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Behavioral Interventions:

**Integrating Tobacco Use Interventions into
Chemical Dependence Services**

Trainer's Manual

Module 3



PROFESSIONAL DEVELOPMENT PROGRAM
ROCKEFELLER COLLEGE UNIVERSITY AT ALBANY State University of New York

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About This Training

PDP Background

Since its founding in 1976, the Professional Development Program (PDP) has been committed to making extended learning and public engagement a reality for the public service and not-for-profit workforces through its ongoing education and training programs. The mission of the Professional Development Program is to make a difference in a changing world by linking the learning, applied research, and evaluation resources of the university with the continuing professional education needs of the public service.

Over the past 30 years, PDP has had a wide variety of partners and has secured funding in excess of \$350 million to help organizations meet their workforce development needs. Current programs and services offered by PDP include:

- Child Welfare Training
- Computer Training Services
- Regional HIV/AIDS Training Center
- Instructional Technologies
- Temporary Assistance Training
- Tobacco Interventions Project
- Media Production

For further information on the programs and services offered by the Professional Development Program, contact us at:

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University Administration Building, 4th floor
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www.pdp.albany.edu

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About This Training, Continued

About the New York Tobacco Control Program

The New York Tobacco Control Program, located at the New York State Department of Health, envisions all New Yorkers living in a tobacco-free society and works aggressively to reduce the morbidity and mortality, and alleviate the social and economic burden, caused by tobacco use in New York State.

About the Tobacco Interventions Project

In August 2007, the New York Tobacco Control Program, in collaboration with the New York State Office of Alcoholism and Substance Abuse Services (OASAS), released a Request for Applications entitled *Integrating Tobacco Use Interventions into New York State Chemical Dependency Services*.

In January 2008, this contract was awarded to PDP to serve as the Development, Management, and Oversight Agency (DMOA). PDP oversaw the six Regional Technical Assistance and Training Centers (RTATC) across the state, and developed all classroom-based training curricula, web-based learning, technical assistance tools, and the Tobacco Recovery Resource Exchange website. Classroom training and technical assistance was completed in December 2009, and online training was continued.

The Tobacco Interventions Project provided training and technical assistance to all NYS Office of Alcoholism and Substance Abuse Services (OASAS) funded and/or certified chemical dependence service providers to implement integrated tobacco use interventions (tobacco-free environment policies, tobacco education, and tobacco dependence treatment) into existing treatment protocols.

Visit the project website: www.tobaccorecovery.org for online learning and other resources.

Continued on next page

About This Training, Continued

**Tobacco Use:
A Serious
Public Health
Problem**

Tobacco use is a serious public health problem. Tobacco use is the most preventable cause of death in the United States. Over 440,000 Americans die each year from tobacco-related disease. Cigarette use alone results in 25,500 deaths in New York State.

People who breathe in second-hand smoke from cigarettes also suffer adverse health consequences. In June 2006, the US Surgeon General issued a comprehensive scientific report, which concluded that there is no safe level of exposure to secondhand smoke (US Surgeon General, 2006). In 1993 and 2006, the US Environmental Protection Agency (EPA) concluded that environmental tobacco smoke (ETS) is responsible for approximately 3,000 lung cancer deaths annually among adult U.S. nonsmokers, and contributes to the risk of heart disease. Furthermore, among infants and young children, ETS exposure causes:

- An increased risk of lower respiratory tract infections such as bronchitis and pneumonia. EPA estimates that 150,000 to 300,000 cases annually in infants and young children up to 18 months are attributable to ETS.
- An increased prevalence of fluid in the middle ear, symptoms of upper respiratory tract irritation, and small reductions in lung function.
- Additional episodes and increased severity of symptoms in children with asthma. EPA estimates that up to 1 million asthmatic children have their condition worsened by exposure to ETS.

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About This Training, Continued

The Cost of Tobacco Use

Tobacco use is also a costly problem. Research has clearly shown that the annual health care costs in New York directly caused by smoking total \$8.17 billion, with \$5.41 billion covered by New York Medicaid funding (CDC, 2008). The state and federal tax burden to New York State amounts to \$842 per household annually for government expenditures that are related to tobacco use (Campaign for Tobacco-Free Kids, 2008).

Tobacco Use and Chemical Dependence

Nationally, approximately 19.8% of all adults use tobacco (CDC, 2009). This is a decline over the past 5 years from a tobacco use rate of over 21%. People with substance use and co-occurring mental disorders, more than other populations, are likely to be addicted to tobacco. Historically, chemical dependence treatment agencies have not treated tobacco dependence concurrently with other chemical dependencies.

Among people with drug or alcohol problems, the rate of tobacco use ranges from 75% to 100% (Campbell et al., 1998).

People with substance use disorders who smoke are much more likely to die from their tobacco use than from their drug or alcohol addiction (Hurt et al., 1996; Hser, 2001).

Until recently, many chemical dependence treatment agencies have not addressed patient tobacco use. Some agencies have expressed concern that patients who are denied access to tobacco may choose to leave treatment. Other agencies have been unsure how to institute a tobacco use policy, or how staff would react.

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About This Training, Continued

Addressing the Issue Current research shows that many staff and patients are in favor of tobacco abstinence. Tobacco abstinence is also associated with improved treatment completion rates and improved post-treatment abstinence from alcohol and other drugs (Prochaska et al., 2004). Tobacco relapse is shown to trigger relapse to alcohol and other drug use and vice-versa (Stuyt, 1997; Sobell et al., 1995), a concern that was also noted by early pioneers of the treatment for alcohol and narcotic dependence (White, 1998).

Tobacco dependence is chemical dependence and addiction service providers already possess much of the essential knowledge and many of the skills necessary to incorporate tobacco use interventions into chemical dependence services.

This training and technical assistance initiative was designed to help agencies use a multidisciplinary approach to integrate tobacco interventions into chemical dependence agencies. PDP supported OASAS certified and/or funded agencies as they addressed tobacco dependence treatment and recovery.

-
- Original Project Goals**
- Create and maintain a tobacco-free environment in buildings, vehicles, and on the grounds of chemical dependence service programs
 - Integrate tobacco use interventions into chemical dependence services
-

Background Information for the Trainer

Trainer Note

The trainer is an integral part of making this workshop format successful. This manual is designed to be a guide for creating and facilitating the training entitled *Behavioral Interventions: Integrating Tobacco Use Interventions into Chemical Dependence Services*. The suggested scripts and activities in each unit will guide you through the entire training process. It is important to become familiar with the Trainer and Participant Manuals in order to direct participants to particular pages as these are discussed.

This training module is designed to be presented as an eight and one quarter hour training divided into morning and afternoon sessions or can be divided into two half-day sessions. The training module includes large and small group activities and case studies, which will require preparation by the trainer prior to the training. It is organized into four Units and is prefaced by an introduction.

There are three main topics in the two Units covering counseling techniques: Motivational Interviewing (MI), Cognitive-Behavioral Therapy (CBT), and Relapse Prevention Therapy (RPT).

Unit 1 provides participants with the basic knowledge and skills for using Motivational Interviewing, an effective, evidence-based approach to overcoming the ambivalence that keeps people from making desired changes in their lives. Participants will learn fundamental MI interventions specific to tobacco dependence, identify strategies to address resistance, and practice using MI micro-skills to identify a patient's motivation to change.

Unit 2 provides participants with an overview of Cognitive-Behavioral Therapy, a form of counseling that emphasizes how thinking affects how we feel and what we do. The unit also reviews Relapse Prevention Therapy, which teaches individuals who are trying to maintain healthy behavior changes how to anticipate and cope with the problem of relapse

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Background Information for the Trainer, Continued

Trainer Note, continued

Unit 3 provides participants with an opportunity to assess stage of change readiness and appropriate treatment methodology in a series of five short case studies. This unit draws on material presented in Units 1 and 2.

In Unit 4, participants will be introduced to methods for facilitating a tobacco awareness group, including specific engagement topics that are effective in helping patients change the way they think about their tobacco use. Participants will have the opportunity to observe and/or practice skills that can be used when conducting a psychoeducation group. This unit draws material from the work of Tony Klein, a tobacco treatment expert from Unity Behavioral Health, in Rochester, New York, and is primarily focused on the use of Motivational Interviewing techniques.

The content in italics in this manual is intended to provide the trainer with a context and basis for developing his or her presentation. It is not intended to be read aloud, word-for-word. Adaptations such as professional experiences and personal observations, and using the trainer's style of expression, are expected. The acronym **PM** refers to the Participant Manual and indicates the page number and **Slide** refers to the Slide Number in the PowerPoint Presentation.

The purpose of this training is to build awareness and provide participants with the knowledge and skills they need to begin to successfully integrate tobacco use interventions into the addiction services continuum. This training module will provide specific clinical skill-building tools that the addiction professional will need in order to diagnose and treat tobacco dependence.

Trainer Tips and Responsibilities

Trainer Tip

Adult Learning Principles:

There are specific learning principles that are based on the needs of adult learners:

- Emphasize how the learning can be applied to practice
- Relate the learning to the goals of the learner
- Relate the materials to the past experiences of the learner
- Allow debate and challenge of ideas
- Listen to and respect the opinions of learners
- Encourage learners to be resources to the trainer and to one another
- Treat learners as adults

Trainer Tip

As learners, adults:

- Decide for themselves what is important to be learned
- Need to verify the information based on their beliefs and experiences
- Expect what they are learning to be immediately useful
- Have much past experience upon which to draw - may have fixed viewpoints
- Have significant ability to serve as a knowledgeable resource to the trainer and fellow learners

Continued on next page

Trainer Tips and Responsibilities, Continued

Trainer Responsibilities

In a trainer-led, learner-centered training, you should:

- Provide learners with resources and models to help them develop their own correct approaches and solutions
- Help them develop better ways of relating to stakeholders
- Limit lecture and maximize use of active learning methods and participation
- Demonstrate belief and confidence in the learners' ability to learn and change
- Respect learners by starting and ending on time and using the learners' names
- Encourage the learners to interact with each other during the learning process. As the facilitator, you can encourage this by mixing learners into different groups for small group activities, as appropriate.
- Expand learners' questions/issues to include the larger group
- Ask learners to examine their attitudes and beliefs
- Lead by example; be enthusiastic, positive and considerate
- Value and allow differing viewpoints, even if you do not agree with those viewpoints
- Exercise self-discipline and avoid topping off comments by adding your own opinion

Continued on next page

Trainer Tips and Responsibilities, Continued

Timeframes These timeframes are approximate.

<u>Units</u>	<u>Time</u>
Welcome and Introductions	15 minutes
Unit 1 – Motivational Interviewing	3.25 hours
Break (Trainer Discretion)	15 minutes
Unit 2 – Cognitive-Behavioral Therapy and Relapse Prevention Therapy	30 minutes
Lunch	45 minutes
Unit 3 – Case Studies	30 minutes
Break (Trainer Discretion)	15 minutes
Unit 4 – Facilitating a Tobacco Awareness Group	2.25 hours
Total time	8.25 hours

Continued on next page

Trainer Tips and Responsibilities, Continued

Materials and Supplies Needed

- Laptop
- LCD Projector
- PowerPoint Slides
- Trainer Manual
- Participant Manuals
- Flipcharts
- Easel
- Masking tape
- Markers
- Pre-prepared newsprint for activity
- Workshop Evaluation Forms (WEF)
- Certificates of Attendance
- Rosters/Sign-in Sheets

Optional

- Name Tags or Table Tents
- Pre-tests, Post-tests and Answer Sheets (can be used to evaluate participant learning and to evaluate the impact of training)

Option of Pre-Test and Post-Tests

Pre-tests and post-tests were originally designed for this training as a measure of the training effectiveness, and not as an evaluation of the participants.

If using Pre-Tests and Post-Tests, provide participants with the Test Questions and Answer Sheet and then ask them to complete the pre-test before the class begins. Ask participants to write responses on the answer sheet and make their best guess if they are not sure of the correct answer.

Collect the pre-test questions and ask participants to hold on to their double-sided answer sheet to complete the post-test at the end of class.

Welcome and Introductions

Trainer Note

After welcoming the participants to the training, explain the following information:

Slides 1 - 3

The Tobacco Recovery Resource Exchange, at the Professional Development Program, University at Albany also developed online versions for all the classroom-based training modules. The online modules allow you to learn at your own pace and earn additional professional education hours. To access this, go to www.tobaccorecovery.org.

- Introduce the trainer(s).
- Explain that the training was part of a project sponsored by the NYS Department of Health, Tobacco Control Program.

An introduction about the original project can be crafted based on the information found on page 4 of this Trainer Manual.

Trainer Note

Review Housekeeping Issues

Slide 4

- Training schedule
 - Breaks & lunch
 - Restrooms - location and access
 - Tobacco use policy for the training location
 - Cell phones - off or silent mode
 - Active participation encouraged
 - Complete pre-test/post-test (If this evaluation method is being used)
 - Complete training evaluation
-

Welcome and Introductions, Continued

Welcome and Introductions, Continued

Trainer Note Refer participants to their PM and ask them to introduce themselves by stating their name, role, agency, and modality.
Slide 5

Trainer Note After introductions are completed, ask participants:

- By a show of hands, how many of you have previously taken the classroom training of Modules 1 or 2?
- How many of you have taken any of the modules online at www.tobaccorecovery.org?

Summarize by stating, *Module 3 will build upon the information and skills learned in the previous two modules.*

Overview of Modules

Trainer Note Slide 6	Review the training topics for each module and refer participants to the topics listed under each module within their PM.
PM 8	Emphasize the e-learning versions of each module, which they can access at www.tobaccorecovery.org .

Modules and Topics

Module 1 - The Foundation

Attitudes and Beliefs
History and Rationale
Tobacco Dependence
OASAS Regulation Part 856

Module 2 - Assessment, Diagnosis, and Pharmacotherapy

Assessment, Screening, and Diagnosis
Stages of Change and Readiness to Change
Pharmacotherapy
Case-based Applications

Module 3 - Behavioral Interventions

Counseling Techniques
Facilitating a Tobacco Awareness Group

Module 4 - Treatment Planning

Treatment Plan Components
Writing a Treatment Plan and Case Study

Module 5 - Co-occurring Disorders

Attitudes and Beliefs, Challenges and Barriers
Prevalence and Basic Neurobiology
Treatment Strategy Review and Case Studies

E-Learning - All Modules (www.tobaccorecovery.org)

Module 3 Agenda and Objectives

Trainer Note Refer participants to the PM to review the agenda and objectives
Slides 7 - 8 Review the agenda and module objectives.
PM 9

**Module 3
Agenda**

- Motivational Interviewing (MI)
- Cognitive-Behavioral Therapy (CBT)
- Relapse Prevention Therapy
- Case Studies
- Facilitating a Tobacco Awareness Group

**Module 3
Objectives**

- Describe the “spirit” of Motivational Interviewing (MI)
- Describe the four broad guiding principles of MI
- Identify and define the Five R’s
- Identify at least two of the four categories of patient resistance
- Identify at least two of the four strategies used to reduce resistance
- Identify at least four strategies for eliciting change talk
- Demonstrate MI micro-skills to enhance a patient’s motivation
- Identify the two components of Cognitive-Behavioral Therapy (CBT)
- Identify at least four contributing factors to tobacco use relapse
- Identify at least three behavioral techniques that support tobacco recovery
- Use a case study to identify the stage of change for tobacco use and determine the most appropriate treatment interventions
- Identify the purpose of a tobacco awareness group
- Identify at least two desired outcomes of a tobacco awareness group
- Demonstrate, through role-play, the skills required to facilitate a tobacco awareness group

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Unit 1

Motivational Interviewing

Trainer Note
Slide 9
PM 11

Unit 1 introduces participants to the philosophy, principles, and main techniques of Motivational Interviewing (MI). The unit will explore how MI techniques can be applied to chemical dependency counseling and specifically to tobacco treatment interventions. Given the limits of time, this unit cannot help participants develop in-depth MI skills; rather, its purpose is to ensure all participants are familiar with the techniques, how they are used, and when these methods are most effective.

Refer participants to the purpose and objectives of Unit 1 found in the PM.

Ask if participants are familiar with Motivational Interviewing (MI) or if they have had training in MI. If people have had MI training or experience, ask them to briefly describe MI and how it is used in their work.

Purpose

Motivational Interviewing (MI) is an effective, evidenced-based approach to overcoming the ambivalence that keeps many people from making desired changes in their lives (Miller and Rollnick, 1991, 2002). This unit is designed to teach clinicians' and prevention staff the basic knowledge and skills of MI techniques. It will also provide guidance and assistance with respect to the use of those techniques, as tobacco use interventions are integrated into chemical dependence services.

- Unit 1 Objectives**
- Describe the “spirit” of Motivational Interviewing (MI)
 - Describe the four broad guiding principles of MI
 - Identify and define the Five R’s
 - Identify at least two of the four categories of patient resistance
 - Identify at least two of the four strategies used to reduce resistance
 - Identify at least four strategies for eliciting change talk
 - Demonstrate MI micro-skills to enhance a patient’s motivation
-

Stages of Change

Trainer Note

Refer to PM and explain the building block design of the tobacco interventions curriculum. The following is suggested language:

Slide 10

PM 12

Many addiction professionals are familiar with the Prochaska and DiClemente Transtheoretical Model (TTM) or the Stages of Changes (SOC).

Prochaska and DiClemente developed their SOC model from an examination of 18 psychological and behavioral theories about how change occurs, and for this reason, it is called a “transtheoretical” model.

In Module 2, we discussed and applied this model to several patients to assess their stage of readiness to address their tobacco use.

In this unit of Module 3, we will explore how the stages of change and strategies for MI are applied in the treatment of tobacco dependence.

**Stages of
Change Model**

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

Continued on next page

Stages of Change, Continued

**Trainer Note,
cont'd**

Review the SOC model with participants by asking them to describe the stages of change and record participant comments on an easel pad.

Slide 11

Ask participants the following series of questions:

PM 12

- *What characteristics, behaviors, or statements might you expect to hear from a patient who is in the Precontemplation Stage?*
- *What characteristics, behaviors, or statements might you expect to hear from a patient who is in the Contemplation Stage?*
- *How do you know when a patient is moving to the Preparation Stage?*
- *How do you know when a patient is ready to “take action?”*

Summarize this discussion and refer the value of the SOC model.

**Practical
Value of the
SOC Model**

The Stages of Change model was developed by Prochaska, DiClemente, and Norcross (1992). It provides addiction professionals with a common language and it is a reminder that not all patients are committed to making a change, and that they may be in different stages for different problems. The motivational approaches that are being discussed in this training are based on the Stages of Change model as an evidence-based practice for tobacco use and dependence intervention according to Treating Tobacco Use and Dependence, 2008 Update (Fiore, Jaen, and Baker et al., 2008) and referred to in this training as the Clinical Practice Guideline (CPG).

Importance and Confidence to Change

Trainer Note	<p>Explain that in general, patients will not be ready to change until they perceive that the change is important and that they have the confidence that they will be able to change. Both importance and confidence are needed in sufficient quantity before moving on to a change plan (Miller and Rollnick, 2002). Patients also need to know how to change, even if confidence and importance are high, patients still need to know what to do to and how to do it, to be successful in making a change.</p> <p>Review the examples in the PM regarding levels of importance and confidence. Ask participants:</p> <p><i>Can you think of patients who appeared to be “unmotivated,” but actually had low confidence, low importance, or low ability to change regarding their tobacco use? What did they look or sound like?</i></p>
Slide 12	
PM 13	

Importance and Confidence Affects Motivation

In order to change, patients need to be willing, ready, and able to change. In addition, both importance to make the change and confidence are needed in sufficient quantity before moving forward with a change plan. Motivational interviewing strategies are designed to increase importance and confidence, thus increasing readiness to change.

Importance + Confidence = Readiness (Miller and Rollnick, 2002).

Patients also need ability (skills and knowledge) to change. Even if confidence and importance appears high, patients need to know what to do and how to do it (e.g. how and when to use NRTs, coping with triggers, etc.).

A patient may appear “unmotivated” because:

- Importance is low, but confidence is high
 - Importance is high, but confidence is low
 - Both importance and confidence are low
 - Importance and confidence are high, but ability (skills and knowledge needed to change) is low
-

The Clinical Practice Guideline

Trainer Note

Slides 13 - 14

PM 14

Explain that in Modules 1 and 2, participants were introduced to Treating Tobacco Use and Dependence, 2008 Update (Fiore, Jaen, and Baker et al., 2008) and referred to as the Clinical Practice Guideline (CPG).

Review these points:

- The CPG 2008 Update strongly recommends that health care clinicians should assess a patient's willingness to stop using tobacco and use interventions such as MI for those in precontemplation or contemplation about their tobacco use (Fiore, Jaen, and Baker et al., 2008).
- The CPG 2008 advises that clinicians strongly recommend the use of both tobacco dependence medications and supportive counseling to treat patients who use tobacco (Fiore, Jaen, and Baker et al., 2008).

**Clinical
Practice
Guideline
(CPG) 2008**

Treating Tobacco Use and Dependence, 2008 Update (Fiore, Jaen, and Baker et al., 2008) and referred to as the Clinical Practice Guideline (CPG), strongly recommends that health care clinicians should advise all tobacco users to stop using and assess a patient's willingness to stop using.

For patients who are unwilling or willing but not ready to discontinue tobacco use, clinicians should use brief interventions, such as MI to increase their patients motivation to stop using tobacco (Fiore, Jaen, and Baker et al., 2008).

The CPG specifically advises that MI strategies be used for patients who are in precontemplation and contemplation regarding their tobacco use, as a means to help them move towards preparation, action and maintenance (Fiore, Jaen, and Baker et al., 2008).

The CPG 2008 also advises that clinicians should strongly recommend the use of both tobacco dependence medication and supportive counseling to treat patients who use tobacco, and that health systems, insurers, and purchasers assist clinicians in making such effective treatments available (Fiore, Jaen, and Baker et al., 2008).

Motivational Interviewing (MI) Basics

<p>Trainer Note</p> <p>Slide 15</p> <p>PM 15</p>	<p>Remind participants that as discussed in Modules 1 and 2, the CPG 2008 found that brief interventions, intensive interventions, and the use of tobacco medications are all effective in treating tobacco dependence. (Fiore, Jaen, and Baker et al., 2008).</p> <p>Explain that the CPG 2008 also noted that Motivational Interviewing (MI) is especially effective to help increase motivation and help resolve ambivalence of patients who are in the precontemplation and contemplation stages of change (Fiore, Jaen, and Baker et al., 2008).</p>
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<p>Motivational Interviewing - an Evidenced-Based practice</p>	<p>Brief interventions, intensive interventions, and pharmacotherapies have been shown to be effective in treating tobacco dependence. The CPG 2008 identifies Motivational Interviewing (MI) as an evidence-based counseling strategy that is an effective tool to motivate precontemplative and contemplative patients (Fiore, Jaen, and Baker et al., 2008).</p> <p>MI is a counseling style designed to help the patient build commitment and reach a decision to change. The principal purpose of MI is to help patients resolve their ambivalence about change (Miller and Rollnick, 2002).</p>
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<p>Trainer Note</p> <p>Slide 15</p> <p>PM 15</p>	<p>Define Motivational Interviewing as “a patient-centered, directive method for enhancing intrinsic (internal) motivation to change by exploring and resolving ambivalence” (Miller and Rollnick, 2002).</p> <p>Note: A discussion about defining the terms “directive” and “ambivalence” will occur following this definition.</p>
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<p>MI Definition</p>	<p>Definition of Motivational Interviewing: “a patient-centered, directive method for enhancing intrinsic (internal) motivation to change by exploring and resolving ambivalence” (Miller and Rollnick, 1991, 2002).</p>
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Motivational Interviewing (MI) Basics, Continued

Trainer Note

PM 15

Explain that within MI, the word “directive” means that the clinician does not tell patients what they should do, nor does the clinician try to convince or persuade patients to take action. Instead the term “directive” means being an active partner who:

- Uses evocation (draws ideas from the patient) and elicits motivational statements (reasons for why they should change) from the patients
- Works in collaboration with what patients desire
- Supports autonomy by acknowledging that patients are the experts in their own life, and that it is their decision if they choose to make changes
- Build discrepancy between patients’ stated desires or goals and their present condition or state.
- Helps the patient to identify and resolve their ambivalence.

**Defining
“Directive” in
MI**

For some clinicians, using the word “directive” may cause some confusion. Directive does not mean the clinician is telling patients what they should do. The clinician also does not work to convince or persuade the patient to take a certain action.

In the spirit of MI, being “directive” means being an active partner who:

- Uses evocation and eliciting motivational statements (reasons for why they should change) from the patients
 - Works in collaboration with what patients desire
 - Supports autonomy by acknowledging that patients are the experts in their own life, and that it is their decision if they choose to make changes
 - Builds discrepancy between patients’ stated desires, values, and goals verses their present condition or state.
 - Helps the patient to identify and resolve their ambivalence.
-

The Spirit of MI

Trainer Note Slide 16 PM 16 - 17	<p>Explain that MI concepts evolved from the treatment of people with alcohol use disorders as described by Miller (1983) and elaborated by Miller and Rollnick in their text <i>Motivational Interviewing</i> (1991 and 2002).</p> <p>Refer to PM and ask participants to review the spirit of MI.</p> <p>Conduct a large group discussion about how this style (Spirit of MI) fits with or runs contrary to participants' own counseling style.</p>
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The Spirit of MI

The concept of MI evolved from experience in the treatment of people with alcohol use disorders. It was first described by William Miller (1983), in an article published in the United Kingdom journal, *Behavioural Psychotherapy*. Miller and Stephen Rollnick (1991 & 2002) later elaborated upon these fundamental concepts, approaches, and clinical strategies.

It is important to distinguish between the techniques of MI and the "spirit" of MI. These key points characterize the spirit of MI:

- **Motivation to change is elicited from the patient, and is not imposed from outside by the clinician.** Some approaches emphasize coercion, persuasion, constructive confrontation, and external contingencies (e.g., the threatened loss of job or family). Such strategies have their place in evoking change, but they are not in spirit of MI, which identifies and mobilizes a patient's intrinsic values and goals to stimulate change.
- **It is the patient's task, not the clinician's, to articulate and resolve his or her ambivalence about change.** Ambivalence takes the form of a conflict between two courses of action (e.g., indulgence versus restraint), and each has perceived benefits and costs. Many patients have never had the opportunity to explore or express the confusing, contradictory, and unique elements of their conflict. For example, "If I stop smoking, I will feel better about myself, but I may also put on weight, which will make me feel unhappy and unattractive." The clinician's task is to facilitate expression of all sides of the patient's ambivalence, guiding the patient toward an acceptable resolution that triggers change.

Continued on next page

The Spirit of MI, Continued

The Spirit of MI, cont'd

- **Direct persuasion is not an effective method for resolving ambivalence.** It is tempting to try to be "helpful" by persuading the patient of the urgency of the problem and about the benefits of change. It is clear, however, that these tactics generally increase patient resistance and diminish the likelihood of change.
- **The counseling style is a quiet and eliciting one, that generally avoids a confrontational style.** Direct persuasion, aggressive confrontation, and argumentation are the conceptual opposite of MI, and are avoided. To a clinician accustomed to confronting and giving advice, MI can appear to be slow and passive. However, more aggressive strategies, guided by a desire to "confront patient denial," end up pushing patients to make changes for which they are not ready, and often increase resistance.
- **The clinician is not passive but directive with helping the patient to explore the benefits/consequences of changing and of not changing, and helps the patient identify and resolve his/her ambivalence.** MI does not train patients in using behavioral coping skills, although the two approaches can be combined. The operating assumption of MI is that ambivalence or lack of resolve is the main obstacle to be overcome when facilitating change. Once that has been accomplished, there may or may not be a need for further interventions, such as skills training. The strategies of MI are designed to elicit, clarify, and resolve ambivalence in a patient-centered, respectful counseling atmosphere.
- **Readiness to change is not generally viewed as a patient trait, but a fluctuating product of interpersonal interaction.** The clinician is highly attentive and responsive to the patient's motivational signals. Resistance and "denial" are not generally viewed as innate traits, but as feedback regarding clinician behavior. Patient resistance is often a signal that the clinician is assuming that the patient is more ready to change than is the case. It suggests that the clinician needs to modify their approach.
- **The therapeutic relationship is more like a partnership or collaboration than expert/recipient roles.** The clinician respects the patient's autonomy and freedom of choice (and consequences) regarding their own behavior, even if the patient's decision is a poor choice.

(Miller and Rollnick 1991, 2002; Miller, Benefield, and Tonigan, 1993).

MI Guiding Principles

Trainer Note	Explain and discuss how a clinician's actions can positively or negatively affect a patient's motivation to change. In order to be successful when using MI interventions, the following clinician behaviors are important:
Slide 17	
PM 18	<ul style="list-style-type: none">• Demonstrates empathy and uses empathic statements• Promotes patient autonomy (e.g., allowing choices among options, including the choice not to change)• Avoid arguing for change and avoid pushing "their own agenda"• Supports the patient's self-efficacy (e.g., identifies previous successes in behavior change efforts)

MI Interventions	Motivational interventions are more likely to be successful when clinicians: <ul style="list-style-type: none">• Use a collaborative and respectful approach• Promote patient autonomy (e.g., allowing choices among options, including the choice not to change)• Avoid arguing for why the patient "should change"• Avoid pushing "their own agendas"• Support the patient's self-efficacy (e.g., by identifying strengths, knowledge, and abilities, identifying previous successes in behavior change efforts)
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MI Guiding Principles, Continued

Trainer Note **Slide 17** **PM 18** **Explain** that there are four broad guiding principles that underlie MI, i.e., express empathy, develop discrepancy, roll with resistance, and support self-efficacy. These principles are one step towards the general spirit of MI, and begin to move toward greater specificity of practice (Miller and Rollnick, 2002).

As you discuss each principle, be sure to relate this to the “spirit” of MI.

MI Guiding Principles

Express empathy

Be non-judgmental; listen reflectively; accept ambivalence; see the world through the patient’s eyes. Accurately understanding the patient’s experience helps to facilitate change.

Develop discrepancy

Help the patient perceive the difference between their present behavior and their desired lifestyle change. Patients are more motivated to change when they see that their current behavior will not help them achieve a desired future goal.

Roll with resistance

Avoid arguing with the patient. Reframe the patient’s thinking/statements; invite the patient to examine new perspectives; value the patient as being their own change agent.

Support self-efficacy

Provide hope; help the patient build self-confidence in their ability to change behavior; highlight other areas where the patient has been successful.

Continued on next page

MI Guiding Principles, Continued

Trainer Note	Refer to the definition of MI “a patient-centered, directive method for enhancing intrinsic motivation by exploring and resolving ambivalence”.
Slide 18	
PM 19	<p>Ask the large group to define “ambivalence”, and then discuss how ambivalence affects a person’s motivation (willingness, ability, and readiness) to change.</p> <p>Ask the group to share some things they might feel ambivalent about in their own lives, such as making a major change in their diet, beginning an exercise program, stopping tobacco use, or changing jobs.</p>

Exploring and Resolving Ambivalence

Unresolved ambivalence blocks people from change and resolving ambivalence moves people towards change

- Ambivalence is a natural part of any change process
- Ambivalence must be resolved for change to occur or continue
- Ambivalence to change will come and go, so it is important to monitor and reassess ambivalence during the course of treatment

Helping resolve ambivalence:

- Help patients explore all sides of their ambivalence about change (what is good about using tobacco, what is not so good, what are negatives of stopping use, what are consequences of continuing to use)
- Explore with patients to determine what and who is important to them
- Reflect back the patients’ own statements to help them recognize their need for change
- Help develop patient discrepancy - this is the difference between where they are now and where they want to be, and/or how their behavior is not matching with their stated values or what is important to them.

Resistance to Change

Trainer Note **Guidelines for using a brainstorming activity**

A brainstorming activity is a useful way to find out what people are thinking, to stimulate creative suggestions, and to enhance active engagement in learning.

The cardinal rule during the brainstorming is to avoid any evaluation of suggestions made. The goal is to generate many ideas, not to analyze them. Even outlandish and humorous responses are accepted. A brainstorming task can also be assigned to small groups, who then report out their responses to the large group.

Group brainstorming tends to inhibit individual generativity, and yet it allows members to take off from or build upon each other's ideas.

As an alternative to brainstorming, you can use solitary writing, whereby each member is challenged to take time to write down as many ideas as he or she can generate alone. This tends to triple the total number of responses generated during the activity, because each member takes active responsibility for coming up with their own ideas. After a solitary writing period, encourage members to contribute all ideas that they wrote to create a complete list.

Trainer Note **Explain** that this next section will discuss resistance. In MI theory, resistance generally arises from the interpersonal interaction between the clinician and the patient (Miller and Rollnick, 2002).

Conduct a large group brainstorming exercise to elicit from the participants many examples of resistant behaviors that they have experienced with their patients.

Record the responses on an easel pad. Then make a mental note if examples of the four main categories of patient resistant behavior, i.e., arguing, interrupting, negating or denying, and ignoring are among the list.

Continued on next page

Resistance to Change, Continued

Trainer Note Slide 19	Explain that clinicians often perceive resistance when patients are not in agreement with a clinician's own desires (or directions) for treatment goals, treatment priorities, or treatment strategies. Resistance is interpersonal, and it happens only in the context of the relationship between the clinician and the patient. Resistance is feedback from the patient about something that the clinician is doing and suggests the two parties are not in agreement or collaboration.
Slide 20 PM 20	Refer to PM about the four main types of resistance, i.e., arguing, interrupting, negating/denying, and ignoring Mention that resistance is a signal that what the clinician is doing is not working and that the clinician needs to change strategies.

Resistance **Clinicians often perceive resistance when patients are not in agreement with a clinician's own desires, directions for treatment goals, treatment priorities, or treatment strategies.**

People cannot resist in isolation. Resistance is interpersonal, and it happens only in the context of the relationship between people, in this case, between the clinician and the patient.

Resistance is a signal that what the clinician is doing is not working and that the strategy needs to be changed.

The four main categories of resistance are:

- **Arguing** - The patient challenges the expertise or integrity of the clinician.
- **Interrupting** - The patient breaks in to stop and disrupt the clinician.
- **Negating/Denying** - The patient expresses unwillingness to recognize a problem, to accept responsibility, to cooperate, or to take advice.
- **Ignoring** - The patient pays little or no attention to the clinician.

Continued on next page

Resistance to Change, Continued

Trainer Note Ask participants to recall the four guiding principles of MI.

Slide 20 • Express empathy

PM 20 • Develop discrepancy

• Roll with resistance

• Support self-efficacy

Then ask:

“How can you use MI principles to address a patient’s “resistance” about his or her tobacco use?”

(Roll with resistance by avoiding arguing for change, and respecting the patient’s ultimate responsibility for making an individual decision about a problem. Avoid arguing or confrontation as this will likely push the patient in the opposite direction, away from healthy change, Express empathy. Help the patient see the discrepancy between their negative behavior and desired goals. Support a patient’s confidence to change and learn how to change).

Refer to PM and Ask for other examples of rolling with resistance statements that participants may have used. Alternately, the trainer can offer some of their own examples.

Rolling with Resistance

Example of Rolling with Resistance:

Patient: “I know that smoking is bad for me, but I’m under so much stress that I don’t want to stop right now.”

Clinician: “We both agree that it’s important for your health and your recovery to stop using tobacco and alcohol, I also respect your decision that at this point in time you are not yet willing to make that change.”

Using OARS

Trainer Note **Refer to PM**

Slide 21
PM 21

Explain that these four techniques are derived from patient-centered counseling and help patients explore their ambivalence and clarify reasons for change. These techniques are summarized by the acronym **OARS** - **O**pen Questions, **A**ffirmations, **R**eflective Listening, and **S**ummarizing. These techniques are sometimes referred to as MI micro-skills.

OARS **Open Questions**

An open question is designed to encourage a full, meaningful answer based upon the patient's own knowledge and/or feelings. The general pattern in MI is to ask an open question that sets the topic of exploration, followed by reflective listening. The suggested guideline ratio is to use three reflective listening statements for each open question.

Affirmations

Patients are working on very difficult issues. The clinician should show appreciation for their commitment and hard work. Affirmations need to be genuine if the patient is to accept them. Affirmations build rapport and can help reduce resistance to change.

Reflective Listening

Reflective listening allows the patient to feel heard, and is a very important part of MI. Some clinicians are reluctant to use this strategy, fearing “what if I am wrong or off base?” Patients appreciate having the opportunity to clarify the clinician’s understanding of their statements. By using reflective statements, the clinician is letting the patient know that they understand and value what the patient is saying. Reflective statements should be used three times more often than questions.

Summarizing

Summarizing is very similar to reflective listening, only longer. "I'd like to summarize what I understand so far. We have discussed... Does that capture the key points? Did I miss anything?"

Using Open and Closed Questions

Trainer Note	Refer to PM and ask participants to decide if each question is open or closed. Participants can complete the answers to each question individually or by working in pairs or triads. Allow about 5 minutes to complete, and then process the answers to each question with the large group. The trainer has the correct responses shown in bold type below
Slide 22	
PM 22	

Activity - Circle “O” if it is an Open Question or “C” if it is a Closed Question

1. How did stopping tobacco use affect you? O or C **Open**
2. What time is your counseling appointment? O or C **Closed**
3. What do you want to do about smoking, stop, cut back, or keep using? O or C **Closed**
4. Tell me about when you first started using tobacco? O or C **Open**
5. When would you like to return for an appointment? O or C **Closed**
6. Don't you think you should quit smoking due to your child's asthma? O or C **Closed**
7. What do you already know about tobacco treatment medications? O or C **Open**
8. Are you willing to come back for a second appointment? O or C **Closed**
9. What are your biggest fears about stopping tobacco use? O or C **Open**
10. What are the most important things to you? O or C **Open**
11. When do you want to set a quit date? O or C **Closed**
12. When you used the patch and gum, what was the result? O or C **Open**
13. How does smoking tobacco affect your alcohol and other drug use? O or C **Open**
14. Is it OK to share some information with you or ask you some questions? O or C **Closed**

Refer to PM and explain closed questions and open questions both have importance but each is used at different times and for different purposes.

Continued on next page

Using Open and Closed Questions, Continued

Activity - Circle “O” if it is an Open Question or “C” if it is a Closed Question

1. How did stopping tobacco use affect you? O or C
2. What time is your counseling appointment? O or C
3. What do you want to do about smoking, stop, cut back, or keep using? O or C
4. Tell me about when you first started using tobacco? O or C
5. When would you like to return for an appointment? O or C
6. Don't you think you should quit smoking due to your child's asthma? O or C
7. What do you already know about tobacco treatment medications? O or C
8. Are you willing to come back for a second appointment? O or C
9. What are your biggest fears about stopping tobacco use? O or C
10. What are the most important things to you? O or C
11. When do you want to set a quit date? O or C
12. When you used the patch and gum, what was the result? O or C
13. How does smoking tobacco affect your alcohol and other drug use? O or C
14. Is it OK to share some information with you or ask you some questions? O or C

Open and closed questions are equally important to use but at different times and different reasons.

Open questions - use during counseling to help patient to more fully explain their feelings, perceptions, thoughts, ambivalence, to expand hints of change talk, etc.

Closed questions - use when you need to know specific information; when confirming if a patient understands some information; when asking if the patient is willing to try a new direction or to take a next step forward in treatment; and when asking a patient's permission.

Using Reflective Listening

Trainer Note

Slide 23

PM 23 - 24

State *reflective listening is one of the most important and most challenging skills utilized in motivational interviewing. The crucial element of reflective listening is how the clinician responds to what the patient says. The clinician forms a reasonable hypothesis about what the patient means and/or feels, and then voices this hypothesis in the form of a statement.*

Identify and discuss the three types of reflective listening responses, using the examples in the manual.

Reflective Listening

There are three types of reflective listening statements:

- Simple reflection
 - Amplified reflection
 - Double-sided reflection
-

Focus of Reflective Responses

Reflective responses can focus on different issues, such as content (what is actually said), emotions, perceptions, beliefs, thinking, meaning, themes, or a combination of issues.

- A reflection of the verbal content: “You did not smoke last week.”
 - A reflection of feelings or emotions: “You feel angry, sad, etc.”
 - A reflection of thinking: “So you told yourself this was not a good idea.”
 - A reflection of perception or belief: “You believe that your family is the most important part of your life.”
 - A reflection of meaning “You were angry that after making several calls, she didn’t call you back. It also sounds like you feel really disappointed and maybe are wondering if you should stay in this relationship.”
-

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Using Reflective Listening, Continued

Reflective Listening

Simple reflection

The simplest approach is to reflect the patient's statement with little or no elaboration. This acknowledges and validates what the patient has said and may elicit a "change talk" (helping the patient talk about solutions, how to change, ways to resolve a problem, etc.) response.

Patient: "Who are you to give me advice? You don't even use tobacco!"

Clinician: "It's hard for you to imagine how I could possibly understand how tough it is to stop using tobacco and begin recovery."

Amplified reflection

Reflecting back what the person has said in a somewhat exaggerated form is an amplified response. Amplified responses must be supportive, straightforward, and matter of fact, without any hint of sarcasm or impatience. If successfully used, it will prompt the patient to reflect and will elicit the other side of their ambivalence.

Patient: "My wife really nags at me about my tobacco use, so much that I want to take our long vacation without her!"

Clinician: Your tobacco use is so important to you that you are seriously considering vacationing without her, so you can smoke in peace."

Double-sided reflection

A double-sided response captures both sides of the patient's ambivalence. It acknowledges what the patient has stated and adds the other side of the patient's ambivalence, usually drawing from material that the patient has offered in previous sessions.

Patient: "I know smoking cigarettes is bad for my health, but I've already quit cocaine, and smoking lifts my mood and energizes me."

Clinician: "So you know that tobacco is ruining your health, and on the other hand you feel using tobacco lifts your mood and energizes you, just like when you used cocaine."

Continued on next page

Using Reflective Listening, Continued

Trainer Note

Slide 23

PM 25

Explain that reflective statements usually have a neutral tone and it does not imply judgment. Some people find it helpful to have a lead-in phrase to get them started in making a reflective listening statement. Examples are:

- What I hear you saying is that you . . .”
- “So you feel . . .”
- “It sounds like you . . .”
- “You're wondering if . . .”

Remind participants to be careful about overusing lead-in phrases.

Lead-in Phrases

Some people find it helpful to have a lead-in phrase to get them started in making a reflective listening statement. Examples are:

- What I hear you saying is that you . . .”
- “So you feel . . .”
- “It sounds like you . . .”
- “You're wondering if . . .”

Be careful about overusing lead-in phrases. These are not necessary to form an effective reflective listening statement.

Continued on next page

Using Reflective Listening, Continued

Trainer Note

Slide 23

PM 25

State: *Reflective listening statements can also be used in a way that is similar to asking: "Do you mean . . ." questions. They offer a hypothesis about what the speaker means, but in the form of a statement that sounds like a question. The difference is in the use of an upward inflection at the end of the sentence.*

Demonstrate this by inflecting the word "use" differently in this sentence:

"You're angry about what I said about your tobacco use?" (up inflection)

vs.

"You're angry about what I said about your tobacco use." (neutral or down inflection)

Mention that this is not always easy to do. Therefore, you can opt to have participants try using an upward versus downward inflection using a few different statements.

**Using
Inflection**

An upward inflection can also be used at the end of a reflective statement to imply or ask a question. A neutral or downward inflection is used to reflect information and to indicate that you are listening.

Try stating each example below first with an upward inflection and then with a downward inflection.

"You're angry about what I said about your tobacco use?" (upward inflection)

vs.

"You're angry about what I said about your tobacco use." (neutral or downward inflection)

Continued on next page

Using Reflective Listening, Continued

Trainer Note The trainer may choose to demonstrate examples of simple, double-sided, and amplified reflective responses before conducting this activity.
Slide 24

PM 26 **Assign** participants into pairs or triads. Ask each pair/triad to read each statement and then write a simple, double-sided, and amplified reflective response.

Process the examples with the large group. Ask other participants for additional examples or directly suggest other effective ways to reflect a specific example.

Reflective Listening Activity

Patient Statement 1: “I have been smoking since I was 12 years old. After 30 years of doing this, I be lost without a cigarette.”

Write a Simple Reflection:

Patient Statement 2: “All of my friends smoke tobacco, it helps us have a conversation. If I stop smoking, I will look like the oddball and won’t know how to act.”

Write a Double-sided Reflection :

Patient Statement 3: “I understand that smoking is bad for my health and might harm my recovery, but smoking is just part of who I am.”

Write an Amplified Reflection :

Change Talk vs. Problem Talk

Trainer Note

Slide 25

PM 27

Explain that eliciting “change talk” (defined as “helping the patient to talk about solutions, talk about reasons for or benefits of change, talk about how to change, or ways to resolve a problem, etc.”) is the guiding strategy for motivating the desire to change.

The clinician’s goal is to reinforce change talk and to shift the conversation away from “problem talk” (the patient talking about the problem, why they cannot change, causes of problem, history of the problem, etc.). Change talk ultimately decreases resistance and leads to an increased commitment to change.

The more the patient’s level of commitment language increases, the greater the chances that behavioral change will occur (Miller and Rollnick, 2002).

Problem Talk and Change Talk

What is problem talk?

- Problem talk is when patients talk about the problem, why they cannot change, causes of the problem, the history behind the problem, etc., and represents a patients’ movement away from making a change.

What is change talk?

- Change talk is when patients talk about solutions, about benefits of change or disadvantages of staying the same, about how to change, about ways to resolve a problem, etc., and reflects movement of the patient towards making a change.

Why focus on change talk?

- When used effectively, MI principles tend to evoke high levels of change talk and lower levels of problem talk (and lower levels of resistance).
- When patients start to talk about the reasons they should change, it is a sign that their motivation for change is increasing.
- In contrast, confrontational counseling, arguing for change, advice giving, or telling people what to do, evokes higher levels of resistance, more problem talk, and lower levels of change talk.

“As I hear myself talk, I learn what I believe.”(Miller, 1983)

Identifying Change Talk

Trainer Note **Explain** that a person's change talk can fall into several general categories:

Slide 26

- Disadvantages of the status quo (disadvantages of not changing or disadvantages of staying the same)
- Advantages of making a change
- Ways to overcome obstacles to making a change
- Optimism about making a change
- Intentions for making a change
- Identifying and describing solutions to effect change

Slide 27
PM 28

Explain an easy way to remember if the patient is using change talk is by the acronym **DARN-C** or Desire, Ability, Reasons, Need, and Commitment.

Emphasize that the focus is to have the patient present the arguments for change. The clinician's role is to facilitate the patient's use of change talk, not make arguments for why the patient should change.

DARN-C

Change talk can be remembered by using in the acronym **DARN-C**, when the patient makes statements that hint at or openly suggest the following:

Desire to change (intentions to change, talks of plan to change)

Ability to change (optimism to change, knowledge or skills to change)

Reasons for change (disadvantages of status quo or of not changing)

Need to change (importance to change)

Commitment to change (makes preparations, takes action, follows through)

Remember: The focus is to have the patient present the arguments for change. The clinician's role is to use MI skills to facilitate the patient's increased use of change talk, and not to argue for change or tell the patient to change.

Continued on next page

Identifying Change Talk, Continued

Trainer Note
Slide 28

This list of questions is only in the Trainer's Manual and is not in the PM.

Explain that change talk is often subtle and patients are not always aware that their own words are suggesting that they are moving towards change.

Lead the "Change Talk Activity" by reading aloud each statement. Ask the participants to do a drum roll with their hands or fingers or say "change talk" aloud when they hear a change talk example. The trainer manual has statements that contain change talk are in **bold type**.

1. I only smoke when stressed and it relaxes me.
2. **I've tried to quit at least four or five times in the past few years but I always go back.**
3. My mom is always on me about my smoking but I don't smoke anymore than my friends do and nobody is on their back to quit.
4. **I used to run 2 miles at least three times a week. I know that if I stopped smoking that I would be able to get back to running.**
5. **I did order patches through the Quitline, but I haven't used them yet.**
6. Everybody in my family smokes, and none of them have any health problems.
7. **My kids hate that I smoke, so I try to hide it from them. I feel like a bad parent.**
8. If only my parents hadn't smoked, I would not have picked up the habit myself.
9. **I would like to go to a movie and be able to sit through the whole thing without having to go out for a cigarette.**
10. **I'm scared, every time I go to the doctor; he tells me that with high blood pressure, diabetes and smoking, I am at high risk for a heart attack.**

How to Elicit Change Talk

Trainer Note	Review the ten strategies for evoking change talk. Ask the participants if they have ever used any of these strategies and if so, to provide an example for how they have used it.
Slide 28	
PM 29 - 31	Time permitting; the trainer can briefly demonstrate each strategy with the large group, by asking participants to provide a patient tobacco statement and demonstrating the strategy in response. The trainer can also ask participants to offer an example of the strategy in response to a patient statement.

Strategies for Eliciting Change Talk

Ask Evocative Questions

Ask open questions (who, what, where, when, and how). Remember to use three reflective statements for each question asked.

Use Decisional Balance

Explore the four quadrants - advantages of using tobacco (good things about using), disadvantages of using tobacco (not so good things about using), consequences of stopping tobacco (not so good things about stopping), and advantages of stopping tobacco use.

Ask for Elaboration

When a change talk theme emerges, ask for detail. “Tell me more about that”.

Ask for Examples

When a change talk theme emerges, ask for specific examples. “When was the last time that happened?” “Give me an example” “What encourages or increases your desire to do that?”

Look Back

Ask about a time before the current situation emerged. “How were things better in the past? (Reflect response) “How have things changed since then?” (Reflect response), “What things are different now?” (Reflect response).

Continued on next page

How to Elicit Change Talk, Continued

Strategies for Elicit Change Talk

Look Forward

“How will things be in the future if things continue, as they are (status quo).” Then shift to asking how things would be if the patient made this change. Be sure to ask for specifics.

You can also try the crystal ball question, following by reflective statements: “If you were 100% successful in making the changes you want, what would be different? For example, what would be the first thing you would notice that was better? What would be different about your health and your recovery? How would your relationship with your family be different?”

Query Extremes

“What are the worst things that might happen if you don’t make this change? What are the best things that might happen if you do make this change?”

Explore Goals and Values

Ask what the person’s guiding values are. What do they want in life? If there is a problem behavior, ask how that behavior fits in with the person’s goals or values. “Does this behavior help you to realize an important goal or value? Does it interfere with it? Or is it not relevant?”

Come Alongside

Explicitly side with the negative side of the patient’s ambivalence. “Perhaps using tobacco is so important to you, that you won’t give it up, no matter what it costs you.”

Continued on next page

How to Elicit Change Talk, Continued

Trainer Note, cont'd Slide 27 PM 31	Refer to PM and explain that knowledge and skills increases importance and confidence. Show the first slide when talking about using scaling questions to elicit change talk. Follow-up with explaining the “seesaw effect” that the more change talk patients use, the more likely they will move (lean or tilt) towards healthy change, using the next slide.
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**Strategies for
Eliciting
Change Talk,
cont'd**

Use Scaling Questions about Importance and Confidence

Importance - “On a scale from zero to ten, where zero is low and ten is high, how important is it for you to stop using tobacco?”

Confidence - “On a scale of zero to ten, if you decided to stop using tobacco, how confident are you that you could stop and remain abstinent from tobacco?”

Suggestion: for either question, if a score is less than six, follow-up with something like “why are you at a score of two, three, etc. and not at zero? What keeps your score this high? What keeps it from going lower than it is?”

Then follow by asking: “What would have to happen to move you from three to a four? What would have to happen to move you from a four to a five?”

If the patient scores six or higher on the importance scale (indicating a higher importance to make a change), shift to asking: “Obviously this is an important issue for you. How high on the scale would your confidence need to be to make this change?” Alternatively, “Using the zero to ten scale, how high on the scale does your importance need to be to make this change? What would it take to move your score to the higher level?”

“How would you know that you moved from six to a seven or eight? What would seven or eight look like? What might interfere with your plan and how would you overcome a set-back?”

Using the 5 Rs

Trainer Note *State for patients not ready to address their tobacco use, the CPG, 2008 recommends that clinicians use brief interventions designed to increase motivation to stop tobacco use (Fiore, Jaen, Baker, et al., 2008).*

Conduct a brainstorming activity and ask participants to generate a list of reasons why patients may be unwilling to stop using tobacco. Record on an easel pad as the list is generated. Possible responses are that the patient may:

- Lack information about the harmful effects of tobacco
- Lack the financial resources to access treatment
- Have fears or concerns about not using tobacco
- Be demoralized because of previous tobacco relapse
- State they enjoy the benefits of tobacco too much
- Refuse to believe that tobacco is harmful

Trainer Note **Slide 29** **PM 32** **Explain** that a motivational intervention should educate, reassure, develop discrepancy, and help a patient resolve their ambivalence. These interventions include the Five R's.

Relevance, Risks, Rewards, Roadblocks, and Repetition

Research shows that the utilization of the Five Rs enhances future attempts at tobacco abstinence (Fiore, Jaen, Baker, et al., 2008).

Continued on next page

Using the 5 Rs, Continued

Trainer Note	Refer to PM and ask participants to review the descriptions of the Five Rs
Slide 29	Explain that these basic content areas should be discussed as part of any MI intervention.
PM 33 - 34	Discuss each area with the large group, having participants follow along in their PM and explain that the clinician's goal when focusing on each content areas is to develop discrepancy within the patient and to help the patient resolve their ambivalence.

Five Rs

Five Rs

- **Relevance**
- **Risks**
- **Rewards**
- **Repetition**
- **Roadblocks**

These basic content areas should be discussed as part of any MI intervention.

The clinician's goal for focusing on the five content areas is to develop discrepancy and to help the patient explore and resolve their ambivalence about making a change.

Continued on next page

Using the 5 Rs, Continued

Clinical Components of the Five Rs

Relevance

Encourage the patient to explain why stopping use might be personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's family or social conflicts, (e.g., having children in the home); health concerns, age, gender, and other important patient characteristics, (e.g., relationship to the use ritual of other substances, a lifestyle of chronic craving, drug-seeking behavior, and self-medication of withdrawal symptoms, and other personal barriers to tobacco recovery).

Clinical Components of the Five Rs, cont'd

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician should emphasize that using low-tar/low-nicotine cigarettes or other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks.

Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide (CO).
 - Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
 - Environmental risks: Increased risk of lung cancer and heart disease in spouses, higher rates of smoking by children of tobacco users, increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of people who smoke.
 - Relapse: For many, active tobacco use increases the probability of relapse to other substances.
-

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Using the 5 Rs, Continued

Clinical Components of the Five Rs, cont'd

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those items that seem most relevant to the patient.

Examples of rewards:

- Enhances the quality of recovery and decreases the probability of relapse to other substances
 - Improved health and feel better physically
 - Save money
 - Feel better about yourself
 - Home, car, clothing, breath will smell better
 - Can stop worrying about quitting
 - Set a good example for children
 - Have healthier babies and children
 - Not worry about exposing others to smoke
 - Perform better in physical activities
 - Reduced wrinkling/aging of skin
 - Improved sense of smell and food will taste better
-

Clinical Components of the Five Rs, cont'd

Repetition

The motivational intervention should be repeated every time a resistant patient meets with the clinician. Tobacco users who have experienced prior periods of abstinence should be provided education about substance use relapse, should be encouraged to establish a new tobacco recovery date, and should develop a relapse prevention plan (Fiore, Jaen, Baker, et al., 2008).

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Using the 5 Rs, Continued

Trainer Note	Emphasize one of the most common roadblocks is patient fears.
Slide 30 PM 35	<p>Ask: <i>What are the main fears that patients have if they were to stop using tobacco?</i></p> <p>(Fear of relapse to alcohol or other drug use; fear of not being able to handle the stress; fear of anxiety of daily living; fear of not being able to socialize with friends or family who continue to use tobacco)</p> <p>Remind participants that fear creates ambivalence and ambivalence keeps people “stuck” in the status quo. The clinician should address any fears and help the patient resolve their concerns, and may need to help patients identify specific strategies to deal with each fear identified.</p>

Clinical Components of the Five Rs, cont'd

Roadblocks

The clinician should ask the patient to identify barriers or impediments to stopping tobacco use and identify elements of treatment (problem solving, pharmacotherapy, etc.) that could address barriers, such as:

- Withdrawal symptoms
- Fears (fear of relapse to AOD, fear of inability to handle the stress, fear of anxiety, fear of inability to socialize without tobacco, fear of socializing with people who use tobacco)
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco
- Boredom and anxiety
- Belief that tobacco use should not be addressed in early recovery
- Tobacco use prevalence at 12-Step meetings and other groups

Providing Information vs. Giving Advice

Trainer Note
Slide 31

Ask: *How is providing information by using MI principles different from giving advice?*

PM 36

Explain that some clinicians give advice, and expect patient to follow their advice as a directive. In contrast, providing information using MI principles requires determining what the patient wants to know, what the patient already knows, and asking if the patient is interested in learning more information.

Refer to PM and Ask participants to review the MI principles for providing information to patients as described below, before moving to the activity on the next page.

Providing Information vs. Giving Advice

Providing information is different from giving advice.

Clinicians have a wealth of expertise, which can be shared with patients when appropriate. To avoid patient resistance, information should be offered to patients within the spirit and principles of motivational interviewing.

- Notice the difference between “you need to stop smoking because it is bad for you” vs. “smoking involves many health risks” or “tobacco use can negatively affect recovery from alcohol and other drug use.”
- Information should be relevant to the patient and something the patient is ready and open to learn about.
- If the clinician presses the patient to recognize a connection or offers unsolicited information, it turns into giving advice and that leads to patient resistance.
- Keep information patient-centered and without arguing your own agenda, preference, or bias.
- Avoid using: “you need to”, “you should” “you must”, etc. when providing information.
- Use a neutral, business-like tone when giving information that does not imply what the patient should or should not do.

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Providing Information vs. Giving Advice, Continued

Trainer Note	This activity can be completed with the large group, or in small groups.
Slide 31	Refer to the PM and ask participants to review the list of statements and decide if the statement provides information or if it gives advice. Review the correct answers with the large group using answers.
PM 37	

Information or Advice Activity	Which examples provide information and which give advice? Circle "I" for the statements that provide information or circle "A" for those that give advice.
PM 37	<ol style="list-style-type: none"> 1) "Smoking is bad for you and you should quit immediately." A 2) "Tobacco dependence, like any other chemical dependency, is a chronic, disease that affects the entire person." I 3) "You may not die from your cocaine or alcohol use, but you will certainly die from your tobacco use." A 4) "Research on addictions has found that when people are abstinent from tobacco, they often have better abstinence rates from other substances." I 5) "You just have to accept that this program is tobacco-free. Ultimately this is for your own good." A 6) Personally, I don't agree with this tobacco-free regulation. I can't imagine that I would be able to stop drinking and smoking at the same time." A 7) "Cold turkey is just not the way to go for you. You should use the nicotine patch and gum." A 8) "Several studies show that people can maintain abstinence from tobacco while actively working on recovery from alcohol or drug addiction." I 9) "You're only wrecking your lungs by continuing to smoke. You'd be much better off if you stopped." A 10) "The studies with smokers show that generally all the tobacco treatment medications are effective. It often comes down to what patients want to use, what their experience has been with medication, and what's available." I

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Providing Information vs. Giving Advice, Continued

**Information
or Advice
Activity**

Which examples provide information and which give advice?

Circle "I" for the statements that provide information or circle "A" for those that give advice.

- 1) "Smoking is bad for you and you should quit immediately." I or A
- 2) "Tobacco dependence, like any other chemical dependency, is a chronic, disease that affects the entire person." I or A
- 3) "You may not die from your cocaine or alcohol use, but you will certainly die from your tobacco use." I or A
- 4) "Research on addictions has found that when people are abstinent from tobacco, they often have better abstinence rates from other substances."
- 5) "You just have to accept that this program is tobacco-free. Ultimately this is for your own good." I or A
- 6) Personally, I don't agree with this tobacco-free regulation. I can't imagine that I would be able to stop drinking and smoking at the same time." I or A
- 7) "Cold turkey is just not the way to go for you. You should use the nicotine patch and gum." I or A
- 8) "Several studies show that people can maintain abstinence from tobacco while actively working on recovery from alcohol or drug addiction. I or A
- 9) "You're only wrecking your lungs by continuing to smoke. You'd be much better off if you stopped." I or A
- 10) "The studies with smokers show that generally all the tobacco treatment medications are effective. It often comes down to what patients want to use, what their experience has been with medication, and what's available." I or A

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Providing Information vs. Giving Advice, Continued

Trainer Note
Slide 31**PM 38**

Explain that when providing information, MI uses a technique called **Elicit-Provide-Elicit or EPE**

EPE is a cyclical process of gradually providing information in small bits and in a neutral, straightforward style. It involves asking open questions, then asking permission to offer information and if the patient is open to receiving information, providing a small amount of information, followed by more open questions as well as the use of reflective listening.

The trainer should demonstrate a few examples of EPE with participants or ask participants to demonstrate a few examples to illustrate this technique.

Elicit-Provide-Elicit (EPE)

A useful method of effectively providing information is known as **Elicit-Provide-Elicit or EPE**

EPE is a cyclical process of gradually providing information in small chunks by using a neutral, straightforward style. It revolves around asking open questions, then asking permission to offer information, then providing a small amount of information, followed by more open questions as well as the use of reflective listening.

1. First, the clinician asks patients an open question to focus the scope of information (example: “What would you like to know more about...” or “What do you already know about...?”)
 2. Then, the clinician asks permission to provide information, which is presented in a manageable chunk (example: “Would you like some information about...?” Is it alright with you, if I share information about what seems to help people stop smoking?”)
 3. Then the clinician asks for the patient's response to the chunk of information (example: “How does this information fit into your experience?” or “What does this mean to you?” or “What more would you like to know?”)
-

Unit Summary

Trainer Note

PM 39

Summarize the CPG (Fiore, Jaen, Baker, et al., 2008) about MI strategies using the following points:

- An effective tool to motivate precontemplative and contemplative patients
- The MI approach requires the clinician to use reflective techniques to help patient recognize and resolve their ambivalence
- The approach avoids arguing or pressing the patient to accept the change
- MI uses strategies that help the patient express their reasons to make a change (e.g., stop using tobacco)
- The goal is to help patients resolve their ambivalence and move toward healthy behavior change

**Motivational
Interviewing
Summary**

The CPG 2008 states that MI strategies are an effective tool to motivate precontemplative and contemplative patients (Fiore, Jaen, Baker, et al., 2008). This approach requires that the clinician use reflective techniques, help patients recognize and resolve their ambivalence, avoids arguing or pressing the patient to accept the need for change, and uses strategies that help the patient express their reasons to make a change (e.g., stop using tobacco). Clinicians need to listen carefully for and elicit change talk. Information is provided using the EPE (elicit-provide-elicit) method and is not imposed on patients. The goal is to help patients resolve their ambivalence and move toward healthy behavior change.

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Unit 2

Cognitive-Behavioral Therapy and Relapse Prevention Therapy

Trainer Note	Refer to PM regarding the purpose and objectives for this unit and address any questions.
Slide 32	
PM 41	Explain that this unit will only provide an introduction and overview of Cognitive Behavioral Therapy (CBT) and Relapse Prevention Therapy (RPT), not an indepth review. If participants are interested in learning more about these techniques, they can take a more detailed version of CBT and RPT online at www.tobaccorecovery.org .

Purpose When a patient enters the preparation or action stage of change, evidence shows that providing counseling using problem-solving skills, coping skills, and stress management skills, results in higher abstinence rates (Fiore, Jaen, Baker, et al., 2008). In this unit, participants will become familiar with two examples of these counseling methods, Cognitive-Behavioral Therapy (CBT), and Relapse Prevention Therapy (RPT), and their application in treating tobacco dependence in chemical dependence services.

This unit is only a brief introduction; if you are interested in learning more about CBT and RPT, consider taking the online version of CBT (e-Learning Module 4) at www.tobaccorecovery.org.

- Unit 2 Objectives**
- Identify the two components of Cognitive-Behavioral Therapy (CBT)
 - Identify at least four contributing factors to tobacco use relapse
 - Identify at least four behavioral techniques that support tobacco recovery
-

The Importance of Using Psychosocial Therapies

Trainer Note

Slide 33

PM 42

Refer to PM and explain that psychosocial treatments for tobacco dependence are a first-line treatment, yet only about 5% of people who try to become abstinent from tobacco use psychosocial therapy.

Explain that the effectiveness of psychosocial treatments depends on many factors, e.g. the stage of change, the duration of the intervention, and the number of contacts/sessions, and suitable methods for chemical dependence settings.

The CPG 2008 recommends that the combination of medication and supportive counseling is most effective for patients attempting to stop using tobacco.

Effective Treatment Methods

Psychosocial therapies for tobacco dependence are effective, first-line treatments and increase the chance of recovery. The effectiveness of psychosocial treatments for tobacco dependence depends on factors such as the patient's stage of change readiness, the duration of the intervention, and the number of patient contacts, making such interventions well suited for chemical dependence settings.

In general, there is a dose-response effect, the more treatment contacts and sessions, the higher the intensity, and the longer the duration, the better the chance of recovery (Fiore, Jaen, and Baker et al., 2008).

However, only about 5% of people who use tobacco seek out or receive psychosocial therapy to help them make an attempt at abstinence (Fiore, Jaen, and Baker et al., 2008). A key reason is that many people, even those who personally understand substance dependence as a biopsychosocial disease, tend to believe their tobacco dependence is more an issue of will power and "bad habit."

The CPG 2008 also recommends that combining medication along with supportive counseling is more effective for patients attempting to stop using tobacco, than using either counseling or medication alone (Fiore, Jaen, and Baker et al., 2008).

Continued on next page

The Importance of Using Psychosocial Therapies, Continued

Trainer Note
Slides 34 - 35
PM 43

Explain *For patients in the preparation and action stages of change, practical problem-solving skills training help support higher abstinence rates and two evidence-based methods for patients in these two stages of change are cognitive-behavioral therapy (CBT) and relapse prevention therapy (RPT). CBT and RPT can easily be combined with MI techniques to help patients to address everyday situations and emotional states that cue patients to use tobacco.*

CBT and RPT
Evidenced-
Based
Practices

The CPG 2008 (Fiore, Jaen, and Baker, et al., 2008) recommends that patients in the preparation and action stages of change be provided practical problem-solving skills training and this supports higher abstinence rates.

Two evidence-based methods are cognitive behavioral therapy (CBT) and relapse prevention therapy (RPT). CBT can be combined with MI techniques and/or with the stages of change.

These methods help patients to address everyday situations, behavioral, and emotional states that cue patients to use tobacco (Gottlieb, 1992). Situational cues can also be addresses such as drinking coffee, talking on the phone, watching TV, finishing a meal, driving, anger, frustration, stress, and boredom (Fiore, Jaen, and Baker et al., 2008).

CBT is most effective for patients in the preparation and action stages of change.

Continued on next page

Principles of CBT

Trainer Note **Refer to PM and explain**

Slides 36 -37

PM 44

CBT has been well studied and has been shown to be effective after many clinical trials. The premise of CBT is that feelings and behaviors are caused by a person's thoughts and beliefs, not from outside stimuli, and that a change in thinking will improve how they feel and act.

The goal of CBT is to identify and challenge thinking errors, gain new knowledge, and develop new coping skills. CBT is most effective for people in the preparation or action stage of change.

CBT

CBT treatment is among the most frequently evaluated psychosocial approaches for the treatment of substance use disorders and has a comparatively strong level of empirical support (Holder et al., 1991; American Psychiatric Association 1995; General Accounting Office, 1996).

To date, more than 24 randomized controlled trials using CBT have been conducted among adult users of tobacco, alcohol, cocaine, marijuana, opiates, and other types of substances (Carroll, 1996).

CBT is based on the idea that feelings and behaviors are caused by a person's thoughts and beliefs, not on outside stimuli like people, situations, and events. People may not be able to change their circumstances, but they can change how they think about them, and therefore change how they feel and behave.

In the treatment for alcohol and other drug dependence, the goal of CBT is to teach the person to recognize situations in which they are most likely to use alcohol, tobacco, or other drugs, to avoid these circumstances if possible, and to cope with other problems and behaviors, which may lead to their substance use.

For patients in the preparation and action stages of change, providing practical problem-solving skills training results in higher abstinence rates (Fiore, Jaen, Baker, et al., 2008). Patients benefit from such training that addresses physical, behavioral, and emotional arenas.

The Components of Cognitive Behavioral Therapy (CBT)

Trainer Note

Slide 38

PM 45 - 46

Review the two main components of CBT (functional analysis and skills training) and explain how these are applied in tobacco treatment. Then explain the use of “homework” to encourage patients to practice new skills outside of treatment sessions.

The slide illustrates that CBT is more useful in the preparation and action stages of change.

Remind participants that CBT can be used in conjunction with MI techniques.

What Are the Components of CBT?

Functional Analysis

The clinician and the patient work collaboratively to identify the patient’s thoughts, feelings, and circumstances that occur before, during, and after they have used alcohol, tobacco, or other drugs. It also examines the benefits gained from using the drug. This helps the patient determine the supporting factors and risks that are likely to lead to use.

Functional analysis can also give the patient insight into cues and triggers for alcohol, tobacco, or other drug use, and identify situations in which the patient has coping difficulties. The objective is to identify irrational thought patterns.

Skills Training

When someone needs professional treatment for their alcohol, tobacco, or drug dependence, chances are that alcohol, tobacco, or other drugs are their main means of coping with their problems. The goal of CBT is to help the person learn or re-learn better coping skills.

The clinician tries to help the patient change old behavior and learn to develop healthier skills and habits, and to challenge and replace irrational thinking patterns with more appropriate and rational thinking. The main goal of CBT is helping the chemically dependent patient change the way they think about their substance use and learn new ways to cope with the cues and triggers that led to their drinking or drugging episodes in the past.

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The Components of Cognitive Behavioral Therapy (CBT)), Continued

What Are the Components of CBT?
cont'd

Skills training (to change behavior and thinking) requires a lot of practice, which is often given with “after session homework.”

A patient might be asked to practice deep-breathing exercises or role-play how to act and talk differently in certain social situations. A person dealing with substance problems might practice ways to decline an alcoholic drink or the offer of a cigarette.

Homework is vital to the success of CBT. Patients must practice new, rational responses until they replace their previous, unhealthy responses. Homework also allows the patient to try new skills and give feedback to the clinician on what works best for them.

Because CBT is a structured, goal-oriented change process focused on the immediate problems of the chemically dependent patient, it is usually short-term. Although other forms of therapy can take months or years, CBT can usually be completed in 12 to 16 sessions.

Principles of Relapse Prevention Therapy (RPT)

Trainer Note

Slide 39

PM 47

Refer to PM and explain: Tobacco dependence is a chronic biopsychosocial disease characterized by frequent relapse. Chronic disease management requires a multidisciplinary approach including medication, supportive counseling, patient education, skills training, development of coping skills, and social support.

A central element of all clinical approaches to RPT is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance (in this case tobacco) use, then helping patients develop effective strategies to cope with those high-risk situations without having a relapse.

A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that exposure to high-risk situations may well result in a relapse, unless effective coping strategies are available to the patient and implemented quickly and adequately (Center for Substance Abuse Treatment, TIP Series 42).

Relapse Prevention

“The goal is not just to prevent relapse; it is to gain the positive dimensions of recovery” (Fisher, 2000).

Relapse is not a failure of the patient. It is a common symptom of all chemical dependencies, especially tobacco dependence.

Due to the chronic relapsing nature of tobacco dependence, providing tobacco users with practical counseling (problem-solving skills training) results in higher abstinence rates. Relapse prevention should be addressed in treatment by using the most effective treatments available, including tobacco treatment medications and intensive supportive counseling. This is the best strategy for producing high, long-term abstinence rates (Fiore, Jaen, Baker, et al.2008), The primary goal of relapse management is to prevent the patient’s setback from escalating, to help the patient stabilize, and to help the patient develop competent coping strategies for present and potential future problems.

Continued on next page

Principles of Relapse Prevention Therapy (RPT), Continued

Trainer Note
Slides 39 - 40
PM 47

Trainer option: If time permits, conduct a large group brainstorming activity to elicit responses to this question:

What are the major factors that contribute to relapse?

The responses can be recorded on an easel pad. Once the list is complete, ask participants to compare their list to the relapse factors in the PM and add factors not identified.

Alternately, if time is limited, you can refer to the following factors and refer participants to the PM.

**Relapse
Factors**

Major contributing factors to relapse:

- Withdrawal discomfort
 - Social environment
 - Stressful situations
 - Loneliness and boredom
 - Depression
 - Relapse to other substances
 - Weight gain
 - Lack of social support
-

Components of RPT

Trainer Note Ask participants to review the Minimal Components of Relapse Prevention and explain that the components listed below in the PM should be part of every encounter with a patient.

Slides 41 -

PM 48

When discussing this material with the large group, ask them to add other ideas about relapse prevention that they have used in their counseling work.

**Preventing
Relapse to
Tobacco Use**

Minimal Components of Relapse Prevention Practice

These interventions should be part of every encounter with a patient who has recently established tobacco abstinence.

- When providing relapse prevention counseling, use open questions designed to initiate patient problem-solving and to identify solutions that work (e.g., “How has stopping tobacco use helped you?”, “What do you notice is better, even if only a little bit better”? “What seems to be helping you the most with your recovery”?)
 - Every patient who stops using tobacco should receive congratulations on their success and strong encouragement to remain abstinent
 - The rewards (e.g. improvements to the physical, emotional, social, and spiritual aspects of life)
 - Any success the patient has had in their tobacco recovery process (duration of abstinence, reduction in withdrawal, etc.)
 - The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, being around other tobacco users)
-

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Components of RPT, Continued

<p>Trainer Note</p> <p>Slide 41</p> <p>PM 49</p>	<p>Explain that the clinician's use of prescriptive relapse prevention is to address specific problems that have been identified by the patient, or which might surface as a patient concern during their tobacco recovery.</p> <p>Refer to PM and ask participants to review the examples of problems and responses (actions taken by the clinician) listed in the PM.</p>
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Preventing Relapse to Tobacco Use, cont'd

Components of Prescriptive Relapse Prevention

A patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients and potential responses follow:

Problem: Lack of support for tobacco recovery

- Schedule follow-up visits or telephone calls with the patient
- Help the patient identify sources of support within his or her environment
- As indicated, coordinate tobacco treatment with other allied professionals including the patient's primary counselor, mental health therapist, and health care provider(s)
- Provide supportive counseling, help the patient get access to appropriate medications, or refer the patient to a specialist

Problem: Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy, increasing the dose, or adding medications to reduce strong withdrawal symptoms

Continued on next page

Components of RPT, Continued

Trainer Note
Slide 40
PM 50

Explain that the fear of weight gain and reduced motivation to maintain abstinence due to feeling deprived, are common among tobacco users who begin recovery.

Refer to PM regarding strategies, which can be used to assist patients to address these concerns. These items can be reviewed at their leisure.

**Preventing
Relapse to
Tobacco Use,
cont'd**

Problem: Weight gain

- Recommend starting or increasing physical activity; discourage strict dieting
- Reassure the patient that some weight gain is common after stopping the use of all drugs of addiction, including tobacco, and appears to be self-limiting
- Emphasize the importance of a healthy diet
- Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, NRTs, particularly nicotine gum)
- Refer the patient to a specialist or program

Problem: Flagging motivation/feeling deprived

- Reassure the patient that these feelings are common
 - Recommend rewarding activities
 - Probe to ensure that the patient is not engaged in periodic tobacco use. Carbon Monoxide (CO) monitoring may provide “clinical information” to aid in this discussion
 - Sporadic tobacco use will increase the frequency of tobacco craving
-

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Components of RPT, Continued

Trainer Note Slide 41 PM 51 - 54	Refer to PM and Review the related behaviors that are often associated with tobacco use, along with the RPT coping strategies and techniques that can be used to help patients maintain abstinence, and continue their recovery from tobacco.
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Preventing Relapse to Tobacco Use, cont'd

Related behavior patterns associated with tobacco use:

Comprehensive counseling includes helping the patients gain insight into their tobacco-use behaviors and educates them about various behavioral techniques and strategies that will facilitate success in their tobacco recovery. This is reflective of the 12-Step adage that recovery requires one to “change people, places, and things.”

These can include encouraging the patient to:

- Maintain an inventory of tobacco use behavior by keeping a log of every time they use tobacco - the time of day, the physical surroundings, whether under stress or while relaxing, etc. This answers the questions of “when and where.”
- Recognize cues to use tobacco and identify events, internal states, or activities that can trigger tobacco use (e.g., depressed mood, anxiety, being around other tobacco users, drinking coffee). This answers the questions of “what, how, and why.”

Continued on next page

Components of RPT, Continued

Preventing Relapse to Tobacco Use, cont'd

Develop coping skills

- Anticipate and avoid temptation - clear tobacco and tobacco-related items out of the home, work, and play environment (Fiore, Jaen, Baker, et al., 2008)
- Mentally rehearse not using tobacco in situations where historically the patient has used tobacco (Fiore, Jaen, Baker, et al., 2008)
- Reframe. Change the word selection regarding the recovery process from one of “difficulty” and “loss” to one of “challenge” and “choice”
- Implement lifestyle changes to reduce stress and improve quality of life
- Assertiveness training, where the patient learns how to state what he or she needs without impinging on the rights of other people in the situation (American Lung Association, 1996)
- Moderate physical exercise and physical activity should be encouraged (Fiore, Jaen, Baker, et al., 2008)
- Weight gain can occur when stopping the use of tobacco but does not occur in all instances and, in any event, can usually be managed. Most weight gain after stopping tobacco use is due to increased food consumption, and not due to metabolism changes. It must be stressed that tobacco abstinence provides health benefits that far outweigh any health risks incurred by a slight weight gain (Fiore, Jaen, Baker, et al., 2008)
- Nutrition: withdrawal diet plans (Waltz, 1996)
- High-fiber, low-fat diet encouraged to limit weight gain when in the early stages of recovery. Alkaline diet (a diet high in raw fruits and vegetables) can slow nicotine metabolism and ease withdrawal (Waltz, 1996)

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Components of RPT, Continued

Preventing Relapse to Tobacco Use, cont'd

Learning strategies to cope with urges and cravings.

Cravings generally last about 30 - 90 seconds and they can be effectively deflected until they go away. One technique for dealing with cravings is the Four Ds:

- **Delay** (e.g., “I am going to wait 15 minutes until my next cigarette” - and then increase this period as the days go by)
- **Drink water**
- **Deep breathe**
- **Distract** (find something else to do, something that does not trigger tobacco use, such as taking a walk, changing surroundings, taking a shower)

Other strategies include:

- Imagery
- Relaxation
- Affirmations regarding self-confidence and worth, that the patient can establish a life that is free of addiction and that the individual deserves to be healthy

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Components of RPT, Continued

Preventing Relapse to Tobacco Use, cont'd

Supportive interventions are an effective component of a comprehensive treatment program for tobacco dependence. The effectiveness of encouragement and support as part of treatment is consistent with the literature regarding the importance of providing a caring, empathic, and understanding context when patients are making significant health changes. Increasing the unity among members of tobacco recovery groups can enhance social support (Fiore, Jaen, Baker, et al., 2008).

Elements of intra-treatment supportive interventions (within the treatment setting):

- Treatment provider offers encouragement and belief in the patient's ability to establish and maintain tobacco abstinence
 - Clinician communicates caring and concern, is open to the patient's expression of fears of stopping his or her tobacco use and ambivalent feelings
 - The patient is encouraged to talk about the tobacco recovery process (reasons to abstain, previous successes, difficulties encountered)
-

Unit Summary

Trainer Note**PM 55**

While MI has been shown to be effective with engaging patients in the stages of precontemplation and contemplation, for patients in the preparation or action stages of change, CBT has been shown to be an effective counseling method for the treatment of tobacco use and dependence. However, MI techniques are useful for all stages and can be blended with CBT and RPT.

Using functional analysis and skills training, the clinician uses CBT to help patients change their thinking and behavior patterns, which in turn affects their emotional reaction. As tobacco dependence is like any other chemical dependence (a chronic, biopsychosocial disease), it often involves relapse. RPT can be used to help patients identify and anticipate factors that can impede recovery and develop a relapse plan to address biological, psychological, and social aspects of relapse.

**CBT and RPT
Summary**

For patients in the preparation or action stages of change, CBT has been shown to be an effective counseling method for the treatment of tobacco use. MI techniques are also useful in these stages and can be blended with CBT and RPT. Using functional analysis and skills training, the clinician uses CBT to help patients change their thinking and behavior patterns, which in turn affects their emotional reaction. As tobacco dependence is like any other chemical dependence (a chronic, biopsychosocial disease), it often involves relapse. RPT can be used to help patients identify and anticipate factors that can impede recovery and develop a relapse plan to address biological, psychological, and social aspects of relapse.

Unit 3

Case Studies

Trainer Note This unit is designed to help participants use a case study in order to identify the stage of change, decide which interventions are most appropriate, and to outline the reasons for their choices.

Slide 42

PM 57 **Refer to the PM** regarding the purpose and objectives for this unit. Address any questions about the unit objectives.

Purpose A foundation of knowledge about the stages of change, the principles and techniques for using MI, CBT, and Relapse Prevention Therapy are important for effective tobacco treatment. In this unit, participants will apply their new learning using case studies. After reading the case study, the participants will determine the stage of change; indicate the recommended strategies, and outline the reasons for their selections.

Unit 3 Objectives

- Use a case study to correctly identify the stage of change for tobacco use and determine the most appropriate treatment intervention

Case Study Directions

Trainer Note**Slide 43****PM 58**

When giving directions for the Case Study Activity, have participants work in pairs or small groups, or conduct as a large group activity. Ask participants to read one of the five short vignettes in which a clinician is conducting an intake evaluation with a patient.

The trainer can ask everyone to read the same case. Give the participant teams about three to five minutes to read and complete each assigned vignette and then debrief.

Alternately, the trainer can assign a different case to each pair/small group of participants, and then have each pair/small group report out their conclusions.

Case Study Directions

Read the assigned vignette, then discuss the case study with your partner or group, and answer the following questions:

- 1. What stage of change is the patient in with respect to their tobacco use?**
 - a. precontemplation
 - b. contemplation
 - c. preparation
 - d. action
 - e. maintenance
 - 2. What treatment approaches would work best with this patient? (you may choose more than one)**
 - a. confronting the patient's resistance
 - b. relapse prevention therapy
 - c. tobacco treatment medication
 - d. motivational interviewing
 - e. clinician, as the expert, suggesting solutions
 - f. cognitive-behavioral therapy
 - g. using scare tactics to get the patient to stop
 - h. a combination of medication and supportive counseling
-

Case Study 1 - Bill J.

Trainer Note

Case Study 1 - Bill J.

Slide 44

What stage of change is the patient in with respect to their tobacco use?

PM 59

1. **precontemplation (could be in either stage at different times)**
2. **contemplation**
3. preparation
4. action
5. maintenance

What treatment approaches would work best with this patient? (you may choose more than one)

1. confronting the patient's resistance
2. relapse prevention therapy
3. **tobacco treatment medication**
4. **motivational interviewing**
5. clinician, as the expert, suggesting solutions
6. cognitive-behavioral therapy
7. using scare tactics to get the patient to stop
8. **a combination of medication and supportive counseling**

Case Study Number 1 - Bill J.

Bill J. is a 36-year-old white male who is presenting for the first time at your outpatient clinic. His wife Amy accompanies him to the intake appointment. Bill states in a rather annoyed fashion that the only reason he is there is because Amy made him come. When you ask the couple what brings them to your office, Bill states that he doesn't have a clue, and if his wife weren't such a nag, everything would be fine.

Bill sees no reason to stop drinking or smoking. He states that it's the only thing that relaxes him and makes him feel better. He used to work out at a local gym and play golf, but has given up these activities, as he'd rather have a few cold ones at the house.

When you speak to Bill about the health effects of his drinking and smoking, he replies that everybody should just leave him alone because he is not hurting anybody but himself. He also states that he has tried to stop smoking a bunch of times but just gave up finally, so he asks that you stop bugging him.

Case Study 2 - Barbara G.

Trainer Note	Case Study 2 - Barbara G.
Slide 44	What stage of change is the patient in with respect to their tobacco use?
PM 60	<ol style="list-style-type: none"> 1. precontemplation 2. contemplation 3. preparation 4. action 5. maintenance <p>What treatment approaches would work best with this patient? (you may choose more than one)</p> <ol style="list-style-type: none"> 1. confronting the patient's resistance 2. relapse prevention therapy 3. tobacco treatment medication 4. motivational interviewing 5. clinician, as the expert, suggesting solutions 6. cognitive-behavioral therapy 7. using scare tactics to get the patient to stop 8. a combination of medication and supportive counseling

Case Study Number 2 - Barbara G.

Barbara G. is 29-year-old single white female who is referred by her probation officer to your therapeutic community (TC) for women. Barbara was arrested when she tried to buy 3 grams of cocaine from an undercover police officer.

Barbara has been on probation for a prior drug-related crime. She was caught with a gram of cocaine after police observed her driving erratically. Her probation officer is trying to get her into a TC in lieu of a jail sentence.

Barbara stated that she has tried to stop using cocaine several times without success. She is also thinking about stopping tobacco use but is afraid it would be too stressful for her. She states that she knows how harmful smoking is.

Barbara stated that her life is a mess. She has no friends, no social life, no job, and no prospects. She is willing to come into the program, but is extremely scared that if she breaks the rules and uses tobacco, she may be kicked out and sent back to jail.

Case Study 3 - Jorge R.

Trainer Note

Case Study 3 - Jorge R.

Slide 43

What stage of change is the patient in with respect to their tobacco use?

PM 61

1. precontemplation
2. contemplation
- 3. preparation**
4. action
5. maintenance

What treatment approaches would work best with this patient? (you may choose more than one)

1. confronting the patient's resistance
2. relapse prevention therapy
- 3. tobacco treatment medication**
4. motivational interviewing
5. clinician, as the expert, suggesting solutions
- 6. cognitive-behavioral therapy**
7. using scare tactics to get the patient to stop
- 8. a combination of medication and supportive counseling**

**Case Study
Number 3 -
Jorge R.**

Jorge R. is a 27-year-old Hispanic/Latino male who is referred to your outpatient clinic from the emergency room of the local hospital, after his girlfriend Carmen discovered him passed out on the bathroom floor. Jorge's BAC at the emergency room was .16, and he seemed disoriented and confused. Jorge was stabilized and sent home with a referral to your clinic.

Jorge presented as very open to talking about his "problem" and indicated that he was at the point that he was thinking about "getting some help". He stated that this had been on his mind for a while now. He stated that he valued his relationship with Carmen and didn't want to ruin it with his drinking.

Jorge is surprised when you ask him about his tobacco use. He stated that he really wants to address his tobacco use also and has actually used a nicotine patch recently, but it didn't seem to work and he picked up again. He acknowledges that his tobacco use is bad for his health and is ready to stop alcohol and tobacco use at the same time.

Case Study 4 – Alvin C.

Trainer Note	Case Study 4 - Alvin C.
Slide 43	What stage of change is the patient in with respect to their tobacco use?
PM 62	<ol style="list-style-type: none"> 1. precontemplation 2. contemplation 3. preparation 4. action 5. maintenance <p>What treatment approaches would work best with this patient? (you may choose more than one)</p> <ol style="list-style-type: none"> 1. confronting the patient's resistance 2. relapse prevention therapy 3. tobacco treatment medication 4. motivational interviewing 5. clinician, as the expert, suggesting solutions 6. cognitive-behavioral therapy 7. using scare tactics to get the patient to stop 8. a combination of medication and supportive counseling

Case Study Number 4 - Alvin C.

Alvin C. is a 44-year-old African-American male who presents at your outpatient clinic along with his wife Adrienne. Alvin was referred by his primary care physician due to Alvin's admitting that he was a daily marijuana user. Adrienne stated that she is concerned that Alvin's current lifestyle is very unhealthy and she's worried that his "habits" are going to kill him.

Alvin admits that he is not an ambitious person and doesn't see what all the fuss is about. Alvin stated that he has been a marijuana user since he was about 15 years old. Alvin has also been using tobacco since age 13, and now is a daily user of both tobacco and marijuana. Alvin denies any other drug use other than an occasional beer now and then. Adrienne confirmed this.

Alvin states that Adrienne is making too big a deal out of everything. He states that it never crossed his mind to stop using marijuana and tobacco, and it is one of his only pleasures. Alvin states that he's not hurting anyone else, and just wants to be left alone.

Case Study 5- MaryAnn P.

Trainer Note

Case Study 5 Maryann P.

Slide 43

What stage of change is the patient in with respect to their tobacco use?

PM 63

1. precontemplation
2. **contemplation (as evidenced by multiple attempts to stop)**
3. preparation
4. action
5. maintenance

What treatment approaches would work best with this patient? (you may choose more than one)

1. confronting the patient's resistance
2. relapse prevention therapy
3. tobacco treatment medication
4. **motivational interviewing (medication not recommended for pregnancy)**
5. clinician, as the expert, suggesting solutions
6. cognitive-behavioral therapy
7. using scare tactics to get the patient to stop
8. a combination of medication and supportive counseling

Case Study Number 5 - Maryann P.

Maryann P. is a 30-year-old white female who is referred to your hospital-based outpatient clinic by her private therapist. Maryann first went to see the therapist at the urging of her mother Anita, who was concerned about the effects of Maryann's use of prescription painkillers on her 2 small children. Anita is also concerned about Maryann's chain smoking in the apartment and how that may harm the children.

Maryann shares with you that she has been injecting heroin for several months. She states that if she doesn't have her drugs and tobacco she just can't function. Maryann also shared that she is about 2 months pregnant, and is worrying about the effects on the baby, but she can't stop using.

Maryann states she is feeling powerless and hopeless. She tells you she has thought about "ending it all", but is worried what will happen to the children. She states she has tried to stop tobacco use so many times she can't remember how many, and is frustrated and discouraged.

Case Study Debriefing

Trainer Note **Process vignettes using the following questions:**

Slide 43
PM 64 *How difficult was it for you to assess the stage of change in these case studies?*

(Responses will vary; most likely participants will report that it was not very difficult to assess each stage. If a participant responds that it was very difficult, explore the possible reasons.)

What are some of the challenges of working with a patient who may be in one stage of change for their alcohol or other drug use, and a different stage of change for their tobacco use?

(Possible responses include incorrectly assuming the same stage of change for all problems, the need to use different treatment approaches for different stages of change, the need to increase motivation in the areas where it is low, and the challenge to avoid becoming confrontational or acting prescriptive in areas that the patient is not showing progress.)

What does “patient-centered treatment” mean?

(Patient-centered treatment means meeting patients “where they are at”. The clinician does not push an agenda that the patient may not be ready to address. The clinician and patient enter into collaboration where goal setting is the primary responsibility of the patient. Treatment interventions are based on the patient’s readiness to change.)

How challenging will it be for you to change your perspective from traditional addiction treatment models to a patient-centered model when working with tobacco dependent patients?

(Responses will likely be varied. Facilitate this discussion as appropriate. The important take away message is that traditional treatment approaches (such as confronting resistance and offering expert advice) are not effective methods of treating tobacco dependence. Depending on a patient’s stage of change readiness, motivational interviewing or cognitive-behavioral approaches, combined with medications where appropriate, are the most effective treatments for tobacco dependence.)

Continued on next page

Case Study Debriefing, Continued

Debriefing Questions

How difficult was it for you to assess the stage of change in these case studies?

What are some of the challenges of working with a patient who may be in one stage of change for their alcohol or other drug use, and a different stage of change for their tobacco use?

What does “patient-centered treatment” mean?

How challenging will it be for you to change your perspective from traditional addiction treatment models to a patient-centered model when working with tobacco dependent patients?

Unit Summary

Trainer Note **Summarize** the unit by emphasizing the importance of knowing the stage of change for tobacco use, and the challenges that arise when a patient’s stage of change for tobacco is different from the stage of change for alcohol and other drugs. Remind participants about using combinations of medication and counseling, the importance of being “patient-centered,” avoiding advice giving and confrontation, and the use of MI philosophy and techniques.

PM 65

Summary It is important to know what stage of change a patient is in so that the appropriate treatment approach is employed.

There are several challenges working with a patient who may be in one stage of change for their alcohol or other drug use, and a different stage of change for their tobacco use.

These challenges may include incorrectly assuming the same stage of change across the board, the need to use different treatment approaches for different change processes, the need to increase motivation in the areas it is low, and the challenge to avoid becoming confrontational or prescribing in areas that the patient is not progressing.

A combination of medication and supportive counseling (motivational interviewing and behavioral counseling) is the best approach to treating tobacco dependence (Fiore, Jaen, Baker, et al., 2008).

Patient-centered treatment means meeting the patient “where they’re at”. The clinician does not push an agenda that the patient is not be ready to address. The clinician and patient enter into a collaboration where goal setting is the primary responsibility of the patient. Treatment interventions are based on the patient’s readiness to change.

The most important take away message of this unit is that traditional treatment approaches (such as confronting resistance and offering expert advice) are not effective methods of treating tobacco dependence. Depending on a patient’s stage of change readiness, motivational interviewing or cognitive-behavioral approaches, combined with medications where appropriate, are the most effective treatments for tobacco dependence.

Unit 4

Facilitating a Tobacco Awareness Group

Trainer Note Refer participants to the purpose and objectives of this unit in their PM.

Slide 45 **Explain:**

PM 67

*Addiction professionals possess many skills that they utilize to provide a broad range of services to their patients. These skills are delineated in the manual titled *Addiction Counseling Competencies, The Knowledge, Skills and Attitudes of Professional Practice, Technical Assistance Publication 21 (TAP 21)* produced by the Center for Substance Abuse Treatment.*

These competencies include individual and group counseling, and clinicians must be skilled in the facilitation of psychoeducation groups that help patients to raise awareness about the impact of their substance use, develop discrepancy, and help them to shift their thinking about their substance use. An example of one of these groups is the Tobacco Awareness Groups (TAG).

Purpose By using motivational techniques and group facilitation strategies, the clinician works with patients in a Tobacco Awareness Group (TAG) to resolve their ambivalence about their tobacco use by raising awareness of tobacco related issues and topics. The clinician does not advocate for change, but elicits change talk from the patients. This unit will discuss the structure, content, desired outcomes, and provide an opportunity to practice facilitation skills when conducting a Tobacco Awareness Group.

Unit 4 Objectives

- Identify the purpose of a Tobacco Awareness Group
- Identify at least four desired outcomes of a Tobacco Awareness Group
- Demonstrate through role-play, the participation in and facilitation of a Tobacco Awareness Group

Principles of Group Facilitation

Trainer Note **Refer to PM and explain** that group treatment methods are effective and widely used in addictions treatment. Group process is concerned with what is currently happening and how it is happening between and to group members, in the here and now. It is not as concerned with group content (what group members actually state in words).

Slide 46

PM 68

**Basics of
Group
Facilitation**

Group facilitation skills are necessary to engage patients using group process. Group process is concerned with what is currently happening between and to group members in the here and now. Group facilitation, when done well, enables participants to:

- Discover new knowledge,
- Develop insight,
- Move toward achieving their goals.

Group facilitation is not doing things for the members; it is about eliciting and presenting information in a non-threatening, non-judgmental manner, asking effective questions, and supporting self-efficacy.

Trainer Note **Explain** the comprehensive integration of tobacco dependence treatment into the service continuum should include psychoeducation (tobacco awareness education) as a way to increase patient knowledge and identify attitudes and beliefs that affect substance use behaviors. Clinicians are usually familiar with facilitating psychoeducation groups.

Slide 46

Continued on next page

Principles of Group Facilitation, Continued

Trainer Note **Refer to PM and explain:** Participants who have participated in Module 1 or Module 2 training have learned the importance of referring to tobacco use and dependence in the language of addiction treatment and recovery. If participants have not participated in previous tobacco dependence training, introduce reframing the language from the public health cessation terms to terminology that is consistent with that of addiction treatment and recovery.

Slide 46

PM 68

Reframing Tobacco Use

- De-normalize tobacco use and define as negative to recovery
 - De-glamorize tobacco use in the treatment and recovery culture
 - Talk about tobacco use as a biopsychosocial disease
 - Talk about tobacco as a drug of choice
 - Frame tobacco abstinence as part of one-day-at-a-time recovery
-

Reframing Language

<u>Public Health Terminology</u>	<u>Recovery Terminology</u>
smoking	tobacco use, dose
smoker	tobacco user
quit date	recovery start date
cessation	treatment / recovery

Continued on next page

Principles of Group Facilitation, Continued

Trainer Note Slide 47 PM 69	<p>Refer to PM and explain that the clinician in the awareness group does not tell the patients they need to stop using tobacco or suggest solutions for the patients. The purpose of the Tobacco Awareness Group is to stimulate the patients' thinking, develop discrepancy, help them to resolve their ambivalence, and make a decision to move towards healthy change.</p> <p>The Tobacco Awareness Group is about introducing <u>new knowledge</u> and <u>new thinking</u>, while the Tobacco Recovery Group is about <u>taking action</u> and <u>making behavioral changes</u>.</p>
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Patient-Centered Psycho-education	<p>Make it conversational and fun - use a communication style to support increased motivation and to promote an interest in the topic. The goals of psychoeducation in the context of addiction treatment and recovery are:</p> <ul style="list-style-type: none"> • Promote insight into tobacco use behavior • Identify the correlation of tobacco use to alcohol and other drug use • Talk about how tobacco impacts the recovery/relapse process • Identify ambivalence towards tobacco use and elicit change talk
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Awareness Group vs. Recovery Group	<p>Tobacco Awareness Group (gaining knowledge and changing thinking)</p> <ul style="list-style-type: none"> • Develop interest • Elevate importance • Enhance motivation <p>Tobacco Recovery Group (taking action and making changes)</p> <ul style="list-style-type: none"> • Develop skills • Elevate confidence • Embrace lifestyle change
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Principles of Group Facilitation, Continued

Trainer Note **Refer to PM and explain** that conducting a tobacco awareness group is the focus of this session. The Tobacco Awareness Group is designed to help patients resolve their ambivalence and move towards healthy change. Listed below are several desired outcomes of the Tobacco Awareness Group.

Slide 48

PM 70 - 71

Remind participants about using motivational techniques (reflective listening, open-ended questions, rolling with resistance, and supporting self-efficacy) to help to achieve these outcomes

Tobacco Awareness Group Outcomes

Telling the patients that they should change, or suggesting possible solutions, is not the clinician’s task in a Tobacco Awareness Group.

The outcomes of a TAG are as follows:

- Raise awareness of tobacco effects and related topics
- Develop discrepancy
- Identify ambivalence about tobacco use
- Increase motivation to change
- Help patients to move to the next stage of change

The goal is to help the patient start to think differently about their tobacco use and recognize how it connects to their other substance use, to relapse, and to recovery.

Continued on next page

Principles of Group Facilitation, Continued

Trainer Note	Explain that facilitating a series of Tobacco Awareness Groups and incorporating specific topic areas is effective toward helping patients resolve their ambivalence and move towards healthy change.
Slide 48	
PM 70	The content of the three topic areas is provided in this training in the format of a script. It is not intended that a clinician use these scripts verbatim. Rather, each of the sample scripts serve as a roadmap. It is expected that counselors will be able to take this material, modify it as needed, and use it to facilitate tobacco awareness groups at their facilities.

Tobacco Awareness Group Topics

The following topics should be covered in a Tobacco Awareness Group:

- Tobacco's Relationship to Alcohol and Other Drug Use and Recovery
- The Path to Healthy Recovery
- The Pros and Cons of Continued Tobacco Use

Additional topics can be included at the discretion of the clinician, using language and terminology that patients will understand.

Continued on next page

Principles of Group Facilitation, Continued

Trainer Note Slide 48 PM 71	<p>Refer to PM and explain the importance of using MI techniques when facilitating a Tobacco Awareness Group in order to develop discrepancy, express empathy, and help patients recognize and resolve their ambivalence in order to move towards making healthy change.</p> <p>Emphasize that the clinician is not giving solutions or advice, and instead is using reflective listening, open questions, affirmations, summarizing, developing discrepancy, and eliciting change talk.</p>
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Using MI in a Tobacco Awareness Group	<p>Motivational techniques are effective in helping patients develop discrepancy, resolve their ambivalence about their tobacco use, and begin moving towards healthy change. The techniques and topic areas of the Tobacco Awareness Group help the patient to think differently about their tobacco use.</p> <p>The clinician in the Tobacco Awareness Group does not suggest solutions or teach practical skills about stopping tobacco use.</p> <p>Instead, the clinician uses motivational interviewing tools such as reflective listening, asking and obtaining permission, asking open-ended questions, and using affirmations and summarizing to reduce resistance and elicit change talk from the patients, provide information, and elicit change talk (EPE).</p> <p>Remember: the more the patient talks about healthy change, the more likely it is that change will occur.</p>
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Tobacco Awareness Group (TAG) Demonstration 1

Trainer Note **Explain** the structure of the session activities.

Slide 49
PM 72 - 83 Participants will have the opportunity to be involved in two or three TAG role-play exercises during the session. There are three scripts included in this section of both the Trainer Manual and the Participant Manual. The scripts are to be used as suggested language and as a content guide, they are not intended to be stated verbatim.

Role-play Activity 1

The trainer(s) should demonstrate the first Tobacco Awareness Group, “Tobacco’s Relationship to Alcohol and Other Drug Use and Recovery.” The demonstration should take about 25 - 30 minutes. The trainer will model how to use MI skills and strategies for running a TAG.

Ask for between six to ten participants to role-play patients for this exercise. You can assign them patient roles with different stages of change (precontemplation, contemplation, preparation, etc.) regarding their tobacco use.

Explain that upon completion of this first demonstration, there will be an opportunity for the group to debrief and process the experience. Following the completion of the first activity, explain that the participants will have the opportunity to plan, facilitate and participate in one or two additional Tobacco Awareness Groups.

A list of suggested patient scenarios is on the next page. This can be divided into separate pages so a different role is assigned to each participant in the role-play.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Sample Patient Scenarios

Patient #1: Smoking tobacco since age 15 and steady use for 15 or more years. Currently uses a pack a day. Began alcohol use at age 18 and marijuana at age 19. Has thought about stopping tobacco several times due to the increasing costs. Uncertain she/he can quit, even if he/she tries.

Patient #2: Smoking tobacco since age 12 and used 20 or more years. Uses two packs a day since age 20. Uses tobacco when awakens from sleep, smokes several cigarettes just before bedtime, and often needs to get up in middle of night to smoke. Confident he/she can stop anytime, if s/he wants to. Began alcohol use at 16 and heavy alcohol use since 20. If asked will state that drinking and smoking go always “hand-in- hand” and drinks more when smoking.

Patient #3: Smokes half to full pack per day for at least 10 years. Smoking on and off since age 15, has consistently returned to cigarettes after stopping for a several weeks. Has only used “cold turkey” method. Would like to stop and recently reduced cigarette use due to increased cost, but cannot stop altogether, and after a while seems to “slowly creep back to a full pack”. Has history of seriously abusing cocaine, running up cocaine–related bills, and realizes in TAG session that s/he never uses cocaine without also smoking tobacco.

Patient #4: Smoking 10 or more years and uses a pack a day. Started at age 16. Believes that smoking helps keep his/her weight down. Fears if quits will gain 20 lbs. and will look less attractive. Smoking also goes with all social activities and conversations with others, all friends and family members smoke. Also heavy alcohol user and likes oral narcotics.

Patient #5: Light smoker, uses less than 10 cigarettes a day. Does not re-use or re-light cigarettes. Does not think s/he is addicted and that smoking is simply a “bad habit”. Uses marijuana and typically smokes both together. Wants to stop marijuana use “it has gotten out of hand”, but has no need to stop smoking.

Patient #6: Currently being treated for alcohol and benzodiazepine dependence. Stopped using tobacco in past year on a dare from spouse and abstinent for four weeks using “cold turkey” method. Claims smoking controls his anxiety. Smoking heavily for past 9 months and drinks more when smoking. Not sure he can quit tobacco, but wants become “alcohol and pill free”.

Patients #7 - 10 Mostly silent in the group. Maybe secretly thinking about stopping tobacco or may be silently angry about attending the group, and avoids speaking at all.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

TAG Group 1 Activity Participants will have the opportunity to be involved in two or three TAG role-play exercises during this unit.

There are three scripts included in this section that provide suggested language and serve as a content guide, but are not intended to be stated verbatim when conducting a group.

Role-play Activity 1

The trainer(s) will usually demonstrate and model how to conduct the first Tobacco Awareness Group, “Tobacco’s Relationship to Alcohol and Other Drug Use and Recovery.” The demonstration should take about 25 - 30 minutes. The trainer will model how to use MI skills for running a TAG.

Between six to ten participants are needed to role-play patients for this exercise. You take the role of observer or assume a “patient role” with a specific stage of change regarding his/her tobacco use.

After completion of this first demonstration, there will be an opportunity for the group to debrief and process the experience.

You will then have the opportunity to plan, facilitate and participate in one or two additional Tobacco Awareness Groups.

Continued on next page

Session One - Tobacco's Relationship to AOD and Recovery

Session One Outline and Facilitator Notes

1. Getting started.
 2. Acknowledge traditional role of tobacco use in alcohol and other drug treatment and recovery. (i.e., coffee, cigarettes) while attending twelve-step, self-help meetings.
 3. Explore the significance of the role of tobacco use within alcohol and drug use ritual.
 4. Share information on how cigarettes have been “re-engineered” to make them more addicting.
 5. Equate the progression of AOD dependency to tobacco dependence.
 6. Identify the role of tobacco use in the process of AOD relapse.
 7. Relate all of the above to the First Step (powerlessness and unmanageability).
-

Facilitator Note:

Depending upon the group size and how verbal the group members are, this session can take from 60 to 90 minutes to present the topics and facilitate an active discussion by getting the patients to share their thoughts, feelings, and patterns of tobacco use. This session can also be presented more slowly by dividing it into two, 45 - 50 minutes sessions (Session A and Session B). A useful stopping point for Session A is just before beginning Topic 5 Equate the Progression of AOD Dependency to Tobacco Dependence (See note later in the script).

The group facilitator should begin Session B by first asking the group to help summarize all key points they discussed in the prior session. It is also useful to ask them if they would like to share any new realizations about their tobacco use since that session.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Session One Outline, continued

Facilitator Note:

Incorporating tobacco issues into all aspects of patient education is a critical strategy for treating patients at all levels of motivation to stop using tobacco. Many misconceptions or “clinical lore” exist about tobacco use, such as “tobacco is not a real drug,” “it’s too hard to address all the substances together,” and “quitting tobacco will definitely worsen other substance recovery” (Ziedonis, Gydish, Williams, Steinberg, and Foulds, 2006).

Additionally, for more than half a century, tobacco use has been woven into the fabric and culture of addiction treatment and recovery.

Raising patient awareness as to how their tobacco use is so very interconnected to their alcohol and other drug use can be a first step toward developing discrepancy and resolving ambivalence. This is especially important for the patient who is ambivalent about or is not willing to address their tobacco use concurrently in their recovery work.

Notes:

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Session One Script

Tobacco's Relationship to AOD and Recovery

Getting Started

Begin by introducing yourself to the group. Introduce the day's topic.

The information that we are going to discuss today is about tobacco's relationship to alcohol and other drug use and recovery. As you are well aware, NYS addiction treatment providers are now treating tobacco dependence in all chemical dependence service programs. Therefore, we need to challenge the way we have all viewed tobacco use for more than seventy-five years. We will explore the reasons why we are looking at tobacco use in a completely new way.

Confirm with group members that they understand your explanation thus far.

Ask permission to ask them questions about the history of their tobacco use, and the connection to how their tobacco use relates to their alcohol and other drug use.

Acknowledge traditional role of tobacco use in alcohol and other drug treatment and recovery (i.e., coffee, cigarettes) while attending twelve-step, self-help meetings.

Tobacco use has been common in AA, the first twelve-step recovery program, since its inception in 1935. Prior to the twelve-step movement, tobacco was commonly addressed in the treatment of alcoholism, a fact that most of us have never really thought about. However, AA's co-founders, Bill Wilson, Dr. Bob Smith, Marty Mann, and the others in the early movement of AA did not address tobacco in the self-help recovery program.

You may want to ask participants to speculate why that may have occurred using the following:

For many decades, practice wisdom (the idea that treatment should be done in a certain way) was the basis for treatment methods. That is not to mean we throw out the practice wisdom of the past, however, science and research now supports the use of new, evidence-based practices in the treatment of addiction.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Explore the significance of the role of tobacco use within alcohol and drug use rituals.

Many of you are probably familiar with the term, “drug of choice,” a term that we use to describe the primary drug a person chooses over any other drug to get high. For some people, that may be alcohol and for others that may be heroin, or cocaine.

*Would anyone be willing to share some examples of your drug of choice? **Ask what drug they identify as their “drug of choice.”***

Follow-up by asking *Would any of you be willing to share how tobacco use is a part of your drug use ritual?*

Ask if anyone who volunteered to speak if they would describe their experience. Use clarifying statements and then summarize what the group member (or multiple members) state.

Speculate by stating something like: *Would it be safe to say that every time or almost every time, you drank or used cocaine, smoking a cigarette was part of the ritual for you?*

Follow-up questions: *Why did you think that occurred? What did tobacco do for you? Why was tobacco an important part of getting high? Did you ever drink/use without a cigarette being part of the experience?*

Summarize *It sounds like it was very important to your alcohol or other drug use to have a cigarette be part of that experience. You can also add Tobacco was always there for you. Your tobacco use went hand in hand with your alcohol/heroin use. A summarizing statement helps the group members come to the realization that “yes, my tobacco use is very important to me.”*

If they are willing, ask others to share their story about their ritual of tobacco use with alcohol or drug use. Frame follow up questions from the position that it is important to understand what that relationship meant to each group participant who speaks. If no one says that their tobacco use “boosted” their high, state *“I’ve heard many people say that smoking a cigarette while using cocaine, or other drug or alcohol, would give them a greater “buzz.”*

After a number of people have shared their experiences, ask *What would you do if you had some cocaine or a six-pack but didn’t have any cigarettes?* Generally, people will say they would get some tobacco before using. Members may disclose that tobacco was actually the first drug that they picked up in their youth. This point can also be explored further.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Summarize: *From what many of you have just shared; using tobacco is a very important part of your alcohol and other drug use ritual.*

Transition to the next point by asking, *“Do you believe that tobacco is addicting?” If so, why do you think that is true?* Tease out as many reasons as possible for why tobacco is addicting.

Share how cigarettes have been “re-engineered” to make them more addicting.

As many of you have shared, cigarettes have always been there. It sounds like perhaps for many of you, tobacco is your drug of choice. It is a very important part of your alcohol and other drug use. What you have shared is fascinating. I’d like to share some information with you if that’s OK. (Ensure people are willing).

The cigarette of today (2009) is not the same as it was back in the early days (i.e. the early 1900s to mid 1950s). One of the facts that might change your thinking about how tobacco use fits into your addiction and recovery is that the cigarette is a highly engineered drug delivery system. When we talk about how addicting a drug is we are really taking about two things: (1) how a chemical changes or alters our mood, and (2) how reinforcing it is. Therefore, if you try it once and like how it feels, you tend to want to do it again. A cigarette is engineered to be highly reinforcing but low in intoxication. Using tobacco is not going to get you the same feeling as hitting on the crack pipe or having a few drinks, but you probably learned to use them together. That reinforcing way, as many of you have described includes weaving tobacco use into the rituals of your alcohol and other drug use. Cigarettes are purposely designed not to get you high; they are designed to get you addicted and to keep buying them.

Ask: *How do you feel about what I have just described? What hits home for you? Listen and reflect. Draw out from as many patients as possible, before moving to the next point.*

If it is OK, I would like to share a little information about cigarettes that might be interesting to know. Back in the 1950’s, the tobacco industry wanted to learn how they could increase their sales. Therefore, they studied people who were addicted to alcohol and other drugs. They wanted to understand what happens to a person’s brain chemistry from using heroin, cocaine, and alcohol. They wanted to find what makes using a drug reinforcing. They wanted to understand why the heroin user continues to use despite having uncomfortable withdrawal. They wanted to understand why the person who uses alcohol continues to drink despite having two or three DWIs. They wanted to find out what causes the compulsion to use again. Through their research and study, the tobacco industry figured it out and did it really well. The additives in cigarettes today, they affect a user’s brain chemistry in a way that it has never done before.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Check in with the participants Ask if anyone has heard this information before, or if this is new information? Continue by saying that you would like to add a little more information to what we have just discussed if that is OK.

Explain *One of the additives that the tobacco industry uses to make cigarettes more addictive is menthol. Ask participants if they know what menthol is and what it does.*

Clarify and Explain *Menthol is an organic compound made synthetically or obtained from peppermint or other mint oils. What happens if you have a cold and you put some Vicks, which has menthol in it, under your nose? It opens up your head. It is a bronchodilator and it opens up airways. By putting menthol in a cigarette and the menthol in the smoke, your bronchial airways open up and you are able to take in more nicotine to keep you addicted with fewer cigarettes per day. The tobacco industry is concerned that if you need a pack or more of cigarettes a day to keep you addicted but you can't afford a pack a day, they can keep you addicted using a half a pack a day and taking in more nicotine, by adding menthol.*

Ask *How do you feel what I have shared with you?*

Explain *There are more than 4,000 chemicals in a cigarette, one is ammonia. Ammonia works to increase the absorption of smoke in the mucous membrane of the mouth and hence nicotine absorption is increased. What many people don't realize is that every cigarette that you smoke causes damage. There are many health related consequences to smoking. Smoke does a lot of damage to every system in our body.*

Facilitator Note:

If you decide to divide Session One into two 45 or 50 minute group sessions (Session A and B), this is a good place to stop and summarize the session. Ask group members to summarize what they learned as a concluding point.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

If this is Session B, begin by asking group members to summarize what they can recall from Session A. It is also useful to ask them if they had any new realizations from that session they would like to share. The facilitator should add anything important that was not mentioned, and then move to the next item below. At end of session B, connect all key points from Sessions A and B to the patients' experience and substance use.

Equate the progression of AOD dependence to tobacco dependence

Ask: *How old were you when you first started using?* Generally, patients will respond between 12, to 18, but some may be younger and others older.

Explain: *Most people start using at a young age and for many people, tobacco use progresses very quickly and often they move quickly from this first drug to another like alcohol, and another, like cocaine or heroin. Picking up in our early adolescence is significant. Adolescence is a critical point in our life. As adolescents, we all had a lot of developing to do. We have to learn how to cope with stress, we have to develop our identity, we have to learn how to relate to others in all kinds of relationships, develop skills for dealing with anger, loss, disappointment.*

For example, let's say I am 15 years old and every time I get angry, I smoke marijuana. Then I begin to make the connection in my head, when I get angry, I smoke weed. I don't develop alternative strategies for dealing with anger. Remember, this is just one strong emotion that as adolescents we need to figure out how to deal with. Therefore, if pot works for anger, and we are 14 or 15, then maybe when I feel frustrated or depressed, I will try alcohol for that as well. Because what I know is that marijuana works for me when I am angry. Pot continually becomes more and more important to me. I always make sure that there is some around. If we tie our chemical use to a feeling state, whether it is when I'm bored, happy, angry, partying, and I am using every time I am in that feeling state or with a particular group of people or person or situation then that becomes the main coping method. Can anybody relate this to his or her tobacco use?

If members say they are aware or appear to recognize the connection between their tobacco use and AOD use, ask for examples and cull as many responses as possible. Then summarize the comments from patients up to this point.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Identify the role of tobacco use in the process of AOD relapse

Another point is that if every time you use cocaine and tobacco or alcohol and tobacco together, then the addiction is not just to the cocaine or the alcohol but rather to the connected addictions of several drugs – that happens when you use them together.

For example, if I make the decision to stop using cocaine or stop using alcohol, but continue to use tobacco, then half of the "pilot light to my disease" is still lit. Am I not drug craving every day? Aren't I drug seeking every day? How many cigarettes do I have left? Who has a cigarette that I can get? Do I have seventy-five cents to buy a loosie? We need to medicate the feelings of withdrawal and when we use we get relief. When we think about it, are we not keeping alive "active addict thinking, feeling and acting?"

The research on addiction tells us that if people keep part of their addiction alive, like continuing their tobacco use but stopping their alcohol use or cocaine use, then the probability of relapsing is significantly higher.

Continually solicit examples from the patients as you present more information.

Ask, do any of you have something to share about that? Alternatively, How are you thinking about the information that we are discussing?

Help the patients conclude that if tobacco use is an integral part of their drug use ritual, if they continue to use tobacco, it can seriously compromise their recovery from alcohol or other drugs.

Summarize at this juncture:

People, places and things. What is more significant than another addiction that is so closely connected to your alcohol or other chemical dependence? If that is true for you, and it is not the case for everyone, what is a more significant thing than if I am dosing my body with tobacco every time I use heroin or cocaine? It is my relationship to the chemical. For many people who suffer from the disease of addiction, the relationship that they have with tobacco can be a serious threat to recovery.

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Relate all of the above to the First Step (powerlessness and unmanageability)

If you take all that we have talked about in the group today and put it in the context of the first step (ask who knows what the first step is: powerlessness and unmanageability). Let's relate tobacco use to the powerlessness and unmanageability that you learn in the first step. Many of you have heard stories of family members or friends who have been told that they must stop using tobacco because of serious health risks. Yet, despite the fact that a person is having serious problems breathing, maybe even emphysema or asthma, has had a heart attack, high blood pressure, or is suffering from serious circulation problems, they continue to use tobacco. What is so hard for others to understand is that when talking about addiction, all rational thought goes out the window. (You may want to relate a personal story, perhaps a patient that you have worked with that illustrates this point) Can anyone identify his/her own unmanageability and the powerlessness with tobacco?

To wrap up this session begin by asking: *How does all that we talked about today relate to your recovery?*

Allow participants to respond.

If you equate recovery with giving up things, how long do you think it will stick? Not long. Because you are going to feel deprived and feel the loss. If you continue to go through your day and experience the triggers that used to cause you to pickup, and you don't have an alternative plan or strategy, you're at risk for relapse. Your recovery is not about giving up things, it is about learning that we have choices that we may never have known that we had before.

Ask: *does anybody have any ideas of alternative behaviors that he/she may be able to put in place when a trigger happens that we would have responded to with a cigarette, or a drink or a joint? What are the tools of recovery that you want to put in place?*

My question to you all as we wrap up: what do you think? How do you feel about the information that we have discussed?

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Final summary:

Summarize key points that patients have mentioned or described over this session and connect these to the topics. It is often more helpful to ask the patients to summarize the key learning points. Then conclude with the following:

We discussed that nicotine hits our brain in exactly the same place that other chemicals hit to cause addiction. There is evidence for this from the number of people that weave the ritual of alcohol and other drug use with tobacco use. We discussed that for many of you, your tobacco use and AOD use are very connected. Tobacco use is an important part of the process for getting high. We also discussed that research says if people address all of their chemical dependencies simultaneously in treatment, that they will have a better opportunity to learn replacement behaviors and ways of coping and thinking and socializing, reducing the risk of relapse and improving the quality of our recovery.

Notes:

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Tobacco Awareness Group Fact Sheet

Tobacco's Relationship to Alcohol and Other Drugs

Several studies indicate that the prevalence of tobacco use among people receiving treatment or in recovery for alcohol or other drug use is dramatically higher (about 80-90%) than the general U.S. adult population rate of 20.9 % (CDC, 2006).

Note: according to recent CDC data, the current rate of tobacco use nationally has dropped to about 18.9%.

- 90% among alcoholic inpatients in the U.S. (Bien & Burge, 1990)
- 83% among urban methadone maintenance patients in the Northeastern U.S. (Richter et al., 2001)
- 77% among methadone maintenance patients in the Midwestern U.S (Nahvi, et al., 2006)
- 71-93% among alcoholic outpatients (Istvan & Matarazzo, 1984)
- 85-90% among substance abuse inpatients (Burling & Ziff, 1988)
- People with a DSM-IV-TR diagnosis of a substance use or mental health disorder (not including nicotine dependence) consume 44% of all tobacco sold in the U.S. (Lasser, et. al, 2000)
- People with at least one psychiatric disorder and who are tobacco dependent, consume 34% of all cigarettes in the US (Grant et al., 2004)

Continued on next page

Tobacco Awareness Group (TAG) Demonstration 1, Continued

Trainer Note Slide 49	Upon completion of the demonstration role-play by the trainer, process with the group about what the experience was like for them. Allow about 10-15 minutes for the debriefing.
PM 84	<p>Participants can also summarize their responses using the form on PM 65.</p> <p>Use the following questions to guide the discussion with the participants in the role play and those who were observing:</p> <ul style="list-style-type: none"> • What did they learn from participating in this activity? • What strategies did they observe the facilitator employ? (reflective listening, rolling with resistance, eliciting change talk, affirmations, summarizing, open-ended questions, EPE, and the 5 Rs) • What skills were demonstrated, which they already use in their work with patients? • On a scale of 1-10, with 10 being high, how confident are they as to their ability to facilitate a Tobacco Awareness Group? • What else do they need to increase their level of confidence in order to conduct Tobacco Awareness Groups?

Debriefing of TAG Group 1 Activity	<ul style="list-style-type: none"> • What did they learn from participating in this activity? • What strategies did you observe the facilitator employ? (reflective listening, rolling with resistance, eliciting change talk, affirmations, summarizing, open-ended questions, EPE, and the 5 Rs) • What skills were demonstrated, which they already use in their work with patients? • On a scale of 1-10, with 10 being high, how confident are they as to their ability to facilitate a Tobacco Awareness Group? • What else do they need to increase their level of confidence in order to conduct Tobacco Awareness Groups?
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Session Two - The Path to Healthy Recovery

Trainer Note

Slide 48

PM 85 - 96

For role-play activity 2 and 3, use your discretion to best structure each activity. If you have time to conduct two groups, assign participants to Group A and Group B. After the groups have formed, assign The Path to Healthy Recovery to one group and The Pros and Cons of Continued Tobacco Use to the other group.

Instruct participants from both groups to read their assigned script, become familiar with the content of the session, and for the facilitators to discuss their presentation strategy. At least two facilitators should be selected to co-facilitate or tag-team. Allow at least 10-minutes of preparation time.

Request for each group at least four or five people role-play patients, each in a different stage of change. Those who are role-playing “patients” can model some degree of patient resistance (arguing, ignoring, denying, and interrupting), some who are ambivalent, and perhaps one or two who are considering stopping tobacco use. There is no need for “over the top, worst patient” scenarios. The non –presenting group members will be observers.

Explain that each group should plan to present for between 25 to 30 minutes. Two participants can jointly facilitate or trade off the lead role at about equal intervals to allow more than one person the opportunity to facilitate. Some members will be in the role of patients and others will be observers.

**Trainer Note,
cont'd**

Options for Small, Medium, Large Class:

If the class size is small (7 - 10 people), you can ask participants to role-play patients in the Group A and then role-play facilitators or become observers for the Group B role-play. If you have at a medium size group (14 - 20) divide them into two equal size groups, Group A and Group B. If the size of the group is large (25 or more) and plan to conduct two follow-up role-plays, you may consider using a fishbowl technique with Group B observing Group A role-play, process and then reverse roles for the presentation of the last topic.

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

**Trainer Note
Role-play
Activity 2** Group A will now simulate and demonstrate a Tobacco Awareness Group using the second topic, “The Path to Healthy Recovery”, using the script on the following pages.

**Slide 54
PM 78 - 82** Ask at least two people to act as facilitators and for a group of between six to ten participants to role-play tobacco-using patients for this exercise. The trainer or participants themselves can assign roles and different stages of change (precontemplation, contemplation, preparation, etc.) regarding their tobacco use, with some more willing to examine their use and others more reluctant.

Allow the two facilitators (and the other members of the class) about 10-15 minutes to review the script. The facilitators can co-lead or trade off leading the exercise. Suggest they plan for about 25-30 minutes to conduct the exercise. At the end of this activity, debrief using the discussion questions that are listed following this session.

**Instructions
for TAG
Group 2
Activity** For the TAG 2 and 3 activities there will be two groups. Group A will use The Path to Healthy Recovery and Group B will use The Pros and Cons of Continued Tobacco Use. Each group should plan to present for between 25 to 30 minutes, and we will then debrief.

For Group A, read the assigned script The Path to Healthy Recovery and become familiar with the content of the session.

The participants who are acting as group facilitators will need to discuss their presentation strategy. At least two facilitators should be selected to co-facilitate or you can tag-team the lead role. Facilitators should be sure to use MI skills throughout the activity.

The remaining Group A participants should assume role-play patients each in a different stage of change. Those who are role-playing “patients” should model some degree of patient resistance (arguing, ignoring, denying, and interrupting), some who are ambivalent, and perhaps one or two who are considering stopping tobacco use. Please no “over the top, worst patient” scenarios. The rest of the class will be observers

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Session Two Outline The Path to Healthy Recovery

1. Getting started
 2. The biopsychosocial nature of addiction
 3. Denial and acceptance
 4. The stages of change
 - Precontemplation
 - Contemplation
 - Preparation
 - Action
 - Maintenance
 5. Process and summary
-

Facilitator Note:

Depending upon the group size and how verbal the group members are, this session can take from 60 to 90 minutes to present the topics and facilitate an active discussion by getting the patients to share their thoughts, feelings, and patterns of tobacco use. This session can be also be presented by dividing it into two, 45 - 50 minutes sessions (Session A and Session B). A useful stopping point for Session A is just before beginning Preparation under the topic on Stages of Change.

If using this option, the group facilitator should begin Session B by first asking the group to help summarize all key points they discussed in the prior session. It is also useful to ask them if they would like to share any new realizations about their tobacco use since that session.

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Facilitator Note:

Helping patients change behavior is integral to the work of addiction professionals. The concepts of "patient noncompliance" and clinician perceptions of lack of motivation often focus on patient failure. Understanding patient readiness to make a change, appreciating barriers to change and helping patients anticipate relapse triggers can improve patient satisfaction and lower clinician frustration during the change process.

Researchers have found that people tend to go through a similar process when they make changes and that this process can be conceptualized in a series of stages. The Stages of Change model, part of the Transtheoretical Model of Change (Prochaska & DiClemente, 1984), depicts a process that people go through when they successfully make changes in their lives.

The Stages of Change identified by Prochaska and DiClemente are: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Understanding the stages of change can be beneficial for both patient and clinician. For patients, knowing their stage can increase their understanding of their own progress. Understanding a patient's stage helps the clinician identify appropriate interventions and supports that may be useful in moving the patient to the next stage of change readiness.

Notes:

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Session Two - The Path to Healthy Recovery, Continued

Session Two Script - The Path to Healthy Recovery

Getting Started

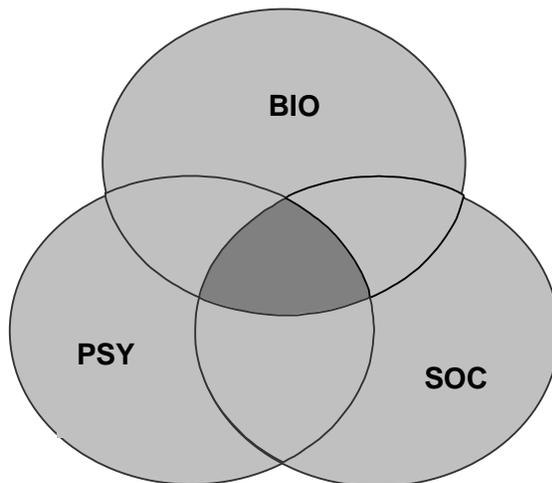
Begin by introducing yourself to the group. Welcome participants to the second in a series of Tobacco Awareness Groups.

Today we will be talking about our unhealthy relationships with alcohol, tobacco, and other drugs, (with the emphasis on tobacco), and how we go through a process that results in healthy change.

Ask the group members to talk about their relationship (connections) with alcohol, tobacco, or other drugs, and how their relationship with these substances is “unhealthy”. Use reflective listening responses, while recording the patient responses on an easel pad.

The biopsychosocial nature of addiction

Propose that if a person has become invested in an unhealthy relationship to alcohol, tobacco, and other drugs for a variety of reasons. On the easel pad, draw three large overlapping circles (the biopsychosocial model). Discuss the biopsychosocial nature of addiction, including how their substance use affects each sphere.



Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Ask: *What are some of the biological reasons for this relationship? What are some of the psychological reasons? What are some of the social reasons?*

Use reflective listening, while recording the patient responses on an easel pad.

Explain that: *It's easy to see why it's very hard to "break" an unhealthy relationship. What if you address only one or two parts of your disease, but not all three? For example, what if you address the physical part of the disease, but not the psychological or social part? What happens?*

Have some of you tried to address only one or two parts your addiction in the past? What happened?

Summarize this point: *All of the different parts of the relationship (physical, emotional, social), need to be addressed for a good recovery.*

Notes:

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Denial and Acceptance

Write the word “denial” on the top left of an easel pad. **Ask:** *Can anyone provide a definition of denial as we refer to it in addiction treatment? What does denial look like or how do you know when someone is in denial?* Allow for several responses and establish a consensus of the group.

Write the word “acceptance” on the top right of the easel pad. Ask the following questions, allowing reflection and summarization for responses to each question:

Can anyone provide a definition of acceptance as we refer to it in addiction treatment?

What is the difference between “admitting” and “accepting?” Admitting is simply stating “I have a problem” accepting is realizing you are responsible for correcting the problem

What is compliance? How is compliance different from acceptance when talking about addiction and recovery? Cull out the differences from the group and ask for examples from individuals that illustrate acceptance as compared to admitting and compliance?

Draw an arrow from the word “denial” to the word “acceptance. Ask the group members to describe examples where they overcame denial and demonstrated acceptance, not just admitting they had a problem.

Summarize the discussion and comments up to this point.

Facilitator Note:

If you divide Session One into two 45 or 50 minute group sessions (Session A and B), this is a good place to stop and summarize as Session A. If concluding here, ask group members to describe what they have learned as a concluding point.

Begin Session B by asking group members to summarize what they can recall from Session A. It is also useful to ask them if they had any new realizations from that session they would like to share. The facilitator should add anything important that was not mentioned, and then move to the next item below. At end of session B, connect all key points from Sessions A and B to the patients’ experience and tobacco and substance use.

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

The Stages of Change

Summarize the earlier session about Denial, Admitting, and Acceptance. Ask if anyone has had any new realizations since that session. Reflect and summarize. Then explain.

We will talk about a “5-stage” process of how we move from being in denial of an unhealthy relationship with tobacco, to a place of acceptance, which gives us the willingness and courage to change our behavior and establish tobacco abstinence. We call this the stages of change.

Stage One - Precontemplation (Write it on the easel pad). Ask *What does precontemplation mean? What do you think it might mean?* Try to cull out one or more definitions from the group.

Explain: *“Contemplation” means thinking about something. “Pre” means before. So, literally, precontemplation means “before thinking.”* **Then ask the following questions:**

Does anyone recall his or her reaction the first time someone brought to your attention that your use of tobacco was a problem? Reflect and summarize responses from the group.

What did you think the very first time when you heard that your tobacco use was a problem? How did it make you feel? Reflect and summarize responses from the group.

Do you recall the first time you thought that your tobacco use might be a problem for you? How did that make you feel? Reflect and summarize responses from the group. Many patients will report that they did not believe that they had a problem and became angry and defensive.

Explain: *in most cases, those people around us will (1) recognize a problem before we have the ability to see it; and (2) if we don't see it, there is no reason to believe that a problem exists. Define this as “precontemplation” or “before thinking” about having a need to change.*

Ask *Who thinks they might be in the precontemplation stage when it comes to tobacco use? To inject a little humor, you might say, “Some people call this the ‘screw you stage’.”*

Notes:

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Stage Two - Contemplation

Explain: *Contemplation means that you are thinking about making a change, but haven't decided yet whether you really want to do it (or have the ability to do it.) You are feeling ambivalent. (Ask the group to define what this means or if needed define ambivalence for the group)*

Process with the group by asking and reflecting answers about how it feels to be “ambivalent”
Think about some things that you are ambivalent about. Ambivalence means you are thinking two ways about something. There are always pros and cons. What's good about my tobacco use? What's not so good about it? What's good about stopping my tobacco use? What's good about not stopping? People in the contemplation stage are sitting on the fence, trying to decide which way to go.

Explain that ambivalence is a normal part of the change process. Ask the following questions allowing for reflection and summarization:

Most patients in addiction treatment are in the precontemplation or contemplation stage of change when it comes to their tobacco use.

Who thinks they might be in the contemplation stage when it comes to tobacco use? How did you get there?

For those of you who think you are in the precontemplation stage, what would have to happen for you to move to the contemplation stage? How will you know that you have progressed to the contemplation stage?

Notes:

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Stage Three - Preparation

Ask: *So what do you think happens (or what is different from the other stages) when a person is in the preparation stage of change? Cull out answers from the group.*

In the preparation stage, you know with certainty that you need to end the relationship with tobacco and become abstinent from tobacco. The willingness to change replaces ambivalence and you become focused on what we need to do in order to end it. A person has decided to make changes and is considering how to make them instead of if they should make them.

Ask: *How many of you have decided that you are going to stop using tobacco? Congratulations! You are in the preparation stage. (If anyone is in the preparation stage, ask about his or her plans.)*

Follow-up with: Now is the time to put together your plan to stop using. Your plan should include tobacco treatment medication, supportive counseling, and social support. Research has shown that this combination of treatment methods works best in achieving and maintaining abstinence from tobacco.

Ask: *For those of you in the contemplation stage (still thinking about it), what would have to happen for you to move to the preparation stage? How will you know that you have progressed to the preparation stage?*

Notes:

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Stage Four - Action

Ask: *So what do you think happens (is different from the other stages) when a person is in the action stage of change? Cull out answers from the group.*

Preparation is talking the talk, action is walking the walk. In the action stage, you are actively doing something to change. You are using your plan to stop your tobacco use. Since this is a Tobacco Awareness Group, and probably no one in the group has actually progressed to the action stage, how many of you can imagine yourselves taking action and putting down tobacco? How far down the road might that happen? How would things be different for you if you stopped using?

Encourage the group to talk about this, while reflecting group member responses. Also, note that the questions you use should focus on eliciting change talk from the group. Listen for the change talk and reflect it back to the group.

Notes:

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Stage 5 - Maintenance

Ask: *So what do you think happens (is different from the other stages) when a person is in the maintenance stage of change? Cull out answers from the group.*

Maintenance is the stage of the process when we allow ourselves to be free of the relationship long enough so that we begin to think of it in the past tense: "I used to use tobacco." This is the stage where we are using our relapse prevention plan to maintain a healthy recovery from tobacco.

Acknowledge that at this time in the process people become comfortable with the change or sometimes state: *"being a grateful recovering person."*

Ask the group if they understand the flow of the 5-stage process as described. Explain how the stages are fluid and not exact.

The stages of change are always active, and a person may move through them once or recycle through them several times before reaching success and maintaining a behavior change over time. In addition, individuals may move back and forth between stages on any single issue or may simultaneously be in different stages of change for two or more behaviors.

Notes:

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Session Two - The Path to Healthy Recovery, Continued

Transition: Explore with the group if they can connect or relate the stage of change to their relationship with tobacco (and to other substances that they have used).

Ask: *Let's think about the relationship you have with tobacco. What stage of change do you think you are in? What stage of change are you in with regard to alcohol or other drugs?*

Often patients will offer feedback that they thought that they could stop their alcohol or other drug use (drug of choice) and continue to use tobacco. This indicates being in an “action” stage of change in their relationship to alcohol and other drugs and a “screw you” (precontemplation) stage in their relationship to tobacco. Use the model to process how they may come to accept also needing to let go of their relationship to tobacco.

Ask evocative questions to raise the emotional level of patients and elicit responses that may include hints of change talk. When talking about letting go of the unhealthy relationship with tobacco, framing the issue in recovery language often gets patients to think differently about their tobacco use.

Revisit examples about how group members thinking, feeling, and behavior reflect the precontemplation (“screw you” stage) and “contemplation” stages.

Ask tobacco-specific open and thought challenging questions:

I understand that some of you may want to stop using alcohol, cocaine, heroin, pot, etc. yet continue to use tobacco. If it is OK, I'd like to ask a tough question (get permission before asking).

Is it possible that your drug of choice is really tobacco?

Is it possible that the disbelief or anger you felt when your spouse first suggested to you that you have a drinking problem is similar to how you may react when we talk about tobacco use as a part of the disease of chemical dependency?

If so, what does that mean? Is it possible for you to develop a willingness to let go of all substances, including tobacco? If so, how will that happen?

Process using reflective listening and listen for change talk. Summarize the group discussion, including key themes and points raised.

Thank the group for their participation and end the session.

Continued on next page

Session Two - The Path to Healthy Recovery, Continued

Trainer Note Upon completion of the demonstration role-play by the trainer, process with the group about what the experience was like for them. Allow about 10-15 minutes for the debriefing.

Slide 50

PM 97

Participants can also summarize their responses using the form on PM 65.

Use the following questions to guide the discussion with the participants in the role play and those who were observing:

- What did they learn from participating in this activity?
- What strategies did they observe the facilitator employ? (reflective listening, rolling with resistance, eliciting change talk, affirmations, summarizing, open-ended questions, EPE, and the 5 Rs)
- What skills were demonstrated, which they already use in their work with patients?
- On a scale of 1-10, with 10 being high, how confident are they as to their ability to facilitate a Tobacco Awareness Group?
- What else do they need to increase their level of confidence in order to conduct Tobacco Awareness Groups?

**Debriefing of
Second TAG
Activity**

- What did they learn from participating in this activity?
 - What strategies did you observe the facilitator employ? (reflective listening, rolling with resistance, eliciting change talk, affirmations, summarizing, open-ended questions, EPE, and the 5 Rs)
 - What skills were demonstrated, which they already use in their work with patients?
 - On a scale of 1-10, with 10 being high, how confident are they as to their ability to facilitate a Tobacco Awareness Group?
 - What else do they need to increase their level of confidence in order to conduct Tobacco Awareness Groups?
-

Session Three - Pros and Cons of Continued Tobacco Use

Trainer Note Ask the facilitator(s) and group of participants that are role-playing patients to demonstrate Group B, using the third topic: “The Pros and Cons of Continued Tobacco Use.”

Slide 50

PM 98 - 104

The script is detailed on the following pages.

Alternatively, if time is limited after completing the second group role-play, “The Path to Healthy Recovery”, the trainer can demonstrate or walk-through how to lead the third activity, “The Pros and Cons of Continued Tobacco Use.” The trainer can ask participants to provide examples for each quadrant acting as if they were patients, and then discuss how to debrief the activity with the patients.

If the trainer chooses to lead and demonstrate this third exercise, modify the debriefing as needed.

**Instructions
for TAG
Group 3
Activity**

For Group B, use the assigned script The Pros and Cons of Continued Tobacco Use and become familiar with the content of the session. This is a Benefits and Consequences Exercise and should move quickly.

The participants who are acting as group facilitators will need to discuss their presentation strategy. At least two facilitators should be selected to co-facilitate or you can tag-team the lead role. Facilitators should be sure to use MI skills throughout the activity.

The remaining Group B participants should assume role-play patients each in a different stage of change. In general the group members should act cooperative and provide answers to each of the four quadrants. Those who are role-playing “patients” can model some degree of patient resistance (arguing, ignoring, denying, and interrupting), some ambivalence, and perhaps one or two who are considering stopping tobacco use. Please no “over the top, worst patient” scenarios. The rest of the class will be observers.

Plan to present for between 20 to 25 minutes, and we will then debrief.

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Outline of Session Three Pros and Cons of Continued Tobacco Use

1. Getting Started
2. Introduce the decisional balance diagram
3. Eliciting patient responses
4. Process and Summary

Notes:

Facilitator Note:

This session can usually be completed in 45-50 minutes, however the list that patients create for their Benefits/Consequences of tobacco use, can be kept and used a second time for a follow-up session.

In the follow-up session, the group facilitator should begin the session by first asking the group to help summarize all key points they discussed in the prior session. It is also useful to ask them if they would like to share any new realizations about their tobacco use since that session.

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Facilitator Note:

A facilitated discussion around the Decisional Balance activity can be particularly helpful to patients who are in the contemplation stage in prioritizing their own needs and decisions related to their tobacco use. The main task for the clinician working with the contemplative patient is to help resolve ambivalence.

In any Tobacco Awareness Group that a clinician facilitates, there will potentially be patients in all stages of change. Soliciting feedback from all participants is desirable. Group members who are further along in their stage of change readiness will share thoughts and insights throughout the group discussion. Other group members still struggling with ambivalence or who are in the precontemplation stage will benefit from exposure to peer input and feedback.

You will need an easel, easel pad, and markers to complete this session with the group.

Notes:

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Session Three Script

The Pros and Cons of Continued Tobacco Use

Getting Started

Begin by introducing yourself and welcome participants to the third in a series of Tobacco Awareness Groups. Ask for a summary of the last session and for new insights that group members may have had since that session.

Ask: *What take home messages or important points do you recall from the previous session, "The Path to Healthy Recovery?"*

Record responses on an easel pad. Reflect and summarize key points.

Ask by show of hands for the following questions:

How many of you have decided to start tobacco abstinence in your AOD recovery?

How many of you intend to continue using tobacco?

How many of you are already in tobacco recovery?

Would anyone like to share how many days, weeks, months, or years he/she has been tobacco-free? What has that change been like? How has it benefited you to be tobacco-free?

Follow-up by asking patients for their permission to explore the reasons for their selections.

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

1) Pros of continued tobacco use (benefits of not changing)	2) Cons of continued use (consequences of not changing)
3) Pros of not using tobacco (benefits of change)	4) Cons of not using tobacco (consequences of change)

Notes:

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Quadrant 1

Ask *What are the pros (benefits) of continued tobacco use?* Reflect each group member statement and record each response. Keep asking until the group has exhausted this topic.

Quadrant 2

Follow by asking: *What are the cons (negatives or disadvantages) of continued tobacco use that you can identify?* Reflect and record each response. Keep asking until the group has exhausted this topic.

Quadrant 3

Ask *What are the pros (benefits) of not using tobacco? Alternatively, What are the benefits of stopping use?*

Quadrant 4

Ask: *What are the cons (negatives or disadvantages) of not using tobacco? Alternatively, What are the disadvantages of stopping tobacco use?*

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Summarize each quadrant during the exercise to verify that all patient input is listed.

Ask the patients to examine and compare the four categories, then ask: *what conclusions can make from reviewing your lists?*

(It is common that a consensus will be made that the Pros of Not Using” (Quadrant or Box #3) list has **much more** weight than the “Benefits of Continued Tobacco Use” (Quadrant 1 or Box #1) list. If this difference is evident, but not mentioned by the group, point this out and ask why there is a difference?

Ask the patients to shift gears and ask if the reasons listed under benefits of using tobacco and disadvantages of stopping tobacco, could also be used to rationalize a desire to use alcohol or use other drugs? The conclusion you are looking for is “a psychoactive drug is a psychoactive drug” or “that tobacco dependence is also chemical dependence”.

Ask them to revisit the four Quadrants, and add any additional ideas to each quadrant/box. If new items are added to the benefits of stopping tobacco use or disadvantages of continued use, point this out.

Now ask, what quadrants carry the most weight?

Solicit comments from the patients on the “lessons learned” or take away messages from the session relevant to their recovery.

Utilizing the MI skills, summarize what the patients have shared and the learning points mentioned. Thank them for their participation and contributions.

Continued on next page

Session Three - Pros and Cons of Continued Tobacco Use, Continued

Trainer Note Debrief in same manner as for Group A.

- Slide 50**
- PM 105**
- What did they learn from participating in or observing these two activities?
 - What strategies did they observe the facilitator employ? (reflective listening, rolling with resistance, eliciting change talk, affirmations, summarizing, open-ended questions, EPE, and the 5 Rs).
 - What skills were demonstrated which they already know and use in their work with patients?
 - On a scale of 1-10, with 10 being high, how confident are they as to their ability to facilitate a Tobacco Awareness Group?
 - What else do they need to increase that level of confidence in order to conduct Tobacco Awareness Groups?

- Debriefing
Third TAG
Activity**
- What did you learn from participating in or observing these two activities?
 - What strategies did you use as a facilitator or that you observed other facilitator(s) using? (reflective listening, rolling with resistance, eliciting change talk, summarizing, open-ended questions and the 5 Rs)?
 - What skills were demonstrated that you already know and use in your work with patients?
 - On a scale of 1-10, with 10 being the highest, how confident are you that you have the ability to facilitate a Tobacco Awareness Group?
 - What do you need to increase your level of confidence to conduct Tobacco Awareness Groups?
-

Unit Summary

Trainer Note

When we began this unit, the importance of providing psychoeducation programming for patients as part of a comprehensive treatment plan was discussed in depth.

PM 106

Ask participants if they feel that this session will be helpful as they work to integrate Tobacco Awareness Groups into their programs.

Remind participants that in addition to this training, there are e-Learning opportunities and web resources at www.tobaccorecovery.org.

**TAG Group
Unit
Summary**

The general goal of psychoeducation in addiction treatment is to help patients gain insight into their tobacco use behavior, to identify how their tobacco use connects to their alcohol and other drug use, to discuss how tobacco impacts the recovery/relapse process, and to identify ambivalence towards tobacco use and elicit change talk.

Psychoeducation groups are a part of a comprehensive treatment for any addiction, and can be especially useful for tobacco dependence. Group facilitators can use structured or scripted content to help patients develop interest in tobacco, to elevate the importance of addressing their tobacco use, and enhance their motivation to address tobacco use.

Course Closure

Trainer Note

Slides 51 – 52

PM 107-108

Distribute the Workshop Evaluation Form and Post-Test if it is being used. Thank participants for their participation, and remind them that the post-test is a measure of the training and that their completion of the evaluation is appreciated. When participants hand in the completed post-test and evaluation, provide each participant with a Certificate of Completion.

Resources

**Resource
Directory**

Tobacco Recovery Resource Exchange (<http://www.tobaccorecovery.org>) can be used to access e-learning opportunities, technical assistance, resources, web tools, and more.

**New York State Office of Alcoholism and Substance Abuse Services
Tobacco Independence** <http://www.oasas.state.ny.us/tobacco/index.cfm>

New York State Tobacco Dependence Resource Center
<http://www.tobaccodependence.org>. A wealth of resources including sample policies, research articles, and more.

Treating Tobacco Use and Dependence: Clinical Practice Guideline 2008
Update: call to order a copy at 1-800-358-9295 or go to
<http://www.surgeongeneral.gov/tobacco/default.htm>.

Continued on next page

Resources, Continued

Resource Directory, cont'd**NYS Medicaid Policy Smoking Cessation Policy**

- Smoking cessation therapy consists of prescription and non-prescription agents. Covered agents include nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the-counter nicotine patches and gum.
- Two courses of smoking cessation therapy per recipient, per year are allowed. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30 day supply is dispensed in any fill).
- If a course of smoking cessation therapy is interrupted, it will be considered one complete course of therapy. Any subsequent prescriptions would then be considered the second course of therapy.
- Some smoking cessation therapies may be used together. Professional judgment should be exercised when dispensing multiple smoking cessation products.
- Duplicative use of any one agent is not allowed (i.e., same drug and same dosage form and same strength).
- For all smoking cessation products, the recipient must have an order. A prescription is the terminology for an order of a prescription product. A fiscal order refers to an order, which looks just like a prescription - written on a prescription blank, for an over-the-counter product.
- NYS Medicaid reimburses for over-the counter nicotine patches. Prescription nicotine patches are not reimbursed.
- Name brand Zyban requires a prior authorization, but generic bupropion does not.

NYS Smokers Quitline (866) NY-QUITS (866-697-8487)

American Cancer Society 1-800-227-2345

American Lung Association 1-800-586-4872

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Glossary

Agonist: A medication that stimulates an action on a given receptor

Ambivalence: Uncertainty or inability to make choices caused by having thoughts or feelings that oppose or contradict each other

Antagonist: A medication that acts against or blocks an action on a given receptor

AOD: Alcohol and Other Drugs

Articulate: Clearly explain, describe, or talk about

ASAP: Alcoholism and Substance Abuse Providers of New York State (www.asapnys.org)

ATC: New York State Office of Alcoholism and Substance Abuse Services (OASAS) Addiction Treatment Centers (<http://www.oasas.state.ny.us/atc/index.cfm>)

ATOD: Alcohol, Tobacco, and Other Drugs

Autonomy: Personal capacity to consider alternatives, make choices, and act without undue influence or interference of others

Blended Learning: The combination of multiple approaches to learning, for example, a combination of technology-based materials and classroom sessions to deliver instruction

Bupropion (Zyban® or Wellbutrin ®): A first-line non-nicotine medication used in the treatment of tobacco dependence

CASAC: New York State Credentialed Alcoholism and Substance Abuse Counselor (<http://www.oasas.state.ny.us/sqa/credentialing/CASACCover.cfm>)

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Glossary, Continued

CBT: Cognitive-Behavioral Therapy. CBT is a form of counseling that emphasizes the important role of thinking in how we feel and what we do

CDC: Centers for Disease Control, U.S. Department of Health and Human Services

Cessation Centers: Funded community partners that provide technical assistance, training, and follow-up to health care institutions in their catchment areas in implementing the Clinical Practice Guideline, 2008 Update (CPG). The main task is to help screen patients for tobacco use and prompt health care providers to offer brief interventions for stopping tobacco use (http://www.health.state.ny.us/prevention/tobacco_control/community_partners/tobacco_cessation_centers.htm)

Change Talk: Patient statements (e.g., desire, ability, reasons, and need to change) that indicate a patient's beginning to commit to change

CIAA: NYS Clean Indoor Air Act, in effect July 24, 2003
(http://www.health.state.ny.us/nysdoh/clean_indoor_air_act/general.htm)

Cognitive: The use of mental activities such as perception, thinking, remembering, reasoning, mental images, and taking information to create new ideas

CO Monitor: A carbon monoxide (CO) monitor is a non-invasive device that estimates the amount of carbon monoxide in a person's blood, providing evidence of one of the harmful consequences of smoking

Co-morbid Condition: Two or more disorders or illnesses occurring in the same person, simultaneously or sequentially (example: opiate dependence and HIV)

Co-morbidity: Describes the negative interaction between the two or more illnesses, which affects the progression and prognosis of each disorder

Continued on next page

Glossary, Continued

Competency: The required knowledge, skills, and attitudes of addiction professional practice. (See Technical Assistance Publication (TAP) Series 21, which is available online at <http://www.kap.samhsa.gov/products/manuals/pdfs/TAP21.pdf>)

Co-occurring Disorders: Co-occurring substance use (abuse or dependence) and mental health disorders (example: alcoholism and depression)

CPD: Cigarettes Per Day

CPG: Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, U.S. Department of Health and Human Services, Public Health Service, 2008 Update (http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf)

CPP: New York State Credentialed Prevention Professional

CPS: New York State Credentialed Prevention Specialist

Craving: An urgent, seemingly overpowering desire to use a substance, which often is associated with tension, anxiety, or other dysphoric, depressive, or negative affective states

DARN-C: An acronym for how to increase change talk. Used to encourage patients to make statements that tell about their **D**esire, **A**bility, **R**easons, and **N**eed to change, which leads to stronger language for making a **C**ommitment to change

Discrepancy: A variance or difference between present behavior and a desired goal, or the difference between what is happening now and how one wants things to be. The larger the discrepancy, the greater the importance of change

DMOA: Development, Management, and Oversight Agency

Continued on next page

Glossary, Continued

DOH: NYS Department of Health (www.health.state.ny.us)

Dopamine: An important neurotransmitter (messenger) in the brain that can trigger feelings of pleasure

DSM-IV-TR: Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision

Effectiveness: The outcome achieved from a treatment that is provided in a “real-world setting” (in a clinic or community)

Efficacy: The power to produce a desired effect. Efficacy is the outcome achieved from a treatment provided under near-ideal circumstances of control (for example treatment provided during a controlled research study)

E-Learning: Self-paced instruction or professional development activities provided over the internet

Empathy: Nonjudgmental understanding, compassion, and acceptance of the patient's experience. Empathy requires understanding another person’s experience and effectively communicating that understanding

ETS: Environmental Tobacco Smoke, also known as second hand smoke

Evidence-Based Practice: Interventions that have been repeatedly documented in the scientific literature as effective in treating tobacco dependence

Expectancy: A learned anticipation of an effect from a cause

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Glossary, Continued

FDA: U.S. Food and Drug Administration (www.fda.gov)

First-Line Medications: Medications approved by the FDA for a specific use and which have an established empirical record of effectiveness

Functional Analysis: A behavior analysis (or assessment) problem-solving process that identifies why a person behaves in a certain manner. It identifies triggers for the behavior, patterns of the behavior, and the consequences or benefits from the behavior

Individualized Intervention: Tailoring an intervention to fit the needs of a particular patient. For example, relapse prevention can be individualized based on information obtained about problems the patient has encountered in maintaining abstinence

Intervention: An action or program that aims to bring about identifiable outcomes. In tobacco dependence treatment, the intervention generally is clinical in nature and may consist of counseling and the use of medications. Also referred to as "treatment"

LCSW: Licensed Clinical Social Worker

LGBT: Lesbian/Gay/Bisexual/Transgender

Medication Assisted Treatment: The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders

Metabolism: The chemical processes occurring within a living cell or organism that are necessary for the maintenance of life

MI: Motivational Interviewing. Motivational interviewing is an effective evidence-based approach to overcoming the ambivalence that keeps people from making desired changes in their lives (<http://motivationalinterview.org>)

Continued on next page

Glossary, Continued

Modality: A treatment modality is any specific treatment method or procedure used to relieve symptoms or motivate behaviors that lead to recovery

Modulate: To alter the function or status of something in response to a drug effect

Module: A self-contained component of an instructional system. PDP instruction is broken into modules to make the instruction easy to access and deliver

Negative Reinforcement: A behavior is reinforced when a negative condition is stopped or avoided as a consequence of the behavior (example: use of tobacco to avoid withdrawal symptoms). Negative reinforcement should not be confused with punishment, which weakens a behavior when a negative condition is introduced

Neuron: A cell specialized to conduct and generate electrical impulses and to carry information from one part of the brain to another

Neurotransmitter: A natural chemical in the body released by one neuron to influence or communicate with another. Examples include dopamine, serotonin, norepinephrine, and acetylcholine, GABA, glutamate, beta-endorphin, and others

New York State Clean Indoor Air Act: Effective July 24, 2003, the New York State Clean Indoor Air Act (Public Health Law, Article 13-E) prohibits smoking in virtually all workplaces, including restaurants and bars

Nicotine: The psychoactive and highly addictive substance found in tobacco products

NIDA: The National Institute on Drug Abuse (NIDA), part of the National Institutes of Health (NIH) organized within the U.S. Department of Health and Human Services

NRT: Nicotine Replacement Therapy, including the nicotine patch, gum, lozenge, inhaler, and nasal spray

Continued on next page

Glossary, Continued

NYS Smoker's Quitline: A free statewide helpline through which tobacco users can obtain information, services, and nicotine medication to support an attempt at tobacco abstinence (www.nysmokefree.com)

OARS: An acronym from Motivational Interviewing that refers to the counseling micro-skills of Open Questions, Affirmations, Reflective Listening, and Summarizing

OASAS: NYS Office of Alcoholism and Substance Abuse Services (www.oasas.state.ny.us)

OASAS Regulation Part 856: Requires all New York State OASAS funded and/or certified providers of prevention, treatment, or recovery services for chemical dependence and/or gambling to implement tobacco-free policies as of July 24, 2008 (<http://www.oasas.state.ny.us/tobacco/providers/reg856.cfm>)

OTC: Over-the-Counter, a medication for which a prescription is not needed

Partial Agonist: Bind and activate a given receptor, but have only partial efficacy at the receptor relative to a full agonist

PDP: Professional Development Program, Rockefeller College, University at Albany (www.pdp.albany.edu)

Pharmacotherapy: The treatment of disease using medications

Positive Reinforcement: A behavior is reinforced as a consequence of experiencing a positive response from the behavior (example: use of tobacco provides a pleasurable effect, increasing the likelihood that the behavior will be repeated)

PPD: Packs Per Day (of cigarettes)

Continued on next page

Glossary, Continued

Promising Interventions Partners: Funded community partners who worked to demonstrate the effectiveness of promising, but not yet established, tobacco control interventions

Rapport: The degree to which trust and openness are present in the relationship between counselor and patient; an essential element of the therapeutic relationship

Readiness: A person's stage of awareness of the need and willingness to change. Can be influenced by external pressure (family, legal system, employer) or internal pressure (physical health concerns)

Receptor: A structure on the surface of a neuron (or inside a neuron) that selectively receives and binds a specific substance

Recovery: Achieving and sustaining a state of health or actively working to regain a state of health (i.e., stopping tobacco use and non-medical psychoactive drug use), and establishing a lifestyle that embraces healthy behaviors.

Relapse Prevention Therapy (RPT): A clinical approach that helps patients to anticipate obstacles and high-risk situations when working to maintain a change, and when such obstacles or situations occur, to use effective coping strategies

Route of Administration: The path by which a substance is taken into the body (i.e., by mouth, injection, inhalation, rectum, or by topical application)

RPT: An acronym for Relapse Prevention Therapy, which is a clinical approach that helps patients to anticipate obstacles and high-risk situations when working to maintain a change, and when such obstacles or situations occur, to use effective coping strategies

RTATC: An acronym for Regional Technical Assistance and Training Center

Continued on next page

Glossary, Continued

SAMHSA: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (<http://www.samhsa.gov>)

Screening: Gathering and sorting of information to determine if a person may have a problem with substance use (i.e., Fagerström Test for Nicotine Dependence) and, if so, whether a more detailed clinical assessment is appropriate

Second-Line Medications: Medications that have not been approved by the FDA for a specific purpose but which health practitioners prescribe as “off- label” drugs to treat a disease or condition (i.e., nortriptyline, an antidepressant, is sometimes used for helping some people stop tobacco use, but is not FDA approved for this purpose)

Self-efficacy: One’s beliefs about his or her capability to successfully act to achieve specific goals or influence events that affect one’s life

SES: Socioeconomic Status

SOC: an acronym for Stages of Change (i.e., precontemplation, contemplation, preparation, action, and maintenance)

Stages of Change: The Transtheoretical Model of Change or Stages of Change (SOC) is a theory developed by James Prochaska and Carlo DiClemente, which suggests that most people progress through five different stages on their way to successful change. The stages are precontemplation, contemplation, preparation, action, and maintenance

TAG: Tobacco Awareness Group

Tailored Interventions: Treatments based on a dimension or a subset of dimensions of the patient (e.g., weight concerns, dependency). See also Individualized Interventions

Continued on next page

Glossary, Continued

TC: Therapeutic Community, a drug-free residential setting where the community (treatment staff and patients in recovery) interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use. This approach is often referred to as “community as method”

TCP: Tobacco Control Program, within the NYS Department of Health (http://www.health.state.ny.us/prevention/tobacco_control)

Technical Assistance: Help, resources, practical advice, problem-solving, and guidance to establish, strengthen, or enhance a program’s capacity to implement tobacco use interventions provided by Regional Technical Assistance and Training Centers (RTATCs)

Titration: The process of gradually adjusting the dose of a medication until the desired effect is achieved

Tobacco Awareness Group: A treatment modality primarily helpful for patients in the precontemplation and contemplation stages of change. The goal of the group is to help patients resolve their ambivalence about their tobacco use and move on to the next stage of change. The Tobacco Awareness Group develops interest, elevates importance, and enhances motivation

Tobacco dependence: A chronic biopsychosocial disease characterized by persistent use, inability to limit or control use, withdrawal symptoms when use is stopped abruptly, frequent relapse after attempts at abstinence, and continued use despite knowledge of serious physical and psychological consequences

Tobacco Interventions Project: NYS Department of Health Tobacco Control Program, state-wide, Technical Assistance and Training grant awarded to the Professional Development Program (PDP) to support NYS addiction service providers to integrate tobacco interventions into chemical dependence and gambling programs

Continued on next page

Glossary, Continued

Tobacco Recovery Group: A treatment modality primarily helpful for patients in the preparation, action, and maintenance stages of change. The goal of the group is to define tobacco recovery and teach recovery tools in the physical, behavioral, and emotional arenas. The tobacco recovery group helps patients develop skills, elevate confidence, and embrace lifestyle change

Tolerance: There are different forms of tolerance, and in this manual the term refers to metabolic tolerance, a need for increased amounts of a substance to achieve the desired effect

Treatment: An action or program that aims to bring about identifiable outcomes. For tobacco dependence, the treatment generally is clinical in nature and may consist of counseling and the use of medications. Also may be referred to as "intervention"

UMDNJ: University of Medicine and Dentistry of New Jersey (<http://www.umdnj.edu/>)

Varenicline (Chantix®): A first-line non-nicotine medication used in the treatment of tobacco dependence

Withdrawal: Symptoms of discomfort and distress when use of a substance is abruptly stopped, and may include intense craving for the substance

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Appendix A

Module 3 Pre-Test /Post-Test Questions

Module 3 Pre/Post Test Answer Key

Module 3 Answer Sheet

Workshop Evaluation Form (WEF)

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Module 3 Pre-Test and Post-Test Questions

- 1. Which of the following words does not describe a counseling technique consistent with the spirit of motivational interviewing?**
 - a. collaborative
 - b. evocative
 - c. prescribing
 - d. respectful

- 2. At any given point in time, approximately what total percentage of tobacco users are in the precontemplation or contemplation stage of change?**
 - a. 80%
 - b. 50%
 - c. 35%
 - d. 95%

- 3. The main goal of motivational interviewing is to help the patient**
 - a. change behavior by learning new skills
 - b. resolve ambivalence in favor of healthy change
 - c. change by being subjected to harsh confrontational techniques
 - d. understand that the clinician is the expert and knows what's best for the patient

- 4. Which of the following is a broad guiding principle of motivational interviewing?**
 - a. express empathy
 - b. develop discrepancy
 - c. support self-efficacy
 - d. all of the above

- 5. Which of the following statements reflects how resistance is viewed in motivational interviewing?**
 - a. the patient is being resistant because of outside forces
 - b. the patient is resistant because it's part of the patient's personality structure
 - c. the patient is resistant because the clinician's method or technique is not working
 - d. the patient is resistant because the patient requires a higher level of care

6. What is the best description of a double-sided reflection?

- a. reflecting the patient's statement in a somewhat exaggerated form
- b. reflecting the patient's statement with little or no elaboration
- c. reflecting the patient's statement capturing both sides of the patient's ambivalence
- d. reflecting the patient's statement, and adding a suggested solution to the problem

7. What does the acronym OARS stand for?

- a. ordering, affirming, respecting, stimulating
- b. open questions, affirming, reflecting, summarizing
- c. open questions, assuming, reaction, stating
- d. optimism, alternatives, responding, selecting

8. What are the two main components of cognitive-behavioral therapy?

- a. evocation and learning
- b. motivation and relapse prevention
- c. thinking and action
- d. functional analysis and skills training

9. What is one of the desired outcomes for a Tobacco Awareness Group?

- a. develop skills
- b. embrace lifestyle change
- c. enhance motivation
- d. elevate confidence

10. For a patient in the preparation stage of change, which of the following is the appropriate method of treatment?

- a. motivational interviewing
- b. relapse prevention
- c. confrontation
- d. cognitive-behavioral therapy

Module 3 Pre-Test and Post-Test Questions Answer Key

1. Which of the following words does **not** describe a counseling technique consistent with the spirit of motivational interviewing?
 - a. collaborative
 - b. evocative
 - c. **prescribing**
 - d. respectful

2. At any given point in time, approximately what total percentage of tobacco users are in the precontemplation or contemplation stage of change?
 - a. **80%**
 - b. 50%
 - c. 35%
 - d. 95%

3. The main goal of motivational interviewing is to help the patient
 - a. change behavior by learning new skills
 - b. **resolve ambivalence in favor of healthy change**
 - c. change by being subjected to harsh confrontational techniques
 - d. understand that the clinician is the expert and knows what's best for the patient

4. Which of the following is a broad guiding principle of motivational interviewing?
 - a. express empathy
 - b. develop discrepancy
 - c. support self-efficacy
 - d. **all of the above**

5. Which of the following statements reflects how resistance is viewed in motivational interviewing?
 - a. the patient is being resistant because of outside forces
 - b. the patient is resistant because it's part of the patient's personality structure
 - c. **the patient is resistant because the clinician's method or technique is not working**
 - d. the patient is resistant because the patient requires a higher level of care

-
- 6. What is the best description of a double-sided reflection?**
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 - c. reflecting the patient's statement capturing both sides of the patient's ambivalence**
 - d. reflecting the patient's statement, and adding a suggested solution to the problem
- 7. What does the acronym OARS stand for?**
- a. ordering, affirming, respecting, stimulating
 - b. open questions, affirming, reflecting, summarizing**
 - c. open questions, assuming, reaction, stating
 - d. optimism, alternatives, responding, selecting
- 8. What are the two main components of cognitive-behavioral therapy?**
- a. evocation and learning
 - b. motivation and relapse prevention
 - c. thinking and action
 - d. functional analysis and skills training**
- 9. What is one of the desired outcomes for a Tobacco Awareness Group?**
- a. develop skills
 - b. embrace lifestyle change
 - c. enhance motivation**
 - d. elevate confidence
- 10. For a patient in the preparation stage of change, which of the following is the appropriate method of treatment?**
- a. motivational interviewing
 - b. relapse prevention
 - c. confrontation
 - d. cognitive-behavioral therapy**

Module 3 Pre-Test Answer Sheet

Workshop Title Module 3 - Behavioral Interventions: Integrating Tobacco Use Interventions into Chemical Dependence Services

Date

Please circle the most appropriate response to each question using this page.

1. a b c d
2. a b c d
3. a b c d
4. a b c d
5. a b c d
6. a b c d
7. a b c d
8. a b c d
9. a b c d
10. a b c d

Module 3 Post-Test Answer Sheet

Please circle the most appropriate response to each question using this page.

1. a b c d

2. a b c d

3. a b c d

4. a b c d

5. a b c d

6. a b c d

7. a b c d

8. a b c d

9. a b c d

10. a b c d



PROFESSIONAL DEVELOPMENT PROGRAM ROCKEFELLER COLLEGE

UNIVERSITY AT ALBANY
State University of New York

Workshop Evaluation Form

Workshop Title _____ Date _____

Workshop Location _____

Instructor(s) Name(s) _____

Please use this form to evaluate the training you have just received. It is important for us to know whether the instruction is meeting the needs of the participants. Your comments will make a valuable contribution to course improvement. All responses are confidential. Thank you.

- Section One -

Instructions: Please use the following scale to indicate your level of agreement with each of the following statements.

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
1. The course objectives were very clear	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
2. The course content supported the objectives	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
3. The knowledge and skills gained from this course will help me perform my job more effectively	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
4. The instructor(s) was well prepared and well organized	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
5. The instructor(s) was very knowledgeable about the content	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
6. The instructor(s) demonstrated excellent communication skills	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
7. The instructor(s) allowed for and responded appropriately to questions	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
8. The materials and handouts were very helpful	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁
9. The course was of overall high quality	<input type="checkbox"/> ₅	<input type="checkbox"/> ₄	<input type="checkbox"/> ₃	<input type="checkbox"/> ₂	<input type="checkbox"/> ₁

Over

—

Please complete items on back

—

Over

- Section Two -

Instructions: Please be as specific as possible when responding to the following two items.

10. Which content areas or training methods do you feel were most helpful?

11. Do you feel any of the content areas or training methods should be changed?

12. What additional training would help you perform your job better?

Appendix B

(Labeled as Appendix in Participant's Manual)

Facilitation Skills Tip Sheet

Facilitation Skills Tip Sheet

Facilitation: to ease the communication among and between participants in a group

Are you one of those individuals who begin to panic when someone asks you to “facilitate” a group meeting?

Mastering a basic set of skills cannot only make you feel more confident and competent, it can also make rising to the challenge a feather in your professional cap.

What does a great facilitator do?

An effective facilitator helps people both speak to and hear each other in a group situation. A facilitator does not control a group. Instead, he “applies the grease” when the conversation gets bogged down, or “opens a window” when things get too heated.

The facilitator’s primary responsibility is to keep the group on its task. In tobacco awareness groups, the facilitator both presents the content and helps the participants stay focused, encourages their participation, validates individual contributions, and clarifies misunderstandings.

Critically, the facilitator:

- doesn’t take sides
- uses the discussion space and time effectively
- demonstrates confidence and honesty (authenticity)
- is not easily distracted
- is a skilled negotiator
- is an active listener
- asks great questions
- has a sense of humor
- can summarize the discussion simply

Continued on next page

Facilitation Skills Tip Sheet, Continued

Getting a tobacco awareness meeting off the ground

1. Welcome the members to the group and introduce yourself. Ensure that everyone in the group knows who everyone else is. Have people introduce themselves if they do not know one another.
 2. Review the “ground rules” for participation—who will speak, when, and for how long.
 3. Review “housekeeping”—who will keep time for the group, the location of the bathrooms, where the exits are, where trash should be deposited, the length and location for any scheduled “breaks.”
 4. State the agenda for the meeting: what topic you intend to cover, and how long you expect to spend on each part of the discussion.
 5. Proceed to your opening exercise.
-