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Smoke-Free Workplace Policy: Unintended Consequences at Northern Plains Reservations

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Years of research documenting the harmful health effects of secondhand smoke have led to the establishment of governmental agency and employer policies that restrict smoking in various public places, including the workplace.[1] Studies have shown that workplace policies reduce smoking prevalence, reduce workplace exposure to environmental tobacco smoke, and reduce the number of cigarettes smoked among those workers who do not completely quit smoking.[2] A ban of smoking in the workplace has also been shown to reduce daily cigarette consumption for most race/ethnic groups.[3]

As the rest of the nation continues to move toward a smoke-free society, American Indian communities lag far behind and benefit little from smoking cessation and control activities. The prevalence of adult smoking in the general population is reported to be 19 percent,[4] whereas for American Indians and Alaska Native adults smoking far exceeds the national rate and at 31.5 percent is the highest of any ethnic group. In the northern region of the United States, smoking rates have been reported to be two to six times the national average, ranging from 34 to 79 percent for adult Indians.[5]

Smoking cessation policies and programs that have been implemented in American Indian communities include educational pamphlets, media campaigns, individual counseling, pharmaceuticals (e.g., nicotine patches and gum), and workplace smoking bans.[6] Few demonstrate significant effectiveness, with the possible exception of the

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quit-smoking "cold turkey" method, which relies upon the smoker's incentive and determination.[7] However, little or no research has taken place to test the effectiveness of workplace smoke-free policies on reservations.

Workplace smoke-free policies date back to the 1970s and generally range from requesting smokers to be considerate of others to posting signs in order to define smoking and nonsmoking areas.[8] In earlier years, smoking policies were centered primarily on safety issues (cigarette-caused fires) and protection of equipment. Today, workplace smoking policies are more concerned about the protection of nonsmokers and can be categorized as "passive" or "active" policies. Passive policies are those that request the smoker to consider the comfort of nonsmokers by voluntarily moving to a designated area to smoke, whereas active policies cite rules one must follow regarding where and when smoking is or is not allowed.

The General Services Administration first issued smoking regulations in 1973 to control cigarette smoking in federal buildings.[9] These initial policies were largely passive in that they reminded smokers to take into account the discomfort of others. Because hospitals and clinics on or near reservations are under federal Public Health Service jurisdiction, they are bound to abide by the General Services Administration policies. These workplace policies initially banned smoking in certain common areas, such as in cafeterias and elevators, and later expanded the smoking ban to buildings, often extending to within fifty feet of buildings.

More recently, tribal governmental offices, schools, and other such public sites have adopted workplace smoke-free policies, often due to regulations and requirements for receipt of federal funding. In reservation-based federal and tribal governmental facilities, more active policies such as the posting of "no smoking" signs and creating designated smoking areas have been established. However, casinos, eating establishments, and local stores on or near reservations are often less agreeable to implementing a workplace smoke-free policy. Indeed, several Northern Plains casinos, such as the Rosebud casino in South Dakota[10] and the Winnebago casino in Nebraska,[11] were not smoke-free facilities at the time of this publication. However, the Mille Lacs casinos in Minnesota have taken extra steps to notify potential and current employees of regular exposure to secondhand cigarette/cigar smoke in their casinos.[12]

Background

This study was funded by the University of Minnesota Cancer Center to investigate how to improve tobacco cessation and control policies among Sioux, Winnebago, and Ojibwe Indian tribes. The project was designed to assess policies, describe tobacco-related ceremonies and functions, and to identify environmental and media influences.

There are several factors related to tobacco control policy-making and implementation that may affect tribal members, including issues of sovereignty, federal jurisdiction, and the desires of the tribal authority to enact their own tribal-specific policies. Tribal sovereignty has been upheld as a retained right in treaties, recognized in legislation, and enacted by policies. Federal jurisdiction over tribal matters in areas of law, environment (water, land, etc.) and education does affect community decision-making. For instance,

Public Law 83-280 (1953) provides for the right of states to enforce laws on some reservations.[13] Federal law also "protects" environments, closely monitors and records probates over land and water rights, and provides federal guidelines to inform the education of Indian youth. However, each reservation retains the right of self-determination and thus the right to implement policies, rules, and regulations by which to govern their people. Tribes can establish no-smoking rules, workplace smoking bans, and enact sanctions on the use and abuse of tobacco and other such substances on reservations. Although tribes are not governed or bound by federal workplace smoking bans, receipt of federal funding, federal contractual agreements, and placement of federal buildings and programs on reservations influences the enforcement of the federal workplace policies on those reservations.

Experiences from past federal-tribal relationships can greatly influence the acceptance and enforcement of policies in Indian communities. For instance, policies that prohibited the selling and consumption of alcohol on reservations are widely enforced and have been for many decades. Alcohol-free or "dry" communities came about through an 1832 Congressional Act which banned alcohol on reservations in an effort to protect tribes from the devastating effect of the so-called "firewater."[14] The prohibition was repealed in 1953, but reservations remained dry unless they opted to permit the possession and sale of alcohol. Many reservations have subsequently allowed alcohol sales, but they are often restricted to casinos and resort facilities frequented by non-Indian tourists or visitors.

Other examples of prohibitions placed by the federal government include a ban on certain American Indian religious practices, later successfully repealed by the American Indian Religious Freedom Act of 1993 and the American Indian Religious Freedom Amendments of 1994.[15] In the 1930s through the 1950s federal Indian boarding schools reportedly severely punished youngsters who spoke their native language, kept traditional clothes, or wore their hair long. The boarding schools' power to suppress traditional American Indian clothing and culture has been documented in many photos and reports.[16] Over time, fear of religious ceremonies such as the Ghost Dance and other Native practices eased and such prohibitions on ceremonies, language use, and manner of dress ended. In fact, the consumption of peyote and other substances used as religious sacraments are now protected by federal law.[17]

Cultural sensitivity in communications and community decision-making practices are also important factors in the acceptance and implementation of policies on reservations. To force a policy on a community is never wise if one's goal is the successful implementation of the policy. Rather, introducing a workplace smoking-ban policy should entail town hall meetings as well as group and individual meetings with elders, smokers, parents, tribal council leaders, spiritual leaders, employees, and employers. All stakeholders should be invited to the table for their input. Although each tribe may have specific decision-making protocols (e.g., community voting vs. tribal council decision-making), the opportunity to learn of the new policy, to consider it, and to provide feedback is an important step in many reservation communities. Also, showing respect to elders, leaders, and elected officials is expected in any effort to change or enact policies. Without such steps, non-acceptance of the policy may become a long-term problem.

Methods

Eight focus groups were held with American Indian adults residing within a three-state cluster on the following seven reservations: Leech Lake, White Earth, and Mille Lacs in Minnesota; Pine Ridge, Yankton, and Rosebud Sioux in South Dakota; and the Winnebago, Nebraska reservation.[18] These reservations are moderate in size, and report low socioeconomic status in terms of levels of family resources as derived from AI/AN-reported eligibility for free school lunch.[19]

Potential participants were screened for study eligibility and those who agreed to participate were provided information about the focus group sessions. Each participant was consented by the project coordinator. They were told that their involvement was voluntary and confidential, and that their participation did not depend upon services at the healthcare facilities. Protection of human subjects' approval was received from the Institutional Review Boards at the University of Minnesota with additional appropriate tribal approvals.

Each focus group was coordinated by two experienced American Indian female researchers. Inclusion criteria specified those individuals who were: (1) American Indian, (2) aged 18 years or older, (3) a member of the targeted reservation tribe, (4) living on one of the seven participating reservations, and (5) provided written informed consent. Participants were recruited via flyers at tribal centers, local hospitals and clinics, support groups, senior centers, tribal government offices, reservation stores, and by word of mouth. Refreshments and snacks were provided at each focus group. Incentives were provided to all participants. The sessions were sixty to ninety minutes in length and were held in a tribal conference or meeting room at each respective reservation.

Focus group questions were designed to: elicit information on smoking policies, policy implementation, and responses to policies; identify patterns of smoking, tobacco-related ceremonies and functions; and ascertain environmental and media influences on smoking behaviors. Following accepted qualitative data analysis procedures with regard to coding by audience type[20] and by selective coding[21] (the process of choosing one category to be the core category and relating all other categories to that category), we narrowed our scope to smoking-ban policies and reported on the findings derived from the focus groups.

Data analysis followed Krueger and Casey's focus group analysis methodology, which consisted of identifying patterns and categories, constant comparisons of themes and patterns, and validation of findings elicited from the focus groups.[22] Continuous probing for clarification and understanding of comments during the focus group sessions provided for a richer dataset and stronger interpretation of the findings. The analysis had a seven-step process:

(1) Audiotape each focus group session;
(2) Probe for clarification and corrections;
(3) Summarize at the end of the session for verification, clarification, and corrections;
(4) Code groups of interest for special analysis;

(5) Examine each focus group separately for major themes, patterns, and responses. Code emerging themes in preparation for the next step of analysis;
(6) Merge major themes, patterns and responses from all focus group sessions;
(7) Conduct constant comparative analysis of comments and responses to elicit clarifications, understanding, and emerging phenomena; and
(8) Reduce focus group findings by merging related themes and responses.

Results

A total of fifty-one adult American Indians participated in the study. Sixteen Ojibwe members participated in three focus groups; twenty-nine Sioux members participated in four focus groups; and six Winnebago adults formed one focus group. The average age was thirty-nine years; 57 percent were females, and 70 percent of these females were current cigarette smokers. Statistics from the census report low socioeconomic status among residents of the Northern Plains reservation.[23]

The exploration of patterns and themes that emerged from the analysis of the focus group data indicated a strong resistance to the smoking ban policy. "They just put the signs up one day and we were told to go outside to smoke," noted one participant. The policy was publicized by employee training sessions and at staff meetings. One sign visible at the Rosebud Sioux hospital grounds stated, "No smoking within 50 feet of building" (fig. 1). Signs are posted at employee "clock-in" stations (fig. 2), and on windows and doorways of the buildings indicating that the facility is "a smoke-free building" (fig. 3). There are cans with the sign "ashes" painted on their sides placed at the entry of the building. Federal employees are regularly reminded of the

Figure 1: *"NO SMOKING WITHIN 50 FEET" sign posted on outside wall of Native American hospital*

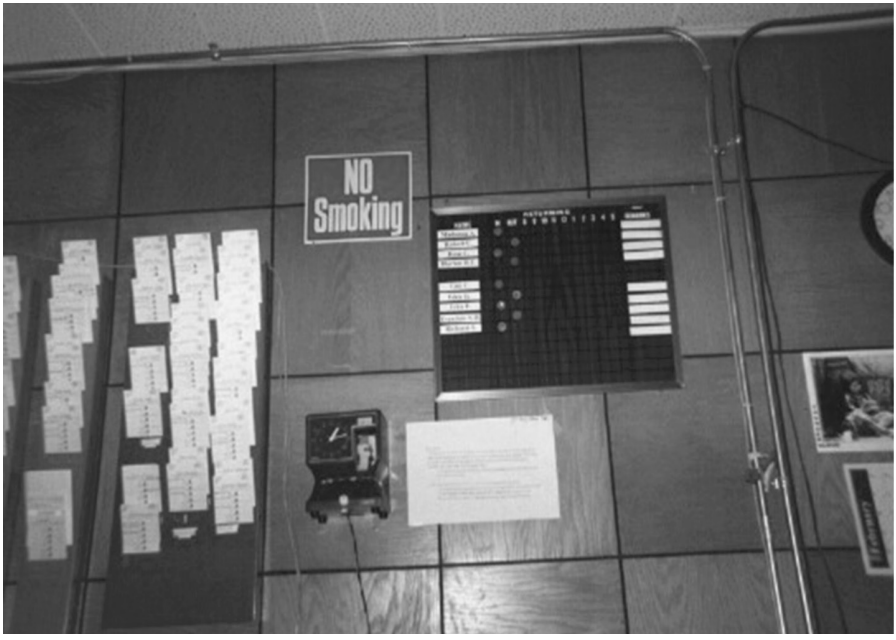

Figure 2: *"NO SMOKING" sign posted near employee clock-in*

Figure 3: *"NO SMOKING" signs posted on community building doors*

workplace ban on smoking; however, tribal office buildings were reported to be less stringently monitored.

Resistance to Workplace Smoking Ban

The focus group members reported that the workplace smoking ban is unpopular and widely resisted by reservation members in their communities. Participants report that American Indian females are more likely to be employed at the federal hospitals and clinics. Most smoke (70 percent of females participating in the focus groups report that they currently smoke cigarettes), and are aware of the workplace smoking ban. All focus group participants agreed that smoking was common among family members, friends, and coworkers. Most gather together for "smoking breaks" taken outside in the late mornings and afternoons, often standing far closer than the required fifty-foot distance from the building. Severe winter weather (often below minus 10 degrees F) makes it uncomfortable for smokers to venture too far beyond the facility's doorway. Others state that they go outside "when I can."

For those employed at tribal governmental facilities, the no-smoking ban is less tolerated and often ignored. Enforcement of the ban is sporadic and repercussion for smoking was reported as largely nonexistent. During the daily break time, focus group participants related how employees would gather together outside the doorways for smoking breaks, often walking in and out of entryways during the recess.

Workers reported that resistance to the smoking ban often took the form of ignoring the workplace no-smoking policy (blatant disregard of signs) and public displays of smoking at or near posted signs. If a sign was outside of the facility, the smokers reported that they may rest or lean on the sign while they smoked a cigarette.

A Sense of Freedom

Focus group members commented that they associated smoking with a strong sense of freedom. One participant stated that they "should have the freedom to smoke," and another stated, "people feel it is a person's right and freedom to smoke." They expressed weariness at defending their "right" to smoke. "Smoking is the one legal thing they can choose to do," said one participant. Because local reservations are "dry," purchasing or use of alcohol is prohibited by law. Other prohibitions voiced by participants included past prohibition of speaking their Native language at federal boarding schools and other current rules regarding social sanctions at ceremonies and gatherings. "There is not much else to do," said another focus group participant.

When asked about their favorite cigarette brand, many noted that the Marlboro brand was among their favorites. "It says the open roads," one participant stated, and another commented, "riding on horses and getting out in the open." Given the opportunity to make choices regarding picking up habits that were "not that bad" provided the freedom to make choices. "I choose to smoke," stated one participating smoker.

Lenient Attitudes

Participants noted an unwillingness to tell others not to smoke since "they will smoke if they want to." Tribal members related that they do not (or cannot due to cultural constraints) tell elders and others within their immediate family to stop smoking. "Children will learn and see what to do and what not to do" (by observation), which was what focus group members reinforced as their cultural manner of teaching. Participants noted that smoking was common within family groups, including children as well as friends and coworkers. They voiced a strong reluctance to tell others not to smoke because "they will smoke" if provided the opportunity and explained "if they make that decision" it was deemed to be a personal one. When asked about smoking policies in their homes, most stated that smoking was allowed at home. While someone "may go outside so that they don't bother others," poor weather and inconvenience often limited smoking outdoors. The majority of the focus group members reported that their siblings and community members started smoking in their youth and that there were few negative sanctions, prohibitions on smoking, or counseling. One woman explained, "Everybody needs to experiment when they are teenagers, even though they know it is wrong." To be allowed to experiment, "learn their lesson," and decide when and if they want to smoke were common statements made by the focus group members.

Mixed Messages

Some exceptions to the workplace smoke-free policy must be noted. The use of traditional tobacco in healing and other ceremonial functions are events that can hardly be prohibited by tribal policies. One focus group participant shared, "At funerals one can smoke in buildings." Another announced that "traditional healers may use tobacco in the health building and [we can] also conduct sageing and smudging (burning of sage and herbs) in the hospital." While these uses of tobacco products in tribal buildings and hospitals are understandable, other smoking-related polices enacted by the tribal government create an environment of mixed messages.

Two additional tribal policies, strongly embraced by the local communities, provide conflicting messages and have the effect of sustaining high smoking rates. Low-priced cigarettes at stores, casinos, and on the Internet provide increased purchasing power due to the lack of taxation.[24] Cigarettes can be purchased for less than one-half the price of those sold at off-reservation towns. Also, local policy decisions to sell Native-branded cigarettes have not only resulted in brand loyalty and reinforced Indian identity (fig. 4)—Native-branded cigarettes often displaying a picture of an Indian or other images—but have also led to unabated smoking among the reservation residents. Focus group participants commented, "It is accessible and I like it." Another participant stated, "I feel a loyalty to my brand. I don't even smoke generic brands." There were at least eight "Native" brands of cigarettes sold on reservations and their Internet websites. These brands have such "ethnic" names as "Smoking Joes," "Omaha," "Noble," "Geronimo," and "Seneca."

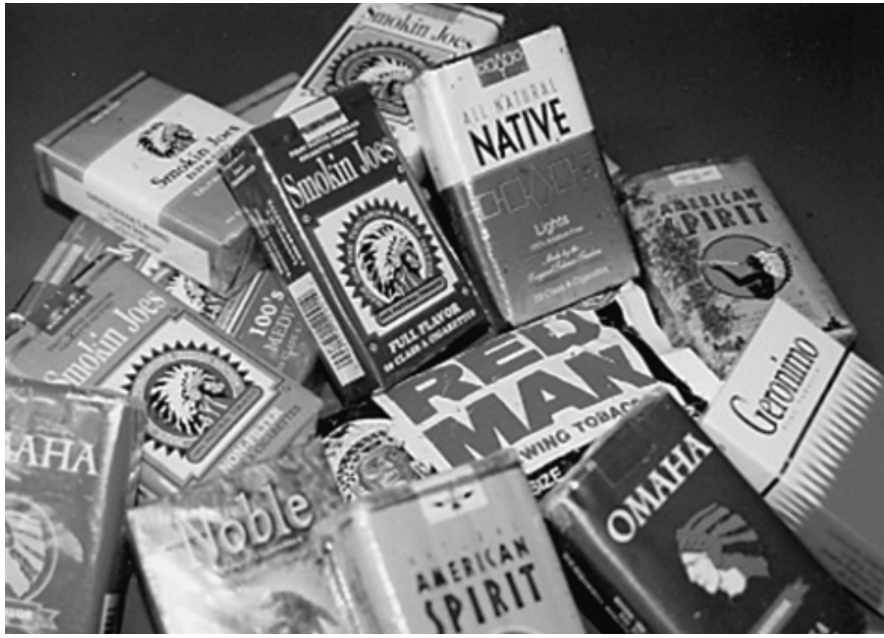

Figure 4: *American Indian branded cigarettes*

Establishing workplace smoke-free policies in an atmosphere of community resistance—one in which people hold lenient smoking attitudes, voice loyalty to Native-branded cigarettes, and have access to low-priced cigarettes—conveys mixed messages to smokers. On its own, a workplace ban on smoking sends a strong no-smoking message; however, when it is implemented in harness with two policies established to enable ease of tobacco purchase and to reinforce American Indian identity and pride in particular tobacco brands, the message not only becomes deflated but loses creditability as well.

Culture-bound Perceptions

Focus-group exploration into the influence of culture-bound perceptions identified beliefs and behaviors that motivated smoking behaviors. Perceptions that illness and conditions were not "in their hands," or even meant to be under their control, were coupled with a belief that the "real harm" value was low. Illnesses were often described as "treatable by Indian medicine" or "not treatable." Those illnesses that were not treatable included diabetes and cancer, or "white-man's disease," as one participant identified it. A sense of resignation—"there is nothing that can be done"—was prevalent, an attitude which was also identified in a study on diabetes.[25] Recognition of the harmful effects of cigarette smoking was fleeting, however, as participants placed a low value on the "real harm" of the smoking, especially in light of myriad everyday problems. One participant shared, "I saw in a magazine that smoking is called tobacco abuse, but

we don't call it that on the reservation." Another stated, "The majority of friends and coworkers are becoming more aware of the harmful effects and are determining within themselves whether that is a good thing or not."

More than 50 percent of participants reported that they had not contemplated quitting smoking as they did not think about those things "that far in the future." Recognition of the harmful effects of cigarette smoking and of secondhand effects is thus mediated by lenient beliefs and also temporal orientation, or how one perceives the significance of events and the consequences of actions in terms of past, present, and future—a trait recognized in the focus group sessions. Focus group members shared that their comments regarded collective orientation, identity, and inclusivity. Collective orientation, or the social value of the group over the individual, extended families, and strong community and tribal identity were openly discussed in the focus group sessions. The comments of participants and their inclination toward inclusivity—all group members should be given the chance to talk, and respect for all input is a must—were deemed important aspects of the focus group process and dialogue. Thus, collective orientation, coupled with perceptions of low harm value ("we don't call it that [abuse] on the reservation"); passivity or resignation ("don't care" what happens to their body as it is not within their control; and lenient attitudes (reluctant to tell others not to smoke) all provide important insights into motivation, smoking behavior, and intention to quit smoking among American Indians.

Recommendations, Limitations, and Conclusion

Based on the analysis of the focus group sessions, it appears that the workplace smoke-free policy established on the Northern Plains reservations was not deployed in a culturally sensitive fashion. A perceived lack of competence on the part of American Indians to make decisions regarding their health, coupled with a lack of expert knowledge on the issues of importance to American Indians may have contributed to the poor adherence to the smoking-ban policy. Better understanding of and failure to integrate a group's past experience with the imposition of policies or laws would facilitate improved policy development and implementation. Understanding that their association between smoking and "freedom" is in conflict with policies that ban personal activities may help to improve personal decisions by American Indian smokers.

The following recommendations are offered to aid those who wish to develop and implement policies on American Indian reservations:

Recommendation 1: The policy-making process should consider the historical context under which policies are developed and enacted so that compatibility and consistency are maintained.

A visible demonstration of awareness by public officials of the context and circumstances within which American Indians live and a more proper prioritizing of public health policies and government efforts to improve living conditions is needed. Creating an environment that encourages smoking through ease of access can have harmful consequences. Focus group participants discussed that the promotion of tobacco products with low-priced cigarettes and Native-branded tobacco products began to take

place on reservations following the workplace ban on smoking, and thus mediated the intended workplace smoke-free policy. The reservation communities largely ignored the workplace smoking-ban policy, particularly at tribal facilities.

Recommendation 2: Policy makers should begin a dialogue with community leaders and community members regarding the suggested policy.

This demonstrates the translation of the value for the collective, as represented in the importance of smoke-free areas for members of the American Indian public. Town hall meetings, flyers, and newsletters are excellent venues for alerting the township with regard to the planned policy development and implementation. If these policies were introduced via a process of community dialogue with town hall meetings, tribal council discussions, and meetings with the spiritual leaders, elders, family/clan leadership, and employees, the policies may have been received with greater acceptance and adherence. There is a "proper" way to counsel community members who smoke. One participant shared, "Smokers must want to stop smoking" (as opposed to the tribe or workplace wanting a ban on smoking). Another stated, "Forcing smoking cessation is not effective or OK" as a culturally appropriate approach.

Recommendation 3: Establish educational and outreach programs for families and/or community members.

Proactive measures that distinguish current public health efforts from past government actions that symbolize a loss of freedom and authority to American Indians is needed. Educational programs with outreach to the family and the community regarding the harmful effects of smoking can promote the awareness of health and encourage healthier lifestyles. These measures can counteract the prevalence of smoking and can lead to the acceptance of a workplace smoking ban policy.

Recommendation 4: Coordinate ongoing communication for updates and for evaluation of the policy.

Focus group members noted that forcing smoking cessation on community members is not a culturally appropriate or acceptable approach to prevention or control of tobacco products. The integration of how American Indians interpret personal freedom and its relationship to smoking behavior into health education efforts needs to be better understood. The workplace smoking cessation policy implementers would have been well advised to have taken steps to coordinate culturally sensitive meetings to discuss the policy, to encourage and accept feedback from tribal leadership, employees, and community members, and to implement those recommendations that were feasible regarding the announcement and implementation of the policy. Involving the community and tribal membership in the establishment and implementation of such an important policy as a workplace smoke-free policy is an important step, one in which the garnering of support and widespread agreement and cooperation would have been desired and indeed may have increased reservation acceptance of the policy.

Although the study was conducted in 2005, the data gathered is informative to current situations where smoking cessation policies are not established or are difficult to enforce. Limitations of the study findings include the age of the data and lack of

follow-up reporting to assess if policies were stabilized and/or enforced. Establishing a smoke-free policy on these northern reservations may have unwittingly contributed to unanticipated outcomes—increased resistance ("it is a person's right and freedom to smoke" and "people should be able to smoke if they want to") and increased smoking rates. Forcing rules and policies upon communities can be seen as counterproductive. Smokers must want to stop smoking: they cannot be forced, as they may resist the policy. Valuable time may be lost in the effort to enforce these unpopular policies. Communication with tribal leaders, dialogue with the communities, and an agreed-upon method to establish and monitor the smoke-free policy is needed. Without the respect of an open dialogue, resistance to smoke-free policies may continue.

Notes

1. US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, "The Health Consequences of Involuntary Smoking: A Report of the Surgeon General" (Washington, DC: US Government Printing Office, 1986), DHHS Publication No. (CDC) 87-8398, https://profiles.nlm.nih.gov/ps/access/NNBCPN.pdf; US Environmental Protection Agency, Office of Research and Development and Office of Air and Radiation, "Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders" (Washington, DC: US Government Printing Office, 1992), Publication No. EPA/600/6-90/006F, https://www.epa.gov/sites/production/files/2014-09/documents/passive_smoke.pdf.

2. Robert W. Jeffery, Steven H. Kelder, Jean L. Forster, Simone A. French, Harry A. Lando, and Judith E. Baxter, "Restrictive Smoking Policies in the Workplace: Effects on Smoking Prevalence and Cigarette Consumption," *Preventive Medicine* 23, no. 1 (1994): 78–82, https://doi.org/10.1006/pmed.1994.1011; Matthew C. Farrelly, William N. Evans, and Andrew E. S. Sfekas, "The Impact of Workplace Smoking Bans: Results from a National Survey," *Tobacco Control* 8 (1999): 272–77; Vicki L. Shavers, Pebbles Fagan, Linda A. Jouridine-Alexander, Richard Clayton, Jennifer Doucet, and Lourdes Baezconde-Garbanati, "Workplace and Home Smoking Restrictions and Racial/Ethnic Variation in the Prevalence and Intensity of Current Cigarette Smoking among Women by Poverty Status, TUS-CPS 1998–1999 and 2001–2002," *Journal of Epidemiology & Community Health* 60, Suppl. 2 (2006): 34–43, https://10.1136/jech.2006.046979.

3. Farrelly, et al., "The Impact of Workplace Smoking Bans"; Shavers, et al., "Workplace and Home Smoking Restrictions."

4. Israel Agaku, Brian King, and Shanta R. Dube, "Current Cigarette Smoking among Adults—United States, 2011," *Morbidity and Mortality Weekly Report* 61, no. 44 (November 9, 2012): 889–94.

5. Office on Smoking and Health, Centers for Disease Control, "Progress in Chronic Disease Prevention: Indian Health Service Facilities Become Smoke-Free," *Morbidity and Mortality Weekly Report* 36, no. 22 (June 12, 1987): 348–50; US Department of Health and Human Services, *Tobacco Use among U.S. Racial/Ethnic Minority Groups-African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General* (Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998); Betty A. Geishirt-Cantrell, Felicia S. Hodge, Roxanne Struthers, and Lorelei H. DeCora, "The High Incidence of Cigarette Smoking among American Indians of the Northern Plains," *Journal of Cancer Education* 20, suppl. 1 (2005), 97–100.

6. Felicia S. Hodge, *Diabetes Wellness: A Report of a Four-Year Research Study of Diabetes and American Indians on the Winnebago, Pine Ridge, Rosebud, and Yankton Sioux Reservations* (Berkeley and Minneapolis: Center for American Indian Research and Education, 2002).

7. Felicia S. Hodge, Steven Cummings, Larri L. Fredericks, Patricia Kipnis, Melody Williams, and Kevin Teehee, "Prevalence of Smoking among Adult American Indian Clinic Users in Northern California," *Preventive Medicine* 24, no. 5 (1995): 441–46, https://doi.org/10.1006/pmed.1995.1071.

8. Helen Gelband, Brad Larson, and Karl Kronebush, US Congress Office of Technology Assessment, "Passive Smoking in the Workplace: Selected Issues," report prepared by the staff of the Special Projects Office of the Health Program (May 1986), NTIS order #PB86-217627, http://ota.fas.org/reports/8617.pdf.

9. Ibid.

10. Rosebud Casino, 30421 US Highway 83, Valentine, NE 69201; confirmed via telephone contact; see http://www.rosebudcasino.com/index.php/contact.

11. Winnebago Tribe of Nebraska, 100 Bluff Street, Winnebago, Nebraska 68071, www.winnebagotribe.com; WinnaVegas Casino, https://winnavegas.com.

12. The position of bartender under "Careers" on the Mile Lacs tribe's casinos website, for example, recently listed under its "Work Environment" heading "Second-hand cigarette/cigar smoke." See website of Grand Casino Mille Lacs, 777 Grand Avenue, Onamia, MN, https://www.appone.com/MainInfoReq.asp?R_ID=1479306&B_ID=44&fid=1&SearchScreenID=4386&ssbgcolor=#FFFFFF.

13. US Public Law 280, 83d Congress, 67 Stat. 588 (1953), https://www.gpo.gov/fdsys/pkg/STATUTE-67/pdf/STATUTE-67-Pg588.pdf.

14. Jill E. Martin, "'The Greatest Evil': Interpretations of Indian Prohibition Laws, 1832–1953," *Great Plains Quarterly* 23, no. 1 (2003): 38, http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=3432&context=greatplainsquarterly.

15. The American Indian Religious Freedom Act is Public Law 95-341, 92 Stat. 469 (1978), https://www.gpo.gov/fdsys/pkg/STATUTE-92/pdf/STATUTE-92-Pg469.pdf; the 1994 Amendment is Public Law 103-344, 108 Stat. 3125, https://www.gpo.gov/fdsys/pkg/STATUTE-108/pdf/STATUTE-108-Pg3125.pdf.

16. For a collection of a few overview essays and photographs of Indian boarding schools, see http://www.english.illinois.edu/maps/poets/a_f/erdrich/boarding/index.htm.

17. Public Law 103-344, 108 Stat. 3125 is "an act to amend the American Indian Religious Freedom Act to provide for the traditional use of peyote by Indians for religious purposes, and for other purposes"; see endnote 15.

18. For further details, see "Tobacco Control among Plains Indians," University of Minnesota Cancer Center (National Cancer Institute, 2005), unpublished report on file with author.

19. Jill Fleury Devoe and Kristen E. Darling-Churchill, "Status and Trends in the Education of American Indians and Alaska Natives: 2008" (Washington, DC: National Center for Education Statistics, http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2008084.

20. Richard A. Krueger, "Designing and Conducting Focus Group Interviews" (October 2002), 11, http://www.eiu.edu/ihec/Krueger-FocusGroupInterviews.pdf.

21. Juliet M. Corbin and Anselm Strauss, "Grounded Theory Research: Procedures, Canons, and Evaluative Criteria," *Qualitative Sociology* 13, no. 1 (1990), https://doi.org/10.1007/BF0098859; Jane F. Dye, Irene M. Schatz, Brian A. Rosenberg, and Susanne T. Coleman, "Constant Comparison Method: A Kaleidoscope of Data," *The Qualitative Report* 4, no. 1 (2000), http://nsuworks.nova.edu/tqr/vol4/iss1/8/.

22. Richard A. Krueger and Mary Anne Casey, *Focus Groups: A Practical Guide for Applied Research* (Thousand Oaks, CA: Sage Publications, Inc., 2000). Subsequent quotations are taken from these focus groups but names are anonymous.

23. Economic data for individual reservations can be viewed at https://www.census.gov/tribal/.

24. Felicia S. Hodge, Betty A. Geishirt-Cantrell, Roxanne Struthers, and John Casken, "American Indian Internet Cigarette Sales: Another Avenue for Selling Tobacco Products," *American Journal of Public Health* 94, no. 2 (2004): 260–61, http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.94.2.260.

25. Felicia S. Hodge, Lorelei DeCora, Betty A. Geishirt-Cantrell, and Thomas K. Welty, *Fatalistic Behavior Change in Talking Circles Interventions*, unpublished report on file with author.