

- Niche mental health services include acute, forensic, and early intervention services, and services for specific client groups.
- Other sectors are structurally aligned and work closely with primary services and mental health services to promote well-being for all.
- All agencies are accountable to powerful and well-resourced district leadership groups.

### Systems in our vision:

- Policy is profoundly influenced by service users, families and those most affected by mental distress, and funding is planned and responsive.
- Measures of effectiveness of services are simple and focus on outcomes that are important to service users.
- Coordinated service development, workforce development

and research lead to adaptive, responsive services for all.

- An independent national agency monitors services and provides information on quality and advocacy for service users and whanau.

### The discussion paper is available at:

[http://www.mentalhealth.org.nz/file/downloads/pdf/Destination%20Recovery\\_FINAL\\_low%20res.pdf](http://www.mentalhealth.org.nz/file/downloads/pdf/Destination%20Recovery_FINAL_low%20res.pdf)

## PRACTICAL POINTERS

# Effective communication strategies to enhance patient self-care

**Fiona Moir** MBChB; **Renske van den Brink** MBChB, FRNZCGP; **Richard Fox** MBChB, FRNZCGP; **Susan Hawken** MBChB, FRNZCGP

## Introduction

Can primary care practitioners influence and improve patient self-care, simply by the way they communicate with their patients? If so, can this be done within the consultation, even when practitioners already feel constrained by lack of time?<sup>1</sup> Currently in New Zealand (NZ) there is significant morbidity and mortality associated with lifestyle-related disease, and constraints on health resources increasingly mean that patients need to be more responsible for their own health. After indicating the general context of lifestyle-related illness, this paper will outline the different approaches available to primary care practitioners. The prin-

ciples of motivational interviewing, the stages of change model, the 'catastrophe theory' model,<sup>2</sup> and the essential elements of brief intervention in primary care settings will be outlined. This will be followed by practical examples on how to communicate with the patient in ways that will enhance behavioural change and self-care.

## Background

There are some concerning trends in the rates of lifestyle-related disease. The prevalence of obesity has more than doubled from 1982 to 2003,<sup>3</sup> and the future impact of the obesity epidemic on the NZ population and health system will be significant.<sup>4</sup> Smoking rates are no longer dropping.<sup>3</sup> Although the overall ischaemic heart disease mortality rate for 2011–15 is predicted to decline, there is an expected actual increase in the mortality rate for Maori.<sup>5</sup> Disparities across a range of risk factors and health outcomes for Maori and Pacific peoples, compared to the total population, persist and are of grave concern.<sup>6</sup> With effective lifestyle

intervention targeting obesity, smoking, exercise, and alcohol use, such lifestyle-related conditions could be reduced.

A NZ study identified patients with lifestyle issues by using a short screening tool consisting of lifestyle and mental health risk factors. It was found to be acceptable to patients and not burdensome to practitioners.<sup>7</sup> It is well known that offering patients information only does not necessarily effect behaviour change, so other approaches are needed. An intervention that is currently being trialled and evaluated<sup>8</sup> involves a 'lifestyle script' administered by primary care nurses and followed up with telephone counselling. Utilising programmes that are culturally appropriate is important to success.<sup>9</sup> Other studies have shown that although there is acceptability and recognition of the value of chronic disease management programmes, there is still concern by practitioners about the amount of time involved.<sup>10</sup>

Promoting patient self-care ideally is the responsibility of all members of the

### CORRESPONDENCE TO:

**Fiona Moir**  
Department of General  
Practice and Primary  
Health Care, Faculty  
of Medical and Health  
Sciences, The University  
of Auckland, PB 92019,  
Auckland, New Zealand  
[f.moir@auckland.ac.nz](mailto:f.moir@auckland.ac.nz)

multi-disciplinary team. For example, a current initiative to improve medication adherence involves pharmacists undertaking a 'Medicine Use Review' (MUR), and discussing all of the patient's medications with them. Central to the MUR consultation is the way in which the pharmacist communicates with the patient, exploring their health beliefs and their illness perspective. An exploration of the patient's illness perspective involves finding out their ideas, concerns and expectations relating to their illness and medications.<sup>11</sup> Once this information has been gathered, the pharmacist and the patient use joint decision-making to agree on the next step. This is a good example of how communication can aid patient behaviour change.

A variety of models have attempted to facilitate patient self-care in the context of the patient-centred interview, but one of their limitations in primary care is the amount of time they take to deliver. In this paper we briefly describe four of these models, and then indicate stylistic elements within them, which may usefully be used within a time-constrained interview.

## Motivational interviewing

Motivational interviewing is a directive client-centered style of counselling for eliciting behaviour change. It has its roots in the drug and alcohol field, and has been used for many years in addictions counselling, predominantly focusing on problem drinking. Although initially developed for longer consultations, elements of it have been adapted for use in shorter interactions in many other areas of health behaviour change.<sup>12</sup>

The underlying ethos or spirit of motivational interviewing is that the practitioner-patient relationship works best as a partnership, that the quality of that relationship is the key to behaviour change, and that the motivation and ideas about

change come from the patient, not from the practitioner. For example, the patient can be asked to identify and explore any ambivalence they have to the particular behaviour, e.g. 'what are the good things and the not so good things about smoking?' In motivational interviewing, it is the practitioner's job to direct the patient towards exploring and discussing ambivalence and to summarise this for them, and it is the patient's job to examine the ambivalence and to decide on the next step.

The main aspects of motivational interviewing<sup>13</sup> are summarised in Table 1.

## The stages of change

Another model, referred to as 'the stages of change', played a vital role in the development of both motivational interviewing and brief intervention.<sup>15</sup> Central to this model is the idea that behaviour change is incremental and involves specific tasks. The model describes a series of changes progressing from *pre-contemplative* (unaware, unable or unwilling to change), to *contemplative* (evaluating pros and cons of change), to *preparation*, then *action* and *maintenance*. The model recognises that relapse is common, and that many people will have several attempts before achieving a successful outcome.

Table 1

Motivational interviewing <sup>14</sup>	
<b>Spirit</b>	Autonomy Collaboration Evocation
<b>Principles</b>	Roll with resistance and avoid arguments Express empathy Develop discrepancy Support Self-efficacy
<b>Counselling skills required</b>	Open questions Affirm Reflect Summarise

## Catastrophe theory model

Critics of the stages of change model state that the boundaries between the stages are arbitrary, and furthermore that often behaviour change does not actually involve any planning or preparation.<sup>16</sup> In a recent study, almost half of smokers' attempts to stop involved no previous planning, and unplanned attempts to stop were more likely to be successful.<sup>2</sup> A new model in 2006, based on 'catastrophe theory', hypothesizes that behaviour change is influenced by 'motivational tension' (the levels of which depend on beliefs, past experiences, and the current situation), and that in the presence of this tension, even a small trigger can lead to a sudden change.<sup>2</sup>

## Brief intervention

The stages of change can be a helpful model to use alongside motivational interviewing, but where does brief intervention come into play? Brief interventions are those practices that aim to identify a problem and motivate an individual to do something about it, which can often be used in the course of routine practice without requiring significantly more time.<sup>17</sup> Multiple trials have shown the effectiveness of brief intervention.<sup>18</sup> Successful brief interventions have been found to contain six key elements in common.<sup>19</sup>

### Brief intervention: FRAMES<sup>20</sup>

**F**eedback given about impairment/current risks, e.g. giving test results  
**R**esponsibility is the patient's  
**A**dvice about change  
**M**enu of options—alternative strategies  
**E**mpathy  
**S**elf-efficacy and optimism for change

A brief (five to 10 minute) smoking intervention has been developed based on motivational interviewing, assessing the patient's confidence and their level

of motivation.<sup>12</sup> A patient was 'ready to change' if they had a high level of confidence and felt that the change was important to them.

### Integrating the models in practice

By calling on our experience, we have identified ways in which elements of each of these models can be used in day-to-day practice.

First, it is important to bring up the topic of possible health behaviour change carefully, especially if we are introducing the idea opportunistically. A good transition into this is to ask permission to discuss the topic: 'Could we talk about smoking for a couple of minutes?' This approach avoids an abrupt change

the rapport by using reflection, state our concern about the health behaviour and its implications, and leave the door open for future discussion of the behaviour should the patient wish to pursue this. Some argue that we can also offer an intervention at this stage if it is appropriate.<sup>16</sup> However, enthusiastic suggestions by the doctor to think about behaviour change, or an offer to try a new treatment, can sometimes come at the expense of connection with the patient. For this reason it is important to be very aware of the patient's verbal and non-verbal reaction throughout the discussion and to respond to this appropriately for individual situations.

If the patient is contemplative, we can encourage them to explore the pros and cons of the behaviour, whilst we reflect

of possible options of behaviour change they could pursue—some of which have been suggested by the doctor, and some by the patient. The recent model based on 'catastrophe' theory<sup>2</sup> illustrates that many patients' attempts to stop will not involve planning, and that immediate availability of treatment is important to support those attempts.

When time is short, the main idea is to use the underlying spirit of motivational interviewing,<sup>11</sup> and to remember that the practitioner–patient relationship and interaction is the vital component of the success of health behaviour change.

### Practitioner–patient relationship

Judgement, lecturing and advice giving has been shown to be less effective in health behaviour change than genuine empathic use of motivational interviewing styles and strategies. Empathy is a powerful relational skill which helps patients to feel connected with their practitioner even when there is mutual disagreement over issues such as smoking or medication compliance.<sup>21</sup>

The capacity to influence patients hinges upon the quality of rapport between practitioner and patient, and rapport is perceived by the patient as the ability of the practitioner to relate to the patient's world.<sup>22</sup>

Empathy is fairly easy to master when we agree with the patient and we can relate to their culture, their social status and their world view. However, when we disagree or disapprove of our patients, empathy is much more difficult. How can we be empathic when we know that the patient's smoking is making their chest disease worse, and all we want to do is to tell them to stop? Firstly we can remind ourselves that the way in which we communicate can have an impact on the likelihood of the patient changing

## When styles and strategies from motivational interviewing are employed with skill, it begins to feel like a dance instead of a struggle

into a potentially sensitive area for the patient. As emphasised in the FRAMES model, the timing of this can be important. For instance, giving a patient their abnormal liver function test results may provide an opportunity to introduce the topic of alcohol consumption.

Next we can assess the patient's 'readiness to change'. This is best done with an open question: 'What are your thoughts about smoking?' In this way, we avoid making assumptions about what the patient thinks or 'should' be thinking.

The next step can be dictated by where the patient is in the stages of change. Using a motivational interviewing style in our discussion for all of the stages of change can be beneficial. If the patient is precontemplative, we can maintain

their ambivalence or discrepancy about their current behaviour and their goals. We want the patient to take responsibility, and to come up with the motivation and ideas about change, whilst we listen and summarise. The practitioner and the patient can also work together in the preparation, action and maintenance stages. The practitioner can enable the patient to work out a personal action plan, anticipate barriers and triggers, and to identify supports and enablers. A vital part of the practitioner's role is to increase self-efficacy and reinforce any accomplishments. In relapse, we must empathise and normalise the reality of relapse, whilst not assuming the patient's next step.

Brief intervention can be useful with someone who is in the action or preparation stage, as we will be exploring a list

their behaviour. A useful technique to use when we notice ourselves feeling disapproving or annoyed by our patients is to try to 'park' that feeling and to first offer the patient an empathic reflection.

Contrast the difference in these two responses to a patient bothered by lithium side effects:

*Practitioner A:* How about trying to split the dose, as well as having it with food? That should help cut down the nausea.

*Practitioner B:* It sounds like the nausea is really awful for you and taking the lithium regularly is the last thing you feel like doing.

Practitioner A has got their own agenda in the foreground, and the patient is likely to feel isolated and perhaps even irritated. Practitioner B however is putting the patient's concern at centre stage. This is not the same as approving of their behaviour. It just demonstrates to the patient that Practitioner B understands them in a non-judgemental way. After that, once the rapport is more strongly established, Practitioner B can go on to let them know their medical concerns.

When styles and strategies from motivational interviewing are employed with skill, it begins to feel like a dance instead of a struggle. Rather than trying to convince the patient to change, the practitioner uses a Socratic questioning style to evoke the patient's own problem-solving skills and to galvanise them into action. The patient is doing all the work, and the practitioner's genuine non-judgemental reflective style steadily builds rapport. If it feels more like a struggle then usually this is because the practitioner is working very hard to convince the patient to change, resulting in either a confrontation or the patient ceasing to play an active part in the process.

Compare the following interventions for someone who needs more exercise:

*Practitioner A:* How about trying to get off the bus two stops early so that you can get in a bit of exercise that way?

*Practitioner B:* If you were to find a way to increase your exercise even a little bit, what would you choose to try?

Working in a motivational interviewing style challenges the practitioner to initially hold back their own opinions and advice, giving priority to the patient's ideas and reflection of the patient's illness experience, in order to strengthen the therapeutic relationship. Once this is established, the strong therapeutic relationship can then withstand the challenge of the practitioner's medical opinion, even when this is in direct conflict with the patient's view.

## Conclusion

Lifestyle-related disease is of significant concern in NZ, and there is a need to raise awareness of opportunities for intervention. Brief intervention, motivational interviewing, stages of change, and the 'catastrophe model' are all useful frameworks for promoting behavioural change, and elements from all four may be adapted for use in primary care settings. In a short consultation the most important factor is the skilful use of empathy to strengthen rapport in the practitioner-patient relationship. Good rapport creates a platform from which the practitioner can enhance their capacity to influence health behaviour and optimise patient self-care.

## References

- Goodyear-Smith F, Wearn A, Everts H, Huggard P, Halliwell J. Communication in practice: Auckland general practitioners reflect on communication events and identify training needs. *N Z Fam Physician* 2006;33(1):30–38.
- West R, Sohal T. 'Catastrophic' pathways to smoking cessation: findings from national survey. *BMJ* 2006;332(7539):458–60.
- Metcalfe P, Scragg RK, Schaaf D, Dyall L, Black P, Jackson R. Trends in major cardiovascular risk factors in Auckland, New Zealand: 1982 to 2002–2003. *N Z Med J* 2006;119(1245):U2308.
- Turley M, Tobias M, Paul S. Non-fatal disease burden associated with excess body mass index

and waist circumference in New Zealand adults. *Aust N Z J Public Health* 2006;30(3):231–7.

- Tobias M, Sexton K, Mann S, Sharpe N. How low can it go? Projecting ischaemic heart disease mortality in New Zealand to 2015. *N Z Med J* 2006;119(1232):U1932.
- Ministry of Health. A portrait of health: Key results of the 2006/7 New Zealand Health Survey. In: Wellington: Ministry of Health; 2008.
- Goodyear-Smith F, Arroll B, Sullivan S, Elley R, Docherty B, Janes R. Lifestyle screening: development of an acceptable multi-item general practice tool. *N Z Med J* 2004;117(1205):U1146.
- Rose SB, Lawton BA, Elley CR, Dowell AC, Fenton AJ. The 'Women's Lifestyle Study', 2-year randomized controlled trial of physical activity counselling in primary health care: rationale and study design. *BMC Public Health* 2007;7(147):166.
- McAuley KA, Murphy E, McLay RT, Chisholm A, Story G, Mann JI, et al. Implementation of a successful lifestyle intervention programme for New Zealand Maori to reduce the risk of type 2 diabetes and cardiovascular disease. *Asia Pac J Clin Nutr* 2003;12(4):423–6.
- Tracey J, Bramley D. The acceptability of chronic disease management programmes to patients, general practitioners and practice nurses. *N Z Med J* 2003;116(1169):U331.
- Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-centered medicine. Transforming the clinical method. Thousand Oaks: Sage Publications; 1995.
- Emmons KM, Rollnick S. Motivational interviewing in health care settings. Opportunities and limitations. *Am J Prev Med* 2001;20(1):68–74.
- Miller WR, Rollnick S. Motivational interviewing: Preparing people for change. 2nd ed. New York: Guilford Press; 2002.
- Miller W, Rollnick S. Motivational interviewing: preparing people to change addictive behaviour. New York: Guilford; 1991.
- DiClemente CC, Velasquez MM. Motivational interviewing and the stages of change. In: Miller WR, Rollnick S, editors. Motivational interviewing: Preparing people for change. New York: Guilford Press; 2002.
- West R. Time for a change: putting the Transtheoretical (Stages of Change) Model to rest. *Addiction* 2005;100(8):1036–9.
- Babor TF, Higgins-Biddle JC. Brief intervention. For hazardous and harmful drinking. A manual for use in Primary care. In: 2nd ed: Department of Mental Health and Substance Dependence, World Health Organization; 2001.
- Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction* 1993;88(3):315–35.
- Miller WR, Sanchez VC. Motivating young adults for treatment and lifestyle change. In: Howard G, editor. Issues in alcohol use and misuse by young adults. Notre Dame: University of Notre Dame Press; 1993.
- Miller W, Sanchez V. Motivating young adults for treatment and lifestyle change. In: Howard G, editor. Issues in alcohol use and misuse by young adults. Notre Dame: University of Notre Dame Press; 1993.
- Halpern J. Empathy and patient-physician conflicts. *J Gen Intern Med* 2007;22(5):696–700.
- Yapko MD. Breaking the patterns of depression. New York: Doubleday; 1997.