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Center for Tobacco Research & Intervention

What You Can Do to Help those Coping with a Mental Illness Address their Tobacco Use: A Call to Action

Bruce Christiansen, PhD
Karen Conner, MPH

October 20, 2021

The Bucket Approach: A Program to Address Nicotine Addiction that is Tailored for Smokers Coping with a Mental Illness

Objectives

1. Understand the nature of the challenges faced by those with a mental illness who smoke

2. Be familiar with evidence-based tobacco dependence treatments in general and when tailored to this population

3. Identify ways that you can help

4. Know next steps

Roadmap

1. Understanding tobacco use by those coping with a mental illness – Bruce Christiansen

2. Evidence-based tobacco dependence interventions for the general population – Karen Conner

3. The Bucket Approach – Bruce Christiansen

4. What you can do – Bruce Christiansen

5. Key Considerations and Resources – Karen Conner

Disclosures and Conflict of Interests

1. Understanding tobacco use by those coping with a mental illness.

1. Understanding tobacco use by those coping with a mental illness

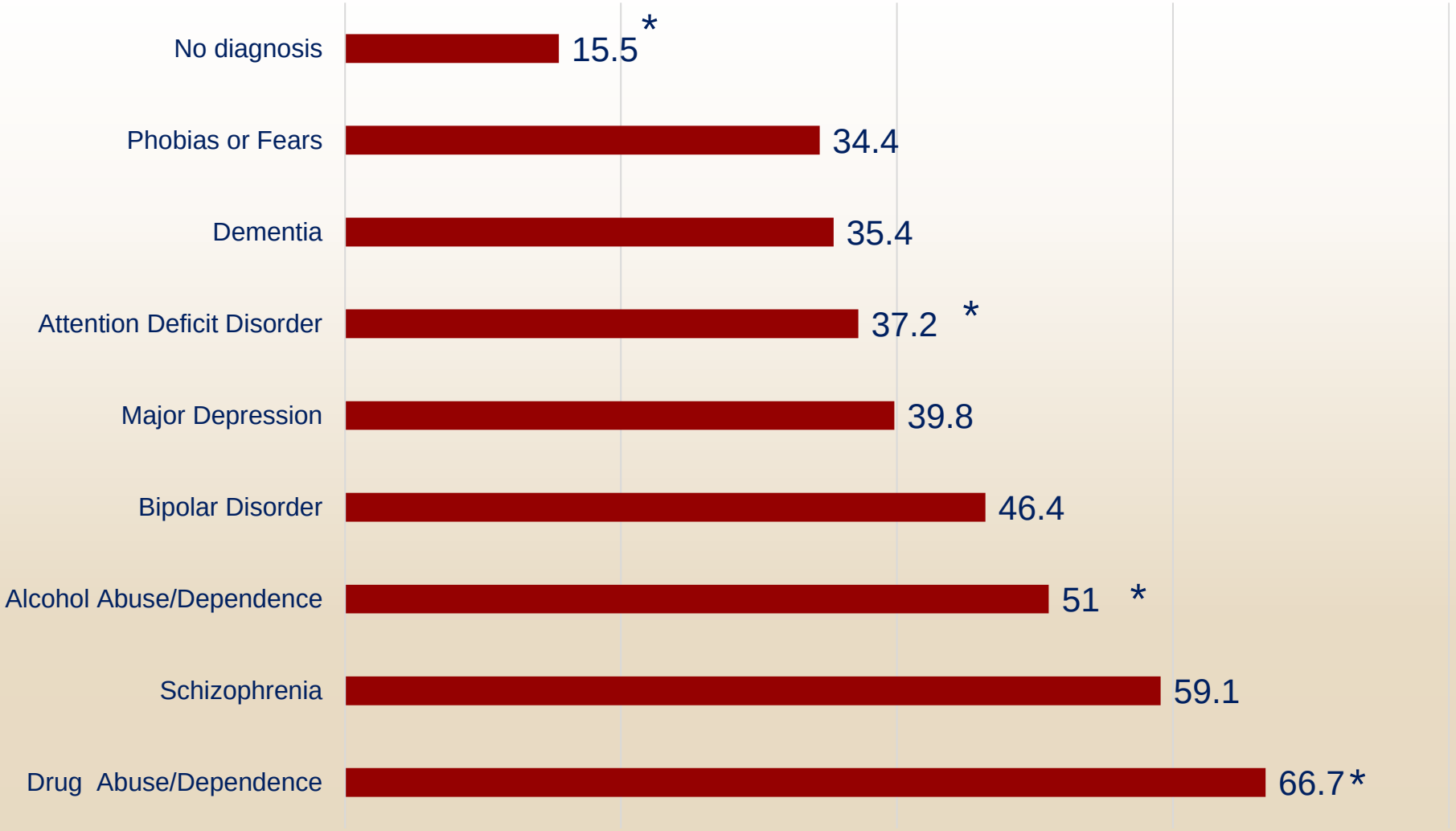
A. High prevalence

B. Reasons for this high prevalence

C. Consequences of this high prevalence

D. What is a person to do?

National Prevalence of Smoking Information by Patient Group:



* Smith, Mazure, McKee "Smoking and Mental illness in the US Population" *Tobacco Control (*2014) Nov.: 23(0) e147 - e153

Figure 1. Any Mental Illness (AMI) or Substance Use Disorder (SUD) in the Past Year among Adults Aged 18 or Older: 2009 to 2011

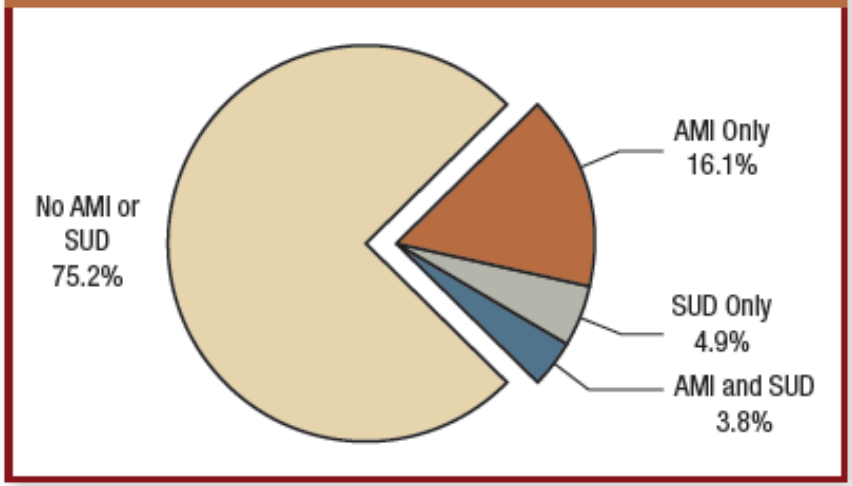
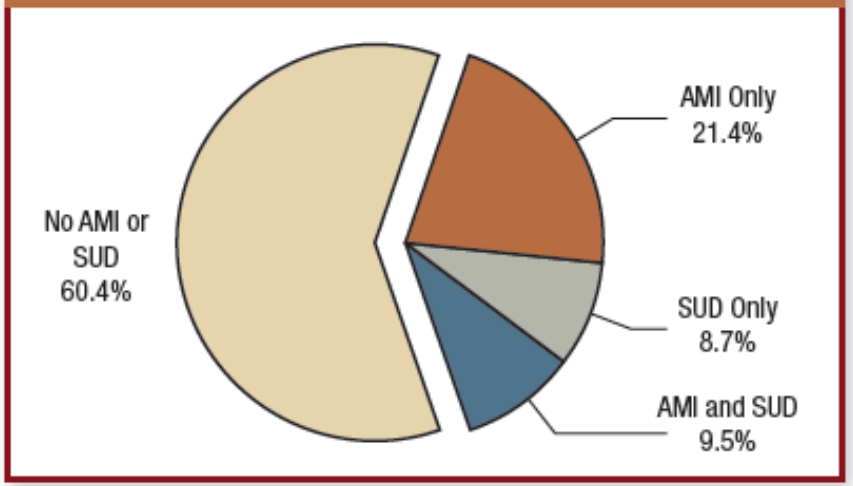
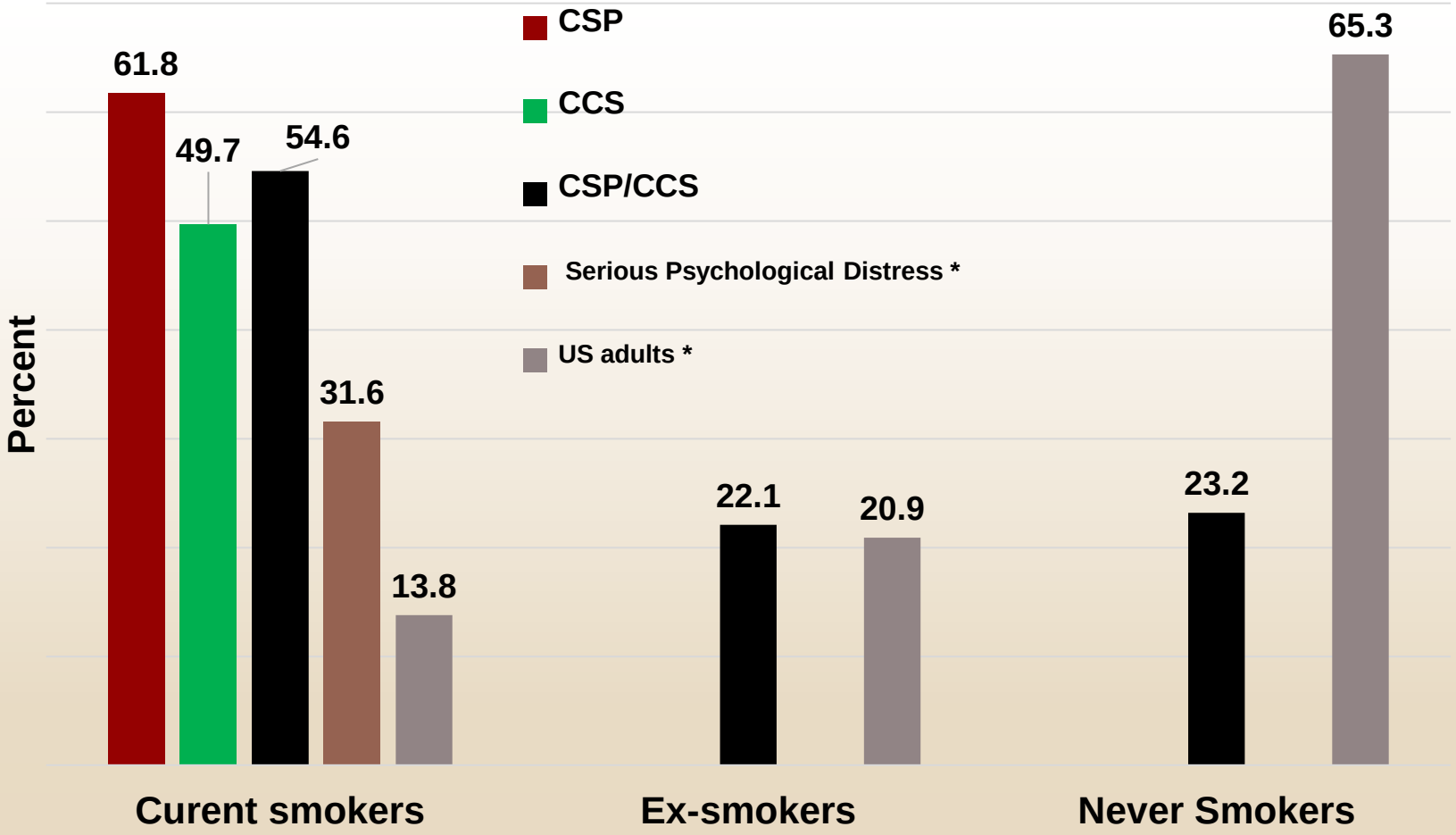


Figure 2. Percentage of Cigarettes Smoked in the Past Month among Adults Aged 18 or Older, by Any Mental Illness (AMI) or Substance Use Disorder (SUD) in the Past Year: 2009 to 2011



Source: 2009 to 2011 National Surveys on Drug Use and Health (NSDUHs). NSDUH is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey collects data by administering questionnaires to a representative sample of the population through face-to-face interviews at their places of residence.

Wisconsin Prevalence



*** 2018 National Health Interview Survey**

Not only is smoking prevalence high….

- ✓ Smoke greater amounts
- ✓ Shorter time between puffs
- ✓ More puffs/cigarette
- ✓ Smoke more of the cigarette
- ✓ Greater nicotine boost
- ✓ Greater dependence/addiction at lower daily amount

Why do so many people who are coping with a mental illness also smoke?

It’s complicated

- **The Big, Bad Tobacco Companies**
- **It's the nature of things – the "haves and the have nots"**
- **The interaction of smoking/nicotine with mental illness**

Big Tobacco

It's the nature of things – the "haves and the have nots"

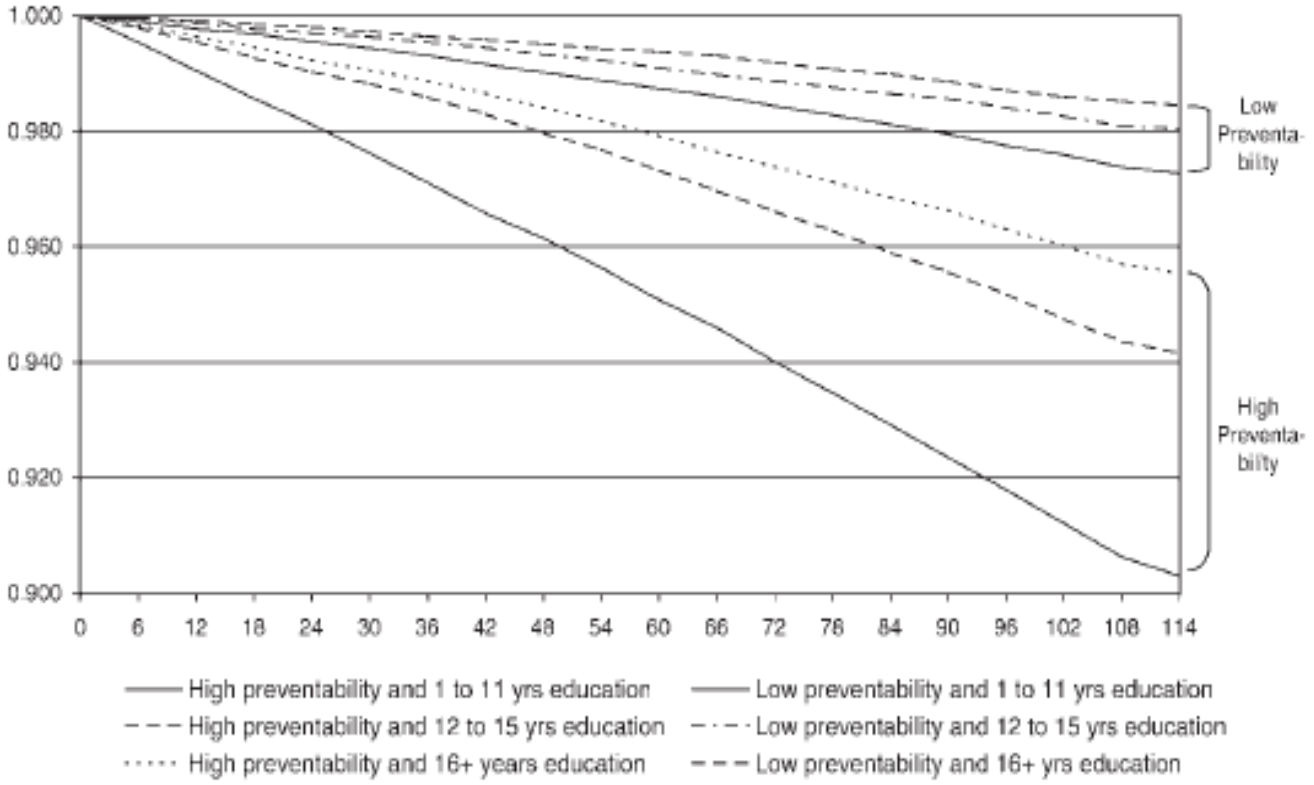
Preventable vs. Non-preventable Causes of Mortality as a Function of Inequality

Each cause of mortality rated as

- Cause of death was preventable "by preventing the incidence of the disease by good hygiene, lifestyle factors (smoking), vaccines etc."
- Cause of death was preventable "by means of medical treatment or other interventions administered after the disease had been detected"

Pheln, Link, Diez-Roux, Kawachi & Levin (2004) "Fundamental Causes" of Socila Inequalities in Mortality: A Test of the Theory *Journal of Health and Social Behavior* (45) 265-285

FIGURE 5. Cumulative Survival by Family Income and Preventability of Death Ages 45 to 64 at Baseline



The Origins of Disparities

The Rhetoric and Reality of Gap Closing:

When the "Have-Nots" Gain but the "Haves" Gain Even More

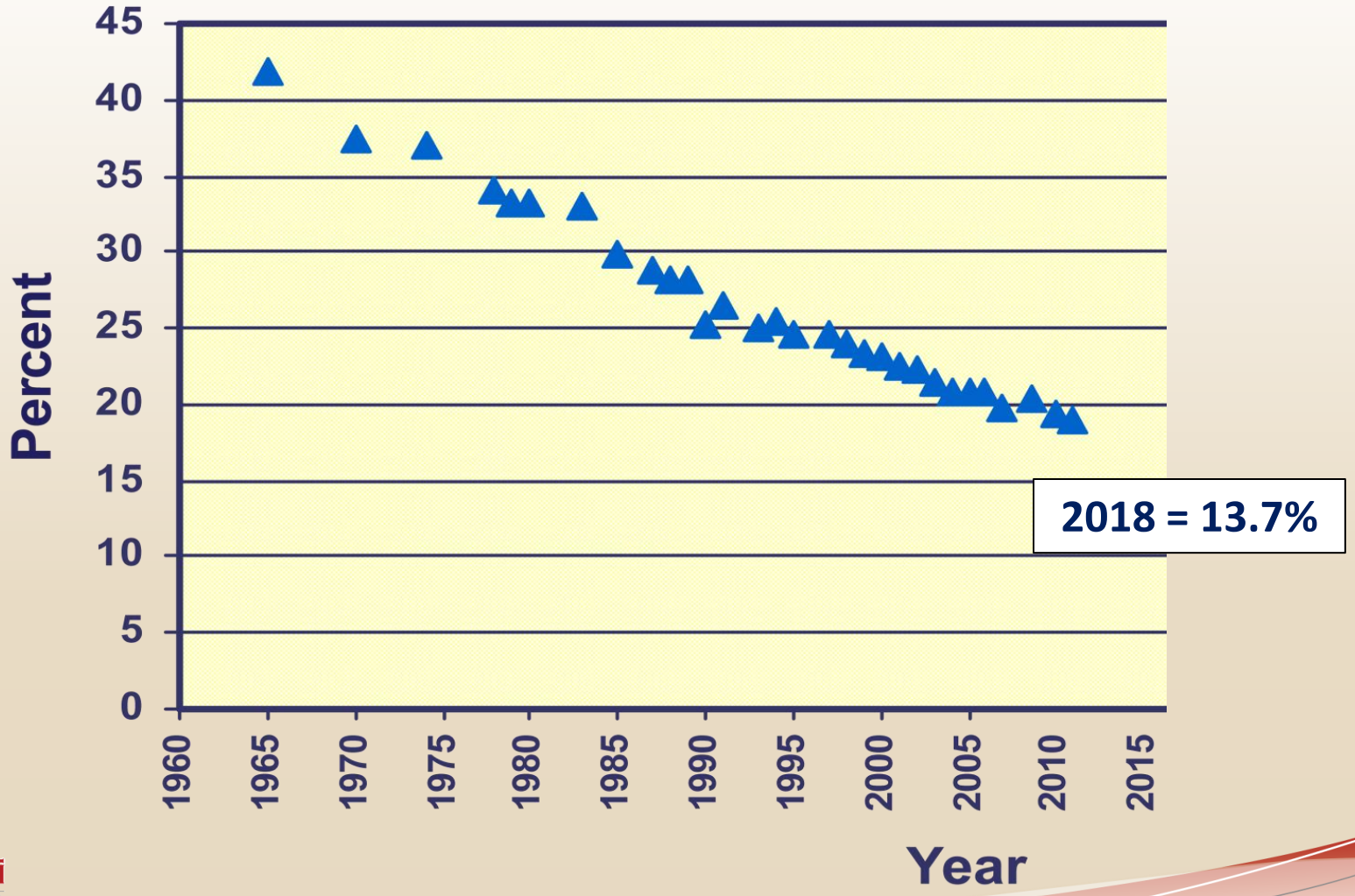
Stephen Ceci and Paul Papierno (2005) American Psychologist 60(2) 149 – 160

1. Widely distributed (health and education) programs designed for maximum improvement across a population inherently create disparities.

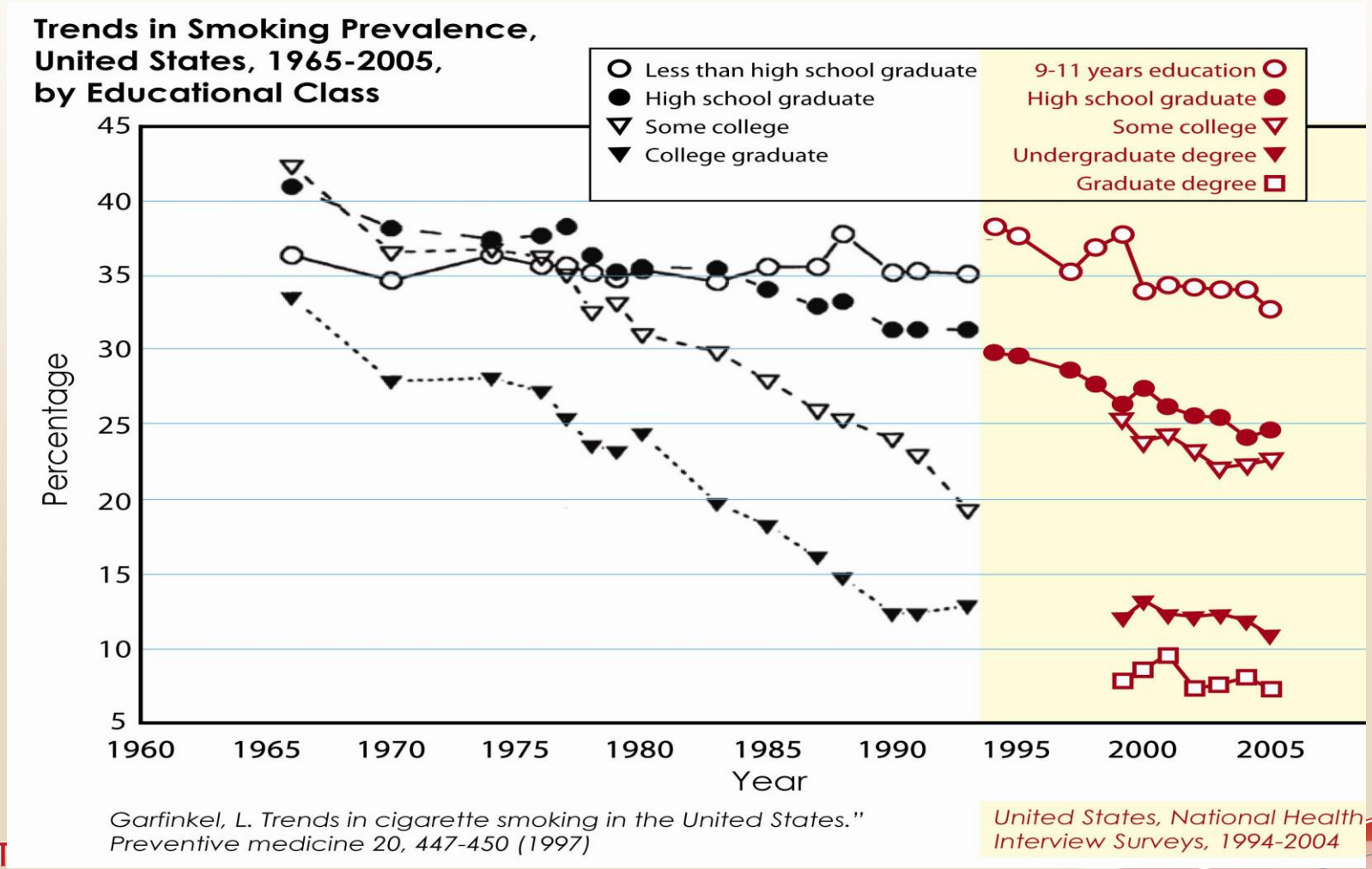
2. It's a zero sum game: Given finite resources, working to close a disparity gap (through targeted programs and resources) will reduce overall population achievement.

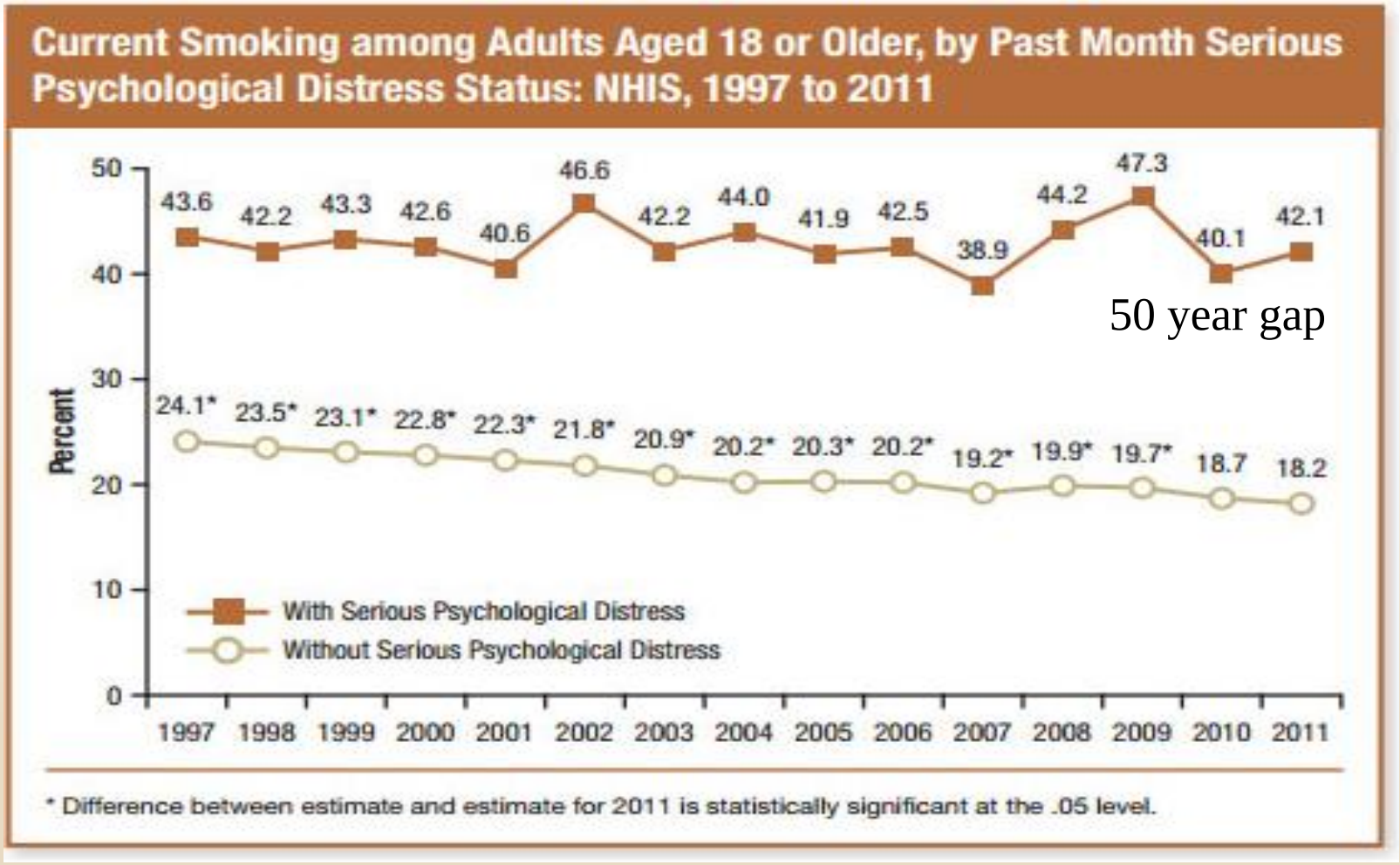
3. The trade off between population progress and closing gaps is not a question for science; it's a question of cultural values and priorities.

The Second Greatest Public Heath Story of the 20th Century



Digging Behind the Success

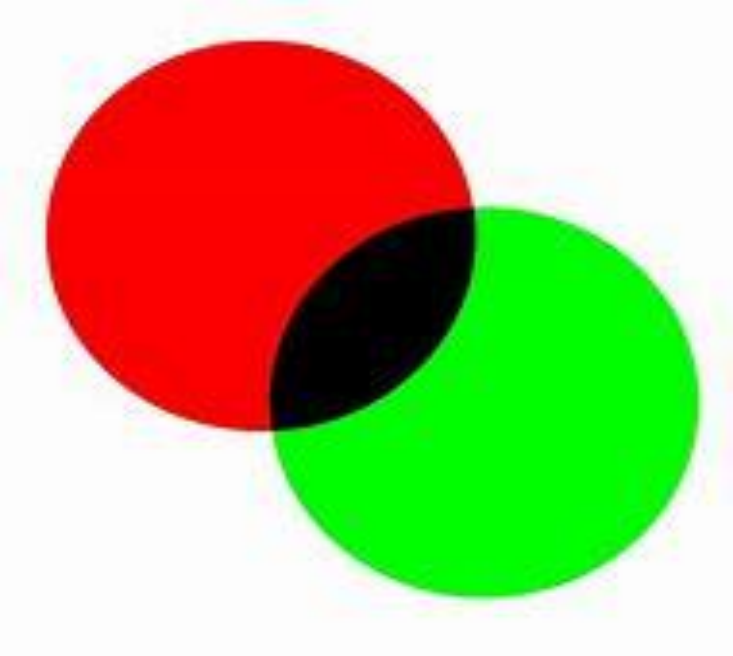



Current Smoking among Adults Aged 18 or Older, by Past Month Serious Psychological Distress Status: NHIS, 1997 to 2011
Percent
50
40
30
20
10
0
43.6
42.2
43.3
42.6
40.6
46.6
42.2
44.0
41.9
42.5
38.9
44.2
47.3
40.1
42.1
24.1*
23.5*
23.1*
22.8*
22.3*
21.8*
20.9*
20.2*
20.3*
20.2*
19.2*
19.9*
19.7*
18.7
18.2
With Serious Psychological Distress
Without Serious Psychological Distress
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
* Difference between estimate and estimate for 2011 is statistically significant at the .05 level.

50 year gap

Those with a mental illness and/or other substance use disorder

The interaction of smoking/nicotine with mental illness



Functional Effects of smoking

- Pleasure
- Increased Attention
- Decreased Hunger/Appetite
- Decreased Negative Affect
- Nausea
- Dizziness

Withdrawal Symptoms

- Dysphoric mood
- Insomnia
- Irritability, frustration, or anger
- Anxiety
- Difficulty concentrating
- Restlessness
- Decreased heart rate
- Increased appetite/weight gain

Hypothetical Pathway from Kernel of Truth to Disparities

Certain Understandable (but mostly incorrect) Beliefs → **High Smoking Prevalence**

Understandable Beliefs

- Needed to relax
- How cope with stress
- Quitting is too hard and will result in failure
- Will lead to exacerbations in mental illness
- Can’t quit
- Don’t want to quit
- One of few joys in life
- One thing they control

1. Quitting will exacerbate their mental illness in part because smoking is how they cope.

- Nicotine use as self-medication
- Exacerbation of symptoms during withdrawal
- Smoking relaxes them

Consider…..

A meta-analysis found that compared to those who did not quit, those that did experienced significant improvements in depression and anxiety and significant reductions in stress.

The amount of reduction in anxiety and depression was equal to or bigger than what would have been expected from medications used to treat anxiety and depression.

Taylor, McNeil, Girling, Farley, Linson-Hawley, Avegard “Change in Mental Health after Smoking Cessation: Systematic Review and Meta-analysis” *BMJ* 2014; 358:g1151

Consider….

Outcome	# of studies	Effect estimate (95% CI)
Anxiety ↓	4	-0.37 (-0.70 to -0.03)
Depression ↓	9	-0.29 (-0.42 to -0.15)
Mixed anxiety and depression ↓	4	-0.36 (-0.58 to -0.14)
Psychological quality of life	4	0.17 (-0.02 to 0.35)
Positive affect ↑	1	0.68 (0.24 to 1.12)
Stress ↓	2	-0.23 (-0.39 to -0.07)

Taylor, McNeil, Girling, Farley, Linson-Hawley, Avegard "Change in Mental Health after Smoking Cessation: Systematic Review and Meta-analysis" *BMJ* 2014; 358:g1151

Populations: general (14), chronic physical condition (3), pregnant women (2), postoperative (1), either chronic condition and/or psychiatric condition (2), psychiatric condition (4)

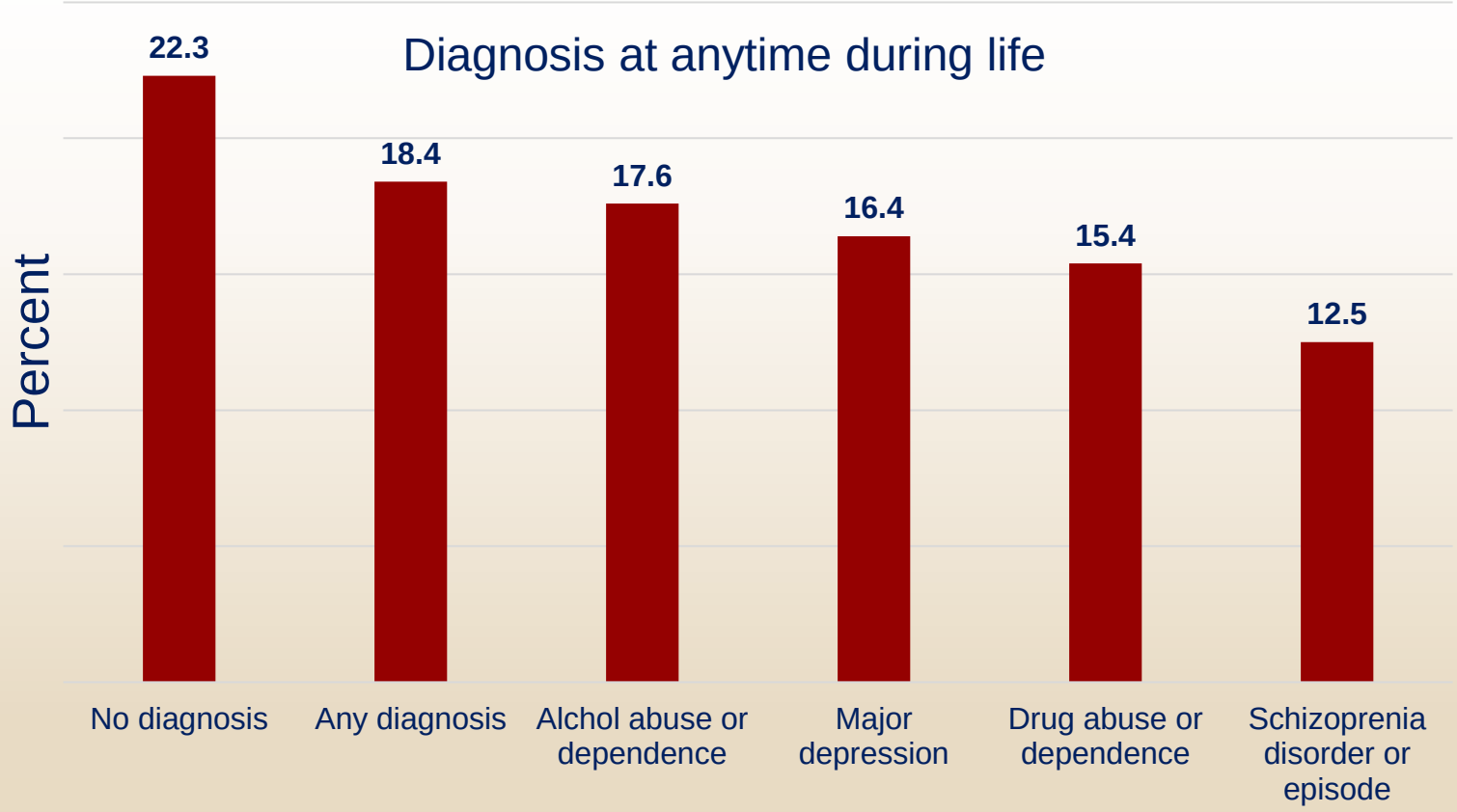
Because smoking increases the metabolism of some medications, those who quit can often lower their dosage of medication

People with schizophrenia who quit smoking, ues less antipsychotic and antiparkinsonian medications three years later

Miyauchi et al BMC Psychiatry (2017) 17:87

2. My clients will experience failure which will be to their detriment because they already have too much failure in their lives.

Quite Rate Over Three Years



National Epidemiologic Survey on Alcohol and Related Conditions

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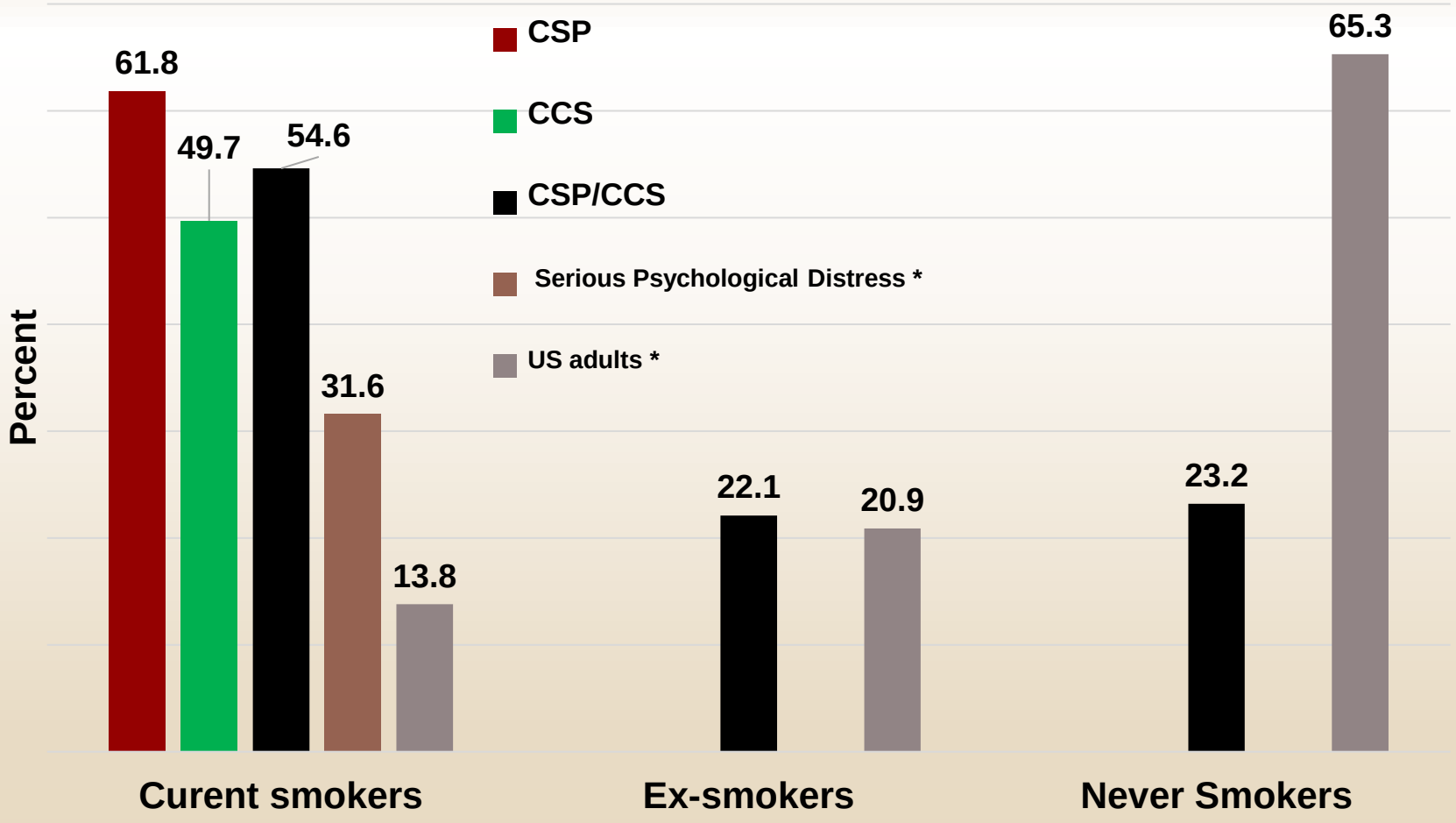
Wisconsin Prevalence



*** 2018 National Health Interview Survey**

3. My clients don’t want to quit

Table 20: Smokers' Attitudes, Opinions, and Beliefs across both Survey Times

Attitude/Belief	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I want to quit	12.9[1]	14.0	20.6	28.6	24.0
2. It's important that I quit	9.8	9.7	20.1	32.5	27.8
3. I want CSP/CCS help to quit	13.0	19.3	28.4	27.6	11.8
4. Help from my CSP/CCS means they care	4.0	3.1	19.2	46.7	27.6
5. I know I need help	7.7	13.6	20.2	36.2	22.3
Reverse Scoring					
6. My smoking is of no concern to CSP/CCS	17.2	33.4	26.0	17.3	6.2
7. I didn't come to address smoking so staff should not address	14.9	25.6	29.2	20.9	8.7
But are you ready to quit?					
8. Not until in full recovery	12.6	21.4	27.1	30.2	8.7
9. Not at all ready to quit	11.6	17.7	23.5	33.8	13.5
10. I want to quit, but don't think I can	11.1	25.5	24.4	29.7	9.3
11. As long as it doesn't interfere with other goals	6.7	7.2	26.4	44.0	15.7

3. My clients don't want to quit

Have you asked?

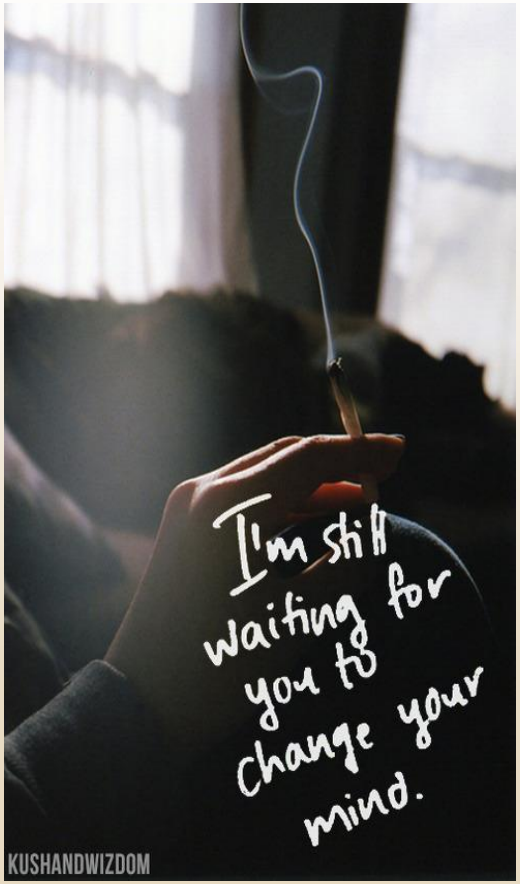
If you ask, they will come.

4. They will lose their friends because they all smoke.

A year after quitting, the social network is larger than when the person was smoking

Bray, B. C., Smith, R. A., Piper, M. E., Roberts, L. J., & Baker, T. B. (2016). Transitions in smokers' social networks after quit attempts. *Nicotine & Tobacco Research, 18,* 2243-2251. PMCID:PMC5103938

5. Smoking is one of their few pleasures and one of the few things they control.



6. Smoking is not why my patients are seeking care; they don't want to quit and it would be unethical for me to impose this goal on them.

7. I don’t what to do; how to treat.

https://ce.icep.wisc.edu/bucket-approach#group-tabs-node-course-default4

8. It is not my responsibility nor is it in my scope of practice.

22% of mental health consumers who smoke report that they started while hospitalized

She writes

"i still love you"

on each of her cigarettes

and hopes

with each one she burns

she would mean it a little

less

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTE OF MENTAL HEALTH
WASHINGTON, D.C. 20032

August 4, 1980

Our Reference: CCS/APN/EFT

SAINT ELIZABETHS HOSPITAL

Mr. G. H. Long
R. J. Reynolds Tobacco Company
Winston Salem, North Carolina 27102

Dear Mr. Long:

I am writing to request a donation of cigarettes for long-term psychiatric patients who have no funds of their own and for whom, because of recent changes in the Department of Health and Human Services regulations, Saint Elizabeths Hospital can no longer purchase cigarettes for them.

The Noyes Division of Saint Elizabeths Hospital has approximately 240 in-patients. Most of them are elderly, long-term patients who have been here many years; e.g. one came to the Hospital originally in 1909. Over the years the Hospital provided tobacco and occasionally cigarettes for these patients. Many became strongly addicted and in fact look upon smoking as their greatest (and often their only) pleasure.

Recent changes in Department of Human Services regulations and their enforcement abruptly terminated the Hospital's practice of providing a modest number of cigarettes to these patients who have no funds with which to purchase their own. Of our 240 patients, approximately 100 are in this category. The result has been nicotine withdrawal (which can be very unpleasant) and the loss of one of the greatest pleasures for patients who have very few, if any, alternatives. Many of the staff have been providing patients with cigarettes out of their own pocket, but this gets expensive if continued indefinitely.

I am therefore requesting a donation of approximately 5,000 cigarettes a week (8 per day for each of the 100 patients without funds). Any help you can give me would be most appreciated.

Sincerely yours,

E. Fuller Torrey, M.D.
Medical Director
A. P. Noyes Division

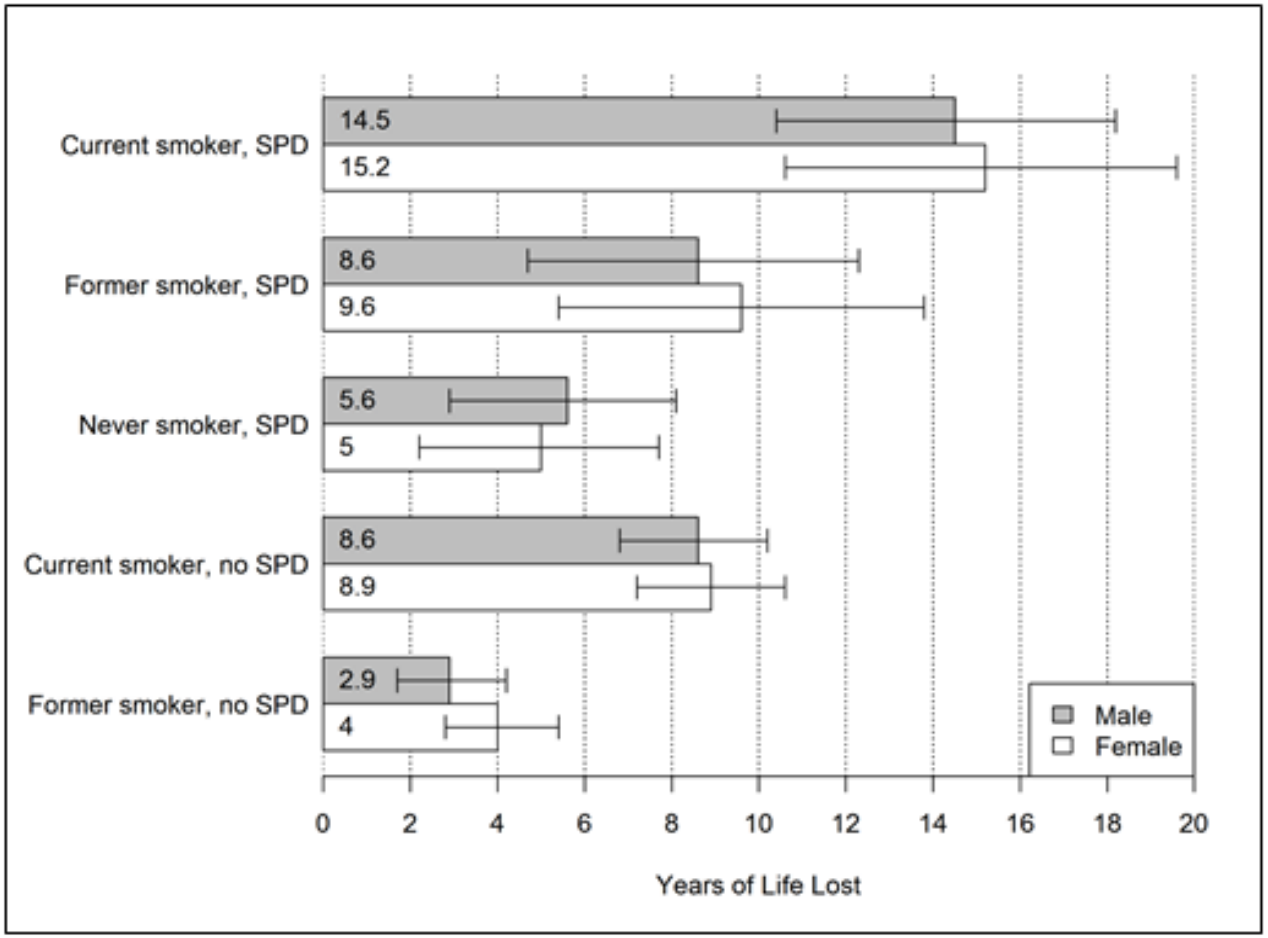
Bottom Line about these Kernels of Truth

Capitulate

or

Roll up your sleeves

Life expectancy reduction at Age 40 by smoking and SPD status compared to never smoker without SPD



SPD: Serious Psychological Distress, National Health Interview Survey

Roadmap

1. Understanding tobacco use by those coping with a mental illness – Bruce Christiansen

2. **Evidence-based tobacco dependence interventions for the general population – Karen Conner**

3. The Bucket Approach – Bruce Christiansen

4. What you can do – Bruce Christiansen

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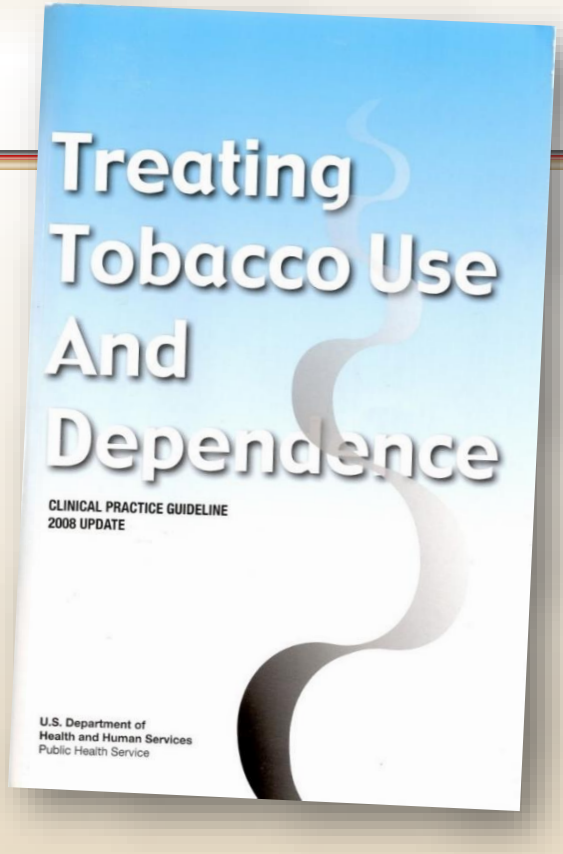
2. Evidence-based tobacco dependence interventions for the general population.

The PHS Guideline

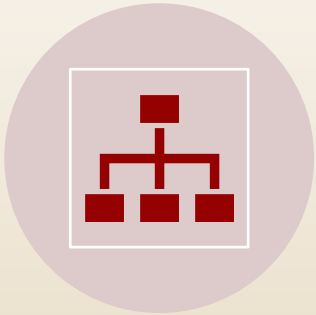
- 2008 – Updated Guideline published
  - Approx. 8,700 total articles (‘75-’07)

- Tobacco treatment requires:
  - System-level changes
  - Medication
  - Counseling



Key Recommendation: All clients should be screened for tobacco use, advised to quit, and offered treatment.

Tobacco Treatment Requires:

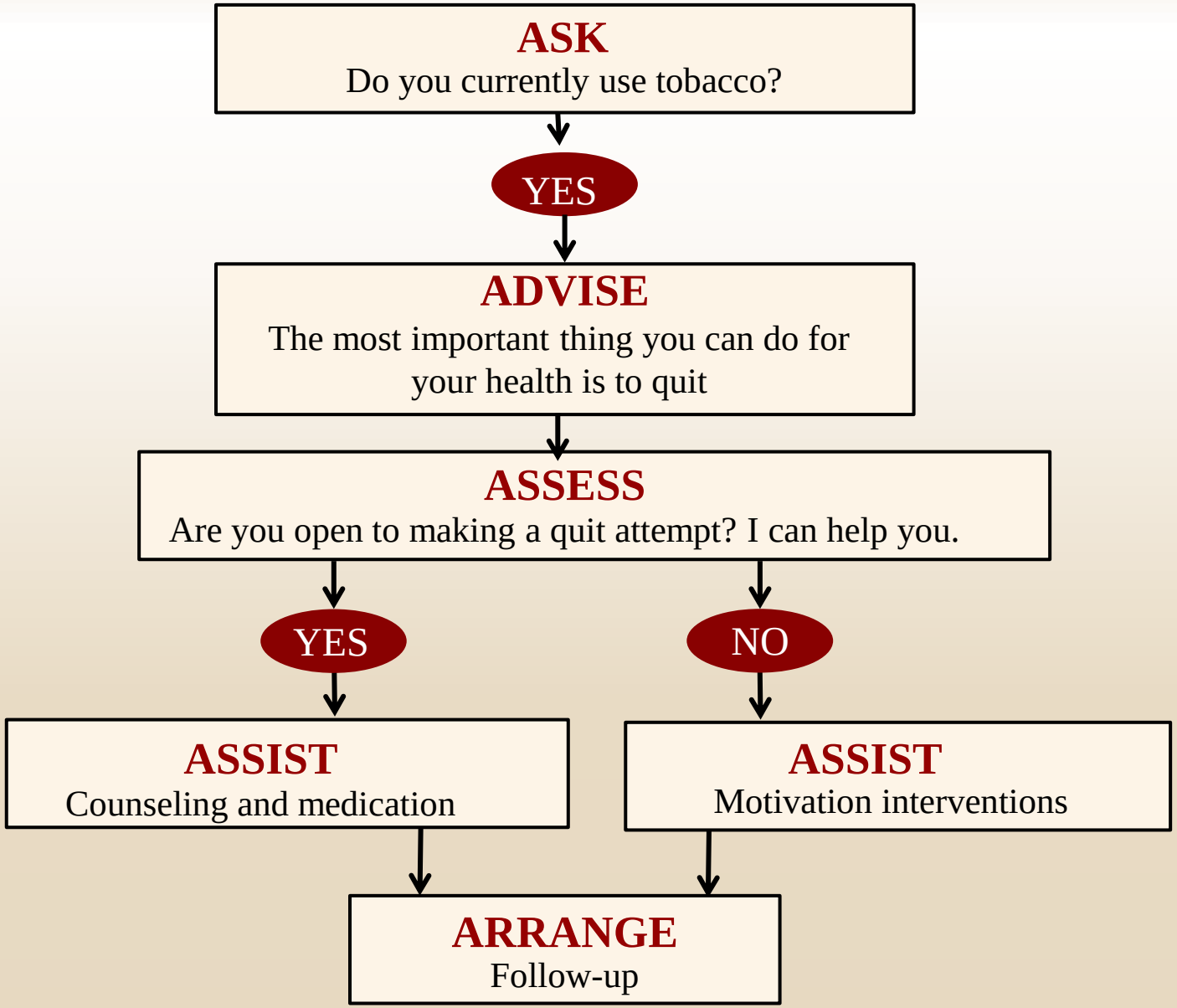


SYSTEM-LEVEL CHANGES

MEDICATION

COUNSELING

How to Treat: 5A's Brief Intervention



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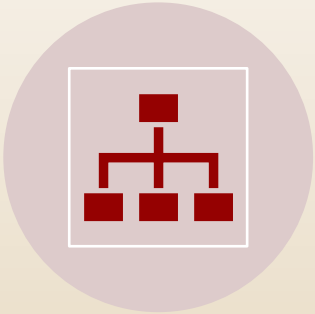


SYSTEM-LEVEL CHANGES

MEDICATION

COUNSELING

Smoking Cessation Medications

Seven FDA-approved medications reliably increase long-term abstinence rates

- **2 non-nicotine prescription-only pills:**
  - Bupropion
  - Varenicline
- **5 nicotine replacement therapies (NRT):**
  - Nicotine patch
  - Nicotine lozenge
  - Nicotine gum
  - Nicotine nasal spray
  - Nicotine inhaler

The FDA-Approved Medications for Tobacco Dependence Treatment:

- Operate to normalize brain chemistry (specifically dopamine levels)
- Block euphoric effects of nicotine
- Relieve physiological cravings
- Relieve symptoms of nicotine withdrawal

Varenicline and Bupropion

Varenicline (Chantix)

- Binds at nicotinic receptor sites
- Agonist and antagonist properties

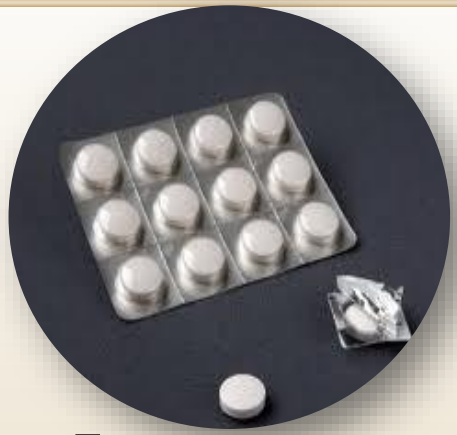
Bupropion (Zyban, Wellbutrin)

- Blocks neural reuptake of dopamine and/or norepinephrine
- Atypical antidepressant

In 2016, FDA removed the boxed warning regarding serious neuropsychiatric events

Nicotine Replacement Therapy (NRT)

Patch



Lozenge

Gum

Inhaler

Nasal Spray

Reasons for Using NRT

- Easy to use and very acceptable intervention
  - Reduction and replacement
- Extremely safe
  - Nicotine is active ingredient
  - Person is getting “clean” nicotine
  - Minimal drug-drug interactions
- Over the counter (lozenge, patch, gum) and Rx options (inhaler, nasal spray)
- Not “another pill” to take for those already on multiple medications

Combination Treatments

- Provide an increase in long-term quit rates

Options:

- Patch + patch
- Patch + oral product (lozenge, gum)
- Oral product + oral product
- NRT + bupropion

Factors to Consider When Choosing a Medication

- Patient preference
- Clinician familiarity with the medications
- Contradictions for selected patients
- Previous patient experiences with a specific medication (positive or negative)
- Patient characteristics (concern about weight gain, history of depression, issue with medications)

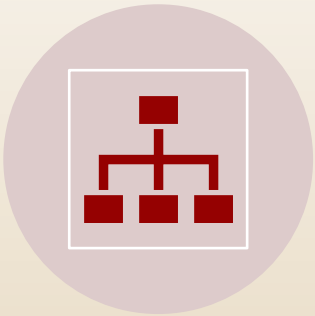
Addressing Medication Adherence

- Is client using medication as directed? (e.g. park gum, don't chew it)
- Does client need to be on a higher dose?
- Is client using enough of the medication?
- Are side effects making adherence difficult?
  - Insomnia – don't take medication right before bed or remove patch at night
- Are medications covered by insurance?

How are medications paid for?

- Commercial insurance varies and covers at least 1 of the medications
- Medicaid covers all 7 of the FDA-approved
  - No co-pay
  - Includes refills
  - Includes combination NRT (patch + lozenge or patch + Buproprion)
  - Must have a prescription

Tobacco Treatment Requires:



SYSTEM-LEVEL CHANGES

MEDICATION

COUNSELING

For Clients Interested in Quitting

Counseling Basics

Counseling, even 3 minutes, significantly improves cessation rates:

- Set a quit date
- Develop and strengthen coping skills
  - Learn from past quit attempts and build on what worked
- Develop a plan for relapse
  - Identify people, places, and events that can lead to smoking

Treatment Extender: Wisconsin Tobacco Quit Line

Refer to the Wisconsin Tobacco Quit Line for around the clock support for clients trying to quit smoking.

- 1-800-QUIT-NOW
- Coaches are trained to address the challenges in quitting that smokers with a mental health condition or other substance use problem might have

Wisconsin Tobacco Quit Line

- Free confidential, tailored phone-based and text message program
- Anyone 13 years and older to quit cigarettes, e-cigarettes, or smokeless tobacco
- Available 24/7
  - **1-800-QUIT-NOW (800-784-8669)**
  - **1-877-2NO-FUME (877-266-3863)**
  - **Text READY to 200-400**

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Quit Line Services

- Quit Coach calls
- Free 2-week supply of NRT for 18yo and older (nicotine patch, gum, or lozenge)
- Web-based support (Web Coach)
- Text2Quit program (18-24yo)
- Quit Kit – printed materials
- Quit Guide self-help booklet

For Clients Not Interested in Quitting

Motivational Interventions

- Roll with Resistance
- Explore Ambivalence
- Develop Discrepancy
- Reinforce Change Talk

For Clients Not Interested in Quitting

Assess interest in **reducing smoking:**

- Reduce number of cigarettes by 1-2 each week
- Stop smoking in certain places or situations (home, car, coffee)
- Delay smoking (1st cigarette in the morning)
- Make practice quit attempts – go without smoking for a couple of hours
- Replace cigarettes with patch/nicotine gum/lozenge

Pulling It All Together

- Individuals who use tobacco will benefit from a combination of medication and behavioral therapies
- They often need more intensive treatment
- They may have lower self-efficacy and would benefit from treatment that is tailored to their readiness for change…

Bucket Approach

Roadmap

1. Understanding tobacco use by those coping with a mental illness – Bruce Christiansen

2. Evidence-based tobacco dependence interventions for the general population – Karen Conner

3. **The Bucket Approach – Bruce Christiansen**

4. What you can do – Bruce Christiansen

5. Key Considerations and Resources – Karen Conner

3. The Bucket Approach: A Program to Address Nicotine Addiction that is Tailored for Smokers Coping with a Mental Illness.

3. The Bucket Approach

A. Tailored? What does that mean?

B. Is it evidence-based?

C. What is it?

D. Does it work?

A. Tailoring

Desirable Characteristics for a Tobacco Intervention

1. **Based on evidence-based best practice**
   - **PHS Guideline – 5As**
   - **Interventions for those willing to quit and those not yet willing to quit**

Desirable Characteristics for a Tobacco Intervention

1. **Based on evidence-based best practice**

2. **Tailored to the smoker**

She writes

"i still love you"

on each of her cigarettes

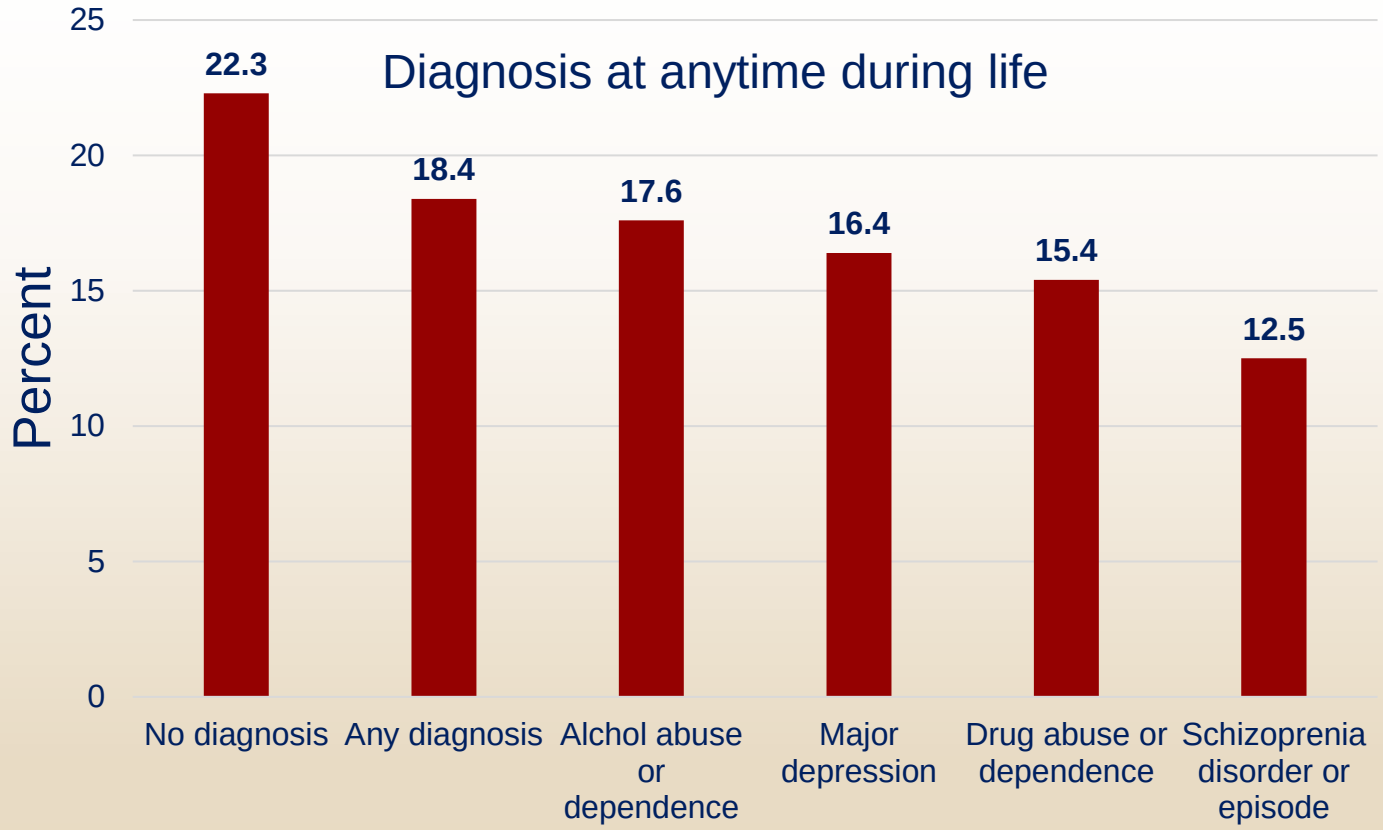
and hopes

with each one she burns

she would mean it a little

less

Quite Rate Over Three Years



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Desirable Characteristics for a Tobacco Intervention

1. Based on evidence-based best practice

2. Tailored to the smoker
   - Matched to behavioral motivation
   - Designed to inherently provide more time to quit
   - Designed to inherently bring more support and resources

Desirable Characteristics for a Tobacco Intervention

1. Based on evidence-based best practice

2. Tailored to the smoker

3. Designed for the behavioral health clinician (who has limited time, multiple treatment goals, but does see the client over relatively long periods of time)
   - Builds on existing skills
   - Brief interventions applied over time
   - Easy and convenient to learn
   - Easy to implement
   - Rewarding to provide

Desirable Characteristics for a Tobacco Intervention

1. Based on evidence-based best practice

2. Tailored to the smoker

3. Designed for the behavioral health clinician

4. Designed for the behavioral health treatment setting to promote system change
   - Measuring outcome
   - Measuring fidelity
   - Support materials

B. Is it Evidence-based?

NAMI Wisconsin
National Alliance on Mental Illness

Motivating and Preparing Smokers with Severe Mental Illness: A Randomized Control Trial

- Twelve Community Support Programs (CSPs): (Milwaukee-2, Dane-3, Sauk, Juneau, Vernon, Ozaukee, Jefferson, Rock-2)

- This study was supported by the Clinical and Translational Science Award (CTSA) program, through the NIH National Center for Advancing Translational Sciences (NCATS), grant UL1TR000427.

Study Design

- 222 clients not motivated to quit were randomly assigned to one of two conditions
- 48 clients ready to quit formed a comparison group (got no intervention)
- I. Experimental Condition- Four Individual Sessions (20 minutes each):
  - Motivational Counseling – Decisional Balance Worksheet
  - Behavioral Smoking Reduction
  - Practice Quit Attempts
  - Pre-Quit use of patch (delivered by CSP)
- II. Attention Control Group- Four Individual Sessions of the same duration (20 minutes each):
  - In depth discussions of the effects of smoking (health, cost, etc.)

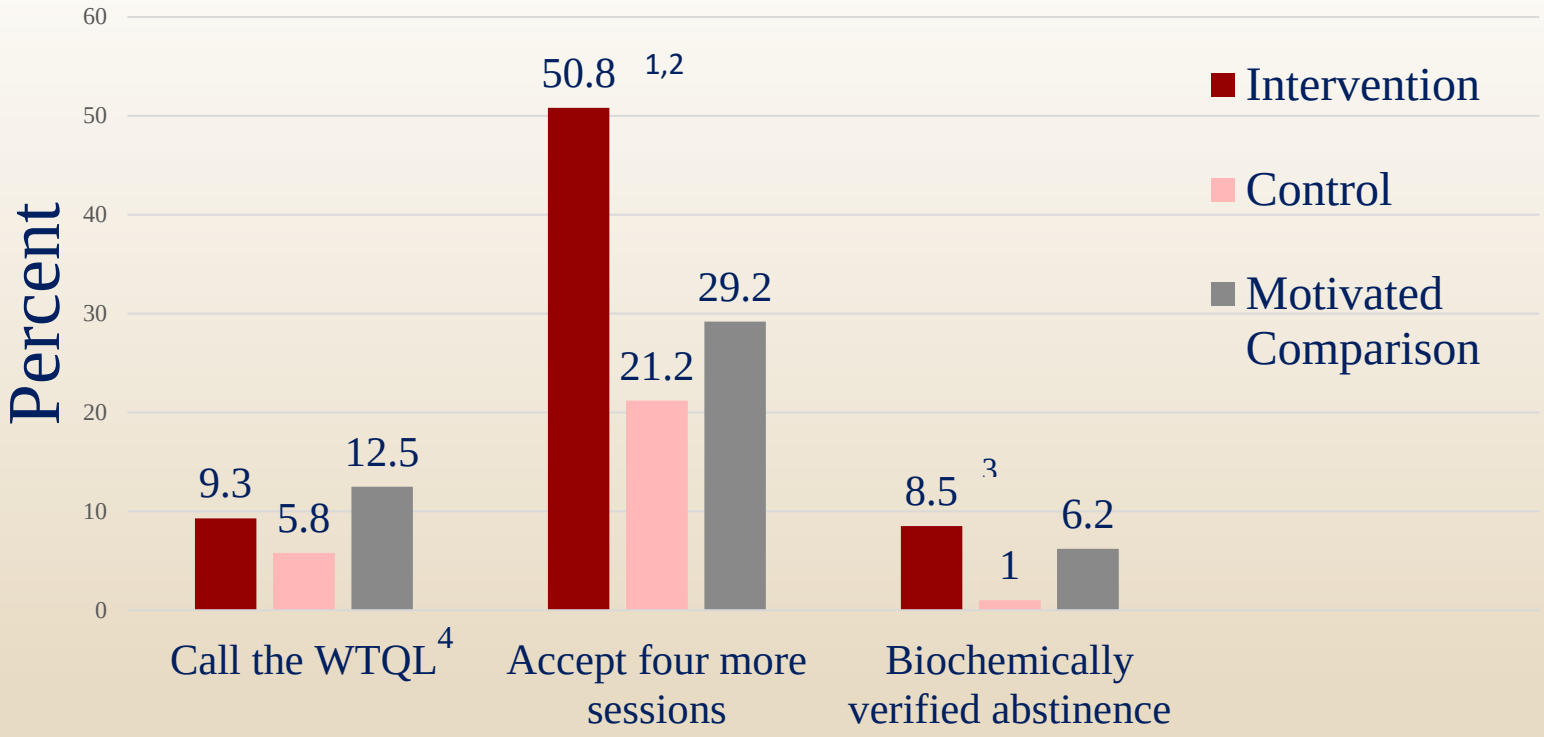
Three outcomes:

1. Call the Wisconsin Tobacco Quit Line to make a quit attempt

2. Accept four more sessions with no incentive to continue to address tobacco

3. Biochemically verified quit, 3 months later

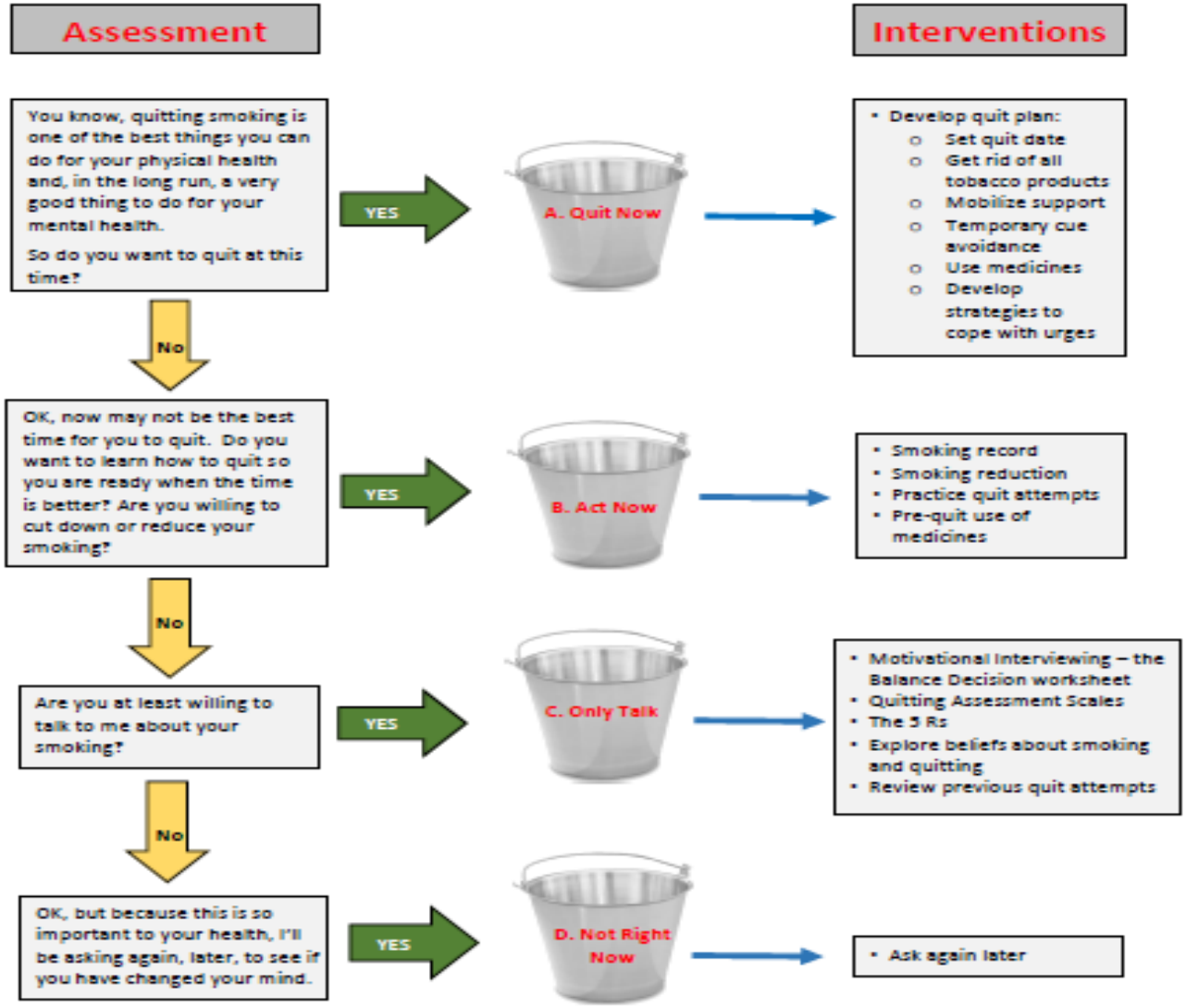
Results



[1] Intervention > Control, p<.001 [2] Intervention > Motivated, p<.05 [3] Intervention > Control, p=.012 [4] Wisconsin Tobacco Quit Line

C. What is the Bucket Approach

The Bucket Approach

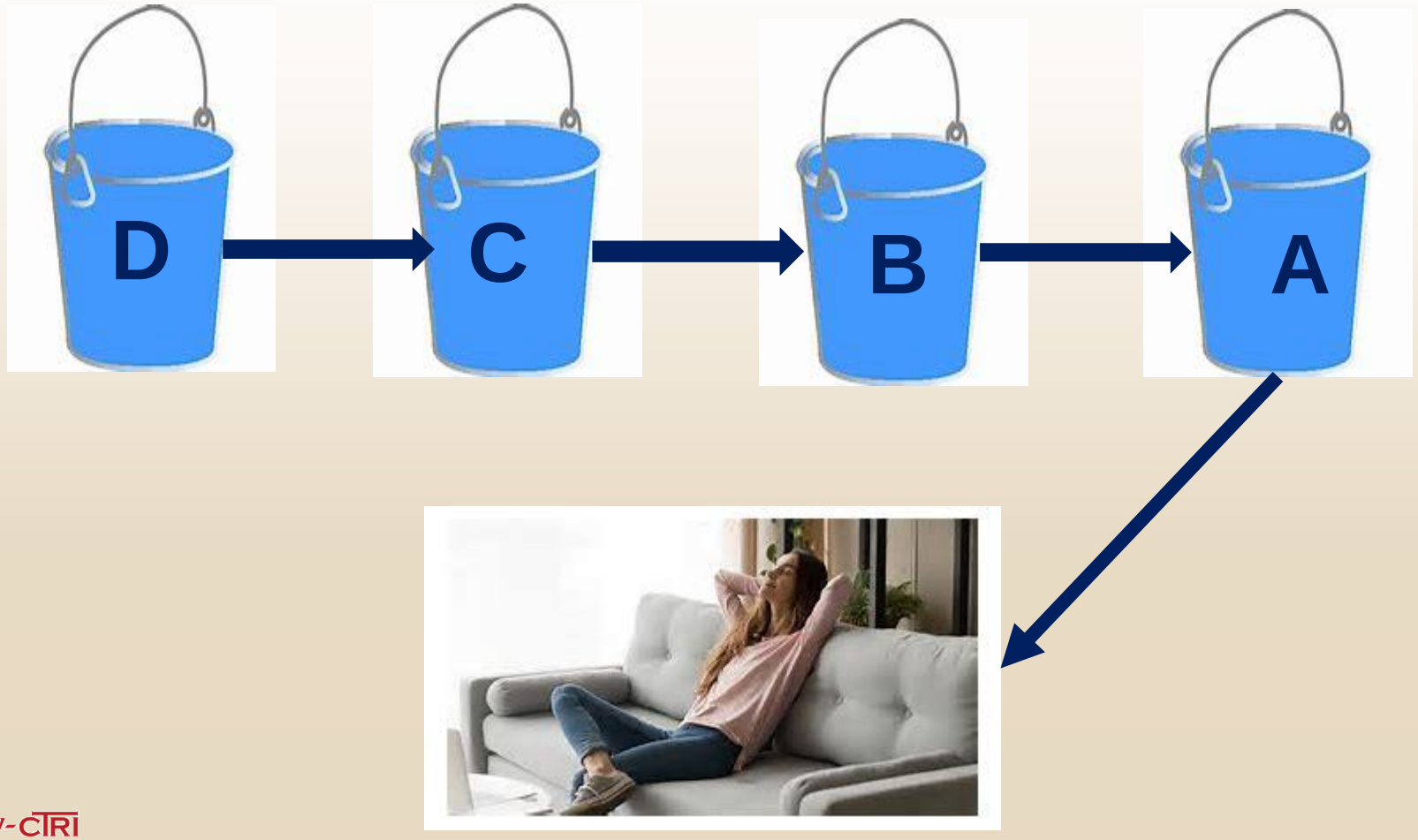


www.ctri.wisc.edu

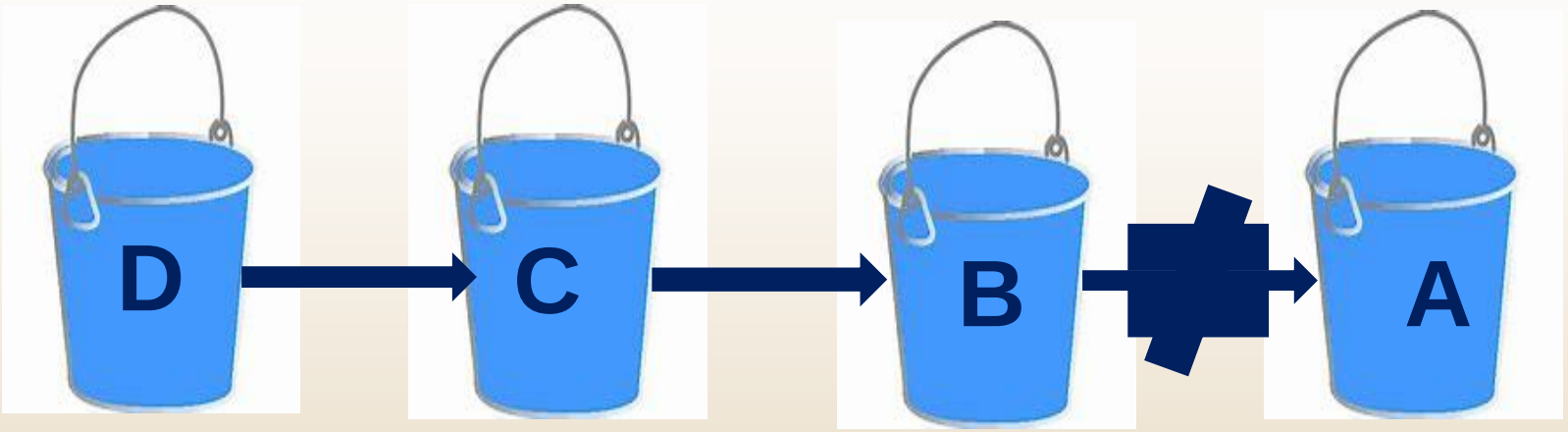
QuitLine 800-QUIT-NOW

UW-CTRI

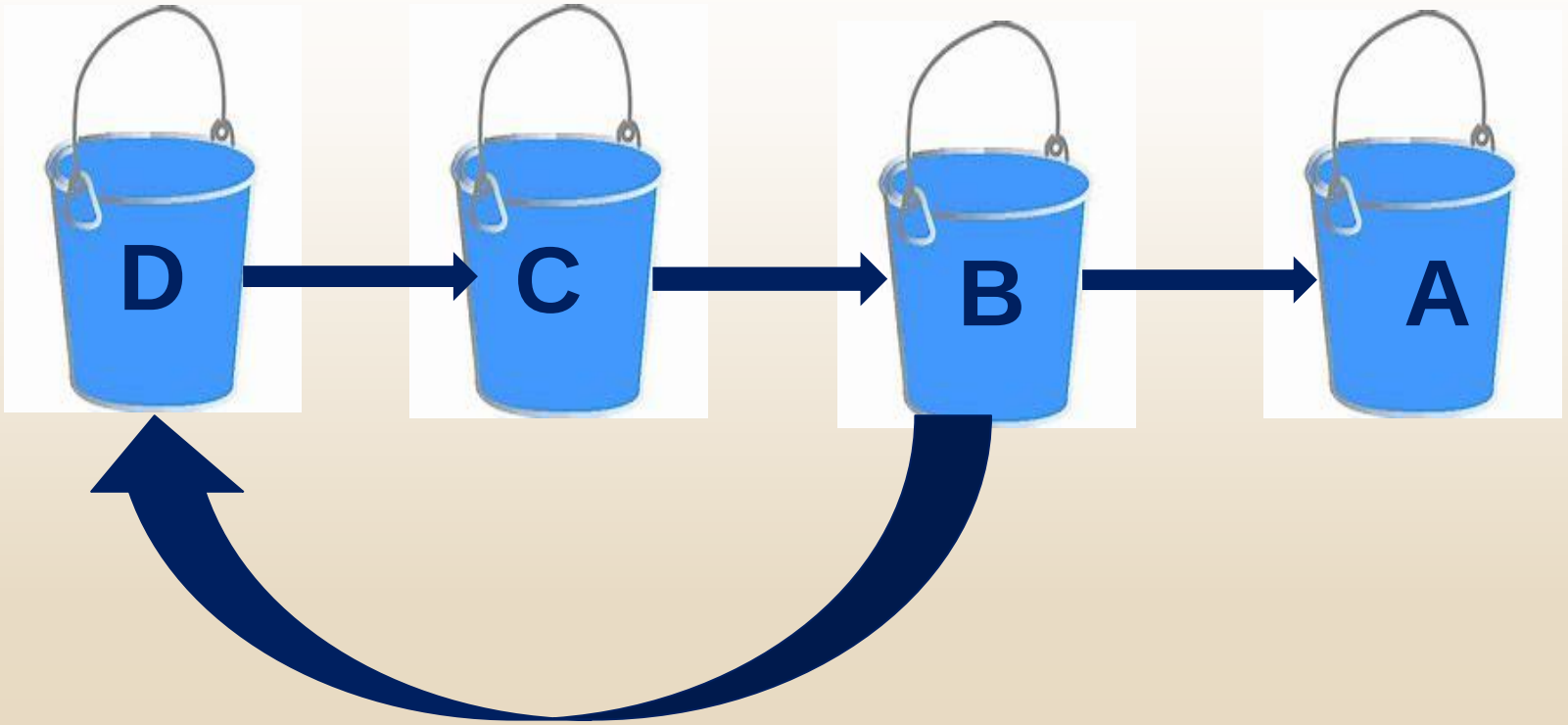
Bucket Approach Progression



Bucket Approach Progression



Bucket Approach Progression



The Bucket Approach Training

- **On-line**

https://ce.icep.wisc.edu/bucket-approach#group-tabs-node-course-default4

https://ctri.wisc.edu/providers/behavioral-health/

- **Free**
- **Free 8.25 CEs**
  - **Physicians**
  - **Nurses**
  - **Psychologists**
  - **Social Workers**
  - **CEU – Continuing Education Units**

(The CEU credit letter indicates that the course was designated for CME, which will help some people (like PAs) submit to their boards for credit.)

ADDRESSING TOBACCO DEPENDENCE IN THE BEHAVIORAL HEALTH SYSTEM: TRAINING IN THE "BUCKET APPROACH"

This course presents evidence-based tobacco dependence interventions that are tailored to smokers who are affected by mental illness and/or other addictions.

TARGET AUDIENCE

Social workers, case managers, psychotherapists/counselors, physicians (primarily psychiatrists), nurses, nurse practitioners, health care administrators working in a behavioral healthcare setting

LEARNING OBJECTIVES

As a result of participating in this learning activity, participants will be able to:

1. Determine the evidence-based tobacco dependence interventions appropriate for the motivational state of their patients who smoke.
2. Provide evidence-based tobacco dependence treatment effectively to their patients who smoke.
3. Organize the treatment of tobacco dependence as a population intervention within their treatments settings.
4. Develop effective teams to implement this population intervention.

COURSE SUMMARY

Course opens:	08/01/2019
Course expires:	09/15/2020
Cost:	$0.00

BEGIN ▸

Rating: ☆☆☆☆☆

Bookmark course

COURSE 2: THE BUCKET APPROACH INTERVENTIONS

COURSE PROGRESS

COURSE HOME

No summary available

Key Ingredients:

1. Role play demonstrations
2. Follow along guides

Course 2: The Bucket Approach Interventions

1. Overview and development of the Bucket Approach
2. How to make the bucket assessment (demonstration video)
3. Bucket C – only talk
   a) Bucket C overview
   b) Review past quit attempts (demonstration video)
   c) Explore beliefs about smoking and quitting (demonstration video)
   d) The assessment scales (demonstration video)
   e) Decisional Balance Worksheet (demonstration video)
   f) The 5Rs (demonstration video)

Course 2: The Bucket Approach Interventions (con't.)

4. Bucket B – take action
    a) Bucket B overview
    b) Smoking journal with follow-up (demonstration videos)
    c) Smoking reduction plus pre-quit use of medicines with follow-up (demonstration videos)
    d) Practice quit attempt plus pre-quit use of medicines with follow-up (demonstration videos)
    e) Combining smoking reduction and practice quit attempt with follow-up (demonstration videos)
5. Bucket A – ready to quit
    a) Bucket A overview
    b) Completing a quit plan (demonstration video)
    c) Follow-up on quit plan (demonstration video)
6. The Bucket Approach as a population intervention

Assessing Buckets

First, you have to bring up the subject of smoking. The following assumes you know that your client smokes (you don't have to ask) and that you have addressed smoking as a health risk in the past, at least in passing. If this is not the situation, you may have to modify the suggestion that follows. Say something like, "**We've talked about your smoking a bit in the past. You know it has very serious health consequences. Smoking also may mean you have to take more medication than you otherwise would. Also quitting would be of great benefit to your mental health. I think it's time we took a serious look at your smoking. I want to start with just asking you a few questions. OK**?" If you haven't addressed smoking as a health risk in the past, you could say something like, **"You mentioned that you smoke. Though it's not the main focus of our meetings, I'd like to discuss that more, if that's okay with you?"**

The next step is to simply follow the Bucket flow chart to determine what bucket your client presently falls into and then provide the interventions associated with that bucket. Say, **"As I said, quitting smoking is one of the best things you can do for your physical health and mental health. So do you want to quit at this time?"** If you would like to ask a more open question, you can ask, **"What are your thoughts about quitting?"**

If your client says they want to make a quit attempt ***proceed to the interventions included in Bucket A.***

If your client says she/he doesn't want to quit at this time (this can include saying they want to quit is such a way that you suspect they are merely acquiescing to your desire for them), say, **"OK, now may not be the best time for you to quit. Do you want to learn how to quit so that you are ready to do so when the time is better? Or do you want to cut down or reduce your smoking at this time?"**

If your client indicates that he/she wants to learn how to quit or wants to reduce smoking at this time, ***proceed to the interventions included in Bucket B.***

If your client says he/she is not interested in learning how to quit or in reducing smoking at this time, say, **"That's OK. Is it Ok that we simply talk about your smoking? I'd like to hear your thoughts about smoking, if you're comfortable with doing so. "**

If your client responds that he/she is willing to talk about smoking, ***proceed to the interventions included in Bucket C.***

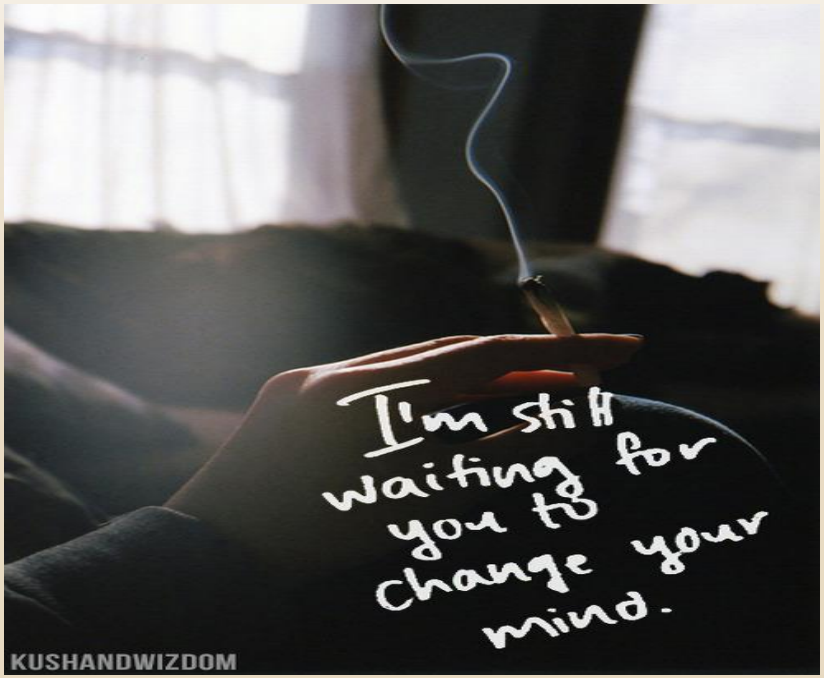
If your client doesn't even want to talk about smoking, say either, **"OK, but as one of your healthcare providers, it's my job to bring up things that greatly affect your health so I will ask you again about this in the future. But you are free to let me know you are not yet ready to talk about this.**

Behavioral Motivation

Willing to make a quit attempt (Bucket A- Quit Now)	25.9%
Not willing to make a quit attempt, but willing to prepare to quit or reduce (Bucket B – Act Now)	43.4%
Only willing to talk about smoking (Bucket C – Only Talk)	11.1%
Prefer not to talk about smoking (Bucket D – Ask Later))	19.8%

Bucket C – Only Talk

1. Review past quit attempts
2. Explore beliefs about smoking and quitting
3. The assessment scales
4. Decisional Balance
5. The 5Rs



Bucket C: Review Past Quit Attempts

Ask the following questions until you believe you have exhausted information about previous quit attempts.

- ✓ **"Tell me about your past quit attempts. How many times have you tried to quit?**
- ✓ **Why did you try to quit? What were your reasons for quitting? What sorts of things got you motivated to make a quit attempt?**
- ✓ **Please, describe the ways you have tried to quit.**
- ✓ **Think about the quit attempt that was most successful, the one that lasted the longest. How long did it last? How did you quit that time? How was this quit attempt different from the other times that you tried?**
- ✓ **What cessation medicines have you used in the past? Did you use them every day? How much did you use every day? Why did you stop using them? Do you think they helped? Why do you think that?**
- ✓ **What things happened that brought previous quit attempts to an end? What happened to get you to smoke again? What does this tell you about what should be different the next time?**
- ✓ **What was the hardest part of your quit attempt? Were there things you expected to be difficult but were not?**
- ✓ **What have you learned from your previous quit attempts?**
- ✓ **Did you let other people know that you were trying to quit or did you keep it a secret? Why?**
- ✓ **Different ways of quitting work for different people. Based on all of your experience, what is the best way for you?"**

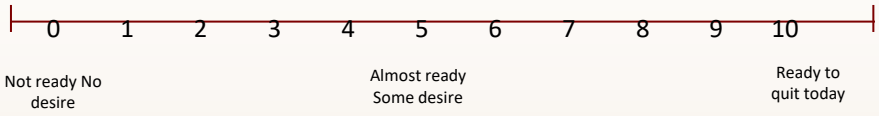
Bucket C: Explore Beliefs about Smoking and Quitting

A person's beliefs about smoking and quitting can serve as barriers to making a quit attempt. Examples from below include: that it's common, to smoke; the best way to quit is cold turkey, using willpower; smoking is a habit and not an addiction; and beliefs that cessation medications are addicting. The purpose of this activity is to address these belief barriers in a factual, non-judgmental, supportive manner.

This activity requires some tact. On the one hand, learning that one's beliefs are not accurate can create discomfort and dissonance and, therefore, a teachable moment. On the other hand, some of the results from our tobacco research suggests that hearing "No, you're wrong", even when done in a supportive manner, may elicit defensiveness and, therefore, reduce the likelihood that the person will listen to and accept a different point of view. Dissonance vs. defensiveness can be navigated by realizing that private dissonance alone creates a teachable moment. Public dissonance, created by being told one is wrong, is not necessary. For this reason, we recommend one address a client' beliefs about smoking and quitting by posing the barrier as one that many belief without asking for the client's belief or answer. This is followed up by providing the correct information or information often with a rationale that makes the incorrect answer/barrier understandable and plausible, but also acts as a bridge to the correct answer (to meet the client where they are at). One can then ask whether the correct information was surprising.

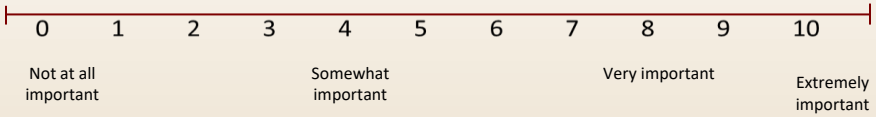
Bucket C: The Assessment Scales

Readiness



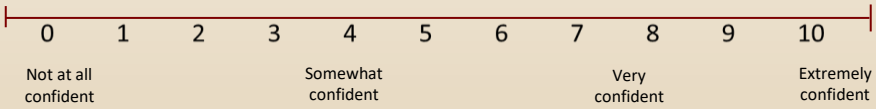
On a scale from 0 – 10, where are you in your desire/readiness to quit?
- What has to happen to move you up the scale from a ___ to a ___?

Importance



On a scale from 1 – 10 , how important would you say it is for you to quit?
- Why are you at a ___ and not a (lower number)?

Confidence



On a scale from 1 – 10, how confident would you say you are, that if you decided to quit, you could do it?
- What would it take to move your confidence up one or 2 numbers?

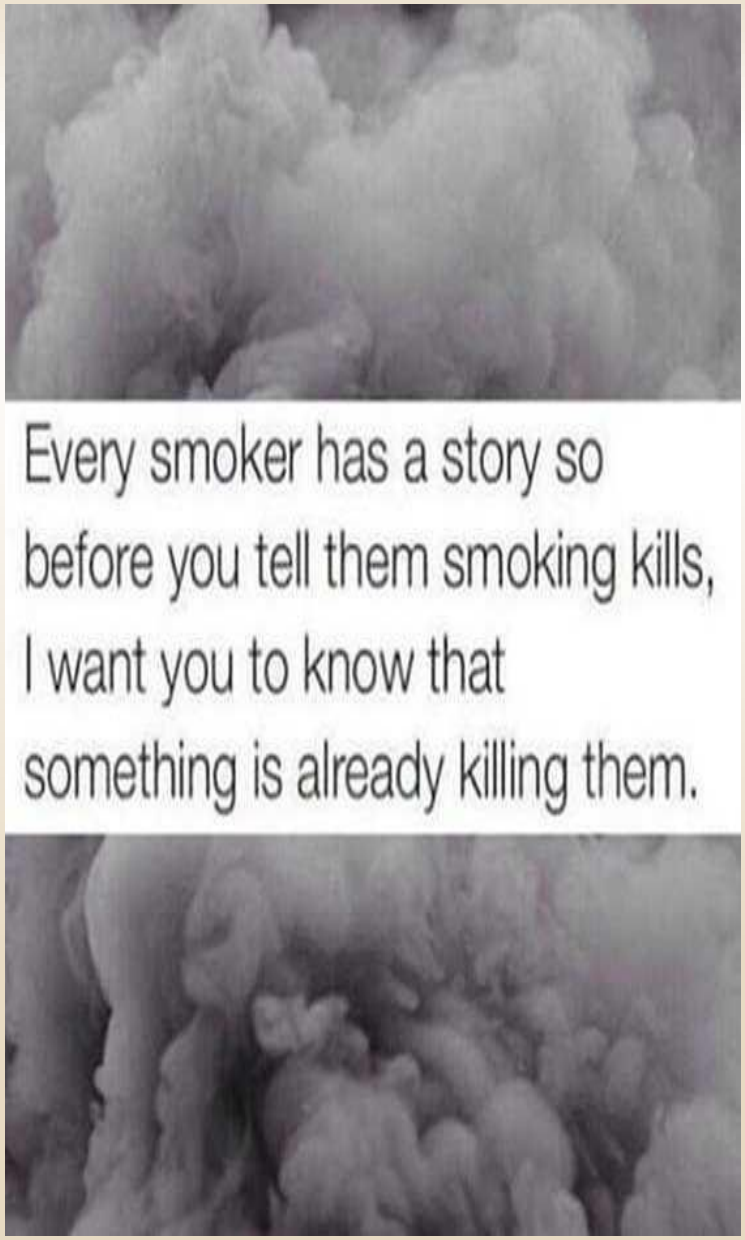
Bucket C: Decisional Balance

Decisional Balance Worksheet

What are the benefits – the good things – about smoking for you?	**What are the costs – the bad things – about smoking for you**
What are the costs – the bad things- about quitting for you?	**What are the benefits – the good things – about quitting for you?**

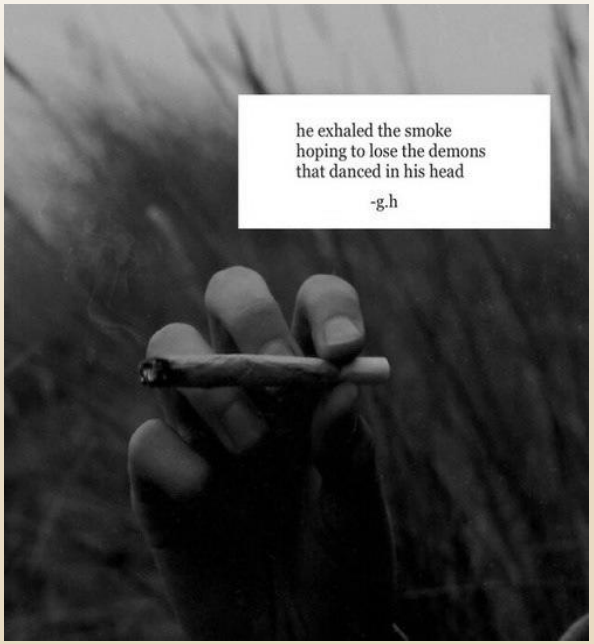
Bucket C: The 5Rs

- ✓ Roadblocks
- ✓ Reasons or Relevance
- ✓ Risks
- ✓ Rewards
- ✓ Repetition



Bucket B: Act

1. Smoking journal
2. Smoking reduction plus pre-quit use of medicines
3. Practice quit attempt plus pre-quit use of medicines
4. Combining smoking reduction and practice quit attempt



Bucket B: Smoking Journal

Day of Week	Time	Place/ Location	Activity	Company	Mood/Feelings/ State of Mind	Prominent Thoughts

Thank you for recording your smoking notes the past week. The next step is to discuss the notes you took with me, your clinician. Are you okay with this?

1. What patterns do you see in your smoking?

2. When do you smoke most often during the day?

3. Are there times that you do little smoking? Why do you think that is?

4. During the week you kept a journal about your smoking, what is the longest time you went without a cigarette? How challenging was that period?

5. I'm curious to know how soon you smoke after you wake up in the morning

6. Often the act of writing down what we do changes what we do. Do you think journaling about your smoking changed any of your decisions to smoke last week? If so, in what why?

7. Are there strong bonds between smoking and certain places or activities to for you? What places and activities?

8. Did you drinking alcoholic beverages while you smoked last week? Did you drink at times when you did not smoke?

9. Would you rather smoke by yourself or with other people?

10. Last week, did you not smoke in front of certain people? If so, why?

11. Do you think there are bonds between your smoking behavior and the way you are feeling when you light up?

12. Reviewing your journal, what seems to be the dominant thought that triggered your smoking?

13. Do you ever think about smoking while you're smoking or do you auto-smoke without thinking about it?

14. Studying your notes in your smoking journal, is there anything that surprises you?

Bucket B: Smoking Reduction Plus Pre-quit Use of Medicines

Smoking Reduction Plan

Average daily cigarette consumption:_____ Smoking reduction goal: _____

Time to first cigarette in the morning:_____ Reduction goal time: _____

Average time between cigarettes: _____ Reduction goal time: _____

Five highest risk situations:

Over the next week, I'll reduce my smoking by:

If I will reduce my smoking by avoiding smoking in certain situations, for each situation my plan is to:

Client signature: __ Date: __ Clinician Signature: __ Date: __

Bucket B: Pre-Quit Use of Cessation Medicine

Now I know you're not ready to make a quit attempt yet. Instead, you're working to reduce your smoking or learning how to quit someday. But I want you to consider using a smoking cessation medicine now, as you prepare and learn for the same reason that I want you to use a cessation medication when you try to quit some day: using a cessation medicine now will help you succeed when trying to reduce your smoking or when learning how to quit. Plus, trying medicines now will give you some experience with them before you make your quit attempt. They won't be new to you and you will know what to expect. So, can I tell you about the medicines you can choose from to see which you would like to try?

If your client is willing to use a cessation medication in the context of cutting down and/or learning how to quit, ***Describe the patch and mini lozenge as the best medications to use pre-quit.*** (We recommend the patch if your client is willing to use this. And if not the patch, suggest the mini-lozenge. The evidence for their usefulness as a pre-quit aid is greatest for these two medications. There is less evidence for the others.) ***Help the client select a medicine, being mindful of their preference and past use. For the patch, use the 21 mg. patch for clients who smoke 10 or more cigarettes/day and the 14 mg. patch for clients who smoke less than 10 cigarettes/day. For the mini-lozenge, use the 4 mg lozenge if the client has her/his first cigarette within 30 minutes of waking and the 2 mg. lozenge if the first cigarette takes place after 30 minutes of waking.*** These medications can be used for up to 6 months before the quit date. Additional information about the medications can be obtained from the UW-CTRI website: ***(https://ctri.wiscweb.wisc.edu/wp-content/uploads/sites/240/2018/06/2.CME-pharmacotherapy-table.pdf). After a medication regimen has been selected, let the client know how the medicine will be obtained.***

Bucket B: Practice Quit Attempt plus Pre-quit Use of Medicines

I will make my practice quit attempt on _____ (insert day of week and date).

Below are the challenges I expect to face that day and how I plan to cope with them:

Challenge	Coping Strategy
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	

I will give all my cigarettes to a friend/family member (name: _____) the day before my practice quit attempt and will not ask for them back until the day after my practice quit attempt.

Client signature: _____ **Date:** _____

Clinician signature: _____ **Date:** _____

Bucket B: Smoking Reduction Plus Practice Quit Attempt

Date: _____ Day of the week:_____

My goal for today was _____ reduce my smoking by half or _____ make a practice quit attempt

Number of cigarettes smoked: _____

How successful do you feel you were regarding your smoking goal today?

_____ I was completely successful – met my goal

_____ I was mostly successful – met almost all my goal

_____ I was moderately successful – met some of my goal

_____ I met little of my goal

_____ I met none of my goal

1. What strategies worked for you and what strategies did not?
   _____
   _____
2. What unexpected things happened to make the day more difficult than you had expected?
   _____
   _____
3. In light of your success on this day, what did you learn about what it will take to quit for good?
   _____
   _____
4. What changes will you make for the next day based on what you learned today?
   _____
   _____

Bucket A: Quit

Elements of a quit plan:

- Set a date
- Anticipate challenges
- Coping with urges/cravings
- Responding to a lapse so that it doesn't become a relapse
- Mobilizing support
- Select a medication

Bucket A: Selecting a medication

“The odds of quitting double or triple when a quit-smoking medication is used. We know that it takes willpower to quit. All the cessation medicines work by reducing the urges and cravings to smoke that are part of quitting. In this way, they support your willpower by making it last longer. For this reason, we strongly recommend you use a cessation medicine when you quit. In fact, we recommend that you use a combination of medications.”

Bucket A: Following Up on a Quit Plan

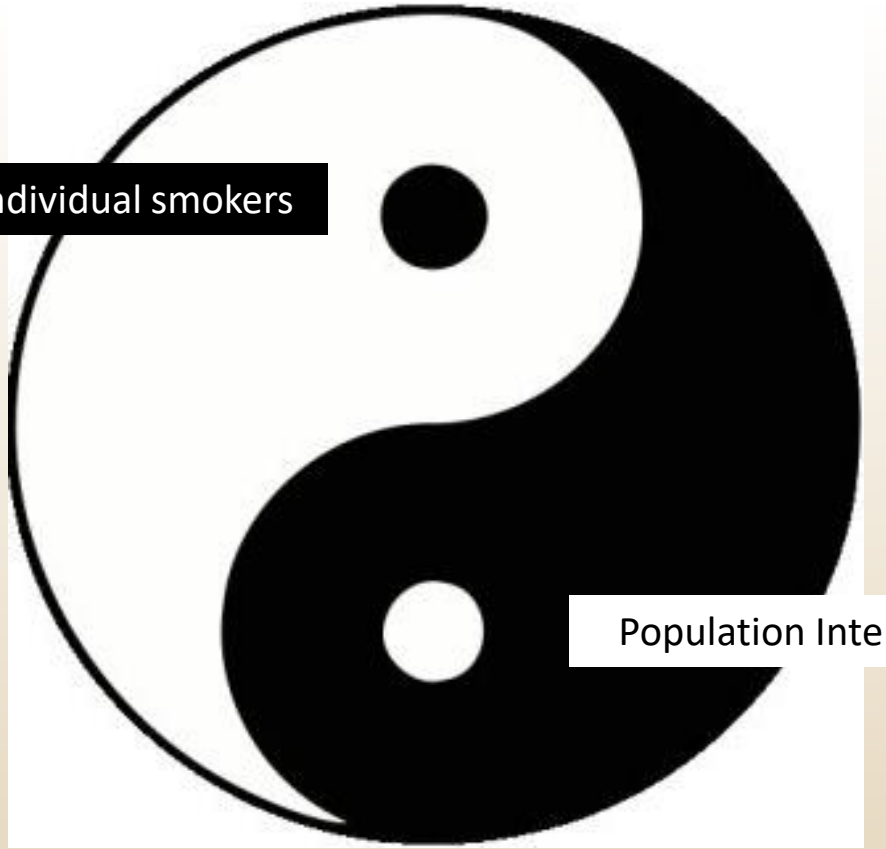
1. No smoking since quit attempt, not even a puff

2. Your client has lapsed

You can respond to a lapse in four ways. First, you can focus on the positive: they didn't return to daily smoking! This is an opportunity to praise their perseverance and determination. Second, you can normalize the lapse and provide hope for the future by saying something like, **"While every quit attempt starts with the same goal of no smoking, not even a puff after the quit date, the fact is that many smokers lapse but then go onto quit successfully. So together, we're just getting started."** Third, you can take the emotional sting out of a lapse by characterizing it as an opportunity to learn rather than a failure. You can say something like, **"A lapse gives us an opportunity to learn. You probably weren't successful the first time you rode a bike but tipping over is part of learning to ride. You'll get better with practice and time. So let's talk about what we learned."**

3. You client has Relapsed

Interventions for individual smokers

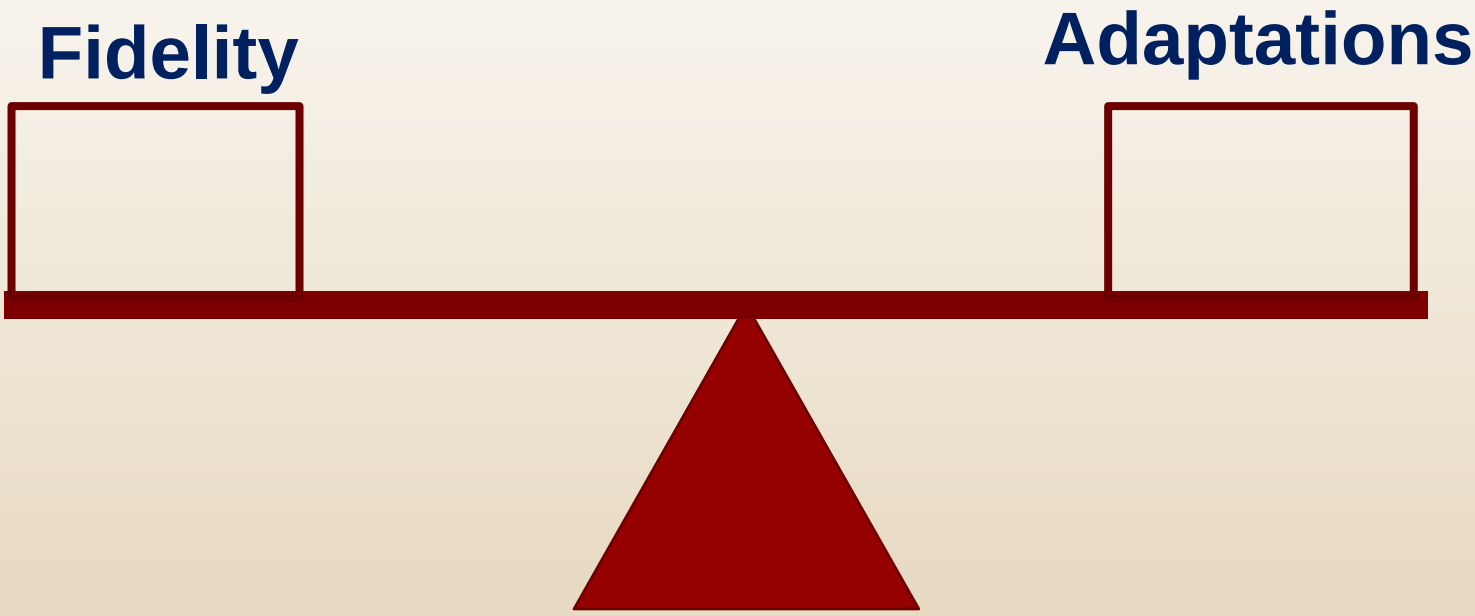


Population Intervention at the clinic level

The Bucket Approach as a Population Intervention:

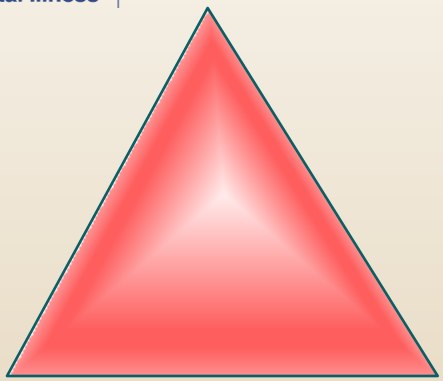
1. How to implement
   a) Champion and supporting tobacco committee
   b) Treatment delivery structure
   c) Employee engagement
   d) Client awareness
   e) Other stakeholders

2. How to sustain
   a) Employee issues
   b) Measuring outcome and recording progress
   c) Measuring fidelity
   d) State reporting (Wisconsin)


Fidelity
Adaptations

D. Does the Bucket Approach work?

NAMI Wisconsin
National Alliance on Mental Illness



UW-CTRI
UNIVERSITY OF WISCONSIN
Center for Tobacco Research & Intervention

Journey
HEALTH WELLNESS RECOVERY
Sharing the Path from Hope to Recovery

Lessons Learned

1. For this population, interventions work best when delivered by a trusted person who has a strong relationship with the tobacco user.

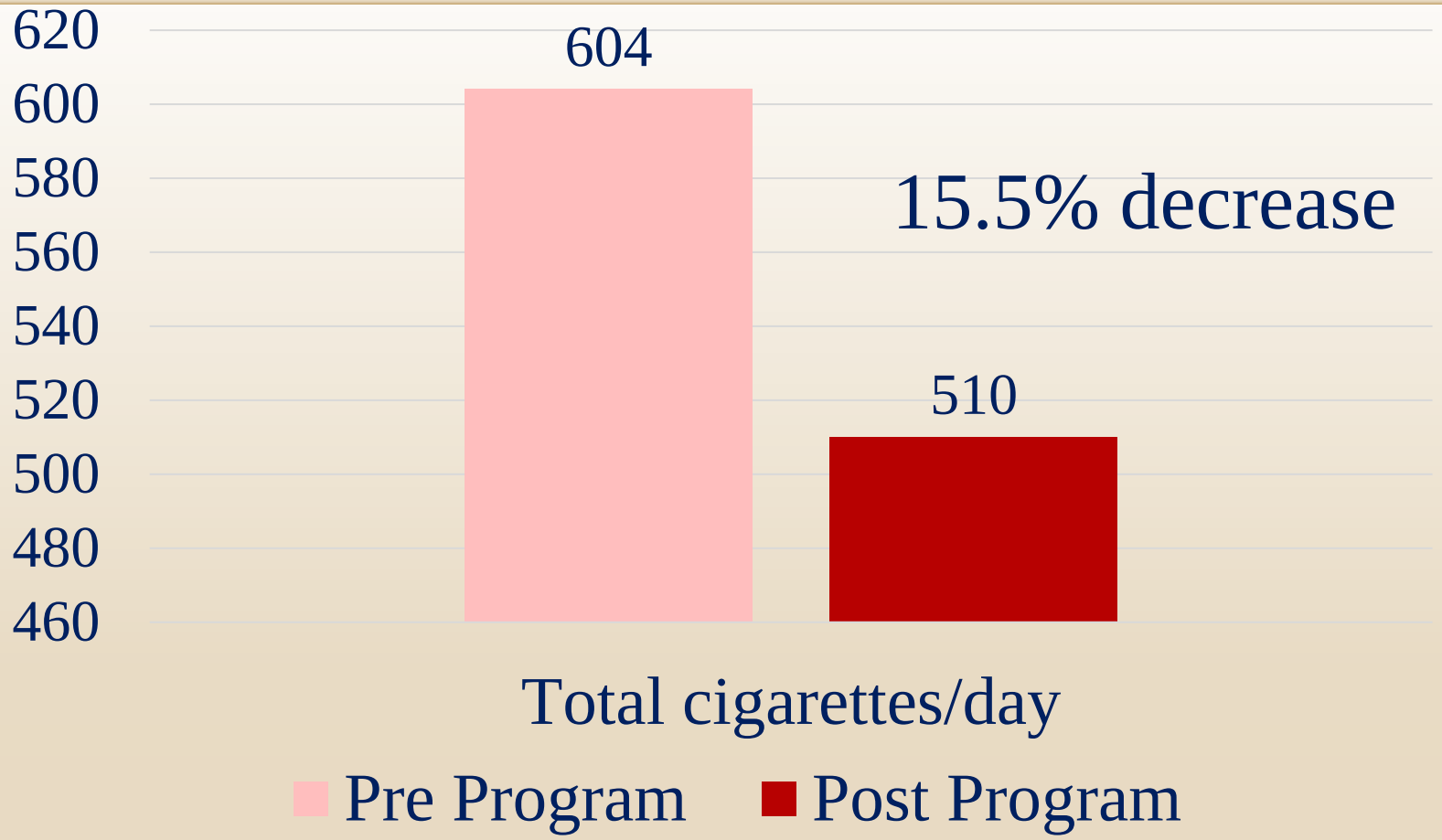
2. But that person needs support because of time burdens. Therefor, primary intervention by CSP/CCS clinical staff with substantial, on-sight support from specifically trained tobacco advocate

3. Reinforcing incentives work well

Results from CTA (Journey Mental Health)

Results from CTA (Journey Mental Health)

Results from CTA (Journey Mental Health)



Results from CTA (Journey Mental Health)

And two people quit!

(And they weren't who was expected to)

Figure 10: People who Completed Training Cumulative

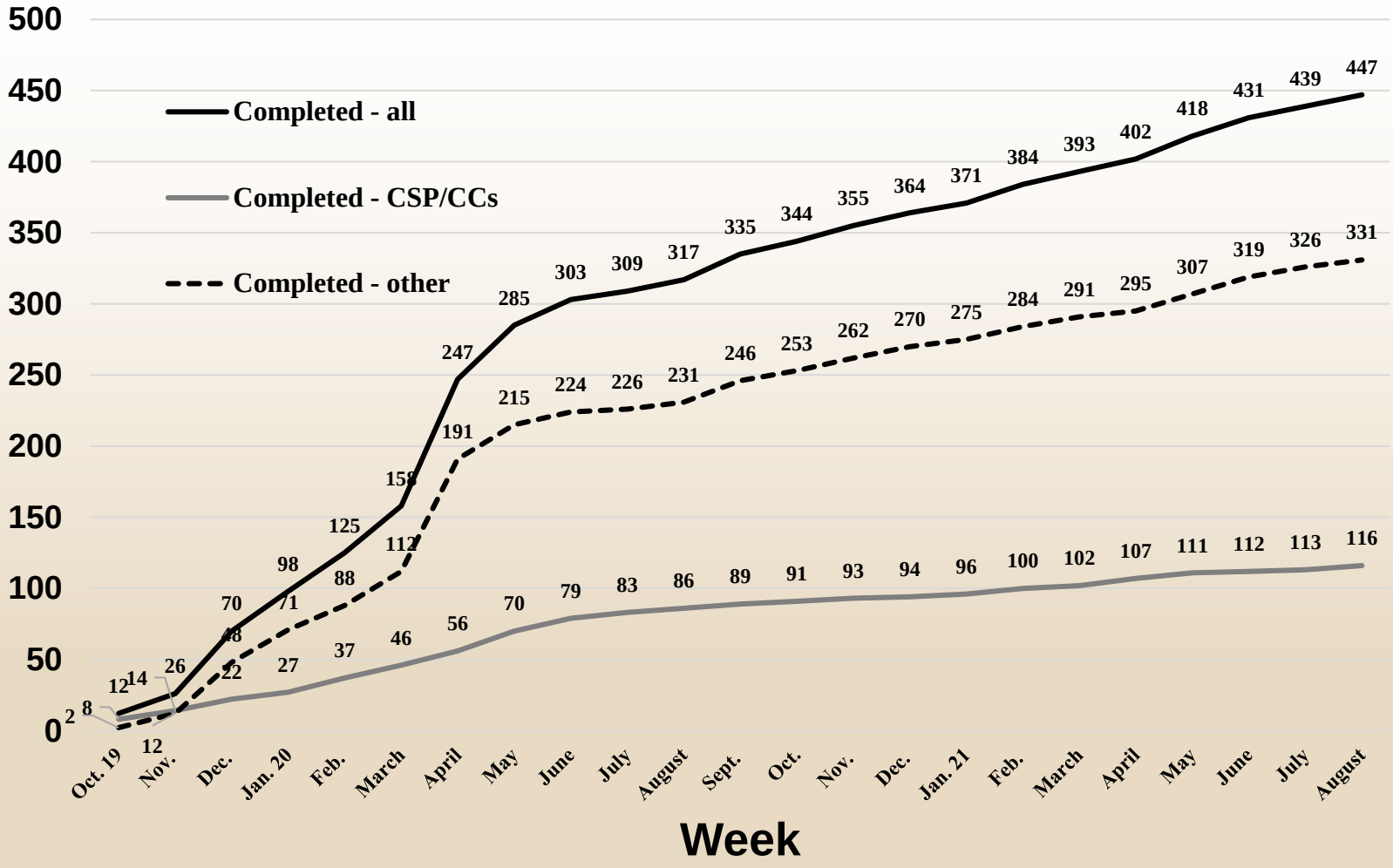


Figure 19: I Learned New Skills about Treating Tobacco Dependence

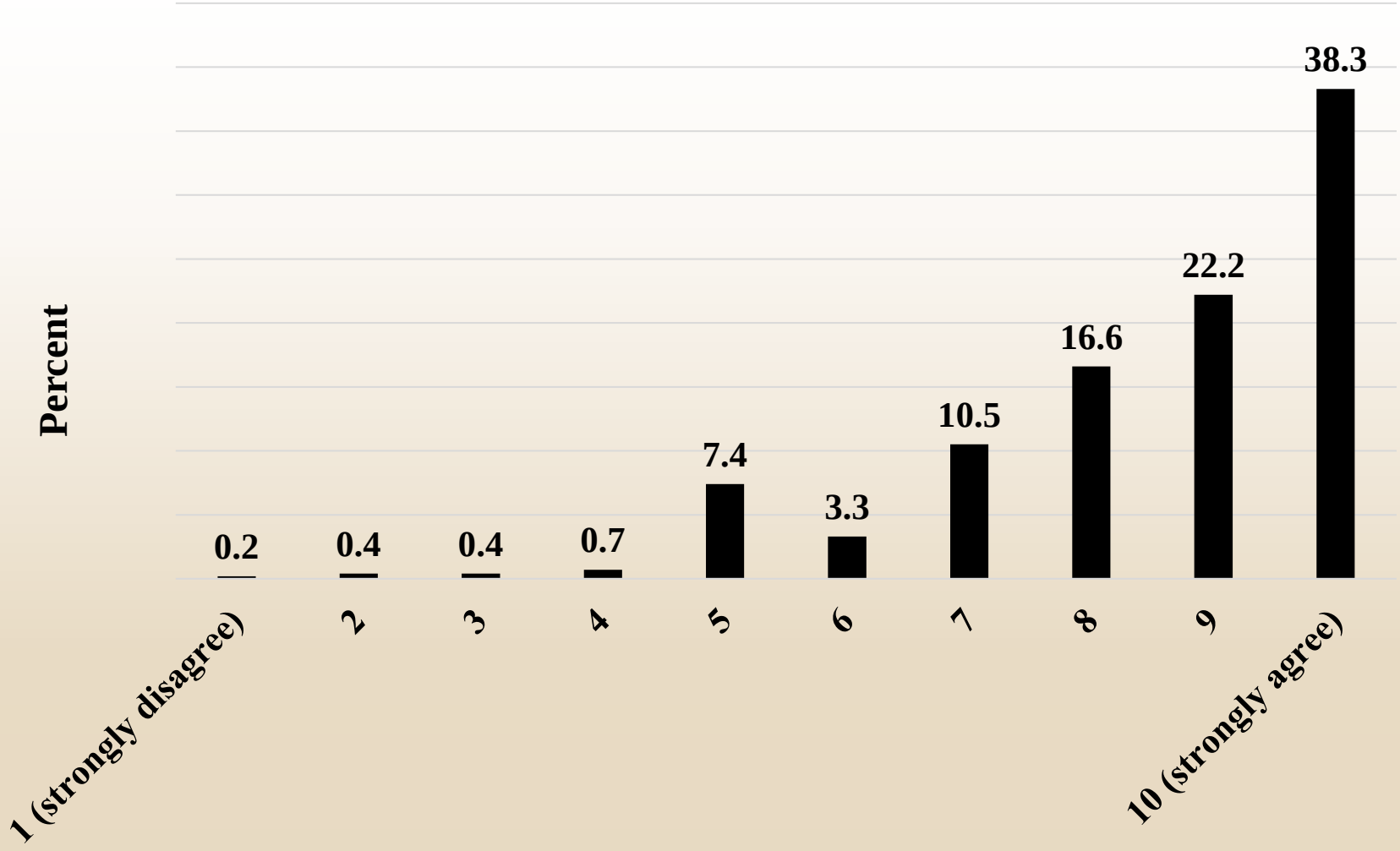


Figure 22: Would you Recommend Course 2 to others?

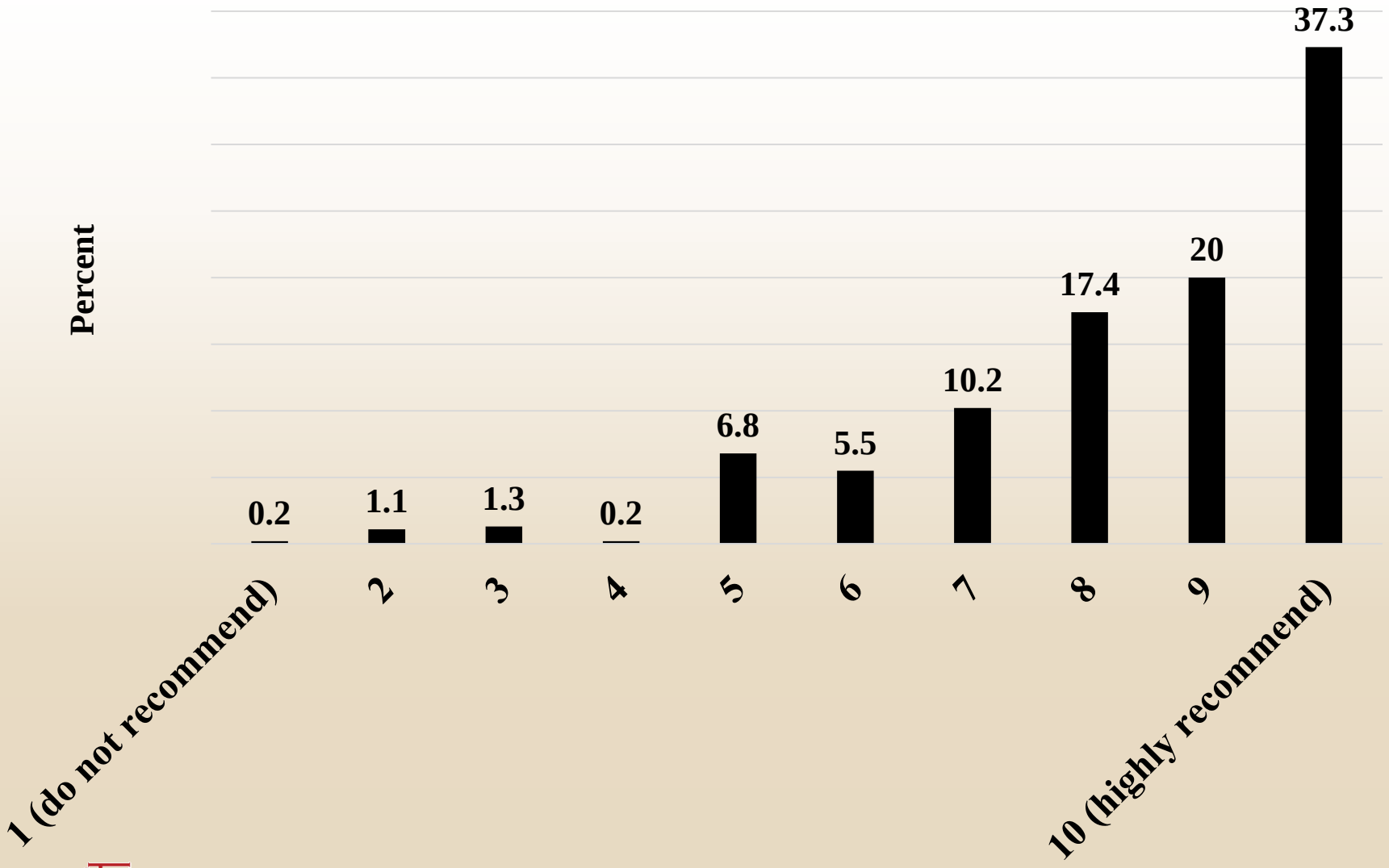


Figure 23: Overall Rating of Course 2

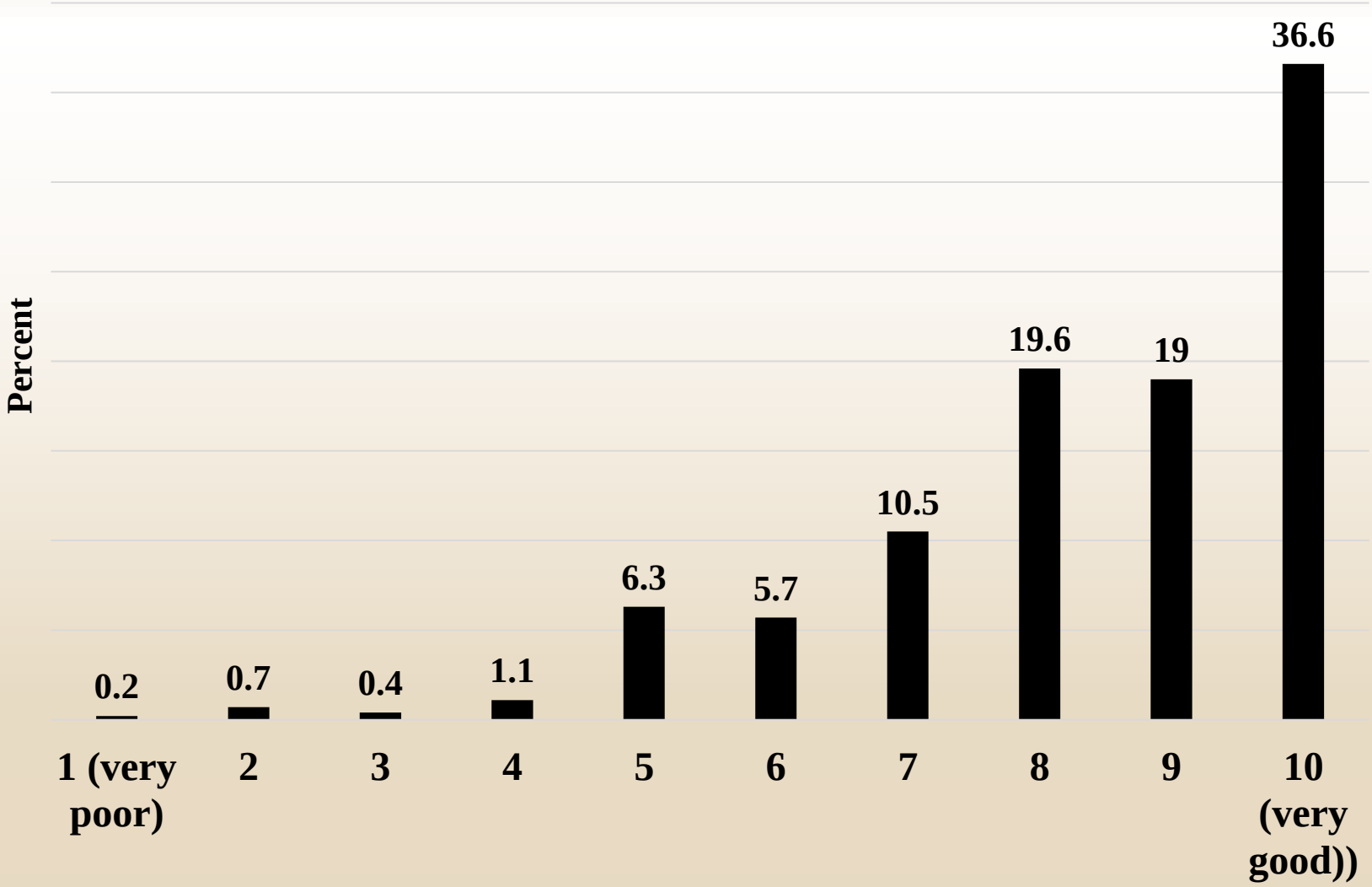


Figure 21: Confidence that You will Use what You Learned in next Month

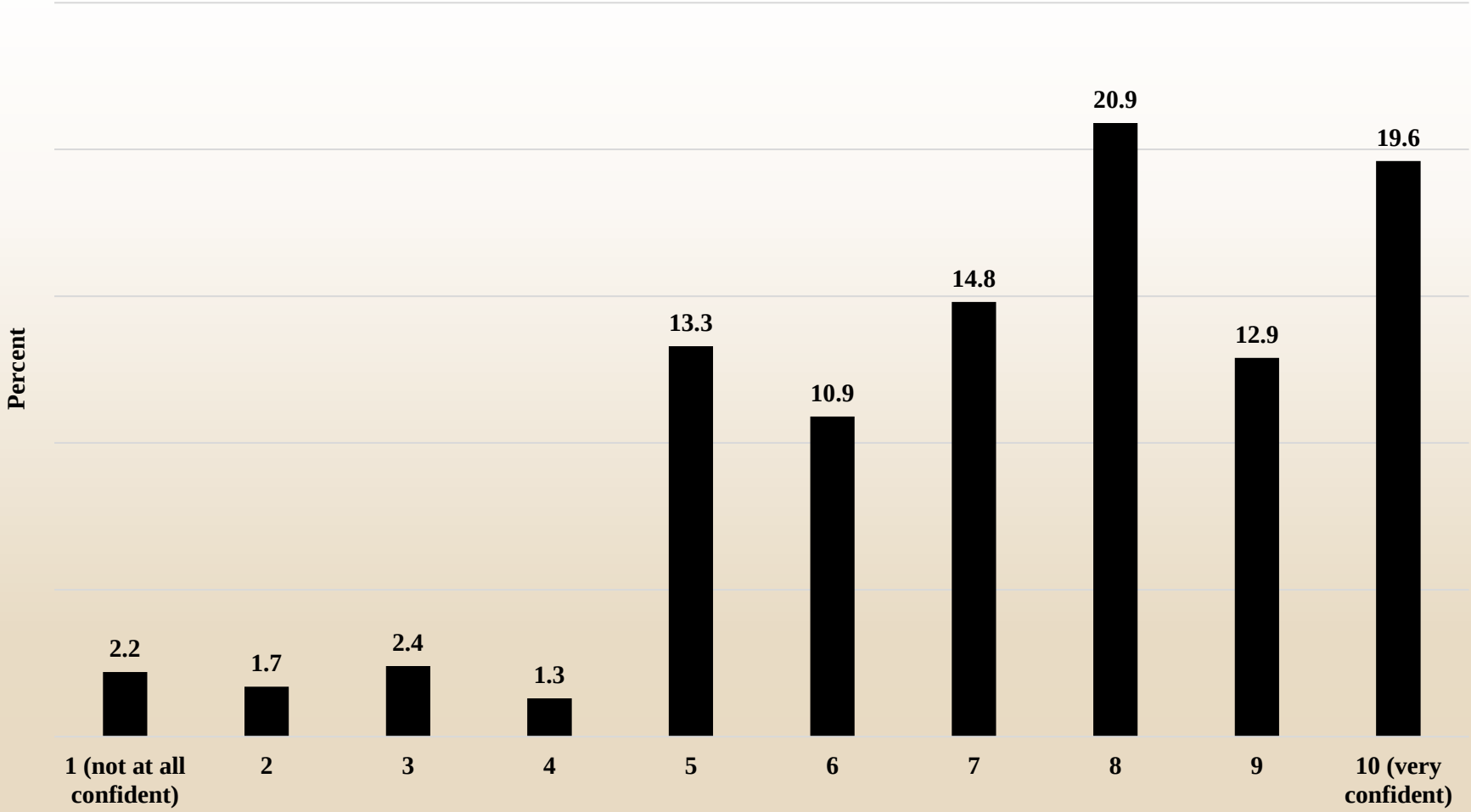


Figure 38: All treatment Programs should Provide Tobacco Dependence Treatment

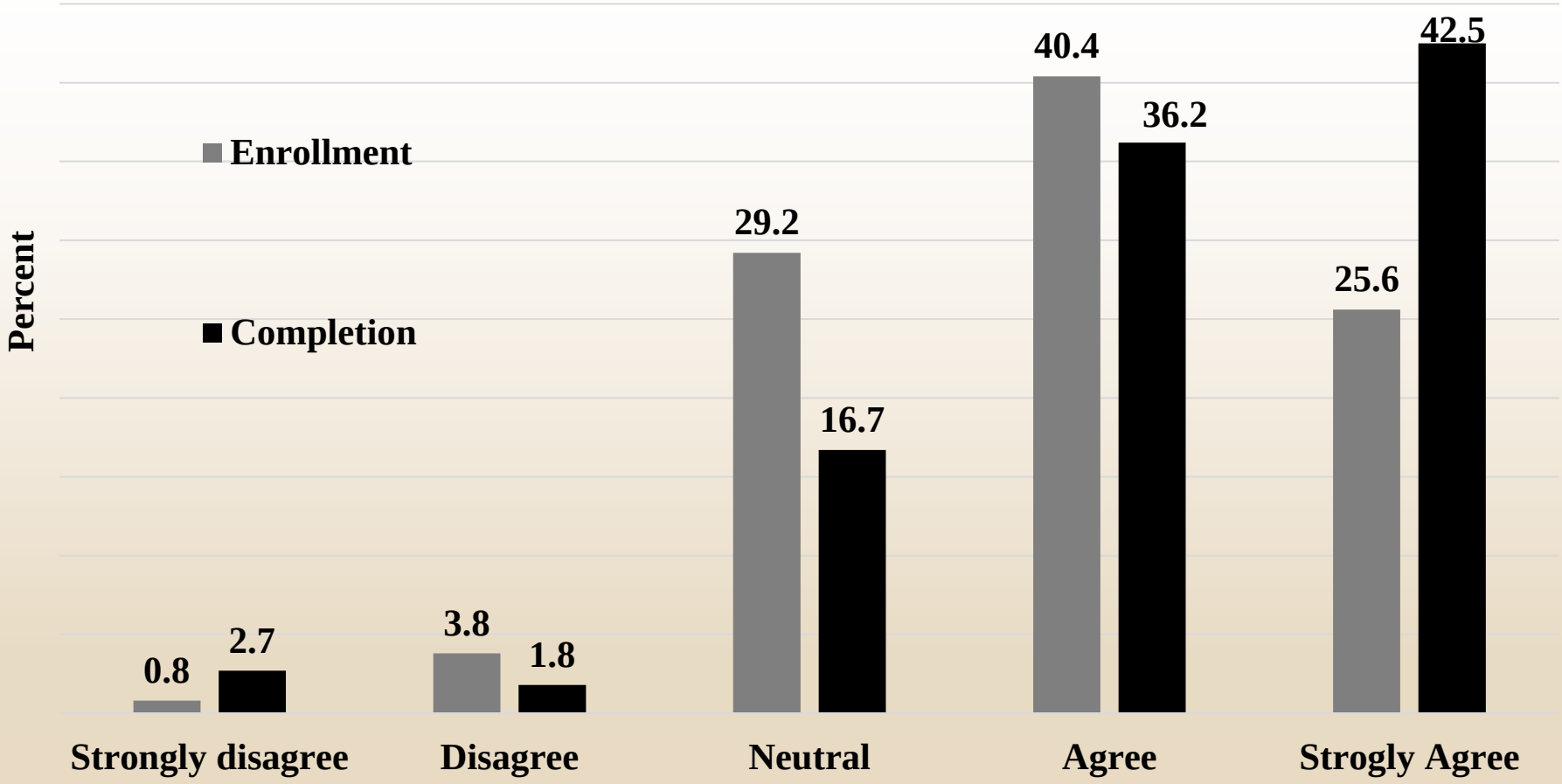


Figure 40: Behavioral Health Clinicians already have the skills needed

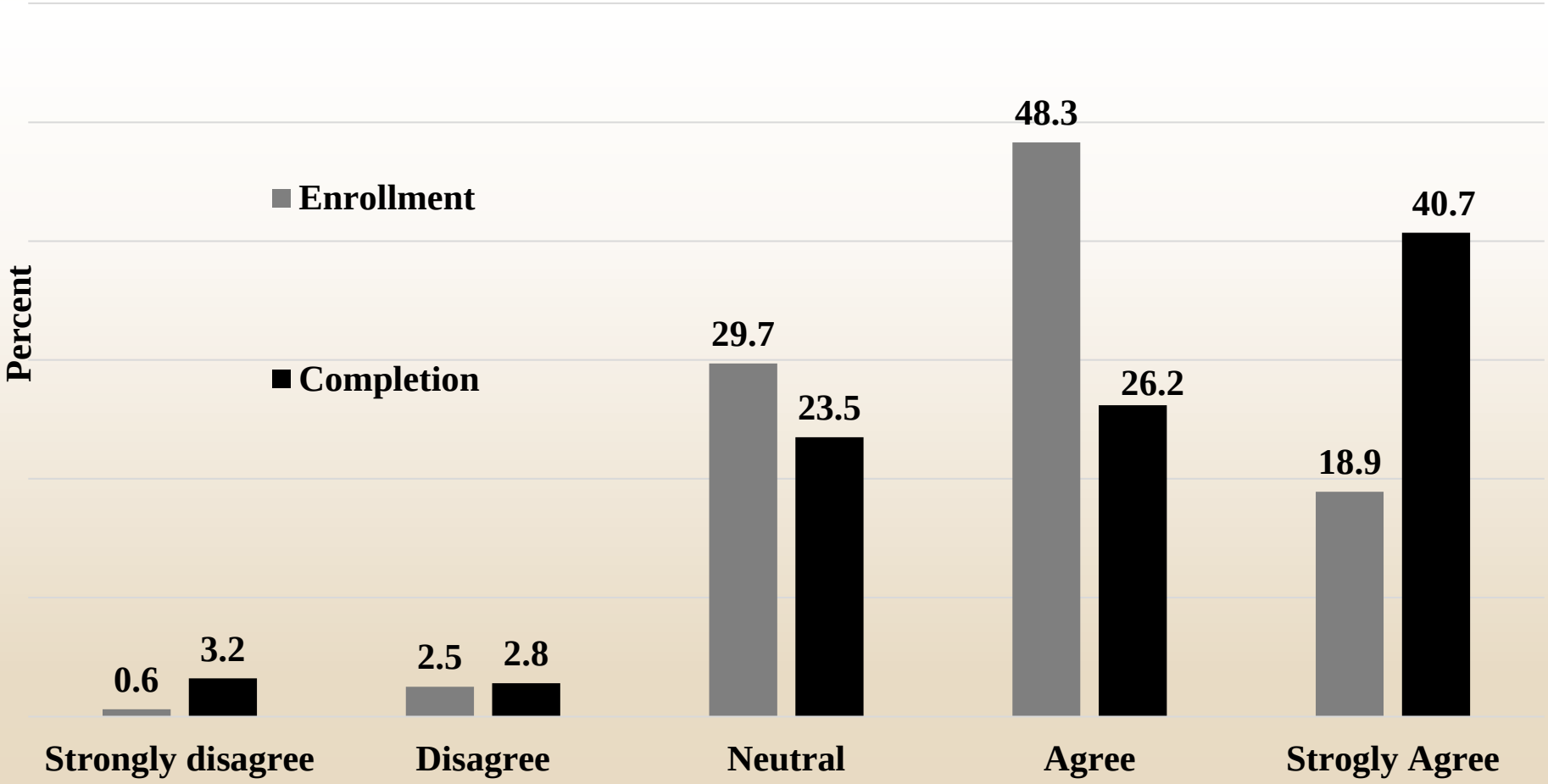


Table 14: Tobacco Intervention Skills at Three Months and Six Months

Skills	Three Month Percent	Six Month Percent
I have none of the skills that I need	0.0	0.0
No, I have some skills, but not enough to effectively help my clients who use tobacco quit.	8.3	15.9
I have a good amount of skills, but I am not sure if I could help my clients who use tobacco quit.	22.9	15.9
Yes, I have most of the skills I need to effectively help my clients who use tobacco quit.	54.1	47.7
Yes, I have all of the skills I need to effectively help my clients who use tobacco quit.	21.4	20.4

Figure 18: Course Evaluation at Three Months and Six Months

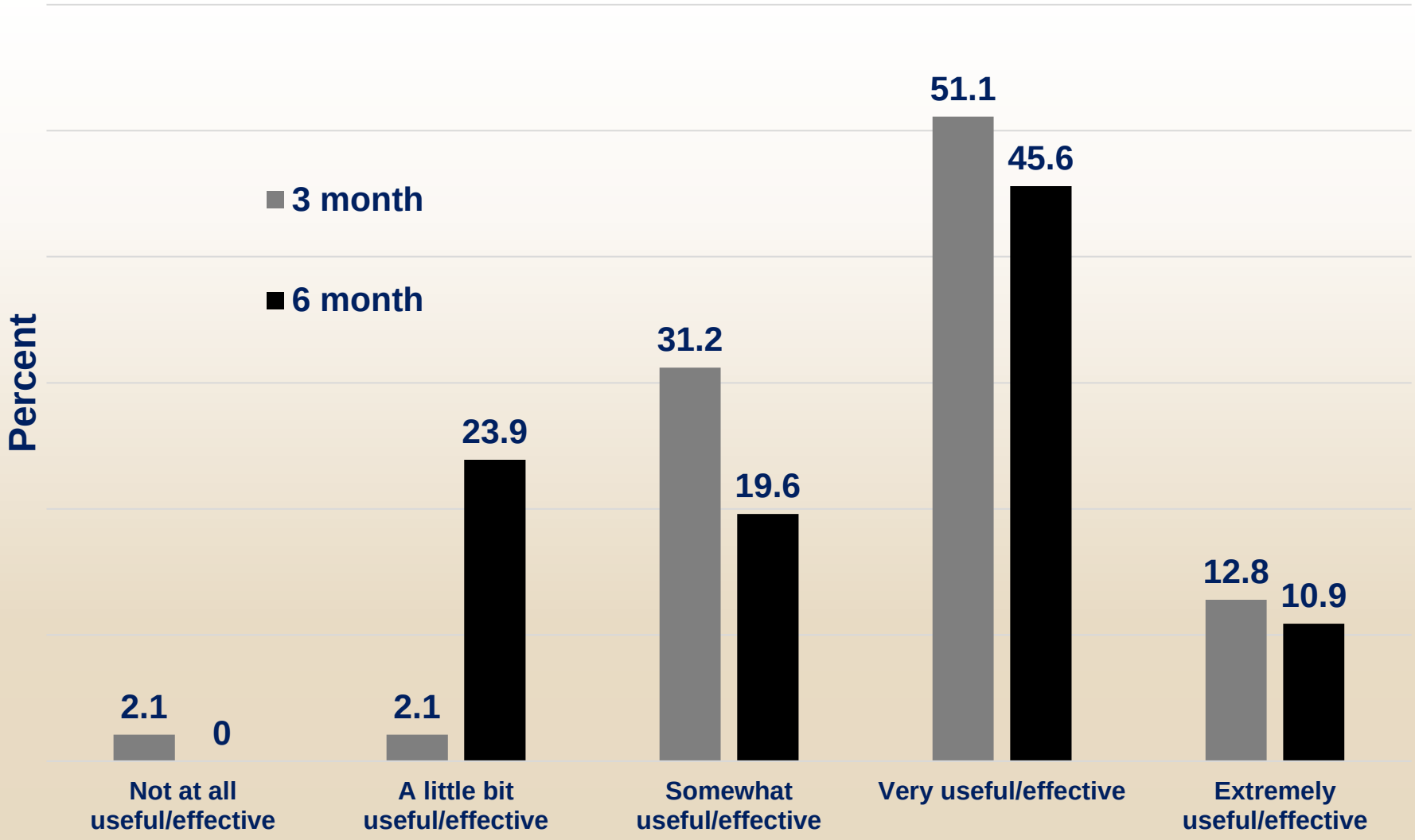


Figure 19: Use of Bucket Approach at Three Months and Six Months

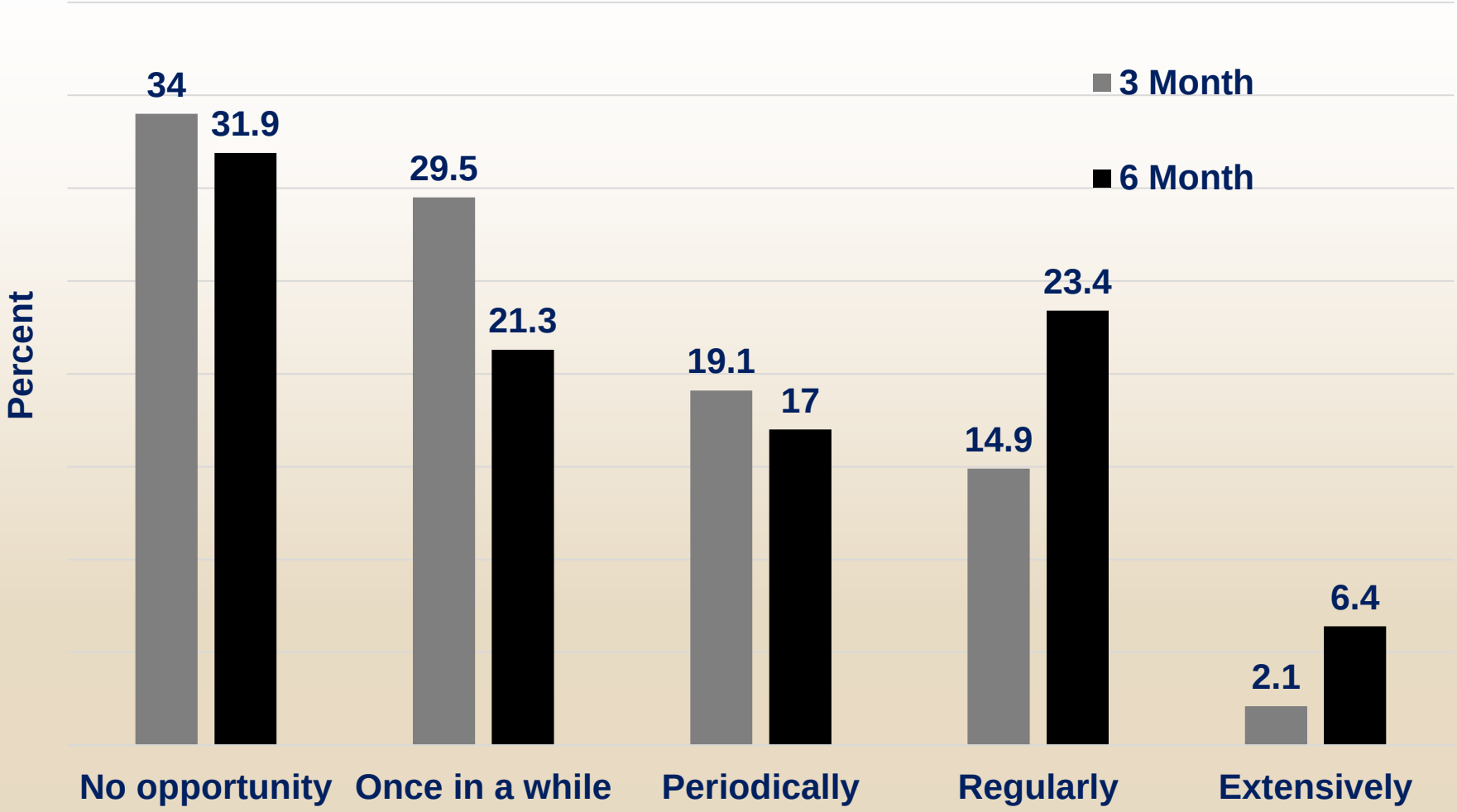


Table 15: Have You Spoken with Others at Your Clinic about the Bucket Approach (Three and Six Months)?

Response	Three Month Percent	Six Month Percent
No, because my clinic does not use the Bucket Approach.	16.7	15.9
No, because no one else at my clinic is trained in the Bucket Approach.	4.2	4.5
No, but not for either of the reasons above.	18.8	15.9
Yes, a little bit.	29.2	43.2
Yes, a fair amount.	20.8	15.9
Yes, a lot.	10.4	4.5

Roadmap

1. Understanding tobacco use by those coping with a mental illness – Bruce Christiansen

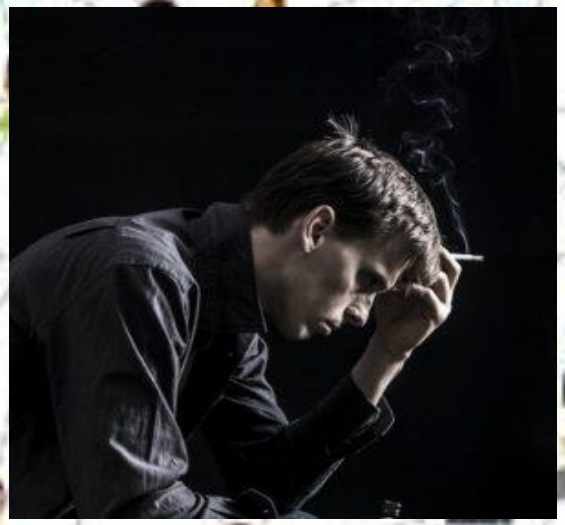
2. Evidence-based tobacco dependence interventions for the general population – Karen Conner

3. The Bucket Approach – Bruce Christiansen

4. **What you can do – Bruce Christiansen**

5. Key Considerations and Resources – Karen Conner

A lot!



Have a Conversation

- **John, I know that you smoke, can we talk about that?**
- **Everyone has a tobacco story. What's yours?**
- **How did it start for you?**
- **Almost everyone has tried to quit. What about you?**
- **Would you like to quit some day (if it were easy and you knew you would succeed)?**

Assess Bucket

Communicate with treatment team; close the loops; know what the person is doing and ask about it and offer support; remain positive – it can be a long journey

Ask permission to talk again

The HUD Smoke-Free Rule: Perceptions of Residents Post-Implementation	Percent of Smokers (n=160)
Change	
Quit	6.4%
Tried to quit	55.6%
Reduced	48.8%
Saw a doctor to get help to quit	26.3%
Used quit aids such as nicotine patch or cessation medicines	21.9%
Called the Wisconsin Tobacco Quit Line	8.8%
Joined Freedom From Smoking	7.5%
Switched to e-cigarettes	5.6%
Joined First Breath program	1.9%
Established a routine of smoking at least 25 feet from the building	35.0%
Made no change	10.6%

Lathen L, Plears M, Shartle E, Conner K, Fiore M, Christiansen, B (2020) The HUD smoke-free rule: Perceptions of residents post-implementation. Pre Med Rep 19:101159 PMCID: PMC 7381686 https//doi.org/10.1016/j.pmedr.2020.101159. PMCID#: PMC32728524

Roadmap

1. Understanding tobacco use by those coping with a mental illness – Bruce Christiansen

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5. **Key Considerations and Resources – Karen Conner**

5. Key Considerations and Resources

Key Considerations: Covid-19 and Tobacco Use

- Cigarette smoking increases the susceptibility to infection and severity of illness among COVID-19 patients
- Desire to quit may be increased due to health concerns from COVID-19
- Use as an opportunity to educate on health effects of smoking and COVID-19 related illness

Source: World Health Organization. COVID-19 and Smoking Scientific Brief. June 30, 2020.

Key Considerations: E-Cigarettes and Dual Use

- More individuals coping with mental illness and/or receiving substance use treatment have tried or are currently using e-cigarettes than the general public
- Most common pattern of use is concurrently using e-cigarettes and combustible cigarettes (dual use)
- Dual use shows higher toxicant and nicotine exposure resulting in poorer health in general, greater difficulty breathing, and worse asthma and COPD outcomes
- E-cigarette use among youth and young adults is associated with progression to combustible tobacco use

Sources: 1) Cummins SE, Zhu S, Tedeschi GJ, et al. Use of e-cigarettes by individuals with mental health conditions *Tobacco Control* 2014;23:iii48-iii53. 2) Stein 2015, Peters 2015, Gubner 2016

Resources

Smokefree.gov

- Text QUIT to 47848
- Mobile apps: Quit Guide and quitSTART

Truth Initiative

- Text DITCHVAPE to 88709
- Mobile app: This Is Quitting
- BecomeAnEx.org

Public Education/Campaigns

- DHS's Tobacco is Changing (tobaccoischanging.com)
- FDA's Real Cost/Fresh Empire (betobaccofree.hhs.gov)

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

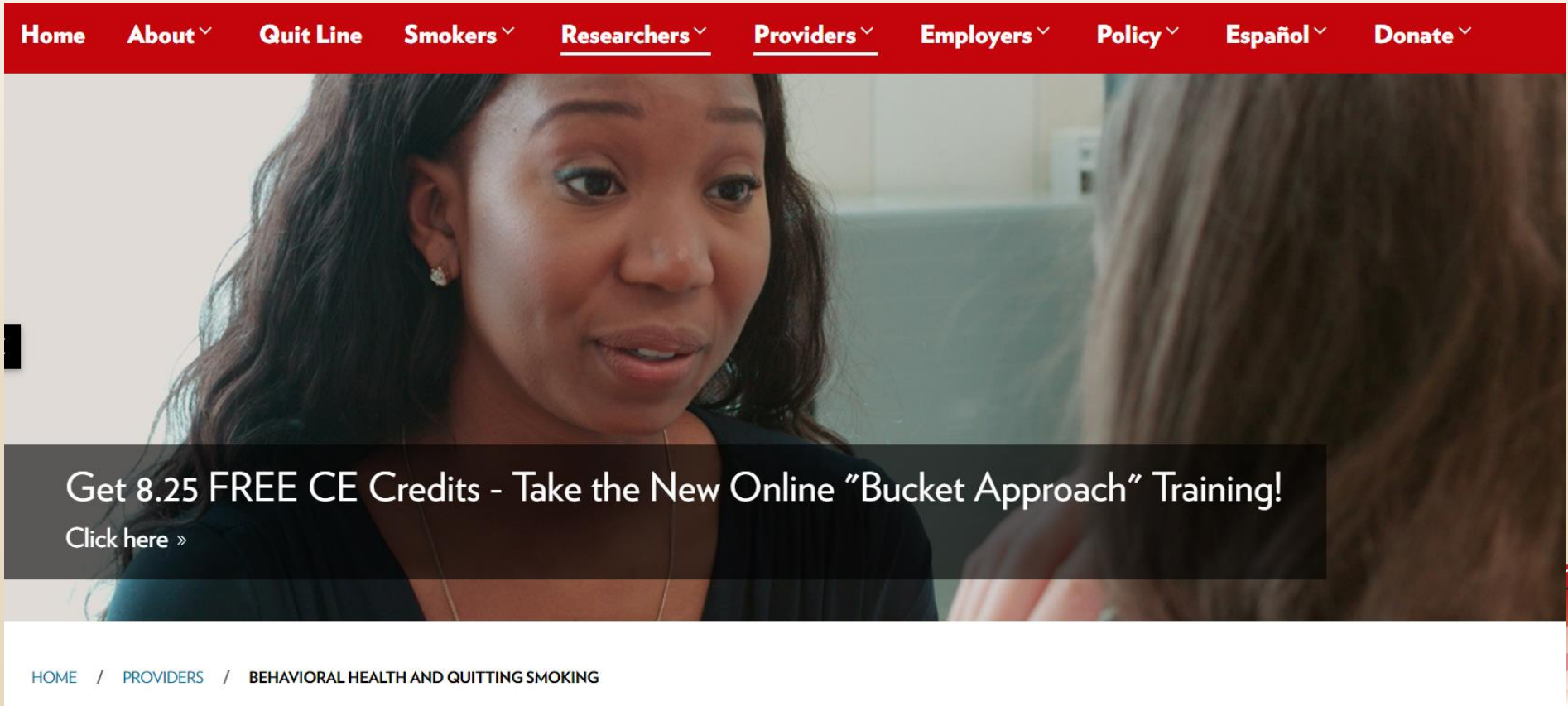
Executive Summary

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.

https://ctri.wisc.edu/providers/behavioral-health/peer-specialists/

Online Training – The Bucket Approach

Go to helpusquit.org
Training is Free
Up to 8.25 CE credits

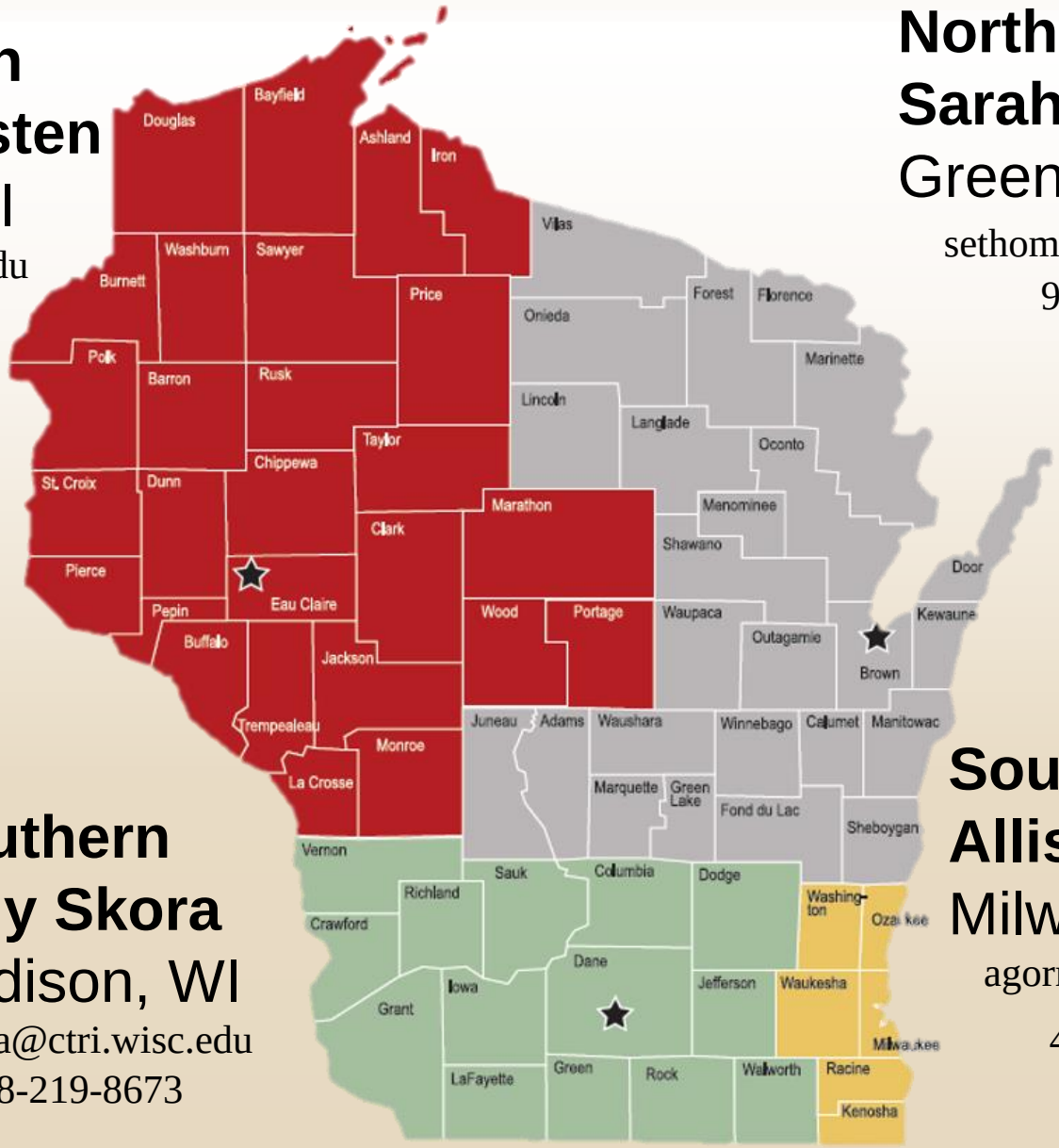


UW-CTRI Training and Technical Assistance

- Education on evidence-based tobacco treatments
- Assistance with Wisconsin Tobacco Quit Line integration
- Developing a comprehensive tobacco policy
- How to help staff quit tobacco
- Resources for staff and clients

UW-CTRI Outreach Specialists

Northwestern
Susan Lundsten
La Crosse, WI
slundsten@ctri.wisc.edu
715-204-8270



Northeastern
Sarah Thompson
Green Bay, WI
sethompson@ctri.wisc.edu
920-370-9358

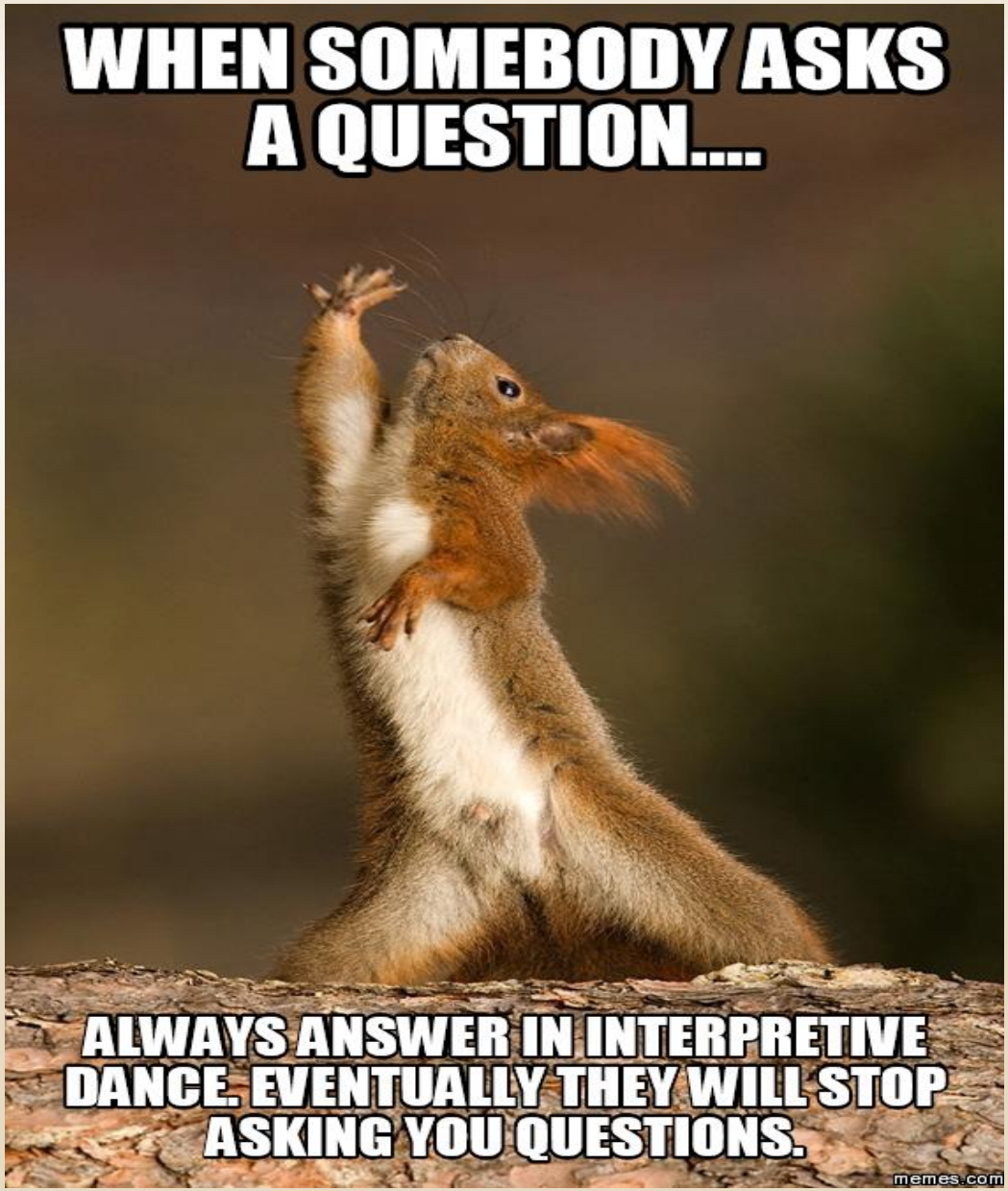
Southeastern
Allison Gorrilla
Milwaukee, WI
agorrilla@ctri.wisc.edu
414-333-3067

Southern
Amy Skora
Madison, WI
askora@ctri.wisc.edu
608-219-8673

UW-CTRI
UNIVERSITY OF WISCONSIN
Center for Tobacco Research & Intervention

UW-CTRI Website

View consumer video, time permitting


WHEN SOMEBODY ASKS A QUESTION....
ALWAYS ANSWER IN INTERPRETIVE DANCE. EVENTUALLY THEY WILL STOP ASKING YOU QUESTIONS.
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