Frequently Asked Questions

NC Standard and Tailored Plans Tobacco-Free Requirement FAQ for Behavioral Health & Medical Provider Agencies

Why have a 100% tobacco-free campus and offer tobacco use treatment?

Why is North Carolina implementing a tobacco-free policy requirement through the Standard and Tailored Plans?

North Carolina is committed to protecting the health of all North Carolinians. Tobacco-related illness is the number one preventable cause of death and disability in North Carolina.(1,2) A 100% tobacco-free campus is an essential part of offering evidence-based tobacco use treatment services.(3,4) The U.S. Surgeon General states there is no safe level of secondhand smoke.(5) No one should be exposed to secondhand smoke when they access care or on the job.

Why focus on smoking and tobacco use in behavioral health settings?

Smoking is the number one cause of death and disability in the US and North Carolina.(1,2) Smoking causes more deaths each year than alcohol, HIV, motor vehicle accidents, homicides, suicides, and drug overdoses combined.(1,2) Every year 520,000 Americans die from tobacco-related illness, about half of them are people with behavioral health disorders.(6)

A little more than 1 in 5 people in North Carolina use any **tobacco products**.(7) People with behavioral health conditions are much more likely to use tobacco. (6) Among people with intellectual or developmental disabilities (IDD) the rate of tobacco use is much lower.(8) However, people with IDD and a substance use disorder are much more likely to smoke.(9) People with traumatic brain injuries (TBI) may also have higher rates of tobacco use and behavioral health conditions, compared to those without TBI.(10)

Among people in North Carolina who are uninsured or have Medicaid, more than half of people who used mental health services use tobacco and more than 2 out of 3 of people who use substance use treatment services use tobacco.(11)

Studies have observed **5%-15**% of people in substance use treatment starting to smoke in treatment. (12–15)

Here are some examples of the impact of tobacco use on people with behavioral health conditions:

- In the US, folks with a behavioral health condition who use tobacco lose 25 years of life, on average (6)

- Life expectancy 14.5 years lower for people with schizophrenia and this is largely attributable to higher rates of tobacco use (16)
- One large, long term study found that over half of people who went to substance use treatment died from an illness caused by tobacco use (17)

I am worried about the how quitting tobacco might affect recovery for mental health or substance use. What is the effect of quitting on mental health and substance use?

Quitting tobacco improves mental health and substance use recovery.(6) Using tobacco might feel like relief for a short time, but long-term relief comes from taking away the craving for tobacco. This is because the body is addicted physically and mentally to nicotine.(3) Here are some of the ways quitting helps mental health and substance use recovery:

- Quitting smoking lowers overall stress after about 1-3 weeks with effects similar to an anti-depressant.(18)
- For someone who wants to quit using other substances, getting treatment for tobacco use at the same time makes them 25% more likely to avoid substance use in the future.(19)

Withdrawal from nicotine makes people feel anxious, angry, sad, irritable, and more.(3) The cycle of withdrawal happens throughout the day between the times you smoke, vape, or use tobacco. Exiting the stressful cycle of nicotine highs and lows, along with having more energy because you can breathe better may explain why quitting is good for long-term mental health.(18) For people with a substance use disorder, using tobacco often happens along with drinking alcohol or using other drugs.(19) One can be a trigger for the other.

For these reasons, treating tobacco use is a key part of evidence-based behavioral healthcare. Interested in quitting? **QuitlineNC** offers free help with quitting that really works via phone, web, or text. **Register online**, call 1-800-QUIT-NOW, or text READY to 200-400 to get started.

What are the risks from secondhand smoke and e-cigarette chemical emissions?

Secondhand tobacco smoke is dangerous; it increases risk for lung cancer, heart attacks, stroke, and lung illness.(5) For people with asthma or COPD, just a few minutes of breathing secondhand smoke can trigger an asthma attack.(5) Some studies have found that secondhand smoke increases the risk for triggering a seizure in people with epilepsy.(20) There is no safe level of secondhand smoke.(5)

Secondhand aerosol is the cloud of chemicals that comes from e-cigarettes or vapes.(21) The U.S. Surgeon General warns e-cigarette aerosol can have harmful chemicals, including nicotine and cancer-causing chemicals.(21) Children especially can be harmed because their lungs are still growing—and nicotine is always harmful to teen and fetal brain development.(21)

One more risk from smoking, vaping, or dipping on site: kids who see adults that they look up to using tobacco are more likely to use tobacco in the future.(4,22)

What factors influence tobacco-related disparities among behavioral health populations?

CDC notes in the *Best Practices User Guide – Health Equity in Tobacco Prevention and Control* that tobacco-related disparities are created and affected by a complex mix of factors. Social determinants of health, tobacco industry influence, a lack of comprehensive tobacco control policies, and a changing U.S. population can contribute to and maintain tobacco-related disparities.(23)

Social Determinants of Health

- Social determinants of health are the conditions in which people are born, grow, live, work, and age.(23)
- Social determinants within each of these broad areas, such as poverty, housing, social support, discrimination, quality of schools, health care access, and transportation, influence tobacco-related disparities. For example, people that lack quality housing may be at greater risk of exposure to secondhand smoke, and people with limited health care access may lack information about the dangers of tobacco use and available cessation options.(23)

Tobacco Industry Influence:

- The tobacco industry has used multiple strategies to market cigarettes to populations with behavioral health conditions.(24) The Centers for Disease Control's Best Practices User Guide: Health Equity in Tobacco Prevention and Control, notes that the tobacco industry heavily markets its products to populations affected by tobacco-related disparities. Marketing, advertising, and promotional strategies are often directed at low-income, minority, and young adult populations. Historically, the industry has also funded groups that work with communities affected by tobacco-related disparities. (23)

Lack of Comprehensive Policies

- Inconsistent adoption and promotion of adherence to tobacco control policies, like tobacco-free policies, create disparities in protections from secondhand smoke exposure and support for people trying to quit.(23)

Changing U. S. Population

- The population of adults living in poverty is more likely to forego needed medical care, experience psychological distress like hopelessness and anxiety, and smoke cigarettes.(23)

Breathe Easier – Become Tobacco-free

Offering a 100% tobacco-free environment with tobacco-use treatment is the first step towards health equity for people with behavioral health conditions. Not only that, but it is an important part of treatment because becoming tobacco free is associated with improved mental health and substance use recovery outcomes.(6)

CDC's Overview of Tobacco Use and Quitting Among Individuals with Behavioral Health Conditions **click here.**

Tobacco Products and Nicotine

What is a tobacco product?

Tobacco products include

- Products you light, like cigarettes, cigars, little cigars, hookah.
- Electronic products like e-cigarettes or vapes
- Heated products such as IQoS
- Smokeless tobacco products like dip, chew, snuff, and snus. Also dissolvable oral products like orbs, sticks, and pouches.
- Nicotine products that are not approved by the FDA as tobacco treatment medications

There is a difference between commercial tobacco products and traditional tobacco used by some American Indians and Alaska Natives. For more about commercial vs. traditional tobacco click **here**.

What is the difference between commercial and traditional tobacco?

Commercial tobacco is manufactured by companies for recreational and habitual use in the form of cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, and other products. Commercial tobacco is mass-produced and sold for profit.(25) It contains thousands of chemicals and produces over 7,000 chemical compounds when burned, many of which are carcinogenic, cause heart and other diseases, and premature death.(25)

Electronic cigarettes or vapes are a newer category of commercial tobacco products that are also known to contain and release potentially harmful chemicals.(21)

Traditional tobacco is tobacco and/or other plant mixtures grown or harvested and used by many American Indians and Alaska Natives for ceremonial or medicinal purposes.(26) Traditional tobacco has been used by American Indian nations for centuries as a medicine with cultural and spiritual importance.(26)

While burning or using commercial tobacco products on campus is prohibited by the 100% tobacco-free policy requirement, service providers should work collaboratively with tribal people that they serve to respect tradition and find ways for people to engage in sacred practices that both adhere to the requirement and meet the needs of clients. Reach out to North Carolina DHHS's **American Indian Tobacco Coordinator** and your **regional commercial tobacco control manager** for assistance in doing this.

For more information on commercial vs. traditional tobacco and resources for American Indian North Carolinians, **click here.**

Why does a tobacco-free policy not allow the use of e-cigarettes and smokeless tobacco?

E-cigarettes and smokeless tobacco are tobacco products. E-cigarettes are a delivery system for nicotine, which is a highly addictive substance. Electronic cigarettes are considered a tobacco product by the FDA and North Carolina law.(21) Nicotine can cause an increase in blood pressure, heart rate, flow of blood to the heart and a narrowing of the arteries (vessels that carry blood).(3) As well as being addictive, nicotine is harmful to fetal and adolescent brain development.(21) Withdrawal symptoms from nicotine include anxiety, anger, sadness, and many more.(3) It is important to treat nicotine withdrawal with **medications** that really work and are safe.(27)

Smokeless tobacco products like chew, dip, snus, and many more have been proven to be harmful and addictive.(3,28) Also, the spitting involved with some smokeless products can spread disease.(29) The use of smokeless tobacco products on campus in front of another client who is trying to quit could be a trigger for that person to use tobacco. It also models tobacco use for children and teens who may be on campus. A tobacco-free campus enables effective tobacco use treatment.

Will the nicotine patch, gum, or lozenge be allowed?

YES! The nicotine patch, gum, and lozenge are not tobacco products. Nicotine replacement therapies like the patch, gum, lozenge, inhaler, and nasal spray are all FDA approved safe medications that are shown to help people quit.(30) They treat nicotine withdrawal so you can focus on using the services you receive to reach your goals. Nicotine replacement therapy is an important part of tobacco use treatment and a successful tobacco-free policy.(30) This is because using nicotine replacement therapy combined with counseling makes it 2x more likely that someone will finally be able to quit.(27) Sometimes people who try the nicotine patch, gum, or lozenge don't know how to use them or that they can be used together. Combining the patch and gum or lozenge is much more effective than either by itself.(31) Learn more about nicotine replacement therapy and how to use it from these flyers in **English** and **Spanish**.

Questions About Rights and Personal Freedom

I started smoking in substance use treatment. Aren't there more important drugs to focus on? Why not just let people smoke?

Tobacco use treatment is an important part of substance use treatment. A tobacco-free policy in healthcare settings enables both. Did you know:

- Studies have observed 5%-15% of people in substance use treatment starting to smoke in treatment.(12–15)
- One large, long term study found that **over half** of people who went to substance use treatment died from an illness caused by tobacco use.(17)
- For years, tobacco companies gave cigarettes away to psychiatric hospitals, causing many to start using tobacco or become more addicted. As a result, smoking is now common in treatment centers.(6,32)
- Yet for people who want to stop using other substances, **getting treatment for tobacco use at the same time increases their chances of maintaining recovery by 25%.** (19)

Why can't we do what we want like other people in the community?

A tobacco-free policy makes behavioral health, intellectual or developmental disabilities (IDD), and traumatic brain injury (TBI) services more like other community settings.(1,3,4,32) Behavioral health programs are often the only healthcare settings that still allow tobacco use onsite.(1) Doctor's offices and hospitals are all generally tobacco-free, because of the dangers of secondhand smoke and the need to have an environment where people can quit. Schools are tobacco-free, many workplaces are tobacco-free, and a lot of apartment complexes are tobacco-free.(1) People with behavioral health conditions, IDD, or TBI deserve the same rights to clean air and support when they try to quit as anyone else in the community.

Smoking is a personal choice. How can you take this choice away?

Allowing secondhand smoke and e-cigarette emissions in healthcare settings hurts everyone's right to breathe clean air.(5) Secondhand smoke and vape chemicals prevent people who are pregnant or people who have asthma, COPD, and heart disease from safely getting healthcare or being in public spaces. Just a few minutes of secondhand smoke can be enough to trigger an asthma attack.(5)

Tobacco-free policies in healthcare settings also protect people's ability to quit tobacco use.(4) Many people receive all the healthcare services they need in tobacco-free environments, like their doctors' office or at the hospital. These environments support people when they set a goal to quit smoking.

Also, a tobacco-free policy doesn't restrict people from using tobacco while they are not on a property covered by the policy. Similar to how not allowing alcohol use at a workplace, campus, or healthcare setting doesn't take away anyone's right to drink alcohol off campus, a tobacco-free policy does not take away people's ability to use tobacco off campus.

Why are some housing supports, such as some group homes, required to have tobacco-free campuses?

It can be hard to find a place to live that meets all our needs. Imagine you found a place to live and get the support you need, but you had to breathe cigarette smoke every day to live there. When you wanted to open your window, use your backyard, or visit with your family or children, you were often breathing that secondhand smoke.

Breathing secondhand smoke day in and day out is what causes heart attacks, lung disease, cancer, and strokes for people who live with someone who smokes in their home or in their porch or yard.(5) No one should have to accept the health risks from secondhand smoke to get the support they need in their home to reach their goals. This is why so many landlords have tobacco-free policies.(1,33)

Tobacco-free policies in housing, such as apartments or group homes, protect people's right to clean air and support their ability to quit tobacco use. It is extremely hard to quit when the people who live with you often use tobacco products in front of you. It is important to note that a tobacco-free policy does not take the ability to use tobacco off campus away from anyone. People who need housing supports have the right to breathe clean air and to reach their goals, as well as broad rights to decide what to put in their body. Tobacco-free policies protect those rights, without harming the rights of others.

Must clients, staff, and visitors quit using tobacco products?

No, the policy only asks individuals to avoid using any tobacco while on a program's property. The goal is a tobacco-free environment that supports success in quitting tobacco use--not to force people to quit or stigmatize clients or staff who use tobacco. This protects the safety of clients, staff, and visitors and their freedom to breathe clean air. A behavioral health, IDD, or TBI program should offer the full range of services to support you, partner with you to set goals, and help you achieve them. Staff might respectfully explore with you if you are interested in quitting and how smoking fits with your other goals. If your goal is quitting smoking that is great, but it is your choice.

This policy gives people who want to quit tobacco a real chance at making the choice to live life tobacco free. For example, we wouldn't expect clients who are trying to quit alcohol use to be successful in a treatment environment with a bar in the backyard. It is unfair to ask people with Medicaid or who are uninsured who want to quit to get treatment in environments that allow tobacco use.

Is a tobacco-free policy person-centered?

Yes. Most people who use tobacco want to quit.(30) In surveys people with behavioral health conditions who use tobacco are just as likely to want to quit as people without.(6) Most people who use tobacco try to quit each year, yet without a tobacco-free environment and evidence-

based treatment, few are successful.(30) Tobacco-free policies in healthcare protect people's right to decide what to put into their own bodies by providing an environment that supports their ability to quit tobacco use, while not taking away anyone's ability to use tobacco while off campus. Taking a person-centered approach means offering tobacco use treatment to people with behavioral health conditions who want to quit.

What about harm reduction?

Evidence-based harm reduction strategies are an important part of healthcare.(34) Allowing tobacco use on campus is not a harm reduction strategy. Tobacco is the deadliest drug in the United States, and an estimated half of people who receive treatment for substance use disorders will die from tobacco-related illness.(2,17)

What happens when a tobacco-free policy goes into effect?

People often come to psychiatric hospitals or substance use treatment centers in crisis. These are times they most want to smoke. Won't this policy worsen the situation?

When someone feels the urge to smoke in a crisis, this is because of nicotine withdrawal. Nicotine is the addictive part of cigarettes, and the withdrawal symptoms are horrible: anxiety, anger, sadness, and hunger are just some examples.(30) A treatment center should treat nicotine withdrawal quickly using medications that are safe, fast, and really work, rather than endanger the safety of clients and staff by exposing them to secondhand smoke. Smoking on campus could trigger vulnerable clients who are in a crisis and have already quit to smoke again. It also models smoking for those that are young and don't smoke who might start. Treatment centers do not treat alcohol withdrawal by allowing alcohol on campus; they treat it with medications. Nicotine patches, gum, and lozenges really work to treat nicotine withdrawal safely.(30) Clients may or may not set a goal of quitting smoking during their stay and that is ok. In the meantime, clients and staff are safe and clients get the support they need to make it through the crisis.

Do fewer people seek help for crises when treatment centers are tobacco-free?

No. We know from real life experience that people still seek treatment for mental health and substance use crises on tobacco-free campuses.(35,36) All of the state-operated psychiatric and substance use treatment hospitals in North Carolina went 100% tobacco-free in 2014, and **they did not experience a drop in people seeking out treatment as a result**.(36) North Carolina is not the only state that has lived this; New York(37) and New Jersey(38) have had similar experiences.

Will more people be discharged from treatment because of tobacco-free policies?

No. We know from experience that tobacco-free policies do not lead to more people being discharged or leaving treatment. When North Carolina state psychiatric and substance use treatment hospitals went tobacco-free in 2014, there was no increase in discharges.(36) Research has also shown that tobacco-free policies do not lead to an increase in discharges or people leaving treatment overall.(35–38)

Change is always hard. There are many ways that providers that are concerned about clients leaving a program can mitigate these concerns. They can take their time with this policy change (3-6 months), communicate transparently well in advance with clients, and integrate tobacco use treatment early on. You can learn more from our **Tobacco-free Policy Road Map.** Lastly, programs should never be punitive in the way that they promote adherence to any policy, including a 100% tobacco free policy. Punitive responses to tobacco use are not **trauma-informed** and are not necessary to promote adherence.

Responses to patients concerned with this policy should be with compassion and working with that person to find ways that work for them to adhere to the policy. It is the responsibility of behavioral health programs to offer clients the tools they need to be successful in avoiding using tobacco on campus, and to be respectful in promoting the policy. It is the responsibility of clients to let staff know what support they need to be successful in avoiding tobacco use on campus, and then do their best to respect the policy.

Support might look like:

- Offering nicotine patches, gum, and lozenges for relief from cravings (you can use these even if you are not ready to set a goal of quitting!)
- Identifying smoking triggers and finding ways to plan for or avoid them
- Offering toothpicks, hard candy, and water to give folks things to do with their hands and mouth when not smoking
- Working together to find other ways to socialize on campus that do not involve tobacco use

How does having a 100% tobacco-free campus policy benefit clients and staff?

Many research studies have looked at the effects of tobacco-free policies at healthcare programs. All North Carolina behavioral health hospitals became 100% tobacco-free campuses in 2014. This policy was implemented after piloting tobacco-free campus at a psychiatric and a substance use treatment hospital and collecting data on the outcomes (36). Here are some of the things that happened:

- Clients were much more successful becoming tobacco-free themselves.
- Fewer staff sick days
- Less conflict among clients
- Better focus on treatment
- Same number of people were admitted to treatment showing that people still sought help in crisis

- A cleaner environment that saved money and staff time that would've been spent cleaning up cigarette butts.
- Discharges did not increase (36)

If you are wondering where to start with implementation, the good news is you do not have to do this by yourself. Reach out to your **regional tobacco control manager** for support. They have the experience to help your organization have a smooth and positive policy implementation process. Also, check out this **Road Map to a Tobacco-Free Policy**.

Questions about quitting

I am a staff member who uses tobacco. What resources are there to help me quit?

You can DOUBLE your chances of quitting for good by using counseling and medication to treat nicotine withdrawal.(30) The good news is that the Affordable Care Act requires health insurance plans to cover tobacco use treatment counseling and medications. Talk with your employer and your health plan to find out what resources there are to help you. Let your health and behavioral health providers know you are interested in quitting, and they can help you as well.

You can also get free help TODAY from QuitlineNC. **QuitlineNC** offers free help with quitting that really works via phone, web, or text. **Register online**, call 1-800-QUIT-NOW, or text READY to 200-400 to get started.

Supporting people to quit

What is evidence-based tobacco use treatment and how can I integrate it into my program?

Evidence-based tobacco use treatment is a combination of **FDA-approved cessation medications** and **counseling**.(30) The NC Division of Public Health promotes the **NC Standard of Care for tobacco use treatment**. This is based on Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guideline(27), as well as more recent research on tobacco use treatment. Standard of care tobacco use treatment is also provided by **QuitlineNC**; learn more about how to refer clients by clicking **here**.
For technical assistance with integrating tobacco use treatment, as well as free training, you can contact:

Regional and local tobacco control staff
You Quit, Two Quit provides free technical assistance on policy implementation and tobacco use treatment for programs that work with reproductive-aged or pregnant people.

Tobacco use treatment integration toolkits:
Dimensions: Tobacco-Free Policy ToolKit is a step-by-step resource for implementing a policy.

Million Hearts Tobacco Cessation Change Package is a compilation of treatment and policy implementation resources that are evidence-based.

It has been my experience that clients don't want to quit. Does anyone want to quit using tobacco?

Yes. The majority of people who smoke report wanting to quit, and more than half of the people who smoke make a quit attempt every year.(30) However, less than a third of the people who try to quit receive evidence-based treatments that can double or triple their chances of success.(30) As a medical or behavioral healthcare provider, you have the power to change that by offering your clients evidence-based treatment. A tobacco-free policy creates a positive environment that supports clients and staff in successfully quitting tobacco use.

Do people with behavioral health conditions want to quit?

Yes. People with behavioral health conditions who use tobacco are just as interested in quitting as people without.(6) Most folks want to quit.(30) Most people who use tobacco try to quit each year, yet--without a tobacco-free environment and treatment--few are successful.(30) Behavioral health programs have the ability to empower clients to set goals and achieve them. People with behavioral health conditions CAN and DO become tobacco-free.(6) Behavioral health programs should offer the full range of services to support clients, partner with them to set goals, and help them achieve those goals.

But… why does it SEEM like no one wants to quit then?

One reason why healthcare professionals sometimes perceive a lack of motivation to quit is the way people are screened. A common screening method is to ask, "Do you smoke cigarettes?" and if the answer is yes, the next question is "Are you ready to quit?" This is a screening method that will probably yield a lot of "no" answers.(39) Desire to quit is not a yes or no question. Just like with any other substance use disorder, there is ambivalence: reasons clients want to continue using and reasons clients want to quit. Meet the client where they are by exploring if tobacco use conflicts with their values and goals. You may be able to set smaller, achievable goals and provide evidence-based treatment to reach those goals. Smaller goals include making the home tobacco-free, staying tobacco-free while at the program, experimenting with cutting down using medications & counseling. You can learn more about evidence-based counseling strategies on this **page**.

Lastly, once your organization starts the process of going tobacco-free, you may find that more clients are interested in quitting.(4) Clients come to your organization because they trust you to help them reach their goals and take care of their health. Research shows that health professionals communicating the message to clients that quitting will benefit their physical and mental health increases quit attempts.(30)

How can I help the uninsured people I serve to access tobacco use treatment medications and counseling?

There are resources for uninsured people who cannot afford to buy over-the-counter nicotine replacement therapies or pay out of pocket for a prescription of FDA-approved cessation medication.

Here are some examples:

-**QuitlineNC** offers up to eight weeks of combination nicotine replacement therapy for uninsured callers. Learn how to refer clients **here**.
-Several health departments offer nicotine replacement therapy to county residents; check with your local health department.
-Many community health centers or free clinics offer free or reduced-price nicotine replacement therapy or medications to uninsured people.
-Check out this list of prescription assistance programs for prescription tobacco use treatment medications.

For in-patient and residential programs, these resources are useful but do not provide nicotine replacement or other medications for the immediate need on-site when someone is admitted to the program. For these settings, it may be necessary for the program to provide the nicotine replacement until clients are connected to another resource, learn more about how to do this on our medications page.

Guidance on Policy implementation and Promoting Adherence

Who does the policy requirement affect?

The 100% tobacco-free policy requirement applies to medical and behavioral health providers and non-residential IDD and TBI service providers contracted with Standard and Tailored prepaid health plans to provide services to people who receive Medicaid or are uninsured. The only Standard or Tailored Plan contracted programs not required to become 100% tobacco-free at this time are retail pharmacies and Intellectual and Developmental Disabilities residences and intermediate care facilities. For more information on tobacco policies in residential I/DD settings see the **Organizations that Serve People with Intellectual/Developmental Disabilities (IDD) or Traumatic Brain Injuries (TBI) FAQ.**

A 100% tobacco-free policy applies to everyone at all times on a program's property: clients, staff, contractors, vendors and visitors.

What comprises a 100% tobacco-free policy?

A tobacco-free policy applies to all the property under the program's control (rented, leased or owned). All of the property (buildings, grounds, including the parking lots and vehicles) is tobacco-free.
Tobacco refers to commercial tobacco products and includes the use of combustible, electronic, heated, and smokeless tobacco products. For more on the difference between commercial and traditional tobacco products, **click here.**
There are no designated areas for tobacco use indoors or outdoors.
Programs do not purchase, accept as donations, or distribute any tobacco products.

For sample policies click **here**.

When are campuses expected to be 100% tobacco-free?

July 1st, 2022.

NC Standard or Tailored Prepaid Health Plans must require contracted medical and behavioral health providers, and some IDD/TBI service providers to furnish a 100% tobacco-free campus starting July 1st, 2022. Intermediate care facilities for people with IDD or residential services covered by the Home and Community Based Services (HCBS) final rule have different policy requirement that will also start July 1st, 2022. Learn more about these through the **Organizations that Serve People with Intellectual/Developmental Disabilities (IDD) or Traumatic Brain Injuries (TBI) FAQ.**

While the requirement goes into effect July 1st 2022, organizations are highly encouraged to implement a 100% tobacco-free policy well in advance and to take the time (usually months) necessary to implement the policy in a thoughtful, transparent, and evidence-based way. Reach out to your **regional or local tobacco prevention and control** staff for assistance.

How do I implement a 100% tobacco-free campus policy?

There are several essential components and processes to implementing a 100% tobacco-free policy. The process of implementation can take six months to a year. Check out the **Tobacco-Free Road Map** for details and resources. Contact your **regional or local tobacco control staff** to help your organization have a positive and smooth implementation process. A few other useful resources are:

You Quit, Two Quit provides free technical assistance on policy implementation and tobacco use treatment for programs that work with reproductive-aged or pregnant people.
Dimensions: Tobacco-Free Policy ToolKit is a step-by-step resource for implementing a policy.
Million Hearts Tobacco Cessation Change Package is a compilation of all of the treatment and policy implementation resources that are evidence-based and really work.

For sample policies click **here.**

An important piece of this planning process is conducting listening sessions well in advance with clients and separately with staff. This gives clients and staff the opportunity to express any concerns and give their input on how the policy should be implemented, making for a smoother implementation process. Your **regional or local tobacco control staff** and You Quit, Two Quit are experienced with this process and can help you plan a listening session. Learn more about how to build support and communicate your policy here.

I rent my space; how do I adhere to this requirement?

You would ensure the policy applies to whatever space and property that is under your program's control. For example, if your program is located in a strip mall and you have control over the interior space, the storefront, the sidewalk in front, and a couple parking spaces, then the policy applies to all of that space. If you rent a building and you have control over the front and backyard of that building, the parking lot, and vehicles for your program, the policy should apply to all that property. For assistance with writing a policy that covers the appropriate property to adhere to this requirement, contact your **regional or local tobacco control staff** and check out the sample policy provided **here**.

How can I promote client adherence to a tobacco-free policy at my program?

Ensuring adherence to a tobacco-free policy is the responsibility of everyone at the organization, particularly staff.(32) If only a few people promote adherence, the policy will not be effective. Clear tobacco-free campus policy signs and other resources are important tools.(32) The response to any problem someone has with not using tobacco on campus should be compassion and working with that person to find ways that work for them to adhere to the policy on campus. It is the responsibility of behavioral health programs to offer clients the tools they need to be successful in avoiding using tobacco on campus, and to be respectful in promoting the policy. It is the responsibility of clients to let staff know what support they need to be successful avoiding using tobacco on campus, and then do their best to respect the policy. Support might look like:

- Offering nicotine patches, gum, and lozenges for relief from cravings (you can use these, even if you are not ready to set a goal of quitting!)
- Identifying smoking triggers and finding ways to plan for or avoid them
- Offering toothpicks, hard candy, and water to give folks things to do with their hands and mouth when not smoking
- Working together to find other ways to socialize on campus that do not involve tobacco use

Tobacco use disorder is a substance use disorder--a chronic condition; recovery is possible and happens every day.(30) However, slips and returns to use are a normal part of the recovery process. Difficulty not using a substance is one of the symptoms of a substance use disorder. Programs should respond to difficulties with adhering to the policy by offering compassion, evidence-based treatment, and collaborating with the client to find ways to prevent future use on campus.

For help creating a policy that adheres to the NC Managed Care Tobacco-Free Policy requirement and is individualized to fit your organization, reach out to your **regional and local tobacco control staff**.

For a sample policies click **here**.

How can I promote staff adherence to a tobacco-free policy at my program?

Start by taking the time to build buy-in for the policy from staff prior to implementation. Staff should receive training on the policy and how to address it when someone is not adhering to the policy as a part of implementation, orientation, and ongoing training. Employee handbooks should detail the policy and the response if employees have trouble adhering to it.

A tobacco-free policy is one of the most effective ways to support employees to quit, but it is just the first step.(32) Educate employees about the tobacco use treatment benefits offered by employee healthcare coverage. Ensure that those benefits provide the NC **standard of care for tobacco use treatment** with no barriers and no co-pays. Refer employees to health insurance's quit resources, **QuitlineNC,** community resources, or offer tobacco use treatment over-the-counter medications and counseling for employees onsite.

For help creating a policy that adheres to the NC Managed Care Tobacco-Free Policy Requirement and is individualized to fit your organization, reach out to your **regional and local tobacco control staff** for help.

For sample policies click **here.**

Why do inpatient and residential treatment programs not allow people to have tobacco products on campus?

Anyone who has tried to quit smoking, drinking alcohol, or using any other drug knows from experience that staying away from triggers to use and having a supportive environment are key to success.(4) In-patient and residential treatment programs are designed to provide temporary support for people who are in a crisis or who need substance-free place to live to reach their goals. Part of that supportive environment is not having substances, including legal ones like alcohol and tobacco, onsite.

Inpatient and residential treatment programs should treat nicotine withdrawal quickly using medications that are safe, fast, and really work. They should not endanger the safety of clients and staff by exposing them to secondhand smoke and triggers to use tobacco. Nicotine patches, gum, and lozenges really work to treat nicotine withdrawal safely.(30) Clients may or may not set a goal of quitting smoking during their stay and that is ok. In the meantime, clients and staff are safe and clients get the support they need. All while clients who want to quit have their needs respected.

The response to someone who brings tobacco products on campus should be compassion and working with that person to find ways that work for them to adhere to the policy, as well as removing the tobacco products from campus. To learn more about how to promote adherence see **How can I promote client adherence to a tobacco-free policy at my program?**

Would employees, clients, or visitors be allowed to smoke in their car while it's parked on property covered by the 100% tobacco-free policy?

No. The policy prohibits smoking and tobacco use on ALL agency property, which includes inside parked and moving vehicles on the property. It also prohibits tobacco use inside agency-owned vehicles.

How do I address concerns about people who go to smoke on my neighbor's property?

An important part of the implementation process is reaching out to your neighbors. Let them know you will be implementing a tobacco-free campus policy and have a discussion ahead of time about how you can work together if individuals from your campus use tobacco on your neighbor's property. Communicate with clients and staff about these discussions. Offer compassion, evidence-based treatment, and collaborate with the client to find ways to prevent use on campus, as well as any encroachment on neighbors' space.

References

1. North Carolina Tobacco Prevention and Control Branch. Vision 2020 North Carolina's Strategic Plan to Reduce the Health and Economic Burdens of Tobacco Use [Internet]. 2016 [cited 2021 May 18]. Available from: www.tobaccopreventionandcontrol.ncdhhs.gov

2. Centers for Disease Control and Prevention. Tobacco Use [Internet]. 2020 [cited 2021 May 18]. Available from: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm

3. U.S. Department of Health and Human Services. The Health Consequences of Smoking - 50 Years of Progress: A Report of the Surgeon General [Internet]. 2014 [cited 2021 May 18]. Available from: www.cdc.gov/tobacco

4. Centers for Disease Control and Prevention. Smokefree Policies Reduce Smoking [Internet]. 2020 [cited 2021 May 18]. Available from: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/reduce_smoking/index.htm

5. Centers for Disease Control and Prevention (US), U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General [Internet]. Publications and Reports of the Surgeon General. Centers for Disease Control

and Prevention (US); 2006 [cited 2021 May 18]. 727. Available from: https://www.ncbi.nlm.nih.gov/books/NBK44324/

6. Prochaska JJ, Das S, Young-Wolff KC. Smoking, Mental Illness, and Public Health. Annual Review of Public Health [Internet]. 2017 Mar 20 [cited 2021 May 18];38:165–85. Available from: https://pubmed.ncbi.nlm.nih.gov/27992725/

7. N.C. Department of Health and Human Services. Behavioral Risk Factor Surveillance System 2019 - North Carolina: (Use of Any Tobacco Product*) [Internet]. 2020 [cited 2021 May 19]. Available from: https://schs.dph.ncdhhs.gov/data/brfss/2019/nc/risk/AnyTobUse.html

8. National Core Indicators. Does this person use nicotine or tobacco products? North Carolina [Internet]. 2018 [cited 2021 May 25]. Available from: https://www.nationalcoreindicators.org/charts/2017-18/?i=77&st=NC

9. Steinberg ML, Heimlich L, Williams JM. Tobacco use among individuals with intellectual or developmental disabilities: A brief review [Internet]. Vol. 47, Intellectual and Developmental Disabilities. NIH Public Access; 2009 [cited 2021 May 25]. p. 197–207. Available from: /pmc/articles/PMC4451812/

10. Bogner J, Corrigan JD, Yi H, Singichetti B, Manchester K, Huang L, et al. Lifetime history of traumatic brain injury and behavioral health problems in a population-based sample. Journal of Head Trauma Rehabilitation [Internet]. 2020 Jan 1 [cited 2021 May 25];35(1):E43–50. Available from: https://pubmed.ncbi.nlm.nih.gov/31033748/

11. N.C. Department of Health and Human Services. NC Treatment Outcomes and Program Performance System NC-TOPPS Outcomes Report 2017 [Internet]. 2017 [cited 2021 May 19]. Available from: https://nctopps.ncdmh.net/Nctopps2/docs/july2017/NC-

12. Kohn CS, Tsoh JY, Weisner CM. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. Drug and Alcohol Dependence [Internet]. 2003 Jan 24 [cited 2021 May 19];69(1):61–71. Available from: https://pubmed.ncbi.nlm.nih.gov/12536067/

13. Friend KB, Pagano ME. Smoking initiation among nonsmokers during and following treatment for alcohol use disorders. Journal of Substance Abuse Treatment [Internet]. 2004 Apr [cited 2021 May 19];26(3):219–24. Available from: /pmc/articles/PMC3272765/

14. Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette smoking is associated with increased risk of substance use disorder relapse: A nationally representative, prospective longitudinal investigation. Journal of Clinical Psychiatry [Internet]. 2017 Feb 1 [cited 2021 May 19];78(2):e152–60. Available from: /pmc/articles/PMC5800400/

15. de Dios MA, Vaughan EL, Stanton CA, Niaura R. Adolescent tobacco use and substance abuse treatment outcomes. Journal of Substance Abuse Treatment [Internet]. 2009 Jul [cited 2021 May 19];37(1):17–24. Available from: /pmc/articles/PMC2735078/

16. Hjorthøj C, Stürup AE, McGrath JJ, Nordentoft M. Years of potential life lost and life expectancy in schizophrenia: a systematic review and meta-analysis. The Lancet Psychiatry [Internet]. 2017 Apr 1 [cited 2021 May 19];4(4):295–301. Available from: https://pubmed.ncbi.nlm.nih.gov/28237639/

17. Bandiera FC, Anteneh B, Le T, Delucchi K, Guydish J. Tobacco-related mortality among persons with mental health and substance abuse problems. PLoS ONE [Internet]. 2015 Mar 25 [cited 2021 May 19];10(3):e0120581. Available from: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0120581

18. Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: Systematic review and meta-analysis. BMJ (Online) [Internet]. 2014 Feb 13 [cited 2021 May 18];348. Available from: http://www.bmj.com/content/348/bmj.g1151?tab=related#datasupp

19. Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. Journal of Consulting and Clinical Psychology [Internet]. 2004 Dec [cited 2021 May 18];72(6):1144–56. Available from: https://pubmed.ncbi.nlm.nih.gov/15612860/

20. Rong L, Frontera AT, Benbadis SR. Tobacco smoking, epilepsy, and seizures [Internet]. Vol. 31, Epilepsy and Behavior. Epilepsy Behav; 2014 [cited 2021 May 25]. p. 210–8. Available from: https://pubmed.ncbi.nlm.nih.gov/24441294/

21. U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA; 2016.

22. Vuolo M, Staff J. Parent and child cigarette use: A longitudinal, multigenerational study. Pediatrics [Internet]. 2013 [cited 2021 May 18];132(3):e568. Available from: /pmc/articles/PMC3876755/

23. Centers for Disease Control and Prevention. Best Practices User Guide: Health Equity in Tobacco Prevention and Control [Internet]. Atlanta; 2015 [cited 2021 Jun 30]. Available from: https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf

24. Centers for Disease Control and Prevention. Tobacco Use and Quitting Among Individuals With Behavioral Health Conditions | CDC [Internet]. 2020 [cited 2021 Jun 21]. Available from: https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/

25. National Native Network. Commercial Tobacco | Keep It Sacred [Internet]. 2015 [cited 2021 May 18]. Available from: https://keepitsacred.itcmi.org/tobacco-and-tradition/commercial-tobacco/

26. National Native Network. Traditional Tobacco | Keep It Sacred [Internet]. 2015 [cited 2021 May 18]. Available from: https://keepitsacred.itcmi.org/tobacco-and-tradition/traditional-tobacco-use/

27. US Department of Health and Human Services. Treating Tobacco Use and Dependence: 2008 Update [Internet]. Rockville, MD: US Department of Health and Human Services; 2008 [cited 2021 Jun 15]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK63952/

28. Siddiqi K, Shah S, Abbas SM, Vidyasagaran A, Jawad M, Dogar O, et al. Global burden of disease due to smokeless tobacco consumption in adults: Analysis of data from 113 countries. BMC Medicine [Internet]. 2015 Aug 17 [cited 2021 May 18];13(1):1–22. Available from: https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-015-0424-2

29. Gaunkar RB, Nagarsekar A, Carvalho KM, Jodalli PS, Mascarenhas K. COVID-19 in Smokeless Tobacco Habitués: Increased Susceptibility and Transmission. Cureus [Internet]. 2020 Jun 25 [cited 2021 May 18];12(6). Available from: /pmc/articles/PMC7384704/

30. U.S. Department of Health and Human Services. Smoking Cessation: A Report of the Surgeon General. Atlanta, GA; 2020.

31. Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: An overview and network meta-analysis [Internet]. Vol. 2013, Cochrane Database of Systematic Reviews. John Wiley and Sons Ltd; 2013 [cited 2021 Jun 15]. Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009329.pub2/full

32. National Association of State Mental Health Program Directors. Tobacco-Free Living in Psychiatric Settings A best-practices toolkit promoting wellness and recovery [Internet]. 2007 [cited 2021 May 19]. Available from: www.nasmhpd.org

33. U.S. Department of Housing and Urban Development. Change is in the Air An Action Guide for Establishing Smoke-Free Public Housing and Multifamily Properties CHANGE IS IN THE AIR An Action Guide for Establishing Smoke-Free Public Housing and Multifamily Properties [Internet]. 2014 [cited 2021 May 19]. Available from: https://www.hud.gov/sites/documents/SFGUIDANCEMANUAL.PDF

34. Ritter A, Cameron J. A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. Drug and Alcohol Review [Internet]. 2006 Nov 1 [cited 2021 May 19];25(6):611–24. Available from: https://pubmed.ncbi.nlm.nih.gov/17132577/

35. Lawn S, Pols R. Smoking Bans in Psychiatric Inpatient Settings? A Review of the Research. Australian & New Zealand Journal of Psychiatry [Internet]. 2005 Oct [cited 2021 May 19];39(10):866–85. Available from: https://pubmed.ncbi.nlm.nih.gov/16168014/

36. North Carolina Department of Health and Human Services. Report on the Pilot to Establish a Tobacco Free Environent in State Operated Healthcare Facilities: Broughton Hospital and Walter B. Jones ADATC. 2011.

37. Eby LT de T, Laschober TC. Perceived implementation of the Office of Alcoholism and Substance Abuse Services (OASAS) tobacco-free regulation in NY State and clinical practice behaviors to support tobacco cessation: A repeated cross-sectional study. Journal of Substance Abuse Treatment [Internet]. 2013 Jul [cited 2021 May 19];45(1):83–90. Available from: /pmc/articles/PMC3642238/

38. Williams JM, Foulds J, Dwyer M, Order-Connors B, Springer M, Gadde P, et al. The integration of tobacco dependence treatment and tobacco-free standards into residential addictions treatment in New Jersey. Journal of Substance Abuse Treatment [Internet]. 2005 Jun 1 [cited 2021 May 19];28(4):331–40. Available from: http://www.journalofsubstanceabusetreatment.com/article/S0740547205000504/fulltext

39. Greenberg MR, Greco NM, Batchelor TJ, Miller AHF, Doherty T, Aziz AS, et al. Physician-directed smoking cessation using patient “opt-out” approach in the emergency department: A pilot program. Journal of the American College of Emergency Physicians Open [Internet]. 2020 Oct [cited 2021 May 19];1(5):782–9. Available from: https://pubmed.ncbi.nlm.nih.gov/33145519/