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Increasing the Health Outcomes of Deaf and Hard of Hearing Oklahomans Through Tobacco Awareness and Cessation Support

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Abstract

As a consequence of limited access to health information, Deaf and hard of hearing (Deaf/hh)¹ individuals may be at higher risk for health complications and tobacco-related diseases. To address this issue, Communication Service for the Deaf (CSD) of Oklahoma sought funding from the Oklahoma Tobacco Settlement Endowment Trust to implement the Deaf and Hard of Hearing Tobacco Use and Cessation Program. The five-year project began in 2006; it was the first major health education initiative in the state that focused on the Deaf community. Prevalence rates and demographic information were collected regarding tobacco use among Deaf/hh participants. In addition, tobacco education and cessation programs were provided, and the changes in participants' knowledge and attitudes toward tobacco use were tracked over a three-year period. At the end of the project, in-depth interviews were conducted to gather additional information from tobacco users. This article provides prevalence and demographic information regarding Deaf/hh individuals' tobacco use in Oklahoma and outcomes of educational programs.

Keywords: deaf, hard of hearing, tobacco prevention, tobacco cessation

The health risks associated with tobacco use have been of national concern for several years. According to the Center on Disease Control and Prevention (CDC) (2011), tobacco use is the single most preventable cause of disease, disability, and death in the United States. Nearly half a million people die prematurely from smoking or exposure to secondhand smoke annually. Further, over eight million suffer from serious illnesses as a result of tobacco use, which places a burden on the health care system. States

¹ *In this study, Deaf and hard of hearing participants were individuals that use American Sign Language as a primary language and have cultural affiliation to the Deaf community.*

have initiated aggressive educational programs to support tobacco cessation and prevent youth initiation of tobacco use. However, the programs are often provided through telephone support programs, creating a challenge for Deaf and hard of hearing (Deaf/hh) individuals who may seek their assistance. This project was initiated to reduce barriers to tobacco education and cessation programs by providing accessible services directly to Deaf/hh individuals. The project evaluators created a culturally-sensitive, community-based, participatory design by establishing partnerships with members of the Deaf community as was recommended by leading researchers in the field (Berman et al., 2000; Harris, Holmes, & Mertens, 2009; & Pollard, 2002).

Often Deaf people are excluded from participation on research teams because of language differences and perhaps lack of research experience; however, Harris, Holmes & Mertens (2009) stated when Deaf researchers conduct studies within their own cultural community, the potential to impact members' lives increases. This project's research team included two Deaf individuals in leadership roles as Project Director and as the Tobacco Specialist. In addition, the primary evaluator was fluent in American Sign Language (ASL) and has strong connections to the Deaf community. The Institutional Review Board at the University of Tulsa approved procedures for the protection of human subjects in the studies that were conducted. Further, evaluation oversight was provided by the Department of Biostatistics and Epidemiology, University of Oklahoma Health Sciences Center.

Methodology

Evaluation consisted of both process and outcome evaluation and employed a mixed method design. Sequential, quantitative studies were conducted during YR2, YR3, and YR4 of the project using a questionnaire that measured growth in health-related tobacco knowledge and attitudes. During YR5 a qualitative, follow-up study was added to help explain the broad trends that emerged from the quantitative data. In addition, project staff collected demographic information regarding tobacco use in Oklahoma in order to make approximations about tobacco use in the Deaf community.

To provide a means to measure the outcomes of the project and to gather demographic data, several instruments were needed. The project staff and the evaluator were cognizant of the challenges of preparing instruments for Deaf/hh participants, not only because of their limited health literacy,

but also because of pervasive low levels of English literacy. With this in mind, instruments were developed to gather demographic information and to measure growth in tobacco literacy based on existing surveys from: 1) the *Interactive Video Questionnaire (IVQ)* for Deaf/hh respondents developed at the *UCLA's Division of Cancer Prevention and Control Research, School of Public Health and Jonsson Comprehensive Cancer Center* (see Berman et al., 2000; Berman et al., 2006) and, 2) the *Tobacco Education and Prevention Technical Support Center Youth Tobacco Survey 2003 Core Questionnaire* was used for additional questions. After a discussion with the developer of the IVQ (B. Berman, personal communication, April, 2007), instruments were modified to further reduce reading levels and to adjust vocabulary terms so they were more compatible with ASL translation. To ensure access for Deaf/hh participants, surveys and questionnaires were administered by using a written form along with ASL for clarification. The following list of instruments were developed or modified for use in the project: *Survey of Non-Tobacco Users, Survey of Tobacco Users that Quit, Survey of Tobacco Users, Survey of Smoke-Free Homes and Work Sites, Adult Knowledge and Attitudes Questionnaire*.

A second round of modifications occurred in October of YR2 after a three-month pilot study. The reason for the revision was that feedback from participants revealed that they were overwhelmed with the amount of information being collected including informed consent, demographic information, and knowledge and attitudes. The revision included further simplifying the language and making the forms one-page in length. Every effort was made to maintain the integrity of the items during this process; however, some items were removed that were deemed of lesser importance for measuring the outcomes of the project in order to reduce the response burden on participants.

Methods and Procedures

Deaf/hh adults that are members of the Deaf community and communicate in ASL were recruited to participate in the project. They were invited to attend community events referred to as Town Hall meetings, where tobacco education and health-related information were shared with participants. Town Hall meetings were held regionally; therefore, participants typically attended one event per year. As a result, the number of participants reflects very little duplication within each year of data collection. We designed the study on the assumption that participants would attend Town Hall meetings

each subsequent year, which allowed us to make comparisons between years. During Town Hall meetings, demographic information was collected along with responses to the *Adult Knowledge and Attitudes Questionnaire*, which was administered annually to assess progress in tobacco-related literacy. Data were collected annually for three years to measure increases in knowledge and attitudes.

Table 1
Summary of Town Hall Participation

	YR2	YR3	YR4
Number of Town Hall meetings	6	6	6
Number of participants	163	95	71
Tobacco users	34 or 20.8%	13 or 14%	17 or 24%

Prevalence and Demographics

The prevalence of tobacco use among Deaf and hard of hearing (Deaf/hh) individuals has not been gathered on a large scale, fundamentally because of the data collection process used by the CDC. The CDC administers the Behavior Risk Factor Surveillance System (BRFSS), the largest health care survey in the world. The surveys are administered through random sample telephone interviews and, because the survey is telephone based, the health status of Deaf/hh people is typically not assessed (Graybill et al., 2010). During this project, as an alternative to a telephone survey which was not feasible, written surveys with clarification in ASL were developed and distributed annually to participants at Town Hall meetings. They surveys collected demographic information, tobacco use history, and information regarding smoke-free homes and worksites. Although data were collected during all three years, YR2 data were used to approximate prevalence and demographic trends due to greater number of participants.

Table 2*Town Hall Participants' Breakdown of Tobacco Use by Type*

	Combined tobacco use	Smokers	Smokeless tobacco users	Dual tobacco users	No report
Tobacco use in Deaf community	20.8%	12.8%	6%	1%	<1%
BRFSS, 2009 (rate of tobacco consumption among general population)	30.4%	25.4%	4.9%	7.3%	

Note: CDC, BRFSS data collected in 2009 were used for comparison because in 2008, Oklahoma did not collect smokeless tobacco or dual tobacco user data.

Prevalence Data Regarding Total Tobacco Use

The prevalence of tobacco use among Deaf/hh participants in Town Hall meetings (cigarettes, smokeless tobacco, and dual users) resulted in 20.8%. Oklahoma's prevalence of total tobacco use in the general population was reported to be 30.4% (BRFSS, 2009). Therefore, the rate of tobacco use in the general population is approximately a 10% higher. When the number of smokers was disaggregated from the total tobacco users, the prevalence rate of Deaf/hh smokers was 12.8% compared 25.4% (CDC, BRFSS, 2009). This finding is similar to that reported by Jones, Renger & Firestone (2005) whose research revealed 15% prevalence rate for smokers in Arizona and Berman et al., (2006) who found that smoking among Deaf/hh college students was less than the general population of college students. Further, lower smoking rates have been reported by the National Center for Deaf Health Research (NCDHR), University of Rochester, which has developed a Deaf Health Survey that is accessible for Deaf/hh individuals that use ASL. The computer-based survey has been piloted to over 500 Deaf adults who were born deaf or became deaf in early childhood. Although results of the survey have not been published, preliminary results revealed low rates of current smoking, and higher rates of other risk factors including obesity (NCDHR, 2011).

Additional findings in the present study regarding gender and tobacco use revealed that more deaf/hh males use cigarettes than females by a 2:1

ratio. More males use smokeless tobacco than females by a 9:1 ratio. The majority of tobacco users at Town Hall meetings were 54+ years of age and had used tobacco for 11+ years. There was a decreasing trend line in the three younger age categories. This could have occurred because older Deaf/hh individuals tend to participate in Deaf community events than younger individuals, creating a false prevalence rating weighted toward older smokers. Other findings:

- Number of Deaf/hh individuals that used tobacco more than one year then quit, $n=27$ or 16.5%.
- Number of individuals living with tobacco users, $n=64$ or 39.2%
- Reasons for starting to use tobacco in order of influence: advertisements, dealing with stress, and peer pressure.
- Tobacco users in the Deaf population were mostly White (85%) compared to national prevalence rates that reveal the highest rate among Native American populations.
- The majority of current tobacco users (38%) responded “had not tried to quit.”
- The intervention most often used was prescription drugs. The second most frequent intervention was going “cold turkey”.
- Most users of smokeless tobacco started because of peer pressure or family role models. The next most stated reason for starting was for more energy.

Smokeless Tobacco

Smokeless tobacco products contain nicotine and are addictive (CDC, National Center on Drug Abuse, n.d.). Their use has been linked to cancer of the mouth and throat (Scientific Committee on Emerging and Newly Identified Health Risks, 2008) and pancreatic cancer (Boffetta, Aagnes, Weiderpass, & Anderson (2005). Further, smokeless tobacco can be equally as harmful as cigarettes; it has been found to elevate the risk of cardiovascular disease (Yatsuya & Folsom, 2010).

Mejia & Ling (2010) conducted a consumer review of tobacco companies' product development and found campaigns to promote smokeless tobacco have escalated, possibly because of the decline of cigarette consumption and the increase of smoke-free ordinances. Initially, tobacco companies targeted blue-collar males and provided sponsorships at rodeos, sport fishing, and baseball events, which are an integral part of culture of Oklahoma along with farming. Today, however, tobacco companies have expanded targets to

include consumers working in smoke-free environments and urban youth, especially females.

In this study, 6% of the Town Hall attendees used smokeless tobacco, higher than the Oklahoma smokeless tobacco consumption rate of 4.9% (CDC, BRFSS, 2009). Fifty percent of users of smokeless tobacco have tried to quit. Most of the respondents tried going “cold turkey.”

In-depth Interview Results

In-depth interviews were conducted during the last year of the project to gather descriptive narratives from tobacco users.

Table 3
Demographics of In-depth Interview Participants

Number of participants	10
Gender	8 males, 2 females
Residency	4 urban, 6 rural
Age range	20 – 29 years = 3, 30 – 39 years = 2, 40 – 49 years = 3, 50 – 59 years = 2
Use of tobacco	2 smoked, 4 males and 1 female used smokeless tobacco, 1 used both, and 3 had quit smoking

Five out of 10 or 50% of the respondents used smokeless tobacco. Reasons for initiating tobacco use revealed that peer pressure played a large role as well as cultural factors in this agricultural-based region. Growing up on a farm where family members used smokeless tobacco while working in the fields/hauling hay, there appeared to be a “right of passage” where younger males were taught to dip/chew. One stated that using smokeless tobacco is less dangerous to his children. Some initiations occurred during adolescence and tobacco use has continued for their entire lifetimes, proving to be a powerful addiction for which they have failed to quit after numerous attempts. One respondent commented that in his place of employment using smokeless tobacco is common and more accepted than smoking.

Adult Knowledge and Attitudes Questionnaire

Participants in Town Hall meetings completed a 30-item *Adult Knowledge and Attitudes Questionnaire* annually over a three-year period. All responses were aggregated annually; individual responses were not tracked. Participants

were asked to respond YES (in agreement) or NO (disagreement) to each item. Educational interventions (formal presentations, individual coaching, and distribution of materials) were provided on an annual basis.

Figure 1
Results of Adult Knowledge and Attitudes Questionnaire

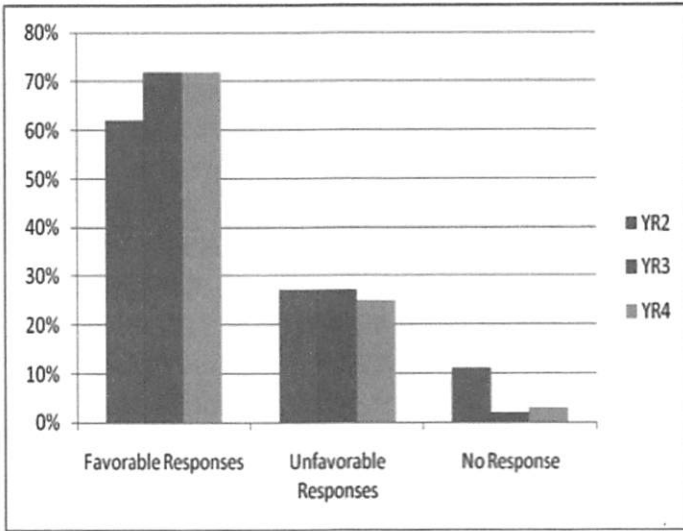


Figure 1 provides a comparison of YR2, YR3, and YR4 results of the *Adult Knowledge and Skills Questionnaire*. The results reveal an increase in favorable responses from YR2 to YR3; unfavorable responses remained the same during that period. Favorable responses remained static from YR3 to YR4, but there was a slight decrease in the unfavorable responses in YR4.

An analysis of individual items revealed that 25 out of 30 questions had positive gains in favorable responses. Eleven questions achieved $\geq 20\%$ change over the three-year period; five questions had negative growth rates. The reason for negative results on these questions has not been ascertained; however, because it was administered in written form with limited ASL translation, the item construction may have interfered with participants' understanding.

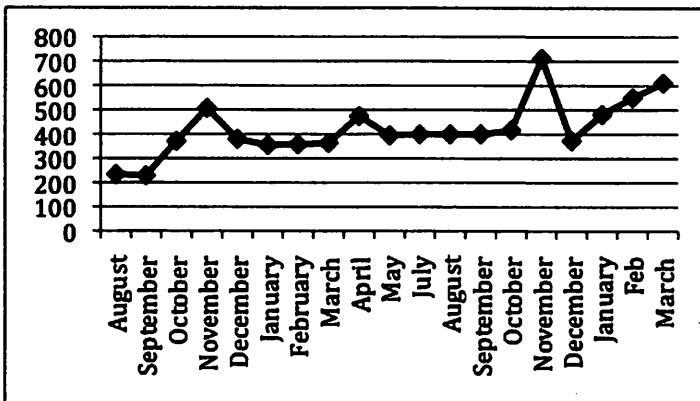
CSD-Oklahoma Deaf Quit Website

A pilot study by Jones, Goldsmith, and Effkin (2010) found that providing tobacco intervention online through a website produced similar results as other training mechanisms. We did not attempt to compare changes in tobacco awareness between website users and non-website

users during this project. Instead, the project's website located at <http://www.oklaDeafquit.com/> was another tool to assist Deaf/hh individuals in understanding the harmful effects of tobacco use and cessation strategies. Making the website content accessible through ASL was a primary goal. A documentary section included personal stories by Deaf/hh Oklahomans and their experiences with tobacco, a powerful history of tobacco use in the state. Two methods were used to evaluate the website: the hit counter and the in-depth interviews. The web trends report revealed consistent website visits and spikes in viewing when new content is added. All ten interview respondents reported viewing the website to learn more about tobacco and the associated health risks. They were very positive about the information they received and indicated that they found the documentary section to be the most interesting. Figure 2 reveals the website viewing rate.

Figure 2

Hit Counter Usage Rate August 2010 to March 2011



No live video-chat support was provided on the website because the state operates its own service: The *Oklahoma Tobacco Helpline*.

Oklahoma Tobacco Helpline

The *Oklahoma Tobacco Helpline* at <http://www.ok.gov/tset/Programs/Helpline.html> provides cessation assistance over the telephone for the general population. This approach has been found to be successful for hearing tobacco users and it might be an option for individuals who are late deafened or hard of hearing because they tend to use spoken English for communication and may have higher levels of health literacy. However, it did not appear to be a viable resource for Deaf/hh community members

who communicate in ASL. Of the ten respondents interviewed, only one had used the *Helpline*, and he had successful outcomes. However, he also had additional support from the Tobacco Specialist. The remaining nine stated they would not use the service for several reasons: 1) they want to communicate directly with individuals providing cessation services, 2) they prefer someone who is culturally astute and fluent in ASL, and 3) their past experiences with accessing services over the telephone have been negative. One respondent reported that hearing people use unfamiliar vocabulary and they talk fast, so it is difficult to understand them even when using an interpreter. Researchers at the *National Center for Deaf Health Research* (NCDHR) at the University of Rochester have completed several studies related to health education and health literacy among the adult Deaf population. One study investigated the understanding of health vocabulary in a group of highly-educated Deaf adults (Pollard & Barnett, 2009). The findings revealed that even highly-educated Deaf individuals struggled with health-related terminology.

Barriers to Services through Primary Care Physicians

The *Healthy People 2010 initiative* (CDC, 2000) includes focus areas that promote the health of people with disabilities, prevent secondary conditions, and reduce health disparities. Indeed, people with disabilities have been found to be at a higher risk for health problems; they are less likely than people without disabilities to receive preventive health care (Moorhouse et al. (2011). During in-depth interviews, a similar theme emerged: lack of preventive health care because of communication barriers with primary care physicians. This occurs because primary care physicians tend to be reluctant to provide interpreting services (Barnett, McKee, Smith & Pearson, 2011). As a result, Deaf/hh patients often distrust that the primary care is serving their best interests. This is a long-standing problem. Even though the ADA stipulates that individuals with disabilities should be provided accommodations to ensure equal access, Deaf/hh individuals typically must depend on a family member or friend to serve as an interpreter especially in rural areas. Further, the majority of respondents interviewed reported that their primary care physician had not discussed smoking cessation with them.

Discussion

An important goal of this project was to approximate the prevalence rate of tobacco consumption among Deaf/hh individuals residing in Oklahoma.

Moorhouse et al. (2011) found that people with disabilities are 50% more likely to smoke than the general population. Two previous studies found less smoking among Deaf/hh than hearing individuals (Berman et al., 2006; Jones, Renger, Firestone, 2005) and the NCDHR's Deaf Health Survey's preliminary data revealed lower smoking rates in Deaf/hh participants.

The prevalence of tobacco use among Deaf/hh Town Hall participants found similar results and brings up important questions: Why are Deaf/hh individuals less prone to smoking than the general population or people with disabilities? Could smoking cigarettes interfere with communicating in ASL? Thompson (2009) found that groups with high degrees of self-efficacy are more likely to be influenced by anti-tobacco advertisements. Is this the case for members of the Deaf community? This study asked Town Hall participants why they initiated tobacco use. Most respondents were older and used cigarettes. They responded that advertisements were the major reason. Thus, Deaf/hh individuals may be more sensitive to today's anti-tobacco advertisements that are visual and graphic than other individuals with disabilities who can hear. Future research is needed to explore these questions. Ten in-depth interviews were conducted and revealed a smokeless tobacco rate of 50%. The respondents were younger than the Town Hall attendees, and although it was a sub-sample of the population, it does provide a warning of the potential use of smokeless tobacco in the Deaf/hh population, a topic that should be investigated further. The males in their mid 40's who were long time users of smokeless tobacco indicated that the addiction was so powerful that they had not been successful in quitting after multiple attempts. One male with heart disease stated that in order for him to quit, he would need to enter a short-term "treatment" center and receive support during the cessation process.

The CSD Oklahoma Deaf Quit website continues to be an important resource for Deaf/hh individuals. Information is provided in an accessible format through ASL. Expansion of the website to include direct communication (e.g., video chat rooms with mentors who are Deaf/hh and experienced with tobacco cessation) may reduce tobacco initiation and consumption and may be a more viable way to reach Deaf/hh individuals who are geographically dispersed than tobacco interventions that are provided through telephone systems.

The issue with lack of access to primary care physicians is acute. Instead of contracting on an individual basis, a more cost-effective solution might

be for physicians and other health care professionals to pool their funds and contract with regional health care interpreters who provide a service on a full-time basis.

Study Weaknesses

Weaknesses in this study have been identified. Pollard & Barnett (2009) stated that the use of written surveys may present excessive literacy demands for Deaf respondents. During this project, ASL clarification was provided to alleviate this burden. Issues with fund-of-knowledge (Pollard, 2002) needed to complete the surveys may result in issues with validity. Thus, the appropriateness and adequacy of the instruments used in this project needs to be considered when drawing conclusions about the project's results.

Even though weaknesses were identified, tobacco awareness and health literacy has increased in the Deaf/hh individuals that chose to participate in this project. Since there are numerous studies that show strong correlations between health literacy and health outcomes in the general population (for example see Adkins & Corus, 2009), this project should have positive effects on the future health outcomes of Deaf/hh Oklahomans. Tobacco cessation requires support from multiple sources; trying to quit "cold turkey" as many Deaf/hh participants reported is not an effective strategy. For that reason, this project provided a multi-pronged approach: a full-time Tobacco Specialist provided mentoring, coordinated tobacco education programs, and worked toward systems change within the State of Oklahoma by establishing partnerships with state agencies and non-profit organizations. In addition, the project provided a website with resources and video documentaries of Deaf community members' personal experiences with tobacco use. Because of the multi-pronged approach, it is difficult to conclude that one single activity resulted in increased tobacco awareness and tobacco cessation. As has been reported in previous research (American Lung Association, 2007), the process to quit tobacco usually requires several attempts and multiple interventions.

It is important to credit the Deaf leadership and the Deaf community in Oklahoma for their steadfastness in seeing his project to completion. Certainly, the impact will continue to expand as findings are disseminated to the Deaf community and as publications are released to inform the field about the work of Deaf Oklahomans related to improving their own health outcomes.

Authors' Note

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Adult Knowledge and Attitudes Regarding Tobacco Use

Completing this questionnaire is **VOLUNTARY**. This questionnaire is **ANONYMOUS**. We will not know your name. Your answers will be kept private. Just answer the questions based on what you believe.

PLEASE CHECK ONE

1. It is easy to quit smoking.	YES NO
2. Smoking cigarettes can cause cancer.	YES NO
3. Chew/spit tobacco is safer than smoking.	YES NO
4. It doesn't matter if you are young or old it's still hard to quit using tobacco.	YES NO
5. Smoking helps make people feel more comfortable at parties.	YES NO
6. Nicotine in tobacco is addictive just like drugs like cocaine or heroin.	YES NO
7. Breathing smoke from some else's cigarette is bad for your health.	YES NO
8. Young people who smoke are more popular and have more friends.	YES NO
9. Non-smokers live longer than smokers.	YES NO
10. Smoking cigarettes makes people look cool and sophisticated.	YES NO
11. Smoking causes wrinkles, bad breath, and smelly clothes and hair.	YES NO
12. It is safe to smoke for only 1-2 years if you quit soon afterwards.	YES NO
13. Nicotine is the only harmful chemical in tobacco.	YES NO
14. People who smoke only a few cigarettes a day are safe -- no harm to their health.	YES NO
15. Nicotine in cigarettes is not addictive.	YES NO
16. When someone quits smoking his/her body heals quickly.	YES NO
17. The drug heroin is more addictive than the nicotine in tobacco.	YES NO

18. It is too late for people hooked on tobacco to quit if they used tobacco for a long time—their bodies can't get better.	YES NO
19. Is it OK for someone to smoke around you because only the smoker will have health problems and not you as long as you	YES NO
20. When someone quits using tobacco, they feel better fast.	YES NO
21. If you don't inhale smoke, you won't get addicted.	YES NO
22. It is easy to quit using chew/spit tobacco.	YES NO
23. Second-hand smoke is bad for children, but it does not hurt adults.	YES NO
24. People who quit smoking or chew/spit tobacco will have improved life in terms of physical activities and in general.	YES NO
25. A pregnant woman can harm her unborn baby if she smokes.	YES NO
26. People who smoke a few cigarettes a day are safe—no harm to their health.	YES NO
27. If your parents smoked, then you might inherit their habit.	YES NO
28. Chew/spit tobacco does not cause cancer.	YES NO
29. Smoking light cigarettes with filters is safer.	YES NO
30. Smokers have increased risk of heart disease.	YES NO

YOU ARE DONE. THANK YOU VERY MUCH

Adapted from the Tobacco Survey for Deaf and Hard of Hearing Students – revised - Division of Cancer Prevention and Control Research, School of Public Health and Jonsson Comprehensive Cancer Center, University of California and the Youth Tobacco Survey 2003 core questionnaire - Tobacco Education and Prevention Technical Support Center (TEPTS).

Tobacco Survey

(For people who NEVER SMOKED OR
SMOKED SHORT TIME--not addicted)

Where do you live? Name of city or county: _____

Your Age: 12-18 19-25 26-32 33-39 40-46 47-53 54+

Your Gender: Male Female

Your race: White African American Native American/Indian
Latino Asian/Pacific Islander

Do people smoke around you? Yes No Sometimes

Does someone who lives with you smoke? Yes No

<p>What are the rules about smoking in your house?</p> <p>Smoking not allowed anywhere</p> <p>Smoking is allowed in some rooms not all rooms</p> <p>Smoking allowed only outside</p> <p>No rules, free to smoke anywhere</p>	<p>Do you have a job?</p> <p>yes</p> <p>no</p> <p>What are the rules about smoking where you work?</p> <p>Smoking not allowed anywhere</p> <p>Smoking allowed only outside or in smoking room</p> <p>No rules, free to smoke anywhere</p>
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Would you like for people to quit smoking around you?

Yes No Don't care

THANK YOU!

Tobacco Survey
(For people who used tobacco for
MORE THAN ONE YEAR THEN QUIT)

Where do you live? Name of city or county: _____

Your Age: 12-18 19-25 26-32 33-39 40-46 47-53 54+

Your Gender: Male Female

Your race: White African American Native American/Indian
Latino Asian/Pacific Islander

How many people live with you? _____

Do any of them use tobacco now? Yes no

What kind of tobacco did you use? Cigarettes Spit/chew tobacco
Pipe Other _____

How long did you use tobacco? 1-5 years 6-10 years More than 11 years

What are the rules about smoking in your house?	Do you have a job? yes no
Smoking not allowed anywhere	What are the rules about smoking where you work?
Smoking is allowed in some rooms not all rooms	Smoking not allowed anywhere
Smoking allowed only outside	Smoking allowed only outside or in smoking room
No rules, free to smoke anywhere	No rules, free to smoke anywhere

<p align="center">FILL THIS SIDE IN IF YOU SMOKED</p>	<p align="center">FILL THIS SIDE IN IF YOU CHEWED/SPIT</p>
<p>Why did you start smoking? Peer Pressure (friends smoked) To look older/cool To help with stress To lose weight Because of advertisements Family/lover smoked Other reason: _____</p>	<p>Why did you start using smokeless tobacco? Peer Pressure (friends smoked) To look older/cool For energy Because of advertisements Family/lover smoked Other reason: _____</p>
<p>What helped you quit? Nothing/cold turkey Nicotine Gum Patch RX medicine (pills) Inhaler Counseling</p> <p>What else helped you quit? Support/encouragement from family/ friends Fear of health problems (cancer) Cost of tobacco (cant afford) More exercise Eating candy (licorice) Religion/prayer Other reason _____</p>	<p>What helped you quit? Nothing/cold turkey Nicotine Gum Patch RX medicine (pills) Inhaler Counseling</p> <p>What else helped you quit? Support/encouragement from fam- ily/friends Fear of health problems (cancer) Cost of tobacco (cant afford) More exercise Eating candy (licorice) Religion/prayer Other reason _____</p>

THANK YOU!

Tobacco Survey (Current Tobacco Users)

Where do you live? Name of city or county: _____

Your Age: 12-18 19-25 26-32 33-39 40-46 47-53 54+

Your Gender: Male Female

Your race: White African American Native American/Indian
Latino Asian/Pacific Islander

How many people live with you? _____

What kind of tobacco do you use? Cigarettes Spit/chew tobacco
Pipe Other _____

How long have you used tobacco? .1-5 years 6-10 years
More than 11 years

What are the rules about smoking in your house? Smoking not allowed anywhere Smoking is allowed in some rooms not all rooms Smoking allowed only outside No rules, free to smoke anywhere	Do you have a job? yes no What are the rules about smoking where you work? Smoking not allowed anywhere Smoking allowed only outside or in smoking room No rules, free to smoke anywhere
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<p>FILL THIS SIDE IN IF YOU SMOKE</p>	<p>FILL THIS SIDE IN IF YOU CHEW/SPIT</p>
<p>Why did you start smoking? Peer Pressure (friends smoked) To look older/cool To help with stress To lose weight Because of advertisements Family/lover smoked Other reason: _____</p>	<p>Why did you start using smokeless tobacco? Peer Pressure (friends used) To look older/cool For energy Because of advertisements Family/lover used tobacco Other reason: _____</p>
<p>Have you tried to quit smoking? Yes No When you tried to quit smoking, what did you try? Nothing/cold turkey Nicotine Gum Patch RX medicine (pills) Inhaler Counseling Other reason _____</p>	<p>Have you tried to quit smokeless tobacco? Yes No When you tried to quit tobacco, what did you try? Nothing/cold turkey Nicotine Gum Patch RX medicine (pills) Inhaler Counseling Other reason _____</p>

THANK YOU!