV should consider mandatory cessation coverage by health insurers and should coordinate with existing provider education programs to educate providers about treatment of dual tobacco use.

### FINAL PRIORITIES AND RECOMMENDATIONS FOR ADDRESSING DUAL TOBACCO USE IN WEST VIRGINIA (IN ORDER):

1. Allocate funding for the WV Division of Tobacco Prevention in alignment with the U.S. Centers for Disease Control and Prevention (CDC) recommended Best Practices level of \$28 million annually. Sustain and/or increase funding support for tobacco prevention, especially cessation programming, from the CDC, private funders, and the State of West Virginia (at least \$28 million/year), and include suitable funding to address dual tobacco use.
2. Maintain a statewide West Virginia Tobacco Cessation Quitline with state-based, culturally knowledgeable, well-trained coaches who can readily counsel dual users.
3. Maintain and expand partnerships between the West Virginia Quitline, local coalitions, churches, community-based agencies, and other agencies throughout the state to integrate a statewide dual tobacco use prevention/cessation message.
4. Develop a permanent, operational statewide research group to focus on dual tobacco use issues in West Virginia. Data collection and added surveillance efforts on dual tobacco use must be strengthened.
5. Maintain and expand a regional network of tobacco prevention professionals who can address dual use; continue to foster durable coalitions and grassroots support to increase policy initiatives and educational campaigns for tobacco prevention across the state.

6. Continue and expand healthcare provider education efforts to incorporate education on dual tobacco use.
7. Continue and expand policy efforts to include the passage of local CIA and outdoor air policies prohibiting smoking in all public places. Continue to advocate for a comprehensive, statewide CIA law that is non-preemptive and allows for a local regulation to be stronger than any state law.
8. Enact a \$2 tobacco tax on all individual tobacco products and assure that all SLT products are taxed equitably to cigarettes.

### CONCLUSION

West Virginia is known to have a high prevalence (9.6% among adult males) of dual tobacco use, defined as the regular use of cigarettes and SLT. Given the rapidly proliferating forms of SLT products now being marketed, especially to youth, the state's public health advocates should strive to be the national leader in understanding and addressing dual tobacco use.

Dual tobacco use is most likely increasing in WV as tobacco companies continue to develop and promote new smokeless products to the state as a readily available test-market. SLT products have been specifically designed and are being marketed to augment cigarette use and to circumvent regulatory strategies such as CIA laws. These products may pose significant challenges to efforts by both state and federal agencies to reduce harm caused by tobacco use, and could result in unknown public health effects as well as increased healthcare costs to the state.

It is also apparent in WV that both the industry influence (i.e. increased marketing, lower cost, and price incentives of SLT and snus) and existing tobacco product pricing policies (i.e. significantly lower, unequal state excise tax on other tobacco products) have also added to the increasing dual use problem. While it is clear that some smokers are using SLT in environments where they cannot smoke (i.e. due to CIA regulations, voluntary work and public place smoking restrictions, and in worksites such as coal mines where smoking is prohibited due to safety precautions), it remains to be seen whether individuals are utilizing SLT as a means to quit smoking.

The use of SLT as part of a strategy to reduce the harm from cigarette smoking is a topic of debate within the tobacco control and public health communities. One concern regarding endorsement of such a tactic is the possibility of actually increasing harm should current smokers adopt dual cigarette/SLT use, which could

lead to unintended consequences by perpetuating cigarette smoking, diminishing tobacco cessation, and/or increasing tobacco-related harm. Another concern is the potential for dissolvables or other SLT products to promote initiation among youth.

Little is known about the long term health effects of dual tobacco use. There is an absence of scientific data proving that U.S.-made snus and newer dissolvable tobacco products will reduce harm for an individual or at the population level. Research on the long-term health effects of the newer tobacco products being produced by the US tobacco industry must be conducted as soon as possible. Much more needs to be known about the potential health effects of toxins in dissolvable and SLT, including snus.

Surveillance data on new tobacco products and dual tobacco use is needed, not only in WV but for the entire nation. Specific research to determine who dual tobacco users are and how effective cessation programs can be tailored to meet their needs must be conducted. Based on initial in-depth interviews with WV dual tobacco users, little is known about the health risk trajectories and how practitioners, cessation programs and quitlines can successfully intervene with dual users.

The Expert Panel identified that WV has a solid infrastructure in place and successful programming initiatives underway that can incorporate prevention and cessation strategies to reduce dual tobacco use. The strong partnerships which currently exist between state government, local communities, Quitline representatives and others could be instrumental in effective integration of widespread dual tobacco use initiatives. Community mobilization and educational efforts should focus on policy enactment, including increasing the price on all tobacco products and implementing comprehensive indoor and outdoor tobacco-free policies without preemption.

West Virginia is spearheading efforts to address the increased trend of dual tobacco use. However, until more is known about new smokeless products and dual tobacco use, there will continue to be significant challenges to tobacco prevention and cessation efforts by both state and federal agencies.

## IMPLICATIONS FOR OTHER STATES AND AGENCIES

While use of any single tobacco product remains a concern, the emergence of dual tobacco use must now be considered as a potential health hazard. State tobacco control programs and any others addressing the dangers of tobacco use must now recognize the tobacco industry is producing and aggressively marketing new SLT products. New patterns of regular use of cigarettes and one or more forms of SLT products are the result.

The emerging trends of dual use threaten to reverse progress toward reducing tobacco use and its health burden. There is now a need to monitor use of a combination of tobacco products, rather than monitoring use of each product in isolation. Dual use will also have significant implications on tobacco cessation both from a cessation program standpoint and the user's ability to quit. There is a need for accelerated research regarding long-term harm of recent and any future U.S.-made SLT products, and also investigation of SLT as a 'less harmful' product or tool for cessation.

Raising state tax rates on all other tobacco products to parallel increased cigarette taxes will not only bring more revenues, but would help to promote tobacco cessation rather than partial or complete product substitution and sustained tobacco use. It is imperative that tobacco tax revenues be allocated for tobacco prevention and cessation programs in order to develop strategies to address emerging trends such as dual tobacco use.

The disparity and the high levels of smoking and other tobacco product use, now including dual tobacco use, place an emphasis on the need for more effective tobacco control policy, product price increases, and science-based interventions and cessation assistance. Failure to do so means that the disproportionately high rates of tobacco-related morbidity and mortality will continue, and that there will remain an associated escalating health care burden - especially for those in the low socioeconomic status population.

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## ADDITIONAL RECOMMENDED READING

Break Free Alliance; Report on Tobacco Tax Increases and Their Impact on Populations of Low Socioeconomic Status, November 2009.

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## RESOURCES AND LINKS

American Lung Association: [www.lung.org](http://www.lung.org)

beBetter Networks: [www.bebetternetworks.com](http://www.bebetternetworks.com)

Best Practices for Comprehensive Tobacco Control Programs – 2007: [www.cdc.gov/tobacco/stateandcommunity/best\\_practices/index.htm](http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm)

Centers for Disease Control and Prevention, Office on Smoking and Health: [www.cdc.gov/tobacco/](http://www.cdc.gov/tobacco/)

Health Education Council/Break Free Alliance: [www.healtheducouncil.org/breakfreealliance](http://www.healtheducouncil.org/breakfreealliance)

National Cancer Institute: [www.cancer.gov/cancertopics/tobacco/smoking/](http://www.cancer.gov/cancertopics/tobacco/smoking/)

National Tobacco Control Networks: [www.tobaccocontrolnetworks.org](http://www.tobaccocontrolnetworks.org)

Not On Tobacco: [www.notontobacco.com](http://www.notontobacco.com)

Prevention Research Center, West Virginia University: [www.prc.hsc.wvu.edu](http://www.prc.hsc.wvu.edu)

Quick Reference Guide for Clinicians: [www.surgeongeneral.gov/tobacco/tobaqrg.htm](http://www.surgeongeneral.gov/tobacco/tobaqrg.htm)

Wellness Council of West Virginia: [www.wvwc.org](http://www.wvwc.org)

West Virginia Bureau for Public Health: [www.wvdhhr.org/bph/](http://www.wvdhhr.org/bph/)

West Virginia Bureau for Public Health, Division of Tobacco Prevention: [www.wvdtp.org](http://www.wvdtp.org)

## APPENDIX 1

### DUAL USE OF SMOKELESS TOBACCO AND CIGARETTES: A PUBLIC HEALTH WARNING SIGN

*Ralph Caraballo, PhD, Chief, Epidemiology Branch, Centers for Disease Control and Prevention, Office on Smoking and Health, specifically for the Expert Panel to Address Dual Tobacco Use in West Virginia*

Smokeless tobacco (SLT) includes chewing tobacco, snuff, and, more recently, dissolvable products. Chewing tobacco comes in several forms, including loose leaf, plug, twist, and roll. In recent years, another new generation of SLT products has entered the U.S. market. These products are now widely available in a number of new forms, including snus, a form of moist snuff. These products are being heavily marketed, including to smokers.

These new SLT products have the potential for broader appeal than their precursors because many do not require spitting. Moreover, many of these products are flavored. Research suggests that flavored products are attractive to youth. In addition, these products are often packaged in novel, colorful ways which may also appeal to youth.

Nationally, smokeless use and dual use is much higher among men, specifically among white teen boys and white young adult men. SLT use is on the increase among youth (mainly white) and young adults (mainly white). Many SLT users also smoke cigarettes.

Exclusive use of SLT poses well-documented, significant health risks in its own right. Dual use of SLT and cigarettes poses additional risks. In addition to layering the health risks of smokeless on top of those of cigarettes, dual use may delay smoking cessation or make it more difficult. As a result, it may have the effect of prolonging people's smoking careers and keeping them in the smoking population. This is a serious concern, since smoking duration is the single most important determinant of smoking-related health risks.

A cursory review of recent advertising for SLT products suggests that the messages being used to promote these products have changed. A number of ads emphasize that SLT can be used in settings where smoking is not allowed. The clear implication seems to be that cigarette smokers can use SLT products to sustain their nicotine addiction while they are in these settings, while presumably continuing to smoke while they are in other settings. This impression is reinforced by the fact that smokers now have the ability to

complement use of cigarettes with use of a SLT product with the same brand name and imagery – a point that is also featured in advertising for smokeless products. Some ads seem to suggest subtly or not so subtly that SLT products may play a useful role in helping smokers quit.

Data from the National Youth Tobacco Survey (NYTS) indicate that cigarette and cigar use, both combustible products, have fallen from 2000 to 2009 among middle school students: cigarettes from 11.0% in 2000 to 5.2% in 2009; cigars from 7.4% in 2000 to 4.0% in 2009. SLT use has remained steady in this group from 2004 to 2009. Among high school students, it was also observed that cigarette and cigar use declined from 2000 to 2009. However, even though the prevalence of SLT use increased slightly from 2004 to 2009, it was not a statistically significant increase (Centers for Disease Control and Prevention [CDC], 2000, 2002, 2004, 2006, & 2009).

Looking at cigarette smoking only, SLT use only, and the dual use of cigarettes and smokeless use, excluding use of other tobacco products and e-cigarettes, there was a consistent decline of cigarette smoking only but no statistically significant change in smokeless use or dual use from 2000 to 2009.

Data from the National Survey of Drug Use & Health (NSDUH), as opposed to the NYTS, shows that young adults between the ages of 18 to 25 years old are more likely to dual use cigarettes and SLT than youth or older adults. The prevalence of dual use among youth aged 12-17 years was 0.6% in 2009, the most recent year there is data for, and it was 2.4% for young adults and 0.8% for adults aged 26 years or older (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010).

Looking at the same NSDUH data, this time specifically for those aged 12 to 17 years, in school or not in school, dual use was 0.9% for males and 0.2% for females. Even though prevalence was relatively low, males were 4.5 times more likely to use both cigarettes and smokeless than females. Looking at similar information for young adults, the prevalence of dual use was 4.5% for males and 0.3% for females, making males in this age group were 150 times more likely to dual use. Finally, focusing on adults aged 26 years or older, the prevalence of dual use was 1.6% for males and almost zero among females (SAMHSA, 2010).

Data from the Youth Risk Behavior Survey, another school-based survey, shows that over half of male high school students overall and white male students in particular who reported current SLT use have also reported current smoking over the period 1995-2009.

There is reason to believe that the emerging trends in SLT use and dual use may be a significant factor in the slower rate of decrease in tobacco prevalence rates among youth and adults. These trends should be monitored closely along with their population impact (CDC, 2010).

The emerging patterns of tobacco use also suggest that use of all tobacco products should be monitored, not just cigarette use. Finally, these patterns indicate that we need to monitor the use of tobacco products in combination with each other instead of monitoring use of each product in isolation.

## APPENDIX 2

### DUAL TOBACCO USE IN WEST VIRGINIA: AN ANALYSIS OF IN-DEPTH INTERVIEWS WITH DUAL TOBACCO USERS

*Robert H. Anderson, MA, CHES, Translational Tobacco Reduction Research Program, West Virginia University and Lisa N. Houston, MPH, Break Free Alliance, Health Education Council.*

In the Fall of 2011, West Virginia University, Prevention Research Center, in conjunction with Break Free Alliance, conducted and analyzed interviews with 16 adult dual tobacco users residing in West Virginia. These individuals were recruited with the assistance of the Wellness Council of West Virginia. All of them had a history of smoking and also using smokeless tobacco (SLT). Fifteen of them were dual users at the time of the interview, with one interviewee having just quit smoking. The ages of the participants varied widely; one participant was female.

All interviews were digitally recorded and transcribed. Transcripts were then imported into NVivo 9 software to assist with the analysis. The research team members, Robert Anderson and Lisa Houston, independently coded the transcripts. Subsequently they exchanged their files, among which there was substantial congruence. This report is a brief summary of this analysis.

The goal of this project was to inform Expert Panel members by learning from dual users about the following: patterns of use, opinions about nicotine strength and health risks of each type of tobacco, rules about tobacco use at work and at home, experiences with snus, and history of tobacco cessation.

This report is not generalizable beyond the adults that were interviewed. Nevertheless what was found from this study may further inform the research and practice communities and add to the recommendations of the Expert Panel.

The research protocol was reviewed by West Virginia University's Institutional Review Board and ruled to be exempt research. The Expert Panel Planning Committee assisted in the development of the interview guide.

#### Patterns of Use

Peer pressure was the main reason participants began using tobacco. Most became regular tobacco users of at least one type of tobacco as early as the age of 12. Only a few began at age 18 or higher. Participants typically began with one type of tobacco before adding another. About half began using cigarettes before snuff, and one participant began using both at the same time. Of the 16 participants, 14 used only snuff, and the remaining two used snus. Many participants cited work-related reasons for becoming dual users, as well as avoiding exposure to secondhand smoke at home. Those who work in mines, confined spaces (e.g. a truck) or other workplaces that do not allow cigarettes began using SLT in order to "have some type of nicotine relief." Others were influenced by significant others or in social situations.

#### Risks of Tobacco Use

Opinions about health risks varied, with slightly more people believing the risks of smoking and smokeless to be equal. Others believed smoking to be riskier. In several cases they answered the question without much confidence in their answer. No one felt that SLT was more harmful than smoking. None of the participants denied that their use of tobacco was posing risks to their health. Several men noted that by using more SLT they were smoking fewer cigarettes—doing so provided them with a health "benefit" and one participant felt it was also saving him money.

#### Nicotine

Most of the participants felt nicotine from cigarettes was stronger than nicotine from SLT. Several stated there was no difference between the two products, and two people felt that SLT was stronger. Some participants differentiated the potency of the nicotine they experienced vs. the effect of the nicotine. One noted that SLT provided him with a "calming" effect he did not experience with cigarettes.

#### Home Rules

Most of the participants do not smoke in their home. Several couples do smoke at home, although one couple will not smoke indoors when they have children. Clearly they recognize the risks of secondhand smoke. In some cases, the home rules about not smoking predispose some of the interviewees to use SLT when at home. However, while they were concerned about exposing their children to smoke, there was no evidence

of them being concerned about using SLT in front of their children.

### **Workplace Tobacco Policy**

Most of the participants' employers prohibit all tobacco use. Several noted that it was possible to use SLT without being discovered. Most of the people we interviewed comply with their employer's policy, but when they were on a break they were more likely to smoke than to use SLT. In some cases smoking was prohibited but the use of SLT was not banned. Penalties for violating the policy could be severe. The participants who work in coal mines reported using SLT while at work, and at no other time.

### **Snus**

Of the ten participants who tried snus, eight disliked the product, primarily due to what they perceived to be a weak nicotine dosage. Some expressed doubts about using a smokeless product that did not require them to spit. This would involve swallowing the tobacco juice, which they felt would be a health risk. Two others are regular snus users, one of which also uses snuff and snuff pouches, with the other user being the only woman interviewed.

### **Cost**

Although cost was not a topic that was explored directly, several participants mentioned saving money as a reason for quitting tobacco and/or for using more SLT. Another participant's method of saving money was to roll his own cigarettes from bulk tobacco, and two others either bought the cheapest cigarettes or bought a cheaper brand of SLT because it went on sale more often. One participant noted the weekly tobacco cost as being \$100, while another estimated the monthly cost to be \$400, which he then noted could be a car or a house payment. In both cases the estimate included the cost of their spouse's cigarettes.

### **Tobacco Cessation**

All of the participants had tried to quit tobacco use at some point in their lives, but most had only tried once. One participant was trying to quit at the time of the interview. Participants' reasons for wanting to quit included health risks, saving money, and living longer for the sake of their children. Failed quit attempts were consistent with what is found with others, primarily a stressful event in their life (parents dying, arguments at home) or the offer of a cigarette by a friend, only to have one cigarette lead them back to their former pattern of use.

Many participants tried to quit both SLT and cigarettes at the same time, while others had tried to quit cigarettes only. Three participants quit cold turkey, and three used

some type of pharmacotherapy. Only two participants were not interested in quitting tobacco use; the rest did want to quit, but most were not planning to do so in the near future. Many thought that when they were ready to quit, they would quit both types of tobacco at the same time, while a few thought they would keep using SLT in order to transition out of cigarette use.

### **Conclusions**

The dual users in this study can be grouped into five mutually exclusive types of users:

- 1) Smokers who use SLT when at work, where smoking is prohibited
- 2) Smokers who only use SLT on certain occasions, such as when hunting or fishing
- 3) SLT users who smoke regularly (if not daily) but mostly in social situations
- 4) Dual users who use both types of tobacco products daily
- 5) Smokers who use SLT to eliminate others' exposure to secondhand smoke

Most certainly there are other patterns of dual users that did not emerge in this study. It is important to recognize that since the way tobacco is used can vary, prevention and cessation messaging will need to be tailored to specific subgroups of dual tobacco users. It is important to note that most of the adults interviewed also have a partner who smokes. Messages that are aimed at couples should be considered.

Elimination of smoking due to workplace policy or by government action (i.e., ordinance, regulation, or law) is a primary factor in many adults' decisions to begin SLT use. Another factor is a smoker not wanting to expose family members to secondhand smoke.

The tobacco industry has factored these dual concerns into some of its marketing tactics. Even in this study, several of the people interviewed were first introduced to snus by being offered free samples when they bought cigarettes. To the extent smokers begin and maintain oral tobacco use, they are less likely to successfully quit smoking (Tomar, 2002), and dual users are less likely to be able to quit tobacco completely than those who use one product or the other exclusively (Wetter et al., 2002).

All of the participants recognize that both types of tobacco are harmful. However, many of them saw the health risks to be equal.

They also had different opinions on the effects that nicotine had on them, based on which type of tobacco was used. Five types of dual users have been identified in this study, but future research should explore in greater depth how patterns of use differ among dual users and use findings to inform practitioners.

### **Implications for Policy and Programming**

Since some of the participants began using SLT due to smoke-free worksite policies, worksites should consider offering tobacco cessation programs and incentives to employees and their spouses/partners. Additionally, employers should consider adopting a complete tobacco-free policy. Doing so may bring about more tobacco cessation attempts while also being a disincentive for smokers becoming dual users. With their employees becoming tobacco-free, employers and employees would save money on future health care costs. This could lead to productivity increases and reduced absenteeism.

The adults that were interviewed engage in dual use despite knowing at least some of the health risks. This may mean that messaging about health risks may not succeed in bringing about increased quit attempts. Some participants were practicing “harm reduction”—in some cases perhaps subconsciously—by increasing SLT use while concurrently decreasing cigarette use.

Participants expressed strong concerns over their children's exposure to secondhand smoke, but none broached the topic of whether using SLT around their children or smoking (even if only outside the home) modeled the behavior for them. Messaging that emphasizes the harmful effects of parental modeling of SLT and smoking may be successful in getting dual users to think about quitting.

Snus had no appeal to most of the interviewees who tried it, but coupons and free samples have been an effective marketing strategy in getting people to try it.

Although interviewees were not asked about income, it is reasonable to posit that most of the interviewees have a relatively low income. The cost of tobacco as a percentage of household income is high. It is likely that a significant increase in the West Virginia State tobacco tax could provide an added incentive for tobacco cessation.







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