Intake, Assessment and Treatment Planning

Key Points:

Goals of this module are:

• To apply knowledge gained over the last 3 days to developing an individualized treatment plan based on a comprehensive assessment and evidenced-based strategies.

• Gain more insight through role play and observation on how to initiate this assessment process

• To practice how motivational interviewing techniques allow for a richer understanding of the client and thus better targeted individualized strategies.
Goals of This Module

- Assess a tobacco user from a bio/psycho/social model
- Identify strengths and potential barriers
- Conduct interviews in a manner which advances stage of change and promotes self-efficacy
- Develop a tailored treatment plan based on the assessment

Key Points:

- Explain that this will start with a review of what they know but then explore the nuances of the assessment components

- Mention the goal is to not expect to remove all barriers but to transcend them, find new coping strategies or uncouple them from smoking

- After reviewing the components of a comprehensive intake assessment there will be a chance to apply your knowledge through role play
The "Biopsychosocial" Model of Tobacco Dependence: a Review

Key Points:

• This paradigm was discussed in Day 1. It is helpful to appreciate exactly how these areas can intertwine.

• Give a case example of your own or use the one below.

• Can make the point that smoking for people almost becomes Pavlovian. They so quickly respond to the physical need that they don’t see the correlation with an event and see it only as a habit. Strategies will be much more targeted if you can capture some of this.

Case example:
A 37yo woman always lit up when she heard the phone ring. It seemed like a natural reaction. Later she talked about her mother and how difficult she was to get along with. Her mother lived in another state and would often call unexpectedly. This woman was always afraid of “losing it” on the phone with her mother so got into the habit of lighting up as soon as the phone would ring.

Additional Background:
It is useful throughout this module to have anecdotal stories of actual client encounters at the ready that illustrate the point being made. Refer to Presentation cases for examples you might use (Some are included on the slide notes like above) but always good to use your own.
The Intake and Assessment Process

How and when will assessment be conducted in your system?

Examples:
- Paper forms completed prior to initial session
- Information collected during interview

Sample – MGH Intake Form

Key Points:

- The process for assessment will vary by system

- Ask the group for examples of the assessment process used at their programs. Be sure to discuss setting up new processes and integrating information about tobacco use into existing processes (e.g. intake process at a SUD treatment facility)

- MGH has graciously allowed UMMS to include their intake form on our website (in the Module 6 handouts section in the training manual). You have permission to use/adapt this form. We will review it later this morning.
Assessment Components

- Demographics
- Tobacco Use History
- Level of Tobacco Dependence
- Quitting History
- Social/Cultural/Environmental Factors
- Medical/Psychiatric History
- Beliefs/Stage of Change/Self-Efficacy

**Key Points:**

- This should only be a review or group will get bored so jump right in. Try to keep them on topic and not mixing smoking history with quitting history, for example. Some specific areas will be new like some of the scales used to assess nicotine dependence or depression.

- Make the point that listening to how your client tells their story is as important as the objective information itself, maybe more important. This was a key finding of a focus group conducted at Mayo with smokers seeking treatment. Being able to tell their story was a meaningful piece of the process for them

- All of these factors will influence their readiness to change. Ultimately it is their level of confidence that will determine their ability to make a quit attempt.
Demographics

- Age
- Gender
- Race/Ethnicity
- Relationship status
- Residence
- Educational level
- Employment
- Insurance
- Primary Care MD?

Key Points:

- We can easily collect this information. Very discreet, objective data about your client. What is helpful is to think what more do I want to learn or based on what I know how might this be influencing their motivation/confidence at this time.

- If following points are not raised by the group try to mention them.

- Just a reminder: Be sensitive/respectful of gender. Ask clients how they would like to be addressed.

- With residence/education/employment you are assessing the client’s socioeconomic status. With a higher SES and life in wealthier towns there can be a lot more cognitive dissonance related to their smoking where it might be the norm in more blue collar towns. You might site statistics of smoking prevalence for a couple of your towns.

- Remember that lacking a formal education does not mean the person is not smart. You do need to determine if they can read. You could ask, “did you have any concerns about filling out the questionnaire?” As you establish rapport you can further explore or observe their learning style.

- Occupation may be useful when formulating strategies. Their occupation can tell you something about how they approach tasks or projects. This can be worked into metaphors when talking about preparation for quitting smoking.

- Insurance is obviously a concern when recommending pharmacotherapy. Having and actually seeing a physician for regular follow up may inform you about their access to care or concerns for their health.

Background: This information may seem obvious but from the beginning it all contributes to the building of a working plan. The idea is to start to develop hypotheses about what are the strengths/barriers and what types of strategies (when ready to develop a treatment plan) will work for this client.
### Tobacco Use History

- **Age started**
- **How did you start**
- **Cigarettes per day**
  - **Lifetime**
  - **Current**
- **Brand (Menthol?)**
- **Other tobacco or e-cigarette/vaping use**
- **What do they like about it**

### Key Points:

- MI techniques remind us to be sure to acknowledge that there are positives about smoking. So be sure to deposit into the “Rapport Bank”

**Case study example:** Italian immigrant who had been in this country for many years but was born in Italy. He reported starting smoking when he was 10yo during the aftermath of WWII. Smoking helped take away the hunger.

- Be aware of dual users. If they have switched from cigarettes to cigars or pipes be sure to check for pattern of use. Usually will mimic how they smoked cigarettes.

- Remind them to be curious about changes in pattern of use too. For instance, why did their smoking increase or decrease at a particular time. This may identify a coping strategy that worked, or a barrier that needs to be addressed.

**Case study example:** Client reports smoking less this past year. He thinks it is related to volunteering part time at a museum where smoking is not allowed. However, smoking less also correlated with his psychiatrist starting him on Wellbutrin for depression, and after reflection he noted that cravings to smoke had decreased making it easier to not smoke where it is forbidden, like work.

### Additional Background

If questions arise on menthol cigarettes:

- Menthol cigarettes are often the choice for African Americans. A report issued by the US Food and Drug Administration (FDA) finds the public health risk of menthol cigarettes to be above and beyond that of nonmenthol cigarettes as menthol smokers absorb more carcinogens.

- Young people who start with menthol cigarettes are more likely to become regular smokers.

- Smoking menthol cigarettes is associated with decreased cessation at the population level, and this association is more pronounced among Black and Puerto Rican smokers.

- This is where that old technique of brand switching may be helpful
DSM* 5: Tobacco Use Disorder (review)

3 levels of severity based upon number of symptoms present (at least 2 must be present)

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

*Diagnostic and Statistic Manual of Mental Disorders 5th edition (DSM 5)

Background:
The DSM 5 criteria have been presented in Basic Skills - and were reviewed in Module 1: Determinants of Tobacco Use Disorder – this is just a reminder that these are the criteria for tobacco use disorder (no longer called ‘dependence’) as described in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

It is worth noting that the Mayo focus group referenced earlier also found that clients felt less ashamed and more hopeful after learning about nicotine as an addiction.
Tobacco Use Disorder: Symptoms

1. Taken in larger amounts or over longer period than intended
2. Persistent desire or unsuccessful efforts to cut down or quit
3. Great deal of time spent to obtain or use
4. Craving
5. Recurrent use resulting in failure to fulfill major role obligations
6. Use despite persistent social or interpersonal problems
7. Giving up or reducing important activities because of use
8. Recurrent use in physically hazardous situations
9. Use despite persistent physical or psychological problems
10. Tolerance
11. Withdrawal

Key Points:

Why is it important to have a common list of criteria for tobacco use disorder?

- to provide a common language through which improved communications can be established among clinicians and researchers.
- to serve as a tool to guide treatment.
- to legitimize the disorder and provide a basis for possible reimbursement of services.
- The criteria for inclusion for ‘Tobacco use disorder’ (‘TUD’) are (simplified) as listed on the slide

Case study example: A client related a story about crashing with friends on snowmobiles. Out in wilderness, no cell phone reception. First thought was not of survival but how many cigarettes do we have and how are we going to make them last.
Fagerstrom Test for Nicotine Dependence

- Used in studies to define degree of dependence
- Has correlated with biochemical measures, withdrawal, poorer outcomes without NRT
- Should not be ultimate measure for nicotine dependence

**Background:**

- Formerly called the Fagerstrom Tolerance Questionnaire, it was developed in 1978, based on the theoretical understanding of nicotine dependence at the time.
- Initially it was found to correlate with biochemical measures like CO, nicotine, and cotinine levels. However on further examination, certain factors of the FTQ were found to be more strongly correlated with these measures and certain factors did not add to its predictability.
Fagerstrom Questions

- Time to first cigarette
- Number smoked per day
- Difficulty refraining where forbidden
- Smoke when so ill in bed
- Smoke more in the morning
- Most satisfying is first cigarette

Key Points:

- The title was also actually changed to the Fagerstrom Test for Nicotine Dependence (FTND).
- When it was revised about 10 years ago, certain factors were removed and others enhanced.
- Time to first cigarette or TTF was revised to reflect the stronger need to relieve discomfort upon awakening. Now it is:
  - 5' or less
  - 6'-30'
  - 31'-60'
  - >60 minutes
- Breakdown was superior to the previous category system of < or > 30'.
- Strongest correlates with biochemical measures:
  - CPD and TTF = HSI (heaviness of smoking index)- Also predicts abstinence
- If you have limited time at least assess these two factors.
- Note: Total cigarettes/day may be misleading. Beware of relighters. Background for this is it only takes 3 puffs to fill 90% of the nicotine receptors so craving is mostly satisfied and cigarettes are getting expensive.
- Also are they “night smokers” as they are even more strongly addicted.
- It still requires nuanced assessment in a clinical setting.

Case study example: Forty-year-old man does not smoke for 1 hour after waking. With further exploration he reveals his 8yo son has asthma and he has profound guilt if he smokes in the house. His first foot out the door he has his cigarette lit.

- Other factors can help you identify coping skills already in place. For instance if the client cannot smoke at work how does he/she manage cravings when there is no opportunity to smoke.
TTS – Intake and Assessment and Treatment Planning

Hooked on Nicotine Checklist (HONC)

- 10-item screening tool to assess adolescent smokers
- Has been validated in adult smokers
- Measures loss of autonomy by looking at:
  - Emotional attachment
  - Physical and psychological barriers to quitting

Key Points:

- Refer to page 4 to see the HONC.
- Developed in 2002 by Difranza and others its purpose was to try to capture the onset of nicotine dependence in adolescents, the hypothesis being once autonomy is lost, dependence begins.
- The items actually assess loss of autonomy over tobacco
- Negative affect (like irritability, anger, frustration) is a known major reason for relapse so this scale may tell you more specifically how much this will factor into their ability to resist the urge to smoke.
- The number of symptoms endorsed by a smoker measures the extent to which they have lost their autonomy. Even one yes answer indicates loss of autonomy. So for adolescents this could help them identify over time how much more they are becoming dependent on nicotine.
- Ask the group to reflect on patients they have seen and how they might answer these questions. Elicit responses from the group. Make the point that adults are often embarrassed to admit their attachment to cigarettes. On the other hand it is a source of great pride when they overcome the hold nicotine has over them. It is often one of the top reasons for wanting to quit, especially for people who otherwise pride themselves on making their own decisions. Being in control again could be their number 1 reason for wanting to quit.
### Fagerstrom Test for Nicotine Dependence – Smokeless Tobacco*

- Time to first dip after waking
- Frequency of intentionally swallowing
- Hardest dip to give up
- Number of cans/pouches per week
- Using more in the morning
- Chewing when ill in bed


**Key Points:**

- Few Nicotine Dependence measures have been developed for ST users. Severson and Ebbert have made attempts to objectively measure the dependence on ST.

- Swallowing the juice is correlated with higher cotinine levels BUT not correlated with blood nicotine levels. Theory is that the nicotine is so quickly metabolized by the liver which contributes to high cotinine levels. This makes it difficult to determine how much NRT is required to manage withdrawal. So it is often trial and error. You can start with using # dips/day and/or # cans/week. Current thinking is <2 cans/week start with 14mg patch, 2-3/week use 21mg, >3/week double patch. >12 dips/day is a lot if you consider most likely left in for 30 minutes or more. Can also supplement with nicotine lozenge like you would for a smoker. (Ref: JO Ebbert et al, Addictive Behaviors 29(2004) 349-355)

- One of the case studies for role play will allow us to get into more specifics about treating dippers and chewers

- You might check to see who in the group are %age of clients who are chewers in their program, or any with personal experiences if group is comfortable sharing.

**Additional Background readings:**


- Richter P and Spierto FW *Surveillance of smokeless tobacco nicotine, pH, moisture, and unprotonated nicotine content*. Nicotine & Tobacco Research, Volume 5, Number 6, December 2003, Pages 885-889. Refer to this reference for levels of unprotonated nicotine even various snuff and chew products. Have available if questions arise.
Carbon Monoxide Measurements

- 15 ppm = 1/2 ppd
- 20-25 ppm = 1 ppd
- >30 ppm = 1 1/2 - 2 ppd or deep inhaler
- Cigar smokers higher

Key Points:
- Survey the group to see how many are familiar with or have used a CO monitor. Elicit experience with it.
- For reference CO<6 is considered a nonsmoker though studies tend to use <10 as their cut off. Most nonsmokers test at <3.
- One cigar is equal to about 3-5 cigarettes and CO may be as much as 30 times as high as cigarettes. Little cigars, like Double Diamonds can also result in higher CO levels.

Case Study Example:
- Forty-five year old professional, former cigarette smoker who started to smoke cigars daily. Started to occasionally smoke cigarettes as well so was worried and came for help. Was convinced he did not inhale the cigars. CO was 70. He quit the next day.
- Highest recent level I found was 100ppm in a patient who smoked little cigars but also lived with several roommates who smoked in the apartment.

Activity:
- Demonstrate how to use the CO monitor. If there is a smoker in the building who is a willing “Guinea” pig arrange for them to be the model. Otherwise ask for an attendee volunteer. Be sure to talk to the person as you would speak to a client explaining the rationale for the test, what carbon monoxide is and what they need to do. Then give nonjudgmental feedback using good Motivational Interviewing technique.
Prior Quit Attempts

- Number of attempts
- Time and timing: Why then?
- Specifics on longest and most recent
- Pharmacotherapy
- Other methods like groups, acupuncture
- Withdrawal symptoms
- Reason for relapse

Key Points:
- Obviously you are not going to talk about their thousand attempts to quit. You are interested in attempts that actually result in a quit that lasts more than a day and that was not a forced quit, like a hospitalization or incarceration.
- If never tried to quit before why not and why now.
- For purposes of discussion, elicit from the group, “What do you want to know about the pharmacotherapy they used”?
  1. Why a particular choice
  2. How much
  3. How long
  4. Do you feel it helped
  5. Any side effects
  6. What else helped
  7. What were the withdrawal symptoms. How much did the pharmacotherapy help alleviate withdrawal.
- This is your time to think about how you are going to reframe the next quit attempt, what you might recommend in terms of pharmacotherapy. Look for what will be different this time.

Additional Background if points are not made during the discussion
- How did you feel when you weren’t smoking (Looking for positive self talk. Be ready for “I didn’t feel a thing”)?
- Why do you think you went back to smoking? Did they struggle the whole time and then relapse. Was it that simple “one won’t hurt” idea? Were they lacking in commitment from the beginning? If they answer affirmatively, follow up with what will make this time different for you.
Who smokes at home
Can you smoke in the home/car
What about friends/co-workers
Smoking policy at work?
How does smoking fit into your social life
What supports/stressors exist right now

Key Points:
Elicit from the group what they are listening for:

• Spouse or partner who smokes can have a strong influence on the quit attempt, either positive or negative.

• Smokers associate with other smokers. If smoking connections in their social sphere are dwindling, that is a strong reason for wanting to quit and helps support not smoking.

• Are their medical reasons they cannot/should not smoke in the house like children or visiting grandchildren, home oxygen

• Where do they smoke (In a closet because they are embarrassed vs. any time anywhere)

• Always be on the look out for a chance to express empathy and/or reinforce positive self talk.
Cultural Factors

- Avoid cultural ‘blindspot’ syndrome
- Influence of religious or cultural beliefs
- Cultural reasons that support tobacco use
- Respect boundaries
- Always ask permission
- Recognize differences/Build on similarities

Key Points:
- You might first ask the group if they work predominantly with a cultural group different from their own and what is that like for them. Lessons learned?

Points to share:
- Consider all clients as having a culture unique from your own
- How does their religion or beliefs effect their concern over using medication for instance
- Be sensitive to the fact that quitting smoking may actually alienate them from their reference group.
- Maintain good MI skills. ALWAYS ask permission.
- Keep in mind your client may not share certain information out of fear of embarrassment or being judged. You may need to take longer to build that trust.
- Be careful of nonverbal cues that might be misinterpreted by them or you may misinterpret.
- It is true that SES and education levels the differences somewhat
- Just remember if you find yourself saying this person doesn’t understand you are probably missing some critical piece of information. You may be speaking a different language, both literally and figuratively.
Family Medical History

- Is it motivating a quit attempt?
- Is it creating anxiety?
- Is there an emotional connection?

Key Points:

- Again let them tell their story. You cannot make assumptions that they get the connection between smoking and a particular family illness.

- On the other hand it may cause such anxiety that it promotes smoking or they feel fatalistic about it.

- You might find a very specific connection their decision to quit and someone dying of a smoking related disease. Maybe they made a promise to someone who died that they will quit. Maybe a parent died at 41yo and you are 40 now.

- Don’t paint a rosy picture that doesn’t exist. Reality is for instance the risk of developing lung cancer never goes away. But they could be proactive and get CT scans periodically.

- And be ready for the story of Uncle Joe who smoked 3ppd and lived to be 90 years old. Once rapport is established then you may be able to challenge some of their misconceptions. But only if you feel that this will increase their motivation. YOU must be VERY careful of the righting reflex here.
Key Points:

- It has always been known that patients show up at their doctors office with a respiratory illness or cough are acutely motivated to not smoke, even if they aren’t sure they want to quit. Reflect their belief that the illness is associated with smoking. Or with the person who dips it may be a visit to the dentist that triggers the motivation. Usually asymptomatic, just the words “precancerous” changes (leukoplakia) is enough to get them to make a quit attempt.

- It is also known that heart attacks are probably the most effective quit smoking “intervention”. Sometimes they are lacking in the actual connection though. They often fear nicotine is the culprit so don’t want to use NRT. So listen for misconceptions.

- CO levels can be very helpful here. Clients really like that objective measure of harm. And this provides an opportunity to talk about the silent effects of smoking in your apparently healthy smokers who may be at risk for cardiovascular disease. For instance, clients with diabetes.

- Another objective/subjective measure is having the client reflect on the current health compared to past. Or if they quit in the past how did they feel. Dying does not work as the focus. What you will get in response is “You are going to die of something”. What can work as the focus is function/independence. This is what most middle aged and older smokers, and nonsmokers for that matter, fear the most. How does smoking fit with what they value in life. This tact is often useful in the inpatient setting.

- Chronic pain can make quitting very difficult, especially if they perceive smoking as helping control their pain, which in fact it may. Nicotine can have analgesic properties and also serves as a distraction. So it depends somewhat on their own perceptions, on the severity of the pain, amount of opioid use, and overall function, social supports, presence of anxiety and depression (which are issues themselves).

- Make sure you determine if there are any contraindications for any particular form of NRT or Bupropion or Varenicline – And those are? Elicit from the group as meds were just reviewed the day before: e.g. Severe skin disorders, dentures/bridges/caps, Alcohol abuse (Bupropion), renal failure (Varenicline).

Additional Background:

- In one study Success with an unplanned quit attempt for current health concerns had an odds ration of 1.79 and future health concerns OR 1.41 where as cost had OR of 1.25. So concern for health can be a strong motivator.
Screening for Substance Use

- Current or past use/dependence of other drugs such as:
  - Alcohol
  - Cocaine
  - Heroin and other opioids
  - Marijuana

- If past use:
  - How long off substance
  - Method used to stop
  - Ongoing supports in place

Key Points:

- Alcohol is certainly the most common with 70-80% of alcohol abuser are smokers or former smokers. But drinking is legal so unique from other substance abuse so will address separately.

- Polysubstance use disorder is a very complicated diagnosis. There are often other associated comorbidities and social challenges. If they are actively using there needs to be a comprehensive approach to stopping all substances. It is probably beyond a TTS’s scope, (unless you are an addictions counselor of course), other than being sure the client knows that quitting tobacco at the same time can actually help not hurt their recovery. Problem is the culture does not support this approach yet. So until the system changes you are faced with a difficult challenge.

- However if they have already stopped the other substance use, you know they have accumulated some skills that will be transferable to their quit smoking strategies. As you assess how they quit other substances be sure to affirm what they have already accomplished. Again you are looking for opportunities to reinforce positive self talk. And depending on stage of recovery, they may need to continue with whatever treatment program they are using.

- Marijuana does not carry the same stigma that hard drugs carry. Unfortunately it does reinforce the action of smoking.
Working With The Client in Recovery

- Identify through assessment that the client is in recovery
- Ask questions to allow discussion of other major lifestyle changes that the client has made, including recovery
- “Many roads, one journey” (Charlotte Kasl)
  - Alcoholics Anonymous/other 12-step programs
  - SMART Recovery, Women for Sobriety, SOS, Religious support, family support, psychotherapy

Key Points:

- Remember there is a stigma with having an addiction in this society, even if the person is in recovery. As such, you may need to demonstrate your openness to discuss this and your genuine support for people in recovery.
- Question openers for a client in recovery:
  - What other challenges you have overcome in your life?
  - Are there other addictions you have addressed or given up that you would feel comfortable talking about?
- Emphasize that counselor’s knowledge of a client’s recovery status is important in developing a treatment plan that will work for them.
Screening for Alcohol Abuse: the CAGE Test

C Have you ever felt you should cut down on your drinking?

A Have people annoyed you by criticizing your drinking?

G Have you ever felt bad or guilty about your drinking?

E Have you ever had an eye-opener first thing in the morning (or when you get up) to steady your nerves or get rid of a hangover

Key Points:

• CAGE questionnaire is a simple 4 point scale that can help identify problem drinking. This is often used in primary care though they are now moving to even more sophisticated assessments as drinking has so many other associated illnesses.

• Alcohol is trickier as it is not illegal (unless you are driving of course). There are many functioning alcoholics who do not see their drinking as a problem. It is not your job to treat alcohol dependence but it may be important to inform them that it may be a barrier to their ability to quit smoking if that is their goal.

• Answering yes to 2 or more questions is a strong indicator of alcohol dependence.
Have you been feeling down, depressed, or blue most days in the past 2 weeks

If yes, then ask:

Key Points:

• Adults who have any mental illness are more likely to smoke compared to adults with no mental illness. It is estimated that 1 in 3 adults with mental illness smoke. And half of all adults with bipolar or depressive illness smoke.

• Depression screening with some tool is worthwhile given what we know about it’s link to smoking. If no tool is used you can rely on the basic screening for symptoms of depression.

• That screening starts with the simple question, “Are you depressed, down or blue most days in past 2 weeks”. This is without an obvious cause like a death in the family or a new serious medical diagnosis. Two weeks is the criteria used by the DSM.
Depression Screening Questions

- Sleep too much/too little
- Interest (lack of or lost pleasure in daily life)
- Guilt (feeling like a failure)
- Energy (lacking)
- Concentration (can’t really focus)
- Appetite (increased or decreased)
- Psychomotor (retardation or agitation)
- Suicide (hopeless; feeling worthless)

Key Points:

- This acronym, SIGECAPS, is a way to remember depressive symptoms.

- If there are 5 affirmative answers, and of these 5 must include the depressed or loss of interest or pleasure in doing things you can at least say depressive symptoms are present. Most of us are not licensed to make a formal diagnosis.

- If you suspect someone might be depressed, these questions can help you decide if you should make a referral to a licensed mental health professional.
Key Points:

- Two common pencil and paper screening instruments for depression include the Center for Epidemiologic Studies Depression Scale or CES-D, and the Beck Depression inventory. More information about the CES-D, including the scale, can be found in the handout section of this module. The CES-D can also be found in the MGH Patient Questionnaire. This scale has the advantage of being in the public domain so is free to use. (Ask the group if it would help to look at this questionnaire now. See additional background below.)

- The Beck Scales are available from Pearson Assessment. You can check their website if you are interested in this scale. This is not free.

- The Patient Health Questionnaire – Nine Item (PHQ-9) is the standard among scales for monitoring symptoms of depression. The PHQ-9 consists of only nine items that correspond to the nine DSM-5 criteria for persistent depressive disorder, along with the requirement for clinically significant distress or impairment in social, occupational, or other important areas of life. It is a more formal and reproducible way to get at SIGECAPS. It is available in multiple languages.
Screen for Other Mental Health Disorders

- Generalized Anxiety Disorder
- Panic Disorder
- PTSD
- Obsessive compulsive disorder
- Agoraphobia
- Bipolar or Manic Depressive Disorder
- ADHD
- Schizophrenia

Key Points:

- Tobacco use is strongly correlated with other mental illnesses like schizophrenia. The rate of smoking among schizophrenics is estimated to be about 80%. Others can be in the 50% range with the exception of OCD which is more on the order of the general population.

- Problems like anxiety disorders (top 5 are various forms of anxiety) can make it harder for the person to stop smoking. Anxiety and depression often go and in hand.

- The reality is that these patients end up dying of smoking related illnesses.

- But not all are doomed to be smokers all their lives. You may need to alter your approach somewhat. Also I think it important to show interest in them as a person, and not the pathology. Treatment adherence and retention are your concerns for clients with mental illness.

- Address these issue during the case study discussions
Assessment Questions when Clients Have Mental Health Disorders

- Current medications
- Therapist/Psychiatrist
- Day to day functioning
- Social supports
- Acute stressors
- Speech pattern/Nonverbal cues
- Contribution of medical problems

**Key Points:**

The questions to ask or at least reflect on when seeing a client for tobacco use who has a mental health disorder are the following:

- Are they taking medication (or medications in many cases) and is it effective. Have the doses been stable for awhile (I like 3 months, especially for schizophrenia and bipolar)
- Do they receive regular follow up by a mental health professional (if on medication this should include a psychiatrist). Can you get permission to speak to their therapist
- How much does the diagnosis interfere with their day to day functioning. For instance can they hold a job?
- What are the social supports available: Sources of emotional support can include family, religious groups, community.
- Are there any acute or anticipated stressors that might exacerbate their illness.
- You may learn more from attending to their speech pattern and other nonverbal cues: For instance how is their eye contact, are they agitated. Is their speech slow, pressured or rapid. What is the volume like. Sharing your observations with their therapist will be key.
- How do their medical problems contribute to their psychiatric illness (for example chronic pain)
Beliefs/Self Efficacy/Stage of Change

- Choosing what to reinforce with reflections is key
- What is their stage of change AND
- The etiology for that stage of change
- Listen for the DARN-C
- It all comes down to confidence and commitment

Key Points:

- The bottom line is you need to determine what their beliefs are about smoking and quitting and how do they influence their readiness to quit. This will give you direction on how to summarize reinforcing with their own words what is motivating them to try and make this change.

- Think about not only the Stage of Change BUT the etiology of that stage. For instance are they precontemplators because they do not see importance of quitting OR is their confidence so low they are afraid to try for fear of failing.

- Listen for the DARN-C. You need to hear the C to move forward. Worth getting group to explain what the acronym stands for.
Pulling It All Together

Summarize key information with clients
Focus on identifying strengths and potential barriers
Collaborate on determining next steps

Key Points:

• Reflections are like little summaries and will lead up to a richer final summary. Always check to see if you got it right.

• For your own preparation you need to focus on the client’s strength and find practical ways to manage the barriers keeping in mind you cannot and do not have to solve all their problems but just help them figure out what it is they can control.

• Then discuss collaboratively how they would like to proceed.
Building Motivation to Change...

Is building optimism and…

“Optimism is the faith that leads to achievement. Nothing can be done without hope and confidence”

Helen Keller
Role Play for Training Activity

Demonstration of an intake/assessment interview

Activity:

Set the stage for how the role plays will be carried out starting with the demonstration case. Review the case ahead of time and have a co-instructor or volunteer role play the client.

- Start by reviewing MGH Intake Form on pages in the Handout section as the information collected from this questionnaire is summarized on the Summary of Patient Questionnaire for the case study. Review with the group what you know about this client. Discuss some of the hypotheses you can already generate based on her answers. For example, a female client who indicated “all cigarettes” would be difficult to give up (Sounds like both a physical and emotional attachment) and weight is 128lbs and preferred weight is 115lbs. Given people can gain 5-10lbs when the quit you have some negotiating to do. Does not seem like she perceives a lot of support from her family. Is this real or imagined?

- Have the group pull out the Content and Process Rating Forms in the handout section for this module. Divide the group in half and assign process to one side and content to the other.

- Carry out the role play with your co-instructor or pre-identified participant.

- 10 minute role play with 10 minute class de-briefing.
Now It’s Your Turn . . .

**Group Exercise – Part I**

**Case study: Conducting and evaluating an intake/assessment interview**

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**Activity:**

Set up for Group activity. For this first part you will only ask the individuals to do the intake interview, NOT the treatment planning.

- Before lunch, have participants count to form groups of 4 people (e.g. class of 20 people is 5 groups of 4 so count off to 5). Participants take all belongings and get into their group. The rest of the day’s activities will be within this grouping.
- Over lunch, instructor distributes case packets to each table/group. See further instructions with Case Study Packets.
- Preparing for the interview (15 minutes)
  - **Review roles:** client, TTS, process observers, content observers. Group decides who plays which role. If there are 5 in a group, have 2 process observers.
  -Clients leave room to review case information. Instruct ‘clients’ to learn the role as much as possible, then play the role without worrying about the paper.
  - Instruct TTS and Observers: **After clients leave room,** discuss TTS and observers role:
  - All: read Questionnaire summary – use info to develop interview strategy.
- Conduct the interview (15 minutes):
  - TTS: lead the interview – ask for help from Observers if necessary. Discuss how/where to start with interview, issues to think about. TTS and observers should talk prior to the interview to discuss how to proceed with the case (make the observers active partners).
  - Observers: complete Process and Content forms – offer suggestions to TTS as necessary after the interview.
- Debrief the interviews in small/large group

- (See “Detailed Agenda” for additional details).
Developing a Treatment Plan

- Using assessment information to tailor the plan
  - Strength/Barriers
  - Special Considerations
  - Client preferences

- Incorporating strategies at all phases
  - Pre-Cessation
  - Cessation
  - Maintenance
  - Relapse Recycling

- Sample – Mayo Clinic template

Key Points:
Keep in mind they already had a lecture on Treatment Strategies.
Some points that can be made:
• Ambivalence is ongoing
• Preparation is key
• Use metaphors – Example might be you don’t go on a diet and then sit in a bakery as rationale to make the home smoke free in preparation for quitting. Pick a metaphor the patient can relate to as you explain why preparation is a key to success. (Examples can include planning a vacation. What steps would you take to prepare to make it a successful vacation. Or painting a room. (Pick metaphors you have used and you feel were effective).
• Divorce or separation is an effective metaphor for why people relapse. They only want to separate from the cigarettes. When you divorce them it creates a different mindset. You need to personalize the experience.
• Vicarious experiences often help. (“I just saw this client who reminded me a lot of you. He shared an interesting idea that really helped. Can I share it with you?”)
• Different things work for different people. For example you might try a trial quit date for someone with low self efficacy.
• Try to plan follow up 24-48 hours after quit.
• Refer them to Handouts for the Mayo Clinic Template for treatment planning.
Selecting a Treatment Modality

**Work with the options available at your site**
- 1:1
- Group
- Telephone
- Supplement with other resources

Remind participants that multiple modalities have been found effective. What options will work best for their clients and staffing?
Activity: See detailed agenda for additional instructions on conducting this activity

- Following the role plays the groups will collapse (if more than one group has the same client) and develop a tailored treatment plan.
- Groups determine strength, potential barriers, and treatment plan (remind group to be specific about the plan – they should be able to explain why they choose the treatments they did, and how those barriers/strengths guided their plan. Provide newsprint to be posted during the report out to the larger group (30 minutes)
- Assign reporter.
- After groups have completed plans/30 minutes: Each reporter discusses their client and plan.
- It is helpful to share with the entire group the background information on the client since the rest of the group will not be familiar with the case.
Next Steps for Completing Your TTS Training

- Complete the evaluation (either paper or SurveyMonkey link)
- Take the exam
- Wait for your grade and certificate(s)
- Start using your skills!

Thank you for participating!

Questions? Contact us at cttrt@umassmed.edu

Next Steps:
- You will be sent a link to take the online exam (if you have completed and passed Basic Skills AND have attended each day of TTS training)
- Your exam will be graded, and your grade and certificate(s) will be sent to you a few weeks after the test is completed.
- If you are planning on applying for the National Certificate in Tobacco Treatment Planning, you may start accruing hours!