How to Run a Culturally Competent LGBT Smoking Treatment Group

This document has been prepared by The Fenway Institute under funding from the American Legacy Foundation. It is being printed under the auspices of Howard Brown Health Center with funding from the American Legacy Foundation, and additional support from the National LGBT Tobacco Control Network. The content is solely the responsibility of the authors.

This book is dedicated to Lisa Tonna; her strength and vision ~~insire~~ us.

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NO SMOKING

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Special thanks to Chris Powers and Rikki Spencer, the LGBT Incubation Project Coordinators at the LA and Chicago sites. Their reports and diligent work on this project were integral to the base of information presented here. Special thanks to Lisa Tonna and Suzanne Deveney from Howard Brown for book production.

Suggested Citation

Scout. Miele, AM. Bradford, JB., Perry, D. 2006. Running an LGBT Smoking Treatment Group. The Fenway Institute, Boston, MA.

Partner Organizations

The Fenway Institute
Boston, MA
The Fenway Institute is the research, training, and policy division of Fenway Community Health, a Federally-Qualified Health Center providing comprehensive healthcare to neighborhood residents and to LGBT communities and families throughout Greater Boston and Massachusetts. The Fenway Institute was the lead site for the LGBT Incubation Project. (www.fenwayhealth.org)

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Howard Brown is a multi-site operation serving the LGBT and surrounding communities with comprehensive medical and mental health services, specialized youth services, case management, biomedical and behavioral research, and education and prevention outreach. Howard Brown was a partner site for the LGBT Incubation Project. (www.howardbrown.org)

The LA Gay and Lesbian Center
Los Angeles, CA
The Lesbian, Gay, Bisexual & Transgender Community Center provides a home for the birth, nurture and celebration of our organizations, institutions and culture; cares for our individuals and groups in need; educates the public and our community; and empowers our individuals and groups to achieve their fullest potential. The Center was a partner site for the LGBT Incubation Project. (www.lagaycenter.org)

Introduction

In 2005, an ambitious three-year multi-site research project exploring lesbian, gay, bisexual and transgender (LGBT) smoking treatment was nearing its end. The project staff had lived through many challenges and successes throughout the course of the project, and as the final reports were being written, an idea emerged: Why not create a single document to summarize all the lessons learned about LGBT tobacco treatment groups? The document you are reading is the result of this idea. But first, let us introduce you to that original project.

The LGBT Incubation Project

Phase I: The LGBT Incubation Project was originally funded by the American Legacy Foundation as a one year grant exploring possible innovations in LGBT tobacco treatment. The Fenway Institute led the effort, enrolling two other large community health centers to participate: Howard Brown Health Center in Chicago and the LA Gay and Lesbian Center (LAGLC). Spurred by the disproportionately high prevalence of tobacco use in the LGBT communities, staff at these three institutions created community leader think tanks to brainstorm ideas that might help LGBT tobacco treatment. Once the data from all the ideas was sifted through, one promising concept was chosen for further exploration: enrolling groups of friends into tobacco treatment together.

Phase II: The American Legacy Foundation continued funding for another two years to allow the three sites to pilot test this innovative concept. During those years, each site initiated multiple LGBT tobacco treatment groups to evaluate the feasibility and acceptance of enrolling sets of friends into the project. At the end of two years of research, 21 tobacco treatment groups had been conducted across three sites, with over 120 total participants. Findings at the end of the project were mixed: it was more difficult than anticipated to successfully find groups of friends who were all ready to try quitting simultaneously, but people reported strong positive impact from being in a treatment program with a group of their friends.

Vision for this document

The staff of the LGBT Incubation Project faced many challenges in the piloting of 21 tobacco treatment groups. As a result, the staff often turned to colleagues nationwide for additional suggestions or advice. This document is a compilation of these experiences and lessons in an easy-to-access format. Issues that might be common to all LGBT treatment groups have deliberately been emphasized. Details about the LGBT Incubation Project research have been deliberately de-emphasized, and are presented only as a special case study to supplement the general lessons.

This document is intended to be used by all. Please feel free to take pieces of this document that help you and to put out new information that builds upon the lessons here.

Chapter 1

LGBT Tobacco Control Synergy

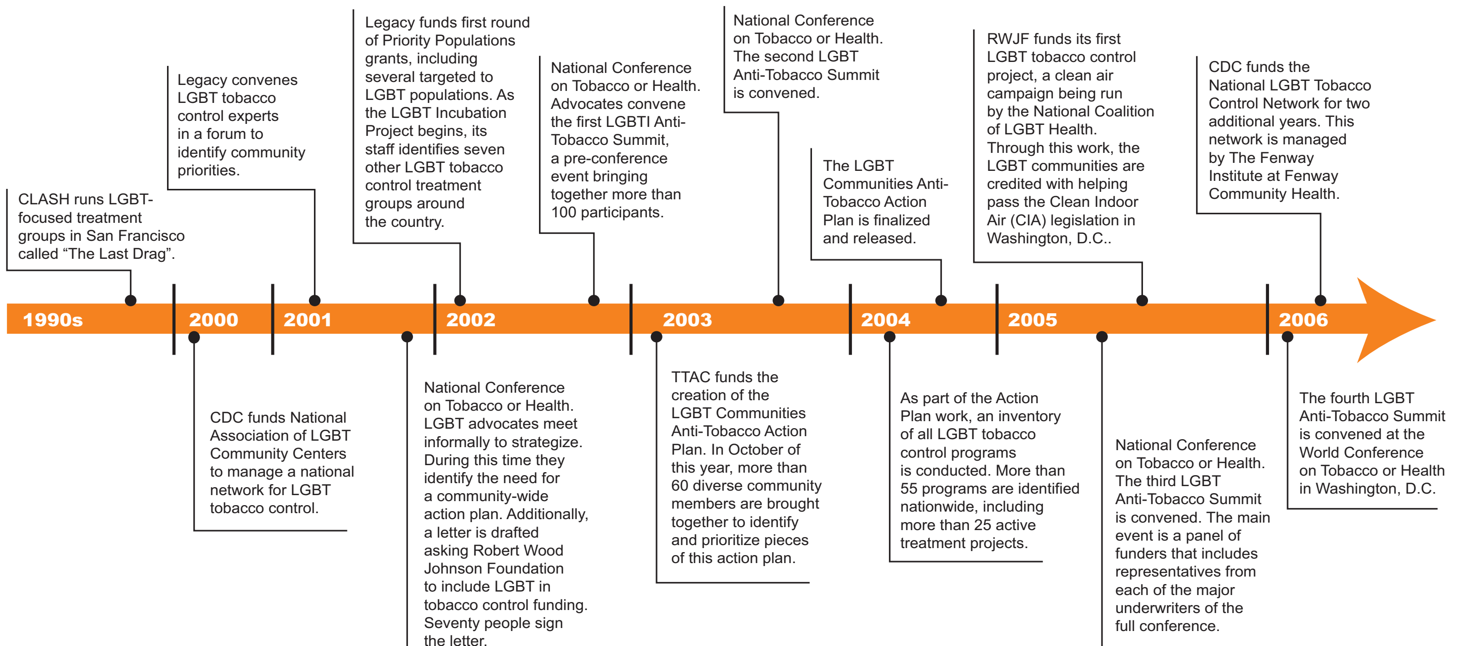
In 2002, the American Legacy Foundation made an important policy decision. They chose to include LGBT populations among their group of “Priority Populations” that would be eligible for funding to reduce tobacco health disparities. This decision was backed up by scientific research showing that LGBT communities had some of the highest tobacco use rates of any in the country. Legacy’s vision was part of a growing trend to recognize and respond to the LGBT population, which has been disproportionately affected by a range of health issues. Since then, additional funding targeting LGBT tobacco use has become a stronger priority. Nonetheless, to this day advocates continue the struggle to ensure anti-LGBT bias does not influence national and local heath decision making.

Legacy subsequently funded a series of projects around the country related to LGBT tobacco use. Importantly, they also built connections between and enhanced awareness among the different people addressing tobacco use in all underserved populations. This infusion of money and information created a synergistic effect in the LGBT tobacco control community. In part, this occurred because the grants built a cadre of LGBT community leaders working in tobacco control. These leaders and other staff were often able to lend effort to larger community-wide tobacco control efforts. The impact of Legacy’s original decision to support LGBT populations now extends well beyond the money and deliverables promised under the original grants, and the level of LGBT tobacco control has reached new heights.

The need now: Stable infrastructure and programmatic funding

Community organizers, advocates, and project staff have been the force that has taken a limited amount of community-specific funding for LGBT tobacco control work and leveraged it into a sweep of programs and initiatives that cross the country. Unfortunately, tobacco control funding has dropped in recent years, threatening nascent LGBT tobacco control efforts. An infusion of funds is needed on every level to recover from these losses. Moreover, the LGBT community-wide effort is especially vulnerable, because it is so dependent on extra time or volunteer hours above and beyond funded projects. Stable, ongoing infrastructure and programmatic funding is needed to move forward the LGBT Communities Anti-Tobacco Action Plan and other key high impact projects.

Partial timeline of key LGBT tobacco control efforts



Chapter 2

LGBT and Tobacco Overview

The following information draws on research early in the LGBT Incubation Project and later supplemental work by Scout to create LGBT tobacco fact sheets for the National Coalition for LGBT Health.

LGBT communities highly impacted

In a recent full-probability study, it was found that LGBT men were 50% more likely to smoke than the general population and LGBT women were almost 200% more likely to smoke than the general population.[1] In an overview of older studies, it was found that LGBT individuals were 40-70% more likely to smoke than non-LGBT individuals.[2,3] This is one of the highest smoking rates among all the disproportionately affected sub-populations. In addition, LGBT adolescents are taking up smoking at an alarming rate; in a recent national study 45% of females and 35% of males reporting same-sex attraction or behavior smoked. In comparison, only 29% of the rest of the non-LGBT adolescents smoked.[4]

American Cancer Society estimates that more than 30,000 LGBT individuals die each year of tobacco-related diseases.[5] This is a conservative estimate, because it presumes they smoke at the same rate as the general population.[2]

Why do LGBTs smoke more?

Researchers theorize several factors contribute to the higher prevalence rates of tobacco use among some LGBT individuals including: higher levels of social stress, frequent patronage of bars and clubs, higher rates of alcohol and drug use, and direct targeting of LGBT consumers by the tobacco industry.[2]

Tobacco companies target LGBT populations

The tobacco industry spends almost $15.2 billion each year on promotion and marketing. This dollar amount is bigger than the budget for the Centers for Disease Control (CDC) or Health Resources Services Administration (HRSA).[6] The money is spread liberally to groups that assist tobacco industry objectives, such as those that fight clean indoor air laws, or work to defuse public outcry over the health impact and costs of smoking.

Tobacco documents show that the industry has hired LGBT leaders, marketing companies, and even bar promoters to help them swing our vote when critical legislation arises. Documents show they've monitored our community festivals, our press, and even gained access to civil rights groups in an effort to obtain our support for pro-smoking positions.[7]

In addition, tobacco companies offer an unknown amount of financial support to LGBT festivals, bars, media, and local organizations. Sometimes this money comes with conditions. For example, some gay bars are prohibited from allowing any tobacco control promotion onsite. Nevertheless, recent research shows that LGBT individuals want clean indoor air. For example, a recent national survey by Harris Interactive Inc. found that of all groups surveyed, the LGBT population was most likely to pay extra to go to a smoke-free bar.[8]

However, members of the LGBT communities may be reluctant to question unfavorable terms and conditions put forth by the tobacco companies because of the early support they received, when other funders avoided or ignored LGBT issues completely. Tobacco industry funding can compromise anti-tobacco activities by LGBT community organizations.

Negative health impacts are under-estimated

Approximately one-half of all people who smoke will die early as a result, on average 10-20 years earlier than non-smokers.[9] In the United States, tobacco is the number one cause of mortality, and kills more people each day than AIDS, alcohol, car accidents, firearms, and illegal drugs – combined.[10]

LGBT people and cessation

LGBT people, like all people, find quitting tobacco extremely difficult. One study reported that, of LGBT individuals who had tried to stop smoking, had on average, tried and failed to quit eight times, the same as all adults.[11]

An increasing number of LGBT-tailored cessation programs are available; the programs are locally based, so most of the LGBT population still does not have access to them.

No Smoking
in the Bar
Thank You

Chapter 3

Promotion and Recruitment

Introduction

A well-planned recruitment strategy is the first step towards running a successful tobacco treatment program. Here are some of the lessons learned from staff at the three different LGBT health centers who recruited for LGBT-specific tobacco treatment groups.

Cultural competency

There has been much attention to this difficult to define term in recent years. Community representatives have long contended that culturally competent health care is essential for underserved or cultural minority populations. Like all cultural minority populations, the LGBT communities have specific ways of gathering and sharing information. LGBT people also have a long history of barriers to healthcare. Negative personal experiences or shared community knowledge of discrimination affects how and if they seek healthcare. Many people take particular efforts to ensure they find and use health providers who have a history of treating the LGBT people. Likewise, LGBT people are likely to be wary of a tobacco treatment group that does not convey that the setting is non-discriminatory. This is especially true in light of the personal disclosures that are a common component of tobacco treatment skills-building groups.

Cultural competency for the LGBT communities follows the same general principles as for any minority population. In our experience, there are four key items which are the foundation for fielding an LGBT tobacco treatment program that is culturally competent.

- Engage a trained LGBT person to facilitate the sessions
- Distribute appropriate, inclusive, and creative promotional materials through community-based outlets
- Provide cultural competency training to all non-LGBT staff who interact with participants
- Modify the curricula to include LGBT-specific and other culturally relevant information for participants

The lessons learned from the LGBT Incubation Project are likely to be applicable to programs targeting all disproportionately impacted communities, including: women, African Americans, Hispanics/Latinos, young adults, working class and poor people, American Indians/Alaskan Natives, and Asian American/Pacific Islanders. People from all these groups participated in the LGBT incubation project. Modifying the steps above may be an excellent starting point for people looking to tailor a treatment group to any specific target population.

For more guidance on cultural competency for the LGBT communities go to:

- Lesbian Community Cancer Project's Standard of Care file on www.lccp.org, or
- Gay and Lesbian Medical Association Provider Guidelines on www.glma.org, or
- GLBT Health Access Project Standards of Practice at www.glbthealth.org

Mixed groups

There are pros and cons to both homogeneous groups (all the same kind of people, i.e., LGBT-only) and heterogeneous (different kinds of people) groups. With successful recruitment, you may be able to run LGBT-only or other population-specific groups. The advantage of these is that people look forward to and can experience a safe haven, and specialized materials for groups do exist (see Resource section on page 13). But since real-world groups will attract many people wanting to quit, it may not be feasible or cost-effective to offer a program primarily for one population. Offering and running groups that are welcoming to all group members, using a basic curriculum with customized materials is effective too. Be sure to give examples and foster discussions of how culture impacts tobacco use and strategies to quit, culture being all-inclusive of race, ethnicity, gender, workplace, age, and sexual orientation.

Most participants in the LGBT Incubation Project highly valued being in an LGBT-focused treatment group. Many of them said they would not have joined a traditional cessation group at a non-LGBT agency. Notably, the few that were in LGBT focused groups that included a few non-LGBT people were not adversely affected by their presence. A smaller amount reported that having an LGBT group and LGBT facilitator did not make a difference to them; for these people, an LGBT-sensitive and inclusive program would have sufficed.

Some LGBT Incubation Project participants expressed the wish to have groups of their own; this was specifically heard in reference to Latinos, transgender people, bisexuals, and HIV+ people. Having a targeted group allows the participants to avoid any discrimination they may experience in the larger

population, ultimately making it a more culturally competent method to give them this service.

Planning to recruit

Overview of recruitment process

As any community worker knows, recruitment for a research study or treatment intervention is a unique challenge. During the LGBT study, it became clear that recruiting groups of friends to quit an addiction and habit so influenced by social behavior was more difficult than expected. Recruiting groups of women, transgender/transsexual people, and people of color – less dominant populations within the LGBT culture – was even more difficult. As a result, the research team explored different recruitment methods over the two years.

The following is a report on what the team learned about community outreach and recruiting. Information and ideas, and lessons learned come from each of the study sites (Fenway Health Center/Boston, Howard Brown Health Center/Chicago, L.A. Gay & Lesbian Center/Los Angeles), from the three cessation programs interviewed (the Mautner Project/Washington DC, Orange County Center Cessation Group/Orange County CA, and The Center Cessation Group/New York NY) and from our focus group of smokers.

Treatment program recruitment: How long does it take?

Administrative support for implementation of a group program is important, and should be included into the cost and planning of any program. Recruiting for a single tobacco treatment group will take one to two months, depending on the level of community outreach and program promotion required.

However, creating a new treatment program for multiple groups requires a much higher level of resource development and system startup, and typically takes about four to eight months. The start-up may be quicker if the agency or organization already does promotion for other support or substance abuse groups, and if the agency already has staff and procedures in place for making appointments and managing calls from participants.

In addition, the presence or absence of trained facilitators makes a big difference in the recruiting timeline. Identifying a strong facilitator can take one to two months, and training a new facilitator takes approximately four months (considering training programs run intermittently).

Recruitment staffing

As with any substance abuse intervention program, it is essential that prospective members be contacted ASAP after they first call, to “strike while the iron is hot,” and reinforce their desire to make a significant behavioral change.

As a result, initial promotion and recruitment efforts are labor-intensive, requiring almost constant staff availability for potential client call-backs. Some sites managed this process through job-sharing. At other sites, such as Fenway, the intensive promotion efforts and closely spaced groups necessitated a full-time staff person. If a full-time person cannot be dedicated to recruitment, the part time staff should be as accessible as possible.

Engaging a recruitment staffer with established professional and personal LGBT networks significantly improves the program’s recruiting success rate. Knowledge of local community resources, organizations, and “movers and shakers” is key. In addition, recruitment staffers must have the ability to create new relationships with individuals and community organizations, as well as foster strong connections within the host agency.

Carefully choosing a person to recruit, one who has the right temperament, interest, enthusiasm, and self-organization needed for this role is vital to the later success of your treatment programs. Recruiters are usually subject to rejection; be cautious of setting reasonable projections and supporting the recruiter so their morale doesn’t suffer.

During the course of the study, the team’s promotion and recruitment tactics changed several times to accommodate unforeseen challenges. Documenting the promotion plan and implementation steps helped to monitor the impact of different items and make changes accordingly. Routine monitoring of the promotional strategy also ensures consistency. Without a steady drumbeat of information flowing out to the target community, impact will be lost and targeted program enrollment levels will not be achieved. A regular calendar of promotional tactics such as ad placements, email blasts, listserv information, etc. should be developed and followed to ensure optimal results. This also allows program staffers to measure program success, and should be part of the recruiting staffers’ performance review.

Specific promotion strategies

Paid ads

This was the most successful promotion strategy used across all sites. Advertisements were placed in local LGBT, free and alternative weekly newspapers and periodicals. Use your community-based recruiter or community advisors to tell you which papers are read by or target LGBTs.

When using paid ads, plan ahead. Most papers follow an editorial calendar and require advance notice. It’s also important to be familiar with the various sections of each paper to ensure optimal placement location.

Depending on budget, either full color or simple black and white ads can be used. Both were used during the study and proved to be equally successful.

Don’t overlook the local free paper. At one location, ads placed in the local free paper’s weekly summary of medical research projects generated many calls.

Flyering and literature drops

Flyering and literature drops can include creative tear-off posters and palm cards at key popular venues. Be sure sites are kept consistently well-stocked.

Scheduling regular literature drops can be overwhelming to a single recruitment staff member responsible for handling all recruitment efforts. One approach is to hire a temporary worker such as a local college student to handle this job. For example, in Boston, the recruiting team hired a freelancer who was already putting up flyers for other community events, for a flat monthly fee this person made rounds two to three times a week to replace postcards and any missing flyers.

Be sure to coordinate with other community organizations or with all departments of the host agency to keep a supply of materials on hand and accessible to possible participants. This will ensure that promotional materials are available at agency events and outreach venues throughout the year.

Promoting through LGBT health or social service agencies

With more than 100 LGBT health or community centers nationwide, many towns have one of these organizations providing services to community members. Most areas also have physicians or therapists who have built a notable LGBT client base. Some also have groups working on lesbian breast cancer, HIV, or other community-interest issues. A healthcare provider can be a powerful motivator to encourage a person to quit smoking, so it is worth the time to build connections with these groups.

Give presentations to the staff to orient them to the project and motivate them to provide direct referrals to your groups.

Consider mailing a packet of information to all groups where you cannot give a direct presentation.

Provide all sites with materials, and restock them regularly. These can include posters with tear-off flyers, palm cards, or business card handouts.

Be sure to maintain your connections by checking back with the provider to help build the habit of referring.

Ask well-connected staff at these agencies to send email blasts of info or ads to their personal online communities.

Promoting at community events

Community events are a natural model for promoting a new or existing program. However, since this kind of outreach takes time, it is most effective to work with other programs within the sponsoring agency as well as outside organizations to share resources and include your materials at a range of events.

Possible outreach venues include all types of community events and health fairs, religious organizations, LGBT community events, film screenings, etc.

If possible, have your own table or an outreach area with a program staff person available.

Visibility is important so develop unique materials with eye-catching visuals. Fenway handed out matchbooks with the slogan “When you’re ready to quit, call us…”. At one dyke march, more than 2,000 matchbooks were distributed. The Lesbian Community Cancer Project in Chicago also successfully promoted its “Bitch to Quit” smoking cessation groups by distributing matchbooks bearing the tag line “Come alone or in a group” along with their website information, at local bars and street fairs.

Free ads: Listservs, community newsletters and websites

There are many, no-cost or low-cost options that provide key information for members of the LGBT communities. For example in Boston, there is a bi-monthly listserv that is broadly targeted at all LGBTs; in California there are Pride email lists; in NYC, the LGBT Community Center has a large email newsletter list.

Submit information and ads, in the appropriate format to online listservs, popular LGBT websites and community bulletin boards. Make them simple, eye-catching, and targeted to the specific audience. Identify or gather new lists from formal or informal focus groups with smokers, friends and colleagues.

Use listservs such as craigslist (www.craigslist.org) that are widely read by the LGBT communities.

College or university alumni or current students can use their affiliation to post ads on LGBT student listservs.

Online social networking services are widely used by younger people. Anyone who has a profile on MySpace, Friendster, or other social network sites, can send a single email to all their friends promoting the groups. It is common for projects and events to have their own profile on these sites (“fakesters”) and recruit friends to promote to directly. This was a tactic often foreign to staffers who were older. It was also a very valuable strategy, so should not be overlooked.

Peer-to-peer recruiting

One of the most successful recruitment strategies for the groups was the direct promotion of the alumni. Keep in touch with your alumni, even if they have not sustained their quit attempt, they are often good links to other smokers who are looking for cessation support.

Summary

Each cessation group used most of the strategies above to engage interested people. They all should seriously be considered for a broad promotional campaign. If groups are

ongoing, there will be less need to promote them over time, so effort spent on this activity can be scaled back as community awareness grows. Importantly, LGBT people in your community will know how they get information about community events and health issues – use those same routes to inform them about your services. If the agency sponsoring the cessation groups is not from the LGBT community, promoting it through community avenues will be even more important, it will convey the implicit message that these groups are LGBT-welcome.

Converting "Interest" into "Participation"

Initial meeting

Depending on the program parameters, it may or may not be important to have a meeting with prospective group members prior to starting the group program. However, some kind of initial intake step is recommended. First, it allows the treatment team to get to know the people in the group; second, it screens out if anyone is inappropriate for group treatment; and third, allows the team to clearly communicate the content and structure of the group. Any contact – whether by phone or in person – is important. In addition, to achieve contact consistency and increase participants' comfort level, it is recommended that the primary program recruiter be present at least for the start of the program.

It is important to be open and honest with people about the program and its goals. That is, clearly define what the group is and what it isn't, and explain what the program is designed to accomplish and what it's not.

The program won't force anyone to quit smoking. It's their choice.

Participants won't be nagged or scared or told how bad it is to use tobacco. They already know that or they wouldn't be there.

The program is a forum to share information, get people to talk with each other, do some tried-and-true quit exercises, and talk about the connection between cultures of all kinds – particularly LGBT – and smoking and quitting.

People are welcome wherever they are in the process of quitting, although the idea is to quit together as a group during the program.

Participants will be encouraged to try out the group and see if they like it. On average, it takes between three and five contact attempts to connect people and make an initial appointment and a commitment to joining the group.

Lessons learned on drop-outs and no-shows

During the course of the study, researchers noticed a steady decrease in participation from first contact to group initiation and then another drop in participation on the planned quit date (a planned joint quit date often occurs in week two or three of cessation group curricula).

Program staffers should expect one-third of the people who commit to join the group to drop out before the group actually begins. In addition, another one-third of participants are likely to drop out part way through the program. To accommodate this, programs should be over-enrolled by as much as one half. For example, for a desired group level of eight, 16 people could be enrolled. Other recommendations to maintain optimal enrollment levels include:

Take time to plan the group schedule for the months ahead. If a participant cannot make the scheduled meeting times of the group program, offer information on other area tobacco treatment resources and specify what, if any, specific populations these other resources serve.

Talk about attendance at the first group meeting, encouraging people to keep coming to the group no matter what is going on with their smoking behavior. Quitting is a process and progress is measured in many ways, like changes in thinking about smoking and quitting, not just by changes in the number of cigarettes per day.

Conduct reminder calls each week. This can be done by the group facilitator, administrative staff, or designated group buddies. Be sure to get permission from each participant about how to leave a message. For example, should you mention that it's a quit smoking group? Should you say the name of the agency or not?

If a member misses a group session, the group facilitator should call and talk with the person; sometimes people need encouragement to come back to the group. This is particularly true around quit-date time, when some who are continuing to smoke may feel uncomfortable returning.

Remember, each setting has its own barriers to participation. Be aware of what these are and make plans to overcome them. Offering incentives is one way to encourage people to attend (see a fuller discussion on this later). Talking with both individuals and the group about attendance and how to solve any attendance barriers can also help and reinforces problem-solving skills used during the quit process.

Chapter 4

Running the Group

Welcome to the world of tobacco treatment groups!

The group facilitation model and curricula used for the LGBT Incubation Project came from interviews with our Advisory Committee of Smokers and interviews with three active LGBT cessation programs. When starting up a program, consider holding focus groups of current smokers in your area, and speak with up-and-running tobacco treatment programs. The following section offers information and lessons learned on group formation, curricula, and group facilitation.

Group size

The ideal group size ranges from 6-12 participants. As mentioned, it is better to "overbook" groups since dropout is an issue. Groups can be successful outside of this range, but too few people means that with absences there are not enough members to create a cohesive group. On the other hand, groups larger than 12 can cause confusion and participants may feel there is not enough time for everyone to participate. Maintaining a waiting list is one way to manage a surplus of interested participants.

Group materials and supplies

Many free and low-cost resources exist to supplement your chosen curriculum and allow you to offer materials that are appropriate and of interest to different members. See the Resource section on page 13 for a review of sources.

Considerations for facilitators

Training and matching the target audience

The importance of using trained facilitators for tobacco treatment groups cannot be overstated. Tobacco treatment is a specialty, and many substance abuse or mental health providers do not know the specific information needed to help people quit using tobacco. Finding trained facilitators may be difficult, but training is available. Be sure to research the expense and availability of this training and make sure it is included in the timeline and budget of your program. See the Resource section on page 13 for training programs.

To create a successful group facilitator, make every attempt to match the membership of the community and group with specific leader characteristics, such as race and gender. Co-facilitation, particularly with a larger group or mixed gender group, can be quite helpful. Many LGBT Incubation Project participants found it a help to know that the facilitator was a member of the LGBT communities. In terms of smoking experience, people who've never smoked as well as ex-smokers can successfully facilitate groups, but it is recommended that an ex-smoker have at least one to two years of abstinence from tobacco. Just as the choice of recruiter is the biggest impact on recruitment success, the choice of facilitator can be the biggest determinant on the success of individuals looking to quit smoking. Make sure the facilitator is passionate about their role, as this is one quality that neither training nor supervision can fix.

Pick a core curriculum: Overview of options

The two biggies: ALA and ACS

Two classic evidence-based curricula exist in the United States – the American Cancer's Society's (ACS) Fresh Start and the American Lung Association's Freedom From Smoking. It seems that the American Lung Association (ALA) offered the most frequent trainings and is therefore more accessible. The American Lung Association also has a curriculum for young people called Not On Tobacco (N.O.T.). Both of these organizations require that group facilitators go through training in order to use their materials.

The exercises in the ALA curriculum were well-received, although the order and wording was changed at times to better match the flow of the group. Part of the ALA curriculum, and always a hit, was the ex-smokers' panel, which also acted as an incentive for participants to maintain lives as non-smokers in order to participate in upcoming panels. Other valuable exercises were the witnessed pledges, the "success-stickers" for calendars. In addition, use of the Carbon Monoxide (CO) monitor at first and last session of group, and for evaluation sessions, was a positive strategy.

LGBT-specific

The QueerTIP curriculum, developed by Greg Greenwood, can be obtained through ~~http://www.caps.ucsf.edu/pubs/reports/pdf/Q-TIPS2C.pdf.~~ The curriculum must be used with permission. Howard Brown used small chunks of the QueerTIP curriculum woven in with the ALA curriculum. There is a QueerTIP curriculum for youth as well.

The New York GLBT Community Center pioneered and tested their own LGBT cessation curricula as well. Contact them for details and permission at www.gaycenter.org.

The American Cancer Society has three brochures regarding LGBT tobacco use, cancer facts for gay and bisexual men, and cancer facts for lesbians and bisexual women. The Last Drag, a groundbreaking program in San Francisco, has three quit pamphlets for lesbian, gay, bisexual, transgender and HIV+ individuals, available at the Tobacco Education Clearinghouse of California. There are several other pamphlets and posters available from TECC as well. To add some fun to the proceedings, www.gaysmokeout.net has lively and creative health education and quit materials to order, including palm cards with tobacco facts and figures.

For an updated list of LGBT-specific cessation resources, see the National LGBT Tobacco Control Network website at www.lgbttobacco.org.

Homegrown

Any basic curriculum can be customized for the populations and individuals in your own groups, integrating appropriate information. Pamphlets, videos, parts of other curricula, information on tobacco industry marketing, and other facts and figures, can be used. The websites and organizations given below have a wealth of information. A truly homegrown curriculum is sometimes advisable, for example if there is a long history of running tobacco cessation groups in your agency, but make sure you're not prioritizing habit over tested-success.

Group facilitations: Lessons learned

A skilled facilitator can help individuals to bridge gaps among participants' backgrounds, beliefs, attitudes, and behaviors to form a cohesive and effective group. Key group facilitation success factors include:

Attitude and tone

A sense of hope and encouragement throughout the group process is necessary, from the first call a potential member makes to the agency to the last group interaction. Sometimes facilitators are cheerleaders, sometimes health educators; sometimes they set limits, sometimes open up conversations. Fostering motivation and confidence are skills learned through the tobacco treatment trainings, and belief in everyone's ability to change can be positively infectious.

Group guidelines

Group guidelines and norms should be reviewed at the first group session. Each setting will have its own rules, particularly for research studies, but some items should be standard. Making up the guidelines as a group adds power to the meaning of the rules. Helpful guidelines can include:

- Agreeing to confidentiality of shared information;
- Explaining the role of the group leader as someone who gives information, but also encourages the group's knowledge to come forth, ensures curriculum is followed and manages the group's time properly;
- Encouraging participants to call the facilitator or each other if they will be late or unable to make a group session;
- Making every effort to attend the group session no matter what is going on with their smoking behavior; and,
- Using respectful language and actions toward each other.

Other tobacco products

Some participants will use other tobacco products besides cigarettes (such as pipes, cigars, bidis, clove cigarettes, smokeless tobacco, etc.). Be sure to provide access to information about these products (see Resources section on page 13). Participants must be reminded that there is no safe tobacco, which can be discussed as needed during group sessions.

Quit Day

For most participants, Quit Day is a time of renewed doubt and renewed dedication. Every cessation curriculum encourages participants to quit as a group, and prepare for the quit date itself beginning on day one of the program. Preparation and the idea that change is a process over time are key tenets of tobacco treatment. Several curricula call for two sessions to be held the week of Quit Day. Whatever the plan, encourage participants to plan for extra support for the time leading up to and immediately following Quit Day. Encouraging use of available websites and Quit hotlines can be very helpful. The buddy system also is a great way for people to get the support they need during the early days of quitting.

Modifying stock language or exercises

The exercises and strategies used by standard curricula are based on research and practice. But sometimes the language is heterosexist, gender-exclusive or gender-binary, sexist, or race exclusive. Facilitators should feel free to change language to more inviting and culturally competent words, while maintaining the integrity of the activity and citing the main source.

Incentives

While incentives are desirable, they often mask a person's lack of true internal motivation to change their behavior. For example, during the LGBT research study, a number of people enrolled only to never show up after they received $20 for filling out early application forms.

Nonetheless, incentives can help the group process run more smoothly. In general, it is always good to make participants feel pampered by offering small-scale incentives. It both recognizes and reduces their stress without being unduly coercive. Incentive programs that proved to be successful during the LGBT Research project included:

- Donated items or tickets to help people cope with Quit Week stress. In one example, The Lesbian Community Cancer Project had a woman-owned sex store donate vibrators to include in participant's "quit bags" which were well-received and added some humor to the quitting process.
- Treats like mints or gum helped participants manage cravings throughout the entire cessation process.
- Holding group celebrations at the end of meetings.
- Offering healthy snacks such as popcorn, raisins, sugar-free gum and candy, sunflower seeds and beverages at all meetings.

Increasing the odds of success

Nicotine Replacement Therapy

Many people want nicotine patches as part of a quit program. Some people who called with interest about the LGBT Incubation Project declined to join the groups because they were looking for one with free NRT. Since NRT does increase the chance of people quitting permanently, consider including it in your program budget.[12]

If the program does offer NRT, it can be integrated by providing the product itself, or offering vouchers, or coupons. Most programs have a sign-off sheet to absolve the program of any liability, asserting that the member understands the proper use of the nicotine replacement product and has contacted their healthcare provider before using the product. Other programs send a letter to the group member's healthcare provider, with a signed release of information, letting the provider know the person's plan to quit, or require permission from the provider for use of the nicotine replacement product. Consultation with a medical provider about if and how to provide nicotine replacement therapy is an important aspect when starting up a program.

Seeing their doctor

Always encourage group members to talk with a healthcare provider about their efforts to quit. Counseling support (either individual or group), NRT, and prescription medications are three of the most effective and tested strategies for treating nicotine dependence.[11] A short conversation with a healthcare provider helps participants explore whether any of these prescription medicines is appropriate for them. Also, the conversation is motivational. Research shows that if healthcare providers take just three minutes to do a tested smoking intervention with their patients, it may double the person's chance of success.[13] The 5As – Ask, Advise, Assess, Assist, Arrange – were once the gold standard for a provider intervention. Newer information shows the shorter Ask/Advise/Refer intervention is highly effective and more practical for integrating into today's time-limited healthcare interactions. See the Smoking Cessation Leadership Center website (http://smokingcessation leadership.ucsf.edu/) for more information about how to train and motivate healthcare providers to include this intervention. It's very important for anyone with chronic physical or mental health problems and anyone who is on medication to let their care providers know that they are planning to quit. Nicotine interacts with various medications, and after quitting, or during tapering, medication dosages may need to be adjusted.

Resources

Please see the National LGBT Tobacco Control Network website, www.lgbttobaco.org, for links to and regular updates on the resources listed here.

For facilitators

- American Cancer Society: www.cancer.org 1-800-227-2345
- American Lung Association: www.lungusa.org 1-800-LUNG-USA
- American Heart Association: www.amhrt.org 1-800-242-1793
- American Legacy Foundation: www.americanlegacy.org

Cross-cultural and basic material resources

- Tobacco Education Clearinghouse of California: Materials to order. http://www.tecc.org/public/
- Tobacco Education Clearinghouse: Materials to order. For MA, RI and NH programs only. 1-800-TRY-TO-STOP (1-800-879-8678).

Clinical guidelines

- ~~http://www.surgeongeneral.gov/ tobacco/default.htm~~ - US Clinical Guidelines

Curriculums and facilitator training

- Information on the American Lung Association curriculum, Freedom From Smoking, can be obtained at 1-800-LUNG-USA or at www.lungusa.org.
- The American Cancer Society may have Fresh Start training in your area at 1-800-227-2345.
- Queer Tips: http://www.caps.ucsf.edu/pubs/reports/pdf/Q-TIPS2C.pdf
- Certified Tobacco Treatment Specialist: http://www.umassmed.edu/behavmed/tobacco/train.aspx
- www.attud.org - National tobacco treatment organization
- www.gaycenter.org – Developed an LGBT-specific curriculum based on ACS materials.
- www.treatobacco.net
- www.ttac.org

General tobacco treatment resources

General Quitting:
- www.trytostop.org
- www.smokefree.gov
- www.quitnet.com
- www.quitsmokeless.org (Smokeless Tobacco)
- www.nicotine-anonymous.org

- http://1800quitnow.org/
- ~~http://smokingcessationleadership. ucsf.edu/~~

Youth Sites:
- www.tobaccofreekids.org
- www.cdc.gov/tobacco/tips4youth.htm
- www.stop-tabac.ch/en/welcome.html

LGBT Sites:
- www.lgbttobacco.org
- www.lastdrag.org
- www.lgbtcenters.org/tobacco.asp
- www.projectscum.org
- http://www.caps.ucsf.edu/pubs/reports/pdf/Q-TIPS2C.pdf
- www.iquit.medschool.ucsf.edu
- http://www.socialmarketing.com
- www.gaysmokeout.net
- www.howardbrown.org
- www.bitchtoquit.com
- www.lccp.org
- www.queertheair.com

Native American:
- www.tobaccoprevention.net

Asian-American:
- www.appealforcommunities.org/

African-American:
- www.naatpn.org
- www.naaten.org
- www.cdc.gov/tobacco/quit/pathways.htm

Hispanic/Latino:
- www.nlcatp.org/

Low Socio-Economic Status:
- www.healthedcouncil.org/nntpp.html

Women:
- www.inwat.org/
- www.join-the-circle.org

Quit lines:

Quit lines offer a range of services, including information, referral to local tobacco treatment programs, packets of information, telephone counseling and/or Nicotine Replacement Therapy. Each quit line has its own model and services offered. Telephone counseling has been found to be effective to help people quit and stay tobacco-free.

- Check for your state's resources at www.smokefree.gov
- Call the National Quitline: 1-800-QUIT-NOW (1-800-784-8669)
- www.naquitline.org

Chapter 5

Special study: The Role of Social Support in Cessation

Social support has long been identified as important to the concept of tobacco cessation, but the strength and nature of its effect are not yet clear. In some cases, social structures indicating lack of support have been linked with lower treatment success rates. As an example, people are less likely to quit if their partner smokes, or they live with other smokers. The most studied use of social support in the tobacco treatment environment is through engagement of a "buddy" in treatment groups. This buddy has taken many forms, sometimes it is assigned, sometimes it is a friend who also wants to quit, and sometimes it is a non-smoking supporter of the participant. While partner involvement has been shown to increase quit-rates, it is less clear how to activate that involvement.[14]

The LGBT Incubation Project was designed to pilot an innovative social support mechanism, the simultaneous recruitment of small social groups into treatment. Through this process, valuable information was gathered on the role of social support in the treatment process. A summary of lessons learned is presented here.

Is it viable to recruit small social groups into a treatment program? This is a very difficult endeavor; it basically takes the probability that any one person is ready to enter treatment and multiplies it by the same probability for each friend they want to bring in as well. In the end, the chance that the group will enter treatment right now gets smaller with each additional person.

Is it valuable? Uniformly, people with friend groups were optimistic pre-group that this support was an important assist in their quit strategy. During the groups, reality sometimes differed from the expectation. Occasionally, people were disappointed with their friend's lack of commitment. In one interview, the participant reported a new rift that arose partially in relation to the stress of quitting. Ultimately, in most all cases the participant assigned a positive value to the experience of coming with their friends, even when pieces of the experience were challenging. In some cases, the participants identified the inclusion of friends as key to their success.

Conclusion

Yes, inclusion of friends is a valuable and strong influence in tobacco treatment. But more information is needed about how to engage friend groups and how to optimize the strength of that influence.

Recommendations

- Create a strategy for recruiting as many friend groups as possible into cessation treatment programs, while still allowing solo people to enroll as well.
- Recruiters should encourage friend participation during the engagement/enrollment process, not after the program has started. Stock cessation curricula sometimes encourage a facilitator to ask about possible buddies at the first group session. The process should start earlier, since participants are reluctant to engage newcomers once the group is underway.
- As soon as an interested participant contacts the recruiter, the recruiter should immediately encourage friend-to-friend outreach. Throughout the LGBT study, participants would quickly indicate if they had any friends who also might be interested in joining the program. Given time and follow-up these participants typically asked their friends to participate without further prompting by the LGBT team. In some cases however, some participants were shy or embarrassed to ask their friends. Two methods are helpful to address these kinds of cases:
    1. The recruiter works with the participant to de-emphasize the asking process by coaching the participant on how to approach their friend(s), explain the program, and contact the recruiter if they're interested in joining; or,
    2. With a recruiter by their side, the participant calls his/her friends, explains the program and asks them if they would like to speak directly with the recruiter about joining the treatment group.

Chapter 6

Evaluation Lessons Learned

Literature on key indicators of success

Through an extensive literature review at the beginning of our research project, the following factors were cited as being related to treatment success.

- Abstinence self-efficacy (ASE), or the level to which you think you will succeed
- Smoking intensity
- Years of smoking history
- Social support
- Current life-stressors
- Mental health and/or other substance abuse issues
- Experience of any smoking-related health problems
- Number and duration of previous quit attempts
- Treatment methods (People who get a healthcare provider intervention, NRT or other quit smoking medication, and some type of individual or group cessation therapy are most likely to quit. See the clinical guidelines in the Resources section on page 13 for more information.)

Case study: Implementing a full evaluation

LGBT Incubation Project integrated a full evaluation of the program into the project design. This level of evaluation is often not feasible for non-research programs but several valuable lessons learned emerged from this experience and they are presented here.

There is a need for a standard group tobacco treatment evaluation model.

Despite the fact that group treatment programs have been occurring for decades, and that there is a high need for proof of efficacy for many of these programs, The LGBT Incubation Project was unable to identify any standard evaluation models for assessing the impact of the group treatment program. As a result, many weeks were spent researching literature and contacting technical assistance organizations for help. A lack of a standard evaluation model for group treatment programs makes it difficult, if not impossible, for smaller non-research treatment programs to evaluate their projects. To help address this deficiency, the LGBT Incubation Project researchers have created a Model Mini-evaluation to be used by organizations conducting cessation groups. It is presented at the end of this section.

Implementing a cross-site evaluation brings a host of challenges.

The LGBT Incubation Project evaluation was implemented across three different health centers. While the goal was to keep the evaluation consistent, factors at each site had an impact on local implementation. For example, at one site the competing needs of an overlapping program resulted in changes to the evaluation form. At another site, staff changes affected the timing of evaluation follow-ups. And in another instance, miscommunication between sites caused differences in how the evaluation was administered. Although the information gleaned from the evaluations was valuable, the time spent to administer the evaluations at multiple locations was greater than anticipated.

The impact of a tobacco treatment group is often underestimated by common evaluation methods.

Our project originally relied heavily on quantitative data collection; each participant was expected to fill out about an hour's worth of instruments before and after their treatment group. This echoed our thinking that the value of the group could be measured in number of people who quit smoking. This approach ultimately collected too little information about a key project marker, social support. Importantly, it also was not able to measure important gradations in the impact of the treatment group. As examples, two people interviewed at project end would both have appeared quantitatively as having a non-successful experience in the group treatment program. But by his or her telling, the treatment program was actually very high impact.

> For John, he was still smoking at the end of the program, and even a few months later. But as a result of his earlier work, he rallied and quit cold turkey. At the time of the qualitative interview, he was approaching his six month cessation mark. For John, he is frank that the program saved his life.
>
> For Stan, the treatment group resulted in a one-day cessation attempt. While this is not very remarkable as a statistic, that bald assessment ignores the importance of this achievement in the context of Stan's life. When he is later interviewed he remarks with amazement that he was able to give up cigarettes or 24 hours. This is more than he has

been able to do in his whole history, and for him, it renews his belief that he one day can and will quit altogether.

Model mini-evaluation

As discussed in the previous section, there is a real need for a model mini-evaluation that non-research tobacco treatment groups can use to measure their program's effectiveness. Below are recommended steps for a mini-evaluation and all needed instruments. Although not yet tested, this evaluation model is based on extensive knowledge of the literature and direct evaluation experience. Please feel free to use this evaluation for your treatment groups. The authors also encourage all efforts to test and disseminate this or any other similarly low-effort treatment group evaluation.

Mini-evaluation steps

Pre-group
- Administer the **Intake**
- Administer the **Fagerstrom Nicotine Tolerance Scale**

Optional
- Monitor the CO readings at every evaluation point.

Last session
- Administer the **Feedback Form**
- Administer the **Followup**
- Readminister the **Fagerstrom Nicotine Tolerance Scale**

30 days later
- Readminister the **Followup and Fagerstrom** (if indicated)

Report out
- Report aggregate data for each intake item
- Summarize feedback data.
- Create charts showing pre-post change in followup items
- Excerpt followup quotes to demonstrate personal impact

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Intake

How did you hear about our program? ______________________________________

What is your age? ________

What is your gender? ☐ female ☐ male ☐ transgender

How many years have you been smoking cigarettes?
☐ 0-5 ☐ 6-10 ☐ 11 or more

Have you experienced any health problems you think are related to your smoking?
☐ yes ☐ no

Do you live with other smokers?
☐ yes ☐ no

How would you describe your friends and family?
☐ Mostly smokers
☐ Some smokers and some non-smokers
☐ Mostly non-smokers

Because it helps us to understand if we are serving populations that are especially hard-hit by tobacco, could you please check all boxes below that apply to you.
☐ African American/Black
☐ Hispanic
☐ Asian American/Pacific Islander
☐ Native American
☐ low income
☐ gay
☐ lesbian
☐ bisexual
☐ transgender
☐ none of the above

On a scale of 1-10, with 10 being the most certain, how certain are you that you can permanently stop smoking…

In the next few months?	1	2	3	4	5	6	7	8	9	10
In the next few years?	1	2	3	4	5	6	7	8	9	10
Ever?	1	2	3	4	5	6	7	8	9	10

How many quit attempts have you made previously?
☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6 or more

How long was your longest previous quit attempt?
☐ days ☐ weeks ☐ months ☐ years

Fagerstrom Tolerance Scale

Participant ID:__________________________________ Date:______________________

Write the number of the answer that is most applicable on the line to the left of the question.

______1. How soon after you awake do you smoke your first cigarette?
- 0. After 30 minutes
- 1. Within 30 minutes

______2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theater, or doctors' office?
- 0. No
- 1. Yes

______3. Which of all the cigarettes you smoke in a day is the most satisfying?
- 0. Any other than the first one in the morning
- 1. The first one in the morning

______4. How many cigarettes a day do you smoke?
- 0. 1-15
- 1. 16-25
- 2. More than 26

______5. Do you smoke more during the morning than during the rest of the day?
- 0. No
- 1. Yes

______6. Do you smoke when you are so ill that you are in bed most of the day?
- 0. No
- 1. Yes

______7. Does the brand you smoke have a low, medium, or high nicotine content?
- 0. Low
- 1. Medium
- 2. High

______8. How often do you inhale the smoke from your cigarette?
- 0. Never
- 1. Sometimes
- 2. Always

SCORING INSTRUCTIONS:

Add up your responses to all the items. Total scores should range from 0 to 11, where 7 or greater suggests physical dependence on nicotine.

TOTAL SCORE: __________

Feedback form

On a scale of 1-5 with 5 being the best, how would you rate these different parts of your tobacco treatment group?

	Poor		OK		Great
Scheduling	1	2	3	4	5
Skills-building	1	2	3	4	5
Information	1	2	3	4	5
Support for quitting	1	2	3	4	5
Facilitation	1	2	3	4	5
Value to you	1	2	3	4	5

Were their particular things you found really helpful?____

Do you have any suggestions for improvement?____

Would you recommend this group to others? ☐ yes ☐ no

Followup

Since you started this group, have you made an attempt to quit smoking? ☐ yes ☐ no

If so, can you tell us how that went?

☐ I am now smokefree
☐ It lasted hours
☐ It lasted days
☐ It lasted weeks
☐ It lasted months
☐ It was my longest quit attempt ever
☐ Not applicable – I didn't try to quit

And, did you use any extra strategies?

☐ I used the gum, patch, lozenge, or nasal spray
☐ I used a prescription medicine such as Zyban or Chantix
☐ I talked to my doctor about the quitplan
☐ I used another strategy like acupuncture or massage
☐ No other strategies
☐ Not applicable – I didn't try to quit

Please tell us about your smoking status now…

Have you smoked any cigarettes or used other tobacco, even a puff, since your quit date?

☐ yes ☐ no

Have you smoked any cigarettes or used other tobacco, even a puff, in the last 7 days?

☐ yes ☐ no

Have you smoked any cigarettes or used other tobacco, even a puff, in the last 30 days?

☐ yes ☐ no

In restrospect, do you think this treatment group was important to you?

☐ yes ☐ no

If so, can you please briefly tell us why it was important?____

If you still smoke…

On a scale of 1-10, with 10 being the most certain, how certain are you that you can permanently stop smoking…

In the next few months?	1	2	3	4	5	6	7	8	9	100
In the next few years?	1	2	3	4	5	6	7	8	9	10
Ever?	1	2	3	4	5	6	7	8	9	10

Are you planning another quit attempt now?

☐ yes ☐ no

[Add Fagerstrom Scale for current smokers]

This facility is smoke free.

For more information on the National LGBT Control Network visit www.lgbttobacco.org.

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