SOUTH DAKOTA TOBACCO CONTROL BEHAVIORAL HEALTH TOOLKIT

EMORY ROLLINS SCHOOL OF PUBLIC HEALTH
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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Commercial Tobacco Statement

We respectfully acknowledge the variations in Lakota, Nakota, and Dakota traditions related to sacred tobacco. Please note that unless specified otherwise, the term “tobacco” refers to commercially produced tobacco products only and never the traditional tobacco of our Northern Plains American Indians.

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SECTION 1

ABOUT THIS TOOLKIT

Purpose

People with behavioral health conditions, such as individuals with a mental illness or substance use disorder, are disproportionately impacted by commercial tobacco use, experiencing higher smoking rates, greater health risks, and poorer outcomes than the general population. In South Dakota, the smoking rate among adults with behavioral health conditions is nearly double that of adults without these conditions, reflecting a critical public health disparity.[1] By supporting tobacco screening, access to cessation treatment and counseling, and recovery services, behavioral health facilities are in a critical position to improve the long-term health outcomes of behavioral health clients.[2]

This toolkit is designed to support behavioral health facilities in creating tobacco-free buildings and grounds policies and effectively integrating tobacco treatment into patient care. It provides evidence-based strategies for securing leadership commitment, staff training, and client education to help facilities overcome the unique challenges they face while implementing these policies.

Objectives

With this toolkit, users should be able to:

1. Describe the importance of addressing tobacco use in behavioral health settings.
2. Respond to challenges and myths associated with addressing tobacco use in behavioral health settings.
3. Describe the steps to implement a comprehensive tobacco-free buildings and grounds policy tailored to their facility.
4. Engage leadership and staff to support the integration of tobacco cessation and recovery into behavioral health treatment plans.
5. Effectively use state resources and materials, such as the SD Quitline, to support patients in tobacco cessation.

Audience

This toolkit is designed to support leadership and staff within behavioral health facilities across South Dakota, offering practical and evidence-based resources tailored to the needs of administrators, counselors, support staff, and other professionals engaged in behavioral health programs. It provides tools to help administrators navigate the complexities of policy planning and implementation, ensuring that tobacco-free environments and integrated tobacco treatment practices align with their facility's goals and operational priorities. For counselors and clinical staff, the toolkit offers guidance on incorporating tobacco treatment plans and leveraging enhanced techniques like motivational interviewing, cognitive behavioral therapy and others to address tobacco use as part of holistic patient care.

Additionally, this resource will support staff who often interact closely with patients, equipping them with the knowledge and strategies to reinforce tobacco-free messaging and provide consistent support for treatment and recovery efforts. Community members and external stakeholders involved in behavioral health programs will find relevant insights for educating on tobacco-free policies and fostering a culture of health within their communities.

The toolkit also serves as a crucial resource for grantees working on policy development and tobacco cessation initiatives within behavioral health settings. It provides frameworks for aligning programmatic efforts with state and federal guidelines, helping grantees overcome implementation challenges and achieve measurable outcomes in tobacco reduction efforts. By addressing the needs of diverse roles and stakeholders, the toolkit ensures a comprehensive approach to reducing tobacco use and improving health outcomes for individuals with behavioral health conditions across South Dakota.

Behavioral Health Terms

Anxiety: A mental health condition characterized by excessive worry, fear, or nervousness that is difficult to control and can interfere with daily activities. Symptoms may include restlessness, difficulty concentrating, irritability, and physical signs like rapid heartbeat or muscle tension. Common types of anxiety disorders include generalized anxiety disorder, social anxiety disorder, and panic disorder.

Depression: A common mental health disorder that causes persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities once enjoyed. It can also involve physical symptoms like changes in sleep, appetite, and energy levels. Depression affects how a person thinks, feels, and functions, and may range from mild to severe.

Trauma: A deeply distressing or disturbing experience that overwhelms an individual's ability to cope, often resulting in feelings of helplessness, a diminished sense of self, and emotional dysregulation. Trauma can result from a single event, repeated exposure, or a prolonged situation, such as abuse, violence, or neglect.

Adverse Childhood Experiences (ACE's): Traumatic events that occur during childhood (ages 0-17) that can significantly impact a person's physical, emotional, and behavioral health. Examples include abuse, neglect, and household challenges such as parental substance use or divorce. ACEs are linked to long-term health issues, including mental health disorders, substance use, and chronic diseases.

Post Traumatic Stress Disorder (PTSD): A mental health condition that develops after exposure to a traumatic event, such as combat, natural disasters, abuse, or serious accidents. Symptoms include intrusive thoughts, nightmares, flashbacks, hypervigilance, and avoidance of reminders of the trauma. PTSD can severely impact a person's ability to function in daily life.

Substance Use Disorder (SUD): A condition in which the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Co-Occurring Disorders: The presence of both a mental health disorder and a substance use disorder in the same individual. These conditions often interact and exacerbate one another, requiring integrated treatment approaches.

Behavioral Health Terms, *continued*

Resilience: The ability to adapt and recover from adversity, trauma, or significant stress. Resilience involves utilizing personal strengths, support systems, and coping strategies to overcome challenges and thrive despite difficult circumstances.

Burnout: A state of emotional, physical, and mental exhaustion caused by prolonged and excessive stress, often related to work or caregiving roles. Symptoms include fatigue, detachment, decreased productivity, and feelings of ineffectiveness.

Mindfulness: A mental practice that involves maintaining an active awareness of the present moment without judgment. Mindfulness techniques are often used in behavioral health to reduce stress, improve emotional regulation, and enhance overall well-being.

Commercial Tobacco Control Terms

Commercial Tobacco or Tobacco Product: Any product made from tobacco and manufactured for human consumption, including cigarettes, cigars, pipe tobacco, smokeless tobacco (e.g., chew, snuff), e-cigarettes, and other vaping products. This definition excludes traditional or ceremonial tobacco used by Indigenous communities for sacred, cultural, or medicinal purposes. A full directory of commercial tobacco products can be found on the Food and Drug Administration's (FDA's) website: https://www.accessdata.fda.gov/scripts/searchtobacco/

Commercial Tobacco Use: Use of any commercial tobacco product.

E-Cigarette: Any electronic smoking device or electronic nicotine delivery system (ENDS) containing or delivering nicotine or any other substance intended for human consumption that may be used by a person in any manner for the purpose of inhaling vapor or aerosol from the product. This includes electronic cigarettes, electronic cigars, electronic cigarillos, electronic pipes, electronic hookahs, vape pens, or other similar products or devices. This does not include drugs, devices, or combination products authorized for sale as tobacco cessation products and marketed and sold solely for that purpose by the U.S. Food and Drug Administration.

Tobacco-Free Behavioral Health Facility Policy: Policies that do not permit tobacco use within the buildings and on the grounds of the facility it is implemented within, including individual rooms, indoor common areas, and outdoor common areas.

SECTION 2

WHY ADDRESSING TOBACCO USE IN BEHAVIORAL HEALTH SETTINGS MATTERS

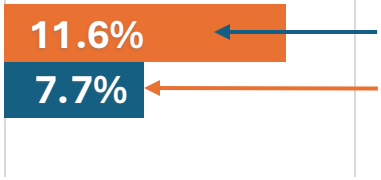
Tobacco Use Among People with Behavioral Health Conditions

Commercial tobacco use is a significant public health concern in the United States and remains the leading cause of preventable disease, disability, and death. The addictive nature of nicotine is formally recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) under Tobacco Use Disorder, underscoring the substantial challenges individuals face in overcoming nicotine dependence.

Significant health disparities exist related to commercial tobacco use. In South Dakota, adults with an income below $35,000 use tobacco at more than double the state average rate, and American Indian adults use tobacco at almost three times the average rate of adults across South Dakota.[3] People with behavioral health conditions, including mental illness and substance use disorders, are also disproportionately affected by tobacco use. They experience significantly higher smoking rates, face greater health risks, and suffer from poorer health outcomes compared to the general population.[4]

DATA GLIMPSE

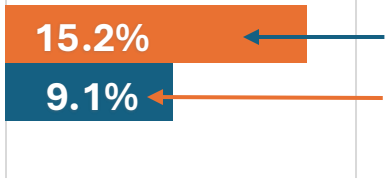
Adults in South Dakota use tobacco at a higher rate than the national average.



NATIONAL DATA

11.6% of US adults report that they currently **smoke**.

7.7% of US adults report that they currently **use e-cigarettes**.

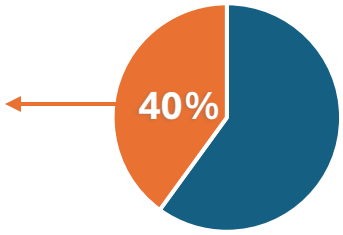


SOUTH DAKOTA DATA

15.2% of SD adults report that they currently **smoke**.

9.1% of SD adults report that they currently **use e-cigarettes**.

People with behavioral health conditions consume approximately 40% of all cigarettes smoked in the United States, even though they make up approximately only 23% of the adult population. [5,6]



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In South Dakota, adults with behavioral health conditions smoke cigarettes at nearly double the rate of the general population—30.2% compared to 15.2%.[4] **This mirrors what is seen nationally. In 2019, the cigarette smoking rate among adults with behavioral health conditions was 27.2% compared to 15.8% of adults with no mental health conditions.**[5]

Only about 2.4% of the estimated 62,000 people with a behavioral health condition who use tobacco in South Dakota have enrolled in SD QuitLine services.[7]

Impact of Tobacco on Individuals with Mental Health and Substance Use Disorders

Tobacco use has severe consequences for individuals with behavioral health conditions, including worsening physical and mental health, increased mortality, and increased difficulty in managing their conditions.

Comorbidities and Health Impacts

Smoking not only exacerbates chronic health conditions, such as diabetes, asthma, various cancers, gum disease, chronic obstructive pulmonary disease (COPD), and cardiovascular disease, but it is also can be a leading cause of these conditions.[9,10] People with mental illness who smoke are at greater risk for cardiovascular disease, respiratory illnesses, and cancers, leading to poorer overall health outcomes.[11]

Mortality

Research has shown that individuals with mental illness bear a disproportionate medical burden from tobacco use.[12] A study in the state of Oregon showed that rates of tobacco related death are higher among those with substance abuse conditions (53.6%) and both substance abuse and mental health conditions (46.8%) when compared to those without substance use or mental health conditions (30.7%).[13]

SECTION 2: WHY ADDRESSING TOBACCO USE IN BEHAVIORAL HEALTH SETTINGS MATTERS

Impact on Mental Health

Tobacco and nicotine use can negatively affect mental health and interact with medications. For example:

- A recent study showed that there is a partially causal association between smoking and schizophrenia and depression.[14]
- Tobacco smoke interacts with many medications through a variety of mechanisms. These interactions can result in an altered pharmacologic response and/or a higher required dose of certain medications. The Smoking Cessation Leadership Center's document Drug Interaction with Tobacco Smoke provides further information.
- Studies have noted that nicotine interacts with antipsychotic medications, which has several clinically relevant implications for patients who are taking antipsychotic medications.[15]
- Nicotine dependence significantly increases the risk of developing psychiatric disorders, including anxiety disorders and substance use disorders, even after controlling for various confounding factors.[16]
- Research has found that individuals who currently use e-cigarettes are twice as likely to report a diagnosis of depression compared to those who have never used them. Among frequent users, the risk is even higher—with more than double the odds of reporting depression, highlighting a strong association between vaping and poor mental health outcomes.[17]

Challenges with Addressing Tobacco Use Among Behavioral Health Clients

Addressing tobacco use among behavioral health clients comes with unique challenges. Several complex factors contribute to the higher prevalence of tobacco use among individuals with behavioral health conditions, including systemic targeting by the tobacco industry, coping mechanisms for managing symptoms, and trauma-related triggers.

Factors Contributing to Tobacco Use

Tobacco Industry Targeting: The tobacco industry has historically targeted individuals with mental illness by providing free cigarettes, funding misleading studies that claimed smoking alleviates stress, and directing marketing campaigns at psychiatric facilities.[18] These efforts have played a significant role in creating and sustaining high smoking rates within this population.

Tobacco Use and Trauma: Many individuals with behavioral health conditions have experienced trauma or adverse childhood experiences (ACEs). Research shows a strong link between ACEs and post-traumatic stress disorder (PTSD) and not only increased tobacco use but also earlier initiation, higher dependence, and greater difficulty quitting.[19]

Coping Mechanisms: Smoking is often used as a coping mechanism for mental illness due to nicotine's mood-altering effects, which often mimics temporary relief of symptoms associated with stress and some behavioral health conditions. However, smoking can interfere with medications, exacerbate stress-related health issues, and is often associated with higher rates of substance use disorders. Quitting smoking has been shown to improve mental health symptoms and support long-term recovery from substance use disorder.[2]

Factors Contributing to Tobacco Use, *continued*

Low Priority in Treatment Settings: Historically, tobacco use has not been prioritized in behavioral health settings. Providers often viewed smoking as a "lesser evil" compared to other substances or crises.[20] This has led to missed opportunities for intervention and a lack of integration of tobacco cessation and recovery programs into mental health and substance use treatment plans. For example, despite tobacco use disproportionately impacting individuals with psychiatric diagnoses, a study found that rates of tobacco screening and cessation counseling during outpatient visits were significantly lower among those with psychiatric conditions when compared to those with nonpsychiatric conditions.[21]

Reluctance from Staff to Promote Cessation: Behavioral health staff who use tobacco may feel conflicted or resistant to promoting tobacco cessation among patients. These staff members may fear losing rapport with patients or struggle with their own tobacco use, which can hinder the implementation of smoke-free policies and cessation programs. Tailored training and support for staff can address these barriers.

SECTION 2: WHY ADDRESSING TOBACCO USE IN BEHAVIORAL HEALTH SETTINGS MATTERS

Common Myths

Misperceptions rooted in cultural, systemic, and personal barriers, can make it difficult to prioritize tobacco use disorder in behavioral health settings. Here are some common myths about addressing tobacco use among people with mental health and substance abuse conditions.

MYTH vs. REALITY	
MYTH: Patients in behavioral health facilities aren't interested in quitting or are unlikely to succeed due to the additional challenges they face.	**REALITY**: Not only do patients want to quit, they CAN, and it only improves their health outcomes- including mental health and substance use recovery![22] Studies have shown that recovery success rates increase as much as 25%, when quitting tobacco.[23]
MYTH: Using tobacco products helps calm clients down, and quitting will increase their stress.	**REALITY:** Using tobacco products can increase anxiety and tension long-term. Withdrawal symptoms can be managed through medication options like nicotine replacement therapy or utilizing healthy coping skills.[24]
MYTH: Tobacco use disorder is a lesser evil when compared to other types of substance use disorders or mental health crises.	**REALITY:** Cardiometabolic disease, lung disease, and cancer, which can all be caused and exasperated by tobacco use, are a few of the leading causes of death for those with mental health conditions.[24]

Additional Sources: National Center of Excellence for Tobacco-Free Recovery[25] and American Lung Association Toolkits.[26]

Benefits of Addressing Tobacco Use Among Behavioral Health Patients

Despite the challenges, addressing tobacco use in behavioral health settings yields significant benefits:

Improved Patient Outcomes

Quitting smoking is associated with reductions in depression, anxiety, and other mental health symptoms. Patients who quit smoking during treatment for other substance use disorders often experience greater long-term sobriety and reduced relapse rates.[22,27] Addressing tobacco use while in treatment for substance use disorders (SUDs) can increase the chances of long-term recovery by 25%. [23]

Reduced Healthcare Costs

Tobacco-related illnesses are a major driver of healthcare costs. Integrating tobacco cessation and recovery into behavioral health care can lower these expenses by reducing the burden of smoking-related diseases, such as cardiovascular conditions and respiratory illnesses. [24]

Better Management of Comorbid Conditions

Smoking exacerbates chronic conditions commonly found in behavioral health patients, such as cardiometabolic disease, lung disease, and cancer. Tobacco cessation improves overall health, leading to better management of these comorbidities and enhanced quality of life. [24]

Creating Healthier Environments for Staff and Patients

Tobacco-free policies and cessation support create a healthier environment in behavioral health settings, reducing secondhand and thirdhand smoke exposure and encouraging a culture of wellness for both patients and staff.

Strengthening Community Collaborations

Partnering with community organizations can enhance tobacco cessation efforts by providing access to additional resources, expertise, and support systems. Collaboration can also help align efforts across healthcare, public health, and community sectors, maximizing impact.

How to Address Tobacco Use at Behavioral Health Facilities

Behavioral health facilities play a critical role in addressing tobacco use among patients with behavioral health conditions. Integrating comprehensive tobacco cessation and recovery strategies into these settings can significantly improve patient outcomes, reduce healthcare costs, and create healthier environments for both patients and staff. The two main approaches to addressing tobacco use in behavioral health facilities are 1) adopting tobacco-free behavioral health campus policies and 2) integrating tobacco cessation and recovery into treatment programs.

Adopt Tobacco-Free Behavioral Health Campus Policies

Implementing tobacco-free facility policies is a foundational step in addressing tobacco use. Such policies prohibit the use of tobacco products on all facility grounds, sending a clear message about the commitment to health and recovery. Tobacco-free policies help protect everyone from secondhand and thirdhand smoke.[28] In addition, studies have shown that tobacco-free policies:

- Improve both staff and patient wellbeing
- Improve patient quality of life and long-term mental health outcomes
- Increase patient's self-efficacy in quitting or cutting down tobacco consumption
- Enhance clinical and recovery focused care.[29,30]

These policies not only reduce exposure to secondhand smoke, they support recovery by eliminating triggers and promoting a culture of wellness.

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Integrate Tobacco Cessation and Recovery into Treatment Programs

Behavioral health facilities can also address tobacco use by promoting cessation and recovery. There is a spectrum of options for how to approach this, ranging from providing resources that link patients to information and services to changing systems and policies to fully integrate cessation and recovery into practice for greater impact:

1. **Promote Accessible Tobacco Cessation and Recovery Resources**: Behavioral health facilities should highlight cessation and recovery resources like the South Dakota QuitLine, which provides free counseling, support, and cessation medication. Ensuring patients have access to these evidence-based interventions can significantly improve cessation rates.

2. **Adopt Clinical Frameworks for Tobacco Cessation and Recovery**: Utilize structured approaches like AAR (Ask, Advise, Refer) or the 5 A's to screen and treat clients for tobacco use. AAR (Ask, Advise, Refer) and the 5 A's (Ask, Advise, Assess, Assist, and Arrange) are good examples of such frameworks. [31,32] These frameworks guide providers in systematically addressing tobacco use by initiating discussions, assessing readiness to quit, and linking patients to cessation services. Embedding these frameworks into clinical workflows ensures consistency in care delivery.

3. **Include Tobacco Cessation and Recovery in Treatment Plans**: Make tobacco cessation a routine part of patient care plans. Providers should collaborate with patients to set achievable goals, identify challenges, and develop personalized quitting and recovery strategies. This approach integrates tobacco cessation and recovery into the broader context of behavioral health treatment.

4. **Promote Holistic Wellness Initiatives**: Address tobacco use as part of comprehensive wellness programming. Educating patients about the dangers of tobacco use can be paired with discussions on healthy living, chronic disease prevention, and stress management. Incorporating activities such as support groups, nutrition workshops, and fitness programs can further engage patients in their recovery journey.

These strategies are described in further detail in the rest of this toolkit. By adopting these strategies, behavioral health facilities can empower patients to improve their overall health, support sustained recovery, and create a culture of wellness and support.

SECTION 3

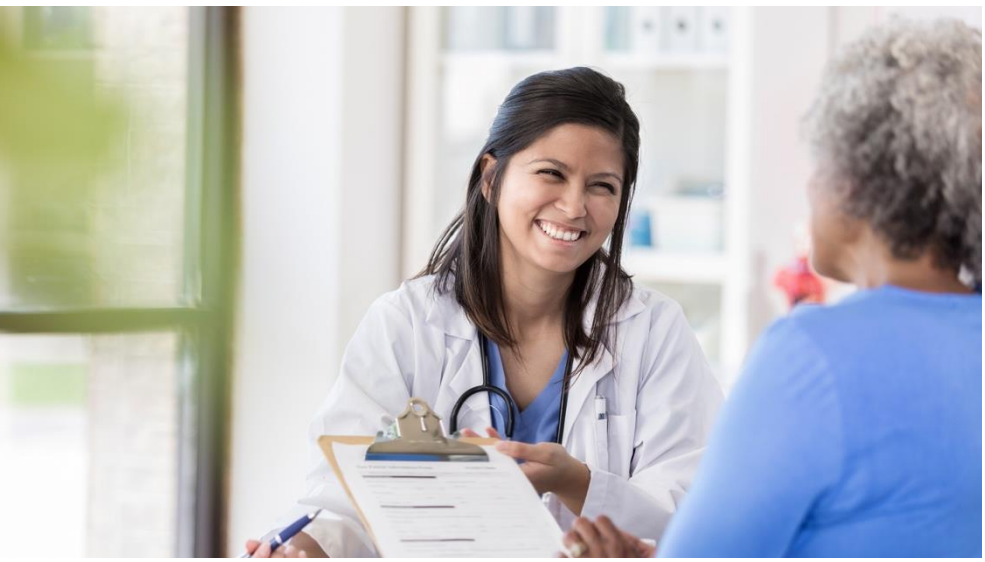
ADOPTING A TOBACCO-FREE CAMPUS POLICY IN BEHAVIORAL HEALTH SETTINGS

Rationale for Tobacco-Free Policies in Behavioral Health Settings

Implementing tobacco-free facility policies is a foundational step in addressing tobacco use. Such policies prohibit the use of tobacco products on all facility grounds, sending a clear message about the commitment to health and recovery. Tobacco-free policies:

- Protect everyone from secondhand and thirdhand smoke
- Improve both staff and patient wellbeing
- Improve patient quality of life and long-term mental health outcomes
- Increase patient's self-efficacy in quitting or cutting down tobacco consumption
- Enhance clinical and recovery focused care [28,30,33]

This section will discuss how to implement a tobacco-free policy in a behavioral health setting. It includes frameworks to assist with leading through change, steps to implement the policy, and tools and resources to guide the process.



The Importance of Integrating Tobacco Cessation Support

Implementing a tobacco-free policy in a behavioral health setting is not just about restricting tobacco use; it must also include meaningful support for individuals who use tobacco. Clients and staff who are dependent on nicotine will need access to cessation resources to successfully comply with the policy and improve their health.

By integrating cessation support—such as counseling, nicotine replacement therapy (NRT), and referrals to QuitLine services—facilities can ensure that their policies are both effective and compassionate. Providing these resources not only aligns with best practices but also reinforces a commitment to holistic wellness. This will be discussed in greater depth in the following section on Integrating Tobacco Cessation and Recovery into Treatment.

Organizational Change Models for Implementing a Tobacco-Free Policy

Implementing a tobacco-free policy for your facility is an important step in fostering a healthy environment. However, organizational change can be complex, requiring thoughtful planning and stakeholder engagement. Several well-established models offer frameworks for successfully guiding change, three of which are described here: Organizational Readiness to Change Assessment, Kotter's 8 Steps for Leading Change, and the Project Management Institute Framework.

ORGANIZATIONAL READINESS TO CHANGE ASSESSMENT (ORCA)

The ORCA Framework evaluates an organization's readiness to implement a tobacco-free policy by examining three key domains:

Evidence: Assessing the level of understanding and agreement among staff and leadership regarding the health and organizational benefits of going tobacco-free.

Context: Evaluating cultural, leadership, and structural factors that could impact policy implementation, such as existing attitudes towards tobacco use and organizational support for change.

Facilitation: Identifying strategies to support successful implementation, including staff training, access to cessation resources, and ongoing mentorship. ORCA helps behavioral health facilities determine their readiness, identify potential barriers, and develop tailored strategies for a smooth transition to a tobacco-free environment.

KOTTER'S 8 STEPS FOR LEADING CHANGE

John Kotter's model provides a structured, stepwise approach for implementing a tobacco-free policy in behavioral health facilities:

1. **Create Urgency:** Communicate the critical need for a tobacco-free policy, using data on health risks, costs, and benefits for clients and staff.
2. **Build a Guiding Coalition**: Assemble a diverse leadership team including administrators, clinicians, and peer advocates to champion the change.
3. **Develop a Vision and Strategy**: Outline clear objectives, timelines, and implementation steps to create a comprehensive policy.
4. **Communicate the Vision**: Use staff meetings, newsletters, posters, and training sessions to inform and engage all affected parties.
5. **Empower Employees for Action**: Provide staff with training on tobacco cessation support, policy enforcement strategies, and handling client concerns.
6. **Generate Short-Term Wins**: Celebrate small milestones, such as increased cessation support program enrollments or initial compliance successes.
7. **Consolidate Gains and Produce More Change**: Use early successes to build momentum, adapting and refining strategies based on feedback.
8. **Anchor the Change in Culture**: Ensure tobacco-free policies are integrated into organizational norms through ongoing reinforcement, leadership commitment, and continuous improvement efforts.

SECTION 3: ADOPTING A TOBACCO-FREE CAMPUS POLICY IN BEHAVIORAL HEALTH SETTINGS

PROJECT MANAGEMENT INSTITUTE (PMI) FRAMEWORK

The PMI framework provides a structured project management approach to implementing tobacco-free policies in behavioral health settings. It emphasizes:

INITIATING	Conducting a needs assessment to define policy goals, scope, and leadership support.
PLANNING	Developing a step-by-step implementation plan with clear milestones, timelines, and assigned responsibilities.
EXECUTING	Launching the policy, ensuring all staff and clients are informed, and providing necessary training and support.
MONITORING& CONTROLLING	Tracking policy compliance, addressing challenges, and making adjustments as needed.
CLOSING	Evaluating policy effectiveness, documenting lessons learned, and ensuring sustainability. Using PMI methodologies ensures that the policy implementation remains structured, goal-oriented, and responsive to challenges that may arise.

Steps to Implement a Tobacco-Free Policy at a Behavioral Health Facility

The following section provides step-by step guidance on implementing a tobacco free policy using elements of the frameworks shared in the previous section.

1. Create a Committee

- Assemble a multidisciplinary team of interested parties to lead policy change efforts. This could include facility administrators, healthcare providers, counselors, and clients.
- Identify key decision-makers and secure their support. Highlight the importance of a tobacco-free policy for improving client health and aligning with evidence-based practices.
- Begin fostering connections with external organizations, such as the South Dakota Tobacco Control Program (SD TCP), who can provide model policy language, educational materials, and cessation support for staff and clients.

2. Develop a Timeline

- Plan a phased implementation or set a specific quit date for the tobacco-free policy. Allow adequate time (e.g., 60–90 days) for preparation, communication, and education.
- Set milestones to assess readiness, such as completing staff training and client education sessions before the policy takes effect.
- Keep in mind that this timeline may be influenced by the size of the worksite as well as the number of employees, decision makers, processes, and workflows that are involved with or may be impacted by this policy.

3. Develop Messaging

- Craft messaging that emphasizes the benefits of a tobacco-free environment, such as improved client outcomes, reduced healthcare costs, and alignment with recovery-oriented care.
- Address potential concerns proactively, such as the impact on clients who use tobacco as a coping mechanism, by ensuring cessation support is part of the policy rollout.
- Tailor communication to different audiences, such as highlighting health benefits to clients and professional advantages to staff.

4. Determine Policy Language with Staff and Client Input

- Develop a clear, comprehensive tobacco-free policy that includes prohibitions on smoking, vaping, and all forms of tobacco use within the facility and on its grounds. It may be helpful to start with a model policy to ensure key components are included. See the Model Polices and Tools section for more details.
- Ensure the policy includes enforcement procedures and accommodations for clients in recovery, such as access to nicotine replacement therapy (NRT).
- Solicit feedback from staff, clients, and families to ensure the policy meets their needs and concerns, while maintaining the facility's therapeutic goals.

5. Communicate and Educate Staff and Clients

- Notify staff, clients, and visitors of the upcoming policy through letters, posters, and meetings.
- Provide education on the reasons for the change, addressing misconceptions and emphasizing the role of tobacco-free environments in supporting holistic recovery.
- Offer training to staff on how to support clients during the transition, including handling resistance compassionately and effectively.
- Update employee handbooks, contracts, and other relevant official documents to include information on the policy.
- Communicate the intent to implement this policy with vendors, contractors, and other establishments in your area who may be affected by the policy.

6. Implement Policy

- Officially implement the tobacco-free policy on the selected date.
- Ensure all staff are trained and prepared to enforce the policy respectfully and consistently.
- Display signage throughout the facility and grounds to clearly communicate the tobacco-free status to all visitors and clients. SD TCP, pending available inventory, can provide signage for free upon receipt and approval of the facility's tobacco free policy.
- Remove cigarette disposal receptacles across the campus to discourage smoking.
- Launch the policy with an event or announcement that reinforces the facility's commitment to health and recovery.

7. Monitor and Respond to Challenges if Needed

- Designate staff or volunteers to monitor compliance. Provide training for employees and enforcement personnel on handling violations.
- Track compliance and address any issues as they arise, using a graduated approach to enforcement (e.g., verbal warnings, education, written notices).
- Provide ongoing support to clients and staff who use tobacco by connecting them with cessation resources and counseling.

Throughout: Emphasize Strategies to Create Buy-In

- Regularly celebrate progress and successes, such as reductions in tobacco use among clients or improved health outcomes.
- Continue educating new staff, clients, and visitors about the policy and its benefits.
- Develop a checklist to validate that all the necessary actions included but not limited to maintaining signage, updating policy and routine task force meeting continue to be a priority.
- Organize periodic tobacco waste clean-up events to remove cigarette butts and related litter. Engage volunteers and community members in clean-up efforts to raise awareness and reinforce the policy.
- Evaluate the policy's impact periodically and adjust as needed, such as enhancing access to cessation tools or refining enforcement procedures to better support recovery efforts.

Useful Tools

Model Policies and Tobacco-Free Policy Checklist

To ensure your facility is implementing a comprehensive policy, using model policy language is recommended. The South Dakota Tobacco Control Program has developed model tobacco-free policies for various settings. Linked here is the Healthcare System Tobacco-Free Model Policy which can easily be modified to apply to behavioral health facilities. The Public Health Law Center also has a Commercial Tobacco & Behavioral Health Sample Policy for a Tobacco-free Setting.

If adjusting model policy language, make sure these core components are included:

- ❑ **Policy Rationale/Purpose**: A clear explanation of why the policy is being implemented.
- ❑ **Tobacco Use Restrictions**: A statement outlining smoking and tobacco use is prohibited throughout the entire campus, including lease and owned property and vehicles.
- ❑ **Applicability**: A statement specifying who the policy applies to, such as staff, clients, visitors, and contractors.
- ❑ **Effective Date**: The specific date when the policy will take effect.
- ❑ **Policy Communication Plan**: Ensure it is clear how all employees, clients, visitors, and stakeholders will be made aware of the policy. For example, tobacco-free policy language can be included in handbooks, contracts, and official documents.
- ❑ **Definition of Tobacco Use**: A detailed definition that includes examples of prohibited products or actions, such as traditional cigarettes, cigars, pipes, electronic smoking devices, chewing tobacco, snuff, nicotine pouches, and more.
- ❑ **Definition of Tobacco Products** : A comprehensive definition that includes smoked, smokeless, and electronic products, such as chewing tobacco, snuff, and vapes.
- ❑ **Disclaimer on Traditional Tobacco**: Clearly delineate the differences between the commercial tobacco use and traditional tobacco use and clarify that the policy relates to commercial tobacco use.
- ❑ **Enforcement Plan**: Clarify how the policy will be enforced. See the Graduated Enforcement section below for more information.
- ❑ **Tobacco Cessation Opportunities**: What cessation and recovery support options are available or will be provided.
- ❑ **Review and Revision Process**: Information on how and when the policy will be reviewed and updated, if necessary.

Sample Graduated Enforcement Plan

Graduated enforcement of a tobacco-free policy ensures that education and support are provided to anyone who is in violation of the policy. Enforcement may also look different depending on who is in violation of the policy. Here is an example of how graduated enforcement may work for both clients and staff:

For Clients

1. **Verbal Warnings and Education:** Clients who violate the policy will receive a verbal reminder of the rules and supportive education about the tobacco-free policy. Cessation resources tailored to clients (e.g., counseling or nicotine replacement therapy) will be emphasized.
2. **Written Warnings:** Subsequent violations may involve a documented warning added to the client's file, reinforcing the importance of the policy while offering additional support resources.
3. **Behavioral Interventions**: Repeated violations may lead to referrals for additional counseling or treatment planning sessions to address tobacco use as part of their overall behavioral health care.
4. **Limitations on Privileges**: As a final step, clients may face limitations on privileges, such as restricted access to outdoor areas, always keeping care and support central to enforcement actions. Discharge or removal from services is avoided whenever possible.

For Staff

1. **Verbal Warnings and Education**: Staff will be reminded of the policy during a verbal warning and offered cessation resources, such as workplace wellness programs or QuitLine access.
2. **Written Warnings**: Repeated violations will result in formal written warnings placed in the employee's personnel file, with clear communication about potential consequences for further non-compliance.
3. **Performance Reviews**: Continued non-compliance may be addressed during performance reviews, with potential impact on evaluations or eligibility for raises and promotions.
4. **Disciplinary Action**: Persistent violations may result in progressive disciplinary actions, including suspension or termination, depending on the severity and frequency of the behavior.

Signage

The SD TCP can provide signs free of cost, pending inventory availability, including window clings and metal signs. You may also wish to create your own temporary signage when launching the policy.

- To order **window clings**, use the online educational materials catalogue: https://apps.sd.gov/ph18publications/secure/puborder.aspx
- **Metal signs for outdoor use** can be ordered through a SD TCP staff member with proof of a policy. Contact South Dakota Tobacco Control Program Staff to request signage: DOHTobaccoControl@state.sd.us. Two 12 X 18" signs will be provided per property; additional signs may be provided with justification as supplies last. Youth & Community Engagement and Disparities awarded applicants can also request funding for metal signs in their request for funding applications.

Tobacco-free signage should be installed at all entrances, in parking lots, and in common areas. Placing signage along fence lines, walking trails, and other outdoor spaces can help reinforce compliance with the policy.

Additional Resources

- The Toolkit to Address Tobacco Use in Behavioral Health Settings from the American Lung Association provides practical guidance for behavioral health facilities on implementing tobacco-free policies and cessation interventions.
- The Tobacco-free Toolkit for Behavioral Health Agencies from the Smoking Cessation Leadership Center outlines strategies and steps agencies can take to create and sustain a tobacco-free environment for both staff and clients.
- Taking Your Facility Tobacco-Free from the National Behavioral Health Network is a concise fact sheet that offers key considerations and action steps to support transitioning to a tobacco-free behavioral health facility.

Case Study: Implementing a Tobacco-Free Campus Policy

New York and Oklahoma have made substantial progress implementing tobacco-free policies in behavioral health settings, creating lasting culture change in the process. If you'd like to read more on New York and Oklahoma's success in implementing Tobacco-Free Policies, read the CDC's short guide on Promising Policies and Practices to Address Tobacco Use by Persons with Mental and Substance Use Disorders.

New York's Approach

In 2008, the New York Office of Alcoholism and Substance Abuse Services (OASAS) mandated all state-funded substance use treatment programs adopt tobacco-free campus policies, including all indoor and outdoor areas.

Despite initial enforcement challenges, the policy resulted in:

- Fewer clients smoking
- Increased awareness of tobacco harms
- More clients attempting to quit and accessing cessation resources

Additionally, the New York Office of Mental Health collaborated with the Department of Health to support mental health providers with training and policy implementation.

Oklahoma's Approach

Oklahoma's Department of Mental Health and Substance Abuse Services (ODMHSAS), in partnership with the Tobacco Settlement Endowment Trust (TSET), rolled out tobacco-free policies across state-funded facilities. Over five years, the state trained providers on tobacco dependence, required policies and enforcement plans at behavioral health facilities, mandated use of the "5 A's" model or referral to the QuitLine, and tracked and increased client referrals to cessation resources.

These efforts resulted in:

- An increase in the number of smoke-free campuses. In fact, Oklahoma had the highest proportion of such facilities in the U.S.
- Significant declines in smoking rates: from 71% to 45% among mental health clients, and 77% to 51% among substance use clients.

Key Takeaways

Comprehensive policy, leadership support, training, and ongoing evaluation can drive significant reductions in tobacco use among behavioral health populations.

SECTION 4

INTEGRATING TOBACCO CESSATION AND RECOVERY INTO TREATMENT

Why Integrate Cessation and Recovery into Treatment?

Tobacco use remains a significant public health challenge, particularly among individuals with behavioral health conditions. Research shows that people with mental illness and substance use disorders use tobacco at higher rates than the general population, leading to increased morbidity and mortality. Individuals with behavioral health conditions account for nearly 40% of all cigarettes smoked in the U.S.[3] Despite the significant health risks, tobacco use has traditionally been overlooked in treatment settings. Addressing tobacco use as part of treatment and recovery efforts presents an opportunity to improve overall health outcomes, enhance long-term recovery success, and reduce healthcare costs.

This section provides a framework for integrating tobacco cessation into behavioral health treatment settings. It includes:

- A guide with best practices for incorporating cessation and recovery into treatment plans.
- Model workflows and tools that facilities can use to implement effective cessation programs.
- Success stories from South Dakota behavioral health facilities that have successfully incorporated screening and treatment services into their programs.

By prioritizing tobacco cessation and recovery as part of comprehensive behavioral health care, facilities can play a critical role in supporting client recovery, reducing health disparities, and improving overall community well-being.

Promoting and Integrating Tobacco Cessation and Recovery into Practice

Tobacco cessation and recovery can be integrated into behavioral health treatment along a spectrum of engagement. Some facilities may start with simple interventions, such as promoting external resources, while others may fully incorporate tobacco cessation and recovery into comprehensive treatment plans. This section outlines different levels of engagement and key strategies to create buy-in at each stage.

Promote the SD QuitLine and Other Cessation Resources

At the most basic level, behavioral health facilities can provide information about external cessation resources like the South Dakota QuitLine, which offers free coaching and tobacco cessation medications. Displaying posters, brochures, and digital materials about cessation services in waiting rooms and clinical spaces can help prompt clients to access these services. Staff can also provide materials like brochures to clients directly.

Many of these materials can be obtained for free from the SD TCP as supplies last. To order, use the online educational materials catalogue: https://apps.sd.gov/ph18publications/secure/puborder.aspx

You can find more information on the SD QuitLine services here: https://www.sdquitline.com/

Incorporate Ask-Advise-Refer (AAR)

Building on promoting cessation resources, Ask-Advise-Refer (AAR) is the next option on the spectrum. AAR is a brief, evidence-based intervention designed to systematically address tobacco use in healthcare settings. AAR is a time-efficient intervention that fits into busy clinical workflows. It ensures that every client receives brief but effective guidance on quitting. Research indicates that even minimal interventions from healthcare providers increase the likelihood of successful quit attempts. Facilities implementing AAR consistently see up to a 30% increase in quit attempts among clients.[37]

SECTION 4: INTEGRATING TOBACCO CESSATION AND RECOVERY INTO TREATMENT

A 1. ASK

Ask every client about their tobacco/nicotine use at each visit.

- *"Do you currently use any tobacco or nicotine products, including cigarettes, vapes, or smokeless tobacco?"*
- *"In the past month, have you used tobacco or nicotine products (cigarettes, e-cigarettes, chew, vaping device)? Are you willing to make a quit attempt within the next 30 days?"*

A 2. ADVISE

Advise them to quit in a clear, personalized, and supportive manner.

- *"Quitting tobacco is one of the best things you can do for your health. Even reducing use can make a big difference."*
- *"Let's work together to create a plan that will support you in quitting tobacco. Have you thought about setting a quit date as a goal?"*

R 3. REFER

Refer them to cessation support services, such as the SD QuitLine, behavioral counseling, or medication assistance.

- *"I can connect you to free coaching and medications through the SD QuitLine. Would you like me to make that referral today?"*
- *"To support you with your quit journey, I can provide some more information on your treatment options. There are medications that can assist you with cravings and withdrawal symptoms. Is this something you would be interested in?"*

Assistance with Promoting Cessation Resources and Implementing AAR

Contact the SD Tobacco Control Program via email for more information or to set up a training at DOHTobacco@state.sd.us. TCP can help with:

- Educating Staff on the SD QuitLine
- Training staff on AAR techniques to ensure consistency across client interactions
- Setting up electronic health record (EHR)
- Helping streamline referrals

SECTION 4: INTEGRATING TOBACCO CESSATION AND RECOVERY INTO TREATMENT

Integrating Cessation as Part of Client Treatment Plans

Some facilities may be able to provide tobacco cessation treatment directly, and/or incorporate tobacco use treatment into client treatment plans. In taking this approach, tobacco use should be treated as a co-occurring disorder. Treating tobacco use alongside mental health and substance use disorders leads to better medication adherence, fewer hospitalizations, and improved overall recovery outcomes.[23]

Here are the steps to integrate cessation into treatment:

1. Conduct an in-depth assessment of tobacco use and readiness to quit. Find examples of these tools in the Clinical Tools and Frameworks section of Appendix A.
2. Set personalized quit goals as part of recovery planning.
3. Offer in-house tobacco treatment counseling (individual or group setting), nicotine replacement therapy (NRT), and/or medication support alongside treatment for other conditions. See the *Tobacco Use Treatment Options* section for more information about these treatment options.

Note: Many behavioral health medications also work more effectively after quitting smoking because tobacco use affects medication metabolism.

Promote a Wellness/Holistic Approach

The most comprehensive level of integration ties tobacco cessation to broader health promotion efforts. It builds on the tobacco use treatment plan to help clients improve their entire health and wellbeing. This can include:

1. Education on the impact of tobacco use and its connection to mental health, substance use, and chronic disease.
2. Lifestyle interventions such as stress management, nutrition, and physical activity programs to support overall wellness.
3. Peer support networks to reinforce motivation and accountability.

Framing tobacco cessation within a holistic wellness framework reduces stigma and encourages client participation.

Tobacco Use Treatment Options

To effectively support tobacco cessation and recovery among behavioral health clients, facilities should offer a range of evidence-based treatment options. These interventions can be used individually or in combination to enhance quit success and recovery rates. The following section is informed by Chapter 6 from the 2020 Surgeon General Report on Smoking Cessation.[24]

Counseling and Behavioral Support

Behavioral Therapy plays a crucial role in supporting individuals who are trying to quit using tobacco by addressing the learned behaviors and environmental triggers that make quitting challenging. Both brief (less than 20 minutes) and intensive (20 minutes or more with follow-ups) interventions have been shown to enhance (quit-success) quit-success, with more intensive sessions yielding higher success rates. These therapy sessions, which may span several weeks, help with developing coping mechanisms, managing triggers, and receiving ongoing adherence support.

Cognitive Behavioral Therapy (CBT) targets maladaptive thoughts that reinforce tobacco use behaviors. Studies confirm its effectiveness, particularly when combined with nicotine replacement therapy (NRT) or other medications. CBT is also beneficial for specific populations, such as individuals with substance use or mental health conditions. Emerging research explores tech-based adaptations, including mobile apps, which may be a cost-effective alternative.

Motivational Interviewing (MI) is a collaborative, nonjudgmental counseling technique that fosters the motivation to quit using tobacco. It is especially effective for individuals who are not yet committed to quitting. Studies suggest that MI increases quit rates when compared to standard care, with both brief (<20 minutes) and extended sessions proving effective.

Nicotine Replacement Therapy (NRT)

NRT is a critical tool for tobacco cessation in behavioral health settings, addressing physical nicotine dependence without exposure to harmful chemicals from tobacco combustion. NRT reduces withdrawal symptoms and cravings, making it easier for individuals to quit.

Five forms of NRT are available: **nicotine patches, gum, lozenges, nasal spray, and inhalers** (the last two by prescription). Research shows that all forms are effective in increasing quit rates, with combination NRT or higher doses recommended for more dependent tobacco users. Patches provide continuous nicotine delivery, while gum, and lozenges offer faster-acting relief for cravings.

NRT is safe for long-term use and particularly beneficial for highly nicotine-dependent individuals, who face greater challenges in quitting. Tailoring NRT dosage to dependence levels improves success rates. Given the high rates of tobacco use among individuals with behavioral health conditions, integrating NRT into treatment plans can be an important tool for improving health outcomes and supporting long-term recovery.

Prescription Medications

Prescription medications further enhance quit success by targeting nicotine receptors in the brain.

- **Varenicline (i.e., Chantix)**: A partial nicotine receptor agonist that reduces withdrawal symptoms and blocks nicotine's pleasurable effects. It is more effective than NRT alone and can be combined with other therapies for greater success.
- **Bupropion (i.e., Zyban)**: An antidepressant that also reduces cravings and withdrawal symptoms, often used in combination with NRT to increase quit rates.
- **Combination therapy**—such as using NRT with bupropion—has proven more effective than using a single method alone, especially for heavy smokers. Research supports the use of dual NRT (patch plus fast-acting form) or combining varenicline with NRT to improve long-term cessation rates. Be sure to discuss combination therapy with the prescribing physician before implementing it into any treatment plans.

Group Based Counseling Approaches

Utilizing group-based approaches provides clients with structured support and behavioral techniques to help individuals quit smoking. Studies show it is more effective than self-help methods and brief advice from healthcare providers, nearly doubling quit rates in some cases.[38] This approach acknowledges the role of nicotine addiction in overall wellness and strengthens long-term recovery outcomes.

Consider utilizing programs like the American Lung Association's Freedom from Smoking or the American Cancer Society's Fresh Start group-based curriculums. You can also consider creating your own program by using a streamlined outline:

- **Step 1:** Identify a trained facilitator (licensed counselor, peer support specialist).
- **Step 2:** Schedule regular weekly sessions (e.g., 6-8 weeks).
- **Step 3:** Integrate evidence-based practices such as Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI).
- **Step 4:** Encourage peer accountability by having clients set small, achievable quit goals each week.
- **Step 5:** Provide access to free or low-cost nicotine replacement therapy (NRT) and medication support.

Note: Given the high smoking rates among individuals with behavioral health conditions, integrating NRT and prescription medications into treatment plans is essential for improving health outcomes and supporting long-term recovery.

Strategies to Secure Buy-In Staff and Clients

For successful integration, facilities should focus on building support among clients, staff, and leadership. Strategies include:

Staff Training and Engagement

Equip providers with the knowledge and skills to deliver effective cessation interventions confidently. For example, host wellness workshops that include mindfulness techniques, stress reduction strategies, and coping skills training to support clients in quitting tobacco.

Resources for Staff who Use Tobacco or Nicotine

Provide accessible, stigma-free support for staff who want to quit tobacco. Offer confidential access to cessation counseling, nicotine replacement therapy (NRT), and employee assistance programs (EAPs). Consider creating a staff-specific quit group or integrating cessation into broader staff wellness initiatives.

Client-Centered Messaging

Frame cessation as an opportunity for empowerment and recovery rather than a mandatory requirement. For example, encourage physical activity as a replacement behavior—exercise has been shown to reduce nicotine cravings and withdrawal symptoms.

Leadership Support

Secure buy-in from administrators to ensure the necessary resources and policies are in place. Leadership backing can lead to greater staff engagement in supporting client cessation and recovery.

Peer Programming

Empower peer programs and support resources to allow for shared experience learning opportunities. For instance, train individuals who previously used tobacco as peer champions to lead cessation discussions and mentor others through the quitting process.

Gradual Implementation

Start with small steps, such as referrals to external programs, before expanding to comprehensive in-house services.

Useful Tools

Additional Resources and Workflows

- The Patient-Centered Tobacco Cessation Workflow toolkit from the University of Colorado School of Medicine describes in detail the various components involved in integrating tobacco cessation and recovery into a healthcare facility, including team roles and responsibilities, recommended trainings, and descriptions of interventions.
- The Tobacco Integration Checklist from the University of Wisconsin Center for Tobacco Research and Intervention can help to evaluate where your facility stands and identify next steps.

Case Study: Integrating Tobacco Cessation into Treatment Plans – Oklahoma & Texas

State-level innovations are driving measurable progress in tobacco cessation efforts in states like Oklahoma and Texas. To learn more about how Oklahoma and Texas have successfully expanded cessation support through system-level integration and clinical training, read the CDC's short guide on Promising Policies and Practices to Address Tobacco Use by Persons with Mental and Substance Use Disorders.

Oklahoma: System Level Integration of Cessation Supports

ODMHSAS required all state-funded mental health and substance use treatment providers to:

- Implement the 5 A's or refer clients to the state quitline
- Track and increase quitline referrals annually
- Offer cessation counseling and medications as standard care

These efforts were supported by TSET funding and technical assistance from the Smoking Cessation Leadership Center.

As a result of this work:

- Oklahoma ranked highest nationally in offering cessation counseling and non-nicotine cessation medications at behavioral health facilities.
- Use of cessation services became standard, reducing tobacco use among clients.

Texas: Clinical Training and On-Site Resources

The Taking Texas Tobacco Free (TTTF) project partnered with over 250 clinics across 22 mental health centers to:

- Train over 5,000 staff on tobacco dependence and cessation
- Screen clients over 120,000 times for tobacco use
- Provide over 15,000 boxes of NRT (patches, gum, lozenges)

These efforts resulted in:

- Mental health facilities offering NRT rose to the highest in the country
- Routine screening and treatment became embedded in clinic workflows

Key Takeaways

When cessation services—including counseling, NRT, and staff training—are embedded into treatment plans, clients are more likely to quit, and facilities are better positioned to support long-term behavioral health.

SECTION 5

APPENDICES & REFERENCES

Appendix A: Additional Resources

Tobacco Cessation Programs and Services

South Dakota QuitLine
https://www.sdquitline.com/
The SD QuitLine offers free telephone and online counseling, cessation medications, and promotional materials. Promotional materials can also be ordered online: https://apps.sd.gov/ph18publications/secure/puborder.aspx

American Lung Association - Freedom From Smoking Program
https://www.lung.org/quit-smoking/join-freedom-from-smoking
The American Lung Association's Freedom From Smoking program is a group-based cessation program focused on behavior change.

American Cancer Society - Empowered to Quit Program
https://www.cancer.org/cancer/risk-prevention/tobacco/empowered-to-quit.html
Empowered to Quit is an email-based program from the American Cancer Society.

U.S. Public Health Service - Clinical Practice Guideline
https://www.ncbi.nlm.nih.gov/books/NBK63952/
The U.S Public Health Service developed evidence-based guidelines for treating tobacco use and dependence.

Behavioral Health Integration and Treatment Models

Behavioral Health and Wellness Program - DIMENSIONS: Nicotine-Free Toolkit
https://www.bhwellness.org/wp-content/uploads/2024/12/Nicotine-Free-Toolkit-2024-12.9.24.pdf
This toolkit from the University of Colorado Behavioral Health and Wellness Program contains a variety of information including education on nicotine use, skills discussing client nicotine use, methods for assessing client's dependence, and evidence-based treatment methods.

SAMHSA – Tobacco-Free Toolkit
https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/2023-04/CTFR_Toolkit_FINAL_May262022_3.pdf
This toolkit contains guidance for integrating tobacco-free policies into behavioral health settings.

Million Hearts- Tobacco Cessation Change Package
https://millionhearts.hhs.gov/tools-protocols/action-guides/tobacco-change-package/index.html
Guide to implementing and improving quality measures for cessation.

SECTION 5: APPENDICES

Policy Development and Implementation

South Dakota Tobacco Control Program
https://quittobaccosd.com/
Provides TA, resources, and signage for tobacco-free policy implementation.

South Dakota Healthcare System Tobacco-Free Model Policy
https://quittobaccosd.com/resources/advocacy-tools/policy-support-materials/health-care-system-policy
Template policy tailored for healthcare and behavioral health facilities.

Good Medicine Keepers
https://goodmedicinekeepers.rmtlc.org/
Provides resources to decrease commercial tobacco use and cancer rates among American Indian and Alaska Native communities.

National Native Network
https://keepitsacred.itcmi.org/
Offers culturally relevant education about traditional vs. commercial tobacco use in Native communities.

Public Health Law Center
https://www.publichealthlawcenter.org/
Provides guidance for the way that law contributes to the success of public health work.

Clinical Tools and Frameworks

American Lung Association - Ask-Advise-Refer (AAR) Quick Reference Guide
https://www.lung.org/getmedia/a366b986-fd9c-4604-b64b-0485060cf770/ask-advise-refer_quick-reference-guide
Clinical intervention guide for providers to identify and refer tobacco users.

Maine Health Center for Tobacco Independence – Tobacco Use Assessment
https://ctimaine.org/wp-content/uploads/2019/11/Tobacco-Use-Assessment.pdf
A comprehensive screening tool designed to evaluate an individual's tobacco use patterns, dependence level, quit history, and readiness to quit.

Maine Health Center for Tobacco Independence - Readiness to Quit Ladder
https://ctimaine.org/wp-content/uploads/2019/11/Readiness-to-Quit-Ladder.pdf
A motivational assessment tool to help evaluate client's current stage of readiness to quit smoking, ranging from no interest in quitting to having already quit

University of Colorado – Workflow Toolkit
https://www.bhwellness.org/wp-content/uploads/A-Patient-Centered-Tobacco-Cessation-Workflow-for-Healthcare-Clinics.pdf
Details roles and steps for integrating cessation into behavioral health services.

University of Wisconsin – Integration Checklist
https://ctri.wisc.edu/wp-content/uploads/sites/240/2022/06/TOOL-Treatment-Integration-Checklist.pdf
Helps facilities assess readiness and plan cessation integration.

Appendix B: Definitions

Behavioral Health Terms

Anxiety: A mental health condition characterized by excessive worry, fear, or nervousness that is difficult to control and can interfere with daily activities. Symptoms may include restlessness, difficulty concentrating, irritability, and physical signs like rapid heartbeat or muscle tension. Common types of anxiety disorders include generalized anxiety disorder, social anxiety disorder, and panic disorder.

Depression: A common mental health disorder that causes persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities once enjoyed. It can also involve physical symptoms like changes in sleep, appetite, and energy levels. Depression affects how a person thinks, feels, and functions, and may range from mild to severe.

Trauma: A deeply distressing or disturbing experience that overwhelms an individual's ability to cope, often resulting in feelings of helplessness, a diminished sense of self, and emotional dysregulation. Trauma can result from a single event, repeated exposure, or a prolonged situation, such as abuse, violence, or neglect.

Adverse Childhood Experiences (ACE's): Traumatic events that occur during childhood (ages 0-17) that can significantly impact a person's physical, emotional, and behavioral health. Examples include abuse, neglect, and household challenges such as parental substance use or divorce. ACEs are linked to long-term health issues, including mental health disorders, substance use, and chronic diseases.

Post Traumatic Stress Disorder (PTSD): A mental health condition that develops after exposure to a traumatic event, such as combat, natural disasters, abuse, or serious accidents. Symptoms include intrusive thoughts, nightmares, flashbacks, hypervigilance, and avoidance of reminders of the trauma. PTSD can severely impact a person's ability to function in daily life.

Substance Use Disorder (SUD): A condition in which the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Co-Occurring Disorders: The presence of both a mental health disorder and a substance use disorder in the same individual. These conditions often interact and exacerbate one another, requiring integrated treatment approaches.

Resilience: The ability to adapt and recover from adversity, trauma, or significant stress. Resilience involves utilizing personal strengths, support systems, and coping strategies to overcome challenges and thrive despite difficult circumstances.

Appendix B: Definitions

Behavioral Health Terms (cont.)

Burnout: A state of emotional, physical, and mental exhaustion caused by prolonged and excessive stress, often related to work or caregiving roles. Symptoms include fatigue, detachment, decreased productivity, and feelings of ineffectiveness.

Mindfulness: A mental practice that involves maintaining an active awareness of the present moment without judgment. Mindfulness techniques are often used in behavioral health to reduce stress, improve emotional regulation, and enhance overall well-being.

Commercial Tobacco Control Terms

Commercial Tobacco Product or Tobacco Product: Any product made or derived from tobacco or that contains nicotine, whether natural or synthetic, that is intended for human consumption, whether chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, or any component, part, or accessory of a tobacco product, including but not limited to: cigarettes; electronic smoking devices; cigars; little cigars; snuff; snus; bidis; dip; chewing tobacco; and other kinds and forms of tobacco. Tobacco Product also includes vapor products. Tobacco Product does not include traditional tobacco.

Commercial Tobacco Use or Tobacco Use: Use of any commercial tobacco product.

Smoke or Smoking: inhaling, exhaling, burning, operating, or carrying any Tobacco Product (lighted or heated) containing, made, or derived from nicotine, tobacco, or other plant, whether natural or synthetic, that is intended for inhalation. Smoke or Smoking also includes carrying or using an electronic smoking device.

Electronic smoking device: any device containing or delivering nicotine, or any other substance, whether natural or synthetic, intended for human consumption through the inhalation of aerosol or vapor from the product. Electronic smoking devices include, but is not limited to, devices manufactured, marketed, or sold as e-cigarettes, e-cigars, e-pipes, vape pens, mods, tank systems, or under any other product name or descriptor. Electronic smoking device includes any component part of a product, whether or not marketed or sold separately, including but not limited to e-liquids, e-juice, cartridges, or pods.

Nicotine Analog Product: Any chemically engineered product designed for human use that contains compounds structurally similar to nicotine, including its derivatives or metabolites.

Nicotine Replacement Therapy: A type of treatment that uses special products to give small, steady doses of nicotine to help stop cravings and relieve symptoms that occur when a person is trying to quit smoking.

Tobacco-Free Behavioral Health Facility Policy: Policies that do not permit tobacco use within the buildings and on the grounds of the facility it is implemented within, including individual rooms, indoor common areas, and outdoor common areas.

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