

Tribal Tobacco Policy Workbook

2005

Compiled by,
Stephanie Craig, MPH

Northwest Portland Area Indian Health Board
Western Tobacco Prevention Project
527 SW Hall, Suite 300, Portland, OR 97201
(503) 228-4185 www.npaihb.org



**Tobacco artwork designed by Amanda Wright, 2004.
Cover design by Maisie MacKinnon, 2005.**



Introduction



Since 1995, the Tribal Tobacco Policy Workbook has remained among the most comprehensive guides for achieving tobacco policy change in Tribal communities. With step-by-step guidance, this workbook has served as a resource for tribes throughout North America to write, pass, and enforce tobacco-related policies.

The original Tobacco Policy Workbook focused specifically on policy change addressing Secondhand Smoke exposure in the workplace and in tribal buildings. In response, many tribes implemented smoke-free policies in their community buildings. Such changes mark an important step towards protecting the health and wellness of Native communities.

Unfortunately, with 40% of American Indian and Alaska Native deaths still linked to commercial tobacco use, this matter has not been put to rest. The Tobacco Industry spends over \$11 billion dollars a year promoting and advertising commercial tobacco, targets our children, fosters addiction, and uses our sacred images to increase their profits. This fight is not over -- A great deal still remains to be done!

Whether this is your first attempt at creating a tobacco-related policy for your Tribe, or you are moving on to new areas for change, this workbook will provide you with approachable steps, usable templates, and concrete examples. Using the wisdom and experience gained by Tribes across the U.S., this guidebook now shares practical lessons learned by those who successfully passed tobacco-related policies in their tribes.

After extensive collaboration and sharing among Tribes, members of the National Tribal Tobacco Prevention Network, and numerous health-related partners, we are excited to share with you the benefits of this labor.

Please enjoy the second edition of the Tribal Tobacco Policy Workbook!



Contributing Writers and Readers



Alaska Native Health Board:
Nick Gonzales

**California Department of Health
Services - Tobacco Control Section:**
Kelli Bliss
Rosanna Jackson

**California Rural Indian Health Board
- American Indian Tobacco Education
Network:**
Donna Archuleta
Raul Salazar

**California Rural Indian Health Board
- Tobacco Education and Prevention
Technical Support Center:**
Jacelyn Macedo
Maylynn RidingIn

**Centers for Disease Control and
Prevention:**
Lorene Reano
Alfreda Beartrack

Confederated Tribes of Colville
Desirae BearEagle

Cowlitz Tribe
Debbie Norberg

**Eight Northern Indian Pueblos
Council Inc.:**
James E. Chancellor

**Idaho Department of Health and
Welfare:**
Galen Louis, PhD

Inter Tribal Council of Michigan:
Lisa Kerfoot

Jamestown S’Klallam Tribe
Kim Kettel

Kalispel Tribe
Karen Martin

Muscogee (Creek) Nation:
Cynthia Coachman

Nisqually Tribe
Linda Kramer

Nooksack Tribe
Dana Harkins

**Northwest Portland Area Indian
Health Board - National Tribal
Tobacco Prevention Network:**
Gerry RainingBird
Terresa White

**Northwest Portland Area Indian
Health Board – Western Tobacco
Prevention Project:**
Amanda Wright
Joe Law
Karen Schmidt, MPH
Lisa Griggs
Nichole Hildebrandt
Stephanie Craig, MPH

Puyallup Tribe:
Nancy Meyer

Resources for Indian Student Education, Inc. (RISE):
April Go Forth, PhD

Samish Indian Nation:
Jennifer Paddock, MA, MAC

Sault Ste. Marie Tribe of Chippewa Indians
Kim Sakis, BS, CHES

Siletz Tribe:
DeAnna Pearl

Spokane Tribes
Julia Greeson

Squaxin Island Tribe:
Kelly S. Croman
Michelle Wiley

Stillaguamish Tribe:
Melanie Hein
Kathleen Baker

Tulalip Tribes
Deborah Parker-George

University North Carolina at Chapel Hill:
Catherine L. Rohweder, MPH
Lawrence A. Shorty

Washington State Department of Health – Tobacco Prevention and Control Program:
Tom Wiedemann

Yakama Nation
Diane Pebeahsy
Mike Sekaquaptewa



Funding for this project was provided by the Centers for Disease Control and Prevention (UIA – CCU019281-01) and the Washington State Department of Health’s Tobacco Prevention and Education Program (Contract # N12228).

Suggested Citation:

Craig SN, *et. al.*, 2005 Tribal Tobacco Policy Workbook. Portland, OR. Northwest Portland Area Indian Health Board, Western Tobacco Prevention Project, 2005.



Dedication



In dedicating this manual to our elders and to our children, I want to take this opportunity to urge local health workers and tribal leaders to learn more about the dangers of smoking and chewing tobacco. To many Indian tribes, tobacco was considered to be a sacred element when used for religious purposes. It was not abused in traditional Indian life. Today, the evidence of tobacco abuse can be seen in the diseases that now plague our communities. Many of our Indian people are dying from heart diseases, cancers, and strokes caused by commercial tobacco products.

Our children learn by seeing what we do. It is by our example as tribal leaders and health workers that our children will either learn about the dangers of tobacco use or continue to put their bodies at risk. And secondhand smoke endangers the lives of elders, making it impossible for them to fully participate in community gatherings that allow smoking to take place.

Additionally, I want urge all tribal councils, CHRs, tribal health directors, and tribal health administrators to stand up and take action. Tobacco control policies increase community awareness and can save the lives of future generations.

Let's work together to stop tobacco addiction. Thirty years ago, Indian leaders took a stand against alcohol, and today we are seeing positive changes among our people. Our leadership can make a difference.

In the last fifteen years, Northwest tribes moved to the forefront of tobacco control by passing tobacco restrictions in tribal buildings and workplace, by instituting age restrictions on tobacco purchases, and by developing comprehensive cessation services within the healthcare system. It is our hope that other Indian communities will benefit from our experience and use this workbook for tobacco control in their own communities.

Pearl Capoeman-Baller, Quinault
President, Board of Directors
Northwest Portland Area Indian Health Board

SECTION 1: THE POLICY CHANGE PROCESS



Chapter 1: Tobacco Use in American Indian and Alaska Native Communities..... 15

- The Traditional Sacred Use of Tobacco
- The Commercial Use of Tobacco
- Rates of Commercial Tobacco use Among American Indians and Alaska Natives
- The Pacific Northwest – Idaho, Oregon, Washington
- Health Risks Associated with Commercial Tobacco Products
- The Financial Impact Of Commercial Tobacco Use
- The Social Impact of Commercial Tobacco Use
- Why Develop and Enforce a Tobacco Policy?

Chapter 2: General Steps for Developing A Tribal Tobacco Policy..... 39

- Steps Involved in Policy Change
- Step 1: Create a Committee and Involve Stakeholders
- Step 2: Develop an Action Plan
- Step 3: Gather Background Information
- Step 4: Analyze Available Data
- Step 5: Review Sample Policies
- Step 6: Demonstrate Need and Build Community Support
- Step 7: Draft a Policy
- Step 8: Obtain Feedback
- Step 9: Revise as Necessary
- Step 10: Pass the Policy
- Step 11: Enforce the Policy
- Step 12: Evaluate the Policy
- Common Challenges and Barriers to this Process

Chapter 3: Drafting the Right Policy 77

- Choosing the Right Policy
- Types of Policies
- Moving Forward with this Guidebook

SECTION 2: TOBACCO RELATED POLICIES

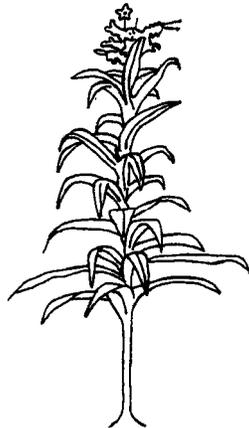


Chapter 4: Secondhand Smoke Policies	85
Purpose of Tobacco-Free Spaces	
Locations for Secondhand Smoke Policies	
Types of Secondhand Smoke Policies	
Special Considerations for Writing, Passing and Implementing Secondhand Smoke Policies	
Generating Community Support for Secondhand Smoke Policies	
Secondhand Smoke Policy Templates and Tribal Examples	
Chapter 5: Youth Prevention Policies	115
The Purpose of Policies that Prevent Tobacco Use among Youth	
Types of Youth Prevention Policies	
Special Considerations for Writing, Passing and Implementing Youth Prevention Policies	
Generating Community Support for Youth Prevention Policies	
Experience from the Field: Youth Prevention Policy Change	
Secondhand Smoke Policy Templates and Tribal Examples	
Chapter 6: Tobacco Tax Policies.....	141
The Purpose of Tobacco Taxes	
Types of Tobacco Taxes	
Special Considerations for Writing, Passing and Implementing Tobacco Taxes	
Generating Community Support for Tobacco Taxes	
Experience from the Field: Establishing Tobacco Taxes	
Tobacco Tax Policy Templates and Tribal Examples	
Chapter 7: Workplace Cessation Policies.....	175
The Purpose of Workplace Cessation Policies	
Types of Workplace Cessation Policies	
Special Considerations for Writing, Passing and Implementing Workplace Cessation Policies	
Generating Employer Support for Workplace Cessation Policies	
Experience from the Field: Establishing Workplace Cessation Policies	
Workplace Cessation Policy Templates and Tribal Examples	

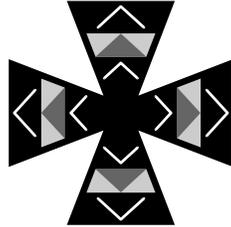
Chapter 8: Clinic-based Policies..... 191
The Purpose of Clinic-based Tobacco Policies
Types of Clinic-based Tobacco Policies
Special Considerations for Writing, Passing and Implementing Clinic-based Tobacco Policies
Generating Clinic Support for Clinic-based Tobacco Policies
Experience from the Field: Establishing Clinic-based Tobacco Policies
Clinic-based Tobacco Policy Templates & Tribal Examples

Chapter 9: Secondhand Smoke Policies in Casinos & Tribal Businesses..... 235
Purpose of Tobacco-Free Spaces in Casinos and Tribal Businesses
Special Considerations for Writing, Passing and Implementing Casino-Based Policies
Generating Casino Support for Secondhand Smoke Policies
Data Collection Tools
Casino Policy Template

Chapter 10: Traditional Tobacco Policies..... 273
The Purpose of Traditional Tobacco Policies
Types of Traditional Tobacco Policies



SECTION 3: APPENDECIES



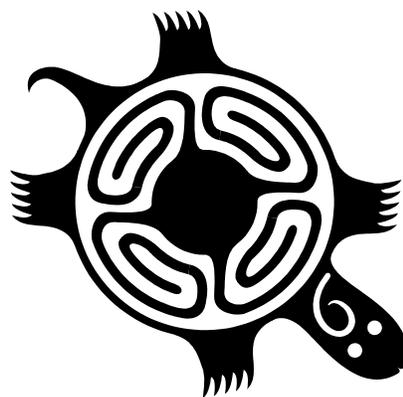
Chapter 11: Additional Resources.....	279
Tribal Tobacco Prevention Programs	
Smoking Cessation Quit Lines	
Additional Tobacco Resources	
Chapter 12: 1995 Tobacco Policy Workbook.....	285
Chapter 13: Citations and References	289

SECTION 1: THE POLICY CHANGE PROCESS

Chapter 1: Tobacco Use in American Indian and Alaska Native Communities.....15

Chapter 2: General Steps for Developing A Tribal Tobacco Policy..... 39

Chapter 3: Drafting the Right Policy77



Using this Guide

While the length of this guidebook may look intimidating, take heart, it is not meant to be read in its entirety! Please read Chapters one, two and three, which will provide you with information about tobacco and the steps involved in policy change. Once you have chosen a policy topic of interest, you can then skip ahead to that chapter. When read in conjunction with Chapters 1-3, Chapters 4 through 10 may be read independently.

Chapter 1:

Tobacco Use in American Indian and Alaska Native Communities



The Traditional Sacred Use of Tobacco



Tobacco has an important role in traditional American Indian life. For tribes throughout North America, the use of traditional tobacco plants for spiritual, ceremonial, and medicinal purposes goes back thousands of years. Most Indigenous nations have traditional stories explaining how tobacco was introduced to their communities, many of which emphasized the sacred properties of the plant, containing both the power to heal if used properly and the power to cause harm if used improperly.



Some Indian religions believe that tobacco was a gift from the Great Spirit and was to be used for religious and ceremonial purposes. Among many tribes, tobacco was as part of rituals involving healing, conflict resolution, trading, preparing for war, trances, sundances, or sweat lodge ceremonies. Tobacco was often given as a sacrifice to the Great Spirit, and sometimes mixed with other plants, including parts of the willow, dog-wood, sumac, bearberry, or rose bush. As a natural pesticide, tobacco was used as a smudge to ward off pests, and by Medicine People to perform healings and blessings. It was used as a gift when welcoming guests to the community, and as an offering to those asked to pray or share wisdom.¹ At the time of

European colonization of the Americas, records show that tobacco was one of the main items exchanged between Europeans and Native Americans. It was traded among tribes, used as a sign of friendship in conducting business, and as an item for barter.

Medicinally, tobacco was used as an analgesic, alleviating childbirth pains, toothaches, headaches and earaches. It was also used for the treatment of a variety of other ailments, including asthma, cough, rheumatism, convulsions, and intestinal disorders.¹ It was applied to snake bites and insect bites, and was used in the treatment of open wounds because of its presumed antiseptic qualities.¹ On long journeys, some tribes used tobacco to keep away hunger and thirst, and to prevent fatigue.

When smoked, ceremonial pipes were used. Pipe design varies among the different tribes, with pipe stems often made of ash or sumac and pipe bowls carved from various types of stone and clay. Archeological evidence of these pipes goes back at least a thousand years. Some Northwest coastal Indians also placed small tobacco pellets mixed with lime or conifer directly in their mouths.

This historic and enduring relationship with sacred tobacco must be recognized and addressed when shaping meaningful, culturally appropriate tobacco-related policies in American Indian and Alaska Native communities.

The Commercial Use of Tobacco

Commercial tobacco use is the single most preventable cause of disease and death in the United States, killing more than 440,000 people per year.² Smoking results in more deaths each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined³, and costs the Indian Health Service over \$200 million per year in medical services.⁴ Further, smoking contributes to the development and exacerbation of numerous diseases, including heart disease, stroke, lung cancer, and chronic lung diseases—all of which are leading causes of death for the American Indian and Alaska Native population.⁵

Tobacco Addiction:

The commercially manufactured cigarette is a well-engineered delivery system that rapidly transmits psychoactive chemicals to the brain. Nicotine, an oily and poisonous chemical, is the addictive substance that is naturally present in tobacco plants. As an addictive substance, nicotine (on a milligram for milligram basis) is 10 times more potent than heroin, and is considered by some to be more addictive than cocaine or heroin.⁶



Addictive substances generally exhibit four distinguishing characteristics.⁷ The drug:

1. produces a psychoactive effect on the user, altering their behavior.
2. provides a “reinforcing” effect on the body, meaning that its physiological effects are rewarding enough to produce continued self-administration.
3. generates “tolerance” in the user, requiring that, over time, larger and larger doses are needed to produce the desired effects.
4. causes a physical and emotional “dependence” on the drug that can produce physical withdrawal when discontinued.

Nicotine meets all of these standards, and requires only a short period of exposure to cause serious addiction.⁸ As a psychoactive drug, nicotine use permanently alters the chemical make-up of the brain, and fosters physical and emotional dependence over time.⁹

The Medicine Wheel provides no room for addiction. A balance of thought, emotion, spirit, and physical well-being are fundamental to the traditional Indian lifestyle. Commercial tobacco causes not only physical and behavioral habits, but also an intense chemical addiction. In developing tobacco-related policy, it is important that tribal planners remember how difficult it may be for community members to break this addiction. While respect should be given to those who struggle with this challenge, it should not deter tribes from developing strong tobacco policies. The goal of this workbook is to promote respect for and adherence to tribal policies that improve community health.



Rates of Commercial Tobacco use Among American Indians and Alaska Natives



While the United States as a whole has enjoyed vast improvements over the last decade in its rates of tobacco-related death and disease, many minority populations, including American Indians and Alaska Natives, have not shared in this success. Nationally, American Indians and Alaska Natives have the highest rates of commercial tobacco use among nearly every age, gender, and ethnic category. In 2002, 40.5% of AI/AN men and 40.9% of AI/AN women reported current cigarette use.^{* 10}

Percentage of current smokers aged ≥ 18 , National Health Interview Survey, United States, 2001

Race/Ethnicity	Men (%)	Women (%)	Total (%)
White, non-Hispanic	25.5	21.8	23.6
Black, non-Hispanic	27.1	18.7	22.4
Hispanic	22.7	10.8	16.7
American Indian, Alaska Native	40.5	40.9	40.8
Asian	19.0	6.5	13.3

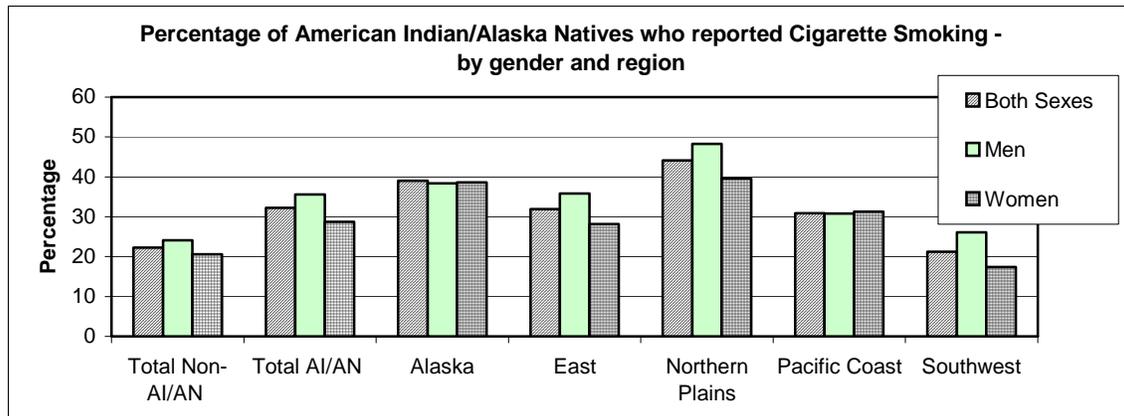
Among teens, AI/AN smoking prevalence rates also appear higher than those found among other ethnic populations. Among AI/AN high school seniors, 41.1% of males and 39.4% of females are current smokers.¹¹

Percentage of High School Seniors who are current smokers, Aggregated 1990–1994 Monitoring the Future Survey

Race/Ethnicity	Male (%)	Female (%)
White, non-Hispanic	33.4	33.1
Black, non-Hispanic	11.6	8.6
Hispanic	28.5	19.2
American Indian, Alaska Native	41.1	39.4
Asian	20.6	13.8

* Current smoking defined as those people who have smoked ≥ 100 cigarettes during their lifetime and who currently smoke every day or some days.

It is important to note, however, that national rates may appear misleading. Use of commercial tobacco products, including both cigarettes and smokeless tobacco, varies considerably between tribes, by region, by gender, and by age. In general, AI/AN smoking rates are highest in the Northern Plains (44.1%) and Alaska (39.0%) and lowest in the Southwest (21.2%).¹²



Percentage of American Indian and Alaska Natives (AI/ANs) who reported cigarette smoking, by gender and region – Behavioral Risk Factor Surveillance System, 1997-2000*

	Both Sexes %	Men %	Women %
Total Non-AI/AN (36 States)	22.3	24.1	20.6
Total AI/AN (36 States)	32.2	35.6	28.7
Alaska	39.0	38.4	38.6
East	31.9	35.8	28.2
Northern Plains	44.1	48.3	39.6
Pacific Coast	30.9	30.8	31.3
Southwest	21.2	26.1	17.4

Even within a single state, tobacco prevalence rates can vary considerably by tribe. For example, survey results generated from the 2001 Tribal BRFSS Project indicate that current smoking rates ranged from 32% to 45% among the six participating tribes in the Pacific Northwest.¹³ When broken down by gender, male current smoking rates ranged from 29% to 49% among tribes, and current smoking rates among females ranged from 33% to 48%.

By obtaining tobacco-related data for your own community, you will be better able to respond to changing trends or priority areas in your program planning and policy work. For help generating this information, contact your regional tribal Tobacco Support Center (contact information available in Chapter 11 of this Workbook), your State or County Health Department, or the RPMS specialist at your tribal health clinic.

* Weighted and standardized to the 2000 US projected population. Includes persons who reported having ever smoked \geq 100 cigarettes and who currently smoke.

Smoking Prevalence Among Adult Population by State: ¹⁴

State	Race/Ethnicity (%)				
	White	African American	Hispanic	Asian or Pacific Islander	American Indian/Alaskan Native
Alaska	23.9	21.0	33.4	17.7	43.1
Arizona	24.3	16.5	15.9	36.8	15.8
Arkansas	26.3	21.2	22.3	NA	44.7
California	17.2	20.7	16.2	11.2	31.9
Connecticut	20.0	19.2	21.8	14.0	45.5
Florida	23.9	17.8	18.0	19.0	37.0
Georgia	25.0	19.9	20.4	11.7	46.1
Illinois	23.2	24.9	20.5	15.5	54.8
Indiana	27.4	27.2	26.5	22.6	46.8
Kansas	21.9	23.0	20.6	26.2	33.9
Kentucky	31.4	36.4	37.5	NA	54.0
Louisiana	25.3	22.0	24.4	19.2	42.5
Maryland	21.0	24.3	20.0	11.4	32.7
Massachusetts	19.5	19.5	18.0	11.8	29.2
Michigan	24.5	27.1	29.9	8.7	36.6
Minnesota	21.5	28.6	26.5	20.0	57.8
Missouri	25.5	30.5	26.3	12.4	48.1
Montana	20.5	NA	23.3	NA	44.1
Nevada	26.0	28.8	21.7	21.2	34.6
New Mexico	21.8	22.0	23.9	18.9	17.6
North Carolina	27.3	21.8	24.2	17.1	35.4
North Dakota	20.5	NA	28.3	NA	49.6
Ohio	27.2	23.3	22.3	19.3	55.8
Oklahoma	27.5	25.0	22.5	19.8	39.9
Oregon	21.1	NA	19.3	15.6	31.5
Rhode Island	23.1	25.2	16.8	33.2	57.6
South Carolina	27.1	22.5	34.0	NA	47.5
South Dakota	21.1	NA	26.7	NA	43.7
Washington	21.4	19.7	20.9	17.8	35.9
Wyoming	21.6	NA	30.6	NA	53.0
Median	23.3	22.8	22.3	16.6	39.9

*NA: Not available. Data are shown only for demographic groups with at least 50 respondents.



The Pacific Northwest

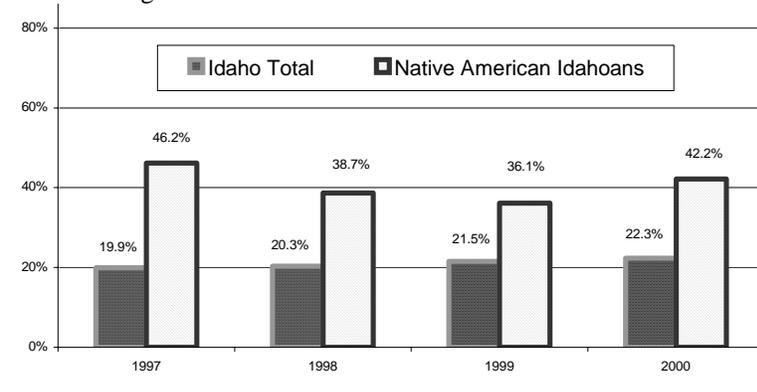


Idaho:

As long as data has been available in Idaho, AI/AN tobacco use rates have remained nearly double the rate of the general state population. In 1997, 46.2% of AI/ANs reported current tobacco use compared to 19.9% of Idaho's total adult population. By 2000 this disparity was just under 50%, with 42.2% of AI/ANs in Idaho reporting current commercial tobacco use (equating to nearly 5,000 adults), and 22.3% of the total population reporting such use.¹⁵

Encouragingly, between 2000 and 2002 the average AI/AN current smoking rate dropped to 37.9% (nearly 4 percentage points), compared to 20.5% for all other races.¹⁵

Smoking Trend Comparison Between Native American Idahoans and the Total Adult Population, 1998-2000 Aggregated Idaho BRFSS Weighted Data

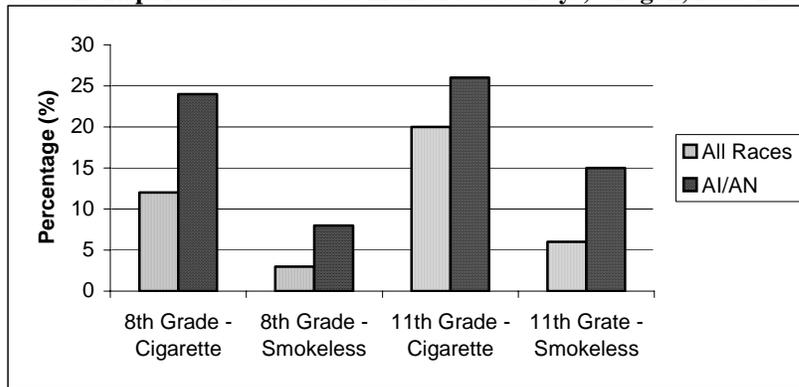


Oregon:

Commercial tobacco use rates have gradually risen among American Indian Oregonians over the last several years. Between 2000 and 2001, 44% of AI/AN adult Oregonians reportedly smoked cigarettes (accounting for 4% of all Oregonians), compared to 27% of African Americans, 14% of Asian and Pacific Islanders, 18% of Hispanics and 21% of Caucasians.¹⁶ During this period, 16% of AI/AN adults reported the use of smokeless tobacco, a figure that was twice as large as Caucasians and over 8 times greater than the rate documented for any other ethnic group.¹⁶

In 2003, 24% of AI/AN infants were born to mothers who used commercial tobacco during pregnancy, a rate that was significantly higher than rates documented for all other ethnic groups. Only 12% of infants in the overall population were born to mothers who smoked during pregnancy.¹⁶

Student Reported Tobacco Use in the Past 30 Days, Oregon, 2000-2001



Among youth, AI/AN adolescents reported the highest smoking rates of all ethnic groups in both the 8th and 11th grade. In 8th grade, 24% of AI/AN students reported cigarette use in the past 30 days in 2001-2002, compared to 12% of all 8th grade

students. In 11th grade, 26% of AI/AN students reported recent tobacco use, compared to 20% of all students.¹⁷ Similarly, AI/AN youth also reported elevated use rates for smokeless tobacco. 8% of AI/AN 8th grade students reported recent smokeless use, compared to 3% of all 8th grade students, and 15% of AI/AN 11th grade students reported use, compared to 6% of all 11th grade students.¹⁷ Fortunately, these trends may be improving. By 2003, cigarette use among AI/AN 8th grade students dropped to 14%, and smokeless tobacco use dropped to 4%.¹⁶

According to the Oregon Death Certificate Statistical File for 1999, 29% of all AI/AN deaths in the state of Oregon were caused by commercial tobacco use, accounting for 62 lives.¹⁶

Washington:

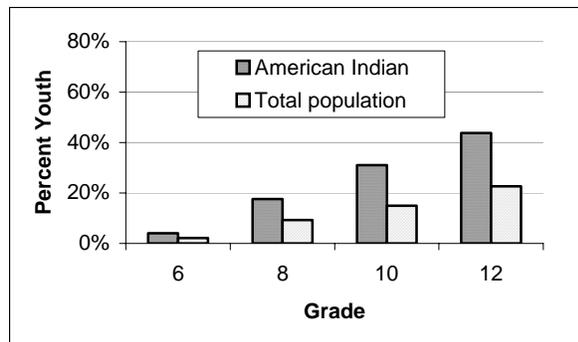
Between 1998 and 2000, the current smoking rate among Native Americans in Washington State was about 34.1 percent (29.9 percent for males and 39.1 percent for females). In comparison, the total smoking rate for the state as a whole was 20.7 percent in 2000 (21.7 percent for males and 19.7 percent for females). In 2002, the AI/AN adult rate rose to 39%.¹⁸ Likewise, smokeless tobacco use among Native Americans in Washington was about double the state average, at 6% and 3% respectively. The number of women smoking during pregnancy was also higher than the state average (nearing 27%, with nearly 520 AI/AN children born annually to mothers who smoked during pregnancy.¹⁸ Annually, it is estimated that 19% of deaths for the AI/AN population in Washington is attributable to tobacco use, amounting to nearly 100 deaths per year.¹⁹

Health Impact for Washington's Native Americans	
<i>Size of AI/AN population in Washington State (1.9% of State)</i>	<i>93,301</i>
Number of AI/AN adults who currently smoke	21,200
Number of AI/AN adults who currently use smokeless tobacco	4,300
Number of AI/AN youth who currently smoke	4,500
Number of AI/AN youth who currently use smokeless tobacco	1,100
Number of AI/AN infants born annually to mothers who smoked during pregnancy	440
Estimated Annual Deaths Due to Tobacco Use (19% of annual deaths)	100

Source: WA DOH - Census, BRFSS, WSSAHB, Birth Certificate System.

Among youth, smoking and smokeless tobacco rates for AI/AN adolescents remain higher than state averages for the total population at all grade levels, with a total of 4,500 AI/AN youth currently reporting cigarette use.¹⁹ Four percent of AI/AN 6th graders reported smoking at least one cigarette in the past 30 days, 18% of 8th graders smoked at least one cigarette in the past 30 days, 31% in 10th grade, and 44% in 12th grade. Declines were reported for current smoking rates among AI/AN 6th and 8th graders, but no change was observed among older students.²⁰

Smoking Among Youths, Washington State, 2002





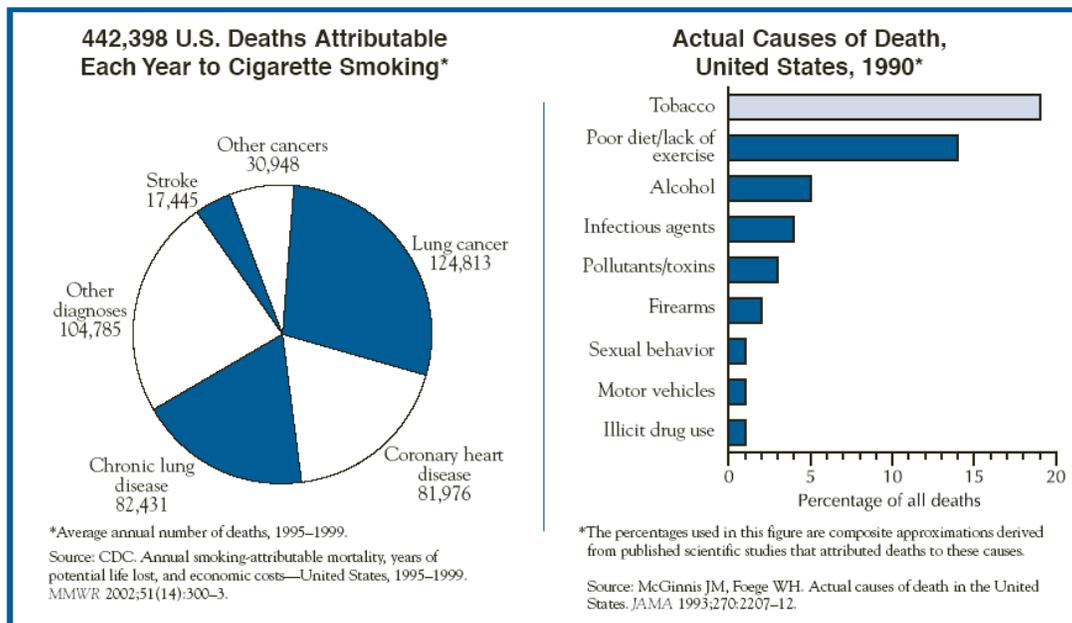
Health Risks Associated with Commercial Tobacco Products



General Health Impacts:

It is estimated that nearly two out of every five deaths in Indian Country are caused by commercial tobacco use or exposure to its smoke.²¹ As a sacred plant, many believe that it contains both the power to heal if used properly and the power to cause harm if used improperly. Many of the illnesses now common in our communities are the result of regular cigarette use, without respect for the power of the plant. Because of this addiction, Indian people who smoke do not live as long as non-smokers.

Exposure to secondhand smoke and use of commercial tobacco products are both major causes of and contributors to a great number of health conditions, including cancer, heart disease, bronchitis, emphysema, asthma, infertility, early menopause, diabetes, osteoporosis, rheumatoid arthritis, gastrointestinal diseases, vision problems, stroke, and contribute significantly to the severity of colds and pneumonia.²² Tobacco addiction also severely impacts women's health, and smoking during pregnancy is associated with increased risk of miscarriage, preterm delivery, complications during pregnancy, stillbirth, infant death, developmental problems, and low birth weight in infants.²³ In the United States, smoking is directly responsible for an estimated 440,000 deaths each year, and secondhand smoke causes an additional 65,000 deaths per year.²



Health Consequences of Smoking: A Report of the Surgeon General

Diminished Health Status:

After rigorously reviewing well over a hundred scientific studies, the Surgeon General concluded that there is sufficient evidence to conclude that commercial tobacco use causes diminished health status among smokers, which may cause “increased absenteeism from work and increased use of medical care services.” This investigation also concluded that smoking increases patients’ risk for adverse surgical outcomes related to wound healing and respiratory complications.²²

Cardiovascular Diseases:

Heart disease and stroke—the main types of cardiovascular disease caused by smoking—are among the leading causes of death for American Indians and Alaska Natives. Today, cardiovascular disease is the most common cause of death for American Indian men and women, accounting for nearly 22% of all deaths within the IHS service area.²⁴ Current evidence now confirms that smoking and exposure to cigarette smoke affect the health of the heart. Smoking leads to atherosclerosis and heart disease, and components of cigarette smoke diminish the ability of the blood to efficiently carry oxygen to the rest of our body. Consequently, smoking is now known to cause atherosclerosis, coronary heart disease, stroke, and abdominal aortic aneurysms. Smoking is the “most important of the known modifiable risk factors for heart disease in the U.S.”²²

Cancer:

Nationally, cancer is the second leading cause of death among American Indians and Alaska Natives, with lung cancer being the most common cause of cancer death.⁵ Nearly three times as many AI/AN people die of lung, bronchial, or tracheal cancer than the next leading type, accounting for over 26% of all cancer deaths.²⁴ Since 1975, AI/AN lung cancer death rates have increased over 180%, and while AI/AN lung cancer rates are slightly lower than rates found among all races in the U.S., the gap between the two rates is diminishing over time.²⁴ In 1998, lung cancer took the life of about 362 American Indian and Alaska Native adults.²⁴ For men, over 90% of lung cancer cases are typically caused by tobacco use, while nearly 80% are caused by commercial tobacco among women.²⁵ Consequently, over 300 American Indian and Alaska Native men and women now die from tobacco-related lung cancer each year. Commercial tobacco use is now known to cause lung cancer, laryngeal cancer, oral cavity and pharyngeal cancers, esophageal cancer, pancreatic cancer, renal cell, renal pelvis, and bladder cancers, cervical cancer, stomach cancer, acute leukemia, and likely causes colorectal cancer and liver cancer.²² Although there is evidence that smoking may not contribute to the risk of developing prostate cancer, once prostate cancer arises, it is probable that smoking contributes to a higher cancer mortality rate.²²

In 1998, lung cancer took the life of nearly 362 American Indian and Alaska Native adults.

Respiratory Diseases:

Acute respiratory diseases and chronic obstructive pulmonary disease (COPD) are among the leading causes of morbidity and mortality in the United States and abroad. Smoking has adverse health effects on the entire lung, disrupting every aspect of the lung's structure and function.²² Commercial tobacco use causes several acute respiratory illnesses, including pneumonia and bronchitis. It is also responsible for numerous chronic conditions, causing reduced lung function in infants of mothers who smoked during pregnancy, and a greater frequency of lower respiratory tract conditions during infancy and early adulthood. Active smoking causes respiratory symptoms in people of all ages, including coughing, phlegm, wheezing, and dyspnea, as well as impaired lung growth for children and adolescents who begin smoking before their lungs have developed to complete maturity.²² Additionally, smoking causes asthma-related symptoms (i.e., wheezing) in childhood and adolescence, and is often responsible for outcomes indicating poor asthma control. In 1998, 13 American Indian and Alaska Native children and adults died of asthma-related complications.²⁴

Reproductive Effects:

Smoking harms many aspects of reproduction. Research has now concluded that women who smoke are at an increased risk for both primary and secondary infertility or delays in becoming pregnant.²² Research has also shown that women who smoke during pregnancy risk complications (including premature rupture of the membranes, placenta previa, placental abruption, and ectopic pregnancy), premature birth, low birth weight (LBW) infants, and stillbirth. Studies also indicate that maternal smoking can cause oral clefts and Sudden Infant Death Syndrome (SIDS).²²

Despite increased knowledge of the adverse health effects of smoking during pregnancy, only 18 to 25 percent of women quit smoking once they become pregnant.²² Data also suggest that a substantial number of American Indian and Alaska Native pregnant women and girls continue to smoke during their pregnancy (estimates range from 27 to 33 percent in the Pacific Northwest).^{16,19}

Erectile Dysfunction:

Evidence now suggests that smoking may cause erectile dysfunction among men. At this time, sufficient evidence is not available to clearly conclude whether or not smoking effects sperm quality or quantity.²²

Dental Diseases:

Commercial tobacco use also has a significant impact on oral health. Smoking causes periodontitis and is a likely cause of root-surface cavities. Smokeless (or Spit tobacco) is also known to cause tooth abrasion, gum disease, gum recession, tooth discoloration, bad breath, and cancer in the mouth, pharynx (voice box), esophagus, and pancreas.²²



Loss of Bone Mass and the Risk of Fractures:

Among chronic smokers, tobacco use leads to less strong, less healthy, mineral-deficient vertebrae with reduced bone blood supply, and fewer, less functional bone-forming cells. Exposure to tobacco smoke also puts postmenopausal women at greater risk for developing osteoporosis. Postmenopausal women who currently smoke have lower bone density than do women who do not smoke, making them more susceptible to hip fracture, spinal column degenerative disease, and traumatic vertebral injury.²²

Eye Diseases:

Smoking has also been found to impact one's vision. It has been found to cause nuclear cataract, and may also be responsible for exudative (neovascular) age-related macular degeneration, atrophic age-related macular degeneration, and eye problems associated with Graves' disease.²²

Peptic Ulcer Disease:

Smoking can cause peptic ulcer disease in people who have *Helicobacter pylori*, a bacteria that has been associated with the development of gastric ulcers, and may be responsible for increased risk for peptic ulcer complications.²²

Children's Health:

Commercial tobacco use within the community also has vast implications for the health of our children and young adults. As mentioned previously, smoking or exposure to secondhand smoke during pregnancy can result in low birth-weight babies or other complications leading to neonatal intensive care. Between 1996-1998, 6,442 American Indian and Alaska Native infants were born at low birth-weight, making up over 6% of all AI/AN births.²⁴

After birth, cigarette smoke increases a child's chances of developing sudden infant death syndrome, respiratory disorders, ear and eye problems, growth and mental retardation, attention deficit disorder, other learning and developmental problems, and even long-term behavioral problems, violent tendencies, and criminality.²⁶ Each year, the health of over 30,000 children is compromised by mothers who smoke (or are exposed to smoke) during pregnancy.

Each year, 280 children die from respiratory illness caused by secondhand smoke; and another 300 kids suffer from injuries caused by smoking-caused fires.

Among AI/AN children, sudden infant death syndrome is the second leading cause of death to children under the age of one, taking the life of approximately 150 children.²⁴ Disorders related to short gestation and low birth-weight are the next leading cause, claiming the life of nearly 60 AI/AN children.²⁴ Tragically, nearly 70% of women who lose a baby to SIDS, smoked during her pregnancy. In addition to these causes, respiratory distress syndrome is the fourth leading cause of neonatal death (under 28 days).²⁴

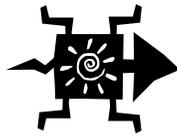
Smoking in the home, car, or around children increases the likelihood that exposed children will suffer from smoke-caused coughs and wheezing, bronchitis, asthma, pneumonia, potentially fatal lower respiratory tract infections, eye and ear problems, or injury or death from cigarette-caused fires.²⁶ According to a 1997 study, exposure to secondhand smoke produced over 500,000 clinic visits for asthma, 1.3 million visits for coughs, 115,000 episodes of pneumonia, 14,000 tonsillectomies or adenoidectomies, 260,000 episodes of bronchitis, two million cases of middle ear infection, and 5,200 middle ear operations.²⁶ Thousands of potentially toxic exposures are also reported each year to Poison Control centers for young children who ingest cigarettes, cigarette butts, and other tobacco products found around the house, in ashtrays, or in the garbage.

Community Health:

A child's worldview is shaped by the social norms of their community, and tribal adults are their primary role models. For both good and bad, the actions, values, and habits of our adults and elders are seen and emulated by our young people. If our children believe it is "okay" for adults to smoke or chew tobacco, they will likewise believe that it is "okay" for them. Because of this, over half of young smokers have parents who smoke, and teens are three times more likely to smoke if a parent or sibling smokes.²⁷

By not creating policies to define appropriate boundaries for tobacco use, it becomes socially acceptable for community members to smoke or chew tobacco outside the health clinic, at Powwows, in tribal buildings, during community celebrations, or near children and elders. This pattern of behavior sends a clear message to young people that it is acceptable to participate in this activity.

Teens are **three times more likely** to smoke if a parent or sibling smokes.

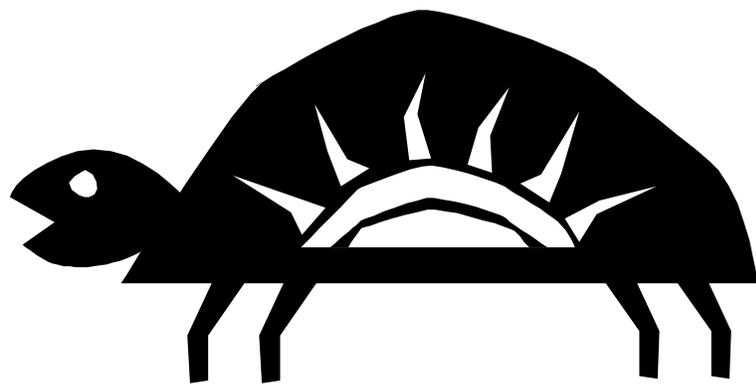


Secondhand Smoke:

The health risks associated with smoking (heart attack, stroke, cancer) have been known for some time. Less well known among community members are the risks attributed to secondhand smoke. Secondhand smoke (referred to by the tobacco industry as "environmental tobacco smoke") is made up of the smoke exhaled by a smoker, as well as the side-stream smoke that is unfiltered and comes from the burning end of the cigarette. The chemicals in secondhand smoke include: carbon monoxide, nicotine, various carcinogens, hydrogen cyanide, arsenic, pesticides, and radioactive compounds.

The Environmental Protection Agency classified secondhand smoke as a substance that is "known to cause cancer in humans."²⁸ This classification is the highest level of warning given to known carcinogens. Scientific studies have linked second hand smoke to heart disease, respiratory problems, and many types of cancers, including lung cancers, cervical cancer and bladder cancer. Each year, secondhand smoke causes nearly 65,000 deaths among non-smokers.

Tobacco policies can prevent exposure to secondhand smoke among children and non-smoking adults.





The Financial Impact of Commercial Tobacco Use



Cost to Health Services:

In addition to hurting a community's physical health, commercial tobacco use also significantly impacts its financial resources as well. Tobacco-related illness or death increases direct medical care spending and lessens the number of years people can economically contribute to the health and wellness of their community. Nationally, \$75 billion is spent on direct medical costs associated with tobacco use, and \$82 billion is left unrealized due to lost productivity.²⁹ The Indian Health Service estimates that about \$200 million dollars is spent each year by the IHS system to treat tobacco related diseases.⁴

National Smoking-Related Economic Costs²⁹

ADULT	Annual Smoking-Attributable Productivity Costs, 1995-1999	Total Cost (in millions)	Cost Per Smoker
	Men	\$ 55,389	\$ 2,287
	Women	\$ 26,483	\$ 1,193
	Total	\$ 81,872	\$ 1,760
ADULT	Smoking-Attributable Medical Expenditures, 1998	Total Cost (in millions)	Cost Per Smoker
	Ambulatory Care	\$ 27,182	\$ 584
	Hospital Care	\$ 17,140	\$ 368
	Prescription Drugs	\$ 6,364	\$ 137
	Nursing Home	\$ 19,383	\$ 417
	Other Care	\$ 5,419	\$ 116
	Total	\$ 75,488	\$ 1,623
INFANT	Smoking-Attributable neonatal Medical Expenditures, 1996	Total Cost (in millions)	Cost Per Smoker
	Infant (low birth weight, complications, SIDS)	\$ 366	\$ 704
Adult and Infant	Total Cost	\$ 157,726	\$ 3,391

When calculated for each adult smoker, financial costs amount to nearly \$1,760 in lost productivity and \$1,623 in excess medical expenses for each and every smoker – totaling \$3,391 per smoker per year.²⁹ With limited IHS dollars to fund health services, and nearly 40% of our adult AI/AN population currently smoking, this figure represents a significant financial loss to our Tribal communities. All told, commercial tobacco use nationally triggers “approximately \$157 billion in annual health-related economic losses.”²⁹

Secondhand Smoke Policies, Costs of Smoking:³⁰

	Policies		Costs of Smoking				
	% People Protected by Non-Smoking Policies		Cigarette Price Per Pack, Medical & Productivity Costs Per Pack, & Cigarette Consumption			Medicaid Costs	
	Worksite (%)	Home (%)	Cigarette Price Per Pack	Smoking Attributable Medical & Productivity Costs Per Pack	Cigarette Consumption Per Capita (Pack Sales)	Smoking-Attributable Medicaid Costs Per Pack	Smoking-Attributable Medicaid Costs Per Capita
Alabama	63.9	58.1	\$3.28	\$8.71	84.80	\$0.58	\$64.93
Alaska	73.6	61.5	\$4.59	\$7.30	63.70	\$1.75	\$156.82
Arizona	68.7	71.5	\$3.85	\$9.40	52.00	\$1.06	\$73.22
Arkansas	63.5	53.2	\$3.52	\$8.34	87.20	\$0.95	\$109.69
California	77.6	74.3	\$4.08	\$13.38	35.80	\$2.21	\$106.18
Colorado	72.8	67.0	\$3.26	\$7.29	66.20	\$1.00	\$87.54
Connecticut	73.8	61.0	\$4.32	\$10.73	66.40	\$1.74	\$153.18
Delaware	70.8	55.4	\$3.23	\$4.76	142.40	\$0.64	\$118.41
D.C.	74.6	57.1	\$3.81	\$17.82	44.40	\$2.83	\$156.85
Florida	69.0	66.8	\$3.39	\$9.15	77.90	\$0.90	\$89.73
Georgia	66.6	62.2	\$3.16	\$7.54	79.50	\$0.74	\$78.56
Hawaii	72.2	64.7	\$4.54	\$9.47	51.10	\$1.71	\$113.07
Idaho	71.4	71.8	\$3.18	\$7.01	63.30	\$0.92	\$78.99
Illinois	67.5	54.6	\$4.04	\$9.03	70.90	\$1.63	\$154.75
Indiana	58.3	50.1	\$3.57	\$5.73	121.40	\$0.60	\$98.22
Iowa	69.9	54.5	\$3.31	\$7.31	85.40	\$1.11	\$123.83
Kansas	73.4	59.6	\$3.73	\$7.92	77.50	\$0.86	\$89.38
Kentucky	57.1	39.7	\$2.98	\$5.88	140.80	\$0.78	\$141.80
Louisiana	64.2	56.7	\$3.33	\$7.27	97.00	\$1.41	\$185.34
Maine	75.3	55.4	\$4.18	\$9.69	79.60	\$1.95	\$196.34
Maryland	81.7	64.9	\$4.01	\$11.58	56.00	\$1.46	\$107.61
Massachusetts	77.3	62.0	\$4.84	\$14.05	55.50	\$2.72	\$194.14
Michigan	61.0	53.5	\$4.35	\$8.72	78.10	\$1.33	\$138.94
Minnesota	74.3	63.4	\$3.52	\$8.52	71.00	\$1.21	\$113.66
Mississippi	61.5	54.4	\$3.19	\$7.88	91.50	\$0.93	\$115.12
Missouri	65.9	54.9	\$3.08	\$7.72	99.20	\$0.88	\$114.52
Montana	69.1	61.4	\$3.22	\$7.74	74.40	\$0.91	\$88.50
Nebraska	67.6	59.6	\$3.87	\$7.31	77.30	\$0.94	\$96.04

	Policies		Costs of Smoking				
	% People Protected by Non-Smoking Policies		Cigarette Price Per Pack, Medical & Productivity Costs Per Pack, & Cigarette Consumption			Medicaid Costs	
	Worksite (%)	Home (%)	Cigarette Price Per Pack	Smoking Attributable Medical & Productivity Costs Per Pack	Cigarette Consumption Per Capita (Pack Sales)	Smoking-Attributable Medicaid Costs Per Pack	Smoking-Attributable Medicaid Costs Per Capita
Nevada	48.9	64.5	\$3.31	\$7.75	82.20	\$0.65	\$70.74
New Hampshire	74.3	61.0	\$3.58	\$5.34	131.60	\$0.64	\$109.83
New Jersey	72.9	62.4	\$4.63	\$10.76	58.40	\$1.80	\$137.81
New Mexico	68.3	63.0	\$3.35	\$8.94	52.20	\$1.78	\$125.41
New York	72.6	58.8	\$5.68	\$14.97	46.50	\$5.70	\$346.42
North Carolina	60.9	52.1	\$3.07	\$6.59	98.50	\$0.88	\$113.23
North Dakota	65.8	58.2	\$3.60	\$9.17	68.50	\$1.01	\$89.57
Ohio	63.2	51.0	\$3.59	\$7.72	96.80	\$1.19	\$153.72
Oklahoma	67.3	54.2	\$3.21	\$7.11	102.00	\$0.57	\$76.54
Oregon	66.3	71.1	\$4.05	\$8.67	66.60	\$1.14	\$99.10
Pennsylvania	68.9	57.1	\$3.98	\$8.46	86.90	\$1.48	\$166.27
Rhode Island	72.3	61.8	\$4.42	\$9.75	74.70	\$2.09	\$198.87
South Carolina	64.4	60.6	\$3.11	\$7.09	97.50	\$0.91	\$115.78
South Dakota	60.0	57.0	\$3.41	\$7.99	75.40	\$0.93	\$93.88
Tennessee	63.4	52.9	\$3.27	\$7.79	103.40	\$1.06	\$142.60
Texas	66.4	65.9	\$3.53	\$9.11	58.30	\$1.20	\$95.19
Utah	84.4	81.7	\$3.81	\$6.43	40.10	\$1.05	\$59.60
Vermont	77.1	61.3	\$3.90	\$7.02	93.00	\$1.16	\$138.51
Virginia	70.5	58.4	\$3.08	\$6.29	92.10	\$0.56	\$66.96
Washington	73.9	68.8	\$4.77	\$12.70	45.00	\$2.22	\$131.55
West Virginia	63.5	42.5	\$3.05	\$7.78	110.70	\$1.06	\$149.47
Wisconsin	64.4	55.4	\$3.95	\$8.30	75.30	\$1.08	\$107.82
Wyoming	66.1	59.9	\$3.14	\$5.89	93.20	\$0.74	\$90.90
National	69.0	61.1	\$3.72	\$8.61	79.80	\$1.31	\$122.06

Cost to Businesses:

Tobacco use in the workplace also contributes to significant costs for local businesses. Smoking in the workplace damages property and increases cleaning costs by an average of 10%.³¹ Tobacco use in the workplace also increases an employer's potential legal liability for secondhand smoke exposure to non-smoking employees. Studies estimate that secondhand smoke damages the health and reduces the productivity of nonsmokers, costing employers an estimated \$56 - \$490 per smoker per year.³¹

Individual Costs:

In addition to increasing costs for businesses and health services, commercial tobacco use also impacts our personal wallet. Based on an average cost of \$5.00 per pack, calculate how much money you or your family would save by not smoking.

How many Packs do you Smoke Each Day?				
You Will Save in:	1/2 Pack	1 Pack	1 1/2 Packs	2 Packs
1 Day	\$2.50	\$5.00	\$7.50	\$10.00
1 Week	\$17.50	\$35.00	\$52.50	\$70.00
1 Month	\$70.00	\$140.00	\$210.00	\$280.00
1 Year	\$840.00	\$1,680.00	\$2,520.00	\$3,360.00
10 Years	\$8,400.00	\$16,800.00	\$25,200.00	\$33,600.00

Cigarette prices range from \$5 to \$6 at local convenience stores, 2004.
Based on cigarette cost of \$5.00 per pack.



The Social Impact of Commercial Tobacco Use

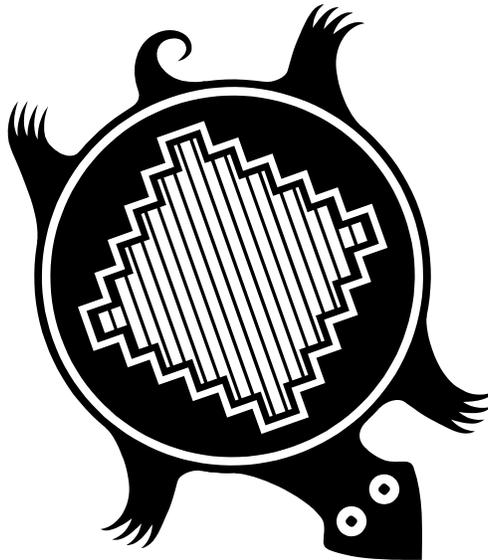


Studies conducted by the IHS indicate that two out of every five Native American deaths – all children, parents, elders, friends, brothers, sisters, role models or grandparents – are related to or caused by smoking.²¹ And nationally it is estimated that nearly 8.6 million people suffer from serious illnesses attributed to commercial tobacco use.²⁹ The great atrocity, though, is that each and every one of these illnesses are ultimately preventable. On average, people who use commercial tobacco products die 7-10 years earlier than those who do

40% of American Indian and Alaska Native deaths are related to or caused by commercial tobacco use.

not smoke or chew. This amounts to 5.6 million years of wisdom, experience, and culture that are lost to future generations each year because of commercial tobacco products.

Commercial tobacco use robs our community of the **wisdom, culture, and relationships** shared by our elders.





Why Develop and Enforce A Policy?

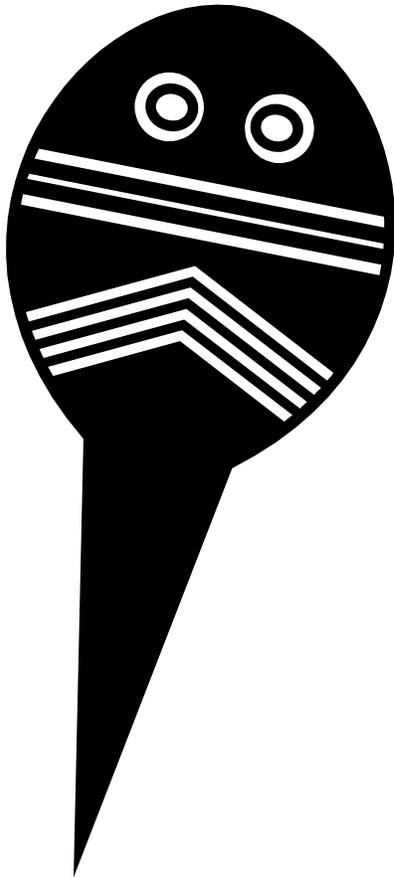


Historically, tobacco use was governed by each Tribe's cultural traditions and plant availability within seasonal cycles. In effect, limited access and traditional norms served as the first "tobacco control policies." With the availability of commercial tobacco products now widespread, plant availability and traditional norms no longer guide responsible or appropriate tobacco use in the manner they once did. Today, commercial tobacco policies are needed to protect the health of all tribal members.

- Children, non-smokers, and elders deserve **protection** from the harmful effects of secondhand smoke exposure.
- Our youth deserve **guidance** that will help them escape the grips of nicotine addiction.
- Those who want to quit using commercial tobacco deserve **access** to the services and support that can assist them in their attempt.
- And our young people deserve **freedom** from the manipulative media tactics employed by the Tobacco Industry.

Experience has shown that only well written tobacco policies can provide this needed protection, guidance, access, and freedom. Tobacco policies have the ability to resolve disputes between smokers and nonsmokers, employers and employees, and businesses and patrons. A tobacco policy is a way to keep peace and a means to help all community members know what is expected of them.

A tobacco policy states a Tribe's official position on tobacco use in public places, accessibility for minors, treatment in the clinic, and exposure to Tobacco Industry pressure. A strong tobacco policy will protect all tribal members. It will strengthen educational programs that can return tobacco to its traditional role. If your tribe already has a tobacco policy, this workbook will help you evaluate and improve that policy, and can help you identify other areas that would benefit from policy change. If this is your Tribe's first tobacco policy, this workbook will introduce you to the variety of tobacco-related policies that are available, discuss their strengths, and guide you through the policy change process.



Chapter 2:

General Steps for Developing a Tribal Tobacco Policy



Steps Involved in Policy Change



There are a number of steps involved with writing, passing and enforcing an effective tobacco policy that will protect the health of your community. The following list provides a brief map of the path you will travel when embarking on this journey. This tool can also help validate the policy change process that you engaged in with decision-makers.

A Policy Change Check List:

1. Create a Committee and Involve Stakeholders
2. Develop an Action Plan
3. Gather Background Information
4. Analyze Available Data
5. Review Sample Policies
6. Demonstrate Need and Build Community Support
7. Draft a Policy
8. Obtain Feedback
9. Revise as Necessary
10. Pass the Policy
11. Enforce the Policy
12. Evaluate the Policy

Writing and passing a tobacco policy is not a quick process. It can take months or even years to get your new policy enacted. Do not feel discouraged – Take comfort in knowing that your effort will save lives! While it may be time consuming, policy change is one of the few ways you can guarantee that your work will have a lasting effect on the health of your community for generations to come.



Step 1: Create a Committee and Involve Stakeholders



The Tobacco Policy Change “Committee”:

In the Northwest, tribes have brought together at least four different groups to initiate the development or revision of tobacco policies. Each of these groups can work independently or in combination:

- A standing health committee or health board
- A tobacco workgroup, coalition, or committee
- One or two key tribal members
- Youth groups

In this workbook, we use the term “committee,” but the same steps and strategies apply, even if your tribe chooses another group to develop your tobacco policy. It is not unusual to share the responsibility for developing a tobacco policy among many individuals or groups. Because this is a large undertaking, we encourage the participation of several committed committee members in order to share the burden of necessary tasks.

While all of your committee members may not actively participate in each and every step of the process, committee members ought to be available to meet periodically to help support the forward progress of the group. In selecting committee members, you may also want to recruit individuals who have a variety of skills and talents needed for each task.

Involve other Stakeholders:

Successful policy change and enforcement requires the support and approval of your entire community. This support must be gained among all groups affected by the policy, including smokers and non-smokers, businesses and patrons, students and school staff, elders and youth, employers and employees. For this reason, it is important that a wide variety of stakeholders be included in the policy change planning process. By obtaining input from all perspectives, no group will feel alienated by the process, and you will better understand the concerns that need to be addressed before community support is achieved.

Depending on the type of policy that you are interested in passing, you may want to invite people from the following groups to participate in specific portions of the planning process:

- Tribal Council Members
- Tribal Business Groups
- Tribal Employees
- The Youth Council or Young Adults
- Elders
- Tribal Housing personnel
- School Staff and Administrators
- Youth Recreation/Prevention staff
- Environmental Department personnel
- Tribal Clinic or Physicians
- Head Start personnel
- WIC or First Steps program personnel
- Dental Clinic personnel
- CHR staff
- Media (Tribal Newspaper, radio)
- Alcohol/Drug Prevention personnel
- Community Health Director
- Current/Former Smokers
- Tobacco-related Cancer Survivors
- Community members
- Culture and Heritage staff
- Parent Organizations
- Faith-Based Groups
- Fire Department personnel
- Tobacco Retail Owners or Managers
- Tribal Court personnel
- Law Enforcement personnel

A Note About Recruitment:

When recruiting participants, try to provide people with:

- A clear reason why they should get involved → let them know what's in it for them.
- A timeline → how long will you need their involvement.
- A description of what they can contribute to the process → be it skills, experience, or a valuable perspective

People will be more likely to assist if they have a specific task to work on, rather than a vague, open-ended request. Nebulous requests could potentially be more work than they are willing to commit to, making people more likely to decline involvement.

If key individuals are not available to participate in the entire planning process, try to keep them informed about your activities. Be sure to obtain feedback along the way from those who will be impacted by the policy. To do this, you can either contact individual stakeholders one-on-one, or host community forums to allow for group discussion. If community-wide events already exist, such as elder's events, youth events, or health service meetings, you may want to inquire about getting on their agenda. As you present your plan to various community members, allow them to sign-up to volunteer their time or resources to activities that they would be interested in supporting.

Not all of the steps of the planning process will require input from all of your stakeholders; some of the steps should be carried out by smaller teams or individuals on your committee. Keep this in mind when deciding whom to invite to what step of the process. Steps 4 (Analyze Data) and 8 (Obtain Feedback) are the phases that will benefit from broad community input.

Involving Youth in the Process:

Young people are an incredible resource for helping promote or initiate policy change – particularly policies that affect their health. Teens and pre-teens are smart, creative, and bring new perspectives and energy to the policy change process. When mentored, young people can serve as effective spokespeople and engaged community advocates. They can help to increase community awareness, provide student-to-student training, and reach media sources and policy-makers that may not be influenced by the adult population. Teen involvement can also provide them with an enriching leadership experience, helping them to develop skills in public speaking, event planning, and community health advocacy.

To best tap the skills and energy of young community members, it is important that you have supportive adults who will guide them through the planning process, keep them focused on their goals, and provide logistical support and training so that they can succeed at their activities. Successful youth development programs often suggest that you:

- Give youth a voice in issues that affect them
- Give decision-making power to youth
- Make the project fun
- Offer meaningful opportunities to build new skills and experiences
- Provide a safe and positive environment
- Encourage youth and adult partnerships
- Offer training that is relevant, experiential and interactive
- Provide opportunities for reflection and feedback
- Acknowledge the efforts of youth, personally and publicly

Of course, working with students will add a few challenging elements that will require consideration. With unique schedules and transportation issues inherent among teens, you should consider appropriate meeting times and locations to optimize their involvement. Incentives for participation might also be useful, and can include food or snacks, prizes for activities accomplished, media recognition, or community service credits.

Allowing youth to have legitimate decision-making power requires that adult leaders are willing to accept their decisions, even if they must face the prospect of learning from unsuccessful activities. Often, adults will try to “rescue” precarious situations, which takes away the youths’ power and self-efficacy.

Seek adults who are truly willing to let the youth lead, providing them with the tools, information, and guidance to succeed. Young people can provide valuable insight and energy to the tobacco education movement, and should not be overlooked!

Case Study: Native American Youth Speak Out

By: Diane Pebeahsy

The Yakama Native American Speak Out youth group has attended a number of trainings on commercial tobacco abuse, including Tobacco 101, Traditional Tobacco among Natives, Secondhand Smoke, and has learned about other health outcomes associated with tobacco. Armed with this information, the teens felt compelled to take action. They, like many Native American Youth Groups, wondered how this subject truly impacted their lives out on the Rez. As the group leader, I facilitated the group as they began to look more closely at the social and economic role that tobacco plays on the Yakama Reservation – this was really an eye opener for them. Through conversations with leaders and friends, the teens began to see how the Tobacco Industry had a hold on their Rez.

To address this, the teens partnered with the American Cancer Society to conduct Operation Storefront on the Yakama Reservation. Operation Storefront is an activity that guides students as they measure and evaluate Tobacco Industry advertising in their community. We wanted to have data to present to our tribal leaders, so that the issue of tobacco abuse and control could be brought to the table. This information empowered the youth to speak before the Council, and made the issues discussed much more real.



As a coordinator for the YNASO youth, I encourage them to come to meetings and periodic trainings. I provide food, which is great incentive. I design each training to fit within their schedules, because many students have sports or summer jobs. Often we have meetings or trainings over lunch - The kids love it. I schedule major events, like Operation Storefront, to take place the week after most of the summer jobs end, which helps continue the kid's momentum of getting up early. And after the event, we reward them with a pizza party.

More information about working with teens can be found in “*Working with Teens on Tobacco Issues*,” which can be ordered from the Oregon Tobacco Education Clearinghouse (OTEC) Catalog (<http://www.ohd.hr.state.or.us/tobacco/otec>) or on the Tobacco-Free Kids website (<http://tobaccofreekids.org/>).



Step 2: Develop an Action Plan



With a little preparation, you can do this! An action plan will help to ensure that your policy is developed, passed, and implemented in an efficient and effective manner. The plan should include input from the stakeholders participating in the planning process, so it might be useful to host a meeting or talking circle to discuss the topics mentioned below. If you cannot meet as a group, these topics should be discussed by the lead coordinating person one-on-one with committee members and stakeholders.

Topics to discuss when developing an Action Plan:

Step 3: Gather Background Information - You should decide who will research your own tribe's history with tobacco-related policy change, and where and when you will share this information with other committee members. As a group, brainstorm who might be helpful to contact in pursuit of this information. The person chosen to complete this task will find more information on gathering background information on page 48 of this workbook.

Step 4: Analyze Available Data - You should decide who will compile appropriate data, who will analyze the information, where and when you will decide what type of policy is most appropriate for your tribe's needs, and when each of these tasks ought to be completed. Different people may be able to bring different types of data to the table. The person (or people) chosen to complete this task will find more information on available data sources on page 49 of this workbook. If, after gathering all available data, you find that you still need more information, it could be useful to conduct your own survey of the community.

Step 5: Review Sample Policies – There are many sample policies contained in this book that you can use to draft a tobacco policy for your tribe. You should decide who will locate and obtain any other policy samples that might be of interest to the group. The person (or people) chosen to complete this task will find more information on page 54 of this workbook

Step 6: Demonstrate Need and Build Community Support - You should decide who will help gather information about your community's current level of support for your policy, and determine who will coordinate activities to educate and build support among community members and decision makers. This task will likely be ongoing throughout each of the remaining steps. The person (or people) chosen to complete this task will find more information on building support on page 58 of this workbook.

Step 7: Draft a Policy - Decide who will help draft the policy chosen by your committee and stakeholders. The person chosen to complete this task will find more information on page 61 of this workbook.

Step 8: Obtain Feedback – Discuss who will coordinate activities designed to share the policy draft with stakeholders and community members in order to obtain their feedback, suggestions, and concerns. The person chosen to complete this task will find more information on generating feedback on page 64 of this workbook.

Step 9: Revise as Necessary - Discuss who will revise the policy draft to incorporate the feedback, suggestions, and concerns of your community members and stakeholders. The person chosen to complete this task will find more information on page 65 of this workbook.

Step 10: Pass the Policy - Consider who will be responsible for presenting the policy to your community's decision-makers. Depending on the policy, you may need to meet with the Tribal Council, School Board, an employer, or some other leader. More information on passing the policy is discussed on page 66 of this workbook.

Step 11: Enforce the Policy – Consider who might coordinate efforts to educate the community about the new policy, as well as those who will be required to enforce it. Enforcement is discussed in more detail on page 67 of this workbook.

Step 12: Evaluate the Policy - Discuss who will be responsible for evaluating the policy's short term, intermediate, and long term goals. Evaluation is discussed in more detail on page 73 of this workbook.

While it is probably too early at this point to establish clear deadlines and individual responsibilities for fulfilling these tasks, it may be helpful to start thinking about a general timeline, and any activities that require early completion. Some of the steps will need attention throughout the entire process, such as generating community support and involving affected stakeholders. If you would like to enact your policy on a special day in order to draw attention to the change through the media (like the Native American Smokeout on November 20th), it will be helpful to think backwards in order to determine when the necessary steps will need to be completed.

You might also want to discuss how the committee will communicate about progress with one another – Will you organize weekly or monthly meetings, periodic emails, phone conversations? Choose a method that will best meet the needs of those who are involved.



Step 3: Gather Background Information



If your tribe has an existing tobacco policy, obtain a copy of it and, if possible, learn as much as you can about how it was originally developed. When passing tobacco policies, some tribes have issued resolutions, ordinances, or other types of law. Tribal employers may have passed tobacco-related memos or personnel policy statements, and tribal schools may have passed their own policies, rules, or codes. To achieve a clear picture of the situation, each type of policy should be investigated. If your tribe does not have any tobacco-related policies, try to find out if one has ever been considered. If your tribe is making a profit from tobacco sales, learn as much as you can about that enterprise as well.

It can also be useful to look at existing tobacco policies to make sure that they are being upheld. If your tribe already has a policy, you may want to evaluate whether or not it is producing the intended outcome. You may decide that your current policy is inadequate, or you may decide to change it. It may be easier to tweak an existing policy than to start from scratch.

In order to learn about existing tobacco policies, you may need to consult with tribal elders, the tribal council secretary, or others who were involved with their passage. If you can't find any information about tobacco-related policies, find out how other policies were developed, such as an alcohol or drug policy. Ask those who were involved with the process what worked well during the development and implementation phase. Ask what difficulties occurred, and how they were overcome.

If you are interested in having your policy passed by the Tribal Council, you will need to consider the membership of your council. Learn about the members that are opposed to a tobacco policy and why they are in opposition. Talk to these people throughout the process and answer their concerns. Most leaders are willing to make this issue a priority once they know the facts and have had their concerns addressed. If upcoming elections will change the Council membership, talk to candidates that might be elected as well.

To develop and implement an effective policy, it is also essential that you understand your own tribe's protocol for how policies are written and passed. If you are not familiar with this process, talk to the Tribal Council's secretary or a member of Tribal Council, and ask them to share this experience with you.

Once you have gathered this background information, you will be ready to involve other people in this process.



Step 4: Analyze Available Data



Choosing the right type of policy for your community and its goals will require you to analyze data. While this prospect may sound daunting, don't be intimidated. You probably already have most of the information needed to make an educated decision about the type of policy you ought to pursue. If you don't already have this data, this workbook will offer suggestions for obtaining useful information.

By “analyzing” information about the current pattern of tobacco use in your community, your tobacco program's priorities, your community's readiness to initiate change, and your community's knowledge about commercial tobacco, you will be better prepared to draft a policy that will be effective and can be realistically passed and enforced.

Tobacco Program Priorities:

If your tribe has a tobacco program in place, ask them what priorities they have identified to address. Does the tobacco program focus on (1) Preventing Youth Initiation, (2) Reducing Exposure to Secondhand Smoke, (3) Promoting Adult Cessation, (4) Counteracting Tobacco Industry Marketing, (5) Promoting respect for the traditional use of Sacred Tobacco, (6) or another related topic? If the tribe has already established priorities, this might lead you to choose a policy that would support their current efforts.

If you do not have a tobacco program, or the program has not established priorities, which of these topics are of greatest concern to your committee and stakeholders? Your observation of community problems and needs can be just as important as facts and hard data.

Tobacco Education and Prevention Resources:

If you have an existing tobacco program, it might also be helpful for you to assess the current education and prevention resources that it has at its disposal. If you were to eliminate tobacco use in tribal buildings, for example, it would be important for your community members to have access to cessation services. If they do not, this policy might face opposition and fail to support the requisite changes within the community. As your committee begins to think about possible policies to implement, assess whether or not your program (or tribe as a whole) has the resources needed to adequately enforce and support the desired change.

Tribal Tobacco Data:

Data on “tobacco use” typically consists of information on:

- The prevalence of cigarette smoking by gender and age group
- The quantity of cigarettes smoked per day
- The prevalence of “spit” use by gender and age group
- The average age at which tobacco use began
- The percentage of smoke-free homes and worksites
- The ease at which adolescents are able to obtain commercial tobacco products
- The availability and use of cessation services
- The prevalence of Tobacco Industry marketing in the community
- And other related findings

If you do not have this data on hand, you can obtain some of this information from your health clinic (through RPMS) or other tribal programs (prevention, family services, A&D program, environmental department, housing etc), from your State or County’s tobacco control program, or from your regional tribal health board. Contact information for the regional tribal Tobacco Support Centers can be found in Chapter 11 of this workbook – they can provide you with information about accessing available data sources. Data collected at the State or County level may not be specific to your tribe, but will give you a reasonable ballpark to inform your decision-making.

If, after tapping these resources, you find that you are still missing information that would help in the decision making process, it might be necessary for your committee to conduct a formal or informal survey.

Formal surveys, such as the Adult Tobacco Survey (ATS), Behavioral Risk Factor Surveillance Survey (BRFSS), or Youth Risk Behavior Survey (YRBS), can provide you with very reliable, comprehensive information about patterns of tobacco use within your community. The down side of such surveys is that they are often time-consuming and expensive. Because the information generated from these tools can be of benefit to other programs as well, it might be useful to partner with other tribal health programs to carry out this task.

Informal surveys are conducted in a less scientifically rigorous manner, but can provide you with enough information to make an educated decision about policy change. You can conduct a brief, informal survey at a community event or gathering (such as a Powwow, feast, health fair, or rodeo) or at a specific destination (workplace, casino, restaurant, or school). For information about how to conduct an informal survey and appropriate questions to include, contact your local tribal Tobacco Support Center or the National Tribal Tobacco Prevention Network.

By pulling this information together, your policy change committee will be better able to identify areas of particular need, and determine which policies would make the greatest impact.

Community Readiness:

Once you have identified a few priority policy change options, the next question to pose is, “*Is the community ready for and supportive of this type of policy change?*” One way to do this is to assess the community’s readiness to change. This information, too, can be gathered in a formal or informal manner.

A typical readiness survey would assess:

- a) The community’s perception of whether or not “the problem” (adolescent tobacco use, exposure to secondhand smoke, Tobacco Industry marketing etc.) is a significant community problem.
- b) How important they feel “the problem” is.
- c) If they believe policy change is an appropriate way to address the issue.
- d) How committed they are to mobilizing to prevent “the problem.”

Such a survey can be conducted in a formal manner, with a scientifically selected sample of your community, or in an informal manner, asking community members at local community buildings or gatherings. For information about how to conduct a formal or informal community readiness survey, and appropriate questions to include, contact your local tribal Tobacco Support Center.

The Tri-Ethnic Center for Prevention Research also provides a useful handbook for assessing “Community Readiness,” which can be ordered free of charge. The guide was written to address tribal HIV/AIDS, but can be modified to evaluate any community health concern. Visit their website or contact:

Tri-Ethnic Center for Prevention Research

Sage Hall, Colorado State University

Fort Collins, CO 80523-1879

(970) 491-7902/Fax (970) 491-0527

Toll-free (800) 835-8091

www.TriEthnicCenter.ColoState.edu

As you conduct this type of investigation, it might be helpful to question community members about two or three different policies in order to better understand the types of actions they would support. Once gathered, this information can serve as a powerful tool for educating community members and decision makers.

If you find that community opinion does not support the policy you’ve proposed but you still feel it’s an important issue to address, it may indicate that more community education is needed on the issue. For example, many people are not fully aware of the health dangers associated with secondhand smoke and therefore don’t see it as a public significant issue. Once people learn more about secondhand smoke, their support for smoke-free polices will go up considerably.

Case Study: One Size Does not Fit All

By: Alfreda Beartrack

In 2003, the South Dakota Department of Health partnered with the Minnesota Institute of Public Health to conduct a *Community Readiness Survey* in three pilot communities. The reservation community of Lower Brule, South Dakota (approx. pop. 1,200) was one of the pilot communities selected. The purpose of the survey was to determine the community's level of readiness for prevention services targeting alcohol, tobacco, and other drugs (ATOD), and to assess their attitudes around different prevention strategies. By doing this, health program planners hoped to thoughtfully match prevention strategies to the needs of the community, rather than use a "one size fits all" approach.

Strategy:

The survey consisted of 52 questions within five domains:

(Domain 1) *Perception of an ATOD Problem within the Community*

(Domain 2) *Permissiveness of Attitudes toward ATOD Use*

(Domain 3) *Support for ATOD Policy and Prevention*

(Domain 4) *Adolescent Access to ATOD*

(Domain 5) *Perception of Community Commitment*

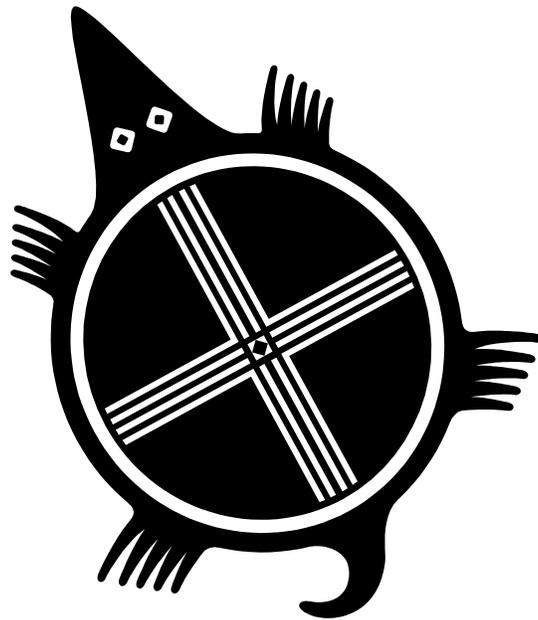
The survey methodology included several strategies to boost response rates. First, the survey was administered by members of the Lower Brule Tobacco Coalition at a community event, attracting ninety-four residents to complete the survey. Potential respondents were invited to read a letter from the Minnesota Institute of Public Health explaining the survey process and how the results would be used. A \$10 incentive was given to each participant that completed the survey. This allowed them to know that their contribution was acknowledged and appreciated. Secondly, "background buzz" was created in the community to rouse curiosity and interest, and provided additional information about why the survey was being conducted. And finally, the survey was anonymous.

Results:

The results of the survey suggested that the tribe did perceive alcohol, tobacco, and other drug use to be a community problem. In response, the tribe felt they needed to concentrate on raising the community's level of commitment. Respondents felt they needed to change community norms that permitted teen alcohol, tobacco, and other drug use, needed to generate community support for prevention, and needed to increase knowledge about youth access to alcohol and tobacco products. The data collected with this survey provided information that was useful for both community members and decision makers, and helped to create a guidepost for setting a vision for the future.

Using Data to Choose an Appropriate Policy Goal:

Once you have compiled information about your tribe's tobacco control priorities, patterns of tobacco use, readiness to change, and the availability of program resources, you will be ready to evaluate what types of policies will best meet the needs of your community. The next section of this workbook outlines the types of tobacco-related policies that are available to you. Once you have identified this and determined the policy format that will help you best reach your goal (covered in Chapter 3), you can skip through the workbook to the chapters that most interest you.





Step 5: Review Sample Policies



From preventing youth access to promoting adult cessation, tobacco policies can be drafted to achieve a variety of different outcomes. Arranged by the outcome goal, the following is a partial list of policies that you can consider:

Policies that Limit Exposure to Secondhand Smoke - Chapter 4

1. Prohibit commercial tobacco use in all public places.
2. Establish commercial tobacco-free spaces in and around tribal buildings or workplaces.
3. Establish commercial tobacco-free spaces in and around tribal vehicles.
4. Establish commercial tobacco-free spaces in and around tribal businesses.
5. Establish commercial tobacco-free spaces in and around tribal schools.
6. Establish commercial tobacco-free spaces in and around tribal daycares.
7. Establish commercial tobacco-free spaces in and around tribal parks.
8. Establish commercial tobacco-free spaces in and around tribal housing.
9. Establish smoke-free campus/property rules.
10. Incorporate secondhand smoke as an identified public nuisance in existing public nuisance policies/rules/laws.

Policies that Prevent Commercial Tobacco use by Youth - Chapter 5

1. Promote social, tribal, and familial responsibility for youth access to tobacco products. Protect youth from easy access to cigarettes at funerals, at social events, or from family members.
2. Prohibit the sale of cigarettes and smokeless tobacco products to those under 18 years of age by tobacco retailers.
3. Require all tobacco retailers to verify a customer's age.
4. Require the posting of warning signs to not sell tobacco to minors at all points of sale in all retail stores.
5. Prohibit or regulate the sale of tobacco products through vending machines.
6. Prohibit the distribution of free tobacco product samples at community events or at tobacco retailers.
7. Prohibit self-service tobacco displays. Require all tobacco products (cigarettes, chew, cigars, etc.) to be locked up and/or behind the counter.
8. Prohibit the sale of "Kiddie packs," packages of fewer than 20 cigarettes, and individual cigarettes at tobacco retailers.

Policies that Prevent Commercial Tobacco use by Youth - Chapter 5

1. Prohibit the sale of tobacco-like candies (such as candy cigarettes, bubble gum packaged like chew tobacco).
2. Prohibit the sale of “blunts” (sweetened cigarette wrapping papers composed of fruit and tobacco) and other youth targeted tobacco products (single sale cigarettes, bidi’s).
3. Make it illegal for retailers to display Tobacco Industry advertisements on tribal land.
4. Define appropriate placement of Tobacco Industry advertisements: For example, prohibit the placement of Tobacco Industry advertisements below 4 ft (from ground level) or near youth oriented products such as candy, toys, or magazines; Or, for every Tobacco Industry advertisement displayed by a retailer, an equal number of anti-commercial tobacco posters must displayed; Or, prohibit the display of outdoor tobacco ads within 1,000 feet of schools and playgrounds.
5. Prohibit tobacco-brand advertising at community events, Powwows, Rodeos, and sporting events.
6. Prohibit tobacco industry sponsorship of events and organizations.
7. Prohibit tobacco industry free or low cost tobacco industry related materials.
8. Deter the social sources of tobacco products for minors by making it illegal to provide commercial tobacco products to underage youth. (Similar to laws deterring the provision of alcohol to minors).
9. Increase the cost of tobacco through taxation. (See Chapter 7)
10. Establish a maximum number of tobacco retailers on tribal lands (such as communities that restrict the number of gas stations per 1000 people).
11. Prohibit clothing or other items that bear tobacco company/brand logos at schools and/or other community events/venues.
12. Require classroom or culture camp education on the difference between commercial tobacco use and sacred/traditional tobacco use.

Policies regarding Tobacco Taxation - Chapter 6

1. Establish a tax on the purchase of commercial tobacco products to decrease tobacco use by youth and adults.
2. Earmark a portion of new or existing tobacco taxes to benefit tobacco prevention and cessation activities.
3. Provide tax breaks or other incentives (such as reduced license fees) to retailers who choose to not sell tobacco.

Policies that Support Cessation in the Workplace – Chapter 7

1. Establish a tobacco-free Workplace. (See Chapter 4)
2. Create a sheltered “designated smoking area” outside that is away from buildings, entrances and exits.
3. Provide insurance coverage for the use of tobacco-cessation drug therapies.
4. Provide on-site community, intranet, or telephone-based counseling services.
5. Support/allow employee attendance at tobacco-cessation counseling sessions with designated healthcare providers.
6. Provide incentives for employees to remain free of commercial tobacco use.

Policies that Support Cessation in the Workplace – Chapter 7

7. Establish tobacco use policies for employees (ie no tobacco use on the job, healthcare incentives for those that don't use tobacco).
8. Provide incentives for employees who decide to quit commercial tobacco use.
9. Provide information about the benefits of quitting with invited guest speakers, in employee Newsletters or Paycheck stubs, or in other staff literature.
10. Provide self-help materials and information about local cessation resources to those seeking to quit.
11. Promote workplace health promotion and wellness activities.
12. Sponsor an on-site support group for recent quitters or those attempting to quit.
13. Participate in special events, such as the Native American Smokeout, World No Tobacco Day, or Health Fairs as a matter of policy.
14. Require education on the difference between sacred/traditional tobacco use and commercial tobacco use.

Policies at the Health Clinic that will help foster a tobacco-free community -- Chapter 8

1. Establish an office-based system of care for treating tobacco dependence, including a method for tracking and monitoring the tobacco use status of patients during each visit.
2. Establish a protocol for providing the “Five A’s” to all patients over the age of 6 (Five A’s: Ask, Advise, Assess, Assist, and Arrange).
3. Offer provider education and training on the use of the Five A’s, providing CME credit.
4. Reimburse providers who document the delivery of the “5-A’s.”
5. Provide group or individual cessation classes for tobacco-dependent patients, including appropriate follow-up.
6. Include nicotine replacement pharmacotherapies on the formulary available for clinic users.
7. Require health facilities to explore 3rd party resources to treat tobacco dependence. Medicare and other health plans are now more commonly reimbursing nicotine-replacement pharmacotherapies, especially when combined with participation in a cessation class.
8. Establish a clinic-based system to refer patients to the State Quitline, available cessation classes, or cessation specialists.
9. Display or distribute materials concerning the dangers associated with environmental tobacco smoke.
10. Display or distribute materials concerning cessation and available support groups.

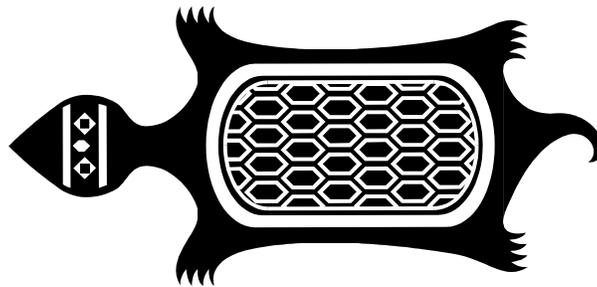
Policies that Limit Exposure to Secondhand Smoke in Casinos and Tribal Businesses – Chapter 9

1. Prohibit commercial tobacco use in all public places.
2. Establish tobacco-free spaces in and around Tribal Casinos.
3. Establish tobacco-free spaces in and around other Tribal Businesses.
4. Prohibit tobacco industry sponsorship and/or the display of tobacco industry logos/promotional materials in casinos.
5. Prohibit sampling of tobacco products, coupons, and promotional gear at casinos.

Policies to Encourage the Traditional use of Sacred Tobacco – Chapter 10

1. Create a traditional tobacco garden that is cared for and used by community members.
2. Encourage community members to use naturally grown tobacco for tribal events and ceremonies – discourage the use of commercial tobacco products during these activities.
3. Prohibit the receipt of funds or sponsorships by the Tobacco Industry for community events or tribal activities.

Each of these topics are discussed thoroughly in the remaining chapters of this workbook, and include policy templates, case studies, and examples implemented by Tribes from around the U.S.





Step 6: Demonstrate Need and Build Community Support



Once you identify the type of policy that you are interested in implementing, it is crucial that you initiate a plan to build community awareness about the problem you've identified and support for the solution you've designed. Experience has shown that people support or reject policy change based on their own unique values and beliefs. Because all people are not the same, different "Talking Points" will be needed to garner support from different groups within the community.

As you begin creating a plan, think about each of the stakeholders impacted by your policy, and the values that each group might hold. For example, council members might be influenced by arguments about the collective health or economic well being of the tribe, while parents may be influenced by stories addressing the health of their children. Businesses may be influenced by arguments addressing their profitability and the productivity of their staff, while health professionals might be influenced by data suggesting reduced morbidity and mortality rates.

During this planning period, think critically about the concerns that each of these groups might have with your policy. In order for your policy to gain support, you will need to respond to their concerns. Anticipate their questions and use the "Talking Points" included in each chapter to help build approval for your policy. Whenever possible, your own tribal or local data should be used to replace national figures.

Whenever possible, your own tribal or local data should be used to replace national figures.

Endorsements from local leaders, businesses, or health professionals should also be publicized in order to strengthen community buy-in. In building support for your policy, consider initiating one-on-one meetings with decision makers, organizing staged media events with the local newspaper or radio station, writing articles for the tribal paper, and providing brief presentations to affected stakeholder groups.

Health Advocacy:

For help and ideas planning effective community advocacy, visit Chapters 30-35 of the *Community Toolbox*, which is available online through Kansas University at: http://ctb.ku.edu/tools/en/tools_toc.htm. Part I discusses “Organizing for Effective Advocacy,” and has a number of helpful suggestions and examples.

For additional assistance regarding media advocacy, download the American Public Health Association’s Media Advocacy Manual at:

http://www.apha.org/news/Media_Advocacy_Manual.pdf.

Remember, tobacco policies are not designed to force smokers to stop smoking, and they do not blame the tobacco user for his or her addiction. All of the policies included in this workbook are designed to improve the health and wellness of tribal members.

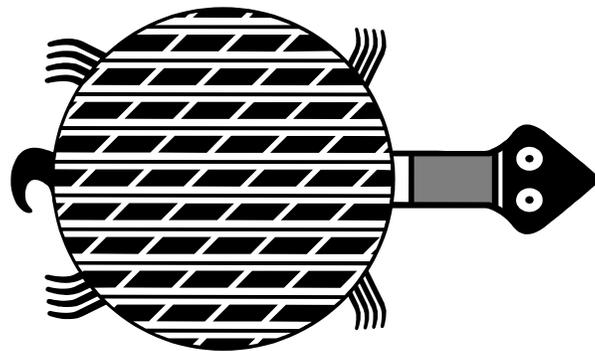
Petitions:

Petitions allow individuals, community groups, and organizations to participate fully in the decision-making process, by raising issues of public concern with the Council and allowing them to consider the need for change. By encouraging community members to sign a petition, you can build community awareness about a newly proposed policy, generate thoughtful discussion about the topic, and demonstrate strong community support. Generally, any person or group can submit a petition to the Tribal Council.

In order to be considered, your Council may require that the petition meet certain specifications. Check with your Council Secretary to see what elements are required. Often, they must clearly display the following information:

- (a) A description of the policy change being proposed
- (b) The name, address, and signature of any person supporting the petition

Use community gathering places, workplaces and events to encourage tribal members to sign your petition. Youth groups can also be involved in collecting signatures.





Step 7: Draft A Policy



Using the policies available in this book as a guide, the next step will be to produce a draft of your own policy. There are several elements that can be found in nearly every tobacco-related policy: (1) a section discussing why the policy is needed, (2) a section highlighting the physical, economic, and/or social benefits of the policy, (3) a clear description of the policy and how it will rectify the problem, (4) the date the policy will go into effect, (5) the penalty for infractions, and (6) a process to enforce the policy.

As you begin to draft your policy, check to see that the following elements are included:

Checklist for a Tobacco Policy

- Includes a statement regarding the local tobacco problem.
- Provides information regarding the health incentives for adopting the policy.
- Provides information regarding the economic incentives for adopting the policy.
- Provides information regarding the social motivations for adopting the policy.
- Description of the policy, clearly stating how the problem will be addressed and what actions will be implemented.
- Gives the date the policy will become active.
- Includes provisions for Smokeless or Chew Tobacco.
- Indicates penalties for infractions -- there should be different consequences for first time offenders and repeated offences.
- Defines who will manage and/or enforce the policy.

You may borrow language from the policy templates that are found at the end of Chapters 4-10, to serve as a guide when drafting your policy.

Common Tobacco Policy Definitions:

In order to clarify the intent of your policy, you will need to clearly define the elements discussed in the policy checklist. Here are some common definitions for your use. Feel free to alter them to meet the needs of your community, policy, or situation.

Locations affected - All tribal buildings, future buildings, individual offices, schools, daycares, parks, recreation centers, tribal events and community gatherings on the _____ Tribe _____ reservation will be subject to this policy.

Commercial Tobacco Products - The use of commercially produced cigarettes, bidis, cheroots, stogies, cigars, pipe and other smoking tobacco, snuff, snuff flour, plug and twist tobacco, smokeless, spit, chew, fine cut and other chewing tobacco, shorts and other kinds and forms of tobacco, prepared in such a manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for chewing and smoking are all subject to this policy. Because smokeless tobacco is just as addictive as cigarettes and causes cancer of the throat and mouth, all forms of smokeless tobacco are also restricted by this policy. This policy is not intended to restrict the use of traditional, sacred tobacco.

Cigarette - Means any roll for smoking, made wholly or in part of tobacco, irrespective of the size or shape, and irrespective of the tobacco being flavored, adulterated, or mixed with any other ingredient, where such wrapper is wholly or in the greater part made of paper or any material, except where such wrapper is wholly or in the greater part made of natural leaf tobacco in its natural state.

Tobacco-free Radius - Commercial tobacco use will not be permitted within 50 feet of any tobacco-free building to prevent children from being visually exposed to commercial tobacco use, and to prevent smoke from entering buildings through windows or doors.

Reservation - Means lands lying within the boundaries of the _____ Tribe Name _____ as established by the _____ Treaty _____ by Executive Order on _____ Date _____.

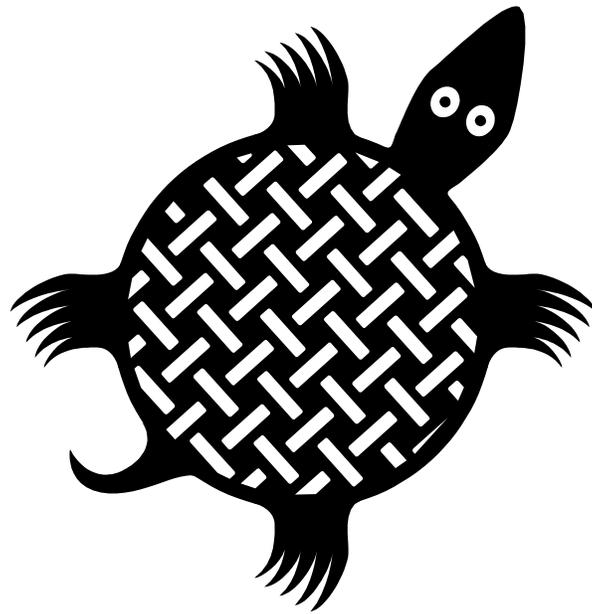
Retailer or Seller - Refers to any person(s), association(s), corporation(s), partnership(s), or other enterprises engaging in any manner of selling, trading, exchanging, or bartering cigarettes or other tobacco products for consideration on the _____ Reservation _____.

Tobacco sales - Includes any transfer of the ownership of, title to, or possession of property; exchange; or barter in any manner or by any means whatsoever for consideration by any person, association, partnership, corporation or enterprise of cigarettes or other tobacco products. It includes a gift made as a means of evading the provisions of this ordinance.

Tobacco sales price - Means the retail price at which any tobacco product herein defined is sold to the consumer before any taxes are imposed on it.

Tobacco Promotional Products - Means baseball caps, tee-shirts, gym bags, lighters, coffee mugs, sunglasses, jackets and related items that have tobacco advertising, logos, images, characters, messages, and/or themes printed on them.

Writing a tobacco policy draft doesn't take too long, maybe an hour or two. Once complete, it will probably take at least three more months to get your policy ready for passage. If you are new to this process or would like additional support, contact a council member or tribal lawyer to help guide you through this process. It may be helpful to have them check the format and content of your policy before distributing it to others.





Step 8: Obtain Feedback



Getting feedback on one or more drafts of a policy is important, and often takes longer than expected. After a tobacco policy has been drafted, distribute it to key individuals for their review. Individuals to consider for feedback include the tribe's general manager, tribal health director, community health representatives or public health nurses, other medical personnel, the tribal chair, a tribal lawyer, and those who will be expected to enforce the policy. Also include community members that are likely to have strong opinions about the policy, including smokers, youth, or business owners. Some people may not feel comfortable providing written comments, so it may be best to contact them in person to discuss their thoughts. For those with concerns about the policy, you can also use this opportunity to answer questions and discuss possible compromises or alternate solutions. If you work together to address their concerns in a positive way, these individuals may turn out to be active supporters of the policy.

In addition to the groups mentioned above, your regional tribal Tobacco Support Center, tobacco prevention program(s), and State Tobacco Program are also available to help review and provide feedback on your policy.



Step 9: Revise as Necessary

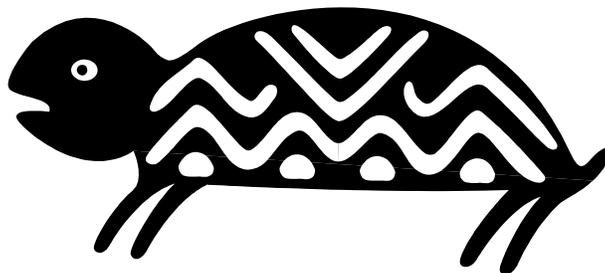


Consider all of the input provided by community members and make any necessary changes to the policy. Not all comments can be used, so consider how you will address any suggestions that are not eventually implemented.

During these discussions, you may find that only small changes to the policy are needed. It is also possible that you find that a different policy is needed to achieve strong community support. Decide as a group whether it is more beneficial to retain your original policy (and then spend additional time building community support), or whether it is more realistic for you to shift your focus to a different type of policy.

If you are working with a committee, discuss each revision point with other committee members. After the final revisions are made, the policy should be ready for approval by the tribal council (or whomever will be making the decision).

Even if your entire committee agrees on a particular policy, it is possible that additional changes may be required by your tribal leadership or those in legal services. Continually educate decision makers about the need for and benefits of your policy.





Step 10: Pass the Policy



Depending on the type of policy you have designed, the decision to implement the policy may involve the Tribal Council, an employer, a personnel committee, a CEO, or some other authority figure. Advance notice may be needed to get on their agenda, so be prepared for this step to take a little time.

Consider who will be the most effective spokesperson for your audience. It may be someone with experience presenting to this group, someone with an established rapport with the group, or a youth group that has spent time working on this issue.

If possible, attend a meeting held by the deciding body prior to your presentation, so that you are familiar with the process and their expectations. Practice your speech so that you feel comfortable with the material you plan to cover and the time limit you are given. Determine which talking points are most important to the decision makers, and focus on those. Just as you did when building community support, anticipate any concerns they might have and address them in the body of your presentation.

If your tribe is making a profit from tobacco sales, contrast the tribe's profits with the economic cost of tobacco-caused death and disease. If the tribe is profiting from this enterprise, suggest that they consider using a portion of the money to create tobacco prevention or cessation programs.



Step 11: Enforce the Policy



Putting your policy into action and informing all tribal members of the changes will also take time – it is best not to rush through this step. Plan to announce the policy at least one month before it will take effect, maybe more. Time will be needed to post NO SMOKING signs, develop new protocols, or make other necessary changes. Your policy committee, or a new implementation committee, will be needed to help facilitate this process.

Choose a Date:

Choose a realistic date for the policy to begin. Some tribes have used the date the policy passed as a council resolution. Other policies have started at the beginning of a new year, similar to a New Year's resolution. More attention can be drawn to the policy by introducing it during a major tribal event or during the Native American Smokeout (November 20th of each year). Choosing a date early will help the committee establish a planning schedule.

Enforcement:

Your tribe should treat commercial tobacco use just as you would any other health or safety issue.

Like the policy itself, enforcement should be designed to fit the needs of your tribe. In the Northwest, smoke-free zone infractions have varied from strict fines to friendly reminders. With appropriate signs and lead-time, tribes found that violations were rare. When the majority of the community agreed with the policy, a friendly reminder to those in violation was all that was needed to correct problems -- simple social pressure was sufficient. Tribes commonly included verbal or written warnings followed by fines or classes, if necessary. Visibly posted information about the policy change can help reduce confusion and conflict.

It is also important to identify who will be responsible for handling violations, and then train them about their expected response. A tribal department, agency, or committee will likely oversee the enforcement of policies that affect tribal business, such as those that restrict the sale or purchase of products, those that restrict advertising, or those that increase taxes. To support the work of this department, offer to provide training or assistance throughout the transition.

When designing the consequences that will be used on those who break the policy, make sure that the penalties are realistic and can be truly be enforced. If you were to develop an unrealistic penalty – i.e. required attendance at a tobacco education class, when you know it would be impossible to provide a sufficient number of instructors to cover your large geographic region – people may be hesitant to enforce the new policy. The policy will only be effective if those who enforce the policy can realistically perform that activities needed. If you will need tribal police, business owners, or teachers involved with enforcement, be sure to work with them to develop realistic penalties.

Finally, decide how general complaints about the policy will be handled. Widely publicize the policy in Newsletter articles, and present it at meetings where the policy is discussed. Most often, complaints about the policy generally subside after the policy has been in place for a few months.

Increase Awareness about the New Policy:

Consistent communication regarding the new policy to the tribe is essential. Holding a community meeting in conjunction with a health fair or other community gathering can get the message out to the tribal community. Each tribe must use its own resources and ideas to identify the methods that work best for their respective cultures. Listed are several common ways of notifying members.

Signs: Simple signs can be an effective way to educate about the policy change, especially messages or signs that are culturally relevant and resonate with the community:

- This is a Tobacco-free Building
- Thank you for Not Smoking
- If you smoke, please do so in a designated area.
- This is a Tobacco-free School
- It is illegal to purchase tobacco products for youth age 17 or younger
- Tobacco products will not be sold to people under 18 years of age
- Keep tobacco Sacred
- Use tobacco in a Sacred Way

Signs are a useful and low cost way of informing people about a new policy. Signs warn and remind community members about the tribe's expectations for behavior. You can get some signs free or at low cost from the American Cancer Society, American Lung Association, or American Heart Association (see the Resources section). For information about culturally appropriate signs, contact your regional tobacco Tribal Support Center. You can also choose to create your own, integrating community artwork or designs.

To provide consistent messaging within and between tribal communities, it may be useful to replicate a single sign format or message, which would also help stretch limited resources. Consult with your local tribal Tobacco Support Center, state Department of Health, or other state agencies if this is of interest to you.

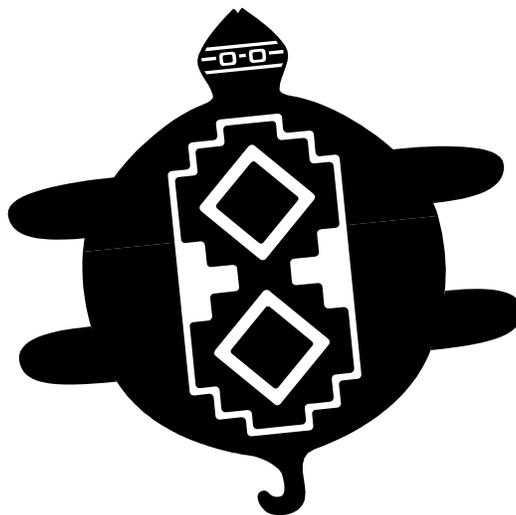
Posters/Pamphlets - Many excellent culturally sensitive materials are available for free or at very low cost (see the Resource section). You can also consider having a poster contest for tribal youth. This will inform families of the new policy while providing wonderful artwork to decorate community areas.

Tribal Newsletter - Tribal Newsletters are an important channel for communicating about the tribe's new policy change. It could be helpful to place an article or a notice at least twice in the local newsletter before the start of the policy and then write a follow-up article after the policy has been passed. A series of articles about tribal members who have successfully stopped smoking are a good way to draw attention to their accomplishments and simultaneously inspire other smokers to quit.

Meetings - Meetings are a great way to announce a new policy. A brief statement can be made that outlines the social harms and health risks associated with exposure to commercial tobacco. Additionally, a meeting is an excellent avenue to gather community input and support. At these meetings, the tribe can announce how the policy will be enforced and the date of the policy will go into effect.

Statement on Tribal Letterhead - Tribal stationary that includes a statement supporting the new policy can serve as a constant reminder.

Written Copies of the Policy - The tribal policy may be short. This will make it easier to publish in newsletters, post in appropriate places, or even distribute in mailings.



Provide Help to those Wishing to Quit:

For policies that create or enlarge tobacco-free areas, the committee should also provide information and referrals for those who want to quit smoking or chewing tobacco. By offering help, you show concern for tobacco users. Helping smokers quit is also referred to as “cessation.”

Remember, nicotine is more addictive than heroine or cocaine. It is very likely that smokers in your community will have to “quit” on more than one occasion. The average smoker quits seven times before successfully quitting for good. Be supportive of this challenging process - Each try will better prepare them for their next attempt!

One option is to advertise telephone help-lines that guide users through the quitting process. Research has shown that the use of a quitline can significantly improve a smoker’s chances of quitting successfully. These services are free and available to all, and many can provide both written materials and individual counseling.

United States National Quitline 1-800-QUITNOW

The toll-free number (1-800-784-8669) is a single access point to the National Network of Tobacco Cessation Quitlines. Callers are automatically routed to a state-run quitline if one exists in their area. If there is no state-run quitline, the call goes to the National Cancer Institute (NCI) quitline.

Web site: www.smokefree.gov - offers online advice and downloadable information to make cessation easier.

The Smoking Quitline of the National Cancer Institute 1-877-44U-QUIT

Contact them for:
Help with quitting smoking
Answers to your questions
Informational materials
Other resources

By telephone:
1-877-44U-QUIT
TTY: 1-800-332-8615

NCI's Smoking Quitline is available to answer cancer-related questions
Monday through Friday, from 9:00 to 4:30 local time.

The National Cancer Institute provides materials and individual counseling every Monday-Friday, from 9:00 to 4:30 local time. This service is free and available to anyone. In addition to this service, many States also have their own “Quitlines” available for residents. For more information on telephone support available in your state, visit: <http://www.smokefree.gov/> and then click:

 [Telephone support in your state](#)

To ensure your state’s quitline proves culturally appropriate counseling to American Indian and Alaska Native callers, training is available to Call Center staff members through the California Rural Indian Health Board (Contact information is available in Chapter 11).

Your tribal clinic, drug and alcohol counselors, CHRs, or tobacco program coordinator may also provide stop-smoking classes or nicotine replacement therapies (such as the Gum, Patch, Spray, Inhaler, Zyban, Wellbutrin, or Bupropion). If there is enough interest, you can begin a stop-smoking class close to the start of your policy.

Particularly effective among tribal members, the Second Wind Cessation Curriculum is a six-session group cessation program designed for American Indian and Alaska Native communities. The curriculum was designed by Cynthia Coachman of the Muscogee (Creek) Nation, and can be used free of charge. To obtain a copy, please contact:

Cynthia Coachman, RN
Muscogee (Creek) Nation
Tobacco Prevention and Control Program
1801 East 4th St (Lackey Hall Building)
Okmulgee, Oklahoma 74447
1-800-782-8291 Ext. 287
cynthia.coachman@mail.ihs.gov

In addition, the National Partnership to help Pregnant Smokers Quit has a list of cessation programs and resources for pregnant women, which can be found at:

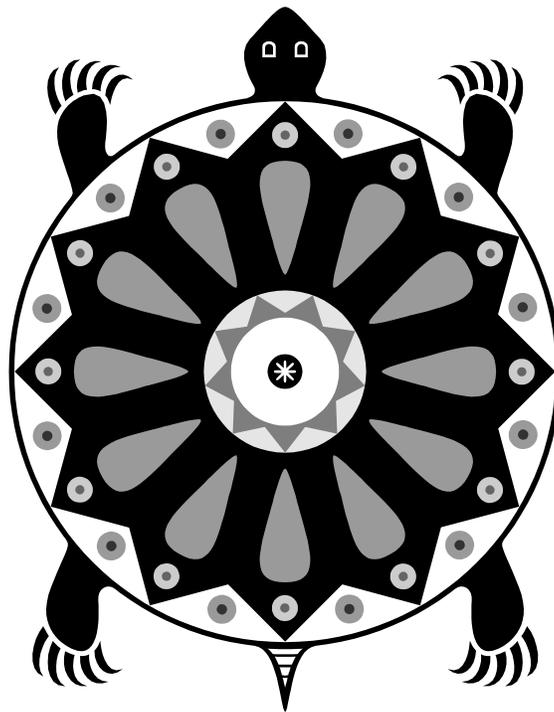
<http://www.helppregnant smokersquit.org/care/partnerprod.asp>

Numerous websites also provide on-line cessation support, including: www.quitnet.com; www.quitsmoking.com; the American Lung Association (at www.lungusa.org); and the Center for Disease Control and Prevention (at www.cdc.gov/tobacco/how2quit.htm).

At a minimum, make self-help materials such as booklets or manuals available to community members affected by the policy change. There are many good materials available at little or no cost, and some that are written specifically for Indian people. To locate materials and more information in your state, visit the “Resources” chapter in this guidebook.

Encourage Success:

Acknowledge the success of tribal members who stop smoking. This is an incredible accomplishment -- Tobacco use can be harder to quit than heroine or cocaine! Think of ways your culture would traditionally honor a persons' achievements. Can you recognize those who quit in this way? You can also honor them by printing an article in the tribal newsletter, giving them certificates of achievement, or by placing their names and pictures on a tribal bulletin board. Having a general recognition ceremony during the Native American Smokeout is another way to congratulate people who have defeated commercial tobacco addiction.





Step 12: Evaluate the Policy



Evaluating Tobacco-Free Spaces - Some policies are easier to evaluate than others. Secondhand smoke policies are usually fairly easy to assess, requiring you to visually check periodically to see how the policy is working. This could involve:

- Visiting Non-Smoking areas regularly.
- Checking that appropriate signs are kept in place.
- Tracking complaints to how many are generated.
- Tracking complaints to see if they diminish over time.

Many states regularly conduct a BRFSS survey (behavioral risk factor surveillance system). The results of this survey can also be accessed to help evaluate outcomes of policy implementation.

Evaluating Clinic-based Policies - Clinic-based policies, on the other hand, can be more challenging and time intensive to assess. In collaboration with clinic personnel, determine which outcomes would be most valuable and feasible to assess. Possible outcomes might include measures such as:

- Percentage of staff who have been trained to provide the 5-A's
- Percentage of charts that document the patient's tobacco use status – requires that chart audits are done on a routine basis to check if documentation is done
- Number of patients provided NRT's per month
- Number of cessation referrals provided per month
- Number of tobacco-related brochures distributed to patients per month

During this discussion, determine if there are any tracking systems already in place that could help generate this information. Of not, identify how the data will be gathered, who will gather it, and how often this assessment will take place.

Evaluating Youth Access Policies - Policies that affect tobacco retailers also pose a unique challenge. Consider partnering with local law enforcement personnel to periodically conduct retailer compliance checks. If your policy has established consequences for the underage purchase of tobacco products, you can grant teens immunity from the law while conducting a “sting” operation.

Compliance check protocols, forms, and evaluation tools are available from the Washington State Department of Health, and can be used as models for your program. For assistance in developing tribal specific materials, contact the Washington State Department of Health at 360-236-3643 or

<http://www.doh.wa.gov/Tobacco/compliance/youthaccess.htm>

Policies restricting the placement of tobacco products and advertisements in stores can be evaluated with a program called “Operation Storefront.” This activity was developed to “document the placement and number of cigarette and smokeless tobacco brand advertising in stores in local communities in Washington State.” While some of the materials may need to be adapted to the particular restrictions your tribe has enacted, their tools can provide an excellent starting point.

Operation storefront materials, protocols, forms, and evaluation tools are available from the Washington State Department of Health, and can be used as models for your program. For assistance in developing tribal specific materials, contact the Washington State Department of Health at 360-236-3643 or

<http://www.doh.wa.gov/Tobacco/compliance/youthaccess.htm>

Once again, take the time to determine how efficacy data will be gathered, who will gather it, and how often this assessment will take place.

Committee member communication should not stop with the start of the policy. The tobacco policy committee should continue to submit occasional Newsletter articles, make community announcements, and post reminders such as signs or posters. The tribal business manager or another designated person can use council meetings as opportunities to invite comments or complaints from smokers and non-smokers.



Common Challenges and Barriers to this Process



Our experience has shown that there are at least two common barriers and obstacles that are faced when developing policy. The first challenge is often finding the time and manpower to initiate the process; others struggle to find the right place to begin. Fortunately, this guide was written to help minimize these barriers. One step at a time, begin the processes described in this chapter. Start to seek partners who are willing to help tackle this issue and formulate a plan. While it may take a while to see your policy enacted, this undertaking will be well worth the effort!

The second challenge is the mistaken belief, held in many communities, that tobacco use isn't a priority problem. With limited funds, growing concerns about obesity and diabetes, and a hundred other health issues vying for our attention, it is sometimes difficult to convince decision makers that tobacco use is a significant issue -- Particularly while it remains the norm in Indian Country. To overcome this challenge, we must strive to raise our community's level of awareness about tobacco. Use the data in Chapter 1 and the "Talking Points" included throughout this guide to demonstrate the magnitude of this issue. Share personal stories and the stories of loved ones impacted by tobacco related diseases. Continue to remind community members that:

- Nearly 40% of the deaths in Indian Country are related to or caused by commercial tobacco.²¹
- The IHS now spends over \$200 million dollars a year to treat tobacco-related death and disease.⁴
- Those who smoke die 7-10 years earlier than those who do not; Commercial tobacco thus robs our community of the culture, wisdom, and relationships shared by our elders.²²
- And of greatest importance -- With action, all of these problems can be prevented!

Tribal councils are responsible for a great deal of oversight (including economic development, gaming, housing, education, and community health) with limited time and resources. In light of all this, it is not surprising that tobacco abuse is often overlooked. During meetings with decision makers, it is important to validate the importance and urgency of all the other issues faced by tribal leadership. To make tobacco policy a priority, let tribal leaders know that tobacco policy is an effective and lasting tool to improve the health of the tribe. A relative short-term investment by decision makers can result in better health for generations to come.

Following these steps, you and your committee are now ready to think about the types of policies that are available for your use.

Chapter 3: Drafting the Right Policy



Choosing the Right Policy



After assessing your data and identifying the priority tobacco needs within your community, have your committee choose an issue that is of greatest concern. Next, brainstorm actions that your community could take to respond to this concern. There is no single answer to any one problem. Secondhand smoke, youth access, cessation services -- Each can be dealt with in a variety of ways, both formally and informally. Be creative, only you know best what would work for your community.

As you generate this list of possible solutions, think about the benefits and challenges associated with each option. Discuss which options are realistic and can be feasibly achieved. Consider the resources and expertise that you and your committee have to lend to this project, and the personal interest of those who are involved. Consider what role, if any, tribal agreements with state government have on the policies you discuss. Tobacco taxes, for instance, may be impacted by tribal-state contracts or compacts (Check with a tribal attorney if you are unsure.).

Above all, choose an issue that you are passionate about and that you feel personally committed to.



Types of Policies



It is now time to determine what “type” of policy will be most appropriate for your community’s needs. In the most general sense, there are two types of policies: formal and informal, each having their own advantages and disadvantages.

Formal Policies:

Formal policies include tribal resolutions or ordinances, memos or rules that are included in personnel and program operation manuals, and school or business policies that are written or posted. Formal policies are often more likely to remain consistently enforced regardless of personnel turnover, and are thus more likely to continuously safeguard the health of future generations. While such a policy provides obvious merit, it does bring with it additional burdens. Formal policies often require a significant dedication of time and energy in order to research, write, educate about, advocate for, pass and enforce rules that are new to the community.

This level of formality is often required when creating tobacco-free buildings, schools or workplaces, when obtaining employer support for employee cessation, when increasing taxes on commercial tobacco products, when regulating adolescent access to tobacco products, or when reducing youth exposure to tobacco industry advertising and promotions.

Tribal Council Resolutions - To effectively realize change, it might be necessary that you request a Tribal Council resolution adopting your policy. A resolution is a formal tribal endorsement of the policy. It reinforces the importance of an issue within the community, and provides an opportunity for open discussion about possible solutions. Obtaining a formal resolution will help call attention to the policy and will institutionalize the policy as tribal law.

A council resolution or ordinance will likely be needed to create tobacco-free spaces, to increase taxes on commercial tobacco products, to regulate adolescent access to tobacco products, and to reduce youth exposure to tobacco industry advertising and promotions.

If you are not familiar with your own tribe’s protocol for how policies are written and passed, talk to someone who can walk you through this process. You will find numerous examples of tribal tobacco policies in the remaining chapters of this workbook, but each tribe’s formats and processes are unique and must be respected.

Workplace Policies - Workplace-based tobacco policies are critical to the health of workers and patrons. Policy change within the workplace requires the support of employers or managers, and can be instituted through changes to personnel and program operation manuals, protocols, or through less formal processes including casual agreements, memos, or letters to employees.

Workplace-based tobacco policies can include: tobacco-free spaces, insurance coverage for tobacco-cessation drug therapies, on- or off-site cessation support, incentives to quit or remain free of commercial tobacco use, the distribution of health and cessation information, and support of employee wellness activities and events.

Information provided in Chapter 8 will guide you through this process.

Clinic Policies - Likewise, clinic-based tobacco policies are tremendously important in the battle against tobacco-related death and disease. Systems to treat tobacco dependence are strongly endorsed by the medical community, and effectively reduce commercial tobacco use within the clinic population.³² Most changes to a clinic's current system of care will require the development of new protocols, which will be added to personnel and program operation manuals.

Information provided in Chapter 9 will help walk you through this process.

Informal Policies:

Informal policies, on the other hand, sidestep the formal policy-change process and consist of unwritten agreements or behavior expectations. Informal policies can be easier and less time-consuming to establish, but may be less sustainable and more difficult to enforce. Informal policies can be useful for establishing tobacco-free community events or public places. For example, some communities have posted signs in parks that read "*Thank you for not to smoking here*" without having passed any formal policies making the action illegal; Others have established substance-free Powwows and community gatherings by meeting with event organizers. Informal agreements can also be effective when conducting retailer education programs seeking to trade "Tobacco Industry" advertisements for more "health-friendly" materials.

Informal policies can set the stage for healthy social norms, and may be your first step in working towards a more formal policy. If your committee chooses to work towards an informal policy, schedule a meeting with the individual or group responsible for making a decision. Come prepared with a clear description of the problem you are trying to address, the solution that you would like to see implemented, and "talking points" that list the beneficial outcomes achieved through your policy change. Just as you would for a formal policy, anticipate potential concerns and provide appropriate solutions. Work together to reach consensus, and be prepared to provide additional support to ensure the policy is implemented. This may require that you initiate follow-up, provide additional training, or maintain on-going contact with key personnel.



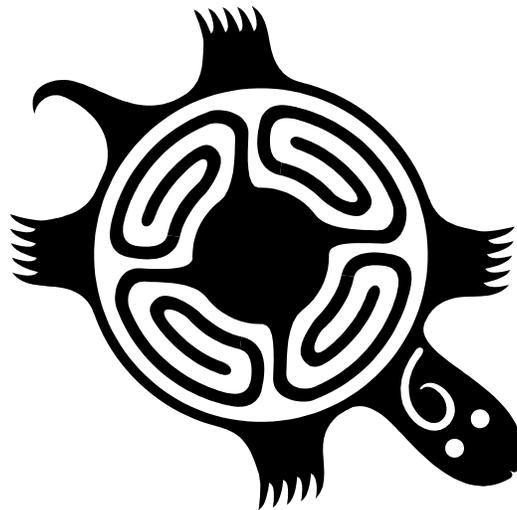
Moving Forward with this Guide



After journeying through the first three chapters of this workbook, you are now prepared with the foundational skills needed to pass any type of tobacco policy. Feel free to skip ahead to any of the chapters that are pertinent to the work that you are doing. In each you will find policy-specific background information, templates, case studies, and talking points.

If you have any questions or concerns along the way, please feel free to contact your regional tribal Tobacco Support Center. Contact information is available in Chapter 11.

Good luck in this endeavor!



SECTION 2: TOBACCO RELATED POLICIES

Chapter 4: Secondhand Smoke Policies	85
Chapter 5: Youth Prevention Policies	115
Chapter 6: Tobacco Tax Policies.....	141
Chapter 7: Workplace Cessation Policies.....	175
Chapter 8: Clinic-based Policies.....	191
Chapter 9: Secondhand Smoke Policies in Casinos & Large Businesses.....	235
Chapter 10: Traditional Tobacco Policies.....	273



Using this Guide

While the length of this guidebook may look intimidating, take heart, it is not meant to be read in its entirety! Please read Chapters one, two and three, which will provide you with information about tobacco and the steps involved in policy change. Once you have chosen a policy topic of interest, you can then skip ahead to that chapter. When read in conjunction with Chapters 1-3, Chapters 4 through 10 may be read independently.

Chapter 4:

Policies that Limit Exposure to Secondhand Smoke



The Purpose of Tobacco-free Spaces



Establishing commercial tobacco-free spaces might just be the most important thing you can do to protect the health of your tribe. Cigarette- and chew-free spaces provide five significant benefits to the community:

First - Commercial tobacco-free spaces protect community members from the deadly effects of secondhand smoke, especially those who are most vulnerable, including children, elders and people with respiratory conditions. Secondhand smoke is the third leading cause of preventable death in the U.S. (smoking is first, followed by obesity), and takes the life of one non-smoker for every sixteen smokers.³³

Secondhand smoke is comprised of exhaled “mainstream” smoke and noninhaled “sidestream” smoke, and many of its 4,800 chemical components have been labeled “hazardous” by state, federal, and international agencies. To date, over 69 compounds in tobacco smoke have been identified as carcinogens, 500 as poisons, and six as developmental or reproductive toxicants.³⁵ Research has determined that there is no safe level of exposure to secondhand smoke, and that even well designed ventilation systems cannot eliminate exposure to the poisonous and carcinogenic chemicals it contains.³⁶

Secondhand smoke kills approximately 65,000 nonsmokers in the U.S. each year.³⁴

Secondhand smoke causes cancer in both children and adults, and aggravates asthma and respiratory problems. This exposure is particularly problematic among infants and children, whose lungs have not fully developed. Secondhand smoke reduces lung function in young children, and significantly increases their risk of developing respiratory illness.²² According to the Environmental Protection Agency (EPA), “there is now sufficient evidence to conclude that passive smoking is associated with additional episodes and increased severity of asthma in children who already have the disease.”³⁷ Among adults, nonsmokers can experience coughing, phlegm, chest discomfort and reduced lung function when exposed to secondhand smoke.

Also of concern, tobacco smoke contains high levels of carbon monoxide, a chemical found in car exhaust. When inhaled, carbon monoxide replaces the oxygen in the blood stream, starving the heart, lungs, brain, and other vital organs of needed oxygen. Consequently, long-term exposure to secondhand smoke has been shown to cause a 30% increase in the risk of coronary heart disease in nonsmokers, and may increase the chance of suffering a stroke.³⁸ Exposure to secondhand smoke also negatively affects cardiovascular health by decreasing endurance for exercise, damaging blood vessel walls, and increasing the tendency of blood platelets to clot, all contributing to heart attacks.³⁹

Second - Commercial tobacco-free spaces reduce children's exposure to adults modeling unhealthy behaviors. It comes as no surprise that our community's adults, parents and elders are the most influential role models in the lives of our children. From toddlers learning to clap to adolescents learning to drive, young people see and emulate adult behaviors. As commercial tobacco use has increased among adults, so too has this behavior risen among youth. Because of this, over half of young smokers have parents who smoke, and teens are three times more likely to smoke if a parent or sibling smokes.²⁶

By reducing children's exposure to adults modeling commercial tobacco use, the tribe sends a clear message to young people that it is not acceptable to participate in this activity. This action can help reduce social pressures to smoke and use chew, and will protect youth from the grips of future addiction.

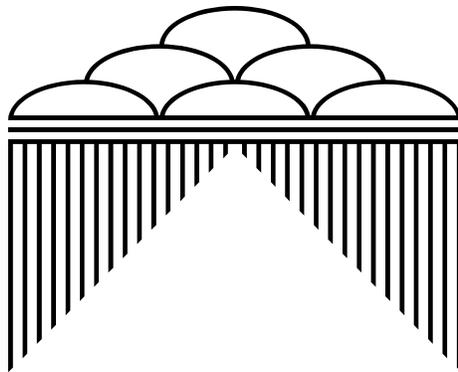
Third - Commercial tobacco-free spaces provide support to those who are choosing to quit. In community polls, over two-thirds of smokers in the U.S. say that they wish they could quit, and 80% say that they wish they had never started.⁴⁰ Clean indoor air policies prompt smokers to quit, and increase their success rate when trying. According to the Institute of Medicine, a 1996 review estimated that smoke-free workplaces reduced the number of smokers by 5% on average (meaning that more than one in five smokers quit, as smoking prevalence is over 25%) and reduced use among continuing smokers by 10%.⁴¹ Another review attributed almost 13% of the drop in tobacco use in the United States between 1988 and 1994, to smoke-free workplace policies.⁴¹ Creating smoke-free spaces reduces tobacco use among smokers while reducing involuntary smoking by nonsmokers.

No smoking policies also reduce the number of cigarettes that continuing smokers consume. According to Philip Morris' own research, smokers facing restrictions consume 11%-15% fewer cigarettes than average and quit at a rate that is 84% higher than average.⁴² Milder workplace restrictions, such as those that allow smoking in designated areas, are less effective at increasing quit rates and have very little effect on consumption.⁴²



Fourth - Commercial tobacco-free spaces save limited tribal dollars. Tobacco-related health concerns increase healthcare costs, increase business costs, and reduce the number of years people can economically contribute to the health and wellness of their community. When calculated for each adult smoker, financial costs amount to nearly \$1,760 in lost productivity and \$1,623 in excess medical expenses for each and every smoker – totaling \$3,391 per smoker per year.²⁹ Consequently, the Indian Health Service estimates that it spends about \$200 million dollars annually to treat tobacco related diseases.⁴ All told, commercial tobacco use Nationally elicits “approximately \$157 billion in annual health-related economic losses.”²⁹

Secondhand smoke in the workplace also contributes to significant costs for local businesses. Men who smoke are absent from work 4 days more per year than men who do not smoke, and women who smoke are absent from work 2 days more.⁴³ Smoke in the workplace damages property and increases cleaning costs by an average of 10%. Tobacco use in the workplace also increases an employer's potential legal liability for non-smoking employees. Studies estimate that secondhand smoke damages the health and reduces the productivity of nonsmokers, costing employers an estimated \$56 - \$490 per smoker per year.⁴³



Fifth - Commercial tobacco-free spaces protect the environment. Tobacco use is not just a health issue; it is also an environmental issue. Tobacco cultivation rapidly depletes nutrients from the soil and requires extensive use of herbicides, pesticides, and other chemicals. Tobacco use also contributes to air pollution, deforestation, and increases in landfill.⁴⁴

Because cigarettes are wrapped in paper and sold in packs, the cigarette manufacturing process requires a great deal of paper and therefore endangers precious forest resources. Tobacco curing is the single largest commercial cause of deforestation worldwide, destroying around 8.55 million acres of forest each year. In most developing countries, fuel wood is used for curing and this process requires about one tree for every 300 cigarettes.⁴⁴

And each year, smokers throw out 4.5 trillion NON-BIODEGRADABLE cigarette butts – amounting to 8 million butts every minute!⁴⁵



Locations for Tobacco-free Spaces



There are many areas that you can consider when establishing smoke-free or tobacco-free spaces for your tribe:

- In all public places.
- In and around workplaces.
- In and around tribal buildings.
- In and around tribal vehicles.
- In and around personal vehicles if children are on board.
- In and around tribal businesses.
- In and around tribal schools.
- In and around tribal daycares.
- In and around tribal parks.
- In and around tribal housing.

You can be as inclusive or exclusive as you like when defining the areas where you will restrict commercial tobacco use. Obviously, prohibiting commercial tobacco use in all public places would provide your community with the greatest level of protection from secondhand smoke and the social influences of tobacco use. Such policies have been passed in the states of California, Delaware, New York, Connecticut, Maine, Massachusetts, and Rhode Island (protecting ALL workers, including office, restaurant, bar, bingo, bowling, nightclub, and casino workers), and in nearly 50 local communities, drastically improving community health and reducing tobacco consumption.

As you draft your tobacco- or smoke-free policy, be sure to clearly define exactly where smoking is permitted and where it is not. Remind community members that these bans are not intended to limit people's right to smoke, but are designed to remove the health hazard of secondhand smoke by taking the activity outside and away from non-smokers and young people.



Types of Tobacco-free Policies



Smoke-free versus Commercial Tobacco-free Spaces:

Smoke-free spaces restrict the use of cigarettes, pipes, cigars and other commercial tobacco products that produce smoke. Such policies provide immense health and community benefits to non-smokers.

Tobacco-free spaces, on the other hand, restrict the use of all commercial tobacco products, including smokeless, chew, and spit tobacco. While smokeless tobacco does not pose a physical threat to non-users, it is not a safe alternative to smoking, and when used in public, can still set a bad example for children who observe and emulate. One can of chew contains the equivalent amount of nicotine and carcinogens as three packs of cigarettes. By passing a tobacco-free policy, your tribe will convey the magnitude of this health risk to users, and will protect youth from additional access and exposure.

Comprehensive Tobacco-free and Smoke-free Policies:

Comprehensive tobacco- and smoke-free policies prohibit all commercial tobacco use (or all smoking) in all public buildings at all times. Such a policy does not, of course, include private vehicles or homes. This type of policy is the easiest to enforce because it is clear-cut and allows no exceptions. This is the best method for protecting tribal members from secondhand smoke. Comprehensive tobacco- and smoke-free policies usually cover all indoor and outdoor areas, and can be established for a single building, a group of buildings, or for an entire reservation or community.

The comprehensive tobacco-free policy will do the best job of improving the health of your tribe.

Mixed Policies:

Mixed policies have a combination of smoke-free and separate areas statements. Depending on your tribe's needs, you may find that it is necessary to permit smoking in some buildings while restricting it in others. An example of a mixed policy is one that includes a tobacco-free statement for the tribal clinic, the school, the community center and tribal office buildings, and a separate statement for a bingo hall that allows smoking.

Because it permits use in some areas, it allows for flexibility and may be better received by those resistant to comprehensive tobacco policies. Such policies require a clear delineation of where tobacco use is permitted and where it is not, and all areas must be well marked by signs.

Separate Areas Policies:

Separate areas policies restrict smoking or commercial tobacco use to specific areas within a single building. It is important to note, however, that separate areas policies provide tribal members with little to no protection from secondhand smoke. When smoking is allowed in a separate area within the same room or building, research indicates that atmospheric nicotine and particulate matter are only cut by about 50% in non-smoking areas.⁴⁶ Because there is no threshold for safe exposure to secondhand smoke, tribal members will not be adequately protected by this type of policy.

Ventilation systems are not considered a viable alternative, as these systems are not capable of removing all smoke particles from the air that contain potentially carcinogenic pollutants. When smoking sections share ventilation with non-smoking areas, the smoke is dispersed throughout the building (...like trying to enforce a “no-chlorine” section in an open pool!). Smoking sections only help protect non-smokers when they are completely enclosed, have a separate ventilation system that goes directly outdoors without re-circulating air in the building, and when employees are not required to pass through one section to the get to the next.⁴⁸

The American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) sets standards for ventilation rates in North America. ASHRAE maintains that there is NO acceptable ventilation process for second hand smoke.⁴⁷

Research indicates that the room air-cleaning devices that are now on the market are also ineffective at removing cancer-causing chemical pollutants.⁴⁹ If you do choose to implement separate smoking and non-smoking areas, be sure to make every effort to achieve a high level of air circulation. And if possible, equip each room with its own ventilation system.

While more flexible, this type of policy is often more challenging to enforce, as some people forget to honor a specific place as being tobacco- or smoke-free.



Special Considerations for Writing, Passing and Implementing Secondhand Smoke Policies



Including provisions for Smokeless Tobacco:

If restricting cigarette use, the use of chewing tobacco and snuff (smokeless tobacco) should also be included in the policy. Smokeless tobacco is addictive. It causes cancer and other serious health problems, and is not safer than smoking cigarettes. For a few communities, this may present some special concerns. Chewing tobacco does not cause the environmental risks that are associated with smoking. It does not immediately impact non-users. However, chewing tobacco is often more accessible to youth than cigarettes, and may be disposed of in unsanitary ways. Like smoking, its use is observed by young people, thus encouraging unhealthy behaviors. A tobacco policy that includes a ban on smokeless tobacco will communicate the seriousness of this health hazard. Consequently, the policy should have a clear statement about smokeless tobacco.

Tobacco- and Smoke-free Perimeters:

Any policy that restricts smoking or commercial tobacco use inside a building should consider adding a provision regarding tobacco-free perimeters. Without such a policy, smokers tend to congregate around doorways or walkways, which allows smoke to enter the building, promotes tobacco use in front of young people, and impedes traffic. Within the policy statement, be sure to clearly define a “designated smoking area” that is well removed from doorways, walkways, and entrances, and that is out of the view of young people.

When choosing a “designated smoking area,” discuss options with regular smokers in order to identify a location that is comfortable and accessible, while remaining safe for non-smoking community members.



Tobacco-free Preparation:

Smokers may need time to get used to the idea that their tobacco use will be restricted. Provide smokers with ample warning before the policy is put into effect so that they can mentally and physically prepare for the change. Prior warning will allow community members to adjust their smoking habits to the new rules, or to consider the possibility of quitting. Smokers generally go through six stages in the process of quitting.⁵⁰

- 1. Pre-contemplation (not thinking about quitting)** - People who are at this stage are not thinking about quitting, and if challenged, will probably defend their smoking behavior. These smokers are not likely to be receptive to messages about the health benefits of quitting. For smokers at this point, it is important to initiate thoughts about quitting by personalizing their risk factors.
- 2. Contemplation (thinking about quitting but not ready to quit)** - During this stage, smokers are thinking about quitting sometime in the near future (probably six months or less). Smokers are considering the challenges they would face in the process. They acknowledge the personal consequences of smoking, and see it as a problem that needs resolution. At this point they are more open to receiving information about smoking and identifying the barriers that prevent them from quitting.
- 3. Preparation (getting ready to quit)** - In the preparation stage, smokers have made the decision to quit and are getting ready to stop smoking. They may switch to a different brand of cigarettes or try to cut back. Now is the time to develop a personalized quit plan and set a quit date.
- 4. Action (quitting)** - In this stage, people are actively trying to stop smoking, perhaps using short-term rewards to keep themselves motivated, or turning to family, friends and others for support. They mentally review their commitment to themselves and firm-up action plans to deal with both personal and external pressures that could lead to slips. This stage, generally lasting up to six months, is the period during which smokers need the most help and support.
- 5. Maintenance (remaining a non-smoker)** - Former smokers in the maintenance stage have learned to anticipate and handle temptations to smoke, and are able to use new ways of coping with stress, boredom, and social pressure. Although they may slip, they learn from the experience to prevent it from happening again. The maintenance phase can last months or years.
- 6. Termination** - People in the termination phase have quit for good and don't have any temptations to smoke again. Only about 20 percent of smokers who have quit in the past five years report no temptations.

Movement through these stages of change can take months, years, or may never be fully realized. Your policy should support the progression of community members through this sequence, wherever they are in the process.

Federal Grant Requirements:

Some of the grants held by your tribe may already have secondhand smoke provisions written into the contract. Funding is often reliant on compliance with these stipulations, and can provide you with additional leverage when talking to those who are resistant to change. Double-check federal grants held by the tribe to see if such provisions exist, and if so, work to ensure that they are being adequately enforced.

Example: Smoke-Free Environment in Head Start Programs⁵¹

Legal References - The Head Start Act, as amended, 42 U.S.C. 9801 et seq.; 45 CFR 1304.2-3

SUMMARY: This Program Instruction contains requirements governing all Head Start programs, including those programs serving infants, toddlers and pregnant women. It requires all Head Start programs to provide a smoke-free environment for children and adults who participate in their program.

DATES: These Program Instructions are effective May 1, 1995.

INSTRUCTION: Because there is considerable evidence that environmental tobacco smoke is harmful to children and adults, and because Head Start has the mission of promoting the healthy development of the children and families it serves, it is imperative that all Head Start programs create smoke-free environments. Therefore, we are requiring all grantees to work with their policy councils, Health Advisory Committees, parents, and staff in order to establish and enforce written policies which will ensure that, effective May 1, 1995, their Head Start program sites will be smoke-free.

The smoke-free policies contained in this Program Instruction are not intended to prohibit parents from smoking in their own homes during home-based services and home visits. Rather, the intention is to encourage local planning, education, and policy development (related to smoke-free environments during home-based services and home visits) by policy councils, parents and staff. Additionally, all programs should give consideration to providing smoking cessation support for those adults who are interested. Head Start programs must prohibit smoking at all times in all space utilized by the program. This includes classrooms, staff offices, kitchens, restrooms, parent and staff meeting rooms (used in the evenings as well as during the day), hallways, outdoor play areas, and vehicles used for transporting children.

Head Start programs must develop policies that address group socialization activities (which include field trips, neighborhood walks or other outdoor group activities) and that are intended to have parents and staff refrain from smoking when Head Start activities are taking place. Parents and staff should recognize that they serve as role models for the children and should not smoke in front of them. **The only situation under which this does not apply is during a presentation or field trip related to American Indian cultural customs in which tobacco is utilized.** Continued...



Generating Support for Tobacco-free Policies



As mentioned in Chapter 2, different “Talking Points” will be needed to garner policy support from different groups within the community. As you begin to formulate supporting evidence, think about each of the stakeholders impacted by your policy, and the values that each group might hold. Whenever possible, use your own tribal data or frame statistics in a manner that will relate to your community.

For each group of stakeholders, choose 3-5 statements that best support your position. Too many facts tend to complicate the issue, and will distract your audience. To make a lasting impact, try to give evidence in a format that people are likely to remember.



Talking Points About Secondhand Smoke Exposure:

What is Secondhand Smoke (Environmental Tobacco Smoke - ETS)?

- Secondhand smoke, is a mixture of the smoke given off by the burning end of tobacco products (sidestream smoke) and the smoke exhaled by smokers (mainstream smoke).⁵²
- Secondhand smoke contains a complex mixture of more than 4,000 chemicals.⁵² To date, over 69 compounds in tobacco smoke have been identified as carcinogens, 500 as poisons, and six as developmental or reproductive toxicants.³⁵
- The burning of tobacco generates more than 150 billion tar particles per cubic inch, constituting the visible portion of cigarette smoke. According to chemists at R. J. Reynolds Tobacco Company, cigarette smoke is 10,000 times more concentrated than the automobile pollution at rush hour on a freeway. The lungs of smokers, puffing a daily ration of 20 to 60 low to high tar cigarettes, collect an annual deposit of one-quarter to one and one-half pounds of the gooey black material, amounting to a total of 15 to 90 million pounds of carcinogen-packed tar for the aggregate of current American smokers.⁵³

See Chapter 2 - Secondhand Smoke significantly hurts the health of men, women, children, and elders.

- Because their lungs are not fully developed, young children are particularly sensitive to secondhand smoke. Exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma (8,000–26,000 cases per year), bronchitis, and pneumonia in young children.⁵² Annually an estimated 150,000–300,000 new cases of bronchitis and pneumonia in children aged less than 18 months are associated with secondhand smoke exposure in the United States (5% of which will require hospitalization).⁵² Exposure to secondhand smoke causes a small, but significant decrease in children's lung function and increases fluid levels in their middle ear, resulting in ear infections.²⁶
- Secondhand smoke is the third leading cause of preventable death in the United States. For every eight smokers the tobacco industry kills, it takes one nonsmoker with them.⁵⁴
- Second-hand smoke has been established as a cause of lung cancer in non-smokers, while more recent research links secondhand smoke exposure to an increased risk of breast cancer.²² There is overwhelming scientific evidence that secondhand tobacco smoke is a direct cause of heart disease (causing 35,000 deaths each year).⁵⁵ Heart disease is the leading cause of death for American Indians and Alaska Natives.⁵

Tobacco- and Smoke-free environments are the most effective method for reducing exposure to Secondhand Smoke.

- Nonsmokers have the right to breathe clean air, and involuntary exposure to secondhand smoke remains a common, serious public health hazard that is entirely preventable.
- Smoke-filled rooms can have up to six times the air pollution of a busy highway.⁵⁶
- Nonsmoking sections do not eliminate nonsmokers' exposure to secondhand smoke; the smoke knows no boundaries.⁵⁷ Ventilation systems in homes and public places cannot filter and circulate air well enough to eliminate secondhand smoke.⁵⁸
- Blowing smoke away from children, going into another room to smoke, or opening a window may help reduce children's exposure but will not protect them from the dangers of secondhand smoke.
- Restaurant workers are exposed to secondhand smoke at rates 1.6 to 2 times higher than that of other workers. Bar workers are exposed at rates 4 to 6 times higher.⁵⁹
- More than 70% of smokers want to quit, but few succeed without help. No Smoking policies promote healthy community norms, encourage wellness, and discourage kids from ever starting to smoke.
- Smoke-free homes and buildings are associated with significantly lower rates of adolescent smoking.⁴²
- Over 1600 communities across the country have passed local clean indoor air laws protecting workers and the public from the dangers of secondhand smoke. Of those 1600 communities, 48 are 100% smoke-free laws for all workplaces, restaurants and bars. In addition, seven States have complete smoking bans in all restaurants, bars, and workplaces.⁶⁰

Smoke-free areas are cost effective.

- Most employers who go smoke-free save money by increasing productivity, lowering maintenance and cleaning costs, and lowering insurance coverage. Studies of sales receipts from restaurants and bars in the US before and after smoking bans have found that sales usually stay the same or go up after a smoking ban.⁶¹

Smoke-free Zones Gain New Territory

Excerpts from the February 08, 2005 edition - <http://www.csmonitor.com/2005/0208/p01s04-ussc.html>. By Mark Sappenfield | Staff writer of The Christian Science Monitor

Fifteen years after antismoking forces struck their first major blow, the drive to make workplaces and public spaces across the United States smoke-free is experiencing a new surge.

In February 1990, airlines for the first time outlawed smoking on flights lasting less than six hours. This year, legislators have proposed far-reaching public smoking bans in nine states, with similar legislation expected in as many as 11 more. In other states, large cities such as Houston and Salt Lake are considering bans of their own - including laws that would prohibit smoking on beaches and parks.

It is also a vanguard of the antismoking laws now advancing through state legislatures nationwide. In the 11 years since California first instituted a ban on smoking in restaurants and bars, a handful of states have considered similar restrictions each year. So far, measures to prohibit smoking in restaurants, bars, or workplaces have taken effect in 10 states. As many as 20 states may take up the issue this year. "This hasn't really happened before," says Bronson Frick of the American Nonsmokers' Rights Foundation in Berkeley, Calif.

He expects most bills to fail, but the fact that antismoking laws are being considered in states such as Georgia and North Carolina represents progress to him. Add to that the cities that have already passed workplace bans - including Laramie, Wyo., and Lincoln, Neb. - and he sees an expanding antismoking imprint. "The political will is changing," says Mr. Frick.

While many states have some restrictions, the following states have total smoking bans in restaurants, bars, and workplaces as of March 1, 2005:

**California, Connecticut, Delaware, Maine,
Massachusetts, New York, Rhode Island**

Source: American Lung Association

Smoke-free areas wont hurt Tribal business.

- Numerous careful scientific and economic analyses show that smoke-free laws do not hurt restaurant and bar patronage, employment, sales, or profits. At worst, the laws have no effect at all, and they sometimes even produce slightly positive trends.⁶²
- Studies of sales tax data from 81 localities in six states consistently demonstrated that policies restricting smoking in restaurants had no effect on restaurant revenues.⁶³
- In a comprehensive study reported in the journal *Tobacco Control*, it was concluded: “All of the best designed studies report no impact or a positive impact of smoke-free restaurant or bar laws on sales or employment. Policy makers can act to protect workers and patrons from the toxins in secondhand smoke confident in rejecting industry claims that there will be an adverse economic impact.”⁶³

Workplaces benefit from Smoke-free Environments.

- Smoke-free policies reduce employee and community conflict.
- In 1999, each adult smoker cost the community \$1,760 in lost productivity and \$1,623 in excess medical expenditures.²⁹
- Men who smoke are absent from work 4 days more per year than men who do not smoke. Women who smoke are absent from work 2 days more each year than nonsmoking women.²⁹
- Clean indoor air policies prompt smokers to quit, and increase their success rate when quitting. No smoking policies also reduce the number of cigarettes that continuing smokers consume. According to Philip Morris’ own research, smokers facing restrictions consume 11%-15% fewer cigarettes than average and quit at a rate that is 84% higher than average.⁶⁴

Smoke-free areas will save the tribe money.

- Tobacco-related diseases increase healthcare costs, increase business costs, and reduce the number of years people can economically contribute to the health and wellness of their community.
- The IHS estimates that it spends \$200 million dollars per year treating tobacco related diseases.⁴ Smoking increases costly complications of pregnancy, such as pre-term delivery and low birth-weight infants.
- About 9% of the total direct medical costs in the first year of life can be attributed to passive smoking. Postnatal exposure to secondhand smoke at home has been linked to higher rates of hospitalizations for any illness compared with non-exposed infants, costing millions of dollars.⁶⁵
- Nationally, men who smoke incur \$15,800 (in 2002 dollars) more in lifetime medical expenses than men who do not smoke. Women who smoke incur \$17,500 (in 2002 dollars) more in lifetime medical expenses than nonsmoking women.

Remember, tobacco restrictions don't take away the right to smoke. They simply remove the public health hazard of secondhand smoke by taking the habit outside and away from others!



Secondhand Smoke Policy Templates & Tribal Examples



A Comprehensive Tobacco-Free Policy Template:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, the _____ Tribal Council is responsible for providing healthcare oversight on behalf of its tribal members; and,

WHEREAS, _____% of our tribal adults currently use commercial tobacco products, and _____% of our high school seniors currently smoke; and,

WHEREAS, the Tribal Council acknowledges that numerous studies have found that tobacco smoke is the third leading cause of preventable death and disease, and causes cancer, heart conditions, respiratory problems, and aggravates asthma in both children and adults. At particular risk are children, elders, tribal members with cardiovascular disease, diabetes, and individuals with impaired respiratory function, including asthmatics and those with chronic obstructive pulmonary disease who utilize the tribal facilities and gather in public meeting places; and

WHEREAS, it has been documented that nearly 40% of all deaths among American Indians and Alaska Natives can be attributed to commercial tobacco use, and that lung cancer is the leading cause of cancer death, making exposure to commercial tobacco a significant risk for the health of our community and future generations; and,

WHEREAS, there is no threshold for safe exposure to secondhand smoke, which has been classified by the Environmental Protection Agency as a substance that is “known to cause cancer in humans,” the highest level of warning given to known carcinogens; and,

WHEREAS, commercial tobacco use also significantly impacts our tribe’s limited IHS dollars, costing the Indian Health Service about \$200 million dollars each year to treat tobacco related diseases; and,

WHEREAS, it is the responsibility of the tribe to create healthy social norms for future generations, thereby sending a clear message to young people that it is not acceptable to participate in this life threatening activity; and,

WHEREAS, currently there are no commercial tobacco policies to adequately protect tribal members from the health risks associated with secondhand cigarette smoke,

THEREFORE, BE IT RESOLVED, that the Tribal Council hereby adopts the following policy: As of (Date) , the use of commercial tobacco products will not be permitted in any public places or vehicles on the (Reservation) . This resolution is designed to ban smoking and the use of smokeless tobacco in all tribal buildings, offices, parks, schools, gathering places and vehicles. This policy is not intended to ban any traditional or sacred tobacco use, or to impact commercial tobacco use on personal property or in personal vehicles.

BE IT FURTHER RESOLVED, that the use of commercial tobacco products will not be permitted within 100 feet of any tobacco-free building or space to prevent children from being visually exposed to commercial tobacco use, and to prevent smoke from entering buildings through windows or doors. Directors responsible for overseeing activities at each tribal building are responsible for identifying and enforcing an appropriate “designated smoking area” for each building.

BE IT FURTHER RESOLVED, that “No Smoking” signs or the international "no smoking" symbol (consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across the cigarette) shall be clearly, sufficiently, and conspicuously posted in every building or other area where smoking is prohibited by this article, by the owner, manager, or other person having control of such building or other area, including private residences used as a child care, adult day care, or healthcare facility. Every public place where smoking is prohibited by this section shall have posted at every entrance a conspicuous sign stating that smoking is prohibited.

BE IT FURTHER RESOLVED, that the _____ tribal council will impose a fine of \$100 for commercial tobacco use within any tribal buildings, offices, parks, schools, gathering places or vehicles, following a one time verbal warning. Any controversy, questions, or complaints regarding this policy should be directed to the Tribal Council for final determination. If caught smoking, tribal police will tell tribal members under the age of 18 to put out their cigarette.

DEFINITION: Commercial Tobacco Products: The use of commercially produced cigarettes, bidis, cheroots, stogies, cigars, pipe and other smoking tobacco, snuff, snuff flour, cavandish, plug and twist tobacco, smokeless, spit, chew, fine cut and other chewing tobacco, shorts and other kinds and forms of tobacco, prepared in such a manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for chewing and smoking are all subject to policy. Because smokeless tobacco is just as addictive as cigarettes and causes cancer of the throat and mouth, all forms of smokeless tobacco are also restricted by this policy. This policy is not intended to restrict the use of traditional, sacred tobacco.

CERTIFICATION:

On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was: _____ For _____ Against _____ Abstain

Chairperson

Vice-Chairperson

A Comprehensive Tobacco-Free School Policy Template*:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, research indicates that cigarettes are the gateway drug to cocaine and marijuana use by teens, and that each day, approximately three thousand American teenagers start smoking; and,

WHEREAS, nicotine addiction can be considered a childhood disease because the average age of cigarette first use is 13 years; and,

WHEREAS, allowing adults but not students to smoke gives students the message that smoking is for adults, providing a powerful incentive for children to smoke; now, therefore be it

RESOLVED, that effective ____(Date)____, the Board of Education of ____(Tribe)_____ bans smoking and the use of commercial tobacco products in all school buildings and places in the District and in all school vehicles at all times by all persons, including all employees, students, and visitors at any school site or attending any school sponsored activities, athletic events, and meetings; and be it

RESOLVED FURTHER, that tobacco products not be sold at District owned or District operated facilities either through vending machines or other concessions; and be it

RESOLVED FURTHER, that in order to assist employees in complying with the tobacco-free workplace policy, the tribe’s healthcare providers will be requested to provide smoking cessation seminars and informational literature for employees and students; and be it

RESOLVED FURTHER, that a planning group be established to suggest policies and creative enforcement strategies to be voted on by the Board of Education no later than ____(Date)____, so that these policies and strategies can ultimately be used to enforce the tobacco-free policy in schools and offices throughout the District.

CERTIFICATION:

On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was: _____ For _____ Against _____ Abstain

Chairperson

Vice-Chairperson

*Source: The American Heart Association, California and Greater Los Angeles Affiliates gratefully acknowledge the assistance of Americans for Nonsmokers Rights, STAT (Stop Teenage Addiction. to Tobacco), American Lung Association, and American Cancer Society.

Tribal Example 1*:

██████████ Tribe
██████████ Tribal Council

Resolution No. ██████████

No Smoking Policy

WHEREAS, The ██████████ Tribe is an unincorporated Tribe of Indians having accepted the Indian Reorganization Act of June 18, 1934, as amended, and the authorized governing body of the Tribe is known as the ██████████ Tribal Council; and

WHEREAS, The ██████████ Council, pursuant to Constitution of the ██████████ Tribe, Article VI, Section 1 (r) and Section 1 (s), is empowered to exercise any power or duty which may now or in the future be delegated to the Tribal Council, and to take any and all action necessary and proper for the exercise of the foregoing powers and duties and all other powers and duties now or hereafter delegated or vested in the Tribal Council; and

WHEREAS, The ██████████ Tribal Council places great emphasis on health and welfare of tribal staff, clients, patients and other visiting persons; and

WHEREAS, The Environmental Protection Agency concludes that Passive Smoking or exposure to environmental tobacco smoke is responsible for lung cancer among non-smoking adults, and impairs the respiratory health of children; now

THEREFORE BE IT RESOLVED, that the ██████████ Tribal Council, hereby agrees, establishes and implements a NO SMOKING POLICY to be effective in all tribal buildings, the Administration office, Law Enforcement, Tribal Courts, Tribal Health, Youth Center, Shelter Home, and Silversmithing buildings; and or any tribal facilities of the tribe.

BE IT FURTHER RESOLVED, that any violation to this policy shall be grounds for immediate disciplinary action.

CERTIFICATION - We, the undersigned Chairman and Secretary of the ██████████ Tribal Council, hereby certify that the Tribal Council is composed of seven (7) members of whom five (5) constituting a quorum, were present at a meeting thereof duly and regularly called, noticed, and convened and that the foregoing resolution was duly adopted by the affirmative vote of _____ members, with _____ opposing and _____ abstaining. The Chairman's vote is not required except in case of a tie.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 2*:

Resolution No.: [REDACTED] Date of Passage: November 25, 1991

Subject (title): Tribal Tobacco Policy

WHEREAS, This Council is the Governing Body of the [REDACTED]
[REDACTED] Indians, and;

WHEREAS, This Governing Body is authorized to act on behalf of said Tribes, and;

WHEREAS, Smoking has been identified by the U.S. Surgeon General as the nation's single most important preventable cause of disease and premature death, and;

WHEREAS, Evidence shows that smoking during pregnancy has a significant adverse effect upon the well being of the fetus and the health of the newborn, and;

WHEREAS, Children of parents who smoke have an increased prevalence of respiratory symptoms, bronchitis and pneumonia, and;

WHEREAS, Smokeless tobacco is also very harmful to the health of those using it, and;

WHEREAS, There is a need to protect the health of employees and tribal members.

BE IT RESOLVED, that in view of the findings of adverse health effects and the decreased well being of those exposed to smoke, these Tribes ban smoking and the use of smokeless tobacco in all Tribal offices and buildings.

BE IT FURTHER RESOLVED, that any smoking and/or smokeless tobacco controversy which cannot be resolved by the supervisor of the individual(s) involved will be referred to the Tribal Council for a final determination.

CERTIFICATION - On November 25, 1991, this Resolution was adopted at a regular Council meeting, held this date, and the vote was:

____For ____Against ____Abstain

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 3*:

Resolution No. [REDACTED]

WHEREAS, The Board of Directors of the [REDACTED] Tribe of Indians, pursuant to Article VII, Section 1, of the Tribal Constitution approved [REDACTED] by the Department of the Interior, Bureau of Indian Affairs, is the official governing body of the Tribe, authorized to act on behalf of the Tribal Council, and

WHEREAS, the [REDACTED] Tribe of Indians is a federally recognized Tribe and is a sovereign nation, and

WHEREAS, The U.S. Surgeon General's 1989 report on smoking has determined that environmental tobacco smoke contains substances that are toxic and cause cancer, and

WHEREAS, one out of five Americans and two out of five Native Americans die each year from causes directly related to smoking, and

THEREFORE BE IT RESOLVED, to adopt the following policy:

TOBACCO POLICY

The [REDACTED] Tribe of Indians is concerned about the health of all of its members and has, therefore, adopted the following tobacco policy:

All Tribal Administrative offices, as well as Tribal Health Program facilities, will be smoke-free. This also includes Tribal hall, waiting areas, and private offices.

In addition, chewing tobacco will not be used inside the Tribal Buildings.

This decision has been made by the Board of Directors on the recommendation of the Tribal Health Committee.

We adopt this policy because habitual tobacco use is a major cause of death and disease and does not reflect the ceremonial and spiritual use of our ancestors. Since we are concerned about the effects of secondhand smoke on all our people, a smoke-free policy is a positive step in improving the health and well-being of our Tribe. The policy shall be effective April 1, 1992.

CERTIFICATION - This resolution was adopted by a vote of the Board of Directors at a regularly scheduled meeting, with a quorum present, on the 12th day of April, 1992 by a vote of ____ For ____ Against and ____ Abstaining.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 4*:

Policy Announcement

No Smoking Areas

Historically, Native Americans view tobacco as a sacred plant and often use it for prayer and in ceremonies. In honor of the traditional practices and ceremonies conducted on the premises and in an effort to protect and promote health of staff and clients, smoking is prohibited within the fenced courtyard of [REDACTED]. Smoking is also prohibited within 25 feet of any entrance to the facilities. Policy effective November 1, 2000.

***To ensure confidentiality, all identifying features have been blacked out.**



Tribal Example 5*:

No Smoking Policy

It is the policy of the [REDACTED] to comply with all applicable Federal, State, and local regulations regarding smoking in the workplace and to provide a work environment that promotes productivity and the well-being of its employees. The [REDACTED] recognizes that smoking in the workplace adversely affects employees. Accordingly, **SMOKING IS PROHIBITED INSIDE ALL OF THE TRIBAL CENTER FACILITIES.** Supervisors are expected to enforce regulations. The **NO SMOKING POLICY** applies to employees during working time and to visitors while on the premises. Employees are expected to exercise common courtesy and to respect the needs and sensitivities of co-workers with regards to the smoking policy. Smokers have a special obligation to keep outdoor smoking areas litter-free and not to abuse break and work rules. Complaints about smoking issues should be resolved at the lowest level possible, but may be processed through the grievance procedure. Employees who violate the policy will be subject to disciplinary action. The [REDACTED] does not discriminate against individuals on the basis of their use of legal products, such as tobacco, if the use occurs during non-working time and off the premises. The Health and Human Services Department maintains information regarding the effects of smoking and the availability of smoking cessation programs.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 6*:

Notice

To: Students, Staff, Parents and Community Members

On November 9th, 2000 at a regularly scheduled meeting of the [REDACTED] Indian School Board of Education, a motion was passed to make the school buildings and grounds drug and smoke free (effective Monday, November 13th, 2000).

This means there will be no smoking or drugs allowed in the school buildings or on the school grounds at any time by the students, staff, parents, or community members.

This is an attempt by the Board of Education to make the school environment as healthy as possible and to provide a positive role model. Your cooperation in this matter is greatly appreciated. If you have any questions, please contact the school office.

***To ensure confidentiality, all identifying features have been blacked out.**



Tribal Example 7*:

Resolution # 16-94

WHEREAS, the [REDACTED] Indian Tribe (hereinafter referred to as “the Tribe”) has been Federally acknowledged by the Secretary of the Interior of the United States of America on February 10, [REDACTED]; and

WHEREAS, the [REDACTED] Tribal Council (hereinafter referred to as “the Council”) is the governing body of the [REDACTED] Tribe in accordance with its Constitution adopted on November 19, [REDACTED], and conducted by the Bureau of Indian Affairs following Part 81 of the Code of Federal Regulation; and

WHEREAS, the health, safety, welfare, and education of the Indian people of the [REDACTED] Tribe is the responsibility of the [REDACTED] Tribal Council; and

WHEREAS, the health and social services department are promoting and advocating health policies to enhance the health status of all Tribal members and Tribal staff, especially our youth and elders, respectfully submit the following tobacco policy to be considered by the Tribal Council; and

WHEREAS, the Indian Health Service (IHS) study, “Trends in Indian Health”, show three out of five deaths in Indian Country are related to smoking; and

WHEREAS, IHS lists diseases of the heart, malignant neoplasms (cancers), cerebrovascular diseases and Chronic Obstructive Pulmonary Disease as leading causes of all AI/AN deaths; and

WHEREAS, these diseases are highly related to tobacco and as a result, American Indians have twice the mortality rate from smoking than the general population; and

WHEREAS, Environmental Tobacco Smoke (ETS) has been classified as a Group A Carcinogen, the most dangerous classification; and

WHEREAS, ETS is responsible for the death of 53,000 non-smokers each year; and

WHEREAS, Indian children suffer from bronchitis, asthma, ear infections, and low birth weight, all of which are exacerbated by environmental tobacco smoke; and

WHEREAS, Indian women have cervical cancer at higher rates than the general population and tobacco is one of the behavior factors considered to elevate the risk of cervical cancer; and

WHEREAS, smokeless, spit, or chew tobacco is known to cause 80% of oral cancers, gum recession, general dental problems, and high blood pressure; and

WHEREAS, the Tribe realizes that its leadership and elders are the role models for the younger generation and need to set an example; now

THEREFORE BE IT RESOLVED, that the Tribal Council does hereby declare that effective immediately all Tribal public facilities, excluding workshops and outside facilities, will be tobacco-free; and

BE IT BE FURTHER RESOLVED, that the Tribal Council does hereby ban smoking and the use of smokeless tobacco in all Tribal public facilities, vehicles and the community center including Tribally sponsored social events and dinners; and

BE IT FURTHER RESOLVED, that the Community Center shall allow smoking between the hours of 8:00-10:00 am and 1:30-3:00 pm Monday - Friday; and

BE IT FURTHER RESOLVED, that the Tribal Council will prioritize the construction of a covered Smoking Area when the Community Center add-on is built, after which, the Community Center will also become smoke-free; and

BE IT FURTHER RESOLVED, that smokeless, chew, and spit tobacco will not be permitted inside Tribal Facilities, and when used outside, will be disposed of in a sanitary manner; and

BE IT FURTHER RESOLVED, that Tribal members and employees will take responsibility for reminding one another and visitors about the no smoking policy; and

BE IT FURTHER RESOLVED, that the [REDACTED] Tribe approves the cultural and traditional use of tobacco in its ceremonial manner; and

BE IT FURTHER RESOLVED, that the Smoking Policy for Tribal businesses shall be developed by the Boards that provide policy oversight, as authorized by the Tribal Council; and

BE IT FINALLY RESOLVED, that this policy shall be incorporated into the Tribe's Management and Operations Policy Manual.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 8*:

Human Resource Policy Manual
Smoking Policy

PURPOSE

To provide a totally smoke-free environment for all employees and visitors of the [REDACTED].

Policy

Smoking is not a legally protected right. The [REDACTED] Indian Tribe endorses the philosophy that every person ought to have the right to breathe clean air. It is recognized that smoking is dangerous to the health of the smoker. Tobacco smoke in a confined area also creates a health hazard to non-smokers, especially those suffering from heart disease, respiratory disease, or allergies. "Side-stream" smoke is a health hazard to all individuals and violates their privilege of breathing air relatively free from tobacco smoke contaminants.

Since all legal cases to date have been found in favor of non-smoking employees, it is necessary that the [REDACTED] Indian Tribe take such steps as necessary to (not only comply with the [REDACTED] New Clean Indoor Air Act – Public Health Act 198 of 1986), but to also provide air free of smoke for all employees, visitors, medical staff, and patients at the [REDACTED].

Therefore, it is the intent of the [REDACTED] Indian Tribe to provide a totally smoke-free environment in the [REDACTED] effective the date of this policy.

The [REDACTED] Indian Tribe will implement this policy in the steps and manner established in the "Procedures," following.

The immediate objectives to be implemented at the date of this policy include the following:

1. To involve all Tribal employees in this program.
2. To establish all worksites and patient waiting areas in [REDACTED] as smoke-free.
3. To establish smoking cessation programs to be held at convenient times for Tribal members/employees.
4. All meetings are to be smoke-free.
5. To encourage all Tribal employees and health/medical staff to be especially supportive of all employees who are attempting to stop smoking.

Procedures

There will be absolutely no designated smoking areas in the [REDACTED] [REDACTED] effective the date of this policy. Thus, smoking is strictly prohibited in all areas of the [REDACTED] including hallways, reception and waiting areas, all meeting and conference rooms, the Fitness Center, storage areas, restrooms and offices.

This policy will be evaluated on an annual basis.

The Health Educator will be responsible for scheduling all Tribal smoking cessation programs. Department supervisors are encouraged to work with the Health Educator to ensure that the needs of employees are met.

The management staff for each Tribal employee will ensure that each employee has been notified and briefed that non-compliance with this policy will be considered a violation of rule #4 (a-6) listed under B – Disciplinary Action in “[REDACTED] Indian Tribe – Personnel Policies and Procedures” and shall result in the disciplinary actions as listed.

Exceptions will not be made to this policy until such steps are taken to revise the written policy and it is approved and published.

*** To endure confidentiality, all identifying features have been blacked out.**



Tribal Example 9*:

Letterhead

To: All employees

From: [REDACTED], President
[REDACTED] Indian Nation

Subject: Recently established non-smoking policy

To prevent problems with complying with the non-smoking policy, it may help if employees are aware of the following factors that the business Committee considered in establishing the policy that all tribal buildings and offices be smoke-free:

This policy is intended to assist employees in stopping smoking.

As the [REDACTED] Nation operates many health-related programs, it is necessary for us to exemplify by our actions that we consider the health of all tribal members and employees important. Smoking is the major cause of death among Indians, costing more lives than all other diseases and injuries combined. In the U.S. more people die every year from tobacco-related diseases than have died in World War I, World War II, the Korean War, and the Vietnam Wars combined.

An employee who smokes is generally a less productive employee than a non-smoker. The decrease in productivity, increased sick leave, and additional damage to equipment caused by tobacco smoke, fires, and other factors cost the [REDACTED] Nation \$450,000 per year.

You are asked to voluntarily comply with the non-smoking policy and not make it necessary for the Nation to expend additional administrative time and money enforcing the policy. Sick leave will be granted as you feel necessary if you elect to enter a tobacco treatment program.

In summary, this policy is established for the overall betterment of the health of the people of the [REDACTED] Nation.

*** To ensure confidentiality, all identifying features have been blacked out.**

Additional Policy Templates:

BE IT RESOLVED, that as of (Date) , the use of commercial tobacco products will not be permitted in any public places or vehicles on the (Reservation) . This resolution is designed to ban smoking and the use of smokeless tobacco in all tribal buildings, offices, parks, schools, gathering places and vehicles.

BE IT RESOLVED, that as of (Date) , to create healthy environments for American Indian people, staff, clients, patients, and members, all facilities will only permit traditional use of tobacco in/on the premises, including (Location) .

BE IT RESOLVED, that as of (Date) , commercial tobacco use shall not be permitted within fifty (50) feet of any entrance of any enclosed area where smoking is prohibited or of any work areas that extend out of doors.

BE IT RESOLVED, that as of (Date) , smoking will be restricted to the location only. All other areas, including private offices, waiting rooms, and... (define all areas) will be smoke-free.

BE IT RESOLVED, that as of (Date) , all tribal housing will be commercial tobacco-free. This tribe bans smoking and the use of smokeless tobacco in all housing or apartments owned by the tribe.

Additional Policy Exception Templates:

This policy is not intended to ban any traditional or sacred tobacco practices, or to impact commercial tobacco use on personal property or vehicles.

No commercial tobacco use will be allowed in tribal buildings, offices, parks, schools, daycares, gathering places, and vehicles, except in areas that are designated and marked as a “designated smoking area” by the tribal council. These designated smoking areas will include _____.

Example: Independent School District 199

Tobacco-free Environment Policy, , MN

IV EXCEPTION

It shall not be a violation of this policy for an Indian adult to light tobacco on school district property as a part of a traditional Indian spiritual or cultural ceremony. An Indian is a person who is a member of an Indian tribe as defined under Minnesota law in Minnesota Statute 144.4165 and 260.755

Additional Penalty and Enforcement Templates:

BE IT RESOLVED, that all tribal members and employees will take responsibility for reminding one another and visitors about the no tobacco policy.

BE IT RESOLVED, that any controversy, questions, or complaints regarding this policy should be directed to _____ for final determination.

BE IT RESOLVED, that the _____ tribal council will impose a fine of \$_____ for using commercial tobacco products within a tribal building following a verbal warning.

BE IT RESOLVED, that it shall be the responsibility of employers to provide a tobacco- and smoke-free work place for all employees.

BE IT RESOLVED, that it shall be a violation of this section for any person to smoke or chew tobacco in any area where tobacco is prohibited by the provisions of this section. Any person who violates this section shall be guilty of an infraction, punishable by a fine of: Not less than fifty dollars (\$50.00) nor more than one hundred dollars (\$100.00) for a first violation within any twelve month period; Not less than one hundred dollar (\$100.00) nor more than two hundred dollars (\$200.00) for a second violation within any twelve month period; Not less than two hundred and fifty dollar (\$250.00) nor more than five hundred dollars (\$500.00) for each additional violation of this section within any twelve month period. Notwithstanding any other provisions of this section, an employer or private citizen may file a complaint to enforce this section with the Tribal Council.

BE IT RESOLVED, that “No Smoking” signs or the international "no smoking" symbol (consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across the cigarette) shall be clearly, sufficiently, and conspicuously posted in every building or other area where smoking is prohibited by this article, by the owner, manager, or other person having control of such building or other area, including private residences used as a child care, adult day care, or health care facility. Every public place where smoking is prohibited by this section shall have posted at every entrance a conspicuous sign stating that smoking is prohibited.



Chapter 5: Youth Prevention Policies



The Purpose of Policies that Prevent Tobacco Use among Youth



It is the responsibility of tribal parents and elders to create policies that protect the health and welfare of children and future generations. Because young people are particularly vulnerable to social pressure and nicotine addiction, they deserve guidance from social norms, and strong regulations that protect them from the deadly grip of nicotine addiction.

Youth Have Access to Tobacco Products:

Policies that prevent youth access to commercial tobacco products also play a significant role in protecting youth from tobacco addiction. Roughly half of young smokers purchase their own cigarettes, either from retailers or vending machines or by giving money to others to buy for them. Another third typically “bum” their cigarettes from others, and a smaller percentage obtain their cigarettes by shoplifting or stealing.⁶⁶ These routes of acquisition can vary considerably from one tribe to the next. Effective policies thus require an understanding of how young people in your tribe typically access tobacco products.

Tobacco Addiction Starts Early:

In the United States, tobacco experimentation typically starts between the ages of 11 and 12, with a considerable number of Native youth starting even earlier.²⁶ Thirteen percent of eighth grade students in a national study reported having first smoked by the fifth grade (ages 10 and 11), and in a survey of fifth grade students in Washington State, nearly 30% of 10- and 11-year-olds had already tried at least one cigarette.^{67, 68} What is particularly worrisome about this trend, though, is that more than a third of all kids who ever try smoking a cigarette will become regular, daily smokers before leaving high school.⁶⁹

Research suggests that symptoms of addiction, including strong urges to smoke, anxiety, irritability, or unsuccessful quit attempts, can appear in kids within days or weeks, well before daily smoking has even begun.⁷⁰ And changes in the brain can be observed even upon their first exposure to nicotine. While smoking can start at any age, addiction is more likely to occur during early adolescence when their brains are most sensitive to the rewarding effects of nicotine.⁷¹ Consequently, over 80% of today’s adult smokers became regular smokers before age 18.⁷²

While only 3% of daily smokers in high school think that they will still be smoking in five years, more than 60% remain daily smokers seven to nine years later.⁷³ It is imperative that comprehensive tobacco policies protect young people from this powerful addiction.

Teen Tobacco Use is associated with other Risky Behaviors:

Tobacco policies can also protect young people from engaging in other unhealthy behaviors. Among youths who have used both cigarettes and marijuana, 65% reported smoking cigarettes before trying marijuana; and 98% of those who had used both cocaine and cigarettes smoked cigarettes first.⁷⁴ It comes as no surprise that teens who smoke cigarettes are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is also associated with a variety of other dangerous behaviors, including fighting and unprotected sex.⁷⁴

Similarly, high school students who regularly use spit tobacco are nearly four times more likely to use marijuana than nonusers, almost three times more likely to use cocaine, and nearly three times more likely to use inhalants.⁷⁵

Tobacco Industry Marketing Influences Tobacco Use among Teens:

A number of studies have demonstrated a direct causal relationship between exposure to tobacco industry marketing and youth smoking behavior, a fact that has been well exploited by the tobacco industry. Major cigarette companies now spend more than \$11.2 billion per year to promote their products (spending over \$30.7 million each day), with many of their efforts directly reaching young community members.⁷⁶ Teens are more influenced to smoke by advertising than they are their peers, and are three times more sensitive to tobacco advertising than adults. Policies that reduce adolescent exposure to tobacco industry advertising can dramatically prevent youth initiation.

Our Responsibility to Our Future:

Adults know how addictive commercial tobacco is and how damaging it is to our health. Tribal leaders and other adults must help young people understand – Using cigarettes and chew is not a sign of being mature, sexy, rebellious, cool, or independent. Unless current rates are reversed, more than 6.4 million children under the age of 18 alive today will eventually die from smoking-related disease.⁷⁷ Tobacco policies are a necessary step in modeling healthy behavior and protecting young people from a life of addiction.





Types of Youth Prevention Policies



There are many different policies that can be enacted by your tribe to prevent and reduce tobacco addiction among young people. Each policy listed below can be passed and enforced as a stand-alone policy, or several can be written together to provide even more strength and protection. As is the case with all policies mentioned in this workbook, the following ideas are merely suggestions and possible solutions. Only you and your committee know what steps would make the greatest impact in your community. Feel free to alter any of these policies or consider unique solutions to meet the needs of your tribe.

Policies that Prevent Commercial Tobacco use by Youth:

1. **Expand Tobacco-free spaces.** (See Chapter 4). Rationale: Numerous studies have found that, “smoke-free workplaces and homes are associated with significantly lower rates of adolescent smoking.”⁷⁸
2. **Promote social, tribal and familial responsibility for youth access to tobacco products.** Protect youth from easy access to cigarettes at funerals, at social events, or from family members. Deter the social sources of tobacco products for minors by making it illegal to provide commercial tobacco products to underage youth (similar to laws deterring the provision of alcohol to minors). Rationale: Approximately one third of underage smokers obtain their cigarettes from social sources – friends, family members, or strangers.⁷⁹
3. **Prohibit the sale of cigarettes and smokeless tobacco products to those less than 18 years of age.** Or prohibit the sale of cigarettes and smokeless tobacco products to those less than 21 years of age. Rationale: Age limits reduce underage tobacco use and send a clear message about the risks associated with commercial products. Research suggests that if the legal smoking age were increased to 21, the overall smoking prevalence rate would drop by nearly 70%.⁸⁰ This drop would reduce the community’s burden of tobacco-related death and disease, and save millions in IHS healthcare costs.





4. **Require all tobacco retailers to verify a customer's age.** Rationale: Age identification at the point of sale helps enforce purchasing restrictions.
5. **Require the posting of warning signs to not sell tobacco to minors at all points of sale in all retail stores.** Rationale: Signs warning about age identification at the point of sale help to enforce underage purchasing restrictions.
6. **Prohibit or regulate the sale of tobacco products through vending machines.** Rationale: Vending machine restrictions help to enforce underage purchasing restrictions.

7. **Prohibit self-service tobacco displays.** Require that all commercial tobacco products be kept behind the counter. Rationale: Self-service displays provide youth with easy access to tobacco products. A significant number of adolescents obtain their cigarettes by shoplifting or stealing products that are not kept behind the counter.⁸¹

8. **Prohibit the sale of “Kiddie packs,” packages of fewer than 20 cigarettes, and individual cigarettes at tobacco retailers.** Rationale: The sale of “Kiddie” packs and individual cigarettes reduce the cost of purchasing cigarettes, making them more accessible to young people with limited financial resources.



9. **Prohibit the sale of tobacco-like candies** (such as candy cigarettes, bubble gum packaged like chew tobacco). Rationale: Tobacco-like candies “teach” children how to use tobacco products, and give young people the false impression that it is an activity that is fun, cool, and okay to engage in.



10. **Prohibit the sale of “blunts” (sweetened cigarette wrapping papers composed of fruit and tobacco) and other youth targeted tobacco products (cloves, bidi’s).** Rationale: These products are designed to hook young people, enticing them with sweetened products before shifting them to full addiction.

11. **Establish a maximum number of tobacco retailers on tribal lands** (such as communities that restrict the number of gas stations per 1000 people). Rationale: Establishing a maximum number of tobacco retailers allows for better enforcement of retailer policies, and limits youth’s access to tobacco.

12. **Establish compliance checks and retailer education on tribal lands to ensure tobacco retailers remain compliant with the tribe’s established tobacco policies.** Rationale: Education and compliance checks play an important role in maintaining retailer accountability and helping to establish healthy community norms around tobacco use. At least three quarters of all cigarettes consumed by kids are purchased by kids. By eliminating retail sources of tobacco products for youth, children will have fewer opportunities to experiment with commercial products, and tobacco use will be reduced among older adolescents.
13. **Define appropriate placement of Tobacco Industry advertisements:** For example, make it illegal for retailers to display Tobacco Industry advertisements on tribal land, prohibit the placement of Tobacco Industry advertisements below 4 ft (from ground level) or near youth oriented products such as candy, toys, or magazines; Or, for every Tobacco Industry advertisement displayed by a retailer, an equal number of anti-commercial tobacco posters must displayed; Prohibit clothing or other items that bear tobacco company brand logos at schools and/or other community events and venues; Or, prohibit the display of outdoor tobacco ads within 1,000 feet of schools and playgrounds. Rationale: There is a direct causal relationship between exposure to tobacco industry marketing and adolescent smoking. Surprisingly, teens are more influenced to smoke by advertising than they are by peer pressure, and are three times more sensitive to tobacco advertising than adults.
14. **Monitor Tobacco Industry Advertisements - carryout “Operation Storefront” on a regular basis.** Rationale: As mentioned above, there is a direct causal relationship between exposure to tobacco industry marketing and adolescent smoking. Operation Storefront is a community-based project designed to teach community members and young people how to assess the placement of indoor and outdoor tobacco ads. Surveyors count the number of tobacco advertisements outside and inside local retail stores to determine the amount of advertising in their local community. The project teaches teens critical thinking skills to counteract the daily normalization and glamorization of tobacco that happens through local advertising. Assessment materials can be obtained through the Washington State Department of Health’s Tobacco Prevention and Control Program: (<http://www.doh.wa.gov/Tobacco/Archive/Operation%20Storefront/operationstorefront.htm>)



15. **Prohibit the distribution of free tobacco product samples at community events or at tobacco retailers.** Rationale: Free tobacco products are designed to hook young people, and give young people the false impression that tobacco use is fun, cool, and okay to engage in.
16. **Prohibit tobacco-brand advertising at community events, Powwows, Rodeos, and sporting events.** Prohibit tobacco industry sponsorship of events and organizations. Prohibit the distribution of free or low cost tobacco industry related materials. Rationale: Like all tobacco industry advertising or promotions, advertising at community events is designed to entice new smokers – namely youth. When promoted at community events, it gives the impression that commercial tobacco use is welcomed and supported by the tribe.
17. **Increase the cost of tobacco through tax increases.** (See Chapter 7). Rationale: Research suggests that for every 10 percent increase in the real price of cigarettes, overall cigarette consumption will be cut by three to five percent and the number of kids who smoke will be reduced by six or seven percent.⁸²
18. **Require classroom or culture camp education on the difference between commercial tobacco use and traditional tobacco use.** Rationale: It is important for young people to understand and respect the traditional use of tobacco in Tribal communities, and appreciate how this differs from the use of commercial products.





Special Considerations for Writing, Passing and Implementing Youth Prevention Policies



Involving Youth in the Process:

As mentioned in Chapter 2, teens are an incredible resource for helping promote or initiate policy change, and can be instrumental in writing, passing, and implementing policies that affect the health of young people or their families. As you begin to plan, be sure to engage youth in all aspects of the process. They will likely have the best understanding of which policies might work, how they can be enforced, and what penalties will most effectively discourage noncompliance.

Tobacco Cessation Support for Teens:

Because young people typically initiate tobacco use in their early teens, and because of tobacco's highly addictive properties, you may find that smoking cessation services are needed to support some types of policy adherence.

Several programs exist to support teens who would like to quit - The American Lung Association's Not On Tobacco (N-O-T) program offers a free program for helping teens quit. N-O-T was designed specifically for teens, as a voluntary, non-punitive program comprised of 10-sessions. An Alternative-to-Suspension program is also included to address the violation of a school tobacco policy. Typically, groups are divided by gender and are led by a same-gender facilitator. This allows teens to discuss issues that relate specifically to males or females and to express their own feelings and experiences in an accepting environment. N-O-T incorporates life management skills to help teens deal with stress, decision-making, and peer and family relationships. It also addresses healthy lifestyle behaviors such as alcohol or illicit drug use as well as related health issues such as exercise and nutrition. For more information, please contact the American Lung Association at 1-800-LUNG-USA or visit www.lungusa.org

The Community Intervention Inc. provides a program for youth age 12-18. This award-winning, eight-session, voluntary program provides young people with information, motivation, and support to quit using cigarettes or chewing tobacco. In a supportive group setting, tobacco users are gently guided toward their personally selected quit date and are helped to remain tobacco-free. For information visit: www.youthtobacco.com, or email: service@communityintervention.org.



Generating Community Support for Youth Prevention Policies



As is the case with other policies, different “Talking Points” will be needed to garner policy support from different groups within the community. As you begin to formulate supporting evidence, think about each of the stakeholders impacted by your policy, and the values that each group might hold. Whenever possible, use your own tribal data or frame statistics in a manner that will relate to your community. If you do not already know tobacco use prevalence rates for your young people, contact your local school district or county health department. They may be able to provide local rates based on student participation in periodic state-based surveys, including the Healthy Youth Survey (HYS) or the Youth Risk Behavior Survey (YRBS).

For Example:

If you know that, on average, 40% of the youth in your tribe smoke --

When addressing a group of 20 young people you could have 8 of them stand up to demonstrate the percentage of “teen smokers” in your community. Then have 5 of them stand aside to illustrate the 60% of smokers who will remain daily smokers seven to nine years after high school. This can be done to demonstrate how addictive commercial tobacco products can be - while only 3% of daily smokers in high school think that they will still be smoking in five years, more than 60% remain daily smokers seven to nine years later.⁸³

Talking Points About Youth Access and Prevention:

Access to commercial tobacco products increases use among youth.

- Easy access to commercial tobacco products allows for adolescent experimentation and addiction. Every day, more than 3,000 adolescents in the United States smoke their first cigarette, taking the first step toward becoming regular smokers by the time they reach adulthood.⁸⁴
- Most American Indian/Alaska Native commercial tobacco users began using tobacco between the ages of 8 and 18 (Over 90%). The younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine.⁸⁵
- Teens who smoke are three times more likely than nonsmokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviors, such as fighting and engaging in unprotected sex.⁸⁵

- Smoking is associated with poor overall health and a variety of short-term adverse health effects in young people, and may also be a marker for underlying mental health problems, such as depression. High school seniors who are regular smokers and began smoking by grade nine are over twice as likely than their nonsmoking peers to report poorer overall health, nearly three times more likely to report cough with phlegm or blood, shortness of breath when not exercising, and wheezing or gasping, and are three times more likely to have seen a doctor or other health professional for an emotional or psychological complaint.

Youth are influenced by Tobacco Industry advertising.

- A study in the *Journal of the National Cancer Institute* found that teens are more likely to be influenced to smoke by cigarette advertising than they are by peer pressure. Approximately one third of underage experimentation with tobacco is attributable to tobacco company advertising and promotion.⁸⁶
- Teens are three times more sensitive to tobacco advertising than are adults, and teens are twice as likely to recall seeing a tobacco advertisement in the previous two weeks. Tobacco Industry advertisements target youth, marketing commercial tobacco products as cool, popular, sexy, rebellious, fun, exciting, relaxing, and mature.⁸⁶
- The Tobacco Industry currently spends more than \$11 billion a year (more than \$30 million per day) on advertising, discounts and promotional efforts at stores and smoke shops (this is called “point-of-purchase” advertising.) Studies show that point of purchase advertising and promotion directly influences the number of kids who buy cigarettes and what products and brands they choose to buy and use.⁸⁶
- More than 99% of seventh graders report seeing tobacco advertising and promotions and 70% report receptivity to tobacco marketing and materials.⁸⁶
- Marlboro is the cigarette brand preferred by 50% of smokers aged 12–17 years, followed by Newport (25%) and Camel (11%). These are the brands most heavily advertised in the United States.⁸⁶
- Despite tobacco industry claims that promotional items are meant for smokers over age 21, one study found that 30% of all kids (12-17 years old) owned at least one tobacco promotional item, including T-shirts, backpacks, or CD players. Teens who own promotional items and can name a cigarette brand that has attracted their attention are twice as likely to become established smokers. In 2000, more than 1 in 10 middle school and high school students bought or received something with a tobacco company name or picture on it, such as sports gear, sunglasses, or T-shirts. More than three times as many current tobacco users in middle or high school bought or received such products.⁸⁶

Indians do not profit from the sale of products that intentionally market to Natives – Including American Spirit, Geronimo, Noble, and Big Red.

- Brands such as American Spirit, Geronimo, Noble, and Big Red intentionally market to American Indian and Alaska Native populations, make profits off our native symbols and sacred images, and misrepresent the traditional use of Sacred tobacco. These brands are not owned by Tribal governments, and Indians do not profit from their sales.

In-Store Tobacco Placements Influence Youth.

- Tobacco retailers are often paid to keep special tobacco self-service displays on or in front of the counter, paid to put tobacco products on “good” shelving space, and given other promotional items for the store. In 2001, these allowances made up 40% of cigarette advertising and promotional expenses in the US.⁸⁶
- Self-service displays make it easier for kids to purchase cigarettes or even steal them; and studies indicate that roughly 5% of young smokers steal commercial tobacco products.⁸⁶
- A study reported in the journal *Tobacco Control* found that teens perceive easier access to tobacco products in stores that have tobacco advertising than in stores without “point-of-purchase” advertising.⁸⁶
- Point-of-purchase advertising and displays have been found to increase average tobacco sales by 12%.⁸⁶
- Studies show that point of purchase advertising and promotion directly influences the number of kids who buy cigarettes and what products and brands they choose to buy and use. 75% of kids visit a convenience store at least once a week. A 1999 study found that teens are more likely than adults to be influenced by promotional displays in convenience stores (73% of teens are influenced, only 47% of adults are influenced by these ads.)⁸⁶



Tobacco Taxes Prevent Youth Initiation.

- Young people are much more sensitive to fluctuations in tobacco price than are adults. Even a small increase in price can cause a significant decline in adolescent tobacco use.⁸⁷
- The Institute of Medicine concluded that the single most direct and reliable method for reducing tobacco consumption is to increase the price of tobacco products, thus encouraging cessation and reducing initiation of tobacco use.⁸⁷
- At least three quarters of all cigarettes consumed by kids are purchased by kids -- which is why raising cigarette prices through tax increases and strictly enforcing laws forbidding retailer sales to kids can quickly and significantly reduce youth smoking.

“Starter Products” are intended to Hook Young People.

- According to the U.S. Centers for Disease Control and Prevention, the development and marketing of “starter products” with such features as pouches and cherry flavoring have switched smokeless tobacco from a product used primarily by older men to one for which young men comprise the largest portion of the market. More than 14 percent of high school boys are current smokeless tobacco users.

Candy Cigarettes Create New Controversy

Excerpts from: KIROTV.com, Bebe Emerman, 9/15/04

Many of us grew up with candy cigarettes that looked real but weren't. Now the tobacco industry has come out with candy-like cigarettes that are all too real. Public health leaders say they're a blatant attempt to "hook" our kids.

Twista Lime, Mocha Taboo and Strawberry -- sound like flavors of gum or candy, doesn't they? Think again. They're new flavors of cigarettes.

"Parents need to know that these are real cigarettes. This isn't fake; this isn't candy. There's tobacco in them [and] they can actually cause disease and destruction and death," said Sherri Watson Hyde of the Tobacco Prevention Network.

Health experts estimate that more than 400,000 Americans die each year from smoking-related diseases and 90 percent of all smokers start in their teens or younger.

"We've seen a virtual explosion of candy-flavored cigarettes by the tobacco industry. It doesn't take a rocket scientist to understand that the tobacco industry is grasping at straws to reclaim the market, our children," said Matt Myers, Campaign For Tobacco Free Kids.

Youth advocates are trying to educate their peers to reject all forms of tobacco marketing, specifically their most recent: candy flavored cigarettes.



Experience from the Field: Youth Prevention Policy Change



Colville Confederated Tribes:

In our tribal system, we have established two specific codes that give our youth boundaries regarding the use, possession, purchase, or acquisition of tobacco.

The first code restricts the use of tobacco products and the possession of tobacco by minors under the age of 18. If minors are found using or carrying commercial tobacco products, the tobacco products are considered contra band and can be seized by the police. This does not include tobacco products that are used, possessed, purchased, or obtained for traditional tribal ceremonial purposes, as written in the Colville Tribal Law and Order Code.

The second tobacco code regulates those who sell or give tobacco products to minors. If an adult is caught giving or selling tobacco to minor, the first infraction is supposed to be a \$50.00 fine and each subsequent infraction is a \$100.00 fine.

A minor who is convicted of breaching this policy is referred to the tobacco program coordinator, and is required to:

- A) participate in a tobacco cessation program for one hour; or
- B) provide community service for two hours;

If a second infraction occurs (under the discretion and administration of the tobacco coordinator) the minor is required to:

- A) participate in a tobacco cessation program for one hour;
- B) provide community service for two hours; and
- C) participate in a peer training group for four hours;

If a third infraction occurs, the minor is required to attend rehabilitative treatment in a one-hour, six-week cessation program (or a substantially equivalent program), or conduct 20 hours of community service.

This code was established and revised on September 20, 2001 in a special session held by the Colville Business Council. Unfortunately, in all the years that this policy has been in effect there has not been a single case reported in the Colville Tribal Court system.

While the overall concept to have a tobacco policy in place was achieved, I feel that in order for this policy to work, the Business council needed to add a section to the law enforcement code that would monitor our youth and their access to tobacco, and the policy needed a more feasible penalty.

Right now, I think that the Law Enforcement looks at all of the issues that are on their plate, and must feel like they have priorities that are more important than tobacco and youth. To make this policy more effective, more individuals with signing power needed to be involved with the process. There needed to be some sort of way to increase the police officer's salary or some kind of incentive for them to monitor the youth. I think teen tobacco use needs to be monitored in school areas or at youth hangouts, and the current policy doesn't consider this.

To improve the situation, I am working with members of the court staff to get their input and determine what they feel would be an effective way to deal with those who get caught or charged with this offense. I have been getting referrals from the Court for children who are under the care of Children and Family Services. Right now I am in the process of trying to create a working relationship with the court and law enforcement, then we can work together to add to or revise the policy. It is a slow process, but we will get there.

I feel the policy is worth upholding since the leading cause of death in Native American people is Cancer. I understand each community is unique in that we have set priorities. I look at statistics and see that smoking cigarettes is an addictive habit, which leads to more serious drug use. If we could look at smoking in this sense, shouldn't we stop one addiction now, before helping to create another?

Desirae Bear Eagle
Tobacco Coordinator,
Colville Confederated Tribes



Youth Prevention Policy Templates and Tribal Examples



Template for Regulating the Sale and Distribution of Tobacco and Tobacco Products:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, the _____ Indian Tribe has a Health Program duly appointed by the Tribal Council to provide healthcare oversight on the behalf of its tribal members; and,

WHEREAS; tobacco use is the leading preventable cause of death within American Indian populations; and

WHEREAS; according to the 1990–1994 *Monitoring the Future Survey*, smoking prevalence rates are highest among American Indian and Alaska Native high school seniors (males, 41.1%; females, 39.4%); and

WHEREAS; more than half the tobacco retail outlets in our community have self-service tobacco displays where customers, including young people, have access to cigarettes, spit tobacco, and cigars without the assistance of a store employee; and

WHEREAS; cigarettes are the item most frequently taken by shoplifters; and

WHEREAS, there are currently no tobacco policies to adequately prevent young people from gaining access to these deadly products,

THEREFORE, BE IT RESOLVED, that the Tribal Council hereby adopts the following tobacco policy:

Include One or More of the Following Policies:

It shall be unlawful for any person, business, or tobacco retailer to sell tobacco products, or provide tobacco products free of charge, to anyone who is less than _____ years of age.

No person, business, tobacco retailer, or owner, manager or operator of any establishment subject to this ordinance shall sell, offer to sell, or permit to be sold any tobacco product to an individual without requesting and examining identification establishing the purchaser's age as _____ years or greater, unless the seller has some reasonable basis for determining the buyer's age.

Any person, business, tobacco retailer or other establishment subject to this ordinance shall post plainly visible signs at the point-of-purchase of tobacco products that state "The sale of tobacco products to persons under ___ years of age is prohibited by law. Photo ID is required to purchase tobacco." The letters of these signs shall be at least one-quarter inch (1/4") high.

No person, business, or tobacco retailer shall locate, install, keep, maintain or use, or permit the location, installation, keeping, maintenance or use on his, her or its premises, any vending machine for the purpose of selling or distributing any tobacco product.

It shall be unlawful for any person, business, or tobacco retailer to sell, permit to be sold, offer for sale, or display for sale, any tobacco product or tobacco promotional product by means of self-service merchandising or by means other than vendor-assisted sales.

It shall be unlawful for any person, business, or tobacco retailer to sell, permit to be sold, offer for sale, or display for sale, any tobacco packages containing fewer than 20 cigarettes, or un-packaged individual cigarettes.

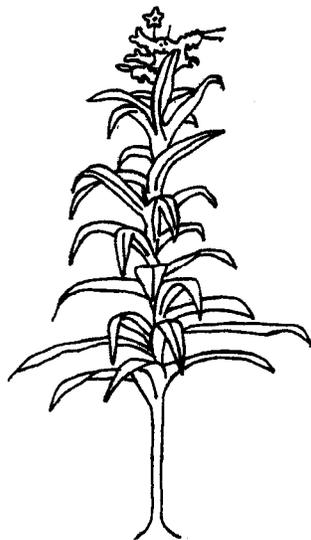
Cont...

It shall be unlawful for any person, business, or retailer to sell, permit to be sold, offer for sale, or display for sale candy “cigarettes,” bubblegum packaged like chewing tobacco, or any other tobacco-like candy.

It shall be unlawful for any person, business, or tobacco retailer to sell, permit to be sold, offer for sale, or display for sale tobacco “blunts” (sweetened cigarette wrappers composed of fruit and tobacco), and other youth targeted tobacco products, including bidis, cloves, or “sweet” flavored cigarettes or chew.

It shall be unlawful for any person, business, or tobacco retailer to sell or distribute any Tobacco Product for free or below the cost of such products to the sellers or distributors of the products for commercial or promotional purposes, to members of the general public in public places or at public events.

BE IT FURTHER RESOLVED, that any smoking or smokeless tobacco issue that cannot be resolved by (Enforcer of this Policy) will be referred to the Tribal Council for final determination.



Section 1: Definitions.

Section 2: Intent and Scope of Ordinance

This resolution shall apply to _____.

Or shall not apply to _____.

Section 3: Non-retaliation. No person or employer may discharge, refuse to hire or in any manner retaliate against any employee, applicant for employment, or customer because such employee, applicant, or customer reports or attempts to prosecute any violation of this policy.

Section 4: Penalties.

Offenses under this policy shall be subject to the following penalty:

_____ (How will violations be dealt with)_____.

Every full business day during which a business activity continues to be conducted in violation of this Ordinance shall be considered a separate offense.

Section 5: Effective Date. This resolution is effective on and after _____.

CERTIFICATION:

On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was:

_____ For

_____ Against

_____ Abstain

CHAIRPERSON

VICE-CHAIRPERSON

Template For Regulating Tobacco Industry Adverting on Tribal Lands:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, the _____ Indian Tribe has a Health Program duly appointed by the Tribal Council to provide healthcare oversight on the behalf of its tribal members; and,

WHEREAS; tobacco use is the leading preventable cause of death within American Indian populations; and

WHEREAS; according to the 1990–1994 *Monitoring the Future Survey*, smoking prevalence rates are highest among American Indian and Alaska Native high school seniors (males, 41.1%; females, 39.4%); and

WHEREAS; tobacco retailers are often paid to put tobacco products on “good” shelving space, and given other promotional items for the store; and

WHEREAS; a study in the *Journal of the National Cancer Institute* found that teens are more likely to be influenced to smoke by cigarette advertising than they are by peer pressure. Approximately one third of underage experimentation with tobacco is attributable to tobacco company advertising and promotion; and

WHEREAS; teens are three times more sensitive to tobacco advertising than are adults, and teens are twice as likely to recall seeing a tobacco advertisement in the previous two weeks. Tobacco Industry advertisements target youth, marketing commercial tobacco products as cool, popular, sexy, rebellious, fun, exciting, relaxing, and mature; and

WHEREAS; the Tobacco Industry currently spends more that \$11.2 billion a year on advertising, discounts and promotional efforts at stores and smoke shops.

WHEREAS; studies show that this type of advertising directly influences the number of kids who buy cigarettes and what products and brands they choose to buy and use; and

WHEREAS, there are currently no tobacco policies to adequately protect young people from the grips of tobacco industry advertising,

THEREFORE, BE IT RESOLVED, that the Tribal Council hereby adopts the following tobacco policy:

Include One or More of the Following Policies:

It shall be unlawful for any person, business, or tobacco retailer to display Tobacco Industry advertisements on tribal land.

It shall be unlawful for any person, business, or tobacco retailer to display Tobacco Industry advertisements below ____ feet, as measured from ground level.

It shall be unlawful for any person, business, or tobacco retailer to display Tobacco Industry advertisements within ____ feet of youth oriented products such as toys, candy or magazines.

For every Tobacco Industry advertisement displayed by a business or tobacco retailer, an equal number of anti-commercial tobacco posters must displayed in a similarly prominent location.

Is shall be a violation of this policy for any person to wear clothing or other items that bear tobacco company brand logos at schools or other community events and venues.

Is shall be a violation of this policy for any person, business, or tobacco retailer to display outdoor tobacco ads within 1,000 feet of a school or playground.

It shall be unlawful for any person, business, or entity to distribute free tobacco samples at community events or at tobacco retailers.

It shall be unlawful for any person, business, or entity to advertise any commercial tobacco products, or distribute free or low cost tobacco industry materials.

Is shall be a violation of this policy for any tribal group, organization, or agency to accept tobacco industry sponsorship for financing community events, powwows, rodeos, or sporting events.

BE IT FURTHER RESOLVED, that any smoking or smokeless tobacco issue that cannot be resolved by (Enforcer of this Policy) will be referred to the Tribal Council for final determination.

Section 1: Definitions.

Section 2: Intent and Scope of Ordinance

This resolution shall apply to _____.

Or shall not apply to _____.

Section 3: Non-retaliation. No person or employer may discharge, refuse to hire or in any manner retaliate against any employee, applicant for employment, or customer because such employee, applicant, or customer reports or attempts to prosecute any violation of this policy.

Section 4: Penalties.

Offenses under this policy shall be subject to the following penalty:
_____ (How will violations be dealt with) _____.

Every full business day during which a business activity continues to be conducted in violation of this Ordinance shall be considered a separate offense.

Section 5: Effective Date. This resolution is effective on and after _____.

CERTIFICATION:

On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was:

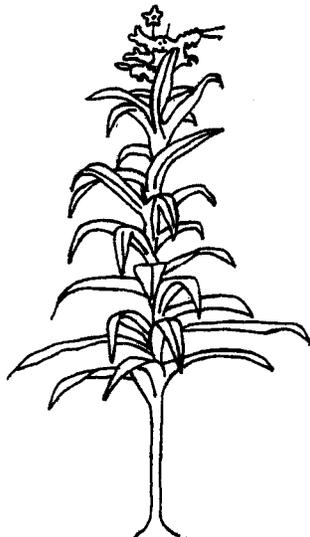
_____ For

_____ Against

_____ Abstain

CHAIRPERSON

VICE-CHAIRPERSON



Template For Promoting Social, Tribal, and Familial Responsibility for Youth Access to Tobacco Products:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, the _____ Indian Tribe has a Health Program duly appointed by the Tribal Council to provide healthcare oversight on the behalf of its tribal members; and,

WHEREAS; tobacco use is the leading preventable cause of death within American Indian populations; and

WHEREAS; according to the 1990–1994 *Monitoring the Future Survey*, smoking prevalence rates are highest among American Indian and Alaska Native high school seniors (males, 41.1%; females, 39.4%); and

WHEREAS; youth who have parents or family members that smoke are three times more likely to begin smoking themselves; and

WHEREAS; parents, elders, and community members are roll models for tribal youth, and the actions of all adults shape the beliefs of our young people; and

WHEREAS, there are currently no policies that provide guidance to young people about the appropriate use of sacred tobacco, and the misuse of commercial tobacco products; and

THEREFORE, BE IT RESOLVED, that the Tribal Council hereby adopts the following tobacco policy.

Include One or More of the Following Policies:

Is shall be a violation of this policy for any person to provide young people with easy access to tobacco products at funerals, social events, or family gatherings.

It shall be mandatory that all schools and culture camp programs educate our young people about the difference between commercial tobacco products and traditional tobacco use.

BE IT FURTHER RESOLVED, that any issue that cannot be resolved by (Enforcer of this Policy) will be referred to the Tribal Council for final determination.

Section 1: Definitions.

Section 2: Intent and Scope of Ordinance

This resolution shall apply to _____.

Or shall not apply to _____.

Section 3: Non-retaliation. No person or employer may discharge, refuse to hire or in any manner retaliate against any employee, applicant for employment, or customer because such employee, applicant, or customer reports or attempts to prosecute any violation of this policy.

Section 4: Penalties.

Offenses under this policy shall be subject to the following penalty:
_____ (How will violations be dealt with)_____.

Section 5: Effective Date. This resolution is effective on and after _____.

CERTIFICATION:

On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was:

_____ For

_____ Against

_____ Abstain

CHAIRPERSON

VICE-CHAIRPERSON



Tribal Example 1*:

██████████, Michigan, 01-02-03

TRIBAL ORDINANCE PROHIBITS MINORS' POSSESSION OF ANY TOBACCO PRODUCTS

The ██████████ Executive Council voted Oct. 14, 2002 to amend Chapter VI of the Tribal Code to prohibit the use of tobacco products by minors, punishable under tribal law.

The amendment was approved by the Bureau of Indian Affairs on Nov. 5. It goes into effect immediately for all minors of the ██████████ Indian Community.

Resolution Number 02-10-14 Amendment to Chap VI of the Tribal Code reads as follows:

648. Possession or use of tobacco products by a minor - A person under the age of 18 shall not possess or smoke cigarettes or cigars; or possess or chew, suck, or inhale tobacco or tobacco snuff, or possess or use tobacco in any form, on any lands comprising the Reservation of the ██████████ Indian community. A person who violates this section is subject to a civil remedial forfeiture of \$50 for each violation.

A. False representation of age sets him/herself to be 18 years of age or older for the purpose of purchasing or attempting to purchase tobacco products shall be subject to a civil remedial forfeiture of \$75 for each violation.

B. Application of Chapter VII - Juvenile Code - Any minor who is alleged to have violated this section shall be tried as an adult, and shall be subject to the procedures of Chapter VI of the Tribal Code.

C. Sale of tobacco products to minors - Any person who sells, gives, or furnishes any cigarette, cigar, chewing tobacco, tobacco snuff, or tobacco in any other form to a minor is guilty of misdemeanor, punishable by incarceration of not more than 30 days, a fine of \$500, or both.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 2*:

3-7-37 Using, Possessing, Purchasing or Obtaining Tobacco Products by Minors

“Minor,” for purposes of this section, means a person under the age of 18.

A minor commits the infraction of using, possessing, purchasing, or obtaining tobacco product, as defined in Chapter ■■■, if the minor uses, posses, purchases, or obtains tobacco products.

Rehabilitation, Community service: The following penalties shall be given:

1. For first infraction: Under the discretion and administration of the tobacco coordinator:
 - participation in a tobacco cessation program for one hour; or
 - community service for two hours;
2. For second infraction: Under the discretion and administration of the tobacco coordinator:
 - participation in a tobacco cessation program for one hour;
 - community service for two hours; and
 - participation in a peer training group for four hours;
3. For third infraction: rehabilitative treatment in a one-hour, six week cessation program or substantially equivalent program, or 20 hours of community service.

Tobacco products possessed by minors are considered contraband and may be seized by police, as provided in Chapter ■■■.

It shall be a defense to a charge of a violation of this section that tobacco products were used, possessed, purchased, or obtained for traditional tribal ceremonial purposes.

Cont...

3-7-38 Selling or Giving Tobacco Products to Minors

“Minor,” for purposes of this section, means a person under the age of 18.

“Person,” for the purposes of subsection 3-7-38(c), does not include an

“Operator,” as defined in Chapter ■■■, which governs violations by an operator.

A person commits the infraction of selling or giving tobacco products, as defined in Chapter ■■■, to a minor if the person sells or gives, or permits to be sold or given, tobacco products to a minor, while knowing that the minor is a minor.

Fine: The following penalties shall be given:

- For first infraction: \$50 fine;
- For each subsequent infraction: \$100 fine.

It shall be a defense to a charge of a violation of this section that tobacco products were used, possessed, purchased, or obtained for traditional tribal ceremonial purposes.

***To ensure confidentiality, all identifying features have been blacked out.**

Chapter 6:

Tobacco Tax Policies



The Purpose of Tobacco Taxes



Taxes are designed to increase the price of commercial tobacco products, which in turn make them more difficult for young people to purchase. Consequently, many of the “reasons” discussed in the previous chapter for implementing youth prevention policies hold true for tobacco taxes as well. Tobacco taxes reduce youth access to tobacco, thereby preventing early addiction, ill-health, and other risky behaviors.

Taxes Prevent Addiction among Youth:

Research suggests that young people are more sensitive than adults to fluctuations in tobacco price, with even a small increase causing significant declines in adolescent tobacco use. According to the Institute of Medicine, “the single most direct and reliable method for reducing tobacco consumption is to increase the price of tobacco products, thus encouraging cessation and reducing initiation of tobacco use.”⁸⁷ Similarly, the World Bank carefully evaluated existing research and data worldwide, and concluded that “the most effective way to deter children from taking up smoking is to increase taxes on tobacco. High prices prevent some children and adolescents from starting, and encourage those who already smoke to reduce their consumption.”⁸⁷ This research found that for every 10% increase in price, adolescent smoking rates were cut by 7% and overall cigarette consumption was reduced by 3-5% for the entire population.

Even more significant, according to studies conducted by a leading tobacco manufacturer, RJ Reynolds, if prices were 10% higher, the incidence of smoking among youth age 12-17 years would be 11.9% lower. And research conducted by Philip Morris, another leading producer of commercial tobacco products, has found that “a high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the share of the quitting population...price, not tar level, is the main driving force for quitting.”⁸⁷

Nationally, it is estimated that a \$2-per-pack tax increase would reduce cigarette sales by more than 4 billion packs each year, and would generate a 10-percent reduction in smoking. Consequently, 4.7 million smokers would quit commercial tobacco use, and 3 million premature deaths would be prevented. Such a tax increase would enhance quit rates disproportionately among teenagers, deterring nearly 6 million youths from becoming regular smokers in adulthood.

Communities Support Tobacco Taxes:

Tribal communities recognize the need to protect young people from addiction and guide them towards healthy decision making. When polled, many communities favor an increased tobacco price when the revenue is earmarked to help smokers quit and support youth prevention.⁸⁷

Tribe to charge cigarette tax

EIJIRO KAWADA; The News Tribune - January 6th, 2005

<http://www.thenewstribune.com/news/government/v-printer/story/4408996p-4183482c.html>

Smoke shops run by Puyallup Tribe members likely will start collecting taxes on cigarettes sold to nontribal customers, generating about \$10 million a year for the state. In exchange, the Puyallups will be allowed to retain at least some competitive edge by taxing smokers at a lower rate than retailers off the reservation – and lower than the state’s 17 other tribes. Tribal smoke shops also will no longer face raids from government agents confiscating their merchandise and cash registers. Chewing tobacco and cigars would not be affected by the deal.

If the agreement is approved by the Legislature and ratified by the next governor, the Puyallups will collect \$2.50 less per carton than the state collects from other retailers. Other Washington tribes collect more tax than the Puyallup Tribe will, and thus charge higher prices for a carton of 10 cigarette packs. But they get to keep all the revenue.

The state began talks with the tribes in 2001, and the deal with the Puyallups is the 18th agreement regarding cigarettes. With it, Locke said, 90 percent of cigarettes sold on tribal land in Washington would be covered by such agreements with the state.

Although other tribes don’t share their cigarette tax revenues with Washington, the state also considers the agreements with them a success because they’ve closed the gap between prices of cigarettes sold by tribal and nontribal retailers. This levels the competitive playing field and discourages illegal cigarette trafficking.

The agreement with the Puyallups also requires that the tribe’s 23 independent retailers buy their cigarettes through state-licensed wholesalers and not sell the cigarettes below the wholesale price.

Wednesday’s announcement was received with mixed reactions at Puyallup smoke shops. Many customers expressed disappointment with losing cheaper cigarettes and frustration with having to pay taxes on them to the state.

But some, such as Barbara Fish of Tahuya, Mason County, who stopped by BJ’s II in Fife, said they don’t mind paying more. “As long as the Native Americans are getting a fair share (from the tax), I don’t have a problem with it at all,” she said.



Types of Tobacco Taxes



As sovereign nations, federally recognized tribes can establish taxes on tobacco products in any manner that they choose. Tribes may choose to tax all tobacco products, including cigarettes, chew, snuff, bidis, and pipe tobacco, or may choose to tax only specific products determined by the tribe. They may choose to tax tobacco products at any amount, and may designate how the revenue that is generated is spent. All tobacco policies will require going through a formal policy change process, likely involving the Tribal Council's economic committee and the tribe's attorney.

Tribe will apply tax to tobacco sales, education

Excerpts from: Associated Press, 05:50 PM MST on Tuesday, January 20, 2004

FORT HALL -- Smokers who light up cigarettes purchased on the Fort Hall Indian Reservation now contribute to tribal health and education every time they buy smokes. Some of the money will help acquaint tribal youth with the dangers of tobacco and the role the plant has played in Indian culture.

Shoshone-Bannock leaders introduced a tobacco tax in November that provides the tribe with three dollars for every carton of cigarettes sold on the reservation. Idaho's other tribes also set taxes.

A tobacco prevention program is under way at Shoshone-Bannock Junior-Senior High School. Students will design anti-smoking posters as part of an exhibit that will travel to other schools. But the exhibit also will educate people about tobacco's religious role in Indian culture. The smoke is considered a prayer sent to heaven.



Special Considerations for Writing, Passing and Implementing Tobacco Taxes



Tribal members in many states are not required to pay state tax for tobacco products that are purchased on reservation lands or in other tribally owned properties. Consequently, tobacco sales among many tribes have increased drastically as a result of the lower price of commercial tobacco products.

Initiating the Process:

As is the case with many of the policies discussed in this workbook, the key to reaching agreement for policy change is found in initiating the process with an open mind and a sincere interest in finding common ground. Beginning the process with a strong desire to push a certain agenda or position can foster mistrust or resistance.

Economic Challenges:

For tribes that do not have any form of tobacco tax in place, a great deal of discussion and education will likely involve the economic challenges associated with such an undertaking. By selling tobacco at prices lower than elsewhere in the State, your tribe may benefit from this price advantage by generating income from tobacco sales. This revenue is likely used to fund much needed community services. While these services are undoubtedly of great benefit to the tribe, these advantages must be openly weighed against the many disadvantages caused by commercial tobacco use and easy youth access to these products (discussed in Chapters 1 and 4). The benefits of these services come at a significant price, contributing to ill health, increasing community healthcare costs, and fostering addiction. Use the formulas found on page 148 to estimate the true cost of tobacco to your community, and weigh these costs when discussing new taxes with tribal decision-makers.



State Compacting:

In some States, Tribes and States have established compacts that determine the tribe's tax on tobacco. Consider what role, if any, such an agreement might have on your Tribe's current tax structure. Before getting too invested in the policy change process, talk with your tribe's attorney or council members to better understand your own tribe's status.

If your tribe is interested in developing a State compact, identify State representatives who will consider the unique culture, governmental structure, business structure, location, needs, and challenges present within your tribe. Likewise, when gathering tribal supporters, find people who can see the benefit of working with the state on a compact, memorandum of agreement, or other suitable mechanism. For some tribes, the discussion will need to start with your elected officials or with economic development staff, for others it may be with tribal administrators, tribal attorneys, or some person with authority for setting or influencing policy. While you may find sympathetic ears among tribal health directors, if the issue ultimately has an economic impact, you will probably have to engage people outside the health field.

Yakamas Agree to Cigarette Tax

Excerpts from: Yakima Herald-Republic (WA), July 23, 2004.

Author: Philip Ferolito

Ending decades of dispute, the Yakama Nation and the governor's office reached an agreement on taxing tobacco purchased by non-Indians on the reservation, state officials announced Thursday. The agreement calls for the tribe to initiate a tax equivalent to the state's, allowing tobacco sales to remain competitive. The state, in return, won't impose its tax on tribal sales to non-Indians.

As a sovereign nation, the Tribe is immune from state taxes, and a dispute over the state losing revenue for tobacco sales on the reservation to non-tribal members has led to many stores getting their stock confiscated by the state, Tribal Council chairman Jerry Meninick said. But the agreement, which allows the tribe to retain revenue garnered from the tax, ends that. The tax could garner about \$1 million annually for the tribe.

The Yakama Nation, which has 20 cigarette vendors, is one of 12 tribes to enter into such an agreement with the state of Washington, and nine other tribes have shown interest.

Additional Resources:

“Strategic Thinking on State Tobacco Tax Increases”

<http://www.ttac.org/assistance/pdfs/TobaccoTax.pdf>

This document was designed to assist public health advocates in recognizing and weighing the strategic decisions that must be made before beginning a campaign to increase tobacco taxes at the state level. Many of the guide’s strategies and recommendations are also of value to tribal representatives.





Generating Community Support for Tobacco Taxes



Because the decision on this topic will likely lie with economic decision-makers, your “Talking Points” ought to include the economic benefits of enacting such a change. After identifying the smoking prevalence rate for your tribe, use the following formulas to estimate the total cost of tobacco on your community, including healthcare costs, loss of economic productivity, the cost of premature loss of community members to tobacco-related diseases, and the social cost of addiction.

Talking Points For Increasing Taxes:

Current commercial tobacco use rate: _____ percent

If you do not know your tribe’s tobacco use rate, use 40% - Nationally, nearly 40% of AI/AN adults currently use tobacco.

Number of adult tribal members: _____

Estimate the healthcare cost for your tribe: The Indian Health Service estimates that it spends \$200 million dollars each year to treat tobacco related diseases,⁴ and the CDC estimates that the U.S. spends \$1,623 per smoker per year on direct medical costs associated with tobacco use. These same figures can be used to estimate the cost of tobacco use for your tribe’s healthcare system.

(# of adult community members) X (% that use tobacco) X (\$1,623 per year) =
Estimated cost per year in excess medical expenditures due to tobacco use.

If you have a population of 1,000, with a 40% smoking rate, this equation would look like:

$(1000) \times (.40) \times (\$1,623 \text{ per year}) = \mathbf{\$649,200}$

\$649,200 dollars are spent each year on smoking-related health services for the 400 adult smokers in your community.

Estimate the cost of declining economic productivity: The CDC estimates that the U.S. loses \$1,760 per smoker per year because of productivity declines associated with tobacco use. These same figures can be used to estimate the cost of declining economic productivity for your tribe. (Loss of economic productivity includes tobacco-related disability and absences from work and community activities.)

(# of adult community members) X (% that use tobacco) X (\$1,760 per year) =
Estimated cost of productivity loss due to tobacco use per year.

If you have a population of 1,000, with a 40% smoking rate, this equation would look like:

$$(1000) \times (.40) \times (\$1,760 \text{ per year}) = \mathbf{\$704,000}$$

\$704,000 dollars are lost each year by the tribe as a result of tobacco-related disability and absences from work for the 400 adult smokers in your community.

Given a population of 1,000 and a smoking rate of 40%:

When taken together, the financial cost of tobacco-related healthcare and productivity loss amount to **\$1,353,200** per year for the tribe.

Estimate the cost of premature death due to tobacco-related diseases: Nearly 50% of smokers will die prematurely as a result of their addiction. On average, people who use commercial tobacco products die 7-10 years earlier than those that do not smoke or chew.

(# of adult community members) X (% that use tobacco) X (.50) =
**Number of tobacco-related premature deaths
that will occur within the community.**

If you have a population of 1,000, with a 40% smoking rate, this equation would look like:

$$(1000) \times (.40) \times (.5) = \mathbf{200}$$

Of the 400 adult tribal members that currently smoke in your community, 200 of them will die 7-10 years early from a tobacco-related disease.

$$(\text{\# of adult community members}) \times (\% \text{ that use tobacco}) \times (.5) \times (8.5) =$$

Number of years lost due to premature death.

If you have a population of 1,000, with a 40% smoking rate, this equation would look like:

$$(1000) \times (.40) \times (.5) \times (8.5) = \mathbf{1,700}$$

With the premature death of 200 community members, 1,700 years worth of wisdom, friendship, and culture will be lost.

What price would you place on each life, and the opportunity for additional time spent with loved ones?



Estimate the social cost of guiding young people towards a path of addiction: Teens model adult behavior, and are three times more likely to smoke if a parent or sibling smokes.

$$(\text{\# of adult community members}) \times (\% \text{ that use tobacco}) =$$

Number of adult roll models that the tribe's youth observe smoking in the community.

If you have a population of 1,000, with a 40% smoking rate, this equation would look like:

$$(1000) \times (.40) = \mathbf{400}$$

Teens have 400 adult role models from which they can learn how to smoke, perpetuating addiction.

What price would you place on a life free of addiction? Over the course of 10 years, a pack a day smoker will spend nearly \$16,800 on cigarettes.

Talking Points For Increasing Taxes:

Tobacco taxes affect adolescent access to and use of commercial tobacco products.

- Young people are much more sensitive to fluctuations in tobacco price than are adults. Even a small increase in price can cause a significant decline in adolescent tobacco use.
- The Institute of Medicine concluded that the single most direct and reliable method for reducing tobacco consumption is to increase the price of tobacco products, thus encouraging cessation and reducing initiation of tobacco use.⁸⁷
- The World Bank carefully evaluated existing research and data worldwide, and concluded that “the most effective way to deter children from taking up smoking is to increase taxes on tobacco. High prices prevent some children and adolescents from starting, and encourage those who already smoke to reduce their consumption.”⁸⁷
- Increasing tobacco taxes is an effective way to prevent and reduce smoking, especially among kids. According to RJ Reynolds, if prices were 10% higher, the incidence of smoking among youth age 12-17 years would be 11.9% lower. According to Philip Morris, “*A high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the share of the quitting population...price, not tar level, is the main driving force for quitting.*”⁸⁷
- Nationally, it is estimated that a \$2-per-pack tax increase would reduce cigarette sales by more than 4 billion packs each year, which would achieve a 10-percent reduction in smoking. An estimated 4.7 million smokers would quit in response to such an increase, and 3 million premature deaths would be prevented. The tax increase would enhance quit rates disproportionately among teenagers, and would deter about 6 million youths from becoming regular smokers as adults.⁸⁷
- Survey data shows that the public supports such a tax. A 2002 survey found that 61 percent of Americans would favor such a tax increase if the revenue were used to help smokers quit and prevent children from starting to smoke.

We can predict that for every 10 percent increase in the price of cigarettes, youth smoking will drop by about 7%, and overall adult cigarette consumption will drop by 3%-5%.

(TobaccoFreeKids)

Tribal tobacco taxes decrease tobacco consumption among youth and increase tribal revenue.

- Using Idaho's statewide tribal smoking and tobacco sales rates as an example (see the tables on the following two pages), by raising the tobacco tax by only 10¢, over \$4,400 in tribal revenue would be generated, and 2.1% of youth (and 0.6% of adults) would either be deterred from initiating tobacco use or would end their addiction to commercial tobacco products. **Note:** The \$4,400 net revenue gain does account for revenue lost due to the 2.1% drop in adolescent tobacco use and the .6% drop in adult tobacco use.
- Likewise, if the tobacco tax was increased by 50¢, over \$21,600 in tribal revenue would be gained and 10.3% of youth (and 3.2% of adults) would either be deterred from initiating tobacco use or would end their addiction to commercial tobacco products.
- If the tobacco tax increased by \$1.00, over \$41,800 in tribal revenue would be gained and 20.5% of youth and (6.3% of adults) would either be deterred from initiating tobacco use or would end their addiction to commercial Tobacco products.
- As you can see through this pattern, young people are much more sensitive to fluctuations in tobacco price than are adults. Even a small increase in price can cause a significant decline in adolescent tobacco use.

Tribe hikes cigarette tax on reservation

Great Falls Tribune <<http://www.greatfallstribune.com/apps/pbcs.dll/frontpage>>
ACROSS the BIG SKY. Thursday, January 27, 2005

HAVRE - Chippewa Cree tribal officials have raised the tax on cigarettes sold on the Rocky Boy's Reservation.

With the 50-cent tax hike, a pack of cigarettes at a Rocky Boy Agency grocery costs \$3.50, according to a survey by the Havre Daily News. Packs of the same brand started at \$4.41 in Havre stores, the survey found. Cigarettes sold on the reservation without state tax may be sold only to tribal members, said Neil Peterson of the state Bureau of Revenue.

Money generated by the tribal tax will cover youth and health programs on the reservation, said Richard Sangrey, tribal council chief of staff.

Idaho State - Estimated Effect of Tribal Taxes on Youth Smoking Prevalence:

Estimated prevalence of Indian Youth Smokers (in Idaho): 39%						
Amount of Tax and effect on per pack price			Estimated effect of tax increases on number of smokers/quitters and overall prevalence			Projected reduction in smoking behavior
Proposed Increase of Tax Amt.	Total per pack tax with new tax	Avg. Cost per pack with tax	Est. # of Smokers at tax level	Est. # of Quitters at tax level	Effect of Tax on Prevalence	
	\$ 0.04	\$ 3.37	928		39.0%	
\$ 0.10	\$ 0.14	\$ 3.47	909	19	38.1%	-2.1%
\$ 0.15	\$ 0.19	\$ 3.52	899	29	37.8%	-3.1%
\$ 0.20	\$ 0.24	\$ 3.57	890	38	37.4%	-4.1%
\$ 0.25	\$ 0.29	\$ 3.62	881	47	37.0%	-5.1%
\$ 0.30	\$ 0.34	\$ 3.67	870	58	36.5%	-6.2%
\$ 0.35	\$ 0.39	\$ 3.72	861	67	36.2%	-7.2%
\$ 0.40	\$ 0.44	\$ 3.77	852	76	35.8%	-8.2%
\$ 0.45	\$ 0.49	\$ 3.82	843	85	35.4%	-9.2%
\$ 0.50	\$ 0.54	\$ 3.87	832	96	34.9%	-10.3%
\$ 0.55	\$ 0.59	\$ 3.92	823	105	34.6%	-11.3%
\$ 0.60	\$ 0.64	\$ 3.97	814	114	34.2%	-12.3%
\$ 0.65	\$ 0.69	\$ 4.02	805	123	33.8%	-13.3%
\$ 0.70	\$ 0.74	\$ 4.07	794	134	33.3%	-14.4%
\$ 0.75	\$ 0.79	\$ 4.12	785	143	33.0%	-15.4%
\$ 0.80	\$ 0.84	\$ 4.17	776	152	32.6%	-16.4%
\$ 0.85	\$ 0.89	\$ 4.22	767	161	32.2%	-17.4%
\$ 0.90	\$ 0.94	\$ 4.27	756	172	31.8%	-18.5%
\$ 0.95	\$ 0.99	\$ 4.32	747	181	31.4%	-19.5%
\$ 1.00	\$ 1.04	\$ 4.37	738	190	31.0%	-20.5%

Idaho State - Estimated Effect of Tribal Taxes on Tobacco Revenue and Adult AI/AN Smoking Prevalence:

Estimated Prevalence of Adult Indian Smokers in Idaho 39.0%									
Amount of Tax and effect on per pack price			Estimated effect of tax increase on number of smokers/quitters and overall prevalence				Estimated sales are based on State average.		
Proposed Increase of tax amt.	Total per pack tax with new tax	Avg. Cost Per Pack with tax	Est. # of Smoker at tax level	Est. # of Quitters at tax level	Effect of Tax on Prevalence	Percent of Projected decrease in use	44,752 Avg. packs sold per retail outlet	Revenue at proposed tax w/ reduced sales per outlet	Net change of proposed tax w/ reduced sales (Tribal Income)
	\$ 0.04	\$ 3.37	4,345		39.0%		44,752	\$ 1,790	-
\$ 0.10	\$ 0.14	\$ 3.47	4,319	26	38.8%	-0.6%	44,483	\$ 6,228	\$ 4,438
\$ 0.15	\$ 0.19	\$ 3.52	4,306	39	38.7%	-0.9%	44,349	\$ 8,426	\$ 6,636
\$ 0.20	\$ 0.24	\$ 3.57	4,289	56	38.5%	-1.3%	44,170	\$ 10,601	\$ 8,811
\$ 0.25	\$ 0.29	\$ 3.62	4,275	70	38.4%	-1.6%	44,036	\$ 12,770	\$ 10,980
\$ 0.30	\$ 0.34	\$ 3.67	4,262	83	38.3%	-1.9%	43,902	\$ 14,927	\$ 13,137
\$ 0.35	\$ 0.39	\$ 3.72	4,249	96	38.2%	-2.2%	43,767	\$ 17,069	\$ 15,279
\$ 0.40	\$ 0.44	\$ 3.77	4,236	109	38.0%	-2.5%	43,633	\$ 19,199	\$ 17,409
\$ 0.45	\$ 0.49	\$ 3.82	4,223	122	37.9%	-2.8%	43,499	\$ 21,314	\$ 19,524
\$ 0.50	\$ 0.54	\$ 3.87	4,206	139	37.8%	-3.2%	43,320	\$ 23,393	\$ 21,603
\$ 0.55	\$ 0.59	\$ 3.92	4,193	152	37.6%	-3.5%	43,186	\$ 25,480	\$ 23,689
\$ 0.60	\$ 0.64	\$ 3.97	4,180	165	37.5%	-3.8%	43,051	\$ 27,553	\$ 25,763
\$ 0.65	\$ 0.69	\$ 4.02	4,167	178	37.4%	-4.1%	42,917	\$ 29,613	\$ 27,823
\$ 0.70	\$ 0.74	\$ 4.07	4,154	191	37.3%	-4.4%	42,783	\$ 31,659	\$ 29,869
\$ 0.75	\$ 0.79	\$ 4.12	4,141	204	37.2%	-4.7%	42,649	\$ 33,692	\$ 31,902
\$ 0.80	\$ 0.84	\$ 4.17	4,128	217	37.1%	-5.0%	42,514	\$ 35,712	\$ 33,922
\$ 0.85	\$ 0.89	\$ 4.22	4,110	235	36.9%	-5.4%	42,335	\$ 37,678	\$ 35,888
\$ 0.90	\$ 0.94	\$ 4.27	4,097	248	36.8%	-5.7%	42,201	\$ 39,669	\$ 37,879
\$ 0.95	\$ 0.99	\$ 4.32	4,084	261	36.7%	-6.0%	42,067	\$ 41,646	\$ 39,856
\$ 1.00	\$ 1.04	\$ 4.37	4,071	274	36.6%	-6.3%	41,933	\$ 43,610	\$ 41,820

Cigarette taxes do not disproportionately hurt low income communities.⁸⁸

- It is the harms from smoking that are truly regressive. Lower-income communities already suffer disproportionately from smoking-caused disease, disability, death, and costs (thanks in no small part to cigarette company marketing tactics). Raising cigarette taxes, by getting more lower-income smokers to quit and cutback, will reduce those regressive harms and costs, not only helping lower-income smokers but reducing harms and costs to their families.
- Raising cigarette taxes helps lower-income communities the most because lower-income smokers are more likely to quit because of tax increases. That means that cigarette tax increases will reduce smoking-caused harms more sharply among lower income families and communities
- Numerous polls show that there is strong support for tobacco tax increases among lower income communities. Nobody wants cheap cigarettes in their neighborhoods.

Cigarette tax increases provide a reliable source of future tribal revenue.⁸⁸

- After a tax increase, cigarette tax revenues sharply increase and then slowly decline because of smoking rate declines -- but those declines will be gradual and completely predictable. There will be no surprises and the tribe can easily adapt.
- Tribal tobacco tax revenues are more predictable and stable than income tax or corporate tax revenues, which can decline sharply because of unexpected economic recessions.
- A tribe could easily compensate for the slow and predictable tobacco tax revenue declines by periodically increasing its tobacco tax rates, instituting an automatic inflation adjustment to its tobacco tax rates, and/or by implanting automatic rate increases whenever revenues fall below an established floor. The inflation adjustment, for example, could be based on the MSA inflation adjustment (i.e., an annual increase of 3% or the actual rate of inflation for the prior year, whichever is highest).
- Along with the small, gradual declines in cigarette tax revenue caused by smoking declines, the tribe will also be accruing significant reductions to its smoking-caused costs. Over time, these savings will more than make up for any cigarette tax revenue reductions.
- Money spent on cigarette sales will not disappear when cigarette sales decline, it will simply shift to consumer expenditures on other products or to consumer savings or investments. In other words, smokers who quit or cutback will spend or use the money they formerly spent on cigarettes in other ways – and those alternative uses are likely to produce more jobs and more productive economic activity.
- State-specific economic impact studies in New Hampshire, Texas, and Virginia found that substantial cigarette tax increases in those states would actually increase total state employment – and that reduced cigarette sales have, historically, been linked with increased state retail employment.



Experience from the Field:

The Crow tribe may soon start getting money from cigarettes sold on the reservation. Excerpts: February 1, 2005. By MIKE STARK - Of The Gazette Staff

The Crow Legislature last week approved a bill authorizing a tobacco tax. Negotiations will now begin between tribal officials and the state about a revenue-sharing agreement allowing a portion of the \$1.70 state tax to be returned to the Crow administration. Right now, cigarettes sold on the reservation include the state tax but none of that money is returned to the tribe. The only exception is the Little Big Horn Casino, where the state allows a set number of tobacco products to be sold to tribal members without the tax.

Under a revenue-sharing agreement, all tobacco products on the reservation would be sold with the state tax. The state would return a portion of the tax back to the reservation. Tribal officials estimate the tax revenue could mean an extra \$1.5 million each year for the tribe.

"This is an opportunity," said Cedric Black Eagle, vice-chairman of the Crow tribe.

Some of the money may be used to discourage nonceremonial use of tobacco products on the reservation, according to tribal officials.

The tobacco tax sparked debate in the Crow Legislature because some were concerned the tax system would compromise the tribe's sovereignty. Legal research indicated that the Crow tribe's sovereignty might actually be bolstered because implementing the tax could be seen as affirming its rights.

"Our view is that the tribe is asserting its sovereignty by enacting a tax," said Bill Watt, an attorney for the tribe. Currently, the state of Montana has revenue-sharing agreements on the Blackfeet, Fort Belknap and Fort Peck reservations, according to Neil Peterson, administrator of the Department of Revenue's customer service division.

Without the agreements, the state, wholesalers and others are faced with an increased workload by tracking a fixed number of products to be sold at tax-free stores. A revenue sharing agreement would streamline the process and provide the tribe with increased revenue.

The tax won't take effect until after the state and the tribe have completed negotiations and an agreement is approved by the Crow Legislature.

Copyright © The Billings Gazette, a division of Lee Enterprises.



Tobacco Tax Policy Templates and Tribal Examples



Tobacco Tax Template:

WHEREAS, the Tribal Council is committed to the health of _____ tribal members; and,

WHEREAS, the _____ Indian Tribe has a Health Program duly appointed by the Tribal Council to provide healthcare oversight on the behalf of its tribal members; and,

WHEREAS; tobacco use is the leading preventable cause of death within American Indian populations; and

WHEREAS; according to the 1990–1994 *Monitoring the Future Survey*, smoking prevalence rates are highest among American Indian and Alaska Native high school seniors (males, 41.1%; females, 39.4%); and

WHEREAS; young people are more sensitive to fluctuations in tobacco price than adults, with even a small increase causing significant declines in adolescent tobacco use; and

WHEREAS, there are currently no tobacco tax policies to adequately deter young people from purchasing these deadly products,

THEREFORE, BE IT RESOLVED, that the Tribal Council hereby adopts the following tobacco policy:

Include One or More of the Following Policies:

It shall be unlawful for any person, business, or tobacco retailer to sell tobacco products, or provide tobacco products free of charge, to anyone who is less than _____ years of age.

There is hereby levied and imposed, a tax upon the sale of all commercial tobacco products sold within the Reservation in the amount of ___ per pack, or if sold by the carton, ___ per carton. This tax is imposed upon all tobacco retailers.

To promote community health and wellness, ___ percent of all revenue generated as a result of this tax will be used to fund tobacco prevention activities among youth and cessation support for current smokers wanting to quit.

BE IT FURTHER RESOLVED, that any smoking or smokeless tobacco issue that cannot be resolved by (Enforcer of this Policy) will be referred to the Tribal Council for final determination.

Section 1: Definitions.

Section 2: Intent and Scope of Ordinance

This resolution shall apply to _____.

Or shall not apply to _____.

Section 3: Non-retaliation. No person or employer may discharge, refuse to hire or in any manner retaliate against any employee, applicant for employment, or customer because such employee, applicant, or customer reports or attempts to prosecute any violation of this policy.

Section 4: Penalties. Offenses under this policy shall be subject to the following penalty:
_____ (How will violations be dealt with) _____.

Every full business day during which a business activity continues to be conducted in violation of this Ordinance shall be considered a separate offense.

Section 5: Effective Date. This resolution is effective on and after _____.

CERTIFICATION - On _____, 2005, this resolution was adopted at a regularly scheduled council meeting, and the vote was:

_____ For _____ Against _____ Abstain

CHAIRPERSON

VICE-CHAIRPERSON

Tribal Example 1*:

WHEREAS, The ██████████ Tribal Council has been empowered to act for and on behalf of the ██████████ Tribe of Idaho, pursuant to the Constitution and By-Laws, ratified by the members of the ██████████ Tribe on April ██████████, and

WHEREAS, The ██████████ Tribe of Idaho, rather than the State of Idaho, has civil jurisdiction over Indian trust lands of the ██████████ Tribe and its members, and

WHEREAS, The ██████████ Tribal Council deems it essential to the health, security and general welfare of the ██████████ Tribe and its members to enact a comprehensive tobacco ordinance levying an excise tax upon their distribution and sale, now therefore,

THE ██████████ TRIBE OF IDAHO does hereby promulgate as a Tribal Ordinance the regulations listed below.

Tobacco Regulations

Section 1. Title.

This chapter shall be known as the ██████████ Tobacco Code.

Section 2. Definitions.

For the purposes of this chapter, unless otherwise required by the context, the following words and phrases shall have the following meanings:

- 1) "Tribe" shall mean the ██████████ Tribe of Idaho.
- 2) "Council" shall mean the ██████████ Tribal Council.
- 3) "Tobacco Products" shall mean cigarettes, cigars, pipe or other smoking tobacco, snuff, chewing tobacco, and other forms of tobacco prepared in such manner as to be suitable for chewing or smoking.
- 4) "Cigarettes" shall mean any roll for smoking made wholly or in part of tobacco, irrespective of size or shape and irrespective of the tobacco being flavored, mixed with any other ingredient, or otherwise adulterated, where such roll has a wrapper or a cover made of paper or any material, except where such wrapper or cover is wholly or in the greater part made of natural leaf tobacco in its natural state.
- 5) "Tobacco Outlet" shall mean a retail sales business licensed by the council to sell tobacco products on trust land.

Cont...

- 6) "Operator" shall mean an enrolled member of the [REDACTED] Tribe licensed by the Council to own and operate a tobacco outlet on trust lands. In the event of a tribally rather than individually owned outlet, the operator shall be the Tribal Council or an individual to whom the Council delegates an operator's duties. The Council will be required to purchase a license in the same manner and be bound by the same requirements applicable to an individual operator except that no provision of this ordinance is to be construed as a waiver of sovereign immunity.
- 7) "Tribal License" or "Tobacco License" or "Tobacco Outlet License" shall mean the license issued to the operator pursuant to this chapter by the Council.
- 8) "Retail Selling Price" shall mean that price paid by the ultimate consumer to the operator for the tobacco product.
- 9) "Excise Tax" shall mean the tax levied by the council on each sales unit (eg. Pack, carton, etc) which is to be collected by the operator from the ultimate consumer and remitted to the Tribe.

Section 3. Licensing of Tobacco Outlets.

The Council may license one or more tobacco outlets on trust lands.

Section 4. Nature of Tobacco Outlets.

Each Tobacco Outlet shall be managed by an operator pursuant to the provisions of this chapter and of the tribal license granted hereunder, and shall also be managed pursuant to a Federal Indian Trader's License, as provided by Section 7 of this chapter.

Section 5. Application for Tobacco Outlet License.

- a) Any enrolled member of the [REDACTED] Tribe of Idaho or the Tribe itself or any legal entity incorporated by the [REDACTED] Tribe may apply to the Council for a tobacco outlet license.
- b) The Tribal Executive Director, or any other person designated by the Council to be its authorized representative, shall receive and process the application for a tobacco license.
- c) Each application for a license or renewal of a license shall be accompanied by an application fee of \$25.00 if the application is for a one-year license. Said charge may be ratably reduced to quarters of a year if the application is for a license less than one year's duration. For example, a license may be issued for one quarter, two quarters, or three quarters of a year for a fee of \$6.25 per quarter.

Cont...

Section 6. Tobacco Outlet License.

Upon arrival of an application the Council shall issue the applicant a non-transferable Tobacco Outlet License for quarters of a one year period which shall entitle the operator of the establishment and maintain one tobacco outlet on Indian trust land. The Tobacco Outlet License shall be renewable for one year in such manner as prescribed by this chapter and the Council.

As Provided in Section 5(c), on proper application therefore, the license may be limited to a period less than one year, but the year may not be broken down into segments of less than three month or quarters of a year.

Section 7. Trader's License.

- a) No tobacco outlet license shall be issued to an operator until he has obtained a Federal Indian Trader's License from the Superintendent of the North Idaho Indian Agency, provided, however, that a full-blooded [REDACTED] Indian need not obtain a Federal Indian Trader's License to qualify for a tobacco outlet license.
- b) Revocation of the Federal Indian Trader's License shall be among the grounds for revocation of the operator's tobacco outlet license.

Section 8. Excise Tax Imposed upon the Sale or Distribution of Tobacco Products.

- a. There is levied and there shall be collected and remitted by the operator to the authorized representative of the Council, if required by the Council, a tax upon the distribution of all cigarettes sold or otherwise distributed by each tobacco outlet in the amount of one (1) cent per cigarette package. The Council may levy an additional tax upon the sale or distribution of cigarettes and other tobacco products as it deems desirable.
- b. The Council may waive collection of the excise tax for a period of time not to exceed six months to encourage the development of [REDACTED] tribal or individual businesses.
- c. Such tax levied hereunder shall be added to the retail selling price of the tobacco products.
- d. The excise tax owed the Tribe by the operator shall be remitted to the authorized representative of the Council monthly with reports thereof on forms to be supplied by the tribe.

Section 9. Performance Bond for Excise Tax.

The operator shall, if required by the Council or its authorized representative, furnish a satisfactory bond to the Tribe on the principal amount of \$10,000 or less, but sufficient to guarantee payment of the excise tax.

Cont...

Section 10. License and Liability for Bills.

- a) When the tobacco outlet is an individually-owned business licensed by the Council: The operator is responsible for the payment of all tobacco outlet bills; the operator is forbidden to represent or give the impression to any supplier that he is an official representative of the Tribe; the operator shall hold the Tribe harmless for all claims and liability related to the operation of the tobacco outlet; and the Tribe shall have no legal responsibility for the nonpayment of bills by the operation of such individually-owned business to a wholesale supplier or to any other person.
- b) The Council may revoke any operator's tribal license if the tobacco outlet is not operated in a business-like manner or does not remain financially solvent or if the operator does not pay the tobacco outlet's operating expenses and other bills.
- c) Tribally-owned tobacco outlets are not to be deemed to have waived any sovereign immunities by virtue of being licensed by the Council. Net profits of tribally-owned outlets shall be used to meet the Council's governmental obligation to promote health, security, and general welfare of the [REDACTED] Tribe and its members.

Section 11. Audits – Tribal Regulations.

- a) The operator shall provide the authorized representative of the Council copies of all tobacco outlet purchase invoices.
- b) The books and other business records of a tobacco outlet may be available for inspection by the Council, its authorized representative, or any other person authorized by the authorized representative of the Council, at any reasonable times and shall be especially inspected by the Council or its authorized representative prior to a renewal of a tobacco outlet license. Failure of the operator to maintain adequate business records is reason for the revocation or non-renewal of this tobacco outlet license, as contemplated in Section 19 (b) of this chapter.

Section 12. Other Business by Operator.

An operator may conduct other business on the premises of the tobacco outlet. The operator is required to maintain separate books of account, however, for his cigarette business or that of any other tobacco products for which an excise tax is collectable and payable to the Tribe.

Section 13. Revocation of Tobacco Outlet License.

Failure of an operator to abide by the provisions of this ordinance shall result in the revocation of this Tobacco Outlet License by the council and the enforcement of the penalties provided in Section 14 of this chapter.

Cont...

Section 14. Violation - Penalties.

Any operation violating the provisions of this chapter shall be guilty of an offense and subject to a fine in the [REDACTED] Tribal Court of not less than \$250.00 and forfeiture of all remaining stock of products distributed hereunder and situated in the tobacco outlet. The tribal law enforcement officers shall be empowered to seize forfeited goods. The Council is empowered to dispose of forfeited goods.

Section 15. Separability.

If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of this ordinance or the application of the provision to other persons or circumstances is not affected.

Certification:

On [REDACTED], this resolution was adopted at a regularly scheduled council meeting with a quorum present, by a vote of _____ For
_____ Against

Chairperson

Vice-Chairperson

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 2*:

Repealing Amended Ordinance 29
And Adopting A New [REDACTED] Tobacco Ordinance

WHEREAS, the [REDACTED] Indian Tribal Community ("Tribe") is a federally recognized Indian Tribe organized pursuant to Section Sixteen of the Indian Reorganization Act of 1934; and

WHEREAS, the [REDACTED] Indian Senate ("Senate") is the duly constituted governing body of the [REDACTED] Indian Reservation ("Reservation") established in Article [REDACTED]; and

WHEREAS, the Senate finds that tobacco products have the potential of causing personal injury and harm to human health; that tobacco products are particularly injurious and hazardous to the health of youth and minors; and that revenues from the enforcement of this ordinance are needed by the Tribe to protect the health and welfare of Tribal members and the general public; and

WHEREAS, the Senate further finds that the Tribe provides numerous services to cigarette and tobacco sellers within the Reservation, including but not limited to protection by Tribal law enforcement, the availability of a Tribal Court, Tribal land use programs and controls, Tribal environmental protection programs and regulations, access to Tribally owned property such as tidelands, beaches and parks that are open to the general public (including the [REDACTED] playfield and [REDACTED] Public park), Tribal utilities (such as sewer, water and solid waste), Tribal housing and a variety of Tribal social service programs including medical and dental services through the Tribe's dental clinic and soon to be opening medical clinic and employment and job retraining programs for displaced workers, and

WHEREAS, under the Constitution and Bylaws of the Tribe, the Senate is charged with the duty of protecting the health, security and general welfare of the [REDACTED] Tribal Community, and

WHEREAS, the Senate deems it essential to the health, security and general welfare of the [REDACTED] Indian Tribal Community to enact a comprehensive tobacco ordinance regulating the sale of cigarettes and other tobacco products and levying an excise tax upon their sale on the [REDACTED] reservation: NOW THEREFORE,

BE IT ENACTED by the [REDACTED] Indian Senate that the following Ordinance is adopted as a law of the [REDACTED] Indian Tribal Community:

Cont...

Section 1. Title

This Ordinance shall be known and referred to as the [REDACTED] Tobacco Ordinance.

Section 2. Constitutional Authority

This Ordinance is adopted pursuant to authority provided by the following provisions of the [REDACTED] Constitution and Bylaws, as amended on October 22, 1985: Article VI, Sections 1.(h), 1(k), and 1(l), of the [REDACTED] Constitution.

Section 3. Purpose

The purpose of this Ordinance is to regulate the sale of cigarettes and tobacco products within the [REDACTED] Reservation and to impose an excise tax on the gross sales of such items. This ordinance also eliminates prior provisions in Amended Ordinance 29 which authorized Tribal Agents to purchase, distribute and sell cigarettes and tobacco products on behalf of the Tribe in licensed, but privately owned, Tobacco outlets.

Section 4. Repeal

This Ordinance repeals and replaces Amended Ordinance 29 adopted by the Senate on October 3, 1978.

Section 5. Definitions

(a) "Cigarette" shall mean any roll for smoking made wholly or in part of tobacco, irrespective of size or shape and irrespective of the tobacco being flavored, adulterated, or mixed with any other ingredient, where such roll has a wrapper or cover made of paper or any material, except where such wrapper is wholly or in the greater part made of natural leaf tobacco in its natural state.

(b) "Cigarette Seller" shall mean a person that sells cigarettes within the [REDACTED] Reservation.

(c) "Manager" shall mean the General Manager of the Tribe or his duly authorized designee.

(d) "Person" shall mean any individual, receiver, assignee, trustee in bankruptcy, trust, estate, firm, partnership, joint venture, club, company, joint stock company, business trust, tribal, state, or other local government or any agency thereof, private or municipal corporation, association, society, or any group of individuals acting as a unit, whether mutual, cooperative, fraternal, non-profit or otherwise.

(e) "Retail Selling Price" shall mean the actual price paid by the consumer for each tobacco product, less the tax levied by this ordinance.

(f) "Senate" shall mean the [REDACTED] Indian Senate.

Cont...

- (g) "Stock on hand" shall mean all cigarettes and tobacco products that are:
- (1) located at a Tobacco licensee's Tobacco outlet, or
 - (2) all cigarettes and tobacco products located within the [REDACTED] Reservation that are owned by or in the possession of a Tobacco licensee.
- (h) "Tobacco Licensee" shall mean a Cigarette Seller or a Tobacco Seller that has obtained, or is required to obtain, a Tribal Tobacco License pursuant to this ordinance.
- (i) "Tobacco Outlet" shall mean a location licensed by the Tribe for the purposes of selling cigarettes or tobacco products within the [REDACTED] Indian Reservation.
- (j) "Tobacco Products" shall mean cigars, smoking tobacco, snuff, chewing tobacco, and any other kind and form of tobacco prepared in such manner as to be suitable for chewing or smoking except cigarettes.
- (k) "Tobacco Seller" shall mean a person that sells tobacco products within the [REDACTED] Reservation.
- (l) "Tribe" shall mean the [REDACTED] Indian Tribal Community.

Section 6. Tobacco License Required.

No person may sell cigarettes or tobacco products within the Reservation without a Tribal tobacco license. Any person may make written application for a tobacco license to the Manager which shall state the name of the applicant and the address of the Tobacco Outlet(s) where cigarette or tobacco products are to be sold. The application shall be signed by the applicant, or if the applicant is not a natural person, by a legally authorized representative of the applicant, under oath and be accompanied by a nonrefundable application fee of \$100.00.

Section 7. Tobacco License

Upon receipt of an application for a tobacco license and applicant's compliance with the other provisions of this ordinance, the Manager shall issue the applicant a tobacco license for a one-year period which shall entitle the licensee to sell cigarettes and tobacco products at the tobacco outlets described on the tobacco license. All of the tobacco licensee's rights associated with the tobacco license shall expire at the end of the one-year period and the tobacco licensee shall not be entitled or have any right to a new license or a renewal of the former license. No tobacco license shall be issued until the applicant has provided proof of a current Payment Bond, if one is required, pursuant to Section 19 herein, in an amount approved by the Manager.

Cont...

Section 8. Federal Traders License.

No tobacco license shall be issued until the applicant has obtained a Federal Indian Trader's License from the United States Bureau of Indian Affairs. Revocation of the Federal Indian Trader's License shall be grounds for immediate revocation of the licensee's tobacco license. The Tribe and any Tribally owned enterprise shall be exempt from this provision.

Section 9. Cigarette Excise Tax Imposed.

There is hereby levied and imposed, a tax upon the sale of all cigarettes sold by a cigarette seller within the Reservation in the amount of twelve cents (\$.12) per pack or if sold by the carton, one dollar and twenty cents (\$1.20) per carton. This tax is imposed upon all cigarette sellers.

Section 10. Tobacco Excise Tax Imposed.

There is hereby levied and imposed, a tax upon the sale of all tobacco products sold by a tobacco seller within the Reservation in the amount of five and one half percent (5.5%) of the retail selling price thereof. This tax is imposed upon all tobacco sellers.

Section 11. Tax Payments - When Due.

All cigarette taxes and all tobacco taxes shall be paid monthly for all sales made during each calendar month on the twentieth (20th) day of the month immediately following such calendar month. Monthly reports of purchases and sales during that month shall be made at the same time.

Section 12. Reports of Sales.

All cigarette sellers and all tobacco sellers shall submit to the Manager monthly reports of all sales of cigarette and tobacco products sold within the Reservation on forms approved by the Manager. Tobacco sellers shall also submit to the Manager monthly reports of all purchases of cigarettes and tobacco products on forms approved by the Manager together with copies of all invoices for such purchases. Monthly reports shall be submitted at the same time and for the same periods that taxes are required to be paid.

Section 13. Records and Audits.

All cigarette sellers and tobacco sellers shall maintain a record system that includes a "perpetual inventory" that records on a daily basis:

- (1) the quantity and price paid for all cigarettes and tobacco products purchased or received including any other additions to inventory stock,
- (2) the quantity and price of all stock on hand, and
- (3) the quantity and price of all sales of stock including any deletions to stock.

Cont...

The beginning inventory shall be verified by the Manager by making a physical count of stock on hand. Records shall be maintained either manually or on a computer and all stock on hand shall be accessible for physical inventory by the manager. Manager may audit such records and conduct a physical inventory during normal business hours, or at such other times that are agreeable with cigarette and tobacco sellers, without prior notice. All records and all stock on hand shall be kept at the Tobacco Outlet and made immediately available to Manager during Manager's audit and physical inventory. Annual financial statements audited by an independent certified public accountant shall be submitted to the Manager for the prior calendar year no later than April 1st of the following year, provided that the Manager may authorize statements for other than a calendar year to be submitted by written agreement, in writing.

Section 14. Ownership and Risk of Loss.

All tobacco products purchased by tobacco licensees shall be the property of the tobacco licensee or some person other than the Tribe, and any loss, injury or penalty shall be at the sole risk of the licensee.

Section 15. Restricted Sales to Minors.

No tobacco seller shall sell any cigarettes or tobacco products to any person under the age of 18 years.

Section 16. Other Business.

A tobacco licensee may conduct other business at Tobacco Outlets and shall not be required to maintain separate books of account for such other business.

Section 17. Tribal Immunity, Liability and Credit.

Tobacco licensees shall not have the authority, and shall not attempt in any way, to waive the sovereign immunity of the Tribe from suit nor shall such licensees have the authority, or attempt in any way, to create any liability on behalf of the Tribe or utilize Tribal credit. This provision shall not apply to the Tribe and tribal enterprises wholly owned by the Tribe to the extent that they have been delegated special express authority by resolution of the ██████████ Senate.

Section 18. License Required.

No person shall sell tobacco products within the Reservation without having in effect a valid tobacco license issued pursuant to this ordinance.

Cont...

Section 19. Payment Bond.

In the event that a Tobacco Licensee fails to remit the taxes due under this ordinance for more than 60 days or is late in remitting such taxes more than twice in any twelve (12) month period, the Manager may require Tobacco Licensee to maintain a Payment Bond that names the Tribe as the principal beneficiary and guarantees payment of all taxes required to be paid to the Tribe by this ordinance. The Payment Bond shall be in an amount not less than the actual or anticipated average tax payment due under this ordinance during an average six month period. The Manager may require the bond amount to be adjusted (up or down) to reflect the amount of actual taxes due during an average six month period. The Manager may require a Payment Bond, when applicable, and determine the appropriate amount of the bond as a condition of granting a tobacco license. Any lapse in the coverage of a tobacco licensee's Payment Bond shall be grounds for immediate revocation of licensee's tobacco license. The Tribe and tribal enterprises wholly owned by the Tribe shall be exempt from this provision.

Section 20. Revocation of Tobacco License.

Failure of a tobacco licensee to abide by the requirements of this ordinance shall constitute grounds for immediate revocation of the tobacco licensee's tobacco license as well as enforcement of the penalties provided in Section 21 below.

Section 21. Violations and Civil Penalties.

Any person violating any of the provisions of this ordinance shall be subject to a fine imposed by the Tribal Court in an amount not less than \$50.00 nor more than \$5,000.00 per violation and forfeiture of the Tobacco License held by such person. In addition to any fine or license forfeiture, any person violating this ordinance shall be required to pay any unpaid cigarette and tobacco taxes plus interest from the date such tax payment was due at a rate of eighteen percent per year compounded monthly.

Section 22. Manager's Duties.

The Manager, or his designee, shall perform all of the acts required by this ordinance to be performed by the Tribe or the Manager.

Section 23. Severability.

If any provision of this ordinance or its application to any person or circumstance is held invalid, the remainder of this ordinance, or the application of the provision to other persons or circumstances shall not be affected.

Cont...

THE FOREGOING ORDINANCE was duly enacted by the [REDACTED] Indian Senate with a quorum present.

[REDACTED] Chairman [REDACTED] Indian Senate

CERTIFICATION

As Secretary of the [REDACTED] Indian Senate, I hereby certify that the foregoing resolution was approved at a _____ Meeting of the [REDACTED] Indian Senate held on _____, 20____, at which time a quorum was present and the resolution was passed by a vote of ___ FOR, ___AGAINST, and ___ ABSTENTIONS.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 3*:

CIGARETTE TAX CONTRACT
Between
THE [REDACTED] TRIBE
and
THE STATE OF [REDACTED]

PREAMBLE

WHEREAS, the [REDACTED] Tribe is a federally recognized Indian Tribe, possessed of the full inherent sovereign powers of a government; and

WHEREAS, the state of [REDACTED] is a state within the United States of America, possessed of full powers of state government; and

WHEREAS, the body of Federal Indian law and policy recognizes the right and the importance of self-determination for Indian Tribes, the authority of a Tribe to tax certain activities, and the need for economic development in Indian country by Indian Tribes; and

WHEREAS, the state of [REDACTED] has committed, through the Centennial Accord and Millennium Agreement, to the political integrity of the federally recognized Indian Tribes within the state of [REDACTED] and has formally recognized that the sovereignty of each Tribe provides paramount authority for the Tribe to exist and to govern; and

WHEREAS, a long-standing disagreement exists between the Tribe and the State over questions regarding jurisdiction over and the taxation of the sale and distribution of cigarettes; and

WHEREAS, the State and Tribe will benefit from resolution of that disagreement by the change in focus from enforcement and litigation to a focus on the administration of this cigarette tax Contract; and

WHEREAS, the Tribe and State will benefit from resolution of that disagreement by the tax base this Contract will enable, taxation being an essential attribute of sovereignty and a tool of self-sufficiency; and

Cont...

WHEREAS, the State and Tribe will also benefit by the exercise of the attributes of Tribal sovereignty and from the improved well-being of members of the Tribe that will result from economic development by the Tribe and its members; and

WHEREAS, both the Tribe and the State desire a positive working relationship in matters of mutual interest and seek to resolve disputes and disagreements by conducting discussions on a government-to-government basis; and

WHEREAS, the mutual interests of the [REDACTED] Tribe and the state of [REDACTED] brought these two governments together to pursue their common interest in resolving this tax disagreement; and

WHEREAS, both governments worked diligently to gain for the Governor of the state of [REDACTED] the authority to enter into a tax contract regarding cigarettes with the [REDACTED] Tribe; and

WHEREAS, legislation was enacted by the 57th Legislature and signed by the Governor, authorizing the signing of contracts such as this, such authority effective July 22nd, 2001; and

NOW THEREFORE, the Tribe by and through its Tribal Council, and the state of [REDACTED] by and through its Governor, do hereby enter into this Contract for the mutual benefit of the Tribe and the State:

To obtain a complete copy of the Compact, please contact the Northwest Portland Area Indian Health Board. Contact information can be found in Chapter 11.

***To ensure confidentiality, all identifying features have been blacked out.**



Chapter 7:

Workplace Cessation Policies



The Purpose of Workplace Cessation Policies



For many people, a great portion of the day is spent at their place of employment. Consequently, policies in the workplace significantly affect the actions and health of tribal members. Supporting employees who would like to quit using tobacco (also referred to as “cessation”) is one of the best investments you can make for your employees and your business.

Cessation Policies Promote Wellness:

Comprehensive workplace policies are an effective way to promote, protect, and improve the health of your company’s most valuable asset – your employees! Commercial tobacco use, and exposure to secondhand smoke, pose a significant health risk to all people. Review the contents of Chapter 1 for information regarding the many health risks associated with tobacco use and exposure to secondhand smoke.

Cessation Policies are Cost Efficient:

There are significant costs associated with employees who smoke. In 1999, each adult smoker cost this nation \$1,760 in lost productivity and \$1,623 in excess medical expenditures (totaling \$3,383 per smoker). Commercial tobacco use has been attributed to greater health care costs, increased absenteeism, decreased productivity, increased life insurance premiums, greater risk of occupational injuries, costlier disabilities, more disciplinary actions, and increased cleaning and ventilation costs in the workplace.⁸⁹ (See Chapter 4 and 9 for additional facts.)

Smoking cessation programs in the workplace can achieve substantial cost savings and improve productivity. According to research, workers who have stopped smoking for at least one year lose significantly fewer days of work, and have fewer hospital admissions than those who continue to smoke.⁹⁰

Cessation Policies Encourage Better Business:

Comprehensive tobacco policies are good for business. By protecting the health of employees, tribes and individual businesses project a positive image in the community and encourage tribal wellness. Tobacco cessation policies send the message that worker safety and health are the business’s number one priority. Because employee tobacco use costs businesses money, policies that help smokers quit will also be cost efficient.

Cessation Policies Improve Employee Satisfaction:

By providing cessation services similar to those provided to employees that are addicted to other substances, businesses demonstrate an understanding that smoking is an addiction that deserves help.

Research has found that most smokers and non-smokers favor tobacco-free workplaces. Nearly 70% of smokers would like to quit, and employees feel encouraged by employers that support cessation. Environments that support cessation can also ease tensions between smokers and non-smokers, and between management and smoking employees.





Types of Workplace Cessation Policies



Policies that Support Cessation in the Workplace:

1. **Expand Tobacco-free spaces.** (See Chapter 4). Rationale: Nonsmokers have the right to breathe clean air, and involuntary exposure to secondhand smoke remains a common, preventable public health hazard. Numerous studies have found that smoke-free workplaces can produce an environment favorable to quitting. Workplace smoking bans decrease daily tobacco consumption among smokers, while increasing the number and success of quit attempts.
2. **Provide reimbursement for the use of tobacco-cessation drug therapies.** Rationale: Smoking is costly to employers both in terms of smoking-related medical expenses and lost productivity. Tobacco cessation is more cost-effective than other common prevention interventions covered by insurance (such as the treatment of hypertension and high blood cholesterol), and cost analyses have shown tobacco cessation benefits to be either cost-saving or cost-neutral. Research has shown that reducing a patient's out-of-pocket expense for tobacco treatment increases cessation rates. If medications are not available through your local IHS clinic, reimburse the cost of Nicotine gum and nicotine patches. Both are available without a prescription and have been shown to help smokers quit and stay smoke-free. If your business provides medical insurance to employees, ensure that tobacco-cessation drug therapies are covered by your plan.
3. **Allow employees to engage in on-site community, internet, or telephone-based counseling services.** Rationale: Counseling is an effective treatment for tobacco dependence. Counseling can be provided in a number of different venues, including face-to-face (individual or in a group), on the internet or via telephone. When combined with pharmacological treatment, the effectiveness of treatment doubles or triples. On-site counseling requires no more time than regular smoking breaks, and internet and phone-based services can be accessed free of charge. Explore opportunities to implement cessation programs with partners such as the Clinic, the tribal CD or A&D program, the American Lung Association, the American Cancer Society, or the tribal health department.
4. **Support attendance of employees at tobacco-cessation counseling sessions with designated healthcare providers.** Rationale: Counseling provided by a doctor, pharmacist, nurse, or other treatment personnel can be effective for helping smokers quit. Allow smokers who are in the process of quitting to attend weekly or bimonthly counseling sessions. Tobacco use is an addiction that deserves treatment, just as any other addiction would require.

5. **Provide incentives for employees to remain free of commercial tobacco use.** Rationale: Smokers are more often absent from work than their non-smoking counterparts, and often take breaks throughout the day to smoke. Reward nonsmokers, and encourage smokers to quit, by providing a bonus incentive to nonsmokers. Incentives could include an additional “personal health day” of leave with pay (or an afternoon, or an hour... any duration that is recognized as being for “personal health”), a tee shirt, a small gift, a certificate, or some other form of recognition.
6. **Include information about the benefits of quitting commercial tobacco use in employee Newsletters, Paychecks, with invited guest speakers, or with other staff literature.** Include self-help materials and information about local cessation resources available to those seeking to quit. Rationale: Most people who quit smoking obtain help from self-help materials such as pamphlets or booklets. Educate employees about the risks of tobacco use and available cessation services on a regular basis.
7. **Promote workplace health promotion/wellness activities.** Rationale: Participation in health promotion activities can encourage tribal wellness, and can send a positive message to the community at large. Use contests to see how many people can quit in a four-week period. Provide a high profile kick-off and prizes to enhance participation. Gather and share testimonials from successful quitters.
8. **Sponsor an on-site support group for recent quitters or those attempting to quit.** Rationale: Tobacco is more addictive than heroine, speed and cocaine - encourage quitters to gather for informal social support (e.i., buddy systems, or encouragement from fellow workers). Allow on-site support groups to meet periodically for those quitting or planning to quit.
9. **Participate in Special Events – The Native American Smokeout, World No Tobacco Day, and Health Fairs.** Rationale: Workplace participation in special events will foster a healthy living environment. Host power breakfasts, potlatches, or other special events tied in with theme weeks such as Native American Smokeout (November), World No Tobacco Day (May), or local Health Fairs.



Special Considerations for Writing, Passing and Implementing Workplace Cessation Policies



Type of Policy Needed:

If you are an employee of a business seeking to initiate change, speak to your manager or supervisor to determine what type of policy will be needed, and the steps that will be required to seek change. Some business policies are informal, and can be easily incorporated to the organization's culture. Other policies may require a formal change to the operations manual, either through an executive committee, the Executive Director, or the CEO. Use the outline in Chapters 2 and 3 to guide this process. Be sure to create an employee steering committee to provide feedback when molding new policies to the needs of your office or business.

Additional Resources for Employers:

- Employers' Smoking Cessation Guide: Practical Approaches to a Costly Workplace Problem, is a guide published by the Professional Assisted Cessation Therapy (PACT) consortium for large and small employers interested in enacting an affordable, effective smoking cessation program. Available at:
<http://www.endsmoking.org>.
- Towards a Healthier Workplace: A Guidebook on Tobacco Control Policies. This guidebook provides examples of effective workplace policies and programs, useful tools and handouts, case examples, and presentation materials.
<http://www.hc-sc.gc.ca/hecs-sesc/tobacco/facts/blueribbon/healthier/index.html>
<http://www.hc-sc.gc.ca/hecs-sesc/tobacco/facts/blueribbon/healthier/english.pdf>
- Making Your Workplace Smokefree: A Decisionmaker's Guide provides information on the costs of tobacco use to employers. The entire guide or selected chapters are available in PDF format at:
http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm.
- Sample Purchasing Specifications - Provides valuable contract language that can be used by employers and purchasers to structure benefits related to tobacco-use prevention and cessation. Available at:
<http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/tobacco/tobacco-prevent.html>

- Build a Financial Infrastructure: Health Plan Benefits and Provider Reimbursement combines evidence-based recommendations with the experiences of the Pacific Center on Health and Tobacco (PCHT), a consortium of five western states (California, Oregon, Washington, Arizona, and Hawaii) concerning tobacco cessation benefits and provider reimbursement. Available at: <http://www.paccenter.org>.
- World Health Organization: Tobacco in the Workplace - Meeting the Challenges. A handbook for Employers (2002) <http://www.euro.who.int/document/e74819.pdf>





Generating Employer Support for Workplace Cessation Policies



The following “Talking Points” can be used to generate employer support for workplace cessation policies: (See the “Talking Points” in Chapters 4 and 9 for additional facts.)

Talking Points For Workplace Cessation Policies:

Cessation Policies Promote Wellness.

- Making all workplaces smoke-free would prevent an estimated 610 stroke and heart attack deaths in the first year alone, mostly among non-smokers. Over seven years, more than 2,420 lives and \$280 million would be saved -- not including the costs associated with other smoking-related illnesses or lost productivity.⁹¹
- A national smoke-free workplace policy would cause 1.3 million smokers to quit (studies have shown that nearly 15 percent of smokers would quit if they couldn't smoke at work). These quitters would have 360 fewer strokes and 630 fewer heart attacks in the first year, preventing 320 deaths. Those who continue to smoke would average 1.3 fewer cigarettes per day, adding up to 401 million fewer packs nationwide per year. Among those currently exposed to secondhand smoke, a smoke-free policy would prevent 910 heart attacks, 210 of them fatal.⁹¹

Tobacco Cessation Cuts Costs in the Workplace.

Over time, tobacco-use cessation benefits generate financial returns for employers in four ways:

1. Reduced health care costs: A smoking employee costs employers at least 1,000 dollars per year in total excess direct and indirect health care costs, compared with a similar nonsmoking employee.⁹²
2. Reduced absenteeism: Smokers miss 6.16 days of work per year compared with the 3.86 days missed by nonsmokers, according to the medical journal Tobacco Control in September 2001.⁹³
3. Increased on-the-job productivity: Smokers take frequent cigarette breaks. Also, studies have found that workers who smoke have twice the accident rate of nonsmokers on the job, perhaps due to distraction, the fact that the person's hands are busy, eye irritation, or coughing. Elevated carbon monoxide levels may also lower alertness and reflex speed.⁹³
4. Reduced life insurance costs: Over time, businesses with staff that smoke have higher life insurance premiums (due to increased levels of claim submissions on behalf of smoking employees). Non-smokers submit fewer claims, and fewer claims will reduce a company's life insurance premiums over time.⁹³

Smoke-free zones gain new territory

Excerpts from the February 08, 2005 edition - <http://www.csmonitor.com/2005/0208/p01s04-ussc.html>

By Mark Sappenfield | Staff writer of The Christian Science Monitor

Businesses are targeting smokers in an effort to bring down healthcare costs. Some corporations are refusing to hire smokers - or firing them. A larger number are putting increasing emphasis on counseling and stop-smoking programs, even as they ban smoking anywhere on their property. In many ways, all the activity is simply the continuation of a long-term trend, as cities and companies gradually impose more smoking restrictions. But as these bans push further into everyday life, this year's increased activity suggests that the issue might be nearing a hinge-point when Americans will define the limits of how far antismoking policies can go.

For some companies, even that is not enough. Late last month, a Michigan company made national news by firing four workers who refused to submit to a nicotine test. Alaska Airlines has a policy of not hiring smokers. Union Pacific railroad recently began a policy of rejecting all work applications by smokers. In a time when companies are straining to meet rising healthcare costs, the rationale is purely financial. "The basic idea is that smokers have higher healthcare costs than nonsmokers," says John Bromley, a spokesman for Union Pacific in Omaha, Neb. According to company estimates, he adds, each smoking employee costs \$922 more per year than a nonsmoking employee. In 21 states, the policy is perfectly legal.

According to the survey, 5 percent of companies have taken the slightly softer approach of passing on higher healthcare premiums to employees who smoke. "There's a lot more effort to help people quit smoking," says Helen Darling of the National Business Group on Health in Washington. "And more companies will not allow smoking anywhere on the campus - that's a trend."

It is also a vanguard of the antismoking laws now advancing through state legislatures nationwide. In the 11 years since California first instituted a ban on smoking in restaurants and bars, a handful of states have considered similar restrictions each year. So far, measures to prohibit smoking in restaurants, bars, or workplaces have taken effect in 10 states.

Tobacco Cessation Cuts Costs in the Workplace.

- Employers who provide a smoke-free workplace may also realize savings on fire insurance and costs related to items such as ventilation services and property repair and upkeep.
- Smoking in the workplace damages property and increases cleaning costs by an average of 10%.
- Employers face legal liability for secondhand smoke exposure to non-smoking employees.
- Men who smoke incur \$15,800 (in 2002 dollars) more in lifetime medical expenses and are absent from work 4 days more per year than men who do not smoke. Women who smoke incur \$17,500 (in 2002 dollars) more in lifetime medical expenses and are absent from work 2 days more each year than nonsmoking women.

Cessation Benefits Are Cost-Effective.

- Tobacco cessation is more cost-effective than other commonly covered preventive services, such as the treatment of hypertension and high blood cholesterol.⁹⁴
- Cost analyses have shown tobacco cessation benefits to be either cost-saving or cost-neutral. Overall, cost/expenditure to employers equalizes at 3 years; benefits exceed costs by 5 years.⁹⁵
- It costs between 10 and 40 cents per member per month to provide a comprehensive tobacco cessation benefit (costs vary based on utilization and dependent coverage). In contrast, the annual cost of tobacco use is about \$3,400 per smoker or about \$7.18 for each pack of cigarettes sold.⁹⁴
- Neonatal health care costs related to smoking are equivalent to \$704 for each maternal smoker. Randomized controlled trials indicate that a smoking cessation program for pregnant women can save as much as \$6 for each \$1 spent.⁹⁴
- Businesses that have included a tobacco cessation benefit report that this coverage has increased the number of smokers willing to undergo treatment and increased the percentage that successfully quit.⁹⁴

Cessation Policies Encourage Better Business.

- Tobacco cessation policies demonstrate that worker safety and health are a top business priority.
- Environments that support cessation ease tensions between smokers and non-smokers, and between management and smoking employees.

Cessation Policies Improve Employee Satisfaction.

- More than 70% of smokers want to quit, but few succeed without help. Tobacco use treatment *doubles* quitting success rates.
- All workers deserve access to programs and policies that will support them when they feel ready to quit.



Experience from the Field: Establishing Workplace Cessation Policies



Confederated Tribes of Siletz – Passing New Workplace Policies:

To build awareness about tribal tobacco issues and rapport with the tribe's decision makers, the Tobacco Program Coordinator for the Siletz Tribe, DeAnna Pearl, met regularly with the Siletz Tribal Council to provide quarterly updates about the project's activities and successes. For some people, discussions about tobacco control can feel accusatory, be controversial, or produce a climate of defensiveness. To ease these possible tensions, DeAnna kept the messages about her program positive, particularly during council meetings, without blaming those addicted to tobacco. She distributed examples of educational materials such as stress balls, t-shirts, water bottles, and pictures of youth participating in program activities. By meeting often with the Council, DeAnna was able to build support for her program, and develop allies for future efforts.

The tribe's existing tobacco policy "prohibited the use of all tobacco products in Tribal offices and vehicles." Several concerned employees and supervisors felt that a stronger and more specific policy was needed, and asked the Tobacco program to approach the Tribal Council Health Committee in Oct. 2004. They wanted to see provisions that would protect young people from exposure to secondhand smoke, prevent future addiction, and policies that would help current smokers quit. After working for almost 2 years developing a policy that followed current practices, DeAnna approached the Tribal Council Health Committee (comprised of 8 members) to officially present a number of proposed changes to the smoking policy for the tribe's administration. She gained the endorsement of the Community Health Clinic's Policy, Planning and Safety committees prior to approaching the Tribal Council Health Committee.

The Tribal Council's Health Committee supported the proposed policy that would establish a 25-foot "Smoke-free Zone" around building entrances, exits, and in front of air intake ducts. This policy was designed to provide non-smoking employees and visitors with access to all buildings without risk of exposure to the effects of secondhand smoke.

To protect young people from seeing tobacco use as a social norm, this 25-foot "Smoke-free Zone" was also written to prohibit commercial tobacco use in sight of youth participating in any Tribally sponsored activities.

To protect the sacred use of tobacco and educate young people about its use, the Tribal Council Health Committee also asked that the policy state: "Traditional Tobacco use for cultural & ceremony use will be exempt from this policy."

Additionally, the Tribal Council Health Committee endorsed activities that support smokers who are ready to quit. The proposed Smoking Cessation section read:

Section 3. Smoking Cessation Programs. The Tribe encourages and supports employees who wish assistance in eliminating dependence of the use of commercial tobacco products through enrollment in a cessation program (SCP). Employees will be given permission to attend smoking cessation classes during regular business hours upon proper approval. Information about these programs will be made available to the Tribal community. For information on Tribal sponsored smoking cessation programs, contact the Tobacco Prevention and Education Program Coordinator.

To shape the needed changes, DeAnna brought together a tobacco policy committee, including a representative from the tribe's Human Resources department, a representative from the tribe's Education department, two current smokers, and a community health advocate. The committee discussed strategies to facilitate the new policy's implementation, and positive ways to address the needs of smokers through a designated smoking area.

During discussions with the Tribal Council Health Committee, the council was very supportive of incorporating these elements and provided positive comments and changes. DeAnna found their support to be very affirming.

When the Tribal Council passes the policy at an upcoming meeting, this team will add the policy changes to the CTSI Operations and Policy manual, instruct fellow staff members about the new policy, and review enforcement goals with department managers.

DeAnna Pearl, Tobacco Program Coordinator
Confederated Tribes of Siletz

The San Antonio-based company *USAA* gives \$200 to each employee and each dependent that would like help to stop smoking. The money can be used on smoking replacement gum, patches, and other therapies, including acupuncture and hypnosis. In addition, *USAA* sponsors smoking cessation classes and waives co-pays on drugs used to help people stop smoking.



Workplace Cessation Policy Templates and Tribal Examples



Workplace Cessation Policy Template:

The Company is committed to providing a healthy, comfortable and productive work environment for our employees. In order to eliminate hazards and ensure a safe and healthy workplace, the following policies will be effective _____.

Include one or more of the following policies:

1. The Company shall be entirely smoke-free. All forms of tobacco use will be strictly prohibited within company buildings including but not limited to offices, hallways, waiting rooms, washrooms, lunch rooms, stairwells, elevators, meeting rooms and all enclosed facilities. Smoking is also prohibited in all doorways and on all outdoor property belonging to the company. All company vehicles will also be designated smoke-free, including rental cars used for company business.
2. Because there are significant costs associated with employees who smoke (totaling \$1,760 in lost productivity and \$1,623 in excess medical expenditures each year), The Company will reimburse current full-time staff members for the use of non-prescription tobacco-cessation drug therapies. This benefit is not to exceed \$100 per employee per year, and reimbursement must be accompanied with a signed quit-date contract (available from program managers) and receipts for non-prescription tobacco-cessation purchases, including nicotine gum, patches, or lozenges.
3. Because smokers are twice as likely to successfully quit tobacco if they receive counseling support in addition to pharmacotherapies, The Company will allow quitting employees to engage in on-site community, intranet, or telephone-based counseling services during working hours. Employees may call the national quitline number (1-800-QUITNOW), or access <http://www.smokefree.gov/>, <http://www.quitnet.org>, or <http://women.americanlegacy.org/> for 15 minutes, two times a day, during regularly scheduled breaks. To utilize this benefit, employees should discuss and agree upon convenient counseling times with their immediate supervisor, and sign a quit-date contract (available from program managers).

Cont...

4. Likewise, The Company encourages current quitters to attend tobacco-cessation counseling sessions with certified tribal Clinic, A&D, or CD providers. In the first month of quitting, full-time staff members may take 2-hours of sick leave per week to attend tobacco-cessation counseling sessions with a certified medical provider. During the following four months of quitting, full-time staff members may take 2-hours of sick leave every two weeks to attend tobacco-cessation counseling sessions with a certified medical provider. To utilize this benefit, employees should discuss and agree upon convenient counseling times with their immediate supervisor, and sign a quit-date contract (available from program managers).

5. Employees that smoke are more often absent from work than their non-smoking counterparts, and frequently take smoking breaks during business hours. To reward nonsmokers, and encourage smokers to quit, The Company will provide one additional “personal health day” of leave with pay each year. To utilize this benefit, non-smoking employees should discuss and agree upon a convenient “smoke-free personal day” with their immediate supervisor. Supervisors are responsible for tracking the use of this benefit for each staff person supervised.

6. To provide information about the risks of commercial tobacco use and the benefits of quitting, The Company will include relevant information in employee newsletters, paychecks, through invited guest speakers, or with other staff literature at least four times per year.

7. To promote workplace health, The Company will host an annual, “New Years Resolution – Quit Tobacco” contest, and will participant in the Native American Smokeout.

8. To support recent quitters and those attempting to quit, The Company endorses the use of the employee lunchroom for on-site support group meetings before or after work.

Copies of this policy will be distributed to all employees. Signs will be posted at all building entrances.

This policy is being announced in advance to facilitate a smooth transition. Those employees who smoke and would like to take this opportunity to quit smoking are invited to participate in any of the cessation supports being offered by The Company.

The success of this policy will depend on the thoughtfulness, consideration and cooperation of smokers and non-smokers. All of us share in the responsibility for adhering to and enforcing this policy.

Signature of Business CEO or President

Tribal Example 1:

Section 3. Smoking Cessation Programs. The Tribe encourages and supports employees who wish assistance in eliminating dependence of the use of commercial tobacco products through enrollment in a cessation program (SCP). Employees will be given permission to attend smoking cessation classes during regular business hours upon proper approval. Information about these programs will be made available to the Tribal community. For information on Tribal sponsored smoking cessation programs, contact the Tobacco Prevention and Education Program Coordinator.

(Contained Within the Tribe's Personnel Manual, which applies to all Tribal Employees)

Chapter 8: Clinic-based Policies

Note: Unless otherwise referenced, the information contained in this chapter is adapted from Melvin, C and Gaffney, C. Treating nicotine use and dependence of pregnant and parenting smokers: An Update. Nicotine and Tobacco Research Volume 6, Supplement 2 (April 2004) S107-S124.



The Purpose of Clinic-Based Tobacco Policies



Tobacco dependence is a chronic condition that often requires repeated intervention, making the healthcare system an ideal location for patient evaluation, education, and cessation support. Epidemiological data suggests that over 75% of smokers would like to quit, and nearly half of all smokers have made a serious quit attempt in the last year.⁹⁶ Clinician reminder systems, patient referral services, treatment, and brief interventions can all significantly improve successful cessation.

Because nicotine is a biologically addictive substance, quitting often produces uncomfortable withdrawal symptoms, including depressed mood, irritability, anger, difficulty concentrating, weight gain, decreased heart rate, and anxiety. Fortunately, the use of pharmacotherapies can alleviate many of these troubling symptoms and increase the patient's chance of a successful quit.

In addition to being biologically addictive, commercial tobacco products are psychologically addictive, shaping ingrained daily habits, serving as a coping mechanism, and medicating other untreated mental conditions. The psychological void that is produced when quitting is not addressed by pharmacotherapy. Consequently, counseling interventions are an important component of treatment to help mediate their effect. Likewise, the social norm of tobacco use can be challenging to overcome, affecting social activities, friendships with other smokers, and daily routines. These factors must also be considered to improve one's chance of success.

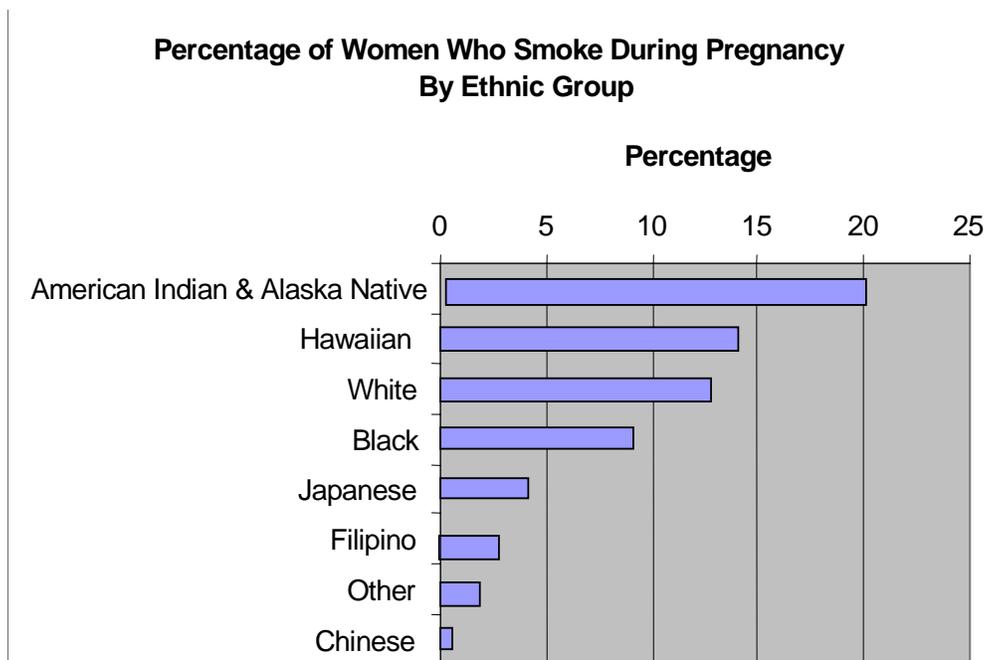
Despite recommendations from the Surgeon General to provide systematic brief interventions during every visit, one third of all smokers report not being asked by their primary care physician in the last year about their smoking status or being advised to quit.⁹⁷ Substantial evidence suggests that brief interventions, delivered by several different people within the clinic setting, are effective at increasing quit rates (25.5%) when compared to minimal interventions, such as distributing free literature (8.1%).⁹⁸

Tobacco Use Among Pregnant Women:

Particularly important, protocols must be established to treat commercial tobacco dependence among pregnant smokers. According to vital records data, 19.7% of American Indian and Alaska Native women who had a live birth in 2002 smoked cigarettes while they were pregnant.⁹⁹ Smoking during pregnancy is the most important modifiable cause of poor pregnancy outcomes, and is linked to higher rates of low birthweight, preterm birth, and infant mortality.²³ Additionally, 48% of the AI/AN female population ages 18-34 smoke commercial tobacco, a rate that has been constant for the past twenty years.²³

Currently, there are a variety of recommendations for treating pregnant smokers in the clinical environment. The 2000 U.S. Public Health Service Clinical Practice Guidelines, *Treating Tobacco Use and Dependence*, recommends that pregnant smokers be given interventions that surpass the basic advice to quit, including pregnancy-specific pamphlets, brochures, and videos etc.¹⁰⁰

While it is best for women to quit smoking before they become pregnant, it is important for health care providers to stress the fact that quitting at any time throughout the pregnancy can greatly decrease the health risks to the mother and her infant.



National Vital Statistics Report, Vol 50, No 5, Feb 12, 2002: Table 24

By developing a series of clinic-based tobacco policies, the Tribe's tobacco quit rate can be greatly increased, thereby improving the long-term health of smoking patients and their families, and the health of the tribe as a whole.



Types of Clinic-Based Tobacco Policies



Published in 2000, the Clinical Practice Guideline for Treating Tobacco Use and Dependence provides research-based guidelines for providing effective treatment in the clinic setting.³² Clinician reminder systems, patient referral services, pharmacotherapy, and brief interventions can all significantly improve quit rates. Because effective treatments are available for tobacco dependence, every patient who uses tobacco should be provided one of two interventions:³²

1. Patients willing to try to quit tobacco use should be provided with an effective treatment.
2. Patients unwilling to try to quit tobacco use should be provided with a brief intervention designed to increase their motivation to quit.

Effective Clinic-based Tobacco Policies:

Provider Reminder System - It is essential that clinicians and healthcare delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of tobacco users in the healthcare setting.³² Provider reminder systems help clinicians identify patients who use tobacco products, and can prompt providers to discuss the importance of quitting with patients. Healthcare providers can receive reminders through stickers on patients' charts, vital sign stamps, medical record flow sheets, checklists, or by computer. All patients should be asked about tobacco use at each and every visit.

When developing your provider reminder system, work with clinic staff to determine who would be best equipped to carry out this role. Receptionists, nurses, and physicians are all possible candidates for documenting this information on charts or other in-take forms.

In addition to a well-defined procedure, the clinic's tobacco policy should include staff education on the process chosen by the clinic, provide staff accountability through regular chart review, and include tobacco-related tasks in the defined duties of clinicians and other designated staff members.

Vital Signs¹⁰¹		
Blood Pressure:	_____	
Pulse:	_____	Weight: _____
Temperature:	_____	
Respiratory Rate:	_____	
Tobacco Use:	<i>(circle one)</i>	
	Current	Former Never
Packs per day:	_____	

* Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Brief Counseling Interventions - Tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (i.e., minutes of contact).³²

Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are the "5 A's": Ask, Advise, Assess, Assist, and Arrange.¹⁰¹

1. **Ask** - Identify and document tobacco use status for every patient at every visit. This can be done with a provider reminder system.
2. **Advise** - In a clear, strong, and personalized manner, urge every tobacco user to quit.
3. **Assess** - Is the tobacco user willing to make a quit attempt at this time?
4. **Assist** - For those willing to make a quit attempt, use pharmacotherapy to help him or her quit. Refer the patient to the Pharmacist, State Quitline, or the tribe's Tobacco Program Coordinator to access additional counseling and obtain help developing a quit plan. For those who are not ready to quit, discuss the 5 R's: **Roadblocks**: "What is keeping you from quitting?" **Relevance**: "The carbon monoxide in the tobacco smoke goes right through the placenta to the baby robbing the baby of oxygen." Or "Exposure to nicotine makes it more difficult to control your blood pressure." **Rewards**: "If you quit smoking now you will have a healthier baby and an easier delivery." Or "If you quit smoking now, you will serve as a good role model for your grandchildren." **Risks**: "If you keep smoking you increase the risk of the baby being born too early or of miscarrying." Or "If you keep smoking, you increase your risk of having a second heart attack." **Repetition**: Repeat the message to quit at every visit to increase the likelihood of a quit attempt.
5. **Arrange** - For those interested in quitting, flag them for follow-up by clinic personnel, in person, or by telephone within the first week of their quit date.

The 5A's should be used with all patients 6 years and older. The average age of initiation is 13 years in the U.S., and many kids experiment with tobacco before this age. While your committee can choose an age that is appropriate for your community, it is important for healthcare providers to ask all young people about their tobacco use. Kids who have not experimented with tobacco can be praised for their good decision-making, and kids who have tried commercial products can be identified and helped early on. Special consideration should also be given to pregnant women and parents, as the health of their children are also at risk. If expectant mothers or parents are not ready to quit, they should be advised to smoke only outside and away from their children.

While physicians and clinic staff may feel uncomfortable discussing tobacco with their patients, it is very important that they do so! Following the Basic Tobacco Intervention Skills (BTIS) Guidelines, this topic can be discussed in a very non-threatening manner, without being offensive. For training on implementing the Five A's in the clinic setting (also known as Basic Tobacco Intervention Skills (BTIS)), contact your State or County Health Department's tobacco control program or your regional tribal health board. See Chapter 11 for their contact information.

- Three types of counseling and behavioral therapies have been proven to be especially effective, and should be used with all patients attempting tobacco cessation:³²
 - Practical counseling, including problem-solving and skills training.
 - The development of social support within the treatment setting.
 - Help in securing social support outside of treatment.

These counselling techniques could be provided by the clinician, nurse, office assistant, pharmacist, tobacco program coordinator, CHR, CD personnel, or another trained clinic team member. If counseling options are not available in the community, suggest calling the State or National Quitline: 1-800-QUITNOW



Brief Intervention – 30 Seconds to Save a Life!

The dialoge for a brief intervention need not take any longer than 30 seconds.

Staff: Do you currently use commercial tobacco?

Patient: Yes, but only when I'm out with my friends.

Staff: Here at the Clinic we advise all patients to quit using commerical tobacco products, even if you aren't smoking every day. Quitting would improve your insulin control, reduce your risk of diabetic complications, and improve the health of your child with asthma (Use a statement that would be personnally applicable). Have you thought about quitting?

Patient: No, not right now.

Staff: Nicotine replacement therapies and personal support can greatly increase your success when quitting. We can support you when you do choose to take that next step.

Patient: Yes, but I'm not sure if I can.

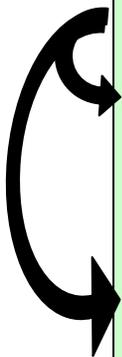
Staff: Nicotine replacement therapies and a personal quit plan can greatly increase your success when quitting. Would you like to talk about creating a treatment plan that will work for you?

Patient: Yes, I'm scared to quit, but I would like to try.



Treatment options (including pharmacotherapy and counseling) can then be discussed by the clinician, nurse, office assistant, pharماسist, tobacco program coordinator, CHR, CD personnel, or another trained clinic team member. If counseling options are not available in ytour community, suggest calling the State or National Quitline: 1-800-QUITNOW

OR



Pharmacotherapy - Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.³²

- Six *first-line* pharmacotherapies have been identified that reliably increase long-term smoking abstinence rates:³²
 - Bupropion SR
 - Nicotine Gum
 - Nicotine Inhaler
 - Nicotine Nasal Spray
 - Nicotine Patch
 - Nicotine Lozenge
- Two *second-line* pharmacotherapies have been identified as efficacious, and may be considered by clinicians if first-line pharmacotherapies are not effective:³²
 - Clonidine
 - Nortriptyline
- Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

Reimbursement: Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, tribal clinics should ensure that their prescription formulary includes effective pharmacotherapies, and that clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.³²

According to the CDC, from 2001 to 2002, the number of state Medicaid programs that provided some type of coverage for counseling or medication increased from 37 states (73%) to 40 states (78%). Of the 40 states that now offer coverage, all but one cover at least one pharmacotherapy treatment.¹⁰² Unfortunately, only 11 of the state Medicaid programs that provided this coverage informed their recipients about the available benefits.

To learn more about Medicaid coverage in your state, and access tools to facilitate Medicaid reimbursement, visit The National Partnership to Help Pregnant Smokers Quit at: <http://www.helppregnant smokersquit.org/policy/medicaid.asp>. You can download pregnancy-specific materials in pdf format or call 919-843-7663 for a hard copy of the packet. Materials detailing coverage for smokers in general can be accessed from the Center for Tobacco Cessation at:

<http://www.ctcinfo.org/resources/Guides & Toolkits for State Medicaid Pro>

Work with the clinic's Health Director and pharmacists to ensure that appropriate nicotine replacement therapies (NRT) are available to your clinic's user population, and to develop a system to document both the utilization of NRT, and the implementation of the 5A's by providers. Tribal clinics that bill Medicaid may be able to seek reimbursement for these tobacco dependence treatments.^{103,104}



Special Considerations for Writing, Passing and Implementing Clinic-Based Tobacco Policies



Clinic-based policies may not require the formal “resolution” policy change process. By engaging a variety of stakeholders from within the clinic setting (such as the health director, physician, nurse, receptionist, pharmacist, and tobacco program coordinator), protocols may be designed to meet the unique structure, needs, and skills of your tribe’s clinical practice.

To facilitate positive change, propose a meeting with your clinic’s health director and other interested personnel. During this meeting, offer to provide consultation on their current system of care for treating tobacco dependence among patients. By discussing which recommendations are and are not currently in place, you will be able to identify opportunities for positive change. As with any policy change, you will need to use your talking points to justify the value of your suggested changes. To maintain clinic buy-in and support, maintain open discussion with those implementing the changes and obtain feedback on their suggestions and concerns. Outreach visits to providers, performance audits, feedback on smoking cessation services, reminder systems, and CME training on tobacco treatment have all been shown to positively influence clinician behavior.

Increasing Compliance with Best Practice Guidelines:

Clinicians often have a short amount of time to address a large number of issues, and may find it challenging to focus solely on smoking cessation. Surveys suggest that nearly all clinicians ask patients about their smoking status and advise them to quit. Unfortunately, fewer than 25% then assess their patient’s willingness to quit and follow-up with assistance in doing so. By coming together as a clinic staff to develop a usable clinician reminder system, a brief intervention plan, and patient referral services, your clinic will vastly improve your patients’ chances of overcoming this addiction.



Recommendations for Increasing Compliance include:

1. Seek Continuing Medical Education on counseling techniques for smoking cessation. Trainings on *Basic Tobacco Intervention Skills* (BTIS) or the *Five A's* can be coordinated through your state or county health department, or your regional Indian Health Board.
2. Work with office staff to modify the current office system to:
 - Document tobacco use for all patients
 - Conduct “5 A’s” for all patients who smoke
 - Monitor the provision of the “5 A’s” for quality and consistency
3. Familiarize Staff with external resources – Quitline, Cessation Services, etc.

Biomarker Feedback as a Motivator to Quit:

Biomarker lab tests have shown to be an effective clinical tool for educating smokers about the health risks associated with commercial tobacco use. While adults are generally aware of the risks associated with smoking, they often misjudge the magnitude of this risk. Thus, showing patients lab reports indicating toxins in their body can be an effective way to educate them about health risks. Likewise among pregnant smokers, women who are more educated about the risks to their baby are more likely to quit smoking. While this method has only been tested in the non-pregnant population, The Robert Wood Johnson Foundation reports that such practices would be useful with the pregnant population, given that the lab report can serve as a tool to start the conversation about cessation. This strategy must be used in conjunction with other counseling techniques to be effective.

Financial Incentives to Help Smokers Quit:

Research has demonstrated that financial incentives do increase short-term cessation rates in the general population. However, in studies with pregnant women, such incentives alone were less effective than combining the incentives with social support and education. Given the low income of the majority of pregnant and non-pregnant smokers, financial incentives, when confirmed by biochemical validation of quitting, may assist smokers in attending and participating in treatment, increasing abstinence, and preventing relapse.

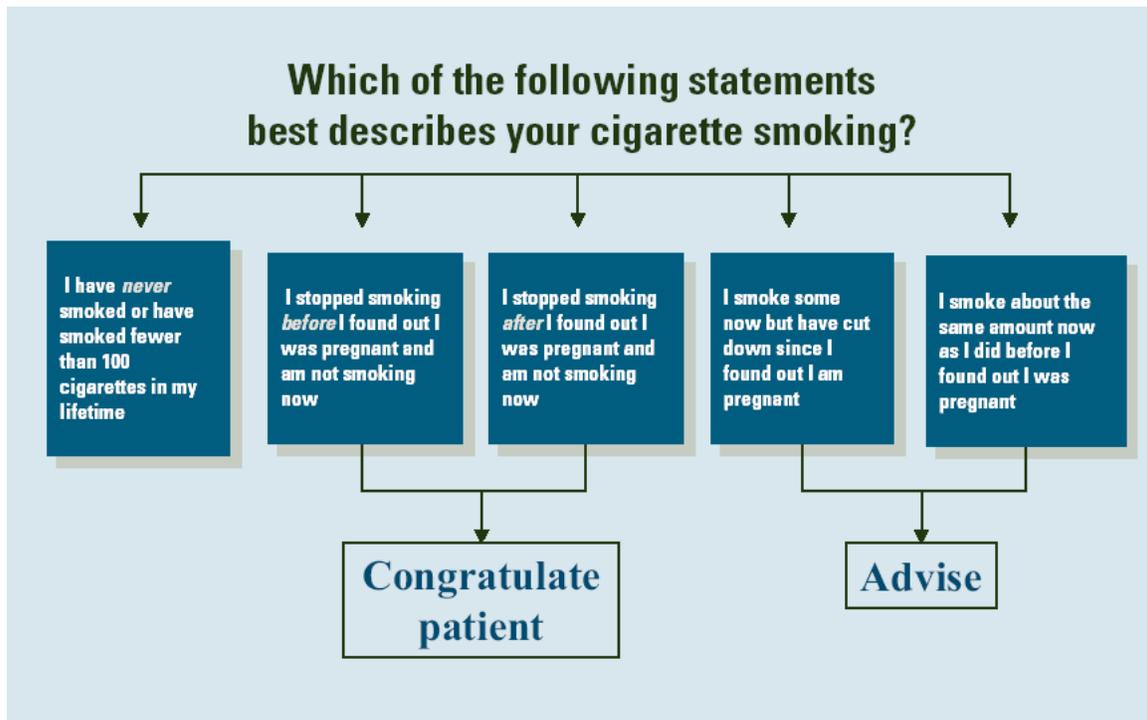
Exposure to Secondhand Smoke:

Another area in need of attention is child (and fetal) exposure to secondhand smoke. While quitting is the best option for reducing the health risks to children, not all women and parents are successful. For parents that are repeatedly unsuccessful in quit attempts, it is important to educate them about available options for harm reduction. Meaning, if parents must smoke, they should not smoke in the home or car and avoid smoking in the presence of their children. Encourage all parents to “Take it Outside!”

Considerations for Pregnant Women in the Clinic Population:

Improving Disclosure of Smoking Status Among Pregnant Women - Recent studies report that 3-6% of women do not report their smoking status, and as much as 13% of pregnant low-income smokers underreport the amount that they smoke. For a clinician, it is essential to be aware of how much and how frequent pregnant patients smoke.

To obtain more accurate information on smoking status, ACOG and Smoke-Free Families recommend the use of a tested structured question. Given the difficulties associated with implementing such a practice, clinicians should be given pocket guides to aid them in asking the correct questions.



105

Once a woman has been identified as a pregnant smoker, the recommended best practice is to counsel using the "5 A's". This method has demonstrated efficacy across various racial groups, and can increase cessation rates by 30-70%.¹⁰⁶ While clinicians are the best first line for identifying pregnant smokers, it is important they utilize external services such as Quit Lines to assist them in the cessation process. Currently, 28 states offer a pregnancy specific Quit Line, which can be highly effective in increasing cessation rates.

Spontaneous Quitters - Spontaneous quitters are women who quit smoking as soon as they become aware of being pregnant. Depending on the demographic, such quit rates range from 11% to 28% percent in the publicly insured population. In the privately insured population, spontaneous quit rates range from 40% to 65%. These types of quitters represent a large proportion of all women who quit during pregnancy, and are typically more successful in maintaining abstinence throughout the duration. However, there is a high rate of postpartum relapse in this group. Historically, interventions such as self-help materials, telephone and in person counseling, have not successfully prevented the relapse.

Preventing Postpartum Relapse - In the general population, of women who succeed in quitting smoking during pregnancy, 80% become smokers after they give birth, and 45% are smoking within 3 months of delivery. Breastfeeding appears to be a significant factor in smoking relapse; women who are breastfeeding tend to stay abstinent for a longer period of time. However, the most predictable factor contributing to postpartum smoking relapse is the smoking status of the women's partner. Women living in the same house as a smoker are three times more likely to relapse than women who do not live with a smoker. The problem lies in the fact that women tend to be more educated on the risks associated with smoking while pregnant, but less informed on the risks of environmental tobacco smoke.

Pharmacotherapies to Aid Smoking Cessation During Pregnancy - The use of pharmacotherapy to assist pregnant smokers in quitting has been an issue of debate. Of the literature that does exist, conclusions indicate that using NRT during pregnancy does pose a risk to the fetus, but the risk associated with exposure to cigarette smoke are far greater. Therefore, NRT is generally regarded as a last resort treatment for women who have been unsuccessful in their efforts to quit, even in the presence of counseling. The use of NRT should be a personal decision on the part of the pregnant smoker and her clinician. Guidelines recommend that pregnant smokers use a patch for 16 hours as opposed to 24 hours. Before initiation of NRT, every clinician should ask these questions:

- Has the patient indicated that she wants to quit?
- Has the patient received effective counseling procedures and not been able to quit?
- Has the patient reported smoking 10 cigarettes per day or more?
- Are there coexisting medical problems that need to be addressed, such as other drug dependence or depression?
- Is NRT acceptable to the patient? If so, which method does she prefer?

Clinic Resources:

A. **Treating Tobacco Use and Dependence: Clinical Practice Guideline**

This guideline, a product of a consortium of federal agencies and non-profit organizations, is an updated version of the Smoking Cessation Clinical Practice Guideline No. 18 (AHRQ, 1996). The recommendations presented are the result of a systematic literature review and analysis, peer-review process and expert panel opinion.

PDF Download: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

B. **Alliance for the Prevention and Treatment of Nicotine Addiction**

A tool kit for use when educating healthcare providers on implementing the Public Health Service Clinical Practice Guidelines.

<http://www.aptna.org>

C. **Health Care Providers' Tool Kit for Delivering Smoking Cessation Services**

This is a manual for physicians, medical office personnel and medical group staff. It seeks to help establish office-based systems to track smoking status, conduct cessation interventions with patients and refer patients to additional resources for more intensive assistance in their quit attempts.

http://www.cessationcenter.org/pdfs/NGAToolkit_FINAL_FORWEB.pdf

D. **Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking**

This free CME-accredited guide outlines how to integrate the "5 A's" into a clinical setting serving pregnant women. To order a single copy of the guide: e-mail smoking@acog.org. Please include your name, affiliation, and mailing address with your request.

E. **Leading the Way: Helping Our Patients Be Tobacco Free**

A carefully researched and developed comprehensive tobacco control curriculum available to dental hygiene faculty at no charge that includes a faculty guide, six training modules, and a useful toolbox.

<http://www.siu.edu/~hcp/tobacco/>

F. Tobacco Treatment Quick Clinician Guide

All health professionals play an essential role in helping patients stop tobacco use. Most smokers want to quit, and half of smokers make a serious attempt each year. Without effective treatments - counseling and medications - long term-success is difficult.

http://www.mainehealth.com/clinical_integration/resources/CTI_Clinician_Guide_2-14-03.pdf

G. Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide

This guide was developed to provide information on how to obtain reimbursement for smoking cessation counseling. It contains advice for providers who wish to maximize benefits for smoking cessation, navigate around coverage deficiencies, and advocate effectively for adequate coverage.

Appendix A: The latest Web Resources for Providers and Policymakers

Appendix B: The most current and important Web Resources for Consumers

Appendix C: Changes in State Medicaid Program Coverage of Pharmacotherapy and Counseling for Tobacco Dependence

<http://www.endsmoking.org/>

H. Invest in a Healthy State: Covering Tobacco Cessation Services Under Medicaid

The Center for Tobacco Cessation, in partnership with the National Partnership to Help Pregnant Smokers Quit, has developed a Medicaid and smoking cessation information packet. The materials included address issues of critical importance to Medicaid programs, including the health and economic costs and benefits of coverage, snapshots of current state activities, and how states can improve their cessation benefits and coverage. A tool kit clarifying Medicaid law and policy (including EPSDT) related to tobacco treatment for pregnant women, "*Helping Pregnant Women Quit Smoking: Providing Coverage for Tobacco Treatment Under Medicaid*," is also available.

http://www.ctcinfo.org/resources/toolkits.asp#Guides_&_Toolkits_for_State_Medicaid_Programs

www.helppregnantmokersquit/policy/medicaid.asp



Generating Support for Clinic-Based Tobacco Policies



Talking Points:

Tobacco Treatment is needed in the Clinic Setting.

- Epidemiologic data suggests that over 75% of smokers would like to quit, and nearly half of all smokers have made a serious quit attempt in the last year.¹⁰⁷
- Despite recommendations by the Surgeon General to treat tobacco dependence in the clinic setting, one third of all smokers report not being asked by their primary care physician about their smoking status in the last year, and one third report not being advised to quit.⁹⁷
- According to the Surgeon General, if every health professional used the 5 A's with every smoker, the US could reduce tobacco use by 20%.⁹⁷
- Smoking cessation intervention during physicians visits are associated with increased satisfaction among smokers.¹⁰⁸
- Research has shown that stopping smoking results in an improvement in health status at any age, including people aged 65 and older. Some health benefits are almost immediate, and the longer people refrain from smoking, the more their health improves. People live substantially longer when they stop smoking, regardless of the age at which they quit.¹⁰⁹
- Smoking cessation treatments have been found to be safe and effective. These include counseling and medications, or a combination of both. Scientifically proven treatments can double a person's chances of quitting smoking.³²
- Face-to-face counseling and interactive telephone counseling are more effective than services that only provide educational or self-help materials.^{32,110}
- The effectiveness of counseling services increases as their intensity (the number and length of sessions) increases.³²

Brief Interventions are Effective.

- Substantial evidence suggests that brief interventions, delivered by several different people within the clinic setting, are effective at increasing quit rates (25.5%) when compared to minimal interventions, such as distributing free literature (8.1%).¹¹¹
- Brief interventions require personal interaction and take from 30 seconds to 3 minutes. Brief interventions are based on the Five A's, as defined by the Public Health Service at the Department of Health and Human Services.
- Short messages do make an impact: Sharing sixty one-minute health education messages, delivered over time, makes a greater impact on patient behavior than delivering one sixty-minute health education message.
- About 20% of current tobacco users are ready to quit.¹¹²

Nicotine Replacement and other Pharmacotherapies are Effective.

- Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients attempting to quit smoking.³²
- The Food and Drug Administration has approved six first-line medications to help smokers quit:
 - Five are nicotine replacement therapies that relieve withdrawal symptoms. They include nicotine gum, patch, nasal spray, inhaler, and lozenge.³²
 - The sixth medication, bupropion SR (sustained release), is a non-nicotine medication that is thought to reduce the urge to smoke by affecting the same chemical messengers in the brain that are affected by nicotine.³²

Prescription and Over-the-Counter Tobacco Cessation Medications*

	Type/Form	Common Brand Name(s)	Availability
Nicotine Replacement Therapy	Gum	Nicorette®	Over-the-counter (OTC)
	Patch	Nicoderm®, Habitrol®, Prostep®, Nicotrol®	OTC and prescription
	Inhaler	Nicotrol®	Prescription
	Nasal Spray	Nicotrol®	Prescription
	Lozenge	Commit®**	OTC
Bupropion SR	Pill	Zyban®, Wellbutrin®	Prescription

* Approved by the Food and Drug Administration (FDA) and addressed in the 2000 PHS Guidelines.

** Received FDA approval on October 31, 2002, therefore not addressed in the 2000 PHS Guidelines.

Tobacco addiction poses a serious health threat for pregnant women, infants, and children.

- According to vital records data, 19.7% of American Indian and Alaska Native women who had a live birth in 2002 smoked cigarettes while they were pregnant.⁹⁹
- Smoking during pregnancy is the most important modifiable cause of poor pregnancy outcomes, and is linked to higher rates of low birthweight, preterm birth, and infant mortality.²³ Reducing smoking during pregnancy offers great benefits for Native American and Alaska Native women and their families.
- After birth, cigarette smoke increases a child’s chances of developing sudden infant death syndrome, respiratory disorders, ear and eye problems, growth and mental retardation, attention deficit disorder, other learning and developmental problems, and even long-term behavioral problems, violent tendencies, and criminality.²⁶
- Smoking in the home, car, or around children increases the likelihood that exposed children will suffer from smoke-caused coughs and wheezing, bronchitis, asthma, pneumonia, potentially fatal lower respiratory tract infections, eye and ear problems, or injury or death from cigarette-caused fires.²⁶



Experience from the Field: Implementing Clinic-Based Tobacco Policies



Treatment of Nicotine Dependence: A Clinic System

Contributed by Nancy Meyers, Puyallup Tribal Health Authority

The mission of the Puyallup Tribal Health Authority is “to achieve a 10% decrease in the prevalence of tobacco use among the Puyallup Tribal Health Authority (PTHA) adult user population by 2006.”

To meet this lofty challenge, the PTHA set the following goals for themselves:

Goals:

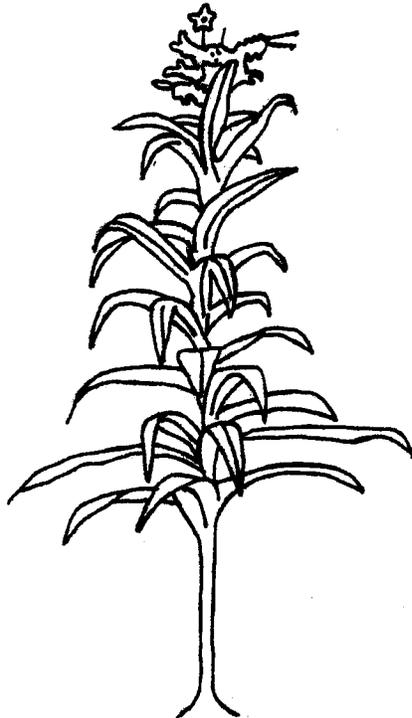
- 2000 Complete the development of the office-based clinic system, which supports the identification, tracking, treatment and follow-up of PTHA adult tobacco users. Train clinical staff on the system and effective interventions.
- 2002 Implement the system in the Medical and Dental clinics. Conduct quarterly chart audits and make the necessary changes. Conduct trainings to ensure accuracy and compliance. Review data from PTHA’s cessation program and revise the process and educational materials as needed to get quit rates to at least equal with national standards (18% overall at one year).
- 2003-5 Implement the clinic system in all other clinics. Continue quarterly chart audits and provider training. Conduct a patient survey in 2005. Revise the system as needed and certify all providers in the State Department of Health “Brief Tobacco Intervention Skills.
- 2006 Calculate the tobacco use prevalence rate of all adult patients. All clinics will have fully integrated the clinic system into daily practice.

Implementing the PHS clinic guidelines to treat nicotine dependence (excerpts appear on pages 214-234 of this chapter) seems to have produced quit rates in our Native clinic that are similar to those found in non-native clinics.

I have recently reviewed over 80,000 patient visits over the past three years and have done a random sample of 500 active adult patient charts to determine that we have reduced tobacco use rates over the past 5 years by 20% - from 55% to 44%. The 1999 data had a confidence interval of around 8 and the 2004 data has a confidence interval of about 3. In comparison, ten years after implementing the PHS guidelines on a clinic-wide basis, Group Health of Puget Sound reduced their rates by 40% (from 25% to 15%).

We know that we cannot expect to see the same rate of decrease in the next 5 years. While our cessation program is getting an 80% quit rate at one year for program graduates (those who successfully quit for 3 month), we do not anticipate that two and three year quit rates will stay at that level. We are currently in the process of evaluating the components of the program that are essential to long-term success.

Nancy Meyers
Puyallup Tribal Health Authority
Tobacco Program Coordinator





Clinic-Based Tobacco Policy Templates And Tribal Examples



Workplace Cessation Policy Template:

The Tribal Clinic is committed to supporting the health of its patients, and tobacco use is the number one cause of preventable death and disease. The Tribal Clinic will develop and implement a consistent procedure for identifying, documenting, and treating tobacco users in the healthcare setting. To do this, the following protocols will be adhered to by all clinic staff:

Provider Reminder System - The Health Director will be responsible for ensuring all clinic intake forms are modified to include a designated “Tobacco Use” section, as well as any other forms needed to implement the Provider Reminder System.

During patient intake, the staff person responsible for obtaining the patient’s vital signs must ask all patients (age 6 years and older) about current and past tobacco use. For pregnant women, ask the patient to respond to one of the following statements:

- A. I have NEVER smoked, or I have smoked less than 100 cigarettes in my lifetime.
- B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
- C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- D. I smoke some now, but I cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
- E. I smoke regularly now, about the same as **BEFORE** I found out I was pregnant.

This information shall be documented in the chart for all patients. For current and former smokers, the number of packs smoked per day should also be obtained and documented in the designated “Tobacco Use” section of the “Vital Signs Intake Chart”. All patients age 6 years and older must be asked about tobacco use at each and every visit.

Brief Counseling Interventions - Physicians (or attending PAs or NPs) should congratulate “past smokers” on their decision to quit, and “never smokers” will likewise be encouraged to continue making healthy decisions. In accordance with the Surgeon General’s *Smoking Cessation Clinical Practice Guideline*, physicians will briefly intervene with all current smokers using the Five A’s model: Ask, Advise, Assess, Assist, and Arrange. This discussion need not take longer than 30 seconds.

1. **Ask** - Identify and document tobacco use status for every patient at every visit. This can be done with a provider reminder system.
2. **Advise** - In a clear, strong, and personalized manner, urge every tobacco user to quit.
3. **Assess** - Is the tobacco user willing to make a quit attempt at this time?
4. **Assist** - For those willing to make a quit attempt, use pharmacotherapy to help him or her quit. Refer the patient to the Pharmacist, State Quitline, or the tribe's Tobacco Program Coordinator to access additional counseling and obtain help developing a quit plan. For those who are not ready to quit, discuss the 5 R's: **Roadblocks**: "What might be keeping you from quitting?" **Relevance**: "The carbon monoxide in the tobacco smoke goes right through the placenta to the baby robbing the baby of oxygen." Or "Exposure to nicotine makes it more difficult to control your blood pressure." **Rewards**: "If you quit smoking now you will have a healthier baby and an easier delivery." Or "If you quit smoking now, your quit will serve as a good role model for your grandchildren." **Risks**: "If you keep smoking you increase the risk of the baby being born too early or of miscarrying." Or "If you keep smoking, you increase your risk of having a second heart attack." **Repetition**: Repeat the message to quit at every visit to increase the likelihood of a quit attempt.
5. **Arrange** - For those interested in quitting, flag them for follow-up by clinic personnel, in person or by telephone, within the first week of their quit date.

Pharmacotherapy - To ensure that appropriate medications are available for the treatment of tobacco dependence, the Health Director will consult clinic physicians and pharmacists to ensure that effective options are present on the clinic's formulary. Provided no contraindications exist, all patients interested in quitting tobacco should be offered the use of medication.

Comprehensive Tobacco Cessation Counseling - In depth tobacco cessation counselling should be offered to all smokers interested in quitting. Clinicians will refer patients to the tobacco program coordinator or tribal CD personnel to obtain this treatment, or to the State or National Quitline (1-800-QUITNOW) if that is preferred by the patient. All comprehensive counseling programs must include the creation of a quit plan, discussions regarding methods of quitting, discussions regarding the physical changes that will occur when quitting, discussions regarding strategies for coping with withdrawal, and discussions regarding possible barriers and support systems. At least six counselling sessions are advised, carried out over the course of 5-6 weeks.

Staff Education - All clinic personnel will be trained on their role in the tobacco treatment process. An assessment of this role will be integrated into annual personnel evaluations, to provide staff accountability. Training for all clinic staff on the Five A's (also known as the Basic Tobacco Intervention Skills (BTIS)), will also be arranged annually by the Clinic Health Director.

Enforcement - A random sample of charts will be reviewed bi-annually by the Clinic's Health Director to ensure all tobacco treatment procedures are consistently implemented. Staff members found not to meet required standards of care will be told of this lapse, and future performance goals will be discussed.

Tribal Example 1*:

Tobacco Use Cessation Policy

Tobacco Use is a significant cause of morbidity and mortality. Consistent recommendations to stop smoking and assistance with smoking cessation is an essential part of preventative healthcare. Chewing tobacco use must also be included in prevention interventions.

Standards of Care:

All patients over the age of 12 should be asked if they use tobacco. If so, “tobacco Use” must be documented on the “Problem list” and counseling given regarding the need to discontinue tobacco use.

Chewing Tobacco: Counseling must include the increased risk of head and neck cancer and dental disease. Exam should include evaluation of mouth for oral lesions and dental disease and checking for cervical adenopathy. Referral to the dentist for evaluation and education must be documented.

Cigarette Smoking: Counseling should include the increased risk of coronary artery disease, chronic lung disease, head and neck cancer, ulcers, premature skin aging and dental disease. History should include the total pack-years smoking, current pack-per-day usage, prior attempts at quitting and motivators (to the Patient) to quit.

Stop Smoking Program:

Ideality, the Community Health program of the [REDACTED] Tribe will conduct periodic “Smoking Cessation” programs. When available, patients will be referred to these programs. Requests for Indian Health Service (IHS) funded nicotine patches will only be honored for those people enrolled in a formal program, when a program is available.

Cont...

When a formal stop-smoking program is not available, clinic providers may offer a clinic-based stop-smoking program. IHS funded nicotine patches will be prescribed only to those patients compliant with the program. The program will include:

- a) A patient contract with the provider.
- b) Giving the patient the American Cancer Society “Tip Sheet”.
- c) Follow-up visits every two weeks minimum while using nicotine patches.
- d) Patches are to be prescribed in two-week increments for a maximum of twelve weeks. Patches are only to be prescribed for those patients with no contraindications (vascular disease and cardiac disease).
- e) A quit date must be set.
- f) A plan that addresses smoking “triggers” and alternatives must be discussed.

Resumption of any smoking while using patches will remove the patient from IHS funding for patches. (The only exception is the use of tobacco in traditional Indian ceremonies. Caution must be given regarding removal of the patch during ritual tobacco use and the high risk of re-addiction. Non-tobacco products should be recommended as alternatives: sage or clove.)

The above procedure is recommended for all patients who request smoking cessation assistance. It is required for IHS payment of patches.

If a patient fails the program or does not keep the contractual agreement, IHS will not pay for additional patches for a period of three years. If a patient resumes smoking on completion of the program, the IHS will not pay for additional patches for a period of three years.

The provider must enter each patient’s name in the “Stop Smoking Log Book” and indicate if they are IHS eligible or not. The “quit date” must be entered and a record made of subsequent visits. The “final outcome” will note successful completion of the program or the reason for removal from the program, and subsequent follow-up after completion of the program. The Medical Director will forward copies of the log to the [REDACTED] Chief Pharmacist every two weeks. This will allow the Contract Health Service payment of the authorized prescriptions.

“Certificates of Achievement” may be awarded to patients who have quit smoking at an interim visit to reinforce the stop smoking behavior, or at the completion of the program. For patients who complete the program, questioning regarding smoking status should still be done and document on subsequent visits.

***To ensure confidentiality, all identifying features have been blacked out.**

Tribal Example 2:

Puyallup Tribal Health Authority Treatment of Nicotine Dependence



Clinic System Manual (Select excerpts)

The complete document can be obtained by contacting:
Puyallup Tribe, Puyallup Tribal Health Facility
2209 E 32nd St, Tacoma, WA 98404
Phone: 253-593-0232 Fax: 253-272-6138

Office-Based “Brief Intervention” Overview

- The brief intervention model - from the Agency for Health Care Policy and Research (AHCPR) - is based on more than ten years of research and the review of over 3,000 articles.
- In 2000, the Surgeon General stated that the implementation of AHCPR’s model in every clinic would reduce tobacco use in the United States by over 20% in five years.
- PTHA health care providers will follow AHCPR’s brief intervention model when treating nicotine dependence in the PTHA patient population.
- This model can be delivered in a culturally appropriate manner by being non-confrontational, respectful of the patient’s readiness to quit, and by not lecturing. A brief intervention of 30 seconds to 3 minutes using the model below is effective without putting the patient on the spot and without probing into personal issues.

Clinical Tobacco Use Algorithm 18 years of age and older

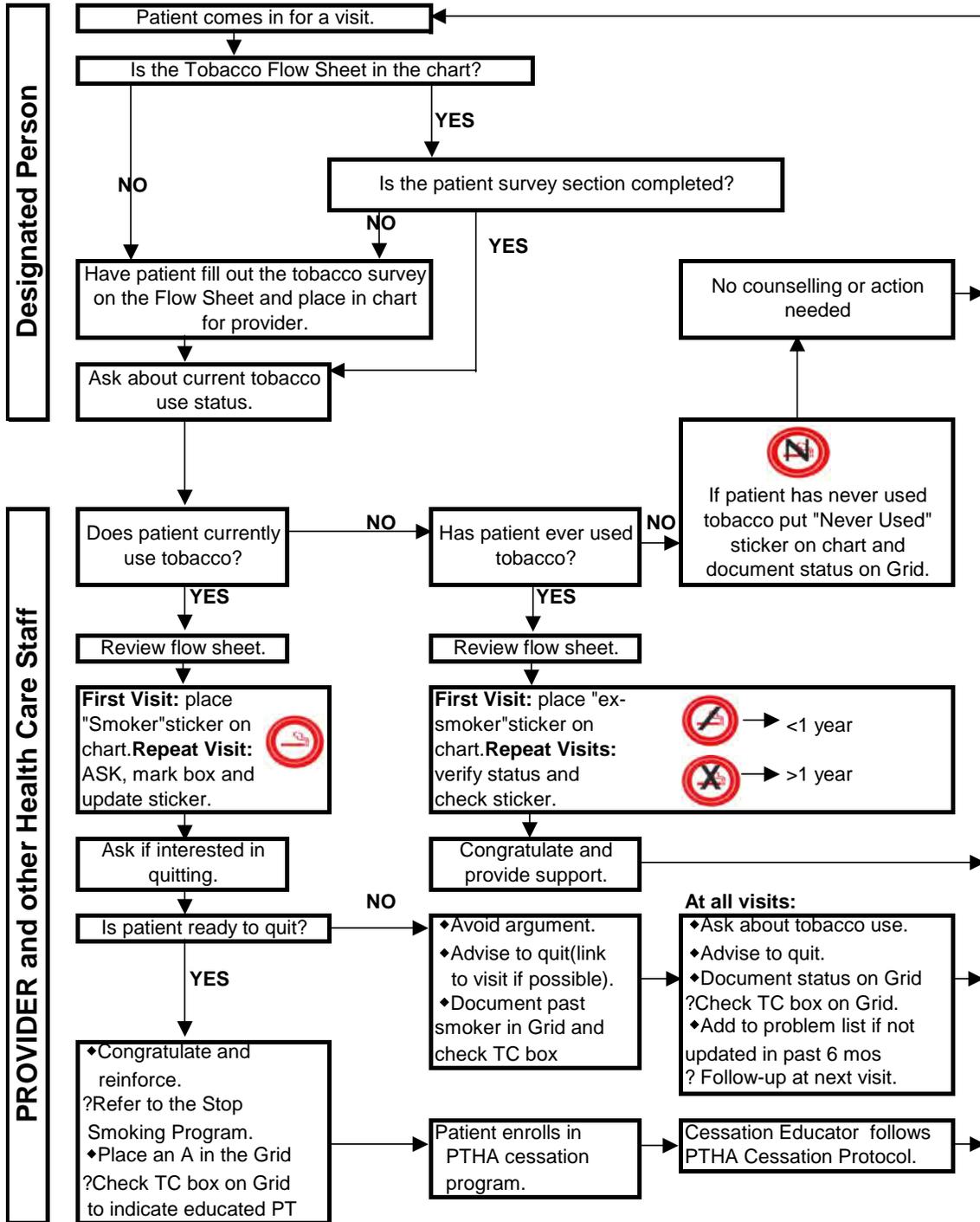


Chart Flagging System

The following stickers are to be placed on a patient's chart to indicate the patient's tobacco use status. The stickers provide a cue for asking about tobacco use at every visit. Check stickers at every visit to insure accuracy.

No Target Date  = Current tobacco user

Target Date __/__/__ = Tobacco user with a set quit date

Ex-Smoker  = Former tobacco user (3 months to 1 year)

Ex-Smoker  = Former tobacco user (more than one year >1 yr)

Never Smoker  = Non tobacco user (never used)

Stop Smoking Program Intervention Guideline

Initial Process:

- Patient is referred or self-referrers to the Stop Smoking Program.
- Appointment is made within one week if possible.
- Patient receives brochure and program information sheet (mail if appointment is made by phone).
- Patient is informed that medications may not be provided at the first appointment.

At Each Appointment – *Cessation Educator (CE) will:*

- Order patient charts or request charts to be ordered.
- Use Motivational Enhancement Therapy (MET) to help the patient develop a plan and to problem solve.
- Use appropriate education materials to support patient cessation process.
- Review patient goals and progress at each visit and help patient set new goals.
- Follow the cessation medication protocol on page 11 – 13 in the Clinic Manual for Treating Nicotine Dependence.
- Use the Cessation PCC for every visit and document visits on the Flow Sheet in the patient chart.
- Place the Cessation PCC in the patient chart and place in appropriate LIP box for signature.
- Attach a copy of the Cessation PCC to the Cessation Program Control Sheet.
- Schedule follow-up appointments every two weeks if possible.
- Make reminder calls the day prior to the next appointment or assign someone else to make the calls.
- Call the patient if the appointment is missed to assess problems/issues and reschedule if patient is still interested in quitting.
- Cessation handouts are filed in the Materials Section of the Clinic Manual for Treating Nicotine Dependence.

Step 1 Assessment:

- Review the patient tobacco survey on the Tobacco Flow Sheet in the chart, the Cessation Program Information Sheet and patient active problem list to prepare for the visit.
- Have the patient complete the patient survey on the Flow Sheet if one is not in the chart.
- Review program steps with patient and provide information about medication options.
- Use the cycle of addiction handout to help the patient identify triggers and alternative behaviors.
- Complete the program enrollment form if the patient is ready to commit to the program.
- Help the patient develop goals for the next appointment and review goals with patient.

Step 2 Setting a Quit Date: (Step 1 and Step 2 may be combined into one visit)

- Assess how the patient is doing with goals and readiness to quit.
- Ask about decision on NRT use and Bupropion and follow medication protocol.
- Help patient set a quit date and make plans for behavior changes to get ready to quit.
- Schedule appointment for the day before quit day.
- Give the patient appropriate educational materials and support items.

Step 3 Day Before Quit Day:

- Assess how the patient is doing with goals and Bupropion (if prescribed at Step 2).
- Help the patient address issues about quitting i.e. stress, weight gain, and irritability.
- Review triggers and alternative behaviors.
- Help the patient develop plans and tools for managing urges and dealing with issues.
- Give the patient appropriate educational materials and support items.
- Follow medication protocol if NRT is to be used on quit day.
- Place the “Target Date Sticker” on the chart.

Step 4 Week Two of Quit

- Assess how the patient is doing with withdrawal symptoms and NRT/Bupropion.
- Assess trouble areas and help the patient problem solve.
- Use the medicine wheel handout to help the patient develop a plan for healing from nicotine addiction and developing a plan for managing stress and social pressures to smoke.
- Help the patient set goals for the next two weeks.

Step 5 Week Four of Quit

- Assess how the patient is doing with withdrawal symptoms, NRT/Bupropion.
- Change medication dose according to medication protocol.
- Discuss concerns and issues the patient may have.
- Help the patient develop a plan for exercise and healthy eating.
- Provide appropriate educational materials and support items.

Step 6 Week Six of Quit

- Assess how the patient is doing with urges and NRT/Bupropion.
- Change medication dose according to medication protocol.
- Provide support and assistance with trouble areas.
- Provide appropriate educational materials and support items.

Step 7 Week Eight of Quit

- Assess how the patient is doing with urges and NRT/Bupropion.
- Change medication dose according to medication protocol.
- Provide support and assistance with any remaining trouble areas
- Help the patient prepare to transition off NRT if getting close to three months of being nicotine free.

Step 8 Week Ten of Quit

- Assess how the patient is doing with urges and NRT/Bupropion.
- Discontinue NRT if ready to graduate in two weeks.
- Help the patient develop a relapse prevention plan.
- Continue Bupropion for two more weeks.

Step 9 Week Twelve of Quit – Graduation

- Give patient a Smoke Free T-shirt if still not smoking.
- Confirm relapse prevention plan is working.
- Continue Bupropion if indicated.
- Place the “Less Than 1 Year” sticker on the chart.
- Remove the smoking status from the problem list.
- Call patient monthly until one-year anniversary.

Note: Slips (smoking one or a few cigarettes) are common during the cessation process. If the patient has relapsed (smoking one or more on a regular basis) at any time during the quit process:

- Help set a new quit date.
- Assess problem areas and help problem solve.
- Assess medication strength and consider increasing dose.
- Assess patient readiness to follow through with the quit process.
- Make a new plan.

Puyallup Tribal Health Authority
POLICY AND PROCEDURES – ADMINISTRATION

SUBJECT: Tobacco Cessation Program

PURPOSE: Provide guidelines for prescribing and managing medications for tobacco cessation

POLICY: All Puyallup Tribal Health Authority (PTHA) Licensed Independent Practitioners (LIP), Pharmacists and Stop Smoking Program Cessation Educators (CE) will use the following guidelines.

GENERAL PROCEDURES FOR TOBACCO CESSATION PROGRAM:

- If the patient is ready to quit using tobacco within 30 days, the health care provider may refer the patient (or the patient may self-refer) to the Stop Smoking Program. The patient will be informed that cessation medications **may not** be provided at the first Stop Smoking Appointment.
- The nicotine addiction profile of each patient in the Stop Smoking Program will be assessed at the first visit and the patient will be educated about medication options. If the patient is interested in medications for cessation, the procedures laid out in this policy will be followed.
- When a non-prescribing Cessation Educator (CE) sees a patient who indicates an interest in using Bupropion, the CE will provide the patient's Licensed Independent Practitioner (LIP) with the Cessation PCC, the nicotine addiction profile assessment and the patient chart for review. The LIP will follow the medication protocol as defined in this policy for prescribing Bupropion. If the patient does not have a designated LIP the Health Director will review the patient record.
- Nicotine Replacement Therapy (NRT) will be prescribed according to the protocol in this policy.

- All new clinic patients seen in the Stop Smoking Program, and requesting medications for cessation, will need to be evaluated by a LIP to gather essential baseline health data before medications can be prescribed. If the patient can not be seen in walk-in or an appointment cannot be scheduled within one week of the Stop Smoking Program appointment, a designated LIP will assess the patient health profile by phone before prescribing medications for cessation.
- The CE will document all Stop Smoking Program visits on the patient Tobacco Use Flow Sheet, the Cessation PCC and on all appropriate Stop Smoking Program forms.
- When a LIP prescribes NRT/Bupropion for a patient **not** in the Stop Smoking Program, the provider will follow the prescriptive guidelines in this policy and implement an appropriate follow-up schedule to assist the patient with the cessation process and monitor medications.
- PTHA reserves the right to not prescribe cessation medications for patients whose medical condition(s) and care are deemed too complicated, too obscure, or too risky to safely prescribe medications for cessation.

Guidelines for Dosing and Duration of Cessation Medications

Nicotine Replacement Therapy - Transdermal Patch and Nicotine Gum:

The duration of NRT can range from four to twelve weeks with from two to four weeks for each step. Step duration may be increased at the discretion of a LIP or a pharmacist following the dosing protocol below. A pharmacist may prescribe NRT for patients in the Stop Smoking Program in a quantity sufficient to last between scheduled appointments. A non-prescribing CE will provide information on the Cessation PCC regarding number of cigarettes smoked or tins of chew used on a daily basis to assist the pharmacist or LIP in dosing. Standing refill protocols will be followed.

Contraindications for NRT: pregnant or breast-feeding, heart attack in the past two months, CAD (not to exceed 14 mg patch), allergy to adhesive (no patch) and under 18 years of age. A LIP will review the health record for patients with the above contraindications before NRT can be prescribed. If an LIP determines that NRT is appropriate for patients with contraindications, standing refill protocols will be followed.

Nicotine Patch Dosing* – up to 4 weeks per step

5 -9 Cigs/day Patch Dose	10 - 14 Cigs/day Patch Dose	15 or more Cigs/day Patch Dose
7 mg	14 to 21 mg	21 mg

Nicorette GUM (N-Gum) Dosing*

10 or fewer Cigs/day N-Gum Dose	11 - 20 Cigs/day N-Gum Dose	21 plus Cigs/day N-Gum Dose
2 mg – up to 10 pieces/day	2 mg – up to 15 pieces/day	2 mg – up to 24 pieces/ day

*This is a general guide for NRT dosing. NRT dose may vary depending on number of years of tobacco use, nicotine content of tobacco product, use patterns and individual patient response to NRT therapy.

Bupropion:

The standard PTHA Bupropion dose for smoking cessation is 150 mg BID for a minimum of three months. Bupropion for cessation may be prescribed in doses up to 300 mg/day and continued for up to one year depending on length of tobacco use, prior failed quit attempts, co-morbidity issues and extent of nicotine addiction. Bupropion may be used alone or with NRT and must initially be prescribed by a LIP with the number of refills indicated on the prescription. Dosing increases for patients in the Stop Smoking Program not started on 300mg/day will be prescribed by a LIP. Bupropion refills for patients in the Stop Smoking Program will be provided consistent with standard refill protocols and dispensed in a quantity to last between scheduled appointments.

Before prescribing Bupropion for smoking cessation, a LIP will review the patient's health record to determine appropriateness of use with attention to the following **contraindications**: seizure disorder, already taking medications with the active ingredient Bupropion hydrochloride, have or have had an eating disorder (bulimia or anorexia nervosa), currently taking or have recently taken an MAOI medication, allergic to Bupropion hydrochloride, pregnant or breast feeding. If a LIP determines that Bupropion is appropriate for a person with contraindications, standing refill protocols will be followed.

Tobacco Cessation Program Monitoring:

If a patient is enrolled in the Stop Smoking Program and using NRT/Bupropion, a pharmacist will review and monitor the medication dose at each appointment and follow standing refill protocols. When medications for cessation have been prescribed, the cessation PCC will be signed by the pharmacist and the patient's health care provider. If the patient has no designated health care provider, the Medical Director will sign the PCC. If a LIP has prescribed NRT/Bupropion for cessation outside of the Stop Smoking Program, the LIP will monitor dosage and side effects as well as assisting the patient with the behavior changes needed for successful cessation.

Method of Distribution:

A pharmacist will dispense all NRT/Bupropion, educate the patient about its proper use and reinforce the behavior change components of the patient's plan.

Stop Smoking Program Eligibility Criteria:

Registered patients eligible for care at PTHA, are generally eligible for services through the Stop Smoking Program. Spouses and family members of PTHA eligible patients, who are not otherwise eligible for care at PTHA, may enroll in the Stop Smoking Program if the eligible spouse/family member is enrolled in the program. No medications will be provided for the non-eligible spouse/family members.

RATIONALE:

- PTHA recognizes the addictive nature of nicotine and believes that it is important to assist patients with withdrawal symptoms with recommended medications for cessation. If a decision is made to use pharmacotherapy support, these guidelines need to be followed to assure safe and effective medication use. Medications are used to help reduce common withdrawal symptoms (craving, irritability, anxiety, sleep disturbance, impaired concentration, hunger, weight gain, depression and minor somatic complaints) that tend to lead to relapse when not managed.
- Research-based studies of NRT usage (e.g. transdermal nicotine patch, nicotine chewing gum and other nicotine replacement products) show that cessation rates improve when NRT is used in conjunction with a structured, behavioral-change stop smoking program. Cessation rates also increase again when Bupropion is used in conjunction with NRT and a structured behavior change program that is four to eight weeks in length and minimum of 30 minutes/session. The collaborative use of a non-physician stop smoking program educator and/or other tobacco cessation-trained clinical staff (i.e. P.A.s, ARNPs, RN's and pharmacists) has been shown to be a safe and effective method of reducing tobacco use rates.

**PUYALLUP TRIBAL HEALTH AUTHORITY
POLICY AND PROCEDURES – TREATMENT CENTER**

SUBJECT: Tobacco Cessation Program

PURPOSE: To provide guidelines for prescribing and managing medications for tobacco cessation

POLICY: All Puyallup Tribal Health Authority (PTHA) staff involved in the Treatment Center’s nicotine addiction treatment program will use the following guidelines for prescribing medications for cessation.

GENERAL PROCEDURES FOR TOBACCO CESSATION

- All clients will fill out the intake form to assess for tobacco use.
- All clients indicating tobacco use will receive an informational handout about the treatment of nicotine dependence at the treatment center.

Procedure for clients interested in using medications for quitting tobacco use while in treatment:

- a) The client will talk with his or her counselor.
- b) The counselor will discuss the cessation process and medication options with the client.
- c) The counselor will fill out the “Interdepartmental Referral Form” and the “Stop Smoking Program Enrollment Form” and send both forms to the Treatment Center Health Care Provider.
- d) The Treatment Center Health Care Provider will follow the protocol in this policy to assess appropriateness of medications for quitting tobacco use and for prescribing medications.
- e) Clients using medications for quitting tobacco use prescribed by the Treatment Center medical provider will attend the weekly cessation class and the weekly Nicotine Anonymous meeting.
- f) Clients using medications for quitting tobacco use will give up their tobacco on or before the day they receive NRT. Clients continuing to use tobacco products while on medications will be disciplined.

GUIDELINES FOR DOSING AND DURATION OF CESSATION MEDICATIONS

Nicotine Replacement Therapy – Transdermal Patch and Nicotine Gum (NRT)

Duration of NRT therapy can range from four to twelve weeks with from two to four weeks for each step. Duration may be increased to up to eighteen weeks by the discretion of the Treatment Center Health Care Provider. NRT will be prescribed by a Licensed Independent Practitioner (LIP) in a quantity sufficient to last until the next follow-up appointment with the Treatment Center Medical Provider (preferably every two weeks). The medical protocol governing Treatment Center prescriptions apply to cessation medications.

Contraindications for NRT: pregnant or breast-feeding, heart attack in the past two months, CAD (not to exceed 14 mg patch), allergy to adhesive (no patch) and under 18 years of age. A Licensed Independent Practitioner (LIP) must review the health record for patients with the above contraindications before NRT can be prescribed. If a LIP determines that NRT is appropriate, the LIP will take full responsibility for prescribing and monitoring for adverse effects for duration of use.

Nicotine Patch Dosing – up to four weeks for each step*

5 -9 Cigs/day Patch Dose	10- 14 Cigs/day Patch Dose	15 or more Cigs/day Patch Dose
7 mg	14 mg to 21 mg	21 mg

Nicorette GUM (N-Gum) Dosing*

10 or fewer Cigs/day N-Gum Dose	11 - 20 Cigs/day N-Gum Dose	21 plus Cigs/day N-Gum Dose
2 mg – up to 10 pieces/day	2 mg – up to 15 pieces/day	2 mg – from 16 to 24 pieces/ day

*This is a general guide for NRT dosing. NRT dose may vary depending on number of years of tobacco use, nicotine content of tobacco product, use patterns and individual patient response to NRT therapy. An LIP can change the dose after an assessment.

Bupropion:

The standard PTHA Bupropion dose for tobacco cessation is 150 mg BID for a minimum of three months but medication dosing and duration may vary depending on the individual patient's needs and length of stay. Bupropion may be prescribed alone or with NRT by a LIP. The medical protocol governing Treatment Center prescriptions apply to cessation medications. Bupropion will be provided for cessation at the discretion of the Treatment Center LIP only for clients that qualify for medical services at PTHA. Bupropion for cessation will not be provided to non-native clients.

Contraindications for Bupropion:

Before prescribing Bupropion for tobacco cessation, a LIP will review the patient's health record to determine appropriateness of use with attention to the following **contraindications**: seizure disorder, already taking medications with the active ingredient Bupropion hydrochloride, have or have had an eating disorder (bulimia or anorexia nervosa), currently taking or have recently taken an MAOI medication, allergic to Bupropion hydrochloride, pregnant or breast feeding. If a LIP determines that Bupropion is appropriate for a person with contraindications, the LIP will take full responsibility for prescribing and monitoring for adverse effects.

Method of Distribution:

The Treatment Center Health Care Provider will dispense all Bupropion, educate the patient about its proper use, reinforce cessation behavior change, and monitor the client. Resident Assistants may dispense NRT with proper documentation that the medication has been dispensed. All nicotine cessation medications will be dispensed daily and all other policies governing the dispensing of medications to Treatment Center clients will apply.

RATIONAL:

- PTHA recognizes the addictive nature of nicotine and believes that it is important to assist treatment center clients with withdrawal symptoms if the client chooses to include the treatment of nicotine addiction in their treatment plan.
- Medications are used to help reduce common withdrawal symptoms (craving, irritability, anxiety, sleep disturbance, impaired concentration, hunger, weight gain, depression and minor somatic complaints), which tend to lead to relapse when not managed well and to increase the chance of long-term cessation.
- Research also shows that people who quit smoking while in treatment for alcohol and other drugs have a lower recidivism rate than those who continue to smoke.

Eligibility Criteria:

- PTHA-registered patients (who are otherwise eligible for care at PTHA) and other Native American/Alaska Native clients eligible for care under IHS criteria are generally eligible for medications from the PTHA pharmacy for quitting tobacco use while in the Treatment Center.
- Non-native patients choosing to quit tobacco use and requesting medications to assist with withdrawal will be screened by the Treatment Center Medical Provider to determine appropriateness of medications. Nicotine patches and nicotine gum will be prescribed according to protocol as long as there is grant money to provide such products. Bupropion for cessation will not be prescribed for non-native clients.
- The Treatment Center reserves the right to **not** prescribe medications for patients whose medical condition(s) and care are deemed too complicated, too obscure, or too risky to safely provide tobacco cessation prescriptions.

Evaluation and Measurement Process

Successful implementation of the PTHA Tobacco Use Guideline requires continued monitoring, measurement, and feedback.

- Clinics are strongly encouraged to develop a mechanism for bi-weekly monitoring of guideline implementation i.e. are charts flagged, are providers documenting on the PCC/Progress Note, do all charts have a completed patient survey on the Tobacco Use Profile/Flow Sheet.

Tobacco Use and ETS exposure data from the Health Factor List will be used to generate provider status reports for provider feedback and education.

- Problem lists will be generated to insure that smoking comes up as a problem for current smokers.
- Health factors will be run for individual patients to determine tobacco use rates.
- The RPMS database will be used to generate reports.

Quarterly chart audits will be conducted by each clinic.

- Charts will be audited for flagging, PCC documentation, completed patient tobacco use survey, and documentation of patient education.
- Chart audits will be compared with the data from RPMS.

Key indicators that the system is working:

1. The presence of a sticker on the chart indicating smoking status.
2. Documentation on the PCC that tobacco use was assessed and addressed during the visit.
3. Enrollment in the cessation program.

Methods of Assessing Compliance

Documentation of tobacco use status.

Is the tobacco use status identified on the chart and recorded on the PCC/Progress Note?

Method:

- Chart audit.
- Data from RPMS

Frequency of brief intervention

Do providers educate smokers and document the education on the PCC/Progress Note?

Method:

- Chart audit
- Data from RPMS
- Patient Satisfaction Survey

Utilization of cessation program.

Are tobacco users aware of and using the PTHA cessation program?

Method:

- Chart audit
- Patient Satisfaction Survey
- Cessation program enrollment data

Clinic level methods to insure successful implementation:

- Review a sample of charts once every month before they are returned to the chart room (10-20 charts may be sufficient for this purpose).
- The chart reviewer should look for the following indicators: accurate tobacco use sticker on the chart, completed patient survey, PCC/Progress Note documentation of tobacco use status and education.
- Providers should not be alerted to the day the review will take place.
- Continue to review the charts every month to insure that yearly objectives will be met.
- *For example:* If six out of ten charts show all indicators documentation requirements have been met, the 2002 goal of 60% has probably been reached. By 2005, 95% of the charts reviewed should have all measurable met to insure compliance with the 2005 goal.

Methods to Increase Compliance

- Meet with staff to identify barriers.
- Facilitate solutions with staff.
- Revise the system/forms to address problem areas.

Office-based Prevention and Intervention Patients Ages Birth to Seventeen

The Surgeon General has classified smoking as a pediatric disease!

- Health care providers should screen pediatric patients ages 6 to 17 for tobacco use at every visit and advise the patient to stop smoking/chewing if any use is evident.
- Health care providers should screen for exposure to secondhand smoke at every visit.
- Health care providers should screen for parent/guardian smoking at every visit.
- Health care providers should advise parent/guardian to quit smoking at every visit. If parent/guardian is not ready to quit smoking, advise them to make their home and car smoke free to protect their children.
- Health care providers should refer parent/guardian ready to quit smoking to the Stop Smoking Program or the state quit line if parent/guardian is not a PTHA patient.

Ages 6 to 11

Assess for tobacco use at every visit.

Check Appropriate Box on PCC/Progress Note.

Document education by checking the TC box on the PCC/Progress Note.

- **Ask** about tobacco use at every visit:
 “Have you ever tried a cigarette or chewing tobacco?”
 “Have you smoked/chewed in the last 30 days?” “Do you smoke/chew every day?”
- **Advise** child to quit smoking/chewing:
 “I really care about you and I want you grow up healthy.”
 “Do you think you can say no the next time someone offers you a cigarette/chew?”
- **Prevention message for all 6 to 11 year olds:**
 “Smoking cigarettes or chewing tobacco hurts your body and makes it hard for you to run and play.”
 “Smoking/chewing makes you stink.”
 “I hope you don’t ever smoke or chew because I want you to be healthy.”

<p>Ages 12 to 17</p> <p>Assess for tobacco use at every visit.</p> <p>Document use on the PCC/Progress Note by checking the correct box on the Health Factor Grid.</p> <p>Document education by checking the TC box on the PCC/Progress Note.</p>	<ul style="list-style-type: none"> • Ask about tobacco use at every visit: <ul style="list-style-type: none"> <i>“Have you ever tried a cigarette or chewing tobacco?”</i> <i>“Have you smoked/chewed in the past 30 days”?</i> <i>“Do you smoke/chew every day?”</i> • Advise youth to quit: <ul style="list-style-type: none"> <i>“I care about you and I want you grow up healthy.</i> <i>“I’d like you to quit smoking/chewing now before you get hooked? It is hard to quit once you get started.”</i> • Assess readiness to quit: <ul style="list-style-type: none"> <i>“Do you want to quit?”</i> • Assist youth not ready to quit: <ul style="list-style-type: none"> <i>“Smoking makes it hard to play sports. It also makes your fingers and teeth yellow.” “I want to help quit.”</i> <i>“Let me know when you’re ready.”</i> <i>“Chewing tobacco can cause you to get a lot of cavities. Did you know that an 18-year-old football star died from chewing tobacco.”</i> • Arrange follow-up for youth ready to quit: <ul style="list-style-type: none"> <i>“I am very happy you want to quit smoking/chewing.”</i> <i>“Let’s look at this brochure about quitting and make a plan to help you quit. Do you feel comfortable asking your parents to help you?”</i> <p>Refer to the PTHA Stop Smoking Program or a community youth cessation program if available.</p>
--	---

Assessment and Documentation

- Experimentation with cigarettes begins early with American Indian and Alaska Native children. The Indian Health Service recommends assessing for tobacco use starting at age six.
- The Surgeon General has classified smoking in children as a pediatric disease.
- Assess for depression in patient's age 6 to 17 that show an established tobacco use pattern – begins a pattern of regular 30 day use or indicates daily use. Use the CES-DC depression scale to assess depression in children.
- Assess for tobacco use at every visit. Experimentation can change to regular use from one visit to the next.

Use the grid on the pediatric PCC to assess for secondhand smoke exposure and tobacco use.

				ET		30		C		TC		ETS		TC	
	S											N			
	C											Y			

- Grid Key:**
- S** = Smoker
 - C** = Chewer
 - ET** = Ever Tried – even one
 - 30** = Any use in the last 30 days
 - C** = Current Daily use
 - TC** = Educated child about tobacco use (whether or not he/she uses)
 - ETS** = Environmental Tobacco Smoke Exposure
 - N** = smoke free home
 - Y** = Exposure
 - TC** = Educated parent/guardian about tobacco smoke exposure and/or advised to quit

Identification:

Since children stop and start smoking on a regular basis, tobacco stickers will not be used on charts for patients ages 6 – 17 and the definition of smoker/chewer will not be used. The only documentation of use will be on the tobacco assessment grid as described above.

Treatment:

- Comprehensive health and substance abuse prevention curricula show the same cessation effect as cessation programs for youth. The Association of Pediatricians endorses office-based brief interventions – 5 A’s.
- The nicotine patch is not recommended for persons under eighteen years of age. Children, adolescents and teens often have fluctuating smoking patterns. The patch may deliver more nicotine to a young person’s body than would be delivered though their smoking/chewing.
- Bupropion has not been tested for cessation with teens and is not recommended as appropriate treatment.
- If the patch is considered for older teens (15 to 17) it should be prescribed by a Licensed Independent Practitioner. The teen should be enrolled in the Stop Smoking Program and a careful assessment of nicotine addiction should be conducted.
- Teens that show a desire to quit smoking can be referred to the PTHA stop smoking program or a community/school program if available. Referring children to community resources for sports, cultural and other activities can play a role in preventing use.

Included with permission from the:

Puyallup Tribal Health Authority
Treatment of Nicotine Dependence
Clinic System Manual

The complete document can be obtained by contacting:
Puyallup Tribe, Puyallup Tribal Health Facility
2209 E 32nd St, Tacoma, WA 98404
Phone: 253-593-0232 Fax: 253-272-6138

Chapter 9:
Secondhand Smoke
Policies for Casinos &
Tribal Businesses



The Purpose of Tobacco-Free Spaces in Casinos and Tribal Businesses



Commercial tobacco restrictions in the workplace benefit business owners, patrons, employees, and their families. There are many good reasons for protecting employee's health and creating workplaces free from second-hand smoke:

- Employee health, productivity, and morale are higher in a smoke-free workplace.
- Smoking restrictions can encourage employees to smoke less or quit, leading to lower absenteeism, lower health care costs, and increased productivity.
- Smoke-free workplaces reduce the cost of cleaning, generate less damage to furniture and equipment, and lower the risk of fire.
- Smoke-free workplaces reduce risks from other industrial hazards, particularly from chemical products.
- Smoke-free workplaces can help employers avoid smoking-related worker's compensation claims.

International Commission on Occupational Health¹¹³
TOBACCO FREE WORKPLACES
GENEVA - 28 January 2002

Tobacco smoking should be considered an "occupational hazard":

- Tobacco smoke originates from smokers and is not the result of a production process. Tobacco smoke must not be an element of the ambient air at the workplace. If it is, then it should be considered as a work-related hazard.
- Employees at their workplaces must not breathe air that is contaminated by tobacco smoke.
- If the ambient air at the workplace is contaminated by tobacco smoke, workers have to be informed of the presence and consequences of this health hazard. This provision does not free the employer from the responsibility to provide a tobacco-free environment.
- According to regulations, employers have to protect health at the workplace, thus they have to protect workers from tobacco smoke.

Occupational health professionals should be active in tobacco control at the workplace. The achievement of tobacco-free workplaces will require the implementation and evaluation of policies and regulations that reflect the above points at the local, national, and international level.

Geneva , 28 February 2002



Special Considerations for Writing, Passing, and Implementing Tobacco-Free Policies in Casinos and Tribal Businesses



Like any policy change processes, casino-based policies require the formation of a committee and an action plan, data collection and analysis, a review of sample policies, a policy draft, an awareness campaign, and a plan to enforce and evaluate the policy's outcomes. Many of these steps will occur just as described in Chapter 2, with a few minor variations.

Create a Committee and Involve Stakeholders:

For both practical and ethical reasons, it is important that you work closely with tribal members, tribal government officials, and casino managers in gathering information from the very beginning. Policy change advocates who understand the inner workings of tribal government, and the relationship between the government, its casino, and its health program, will serve as a valuable resource for your policy change committee.

Example: The Value of Committees and Stakeholder Input

The American Indian Tobacco Education Network (AITEN) is a project of the California Rural Indian Health Board, whose mission is to promote, support, and protect the health, traditions, and cultural values of American Indians as they relate to sacred tobacco use and to commercial tobacco abuse.

In order to approach secondhand smoke policy change within California's tribal casinos, AITEN created an Advisory Committee of local tribal tobacco activists from each tribe, and kept them directly involved in all steps of the policy change process. These community members gathered information that could not have otherwise been gathered by non-tribal members, and were careful to preserve the confidentiality of their sources and to protect their standing in the community.

During discussions with committee members and stakeholders, obtain the names of casino managers and their suggestions for appropriate interview techniques (which will be discussed in the data collection section). In California, most casino managers are not members of the tribes for whom they work, though this may be different elsewhere. In many places they are professional managers, most with Master of Business Administration degrees (MBA) and a strong capacity for technical and statistical understanding. Their interest is in making the casino as profitable as possible and in

retaining their job. Consequently, it will be important that you frame your suggestions from an economic perspective, rather than emphasizing public health concerns. Professional courtesy and professional behavior are generally valued - when communicating with them, be polite and to the point. Come prepared to answer questions about the intent of your program and the impact that their participation will have on their work. It may be helpful to prepare a set of responses to questions you anticipate.

Permission is often needed from the tribal government before approaching casino managers. To broach the conversation, send a “Casino Proposal Packet” to tribal officials and to casino managers requesting permission to approach their casinos. The Tribal Administrator is a good first contact. A sample “Packet,” including an introductory letter and example surveys, summary reports, and sample policies is included on page 251 of the workbook.

Once permission has been secured, set up a meeting with the Tribal Chair, other Tribal Council Members (such as Casino Committee Members), and Casino Management. If possible, arrange your meeting with another policy change committee member or stakeholder in attendance so that you both can be prepared to answer questions and provide information.

Develop an Action Plan:

Good information about the needs and goals of all stakeholders is important for strategic planning. Drafting the right Secondhand Smoke (SHS) policy for a casino is essential.

Example: Action Plan used to Achieve Casino Policies in California

The American Indian Tobacco Education Network (AITEN) developed a successful tribal casino tobacco policy program in four steps. First, the staff studied the full nature of the situation, considering both the economic needs of the tribe and the health and safety of casino patrons and staff. Tribal members were involved in the study at the earliest possible opportunity for both practical and ethical reasons. Second, AITEN chose a policy objective, balancing each policy’s health outcomes against the feasibility of passing the policy. Long-term strategic plans were considered when choosing objectives. Third, the staff developed a policy advocacy campaign. When designing the campaign, the team considered how much support the community already had for the policy and the steps needed to successfully pass the policy. Finally, AITEN carried out the advocacy campaign. Through this experience, they found that it was absolutely essential for them to collaborate respectfully with the local community at all times. They suggest, “Under no circumstances should a campaign move forward unless tribal members are in full control of the strategy and activities of the program.”

Gather Background Information:

Along with researching your tribe's history with tobacco-related policy change, information should be gathered on the casino's written and un-written SHS policies. Many casinos have verbal policies restricting tobacco use in Administrative Offices, Restaurant Areas, Bingo Halls and certain Smoke-Free gaming areas. If such verbal, informal policies are present, it may be a good idea to first pursue these policies by getting them formally written. These are easy targets – by making informal policies formal, you can open the door to establishing stronger restrictions.

Example: Background

AITEN also needed background information on current tobacco policies at the casinos. The process used to gather this data was intended to benefit the casino and the tribe, not work against it. AITEN decided to create a guide brochure to smoking policies in the state's tribal casinos that could be distributed to potential casino patrons. The brochure identifies casinos with smoke-free areas, rooms, events, and pavilions. The information used to develop the guide also helped AITEN identify possible policy objectives, including non-smoking events, clean-air areas or rooms, improved ventilation or enforcement, and clean-air casinos. It is important to note that AITEN actually developed, produced, and distributed the brochure. Maintaining a good relationship with the tribes and casinos required fulfilling all agreed upon services.

Analyze Available Data:

Prior to your first meeting with Casino Management, research and observe the casino. A walk through the facilities will arm you with the information needed to engage in an educated discussion. Look for “no-smoking” signs to see if there are any tobacco restrictions throughout the building. If the casino already has a non-smoking room or area, this can be added to the policy you draft. As you observe the casino, be sure to write down notes only after you have left the casino property. Use this time to identify posted policies, spot-check enforcement behavior, roughly gauge the level of secondhand smoke in the air, and estimate the proportion of patrons smoking. This research will help to identify possible objectives for policy change. Throughout this process, it may be helpful for your Committee members to lobby tribal officials to encourage their casino managers' participation.

Phone Surveys - Telephone interviews can provide an excellent source of information to guide your decision making process. To help get your foot in the door, offer to provide the casino with valued services – “market research” is one such service that you can provide. In California, the offer of a “free, independently evaluated” study on the economic impact of tobacco policies on the casino has been particularly well received. Because casino managers already collect marketing information from their patrons through surveys, many were interested in gathering this information as well.

In your first meeting or phone call with the Casino management, discuss the possibility of conducting a casino survey, and discuss the benefits that the tribe and the casino will gain from this work.

During this meeting:

- Remind them that the survey services and reports are free, and that the information gained will help them offer better services to their clientele.
- Indicate that a written secondhand smoke policy is the only outcome that your organization or committee is requesting.
- Indicate that they are welcome to alter any suggested policies to fit the unique needs of their casino.
- Offer them a sample secondhand smoke policy (see attached on page 270). Remind them that they can implement any segment of the sample policy.

Example: Sharing Data

The American Indian Tobacco Education Network (AITEN) quickly discovered that casino managers were interested in sharing certain kinds of information with the public but not others. For example, AITEN published a brochure that identified the different types of smoking policies present at 31 tribal casinos in California (this information was gathered during a telephone survey). Casino managers considered this to be free advertising, and requested that their Casino be included in the brochure.

Managers strongly objected, however, to publishing the results of their economic impact surveys. They considered this to be “marketing information” that would help them compete with other casinos, and did not want the results available to competitors. Casino managers also wanted control over how the economic impact summary reports were shared. They considered themselves to be the best judge of whether information was considered “advertising,” “public relations,” “marketing,” or “confidential,” and thus AITEN was careful to respect their judgment and ask their permission before sharing materials. After the surveys were collected, all participating casinos requested a copy of the cumulative summary report. If a summary report is made including information from more than one casino, the report should give general demographics for each site but should not divulge any specific private information identifying participating Casinos. The comprehensive report is used to track the overall casino community norm change.

Economic Impact Surveys - An economic impact survey can generate information from four groups of informants: patrons (guests), casino staff, community members, and financial officers. To keep casino managers involved in the process, be sure to show all survey questions to them prior to use. An example of an observation protocol, Patron/Guest Survey, and Casino Staff Surveys are included on page 259, 261, and 266 respectively.) In order to obtain a representative sample of casino patrons, try to schedule at least two survey sessions, with one held during the day and one during the evening. Ask the casino management what days and at what time they would like you to survey. To get reliable results, try to conduct the Patron/Guest survey with about 100 guests, and the Casinos Staff survey with about one-third of casino's employees. For help designing questions or analyzing the results you can contact an independent evaluator, a tribal *EpiCenter*, or a regional tribal health organization (see Chapter 11).

Once the responses are analyzed, present a formal report to the tribal government and the casino management, including suggestions and recommendations based on the results. Host meetings to review the results, and send thank you letters to both groups. You can also recognize the casino for their willing participation by presenting them with a certificate or an engraved display.

When tribes in California followed this process, tribal council members and casino officials found the results useful, and asked that the survey be renewed on a quarterly basis. These follow-up visits often received a much warmer response than initial visits. This process has been used with several casinos in California, collecting data at multiple points over the course of a year. Of these, five have now adopted new written policies on second-hand smoke.

Demonstrate Need and Build Casino Support:

Tribes have found that survey results were instrumental when convincing casino managers and tribal officials to adopt new policies.

Example: Using Data to Demonstrate Need

During the first telephone survey conducted by AITEN of Casino Managers in California, it was clear that managers were not interested in receiving health education, and none expressed interest in developing a tobacco policy. However, in an early summary report in January 2003, more than 80% of the casino guests and staff, including 98% of the nonsmokers, said that they preferred to play or work in a smoke-free environment. Support for clean air policies was strongest in large casinos that were close to major metropolitan areas, and were weaker in smaller, more isolated communities. Clearly, this information strongly supported smoke-free policy change. The first casino to make the shift did so after only two quarterly rounds of surveys.

For tribes that have developed smoke-free spaces in casinos, the most popular change has been to create smoke-free rooms within existing gaming rooms. To build support for smoke free spaces, negotiate with casino managers to hold a Smoke-free event (perhaps during the Native American Smoke Out), or host a commercial tobacco-free night. Encourage community attendance to show support for such policies. High attendance will show managers that patrons will remain loyal even if new policies are created. When organizing such events, be mindful of the many variables that will affect participation rates (Ie. If guests have money that day to attend, other activities going on in the community, weather, etc.). Many variables can come into play when making a smokefree day successful, and may or may not truly represent the community's needs or wants.

Understand that Casino gaming rooms must remain profitable for the tribe, and that strong-arm tactics to initiate policy change are likely to be both unnecessary and counterproductive. Gentle, ongoing education that respects the sovereignty of the tribe and their right to decide is the most likely method to prove effective. To gain their support, always focus discussions on the many economic benefits of going smoke-free.

Drafting a Casino Policy:

The casino is in the hospitality industry, so maintaining a high-quality appearance is essential to any casino. To support this image, when designing smoke-free spaces with casino management, discuss restrictions for casino patrons and staff in the front of the casino and in the main casino gaming room. Reassure the Management that you will take into account smoker and non-smoker perspectives when making policy suggestions.



Evaluating Casino Policies:

Offer to conduct follow-up tobacco observations and surveys at your local casino, and provide the results of the surveys to the casino managers. Each time, create a summary report on the results of the survey.

Example: American Indian Tobacco Education Network

Several of the casinos with which AITEN works, has developed and implemented changes in their smoking policies. During the transition, AITEN offered to revise the Economic Impact surveys originally used in these casinos to reflect the new policy changes. The Valley View Casino (San Diego) built a new no-smoking pavilion because of the information they received from the surveys, and accepted the offer of a revised survey. The revisions have been drafted, and are currently being reviewed. Other casinos made smaller policy changes, and were satisfied to continue using the original survey format.

AITEN continues to track the smoking policies of each tribal casino using an abbreviated version of the original phone survey, and updates the Casino Smoking Guide Brochure based on the results.

Reassure the Casino Management that you will take into account smoker and non-smoker considerations when making any SHS policy suggestions. To do this, it will be important that you continually survey the guests' and employee's needs on the issue of SHS.

The Enoch Cree Nation has agreed to make its proposed new casino 70% smoke-free. Edmonton Mayor Bill Smith said that Enoch Chief Ron Morin also promised to move towards a complete ban on smoking at a future time. The City of Edmonton's new smoking bylaw exempts casinos until July 1, 2005 but the proposed Enoch casino would not be impacted, as it is to be located outside of city limits.

Resources:

AITEN staff members are available for consultation with outside agencies interested in conducting Casino Economic Impact surveys. The Tobacco Control Section of the California Department of Health Services furnishes the survey and evaluation efforts of the AITEN. Feel free to contact them if you are interested in initiating a Casino Secondhand Smoke Campaign. To support this effort, the American Indian Tobacco Education Network has also produced a "Casino How-To Guide: A Guide to Help you Conduct a Smoke-free Casino Advocacy Campaign" (See Chapter 11 for contact information).



Generating Support for Tobacco-Free Policies In Casinos and Tribal Businesses



Because the policy “decision makers” are council members or casino managers, focus your talking points on economic and employer-based arguments when advocating for change. See Chapters 4 and 7 for additional health-related “taking points.”

Talking Points:

Employee health, productivity, and morale are higher in a smoke-free workplace.

- A significant amount of time is lost from business due to smoking breaks, and the illnesses and fatalities that are caused by smoking. Smokers are more likely to suffer a disability, are more likely to miss work, and are less productive than nonsmokers.⁹⁴
- Secondhand smoke threatens the health and lowers the productivity of nonsmoking employees. The estimated cost of secondhand smoke on the productivity and health of nonsmokers ranges from \$56 to \$490 per smoker.¹¹⁴
- Men who smoke incur \$15,800 (in 2002 dollars) more in lifetime medical expenses and are absent from work 4 days more per year than men who do not smoke.⁹⁵
- Women who smoke incur \$17,500 (in 2002 dollars) more in lifetime medical expenses and are absent from work 2 days more each year than nonsmoking women.⁹⁵
- In 1999, each adult smoker cost communities \$1,760 in lost productivity and \$1,623 in excess medical expenditures (totaling \$3,383).²⁹
- Making workplaces smoke-free nationwide would prevent an estimated 610 stroke and heart attack deaths in the first year alone, mostly among non-smokers. Over seven years, the study projects that more than 2,420 lives and \$280 million would be saved -- not including the costs associated with other smoking-related illnesses or lost productivity.¹¹⁵
- Regular exposure to Secondhand smoke at work can cause a 91% increase in Coronary Heart Disease.¹¹⁶



Secondhand Smoke Is Real Cancer Risk, Casino Study Shows

Excerpts from: [ABC News, 2003-12-22](#), Marc Lallanilla / ABCNEWS.com

A few hours in a casino may cost you more than your paycheck. According to a new study, the amount of secondhand cigarette smoke in a casino may present a substantial cancer risk to nonsmokers. Researchers at the University of Minnesota, found elevated levels of a cancer-causing agent, NNAL, in the urine of nonsmokers after they spent just four hours in a commercial casino. Researchers also found elevated levels of cotinine, a byproduct of nicotine, in the samples. Both NNAL and cotinine are specific to tobacco and were not found in the nonsmokers' urine before their casino visit.

"This evidence could be dynamite," said Robert West, an epidemiologist at University College London. "It is one thing to know that one is breathing in carcinogens; psychologically it is another to know that one's own body has been contaminated by them." The study provides additional evidence to the long-held belief that secondhand smoke poses a health risk, and is expected to add fuel to the drive for anti-smoking regulations in public spaces.

Calculate the Cost of Smoking to your Business:

- Nearly 40% of AI/AN adults currently use tobacco, which can be generalized to any workplace population. You can change the percentage below if you have a more accurate estimate for your community or workplace.
- The CDC estimates that communities spend \$3,856 per smoker per year in direct medical costs and lost productivity.

**(Number of Employees) X (.40) X (\$3,856 per year) =
Estimated cost per year in excess medical expenditures and lost productivity.**

- Tobacco related diseases probably account for 25-35% of the days lost to your organization in absenteeism. Ignoring this problem costs your business money.¹¹⁷
- According to a recent study, the average smoking employee takes 18 days a year in time for smoking breaks.¹¹⁸
- To calculate the amount of productive work time lost due to smoking breaks:

One 5-minute break per day = 1% of salary lost

(In one study, smoking break lost-productivity costs equaled the healthcare expenses for some businesses.)

Study Shows Smokers are Less Productive

Excerpts from: 10/03/01

<http://biz.thestar.com.my/news/story.asp?file=/2001/10/3/business/mansmoke&sec=business>

A study now shows that smokers not only take more time off for sickness, but are also less productive than non-smokers. The study covered 300 booking clerks at a large US airline, comprising 100 current smokers, 100 former smokers and 100 others who had never smoked at all. Current smokers were absent from work for sickness for 6.16 days per year on average, compared with 4.53 days among ex-smokers and 3.86 among “never” smokers.

The airline's reservation computers also provided objective details as to an employee's productivity by recording how much sales income that clerk had notched up for the company, how long he or she took to answer a call and how long that person was away from their desk. Current smokers performed the worst of the group. Their production was 4% below “never” smokers and 8.3% below ex-smokers.

In 1990, the US Office of Technology and Assessment estimated that the workplace cost of disability and premature mortality from smoking employees for American businesses was \$47 billion a year.

Smoking restrictions can encourage employees to smoke less or quit, leading to lower absenteeism, lower health care costs, and increased productivity.

- More than 70% of smokers want to quit, but few succeed without support.³²
- Studies have shown that nearly 15 percent of smokers would quit if they couldn't smoke at work. Those who quit would have fewer strokes and heart attacks, and those who would continue to smoke would average 1.3 fewer cigarettes per day, adding up to 401 million fewer packs nationwide per year.¹¹⁵
- Clean indoor air policies prompt smokers to quit, and increase their success rate when quitting. No smoking policies also reduce the number of cigarettes that continuing smokers consume. According to Philip Morris' own research, smokers facing restrictions consume 11%-15% fewer cigarettes than average and quit at a rate that is 84% higher than average.⁶⁴
- “Multiple workplace observations have demonstrated that instituting a change in workplace smoking restrictions is accompanied by an increase in cessation attempts and a reduction in the number of cigarettes smoked per day by continuing smokers. Once restrictions on smoking in the workplace have been successfully implemented, they continue to have effects. Observations... demonstrate that being employed in a workplace where smoking is banned is associated with a reduction in the number of cigarettes smoked per day and an increase in the success rate of smokers who attempt to quit.”¹¹⁹

Smoke-free workplaces reduce the cost of cleaning, generate less damage to furniture and equipment, and lower the risk of fire.

- Smoking in the workplace damages property and increases cleaning costs. According to a study by the Building Owners and Managers Association (BOMA), a trade association representing commercial office building owners and managers. The elimination of smoking from a building reduces cleaning expenses by 10 percent. According to BOMA, which supports a national ban on smoking in all workplaces, cleaning makes up 13 percent of a building's annual expenses.¹²⁰
- BOMA noted that smoke-free offices eliminate the need to clean ashtrays and cigarette butts, reduce the number of filter changes and cleanings, reduce the need for cleaning and painting walls, reduce dusting and vacuuming, and reduce the risk of fires in the workplace. Smoking was cited as the number one cause of fires in BOMA's fire safety survey, causing more than one-quarter (26 percent) of the fires in non-residential buildings.¹²⁰
- Employers who provide a smoke-free workplace may receive savings on fire insurance and costs related to items such as ventilation services and property repair and upkeep.

Designated smoking areas within casinos do not adequately protect people from secondhand smoke.

- Nonsmoking sections do not eliminate nonsmokers' exposure to secondhand smoke; the smoke knows no boundaries.¹²¹
- Ventilation systems cannot filter and circulate air well enough to eliminate secondhand smoke.⁵⁸
- Designated "no smoking" areas in licensed (gaming) clubs in Australia were found to provide, at best, partial protection from ETS—typically providing a 50% reduction in exposure. The protection afforded is not comparable with protection afforded by prohibiting smoking on the premises.¹²²

Tobacco-Free Policies do not Hurt Business.

- Numerous scientific and economic analyses show that smoke-free laws do not hurt restaurant and bar patronage, employment, sales, or profits. At worst, the laws have no effect at all, and they sometimes even produce slightly positive trends.¹²³
- A study in the journal *Tobacco Control* (in 2003) offered a comprehensive review of all available studies on the economic impact of smoke-free workplace laws and concluded that: "All of the best designed studies report no impact or a positive impact of smoke-free restaurant and bar laws on sales or employment. Policymakers can act to protect workers and patrons from the toxins in secondhand smoke confident in rejecting industry claims that there will be an adverse economic impact."

Smoke-free workplaces can help employers avoid smoking-related worker's compensation claims.

- Businesses pay an average of \$2,189 in workers' compensation costs for smokers compared with \$176 for nonsmokers.¹²⁴
- This estimate does not include any amounts that a non-smoking employee may win in a lawsuit against an employer for the health effects of exposure to tobacco smoke. Workers have been awarded unemployment, disability, and worker's compensation benefits for illness and loss of work due to second hand smoke.

Casino Dealers Sue Tobacco Biz , APO (AP Online)

Excerpts from: The Associated Press. Fri, Oct 10, 1997. Copyright 1997.

CARSON CITY, Nev. (AP) -- Claiming years of exposure to secondhand cigarette smoke has impaired their health, nine casino dealers have filed a lawsuit against the nation's tobacco companies seeking financial compensation that could run in the tens of millions of dollars.

The lawsuit, filed by Tony Badillo and eight other dealers in U.S. District Court in Reno, alleges the tobacco companies lied about the addictive nature of nicotine and the ill health effects of breathing secondhand cigarette smoke.

The complaint against 17 tobacco companies and organizations, including R.J. Reynolds Tobacco Co., Brown & Williamson and the Tobacco Institute, seeks compensatory damages and a finding that the case qualifies as a class action lawsuit. The complaint suggests that upward of 45,000 casino dealers working in Nevada could potentially become part of the legal action.

"Through a fraudulent course of conduct that has spanned decades, the defendants have manufactured, promoted and sold cigarettes to tens of millions of Americans, knowing but denying and concealing that their cigarettes were dangerous and toxic," the complaint says.

This suit is similar to one now going on in Florida filed by 60,000 current and former flight attendants. That case, which went to trial in July, could cost the tobacco companies an estimated \$5 billion. It was the first tobacco class action case to reach trial, and the first secondhand smoke trial.



Data Collection Tools



Phone Survey Script

Tribal Office:

Hi, I am **NAME**;

I am with **NAME OF YOUR ORGANIZATION**;

May I speak to your Tribal Administrator? (make sure to get their name)

Tribal Administrator (TA):

Hi, I am **NAME**;

I am with **NAME OF YOUR ORGANIZATION**;

We are developing a brochure on the American Indian Casinos in **YOUR REGION**. The brochure will list all the casinos with any type of smoking restrictions. This brochure is no charge to your tribe or casino.

Our program is a health education program and creating this brochure is a part of our scope of work. There is a list of questions I need to ask regarding smoking restrictions... -now start asking your survey questions.... At his point they will answer your questions and/or refer you to casino management... usually you will be sent to the advertising department... (make sure you get a contact name at the casino and at the tribal office).

Thank you... (leave your contact information)

Casino:

Hi, I am **NAME**;

I am with **NAME OF YOUR ORGANIZATION**;

May I speak to **Casino Contact Name**;

We are developing a brochure on the American Indian Casinos in **YOUR REGION**. The brochure will list all the casinos with any type of smoking restrictions. This brochure is no charge to your tribe or casino.

Our program is a health education program and creating this brochure is a part of our scope of work. There is a list of questions I need to ask regarding smoking restrictions... -now start asking your survey questions....

Thank you... (leave your contact information)



Data Collection Tools



Sample Phone Survey Questions

1. Does your casino permit smoking indoors?
2. Does your casino have a smoke-free room?
3. Does your casino offer a no-smoking night?
4. Is your smoking policy written down?
5. Does your casino or tribe sell tobacco?
6. In the last two years, has your casino participated in any tobacco-funded event?
7. Overall, do you think it is a good idea for the casino or tribe to sell tobacco?
8. Do you think it is a good idea to forbid smoking in the casino?
9. Do you think it is a good idea to have a smoke-free room or area in the casino?
10. Do you think it is a good idea for the casino to have smoke-free nights?
11. Would you be interested in learning more about the economic impact of different smoking policies on tribal casinos?
12. Would your casino be willing to participate in a free study of the economic impact of different smoking policies in casinos?
13. We would do all the work, and the results would protect your casino's privacy completely. Would you be willing to help encourage tribal casinos to adopt stronger smoke-free policies?



Sample “Casino Proposal Packet”



Date

Addressee

Dear Chairman:

The [REDACTED] Secondhand Smoke Program is now able to work with your gaming facility to help improve its efficiency. We can provide free surveying assistance, including survey design and development, survey implementation, policy development, and reporting.

Currently, we are conducting a study of various casino smoking policies to determine their economic impacts. We would like to perform a brief survey of the staff and customers of up to six tribal casinos across California, comparing the economics of each of their policies. We would also conduct some limited market research, and unobtrusively observe your clientele in action. If your casino is chosen to participate, we will gladly customize our survey to include questions that you want answered, even if they do not relate directly to tobacco policy. We can also help you determine the optimum policy to suit your financial needs.

All our studies are designed by an independent economic research firm, led by a Ph. D. economist with more than twenty years of University research experience. She will meet with you individually at your facilities to help your casino find the answers it needs. We can develop a report that focuses on only your facility, or include you anonymously in our larger project so that you can compare your policies with those of other tribal casinos around the state. If you would like to include explicit financial information in your report, we can do so with complete confidentiality, or we can estimate the demand for each form of tobacco policy directly from your potential customers.

If you would like to participate in this groundbreaking study, please let us know. You can reach us at [REDACTED].

Sincerely,

Name

Position



Sample “Casino Proposal Packet”

**INTERFACE ASSISTANCE
PROJECT DEVELOPMENT AND EVALUATION
DR. ANE MCDONALD, DIRECTOR**

**Tribal Casinos and Tobacco
Summary Report**

December 2004

Dr. Ane McDonald, Director

**AMERICAN INDIAN TOBACCO
EDUCATION PARTNERSHIP (AITEP)**

IN COLLABORATION WITH THE

PRIORITY POPULATION PARTNERSHIPS OF THE
TOBACCO CONTROL SECTION,
CALIFORNIA DEPARTMENT OF HEALTH



Sample “Casino Proposal Packet”

SUMMARY

The American Indian Tobacco Education Partnership (AITEP) is currently offering free guest preference studies to selected tribal casinos across California. Participating tribes are offered the opportunity to custom-design a questionnaire that is professionally administered to their guests and/or staff members. Guests are told that the casino is researching the current smoking policy, and they are offered an opportunity to participate. Questions focus on their preferences and predicted behaviors under several possible options.

Results so far indicate that there is a great deal of support among both guests and staff of the six participating tribal casinos for restricting tobacco use inside gaming facilities. An estimated 80% to 85% of current casino guests would play at least as often in a non-smoking room or casino building. More than half report that they would come more frequently, and less than 10% say that they would not return if the entire casino were to ban smoking. Among non-smokers, representing between two-thirds and three-fourths of the current patrons and 80% of the adult population of the state, virtually everyone would prefer non-smoking rooms and/or casinos. In addition, the vast majority of smokers report that they would prefer to play at least some of the time in a smoke-free environment. Clearly, there is profit to be made in cleaning up the indoor air in the tribal casinos.

Even though casino guests prefer a smoke-free environment for themselves, many also believe that there should be areas in which smoking is permitted. At casinos that currently do not have separate smoke-free sections, some guests were asked whether they believed there should be a smoke-free room at their casino, and/or that the entire casino should be smoke-free. More than half disapproved of an entirely smoke-free policy, even though about half of these said that they would personally visit more often. However, 85% of both smokers and non-smokers supported the construction of a smoke-free room. Support for entirely smoke-free casinos is much stronger for larger casinos that draw primarily on nearby urban populations, and weaker for smaller casinos in more isolated rural areas.

Casino guests are more likely to smoke than the adult population of California at large. While only about 20% of all adults statewide are current smokers, almost 30% of the guests surveyed were smokers. At present, tribal casinos are among the very few indoor public spaces in which smoking is permitted, and this likely makes the casinos an attractive form of entertainment for those who smoke. Also, casinos very likely draw visitors from out of state, particularly the larger casinos near Los Angeles, San Diego, and Palm Springs. Because Californians smoke at much lower rates than others, these tourists probably increase the smoking rate of casino guests.

A smoke-free policy for at least some parts of many casinos would probably attract a larger non-smoking crowd. Non-smokers in California are on average younger, better educated, and more affluent than smokers, making them an ideal target market for entertainment venues. A comparison of the evidence from patrons of casinos with and without smoke-free buildings suggests that there is a significant body of potential visitors who are repelled by the smokiness of the casinos at present, who would visit if the air were cleaner. Youth and young adult smoking rates have been declining rapidly in recent years, creating a non-smoking market segment that can be expected to grow over time.

Staff preference studies are also available to participating casinos. Employees report that they would prefer to work in smoke-free environments. They see guests smoking a great deal on the casino floor, and express concern that entirely smoke-free casinos might not succeed.

METHODS

Between July 2002 and October 2004, surveyors from the American Indian Tobacco Education Network (AITEN, now called AITEP), assisted by the staff at several California Tribal Health Tobacco Programs, Interface Assistance, and several tribal casinos in California, conducted a series of eleven rounds of surveys with 1079 guests at six California tribal casinos.

The survey questions were customized for each of the participating casinos. Guests were either approached while standing in lines or induced to approach the surveyors with a small incentive, such as a deck of cards, a T-shirt, a mouse pad, or a free meal at the casino café. Casino-specific incentives, especially T-shirts, proved to be the strongest draw. When t-shirts were available, guests formed long lines to participate, forcing the surveyors to abandon interviews as a process and distribute the questionnaires directly to the guests.

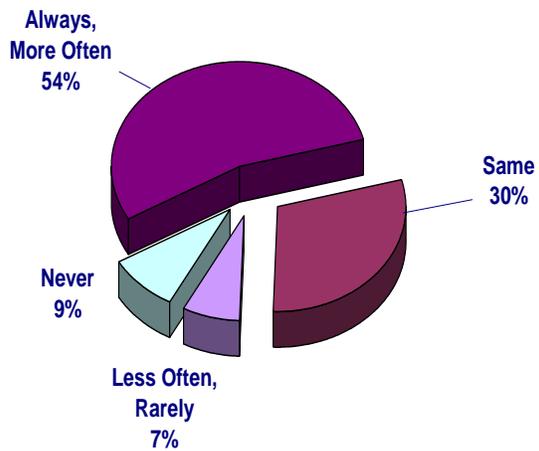
Each guest interview began with a series of “soft” questions about the informants’ favorite games, how they liked the food, and the like. These were followed by a set of questions about various smoking policies. Some participating casinos asked that data on staff members’ observations and preferences be gathered as well. Surveyors also conducted brief observation surveys, counting the number of guests smoking in each area of the casino at the time of the observation, and subjectively assessed the relative level of smoke in the air between casinos. The results of all questions were reported to the casino managers. A summary of the guest tobacco-related responses are analyzed here.

ANALYSIS

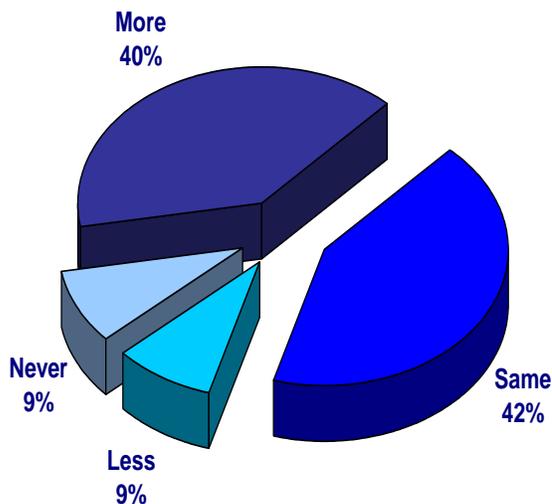
Out of the 1079 guests surveyed, 29% were smokers. Nearly all of them reported smoking as they played. Observers noted that roughly 1 player in 6 was smoking at the gaming tables and machines, suggesting that smokers have a cigarette lit about two-thirds of the time they are on the floor. As players concentrate on their games, a great deal of that smoke goes directly into the air. At some casinos, ventilation systems filter out much of this, but at others it can be difficult to see from one side of the room to the other.

More than 80% of those surveyed reported that they would play in a smoke-free room and/or a smoke-free casino at least as often as they visit now. Nearly 60% said they were annoyed by ambient smoke, 54% would play more often in a smoke-free room, and 40% would play more often in a smoke-free casino. If a separate non-smoking building or casino were available, 40% of current guests said that they would never play anywhere else. About 10% reported that they enjoyed playing in a smoke-filled room, would never play in a smoke-free room, and would not visit a smoke-free casino.

How Often Would You Play in a Smoke-Free Room?



How Often Would You Visit a Smoke-Free Casino?



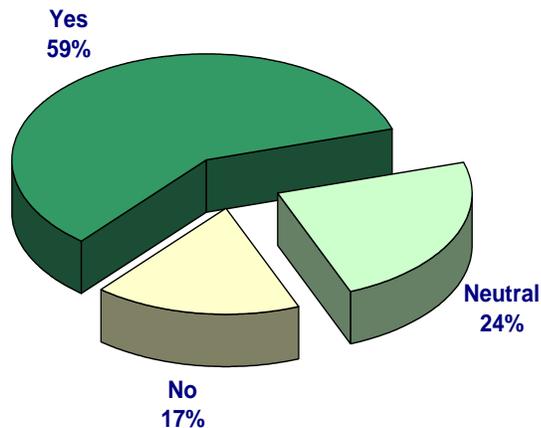
Virtually all of the non-smokers and about two-thirds of the smokers indicated that they would have no objection to restricting smoking on the casino floor. Many smokers reported that they genuinely enjoyed getting out of the smoky areas from time to time, even though most would probably spend most of their time in the areas where smoking was permitted.

In 2002, there were few genuinely smoke-free areas in tribal gaming facilities. Several participating casinos requested that AITEN estimate the extent to which current guests would support their construction. Nearly 85% of those surveyed in casinos without smoke-free rooms or buildings said that they believe the casino should construct one. Smokers were almost as likely to support the construction of a smoke-free room as non-smokers. Non-smokers were almost equally opposed to prohibiting smoking in the entire casino.

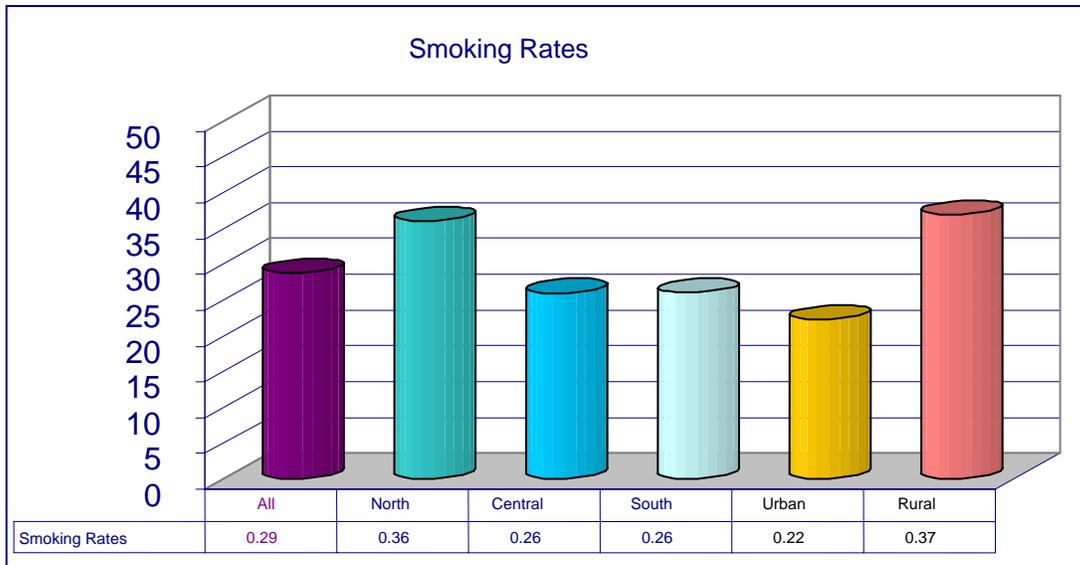
In 2003, the Valley View Casino in San Diego County became the first big casino to construct an entirely non-smoking gaming pavilion. Valley View was an early participant in the AITEN survey project, and has been with the program since it began in 2002. While the results of these surveys are confidential, even the casual observer can see that the heavily-promoted pavilion has been wildly successful. By 2004, many new facilities include separate non-smoking rooms, and as existing tribal casinos expand, some are adding smoke-free sections as well.

Most tribal casinos prohibit smoking in the restaurant areas. However, these prohibitions are not always uniformly enforced. Overall, nearly 60% of the patrons support stronger enforcement of the casino's smoking policy in the restaurant areas. Only a few (17%) opposed this, and the others were neutral or did not answer. Some would support enforcement in the restaurants, but not in the bars, even if food was served there.

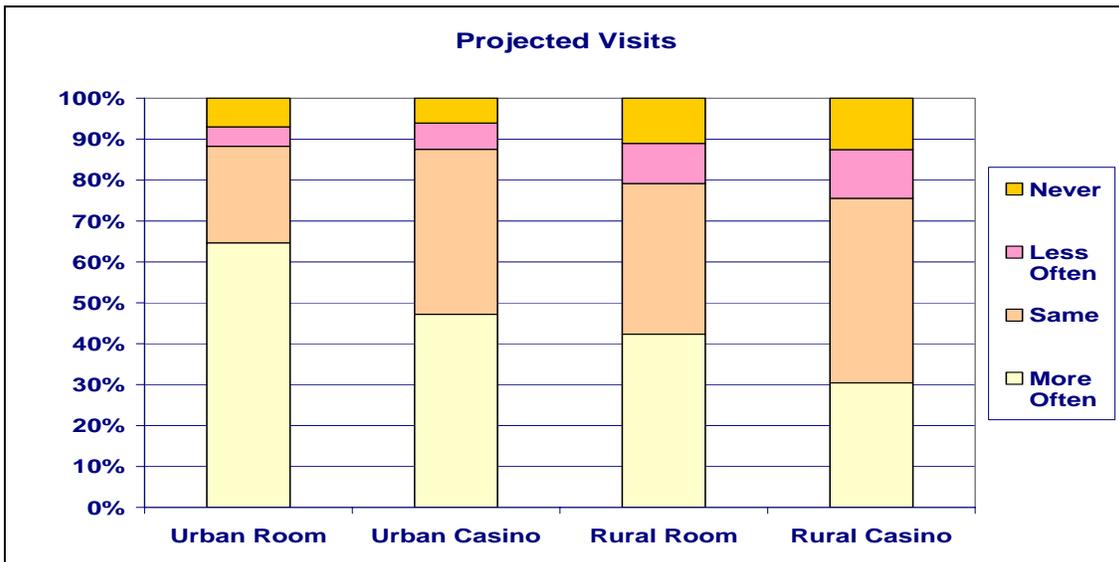
Should The No-Smoking Policy in Food Service Areas Be More Strictly Enforced?



Results differed somewhat between casinos. The larger, more urban casinos attracted a larger non-smoking clientele than did the smaller rural casinos. At least one of the casinos surveyed already had a large non-smoking area, which brought in a proportionately larger non-smoking crowd. In another, the air was thick with tobacco smoke, limiting visibility and probably reducing the market of the casino to smokers and their gaming partners.



While casino guests are overall more likely to smoke than California adults, there is substantial variation by region and by the character of the area in which the casino is located. About 36% of guests in northern casinos reported smoking, while only 26% did so in the central and southern regions. While 22% of the guests at casinos drawing on nearby urban areas were smokers, 37% of guests in the more isolated, rural casinos were smokers. Not surprisingly, similar patterns of projected visits to smoking and non-smoking sections and casinos were also apparent.



CONCLUSIONS AND RECOMENDATIONS

Many casinos across California could profit from tighter restrictions on indoor smoking. For the urban casinos participating in the AITEP project so far, there is essentially no risk in creating smoke-free rooms, and very little risk in creating entirely smoke-free casinos. Rural casinos would very likely profit from smoke-free rooms, although completely prohibiting smoking in rural areas could be risky. The sample size for rural casinos is relatively small, making it more difficult to assess either the risks or the returns.

Currently there are only a few truly smoke-free rooms or buildings. Informal observations of non-participating casinos indicates that many have rooms and sections with no-smoking signs posted, but guests can often be observed lighting up, and the air quality is relatively low. At some, there are no barriers of any kind between smoking and non-smoking sections. However, a number of the large, urban-market casinos in the southern part of the state have created spacious, well-appointed clean air rooms with full glass enclosures and adequate to excellent ventilation systems and more are now on the way.

Fortunately for California's tribal casinos, survey data on the smoking policy preferences of their own guests can be made available quickly and at little to no cost. AITEP is currently accepting requests to participate in the data gathering process, and at this point full funding is available for all participating casinos. If the number of requests grows beyond the current source of funding, additional participants may be asked to make very small in-kind contributions, such as providing casino-logo t-shirts as guest incentives, or rooms and meals for surveyors. The California Rural Indian Health Board, Inc. has the capacity to provide survey design, data collection, and complete data analysis including casino-specific reports to each casino selected to participate in the project at no cost to the casinos. A grant from the Tobacco Control Section of the California Department of Health finances this program, and is itself funded by resources made available under the Tobacco Master Settlement Agreement and Proposition 99.



Sample "Casino Proposal Packet"



Casino Observation Form

Staff use only

Casino Name _____

Location _____

Date and time of survey _____

1. Estimate the total number of patrons and the number of smoking patrons in the following areas of the casino.

Smoking Sections	#Patrons	#Smoking	Smoking Sections	# Patrons	#Smoking
Slots Area			Tables Area		
			Restaurant		
			Entertainment Area		
			Bar Areas		
			Other Area (describe) _____		

Non-smoking Sections	#Patrons	#Smoking	Non-smoking Sections	# Patrons	#Smoking
Slots Area			Tables Area		
			Restaurant		
			Entertainment Area		
			Bar Areas		
			Other Area (describe) _____		

2. Are there ashtrays in these two areas?

Restaurant: **YES** **NO**
Bar: **YES** **NO**

3. Is there a posted smoking policy?

- No posted policy
- Smoking is allowed everywhere
- Restaurant/bar is non-smoking
- Entertainment area is non-smoking

- Slots and tables area is non-smoking
- Enclosed playing room is non-smoking
- Casino is entirely non-smoking

4. In general, how much does the casino smell like smoke?

- NOT AT ALL
- A LITTLE
- SOMEWHAT
- QUITE A LOT
- DIFFICULT TO BREATHE

5. Record any areas that smell particularly smoky:

6. Tobacco is sold (check all that apply):

- Indoors
- Outdoors
- From vending machines
- Over the counter (gift shop, etc)
- In a smoke shop
- In the restaurant
- Close to the snack bar
- In the staff break room

7. Is the tobacco sold using Indian images?

YES

NO

8. Identify the brands with Indian images that are sold.

Other comments?



Sample “Casino Proposal Packet”



Patron Interview Protocol for Casinos with Smoke-Free Rooms and Pavilions

Staff use only

Casino Name _____

Date and time of survey _____

Smile at a patron. If that person smiles back, approach. Be exceptionally nice.

Hi. My name is _____, and I’m with the American Indian Tobacco Education Partnership. Is this a good time to talk for a minute?

1. What do you like best about this casino? ¿Qué te gusta más de este casino? (Check one box below that best generalizes their answer. Verify.)

- No-Smoking Room/Pavilion**
- Food**
- Location**
- Staff**
- More winning**
- Favorite game**
- Other response** _____

2. Do you smoke tobacco? ¿Fumas? **YES** **NO**

If yes:		
Do you often buy tobacco here?	YES	NO
¿Compras tu tabaco aquí?	(SI)	(NO)
Do you usually smoke while you play?	YES	NO
¿Fumas cuándo estas jugando?	(SI)	(NO)

3. Do you play the **SLOTS,** **CARDS,** and/or **BINGO**?
¿Juegas?

4. Have you tried the games in the no-smoking room/pavilion? **YES** **NO**
¿Trataste los juegos en el cuarto libre de humo?

If the answer is yes: How do you like it? ¿Cómo te gusto? (Choose the words that best match the response.)

A lot (Mucho)	Somewhat (Un tanto)	Not much (No mucho)	Not at all (No me gusto nada)
-------------------------	-------------------------------	-------------------------------	---

5. How often do you think you will play in the no-smoking room/pavilion? ¿Con que frecuencia regresaría al casino el cuarto libre de humo/pabilón?

- ALWAYS** (Siempre)
- MOST OF THE TIME** (Mas)
- SOMETIMES** (A veces)
- RARELY** (Raras veces)
- NEVER** (Nunca)

6. Would you like to see any other games in the no-smoking room/pavilion? If so, which games? ¿Cuál juegos quieres en el cuarto libre de humo/pabilón?

Cards _____ **Bingo** _____ **Other** _____
Slots _____

7. What do you like best about the no-smoking pavilion? ¿Que te gusta mas de el cuarto libre de humo/pabilón?

- CLEAN AIR** (Aire limpio)
- GOOD GAMES** (Los juegos)
- WINNING** (Ganadas)
- PROMOTIONS** (Promocionas)

OTHER _____

8. How could the no-smoking pavilion be improved? ¿Como pueden mejorar el cuarto libre de humo/pabilón?

- BIGGER** (Mas Grande)
- MORE WINNING** (Mas Ganado)
- ADD BAR** (Mas Barra)
- ADD FOOD** (Mas Comida)
- PROMOTIONS** (Mas promocionas)

OTHER _____

9. How often would you come here if there were a no-smoking policy in the entire casino? ¿Con que frecuencia regresaría al casino si hay una póliza para prohibir fumar en todo el casino?

- MORE OFTEN** (Más frecuente)
- ABOUT THE SAME** (Lo mismo)
- LESS OFTEN** (menos)
- NEVER** (nunca)

10. Should there be stronger enforcement of the no-smoking policy in the restaurant and bar areas? ¿Crees que el casino debe de enfocar la póliza de no fumar cerca del restaurante y barra?

- YES** (SI)
- NEUTRAL** (NEUTRO)
- NO** (NO)

11. Do you have any other comments about the casino's smoking policy?
¿Tienes algunos comentarios sobre la póliza del casino?

Thank you very much. Your answers will help the casino make the right decision about its smoking policy.

Gracias. Su respuestas puede evitar el casino a tomar la decisión correcta acerca de su policía de fumando.



Sample “Casino Proposal Packet”



Patron Interview Protocol for Casinos without Smoke-Free Rooms and Pavilions

Note: The question numbers on this survey match the equivalent questions on the survey form for the casinos with no smoking rooms or pavilions. There are additional questions on that form, and therefore there are gaps in the sequence of numbers on this form.

Staff use only

Casino Name _____

Date and time of survey _____

Smile at a patron. If that person smiles back, approach. Be exceptionally nice.

Hi. My name is _____, and I’m from the American Indian Tobacco Education Partnership. The casino manager has asked me to help him/her understand the impact of different possible policies on this casino. Your input will really help.

Is this a good time to talk for about a minute?

1. What do you like best about this casino? ¿Qué te gusta más de este casino? (Check one box below that best generalizes their answer. Verify.)

- Food**
- Location**
- Staff**
- More winning**
- Favorite game**
- Other response** _____

2. Do you smoke tobacco? **YES** **NO**
¿Fumas? (SI) (NO)

If yes:

Do you often buy tobacco here?	YES	NO
¿Compras tu tabaco aquí?	(SI)	(NO)
Do you usually smoke while you play?	YES	NO
¿Fumas cuándo estas jugando?	(SI)	(NO)

3. Do you play the **SLOTS, CARDS,** and/or **BINGO?**
¿Juegas?

5. If your favorite game were included, how often would you play in a no-smoking room/pavilion? ¿Con que frecuencia jugaría usted su juego favorito si estuviera localizado en una área que prohibí fumar?

- MORE OFTEN** (MÁS FREQUENTE)
- ABOUT THE SAME** (CASI LA MISMO)
- LESS OFTEN** (MENOS)
- NEVER** (NUNCA)

9. How often would you come here if there were a no-smoking policy in the entire casino? ¿Con que frecuencia regresaría al casino si hay una póliza para prohibir fumar en todo el casino?

- MORE OFTEN** (MÁS FREQUENTE)
- ABOUT THE SAME** (CASI LA MISMO)
- LESS OFTEN** (MENOS)
- NEVER** (NUNCA)

10. Should there be stronger enforcement of the no-smoking policy in the restaurant and bar areas? ¿Creas que el casino debe de enfocar la póliza de no fumar cerca del restaurante y barra?

- YES** (SI)
- NEUTRAL** (NEUTRO)
- NO** (NO)

11. Do you have any other comments about the casino's smoking policy?
¿Tienes algunos comentarios sobre la póliza del casino?

Thank you very much. Your answers will help the casino make the right decision about its smoking policy.
Su responsos puede evitar el casino a tomar la decisión correcta acerca de su policia de fumando.



Sample “Casino Proposal Packet”



Casino Staff Interview Protocol

Staff use only

Hi. My name is _____, and I’m from the American Indian Tobacco Education Partnership. Is this a good time to talk for about 5 minutes?

(If no, what time would be better?) _____

Your manager _____ has asked me to help him/her understand the impact of different possible smoking policies on this casino. Your manager wants to know how you feel about these different policies, even if you disagree with the existing policies or the management. Your input will really help us to help your casino.

Are you Indian or Native American? **YES** **NO**

(If yes:) Are you a member of (the tribe supported by this casino)?

YES **NO**

What kind of work do you do here? (Administrative, Floor, Restaurant, etc)

Do you smoke tobacco? **YES** **NO**

Do patrons often smoke in the area in which you work? How often?

Very often **Sometimes** **Not much** **Not at all**

Does it bother you when patrons smoke in your area?

Yes, a lot **Yes, somewhat** **Not much** **Not at all**

Would you prefer to work in a non-smoking room/pavilion in the casino?

YES **NO**

Would you prefer to work in a non-smoking casino?

YES **NO**

Is there anything else about the smoking policy here that you would like to tell me?
THANK YOU. I really appreciate your input.



Sample Introductory Letter



To Tribal Health Programs

Date

Addressee

Dear:

The _____ Secondhand Smoke Program is interested in collaborating with **TRIBE NAME**, **NAME OF TRIBAL HEALTH ORGANIZATION**, and **CASINO NAME** to advocate for secondhand smoke (SHS) policy development within **CASINO NAME**. We would like to help the **TRIBE NAME** and **CASINO NAME** to develop policies that will protect the health and well being of their staff and patrons, while also increasing the economics of the casino.

According to the California Department of Health Services, approximately 80% of Californians are non-smokers. Offering a smoke-free gaming environment is a courtesy that the majority of Californians appreciate and demand as an industry standard. This non-smoking rate parallels the American Indian gaming facilities guest non-smoking rates.

We can provide free surveying assistance, including survey design and development, survey implementation, policy development, and reporting. Currently, we are conducting a study of various casino smoking policies to determine their economic impacts. We would like to perform a brief survey of the staff and customers, comparing the economics of each of their policies. We would also be willing to conduct some limited market research, and unobtrusively observe your clientele in action. If your Tribe and Casino participate, we will gladly customize our survey to include questions that you want answered, even if they do not relate directly to tobacco policy. We can also help you determine the optimum policy to suit your financial needs.

Please find the attached sample letters that will be sent to the tribal office and the casino management with approval of **NAME OF TRIBAL HEALTH ORGANIZATION**.

If you would like to collaborate with this advocacy project or if you have any questions or concerns, please contact us. You can reach us at (777) 888-9999 x 0000. Thank you.



Sample Introductory Letter



Date

Addressee

Dear:

The _____ Secondhand Smoke Program is now able to work with your gaming facility to help improve its efficiency. We can provide free surveying assistance, including survey design and development, survey implementation, policy development, and reporting.

Currently, we are conducting a study of various casino smoking policies to determine their economic impacts. We would like to perform a brief survey of the staff and customers of up to six tribal casinos across California, comparing the economics of each of their policies. We would also conduct some limited market research, and unobtrusively observe your clientele in action. If your casino is chosen to participate, we will gladly customize our survey to include questions that you want answered, even if they do not relate directly to tobacco policy. We can also help you determine the optimum policy to suit your financial needs.

All our studies are designed by an independent economic research firm, led by a Ph. D. economist with more than twenty years of University research experience (If Applicable). She will meet with you individually at your facilities to help your casino find the answers it needs. We can develop a report that focuses on only your facility, or include you anonymously in our larger project so that you can compare your policies with those of other tribal casinos around the state. If you would like to include explicit financial information in your report, we can do so with complete confidentiality, or we can estimate the demand for each form of tobacco policy directly from your potential customers.

If you would like to participate in this groundbreaking study, please let us know. You can reach us at (777) 888-9999 x 0000.



Sample Acceptance Letter



Date

Addressee

Dear :

Thank you for your interest in the American Indian Tobacco Education Network (AITEN) Casino Secondhand Smoke Program. The AITEN is pleased to include the **CASINO NAME** on this program.

- In cooperation with the **NAME OF ALL THAT WILL BE INVOLVED**, AITEN will custom design the survey instrument to fit your needs. The standard survey includes these elements:
 1. Percentage of your patrons who are smokers and non smokers.
 2. Patron opinion on current smoking policy, broken down by smoking status.
 3. Percentage of patrons who would increase or decrease their visits under different smoking policies.
 4. Favorite games of smokers and non smokers.
 5. What time of day the smokers and non smokers play
 6. Employee exposure to secondhand smoke.
 7. Employees and managers preferences about the current smoking policy.
 8. Any other information the casino deems essential.
- AITEN will survey the patrons during regular business hours. We usually prefer to conduct a survey during the day, and another in the evening, to identify differences between these two groups of players. AITEN will only approach patrons that are not gambling. The patron survey will take approximately 5 minutes. We will provide a small gift to patrons who participate in the survey.
- AITEN will also survey the employees and managers of the casino. The employees will be surveyed on breaks, lunch periods, and/or at scheduled appointments. The interviews will take approximately 5-10 minutes.
- The surveying will take 3-4 days to complete.
- In order to get reliable and valid survey results, AITEN is willing to survey the **NAME OF CASINO** on a quarterly basis.
- Again, AITEN is pleased to work with the **NAME OF CASINO**. If I can be of any further assistance please contact me at (777) 888-9999 x 0000. Thank you.



Casino Policy Template



Casino Secondhand Smoke Policy Template:

The purpose of this policy is to provide a comprehensive statement identifying active participation on the issue of smoking, and secondhand smoke in the casino.

Smoking is allowed in the following designated smoking areas:

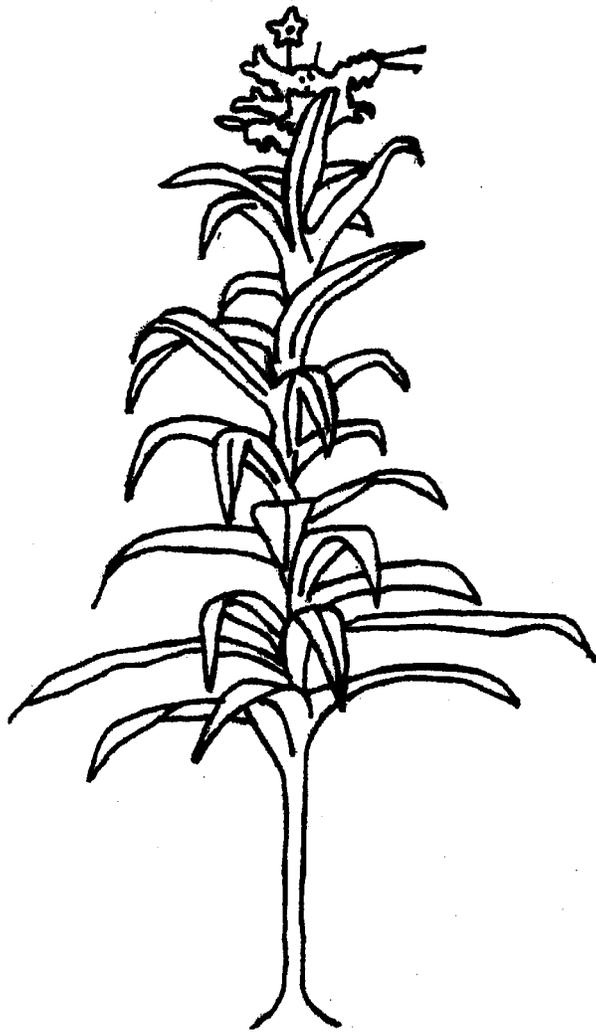
1. By guests in the main gaming facility(s) - At any machine and at any card gaming table.
2. By employees during breaks and lunch periods at designated outdoors areas - Smokers' considerations, needs, and opinions will be taken into account on all actions taken by the casino.

Smoking restrictions:

1. Smoking is not permitted in the Casino administrative offices, or in any eating area or buffet area.
2. Smoking is not permitted in break or eating area(s) where casino employees gather.
3. Smoking is not permitted in any designated "Non Smoking areas" of the casino main gaming area(s).
4. Employees are not allowed to smoke during their work periods or in the main gaming facility(s).
 - a. Designated smoking areas are located at the side and rear of the casino.
 - b. Employees may not smoke at any entryways. No smoking will be allowed by employees at the front entry of the casino where guests may view casino employees.
5. Non-smokers' considerations, needs and opinions will be taken into account on all actions taken by the casino.
6. Casino Name will not sell commercial tobacco products that contain the Native American image, (ie. Natural American Spirit, Redman Chew, etc.).
7. Casino Name, will not hang banners or advertisements that contain Native American images selling commercial tobacco products, (ie. Natural American Spirit, Redman Chew, etc.)

Continuous Surveying and Research:

1. Casino Name will take proactive steps in the area of smoking and secondhand smoke.
 - a. Casino Name commits to regularly conduct satisfaction surveys of guests and casino employees.
 - b. Decisions made on any smoking and secondhand smoke issue will consider the health of the guests and employees, as well as the economic impact on the casino as a priority.

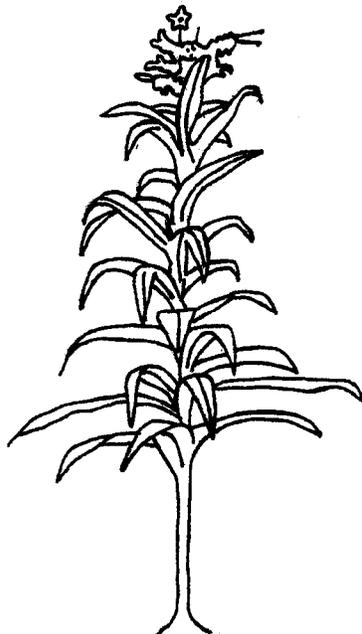


Chapter 10: Traditional Tobacco Policies



The Purpose of Traditional Tobacco Policies

As discussed in the first section of this guidebook, tobacco use was historically regulated by each Tribe's cultural traditions and plant availability during the changing seasons. These cultural beliefs defined which tribal members could use tobacco, when it was used, and how it was used. Likewise, geology and weather regulated where tobacco would grow and when it would be available for gathering. Traditional norms and limited access thus served as the first "tobacco control policies." Today, traditional tobacco policies are needed to support community members in the sacred use of tobacco, make traditional tobacco plants available for ceremonies and prayer, and to keep the Tobacco Industry from manipulating the sacred intent of the plant.





Types of Traditional Tobacco Policies



Bring together elders, spiritual leaders, and community leaders to discuss the possibility of establishing traditional tobacco policies. You may want to discuss options for harvesting or accessing plants from a traditional tobacco garden. You may also want to encourage community members to use naturally grown tobacco for tribal events and ceremonies. Only you and your community can determine what changes will benefit the tribe and will maintain the integrity and customs of this sacred plant for your people.

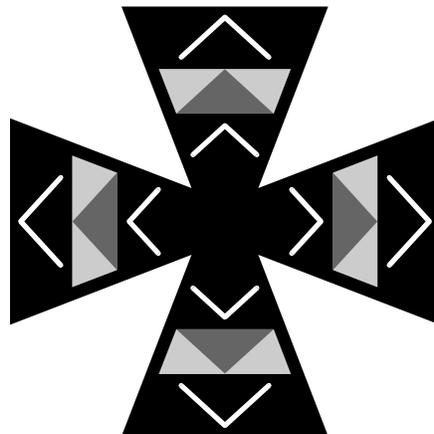
Traditional tobacco policies can come in a variety of forms. A formal policy could be drafted for consideration by the Tribal council as a whole, or by a school or business. An informal policy could be adopted by an event committee, a community group, or a tribal organization. Whichever method is used, be sure to create an inclusive decision-making process for this sensitive topic.

SECTION 3: APPENDECIES

Chapter 11: Additional Resources..... 281

Chapter 12: 1995 Tobacco Policy Workbook..... 287

Chapter 13: Citations and References 291



Chapter 11: Additional Resources



Tribal Tobacco Prevention Programs



**Aberdeen Area Tribal Chairman's Health Board
Aberdeen Plains Tobacco Prevention Project**

(605) 229-3846

Contact: Terry Salway

Email: tgsalw@aatchb.org

Website: www.aatchb.org

**Alaska Native Health Board
Support Center for Tobacco Programs**

3700 Woodland Drive, Suite 500

Anchorage, AK 99517

(907) 743-6118

Contact: Nick Gonzales

Email: ngonzales@anhb.org

Website: www.anhb.org

**California Rural Indian Health Board
American Indian Tobacco Education Network**

Michael Weahkee-Director

4400 Auburn Boulevard, 2nd Floor

Sacramento, CA 95841

(916) 929-9761

Email: michael.weahkee@ihs.gov

Website: www.crihb.org

**California Rural Indian Health Board
Tobacco Education Prevention Technical Support Center**

4400 Auburn Blvd., 2nd Floor

Sacramento, CA 95841

(916) 929-9761 or 800-274-4288

Contact: Jacelyn Macedo, Tobacco Program Coordinator.

E-mail: jacelyn.macedo@mail.ihs.gov

Website: www.crihb.org

Great Lakes Inter-Tribal Council
Native American Youth Tobacco Abuse Prevention Project
PO Box 9
Lac du Flambeau, WI 54538
(715) 588-3324
www.glitc.org

Inter-Tribal Council of Arizona
Community Tobacco Education and Prevention Program
2214 N. Central Ave., Ste. 100
Phoenix, AZ 85004
(602) 258-4822
Contact: Teresa Aseret-Manygoats
Email: teresa.aseret-manygoats@itcaonline.com
Website: www.itcaonline.com

Inter-Tribal Council of Michigan, Inc.
Strengthening and Educating Michigan's
Anishinaabe Tobacco Project
2956 Ashmun St.
Sault Ste. Marie, MI 49783
(906) 635-4208 or 877-483-3601
Contact: Lisa Kerfoot
Email: lkerfoot@itcmi.org
Website: www.itcmi.org

Muscogee (Creek) Nation
Tobacco Prevention Program
PO Box 400
Okmulgee, OK 74447
(918) 756-4333
Contact: Cynthia Coachman
Email: cynthia.coachman@mail.ihs.gov
Website: www.muscogeehealth.org

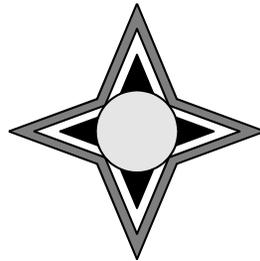
Northwest Portland Area Indian Health Board
National Tribal Tobacco Prevention Network &
Western Tobacco Prevention Project
527 SW Hall, Suite 300
Portland, OR 97201
(503) 228-4185
Contact: Gerry RainingBird and Nichole Hildebrandt
Email: grainingbird@npaihb.org and nhildebrandt@npaihb.org
Website: www.npaihb.org



Smoking Cessation Quit Lines



Quitlines are among the fastest growing smoking cessation tools in the nation. Studies have shown that Quitlines can significantly improve a smokers chance of quitting successfully. Below is a list of national and state toll-free telephone numbers that offer counseling and information about quitting commercial tobacco.



National Quit-line Phone Numbers

National Quitline

1-800-QUITNOW

www.smokefree.gov

American Cancer Society

1-800-227-2345

www.cancer.org

Great Start

(For Pregnant Women)

1-866-667-8278

American Lung Association

1-800-586-4872

www.lungusa.org

National Cancer Institute

1-800-422-6237

www.nci.nih.gov



Additional Tobacco Resources



American Cancer Society

Toll free 800-227-2345

www.cancer.org

American Heart Association

National Center

7272 Greenville Avenue

Dallas, TX 75231

Toll free 800-242-8721

www.americanheart.org

American Legacy Foundation

1001 G Street N.W., Suite 800

Washington, DC 20001

(202) 454-5555

www.americanlegacy.org

American Lung Association

61 Broadway, 6th Floor

New York, NY 10006

(212) 315-8700

www.lungusa.org

Center for Disease Control (CDC) and Prevention

1600 Clifton Road

Atlanta, GA 30333

Toll free 800-311-3435, (404) 639-3311,
for public inquiries (404) 639-3534

www.cdc.gov

CDC- Office on Smoking and Health (OSH)

4770 Buford Highway, MS K-50

Atlanta, GA 30341

Toll free 800-311-3435

www.cdc.gov/tobacco

Department of Health and Human Services (DHHS)

U.S. EPA, Region 10

1200 Sixth Avenue

Seattle, W A 9810 1

Toll free 800-424-4EPA or (206) 553-1200

www.hhs.gov

Division of Adolescent and School Health (DHHS)

4770 Buford Highway NE

Atlanta, GA 30333

(404) 639-3311

www.cdc.gov/nccdphp/dash

Environmental Protection Agency

75 Hawthorne Street

San Francisco, CA 94105

Toll free 800-438-4318 or (415) 744-1500

www.epa.gov/smokefree/

Indian Health Services (IHS)

Portland Area Indian Health Service

1220 SW Third Avenue # 476

Portland, OR 97204

(503) 326-4123

www.ihs.gov

Join Together Online

One Appleton Street, 4th Floor

Boston, MA 02116-5223

(617) 437-1500

www.jointogether.org

MediaCampaign

Office of National Drug Control Policy,
National Youth Anti-Drug Media
Campaign Drug Policy Information
Clearinghouse
PO Box 6000
Rockville, MD 20849-6000
Toll free 800-666-3332
www.mediacampaign.org

National Campaign for Tobacco-Free Kids

1400 I Street N.W., Suite 1200
Washington, DC 20005
Toll free 800-284-KIDS
www.tobaccofreekids.org

National Cancer Institute

NCI Public Inquiries Office
Suite 3036A, 6116 Executive Boulevard
MSC 8322 Bethesda, MD 20892-8328
Toll free 800-4-CANCER or (301) 435-3848
www.cancer.gov

National Clearinghouse for Alcohol and Drug Information (NCADI)

Department of Health and Human
Services
PO Box 2345
Rockville, MD 20847-2345
Toll free 800-729-6686
www.health.org

National Indian Health Board

1385 South Colorado Boulevard, Suite
A707
Denver, CO 80222
(303) 759-3075
www.nihb.org

National Institute on Drug Abuse (NIDA)

NIDA NIH, 6001 Executive Boulevard,
Room 5213
Bethesda, MD 20892-9651
(301) 443-1124
www.nida.nih.gov

Native American Plant Co-operative (NAPC)

Joseph C. Winter, Director
PO Box 36748
Albuquerque, NM 87179
(505) 289-3203 or fax (505) 0277-6726
Email: iwinter@unm.edu

QuitNet

1 Appleton 4th Floor
Boston, MA 02116
(617)-437-1500
www.quitnet.com

Robert Wood Johnson Foundation (RWJF)

PO Box 2316, College Road East and
Route 1
Princeton, NJ 08543-2316
Toll free 888-631-9989
www.rwjf.org

United National Indian Tribal Youth, Inc. (UNITY)

PO Box 800
Oklahoma City, OK 73101
(405) 236-2800
www.unityinc.org

Chapter 12:
1995 Tribal Tobacco
Policy Workbook



Tobacco Policy Workbook 1995



The material contained in this toolkit was originally assembled through a partnership forged between research, academic, and Tribal organizations. The Tribal Tobacco Project was funded for five years through the National Cancer Institute (Grant #U01 CA52230), and ended in May 1995. The goal of this project was to develop a consultative process with the 40 tribes of Oregon, Washington, and Idaho to assist in establishing tribal tobacco policies and to evaluate their impact in the community. To ensure cultural sensitivity, Indian professional staff implemented interventions and collected evaluative data. The original Tobacco Policy Workbook was the final product of their work.

Original Contributing Members:

Northwest Portland Area Indian Health Board:

Kerri Lopez, Doni Wilder, Bryson Liberty, Bruce Meyers, Gary Brown, Alameda Rocha, Lynn DeLorme, Pauline Badroads

Oregon State University:

Roberta Hall, Cynthia Viles, Gina Hovet

Oregon Research Institute

Edward Lichtenstein, Russell Glasgow, Suzanna Gilbert McRae, Teresa Alvernaz, Shawn Boles, Lisa Strycker, Stephanie Shaff

With additional thanks given to Linda Nettekoven and the COMMIT Project.

Further references to the original Tribal Tobacco Policy Project can be found in:

Glasgow, R.E., Lichtenstein, E., Hall, R., Meyers, G.B., Wilder, D., McRae, S.G., (1993). Indoor smoking policies of Indian tribes in the Northwest U.S. *Tobacco Control*, 2(1), 35-37, March.

Hall, R.L., Lichtenstein, E., Burhansstipanov, L., Davis, S.M., Hodge, F., Schinke, S., Singer, B., Fredricks, L., Glasgow, R.E. Tobacco use policies and practice in diverse Indian settings. *American Indian Culture and Research Journal*. Vol. 19, No. 3 1995.

Lichtenstein, E., Glasgow, R.E., Lopez, K., Hall, R., McRae, S.G., Meyers, G.B. (1995). Promoting tobacco control policies in Northwest Indian tribes. *American Journal of Public Health*, 86(7), 991-993.

The original artwork was created by Ramon Murillo in 1993, "A Prayer Salmon."

Chapter 13:

Citations and References



Citations and References

- ¹ Pego *et al.*, 1996. Tobacco, Culture, and Health Among American Indians: A Historical Review. The IHS Provider. February 1996.
- ² Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: <http://www.cdc.gov/tobacco/issue.htm>. Accessed January 12, 2005.
- ³ Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: http://www.cdc.gov/nccdphp/aag/pdf/aag_osh2004.pdf. Accessed January 12, 2005.
- ⁴ W. Ron Allen, President of the National Congress of American Indians, to the Senate Committee on Indian Affairs. Oversight Hearing on the Unmet Health Care Needs in Indian Country. May 21, 1998. Available at: http://indian.senate.gov/1998hrags/0521_ra.htm. Accessed January 12, 2005.
- ⁵ Indian Health Service. Publications and Reports. Regional Differences in Indian Health 2000-2001. Available at: <http://www.ihs.gov/PublicInfo/Publications/index.asp>. Accessed January 12, 2005.
- ⁶ Sachs DPL. Advance in Smoking Cessation Treatment. In: Simmons, ED. Current Pulmonology. Chicago: Year Book Medical Publishers. 1981; 12: 1139-1198. Available at: http://www.alaskapublichealth.org/Documents/David%20Gonzales_2003%20Alaska%20Health%20Summary%20Address.ppt. Accessed January 12, 2005.
- ⁷ Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. American Psychiatric Association. Washington D.C.; 1994.
- ⁸ National Center for Tobacco-Free Kids. Research Center Fact Sheets. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0263.pdf>. Accessed January 12, 2005.
- ⁹ Liberty Science Center. The Science Behind Tobacco. Available at: <http://www.lsc.org/tobacco/health/addiction.html>. Accessed July 29, 2004.
- ¹⁰ Centers for Disease Control and Prevention. *MMWR* - Cigarette Smoking Among Adults — United States, 2002. May 28, 2004. 53: No. 20. Available at: http://www.cdc.gov/tobacco/research_data/adults_prev/mm5320a2_intro.htm. Accessed January 12, 2005.
- ¹¹ Centers for Disease Control and Prevention. Monitoring the Future Survey, 1998. Available at: http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-nat.htm. Accessed January 12, 2005.
- ¹² Centers for Disease Control and Prevention. Surveillance for Health Behaviors of American Indians and Alaska Natives: Findings from the Behavioral Risk Factor Surveillance System, 1997-2000. August 1, 2003. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5207a1.htm#tab4>. Accessed: January 12, 2005.
- ¹³ Romero FC, *et al.*, Northwest Tribal Behavioral Risk Factor Surveillance System (BRFSS) Project. Aggregate Final Project Report. Northwest Portland Area Indian Health Board, 2003. Available at: http://www.npaihb.org/epi/brfss/webpage_brfss.htm. Accessed January 12, 2005.
- ¹⁴ Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: <http://www.cdc.gov/tobacco/datahighlights/Page5.htm>. Accessed: January 13, 2005.
- ¹⁵ Idaho Department of Health and Welfare. Tobacco Prevention and Control. Project Filter Correspondence, 2003.
- ¹⁶ Oregon Department of Human Services. Oregon Tobacco Facts. September 2004. Available at: <http://www.ohd.hr.state.or.us/tobacco/facts04/facts04.pdf>. Accessed: January 12, 2005.
- ¹⁷ Oregon Department of Human Services. Oregon Tobacco Facts. 2003. Available at: <http://www.dhs.state.or.us/publichealth/tobacco/facts03/index.cfm>. Accessed: January 12, 2005.
- ¹⁸ Washington State Department of Health. Native Americans and Tobacco in Washington. Available at: <http://www.doh.wa.gov/Tobacco/disparities/populations/native.htm>. Accessed: January 12, 2005.
- ¹⁹ Washington State Department of Health. Native Americans and Tobacco in Washington. Available at: <http://www.doh.wa.gov/Tobacco/disparities/populations/native.htm>. Accessed: 2003.
- ²⁰ 2003 American Indian Healthcare Delivery Plan. Available at: <http://www.aihc-wa.org/AIHCDF/aihcdf.htm#aihcdf>. Accessed: January 12, 2005.

-
- ²¹ Nathaniel Cobb, MD, BS. Chief, Chronic Disease Branch, Indian Health Services. Personal correspondence 2003.
- ²² The Health Consequences of Smoking: A Report of the Surgeon General. 2004. Available at: http://www.cdc.gov/tobacco/sgr/sgr_2004/index.htm. Accessed: January 13, 2005.
- ²³ Women and Smoking: A Report of the Surgeon General. 2001. Available at: http://www.cdc.gov/tobacco/sgr/sgr_forwomen/index.htm. Accessed: January 13, 2005.
- ²⁴ Indian Health Service. Division of Program Statistics. Trends in Indian Health 2000-2001.
- ²⁵ World Health Organization. Cancer. Available at: <http://www.who.int/tobacco/research/cancer/en/>. Accessed: January 13, 2005.
- ²⁶ Tobacco Free Kids. Tobacco Harm To Kids. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0077.pdf>. Accessed: January 13, 2005.
- ²⁷ Bauman K *et al.*, "Effect of parental smoking classification on the association between parental and adolescent smoking," *Addictive Behaviors*, 1990, 15(5): 413-22. See, also, Osler M *et al.*, "Maternal smoking during childhood and increased risk of smoking in young adulthood," *International Journal of Epidemiology*, 1995, Aug, 24(4): 710-4.
- ²⁸ Environmental Protection Agency. Environmental Tobacco Smoke. Available at: <http://www.epa.gov/iaq/pubs/insidest.html#Look2>. Accessed: January 13, 2005.
- ²⁹ Centers for Disease Control and Prevention. MMWR. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs --- United States, 1995—1999. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm>. Accessed: January 13, 2005.
- ³⁰ Centers for Disease Control and Prevention. Tobacco Information and Prevention Source. Available at: <http://www.cdc.gov/tobacco/datahighlights/Page6.htm>. Accessed: January 13, 2005.
- ³¹ Centers For Disease Control and Prevention. Making Your Workplace Smokefree - A Decision Maker's Guide. Available at: http://www.cdc.gov/tobacco/research_data/environmental/etsguide.htm. Accessed: January 13, 2005.
- ³² Fiore *et al.*, 2000. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services. Available at: <http://www.ahcpr.gov/path/tobacco.htm>. Accessed: January 14, 2005.
- ³³ Glantz, S.A. & Parmley, W., "Passive Smoking and Heart Disease: Epidemiology, Physiology, and Biochemistry," *Circulation*, 1991; 83(1):1-12; and, Taylor, A., Johnson, D, & Kazemi, H., "Environmental Tobacco Smoke and Cardiovascular Disease," *Circulation*, 1992; 86:699-702 and Health Harms from Smoking and Other Tobacco Use, National Center for Tobacco-Free Kids, October 8, 2002.
- ³⁴ MMWR (Morbidity and Mortality Weekly Report) -CDC Dec. 14, 2001, Vol.50/No. 49;
- ³⁵ Repace, J., Kawachi, I., Glantz, S., Fact Sheet on Secondhand Smoke. Available at: http://repace.com/fact_exp.html. Accessed: January 14, 2005.
- ³⁶ Repace, J. Can Ventilation Control Secondhand Smoke in the Hospitality Industry? California Department of Health Services, 2000. Available at: <http://www.dhs.ca.gov/tobacco/documents/FedOHSHAets.pdf>. Accessed: January 14, 2005.
- ³⁷ American Heart Association. Active and Passive Tobacco Exposure: A Serious Pediatric Health Problem. Available at: <http://www.americanheart.org/presenter.jhtml?identifier=1213>. Accessed: January 14, 2005.
- ³⁸ P. H Whincup, J. A Gilg, J. R Emberson, M. J Jarvis, C. Feyerabend, A. Bryant, M. Walker, and D. G Cook. Passive smoking and risk of coronary heart disease and stroke: prospective study with cotinine measurement. *BMJ*, July 24, 2004; 329(7459): 200 - 205. Available at: <http://bmj.bmjournals.com/cgi/reprint/329/7459/200>. Accessed: January 14, 2005.
- ³⁹ Tobacco and CVD. Available at: <http://www.wvdhhr.org/bph/cvd/page1.htm>. Accessed: January 14, 2005.
- ⁴⁰ Washington State Department of Health. Tobacco Prevention and Control in Washington State. Available at: <http://www.doh.wa.gov/Tobacco/program/reports/tpcpprogrpt.pdf>. Accessed: January 14, 2005.
- ⁴¹ National Cancer Policy Board and the Board on Health Promotion and Disease Prevention. Available at: <http://www.tobaccofreedom.org/msa/articles/reduction.html>. Accessed: January 14, 2005.
- ⁴² Tobacco Free Kids. Clean Indoor Air Laws Encourage Smokers to Quit and Discourage Youth from Starting. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0198.pdf>. Accessed: January 14, 2005.

-
- ⁴³ Centers for Disease Control and Prevention. Coverage For Tobacco Use Cessation Treatments. Available at: http://www.cdc.gov/tobacco/educational_materials/cessation/. Accessed: January 14, 2005.
- ⁴⁴ Muskoka-Parry Sound Health Unit. Available at: <http://www.mpslu.on.ca/Tobacco/enviro.htm>. Accessed: February 8, 2005.
- ⁴⁵ Available at: <http://www.colorado.edu/studentgroups/wellness/NewSite/TobaccoEnvironment.html>. Accessed: February 8, 2005.
- ⁴⁶ New Study: Non-Smoking Areas Offer No Protection from ETS Dangers. Excerpts from: Non-Smoking Areas 'Ineffective' Protection. Available at: <http://news.scotsman.com/latest.cfm?id=2564815>. Accessed: January 14, 2005.
- ⁴⁷ American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE). Available at: <http://www.ashrae.org/template/AssetDetail/assetid/29525>. Accessed: February 8, 2005.
- ⁴⁸ World Health Organization. Frequently asked questions about second-hand smoke. Available at: <http://www.emro.who.int/tfi/wntd2001/factsheets-p7.htm>. Accessed: January 14, 2005.
- ⁴⁹ Study finds air cleaners ineffective against hazardous pollutants. Available at: <http://www.tobacco.org/news/169396.html>. Accessed: January 14, 2005.
- ⁵⁰ Health A to Z. The Stages of Quitting. Available at: <http://www.healthatoz.com/healthatoz/Atoz/dc/caz/suba/smok/alert08012000.jsp>. Accessed: January 14, 2005.
- ⁵¹ Administration for Children and Families. Head Start. Available at: http://www.headstartinfo.org/publications/im95/pi95_04.htm. Accessed: January 14, 2005.
- ⁵² Centers for Disease Control and Prevention: Secondhand Smoke Fact Sheet. Available at: http://www.cdc.gov/tobacco/factsheets/secondhand_smoke_factsheet.htm. Accessed: January 14, 2005.
- ⁵³ (From Priorities, Vol 2, No. 4) What's in a Cigarette? K. H. Ginzler, M.D. Available at: <http://www.tarnival.org/cigarette/ingredients/smoke.html>. Accessed: January 14, 2005.
- ⁵⁴ Glantz, S.A. & Parmley, W., "Passive Smoking and Heart Disease: Epidemiology, Physiology, and Biochemistry," *Circulation*, 1991; 83(1):1-12. Taylor, A., Johnson, D, & Kazemi, H., "Environmental Tobacco Smoke and Cardiovascular Disease," *Circulation*, 1992; 86:699-702.
- ⁵⁵ Tobacco Free Kids. Health Harms of Secondhand Smoke. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0103.pdf>. Accessed: February 8, 2005.
- ⁵⁶ Centers for Disease Control. It's Time to Stop Being a Passive Victim, 1993.
- ⁵⁷ The Health Consequences of Involuntary Smoking: A Report of the U.S. Surgeon General, 1986. Centers For Disease Control and Prevention. Available at: http://www.cdc.gov/tobacco/sgr/sgr_1986/index.htm. Accessed: February 8, 2005.
- ⁵⁸ Tobacco Free Kids. Ventilation Technology Does Not Protect People from Secondhand Tobacco Smoke. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0145.pdf>. Accessed: February 8, 2005.
- ⁵⁹ "Involuntary Smoking in the Restaurant Workplace," *Journal of American Medical Association* 1993; 270:490-493
- ⁶⁰ Christian Science Monitor. Available at: <http://www.csmonitor.com/2005/0208/p01s04-ussc.htm>. Accessed: February 8, 2005.
- ⁶¹ World Health Organization. Available at: <http://www.emro.who.int/tfi/wntd2001/factsheets-p7.htm>. Accessed: February 8, 2005.
- ⁶² "Review of the Quality of Studies on Economic Effects of Smoke-Free Policies on the Hospitality Industry," Scollo, Lal, Hyland, Glantz, *Tobacco Control*, 2003 12:13-20.
- ⁶³ Tobacco Free Kids. Smoke-Free Laws Do Not Harm Business at Restaurants and Bars. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0144.pdf>. Accessed: February 8, 2005.
- ⁶⁴ Tobacco Free Kids. Clean Indoor Air Laws Encourage Smokers to Quit and Discourage Youth from Starting. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0198.pdf>. Accessed: February 8, 2005.
- ⁶⁵ G M Leung, L-M Ho, and T-H Lam. The economic burden of environmental tobacco smoke in the first year of life. *Tobacco Control* 2003; 12: 400.
- ⁶⁶ Tobacco-Free Kids. Where Do Youth Smokers Get Their Cigarettes? Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0073.pdf>. Accessed: February 8, 2005.

- ⁶⁷ Johnston, L.D., et al., Institute for Social Research, University of Michigan. *Monitoring the Future National Survey Results on Drug Use, 1975-2002. Volume I Secondary School Students*, (2003). National Institute on Drug Abuse, NIH Publication No. 03-5375. Available at: http://monitoringthefuture.org/pubs/monographs/vol1_2002.pdf.
- ⁶⁸ Bowen, D.J., et al., "Description of Early Triers," *Addictive Behavior* 16(3-4): 95-101 (1991).
- ⁶⁹ CDC, "Selected Cigarette Smoking Initiation and Quitting Behaviors Among High School Students – United States, 1997," *MMWR* (May 22, 1998).
- ⁷⁰ DiFranza, J.R. et al., "Initial Symptoms of Nicotine Dependence in Adolescents," *Tobacco Control* 9: 313-19. September 2000.
- ⁷¹ University of California Irvine Transdisciplinary Tobacco Use Research Center. Closing the Gap on Youth Tobacco Use through Transdisciplinary Research.
- ⁷² NHSDA 1998. National Survey on Drug Use & Health.
- ⁷³ Monitoring the Future Study (1998).
- ⁷⁴ U.S. Department of Health and Human Services, Preventing Tobacco Use Among Young People: A Report of the Surgeon General (1994).
- ⁷⁵ Everett, Sherry et al. "Other Substance Use Among High School Students Who Use Tobacco." *Journal of Adolescent Health*. November 1998.
- ⁷⁶ U.S. Federal Trade Commission (FTC), *Cigarette Report for 2001*, June 12, 2003 [data for top six manufacturers only], <http://www.ftc.gov/os/2003/06/2001cigreport.pdf> See, also, FTC, *Federal Trade Commission Smokeless Tobacco Report for the Years 2000 and 2001*, August 2003, <http://www.ftc.gov/os/2003/08/2k2k1smokeless.pdf> [top five smokeless tobacco manufacturers spent more than \$236 million on marketing in 2001].
- ⁷⁷ CDC, State Highlights 2002: Impact and Opportunity, April 2002, www.cdc.gov/tobacco/StateHighlights.htm See, also, U.S. General Accounting Office (GAO), "CDC's April 2002 Report on Smoking: Estimates of Selected Health Consequences of Cigarette Smoking Were Reasonable," letter to U.S. Rep. Richard Burr, July 16, 2003, <http://www.gao.gov/new.items/d03942r.pdf>
- ⁷⁸ Farkas, A., et al. "Association Between Household and Workplace Smoking Restrictions and Adolescent Smoking," *Journal of the American Medical Association* 284(6), August 9, 2000, <http://jama.ama-assn.org/issues/v284n6/rfull/joc00094.html>.
- ⁷⁹ The National Center for Tobacco-Free Kids, Smoking and Other Drug Use Fact Sheet. January 3, 2002
- ⁸⁰ University of California Irvine Transdisciplinary Tobacco Use Research Center. Closing the Gap on Youth Tobacco Use through Transdisciplinary Research.
- ⁸¹ The National Center for Tobacco-Free Kids, Smoking and Other Drug Use Fact Sheet. January 3, 2002
- ⁸² See, e.g., Tauras, J., et al., "Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis," Bridging the Gap Research, ImpacTeen, April 24, 2001, and other price studies at www.uic.edu/orgs/impacteen Chaloupka, F., "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research*, 1999, and other price studies at <http://tigger.uic.edu/~fjc>; Chaloupka, F. & R. Pacula, *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541, April 1998), <http://tigger.uic.edu/~fjc>. Emery, S., et al., "Does Cigarette Price Influence Adolescent Experimentation?," *Journal of Health Economics* 20:261-270, 2001. Evans, W. & L. Huang, *Cigarette Taxes and Teen Smoking: New Evidence from Panels of Repeated Cross-Sections*, working paper, April 15, 1998, www.bsos.umd.edu/econ/evans/wrkpap.htm. Harris, J. & S. Chan, "The Continuum-of-Addiction: Cigarette Smoking in Relation to Price Among Americans Aged 15-29," *Health Economics Letters* 2(2) 3-12, February 1998, www.mit.edu/people/jeffrey.
- ⁸³ Monitoring the Future Study (1998).
- ⁸⁴ Tobacco Free Kids. Smoking and Kids. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0001.pdf>. Accessed: February 9, 2005.
- ⁸⁵ Tobacco Free Kids. The Path to Smoking Addiction Starts at Very Young Ages. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0127.pdf>. Accessed: February 9, 2005.
- ⁸⁶ Tobacco Free Kids. Tobacco Company Marketing to Kids. Available at: <http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=23>. Accessed: February 9, 2005.
- ⁸⁷ Tobacco Free Kids. Tobacco Taxes – State. Available at: <http://tobaccofreekids.org/research/factsheets/index.php?CategoryID=18>. Accessed: February 9, 2005.

- ⁸⁸ Tobacco Free Kids. Responses to Misleading and Inaccurate Cigarette Company Arguments Against State Tobacco Tax Increases. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0227.pdf>. Accessed: February 10, 2005.
- ⁸⁹ Smoke-free work sites top ten financial benefits to employers. Western CAPT/CASAT. University of Nevada, Reno. Available at: http://www.paccenter.org/public/reports_folder/cess_in_wp_web.pdf. Accessed: February 10, 2005.
- ⁹⁰ Henningfield, J.E., Ramstrom L.M., Husten C.G., et al. (1994). Smoking and the Workplace: Realities and Solutions. *Journal of Smoking Related Diseases*, 5 (Suppl. 1): 261-270.
- ⁹¹ New Study: The Health Benefits of Smoking Bans in All American Workplaces [06/22-4] Excerpts from: Health Benefits of Snuffing out Workplace Smoking Detailed by Stanford Researcher.
- ⁹² American Lung Association. Smoking Policies in the Workplace Fact Sheet. Available at: <http://www.lungusa.org/site/pp.asp?c=dvLUK9O0E&b=36000>. Accessed: February 10, 2005.
- ⁹³ Centers for Disease Control and Prevention. Taking Action Against Secondhand Smoke – Workplaces. Available at: http://www.cdc.gov/tobacco/ETS_Toolkit/worksites/intro.htm. Accessed: February 10, 2005.
- ⁹⁴ Centers for Disease Control and Prevention. Coverage For Tobacco Use Cessation Treatments. Available at: http://www.cdc.gov/tobacco/educational_materials/cessation/page2.html. Accessed: February 10, 2005.
- ⁹⁵ Warner KE, Health and economic implications of work-site smoking cessation program: a simulation analysis. *Journal of Occupational & Environmental Medicine*. October 1996; 38 (10): 981-992.
- ⁹⁶ 1998-2000 Behavioral Risk Factor Surveillance Survey (BRFSS)
- ⁹⁷ Centers for Disease Control and Prevention. Reducing Tobacco Use: A Report of the Surgeon General. 2002. Available at: http://www.cdc.gov/tobacco/sgr/sgr_2000/index.htm. Accessed: January 13, 2005.
- ⁹⁸ Fiore et al. 1996
- ⁹⁹ Martin, J. A., Hamilton, B. E., Sutton, P. D., Ventura, S. J., Menacker, F., Munson, M. L. Births: final data for 2002. *National Vital Statistics Report* 2003;52(10): Table 24.
- ¹⁰⁰ Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tobacco Control* 2000;9(Supplement 3):iii80-iii84.
- ¹⁰¹ Five Major Steps to Intervention (The "5A's"). U.S. Public Health Service. Available at: <http://www.surgeongeneral.gov/tobacco/5steps.htm>. Accessed: February 10, 2005.
- ¹⁰² Centers for Disease Control and Prevention. *MMWR* — State Medicaid Coverage for Tobacco-Dependence Treatments - United States, 1994-2002. January 30, 2004 / Vol. 53 / No. 3. Available at: http://www.cdc.gov/TOBACCO/research_data/economics/mmwr5302a2_intro.htm. Accessed: February 10, 2005.
- ¹⁰³ Center for Tobacco Cessation. *Invest in a Healthy State: Covering Tobacco Treatment under Medicaid*. Washington, DC: Center for Tobacco Cessation, March, 2004.
- ¹⁰⁴ National Partnership to Help Pregnant Smokers Quit. *Helping Pregnant Women Quit: Providing Coverage for Tobacco Treatment Under Medicaid*. Chapel Hill, NC: Cecil Sheps Center for Health Service Research, March, 2004.
- ¹⁰⁵ Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking. Available at: http://www.acog.org/from_home/departments/dept_notice.cfm?recno=13&bulletin=1863. Accessed February 10, 2005.
- ¹⁰⁶ Mullen PD. "Maternal smoking during pregnancy and evidence-based intervention to promote cessation." In: Spangler J, ed. *Primary Care; Clinics in Office Practice (Tobacco Use and Cessation)*. Vol. 26. Philadelphia, PA: WB Saunders, 1999; 577-589.
- ¹⁰⁷ 1998-2000 Behavioral Risk Factor Surveillance Survey (BRFSS)
- ¹⁰⁸ Solberg et al., 2001 – From Washington State Department of Health BTIS Training Manual.
- ¹⁰⁹ NCI, 2000 – From Washington State Department of Health BTIS Training Manual.
- ¹¹⁰ McAfee T, Sofian N, Wilson J, Hindmarsh M. The role of tobacco intervention in population-based health care. *American Journal of Preventive Medicine* 1998;14:46-52.
- ¹¹¹ Fiore et al. 2000, Fiore et al., 1994, Manley et al., 1991; Russell et al., 1979.
- ¹¹² Prochaska et al., 1997 – From Washington State Department of Health BTIS Training Manual.
- ¹¹³ ICOH Network on Tobacco Free Workplaces. Available at: http://www.icoh.org.sg/news/tobacco_free_network.html#. Accessed: February 11, 2005.
- ¹¹⁴ Kristein, "How Much Can Business Expect to Profit from Smoking Cessation?", *Preventative Medicine*, 1983; 12:358-381; Jackson & Holle, "Smoking: Perspectives 1985" *Primary Care*, 1985; 12:197-216.

¹¹⁵ New Study: The Health Benefits of Smoking Bans in All American Workplaces. (06/22/4). Excerpts from: Health Benefits of Snuffing out Workplace Smoking. Detailed by Stanford Researcher. Business Wire.

¹¹⁶ Repace, J., Kawachi, I., Glantz, S., Fact Sheet on Secondhand Smoke. Available at: http://repace.com/fact_cardio.html. Accessed: February 11, 2005.

¹¹⁷ World Health Organization. Why Smoking in the Workplace Matters. Available at: <http://www.euro.who.int/document/e74820.pdf>. Accessed: February 11, 2005.

¹¹⁸ Conference Board of Canada, "Smoking and the Bottom Line: the Costs of Smoking in the Workplace," 2001

¹¹⁹ National Cancer Institute, Population Based Smoking Cessation: Proceeding of a Conference on What works to influence Cessation in the General Population, Smoking and Tobacco Control Monograph No. 12, NIH Pub. No. 00-4892, November 2000.

¹²⁰ Campaign for Tobacco Free Kids, the Toll of Smoking in Wisconsin, May 2001.

¹²¹ Centers For Disease Control and Prevention. The Health Consequences of Involuntary Smoking: A Report of the U.S. Surgeon General, 1986.

¹²² Designated "no smoking" areas provide from partial to no protection from environmental tobacco smoke. T Cains, S Cannata, R Poulos, M J Ferson, and B W Stewart. Tobacco Control 2004; 13: 17-22.

¹²³ Tobacco Free Kids. Smoke-Free Laws Do Not Harm Business at Restaurants and Bars. Available at: <http://tobaccofreekids.org/research/factsheets/pdf/0144.pdf>. Accessed: February 11, 2005.

¹²⁴ Journal of Occupational and Environmental Medicine, July 2001.

