D1. Overall Aim & Objectives: The overall aim of our proposal is to increase tobacco education and smoking cessation training opportunities targeted to staff and administrators working with behavioral health populations. In the long run, we wish to influence the integration of tobacco addiction and recovery into the bio-psycho-social approach necessary to treat people with behavioral health issues. The impact of tobacco use on behavioral health populations can be seen in terms of higher morbidity and mortality, higher rates of relapse to alcohol and drug use, interference with efficacy of medications, and the contribution to common psychosocial challenges, including decreased financial resources and access to housing. Addressing a complex, chronic, relapsing condition such as tobacco dependence takes counseling and intervention skills, as well as a framework that enables health care professionals to maintain empathy, roll with resistance, develop discrepancy and support self-efficacy in clients (Motivational Interviewing). In our experience, without ongoing support and tailored training strategies, behavioral health administrators and clinicians lose focus on tobacco as a critical issue and feel hopeless to foster change in systems and clients.

On-PAR Online Training will be an online training that addresses specific practice/treatment barriers and challenges to integration and implementation of tobacco treatment in behavioral health settings. It will assist behavioral health programs to treat tobacco dependence on par with other addictions treatment. Our key objectives for the project are as follows:

- To develop 2 modules informed by our 18 years of experience providing in-person training, technical assistance and consultation in the Massachusetts Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) system. The 2 modules envisioned are:
    - First, a module that offers strategies for integrating tobacco education and treatment into behavioral health systems, featuring the rationale for treating tobacco dependence in behavioral health populations and evidence-based cessation treatment information, with Motivational Interviewing as the treatment framework. Learning objectives include the following: to review common staff barriers and facilitators for addressing tobacco dependence with behavioral health clients; to identify a research-based rationale for addressing and treating tobacco dependence in people with behavioral health histories; to introduce a bio-psycho-social model of nicotine addiction and recovery; to introduce and apply concepts of the Stages of Change model of behavioral change; to introduce and review motivational interviewing strategies.
    - Second, a systems change/policy development track to assist behavioral health programs in advancing tobacco interventions and integration, and moving toward tobacco-free environments by identifying options for and steps to policy change. Learning objectives will include exploring policy definitions such as “smoke-free” and “tobacco-free” and the implications of each level; identifying specific staff concerns that surface in systems change and how to address them and support managers and staff; reviewing experiences of behavioral health systems and institutions as they have enacted policy change, and their lessons learned.
- To implement, maintain, staff and evaluate the effectiveness of an online education and training program that enhances our existing project by increasing training opportunities for

DPH/BSAS Tobacco Education Coordinators (TECs), and further increases the integration of tobacco education and treatment into other existing behavioral health programs.

- To increase the capacity of other social services and healthcare providers to develop practices and policies to address/treat tobacco dependence in the behavioral health populations they serve. These populations are also affected by high smoking prevalence, HIV/AIDS, Hepatitis C, and other chronic health conditions negatively impacted by tobacco use. For example, we have consulted with and presented to a consortium of Boston homeless services providers, spearheaded by the Boston Health Care for the Homeless Program, who are looking for ways to train staff on and implement policies to reduce the devastating health consequences of tobacco use within the behavioral health population they serve.
- To apply for and award Continuing Education Unit (CEU) and Continuing Medical Education (CME) credits from various disciplines to draw a broad range of participants, with the assistance of AdCare Educational Institute, Inc., a private, non-profit organization in Worcester, Massachusetts. A large portion of the funding AdCare Educational Institute, Inc., receives comes from DPH. Presently, the agency holds a combined contract for the development of statewide trainings, education, and logistics management with BSAS and the Bureau of Community Health and Prevention. Additionally, AdCare also maintains a contract with the DPH Office of HIV/AIDS Bureau for research, training and support services.

In its first 15 months, IHR's online training initiative proposes to reach health care administrators, clinicians and peer recovery specialists working with behavioral health populations in Massachusetts. This will include providers who are involved in focus groups and piloting of early modules. The breakdown of participants includes the following: 60 Tobacco Education Coordinators representing 60 DPH/BSAS program sites (10 per DPH region); 15 BSAS program administrators, such as directors, clinical supervisors, medical directors and other agency management staff; and 30 case managers, peer recovery specialists, and site directors from the Massachusetts Department of Mental Health (DMH) vendor sites, including Community-Based Flexible Supports and the Program for Assertive Community Treatment team. Together, these providers and peer specialists interact with thousands of behavioral health clients and their families annually.

BSAS-funded and licensed provider agencies have a contractual requirement to designate a staff member to be a Tobacco Education Coordinator. IHR's Tobacco, Addictions, Policy and Education (TAPE) Project conducts orientation trainings and ongoing consultation, as well as plans and facilitates twice-annual resource-sharing and training meetings in each of 6 state regions for Tobacco Education Coordinators, though attendance is not mandatory. With over 400 main sites and satellites under BSAS contract, our meetings have averaged 90 people per series since fiscal year 2009. The largest number to attend a series was 115 people in spring 2011. In order to reach a larger percentage of Tobacco Education Coordinators, we must develop and implement other forms of outreach and training, which online training can provide. In Massachusetts, BSAS providers receive training opportunities including distance learning through AdCare Educational Institute and the New England Addiction Technology Transfer and Training Center Network. AdCare has offered distance learning for several years, and has seen increasing numbers of substance use providers sign-up for online courses.

We have found that education and training increases staff buy-in, commitment and actions taken to address and treat tobacco use, as well as program leadership's commitment to implement and support policy change. The impact of this project is that it will further foster the cultural change necessary to integrate tobacco dependence assessment, education and treatment into behavioral health services and outcomes. Tobacco has historically been viewed as a benign substance by behavioral health services systems. Use of tobacco has been promoted as a privilege and a reward for patients and clients, often to reinforce good behavior and provide a rest period or break from usual routines. In Massachusetts, through the leadership of our tobacco control program, the Massachusetts Tobacco Cessation and Prevention (MTCP) program, DPH has de-normalized tobacco use through state regulations, price increases, smoke-free policies, public education, and provision of cessation resources. IHR's TAPE Project has made direct inroads into the behavioral health world through consultation, technical assistance, trainings, presentations, conferences, Tobacco Education Coordinator meetings, policy development, development of resources, access to posters and pamphlets to disseminate positive messages about quitting, and policy implementation and evaluation. Through the auspices of MTCP and BSAS, both DPH agencies, we have distributed free Nicotine Replacement Therapy (NRT) to selected substance use treatment programs. IHR's TAPE Project staff has provided NRT-funded programs with ongoing consultation, staff training and technical assistance to build a treatment infrastructure and supports throughout the agency. In this initiative, NRT is also available to program staff.

The option of online training addresses a tremendous barrier in terms of staff being able to take advantage of training and education opportunities: time. Many of our substance use and mental health treatment facilities are short-staffed and under-staffed; leaving an agency for full-day training is therefore prohibitive due to safety and other program needs. We have also found this barrier of time in reaching Masters-level staff in our outpatient programs, where many staff are paid per diem, making training less of a priority and only allowing for short in-service sessions, i.e., 60 minutes maximum. We have adapted our training services to meet programs where they are, designing and tailoring in-person training into several formats, but believe another option is needed.

D2. Current Assessment of Need in Target Area: From the work begun in the early 1990's by New Jersey's Addressing Tobacco in the Context of Other Addictions Program to the national leadership shown by the Tobacco Cessation Leadership network, Legacy Foundation, Robert Wood Johnson Foundation, the Smoking Cessation Leadership Center, and the Substance Abuse and Mental Health Services Administration, it is clear that mental health and substance use disorder treatment programs and systems can integrate tobacco use policies and tobacco education and treatment activities without adversely affecting access to and retention in treatment. In Massachusetts, steady progress over the past 18 years in the BSAS system has demonstrated success by building the foundation for this work and then employing specific ongoing approaches to support and maintain change. The lasting impact of these policy and treatment components has implications for behavioral health provision and for the health and recovery of staff and clients. Concerns about the perceived dangers of quitting tobacco use for people in recovery have been answered with research on benefits of quitting and development of evidence-based treatments that are also effective for people with behavioral health

conditions. Dr. Judith Prochaska's 2010 commentary in *Drug and Alcohol Dependence,* "Failure to treat tobacco use in mental health and addiction settings: A form of harm reduction?," identifies and disproves many of providers' concerns regarding integrating tobacco use interventions into behavioral health. These historic misconceptions include: tobacco use is less harmful; tobacco use supports abstinence from other substances; tobacco use aids mental health treatment; tobacco use is an effective coping strategy for stress; and quitting smoking leads to decompensation in mental health functioning. The downside of providers' silence and denial of the importance of nicotine dependence in behavioral health populations has been elevated morbidity and mortality among clients and staff, relapse to alcohol and other drugs, and missed opportunities to intervene with a widespread and lethal addiction.

Our model in Massachusetts only partially focuses on policies, such as establishing smoke-free grounds and restricting staff and clients from using tobacco together. Key ingredients in achieving buy-in and success have been ongoing staff training and education; increasing staff effectiveness to provide counseling and peer support and treatment; utilizing staff who have received training to deliver integrated psycho-education and group tobacco education sessions; Motivational Interviewing; a Stages of Change approach that also utilizes an organizational Stages of Change framework; targeted distribution of pharmacotherapy; and supports, follow-up, and monitoring of those attempting to quit tobacco use. Program messages stressing the seriousness of tobacco addiction and offering support for quitting are formalized in assessment and intake tools and individual treatment plans. Asking clients about interest in quitting and following up over time recognizes a change process that occurs and can be telescoped through staff and peer interventions. Clients' interest in quitting was often overlooked or dismissed before there was a standard assessment in place to ask all smokers and tobacco users about their interest in quitting and before accessible evidence-based treatment options were available.

IHR's TAPE Project has been funded to conduct a systems change initiative since 1994. TAPE staff have delivered numerous workshops and other presentations at conferences in Massachusetts and nationally, addressing audiences from the fields of behavioral health, tobacco control, and other areas of public health. The TAPE Project provided consultation to the MTCP Smoker's Helpline clinical director on program development and clinical issues and has provided training to Smoker's Helpline counselors on treating smokers with behavioral health issues. The TAPE Project Director is on the faculty of the University of Massachusetts Medical School's Tobacco Treatment Specialist Core Certification Training Program, and assisted in the planning and development of the Massachusetts Tobacco Treatment Specialist certification process. TAPE provided consultation to DMH sites and providers, as well as provided on-site and regional trainings to clinicians and peer recovery specialists. TAPE has provided extensive consultation to BSAS and has made a significant contribution to the evolution of BSAS's awareness of tobacco use issues in its target populations and the application of that knowledge to the development of policy recommendations. This work assisted BSAS to develop its Tobacco Guidelines, released in 2004, as well as contributed to DPH statewide licensing regulations. The Tobacco Guidelines have effected system-wide policy changes and integrated modality-specific education, assessment and treatment components. In addition, each BSAS program is required to designate a Tobacco Education Coordinator (TEC),

and the TAPE Project staff conduct twice-yearly meetings for TECs in each of the state's 6 regions to provide training, resources, and support.

To monitor status and progress in building substance use treatment programs' capacity to address tobacco use, BSAS has undertaken three surveys of the treatment system, collecting information on policies, strategies, and treatment approaches. In the first two surveys, conducted in 1996 and 2000, respondent agencies identified their stage of readiness and implementation in relation to written policy, tobacco cessation resources and integration of nicotine addiction treatment. More than 200 programs (out of 372 licensed and funded at the time) responded to the third survey, conducted in 2007-2008. Survey responses indicated needs for more targeted technical assistance and capacity-building. This has been evident in ongoing work with the TECs. Due to frequent turnover in the staffing of behavioral health programs, ongoing training opportunities are needed.

In Massachusetts there is one online "Basic Skills for Working with Smokers" course offered through the University of Massachusetts Medical School, but, beyond listing some of the overlap between nicotine dependence and other substance dependence and increased health consequences in smokers with behavioral health issues, it neither targets the complex issues specific to engaging and treating smokers with behavioral health nor addresses strategies for systems change. The "Basic Skills" course serves as a prerequisite to University of Massachusetts Medical School's in-person Tobacco Treatment Specialist Certification 4-day course. BSAS provides scholarships for BSAS program staff to take the online course, and at this time requires it for TECs and clinical directors, but compliance has been limited. On-PAR Online Training would speak specifically to the skills and key messages that should be integrated into BSAS, DMH and other behavioral health settings, and will be an important option for building the behavioral health field's capacity. We have been aware of the excitement in the behavioral health field regarding in-person training: our two most recent statewide TAPE Project conferences drew 130 (2006) and 140 (2012) participants, more than the previous 10 conferences, representing BSAS, DMH programs, MTCP staff, and certified tobacco treatment specialists. In 2011, 50 people signed up for a 1-day "Advanced Issues in Treating Tobacco Dependence in BSAS Programs" workshop, our largest ever workshop turnout.

D3. Technical Approach, Intervention Design and Methods: The content of the online trainings will be constructed based on key messages and themes identified in the focus groups and verified by the feedback received from people who pilot the online modules. This feedback will be gathered through SurveyMonkey online questionnaires as well as through webinars, which will provide a live opportunity to discuss questions. Focus group members and people in the piloting group will be representative of our target audience, behavioral staff and administrators from programs focused on substance use, mental health, HIV/AIDS, and homelessness services. We will utilize the focus groups and piloting processes to inform, test and retest the training content, in order to make it most relevant and useful to our participants.

We will gather feedback using evaluations and discussing lessons learned with our team in order to improve the development process as well as the design and dissemination of the second module. We will use lessons learned from our pilot phase, when we present a pilot training as a webinar or series of webinars (using WebEx or GoToMeeting) to members of the

target audience. All participants will then be asked to complete post-session evaluations to provide input on how the session could be improved. We will use that information to tailor the design, content and language of the online sessions.

Once we have developed all the components and contents of the training, we will put the training onto software from which participants will access the modules. Participants will interact with the modules in the following ways: watch slides, review video, take pop-up quiz questions, and fill out evaluations. They will also be able to access links to other supplementary materials.

We will track specifics on our course registrants through the use of a course management system (also known as a learning management system or virtual learning environment) called Moodle (moodle.org). It is a free web application that educators can use to create effective online learning sites.

Specific roles for the different organizations have been delineated. IHR will manage the project; market the opportunity to the behavioral health field and services serving behavioral health clients, such as HIV/AIDS and homelessness services providers; design learning objectives; develop curriculum for courses; facilitate webinars; identify and outreach to focus group members; work with focus groups and summarize findings; implement Survey Monkey questionnaires and input data received from Survey Monkey questionnaires and participant satisfaction surveys; and analyze data from Survey Monkey and participant questionnaires.

JSI Research and Training Institute, Inc. will collaborate with IHR by gathering formative qualitative feedback through focus groups, develop process and outcome and satisfaction measures, develop online questionnaires, set up tracking to monitor web traffic, and work with IHR to review and interpret formative process and outcome findings toward developing and delivering training. JSI staff will meet quarterly with IHR staff to review data.

AdCare Educational Institute will handle the logistics of registration of participants and collect on-line evaluations from webinar and distance learning participants. In addition, AdCare will research and apply for CEUs and CMEs from multiple accreditation bodies: National Association of Social Workers, Massachusetts BSAS Licensure of Alcohol and Drug Counselors, Massachusetts Board of Substance Abuse Counselor Certification, Licensed Mental Health Counselor, American Psychological Association, Massachusetts Nurses Association, and process and award CEUs and CMEs to participants.

There are several steps that we plan to take in order to sustain On-PAR Online Training after the funding period has ended. First, we will maintain the online training opportunity on IHR's website, and BSAS will provide IHR and AdCare with the needed support to maintain the program. We plan to charge nominal fees for CEUs and CMEs, which will support the ongoing maintenance of the website. In addition, outcome data from the first two years of the program will assist us in increasing the efficacy of the training, and we plan to make it available both statewide, and nationally.

D4. Evaluation Design: Evaluation will draw on formative, process and outcome monitoring strategies and will be implemented as a collaboration between IHR and JSI. Data will be collected and reviewed on an ongoing basis to inform the development of training modules

and, once modules are live, will provide detailed information about who is accessing the modules and what they are learning. Summary data from each of the following evaluation components will contribute to the final project report.

A *formative* evaluation process will gather qualitative feedback through focus groups, toward identifying training needs and tailoring content development to the target audience. Focus group guides will be prepared to test draft learning objectives and key messages, and to assess the baseline knowledge of likely participants. Two focus groups will be conducted by an experienced facilitator and a trained note-taker, and summaries of each focus group will be organized based on identified themes as they respond to key questions.

Process evaluation data will be collected in the form of attendance details for webinars and online training modules as well as web indicators. Webinar attendance will be recorded by asking registrants to complete basic information regarding their name, agency and role during the registration process. Using a combination of note-taking during webinars to gather live feedback, and an online questionnaire afterward, IHR will collect qualitative feedback on presentation style, appropriateness of content and design, knowledge gained, and overall satisfaction. The online survey will be created using SurveyMonkey, which is particularly appropriate for this effort because it automatically generates aggregate summary data in tabular and chart form and as such will be immediately available to IHR to inform module development.

Once the modules are live, attendance will be tracked using the course registration system. Registration data will include the number and characteristics of people that access the training, as well as the number that complete the training. Measures may include the type of provider (e.g., health care program administrator, clinician, peer recovery specialist), and the behavioral health population(s) they serve (e.g., tobacco education, behavioral health, tobacco treatment, homelessness services, HIV/AIDS services). Google Analytics will be used to track and generate reports on web indicators including number of new and repeat visitors, length of visits and individual page visits, user loyalty, downloads, and posts.

An *outcome* evaluation will be conducted for the online training modules. Questionnaires will be set up using SurveyMonkey or using forms within the eLearning application, and participants will be asked to complete the evaluation in order to complete the course and receive continuing education credits. The outcome evaluation will be designed to measure participants' increased knowledge, self-efficacy and skills toward developing policies and practices to address and treat tobacco dependence in the behavioral health populations they serve. Participants will be asked questions regarding specific information that was conveyed during the session, and also to rate how confident they are that they will be able to use what they learned in their professional work. Specific outcome measures may include: increased knowledge of common successes and challenges in addressing tobacco dependence; increased familiarity with specific points of a research-based rationale for addressing and treating tobacco dependence; increased ability to identify pharmacological and behavioral treatment approaches for behavioral health clients; and increased awareness of specific Massachusetts and national resources for help and information.

Participant satisfaction data will also be collected as part of the outcome evaluation, and will ask participants to indicate how well the sessions met their expectations, how useful the sessions were, and how satisfied they were with what they learned during the sessions.

E. Detailed Work Plan and Deliverables Schedule: In months 1-3, the focus group instrument will be developed in conjunction with JSI Research and Training Institute, the evaluators. Focus group participants from among the target audience will be identified and invited to two group sessions, and meeting sites will be reserved. Research will be conducted to update and enhance potential training content for the online modules. Case scenarios will be written for both client and program policy scenarios and supplemental materials will be collected. In March 2013, focus groups will be held in Boston and Springfield, Massachusetts. JSI will summarize themes and key messages. In the next quarter, months 3-6, we will draft key messages and learning objectives for both training modules. Module 1 will be piloted and finalized during months 6-9, and CEUs will be researched and sought for both modules and the webinars. Curriculum development for Module 2 will also occur during months 6-9. The training will be marketed and promoted via in-person presentations and online, and a kick-off webinar to build interest in and enthusiasm for the trainings will be held in September 2013. A webinar participant survey will further inform Module 1 development, and then the module will go live at 12 months. Module 2 will be piloted between 12-15 months into the project and go live in March 2014.

Beginning in December 2012, JSI and TAPE Project staff will meet quarterly to develop and review instruments and share updates, results and data over the course of the funding period. Webinars on specific training topics will be held in May 2014 and December 2014; the 2014 webinar will also review lessons learned from participants and by the TAPE Project over the course of the program. Webinars will be utilized to promote the online trainings. Ongoing feedback and updating of training modules will continue, and lessons learned will be reviewed and shared with the behavioral health field through papers and at conferences.

Deliverables	Schedule for Completion
IHR-JSI quarterly meetings (1.5 hours; in-person and/or conference call)	12/2012, 3/2013, 6/2013, 9/2013, 12/2013, 3/2014, 6/2014, 9/2014 and 12/2014
Develop focus groups instrument	January – February 2013
Identify, invite, and prepare focus group members	January – February 2013
Conduct 2 focus groups	March 2013
Focus groups summary report from JSI	March 2013
Key messages and learning objectives for both modules	March – June 2013
Curriculum/production development, Module 1	March – June 2013
Research/apply for CEUs, CMEs	March – June 2013
Schedule and arrange webinar dates and topics	April – May 2013
Pilot Module 1	June – September 2013

Review and utilize feedback from Module 1 SurveyMonkey questionnaires	June 2013
Promote and market online trainings and webinars	June 2013 and ongoing
Curriculum/production development Module 2	June – September 2013
Develop, promote and hold project "kick-off" webinar	September 2013
Finalize Module 1	September – December 2013
Pilot Module 2	September – December 2013
Module 1 goes live on-line	December 2013
Module 2: evaluate, gather feedback, finalize learning objectives and content of Module 2	January – March 2014
Module 2 goes live	March 2014
Webinar 2 in conjunction with World No Tobacco Day: develop, promote, facilitate	May 2014
Webinar 3: develop, promote, facilitate; review outcomes	December 2014
Outcome evaluation written	December 2014