Maine Tobacco-Free Behavioral Health:

FREQUENTLY ASKED QUESTIONS TEMPLATE

[Behavioral Health Organization] Tobacco-Free Policy Frequently Asked Questions

ABOUT THE POLICY:

1. Why did [Behavioral Health Organization] implement a tobacco-free policy?
Tobacco use and secondhand smoke exposure are among the country's most preventable causes of death today. There is no safe level of exposure to secondhand smoke. As a quality behavioral health provider, [Behavioral Health Organization] is committed to protecting the health of its employees, clients, visitors, and vendors by providing a safe and clear air environment. Creating a tobacco-free environment and providing support for tobacco-free lifestyles through our tobacco treatment programs and activities show our commitment and leadership in health promotion and disease prevention for our staff, clients, and communities.

2. What does the tobacco-free policy entail?
The tobacco-free policy prohibits the smoking of, or use of, any tobacco products including but not limited to cigarettes, cigars, snuff, chewing tobacco, snus, and non-FDA approved nicotine delivery devices, such as e-cigarettes (vape pens/JUUL) anywhere on the [Behavioral Health Organization] campus. This includes all organization-affiliated buildings, on all facility grounds, including parking lots, and in all organization-owned or leased vehicles.

3. How will the policy be enforced?
Our hope is that we can work together to enforce this policy through friendly interactions. All employees who are seen using tobacco products on the premises after [Date] will be asked to stop, reminded of the new policy, and informed of tools that can ease symptoms while they are at work.

4. Can I use e-cigarettes?
Electronic cigarettes, or e-cigarettes, are non-FDA approved nicotine delivery devices which are prohibited on [Behavioral Health Organization]'s campus. Electronic cigarettes, and other nicotine delivery devices (vape pens, JUULs, etc.), contain nicotine which may yield negative health effects for clients and those exposed to the aerosol that the device emits.

ABOUT QUITTING TOBACCO & TREATMENT:

5. I'm a tobacco user. How can I get help?
We know that quitting is a process that doesn't happen the same way for everyone. Research shows that you will be most successful with a combination of support, coaching, and medications.

1) Employees can talk with an administrator within their organization about available treatment options.
2) Talk with your healthcare provider.
3) Connect with the Maine QuitLink at 1-800-QUIT-NOW or MaineQuitLink.com for free tobacco treatment, including nicotine replacement therapy. You can enroll online or over the phone and connect with resources that best meet your needs.

6. Can I use Nicotine Replacement Therapy (NRT) products, such as gum, lozenges, or patches, at work?
Yes. Some tobacco users may choose to use NRT products—particularly gum or lozenges—to manage their nicotine cravings while they quit or during work hours. If you are still smoking or using tobacco, please be cautious if you choose to use NRT therapy at work. Taking too much nicotine by using NRT while you still use tobacco can cause unpleasant side effects. If you want to use NRT at work, you may want to talk to your physician about appropriate dosing and use.

7. How can we expect people to quit smoking, while they're quitting everything else? We are here to deal with "real drugs," not cigarettes. Besides, clients don't want to quit. Even those who want to quit, won't be able to.
Tobacco products are "real drugs". They contribute to more illness and early death than any other drug - legal or illegal. As we transition to a healthier environment, we will train staff and clients about tobacco use, treatment options, and how use impacts other addictions. Evidence suggests that stopping tobacco product use can actually increase chances of maintaining abstinence from other substances. Clients will also learn refusal skills, be able to identify triggers, and regain control if they relapse. Our organization recognizes that quitting is hard, especially in environments where tobacco use is acceptable. We hope our commitment to healthy behaviors will inspire other behavioral health facilities in our community to similarly prohibit tobacco use in hopes of promoting wellness and recovery.

8. Smoking calms clients down. When they can't smoke, won't we experience complete mayhem?
Prohibiting smoking in behavioral health organizations actually *reduces* mayhem. Facilities that do not allow smoking report fewer incidents of seclusion and restraint and a reduction in coercion and threats among patients and staff. We are carefully planning this effort so the clients, staff, and visitors here have plenty of time and support to prepare for change. We will reduce uncomfortable nicotine withdrawal symptoms by appropriately using nicotine replacement therapy and other medications. We plan to post a countdown to our launch date in the main lobby. Meanwhile, we invite you to voice your concerns and join our team as we become tobacco-free and embrace recovery.

9. People come to behavioral health organizations in crisis. These are times they most need to use tobacco. Won't this new policy worsen their crises? Or worse yet, people won't get help when they need it because they don't want to quit smoking or vaping.
At a time of crisis, our immediate job is to deal with the crisis, not with tobacco use. As the person recovers, we will provide a healthy environment that promotes wellness, and being free of nicotine and tobacco is part of becoming well. We will not and cannot require anyone to quit smoking or vaping for a lifetime. What we will do is provide a safe environment where clients or staff members can learn how tobacco and nicotine impact their lives and find resources and opportunities that will support them to quit. Research has not yet determined the best time to help someone quit smoking. We know, however, that the best time to encourage healthy behavior is now.

10. Will prohibiting clients from using tobacco products on [Behavioral Health Organization] property negatively impact their treatment outcomes?
Research has shown that those who have a mental illness see a decrease in depression, anxiety, and stress levels after they quit using tobacco. For individuals receiving services for chemical dependency, quitting tobacco can actually increase the likelihood of long-term abstinence by 25%. However, it is important to recognize nicotine withdrawal symptoms that often mimic psychological disorders (such as increased agitation, anxiety, restlessness) and can be confused as exacerbating psychological conditions. Nicotine Replacement Therapy (NRT) can help address these symptoms and can be considered as part of a treatment plan.

11. How do we (as providers) convince staff members to comply and adhere to this policy?
A survey of more than 2,000 substance abuse counselors by Knudsen & Studts (2010) found that nearly half of counselors were in addiction recovery themselves. These individuals tend to smoke at rates higher than the general population (Ratschen et al., 2009) and the likelihood of staff members discussing quitting with clients is linked to their smoking status (Bobo & Davis, 1993). The high prevalence of tobacco use among treatment staff requires that organizational leadership quickly create staff buy-in for the program and that a full tobacco cessation program be offered to both clients and staff members. Staff buy-in can be created through:

1) Communicating the policy change openly to all staff members;
2) Conducting a survey or focus group with staff members to gather feedback;
3) Holding educational meetings to inform staff about the importance of discussing treatment with clients, as well as providing research related to the results of concurrent tobacco treatment with addiction or mental health treatment; and
4) Providing an employee treatment program similar to the one offered to clients.

Maine Tobacco-Free Behavioral Health:

FREQUENTLY ASKED QUESTIONS TEMPLATE

ABOUT LEGAL AND SAFETY ISSUES:

12. Isn't smoking or vaping a personal legal right?
Recent court rulings maintain that smoking or vaping is a privilege, not a right. Smokers are not entitled to protection against discrimination as "addicts" or as "disabled persons". Smokers are addicted to the nicotine, not the cigarette or electronic product, which is the delivery device.

13. What about client and staff safety when leaving the [Behavioral Health Organization] property to use tobacco products? This could include being struck by a vehicle while needing to go into or across the street.
Client and staff safety is a priority for [Behavioral Health Organization]. We recognize that for those who continue to use tobacco products there may be times where the individual leaves the campus to use tobacco products. Individuals are encouraged to be mindful of surroundings and practice caution if crossing streets. There is no evidence showing an increase of people being struck by a vehicle when leaving campus grounds to use a tobacco product.

14. Can clients and staff go onto on neighboring property to use tobacco products? Are these businesses and homeowners aware of the [Behavioral Health Organization] policy and supportive?
[Behavioral Health Organization] recognizes that staff and clients who use tobacco may leave campus to do so but we ask that individuals be good neighbors and be respectful neighbors and refrain from using tobacco products directly in front of neighboring businesses or homes. Those who use tobacco products off campus should dispose of any cigarette butts or other tobacco related litter appropriately after use.

As a component of preparing for this policy change, [Behavioral Health Organization] notified neighboring businesses and homeowners of the new tobacco-free policy. Concerns or questions from neighbors should be directed to [Organization contact] who will work to ensure any issues are addressed.

15. Is it legal for residential housing complexes to adopt smoke- and tobacco-free policies? Shouldn't someone be able to do what they want in their own unit?
Smoke-free multi-unit housing policies are permitted under both federal and Maine laws. Common areas of the building, like hallways, stairwells, and laundry rooms, must be smoke-free under Maine's public place smoking law. Additionally, the US Department of Housing and Urban Development (HUD) has rules requiring Public Housing Authorities to be smoke-free.

Smoking is a leading cause of home fire death in Maine and also continues to be a leading location of exposure to secondhand smoke. Research has found that up to 65% of air moves between units in a multi-unit building, so if smoking is allowed secondhand smoke travels through air ducts and ventilation systems. ASHRAE has said that "the only means of effectively eliminating the health risk associated with indoor exposure is to ban smoking activity."