Frequently Asked Questions
About NC Standard and Tailored Plans Tobacco-Free Requirement for Clients, Families, and Staff

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

Why is North Carolina implementing a tobacco-free policy requirement through the Medicaid 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.

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.(34,35) 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**.(35) North Carolina is not the only state that has lived this; New York(36) and New Jersey(37) 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.(35) Research has also shown that tobacco-free policies do not lead to an increase in discharges or people leaving treatment overall.(34–37)

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

Questions about quitting

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) A behavioral health program should not assume what clients' goals are or put limits on what they can achieve. People with behavioral health conditions CAN and DO become tobacco free.(6) A good behavioral health program will offer the full range of services to support you, partner with you to set goals, and help you achieve them.
Are you ready to talk about 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.

I want to quit. How can I be successful?

You can DOUBLE your chances of quitting for good by using counseling and medication to treat nicotine withdrawal.(30) **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. Let your health and behavioral health providers know you are interested in quitting, and they can help you as well. Learn more about medications like the nicotine patch, gum, and lozenges from these flyers in **English** and **Spanish**.

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.

How can I deal with stress without smoking, vaping or using tobacco?

Though it feels like a relief for a short time, the body actually goes through withdrawal--physically and mentally--between cigarettes, because it's addicted.(30) Quitting smoking will actually lower one's overall stress after about 1-3 weeks, with effects similar to an anti-depressant.(18)
In the meantime, it's important to get quit coaching and medication that will lessen your stress and make it 2x more likely that you will be able to quit for good.(30) **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.

You can also learn more about medications like the nicotine patch, gum, and lozenges from these flyers in **English** and **Spanish**.

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.   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/

35.   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.

36.   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/

37.   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