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NURSING TOBACCO INTERVENTIONS – PART I

Goal:
The learner will be able to screen for tobacco use in adolescent and adult patients and provide basic motivational and behavioral tobacco interventions. This module focuses on interventions for patients who are not ready to quit tobacco.

After completing this activity participants will be able to:
- Screen patients for tobacco use
- Provide brief counseling interventions for patients who are not ready to quit tobacco
- Use motivational interviewing skills when counseling patients in tobacco interventions

Professional Practice Gaps
Tobacco use is still fairly common; in the United States. Approximately 35.8% of persons aged 18 to 25 and 21.7% of those 26 and older use of any tobacco products in 2017 (American Lung Association, 2017) and 14% smoke cigarettes (USDHHS, 2020). The bulk of the difference between any tobacco use and cigarette smoking is due to the recent increase in use of e-cigarettes or vaping of nicotine. Tobacco use in the form of smoking and second hand smoke is estimated to be responsible for more than 480,000 premature deaths annually (CDC, 2019) and cause significant morbidity (USDHHS, 2020). The effectiveness of tobacco interventions by health care providers was evaluated in a review of the literature by the review panel for the U.S. Public Health Service Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update (Fiore, et al., 2008). They found that medication and counseling are more effective for promoting tobacco cessation than no treatment and that intervention effectiveness increases with increased intervention intensity. The Clinical Practice Guideline (Fiore, et al., 2008), also provided evidence-based guidelines for clinicians on how to provide brief and more extensive interventions in tobacco use. Despite the documented need for tobacco cessation and effectiveness of clinical interventions and availability of practice guidelines, many health providers still are not providing evidence-based tobacco interventions. A number of studies have found that screening for tobacco use and recommending cessation occurs as frequently as 75% of the time in primary care, other appropriate tobacco interventions are made by in primary care less frequently (Schnoll R et al., 2006; Braun et al., 2004; Jaen et al., 2001; Eillerbeck et al., 2001). Training health care professionals in evidence-based, brief tobacco interventions in order to assure that all health providers know and are confident to provide tobacco interventions will help address this practice gap.

SCREENING FOR TOBACCO USE

First Step: Simply Ask
Guidelines from the U.S. Preventive Task Force (USPSTF) recommend that clinicians ask all adults about tobacco use, recommend that those who use tobacco stop using it, and provide behavioral interventions and FDA-approved pharmacotherapy to help them stop (Siu and U.S. Preventative Services Task Force, 2015).

Pre-screening questions help determine which patients require further screening/assessment. They are often included in forms filled out by the patient that are given to them by the front desk OR asked
quickly by a medical assistant or nurse when the patient is taken to a treatment room. They help identify which patients use or have ever used tobacco.

**Tobacco Pre-Screening Question:**

*Have you ever used tobacco?*

- If "Yes" Continue with screening questions on next page.
- If "No:" Encourage them never to start

**Case**

**Ms. Ashley Mason, 28 yo female with upper respiratory infection**

Ms. Mason is visiting the clinic for an upper respiratory infection. She gets several upper respiratory infections per year.

Nurse Brown asks Ashley whether she ever used tobacco, just as she asks every patient:

*Nurse Brown: Have you ever used tobacco?*

*Ms. Mason: Yes, I do smoke*

Nurse Brown realizes that further screening is indicated. On the next page you will see several questions that can follow quickly after a positive pre-screening.

**PRACTICE TIP**

Ask about all tobacco use and not just smoking.

**BEST PRACTICE**

The US Dept of Health and Human Services’ guidelines (Fiore et al., 2008) recommend that all patients be screened for tobacco use. Ask all patients about tobacco use and exposure at least annually.

**CURRENT RATE OF CIGARETTE SMOKING IN THE U.S.**

The current rate of cigarette smoking in the U.S. is 14% of all adults (aged 18 years or older) (2020 Surgeon General Report)

**CASE STUDY – MS. ASHLEY MASON**

Case
ASHLEY MASON, 28 YO FEMALE WITH UPPER RESPIRATORY INFECTION

Ms. Mason has responded positively to the pre-screening question about whether or not she ever used tobacco by saying that she smokes.

The following dialogue illustrates how Nurse Brown continued to screen Ms. Mason:

[A question asking whether tobacco use is current or past can be skipped because Ms. Mason volunteered that she currently smokes. But she did not say what she smokes.]


    Ms. Mason: A variety of non-menthol cigarettes

Nurse Brown: How long have you smoked?

    Ms. Mason: Around 10 years

Nurse Brown: How much do you smoke per day now?

    Ms. Mason: A pack and a half. I cut back from 2 packs per day.

Nurse Brown: That’s great that you could do that. Do you usually smoke in the first 30 minutes after waking up?

    Ms. Mason: Yes, it usually is within a half hour of waking.

Nurse Brown: Are you interested in quitting?

    Ms. Mason: Not really; not now.

Nurse Brown: Have you ever used nicotine replacement products or other medication to help you quit smoking?

    Ms. Mason: I use the patch when I can’t smoke somewhere, but never to help me quit.

FURTHER SCREENING FOR TOBACCO USERS

SUMMARIZE

Distinguish Current Use from Past Use

Here is a summary of the further screening that was provided for Ms. Mason and all who answer positively to the tobacco pre-screening question:

For those who answered "Yes" to the question: Have you ever used tobacco? Ask: Are you currently using tobacco?

• If "Yes" Ask the questions for "Further Screening of Current Tobacco Users" described below.
• If "No" Ask: When did you last use tobacco?
  • Recent quitters (less than one year) should receive a brief intervention to prevent relapse, described later in this module.
  • Stable quitters, ie, those who quit over a year ago and feel they have stabilized in their abstinence may simply need encouragement not to relapse.
Further Screening of Current Tobacco Users

Type of tobacco used
- Type of tobacco and brand name?

Level of dependence on tobacco
- Length of use (in months or years)?
- Amount used per day on average?
- After you wake up do you smoke your first cigarette or use other forms of tobacco in less than 30 minutes? (correlates with dependence)

Readiness to quit
- How interested are you in stopping smoking or stopping use of other forms of tobacco? (Not at all? A little? Some? Very?)

Use of quitting medications
- Past or current use of nicotine replacement or other tobacco cessation medications and their effectiveness

Pre-screening and screening questions can be presented in a questionnaire for the patient to fill out as in the Tobacco Use Assessment Form (Adapted from Glynn & Manley 1998) provided in the "Related Resources" at the end of the module.

FYI
If your practice uses a substance screening tool that does not include questions on tobacco use, such as the CAGE or CAGE-AID, be sure to ask about tobacco use.

SCREENING FOR SECONDHAND SMOKE

Secondhand Tobacco Smoke Pre-Screening Question:
Ask all patients about how much exposure to tobacco smoke they have in their lives.

How often are you exposed to tobacco smoke?

If any exposure: Patients regularly exposed to tobacco smoke or at high risk for cardiovascular disease should be counseled regarding the health risk of second and third-hand smoke. This module focuses on screening and brief interventions for the tobacco users, but tobacco smoke exposure is important and should receive appropriate follow-up.

(CDC, 2010)

Case

Ashley Mason, 28 yo female with upper respiratory infection who smokes cigarettes herself, should be asked this question because the effects of tobacco smoke are additive.
Nurse Brown: Are you regularly exposed to tobacco smoke from other smokers in your life?
Ms. Mason: Only when I go out with friends who smoke.

PRACTICE TIPS FOR TOBACCO SCREENING

Fitting tobacco counseling into a busy schedule
- Do as many steps as you can in a particular appointment. Even one step is better than none.
- Interventions made over a period of time can make a difference. Complete an intervention step at each office visit for a patient who will return for treatment of a chronic condition. Ask each time if they have given any further thought to what you talked about last time.
- Involve the whole clinic team. Many of these steps can be achieved by nursing or other staff.

A Note on Alcohol and Tobacco
Screening for other substances is also important but not the focus of this module. The comorbidity between alcohol and tobacco dependence is high. Alcoholics tend to smoke heavily and become more addicted to nicotine (USDHHS, 2007). People who use alcohol are less likely to quit tobacco use successfully. Ms. Mason's drinking of alcohol is within recommended limits and she denies use of illicit drugs or abuse of prescription drugs.

PRACTICE TIP
Be sure to mark the patient record so that the patient's tobacco use status can be seen at a glance.

MS. MASON – TOBACCO SCREENING STEPS

Question 1 of 1

CASE: Ashley Mason, 28 yo female with upper respiratory infection

Ms. Mason is visiting the clinic for an upper respiratory infection. She gets several upper respiratory infections per year.

Instructions: To become more familiar with all the information you need to obtain during tobacco screening, match the question Nurse Brown asked with the category of information she was trying to obtain. Make your selection by clicking on each drop down menu:

Question: Do you smoke cigarettes or use another type of tobacco?

Information elicited: Type of tobacco used
Feedback: Learning the type of tobacco used is important. Although cigarette smoking is the most common, it is not the only form of tobacco use. Health risks vary somewhat by form of tobacco and brand used. Some people, for example, are using e-cigarettes. Snuff, for example, has less risk of lung cancer. Menthol cigarettes may actually have more health effects because the cooling effect may
lead to breathing smoke in more deeply. Before this question, of course, you should have asked, "Have you ever used tobacco?" "Are you currently using tobacco?" and "How often are you exposed to tobacco smoke?"

**Question:** Do you usually smoke in the first 30 minutes after waking up?

**Information elicited:** Level of tobacco dependence  
**Feedback:** Level of tobacco dependence is found by asking about length of use, amount used per day, and whether tobacco is used within 30 minutes of waking.

**Question:** Are you interested in quitting?

**Information elicited:** Readiness to quit.  
**Feedback:** All patients who use tobacco should be assessed for their readiness to quit. Assessing readiness to quit is a step in 5 steps that begin with A that are often recommended in tobacco and other health counseling: Ask (tobacco use status), Advise (to quit), Assess (willingness to quit), Assist (with quitting or getting ready to quit), Arrange (for followup)

**Question:** How long have you smoked?

**Information elicited:** Level of tobacco dependence  
**Feedback:** Level of tobacco dependence is found by asking about length of use, amount used per day, and whether tobacco is used within 30 minutes of waking.

**Question:** How much do you smoke per day now?

**Information elicited:** Level of tobacco dependence  
**Feedback:** Level of tobacco dependence is found by asking about length of use, amount used per day, and whether tobacco is used within 30 minutes of waking.

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**BRIEF INTERVENTIONS FOR PATIENTS NOT READY TO QUIT**

**Motivating Patients Who Are Not Ready to Quit**

Brief interventions for patients who are at any stage before being ready to quit often include the following elements:

1. Indicate your concern regarding their tobacco use.
2. Advise the patient to quit tobacco for the sake of their health.
3. Ask about what quitting would mean to them (relevance), risks if they don't quit, rewards from quitting, and their barriers/roadblocks to quitting, which can be remembered as the 4 Rs: relevance, risks, rewards, roadblocks
4. Mention treatment options and gauge patient's reaction
5. Encourage and support the patient – Includes soliciting patient commitment to a clear goal, even if it is not quitting, such as committing to reading the literature you provide.
6. Provide patient education and resources

FYI
Many smokers want to quit (68% – 2015 CDC data, but just a little over half try to quit each year (55.4% – 2015 CDC data).
(Babb et al., 2017)

CASE: MOTIVATIONAL BRIEF INTERVENTIONS FOR MS. MASON

Brief Interventions for a Patient Not Ready to Quit Tobacco

CASE: ASHLEY MASON, 28 YO FEMALE WITH UPPER RESPIRATORY INFECTION

Ms. Mason is visiting the clinic for an upper respiratory infection, which she has frequently. She smokes one and a half packs per day and has smoked for the past ten years. Her drinking of alcohol is within recommended limits and she denies use of illicit drugs or abuse of prescription drugs. During her screening she said she is not interested in quitting tobacco.

Brief Intervention Step 1: Confirm screening results and indicate your concern.
_Nurse Brown:_ I am concerned to see that you are currently smoking cigarettes, Ms. Mason, because of the serious implications for your health....

Motivating a smoker who is not ready to quit.
A brief intervention to motivate a tobacco user who is not yet willing to quit starts with a straightforward step:

Brief Intervention Step 2: Advise the patient to quit
This simple, quick, important step will be most effective when delivered in a clear, strong, supportive, positive, and personalized manner. For example:

_Nurse Brown:_ I feel it is essential to let you know that quitting tobacco use is one of the most important steps for you to take to protect your health, now and for years to come. My staff and I can help you if you decide to quit.
**Ms. Mason:** I appreciate that, but I don't know...

(Fiore 2008)

**MS. MASON – MOTIVATING WITH FOUR RS**

**Step 3: Ask about relevance, risks, rewards, and roadblocks**

**Case:** Ashley Mason, 28 yo female with upper respiratory infection

A system for remembering what to discuss in a motivating intervention is to think of 4 topics that start with "R": Relevance, Risks, Rewards, and Roadblocks. Discuss these topics at each appointment until the patient is motivated to quit.

**Relevance:** How do the benefits of quitting relate to this patient specifically, such as specific health issues and the effects of secondhand smoke on their loved ones.

**Nurse Brown:** If you were to quit smoking, you would be likely to have fewer upper respiratory infections like the one you have today.

**Ms. Mason:** That would be nice.

**Risks:** What happens if the patient does not quit? In a non-judgmental way, emphasize the patient's personal responsibility for their own health. In Ms. Mason's case, due to her younger age, emphasize "costs" most immediately relevant to someone her age, etc., in addition to more serious health concerns.

**Nurse Brown:** In addition to major health effects, have you noticed any other "costs" to smoking, such as more rapid aging of the skin, decreased attractiveness to potential romantic partners, financial costs, difficulty smoking in public places and at work with modern laws, or social stigma?

**Ms. Mason:** I have felt like a social outsider with my smoking lately, but I'd have to give the other things you listed some thought.

**Rewards:** What are the rewards of quitting? e.g. more money to spend on other things, more stamina, better smelling home and car, etc.

**Nurse Brown:** What rewards that you care about the most would come into your life if you quit smoking?

**Ms. Mason:** I would not send people running every time I light up. And like I said, I really want to get back to playing tennis. I hope I wouldn’t get so short of breath.

**Roadblocks:** What gets in the way of quitting? Look for reasons, in addition to cravings, that can be managed, such as fear of weight gain (referral to a registered dietitian for diet support), use of smoking as for mood management (do they need an antidepressant/counseling instead?), being
tempted when around smokers (avoid bars when quitting), etc. Ask what has helped in similar circumstances in the past.

**Nurse Brown:** What's the biggest obstacle to your quitting?  
**Ms. Mason:** I'd say the stress I'm under at work

**Nurse Brown:** What's worked for you in the past when you faced similar obstacles?  
**Ms. Mason:** I did take a yoga class last year. That helped a lot with my stress...

**Nurse Brown:** Besides the stress of your work, are there any "roadblocks" to quitting?  
**Ms. Mason:** Just craving cigarettes. It's hard to overcome.

**Nurse Brown:** Avoiding things that remind you of smoking and medication can help you with cravings.

Provide the local quit-line number or the national one: 1 800 QUIT NOW for continued support in finding the motivation to quit.

(Fiore 2008)

**Steps 4 and 5**

**Step 4.** Skip Step 4, which is describing treatment options, for patients who are not ready to quit.

**Step 5.** Step 5, which is to encourage and support the patient and obtain their commitment to a clear goal can be performed, even if the goal is not quitting. Patients who are not ready to quit can commit to a goal, such as committing to reading the literature you provide.

**RELEVANCE: HEALTH EFFECTS OF TOBACCO USE**

**Tobacco Use Risks**

Without trying to scare patients into quitting, educate them about the health effects of tobacco use, particularly the effects that they are experiencing or are at greatest risk for experiencing. Patients may tune out scare tactics but are likely to respond to information about symptoms they have experienced.

Patients are more likely to relate to current tobacco-related health problems than ones they may develop in the future. Smoking can lead to an increased risk for many health problems. These include lung cancer and many other forms of cancer (e.g., oral, colorectal, bladder, pancreatic, uterine, kidney, and breast), cardiovascular disease, reproductive health problems, periodontal disease, emphysema and chronic obstructive pulmonary disease (CDC 2014, USDHHS 2014). Furthermore, it causes other adverse effects on the body, such as causing inflammation and impaired immune functioning.
Mortality
Many people underestimate the number of deaths that are tobacco-related. Correcting these misconceptions may help motivate patients to quit. Cigarette smoking is responsible for more than 443,000 deaths annually in the United States. This is equivalent to approximately 1 in every 5 deaths (CDC 2010.)

Lung Cancer
Lung cancer is the leading cause of cancer deaths in men and women. Smoking also contributes to other forms of cancer. 87,698 men and 70,550 women died of lung cancer in 2010 (CDC 2013). Lung cancer is almost always linked to smoking (in over 90% of all cases)(USDHHS 2014). Changes in cigarettes have led to more deaths from lung cancer and different types of lung cancer (adenocarcinoma has increased in the past 30 years (USDHHS 2014).

Cardiovascular Disease
There is a significantly increased risk of cardiovascular disease including myocardial infarction with both cigarettes and smokeless tobacco use (USDHHS 2014). Smoking is a primary risk factor for cardiovascular disease. Nicotine replacement therapies have been found to be effective for cessation but should be closely monitored in heart patients. Risk of stroke is markedly increased by smoking.

Respiratory
Chronic obstructive pulmonary disease (COPD) is a long-lasting, irreversible illness in which respiratory function declines and heath status deteriorates, often resulting in death. It includes emphysema and chronic bronchitis. Smoking is the major risk factor for developing COPD; it affects 6.3% of the adult population over 18 (USDHHS 2014). Many patients will relate to having seen someone who needed to carry an oxygen tank around for advanced cases of this condition. Upper and lower respiratory infections are also more common in smokers.

Pregnancy and Tobacco
All pregnant patients should be encouraged to quit smoking because of the many health risks that face the infant (USDHHS 2014, CDC 2014). Children of mothers who smoked during pregnancy also have an increased risk of health problems, from otitis media to neurological deficits affecting cognitive ability and behavior, that may continue as they grow older.

Oral Health Problems
Tobacco use is linked to increased risk of periodontal disease and thus premature tooth loss (Eke et al. 2012). It is also linked with increased risk of oral cancer.

PATIENT EDUCATION

Step 6. Provide Patients with Education and Resources
Because appointment time is so limited, it is helpful to provide written patient education materials to reinforce and expand upon the information discussed during the visit. After implementing the brief intervention,

- Review the treatment plan with the patient.
- Make sure that you leave ample time for him or her to ask any questions.
• Provide verbal education supported by printed or online educational materials.
• Give information on appropriate community resources to the patient.
• Create a plan to follow up with a phone call or another appointment.

(Moyer 2013; CDC 2014)

PRACTICE TIPS
Keep your patient's health literacy level in mind during the patient interview – It is not necessarily based on race, gender, education level, or socioeconomic status – a high income, middle-aged white male aeronautical engineer may not have any better understanding of alcohol’s effect on sleep than you have of space shuttle electrotechnology.

POLL: WHAT PERCENT OF TOBACCO USING PATIENTS IN YOUR PRACTICE ARE CURRENTLY GIVEN TOBACCO-RELATED PATIENT EDUCATION MATERIALS?

1. Fewer than 10%
   - 25% (166 votes)
2. 10 to 29%
   - 24% (159 votes)
3. 30 to 49%
   - 20% (130 votes)
4. 50 to 75%
   - 15% (98 votes)
5. 75% to 100%
   - 15% (100 votes)

MOTIVATIONAL INTERVIEWING

What is Motivational Interviewing?
Communication skills adapted from a counseling technique called motivational interviewing can help motivate the patient. Motivational interviewing differs from an advice-giving approach by recognizing the expertise of the patient on his or her own motivations and guiding the patient to examine and resolve his/her ambivalence about the problem (Miller & Rollnick 2013). These techniques have been shown to be effective with substance use disorders.

Fitting it in
While we will present an overview of the whole system of motivational interviewing techniques, the techniques can be used individually involving little time. Please read the following for ideas to expand your repertoire of effective patient interactions.

Pauses
Pauses are a very powerful way to draw people out without asking further questions. After making a simple question or a reflective statement, pause and wait patiently. Most people will fill the pause.
Example 1:
Nurse Brown: What is the hardest part about your tobacco habit? [Wait after asking the question. Try counting five breaths. Then follow with a prompt, such as "What do you think? And count five more breaths.]

Ms. Mason: Just what it does to my health, and knowing I'm addicted to something that's so hard to quit....

Example 2:
Nurse Brown: That sounds difficult. [Wait, wait, wait]

Ms. Mason: [Eventually, sighing] Yes, it is. I suppose it is time I do something about it....

MOTIVATIONAL INTERVIEWING COMMUNICATION SKILLS

Asking Rather Than Telling
Eliciting insights from the patient may take a little longer than simply providing advice, but if time permits, this patient-centered approach can be used to increase the effectiveness of brief interventions. For example, in tobacco counseling, instead of saying, "I recommend that you quit smoking because it's already affecting your health and likely to cause more problems" you might say:

Nurse Brown: Would it be okay if we talked about the health problems associated with smoking? (Patient answers yes) Tell me what you already know about them? (Patient answers) And there are also x, y, and z problems. How does that compare to what you want for your own health? (Patient answers) What effect does that have on your desire to continue smoking?

Employ Active Listening Skills
Repeating back to the patient what you heard is called active listening. Use your own style and summarize. Rather than repeating everything, choose statements that have a relatively strong emotional component. Discussing concerns using the same words and phrases as the patient, helps them feel heard. But use your judgment so you don't seem condescending. For instance, you might say:

Nurse Brown: No one seems to understand what you're going through.

Ask Open-Ended Questions
Avoid questions that have a yes or no answer. For instance, instead of asking, "Do you smoke very much?" ask the following:

Nurse Brown: How many cigarettes do you smoke per day? Per hour?

MOTIVATIONAL INTERVIEWING STEP
In motivational interviewing, the clinician directs the focus of the interaction toward increasing the patient's readiness for change through the following basic steps:
1. Introduce the topic with openness, concern, and lack of judgment and establish rapport
It is important to establish rapport with the patient in order to decrease defensiveness and increase openness to the possibility of change. Expressing acceptance and affirmation are important (Miller & Rollnick 2013). Try opening the conversation to talk about the subject without giving the option of a "no" response, for instance, say:

Nurse: You’ve mentioned you might like to quit smoking soon. I’d like to explore ways I can help you with that. What can you tell me about it?

2. Assess motivation
One method of assessing motivation is to ask how important the change is for the patient on a scale of 1 to 10, and then asking,

Nurse Brown: On a scale of 1 to 10, how ready are you to quit?

Ms. Mason: Uh....I’d say a 4.

Nurse Brown: Why not lower?

Ms. Mason: Lower?....Why not lower? Um, well, there’s my job that’s important to me......

This question is likely to produce some statement of motivation, whereas asking, "Why not higher?" is likely to produce excuses. Also, gauge the patient’s confidence in his/her ability to change and readiness for change (Walters & Rotgers 2011).

3. Elicit statements of motivation
Use open-ended questioning and reflective listening to elicit the patient’s own explanations for behaviors; recognition or concerns about a problem; and desire, intention, and ability to change. For example, say

Nurse Brown: How is smoking affecting your life?

4. Evaluate and help them resolve ambivalence
Patients often have a high degree of ambivalence about changing their addictive behavior (Resnicow & McMaster 2012); they want both the pleasures of indulgence and the benefits of restraint in substance use. Help the patient explore, articulate, and clarify any ambivalence he or she may have about the problem behavior. Highlight discrepancies in what the patient says in order to produce internal tension that can lead to change. For example say

Nurse Brown: So from what you say, smoking is important to help manage stress, while at the same time, it is hurting your most important relationships.

Resolving the ambivalence might go like this:

Nurse Brown: On the one hand you say smoking helps you relax and on the other hand you are concerned about your relationships. Can we talk about the importance of each of these pros and cons for smoking?

5. Plan for change
In motivational interviewing, the client comes up with his or her own plan for change (Miller & Rollnick 2013; Walters & Rotgers 2011). Elicit a plan from the patient for the next 30 to 90 days. The plan is
based on the patient's current stage of change and does not need to include quitting if the patient isn't ready. For example, you could ask,

_Nurse Brown: What step, if any can you do in the next month to move in the direction of thinking about quitting?_

If they cannot think of any, ask if they can commit to a follow-up appointment.

**MOTIVATIONAL INTERVIEWING PRINCIPLES**

**Principles of Motivational Interviewing**
The following principles of motivational interviewing are important in primary care:

- **Understand the patient’s view accurately**
Verify what you understood that they said. This is achieved by using reflective listening (Miller & Rollnick 2013).

  _Ms. Mason: It is not that I don't want to quit; I just can't._

  _Nurse Brown: So you want to quit but have not been able to do it._

  _Ms. Mason: Right. I've tried to quit many times._

- **Express empathy**
This is a simple expression of understanding of the patient's emotions/feelings. For example,

  _Nurse Brown: Sounds like you've been going through a rough time._

- **Avoid or de-escalate resistance**
Be willing to compromise. If the patient is not ready to even talk about the problem behavior, try talking about a less-threatening health behavior, like getting enough sleep or exercise, just to introduce the topic of change (Lai et al. 2010; Smedslund et al. 2011).

  _Nurse Brown: Okay. Can we talk about the sleep problem you mentioned?_ Or ask if he or she would be willing to review a past, successful health behavior change. Remembering a past success may build self-efficacy about the current problem. The patient may be more open to talking about the problem behavior at the next visit.

  _Nurse Brown: I remember being impressed when you completely cut out all caffeine a couple years ago. How did you go from drinking 3 or 4 cups of coffee a day to not drinking any coffee at all?_

  _Roll with the resistance._ Instead of confronting a patient who resists change, try agreeing with them. This is called rolling with the resistance. For example:

  _Ms. Mason: If I quit smoking, I won't want to spend as much time with my friends who smoke._

  _Nurse Brown: That may be, it may be difficult to spend time with them at first._

  _Ms. Mason: Well, I suppose I might be able to gradually spend more time with them once I was really sure I could resist the temptation._

  (Miller & Rollnick 2013)
SUMMARY OF MOTIVATIONAL INTERVIEWING TECHNIQUES PRESENTED

Here are the Motivational Interviewing techniques that were presented in this section. Remember, you do not have to use all of them in one sitting. Even remembering and using one of them can be helpful in motivating a patient.

- Ask rather than tell; Ask permission and establish rapport
- Evaluate and resolve ambivalence
- Use active listening; understand the patient's view accurately
- Ask open-ended questions
- Be non-judgmental; use non-accusatory language
- Express empathy
- Avoid or de-escalate resistance
- Assess motivation and elicit statements of motivation
- Plan for change
- Compromise on partial solution or treatment
- Summarize the discussion and treatment plan at the end of the appointment.

VIDEO: MOTIVATIONAL INTERVIEWING

The following video illustrates the use of motivational interviewing in a patient interview related to substance use.

**Video:** The video "Motivational Interviewing" (Clinical Tools, Inc., 2016) a provider interviewing a patient using motivational interviewing, can be found here: [https://www.youtube.com/watch?v=cOlb7ADwsMw](https://www.youtube.com/watch?v=cOlb7ADwsMw)

As you watch the video, notice how the provider uses various techniques from motivational interviewing (MI), such as empathy, reflective listening, and open-ended questions, to achieve the four steps of MI:

1. Engage
2. Focus
3. Elicit
4. Plan
Patient: Ashley Mason, 28 y/o

Scenario: Ms. Mason is visiting the clinic for an upper respiratory infection, which she has frequently. She smokes one and a half packs per day and has smoked for the past ten years. Her drinking of alcohol is within recommended limits and she denies use of illicit drugs or abuse of prescription drugs. During her screening, she said she is not interested in quitting tobacco.

Question: Ms. Mason, "If I quit, I might lose some of my friends who smoke." Which of the following responses is an example of rolling with the resistance?

Choose one

1. That could be true. You might find that they won't be your friend unless you smoke.
   - Correct. The statement 'That could be true. You might find that they won't be your friend unless you smoke.' is rolling with the resistance. Rolling with the resistance is agreeing with the patient's negative statement in an attempt to elicit a paradoxical disagreement from the patient.

2. So, you are worried about losing friends when you quit.
   - Incorrect. This is an example of active listening, which is helpful, but it is not an example of rolling with the resistance. The statement 'That could be true. You might find that they won't be your friend unless you smoke.' is rolling with the resistance. Rolling with the resistance is agreeing with the patient's negative statement in an attempt to elicit a paradoxical disagreement from the patient.

3. That's a pretty ridiculous attitude, isn't it?
   - Incorrect. This is confrontational and likely to build resistance. The statement 'That could be true. You might find that they won't be your friend unless you smoke.' is rolling with the resistance. Rolling with the resistance is agreeing with the patient's negative statement in an attempt to elicit a paradoxical disagreement from the patient.

4. How did you have friends before you smoked?
   - This is a form of insight development by learning from the past for problem-solving, which might be helpful. But the statement 'That could be true. You might find that they won't be your friend unless you smoke.' is rolling with the resistance. Rolling with the resistance is agreeing with the patient's negative statement in an attempt to elicit a paradoxical disagreement from the patient.
MOTIVATIONAL INTERVIEWING WITH TEENS

Effectiveness and Limitations of MI With Teens

Effectiveness: Motivational Interviewing as also an effective intervention for substance use problems with teens (Jensen et al. 2011). It can be well suited for adolescents who are rebellious because it avoids confrontation.

The techniques for eliciting motivations and examining ambivalence can be especially useful for mobilizing teens who are not ready to consider quitting. Reflective listening in combination with a non-judgmental approach gives teens a sense of being heard, which they often long for at this age. Similarly, their typical craving for autonomy is met through the process of eliciting their opinions. Finally, their often shaky sense of identity and self-esteem is calmed by meeting them where they are, developing rapport, and providing positive feedback, such as admiring their resourcefulness or expressing your faith in them.

Limitations: There are some considerations when working with teens, however.

- Complete autonomy in determining drinking cannot be achieved, because drinking is illegal for people under age 21
- Minors are subject to more social restrictions on drinking than adults, for example, by parents and school.
- Confidentiality may need to be broken if the teen’s safety is at stake – see guidelines below from the AAP for when to consider breaking confidentiality.
- The goals teens set need to consider safety. Because they are still developing, they may need assistance in use of good judgment.

Brief Intervention for Each Stage of Teen Substance Use

<table>
<thead>
<tr>
<th>Stage</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence</td>
<td>Positive reinforcement; patient and parent education to prevent or delay substance use</td>
</tr>
<tr>
<td>Experimentation</td>
<td>Encourage abstinence/cessation and promote patient strengths</td>
</tr>
<tr>
<td>Limited use</td>
<td>Encourage cessation and promote patient strengths</td>
</tr>
<tr>
<td>Problematic use (Mild)</td>
<td>Brief interventions to motivate behavior change, such as advice to stop and education on health effects and risks or a signed contract to stop problem use, close follow-up; consider breaking confidentiality and referral</td>
</tr>
<tr>
<td>Moderate substance use disorder</td>
<td>Same as for problematic (mild) use above, plus exploring ambivalence, refer for comprehensive assessment and treatment</td>
</tr>
<tr>
<td>Severe substance use disorder</td>
<td>Same as above plus encourage parental involvement, enhance motivation to accept referral</td>
</tr>
</tbody>
</table>

(AAP 2011)

Special Considerations

- Include parents and potentially other family members in the patient education component
- For driving when using alcohol or drugs or being a passenger for a driver who has used them, provide education on risk and a safety plan.
Other signs of acute danger include: hospital visits related to substance use, IV drug use, combining substances especially alcohol and benzodiazepines, barbiturates, or opiates; consuming potentially lethal doses or large volumes of alcohol.

If breaking confidentiality is being considered, discuss what details will be revealed with the teen.

**PRACTICE TIP**

Look for brief check-in appointments in which there might be time to add a discussion of SBIRT topics with teens, such as a follow up on acne treatment.

**ESTABLISHING RAPPORT WITH TEENS**

In order to encourage teens to open up to you enough to do an intervention about substance use, establishing rapport will be critical. The following steps are important:

1. Talk to the teen alone
2. Explain a confidentiality policy that you will not tell parents about your conversation if the patient is not in danger. Parents should be made aware of this policy, too.
3. Explain that you talk with all teens about this, not just them
4. Emphasize that you are on their side and your goal is their health and sound medical advice.

(Jensen et al. 2011)

**Sample case on establishing rapport:**

15-year-old Marco presents for a TB test to get a job at a restaurant. He answered the screening questions that he does have friends who drink and use drugs but answered no to these questions about himself.

**Clinician:** I see you have some friends who use alcohol and drugs. I want to encourage you to stay safe and healthy and not get caught up in their drug and alcohol use; can you tell me what your plan is for staying safe and healthy around them?

**Marco:** Uh, I don't know. I just haven't done that stuff (looks at the floor, raising the clinician's suspicions)

**Clinician:** The safest thing is to not take even just a little. How many times have you tried just a sip or just a little of a drug?

**Marco:** [shrugs]

**Clinician:** I know it’s kind of hard to talk about, but I think it’s really important. That is why I made sure we could be alone to talk about this and I want you to know that our conversation will remain just between the two of us – unless you are in danger. I talked with your parents and let them know that is
my policy. I talk to all my adolescent patients about this, not just you, because I think it is so important.

**Marco:** Sure, okay.

**Clinician:** So, can you tell me what you've tried or thought about trying?

**Marco:** I did get drunk once... and I took something at a party, but I don't know what it was.....

**Clinician:** As a health professional, hearing that you didn't know what it was scares me. What do you think about it now?...

FYI
If an adolescent uses a parent's insurance and you use a billing code related to substance abuse, the insurance statement sent to the parent may break confidentiality.

**PART I MODULE SUMMARY**

Here is a summary of the skills learned in this module:

**Screening**
- Screen all patients over 12 regarding tobacco use and all patients regarding exposure to tobacco smoke on a regular basis. The most recent available survey results reported that 19.3% of adults over age 18 in the U.S. smoke cigarettes.
- Screen current tobacco users for type of tobacco used, level of dependence, readiness to quit, and use of quitting medications
- Congratulate past users and support them in continued abstinence.

**Brief Intervention for Patients Who Are Not Ready to Quit**
- Indicate your concern with tobacco use and advise patients to quit
- Provide a motivational intervention using steps remembered as the 4 Rs: 4 Rs: relevance, risks, rewards, roadblocks
- Use techniques from Motivational Interviewing, such as:
  - evaluate ambivalence about quitting
  - use active listening and open-ended questions
  - be non-judgmental
  - express empathy
  - "roll" with their resistance
  - elicit statements about motivation
  - make a plan for change
- Encourage patients to commit to at least a small step in the direction of quitting
- Provide patient education

**RESOURCES AVAILABLE THROUGH THIS MODULE:**
- Guide to Quitting Smoking
This printable booklet explains why quitting is hard, benefits of quitting, resources available to help with the mental and physical aspects of addiction, other methods of quitting, success rates, and concerns related to quitting, such as weight gain.

- **Help for Smokers and Other Tobacco Users**
  This booklet provides support for tobacco users. It describes good reasons for quitting, the right time to quit and preparation for quitting, as well as medicine and help available to quit and stay quit.

- **Helping Smokers Quit – A Guide for Clinicians**
  A website that explains the 5 A's for tobacco cessation.

- **NIAAA Alcohol Screening and Brief Intervention for Youth**
  NIAAA guide for practitioners on alcohol screening and brief interventions for youth

- **Patient Handout: Basics of Nicotine**
  Patient handout with information on the basics of nicotine.

- **Reasons Why Different People Might Want to Quit**
  Reasons why different people might want to quit tobacco: symptomatic adults, asymptomatic results, people with family history of cancer or heart disease, long-term users, new users, parents, women, pregnant women, teenagers, and any users.

- **Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians**
  Published online October 31, 2011
  PEDIATRICS Vol. 128 No. 5 November 2011, pp. e1330-e1340 (doi:10.1542/peds.2011-1754)

- **Tobacco Use Assessment Form**
  Tobacco Use Assessment Form

- **Treating Tobacco Use and Dependence: 2008 Update**
  Treating Tobacco Use and Dependence: 2008 Update, sponsored by the Public Health Service, includes new, effective clinical treatments for tobacco dependence that have become available since the 2000 Guideline was published. This update will make an important contribution to the quality of care in the United States and to the health of the American people. (From Their Website)
REFERENCES USED IN THIS MODULE:

For Practice Gap References, See Activity Description

Module References


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