KEEPING THE SACRED IN TOBACCO

A TOOLKIT FOR TOBACCO CESSATION

NATIONAL NATIVE
ADDICTIONS PARTNERSHIP
FOUNDATION

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Acknowledgements

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PRELUDE

Tobacco use is a leading cause of preventable death in First Nations communities. Although smoking has been decreasing, mortality and morbidity related to tobacco use remains very high. The number of First Nations and Inuit men, women, youth, and children smokers is exceptionally high when compared to the rest of the Canadian population. Notably, the rate of First Nations youth whom smoke is higher than that of their contemporaries in non-First Nations society. Some estimates indicate one-half of all children in Canada try smoking by the time they are twelve years old. Reportedly, it is estimated, First Nations children try smoking as early as eight years old. Consequently, The National Native Addictions Partnership Foundation (NNAPF) recognizes the severity of tobacco usage in First Nations and Inuit communities and wishes to address this usage through the training of National Native Alcohol and Drug Abuse Program (NNADAP) workers across the country in tobacco cessation practices.

Community addictions workers and others in the substance abuse field do not tend to play a major role in addressing smoking and addiction to nicotine. Up until now, the treatment and rehabilitation approaches towards alcohol and tobacco have not been the same. It appears that the consequences of alcohol and drug abuse and their devastating impacts are viewed as a greater immediate risk than the long term and less immediately evident impacts of tobacco.

Addictions workers are not offered a great deal in formal training within alcohol and drug fields and less so in the field of tobacco usage and cessation. As a result, NNAFP decided to create the *Keeping the Sacred in Tobacco Toolkit for Smoking Cessation* to aid NNADAP workers to implement tobacco cessation in their communities.

Prior to drafting the manual NNAPF sent a Tobacco Cessation Capacity Building and Training Needs Assessment to all NNADAP workers across Canada for feedback. The *Needs Assessment Surveys* were subsequently reviewed and a toolkit was developed to address the needs of the NNADAP workers in the area of tobacco cessation. The toolkit was piloted for feedback and reviewed before it was finalized. This process ensured that the toolkit would be appropriate, relevant, and user friendly.

NNAPF sincerely believes that NNADAP workers can work within their communities to enhance tobacco cessation. NNADAP workers are dedicated, motivated, enthusiastic, and key members working in their communities to achieve healthier families and Nations.

We are honoured to offer this toolkit to you in hope that together we can all contribute to healthier communities, families, and Nations.

Basic Facts & Information on Tobacco and Tobacco Addiction

COURSE DEFINITIONS

During the course of piloting the toolkit there was discussion around the precise meaning of several concepts. As a result, a request for clarification was recommended. Below are those concepts in question and their definitions for the purpose of this toolkit.

Elder: An Elder is someone in the community who has raised their families, sometimes families of others, has wisdom and has retained the cultural knowledge passed on from generation from generation, has passed on teachings, walks their walk, and demonstrates humility. Communities usually know who the Elders are and where they can be found.

Sacred: Ways of life, rituals, and teachings that are important, respected, and valued.

Tradition: A story or custom that is passed down from generation to generation. There is no universal singular First Nations tradition.

Traditional: Anything that follows the customs that are passed down from generation to generation.

Traditional/Sacred Tobacco: The original tobacco plant used by First Nation Peoples or the herb or combination of herbs used by First Nations which are considered traditional or sacred tobacco, i.e. kiniknik. There are protocols for usage of these plants.

HISTORY OF TOBACCO

The majority of Indigenous peoples in the Americas have used tobacco since time immemorial. The Europeans first contact with tobacco in the Americas happened on October 12, 1492, the day Columbus first bumped into Turtle Island (the Americas).* As Columbus and his crew raised the flag of Spain to claim possession of what is now known as the Americas, in the name of Ferdinand and Isabella, the king and queen of Spain, the Indigenous people presented them with gifts of welcome to their territory. Among these gifts were dried, yellowish, aromatic leaves of an unknown plant. The sailors did not know what these leaves were, felt they had no use for them, and threw their gifts away. After all, they were looking for gold. Years later, they realized that they had indeed found *gold* in these leaves.

As more and more sailors and merchants came into the Americas, tobacco became more popular and within a century the use of tobacco had spread to every part of the world. Its spread continues on today and nothing else from anywhere has been so widely used as tobacco.

In the 1600s English settlers in what is now known as the United States were impoverished and realized that there was a potential for profit if they grew and exported tobacco. The first known shipment of tobacco was made to England in 1613. Because tobacco became a fad and was seen as fashionable it was easy to tax and became a money making endeavour in England. Tobacco for profit and high taxation of tobacco continues on to the present, and interestingly enough Canada, based on its population, uses more manufactured cigarettes than any other major industrialized nation.

It was the Hudson's Bay Company and the North West Company who first gave tobacco and alcohol in *gift-giving* ceremonies to attract and promote trade with First Nation peoples. However, First Nation peoples recognized the difference between the tobacco they grew and that of the traders. They continued to use the tobacco they grew for ceremonial purposes and began smoking the imported tobacco of the traders in a non-ceremonial way.

After colonization, the signing of treaties, and the Indian Act the Canadian government banned traditional ceremonies and this made it virtually impossible for the passing down of the traditional ways of growing and using ceremonial tobacco.

Forced assimilation and residential schools also had an impact on tobacco use by First Nation peoples, as they adopted and participate in European practices: one being smoking.

* There is a myth that Columbus was looking for India and that is why First Nations/Native Americans/Indigenas are called Indians. However, this is one of the greatest myths that has been told. At the time that Columbus came to Sacred Turtle Island (The Americas), India was called Hindustan not India. Therefore, Columbus was not looking for India. There are maps available from 1492 that back this fact up. The name Indian, instead, comes from the name that Europeans gave to the original inhabitants, Niños in Dios, which means children of God. They used this name because they found the peoples who lived here to be close to God or godlike. There are archives in Spain that document this information. As time went on people did not use the full name Niños in Dios but rather shortened it to In Dios – of God. As time went on the British colonized Hindustan and the name was changed to India. In Spanish the name for Indians is Indios which sounds exactly like In Dios and from here the fabrication of the story in regards to Columbus looking for India and the original inhabitants thus being named Indians. This myth serves history well. It helps rationalize some of the genocide and atrocities committed on First Nations/Native American/Indigenas since to acknowledge that they were children of God would not condone what occurred.

TOBACCO AS SACRED

Historically, tobacco has been used among most Indigenous Peoples in the Americas for thousands of years. For many First Nations, it is sacred and used in ceremonies, prayers and offerings. Tobacco was never meant to enter our bodies, and we must respect it and not abuse it: to do so endangers our lives and the lives of the future generations.

The following quote from a Saskatchewan Elder, Danny Musqua, illustrates a First Nation worldview and explanation of the sacredness, use, and abuse of tobacco:

> Tobacco was seen by our people as a gift from the Creator which would enable us to communicate with him. We were given tobacco because it affected the way we were able to think. It would give us an immediate feeling of heightened awareness because the tobacco we inhaled was that strong. We were given knowledge to fashion a pipe with which we could take very small puffs of tobacco smoke. We would only take small puffs, and then we would immediately blow out the smoke because smoke was not meant to be taken into our body and held there. The smoke needed to leave us in order to rise to the Creator with our prayers and thoughts. If we held it in our body, it would be an unnatural presence there. Immediately after taking the puff of smoke, our minds would race, and our whole body would be affected by this smoke since tobacco is very powerful medicine. It has a specific purpose which must not be abused.
>
> Elder Danny Musqua, WUNSKA.
> First Nations Youth Inquiry into Tobacco Use: Final Comprehensive Report to Health Canada,
> April 1997. (Saskatchewan Indian Federated College, p.52)

TOBACCO AS THE UN-SACRED

Although traditional uses of tobacco are a sacred and essential part of many First Nation peoples' life, non-traditional misuse has become a deadly epidemic.

Tobacco is no longer sacred when it is misused and used for non-ceremonial or in non-traditional ways. Non-traditional use misuse and abuse of tobacco has become a major problem for First Nations and Inuit communities. This misuse comes in the form of smoking and the use of smokeless tobacco.

Inuit peoples have a different history with tobacco culturally and traditionally. Tobacco is not a sacred plant to most Inuit, although some Inuit use it in ceremonies. It is too cold to grow tobacco in Inuit territories. Tobacco was introduced to the Inuit through trade, especially in the more southern areas of their territories. Tobacco trade increased with the arrival of European traders and now Inuit communities have some of the highest smoking rates in the world.

Tobacco smoke known as Environment Tobacco Smoke (ETS) exposes people to over 4,000 chemicals; some are toxic, and at least 50 are known to cause cancer. Some of these chemicals include formaldehyde, hydrogen cyanide, carbon monoxide, tar, and arsenic. The amount of chemicals in each cigarette is small, however, it intensifies with each cigarette and even puff of the cigarette.

Smoking contributes to many health problems such as heart problems, cancer of the mouth, throat, tongue, voice box, bladder, cervix; emphysema, chronic bronchitis, tooth loss, and gum disease. Smoking also plays a role in the severity of diabetes complications such as amputation, vision loss, and stroke.

Second-hand tobacco smoke can hurt non-smokers as much or more than smokers. This is because there is more than three times the amount of tar, and over six times the amount of nicotine in second-hand smoke than inhaled smoke. Second-hand smoke can therefore affect the future generations as well. If parents or others smoke around a child there is a higher incidence of middle ear problems, coughing, wheezing, and asthma attacks in the children. Smoking also contributes to infant mortality as well as damage to the unborn child.

Smoking is not the only form of tobacco misuse and addiction. Some people do not smoke tobacco but use chewing tobacco or *snuff*. Chewing tobacco is just as unhealthy and addictive as smoking tobacco and contains hundreds of poisons. It is associated with significant health risks such as mouth cancer, throat cancer, heart disease and stroke, gum disease, stomach ulcers, and problems with the urinary tract and bladder.

Tobacco smoke kills 47,000 people in Canada each year. That is four times higher than death caused from AIDS, traffic accidents, suicide, fires, and accidental poisoning combined. It is quickly becoming the number one killer in First Nation and Inuit communities and is beginning to surpass deaths caused by diabetes.

TOBACCO ADDICTION

The nicotine found in tobacco is addictive; consequently cigarette smoking and other forms of tobacco use are addictive. This addiction is not to be taken lightly just because it is socially acceptable. Nicotine addiction is similar to, and can be as severe as, heroin or cocaine addiction.

Nicotine causes psychoactive effects which cause chemical or biological changes in the brain. The body builds a tolerance to nicotine that result in an increase of the amount of cigarettes a person smokes. Tobacco is a *reinforcing drug*, which means users desire the drug regardless of the damaging effects it causes

Withdrawal symptoms are severe. The worst symptoms can last over a month with the most severe withdrawals occurring during the first week.

Typical withdrawal symptoms include the following:

- Headaches
- Anxiety
- Irritability
- Concentration difficulties
- Sleep problems
- Hunger
- Decreased heart rate
- Decreased blood pressure
- Nicotine craving
- Tiredness
- Cough

KEEPING THE SACRED IN TOBACCO: RECLAIMING OUR CULTURES AND TRADITIONS AS A MEANS TO TOBACCO CESSATION

"Culture is the way I live today. I have a choice"

—Elder Abe Burnstick, NECHI
(http://www.ayn.ca/quit/en/manual_pdfs/tobacco_manual72.PDF)

When trying to recover from addiction, spirituality can help. It gives you a sense of security, purpose, and a sense of belonging. It can help you find your place in the world, give you guidance and help you make important decisions. Most importantly, spirituality helps in the healing process.

(http://www.ayn.ca/quit/en/manual_pdfs/tobacco_manual72.PDF)

First Nations and Inuit peoples can and do heal from tobacco addictions through learning about and reclaiming their traditions and culture and looking to them as a source of healing and strength. Additionally, each Nation and community has their own practices and Elders who can guide them through learning about their culture and traditions.

Even those people who do not wish to participate in First Nation or Inuit spirituality can benefit from the traditions and culture of their communities. For instance, they can participate in Talking Circles to help them work through their tobacco addictions.

Examining tobacco addiction through a holistic approach and/or what is known as the Four Directions or Medicinal Wheel teachings can be beneficial as well. This allows one to explore the spiritual, emotional, mental, and physical aspects of their beings and needs for tobacco cessation.

Keeping the Sacred in Tobacco Toolkit

INTRODUCTION

This toolkit was developed for NNADAP workers in hope that they can address tobacco usage in their communities and treatment centres; in hope they will feel comfortable enough to become involved in tobacco cessation initiatives in their communities, within Band offices, schools, treatment centres, and wherever they deem necessary and; in hope that those addictions workers who still smoke can help themselves toward cessation.

Studies have shown that many smokers can be motivated to change through contact with appropriate mental health and addictions workers. They also indicate that people who attend treatment programs for other addictions, can and do effectively deal with their addiction to tobacco at the same time.

SThis toolkit provides resource materials for training addictions workers to address tobacco addiction of their clients, communities, families, and Nations. It includes the following:

- Plans for sessions of between 30 and 90 minutes in duration.
- Background notes for each session.
- Handouts.

The toolkit is flexible in design and may be used according to the background knowledge of participants. Trainers can select material to meet the needs of their participants and can deliver a one day workshop that contribute to the general knowledge on tobacco, tobacco cessation, and change, or a three-day workshop for addictions workers to become tobacco cessation specialists in their communities and schools.

Once NNADAP workers have the tools to become tobacco cessation specialists, they will contribute to the well being of their communities and clientele. They will be leaders in the area of tobacco cessation and will contribute to the well being of, not only to the present population but as well for the future generations to come.

The toolkit is First Nations focused and does not contain a great deal of information on Inuit peoples and cultures. However, it is broad enough that Inuit communities may want to use it in addition to the culturally appropriate materials they have already developed to date.

The toolkit was developed as a *train the trainer* package in hope that those who participate in the training can use what they learn to work within and train others within their own communities. It can be used as a one day presentation to help participants gain general knowledge in tobacco cessation, or it can be used as a three day presentation where participants will gain sufficient knowledge to become tobacco cessation specialists in their communities.

The one day presentation includes presentation of the Basic Facts and Information, Introductions and communications, Tobacco and Health, Traditional Use of Tobacco, Tobacco Cessation, Stages and Process of change, and Closing Circle. The three day presentation allows participants to take part in every section of the toolkit in order to become *tobacco cessation specialists*. Evaluation of specialists is provided through a pre-test and post-test.*

*Further testing is being developed in conjunction with the Online Course.

PRE-TEST

Before introducing the toolkit and the sessions hand out the following pre-test to assess the knowledge-base of the participants. Let participants know there are no right or wrong answers. The purpose of the pre-test is to help assess the knowledge and skills they already have.

TOBACCO SESSATION PRE-TEST

What do you perceive as your role in tobacco cessation?

List some effective strategies for the promotion of motivation to quit tobacco usage.

Describe what you feel are the necessary knowledge and skills addictions workers need for involvement in smoking cessation initiatives.

List any information and/or resources you are aware of that exist on tobacco cessation and dependence treatment practices.

Describe how you think policies and protocols are set up.

Describe any involvement you have in community interventions.

What skills do you think are necessary for community interventions?

Define child development.

What skills do you need to work with adolescents?

List some of the tools you need for working with adolescents

What roles do you feel schools play in tobacco cessation?

Explain how tobacco was and is used traditionally.

How do you think you can work with schools in the promotion of tobacco cessation?

SESSION 1
INTRODUCTIONS AND COMMUNICATION

Purpose: This session introduces the participants to one another, the toolkit, and to the idea of tobacco cessation.

Objectives: By the end of the session participants will be able to:

- Participate in group introductions.
- Review course objectives and ground rules.
- Describe the work of tobacco cessation programming.

Materials: Flip chart, markers, and name tags.
Handouts: *Icebreaker Examples, Typical List of Ground Rules, Course Objectives*

Time: 30 minutes

Introductions: 10 minutes

- Start the session with greetings and an introduction of the trainer followed by an icebreaker.
  (See *Icebreaker Examples* handout *page 16* for suggestions)
- Ask group to participate in giving ideas for the ground rules of the course.
  Write suggestions on a flip chart paper to be posted in the training room at all times.
  (See *Typical List of Ground Rules* handout *page 17* for suggestions)
- Seat participants seated in a circle. Introduce the toolkit and list the objectives of the course.
  (See *Course Objectives* handout *page 18*)

Activity: Three Way Brainstorm on Tobacco Cessation Work: 20 minutes
The purpose of the following activity is to generate thoughts on tobacco cessation promotion.

- Divide the participants into groups by numbering them off
  (will vary depending on size of main group).
- Give each group a flip chart paper and a marker.
- Tell each group they have five minutes to brainstorm ten ways to promote tobacco cessation and write them on the flip charts.
- After approximately five minutes call time and have each group pass their pages to the group to their left.
- The next group is to pick the five most important points on the page passed to them and cross out the other points.
- After approximately five minutes call time and have each group pass the page to the group on their left.
- The next group is to pick the three most important points on the page passed to them and cannot pick from the crossed out list.
  They can only chose from the 5 points they received.
- After approximately five minutes call time and have each group read out their final three points.
  Write down their responses on a flip chart paper and post the responses on the wall.

ICEBREAKER EXAMPLES

Truth and Lie

Have participants say three things about themselves – two things are true and one is a lie. Other participants guess what the lie is

Do you love your neighbour?

Have participants sit in chairs in a circle. The group facilitator is to stand in the middle of the circle and explain to the participants that he/she will ask one of them the question *Do you love your neighbour?* The participant is to answer either *no* (which means that all participants are to find another seat at least two seats away from the seat they are sitting in) —or to answer *yes* (but only those with any kind of trait such as glasses, black shoes, blue shirts, etc) —which means that only those participants with the trait mentioned will move to another seat. While participants change seats the facilitator sits in one of the seats, thus leaving one participant without a seat. The participant left without a seat then stands in the middle and asks another participant, *Do you love your neighbour?* After the response the person asking the questions runs for an empty seat leaving another participant without a seat and the cycle continues.

End the ice-breaker after five minutes. If you are leaving participants in a circle for the training, have them remain in the seats they are sitting in when the ice-breaker ends.

What's in there?

Have everyone pull out their wallet or purse and pick two items they store away and explain why they keep them (pictures, tickets, receipts, etc.).

Marooned

Tell participants they are marooned on an island. Ask the participants what five (you can use a different number, such as seven, depending upon the size of each team) items they would bring with them, if they knew there was a chance that they might be stranded. Put them in teams and explain that they are only allowed five items per team, not per person. Each team is to place their five final items on flip chart paper. Once this is done participants are bought back into the group at large and are told they must pick only five items for the whole group. It is at this time they can discuss and defend the five items their small group chose. This activity helps them to learn about other's values and problem solving styles and promotes teamwork.

TYPICAL LIST OF GROUND RULES

(Adapted from http://www.who.dk/Document/E73085.pdf)

We agree to:

- Keep confidentiality, do not talk abou each other's personal matters outside the course: What you see here, What you hear here, Let it stay here
- Respect everyone's viewpoint, even if we do not agree with it
- Be punctual in attending, and returning from breaks
- Speak one at a time and listen to each person's contributions
- Respect differences, beliefs, values, traditions, and cultures
- Ask questions if anything is not clear
- Attend all sessions

COURSE OBJECTIVES

The *Keeping the Sacred in Tobacco: A Toolkit for Tobacco Cessation* has been developed as a user friendly tool for NNADAP workers to address tobacco cessation in their communities.

The objectives of the toolkit are as follows:

1. To incorporate a tobacco cessation program into NNADAP organizations.
2. To influence behaviours and attitudes on tobacco smoking, smokeless tobacco and the impact of second-hand smoke among all age groups with a focus on youth through the ongoing work of NNADAP workers in the community and schools.
3. To facilitate community networks to examine protocols, and policies through the ongoing work of NNADAP workers revolving around cessation protocols.

SESSION 2
TOBACCO AND HEALTH

Purpose: This session provides the history of tobacco, information on what tobacco is made of, and tobacco and health.

Objectives: By the end of the session participants will be able to:

- Describe the history of tobacco.
- Describe the main chemical compounds in tobacco.
- Assess personal knowledge about tobacco and health.

Materials: *History of Tobacco, Six Toxins in Tobacco, Smokeless Tobacco, Environmental Tobacco Smoke, and Tobacco Quiz* handouts

Time: 90 minutes

History of Tobacco:

Discussion: 10 minutes

Give participants the *History of Tobacco* handout. Discuss the handout with them *(page 21)*.

Activity: 5 minutes

Have participants discuss how they think that the use and sale of tobacco evolved over time.

Tobacco: 25 minutes

Discussion: 10 minutes

- Tobacco smoke exposes smokers and others, to over 4,000 chemicals; some are toxic, and at least 50 are known to cause cancer. Some of these chemicals include formaldehyde, hydrogen cyanide, carbon monoxide, tar, and arsenic. The amount of chemicals in each cigarette is small; however, it intensifies with each cigarette and even puff of the cigarette.
- First Nation communities are often over-crowded. Due to housing shortages, it is common for multiple or extended families to live under one roof. Because the percentage of First Nation smokers is so high, with the added factor of over-crowded living conditions, ETS is a serious health consideration that needs to be addressed.
- Only a fraction of the tobacco inside a cigarette comes from the leaf of a tobacco plant. What you see inside a cigarette is mostly made up of something called *reconstituted tobacco* or *homogenized sheet tobacco*. These are made mainly from mashed tobacco stems, which are flattened into a sheet. The sheet is sprayed with nicotine and other substances, including as many as 600 chemical additives. Ammonia is used to aid in the delivery of nicotine, and chocolate is used to hide the bitter taste of tobacco. This sheet is chopped up to make it look like shredded leaf tobacco. (http://www.niichro.com/Tobacco%202002/tob02_8.html)
- Cigarette paper is responsible for how fast a cigarette burns and how much smoke it lets out. Like tobacco, cigarette paper contains many chemicals, including titanium oxide, which is also found in jet fuel. It is used to ensure the cigarette does not go out, and enables the smoke to burn evenly with each puff. The chemicals in the paper wrap have contributed to many cigarette-caused fires. Cigarette manufacturers are just now beginning to address this problem. (NIICHRO. http://www.niichro.com/Tobacco%202002/tob02_8.html)

- *Light* tobacco is exactly the same as *regular* tobacco. Cigarettes that are called *light* simply have more holes in the filter. This enables more fresh air to be sucked out when a machine tests the cigarette. The holes make the machine think that there is less tar and nicotine in the cigarette. But in reality, smokers block these extra holes with their mouth while they smoke, and can still draw out the higher nicotine and tar levels they crave. (NIICHRO. http://www.niichro.com/Tobacco%202002/tob02_8.html)
- The addictive agent in cigarettes is nicotine. Nicotine is more addictive than heroin or cocaine.
- Let participants know that people not only smoke tobacco but chew it as well. Ask them if they are aware of this happening in their communities.

Activity: 15 minutes

- Pair participants up and give them the handouts *The Top Six Toxins Found In Tobacco Smoke* and *Smokeless Tobacco (pages 22-23)*. Have them discuss the handouts and what they have learned about tobacco and how this information does or does not influence what they think about tobacco cessation.

Tobacco and Health: 50 minutes

Discussion: 15 minutes

- "Smoking causes more deaths than homicide, suicide, motor vehicle accidents, drugs, alcohol, and AIDS combined." Ask the participants for their reactions to this statement.
- Tobacco smoke contributes to the following diseases or conditions: cancer of the lung, mouth, voice box, throat, kidney, bladder, cervix and bowel, heart attack, impotence, circulatory problems, stroke, lung disease including chronic obstructive pulmonary disease such as emphysema, chronic bronchitis tooth loss, gum disease, contributes to complications in diabetes that lead to loss of vision and amputations.
- Smoking around a child contributes to middle ear problems, coughing, wheezing, asthma attacks, infant mortality, and damage to the unborn child.

Activity: 35 minutes

- Give participants the handout *Environmental Tobacco Smoke (page 24)* and have them get into groups to discuss second-hand smoke, its effects, how smokers contribute to the disease and death of non-smokers, and what they think the solutions might be for this issue.
- Distribute the *Tobacco Quiz (page 25)* to the participants and ask them to answer the quiz in partners.
- Debrief and discuss the answers to the quiz with the participants. *Tobacco and Health Quiz Answers (pages 26)*

HISTORY OF TOBACCO

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THE TOP SIX TOXINS FOUND IN TOBACCO SMOKE

(http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/legislation/label- etiquette/tox/index_e.html)

TAR

In tobacco smoke, tar is a sticky, black residue containing hundreds of chemicals, many of which are considered carcinogenic or classified as hazardous waste. They include polyaromatic hydrocarbons (PAH), aromatic amines and inorganic compounds.

NICOTINE

Nicotine occurs naturally in tobacco plants and is responsible for causing the addiction to tobacco products. It harms your cardiovascular and endocrine systems.

CARBON MONOXIDE

Carbon monoxide (CO) is in tobacco smoke as a result of burning tobacco. It reduces the ability of your red blood cells to deliver oxygen to tissues, causing the greatest potential damage to the heart, brain and skeletal muscles – tissues that have the most demand for oxygen. You're probably also familiar with the potentially fatal effects on people who breathe this colourless, odourless gas also found in automobile exhaust.

FORMALDEHYDE

Formaldehyde is classified by the United States Environmental Protection Agency as a probable human carcinogen. It is registered in Canada as a pesticide. Its health effects can be drastic on smokers and those exposed to tobacco smoke. Eye, nose and throat irritations and other breathing problems are just some of the symptoms.

HYDROGEN CYANIDE

This is considered one of the most toxic agents found in tobacco smoke. Many short and long-term toxic effects of cigarette smoke have been associated with hydrogen cyanide. Frequent exposure to lower concentrations will cause weakness, headache, nausea, vomiting, rapid breathing and eye and skin irritation.

BENZENE

Declared toxic under the Canadian Environmental Protection Act, benzene is believed to harm you at any level of exposure. The International Agency for Research on Cancer describes it as a Group 1 carcinogen.

SMOKELESS TOBACCO

(Adapted from http://www.niichro.com/Tobacco%202002/tob02_5.html)

Smokeless tobacco is usually referred to as chewing tobacco or snuff. Snuff is finely ground tobacco. Chewing tobacco is not actually chewed. A wad of chewing tobacco, called a *quid* or a *chaw*, is placed between the cheek and teeth. This wad is sucked on creating a saliva/chew mixture which is then spit out. It is *dipped* by placing a pinch between the lower lips and teeth.

Chewing tobacco/snuff is not better for you than smoking. It is just as bad, equally addictive, and unhealthy. It contain hundreds of poisons (as well as sweeteners and salts) that can cause seriously health issues including death. Those who *dip* or *chew* get a quicker buzz from nicotine than cigarette smokers do. The blood level of nicotine is just as high or higher in smokeless tobacco users as it is in cigarette smokers. Smokeless tobacco users become equally addicted to chewing tobacco as smokers do to cigarettes.

Statistics show that more youth at very young ages are trying and using smokeless tobacco. This is especially dangerous as it leads to addiction at a very early age.

Smokeless tobacco is associated with significant health risks. Some of the health effects of smokeless tobacco include mouth cancer, throat cancer, heart disease and stroke, gum disease, stomach ulcers, problems with the urinary tract, and bladder.

Other unpleasant side effects include bad breath, black hairy tongue, stained teeth, tooth loss, difficulty tasting/loss of taste (leads to increased sugar and salt consumption), excess saliva, and a need to spit.

ENVIRONMENT TOBACCO SMOKE

(Adapted from NIICHRO: http://www.niichro.com/Tobacco%202002/tob02_5.html

Environmental tobacco smoke (ETS) is a combination of smoke that comes from the burning end of a cigarette, pipe or cigar (also known as side-stream smoke) and the exhaled smoke from a smoker's lungs (also known as second-hand smoke).

Second-hand smoke is the opposite of mainstream smoke, which is smoke directly inhaled by the smoker. The term for a person who gets exposed to environmental tobacco smoke is a passive smoker. Passive smokers are those who are not smoking but are in sufficiently close proximity to someone who is smoking that they necessarily breathe in the side-stream smoke and the second-hand smoke.

At least two-thirds of the smoke from each cigarette goes into the environment, even when smokers are inhaling. The home, workplace and public gathering spaces are locations where people who are not smoking are exposed to this environmental smoke. In the home, children are especially vulnerable to exposure from adult smoke.

ETS contains over 4,000 chemicals, many of which cause cancer. ETS is more dangerous than mainstream smoke. There is over three times the amount of tar, and over six times the amount of nicotine in ETS than in smoke that is inhaled directly into the lungs by a smoker. An estimated 4,000 people are killed annually in Canada by ETS. ETS causes short-term health problems and discomfort, including nasal discomfort, eye irritation, headaches, nausea and dizziness, and allergic reactions. Long-term health problems also result directly from the inhalation of ETS, including various cancers.

Spouses of smokers have a 34 per cent higher risk of getting lung cancer than those whose partners are non-smokers. Children who are exposed to ETS are twice as likely to suffer from respiratory diseases such as asthma, bronchitis, and pneumonia. Non-smoking pregnant mothers who are near smokers also place their babies at high risk. First Nations communities are often over-crowded, and because so many people in the community smoke, ETS is a serious health consideration that needs to be addressed.

TOBACCO AND HEALTH QUIZ

1. It is just like inhaling car exhaust when you smoke a cigarette.
T **F**

2. It is harder to quit tobacco than heroin or cocaine.
T **F**

3. Tobacco smoke contains about 500 different chemical compounds.
T **F**

4. Smoking causes early tooth decay and gum disease.
T **F**

5. Sacred tobacco is not harmful if used in the traditional manner.
T **F**

6. If someone has smoked for 25 years they have probably brought so many health problems on themselves that they shouldn't bother to quit.
T **F**

7. Smokers are only harming themselves.
T **F**

8. Women who stop smoking before pregnancy have smaller babies than those who never have smoked.
T **F**

9. Smokers do not pay attention to mental health or addictions workers who tell them it would be in their best interest to quit.
T **F**

10. You have to smoke traditional tobacco to use it
T **F**

11. How toxic is nicotine?
- **a** not toxic at all
- **b** somewhat toxic
- **c** only toxic when combined with other substances found in tobacco products
- **d** toxic in high doses

12. What percentage of lung cancer deaths are smoking related?
- **a** half
- **b** three quarters
- **c** all

13. Sacred tobacco is to be used
- **a** at parties
- **b** as medicine and for prayers
- **c** never

TOBACCO AND HEALTH QUIZ ANSWERS

1. It is just like inhaling car exhaust when you smoke a cigarette.
True: You take in the same thing that comes out of the tail pipes in cars when you smoke a cigarette.

2. It is harder to quit tobacco than heroin or cocaine.
True: This is why people are addicted to smoking. Think before you start.

3. Tobacco smoke contains about 500 different chemical compounds.
False: There are at least 4000 and approximately 50 of them are known to cause cancer

4. Smoking causes early tooth decay and gum disease.
True: Dentures anyone?

5. Sacred tobacco is not harmful if used in the traditional manner.
True: Traditions teach that tobacco is not to be inhaled

6. If someone has smoked for 25 years they have probably brought so many health problems on themselves that they shouldn't bother to quit.
False: health risks begin to dwindle immediately, and after fifteen years of abstaining from smoking your risks of acquiring lung and heart disease are the same as any other non-smoker.

7. Smokers are only harming themselves.
False: Being exposed to other people's cigarette smoking gives you a 10-30% higher risk of lung cancer. It also causes health risks for children, asthma, and heart disease.

8. Women who stop smoking before pregnancy have smaller babies than those who never have smoked.
False: Those who stop smoking before pregnancy have babies the same birth weight as mothers who have never smoked.

9. You have to smoke traditional tobacco to use it.
False: Tradition says just the opposite

10. Smokers do not pay attention to mental health or addictions workers who tell them it would be in their best interest to quit.
False: Even brief advice from a mental health of health care professional results in and increase by 2% of smokers quitting. If more intensive interventions and programs are available there are more people who quit and remain non-smokers.

11. How toxic is nicotine?
d It is toxic in high doses.

12. What percentage of lung cancer deaths are smoking related?
b Three quarters: This is from the tar found in cigarettes. Tar is carcinogenic and very few other things cause lung cancer. The risk of lung cancer increases with how much and how long you smoke. Quit while you are ahead!

13. Sacred tobacco is to be used
b as medicine and for prayers

SESSION 3
TRADITIONAL USE OF TOBACCO

Purpose: This session presents a general picture of *traditional uses of tobacco*. Participants will examine the *sacredness of tobacco*.

Objectives: By the end of the session participants will be able to:

- Identify traditional uses of tobacco
- Discuss the difference between the *sacredness of tobacco* and the day-to-day abuse of tobacco through the practice of smoking
- Determine how to present the concept of 'traditional use of tobacco' in First Nation communities.

Materials: *Traditional Use of Tobacco* handout

Time: 30 minutes

Discussion: 5 minutes

If possible, have an Elder(s) present this session.

- This session will be very general and *pan-Indian*, since each Nation has its own ways of being and doing. Let the participants know that the Elders of their community will be the experts in this area and it is important that they include them in their tobacco cessation work.

Activity: 5 minutes

- Have participants brainstorm traditional ways that tobacco is used. Post their answers on flip chart paper and place it on the wall.

Discussion: 5 minutes

- If Elders are available have them talk about the traditional use of tobacco. If not, give the participants the handouts *Traditional Use of Tobacco* and *What Elders Say About the Traditional Use of Tobacco (pages 28-29)*

Activity: 5 minutes

- Have participants group into pairs and compare and contrast the traditional and non-traditional use of tobacco.

Discussion: 5 minutes

- Many First Nations receive revenue from tobacco. In those communities it could be more difficult to implement tobacco cessation. Get participant ideas and comments on this issue.
- Some First Nations are growing their own tobacco and distributing it for ceremonies so that commercial tobacco does not have to be used.

Activity: 5 minutes

- Facilitate a group discussion on how to deal with people who say they do not have to quit smoking because tobacco is sacred and part of First Nation culture.

TRADITIONAL USE OF TOBACCO

Tobacco is one of the four sacred medicines (Tobacco, Sage, Cedar, and Sweetgrass) given to First Nation peoples. It is used for communication with the Creator and the grandmothers and grandfathers (ancestors). It is used for purification, decision-making, prayer, giving thanks, as well as an offering.

Tobacco is often used in sacred fires where its smoke carries prayers to the spirit world. It is also placed on Mother Earth as an offering of thanks. It is carried in medicine bundles. Tobacco is given as a special gift to Elders and other respected people when seeking advice, wisdom, and knowledge. Tobacco is also used in ceremonial Pipes which are sacred and have many meanings and uses. Elders are the appropriate people to teach about the Pipe and Pipe ceremonies.

The growing and picking of tobacco should be done through ceremony and is considered sacred. Once tobacco is used in ceremony, Elders tell us that it was (and often still is) mixed with other plants and should not used more than one to three times a day. They also tell us that tobacco was never meant to be inhaled and that people were and should still be instructed never to put the smoke into their bodies through inhalation.

Many Elders carry forth the traditional teachings and uses of tobacco. To this day many First Nation peoples everywhere still use this sacred plant in ceremonies, and it is still used as gifts to honour traditional teachers and Elders.

The commercial tobacco used in the present has little or no connection with First Nation spirituality. It is not grown in a sacred manner; it is inhaled or chewed; and harmful chemicals are added to it during the manufacturing process. It is time to bring back the teachings that pertain to tobacco and to honour and use tobacco as the sacred plant and medicine that it is!

WHAT ELDERS SAY ABOUT THE TRADITIONAL USE OF TOBACCO

Below are three quotes by Elders from Quebec, Saskatchewan and Albert, about the traditional use of tobacco.

"For us, tobacco is sacred. In the older teachings of what it was all about, it was very important to see that it was sacred. A lot of us have forgotten the sacred purposes of tobacco, for various reasons."

—Dennis Nicholas, Kanehsatake Elder, March 2002.
(http://www.niichro.com/Tobacco%202002/tob02_4.html)

"Tobacco was seen by our people as a gift from the Creator which would enable us to communicate with him. We were given tobacco because it affected the way we were able to think…We were given knowledge to fashion a pipe with which we could take very small puffs of tobacco smoke. We would only take small puffs, and then we would immediately blow out the smoke because smoke was not meant to be taken into our body and held there. The smoke needed to leave us in order to rise to the Creator with our prayers and thoughts. If we held it in our body, it would be an unnatural presence there.

Immediately after taking the puff of smoke, our minds would race, and our whole body would be affected by this smoke since tobacco is a very powerful medicine. It has a specific purpose which must not be abused."

—Elder Danny Musqua, Wunska.
(First Nations Youth Inquiry into Tobacco use: Final Comprehensive Report to Health Canada, [Saskatchewan Indian Federated College, April 1997], p.52).
(http://www.ayn.ca/quit/en/c3_2spiritual_use.asp)

"If you have ever been in the sunlight and watched the smoke - it doesn't go up, it goes down toward the floor, and that is where the kids are. In the pipe ceremony the pipe smoke goes straight up because the smoke carried the prayers right up."

—Anonymous Elder, Alberta.
(http://tobacco.aadac.com/programs/community_programs/aboriginal_tobacco_strategy/Aboriginal%20Tobacco%20Use%20Strategy.pdf)

SESSION 4
TOBACCO CESSATION

Purpose: This session introduces the participants to tobacco cessation, the need for it, what it entails, and who is involved.

Objectives: By the end of the session participants will be able to:

- Describe the use of tobacco in First Nation and Inuit communities.
- Define tobacco cessation.
- Identify the tobacco cessation process.
- Generate ideas for best practices in tobacco cessation.

Materials: Flip chart, and markers.
Handout: *First Nations Inuit Tobacco Control Strategy: A Framework*.
Four Components of the Federal Tobacco Control Strategy,

Time: 70 minutes

Brief Information on Tobacco Use Statistics in First Nations and Inuit Communities: 7 minutes

Provide participants with the following statistics:

- In Canada in general about 25% of the population smoke.
- Prior to 2004 approximately 62-70% of First Nation people were smokers.
- Studies of First Nations (On-Reserve) and Inuit conducted by the Environics Research Group, NAHO, and Statistics Canada in 2004 indicated that between 56.9-59% of First Nation people were smokers.
- Prior to 2004, approximately 72% of Inuit people were smokers.
- 2004 studies indicate that approximately 66-71% of Inuit smoke.
- 71% of First Nation people in the Northwest Territories smoke.
- 51% of First Nation people in British Columbia smoke.
- The largest demographic population group within First Nations is the youth. About 30% of First Nations are under 25 years old. This means, in conjunction with the above statistics, First Nations youth are smoking at an alarmingly high rate.
- According to Stats Canada's 1991 Aboriginal Peoples Survey:
    - 54% of Aboriginal teenagers smoke and rates increase to 65% for those aged 20-24.
    - By age 19, 71% of Inuit smoked.
    - 12% of boys and 7% of girls use chewing tobacco.
    - Some boys and girls start using chewing tobacco between the ages of five and nine.
- According to Health Canada's First Nations and Inuit Regional Health Survey conducted in 1997:
    - 45% of Aboriginal males use tobacco.
    - 23% of non-Aboriginal males use tobacco.
    - 44% of Aboriginal Females use tobacco.
    - 21% of non-Aboriginal females use tobacco.
- The average age that First Nations children start smoking is nine.
- The average age that non-First Nations children start smoking is 18.
- The high rate of youth tobacco user has concerning health implications. Therefore First Nation youth should be one of the main target groups for those who work in tobacco cessation.
- Exposure to second-hand smoke in First Nation or Inuit communities is double that of the Canadian population.

- First Nation and Inuit mothers are more likely to be smokers and/or to be exposed to second-hand smoke.
- Many First Nation communities have limited access to screening and early detection for cancer. As a result First Nation people will have later stage diagnosis contributes to poor survival rates.
- Approximately 50-60% of smokers will die of smoking related illnesses.

Activity: 3 minutes

- Have participants respond to these statistics and how they relate to tobacco use in their communities.

Tobacco Cessation: 30 minutes

Discussion: 10 minutes

- Ask participants to define tobacco cessation. Post their responses on flip chart paper. After this is done, discuss with participants the following points.
- Tobacco cessation is a process where smokers and those who use smokeless tobacco will gradually work at quitting the use of tobacco.
- Tobacco cessation is being addressed in Canada and in First Nation and Inuit communities and there are programs that are working to reduce the prevalence of tobacco misuse.
- Tobacco cessation will help reduce the extremely high health risk levels associated with tobacco misuse.
- First Nation and Inuit health will improve through tobacco cessation programs and thousands of lives will be affected.
- Tobacco cessation is being addressed by Health Canada through an overall Tobacco Control Strategy and by its First Nations and Inuit Tobacco Control Strategy.
- The overall purpose of the First Nations and Inuit Tobacco Control Strategy.
- Is to reduce smoking rates among First Nation and Inuit communities.
- The long term goal of the First Nations and Inuit Tobacco Control Strategy is to decrease the illness and deaths resulting from smoking and smokeless tobacco use among First Nations and Inuit communities.
- First Nation and Inuit cessation programs must have the participation of First Nation and Inuit peoples.
- First Nation people must be trained to deliver these programs.
- It is important to understand and respect the traditional uses of tobacco and incorporate this knowledge into First Nation tobacco cessation programs.
- There are four important components of the Federal Tobacco Control Strategy: Protection, Prevention, Cessation and Harm Reduction.
- The goals of a comprehensive tobacco cessation program are to reduce disease, disability, and death related to tobacco through prevention, promotion, and protection.
- Prevention involves preventing the start of tobacco use.
- Promotion involves the promotion of tobacco cessation.
- Protection involves eliminating exposure to second-hand smoke.

Activity: 20 minutes

- Give participants the handout *First Nations Inuit Tobacco Control Strategy: A Framework (pages 33-36)* and have them discuss it in groups to determine how they can use the document in their workplace and communities.
- Divide participants into groups and give group members the handout *Four Components of the Federal Tobacco Control Strategy (page 37)*.
- Assign each group one of the components and have them design a way to use this component in a *tobacco control strategy* in their community. Have the groups share their plan with everyone when they are done.

Tobacco Cessation Best Practices: 30 minutes

Discussion: 30 minutes

- There are many ways to address tobacco cessation and each Nation has their own ways of doing things. It is helpful to learn about some of the ways other communities have been successful in working with tobacco cessation.
- A *Best Practice* is generally accepted as the best way of doing something. In First Nation tobacco cessation this would include the activities and/or programs that are successful and readily accepted. These practices may vary from community to community.
- It is important to learn about activities and programs that are being used in other communities to address tobacco cessation.
- As you learn about Best Practices share them with your community and use them as a guideline, but always remember that each community knows what they need.

Activity: 20 minutes

- Have participants brainstorm ideas for best practices in tobacco control. Post their ideas.
- Divide the participants in groups and have them design a plan of action for tobacco cessation in their community.

FIRST NATIONS AND INUIT TOBACCO CONTROL STRATEGY A FRAMEWORK

(Adapted from http://www.naho.ca/english/pdf/FNITCS.pdf)

Collaborators - First Nations and Inuit Tobacco Control Strategy Advisory Circle:

C Carry, S Clark, S Deranger, L Dessureault , B Downey, M Doyle, L Garrow, T Gibbons, D Hache, S Hardy, M Horn, P Janyst, R Jenkins, M Leblanc, S McGregor, L Okalik , P Peter, T Porter, VR Ramsden, L Roberts, B Roos, D Schwartz, P Selby, V Stevens, R Thatcher, D Schwartz, P Selby, V Stevens, R Thatcher

Introduction:

- Misuse of tobacco is placing at high risk the health, quality of life and even life expectancy of a very large number of adults and children in First Nations and Inuit communities. Nations and Inuit communities.
- The prevalence of regular smoking and smokeless tobacco habits among First Nations and Inuit people is more than double the rate for the rest of Canada.
- The First Nations and Inuit Tobacco Control (FNITC) Strategy is one component of the Federal Tobacco Control Strategy (FTCS). The latter Federal strategy builds upon the previous Tobacco Control Initiative, a three year program that ran program that ran until 1997, and emerges from the National Tobacco Control Strategy introduced in 1998, and adds substantially more resources to the Government of Canada's tobacco control efforts First Nations and Inuit communities.

Target Population:

- First Nations people living on reserves south of 60 latitude;
- First Nations communities north of 60° latitude;
- Inuit in Inuit communities.

Within these population groups, the Strategy will give special emphasis to tobacco control among pregnant women and youth, as well as, to reducing the exposure of non-smokers to second-hand smoke.

Program Vision:

The First Nations and Inuit Tobacco Control Strategy vision for the future can be stated as follows:
Healthier First Nation and Inuit communities, free of tobacco misuse and addiction.

Program Mission:

To promote and support policy, project initiatives and the program vision. To create healthy First Nation and Inuit communities free of tobacco misuse and addiction.

Guiding Values:

- Respect
- Trust
- Responsibility
- Freedom
- Holism
- Kindness
- Humility

Program Objectives:

- To build capacity within First Nation and Inuit communities to develop and deliver comprehensive culturally sensitive and effective tobacco control programs at a pace acceptable to those communities.
- To promote the health of First Nation and Inuit people by decreasing the prevalence of tobacco smoking and smokeless tobacco use among all age groups, but in particular among youth and pregnant women.
- To decrease the uptake of smoking among youth.
- To decrease the impacts of environmental tobacco smoke on the health of First Nations and Inuit.
- To engage the leadership of First Nations and Inuit in learning about, voicing opinions and supporting tobacco control strategies.

Intended Program Impact:

- Leadership support for tobacco control strategies will increase over the life of the FNITC Strategy and tobacco control will be increasingly recognized as a health priority in First Nations and Inuit communities.
- Over the years of the Strategy's implementation, smoking prevalence in Canada among adult First Nations people on-reserve and Inuit in Inuit communities will be reduced, with reductions occurring in each year the program operates.
- Youth smoking rates will be reduced over the life of the program.
- The rates of smokeless tobacco use among youth will be reduced.
- Each region will witness substantially reduced smoking rates.
- Over the life of the program, an increasing percentage of residences and shared spaces on-reserves and in Inuit communities will be free of commercial tobacco smoke.

Development and Implementation Principles:

- Staged program development.
- Efficiencies and economies should be realized through partnerships.
- Emphasis on capacity– a process grounded in relationship building and trust.

Capacity-building should be realistic, with a view to "building best practices with communities" and to sustainable development within the community.

- Community-Based Project Initiatives will reflect local needs, National Guidelines and Regional Planning Priorities, while meeting Quality Assurance Standards.
- The National Dimension of the Program Partnership is essential.
- Emphasis on Regional Planning that is based on collaboration with communities.
- Project Funding will be Proposal Driven.
- Contemporary health promotion approaches [evidence- based practice] will be utilized

In message diffusion, attempts to influence behavioural change should emphasize the positive rather than the negative, thus, the Strategy should build on the strengths rather than weaknesses. The *tone* of educational and information-sharing materials needs to be positive, candid and assertive.

Implementation Goals:

1. **Establishing a strong foundation.**
2. **Facilitating leadership support.** *The First Nations and Inuit Tobacco Control Strategy (FNITCS) will engage in a facilitative process with First Nations and Inuit and community influentials intended to identify tobacco as a health priority and to integrate appropriate tobacco control strategies into existing and future programs and policies.*
3. **Collaborative Strategy-Building and Program Development.** *Regional First Nations and Inuit Tobacco Control Plans will be developed in collaboration with First Nations and Inuit communities.*
4. **Common Program Elements in Distinctive Regional Strategies.** *All regional tobacco control plans will include the elements of prevention, cessation and protection.*
5. **Comprehensive Evaluation to Gain Knowledge of Effective Practices.** *All national plans, regional plans and community projects will include some elements that contribute to an evaluation process. An ongoing, comprehensive evaluation plan will be developed and its recommendations implemented. It will include both process and outcome dimensions.*

Building Best Practices with the Community:

- The "Building Best Practices with Community" Model is based upon the traditional values of respect for others, building trust in relationships, responsibility of the individual and community, freedom of the individual, holism, kindness, compassion and humility.
- This model bridges a gap between science and community action by striving to build upon existing evidence and knowledge, and working with the community to raise the level of awareness regarding smoke smoke-free spaces and the misuse of tobacco.
- The model stresses the use of fully participatory methods when working with communities.
- It respects First Nation and Inuit communities by recognizing that they have the knowledge and are capable of working out their own unique solutions to the challenges that they face, such as dealing with the health risks of tobacco use.
- It promotes teamwork among individuals, health workers, health care practitioners and other service agencies in the communities, both government and non-government.
- It offers the hope of holistic and innovative solutions that are made possible when individuals with all kinds of resources and skills work together to solve a problem.
- It offers opportunities for joint funding of innovative projects which are affordable, practical and accountable.

Context:

"Health promotion is the process of enabling people to increase control over, and to improve their health. Health is, therefore, seen as a resource for everyday life, not the objective of living."

Ottawa Charter for Health Promotion, 1986 Ottawa Charter for Health Promotion, 1986

Stories integrated into the world of logic/science add significance to the relationship, organization and individuals. Trusting people to solve problems generates higher levels of motivation and better solutions.

Bolman LG & Deal TE (2001). Leading with soul: An uncommon journey LG & Deal TE (2001). Leading with soul: An uncommon journey of spirit. San Francisco, CA: of spirit. San Francisco, CA: Jossey-Bass. Bass.

Moving from a hierarchical culture (competitive) to a culture of empowerment (collaborative) is and always has been a huge undertaking but it is possible.

Blanchard K, Carlos JP & Randolph A (2001). The 3 keys to empowerment: Release the power within people for astonishing results. San Francisco, CA: Berrett-Koehler Publishers, Inc. Koehler Publishers, Inc.

Outcomes of Participatory Methods

- People gain a sense of confidence in their ability to make and facilitate change.
- People develop a wide range of skills— negotiation, reflection and *working with.*
- People begin to understand personal success and are then able to build upon what they what they know from their experiences.

Conclusions

Changing behaviour is a process and not an outcome, thus, health care practitioners are often discouraged by *working with* due to the lack of predictable outcomes.

The wisdom of the individual once recognized, respected and validated will support and enhance the capacity for transformation.

The strength of participatory methods of learning, evaluation and research are that we learn together what the reality in the community is not what we perceive it to be!

The *silent voices* of the community speak when invited to do so.

Evaluation Plan

The FNITCS Evaluation Plan will include both process and outcome data-gathering processes and will guide evaluation processes in community-based projects, regions and the overall program. It will examine how and how well the program was implemented and how to measure outcomes prescribed by projects and targets.

The guidance given will include information on utilization of participatory research/evaluation methods integrated with action research.

FOUR COMPONENTS OF THE FEDERAL TOBACCO CONTROL STRATEGY

PROTECTION

This component is designed to reduce access to tobacco and to regulate the manufacture and sale of the product. This can be accomplished through a variety of mechanisms such as: creation of an environment (physical, legal or regulatory) that supports non-smoking as the norm in Canada, and developing policies and regulations which protect both smokers and non-smokers and ensure that tobacco is not sold to minors.

PREVENTION

This component aims to contribute to a reduction in smoking uptake by youth, a reduction in the number of smokers in Canada, and a reduction in the number of Canadians who are involuntarily exposed to second-hand tobacco smoke.

CESSATION

This component is designed to contribute to a reduction in the number of smokers in Canada, and a reduction in the number of Canadians who are involuntarily exposed to second-hand tobacco smoke.

HARM REDUCTION

This component represents a new initiative in tobacco control that is aimed at reducing harm to smokers and those exposed to tobacco. This is viewed as a longer term component of the Tobacco Control Strategy.

SESSION 5
PROCESSES OF CHANGE

Purpose: This session introduces the stages and process of change that can be used as tools in tobacco cessation consultations.

Objectives: By the end of the session participants will be able to:

- Describe the course of action that people go through as they implement change.
- Identify the stages and process of change.
- Describe how the empowerment process contributes to tobacco cessation.

Materials: *Stages of Change Questions* and *Stages of Change Answers* handouts.

Time: 70 minutes

Stages of Change: 20 minutes

Discussion: 10 minutes

Model:

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

- Prochaska and DiClement are renowned for their theory and model on stages of change. They have pinpointed and outlined a series of stages that people pass through as they make behaviour changes. Prochaska and DiClement indicate that at each stage a person thinks and feels differently about the behaviour and find different processes and interventions to help them move on. Their model is based on cycles of change and they state that before anyone enters into these cycles they are said to be in *precontemplation*.
- In precontemplation, a person is not interested in change for a variety of reasons: they do not see their behaviour as a problem; they do no know that it is causing or putting them at risk or; they are fully aware of the risks but value what they are doing more than they wish to change.
- Raised awareness or concern about risks associated with the problem can lead the person toward the *contemplation* stage. In this stage a person is confused about what he or she feels. This person is aware that he or she should change but is too drawn to the behaviour. Thus, people may not be ready to change and could stay in the contemplative stage for years even though they continue to think about making a change the whole time.
- Once people begin to make some small changes and try out different ways to behave they are in the *preparation* stage. Here they may tell others about their intention to change and begin to make clear plans on how they are going to go about changing.
- It is in the *action* stage that people visibly make changes and put lots of energy into making change. It is during this stage that people seek out professional helpers or self-help groups.

- The action stage is followed by the *maintenance* stage. In this stage behavioural change is continued and made stronger. The temporary changes people made in the action stage become more a part of a pattern. This is key because an action is not made stronger and maintained, a person will enter into the relapse stage and go from there to precontemplation and contemplation once again.
- If no relapse occurs and successful changes are made through all stages until people can maintain their changes so well that they exit the cycle. At this point people's behaviour changes become an established way of living.
- Some people are in a hurry to change and move too quickly through the stages or even skip stages. If the contemplation or preparation stages are rushed, there is a greater risk of relapse since the decision to change and the plan to support this change are not sound.

Activity: 10 minutes

- Place participants in pairs and have them discuss a behaviour change they made in their lifetime. As they do this have them map out the stages of change that applied to the actions they took.

Process of Change: 35 minutes

Discussion: 15 minutes

When people change their behaviours they become aware of themselves and how the behaviour they want to change affects their lives. They become more aware and in tune with the following:

- Awareness of themselves.
- Awareness of the effect the behaviour they want to change has on them.
- Feelings about the behaviour they want to change.
- Self image.
- Thought processes.

As people go through the stages of change they also go through a number of processes. Literature reveals that there are nine processes of change:

1. Consciousness raising
2. Social liberation
3. Emotional arousal
4. Self re-evaluation
5. Commitment
6. Rewards
7. Countering
8. Environmental Control
9. Helping Relationships

Let's examine what each stage involves. (Adapted from http://www.who.dk/Document/E73085.pdf)

1. Consciousness Raising

This is a process in which a person becomes informed and begins when a person gains increased knowledge of him or herself. This can occur through reading, attending workshops, attending or learning about traditional ceremonies, or becoming aware of his or her behaviour patterns through keeping a diary/journal or receiving feedback from others.

2. Social Liberation

This process is seen differently by people at different stages of change. Social liberation comes from outside forces that arise from environmental changes. For example, if a Bingo hall is made a no smoking area, people who are in the precontemplation stage might become more aware of how important smoking is to them and how they feel after not having a cigarette while they are in the building. This may raise their consciousness about how dependent they are on smoking. However, people in the maintenance stage might find that a no smoking rule is supportive to them as playing bingo might be a high risk place for maintenance of their smoking behaviour.

3. Emotional Arousal

This is called a *catharsis* which is a major emotional experience that is triggered by an event that is related to the behaviour people are engaged in. It can result as a tragedy such as the ill-health or death of a loved one which can lead someone from the precontemplation to the contemplation stage.

4. Self Re-evaluation

This process often occurs in the contemplation and preparation stages. It is a process where one creates a new image for his or herself. Here one thinks through how he or she perceives him or herself, what his or her important values and goals are and how one's behaviour fits or conflicts with his or her values. During this process one often weighs the pros and cons of changing his or her behaviour.

5. Commitment

Commitment is important in the preparation, action and maintenance stages of change. It comes as one accepts responsibility, chooses to change, and takes appropriate actions to change. Commitment is very important and it is for this reason that self help groups encourage public statements of commitment. It appears that when a private commitment is made public there is a type of social pressure to support the change.

6. Rewards

When people are in the action stage, they find different ways to reward themselves for behaviour change. For example they might use self-praise or get praise from friends, family, or co-workers. Some people buy themselves presents or save the money they might have spent on tobacco (or other behaviour) and use it to buy something they could not afford before. Rewards are more important in the action stage, because it takes time to see the benefits of the change. Some benefits, such as *reduced health risk* are not clearly visible and less apparent.

7. Countering

People who are in the action and maintenance stage use countering. This is a time when people use substitutes for their behaviour. It is a time when healthy behaviours replace harmful ones. This is where healing, traditions, and learning about culture come into play. Mood changing activities like listening to music, physical activity, and relaxation therapies are some examples of countering. Another example is becoming involved in any healthy activity that distracts you from thinking about or craving tobacco.

8. Environmental Control

It is helpful to control the environment around you so that you can reduce temptations. This helps the healthier behaviours become easier to choose than the unhealthier ones. For example, if you quit smoking, you might want to stay away from places where people smoke all the time.

9. Helping Relationships

This is an important process and the role can be filled by anyone. This includes, a health professional, mental health, addictions workers, a member of a self-help group, a family member, friend, Elder, minister, co-worker, etc. Keep in mind, that people need different types of help at different stages and times. They seek this process the most when they are in the action and maintenance stages. Interestingly, mental health and addictions workers and other health professionals tend to want to provide a helping relationship during the precontemplative, contemplative, and preparation stages.

Activity: 25 minutes

- Divide participants into groups and give them the handout *Stages of Change Questions (pages 42-45)*. Have the group answer the questions. Discuss the answers in the main group. Give the participants the *Stages of Change Answers (pages 46-47)* handout and allow enough time to review Answer handout and any discussion following that.
- Have participants discuss how this activity and session will help them assist their clients to use the outlined processes as they move through the stages of change.

Empowerment: 15 minutes

Discussion: 5 minutes

- As people change they become empowered. As they become empowered they make healthy life choices and help others and their communities to become empowered. The empowerment process is much like the processes and stages of change. The process of empowerment involves three stages as well: intra-personal, interpersonal, and community empowerment.
- Intra-personal empowerment comes from learning and being with other people. It comes from realizing the causes and effects of behaviours and systems. It helps people to see outside the box and not fall into victim mentalities
- Interpersonal empowerment is when a person looks inside, makes changes, and feels good about who they are and where they are going. Interpersonal empowerment often comes as a result of intra-personal empowerment.
- Community empowerment occurs when individuals in a community have become empowered. They bring forward the enthusiasm and knowledge they acquired from intra and interpersonal empowerment. This in turn empowers the whole community.

Activity: 10 minutes

- Divide participants in groups and have them outline the empowerment process and how it contributes to tobacco cessation. Make sure they give tobacco cessation examples for each stage.

STAGES OF CHANGE QUESTIONS

(Adapted from http://www.who.dk/Document/E73085.pdf)

Consider the 10 actions listed below. Each might trigger one or more of the processes of change. Beneath each action, write down the processes that might be engaged by this action and circle one or more of the answers (as many as you wish) to indicate at which stage or stages someone would find this action helpful.

1. Keeping a diary/journal recording your smoking pattern for a day.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

2. Joining a smoking cessation group

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

3. Telling friends and family that you have decided to stop smoking

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

4. Receiving medical test results that show that your smoking is beginning to cause real damage to your health.

Processes:

_____

_____

_____

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

5. Weighing up the costs and benefits of smoking for you.

Processes:

_____

_____

_____

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

6. Watching a TV film about someone with a very unhealthy lifestyle dying from heart disease.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

7. Declaring your office, your bedroom or your car, a smoke-free area and putting up a no smoking sign.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

8. Buying yourself a small present as a reward for stopping smoking for a month.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

9. Learning relaxation skills.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

10. Attending traditional ceremonies.

Processes:

Stages: (circle one or more)

- precontemplation
- contemplation
- preparation
- action
- maintenance

STAGES OF CHANGE ANSWERS

(Adapted from http://www.who.dk/Document/E73085.pdf)

Each of the activities considered in this exercise might trigger one or more of the processes of change and thus be more useful in some stages than others. Below are some examples of how individuals might respond to these activities.

Please note: Processes are bolded and stages of change italicized.

1. **Keeping a diary recording your smoking patterns for a day.**

   This will inform the smoker about his or her behaviour and might **raise consciousness** of the pattern of the behaviour, its implications and consequences. Used in this way it is most helpful in the *precontemplation* and *contemplation* stages. Someone in preparation might use a diary to identify triggers to the behaviour and thus construct a good action plan, using substitutes as **countering** strategies.

   Some people keep a diary to record their efforts at change. If the efforts are at least partially successful the diary may serve as a **reward** in the *action* or *maintenance* stage.

2. **Joining a smoking cessation group.**

   This may fulfil a number of functions. Commonly, it is a part of the process of **commitment** to a new way of life, it provides **rewards** and supportive **helping relationships**. Therefore it is most likely to be of value in the *preparation, action,* and *maintenance* stages.

3. **Telling friends and family that you have decided to stop smoking.**

   This is an expression of **commitment** and may lead to enlisting **support** and help with **rewards** or **environment control**. It is useful in the *preparation, action,* and *maintenance* stages.

4. **Receiving medical test results that show that your smoking is beginning to cause real damage to your health.**

   This information may well lead to **raised consciousness** and **emotional awareness** so will have most impact in the *precontemplation, contemplation* and *preparation* stages.

5. **Weighing up the costs and benefits of smoking for you.**

   This will lead to **self re-evaluation** and considering a **new self-image** and will be most useful in the *contemplation* and *preparation* stages.

6. **Watching a television film about someone with a very unhealthy lifestyle dying from cancer.**

   This may lead to **emotional arousal** or to **consciousness-raising** and will be useful in the *precontemplation* or *preparation* stages.

7. Declaring your office, your bedroom, or your car a smoke-free area and putting up a no smoking sign.

This may reinforce **commitment** and be a way of **controlling the environment**. It is most likely to be used by people in the *preparation, action* and *maintenance* stages.

8. Buying yourself a small present as a reward for giving up smoking for a month.

As a **reward** this will be useful in the *action* and *maintenance* stages.

9. Learning relaxation skills.

Using relaxation skills is **countering**; using a substitute way of relaxing. Someone might learn these skills during *preparation* and then use them in the *action* and *maintenance* stages.

10. Attending traditional ceremonies.

Attending a traditional ceremony indicates a **commitment**. It also is part **of countering**, as it substitutes a healthy behaviour for an unhealthy one, and is definitely part of a **helping relationship**, since we heal through spirituality and a return to our cultures and traditions. This can be used in all stages of change.

SESSION 6
RESISTANCE TO CHANGE

(Adapted from http://www.who.dk/Document/E73085.pdf)

Purpose: This session assists participants to realize that reluctance to change is a normal part of the change process. It explores the factors that contribute to unwillingness to change in the *precontemplation* and *contemplation* stages.

Objectives: By the end of the session participants will be able to:

- Identify ways people show resistance to tobacco cessation advice.
- Describe reasons why people are attached to unhealthy behaviours.
- Describe how intervention styles can cause or reduce resistance.

Materials: *Why Smokers Sometimes Resist Change* handout.

Time: 60 minutes

Discussion: 5 minutes

Review the stages and processes of change with participants. Tell them that this session will focus on the precontemplation and contemplation stages where reluctance to change occurs most often.

Activity: 25 minutes

Have the participants do the following exercise in pairs.

- Each person tells their partner about a *bad habit* he or she has.
  The partners then take turns giving strong advice on how to change this *bad habit* to each other.
- Each person discusses their responses and what it felt like to be given strong advice about change.
- Facilitate a discussion on how many people found themselves resisting strong advice and how they showed this resistance: arguing, non-verbal responses, pretending to respond and to have a willingness to change that was not real.
- Have participants discuss how strong advice or confrontational methods of implementing change affects people especially in precontemplative and contemplative stages of change. Have them discuss how this style might be taken differently if they were in other stages of change such as action or maintenance.

Discussion: 5 minutes

Now that we see how strong advice and confrontation may work on clients who are thinking of change, we need to look at some alternatives. One of these is the use of empathy. This approach aims to get addictions workers and their clients working together in confronting tobacco cessation. Have participants define empathy.

- Empathy is when you can understand and identify with another persons situation, feelings, and motives.

Activity: 10 minutes

- Have participants go back to their pairs and once again discuss their *bad habit*. However, this time the partners are to ask and listen, with empathy, to the benefits the person feels they get from the bad habit and reasons why they feel it would be difficult or undesirable to change.
- Have participants discuss the feelings they had about this interaction and compare and contrast it to the strong advice activity.

Discussion: 10 minutes

- A major frustration for addictions workers who promote smoking cessation is that smokers often resist change. Consequently, it is important to try to understand why people are sometimes attached to behaviours and to understand the processes that need to take place for someone to move into the preparation and action stages of change.
- People generally seek survival and comfort. Smoking or smokeless tobacco may seem to have a positive function in someone's life: stress relief: pleasure, and/or facilitate social or business relations.
- In order to want to change, the smoker has to balance the risks or harm associated with smoking with its believed benefits. Unfortunately, many of the benefits are immediate and the risks or harms are long term. As a result, it can seem more important to continue smoking than to change, and the balance of risks and harms will have to tip before the person will be ready to act.
- People are not easily convinced that tobacco is a problem for them.
- There is a difference between knowing that tobacco use increases health risks and believing that it will happen to you. Generally until a health problem arises in a person's life or someone close to them, the theoretical risk may not appear to be a personal threat.
- The short term benefits and the regular part of one's life that tobacco plays makes it very hard to quit.
- When people stop using tobacco, they have to change many other things in their lives and learn new skills. For example, someone who relaxes by sitting down with a cigarette might find it difficult to find other ways to relax.
- If someone has tried to quit many times and failed he or she can lose confidence in his or her ability to change and feel hopeless about this change. Many smokers are in this predicament.
- When there is little support in the environment to quit, it is more difficult to do so. Smoking in public places and tobacco advertisements contribute to a lack of a supportive environment.
- In order for tobacco users to move into the preparation and action stages of change, they need to believe it is important enough to do so. They also need to feel confident that they have the ability to change.

Activity: 5 minutes

Give the participants the handout, *Why Smokers Sometimes Resist Change (page 50)* and have them discuss the reasons people are attached to unhealthy behaviours especially smoking and brainstorm solutions to these reasons.

WHY SMOKERS SOMETIMES RESIST CHANGING

(http://www.who.dk/Document/E73085.pdf)

- They feel they get some benefits from smoking, so for them it is

IMPORTANT TO CONTINUE.

- They are not really convinced that smoking is bad for them personally, so it is

NOT IMPORTANT TO CHANGE.

- It seems almost impossible to stop smoking, so they have

INSUFFICIENT CONFIDENCE IN THEIR ABILITY TO CHANGE.

SESSION 7
SKILLS FOR ENABLING CHANGE

Purpose: This session will introduce participants to specific strategies that are helpful in assisting in tobacco cessation.

Objectives: By the end of the session participants will be able to:

- Define the motivational interviewing approach.
- Describe how motivational interviewing can be useful in brief interventions.
- Describe two methods of motivating clients through the early stages of change.
- Develop confidence to initiate tobacco cessation counselling with clients.
- Respond to resistance in appropriate and relevant ways.

Materials: *Brief Intervention, Skills for Enabling Change* and *Skills for Enabling Change Case Studies* handouts.

Time: 45 minutes

Motivational Interviewing Approach:

Discussion: 10 minutes

- Understand that clients often have mixed feelings about making changes, and you can't press them to make immediate changes or you risk resistance, termination, and miss the internal and external issues that can lead to relapse.
- Remember despite your best efforts to convince clients to do as we wish, they are free to make their own choices.
- Introduce the clients to a variety of options for tobacco cessation and support. Have them choose the course they think will be most helpful for them to quit.
- If we allow clients to find the ways that help them change, it increases the likelihood of long term success.
- A very effect way to motivate people to change is through the motivational interview approach.
- The motivational interview encourages the use of client-centered reflective listening that enhances real motivation to change by exploring and resolving confusion.
- The basic way to counsel using the motivational interview approach is through the use of Open-ended Questions, Affirmations, Reflective listening, and Summaries (OARS).
    - In open ended questions a client can not answer yes or no or give short specific answers. An example of an open ended question is, "So what makes you feel that it might be time for a change?" (http://motivationalinterview.org/clinical/interaction.html)
    - Affirmations recognize clients' strength and help to build confidence for change. It helps them not only feel that change is possible, but they are capable of making that change.
    - Reflective listening means you listen to your clients carefully. You allow them to tell you what has worked and what hasn't worked. You will focus on talk about change and pay less attention to things that didn't change. An example of reflective listening is, "You are not quite sure you are ready to make a change, but you are quite aware that your drug use has caused concerns in your relationships, affected your work and that your doctor is worried about your health." (http://motivationalinterview.org/clinical/interaction.html)
    - Summaries are a form of reflective listening where a helper reflects back to the client what the client told them.

- The goal of the motivational interviewing approach and OARS is to get the client to talk about change or to make self motivational statements. This type of communication shows that the client might be considering change which involves problem recognition, concern about the problem, commitment to change, and the belief that change is possible... Examples of self motivational statements are the following: "I think that smoking may be causing my health problems"; "I'm going to do something about my smoking"; "You know, I'm starting to feel like I just might quit."
- Another way to help smokers address their smoking is to engage in a brief intervention which is a time effective way to start the tobacco cessation process. A brief intervention consists of asking, advising, assessing, assisting, and arranging.

Activity: 35 minutes

- Give participants the *Brief Interventions, Skills for Enabling Change* and *Skills for Enabling Change Case Studies (pages 53-58)* handouts.
- Put participants in groups of three and tell them to follow the instructions on the *Skills for Enabling Change Case Studies* handout.
- Debrief the exercise with the participants. Ask them what they learned and about any difficulties they had during the exercise.

BRIEF INTERVENTIONS

(Adapted from http://www.who.dk/Document/E73085.pdf)

Many addictions workers see a large number of smokers in the course of their work, but don't have a great deal of time to discuss smoking with them. However, it is has been show to be worthwhile to spend a few minutes doing so. Very brief advice increases the number of smokers who achieve abstinence for six months or longer by two percent. If this is increased to a 10 minute intervention a further three percent will quit.

Because smoking is so dangerous and results in such huge costs to health care and society, even these relatively low success rates are worthwhile. One way of looking at this success rate is that if an addictions worker gave 100 people three minutes of very brief advice to quit, two of them will succeed in doing so who would not otherwise have stopped. Of these two ex-smokers we can expect that one of them would have been killed by his or her smoking if he or she had continued. Thus, a total of two and a half hours work has saved a life. This makes it a very successful intervention.

The essential features of a brief intervention are **Ask**, **Advise**, **Assess**, **Arrange**.

ASK

Smoking is an important aspect of a client's health status and it is therefore important to maintain up-to-date records about this. Two pieces of information are important: whether the person smokes currently and if so, whether they are interested, at present, in stopping.

ADVISE

The addictions worker should ensure that if the client does smoke, he or she is aware of the value of stopping and the health risks associated with continuing to smoke. Addictions workers are in a good position to be able to motivate smokers to quit and to understand how the general facts about smoking addiction and health apply to them personally and to consider their implications.

ASSESS

Assess the smoker's motivation to stop. A useful question to start with is: "Have you ever thought of trying to stop smoking?"

ASSIST

If the smoker does want to stop, a few key points can be covered in a few minutes.

- Set a stop day and stop completely on that day
- Review past experience and learn from it (What helped? What hindered?)
- Make a personalised action plan
- Identify likely problems and plan how to cope with them
- Ask family and friends for support

Information relating to how to stop can be reinforced with leaflets, booklets, or other self-help materials. All smokers can be given information on NRTs. [Nicotine Replacement Therapy: will be further discussed in Session 8].

ARRANGE

Follow up is important, in maintaining motivation and in providing continuing support. For some smokers referrals to community supports will be appropriate. Addictions workers therefore need to keep themselves well informed about sources of community help and about NRTs. It is important to remember that most smokers will make several attempts to quit before succeeding. Follow up provides an opportunity for support with relapse.

SKILLS FOR ENABLING CHANGE

(http://www.who.dk/Document/E73085.pdf)

When considering change, people weigh the advantages and disadvantages. They are motivated by any perceived disadvantages of smoking and by the benefits and advantages they expect to accrue from stopping.

Often they are torn, however, between wanting to continue smoking, but also wanting to stop. This *ambivalence* is a source of conflict within them. When talking about change with someone else (health professional, family member, friend) this conflict becomes apparent. Often the helper is tempted to take on one side of the conflict, i.e. to put forward the disadvantages of smoking and or the advantages of stopping. This can result in the client adopting the opposite stance and the conflict moves from being within the client to being external between the client and the helper.

Unfortunately, the consequence of such a dialogue is that the client finds himself or herself explaining to the helper all the reasons why change would be a bad idea, and why the smoking is not really a big problem. This can increase his or her attachment to smoking. If the dialogue then becomes heated or confrontational, the client will become more resistant to change.

Motivational interviewing (Miller & Rollnick, 1991) is an approach designed to raise the client's awareness of this conflict or ambivalence and enable them to view it as clearly as possible and decide how best to resolve it. Described below are some of the principles of motivational interviewing that can be useful in conducting brief interventions with clients who are reluctant to change.

If clients in precontemplation and contemplation are prone to being resistant, and if confrontational approaches tend to increase resistance, other strategies are needed. Miller and Rollnick, in describing such strategies, use an analogy from martial arts where, instead of blocking or countering an attack, the martial artist *rolls* with it, thus rendering it harmless.

This translates to a consultation as follows. If the health professional raises the topic of change and the client puts up resistance, instead of putting up a counter argument, the health professional accepts and acknowledges the resistance, using reflective listening skills. Once the resistance has been accepted the client no longer has to keep making that particular point and is free to consider other aspects of the issue.

It can even be helpful to encourage the client to explore the resistance a little so that both client and health professional come to understand it better. This may seem paradoxical when the health professional wishes to promote change. It can, however, enable the client to see the resistance and the obstacles to change as objectively as possible without becoming attached to them by having to defend then in an argument with a health professional who appears not to value their importance.

Resistance can also be side stepped, to use another combat analogy. If the client puts up resistance to a particular line of questioning the health professional can move the discussion to another topic. Or approach the topic from another angle. The aim is to continue a constructive, collaborative discussion for as long as possible without getting into an unproductive argument about it. While the client continues talking about it he or she continues to explore his or her feelings and thoughts on the topic and this aids the contemplation process.

Eliciting self-motivating statements

Hearing ourselves express a view, out loud, tends to reinforce our attachment to that view. Therefore if we want to encourage and enable change, it is helpful to conduct the consultation so that the client is encouraged to put forward the reasons he or she can see for changing.

Examples of such self-motivating statements might be:

- "I am concerned that, by smoking, I am setting a bad example to my children."
- "My father died of a heart attack. I don't want that to happen to me."
  "I know that by stopping smoking I could reduce that risk."
- "I spend a lot of money on smoking."

Self-motivating statements may be elicited by questions such as:

- "You have told me some of the things you enjoy about smoking."
  "Do you have any concerns about it at all?"
- "Have you ever considered stopping smoking?"
- "From your point of view, would there be any advantages in stopping smoking?"

References:

Miller, WR & Rollinick S (1991) Motivational interviewing, (New York: Guilford Press).

Rollinick, S, Mason, P & Butler C (1991) Health behavior change, (Edinburgh: Churchill Livingstone).

SKILLS FOR ENABLING CHANGE: CASE STUDIES

(Adapted from http://www.who.dk/Document/E73085.pdf)

Instructions

The aim of this exercise is to practise the skills of rolling with resistance and drawing out self-motivation statements. It is a role play requiring three participants. Two participants will take the roles of client and addictions worker and a third will take the role of observer.

Play the role for 8 minutes and then the observer should give feedback for 2-3 minutes. Then move on to the next scenario, exchange roles so everyone gets at a turn at being the client, addiction worker, and observer.

Scenario 1

Client

You are a young, single parent who has maintained sobriety for the last six months but continue to smoke. You would like to stop smoking so you can be an even better role model to your children. Both of your children are inclined to chest infections and asthma. However, your life is very stressful. You cannot see how you could cope without the cigarettes which help you to relax. You are also concerned that the withdrawal symptoms could make you even more stressed and miserable.

Addictions Worker

The client is in recovery, a smoker, and a parent. Acknowledge that he or she is a caring and loving parent. Try to discuss the smoking in a way that encourages the client to tell you any of his or her own concerns about it, or reasons for wanting to change. Handle any resistance in a way that acknowledges the issues and avoids arguments.

Observer

Watch carefully for anything the health professional does which contributes to

- Drawing out self-motivating statements from the client
- Avoiding confrontation and arguments
- Acknowledging and rolling with any resistance from the client

Keep time and after 8 minutes stop the role play and report your observations. Help them to see the things they did well.

Scenario 2

Client

You are a middle-aged heavy-smoker. You know that smoking is bad for your health but you enjoy it and you believe it would be very difficult for you to give up. You like to believe that because you eat well, live an active life, have maintained sobriety for one year, and attend Sweat Lodges, and Healing Circles you will not come to any harm from your smoking – everyone is entitled to one bad habit in your opinion!

Addictions Worker

You are concerned about your client's smoking. Talk to your client about it and try to do so in such a way that you draw out self-motivating statements and roll with any resistance.

Observer

Watch carefully for anything the health professional does which contributes to:

- Drawing out self-motivating statements from the client
- Avoiding confrontation and arguments
- Acknowledging and rolling with any resistance from the client

Keep time and after eight minutes stop the role play and report your observations. Help them to see the things they did well.

Scenario 3

Client

You are an elderly person who lives alone. You have smoked for 40 years and consider tobacco to be part of First Nations cultures and traditions. You attend AA functions regularly and volunteer anywhere you can in the program. You have a lot of problems with bronchitis and emphysema, which you acknowledge are probably connected to smoking. Doctors are telling you that your lung function is becoming very poor.

Addictions Worker

You know this elderly person well. On a couple of occasions you have given this person a lecture about smoking, but it didn't make any difference. Today you raise the issue again when he comes to visit you at the treatment or community centre. Talk to this elderly person in a less confrontational way this time and acknowledge how difficult it would be to break a lifetime habit. Talk about the information you have learned in regards to traditional use of tobacco, and ask the person what he knows about this. Try to draw out self-motivating statements and roll with resistance.

Observer

Watch carefully for anything the health professional does which contributes to:

- Drawing out self-motivating statements from the client
- Avoiding confrontation and arguments
- Acknowledging and rolling with any resistance from the client

Keep time and after eight minutes stop the role play and report your observations. Help them to see the things they did well.

SESSION 8
HELPING SMOKERS QUIT

Purpose: This session will provide participants with the information they need to help smokers quit and to examine available support.

Objectives: By the end of the session participants will be able to:

- Describe how families, friends, and communities can help smokers quit tobacco use.
- Identify community supports.
- Review common questions and answers about smoking cessation.
- Describe two methods of motivating clients through the middle stages of change.
- Describe the importance of developing client confidence to move into the action stage of change.
- Develop strategies to build motivation for smokers to quit.

Materials: *Questions Clients Ask About Smoking Cessation, Answers To Clients' Questions Ask About Smoking Cessation, Nicotine Replacement Therapy, Decisional Balance and Self Re-Evaluation, Enlisting Support, Developing Confidence, Developing Confidence Role Play*

Time: 90 minutes

Discussion: 5 minutes

- Although smoking is viewed as a habit, it is becoming more and more evident that smoking is another form of drug dependence.
- Some people find it easy to quit, while others find it very difficult.
- The majority of smokers who attempt to quit return to smoking within the first year of their attempts.
- There are social rituals and habits around smoking.
- Support and help for smokers is found in Elders, professionals, family, friends, and communities.

Activity: 5 minutes

- Have participants brainstorm social rituals and habits of smokers. Post their ideas.

Discussion: 5 minutes

- Tobacco cessation is worthwhile: (Adapted from http://www.who.dk/Document/E73085.pdf)
  - Health risks decline immediately upon stopping smoking.
  - In 20 minutes, of tobacco cessation blood pressure and pulse rate return to normal. Circulation improves in hands and feet.
  - In 24 hours, carbon monoxide is eliminated from the body. Lungs start to clear out mucus and other debris.
  - In 48 hours senses of taste and smell are greatly improved. The stale smoke odours on breath and body disappear.
  - In 3 months, the lung function increases making it easier to breathe. The nagging cough can disappear. The risk of further gum disease reduces significantly. Tooth staining begins to reduce.
  - In 9 months, the risk of experiencing complications during pregnancy or foetal death has returned to that of a non-smoker.

- In 5 years, the probability of contracting mouth, throat and oesophageal cancer has been reduced by 50%. The risk of a heart attack falls to about half that of a smoker.
- After 15-20 years, the risk of lung disease is almost as low as for non-smokers.
- After 15-20 years of tobacco cessation the risk of coronary heart disease is no greater than if the smoker had never smoked.
- After 15-20 years of tobacco cessation, the risks of lung disease are almost as low as for non-smokers. The risk of coronary heart disease is no greater than if the smoker had never smoked. The symptoms of bronchitis, asthma, emphysema, and coronary heart disease improve.
- Quitting before middle age reduces health risks.

- There are many ways to support clients to quit.
  - Sharing the knowledge you have on the effects of tobacco.
  - Sharing the benefits of quitting.
  - Having the ability to answer commonly asked questions. See *Questions and Answers for Tobacco Cessation (pages 62-64)* handout, which includes: common questions clients ask about smoking cessation and answers to clients' questions about smoking cessation.
  - Engaging in motivational counselling.
  - Engaging clients in a Decisional Balance activity handout. A Decisional Balance activity helps the addiction worker understand their client's motivation and helps the client to determine the importance of quitting smoking or smokeless tobacco. In this process the client looks at the advantages and disadvantages of using tobacco. They next think ahead to the future and imagine what it would be like when they no longer use tobacco and consider the advantages and disadvantages to quitting tobacco usage.
  - Using effective lines of enquiry.
- Some people not only need counselling and support, but also need pharmacological aids which are generally nicotine replacement therapy (NRT) agents. (NRTs can also be used to assist those who are quitting the use of chewing tobacco.)
  - NRTs do have nicotine but not the toxic smoke components. It is safer to use NRTs than to smoke cigarettes.
  - NRT alleviates the discomfort of withdrawal and comes in the form of chewing gum, patches, nasal spray, inhaler, and Zyban (prescription drug).
  - Choosing an NRT depends on the clients' likes and dislikes, availability, and cost.
  - The cost of NRTs is covered for Status Indians.
  - Some NRTs, such as the patch, result in slower absorption of nicotine, while others, such as nasal spray absorb nicotine very quickly.
  - Advise your clients to see a medical professional or a pharmacist before using an NRT and to follow the instructions closely.
  - Zyban is a prescription drug and an anti-depressant.
  - More information on NRT's can be found in the *Nicotine Replacement Therapy (pages 65-66)* handout.

Activity: 25 minutes

- Provide participants with the *Decisional Balance and Self Re-Evaluation* and *Decisional Balance Activity (pages 67-70)* handouts and group them in pairs. Have each person pick an area in which they wish to change and go through the *Decisional Balance* activity with their partner in order to assist them in their change.
- Debrief the activity with the group as a whole to see what they learned while participating in this activity. Ask participants how this activity would or would not work with their clients, etc.

Activity: 20 minutes

- Divide participants into groups and provide them with the handouts: *Enlisting Support (page 71)*.
- Have the groups design a plan for using these tools to assist them in helping their clients to quit smoking or using smokeless tobacco.

Discussion: 5 minutes

- Although people may want to change, they might not have the confidence in themselves to change. It is important for addictions workers to help their clients develop the confidence to change.
- Confidence is developed through addressing fears and supposed obstacles. This is usually done with practical strategies as those found in the processes of change: countering, environmental control, rewards, learning from previous efforts to change, and having specific plans.

Activity: 25 minutes

- Give participants the *Developing Confidence* handouts and have them pair up to complete the *Developing Confidence Role Play (pages 72-74)*.
- Debrief with the whole group and ask them how using *Brief Interventions*, the *Decisional Balance*, and *Developing Confidence* will assist them in their work to help their clients quit smoking or using smokeless tobacco.

QUESTIONS CLIENTS ASK ABOUT SMOKING CESSATION

(Adapted from http://www.who.dk/Document/E73085.pdf)

1. **Aren't lower tar cigarettes safer?**

2. **Is it okay to have an occasional cigarette?**

3. **Will I get withdrawal symptoms?**

4. **What is nicotine replacement therapy?**

5. **Doesn't smoking help me cope with stress?**

6. **Will I gain weight if I stop smoking?**

7. **If I stop smoking, are there any immediate benefits?**

8. **Tobacco is sacred, so why shouldn't I smoke?**

ANSWERS TO CLIENTS' QUESTIONS ABOUT SMOKING CESSATION

(Adapted from http://www.who.dk/Document/E73085.pdf)

1. Aren't lower tar cigarettes safer?

Switching to lower tar cigarettes is not usually helpful or safer. In practice, smokers who switch brands tend to compensate for the reduction in nicotine either by smoking more cigarettes or by inhaling more deeply or both. They often do not realize they are doing this and therefore it offsets the benefits of switching brands (Russell, 1980).

2. Is it okay to have an occasional cigarette?

The less smoke you inhale the less health risk you run. Risk is proportional to consumption. It may be better to smoke two a day than 40 a day, but even healthier not to smoke at all. As mentioned before, people who cut down often inhale more and take more puffs of the cigarettes they do smoke. Unfortunately, nicotine is a very addictive drug and very few people are successful in cutting down. Those who try occasional smoking tend to find it becomes more and more frequent until they revert to the original pattern. Therefore, it is agreed that stopping altogether is the best advice.

3. Will I get withdrawal symptoms?

Many smokers experience withdrawal symptoms when they stop. Usually the worst is over in a month or so. These can include:

1. craving to smoke
2. irritability
3. light-headedness or dizziness
4. headaches
5. sleeplessness and inability to concentrate
6. tiredness/fatigue
7. sore tongue, mouth ulcers
8. upset stomach

4. What is nicotine replacement therapy?

Nicotine replacement therapy (NRT) replaces the nicotine smokers were getting from smoking tobacco, but in a much 'cleaner' and safer form (with no tar, carbon monoxide, or smoke). It reduces withdrawal symptoms, enabling the user to concentrate first on breaking the habit of smoking. A gradual reduction in the replacement nicotine then enables the nervous system to re-adapt gradually with less discomfort. Nicotine replacement therapy is available as chewing gum, patches, nasal spray, inhaler, and pills (Zyban). The chewing gum and the patch have been around the longest. It is important that these products are used according to instructions to ensure the dependence on nicotine is reduced effectively and gradually. Skin patches give a steady, gradual intake of nicotine whereas other forms such as gum, inhalers and nasal sprays produce higher nicotine levels and permit better control of the nicotine dose. Zyban is a prescription only medicine. It is an anti-depressant. It has a start and a stop date and should not be used by pregnant and breast feeding smokers, by people under eighteen, and a range of other conditions.

There is no strong evidence of a difference in effectiveness between the different forms of NRTs. User can choose on the basis of availability and personal preference. What follows is some advice given to users of nicotine replacement therapy *(Health Education Authority, 1999)*.

- It is not a magic cure and will not, by itself, stop someone from smoking.
- It reduces withdrawal symptoms like irritability and craving.
- It provides nicotine but not as quickly or as much as a cigarette.
  It will not be as satisfying as a cigarette and will not remove the need for willpower.
- NRT should be used instead of a cigarette, not as well as.
- NRT is safer and less addictive than cigarettes.
- Very few people become addicted to NRT.
- NRT should be used in sufficient quantities, and for the length of time determined/suggested by our doctor, pharmacist, or the package instructions. You should follow the instructions in the package and seek advice from a doctor or pharmacist if you need more information.

5. Doesn't smoking help me cope with stress?

Not really. If a smoker feels edgy due to falling nicotine levels, a cigarette will reduce this perceived *stress* which is actually the beginning of withdrawal from smoking. Nicotine is a stimulant. In fact smokers as a whole tend to have slightly higher anxiety levels than non-smokers or ex-smokers.

6. Will I gain weight if I stop smoking?

It is common for people to put on a few kilograms when they first stop smoking. This can be made worse by snacking on sweet and fatty foods as a substitute for smoking. Choose snacks wisely; carrot sticks keep the hands and mouth busy providing a good distraction. Weight gain does not happen to everyone and being slightly overweight is less of a health risk than being a smoker.

7. If I stop smoking, are there any immediate benefits?

Giving up smoking begins to have benefits straight away. The following are typical benefits.

After 20 minutes Blood pressure and pulse rate return to normal. Circulation improves in hands and feet.

After 24 hours Carbon monoxide is eliminated from the body. Lungs start to clear out mucus and other debris.

After 48 hours Senses of taste and smell are greatly improved. The stale smoke odours on breath and body disappear.

After 3 months The lung function increases making it easier to breathe. The nagging cough disappears. The risk of further gum disease reduces significantly. Tooth staining begins to reduce.

After 9 months The risk of experiencing complications during pregnancy or foetal death has returned to that of a non-smoker.

After 5 years The probability of contracting mouth, throat and oesophageal cancer has been reduced by 50%. The risk of a heart attack falls to about half that of a smoker.

8. Tobacco is sacred, so why shouldn't I smoke?

Tobacco is sacred and should be used with respect. There are many traditional uses for tobacco; inhaling the smoke is not one of them nor is using it more than once to three times a day. The traditional respect that First Nation people had for tobacco has faded over the years and needs to return. Tobacco is not grown in the same way that it was traditionally; tobacco manufactures have added hundreds of dangerous chemicals in to tobacco in order to preserve it and make it more addictive and dangerous.

References

Health Education Authority, Nicotine Replacement Therapy (London: Health Education Authority, 1999)
Russell, M A H Relation of nicotine yield of cigarettes to blood nicotine concentration in smokers, (British Medical Journal, 1980, pp 972-6.)

NICOTINE REPLACEMENT THERAPY

Nicotine Replacement Therapy: Does it help?

(Adapted from http://www.abconlinepharmacy.com/ns/customer/quitting-smoking-nicotine-replacement-therapy.php)

Quitting smoking involves overcoming the physical addiction to nicotine and breaking the actual habit involved with the action of smoking. Nicotine replacement therapy will help by decreasing the cravings and some of the withdrawal symptoms. The most common types of nicotine medication are the patch and gum and are available over the counter.

Nicotine nasal spray and inhaler, as well as Zyban—a pill—are available only by prescription. Research has shown that smokers who use some form of replacement therapy double their chances of quitting smoking for good, but for best results, medications should be joined with a change in behavioral routines.

The patch:

- The nicotine patch releases nicotine into the body at a constant rate by dissolving through the skin and entering the body. They are available in different shapes and sizes; the larger the patch the more nicotine dispensed into the body. They reduce the urge to smoke by replacing the nicotine into the body that the smoker would have normally assimilated from cigarettes.
- Less nicotine is obtained from the patch than in cigarettes, it also does not contain the other harmful components found in cigarettes, such as tars and poisonous gases.
- Most patch products require changing/replacing every 24 hours, where some need to be removed at night and only worn during waking hours.
- Studies have shown that it is easier to quit the patch than it is cigarettes. Mostly because the sensation of immediate satisfaction is removed, as the nicotine is dispensed at a constant rate throughout the day.
- It is very important not to continue smoking while on the patch; it is design for people who have stopped smoking completely.
- Side effects include: headaches, dizziness, upset stomach, weakness, blurred vision, vivid dreams, mild itching and burning of skin, and diarrhoea.
- The patch will lessen the chance of tenseness, irritability, drowsiness, and lack of concentration.

The gum:

- Nicotine gum releases small amounts of nicotine into the body, which will cut down on withdrawal symptoms, making it easier to break an addiction.
- Available over the counter and recommended treatment period is about 12 weeks
- The gum contains enough nicotine and available in the same strength as the prescription product, 2 mg (for smokers of 24 or less cigarettes per day) and 4 mg (for smokers of 25 or more cigarettes per day).
- It is a temporary aid that reduces the symptoms of nicotine withdrawal.
- Must be used properly to be effective:
    - Stop smoking completely before starting nicotine gum therapy
    - Do not eat or drink 15 minutes before using the gum or while using it as it will reduce the effectiveness.
    - Chew the gum slowly for about 30 minutes.
    - Chew enough gum to reduce the withdrawal symptoms (10-15 pieces per day) but not more than 30 pieces per day.
    - Use the gum everyday for about a month, then start to reduce the amount of gum used.
    - Discontinue after 3 months.

The nasal spray:

- Dispensed from a pump bottle, and relieves the craving for a cigarette.
- The nasal spray releases nicotine directly into the nasal membrane, which reached the blood stream faster than other nicotine replacement therapy products.
- It is available only by prescription.

The inhaler:

- The inhaler is a plastic cylinder that contains a cartridge which releases nicotine when puffed on.
- Although it appears similar to a cigarette, the nicotine is released into the mouth and not the lungs, which causes it to enter the body much slower that a cigarette.
- It is available only by prescription.

The pill:

- Bupropion Hydrochloride (Zyban) was approved in 1997 and is sold by prescription only.

With all types of nicotine replacement therapy it is necessary to follow your doctor's orders, and use products only as direct to do so by the doctor or by packaging instructions. All of the products mentioned above can be extremely harmful if used by pregnant women.

THE DECISIONAL BALANCE AND SELF RE-EVALUATION

(Adapted from http://www.who.dk/Document/E73085.pdf)

Self re-evaluation (creating a new image) is a helpful process in the stages of contemplation and preparation. People can be helped to re-evaluate their current situation, which includes the implications of the problem or risk behaviour and also how the future might be for them, with or without the behaviour.

The Decisional Balance is a framework for such a re-evaluation. It was first discussed at length by Janis and Mann (1977) and a major focus of much motivational interviewing (Miller and Rollnick, 1991). In brief interventions it can be used either during the intervention or as a piece of self-help 'homework' for the client.

With a focus on smoking, the client can first consider the advantages and disadvantages of their current situation as a smoker. They may then think ahead to an imagined scenario when they no longer smoke, and consider the advantages and disadvantages of change.

It can be helpful to invite a smoker to fill in the matrix below:

	Advantages	**Disadvantages**
Smoking		
Not Smoking		

There will obviously be some similarities between the advantages of smoking and the disadvantages of quitting and there will also be an overlap between the disadvantages of smoking and the advantages of quitting.

There are four categories of responses that the client might be encouraged to consider:

1. Consequences to self *(e.g. if I continue smoking I will be less healthy)*.
2. Consequences to others *(e.g. if I stop smoking my family will not have to endure passive smoking)*.
3. How I feel about myself (*e.g. if I continue smoking I will feel guilty about setting a bad example to my children)*.
4. How other feel about me *(e.g. my partner will be proud of me if I stop smoking)*.
5. Personal Balance *(e.g. I can become whole and achieve health, well being, and balance in the physical, spiritual, emotional, and mental realms)*.
6. A client may also want to examine advantages and disadvantages of smoking in the physical, spiritual, emotional and mental realms.

In a one-to-one setting it is helpful, in order to build a good supportive relationship, to begin by showing a willingness to understand the attraction, or the positive aspects of smoking. Good active listening skills can be used to demonstrate empathy. Even if the client talks about advantages of smoking or disadvantages of change with which you disagree, or which you consider trivial, remember that you need to understand how it seems to them in order to proceed. Ask for clarification rather than arguing. Arguing will likely elicit resistance.

A counselling session based the Decisional Balance framework might pursue the following lines of enquiry:

- What are the good things for you about smoking?
- Are there and things about smoking that are not so good for you?
- If you were to consider quitting what might be difficult for you?
- Do you see that there would be any advantages for you in stopping smoking?
- So from what you say, it looks like this (summarize)
- Where does that leave you?

With a client who is only just beginning to consider a change, it is sometimes best just to look at the advantages and disadvantages of smoking. If someone is already preparing to change, he or she may my wish to focus primarily on the advantages and disadvantages of change.

This process is subjective. It is crucial that the client is helped to consider how it seems to him or her and how the behaviour fits in with other important goals and values in his or her life. **Addictions workers should be wary of putting their own values and assumptions onto the balance sheet. What is important to one person is not necessarily important to others.**

The Decisional Balance can be changed in several ways. For example:

- Environmental changes, such as no longer being able to smoke at work.
- New information, such as personal evidence or physical harm resulting from smoking.
- The clients priorities changing, for example through becoming a parent.
- Acquisition of new skills, such as learning a new way to relax after work.

The addictions workers most important tool therefore consists of being someone to listen and reflect back the client's self re-evaluation without judging, or hurrying the process to a premature conclusion. This may also include:

- Helping the client take a clear view of how the Decisional Balance looks at the moment.
- Ensuring the client has, or has access to, any information relevant to the Decisional Balance, and understands its implications, particularly if it increases the advantages of change.
- Helping identify any barrier to change that the client would like to try to remove (i.e. skills deficits) thus decreasing the disadvantages of change.
- Advocating for relevant environmental changes.

The skills of rolling with resistance and eliciting self-motivating statements are central to the use of this framework.

As an alternative to using it in counselling, clients can be asked to complete this as a pencil and paper *homework* exercise. This gives them time to think through what the behaviour—and the prospect of changing it—means to them.

References

Janis, I and Mann, L (1977) Decision making, (New York: Free Press)

Miller, W R and Rollinick, S (1991) Motivational interviewing, (New York: Guilford Press).

THE DECISIONAL BALANCE ACTIVITY

(Adapted from http://www.who.dk/Document/E73085.pdf)

This is an experiential exercise. You do not need to role play. Just be yourself—a course participant with your real life and real concerns.

Pair up. Each of you should choose an issue of your own to talk about to your partner. It should be a lifestyle issue that you are considering changing (i.e. contemplating or preparing to change). Do not pick something that is very traumatic, or too painful to discuss in a setting like this. Lifestyle issues such as eating, physical activity, smoking, working long hours, moving house or taking up a course of study are usually suitable.

Take turns talking about your issues. While the first person talks, the other should help them to complete a Decisional Balance in regard to the chosen lifestyle issues. You will probably find it helpful to fill in the boxes as you talk. Each person should take about 15 minutes.

1. Examine your current behaviour and the advantages and disadvantages to this behaviour. Examine and discuss these advantages and disadvantages holistically. Put your answers in the charts provided below. While doing this activity consider the following:
    - Consequences to self
    - Consequences to others
    - How I feel about myself
    - How others feel about me
    - Personal balance
2. When you are done with the first part of the activity, imagine that you have changed your current behaviour and examine the advantages and disadvantages of your changed behaviour.
3. Record your answers to both activities in the following chart.

	Physical Advantages	**Disadvantages**
Current Behaviour		
Changed Behaviour		

ENLISTING SUPPORT

(Adapted from http://www.who.dk/Document/E73085.pdf)

The helping relationship is of critical importance. It need not be provided by a professional helper. Informal and family networks probably have the greatest potential for providing support and help. People usually spend more time at home or at work than they do with their addictions worker, doctor, or community worker. Family and friends are often aware of problems before heath professionals are. It is not uncommon for a family member to approach a health professional before the person with the addiction – to seek advice on how to help.

(We must keep in mind, an unsupportive partner or colleague can make it very difficult for someone to change. One person changing has an impact on those close to him or her and this impact is not always wanted or supported.)

Prochaska and colleagues give the following advice to those seeking to help people change:

- Don't push someone into action too soon. Allow them time to go through the earlier stages.
- Don't give up—show that you continue to be concerned although you are not pushing for premature action.
- Don't enable, i.e. don't make it easier for them to continue the behaviour by avoiding discussing it, minimizing negative consequences or making excuses for them.
- Show empathy and unconditional warmth while the person is contemplating change.
- When the person begins to make changes, help them to control the environment to avoid temptations.
- Tell them what they are doing well, as well as when they are slipping.
- Keep up the support during the maintenance stage.

Some people find joining groups particularly helpful in that they provide opportunities both to gain extra support and to give help to others, which can strengthen commitment.

References

Prochaska, JO, Norcross, JC, DiClemente, (CC 1994) Changing for good. The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits, (New York: William Morrow and Company).

DEVELOPING CONFIDENCE

(Adapted from http://www.who.dk/Document/E73085.pdf)

In order to move successfully into action, people need to develop confidence in their ability to do so. In completing a Decisional Balance it may be clear that it is very important to a client to change. They can see lots of advantages of change. They want to do it, however they are not confident that they can do it and this hold them back.

Lack of confidence about stopping smoking may arise from several factors:

- Some people may have had few good experiences for changing other aspects of their lives but have a low level of confidence in themselves in general. Recent trauma, or having been brought up in an environment that did not encourage self-confidence, can underlie such general low self-esteem.
- Some people have repeated failures at trying to stop smoking. Indeed many only seek help when they have tried and failed (more than once) to do it alone.
- On considering their Decisional Balance, some people can see that although there will be lots of advantages in changing there will also be disadvantages. If they are not sure how to cope with these, their confidence in their ability to change will be undermined.
- Without a clear cut plan to focus on, it is difficult to imagine exactly how the change will happen and therefore there is nothing concrete to feel confident in.

Usually, confidence is best developed through having practical strategies for dealing with the perceived or feared obstacles. Some of the processes of change directly address this.

Countering

Finding alternative ways to behave in high risk situations is a way of countering the urge to smoke in the short term. Examples might be having a bath/shower, listening to music on returning from work instead of having a cigarette; nibbling fruit, raw carrots, celery etc; engaging in activities which preclude smoking such as swimming. Some people develop ways of distracting themselves in moments of craving.

Countering may also involve finding different ways to think in high risk situations. Some people have habits of self-defeating thoughts such as:

> "I'm no good at this sort of thing"
> "I'll mess it up again"
> "Just one won't hurt."

When people catch themselves thinking their self-defeating thoughts they can replace them with positive ones such as:

> "I've done this before, I can do it again"
> "This craving will pass if I wait 5 minutes"
> "I'll do without it this time"

or with visual images of the healthy self they are aiming to become. This takes practice, but in time the new thoughts can become habitual.

Environmental Control

Lack of confidence can arise from a fear that the immediate environment will be hostile to the change. Unsupportive friends and colleagues, easy availability of cigarettes and poor access to healthy alternatives such exercise facilities and healthy foods can make the task of change seem impossible.

It can be helpful to take these concerns seriously. Do not expect willpower to be sufficient; practical plans are needed. Helpful questions to ask someone trying to develop confidence are:

- Are there some situations that, for now, you had best avoid completely? What are they? How can you avoid them? What excuses will you make and what alternatives can you find?
- What are the cues that trigger the behaviour? Are there particular feeling or thoughts that put you at risk? How can you prepare for or even practise dealing with these cues?
- In order to make the change feasible, are there any other aspects of your life you need to change, to create an environment that will support you (i.e. have lunch somewhere different, change working hours to fit with leisure or sports opportunities?
- Would it be helpful to make your home, car or office a non smoking zone or to throw away lighters, ash-trays etc?

Rewards

The intrinsic benefits of quitting smoking may not be immediately obvious. Some people build shot term rewards into the action plan, such as buying something they would not otherwise be able to afford with the money saved or eliciting and giving themselves praise for achieving 'quit milestones' such as one day, one week, one month, one year.

Taking care of themselves physically by eating well, getting moderate (enjoyable) exercise and getting enough sleep and relaxation can be a reward too.

Learning from previous efforts to change

In helping the client to use the process of change, try to use their previous experiences constructively. Useful questions are:

- When you tried to change this behaviour in the past, are there any things that were helpful? If so can they be built into your plan this time?
- Is there anything you can learn from the problems you experienced the last time you tried to change?

Having a specific plan

Many people succeed by setting a date for stopping smoking in the near future *(commitment)* and then working towards it. Once the date is set, confidence can be increased by making a concrete plan for how to achieve it. *"I will try hard"* is a laudable sentiment and intention but does not give any practical indication of how the good intentions can be made to work.

A good plan will include *countering, rewards* and *environment control*. It also takes into account the value of having a *helping relationship* with a supporter.

Recording such a plan ensures both client and professional can check whether it has been followed and if so whether it resulted in achievement of the goals.

DEVELOPING CONFIDENCE ROLE PLAY

(Adapted from http://www.who.dk/Document/E73085.pdf)

In pairs decide who will be the client and who will be the addictions worker by using this method: the one whose birthday falls earlier in the year plays the client.

Take the following roles. You are in a one-to-one counselling session. If you wish, instead of the client described below use an example from your own experience where *low confidence* is the major obstacle to change.

Client

You are a 40 year old addictions worker. You have smoked since you were an adolescent and would like to quit smoking to be a role model and for your personal well being. You are well informed about the damage smoking does to you and others. It is important for you to stop.

You have tried to quit twice before. The first time lasted 3 weeks and then you decided to just have one cigarette and ended up smoking heavily again.

The second time lasted one year. You had support from a colleague who gave up the same time as you. Then you changed jobs and the stress of this led to you beginning again 6 months ago. You always seem to want a cigarette when life is stressful.

Usually you are a confident, competent person and you find it frustrating to feel that you are not 'in control' of your smoking.

Addictions Worker

You have discussed the client's smoking with him or her. You both agree s/he should stop smoking. You sense the client has little confidence about being able to stop.

Find out what factors lead to this lack of confidence. Try to help the client find practical strategies to develop confidence.

In 10 minutes debrief and discuss the nature of the central confidence problem(s), and if you were able to come up with any practical solutions.

SESSION 9
SMOKING CESSATION GROUPS

Purpose: This session provides participants with a framework for planning and running smoking cessation groups with a focus on Healing Circles and tobacco courses.

Objectives: By the end of the session students will be able to:

- Describe the reasons for running a cessation group.
- Describe how to run a Healing Circle.
- Describe how to handle difficult situations that may arise with group members.

Materials: *Checklist For Setting Up a Group, Healing Circles, Running a Stop Smoking Group, Group Members Case Study* handouts.

Time: 70 minutes

Discussion: 5 minutes

- Groups are important tools for change.
- Groups help people stay in the commitment stage of change.
- Groups help the maintenance stage of change.
- Members of a group gain support from one another.
- Groups effect changes in attitudes and behaviour.
- Groups offer shared experiences and create a sense of belonging and growing together.
- Groups provide for a more permanent and faster changes.
- Groups help break down preconceived notions and barriers to change.
- Groups are instruments to help others.

Activity: 5 minutes

Place participants in groups and have them participate in a three way brainstorm on how smoking cessation groups can help in their communities.

Discussion: 1 minute

- There are many steps to organizing a group such as deciding when and where a group will meet; how long each group session will be; how to recruit members; and how to keep the group running and consistent.
- There are different ways to run a group such as in the style of a 12 step group, a Healing Circle, or as a course.

Activity: 3 minutes

- Facilitate a discussion on what participants know about groups a – Healing Circles in particular.

Discussion: 1 minute

- Healing Circles are traditional First Nation ways of addressing healing. They consist of a group of people who come together in a safe environment where they are surrounded by others who understand them and provide emotional support.
- There are protocols for running Healing Circles that are based on respect, teachings of the circle, healing, and trust.
- Have participants share what they know about Healing Circles.
- The basic rules of a Healing Circle is that while in the Circle each person gets a chance to say whatever is on their mind without being criticized or judged by others. Sometimes groups pass around a feather, stone, or talking stick. Whoever is holding the object has the floor.
- When possible, it is important to have an Elder attend and facilitate the Circle.
- Bringing people together in a course like atmosphere to attend tobacco cessation groups is another way to approach tobacco cessation group work. This group usually has an introductory session and then runs for four weeks at weekly intervals and if possible is followed up two, three, and six months after the course start date. Discussions in this group revolve around the actions plans, support, and maintenance.

Activity: 25 minutes

- Provide participants with the *Checklist For Setting Up a Group, Healing Circle and Running a Stop Smoking Group (pages 77-80)* handouts.
- To create groups, number off participants and then have them join their numbers groups. Have the even numbered groups work on planning a tobacco cessation Healing Circle and have the odd numbered groups work on a planning a tobacco cessation course group.
- When the groups are finished have them present their plans to the group as a whole.
- Discuss the similarities and differences of Tobacco Cessation Healing Circles and a tobacco cessation course group.
- Have participants discuss when and where they could use each of these groups in their communities.

Discussion: 5 minutes

- When groups are in place there are group dynamics that take place.
- Conflict can result in group members personal relationships due to the fact that in a group they have to bend their feelings, ideas, attitudes, and beliefs to suit the group. Because people fear failure and exposure there will be a need for structure and commitment.
- It is important to be prepared for group conflicts.

Activity: 20 minutes

- Have participants brainstorm possible conflicts in a group and their solutions.
- Divide participants in groups and provide them with the handout *Group Members: Case Studies (page 81)*. Assign a main case study to each group, when they have come to consensus on their case study they can move on to another case study.
- Discuss the case studies with the whole group and post solutions to each situation.

CHECKLIST FOR SETTING UP A GROUP

(Adapted from http://www.who.dk/Document/E73085.pdf)

When planning a group, complete this checklist to ensure you have considered all the important issues.

1. What is the purpose and what are the objectives of the group?
2. What methods can you use? Talk discussion, buzz groups, role play, pencil and paper exercises, 12 Step, Talking Circles, Healing Circles.
3. Is the venue suitable?
4. How frequently will the group meet?
5. How long will each session last?
6. At what time will the group meet?
7. How will members be recruited and selected? Who is eligible? What is the exclusion criteria?
8. Is it a closed group or can people join at any time?
9. What will the group contract consist of?
10. What resources do you need to get (including leaflets, equipment etc)?
11. How many group leaders do you need? If more than one what are their roles? When do they meet to plan and debrief?
12. What style of leadership is required for this group?
13. Will individual sessions be available for group members?
14. How will effectiveness be monitored?

TOBACCO CESSATION HEALING CIRCLE

Healing Circles have been around for a long time. They are a traditional First Nation way for addressing healing. Healing Circles are guided by the concept of a circle and the circle of life and the main rule of the circle is one of respect. It is important to find an Elder to attend or run the Healing Circle, if possible.

Circles are generally started and ended with smudging and a prayer. Usually a stone, a feather, or a talking stick is passed around the circle and the person holding this object is the only one who can speak. Other people listen to the speaker respectfully. This process allows participants to act from the heart. This is different from mainstream groups where the focus is more from the head.

The tobacco cessation Healing Circle provides a safe place for people to share their experiences with smoking and trying to remain smoke-free. The only criterion for participation is a desire to be tobacco free.

There are some basic rules and guidelines for a tobacco cessation Healing Circle which are as follows:

- Respect everyone in the group.
- An object is passed around from speaker to speaker. It can be passed clockwise or counter clockwise depending on the traditions of the First Nation where the Healing Circle takes place.
- The circle is always complete. There are no semi-circles and all participants are included in the circle.
- Discussions are always related to tobacco addiction, cessation, and recovery.
- Speak honestly and truthfully from the heart.
- Be brief.
- Listen attentively.
- One person talks at a time.
- Everyone listens to the person talking, without interrupting.
- Be supportive of each other and encourage each other.
- Everyone in the group is assured a chance to speak if they want to.
- Group members are not pressured to speak.
- What is said in the Healing Circle stays in the Healing Circle.

The tobacco cessation Healing Circle is specific to becoming tobacco free and thus Healing Circle sessions might have a focus on the following topics:

- Stages of change
- Sharing of smoking stories
- Coping without tobacco
- Developing a support network
- Developing action plans
- Withdrawal symptoms
- “Why I want to quit”
- “What do I need to do to quit?”
- Traditional uses of tobacco
- Helping each other
- Helping our families
- Helping our communities
- Creating tobacco free communities

RUNNING A STOP SMOKING GROUP

(Adapted from http://www.who.dk/Document/E73085.pdf)

The approach to running a group described below evolved from several decades of work, which started in Russell's Maudsley Smokers' Clinic in South London in the 1970s and continues in his and other clinics to this day. Different people worked with Professor Russell and then moved on and adapted their methods a little, but the basic approach remains similar and has become known in Britain as the *Maudsley Approach*.

Advertising and recruitment

The groups are advertised as widely as possible. Clients do not need to be referred to the groups.

Course format and style

Weekly walk-in groups are not run because smoking cessation groups are easier to run if everyone shares the same goal: to stop smoking. Thus a waiting list is built up and a course run when there are enough people to make up a group of smokers all committed to stopping and who are ready to change. Approximately 40 people can be admitted to an introductory session where they will learn about the course, how it can help them, and decide if they are ready to try to stop smoking.

Typically around half of the participants will decide they are not ready, leaving about 20-25 smokers who return the following week to start the cessation part of the course. A typical course comprises the introductory session and four sessions at weekly intervals. Course follow up ideally occurs two, three, and six months after the course ends, if resources permit.

Small groups of 5-10 people can present problems. With groups this small, if after a couple of weeks several drop out, the group can dwindle to just a few people, none of whom may have succeeded in stopping. This can be demoralising for smokers and the leader. Large groups of 20-25 smokers are hard work initially, but can be very rewarding and effective once established. They cannot be run didactically with the leader controlling the conversation and telling the participants what to do.

The leader's role is to facilitate, help build self-help skills and networks within the group, make general points and give information. The first task is to build group cohesiveness so that group members feel comfortable with each other. When this works well, the group naturally breaks up into sub-groups, and the room becomes very noisy. Because the leader is not trying to *control* the proceedings and have all conversation channelled through him or her like a *chairperson*, he or she is free to circulate and give each sub-group or individual more attention. Groups this large are also guaranteed to produce some early success, and these will motivate other group members.

Initial introductory session

Between 90 and 120 minutes are allowed for the introductory session. After the welcome each member of the group is invited to introduce his or herself and say a few words about their smoking and desire to stop.

A booklet on how to stop smoking and a leaflet is distributed which explains the nature of the course and the principles on which it runs. Group leaders explain that the course is based on the idea that smoking is a habit, an addiction, a process, and a choice. They refer to the cycle of change and to the evidence that most smokers try several times to stop before finally succeeding. The idea and use of the word 'failure' is discouraged and the importance of the process of 'commitment' is emphasised.

A handout on the Decisional Balance is given out and smokers are invited to fill in the columns headed *Reasons for stopping and Reasons for continuing*. Group leaders initiate discussion on where each smoker is in the cycle of change. If some are not ready they are given an opportunity to explore their beliefs about the health risks and are given a handout or booklet. A video may be shown and group leaders discuss the nature of the risks as required. Smokers are given the space to make their own decisions. Smokers who want to try to stop are helped to resolve their questions and concerns, for example: "Will I gain weight?" or "What about coping with stress?" Since most of the time smokers are not with a cessation counsellor, the course is built around booklets and leaflets that can be made available to smokers and to which they can refer at all times.

Second and subsequent sessions

The second and subsequent sessions run for around 90 minutes and are for those who are ready to try to stop smoking. Those people who have committed themselves to continuing in the group are welcomed, and there is a brief round of names and comments on how the last week or so has gone. Although the first session was actually to help people decide if they were ready to join a stop smoking group, some will have been ready and will have stopped in the intervening period. Their experience is a valuable resource and will help in motivating other members.

Discussion focuses on the basic elements of their action plans, reviewing the experience of the last week or so, drawing out the experiences of those who have already stopped and seeking experiences and views on NRT and Zyban. After describing how to build an action plan the leader splits the group into small sub-groups to help each other develop personalized action plans. If possible, each group should have at least one person who has quit smoking placed in the group.

The sub-groups are brought back into a plenary session about 15 minutes before the end of the weekly session to review progress, discuss general questions that have arisen, ie:

- Is it worth stopping?
- Will I put on weight?
- Does smoking help me cope with stress?
- What if I haven't got any willpower?
- What are the withdrawal symptoms and how long will they last?

These discussions also focus on practical issues such as:

- Action plans
- Planning ahead and anticipating problems
- Avoiding problem situations and finding alternatives
- Cutting down gradually or stopping suddenly
- Setting a date and time
- Keeping cigarettes or getting rid of them
- Telling other people or keeping quiet
- Choosing the right day
- Getting support
- Planning rewards
- NRT, Zyban and other treatment aids.

GROUP MEMBERS: CASE STUDIES

(Adapted from http://www.who.dk/Document/E73085.pdf)

Each group is assigned a case study. They are to consider the following situations that arise amongst members of a smoking cessation group. The group is to discuss what they would do if they ran the cessation group in the case study. They are to begin with the scenario assigned to their group and then discuss the others as time allows.

Smoker 1

In the group is a woman in her thirties who seems lacking in confidence and low in self-esteem. She has said she is living alone with her mother who she describes as 'difficult'. She seems mildly depressed with life in general. She comes up after the first group to ask you what you think; she says she would really like to stop but doesn't think she could manage it at the moment.

What do you ask her? What do you advise her?

Smoker 2

A young woman has joined the group saying she does not want to stop but wants to cut down. In the second session she tells the group that she has not cut down yet, but will do so when she is ready. She says she will be able stop easily once she decides to do so. Another group member begins to question why she joined the group and other people seem irritated by her statement.

How do you handle it?

Smoker 3

At the end of the introductory session a 50 year old man who is a Band Councillor comes to talk to you. He is on the waiting list for a heart bypass surgery. His doctor has told him not only that he must stop smoking but that if he does not stop he will not get the operation. Although he wants to stop, he seriously doubts his ability to do so. He asks if you will tell the surgeon if he fails to stop.

What do you say?

SESSION 10
RELAPSE PREVENTION

Purpose: This session will present practical coping strategies for the prevention and management of tobacco usage relapse.

Objectives: By the end of the session students will be able to:

- Identify situations that contribute to relapse.
- Describe how to help clients learn from their relapses.
- Demonstrate how to help clients learn from their relapses.
- Examine feelings and reactions to clients' relapse.

Materials: *Relapse Prevention and Recycling* and *Recycling Practical Exercise* handouts.
Flip chart and markers.

Time: 60 minutes

Discussion: 5 minutes

- Relapse: is a recurrence of actions of an addiction after a period of improvement.
- Smoking has the highest rate of relapse compared to that of any other addiction.
- Relapse is usually a way of coping with emotional distress, giving in to urges, or responding to social pressure.
- It is important to give people the skills to cope with potential relapse situations where they can prepare themselves for potential high risk situations, find substitutes, control their environment, and turn to their support systems.
- Assertiveness training, anxiety and/or anger management skills, and the development of support networks, all help in the avoidance of relapse.
- Remind clients and yourself every relapse is a slip but every slip does not have to become a relapse.

Activity: 20 minutes

- In pairs have participants discuss a time in their lives when they changed behaviour and relapses. Have them express how they felt before, during, and after their relapse.
- Debrief the activity in the whole group and ask participants to list some of the feeling people have when they relapse. Write these down on the flip chart for participants to see.

Discussion: 5 minutes

- There is much to be learned from relapsing.
- People feel guilty, hurt, and ashamed when they relapse; it is important to help them get through these feelings and to address them and to move forward.
- Addictions workers can help their clients explore what happened to them during the relapse and examine such things as client's substitutes, support networks, reward systems, commitment, and need for NRT or Zyban.

Activity: 25 minutes

- Provide the participants with the handouts *Relapse Prevention and Recycling* and *Recycling: Practice Exercise (pages 83-85)* and pair the participants up. Assign alternate case studies to each pair and have them incorporate the awareness wheel into the exercise.
- Debrief the activity and ask for feedback on the exercise. Have participants discuss what they learned from the activity and how it will assist them in their work with tobacco cessation.

Activity: 5 minutes

- Have participants discuss the feelings they have or might have when their clients' relapse.
- Have participants brainstorm ways to handle those feeling. Write their answers on the flip chart.

RELAPSE PREVENTION AND RECYCLING

(Adapted from http://www.who.dk/Document/E73085.pdf)

Maintenance is a busy, active period of change. New coping strategies are learned in order to avoid relapse and to establish a new healthier lifestyle. Only about 20 percent of people permanently change long-standing problems at the first attempt *(Prochaska, 1994)*. Most people revert, at least for a while, to the problem behaviour, before trying again.

What precipitates relapse?

Relapse is usually a way of:

- Coping with emotional distress (i.e. to feel better when they feel bad). For example: someone has a bad day at work; has a minor car accident on the way home from work; has a teething baby at home and; the stove breaks down. He or she has a cigarette *to cope*.
- Enhancing positive emotional states (i.e. to feel even better when they feel good). For example: someone goes out to socialize for the first time in a long time and begins to unwind and have a cigarette to mark that they can finally relax.
- Giving in to temptations or urges.
- Responding to social pressure.

Avoiding relapse

People need the skills to cope with situations and to feel confident that they can succeed. Each time someone successfully avoids a potential relapse their confidence will be increased, making it more likely they will use the strategy successfully next time. People can prepare themselves against such high risk situations when they are in the maintenance stage.

Looking ahead over future weeks they can list situations in which they can foresee wanting to return to the problem behaviour. They can then be helped to develop appropriate coping strategies: using substitutes, controlling the environment and using their supportive, helping relationships. Typical examples are:

- assertiveness skills to cope with social pressure,
- anxiety management or anger management to cope with those negative emotional states,
- support networks to cope with other emotional distresses,
- mood changing strategies to help distract themselves from urges or cravings,
- changes in routine to avoid situations where temptation is great.

Slips and relapses

Often people set themselves on a path of strict adherence to a non-smoking lifestyle and then slip from this path on occasion. Many people give up as soon as they slip, believing that they have failed and a complete relapse is inevitable. They then feel guilty and blame themselves. They lose confidence in their coping strategies and it becomes harder for them to get back on the path to a healthy lifestyle. Every relapse begins with a slip but not every slip needs to become a relapse. People can learn to manage their slips and to get straight back on course as quickly as possible. It is possible to smoke one cigarette without become a smoker again.

Helping people to *recycle*

Slips and relapses can teach us a lot about our habits and attempts to change. However we need first to acknowledge that our first response to the relapse may be disappointment, anger or frustration.

Having acknowledged these feelings, identifying what triggered a slip or a complete relapse can help to clarify what situations are *high risk* and what sort of coping strategies need to be developed.

It can be helpful to explore:

- Did the person have enough good substitutes to use? Do more need to be developed?
- Does their use of pharmaceutical therapy need reviewing?
- Was there enough support available? Can the existing helping relationships be strengthened?
- Was the person giving themselves enough rewards?
- Was the person truly ready and committed to change or was the attempt premature? Is it a good idea to try again yet or is more contemplation and preparation needed?

Similarly, people can learn from successful attempts to avoid slips in high risk situation. These can show which coping strategies work and how skills are developing. This in turn builds confidence.

References

Prochaska, JO, Norcross, JC, DiClemente, CC (1994) Changing for good. *The revolutionary program that explains the six stages of change and teaches you how to free yourself from bad habits*. (New York: William Morrow and Company)

RECYCLING:
PRACTICE EXERCISE

(Adapted from http://www.who.dk/Document/E73085.pdf)

In pairs, you will be assigned one of these case studies to role play. You have about 20 minutes to discuss the relapse and help the client to recycle, then 5 minutes to discuss the process. One of you is to be the addictions worker and one the client. If time permits, change roles and choose one of the other case studies.

Client 1

A young single parent mother of two 2 children has just found out she is pregnant again. She gave up smoking two weeks ago, but just had a slip. She finds it too stressful to have two small children and have another one on the way. The mother is disappointed about her slip as she wants to try and keep her unborn child and her other children healthy.

Client 2

A teenage youth has been involved in sports at school and in the community. He gave up smoking about six months ago. However, he attended a social function about a week ago and began to smoke again.

Client 3

A 55 year old woman has been clean and sober for 2 years. Three months ago, she tried to give up smoking. She felt that she had done so well in her sobriety that she was ready to tackle smoking. So far two attempts to quit have not succeeded.

Client 4

An older couple attended a smoking cessation workshop about 2 months ago. At the workshop the husband realized his second-hand smoke was harmful to his wife and that smoking 30 cigarettes a day was harmful to him as well. He cut back to smoking 5 cigarettes a day and smoked outside the house for those two months. However, in the last week he began to smoke 20 cigarettes a day and to smoke at the door or window instead of smoking outside.

SESSION 11
YOUTH AND TOBACCO

Purpose: This session will allow participants to explore issues specific to youth and tobacco. It will allow them to identify adolescent behaviour and skills for working with youth.

Objectives: By the end of the session students will be able to:

- Identify First Nation and non-First Nation child development paradigms.
- Describe the importance of incorporating knowledge of child and youth development in tobacco cessation activities.
- Describe four strategies to engage youth in tobacco cessation activities.
- Explore avenues for working with youth in tobacco cessation.
- Describe effective strategies for preventing tobacco use in youth.

Materials: Handouts: *Understanding Child Development,*
Recommendations for School Health Programs to Prevent Tobacco Use and Addiction.

Time: 90 minutes with inclusion of Western/mainstream child development paradigms.
70 minutes without this section.

Discussion: 5 minutes

- Tobacco is one of the most commonly available and widely used drugs and contributes to the most widespread drug dependency for all peoples and youth.
- On an average about 50% of the Aboriginal population consists of youth under 24 years of age. This is far higher than that of the non-Aboriginal general population.
- The average age First Nation youth start smoking is younger than that of other Canadians.
- Many smokers start smoking while in elementary school.
- Three-quarters of young smokers become addicted before they turn 17 years old.
- Nearly two-thirds of current smokers aged 10 to 19 years reported trying to quit smoking at least once, but most attempts result in failure.
- Peer pressure and a perception that smoking is *cool* appear to be the most important reasons for youth to start smoking.
- Aboriginal female youths from the ages of 11 - 16 have the highest smoking rates in Canada.
- Young smokers had close friends who also smoke.
- The probability of being exposed to second-hand smoke in First Nation or Inuit communities is double that of the Canadian population.
- Youth who smoke have higher rates of illness such as asthma, colds, flu, pneumonia, and bronchitis.
- Youth who smoke visit the doctor or other health practitioners much more often than those who do not smoke.
- Youth who smoke are three times more likely to use alcohol, eight times more likely to use marijuana and 22 times more likely to use cocaine.
- 90% of children are aware of the ill effects of smoking.
- Peer pressure has an impact on youth and smoking.
- Youth who do not drink are seven times less likely to smoke
- Youth whose friends do not smoke are four times less likely to smoke
- Youth whose parents do not smoke and disapprove of smoking are two times less likely to smoke.
- It is important to establish peer supports that reinforce the message that non-smoking is *cool*.
- Statistics indicate that it is very important to have a high priority focus on Aboriginal youth in tobacco cessation work and that this work needs to start very early in a child's life.

Activity: 5 minutes

Have participants discuss why it is important to work with youth in tobacco cessation and how they might go about this.

Discussion: 10 minutes

- In order to work with youth we need to understand child development.
- It is important to understand that each First Nation is different and the following points about First Nation child development and rearing are very general. Each Nation will have its own beliefs on this matter. Elders in each community should have input in this area.
    - Traditional First Nation family life provided a firm foundation of security and encouragement for children.
    - Elders are the backbone of First Nation families and teachings.
    - Even the prenatal period was seen as important to teaching children. There were ceremonies and protocols for a family to follow during a woman's pregnancy.
    - The beginning of life and the childhood years are the times when beliefs, values, and attitudes were to be communicated to the child. This was a time when children were taught to respect their heritage and uphold their community values.
    - First Nation children learned by seeing and doing, when they mastered a skill they went on to the next one. Because of this, First Nation children were included in all social, economic, and spiritual activities.
    - Children were taught respect and obedience.
    - Storytelling was a means for teaching First Nation children.
    - Spirituality was an important part of child rearing.
    - Children were taught their responsibilities to each member in their kinship group.
    - Children were allowed to be children.
    - Children were to be talked to as opposed to punished.
    - Extended families and communities raised children.
    - There were rites of passage in each life cycle. Puberty ceremonies are one example of these. Each rite of passage allowed people to learn about and accept the roles of each life cycle.
    - Many First Nation people believe that there are four stages of life. Each Nation has their own teachings on this. Below is an example of a generalized view of four stages of life. Please talk to the Elders in the community you work in to understand the teachings of that community.
        - There are four stages of life – child, youth, adult, and Elder
        - Each stage has its own roles and responsibilities.
        - Individuals can reach each stage at different times.
        - Each stage is defined in relationship to all other stages.
        - The child stage is a time of innocence. It is a time a child plays and learns how to live respectfully in his or her community.
        - The youth stage is a time of being nurtured to learn practical skills and knowledge as one grows.
        - The adult stage is a time for protection and preservation of culture. The adult uses the knowledge and skills he or she has acquired to sustain his family, nation, and community.
        - The Elder stage is one of purity and gentleness. The Elder uses all that he has gained in life to provide guidance and direction.

Activity: 5 minutes
In pairs participants are to talk about some of the First Nation child development and child rearing practices are familiar with.

Discussion: 5 minutes

- There are also a variety of Western/mainstream child development theories. There is a summary of these theories in this module titled Understanding Child Development should participants desire to learn about these theories (*page 90*). Discuss the pros and cons of learning about these theories.

Discussion: 20 minutes

- There are a number of ways to approach youth in tobacco cessation work.
- Schools are an important place to reach youth. Research shows that school programs starting in kindergarten and extending through high school can be effective in preventing tobacco use among youth
- School programs can help children and youth who have not experimented with tobacco to continue to stay away from it; encourage; help those who are using tobacco to stop; aid tobacco users to seek additional help to quit; and introduce traditional use of tobacco.
- School programs geared at tobacco cessation can help prevent the use of drugs, if they are designed to address all addictions: tobacco, drugs, and alcohol.
- The Centers for Disease Control and Prevention offer seven recommendations that summarize effective strategies in preventing tobacco use among youth:
    - Develop and enforce school policy on tobacco use.
    - Provide information on physiological, cosmetic and social consequences of short and long term tobacco use.
    - Provide prevention education, from kindergarten to Grade 12, especially junior and senior high school
    - Provide program-specific training for teachers.
    - Involve parents and families in support of school-based programs.
    - Support cessation efforts among students and school staff who use tobacco.
    - Assess effectiveness of tobacco cessation at intervals. Evaluate Strategies.
      See handout Recommendations for School Health Programs to Prevent Tobacco Use and Addition for more details. (ftp://ftp.cdc.gov/pub/Publications/MMWR/rr/rr4302.pdf)
- It is very important to start off all school programs with a comprehensive understanding of the traditional use of tobacco.
- In order to be effective school programs need to target children and youth before they start smoking or drop out of school.
- Carefully planned school programs can be effective in reducing tobacco use among students if schools, First Nations, Tribal Councils, and the leadership make a commitment to implement and sustain such programs.
- Community awareness is another way to approach youth in tobacco cessation. This can be done through the sponsorship of poster contests, smoke-free pow-wows, smoke-free drum groups, smoke-free dance groups, smoke-free bingo halls, community workshops about tobacco issues, production of culturally relevant tobacco cessation materials, and assistance in the creation of community tobacco policies.

- Enforcing age limits on the sale of tobacco is another important approach to addressing youth and tobacco cessation. This is a bit more complex and needs the assistance of retailers, laws, health, mental health, addictions professionals, teachers, parents, children and youth.
- Involving youth in discouraging their exposure to second-hand smoke is important. Youth will feel productive and involved in the tobacco cessation process if they become active in creating smoke free communities.
- The Indian and Inuit Health Committee of the Canadian Paediatric Society (CPS) states the following:

  > Reducing tobacco use among Aboriginal youth requires a multifaceted approach. Central to this is community involvement. Unless community members, particularly parents, become convinced that there is a problem and act, programs are doomed to failure. Schools must also become involved, not only to insist on tobacco-free premises, but to provide prevention programs early in elementary school that will help children establish non-smoking peer groups, who can in turn influence other children. Medical personnel can provide information about and support for stop smoking programs and act as resources for the community. Enforcement agencies must enforce laws regarding the sale of tobacco products to minors. Only with the cooperation of all of these groups can this severe public health menace be addressed.
  > (http://www.cps.ca/english/statements/II/ii99-01.htm)

- One of the most effective ways to involve youth in tobacco cessation is to create youth-to-youth based programs where youth are trained in tobacco cessation and then go on to present the knowledge they have gained to their peers.
- Trained youth then can form peer support groups and become engaged in youth driven projects for tobacco cessation.

Activity: 20 minutes

- Provide participants with the handout *Recommendations for School Health Programs To Prevent Tobacco Use and Addiction (pages 91-94)*. Give them a few minutes to read this.
- Have participants discuss how these recommendations can be used in the community as well as within the schools.
- In groups have participants create a strategy for working with youth and tobacco cessation in their communities and schools.

UNDERSTANDING CHILD DEVELOPMENT

If participants ask to learn about child development, discuss the following with them and have them participate in the suggested activities.

Discussion: Give participants the following brief summary of the theorists to read about:

Some of the major theorists are *Maslow, Erikson, Piaget, Kohlberg*, and *Bandura*.

- **Maslow** focuses on an individual's self-actualization and fulfillment of his or her potential. He identified five levels of basic human needs: physiological, safety, belongingness and love, esteem, and self-actualization, as well as cognitive and aesthetic needs. Maslow believes that, as we go most deeply into ourselves and seek our individual identity, we begin to think about all humans. Further when we become fully human we learn that we are not only different from one another but also similar. Human needs form a hierarchy or ladder of basic physiological demands. Needs at the lower levels must be reasonably well satisfied before the individual will turn his or her attention to those at the higher levels. For example, a child who is always hungry is not likely to develop much intellectual curiosity.
- **Eriksson** is concerned with the development of individual identity and his or her ability to function in society. He believes that development consists of a series of psychosocial crises which individuals must successfully resolve as they mature. Those conflicts involve the person's struggle to achieve individuality and, at the same time, to learn to function in society. The different stages of psychosocial development which Erikson has identified are produced by experiences each child has in interaction with his or her world. The way children and adults interact early in a child's life is very important. According to Erikson, every individual moves through an orderly sequence of stages, each of which is more complex than the last. We become mature as we move from one stage to another. At each stage, we are faced with a psychosocial conflict which must be resolved before moving on to the next stage of development.
- **Piaget** focuses mostly on children's cognitive (thinking or mental process) development, but he also looks at moral growth. He believes that human emotion evolves from the same processes as cognitive development or the ability to think. Piaget bases this on four kinds of operations: assimilation, accommodation, conservation, and reversibility. These operations are closely related, because children develop units of knowledge about the world, called schemata. As children learns new information about their environment, that information becomes part of their thinking (schemata) and the thinking and behaviour are accommodated (changed) to reflect those new perceptions. Piaget also says that children move through the four stages in order, although not always at the same pace.
- **Kohlberg** concentrates on moral development that grows and changes with maturity. He examined Piaget's thinking and developed a hierarchy (a system in which people or things are arranged in order of importance) of moral development where each person must progress through each stage to get to the next. Not everyone agrees with Kohlberg's theories and many people say they only fit middle class western lives.
- **Bandura** studied the influence of social models. He says that children learn by observing the behaviour of those around them. Bandura shows that learning may occur when a child observes the behaviour of others even when the child does not copy what he has learned. Further, whether or not the child will copy the behaviour depends on the consequences of that behaviour and its rewards and punishments.

Activity: 20 minutes

- Have participants discuss the differences and similarities in the Western/Mainstream theories and First Nation child development practices, and how they can or can't use a combination of theories and ideas in their work with youth.

RECOMMENDATIONS FOR SCHOOL HEALTH PROGRAMS TO PREVENT TOBACCO USE AND ADDICTION

(Adapted from ftp://ftp.cdc.gov/pub/Publications/MMWR/rr/rr4302.pdf. p 11-18)

The seven recommendations below summarize strategies that are effective in preventing tobacco use among youth. To ensure the greatest impact, schools should implement all seven recommendations.

1. Develop and enforce a school policy on tobacco use.
2. Provide instruction about the short and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.
3. Provide tobacco use prevention education in kindergarten through to grade twelve; this instruction should be especially intensive in junior high or middle school and should be reinforced in high school.
4. Provide program-specific training for teachers.
5. Involve parents or families in support of school-based programs to prevent tobacco use.
6. Support cessation efforts among students and all school staff who use tobacco.
7. Assess the tobacco use prevention program at regular intervals.

Discussion of Recommendations

Recommendation 1: Develop and enforce a school policy on tobacco use.

A school policy on tobacco use must be consistent with state and local laws and should include the following elements:

- An explanation of the rationale for preventing tobacco use (i.e., tobacco is the leading cause of death, disease, and disability).
- Prohibitions against tobacco use by students, all school staff, parents, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property.
- Prohibitions against tobacco advertising in school buildings, at school functions, and in school publications.
- A requirement that all students receive instruction on avoiding tobacco use.
- Provisions for students and all school staff to have access to programs to help them quit using tobacco.
- Procedures for communicating the policy to students, all school staff, parents or families, visitors, and the community.
- Provisions for enforcing the policy.

To ensure broad support for school policies on tobacco use, representatives of relevant groups, such as students, parents, school staff and their unions, and school board members, should participate in developing and implementing the policy. Examples of policies have been published, and additional samples can be obtained from state and local boards of education.

Clearly articulated school policies, applied fairly and consistently, can help students decide not to use tobacco. Policies that prohibit tobacco use on school property, require prevention education, and provide access to cessation programs rather than solely instituting punitive measures are most effective in reducing tobacco use among students.

A tobacco-free school environment can provide health, social, and economic benefits for students, staff, the school, and the district. These benefits include decreased fires, discipline problems related to student smoking, improved compliance with local and state smoking ordinances, and easier upkeep and maintenance of school facilities and grounds.

Recommendation 2: Provide instruction about the short and long-term negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.

Some tobacco use prevention programs have been limited to providing only factual information about the harmful effects of tobacco use. Other programs have attempted to induce fear in young persons about the consequences of use. However, these strategies alone do not prevent tobacco use, may stimulate curiosity about tobacco use, and may prompt some students to believe that the health hazards of tobacco use are exaggerated.

Successful programs to prevent tobacco use address multiple psychosocial factors related to tobacco use among children and adolescents. These factors include:

- **Immediate and long-term undesirable physiologic, cosmetic, and social consequences of tobacco use.** Programs should help students understand that tobacco use can result in decreased stamina, stained teeth, foul-smelling breath and clothes, exacerbation of asthma, and ostracism by non-smoking peers.
- **Social norms regarding tobacco use.** Programs should use a variety of educational techniques to decrease the social acceptability of tobacco use, highlight existing antitobacco norms, and help students understand that most adolescents do not smoke.
- **Reasons that adolescents say they smoke.** Programs should help students understand that some adolescents smoke because they believe it will help them be accepted by peers, appear mature, or cope with stress. Programs should help students develop other more positive means to attain such goals.
- **Social influences that promote tobacco use.** Programs should help students develop skills in recognizing and refuting tobacco-promotion messages from the media, adults, and peers.
- **Behavioural skills for resisting social influences that promote tobacco use.** Programs should help students develop refusal skills through direct instruction, modeling, rehearsal, and reinforcement, and should coach them to help others develop these skills.
- **General personal and social skills.** Programs should help students develop necessary assertiveness, communication, goal-setting, and problem-solving skills that may enable them to avoid both tobacco use and other health risk behaviours.

School-based programs should systematically address these psychosocial factors at developmentally appropriate ages. Particular instructional concepts should be provided for students in early elementary school, later elementary school, junior high or middle school, and senior high school. Local school districts and schools should review these concepts in accordance with student needs and educational policies to determine in which grades students should receive particular instruction.

Recommendation 3: Provide tobacco use prevention education in kindergarten through to Grade 12. This instruction should be especially intensive in junior high or middle school and should be reinforced in high school.

Education to prevent tobacco use should be provided to students in each grade, from kindergarten through to grade twelve. Because tobacco use often begins in grades six through eight, more intensive instructional programs should be provided for these grade levels. Particularly important is the year of entry into junior high or middle school when new students are exposed to older students who use tobacco at higher rates. Thereafter, annual prevention education should be provided. Without continued reinforcement throughout high school, success in preventing tobacco use dissipates over time. Studies indicate that increases in the intensity and duration of education to prevent tobacco use result in concomitant increases in effectiveness.

Most evidence demonstrating the effectiveness of school-based prevention of tobacco use is derived from studies of schools in which classroom curricula focused exclusively on tobacco use. Other evidence suggests that tobacco use prevention also can be effective when appropriately embedded within broader curricula for preventing drug and alcohol use or within comprehensive curricula for school health education. The effectiveness of school-based efforts to prevent tobacco use appears to be enhanced by the addition of targeted communitywide programs that address the role of families, community organizations, tobacco-related policies, antitobacco advertising, and other elements of adolescents' social environment. Because tobacco use is one of several interrelated health risk behaviours addressed by schools, CDC recommends that tobacco use-prevention programs be integrated as part of comprehensive school health education within the broader school health program.

Recommendation 4: Provide program-specific training for teachers.

Adequate curriculum implementation and overall program effectiveness are enhanced when teachers are trained to deliver the program as planned. Teachers should be trained to recognize the importance of carefully and completely implementing the selected program. Teachers also should become familiar with the underlying theory and conceptual framework of the program as well as with the content of these guidelines. The training should include a review of the program content and a modeling of program activities by skilled trainers. Teachers should be given opportunity to practice implementing program activities.

Studies indicate that in-person training and review of curriculum-specific activities contribute to greater compliance with prescribed program components. Some programs may elect to include peer leaders as part of the instructional strategy.

By modeling social skills and leading role rehearsals, peer leaders can help counteract social pressures on youth to use tobacco. These students must receive training to ensure accurate presentation of skills and information. Although peer-leader programs can offer an important adjunct to teacher-led instruction, such programs require additional time and effort to initiate and maintain.

Recommendation 5: Involve parents or families in support of school-based programs to prevent tobacco use.

Parents or families can play an important role in providing social and environmental support for non-smoking. Schools can capitalize on this influence by involving parents or families in program planning, in soliciting community support for programs, and in reinforcing educational messages at home. Homework assignments involving parents or families increase the likelihood that smoking is discussed at home and motivate adult smokers to consider cessation.

Recommendation 6: Support cessation efforts among students and all school staff who use tobacco.

Potential practices to help children and adolescents quit using tobacco include self-help, peer support, and community cessation programs. In practice, however, these alternatives are rarely available within a school system or community. Although the options are often limited, schools must support student efforts to quit using tobacco, especially when tobacco use is disallowed by school policy.

Effective cessation programs for adolescents focus on immediate consequences of tobacco use, have specific attainable goals, and use contracts that include rewards. These programs provide social support and teach avoidance, stress management, and refusal skills . Further, students need opportunities to practice skills and strategies that will help them remain non-users .

Cessation programs with these characteristics may already be available in the community through the local health department or voluntary health agency (i.e. American Cancer Society, American Heart Association, American Lung Association). Schools should identify available resources in the community and provide referral and follow-up services to students. If cessation programs for youth are not available, such programs might be jointly sponsored by the school and the local health department, voluntary health agency, other community health providers, or interested organizations (i.e. churches).

More is known about successful cessation strategies for adults. School staff members are more likely than students to find existing cessation options in the community. Most adults who quit tobacco use do so without formal assistance. Nevertheless, cessation programs that include a combination of behavioural approaches (i.e. group support, individual counselling, skills training, family interventions, and interventions that can be supplemented with pharmacologic treatments) have demonstrated effectiveness.

For all school staff, health promotion activities and employee assistance programs that include cessation programs might help reduce burnout, lower staff absenteeism, decrease health insurance premiums, and increase commitment to overall school health goals.

Recommendation 7: Assess the tobacco use prevention program at regular intervals.

Local school boards and administrators can use the following evaluation questions to assess whether their programs are consistent with CDC's (Centers for Disease Control and Prevention) Guidelines for School Health Programs to Prevent Tobacco Use and Addiction. Personnel in federal, state, and local education and health agencies also can use these questions to A) assess whether schools in their jurisdiction are providing effective education to prevent tobacco use and B) identify schools that would benefit from additional training, resources, or technical assistance. The following questions can serve as a guide for assessing program effectiveness:

1. Do schools have a comprehensive policy on tobacco use, and is it implemented and enforced as written?
2. Does the tobacco education program foster the necessary knowledge, attitudes, and skills to prevent tobacco use?
3. Is education to prevent tobacco use provided, as planned, in kindergarten through to grade twelve, with special emphasis during junior high or middle school?
4. Is in-service training provided, as planned, for educators responsible for implementing tobacco use prevention?
5. Are parents or families, teachers, students, school health personnel, school administrators, and appropriate community representatives involved in planning, implementing, and assessing programs and policies to prevent tobacco use?
6. Does the tobacco use prevention program encourage and support cessation efforts by students and all school staff who use tobacco?

SESSION 12
POLICY DEVELOPMENT

Purpose: This session will allow participants to gain an understanding of policy development: what policy development is, the steps involved in policy development, and how to engage the community in the policy development process. Participants will also explore ways of using these tools in initiating tobacco cessation policies in their communities.

Objectives: By the end of the session students will be able to:

- Define policy and policy development.
- Describe the steps in policy development.
- Describe how to involve communities in policy development.
- Describe how to initiate tobacco cessation policies in communities.
- Develop an outline of a tobacco cessation policy.

Material: *Policy Development* handout.
Flip chart and markers.

Time: 80 minutes

Activity: 5 minutes

Have participants define policy and policy development. Post their answers on the flip chart.

Discussion: 5 minutes

- There is no one definition of policy. Everyone defines policy different. People see policy as rules or guidelines; an organizations principles; the way that things are done; a framework; the standards for the organisation; and best practice. Consequently, it is helpful to see policy as something that has a variety of elements, all of which define policy. These elements are as follows:
  - Policy creates a framework for action
  - Policy is a decision grounded in legitimate authority
  - Policy is a written product
  - Policy is in the hearts and minds of people
  - Policy creation is an ongoing process
- There are different words for policy and they include different levels of authorization: laws, regulations, rules, and guidelines.
- Policies help people who work in an organization to have a framework for action that helps them do the work they need to do; get rid of discussing and re-discussing the same issues over and over again; meet legal or other requirements, and serve as a tool to improve the quality of the organization or community it serves.
- Policies or policy issues emerge from a different sources such as government proclamations, research findings, trends with in a professional field, anecdotal experiences, and community/stakeholder initiatives.
- In order to create comprehensive and integrated policy you need to start an organized process which involves the participation of stakeholders, organizations, and communities.
- Consultation and communication are essential components in policy development.
- Policies often initiates change.
- Policies are is usually written up in a manual called a policy manual.

Activity: 5 minutes

Have participants discuss the policies on tobacco cessation that exist in their communities and how they think they came to exist.

Discussion: 10 minutes

- In order for policy to be good it should answer the following questions:
  - Is it useful for the intended users such as the community?
  - Does it include policies in all areas that are important to accreditation or legislative requirements.
  - Will it improve the quality of a service or a community?
- In order to develop policy are a number of steps that need to occur. They are as follows:
  - Organize and get the support of key community leaders and establish a group of people who are interested in forming the policy and have them make up a working group who will guide the process, research the information needed for the policy. These people will define the problem. They will be involved in the following activities during the entire policy development process: identification of issues, defining the need for policy, clarifying the policy issues, assessing the policy, implementing the policy, evaluation, and review of the policy and ensuring for continual community consultation.
  - Define the mission, vision, goals, and objectives of the policy and in doing so answer questions such as, what is the purpose; how will work be accomplished; who will be involved? Look for the best solutions.
  - Gather information that will present the nature of the issue to be addressed in the policy. This can happen through working with the community through focus groups, community meetings, etc. to examine the questions: What are we going to do? Why are we doing it? How are we going to do it? Who is going to do it? When are we going to do it? How long will it take? How does the plan relate to our vision and goals? Do we need to re-think our goals and objectives?
  - Plan for implementation and decide what actions you need to take; What individuals and agencies should be involved in the implementation? What resources are available? What are the estimated costs and timelines?
  - Develop a program and budget.
  - Overcome barriers as there could be any number of barriers to implementing policy such as inadequate funding, lack of awareness of the problem at hand, lack of commitment by the community, leadership, or others.
  - Lobby for legislation and get community members to help you as you lobby.
  - Distribute findings once all information is gathered.
  - Evaluate. Once a policy is created it needs to undergo an evaluation to see how the policy has affected the community, to compare the actual results with the desired results, review successes and mistakes and modify anything that needs to be modified.

Activity: 10 minutes

In groups have participants outline how they will initiate and implement a tobacco cessation policy in their communities.

Discussion: 10 minutes

- There are different ways to write up policies. The people writing the policy will have to decide which way serves them best.
- Most policies do include a vision statement, a mission statement, a value statement goals and/or objectives, service delivery, and evaluation.
- There is a very useful process for involving the community before you start to write policy. This process involves engaging in a policy planning day or weekend, community consultation, review, continual evaluation, and community involvement.
    - **The policy planning day or weekend** consists of bringing concerned people together to develop the vision, mission, values, aims, objectives, goals, strategies, and policy development strategies.
    - **Community consultation** takes place once the policy is drafted. This process helps ensure that the policy meets the needs, gets the support of the community, and can be implemented. After the consultation policies usually are revised and then may be circulated once more, if time permits.
    - **A policy review** occurs once a year or sooner, depending on how the stakeholders and community feel about this. This review makes sure that the policy is still appropriate and meaningful. If the policy needs revision, the policy process must start over again. The policy review process ensures **continual evaluation and organizational and/or community involvement.**

Activity: 35 minutes

- Review the *Policy Development (pages 98-99)* handout with participants.
- In groups have participants design a policy making process and draft a brief tobacco cessation policy.
- Have participants share their policies with the group as a whole.
- Debrief what participants gained from this exercise.

POLICY DEVELOPMENT

Policy Components

1. **Vision Statement**
   A vision statement includes a clear description of the organization, its operations and/or what it wants to achieve in the policy.
2. **Mission Statement**
   A mission statement outlines core beliefs, needed services, and benefits of the policy.
3. **Value Statement**
   A value statement represents the spirit and intent of the organization.
4. **Goals and Objectives**
   The goals and objectives contain the aims and benefits of the policy with a focus on community members.
5. **Service Delivery**
   Service delivery examines and outlines how objectives will be achieved as it the procedures for getting things done.
6. **Evaluation**
   The evaluation process addresses policy examination, observation and updates. Evaluation can occur from within the organization and community and look at outcomes and objectives, or can occur from outside and look at outcomes and effectiveness.

Policy Development Steps

1. **Organize**
   Get the support of key community leaders and establish a group of people who are interested in forming the policy. Establish a working group who will guide the process, research the information needed for the policy, define the need for policy, clarify policy issues, implement the policy, evaluate and review the policy, and ensure continual community consultation.
2. **Define the mission, goals and objective of the policy**
   Answer questions: what is the purpose, how will work be accomplished, who will be involved. Look for best solution.
3. **Gather Information**
   Get community in put on the policy through focus groups, community meetings, etc. Examine the questions; what are we going to do; why are we doing it; how are we going to do it; who is going to do it; when are we going to do it; how long will it take, how does the plan relate to our vision and goals; do we need to re-think our goals and objectives?
4. **Plan for Implementation**
   Decide what actions you need to take, what individuals and agencies should be involved in the implementation, what resources are available, and what the estimated costs and timelines are. Develop a program and budget.

5. **Overcome Barriers**
   Discuss possible barriers to policy implementation such as inadequate funding, lack of awareness of the problem at hand, lack of commitment by the community, leadership, or others.
6. **Lobby for Legislation**
   Involve community members.
7. **Distribute Findings**
   Once information is gathered and compiled.
8 **Evaluate**
   Examine how the policy has affected the community, compare actual results with desired results, review success and mistakes and change anything that needs to be modified.

Community Involvement Process

1. **Policy Planning Day or Weekend**
   Organize a day to bring concerned community members together to develop policy vision, mission, values, aims, objectives, goals, strategies, and policy development strategies.
2. **Community Consultation**
   Once the policy is drafted concerned community members are consulted on the contents in order to ensure that the policy meets community needs, gets the support of the community, and can be implemented. After community consultation are finished policies usually are revised and may be circulated once more, if time permits.
3. **Policy Review**
   Policy review generally occurs once a year or sooner, depending on what stakeholders and community members decide. The review process ensures that the policy is still appropriate and meaningful. If the policy needs revision, the policy process must start over again. The policy review process ensures continual evaluation and community involvement.

SESSION 13
COMMUNITY DEVELOPMENT STRATEGIES

Purpose: This session will allow participants to explore how community development takes place. It will aid them in understanding the dynamics of community development and the role they can play in this process.

Objectives: By the end of the session students will be able to:

- Describe the concept of community development.
- Identify the steps in community development.
- Describe the community's role in tobacco cessation.
- Describe their role in community development.
- Discuss how to use community development strategies in tobacco cessation activities in communities.
- Design a community development strategy for tobacco cessation.

Material: *Visions, Realities, and Guiding Principles for the Future* handout

Time: 80 minutes

Activity: 5 minutes

- Ask participants to define community and post their responses.
- Have participants define community development and post their responses.

Discussion: 10 minutes

- A community is made up of a group of people who live in the same area, share the same government, interests, identity, and can be a group that is seen as belonging to part of a distinct segment of society.
- We all belong to communities, whether it is a First Nation, a school, a church, a city, a country, etc.
- As First Nation people we have a strong sense of community. We each represent our families, our communities, and our Nation. This is a value that we carry and is the basis of our Nations.
- First Nation communities include the whole family: infants, children, youth, adults, and Elders.
- As in all life, First Nation communities are seen as circular and interconnected.

Activity: 5 minutes

- In pairs have participants discuss the meaning of community and the ways in which they have been a part of a community.

Discussion: 5 minutes

- Community development involves the active participation of its member in issues which affect their lives.
- Community development focuses on the relation between individuals, groups and institutions that shape their lives.
- Community development is a process that is both individual and collective.
- Community development is about partnerships and the sharing of awareness, experience, knowledge, and skills that will contribute to change.
- The main reason for community development is to assist in the identification of needs and rights; the clarification of objects, and the creation of strategies and actions to obtain needs and rights in a respectful manner.
- "Development comes from within. The process of healing and development unfolds from within each person, relationship, family, community or nation." (Phil Lane, http://ishgooda.nativeweb.org/respect2.htm)

- First Nation community development needs to have a focus on our cultures and the interconnectedness between us and the world around us.
- First Nations community development has a basis on cultural and spiritual revitalization, uses a holistic approach, involves the whole community, and exercises community control. There are key elements of a community development project. They are important to the implementation and follow through the project. These elements include the following:
  - A strong community organizer.
  - The training of the organizer.
  - Resources that support the organizer.
- First Nation community development uses the circle to make up its framework and includes the continual involvement and interaction between the community development process, the goals, activities, and all community members.

Activity: 10 minutes

- Have participants take part in a three-way brainstorm activity to outline community development from a First Nation worldview.

Discussion: 5 minutes

- The National Tobacco Control Strategy has a basis in community development strategies and aims to create "a comprehensive and balanced integration of community policies, programs and services designed to protect, prevent, and promote cessation through the active collaboration of local citizens and organizations" (http://www.healthservices.gov.bc.ca/aboriginal/pdf/honouring.pdf).
- In order to reach this point it is important to understand the following:
  - The best way to change behaviour is to intervene through social structures within a community.
  - Interventions delivered through community channels reach larger proportions of the smoking population than is possible with individually orientated programs.
  - The goal is to create a social climate that does not support tobacco use.
- According to studies and reports in British Columbia First Nation communities, it appears that the following holds true:
  - Peer and family relationships have the greatest influence on First Nation individuals in their decision to use tobacco.
  - First Nation smoke most when socializing during recreational events such as Bingo, as well as ceremonial occasions such as funeral feasts where cigarettes are often put in a bowl on the table along with the food.
  - Easy access to tobacco and its low cost on reserves support smoking.
  - Tighter controls on tobacco and smoke-free zones would support their efforts to quit, but feel these initiatives would have to be approached collectively, since individualistic "crusades" conflict with Aboriginal values.
  - Social acceptance and tolerance of smoking allows it to continue.

  (http://www.healthservices.gov.bc.ca/aboriginal/pdf/honouring.pdf)
- Each First Nation community has to decide what community development strategy works for them. Each First Nation is distinct.

- Elders, local, provincial, and national First Nations leadership, and volunteers are important in tobacco cessation community development projects.
- Effective First Nation community development tobacco cessation strategies include policy development, public education, networking, and cessation programs.

Activity: 40 minutes

- Give participants the handout *Visions, Realities, and Guiding Principles for the Future (pages 103-104)*.
- In groups have participants design a community development strategy for tobacco cessation and share their strategy with the group.
- Debrief and discuss the complexities of community development and the similarities and differences in First Nations and non-First Nations community development strategies.

VISIONS, REALITIES AND GUIDING PRINCIPLES FOR THE FUTURE

Presented by Phil Lane, Jr.,
International Coordinator of the
Four Worlds International Institute for Human and Community Development
(http://ishgooda.org/respect2.htm)

FOUR WORLDS PRINCIPLES FOR BUILDING A SUSTAINABLE WORLD

"Starting from within, working in a circle, in a sacred manner, we heal ourselves, our relationships and our world."

STARTING FROM WITHIN

Development Comes From Within

The process of healing and development unfolds from within each person, relationship, family, community or nation.

Vision

A vision of who we can becomes is like a magnet drawing us to our potential. Where there is no vision, there can be no development.

Culturally-Based

Healing and development must be rooted in the wisdom, knowledge and living processes of our cultures.

Interconnectedness

Because everything is connected to everything else, any aspect of our healing and development is related to all the others (personal, social, cultural, political, economic, etc.). When we work on any part, the whole circle is affected.

WORKING IN A CIRCLE

Personal growth and healing and the healing and development of our families and communities must go hand in hand.

Working at one level of development without attending to the other is not enough. Personal and social development as well as top-down and bottom-up approaches must be balanced.

Unity

We need the love, support and caring of others to heal and develop ourselves. Unity is the starting point for development, and as development unfolds, unity deepens.

Participation

People have to be actively engaged in the process of their own healing and development. Without participation, there can be no development.

Justice

Every person must be treated with respected as a human being and a child of the Creator, regardless of gender, race, culture, religion or any other reason. Everyone should be accorded the opportunity to fully participate in the processes of healing and development, and to receive a share of the benefits.

IN A SACRED MANNER

Spirituality

Spirituality is at the heart of healing and development. Connection with the Creator brings life, unity, love and purpose to the process, and is expressed through a heart-centred approach to all that we do.

Harmonizing With Natural Law

Growth is a process of uncovering who we truly are as human beings in harmony with the natural laws of the Universe.

Walking In Balance

Codes or morality, ethics and protocol teach us how to walk the road of life in a good way. Violating moral and ethical boundaries can destroy the process of healing and development.

Working From Principle

Our plans and actions are founded on our deepest understanding of the principles that describe how the universe is ordered and how healing and development unfolds.

WE HEAL AND DEVELOP OURSELVES, OUR RELATIONSHIPS AND OUR WORLD

Learning

Learning to live in ways that promote life and health is the essence of our development. Our primary strategy is therefore the promotion of this type of learning.

Sustainability

When we take actions to improve our lives or the lives of others, it is critical to avoid undermining the natural systems upon which all life depends and to work in ways that enhance the capacity of people to continue in the path of their own healing and development.

Move To The Positive

Solving the critical problems in our lives and communities is best approached by visualizing and moving into the positive alternative that we wish to create, as well as building on the strength we already have, rather than giving away our energy fighting the negative.

Be The Change You Want To See

In all of our actions, we seek to be living examples of the changes we wish to see in the world. By walking the path, we make the path visible.

With the courage and dedication to utilize the wisdom and guiding spiritual principles of our Elders on the path to a peaceful and equitable future, we will find that we have the power and ability to carefully and lovingly remove any barriers that have limited the development of our full potential as human beings and communities. The greater the difficulty in our path, the even greater opportunity for our growth and ultimate victory; we can always become more than we have ever been.

We know from our ancient teachings that the sacred eagle of humanity has two perfectly balanced and harmonious wings; one representing woman, and one representing man. In our relationships as women and men, brothers and sisters, mothers and fathers, we must join together to eliminate all forms of disrespect, mistreatment, or lack of sharing in the responsibility of raising the world's children. It is my deepest prayer that with every new sunrise, we can recognize more and more that the most sacred and holy of all the wonderful ceremonies and gifts that the Creator has given us is the birth of child, and that everything we can do to provide our children and communities the best possible future is a sacred gift and responsibility.

For is not the moment long, long overdue by beloved relatives, through the unfailing power and love of our good Creator, for us to free ourselves completely from the hurt of both the past and present so we may truly soar like majestic eagles to the promised greatness of our sacred destiny and future.

"True peace is not merely the absence of tension; it is the presence of justice"
Dr. Martin Luther King

POST-TEST

Upon completion of the training, pass out the following post-test to access the knowledge that participants have acquired. Let participants know that there are no right or wrong answers. This test helps you access what they have learned and helps them to do so as well.

Activity: 30 minutes

Tobacco Cessation Post-test

- Describe your role in tobacco cessation in your facility and community.

- List and describe the most effective strategies for the promotion of motivation to quit tobacco usage.

- What are the necessary knowledge and skills addictions workers need for involvement in smoking cessation initiatives?

- List the most important information and resources that exist on tobacco cessation

- Define how policies and protocols are set up.

- Describe the steps for involvement in community interventions.

- What skills are necessary for involvement in community interventions?

- List the training addictions workers need for tobacco cessation and community intervention work.

- How does understanding child development assist your work in tobacco cessation interventions in your community?

- Describe the traditional use of tobacco.

- List the skills you need to work with adolescents.

- List the tools you need to work with adolescents.

- How and why does understanding how to work with adolescents assist your work in tobacco cessation interventions in your community?

- Describe the role schools play in tobacco cessation

- Define your role in working within schools towards the promotion of tobacco cessation.

SESSION 14
CLOSING CIRCLE

Purpose: To allow participants to find closure for the sessions they have participated in, share their visions in regards to tobacco cessation in their communities, and define their part in tobacco cessation.

Objectives: By the end of this session participants will be able to:

- Share their ideas about their role in tobacco cessation.
- Demonstrate how to bring closure to sessions they may facilitate.

Material: None

Time: 60 minutes maximum

Activity:

- Have group participate in a Talking Circle and share what they experienced in the training, how they see tobacco cessation in their communities, and define their role in tobacco cessation within their communities.
- After participants have finished the Talking Circle have them stand up and engage in the friendship circle to close. In this activity one person turns in the circle will be first. The first person will turn to their neighbour and shake their hand, then proceed through the circle until they have shaken everyone's hand and come back to their spot. Each person follows in a continuum and does this same thing until everyone in the circle has gone around once and returned to their original spot. Each person will give and received a handshake. Participants may also hug other participants with permission and/or say something positive.

RESOURCES

Below is a list of useful available resources for tobacco cessation information and training kits. There are many more available and additional internet and network searches are recommended.

A Resource Pack for Training Health Professionals: Helping Smokers Change
An Aboriginal Tobacco Strategy For British Columbia - Honouring our Health

Aniqsaattiarniq Breathing Easy: Community Resource Kit, Pauktuutit Inuit Women's Association

Avoiding Relapse Using the Awareness, Carmen Daniels, editor, Published by Nechi Institute, Page 68

First Nations and Inuit Tobacco Control Strategy Framework, prepared by the First Nations and Inuit Health Branch and the FNITCS Advisory Circle with the Assistance of Socio-Tech Consulting Services August 6, 2002

First Nations and Métis Tobacco Control Strategy Training for Trainers: Traditional Tobacco. First Nations Indian Inuit Health Branch: Alberta. 2004
First Nations Inuit Health Branch Cessation Resources
Health Canada. The Facts About Tobacco

Quitting: Guide to Tobacco Use Cessation Programs in Canada. Health Canada.

Lessons from Other Community-Based Strategies, Page 13
Ministry of Health and Ministry responsible for Seniors Paediatrics & Child Health 1999; 4(4):277-281

Pip Mason, Helping Smokers Change, Page 60, World Health Organization – Europe. World Health Organisation – Europe

Protecting our Families: The Non-Traditional Use of Tobacco. NICHRO. 1996
Reading, Dr. Jeff., Chapter Four: The Tobacco Report. Manitoba: Northern Research Unit, University of Manitoba, First Nations and Inuit Regional Health Survey

Tobacco materials available from the Indigenous People's Task Force Resource Library.

Tobacco use among Aboriginal children and youth. Canadian Paediatric Society: Indian and Inuit Health Committee.

Tobacco: A Cultural Approach to Addiction and Recovery for Aboriginal Youth: A Tribe Called Quit. Nechi Institute. Alberta: Edmonton

Vidal, Colette. Tobacco Reduction: The Fight Against Tobacco Abuse. NICHRO

WUNSKA. First Nations Youth Inquiry into Tobacco Use: Final Comprehensive Report to Health Canada, April 1997. Saskatchewan Indian Federated College. Page 52.

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http://theliterarylink.com/understanding.html

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http://www.abconlinepharmacy.com/ns/customer/quitting-smoking-nicotine-replacement-therapy.php

http://www.ayn.ca/quit/en/c3_2_spiritual_use.asp

http://www.ayn.ca/quit/en/manual_pdfs/tobacco_manual72.PDF

http://www.cps.ca/english/statements/II/ii99-01.htm

http://www.hc-sc.gc.ca/hecs-sesc/tobacco/facts/topsix.html#nicotine

http://www.healthservices.gov.bc.ca/aboriginal/pdf/honouring.pdf

http://www.mapl.com.au/ideas/ideas0.htm

http://www.naho.ca/english/pdf/FNITCS.pdf

http://www.niichro.com/Tobacco%202002/tob02_4.html

http://www.niichro.com/Tobacco%202002/tob02_5.html

http://www.niichro.com/Tobacco%202002/tob02_8.html

http://www.who.dk/Document/E73085.pdf

http://www3.bc.sympatico.ca/kakakaway/wheel6.htm

PARTICIPANT EVALUATION

Participant Evaluation

Please rate the following on a scale of 1 to 10 with 1 being the lowest and 10 the highest.

The Instructor:

- Presenter was effective ___
- Presenter covered concepts in a clear manner ___
- Presenter appeared to be confident ___
- Presenter understood the training material ___
- Presenter spoke clearly and loudly enough to suit the audience ___
- Presenter taught at a suitable pace and level. ___
- Presenter left sufficient time for questions and answered each thoroughly ___

The Training:

- The sessions were relevant and useful ___
- The training met my expectations ___
- The materials were appropriate and useful. ___
- The sessions were just the right length of time ___
- The sessions and over all training will help me work more effectively in my workplace and/or community. ___

General Observations:

Please answer the following questions in the spaces provided below.

- What part/s of the training did you consider most valuable?

- What part of the training did you consider least valuable?

- Describe the skills/tools/implementation strategies/knowledge that you learned in the training that you can take back to your community?

- What additional topics or sessions would you consider important to include in the training that were not covered?

Comments:

Please feel free to make additional comments below:

FACILITATOR EVALUATION

Please rate the following on a scale of 1 to 10 with 1 being the lowest and 10 the highest.

The Tobacco Cessation Toolkit:

- The sessions were relevant and useful ___
- The materials were appropriate and useful. ___
- The sessions were just the right length of time ___
- The sessions covered the concepts in a clear manner. ___
- The sessions were deliverable at a suitable pace and level. ___
- The toolkit and training was well organized. ___

The Facilities:

- The facilities were clean, comfortable, and pleasant ___
- The location was convenient ___
- The equipment was adequate and functional ___

General Observations:

Please answer the following questions in the spaces provided below.

- What sessions did the participants respond to the most positively?

_____

_____

_____

_____

- What sessions did the participants respond to the most negatively?

_____

_____

_____

_____

- Please explain whether the Tobacco Cessation Toolkit did or did not provide relevant training to the participants.

- What additional topics or sessions would you consider important to include in the training that were not covered?

- How do you think the tobacco cessation training could be strengthened?

Comments:

Please feel free to make additional comments below: