Five Minutes to Help

Developed by the NJ Office of Emergency Management and Rutgers School of Public Health

Key Points:

The purpose of today's training is to help first responders develop new knowledge and communication skills that can be applied on the scene, post overdose reversal, in an effort to encourage Substance Use Disorder (SUD) patients to seek help for their addiction. and make them better aware of available recovery resources.

Five-Minutes to Help was envisioned by the NJ Department of Health's Office of Emergency Medical Services, and the content in today's training was developed by the Rutgers School of Public Health, with funding from the NJ Department of Health.

NOTE THAT PARTICIPANTS should have all already viewed the pre-requisite webinar to this course, 'After the Narcan… Introduction to Five Minutes to Help Program For First Responders.'

This is a four-hour session, and 4 CEU will be issued upon completion of your evaluation; we will provide the link to the online evaluation at the end of the program.

Instructor Names & Organization
ADD HERE

Provide these and any other 'housekeeping' info….

After the Narcan:
Intro to Five Minutes to Help for First Responders

1-hour webinar

https://njlmn.njlincs.net/

'Online Catalog'

Topic Key Word: Narcan

Participants SHOULD HAVE WATCHED this program BEFORE participating in your Five Minutes to Help class. Try to confirm, and if they have not watched it, encourage them do so!

- Program offers one EMT credit
- Free – just need to set up account in NJLMN
- Only one-hour in length

Key Points:

In looking at three months of data in summer / fall 2018, 55% of naloxone-reversed individuals who accept transport to a hospital leave before being seen by a healthcare provider

Up to 30% statewide refuse entirely – THIS IS AN AVERAGE – it may be higher or lower in any given county in any given month.

The pandemic has contributed to increases in substance use, and mental health concerns

Goal of *Five Minutes to Help*

To provide first responders with new skills in motivational interviewing and other communication techniques, to apply after revival from an opioid overdose

5 MINUTES TO HELP
MAKE MINUTES COUNT
Help Change a Life

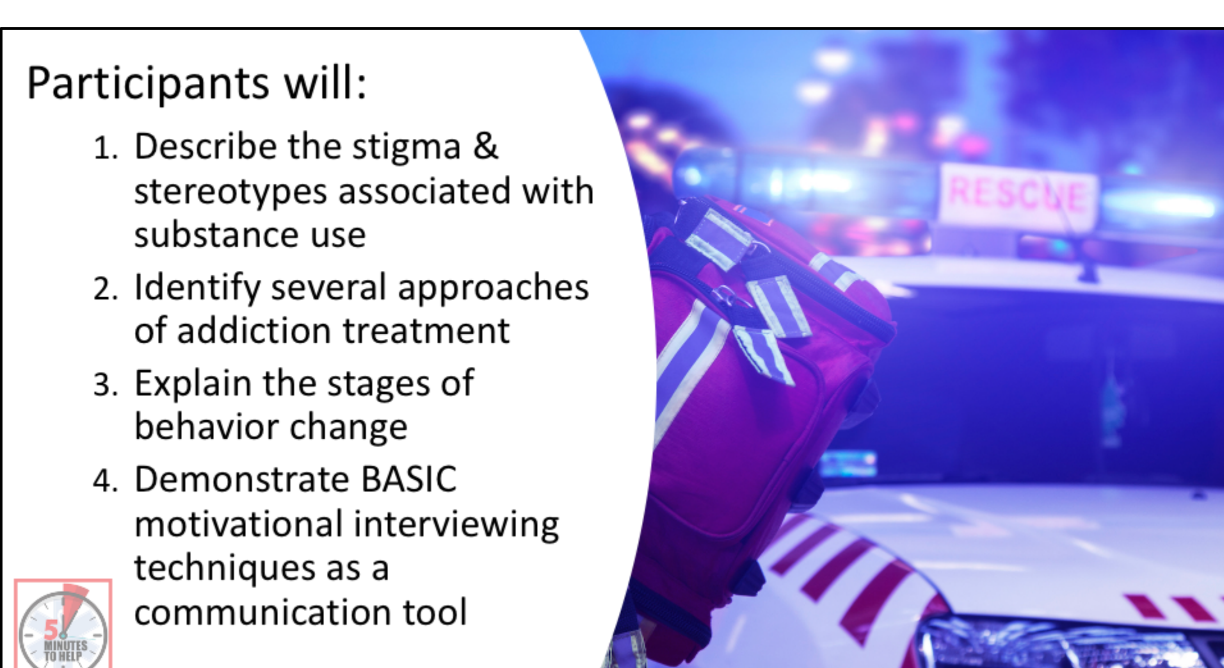
Key Points:

The goal of today's training is to train responders in basic concepts of Motivational Interviewing and other communication techniques, to apply *after* revival from an opioid overdose.

Our objectives for the day are: (Review from slide)

But please note: We fully realize and understand what it's like when an individual has been revived with Narcan – they may be combative / agitated / ashamed / angry … and may not be willing – or even able - to hear what you have to say. Or, just possibly, they might be.

We also recognize that you may only have success (in whatever form that takes) in one out of twenty patients; but clearly we need a new approach to this epidemic. Our hope is that by trying a different way of communicating with individuals, we may see a different outcome.



Key Points:
Review Objectives

Key Points:
Convey reality of expectations and the need for their input and feedback from 'on the ground''. THIS IS what Melissa O'Mara has shared with her classes: Feel free to use / adapt!

We aren't asking you to be counselors. We aren't asking you to spend hours with individuals begging them to go to treatment. We know that is unrealistic.

What we are asking you is to treat the people you encounter with the same compassion and empathy you would give a loved one or a patient who has another chronic illness that isn't associated with the stigma addiction is.

What we are asking is for you to take what you learn and apply what you can, when you can, and to be aware of the resources in your municipalities.

-If you are able to show compassion to someone with a substance use disorder after this program that is a win.

-If you can change the culture and language in your police department or workplace to destigmatize addiction and promote recovery that's a win.

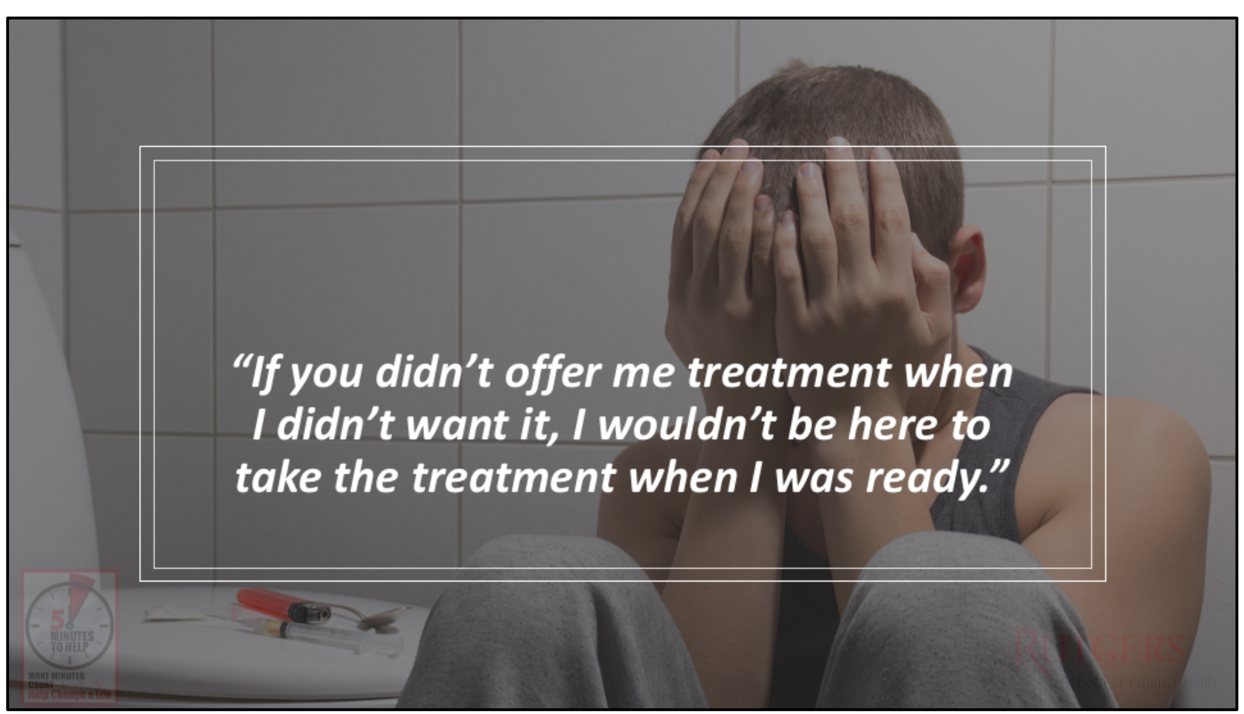
-If you can connect an individual to social services to get housing or Medicaid to get them one step closer that's a win.

-If you can provide information about medically-assisted treatment (or: Medically-Assisted RECOVERY), a local syringe exchange program, or a place to receive Narcan that's a win.

-If you connect with a person's loved one so that they can supply the information about resources available at a later time that's a win… and

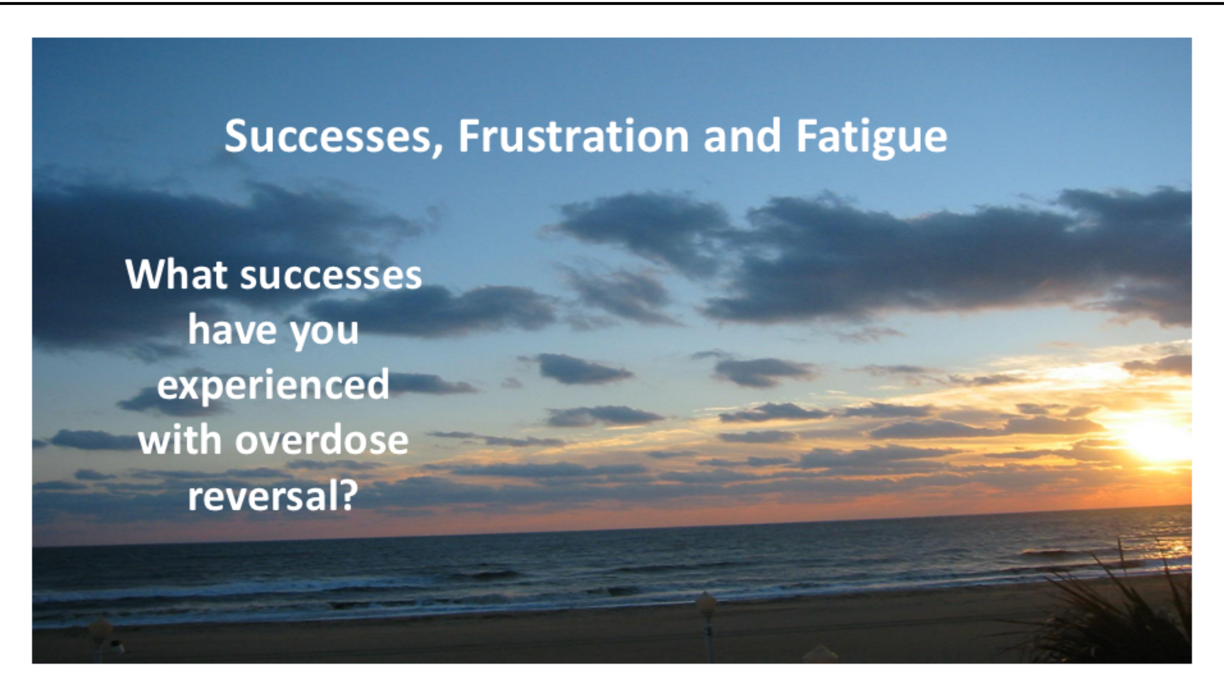
-If you can give the person you have just revived a glimmer of hope that someone out there is invested in seeing them succeed that's a win.

We aren't here to tell you how to do your job, ***we are here to give you one more tool to utilize to save lives and makes your communities better."***



This is an actual quote overheard from someone receiving treatment for an opioid addiction. So, while of course not every substance user will be responsive every time, some will be – and our goal as we go through today's training, and as you apply the communication techniques out in the field, is to try to connect with the ones who are ready to hear it.

READ LETTER from individual in recovery – *This is available on the instructor website or at: https://rutgerstraining.sph.rutgers.edu/Fiveminutes/download/letter_from_individual_in_recovery.pdf*

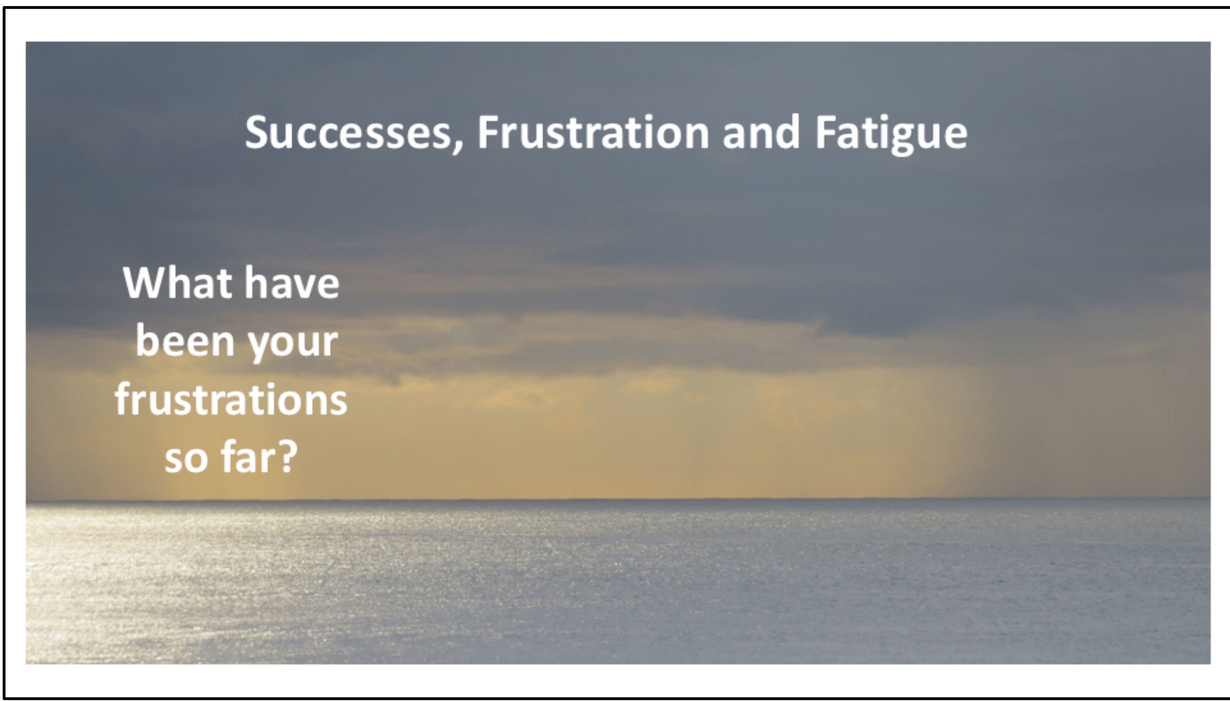


<u>KEY POINTS:</u> This is a Facilitated Discussion (Allow about 8 minutes for this slide and the following)

- *As first responders, you are seeing the frontlines of the data I am sharing here. Everyday, in real time. Which is why we believe you have the most critical role to play.*
- We would like to hear about your personal experiences ***with OD reversal***. Remind participants: These should be "I" statements. Should participants start 'blaming the system' be sure to bring group back to personal experience. Acknowledge the frustrations … but bring it back to personal experience.
- What has been your experience with overdose reversal? Based on these, which can we say were positive outcomes? What worked?
- What do you consider SUCCESSFUL? (Individual goes to hospital? Connected to a support of some type?)
- ***In the absence of going to hospital / treatment center, what would / could***

be another measure of success? **Note that this question can help students begin to consider and explore 'Small measures of success' - brainstorm a few.

- Other 'measures of success' might include:
  - Friends or family having narcan on-hand / in the house
  - Successful communication / intervention / resource-sharing with anyone OTHER THAN the revived individual (such as family member or friend at the scene…)
  - Other harm-reduction (ie: user not using alone (safe injection / safe injection site) -- will discuss 'harm reduction' later



KEY POINTS

What has been your frustrations so far?

Facilitators should remember to:

- Normalize these emotions / frustrations;
- Acknowledge they are normal, human emotions
- Allow attendees to voice their own concerns / experiences
- Recognize they may reference their built-in skills of detachment; this is a logical and understandable way of managing extremely stressful situations and human encounters

SO lets take a minute, here and now - to focus, to get centered.

KEY POINTS: (3 – 4 minutes)

Acknowledge the stress of the role of FIRST RESPONDERS - Especially when they also have full-time jobs; families; sometimes frustrations when responding to situations that may feel as though they 'should not be happening'. We must acknowledge 'Provider Fatigue' or 'Compassion Fatigue' as a legitimate experience.

THIS IS WHY SELF-CARE IS SO IMORTANT! FIRST RESPONDERS must be sure to make time to manage stress, to 'de-compress.'

In fact, based on research out of the Cleveland Clinic's Center for Integrative Medicine (https://www.npr.org/2010/12/06/131734718/just-breathe-body-has-a-built-in-stress-reliever), simply BREATHING is a proven stress reliever, and can have a profound impact on our physiology and our health. Slow, deep breathing actually creates a relaxation response.

So before we move on to our education, let's take a few minutes to get centered with deep breaths…

- Invite the group to place both feet flat on the ground; close their eyes.

- Lead group through a few slow deep breaths; As a group – let's take a moment to take 3 – 4 very deep breaths. Let's breathe IN … counting to you yourself for four seconds; and then SLOWLY BREATH OUT for 8 seconds.
- Release the tension in your shoulders; roll your head a bit, slacken you jaw;

…. And let's get started.

(Do this with the group – and lead them through four deep slow breaths, encouraging them to release the tension in their shoulders…. Maybe roll their head a bit, slacken your jaw….)

**Note: this brief 'centering' replaces the full, guided meditation in original Instructor training.*

Substance Use Disorder is a CHRONIC DISEASE

- Addiction – also referred to as substance use disorder – ***is a chronic disease of the brain.*** and treated successfully.
- It is a disease that can be treated – and treated successfully

KEY POINTS:

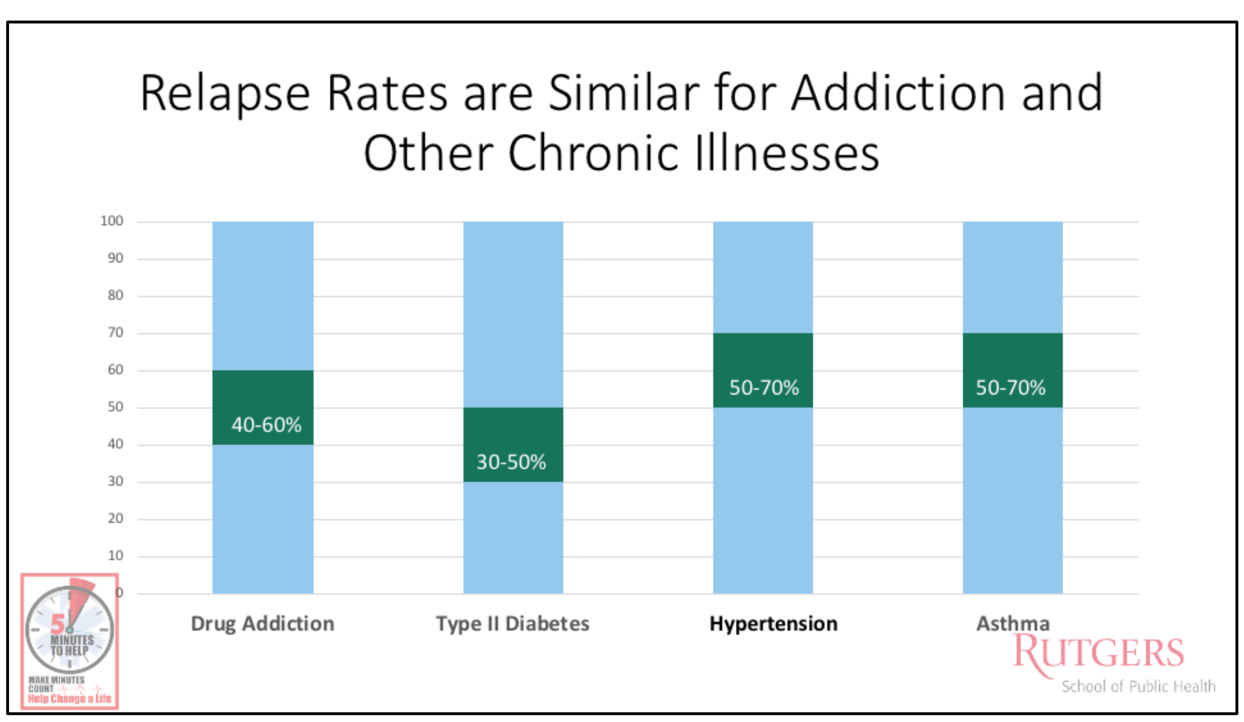
Understanding that addiction is a chronic disease that IS treatable

Substance Use Disorder is a CHRONIC DISEASE

- No one chooses to develop this disease!
- Instead, a combination of genetic predisposition and environmental influences – similar to other chronic diseases like diabetes and hypertension – can result in physical changes to the brain's circuitry, which lead to *tolerance, cravings, and the characteristic compulsive and destructive behaviors of addiction that are such a large public health burden for our nation.*

KEY POINTS:

Understanding that addiction is a chronic disease that IS treatable



Key Points:

Our goal is to remove the stigma / victim-blaming associated with substance use.

Note that EMTs must all be on the same page with this! (Note Handout: https://addiction.surgeongeneral.gov/sites/default/files/fact-sheet-healthcare.pdf

This slides show the relapse in addictions are similar to chronic diseases. Illnesses can be managed, but its not always consistently; There are highs and lows, and ups and downs. It's NOT about willpower.

Note:

1 –It's not always the fault of the person as much as the consequence of the disease (ie meds not working anymore)

2 - Sometimes in spite of managing disease / stopping use of a particular substance, someone can still die from the disease (Think: Tobacco - lung

cancer, even if quit smoking; Alcohol use - liver failure). Sometimes diseases can be treated, but the effects or impact is not arrested.

3 - Quality of Life issues: In spite of damage that may have been done, quality of life CAN STILL IMPROVE upon receiving treatment / stopping the behavior.

Pause here and get thoughts from attendees. If there is strong resistance, you MAY need to ask people to 'suspend that belief' for now. This is a challenge - acknowledge the frustrations; those beliefs really must be suspended in order to execute this model of intervention / engagement. How do you feel about this information? Must get audience on the same page.

THIS IS AN INSTRUCTOR-FACILITATED ACTIVITY.
8 - 10 minutes

KEY POINTS:
This activity is about value judgement vs. Moral failing… -- to help you understand where audience is coming from.

Park Bench Scenario

Facilitator: Describe this scenario for the students:
Walking through the park, you notice a person laying on a park bench. You notice they are breathing normally. On the ground just beyond their outstretched hand is a bag with a bottle partially exposed. The bottle appears to be a pint liquor bottle.

Ask Students to:
1. Write down your immediate reaction and feelings about the situation.
2. What are your feelings about the person?

3. What are your feelings about what you believe they have done?
(You can ask students to put thoughts in the chat box; or write them down – and then ask them to share)

Hear from a few people – and then move on:

Facilitator: Describe this scenario for the students:
This time picture a different scenario.
As you walk through a park you notice a person lying on the bench. You notice they are breathing rhythmically and not showing any signs of distress. However, you notice a drop of blood running down their outstretched arm and a syringe laying on the ground just beyond their open hand.

1. Write down your immediate feelings about the situation.
2. What are your feelings about the person?
3. What are your feelings about what you believe they have done?

(You can ask students to put thoughts in the chat box; write them down – and then ask them to share)

Reflections
Facilitator: Ask the students to share…:
What did you notice about your perceptions??
What did you feel?
Was there a difference between the way you felt about the person who had been drinking versus the person who had injected some type of drug?
Would your feelings change if they were male or female?
Would your feelings change depending on how they were dressed?
Would the surroundings make a difference?

*****Remember that what you see is not the whole story*****

Key Notes
This is an Instructor-facilitated activity.
8 – 10 minutes

Another reminder of using language that does not further stigmatize, and that ***we all need to remove these terms from our own vocabulary.*** This is an important activity for the purpose of examining bias. Important to spend time to address the biases audience members may have. Must be aware of the fact that there are people in the room with different points of view - in this exercise, you are looking for *introspection*.

Note that this exercise can feel uncomfortable – and that's ok.

Steps:

- Ask participants to call out – or write in the chat box - terms that are sometimes used to describe individuals with Substance Use Disorder. These may be terms like 'addict', 'user', 'frequent flyer', etc.; terms may also include *characteristics or traits* such as 'manipulative.' All are acceptable.

- List all terms as they are called out, without discussion. (If co-facilitator wants

to use chat feature to list in online platform – great – otherwise, just discussing is fine)

After all terms are added, ask the group: "Is this list true? Is everything on this list true of ALL PEOPLE in that group? Not true?" Are these terms generally negative? How many of these are positive?? If there are no positives… Perhaps you can say "Can you think of someone you know personally with SUD? Can you think of something positive about them?"

How can we reverse some of this prejudice / transition use of the term "addicts" to 'those who use substances / substance user?"

*****Are any of the terms perceived as negative that can also be an indicator of a strength?*****

Individuals with Addiction Need Support - Not Stigma

Junkie. Stoner. Crackhead. Addicts. Alkie.

- These words are dismissive and disdainful
- We need to change the national discussion
- Individuals with substance use disorders ***are people who need help***

- Such terms DE-HUMANIZE individuals; Instead, we need ***PERSON-FIRST LANGUAGE***

AMA Task Force to Reduce Opioid Abuse | December 15, 2015

RUTGERS School of Public Health

KEY POINTS:

We all know these terms; "Addicts" are sick people needing help to get well; Not about "Bad people getting good"; the focus is on the disease not on the person's will power / moral character. "Frequent Flyer" is another common term that is often used….

These terms reflect a moral judgment that is a relic of old thinking when our understanding of addiction was limited, when many thought that addiction was some sort of moral failing and should be a source of shame.

We all need to remove these terms from our own vocabulary.

Stress that these terms also work to 'de-humanize' individuals – and that instead, we need to use person-first language.

Reducing Stigma by using Person-First Language

Great Resource: Addictionary

https://www.recoveryanswers.org/addiction-ary/

WORDS TO AVOID	WORDS TO USE
Addict	**Person w/ a substance use disorder**
Alcoholic	**Person with alcohol use disorder**
Drug Problem / Drug Habit	**Substance use disorder**
Drug Abuse / Abuser	**Drug misuse, harmful use**
Drug Abuser	**Person w/ a substance use disorder**
Clean	**Abstinent, not actively using**
Dirty	**Actively using**
A clean drug screen	**Testing negative for substance use**
A dirty drug screen	**Testing positive for substance use**
Former / Reformed addict / alcoholic	**Person in recovery, person in long-term recovery**
Opioid replacement, methadone maintenance	**Medication-Assisted Treatment (MAT) / Medication-Assisted Recovery**

This is another reminder of using language that does not further stigmatize, and that ***we all need to remove these terms from our own vocabulary!***

******NOTE: This is language that should be used by professionals – THIS IS NOT trying to change the language of substance users themselves.***

WHEN DISCUSSING ADDICTIONS….

Remember that language is powerful – especially when talking about addictions.

Stigmatizing language perpetuates negative perceptions.

Using **‘Person first’** language focuses on the person, not the disorder.

Point out the resource on the slide for more examples: https://www.recoveryanswers.org/addiction-ary/

How do we get more substance-abusing people into treatment?

- The "treatment gap" is massive—that is, among those who need treatment for a substance use disorder, few receive it.
- Only about **10 percent** of people with a substance use disorder receive any type of specialty treatment
- Further, over 40 percent of people with a substance use disorder also have a mental health condition, yet fewer than half (48.0 percent) receive treatment for either disorder
- Of the 20.8 million people with a substance use disorder in 2015, 15.7 million needed treatment for an alcohol problem and nearly 7.7 million needed treatment for an illicit drug problem.

**2015 Data - Center for Behavioral Health Statistics and Quality. (2016) - http://www.samhsa.gov/data/

KEY POINTS:

1- We fully recognize that direct referral to 'Treatment' may very likely NOT occur at the point of revival; that is not the only measure of success

2 - No single treatment is right for everyone!

3 - Draw audience attention to the two handouts: Fact-sheet-healthcare and Drug Facts- Treatment Approaches

Everyone can play a part in reducing the gap between using and treatment – this is reinforcing that EMS responders do not / cannot bear the full burden; but we are reinforcing that you are playing a critical role.

Trainer should be familiar with varied components / variations of treatment; This is only a high-level overview; trainer should read each handout thoroughly in advance, to be best prepared to deliver this information!

https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

Drug addiction can be treated – but it's not simple

Addiction treatment must help the person do the following:

- Stop using drugs – *or reduce the frequency*
- Stay drug-free – *or reduce the risk of harm*
- Be productive in the family, at work, and in society

KEY POINTS:

So, let's speak briefly about treatment. Drug addiction can be treated, but it is definitely not simple

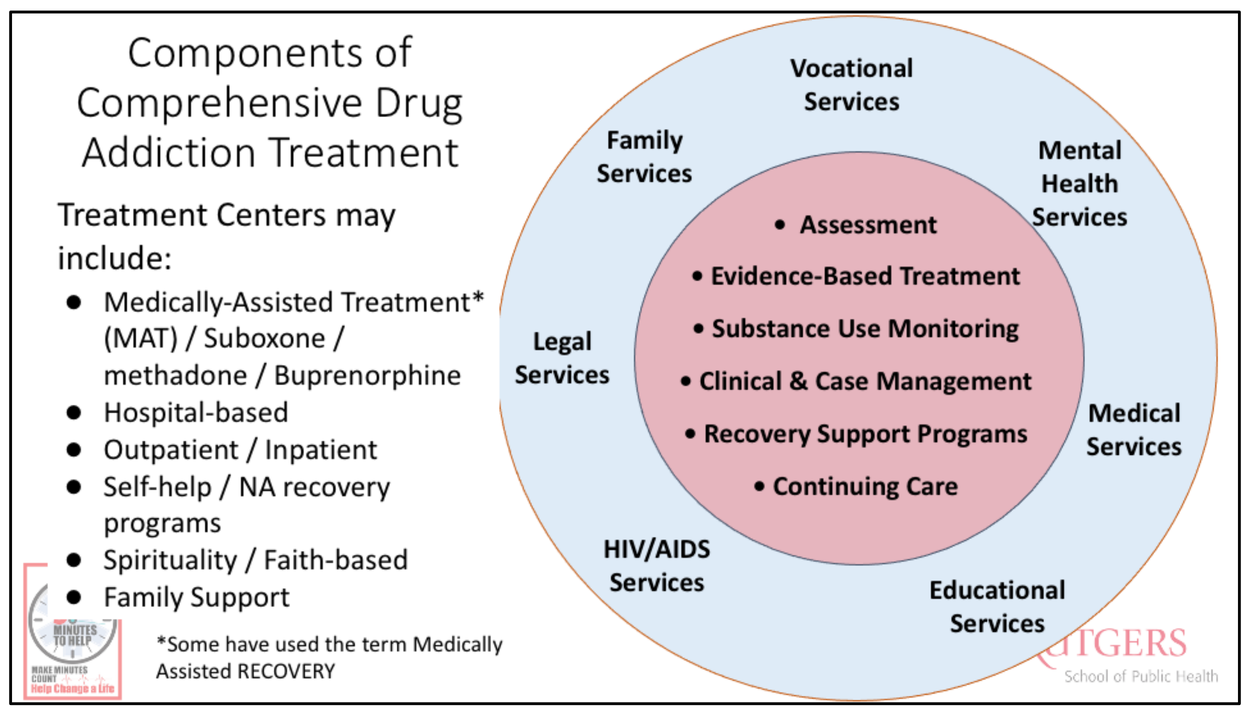
Note:

1- We fully recognize that direct referral to 'Treatment' may not occur at the point of revival; that is not the only measure of success (reinforce this routinely)

2 - No single treatment is right for everyone!

3 - Draw audience attention to the two handouts: Fact-sheet-healthcare and Drug Facts- Treatment Approaches - encourage them to read these.

Everyone can play a part in reducing the gap between using and treatment; EMS workers do not / cannot bear the full burden! However, EMS responders CAN PLAY A CRITICAL ROLE - if only to nudge someone just a small step.



Key Points:

The main point here is that the best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient; no single approach works for every individual.

Again, please be sure to have reviewed materials – you do not need to be an expert in the varied approaches, but stress that there ARE MANY VARIED APPROACHES, and a combination of theses different approaches may work best.

Harm Reduction

Key Principles

- A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.
- A movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

- *Reduces risks for INDIVIDUALS developing diseases like HIV, Hepatitis B and C*
- *Reduces risks for RESPONDERS from needle sticks that may cause infection*
- *Reduces community spread of disease*
- *CONNECTS individual / families to healthcare and social supports*

5 MINUTES TO HELP
MAKE MINUTES COUNT Help Change a Life

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Key Points:
Additional Resource: https://harmreduction.org/
Learn more about Safe Syringe Programs (SSPs) at https://www.cdc.gov/ssp/index.html)

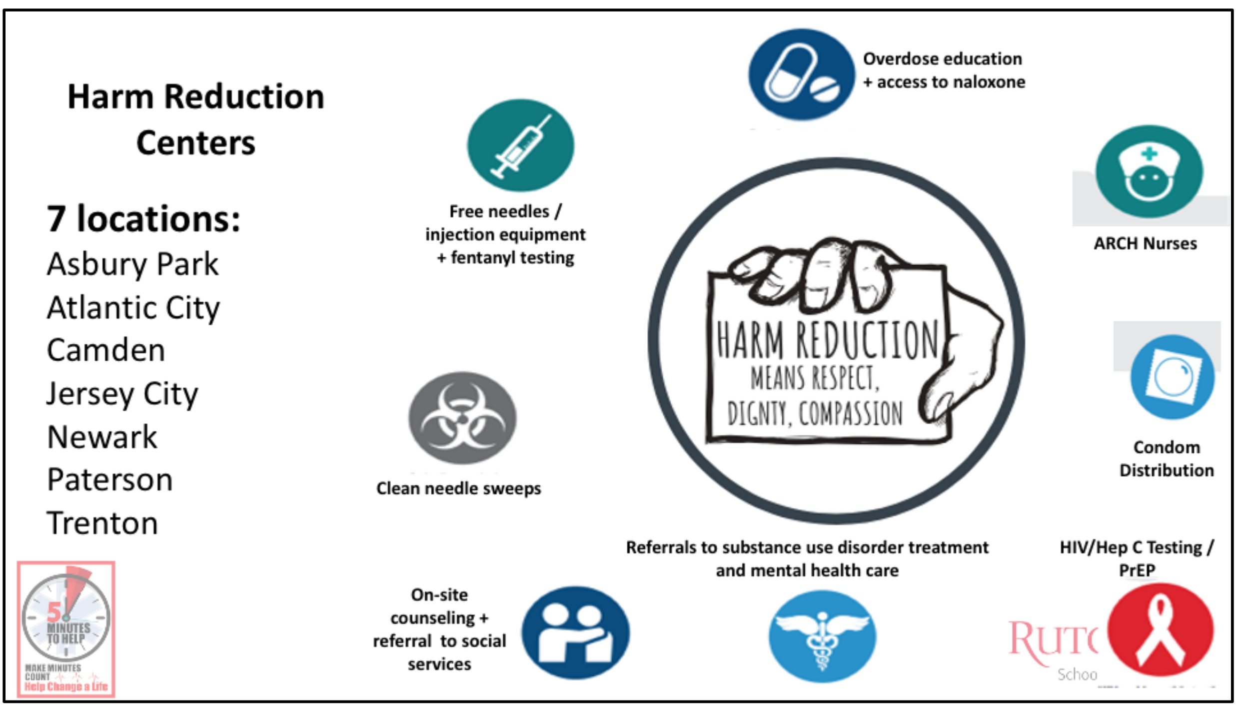
For some individuals, this may be the first step in early efforts to change – simply reducing harm. With support, this can be the beginning of process that may lead to abstinence.

For some, the concept of "harm reduction" is controversial, despite overwhelming national evidence that shows the benefits. We are not here to 'promote' harm reduction, per se, but to explain what it is.

The New Jersey State Health Department is committed to offering 'Harm Reduction' services throughout the state - and they continue to seek opportunities to provide more.

Here are some examples –
Needle exchange

Methadone clinics
Not driving while high
Designated drivers
Safe Injection Sites (also known as Syringe Service Programs, or SSPs). Fentanyl strips



Key Points:

The New Jersey State Department of Health is committed to offering ‘Harm Reduction’ services throughout the state - and they continue to seek opportunities to provide more.

The important piece in these is that not only are the intended to PREVENT the ‘worst possible outcomes’ -- they include trained substance use professionals, peer navigators, social service providers -- available to help encourage the individual to explore more help.

By you becoming a little more aware of these centers, you are a better able to suggest them to the individual as another available resource.

*** Should you need to ‘convince’ other first responders that HARM REDUCTION is worth the effort, here are some reasons:

- Protects the individual from disease (sharing needles leads to HIV / Hepatitis B or C)
- Protects RESPONDERS from needle sticks that may cause infection

- Protects COMMUNITIES from spread of disease
- CONNECTS person to healthcare and social supports

Harm Reduction Resources

https://harmreduction.org/

https://njharmreduction.org/

https://americanaddictioncenters.org/harm-reduction

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Resources – attendees should be encouraged to learn about these in their communities – so they can make referrals

Harm Reduction Resources
https://harmreduction.org/

https://njharmreduction.org/

https://americanaddictioncenters.org/harm-reduction

KEY POINTS:
When offering this course remotely, facilitate this discussion as a group.
'Who here has tried to lose weight?' 'Who has tried to give up sugar?' , etc….
If no one starts, be prepared to share a personal example)

What Have you Tried to Change?
The overall goal of this facilitated group discussion is to help participants consider the challenges of making behavior changes in their own personal lives. Point out how some changes are routine or mandatory, other changes require much more significant thoughts and actions.

STEPS:

Ask participants to describe something they tried to change. This may include diet / smoking / job change, etc. Be sure to describe what the change was, what you did, what were the challenges, how did you change?

Ask the audience to share: (Not necessarily specific details of the specific change, but rather the PROCESS OF CHANGE).

<u>Some discussion questions</u>:

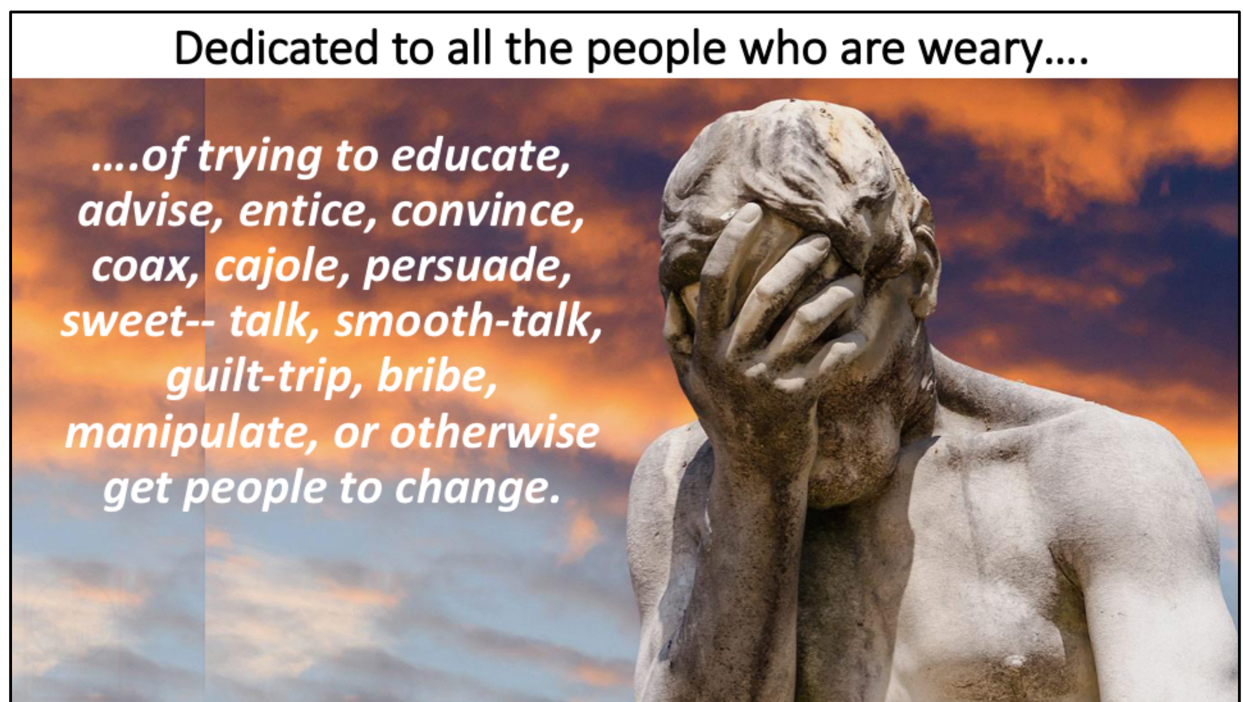
After a few have shared some experiences, ask:

Can anyone here relate to these challenges? Frustrations?

Was the change easy to make or difficult? Did it take a few attempts to be successful? Did you ever slip-up or miss your goal?

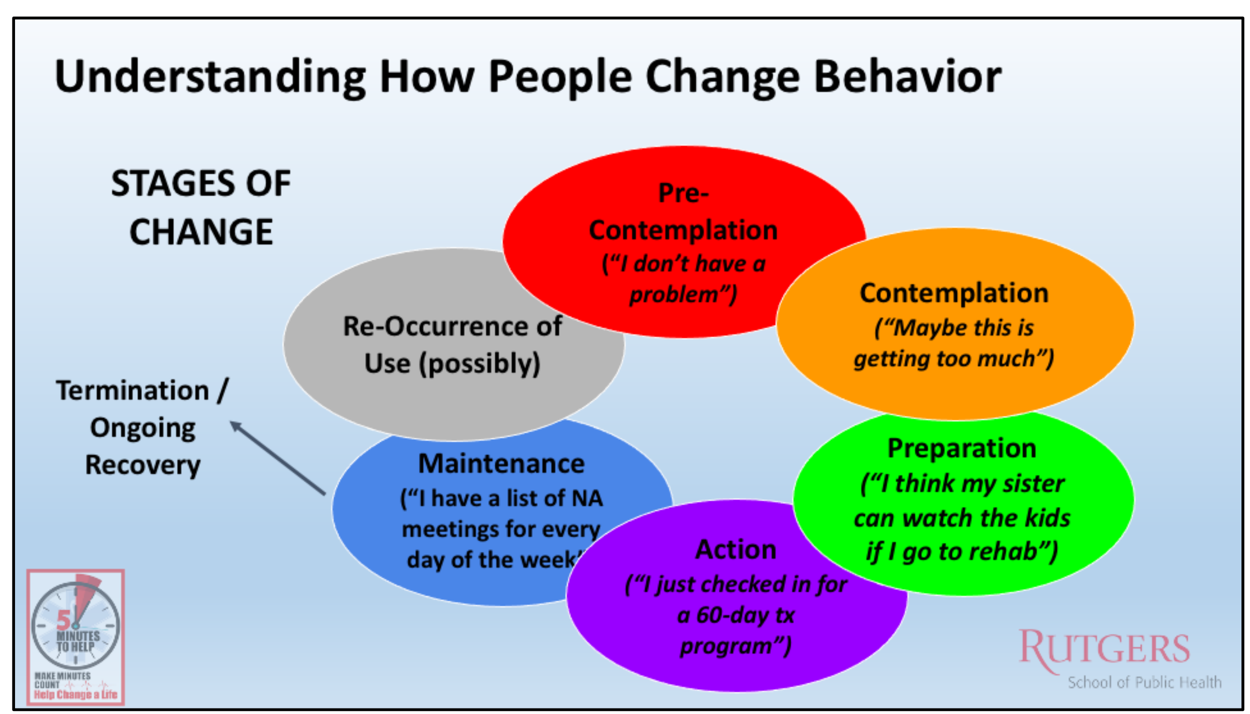
GOAL: Trying to get at the **<u>process</u>** individuals went through to make the change – not the specifics of the change. The idea here is to reflect that behavior change is NOT EASY FOR ANYONE – it takes 'preparation' / sometimes many attempts – sometimes we make our goals and sometimes we don't….Change can be difficult.

THIS **<u>PROCESS</u>** OF CHANGING BEHAVIOR IS NORMAL and TYPICAL.



<u>Key Points:</u>
(Let group read the slide to themselves)

- These efforts rarely get people to change!
- All are well-intentioned, but change must come from within
- **Possibly tie this into to some earlier comments / frustrations.**



KEY POINTS: (COL ANIMATE)

General statement:
Before we make a change we need to think about what the change will be!
Next we need to prepare for the change.
The better we prepare the easier it will be to take action.
After the initial change we need to continue to apply effort to maintain the change.

We may not always be successful, but we can learn more about what we need to be better prepared for the next time.

So the focus here is not so much the definitions of each stage, but rather to acknowledge this 'universal concept' that there are ***stages we go through*** during the process of making a change. (NOTE: The changes are described below for your information and understanding - see handout also.)

THE GOAL OF THE first responder Is to meet the individual ***WHERE THEY ARE***, recognizing that this brief interaction may only result in someone being open to receiving resources.

It is NOT necessarily what the EMS worker wants them to do!! This is NOT about ***responders providing treatment***.

We generally note that there are in fact five stages of change:

1. **Precontemplation**
   People in this stage are not thinking seriously about changing and tend to defend their current AOD use patterns. May not see their use as a problem. The positives or benefits, of the behavior outweigh any costs or adverse consequences so they are happy to continue using.
2. **Contemplation**
   People in this stage are able to consider the possibility of quitting or reducing AOD use but feel ambivalent about taking the next step. On the one hand AOD use is enjoyable, exciting and a pleasurable activity. On the other hand, they are starting to experience some adverse consequences (which may include personal, psychological, physical, legal, social or family problems).
3. **Preparation**
   Have usually made a recent attempt to change using behavior in the last year. Sees the 'cons' of continuing as outweighing the 'pros' and they are less ambivalent about taking the next step. They are usually taking some small steps towards changing behavior. They believe that change is necessary and that the time for change is imminent. Equally, some people at this stage decide not to do anything about their behavior.
4. **Action**
   Actively involved in taking steps to change their using behavior and making great steps towards significant change. Ambivalence is still very likely at this stage. May try several different techniques and are also at greatest risk of relapse.
5. **Maintenance**
   Able to successfully avoid any temptations to return to using behavior. Have learned to anticipate and handle temptations to use and are able to employ new ways of coping. Can have a temporary slip, but don't tend to see this as failure.

Relapse

During this change process, most people will experience **relapse**. Relapses can be important for learning and helping the person to become stronger in their resolve to change. Alternatively relapses can be a trigger for giving up in the quest for change. The key to recovering from a relapse is to review the quit attempt up to that point, identify personal strengths and weaknesses, and develop a plan to resolve those weaknesses to solve similar problems the next time they occur.

Relapse is a factor in the action or maintenance stages. Many people who change their behavior decide for a number of reasons to resume their drug use or return to old patterns of behavior. Research clearly shows that relapse is the rule rather than the exception.

Motivational Strategies

Fear-Based ⟷	Goal-Based
Extrinsic	Intrinsic
Short Term	Long Term
Power is External	Empowering
Disempowering	Self-sustaining

Think of goal-based motivation as 'doing the work from the inside out'

KEY POINTS: 8-10 minutes

Everyone is motivated by something. Sometimes It's fear and other times it's a goal. Individuals with limited experience of success may find themselves **predominantly fear-motivated.**

FEAR-BASED Motivation:

-Tends to be governed by external forces, which might mean that when the pressure is off, their motivation lessens / wanes.

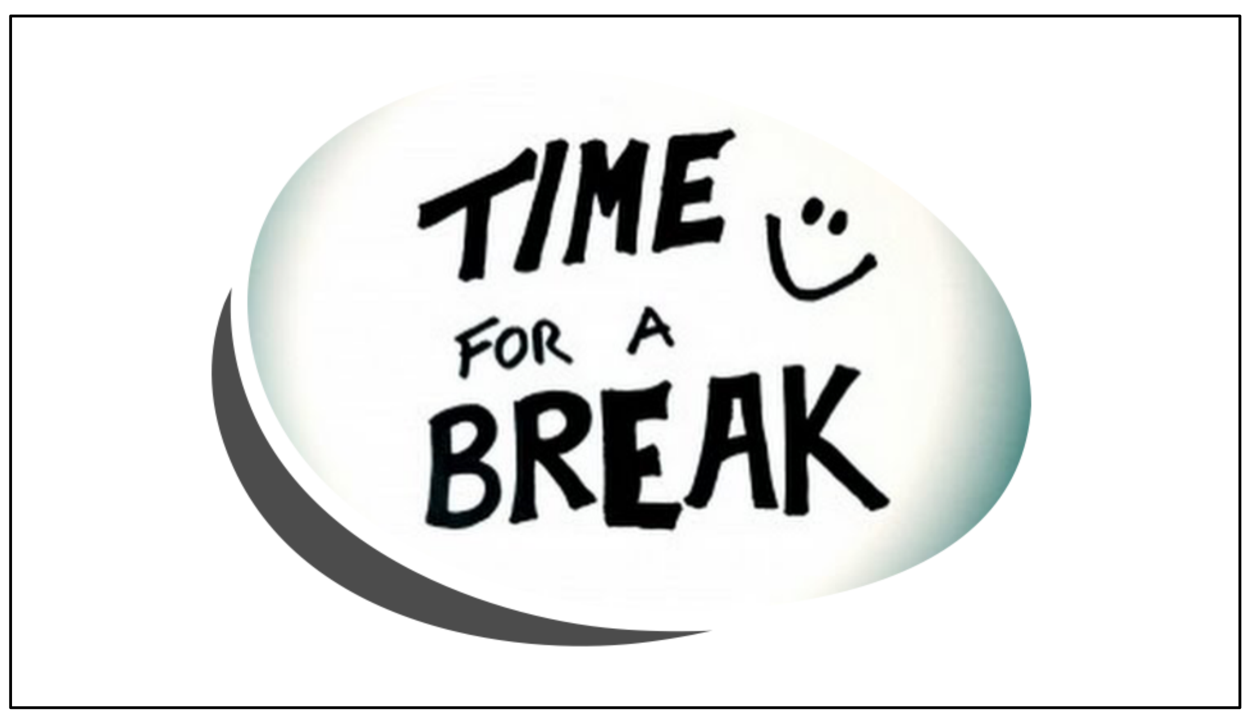
- As a result, fear-based motivation is short-lived. Since something ***outside of*** the individual is the source of their motivation, the power the motivation is also external.
- This can rob the individual ***of their personal power*** and can lead to learned helplessness and disempowerment, which can be a self-fulfilling condition.

GOAL-BASED Motivation

-Generally built overtime and learned from cumulative successes.

- As an individual begins to recognize that their actions can have benefits, they learn that they have the power to change their condition.
- This self-mastery, or actualization provides insights, ***which the individual then***

owns.
- Because their motivation is self-derived, the duration tends to be long-term.
- With each success the individual is empowered to make more change.
-This continually extending perspective lends itself to self-fulfilling accomplishments reinforcing goal achievement.



Instructors: Prepare for Roleplays!

NOW IS THE TIME to get your breakout rooms ready!! Divide group into approx. 5 per breakout room. Be sure each room as one instructor (if you have enough trained facilitators to assist, place one in each breakout room)

Ask participants are coming back and getting settled …

In a minute, I am going to show you a video – it's about three minutes long– that highlights the <u>differences</u> between SYMPATHY and EMPATHY.

As we begin our discussions around how we can try to engage with someone who has been revived after an overdose and the motivational interviewing techniques you can use, it is important to keep in mind the importance **of being EMPATHIC**

In fact, when we discuss Motivational Interviewing in a few minutes, you'll see that 'EXPRESSING EMPATHY" is actually a 'Guiding Principle' of motivational interviewing.

But understanding exactly what it means to be empathetic may not always be clear – so let's take a look at what empathy really means…..

KEY POINTS:

- Recognize that this is NOT necessarily how first responders see themselves
- With 'Five-Minutes-to-Help', our intent is to '***help move the needle***' - to get someone just a little bit closer ..to considering... to thinking about … seeking help.
- SO HOW DO WE DO THIS, in such a challenging situation, with only a very brief window of opportunity? That's what we will be addressing for the rest of the class.

Sympathy vs. Empathy

https://brenebrown.com/videos/rsa-short-empathy/

Brene Brown video:
https://brenebrown.com/videos/rsa-short-empathy/

IMPORTANT: If the participants in your course CANNOT HEAR THE VIDEO, Stop sharing slides; and then “Re-share” being certain you click ‘Share Computer audio’ – this will allow them to hear the sound in video.

Remember that others ‘on the scene’ may also need this support….

KEY POINTS HERE:
NOTICE how the bear “Came Down to the same level” as the fox – THIS IS EMPATHY …. And a critical aspect to start building rapport.

NOTICE HOW THE DEER ‘Stayed above it all’ –and did not truly come down to the fox’s level …. Notice the 10-foot pole to “Silver-line” the situation …… THAT IS NOT EMPATHY.

- Try to go to person's eye level or below
- Once lucid, ask permission before entering their personal space
- Use her or his name, if possible
- Unless agitated, join person's verbal tone and pace
- Lead in slow deep breathing for someone who is anxious
- Unless agitated, join person in her or his emotional "state"

KEY POINTS:

- This is almost the "Rapport before the rapport"
- Recognize and convey the 'likely state of mind' of an individual who has just been revived. They are agitated, angry, in shock, disoriented, possibly combative; Most of you have witnessed this.
- The 'usual' ways in which you may typically try to develop rapport with someone will most likely NOT be enough in this scenario -- A more ACTIVE, INTENTIONAL approach to establishing a rapport IS CRITICAL
- Let's explore some key actions you can take .....
- Remember this rapid rapport MAY ALSO NEED TO BE DEVELOPED with the family member / friend who is also present....

What is Motivational Interviewing (MI)?

- General approaches to facilitate change
- Communication style to build rapport
- Not based on one scientific theory
- Blending of techniques from other theories
- Avoids labeling patients

KEY POINTS:
RESOURCE: https://www.communitycarenc.org/media/files/mi-guide.pdf

General Reminders:
We must note here that MI is most typically used in 'calmer environments' - office settings, doctor's offices, etc… But that does NOT mean it can't be applied here. The 'big picture' purpose for this effort to attempt to foster dialogue and engagement with the revived individual. The more you can engage, the better the chance of 'moving the needle' - and encouraging the person to consider seeking assistance.

The goal of MI is to express unconditional positive regard and empathy so that we can understand why clients want to address their problem(s). *Note that the hardest part of using MI is trying not to solve the patient's problems. In your traditional EMS role, problem solving was a critically important skill. The practice of MI is built on the understanding that the patient is the only expert on their life. They are the only ones who can decide whether their quality of life (e.g., free from addiction) is more important than the high experienced with opioid use). They are the only ones who can choose which healthy behaviors to adopt or ignore. Our role is not to encourage them to do what we think is best but to help them make the best decision given their*

priorities in life.

MI is based on the premise that the ideas most likely to succeed are those generated by the individual. Drawing out ideas from the patient is a different skill and role for EMS providers, who are used to being problem solvers and 'fixers'. Nonetheless, the practice of MI recognizes that the patient is most likely to try and maintain solutions they generate themselves.

Motivational interviewing is based on a series of principles that emphasize **a collaborative relationship** in which the autonomy of the patient is respected and his / her intrinsic resources for change are drawn out. With MI, YOU ARE A FACILITATOR rather than an expert, who adopts a non-confrontational approach to guide the patient toward change. The use of MI strategies in the absence of the spirit of MI is ineffective.

That assistance may ONLY be taking brochure with a few phone numbers. (After the 3rd revival ….); it may ONLY be saying "OK, you can give it to my family member/ friend (whomever is there with the person); but we have to attempt.

EMS responders are literally the most front line contact (or police, of course)

- Motivational Interviewing can help to influence/ encourage progression through the stages of change that we described earlier
- There are a number of components to it, which we will review - and then practice!

What is Motivational Interviewing (MI)?

MI recognizes that:

- The ideas most likely to succeed are <u>those generated by the individual.</u>
- Applies principles that emphasize <u>a collaborative relationship</u>
- Can help to influence/ encourage progression through the stages of change

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KEY POINTS:

MI is based on the premise that the ideas most likely to succeed are <u>those generated by the individual.</u> Drawing out ideas from the patient is a different skill and role for EMS providers, who are used to being problem solvers and 'fixers'. Nonetheless, the practice of MI recognizes that the patient is most likely to try and maintain solutions they generate themselves.

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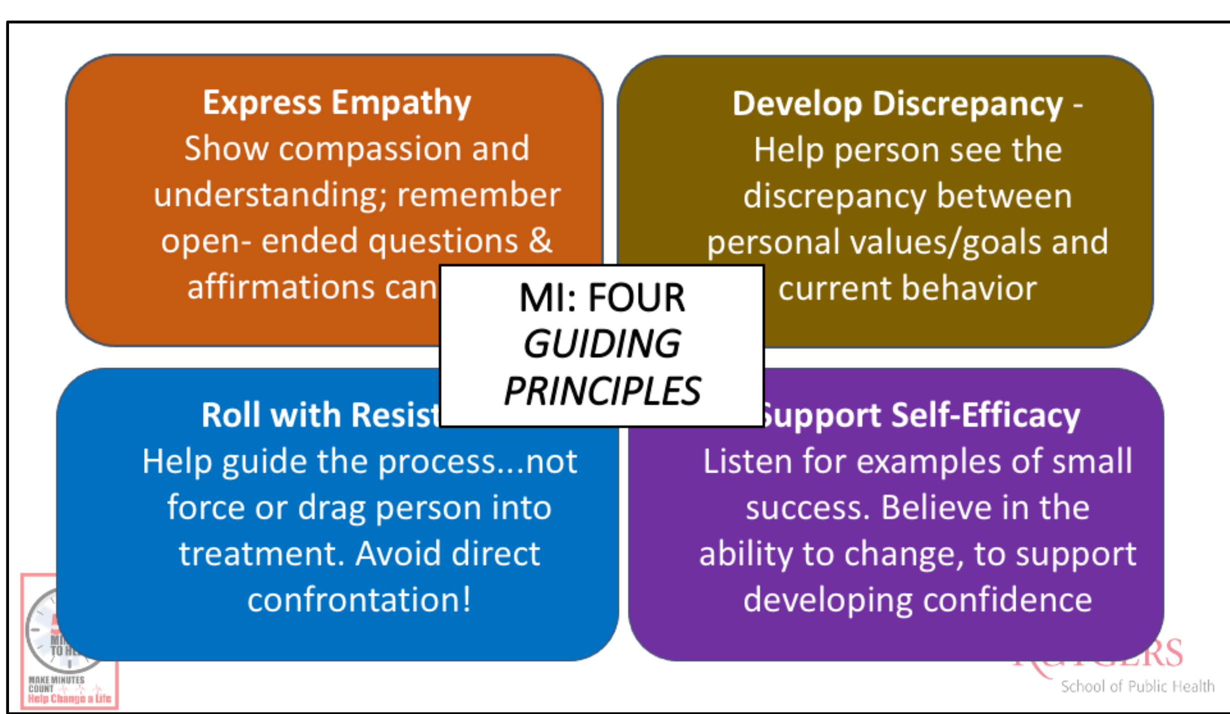
- Motivational Interviewing can help to influence/ encourage progression through the stages of change that we described earlier
- There are a number of components to it, which we will review - and then practice!

LET"S LOOK AT THE 'OVERARCHING" GUIDING PRINCIPLES



KEY POINTS:

We are going to be sharing a lot of information to absorb in a very short day of training. But there are some 'guiding principles' that you will see / hear throughout the day-- and it may be helpful to keep them in mind. Here are a four 'Guiding Principles' to keep in mind throughout the process, and you will see us model them along the way (they might even work with your kids :-)). ***Note that these principles are applied throughout your interaction – they are not necessarily 'steps' to be done in order!***

Specific Resource:
https://www.ncbi.nlm.nih.gov/books/NBK64964/?report=printable

Express Empathy

Empathy is a specific and learnable skill for understanding what the person is trying to convey, mostly through the use of reflective listening. But it means you must pay close attention to what the person is saying - and try to understand the 'underlying' meaning … Empathy communicates respect for and acceptance of clients and their feelings; it encourages a nonjudgmental, **collaborative** relationship; and allows you to be a supportive and knowledgeable partner.

Develop Discrepancy

Motivation for change increases when clients perceive discrepancies between their current situation and their hopes for the future. Your task is to help focus your client's attention on how current behavior DIFFERS from ideal or desired behavior. Discrepancy is initially highlighted by raising your

clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences. Although helping a client perceive discrepancy can be difficult, carefully chosen and strategic reflecting can underscore incongruities.

Separate the behavior from the person and help your client explore how important personal goals (e.g., good health, marital happiness, financial success) are being undermined by current substance use patterns. This requires you to listen carefully to your client's statements about values and connections to community, family, and church. If the client shows concern about the effects of personal behavior, highlight this concern to heighten the client's perception and acknowledgment of discrepancy.

Roll with Resistance

You may occasionally be tempted to argue with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed often results in even more resistance.

If you try to prove a point, the person predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change. When it is the individual, not you, who voices the reasons for change, progress can be made. The goal is to "walk" with clients (i.e., accompany clients through the decision), not "drag" them along (i.e., direct clients' next steps).

Self-Efficacy:

Many people with enduring behaviors that have negative impacts on their health have made their own attempts to change at some time or other and been unsuccessful. They may have attempted to cease smoking and only lasted a week, or tried to lose weight but been unable to sustain a diet. They may have attempted to comply with their medication several times in the past but found it difficult because

of side effects or a complicated dosing regimen.

By highlighting the patient's strengths and reflecting on times in their life when they have successfully changed, even if just in one small area, self efficacy can be promoted. ("it's great that you chose not to drive" … "Great that you attempted rehab last month … that tells me you are trying to change something") YOUR BELIEF in the person's ability to change is a powerful way to promote self efficacy. By promoting self efficacy, you can help the individual develop the confidence that they are capable of change

Motivational Interviewing: Three Techniques

1. OARS

2. Eliciting Change Talk

3. Generating Commitment

KEY POINTS:

Training in MI can take years …. and certainly even providing a basic understanding can take several days of training.

For this particular training, given the reality of potential time constraints on your interactions, we have tried to streamline the focus to a few core techniques. In addition, we have provided background resources.

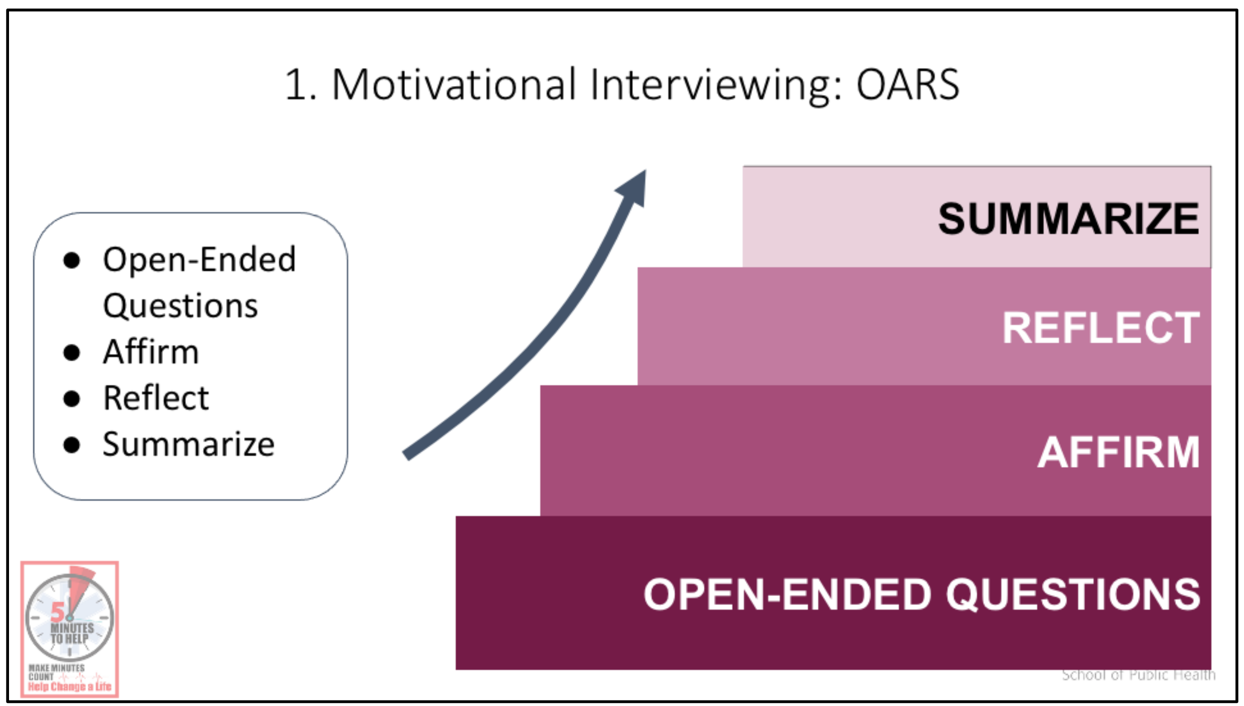
There are three basic techniques that are used in 'MI'.

OARS

Eliciting Change Talk

Generating Commitment

Let's look at each one separately..



KEY POINTS:

Resource: MI Cheat Sheet

- **OARS** includes a set of four basic communication techniques to help accomplish

- TWO IMPORTANT GOALS:
  - Building Rapport and
  - Understanding the issues more fully

- Let's Look at each of those four techniques separately

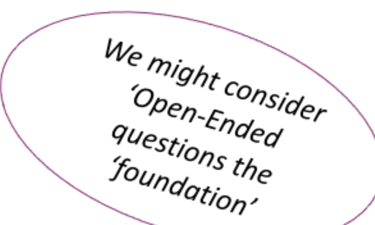
1. Motivational Interviewing: OARS

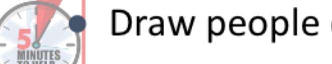
Open-ended questions

- Cannot be answered with yes or no • Are ***NOT*** rhetorical!

They can help you

- Probe widely for information
- Uncover the person's priorities & values
- Avoid 'socially desirable' responses
- Draw people out





KEY POINTS:

General:

OARS is the foundation of Motivational Interviewing….. And asking *Open-ended questions* is the foundation of OARS. So let's say upfront that using open-ended questions...

- ...is not necessarily how we typically speak!
- ...may feel time-consuming and even awkward; but with practice, it can be more efficient because it elicits more reliable and complete information
- ...can be trickier than it first appears!

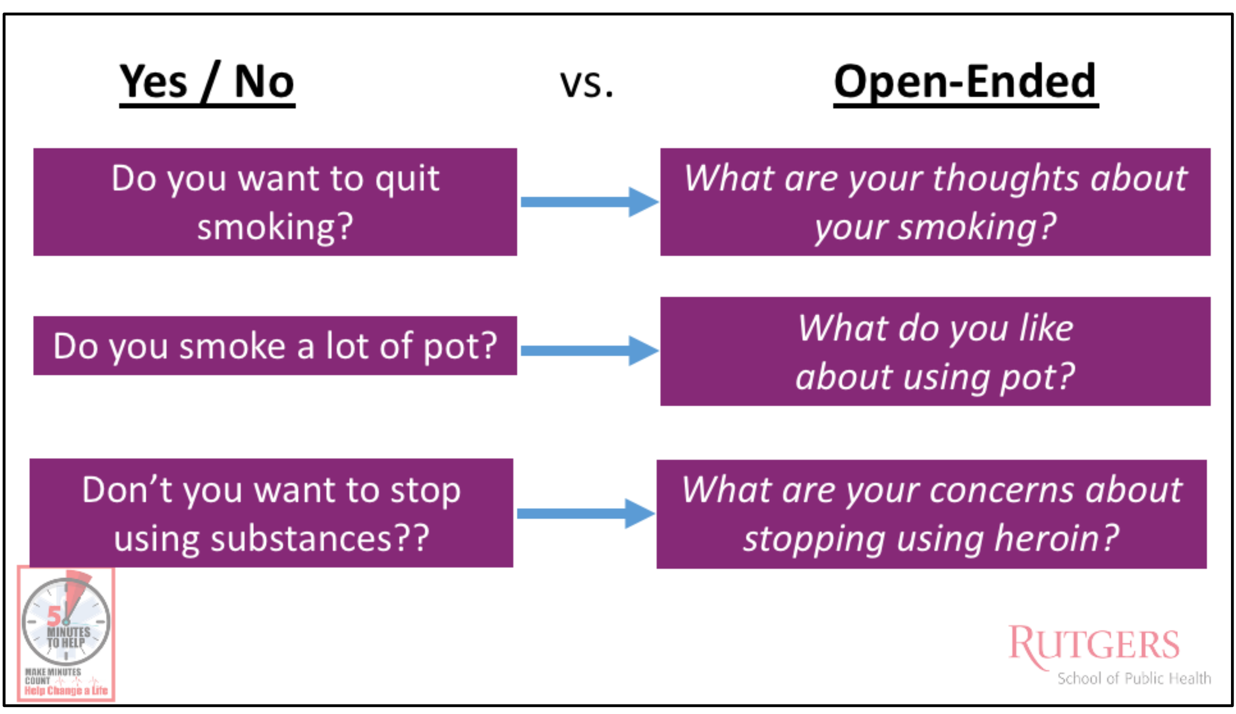
As EMS responders, we tend to ask 'close-ended questions' to quickly collect specific information. We are often 'pressed for time' and concerned about getting into a time-consuming discussion. Motivational Interviewing works to CHANGE THAT.

What we are trying to do is move **AWAY FROM** asking the individual '*Do you want to go to the hospital?*' ….and the only options are 'yes' or 'no'. (More typically 'no').
We are seeking an opportunity to begin to engage with the individual.

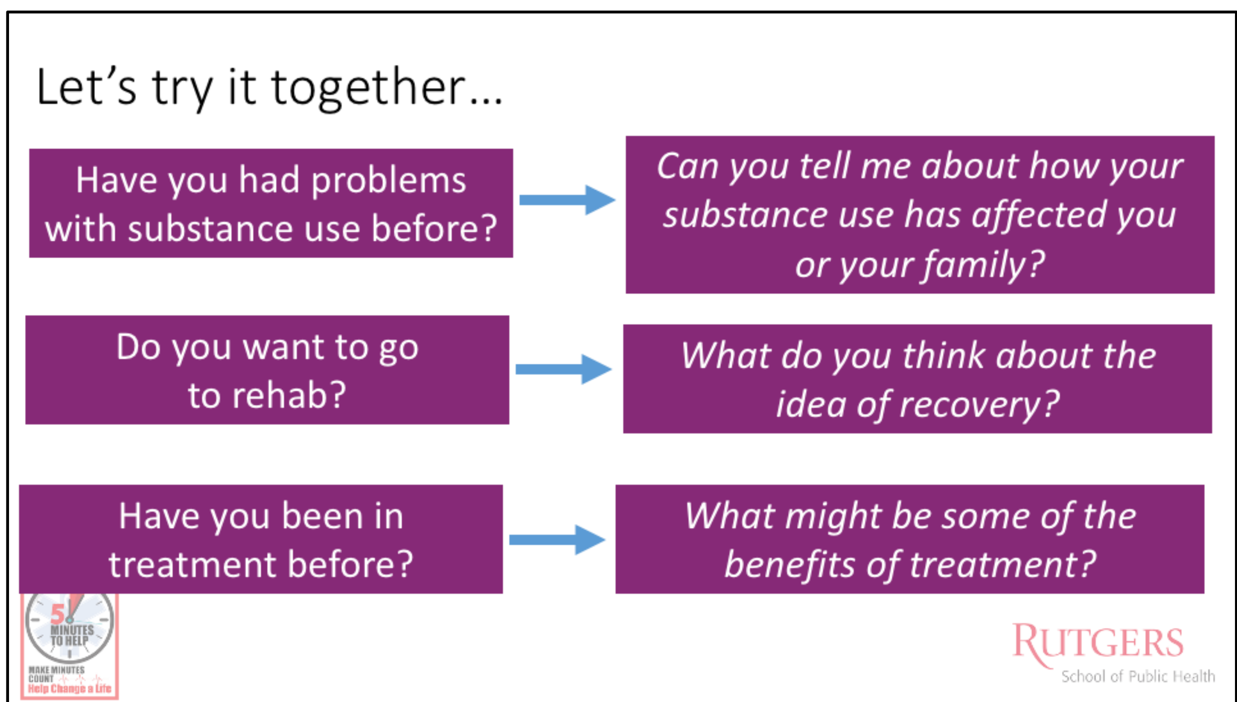
Open-ended questions may seem more time consuming but can actually be more

efficient because they elicit more reliable and complete information and, when skillfully managed, do not have to lead to lengthy discussions.

USE THIS TO LEARN ABOUT THE INDIVIDAL AND SITUATION



Each "Yes/No" version will appear on mouse click – and then the Open-ended version will appear. Use these simple examples to frame the general concept of 'Open-Ended Questions". … (The next slide: Let the group provide suggestions)



Each mouse click will open next 'box.'   First the 'Yes/No' option will appear.

Ask the group for suggestions to re-phrase the Yes/No version to an Open-Ended version.

There are certainly a variety of ways the Yes/No version could be modified to an 'Open-Ended' version.

If you are uncertain, just consider: Can this new version of the Q be answered as a Yes or No? Or does it require some dialogue?

What we are looking for is a way to get the revived individual to start speaking; this will open the door to ***<u>further engagement</u>*** … and the next the next step of OARS – which is ***Affirmation.***

***NOTE: A family member may be present – thus included 'family' in the first question**

1. Motivational Interviewing: OARS

AFFIRMATIONS

- Affirm the person's struggle, achievements, values and feelings
- Emphasize a strength
- Notice and appreciate a positive action, even a small one.

AFFIRM

OPEN-ENDED QUESTIONS

KEY POINTS:

RESOURCE: https://www.communitycarenc.org/media/files/mi-guide.pdf
Affirmations can help the person feel more comfortable, forthcoming and open to feedback. In fact, acknowledging even small efforts / small successes (even if the success was short-lived) can help boost a person's believe in himself -

You may even be the first person they come in contact with who believed in her / was actually listening to him.
Here are a couple of examples of affirming statements….

1. Motivational Interviewing: OARS

Example Affirmations

- *"It takes courage to face such difficult challenges"*
- *"You've quit before; That took a lot of strength"*
- *"I know you didn't expect to talk to me about today, so I think it's great that you're willing to speak with me"*

AFFIRM

OPEN-ENDED QUESTIONS

Read slides … Can ask group for additional examples

1. Motivational Interviewing: OARS

REFLECTIONS (Reflective Listening)

- Communicates that you have listened
- Serves as a 'check' that you correctly understood what was said
- An effective, non-confrontational way to reduce resistance
- Expands on the meaning of what was said

REFLECT

AFFIRM

OPEN-ENDED QUESTIONS

1. Motivational Interviewing: OARS

Example Reflections

- *"I sense you may be feeling…"*
- *"What I'm hearing you saying is…"*
- *"So on the one hand it seems like.. and, yet on the other hand..."*
- *"Let me see if I heard you correctly..."*

REFLECT
AFFIRM
OPEN-ENDED QUESTIONS

Other examples

1. Motivational Interviewing: OARS

SUMMARIZATION

Summarization brings closure and *consensus* to what has been discussed and sets the stage for the next steps

- *"What you've said is important, and I want to be sure I have it right…"*
- *"So, what I think I hear you saying is…"*
- *"Is there anything else you'd like to tell me about this?"*

SUMMARIZE

REFLECT

AFFIRM

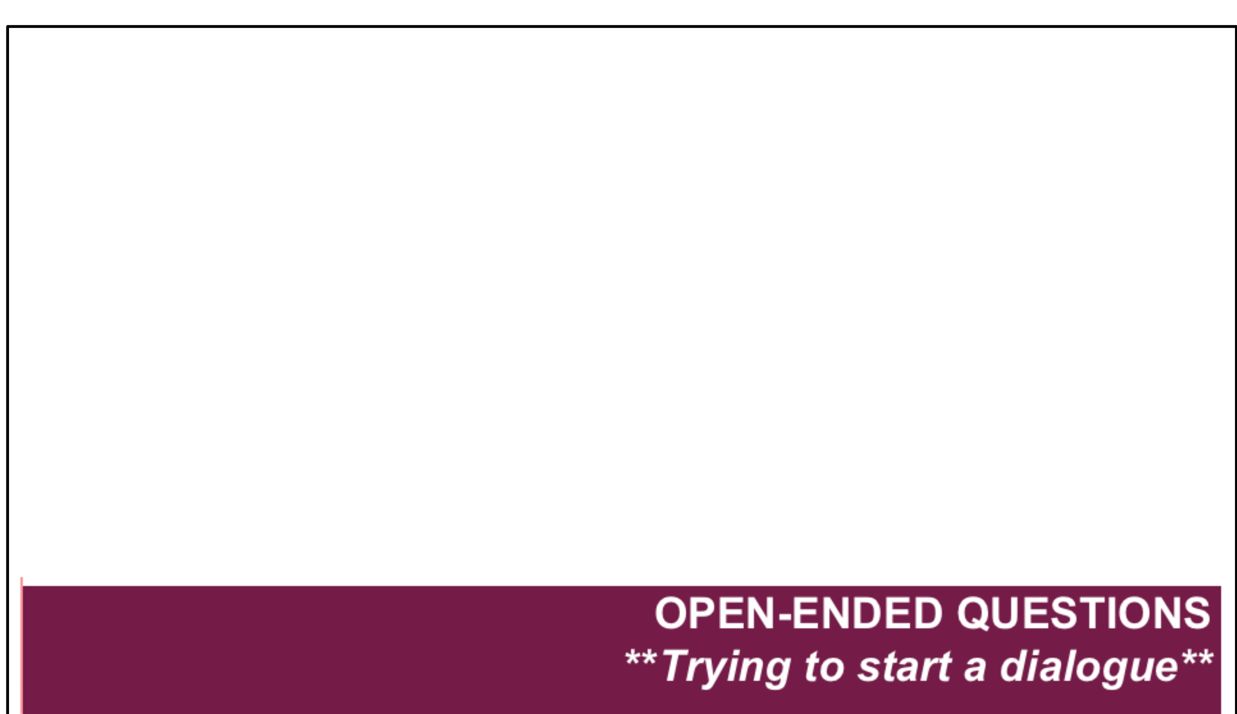
OPEN-ENDED QUESTIONS

Key Points:

Summarization involves acknowledging the key statements / ideas conveyed by the person, to assure your understanding, that you both AGREE on that understanding … so that you can begin to consider 'next steps.'

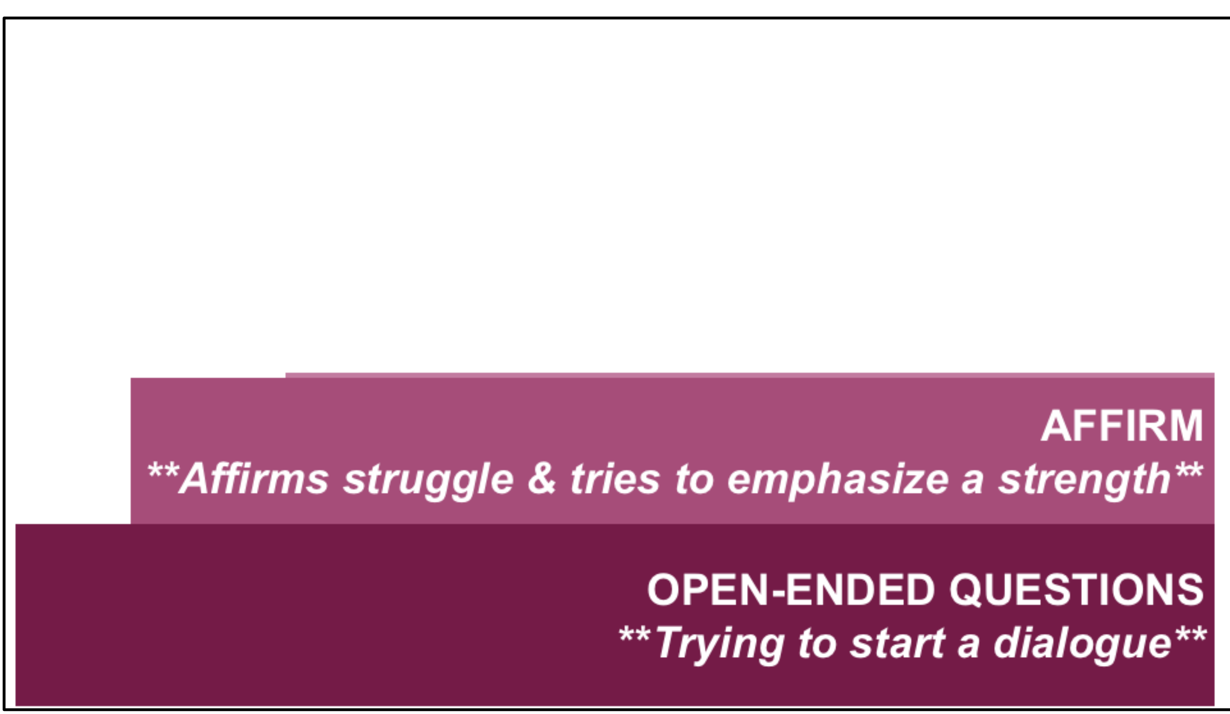
Here are a few examples of 'summarizing statements'...

SO LET'S REVIEW EACH AGAIN….



Key Point:

This is just a brief ‘re-cap’ – convey how open-ended Qs are really just a way to engage with the individual and get them to participate in a dialogue if at all possible



Key Point:

This is just a brief 're-cap' – offers some positive feedback on efforts the individual has made

REFLECT

Shows that you are listening

AFFIRM

Affirms struggle & tries to emphasize a strength

OPEN-ENDED QUESTIONS

Trying to start a dialogue

Key Point:

This is just a brief 're-cap' – its really important that the individual feels you are genuine and really listening to what she / he is saying

SUMMARIZE
Brings consensus to what's been said; sets stage for next step*

REFLECT
Shows that you are listening*

AFFIRM
Affirms struggle & tries to emphasize a strength*

OPEN-ENDED QUESTIONS
Trying to start a dialogue*

<u>Key Point:</u>
This is just a brief 're-cap' – Summarizing gains agreement in what was said – and allows the next steps to begin…

PAUSE HERE TO ASK QUESTIONS OR OFFER A <u>SHORT</u> BREAK / PAUSE – GUAGE YOUR AUDIENCE based on engagement – 2 minutes or less!

2. Motivational Interviewing: Eliciting Change Talk

'Change talk' is the language (words) someone uses that can 'hint' at - and even increase the chances for - a positive change

Key Points:
In order to support / enhance the person's motivation, you must listen for 'spot' those moments when she or he expresses that they MAY be ready for change, as indicated by self-motivational statements or "change talk."

These statement / words are not always apparent - the responder must be truly focused on what the person is saying, to listen for change talk.

Goal: Is to elicit more conversation; try to listen for opportunities where you can offer support / referral to 'help you that' ...

Once you hear these statements from the person, we must then reduce their resistance and develop discrepancies between the client's goals, values, self-image, and their current behavior. Here are a few examples ...

2. Motivational Interviewing: Eliciting Change Talk

Listen for signs that the person...

...Recognizes the problem (*"Yeah, this is getting pretty bad")*

...Expresses concern *("I don't know how I can keep up like this")*

...Expresses awareness *("I think my mom must be really mad at me")*

...Sees the benefit of change *("I could probably keep my job if I stopped using")*

...Sees the cost of not changing *("No one will ever hire me if I keep this up")*

Key Points:
In order to support / enhance the person's motivation, you must listen for 'spot' those moments when she or he expresses that they MAY be ready for change, as indicated by self-motivational statements or "change talk."

These statement / words are not always apparent - the responder must be truly focused on what the person is saying, to listen for change talk.

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Once you hear these statements from the person, we must then reduce their resistance and develop discrepancies between the client's goals, values, self-image, and their current behavior. Here are a few examples ...

*****Acknowledge the chaos that may be happening on the scene … AND THAT really listening can be challenging and difficult. But the goal is to try…***

2. Motivational Interviewing: Eliciting Change Talk

Here are a few more examples:

- *"I guess this has been affecting me more than I realized."*
- *"Sometimes when I've been using, I just can't think or concentrate."*
- *"I guess I wonder if I've been killing my brain cells."*
- *"I feel terrible about how my drinking has hurt my family."*
- *"I don't know what to do, but something has to change."*
- *"Tell me what I would need to do if I went into treatment."*
- *"I think I could get clean if I decided to."*

Key Points:

And here are a few additional examples... (Let audience review independently)

We are stressing here the importance for the responder to really listen closely and carefully

2. Motivational Interviewing: Eliciting Change Talk

Change talk can increase the chances that the person will make actual changes. *How do you evoke 'Change Talk' in the substance user? More conversation can help…*

Another opportunity for Open-Ended questions…

Ask for details about how substance use has affected the person's life:

- *How has using heroin affected your family?*
- *What has been the impact of heroin use on your job?*
- *What are some things you liked to do before using heroin?*

Key Points:

Change talk increases the chances that your patient will make actual changes. ***Remember those open-ended questions?*** Here's another spot they can be used to learn more about the person; listen carefully 'change talk'.

Goal: Is to elicit more conversation. *"Tell me about what you've tried before?"* Reinforce positive efforts (three rounds of rehab? Great that you keep going back! As long as you're here you can still try..)

So making this change could really affect your goal of stopping using…"

IF person starts to talk about a small change, try to help support that!

2. Motivational Interviewing: Eliciting Change Talk

Developing Discrepancy:

- Listen carefully to the person's statements about personal values and connections to community, family and faith
- If shows concern about the effects of behavior, highlight this concern to heighten awareness and acknowledgment of discrepancy.

GOAL: Help the person see the **discrepancy** between present behavior (what they are ACTUALLY doing) and her / his desired behaviors or values (what they SAY they want to be doing) .

5 MINUTES TO HELP
MAKE MINUTES COUNT Help Change a Life

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KEY POINTS:

Motivation for change is strengthened when the person sees the discrepancies between their current situation and their hopes for the future. *Your role is to help focus the person's attention on how current behavior differs from ideal or desired behavior.* Discrepancy is initially highlighted by raising the person's awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences.

- Developing awareness of consequences helps person examine their behavior.
- A discrepancy between present behavior and important goals can motivate change.
- The PERSON should present the arguments for change …. Not the responder!

2. Motivational Interviewing: Eliciting Change Talk

Developing Discrepancy:

- Ask for the 'Pros' of the current behavior: (*"Tell me what you enjoy when using heroin…"*)
- Ask for the 'Cons' of the current behavior: (*"What worries you about using drugs? How do drugs affect your family life? What might be different in your life if you stopped using?)*

Once the person begins to understand how the current behavior conflicts with personal values, amplify and focus on this discordance until she / he can see this discrepancy and consider a commitment to change

KEY POINTS:

This process takes time.

Assisting patients to identify discrepancies between their current behavior and future goals or values about themselves as a person, partner, parent, or worker is a powerful motivator that can help 'tip the balance' toward change. Exploring the pros and cons of change can help a patient develop 'discrepancy'.

"So it sounds like even though you enjoy using in the moment, it has put your job at risk, and has sometimes even lead to losing your job i the past… Which of course means you can't pay your rent / buy food / help support your family, etc…

So I think you saying that using heroin can help you forget about the problems with your husband ….. yet when you are using heroin, you and your husband fight about it more…"

By acknowledging and recognizing the discrepancy, you can help the person move to GENERATING COMMITMENT

3. Motivational Interviewing: Generating Commitment

Generating commitment should follow closely after a patient begins to talk about change.

- Commitment to action - *of ANY TYPE* - is a win! AFFIRM that commitment!
- Provide support to help implement the effort: "*What would you like to do next?" How can we help you?*

<u>Key Points:</u>

The 'old' approach: You ask the person "Do you want to go to the hospital?" -- they say "No" and EMS leaves the scene.

<u>With 'Five Minutes to Help:</u> The goal is to engage with the individual - to whatever degree possible - to seek opportunities to help 'move the needle' towards change.

Remember: You are trying to elicit a goal / commitment from the individual; However it's ***NOT what <u>you</u> want them to do*** - you must meet her/him WHERE SHE/HE IS - in that brief moment. REMEMBER: The best ideas for change COME FROM THE INDIVIDUAL.

Formulating a 'next step' / a commitment – even if the first steps are small – ***helps to translate thought into commitment and actual behavior change***. Perhaps its taking information with resources to call, perhaps its going to the hospital…

The change may be as simple as an agreement to read information left with the family; Or make one phone call to a family member. The goal is to help the the

individual do something that will build commitment.

Some questions you might ask the individual:
What do you think might work now? • What makes you concerned?
It sounds like you feel stuck. • What have you tried before?
What's most important now • What would you like to do next? • HOW CAN I HELP?

Note that the commitment MAY ONLY BE TO REDUCE HARM. A common term used is "Harm Reduction"

R	**RESIST** telling person what to do: *Avoid telling, directing, or convincing the person about the right path to good health*
U	**UNDERSTAND** person's motivation: *Seek to understand their values, needs, abilities, motivations and potential barriers to changing behaviors*
L	**LISTEN** with empathy: *Effective listening skills are essential to understand what will motivate the patient, as well as the pros and cons of their situation*
E	**EMPOWER** person: *Work with the individual to set achievable goals and to identify techniques to overcome barriers*

KEY POINTS:

Summary: So as we went through the steps of MI … you noticed some recurring themes that you must keep in mind during your interactions - even when you're frustrated, even when its the 3rd time with the same individual.

Review slide, and below are a few additional thoughts.

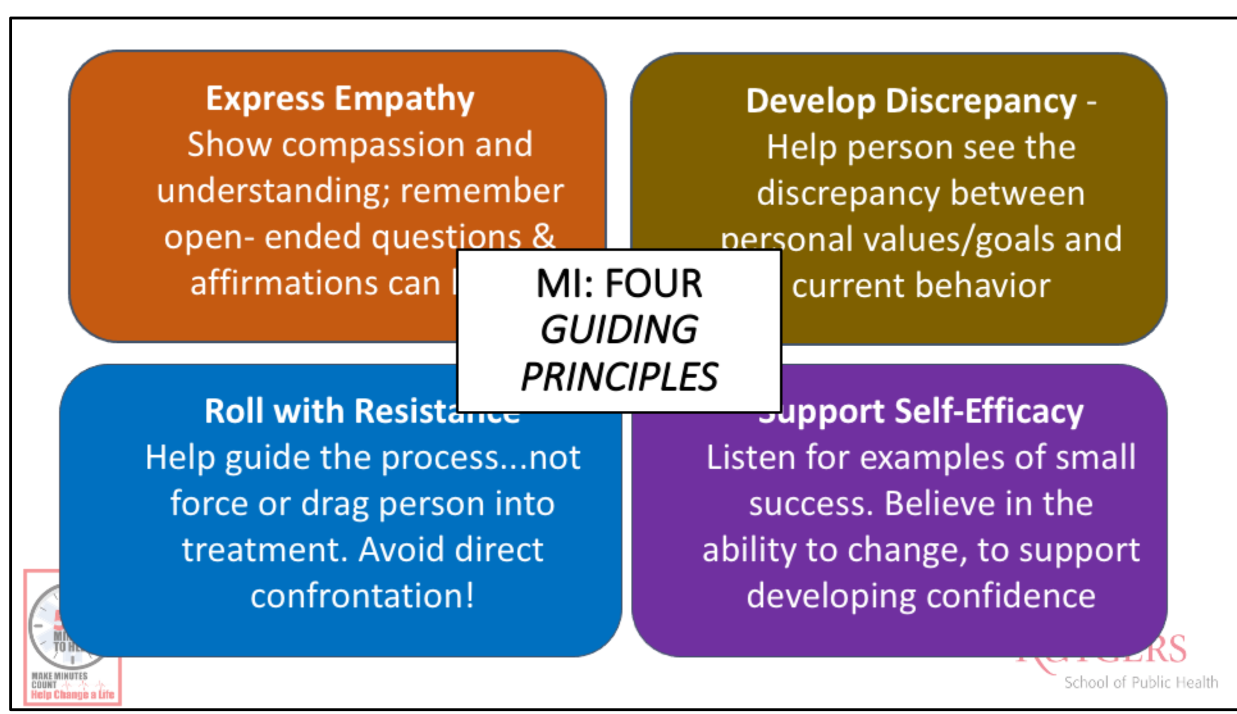
RESIST -- This can be very difficult, when its your job to give instruction / direction, and to 'fix' the problem

UNDERSTAND - It can be very hard to understand WHY someone would use substances that can kill them, often times, repeatedly. But by engaging with the person, you can start to learn what's important to them, and what the barriers to change might be.

LISTEN - Remember to speak WITH the person, not at them

EMPOWER - EMS workers are there to EMPOWER the substance user to make

changes; Consider it power **WITH** the individual, not power **OVER** the individual. In this moment, the EMS worker is a **partner** in the change process; not the director.



KEY POINTS:
We recognize this is a lot of information to absorb in a very short day of training. Here are those four 'Guiding Principles' we mentioned in the beginning to keep in mind throughout the process …. (they might even work with your kids :-))
* We can bring this back to general public safety rules – there to facilitate a discussion! And get home safely….

Specific Resource:
https://www.ncbi.nlm.nih.gov/books/NBK64964/?report=printable

Express Empathy
Empathy is a specific and learnable skill for understanding what the person is trying to convey, mostly through the use of reflective listening. But it means you must pay close attention to what the person is saying - and try to understand the 'underlying' meaning … Empathy communicates respect for and acceptance of clients and their feelings; it encourages a nonjudgmental, **collaborative** relationship; and allows you to be a supportive and knowledgeable partner.

Develop Discrepancy

Motivation for change is enhanced when clients perceive discrepancies between their current situation and their hopes for the future. Your task is to help focus your client's attention on how current behavior differs from ideal or desired behavior. Discrepancy is initially highlighted by raising your clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences. Although helping a client perceive discrepancy can be difficult, carefully chosen and strategic reflecting can underscore incongruities.

Separate the behavior from the person and help your client explore how important personal goals (e.g., good health, marital happiness, financial success) are being undermined by current substance use patterns. This requires you to listen carefully to your client's statements about values and connections to community, family, and church. If the client shows concern about the effects of personal behavior, highlight this concern to heighten the client's perception and acknowledgment of discrepancy.

Roll with Resistance

You may occasionally be tempted to argue with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed often results in even more resistance.

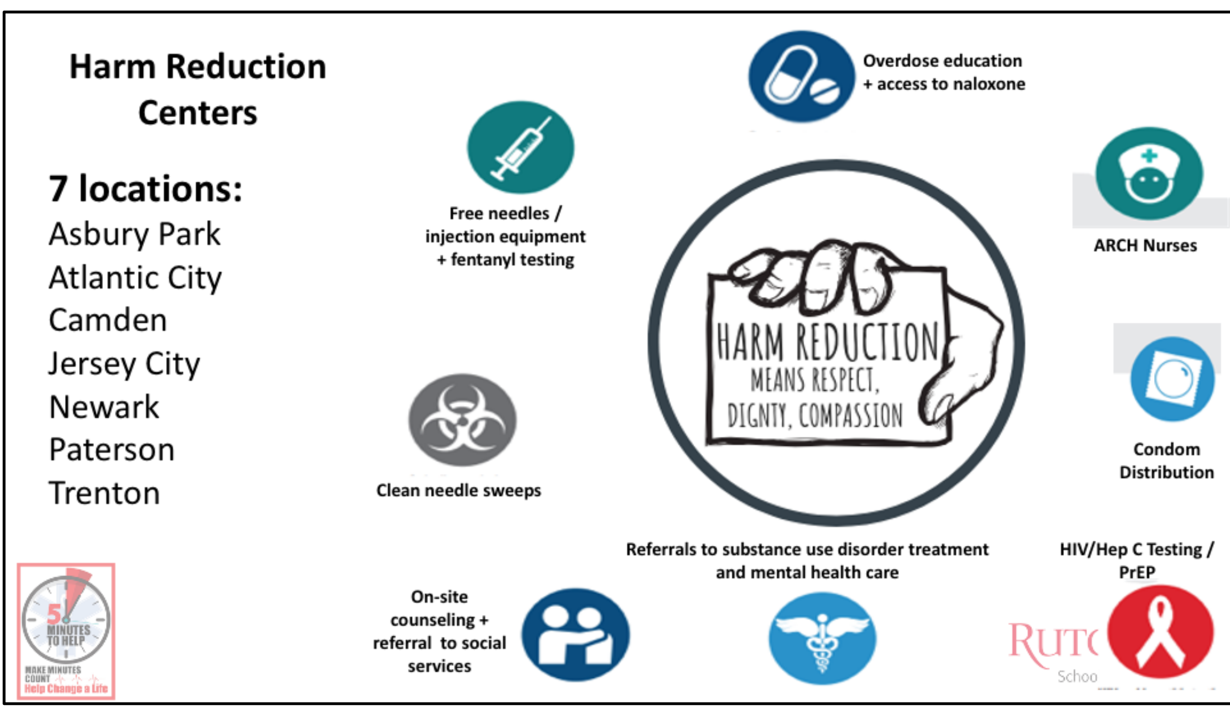
If you try to prove a point, the person predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change. When it is the individual, not you, who voices the reasons for change, progress can be made. The goal is to "walk" with clients (i.e., accompany clients through the decision), not "drag" them along (i.e., direct clients' next steps).

Self-Efficacy:

Many people with enduring behaviors that have negative impacts on their health have made their own attempts to change at some time or other and been unsuccessful. They may have attempted to cease smoking and only lasted a week, or tried to lose weight but been unable to sustain a diet. They may have attempted to comply with their medication several times in the past but found it difficult because of side effects or a complicated dosing regimen.

By highlighting the person’s strengths and reflecting on times in their life when they have successfully changed, even if just in one small area, self efficacy can be

promoted. YOUR BELIEF in the person’s ability to change is a powerful way to promote self efficacy. By promoting self efficacy, you can help the individual develop the confidence that they are capable of change



Key Points:

SO REMEMBER: You may not get someone into treatment on the first interaction. But they may be willing to participate in a HARM REDUCTION program – so adding this slide again, to remind participants that harm reduction centers are excellent and valuable resources ….

THIS MAY ALSO BE HELPFUL with a family member / other individual in the space… Someone else may also be helped in this process

The New Jersey State Department of Health is committed to offering ‘Harm Reduction’ services throughout the state - and they continue to seek opportunities to provide more.

The important piece in these is that not only are the intended to PREVENT the ‘worst possible outcomes’ -- they include trained substance use professionals, peer navigators, health professionals, social service providers -- available to help encourage the individual to explore more help.

By you becoming a little more aware of these centers, you are a better able to suggest them to the individual as another available resource.

Attention Participants: Switch to 'Speaker View" while the instructors conduct a role play!

Be observant - We'll want your feedback!

What Worked Well?

What didn't work so well?

ROLE PLAY

The goal here is to provide your group with an example of an interaction. It is helpful to have pre-planned with a group member (or better yet – co-facilitator) a general scenario. It may feel 'controlled or scripted' – but will serve as as example.

Tell group:
SWITCH TO SPEAKER VIEW to observe this roleplay. PLEASE be observant! Take down notes or observations.

Key Points:
As the 'Trainer' -- you are NOT expected to be perfect at MI - this is a learning process for all, and certainly a change in how responders typically engage. HOWEVER: it IS important for you to take time to read / learn more about MI to see how it is applied. A number of resources are provided to help enhance your knowledge. it is PERFECTLY ACCEPTABLE to 'switch tactics' if you feel you may have gotten 'stuck' - and need to try an alternate approach - this is a learning process for all.

Be sure to ask the ’PATIENT’ how it felt for them during the role play. After your demo, ask the group: What do you think worked? What might you do differently?

The goal is to provide attendees an opportunity to ‘practice’ so they can begin to feel comfortable using the types of language described in Motivational Interviewing (MI).

Please note: Should the individual indicate a suicidal intent, IT IS ESSENTIAL THAT EMS FOLLOWS IT’S STANDARD PROTOCOLS.

FACILITATE FEEDBACK – Ask the group – what worked? What didn’t?

YOUR TURN!
Break into
groups of four - six!

Key Notes. – Plan on 20 minutes

INSTRUCTIONS:

Have your students break into small groups of 4 – 6, max. Have one instructor plan to be in each breakout room / or move room to room to check in.

You will find the role play scenarios on the Five Minutes to Help website, (**FOR ONLINE COURSES: Plan to EMAIL the scenarios in advance!)

You can share copies of these with each small group, and have one individual be the responder, another be the patient, and the remainder of the group be observers. After each role play, the group should discuss what seemed to work / what didn't / suggestions for changes, etc.
Then have the groups 'switch roles' and repeat the same scenario / share observations, etc..

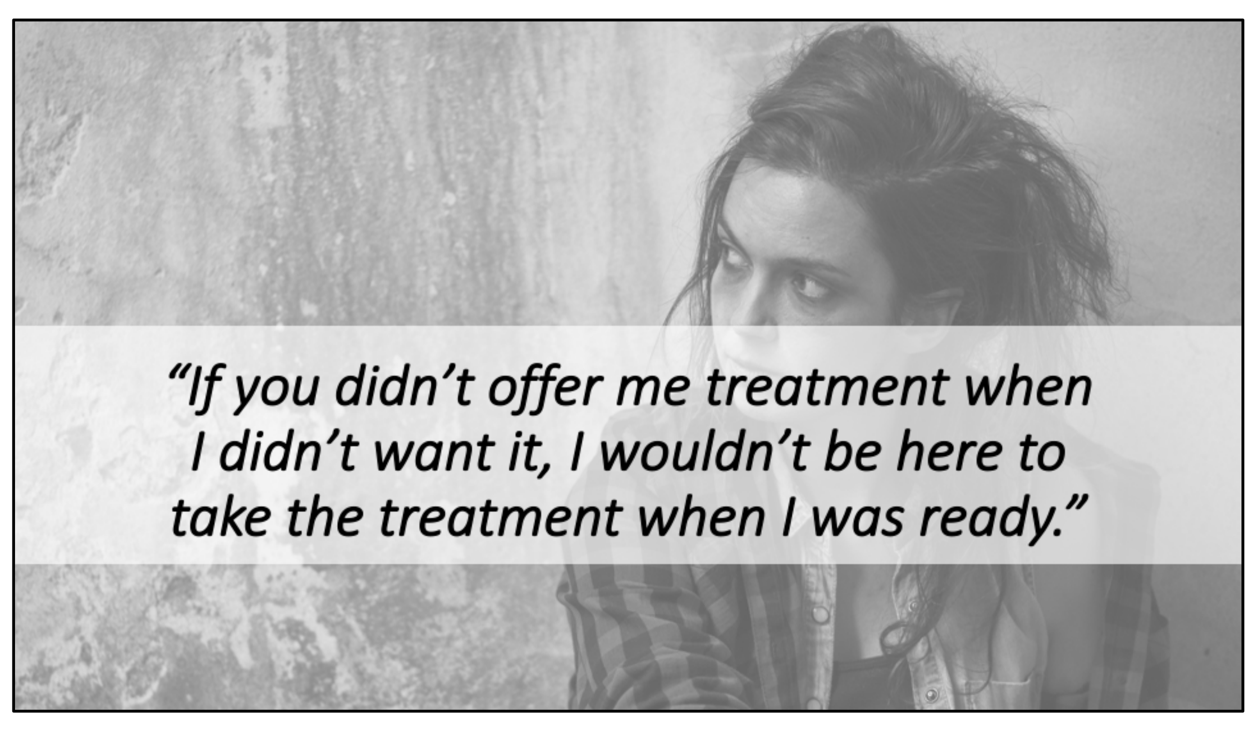
Ideally, each group will have two or three different scenarios, that can each be role played twice.

WHY? Because it gives the group opportunities to see how different responders may address the patient and situation, gives each more practice, etc..   The key is repeated practice!!

Be sure to acknowledge that THIS IS A NEW WAY OF INTERACTING with patients! It may not come ‘naturally’ but with practice – and follow-up discussions with on-the-scene fellow responders - it will become easier!

How Did it Go?

- Who felt awkward doing this?
- What did you feel comfortable doing?
- How is this similar or different than how you typically interact post-overdose?



So this is just a reminder of why we are doing this (this is the same quote from the start of the program.

Hold your smartphone camera up to the QR Code

OR:

https://tinyurl.com/wgmqn2l

Questions / Comments / Concerns?
Be sure to complete your evaluation!

CONTACT INFORMATION

INSTRUCTOR NAME
Instructor Email

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