CHOICES

A Program for Women About Choosing Healthy Behaviors

FACILITATOR GUIDE

National Center on Birth Defects and Developmental Disabilities
Division of Birth Defects and Developmental Disabilities

CHOICES

A Program for Women About Choosing Healthy Behaviors to Avoid Alcohol-Exposed Pregnancies

FACILITATOR GUIDE

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

National Center for Birth Defects and Developmental Disorders
Division of Birth Defects and Developmental Disabilities
Atlanta, GA

August 2011

ACKNOWLEDGEMENTS

The Project CHOICES Intervention Development Team developed and wrote the CHOICES intervention that included the Client Workbook and Counselor Manual from which the Facilitator Guide for this curriculum was developed. The Team included Mary M. Velasquez, PhD, Karen Ingersoll, PhD, Mark B. Sobell, PhD, ABPP, R. Louise Floyd, DSN, RN, Patricia D. Mullen, DrPH, Mary Nettleman, MD, MS, Linda Carter Sobell, PhD, ABPP, Deborah Gould, PhD, Sherry Ceperich, PhD, and Kirk Von Sternberg PhD. The following participated in the development of the curriculum materials: Mary M. Velasquez, PhD, Karen Ingersoll, PhD, Mark B. Sobell, PhD, ABPP, R. Louise Floyd, DSN, RN, Linda Carter Sobell, PhD, ABPP, and Sherry Ceperich, PhD.

Centers for Disease Control and Prevention (CDC) provided oversight of the curriculum development project and participated in all aspects of the process. CDC participants were R. Louise Floyd, DSN, RN and Catherine A. Hutsell, MPH.

TKC Integration Services (TKC) worked with key members of the CHOICES Intervention Development Team and CDC in the development of a training curriculum based on the original protocols used in the successful Project CHOICES Efficacy Study. TKC staff included Caroline Bailey, MA, MPH, Julie Emery, MS, MPH, Jim Sacco, MSW, Sheryl Scott, MPH, and Jodi Verbeek.

Social Solutions International, Inc. (SSI) worked with TKC to provide support services in formatting and editing the printed curriculum components. SSI staff included Susanna Nemes, PhD, Jenny Namur Karp, MPH, Ami Lynch, PhD, Sakiya Thomas, and Elaine Bonneau.

The Academic Edge, Inc. provided video production services in filming selected components of the intervention using actual interventionists and actors hired by the Academic Edge. These individuals included Sherry Ceperich, PhD, Nanette Stephens PhD (interventionists), TyMyra Henderson, Angie Raygada, Amy Morgan , and Rae Damon (actors). Richard Goldsworthy, Peter Honebein, and Steve Rapa filmed and produced the videos.

CONTENTS

Overall Learning Objectives

By the end of the training, participants will be able to:

- Discuss the risks of an alcohol-exposed pregnancy (AEP)
- Discuss ways to prevent an AEP
- Describe components of the Motivational Interviewing (MI) spirit that are fundamental to the CHOICES program
- Demonstrate MI strategies used in CHOICES
- Discuss the key components in each of the four CHOICES intervention sessions

Facilitator's Checklist

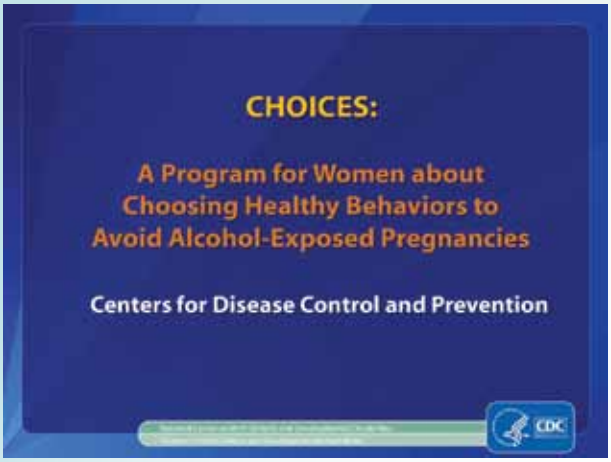
Equipment and Materials Needed:

- Laptop/PC, LCD projector, and screen
- Training videos
- Copies of handouts and training exercises
- Flip chart or whiteboard, easel, markers, paper, and masking tape
- Counselor Manual
- Client Workbook
- Pre-tests
- Post-tests

CHOICES

Introduction:

- Review of Learning Objectives
- Questions about CHOICES
- Post-tests
- Training evaluation



Slide 1

Facilitator Notes:

Welcome to the CHOICES training program!

CHOICES is a program for women about choosing healthy behaviors to avoid alcohol-exposed pregnancies.

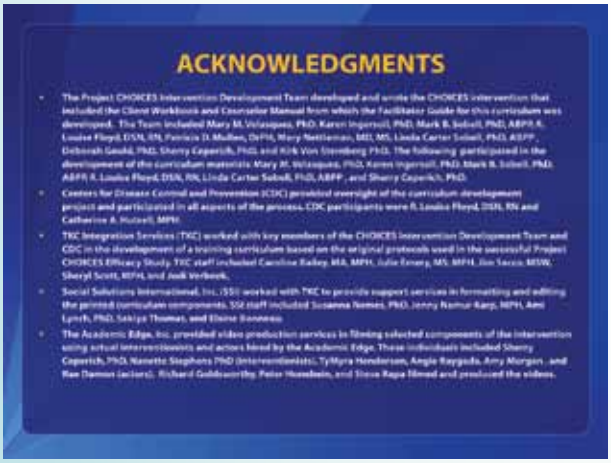
Housekeeping announcements:

- Location of bathrooms
- Location of phones and water
- Any logistics that will enhance trainees' personal comfort during the training

(Administer Pre-Tests)

Overview:

- Workshop materials were developed by the original Project CHOICES Investigators, Drs. Velasquez, Ingersoll, M. Sobell, Floyd, L., and L. Sobell; CDC; and TKC Integration Services.
- You have already received a number of materials that we will be referring to during the training. These materials include: PowerPoint presentation, Counselor Manual, and Client Workbook. They also will be good resources for you when you return home.



Slide 2

Facilitator Notes:

(Read slide)

Slide 3

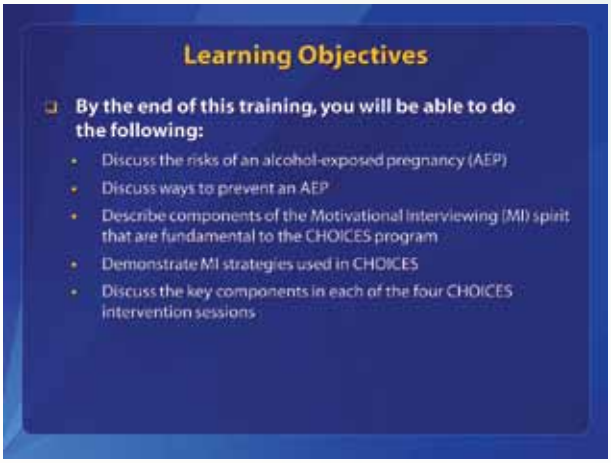
Facilitator Notes:

In 2005, the Surgeon General reaffirmed the risks of alcohol use during pregnancy. Although some women drink without harming the fetus, this advisory signals the range of potential consequences of drinking during pregnancy and advises that women should avoid all alcohol consumption while pregnant.

- There is no known safe level of alcohol use during pregnancy.
  - Even at low levels, alcohol can cause learning and other cognitive problems from exposure during pregnancy.
- Alcohol can cause damage at any stage of pregnancy.
  - Damage can occur during each trimester, even before a woman knows she is pregnant.
- Alcohol use can cause a broad spectrum of effects.
- The impact of fetal alcohol exposure is lifelong.
- Women who are pregnant or considering becoming pregnant should not consume alcohol.

In support of this advisory, we hope you will join us in promoting the CHOICES intervention broadly in public health settings.

(Before going to the next slide, take a few minutes to ask participants to state what they expect to learn from the training and what questions they expect to have answered. Write these expectations on a flip chart.)



Slide 4

Facilitator Notes:

(As you provide the following information, review trainees stated expectations and identify those that will be addressed during the training, and those that may be deferred to a "parking lot" list to be discussed at the conclusion of the training, or that may require additional follow-up.)

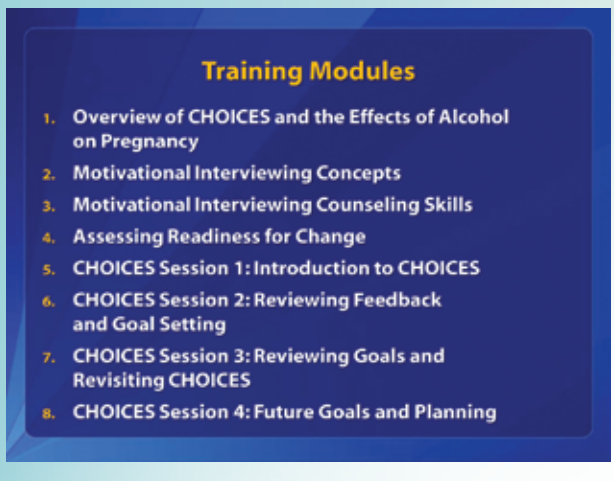
The CHOICES program is about helping women know when they are at risk for an alcohol-exposed pregnancy and learn methods that will help them make changes to avoid becoming pregnant or avoid drinking at risky levels.

To do this, there are just a few simple objectives that you will learn during this training:

- Risks of an alcohol-exposed pregnancy, or AEP — A background of the risks will show why this intervention was developed and the intervention strategies used.
- Three ways to prevent an AEP — The idea that there are multiple ways to prevent an AEP (in other words, that there are "choices") is fundamental to the intervention.
- Components of the Motivational Interviewing, or MI spirit that are fundamental to CHOICES — We will define the MI spirit and explain how its use is essential to the intervention.
- MI strategies used in CHOICES — These are evidence-based, client-centered approaches to promoting healthy behavior change.
- Key components in each of the four sessions — The program consists of four carefully designed sessions along with supporting materials to help with their delivery.

You will develop skills by conducting a number of the exercises from the CHOICES intervention during the workshop.

Feedback and evaluation are requested at the end of the workshop.



Slide 5

Facilitator Notes:

The workshop is presented in eight modules.

The first four modules give an overview of CHOICES, explain why it was developed, and discuss the key strategies used for implementation.

The last four modules outline each of the four counseling sessions and their components.

MODULE 1:

Overview of CHOICES and the Effects of Alcohol on Pregnancy

MODULE 1:

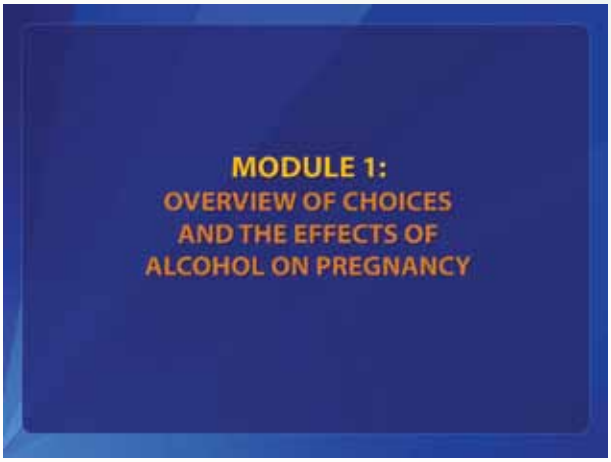
Trainer Objectives:

- To introduce CHOICES
- To identify the risks and dangers of alcohol use during pregnancy
  - Fetal Alcohol Spectrum Disorders (FASD)
  - Fetal Alcohol Syndrome (FAS)
  - Other adverse outcomes
- To present the evidence for CHOICES
- To present the CHOICES goals and approach

Materials Required:

- Flip chart or whiteboard, markers, paper, and tape
- Counselor Manual
  - Assessment Tools
- Client Workbook

Time Required: 90 Minutes

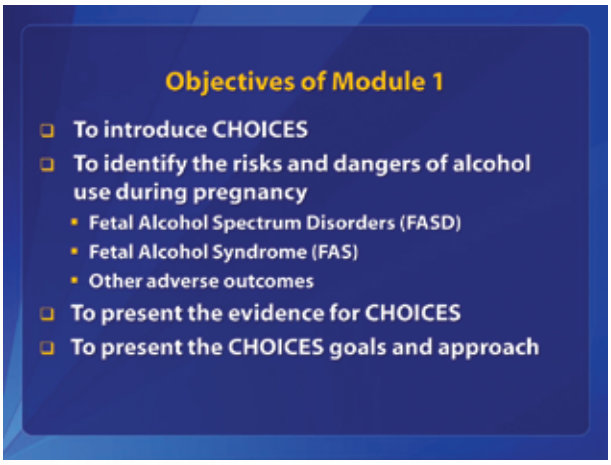


Slide 6

Facilitator Notes:

Why is CHOICES important?

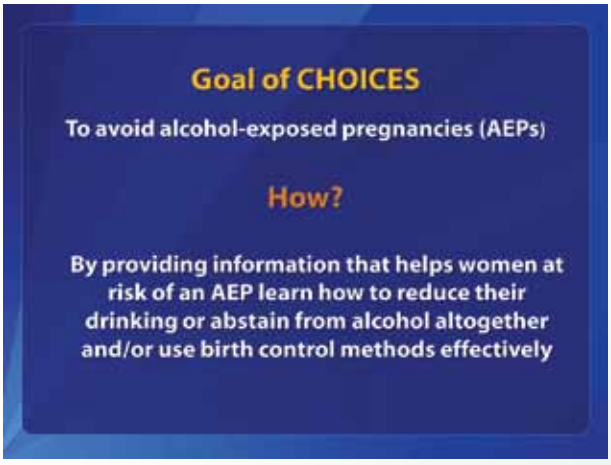
In this module, we'll talk about the adverse effects of alcohol during pregnancy that result in lifelong challenges for individuals and their families, as well as provide an overview of CHOICES. The goal is to help you understand the effects of alcohol-exposed pregnancies and how CHOICES can help prevent them.



Slide 7

Facilitator Notes:

(Read slide)



Slide 8

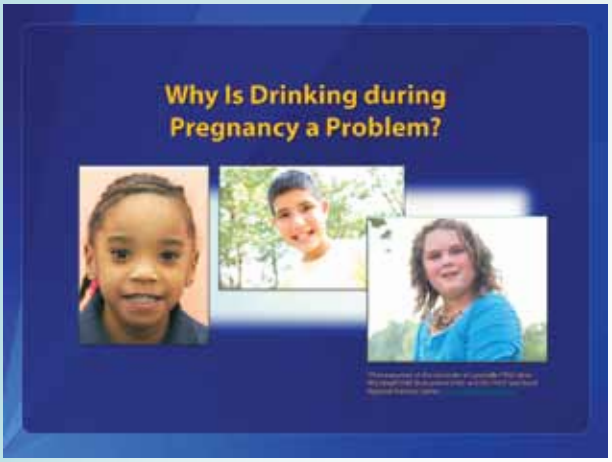
Facilitator Notes:

With CHOICES, we hope to lower rates of alcohol-exposed pregnancies among women.

How do we achieve this?

We encourage reduced drinking and/or effective contraception *before* women become pregnant.

We identify women who are drinking at risky levels and having sex without consistent contraception. We do an intervention that helps these women to avoid an AEP by changing risky behaviors into less risky behaviors before they become pregnant. They accomplish these behavior changes by reducing high-risk drinking and/or using effective contraception.



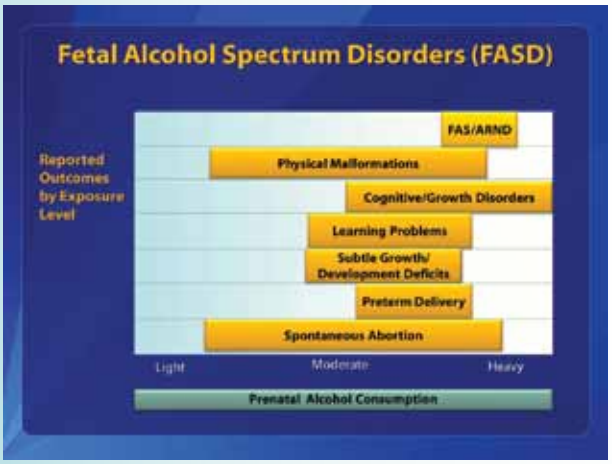
Slide 9

Facilitator Notes:

The primary reason we are here today is because alcohol exposure during pregnancy can have profound and lifelong effects on children. The children you see here, and thousands more like them, have suffered brain and central nervous system damage caused by alcohol exposure in the womb. Their fetal exposure to alcohol can affect many facets of their lives and the lives of their families.

The children pictured on this slide have been severely affected because their mothers drank during their pregnancy. It is important to know that drinking can also have more subtle effects on the fetus in less evident but important ways.

Alcohol use and contraception use are changeable behaviors. Therefore, we can prevent this damage from occurring if we can identify women of childbearing age who are at risk for an alcohol-exposed pregnancy, and work with them to change their risky behaviors.



Slide 10

Facilitator Notes:

FAS was first described in medical literature in 1973 by physicians Ken Jones, David Smith, and Cathy Ulleland, from the University of Washington. Since then we have learned FAS is only one point along a spectrum of effects that can occur, as you see here. The term Fetal Alcohol Spectrum Disorders, or FASDs, describes the range of prenatal alcohol-related effects that can occur when a woman drinks during pregnancy.

Slide 11

Facilitator Notes:

These effects may include physical, mental, behavioral, and/or learning disabilities, with possible lifelong implications, and are known collectively as FASDs. The severity depends on the amount of alcohol consumed, the timing of the exposure, and possibly on genetic factors in the mother and fetus that affect alcohol metabolism. Sampson, et al. (1997) from the University of Washington estimated the number of cases of FAS and Alcohol-Related Neurodevelopmental Disorders, or ARNDs, equal about nine cases per 1,000 live births. That translates to 36,000 cases per year.

Slide 12

Facilitator Notes:

In 2004, a group of federal officials and experts in the field adopted the term Fetal Alcohol Spectrum Disorders as an umbrella term that describes the range of potential effects on a person whose mother drank during pregnancy. It includes:

- Fetal Alcohol Syndrome, often referred to as FAS
- Partial FAS
- Alcohol-related neurodevelopmental disorders (ARND)
- Alcohol-related birth defects (ARBD)
- Other conditions specified with different names using other diagnostic schemes, such as the University of Washington's Diagnostic 4-Digit Code

  The University of Washington's Diagnostic 4-Digit Code assigns a number for (1) growth deficiency, (2) the FAS facial phenotype, (3) CNS abnormalities, and (4) prenatal alcohol exposure, based on findings during a patient exam. At the end of the exam, a 4-digit code is generated based on these findings. There are 22 possible diagnostic categories.

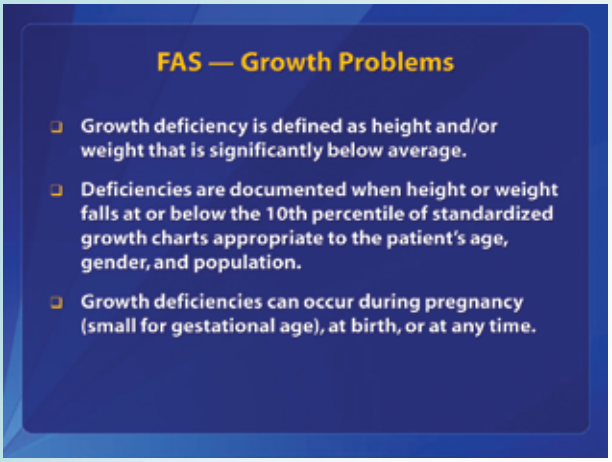
Slide 13

Facilitator Notes:

FAS is the most commonly recognized condition under the FASD umbrella.

Although some of these characteristics are present in an infant, such as smooth philtrum and thin vermillion, the palpebral fissures do not appear to be small during infancy. The decreased eye width is much more distinct as a child grows and may give the appearance of wide-spaced eyes.

Many cases of FAS may go undiagnosed until the child is of preschool age or older.

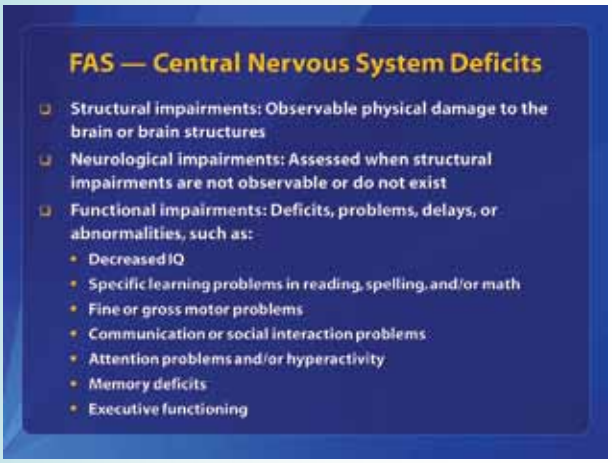


Slide 14

Facilitator Notes:

Children with FAS also are affected by prenatal alcohol exposure in their growth. The general guideline for documenting growth deficiency is when prenatal or postnatal height, weight, or both are below the 10th percentile for a specific age at any time. Growth deficiencies can also occur during pregnancy, referred to as "small for gestational age."

Some children with FAS "catch up" in this area. For example, many adolescents gain weight on par with children who do not have FAS.



Slide 15

Facilitator Notes:

Central nervous system deficits caused by FAS may include structural impairments that can be physically observed, neurological impairments, or functional deficits.

The structural impairments may include small head size (microcephaly), or complete or partial absence of the corpus callosum (the band of tissue that connects the two sides of the brain), known as agenesis of the corpus callosum.

The functional impairments can be a number of functional deficits, problems, delays, and/or abnormalities, including:

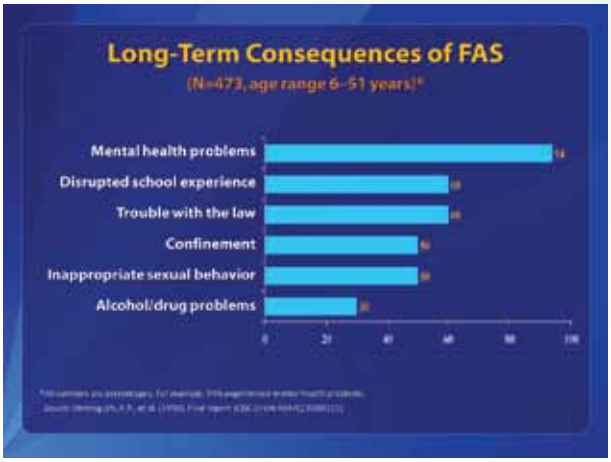
- Decreased IQ — about 25% of children with the full syndrome have an IQ in the range of intellectual deficit (below 70)
- Specific problems with reading, spelling, and math — demonstrated in difficulties in learning
- Fine or gross motor problems—such as hand/eye coordination and movement
- Communication or social interaction problems
- Attention problems and/or hyperactivity
- Memory deficits
- Executive functioning—which is one's ability to plan, organize, and keep things in working memory.

The combination of lower intelligence, learning difficulties, problems managing impulses, and other impairments often result in serious problems in school and with relationships.

References:

Sokol, R.J. , Delaney-Black, V., & Nordstrom, B. (2003). Fetal alcohol spectrum disorder. Journal of the American Medical Association, 290(22), 2996-2999.

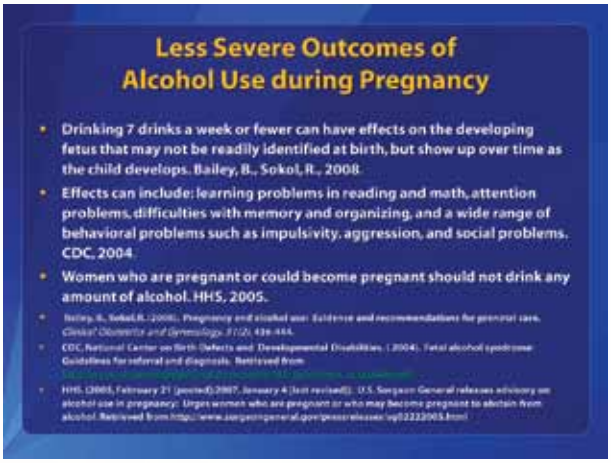
Streissguth, A.P., & O'Malley, K. (2000). Neuropsychiatric implications and long-term consquences of fetal alcohol spectrum disorders. Seminars in Clinical Neuropsychiatry, 5(3), 177-190. doi:ascnp0050177 [pii]



Slide 16

Facilitator Notes:

As demonstrated in this study, there may be a number of long-term consequences of FAS. These are often referred to as secondary disabilities of FAS and develop later in life as a result of central nervous system damage. These disabilities result from a gap between the primary disabilities and environmental expectations. It is important to note that secondary disabilities can be reduced with early interventions and appropriate support services. Sadly, many people with FAS end up in trouble with the law. They also suffer a high rate of mental illness and addiction problems.



Slide 17

Facilitator Notes:

Adverse outcomes of prenatal alcohol use may result from drinking levels that some would not think of as harmful. For example, drinking at levels of 7 drinks or fewer per week can cause problems that may not be recognizable at birth but emerge as the child begins preschool, kindergarten, or primary grades. Learning and behavior problems connected with prenatal alcohol exposure include problems in reading and math, attention problems, difficulties with memory and organizing, and a wide range of behavioral problems such as impulsivity, aggression, and social problems.

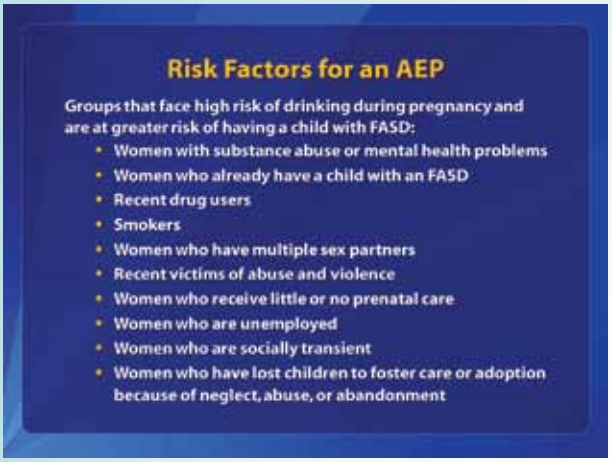
Slide 18

Facilitator Notes:

Finally, as mentioned earlier, other adverse outcomes may result from alcohol use during pregnancy. These include:

- Spontaneous abortion, miscarriage
- Prenatal and postnatal growth restriction
- Prematurity
- Birth defects (cardiac, skeletal, renal, ocular, auditory)

Some of these effects also may be observed in individuals diagnosed with FAS or other clinical diagnoses.



Slide 19

Facilitator Notes:

Any woman may be at risk for an alcohol-exposed pregnancy; however, research has identified a number of high-risk groups who may be more likely to drink alcohol during pregnancy and are thus at greater risk of having a child with an FASD.

(Read slide)

Estimates of FAS vary depending on the methods used to identify cases and the populations being targeted. Published estimates from CDC (MMWR, 2002) range from 0.3 to 1.5 per 1,000 live births, or 1,200 to 6,100 cases per year. Another estimate (May & Gossage, 2001) using different methods estimates the prevalence of FAS at 0.5 to 2.0 cases per 1,000 live births, or 2,000 to 8,000 cases per year.

References:

CDC. Fetal alcohol syndrome—Alaska, Arizona, Colorado, and New York, 1995–1997. MMWR Morbidity and Mortality Weekly Report. 2002;51(20):433-5.

May, P.A., and Gossage, J.P. Estimating the prevalence of Fetal Alcohol Syndrome: A summary. Alcohol Research & Health 25:159–167, 2001.

Slide 20

Facilitator Notes:

A goal of CDC's National Center on Birth Defects and Developmental Disabilities is to prevent these conditions and improve the lives of people who are living with them. We do not know the causes of many birth defects and developmental disabilities. We do know the cause of FASDs.

CDC studies estimate rates of 0.3 to 1.5 cases per 1,000 live births.* Other studies estimate the prevalence is 1 to 2 per 1,000 live births nationally. Some recent studies using different methods have higher estimates. The lifetime cost of FAS is estimated at $2 million per case, with a total cost in the United States of $4 billion annually.

Alcohol use during pregnancy is an important public health problem in our country. For this reason CDC is actively developing prevention programs like CHOICES.

(Read slide)

Through CHOICES, you can help prevent one of the leading causes of birth defects and developmental disabilities in the U.S.

(This rate may also be expressed as 3 to 15 cases per 10,000 live births.)

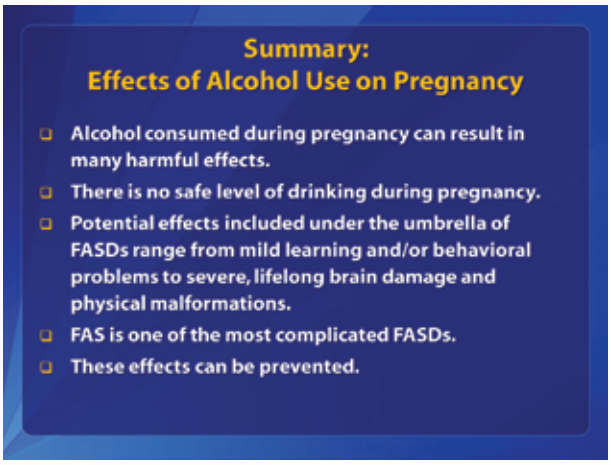
Slide 21

Facilitator Notes:

Once a woman becomes pregnant, rates of drinking drop significantly compared with nonpregnant women. However, a notable percentage of women continue to drink while pregnant. This graph shows alcohol use during pregnancy over a 15-year period.

Approximately 12 percent of pregnant women ages 18–44 years report alcohol consumption. Notably, women ages 18–24 have higher rates of binge drinking. Even more disconcerting, about 2 percent of women of all women continue to binge drink during pregnancy.

Women are asked about alcohol consumption for the previous 30 days.

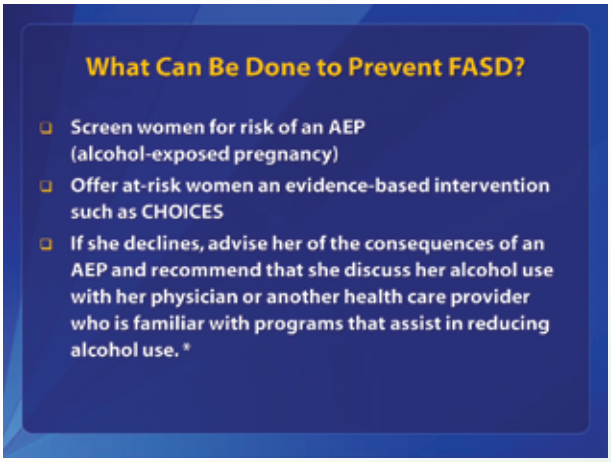


Slide 22

Facilitator Notes:

(Read slide)

Now that we have discussed the many harmful effects of alcohol-exposed pregnancies, we will move forward to discuss the strategies that can be used with the CHOICES program to address and prevent AEPs.

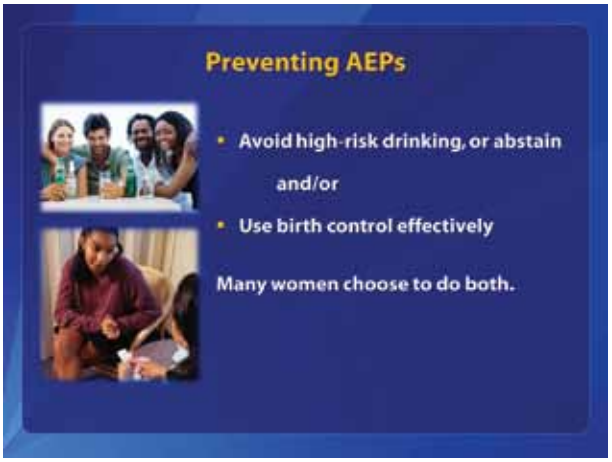


Slide 23

Facilitator Notes:

(Read slide)

*The American College of Obstetricians and Gynecologists (ACOG) recommends that any woman at risk for an AEP be counseled to use effective contraception until she reduces risky drinking.



Slide 24

Facilitator Notes:

In CHOICES, we have taken a preconception approach to preventing AEPs. This is because many women become pregnant and continue to drink before they realize they are pregnant. This is especially true during the first eight weeks of pregnancy, which is a critical period of fetal development.

There are two primary ways to reduce AEPs:

1. Reduce high-risk drinking in women, including abstinence.
2. Prevent pregnancy—for example, by using contraception effectively.

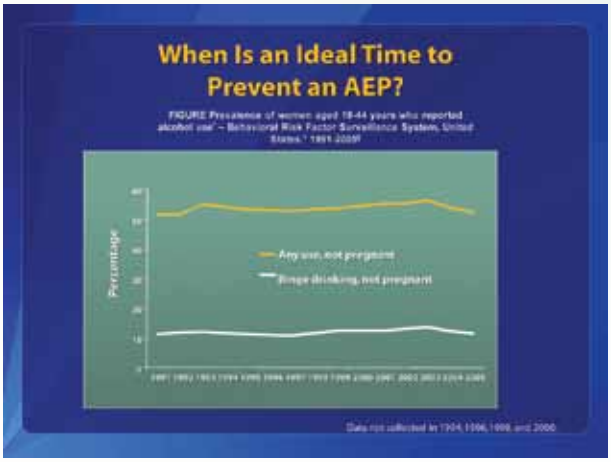
The optimal outcome would be for women to do both.

Slide 25

Facilitator Notes:

There are a number of reasons why we should seek to reduce risky drinking and improve effective contraception among women:

- Many women become pregnant and continue to drink alcohol before they realize they are pregnant.
  - Surprisingly, about half of all pregnancies in our country are accidental or unplanned.
  - Drinking at risky levels is associated with unprotected sex.
  - Women of childbearing age are at a prime time for drinking. For some of them, drinking during pregnancy includes heavy or binge drinking, or drinking that is frequent enough to harm to the developing fetus.
- Alcohol can damage the fetus at any time during pregnancy.
  - Alcohol is known to be a teratogen, meaning it is a substance that causes birth defects.
- If a woman of childbearing age is sexually active and chooses to drink alcohol, she should practice effective contraception if she drinks at risk levels—or never go over risk levels if she does not use contraception effectively.

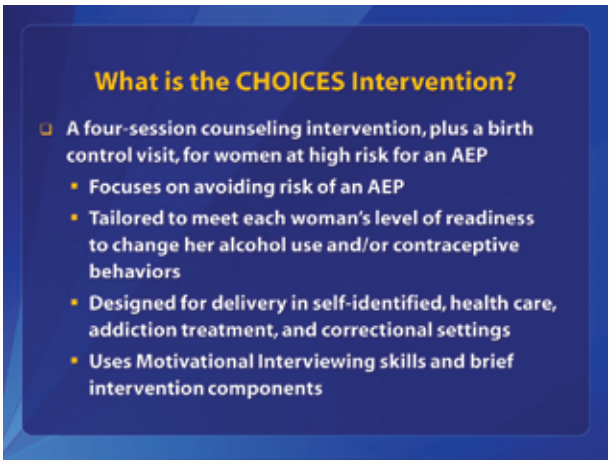


Slide 26

Facilitator Notes:

The best time to start AEP prevention activities is before the pregnancy begins.

This graph shows a 15-year period during which about 50 percent of nonpregnant American women drink any amount of alcohol, and about 11 percent of nonpregnant American women binge drink. You can see there are no major changes, neither increases nor reductions, in these rates over time. These data indicate about 50 percent of women in their prime childbearing years are drinking, with a subset drinking at hazardous levels. Binge drinking levels are highest in women ages 18 to 24 years, which are also the peak childbearing years. Alcohol consumption is reported for the previous 30 days.



Slide 27

Facilitator Notes:

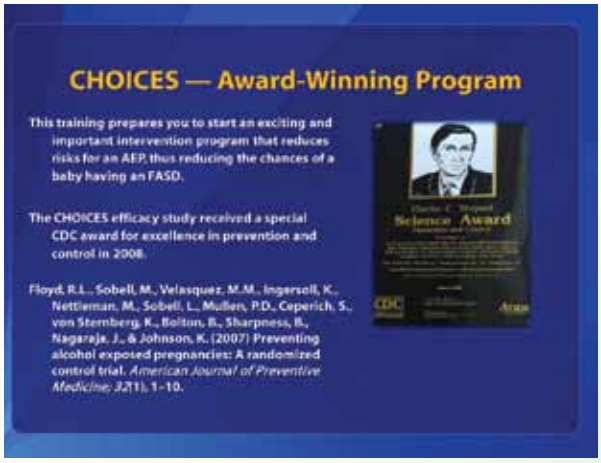
CHOICES was developed to be a motivational intervention.

(Read slide)

(Summarize)

The CHOICES intervention is simple: Evaluate your clients' drinking and contraception use. For those whom you find are at risk for an AEP, give a four-session counseling intervention using the materials you receive in this training, and arrange for a birth control visit.

This simple plan was tested in a research study and was found to be successful.

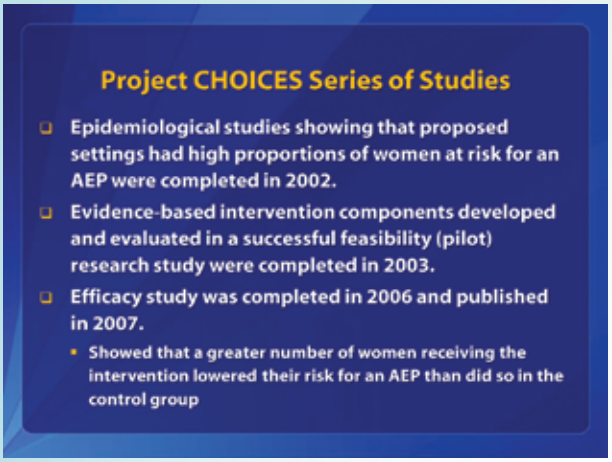


Slide 28

Facilitator Notes:

We look forward to the coming days with you as we move through the training. The intervention was designed to be delivered by individuals such as you, with women at risk for an AEP, and help improve their lives and their families'.

(Read slide)

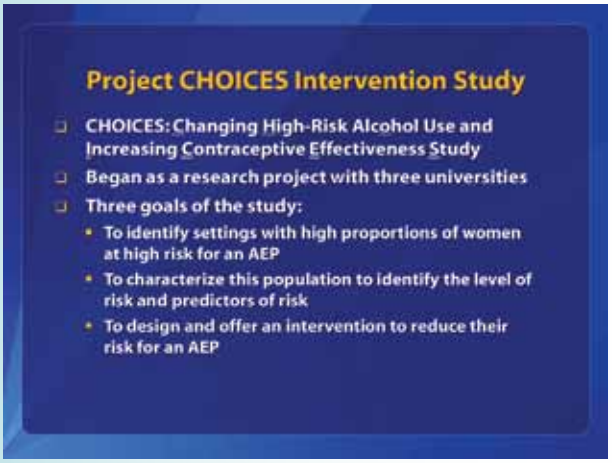


Slide 29

Facilitator Notes:

There actually were three Project CHOICES studies needed to get to the final product.

(Read slide)



Slide 30

Facilitator Notes:

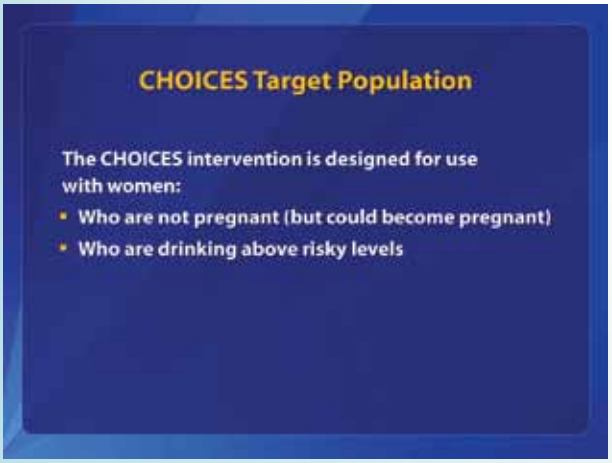
CHOICES is offered to you today because a study done to assess the intervention proved it to be effective.

(Read bullets 1 and 2)

Before the study, CHOICES began as a research project involving three universities:

- University of Texas Health Science Center at Houston
- Nova Southeastern University at Ft. Lauderdale
- Virginia Commonwealth University at Richmond

(Read remaining bullets)



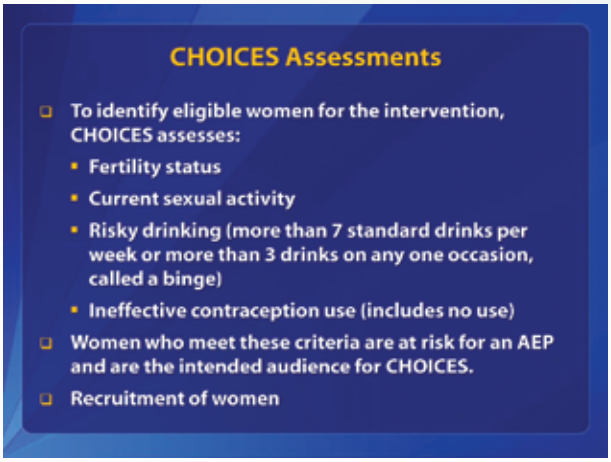
Slide 31

Facilitator Notes:

CHOICES is a proven effective intervention for women who are at risk for pregnancy and who are drinking above risk levels.

(Read slide)

The target population includes women who are at risk for pregnancy because they are sexually active but not using effective contraception. Their risky drinking patterns include binge drinking.



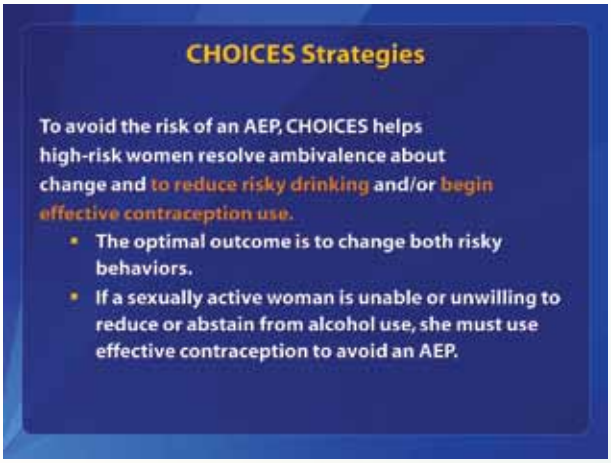
Slide 32

Facilitator Notes:

To identify eligible women for the intervention, CHOICES assesses:

- Fertility status — to ensure that a woman is capable of getting pregnant
- Current sexual activity — whether or not a woman is sexually active
- Risky drinking — defined as more than 7 standard drinks per week or more than 3 drinks on any one occasion, which is called a binge
- Ineffective contraception use — inconsistent and/or ineffective use, or no use at all

A variety of recruitment strategies have been used depending on the client settings being targeted. Advertisements in local newspapers, cable television public service outlets, and local radio stations have been used for recruitment when casting a broad net for participants. Flyers have been used in clinics serving women of childbearing age, including family planning clinics, WIC clinics, STD clinics, and primary care clinics. If the intervention setting is an existing clinic, the clinicians should be a key source of referrals. In some settings, information on potential candidates may be identified from the EMR system based on age, drinking levels, and contraception status. Other strategies include approaching women as they wait for their appointment in the clinic waiting room.

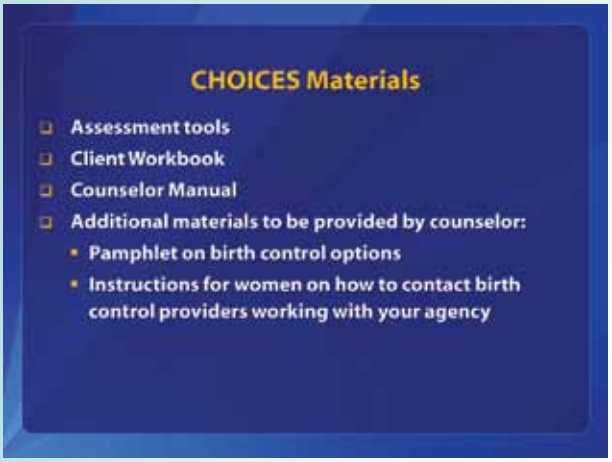


Slide 33

Facilitator Notes:

Women who engage in risky health behaviors usually feel two ways about it: While they get pleasure from the behavior, they also feel guilty because they know it may not be good for them and may sometimes affect others. Risky drinkers experience this ambivalence.

(Read slide)



Slide 34

Facilitator Notes:

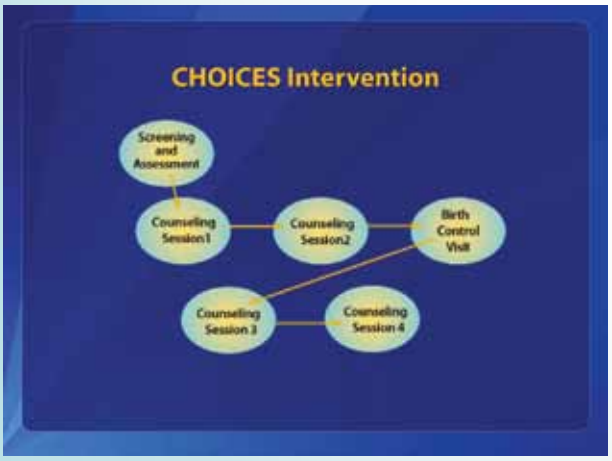
The CHOICES package includes four main pieces:

There are two primary ways to reduce AEPs:

1. Assessment tools — to help you assess whether clients are at risk for an AEP and to develop some personalized feedback for clients as part of the intervention
2. Client Workbook — given to your client to help her track her changes and progress
3. Counselor Manual — the most important component
   - — Will guide you every step of the way in providing this intervention
   - — Designed to be used with the client when she is in sessions with you
   - — A resource for giving CHOICES to women at risk for an AEP

You will provide, as appropriate:

4. Birth Control Information —
   - A correct and up-to-date birth control options pamphlet
   - Instructions for women on how to make appointments with the birth control providers working with your agency



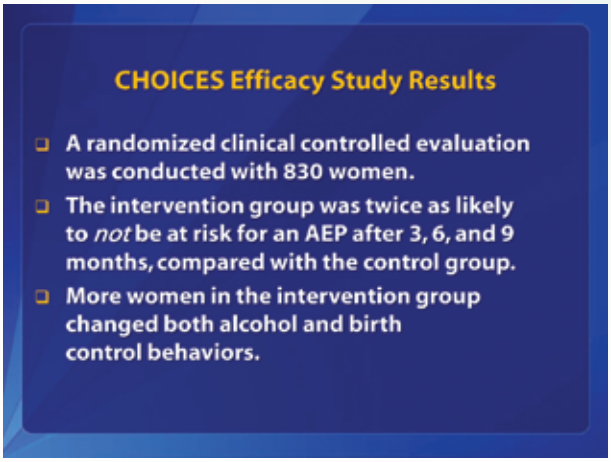
Slide 35

Facilitator Notes:

This diagram illustrates the flow and direction of the CHOICES intervention:

- First, a patient is screened and assessed to determine if she is at risk for pregnancy and drinking at risky levels. If so, then she is at risk for an AEP.
- Once screened and identified, the patient attends counseling sessions 1 and 2, followed by a birth control visit, which is discussed in counseling session 3 or 4.

Each session involves recommended activities that the counselor and his/her patient will complete. The program is designed to increase the woman's motivation to change one or both of the target behaviors — risky drinking and ineffective contraception use.

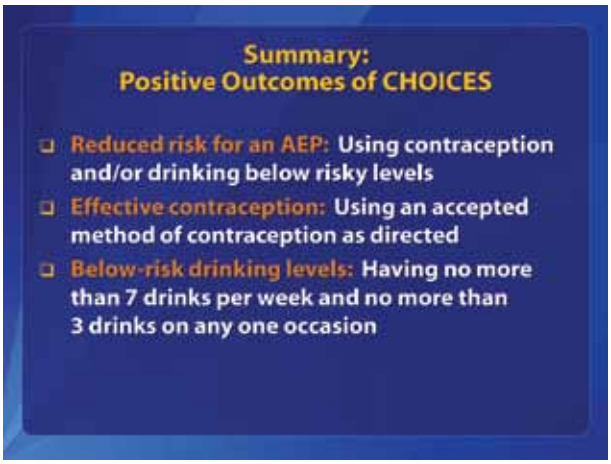


Slide 36

Facilitator Notes:

The efficacy study was conducted as a large multisite study.

(Read slide)

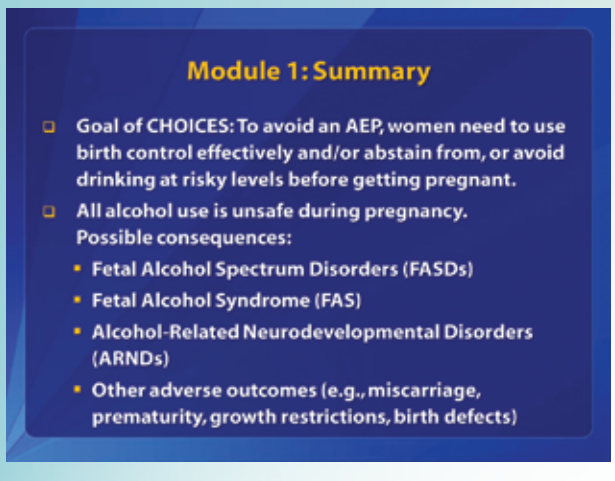


Slide 37

Facilitator Notes:

Given the design of the CHOICES intervention, there are three primary positive outcomes that will reduce the risk of an alcohol-exposed pregnancy.

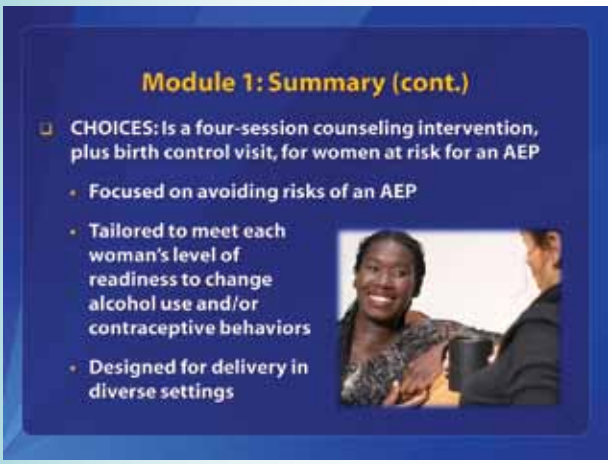
(Read slide)



Slide 38

Facilitator Notes:

(Read slide)



Slide 39

Facilitator Notes:

(Read slide)

MODULE 2:

Motivational Interviewing

MODULE 2:

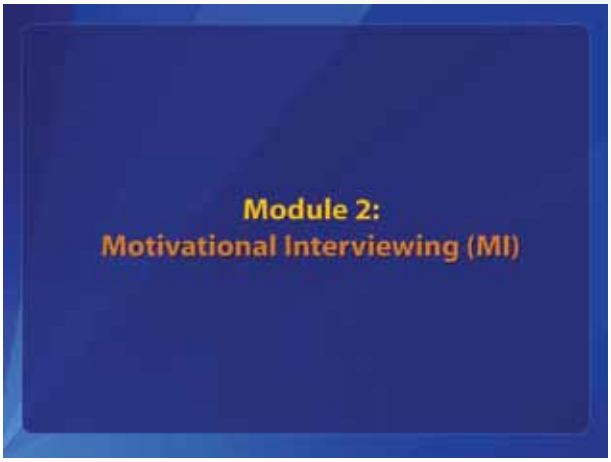
Trainer Objectives:

- Introduce and define Motivational Interviewing (MI), the counseling style used in CHOICES
- Provide the rationale for using MI
- Distinguish between MI and non-MI counseling styles
- To identify the risks and dangers of alcohol use during pregnancy
  - Fetal Alcohol Spectrum Disorders (FASD)
  - Fetal Alcohol Syndrome (FAS)
  - Other adverse outcomes
- To present the evidence for CHOICES
- To present the CHOICES goals and approach

Materials Required:

- Flip chart or whiteboard, markers, paper, and tape
- MI rulers
- Handouts
  - MI/Non-MI Exercise
    - Role Play 1
    - Role Play 2

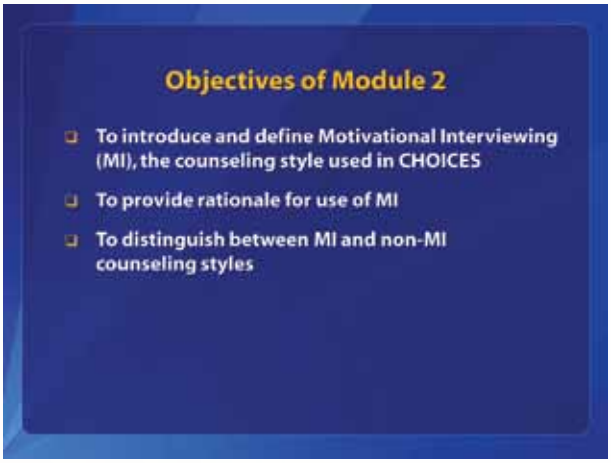
Time Required: 75 Minutes



Slide 40

Facilitator Notes:

(Read slide)

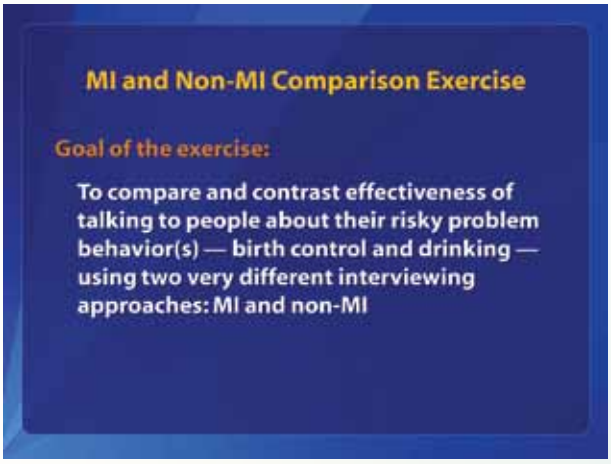


Slide 41

Facilitator Notes:

(Read slide)

(During Module 2, the trainer hands out the MI Ruler.)

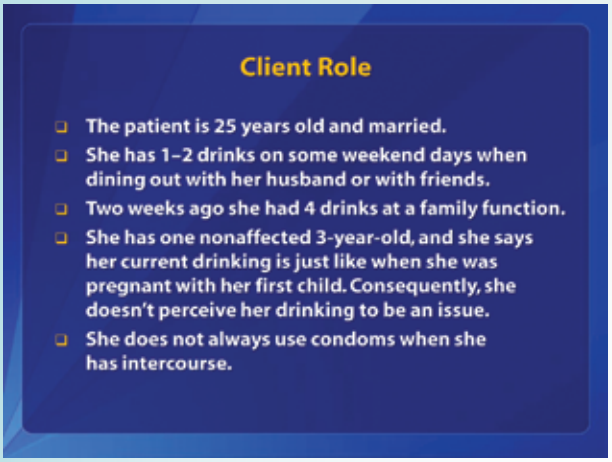


Slide 42

Facilitator Notes:

In this exercise, we will divide you into pairs and assign you to the roles of client and counselor.

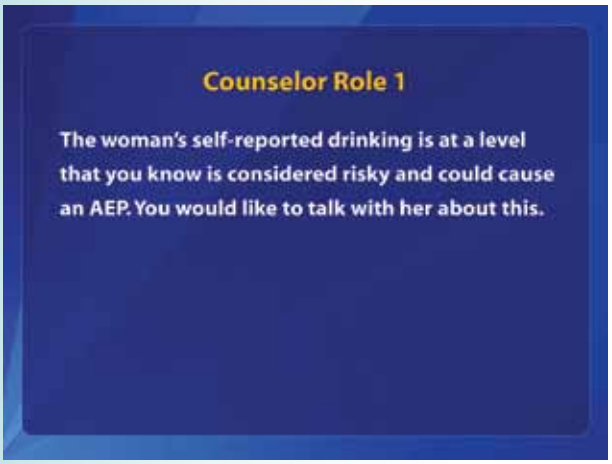
(Read slide)



Slide 43

Facilitator Notes:

(Read slide)



Slide 44

Facilitator Notes:

(Read slide, then follow these instructions for Role Play 1:

- *Divide participants into pairs: One is the counselor, one is the client.*
- *Give participants the handout titled MI/Non-MI Exercise*
- *Instruct those playing the counselor to read the questions exactly as they are written.*
- *Instruct those playing the client to answer however they would like.*
- *Give them 90 seconds, no more, to do the role play.)*

(Prepare the flipchart or white board with the title, "Role Play 1," and divide it into two columns: "Client" and "Counselor".)

(When 90 seconds are up)

(To participants playing the client)

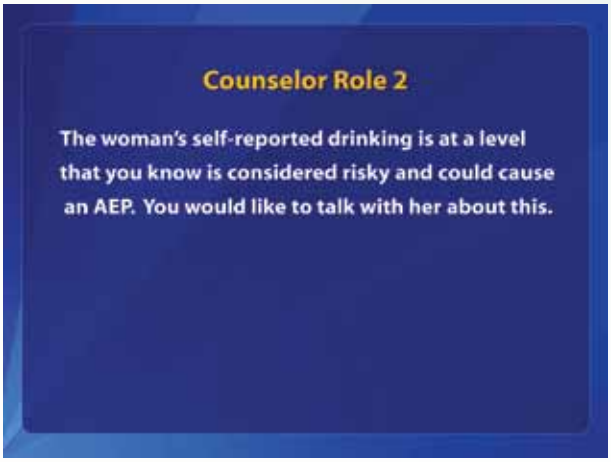
In one word, what was this experience like for you?
(*Write responses in one column on flipchart.)*

(To participants playing the counselor)

Can someone read the column with the client responses?
(Participant reads responses.)

Can someone read the column with the counselor responses?
(Participant reads responses.)

Overall, what do all these words have in common?
(Answer should be "they are negative".)



Slide 45

Facilitator Notes:

(Read slide, then follow these instructions for Role Play 2:

- *Remain in the same pairs: same person as the counselor, the other as the client.*
- *Give participants the handout for Role Play 2 titled MI/ Non-MI Exercise.*
- *Instruct those playing the counselor to read the questions exactly as they are written.*
- *Instruct those playing the client to answer however they would like.*
- *Give them 90 seconds, no more, to do the role play.)*

(Prepare the flipchart or white board with the title, "Role Play 2," and divide it into two columns: "Client" and "Counselor".)

(When 90 seconds are up)

(To participants playing the client)

In one word, what was this experience like for you? (*Write responses in the other column on flipchart.)*

(To participants playing the counselor)

In one word, what was this experience like for you? *(Write responses in the other column on flipchart.)*

Can someone read the column with the client responses? *(Participant reads responses.)*

Can someone read the column with the counselor responses? *(Participant reads responses.)*

Overall, what do all these words have in common? *(Answer should be "they are positive".)*

Slide 46

Facilitator Notes:

Ask the group to notice the differences between the specific words and their connotations on the lists generated by the non-MI style and MI style. Ask the group for any further comments about their experiences when using either style as a counselor, or when encountering either style as a client.

Sum up by stating that we will be using the style and techniques that felt more positive within this training and within the CHOICES intervention, which reflects the MI (Motivational Interviewing) style

Slide 47

Facilitator Notes:

(This exercise is designed for you to model Motivational Interviewing, or MI, skills. Be sure to use open-ended questions, reflect participant responses, and elicit change talk.)

Over the next two days you will be trained in the counseling style called "Motivational Interviewing." Some of you may have had some training in MI before today, and others may be hearing about it for the first time. We are going to demonstrate a "scaling ruler," which is one of the strategies used in CHOICES, while at the same time learn a little bit about you and your previous exposure to MI.

I have placed numbers in a line on the floor, from 1-10. I would like for you to form a line by standing on the number that best represents how confident you are at the current time, in your use of MI. The number 1 is least confident and the number 10 is most confident. There are no right or wrong answers.

(Use scaling questions accordingly. Some examples are below.)

You have chosen a 3. Why did you assign yourself to that number instead of 1 or 2?

(Confirm responses for other participants in the same position).

What would it take for you to move to 4 or 5?

(Listen and confirm responses. Repeat the questions with participants who assigned themselves to 7 or 8, asking them why they did not choose 5 or 6.)

This exercise provided us, as trainers, the opportunity to model some MI skills and a strategy that is used in the CHOICES sessions and will be explained later in the training. In the meantime, thank you for your honesty about your comfort with MI.

Slide 48

Facilitator Notes:

(Trainer hands out MI ruler.)

MI is a goal-oriented, client-centered approach that speaks to the unique strengths, needs, challenges, and desires of each client.

Remember…MI is NOT a treatment!

- It enhances the motivation for change by empowering the client to take an active role in the process of change.
- It helps the client clarify and resolve ambivalence about behavior change. Ambivalence is the idea that even when part of us wants to change, there is another part of us that may resist or feel unsure. It is having two opposing feelings at the same time.

The goal of MI is:

- To prepare people to consider changing. The provider acts as a guide in the MI process and helps the client to address her ambivalence about behavior change. But the decision to change is always the client's.
- To maintain motivation once change is established
- To not "push" people to change. You are not persuading or directing a client to change; the motivation to change can be enhanced by effective and supportive listening, but the desire to change must come from the client.

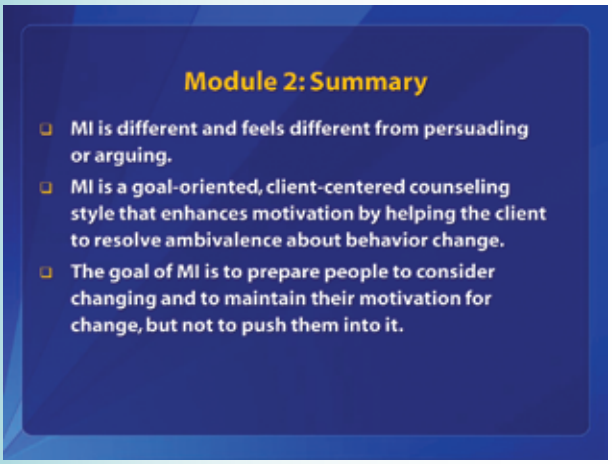
Slide 49

Facilitator Notes:

We based CHOICES on MI because of evidence. There have been more than 120 clinical trials that show MI to be an effective strategy to effect change in health behaviors.

(Read remaining bullets.)

To increase your familiarity and comfort with MI, this training will give you some background on the MI spirit, principles, and techniques that you will use in CHOICES.



Slide 50

Facilitator Notes:

(Read slide)

MODULE 3:

Motivational Interviewing Counseling Skills

MODULE 3:

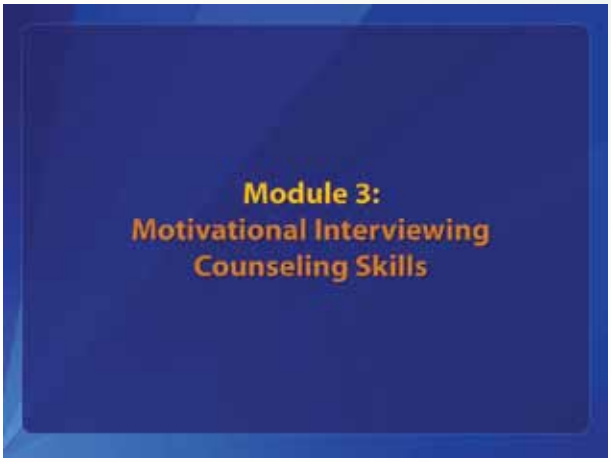
Trainer Objectives:

- To define the importance of the MI spirit, empathy, and direction in MI
- To define OARS counseling techniques
- To explain goals and strategies to elicit change talk
- To identify potential pitfalls in MI
- To practice MI

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Drumming for Change Instructions
- Video
  - Demonstrating O.A.R.S.

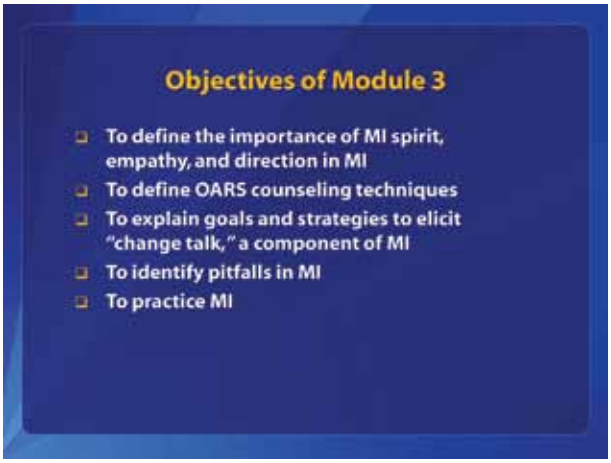
Time Required: 75 Minutes



Slide 51

Facilitator Notes:

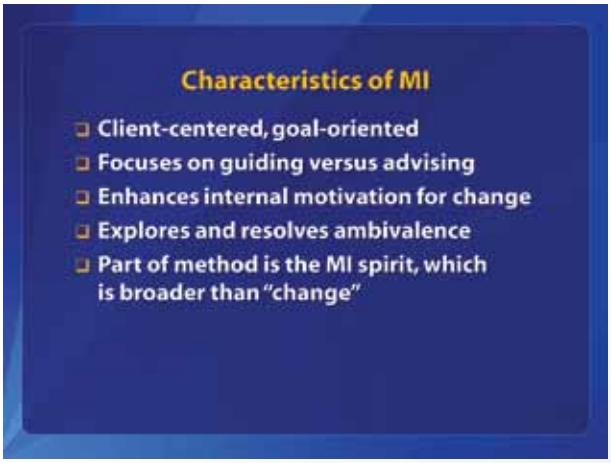
We've talked in general about the spirit and components of MI. In Module 3, we will discuss specific Motivational Interviewing and counseling skills. This will give us an opportunity to discuss the MI spirit in greater detail and to add MI strategies and processes to your toolkit as CHOICES counselors.



Slide 52

Facilitator Notes:

(Read slide)



Slide 53

Facilitator Notes:

We have mentioned some of these already.

(Read slide)

Throughout this training, we will review a number of skills and techniques in MI to prepare you to use the counseling style with your clients.

Slide 54

Facilitator Notes:

Let's discuss the "spirit" of MI. The three main components of the MI spirit are collaboration, evocation, and autonomy/support.

What does collaboration mean to you?

What does evocation mean to you?

What does autonomy mean to you?

Collaboration is the partnership that is established between counselors and their client. This is fundamental to the successful delivery of CHOICES. Although counselors may be experts in their field, the client is the expert on herself, her perspective, and her experiences. When done well, MI is a collaboration between these two experts, considering an issue together.

Through evocation, what the client says she wants to do about the situation is the most important communication in any session. The role of the counselor is to evoke from the client what she wants to do about the problem, if anything.

Finally, autonomy is one of the most respectful things we can offer our clients. By believing in their ability to make decisions and run their own lives, we help them to develop a greater sense of autonomy. The counselor provides support, information, and options, but the decisions rest with the client.

Slide 55

Facilitator Notes:

(Read slide)

CHOICES counselors use the MI spirit to create a positive atmosphere that is conducive to change (collaboration) and a tone that elicits the client's voice (evocation).

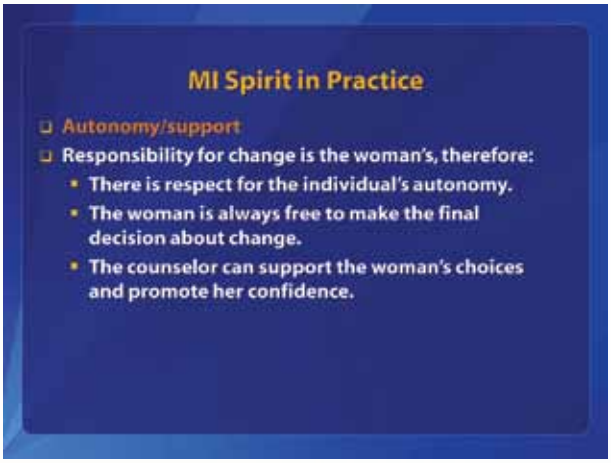
(Discussion questions)

Can someone give an example of what a collaborative session would look like?

(Some examples to look for are: client and counselor working together to find a solution, a give and take relationship.)

How does evocation differ from providing information or education?

(Some examples to look for are: the counselor is gathering information from the client, rather than lecturing or forcing information on her.)



Slide 56

Facilitator Notes:

We discussed collaboration and evocation in the previous slide. Now we are going to elaborate on autonomy/support in the MI spirit and CHOICES.

(Read slide)

(Discussion questions)

How can we support autonomy when counseling women who are at risk for an AEP?

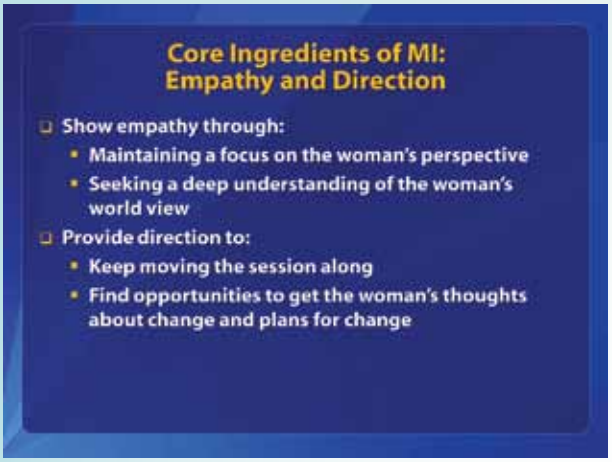
(Support clients to make their own decisions, but provide the tools to allow them to do so.)

What if your client wants to continue having unprotected sex?

(Look at the other option in CHOICES, which is reducing risky drinking.)

What if your client wants to continue drinking?

(Look at the other option in CHOICES, which is using contraceptives.)



Slide 57

Facilitator Notes:

We demonstrate the MI spirit by evoking solutions and perceptions from the client, collaborating with her to find a solution she likes, and supporting her autonomy and rights to make her own choices. Through this process we also display two other global principles of MI: empathy and direction.

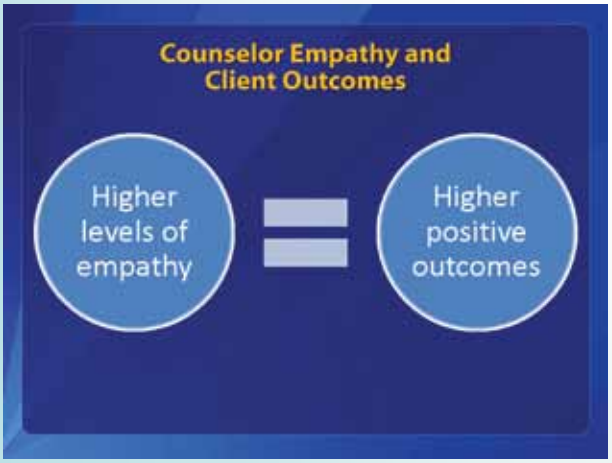
(Read slide)

In combination, empathy and direction really define the MI counseling style. We show empathy when we show a strong interest in understanding the client's world view and, at the same time, provide direction to keep moving the session along, taking advantage of opportunities to bring out the client's thoughts about and plans for change. Note that you can be directive without being empathetic; however, in MI, these skills are used together and in balance.

Given that CHOICES is such a brief intervention, the directive structure provided by the counselor is necessary to keep the client focused and to allow the client and counselor to work together to achieve good outcomes. Remember, these are not general therapy or social work sessions.

Why is empathy so important?

(Keeps sessions moving while also building rapport with clients.)



Slide 58

Facilitator Notes:

Several studies have shown that higher levels of empathy are associated with more positive outcomes. Thus, it is important for counselors to demonstrate empathy when working with clients.

Slide 59

Facilitator Notes:

Now we'll discuss some fundamental skills that will help you to stay focused, provide direction, and express empathy to your clients in the CHOICES intervention.

The OARS Counseling Principles are skills that are fundamental to several forms of counseling by building a good rapport with clients.

- Open-ended questions — Elicit exploration of topics
  - — Asking open-ended versus closed questions helps to get clients talking.
  - — An open-ended question is one that does not invite short responses, but rather encourages the client to take control of the direction of the response, which can help her feel safer and better able to express herself. She may say things she didn't realize she was thinking or believed.
- Affirm the person — Focus on client strengths, efforts, patience
  - — In MI, affirmations are a genuine, direct statement of support during the counseling session that is usually directed at something specific and possibly observable that the client has done. For example, "That's great that you filled in your journal almost every day."
  - — Affirming statements demonstrate the counselor understands and appreciates at least part of what the client is dealing with, and is supportive.
  - — Affirming may be compared to the seasoning in a recipe: The right amount is appropriate, but overdoing it can be problematic.
- Reflect what the person says — Nondirective initially, then subtly directive
  - — Listening reflectively is one way to be empathic.
  - — Listening reflectively is about being quiet and actively listening to the client, and then responding in a way that demonstrates empathy by reflecting back the essence of what the client said or what you think the client meant.

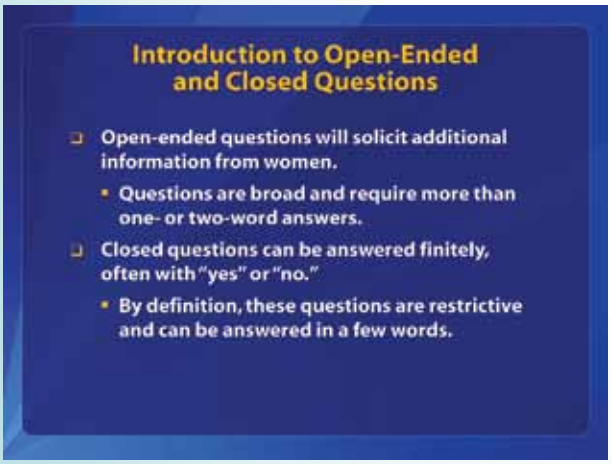
Slide 59 continued on next page

Slide 59 continued from previous page

- Summarize — Capture "essence," link topics, and transition conversation
  - — Summarizing can serve as a way of communicating that you have followed what the client said and you have an understanding of the big picture.
  - — Summarizing can help structure a session so that neither client nor counselor strays too far from the main topics, maintaining focus on the most relevant topics.
  - — Summarizing can be an opportunity to emphasize certain elements of what the client has said.

Although it may be a bit corny, the acronym OARS is easy to recall and can help you figure out what to do next when you are unsure. In MI, our rule of thumb is: When in doubt, go back to your OARS. Listen carefully to the client and you'll soon figure out how to get back on course!

Next, we'll do a few exercises with each of these principles to help you learn them and begin putting them together in a useful way.



Slide 60

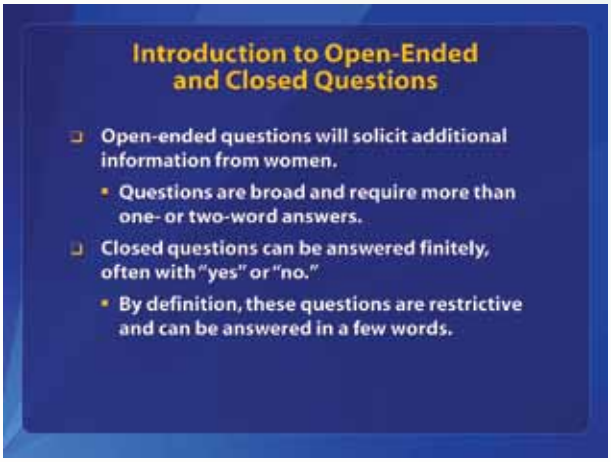
Facilitator Notes:

(Read slide)

Open-ended questions tend to start with the letters "wh," such as "why" or "what," or with action words (e.g. "tell" or "explain").

Closed-ended questions tend to start with the verbs "is" or "do."

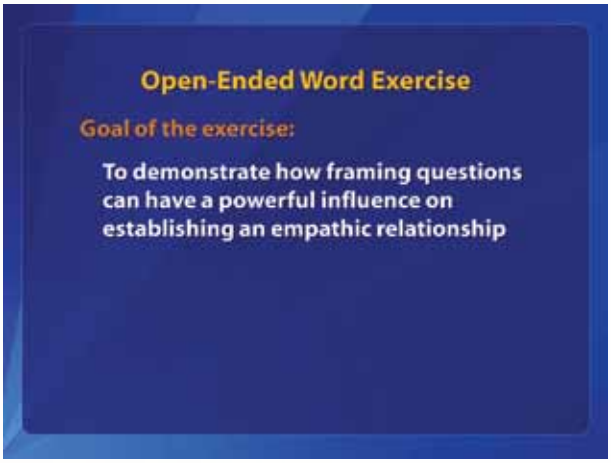
These guidelines are not absolutes.



Slide 61

Facilitator Notes:

(Read slide)



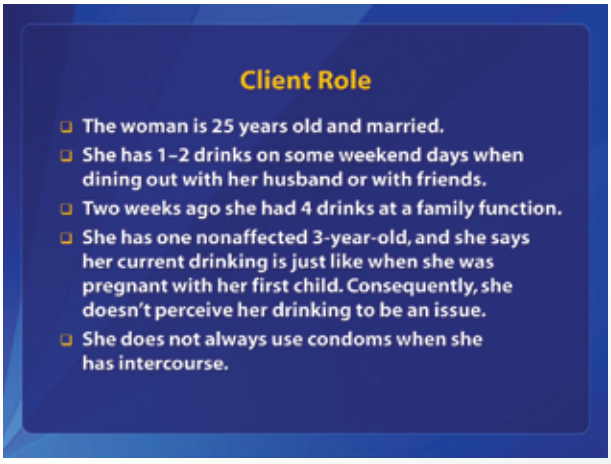
Slide 62

Facilitator Notes:

We are going to do another role play to give you an opportunity to experience the difference between open-ended and closed questions.

(Read slide)

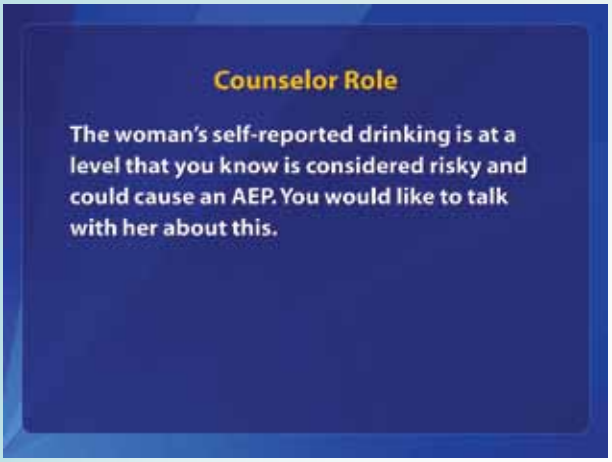
First we will go over the counselor and client roles again.



Slide 63

Facilitator Notes:

(Read slide)



Slide 64

Facilitator Notes:

(Read slide)

Please pair up with the same partner you had for Role Play 1, and maintain the same roles.

In this role play, the counselor is only allowed to ask closed questions. The client can answer however she wants.

Please role-play for 90 seconds.

(When finished)

First the counselors:

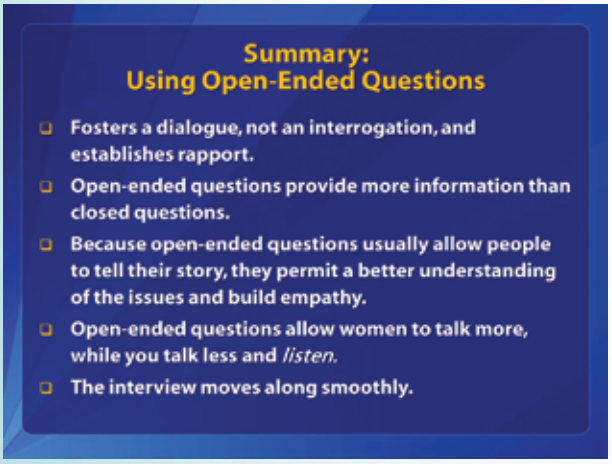
What differences did you experience between asking open-ended questions and closed questions?

What are the benefits of open-ended questions?

Now the clients:

What differences did you experience between answering open-ended questions and closed questions?

What are the benefits of open-ended questions?



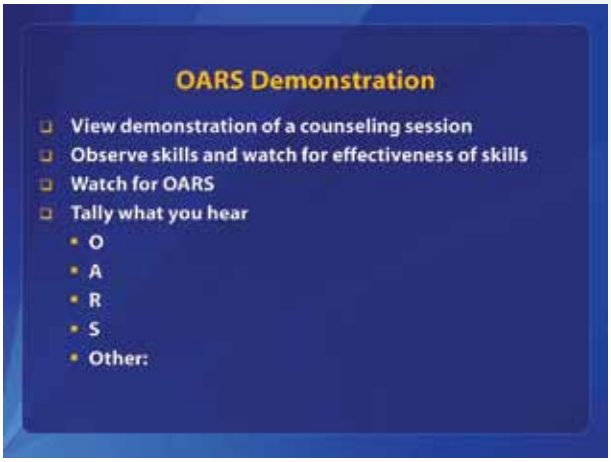
Slide 65

Facilitator Notes:

You have given some good examples of the benefits of open-ended questions.

Now we will reiterate some of your examples and use this slide to add to the benefits that you have listed.

(Read slide)



Slide 66

Facilitator Notes:

Now we will show a video that demonstrates how to use OARS to facilitate a conversation.

You might really get into the content of what the "client" says, but the focus here is to pay attention to what the counselor says.

Please create a tally sheet like the one on this slide. As you watch and listen to the demonstration, put a tick mark to record each time you hear the counselor using each of the communication skills.

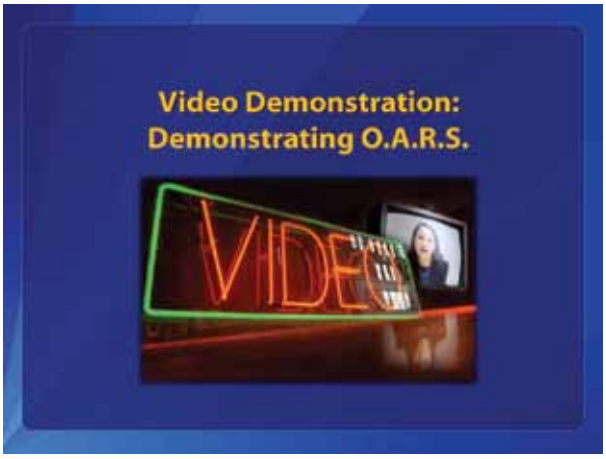
To remind you:

O = Open-ended questions

A = Affirm the person

R = Reflect what the person says

S = Summarize



Slide 67

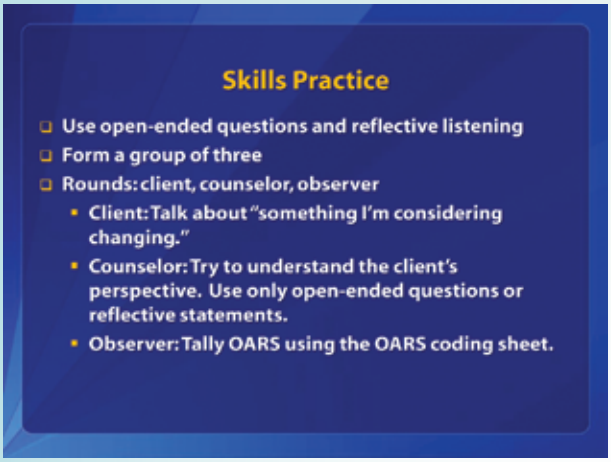
Facilitator Notes:

(Show video)

(Discussion questions)

What did you notice?

Were you able to identify OARS?



Slide 68

Facilitator Notes:

Now you'll get a chance to practice two of the most important parts of OARS: open-ended questions and reflections.

First, get into a group of three.

(Allow time for this to happen before moving on to giving directions.)

This will be a real play in which you, as the client, will talk about something you're considering changing. We call this a "real play" because you will use real-life examples to practice MI counseling skills.

This should be something you're comfortable talking about in this setting — NOT your deepest, darkest secret!

Let's count off 1s, 2s, and 3s. (Count 1, 2, and 3 in each group.)

OK, does everyone remember your number? Let's start with 1s being the client, 2s being the counselor, and 3s being the observer. We will switch roles so all of you will have a chance to play each role.

Now we'll spend just three minutes doing this exercise, just to give you a feel for it. Clients, you will start off by stating the thing you're considering changing. Counselors, use open-ended questions or reflections to try to understand the client's perspective fully. Observers, you'll watch the counselor and count any OARS you hear, marking on the OARS tally sheet. You'll switch roles when we call time, so stay in role until then. Ready? Go.

(After three minutes)

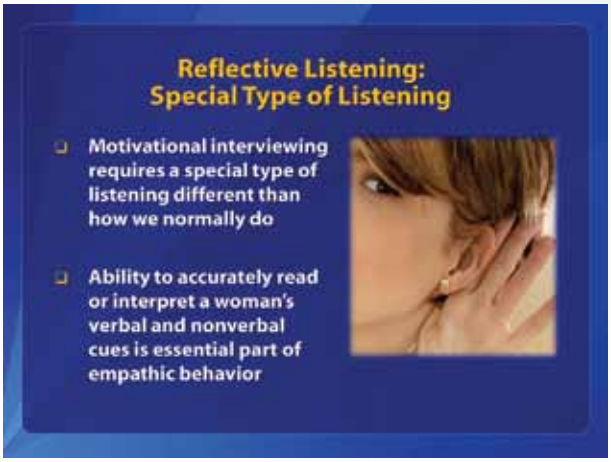
OK, switch roles. Now let's have the 1s be the observer, the 2s be the client, and the 3s be the counselor. Same rules as before. Don't switch roles until we call time. Ready? Go.
(After three minutes)

OK, switch roles. Now the 1s will be the counselor, 2s will be the observer, and 3s will be the client. Same rules as before. Ready? Go.
(After three minutes)

OK, let's discuss. Debrief each role, beginning with the counselors. What was easy or more difficult about asking open-ended questions and making reflective statements? How was it to attempt to fully understand the client?

As clients, what was this like for you? Did you find it easy or hard to talk about your possible change?

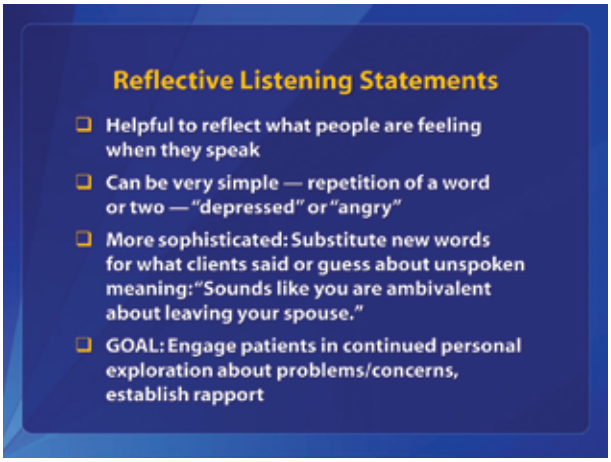
As observers, what did you notice counselors doing most frequently? How did clients react? Summarize key MI points.



Slide 69

Facilitator Notes:

(Read slide)



Slide 70

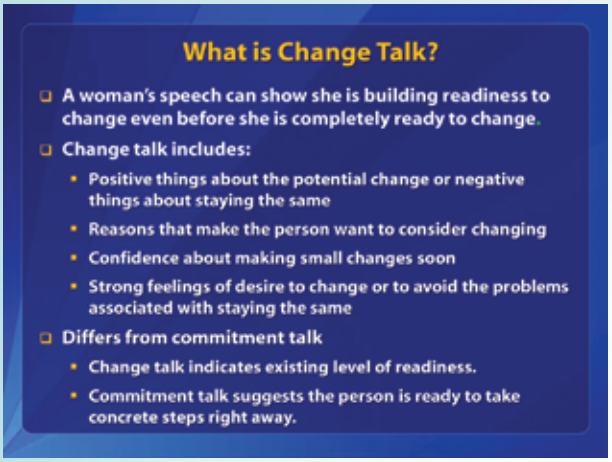
Facilitator Notes:

(Read slide)

Slide 71

Facilitator Notes:

(Read slide)



Slide 72

Facilitator Notes:

Now we are going to discuss change talk.

(Read slide)

Slide 73

Facilitator Notes:

This slide will help us discuss some examples of what change talk sounds like.

(Read slide)

These examples offer varying degrees of commitment to change. Part of effective counseling is the ability to respond in ways that match your client's readiness for change.

Slide 74

Facilitator Notes:

The techniques of motivational interviewing—such as empathy (seeking understanding), direction (keeping the momentum up), spirit (collaborative, evocative, autonomy-supporting), and open-ended questions and reflective listening—tend to elicit some things we want to hear. This will help the client to voice change talk or thoughts on why and how certain behaviors might change.

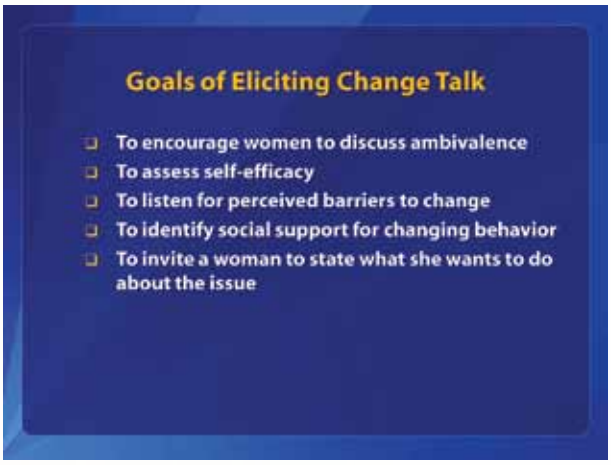
Research shows good motivational interviewing tends to be followed by client change talk, such as statements about the desire to change, the ability to change, the reasons for change, and the need to change. Hence DARN-C, which is the flow of change talk, is illustrated on this slide.

As we can see here, empathy, direction, motivational interviewing spirit, and motivational interviewing techniques lead to desire, ability, reasons, and need, which then lead to commitment and, finally, change.

With increasing change talk, a client likely will make verbal commitment to change, saying things like, "I will do it." If clients voice commitment talk at an increasing rate from session to session, they actually do have a greater chance of changing. Therefore, when we hear change talk, it's a good sign that motivation is building. Using motivational interviewing spirit and techniques makes it more likely that motivation will grow.

References:

Miller, W.R. (2005). Believe your data: Research, theory, practice, and training of motivational interviewing. 39th Annual Convention of the Association for Behavioral and Cognitive Therapies. Washington, DC.



Slide 75

Facilitator Notes:

The goals of eliciting change talk are:

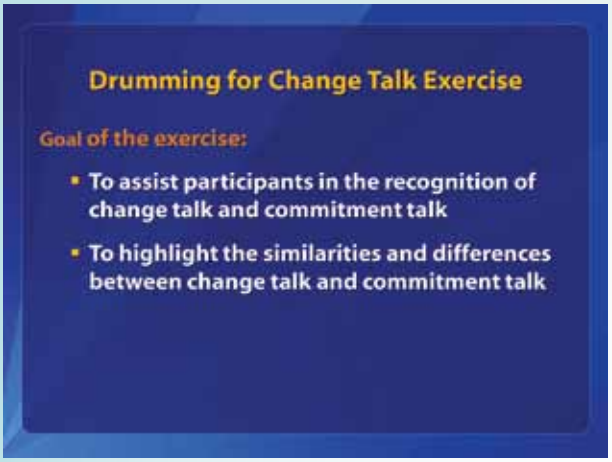
- To encourage the client to discuss ambivalence—The best known way to resolve ambivalence is for a client to acknowledge it and openly discuss it so desire for change becomes the stronger emotion.
- To assess self-efficacy—Self-efficacy is an individual's sense of personal ability to perform a new behavior.
- To listen for perceived barriers to change—The client's views of barriers and benefits are important to incorporate into the change planning process.
- To identify social support for changing behavior—One important determinant of a person's ability to change is the amount of social support available for the new behavior. The importance of this support is confirmed by the success of 12-step groups, weight-loss support programs, and peer education programs.
- To invite the client to state what she wants to do about the issue (empowerment)

  Client intention—In motivational interviewing, the most powerful statements are the client's own claims of what she wants to do about her situation.

Does anyone have any comments or questions?

Can someone describe something that might be an example of change talk?

(Examples to look for include: I want to stop drinking so much, I am going to start using condoms.)



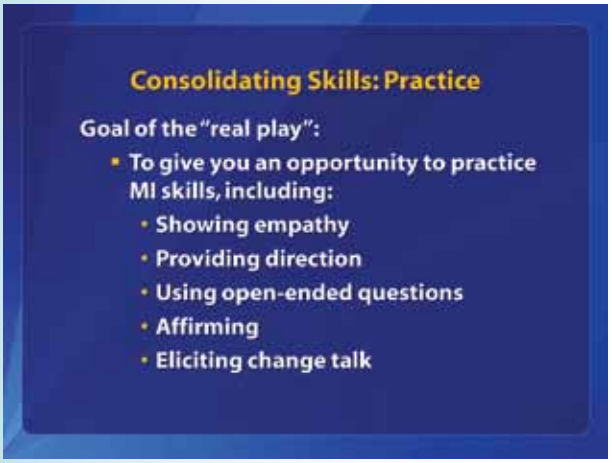
Slide 76

Facilitator Notes:

To effectively respond to change talk, we need to recognize it. In the next exercise, we will tune our ears to hear change talk and distinguish between change talk and commitment talk. As the name implies, commitment talk has a level of readiness, suggesting that a client is ready to take concrete steps right away. In change talk, a client is building readiness but may not be completely ready to change her behavior today.

The name of the exercise is "Drumming for Change."

(Take out "Drumming for Change Trainer Instructions," and read from them.)



Slide 77

Facilitator Notes:

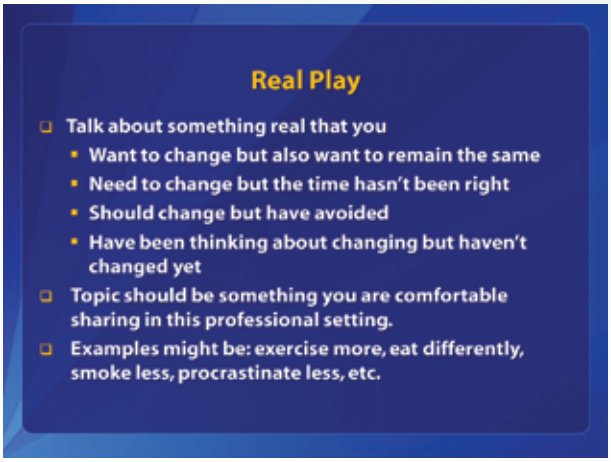
(Read slide)

For this "real play" exercise, please partner with someone you do not work with on a regular basis.

Bring your materials and meet with your partner somewhere in the room where you can hear and see one another and comfortably conduct a counseling skills practice.

Please designate one person to be the client and the other to be the counselor.

Next, I will give you some specific instructions for each role.

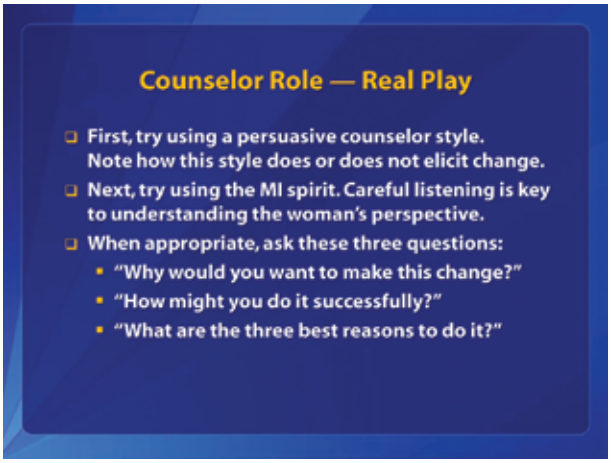


Slide 78

Facilitator Notes:

First I will go over the client role.

(Read slide)



Slide 79

Facilitator Notes:

Now I will go over the counselor role.

(Read slide)

You can now begin the real play with your partners. Remember to first try the persuasive counselor style and then try the MI counselor style.

Please take two minutes to complete the Real Play.

(Discussion questions after completed real play)

Which of the styles was most effective from the client's perspective?

Please keep the spirit of MI at the front of your mind. Which aspects of the MI spirit did you observe in your counselor? How was this accomplished? How did it feel?

What differences did you notice between using persuasion and using MI?

Slide 80

Facilitator Notes:

We have talked a lot about what you should try to do in MI. Now we are going to identify some potential things to avoid — MI pitfalls.

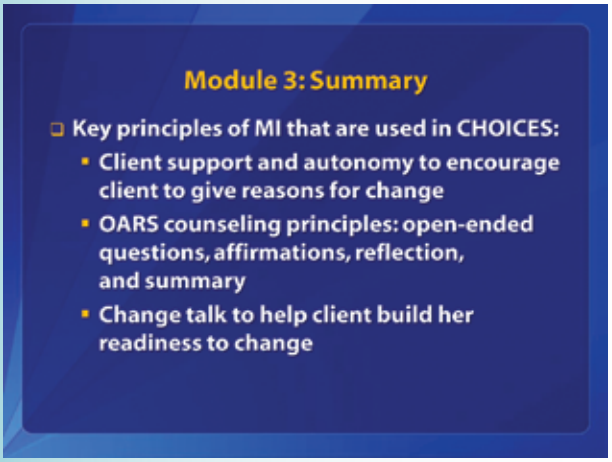
There are some styles of communication that tend to decrease motivation. We try to avoid these in MI.

(Read slide)

By following with no direction we mean…don't allow the conversation to go too off-topic without bringing it back to focus on the goals and objectives of the session.

What principles of MI or aspects of the MI spirit are inconsistent with these styles?

Do you have any questions?



Slide 81

Facilitator Notes:

(Read slide)

MODULE 4:

Increasing Readiness for Change

MODULE 4:

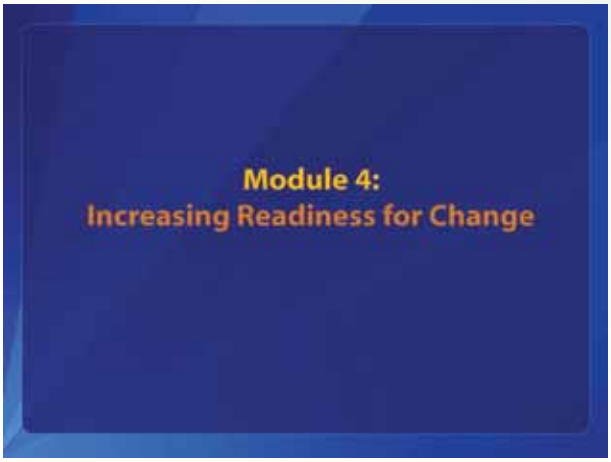
Trainer Objectives:

- To define ambivalence and identify its relationship to the change process
- To define the righting reflex
- To illustrate the connection between ambivalence and the righting reflex
- To review several options to increase readiness to change in CHOICES
  - Stages of change
  - Readiness ruler
  - Decisional balance

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Handouts
  - Decisional Balance Exercise Instructions
  - Decisional Balance Exercise Example
- Video
  - Decisional Balance Activity: Alcohol

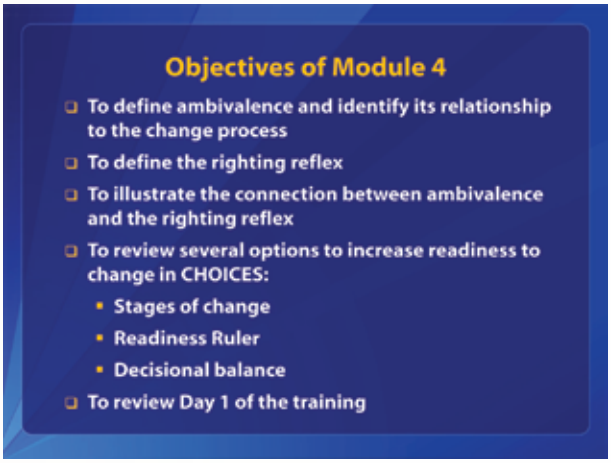
Time Required: 90 Minutes



Slide 82

Facilitator Notes:

(Read slide)

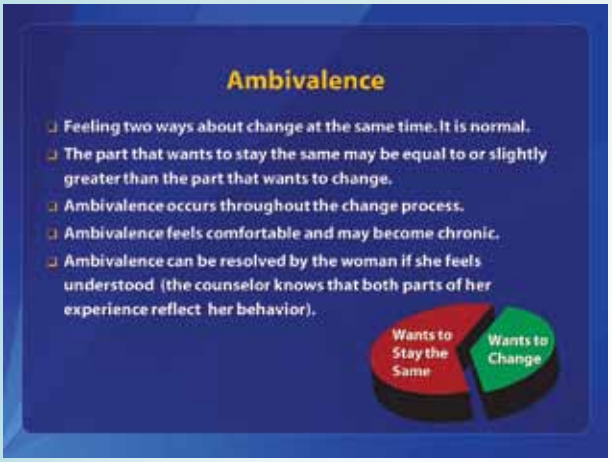


Slide 83

Facilitator Notes:

(Read slide)

(During Module 4, trainer hands out "Decisional Balance Exercise.")



Slide 84

Facilitator Notes:

What does the term "ambivalence" mean to you?

(Listen and confirm responses.)

Ambivalence is:

- Feeling two ways about change at the same time. It's normal.
- It involves some desire to change and some resistance to change — feeling two ways about changing creates conflict.
- Ambivalence is a normal part of the change process, and most people go through it. Raise your hand if you feel that there is a change you should make or want to make but can't seem to make.
- A central reason for our ambivalence is that the cost or perceived costs of changing versus not changing are fairly equal. For many of us, making a change may mean giving something up. Can someone give an example?

(Read the last bullet.)

Change must come from the clients themselves.

- A traditional approach to changing people's behavior has been to offer "correct" information in place of the client's ambivalence. We try to persuade the person to change, or appeal to the part of her that wants to change. That puts pressure on her, and because of the nature of ambivalence — meaning that both parts of her experience are true — she will feel pressured to defend the part that does not want to change. This results in many reasons why the person can't change now, or counter change talk.
- In MI terms, when we put pressure on the client to change, or we correct her, it is referred to as the righting reflex. Managing or avoiding this reflex is key to MI — and a goal for CHOICES counselors.

Slide 85

Facilitator Notes:

Now we will go into a bit more depth on what the righting reflex is and how it might come into play.

(Read slide)

We may be inclined to argue for change in an attempt to be helpful. For example, "You need to stop smoking cigarettes."

Still, the reality is that arguing for change — especially with clients who have strong ambivalence — can be counterproductive.

Slide 86

Facilitator Notes:

When the righting reflex meets ambivalence, there is a risk that the client will feel a need to protect the part of herself that doesn't want to change. Rather than talking about change, the client will talk about why change is not a good idea right now. If you put pressure on the "wants to change" side, the client will naturally defend the "wants to stay the same" side.

(Read slide)

As you can see in this slide, the result of the righting reflex pressuring the client to change has exactly the opposite effect. It increases the part that does not want to change.

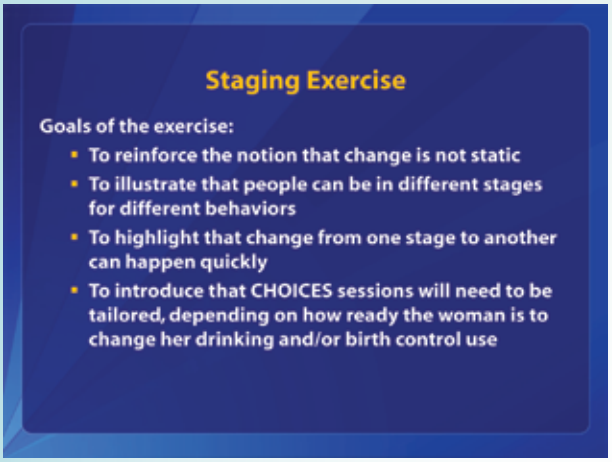
Slide 87

Facilitator Notes:

Fortunately, the opposite is true also. If you protect the part of her that wants to stay the same, she may begin explaining to you why she really needs to change!

In MI, we try to minimize push-back by not pushing in the first place. This increases the likelihood that the client will state a behavior change goal.

(Read slide)



Slide 88

Facilitator Notes:

(Read slide and complete the following exercise)

(In four corners of the room, post signs that read:

1. No way, not gonna change.
2. Thinking about changing.
3. Getting ready to change.
4. No more cell phone for me.)

(Pick a participant at random and ask that person to give you his/her last name.

Introduce the participant to the group as "Dr. _____.")

Dr. ____ has conducted a study on the relation between cell phone use and brain damage. This was an important study published in a very reputable journal. What is the name of the journal, Dr. ____? And how many participants were in the study?

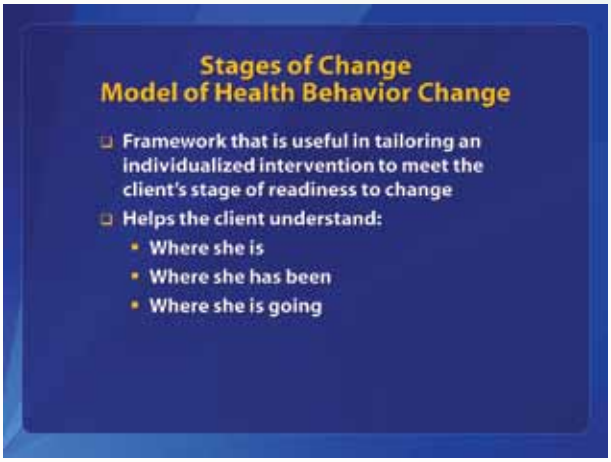
(To the rest of the group) Now, please stand in the corner of the room near the sign that best represents where you are right now with regard to your own cell phone use.

(Once everyone has selected a position, start with the "no way, not gonna change" group and ask them why they selected this position. They will usually respond with statements such as, "using a cell phone hasn't hurt me so far," "I don't talk on the phone that much," etc.)

(Move to the next sign and do the same, eliciting comments in each that are similar to comments clients might make in the various stages of change. When finished, ask the participants to sit down. Review the four stages of change, each in turn, and note that each sign represented one of the stages. Ask participants what comments they heard in each stage that might be typical to that stage.)

What if we had conducted this same exercise with a different behavior change, such as giving up chocolate? How many of you would have selected a different stage of change if that had been the targeted behavior?

This exercise reinforces the notion that change is not static and that clients can be in different stages for different behaviors, or can move from one stage to another rather quickly. In CHOICES, the emphasis in the sessions will be somewhat tailored, depending on how ready the woman is to change her drinking and/or birth control use.



Slide 89

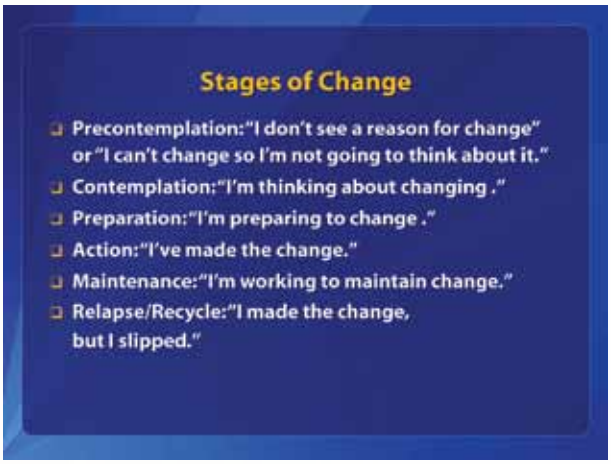
Facilitator Notes:

In this slide, we will address ambivalence by understanding a client's readiness to change. The concept of autonomy (an individual's belief that she knows what is best for her and can manage her own life) presented earlier suggests it is important to start where the client is in terms of her readiness to change.

Raise your hand if you have heard of the Stages of Change.

(Call on someone who has not raised his/her hand.)

What can you tell us about it?



Slide 90

Facilitator Notes:

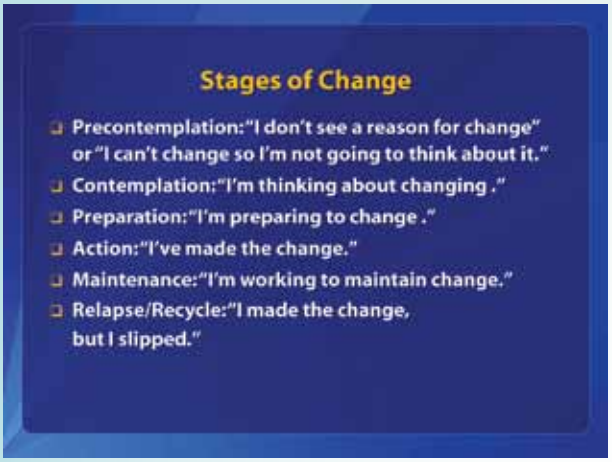
Prochaska and DiClemente developed this model. It complements the MI approach.

There is no single way that people change, but there seem to be predictable patterns or cycles for the individuals who attempt to change their health behavior.

(*Supplement bullet points with the information below.*)

- Precontemplation — a time when someone has no intention of changing her health behavior
  - The person may or may not have an awareness of the potential health risks, but the key is that there is no intention to change.
  - Can someone give an example of when you had no intention to change a health habit?
- Contemplation — a person has an awareness of the situation, but has no concrete plans to change
  - In this stage of change, the pros and cons for change are about equal; in other words, a person's reasons for change are about equal to her reasons for remaining the same.
  - Our goal is to help clients in this stage "tip" the decisional balance.
- Preparation — marked by someone's decision to change and plan to take action
  - In this stage of change, an individual develops a specific plan for how she will make the behavior change.

Slide 90 continued on next page



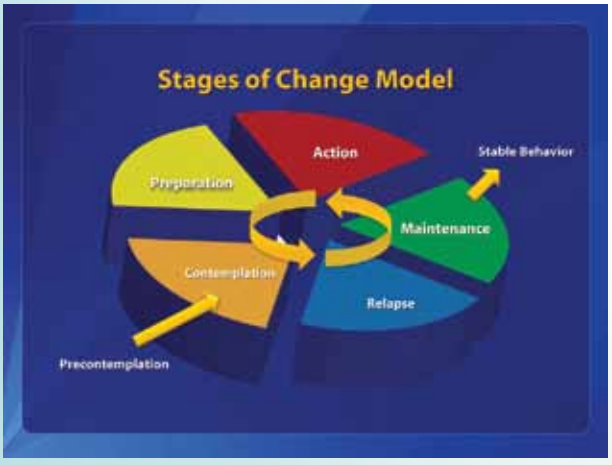
Slide 90 continued from previous page

- Action — the person has made the behavior change
  - This stage requires significant energy and commitment.
  - Although a person may be practicing the healthier behavior, she may be doing it inconsistently, such as exercising only sometimes.
- Maintenance — a person works to consolidate the gains attained during the action stage to sustain the change and prevent relapse
  - In this stage, a client has been performing the new behavior consistently.
  - Many people consider a person to be in this stage if she has successfully changed the behavior for at least six months.
  - What do you think might be significant about sustaining behavior change for six months?

(Emphasize the time it takes for habits to form.)
It generally takes three months of conscious change and three months of new habit formation.

- Relapse/Recycle — often thought of as relapse instead of recycle
  - Why do you think the term "recycle" is preferable to relapse?
    - To eliminate the negative tone of the word relapse

How is the Stages of Change Model similar to the MI spirit?



Slide 91

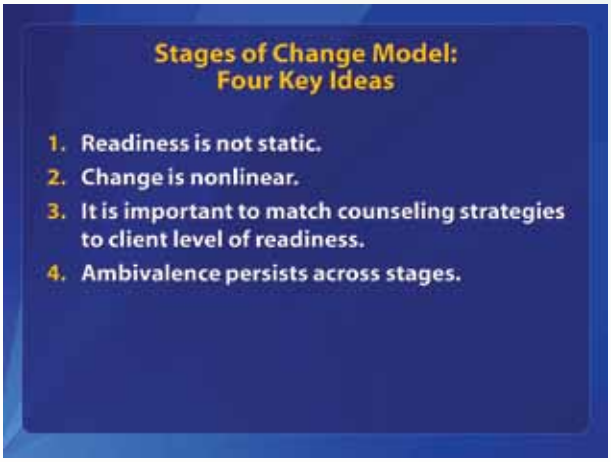
Facilitator Notes:

This graphic shows the cyclical process of the Stages of Change.

So, how does the Stages of Change Model relate to the work of the counselor in CHOICES?

- The counselor should assess the client and understand her stage of change readiness.
- The counselor should help the client understand the concept and that she is not stuck in any one stage.
- In addition, the counselor should identify an intervention that is stage-appropriate for that client.

Take a moment to reflect on a health behavior change that you have made or attempted to make, and how the Stages of Change Model may have applied. Does anyone want to share an example?



Slide 92

Facilitator Notes:

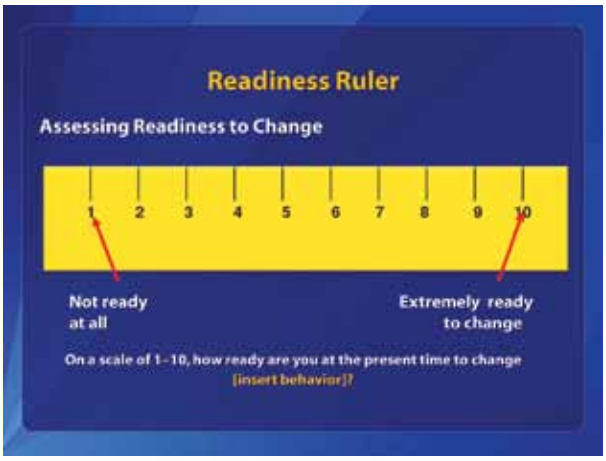
1. Readiness is not static.

   Our readiness to change is malleable; this is a key feature of CHOICES and how we approach behavior change.

2. Change is nonlinear.
   - As we saw in the circular Stages of Change model, change can be cyclical.
   - Change may not always follow the same pattern and it can be different for everyone.

3. It is important to match counseling strategies to client's stage of readiness.

4. Ambivalence persists across stages.
   - We should be aware of strategies to help the client work through her ambivalence so that she can assimilate change into her life.



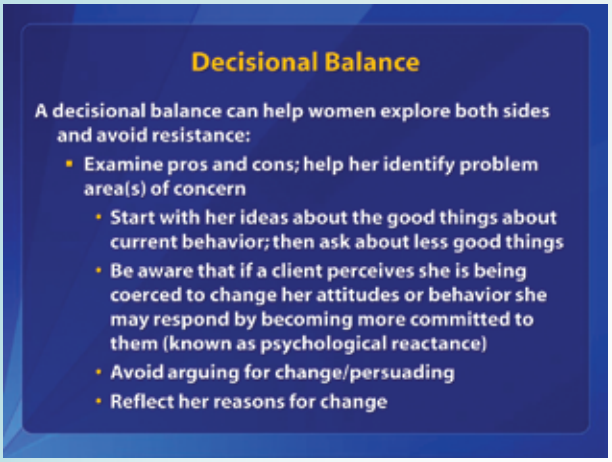
Slide 93

Facilitator Notes:

The Readiness Ruler is another way to think about and assess motivation to change. This is actually what we did earlier today when we conducted the exercise on your familiarity with MI.

You can use a ruler like this to assess how ready someone is to change, how important change is for her, or how confident she is that she can do it.

We will conduct a brief exercise to explore how understanding readiness can help you to have constructive conversations about change.

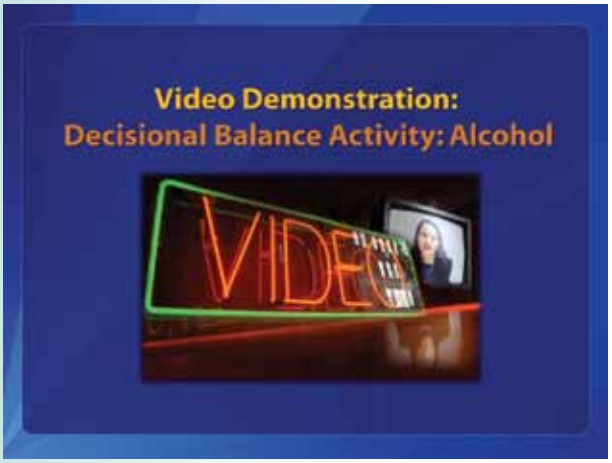


Slide 94

Facilitator Notes:

(Read slide)

Be sensitive to the client's need to retain a sense of autonomy and to resist any attempt by others, including you, to coerce her. Reinforce her reasons for change with the all-important change talk.



Slide 95

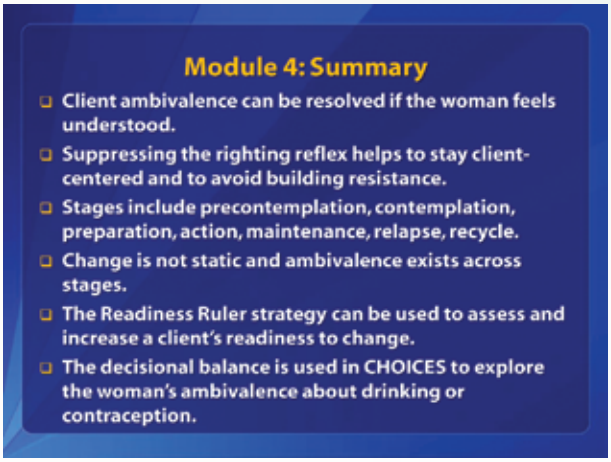
Facilitator Notes:

(Show video)

(Discussion questions)

What did you notice?

What are your responses to the counselor's interview answers?



Slide 96

Facilitator Notes:

(Read slide)

Slide 97

Facilitator Notes:

This concludes our training for today.

(Discussion questions)

Who would like to share something that you found helpful from today that will assist you in working with your clients?

What information or skills would be helpful in working with women at risk for an alcohol-exposed pregnancy?

What is your impression of the spirit and principles of motivational interviewing?

What aspects of MI did you find to be useful?

Please refer to the Counselor Manual. As we discussed briefly at the beginning, assessments are an important component of CHOICES.

We will discuss this further in subsequent modules; however, do you have any questions about the assessment process?

Are there any other questions about Day 1?

To give you a preview of what is to come, we will begin looking at the four counseling sessions of the intervention. I will give you an opportunity to apply many of the MI and behavior change skills and techniques that we discussed today.

MODULE 5:

CHOICES Session 1, Introduction to CHOICES

MODULE 5:

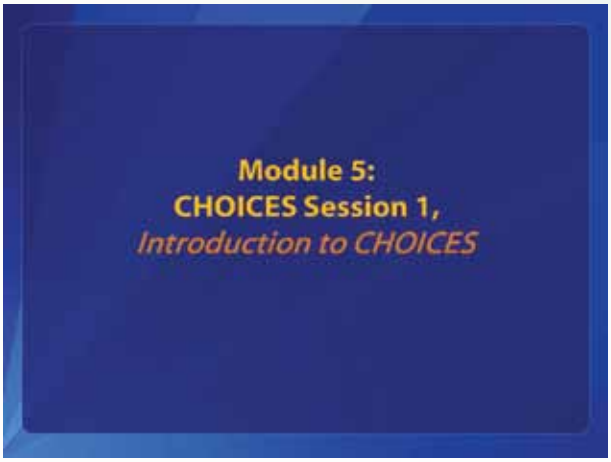
Trainer Objectives:

- To explain the content and components of Session 1
  - Objectives of Session 1
  - Materials and time required for Session 1
  - Activities of Session 1
    - Overview of activities
    - Client introduction
    - Administration of assessments
    - Orientation of client to CHOICES
    - Decisional balance (thinking) exercises
    - Introduction of the daily journal

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Client Workbook
- Counselor Manual
- Video
  - Introducing the Daily Journal

Time Required: 90 Minutes

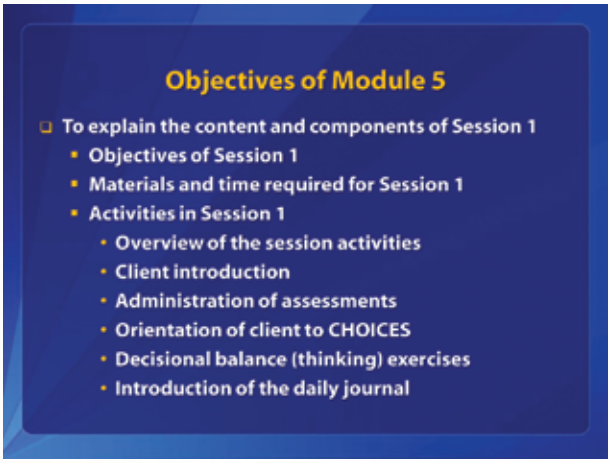


Slide 98

Facilitator Notes:

Now we will give you an in-depth look at each of the four sessions that constitute CHOICES. You will be equipped with the knowledge, tools, and understanding to facilitate the CHOICES intervention.

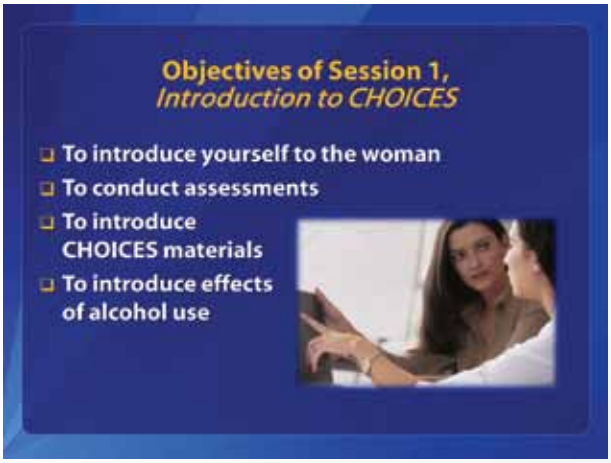
In this module, we'll review the objectives, content, and flow of CHOICES Session 1.



Slide 99

Facilitator Notes:

(Read slide)



Slide 100

Facilitator Notes:

(Read slide)

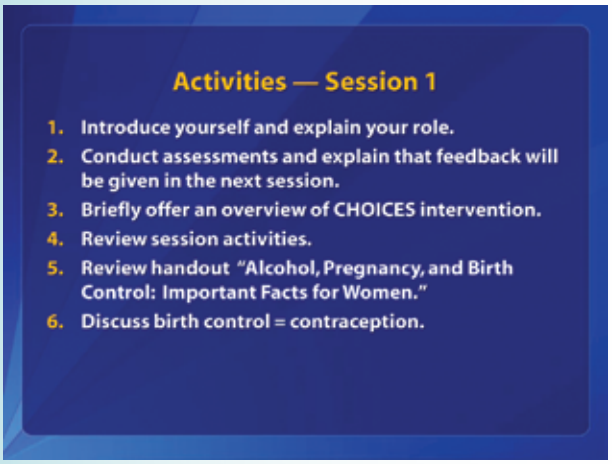
(Trainer provides overview of Counselor Manual and Client Workbook.)

Slide 101

Facilitator Notes:

Assessment tools will be used by the counselors to collect information about the client's alcohol and birth control practices and to provide a baseline measurement of the client's risk for an AEP.

The remaining materials will be given to the woman and used throughout the counseling sessions.



Slide 102

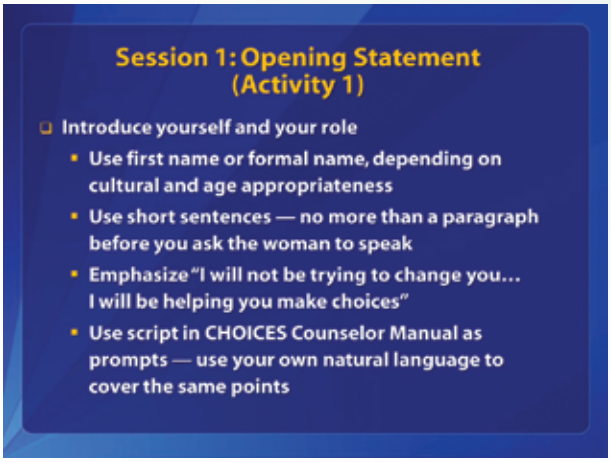
Facilitator Notes:

The next two slides give an overview of the content of Session 1 and the order in which things unfold. After this broad overview, we will go into greater detail for some of the key steps. Please feel free to ask questions any time.

Slide 103

Facilitator Notes:

(Read slide)



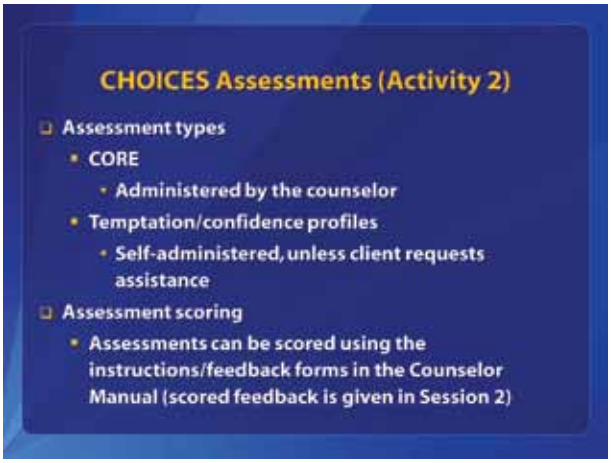
Slide 104

Facilitator Notes:

(Read slide)

Use short sentences—limit the number of sentences to no more than a paragraph before you ask the woman to speak. Don't string sentences together with "and."

Emphasize "I will not be trying to change you. I will be helping you make choices."



Slide 105

Facilitator Notes:

One of the first tasks in CHOICES Session 1 is giving assessments. Please refer to the assessment section of your Counselor Manual.

The assessments are designed to provide information about your client's alcohol risk and contraception behaviors and to assess her motivation and attitudes toward changing these behaviors.

There are two tools used to assess a woman's risk for an AEP, both of which will be the springboard for feedback in Session 2.

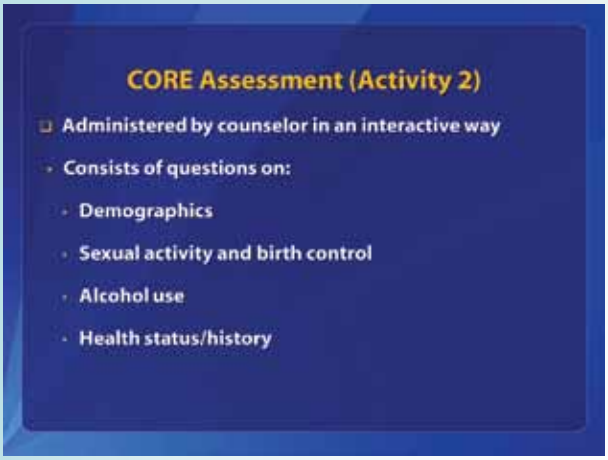
1. CORE — administered by the counselor
2. Temptation/confidence profiles for alcohol and contraception — self-administered, unless the woman requests assistance

The woman can choose the method of assessment (self-administered or not)

We will go into greater detail on the two assessments, but first we will review two challenges in doing the assessments:

1. To avoid a biased assessment process, you should offer the client only minimal information about the intervention.
2. A process as structured as these assessments may be seen as conflicting with the MI spirit.

These instruments are effective in gathering information necessary for offering the CHOICES program. The use of MI builds as the intervention proceeds. Like medical tests, some diagnostic tools are essential for giving clients the information they need.

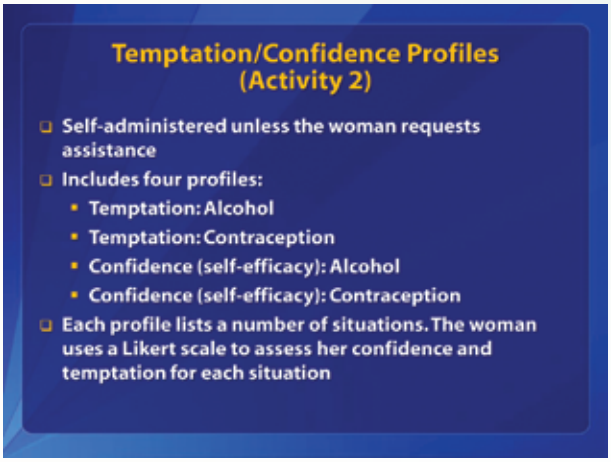


Slide 106

Facilitator Notes:

The CORE Assessment has questions on:

- Demographics — which include date of birth, marital status, race/ethnicity, education, and employment; these questions are optional.
- Sexual activity and birth control — You will be asking questions about the woman's sexual activity and birth control practices for the last three months. You will collect information on the number of partners, types of birth control used, and consistency and effectiveness of the birth control.
- Alcohol use—You will be asking questions about the woman's alcohol consumption in terms of standard drinks for the last 90 days.
- Health status/history — You will be asking questions about any previous treatment that the woman may have had for alcohol or drug problems, or psychological or emotional problems. These questions refer to inpatient or outpatient treatment received any time in her life.



Slide 107

Facilitator Notes:

Temptation

- Alcohol: Lists a number of situations that lead some people to drink alcohol; the client will assess how tempted she would be to drink alcohol in each situation.
- Contraception: Lists a number of situations that affect some people's use of birth control when they have sex; the client will assess how tempted she would be to have sex without birth control for each situation.

For each situation, the client can respond that she is not at all tempted, not very tempted, moderately tempted, very tempted, or extremely tempted.

Confidence (self-efficacy)

- Alcohol: Lists a number of situations that lead some people to drink alcohol; the client will assess how confident she is to not drink alcohol in each situation.
- Contraception: Lists a number of situations that might affect some people's use of birth control when they have sex; the client will assess how confident she would be to use birth control in each situation.

For each situation, the client can respond that she is not at all confident, not very confident, moderately confident, very confident, or extremely confident.

(If needed) Definition of Likert scale: A Likert scale asks respondents to say how strongly they do or don't agree with a statement. The options are usually "strongly agree," "agree," "disagree," or "strongly disagree."

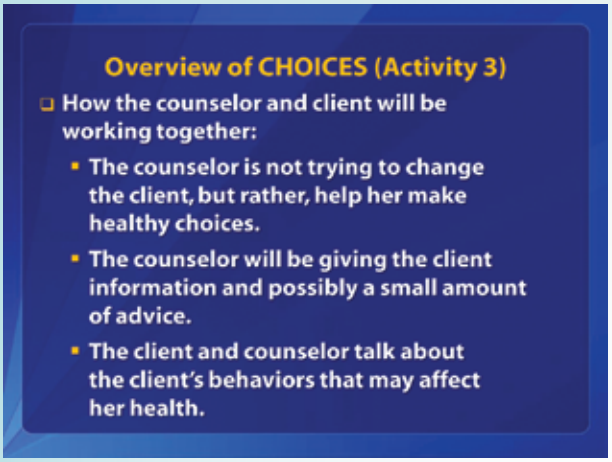
Slide 108

Facilitator Notes:

(You are demonstrating filling out the forms with a client. This is a role play between the counselor and client on how to complete the assessments.)

(Discussion questions)

What value do you think the assessments have for a counselor and a client?



Slide 109

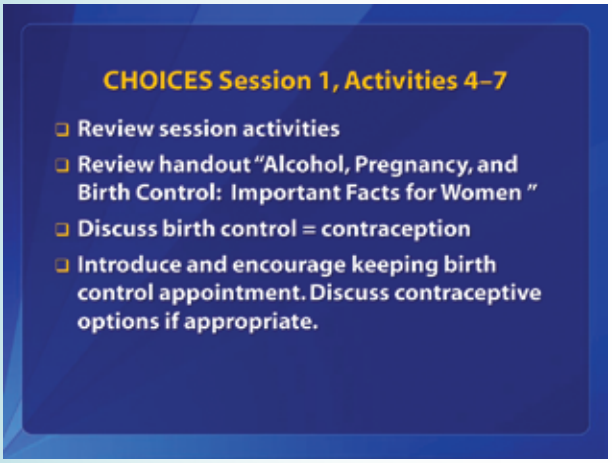
Facilitator Notes:

After the assessment, you'll want to shift the relationship to one that is more collaborative in nature.

Almost right away in Session 1, you will explain how you will work with the client.

(Read slide)

It is important to be overt with the approach and to make it clear that you are not trying to change her. Explain you have some information that may be helpful and, together, you will talk about choices that can affect her health. Remember to emphasize she is ultimately in charge of the decisions she will make to protect her health.



Slide 110

Facilitator Notes:

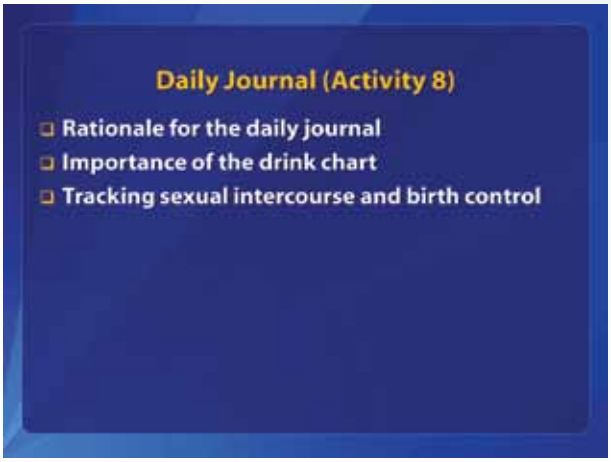
After introducing CHOICES, you will use the Client Workbook to review the session activities for today.

Review the handout "Alcohol, Pregnancy, and Birth Control: Important Facts for Women." This can be done using the elicit-provide-elicit strategy which we will get to shortly.

Clarify that birth control, contraception, and family planning all refer to medically accepted methods of preventing pregnancy, and use the term most familiar to the client.

Note that, as part of CHOICES, you will be helping her to arrange a birth control appointment where she can get accurate medical advice about which contraception options might be right for her. If needed, arrange the visit now, to occur (optimally) before Session 3.

Many women will discuss myths about contraception at this time. Field questions and provide answers if you know them, or record your client's questions and find the answers before her next visit.



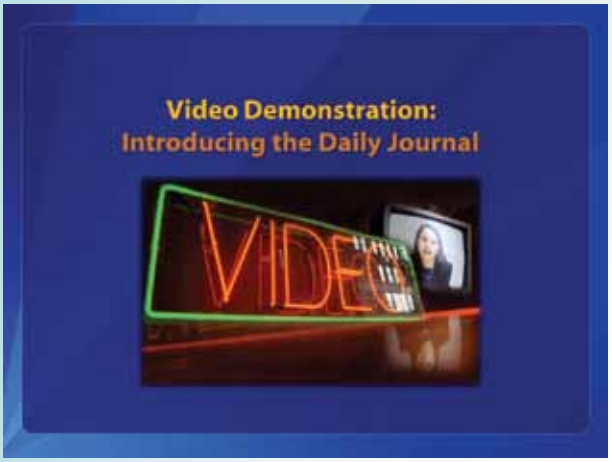
Slide 111

Facilitator Notes:

The daily journal is introduced in activity 8.

- Rationale for the daily journal
  - Writing down one's thoughts, feelings, and experiences is a common purpose of journaling.
  - The daily journal is used to encourage the client to keep track of how many drinks she has, when/if she has sex, and if she uses birth control.
  - Over the course of a week, you can look back at the journal to see if there are any patterns.
  - The daily journal allows the counselor and client to track her risk of an AEP.
- Importance of the drink chart
  - "Please look at the Drink Chart in the Client Workbook. We will go over this in greater detail shortly."
  - You will explain to the client the definition of a standard drink. This may be a reminder because she likely has completed an assessment of her previous level of drinking, for which she would have learned the definition of a standard drink.
  - It is important for the client to complete the journal on a daily basis rather than trying to rely on her memory.
- Tracking sexual intercourse and birth control
  - "Please look at the Daily Journal in your Client Workbook. We will go over this in greater detail shortly."
  - The daily journal will also be used to track sexual intercourse and birth control use.
  - It is important for the client to complete the journal on a daily basis rather than trying to rely on her memory. As an example of the difficulty of relying on memory, ask, "How many of you remember what you had for lunch last Thursday?" This example can also be used with your clients.

    The client will take the daily journal home and complete it before she returns for her next session.



Slide 112

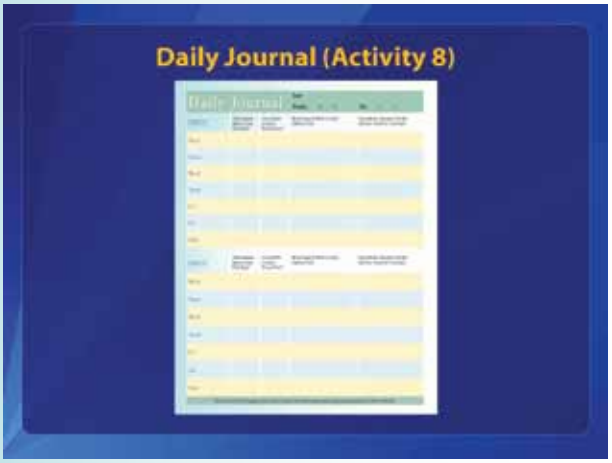
Facilitator Notes:

This video demonstrates how to use the daily journal.

(Show video)

(Discussion question)

What are your thoughts?



Slide 113

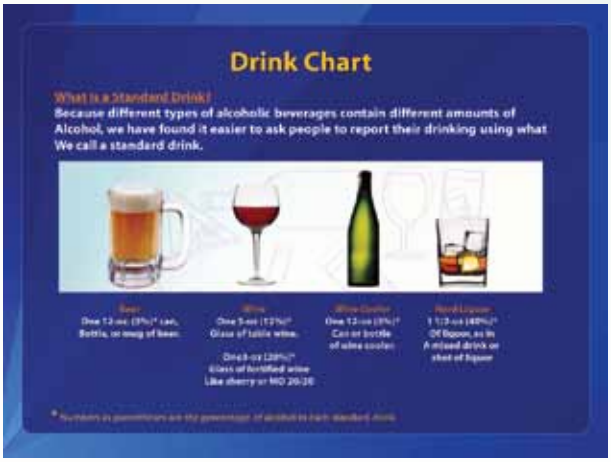
Facilitator Notes:

This is the chart the client will use to track her sexual intercourse, birth control use, and level of drinking as part of her daily journal.

- Instruct the client to fill out this chart daily.
- The client will write down how many times she had vaginal intercourse each day, whether or not she used birth control each time, and what type of birth control she used.
- The client also will record the number of standard drinks she had on each day using the drink chart, which we will go over on the next slide. Help her think through a few days of reports, and ensure she is counting standard drinks correctly.

If the client is having sex with multiple partners, she can include that in the journal. If she uses different types of birth control on different occasions and/or with different partners, she can specify that as well. We will cover more of this in Module 7.

(Refer to the Module 7 "Challenging Situations" slide.)



Slide 114

Facilitator Notes:

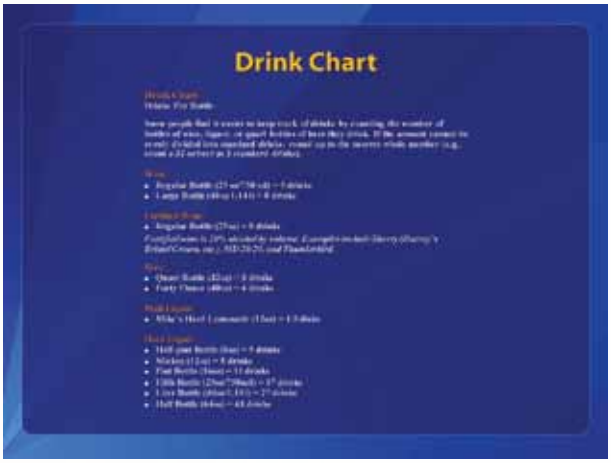
This is the drink chart that we will use to define a standard drink.

(Read slide)

You will explain this chart to your client and ensure she understands the meaning of a standard drink so she can fill out the daily journal accurately.

(Demonstration — have any local materials prepared to explain a standard drink if they differ from those shown on chart.)

(It is very important that trainees understand this chart. Spend extra time on this if necessary.)

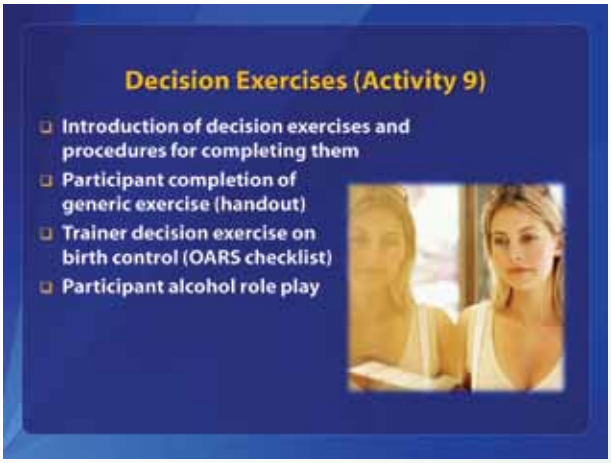


Slide 115

Facilitator Notes:

We recommend as you discuss the drink chart with your client, you invite her to provide examples of the drinks she typically has and help her to measure the number of standard drinks she consumes in a given day. It is helpful to review a "typical" day and an example of a "heavy" day to show her how different amounts of different drinks add up to X standard drinks.

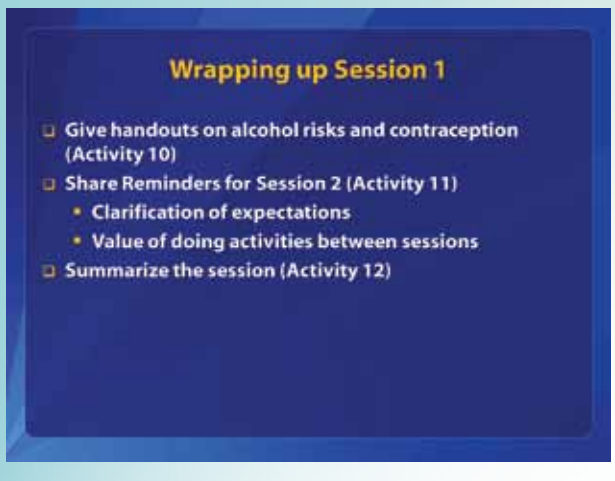
Although reviewing this information may seem tedious, it can help your client track her drinking more accurately, and may in and of itself have an intervention effect. Many women only become aware of the volume of their drinking when doing a diary of this kind. It is worth using your OARS skills to ensure she understands the details here.



Slide 116

Facilitator Notes:

Turn to the pages "Thinking about Drinking" and "Thinking about Birth Control" in your Client Workbook. We will review how to do the decision exercises, also known as a decisional balance, like the one you saw previously in the video. Today we will demonstrate a decision exercise for birth control behavior and then give you a chance to practice doing one on drinking.



Slide 117

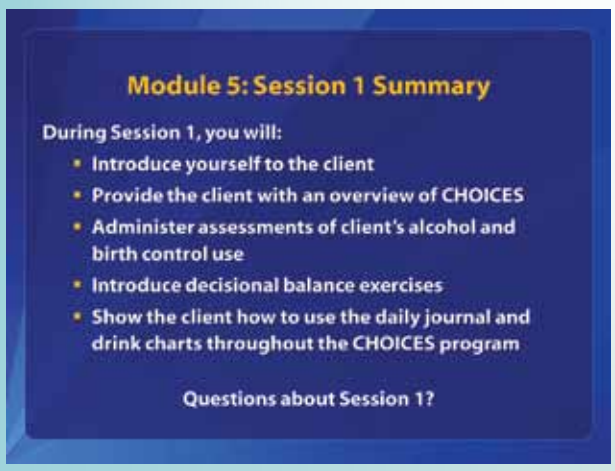
Facilitator Notes:

At the end of Session 1, you will discuss reminders for Session 2, clarify client and counselor expectations, and emphasize the importance of completing activities between sessions.

- Reminders for Session 2
  - Read the "Women and Alcohol Risks" and "Women and Birth Control" handouts.
  - Complete the daily journal each day and bring it to the next session.
  - Make a list of questions you want to ask at your next session.
  - Plan to have three more sessions, plus a visit with an expert on birth control.

- Clarification of expectations
  - Have an open discussion of the client's expectations for the CHOICES program and your expectations for her. You can refer to expectations you have for the actual sessions and for the client's responsibilities between sessions.
  - What are some examples of expectations you might discuss with the client?

- Value of doing assignments between sessions
  - What do you think is the value of having the client complete assignments between sessions? *(Examples that you might discuss: time constraints, monitoring progress, reaching goals, etc.)*



Slide 118

Facilitator Notes:

(Read slide)

MODULE 6:

CHOICES Session 2, Reviewing Feedback and Setting Goals

MODULE 6:

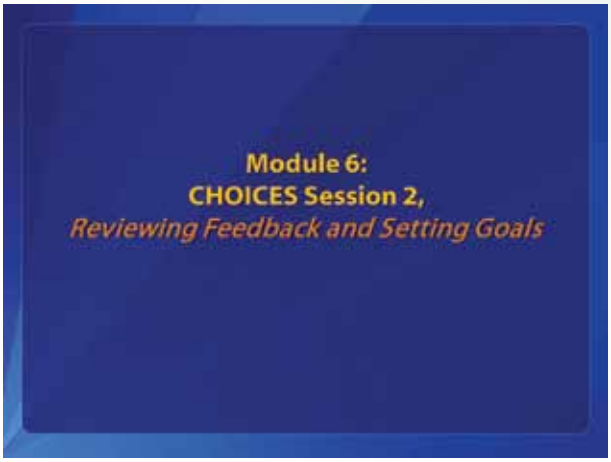
Trainer Objectives:

- To explain the content and components of Session 2
  - Objectives of Session 2
  - Time and materials required for Session 2
  - Strategies to provide information and feedback using the CHOICES approach
  - Activities of Session 2
    - Overview of activities
    - Review of daily journal
    - Personal Feedback Form
    - Birth control visit
    - Self-evaluation exercises

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Client Workbook
- Counselor Manual
- Handouts
  - Personal Feedback Form
  - Example of a Completed Feedback Form
  - Readiness Rulers
- Videos
  - Reviewing the Daily Journal
  - Providing Feedback Activity-Birth Control

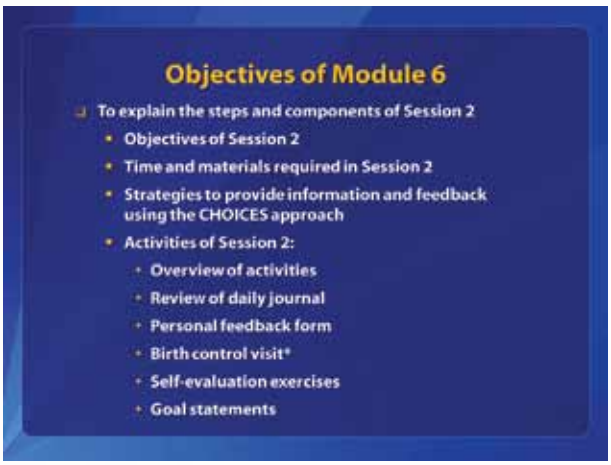
Time Required: 90 Minutes



Slide 119

Facilitator Notes:

In Module 6 we will go over CHOICES Session 2: Reviewing Feedback and Setting Goals.



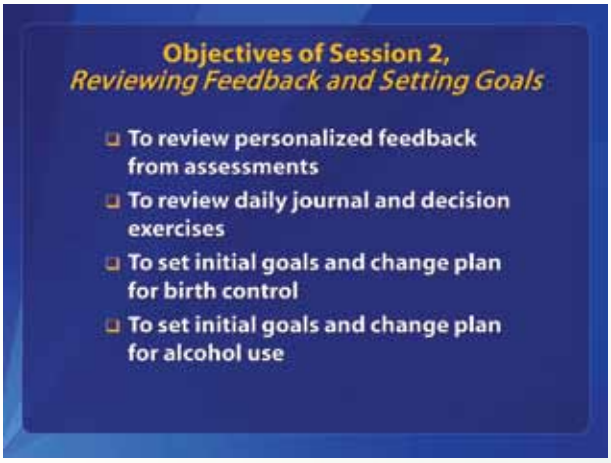
Slide 120

Facilitator Notes:

(Read slide)

*The birth control visit is individualized by clinic.

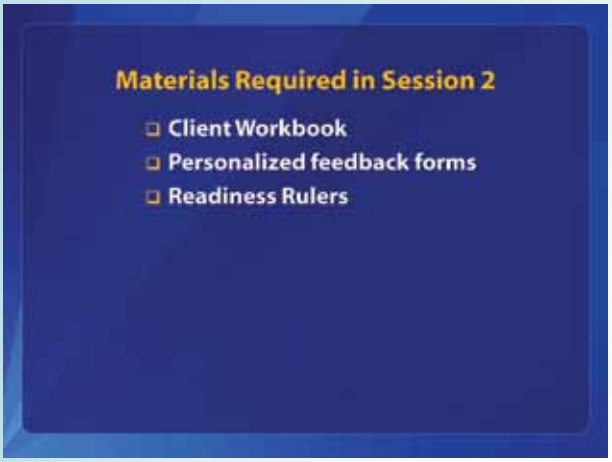
The self-evaluation exercises will look familiar—they are another way to use the MI rulers.



Slide 121

Facilitator Notes:

(Read slide)



Slide 122

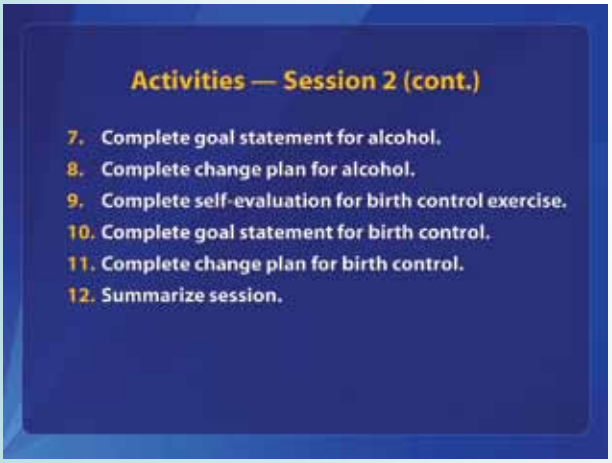
Facilitator Notes:

(Read slide)

Slide 123

Facilitator Notes:

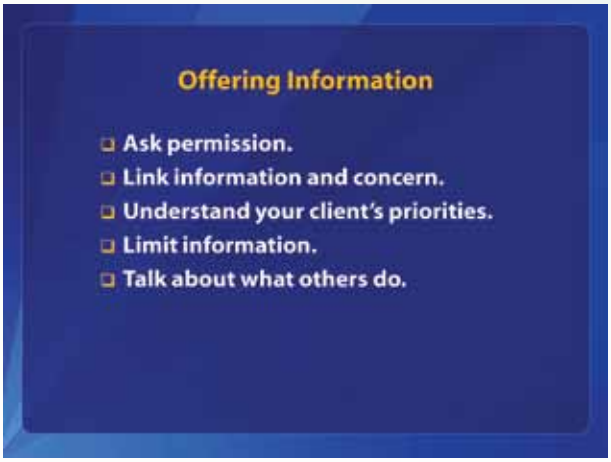
(Read slide)



Slide 124

Facilitator Notes:

(Read slide)



Slide 125

Facilitator Notes:

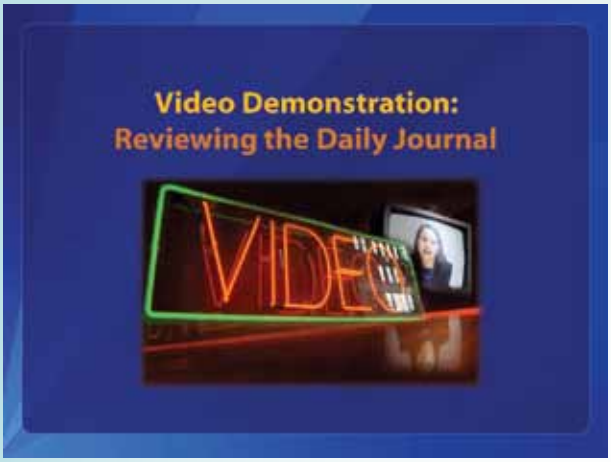
Before we go over the specific steps, we are going to discuss some of the strategies that are important in facilitating CHOICES.

Offering information is one component of the CHOICES approach. Giving information from an MI perspective may be different from more traditional models of educating clients about their health risks.

- Ask permission — An important way to convey respect when offering information can be to ask a client's permission before beginning to teach. For example, "May I share some information with you on…?"
- Link information and concern — One critical component of a client's reaction to health information is her perception of the care provider's concern for her.

  If your education efforts appear to come from a true sense of concern, they are more likely to be well received.
- Understand your client's priorities — It is important not to assume a client's view of her life is the same as yours. For some clients, there are other matters more pressing than their health—or their drinking—and understanding their concerns should direct and guide your practice.

  In CHOICES, it is common to allow the client to take the lead about whether she wants to focus on changing her drinking or contraceptive use to avoid an AEP.
- Limit information — Health education studies suggest clients cannot remember more than three "take-home" messages from any health care visit. Use caution to limit the amount of information and to prioritize the most important messages in an interaction.
- Talk about what others do — When discussing options, one safe way to add alternatives is to talk about what other clients have done. With this approach, the client doesn't feel like you have told her what she must do, but that she has been given important information about her options and about what has worked for other clients.



Slide 126

Facilitator Notes:

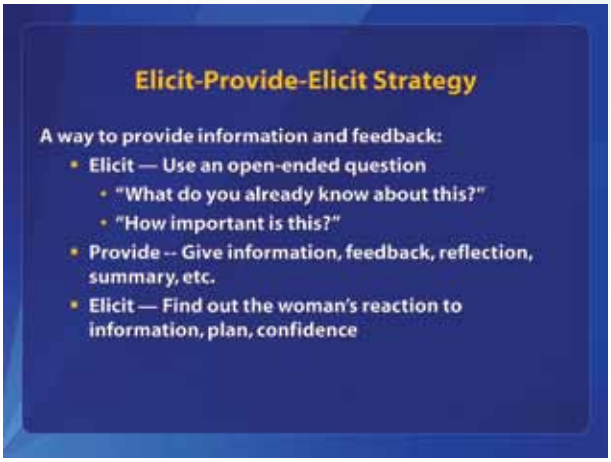
We will now watch a seven-minute video demonstration of daily journal review.

(Show video)

(Discussion questions)

What did you notice?

Do you have any questions?



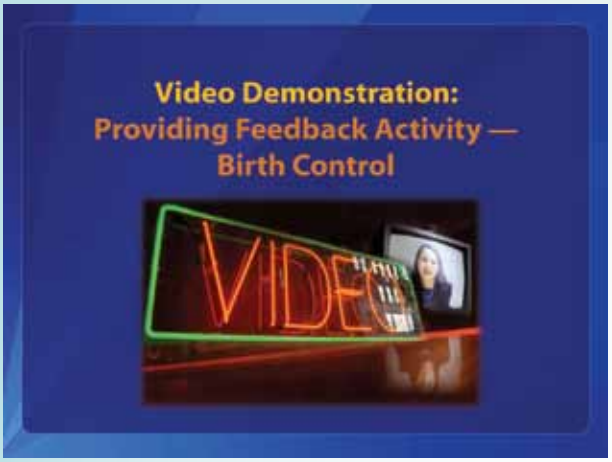
Slide 127

Facilitator Notes:

The Elicit-Provide-Elicit Strategy is one way to offer information — by providing information and feedback.

- In MI practice, the counselor should try to never talk more than the client, even during an exchange of information.
- Elicit-Provide-Elicit is an information-exchange strategy often used in MI, making the exchange of information part of a delicately balanced conversation. Unlike the more traditional approach of imparting information, the counselor adopts a curious and eliciting interviewing style, and the client does much of the talking.
- Elicit — Use an open-ended question
  - For example, when asking the client if she would like more information, you might say: "What would you like to know about alcohol and pregnancy?" or "How much do you know about the different types of contraception?"
  - Do not rush this process. Take your time to understand what information, if any, the client needs.
  - If you get the feeling the client does not really want information, back off a little. Don't appear overly enthusiastic about the whole process.
- Provide -- Give information, feedback, reflection, summary
  - Do this in a neutral manner, using the general principles of good information exchange.
  - Use language you think the client understands.
  - Keep the pacing congruent with the client's grasp of the information.
  - Paint a general picture first, and then move into specifics as the client directs you. Filling in too much detail can confuse people.
- Elicit — Find out the client's reaction to information, plan, confidence
  - The aim is to encourage the client to make sense of the information.
  - For example, you could ask, "What do you make of this? I wonder how you have been affected by …"
  - Follow the client's reaction for as long as you are able. This process of integrating information will help build motivation to change.

    These principles also apply to the information offered to your client to take home. Avoid simply giving information. Assess a client's readiness to receive it first, and then explain where in the materials she might locate the information most relevant to her.



Slide 128

Facilitator Notes:

Here is a seven-minute demonstration of a counselor reviewing the birth control feedback activity.

(Show video)

(Discussion questions)

What did you notice? Could you recognize the Elicit-Provide-Elicit?

Do you have any questions?

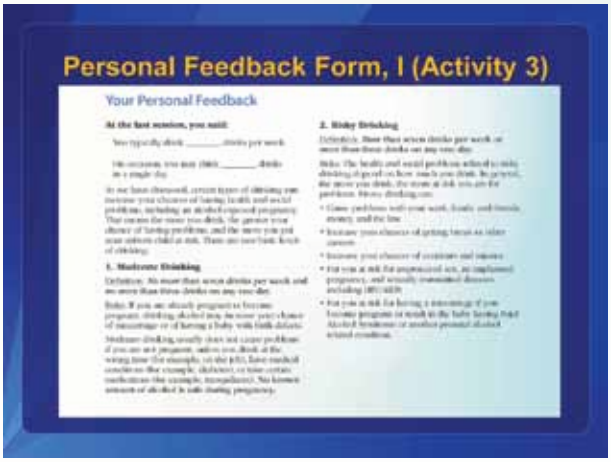
Slide 129

Facilitator Notes:

This is the chart the client will use to track her sexual intercourse, birth control use, and level of drinking as part of her daily journal.

- Instruct the client that it is best to fill out this chart each day, as it will be easier to remember everything. However, if your client finds it easier to complete the journal the next day for the previous day, that is okay.
- The client will write down how many times she engaged in vaginal intercourse each day, whether or not she used birth control each time, and what type of birth control she used.
- The client also will record the number of standard drinks she had on each day, using the drink chart. Help her think through a few days of reports, and ensure she is counting standard drinks correctly.

If the client is having sex with multiple partners, she can include that in the journal. If she uses different types of birth control on different occasions and/or with different partners, she can specify that as well. We will cover more of this in Module 7.

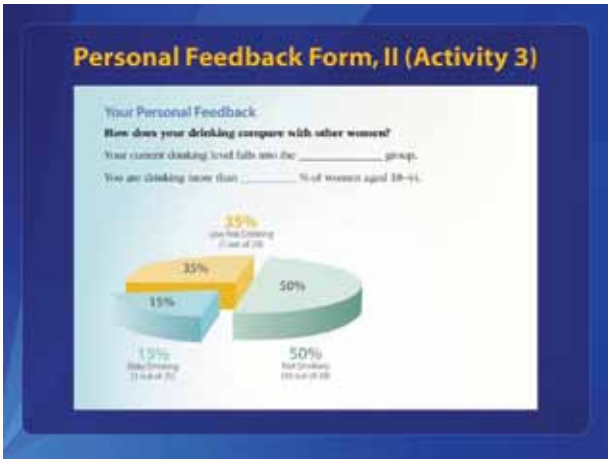


Slide 130

Facilitator Notes:

Please turn to the Personal Feedback Forms in the Client Workbook.

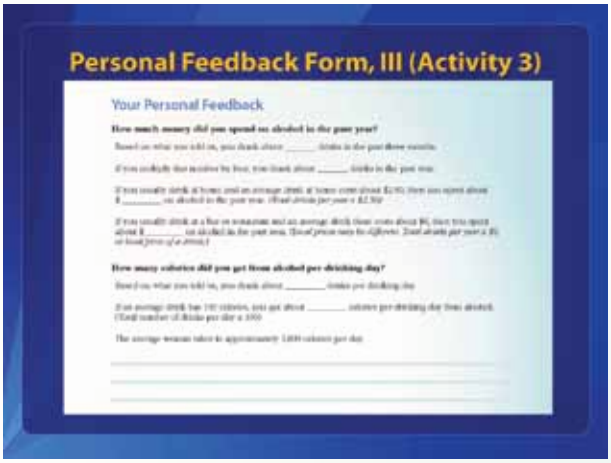
On the first part of the Personal Feedback Form, the client will monitor her risky drinking. She will record the number of drinks per week and the number of drinks in a single day. Based on this information, you will work with the client to determine whether her drinking patterns reflect low-risk drinking or risky drinking.



Slide 131

Facilitator Notes:

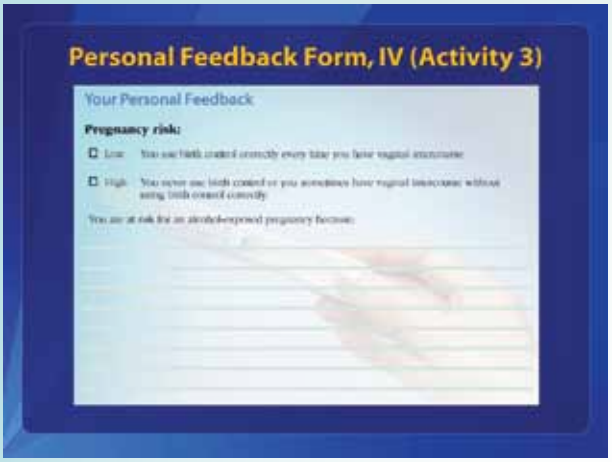
On the second page of the Personal Feedback Form, you will work with your client to examine how her drinking compares with other women. Based on the information that she recorded on the previous page, the client will identify her level of drinking compared with other women ages 18–44.



Slide 132

Facilitator Notes:

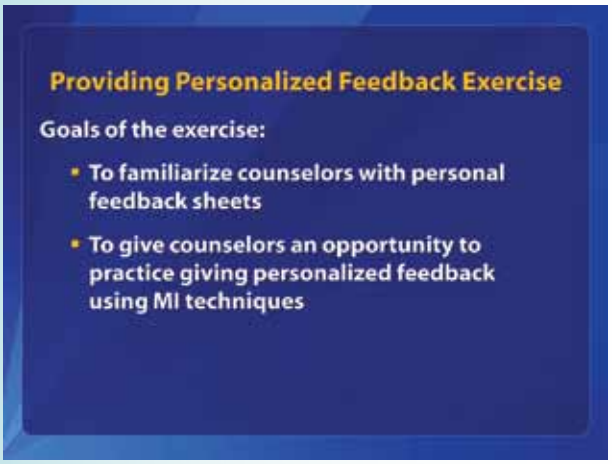
On the third page of the Personal Feedback Form you will work with your client to examine how much she spends on her drinking and how many calories she consumes from alcohol per drinking day.



Slide 133

Facilitator Notes:

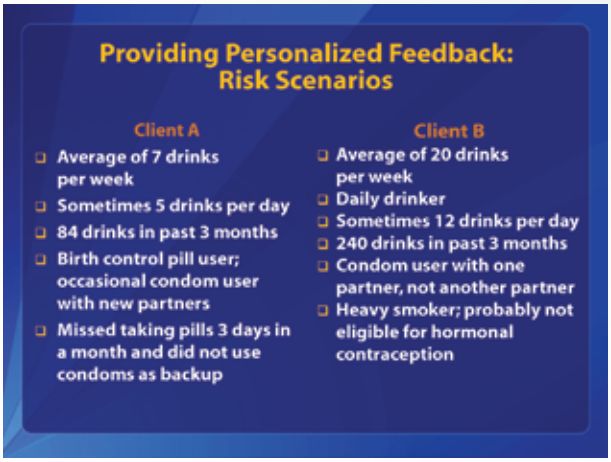
Finally, on the last page of the Personal Feedback Form, you and your client will address her pregnancy risk. Your client's risk will be considered "low" if she uses birth control correctly each time she has vaginal intercourse; it will be considered "risky" if she has never used birth control or only sometimes uses birth control correctly. The client will then have an opportunity to record why she is at risk for pregnancy.



Slide 134

Facilitator Notes:

(Read slide)



Slide 135

Facilitator Notes:

Here are two common scenarios in CHOICES clients. We're going to practice giving feedback.

(Read slide)

(Hand out personalized feedback forms. Then, signal to one side of the room.)

For those of you on this side, use Client A. The other side will use Client B.

Go ahead and complete a set of feedback forms using your Client Workbooks for the appropriate client. You'll have five minutes.

(When finished)

Let's review your answers.

(Look at completed feedback role play sheet.)

(Give answers)

Now let's get into pairs. Each pair should have one partner from this side of the room and the other from that side.

Practice giving your partner feedback as if she were Client A.

Role play three to four minutes

Next, the other counselor will give feedback to Client B.

Role play three to four minutes.

(Debrief)

Slide 136

Facilitator Notes:

Once the woman has received feedback and completed the self-evaluation exercises for alcohol and birth control, you will work with her to complete a goal statement for each behavior, as well as a change plan for that behavior.

Slide 137

Facilitator Notes:

You will help her to think through why she chose her goal, how she can reach it, as well as identify potential barriers to achieving her goal and how to overcome them.

Importantly, you'll also help her think through what her life would be like if she accomplishes her goal.

Let her know that you will be revisiting these goals and change plans each time you meet.

Slide 138

Facilitator Notes:

In Activity 4, you will discuss the birth control visit with your client.

• The CHOICES intervention includes a birth control visit.

This is part of how the CHOICES intervention was developed and it is an important component of the intervention's effectiveness.

(Read remaining bullets)

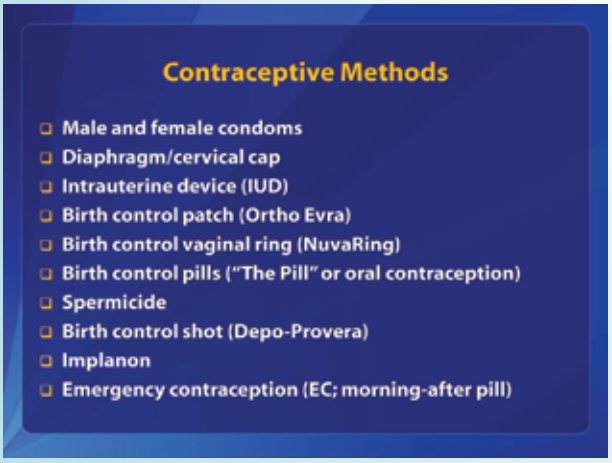
(Discussion questions)

How will you go about partnering with a birth control provider for this purpose?

Can anyone discuss a referral process that can be incorporated to ensure this step is successfully completed?

What concerns do you have about this component of CHOICES?

Are there any questions?



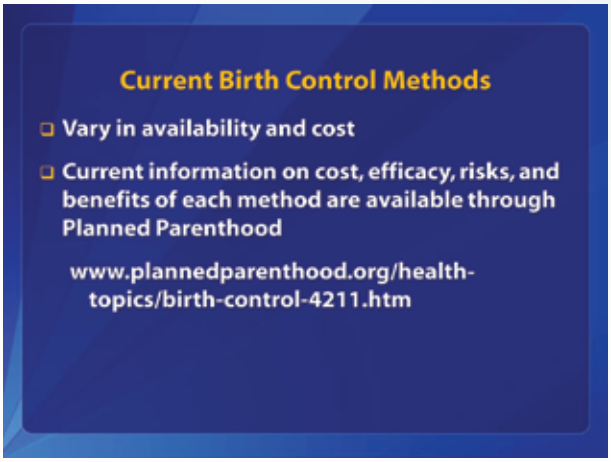
Slide 139

Facilitator Notes:

Here is a list that shows some of the types of birth control available to women.

(Read slide)

Some women are eligible for CHOICES because they do not use birth control. Others use it ineffectively, and therefore are still at risk for pregnancy. Still others use it intermittently, or with some partners and not with others.



Slide 140

Facilitator Notes:

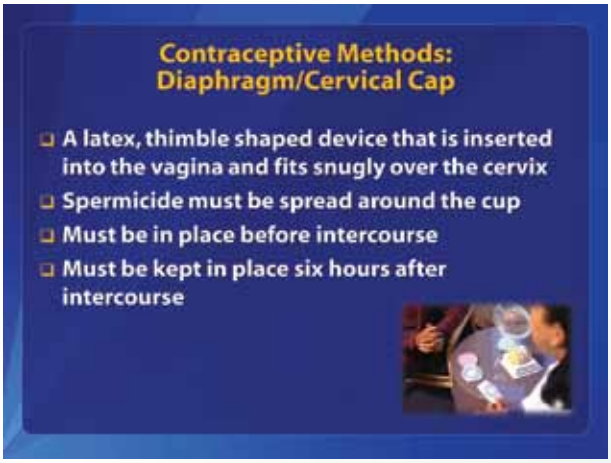
(Read slide)

Slide 141

Facilitator Notes:

Now we will go into more depth on each of the birth control methods. You can also find more detailed information in your Counselor Manual.

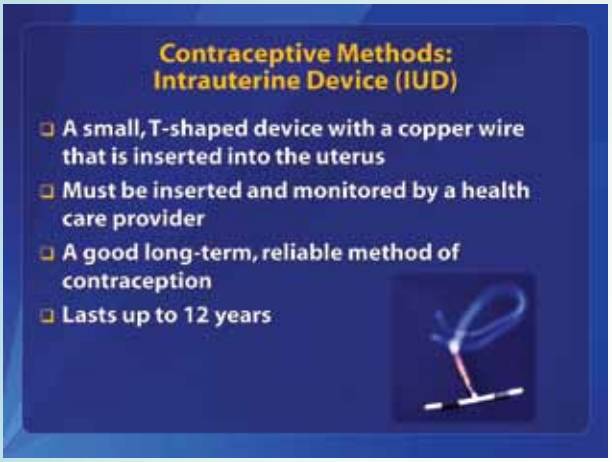
(Read slide)



Slide 142

Facilitator Notes:

(Read slide)



Slide 143

Facilitator Notes:

(Read slide)

Slide 144

Facilitator Notes:

(Read slide)

Slide 145

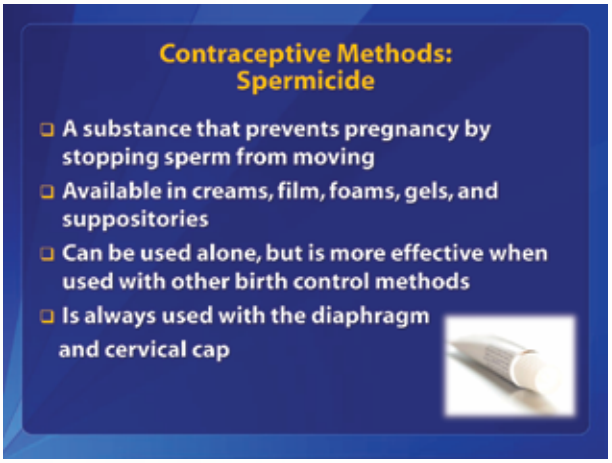
Facilitator Notes:

(Read slide)

Slide 146

Facilitator Notes:

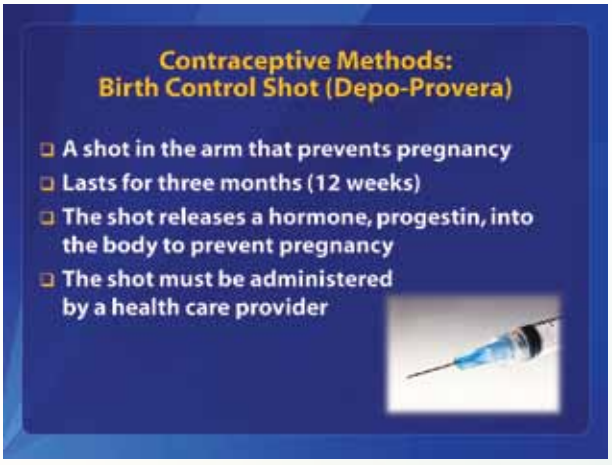
(Read slide)



Slide 147

Facilitator Notes:

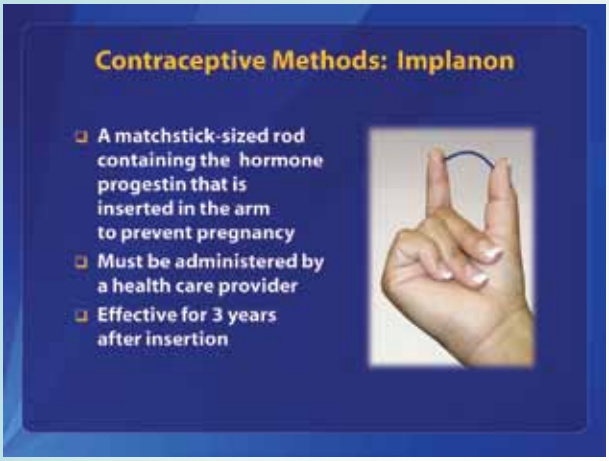
(Read slide)



Slide 148

Facilitator Notes:

(Read slide)



Slide 149

Facilitator Notes:

(Read slide)

Slide 150

Facilitator Notes:

(Read slide)

Slide 151

Facilitator Notes:

Although you are not expected to be a birth control expert, and the CHOICES intervention fills this need in large part through the birth control visit, it is important that you are familiar with birth control options in case your clients have any questions.

We will go over each of these methods to explain their use and effectiveness. In this slide, you'll see an overview of the efficacy of each of the methods. In the second column, you can see the range of efficacy across the birth control methods when used perfectly. In the third column, you can see the range of efficacy with normal use, which is defined to be how average women use the method as instructed by the manufacturer.

As you can see, abstinence is the best possible birth control, at 100 percent effectiveness. The diaphragm is the least effective of the methods listed, with 94 percent efficacy if used perfectly and 84 percent if used normally. Even with perfect use, some women will get pregnant with any form of birth control — with the obvious exception of abstinence.

References:

Planned Parenthood. (2010). Retrieved from http://www.plannedparenthood.org/health-topics/birth-control-4211.htm.

Slide 152

Facilitator Notes:

There are some methods that have lower rates of efficacy, or efficacy that varies depending on the woman's history. These methods generally are not considered to be effective or medically acceptable birth control when used alone.

As you can see in this table, both the sponge and cervical cap have a higher level of efficacy among women who have never given birth.

In the bottom table, we see that the level of efficacy goes down significantly with normal use for spermicide and withdrawal.

Emergency contraception is not recommended as a primary method of birth control.

References:

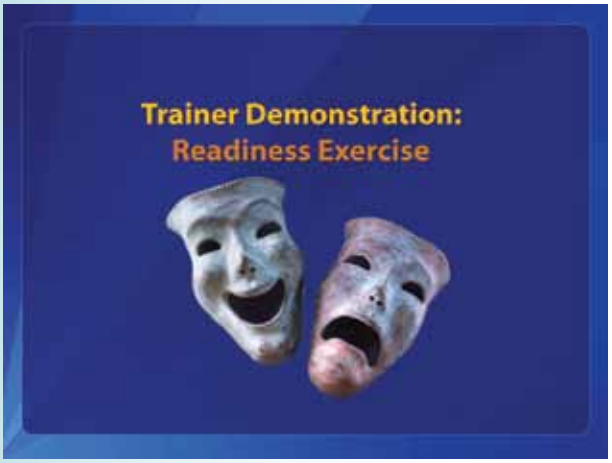
Planned Parenthood. (2010). Retrieved from http://www.plannedparenthood.org/health-topics/birth-control-4211.htm.

Slide 153

Facilitator Notes:

Here's an example of a Readiness Ruler, which will be used several times over the course of the sessions, on which the client can indicate her readiness to change one of the target behaviors.

(Read slide)



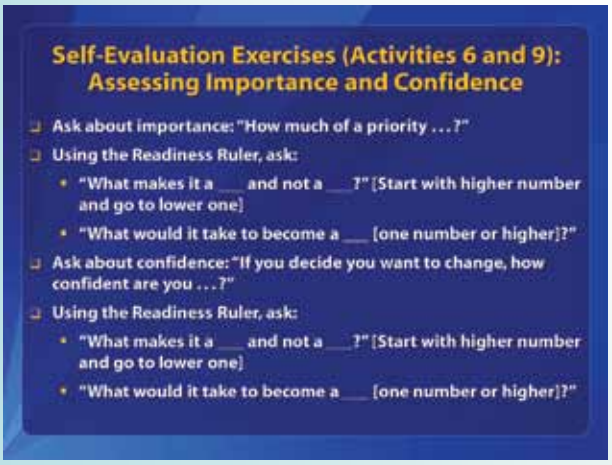
Slide 154

Facilitator Notes:

When trying to counsel a client about her interest in changing her behaviors, there is an easy way to determine how ready she is to change.

For a client to feel ready to change, she must perceive the problem as an important issue and must have confidence she can change the behavior.

Earlier, we reviewed the idea of readiness to change and the Stages of Change. Now we will demonstrate how to use a Readiness Ruler to elicit change talk in the CHOICES session.



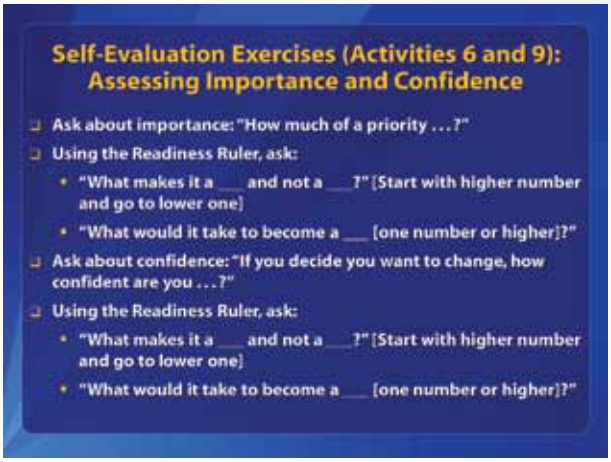
Slide 155

Facilitator Notes:

In Activities 6 and 9 of Session 2, you will work with the woman to complete self-evaluation exercises that will assess her level of importance and confidence in changing her behaviors. Please refer to the pages on self-evaluation for both alcohol and birth control in the Client Workbook to review the exercises.

We use the self-evaluation exercises for both alcohol and birth control use throughout CHOICES.

- Ask about importance: How much of a priority is it for you to drink below risky levels? How much of a priority is it for you to use birth control every time you have sex?



Using the Readiness Ruler: If the client responds with a 7, you can probe by asking, "What makes it a 7 and not an 8?" You can then follow up by asking, "What would it take to become an 8?"

- Ask about confidence: If you decide that you want to change, how confident are you that you can drink below risky levels? Or in the case of the birth control self-evaluation, how confident are you that you can use birth control every time you have sex?

Using the Readiness Ruler: If the client responds with a 5, you can probe by asking, "What makes it a 5 and not a 6?" You can then follow up by asking, "What would it take to become a 6?"

Slide 156

This should look familiar to you. We discussed DARN-C during Module 3.

The techniques of MI—such as empathy (seeking understanding), direction (keeping the momentum up), spirit (collaborative, evocative, autonomy-supporting), and open-ended questions and reflective listening—tend to elicit some things we want to hear. This will help the client to voice change talk or her thoughts on why and how certain behaviors might change.

As we can see here, empathy, direction, MI spirit, and MI techniques lead to desire, ability, reasons, and need, which then lead to commitment, and finally, change.

References:

Miller, W.R. (2005). Believe your data: Research, theory, practice, and training of motivational interviewing. 39th Annual Convention of the Association for Behavioral and Cognitive Therapies. Washington, DC.

Slide 157

Facilitator Notes:

Readiness Rulers, recently discussed in the self-evaluation exercises, are an effective way to elicit DARN-C.

You can use this ruler to elicit change talk by asking the same series of questions about importance, confidence, and readiness. Let's practice now. Can I have a volunteer?

Using the same approach as in the self-evaluation exercises, you will be the counselor and I will be the client.

(Read question on slide.)

Slide 158

Facilitator Notes:

Can I have another volunteer?

Again, I will be the client and you can be the counselor. As shown on this slide, we will use the ruler to measure confidence.

(Read question on slide.)

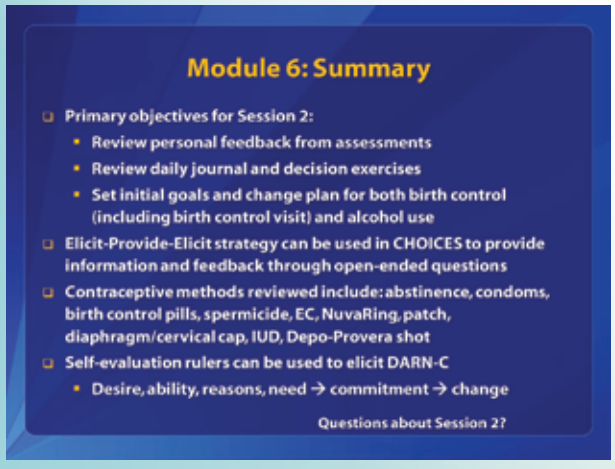
Slide 159

Facilitator Notes:

Can I have a third volunteer?

Once again, I will be the client and you can be the counselor. We will now use the ruler to measure commitment.

(Read question on slide.)



Slide 160

Facilitator Notes:

(Read slide)

MODULE 7:

CHOICES Session 3, Reviewing Goals and Revisiting CHOICES

MODULE 7:

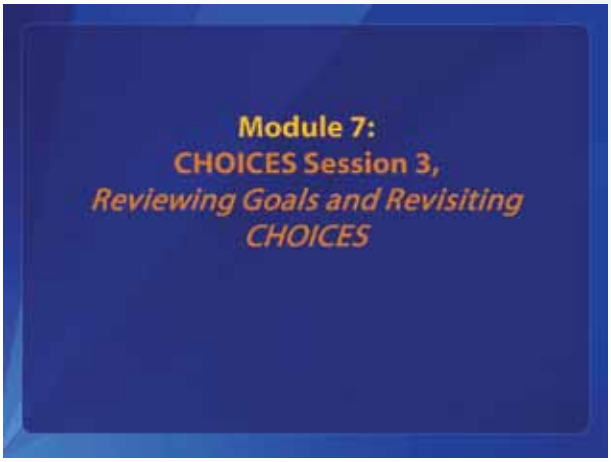
Trainer Objectives:

- To provide an overview of the eight activities in Session 3
- To define objectives of Session 3
- To practice Session 3

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Client Workbook

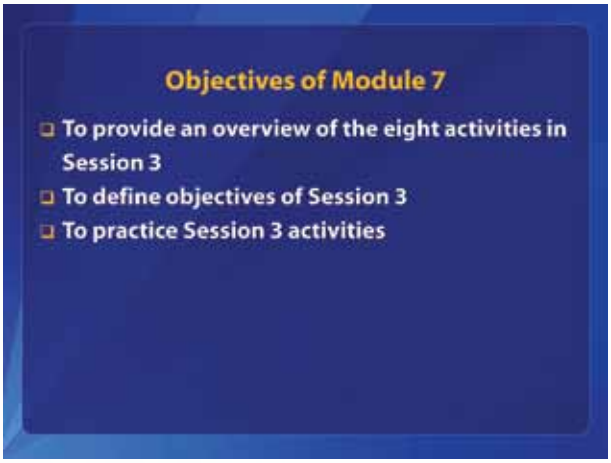
Time Required: 60 Minutes



Slide 161

Facilitator Notes:

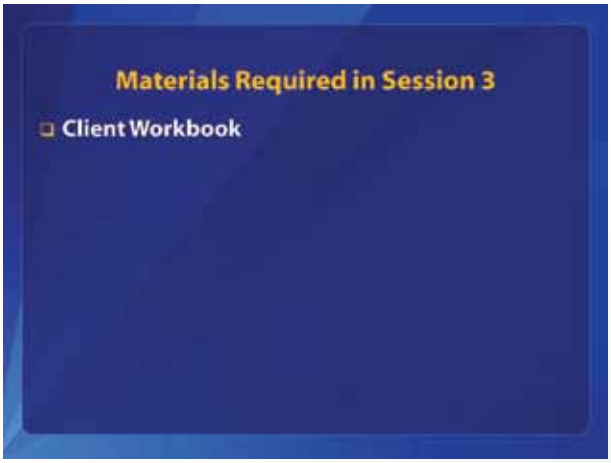
We will now go over CHOICES Session 3: Reviewing Goals and Revisiting CHOICES.



Slide 162

Facilitator Notes:

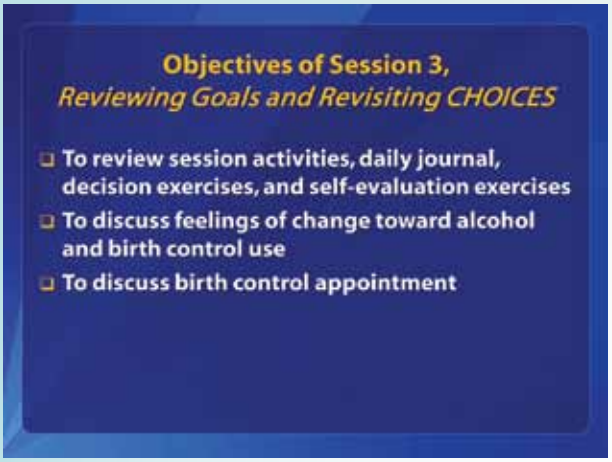
(Read slide)



Slide 163

Facilitator Notes:

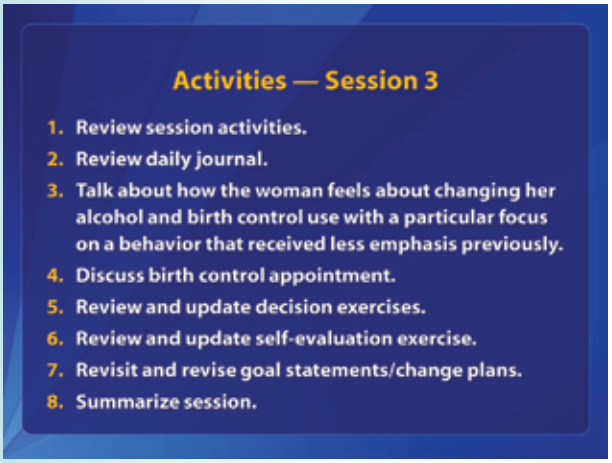
(Read slide)



Slide 164

Facilitator Notes:

(Read slide)



Slide 165

Facilitator Notes:

(Read slide)

Please refer to Session 3 in your Counselor Manual.

- As with Session 2, this session begins with a review of the daily journal. Just to reiterate, the daily journal offers an opportunity to reinforce positive changes and to problem-solve challenges.
- It is important that counselors consider any movement toward healthy change as progress toward reducing the risk of an alcohol-exposed pregnancy.
- Reviewing the decision and self-evaluation exercises offers an opportunity to assess any movement toward change, either decreasing alcohol use or using birth control.

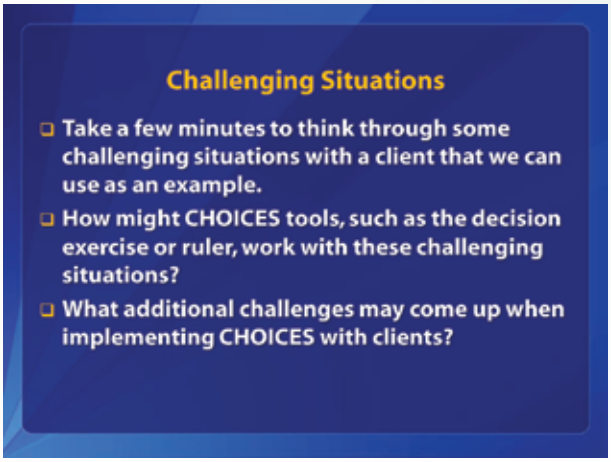
When progress is detected, use affirmation and positive reinforcement to build self-efficacy and increase the likelihood that clients will sustain attempted changes or set additional goals.

You also can use information about setbacks and struggles to revise action planning.

Please begin on page 33 in your Counselor Manual to review Session 3.

(After giving participants time to read through)

You can see that much of the session centers on the review of work from the previous session. There are essentially no new intervention activities in this session; instead we continue a dialogue from the first two sessions.



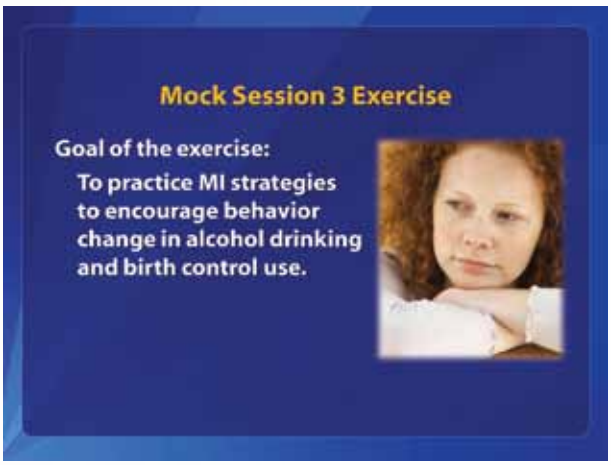
Slide 166

Facilitator Notes:

(Give trainees a few minutes to brainstorm challenging situations, and then choose three or four trainees to explain their challenging situations to the group.)

(After each example, work through the example with the tools provided by choices.)

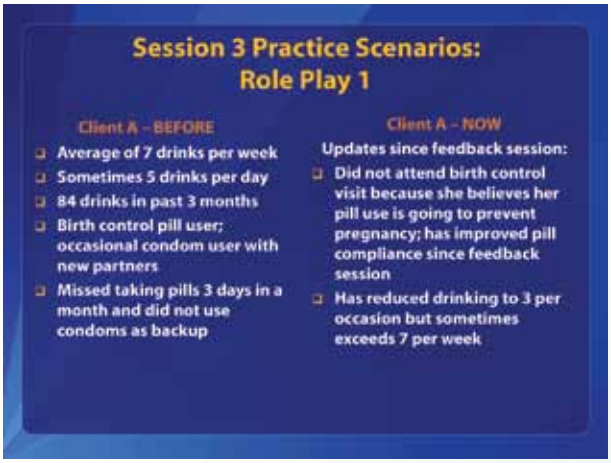
(Ask what other challenges there might be, such as multiple partners, multiple types of birth control, etc.)



Slide 167

Facilitator Notes:

We will now practice Session 3 with a mock exercise that consists of two role plays.



Slide 168

Facilitator Notes:

For this mock exercise, we will use the same scenario we used earlier in the training. However, we have added some information about Client A "before" and Client A "now." You will use this information to conduct the mock Session 3.

Please divide into pairs and follow the steps outlined for Session 3 to lead a discussion.

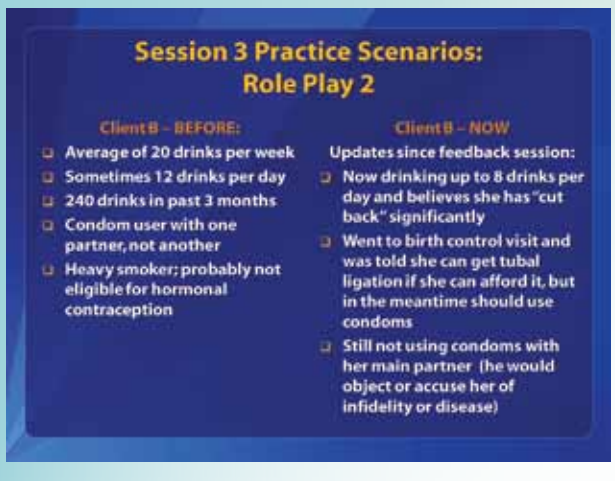
(Complete activity)

(Discussion questions)

What was effective in conducting Session 3?

How could MI skills/principles help with difficult client issues that arose?

What else will be important when you use CHOICES?



Slide 169

Facilitator Notes:

Again, we will use the same scenario for Client B, but with additional information about Client B "before" and Client B "now." Switch roles with your partner and use this information to conduct another mock Session 3.

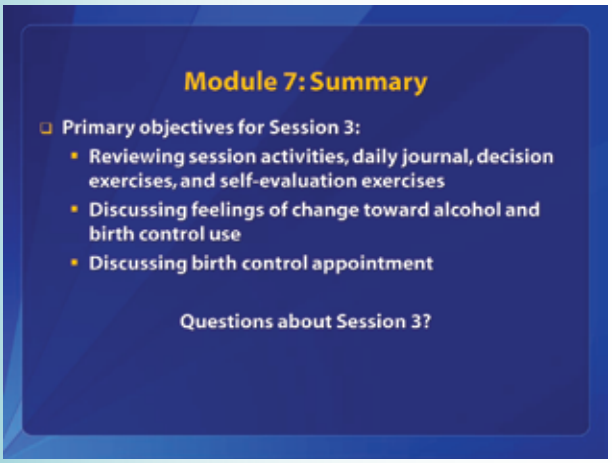
(Complete activity)

(Discussion questions)

What was effective in conducting Session 3?

How could MI skills/principles help with difficult client issues that arose?

What else will be important when you implement CHOICES?



Slide 170

Facilitator Notes:

(Read slide)

MODULE 8:

CHOICES Session 4, Future Goals and Planning

MODULE 8:

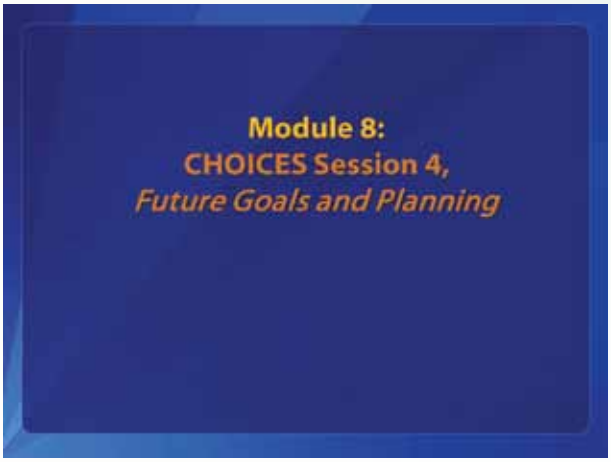
Trainer Objectives:

- To provide an overview of the 11 activities in Session 4
- To define objectives of Session 4
- To identify required materials for Session 4
- To review Day 2 of the training

Materials Needed:

- Flip chart or whiteboard, markers, paper, and tape
- Client Workbook
- Counselor Manual
- Handouts
  - What I Learned from CHOICES

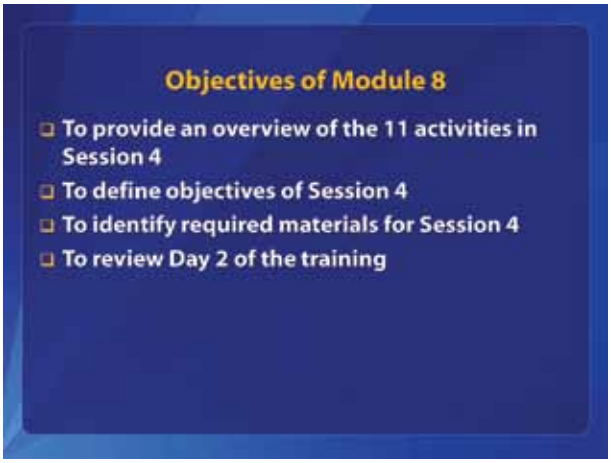
Time Required: 60 Minutes



Slide 171

Facilitator Notes:

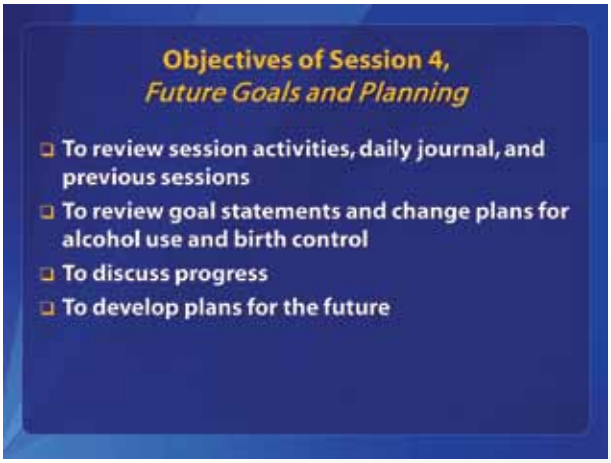
In Module 8, we will discuss the final CHOICES session — Session 4: Future Goals and Planning.



Slide 172

Facilitator Notes:

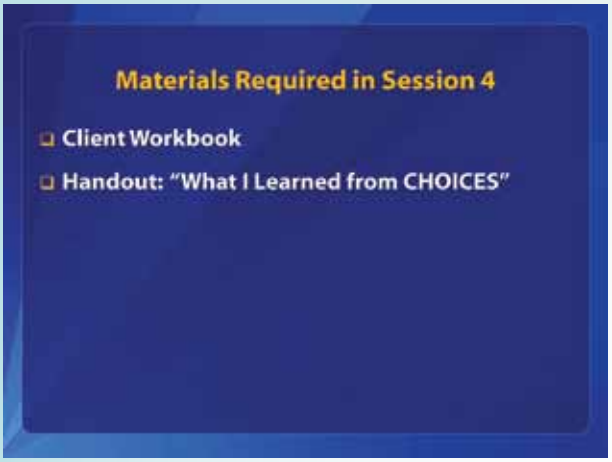
(Read slide)



Slide 173

Facilitator Notes:

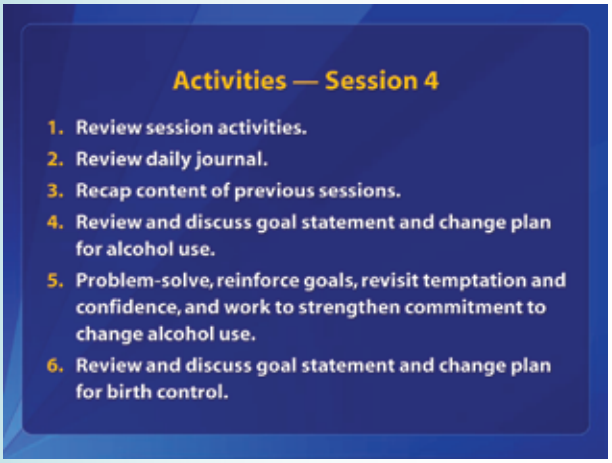
(Read slide)



Slide 174

Facilitator Notes:

(Read slide)

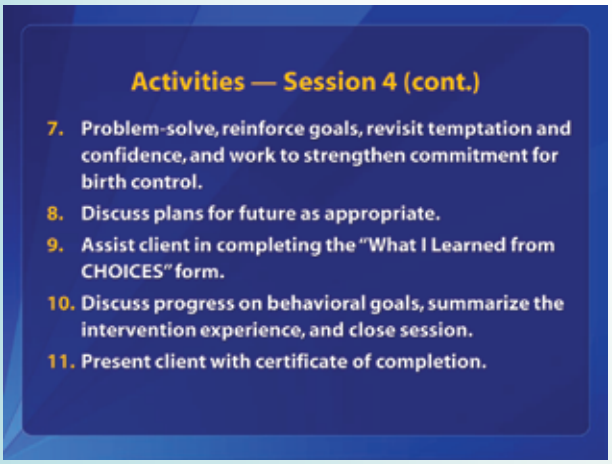


Slide 175

Facilitator Notes:

Much of the initial work in Session 4 is a continuation of the dialogue from the previous three sessions. Again, we will conduct a review of the daily journal, discussion of progress toward CHOICES goals, and problem-solving and sustaining motivation to change.

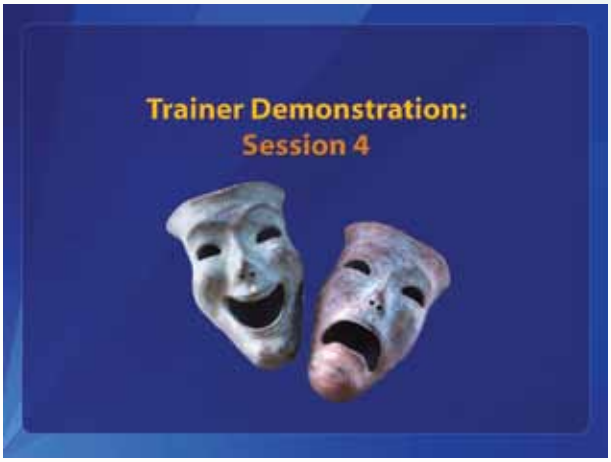
Reviewing the daily journal and connecting this with the client's identified goals is a critical element in CHOICES.



Slide 176

Facilitator Notes:

(If time allows, have participants role play the end of session 4.)



Slide 177

Facilitator Notes:

We will now watch a demonstration on how to lead Session 4. Let's pay particular attention to examples for activities 5, 7, 8, 9, and 10.

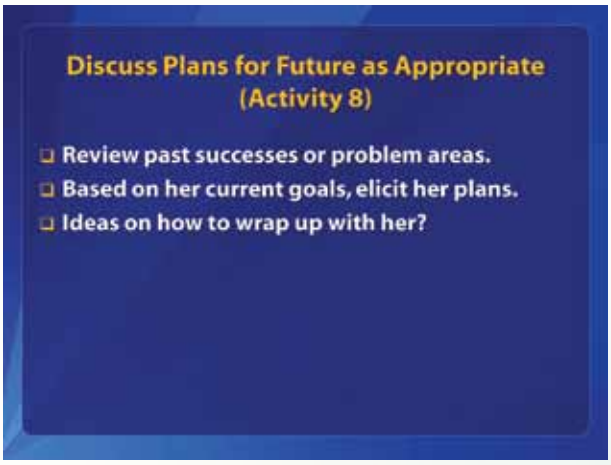
Slide 178

Facilitator Notes:

(In this demonstration, using the counselor manual, show several critical sections of the Session 4 interview.)

(Ask for a volunteer who can demonstrate one of the cases used in the previous examples. Prepare the volunteer before the demonstration.)

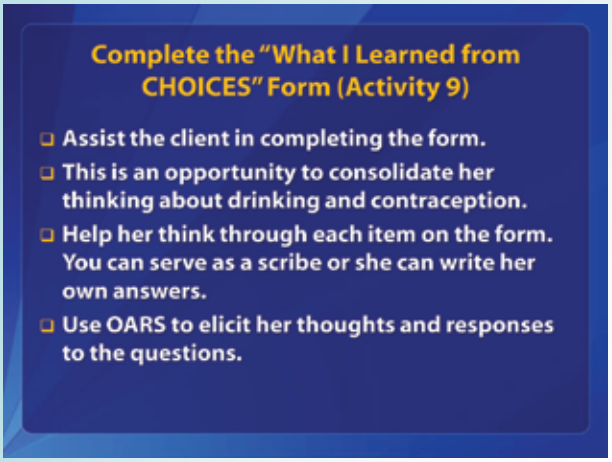
(Demonstrate a natural conversational flow through these activities.)



Slide 179

Facilitator Notes:

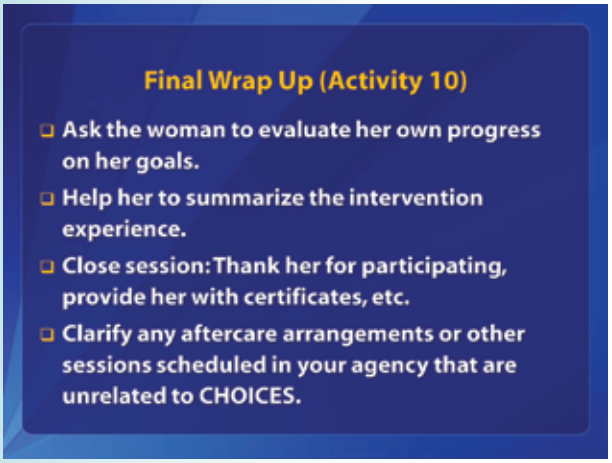
(After reviewing the previous demonstration, ask the group how it would approach wrapping up the choices intervention. Note appropriate responses on an easel chart pad.)



Slide 180

Facilitator Notes:

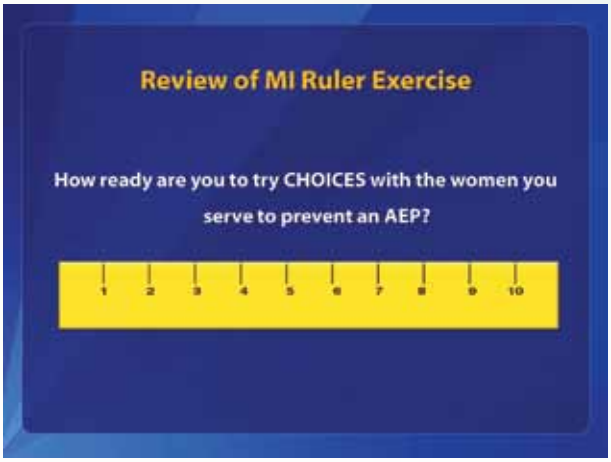
Continue to use a conversational style to ask the woman to complete the form "What I Learned from CHOICES." This form is a way for you to help her consolidate her thinking about her risks for alcohol-exposed pregnancy, what she can do about them, and what she plans to do.



Slide 181

Facilitator Notes:

The last step in this last session is to end the CHOICES intervention well, in a thoughtful and appreciative manner. Using MI communication skills, you help her to state where she is and where she is going in terms of her AEP risk. You will also finalize your sessions with her, and this should not be a surprise—make sure she knows before the third session that the fourth session is her final one. If she is continuing to receive services from you or your agency, clarify that the CHOICES component is over, but she will continue in other services. If not, but you are referring her to another service such as aftercare, ensure the client clearly understands what, when, and where these services will be.



Slide 182

Facilitator Notes:

We will now perform this Readiness Ruler exercise again. Please stand up and form a line or a semi-circle.

Remember: There are no right or wrong answers.

(Once participants have established a position, address someone who has assigned themselves to a 3 or a 4.)

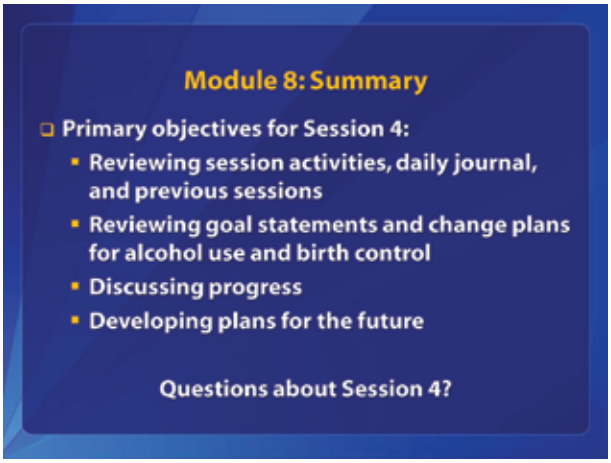
What led you to you assign yourself to that number? What made it an [X] and not a [X]?

(Confirm responses for other participants in the same position.)

What would it take for you to move up one?

(Listen and confirm responses. Repeat the questions with participants who assigned themselves to a 7 or an 8.)

Does anyone else want to offer ideas about what might help to improve your comfort level with MI and CHOICES?



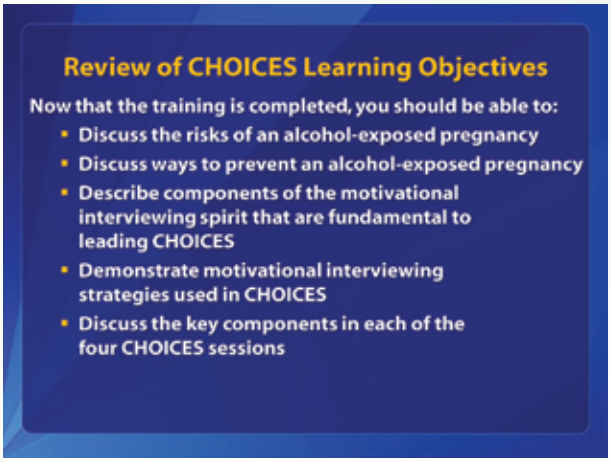
Slide 183

Facilitator Notes:

(Read slide)

Conclusion:

- Review of Learning Objectives
- Questions about CHOICES
- Post-tests
- Training evaluation



Slide 184

Facilitator Notes:

These are our original learning objectives. You should now be able to . . .

(Read slide)

Slide 185

Facilitator Notes:

Before we address questions, I would like to discuss the concept of follow-up for clients exiting CHOICES.

The first question that you will ask clients is what else they need to do after the intervention to continue their progress. I would like to ask the same question of all of you.

(Add additional probes if necessary.)

What can you do to continue to increase your comfort as CHOICES interventionists?

- Resources are available at www.cdc.gov/fasd that provide additional reading on AEP in general. This is a good place to go for more information.
- Supervision of your own counseling is one of the most important tools you can use to ensure you are leading CHOICES with integrity. For example, there are tools and resources for listening to audio recordings and tracking the use of MI skills; and there is a list of providers who will actually listen to audio-recorded transcripts and offer feedback. The Motivational Interviewing Treatment Integrity code has been developed as a tool for clinical supervision of counselors employing MI skills.

What are your remaining questions about what we've discussed or appropriate next steps?

Slide 186

Facilitator Notes:

(Distribute workshop Training Post-test and Evaluation surveys to participants. Explain that evaluations will be used to improve future training and that participant honesty is greatly appreciated. Be sure to allow participants enough time to thoroughly complete the post-test and evaluation.)

Slide 187

Facilitator Notes:

Thank you for your honesty and hard work. This training was designed to offer a foundation that will allow counselors to begin implementing CHOICES. However, many participants have found additional training and support to be helpful. Your organizations should develop forms and processes to decide how the CHOICES intervention fits into your existing practices.

Are there any final questions?

APPENDIX

Module 2 Exercise

Motivational Interviewing vs. Nonmotivational Interviewing

Role Play #1: Nonmotivational Interviewing Scenario

Counselor questions:

How often do you engage in unprotected sex?

Why are you doing that? You know it can only cause you all sorts of problems, such as an unwanted child.

I don't understand why you can't use some easy method of birth control like condoms.

Module 2 Exercise

Motivational Interviewing vs. Nonmotivational Interviewing

Role Play #2: Motivational Interviewing Scenario

Counselor questions:

You indicated that you have been having unprotected sex with your partner for a year now. (reflection of what the woman said on her screening form)

If I recall correctly you said earlier that condoms really ruin the moment for you and your partner, and he does not like to use condoms at all? Tell me a bit more about that.

What concerns do you have about not using birth control regularly?

What are some possible consequences for you and your partner of not using birth control regularly?

What are some other birth control methods you might try to avoid an alcohol exposed pregnancy?

Module 3 Exercise

Drumming for Change Talk

Contributor: Steven Malcolm Berg-Smith
Approximate time required: 15 minutes

1. Opening comments

A primary goal of Motivational Interviewing is to evoke change talk–to counsel in a way that invites the client to make arguments for change and ways of achieving it. This is important because we know from research there is a relationship between clients' change talk and the probability of change actually happening. Again, change talk is a broad term referring to all kinds of dialogue that favor change. On the slide (or flipchart) are the primary categories of change talk that we summarize with the acronym DARN-C. This stands for the flow of change talk: **d**esire to change, **a**bility to change, **r**easons to change, **n**eed to change, and **c**ommitment/change.

As the training progresses, we'll be exploring different approaches for evoking client change talk, and what to do when you start hearing it. Before we do all of that, there's a very important first step: becoming adept at recognizing change talk, training your ears to be very sensitive to it. When you start to hear change talk, immediately encourage it, reinforce it, and reflect it.

2. Drum roll

Can you all give me a drum roll on your tabletops? Excellent!

Right now I am going to read you some statements that clients have made to me over the years. And I want you to be the judge of whether or not what I'm reading is change talk. If it is an example of change talk, please give me a drum roll.

(Begin reading statements from the list titled "Change Talk Statements, Round 1: Drum Roll." Wait for participants to respond before moving on to the next statement.)

Fantastic! We're getting the hang of recognizing change talk.

3. Commitment talk

Now there is a certain kind of change talk we especially want to listen for, and that's commitment language: a client giving voice to intentions, obligations, or agreements. Recent linguistic research suggests the kind of change talk that actually predicts behavior change is commitment language—or more specifically, strong commitment language. Clients may express their desire, ability, reasons, and need, but still not take the step of committing to doing something. However, encouraging DARN-C is still very important because it moves a person toward commitment to change.

DARN-C is the prep-step before commitment. And commitment language is what actually predicts change.

4. Massage the pearl

In parts of Asia there is a tradition called dragon paws. The idea is to rub your hands together when you hear something positive, something life-affirming, a dream, a vision, a commitment, something hopeful. You treat it as if it's a pearl and you want to massage the pearl.

There's a certain kind of change we might think of as a pearl. What do you suppose that is? The "pearl" of change talk is commitment language. When we hear commitment talk, we really want to massage that pearl. This is the kind of change talk we want to especially reinforce in our clients.

I'm again going to read you some statements clients have made to me over the years. And this time I want you to be even more discriminating. As I'm reading the statements, I want you to judge if what I'm reading sounds like general change talk (desire, ability, reasons, need), commitment talk (intentions, obligations, agreements), or neither. If it sounds like general DARN-C talk, what are you going to do? [drum roll]. If it sounds like commitment language, what are you going to do? [massage the pearl]. If it sounds like neither, what are you going to do? [silence]. Let's begin …

(Begin by reading the list of Change Talk Statements on a separate page, "Round 2: Massage the Pearl," and wait for participants' responses before moving on to the next statement.)

5. Closing

When you start to hear change talk, be ready to immediately encourage it, reinforce it, and reflect.

Change Talk Statements

Round 1: Drum Roll

I love to smoke my weed.

I hate this treatment program.

I need to get high to feel right.

I just want to wake up sober in the morning.

I actually tested my blood sugar every day this week.

Yeah, I blew off school on Thursday.

I stayed away from drug dealing all week.

It's just such a hassle to floss my teeth.

I mostly forgot to call my probation officer.

There's no way I want to be on insulin.

I didn't hang with my homies last night and instead took care of my little sister.

My baby behaves a lot better when I smack him.

I definitely can't afford to get another DWI.

I wish I could lose weight easily.

I don't think I can eat any more fruits and vegetables than I do.

I have my reasons for indulging in cocaine every once in a while.

I need to have breaks from my kids. That's why I don't come home some nights.

I tried out for the track team.

I took a walk several times this week.

I've been kinda forgetting to take my antidepressants.

I could probably do it if I tried.

I hate keeping food records.

I could probably take a walk after dinner.

If I lose this job, my girlfriend is definitely going to leave me.

I can't keep having those one-nighters.

I think I have it in me to find work.

I might be able to cut down a bit.

I have to clean up my act.

Something has to change or I'm going to lose my job.

I'll do anything to get rid of the pain.

I'm sick of smoking; it disgusts me.

I don't want to set a bad example for my kids.

I want to be clean and sober, period.

I don't see how drinking four or five beers a night is a problem.

I need to get back some energy.

I'm sure I'd feel better if I exercised regularly.

I broke down and went to the casino on Tuesday.

I'm happy with living on the streets. I ain't going to do anything different.

I totally cleaned the cigarettes out of my house and car yesterday.

Mostly I just don't see any benefits to getting my high school degree.

I am tired of being overweight.

I want to be around to see my grandchildren grow up.

I positively can't get off heroin because my boyfriend always wants me to fix with him.

I need to do some things to get my energy back.

I'm killing myself.

It's important for me to be a good example for the children in my life.

I've got to do something about my marriage before it's too late.

I'm positive I can quit.

Round 2: Massage the Pearl

I guarantee I'll make my next appointment.

It would be hard for me to exercise because I really hate running.

There's no way I could make it without my gang bros.

I'm starting to get a little tired of the drug scene.

I might be able to cut down a bit.

I'm going to commit to no more than one drink a day, and go at least two days a week when I'm not drinking.

I swear I'm going to weigh myself at least once a week.

I really like the ritual of doing it, you know.

I'm sure I'd feel better if I exercised regularly.

I'm ready to do what it takes to lose five pounds.

I'm not very motivated to exercise.

If I don't begin and finish this treatment program, I might as well throw in the towel.

I love my baby. That's why I'm definitely not going to smoke around her.

I'm a little tired of eating junk food.

I kinda have to keep dealing drugs.

Sure I can lose weight; it's just a matter of sticking to it

I don't want to have fat kids.

I borrowed some kid books from a friend and actually read my daughter a story. No more online poker for me! I'm done!

I'll do my best to eat more fruits and vegetables every day.

Today is the day I say "so long" to chewing tobacco.

I'm going to think about maybe breastfeeding my new baby.

I hate eating vegetables, and besides, they're way too expensive.

I promise I'll keep a food record at least two days each week.

Yes, I'm going to take care of business and take a 45-minute walk three mornings a week.

I give you my word that I will follow through with my action plan.

Module 4: OPTIONAL EXERCISE

Decisional Balance Exercise

Instructions

The Decisional Balance Exercise will help the client think about:

- The benefits and costs of changing (insert behavior)
- What is involved in her decision to change

Weighing decisions – When people weigh decisions, they look at the benefits and costs of the choices they can make. Remember that having mixed feelings often occurs when making decisions.

Many people change on their own – When they are asked what brought about a change, they often say they just "thought about it," meaning they looked at the results of their current behavior and of changing before making a final decision.

You can do the same thing by listing the benefits of changing on one side of a sheet of paper and the costs of changing on the other side. This exercise will help you look at the good things and less good things about changing.

Decisional Balance – To change, the scale needs to tip so the benefits of changing current behavior outweigh the costs of continuing the behavior. Weighing the pros and cons of changing happens all the time—for example, when changing jobs or deciding to move or get married.

Ask yourself, "What do I stand to gain and lose by continuing my current behavior?" At some point, you may have received real benefits from the behavior you want to change, such as relaxation, fun, or stress reduction. However, because you are here, you are considering both the benefits and the costs.

Now it is your turn – Go through this exercise yourself. Read the handout titled, "Sample Decisional Balance Exercise." Fill in the benefits and costs of changing a behavior that you would like to change. Compare the two lists, and ask yourself, "Are the benefits worth it?"

Decisional Balance Exercise: Example

This exercise will help you:

Think about the costs and benefits of changing and what is involved in your decision to change.

The behavior I am thinking of changing is:

_____

Weighing decisions

When people weigh decisions, they look at the benefits and costs of the choices they can make. Remember that having mixed feelings often occurs when making decisions.

Decisional Balancing

Many people change on their own. When they are asked what brought about the change, they often say they just "thought about it", meaning they looked at the results of their current behavior and of changing before making a final decision.

You can do the same thing by writing the costs of changing on one side of this sheet and the benefits of changing on the other side. This exercise will help you look at the good things and less good things about changing.

To change, the scale needs to tip so the benefits outweigh the costs. This is called "decisional balancing."

Weighing the pros and cons of change happens all the time--for example, when changing jobs or deciding to move or get married.

Thinking about Changing?

Ask yourself: What do I stand to lose and gain by continuing my current behavior? At some point, you may have received real benefits from the behavior you want to change, such as relaxation, fun, or stress reduction. However, because you are reading this, you are considering both the benefits and the costs.

Example of Decisional Balancing

Benefits of changing

- Increased control over my life
- Support from family and friends
- Decreased job problems
- Improved health and finances

Costs of not changing

- Increased control over my life
- Support from family and friends
- Decreased job problems
- Improved health and finances

Your Turn: A Decisional Balancing Exercise

Fill in the costs and benefits of changing and compare them. Ask yourself, "Are the costs worth it?"

Benefits of changing

Costs of not changing

Benefits of changing

You are the one who must decide what it will take to tip the scale in favor of change.

The most important reason I want to change is:

_____

Example of Completed Feedback Forms

Client A

You typically drink **8** drinks per week.

On occasion, you may drink **5** drinks in a single day.

Your current drinking level falls into the **risky drinking** group.

You are drinking more than 85% of women your age.

How much money did you spend?

You drank about **96** drinks in the past 3 months (12 weeks).

You drank about **416** drinks in the past year (52 weeks).

If the average drink is about $2.50 at home, then you spent about **$1,040** on alcohol in the past year.

If you usually drink at a bar and the average drink costs $6, then you spent about $2,496 on alcohol in the past year.

How many calories did you consume from alcohol per drinking day?

You drank about 1 drink per drinking day.

If an average drink has 100 calories, you consumed about 100 calories per day from alcohol.

Client B

You typically drink **20** drinks per week.

On occasion, you may drink **12** drinks in a single day.

Your current drinking level falls into the **risky drinking** group.

You are drinking more than 85% of women your age.

How much money did you spend?

You drank about **240** drinks in the past 3 months (12 weeks).

You drank about **1,040** drinks in the past year (52 weeks).

If the average drink is about $2.50 at home, then you spent about **$2,600** on alcohol in the past year.

If you usually drink at a bar and the average drink costs $6, then you spent about $6,240 on alcohol in the past year.

How many calories did you consume from alcohol per drinking day?

You drank about 3 drink per drinking day.

If an average drink has 100 calories, you consumed about 300 calories per day from alcohol.

Temptation and Confidence Feedback

This is a graphic template for providing feedback on confidence and temptation for both the alcohol and the birth control measures. It is simple to produce the graphs. The numbers on the feedback template graphs correspond to the response categories on the measures. Using two different colored markers, you simply draw a line to represent how far along the scale of confidence or temptation the woman responded. Starting at the left side of the graph, for an item response of 3 (e.g., Moderately Confident), you would draw a line up to the third line on the graph (labeled 3 at the bottom). See examples:

Example:

TEMPTATION AND CONFIDENCE – ALCOHOL						
Unpleasant emotions						T
						C
Physical discomfort						T
						C
Pleasant emotions						T
						C
Testing control over my use of alcohol						T
						C
Urges and temptations						T
						C
Conflict with others						T
						C
Social pressure to drink						T
						C
Pleasant times with others						T
						C
	1	2	3	4	5	

TEMPTATION AND CONFIDENCE – ALCOHOL						
Unpleasant emotions						T
						C
Physical discomfort						T
						C
Pleasant emotions						T
						C
Testing control over my use of alcohol						T
						C
Urges and temptations						T
						C
Conflict with others						T
						C
Social pressure to drink						T
						C
Pleasant times with others						T
						C
	1	2	3	4	5	

Example:

TEMPTATION AND CONFIDENCE – BIRTH CONTROL						
I have been using alcohol or drugs						T
						C
My partner gets upset or angry						T
						C
I experience side effects from the birth control						T
						C
The birth control is too much trouble						T
						C
I am with someone other than my main partner						T
						C
	1	2	3	4	5	

TEMPTATION AND CONFIDENCE – BIRTH CONTROL						
I have been using alcohol or drugs						T
						C
My partner gets upset or angry						T
						C
I experience side effects from the birth control						T
						C
The birth control is too much trouble						T
						C
I am with someone other than my main partner						T
						C
	1	2	3	4	5	

Your Personal Feedback

At the last session, you said:

You typically drink _____ drinks per week.

On occasion, you may drink _____ drinks in a single day.

As we have discussed, certain types of drinking can increase your chances of having health and social problems, including an alcohol-exposed pregnancy. That means the more you drink, the greater your chance of having problems, and the more you put your unborn child at risk. There are two basic levels of drinking:

1. Low Risk (Moderate) Drinking

Definition: No more than seven drinks per week and no more than three drinks on any one day.

Risks: If you are already pregnant or become pregnant, drinking alcohol may increase your chance of miscarriage or of having a baby with birth defects.

Moderate drinking usually does not cause problems if you are not pregnant, unless you drink at the wrong time (for example, on the job), have medical conditions (for example, diabetes), or take certain medications (for example, tranquilizers). **No known amount of alcohol is safe during pregnancy.**

2. Risky Drinking

Definition: More than seven drinks per week or more than three drinks on any one day.

Risks: If you are already pregnant or become pregnant, drinking alcohol may increase your chance of miscarriage or of having a baby with birth defects.

Moderate drinking usually does not cause problems if you are not pregnant, unless you drink at the wrong time (for example, on the job), have medical conditions (for example, diabetes), or take certain medications (for example, tranquilizers). No known amount of alcohol is safe during pregnancy.

Heavy drinking can:

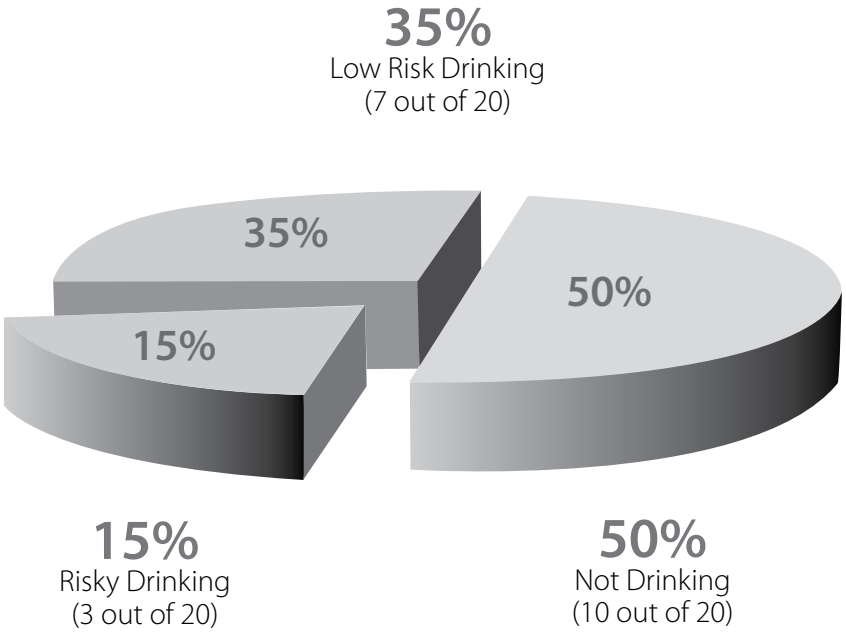
- Cause problems with your work, family and friends, money, and the law
- Increase your chances of getting breast or other cancers
- Increase your chances of accidents and injuries
- Put you at risk for unprotected sex, an unplanned pregnancy, and sexually transmitted diseases, including HIV/AIDS
- Put you at risk for having a miscarriage if you become pregnant or result in the baby having Fetal Alcohol Syndrome

Your Personal Feedback

How does your drinking compare with other women?

Your current drinking level falls into the _____ group.

You are drinking more than _____ % of women aged 18–44.



Reference:

Centers for Disease Control and Prevention (CDC).
Behavioral Risk Factor Surveillance System Survey Data.
Atlanta, Georgia: U.S. Department of Health and Human Services,
Centers for Disease Control and Prevention, 2009.

Your Personal Feedback

How much money did you spend on alcohol in the past year?

Based on what you told us, you drank about _____ drinks in the past three months.

If you multiply that number by four, you drank about _____ drinks in the past year.

If you usually drink at home and an average drink at home costs about $2.50, then you spent about $ _____ on alcohol in the past year. (Total drinks per year x $2.50)

If you usually drink at a bar or restaurant and an average drink there costs about $6, then you spent about $_____ on alcohol in the past year. (Local prices may be different. Total drinks per year x $6 or local price of a drink.)

How many calories did you get from alcohol per drinking day?

Alcohol has calories with no nutritional value. Sometimes women gain weight because of the extra calories they consume from alcohol.

Based on what you told us, you drank about _____ drinks per drinking day.

If an average drink has 100 calories, you got about _____ calories per drinking day from alcohol. (Total number of drinks per day x 100)

The average woman takes in approximately 1,800 calories per day.

Your Personal Feedback

Pregnancy risk:

○ Low — You use birth control correctly every time you have vaginal intercourse.

○ High — You never use birth control or you sometimes have vaginal intercourse without using birth control correctly.

You are at risk for an alcohol-exposed pregnancy because:

Readiness Ruler

NOT READY AT ALL

EXTREMELY READY

What I Learned from CHOICES

What are the three most important things you learned from CHOICES?

1.

2.

3.

CHOICES TRAINING PRE-TEST

Anonymous ID # __ __ / __ __/ __ __ (birth month/ birth year/ middle & last initial)

1. Have you ever received training in Motivational Interviewing?
   - ☐ No
   - ☐ Yes, training was less than 4 hours
   - ☐ Yes, training was 4 to 8 hours
   - ☐ Yes, training was more than 8 hours
   - ☐ Unsure

2. My worksite/organizational setting is (choose one):
   - ☐ Residential alcohol/drug treatment center
   - ☐ Outpatient alcohol/drug treatment center
   - ☐ Public health clinic i.e. STD, family planning, community health center
   - ☐ State or local public health agency (administration/management)
   - ☐ Other _____

3. My primary job role is to (choose one):
   - ☐ Provide direct services to clients
   - ☐ Supervise others who provide direct services
   - ☐ Program manager/director at state agency
   - ☐ Evaluate programs
   - ☐ Other_____

4. I will be providing CHOICES directly to clients:
   - ☐ Yes
   - ☐ No
   - ☐ Unsure

5. Please read the following statements and check your opinions.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Unsure
For preconception women dealing with problem drinking, it is best to direct them to eliminate risk rather than encourage them to set their own goals.					
Clients with unhealthy behaviors need friendly but direct persuasion to break through old habits to make important behavior changes.					
I am generally optimistic that most of my clients will change their behavior.					

6. **In working with clients on changing behavior, the concept of self efficacy refers to (choose one):**
   - ☐ A counselor's efficacy at putting herself in the other's person's shoes.
   - ☐ A counselor's confidence in the client's ability to hear positive messages..
   - ☐ A person's general feeling (positive or negative) about themselves as a person.
   - ☐ A person's belief in her/his ability to perform a behavior.

7. **Based on behavior change research, which of the following statements is true about building a client's internal motivation for change *(choose one)*:**
   - ☐ It is important for the counselor to argue for the reasons to change to help educate the client about why he or she should change a problematic behavior.
   - ☐ A counselor arguing for the reasons to change is likely to result in the client arguing for the reasons not to change.
   - ☐ A counselor arguing for change provides a role model which helps clients through social learning.
   - ☐ It is important to create an environment where both counselor and client argue for reasons to change.

8. **List 3 methods that are considered less effective for birth control:**

   1. _____

   2. _____

   3. _____

9. **Risky drinking for women is defined as "more than ____ standard drinks on any one occasion or more than ____ drinks per week."**

10. **For each of the statements below, choose the letter of the communication style which best describes the statement (NOTE: a letter can be used more than once or not at all).**

    a. affirmation
    b. open-ended question
    c. reflective listening statement
    d. none of the above

    ____ It sounds like having people talk to you about your drinking makes you angry.

    ____ Tell me more about the birth control methods you've been using the past few months.

    ____ You are frustrated that you have to come here when you don't think you have a problem.

    ____ I appreciate that you are here today even though your back pain is severe.

    ____ It sounds like you should start drinking less, especially at night when you go out with your friends.

The next three questions focus on how you might work with a client named Tami. Her situation is described in the box below.

Tami likes to go out with her friends and drink a lot, especially on weekends. She looks forward to it all week but doesn't like the hangovers she often experiences, or that she sometimes forgets to use a condom. She recently saw a TV special about fetal alcohol syndrome that made her think twice about her drinking. She would hate to accidentally get pregnant, then get drunk and not realize she could be hurting her baby. On the other hand, she isn't planning to get pregnant and she drinks like her friends so isn't sure if she needs to worry about it.

11. Give an example of a typical statement or question that you might use with Tami to work with her to explore her situation.

12. Please check the box next to the appropriate readiness stage related to alcohol use for Tami.

- ☐ Not at all ready (precontemplation)
- ☐ Considering change (contemplation)
- ☐ Preparing to change (preparation)
- ☐ Action
- ☐ Relapse/Recycle

13. You are working with Tami to review her behavior and create a *personal goal statement* to avoid an alcohol exposed pregnancy (AEP), so you begin with *(choose one)*:

- ☐ Sharing with Tami that the safest way to avoid an AEP is no alcohol use and/or effective birth control
- ☐ Inviting Tami to discuss the dangers of alcohol use for the fetus and for her own health
- ☐ Inviting Tami to discuss her ideas about changing her behavior
- ☐ Sharing information with Tami on ideas for how to abstain until she has been to a health care provider and is using effective birth control

CHOICES POST-TEST AND EVALUATION

Anonymous ID # __ __ / __ __/ __ __ (birth month/ birth year/ middle & last initial)

1. Please choose **one** response that best describes how ready you feel to apply your new skills:
   - ☐ Not ready to get started
   - ☐ A little ready, but need more training
   - ☐ Moderately ready, could use a little more preparation
   - ☐ Completely ready to go!
   - ☐ I am ready but unlikely to use the skills because they don't fit my work setting
2. In thinking about returning to work, share the top 2 factors that would help you get started:

   (1)

   (2)

3. Please share the top 2 factors that might slow you down:

   (1)

   (2)

4. Please share your assessment of how beneficial this training was for you in your job role:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Unsure
The skills I learned during this training fit very well with my current work.					
The skills I learned during this training will help me improve my service to clients.					

5. Please read the following statements and check your opinions.

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Unsure
For preconception women dealing with problem drinking, it is best to direct them to eliminate risk rather than encourage them to set their own goals.					
Clients with unhealthy behaviors need friendly but direct persuasion to break through old habits to make important behavior changes.					
I am generally optimistic that most of my clients will change their behavior.					

6. In working with clients on changing behavior, the concept of self efficacy refers to *(choose one)*:
   - ☐ A counselor's efficacy at putting herself in the other's person's shoes.
   - ☐ A counselor's confidence in the client's ability to hear positive messages..
   - ☐ A person's general feeling (positive or negative) about themselves as a person.
   - ☐ A person's belief in her/his ability to perform a behavior.

7. Based on behavior change research, which of the following statements is true about building a client's internal motivation for change *(choose one)*:
   - ☐ It is important for the counselor to argue for the reasons to change to help educate the client about why he or she should change a problematic behavior.
   - ☐ A counselor arguing for the reasons to change is likely to result in the client arguing for the reasons not to change.
   - ☐ A counselor arguing for change provides a role model which helps clients through social learning.
   - ☐ It is important to create an environment where both counselor and client argue for reasons to change.

8. List 3 methods that are considered less effective for birth control:

   1. _____

   2. _____

   3. _____

9. Risky drinking for women is defined as "more than ____ standard drinks on any one occasion or more than ____ drinks per week."

10. For each of the statements below, choose the letter of the communication style which best describes the statement (NOTE: a letter can be used more than once or not at all).

    a. affirmation
    b. open-ended question
    c. reflective listening statement
    d. none of the above

    ____ It sounds like having people talk to you about your drinking makes you angry.

    ____ Tell me more about the birth control methods you've been using the past few months.

    ____ You are frustrated that you have to come here when you don't think you have a problem.

    ____ I appreciate that you are here today even though your back pain is severe.

    ____ It sounds like you should start drinking less, especially at night when you go out with your friends.

The next four questions focus on how you might work with a client named Tami. Her situation is described in the box below.

Tami likes to go out with her friends and drink a lot, especially on weekends. She looks forward to it all week but doesn't like the hangovers she often experiences, or that she sometimes forgets to use a condom. She recently saw a TV special about fetal alcohol syndrome that made her think twice about her drinking. She would hate to accidentally get pregnant, then get drunk and not realize she could be hurting her baby. On the other hand, she isn't planning to get pregnant and she drinks like her friends so isn't sure if she needs to worry about it.

11. Give an example of a typical statement or question that you might use with Tami to work with her to explore her situation.

12. Please check the box next to the appropriate readiness stage related to alcohol use for Tami.
    - ☐ Not at all ready (precontemplation)
    - ☐ Considering change (contemplation)
    - ☐ Preparing to change (preparation)
    - ☐ Action
    - ☐ Relapse/Recycle

13. You are working with Tami to review her behavior and create a *personal goal statement* to avoid an alcohol exposed pregnancy (AEP), so you begin with *(choose one)*:
    - ☐ Sharing with Tami that the safest way to avoid an AEP is no alcohol use and/or effective birth control
    - ☐ Inviting Tami to discuss the dangers of alcohol use for the fetus and for her own health
    - ☐ Inviting Tami to discuss her ideas about changing her behavior
    - ☐ Sharing information with Tami on ideas for how to abstain until she has been to a health care provider and is using effective birth control

14. CHOICES councelors should guide Tami to include which of the following in her Daily Journal? *(place a mark beside only those item(s) that should be included)*
    - ☐ number of drinks of alcohol she had
    - ☐ her friends alcohol use
    - ☐ number of drinks her boyfriend or partner had
    - ☐ her contraceptive use
    - ☐ whether she had vaginal intercourse
    - ☐ number of of sexual partners she had each day

15. Define OARS using the basic terms for each concept:

O _____

A _____

R _____

S _____

16. Draw an example of a ruler and briefly describe what the rulers measure in the CHOICES protocol:

17. Briefly describe the decision exercise.

17a. How is the decision exercise important to the CHOICES protocol?

On a scale of 1-10, please tell us how confident you feel to do each of the following activities:

	Not Very Confident 1	Very Confident 10
18. Provide the CHOICES intervention to clients to help them stop drinking and use effective contraception		
19. Use the Counselor Manual and CHOICES materials		
20. Conduct the client assessments and provide personalized feedback		
21. Use the decision exercise to help my clients to reduce risk for an AEP		
22. Use the rulers with my clients to reduce risk for an AEP		
23. Guide clients through the four sessions of CHOICES		

SKILL SELF ASSESSMENT

24. We would like to know if your skills have increased due to participation in this training. Please think back to before you attended this training, and rate your skill level about each topic at that time by ***circling*** whether it was very low (1), low (2), medium (3), high (4) or very high (5). Then, think about after having participated in the training, and rate your skill level using the same scale.

a.	Using Motivational Interviewing with my clients	Very Low	Low	Med	High	Very Hig
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5
b.	Using communication skills to help clients change their behavior	Very Low				
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5
c.	Considering a client's readiness to change to help understand my client's behavior	Very Low				
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5
d.	Controlling my righting reflex around my client's behavior	Very Low				
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5
e.	Working collaboratively with my client to assist in developing a plan for change	Very Low				
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5
f.	Helping my clients explore their ambivalence using the Decision Exercises	Very Low				
	My skill level BEFORE this training	1	2	3	4	5
	My skill level AFTER the training	1	2	3	4	5

TRAINING ASSESSMENT

Circle the phrase that best reflects your opinion for each statement.

25. The Pre-workshop information was:	Very Helpful	Somewhat Helpful	Not Helpful
26. The length of the training was:	Just Right	Too Short	Too Long
27. The length of the individual sessions was:	Just Right	Too Short	Too Long
28. The pace of the training was:	Just Right	Too Short	Too Long
29. The amount of practice time was:	Just Right	Too Short	Too Long
30. The amount of interaction between the participants and the presenter was:	Just Right	Too Short	Too Long

31. Overall, I would rate this training on CHOICES as:

Poor Fair Good Very Good Excellent

32. What worked well at the training?

33. What could be improved at the training?

Thank you for your help in evaluating this course!

National Center on Birth Defects and Developmental Disabilities
Division of Birth Defects and Developmental Disabilities

CS219815-B