Evidence-based tobacco dependence treatment support for mental health/addiction patients in Portugal
(Brazil-Portugal Champions Project)

Request ID: 25629313

Abstract

Overall goal: To reduce tobacco-related health disparities among Portuguese with substance use disorders (SUD), by training treatment providers and developing a select cadre of advocates—*Champions*—within the Portuguese SUD treatment system. The project will specifically target the providers and clients of Integrated Response Centers (Centros de Resposta Integrada-CRI) in Portugal.

Target population: We aim to directly train 150 professionals involved in SUD treatment in 15 CRI units, with an average of 10 professionals per unit. In addition, we are going to develop 15 Champions (1 per CRI unit) among these 150 professionals, to advocate for effective tobacco control policy for SUD patients, and also for the general population. We estimate that our intervention can benefit approximately 16,416 smokers, among those who searched for treatment for another SUD in CRI units.

Methods: The planned project consists on (i) *Basic training a*nd (ii) *Champion development*. We are going to offer training utilizing the peer credibility and capacity of the CRI and the expertise of the Clima Clinic. We will also search for and make use of key stakeholders and peer leaders from the CRI to broaden information distribution and follow-up avenues; expand expertise; and maximize data collection capability.

Assessment: Our evaluation design will use Moore's analytic framework to assess learning outcomes. Following this rationale, we plan to collect data from (i) Champions, (ii) other members of the clinical staff and (iii) CRI units (aggregated individual data), using the first five Moore's levels: 'Participation'; 'Satisfaction'; 'Learning – Knowledge'; 'Learning – Competence'; and 'Performance'.

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C. Reviewers Comments

"Please provide more information on the partners in Portugal and confirm their commitment to, and planned engagement in this project. Also, please include evidence to support applicant's prior successful track record with previous projects."

1. Information on the partners in Portugal/Commitment and engagement in this project

The Project Lead (PL), Dr. João Mauricio Castaldelli-Maia, initiated the contact with partners in Portugal through a presential meeting in Brazil with representatives of the Portuguese Society of Psychiatry and Mental Health (SPPSM): Dr. Antonio Pacheco Palha, former president of SPPSM; and Dr. João Marques Ribeiro, Professor at the Faculty of Medicine of Porto. At that time, Dr. Castaldelli-Maia presented to them the current proposal. Then, the Portuguese representatives connected the PL with Dr. João Andrade Ribeiro, Technical Coordinator of the West Lisbon Centro de Resposta Integrada (CRI), which is part of the Divisão de Intervenções e Comportamentos Aditivos (DICAD). Our project was very well received by Dr. João Andrade Ribeiro (please find the email enclosed). Dr. Ribeiro connected Dr. Castaldelli-Maia with Dr. Joaquim Fonseca, Coordinator of the DICAD. Dr. Fonseca is the Superintendent of various CRI units in Portugal. The DICAD is responsible for coordinating CRI units in Portugal. Since then, Dr. Castaldelli-Maia have had several telephone calls with Dr. Joaquim Fonseca, who promised to facilitate the realization of the current project by contacting the coordinators of the National Programme of Tobacco Control of Portugal. Dr. Joaquim Fonseca promised to send us a formal letter of support to the realization of our project by the next weeks. Once we receive it, we will send to the Global Bridges Executive Team. Please find attached his Email of support to our project.

2. Evidence to support applicant's prior successful track record with previous projects

Firstly, we would like to mention that the reviewers will find in the main section of this project more detailed information on the successful training project we have been carrying out in Brazil since 2014, led by the PL of the present proposal (please see items 2.6 and 4.2). In addition, we describe in the PL's CV, his executive capacity as a leader in various multinational projects in SUD and Tobacco field, which involved professionals from countries in Europe and the United States.

Finally, we are happy to have incorporated in our project the presence of a Senior Advisor with extensive experience in smoking treatment for patients with SUD - Kim Richter, MPH, PhD - who has been leading several training projects in this area in several countries, including Portugal. Besides having extensive experience in the field, Dr. Richter also has domain of the Portuguese language, because of her previous projects in Brazil and Portugal.

D. Main Section

1. Overal Goal & Objectives:

The overall goal of the Brazil-Portugal Champions project (BP Champions) is to reduce tobacco-related health disparities among Portuguese with Substance Use Disorders (SUD)*.* BP Champions will achieve this by training treatment providers and developing a select cadre of advocates—*Champions*—within the Portuguese substance abuse treatment system. The project will specifically target the providers and clients of Integrated Response Centers (Centros de Resposta Integrada--CRI) in Portugal.

This goal aligns with the focus of the RFP and the goals of the Clima Clinic (applicant organization). The RFP seeks to build treatment capacity, improve clinical outcomes, and improve health outcomes. The RFP specifically encourages collaborations across countries and regions. The Clima Clinic has the mission of (name mission of Clima Clinic and your current Global Bridges project). By extending its successful Global Bridges funded project to Portugal, the Clima Clinic will partner with another country in a new global region to expand capacity to treat tobacco dependence in behavioral health care settings. The BP Champions project will create a bridge across two very different countries that share a common language, and create a pipeline for sharing expertise and innovations as they emerge in both countries.

The goals of the current proposal, which aligns with the focus of the RFP, are the following:

(i)   Increasing number of behavioral healthcare providers among CRI clinical staff
(ii)   Improving their knowledge and awareness of tobacco cessation treatment resources;
(iii)   Changing administration and staff attitudes towards the use of tobacco in the substance abusing population and increasing provider receptivity to integrating evidence-based tobacco cessation practices;
(iv)   Integrating effective tobacco dependence treatment protocols into substance use healthcare system;
(v)   Enabling access to smoking cessation information and assistance for those in substance use disorder recovery; and
(vi)   Creating and mobilizing a network of Portuguese behavioral health champions to advance evidence-based tobacco dependence treatment and advocate for effective tobacco control policy, as a part of the Global Bridges (GB)

The key objectives of BP Champions are the following:

(i)   To adapt, in consultation with Portuguese collaborators, the Brazilian Clima Clinic training to the context and resources of substance abuse treatment in Portugal
(ii)   To recruit 15 of the 22 CRI units that are geographically distributed across Portugal to participate in B-P Champions

(iii)   To train at least 150 substance abuse treatment professionals in tobacco dependence treatment and tobacco control advocacy (at least 10 professionals per CRI unit)

(iv)   To provide advanced training and support to 15 Champions from this group (1 per CRI) who will maintain the Portuguese network and launch future Portuguese training and advocacy initiatives

(v)   To increase the number of Portuguese GB members, establishing a Portuguese network of smoking treatment linked to the other Portuguese-language speakers of the GB network (mainly Brazilian).

(vi)   In collaboration with the 15 BP Champions, to transform CRI administration and staff attitudes towards tobacco use and the treatment of tobacco dependence

(vii)   In collaboration with Champions, to integrate evidence-based tobacco treatment office systems into their CRI units

(viii)   To increase participants' and Champions knowledge and awareness of Portuguese and global trends in tobacco cessation treatment and tobacco control;

(ix)   To assist participants and Champions in optimizing programs, policies, and practices in Portugal to fully implement FCTC Article 14 objectives

2. Current Assessment of need in target area

2.1. Prevalence

Portugal has a high prevalence of daily smoking (23.6%) for both men (31.7%) and women (15.9%) (Ng et al., 2014). In addition, Portugal was the one of the countries that experienced statistically significant increases in women's smoking between 1980 and 2012 (Ng et al., 2014). There is no Portuguese data to show smoking prevalence in individuals with SUD disorders. However, from the global estimates, we can infer that this rate should be 2-4 times higher than in the general population (Evins et al., 2015). Interestingly, around three-quarters of Portuguese smokers report that they would like to quit smoking if they could do so with help (Balsa et al., 2014). Thus, it is necessary to increase the availability of smoking cessation treatment, especially for the more seriously affected, such as those with SUD disorders (Castaldelli-Maia et al., 2013).

2.2. National tobacco control policies

The WHO Framework Convention Alliance for Tobacco Control (WHO FCTC) was signed by Portugal in January 2004, approved in November 2005 and entered inforced in February 2006. The Law 37/2007 has been created, intended to implement the contents arranged in WHO FCTC establishing "standards for the protection of citizens from involuntary exposure to tobacco smoke and measures to reduce demand related to dependence and cessation of consumption." In this context, smoking was considered a public health priority problem in the Portuguese National Health Plan 2012-2016, thus justifying the creation of the Portuguese National Plan for Tobacco Control 2012-2016 (PNCT) by the Ministry of Health. With this program, the Portuguese government intends to outline the main intervention strategies and create conditions for their effective implementation, monitoring and evaluation of tobacco control, with reference to the WHO FCTC and the Ottawa Letter. The main topics of the Ottawa Letter refer to: the definition of public policies that promote the prevention and control of

smoking; decreased social acceptability of tobacco use; strengthening community action around smoke-free environments; promoting literacy and empowerment, individual and collective, regarding prevention and smoking cessation; and reorienting health services to a more effective response to the needs of smokers.

2.3. National smoking treatment guidelines

The PNCT aims to encourage smoking cessation in the context of the priority national programs, in particular those relating to pregnancy, young teens, cancer, respiratory and cardiovascular diseases, diabetes and mental health disorders. However, the PNCT is almost entirely focused on primary care. There is an incentive for articulation with other levels of health care through the Regional Health Administrations (ARS), Health Centre Groupings (ACES). In addition, the PNCT provides an inter-sectorial integration with the National Educational Health Program, the National Program of Oral Health, and the National Program of Occupational Health. However, there is no specific program for treatment of smoking in patients with SUD. Unfortunately, there is mention to the CRI anywhere in the PNCT, being CRI the key location for the treatment of SUD in Portugal. Therefore, in Portugal as well as in Brazil, there is no specific policy to control smoking in people with SUD.

2.4. The unique context of Substance Use

Portugal has a unique policy towards drug use, in which possession is a minor infraction, not a major crime. Thus, Portugal is a strategic location for interventions for people with SUD. In the late 90s, the Portuguese government invited a committee of experts from different areas, to prepare a detailed report of the situation and at the same time, contained recommendations of various kinds that could shaping for the first time, the development of a comprehensive intervention strategy that guide any intervention in SUD, in a consistent and sustained manner. So it is approved by the government, through the Resolution of the Council of Ministers 46/99 of 22 April, the first National Strategy for the Drug Use Control and SUD Treatment for the 1999-2004 period. It started a new cycle in the Portuguese policy on drugs and SUD. In addition to other extremely important measures of the major changes introduced by the National Strategy, the most emblematic have been the decriminalization of the consumption of all psychoactive substances through the approval of the Law 30/2000 which defines the legal framework applicable to the use of narcotic drugs and psychotropic substances and health and social protection of people who consume such substances without a prescription. Later in the Decree-Law 130-A/2001 allowed drug use, acquisition and possession for personal use. To enforce this new law, it were created Committees for the Deterrence of Addiction, which have replaced the criminal courts as the State's response to drug use. These committees, consisting of a technical college of health and justice, but always chaired by the health, seek to inform people and dissuade them from using drugs. They have also the power to impose administrative sanctions and refer people for treatment, always with their consent. However, the approach to facilities in Portugal, was not only the decriminalization of drug use. In addition, to strengthening all existing intervention in the areas of prevention, treatment and rehabilitation, it were created under the Decree-Law 183/2001, responses in the area of risk reduction and harm reduction (RRMD), such as, Street Teams, Support Offices, opioid substitution programs of low threshold requirement, Home centers, shelter centers with the

presence of health teams specialized in SUD and Contact and Information centers that today constitute the National RRMD Network.

2.5. Current National Drug Use Policy

In 2004, Portugal proceeded to the internal and external evaluation of the National Strategy for the Drug Control and SUD, as well as the beginning of the design of a new strategic cycle 2005-2012. This evaluation resulted in recommendations, which have been taken into account in the drafting of the 2012 National Strategy for the Drug Control and SUD. However, it remained as the main reference principles set out in the 1999 Strategy, in particular the principles of humanism and pragmatism, have been included in the principles of centrality citizen of territoriality and integrated responses. The main changes made were to strengthen the coordination and integration of responses at the local level that assumes greater expression. Maintaining a logical proximity to the community, all the intervention work on the premises was being developed, by creating a network of integrated and complementary responses to the phenomenon of the use and abuse of psychoactive substances on a territorial basis advocated by the *Integrated Response Centers (CRI)*, which are constituted with local intervention units operating in nature, referred to a defined territory and having specialized technical teams to the various areas of SUD intervention, namely, treatment, prevention, rehabilitation and RRMD. It is also of note that, the key role that these units have taken in the community, providing in-depth knowledge of the needs, the mobilization of existing resources and the structuring of appropriate responses to the specific characteristics of their territory. In 2014, the CRI have gone through a process of adaptation for improving their quality in the services provided to citizens, coordinated by the Working Group for Quality, a part of the Portuguese Service Intervention in Drug Addiction (SICAD). They evaluated together with the General Health Directorate Department of Quality in Health (DGS/DQS) that the CRI units were the Quality Standards for the treatment of SUD in Portugal (SICAD, 2015). However, no intervention focused on smoking has been planned in the Action Plan for Reducing Additives Behaviors and Dependencies 2013- 2016 (SICAD, 2013).

2.6. Comparing Portuguese and Brazilian situation

Despite the availability of treatment for regular smokers through large national programs (such as the INCA and PROAD programmes) in Brazil, the population of SUD patients has received little help to combat smoking. Recent Brazilian studies show that success rates in quitting smoking and retention in the treatment are at least comparable to the general population (Castaldelli-Maia et al., 2013; Castaldelli-Maia et al., 2014), since the treatment of smoking is incorporated into ongoing treatment for mental disorder or other addiction. Considering this, units of specific outpatient treatment for treatment of mental disorders and addictions are strategic locations for such processing. However, in Brazil and in several other countries, such units that are engaged in the fight against smoking are the exception. Psychosocial units (CAPS - Centros de Atenção Psicossocial) promote public comprehensive care for people with severe and persistent mental disorders in Brazil (Mateus et al., 2008; Miranda & Campos, 2008). Psychosocial units for alcohol and drugs (CAPS-AD) are specifically designed for individuals with substance use disorders (Castaldelli-Maia et al., 2013; Castaldelli-Maia et al., 2014). Brazilian CAPS-AD are the similar of CRI in Portugal. They have staff from multiple professions, and

represent interesting locations for treating smoking addiction. Almost all of the recommendations made in previous studies (Hitsman et al., 2009; Morisano et al., 2009; Aubin et al., 2012) with focus on smoking treatment for patients with mental health and addiction disorders, could be implemented in CAPS-AD/CRI. Because CAPS-AD/CRI staff teams include professionals specialised in mental health and addiction disorders, it is possible to perform smoking cessation treatment integrated with ongoing psychiatric and/or addiction treatment. Professional care is available during business hours for any clinical demand from patients who are undergoing smoking treatment and other regular treatments, as recommended in recent studies for smoking cessation patients with mental health and addiction disorders (Hitsman et al., 2009; Morisano et al., 2009; Aubin et al., 2012). Up to date, our team trained the staff of 14 CAPS units within Brazilian 10 cities – which included 184 health professionals - that have not been running specialized treatment for smoking. This project enabled the implementation of a smoking treatment protocol in at least 1 CAPS unit in each of the 5 Brazilian administrative regions.

2.7. Implementation issues
There are 22 CRI units geographically distributed within the Portuguese territory: Algarve; Aveiro; Baixo Alentejo e Alentejo Litoral; Braga; Bragança; Castelo Branco; Coimbra; Évora, Oeste; Leiria; Lisboa Ocidental; Lisboa Oriental; Península de Setúbal; Portalegre; Porto Central; Porto Ocidental; Porto Oriental; Ribatejo; Viana do Castelo; Vila Real; Viseu; Taipas. According to the last Portuguese General Population Survey on Drug Use (Balsa et al., 2014), the CRI units are not sought for tobacco dependence treatment, which is not the case with other drugs. Among alcohol users, almost 10% sought help to treat alcohol dependence at the CRI. Depending on the drug concerned - cannabis, cocaine, ecstasy, or heroin - some 20-37% sought help at a CRI unit (Balsa et al., 2014). Not surprisingly, the CRI units do not run tobacco dependence treatment, such as the majority of the addiction care units around the world.

2.8. Statement of need
Considering the high prevalence of smoking, high smoking rate in patients with SUD, and the absence of a specific treatment policy for smoking cessation in patients with SUD in Portugal, we aim to conduct a project on: (i) capacity building and (ii) advocacy development with professionals of the CRI. Because of the decriminalizing of drug use of in Portugal, this country is a unique place for holding a smoking design approach in patients with SUD. We intend to use the experience of our CAPS-AD professional training project in Brazil (capacitiy building), adding the Champions training – selecting them among all trained professionals - to further advocate for effective tobacco control policy in patients with SUD and also in the general population in Portugal. Our team aims to fill this gap by conducting a series of educational interventions with the CRI teams, to trying to illustrate the importance of smoking cessation treatment for SUD patients, and expanding the Portuguese Global Bridges network (currently only 25 members). The smoking cessation treatment available to the general population in Portugal has so far only been offered in primary care and general hospitals. Unfortunately, the Portuguese tobacco control plan for 2012-2016 does not specify a specific place for the treatment of smoking in Individuals with SUD (Nunes et al., 2013). We think there are many potential strengths in the

Portuguese SUD treatment system-once you change providers' attitudes / beliefs, there is good potential for sustainability and wide dissemination spread.

3. Target audience

3.1. Health Professionals
We aim to directly train 150 professionals involved in substance abuse treatment in 15 CRI units, with an average of 10 professionals per unit.

3.2. Smokers
Unfortunately, there is no data on smoking prevalence in patients being treated for any other substance use disorder (SUD) in CRI units. However, we can infer this prevalence based on a recent survey conducted in Portugal (Balsa et al., 2014), taking into account: (i) lifetime substance use; (ii) search for treatment; and (iii) search for treatment in CRI units. Making use of a classic paper (Morisano et al., 2009), that shows the percentage of smokers among people with another SUD, we estimate that our intervention can benefit approximately 16,416 smokers, among those who searched for treatment for another SUD.

Table 1. Estimated number of smokers not receiving cessation aids among those with alcohol and drug disorder attending a CRI, 2012.

	Portugal Population (15-64 years)*	Lifetime Users (%/n)*		Seek Help (%/n)*		Seek CRI (%/n)*		Smokers (%/n)**	
Alcohol	8113212	73.6	5971324	0.7	41799	9.4	3929	67.9	2668
Cannabis	8113212	9.4	762642	2.8	21354	36.8	7858	67.9	5336
Cocaine	8113212	1.2	97359	17.7	17232	20.7	3567	67.9	2422
Ecstasy	8113212	1.3	105472	8.9	9387	37.7	3539	67.9	2403
Heroin	8113212	0.6	48679	42.9	20883	25.3	5284	67.9	3587
Balsa et al., 2014								**Total**	16416

Balsa et al., 2014

**Morisano et al., 2009*

4. Project Design & Methods

4.1. Planned project:
Basic training. The main focus of the BP Champions Project will be to offer training utilizing the peer credibility and capacity of the CRI and the expertise of the Clima Clinic. The BP Champions Project will also search for and make use of key stakeholders and peer leaders from the CRI to broaden information distribution and follow-up avenues; expand expertise; and maximize data collection capability, to accomplish the overall aim of improving the health and wellness of the Portuguese by increasing tobacco cessation among individuals diagnosed with SUD who receive treatment in a CRI.

Champion development. We are going to develop Champions to advocate for effective tobacco control policy in Portugal. The Champions Training will be carried out after all the Basic

Trainings, and will follow the Johns Hopkins Bloomberg Medical Tobacco Control Certificate, adapted to the Portuguese context:

- Review the history of tobacco use and the tobacco epidemic;
- Identify the types and sources of tobacco control evidence including surveillance data, epidemiological studies, intervention research, and program and policy evaluation;
- Describe the specific activities, strategies and methods that have been undertaken to reduce tobacco use in the Portugal and countries around the world;
- Discuss, compare and critique current global tobacco control efforts and strategies;
- Apply epidemiological, quantitative, and qualitative research and evaluation methods to specific tobacco control topics;
- Discuss theories of change and how they apply to tobacco control at individual, organizational and societal levels;
- Recognize and describe communication approaches that are currently used to educate and inform individuals, communities and countries concerning tobacco control;
- Practice specific methods and approaches to improve leadership and management of tobacco control interventions;
- Discuss tobacco industry strategies to undermine tobacco control interventions as well as apply specific techniques to use the on-line tobacco industry document libraries.

4.1.1. Stakeholder and Peer Leadership Involvement:
Firstly, key stakeholders and key treatment leaders from CRIs will be identified and recruited to serve on a workgroup (the CRI workgroup). The "CRI workgroup" will include 8 CRI professionals from several levels in the treatment system. Then, we aim to work with the CRI workgroup to adapt the Brazilian training - which has been delivered in Brazil to CAPS-AD professionals – to CRI professionals (please see below the item 4.1.2). We are going to perform a smoking cessation treatment knowledge/skills gap analysis with this group, assessing the learning needs for CRI units' staff. The expertise of this workgroup in the day-to-day routine of the CRI units and the results of the gap analysis will be added to the expertise of the Clima Clinic in smoking cessation treatment among SUD patients. As such, a training plan will be created, determining promotional messages targeting both clients and staff, and selecting best practices for CRIs education/training. After that, we are going to work to the CRI workgroup to create the "Champion" training. During the regular training among 150 CRI professionals (item 4.1.2) we are going to select candidates for Champion training. Criteria include commitment, multidisciplinary (physicians, nurses, administrators), and leadership qualities.

4.1.2 Training:
This is the main focus of the project. Clima Clinic staff will hold two types of training:
1) Champion training (described above) and;
2) Clinical staff basic skills training. This training will address the need to change provider attitudes, increase knowledge and develop skills to integrate evidence-based tobacco cessation treatment into CRIs, being customized for physicians (more focused on pharmacotherapy) and licensed healthcare professionals (more focused on behavioral therapy).

The training content and materials will be developed based on the U.S. guidelines for smoking cessation treatment (AHRQ, 2012), the latest information for the treatment of smoking in MHA patients (Evins et al., 2015) and the ATTUD competences (ATTUD, 2005). This content will be adapted to best meet CRI unit needs, after discussion with the CRI workgroup. As the training aims to increase knowledge and develop skills, a mixed approach with lectures, small-group discussions and role-plays will be employed. Global Bridges membership will be strongly supported for all the Portuguese health professionals trained, in order to facilitate further information dissemination.

4.1.3. Information Dissemination (ID):
Via direct email, E-newsletters & meetings, the project will distribute educational messages and recovery materials and existing media and educational resources, making use of the Portuguese language version of the Global Bridges website.

4.1.4. Technical Assistance (TA):
This will address provider resistance and improve knowledge. The opportunity to consult one-on-one with peers, and experts from Clima Clinic will be built into the project. It will impact the outcome by personally addressing concerns, suggesting solutions and ways to overcome barriers. This method will also help sustain the project going forward through peer- and trainer-support.

4.1.5. Data Collection (DC):
Currently the information collected at CRIs on tobacco use and treatment is minimal. Efforts will be made at CRIs to improve data collection for tobacco cessation activity and outcome purposes.

4.2. Ongoing Project
This project builds on an existing project that supports smoking cessation treatment for SUD patients in Brazil (Castaldelli-Maia et al., 2013; 2014). There are few groups in the world engaged in the implementation of the WHO FCTC Article 14 for that sub-population. The PL (JM Castaldelli-Maia) has been leading a GB/Pfizer grantee project to increase the number of CAPS (*Centro de Atenção Psicossocial* or Psychosocial Care Center) units that perform treatment for smoking in all five Brazilian regions, through the training of professionals in these units.
Up to now, this project has trained 186 health professionals (including 19 managers within them), around 75% female, 50% aging 30-39 years, among those:
- 32 Doctors
- 38 Psychologists
- 48 Nurses
- 21 Pharmacists
- 15 Social Workers
- 6 Dentists
- 25 Other professionals

Up to now, we trained staff from 17 CAPS units from four of the 5 Brazilian regions:

- CAPS-AD Continente (Florianópolis, South region)
- CAPS-AD Guará (Brasília, Middle-West region)
- CAPS Infantil Manaus (Manaus, North region)
- CAPS Sul (Manaus, North region)
- CAPS Iranduba (Iranduba, North region)
- CAPS-AD Manacapuru (Manacapuru, North region)
- CAPS-AD Mané Garrincha (Rio de Janeiro, Southeast region)
- CAPS-AD Cachoeirinha (São Paulo, Southeast region)
- CAPS Alvarenga (São Bernardo do Campo, Southeast region)
- CAPS Farina (São Bernardo do Campo, Southeast region)
- CAPS 3 Centro (São Bernardo do Campo, Southeast region)
- CAPS-AD Centro (São Bernardo do Campo, Southeast region)
- CAPS-AD Norte (Natal, Northeast region)
- CAPS-AD Leste (Natal, Northeast region)
- CAPS Infantil Natal (Natal, Northeast region)
- CAPS 2 Oeste (Natal, Northeast region)
- CAPS 3 Leste (Natal, Northeast region)

Among these CAPS units, 50% have already reported on the implementation of tobacco dependence treatment for SUD and/or Mental Health patients.

The main problems faced were:
- Resistance to treat smoking in addiction/mental health care units;
- Resistance to the implementation of cognitive-behavioral therapy (CBT) (psychodynamic therapy and harm reduction as preferred);
- Treatment for smoking is already implemented in primary care network (but the general practitioners do not feel confortable in treating MHA patients);
- Resistance to the use of medication in addiction treatment (a huge preference for psychotherapy and psychosocial approach).

In addition, the main lessons learned were:
- Give clinicians an opportunity to explore how they feel/think about treating their clients' tobacco dependence before diving into how to do it;
- Avoid the red flag term of CBT and focus on "supportive" counseling;
- Include in training professionals who aren't so tied to psychoanalysis;
- Discuss the strengths that CAPS units have in helping their smokers quit.

During this project we have the opportunity to get input from several experts on smoking cessation treatment, such as:
- Kim Richter, MPH, PhD, KU Medical Center, University of Kansas
- Jill Williams, MD, Division of Addiction Psychiatry, Rutgers Robert Wood Johnson Medical School
- Montezuma Pimenta, MD, MSc, Institute of Psychiatry, University of São Paulo

- Martin Raw, PhD, UK Centre for Tobacco Control Studies, University of Nottingham

Finally, we had the opportunity to present the results of our project in the 2016 SRNT Annual Confernece in Chicago last March, and also in the APAL-WPA meeting in Bogota last February (APAL = Latinamerican Psychiatry Association / WPA = World Psychiatry Association), where the PL could advocate for the implementation of smoking cessation treatment for Mental Health/Substance Use Disorder patients in Latin America.

4.3. Innovation

Portugal is the only Portuguese-speaking country in Europe. Although the Portuguese have a good level of proficiency in English, Portuguese-language training would be the ideal way to convey the highest level of knowledge and skills. Spain tends to receive more health focused educational interventions than Portugal, probably due to its larger population. However, Portugal has about 2.5 million smokers (Nunes & Narigão, 2014). More importantly, as in the majority of European countries, no special attention is given to SUD patients in the Portuguese National Program for Tobacco Control 2012-2016 (Nunes et al., 2013). In addition, we intend to develop Portuguese Tobacco Control Champions in the present project, which would be and important extension from our previous Brazilian project, in which we just offered basic training. Finally, this project could expand the international activities of the Global Bridges (GB) Portuguese-language network, and foster a greater exchange of expertise and ideas between health professionals from Brazil and Portugal. Currently, only 25 members of the GB network are from Portugal. There is also the possibility of further expansion of this project to other Portuguese-speaking countries like Mozambique, Angola, and Timor Leste—a country in which nearly 2/3 of men smoke.

5. Evaluation Design

5.1. Measurement of the success of the project

Our evaluation design will use Moore's analytic framework to assess learning outcomes (Moore et al., 2009). Following this rationale, we plan to collect data from (i) trainers, (ii) other members of the clinical staff and (iii) CRI units (aggregated individual data), using the first five Moore's levels:

'Participation' through attendance records; 'Satisfaction' through post-training questionnaire; 'Learning – Knowledge' by means of pre and post knowledge tests; 'Learning – Competence' through self-report of competence and intention-to-change questionnaires; and 'Performance' using a websurvey to generate self-report of performance in patient care setting.

Table 2. Learning outcomes evaluation measures for the MHA Tobacco Cessation Project in Portugal, 2016-2018.

Target Level		Moore's Levels				
		1 (Participation)	2 (Satisfaction)	3 (Learning - Knowledge)	4 (Learning - Competence)	5 (Performance)
Champions	*Measure*	Individual attendance records	Post-training questionnaire	Pre- and Post-test of knowledge	Self-report of competence and intention to change questionnaire	Websurvey for self-report of performance in patient care setting
	Target	15	90% of satisfaction	75% of increase	90% of self-report of competence and 90% of intention to change	90% of performance
Individual	*Measure*	Individual attendance records	Post-training questionnaire	Pre- and Post-test of knowledge	Self-report of competence and intention to change questionnaire	Websurvey for self-report of performance in patient care setting
	Target	135	50% of satisfaction	50% of increase	50% of self-report of competence and 50% of intention to change	50% of performance
CRI	*Measure*	Number of CRI units reached	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit	Aggregated individual data per CRI unit
	Target	15	50% of satisfaction	50% of increase	50% of self-report of competence and 50% of intention to change	50% of performance

Two scales will be translated and possibly validated for Portuguese, in order to evaluate the most problematic Moore's levels (levels 4 & 5):

5.1.1. Tobacco Treatment Commitment Scale (TTCS) (Hunt et al., 2014):
The TTCS is a brief and reliable scale of staff commitment to providing tobacco treatment. It was developed based on extensive qualitative data collection and solicited expert input to design initial items with high content validity. The final TTCS contains 14 items in 3 domains: "Tobacco is less harmful than other drugs;" "It's not our job to treat tobacco;" and "Tobacco treatment will harm clients." These three core constructs together account for most of the

variance in the survey items, which suggests they are the major sentiments driving commitment, or lack of commitment, to providing tobacco treatment services. In the present project, this scale will be used to patially evaluate Moore's levels 4 & 5.

5.1.2. Index of Tobacco Treatment Quality (ITTQ) (Cupertino et al., 2013):
The ITTQ is a brief and reliable tool for measuring tobacco treatment quality in substance abuse treatment facilities. Their items were developed based on current tobacco treatment guidelines, existing surveys, expert input, and qualitative research. It has a subset of 7 items that have the strongest clinical evidence for smoking cessation. Given the clear-cut room for improvement in tobacco treatment, the ITTQ could be an important tool for quality improvement by identifying service levels, facilitating goal setting, and measuring change. In the present project, this scale will be used to partially evaluate Moore's level 5.

5.2. Dissemination of the outcomes:
The project outcomes will be disseminated in 6 different ways:
1 - Global Bridges Executive Team is going to receive quarterly reports on the execution of the deliverables of the project.
2 – The Portuguese National Service for Addictive Behaviors/Dependence Intervention (SICAD), the Portuguese National Program for Tobacco Control, and the managers of the 22 CRI units will receive a final report on the learning outcomes of our project.
3 – Creation of an Empirical Report to be submitted to a peer-reviewed journal (target journal = Academic Psychiatry), describing both the learning outcomes and the barriers to the implementation of smoking cessation treatment in MHA patients.
4 - Tobacco/Addiction/Psychiatry Conferences: WCTOH, SRNT-e, Portuguese Congress of Psychiatry
5 - Media: We are going to contact the health section staff of the main printed and online Portuguese journals and magazines – Correio da Manhã, Diário de Notícias, Jornal de Notícias, Visão, Sábado, Focus, Jornal Digital, Diário Digital, among others – to suggest they cover the project
6 - To contact ONG/people/bloggers who are involved in the anti-smoking cause in Portugal

6. Workplan & Schedule

Summary:
Months 1-3: Contact, selection and confirmation of CRI units / Training preparation
Months 4-6: Finalization of the training model / Formulation of evaluation questionnaires
Months 7-9: Elaboration and selection of educational and recovery resources / Training of CRI units 1-5
Months 10-12: Training of CRI units 6-10 / TA / ID / Support for DC / Websurvey
Months 13-15: Training of CRI units 11-15 / TA / ID / Support for DC / Websurvey
Months 16-18: Champions training / TA / ID / Support for DC / Websurvey
Months 19-21: TA / ID / Support for DC / Websurvey
Months 22-24: Outcome database creation, report writing and dissemination

Schedule for completion	Deliverables
Year	*Year 1*
First Quarter	Meeting with Portugal Substance Abuse Division coordinators All the 22 CRI units contacted CRI workgroup selected and cofirmed Convene CRI workgroup roster, meeting agenda and minutes Clima Clinic staff meeting 1,2,3: training model discussion Smoking Cessation Best Practice Protocol selected
Second Quarter	CRI workgroup meeting 1 Clima Clinic staff meeting 4: Final training model ellaboration Ellaboration of the competence questionnaire Ellaboration of the intention to change questionnaire Ellaboration of the pre- and post-test of knowledge Ellaboration of the satisfaction questionnaire Ellaboration of the competence questionnaire Ellaboration of the intention to change questionnaire
Third Quarter	Printing of Training Materials Training: CRI 1,2,3,4,5 Post-training questionnaire: CRI 1,2,3,4,5 Pre- and Post-test of knowledge: CRI 1,2,3,4,5 Self-report of competence and intention to change questionnaire: CRI 1,2,3,4,5 Ellaboration and selection of educational messages Ellaboration and selection of recovery materials Selection of existing media and educational resources
Fourth Quarter	Training: CRI 6,7,8,9,10 Post-training questionnaire: CRI 6,7,8,9,10 Pre- and Post-test of knowledge: CRI 6,7,8,9,10 Self-report of competence and intention to change questionnaire: CRI 6,7,8,9,10 Technical Assistance focus: CRI 1,2,3,4,5 Information Dissemination focus: CRI 1,2,3,4,5 Support for Data Collection focus: CRI 1,2,3,4,5 Websurvey for self-report of performance in patient care setting: CRI 1,2,3,4,5
	Year 2
Fifth Quarter	Training: CRI 11,12,13,14,15 Post-training questionnaire: CRI 11,12,13,14,15

	Pre- and Post-test of knowledge: CRI 11,12,13,14,15 Self-report of competence and intention to change questionnaire: CRI 11,12,13,14,15 Technical Assistance focus: CRI 6,7,8,9,10 Information Dissemination focus: CRI 6,7,8,9,10 Support for Data Collection focus: CRI 6,7,8,9,10 Websurvey for self-report of performance in patient care setting: CRI 6,7,8,9,10
Sixth Quarter	Champion Training Post-training questionnaire: Champion Training Pre- and Post-test of knowledge: Champion Training Self-report of competence and intention to change questionnaire: Champion Training Technical Assistance focus: CRI 11,12,13,14,15 Information Dissemination focus: CRI 11,12,13,14,15 Support for Data Collection focus: CRI 11,12,13,14,15 Websurvey for self-report of performance in patient care setting: CRI 11,12,13,14,15
Seventh Quarter	Technical Assistance focus: Champions Information Dissemination focus: Champions Support for Data Collection focus: Champions Websurvey for self-report of performance in patient care setting: Champions
Eighth Quarter	Learning Outcomes Database creation Ellaboration of the final Report of Learning Outcomes Meeting with representatives from Portugal government Health sector Ellaboration of the Empirical Report to Academic Psychiatry Submission of abstracts to Tobacco/Addiction/Psychiatry conferences Contact with Media: print and online journals and magazines Contact with ONG's/people/bloggers

References

Agency for Healthcare Research and Quality (AHRQ). Clinical Guidelines for Prescribing Pharmacotherapy for Smoking Cessation. Rockville, MD, 2012. http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/prescrib.html [Accessed in Jan 12th, 2015]

Association for the Treatment of Tobacco Use and Dependence (ATTUD). Core competencies for evidence-based treatment of tobacco dependence. ATTUD website, 2005. http://www.attud.org/docs/Standards.pdf [Accessed in Jan 12th, 2015]

Aubin, H. J., Rollema, H., Svensson, T. H., & Winterer, G. (2012). Smoking, quitting, and psychiatric disease: a review. *Neuroscience & Biobehavioral Reviews*, *36*(1), 271-284.

Balsa, Vital, Urbano. III Inquérito Nacional ao Consumo de Substâncias Psicoativas na População Geral/Portugal 2012. CESNOVA – Centro de Estudos em Sociologia da Universidade Nova de Lisboa, SICAD – Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências, 2014.

Castaldelli-Maia, J.M., Carvalho, C.F., Armentano, F., Frallonardo, F.P., de Toledo Ferraz Alves, T.C., Andrade, A.G., Nicastri, S. (2013). Outcome predictors of smoking cessation treatment provided by an addiction care unit between 2007 and 2010. *Revista Brasileira de Psiquiatria*, 35, 338–346.

Castaldelli-Maia, J. M., Loreto, A. R., Carvalho, C. F. C., Frallonardo, F. P., & de Andrade, A. G. (2014). Retention predictors of a smoking treatment provided by a public psychosocial unit in Brazil. *International Review of Psychiatry*, 26(4), 515-523.

Cupertino, A. P., Hunt, J. J., Gajewski, B. J., Jiang, Y., Marquis, J., Friedmann, P. D., ... & Richter, K. P. (2013). The index of tobacco treatment quality: development of a tool to assess evidence-based treatment in a national sample of drug treatment facilities. *Substance abuse treatment, prevention, and policy*, *8*, 13.

Evins, A.E., Cather, C., Laffer, A. (2015). Treatment of Tobacco Use Disorders in Smokers with Serious Mental Illness: Toward Clinical Best Practices. *Harvard Review of Psychiatry*, 23, 90-8.

Hunt, J. J., Cupertino, A. P., Gajewski, B. J., Jiang, Y., Ronzani, T. M., & Richter, K. P. (2014). Staff commitment to providing tobacco dependence in drug treatment: Reliability, validity, and results of a national survey. *Psychology of Addictive Behaviors*, *28*(2), 389-95.

Hitsman B, Moss TG, Montoya ID, George TP. Treatment of tobacco dependence in mental health and addiction disorders. *Can J Psychiatry 2009*; 54(6): 368-78.

Mateus, M. D., Mari, J. J., Delgado, P. G., Almeida-Filho, N., Barrett, T., Gerolin, J., ... & Andreoli, S. B. (2008). The mental health system in Brazil: Policies and future challenges. *International Journal of Mental Health Systems*, *2*(1), 1.

Mielke FB, Kantorski LP, Jardim VM, Olschowsky A, Machado MS. Mental care delivered in psychosocial care centers (CAPS) from the viewpoint of the professionals. *Cien Saude Colet* 2009; 14(1): 159-64.

Miranda, L., & Campos, R. T. O. (2008). Análise do trabalho de referência em Centros de Atenção Psicossocial. *Revista de Saúde Pública*, *42*(5), 907-913.

Moore, D. E., Green, J. S., & Gallis, H. A. (2009). Achieving desired results and improved outcomes: integrating planning and assessment throughout learning activities. *Journal of Continuing Education in the Health Professions*, 29(1), 1-15. 29(1): 1-15.

Morisano, D., Bacher, I., Audrain-McGovern, J., George, T.P. (2009). Mechanisms underlying the comorbidity tobacco use in mental health and addiction disorders. *Canadian Journal of Psychiatry*, 54(6), 356-67.

Ng, M., Freeman, M.K., Fleming, T.D., et al. (2014). Smoking prevalence and cigarette consumption in 187 countries, 1980-2012. *Journal of the American Medical Association*, 311, 183-192.

Nunes, E., Dias, C. M., Conceição, C., Pestana, E., Baptista, I., & Bonito, J. (2013). Programa Nacional para a Prevenção e Controlo do Tabagismo 2012-2016. Direção-Geral da Saúde de Portugal, Lisboa.

Nunes, E. & Narigão, M. (2014) Programa Nacional para a Prevenção e Controlo do Tabagismo em Números - 2014. Direção-Geral da Saúde de Portugal, Lisboa.

Serviço de Intervenção em Comportamentos Aditivos e Dependências (SICAD) (2015). Relatório de Atividades 2014. Serviço de Intervenção em Comportamentos Aditivos e Dependências (SICAD), Lisboa, 2015.

Serviço de Intervenção em Comportamentos Aditivos e Dependências (SICAD) (2013). Plano de Ação para a Redução dos Comportamentos Aditivos e das Dependências 2013- 2016. Serviço de Intervenção em Comportamentos Aditivos e Dependências (SICAD), Lisboa.