



World Health
Organization

TELEPHONE

TRAINING FOR TOBACCO QUIT LINE COUNSELLORS:

COUNSELLING



WHO Library Cataloguing-in-Publication Data

Training for tobacco quit line counsellors: telephone counselling.

1.Hotlines. 2.Smoking Cessation - methods. 3.Directive counselling - methods. 4.Teaching Materials. I.World Health Organization.

ISBN 978 92 4 150726 4 (print)
ISBN 978 92 4 069280 0 (Epub)

(NLM classification: WM 290)

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TRAINING PACKAGE OVERVIEW

INTRODUCTION

The quit line has been recommended as one of the population-wide approaches to support tobacco users in quitting by the guidelines for implementation of Article 14 of the WHO Framework Convention on Tobacco Control (WHO FCTC). All Parties to the Convention should offer quit lines by which callers can receive advice from trained cessation specialists (quit line counsellors). The counsellors provide callers with evidence-based assistance that is easily accessible at any time, in any place and at no cost to the tobacco user.

The role of the tobacco quit line counsellor is to provide personalized assistance to each caller, regardless of whether the caller is ready or not ready to quit. In following quit line protocols and best practices, quit line counsellors can help callers to understand why quitting tobacco is so important and can help them achieve their goal of becoming tobacco-free. Therefore, training of tobacco quit line counsellors is a critical component of quit line operation.

This training package is based on empirical evidence, best practices and over 20 years of clinical experience in delivering quit line services. It is intended to serve as comprehensive initial training, but it is recognized that periodic refresher training will need to take place to ensure that quit line counsellors maintain proficiency and are allowed, and even encouraged, to develop even greater skill.

LEARNING OBJECTIVES, SKILL DEVELOPMENT AND OUTCOMES

Learning objectives

Upon completion of this training participants will be able to:

- articulate the role of tobacco quit line counsellor in a quit line setting;
- provide telephone counselling services within the constraints of provincial and national privacy regulations;
- describe the etiology of tobacco use and tobacco dependence, and demonstrate how to apply this information to educate and motivate quit line callers during treatment;
- describe the value and constructs of establishing rapport between the counsellor and the quit line caller in order to develop a collaborative relationship;
- demonstrate the ability to conduct an assessment in order to collect accurate information for the purpose of treatment planning;
- demonstrate the ability to develop a treatment plan within the scope of quit line services;
- describe and apply the basic principles of counselling strategies used to treat tobacco dependence;
- articulate accurate information about approved forms of pharmacotherapy available to help manage nicotine withdrawal symptoms and demonstrate the ability to provide decision-support for using approved cessation medications;
- demonstrate the ability to provide ongoing support throughout the quitting process that includes practical problem-solving and evidence-based strategies for relapse prevention;
- demonstrate competence in working with population subgroups and those who have specific physical and mental health issues;
- demonstrate the ability to accurately document participant records according to programme standards.

Skills developed

The skills developed will include:

- ability to apply practical and theoretical counselling skills with the callers, regardless of whether they are ready or not ready to quit;
- ability to provide support to all callers, including those within population subgroups such as persons with specific physical and mental health issues;
- ability to support callers by applying scientific evidence and expert information about tobacco addiction and health impacts to educate and motivate callers

Outcomes

The expected outcomes will be:

- increased capacity to provide tobacco cessation treatment that is easily accessible at any time and place;
- delivery of quit line services that align with best practices and the scientific evidence for treating tobacco use and dependence.

STRUCTURE AND CONTENT

Full version of the Training Package

The full training package consists of 14 modules designed to support implementation of a range of quit line services by developing participants' knowledge, skills and confidence to enable them to serve as tobacco quit line counsellors. Each training module addresses a specific aspect of delivering quit line services to quit line callers. Each module is presented in a four-step format: preparation, presentation, practice and evaluation. The modules are summarized below. Further guidance for facilitators follows in the detailed *Facilitators' guide*.

- Module 1: Quit line services and the role of the tobacco quit line counsellor
- Module 2: Tobacco use and tobacco dependence
- Module 3: Practical and theoretical approaches for those ready to quit
- Module 4: Practical and theoretical approaches for those not ready to quit
- Module 5: Pharmacotherapy
- Module 6: Facilitation skills
- Module 7: Basic components of a call
- Module 8: Assessment and agenda-setting
- Module 9: Action planning
- Module 10: The content of telephone counselling interventions
- Module 11: Special populations and cultural awareness
- Module 12: Challenging calls
- Module 13: Supporting the intervention with supplementary resources
- Module 14: Integrated practice

If all 14 modules are used, the training workshop duration is 4.5 days. A sample agenda for the training workshop of 4.5 days is provided below.

Day 1	
08:30 – 09:00	Registration
09:00 – 09:30	Welcome and workshop overview Participant introductions
09:30 – 09:50	Pre course assessment
09:50 – 10:30	Module 1 - Quit line services and the role of the tobacco quit line counsellor (1)
10:30 – 10:45	Break
10:45 – 11:35	Module 1 - Quit line services and the role of the tobacco quit line counsellor (2)
11:35 – 12:00	Module 2: Tobacco use and tobacco dependence (1)
12:00 – 13:00	Lunch
13:00 – 14:00	Module 2: Tobacco use and tobacco dependence (2)
14:00 – 15:30	Module 3: Practical and theoretical approaches for those ready to quit (1)
15:30 – 15:45	Break
15:45 – 16:15	Module 3: Practical and theoretical approaches for those ready to quit (2)
16:15 – 16:30	Module 4: Practical and theoretical approaches for those not ready to quit (1)
16:30 – 17:00	Daily Wrap-Up
Day 2	
08:30 – 09:00	Interactive discussion
09:00 – 10:30	Module 4: Practical and theoretical approaches for those not ready to quit (2)
10:30 – 10:45	Break
10:45 – 11:50	Module 4: Practical and theoretical approaches for those not ready to quit (3)
11:50 – 12:50	Lunch
12:50 – 14:50	Module 5: Pharmacotherapy
14:50 – 15:25	Module 6: Facilitation skills (1)
15:25 – 15:40	Break
15:40 – 16:25	Module 6: Facilitation skills (2)
16:25 – 17:30	Module 7: Basic components of a call
17:30 – 17:45	Daily wrap-up
Day 3	
08:30 – 09:00	Interactive discussion
09:00 – 10:15	Module 8: Assessment and agenda-setting
10:15 – 10:30	Break
10:30 – 12:05	Module 9: Action planning (1)
12:05 – 13:05	Lunch
13:05 – 14:05	Module 9: Action planning (2)
14:05 – 15:00	Module 10: The content of telephone counselling interventions (1)
15:00 – 15:15	Break
15:15 – 16:05	Module 10: The content of telephone counselling interventions (2)
16:05 – 17:20	Module 11: Special populations and cultural awareness
17:20 – 17:30	Daily wrap-up
Day 4	
08:30 – 09:00	Interactive discussion
09:00 – 10:00	Module 12: Challenging calls
10:00 – 10:40	Module 13: Supporting the intervention with supplementary resources (1)
10:40 – 10:55	Break
10:55 – 11:55	Module 13: Supporting the intervention with supplementary resources (2)
11:55 – 12:55	Lunch

12:55 – 14:15	Module 14: Integrated practice (preparation and presentation) (1)
14:15 – 15:30	Module 14: Integrated practice (scenario 1) (2)
15:30 – 15:45	Break
15:45 – 16:30	Module 14: Integrated practice (scenario 2) (3)
16:30 – 16:45	Daily wrap-up
Day 5	
08:30 – 09:00	Interactive discussion
09:00 – 10:30	Module 14: Integrated practice (scenarios 3 and 4) (4)
10:30 – 10:45	Break
10:45 – 12:00	Module 14: Integrated practice (scenarios 5 and 6) (5)
12:00–12:15	Break
12:15 – 13:30	Closing session and workshop evaluation

The simplified version

Those in lower-resource settings or with training time constraints may wish to use a subset of modules focusing on the core quit line service – i.e. telephone counselling. Suggested modules for a shorter training course include:

- Module 1: Quit line services and the role of the tobacco quit line counsellor
- Module 2: Tobacco use and tobacco dependence
- Module 3: Practical and theoretical approaches for those ready to quit
- Module 4: Practical and theoretical approaches for those not ready to quit
- Module 6: Facilitation skills
- Module 7: Basic components of a call
- Module 8: Assessment and agenda-setting
- Module 9: Action planning
- Module 10: The content of telephone counselling interventions
- Module 14: Integrated practice (modified to address the modules included above and shortened to four hours)

Below is a sample agenda for organizing a training workshop of three days.

Day 1	
08:30 – 09:00	Registration
09:00 – 09:30	Welcome and workshop overview Participant introductions
09:30 – 09:50	Pre course assessment
09:50 – 10:30	Module 1 - Quit line services and the role of the tobacco quit line counsellor (1)
10:30 – 10:45	Break
10:45 – 11:10	Module 1 - Quit line services and the role of the tobacco quit line counsellor (2)
11:10 – 12:00	Module 2: Tobacco use and tobacco dependence (1)
12:00 – 13:00	Lunch
13:00 – 13:30	Module 2: Tobacco use and tobacco dependence (2)
13:30 – 15:00	Module 3: Practical and theoretical approaches for those ready to quit (1)
15:00 – 15:15	Break
15:15 – 15:45	Module 3: Practical and theoretical approaches for those ready to quit (2)
15:45 – 17:15	Module 4: Practical and theoretical approaches for those not ready to quit (1)
17:15 – 17:30	Daily Wrap-Up

Day 2	
08:30 – 09:00	Interactive discussion
09:00 – 10:20	Module 4: Practical and theoretical approaches for those not ready to quit (2)
10:20 – 10:35	Break
10:35 – 12:00	Module 6: Facilitation skills (1)
12:00 – 13:00	Lunch
13:00 – 14:00	Module 7: Basic components of a call
14:00 – 15:15	Module 8: Assessment and agenda-setting
15:15 – 15:30	Break
15:30 – 17:15	Module 9: Action planning (1)
17:15 – 17:30	Daily wrap-up
Day 3	
08:30 – 09:00	Interactive discussion
09:00 – 09:45	Module 9: Action planning (2)
09:45 – 10:30	Module 10: The content of telephone counselling interventions (1)
10:30 – 10:45	Break
10:45 – 11:50	Module 10: The content of telephone counselling interventions (2)
11:50 – 12:50	Lunch
12:50 – 14:00	Module 14: Integrated practice (preparation and presentation) (1)
14:00 – 14:45	Module 14: Integrated practice (scenario 1) (2)
14:45 – 15:00	Break
15:00 – 17:15	Module 14: Integrated practice (scenarios 2, 3, 4, 5 and 6) (3)
17:15 – 17:45	Closing session and workshop evaluation

Preparing for the training

Organizing a training workshop requires many practical considerations to be addressed, such as when and where the training will be provided, the need to form a facilitation team, setting up a workshop programme and agenda, selecting participants, plus logistics and materials.

The facilitation team

The training should be delivered by an expert facilitation team identified by the organizer in consultation with key local partners. The team should include:

- a lead facilitator with detailed expertise in treatment of tobacco dependence and tobacco control and experience in facilitating workshops;
- one or two additional facilitators with expertise in one or more aspects of tobacco quit line, medical education, tobacco dependence treatment and tobacco control policy;
- additional content presenters as necessary.

The facilitation team should be supported by one or more logistics assistants to meet logistical needs during the workshop, including production and reproduction of materials.

Workshop programme and schedule

Prior to the training, the organizer and facilitators should gather as much information as possible about each country's situation and resources, and should assess the knowledge, skills and needs of participants in order to determine the training content, teaching methods and structure. If necessary, adjustments can be made to the content, teaching methods and structure to suit the situation. This training package includes

a variety of learning activities for each module. The organizer and facilitators may consider adapting role-playing activities in the “Practice” portion of the modules to match the cultural needs of participants by using group and individual activities. It should be recognized that the goal is to provide participants with opportunities to apply new knowledge and newly learned skills.

The organizer and facilitators will need to design an appropriate training schedule or agenda based on the content they want to offer to the participants, the time needed for each module and the overall timeframe of the workshop. Please try to avoid creating an overcrowded timetable during the planning of the schedule.

Selecting participants

The workshop is targeted at those who are going to be new tobacco quit line counsellors and will provide telephone counselling services, at current quit line counsellors who want to reinforce and enhance their skills for telephone counselling. It is recommended that the workshop should be conducted with a maximum of 25 participants.

Logistics

The workshop requires standard meeting/training tools and facilities, namely:

- one main meeting room, with participants seated around small tables in small groups;
- one or two additional break-out rooms if the large room cannot accommodate small group discussions;
- flipcharts and markers (one for each small group);
- projector and screen for presentations;
- laptop computer with speakers for presentations;
- presenter’s microphone;
- portable microphones for discussions (optional);
- desktop computer, printer and photocopier for document production during the workshop (optional).

Materials

All the workshop training and background materials are provided online by WHO. These include:

- the *Facilitators’ guide*;
- presentations;
- the *Participants’ workbook*;
- workshop evaluation forms.

The “References and Resources” section contains hyperlinks to the relevant materials needed throughout the workshop. In addition to online materials, each participant should receive a binder or folder with key printed materials, particularly:

- hand-outs of presentations;
- key resource documents for each theme.

The facilitation team should decide which resources are most relevant to the participants and should include them in the printed materials. The facilitation team should also ensure that key materials are available in the language of the participants.

MORE INFORMATION AND GUIDANCE

This training package is intended for use by staff of WHO and government departments of WHO Member States. However, its components and tools can be used in other contexts to promote national toll-free quit line services.

If you use this package outside the context of a WHO-sponsored training workshop, please let us know. Your experience and feedback will help WHO improve the package and share lessons learned with others.

For feedback and additional guidance in implementing the package, please contact:

Tobacco Free Initiative
Prevention of Noncommunicable Diseases
World Health Organization
Avenue Appia 20
1211 Geneva 27, Switzerland
Email: pnd@who.int
Telephone: + 41 22 791 21 11
www.who.int/tobacco/en

ACKNOWLEDGEMENTS

The WHO Tobacco Free Initiative of the Department of Prevention of Noncommunicable Diseases (PND) developed this training package. We thank the regional advisers for tobacco control and their teams for their assistance in developing the package. A large number of international experts from various institutions and agencies were involved as contributors.

Dongbo Fu coordinated the production of this package under the direction of Armando Peruga and Douglas Bettcher. Miriamjoy Aryee-Quansah provided administrative support.

Ken Wassum and Etta Short drafted this training package with the contribution from Dongbo Fu.

This package was reviewed at the different phases of its preparation by Luke Atkin, Douglas Bettcher, Adriana Blanco, Fatimah El-Awa, Mahmoud Elhabiby, Dongbo Fu, Tom Glynn, Abigail Halperin, Nyo Nyo Kyaing, Harry Lando, Min Kyung Lim, Kristina Mauer-Stender, Tim McAfee, Ezra Ogwell Ouma, Armando Peruga, Martin Raw, Dhirendra N Sinha, Paula Snowden and Shu-hong Zhu.

The production of this training package was made possible by funding from the United States Centers for Disease Control and Prevention (CDC).

FACILITATORS' GUIDE

Module 1: Quit line services and the role of the tobacco quit line counsellor

Duration	2 hours
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none">• describe benefits of quit lines to tobacco users, health care providers and other tobacco control initiatives;• describe how quit lines can offer a variety of evidence-based services ranging from providing information, dispensing cessation medicines, providing printed materials and e-communications to more intensive counselling;• describe the basic tenets and key considerations for telephone counselling;• recognize that quit line counsellors will provide counselling services to callers who have varying degrees of motivation to quit, including those who are ready to quit and those who are not ready;• articulate that services provided by the quit line counsellors are grounded in protocols based on best practices derived from the scientific evidence-base for treating tobacco use and dependence;• articulate the role of counsellor in a quit line setting.

Time	Trainer activity	Participant activity	Audiovisual
30 minutes	<p>Introduction and housekeeping</p> <p><i>Note:</i> Orientation and introduction to the training will include participant introductions, including why the participants are there and what they are most interested in regarding the role of tobacco quit line counsellor.</p>		
Preparation			
5 minutes	<p>Ask participants to share their expectations of working as a tobacco quit line counsellor with people who call quit lines for help.</p> <p>Record responses on flipchart.</p> <p>Validate responses</p>	Participants share their ideas about quit line counsellors.	Flipchart
10 minutes	<p>Refer participants to a sample caller in the workbook and tell a story about a typical quit line caller who is ready to quit and the caller's experience of interacting with the quit line counsellor.</p> <p>Ask volunteers to share ways that the quit line counsellor supported this caller during the quit process.</p> <p>Validate and reinforce responses by reviewing the following suggested answers:</p> <ul style="list-style-type: none">• Had a friendly, nonjudgemental attitude.• Asked questions to learn about tobacco use and quit history, motivation and confidence to quit.• Provided practical tips and strategies to help with quit.• Planned for quit date; strategies to quit and strategies to stay quit. <p>Conclude story by stating this is an example of a caller who is ready to quit. There will also be times that you will speak with people who are not ready to quit.</p>	Refer to the workbook and participate in the discussion. Volunteers share responses.	Workbook – summary of sample caller

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
15 minutes	<p>Describe how quit lines are a population-wide approach to offering help to tobacco users and thereby reducing the prevalence of tobacco use.</p> <p>Ask participants to brainstorm:</p> <ul style="list-style-type: none"> • What are the benefits of quit lines to tobacco users, health-care providers and other tobacco control initiatives? <p>Write down participants' responses on a flipchart page or a whiteboard.</p> <p>Refer participants to the workbook and use PowerPoint slides to describe the benefits of quit lines to different segments of society, e.g.:</p> <ul style="list-style-type: none"> • benefits to health ministries as an efficient means of delivering evidence-based treatment • benefits to individual tobacco users • benefits to individual health-care providers • potential benefits to other tobacco control initiatives. 	<p>Participate in the discussion and share ideas.</p>	<p>Workbook, flipchart or whiteboard, PowerPoint presentation <i>Module 1-A</i></p>
20 minutes	<p>Refer participants to the workbook and use PowerPoint slides to describe the range of services typically provided by quit lines. For example:</p> <ul style="list-style-type: none"> • telephone counselling • referrals • cessation medication support • printed materials • Internet-based services and mobile telephone text messages. <p>Emphasize that telephone counselling is at the heart of quit line services, and use PowerPoint slides to describe the basic tenets and key considerations of telephone counselling, i.e.:</p> <ul style="list-style-type: none"> • effectiveness • potential wide reach and easier access • a range of callers • a range of telephone counselling services supported by established counselling protocols • various helping styles. 	<p>Refer to the workbook.</p>	<p>Workbook, PowerPoint presentation <i>Module 1-B</i></p>
10 minutes	<p>Refer participants to the workbook and use PowerPoint slides to explain the role of the tobacco quit line counsellor, namely:</p> <ul style="list-style-type: none"> • to provide personalized assistance to the caller regardless of where the person is on the quit continuum; • to assess where the caller is in terms of readiness to quit, and use the appropriate counselling approach and strategy; • to provide warm and empathetic care; • to maintain knowledge about the quitting process and skills in applying treatment strategies, including new data and treatment approaches as they become available; • to follow established quit line treatment protocols to ensure treatment effectiveness and safety. 		<p>PowerPoint presentation <i>Module 1-C</i></p>
Practice			
15 minutes	<p>Introduce the activity by explaining that the quit line counsellor role requires a balance of being facilitative (collaborative) and directive (taking the expert role) when working with caller.</p> <p>Ask participants to work in pairs, with each member of the pair selecting a familiar topic. Each partner will take turns talking about the topic. Notice how you strike a balance of being collaborative and taking the expert role. Each member of the pair will take 5 minutes.</p> <p>Circulate to observe participants' conversations.</p> <p>Debrief the experience with participants.</p> <p>Ask volunteers to share when it was useful to take the expert role and when was it useful to be facilitative.</p>	<p>Participate in the activity.</p>	

Time	Trainer activity	Participant activity	Audiovisual
Evaluation			
10 minutes	Ask trainees whether their expectations for working with tobacco users have changed after learning about quit lines and the quit line counsellor role. Refer to expectations recorded at the beginning of the module.	Participate in the discussion.	Flipchart
5 minutes	<p>Ask participants to rate their confidence to perform the quit line counsellor role using a scale of 1–10.</p> <p>Ask what will give them confidence.</p> <p>Validate responses and assure participants that this training will provide them with knowledge, skills and practice in delivering quit line services to build their confidence to play the role of a quit line counsellor.</p> <p>Inform participants that they will check their confidence at the end of the training.</p>	<p>Scale confidence and participate in the discussion.</p> <p>Anticipate response: training and practice/experience will help improve confidence to be effective in the role.</p>	

Module 2: Tobacco use and tobacco dependence

Duration	1 hour 45 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> describe prevalence and patterns of tobacco use; describe the forms of tobacco delivery systems; describe the health, social and economic impacts of tobacco use and the benefits of quitting tobacco; describe the three elements of tobacco dependence (physical, psychological, habitual or social challenges); describe nicotine addiction from smoking and oral tobacco use; demonstrate the use of information about tobacco use, health impacts and tobacco dependence to educate and motivate callers during treatment.

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
20 minutes	<p>State that tobacco quit line counsellors should have basic knowledge of tobacco use and tobacco dependence in order to assist callers in quitting more effectively.</p> <p>Refer participants to the workbook and ask them to take 10 minutes to check their knowledge by completing the Tobacco and Nicotine Quiz.</p> <p>Take 5 minutes to review the correct answers with the group (*See Answer Key below).</p> <p>Inform them that they will learn about the details of tobacco use and tobacco dependence in this module.</p>	<p>Fill out the quiz.</p> <p>Participate in review of the answers.</p>	Quiz handout
Presentation			
10 minutes	<p>Refer participants to the workbook and PowerPoint slides and present information about local, national and worldwide prevalence and patterns of tobacco use.</p> <p>Emphasize that we have a large population of tobacco users in need of tobacco cessation support:</p> <ul style="list-style-type: none"> Currently more than 1 billion people, one fourth of the world's adults, smoke tobacco. Over 80% of adult male smokers are in low- and middle-income countries. Smoking prevalence of women is lower than that of men, but it has been increasing over the past 40 years. In all WHO regions except Europe, girls aged 13–15 years are using tobacco at higher rates than women aged 15 and older. The rates at which adolescent boys use tobacco average around 18% globally. 	<p>Refer to the workbook.</p>	<p>Workbook,</p> <p>PowerPoint presentation</p> <p><i>Module 2-A</i></p>

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
10 minutes	<p>Refer participants to the workbook and explain that:</p> <ul style="list-style-type: none"> • There is a wide range of tobacco products, and the types and use patterns vary from country to country. • Tobacco types typically include those that are smoked and those that are chewed. 	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 2-B</i>
10 minutes	<p>Ask participants: what is the impact of tobacco use on tobacco users and others?</p> <p>Highlight the facts and continue to ask participants for their views on the benefits of quitting.</p> <p>Reinforce findings with the fact sheet.</p> <p>Expand the group discussion to consider health and non-health benefits.</p>	Discuss the health, social and economic impacts of tobacco use. Refer to the workbook.	Flipchart/white board, workbook, PowerPoint presentation <i>Module 2-C</i>
15 minutes	<p>Ask participants for ideas on why people smoke but do not quit?</p> <p>Prompt for personal experiences as well as professional ones.</p> <p>Present theory and evidence on the three primary aspects of tobacco dependence:</p> <ul style="list-style-type: none"> • physical dependence • psychological connection • social/habitual connection. 	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 2-D</i>
Practice			
30 minutes	<p>Introduce the practice activity.</p> <p>Explain that this activity will provide an opportunity to apply information about tobacco use and tobacco dependence to motivate and educate callers.</p> <p>Assign participants to discuss with the person next to them how they would share information about the impact of tobacco use and tobacco dependence with a quit line caller.</p> <p>Each participant will describe:</p> <ul style="list-style-type: none"> • why tobacco is addictive • the three elements of tobacco addiction • the health impact of smoking and oral tobacco use and the health benefits of quitting. <p>Move around the room to answer questions.</p>	Practice in small groups.	
Evaluation			
10 minutes	<p>Ask the group to reconvene and invite volunteers to read out their responses.</p> <p>Offer comments and invite other participants to provide feedback on responses.</p>	<p>Read out responses and comment on each other's responses.</p> <p>Participants conclude: their knowledge about tobacco use and tobacco dependence can be used to motivate callers during treatment.</p>	

*Answer Key – Tobacco and Nicotine Quiz:

1. Myth; 2. Truth; 3. Myth; 4. Truth; 5. Myth; 6. Truth; 7. Truth; 8. Myth; 9. Truth; 10. Truth.

Module 3: Practical and theoretical approaches for those ready to quit

Duration	2 hours
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • recognize that quit line interventions are based on both practical approaches and theoretical approaches; • describe and apply practical approaches to help callers who are ready to quit; • recognize that key constructs of social cognitive theory, such as personal, behavioural, environmental and self-efficacy factors, can be used by quit line counsellors to help callers quit and gain an insight into their use of tobacco; • describe and apply the basic principles of counselling and strategies used to treat tobacco dependence for those who are ready to quit, including: <ul style="list-style-type: none"> – cognitive behavioural therapy – motivational enhancement – practical problem-solving (skill-building) – persuasive education – modelling – reinforcement.

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
10 minutes	<p>Introduction to social cognitive theory</p> <p>Ask participants to identify challenges people face when trying to quit tobacco.</p> <p>On the flipchart organize responses into social cognitive theory categories:</p> <ul style="list-style-type: none"> • personal (biological and thoughts and emotions) • environmental (social and physical) • behavioural (automatic and conscious). <p>Reinforce the responses. Use these examples as prompts, or add to the list identified by participants:</p> <ul style="list-style-type: none"> • (behavioural) Does not have the skills to avoid smoking in the car, with coffee or after meals. • (behavioural) Does not have the knowledge regarding successful quitting strategies/ medication. • (personal) Keeps thinking "I had a puff of a cigarette so I may as well start smoking again". • (environmental) Lives with other smokers. • (personal) Keeps putting off the quit date. • (personal/biological) Has strong cravings in the morning. 	Participants identify challenges that people face when trying to quit, and volunteers share with the group.	Flipchart
10 minutes	<p>Introduction to intervention strategies</p> <p>Refer participants to the workbook and facilitate a discussion about different strategies people need to overcome these challenges.</p>	Participate in discussion.	Flipchart, Trainee workbook
Presentation			
5 minutes	<p>Explain that the quit line counselling intervention is based on two types of approach: practical and theoretical.</p> <ul style="list-style-type: none"> • Practical approaches are based on looking at what has been empirically proven to help tobacco users to quit. • Theoretical approaches are based on creating intervention content according to established theories on how people change behaviours. 	Workbook	
15 minutes	Refer participants to the workbook and use PowerPoint slides to discuss which approaches are practical in helping people who are ready to quit.		Workbook, PowerPoint presentation <i>Module 3-A</i>

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
15 minutes	<p>Refer participants to the workbook and use PowerPoint slides to present a commonly-used theoretical approach to quitting: social cognitive theory.</p> <p>Make sure to include the following key points:</p> <ul style="list-style-type: none"> • Social cognitive theory acknowledges that, as people change their behaviour, this will cause/require changes in both their environment (including interpersonal relationships) and in themselves. • Social cognitive theory evolved from social learning theory, which suggests that people learn not only from their own experiences but by observing the actions of others (modelling). • Social cognitive theory is a complex model and includes personal, behavioural and environmental factors that can be leveraged by the quit line counsellor to help callers increase their self-efficacy in their ability to quit and gain insight into their use of tobacco. • Key constructs of social cognitive theory include reciprocal determinism, behavioural capacity, expectations, self-efficacy, observational learning and reinforcements. 		Workbook, PowerPoint presentation <i>Module 3-B</i>
25 minutes	<p>Explain that:</p> <ul style="list-style-type: none"> • Intervention strategies that are proven to help tobacco users quit fall under the practical approaches and theoretical strategies. • Quit line counsellors should combine practical counselling approaches with theoretical models when they provide counselling services to callers. • Quit line counsellors should select appropriate counselling intervention strategies to help callers develop a plan based on different types of gaps/barriers that callers deal with when trying to quit tobacco. <p>Refer to the workbook and use PowerPoint slides to present the following strategies:</p> <ul style="list-style-type: none"> • education/persuasive education • skill-building/practical problem-solving • cognitive behavioral therapy • modelling • reinforcement • motivational interviewing (MI) • behavioural contracting. <p>Ask participants when they would apply these strategies.</p> <p>Refer to the workbook for suggested answers.</p>		Workbook, PowerPoint presentation <i>Module 3-C</i>
Practice			
10 minutes	<p>Practise applying intervention strategies</p> <p>Refer participants to the workbook and ask them to match the intervention strategy with the scenario.</p> <p>Invite 1 or 2 volunteers to share their responses with the group.</p>	Trainees work individually to match the intervention strategy with the scenario.	Workbook
20 minutes	<p>Demonstrate intervention strategies</p> <p>Divide participants into five groups and assign one intervention strategy to each group.</p> <p>Ask each group to come up with a way to illustrate their assigned intervention strategy by planning a role play, giving an example, or drawing a diagram. Invite each group to present their assigned strategy and ask remaining participants to determine which intervention strategy is being demonstrated.</p>	Trainees in groups prepare and act out brief role plays or other illustrative activities. The rest of the group assesses which intervention strategy they are illustrating.	Workbook
Evaluation			
10 minutes	Ask trainees to share their experiences: what did they learn about different intervention strategies?		

Module 4: Practical and theoretical approaches for those not ready to quit

Duration	2 hours 55 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • recognize what type of caller is likely to benefit from the use of the motivational interviewing (MI) approach to counselling; • describe and apply the spirit, principles and basic skills of MI to help people who are not ready to quit, including: <ul style="list-style-type: none"> – spirits of MI (collaboration, evocation, autonomy) – key counselling principles of MI – basic skills of MI (open-ended questions, affirmations, reflective listening, summarizing).

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
15 minutes	<p>Instruct participants to work in pairs and to ask each other to identify a behaviour that it would be good for them to change but which they are not motivated enough to start working on. Then they take turns in trying convince their partner to make the change.</p> <p>Invite two volunteers to share their experience. What worked to convince someone to work on a goal they are not motivated to work on (if anything)?</p>	<p>Work in pairs. Volunteers share their experience with the group.</p> <p>Participants conclude: it is challenging to talk someone into doing something they are not motivated to do.</p>	Workbook
Presentation			
30 minutes	<p>Refer participants to the workbook and use PowerPoint slides to discuss:</p> <ul style="list-style-type: none"> • the definition and goal of MI • the basic assumption of MI • the three spirits of MI (collaboration, evocation, autonomy) • how to apply the core principles of MI: <ul style="list-style-type: none"> – expressing empathy – supporting self-efficacy – developing discrepancies – rolling with resistance • basic MI skills (OARS): <ul style="list-style-type: none"> – open-ended questions – affirmations – reflective listening – summarizing. 	<p>Refer to the workbook, ask questions, participate in discussion, take notes.</p>	<p>Workbook, PowerPoint presentation <i>Module 4-A</i></p>
30 minutes	<p>Refer participants to the workbook and use PowerPoint slides and examples to discuss:</p> <ul style="list-style-type: none"> • The two phases of MI • Recognizing “change talk” (self-motivation statements), which can be classified as: <ul style="list-style-type: none"> – desire – ability – reason – need – commitment language. • Eliciting and strengthening change talk. <p>Explain that:</p> <ul style="list-style-type: none"> • Change talk indicates that callers are thinking of the possibility of change. • When change talk is not forthcoming we can use strategies to evoke it. • Once the client has presented some change talk and readiness to hear about the options for change, phase 2 of the MI, which involves strengthening commitments to change and developing a plan to accomplish it, can begin. 	<p>Refer to the workbook.</p>	<p>Workbook, PowerPoint presentation <i>Module 4-B</i></p>

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
15 minutes	<p>Refer participants to the workbook and use PowerPoint slides and examples to discuss the 5Rs model and the six steps for conducting an MI session:</p> <ul style="list-style-type: none"> • 5Rs model: <ul style="list-style-type: none"> – relevance – risks – rewards – roadblocks – repetition. • The six steps for conducting an MI session: <ul style="list-style-type: none"> – Set the agenda, focusing on the relevance of quitting for the participant. – Ask about the aspects of using tobacco they like. – Ask about the negative (less likeable) aspects of using tobacco. – Explore life goals and values. – Ask for a decision. – Set goals – use SMART goals (specific, meaningful, assessable, realistic, timely). 		Workbook, PowerPoint presentation <i>Module 4-C</i>
15 minutes	<p>Use a video demonstrating MI strategies for a caller who is thinking about quitting smoking: Monkey on my Back, part 1.</p> <p>Motivational interviewing is employed to help the client understand her options and the good and bad points about quitting smoking in this role play: http://www.motivationalinterviewing.info/video/.</p> <p>Facilitate a discussion about strategies the counsellor used to help the caller quit.</p>	<p>Participants watch the video.</p> <p>Anticipated response: the counsellor used open-ended questions, reflections, examples, looking forward, showing empathy, asking evocative questions, eliciting change talk.</p>	Projector, computer, Internet connection
5 minutes	<p>Using MI with those who are ready to quit</p> <p>Explain that those who are ready to quit can also benefit from strategies designed to enhance their motivation and commitment to quit and stay quit. Motivational enhancement is an adaption of MI, and is a process by which the quit line counsellor assists the caller to maintain or increase motivation to quit, increase vision and self-efficacy.</p> <p>Helping callers gain clarity on their reasons for wanting to quit can then result in more decisive action.</p>		
Practice			
15 minutes	<p>1. Role play demonstration: using OARS</p> <p>Assign participants to groups of 3 (caller, quit line counsellor, observer) for a role play demonstration.</p> <p>Instruct participants to play different roles as follows:</p> <p>The caller: a 35-year-old woman working in a local grocery store. She has been smoking 20 cigarettes per day for 15 years. She has a 7-year-old son. She feels two ways about smoking: on one hand smoking helps her calm down when she is stressed; on the other hand she knows that as a smoker she is not a good role model for her son.</p> <p>Quit line counsellor: focusing on using OARS to gain a better understanding of the caller, not trying to solve the caller's problem, and giving advice.</p> <p>Observer: who uses a tracking sheet to keep track of OARS that the counsellor used during the role play.</p> <p>Circulate around the room to support participants and provide feedback.</p>	<p>Participate in the role play in a group of 3.</p>	Workbook

Time	Trainer activity	Participant activity	Audiovisual
Practice			
20 minutes	<p>2. Practice: motivational interviewing</p> <p>Ask participants to work in pairs and take turns role-playing a quit line counsellor working with the same caller as above and conducting an MI session following the six steps:</p> <ul style="list-style-type: none"> • Set the agenda. • Ask about the aspects of using tobacco she likes. • Ask about the aspects of using tobacco she does not like. • Explore life goals and values. • Ask for a decision. • Set goals. <p>Circulate around the room to support participants and provide feedback.</p>	Participants participate in role play.	Workbook
Evaluation			
30 minutes	<p>Ask for one pair of participants to volunteer to perform their role play for the large group.</p> <p>Ask participants to observe and identify MI strategies used during the role play.</p> <p>Facilitate a discussion about this experience.</p>	<p>Volunteers demonstrate MI strategies.</p> <p>Participants observe.</p> <p>Everyone identifies MI strategies used and provides feedback.</p> <p>Participants conclude that using MI strategies promotes change and engages callers.</p>	

Module 5: Pharmacotherapy

Duration	2 hour 10 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • provide medication decision-support consistent with quit line protocols; • describe the various tobacco cessation medicines, including dosing regimens, and accurate and clear information about how they are used; • demonstrate the ability to deliver medication decision-support as part of the treatment plan; • demonstrate problem-solving strategies for callers who report: <ul style="list-style-type: none"> – medicines are too expensive – experience of side-effects they believe are attributed to medicines; • demonstrate the ability to reinforce ongoing medication use compliance during follow-up interventions.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
20 minutes	<p>Ask participants to brainstorm: what effective tobacco cessation products are currently available for tobacco users?</p> <p>Write participants' responses on a flipchart page or whiteboard.</p> <p>Use PowerPoint slides to summarize the two categories of medication (nicotine replacement medications and non-nicotine medications) that are currently available for treating tobacco dependence.</p> <p>State that, in this module, participants will have an opportunity to discuss those tobacco cessation medications, with the focus on nicotine replacement therapy (NRT) products.</p>	Participate in discussion and brainstorm currently-available effective tobacco cessation medications.	<p>Flipchart/white board,</p> <p>PowerPoint presentation</p> <p><i>Module 5-A</i></p>

Time	Facilitator activity	Participant activity	Audiovisual
Presentation			
20 minutes	<p>Present the following information for the NRT products, bupropion and varenicline:</p> <ul style="list-style-type: none"> • what these medications are • the purpose of using these medications • formulations/dosage • typical regimen • information/instructions for use • advantages and disadvantages • side-effects and warnings. 	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 5-B</i>
15 minutes	<p>Assessing nicotine dependence</p> <p>State that counsellors need to assess tobacco users' levels of nicotine dependence, which:</p> <ul style="list-style-type: none"> • is a strong predictor of the difficulty a caller may have with quitting smoking; • can help the counsellor recommend a dosage of NRT to the caller. <p>Refer participants to the workbook and present information on how to assess the level of nicotine dependence:</p> <ul style="list-style-type: none"> • Method 1: the Fagerström Test for Nicotine Dependence (FTND) which has six questions. • Method 2: the shorter two-question version called the Heavy Smoking Index (HSI) that has proved equally effective. <p>Emphasize that:</p> <ul style="list-style-type: none"> • Callers who are moderately to highly dependent generally benefit from the use of NRT, or other quit medications, to reduce nicotine withdrawal symptoms. • Treatment guidelines from many countries, including the USA's clinical practice guideline, strongly support the use of medications for moderately and highly dependent smokers. 	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 5-C</i>
15 minutes	<p>Guide participants in reviewing the instructions for use and dosing recommendations for each NRT product based on the level of nicotine dependence:</p> <ul style="list-style-type: none"> • dosage per day • duration of use • how to use each product properly • how to taper down. <p>Leave some time for a brief question and answer (Q&A) session at the end.</p>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 5-D</i>
5 minutes	<p>Common barriers to the use of cessation medications</p> <p>Describe three common barriers to use of medication and medication compliance, e.g.:</p> <ul style="list-style-type: none"> • cost • side-effects (and attributing withdrawal symptoms to medication side-effects) • misinformation or fears about the safety of NRT and other quit medications. <p>Explain that it is prudent for the counsellor to educate the caller that some symptoms experienced after quitting may not be medication side-effects but are simply caused by the user's body and mind adjusting to not using tobacco.</p>		
Practice			
30 minutes	<p>Instruct participants to divide into pairs. The pairs will take 15 minutes to work together to build a pharmacotherapy plan for two sample callers.</p> <p>Refer participants to scenarios in the workbook:</p> <p>Caller # 1 - Kate Caller # 2 – Jack.</p> <p>Debrief the exercise by asking volunteers to share their plan for Kate and Jack.</p> <p>Reinforce or add recommendations about the plans.</p>	<p>Refer to the workbook. Participants work in pairs to develop a medication treatment plan for two sample callers.</p>	Workbook, Case study

Time	Facilitator activity	Participant activity	Audiovisual
Practice			
15 minutes	<p>Decision-support for medication use</p> <p>Introduce the activity by describing how the quit line counsellor will need to provide decision-support for medication use and will also need to help people select a medicine that is the best fit in terms of tobacco use, preferences, cost and other limitations.</p> <p>Refer participants to the instruction in their workbook.</p> <p>Ask participants to work in pairs to practise providing decision-support according to the instruction. The first member of the pair will take 3–5 minutes to provide decision-support for Kate; the second trainee will provide support for Jack.</p>	<p>Refer to the workbook.</p> <p>Participate in the activity.</p>	Workbook
Evaluation			
10 minutes	<p>Ask for one or two volunteers to demonstrate the provision of education to Kate or Jack.</p> <p>Everyone gives feedback.</p> <p>Ask participants to share their experiences:</p> <ul style="list-style-type: none"> • What did they learn about giving medication decision-support? • What did they hear from the quit line counsellor that helped them select a medicine? 	<p>Participate in the discussion.</p>	Flipchart/ whiteboard Workbook

Module 6: Facilitation skills

Duration	1 hour 20 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • describe the value of establishing a rapport between the counsellor and the quit line caller in order to develop a therapeutic relationship; • demonstrate communication with the following key facilitation skills: <ul style="list-style-type: none"> – showing warmth and empathy – active listening – normalizing – flexing the communication style (as needed) – managing time – respecting boundaries.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
10 minutes	<p>Lead a discussion in which participants brainstorm ways to demonstrate:</p> <ul style="list-style-type: none"> • empathy • genuine interest • flexing for different communication styles. <p>Ask participants to identify how they know if someone is showing empathy or genuine interest when communicating with them.</p> <p>Record responses on a flipchart.</p> <p>Ask participants to identify ways they flex their style when talking with someone who has a different communication style from theirs – e.g. if they are a fast talker but the other person takes time to respond.</p> <p>Record ideas on a flipchart.</p>	<p>Participate in brainstorming. Take notes in the workbook.</p> <p>Participants conclude: showing empathy, genuine interest, and flexing their communication style are important parts of good communication.</p>	Flipchart

Time	Facilitator activity	Participant activity	Audiovisual
Presentation			
25 minutes	<p>Explain that the value of establishing a rapport between the quit line counsellor and the caller is to build a therapeutic relationship and to create trust and open communication.</p> <p>Explain that counsellors should understand and apply the following key facilitation skills in order to establish a rapport to help create a therapeutic relationship with callers, and make the counselling process smooth and successful:</p> <ul style="list-style-type: none"> • showing warmth and empathy • normalizing • active listening • flexing communication style • managing time • respecting boundaries. 	Refer to the workbook, ask questions, take notes.	Flipchart, workbook, PowerPoint presentation <i>Module 6-A</i> Facilitation map
Practice			
35 minutes	<p>Applying facilitation skills</p> <p>Explain that this activity will provide an opportunity to apply facilitation skills to build a therapeutic alliance as they talk to a caller about medications, tobacco and nicotine.</p> <p>Assign participants to small groups of three to practise the scenarios below.</p> <p>Explain that there are three roles: the quit line counsellor role, the caller role and the observer role. Each practice session will last 5–10 minutes. Please indicate when it is time for participants to switch roles, so that everyone has the opportunity to play the quit line counsellor.</p> <ul style="list-style-type: none"> • Quit line counsellor role: selects one of the scenarios and demonstrates facilitation skills while discussing the assigned topic. • Caller role: follows the scenario selected by the quit line counsellor role. • Observer role: takes note of the different facilitation skills the quit line counsellor used during the practice session. After each practice session, the observer shares what he or she heard demonstrated. <p>Each participant will demonstrate:</p> <ul style="list-style-type: none"> • showing warmth and empathy • active listening • normalizing • flexing the communication style (as needed) • managing time • respecting boundaries. <p>Refer participants to the workbook for two scenarios.</p> <p>Move around the room to answer questions.</p>	Practise these skills in small groups. Refer to the workbook for scenarios.	Workbook
Evaluation			
10 minutes	<p>Facilitate a debrief of practice sessions.</p> <ul style="list-style-type: none"> • What, if anything, was challenging about using the facilitation skills during the sessions? • What was the impact on the caller? 	<p>Participate in the discussion.</p> <p>Participants conclude: building a therapeutic alliance is an important part of the quit line counsellor role.</p>	

Module 7: Basic components of a call

Duration	1 hour 10 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • describe the basic components of a call (introduction and signposting, assessment and agenda development, action planning, and closing); • demonstrate the ability to introduce each call and signpost the intervention; • demonstrate the ability to engage the caller in a summary of next steps in the quitting process and to schedule the next call.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
10 minutes	<p>Introduce the basic call structure:</p> <ul style="list-style-type: none"> • introduction • assessment (exploration) • setting the agenda • action • closing. <p>Ask participants: what is the goal/purpose of each part of the call? Write on the flipchart and ask participants to fill in the empty chart in their workbook.</p>	<p>Participants identify the purpose of each phase of the call. Write responses in workbooks.</p>	<p>Flipchart, workbook, PowerPoint presentation <i>Module 7-A</i></p>
Presentation			
20 minutes	<p>Refer participant to the workbook and explain the importance of orienting callers to what will happen during each call.</p> <p>Ask participants to list what the introduction part of the call includes.</p> <p>Refer participants to the workbook and use PowerPoint slides to describe:</p> <ul style="list-style-type: none"> • assessment <ul style="list-style-type: none"> – required questions – additional questions the counsellor feels need to be asked to help the caller. • transition to agenda-setting • planning or action plan • closing. 	<p>Participate in discussion.</p> <p>Anticipated responses:</p> <ul style="list-style-type: none"> • State your name. • Thank the caller for calling the XXXX quit line. • State how long the call will take. • Provide an overview of topics that will be discussed. This is called “signposting”. • Give any additional information required by law (or required by the quit line). • Ask the caller if he or she has anything they want to discuss during the call. 	<p>PowerPoint presentation <i>Module 7-B</i></p>

Time	Facilitator activity	Participant activity	Audiovisual
Practice			
30 minutes	<p>Ask participants to use 10 minutes to write:</p> <ul style="list-style-type: none"> • an introduction for an intake call (include transition statement to the assessment); • an introduction for an ongoing call (include transition statement to the assessment); • closing a call – i.e. what it might typically sound like (start with a transition statement that signalizes the end of action planning). <p>Ask participants to work in pairs to read their introductions and closings to each other.</p>	<p>Write introductions and closings in workbooks.</p> <p>In pairs, read introductions and closings to each other.</p> <p>Volunteers share their examples with the group.</p>	
Evaluation			
10 minutes	<p>Invite one or two participants to share their introductions and closings.</p> <p>Ask: what are the benefits of using the basic call structure (for the caller and for the quit line counsellor)?</p>	<p>Anticipated responses:</p> <ul style="list-style-type: none"> • Sets a clear structure. • Keeps the call time down. • Keeps you and the caller focused. • Helps the quit line counsellor to follow a logical sequence. 	

Module 8: Assessment and agenda-setting

Duration	1 hour 40 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • demonstrate the assessment required (if any), and optional information about the caller's tobacco use; • demonstrate use of the caller's readiness to quit to inform the agenda for the intervention; • demonstrate use of the information collected during the assessment to build an intervention strategy.

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
20 minutes	<p>State that the assessment is the phase of the call that follows the introduction and is a part of all calls.</p> <p>Ask participants to brainstorm: What is the purpose of the assessment?</p> <p>Record responses on a flipchart.</p> <p>Refer participants to the workbook and explain that the assessment can help a quit line counsellor:</p> <ul style="list-style-type: none"> • understand the information about the caller such as tobacco use and quitting history in order to develop a plan to help them quit and stay quit; • determine a caller's readiness to quit; • propose the focus for the call (agenda-setting); • build a rapport with callers. 	<p>Participants participate in the brainstorming activity.</p>	<p>Workbook, Flipchart/ whiteboard</p>

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
30 minutes	<p>The content of the assessment</p> <p>Refer participants to the workbook and use PowerPoint slides to explain that:</p> <ol style="list-style-type: none"> 1. The assessment is typically broken down into several different parts that may consist of: <ul style="list-style-type: none"> • readiness to quit • tobacco use • history of previous quit attempts • self-efficacy factors • other tobacco users in the caller's environment • physical and/or mental health problems relevant to quitting. 2. The content of the assessment can be determined by the caller's readiness to quit. 3. The content of the assessment for the first call and for follow-up calls is different: <ul style="list-style-type: none"> • During the first call the assessment provides information about the caller's: <ul style="list-style-type: none"> – nicotine dependence – history of previous quit attempts – reasons for returning to active tobacco use – strengths and challenges associated with quitting tobacco. • During follow-up calls the assessment enables the quit line counsellor to determine: <ul style="list-style-type: none"> – what progress the caller has made – what is working – what challenges the caller is experiencing. 4. Follow-up questions <p>State that a quit line counsellor will need to ask follow-up questions with the intention of understanding issues that arise in order to help the caller. For example, counsellors can determine what additional questions to ask after they understand a caller's readiness to quit.</p>	Refer to the workbook	Workbook, PowerPoint presentation <i>Module 8-A</i>
5 minutes	<p>Tips for conducting the assessment</p> <p>Explain the importance of:</p> <ul style="list-style-type: none"> • using a conversational tone, rather than sounding as if the counsellor is conducting a survey; • using a warm and genuine tone because the assessment is a great opportunity for the counsellor to build rapport. 		
10 minutes	<p>Agenda-setting</p> <p>Refer participants to the workbook and use PowerPoint slides to present the four steps of the agenda-setting process:</p> <ul style="list-style-type: none"> • Phase I: Assessment • Phase II: Clinical decision-making by the counsellor • Phase III: sharing their insight with the caller • Phase IV: proposing a focus for the call and seeking buy-in from the caller. <p>Explain that agenda-setting is based on the readiness of the caller to quit and the other information collected during the assessment, including the caller's stated needs.</p>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 8-B</i>
Practice			
10 minutes	<p>Refer participants to a template in their workbook and ask them to take 5 minutes to create a profile of a sample caller.</p> <p>Suggest that participants draw from their own past experience with tobacco or the experience of friends and family members</p>	Use the template to create a profile.	Workbook, profile template
15 minutes	<p>Role play: assessment and agenda-setting</p> <p>Ask participants to work in pairs to role-play the introduction to the call, the assessment phase, and setting the agenda by using the caller profile they have created.</p> <p>Circulate during the exercise to provide guidance and answer questions.</p>	Work in pairs and role-play the assessment and agenda-setting.	

Time	Trainer activity	Participant activity	Audiovisual
Evaluation			
10 minutes	<p>Ask trainees to report on their role play experience.</p> <p>Ask trainees to rate their confidence in asking assessment questions and setting the agenda for a caller.</p> <p>Debrief on the response to reinforce high confidence and learn what it will take to increase confidence.</p>	<p>Participate in the role play activity.</p> <p>Volunteers share their experience with the activity.</p> <p>Everyone rates confidence in performing skills.</p>	

Module 9: Action planning

Duration	2 hours 30 minutes
Objectives <p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • describe and apply the STAR strategies to develop a quit plan; • describe the steps for developing a relapse prevention plan; • demonstrate the ability to provide ongoing support throughout the quitting process, including practical problem-solving and evidence-based strategies for relapse prevention. 	

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
30 minutes	<p>Brainstorm: action planning</p> <p>Divide participants into two groups and give each group a page of flipchart paper with the group number and description written at the top.</p> <p>Ask each group to brainstorm a list of possible action steps for a caller who meets their assigned criteria, based on evidence-based approaches:</p> <p>Group 1: Not ready to quit</p> <p>Group 2: Ready to quit.</p> <p>Invite each group to share its flipchart and describe their possible action plans with the whole group.</p>	<p>Participants work in small groups and write their possible action plans on a flipchart page.</p>	Flipchart/whiteboard
Presentation			
15 minutes	<p>State that the counselling approach should be matched with the needs of the caller and his or her readiness to quit.</p> <p>Counselling approaches and action steps for callers who are <u>not</u> ready to quit</p> <p>Refer the participants to the workbook and use PowerPoint slides to present the following key information:</p> <ul style="list-style-type: none"> • Callers who are not ready to quit may have different determinants: <ul style="list-style-type: none"> – they think quitting is not important and/or – they do not believe they can quit successfully (low self-efficacy). • MI principles, skills and models (5Rs model) will be the proper approaches for dealing with callers with low motivation. 	<p>Refer to the workbook.</p>	<p>Workbook, PowerPoint presentation <i>Module 2-A</i></p>

Time	Trainer activity	Participant activity	Audiovisual
Presentation			
45 minutes	<p>Counselling approaches and action steps for callers who are ready to quit</p> <p>1. First session</p> <p>State that the STAR strategy is the best strategy for callers who are ready to quit in the first session. The STAR strategy incorporates the following concrete action:</p> <ul style="list-style-type: none"> • Set a quit date. Ideally, the quit date should be within two weeks. • Tell family, friends and co-workers about quitting, and request understanding and support. • Anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. • Remove tobacco products from the environment. <p>2. Follow-up sessions</p> <p>Explain that, for follow-up sessions, the strategy should aim to help callers prevent relapse by developing a relapse prevention plan as early as possible.</p> <p>Refer participants to the workbook and use PowerPoint slides and case studies to present and discuss:</p> <ul style="list-style-type: none"> • How to distinguish a lapse/slip from a relapse. • The best way to prevent relapse is to use evidence-based tobacco dependence treatment and to avoid using unproven tobacco cessation methods. • Three steps for developing a relapse prevention plan are: <ul style="list-style-type: none"> – identify relapse risks – develop coping skills – provide or identify support. • The ACE model relapse prevention tool is especially useful for those who recently quit: • Avoid risky situations when possible. When avoiding risky situations is not possible: • Cope using a variety of behavioural, pharmacological and cognitive strategies. If coping is not working: • Escape the situation by leaving. 	Refer to the workbook and PowerPoint slides	Workbook, PowerPoint presentation <i>Module 9-B</i>
Practice			
30 minutes	<p>Explain that this activity will provide an opportunity for participants to apply the key strategies to develop an action plan for callers.</p> <p>Instruct participants to work in pairs and use the STAR strategy, MI intervention strategies, and the three steps for developing a relapse prevention plan in order to create:</p> <ul style="list-style-type: none"> • an action plan for those not ready to quit; • an action plan for those ready to quit; • a relapse prevention action plan for those who recently quit. <p>Ask participants to take turns rehearsing how they would collaborate with a caller to build the plan.</p> <p>Move around the room to check on progress and answer questions.</p>	Participants work in pairs to build action plans and practise delivering the plans.	Workbook
Evaluation			
30 minutes	<p>Ask for volunteers to demonstrate each of the three action plan scenarios.</p> <p>Invite participants to share ideas about the demonstration and provide feedback.</p>	Everyone participates in discussion and provides feedback.	

Module 10: The content of telephone counselling interventions

Duration	1 hour 45 minutes
Objectives	Upon completion of this module participants will be able to: <ul style="list-style-type: none">• describe the activities/content of different counselling sessions;• describe the sample counselling protocols;• conduct different types of counselling sessions using the sample counselling protocols.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
20 minutes	<p>Content of telephone counselling based on different scenarios</p> <p>Divide the participants into three groups and ask each group to develop the content of telephone counselling for one fictional caller.</p> <p>Refer participants to the workbook for caller scenarios:</p> <ul style="list-style-type: none"> • Group 1: Leo • Group 2: Marlena • Group 3: Jacob. <p>Ask each group to share its responses.</p>	In groups, participants work on the presentations.	Flipcharts/whiteboard
Presentation			
25 minutes	<p>Call content and call sequence</p> <p>Emphasize that counsellors should provide counselling services based on the call protocols.</p> <p>Refer participants to the sample counselling protocols in the workbook and use PowerPoint slides to describe:</p> <ul style="list-style-type: none"> • types of calls; • call sequence <ul style="list-style-type: none"> – initial intake and counselling call – pre-quit date call – quit date call – quit date follow-up – ongoing support call; • call content <ul style="list-style-type: none"> – ready to quit – not ready to quit – counselling flowchart and intervention flowchart visuals. <p>Leave 2–5 minutes for brief Q&A session.</p>	Refer to the workbook.	Workbook, flipchart, PowerPoint presentation <i>Module 10-A</i>
Practice			
50 minutes	Refer participants to the workbook and guide them to complete a series of role plays with the same caller as if participants were accompanying that caller through the programme.	Refer to the workbooks. Role play.	
Evaluation			
10 minutes	<p>Debrief practice activities:</p> <ul style="list-style-type: none"> • How are initial calls and ongoing calls similar/different? • What did you address and how did you address it differently in different calls (calls 1, 2 and 5)? • What agenda did you set in each call? • What intervention strategies did you use in different calls? 	Everyone participates in discussion and provides feedback.	

Module 11: Special populations and cultural awareness

Duration	1 hour 20 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • recognize that the counsellor will provide services to a variety of people who have different needs and face unique barriers in attempting to quit tobacco use; • describe how to adapt the intervention for members of special populations; • build self-awareness about personal values and beliefs and become aware that other people have their own beliefs and experiences; • identify and negotiate different styles of communication, decision-making preferences, and appropriate interventions for special populations.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
10 minutes	<p>Becoming aware Introduce the module by explaining that the quit line counsellor can expect to speak to a variety of people of different cultural backgrounds, ages, sexual orientation, mental health conditions and chronic illnesses, as well as pregnant tobacco users. Explain that: • To deliver culturally competent interventions you need to avoid stereotypes and assumptions. • Having biases and making judgements is normal; these are shortcuts our brains take to understand the world around us quickly. However, suspending judgement is critical when serving quit line callers. • The first step is to become aware of your values and biases.</p> <p>Cultural awareness self-assessment form Ask participants to take five minutes to complete the cultural awareness self-assessment form.</p> <p>Reflection Ask participants to reflect on their responses.</p>	Refer to the workbook. Complete self-assessment and reflect on responses.	Workbook (self-assessment form), PowerPoint presentation <i>Module 11-A</i>
Presentation			
25 minutes	<p>Explain that, while the intervention for general populations is largely effective across cultures, age, race, gender and economic status, there are some factors to keep in mind for different populations that may improve the experience for quit line counsellors.</p> <p>Ask participants to brainstorm:</p> <ul style="list-style-type: none"> • What are the factors that may be relevant to tobacco cessation treatment? <p>Record responses on a flipchart and lead a discussion around the following topics:</p> <ul style="list-style-type: none"> • the role of the family; • occasions when it is important to know the culture of the caller; • the danger of making assumptions about callers; • other factors <ul style="list-style-type: none"> – adolescents – pregnant women – occupation – mental health conditions. <p>Emphasize that understanding these factors may help quit line counsellors to build a better therapeutic relationship with special populations and identify appropriate interventions for them.</p>	Refer to the workbook. Participate in the discussion.	Workbook, flipchart, PowerPoint presentation <i>Module 11-B</i>

Time	Facilitator activity	Participant activity	Audiovisual
Practice			
35 minutes	<p>Small group activity – Part 1 Inform participants that they will learn about tobacco cessation issues for some special populations in this activity.</p> <p>Divide participants into five groups by counting them off from 1 to 5, and grouping all number 1s in a group, all number 2s in another group and so on.</p> <p>Assign the groups 10 minutes:</p> <ul style="list-style-type: none"> • to review information about special populations (women, pregnancy, adolescents, the over-65s, and persons with mental health conditions and substance abuse disorders); • to describe specific issues related to tobacco for their group; • to recommend interventions, as appropriate. <p>Small group activity – Part 2 Ask participants to count off 1 to 5 within each group and to create new small groups by grouping all number 1s in one group, all number 2s in another group and so on.</p> <p>Instruct the new groups to take 10 minutes to share information about the population reviewed in their original group.</p> <p>Bring everyone together to debrief the activity and share the information on the five special populations.</p>	Refer to the workbook. Work in small groups and share ideas.	Workbook
Evaluation			
10 minutes	Ask for volunteers to respond to the questions: <ul style="list-style-type: none"> • What things would always stay the same despite differences across populations? • What things may need to change? 	All participants listen, join in the discussion and provide feedback to each other.	

Module 12: Challenging calls

Duration	1 hour 25 minutes		
Objectives	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> • recognize types of challenging callers and identify the features of a challenging call; • describe and distinguish between challenging calls on the basis of content, process, and issues of perception; • describe and demonstrate strategies to reduce or eliminate challenges by addressing content, process and perceptual skill issues; • apply and demonstrate the 5-step disarming technique to manage challenging calls; • recognize when the crisis intervention protocol is needed; • demonstrate implementation of a quit line crisis protocol; • demonstrate knowledge of the various types of crisis situation. 		
Preparation			
Time	Facilitator activity	Participant activity	Audiovisual
10 minutes	State that quit line callers include a wide range of individuals, some of whom may be more difficult to treat than others. Ask participants to brainstorm: who can be challenging callers? Write responses on a flipchart. In summary, note that those callers are: <ul style="list-style-type: none"> • highly nicotine-dependent • very ambivalent • angry or resistant • suffering from a mental health condition • suffering from a serious chronic illness. This module aims to help build skills to manage challenges.	Refer to the workbook. Participate in the discussion.	Workbook, flipchart

Time	Facilitator activity	Participant activity	Audiovisual
Presentation			
20 minutes	<p>Challenging calls</p> <p>Refer participants to the workbook and explain the three ways in which a call can go off track and how a quit line counsellor can address them:</p> <ul style="list-style-type: none"> • Content: the content you are addressing is not important to the particular caller. • Process: there may be times when you are not able to control the call. If so, move the conversation in a productive direction. • Perceptual skills: sometimes the call is challenging because of your feelings and attitudes. <p>The 5-step disarming technique</p> <p>Explain that:</p> <ul style="list-style-type: none"> • The 5-step disarming technique can help counsellors manage challenging calls. • The technique can help show empathy and restore a relationship with the caller. • The purpose is to engage the caller in the call and redirect the conversation in order to achieve the goals of the call through effective communication strategies. <p>Refer participants to the workbook for an example of the 5-step disarming technique. Explain each of the five steps:</p> <ul style="list-style-type: none"> • Step 1 – Kernel of truth • Step 2 – Empathy • Step 3 – Clarify • Step 4 – I feel (validate) • Step 5 – Thanking. <p>Explain that:</p> <ul style="list-style-type: none"> • It is important to refrain from trying to solve the problem or trying to change the way the caller feels about the situation. • The point is to defuse the situation to bring the call back on track. 	Refer to the workbook. Participate in the discussion.	Workbook, flipchart, PowerPoint presentation <i>Module 12-A</i>
15 minutes	<p>Crisis protocols</p> <p>Explain that:</p> <ul style="list-style-type: none"> • Crisis protocols are intended to provide the counsellor with a clearly defined approach to deal with emergency situations such as: <ul style="list-style-type: none"> – suicidal ideation, threats, or attempts; – threats of harm to others; – medical emergencies such as chest pain, neurological symptoms, etc.; – abuse of children or dependent adults; – verbal abuse aimed at the counsellor. • For the safety of the callers, the counsellors should be very familiar with the crisis protocols of their quit line. <p>Refer participants to the workbook and guide them through the sample crisis protocols. Review the case study that demonstrates how a quit line counsellor manages a crisis situation.</p>	Refer to the workbook.	Workbook, PowerPoint presentation <i>Module 12-B</i> , case study
Practice			
15 minutes	<p>Activity 1</p> <p>Explain that identifying what type of challenge is present in a call will help participants find the appropriate solution.</p> <p>Refer participants to the workbook for scenarios and ask them to identify whether the issue is a content, process or perceptual challenge. Answer the following questions:</p> <ul style="list-style-type: none"> • What are some ways to get this call back on track? • What can the quit line counsellor say? • What actions should the quit line counsellor take? 	Refer to the workbook for scenarios. Work individually. Volunteers share responses with the group.	Workbook

Time	Facilitator activity	Participant activity	Audiovisual
Practice			
15 minutes	<p>Activity 2</p> <p>Explain that the quit line counsellor can use disarming techniques to help show empathy and restore an alliance with the caller. This activity will provide an opportunity to apply the disarming techniques during role play.</p> <p>Refer participants to two fictional callers in their workbook. Instruct them to role-play in pairs how to use the 5-step disarming method to build alliance with a caller showing hot emotions.</p>	Role play in small groups.	Workbook
Evaluation			
10 minutes	<p>Lead the group in debriefing the practice session.</p> <p>Ask the group:</p> <ul style="list-style-type: none"> • What was challenging about these role plays? • What was the impact of using the disarming techniques with your caller? 	Everyone adds to the discussion and gives feedback.	

Module 13: Supporting the intervention with supplementary resources

Duration	1 hour 45 minutes
Objectives	<p>Upon completion of this module participants will be able to:</p> <ul style="list-style-type: none"> • list common types of supplementary printed materials and e-communications used in quit line services; • describe how supplementary printed materials and e-communication can be used to actively engage quit line callers throughout all phases of the quitting process.

Time	Trainer activity	Participant activity	Audiovisual
Preparation			
15 minutes	<p>Introduce the module by stating:</p> <ul style="list-style-type: none"> • Quit lines may offer a variety of support such as printed materials, web-based tobacco interventions, and mobile text messaging (SMS). • Quit lines may also offer information and support for family, friends and health-care providers who want to help tobacco users to quit. <p>Ask participants to:</p> <ul style="list-style-type: none"> • take 10 minutes to review the table of contents of the sample quit guide; • Select 2 or 3 topics/sections in the materials and describe when and how they would refer callers to the materials. 	Everyone reviews materials.	A variety of supplementary materials that quit lines use to enhance interventions
Presentation			
30 minutes	<p>Using supplementary resources</p> <p>Refer participants to the workbook and use PowerPoint slides to describe how the following supplementary materials support active self-management of quitting:</p> <ul style="list-style-type: none"> • printed materials • SMS, or mobile text messaging • web-based services. <p>State that all forms of printed and e-communications have the potential to actively engage quit line callers beyond the limits of phone calls.</p> <p>Such supplementary materials:</p> <ul style="list-style-type: none"> • can be used between scheduled calls; • augment phone-based services and provide more information; • can be reviewed between calls to be used as discussion points in the next call. <p>In summary:</p> <p>Counsellors working for quit lines who have a variety of supplementary materials can guide callers to obtain information in ways that best support them and in ways that the caller is most likely to use.</p>	Refer to the workbook and PowerPoint slides. Participate in the discussion.	Workbook, PowerPoint presentation <i>Module 13-A</i>

Time	Trainer activity	Participant activity	Audiovisual
Practice			
20 minutes	Activity 1 Engage participants in a discussion of how the immediacy of SMS or mobile applications might support callers in engaging in the quitting process.	Practice identifying different modalities and content based on users' preferences and quit status.	Workbook
30 minutes	Activity 2 Ask participants to work independently to review the excerpt from the online quit guide (American Cancer Society) and the <i>Clearing the Air</i> printed guide and answer these questions: <ul style="list-style-type: none"> • How would you use the online sample materials to help callers who <ul style="list-style-type: none"> – start on their quit, or – remain quit? • How would you use the printed sample materials for callers who are <ul style="list-style-type: none"> – ready to quit, or – not ready to quit? 	Refer to the workbook and work individually to answer the questions.	Workbook
Evaluation			
10 minutes	Ask for two or three volunteers to share their recommendations for the online guide and printed guide. Record ideas on a flipchart.	Volunteers share recommendations. Everyone adds suggestions.	Workbook, flipchart

Module 14: Integrated practice

Duration	5 hours 35 minutes
Objectives	Upon completion of this module participants will be able to: <ul style="list-style-type: none"> • demonstrate ability to integrate information about tobacco and nicotine in order to contextualize the cessation process and enhance motivation; • demonstrate ability to synthesize the various counselling strategies based on the caller's readiness to quit; • demonstrate ability to provide pharmacological decision-support; • demonstrate ability to develop a quit plan and a relapse prevention plan according to the call sequence and quit status; • demonstrate cultural awareness in delivering interventions and tailoring interventions to special populations; • articulate how to implement crisis protocols; • demonstrate the integration of resources such as printed quit guides, SMS and social networking into the treatment plan; • demonstrate ability to document caller records accurately and concisely; • articulate the need for confidentiality and ethical care in working with quit line callers.

Time	Facilitator activity	Participant activity	Audiovisual
Preparation			
15 minutes	Assessing trainees' confidence to deliver calls Explain that this module enables participants to practise skills and apply knowledge learned during the training. Ask participants to rate their confidence to deliver calls to callers who are <ul style="list-style-type: none"> • ready to quit • not ready to quit. Reinforce participants with high confidence and encourage participants who have low confidence by explaining that they need more practice and they will become confident once they have done it several times in a real situation.	Participants rate their confidence and describe additional practice and training needed to prepare them fully to deal with calls.	Workbook, flipchart

Time	Facilitator activity	Participant activity	Audiovisual
Presentation			
30 minutes	<p>Refer participants to the workbook and ask them to complete a quiz that assesses knowledge and skills learned during the training.</p> <p>Topics include:</p> <ul style="list-style-type: none"> • tobacco and nicotine • pharmacotherapy • practical and theoretical approaches for those ready to quit and those not ready to quit • facilitation skills • components of a call • assessment • action planning • Special populations • challenging calls • using printed materials. 	Trainees complete a quiz.	Workbook
30 minutes	<p>Review the quiz items with participants.</p> <p>Facilitate a discussion about responses.</p> <p>Ask trainees to describe how they would apply the knowledge and use skills during calls.</p>	<p>Trainees self-assess their knowledge.</p> <p>Volunteers describe how they would apply their knowledge.</p>	Workbook
Practice			
10 minutes	<p>Explain that, in this exercise, participants will practice the skills and knowledge gained during the training.</p> <p>Divide participants into groups of three. Participants will take turns playing the role of quit line counsellor, caller and observer. For each role play:</p> <ul style="list-style-type: none"> • The “caller” will use the scenario to build the characters. • The quit line counsellor will deliver the call and demonstrate the skill(s) described in the scenario. • The observer will identify whether the quit line counsellor performed the skill(s) highlighted in the scenario. <p>Provide brief instructions on how to give useful feedback when working with small groups.</p>	Refer to the workbook.	Workbook
4 hours	<p>Refer participants to the workbook for scenarios for practice sessions.</p> <p>Suggest that participants take 20 minutes for the scenario and 15 minutes for the feedback discussions.</p> <p>Circulate to each group to support practice activities and feedback.</p> <p>Keep track of times. As the groups begin scenarios, alert them after 15 minutes to wrap up the practice and alert them after 30 minutes mark to wrap up the feedback.</p> <p>Guide participants to debrief the experience after they practice each scenario.</p>	<p>Participate in role play and other practice activities.</p> <p>Participate in debrief discussion.</p>	Workbook
Evaluation			
10 minutes	<p>Ask participants about their confidence in delivering interventions to callers who are</p> <ul style="list-style-type: none"> • ready to quit • not ready to quit. <p>If confidence is not high, normalize this by stating that greater confidence will come with more practice. Suggest ways in which they might continue to refine their skills.</p>	Participants rate their confidence.	

PARTICIPANTS' WORKBOOK

Module 1: Quit line services and the role of the tobacco quit line counsellor

OBJECTIVES

Upon completion of this module participants will be able to:

- describe how quit lines can offer a variety of evidence-based services ranging from providing information, dispensing cessation medicines, and providing printed materials and e-communications to more intensive counselling;
- describe the basic tenets and key considerations of telephone counselling;
- recognize that quit line counsellors provide counselling services to callers who have varying degrees of motivation to quit, including those who are ready to quit and those who are not ready;
- explain how services provided by the quit line counsellor are grounded in protocols based on best practices derived from the scientific evidence base for treating tobacco use and dependence;
- articulate the role of counsellor in a quit line setting.

AGENDA

1. Introductions (10 minutes).
2. Expectations about the quit line counsellor (15 minutes).
3. Benefits of quit lines (15 minutes)
4. Range of services (10 minutes)
5. Basic tenets and key considerations of telephone counselling (10 minutes).
6. The role of the tobacco quit line counsellor (10 minutes).
7. Practice using facilitative and directive approaches (15 minutes).
8. Confidence and expectations (15 minutes).

PREPARATION

1. INTRODUCTIONS (10 minutes)

Why are you interested in the tobacco quit line counsellor role?

2. EXPECTATIONS ABOUT THE QUIT LINE COUNSELLOR (15 minutes)

What are your expectations of working as a quit line counsellor with people who call a quit line?

Please review below the sample caller and her typical quit line experience and answer the question: how did the quit line counsellor support this caller during the quitting process?

A sample caller

Demographics: The caller is a 41-year-old female.

Tobacco use

- She smokes within five minutes of waking up.
- She smokes 20 cigarettes per day.

Motivation and confidence

- She is motivated to quit because of a cough, her doctor's advice, the expense and the smell.
- Her confidence is low because she had a difficult time quitting once before. The quit lasted for about two weeks. She did not seek help with quitting or use a tobacco cessation medicine like the nicotine patch or gum.

Triggers for smoking

- She smokes after meals, socializing with friends, during work breaks. She does not want her children to smoke. Her friends smoke and there are smokers at work.

How the caller heard about the quit line

- She calls the quit line after receiving a pamphlet at the doctor's office.

Quit line experience

- When she calls the quit line the quit line counsellor is friendly and greets her warmly.
- The quit line counsellor provides an introduction to the programme so that the caller knows what to expect. The quit line counsellor shares expectations for the call.
- The quit line counsellor transitions to assessment to learn about the caller's tobacco use, quit history, motivation to quit, and triggers for smoking. The quit line counsellor asks questions without judging and asks the caller if she has any questions or specific needs.
- The quit line counsellor collaborates with the caller to plan for quitting, including:
 - setting a quit date;
 - helping the caller find coping strategies to avoid smoking after meals, when socializing with friends and during work breaks;
 - selecting a tobacco cessation medicine;
 - seeking help from friends and family;
 - removing tobacco products from her surroundings.
- The quit line counsellor recommends resources (printed material) to support the caller.
- The quit line counsellor closes the call by asking the caller to summarize action steps she will take to quit. The next call is scheduled. The quit line counsellor suggest topics that will be covered in the next call.

Second call

- During the second call the quit line counsellor checks on progress, including quit status, urge severity, use of medicines, and strategies the caller is using to cope with urges.
- The quit line counsellor reinforces success and helps the caller:
 - by problem-solving the management of urges that she is finding hard to control;
 - to learn about relapse prevention by educating her about avoiding, coping or escaping when feeling urges (ACE model);
 - by encouraging the caller to continue using her nicotine patch medication since it seems to be helping.

Ongoing calls

During ongoing calls the quit line counsellor follows up on progress, confirms quit status, reinforces success, provides practical problem-solving for any urges the caller is still experiencing, and plans for high-risk situations to ensure long-term success. The quit line counsellor helps the caller to identify the benefits of being quit and ways to reward herself for staying quit.

PRESENTATION

3. BENEFITS OF QUIT LINES (15 minutes)

Quit lines are a public health approach to offering help to tobacco users and reducing the prevalence of tobacco use. They have a number of potential benefits to different segments of society. From the perspective of health ministries charged with improving the health of a population by decreasing tobacco use, quit lines provide an efficient means of delivering evidence-based treatment. Quit lines can:

- create a central resource serving as a direct provider of evidence-based services and information;
- serve as a portal for other tobacco treatment services, including community-based face-to-face counselling, medications and Internet-based services;
- potentially reach at least 4–6% of total tobacco users per year in a country;
- be promoted relatively easily and generally meet with broad acceptance by the public;
- serve as a source of training and experience for counselling professionals and paraprofessionals, increasing the pool of tobacco treatment specialists in a country.

From the perspective of individual health-care providers, quit lines can:

- offer providers an easy, convenient, consistent, evidence-based referral resource to help their patients;
- increase health-care provider willingness to conduct routine brief tobacco interventions with tobacco users;
- increase the number of their patients making quit attempts who use evidence-based approaches such as counselling and cessation medications;
- help ensure that patients taking medication receive optimal instructions on use and counselling support, thus increasing effectiveness.

Potential added benefits of quit lines to broader tobacco control can:

- help normalize quitting and stimulate quit attempts even among those who do not call, which is necessary to decrease prevalence;
- increase support for tobacco control initiatives because they are tangible and offer direct help to tobacco users – some health ministries have leveraged positive support for quit-line services to help obtain or maintain general tobacco control funding;

- be used as “hotlines” to report violations of smoke-free legislation, thus encouraging community participation and supporting other tobacco control initiatives;
- ultimately increase the overall cessation rate while reducing relapse.

Finally, from the perspective of the individual tobacco user:

- help is available anywhere, at any time, at no cost to the tobacco user;
- quit lines offer confidential, personal and tailored support, motivating and supporting quit attempts;
- quit line service availability provides tangible evidence that society wants to help them quit, not punish and stigmatize them, thus creating an enabling environment.

4. RANGE OF SERVICES (10 minutes)

Tobacco quit lines provide a range of tailored and confidential evidence-based services that include the following:

- Telephone counselling is at the heart of quit line services. There is some variation in the number of calls provided, the amount of time spent on each call, and the counselling approaches (see below).
- Referral is possible to local in-person cessation support services that may include community-based groups and face-to-face counselling services. These resources can serve as an alternative to quit line services or can be an adjunct to the quit line service by providing additional sources of support.
- Printed materials such as quit guides can be provided.
- Many quit lines offer access to online support in the form of websites that have a variety of articles and interactive activities. Some web-based services provide community forums where users can share their experiences, get support from others who have quit, and offer their support to those who are trying to quit;
- Mobile text messaging (SMS) is being used by an increasing number of quit lines as a way to provide daily reminders about quitting. Some quit lines offer text-only support, while others use CHAT and emails.
- Quit lines offer cessation medication support, including educating callers on the types of quit medications that are available, how they can help the caller to quit, how they should be used to be most effective, and even dispensing these medicines to callers.

5. BASIC TENETS AND KEY CONSIDERATIONS OF TELEPHONE COUNSELLING (10 minutes)

5.1 The type of telephone counselling

Quit lines can provide different types of counselling services to a range of callers as a scalable alternative to group classes and individual face-to-face counselling. They provide callers with assistance that is easily accessible at any time, in any place and at no cost to the tobacco user.

5.2 Effectiveness

There is a strong evidence base for telephone counseling. After pooling nine clinical randomized trials (>24,000 participants), the 2006 Cochrane Review found a risk ratio of 1.37 (people calling the quit line and receiving multiple sessions of counseling were 37% more likely to quit successfully when compared with people receiving self-help materials or brief counselling at a single call). Telephone counselling not initiated by calls to helplines also increased quitting by 29% (the pooled effect of 44 studies, >24,000 participants). The United States Public Health Service conducted a similar analysis in 2008, finding an even higher odds ratio of 1.6. There was a wide range of effectiveness between different quit-line studies.

Quit line effectiveness increases as the number of calls increase. Three or more calls are more effective, and multiple calls are the most effective (i.e. seven calls). Multi-call randomized trial data is based on proactive call backs or appointments initiated by the quit line, not reactive follow-up that depends on the initiative of the quitter to re-establish contact.

5.3 The potential wide reach

The WHO FCTC Article 14 guidelines recommend quit lines as one of the population-wide approaches to supporting tobacco users to quit. When adequately funded and promoted, quit lines have the ability to reach up to 6% or more of tobacco users. Quit line services are free and easy to access. Tobacco users have been very willing to use tobacco quit lines and are very satisfied with quit line services.

5.4 A range of quit line caller needs

Quit lines provide services to a range of callers, including those who are thinking about quitting and those who are ready to quit. The counselling strategy for those who are not ready to quit (i.e. thinking about quitting) is different from the strategy used for those who are ready to quit. Friends and family members of tobacco users may also call and seek advice on how to help tobacco users in their life to quit.

5.5 Telephone counselling protocols

Quit lines offer a range of telephone counselling services according to the protocols based on best practices gathered from empirical evidence generated by scientific studies and clinical experience (see Module 10: The content of telephone counselling interventions).

Special population needs may include protocols for:

- women
- pregnant tobacco users
- adolescents
- persons over 65 years of age
- callers with mental health or substance use disorders
- smokers with smoking-related chronic illnesses.

5.6 Various helping styles

In some cultural settings callers to the quit line may look for a coach who takes the role of an expert and is more directive rather than a facilitator. The helping style established by each quit line will need to strike the right cultural balance between several factors such as:

- a directive versus supportive approach;
- an expert coach versus a facilitator;
- ascribed credibility versus achieved credibility.

6. THE ROLE OF THE TOBACCO QUIT LINE COUNSELLOR (10 minutes)

The role of the quit line counsellor is to provide personalized assistance to the caller regardless of how ready the person is to quit. It is the role of the counsellor to assess where the caller is in terms of readiness to quit and use the appropriate counselling approach and strategy.

It is very important that the counsellor is warm and empathetic. Many callers are embarrassed about calling for help and worry that the quit line will lecture or scold them. For many callers, friends or family have been critical of their tobacco use and callers may fear the quit line will take the same attitude with them. In demonstrating warmth and empathy the counsellor creates a therapeutic environment in which to help the caller.

Finally, it is important that the counsellor is highly knowledgeable about the quitting process and skilled in applying treatment strategies. It is the role of the counsellor to follow quit line treatment protocols to make sure that treatment is effective and safe.

PRACTICE

7. PRACTICE USING FACILITATIVE AND DIRECTIVE APPROACHES (15 minutes)

The quit line counsellor role requires a balance between being facilitative (collaborative) and being directive (taking an expert or educator role) when working with callers.

Work in pairs and practise using facilitative and directive approaches. Select a familiar topic and take turns talking about your topic for 3–5 minutes. Notice when you are being collaborative and when you are taking the expert role.

When was it useful to take the expert role and when was it useful to be facilitative?

Did you experience any challenges in remaining warm and empathetic when being more directive? Please describe:

EVALUATION

8. CONFIDENCE AND EXPECTATIONS (15 minutes)

Has your expectation of working with tobacco users as a quit line counsellor changed after learning about quit lines and the counsellor's role?

Rate your confidence in performing the quit line counsellor role using a scale of 1–10: _____

What is giving you confidence? What will it take to increase your confidence?

Module 2: Tobacco use and tobacco dependence

OBJECTIVES

Upon completion of this module participants will be able to:

- describe prevalence and patterns of tobacco use;
- describe the forms of tobacco delivery systems;
- describe the health, social and economic impacts of tobacco use and the benefits of quitting tobacco;
- describe the three elements of tobacco dependence (physical, psychological, and habitual or social challenges);
- describe nicotine addiction from smoking and use of oral tobacco;
- demonstrate the use of information about tobacco use, health impacts and tobacco dependence to educate and motivate callers during treatment.

AGENDA

1. Checking your knowledge of nicotine (20 minutes).
2. Prevalence and patterns of tobacco use (15 minutes).
3. The impact of tobacco use on tobacco users and others (10 minutes).
4. Benefits of quitting (10 minutes).
5. Tobacco dependence (10 minutes).
6. Using the knowledge of tobacco dependence to deliver counselling interventions (30 minutes).

PREPARATION

1. CHECKING YOUR KNOWLEDGE OF NICOTINE (20 minutes)

Tobacco and nicotine quiz

Consider each statement about nicotine and determine if it is truth or myth.

Question	Truth	Myth
There is no treatment for tobacco addiction		
Nicotine naturally occurs in tobacco		
Nicotine helps to make tobacco smoke smooth		
Nicotine is a stimulant		
Nicotine is the reason lungs turn black		
Nicotine increases blood pressure		
Nicotine turns teeth yellow		
Nicotine causes cancer		
Nicotine delivered by tobacco use is highly addictive		
Nicotine in high doses is a depressant		

PRESENTATION

2. PREVALENCE AND PATTERNS OF TOBACCO USE (15 minutes)

2.1 Prevalence of tobacco use

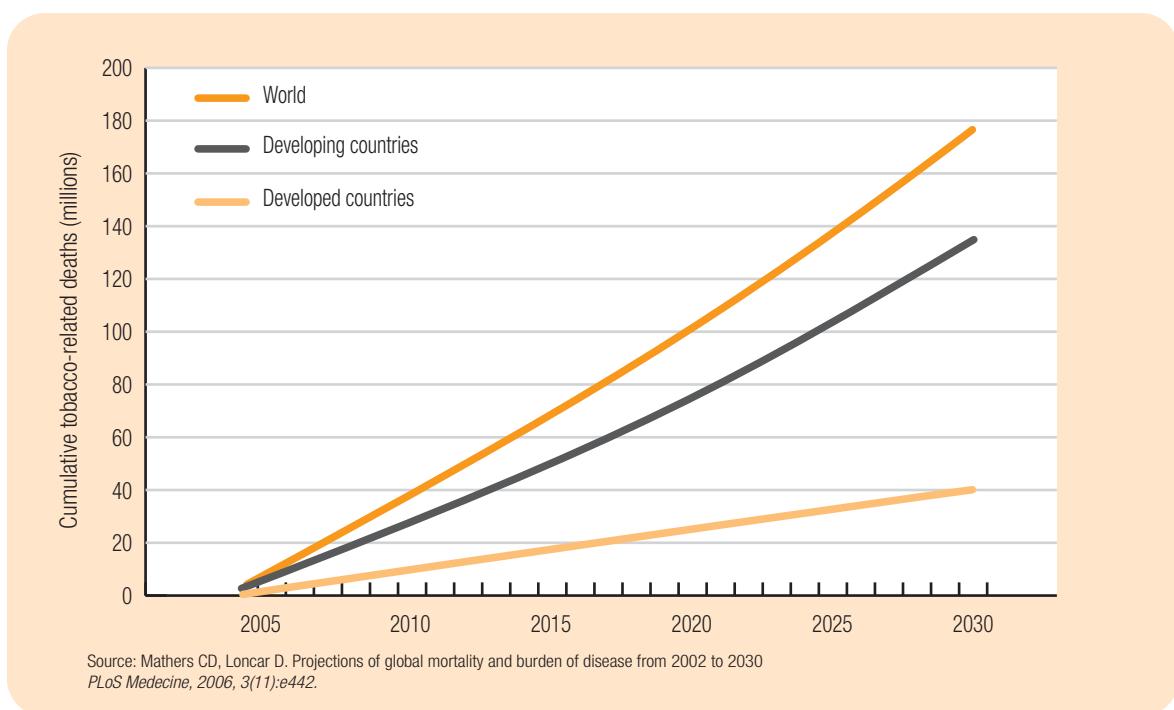
2.1.1 Cigarette smoking

Currently more than one billion people, one fourth of the world's adults, smoke cigarettes. Nearly 80% of them live in low- and middle-income countries. Unless urgent action is taken, the number of smokers worldwide will continue to increase.

2.1.2 Consumption of tobacco products

Consumption of tobacco products is increasing globally, though it is decreasing in some high-income and upper-middle-income countries. Tobacco use is growing fastest in low-income countries due to steady population growth coupled with tobacco industry targeting. Figure 1 shows that tobacco will kill over 175 million people worldwide between now and the year 2030.

Figure 1. Cumulative tobacco-related deaths, 2005–2030



2.1.3 Tobacco use among adolescents and women

Today, surveillance of tobacco use among young people in several countries has revealed that the problem is of equal concern in developed and developing countries. Statistics reveal that the use of any form of tobacco by 13–15-year-old students is greater than 10% (Table 1). In addition, almost one in four students (13–15 years of age) who ever smoked cigarettes smoked their first cigarette before the age of 10 years. Further, recent studies have revealed that there is little difference between the sexes in cigarette smoking or in use of other tobacco products.

Smoking prevalence of women is lower than that of men: women smoke at about one fourth the rate of men. In many countries, women have traditionally not used tobacco, but it has been increasing over the past 40 years.

In all WHO regions except Europe, girls aged 13–15 years of age are using tobacco at higher rates than women aged 15 and older. The rise in tobacco use among younger females in high-population countries is one of the most ominous potential developments of the epidemic's growth.

Because most women currently do not use tobacco, the tobacco industry aggressively markets to them to tap this potential new market.

Table 1. Global Youth Tobacco Survey measures of tobacco use, by sex and WHO region, 1999–2005

	Current any tobacco use*			Current cigarette smoking**			Current other tobacco use***		
	Total	Boy	Girl	Total	Boy	Girl	Total	Boy	Girl
Total	17.3 (14.8-19.8)	20.1 (16.7-23.5)	14.3 (11.5-17.1)	8.9 (7.2-10.6)	10.5 (8.1-12.9)	6.7 (5.0-8.4)	11.2 (9.7-12.7)	13.8 (11.7-15.9)	7.8 (6.0-9.6)
African Region	16.8 (14.1-19.5)	19.7 (15.8-23.6)	13.9 (10.8-17.0)	9.2 (7.0-11.4)	13.0 (9.4-16.6)	5.8 (3.5-8.1)	10.5 (8.3-12.7)	10.9 (8.0-13.8)	9.9 (7.3-12.5)
Region of the Americas	22.2 (19.8-24.6)	24.0 (21.0-27.0)	20.4 (17.6-23.2)	17.5 (15.2-19.8)	17.4 (14.7-20.1)	17.5 (14.9-20.1)	11.3 (9.8-12.8)	14.8 (12.6-17.0)	7.8 (6.2-9.4)
Eastern Mediterranean Region	15.3 (12.7-17.9)	18.8 (15.2-22.4)	11.3 (8.0-14.6)	5.0 (3.3-6.7)	6.7 (4.4-9.0)	3.2 (1.1-5.3)	12.9 (10.6-15.2)	15.6 (12.4-18.8)	9.9 (7.3-12.5)
European Region	19.8 (16.6-23.0)	22.3 (18.0-26.7)	17.0 (13.8-20.2)	17.9 (15.2-20.6)	19.9 (16.1-23.7)	15.7 (13.6-18.8)	8.1 (5.8-10.4)	10.0 (6.7-13.3)	6.0 (4.0-8.0)
South-East Asia Region	12.9 (10.2-15.6)	18.4 (14.3-22.5)	7.1 (4.7-9.5)	4.3 (3.1-5.5)	5.8 (4.4-7.5)	1.9 (1.0-2.8)	13.3 (12.3-14.3)	16.4 (15.0-17.8)	8.4 (6.8-10.0)
Western Pacific Region	11.4 (9.5-13.3)	15.0 (12.2-17.8)	7.8 (5.8-9.8)	6.5 (4.9-8.1)	9.9 (7.1-12.7)	3.3 (2.1-4.5)	6.4 (5.2-7.6)	7.7 (6.1-9.3)	5.4 (3.9-6.9)

Data are prevalence (95% CI).

* smoked cigarettes or used other tobacco products during the past 30 days.

** smoked cigarettes on 1 or more days in the past 30 days.

***used other tobacco products (e.g. chewing tobacco, snuff, dip, cigars, cigarillos, little cigars, pipe, bidis, waterpipe, or betel nut with tobacco) during the past 30 days.

Source: Warren CW et al. Global Tobacco Surveillance System (GTSS) collaborative group. Patterns of global tobacco use in young people and implications for future chronic disease burden in adults. *Lancet*, 2006, 367(9512):749–53.

2.1.4 Local and national patterns of tobacco use

For the profile of tobacco use in each specific country, please refer to the WHO tobacco control country profiles which were generated from data collected for the WHO report on the global tobacco epidemic, 2013: enforcing bans on tobacco advertising, promotion and sponsorship. The country profiles provide information about tobacco prevalence in 193 WHO Member States.

In terms of local patterns of tobacco use, please contact your local health authority for detailed data.

2.2 Tobacco/nicotine delivery systems

There is a wide range of tobacco products and the types and use patterns vary from country to country. Tobacco types typically include those that are smoked and those that are chewed (Table 2).

Table 2. Tobacco delivery systems

Types of tobacco that are smoked	Manufactured cigarettes	The most commonly used form of tobacco worldwide. These consist of tobacco that is processed with many chemicals and flavouring, and wrapped in paper. Some are filtered and some are not.
	Roll-your-own cigarettes	Typically hand-made or rolled by the smoker using a small machine. They are typically considered to be more damaging than manufactured cigarettes. Use of roll-your own cigarettes has been increasing as the price and tax on manufactured cigarettes has increased.
	Kreteks	Clove-flavoured cigarettes. The clove ingredient acts as an anaesthetic, which makes it easier for the user to inhale more deeply and can cause greater damage to the lungs than manufactured cigarettes.
	Bidis	Contain a small amount of tobacco that is rolled in dried leaves (usually tendu or temburni) and tied with a string. They typically deliver high levels of carbon monoxide and tar.
	Cigars	Made of a variety of cured and dried tobacco and wrapped in a tobacco leaf. Because they are often cured (fermented) they can contain high levels of carcinogens called tobacco-specific nitrosamines. Cigars come in many sizes with some containing as much nicotine as an entire pack of manufactured cigarettes. Small, cigarette-size cigars have become very popular with younger smokers in recent years, some of which are flavoured to make them more attractive to younger users. The nicotine content of these cigarette-sized cigars can be much higher than many manufactured cigarettes.
	Pipes	Made of clay, wood or stone materials. The tobacco is packed into the bowl, ignited and inhaled through the stem. Some pipe smokers do not inhale. Those pipe smokers who also smoke cigarettes, or who are former cigarette smokers, are much more likely to inhale pipe smoke.
	Water pipes, also known as shisha, hookah, narghile	Filter the tobacco smoke through water. The tobacco used in water pipes is often flavoured with fruit substances and ignited with pieces of burning charcoal. They are often perceived by the users as safer than other forms of smoked tobacco because of the water filtration. However, the water only cools the smoke and the users are exposed to high levels of tar and carbon monoxide.
	Electronic cigarettes	Look a little like a typical manufactured cigarette. They contain a nicotine solution (often glycol-based) that is heated by an element that is activated when the user puffs on it. The e-cigarette produces a vapour that contains nicotine and is inhaled into the lungs. E-cigarettes are produced by a variety of companies around the world, including tobacco companies. Some propose that e-cigarettes are safer than traditional cigarettes, but at the time of writing this manual there is little empirical data to support this. E-cigarettes are being researched and analysed to determine if they are safe to use and if they are effective in helping smokers quit.
Types of tobacco that are chewed include:	Moist snuff	Made up of ground tobacco that is either finely cut or coarsely cut, and is usually fermented. Some are flavoured, often with mint. The "chew" is placed between the user's cheek and gum and causes the user to spit. However, some experienced users do not spit, and swallow the tobacco juice. Moist snuff can contain high levels of nicotine and tobacco-specific nitrosamines (carcinogens) resulting from the fermentation process. Depending on where it is made, moist snuff is also called khaini, shammaah, naswa or nass.
	Snus	A type of moist snuff that is often pasteurized and refrigerated to prevent fermentation. It is typically inserted under the upper lip, and is sometimes wrapped in a small paper packet. The user usually does not have to spit. Typically used in Scandinavia, snus is now spreading to other parts of the world.
	Gutka	A packet of tobacco, crushed betel nut, lime and savoury flavourings. These are wrapped in a packet, often a leaf, and are chewed by the user.
	Dissolvable tobacco	Products being developed by the tobacco industry and coming onto the market with greater frequency and variety. They usually contain finely ground tobacco with flavourings which are placed in the mouth and which dissolve in a few minutes. They are being marketed to smokers for use "when you can't smoke".

3. THE IMPACT OF TOBACCO USE ON TOBACCO USERS AND OTHERS (10 minutes)

Brainstorming:

What is the impact of tobacco use on tobacco users and others?

Tobacco use will have both health and non-health impacts on tobacco users and others.

3.1 Health impact

Tobacco kills up to half of its users. As a leading cause of death and illness, tobacco kills more than 5 million people who directly use tobacco (both smoking and smokeless).

Second-hand smoke also kills. Second-hand smoke causes more than 600 000 premature deaths per year.

Smoking is bad for health because tobacco smoke contains more than 7000 chemicals, of which at least 250 are known to be harmful and at least 69 are known to cause cancer. Figure 2 shows some examples of the chemicals contained in tobacco smoke. Figure 3 illustrates that tobacco use and second-hand smoke damage every part of the body.

Smokeless tobacco is also highly addictive and causes cancer of the head and neck, oesophagus and pancreas, as well as many oral diseases. There is evidence that some forms of smokeless tobacco may also increase the risk of heart disease and low-birth-weight babies.

Figure 2. Chemicals in cigarette smoke



Source: WHO (2009). WHO report on the global tobacco epidemic, 2009: implementing smoke-free environments.

3.2 Economic impact of tobacco use

Tobacco imposes enormous economic costs on individuals, the family and the country.

Tobacco's economic costs include:

- direct costs:
 - tobacco-related death;
 - tobacco-related productivity losses;
- indirect costs:
 - health-care expenditures for smokers and people exposed to second-hand smoke;
 - employee absenteeism and reduced labour productivity;
 - fire damage due to careless smokers;
 - increased cleaning costs;
 - widespread environmental harm from large-scale deforestation, pesticide and fertilizer contamination, and discarded litter.

3.2.1 Costs to society

The estimated annual cost of tobacco use to societies globally is US\$ 500 billion, exceeding the total annual expenditure on health in all low-and middle-income countries.

Every country suffers huge economic losses due to tobacco use (see some examples in Table 3). Tobacco's total economic costs reduce national wealth in terms of gross domestic product (GDP) by as much as 3.6%.

Figure 3. Diseases caused by smoking and second-hand smoke

Smoking		Secondhand Smoke Exposure	
Cancers	Chronic Diseases	Children	Adults
Oropharynx Larynx Esophagus Trachea, bronchus, and lung Acute myeloid leukemia Stomach Pancreas Kidney and ureter Cervix Bladder	Stroke Blindness, cataracts Periodontitis Aortic aneurysm Coronary heart disease Pneumonia Atherosclerotic peripheral vascular disease Chronic obstructive pulmonary disease, asthma, and other respiratory effects Hip fractures Reproductive effects in women (including reduced fertility)	Middle ear disease Respiratory symptoms, impaired lung function Lower respiratory illness Sudden infant death syndrome	Nasal irritation Lung cancer Coronary heart disease Reproductive effects in women: low birth weight

Source: U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

Table 3. Cost* attributable to tobacco use (US\$) (2007 or latest available data)

USA	167.00 billion
Japan	62.39 billion
Germany	23.75 billion
Canada	17.00 billion
France	15.30 billion
China	5.00 billion
Egypt	1.25 billion

* Direct health-care costs plus indirect costs, including productivity losses, absenteeism and other socioeconomic costs.

3.2.2 Costs to families and individuals

Another significant cost related to tobacco use is the suffering of families and individuals because of diminished quality of life, death and financial burden. “Smoking makes the poor poorer; it takes away not just their health but wealth.” (Dr. Bill O’Neill, Secretary of the British Medical Association Scotland, 2004).

Tobacco products are expensive. For example, the price of 20 Marlboro cigarettes could buy:

- a dozen eggs in Panama;
- one kilogram of fish in France;
- four pairs of cotton socks in China;
- six kilograms of rice in Bangladesh.

Tobacco use is costly with 5–15% of tobacco users’ disposable income spent on tobacco. Poor people often have to cut their expenditure on food and education.

4. BENEFITS OF QUITTING TOBACCO USE (10 minutes)

4.1 Health benefits

Quitting tobacco use saves lives and money. Fact sheet 1 summarizes the health benefits of smoking cessation.

4.2 Economic benefits

Quitting has clear economic benefits. The quit & save exercise can help you understand how much money you can save if you quit.

Quit & Save

How much money can you save if you quit?

Total money spent on tobacco per day	
Amount of money spent per month	
Amount of money spent per year	
Amount of money spent in 10 years	

What you can buy with the money saved?



5. TOBACCO DEPENDENCE (10 minutes)

Addiction to tobacco can be very strong and dependence can occur quickly. The three primary aspects of addiction to tobacco are physical dependence, psychological connection, and social/habitual connection.

5.1 Physical dependence

Physical dependence is caused by the nicotine in tobacco. Smoked and oral forms of tobacco can deliver high levels of nicotine to the user. The user quickly becomes dependent on the nicotine in order to feel "normal". When tobacco use is interrupted for more than two hours, most users begin to experience nicotine withdrawal. Nicotine withdrawal symptoms can include anxiety, nervousness, headache, trouble concentrating, and difficulty sleeping to name a few. These symptoms often cause those trying to quit to fail due to extreme physical and mental discomfort. Nicotine withdrawal is strongest in the first week or two after quitting, but it can take much longer for some tobacco users to adjust to its absence.

Fact sheet 1: Health benefits of smoking cessation

A. There are immediate and long term health benefits of quitting for all smokers.

Time since quitting	Beneficial health changes that take place
Within 20 minutes	Your heart rate and blood pressure drop.
12 hours	The carbon monoxide level in your blood drops to normal.
2-12 weeks	Your circulation improves and your lung function increases.
1-9 months	Coughing and shortness of breath decrease.
1 year	Your risk of coronary heart disease is about half that of a smoker.
5 years	Your stroke risk is reduced to that of a non-smoker 5 to 15 years after quitting.
10 years	Your risk of lung cancer falls to about half that of a smoker and your risk of cancer of the mouth, throat, esophagus, bladder, cervix, and pancreas decreases.
15 years	The risk of coronary heart disease is that of a non-smoker's

B. Benefits for all ages and people who have already developed smoking-related health problems. They can still benefit from quitting.

Time of quitting smoking	Benefits in comparison with those who continued
At about 30	Gain almost 10 years of life expectancy
At about 40	Gain 9 years of life expectancy
At about 50	Gain 6 years of life expectancy
At about 60	Gain 3 years of life expectancy
After the onset of life-threatening disease	Rapid benefit, people who quit smoking after having a heart attack reduce their chances of having another heart attack by 50 per cent.

C. Quitting smoking decreases the excess risk of many diseases related to second-hand smoke in children, such as respiratory diseases (e.g., asthma) and ear infections.

D. Quitting smoking reduces the chances of impotence, having difficulty getting pregnant, having premature births, babies with low birth weights, and miscarriage.

Nicotine is the addictive chemical in tobacco, whether smoked or taken orally. Nicotine from cigarettes and other smoked tobacco products can reach the brain very quickly – as soon as 10 seconds after taking a puff. For smokers, nicotine is distilled from the burning of tobacco where it rides on droplets of tar to the user's lungs. It then binds to nicotinic receptors in the brain, stimulating a chemical reaction. This chemical reaction releases dopamine which rewards the user with a pleasurable feeling and reinforces the act of smoking or chewing.

Tobacco is often treated with ammonia to alter the nicotine molecule chemically. This treatment results in a product known as "free nicotine" or "base nicotine" which is delivered more quickly to the user's brain than untreated nicotine. The fast delivery of nicotine makes it more addictive. Most of the highest-selling brands of cigarettes, such as Marlboro, contain high levels of "free nicotine".

Nicotine is not known to be carcinogenic. It can increase heart rate and blood pressure. Cigarette filters do not reduce the delivery of nicotine to the smoker.

5.2 Psychological aspects of tobacco dependence

Psychological aspects of tobacco dependence affect how the user manages feelings and emotions. Many people use tobacco to cope with sadness or boredom, or to celebrate success and happiness. Nicotine withdrawal can augment these negative feelings, making it more difficult to quit and stay quit. In the immediate days and weeks after quitting, many tobacco users report stronger feelings until their bodies adapt to the absence of nicotine.

5.3 Habitual or social connections

Habitual or social connections come about as smokers and chewers use tobacco for extended periods of time. Use of tobacco becomes associated with daily activities (after meals, driving, talking on the telephone, etc.). These are sometimes called paired behaviours. When tobacco use is paired with other activities, it becomes difficult to quit. When the smoker is around other tobacco users it can be difficult to quit and stay quit.

PRACTICE

6. USING THE KNOWLEDGE OF TOBACCO DEPENDENCE TO DELIVER COUNSELLING INTERVENTIONS (30 minutes)

This activity will provide you with the opportunity to apply information about tobacco use and tobacco dependence and practice by talking about health impacts.

Work with the person sitting next to you to practise how you would share information about the impact of tobacco use and tobacco addiction with a quit line caller.

You will need to describe information about:

- Why tobacco is addictive.
-
-
-

- The three elements of tobacco addiction.

- The health impact of using tobacco and the health benefits of quitting.

EVALUATION (10 minutes)

Please volunteer to read out your information given to the quit line caller.

How comfortable did you feel sharing your knowledge with the quit line caller?

Answer key – Tobacco and Nicotine Quiz

1. There is no treatment for nicotine addiction: (Myth)
2. Nicotine naturally occurs in tobacco: (Truth)
3. Nicotine helps to make tobacco smoke smooth: (Myth)
4. Nicotine is a stimulant: (Truth)
5. Nicotine is the reason lungs turn black: (Myth)
6. Nicotine increases blood pressure: (Truth)
7. Nicotine turns teeth yellow: (Truth)
8. Nicotine causes cancer: (Myth)
9. Nicotine delivered by tobacco use is highly addicting: (Truth)
10. Nicotine in high doses is a depressant: (Truth)

Module 3: Practical and theoretical approaches for those ready to quit

OBJECTIVES

Upon completion of this module participants will be able to:

- recognize that quit line interventions are based on both practical approaches and theoretical approaches;
- describe and apply practical approaches to help callers who are ready to quit;
- Recognize that key constructs of social cognitive theory, such as personal, behavioural, environmental and self-efficacy factors, can be used by quit line counsellors to help callers gain insight into their use of tobacco and to quit;
- describe and apply the basic principles of counselling and strategies used to treat tobacco dependence for those who are ready to quit, including:
 - cognitive behavioural therapy
 - motivational enhancement
 - practical problem-solving (skill-building)
 - persuasive education
 - modelling
 - reinforcement.

AGENDA

1. Introduction to social cognitive theory (20 minutes).
2. Practical and theoretical approaches to promote behaviour change (60 minutes).
3. Practice in applying intervention strategies (10 minutes).
4. Role play: intervention strategies (20 minutes).
5. Experience in applying practical and theoretical approaches (10 minutes)

PREPARATION

1. INTRODUCTION TO SOCIAL COGNITIVE THEORY (10 minutes)

Brainstorming:

What challenges do you anticipate callers will face when trying to quit tobacco?

The challenges can be classified as three types according to social cognitive theory:

Domain	Description	Challenge
Personal	Biological and thoughts and emotions	
Environmental	Social and physical	
Behavioural	Automatic and conscious	

Please consider these challenges listed below and think of other challenges to add to the list?

Challenge	Domain	Strategy
Strong urges. Does not have the skills to avoid smoking in the car, with coffee or after meals.	Behavioural	Client needs new skills (skill-building, modelling, education)
Unsure how to go about quitting. Does not have knowledge of successful quitting strategies/quit medication.	Behavioural	Client needs information on successful quitting strategies (education)
Unproductive thoughts. Keeps thinking "I had a puff of a cigarette; I may as well start smoking again".	Personal (cognitive)	Client needs to break thinking errors (cognitive behavioural therapy)
Lives with other smokers and faces being around other smokers / tobacco-users.	Environmental	Client needs skills to cope or avoid other smokers (skill-building)
Keeps postponing start date.	Personal (cognitive unproductive thoughts, low self-efficacy), or behavioural (lack of skills)	Client needs to work on motivation/ confidence (motivational enhancement)
Has strong cravings first thing in the morning	Personal (biological)	Client can use coping strategies such as mixing up morning routine, etc.

Brainstorming:

What do callers need in order to overcome challenges?

Quit line counsellors might need to understand and use different strategies to help callers achieve their goals according to different types of challenge/barrier.

PRESENTATION

2. PRACTICAL AND THEORETICAL APPROACHES TO PROMOTE BEHAVIOUR CHANGE (60 minutes)

The quit line counselling intervention is based on two approaches: practical approaches and theoretical approaches.

2.1 Practical approaches

Practical approaches are based on what has been empirically proven to help tobacco users quit. The USA's clinical practice guideline¹ summarizes common elements of practical counselling:

- Recognize danger situations – identify events, internal states or activities that increase the risk of smoking or relapse.
- Provide basic knowledge/information. This approach provides basic information about the nature of tobacco use and quitting.
- Develop coping skills – identify and practise coping or problem-solving skills intended to cope with danger situations/urges to use tobacco.
 - Behavioural coping skills
 - ◆ This approach helps the tobacco user recognize dangerous situations (other smokers, situations where alcohol is used, triggers to smoking/using tobacco, or stress).
 - ◆ Identify ways to cope with urges that are sustainable and specific to the situation. These can include substitutes (oral or hand to mouth); distractions, delaying tactics, changes in routine, etc.
 - Cognitive coping skills
 - ◆ Provide the quitter with the ability to recognize unproductive thoughts and replace them with productive thoughts. For instance, unproductive thought "I am really stressed and I want a cigarette now" should be replaced with "Having a cigarette is really not going to help my stress and I am trying to quit smoking, so maybe I will go for a short walk instead".

2.2 Theoretical approaches

Theoretical approaches are based on intervention content according to established theories on how people change behaviours. A commonly used theoretical approach to quitting is social cognitive theory. Social cognitive theory acknowledges that, as a person changes his or her behaviour, it requires changes both in the environment (including interpersonal relationships) and in the person. Social cognitive theory evolved from social learning theory which suggests that people learn not only from their own experiences but by observing the actions of others and the benefits of those actions (modelling).

Social cognitive theory is a complex model and includes personal, behavioural and environmental factors. Social cognitive theory describes how personal factors (P), environmental factors (E) and human behaviour (B) influence each other in ways that can promote healthy or unhealthy behaviours. These factors can be used by the quit line counsellor to help callers increase their self-efficacy in their ability to quit and gain insight into their use of tobacco. This can lead to a well-thought-out plan to quit that can address nicotine dependence (such as using quit medications), urges to use tobacco (developing and using coping strategies), and modifying their environment to support quitting (such as avoiding other smokers and removing tobacco products from their surroundings).

According to social cognitive theory, self-efficacy, or a person's sense of control over his or her environment and behaviour, is central to successful behaviour change. Self-efficacy beliefs are cognitions that determine whether behaviour change will be initiated, how much effort the person will expend, and how long the new behaviour will be sustained in the face of obstacles and challenges.

Key constructs of social cognitive theory are described in Table 4. They include reciprocal determinism, behavioural capacity, expectations, self-efficacy, observational learning and reinforcements.

1. Clinical practice guideline: treating tobacco use and dependence: 2008 update. Rockville, MD: US Department of Health and Human Services; 2008.

Table 4. Social Cognitive Theory

Concept	Definition	Potential Change Strategies
Reciprocal determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	Consider multiple ways to promote behavior change, including making adjustments to the environment or influencing attitudes
Behavioral capability	Knowledge and skill to perform a given behavior	Promote mastery learning through skills training
Expectations	Anticipated outcomes of a behavior	Model positive outcomes of healthful behavior
Self-efficacy	Confidence in one's ability to take action and overcome barriers	Approach behavior change in small steps to ensure success; be specific about the desired change
Observational learning (modelling)	Behavioral acquisition that occurs by watching the actions and outcomes of other's behavior	Offer credible role models who perform the targeted behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	Promote self-initiated rewards and incentives

Source: Theories at a glance: a guide for health promotion practice, 2nd ed. Bethesda, MD: National Institutes of Health; 2005.

2.3 Combining practical and theoretical approaches

It is common for quit lines to combine practical counselling approaches with theoretical models. Careful attention should be given to integrating the two approaches. There are several intervention strategies that are proven to help tobacco users to quit and which fall under the practical and theoretical approaches identified above. These strategies can include:

- education, persuasive education
- skill-building, practical problem-solving
- cognitive behavioural therapy
- modelling
- reinforcement
- behavioural contracting
- motivational interviewing.

The quit line counsellor needs to apply different intervention strategies to develop a plan based on different types of gaps/ barriers that the caller deals with when trying to quit tobacco.

The following table summarizes these intervention strategies and when you would apply them.

Intervention strategies	Description	When to apply
Education/persuasive education	This is intended to provide the caller with information that overwhelmingly supports the concept or action being addressed. It seeks to identify misconceptions or misinformation that the caller may have. An example of this may be the belief that approved quit medications are more dangerous than continuing smoking.	Presenting new information to build a stronger quit plan or motivation.
Skill-building (practical problem-solving)	This is a very important tool and is used to help callers develop the skills they need to achieve their goal of quitting and staying quit. Skill-building can be used when a caller has strong motivation but is unsure of what to do or how to take the next steps. An example may be callers who recognize when and where they smoke but are not sure how to avoid and deal with triggers to smoke. The counsellor can use skill-building to help a person develop effective coping strategies to address triggers and urges to use tobacco.	Facilitating the development of skills needed to perform necessary behaviours.

Intervention strategies	Description	When to apply
Cognitive behavioural therapy	This is a therapeutic treatment for providing callers with skills for changing unproductive thoughts and behaviours that sabotage their quit process. Cognitive behavioural therapy targets a thinking pattern or belief that is inconsistent with a desired change. The strategy can be useful when a caller has an unhelpful thought, belief or expectation.	A counselling strategy to address unhelpful thoughts that get in the way of changing behaviour, or when a person's motivation (reason for quitting) seems somewhat vague and would benefit from further reinforcement.
Modelling	This is used to help callers learn from the success of others in their life who have had success in quitting tobacco or in making other significant changes in behaviour that can be applied to quitting tobacco.	The process of learning new behaviours or skills by watching the actions of other people and the outcomes of their actions.
Reinforcement	This is used to express confidence in the success the caller has achieved and the steps he or she has taken to engage successfully in the quitting process. When a caller has been actively engaged and is successful in quitting, reinforcement can be used to help the person sustain these effective actions. An example of this is when the counsellor supports callers in the way they have been using their quit medications and the strategies they have used to manage urges to smoke after quitting. In this situation reinforcement is used to encourage callers to continue doing what they have been doing as it has yielded success. This strategy is effective in enhancing the caller's self-efficacy in that it enhances both motivation and confidence in the caller's ability to stay quit.	Validating successful or effective behaviours the client is already doing.
Motivational interviewing (MI)	This is a directive counselling approach that is used to facilitate the change process. The goal is to enhance motivation for change by enabling the client to identify and resolve ambivalence. This strategy is useful for callers not ready to quit.	Using open-ended questions and reflections with the objective of resolving a person's diminished motivation to quit.
Behavioural contracting	This is a formal agreement outlining a promise to adhere to a behaviour change plan. Well written plans are SMART (specific, measurable, attainable, relevant and timely). Behavioural contracts can include rewards for performing the behaviour or consequences for not following through with the plan.	Creating a sense of accountability to increase the chances that a client will follow up on specific behavioural strategies.

PRACTICE

3. PRACTICE: APPLYING INTERVENTION STRATEGIES (10 minutes)

Review the scenarios. Then match each scenario to the intervention strategy descriptions found below the scenarios.

Scenario	Intervention strategy
1. Challenge: "I really enjoy smoking after a long day at work." Quit line counsellor's strategy: develop alternative ways of rewarding self, such as watching favorite show after work.	
2. Challenge: "Patches? No thanks. Why would I want to substitute nicotine for nicotine?" Quit line counsellor's strategy: explain how nicotine replacement therapy works and that people are twice as successful when they use it.	
3. Challenge: "If I quit, I won't be able to bond with my partner, because we usually smoke together after work." Quit line counsellor's strategy: help the caller create an alternative, positive belief such as: "I will be able to bond with my partner cooking dinners, since we both really enjoy cooking."	
4. Challenge: "I've been quit for two weeks! I tobacco proofed, and now when I feel stressed, I call a friend instead of lighting up. I just hope I can keep this up and stay quit forever this time." Quit line counsellor's strategy: highlight the behaviour changes; explain that if the caller continues to do these things, she will stay smoke-free.	

Scenario	Intervention strategy
5. Challenge: "I have always smoked with my coffee. I don't even know what coffee without a cigarette would look like." Quit line counsellor's strategy: suggest that caller observes nonsmoking room-mates' morning routine; document things that might work for the caller as well	

Intervention strategy descriptions
A. Skill-building: The quit line counsellor teaches the caller explicit steps regarding how to make a positive behaviour change. Before a quit line counsellor can use skill-building, a caller must understand the importance of making the positive behaviour change.
B. Education: The quit line counsellor gives the caller information or explains the benefits of a behaviour change. Education can help callers change their perspective and feel more motivated to make a behaviour change.
C. Cognitive behavioural therapy: The quit line counsellor pinpoints callers' negative thoughts or predictions which lead to unhealthy behaviours. The quit line counsellor then helps callers create alternative, positive thoughts or predictions, which will lead towards healthy behaviour.
D. Reinforcement: The quit line counsellor recognizes that a caller has made a positive behaviour change and responds in a way that encourages the behaviour to happen again. The quit line counsellor can push callers to reinforce themselves if the counsellor raises callers' awareness of their own positive behaviour changes.
E. Modelling: The quit line counsellor directs the caller to observe someone (e.g. the quit line counsellor, friend or family member) demonstrate a healthy behaviour that the caller is having trouble demonstrating. Modelling can help a caller visualize the behaviour.

Answers:

Scenario 1. A – skill-building; Scenario 2. B – education; Scenario C – cognitive behavioural therapy; 3. Scenario 4. D – reinforcement; Scenario 5: E – modelling.

4. ROLE PLAY: INTERVENTION STRATEGIES

Work in small groups. Your group will be assigned an intervention strategy. Take 10 minutes to plan a brief activity or role play to illustrate your assigned intervention strategy. Your small group will present to the larger group. The rest of the group will guess which intervention strategy you are demonstrating.

Create your own scenario or use a sample scenario below:

Cognitive behavioural therapy

Quit line counsellor explains to the caller how thoughts can impact behaviours and by changing how we think we can change how we act.

Persuasive education

Quit line counsellor gives the caller information on why using quit medication is important.

Reinforcement

Quit line counsellor summarizes all the effective strategies that the caller uses to stay quit and emphasizes that using these strategies will help the caller stay quit in the long term.

Modelling

Quit line counsellor suggests that the caller observes co-workers who already quit to learn about strategies and substitutes they are using to stay quit at work.

Skill-building

Quit line counsellor gives the caller suggestions on how to avoid smoking with coffee, in the car or in social situations.

EVALUATION (10 minutes)

What did you learn about different intervention strategies?

Module 4: Practical and theoretical approaches for those not ready to quit

OBJECTIVES

Upon completion of this module participants will be able to:

- recognize what type of caller is likely to benefit from the use of the motivational interviewing (MI) approach to counselling;
- describe and apply the spirit, principles and basic skills of MI to help people who are not ready to quit, including:
 - spirits of MI (collaboration, evocation, autonomy)
 - key counselling principles of MI
 - basic skills of MI (OARS).

AGENDA

1. The challenges of helping people change when they are not ready to do so (15 minutes).
2. Introduction to motivational interviewing (30 minutes).
3. Basic Motivational Interviewing Skills(20 minutes).
4. Two phases of motivational interviewing (20 minutes).
5. How to conduct a motivational interviewing session (20 minutes).
6. Applying motivational interviewing (10 minutes).
7. Role play demonstration: building motivation for the client not ready to quit (15 minutes).
8. Practice: motivational interviewing (30 minutes).
9. Evaluation (30 minutes).

PREPARATION

1. THE CHALLENGE OF HELPING PEOPLE TO CHANGE WHEN THEY ARE NOT READY TO DO SO

Work in pairs. Ask your partner to identify one behaviour that it would be good for him or her to change but which they are not motivated enough to start working on. Next take turns trying to convince your partner to make the change.

What worked in convincing someone to work on a goal they are not motivated to work on (if anything)?

PRESENTATION

2. INTRODUCTION TO MOTIVATIONAL INTERVIEWING (MI) (30 minutes)

2.1 Definition and goal of MI

MI is a directive, patient-centred counselling approach that enhances motivation for change by helping patients to clarify and resolve ambivalence about behaviour change. The goal of MI is to increase the person's intrinsic motivation based on his or her own personal goals and values.

2.2 Basic assumption of MI

Intrinsic motivation is a state of readiness to change. It relates to the importance of change and confidence in one's ability to change. It is not a patient trait and it can be influenced by interpersonal interaction.

People who consider making a change often have mixed feelings, or ambivalence. Ambivalence is a common stage in the process of change. Ambivalence leads to discrepancy between one's current behaviour and personal goals, values and desires. A person who perceives this discrepancy can be motivated to change.

2.3 The spirit of MI

MI is based on three key elements: collaboration, evocation and autonomy.

Collaboration	Collaboration is grounded in creating a trusting relationship between the quit line counsellor and the client. Using MI, the quit line counsellor works in partnership with the client rather than serving as the "expert" who is imposing their perspective.
Evocation	Evocation recognizes that client can best identify and express their own reasons for engaging in behaviour change, and that these changes are more likely to be lasting when arrived at internally rather than being imposed by the quit line counsellor. It is the role of the quit line counsellor to draw out these motivations from the client.
Autonomy	Autonomy asserts that it is the client's responsibility to change. It is intended to empower them and give them the responsibility to make the necessary changes.

2.4 The core principles of MI

The core principles of MI include:

- expressing empathy
- supporting self-efficacy
- developing discrepancies
- rolling with resistance.

2.4.1 Express empathy

What do you already know about empathy in your role as quit line counsellor?

Why does showing empathy help promote behaviour change?

How can you demonstrate empathy?

Expressing empathy is demonstrated by:

- understanding without judging, criticizing or blaming;
- being willing to accept a patient's position (i.e. stage of readiness to quit);
- demonstrating a desire to understand the patient's perspectives (recognizing that you have to agree with them).

2.4.2 Develop discrepancy

Change is motivated by a perceived discrepancy between present behaviours and personal goals or values ("where they are and where they want to be"). This can be done by helping callers identify what is important to them in their life and how smoking or tobacco use fits in with those values. When clients realize that their behaviours and values are not aligned, a powerful transition can take place.

Example of developing discrepancy:

Patient: "I want to be a good role model for my children"

Quit line counsellor: "How does smoking fit in with this goal?"

What are some ways the quit line counsellor can help a client see this discrepancy?

Strategies can include:

- comparing advantages and disadvantages;
- considering expectations for the future and whether continuing the behaviour helps achieve future goals;
- considering whether values align with behaviour.

2.4.3 Roll with resistance

Arguing with or pushing clients usually has a negative effect.

Resistance is a quit line counsellor problem, not a client problem. When the quit line counsellor encounters resistance it is a signal for the quit line counsellor to change their approach rather than directly confronting the issue. Resistance is clearly present when quit line counsellors feel as if they are lecturing or the interaction becomes an argument. Continuing with these approaches will likely only result in greater resistance and will further erode the therapeutic relationship. Causes of resistance can be:

- misjudging the client's readiness to quit;
- moving ahead too quickly when the client is not ready to take that step;
- arguing with or lecturing the client (this can be perceived by the participant as judgemental and/or parental);
- taking control away from the client.

Strategies can include:

- Re-assess readiness: the counsellor may have misinterpreted how ready the client was to change.
- Reflective listening: the counsellor should make sure the client's feelings are heard by using reflective listening and summarizing.
- Emphasize personal choice and control: the quit line counsellor can effectively put the decision-making choice in the client's lap so the client feels in control.

2.4.4 Support self-efficacy

Participants are more likely to be successful when they have high self-efficacy. We can help them develop self-efficacy from four sources:

- Mastery experience: one way this can be accomplished is by providing opportunities for the client to try short “practice” quits prior to the planned quit date.
- Observation of others’ performance: observing what others do to cope with urges and successfully quit tobacco.
- Verbal/social persuasion: providing encouragement and reframing previous quit attempts as part of the quitting/learning process.
- Emotional and physiological arousal: relaxation techniques, strategies to minimize stress and elevate mood can be helpful.

Below is a summary of strategies for applying the principles of MI:

Express empathy	Use open-ended questions, affirming, listening reflectively and summarizing in order to understand the client’s perspectives without judging, criticizing or blaming. Examples: “How important do you think it is for you to quit smoking?” “What might happen if you quit?” “So you think smoking helps you maintain your weight.” “What I have heard so far is that smoking is something you enjoy. On the other hand, you are worried you might develop a serious disease.” Express your willingness to accept “where” a patient is (his/her stage of readiness to quit). For instance, “I hear you saying you are not ready to quit smoking right now. I’m here to help you when you are ready.”
Develop discrepancy	Use strategies to assist the patient to identify discrepancy and move forward change. Highlight the discrepancy between the patient’s present behaviour and expressed priorities, values and goals. For instance, “It sounds like you are very devoted to your family. How do you think your smoking is affecting your children?”
Roll with resistance	Use strategies to re-assess readiness, and for reflective listening. Example: “You are worried about how you would manage withdrawal symptoms.” Emphasize personal choice and control. Example: “Would you like to hear about some strategies that can help you address that concern when you quit?”
Support self-efficacy	Help the patient identify and build on past successes. Example: “So you were fairly successful the last time you tried to quit.” Offer options for achievable small steps towards change, such as: <ul style="list-style-type: none">• read about quitting benefits and strategies;• change smoking patterns (e.g. no smoking in the home);• ask the patient to share his or her ideas about quitting strategies;• try quitting smoking for one or two days. Arrange for the patient to observe role models who quit smoking successfully. Encourage and convince the patient that success is a result of self: “I have tried 16 times to quit smoking.” “Wow, you’ve already shown your commitment to trying to stop smoking several times. That’s great! More importantly you’re willing to try again.” Teach the patient relaxation techniques to minimize stress and to elevate mood.

3. BASIC MOTIVATIONAL INTERVIEWING SKILLS (30 minutes)

“OARS” is an acronym for the basic MI skills. OARS stands for:

- Open-ended questions
- Affirmations
- Reflective listening
- Summarizing.

Skill	Description
Open-ended questions	Allow callers to tell you what is important to them. The benefits to the quit line counsellor from open-ended questions include the opportunity to learn more about a client and to create a positive therapeutic alliance. Open-ended questions shed light on: <ul style="list-style-type: none"> • Problem recognition: how does the client feel about his/her current tobacco use or health? • Expression of concern: what does the client feel about his/her current tobacco use (or health)? • Intention for change: what would the client like to do about this? • Optimism: what makes the client feel that now is a good time to quit?
Affirmations	Help the participant to feel heard, communicate respect and support good rapport.
Reflective listening	The quit line counsellor makes a statement to clarify meaning and to encourage continued exploration of content. Reflective listening lets callers know that you are listening and actually hearing what they are saying. It helps the caller clarify his/her thoughts by hearing you re-state what was just told you. Reflections should be offered judiciously and at strategic points in the discussion with the caller in order to avoid sounding like you are simply repeating what they say. <p>There are three types of reflection:</p> <ul style="list-style-type: none"> • Simple reflection: simply repeating or rephrasing what the caller has said. • Amplified reflection: similar to a simple reflection, but you amplify or exaggerate a point to the extent that the caller may disavow or disagree with it. • Double-sided reflection (linking summary): you capture both sides of the caller's stated ambivalence.
Summarizing	This can be used to gather information and highlight important parts of what was said by the caller. It further tells callers that you are really hearing them, and can be used to elicit more information from them.

The quit line counsellor can use the OARS strategies to motivate clients through the change process by eliciting self-motivational statements, or “change talk”.

4. TWO PHASES OF MOTIVATIONAL INTERVIEWING (20 minutes)

4.1 Two phases of MI

MI can be seen as occurring in two phases, with different but somewhat overlapping goals. Phase 1 involves building intrinsic motivation for change. The overall goal in Phase 1 is to use the OARS strategies to resolve ambivalence and build motivation for change. The amount of work to be done will depend on the person’s starting point. If the person is starting far down the mountain slope of motivation, this can feel like a long and gradual process. At some point, the motivation for quitting peaks enough to begin talking about strategies rather than reasons for change. Phase 2 involves strengthening commitment to change and developing a plan to accomplish it. Where is the transition point? Phase 2 of the MI can begin when you hear people present some change talk.

4.2 Change talk

When you hear callers use change talk, or self-motivating statements, you get a signal that they are thinking about the possibility of change in the present or future. You can reinforce change talk and work with callers toward change. These self-motivational statements can be classified as:

Desire	“I really want to be a nonsmoker.”
Ability	“I’ve quit before.”
Reason	“I’d have white teeth if I quit.”
Need	“I really have to do this.”
Commitment language	“I’m going to do this.”

Once a caller has presented some change talk, the quit line counsellor can start to work with the caller to identify next steps (action steps). It is usually best to allow the caller to come up with ideas before offering your own. However, counsellors should exercise their expertise to identify meaningful next steps that move the caller closer to the goal of quitting.

If change talk is not forthcoming, the quit line counsellor can use the following strategies to elicit change talk, thereby motivating clients to commit to change:

Strategy	Example
Ask evocative/open-ended questions	When a change talk theme emerges, ask for more details: <ul style="list-style-type: none">• In what ways?• How do you see this happening?
Ask for elaboration	What have you changed in the past that you can relate to this issue?
Ask for examples	When a change talk theme emerges, ask for specific examples. <ul style="list-style-type: none">• When was the last time that happened?• Describe a specific example of when this happens.• What else?
Looking back	Ask about a time before the current concern emerged: <ul style="list-style-type: none">• How have things been better in the past?• What past events can you recall when things were different?
Looking forward	Ask them about their hopes for the future if they make this change: <ul style="list-style-type: none">• How would you like things to be different?
Query extremes	Ask about the best and worst case scenarios to elicit additional information: <ul style="list-style-type: none">• 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?
Use change rulers	Ask open questions about where the caller sees themselves on a scale of 1–10: <ul style="list-style-type: none">• On a scale where 1 is not at all important and 10 is extremely important, how important (need) is it to you to change _____?• What might happen that could move you from _____ to a _____ [higher number]?• How much do you want (desire) to quit?• How confident are you that you could quit and stay quit (ability)?• How committed are you to _____? (commitment)
Explore goals and values	Ask about the person's guiding values: <ul style="list-style-type: none">• What do you want in life?• What values are most important to you? (Using a values card sort can be helpful here).• How does this behaviour fit into your value system?
Come alongside	Explicitly side with the negative (status quo) side of ambivalence: <ul style="list-style-type: none">• Perhaps _____ is so important to you that you won't give it up, no matter what the cost.• It may not be the main area that you need to focus on in our work together.

5. HOW TO CONDUCT A MOTIVATIONAL INTERVIEWING SESSION (20 minutes)

5.1 Models and steps for conducting an MI session

There are some models and steps that can guide you to conduct an MI session.

5.1.1 The 5Rs model

The 5Rs – relevance, risks, rewards, roadblocks and repetition – are the content areas that should be addressed in a motivational counselling intervention. This model can be a very useful tool to guide the quit line counsellor in conducting an MI with those who are not ready to quit:

- **Relevance:** Engage the client in a discussion of why quitting is especially important to them. Motivational information has the greatest impact if it is relevant to them personally. Topics may include the client's health or existing chronic illnesses, family or social situation (e.g. having children in the home), age, gender and other important characteristics, such as prior quitting experience and personal barriers to quitting.
- **Risks:** Ask the client what he/she sees as the possible bad outcomes of continued use of tobacco. This can focus on immediate risks (e.g. shortness of breath), long-term risks (e.g. lung cancer), and the effect of their smoking on those around them (e.g., spouse, partner, and children).
- **Rewards:** Engage the caller in a discussion of how he/she sees quitting benefitting them. Ask for their ideas and then offer suggestions based on what you have learned about them.

- **Roadblocks:** Help identify barriers to the client making a quit attempt and offer solutions that may include problem-solving counselling or quit medications. Some roadblocks may be personal (e.g. fear of nicotine withdrawal, fear of failure or weight gain), while others may be environmental (e.g. being around other smokers at home or work).
- **Repetition:** Repeat assessment of the caller's readiness to quit – Would the caller like to be a non-tobacco user? Does the caller think he or she has a chance of quitting successfully? End positively if the caller is still not ready to quit. This approach should be taken each time the quit line has contact with the caller who is not motivated to quit.

If the caller does not think quitting is important and does not want to be a nonsmoker, the quit line counsellor should focus more time on "risks" and "rewards". If the caller does want to be a nonsmoker but does not think he or she can quit successfully, the quit line counsellor should focus more time on "roadblocks" to help the caller identify the challenges and develop the necessary skills (skill-building) to get started and effectively organize and carry out the quit attempt. Even if callers remain not ready to quit, end positively with an invitation to them to call back if they change their minds.

5.1.2 Six steps for conducting an MI session

Below is another example of six steps for conducting an MI session:

Steps	Examples
1. Set the agenda	Clarify the agenda around a target behaviour about which there is ambivalence. Try a series of special questions to help sort things out.
2. Ask what they like about using tobacco	Use statements: <ul style="list-style-type: none"> • "This is often an engaging surprise. However, it will work only if you are genuinely interested." Ask questions: <ul style="list-style-type: none"> • "What are some of the good things about your smoking/use of tobacco?" • "People usually use tobacco because there is something that has benefited them in some way. How has tobacco use benefited you?" • "What do you like about the effects of using tobacco?" Summarize the positives.
3. Ask what they don't like about using tobacco	Ask questions: <ul style="list-style-type: none"> • "Can you tell me about the down side?" • "What are some aspects you are not so happy about?" • "What are some of the things you would not miss?" Summarize the negatives.
4. Explore life goals and values	These goals will be the pivotal point against which cost and benefits are weighed. Ask questions: <ul style="list-style-type: none"> • "What sorts of things are important to you?" • "What sort of person would you like to be?" • "If things worked out in the best possible way for you, what would you be doing a year from now?" Use affirmations to support positive goals and values.
5. Ask for a decision	Restate their dilemma or ambivalence then ask for a decision. <ul style="list-style-type: none"> • "You were saying that you were trying to decide whether to continue using tobacco or quit." • "After this discussion, are you more clear about what you would like to do?" • "So have you made a decision?"
6. Goal setting – use SMART goals (specific, meaningful, assessable, realistic, timely)	Ask questions <ul style="list-style-type: none"> • "What will be your next step?" • "What will you do in the next one or two days?" • "Have you ever done any of these things before to achieve this?" • "Who will be helping and supporting you?" • "On a scale of 1 to 10, what are the chances that you will take your next step?" (If the answer is under 7, the goal may need to be more achievable.) If there is no decision, empathize with the difficulty of ambivalence and ask: <ul style="list-style-type: none"> • "Is there something else which would help you make a decision?" • "Do you have a plan to manage not making a decision?" • "Are you interested in reducing some of the problems while you are making a decision?" If the decision is to continue the behaviour, go back to explore the ambivalence.

5.2 Video demonstration of MI

Watch the video Monkey on my back. Part 1 demonstrates how a counsellor helps a client understand her options and the good and bad points about quitting. Identify the strategies the counsellor uses. See <http://www.motivationalinterviewing.info/video/>.

5.3 Using MI with those who are ready to quit

There are elements of MI that can be used with those who are ready to quit. Motivational enhancement is an adaptation of MI, and is a process by which the quit line counsellor seeks to assist the caller to maintain or increase motivation to quit. This can be done by helping the caller gain clarity on their reasons for wanting to quit which can then result in more decisive action.

This approach can be very helpful in situations where the client may not fully understand what being tobacco-free might be like. Motivational enhancement helps to increase self-efficacy and helps callers take greater control of their quitting process. While the target audience for MI is those who are not ready to quit, those who are ready to quit can also benefit from strategies designed to enhance their motivation and commitment to quit and stay quit.

PRACTICE

6. ROLE PLAY DEMONSTRATION: USING OARS (15 minutes)

Work in a group of three for a role play demonstration. Please volunteer to play one of the following roles:

- The caller: a 35-year-old woman working in a local grocery store. She has been smoking 20 cigarettes per day for 15 years. She has a 7-year-old son. She feels on one hand that smoking helps her calm down when she is feeling stressed and on the other hand that as a smoker she is not a good role model for her son.
- The quit line counsellor: focusing on using OARS to gain a better understanding of the caller, not trying to solve the caller's problem and giving advice.
- The observer: who uses the following tracking sheet to take note of OARS that the counsellor used during the role play.

OARS tracking sheet	
	Counsellor
Open-ended question	
Affirmation	
Reflection	
Summary	
Other	Closed question Opinion/advice Provide information/teaching Other

7. PRACTICE: MOTIVATIONAL INTERVIEWING (30 minutes)

Work in pairs and take turns role-playing a quit line counsellor to complete an MI session with the same caller using the six steps:

- set the agenda;
- ask about the aspects of using tobacco the caller likes;
- ask about the aspects of using tobacco the caller does not like;
- explore life goals and values;
- ask for a decision;
- set goals.

Use the same caller scenario as in section 6. Take 10 minutes for the first role play, and then switch roles.

EVALUATION (30 minutes)

One pair of participants should volunteer to perform your role play for the full group.

The other participants observe the MI role play and answer the questions:

- What MI strategies did the quit line counsellor use?
 - How did the caller respond?
-
-
-
-
-
-

Module 5: Pharmacotherapy

OBJECTIVES

Upon completion of this module participants will be able to:

- provide medication decision-support consistent with quit line protocols;
- describe the various tobacco cessation medicines, including dosing regimens, and accurate and clear information about how they are used;
- demonstrate the ability to deliver medication decision-support as part of the treatment plan;
- demonstrate problem-solving strategies for callers who report:
 - medicines are too expensive
 - experience of side-effects they believe are attributed to medicines;
- demonstrate the ability to reinforce ongoing medication use compliance during follow-up interventions.

AGENDA

1. Effective tobacco cessation medications (15 minutes).
2. Introduction to cessation medications (20 minutes).
3. Assessing the level of nicotine dependence (15 minutes).
4. Recommendations for use of NRT products (15 minutes).
5. Common barriers to using cessation medications (5 minutes)
6. Practice in recommending NRT treatment plans (30 minutes)
7. Decision-support for medication use (15 minutes).
8. Debriefing (10 minutes).

PREPARATION

1. EFFECTIVE TOBACCO CESSATION MEDICATIONS (15 minutes)

Brainstorming:

What effective tobacco cessation medications are currently available for treating tobacco dependence in your country?

Currently there are two types of effective tobacco cessation medications available:

- nicotine replacement therapy (NRT): nicotine gum, nicotine patches, nicotine nasal spray, nicotine inhaler, nicotine lozenges/sublingual tablets;
- non-nicotine medications: bupropion sustained release (SR), varenicline, cytisine, clonidine and nortriptyline.

In this module, you will have opportunities to discuss these medications, with the focus on NRT products.

PRESENTATION

2. INTRODUCTION TO CESSATION MEDICATIONS (20 minutes)

2.1 Why it is useful to use tobacco cessation medications

Tobacco cessation medicines help people quit by reducing nicotine withdrawal symptoms. Less nicotine withdrawal results in fewer and less strong cravings. Effective use of quit medications can help to prevent lapses and relapse. When those quitting tobacco couple the use of quit medication with use of behavioural coping strategies, they are addressing all three aspects of tobacco dependence: physical dependency, emotional urges, and social cues to use tobacco (USA Clinical practice guideline, 2008).²

2.2 Effectiveness data for tobacco cessation medications

Table 5 provides the effectiveness data for tobacco cessation medications. According to the USA clinical guidelines, NRT, bupropion and varenicline are first-line medications for treating tobacco dependence. Currently, NRT has the best balance of effectiveness, cost and safety. As a result, two forms of NRT (nicotine gum and nicotine patch) have been added to the WHO Model List of Essential Medicines.

Table 5. Summary of effectiveness data for tobacco cessation medications (abstinence at least six months) based on the latest Cochrane Reviews

Intervention	Comparator	Odds ratio (95% confidence interval)	Increased chances of quitting successfully
Nicotine replacement therapy (NRT)	Placebo	1.84 (1.71–1.99)	84%
Bupropion	Placebo	1.82 (1.60 to 2.06)	82%
Varenicline	Placebo	2.88 (2.40 to 3.47)	188%
Cytisine	Placebo	3.98 (2.01–7.87)	298%
Clonidine	Placebo	1.63 (1.22–2.18)	63%
Nortriptyline	Placebo	2.03 (1.48–2.78)	103%

2.3 Description of tobacco cessation medications

Table 6 summarizes the information on NRT, bupropion and varenicline in terms of what those medications are, the purpose of using them, available dosage, advantages and disadvantages, general guidelines for use, side-effects and warnings.

Some medications can be combined. Those that are most commonly combined include:

- nicotine patch plus another short-acting form of NRT, such as nicotine gum, lozenge, inhaler or nasal spray (Cochrane Review, 2013);³
- bupropion SR plus the nicotine patch (USA Clinical practice guideline, 2008).

These combinations of medications have been shown to improve quit outcomes safely over the use of a single form of medication, except for varenicline (Cochrane Review, 2013. Pharmacological interventions for smoking cessation: an overview and network meta-analysis.)

2. Clinical practice guideline: treating tobacco use and dependence: 2008 update. Rockville, MD: US Department of Health and Human Services; 2008. See section on Combining counseling and medication. Strength of evidence A, Table 6.19 on Common elements of practical counselling (problem-solving/skills training).

3. Cochrane Review. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. 2013.

3. ASSESSING THE LEVEL OF NICOTINE DEPENDENCE (15 minutes)

It is important for the counsellor to assess callers' levels of nicotine dependence. Strong nicotine dependence is a strong predictor of the difficulty a caller may have in quitting smoking and the assessment can help the counsellor recommend a dosage of NRT to tobacco users. The most commonly used assessment for nicotine dependence is the Fagerström test for nicotine dependence (FTND) which has six questions. The Heavy Smoking Index is a shorter version that has proved as effective and uses two questions.⁴

The two questions are:

1. How many cigarettes per day do you usually smoke?
a. 31+ = 3 points; **b.** 21–30 = 2 points; **c.** 11–20 = 1 point; **d.** 10 or fewer = 0 points.
2. How soon after waking do you smoke your first cigarette?
a. ≤ 5 minutes = 3 points; **b.** 6–30 minutes = 2 points; **c.** 3–60 minutes = 1 point; **d.** >60 minutes = 0 points.

Scoring:

- 0–1 points = low dependence
- 2–3 points = moderate dependence
- 4–6 points = high dependence.

Callers who are moderately to highly dependent generally benefit from the use of NRT or other quit medications to reduce nicotine withdrawal symptoms. Treatment guidelines from many countries, including the USA's Clinical practice guideline (2008) strongly support the use of medications for moderately and highly dependent smokers.

4. RECOMMENDATIONS FOR USE OF NRT PRODUCTS (15 minutes)

For any medication to be effective it must be used correctly. It is important for the counsellor to instruct callers how to use NRT products, including correct dosages for sufficient periods of time. Instructions for use and dosing recommendations can be found in Table 6. It should be noted that each country will have to assess laws and other regulations that might govern how their quit line addresses tobacco cessation medications. In some countries only physicians or other licensed health-care providers can provide specific information about cessation medications. In these settings the counsellor will need to refer callers to their health-care providers for support regarding cessation medications.

5. COMMON BARRIERS TO USING CESSATION MEDICATIONS (5 minutes)

There are several common barriers to using cessation medications, including lack of information about the medications, doubts about whether they actually work to help someone quit, cost of the medicines and concerns about side-effects. The quit line counsellor can use education and problem-solving strategies to remove these barriers.

Cost can be an issue because, unlike cigarettes which are sold as a daily dose (pack of cigarettes), NRT products are typically packaged to last two weeks. This requires an initial expenditure. The quit line counsellor can educate callers regarding the long-term cost-saving of quitting and can help them find strategies for saving to purchase the medications.

It is important for callers to complete the full regimen of the cessation medication. Callers may stop taking the medicines because they feel little desire to use tobacco, failing to understand that their low desire to use tobacco is because the medication is working. They may also attribute symptoms of withdrawal from nicotine as a side-effect of the cessation medication. Often this is a sign that the caller is not using the medication effectively. The counsellor should educate the caller about common symptoms of nicotine withdrawal and explore whether the caller is using the medication correctly. If appropriate, refer callers to their health-care providers.

4. Fagerstrom test for nicotine dependence vs heavy smoking index in a general population survey. Chabrol H, Journal Addict Behav. 2005); Rios, BMC Public Health, 2009.

PRACTICE

6. PRACTISE RECOMMENDING NRT TREATMENT PLANS (20 minutes)

Work in pairs and take 20 minutes to build a quit medication plan for two sample callers.

Caller # 1 – Kate

Kate is a 55-year-old married female who has smoked one pack per day for the past 40 years. She has tried to quit several times. The only medication she ever tried was patches. Kate is interested in trying the patch again. During a previous quit she used a 14 mg patch. She said “it helped” but she was never able to remain abstinent for more than two days because the cravings were so strong. Kate reported concern that the patches may have made her irritable and anxious. Kate smokes her first cigarette immediately after waking up.

Please recommend a quit medication plan for Kate to use over the next 12 weeks.

Caller # 2 – Jack

Jack is a 35-year-old male who has smoked approximately 15 cigarettes per day for the past 20 years. He usually smokes his first cigarette about an hour after he wakes up. After discussing all medication options, he has decided he does not want the patch and he does not like pills. He is most interested in the lozenge. Jack expresses concern about the cost of the lozenge.

Please make a recommendation to Jack for prescribing the lozenge

Practice: Client case samples: anticipated responses*

Kate			
Nicotine patches	Dose	Quantity	Duration
	21 mg	1 patch per day	4 weeks
	14 mg	1 patch per day	2 weeks
	7 mg	1 patch per day	2 weeks

Jack			
Nicotine lozenge (not to exceed 20 lozenges per day)	Dose	Quantity	Duration
	2 mg	1 lozenge every 1–2 hours	4 weeks
	2mg	1 lozenge every 2–3 hours per day	2 weeks
	2 mg	1 lozenge every 3–4 hours per day	2 weeks

7. DECISION-SUPPORT FOR MEDICATION USE (15 minutes)

The quit line counsellor will also help people select a medicine that is the best fit in terms of tobacco use, preferences, cost and other limitations (gum is hard to use when the caller has problems with teeth, while patches are hard to use for people who have very sensitive skin). Decision-support includes education about:

- why it is useful to use quit medications;
- helping the caller make an informed decision about using a cessation medication;
- how to use quit medications so they really work.

Work in pairs to practise providing decision-support. The first member of the pair will take 3–5 minutes to provide decision-support for Kate; the second one will provide support for Jack. During the practice, educate the caller by:

- explaining why it is useful to use quit medications;
- helping the caller make an informed decision about using a cessation medication;
- describing the plan for patches for Kate and lozenges for Jack.

Practise problem-solving:

- Educate Kate about nicotine withdrawal symptoms and how these may be confused with side-effects from the cessation medication.
- Discuss Jack's concerns about the cost of the cessation medication and propose problem-solving strategies to resolve this issue.

EVALUATION

8. DEBRIEFING (10 minutes)

Please volunteer to demonstrate the provision of education to Kate or Jack.

Please share your experiences:

- What did you learn about giving decision-support?
 - What did you hear from the quit line counsellor that helped select a medicine?
-
-
-
-
-

Table 6. Description of NRT, bupropion and varenicline

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
Nicotine gum (OTC) Delivers nicotine through the lining of the mouth. Available dosage: 2mg, 4mg.	<ul style="list-style-type: none"> Smokers 18 years and over. Smokers with severe heart and circulation problems should start NRT under medical supervision. Pregnant or breastfeeding women if they cannot stop without NRT. 	<ul style="list-style-type: none"> Withdrawal symptom relief. Control of cravings/urges. 	Advantages <ul style="list-style-type: none"> Convenient/flexible dosing. Faster delivery of nicotine than the patches. Disadvantages <ul style="list-style-type: none"> May be inappropriate for people with dental problems and those with temporomandibular joint (TMJ) syndrome. User should not eat or drink 15 minutes before use or during use. Frequent use during the day is required to obtain adequate nicotine levels. 	Dosing: Based on cigarettes/day (cpd) >20 cpd: 4 mg gum ≤20 cpd: 2 mg gum Based on time to first cigarette of the day: ≤30 minutes = 4 mg >30 minutes = 2 mg Initial dosing is 1–2 pieces every 1–2 hours (10–12 pieces/day). Taper as tolerated. Duration: up to 12 weeks with no more than 24 pieces to be used per day. How to use: It is not chewed like regular gum but instead is chewed briefly until you notice a “peppery” taste, then “parked” between cheek and gum for about 30 minutes.	<ul style="list-style-type: none"> Hiccups Jaw ache Stomach irritation Sore mouth
Nicotine patch (OTC) Delivers nicotine through skin. Available dosage: 24 hour delivery systems 7mg, 14mg, 21mg. 16 hour delivery systems 5mg, 10mg, 15mg.	The same as nicotine gum.	<ul style="list-style-type: none"> Withdrawal symptom relief. Control of cravings/urges. 	Advantages <ul style="list-style-type: none"> Achieve high levels of replacement. Easy to use. Only needs to be applied once a day. Disadvantages <ul style="list-style-type: none"> Less flexible dosing. Slow onset of delivery. Mild skin rashes and irritation. 	Dosing (24 hour patch): ≥10 cigarettes/day: 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks ≤10 cigarettes/day: 14 mg/day x 6 weeks 7 mg/day x 2 weeks Duration: 8–10 weeks. How to use: Patches may be placed on any hairless area on the upper body, including arms and back. Rotate the patch site each time a new patch is applied to lessen skin irritation.	<ul style="list-style-type: none"> Skin irritation Allergy (not suitable if you have chronic skin conditions) Vivid dreams and sleep disturbances

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
Nicotine lozenge (OTC) Delivers nicotine through the lining of the mouth while the lozenge dissolves. Available dosage: 2 mg, 4 mg.	The same as nicotine gum.	<ul style="list-style-type: none"> Withdrawal symptom relief. Control of cravings/urges. 	Advantages <ul style="list-style-type: none"> Easy to use. Delivers doses of nicotine approximately 25% higher than nicotine gum. Disadvantages <ul style="list-style-type: none"> Should not eat or drink 15 minutes before use or during use. 	<p>Dosing: Based on time to first cigarette of the day.</p> <p>≤ 30 minutes = 4 mg >30 minutes = 2 mg</p> <p>Based on cigarettes/day (cpd)</p> <p>>20 cpd: 4 mg ≤ 20 cpd: 2 mg</p> <p>Initial dosing is 1–2 lozenges every 1–2 hours (minimum of 9/day).</p> <p>Taper as tolerated.</p> <p>Duration: up to 12 weeks with no more than 20 lozenges to be used per day.</p> <p>How to use: The lozenge should be allowed to dissolve in the mouth. It should not be chewed or swallowed.</p>	<ul style="list-style-type: none"> Irritation of mouth Irritation to stomach (nausea frequent 12–15%) Hiccups Heartburn
Nicotine nasal spray (RX) Delivers nicotine through the lining of the nose when sprayed directly into each nostril. Available dosage: 0.5 mg nicotine in 50 μ l aqueous nicotine solution.	The same as nicotine gum plus those who do not have	<ul style="list-style-type: none"> Withdrawal symptom relief. Control of cravings/urges. 	Advantages <ul style="list-style-type: none"> Flexible dosing. Can be used in response to stress or urges to smoke. Fastest delivery of nicotine of currently available products but not as fast as cigarettes. 	<p>Dosing: 1 spray in each nostril, 1–2 times per hour (up to 5 times/hour or 40 times/day)</p> <p>Most average 14–15 doses/day initially</p> <p>Taper as tolerated.</p> <p>Duration: 3–6 months.</p>	<ul style="list-style-type: none"> Nasal irritation (runny nose, sneezing, burning sensation) Coughing Nausea Headache Dizziness Irritated throat

Medication	Who can use	Purpose of use	Advantages and disadvantages	General guidelines for use	Side-effects and warnings
Nicotine inhaler (Rx) Delivers nicotine to the oral mucosa, not the lung, and enters the body much more slowly than the nicotine in cigarettes. Available dosage: 10 mg cartridge delivers 4mg inhaled nicotine vapour.	The same as nicotine gum plus those who do not have • bronchospastic disease.	• Withdrawal symptom relief. • Control of cravings/urges.	Advantages <ul style="list-style-type: none">Flexible dosing.Mimics the hand-to-mouth behaviour of smoking.Few side effects. Disadvantages <ul style="list-style-type: none">Frequent use during the day required to obtain adequate nicotine levels.Should not eat or drink 15 minutes before use or during use.	Dosing: Minimum of 6 cartridges/day, up to 16/day Taper as tolerated (during the final 3 months of treatment). Duration: up to 6 months.	<ul style="list-style-type: none">Mouth or throat soreness or drynessCoughing
Bupropion SR (Rx) Originally used as antidepressant. Affects the levels of neurotransmitters affecting the urge to smoke. Available dosage: 150 mg sustained release tablet.	All adult smokers except those • pregnant or breast-feeding • with concomitant therapy with medications or medical conditions known to lower the seizure threshold • with severe hepatic cirrhosis.	• Withdrawal symptom relief (anxiety/irritability and depression). • Abstinence.	Advantages <ul style="list-style-type: none">Easy to use.Pill form.Few side-effects.May be used in combination with NRT. Disadvantages <ul style="list-style-type: none">Contraindicated with certain medical conditions and medications.	Dosing: Take doses at least 8 hours apart. Start medication one week prior to the target quit date (TQD). 150 mg once daily for 3 days, then 150 mg twice daily for 4 days, then On TQD STOP SMOKING and continue at 150 mg twice daily for 12 weeks May stop abruptly; no need to taper.	<ul style="list-style-type: none">InsomniaDry mouthNervousness/difficulty concentratingRashHeadache, dizzinessSeizures (risk is 1/1,000) Warnings: advise patients to stop bupropion and contact a health-care provider immediately if they experience agitation, depressed mood, and any changes in behaviour that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behaviour.
Varenicline (Rx) Attaches to nicotinic receptors. Partial blocking of the reward effects of nicotine and partial stimulation of the nicotinic receptors. Available dosage: 0.5 mg, 1 mg tablet.	All adult smokers except those • pregnant or breastfeeding • with severe renal impairment (dose adjustment is necessary).	• Withdrawal symptom relief. • Control of cravings/urges. • Abstinence.	Advantages <ul style="list-style-type: none">Easy to use.Pill form.Generally well tolerated.No known drug interactions. Disadvantages <ul style="list-style-type: none">Nausea is common.	Dosing: Take with food. Start medication one week prior to the TQD 0.5 mg once daily X 3 days, then 0.5 mg twice daily X 4 days, then On TQD STOP SMOKING AND take 1.0 mg twice daily for 11 weeks. May stop abruptly; no need to taper.	<ul style="list-style-type: none">NauseaSleep disturbances (insomnia, abnormal dreams)ConstipationFlatulenceVomiting Warnings: The same as for bupropion.

Module 6: Facilitation skills

OBJECTIVES

Upon completion of this module participants will be able to:

- describe the value of establishing a rapport between the counsellor and the quit line caller in order to develop a therapeutic relationship;
- Demonstrate communicating with the following key facilitation skills:
 - showing warmth and empathy
 - normalizing
 - active listening
 - flexible communication style
 - managing time
 - respecting boundaries.

AGENDA

1. Elements of good communication (10 minutes).
2. Building a therapeutic relationship (25 minutes).
3. Applying facilitation skills (35 minutes).
4. Debriefing (10 minutes).

PREPARATION

1. ELEMENTS OF GOOD COMMUNICATION (10 minutes)

Showing empathy, genuine interest, and flexing the communication style are important parts of good communication.

Brainstorming:

- What are ways you can demonstrate empathy or genuine interest?

- How do you know if someone is demonstrating empathy or genuine interest?

- What are some ways you can flex your communication style when talking to someone who has a different communication style?

PRESENTATION

2. BUILDING A THERAPEUTIC RELATIONSHIP (25 minutes)

It is extremely important to establish a good rapport between the counsellor and the quit line caller to build a therapeutic relationship and to create trust and open communication. The counsellor has only vocal communication in a phone-based intervention, and does not have visual cues, making tone and warmth especially important. In the absence of developing a therapeutic relationship callers may not communicate all their concerns about quitting and may be more resistant to suggestions of how they can effectively move forward to achieve the quit. Counsellors should understand and apply the following key facilitation skills in order to help create a therapeutic relationship with callers:

- showing warmth and empathy
- normalizing
- active listening
- flexing the communication style
- managing time
- respecting boundaries.

2.1 Showing warmth and empathy

Some callers are embarrassed about the fact that they smoke or use tobacco, or about how much they smoke or use. By demonstrating warmth and empathy, you encourage the caller to share with honesty. Empathy is the ability to understand the experiences, thoughts and feelings of another from that person's point of view and without judgement. One can empathize and attempt to understand another's point of view without having experienced the situation. Empathy is different from sympathy; sympathy implies a shared feeling, empathy on the other hand keeps the focus on the caller. Ways to show empathy and warmth include:

- remaining present and honest, and suspending judgement;
- balancing honesty with positive regard;
- using active and reflective listening skills;
- using "you" statements, rather than "I" statements;
- confirming accuracy of understanding;
- using warm vocal tones.

2.2 Normalizing

Normalizing is to validate the caller's experience of using tobacco. By normalizing the fact that many people still smoke or use tobacco, and use as much or more than others do, you help to remove the stigma from them. One barrier to quitting is the sense that "I am worse than anyone you have ever talked to and therefore I will never be able to quit." By hearing the counsellor normalize their use of tobacco or feelings about quitting you help them to feel more hopeful. This in turn can have a positive effect on their sense of self-efficacy.

2.3 Active listening

Active listening shows your desire to understand the other person. This in turn helps build a rapport.

Active listeners:

- try to suspend judgement;
- listen for feeling and content;
- allow and encourage a statement of feelings;
- resist distractions in the environment and in themselves;
- ask relevant questions;
- show empathy;
- hear the speaker out and are comfortable with silence;
- try to rephrase what is heard until agreement on meaning is reached;
- summarize at the end, and check to see if the goal of listening has been met.

Barriers to active listening include:

- interrupting, instead of letting the speaker finish speaking;
- assuming you know what the other person is going to say;
- competing distractions (such as ringing cell phones, other people talking or music) that keep you from hearing what the other person is saying;
- filtering the conversation by listening to some parts of the message and not others;
- listening through the perspective of your own values and beliefs;
- labelling or judging the speaker as “stupid” or “unqualified”, leading you to pay less attention to the speaker or to discount what is being said;
- using “me-ism” (i.e. relating everything the speaker says to your own experience);
- giving advice before the speaker finishes telling his or her story;
- sparring with the speaker by listening for points to debate or argue about.

2.4 Flexing the communication style

Another way the quit line counsellor can help to create a therapeutic relationship is to flex the communication style to match that of the caller. This may include slowing down or speeding up the way you speak with the caller. It may also involve allowing more silence after open-ended questions for the caller to consider his/her response and answer the question.

When you are communicating effectively, conversation moves forward, both parties feel heard and understood, there is mutual agreement, and communication style and tone are matched or adjusted in order to be effective. Listen carefully to the caller’s manner of interacting with you. Match the caller’s style, tone and pace when appropriate. Consider whether your conversational tone is serious and formal or light and informal compared with the tone of the caller.

2.5 Managing time

It is of great importance to manage the time with the caller effectively in order to make the best use of it. Most quit lines limit the time that the quit line counsellor can spend on each call. There is also a point in time at which a caller begins to get tired if the call goes on too long. Callers may become overwhelmed with the amount of information they receive and this may limit their ability to take meaningful follow-up action steps. Finally, if calls last too long the caller may be hesitant to make future calls.

To this end it is imperative that the counsellor should use the information from the assessment and their expertise as a tobacco treatment specialist to focus the intervention strategically.

2.6 Boundaries

The role of a tobacco treatment specialist or quit line counsellor is to help callers make a quit attempt using evidence-based tools and approaches. Other issues that come up during calls may be medical or psychological in nature, or may be completely irrelevant to the quitting process. It is legally and ethically important for counsellors not to stray into areas external to their role, even if they have expertise in other fields. Another role concern is when a counsellor takes on a “buddy” relationship with the caller. This can undermine the relationship in several ways. Similarly, if the counsellor takes on the role as a “parent” and lectures the caller, a negative impact on the intervention can result.

Some quit line counsellors are former smokers and some never smoked. There is no research to show that either one is more effective than the other as a quit line counsellor. If counsellors are former smokers it is very important that they disclose only their own experiences with quitting insofar as they directly inform the plan for the caller. Otherwise the disclosure has the potential to undermine the relationship by making the call about the counsellor’s experiences and not the caller’s. Counsellors who have never smoked should never misrepresent themselves as former smokers in the hope of gaining the confidence of the caller. Besides the ethical concern, there is real potential for the caller to discover that you actually never smoked and any trust that has been developed is completely lost. As a result, this person may never use the quit line again.

In some cultures callers may look to the counsellor to play more of an expert role than a collaborative one. In such circumstances the counsellor may need to take a more active role in being more directive in order to develop trust and rapport with the caller.

PRACTICE

3. APPLYING FACILITATION SKILLS (35 minutes)

This activity will provide you with an opportunity to apply your facilitation skills to build a therapeutic relationship with the caller as you talk to the caller about medications and tobacco and nicotine.

Work in a small group of three to practise the two scenarios below:

Scenario 1

The caller wants to quit, but describes all the challenges he had in past quit attempts. The quit line counsellor explains the role of nicotine and why quitting can be hard, but that there are also strategies and medications that can help this time.

Scenario 2

The caller wants to quit but tells the counsellor that her husband smokes all the time and so it is hard to quit. She is very frustrated about this and wants you to call her husband and tell him that he needs to be more supportive. She does not think she can quit if her husband smokes in the house and around her all the time.

There are three roles: the quit line counsellor role, the caller role and the observer role. Each practice session will last 5–10 minutes. Take turns to play the roles of quit line counsellor, caller and observer.

- Quit line counsellor: select one of the scenarios and demonstrate the following facilitation skills while discussing the assigned topic:
 - showing warmth and empathy
 - normalizing
 - active listening
 - flexing the communication style
 - managing time
 - respecting boundaries.
- Caller: follow the scenario selected by the quit line counsellor.
- Observer: take note of the different facilitation skills the quit line counsellor used during the role play.
After each role play, share what you heard demonstrated.

EVALUATION

4. DEBRIEF (10 minutes)

Please share your experience:

- What, if anything, was challenging about using the facilitation skills during the practice sessions?
 - What was the impact on the caller?
-
-
-

Module 7: Basic components of a call

OBJECTIVES

Upon completion of this module participants will be able to:

- describe the basic components of a call: introduction and signposting, assessment and agenda development, action planning, and closing;
- demonstrate the ability to introduce each call and signpost the intervention;
- demonstrate the ability to engage the caller in a summary of next steps in the quitting process and schedule the next call.

AGENDA

1. Basic call structure (10 minutes).
2. Components of a call (20 minutes).
3. Writing introductions and closing (30 minutes).
4. Debrief (10 minutes).

PREPARATION

1. BASIC CALL STRUCTURE (10 minutes)

Quit line calls are typically divided into five different components: introduction, assessment, setting the agenda, action planning, and closing, with each component having its own purpose and content depending on the needs of the caller.

Using these intervention components will provide a structure to the call that allows the counsellor to tailor the intervention for the tobacco user.

Please brainstorm and fill in the chart below: what is the goal/purpose of each part of the call?

Steps of the intervention	Purpose
Introduction	
Assessment	
Setting the agenda	
Action planning	
Closing	

Here are the suggested answers:

Steps of the intervention	Purpose
Introduction	To set expectations for the current interaction so the caller knows what to expect during the call.
Assessment	To obtain an understanding of the caller's relationship to tobacco, his/her strengths and barriers to quitting.
Setting the agenda	To bridge the assessment and action planning phases of the call and to identify the focus of the call with the intent of encouraging the client to make a quit attempt as soon as he/she is willing.
Action planning	To develop a realistic and sustainable action plan which addresses identified barriers and drives the caller to perform key evidence-based behaviours.
Closing	To set accurate expectations for the next contact so the caller has clear expectations about how and why to engage in the future, including how to call in for support.

PRESENTATION

2. COMPONENTS OF A CALL (10 minutes)

Introduction

Most callers who call the quit line will have no idea what to expect during the call. The introduction will orient them to what will happen during each call. This helps to set expectations and develop buy-in for the intervention from the caller. The introduction also helps to set the tone for the caller and is an important part of creating a therapeutic relationship with the caller. The introduction includes:

- stating your name;
- thanking the caller for calling the quit line;
- stating how long the call will take;
- providing an overview of topics that will be discussed (this is called "signposting");
- (any additional statement of confidentiality required by law or required by the quit line);
- asking callers if they have anything they want to make sure is discussed during the call.

Assessment

The assessment part of the call is when the counsellor asks questions to gain an understanding of the caller's tobacco use, history of trying to quit and other relevant information, and to determine whether the caller is ready to quit or not ready to quit. The information from the assessment helps to inform the agenda and the action plan. It is of great importance that the counsellor explains why she or he is asking these questions. This helps to create a context for the questions and puts the caller at ease. These questions consist of:

- required questions where the caller's response is typically recorded in a database or on a form;
- additional questions the counsellor feels need to be asked to help the caller.

Transition to agenda-setting

Once the assessment is complete, the counsellor can begin developing the agenda for the call. The agenda forms the focus of the intervention, resulting in the action plan. Agenda-setting should be developed by use of a combination of information collected from the caller, application of quit line protocols, and the counsellor's clinical insight.

Action planning

The planning or action plan part of the call is when the counsellor helps the caller create action steps towards quitting or remaining quit. Efforts should be made to encourage those ready to quit to make a quit attempt as soon as possible. This is a process that is informed by the counsellor's expertise, resulting in collaborative planning with the client or more directive suggestions by the counsellor. The action steps should be SMART (specific, meaningful, attainable, relevant and timely).

Closing

The closing is the point when the counsellor:

- asks the caller to summarize the next steps for implementing their plan;
- invites the caller to call as needed for support (give hours, days open and telephone number);
- schedules the next call according to programme protocols;
- informs the caller about topics that will be discussed during the next call.

PRACTICE

3. WRITING INTRODUCTIONS AND CLOSING (20 minutes)

Take a few minutes to write:

- an introduction for an intake call (include transition statement to the assessment);
- an introduction for an ongoing call (include transition statement to the assessment);
- closing a call – what it might typically sound like (start with a transition statement that signals the end of action planning).

You can write a script to read verbatim or write an outline that works for you.

Introduction for the first counselling call	
Introduction for ongoing call	
Closing a call	

Please work in pairs to read your introductions and closing to each other.

EVALUATION

4. DEBRIEFING (10 minutes)

Please volunteer to share your introductions and closing with the group.

Please share your thoughts on:

- What are the benefits of using the basic call structure (for the caller and for the quit line counsellor)?

Module 8: Assessment and agenda-setting

OBJECTIVES

Upon completion of this module participants will be able to:

- demonstrate the assessment required (if any), and optional information about, a caller's tobacco use;
- demonstrate use of the caller's readiness to quit to inform the agenda for the intervention;
- demonstrate use of the information collected during the assessment to build an intervention strategy.

AGENDA

1. Purpose of the assessment (20 minutes).
2. Content of the assessment (30 minutes).
3. Tips for conducting assessment (5 minutes).
4. Agenda-setting (10 minutes).
5. Role play: introduction and assessment (25 minutes).
6. Evaluation (10 minutes).

PREPARATION

1. PURPOSE OF THE ASSESSMENT (20 minutes)

The assessment is the phase of the call that follows the introduction and is a part of all calls.

Brainstorming:

- What is the purpose of the assessment?
-
-

The assessment can help a quit line counsellor to:

- understand information about the caller, such as tobacco use and history of previous quit attempts, in order to develop a plan to help the caller quit and stay quit;
- determine a caller's readiness to quit;
- propose the focus for the call (agenda-setting);
- build rapport with callers.

PRESENTATION

2. CONTENT OF THE ASSESSMENT (30 minutes)

2.1 *The typical contents of the assessment*

The assessment is typically broken down into several different parts that may consist of:

- readiness to quit;
- tobacco use (type of tobacco, amount used per day, and time to first use after waking) to determine nicotine dependence;

- history of previous quit attempts (including number and length of previous quit attempts, relapse causes, and methods used to quit);
- self-efficacy factors (including what is motivating the caller to quit and how confident he/she is in the ability to quit and stay quit);
- other tobacco users in the caller's environment;
- physical and/or mental health problems relevant to quitting;
- other components your quit line may want you to collect.

The assessment questions will help you learn about:

- behaviours such as situational triggers for using tobacco;
- psychological elements such as emotional triggers for using tobacco;
- environment (other tobacco users around the client, and support for quitting);
- biological elements such as nicotine dependence (e.g. time to first use, amount of tobacco used per day);
- cognitive elements (i.e. how the caller's thoughts are connected to the use of tobacco) such as what the client thinks of before lighting up;
- self-efficacy (motivation and confidence).

2.2 The content of the assessment for the caller who is ready to quit and the caller who is not ready to quit

The content of the assessment can be determined by the caller's readiness to quit. The content for the caller who is not ready to quit and the caller who is ready to quit can be different. Below are some possible questions for the two different callers.

Possible questions for callers who are not ready to quit:	Possible questions for callers who are ready to quit:
<ul style="list-style-type: none"> • What do you like about smoking/tobacco use? • How many cigarettes per day are you currently smoking/ how many pouches of chewing tobacco are you using per week? • How soon after waking do you have your first cigarette/dip? • What benefits will you experience when you quit? • How is smoking/use of tobacco affecting your health? Your social relationships? Your finances? • What prompted you to call in today? • How can we best support you as you think about quitting? • What would you like to focus on today? • How does your smoking/use of tobacco fit in with what is important to you in your life? 	<ul style="list-style-type: none"> • When do you plan to quit? • What are your reasons for wanting to quit? • How confident are you that you can quit and stay quit? • How many years have you been using tobacco? • How many cigarettes per day are you currently smoking/how many pouches of chewing tobacco are you using per week? • How soon after waking do you have your first cigarette/dip? • Do you ever wake up in the middle of the night and smoke/chew tobacco? • Are you currently using any medications to help you quit? • What are your triggers for using tobacco? • What do you think before lighting up a cigarette or taking a chew when you are stressed or upset? • Are there other tobacco users at home or at work? • Who is going to support you throughout your quitting process? How?

2.3 The content of the assessment for different calls

The content of the assessment for the first call differs from that of follow-up calls. During the first call the assessment provides information about the caller's nicotine dependence, history of previous quit attempts, reasons for returning to active tobacco use after trying to quit, and other strengths and challenges associated with quitting tobacco. Your quit line may also want you to ask other baseline questions. During follow-up calls the assessment helps the counsellor determine what progress the caller has made, what is working, and what challenges callers are facing in trying to quit or stay quit. The counsellor then uses the information that is gathered during the assessment to help determine the focus of the intervention to move the caller on in the quit continuum. By comparing answers from the assessment during ongoing calls with answers from the assessment during the first call, the counsellor can see what progress the caller has made. This can help the counsellor to better understand how to help the caller.

2.4 Follow-up questions

The quit line counsellor should ask follow-up questions as needed to understand issues that arise in order to help the caller. It is not necessary for the counsellor to ask questions exhaustively on a topic. Instead the questions should be asked with intent and purpose.

3. TIPS FOR CONDUCTING THE ASSESSMENT (5 minutes)

First, it is important to use a conversational tone, rather than sounding as if you are conducting a survey. It is also very important to explain to the caller why you are asking these questions. Conducted properly, the assessment sounds like inquiry from someone who is genuinely interested in helping the caller to quit and stay quit. An example of how the assessment can be introduced might be, “Now I am going to ask you a few questions to help me understand how I can assist you with your goal of [quitting/staying quit].”

Second, by using a warm and genuine tone the counsellor has an opportunity to build a rapport with the caller. It allows the counsellor to demonstrate active listening with reflections, summarizing and normalizing. A well conducted assessment can serve to put the caller at ease.

4. AGENDA-SETTING (10 minutes)

Setting the agenda has four sequential phases:

Phase I: Assessment

- the readiness of the caller to quit;
- other information collected by the counsellor during the assessment;
- the stated needs of the client.

Phase II: Clinical decision-making by the counsellor making sense of the information collected from the client.

Phase III: After collecting this information the counsellor can share insight with the client, identifying the strengths and challenges in moving forward towards quitting or staying quit.

Phase IV: The counsellor proposes a focus for the call and seeks buy-in from the client.

Once the counsellor has collected the assessment information and stated needs of the client, she or he can use clinical judgement to make sense of the information. The counsellor can then summarize the assessment information in the form of strengths and challenges associated with adopting a quit date, developing coping strategies, using support of friends and family, and removing tobacco products from the client’s surroundings. It is very important to stress the client’s strengths as a means to build self-efficacy.

The counsellor, using professional expertise, experience and understanding of quit line protocols, can then propose a focus (agenda) for the call. It is very important that the agenda has buy-in from the caller. There are several ways of doing this. The first might be to share fully what the counsellor has learned in the assessment: *“From what you have told me it sounds like you are very motivated to quit, have tried to quit before and had some success. In addition to helping you set a quit date and learn to manage urges, where you seem to have had trouble in the past is dealing with strong urges when around other smokers. To plan for your quit date, it makes sense to figure out a plan for that challenge. How does that sound?”*

Another way is to be less specific and simply say: *“Now that I have a better understanding of where you are in the quitting process and what has worked for you in the past, let’s focus on how you will deal with other smokers in this call. How does that sound?”*

The agenda for a call is largely determined as follows.

- **Caller not ready to quit:** focus on identifying and planning to overcome ambivalence or other barriers to making the decision to quit.
 - **Caller ready to quit:** focus on setting a quit date as soon as possible; tell family, friends and co-workers about quitting and request understanding and support; anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks; remove tobacco products from the caller's environment.
- Medication decision-support is an important element in quit lines where medications are discussed or provided.

PRACTICE

5. ROLE PLAY: INTRODUCTION AND ASSESSMENT (15 minutes)

5.1 Caller profile

Please take five minutes to create a profile of a sample caller by using the caller profile worksheet below. Please draw on your own past experience with tobacco or experiences of friends and family members.

Name:

Gender:

Age:

Brief description (profession, family, etc.):

How long smoking:

Reasons for quitting:

Cigarettes or other tobacco use per day:

How soon caller smokes or uses tobacco after waking:

Past quit experience:

Smokers/other tobacco users at home/work:

Smoking/tobacco-use triggers:

Tobacco cessation medications:

5.2 Practice

Work in pairs to role-play the introduction to the call, the assessment phase and setting the agenda. Use the caller profile that you created for this practice.

EVALUATION (10 minutes)

Please share with the group:

- What was your experience in performing the role play?
- Rate your confidence in performing the assessment and agenda-setting on a scale of 1–10.
- What will it take to build your confidence to deliver the assessment and agenda-setting?

Module 9: Action planning

OBJECTIVES

Upon completion of this module participants will be able to:

- describe and apply the STAR strategies to develop a quit plan;
- describe the steps for developing a relapse prevention plan;
- demonstrate the ability to provide ongoing support throughout the quitting process, including practical problem-solving and evidence-based strategies for relapse prevention.

AGENDA

1. Brainstorm: action planning (30 minutes).
2. Counselling approaches and action steps for callers who are not ready to quit (15 minutes).
3. Counselling approaches and action steps for callers who are ready to quit (45 minutes).
4. Practice: building an action plan (30 minutes).
5. Debriefing: demonstrating the action plans (30 minutes).

PREPARATION

1. BRAINSTORM: ACTION PLANNING (30 minutes)

Work in small groups and take 10 minutes to brainstorm the possible action steps for a caller.

- Group 1 lists possible action steps for a caller who is not ready to quit.
- Group 2 lists possible action steps for a caller who is ready to quit

Please record your brainstorm ideas on a flipchart and share your responses with the larger group.

PRESENTATION

2. COUNSELLING APPROACHES AND ACTION STEPS FOR CALLERS WHO ARE NOT READY TO QUIT (15 minutes)

The counselling approach should be matched with the needs of the caller and his/her readiness to quit. Use of the incorrect counselling approach will most likely result in the caller's needs going unmet. While most callers will be motivated to quit, some callers will demonstrate low motivation. Motivation is a state of readiness to change, which relates to the importance of change and confidence in one's ability to change (self-efficacy). Therefore, callers who are not ready to quit may have different reasons why: perhaps they do not think quitting is important, or they do not believe they can quit successfully (low self-efficacy).

Motivational interviewing (MI) is the proper approach for most callers who are not ready to quit due to low motivation. With these callers the quit line counsellor should apply the MI principles and skills to help the caller resolve ambivalence and build motivation for quitting (see details in Module 4: Practical and theoretical approaches for those not ready to quit).

The 5R's model and the six steps for conducting an MI session can be two very useful tools to guide the quit line counsellor in conducting motivational counselling intervention with those who are not ready to quit (see details in Module 4: Practical and theoretical approaches for those not ready to quit).

3. COUNSELLING APPROACHES AND ACTION STEPS FOR CALLERS WHO ARE READY TO QUIT (45 minutes)

These callers are typically best served by help with concrete action steps. The assessment part of the intervention is important to enable the quit line counsellor to understand what the caller needs help with or how the caller has struggled when trying to quit in the past.

3.1 The first session

The first session with those who are ready to quit usually focuses on helping them create a quit plan. An evidence-based quit plan typically uses the "STAR" elements:

- **Set a quit date.** Ideally, the quit date should be within two weeks.
- **Tell family, friends and co-workers about quitting,** and request understanding and support.
- **Anticipate challenges to the upcoming quit attempt,** particularly during the critical first few weeks. These include nicotine withdrawal symptoms.
- **Remove tobacco products from your environment.** Prior to quitting, avoid smoking in places where you spend a lot of time (e.g. work, home, car). Make your home smoke-free.

These evidence-based strategies support callers in quitting and staying quit. These strategies and their relevance in the first planning call and during follow-up support calls are discussed below.

Set a quit date

This is defined as the date the caller plans to quit (or the date that the caller actually quits). For planning purposes it is usually best if this date is set within two weeks of the call. Research shows that callers are more likely to make a quit attempt if the date is set as soon as is reasonably possible.

During the follow-up calls with those who have quit, the quit line counsellor should confirm that the caller's quit date has not changed due to slips or lapses back to smoking or chewing tobacco. If the caller has lapsed, then this should be addressed as part of the action plan. If the caller has not had any lapses or slips then the quit line counsellor can enhance rapport by congratulating the caller.

Tell family and friends

Social support is defined as supportive help from friends and family. Callers should be encouraged to tell friends and family about their intention to quit and to ask for their help. They can ask friends and family to avoid smoking around them and not to offer them tobacco.

Recognizing that the environment can have a strong influence on quitting, the counsellor can also help the caller make a plan to negotiate with other smokers in the home or workplace to create "smoke-free zones" where the caller can avoid being around smoke and tobacco products.

Anticipate challenges

Urges to use tobacco after quitting are very normal. Some of these urges are associated with nicotine withdrawal and can usually be effectively reduced through the proper use of quit medications. Other urges tend to be associated with established patterns of tobacco use and emotions. There are two types of coping strategies for addressing urges to use tobacco: behavioural coping skills and cognitive coping skills. Some examples are:

- using distractions, such as doing some activity or staying busy;
- changing daily routines to avoid usual triggers to smoke or chew;

- using substitutes to keep hands, mouth or both hands and mouth busy;
- using self-talk, and replacing thoughts that do not support quitting or staying quit with more productive thoughts.

Urge management takes some practice. Callers should be encouraged to pay attention to when and where they smoke prior to quitting so they can begin thinking about coping strategies that might work for them. Sometimes it is useful to encourage callers to try small practice quits where they can experiment staying quit during times when they normally smoke or use tobacco. These mini-quits are useful in building self-efficacy.

Remove tobacco products

The final key element is to recommend that the caller throws away any tobacco products on the night before the quit date. This helps to avoid temptation to “have just one” when strong urges hit.

It is also a good idea to:

- put away ashtrays, lighters and matches;
- ask other smokers to please not smoke around them or to offer them a cigarette or chewing tobacco.

Case study 1

Robert is a 27-year-old male who is smoking between 15 and 20 cigarettes per day. He has his first cigarette within 5 minutes of waking, while he makes coffee. He has tried to quit only once before but this lasted only about one day before his cravings became so strong that he started smoking again. The counsellor determines that he quit that time using no quit medications.

Robert has a hard time describing when and where he smokes during the day. To help him develop greater awareness of his smoking patterns the counsellor suggests that he track his smoking for a couple of days by writing down where and when he has each cigarette. The counsellor orients him to the concept of managing urges and encourages him to try some “practice quits” each day so he can try out some different ways of coping with urges. He orients him to the pages in the printed quit guide that is being mailed to him where he can find different ways of managing urges to smoke.

Robert decides he wants to use the nicotine patch because a friend of his quit using it. Recognizing that Robert’s nicotine dependence is rather strong, the counsellor also encourages him to use nicotine gum and explains how to use the two medications at the same time.

The counsellor encourages him to get rid of all cigarettes, ashtrays and lighters the night before he quits and Robert agrees. Robert plans to use his friend who quit as his support.

The counsellor sets up the next call for the day after Robert’s planned quit date and encourages him to call in sooner if he needs more help.

3.2 Follow-up sessions

For those who are ready to quit, and are assessed as being quit at the next follow-up call, the strategy should be to help them prevent relapse by developing a relapse prevention plan as early as possible, ideally during the second session.

3.2.1 How to tell a lapse from a relapse

Lapses or slips are defined as short, time-limited use of tobacco after quitting. It is helpful to the caller if the counsellor normalizes slips when they happen and helps the caller to work out what led to the slip and then strategize solutions. The proper reaction to smoking lapses includes:

- encouraging another quit attempt or a recommitment to total abstinence;
- reassuring that quitting may take multiple attempts, and using the lapse as a learning experience;
- suggesting continued use of medication, which can prevent a lapse from leading to a full relapse;
- providing or referring to intensive practical counselling.

Relapse is defined as a return to regular use of tobacco. Callers who relapse should be encouraged to make another quit attempt as soon as possible. Again, it is helpful if the counsellor normalizes relapse as part of the quitting process. It is useful to assess what worked to help the caller quit for as long as he/she did and then analyse the relapse situation so a strategy can be built into the quit plan to avoid that cause of relapse in the future.

3.2.2 The best strategy for preventing relapse

At present, the best strategy for producing high long-term abstinence rates and preventing relapse is to use the most effective cessation treatments available (intense cessation counselling and evidence-based cessation medications) during the quit attempts. The quit line counsellor should suggest that callers avoid using approaches to quitting tobacco which are not strongly supported by scientific evidence and approaches have not been validated in scientific studies. These include hypnotherapy, acupuncture, laser therapy, herbal therapy, unapproved over-the-counter products that contain nicotine (such as nicotine water and nicotine hand gel), electronic cigarettes, and many other products on the market. While they may work for one individual, there is insufficient or no scientific evidence that they will work for most tobacco users.

3.2.3 Steps for developing a relapse prevention plan

The quit line counsellor can use the following three steps to help callers develop a relapse prevention plan:

- identifying relapse risks
- preparing the clients with coping skills
- providing or identifying support.

Identifying relapse risks

Relapse risks can come from many sources. These can include intrapersonal, interpersonal and environmental factors:

- Nicotine withdrawal symptoms
 - craving;
- Negative moods
 - frustration
 - anger
 - anxiety
 - depression or boredom
 - risky thinking or unproductive thoughts, such as “I could have just one” or “I have had such a hard day I deserve just one cigarette”;
- Specific activities
 - drinking alcohol;
- Interpersonal conflicts
 - marriage
 - friendship
 - family members
 - employer–employee conflicts;
- Social pressure
 - influence of another tobacco user.

Developing coping skills

Since relapse risks can come from various sources, the approaches for dealing with them can differ. Things that can help tobacco users deal with risk situations are typically classed as cognitive coping skills (things you can tell yourself) and behavioural coping skills (actions you can take or things you can do).

For example, the following behavioural and cognitive coping strategies can be used to help cope with the discomfort associated with nicotine withdrawal:

- Use substitutes that help to replace the oral and manual aspects of smoking or chewing tobacco.
- Mix up daily routines to avoid triggers to use tobacco.
- Remove tobacco products, including ashtrays and lighters, from the environment.
- Avoid other smokers where possible. Those who have to share living spaces with other smokers might be able to negotiate smoke-free rooms in the home.
- Recognize unproductive thoughts and replace them with productive thoughts. An example might be to replace an unproductive thought such as "I am very stressed. I could really use a cigarette!" with a more productive thought like "A cigarette is really not going to help my stress. Instead I think I will go for a walk."
- For those who are newly quit, especially in the first weeks after quitting, relapse prevention using a quit medication should include encouragement to continue using cessation medications correctly.

Providing/identifying support

As discussed above, preparing clients with coping skills may involve helping them develop a relapse prevention plan. However, the counsellor can also provide a caller with references to sections in the quit line's printed quit guides or Internet sites.

The quit line counsellor can also encourage callers to ask for support from family and friends. The counsellor should encourage them to seek out either a former tobacco user or a never-user. It is often helpful to provide callers with some ideas of how they can approach someone to support them, and even do a role-play with the caller.

Another source of support can be local cessation services that may be available in the community. These can sometimes be found at hospitals.

3.2.4 The ACE model

The **ACE model** is an effective relapse prevention tool. ACE stands for:

- **Avoid** risky situations when possible. When avoiding a risky situation is not possible:
- **Cope** using a variety of behavioural, pharmacological and cognitive strategies. If coping is not working:
- **Escape** the situation by leaving.

This tool is especially useful for those who quit recently. It provides them with a clearly defined set of actions to manage situations that may lead them back to active tobacco use.

Another group of quit line callers are those we sometimes call "quit and stable". These are callers who are reached for later follow-up calls and have been quit for some time with no lapses (weeks or months), have few and/or minor urges to use tobacco, and whose confidence in their ability to stay quit is high. The focus of interventions with these callers is usually on reinforcing strategies that are working, helping them find alternatives to urge situations that still cause them some concern and pose some risk, and helping them assess future high-risk situations. The ACE model is still an effective tool for use in any high-risk situation that may arise.

Case study 2

Robert is reached for his quit date follow-up call two days after he quit. The quit line counsellor assessed him as being quit with no slips or lapses. He is using the nicotine patch, but is not using gum with it because he was not sure he needed it. When asked about the severity of his urges he states they are pretty strong, especially after eating and when taking breaks at work, but also off and on throughout the day for no apparent reason. He rates his confidence in his ability to stay quit at 8 on a scale of 1-10.

The counsellor educates Robert on how using the nicotine gum on a schedule while wearing the patch will help reduce his physical cravings. The counsellor also explores what Robert has been doing after meals and during breaks to avoid smoking. Finding that Robert has been mostly relying on will power to not smoke after meals, the counsellor suggests he try brushing his teeth and using a piece of nicotine gum.

In discussing the challenge of taking breaks, the counsellor finds that Robert has been going out with his smoking friends and just trying not to smoke. Robert tells the counsellor that seeing others smoke sometimes gives him strong urges and he has almost asked his friends for a cigarette. The counsellor suggests that he avoid going out with his smoking friends because it is a very risky situation. Instead Robert will try going for a short walk with a nonsmoking co-worker.

The counsellor ends the call by telling Robert that he is doing a great job and that he should call the quit line if he feels he needs further support. He schedules the next call for one week later.

PRACTICE

4. PRACTICE: BUILDING AN ACTION PLAN (30 minutes)

Work with the person sitting next to you to use the STAR strategy, 5R strategy and the three steps for developing a relapse prevention plan to create:

- An action plan for John who is not ready to quit

John's workplace is going smoke-free, but he is not feeling ready to quit. He says everyone is pressuring him to quit, but he is not sure he really wants to. John is 47 with some health problems.

- An action plan for Sarah who is ready to quit

Sarah is 27 years old and really wants to quit. She recently married and wants to start a family. She has never quit before and is not sure how to go about it.

- A relapse prevention action plan for William who recently quit

William has been smoking for over 25 years and has tried to quit at least six times before. He is now quit for three days. He tells the counsellor that he has never lasted longer than a month, and usually goes back to smoking when he feels frustrated or is around his friends who smoke.

Then take turns rehearsing how you would collaborate with a caller to build the plan.

EVALUATION

5. DEBRIEFING: DEMONSTRATING THE ACTION PLANS (30 minutes)

Please volunteer to demonstrate the action plans.

Please observe demonstrations and provide comments and suggestions to improve action plans.

Module 10: The content of telephone counselling interventions

OBJECTIVES

Upon completion of this module participants will be able to:

- describe the activities/content of different counselling sessions;
- describe the sample counselling protocols;
- conduct different types of counselling sessions using the sample counselling protocols.

AGENDA

1. Developing content of telephone counselling based on different scenarios (20 minutes).
2. Call content and call sequence in the sample counselling protocols (25 minutes).
3. Role play of different calls (50 minutes).
4. Debriefing (10 minutes).

PREPARATION

1. DEVELOPING CONTENT OF TELEPHONE COUNSELLING BASED ON DIFFERENT SCENARIOS (20 minutes)

Work in small groups to develop the content of telephone counselling for the caller you have been assigned.

Group 1

Leo has been smoking for 10 years. He quit in January 2008 with Chantix and was successful for a year when his son was born. Even though it was tough to quit, he was glad he put in the hard work because his son's health is important to him. This January he returned to smoking and he's not sure why. Leo reports that his office initiated a new health policy that makes health insurance more expensive for smokers. The policy goes into effect in 30 days and that is why he called in to quit. He has been taking more smoke breaks at work on purpose because he feels management is discriminating against him. Recently Leo has doubled his number of cigarettes per day. He wants to quit and knows how, but he wants to do it on his own terms.

Group 2

Marlena quit smoking six days ago. You learned during the assessment that she rated her urge severity as high. Her stress was also high. She indicates moderate confidence in her ability to refuse a cigarette if offered one.

She feels at a loss during work breaks – work is very stressful – but she is doing better at not smoking in the car now. She asks about discontinuing nicotine gum now that she has quit. Her family members no longer smoke (they are supporting her) but several friends at work do smoke. She has removed all cigarettes and ashtrays at home but is not able to control the work environment. You also learned that she quit for about two months in the past, but relapsed because of stress related to family and work issues. She is worried about deadlines at work and an upcoming family wedding.

Group 3

Jacob's quit date was three weeks ago. During the assessment you learn that he describes his urge severity as about medium and his stress level as about average. He feels very confident he could refuse a cigarette if offered one. Recently he went to a party with friends and was pleasantly surprised because he did just fine. Jacob is still using patches and uses gum as needed.

His family is proud of him for quitting. At first he spent time with nonsmoking friends, but has not had a problem when socializing with friends who smoke. In fact he cannot imagine himself smoking again.

His house is smoke-free. He is also in a smoke-free environment at work. His longest quit was for six months; he started again when he moved to a new city. He will be taking a vacation in six weeks. He is wondering how he will feel.

Suggested content of telephone counselling for three different callers

Leo	A quit plan using STAR strategies <ul style="list-style-type: none">• Set a quit date as soon as possible.• Tell family, friends, and co-workers about quitting, and request understanding and support.• Anticipate challenges to the upcoming quit attempt.• Remove tobacco products from your environment. Motivation Confidence Experience with quitting/medication.
Marlena	Last puff Urge management Challenging situations Compliance with medication Historic relapse triggers Motivation Confidence.
Jacob	Urge management Challenging situations Motivation (long-term) Confidence Rewards Historic and potential relapse triggers.

PRESENTATION

2. CALL CONTENT AND CALL SEQUENCE IN THE SAMPLE COUNSELLING PROTOCOLS (25 minutes)

Counsellors should provide counselling services based on the call protocols. Here we are going to use the sample counselling protocols to discuss the sequence of counselling calls and how the content differs throughout the sequence.

2.1 Types of calls

Calls are either proactive calls or reactive calls. Proactive (outbound) calls are made by the quit line counsellor to the caller. Reactive (inbound) calls are made by the caller to the quit line.

2.2 Call sequence

The call sequence is further broken down into two main types: the initial planning call and ongoing follow-up calls. Ongoing calls are typically made according to a schedule to prevent relapse after quitting. A typical call sequence is as follows:

#	Call	Description
Call 1	Initial intake and counselling call	Inbound (reactive) call usually initiated by the caller.
Call 2	Pre-quit date call	Proactive outbound call made by counsellor 1–5 days before the caller's planned quit date.
Call 3	Quit date call	Proactive outbound call made by the counsellor on the planned quit date or 1–3 days after the planned quit date.
Call 4	Quit date follow-up call	Proactive outbound call made by the counsellor: <ul style="list-style-type: none"> • 3–5 days after the quit date call (if it is made on the planned quit date). • 5–7 days after the quit date call (if it is made 1–3 days after the planned quit date).
Call 5	Ongoing support call	Proactive outbound call made by the counsellor about 1–3 weeks after the quit date follow-up call.

It should be noted that callers do not always quit as planned. As such, the focus of each call may vary depending on whether the caller has quit, not quit or has relapsed since the previous call. The focus of the call should always be tailored to move the caller to the next phase of the quit continuum.

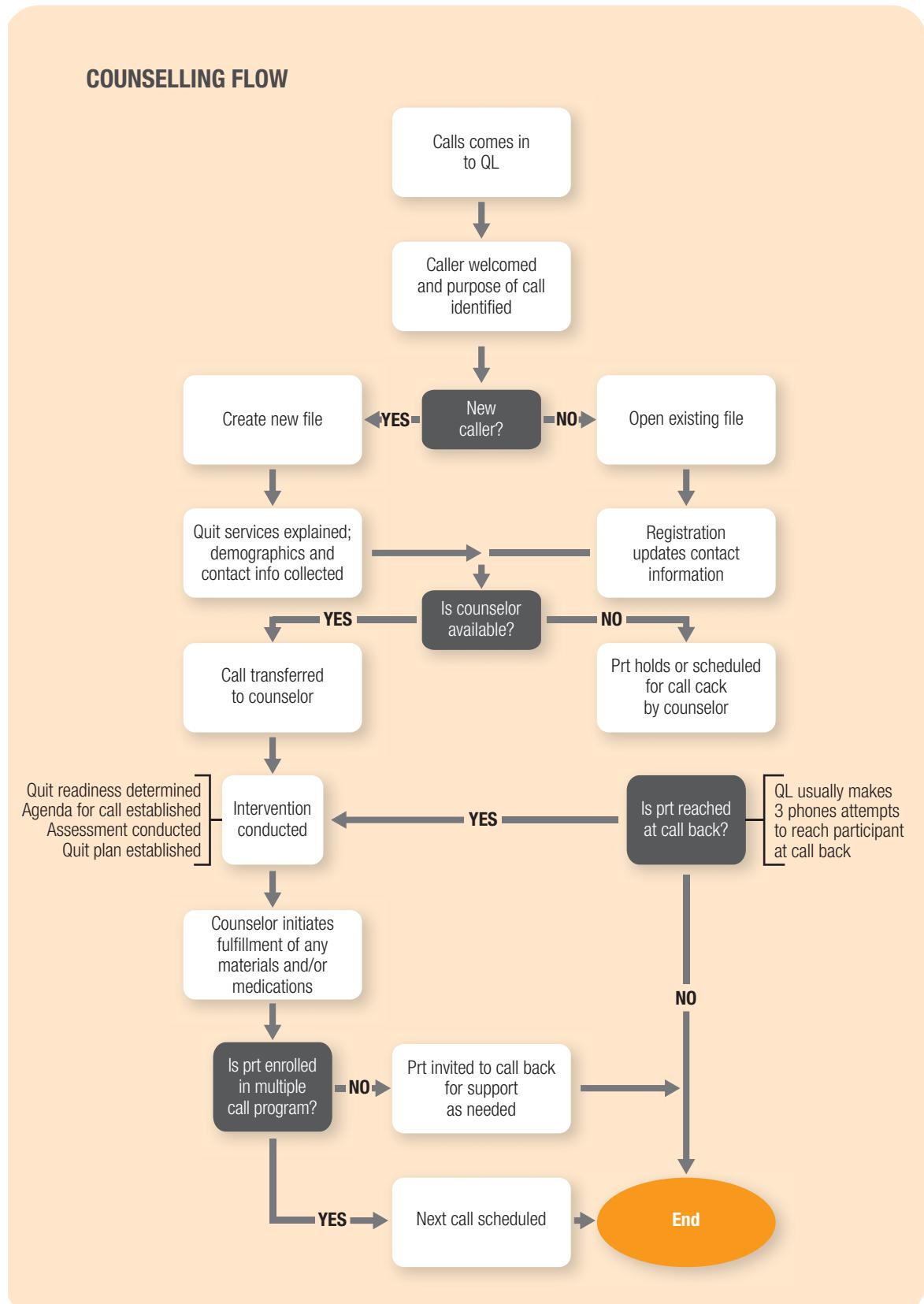
At each call the counsellor will have to make a decision on which counselling approach to use based on the caller's readiness to quit and what aspect of quitting the caller is struggling with. Misapplying the correct counselling approach usually leads to an unsuccessful call outcome. Below is the content of each call:

#	Call	Content
Call 1	Assessment and Planning	<ul style="list-style-type: none"> • Enrol caller. • Conduct assessment, including readiness to quit. • Action planning depends on the caller's readiness to quit: <p>If not ready to quit, the plan should focus on (see Module 4):</p> <ul style="list-style-type: none"> – use MI to identify source of ambivalence and resolve; skill-building as needed; – emphasize the importance of quitting; – build self-efficacy; – future calls will continue to focus on resolving ambivalence until the caller is ready to quit. <p>If ready to quit, quit plan development should focus on (see Module 3):</p> <ul style="list-style-type: none"> – set a quit date (ideally, the quit date should be within two weeks); – tell family, friends and co-workers about quitting, and request understanding and support; ask one or two family or friends to provide support; – anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks; assist the caller to identify coping strategies for common triggers to use tobacco; – remove tobacco products from the environment; prior to quitting, avoid smoking in places where you spend a lot of time (e.g. work, home, car); make your home smoke-free. <ul style="list-style-type: none"> • Summarize next steps to take before the planned quit date in order to continue to prepare. • Enter call notes into the client record. • Schedule next call about five days prior to the planned quit date.

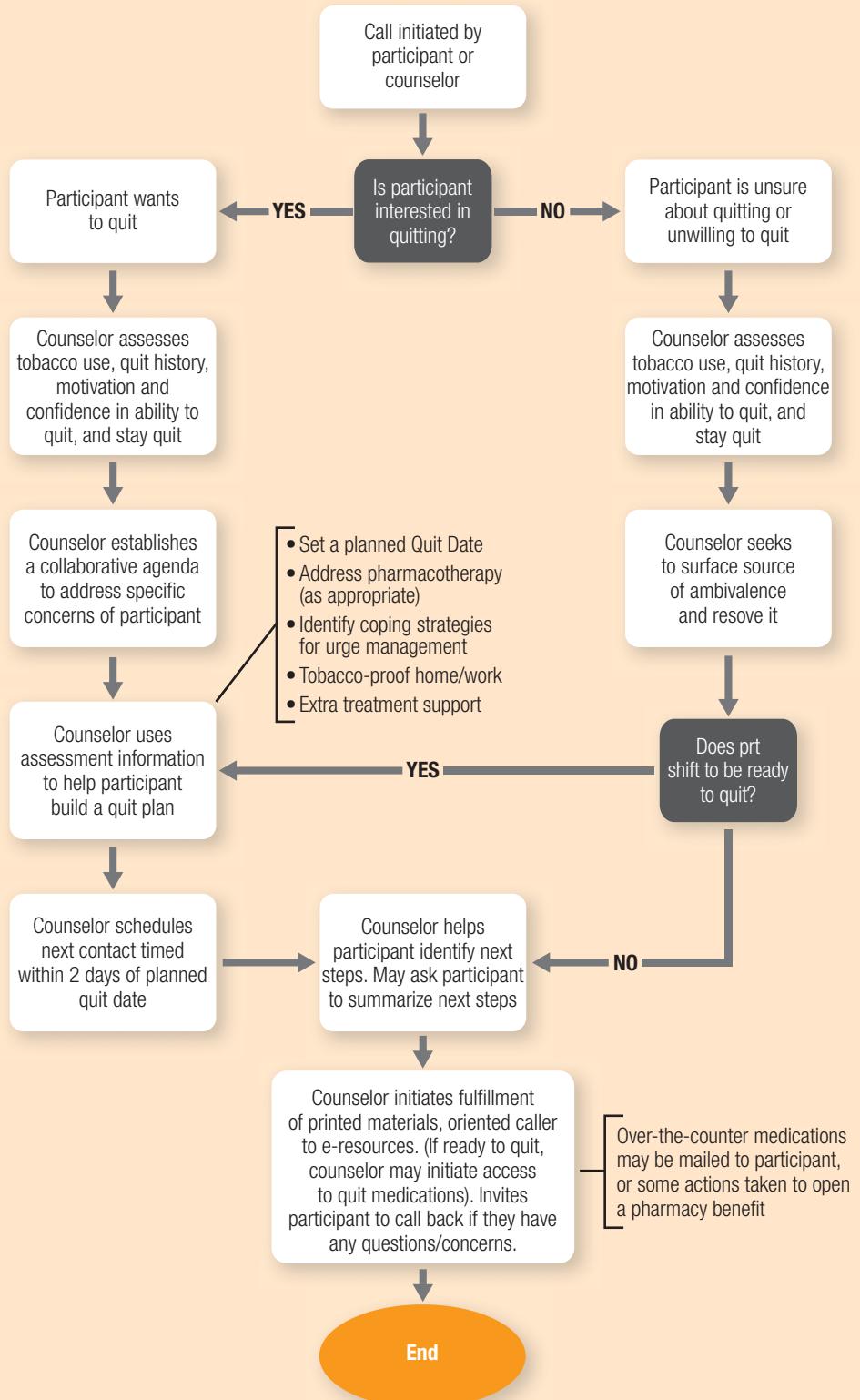
#	Call	Content
Call 2	Pre-quit date call	<ul style="list-style-type: none"> Conduct assessment, including confirming quit date and current cigarettes per day or chewed tobacco per day Assess and enhance self-efficacy in ability to quit and stay quit. Review the caller's plan to quit, including: <ul style="list-style-type: none"> confirm intention to quit on planned quit date; help set a new quit date if the planned date has changed; discuss the plan for anticipating challenges and how to cope with urges to use tobacco; fine-tune the plan as needed; review the plan to use medications to quit, asking the caller to describe how the medications are to be used; determine if the caller has the medications yet or understands how to access them; discuss the plan to remove tobacco products and paraphernalia from home and other surroundings; discuss the plan to tell friends and family about their plan to quit. Summarize next steps to move towards the quit date in the plan. Enter call notes. Schedule next call for one day after the planned quit date.
Call 3	Quit date call	<ul style="list-style-type: none"> Confirm quit status. Assess urge severity; educate on withdrawal symptoms. Assess and enhance self-efficacy in the ability to quit and stay quit. Ensure relapse prevention plan, including: <ul style="list-style-type: none"> identify relapse risks associated with early stages of quitting, addressing nicotine withdrawal and triggers to use tobacco; prepare the caller with coping skills, matching the skills to triggers specific to the caller; provide or identify support from family and friends; confirm that the caller has removed tobacco from the environment and is avoiding other tobacco users when possible. Review proper medication use; offer corrective advice if using incorrectly and reinforce proper use. Help caller set new quit date if caller has relapsed. Summarize next steps in plan to sustain quit or make a new quit attempt. Enter call notes. Schedule the next call five days later.
Call 4	Quit date follow-up call	<ul style="list-style-type: none"> Confirm quit status. Assess urge severity and strength of withdrawal symptoms in the context of the quit status. Assess and enhance self-efficacy in the ability to quit and stay quit. Assess and problem-solve urge management challenges: <ul style="list-style-type: none"> address/problem-solve slips if they have occurred; assist in finding new coping strategies for situations that are proving difficult. Confirm the caller is using medications properly and assess whether the supply is sufficient for a complete regimen. Assess for future high-risk situations and help the caller revise the relapse prevention plan as needed, including long-term plans (see Module 9). Help the caller set a new quit date if he/she has relapsed. Summarize next steps in the plan. Enter call notes. Schedule next call 1–3 weeks later, depending on the needs of the client.
Call 5	Ongoing support call	<ul style="list-style-type: none"> Confirm quit status. Assess urge severity and strength of withdrawal symptoms. Assess and enhance self-efficacy in the ability to quit and stay quit: <ul style="list-style-type: none"> assess motivation for signs of complacency or taking the quit for granted; continue to reinforce successful quit strategies to build confidence. Problem-solve urge management challenges and explore and problem-solve lapses if they have occurred. Review proper medication use (if the caller is still using medications). Assess for future high-risk situations and help the caller revise the relapse prevention plan as needed, including long-range plans. Help the caller set a new quit date if the caller has relapsed. Summarize next steps in plan, including other sources of support. Enter call notes. Inform the client that this is the last call the quit line will make. Invite the client to call for further support as needed.

2.3 Counselling flowchart and intervention flowchart

Below are examples of a counselling flowchart and an intervention flowchart.



INTERVENTION FLOW



Source: Together Plus intervention, the United Kingdom.

PRACTICE

3. PRACTICE FOR DIFFERENT CALLS (50 minutes)

Practise completing a series of calls as if you were accompanying the caller through the programme according to the following instructions. Please work in a group of three doing role plays to practise an intake call, quit date call and relapse prevention call.

For role plays:

- In groups of three, take turns being a quit line counsellor, caller and observer.
- Decide within your group who is going to be the quit line counsellor, the caller and the observer for each call.
- As a group complete three calls – call 1, call 2 and call 5 using the scenario below. The person to be the caller in call 2 and call 5 will have to make up the caller's story by building upon what happens in the first call.
- You are not going to be able to reach your caller for calls 3 and 4.

Call 1 (Caller is ready to quit within 30 days):

Participant A – Quit line counsellor

Participant B – Caller

Participant C – Observer.

Call 2 (Caller has been quit for two weeks)

Participant A – Caller

Participant B – Observer

Participant C – Quit line counsellor.

Call 5 (Caller has relapsed)

Participant A – Observer

Participant B – Quit line counsellor

Participant C – Caller.

Sample caller – Loraine

Lorraine is a 56-year-old married female. **Quit date:** She wants to quit in three weeks. **Tobacco type:** Smoking two packs of cigarettes per day. **How long:** for 30 years. **Motivation:** 6 (she has high blood pressure and wants to be more active, but she feels as if she is losing her best friend). **Confidence:** 8 (Lorraine has done this before and has the tools to deal with urges). **Quit medication:** She wants to use the nicotine gum. **Quit history:** She quit once for two years. Loraine believes she was successful because she did not know any other smokers. She relapsed due to stress and new job around other smokers. **Around smokers:** In the workplace. **Other notes:** Loraine is worried that, because she has smoked for so long, she won't know what to do without her cigarettes.

EVALUATION

4. DEBRIEFING (10 minutes)

Please share your experience:

- How were the initial call and ongoing calls similar/different?
- What did you address and how did you address it differently in different calls (calls 1, 2 and 5)?
- What agenda did you set in each call?
- What intervention strategies did you use in the different calls?

Module 11: Special populations and cultural awareness

OBJECTIVES

Upon completion of this module participants will be able to:

- recognize that the counsellor will provide services to a variety of people who have different needs and face unique barriers in attempting to quit tobacco use;
- describe how to adapt the intervention for members of special populations;
- build self-awareness about personal values and beliefs and become aware that other people have their own beliefs and experiences;
- identify and negotiate different styles of communication, decision-making preferences, and appropriate interventions for special populations.

AGENDA

1. Becoming aware of yourself (10 minutes).
2. Factors that may influence the effectiveness of tobacco cessation treatment for special populations (25 minutes).
3. Understanding tobacco cessation issues for some special populations (35 minutes).
4. Evaluation (10 minutes).

PREPARATION

1. BECOMING AWARE OF YOURSELF (10 minutes)

As a quit line counsellor, you will speak to a variety of people from variety of people of different cultural backgrounds, ages, sexual orientation, mental health conditions and chronic illnesses, as well as pregnant tobacco users. For you to deliver culturally competent interventions you need to avoid stereotypes and assumptions about people's cultural identities, values and beliefs. You will experience different issues relating to culture and communication. Having biases and making judgements is normal; these are shortcuts our brains take to understand the world around us quickly. However, suspending judgement is critical to serving quit line callers. Occasionally something may happen during a call that makes you uncomfortable or gives you a bad reaction. This may be based on a generalization you are making or a reaction that you have to a caller's values. Examples may include pregnant tobacco users, political opinions and religious beliefs. Therefore, for you to deliver culturally competent interventions, the first step is to become aware of your values and biases. The following cultural awareness self-assessment form can help you learn about yourself.

Please take a self-assessment to discover your comfort and skill with interacting with diverse populations. There is no right or wrong answer; the goal is to learn about yourself.

Cultural Awareness Self-Assessment Form	
Items	Response (Yes/ No/ Not Sure)
1. I can define culture and list various factors that influence culture.	
2. Cultural traditions influence health decisions.	
3. I am aware of my own biases and limitations.	
4. I sometimes feel uncomfortable with people whose cultural backgrounds differ from my own.	
5. I am confident that I can explore the relevance of these topics with callers:	
• the role of elders	
• the role of family	
• the role of community	
• spirituality, religion, customs, traditions	
• beliefs about health and illness	
• the role of trust.	
6. I am confident I can incorporate culturally relevant information into the intervention.	
7. I am confident I can communicate with sensitivity, respect and cultural competence in delivering a service to diverse populations.	
8. I am confident I can build alliances with callers from other cultures.	

REFLECTION

What did you learn about yourself? What kinds of things might you change? What will it take to make those changes?

PRESENTATION

2. FACTORS THAT MAY INFLUENCE THE EFFECTIVENESS OF TOBACCO CESSATION TREATMENT FOR SPECIAL POPULATIONS (25 minutes)

While the intervention for general populations is largely effective across different populations, people are complex and a lot of factors may influence the effectiveness of telephone counselling for them. As a quit line counsellor, it is good for you to pay attention to what these factors are and how you can leverage them in your intervention.

Brainstorming:

What are some factors that may influence the effectiveness of tobacco cessation treatment?

These factors may include culture, personal value, family, gender, occupation, unique health issues and conditions. Understanding these factors can help the quit line counsellor to build a better therapeutic relationship with special populations (see details in Module 6: Facilitation skills) and identify appropriate interventions for them.

2.1 The role of family

Quit line counsellors may talk with callers who place a high value on family. For some people it is really important to quit for the sake of their family, or their family is motivating their quit and is a great support to them. However, in other cases callers may not want to tell their family that they are quitting because they do not want their disappointment if they fail. In both cases, the family is important but the behaviour is different.

Other values the quit line counsellor should pay attention to are health, community, spirituality, the role of elders, money, and time.

2.2 When it is important to know the culture of the caller

There are times when it is important to have information about a specific culture, to know something about the population because it will make a difference in your intervention. For example, when quit line counsellors in the USA work with Alaska Natives, it is important to know that the caller may not have access to a telephone. This will affect how calls are scheduled. Another example is tobacco use among North American Indian tribes. Some of them use tobacco for sacred ceremonies, and that will also affect the way the quit line counsellor will frame the discussion about tobacco.

2.3 The danger of making assumptions about callers

It is very important that the quit line counsellor does not make any assumptions about a person just because of their age, gender, race, ethnicity, physical & mental health conditions, etc. However they should be aware of how these criteria may influence their interactions with the caller, and they may use their facilitation and assessment skills to gain insight into how to best support them in their effort to quit.

2.4 Other factors

Prevalence of tobacco use may be higher in some segments of the population the quit line serves than in others. Remaining aware of this may give the quit line counsellor insight into cultural norms regarding tobacco use that might inform the action plan they develop with the caller.

2.4.1 Adolescents

Smokers under the age of 18 present some challenges. There is a lack of good evidence about what is effective in helping teenagers to quit. Most approaches support using strategies that work for adults but tailoring them to the needs of youth. Adolescent and teenage smokers tend to have less control over their environment and may not be able to avoid other smokers, especially if members of their family smoke. Some are not daily smokers as they may not have regular access to cigarettes. It is critically important to create an atmosphere of trust and respect with young callers.

2.4.2 Mental health conditions

Quit lines are receiving higher and higher numbers of calls from tobacco users with mental health conditions. It should be noted that there are many different mental health conditions, ranging from depression to schizophrenia. Within each type of mental health condition there is a range of functionality. Some callers who report mental health conditions are highly functional while others demonstrate significant cognitive challenges.

In working with these callers it is important for the quit line counsellor to treat them with respect, as they would any other caller. The quit line counsellor should tailor the plan to meet the needs of the caller, including dividing the plan into smaller and more manageable steps, if needed, for more challenged callers. All callers with mental health conditions should be encouraged to let their health-care provider know that they are quitting. If they are taking psychotropic medications for their mental health condition, their dosage may need to be adjusted after quitting.

Some callers with mental health conditions can be tangential in their conversation. The quit line counsellor should use open-ended questions more carefully in order to provide more structure to the intervention. The quit line counsellor may need to devote some energy and skill to keeping the call on the topic of quitting tobacco.

As noted in the section on Pharmacotherapy (Module 5), special care should be taken to encourage the callers to inform their mental health provider of their intent to quit tobacco, to inform their health-care provider about any plans to use quit medications, and to have dosages of any psychiatric medications monitored after quitting.

PRACTICE

3. UNDERSTANDING TOBACCO CESSATION ISSUES FOR SOME SPECIAL POPULATIONS (35 minutes)

3.1 Part 1

In this activity you will learn about tobacco cessation issues for some special populations. Please work in five small groups and take 10 minutes to do the following:

- Review information about one of five special populations: women, pregnancy, adolescents, persons aged over 65 years, and those with mental health conditions and substance abuse disorders (each group works on one special population).
 - Describe specific issues related to tobacco for your assigned population.
 - If there is evidence for adapting the intervention, please recommend adaptations.
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3.2 Part 2

Now, move to your new group. In your new group, take 10 minutes to share the information about the population reviewed in your original group. Take notes on what your new group members share about the special populations they discussed in their original groups.

Suggested information on special populations:

Women

- Women may have more difficulty quitting than men because of fear of weight gain, social support needs, identity issues and depression.
- On the other hand, telephone counselling may be appealing to women who are at home caring for children. Women are more likely to use quit line services.
- NRT is sometimes slightly less effective with women than with men, but should still be offered if it is part of the quit line protocol.

Pregnancy

- Because of the urgency of quitting as soon as possible, quit line counsellors should be more directive about setting a quit date as soon as possible.
- Setting shorter intervals between calls is important if the caller has not quit.
- Quit line counsellors should be sure that the woman understands the seriousness of her continued smoking to the health of the fetus, and the immediate benefits of stopping.
- Decision-support on the use medication during pregnancy is complex, and should be handled differently from routine decision-support on medication given to the general population.
- A majority of pregnant women who quit relapse after they have given birth, so it is important also to bolster an intrinsic desire to stop smoking altogether for the sake of the woman's health sake and that of her family.

Adolescents

- General guidelines are to provide treatment for young people as you would for adults except to tailor it to the needs of youth. For example, young people may not be daily smokers since they may not have access to tobacco on a daily basis. The same is the case for the amount of tobacco used per day because of difficulties of access.
- Young people may not have control over their environment and, as such, they may be exposed to other smokers such as siblings or parents.
- It is very important to develop trust and rapport with young people in order to facilitate a relationship in which they feel safe.

Over 65s

- It is often assumed that older people do not want to quit tobacco because it is too late to experience the benefits of quitting.
- However, older people do benefit from quitting regardless of their age.
- Older adults may tell more stories during the intervention. The counsellor should respect this while trying to keep the call on track.

Mental health conditions and substance abuse disorders

- The prevalence of smoking is often much higher in these populations and quitting can be more challenging.
- However, it appears that the desire to quit among those with mental health conditions and drug and alcohol problems is similar to that of other tobacco users. In addition, medication and behavioural support increases their chances of successfully quitting.
- There is no evidence that quitting tobacco makes it harder to quit other drugs, although there is some evidence that it actually makes it easier to avoid relapse. Quit lines are currently grappling with whether special protocols should be introduced for these populations. However, it is unclear whether callers with mental health conditions or substance abuse disorders would benefit more if they received a different counselling protocol. It is very important that quit lines do not restrict access to their services for persons with these conditions, and that they work with mental health and substance abuse providers to help ensure that quitting tobacco is viewed as important.

EVALUATION (10 minutes)

Please volunteer to respond to the questions:

- What things would always stay the same despite differences across populations?
 - What things may need to change?
-
-
-

Module 12: Challenging calls

OBJECTIVES

Upon completion of this module participants will be able to:

- recognize types of challenging callers and identify the features of a challenging call;
- describe and distinguish between challenging calls on the basis of content, process, and issues of perception;
- describe and demonstrate strategies to reduce or eliminate challenges by addressing content, process and perceptual skill issues;
- apply and demonstrate the 5-step disarming technique to manage challenging calls;
- recognize when the crisis intervention protocol is needed;
- demonstrate implementation of a quit line crisis protocol;
- demonstrate knowledge of the various types of crisis situation.

AGENDA

1. Who can be challenging callers (10 minutes).
2. Types of challenging calls (10 minutes).
3. 5-step disarming technique (10 minutes).
4. Crisis protocols (15 minutes).
5. Practice identifying types of challenging calls (15 minutes).
6. Practice applying the 5-step disarming technique (10 minutes).
7. Evaluation (10 minutes).

PREPARATION

1. WHO CAN BE CHALLENGING CALLERS (10 minutes)

Quit line callers include a wide range of individuals, some of whom may be more difficult to treat than others.

Brainstorming:

Who can be challenging callers?

Possible responses: callers who are:

- highly nicotine dependent, including those who use multiple types of tobacco;
- very ambivalent about quitting;
- angry or resistant to receiving help with quitting;
- suffering from a mental health condition and may be cognitively challenged, low functioning and/or tangential;
- suffering from a serious chronic illness and reluctant or unsuccessful at quitting.

Each population requires that the quit line counsellor is proficient in facilitation, the counselling approach, intervention strategies, and implementation of pharmacological treatment if medications are available. Each challenging caller requires that the quit line counsellor tailors the approach to the barriers to quitting presented by that caller. Sometimes success with these populations is measured in small steps towards the goal of quitting.

PRESENTATION

2. TYPES OF CHALLENGING CALLS (10 minutes)

Calls can be challenging and get off track due to content, process or perceptual challenges. Below are symptoms of these challenges and how you can address them.

2.1 Content

The call may be off track because the content you are addressing is not important to the caller. To get the call back on track, use active listening to understand what the caller's need really is. Example: "I don't think I am focusing on the right thing. Let me check back with you to see what is important to you right now."

2.2 Process

There may be times when the intervention appears aimless. For example, you may not be able to control the call or move the conversation in a productive direction, the caller's responses may be rambling or confused, or the conversation is unfocused. To get the call back on track, you can check in with the caller and make sure he/she is able to understand your questions and the purpose of the call. You may need to speak louder or more clearly, or use language that is more familiar to the caller. You may need to be more overt about the focus and purpose of the call.

2.3 Perceptual

Sometimes the call is challenging because of your feelings and attitudes. We bring our personalities, upbringing, values, beliefs, life experiences and prejudices to our interactions. There are times when we are hungry, tired or ready to have a break. While it is human to have feeling, it is essential that we remain aware of our mindset so that we can stay focused and provide the best quality treatment to callers. To get the call back on track, put aside judgement and set an agenda to meet the caller's needs.

3. 5-STEP DISARMING TECHNIQUE

When the call is challenging because the caller has some hot emotions, anger or grief, or the call goes off track, this 5-step disarming technique can help show empathy and restore an alliance with the caller. The goal is to engage the caller in the intervention and redirect the conversation back to the goals of the call. The goals with this strategy are to:

- display unconditional acceptance, using active and reflective listening;
- accurately reflect and summarize the content and feelings of the caller's experience in trying to quit tobacco;
- recognize intrapersonal (personal issues) and interpersonal threats that are barriers to alliance;
- confirm the caller's perception of the accuracy of reflections.

The quit line counsellor does this by expressing:

- the kernel of truth
- empathy
- clarify
- I feel (validate)
- thanking.

Here is an example:

5-step disarming technique	Caller's statement	Quit line counsellor's response
Step 1. The kernel of truth The kernel of truth is a reflection of the meaning or feeling in the caller's statement.	"It's my husband's fault. He knows I want to quit but insists on smoking in the house. No matter what I say or do, he is unwilling to change. And all the rest of those counsellors we talked too just took his side, kind of like how I'm feeling right now."	"Your husband has made it difficult for you to quit, and this is unfair to you."
Step 2. Empathy The second step is to show empathy. You show the caller that you identify with and understand the situation. You can do this by sharing your thoughts and feelings about the situation.		<p>Thought "It sounds like you want to quit but it's been too difficult since your husband smokes around you."</p> <p>Feeling "I can only imagine the anger that you must be feeling right now."</p>
Step 3. Clarify The third step is to clarify. In this step you ask the caller if your understanding is accurate.		"Am I reading you correctly?"
Step 4. I feel (validate) In step 4 you validate the caller's feelings. When you do this you acknowledge that you have an accurate understanding of the way he or she feels about the situation. You also let the caller know he or she is being heard.	"(Sigh)...Yeah. I am angry. He just doesn't understand how important it is for me to do this right now."	"I can see why you are angry ...it doesn't seem fair to you when you really want to quit."
Step 5. Thanking In the last step, you thank the caller. You acknowledge that the caller shared important feelings with you and at the same time you redirect the conversation back to the intervention.	<p>"It's not fair, but I guess I can't change what people do. Only what I do."</p> <p>"Thanks for listening. I'm sorry I bit your head off. Do you really think I can do this?"</p>	"I'm glad you told me about how you feel and the struggles you've been going through. This will allow us to work better together as a team to plan for your quit."

It is important to refrain from trying to solve the problem or trying to change the way the caller feels about the situation. This is a common reaction people have when they hear others share emotions. Trying to solve the problem may escalate the situation because the caller does not feel heard or validated for feelings. The quit line counsellor may not agree with the caller's appraisal of the situation, or the counsellor may see a simple solution, but that is not the point. The point is to defuse the caller and to bring the call back on track.

4. CRISIS PROTOCOLS (15 minutes)

Crisis protocols are intended to provide a clearly defined approach for the counsellor to deal with emergency situations. These may include:

- suicidal ideation, threats, or attempts;
- threats of harm to others;
- medical emergencies, such as chest pain, neurological symptoms, etc.;
- abuse of children or dependent adults;
- verbal abuse aimed at the counsellor.

It is important for the safety of callers that counsellors are very familiar with the crisis protocols created by the quit line. Failure to follow protocols in crisis situations may also put the quit line at risk from the perspective of liability.

Example of a crisis protocol for medical emergencies, such as chest pain:

VI. MEDICAL EMERGENCIES

1. POTENTIALLY LIFE-THREATENING

If the client reports symptoms such as **chest pain** (i.e. possible heart attack or pulmonary embolism) and appears to be **in acute distress** (i.e. having trouble breathing or talking) and/or thinks he/she may need immediate medical attention, Counsellor should alert the Supervisor and advise client to hang up and call for medical assistance. If the client agrees and is able to make the call (or has someone else at home who can make the call for them), the Counsellor should say that he or she will call back in 10–15 minutes to make sure client is OK and medical personnel are on the way. Counsellor should document the incident in the file notes.

If client agrees to an emergency call but is unable to call his or herself, has nobody else with them who can call, or prefers that the Counsellor call for them, follow protocol below.

Stay on line and proceed as follows:

- Make sure we have correct address and phone number.
- Put the phone on “mute” and enlist the aid of those around you...send out “Crisis – need help” email to Supervisors and Managers.
- Have Supervisor or Manager call for medical assistance from another phone. Explain there is a caller on the other line who is having a medical emergency.
- Stay on the phone with the client until help arrives.
- Document in notes, discuss and debrief with Supervisor.

Case study

Omar is on a call with a client who says he is having some chest pain, and has a history of some heart problems. Omar references the crisis protocol for medical emergencies and alerts his supervisor that he has a person on the phone with a potentially life-threatening condition.

He asks the client if he is willing to go to the hospital to be evaluated and the caller agrees. Omar inquires if the client feels able to call himself or if Omar should do it for him. The caller asks Omar to call for him as he feels like he may pass out, and the supervisor makes the call giving medical personnel the caller's name, address and symptoms. Omar stays on the telephone with the client until medical help arrives. Omar documents the situation in the file notes and debriefs with his supervisor for a few minutes. The supervisor asks Omar if he is OK or needs to take a short break. Omar decides to take a short break and have a cup of tea to relax a little.

PRACTICE

5. PRACTISE IDENTIFYING TYPES OF CHALLENGING CALLS (15 minutes)

Please read the three scenarios and answer the following questions for each of them:

- Is the issue a content, process or perceptual challenge?
- What are some ways to get this call back on track?
- What can the quit line counsellor say?
- What actions should the quit line counsellor take?

Scenario 1

A caller keeps asking you to repeat yourself and does not seem to understand your questions.

Scenario 2

Mark calls in to obtain the patches, but the quit line counsellor shares a lot of information about how the patches work and the benefits of using them. Mark just replies “uh, huh” and keeps asking if he can have the patches. Frustrated, Mark finally says “you are not listening to me, I know how to use the patches, and this is not why I called in today.”

Scenario 3

Joan, a 57-year-old “frequent caller” calls in for support. Even though Joan calls into the programme often, the notes indicate that she always remains tobacco-focused. At the beginning of the intervention, the quit line counsellor asks a closed-ended question, “Did you call in because you want to quit soon?” Joan replies after a long pause, “Yes, I want to quit sometimes.” Noticing that Joan calls often, the quit line counsellor offers Joan an agenda topic that Joan neither agrees nor disagrees to discuss. During the intervention Joan’s responses seem confused. She is becoming frustrated because she is being interrupted by the quit line counsellor who does not intend to be rude, but is naturally a fast talker and a quick thinker. The quit line counsellor also becomes frustrated because the intervention is going beyond time expectations and seems to be aimless so she desperately tries to regain control of the call.

Suggested answers:

Scenario 1: Process

- Identify the client’s needs and specifically relate them to his or her quitting process. For example, “What part of your plan should we talk about to help you stay quit (or help you plan for your quit)?”
- Be very clear about the purpose of the call and what the caller’s goals are now, and then apply this to this call. For example, “Let’s do just this today, and next week you can work on the next step.”
- Use signposting to help keep the call on track. If appropriate for the caller, set guidelines at the start, including the amount of time available for the call.
- Be careful not to encourage friendly chatter that is off the topic.
- If the caller goes off the topic, bring it back to smoking and/or remind the caller of the purpose of the programme.

Scenario 2: Content

It appears that the quit line counsellor and the client have different agendas. As a result the quit line counsellor is not addressing the right content. The quit line counsellor can say: “I don’t think I am focusing on the right thing. Let me check back with you to see what is important to you right now.”

Scenario 3: Perceptual

Put aside judgement and set up an agenda based on client needs.

6. PRACTICE APPLYING THE 5-STEP DISARMING TECHNIQUE (15 minutes)

Please role-play in pairs. Use the 5-step disarming technique to build alliance with two callers showing hot emotions.

Caller 1

"I'm lying to my doctors right now... I'm telling my doctors that I'm not smoking because I'm so ashamed that I keep going back."

Step 1. Kernel of truth	
Step 2. Empathy	
Step 3. Clarify	
Step 4. I feel (validate)	
Step 5. Thanking	

Caller 2

"I'm 53 and I've been smoking for 40 years and it's my best friend (crying) and I have to get rid of it."

Step 1. Kernel of truth	
Step 2. Empathy	
Step 3. Clarify	
Step 4. I feel (validate)	
Step 5. Thanking	

Suggested answers:

Caller 1

Kernel of truth	"You're ashamed that you can't quit and stay quit. It's too difficult to admit this to your doctor."
Empathy	"It sounds like you really want to be able to quit but you're afraid of how your doctors will react when they find out you're still smoking."
Clarify	"Am I hearing you right?"
I feel (validate)	"I can only imagine how hard it must be to have to hide this from your doctors because you've tried to quit so many times and then returned to smoking."
Thanking	"I really appreciate you sharing this with me. I think it will help us work together to help you quit for good."

Caller 2

Kernel of truth	"Cigarettes really feel like an old, close friend to you and it's hard to imagine giving that up."
Empathy	"It sounds like it is really upsetting for you to think about letting go of the smokes. They've been around for a long time."
Clarify	"Is that right?"
I feel (validate)	"I understand how tough that is. I felt the same way when I lost a friend before."
Thanking	"Thanks for sharing these feelings with me. This will help in our collaboration to move you closer towards your goal of quitting."

EVALUATION (10 minutes)

Feedback on the role plays:

- What was challenging about these role plays?
 - What was the impact of using the disarming techniques with your caller?
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-
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Module 13: Supporting the intervention with supplementary resources

OBJECTIVES

Upon completion of this module participants will be able to:

- list common types of supplementary printed materials and e-communications used in quit line services;
- describe how supplementary printed materials and e-communications can be used to actively engage quit line callers throughout all phases of the quitting process.

AGENDA

1. Examples of supplementary materials (10 minutes).
2. How can supplementary resources support quitting (30 minutes).
3. Practise using supplementary resources to enhance the call (50 minutes).
4. Evaluation (10 minutes).

PREPARATION

1. EXAMPLES OF SUPPLEMENTARY RESOURCES (10 minutes)

Quit lines may offer a variety of other support such as printed materials (quit guides, support guides for family and friends), web-based tobacco interventions and mobile text messaging (SMS). Quit lines may also offer information and support for family, friend, and health-care providers who want to help tobacco users quit.

Exercise:

Please take 10 minutes to review the table of contents of the sample quit guide.⁵ Select 2 or 3 topics/sections in the materials and describe when and how you would refer callers to the materials.

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5. Clearing the air: quit smoking today. Bethesda, MD: National Cancer Institute; 2008 (<http://www.smokefree.gov/landing.aspx?rid=1>).

PRESENTATION

2. HOW CAN SUPPLEMENTARY RESOURCES SUPPORT QUITTING (30 minutes)

All forms of printed and e-communications have the potential to actively engage quit line callers beyond the limits of phone calls. They provide callers with materials they can use between scheduled calls in preparing to quit and in staying quit. The quit line counsellor can augment telephone-based services by referring callers to printed materials or web-based materials for more information. This is frequently called "active self-management".

The quit line counsellor can provide callers with content to review between calls and then use it as a discussion point in the next call. Below is some information on how supplementary materials can support quitting.

2.1 Printed materials

This is the most common and traditional form of support material. Printed materials can vary in complexity and in how they are used. It is very important that they match the quit line treatment protocols for otherwise they can create confusion among callers. It is also important that they are written in plain language that is easily understood by the reader.

Printed materials are more difficult and expensive to update than e-communications. The advantage is that they do not require the user to have access to any special technology.

2.2 Web-based services

Some quit lines provide Internet-based services ranging from static content to interactive, tailored sites. Some of these include social network components, such as discussion forums. These can have special subgroups where specialty topics, such as smoking and pregnancy or smoking and youth, can be discussed.

The USA's 2008 clinical practice guideline identified Internet-based services as highly promising.⁶ While the treatment intensity is less than that of telephone counselling, the reach potential is very high (Zhu, 2007). The challenge with web-based services is that more and more e-users are transitioning away from the web to mobile devices.

2.3 Mobile technologies

SMS, or text messaging, can provide quit line callers with daily tips. These tips can be tailored to recipients to support them throughout the quitting process. Most SMS messaging is not interactive but users can reply using key words to get additional support as needed. The quit line counsellor should be aware of the content of these messages as quit line clients may reference them and ask questions. Some text messages can be tailored to specific populations, such as pregnant smokers or adolescent smokers.

Some quit lines use chat room formats for their quit line counsellor to talk "real-time" with those using the services. This can be a time-consuming approach since it takes longer to type messages than it does to talk; however, it offers an approach that younger tobacco users like.

An emerging technology is mobile applications. These apps can provide users with a variety of information, activities and communication channels. At this point in time, there is little evidence to support the effectiveness of mobile applications, with most apps using content that is not evidence-based. However, many experts in quit line services see great potential for the use of mobile applications. They may provide a practical approach to post-quit support that is readily accessible to the user.

6. Clinical practice guideline: treating tobacco use and dependence: 2008 update. Rockville, MD: US Department of Health and Human Services; 2008.

In summary:

Quit line counsellor working for quit lines who have a variety of supplementary materials can guide clients in obtaining information in ways that best support them and in ways that the caller is most likely to use. Some will want printed materials, others will want web-based information, while still other may prefer text messages or access to mobile applications. It should be noted that the evidence for effectiveness of these modalities is much less than that for telephone-based interventions, but that they show promise.

PRACTICE

3. PRACTICE USING SUPPLEMENTAL RESOURCES TO ENHANCE THE CALL (50 minutes)

Activity 1

Participate in a large group discussion on:

- how the immediacy of SMS or mobile applications might support callers in engaging in the quitting process;
 - the kind of text messages that might support a caller;
 - an example of when in the quit continuum a message might be sent.
-
-

Activity 2

Please review the excerpt from the online quit guide (American Cancer Society) and brainstorm: how would you use these materials to help a caller get started on his/her quit or remain quit.

Sample online material: Excerpt from online *Guide to quitting smoking*. Atlanta, GA: American Cancer Society (<http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/index>).

Please review the excerpt of the Clear the air guide (United States National Cancer Institute) and brainstorm: how would you use these materials for a call to someone who is:

- ready to quit
- not ready to quit?

Sample printed material: Excerpt from *Clearing the air: quit smoking today*. Rockville, MD: National Institutes of Health, US Department of Health and Human Services; 2008 (<http://www.smokefree.gov/landing.aspx?rid=1>; http://www.smokefree.gov/pubs/Clearing_the_Air_508.pdf).

EVALUATION (10 minutes)

Please volunteer to share:

- What are your recommendations for using web-based materials?
 - What are your recommendations for using printed materials?
-
-
-

Module 14: Integrated practice

OBJECTIVES

Upon completion of this module participants will be able to:

- demonstrate ability to integrate information about tobacco and nicotine in order to contextualize the cessation process and enhance motivation;
- demonstrate ability to synthesize the various counselling strategies based on the caller's readiness to quit;
- demonstrate ability to provide pharmacological decision-support;
- demonstrate ability to develop a quit plan and a relapse prevention plan according to the call sequence and quit status;
- demonstrate cultural awareness in delivering interventions and tailoring interventions to special populations;
- articulate how to implement crisis protocols;
- demonstrate the integration of resources such as printed quit guides, SMS and social networking into the treatment plan;
- demonstrate ability to document caller records accurately and concisely;
- articulate the need for confidentiality and ethical care in working with quit line callers.

AGENDA

1. Assessing confidence to deliver calls (15 minutes).
2. Assessing knowledge and skills learned during the training (60 minutes).
3. Practise the skills and knowledge learned during the training (4 hours).
4. Debriefing (30 minutes).

PREPARATION

1. ASSESSING CONFIDENCE TO DELIVER CALLS (15 minutes)

Please rate your confidence to deliver calls to callers who are ready to quit and who are not ready to quit:

You will become confident once you have done it several times in real situations. In this module you will have opportunities to practise applying the knowledge and skills learned during the training to provide telephone counselling.

PRESENTATION

2. ASSESSING KNOWLEDGE AND SKILLS LEARNED DURING THE TRAINING (60 minutes).

2.1 Quiz: Check your knowledge

Please answer the following 37 questions in 30 minutes.

Tobacco and nicotine

1. Smoking prevalence of women is:

- A. Lower than that of men, but it has been increasing over the past 40 years.
- B. The same as that of men, but has been increasing over the past 40 years.
- C. Higher than that of men and has been increasing over the past 40 years.

2. Some tobacco products are smoked, others are chewed. Select the tobacco products that are smoked:

- A. Bidis
- B. Cigars
- C. Dissolvable tobacco
- D. Electronic cigarettes
- E. Gutka
- F. Kreteks
- G. Moist snuff
- H. Pipes
- I. Roll-your-own cigarettes
- J. Snus
- K. Water pipes, also known as shisha, hookah, narghile.

3. What is the physically addictive ingredient in tobacco products?

- A. Smoke
- B. Tar
- C. Nicotine
- D. Formaldehyde.

4. Smoking is associated with nearly every kind of cancer.

- A. True
- B. False.

5. Quitting smoking will not slow the progression of chronic obstructive pulmonary disease COPD.

- A. True
- B. False.

6. Those who quit smoking can significantly reduce their chances of having a stroke or heart attack, especially a fatal heart attack.

- A. True
- B. False.

Practical and theoretical approaches for those ready to quit

7. Which is NOT a domain in the social cognitive theory model?

- A. Personal
- B. Societal
- C. Behavioural
- D. Environmental.

8. There are practical and theoretical approaches that can be used during a call. Which is NOT an intervention strategy?

- A. Education/persuasive education
- B. Skill-building/practical problem-solving
- C. Cognitive behavioural therapy
- D. Modelling
- E. Reciprocal determinism
- F. Reinforcement
- G. Motivational interviewing
- H. Behavioural contracting.

9. The T quit line counsellor helps the caller to replace the unproductive thought “I am really stressed and I want a cigarette now” with “Having a cigarette is really not going to help my stress, so maybe I will go for a short walk instead.” This is an example of which of these?

- A. Skill-building
- B. Modelling
- C. Cognitive behavioural therapy
- D. Reinforcement.

Counselling approaches for those who are not ready to quit

10. A directive, patient-centred counselling approach that helps callers clarify and resolve ambivalence about behaviour change is called:

- A. Cognitive behavioural therapy
- B. Motivational interviewing
- C. Change rulers
- D. Practical problem-solving.

11. When you ask a caller about a time before the current concern emerged – e.g. “Can you recall past events when things were different?” – this is an example of:

- A. Elaboration
- B. Practical problem-solving
- C. Alongside
- D. Looking backward.

12. When callers use self-motivating statements, it is called:

- A. Change talk
- B. Evocative question
- C. Query extreme
- D. Reflective statements.

13. Which example is NOT one of the principles of MI?

- A. Maintain motivation
- B. Support self-efficacy
- C. Roll with resistance
- D. Express empathy.

Pharmacotherapy

14. Use of cessation medication has an additive effect on quit outcomes when combined with behavioural counselling.

- A. True
- B. False.

15. Which statement about nicotine patches is TRUE?
- A. Higher dosages of nicotine (those exceeding 21 mg) are known to cause heart attacks.
 - B. Patches can be used alone or in combination with other tobacco medicines.
 - C. Patches completely eliminate withdrawal symptoms.
 - D. Only healthy people can use nicotine patches.
16. Which tobacco cessation medicine is not advised for people who have seizures?
- A. Bupropion
 - B. Inhaler
 - C. Varenicline
 - D. Lozenge.
17. Which medication below is NOT considered first-line medication?
- A. Clonidine
 - B. Patch
 - C. Bupropion SR
 - D. Varenicline.
18. Twenty-four hour formulation patches are available in which three different strengths:
- A. 24 mg, 16 mg, 8 mg
 - B. 20 mg, 10 mg, 5 mg
 - C. 21 mg, 14 mg, 7 mg.
19. Dosages of NRT are determined by two commonly accepted mechanisms:
- A. Cpd (cigarettes per day) + ttfu (first-time use after waking)
 - B. Years of using tobacco + cpd
 - C. Cpd + ttfu + cigarette's nicotine content
 - D. Years of using tobacco + ttfu.
- Facilitation skills**
20. When is a good time to use silence in an intervention?
- A. After a caller has said something important, and you want to let the idea resonate.
 - B. When a caller is speaking slowly.
 - C. After you ask a difficult question.
 - D. All of the above.
21. Read the following quit line counsellor statement:
"It sounds like quitting in the past has been really difficult for you. You said you smoke when you're stressed, and there have been a lot of stresses in your life right now with your ex and your family situation. Is that right?"
This statement is an example of:
- A. Meaning reflection, summarizing, content inquiry.
 - B. Signposting, content inquiry, required data elements.
 - C. Open-ended question, summarizing, transition statements.
22. What might "signposting" sound like in a quit line counsellor's introduction to a call?
- A. "What topics would you like to cover today?"
 - B. "I want to make sure that we are covering topics that are important to you, so please tell me if I get off track"

- C. "During our call today I'll be asking you some questions related to your tobacco use in order to understand your situation better. Then we will come together to decide on a challenge and build a plan around it. Lastly we'll talk about what to expect in your next phone call."
- D. "I'm so glad that you called. Tell me all about your history with using tobacco, including past quits and relapse triggers."

23 Which example lists elements of therapeutic alliance?

- A. Accurate empathy, genuine interest, warm tone.
- B. Self-disclosure, genuine interest, warm tone.
- C. Encouraging quitting, genuine interest, warm tone.
- D. Boundaries, genuine interest, warm tone.

24. Are the expected role boundaries met in the following quit line counsellor statement?

"You need to talk to your wife and tell her not to smoke around you. It is going to be difficult to quit if she doesn't. Also, make sure to get rid of all tobacco products and find someone else who can support you in your quitting efforts. I think your wife is trying to sabotage your quit."

- A. Yes, because the quit line counsellor is sharing valuable information that the caller likely does not already know.
- B. No, because the quit line counsellor falls into the "parent" role and relies upon advice-giving and lecturing.

Basic components of a call

25. What is a typical call structure?

- A. Introduction, Assessment, Setting the agenda, Action, Closing.
- B. Introduction, Signposting, Setting a quit date, Closing.
- C. Introduction, Setting a quit date, Setting the agenda, Quit medicines, Closing.

26. Evidence-based treatment for tobacco cessation includes:

- A. Counselling, pharmacotherapy, combinations of pharmacotherapy
- B. Counselling, hypnotherapy
- C. Counselling, laser therapy, e-cigarette.

Assessment and agenda-setting

27. The assessment questions should be asked in the same way you would conduct a survey.

- A. True
- B. False.

28. When conducting an assessment, ask follow-up questions as needed to understand issues that arise in order to help the caller.

- A. True
- B. False.

29. The agenda of the call is based on: (Select all that apply)

- A. The readiness of the caller to quit.
- B. Information collected during the assessment.
- C. The number of times the caller quit in the past.
- D. The caller's stated needs.

Action planning

30. STAR is an acronym for evidence-based strategies for quitting tobacco. What does STAR stand for?

- A. Set a quit date, Talk to a quit line counsellor, Allow people to help, Roll with resistance.

- B. Set a quit date, Tell friends and family, Anticipate challenges, Remove tobacco product.
- C. Stop smoking, Try new things, Action planning, Roll with resistance.
- D. Stop smoking, Take time, Anticipate challenges, Relapse prevention.

31. Focusing on developing a quit plan using the STAR strategy is appropriate for callers who:

- A. Are not ready to quit
- B. Are ready to quit
- C. Already quit.

32. The ACE model (Avoid, Cope, Escape) is an effective strategy for:

- A. Ambivalent callers
- B. Relapse prevention
- C. Managing physical cravings to nicotine
- D. Getting support for quitting.

The content of a telephone counselling intervention

33. A quit date call is typically:

- A. Proactive outbound call made by the counsellor 1–5 days before the caller's planned quit date.
- B. Proactive outbound call made by the counsellor 1–3 days after the planned quit date.
- C. Proactive outbound call made by the counsellor 5–10 days after the quit date call.
- D. Proactive outbound call made by the counsellor about 1–3 weeks after the quit date follow-up call.

34. If a caller is ready to quit, the plan should focus on:

- A. Set a quit date, tell family and friends about quitting, anticipate challenges, remove tobacco products.
- B. Resolve ambivalence, emphasize importance of quitting, build self-efficacy.
- C. Anticipate high-risk situations, relapse prevention.

Special populations and cultural awareness

35. What are cultural factors that may be relevant to your roles as a quit line counsellor?

- A. Role of family
- B. Role of elders
- C. Concept of health
- D. Spirituality
- E. All of the above.

Challenging calls

36. Determine whether this scenario represents a content, process or perceptual challenge:

The quit line counsellor is talking to the caller about the importance of using the patches, but the caller states that he already has them and plans to use them, but that he really just needs some ideas of what he can do to help with his urges when he is stressed. The quit line counsellor continues to state how important using quit medications is. This is an example of a:

- A. Content challenge
- B. Process challenge
- C. Perceptual challenge.

37. Using the 5-step disarming technique is important to: (Select all that apply)

- A. Help solve the caller's problem.
- B. Restore alliance with the caller.
- C. Help change the way the caller feels about the situation.
- D. Help diffuse the caller and get the call back on track.

2.2 Quiz review (30 minutes)

How would you apply the knowledge and use skills during calls?

PRACTICE

3. PRACTICE THE SKILLS AND KNOWLEDGE LEARNED DURING THIS TRAINING (4 hours)

Please complete a series of activities to practise the skills and knowledge gained during the training.

You may work in a group of three and take turns playing the role of quit line counsellor, caller and observer.

For each role play:

- The “caller” will use the scenario to build the characters.
- The quit line counsellor will deliver the call and demonstrate the skill(s) described in the scenario.
- The observer will identify whether the quit line counsellor performed the skill(s) highlighted in the scenario.
- Take 20-minutes for the scenario and 15 minutes for the feedback discussions.
- After each scenario debrief the experience.

You may also work in small groups to practise new skills and knowledge.

Here are the instructions on how to give useful feedback when working with small groups:

- Use descriptive feedback to encourage a nonjudgemental approach.
- Descriptive feedback ensures that nonjudgemental and specific comments are made and prevents vague generalizations.
- Make offers and suggestions. Generate alternatives.
- Make suggestions rather than prescriptive comments and reflect them back to the learner for consideration. Think in terms of alternative approaches.
- Be well intentioned, valuing and supportive.
- When working with a pair or groups of learners be respectful and sensitive to each other.

Scenario 1

Call 1/intake:

Betty has been smoking for over 20 years. She averages a pack a day. She has tried to quit several times in the past but has a hard time coping with the urges. She reports a strong desire to quit and can't wait to get started because she's looking forward to the health benefits. Her husband smokes and doesn't plan on quitting and she doesn't know how she will cope. She called in for help after realizing that her health needs to improve. She's having difficulty breathing and feels "old" lately. At the end of the call Betty feels short of breath and expresses her concern.

Quit line counsellor skills:

- Practise assessment.
- Develop a quit plan (quit date; anticipate challenges; remove tobacco products; support of family and friends).
- Practise providing decision-support for using quit medications.
- Practise using the crisis protocol.

Scenario 2

Call 1/intake

Trish has been smoking two packs per day over the past 30 years. She indicates that she is an “addict” and that cigarettes are what get her through stressful times of the day. She says she wants to quit but is reluctant to engage in planning for a quit attempt. She doesn’t think there’s much hope for her to quit and stay quit. She is concerned about the amount of money she spends on cigarettes.

Quit line counsellor skills:

- Practise assessment
- Use MI strategy:
 - ask evocative questions (use open- ended questions)
 - ask for elaboration
 - ask for examples
 - looking back
 - looking forward
 - query extremes.

Scenario 3

Call 2/pre-quit call:

Luke’s quit day is in three days. He has been practising strategies to manage urges and plans to get rid of all of his cigarettes, ashtrays and lighters. He feels confident about quitting, but is concerned about being around co-workers who smoke. He would like to get support from other people who are quitting tobacco.

Quit line counsellor skills:

- Assess his intention to quit as planned.
- Engage him in ideas on how to solicit support from family and friends.
- Review his plan for anticipating and coping with urges.
- Practice developing a relapse prevention plan using the ACE model:
 - avoid risky situations when possible. When avoiding risky situation is not possible:
 - cope using a variety of behavioural, pharmacological and cognitive strategies. If coping is not working:
 - escape the situation by leaving.
- Practise recommending resources such as a social network community of people who recently quit.

Scenario 4

Call 3/quit date follow-up call: quit for 5–10 days

Marlena is six months pregnant. She quit smoking six days ago but has been experiencing strong urges and her confidence is low. She feels at a loss during work breaks – work is very stressful – but she is doing better at not smoking in the car now. Her family members no longer smoke (they are supporting her) but several friends at work do smoke. She has removed all cigarettes and ashtrays at home but is not able to control the work environment. You also learned that she quit for about two months in the past, but relapsed because of stress related to family and work issues. She wonders whether she should use a nicotine patch or nicotine gum.

Quit line counsellor skills:

- Review/confirm quit status.
- Examine high-relapse risks, slips or relapse.
- Modify relapse prevention plan.
- Provide support.
- Practise recommending printed materials about pregnancy, smoking and second-hand smoke.
- Encourage her to talk with her doctor about whether or not to use NRT.

Scenario 5

Call 4/ongoing call:

Jane is smoking 20 cpd. Her quit day was two weeks ago, but on three occasions she has taken some puffs from her husband's cigarette. Her husband has also called the quit line, but he is not ready to quit. She wants to stop smoking because she realizes she is providing her children with a poor role model and does not want them to start smoking. She is the only one within her social circle who still smokes, but each time she tries to quit nothing seems to work for her (i.e. patches, nicotine gum, etc.). Jane wonders about what happened when her husband called the quit line.

Quit line counsellor skills:

- Assess internal states or activities that increase the risk of smoking or relapse.
- Assess how long she is able to abstain from smoking and problem-solve behavioural strategies with her.
- Help Jane develop a plan to create smoke-free areas in the house.
- Practise collaborating on a behavioural contract to increase accountability.
- Practise protecting the caller's confidentiality.

Scenario 6

Call 4/ongoing call

Jacob's quit date was three weeks ago. He has not experienced strong urges and he is confident that he can stay quit. Recently he went to a party with friends and was pleasantly surprised because he did just fine. Jacob is still using patches and uses gum as needed. Recently he went to a party with friends and was pleasantly surprised because he did just fine. Jacob is still using patches every day. His family is proud of him for quitting. At first he spent time with nonsmoking friends, but has not had a problem when socializing with friends who smoke. In fact he can't imagine himself smoking again. His house is smoke-free. He is also in a smoke-free environment at work. His longest quit was for six months; he started again when he moved to a new city. He will be taking a vacation in six weeks. He is wondering how he will feel.

Quit line counsellor skills:

- Reinforce success and commitment to staying quit.
- Assess any potential high-risk situations, especially related to going on vacation.
- Provide practical problem-solving for challenges.

EVALUATION

4. DEBRIEFING (30 minutes)

Please rate your confidence to deliver interventions to callers who are ready to quit and those who are not ready to quit again:

Answers to quiz

1. A; 2.A,B,D,F,H,I,K; 3. C; 4. A; 5. B; 6. A; 7. B; 8. E; 9. C; 10. B; 11.D; 12. A; 13. A; 14. A; 15. B; 16. A; 17. A; 18. C; 19. A; 20. D; 21. A; 22. C; 23. A; 24. B; 25. A; 26. A; 27. B; 28. A; 29. A,B,D; 30. B; 31. B; 32. B; 33. B; 34. A; 35. E; 36. A; 37. B,D.

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APPENDIX: GLOSSARY OF TERMS

Term	Definition
Acceptance	One of four central components of the underlying spirit of MI by which the interviewer communicates absolute worth, accurate empathy, affirmation and autonomy support.
ACE model	An effective relapse prevention tool. ACE stands for: <ul style="list-style-type: none"> • Avoid risky situations when possible. When avoiding a risky situation is not possible: • Cope using a variety of behavioural, pharmacological and cognitive strategies. If coping is not working: • Escape the situation by leaving.
Affirmation	One of four aspects of acceptance as a component of MI spirit, by which the counsellor accentuates the positive, seeking and acknowledging a person's strengths and efforts.
Ambivalence	The simultaneous presence of competing motivations for and against change.
Arguing	A specific barrier to effective listening characterized by a "me versus you" quality, rather than a collaborative approach.
Autonomy	One of four aspects of acceptance as a component of MI spirit, by which the interviewer accepts and confirms the client's irrevocable right to self-determination and choice.
Bias	A specific barrier to effective listening categorized by a tendency to filter and sort information through one's own beliefs and value system.
Change ruler	A rating scale, usually 0–10, used to assess a client's motivation for a particular change. See confidence ruler and importance ruler.
Change talk	Any client speech that favours movement toward a particular change goal.
Closed question	A question that asks for yes/no, a short answer, or specific information.
Cognitive behavioural coaching	A therapeutic treatment for providing callers with skills for changing unproductive thoughts and behaviours that sabotage their quit process.
Collaboration	One of four central components of the underlying spirit of MI, by which the interviewer functions as a partner or companion, partnering with the client's own expertise.
Coming alongside	A response in which the interviewer accepts and reflects the client's theme.
Commitment language	A form of client-mobilizing change talk that reflects intention or disposition to carry out change; common verbs include "will", "do", "going to".
Communication style	The combination of words, tone and phrases used in speech or writing and how they are arranged and delivered. Ways to describe communication style include "formal", "casual", "awkward", "confident".
Decisional balance	A choice-focused technique that can be used when counselling with neutrality, devoting equal exploration to the advantages and disadvantages of change or of a specific plan.
Directive communication	A natural communication style that involves telling, leading, providing advice, information or instruction.
Discrepancy	The distance between the status quo and one or more client change goals.
Elaboration	An interviewer response to client change talk, asking for additional detail, clarification or example.
Empathy	The ability to understand the experiences, thoughts, and feelings of another from that person's individual point of view without judgement. One can empathize and attempt to understand another's point of view without having experienced the situation.

Term	Definition
Evocation	One of four central components of the underlying spirit of MI, by which the interviewer elicits the client's own perspectives and motivation.
Evocative questions	Strategic open questions, the natural answer to which is change talk.
Labelling	A specific barrier to effective listening characterized by a tendency to ascribe negative terms to a set of traits that usually focus on who the person is, rather than on what he or she does. For example, "You're an addict."
Lapse or slip	A short, time-limited use of tobacco after quitting.
Lecturing	A specific barrier to effective listening characterized by a tone or style that tends to be dominated by the counsellor telling the client what to do.
Looking back	A strategy for evoking client change talk, exploring a better time in the past.
Looking forward	A strategy for evoking client change talk, exploring a possible better future.
Motivation	A feeling of enthusiasm, interest or commitment that makes somebody want to do something, or something that causes such a feeling.
Motivational interviewing (MI)	A set of specific intervention skills developed by William Miller and Stephen Rollnick intended to identify and resolve ambivalence about making a change, thereby increasing motivation to change.
Need	A form of client preparatory change talk that expresses an imperative for change without specifying a particular reason.
Nicotine replacement therapy (NRT)	Tobacco cessation medications that contain a fixed dose of nicotine that is released throughout the day. Common nicotine replacement medications include the patch, gum, lozenge, inhaler and nasal spray.
Nicotine	The addictive chemical in tobacco, whether smoked or taken orally.
Nicotine/tobacco delivery system	Any form of smoked or chewed tobacco that delivers nicotine when used.
Normalizing	A specific type of response intended to reshape the belief that something may be more common than initially thought. For example, "Actually, most people relapse after their first quit attempt."
OARS	An acronym for four basic client-centred communication skills: Open question, Affirmation, Reflection, and Summary.
Open question	A question that offers the client broad latitude and choice in how to respond. Compare with closed question.
Open-ended question	A specific type of question that allows a wide, practically unlimited, range of response options. Example: "What has been difficult about quitting?"
Patient-centred care	A therapeutic approach introduced by psychologist Carl Rogers in which people explore their own experience within a supportive, empathic and accepting relationship. Also called client-centred counselling.
Pharmacotherapy	Refers to two categories of cessation medicines, those with nicotine and those without. Examples of medicines with nicotine include nicotine patch, nicotine gum and nicotine lozenge (see nicotine replacement therapy and prescription cessation medications). Examples of cessation medications without nicotine include varenicline (trade name: Champix or Chantix) and bupropion (trade name: Zyban).
Preparation stage	Term used in the Stages of Change model. In this stage, the person is planning or intending to quit within the next 30 days.
Query extremes	A strategy for evoking change talk by asking clients to imagine the best consequences of change or the worst consequences of the status quo.
Quit and stable	Callers who have <ul style="list-style-type: none"> • been quit for some time, and • have not lapsed or relapsed for weeks or months, and • have few and/or minor urges to use tobacco, and • have confidence in their ability to stay quit is high.
Reflective listening	The skill of "active" listening whereby the counsellor seeks to understand the client's subjective experience, offering reflections as guesses about the person's meaning. See also accurate empathy.

Term	Definition
Relapse	A return to regular use of tobacco.
Self-efficacy	A client's perceived ability to achieve a particular goal successfully or perform a particular task. The term was introduced by Albert Bandura.
Signposting	A directive statement that explains where you are going in the call and why.
Social cognitive theory	A conceptual model that says behaviour change occurs, or does not occur, because of strengths or barriers in three areas: personal, environmental and behavioural. The personal domain includes an individual's biology, thoughts and emotions. The environmental domain includes the individual's immediate surroundings and social support network. The behavioural domain includes the individual's ability to learn, demonstrate and eventually master skills necessary to accomplish the goal.
Spirit of MI	The underlying set of mind and heart within which MI is practised, including partnership, acceptance, compassion and evocation.
STAR strategies	An evidence-based quit plan that incorporates these elements: <ul style="list-style-type: none"> • Set a quit date. Ideally, the quit date should be within two weeks. • Tell family, friends and co-workers about quitting, and request understanding and support. • Anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • Remove tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g. work, home, car). Make your home smoke-free.
Sympathy	The ability to share or adopt the feelings of another person and experience them for oneself.
Therapeutic relationship	The strength of the bond between caller and counsellor demonstrated by using a warm vocal tone, being genuinely interested, and accurately empathizing. Research shows that the caller's perspective of the strength of the alliance is a strong factor in determining positive treatment outcomes.
Tobacco user	A person who uses any tobacco product.



Tobacco Free Initiative
Prevention of Noncommunicable Diseases
World Health Organization
20, Avenue Appia
1211 Geneva 27
Switzerland

Email: pnd@who.int
Tel.: +41 22 791 21 11
Fax: +41 22 791 48 32
<http://www.who.int/tobacco/en>

ISBN 978 92 4 150726 4

A standard linear barcode is located within a rectangular frame. Below the barcode, the numbers "9 789241 507264" are printed vertically.