CAN ADAPTT

Canadian Smoking Cessation Guideline

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Specific Populations: Aboriginal Peoples†

CAN-ADAPTT's Clinical Practice Guideline Development Group;
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† Aboriginal peoples is used as an inclusive term which includes First Nations (both on and off reserve), Inuit, and Métis. This is not meant to take away from the diversity that exists among Aboriginal peoples.

Overview of Evidence

The following recommendations, and supporting evidence, have been extracted from existing clinical practice guidelines to inform the development of the CAN-ADAPTT Summary Statements.

CAN-ADAPTT worked with the Guidelines Advisory Committee (GAC) to conduct a literature search (years: 2002-2009) to identify existing clinical practice guidelines (CPGs). Five existing clinical practice guidelines were identified as meeting the high quality criteria set out in the AGREE Instrument. The recommendations contained in these high quality CPGs have been used as the evidence base for the CAN-ADAPTT guideline development process. Visit www.can-adaptt.net to view CAN-ADAPTT's guideline development methodology.

New Zealand Ministry of Health (2007)[1]

> Offer Ma¯ori who smoke cessation support that incorporates known effective components (such as medication). **(Grade of Evidence = √).**
>
> Where available, offer culturally appropriate cessation services to Ma¯ ori. **(Grade of Evidence = C)**
>
> Health care workers should be familiar with the cessation support services for Ma¯ ori that are available in their area (such as local Aukati Kai Paipa providers) and nationally (such as Quitline) so they can refer appropriately. **(Grade of Evidence = √).**
>
> Health care workers providing cessation support to Ma¯ori should seek training in how to deliver smoking cessation treatment to Ma¯ ori. **(Grade of Evidence = √).**

Background

It should be recognized by healthcare providers that tobacco has played an important part in traditional and spiritual practices in many Aboriginal communities. Traditionally tobacco was used by many First Nations for ceremonial and medicinal purposes and is still practiced across many First Nations.

However, it is well documented that mis-use/abuse of tobacco is of growing concern not only to the general Canadian population, but as well as to First Nations. For example, studies have demonstrated that smoking rates amongst First Nations peoples are more than double that of the general Canadian population. Furthermore, it has been documented that within First Nations populations, there are instances of smoking beginning as early as 6-8 years with an increase in uptake between the ages of 10-12, and peaking at 16 years of age. The relevance of targeting children/youth within this population is therefore evident.

Not only are rates of smoking higher in this population, but the poorer health status of First Nations people in Canada has also been well documented in the literature which

[1] Ministry of Health. (2007, August). New Zealand smoking cessation guidelines. Wellington: Ministry of Health.

together points to significantly higher rates of smoking related illnesses in this population.

There is limited evidence available demonstrating effective strategies for smoking cessation within Aboriginal populations. It should be noted that this does not suggest weak evidence of effective strategies within this population, but rather, a limited amount of research available (see Research Gaps section). However, generally those strategies which are effective for the general Canadian population should be considered effective within Aboriginal peoples. One recent Canadian study provides evidence that quitlines are an effective option for Aboriginal populations[2].

Cultural adaptations should also be considered to tailor interventions for this population. Similarly, all interventions must consider the spiritual and traditional role within the culture and acknowledge other barriers to smoking cessation with the First Nations population such as the concurrent high rates of drug use and alcohol consumption.

CAN-ADAPTT Summary Statements *Comment on the discussion board*

CAN-ADAPTT's development process reflects a dynamic opportunity to ensure that its guideline is practice informed and addresses issues of applicability in the Canadian context. It has built from the evidence and recommendations contained in existing guidelines. It did not review the primary literature to inform the development of its Summary Statements unless emerging evidence was identified by the Guideline Development Group. The CAN-ADAPTT Guideline Development Group has provided the below Summary Statements for Aboriginal Peoples.

[2] Lynda M Hayward, H Sharon Campbell, Carol Sutherland-Brown. Aboriginal users of Canadian quitlines: an exploratory analysis. *Tob Control 2007;16:i60-i64.*

Summary Statement #1 –

Tobacco misuse‡ status should be updated for all Aboriginal peoples by all health care providers on a regular basis.
GRADE*: 1A

Summary Statement #2 –

All health care providers should offer assistance to Aboriginal peoples who misuse tobacco with specific emphasis on culturally appropriate methods.
GRADE*: 1C

Summary Statement #3 –

All health care providers should be familiar with available cessation support services for Aboriginal peoples.
GRADE*: 1C

Summary Statement #4 –

All individuals working with Aboriginal peoples should seek appropriate training in providing evidence-based smoking cessation support.
GRADE*: 1C

‡ Tobacco misuse does not refer to tobacco use for traditional/ceremonial purposes.
*GRADE: See below or click here for Grade of Recommendation and Level of Evidence Summary Table.

Clinical Considerations

Comment on the discussion board

- The Guideline Development group found that there was a significant gap in the research on Aboriginal peoples and tobacco misuse. Guidelines developed in New Zealand were utilized recognizing that these guidelines also require further research. Despite the lack of research there is evidence that there is a disproportionate burden of tobacco use amongst Aboriginal peoples. For example, youth uptake of tobacco is at a much earlier age than that of the general Canadian population (See Youth section).
- It should be emphasized that providers should recognize and distinguish between use of traditional (ceremonial/sacred) tobacco and misuse of commercial tobacco. Therefore assessment and questions need to be conducted with care and respect for this difference.
- Healthcare practitioners should work with community members including health care providers, community health representatives, caregivers, elders and other leaders where possible, to deliver smoking cessation interventions for Aboriginal peoples. There are a growing number of materials and methods to assist with tobacco cessation and prevention that have been developed and/or adapted for Aboriginal peoples. (see Tools and Resources Section)
- Efforts should also be made to identify, engage and understand the range of resources available to provide appropriate referrals and connectivity to the Aboriginal community. For example, local First Nations communities, urban Aboriginal programs, Friendship Centres etc. (see Tools and Resources Section)
- In general, interventions that have been proven to be effective in the general population are also likely to be effective for these population groups. However, the manner in which these interventions are delivered may need to be adapted for each group in order to be as acceptable, accessible and appropriate as possible. Therefore, tools and strategies that have been developed for other populations should be tailored appropriately with a full understanding of the context, barriers, and possible approaches when providing care to Aboriginal peoples within practice settings.
- Practitioners should recognize the heterogeneity of individuals and communities within the Aboriginal population and tailor interventions appropriately.

Tools/Resources

Contribute a Tool/Resource

Title	Description
Cancer Care Ontario: Aboriginal Tobacco Program (ATP) • Program brochure • Flu Shot and Tobacco Use • Tobacco-Wise Fact Sheet • Commercial Tobacco Fact Sheet • Poster Series	• Materials developed by Cancer Care Ontario that tell you all about the dangers of commercial tobacco and the sacred meaning of tobacco.
Inuit Tobacco-free Network (ITN)	• The Inuit Tobacco-free Network aims to keep Inuit health workers and their colleagues up-to-date on tobacco reduction resources, research and events.
Kicking the Addiction: • Facilitators Guide: Helping People to Live Smoke-Free in First Nations Communities • Choosing to Quit Z Card	• Facilitator's guide introduces the "Stages of Change" Model and provides an overview of the 5A's (Ask, Advise, Assess, Assist and Arrange). • Z card: A tool to help providers discuss benefits of quitting and quit tips with First Nations individuals. • Available via Health Canada: 1-866-318-1116 or tcp-plt.questions@hc-sc.gc.ca
National Association of Friendship Centres (NAFC) • Locations: Alberta; British Columbia; Manitoba; Labrador; St. John's; Fort Smith; Rankin Inlet; Ontario; Quebec; Saskatchewan; Yukon	• NAFC Acts as a central unifying body for the Friendship Centre Movement: to promote and advocate the concerns of Aboriginal Peoples and represents the needs of local Friendship Centres across the country to the federal government and to the public in general.

National Indian & Inuit Community Health Representatives Organization (NIICHRO) • "Tobacco Cessation Strategies During Pregnancy and Motherhood" ($25) • "Taking the Lead for Change" ($100) • Protecting Our Families: The Non-Traditional Use of Tobacco ($75)	• Pregnancy Resource: Facilitators Guide only • Taking the Lead for Change: Includes a training manual to assist CHRs with tobacco cessation programs and education as well as a video, activity book and flip chart. • Protecting Our Families: Includes a manual, discussion guide for schools or community groups, video and audiocassettes • All resources can be ordered via NIICHRO (450) 632-0892 or this order form
NECHI: Training, Research and Health Promotions Institute • "Integrated Tobacco Recovery for Urban Aboriginals Adults and Adolescents" • "Tobacco: addiction & recovery – a spiritual journey"	• The Nechi Training, Research and Health Promotions Institute offers specialized training to addictions counsellors working in Aboriginal communities • Culturally appropriate self-help guides to smoking cessation • Resources available via (780) 459-1884
TEACH training course: • "Tobacco Interventions with Aboriginal Peoples"	• Training course for healthcare professionals who provide counselling services to people who use tobacco.
Wabano Centre for Aboriginal Health: • **"**Culture as Treatment - " Mino-Babamadizin - A Good Healthy Journey"	• An Aboriginal Children's Smoking Prevention Program • Resource available online

Research Gaps

Contribute a Research Gap

- Methods to integrate traditional practices and spirituality into tobacco use interventions
- Identify and evaluate programs in the Aboriginal population to determine which interventions are effective
- Research effective dissemination practices
- Gather surveillance data at the local/regional levels and with off-reserve, non-status and Métis

Overview of CAN-ADAPTT's Practice-Informed Guideline

The full text guideline is available online at www.can-adaptt.net. The Guideline includes the following sections:

- Counselling and Psychosocial Approaches
- Pharmacotherapy *(in development)*
- Aboriginal Peoples
- Hospital-Based Populations
- Mental Health and/or Other Addiction(s)
- Pregnant and Breastfeeding Women
- Youth (Children and Adolescents)

We invite you to comment on the applicability and usability of this section, suggest additional tools and resources, and help to identify any gaps in knowledge.

Table 1. Grade of Recommendation & Level of Evidence Summary Table**

GR/LOE*	Clarity of risk/benefit	Quality of supporting evidence	Implications
1A. Strong recommendation. High quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Strong recommendations, can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1B. Strong recommendation. Moderate quality evidence.	Benefits clearly outweigh risk and burdens, or vice versa	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate.	Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present.
1C. Strong recommendation. Low quality evidence.	Benefits appear to outweigh risk and burdens, or vice versa	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Strong recommendation, and applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality.
2A. Weak recommendation. High quality evidence.	Benefits closely balanced with risks and burdens	Consistent evidence from well performed randomized, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk.	Weak recommendation, best action may differ depending on circumstances or patients or societal values
2B. Weak recommendation. Moderate quality evidence.	Benefits closely balanced with risks and burdens, some uncertainly in the estimates of benefits, risks and burdens	Evidence from randomized, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate.	Weak recommendation, alternative approaches likely to be better for some patients under some circumstances
2C. Weak recommendation. Low quality evidence.	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence from observational studies, unsystematic clinical experience, or from randomized, controlled trials with serious flaws. Any estimate of effect is uncertain.	Very weak recommendation; other alternatives may be equally reasonable.

*GR- Grade of Recommendation, LOE – Level of Evidence

**Adapted from: UpToDate. Grading guide. No date. Available from: http://www.uptodate.com/home/about/policies/grade.html; and Guyatt G, Gutterman D, Baumann MH, Addrizzo-Harris D, Hylek EM, Phillips B, Raskob G, Lewis SZ, Schünemann H. Grading strength of recommendations and quality of evidence in clinical guidelines: Report from an American College of Chest Physicians task force. Chest. 2006 Jan;129(1):174-81, originally adapted from the GRADE Working Group.