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Abstract

People with disabilities (PWD) are 50% more likely to smoke compared with the general population, yet interventions tailored to the needs of PWD remain limited. The authors surveyed directors from a leading disability service organization to assess their delivery of tobacco cessation interventions. Although tobacco cessation was identified as a high priority, directors reported that they are ill-equipped to deliver tobacco cessation interventions. To properly address the unique challenges that PWD face when quitting tobacco, disability sensitive cessation interventions are needed.

Keywords

tobacco cessation, Center for Independent Living, health behavior

Background

According to the Centers for Disease Control (CDC, 2008), smoking is the single most preventable cause of morbidity and mortality, accounting for one out of every five fatalities in the United States annually. Although overall smoking rates have declined over the past 40 years (U.S. Department of Health and Human Services [DHHS], 2000), people with disabilities (PWD) are approximately 50% more likely to smoke compared with the general population (Armour et al., 2007; Brawarsky, Brooks, Wilber, Gertz, & Klein Walker, 2002). In addition, PWD are more likely to have ever smoked, have fewer quit attempts, smoke more cigarettes per day, and smoke earlier upon waking (Brawarsky et al., 2002). Although researchers have found that PWD are more likely to receive medical advice to quit smoking (Armour et al., 2007; Brawarsky et al., 2002), this finding may be, in part, because PWD interact more frequently with their doctor and therefore have more opportunity to discuss tobacco use (Brawarsky et al., 2002). When specifically examining the most recent check-up, Iezzoni, McCarthy, Davis, and Siebens (2000) found that people with mobility impairments were less likely to be asked about their tobacco use. Of particular note, only 35.3% of those with major mobility impairments were asked about their tobacco use compared with 56.9% of people without any impairment (Iezzoni et al., 2000).

Current efforts to reduce tobacco use have shifted from individual smoking cessation interventions to population-based interventions (DHHS, 2000). Despite this shift, population-based interventions tailored to the needs of PWD remain limited. Without understanding the disability culture and identifying the unique challenges that PWD face when trying to quit tobacco, traditional interventions for this population may be inappropriate. For example, some people with disabilities hire personal care attendants (PCAs) to assist with their day-to-day care. It is unfortunate that some PCAs may smoke or use other forms of tobacco. Thus, the person with the disability not only is trying to quit using tobacco but also is faced with the additional challenge of asking the PCA to cease using tobacco products. This situation is especially challenging because of the unique relationship between the PWD and PCA. The request to stop using tobacco products may alienate an outstanding PCA or result in the PCA discontinuing his or her working relationship with the PWD. Although traditional tobacco cessation interventions may teach coping skills and assertiveness training,

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Table 1. Center for Independent Living Director Attitudes Toward Various Health Behaviors

Health Behavior	Priority (%)						Adequacy (%)			
	1	2	3	4	5	6	Yes	No	DK	DP
Alcohol education	12.8	14.0	18.6	30.2	11.6	12.8	23.3	23.3	9.3	44.2
Physical exercise	15.1	26.7	18.6	16.3	9.3	14.0	32.6	30.2	10.5	26.7
Substance use	17.4	24.4	17.4	17.4	16.3	7.0	24.4	24.4	12.8	38.4
Nutrition	25.6	15.1	22.1	9.3	17.4	10.5	38.4	30.2	12.8	18.6
Safe sex education	11.6	8.1	9.3	11.6	23.3	36.0	16.3	29.1	9.3	45.3
Tobacco cessation	17.4	11.6	14.0	15.1	22.1	19.8	16.3	30.2	11.6	41.9

Note: DK = do not know; DP = do not provide.

these materials are most likely insensitive to the unique dynamic between PWD and PCAs.

In addition, conventional interventions may offer cessation strategies that are unsuitable for PWD. For example, vigorous walks, deep breathing exercises, and modifications to one's daily routine are often suggested as a way to cope with nicotine cravings. Although these suggestions may be appropriate for the able-bodied population as well as many persons with functional limitations, additional strategies are necessary to ensure that people with varying types of disabilities are offered an assortment of options that will encourage tobacco cessation. Without identifying comparable, alternative tobacco strategies, successful tobacco cessation for all PWD may be limited. Although it is debatable whether modifying existing tobacco cessation programs would sufficiently capture all disability related needs, tobacco cessation interventions that are adapted for PWD increase the probability of successful tobacco cessation.

A national organization that helps PWD overcome barriers to rehabilitation services is the Center for Independent Living (CIL). The CIL, which was founded by PWD, supports the efforts of PWD to lead independent lives by providing immediate and long-term solutions through counseling, enhancing independent living skills, and assistance with securing housing or employment (CIL, 2005). Therefore, the purpose of this study is to assess CIL directors' perspectives concerning the need for tobacco cessation interventions for PWD as well as the extent of tobacco cessation interventions currently being delivered by CILs for PWD.

Method

The survey consisted of 12 items related to the health education needs of PWD, the current CIL resources used to address tobacco cessation, and the estimated number of PWD who use tobacco products. Once the 12 items were developed, the survey was then adapted to the format requirements of a secure online software program, SurveyMonkey (2010). Following the online adoption, the survey was alpha tested with five local university faculty members

to ensure the appropriateness of the items. Directors were e-mailed a letter outlining the purpose of the study as well as the accompanying link to access the survey. Once participants electronically consented to the informed consent, they were allowed to proceed with the questionnaire. CIL directors were identified through the Independent Living Research Utilization directory of Centers and State-wide Independent Living Council (<http://www.ilru.org/html/publications/directory/index.html>). Using SurveyMonkey, surveys were sent to 431 directors. Following e-mail reminders, 106 of the 431 (24.6%) directors responded with full (n = 65) or partial (n = 41) information.

Results

Directors were asked to rate the importance of six health behaviors on a scale of 1 (*greatest priority*) to 6 (*lowest priority*) and then report whether the health education they provide to consumers on that topic is adequate (*yes, no, don't know, do not provide*) (see Table 1). Ranked by the percentage of participants responding to the "greatest priority" category were the following: (1) *nutrition* (25.6%), (2), tie between *substance use* and *tobacco cessation* (17.4%), (4) *appropriate physical exercise* (15.1%), (5) *alcohol education* (12.8%), and (6) *safe sex education* (11.6%). However, when reporting on the adequacy of their efforts, the percentage stating "yes, services are adequate" was ranked as follows: (1) *nutrition* (38.4%), (2) *appropriate physical exercise* (32.6%), (3) *substance abuse* (24.4%), (4) *alcohol education* (23.3%), and (5) tie between *safe sex* and *tobacco cessation* (16.3%).

Additional aspects of the results are included in Table 2. Most notable, no director reported an on-site tobacco cessation specialist or group cessation programs. Moreover, the percentages of CIL programs with individual tobacco cessation services (1.6%) and a specific system that could identify consumers who use tobacco (4.8%) were also low. Finally, directors were asked to estimate the percentage of their consumers who use tobacco products and identify the prevalence of tobacco within particular disability groups.

Table 2. Assessment of Tobacco Cessation Among Centers for Independent Living

Survey Item	% Yes
Way to identify if consumers use tobacco?	4.7
Familiar with Public Health Services Clinical Practice Guidelines for tobacco treatment?	18.8
Adopted any recommendations from the Guidelines?	6.3
Refer consumers to other programs?	
Local	71.9
State	37.5
National	28.1
Self-help cessation materials available on-site?	23.4
Specialist to address tobacco cessation?	0.0
Have individual or group cessation programs?	
Group	0.0
Individual	1.6

Approximately 58% of CIL directors estimated that more than 20% of their consumers smoke cigarettes and average estimates for disability groups were as follows: physical (33.2%), mental health (32.0%), combination (22.0%), cognitive (16.0%), and sensory (11.2%).

Discussion

These findings highlight the need for tobacco cessation interventions targeting PWD. Specifically, with the exception of nutrition, more directors identified tobacco cessation (along with substance use) as the “greatest priority” for CIL consumers. Directors also identified tobacco cessation as the most inadequately delivered health service. As evidenced by the lack of on-site tobacco cessation interventions and the high volume of tobacco cessation referrals, interventions delivered by people sensitive to the needs of PWD appear to be unavailable. These findings, along with the increased tobacco rates among PWD, suggest that disability sensitive tobacco cessation efforts are needed in order to properly address the unique challenges that PWD face when attempting to quit using tobacco.

By and large, PWD face a constellation of unique challenges when abstaining from tobacco products. Although service organizations, like the CIL, are ideal locations for tobacco cessation interventions, they may be ill-equipped to provide appropriate population-based treatments and ultimately have to succumb to traditional interventions. As a consequence, PWD who are trying to abstain from tobacco are confronted with the additional challenge of using tobacco cessation interventions that may be insensitive to their needs. To sufficiently address the needs of PWD, rehabilitation counseling researchers should develop sustainable tobacco cessation interventions tailored to PWD that fit within the core functions of the organizations that serve

them. Input into the design of such programs should include key stakeholders and tobacco cessation scientists. Moreover, rehabilitation counseling researchers could examine the barriers that people with disabilities face when trying to abstain from tobacco, any concerns that people with disabilities have concerning attempting to quit, and what modifications are necessary to improve the effectiveness of tobacco cessation interventions.

In addition, the translation of U.S. policy into reality requires confronting a series of challenges especially within the arena of medical care and preventive health services. For example, the intent of the Americans with Disabilities Act (ADA) is to prohibit discrimination based on disability. Yet, studies have shown that persons with disabilities face a multitude of access and process barriers to health care and preventive services (Diab & Johnston, 2004; Hinton, 2003; Iezzoni et al., 2000; Kroll, Jones, Kehn, & Neri, 2006; Scheer, Kroll, Neri, & Beatty, 2003). It is unfortunate that these barriers may exacerbate disabling conditions as well as increase the incidence of medical, social, emotional, family, or community problems (Diab & Johnston, 2004; Iezzoni et al., 2000; Kroll et al., 2006). Therefore, it is imperative for rehabilitation counselors to be aware of these challenges and advocate for their consumers’ right and access to preventive health care services such as tobacco cessation.

Authors’ Note

At the time of the study, all authors were primarily affiliated with the Department of Behavioral Science and Community Health, College of Public Health and Health Professions at the University of Florida.

Declaration of Conflicting Interests

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