Activities To Enhance the Use of Cessation Resources in COMMIT

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INTRODUCTION Cessation resources include a wide range of methods and materials aimed at encouraging and assisting people to quit smoking. The range includes educational or self-help materials such as books, pamphlets, and audiotapes or videotapes; support services such as smoking hotlines or information services; and group and individual treatment programs offered by nonprofit agencies or proprietary firms or individual practitioners. The Community Intervention Trial for Smoking Cessation (COMMIT) project made several key assumptions that influenced protocol development and implementation. First, because a wide variety of services and resources are generally available in communities through existing agencies, it was not necessary for COMMIT to develop new cessation services. If other COMMIT programs increased demand for services, local agencies would be responsive. Second, the individual smoker is probably the best judge of which method meets his or her needs and should be offered a range of options. Third, because 90 percent of smokers quit on their own, providing motivation and improving their access to self-help materials appear to be the most promising intervention strategies (Pomrehn et al., 1990-91).

Considerable COMMIT resources were directed toward public education (Wallack and Sciandra, 1990-91), health care settings and providers (Ockene et al., 1990-91), and worksites and other organizations (Sorensen et al., 1990-91), with the expectation that the supply of cessation resources—for example, cessation classes and individual counseling—would expand as need and demand increased. As reflected in the protocol, communities were charged with promoting cessation resources that were available and providing regular notice of opportunities for smokers to quit. Because heavy smokers (≥ 25 cigarettes a day) were the primary target for COMMIT, communities also sought to identify and use avenues for reaching them.

This chapter has a twofold purpose: first, to present the rationale for the three required activities, describe how they were implemented, and offer

some practical advice for communities interested in mounting such services with their own resources; and second, to describe how several COMMIT sites used the protocol or conducted optional activities to target heavy smokers and culturally diverse smokers. Both successes and failures are chronicled along with suggestions to guide communities in doing better.

CESSATION RESOURCES ACTIVITIES AND PROCESS OBJECTIVES

Each COMMIT channel had overall goals, a set of impact objectives, and a set of mandated activities designed to meet these objectives if they were successfully implemented (see Chapter 4). The overall goals of the cessation resources and services channel were to:

- increase smokers' awareness of cessation resources in their community;
- assist smokers in identifying cessation assistance; and
- promote participation in community cessation programs and services.

The impact objectives for cessation resources reflect the emphasis on increasing awareness of cessation programs, distributing self-help materials, and reaching out to heavy smokers. This corresponds with the trialwide goal to increase the capacity to modify smoking behavior. In accordance with the focus on self-help or nonassisted quitting, low objectives were set for attending cessation clinics by heavy smokers. The impact objectives were:

- By 1993 80 percent of smokers will be aware of the availability of stop-smoking programs or classes in their community as measured in the evaluation cohort survey.
- By 1993 cessation materials will be distributed to the equivalent of 20 percent of smokers as measured by the cessation resources survey.
- By 1993 cessation clinics will have been attended by the equivalent of 8 percent of smokers as measured by the cessation resources survey.
- By 1993 the Smokers' Network will have enrolled 8 percent of heavy smokers as measured by the COMMIT Program Records System.

The cessation resources channel consisted of five major activities. These activities and their process measures are listed in Table 1.

DEVELOPING AND DISTRIBUTING A CESSATION RESOURCES GUIDE

Smokers are likely to be unaware of all the available resources in their community. Information about timing, location, and expense is important to smokers who are seeking assistance in quitting or who are advised to do so by friends or health care professionals. Many health care professionals—for example, physicians, and dentists—and friends and relatives of smokers would like to be able to provide cessation resource information to smokers as they advise them

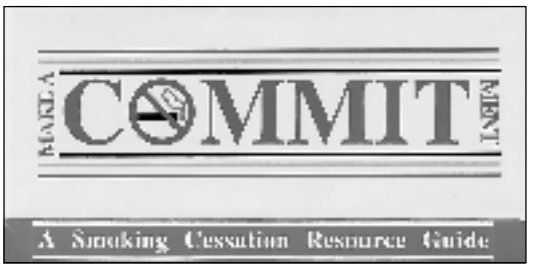


Table 1
Cessation resources activities and process objectives

Activities for Each Community	Cumulative Objectives (1988-1992)	Number/ Percent Completed	Process Objectives Achieved[a] (%)
Produce Cessation Resources Guide	All communities	11	100
Annually Deliver Cessation Resources Guide to:			
Physicians	90%		107
Dentists	90%		104
Targeted worksites	90%		101
Targeted organizations	90%		78
Semiannually Produce and Distribute Newsletters	66 newsletters	92 newsletters	139
Develop Network Recruitment Plan	All communities	11	100
Recruit Heavy Smokers Into a Network	8%	8.4%	105

[a] *Average for combined communities.*

to quit. For these reasons, a community-specific Cessation Resources Guide (CRG) was developed in each COMMIT site.

Resource guides are community-specific, nonevaluative descriptions of local cessation resources. The guides listed organizations or individuals offering smoking cessation programs, sources of self-help materials and cessation aids, and any other resources deemed appropriate by each local task force. A brief description of each service included names and telephone numbers of contact persons and often some information about fees or costs. Decisions about which services to include were made locally and were generally inclusive; those who wished to be listed were. There was virtually no conflict over listings. Most sites included the names of physicians and dentists who had received COMMIT-supported training in cessation counseling (Ockene et al., 1990-91). Several of the guides were formatted as 3×8 pamphlets that easily fitted into a purse or pocket and unfolded into a small poster that could be displayed on a bulletin board. The guides sometimes included motivational material to encourage smokers to quit on their own, such as a self-administered

quiz on nicotine addiction or some other attention-getting visual or verbal material. In one site, a Spanish-language edition was prepared and distributed.

The CRG was probably the most popular and successful COMMIT activity across all 11 communities. Table 2 lists the number of CRG's distributed by each community as derived from the COMMIT Program Records System (Corbett et al., 1990-91). Distribution channels were determined partly by the protocol, with some opportunity for local creativity, and typically involved physicians' and dentists' offices, clinics, hospitals, pharmacies, and health fairs. CRG's also were part of self-help packets distributed during community events such as The Great American Smokeout or "Quit and Win" contests (as described in Chapter 11). In Medford/Ashland, OR, one of the smallest COMMIT sites, nearly 35,000 guides were distributed primarily through health care provider offices and worksites. A key distribution tactic developed by the Medford/Ashland site was the use of clear plastic racks for the CRG's; they were seen as useful and convenient by health care offices. Such racks helped make the guides visible for patients and providers, a strategy emulated by many other communities and proven to be popular at those sites.

The cost of the guides included staff time to collect the information, formatting and layout, printing, and distribution. Obviously, startup costs are greatest, and economies of scale will be realized with larger printings. As popular as this service was during COMMIT, it is not surprising that many sites wished to see it maintained after project funding ended.

A CRG could be produced by a county health department; a voluntary organization, such as the American Cancer Society or American Lung Association; or some consortium of these. A small fee (e.g., $25 per listing) could defray expenses, or one of the pharmaceutical companies producing the nicotine patch might be willing to bear some of the cost. In addition,

Table 2
Cessation Resources Guide distribution, by community

Vallejo, California	76,575
Brantford, Ontario, Canada	16,617
Cedar Rapids, Iowa	16,183
Fitchburg/Leominster, Massachusetts	12,323
Paterson, New Jersey	17,445
Santa Fe, New Mexico	3,566
Utica, New York	46,217
Yonkers, New York	42,089
Raleigh, North Carolina	191,830
Medford/Ashland, Oregon	34,990
Bellingham, Washington	8,719

there could be flexibility in how often such a guide needs to be revised and updated; every 3 years could be sufficient. Many of the COMMIT communities printed extra covers and gave a computerized listing of the contents of the CRG to a local health voluntary agency or health department so that the guide could be updated annually or biannually.

RECRUITING HEAVY SMOKERS INTO A NETWORK

Quitting smoking is a process, and smokers typically go through the stages of quitting several times before achieving long-term success (DiClemente et al., 1991). Therefore, it is desirable to maintain communication with those who are contemplating quitting or trying to quit as a way of encouraging quit attempts, preventing relapse, and encouraging relapsers to try again. For this reason, each COMMIT community established a computerized registry, called a Smokers' Network, that provided a database of smokers who desired regular communication on cessation opportunities. Smokers joined the COMMIT network voluntarily when participating in community-wide Quit and Win contests (see Chapter 6) or when attending health fairs or other promotional events. Some sites used standing displays or posters with tear-off registration forms that could be mailed to the COMMIT office. Several sites struggled to meet network recruitment goals early in the trial, but most eventually succeeded. By the end of the COMMIT trial, seven sites each had recruited at least 8 percent of their total local population of adult heavy smokers. The range of percentage of heavy smokers in the network was 3.1 to 21.7 percent, and for light-to-moderate smokers 1.8 to 10 percent, with average trial percentages of 8.4 and 3.9, respectively. This indicates that efforts were generally successful in enrolling heavy smokers into the registry; more surprising was that a greater portion of heavy smokers enrolled than light-to-moderate smokers.

There were inherent barriers to entering the network: Smokers had to choose to complete and sign the card and sometimes had to mail it to the COMMIT office. COMMIT's contractual Federal funding required that registration cards contain the following statement, "The information you provide will be kept confidential, and will only be used for the purposes of this mailing list and will only be available to the appropriate staff, or as required by law. You may request removal from this mailing list at any time by contacting (local COMMIT ID) at the phone number and address provided in the newsletter." Although this statement may have inhibited some smokers from registering, many sites minimized this impact by sizing and creative placement on the registration cards. Sites found it neccessary to use incentives (e.g., pens or coffee mugs imprinted with nonsmoking messages) to help with network recruitment. Others distributed promotional items, such as a paper clip holder with a "join the network" message, to physicians' offices or

worksites. Many sites creatively developed registration cards for magnet events, such as Quit and Win contests, so that as smokers registered for contests, they concurrently registered for the Smokers' Network.

Perhaps the major lesson learned from COMMIT's network experience is that it is possible to use various cessation and promotional activities to develop a mailing list of smokers. Simple registration cards can be easily filled out and subsequently entered into a database for future contact. Individual agencies conducting smoking control activities could develop their own lists for their own purposes, or such lists could be shared or merged into a centralized resource for a community. Such a network could serve a variety of purposes, including newsletter mailings, supportive mailings or telephone calls to prevent relapse or urge recycling to another quit attempt, or offerings of new cessation programs or services. Such a system also can tell sponsors where in the community people are getting their tobacco information.

For COMMIT, the network was limited to the receipt of periodic newsletters. Enrolling in a network may be a signal that a smoker is considering quitting or is ready to quit (DiClemente et al., 1991). A mechanism that provides a more timely response than that of an infrequently issued newsletter can capitalize on this opportunity.

DISTRIBUTING A SEMIANNUAL NEWSLETTER

The COMMIT newsletters also were aimed at maintaining ongoing communication with smokers to encourage movement along the process-of-change continuum (DiClemente et al., 1991). Although COMMIT newsletters were initially aimed primarily at network-registered smokers, most sites distributed them more broadly, including to physician offices, worksites, organizations, and even locales where smokers were likely to be found. The newsletters attempted to be sensitive to and supportive of smokers and their needs. Content usually included a calendar of local smoking cessation events, tips on quitting, stories or testimonials from local people who had quit, interesting facts about smoking, and often humorous material in the form of cartoons or stories. Most newsletters used testimonials from successful quitters as a way of providing role models for quitting. Forthcoming programs or activities, such as Quit and Win contests, were also routinely featured. The newsletter was produced by COMMIT staff or volunteers using the desktop publishing capabilities of ordinary personal computers. Production sometimes strained the resources of COMMIT personnel who had limited prior experience with such an activity, but by the close of the intervention, the activity had become routine.

During the final 2 years of intervention, COMMIT sites averaged three newsletters a year, and all distributed the required minimum of two. At two sites, newsletters were mailed to all homes in the community, which resulted in many telephone calls to the COMMIT office as well as to other agencies

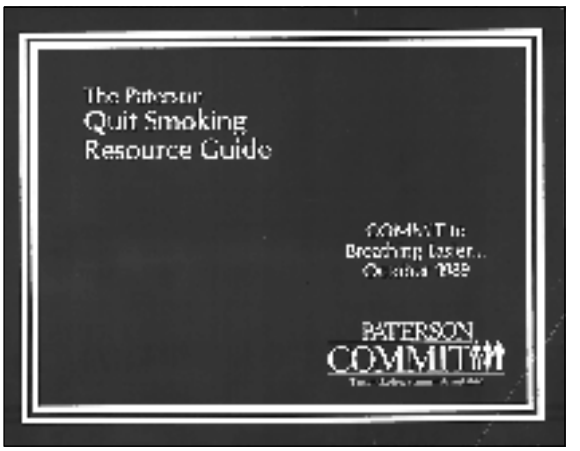
concerned with smoking control. However, such a broad mailing, even with bulk mail rates, can raise cost barriers to programs with limited funding. Most agencies involved in tobacco control already produce newsletters or bulletins for their membership. This technology and capability can be readily adapted to newsletters or to other mailings directed at smokers. Newsletters could be piggybacked onto existing mailings, thereby reducing postage costs, one of the major barriers for this activity. A less desirable but still cheaper option is to include smoking cessation material within a broader health newsletter. Many health maintenance organizations already do so.

In summary, the three mandated cessation resources activities were successfully implemented across the 11 COMMIT sites. The CRG appeared to be the most popular and deserving of attention from communities wishing to enhance their tobacco control capabilities.

SPECIAL RECRUITMENT AND INTERVENTION ACTIVITIES

Heavy smokers are less successful in quitting smoking compared with light smokers (Ockene et al., 1991). Less educated and economically disadvantaged populations are likely to have greater proportions of smokers and are also less likely to use or be reached by conventional cessation programs. The goals of increasing awareness of cessation resources and promoting participation in programs apply equally to disadvantaged segments of the community, but special tailoring of approaches and means is required. For these reasons, COMMIT communities were encouraged to develop and implement optional programs to reach the heavy or disadvantaged smoker. All COMMIT sites did so, and this section describes some of the successes and failures and offers some suggestions for future programs.

Paterson, NJ, an urban site with a high proportion of African-American residents, used an existing network of well-attended hypertension screening clinics to reach the black community. CRG's and self-help materials were displayed at these clinics and were well received. Information about smoking, smoking cessation, and COMMIT activities also was distributed at screening sites in Yonkers, NY. Yonkers COMMIT also participated in city-sponsored summer cultural festivals, including the Arab-American Festival and the African-American Heritage Festival. Network cards and CRG's were distributed, and carbon monoxide testing was offered. Thus, network recruitment and CRG process objectives also were served by this activity.



In Utica, NY, COMMIT staff members and volunteers identified 90 distribution locations for CRG's in neighborhoods with expected high concentrations of heavy

smokers. Indicators used to identify these locations included neighborhood socioeconomic status (SES), proximity to large blue-collar worksites, and retail sites known to be popular places for cigarette purchases (e.g., convenience stores, gasoline stations, corner grocery stores). Merchants agreed to cooperate by providing readily visible locations for brochure holders. The holders were restocked monthly by COMMIT and cooperating agencies. The Utica site also provided one-on-one cessation counseling in Women, Infants, and Children (WIC) program clinics, which serve young, disadvantaged women who have high rates of smoking prevalence. WIC nurses were trained in counseling techniques by COMMIT staff. There were Valentine's Day quit smoking challenges for WIC clients, and successful quitters received donated prizes.

The Cedar Rapids/Marion, IA, site used a local telephone information service, CityLine, to provide cessation services using taped messages and a voice mailbox. The telephone service was promoted through the media. During a 9-month period, the service received 2,450 calls, and 972 "Quitpacks" (cessation materials) were requested. The CityLine was particularly useful for promoting cessation events such as The Great American Smokeout and the "Cold Turkey Challenge."

Fitchburg/Leominster, MA, decided to target smokers in what was referred to as the Four B's: barber shops, bars, bowling alleys, and bingo sites. Field staff members began targeting smokers in these locations and eventually other locations where it was determined that high volumes of heavy smokers would congregate. Activities involved visiting locations with bingo nights and bowling leagues to recruit smokers for the network. This activity also was done to recruit participants for annual Quit and Win contests. A great deal of information was gained about the views and opinions of smokers concerning cessation, policies, and general behavior. Staff members succeeded in recruiting more smokers for the network than were recruited through previous efforts. Field staff members also began to set up booths at community blood donor activities sites, food distribution sites for welfare recipients, and functions held in neighborhood centers. Smoking cessation activity was particularly successful at blood donor activities sites because American Red Cross volunteers routinely tell donors not to smoke for half an hour after donating. This afforded COMMIT volunteers an interesting lead-in when many smokers inquired as to why they should wait the half hour. COMMIT volunteers actually served as attendants in the recovery area, which afforded more opportunity to interact with smokers. By volunteering, COMMIT staff members were rewarded with reciprocal volunteerism from American Red Cross members who recruited smokers even when staff members were not present.

The staff at the Medford/Ashland site also had observed that there was much smoking in bowling alleys and that bowlers were often blue-collar workers likely to have high smoking rates. They designed a campaign to appeal to bowlers—"Spare Your Lungs to Quit and Win"— featuring a Medford native who is a nationally known professional bowler. Unfortunately, few smokers signed up for the program at the various bowling alleys where

campaign publicity was displayed. A great deal of staff time and energy was expended with minimal return in participation or quitting. Staff members concluded that this was not cost-effective. On the more positive side, Yonkers distributed bowling towels and COMMIT network cards at a Big Brother/Big Sister Bowl-a-thon, thereby bringing awareness of COMMIT to an existing, well-attended bowling event.

The Bellingham, WA, site also targeted one of the Four B's—bars or taverns. "Adopt a Tavern" was the name of a program wherein members of the Cessation Resources Task Force each adopted three to five places that they visited approximately once every 2 months to leave COMMIT brochures and newsletters in public places. All were good locations for reaching smokers. They included three golf courses, the Department of Social and Health Services, pharmacies, a bingo hall, two blue-collar taverns, one laundromat, Norway Hall, a Veterans of Foreign Wars hall, a Dairy Queen, the YWCA (Young Women's Christian Association) and YMCA (Young Men's Christian Association), and three alcohol abuse centers.

These examples illustrate the various ways that COMMIT cities tried to reach heavy smokers and ethnically diverse populations of smokers. These efforts typically required much staff and volunteer time. One lesson learned is that it requires extra resources—time and money—to reach ethnically diverse and disadvantaged segments of the smoking population. Staff members sometimes experienced frustration when outcomes did not seem commensurate with effort.

One general strategy that emerged is to integrate or piggyback smoking cessation messages and materials into existing activities or programs. This was done with hypertensive screening clinics, blood donor clinics, ethnic cultural festivals, and bowling matches. This strategy "captures" ethnic or disadvantaged smokers at events they have chosen to attend. This is efficient and economical and helps to integrate smoking cessation with ongoing health screening and health promotion activities. Relatedly, identifying settings with heavy or ethnically diverse smokers—for example, taverns, low SES food markets—and then bringing cessation materials to such settings also proved useful.

Heavy smokers (≥25 cigarettes a day) may profit from more intensive, pharmacologically assisted programs (e.g., the nicotine patches). COMMIT sites reported that there was great interest in nicotine patches when they came on the market in 1991. Cessation programs providing access to nicotine patches seemed to attract more participants than those that did not. In 1991 there appeared to be a pent-up demand for nicotine patches and, therefore, an opportunity to use them to attract heavy smokers. Several years later, this may be less true. Some COMMIT sites were also successful in nurturing Nicotine Anonymous support groups modeled after the 12-step Alcoholics Anonymous programs.

In summary, COMMIT's cessation resources activities were effectively implemented, and communities displayed much ingenuity in shaping them

to particular needs. Efforts to reach ethnically diverse, disadvantaged, and heavy smokers varied widely both in content and in success in reaching the target population. The most promising strategies appear to involve (1) identifying activities (e.g., hypertension clinics) or events (e.g., cultural celebrations) that such smokers already attend and integrating smoking cessation activities into them or (2) bringing cessation materials to the natural enviroment of heavy smokers by identifying locations they are most likely to frequent.

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