Pfizer Independent Grants for Learning and Change (Pfizer IGLC)
Smoking Cessation Endpoint Report

What, if any, proposed activities were not completed? Briefly describe those activities, the reasons they were not completed and your plans for carrying them out.

Project activities changed somewhat due to adjustments to our training model. We initially planned to include a significant train-the-trainer component. We addressed this component by placing a greater emphasis on dissemination of materials into our existing trainings by providing all trainees with a complete, easily shared compilation of training materials to take back to their agencies. Trainees were given paper and electronic copies of all training materials, including manuals, worksheets, and videos, and encouraged to share those materials with others in their agency who were unable to attend the training. Post-training follow-up surveys indicate that between 57-74% of trainees shared materials with colleagues.

We had hoped that state benchmarks would indicate drops in smoking rates among behavioral health populations over the course of the project. This goal was partially met. In June 2011, the Maryland Leadership Academy for Wellness and Smoking Cessation adopted end of year 2014 targets for reducing smoking prevalence by 20% among adult mental health and substance abuse consumers. Baseline prevalence rates from 2010 for smoking in these populations along with the 2014 target goals established are shown below.

	Mental Health	Substance Abuse
Baseline (2010)	47.8%	71.8%
Target (2014)	38.2%	57.4%

In FY 2014, patients smoking rates** in substance abuse treatment settings were 56.5% for adults, and in mental health treatment settings 47.9% of adults reported smoking. Maryland has recently taken strides to integrate mental health and substance abuse treatment -- both administratively at the state-level, as well as with modifications within agencies to integrate the delivery of treatment services. As a result, the data reporting has shifted to reflect this change. Overall in Maryland, the percentage of adults receiving behavioral health treatment (both mental health and substance abuse) who report smoking during their most recent interview during the preceding 12 months is at 45.6% (April 2015).
***These data are collected by State reporting systems.*

These data suggest a need to strengthen efforts to address smoking among behavioral health patients, particularly by understanding the challenges among those receiving both mental health and substance use treatment, in Maryland. As we continue to support smoke free settings and policy, we offer administrator and staff trainings that address policy and administrative issues regarding incorporating smoking cessation protocols within behavioral health settings. Moving forward, we hope to develop and refine tools that will support the patients' smoking cessation efforts by addressing the issue from both a clinical and non-clinical standpoint.

2. *Briefly tell us about any other unexpected issues, concerns or successes you have had during this reporting period.*

Many factors influence population data; however, the difficulty of treating tobacco use among individuals with comorbid use of other substances is well known. Although most our trainees reported using materials from the trainings with their patients, few trainees were able to establish smoking cessation groups if none were already ongoing. Barriers included administrators' reluctance to devote staff time to a group that might not be well attended and patient commitment to attending group. We have begun providing technical assistance to trainees via telephone to support them in their efforts to address these barriers. We have also begun providing trainings for administrative staff to enhance their capacity to address agency-wide factors (e.g., staff smoking, prioritizing smoking cessation) that might impede more extensive delivery of the BH2 intervention.

We discovered that implementing this comprehensive training was more resource-intensive than we had expected. The materials and training required multiple revisions and pilot testing. We felt it was crucial to develop materials that trainees would find easy to use, flexible, and thorough. In addition, delivering the training required significant training for staff. The extra effort devoted to these issues appears to have paid off; trainees consistently tell us that the materials are information and highly relevant to their clinical practice. We also consistently receive positive feedback regarding the trainers' knowledge and effectiveness.

Another unexpected discovery was the need to develop trainings for administrators and staff. Trainees informed us that agency-wide barriers often interfered with smoking cessation treatment. Staff smoking was often cited as an issue, as were administrative challenges such as devoting limited staffing resources to smoking cessation. As a result, we developed a brief training addressing contextual issues related to agency-wide smoking cessation implementation, which we have conducted at several agencies. In addition

to funding received from Pfizer to develop the BH2 videos, manuals and other materials, and initiate training of providers, the Maryland Behavioral Health Administration (formally Maryland Alcohol Drug and Alcohol Administration) also contributed funding for training. This combined support has enabled us to expand training and dissemination efforts, as well as administrative and implementation assistance to agencies, across the State of Maryland.

Finally, the development of the train-the-trainer component proved to be less feasible than originally foreseen. We initially planned to include a significant train-the-trainer component. We chose instead to emphasize dissemination of materials into our existing trainings by providing all trainees with a complete, easily shared compilation of training materials to take back to their agencies. Trainees were given paper and electronic copies of all training materials, including manuals, worksheets, and videos. The BH2 program kit allows for those who attended our trainings to share the materials with others in their agency who were unable to attend. The kit offers a "plug-and-play" approach, where providers in behavioral health settings who have experience running groups can easily familiarize themselves with the content and examine ways to incorporate the material into their existing practices. MDQuit encourages BH2 trainees to share both the training experience and materials with those in their agency to bolster support and efforts within and across behavioral health treatment settings in the State; a "Champion Packet" was also created to help formalize this effort, and is given to trainees who desire to train clinicians within their agencies. Post-training follow-up surveys indicate that between 57-74% of trainees shared materials with colleagues.

Overall, our efforts focused on creating a comprehensive BH2 program kit which includes a manual and all materials needed to run group or offer individual smoking cessation interventions.

3. ***Is there anything else you want to tell SCLC or Pfizer?***

Funding received from Pfizer IGLC supported the research and development of materials used to train behavioral health providers to deliver single- and multiple session smoking cessation interventions to clients with behavioral health disorders. We created a comprehensive, empirically-supported and flexible array of smoking cessation group interventions programs (i.e., single- and multiple-session) for use by providers in substance abuse and mental health treatment settings. We call this our "Breaking the Habit in Behavioral Health: New Hope for Clients Who Smoke (BH2)" program. This multidimensional and flexible program includes targeted teaching approaches using didactics, role plays, and group discussions; detailed session manuals for providers and client workbooks, worksheets, and handouts; and informational and instructional videos demonstrating unique aspects and challenges found in group treatment. During the latter part of the project period, MDQuit received additional support from the Maryland Behavioral Health Administration to expand training of behavioral health providers and agencies across the State of Maryland. As a result, we were able to extend trainings to all counties in Maryland. In addition, we were able to develop and offer two trainings for agency administrators and staff as part of technical assistance efforts to support trained providers and to emphasize the importance of a comprehensive, agency-wide approach to smoking cessation. The BH2 initiative is on-going and continues to allow us to build capacity for smoking cessation services by overcoming barriers and enhancing the skills of behavioral health therapists, counselors, staff, and also addressing implementation with agency administrators.

As noted in No. 2, it was revealed to us the extent to which agency-wide factors affect dissemination and activation of smoking cessation interventions. We believe this to be an important target for intervention and developed a training and materials component to address this during the project period and moving forward.

We also discovered that trainees benefit from technical assistance following trainings. We began providing technical assistance by telephone to trainees in the months following training. We recognize that trainees sometimes encounter challenges for which we may be able to offer solutions. For example, one trainee noted that patients struggle to maintain motivation long enough to follow through on behavioral changes. In talking with her, we discovered that she was habitually using only a limited number of the tools discussed in the training, thereby limiting her ability to enhance her patients' motivation to change their smoking behavior. After being reminded of the other tools available from the training, she reported that she felt that she would be better able to help her patients. Conversations like these support the importance of personalized post-training follow-up to consolidate trainees' learning and enhance adherence to the intervention.

Moving forward, we plan to examine the feasibility of transposing our in-person trainings into an online format. This process requires a full review of materials to determine what is feasible to provide in an online format (e.g., Brief Interventions are difficult to teach in an online format when participant practice and instructor feedback is needed).