

Roles for Certified Peer Specialists to Support Peers as they Address their Smoking

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Executive Summary

There is a pressing need to help smokers coping with a mental health challenge to quit tobacco. This includes both increasing the supply of evidence-based tobacco dependence interventions which includes support, and the demand for such help. Toward this goal, a team from the Center for Tobacco Research and Intervention worked with two Certified Peers Specialists to review relevant literature and conduct 54 informant interviews. The literature documents numerous tobacco roles for consumers. There was a very high level of consensus and enthusiasm across informants that Certified Peer Specialists can have many roles supporting the tobacco journeys of those facing mental health challenges provided that areas of potential role conflict are addressed. Reflecting this, it is recommended that the Bureau of Prevention Treatment and Recovery develop such roles just as it established the Certified Peer Specialist program more generally. Recommendations for qualification, training, and supervision are also included.

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Background

People coping with a mental health challenge or mental illness have a much higher prevalence of smoking than the general public. They are as motivated to quit as others and frequently try to reduce and quit. They find it more difficult to quit than others do even though all the evidence-based cessation treatments are effective for them. Despite this difficulty, many have successfully quit. Quitting provides substantial physical and mental health benefits even though time-limited nicotine withdrawal is stressful, challenging, and frequently results in experiencing failure for all smokers.

Despite this high prevalence, smokers coping with a mental health challenge or mental illness are not as likely to be provided evidence-based tobacco dependence interventions as part of their health care as other smokers. To address this, the Bureau of Prevention Treatment and Recovery (BPTR) collaborated with the Center for Tobacco Research and Intervention at the University of Wisconsin (UW-CTRI) to develop a program designed to increase the supply of evidence-based tobacco dependence interventions to smokers coping with a mental health challenge or mental illness. The **Bucket Approach** emerged from this collaboration. The Bucket Approach tailors evidence-based tobacco dependence interventions to both smokers coping with a mental health challenge or mental illness and behavioral health clinicians. It is tailored to smokers because the specific interventions are tied to their behavioral motivation that span their recovery journey. It is tailored to the behavioral health clinicians because it builds upon the intervention skills already possessed by them and consists of brief interventions that can fit into their busy schedules. The Bucket Approach also includes materials that support its adoption as a system change across a behavioral health treatment program. These materials include assistance in measuring outcomes and fidelity, display materials, and recommendations for training and motivating clinicians to use the Bucket Approach.

BPTR has made implementing and using the Bucket Approach a priority. For example, Community Support Programs (CSPs) and Comprehensive Community Services (CCSs) programs are required to report on their use of the Bucket Approach annually. BPTR also collaborated with UW-CTRI for five specific projects designed to increase the use of the Bucket Approach throughout Wisconsin's behavioral health delivery system. These include: technical assistance to behavioral health programs by UW-CTRI outreach staff; a motivational video highlighting smokers and clinicians who have benefited from the Bucket Approach; Bucket Approach Integration Awards as incentives to treatment programs to implement the Bucket Approach; seminars for behavioral programs designed to motivate taking the on-line Bucket Approach training; and the development of recommendations for how Certified Peer Specialists could support smokers coping with a mental health challenge or mental illness as they address their tobacco use. This last project is the topic of this document.

Research has documented the benefits of peers supporting others who are coping with a mental illness. Sharing lived experience is the corner stone of this support and establishes peers as unique contributors to the behavioral healthcare system. Peer support and peer-run organizations are promoted by federal agencies such as the Substance Abuse and Mental

Health Services Administration (SAMHSA). The Wisconsin Department of Health has developed peer support programs. There is now a Wisconsin training curriculum and certification test to become a Certified Peer Specialist (CPS). To date, more than 1,400 individuals have been credentialed as Certified Peer Specialists.

Given this context of great need to increase the provision of evidence-based tobacco dependence interventions to smokers coping with a mental health challenge and increasing utilization of Certified Peers Specialists in general, BPTR requested recommendations regarding roles consumers could have in addressing tobacco use by those coping with a mental illness.

Method

This project was conducted by two Certified Peers Specialists (Gretchen Wolfe and Marcia Mason) supervised by a UW-CTRI scientist, Dr. Bruce Christiansen. Recommendations are based on two sources of information, a literature search and interviews with key informants.

The literature search utilized key terms such as smoking, tobacco, and smoking cessation linked with other key terms such as support, peer support, and Certified Peer Specialist. Project staff reviewed the articles generated from this search for relevance. Those found relevant were discussed and summarized below.

Project staff interviewed a convenience sample of informants. Perspectives about possible Certified Peer Roles are apt to vary by type of person interviewed. This project sought to document the perspectives of six groups of Informants, four of which were Core Informants and two of which were Additional Informants (See Appendix A).

The first four Core Informant Groups represent the key stakeholders in any effort to create and implement tobacco roles for consumers: clinicians/providers, peer support specialists, tobacco/mental health consumers, and other stakeholders. The first Core Informant group, *behavioral health clinicians*, were recruited from those that completed the Bucket Approach training because they would be most knowledgeable about tobacco interventions. Project staff reached out to graduates of the Bucket Approach training to solicit volunteers to for interviews. The second Core Informant group was *Certified Peer Specialists (CPSs)*. To recruit these, an email invitation was sent out to all current CPSs by a third party. Project staff did not have access to their names or contact information. Those interested in being interviewed were asked to contact project staff. CPSs were give a \$10.00 Walmart gift card as a thank you. (Recovery coaches were not interviewed for this project.) The third Core Informant group was *consumers* (those coping with a mental health challenge or mental illness). At the conclusion of an interview with a behavioral health clinician or a CPS, the interviewer was asked if they knew any consumer who might be willing to be interviewed. If they did, they were asked to forward project staff contact information to the consumer with a request that they contact project staff if they desired an interview. When contacted, project staff told the consumer about the interview process and scheduled a time if the consumer consented to be interviewed. Project staff gave consumers who were interviewed a \$10.00 Walmart gift card as a thank you. When this recruitment method did not yield a sufficient number of consumers, project staff recruited

directly using their knowledge as a CPS. The fourth and final Core Informant group was *other stakeholders* and consisted of state staff involved in the Community Support Program or Comprehensive Community Service's program programs or the Certified Peer Specialist program or were outside of state employment but involved in the CPS program.

Two additional Informant Groups were thought to have perspectives on this topic that were not as deep nor as extensive as those of the Core Informants. The first additional Informant group were people involved in tobacco control. These included state staff in the state Tobacco Prevention and Control Program (TPCP) (within the Division of Public Health), UW-CTRI outreach staff who work across the state to disseminate evidence-based tobacco dependence treatments into the Wisconsin healthcare system, and Community Tobacco Alliances funded by TPCP to address tobacco at the grass root level. The second Additional Informant group was mental health organizations, typically those involved in advocacy.

All interviews were conducted by the two CPS staff. Both staff interviewed representatives from all six groups. The interviews were structured and used questions identified by project staff (see Appendix B). Questions were both open-ended and closed-ended (yes/no, Likert [from strongly disagree to strongly agree]). When it made sense to do so, the interviewers posed the same questions across the Informant Groups to facilitate comparison of results across groups. Some questions were unique to some Informant Groups. Interview staff made notes and entered quantitative answers into a spreadsheet for subsequent analysis. Interviewers did not record Identifying information. While the interviews were structured around a-priori questions, interviewers pursued answers with follow-up questions to ensure understanding, fully explore interviewee perspectives, and provide an opportunity for the full expression by the interviewee. All interviewees were provide an opportunity to ask questions and were thanked for their time and effort.

Interviews continued within an Informant Group until expressed themes were saturated. All interviews ended when the time allotted for this portion of the project expired. Interviewee information was discussed by project staff to identify common themes and summarized below.

Of note, interviewees often wore multiple hats in addition to the one used to select them. For example, a particular person may have been selected as a representative of a mental health organization but also be a clinician. Certainly, an individual recruited as a CPS also would have been a consumer at some time. No effort was made to restrict answers to only the expertise for which the person was selected. Rather, each was free to draw upon the totality of their experiences when answering questions. As a result, specific comments and observations noted below under an Informant Group might reflect perspectives other than the group label.

Interview information and the literature were considered through five distinct lenses or perspectives. **First**, was the role considered part of addressing consumers' tobacco journey, either on an individual basis or in a group, or was it part of addressing tobacco use by those coping with a mental health challenge on a larger scale. Examples of the latter roles would be efforts to destigmatizing tobacco use by both clinics and consumers, helping implement tobacco-free policies, advocating for better funding, educating stakeholders about the importance of quitting and about effective tobacco interventions, and advising treatment

programs about how to make tobacco interventions more patient-centric. **Second**, for those roles that were consistent with helping individuals with their tobacco journey, how did they fit into evidence-based best practice for the treatment of tobacco dependence? Generally, the Public Health Services Guideline emphasizes three distinct elements within tobacco dependence interventions: a) providing practical *behavioral counseling*; b) providing one or more of the seven FDA approved *cessation medicines*; and c) *interpersonal support*. Thus each role was considered relative to whether it was in service to behavioral counseling, use of cessation medicines, or interpersonal support. **Third**, was the role intended to increase the *supply* of tobacco dependence treatment, the *demand* (openness or receptivity to) tobacco dependence treatment or both? **Fourth**, was the possible role consistent with exciting roles of CPSs or not. **Fifth**, are roles consistent with the four buckets in the Bucket Approach, the tailored, evidence-based tobacco dependence intervention designed for this population.

Results

Literature. The literature search yielded 20 articles of possible relevance. A review of these identified six that contained pertinent information (see reference list). These six are summarized below via answers to questions relevant to this project.

A. What roles have consumers played in efforts to address tobacco?

The literature documents several roles for peers. Most served as co-facilitators of tobacco groups, either tobacco education/awareness groups or smoking cessation groups¹. One-on-one peer mentoring/support has been added to group facilitation^{2,3}. Mentors met individually with their assigned group participant either by phone or in person, 1 -2 hours per week. The purpose of this mentoring was to reinforce the group content, establish rapport, provide encouragement, help participants implement their goals, and problem solving toward reduction and cessation. Another program asked its peer co-leaders to reach out daily to group members who recently quit to provide support⁴. Two of these group programs took place in a Clubhouse setting⁴. In a final program, trained peers conducted site events (3 to 4 hours) at behavioral health treatment programs. Run like a health fair, the peers made a brief presentation to the consumer community and then remained on-site for one-on-one interactions with smokers. These 20-minute discussions were designed to motivate smokers coping with mental illness to seek tobacco dependence treatment using motivational interviewing strategies. This discussion included a Carbon Monoxide (CO) breath test, written information about what CO is and information about the financial cost of smoking⁶.

B. Can peers take on tobacco roles?

It is important to ask whether peers, such as Certified Peers Specialists, are capable of taking on roles supporting smokers. While there is no a-priori reason to believe they are not, this is an important question to pose. That is, can peers exhibit fidelity to training, demonstrate the skills needed to support tobacco users, and are they effective in their roles? One study³ reported on

findings relevant to these questions. After training, the average score by eight trained peers on a role-play assessment was 13.6 out of a possible core of 14. All eight achieved at least 85% of the possible total score. The average score on a short-answer knowledge test was 19.3 out of a possible 20. All eight achieved a score of 90 or above. In this study, each of the eight peers had an average of 16 meetings recorded and rated for fidelity. The average Adherence score was 97% while the average Competence score was 93%. From the Working Alliance Inventory, peer to peer mean bond was 5.9 on a 7-point Likert scale and peer-to-peer encouragement score was 4.4 on a 7-point Likers scale. Also the means on the Partner Interaction Questionnaire were positive both at three and six month suggesting that smokers perceived that the peers demonstrated more positive than negative behaviors. The answer to this question of whether peers can take on tobacco roles appears to be an unequivocal “yes,” given appropriate training.

C. Have these programs benefited the smokers?

A number of programs documented positive outcomes. One study reported that 20% of participants that attended at least 10 of 12 group sessions were not smoking 12 months later and 37% had stopped smoking for at least 30 days¹. Another reported 71% of participants reported reducing their tobacco use and 69% said there were now more likely to talk with their medical provider about quitting. Four of eight clubhouses that took part in the project implemented new tobacco use policies for their site⁴. A third study reported a decline in CO levels and number of cigarettes smoked per day. A quit attempt was made by 73% of participants and 10% were successful³. A fourth study reported the results following a brief (20 minute) individual tobacco feedback session. One month after that single session, those found for follow-up had reduced smoking overall and 29% tried to quit. At six months, 47% of those found for follow-up had tried to quit. While these are positive outcomes, with the exceptions of the fourth study that had no control group, they reflect outcomes from multi-faceted programs that include many elements in addition to peers. It would be inappropriate, then, to attribute these positive outcomes solely to the efforts of peers. There have been two randomized control trials that isolated the impact of peer supports. Taken together, they report an effect size of 1.64 which means the peers had a statistically significant positive effect over a control group that did not include peers⁵. However, these two studies did not take place within the behavioral health setting with peers being those with lived experience coping with a mental health challenge. Rather one took place with pregnant women and the other with cancer survivors, so the definition of “peer” is not the same as in this project. This finding, then, may not be of direct relevance. Taken as a whole, outcomes of using peers support is promising but it is premature to conclude that it is proven effective. More research is needed. The State should consider conducting this needed outcome research if it develops tobacco roles for peers.

D. How are peers perceived by the smokers?

Smokers reported that peers increased their confidence about quitting because peers were living proof that having a mental challenge was not a barrier to quitting. They also appreciated

the suggestions peers made from their own experiences. They reported that the peers were understanding and motivating and were positive role models. Participants believed that the peers were effective educators. They also felt that their peers helped them pay attention to their own well-being as they thought about quitting. Interestingly, mental health workers who were also involved in the program concurred with these assessments, but not as strongly¹. In another study, 86% of the participants felt that peers were extremely friendly toward them, 74% felt that peers were very or extremely knowledgeable about smoking and 85% said it was very or extremely important for the peer to give them feedback about their smoking. Most (71%) said it was easier talking with a peer about smoking than their psychiatrist⁶.

E. Do peers benefit?

One study reported on rewards to the peer². Peers felt gratified that the participants appreciated them. They found it rewarding to work on an important, even lifesaving, problem and to see participants make genuine efforts to reduce or quit. They also found it rewarding to be able to share their lived experience. They also reported personal growth. They believed the experience made them more compassionate, kind or patient. Most said it was beneficial for their careers. Finally working as a tobacco peer reinforced their own quitting and increased their resolve not to start smoking again.

F. What are the challenges for peers to take on tobacco roles?

The same study described challenges for peers to take on a tobacco role². Peers found it challenging to promote smoking cessation. There were two distinct elements to this challenge. First, peers were challenged by the inherent difficulty of quitting. They didn't know how to respond when agreed to goals were not met or agreed-to-actions were not taken. At times, they were reluctant to ask. Peers could get personally discouraged when their hard work did not result in progress. (Parenthetically, the Bucket Approach addresses this challenge because it acknowledges the difficulty of quitting, has extensive guidance about how to remain supportive when there is failure and addresses how to keep motivated when effort is reinforced on a very intermittent basis.) Second, peers experienced role conflict between advocating for addressing tobacco and being supportive. When a smoker expressed little interest in quitting, the peer had to choose between actions to advocate for addressing tobacco and actions that were purely supportive, which in this situation meant accepting the client's preference without qualification. Peers came to call this a conflict between their role as a mentor for quitting and their role as a peer. (Parenthetically, the Bucket Approach also addresses this challenge because it provides guidance when to be supportive and when to provide mentorship, based on the behavioral motivation of the smoker.)

Peers were surprised and disappointed that participants were more interested in hearing about their lived experience relative to quitting than in their lived experience more generally with mental illness. Others noted the burden of trying to help someone make positive changes.

Other challenges noted more generally applied to all peer support roles and not just tobacco roles. These included difficult handling rejection by a participant (missing appointments), role

confusion (am I a peer or a professional?), interpersonal boundary issues, and the triggering of their own mental health challenges. These challenges emerged perhaps because peers used for this study were not already trained in peer support so this was their first experience being in a peer support role.

G. What qualifies a peer for a tobacco role? Do such peers need to be ex-smokers or could never smokers take on such a role? How about current smokers?

All the peers used in all the studies were ex-smokers but no rationale was provided for using smoking status as an inclusion criteria. One study described their peers as previous heavy smokers who were confident non-smokers and who have worked as peer workers for more than 12 months¹. Another study⁶ required peers to be tobacco-free for a minimum of one year. Since this project also required travel, applicants also needed a valid license and have access to a car. Criteria in another study³ were: 1) former smoker (at least 100 lifetime cigarettes but none in the past year); 2) willingness to discuss their quitting and maintaining abstinence; 3) a past or current recipient of mental health services for serious mental illness (schizophrenia/schizoaffective disorder, bipolar disorder or current major depression per self report) 4) ≥ 18 ; 5) \geq high school education; 6) ≥ 12 months of work or volunteer experience in the last three years; and 7) ability to engage in effective communication and reflective listening assessed via application interview.

Since all of the studies required all peers to be ex-smokers and none provided any justification/rationale for this, one might conclude this is common sense and accepted. However, it is understood the CSPs are “in recovery” rather than fully recovered. Indeed, facing ongoing challenges might be considered a valuable source of lived experience to share. This perspective might argue that current smokers, who are on their own tobacco recovery journey, need not be disqualified from having a role in addressing tobacco. Here too, the Bucket Approach might provide guidance. Perhaps only those current smokers in Bucket D (I don’t want to address my smoking or even talk about it) would be categorically inappropriate for a tobacco role. Perhaps current smokers in the other three buckets (C (willing to talk), B (learning how to quit or preparing to quit) and A (trying to quit) could all have a tobacco role under some circumstances. Of course, using current smokers in a tobacco role will raise credibility concerns with smokers and would need to be addressed early in the supportive relationship. This leaves never smokers to be considered. One could argue they cannot take on tobacco roles because they have no lived experience (never smoked, never tried to quit just to fail, never went through nicotine withdrawal, never coped with urges and cravings, etc.). The persuasiveness of this argument may rest with how lived experience is understood. A CSP need not have a nearly identical lived experience to a peer in order to be supportive. Rather, a higher level of similarity of coping with mental health challenges is all that is required. Likewise, for non-smokers, facing other addictions or other compulsions might be qualifying lived experience as might the lived experience of a close family member struggling with tobacco addiction and dying from a tobacco-related disease.

H. How much and what type of training/supervision is required for peers to take on tobacco roles?

Regarding training, one project⁶ stated, peers "... receive 30 hours of intensive training and a detailed training manual to provide them with the knowledge and skills needed to perform the job. The curriculum includes both classroom and experiential learning and emphasizes facts about tobacco dependence, as well as how to interact with other consumers, make health information presentations, and how to work as an advocate. Most of the individuals hired had not worked previously as peer counselors and training time was also spent on issues such as self-disclosure and professionalism." Training in a second project³ also addressed the need to learn how to provide support more generally. Training included, "... five, half-day interactive group sessions over a 3 week period for a total of 22 hours. Topics covered included: the peer mentor role; smoking and physical and mental health; cognitive behavioral strategies to reduce or quit smoking, communication skills; motivational interviewing including the 5 R's (Relevance, Risks, Rewards, Roadblocks, and Repetition)("A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report," 2008); sharing personal experiences with successful quitting; smoking cessation group curriculum topics; and boundaries, confidentiality, safety, and dual relationships. Two sessions involved role play activities in which peer mentors practiced using basic counseling skills and responding to typical attitudes and challenges presented by smokers with serious mental illness who are considering quitting." Supervision took place weekly with peers as a group. Training took "two days" in another study⁴. The length of training and its content will vary greatly by whether trainees are already trained how to support peers (Certified Peer Specialists). Presumably, training for these will be shorter and will focus on supporting smokers as they address their tobacco use.

I. How much to peers get paid to take on a tobacco role.

Only one article addressed payment⁶. Peers in this project worked 20 hours/week and received a fixed stipend of \$800.00 (\$9,600/year). This permitted them to retain their health coverage and other entitlements. Note that these amounts were reported in 2011.

J. Who pays these peers?

Only one article addressed funding⁶. Initial funding was provided as a grant from the American Legacy Foundation. Subsequent funding was provided by the Cancer Institute of New Jersey and the New Jersey Department of Health and Human services, Division of Mental Health Services.

Informant Interviews Table 1 displays the percent agreement with specific possible tobacco roles and activities by informant group. Table 2 presents opinions about tobacco roles for consumers (mean scores on a 1 -5 Likert scale).

Core Informant Groups

A. Certified Peer Specialists (12)

The training for a Certified Peer Specialist is centered in four (4) core competencies for professional practice: values, personal attributes, knowledge, and skills. When interviewing CPSs about potential roles working with consumers at any stage of tobacco recovery, they envisioned their new roles would need to address 1) assuring that all aspects of the recovery goals and care plan originates from the consumer, 2) a system of clearly-defined roles, activities and services in workplaces for certified peer specialists when working collaboratively with other team support persons, and 3) empathetic responses directed toward the generalized stigma that consumers experience with mental health challenges and tobacco use.

The role that a CPS assumes in supporting a consumer's recovery plan, is ultimately at the discretion of the consumer. Interviewees could list a plethora of individual or community-based activities and services that could be enacted in conjunction with tobacco-recovery, but underlying all of them is the principle that support activities align with consumer choice, motivation, and strength. The majority of support tasks that CPSs are integrated in community offerings and include a lot of advocacy work. So when contemplating tobacco-related roles, it is important to start from understanding the consumer's motives, strengths, and his or her beliefs about engaging in the series of decisions that will define the recovery journey. The peer support role is to support not only engagement, but also understand when triggers, setbacks, and relapse may occur.

The unique aspect of having lived experience in mental health challenges and/or the recovery process makes CPSs effective consumer advocates. In situations where stigma or lack of clarity might impede a consumer's ability to communicate with the support team, a peer specialist who has empathy and experience with such struggles can lend support to simplifying choices. One CPS observed that simply "... showing up and being the embodiment of healthy living," can make a subtle impact on a consumer's motivation for his/her own self-care, even without having structured conversations about coming up with a specific plan.

Certified Peer Specialists envision a host of peer-run activities to support the physical, mental, and spiritual wellness of consumers in their daily living within their community of support. Their lived experience with alternative activities can be conveyed to consumer peers as viable options for one-on-one support or voluntary group supports. Whether the voice of encouragement to enroll, or the initiator of the wellness activity, CPSs suggested their roles in a recovery community could be focused in supporting replacement activities during the challenge of nicotine cessation and/or while overcoming mental health challenges. Wellness options could span voluntary engagement in yoga, arts and crafts, meditation, mindfulness, physical fitness, music, creative writing, board or virtual games, and nutrition education. Any of these options could run concurrently with smoking cessation activities such as support groups or educational presentations by tobacco experts or clinical staff. The common denominator of these activities is that a consumer feels empowered and informed to make decisions toward self-care. When focused primarily upon establishing an array of choices that support a

consumer's movement toward healthy living routines, the CSP can assume the role of choice coach, researcher, educator, or source of information about community-based services.

A common theme amongst CPS informants was the awareness and readiness to leverage support that could effectively overcome the setbacks that accompany stigma. The stigma that surrounds both mental health and tobacco use is an important factor that consumers and peers should acknowledge and address early in their working relationship, especially if the support peer will be involved in tobacco-related roles, activities, or services. One CPS noted, "There is certainly space to talk about tobacco use because tobacco is more generalized than other substances." However, this CPS cautioned that a direct conversation of the substance might cross lines of triggering a consumer's possible stigma-shame in tobacco use. Therefore, the CPSs must be adept at recognizing what topics or concerns are shaming, stressful, or upsetting for a consumer while establishing a working rapport of trustworthy support. A Certified Peer Specialist program developer noted, "Supporting someone may be a conversation that is more broad..." in situations where a consumer struggles with restrictions at work that prohibit smoking, or receiving dirty looks from strangers in community settings. Support should always reflect what the consumer has identified as the immediate issue for resolution when feeling upset, confined, or pressured to abandon nicotine use. The suggested approach, especially when stigma could be a relational barrier, is for peers to ask questions or share their own struggles to cope with restrictive situations or when they encounter negative words, expressions, and body language in general - apart from tobacco-use situations. By staying with open ended questioning around key issues, a peer would lend support as a choice coach to alleviate the immediate challenges and pivot the discussion to coping strategies. If the consumer has not identified smoking as a topic for collaborative support, the peer and the consumer could direct their efforts toward other emotional, physical, or spiritual needs that are of higher priorities or immediacy.

In a broad sense, the most significant behavioral health support that a CPS can provide stems from solid training and experiences in mental health support. Their specific support tasks will ultimately be determined by the agencies, organizations, or treatment centers in which they work and the policies for services and treatments that they have to offer to consumers. As the consumer progresses through recovery, the collaborative efforts of the team members will be tailored with the consumer's permission and pacing. Relational bonds vary, so support activities specific to medication, therapy, or individual or group supports should be negotiated around the consumer's preferences, and then designated and monitored within the limits of each team member's expertise.

B. Consumers (6)

Six consumers were interviewed. Two consumers were current smokers, three had quit several years ago, and one had never used tobacco. Confidentiality was maintained and consumers were asked for no personal or mental health information.

Five of the six consumers were familiar with Certified Peer Specialists; two had previously worked with a peer. Awareness of peer roles centered on “helping people out” and offering support by “being a good listener.” There was mention of assistance to find housing and accompanying consumers to medical appointments. Interestingly one consumer had participated in a smoking cessation group facilitated by a Certified Peer Specialist. They described group discussions and mutual support, dissemination of tobacco related information, goal setting and individual tracking of tobacco use. The individual used nicotine replacement therapy (NRT) as part of the quit attempt. After numerous quit attempts through adulthood the consumer has been tobacco free for three years and reports feeling more self-confident and energetic. One respondent had quit smoking for a year (on own) but returned to tobacco use due to a particularly anxious time and has not attempted to quit since. The five consumers who had smoked or currently smoke described an increase in smoking during times of stress and depression. Three consumers associated their smoking with drinking. General comments during the interviews made mention of a fear of worsening mental health symptoms during a quit attempt and concern regarding the ability to manage stress.

All consumers indicated a willingness to discuss their tobacco use with a Certified Peer Specialist. When asked how a peer could help address smoking with individuals, responses centered on individual support and accessibility (in person, phone) to support during times of urges, triggers and relapse. A nonjudgmental attitude and encouragement were vital. Instruction detailing how to quit, medical and health information including addiction education was mentioned by the majority of consumers. Many mentioned the need to develop alternative activities to stay busy, such as art and music, walking and bicycling, yoga and exercise along with new social endeavors.

All consumers believed a Certified Peer Specialist who is an ex-smoker or has never smoked could be effective in supporting an individual wanting to quit tobacco use. There was mention that an ex-smoker might have a better understanding but indicated familiarity of the process of addiction and recovery is appropriate to any substance dependence. That was followed with the importance that the peer “do their homework” and assist with a recovery plan. A Certified Peer Specialist who is a current smoker was more problematic, with consumers citing trust and motivational issues. Consumers pointed out it is “like working with someone to stop drinking but you (peer) are an alcoholic who drinks” as well as “do as I say not as I do.” A couple of consumers did note a current smoker might better understand the challenge and the aspects of withdrawal.

C. Clinicians (10)

The Bucket Approach was designed to help clinicians and providers tailor evidence-based tobacco-cessation interventions to various motivational statuses of smokers coping with mental health challenges, mental illness or other addictions. Graduates of the training were invited to provide feedback regarding the tobacco roles Certified Peer Specialists could have within their behavioral treatment agency. Ten providers agreed to be interviewed; distribution represented rural and metro counties throughout Wisconsin. Four of the respondents worked with the

Comprehensive Community Services program (CCS), four worked with the Community Support program (CSP), and two were involved in both CSP and CCS programs.

All respondents reported familiarity with Certified Peer Specialists (CPS); the majority have had the opportunity to work directly with CPSs in a work or volunteer setting.

The informants were asked to describe the activities and services that Certified Peer Specialists have provided for their program or agency, including tasks that the informant directly observed or supervised. All were aware of the foundational premise of lived experience, sharing of personal recovery (when appropriate), and instilling hope by encouragement and “having been there.” All believed that social connection and development of a trusting relationship is foundational to supporting consumers as they reach their goals. The informants reported that Certified Peer Specialists support consumers in personal objectives by developing independent living skills, finding appropriate housing and employment, and creating social supports. Mentions of peers accompanying the consumer in provider meetings suggest this facilitates “helping them find their voice,” ranging from discussing medications with a psychiatrist to a service plan with a case manager. There was some awareness of peers' involvement with support groups. The majority of roles identified were in mental health treatment situations, outpatient or residential. Other settings noted were jail to community re-entry programs and vocational settings such as supported employment. One provider concluded the Certified Peer Specialists are on the “front lines, filling in the gaps, and willingness getting in there - essentially a bridge.”

Clinicians were asked about the services and activities that a Certified Peer Specialist could play specific to addressing tobacco use by consumers coping with mental health challenges. Whatever mode of support, being a part of a collaborative approach emerged as elemental. The informants believed a peer could “support the different pathways and many resources available to quit smoking.” An umbrella approach of motivational interventions such as discussion and exploration of tobacco use, substance dependence education, health related information, available resources, and one to one support throughout the process was a repeating theme. There was recognition of the importance for practical and immediate support during potential relapse and emotional dysregulation. Again, the concept of lived experience surfaced. The majority were open to co-facilitating a tobacco group or having the peer conduct such a group independently. A few mentioned the need for offering a general wellness group with tobacco usage as a component. The use of the Quit Line and discussion of “quit smoking aids” came up as well. One provider stated, “I did not realize you can use the aids while still smoking, and people still believe it is all or nothing. So, to inform them is important.” Providers imagined Certified Peer Specialists playing a tobacco role regarding in-home visitation, group homes, action committees, and school and public outreach. “I think it depends on the culture of the treatment team about the acceptance of that (peer’s) role.”

There was frequent mention of time management issues. Many of the providers welcomed the role of a Certified Peer Specialist to work with the consumer specific to tobacco usage. “It is more like team work for me to receive support.” Another observed it might offer “a more relaxed approach to the consumer’s (tobacco usage) journey.” Consumer involvement with tobacco could permit the clinician to have greater focus on other issues with the consumer. Though the need for coordination was important to these clinicians, “Peers can have a role on the team to bring something up that others may not have observed when interacting with the

consumer.”

This group of informants were all graduates of the Bucket Approach so use of the training was mentioned throughout. Clinicians most often envisioned providing a specific Bucket Approach intervention and then asking the Certified Peers Specialist to provide follow-up. But one noted, “If trained in the Bucket Approach they could do the same thing that I do which is to start a conversation with someone; CPSs could identify where they are in their desire or motivation to quit.” The clinicians often equated motivational interviewing and active listening, which is part CPSs’ formal training, with the Bucket Approach.

Clinicians were asked if Certified Peer Specialists would be better suited to assist in some buckets more than others. (To summarize the Bucket Approach, Bucket D: does not want to talk about their smoking; Bucket C: willingness to only discuss; Bucket B: willingness to act to learn how to quit or to reduce; Bucket A: willingness to make a quit attempt.) The clinicians believed a peer could definitely be effective in Buckets C, B and A. They saw the Bucket Approach as fluid, allowing for “personalizing to client, sorting through issues to readiness at client’s pace.” No matter what bucket the consumer is in, the peer offers a sense of a “shared journey” and “being in their shoes”, role modeling “success” as well as offering practical knowledge and new skill building. Many interviewed felt the lack of “power differential” was an asset to supporting a consumer through tobacco cessation. With regards to Bucket D, as one interviewee suggested, “No is no”, but the majority felt that a peer might sense an opening and could begin the conversation.

The need for Bucket Approach training was a predominant theme. Clinicians noted that CPSs should have knowledge of comorbidity, trauma informed care, and cognitive behavioral skills. Many of the clinicians suggested the need for instruction specific to post quit symptoms such as anxiety, depression, weight gain, sleep disruption, and withdrawal symptoms. Informants also mentioned the need for guidance about addressing crises and suicide ideation.

Thoughts about peer oversight fell along pragmatic lines and was expected to take place within the agency through team meetings and supervising clinicians. Some believed that supervision should be ideally conducted by another Certified Peer Specialist who has tobacco dependence training themselves.

Clinicians firmly believed that a Certified Peer Specialist, whether an ex-smoker or never smoker, could work effectively with a consumer regarding tobacco usage. As one would expect, many saw the value of an ex-smoker having a “special connection.” Knowledge of, or lived experience with, any addiction was suitable. Four clinicians believed a current smoker working with the consumer might be challenging, look “hypocritical,” but the peer might be more empathetic and understand the shame and stigma of tobacco use better.

D. Other Stakeholders (6)

Within this Informant Group were those who bring the perspectives of behavioral health organizations, tobacco and mental health organizations, and Wisconsin’s Certified Peer Specialist networks. Because most persons in this Informant Group had an understanding of the Bucket Approach, their insights for integrating CPS support reflected the key components of treating tobacco dependence as well as core training program principles for Certified Peer Specialist roles.

The informants envisioned Certified Peer Specialists providing strategic support for recovery related to behavioral health, medication, and support to improve upon current practices for consumer tobacco/nicotine cessation. Because of their lived experience with mental health challenges and/or substance use, certified peer support persons might be integrated into client/consumer recovery journeys at any stage. Informants emphasized that a Certified Peer Specialist with a working knowledge of the Bucket Approach could be an asset when implementing tobacco dependence interventions.

Stakeholders agreed that tobacco and nicotine addiction presents serious health concerns for the general public. The same is true for tobacco users who cope with mental health challenges. By maximizing the roles of Certified Peer Specialists in a strategic way, informants believed problems within existing tobacco intervention programs could be resolved. The three problem areas most commonly noted were 1) limited or lack of consumer access to qualified clinicians, 2) lack of consistency in cessation information and/or strategies, and 3) lack of ongoing support for individual clients (aka consumers or peers) for the duration of their recovery journey. Stakeholders were optimistic that the existing roles, activities and services of Certified Peer Specialists could provide pivotal support to reduce these limitations and inconsistencies.

Because CPSs offer support to consumers in the natural flow of community experiences and basic services, they are positioned favorably for authentic conversations about tobacco use. Informants believe consumers may experience more self-consciousness, shame or stigma in reporting on their recovery gains or setbacks in a clinical setting. For this reason, Certified Peers Specialists could be valued collaborative partners in providing front-line information directly to consumers when they are most receptive to engaging in a tobacco recovery journey. Informants agreed that consumers who do not perceive themselves as empowered with choices could remain stagnant and avoid recovery support. Therefore, the activities and services for Certified Peer Specialists support could be crafted around empathetic mental health support while keeping a bridge open for tobacco recovery, optional support groups, and treatment places that a consumer agrees to incorporate into his or her care plan.

Informants concluded that CPSs must be a trustworthy and dependable support person to establish trust so that consumers might be willing to receive information or risk new behaviors. Ongoing communication within the consumer's support team is essential with the consumers actively prepared and empowered to speak to their own recovery wants, needs, and pace for lifestyle changes. The designation of support tasks would most likely reflect the consumer's level of trust and positive relationships with each individual on the care team. Informants recommended that Certified Peer Specialists be well trained and well informed in order to maintain consistency with the consumer's interactions with others on the team. Informants specified the Bucket Approach as the preferred program for evidence-based practices regarding nicotine/tobacco as foundational understanding of this program would improve consistent support from many vantage points. They noted that a peers lived experiences are relatable as "living proof" that substance recovery is possible despite mental or physical challenges.

Working effectively with consumers requires flexibility, empathy, and active listening to accurately gauge meeting consumers' needs and supporting them in multi-faceted ways.

In addition to individualized support, some informants noted that peer-led support groups could be very effective. One informant mentioned an agency currently developing a support group to be co-facilitated by a clinician and a "graduate" of a smoking cessation program in a women's residential setting. Cautions included avoiding working with or supporting an individual beyond the limits of one's expertise and compromising the boundaries that are inherent in the consumer-peer and/or client-therapist relationship. When a consumer is being served by a support team, the CPS could offer clarifications and options that remain consumer-centered and actively engaged in deciding appropriate designation of support tasks within the team. In this way, a CPS would not cross lines with roles that are commonly confused with peer support, such as recovery coaches, mentors, or recovery sponsors.

By equipping CPSs with information that is specific to maintaining a new lifestyle of recovery who then provide that information to consumers, informants believed that consumers will become more receptive to engaging in new social circles and routines. CPSs can connect consumers to a continuum of strengths-based community support. When a consumer has made sufficient gains and prepares to exit a treatment or recovery program, a CPS could serve as a liaison to other community-based options for a healthy lifestyle and recovery-boost places for unforeseen setbacks. Informants mentioned a few clubhouse environments that supported transitional lifestyle options during and beyond recovery, but noted a lack of knowledge about "tobacco-free" environments that they would recommend to consumers. CPSs might be adept at finding and providing choice options as part of their roles in supporting the strengths that a consumer identifies to be integral in his or her plans.

It is important to note that informants made specific reference to Alcoholics Anonymous (AA) and/or Narcotic Anonymous (NA) as well-known and readily accessible for "specific substance recovery." Informants believed that these merit more scrutiny for consumers in dual-recovery situations, such as narcotic and tobacco use disorder and/or alcohol and tobacco use disorders. However, AA and NA may be ambivalent about tobacco use with some meeting permitting smoking while others do not. One informant attributed this to neither Alcoholics Anonymous or Narcotics Anonymous holding nicotine and/or tobacco dependence in the same category of harm as alcohol or narcotics. This might create recovery tensions that a consumer, peer, and/or other members of the support team should anticipate and address when considering tobacco-specific recovery environments.

Stakeholders were optimistic that Certified Peer Specialists could and should be integrated into existing systems of behavioral health and/or community support organizations in order to improve the exchange of information and plan collaborative efforts to reduce the undisputed risks and harm with tobacco use.

Additional Informant groups

E. Tobacco Control Informants (11)

The consensus opinion among the eleven tobacco control informants that were interviewed was that, with adequate training, Certified Peer Specialists would be a welcome addition to the comprehensive services for successful smoking cessation offered by tobacco alliance and coalitions throughout Wisconsin. Tobacco informants made many references to the effectiveness of sponsors, mentors, and recovery coaches in behavioral health organizations that support a consumer's success in overcoming nicotine. However, the informants had limited knowledge or experience working directly with peer support generally. With a generalized understanding of peer support, however, informants gave numerous examples of services that a well-trained peer could provide as part of tobacco recovery as part of community support outreach efforts, as well as active advocacy for engagement in whatever tobacco treatment regimen that a consumer might choose.

These informants envisioned Certified Peer Specialists as frontline support for tobacco coalition or statewide tobacco alliance outreach efforts. As the number of Certified Peer Specialists working in Comprehensive Community Service organizations or Community Support Programs in Wisconsin grow and are paired with consumers to support their mental health, vocational skills, or recovery processes, they have an ideal opportunity to observe and relate to a consumer's tobacco use. At the onset of consumer and peer working relationships, Certified Peer Specialists routinely utilize skills sets of active listening, empathy, and strengths-based approaches for support. Therefore, for consumers who express a goal to engage in tobacco cessation, CPSs could perform immediate and practical support tasks such as assisting the peer to enroll in education or support groups, enroll for Quit Line supports, and/or provide the ongoing encouragement for the consumer to remain engaged in their tobacco recovery program of choice. For consumers who struggle with social interactions with a therapist or group support, CPSs could investigate and present alternative methods of tobacco cessation support that are available via telehealth and virtual platforms by phone, internet, or text.

Given the opportunity to join behavioral health systems, CPSs are equipped to serve as reliable sources of support when partnered with consumers on a consistent basis. Without ongoing mental and emotional support while using cessation medication to quit, informants expressed concern that consumers would continue nicotine use until confidence and strategies adequately prepare them for a quit attempt. Quit attempts are daunting for all smokers and quit attempt failure was acknowledged as a serious setback for persons experiencing compulsive behaviors, heightened anxiety, or other mental health challenges. The fear of relapse was often mentioned by informants as something a knowledgeable and capable CPS might address by sharing his or her own lived experience with mental health struggles and overcoming their own substance addictions. Some informants noted that it need not be lived experience with nicotine per se. Rather, CPS can support perseverance through providing emotional support and building coping strategies in anticipation of relapse.

Informants made occasional mention of medication or nicotine reduction strategies that CPSs might support, but the primary responsibility for monitoring medication efficacy would

ultimately be communicated between consumers and their support team members. For consumers in weakened states of confidence of self-advocacy, the CPS could help by involving the consumer more actively in team support advocacy and action. Important topics for dialog include feedback on consistently using cessation medications such as gum, patches, etc. in between therapy sessions or individual appointments with clinicians.

When contemplating the roles, services and activities that CPS could provide in support of consumers, informants stated that their existing partnerships with CCS, CSP or Targeted Case Management (TCM) services would be able to sustain CPS staff. Additionally, other community treatment providers, in general health or mental health, could offer CPS services in conjunction with tobacco cessation programs. Other potential employment sites in which to provide practical and relevant information to peers include in a variety of community support agencies such as food banks, clothing distribution centers, transitional housing, pregnancy centers, and area health and education centers (AHEC) where community health workers could provide collaborative information to benefit consumer needs. Ideally, consumers who are already connected to these support agencies would be able to encounter more persons of similar culture, socio-economic status, or ethnicity. Funding sources that currently support recovery coach, counseling, clinician, and administrative roles in CCS, CSP or TCM could be extended to support CPS. For this to happen, a tobacco center administrator noted that “There needs to be a better understanding of how a peer support role intersects with behavioral health so that health systems can expand into other potential funding sources like commercial or private health insurance, or public or private health care providers who have instituted sliding scale billing practices that consider household income that must be extended to cover consistent mental health, behavioral health, and physical health needs.”

A frustration from the tobacco informant perspective was the general acceptance of smoking in settings such as AA or NA support groups, CSPs and CCSs. When persons who are dependent upon nicotine are also battling drug or alcohol addictions, a common belief in these behavioral support/treatment settings is that smoking is “too hard” to give up. This mistaken notion of nicotine recovery is something that tobacco experts would like to address through training and reliable information. They viewed CPSs as a reliable delivery system for this training and information that might result in positive system change in behavioral health settings over time.

F. Mental Health Informants (9)

Nine interviews were conducted with representatives of mental health advocacy organizations. Five interviews included principals with the National Alliance on Mental Illness (NAMI) covering both the southern and northern regions of Wisconsin. The remainder were a community development director with a veteran’s outreach organization, a compliance director with an addiction and mental illness treatment organization, a director of clinical programming for a mental health organization, and the chief executive officer of a charitable medical clinic providing free services. All respondents were familiar with Certified Peer Specialists; seven are

presently working with or have worked with peers in the past; two individuals are themselves Certified Peer Specialists.

This group's familiarity with Certified Peer Specialists spanned numerous roles and services. The majority mentioned the foundational qualification of "learned experience" accompanied by an encouraging and supportive approach. One sentiment offered was that "Sharing experiences is what furthers another person in their recovery." Peer support could occur at the beginning of a consumer's introduction to the mental health system and assist with navigation of services and resources. Accompanying a consumer to mental health, medical and service program appointments supports communication of self-identified needs and understanding of terminology and requirements. Many of the interviewees referred to Certified Peer Specialists involvement with support groups and drop-in centers.

Interviewees were asked to envision what activities specific to tobacco cessation and nicotine dependence a Certified Peer Specialist could be involved with; what roles would be of assistance to their organization. There was a wide range of responses and, as one would expect, reflected the organization's mission and niche. All included the importance of consumer empowerment and person-driven recovery. The theme of continuity of care emerged, from entry point to follow-up support. The importance of having a Certified Peer Specialist available to assist the consumer in addressing triggers and relapse was noted, along with supporting development of new and healthy coping skills, new routines and activities. Some were familiar with the Wisconsin Quit Line and they thought it could be a joint activity for the consumer and peer considering mental health challenges can interfere with usage. Those organizations that have a drop-in center believed such facilitation would be natural, either provided individually or in a group setting. A few voiced the need for awareness and education for the community at large: "Not everybody realizes how tied together tobacco use and mental illness are, like the reason behind it." One representative welcomed Certified Peer Specialists offering tobacco cessation training onsite for both the staff and consumers. As one interviewee concluded "Support can look like a lot of things, let's look at what assistance may work." Though all could envision how a Certified Peer Specialist would be of benefit, some did not believe their environment was conducive to developing roles for peers, and "educating boards" would be necessary.

Of note, two interviewees worked at organizations that have implemented the Bucket Approach; one utilized peers in a Community Support Program (CSP) and another offered the training to the Community Treatment Program team.

There was little consensus regarding tobacco specific training. Responses acknowledged a lack of awareness of tobacco programming, required credentials, the need for experts, and the role of supervision for peers. A suggestion of culturally specific training was offered to include the engagement of the Black, the Latina, and Trans community, "so they are supporting culturally relevant services." Some of the NAMI representatives indicated training could be a part of their state conferences. One interviewee thought that the UW Center for Tobacco Research and Intervention (CTRI) could provide training and another concluded that if a program for CPSs develops from this project there would have to be some sort of training.

In terms of supervision of Certified Peer Specialists, two approaches emerged. First, clinical supervision would provide a framework of accountability, working through challenges, self-care check in, and the clinician’s background of recovery for both mental health challenges and addiction. Second, another Certified Peer Specialist could provide supervision. That is, “folks who understand peer support so they in turn can support their CPS staff.” Whatever the supervisory approach it was believed the peer “needs to be integrated into the context of the team.”

Discussion of funding indicated challenges including the many partnerships between non-profit organizations and the need to address multiple boards. Some of the NAMI organizations have contracts to provide Certified Peer Specialists to behavioral treatment centers and peer-run centers. There was mention of needing specific grants. In this context, the Substance Abuse and Mental Health Services Administration (SAMHSA) was mentioned. “SAMHSA is the biggest funder of behavioral health services and fundraising could be a part of it.” Another noted, “I think you could just replicate what is going on in the mental health and substance use community.” A few of the interviewees were familiar with Medicaid reimbursement of peers within the Comprehensive Community Services (CCS) programs. “Getting buy-in from private insurance... Medicaid leads a trend for general insurance market reimbursement.” Some discussed the need for private insurance and Medical Assistance (MA) to reimburse for peer activities and services. Finally, one informant suggested potentially diverting monies from the Tobacco Quit Line. While this state program is effective, it could be made more effective and cost effective for this population.

One of the mental health advocates summarized: There is an expansive need for them (peers), so there is a real need to fund the peer specialist and provide them with rigorous supervision, training. If this could be done, there could be so many opportunities to support treatment within the community: prevention, intervention, relapse prevention.

Conclusions

1. There is universal agreement among interviewees across all informant groups that peers and Certified Peer Specialists can have many roles at the intersection of tobacco use and mental health challenges/mental illness. Interviewees articulated many such roles and there was near 100% agreement with roles suggested (see Table 1). There was no expressed objections to consumers taking on tobacco roles. This conclusion can be understood using the five perspectives applied in this project. **First**, there are roles under each of the three elements of evidence-based tobacco dependence treatments (use of cessation medicines, behavioral counseling, and interpersonal support). Most obvious, CPSs can provide support while those coping with a mental challenge progress through their tobacco journey. CPSs can also assist the smoker apply behavioral counseling by providing support and sharing lived experience as the smoker deals with urges and cravings, risk for elapse, withdrawal-based emotional upheaval, etc. Regarding using cessation medicines, CSPs can help prepare

smokers to interact with prescribers about medication preferences, choices, and use. **Second**, there are viable roles on both the supply and demand side of tobacco interventions. By working as part of the team of caregivers, CSPs can improve the effectiveness of the supply of tobacco interventions. On behalf of consumers, they can advocate for more and, better access to, evidence-based tobacco dependence interventions. By reaching out to consumers about the need to quit smoking and the availability of treatments that increase the odds of success and the availability of support that will increase self-efficacy and confidence, CSPs can increase the demand for help. **Third**, there are CPS roles within each of the buckets of the Bucket Approach. For Bucket A, making a quit attempt, CSPs can support the quit plan the consumer developed in consultation with their clinicians. For Bucket B, take action to prepare to quit or to reduce, CSPs can support consumers while they make practice quit attempts or implement their reduction plan, or try out cessation medicines. For Bucket C, only talk for those not yet willing to take action or try to quit, CSPs can listen to consumer's tobacco story and share their lived experience in the process. For Bucket D, (consumers who don't even want to talk about smoking) CSPs can periodically check back in with the smokers because motivation to address tobacco use fluctuates over time. Other Bucket D roles may conflict with the tenets of being a CSP (see conclusion 5, below). **Fourth**, CSPs can have roles both with individual consumers (both one-on-one and in groups) as part of their tobacco journey and have roles in the broader context of addressing tobacco in behavioral health. Examples of the latter include speaking about the need for more tobacco dependence interventions and better tobacco use policies, and addressing provider and consumer barriers to such treatment on a system-wide basis. However, based on the interviews, there might be slightly less such support for these broader roles. Referring to Table 1, the three roles that reflect this broader mission (talk to groups about the importance of quitting, talk to groups about how to quit/reduce, and advising treatment programs about how to address tobacco dependence) had support in the 80 – 95% range, slightly less than the 100% endorsement expressed for the other roles. **Fifth**, for the most part, possible CPS tobacco roles are consistent with existing CPS roles. Notably, to be part of a consumer's tobacco journey, CSPs provide support through their lived experience. However, some possible tobacco roles may be in conflict with CPS tenets (see conclusion 5, below).

2. The literature documents peers success within a variety of diverse tobacco roles.
3. Peers are already fulfilling tobacco roles in Wisconsin. Some, but not all of these, are in the context of the Bucket Approach. Peers have co-lead cessation groups in Wisconsin. Thus, the building blocks for more and better-organized tobacco roles for peers already exist in Wisconsin.
4. Tobacco roles could take place in the many and diverse settings in which it is possible for peers to connect with consumers. These include formal behavioral health treatment

settings, physical health care settings, Federally Qualified Health Centers, peer-run organizations, respite/drop-in centers, supportive employment settings, public housing, schools, community and non-profit agencies, and jails/prisons/probation/community corrections programs. As an example, the First Breath program is a tobacco intervention program designed for low income, pregnant women who smoke. First Breath is a program of the Wisconsin Women's Health Foundation with financial support from the state Tobacco Prevention and Control Program (TCP) and Maternal and Child Health (Division of Public Health). First Breath staff know that a very large percentage of the mothers enrolled in their tobacco program face mental health challenges. Their training focus in 2019 was the Bucket Approach.

5. Both the literature and the interviewees identified a conflict between some possible tobacco roles and tenets of being a Certified Peer Specialist. The literature noted that some peers experienced conflict between their duties to encourage smoking cessation (labeled as mentoring roles) and their obligation to provide support (labeled as peer roles). This conflict comes into sharpest focus for smokers who have not identified smoking as something they want to address (are in Bucket D). Could an action as innocuous as providing tobacco-relevant material to a smoker who does not want to even talk about smoking violate the tenets of being a CPS and, thereby, undermine the relationship between peer and consumer and reduce the effectiveness of peer support? The concept of "patient centeredness" may be useful when considering this question. Clinicians strive to be as patient-centered as possible as patient-centered care is more effective. However, there are understandable limits and there are times a clinician is obligated by their professional tenets to fall short of complete patient-centeredness. A common example is the professional obligation to raise a topic that an assessment identifies as relevant for health, such as engaging in risky behavior, even if the patient does not want to talk about it. By comparison, remaining 100% patient-centric is essential for CPSs. Failure to do so can quickly undermine the peer-consumer relationship and reduce peer support effectiveness. Consumers must know that the CPSs are 100% dedicated to their journey to the exclusion of all other considerations. In this context of 100% patient-centeredness, the innocent-appearing action of giving tobacco information to a smoker who has expressed a desire not to address tobacco use could well be perceived by the consumer as coercive, thus suggesting that the CPS has an agenda other than supporting the consumer. To avoid this conflict, one should conclude that when working with individual smokers, tobacco roles for CPSs should be limited to contexts in which consumers have identified a willingness to address their tobacco use and embark on a tobacco journey no matter what its duration and pauses. To do otherwise, would compromise CPS tenets. One caveat to this conclusion may be to interject the question of *which* patient does the CPS put at the center? It is well understood that smokers are ambivalent about quitting. This is personified in the very common refrain of "I'd like to quit someday but I don't think I can.... but just not right now as I have too much stress..... but every time I try I fail.....but the cravings are too

great.....if only it would be easier etc.” Does the CPS support that side of the consumer who says they don’t want to talk about tobacco or that side of the consumer who would very much like to quit and has tried to do so numerous times before?

6. Both the literature and interviewees provided examples to justify concluding that CPS tobacco roles would benefit all those involved. There would be greater resources brought to bear on the tobacco challenge. Consumers would receive greater support during their tobacco journey. Treatment teams would become more effective. CPSs have new roles, enhanced skills, more employment opportunities, and new ways to achieve satisfaction. This is not to say that there won’t be any stress for a CPS who takes on tobacco roles. The literature describes the stress associated with being part of a tobacco journey that has many pauses and setbacks.
7. Many of the interviewees asked about next steps in this project and how they could remain involved. This suggests considerable grass roots support for developing tobacco roles for consumers.

Recommendations

1. Just like the Bureau of Prevention Treatment and Recovery developed the overall Certified Peer Support program, BPTR should now develop tobacco roles for consumers. Both the literature and the informant interviews detail a wide range of roles that should be developed. These reflect supporting individual smokers on their tobacco journey as well as roles to promote addressing tobacco within the mental health care delivery system. There appears to be considerable stakeholder support for such an initiative. Consumer tobacco roles would benefit the consumer, the smokers they support, clinicians, and the behavioral healthcare delivery system. BPTR should draw on partners such as CPS stakeholders like Access to Independence, UW-CTRI, and the Tobacco Prevention and Control Program, and CPSs themselves during its developmental process.
2. Tobacco roles should be developed for diverse settings that go well beyond behavioral health treatment programs. These include physical health clinics, peer-run organizations supportive employment settings, housing, corrections, etc. Certified Peer Specialists who take on tobacco roles should be integrated into the Community Tobacco Alliances managed by the state Tobacco Prevention and Control Program.
3. Consumers should become certified as a peer specialist before they take on tobacco roles. The literature noted that training for tobacco roles had to include the skills and understanding that is included in becoming a Certified Peer Specialist. Therefore, a project

to develop tobacco roles for consumers is more likely to succeed and be effective if it is built upon the CPS infrastructure. Of course, additional education/training about addressing tobacco is necessary. This should include completing the Bucket Approach training. A partnership between those already involved in training CPSs and UW-CTRI might make an effective way to accomplish this.

Possible conflict between CPS's tenets and possible tobacco roles such as encouraging reduction/quitting, should be considered carefully, deliberated, and consensus reached as part of the process to develop tobacco roles for CPSs.

4. In addition to the supervision and support now provided by employers of Certified Peers Specialists and the CSP infrastructure, there should be additional support for CSPs who take on tobacco roles. This supervision should contain three elements: 1) ongoing support about how to take on tobacco roles as a CSP; 2) how to improve tobacco support skills; and 3) meetings to facilitate mutual peer support. Those already involved in training CPSs can address the first, a tobacco organization like UW-CTRI the second, and a formal structure to facilitate the third is needed. The Certified Peer Specialist webpage has a resource tool for supervision that can inform the CSP infrastructure.
5. Initially, only Certified Peer Specialists who are ex-smokers or never smokers should qualify to take on tobacco roles. While current smokers could well take on circumscribed roles, developing these roles might prudently wait until the Tobacco Role program has some experience.
6. CPSs who take on tobacco roles should not do so to the exclusion of more traditional CPS roles. Ideally, CSPs who take on tobacco roles should still function as a CPS more generally. A CPS who specializes in tobacco roles exclusively may, over time, drift from being a CPS which would be unfortunate.
7. To address health equity, efforts should be made to recruit diverse CPSs to take on tobacco roles. A diverse workforce should include tobacco support specialists that serve residents in rural Wisconsin counties.
8. While the literature already supports the development of tobacco roles for Certified Peer Specialists, there is much more to be learned. As BPTR developed these roles, it should also develop a rigorous program to measure outcome and impacts to all parties including smokers, the Certified Peer Specialists engaging in tobacco roles, clinical care teams, the behavioral health care delivery system more generally, and other settings in which peer support for tobacco journeys takes place.

9. While BPTR develop tobacco roles for Certified Peer Specialists, or even if decline to do so, Certified Peer Specialists should be encouraged to complete the Bucket Approach training.

Table 1: Percent Agree (yes) to Possible Tobacco Roles

| Informant Group | Inform about the effects of smoking | Inform about where to get help | Inform about how to quit | Share own tobacco story | Listen to other's tobacco story | Help set goals regarding quitting | Discuss pros and cons of smoking/ quitting | Discuss previous quit attempts | Provide support during quit | Check in with person after quit | Talk to groups about the importance of quitting | Talk to groups about how to reduce/ quit | Advise Treatment Programs about how to help people quit |
|--|-------------------------------------|--------------------------------|--------------------------|-------------------------|---------------------------------|-----------------------------------|--|--------------------------------|-----------------------------|---------------------------------|---|--|---|
| Certified Peer Specialists (12) ¹ | 100 | 100 | 91.7 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 91.7 | 100 | 83.3 |
| Consumer (6) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Clinicians (13) | 100 | 100 | 92.3 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 92.3 | 92.3 | 61.5 |
| Other key informants (3) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 66.7 |
| Tobacco informants (5) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Mental health informants (6) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 83.3 | 100 | 100 | 100 | 100 | 100 |
| Total (41) | 100 | 100 | 95.7 | 100 | 100 | 100 | 100 | 97.8 | 100 | 100 | 95.0 | 97.5 | 80.0 |

¹ Number

Table 2: Opinions about Tobacco Roles¹

| Informant Group | Can be of great help | Unique understanding | Can help in ways others can't | Current training is sufficient | In scope for CPS | Consistent with being a CPS | Must be an ex-smoker | Can be current smoker as long as they are on smoking reduction/cessation journey | Program to prepare CPSs is needed | CSPs should be given opportunity |
|---|----------------------|----------------------|-------------------------------|--------------------------------|------------------|-----------------------------|----------------------|--|-----------------------------------|----------------------------------|
| Certified Peers Specialists (12) ² | 1.17 | 1.50 | 1.58 | 3.00 | 1.17 | 1.17 | 3.75 | 3.08 | 1.75 | 1.75 |
| Consumer (7) | 1.71 | 1.71 | 1.57 | - | - | - | - | - | - | - |
| Clinician (13) | 1.38 | 1.23 | 1.23 | 2.46 | 1.23 | 1.31 | 3.69 | 2.46 | 2.46 | 1.08 |
| Other Key Informants (3) | 1.00 | 2.00 | 1.33 | 2.33 | 1.67 | 1.67 | 3.33 | 3.67 | 2.67 | 1.33 |
| Tobacco Informants (5) | 1.00 | 2.00 | 1.20 | 3.60 | 1.80 | 1.40 | 4.00 | 3.20 | 1.00 | 1.20 |
| Mental Health Informants (6) | 1.33 | 1.50 | 1.50 | 3.33 | 1.17 | 1.50 | 3.00 | 1.83 | 1.83 | 1.50 |
| Overall (47) | 1.30 | 1.54 | 1.41 | 2.90 | 1.31 | 1.33 | 3.62 | 2.74 | 1.97 | 1.38 |

Opinions about Tobacco Roles¹

| Informant group | Rather talk to CPS than clinician | Therapist should always be present | Therapist need not be present | CPS should only do helpful things when told to do so by therapist | OK to provide support provided it is care plan |
|---------------------------|-----------------------------------|------------------------------------|-------------------------------|---|--|
| Consumer (7) ² | 2.00 | 3.86 | 1.43 | 3.86 | 2.29 |

¹ Mean score with 1.00 = strongly agree, 5.00 = strongly disagree, and 3.00 = neither agree or disagree, no opinion

² number

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Appendix A: Informants

Core Informant Groups

- A. Certified Peer Specialists (12)
- B. Consumers (6)
- C. Clinicians (10)
 - 1. Leslie Spencer, Clinical Coordinator Racine County
 - 2. Hilleary Reinhart, Service Facilitator and Care Manager at Chrysalis Inc, Madison
 - 3. Kathy Ziegert, CCS/SED Supervisor at Chrysalis Inc, Madison
 - 4. Shannon Lutz Shannon Lutz CSP Case Manager & AODA Counselor, Northland Counseling Services
 - 5. Amy Kuhlka Social Worker, Clark County Community Services
 - 6. Justin Kleitzman Clinical Social Worker, Sauk County Department of Human Services
 - 7. Marj Thorman CSP Supervisor, Jefferson County Human Services
 - 8. Tammy Leonard Service Facilitator, Washington County Human Services
 - 9. Nichol Grathen IDP-AT Unit Manager, Green Lake County Health and Human Services
 - 10. Brooke Zank CSP Professional/Crisis Case Worker, Green Lake County Health and Human Services
- D. Other Stakeholders (6)
 - 1. Danielle Graham-Heine, Services Coordinator, Bureau of Prevention Comprehensive Community Services, Division of Care and Treatment Services, WI Department of Health Services
 - 2. Tim Saubers, Peer Support Program Manager, Access to Independence, Madison
 - 3. Cory Flynn, Contract Administrator for Peer Services, Access to Independence, Madison, WI, Division of Care and Treatment Services, WI Department of Health Services
 - 4. Donna Riemer, Bureau of Prevention Treatment Recovery, Division of Care and Treatment Services, WI Department of Health Services
 - 5. Brad Munger, Mental Health & Crisis Intervention, Division of Care and Treatment Services, WI Department of Health Services
 - 6. Joann Stephens Consumer Affairs Coordinator, Division of Care and Treatment Services, Wisconsin Department of Health Services

Other Informant Groups

- E. Tobacco Control Informants (11)
 - 1. Tara Noye, Health Educator Juneau Health Human Services
 - 2. Lorraine Lathen, President Jump at the Sun Consultants, LLC, Mequon, WI
 - 3. Amanda Bender Maternal Children Educator and Quit Coach at WI Women's Health Foundation, First Breath Program, Madison, WI
 - 4. Wendy Vander Zanden, Community Action for Healthy Living, Kaukauna, WI
 - 5. Karen Connor, Tobacco Disparity Coordinator, Tobacco Prevention and Control Program, Division of Public Health, Department of health services
 - 6. Allie Gorrilla UW-CTRI Outreach Specialist
 - 7. Amy Skora UW-CTRI Outreach Specialist
 - 8. Kris Hayden UW-CTRI Outreach Specialist
 - 9. Sarah Thompson UW-CTRI Outreach Specialist
 - 10. Jennifer Chiamulera Community Health Specialist, Oneida County Public Health; Northwoods Tobacco-Free Coalition
 - 11. Charmaine Swan Manager, Tobacco Control, Northwest Wisconsin Tobacco Free Coalition

- F. Mental Health Informants (9)
 - 1. Chrissy Barnard Co-Chair, NAMI WI Peer Leadership Council
 - 2. Mick Fiocchi Executive Director, NAMI Northern Lakes
 - 3. Linda Jacobson Coordinator, NAMI Northern Lakes Drop-in Center
 - 4. Marcia Galvan, Community Development Director of Rock Valley Community Programs
 - 5. Lindsay Stevens, Executive Director of NAMI Rock County
 - 6. Tanya Lettman-Shue, Chief Clinical Officer at Journey (Dane and Columbia County)
 - 7. Autumn Shaffer, Quality Assurance and Compliance Director of Tellurian, Madison
 - 8. Ian Hedges, Chief Executive Officer of Healthnet Rock County
 - 9. Anna Moffit, Executive Director of NAMI Dane County

Appendix B: Interview Questions

Appendix B: Interview Questions for Informants

Clinicians

1. Are you familiar with Certified Peer Specialists and the sorts of support they give or would you like me to provide a brief description?

DESCRIPTION: A Certified Peer Specialist is an individual with "lived experience" who is trained and certified to support those who live with mental health, psychological trauma, and/or substance use. In 2007, the WI Dept of Health Services developed a credentialing program, considered an evidence based practice. A Certified Peer Specialist is able to share his/her recovery story to support those with whom they work. This involves supporting people to articulate their goals for recovery; implementing recovery plans, adjusting as needed; as well as obtaining appropriate resources and practicing new skills.

2. In your experience, what roles have Certified Peers Specialists had (that you are familiar with) that you have directly observed? What activities or services do they perform

3. What roles could a Certified Peers Specialist play as part of efforts to address tobacco use by those living with a mental health challenge?

3A. What services or activities could they provide (specific to tobacco recovery)?

4. As you think about helping the people with whom you work who smoke and wish to quit - how might a Certified Peer Specialist assist, or support you or others where you work?

5. As you think about working with a Certified Peers Specialist to help your clients address smoking, how would you prefer (or how do you envision) working with them? Let me give you some examples:

_you start the conversation with a person who smokes and then invite the Certified Peer Specialist into the conversation. Or

_you provide a specific Bucket Approach intervention and then ask the Certified Peers Specialist to provide follow-up.

_ you ask the Certified Peers Specialist to provide support separate from any interventions you provide. Or

you set goals with the client and then ask the Certified Peers Specialist to provide the needed interventions. Or

you and the certified peer specialist co-facilitate a tobacco group. Or

the certified peer specialist conducts a tobacco group separate from your work with individual clients. Or

the certified peer specialist collects tobacco information on your behalf?

6. As you think about the different Bucket Approach buckets from bucket D, “I don’t even want to talk about my smoking” to bucket A “I want to make a quit attempt,” are Certified Peers Specialists better suited to provide support in some buckets more than others? If so, which buckets and why?

6A. As you think about the specific Bucket Approach interventions, are there some that Certified Peer Specialists are better suited to assist or support you with? Shifting from a Certified Peer Specialists working with you to support your clients who smoke, what about more general roles for them. For example, could they

talk to groups of smokers about the need for them to reduce and quit? Could they

talk with groups of smokers about the many ways of quitting? Could they

provide guidance to treatment programs about how to engage and approach their clients who smoke?

7. Certified Peer Specialists provide support to others through sharing their (relevant) lived experience. With this in mind, how might sharing their lived experience benefit smokers who are also coping with a mental health challenge/illness?

8. Are there ways a Certified Peer Specialist could be involved in bringing tobacco interventions to those coping with a mental health challenge/illness beyond working with individual smokers or groups of smokers in a treatment setting?

9. How should a Certified Peer Specialist prepare to be involved in supporting a person’s plan to quit smoking? What training should they have?

10. What ongoing support/supervision would a Certified Peer Specialist need in order to remain successful in new tobacco roles? Who should provide this support / supervision / guidance?

11. Must a Certified Peers Specialist be an ex-smoker in order to assume roles supporting smokers? Could a never smoker be effective doing so? What about a current smoker?

12. Thinking back over our discussion today, how compatible are the current roles and functions of Certified Peers Specialists with having a role in addressing tobacco use by those coping with a mental health challenge? Please explain.

13. Could a Certified Peer Specialist provide each of the following services to a peer who smoked: (please answer yes or no)

- | | | |
|-----|----|--|
| Yes | No | Provide them with information about the effects of smoking |
| Yes | No | Provide them with information about where to get help to quit |
| Yes | No | Provide them with information about how to quit |
| Yes | No | Share their own tobacco story with the person who smokes |
| Yes | No | Listen to the person's tobacco story |
| Yes | No | Support the peer in goal setting related to reducing or quitting smoking |
| Yes | No | Discuss the pros and cons of smoking and of quitting |
| Yes | No | Discuss the person's previous attempts to quit |
| Yes | No | Provide support while the person reduces or quits smoking |
| Yes | No | Check in periodically even after the person has quit smoking |
| Yes | No | Talk with groups of smokers about the importance of reducing or quitting? |
| Yes | No | Talk with groups of smokers about the many ways a smoker can reduce or quit? |
| Yes | No | Share treatment program information about the <i>best way</i> to approach their clients/persons who smoke? |

14. I'm going to read you some more statements about Certified Peer Specialists helping others with their smoking. I want you to say if you 1) strongly agree, 2) agree, 3) neither agree nor disagree, 4) disagree, or 5) strongly disagree with each statement.

1 2 3 4 5 Certified Peer Specialists can be of great support to smokers. (Again, do you strongly agree with this statement, agree with this statement, neither agree nor disagree with this statement, disagree with this statement, or strongly disagree with this statement?)

1 2 3 4 5 Certified Peer Specialists have a unique understanding of how smoking helps people cope with a mental health challenge.

1 2 3 4 5 Current Certified Peers Specialist training is sufficient for Certified Peer Specialists to support peers who smoke.

1 2 3 4 5 Supporting peers who smoke is in the scope of what Certified Peers Specialists can do.

1 2 3 4 5 Supporting a smoker reduce or quit smoking is consistent with being a Certified Peer Specialist.

1 2 3 4 5 Only Certified Peers Specialists who are ex-smokers should be allowed to support peers reduce or quit smoking.

1 2 3 4 5 A Certified Peer Specialist who currently smokes can support peers who smoke provided that the Certified Peers Specialist is working toward her/his own tobacco recovery.

1 2 3 4 5 I think Certified Peer Specialists can support smokers who are coping with a mental illness in ways that others can't.

1 2 3 4 5 There should be a program that prepares Certified Peer Specialists to support their peers who smoke.

1 2 3 4 5 Certified Peers Specialists should be given the opportunity to support their peers who smoke to reduce or quit.

2

Other Stakeholders

General Profile - *What is your role where you currently work? In what county? What other roles have you had?*

1-14 from Clinician/Provider Interview Protocol, plus 15-21

15. How might these new roles for Certified Peer Specialists in tobacco be funded?

16. Who might employ Certified Peer Specialists for these tobacco roles?

17. How might tobacco-specific training be provided?

18. What sort of ongoing support and/or supervision and/or training specific to addressing tobacco would be needed?

19. How might this ongoing support/supervision/training be provided?

20. Who else should I interview?

21. Before we end this interview, do you have any questions (or comments) for this study?

Certified Peer Specialists

General Profile - *Do you work as a Certified Peer Specialist now or in the past?*

For how long have you been a CPS? What is your role where you currently work? In what county? What other roles have you had?

1. What are your current Certified Peer Specialist duties, responsibilities, activities?

What specific activities or services do you provide to support a team approach to a peer's

recovery?

2. For any of those that you have described to me, what activities or services have you supported around a peer's use of tobacco alone or in partnership with others on the peer support plan?

2A. How much information did you receive about smoking as part of your training? (Q4_IS)

A. None, B. Very Little C. A moderate amount D. A lot

3. In your role as a Certified Peer Specialist, has tobacco use ever come up? Yes / No

3A. What roles could a Certified Peers Specialist play as part of efforts to address tobacco use by those living with a mental health challenge? How might a peer support another person to reduce or quit smoking?

3B. Have you ever helped anyone with his/her smoking in any way? Yes / No

Comments:

3C. What services or activities could you provide (specific to tobacco recovery) based on your own lived experience or training? How can your lived experience be applied to supporting a peer who wishes to reduce/quit smoking?

4. As you think about helping the people with whom you work who smoke and wish to quit - what types of help do you suppose that a person might need if/when that person wishes to reduce or quit smoking?

5. With the type of help needed in mind, how might a Certified Peer Specialist help a peer reduce or quit smoking. Would you like to hear what activities or general roles have been mentioned to me by others?

a clinician or recovery specialist (in tobacco use) starts conversations with a person who smokes and you (a CPS) enter into the conversation. Or

you provide follow up for tobacco interventions that a clinician or tobacco use specialist asks of you

you provide support separate from any follow up interventions that you are asked to support,

you support a peer in writing his/her goals (as CPS) and support the needed interventions. Or

you co-facilitate a tobacco group (as a CPS) Or

you conduct a tobacco group separate from your work with individual clients as a CPS.

Or

_you collect tobacco information for the peer, caseworker, CCS/CSP

General roles

__talk to groups of smokers about the need for them to reduce and quit? Could they
__talk with groups of smokers about the many ways of quitting? Could they
__provide guidance to treatment programs about how to engage and approach their clients who smoke?

6. So with these examples in mind, how would you prefer (envision) working in any of these roles that are being talked about for a Certified Peer Specialist in Tobacco use recovery?

7. How should a Certified Peer Specialist prepare to be involved in supporting a person's plan to quit smoking? What training should they have?

8. Must a Certified Peers Specialist be an ex-smoker in order to assume roles supporting smokers? Could a never smoker be effective doing so? What about a current smoker?

9. Thinking back over our discussion today, how compatible are the current roles and functions of Certified Peers Specialists (if known by you) with having a role in addressing tobacco use by those coping with a mental health challenge? Please explain.

9A. Comments specific to Recovery -- Coach, CPS, other

9B. Comments specific to Comprehensive Community Services (CCS), Community Support Programs (CSP) - Clinicians, Providers, Therapist, Behavioral Health

9C. Comments specific to "case workers, parole officers, or other community support persons?"

9D. Comments specific to mental health practitioners such as "therapists/counselors and/or psychologists?"

10. How interested are you in supporting a peer to reduce/quit?

- A) Not at all interested B) Just a little bit interested C) Moderately interested
D) Very interested E) Most interest possible

11. If there was a training program that prepares you to help peers who smoke, would you take it? A) No B) Maybe C) Likely D) Yes

12. Could a Certified Peer Specialist provide each of the following services to a peer who smoked: (please answer yes or no)

| | | |
|-----|----|--|
| Yes | No | Provide them with information about the effects of smoking |
| Yes | No | Provide them with information about where to get help to quit |
| Yes | No | Provide them with information about how to quit |
| Yes | No | Share their own tobacco story with the person who smokes |
| Yes | No | Listen to the person's tobacco story |
| Yes | No | Support the peer in goal setting related to reducing or quitting smoking |
| Yes | No | Discuss the pros and cons of smoking and of quitting |
| Yes | No | Discuss the person's previous attempts to quit |
| Yes | No | Provide support while the person reduces or quits smoking |
| Yes | No | Check in periodically even after the person has quit smoking |
| Yes | No | Talk with groups of smokers about the importance of reducing or quitting? |
| Yes | No | Talk with groups of smokers about the many ways a smoker can reduce or quit? |
| Yes | No | Share information about treatment programs about the "best way" to approach their peers who smoke? |

13. I'm going to read you some more statements about Certified Peer Specialists helping others with their smoking. Again, I want you to say if you 1) strongly agree, 2) agree, 3) neither agree nor disagree, 4) disagree, or 5) strongly disagree with each statement.

1 2 3 4 5 Certified Peer Specialists can be of great support to smokers. (Again, do you strongly agree with this statement, agree with this statement, neither agree nor disagree with this statement, disagree with this statement, or strongly disagree with this statement?)

1 2 3 4 5 Certified Peer Specialists have a unique understanding of how smoking helps people cope with a mental health challenge.

1 2 3 4 5 Current Certified Peers Specialist training is sufficient for Certified Peer Specialists to support peers who smoke.

1 2 3 4 5 Supporting peers who smoke is in the scope of what Certified Peers Specialists can do.

1 2 3 4 5 Supporting a smoker reduce or quit smoking is consistent with being a Certified Peer Specialist.

1 2 3 4 5 Only Certified Peers Specialists who are ex-smokers should be allowed to support peers to reduce or quit smoking.

1 2 3 4 5 A Certified Peer Specialist who currently smoke can support peers who smoke provided that the Certified Peers Specialist is working toward her/his own tobacco recovery.

1 2 3 4 5 I think Certified Peer Specialists can support smokers who are coping with a mental illness in ways that others can't.

1 2 3 4 5 There should be a program that prepares Certified Peer Specialists to support their peers who smoke.

1 2 3 4 5 Certified Peers Specialists should be given the opportunity to support their peers who smoke to reduce or quit.

OPTIONAL QUESTION IF TIME PERMITS

14. There is a particular tobacco recovery program that is part of this study. The program meets a peer where he/she/they is/are in their current smoking or tobacco use. It is called the Bucket Approach. In this approach, support is tailored to the needs of the person by assigning the person to one of four buckets. I'm going to describe each and then ask you how a CPS might provide support to people in that bucket.

Bucket A is for people who want to quit.

Bucket B is for people who don't want to quit right away, but are willing to reduce, or learn how to quit, or prepare to quit someday.

Bucket C is for people who are not yet ready to reduce or prepare to quit, but are willing to talk about their smoking.

Bucket D is for people who don't even want to talk about their smoking.

14 A How might a CPS support someone in Bucket A – someone who wants to quit?

14 B How might a CPS support someone in Bucket B – someone not will to quit yet but who is willing to reduce, or learn how to quit or prepare to quit?

14 C How might a CPS support someone in Bucket C – someone who doesn't want to try to quit or even reduce or prepare to quit but who is willing to talk about his/her smoking?

14 D How might a CPS support someone in Bucket D - someone who doesn't even want to talk about his/her smoking?

15. Before we end this interview, do you have any questions (or comments) for me?

Additional Informants: Tobacco Control and Mental Health

1. Are you familiar with Certified Peer Specialists and the sorts of support they give or would you like me to provide a brief description?

DESCRIPTION: A Certified Peer Specialist is an individual with "lived experience" who is trained and certified to support those who live with mental health, psychological trauma, and/or substance use. In 2007, the WI Dept of Health Services developed a credentialing program, considered an evidence based practice. A Certified Peer Specialist is able to share his/her recovery story to support those with whom they work. This involves supporting people to articulate their goals for recovery; implementing recovery plans, adjusting as needed; as well as obtaining appropriate resources and practicing new skills.

2. In your experience, what roles have Certified Peers Specialists had or that you are familiar with? What activities or services do they perform? With what type of agency or organization?

3. How might Certified Peer Specialists assist you in addressing tobacco use by those coping with a mental health challenge? Basically, What roles could a Certified Peers Specialist play as part of efforts to address tobacco use by those living with a mental health challenge?

3A. What services or activities could they provide (specific to tobacco recovery) that might be of help to you or others in this Tobacco Control/Mental Health organization?

4. Certified Peer Specialists provide support to others through sharing their lived experience in mental health, psychological trauma, and/or substance use. With this in mind, how might sharing their lived experience benefit smokers who are also coping with a mental health challenge?

5. How could you support the development of tobacco roles for Certified Peer Specialists?

6. Would you be interested in being involved in developing tobacco roles for CPSs?

7. How might Certified Peer Specialists be funded to take on tobacco roles?

8. Who might employ Certified Peer Specialists for these tobacco roles?

9. How might tobacco-specific training be provided?

10. What sort of ongoing support and/or supervision specific to addressing tobacco use and mental health would be needed?

11. How might this ongoing support/supervision/training be provided?

12. Who else should I interview in tobacco control, mental health or other stakeholders in emerging roles for certified peer specialists that you can think of?

13. Could a Certified Peer Specialist provide each of the following services to a peer who smoked: (please answer yes or no)

- | | | |
|-----|----|---|
| Yes | No | Provide them with information about the effects of smoking |
| Yes | No | Provide them with information about where to get help to reduce or quit |
| Yes | No | Provide them with information about how to reduce or quit smoking |
| Yes | No | Share their own tobacco story with the person who smokes |
| Yes | No | Listen to the person's tobacco story |
| Yes | No | Support the peer in goal setting related to reducing or quitting smoking |
| Yes | No | Discuss the pros and cons of smoking and of quitting |
| Yes | No | Discuss the person's previous attempts to quit |
| Yes | No | Provide support while the person reduces or quits smoking |
| Yes | No | Check in periodically even after the person has quit smoking |
| Yes | No | Talk with groups of smokers about the importance of reducing or quitting? |
| Yes | No | Talk with groups of smokers about the many ways a smoker can reduce or quit? |
| Yes | No | Share treatment program information about the best way to approach their clients/persons who smoke? |

14. I'm going to read you some more statements about Certified Peer Specialists helping others with their smoking. Again, I want you to say if you 1) strongly agree, 2) agree, 3) neither agree nor disagree, 4) disagree, or 5) strongly disagree with each statement.

1 2 3 4 5 Certified Peer Specialists can be of great support to smokers. (Again, do you strongly agree with this statement, agree with this statement, neither agree nor disagree with this statement, disagree with this statement, or strongly disagree with this statement?)

1 2 3 4 5 Certified Peer Specialists have a unique understanding of how smoking helps people cope with a mental health challenge.

1 2 3 4 5 Current Certified Peer Specialist training is sufficient for Certified Peer Specialists to support peers who smoke.

1 2 3 4 5 Supporting peers who smoke is in the scope of what Certified Peers Specialists can do.

1 2 3 4 5 Supporting a smoker reduce or quit smoking is consistent with being a Certified Peer Specialist.

1 2 3 4 5 Only Certified Peers Specialists who are ex-smokers should be allowed to support peers to reduce or quit smoking.

1 2 3 4 5 A Certified Peer Specialist who currently smokes can support peers who smoke provided that the Certified Peers Specialist is working toward her/his own tobacco recovery.

1 2 3 4 5 I think Certified Peer Specialists can support smokers who are coping with a mental illness in ways that others can't.

1 2 3 4 5 There should be a program that prepares Certified Peer Specialists to support their peers who smoke.

1 2 3 4 5 Certified Peers Specialists should be given the opportunity to support their peers who smoke to reduce or quit.

15. Before we end this interview, do you have any questions (or comments) for me?

Consumers

1. Are you familiar with Certified Peer Specialists and the sorts of support they give or would you like me to provide a brief description?

DESCRIPTION: A peer support specialist is an individual with "lived experience" who is trained and certified to support those who struggle with mental health, psychological trauma, and/or substance abuse. In 2007, the WI Dept of Health Services developed a credentialing program, considered an evidence-based practice. A Certified Peer Specialist is able to share their recovery story to assist those whom they are working with. This involves assisting the individual to

articulate their goals for recovery; implementing recovery plans, adjusting as needed; as well as obtaining appropriate resources and practicing new skills.

2. Have you ever worked with a Certified Peer Specialist? (Do not ask for detail)

3. In your experience, what roles have Certified Peers Specialists had? What activities or services do they perform?

4. Would you be willing to talk to a Certified Peer Specialist about your smoking? If no - why not? If yes - in what ways?

5. In what ways could a Certified Peer Specialist support any aspect of your smoking as a peer? Could this support come through things like your lived experience, sharing tobacco facts or resource support, or supporting your personal goals to reduce or quit? What might tobacco-related peer support be like?

6. Keeping in mind that Certified Peer Specialists provides support to others (aka peers) through sharing their lived experience with mental illness/mental health challenges and/or the recovery process for substance use -- how might Certified Peer Specialists share their lived experience benefit smokers who are also coping with a mental health challenge?

7. Must a Certified Peers Specialist be an ex-smoker to be effective in supporting peers who smoke?

8. Could a Certified Peers Specialist who has never smoked be effective in supporting peers who smoke?

9. What about a Certified Peer Specialist who is a current smoker and supporting peers who smoke?

10. Could a Certified Peer Specialist provide each of the following services to a peer who smoked: (please answer yes or no)

| | | |
|-----|----|---|
| Yes | No | Provide them with information about the effects of smoking |
| Yes | No | Provide them with information about where to get help to quit |
| Yes | No | Provide them with information about how to quit |

| | | |
|-----|----|--|
| Yes | No | Share their own tobacco story with the person who smokes |
| Yes | No | Listen to the person's tobacco story |
| Yes | No | Assist the peer in goal setting related to reducing or quitting smoking |
| Yes | No | Discuss the pros and cons of smoking and of quitting |
| Yes | No | Discuss the person's previous attempts to quit |
| Yes | No | Provide support while the person reduces or quits smoking |
| Yes | No | Check in periodically even after the person has quit smoking |
| Yes | No | Talk with groups of smokers about the importance of reducing or quitting? |
| Yes | No | Talk with groups of smokers about the many ways a smoker can reduce or quit? |
| Yes | No | Share information about treatment programs about the best way to approach their clients who smoke? |

11. I'm going to read you some more statements about Certified Peer Specialists helping others with their smoking. I want you to say if you 1) strongly agree, 2) agree, 3) neither agree nor disagree, 4) disagree, or 5) strongly disagree with each statement.

1 2 3 4 5 Certified Peer Specialists can be of great support to smokers. (Again, do you strongly agree with this statement, agree with this statement, neither agree nor disagree with this statement, disagree with this statement, or strongly disagree with this statement?)

1 2 3 4 5 Certified Peer Specialists have a unique understanding of how smoking helps people cope with a mental health challenge/mental illness.

1 2 3 4 5 My therapist/counselor should always be present when I talk to a Certified Peers Specialist about my smoking.

1 2 3 4 5 My therapist/counselor does not have to be present when I talk to a Certified Peers Specialist about my smoking.

1 2 3 4 5 My Certified Peers Specialist can/should only do what my therapist/counselor tells them to do.

1 2 3 4 5 It is OK if a Certified Peer Specialists supports me with my smoking as long as what (s)he does is consistent with my care plan.

1 2 3 4 5 I think Certified Peer Specialists can help smokers who are coping with a mental illness in ways that others can't.

1 2 3 4 5 I'd rather talk to a Certified Peers Specialist about my smoking than talk about it with my therapist/counselor.

12. Before we end this interview, do you have any questions (or comments) for me?