Health
Behaviour
Change

Participant Workbook

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Winnipeg Regional Health Authority
Caring for Health
Office régional de la santé de Winnipeg
À l'écoute de notre santé

The Workbook

This workbook is designed to help health care providers (HCPs) have conversations with people about behaviour change in healthcare settings where time is often limited. The theories, models and strategies advocated in this workbook are based on evidence-based practice for how to be most successful in supporting behaviour change.

This workbook contains a model for giving **Brief Advice** about behaviour change and for conducting brief **Behaviour Change Counselling** sessions. These interventions can range anywhere from 3 to 5 minutes for brief advice to 15 to 30 minutes for behaviour change counselling, depending on the time available and the context of the encounter between the individual and the HCP. The aim of these interventions is to help the individual understand that their behaviour is putting them at risk and to encourage them to consider changing the behaviour. These interventions also offer support to assist with undertaking the behaviour change, when the individual chooses to make change.

The models work for any type of behaviour change, whether the individual is trying to **create a pattern of behaviour** (exercising regularly, taking medications); **modify an existing habitual behaviour** (changing to a low fat diet, eating more fruits and vegetables, engaging in protective sexual behaviours); or **stop a problematic pattern of behaviour** (quitting smoking or drinking).

Contents of this Workbook

Within this workbook you will find:

- The rationale for brief behaviour change interventions by a wide variety of health care providers
- A model of behaviour change that encompasses many theories
- Principles of motivational interviewing and essential skills for encouraging behaviour change
- A model for structuring brief interventions, including Brief Advice and Behaviour Change Counselling

It is more important to understand the **'Spirit'** of behaviour change counselling than it is to memorize the strategies and techniques of the model. While strategies and techniques are explained, adopting the 'Spirit' of the model is a primary goal as you work your way through this workbook.

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What is Health Behaviour Change?

The old paradigm of the health care system, where individuals go to see health care providers to report symptoms for practitioners to diagnose and treat, is shifting. There is a more holistic focus on the overall health of individuals and on preventing illness and promoting health and well-being. There is wide recognition that the illnesses that the symptoms reveal are related, in part, to lifestyle behaviours of individuals. Health care providers are then faced with the need to reveal this to the individual and suggest changes, often radical changes, to their lifestyles in order to promote health and prevent illness.

Among the most frequently encountered **changes in behaviour** that health care providers focus on are:

- Eat less, eat different things, adjust timing of meals
- Drink less alcohol, abstain altogether
- Be more physically active, do particular exercises
- Smoke fewer cigarettes, abstain altogether
- Take a new medication, a different one, replace one with another, at a different time
- Monitor levels of glucose in the blood
- Ingest more / less liquid
- Reduce intake of a substance, abstain altogether

Consultations about these changes occur with a **wide range of individuals** who are:

- At risk for heart disease
- Recovering from a heart attack
- Living with diabetes
- Overweight or obese, or underweight
- Pregnant
- At risk of contracting STIs
- Living with chronic pain
- Having problems with alcohol or other substance use
- Living with asthma

The **health care providers** are usually: doctors, nurses, social workers, nutritionists, dietitians, physiotherapists, psychologists and psychiatrists, kinesiologists and fitness leaders, occupational therapists, dentists, health promotion practitioners, health visitors.

The **settings** in which health behaviour change counselling occurs are widespread, and include: primary care, hospital inpatient and outpatient departments, emergency rooms, leisure facilities, occupational health clinics, homes, and counsellor's offices.

The Transtheoretical Model of Change (TTM)

Self-Assessment: Familiarity with the Transtheoretical Model of Change (TTM)

What are the 6 Stages of Change?

What are the 10 Processes of Change?

Experiential

Behavioural

What are the 2 Markers of Change?

The Framework

4 Key Constructs

The Transtheoretical Model of Change (TTM) describes how people make behavioural changes. The model is sometimes referred to as the "Stages of Change Approach", but to do so is misleading. The stages themselves are only one of the four key constructs of the model, so to refer to the Stages of Change approach ignores the importance of the other three constructs. The four constructs are:

1. Stages of Change
2. Processes (and Techniques) of Change
3. Critical Markers of Change
4. Context of Change

The TTM provides a framework that helps us to understand the overall process that individuals engage in when making change, as well as strategies for how others can support and assist them to make these behavioural changes. The model was developed by James Prochaska and Carlo DiClemente and has been refined over the past 20 years.

The model is one of **intentional change**—individuals make a conscious decision to change. It describes readiness for change, and how people move towards making decisions and behaviour changes in their everyday lives. It describes what happens to people as they change.

The TTM is not a single *method* of change, but rather a **model** that is inclusive of a wide range of therapeutic interventions and one that explains why various interventions work at specific points in the change process. Because it is inclusive of many theories, it was given the name 'Transtheoretical'.

Carlo DiClemente has described the TTM as "a dynamic, developmental, and multidimensional change perspective that offers an integrative framework for understanding change" (DiClemente, 2003, p.ix).

Stages of Change:

The stages highlight the specific tasks that mark an individual's passage towards behaviour change. The six stages are known as: Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination.

Processes of Change:

There are ten processes of change that have been derived from different behaviour change theories that describe key mechanisms that move individuals through the stages of change. There are five experiential processes and 5 behavioural processes.

Critical Markers of Change:

As individuals move through the stages of change, their beliefs about how important the change is for them and how confident they feel that they can make the change and resist temptations to return to old behaviours will fluctuate. It is important to continuously track how important change is for individuals, as well as how confident they are that they can make the change.

Context of Change:

Five areas of functioning comprise the context of change. These areas contain the risk and protective factors, and resources and barriers that influence processes and movement through the stages.

Construct 1

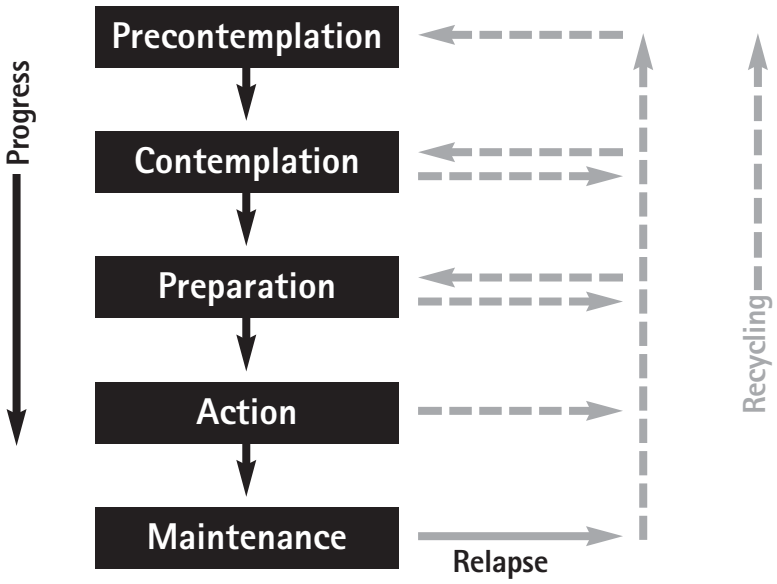
The Stages of Change

Lasting changes to long-time behaviours seldom occur suddenly or dramatically. While a change may appear sudden and dramatic to those observing it, chances are that the individual making the change spent some time thinking about making the change and considering how to do so before they took action. Action is the visible part of the change effort. Within the TTM, change is viewed as gradual, logical, sequential and controllable.

The model suggests that taking active steps to make change—the dramatic, visible portion of change—is only one stage out of six in the overall process. The TTM makes the point that all six stages are important, and none are "bad" stages to be in. The emergence of the TTM into the field of health promotion and behaviour change has been likened to "the discovery of a new planet in astronomy," (Stockwell 1992 in Rollnick, et al., 1999, p. 18).

This is important to recognize as Prochaska and DiClemente's original research indicated that less than 20% of individuals who are making changes in their lives are in the action stage at any given time, but about 90% of all programs and interventions offered by professionals are intended for people in the action stage of change, (Prochaska, et al., 1995). When we offer people assistance to change, we offer them assistance to act, whether they are ready, willing or able to act.

The Stages of Change proposed in the TTM came about after interviews with people who had successfully made changes to their behaviour without professional help or guidance. Prochaska and DiClemente studied "self-changers". They discovered a natural progression through the following 6 stages:



Precontemplation Stage of Change

"I don't need to change."

People in the Precontemplation stage of change are not thinking about change. They do not believe that they need to change. However, other people in their lives have identified a problem with their behaviour and believe they need to change.

It is common for individuals to seek medical assistance for one issue, even an annual physical, and then discover that there is something else to be addressed. It is often the responsibility of a health care provider to identify this need for change.

Individuals tend to remain in the Precontemplation stage of change until some external force or event gets them moving towards thinking about change. An external event could be a health crisis (e.g. heart attack). This external event may expose the individual to information that she/he had not previously been aware of and that gets him/her thinking.

It is useful to think about individuals in the Precontemplation stage as being there for one of four possible reasons, each of which requires a slightly different strategy from the HCP to overcome.

What Kind of Precontemplation?

Reluctant Precontemplation: Individuals are simply unwilling to consider change. They are comfortable with their current situation and do not want to risk the potential discomfort they may feel if they try to change. Usually, they are not aware of experiencing too many negative consequences of their behaviour. Focus of work is increasing importance of change.

Rebellious Precontemplation: Individuals are heavily invested in being independent and making their own choices. They do not like to be told what to do. They often appear hostile and resistant to suggestions for change. They may have a great deal of knowledge about their behaviour and its possible consequences. Focus on factual information to increase importance of change.

Resigned Precontemplation: Individuals feel hopeless and helpless about change. They are resigned to continuing their behaviour, often because they feel overwhelmed by their lives and their problems. They may have attempted change in the past and been unsuccessful, and now feel like failures. Instilling hope for and confidence to change is focus by identifying and overcoming barriers.

Rationalizing Precontemplation: Individuals have created a protective rationalization for why their behaviour does not pose a risk to themselves. They will often engage in point—counterpoint debates with anyone who suggests change. While it may feel the same as rebellion to HCPs who speak with them, it is important to distinguish between the two types. Rebellion is all about emotion, while Rationalizing is all about thoughts. Increase importance for change by focusing on the emotional impact of the behaviour, perhaps by identifying value conflicts.

Contemplation Stage of Change

"I might change"

In order to move from the Precontemplation stage of change to the Contemplation stage, individuals will have received an adequate amount of information about their behaviour and identified some connection on a personal level to that information. They are now considering making a change, though they are still uncertain about that change.

It can be useful to remember that individuals in the Contemplation stage are feeling ambivalent—they feel two ways about their behaviour. On one hand, they want to continue as they always have because that is most comfortable, while on the other hand, they now are aware that there are some really important reasons for them to make changes. Ambivalence is the hallmark of the Contemplation stage of change.

Individuals who are ambivalent are experiencing stress. This stress helps to motivate them to do something. Doing something in the Contemplation stage could mean making a decision to change, or it could mean finding a rationalization to stop thinking about it—or moving back into the Precontemplation stage (A move back to an earlier stage of change in terms of thinking and behaving is known as recycling in the TTM.)

Individuals in the Contemplation stage of change often feel stuck.

Preparation Stage of Change

"I will change, just not yet"

Individuals in the Preparation stage of change have decided that making the behaviour change is important to them and that they are capable of making the change, but they are not yet ready to start actively changing. There are other things that must be taken care of before they can begin to make the change. For example, someone who is changing their diet may want to rid the fridge and cupboards of all the 'wrong' foods. Often, there are barriers or obstacles to change that must be overcome.

It is important not to rush individuals through this stage. It is vital for success that individuals take the time necessary to plan and prepare for change.

There are three major tasks that must be completed in the Preparation stage. One is to answer the question "Why am I doing this?" Answering this question resolves the ambivalence and firmly establishes key reasons for change. The second task is to develop a detailed plan of how they will make the change. The plan includes identifying supports and resources, as well as how and when to use them. The third task is to prepare the significant others in their lives for the change they are about to make. Preparing others involves soliciting support as well as identifying potential barriers to overcome, as not everyone will support their changes.

Action Stage of Change

"I am changing"

Action is the stage of behaviour change that is the most obvious to those outside the change effort. Actions are visible. Others can see the old behaviours being eliminated or modified, as well as the new behaviours being adopted. Because others can see an individual doing something different, this is the stage in which individuals often get the most support from others. Visible change is often equated with progress.

Action, however, is not the only time of progress; it is only one of the stages in the change process. Alterations in thought, awareness, emotions and self-image occur in preceding and following stages and are just as important to overall success.

Another important thing to remember about the Action stage is that it requires the most in terms of commitment of time and energy from the individual making change. It is hard work to change behaviours, and it requires diligence. Individuals are often tempted to return to old behaviours during the first weeks and months of the active change effort. It is natural to have setbacks and brief resumptions of old behaviours. This is not failure or relapse. These slips back to previous behaviours are simply part of the change effort.

Maintenance Stage of Change

"I have changed"

Individuals in the Maintenance stage of change have successfully made the behaviour changes they had set as goals for themselves. Often a six-month time period is used to measure the transition from the Action stage to the Maintenance stage—after an individual has successfully altered their behaviour for six months, they are said to be in Maintenance.

Maintenance is a difficult stage. There are often negative conditions and circumstances that can lead to an erosion of commitment to the sustained, long-term effort needed to maintain the change and the revised lifestyle that goes with that change. Many individuals who make behaviour change are successful in the short term. Behaviour changes that last for short periods of time are often the result of action taken without having a maintenance strategy as well.

In the Maintenance stage, individuals have often developed strategies for coping with common temptations or urges for the old behaviour, but have not planned for the uncommon triggers. Without developing a strong sense of self-efficacy, or belief that they can handle any situation that comes up, individuals may become complacent in a new routine and not be prepared for unusual circumstances that can arise. Such circumstances often include an unanticipated loss, like the death of a loved one, illness or job loss.

Termination Stage of Change

"I am changed"

For individuals in the Termination stage of change, the old behaviour no longer holds any temptation or threat; there is knowledge and confidence that they will not return to old behaviour patterns. There is also a personal sense of confidence in one's ability to cope with life situations by transferring the new skills acquired during the change process to use in other situations.

In the Termination stage, individuals no longer identify with their former behaviour. For example, instead of describing themselves as a 'former smoker' an individual may say that they are a 'non-smoker'.

There are some who believe that changes for certain behaviours can never reach termination, but will remain in lifelong maintenance. These behaviours typically include addictions to alcohol and other drugs.

Recycling & Relapse

Within the TTM, recycling and relapse are two different but related concepts. Both are important, and both are common experiences of people making behaviour change in their lives.

Recycling is what occurs when an individual moves back to a previous stage of change. This move back or 'regression' may involve thoughts and/or actions. For example, an individual who was contemplating making a behaviour change the last time a HCP spoke with them may have recycled back to the Precontemplation stage of change by the next consultation visit.

Recycling between stages is common, and may even be observed during one conversation. It is particularly common in early stages of change when ambivalence is high. Ambivalence can also return and be high when the reality of how difficult changing behaviour can be becomes apparent during the Action and early Maintenance stages of change.

It is important for HCPs to be aware of when an individual is recycling so that the HCP can match the intervention to the correct stage of change. It is not enough to simply offer words of reassurance and encouragement. Recycling to an earlier stage of change is a signal to change strategies and go back to resolve the ambivalence. Recycling is an opportunity for new learning.

Relapse only occurs when an individual who has reached the Maintenance stage of change resumes the old behaviour pattern. A relapse may be a brief, one time 'slip' into the old behaviour, or a full return to previous behaviour patterns.

Returns to old behaviours that occur during the Action stage of change are a normal part of the process of change, not a relapse.

Relapses are also normal—80% of individuals making behaviour changes relapse at least once. It is therefore important to make relapse prevention/management a key part of planning.

Whenever an individual relapses, it is important to return to tasks of the Preparation and Action stages of change to see what can be learned from this opportunity. Reframing relapse as a learning opportunity is important for both the individual and the HCP.

Self-Assessment: Stages of Change

Read the following statements that individuals might make about behaviour change and identify which stage of change the person may be in.

Statement	Stage of Change
1. This is harder than I thought it would be. I'm not sure if I'll make it.	
2. My life is fine. I don't have any problems or concerns.	
3. I never would have thought a few months ago that I could have done this! It's one of the best things I've ever done for myself.	
4. Oh, I'm too old to change. You can't teach an old dog new tricks.	
5. I'm just not sure that it is really worth it.	
6. I don't even think about it any more. It's like all of that was someone else's life.	
7. There's a part of me that wants to change, but I think I'm okay with what I'm doing right now.	
8. I know I'm going to have to make a change, I'm just not sure how. I need a plan.	
9. I've realized that if I want to keep this up, I'll have to make some other changes as well.	
10. I'm going to change, but I have a few other things I need to do first.	

Summary Chart–Stages of Change

Stage	Characteristics	Goal	Tasks
Precontemplation *"I don't need to change"*	There is little or no consideration given to changing the current pattern of behaviour in the foreseeable future Change is viewed as: irrelevant, unwanted, not needed, or impossible.	Serious consideration of behaviour change	• Increase awareness of need for change • Increase concern about the current pattern of behaviours • Envision possibility of change
Contemplation *"I might change"*	Examination of the current pattern of behaviour and the potential for change using a risk/reward analysis. A compelling reason to leave the status quo is needed. Period of instability.	A considered evaluation that leads to a decision to change	• Analyze the pros and cons of the current behaviour pattern • Analyze the costs and benefits of change • Decision making
Preparation *"I will change"*	The individual makes a commitment to take action to change the behaviour pattern and develops a plan and strategy for change.	An action plan that organizes the environment and develops strategies for change to be implemented in the near future (within one month)	• Increase commitment • Create a change plan
Action *"I am changing"*	Implementation of the plan and steps to change the current behaviour pattern and to begin creating a new behaviour pattern.	Successful action for changing current pattern. A new pattern of behaviour established for a significant period of time. (3 to 6 months–Action stage may be shorter for less frequent behaviour patterns)	• Implement strategies for change • Revise plan as needed • Sustain commitment in face of difficulties
Maintenance *"I have changed"*	The new behaviour pattern is sustained for an extended period of time and is consolidated into the lifestyle of the individual. New behaviour becomes habitual, automatic and requires little thought to maintain.	Long-term sustained change of the old pattern and establishment of a new pattern of behaviour	• Sustain change over time and across a wide range of different situations • Integrate the behaviour into the person's life • Avoid slips and relapse back to the old pattern of behaviour
Termination *"I am changed"*	There is no temptation to return to old behaviours and the new behaviour is now part of the identity and self-image of the individual.		

(summarized from: DiClemente, 2003)

Construct 2

The Processes of Change

The Processes of Change represent the internal and external experiences and activities that enable individuals to move from one stage to the next. "The processes are the engines that create and sustain the transitions through the stages and facilitate successful completion of the stage tasks" (DiClemente, 2003, p. 32).

The processes of change emerged from the study of 'self-changers'—those individuals who made behaviour changes without professional assistance. After reviewing more than 400 distinct forms of psychotherapy, each one advocating its own methods for helping people change behaviours, Prochaska and DiClemente (1995) suggested that all of the various therapies could be grouped into 10 basic categories, which they called the Processes of Change. By interviewing self-changers, they determined that in the process of making changes to behaviour, individuals used all of the ten processes, and they used them at different points of time in their change efforts. When the various processes were used remained pretty consistent across self-changers, regardless of what behaviour was being changed. From research into the Processes of Change, the better known construct of the Stages of Change emerged.

The ten Processes of Change are divided into those that are cognitive / experiential and those that are behavioural. The **cognitive / experiential processes** involve the individual experiencing an event that creates a new way of thinking and feeling about their behaviour that , in turn, leads to change. The **behavioural processes** consist of activities that individuals engage in that reinforce the changes they are making.

The ten processes of change are:

Cognitive / Experiential	**Behavioural**
Consciousness Raising	Commitment
Emotional Arousal	Countering
Self Re-evaluation	Environmental Control
Environmental Re-evaluation	Reward
Social Liberation	Helping Relationships

Cognitive/Experiential Processes of Change

When individuals engage in these processes, they do a great deal of reflection about themselves and their lives. Many emotions are evoked, and some of these—fear, anxiety, worry, remorse, guilt, disappointment—may be overwhelming for some people. Strong emotions can paralyze them, or cause them to recycle to a stage of precontemplation, where they either do not think about, or they rationalize, their behaviour. They may also exhibit signs of depression. It is vital for HCPs to help individuals place their emotional reactions into a realistic context and to monitor for depression.

Consciousness Raising

"I recall information people have given me about my behaviour"

When engaged in this process, individuals are increasing their level of awareness about the causes, consequences and treatments for a particular behaviour. It is possible to identify individuals who are engaged in consciousness raising by noticing when they look for or request information; when they discuss articles they have read or seen on TV that relate to their behaviour; or, when prompted, are able to recall information about benefits of change given to them during previous encounters.

Emotional Arousal

"I react emotionally to warnings about my behaviour"

Emotional arousal is also known as 'catharsis' or 'dramatic relief' in the literature. Individuals may experience sudden moments of insight into their behaviour that are precipitated by strong emotions that can arise when engaged in consciousness raising. They may react emotionally to being warned about the consequences of their behaviours, perhaps with fear, worry or anger. Or, they could display sadness, grief or guilt about the impact of their behaviour on others.

Self Re-evaluation

"My behaviour makes me feel disappointed in myself"

When engaged in the process of self re-evaluation, individuals are examining the pros and cons of change. They are thinking in terms of 'good things' and 'not so good things' about their current behaviour as well as a possible new behaviour. A large part of this examination involves comparing their current behaviour and its consequences to their own value system, their life goals, and their self-image.

Environmental Re-evaluation

"I consider the view that my behaviour can be harmful to the people around me or to the environment."

When engaged in the process of environmental re-evaluation, individuals combine cognitive and emotional appraisals of how their personal habits affect both their social and physical environments, as well as how a change in their behaviour could impact others. Individuals develop an awareness of how they serve as a role model for others.

Social Liberation

"I find society changing in ways that make it easier for me to change my behaviour"

Individuals who are engaged in this process of change notice that societal norms and policies have shifted towards support and advocacy for the behaviour change they are considering. A prime example of this phenomenon is the current smoke-free legislation. Individuals not only take note of the societal supports, but they take advantage of such supports and use them.

Behavioural Processes of Change

This second type of change strategy involves processes that are oriented towards taking action. They involve behavioural commitment and actions to create or break behaviour habits. Behavioural processes are visible to outsiders.

Commitment

"I dedicate myself to changing my behaviour"

When engaged in this process, individuals choose to change, from a menu of options. In addition, they accept responsibility for making the change. In some literature, this process is known as 'self-liberation' because the act of committing frees the person from their ambivalence to take action. Health care providers will hear individuals begin to make self-statements that indicate their belief in themselves that they can change.

Countering

"I find other things to do that are good substitutes for my old behaviour"

Individuals engaged in this process actively substitute healthier behaviours for the old behaviour they are changing. They also begin to substitute new ways of thinking and positive self-talk for old beliefs and automatic thoughts. Behaviour change involves a combination of changes to behaviour and changes to thoughts.

Environmental Control

"I remove things from my home (car, office) that remind me of my old behaviour"

When engaged in this change process, individuals are aware of situations or events that will trigger an automatic desire to engage in their old behaviour. They have identified concrete articles that act as triggers and are removing them from their environment. They have also identified places and situations that act as triggers and are developing and implementing plans to avoid these places or situations. Individuals will also be creating an environment that supports their behaviour change by introducing cues for the new behaviour. One of the most difficult activities to control the environment is when individuals make changes to who they spend time with, and under what circumstances.

Rewards

"I acknowledge myself and celebrate when I have successes in my behaviour change efforts"

Individuals who engage in the reward process of change recognize the efforts that they are making towards change and celebrate or reward themselves for these efforts. Reinforcement for progress towards change goals is essential. The old behaviour is self-reinforcing—providing a benefit (perhaps short-term) every time it is done. Rewards may come from self, or from others. Rewards may be tangible (money, a desired item) or emotional (recognition from self, a peer or health care provider).

Helping Relationships

"I have someone who listens when I need to talk about my problems"

Individuals engaged in this process of change actively seek out interactions with individuals they have identified as able to provide support, caring, understanding, openness and acceptance for the individual and the behaviour change being made. Individuals working with this process have also provided education to the people around them about the change they are making and what they need from others to make the change. Both aspects of helping relationships are equally important—asking for support and telling people what type of support is needed.

It is important to recognize that for many people, the only supportive helping relationships they have are with service providers, including HCPs.

How HCPs Assist Individuals to Engage in the Processes of Change

Processes and Techniques

The processes of change should not be confused with techniques. Processes of change are the province and responsibility of the individual making change. Techniques of change are the province of HCPs. HCPs are taught a variety of techniques to use in interventions and treatment, including many presented in this workbook. The techniques employed by HCPs are intended to engage or empower particular processes of change in the individual (Velasquez, et al., 2001). The entire process of intentional behaviour change, however, is more extensive than any single technique used by a health care provider.

It is necessary for HCPs to understand how the processes of change relate to the stages of change. Particular processes are more beneficial at certain stages, so HCPs are encouraged to select and use techniques that target processes that will be most useful to individuals who are at specific stages of change.

If processes of change are the engines that help sustain transitions between stages, then techniques are the keys that HCPs use to get those engines started.

Which Processes Work Best at Which Stages?

Particular processes of change appear to be more helpful if engaged in at specific stages of change. In general, the cognitive / experiential processes tend to be used more by all individuals making behaviour change in the early stages (Precontemplation, Contemplation, and to some extent, Preparation). The behavioural processes are used more in later stages of change (Preparation, Action and Maintenance).

There is evidence that the sequencing of processes is not consistent across stages. Rosen (2000) found in his reanalysis of 47 cross-sectional studies:

> In exercise [adoption, for example], unlike smoking, people use cognitive-affective processes most frequently during action and maintenance. This may reflect differences between ceasing an addictive behaviour and initiating a health-enhancing behaviour. Smoking cessation involves ending an old behaviour. The less one thinks about smoking after deciding to quit, the easier it may be to abstain. Active exercisers, however, must continually reinitiate a new behaviour and may be helped by continuing to think about the benefits of exercising. (p. 62)

STAGE	CREATING New Behaviours	MODIFYING Habitual Behaviours	STOPPING Problematic Behaviours
Precontemplation	Consciousness Raising Emotional Arousal		
Contemplation	Consciousness Raising Emotional Arousal Self Re-evaluation Environmental Re-evaluation		
Preparation	Social Liberation Commitment Environmental Control		
Action	Commitment Countering Environmental Control Rewards		
	Self Re-evaluation Environmental Re-evaluation Consciousness Raising	Self Re-evaluation Environmental Re-evaluation	
Maintenance	Social Liberation Countering Commitment Rewards		
	Self Re-evaluation Consciousness Raising	Self Re-evaluation	

(DiClemente, 2003; Hertzog, et al. 1999; & Rosen 2000)

Self-Assessment: Processes of Change

Read the following statements that individuals might make about behaviour change at particular stages of change and identify at least one process of change that would be beneficial at that stage.

Statement	Stage of Change	Processes of Change
1. This is harder than I thought it would be. I'm not sure if I'll make it.	Action	
2. My life is fine. I don't have any problems or concerns.	Precontemplation	
3. I never would have thought a few months ago that I could have done this! It's one of the best things I've ever done for myself.	Action or Maintenance	
4. Oh, I'm too old to change. You can't teach an old dog new tricks.	Precontemplation	
5. I'm just not sure that it is really worth it.	Contemplation	
6. I don't even think about it any more. It's like all of that was someone else's life.	Termination	
7. There's a part of me that wants to change, but I think I'm okay with what I'm doing right now.	Contemplation	
8. I know I'm going to have to make a change, I'm just not sure how. I need a plan.	Preparation	
9. I've realized that if I want to keep this up, I'll have to make some other changes as well.	Maintenance	
10. I'm going to change, but I have a few other things I need to do first.	Preparation	

Processes and Techniques of Change

	Process	Experiences & Behaviours of Individual that Create & Maintain Change	Techniques Suggested by Health Care Provider
Cognitive/Experiential Processes	**Consciousness Raising** *(Becoming Aware)*	Person becomes aware of problem behaviour, which requires them to learn something new about the behaviour that needs to be changed.	• Providing books or pamphlets to read • Providing personalized feedback • Asking questions about problems with the behaviour
	Emotional Arousal *(Intense Feelings)*	Person experiences strong emotions/intense feelings that result in a movement towards change.	• Showing dramatic portrayals of problem • Inviting significant others to speak about impact of behaviour on them
	Self Re-evaluation *(Looking at Myself)*	Person experiences something that causes them to reflect on personal goals and values and how current or new behaviour fits with those goals and values.	• Look at healthy role models • Self-disclosure • Values clarification • Imagery/"miracle question"
	Environmental Re-evaluation *(Impact on Others)*	Person evaluates how their behaviour affects their home, work, and other lifestyle areas, as well as the people in their lives.	• Family members sharing stories • Information about impact on others • Asking to imagine what it must be like for others • Describe typical day & probe for details
	Social Liberation *(Community Support for Change)*	Person recognizes changes in society, including social alternatives and norms, that make it easier to follow through with the behaviour changes that they are personally willing to make.	• Providing information about policies & laws such as no-smoking zones; tax rebate for children's sports • Community walking trails
Behavioural Processes	**Commitment** *(Creating a Plan)*	Making choices, taking responsibility for, and making commitments to engaging in a new behaviour or behaviour change.	• Short-term behavioural contracts • Telling others of plans • Selecting from a menu of options
	Countering *(Choosing Something New)*	Person chooses to substitute new behaviours and interactions to support the desired change.	• Reduction of behaviour • Quitting behaviour • Altering behaviour • Substituting a new behaviour • Adoption of a new behaviour
	Environmental Control *(Managing my Change)*	Creating, altering, or avoiding cues / stimuli that trigger or encourage a particular behaviour.	• Avoidance • Environmental re-engineering • Self-help groups
	Reward *(Celebrating Achievements)*	Person regularly celebrates progress toward change while removing reinforcement for old behaviours.	• Positive self-statements • Saving money / purchasing desired items • Recognition from others
	Helping Relationships *(Support From Others)*	Person identifies and uses a variety of supportive people to help reinforce the desired changes	• Health care provider • Family • Friends • Support Group

(adapted from: Prochaska, J.O., Norcross, J.C. & DiClemente, C.C. (1995). **Changing for Good.** *New York: Avon Books Inc.)*

Construct 3

The Markers of Change

Two concepts mark movement through the stages of change and are predictive of movement and long-term successful change. These markers are Decisional Balance and Self-Efficacy / Temptation.

Decisional Balance

The decisional balance is an important marker of movement through the early stages of Precontemplation and Contemplation. The concept is based on the work of Janis and Mann (1977). The premise is that rational decisions to take action are based on a weighing of the pros and cons (or good and not-so-good things) about change or remaining in the status quo.

The purpose of consciousness raising and provision of information is to help "tip the balance" in favour of change. For individuals in the Precontemplation stage of change, the balance is heavily weighted towards the status quo. In the Contemplation stage, the balance becomes more equal—hence the heightening of ambivalence. In order to move to the Preparation stage, the individual must shift the balance towards change.

Rational decision-making plays an early role in the change process for stopping a behaviour, but continues to play an important role throughout all stages when an individual adopts a new behaviour.

An example of a Decisional Balance worksheet follows.

Self-Efficacy / Temptation

An individual's confidence in his/her own ability to perform a task is an important predictor of change in early stages and of long-term success in later stages. This concept of self-efficacy is based on the work of Bandura (1977, 1997). Bandura separated out the concept of "Can I do it" from "What do I hope to get out of doing it". Self-efficacy, or lack thereof, often overrides the rational decision-making process of the decisional balance.

An individual has to have both confidence in her/his **ability to do something new**, as well as confidence in his/her ability to **resist temptation to do the old thing.**

High self-efficacy in the early stages of change usually indicates the individual will engage in the behavioural processes of change. High self-efficacy in the later stages of change (Maintenance and Termination) indicate that the individual is less likely to continue to use the behavioural processes of change as they no longer need to actively think about their change.

HCPs can use scaling questions to determine how confident an individual is that they can make a specific behaviour change. In Action and Maintenance stages, scaling questions can be used to determine how confident an individual is they can resist a specific temptation for the old behaviour.

Decisional Balance Worksheet

	PROS The good things about my smoking	CONS The not-so-good things about my smoking
PART 1 **Current** **Behaviour**	**(2)** It relaxes me **(4)** It helps me avoid eating **(1)** It's a way to socialize with my friends **(1)** It's a way to relieve boredom	**(1)** I feel guilty about it **(4)** I may be harming my children with second hand smoke **(3)** It's expensive **(4)** My husband hates it
	The good things about change	**The not-so-good things about change**
PART 2 **New** **Behaviour** **Change**	**(3)** I'll see myself as more responsible **(4)** Children will see me as a role model **(1)** I'll save money **(2)** My health will be better	**(2)** Some of my friends will bug me **(4)** I might feel anxious all the time **(4)** I'm scared of how I'll feel **(4)** I'm scared I'll fail

In this example, the numbers beside each item represent the relative importance assigned by the individual to each consideration as chosen from the following scale:

(1) = slightly important
(2) = moderately important
(3) = very important
(4) = extremely important

By adding the numbers under Pros in Part 1 together with the Cons in Part 2, we have a total number representing **the considerations against change**. (22)

By adding the numbers under Cons in Part 1 together with the Pros in Part 2, we have a total number representing **the considerations for change**. (21)

Those items with high numbers under **considerations against change** will need to be addressed quickly in order to assist the person to choose change.

While completing the decisional balance appears to be a rational action, it is important to recognize that social and cultural factors affect people's perceptions of their behaviour, as well as their evaluation of its costs and benefits. These influencing factors are known as the Context of Change.

Construct 4

The Context of Change

Any single pattern of behaviour occurs within the context of a person's entire life. Therefore, a change in any single behaviour will impact all aspects of an individual's life.

This workbook presents a framework for assisting individuals to make behaviour changes that they have deliberately chosen to make. The framework is based on theories of individual behaviour. Individual choice is all that is really within the scope of brief interventions.

It is important, however, to remember that change takes place within a wider context. Multiple factors from an individual's context will play a role in the decision for or against change, and in the path the change process takes. While these contextual factors may be outside the scope of brief interventions, they must be taken into consideration.

The contextual factors that need to be kept in mind are:

1. Current Life Situation
The internal and external environment in which the change takes place.

2. Beliefs and Attitudes
The belief system and basic values of the individual.

3. Interpersonal Relationships
The close, intimate family members and friends of the individual.

4. Social Systems
Family system, work system, social network, health care system, etc.

5. Enduring Personal Characteristics
Personality traits.

Transtheoretical Model of Change (TTM)–Summary

Construct	Description
Stages of Change	The stages of change divide the process of making behaviour change into distinct segments. Each stage is defined by specific tasks that individuals need to complete in order to move on to the next stage. The stages describe motivational and temporal aspects needed to create sustained behaviour change.
Processes of Change	The processes of change represent internal and external experiences and activities that enable a person to move from one stage to the next. Engaging in these processes provides the means for individuals to complete the stage-specific tasks. The processes create and sustain movement.
Markers of Change	The markers of change are signposts that depict where a person is in two key change-related areas: decision-making for change (decisional balance); and personal self-confidence in ability to make the change (self-efficacy)
Context of Change	The context of change is what surrounds the individual as they attempt behaviour change—issues, problems, resources and liabilities that help or hinder progress towards change.

Motivational Interventions

Motivational Interviewing

Motivational Interviewing (MI) is a unique counselling and communication style that was developed by William Miller (1983). The counselling style was developed within the addictions field and sought a way to assist individuals who were 'unmotivated' to change their addictive behaviours. Along with the Transtheoretical Model of Change, which developed alongside Motivational Interviewing and is congruent with it, MI revolutionized the addictions field.

Motivational Interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Rollnick & Miller, 1995).

Miller's co-author, Stephen Rollnick, has written about a variant of MI that is specifically designed for use by HCPs in health care settings (Rollnick, Mason & Butler, 1999). This variant is designed to be briefer than MI and more 'counsellor' driven, while still maintaining the 'Spirit' of MI. Rollnick's model is called Behaviour Change Counselling.

The 'Spirit' of Motivational Interviewing

The 'Spirit' of MI and its variants is more important than the tasks, strategies or techniques of the method, (Miller & Rollnick, 2001; Rollnick, Mason & Butler, 1999). This 'Spirit' has been described as a **collaborative conversation about behaviour change.** "This is not merely a matter of using techniques or strategies, but of approaching the consultation and the topic of behaviour change with a set of attitudes that promote patient autonomy (Rollnick, et al., 1999, p. 32).

Quantifying the 'Spirit"

Value Base	• Respect for autonomy of individuals and their choices is paramount • Individuals decide what behaviour, if any, to focus on
Role of HCP	• To provide structure, directions and support for conversations about health behaviour change • To provide information that the individual wants • To elicit and respect the individual's views and aspirations
Style	• Collaborative vs. Confrontational • Evocation vs. Education • Autonomy vs. Authority

(Miller & Rollnick, 2002; Rollnick, Mason & Butler, 1999)

Key Concepts of Motivational Interventions

The 'Spirit' of motivational interventions can be achieved by adhering to the key concepts outlined for motivational interventions. HCPs often remember the acronyms for the principles and techniques, but overlook the guiding 'Spirit'. Remember: the following concepts are only tools to assist in preserving the 'Spirit'—they are not motivational interviewing (or behaviour change counselling) itself. These tools are:

Ambivalence
Motivation—Importance, Confidence & Readiness
4 Principles of Motivational Interviewing
OARS—The Techniques
Traps to Avoid

Ambivalence

The Foundational Assumption of Motivational Interventions

MI and its variant, Behaviour Change Counselling (BCC), are founded on the assumption that the reason that people do not change their behaviour is because they have mixed feelings about it. This **ambivalence** is what keeps individuals stuck in current, problematic behaviour patterns. Resolving ambivalence will encourage change. Therefore, in motivational interventions, the key task of the HCP is to assist the individual to resolve their ambivalence.

This focus on ambivalence differs significantly from more traditional theories used for health behaviour change that are premised on different assumptions. These more traditional theories assume that the individual's health is the prime motivating factor for him/her, and that given enough 'expert' information about the dangers of their behaviour, the individual will change. If they do not change, it is due to lack of motivation, which a HCP has no influence over.

By taking ambivalence as the key operating assumption, Miller, Rollnick, and their colleagues challenged all of the old beliefs:

- Health may not be the prime motivating factor—people are motivated by many different things
- Knowing the dangers of a behaviour may not be enough to outweigh the benefits of that behaviour for that individual
- HCPs are not the experts on what will work for an individual—the individual is the expert on him/herself
- Motivation is not a static character trait of an individual, but rather a product of the interaction between HCP and individual

Learning what the individual is motivated for, and helping them to resolve their ambivalence so that they choose to attain their personal motivations through the behaviour change advocated by the HCP are primary tasks of the HCP. The best way to learn about an individual is to **listen** to them talk about themselves and their experiences.

What is Motivation?

Within Motivational Interviewing and all of the motivational interventions that are variants of MI, motivation is viewed as a dynamic rather than a stable character trait. It is one that can be influenced by external factors, including specific behaviours of HCPs.

Motivation is about reasons to take action—to change behaviour. Miller and Rollnick (2002) identify three concepts that must all be present before an individual will take action to change behaviour. These three concepts are: **importance, confidence and priority**. The three are commonly known as being **ready, willing and able to change**.

Willing

The Importance of Change

One factor in motivation is the degree to which a person wants, desires or wills change. How important does the individual rate a particular behaviour change against other changes in their life? The higher the degree of importance, the greater the likelihood of change occurring.

Importance can also be measured as the degree of discrepancy between current life circumstances and values for the future. When the degree of discrepancy is great, individuals are more likely to make change.

Low importance for change suggests a counselling strategy for the HCP—enhance importance by developing discrepancy, using various processes of change, (e.g. provide information about effects of second hand smoke and ask about possible impact on children in the home).

Able

Confidence for Change

Individuals may be willing to change, but feel unable to change. They feel pessimistic about their own ability. Self-efficacy, or the belief in one's own capacity to make change, is often ignored or underestimated by HCPs who suggest behaviour change at this time.

If individuals believe they cannot change, they will often use coping mechanisms such a minimization or rationalization to cover their uncertainty. Such coping mechanisms are often viewed in a negative way by HCPs, but they are really just a way for the individual to communicate that they feel unsafe, vulnerable and not capable of change at this time.

If individuals have many changes to make, as those recovering from a heart attack, they may find it easier to modify an existing behaviour (e.g. diet) or add a new behaviour (e.g. exercise) before they tackle stopping a behaviour (e.g. smoking). Starting with a behaviour an individual feels more confident about can build self-confidence by building successes.

Low confidence for change suggests a counselling strategy—build confidence by directing self-reflection on past successes and using affirmations.

Ready

A Matter of Priorities

Individuals may assign high importance to behaviour change and believe they can make the change, and still not actively engage in making change. This is usually an indicator that, while change is important, it is not the **most important** thing on their plate at this moment.

Having conflicting priorities is part of life. Low readiness to change suggests a counselling strategy—identify barriers to change and help the individual plan to manage these barriers.

Exploring Importance and Confidence

1. Goal for HCP: get individuals in precontemplation and contemplation stages thinking about:

Importance (Why?)	Confidence (What? How?)	Readiness (When?)
• Is it worthwhile? • Why should I? • How will I benefit? • What will change? • At what cost? • Do I really want to? • Will it make a difference?	• Can I? • How will I do it? • How will I cope with x, y, and z? • Will I succeed at it? • What change....?	• Should I do it now? • What about other priorities?

2. Specific techniques and associated open-ended questions HCPs can use to explore:

Importance	Confidence
Scaling Questions: • Why have you given yourself such a high score on importance? • What would need to happen for your importance score to move up from x to y? **Examine Pros & Cons:** • What are the good things about... *(current behaviour)?* • What are some of the less good things about...? **Examine Concerns about Behaviour:** • Tell me about the concerns you have about... *(current behaviour).* • What difficulties or hassles have you had in relation to...? • What is there about... that you or others might see as reasons for concern? • What would have to happen for it to become more important for you to change? • What would have to happen before you seriously considered changing? **Hypothetical Look "over the fence" (Miracle Question)** • How would you like for things to be different? • If you were to change, what would it be like? **Other:** • Where does this leave you now? (when you want to ask about change in a neutral way)	**Scaling Questions:** • Why have you given yourself such a high score on confidence? • How could you move up higher, so that your score goes from x to y? **Brainstorm Solutions:** • What would make you more confident about making these changes? • How can I help you succeed? • If you were to decide to change what might your options be? Are there any ways you know about that have worked for other people? • What are some of the practical things you would need to do to achieve this goal? Do any of them sound achievable to you? • Is there anything you can think of that would help you feel more confident? **Review Past Efforts—successes & struggles:** • What makes you think that if you did decide to make a change, you could do it? • What encourages you that you can change if you want to? • When else in your life have you made a significant change like this? How did you do it? • What personal strengths do you have that will help you succeed? • Is there anything you found helpful in any previous attempts to change? • What have you learned from the way things went wrong the last time you tried?

3. Once importance and confidence are high, it is time to explore READINESS:

- What other things in your life do you need to take care of before you can make this change?
- If you were to start this change today, what might get in your way?
- If you were to start today, are there some things that you think might trip you up? What do we need to do to remove those obstacles?
- On a list of things in your life that you need to deal with right now, where does this change rank?
- What do you think is the first step for you in making this change?
- What do you think you might do?

4 Principles of Motivational Interviewing

Motivational counselling approaches are founded on four primary principles:

- **Express Empathy**
- **Support Self-Efficacy**
- **Develop Discrepancy**
- **Roll With Resistance**

Express Empathy

Empathy is the ability to accurately understand another individual's perceptions and emotional experience. In the MI method, accurate empathy requires the HCP to communicate empathy through accurate reflections of what the individual has communicated, through both verbal and non-verbal means. Further, once the HCP reflects back to the individual what they understand the person has communicated, the individual must acknowledge that the HCP's understanding is accurate.

The information exchange for accurate empathy looks like this:

INDIVIDUAL		HCP
Communicates (verbal & non-verbal)	→	1. Listens 2. Interprets 3. Reflects back content & emotion of individual's communication
Listens, interprets & Responds to Reflection • Accurate • Inaccurate	←	

Taking the time to accurately and clearly express empathy shows that the HCP cares about the individual as a unique person.

"They don't care how much you know until they know how much you care."

Support Self-Efficacy

Self-efficacy is the individual's belief in her/himself that she/he can make and maintain the health behaviour change being discussed. Many people never attempt behaviour change, despite knowing that the change is in their best interest, because they do not have confidence in themselves that they are capable.

Supporting self-efficacy, through genuine respect for and belief in the individual's abilities and capacities is the most important thing an HCP can do to assist behaviour change. Sometimes 'helpers' have to believe in someone before that person can believe in him/herself.

Develop Discrepancy

In MI, helping individuals to identify how their current behaviour differs from their life goals and personal values is a primary task for the counsellor. In briefer motivational interventions, developing discrepancy is not a focal task, but is often an outcome of other activities. While discrepancy is an essential part of experiencing and resolving ambivalence, the task of developing it as part of counselling often requires more time and a deeper therapeutic alliance than is the norm in primary care settings.

HCPs should, however, utilize available opportunities to empathically acknowledge discrepancies between individual goals and behaviours.

Rolling with Resistance

This is one of the most fundamental principles of motivational interventions and one of the most significant contributions MI has made to the field of behaviour change counselling. Rolling with resistance means, at its most basic, **avoid arguing** with the individual.

Many health behaviour consultations involve the HCP telling the individual they **should** do something, then trying to **convince** the individual to do it, or how to do it. These consultations leave both the HCP and the individual feeling frustrated. Often, the result is the HCP stops or avoids talking about health behaviour change.

Adherence to the principle of rolling with resistance allows the 'Spirit' of motivational interventions to shine:

- The HCP is not the 'expert' who has to convince the person to change
- The individual is the 'expert' on what he/she needs in his/her life
- Resistance (arguing, denial, "yes, but") are the individual's way of telling the HCP that the current conversation is not working for them
- The HCP is responsible for recognizing resistance and adjusting his/her strategy accordingly
- Expressing empathy will help the HCP understand why the person is resistant, which then identifies what the individual needs
- This need is greater, at the moment, than the health behaviour change being advocated
- If the HCP acknowledges the need, and helps the person to meet the need, the chance for future consideration of the behaviour change is increased

There are many techniques for rolling with resistance, and they all boil down to one common denominator—active listening. By actively listening to individuals, using the good listening / communication skills listed below, HCPs can **use resistance** to better understand people, rather than **fighting against** resistance.

Examples of Rolling with Resistance:

HCP: I see from your chart that you smoke. I'd like to take a couple of minutes to talk about your smoking, if that is okay with you? *(ask permission)*

Client: I'm sick of people talking about my smoking. I don't want to talk about it. *(resistance)*

HCP: I can see that you are frustrated by others attempts to get you to stop smoking. *(reflection of feeling)* I respect that, and it is up to you whether we talk about it or not. *(emphasizing personal responsibility)* I won't push you. I would just like to say that for many people, quitting smoking is the single most important thing they can do to improve their health. *(advice)* I've got some information here that you are free to take home and look at if you wish. It is entirely up to you. *(emphasizing personal responsibility)* If you change your mind in the future and want to talk about your smoking, just let me know. *(leaving door open)*

By not responding defensively, and acknowledging the client's feeling (frustration), the HCP avoids arguing. The HCP still gets a chance to give advice, but in a non-judgmental way.

The HCP demonstrates respect for the client by emphasizing personal responsibility.

HCP: I see from your chart that you smoke. I'd like to take a couple of minutes to talk about your smoking if that is okay with you? *(ask permission)*

Client: Okay, but I can tell you right now that I won't quit. My grandfather smoked and drank everyday of his life and he lived to be 92. *(resistance)*

While agreeing, the client is doing so in an aggressive way.

HCP: That's great! And you may have inherited those longevity genes. Tell me about your smoking. *(avoid argumentation, elicit information)*

The HCP must be sincere when saying "that's great". The HCP does not bite and get into a debate about why grandpa may have lived so long.

Client: What do you want to know? I'm still not going to quit. *(resistance)*

Client is still being aggressive.

HCP: You are concerned that I am going to tell you to quit smoking. *(reflection of feeling.)* Let me assure you that I won't tell you to do anything. Smoking is entirely your decision. *(emphasizing personal responsibility)* Smoking is an important part of your life, and I would like to hear a little more about it from your perspective, if you want to tell me. *(affirming, asking permission, emphasizing personal responsibility).*

By reflecting feeling again, the HCP makes the client aware of the important role smoking plays for him/her.

The HCP defuses anger further by re-affirming the client's control of the conversation.

Client: I don't mind talking about it. I like to smoke. It helps me relax. I can afford it and I don't have cancer or anything like that. I smoke outside, away from the kids, so I don't see what the problem is.

Client reveals that they have given some thought to the pros and cons of smoking, and has made some behaviour change (smoking outside)

HCP: Smoking is an enjoyable activity for you that reduces stress. You recognize that there are risks and downsides to smoking for some, like the cost, or the relationship between smoking and cancer, and you are prepared to accept those risks for yourself. You aren't prepared to place your children at risk, so you've taken steps to protect them. *(summary)*	*This summary is subtle., It reflects the discrepancy between values (health, being good parent and role model) and behaviour (continuing to smoke) in a non-threatening way.*
	Notice lack of word "but".
Client: Yeah, that's about it. I know that smoking isn't good for you, but we all have to die someday from something and I like to smoke. As long as I'm not hurting anyone else, I say "what's the big deal?"	*Client further acknowledges awareness of risks of smoking.*
HCP: Smoking is not a big deal for you now. *(reframe)* What would have to happen for your smoking to become a big deal to you in the future? *(Open question)*	*HCP subtly introduces the idea of change with the word 'now.' The open question will elicit 'importance' information.*
HCP: The last time we met we talked about how you would start a daily walking program. I was wondering how that is going?	*HCP begins with a quick summary of last session.*
Client: I knew you were going to ask me that.	*Client shows resistance immediately*
HCP: Tell me what you're upset about Tammy.	*HCP invites talk by reflecting feeling*
Client: I don't want to talk about my walking program. I knew you would ask about it. Why can't we talk about something else?	*Client ignores invitation and focuses on what she is resistant to talking about—walking.*
HCP: We can talk about anything you want Tammy. If the walking program is not going well, that is okay and we can talk about what's happening for you with that, or about something else.	*HCP gives control to client. Also, HCP affirms that not walking is okay if that is what has the client upset.*
Client: Ever since I fell and broke my arm all of you people have been pushing me to build my strength up and build up my bones. I don't want to be told what to do. I'm 76 years old and I am not a child.	*Client makes global statement about HCP "all of you people".*
HCP: You are very upset Tammy. You sound really frustrated.	*HCP reflects emotional content.*
Client: Of course I'm frustrated. Everyone is telling me what to do. You won't like it either when you're my age.	*Client acknowledges accuracy of reflection but is still blaming HCP*
HCP: I don't like being told what to do now. I'm sorry that you are feeling pushed. Tell me what you need me to do to help you feel more in control.	*HCP sides with client to let her know she is understood. Invites client to give direction.*
Client: It's not you, really. I know that you are just trying to help me. It's everyone else. My children and grandchildren, my doctor. My daughter saw that chart we made and decided she would pick me up and drive me to the mall to make sure I got there. She even said she would walk with me. I guess she wants to make sure I do what I'm told! I'm not a child.	*This strategy works as client acknowledges that the HCP is not doing anything wrong and goes on to give a great deal of useful information.*

OARS

Techniques of Motivational Interventions

The skill required when talking to individuals about the why, how, what and when of behaviour change is *not a matter of applying techniques on them*, but of *structuring conversation in a useful way* that encourages the individual to take as much of a lead as possible. Techniques are merely guides to structure the type of consultation.

The basic techniques of motivational interventions are summarized by the acronym OARS:

- **Open-ended Questions**
- **Affirmations**
- **Reflections**
- **Summaries**

In MI, these techniques of active listening are used in a strategic way to develop and resolve ambivalence in a specific direction. In briefer motivational interventions, these same active listening techniques, used broadly, evoke similar results, while requiring less specialized counselling skills. The techniques are presented below in the order they are most commonly used in consultations.

Open-Ended Questions

Simply, these are questions to elicit information that cannot be answered with a simple, quantifiable response like, "yes", "no" or "7". Open-ended questions encourage the responder to give thoughtful responses that reveal their thoughts and feelings—the roots of their ambivalence for change.

Reflections

In the terminology of counselling skills, reflections are statements (NOT questions) that 'mirror' or reflect back what the person has told you with their verbal and non-verbal communication. Reflections use similar but different words so that the individual knows that the HCP has understood what they meant (empathy). Reflections can include the factual and emotional content of communications. In health behaviour change counselling, reflection of emotional content is often the most important.

It has been said that people believe what they say, so in motivational interventions, it is particularly important for HCPs to reflect back anything the individual says that supports health behaviour change. By reflecting, the individual hears her/himself speak in favour of change, then hears their words reflected again. The more they hear themselves say something, the more they come to believe it.

Unofficial Rule

In motivational interventions, it is suggested that for every open-ended question that is asked, the HCP provide 3 reflections before asking another question:

Open-ended Question → Answer → Reflection → Individual's Response → Reflection → Individual's Response → Reflection → **Open-ended Question**

Above all, by using reflections, HCPs are not likely to cause harm or get in 'over their heads'. Reflections, unlike questions, keep individuals thinking their own thoughts and are non-judgmental as long as the HCP is careful about the intonation used when reflecting (e.g. avoid sarcasm).

Contrasting Reflections with Alternate Responses:

Individual:	**I guess I don't get as much exercise as I could, but I don't think that's really a problem for me.**
Confrontation:	You don't think it's a problem, yet you have just told me that you can't walk up flights of stairs at work, that you're 'getting too old' to play tag with your children, and that moving file boxes left you extremely fatigued. These could all be related to physical fitness.
Question:	Why do you think you don't have a problem?
Reflection:	So, on the one hand, you can see some reasons for concern, and you really don't want to be labelled as 'having a problem.'

Individual:	**My wife is always telling me that I'm hurting the kids with my smoking.**
Judging:	She probably has some reasons for thinking so.
Question:	Why does she think that?
Reflection:	And that really hurts you.

Individual:	**If I'm crazy, what am I supposed to do for friends? My friends won't hang around with a nut case.**
Advice:	I guess you'll have to make some new friends. Support groups can be a great way to do that.
Suggestion:	Well, you could just tell your friends about your diagnosis and educate them about bi-polar disorder with the pamphlets we have.
Reflection:	It's hard for you to imagine living with the label.

Summaries

Summaries are used to bring together larger amounts of information. After several sets of questions and reflections, an HCP may make a summary statement that links all of the previous conversation together. A summary highlights concerns of the individual, the doubts or ambivalence about change, and points out discrepancies between behaviours and goals.

HCPs may use summaries at any time. They are particularly useful at the end of consultations and the beginning of subsequent consultations with the individual. Summaries are also helpful when the HCP thinks the individual is ready to transition to the next stage of change.

Affirmations

Affirmations are statements of appreciation and acknowledgement of the individual's strengths, talents and skills. HCPs who use affirmations let the individual know that their efforts towards change are recognized and appreciated. Affirmations must be genuine, and when they are, they can encourage the development of self-efficacy.

According to the authors of the TTM (Prochaska et al., 1995) many people are 'failed self-changers', meaning that they tried to alter their behaviour on their own and it did not work. As a result, many individuals that receive counselling for health behaviour change feel demoralized even before the HCP raises the issue of health behaviour change.

Self-Assessment: Motivational Responses

Read the following statements and write out how you would respond to this statement in the 'Spirit' of motivational interventions.

Statement	Stage of Change	Processes of Change	Motivational Response
1. This is harder than I thought it would be. I'm not sure if I'll make it.	Action	Countering Environ. Control Commitment	
2. My life is fine. I don't have any problems or concerns.	Precontemplation	Consciousness Raising Self Re-evaluation Environ. Re-evaluation Emotional Arousal	
3. I never would have thought a few months ago that I could have done this! It's one of the best things I've ever done for myself.	Action or Maintenance	Rewards Countering Environ. Control Social Liberation	
4. Oh, I'm too old to change. You can't teach an old dog new tricks.	Precontemplation	Consciousness Raising Self Re-evaluation Environ. Re-evaluation Emotional Arousal	
5. I'm just not sure that it is really worth it.	Contemplation	Consciousness Raising Social Liberation Environ. Re-evaluation	
6. I don't even think about it any more. It's like all of that was someone else's life.	Termination	Rewards Social Liberation	
7. There's a part of me that wants to change, but I think I'm okay with what I'm doing right now.	Contemplation	Consciousness Raising Social Liberation Environ. Re-evaluation	
8. I know I'm going to have to make a change, I'm just not sure how. I need a plan.	Preparation	Commitment Social Liberation Countering Environ. Control	
9. I've realized that if I want to keep this up, I'll have to make some other changes as well.	Maintenance	Commitment Social Liberation Countering Rewards Self Re-evaluation	
10. I'm going to change, but I have a few other things I need to do first.	Preparation	Commitment Social Liberation Countering Environ. Control	

Self-Assessment: Motivational Responses

Read the following statements and responses and identify which principles of motivational interventions are being focused on, as well as which active-listening skills (OARS) are used.

Statement	Stage of Change	Processes of Change	Motivational Response	Principle	Skill
1. This is harder than I thought it would be. I'm not sure if I'll make it.	Action	Environ. Control Countering	Making a change is hard work. Let's talk about what's difficult right now and find a way past this obstacle. That's what has worked for you so far.		
2. My life is fine. I don't have any problems or concerns.	Precontemplation	Self Re-evaluation	You're happy with your life and you don't want to make any changes now. If something magically changed to make your life even better, what would it be?		
3. I never would have thought a few months ago that I could have done this! It's one of the best things I've ever done for myself.	Action or Maintenance	Rewards	When you look back on the changes you've made, you are able to see how far you've come. It took alot of effort and now you can enjoy the results. It was a gift to yourself.		
4. Oh, I'm too old to change. You can't teach an old dog new tricks.	Precontemplation	Emotional Arousal	You feel like it's too late for you. You just have to make the best of it.		
5. I'm just not sure that it is really worth it.	Contemplation	Environ. Re-evaluation	There's a lot to think about because the effort to change will be great. Tell me how your family feels about the change.		
6. I don't even think about it any more. It's like all of that was someone else's life.	Termination	Rewards	You've developed a whole new habitual behaviour–a healthier one! It is part of who you are now.		
7. There's a part of me that wants to change, but I think I'm okay with what I'm doing right now.	Contemplation	Self Re-evaluation Emotional Arousal	On the one hand, change seems like a good thing, and on the other hand, the change may not be as good as life is now.		
8. I know I'm going to have to make a change, I'm just not sure how. I need a plan.	Preparation	Commitment	You're ready to change and uncertain how to proceed. You want a roadmap. What are some of the methods you know others have used to make this change?		
9. I've realized that if I want to keep this up, I'll have to make some other changes as well.	Maintenance	Self Re-evaluation Environ. Re-evaluation	Now that you've reached your goal you can see that there are some other behaviours that no longer fit the new you. You've now got the skills to make any changes you want.		
10. I'm going to change, but I have a few other things I need to do first.	Preparation	Social Liberation	Change is important and you know you will do it, it's just not the right time yet. Let's look at some options for trying out the change while we work on the other priorities in you life first. What are some options you can think of?		

Traps to Avoid

Motivational interventions identify several behaviours that HCPs should avoid when providing behaviour change counselling. These HCP behaviours are referred to as traps.

Expert Trap

In the 'expert trap', the HCP falls into the habit of providing direction to the individual without first helping him or her to determine her/his own goals, directions and plans. The problem with this approach is that the individual may passively accept the HCPs suggestions while in the consultation, but never commit to using them outside of the consultation.

Premature Focus Trap

In the 'premature focus trap' the HCP tries to identify and focus discussion on what the HCP perceives the individual's problem to be. The individual may have different priorities, or place a lower degree of importance on the behaviour change than the HCP. While motivational interventions allow the HCP to be directive, HCPs should use caution to not focus on a specific behaviour too quickly without first hearing what the individual is interested in discussing and perhaps changing. Focusing too early on one behaviour can initiate resistance.

Prescription Trap

There is a temptation to abandon the motivational, reflective approach when an individual agrees that change is important. If their confidence is low, there is a temptation for the HCP to say, "Here's how you do it." When an HCP gives an individual a prescription for how to change without exploring their ideas and concerns, the individual is likely to come up with reasons why the prescription will not work, (will say "Yes, but...").

Reassurance Trap

Sometimes, HCPs do not take the individual's lack of confidence seriously enough. There is a difference between affirming a person's specific strengths and abilities and offering bland reassuring statements such as "I'm sure you can do it." Reassurance can provoke the "yes you can" / "no I can't" struggle between HCP and individual.

Putting It All Together: Transtheoretical Model & Motivational Interventions

Statement	Stage of Change	Processes of Change	Motivational Response	Motivational Principle	Listening Skill
1. This is harder than I thought it would be. I'm not sure if I'll make it.	Action	Environ. Control Countering	Making a change is hard work. Let's talk about what's difficult right now and find a way past this obstacle. That's what has worked for you so far.	Support Self-Efficacy	Affirmation
2. My life is fine. I don't have any problems or concerns.	Precontemplation	Self Re-evaluation	You're happy with your life and you don't want to make any changes now. If something magically changed to make your life even better, what would it be?	Roll with Resistance Expr. Empathy	Reflection Open-Ended Question
3. I never would have thought a few months ago that I could have done this! It's one of the best things I've ever done for myself.	Action or Maintenance	Rewards	When you look back on the changes you've made, you are able to see how far you've come. It took alot of effort and now you can enjoy the results. It was a gift to yourself.	Support Self-Efficacy	Reflection
4. Oh, I'm too old to change. You can't teach an old dog new tricks.	Precontemplation	Emotional Arousal	You feel like it's too late for you. You just have to make the best of it.	Roll with Resistance	Reflection
5. I'm just not sure that it is really worth it.	Contemplation	Environ. Re-evaluation	There's a lot to think about because the effort to change will be great. Tell me how your family feels about the change.	Roll Resist. Dvlp. Discrep.	Reflection Open-Ended Q.
6. I don't even think about it any more. It's like all of that was someone else's life.	Termination	Rewards	You've developed a whole new habitual behaviour–a healthier one! It is part of who you are now.	Support Self-Efficacy	Reflection
7. There's a part of me that wants to change, but I think I'm okay with what I'm doing right now.	Contemplation	Self Re-evaluation Emotional Arousal	On the one hand, change seems like a good thing, and on the other hand, the change may not be as good as life is now.	Develop Discrepancy	Reflection
8. I know I'm going to have to make a change, I'm just not sure how. I need a plan.	Preparation	Commitment	You're ready to change and uncertain how to proceed. You want a roadmap. What are some of the methods you know others have used to make this change?	Support Self-Efficacy	Summary Affirmation Open-Ended Q.
9. I've realized that if I want to keep this up, I'll have to make some other changes as well.	Maintenance	Self Re-evaluation Environ. Re-evaluation	Now that you've reached your goal you can see that there are some other behaviours that no longer fit the new you. You've now got the skills to make any changes you want.	Dvlp. Discrep. Support Self-Efficacy	Reflection Affirmation
10. I'm going to change, but I have a few other things I need to do first.	Preparation	Social Liberation	Change is important and you know you will do it, it's just not the right time yet. Let's look at some options for trying out the change while we work on the other priorities in you life first. What are some options you can think of?	Support Self-Efficacy Express Empathy	Reflection Open-Ended Question

Melding Theories in Brief Interventions for Behaviour Change

The preceding section described two complementary theories of how to assist individuals to effect changes in their behaviours. Both of these theories were developed in the addictions field, initially for use by addictions specialists. Specialist addictions counsellors often work intensely with individuals for weeks or months, and provide lengthy follow-up. As the TTM and MI were adopted for use in other behaviour change efforts, questions began to arise regarding whether the methods could be applied by HCPs who have less frequent and less intense contact with individuals. Could the TTM and MI be compatible with brief interventions?

Interventions are actions taken to bring the issue of potential or actual health problems to the attention of the affected individual, and to improve motivation for behaviour change to reduce harm. Brief interventions are shorter than typical specialized counselling sessions, and are usually defined as advice-giving or counselling sessions that last anywhere from 3 to 30 minutes. Brief interventions are typically conducted by HCPs who are not specialist counsellors.

The TTM is well suited for use with brief interventions because it advocates starting from the stage of change that the individual is in and working from there. Often, once made aware of problematic behaviours, individuals become self-changers and require little ongoing assistance.

The MI model is not as easily adaptable to briefer interventions, mainly because brief interventions rely on an HCP giving an individual direct, unsolicited advice to consider behaviour change. This is distinctly a non-MI strategy. Advice-giving often creates resistance, so the challenge was to find a way to give advice that would lessen the chance of resistance, still be brief, and remain congruent with other MI strategies.

A framework, based on the TTM, clearly describing the tasks an HCP should perform in order to help effect behaviour change was created for HCPs working in primary care, (Dosh et al., 2005). This framework is known as the 5-A Model. One of these A's stands for clearly advising individuals to make behaviour changes.

At the same time, William Miller, the originator of MI, created a formula for giving brief advice that, while not MI, is still motivational in nature. This formula is known as FRAMES, (Rollnick & Miller, 1995; Miller & Rollnick, 2002). Miller's co-author, Stephen Rollnick, has spent considerable time and effort studying how to apply MI in primary care settings. The process he developed, which he refers to as Behaviour Change Counselling (BCC) fits well with the 5-A Model. The 5-As describe tasks for the HCP while BCC describes how to accomplish the tasks with a motivational 'Spirit'.

This workbook advocates a synthesis of these streams of thought about the two theoretical models to create two types of brief interventions that HCPs can choose from, depending on the circumstances they find themselves in. One is Brief Advice and the other is Behaviour Change Counselling. The 5-A Model, described on the following pages, provides the framework for both.

The 5-A Model

In a Technical Report released in 2001, the Canadian Task Force on Preventive Health Care (CTFPHC) advocated a conceptual framework for HCPs to use when counselling individuals about health behaviour change. (The term counselling includes a wide array of activities: assessing knowledge and motivation, providing information, modifying behaviours, reinforcing desired behaviours, and monitoring long-term progress.) **This conceptual framework is known as the "5 A Model".**

The CTFPHC recommends using this framework when speaking to individuals about six risky health habits—dietary patterns, problem drinking, risky sexual patterns, unintentional injury, physical inactivity patterns, and tobacco use.

The 5 A's outlined by the CTFPHC are:

- **Ask / Assess**
- **Advise**
- **Agree**
- **Assist**
- **Arrange**

The Model was originally developed by the US National Cancer Institute to guide physician intervention in smoking cessation. It began as the 4 A Model, (ask, advise, assist, arrange), and has since been adopted for use with other behaviour change interventions, including alcohol, physical activity, diabetes management, nutrition, and substance use. It has also been expanded to 5 A's from the original four to make it congruent with the TTM. The framework has been identified as an evidence-based model of practice (Whitlock et al., 2002; Goldstein et al., 2004; Fiore et al., 2000). Each of the A's helps the HCP to organize the tasks of health behaviour change counselling, as outlined in the following tables.

Notes about Tables:

The table on the next page describes each of the 5-A's. The table on page 41 compares the 'Spirit' of Rollnick's BCC with the 5-A's. Finally, the table on page 42 merges the 5-A Model and the BCC model, and identifies practical strategies and techniques for HCPs to use with individuals making behaviour change.

The 5-A's
What They Represent

Ask

The HCP first collects, selects and analyzes information about the behaviour.

- Simple question
- Brief screening instrument
- In-depth assessment of risks, consequences and functions of behaviour

Advise

In the context of this framework, the term 'Advise' has a very specific meaning that has two parts.

- To identify what the topic of conversation will be (which behaviour change)
- To clearly convey a recommendation to the individual to consider making a change in the behaviour (Prior to the recommendation, the HCP should provide personalized feedback and education about the behaviour).

In a case where there are several health-related behaviours that the HCP would like the individual to consider, it is good practice to do some type of agenda-setting activity with the individual before advising. This lets the individual select, from a menu, the health behaviour that they are most willing to discuss.

Agree

Within this framework, this term represents the task of the HCP determining what stage of change (from the TTM) the individual is in regarding changing the behaviour. It is vital that the behaviour change is clearly identified before trying to determine the stage or readiness for change. The word agree reminds the HCP that making the identification of stage happens in the process of discussion about the behaviour, in partnership with the individual.

Asking scaling questions (e.g. "on a scale of 1 to 10...") about importance, confidence and readiness helps to determine stage of change.

Assist

'Assistance' for behaviour change is matched to the individual's stage of readiness for change and thus varies from one individual to the next. Assistance is any on-going counselling, advice / recommendations, behavioural contracts, etc. that is offered by the HCP to the individual either in that particular consultation session, or during subsequent sessions.

Assistance is designed to help the individual move from their current stage of change to the next stage of change.

Providing assistance takes the most time in behaviour change counselling.

How to provide stage-appropriate assistance is covered in detail in Appendix A.

Arrange

'Arrange' stands for those activities that happen outside of the consultation process between the HCP and the individual. Activities that fall within 'Arranging' include referral to another resource, as well as monitoring the individual's change process. Monitoring includes monitoring progress of self-change efforts, as well as progress made while working with other resources the individual has been referred to. This latter type of monitoring is case management.

Using Scaling Questions to 'Agree'

In the 5-A Model, the word 'agree' stands for the process of determining what stage of readiness for making a particular behaviour change an individual is at. The ability to offer 'assistance' that is appropriate and timely hinges on identifying the person's stage of change. Remember that individuals will be at different stages for various behaviours, so it is vital to clearly specify what exact behaviour change is being discussed—eating different foods, tapering off a long-term medication, beginning a walking program, getting up and going to bed at the same times every day. There are validated measures for determining stage of change (URICA, 1985), but most are too cumbersome for use outside of research programs.

Using Scaling Questions, or asking someone to rate him/herself on a scale of 1 to 10, is a quick and easy way to determine what stage of change an individual is at. If the scaling questions are repeated at subsequent consultation sessions, they can also be used to measure movement through the stages of change.

The use of scaling questions, a technique from Solution Focused Therapy (de Shazer, 1985), is useful to determine importance of change, as well as confidence to change.

For example, the HCP could ask:

"How important is it for you to take your medication daily? On a scale from 1 to 10, where 1 is not at all important and 10 is extremely important, where would you say you are?" . . . *"And how confident would you say you are, that if you decided to take your medication daily, you could do it? On the same scale from 1 to 10, where 1 is not at all confident and 10 is 100% confident, where would you say you are?"*

Follow-up to a scaling question on importance or confidence could include these related questions:

"Why are you at a _____ and not a one?"

"What would it take for you to move from _____ to (a number 1 or 2 points above where she/he rated her/himself)?"

NEVER ask someone why he or she is at a particular number and not a ten. This type of question sounds judgemental and can discourage the individual or raise resistance.

- If ratings of importance and confidence are **both low,** the individual is likely in the Precontemplation stage.
- If importance and confidence are **both high**, the individual is most likely in the Preparation stage.

Discrepancies in importance and confidence ratings indicate the individual is in the Contemplation stage, as well as indicating what type of work HCPs should focus on—increasing awareness of importance of change or building confidence/self-efficacy to change.

Comparing the 'Spirit' of Behaviour Change Counselling with the Tasks of the 5-A Model

5-A Model	Behaviour Change Counselling Model
	Establish Rapport • Develops rapport and engages with the individual on a personal level
Ask 1. Ask about risk behaviours 2. Ask about related risk factors 3. Ask about individual's health concerns related to behaviour	**Set Agenda** • Invites the person to talk about behaviour change • Demonstrates sensitivity to talking about other issues of importance to the individual
Advise 1. Give direct advice to change the behaviour 2. Tailor advice to individuals person health concerns or history 3. Recommend changing within 30 days	**Exchange Information** • When providing information, it is sensitive to the person's concerns and understanding
Agree 1. Ask, non-judgmentally, if the person wants to change 2. Ask on a scale of 1-10 • How important changing the behaviour is to the person • How able to change this person feels 3. Ask about things the individual likes most about the behaviour or about things the person would miss the most about changing it 4. Ask what the person is willing to do to change	**Assess Importance/Confidence/Readiness** • Encourages individual to talk about current behaviour or the status quo • Encourages the person to talk about change • Asks questions to elicit how the person thinks and feels about the topic • Uses empathic listening statements when the person talks about the topic • Uses summaries to bring together what the person has said about the topic
Assist Help to plan the change attempt by: 1. Providing self-help behaviour change material 2. Being positive and supportive 3. Reviewing past change attempts and problem solving 4. Reviewing what change will be like and building skills 5. Recommending the individual ask for support from others 6. Reviewing all options for change	**Reduce Resistance** **Explore Importance & Build Confidence** • Acknowledges challenges about behaviour change that the person faces • Conveys respect for individual choices about the behaviour change • Exchanges information and ideas with the individual about how that person could change their current behaviour (if applicable)
Arrange Recommending follow-up contact within 4 weeks of behaviour change attempt	**Continue to provide appropriate assistance** • Schedules follow-up appointments as necessary and continues providing any required support
(University of Rochester Medical Center Competency Project)	*(University of Wales College of Medicine BECCI)*

Integrating BCC with the 5-A Model

Task	Possible Strategies	Examples of Techniques
Establish Rapport	View person as unique individual	• Introduce yourself, shake hands, call by first name (with permission), review last visit in positive terms
	Make individual feel comfortable	• Physical environment–temperature, seating, lighting, wall displays
	Demonstrate respect	• Ask permission to discuss subjects, especially sensitive ones and respect "No"
Ask *(Set Agenda)*	Ask about specific behaviours	• Few simple questions or a formal screening instrument
	Identify menu of options for behaviour changes that impact condition & agree on one to discuss	• Use visual aids • Summarize from previous discussions
Advise *(Exchange Information)*	Verbal	• Conversation, using communication skills to clarify meaning • FRAMES • Elicit-Provide-Elecit (EPE)
	Written	• Handouts, reviewed together
	Visual	• Charts, diagrams, etc.
Agree *(Assess Importance, Confidence, Readiness)*	Ask questions	• Direct and closed • Open-ended • Scaling
	Empathic listening	• Reflections • Paraphrases • Summaries
Reduce Resistance	Stay person-centred	• Ask individual what they think or what they want to do
	Roll with resistance	• Agree with individual's perception • Acknowledge & affirm person's experiences • Ask individual what they think would be best
	Avoid arguing for change	• Do not try to persuade • Avoid giving too much information • Reflect feelings
Assist *(Explore Importance & Build Confidence)*	Match intervention to need	• Use scaling questions
	Develop and resolve ambivalence	• Decisional balance • Explore concerns–"Tell me more..." • "Miracle" Question
individual	Support self-efficacy	• Identify past successes with or for the • Brainstorm possible solutions
Arrange *(Continue to provide appropriate assistance)*	Refer for specialized service	• Monitor progress & provide support
	Continue to provide counselling	• Match intervention to need • Develop and resolve ambivalence • Support self-efficacy

Brief Motivational Interventions

The 5-A Model provides a framework for the two most common types of counselling provided by HCPs:

- **Brief Advice**—on the spot information and advice
- **Behaviour Change Counselling**—a few repeated contacts on the same topic

A third type of counselling for behaviour change usually involves the HCP making a referral to a specialist for a planned period of structured counselling sessions. This is the best course of action when the individual is willing to be referred and there are multiple behaviour changes, or there are other factors that significantly complicate the individual's ability to make behaviour changes. Specialist counsellors, such as Mental Health Workers, may use MI to assist with more complex behavioural changes.

Brief Advice

Provision of on the spot information and advice can serve many purposes. It has been demonstrated that brief advice to stop smoking or to reduce harmful drinking increases the number of individuals who stop smoking or reduce their alcohol consumption, (College of Family Physicians of Canada, 1994; Fiore et al., 2000; Henry-Edwards et al., 2003). Brief Advice introduces the topic of behaviour change with individuals who might otherwise never have considered it.

- Brief Advice is most commonly used in opportunistic settings. It requires only a few minutes—three to five as outlined below—and can be given by any HCP, even at a single contact.
- Brief Advice may also be used by a counsellor who has a longer, established therapeutic relationship with an individual, as a way to introduce a new behaviour change for consideration.
- Brief Advice often addresses only three of the five 'A's' in the 5 A Model—Ask, Advise, Arrange.
- Key skills for HCPs providing Brief advice are: providing advice; encouraging choice and responsibility; asking permission; and asking open-ended questions.

Behaviour Change Counselling

Behaviour Change Counselling usually occurs over a few repeated contacts with an individual, but could happen in one contact. The goal of ongoing counselling is to help the individual progress through the stages of change. Sometimes, individuals will make changes on their own, and require very little assistance to accomplish stage-specific tasks.

While Brief Advice is concerned with bringing the subject of behaviour change to the individual's attention, Behaviour Change Counselling focuses on the HCP helping to increase motivation for change.

Key HCP skills for BCC are: encouraging choice and responsibility; asking permission; providing summaries; using reflective statements; and asking open-ended questions.

"A" Model Components	Brief Advice	Behavioural Change Counselling	Motivational Interviewing
Ask	●	●	●
Advise	●	●	
Agree		●	●
Assess		●	●
Assist		●	●
Arrange	●	●	●

Summary Chart	Motivational Interventions			Traditional HCP Interventions	
	Brief Advice for Behaviour Change	Behaviour Change Counselling	Motivational Interviewing	Brief Advice	Generic Counselling
Context					
Session Time	5 - 15 minutes	5 - 30 minutes	30 - 60 minutes	3 - 7 minutes	5 - 30 minutes
Setting	Mostly opportunistic	Opportunistic or help-seeking	Mostly help-seeking	Mostly Opportunistic	Opportunistic or help-seeking
Goals		**BA Goals, plus:**	**BA & BCC goals, plus:**		
	Demonstrate respect	Establish rapport	Develop relationship	Communicate risk	Demonstrate respect
	Communicate risk	Identify individual goals	Resolve ambivalence	Provide Information	Communicate risk
	Provide information	Exchange information	Develop discrepancy	Provide solutions	Provide information
		Choose strategies based on individual readiness		Be clear about need for compliance	Convince / persuade individual to change Provide suggestions for action
	Initiate thinking about change in problem behaviour	Build motivation for change	Elicit commitment to change		
Style					
Health care provider	Collaborative expert	Counsellor	Leading partner	Active expert	Counsellor
Individual	Active recipient	Active participant	Partner	Passive recipient	Active participant
Confrontational or challenging style	Sometimes	Seldom	Never	Sometimes	Sometimes
Empathic style	Sometimes	Usually	Always	Sometimes	Usually
Information	Provided	Exchanged	Exchanged to develop discrepancy	Provided	Provided

(Rollnick et al., 2002, p. 274)

(Elford et al., 2001)

Brief Advice
Using FRAMES as a Guide to 'ADVISE'

As mentioned previously, Miller designed a formula for briefly advising individuals to change their health related behaviours that retains as much of the 'Spirit' of MI as possible (Rollnick & Miller, 1995). The acronym FRAMES represents the components of Brief Advice that are necessary. In the 5-A Model, the FRAMES formula is used in the task of Advise.

Feedback involves providing personalized information regarding the individual's responses to the questions you ask him/her about a particular behaviour, or that behaviour in relation to a condition that he/she is experiencing. This feedback usually involves pointing out a discrepancy between the individual's behaviour and what is considered healthy. Feedback must be provided in a non-judgmental way. Ideally, after providing feedback, the HCP will ask the individual what they think about what has been said. This step is often skipped in the briefest interventions, to the detriment of the motivational aspects of the intervention.

Responsibility involves communicating to the individual the reality that the behaviour, and any choice about changing it, is up to the individual. No one will try to make or coerce the individual to do anything that they are not ready, willing, or able to do.

Advice involves stating clearly to the individual what action, in the HCP's expert opinion, is the best course of action for them to take regarding the problematic behaviour. Words such as "should" and "need" are to be avoided as they generate resistance. Statements like "I encourage you to consider..." leave the door open to the individual without backing them into a corner. It is vital to communicate respect when offering advice, and it is always a good idea to ask permission before offering any. The way advice is phrased is more important than the advice itself, as people only hear what they want to hear. Advice needs to communicate respect, not expertise.

Menu involves having several choices for the individual, should they want to pursue the advice of the HCP. Having a choice improves motivation. Help people to see that there is a range of options for behaviour change and offer to assist them to explore these options to select one that is most appropriate for them.

Empathy involves the HCP communicating to the individual that they have heard and understood what the individual is saying about their life and the role the behaviour plays in it, as well as any difficulties changing the behaviour may raise. True empathy also involves the individual acknowledging that the HCP does understand what he/she has told the HCP. Empathy is about communicating understanding and goes beyond a simple statement of "I understand". The HCP must reflect back to the individual what that person has said and is feeling.

Self-efficacy involves helping the individual to recognize his/her own strengths and abilities that will help in making the behaviour change, should the individual choose to do so. It is not a hollow reassurance, but a personalized identification of strengths and past successes.

Examples of Brief Advice using FRAMES

ASK about the problem / behaviour:

Do you smoke Mrs. Jones? How long have you smoked? How much do you smoke every day? What problems have you had related to your smoking? Have you ever tried to quit?

ADVISE using FRAMES:

Mrs. Jones, I strongly encourage you to consider quitting smoking. *(ADVICE)* For most people, quitting is the single most important thing they can do to improve their health. *(FEEDBACK)* The decision to quit is yours, and yours alone. *(RESPONSIBILITY)* It may be difficult. *(EMPATHY)* There are many different ways that people can quit, *(MENU)* and if you do decide that you want to quit, I'm confident that you can do it. *(SELF-EFFICACY)* If you decide at some point that you're interested, I'd be very willing to help you look at the options.

ARRANGE referral:

I'm going to get the Smokers' Help Line to give you call, if that is okay? They will give you some information that you can think about to make your own decision about quitting.

There is a danger that by following "guidelines" and "rules" and focusing too much on techniques, the 'Spirit' of motivational and person-centred practice can be lost.

Compare the above example, which is a generic combination of FRAMES with the individualized example below.

ASK about the problem / behaviour:

"I see by your chart that you smoke, is that still correct? Tell me about your smoking." *(OPEN-ENDED QUESTION–instead of asking a long list of closed questions–you will likely get the same information)*

ADVISE using FRAMES:

I am concerned about you and your smoking. *(EXPRESSION OF CARE)* Can I share some of my concerns with you? *(ASKING PERMISSION)*

Smoking is, of course, related to respiratory problems. Smoking complicates your asthma and places you at risk for other health complications if you continue to smoke. Your family history of heart disease is also cause for concern, as smoking increases risk for heart disease. If you were to quit smoking, your asthma would likely improve and you would significantly reduce your chances of developing heart disease. *(PERSONALIZED FEEDBACK)* I understand that smoking is a way for you to relax and is an important part of your life. I also know that smoking is an extremely difficult behaviour for you to stop as you have found from previous experience. *(EMPATHY)* Knowing how important smoking is to you, I still strongly advise you to consider quitting smoking so you can achieve the full health benefits of being a non-smoker. *(ADVICE)* It is a decision only you can make. *(RESPONSIBILITY)* I just want you to know that there are many good reasons for you to quit and there are many options available to assist you should you choose to quit. Some of these are: quit-smoking support groups, self-help guides, nicotine replacement therapies, and The Smokers' Help Line, which offers free advice and support. *(MENU)* If you choose to quit, I believe that you can be successful. You have made a great many other changes in your life and you have identified some things you have learned from your previous attempts to quit. Your previous change efforts provide you with a good foundation to make this change as well. *(SELF EFFICACY)*

What do you think about quitting? *(INVITE RESPONSE)*

ARRANGE referral:

I'm going to refer you to the Smokers' Help Line, if that is okay with you? *(ASK PERMISSION)* They will give you a call and answer any questions you have about quitting. You do not have to make a decision to quit now or when they call, but they can give you more information to help you make a decision in the future. *(RESPONSIBILITY)*

Behaviour Change Interventions Summary

Brief Advice (3 to 5 minutes)

Most suitable for tobacco reduction and reduction of substance use, including alcohol, or to first raise the topic of a particular behaviour change.

Ask	Establish rapport, then ask about behaviour to identify those at risk or already experiencing problems related to behaviour.
Advise	For those at risk or already experiencing problems, stimulate consideration of behaviour change: • Give clear, strong and personalized advice to consider changing the behaviour using FRAMES (focus on benefits of change) • Include an expression of care and concern for the individual with the advice For those not at risk: • Affirm their current behaviour and advise to continue
Arrange	For those at risk or already experiencing problems, offer to arrange some type of follow-up: • Future sessions with yourself • Referral to other service provider • Self-help materials

Behaviour Change Counselling (5 to 30 minutes)

Suitable for most health-related behaviour changes, particularly with individuals who do not have complex or conflicting needs.

Ask	Establish rapport, then ask about behaviour to identify those at risk or already experiencing problems related to behaviour. Assess other risk factors related to the behaviour such as co-morbid psycho-social or situational risks.
Advise	For those at risk or already experiencing problems, stimulate consideration of behaviour change: • Give clear, strong and personalized advice to consider changing the behaviour using FRAMES (focus on benefits of change) • Include an expression of care and concern for the individual with the advice • Invite individual to respond to advice given
Agree	• Use scaling questions to determine stage of readiness for behaviour change
Assist	• Match assistance to individual's stage of change • Use motivational skills (Open-ended Questions, Reflections, Summaries & Affirmations) to explore ambivalence, importance, confidence and barriers related to behaviour change • Roll with resistance, support self-efficacy, and express empathy
Arrange	• Provide ongoing assistance yourself and monitor progress towards change • Refer to specialist counselling as necessary and monitor progress towards change at future encounters

Self-Assessment:
Brief Advice using FRAMES

Select one of the following case scenarios (or write out your own) and create a script of what you would say when giving Brief Advice to change behaviour. Use the FRAMES formula and identify the various components.

1. You are a primary care practitioner. An individual has bronchitis and requests antibiotics. You know she is a heavy smoker.
2. You are a nurse in a diabetes clinic. An individual insists he is taking his medicine as prescribed and is sticking to his diet. When he attends for blood tests, the random sugar (a measure of short-term compliance) is always very low but the glycosylated hemoglobin (testing longer-term blood sugar levels) is very high. This suggests he takes his medicines only for those few days just prior to seeing you.
3. You are seeing a woman who has three school-age children. She tells you that she feels terrible and that she is not coping very well. Life seems just one big struggle. You know that improved mood often flows from the individual making changes to aspects of his or her everyday life.
4. You are seeing a middle-aged man who has been diagnosed with high cholesterol and is obese. He lives a sedentary life, operating heavy construction equipment for a living. He still sees himself as one of the guys who works hard and plays hard, but it is more arm-chair quarter-backing these days.

Ask:

Advise:

Arrange (follow-up or referral)**:**

Appendix A:
Stages of Change (with Interventions) Summary Charts

Precontemplation Stage of Change

The individual is not yet considering changing the behaviour–may be unwilling, unable or unaware

Stage Task: To increase concern about behaviour and hope for change
by discovering consequences that arouse consideration of behaviour change.

Processes of Change	Motivational Principles	Potential Goals for HCPs
Consciousness Raising Becoming aware of the effects of behaviour on her/himself and others **Emotional Arousal** Intense feels that lead the individual to think about changing his/her behaviour	*Express Empathy* *Roll with Resistance* *Support Self-Efficacy*	1. Establish rapport. 2. Gain information about individual's behaviour to compare it to objective standards for personalized feedback and advice. 3. Help individual to evaluate his/her current circumstances as related to the behaviour. 4. Help individual to explore his/her motivation/confidence to change behaviour. 5. Help individual to identify need for behaviour change.
Markers of Change	**Motivational Skills**	**Motivational Strategies for HCPs**
Decisional Balance: Strongly weighted to continuing current behaviour **Self-Efficacy:** Some doubts about current behaviour begin to emerge	Use OARS: - Open-Ended Questions - Affirmations - Reflections - Summaries	• Listen well to understand individual issues from his/her perspective • Remain person-centred • Ask permission to explore sensitive issues • Ask for follow-up contact • Respect individual decisions regarding change and interventions • Explore importance of change and confidence to change with individual • Elicit the individual's perceptions of the behaviour and related problems • Offer factual information about the risks/consequences of the behaviour in non-judgemental way • Provide feedback that is personally relevant to individual but not "too scary" • Explore good things and bad things about the behaviour • Express concern and keep the door open • Don't push
Context of Change	**Traps to Avoid**	
Multiple probems in functioning may keep increasing and distract from focusing on suggested behaviour change; these may become alternate focus for change or intervention	Expert Premature Focus	

Contemplation Stage of Change

The individual is ambivalent about behaviour change.

Stage Task: Tip the decisional balance

by gathering and evaluating positive and negative considerations for change, resolving conflict in order to make firm decisions for change.

Processes of Change	Motivational Principles	Potential Goals for HCPs
Environmental Re-Evaluation Looking at the impact of behaviour on other people or relationships **Social Liberation** Identifying and utilizing community supports to change the behaviour **Helping Relationships** Getting support from others while changing behaviour	*Express Empathy* *Roll with Resistance* *Support Self-Efficacy*	1. Help individual to create a list of good things and not-so-good things for continuing the behaviour and one for changing the behaviour. 2. Assist individual to explore discrepancies between what he/she likes and dislikes about their current behaviour and their other life goals (e.g. smoking to relax vs. good role model for children). 3. Assist individual to discover desires, needs, reasons, and abilities related to current situation. 4. Assist individual to identify strengths for solving dilemma.
Markers of Change	**Motivational Skills**	**Motivational Strategies for HCPs**
Decisional Balance: Weight shift back and forth but slowly shifts more strongly for change **Self-Efficacy:** Growing sense that they can make the change	Use OARS: - Open-Ended Questions - Affirmations - Reflections - Summaries	• Normalize ambivalence • Identify individual strengths for change • Empower individual • Help individual "tip the decisional balance" by: - Eliciting and weighing the good and not so good things about the current behaviour and about changing that behaviour - Envisioning what change might look like ("Miracle Question") - Emphasizing individual's free choice, responsibility and self-efficacy for change - Exploring importance and building confidence - Summarizing self-motivational statements - Eliciting individual expectations regarding change and treatment
Context of Change	**Traps to Avoid**	
Multiple life issues complicate the decision to change, contribute to ambivalence and increase the need to continue the current behaviour Understanding the stage of change for other issues can provide direction	Expert Premature Focus Reassurance	

Preparation Stage of Change

The individual has decided to change, but does not have a plan for it.

Stage Task: Creating and strengthening committment needed to support action and to develop an accessible, acceptable, and effective plan for change.

Processes of Change	Motivational Principles	Potential Goals for HCPs
Self Re-Evaluation Looking at self and experiencing hope and confidence in own ability to address behaviours and issues **Social Liberation** Identifying and utilizing community supports to change the behaviour **Helping Relationships** Getting support from others while changing behaviour	*Express Empathy* *Roll with Resistance* *Support* *Self-Efficacy*	1. Assist individual to identify specific changes he/she wants to make regarding the behaviour. 2. Assist individual to develop a written change plan, identifying goals and steps/resources to achieve short-term goals. 3. Assist individual to explore obstacles to achieving change goals and prepare coping strategies to overcome obstacles. 4. Assist individual to indentify and ask others to support her/him to implement the plan.
Markers of Change	**Motivational Skills**	**Motivational Strategies for HCPs**
Decisional Balance: Continues to be weighted strongly towards change **Self-Efficacy:** Confidence in the various elements of the plan as well as in general ability to make the change increases	Use OARS: - Open-Ended Questions - Affirmations - Reflections - Summaries	• Clarify the individual's own goals and strategies for change • Identify together a menu of options for change or treatment • Offer expertise and advice when asked or after you get permission • Negotiate a change plan • Help the individual to enlist social support • Explore with individual what they expect change will be like and what it will do for them • Elicit from the individual what has worked in the past, either for him/her or others they know • Assist the individual to negotiate potential barriers to change
Context of Change	**Traps to Avoid**	
Multiple life issues complicate the change plan Sequencing when and how to deal with these other issues requires significant effort Understanding the stage of change of the other issues can provide direction for sequencing	Expert Prescription Reassurance	

Action Stage of Change

The individual is implementing plans for change.

Stage Task: **Problem solving and supporting self-efficacy** through implementation and revision of change plan;
maintaining commitment to change in the face of difficulties;
managing temptations and slips that provoke return to old behaviour.

Processes of Change	Motivational Principles	Potential Goals for HCPs
Countering Choosing new options for the behaviour **Rewards** Celebrating achievements **Environmental Control** Managing change by removing triggers from the environment **Social Liberation** Identifying and using community support to change the behaviour **Helping Relationships** Getting support from others while changing behaviour	*Express Empathy* *Roll with Resistance* *Support Self-Efficacy*	1. Assist individual to explore successes in making change. 2. Assist individual to re-evaluate action plan and make adjustments as needed. 3. Assist individual to identify ways to reward her/himself for the changes he/she makes. 4. Assist individual to identify common urges/ triggers to return to old behaviour and solutions for avoiding them. 5. Assist individual to identify and use available supports.
Markers of Change	**Motivational Skills**	**Motivational Strategies for HCPs**
Decisional Balance: May fluctuate as difficulties arise, but new good things about change may emerge **Self-Efficacy:** Confidence in ability to change increases as successful behaviour change occurs; coping increases efficacy while slips challenge it; temptations for old behaviour decrease	Use OARS: - Open-Ended Questions - Affirmations - Reflections - Summaries	• Support a realistic view of change through small steps • Acknowledge difficulties for the individual in early change efforts • Help the individual identify high-risk or trigger siutations by analyzing the function of the behaviour in their life • Help individual to develop appropriate coping strategies to overcome these triggers • Assist the individual to find new ways to reinforce/reward positive change • Help the individual to assess the strength of the support they receive
Context of Change	**Traps to Avoid**	
Other life issues often interfere with success and provoke slips; energy and attention can be focused on other issues as period of action extends	Prescription Reassurance	

Maintenance Stage of Change

The individual is maintaining change. She/he may need help with relapse prevention.

NOTE: *Relapse, if it does occur, will occur during the Maintenance stage of change, after the individual has had a period of success with the changes made.*

Stage Task: **Preventing relapse and solve contextual problems** by sustaining change over time and over a wide variety of situations, avoiding slips and relapse;
creating a new life filled with alternative rewarding activities and coping strategies.

Processes of Change	Motivational Principles	Potential Goals for HCPs
Rewards Celebrating achievements **Environmental Control** Managing change by removing triggers from the environment **Social Liberation** Identifying and using community supports to change the behaviour **Helping Relationships** Getting support from others while changing behaviour	*Express Empathy* *Support* *Self-Efficacy*	1. Assist individual to re-evaluate their environment in regard to long-term behaviour change and identify other lifestyle changes that will support Maintenance. 2. Help individual to update new goals for quality of life. 3. Help individual to maintain goals set for self that support the change. 4. If individual relapses to old behaviours, help to identify areas that need more work to prevent future relapses.
Markers of Change	**Motivational Skills**	**Motivational Strategies for HCPs**
Decisional Balance: Balance continues to favour change; attention to balance decreases in intensity as new lifestyle takes hold **Self-Efficacy:** Confidence grows and temptations decrease; efficacy becomes a critical indicator of success	Use OARS: - Open-Ended Questions - Affirmations - Reflections - Summaries	• Support lifestyle changes • Affirm the individual's resolve and self-efficacy • Help the individual practice and use new coping strategies to avoid a return to the old behaviour • Maintain supportive contact • Develop a plan for the individual to use if they relapse into old behaviour • If individual relapses, view this as a learning opportunity and assist them to view it that way as well - Agree / Assess current stage of change and work from there
Context of Change	**Traps to Avoid**	
Other life areas emerge as a focus for change either because they threaten maintenance or because they are needed to create a new, rewarding life that supports long-term change	Prescription Reassurance	

Appendix B:

Typical Counselling Scenarios Using Motivational Skills to 'ASSIST'

Typical Scenario:

Precontemplation Stage (Rebellious/Rationalizing)

Jason is middle-aged and smokes 1-1/2 packs per day. He knows that smoking is bad for his health, but likes it and thinks it would be really hard to quit. He tries to look after his health in different ways (healthy eating, not too much alcohol) and thinks that those healthy choices balance out the harms of smoking. The individual has come to primary care with a badly sprained ankle.

HCP: Hi Jason. This is a pretty bad sprain. How did this happen?	*Establishing Rapport*
Jason: Well, I've been trying to get in better shape and I took up jogging recently. I was at the track and I guess I pushed myself too hard. I was trying to finish one last lap, but I had overdone it and ended up going over on this foot. I should have walked the last couple of laps to cool down.	
HCP: What makes you say that you "pushed yourself too hard"?	*Open-ended Question that focuses on a key aspect of Jason's tale and uses reflection.*
Jason: Well, I was out of breath and had a stitch in my side, but I wanted to finish that last lap, so I kept running.	
HCP: Getting more exercise is a good idea, but it is important to start slow and build up gradually. Getting short of breath and feeling pain is our body's way of telling us to change something. You probably did work too hard too fast. There are other causes of shortness of breath. I would like to explore those as well, if that is okay with you?	*HCP affirms Jason's choice to exercise and provides some information about how to do it. HCP slowly introduces idea of smoking by referring to other causes.* *HCP asks permission to talk about other causes.*
Jason: Sure.	
HCP: Do you smoke Jason?	*Directly asks about smoking.*
Jason: Yeah, I smoke. I know that it is bad for you, so I do other things to make up for it. I eat healthy food, I don't drink much at all, and now I'm exercising more again. I don't think that my smoking is the issue. I think I pushed myself too hard too fast.	*Jason shows some resistance—rationalizing his smoking and attributing his symptoms to other causes.*
HCP: Good health consists of a combination of factors, including personal behaviours such as diet, exercise, alcohol consumption and smoking. Its great that you are eating healthy foods and increasing your exercise. Smoking is part of the health equation. Tell me more about your smoking and how it fits into your life.	*HCP rolls with resistance by affirming again Jason's positive health choices while at the same time providing some information.* *HCP acknowledges role of smoking in Jason's life while asking to hear more about it.*

Jason: Well, I know that smoking is part of the equation. But I like to smoke. I've cut back some already—I used to smoke more than 2 packs a day, but over the past couple of years I'm down to about a pack and a half. I think it would be really hard to quit totally. I know guys that have tried and they said it wasn't worth the hassle. I figure that the other stuff I do for my health balances out the smoking. I don't need the stress of trying to quit. My life is stressful enough.

Jason is now feeling less defensive and more willing to talk about his smoking behaviour. He is still rationalizing, but is open.

HCP: It sounds like you've given this some thought. That's good, because we should be making informed choices about our health behaviours. Unfortunately, one good health choice does not always balance out a poorer choice. You already know that smoking is a poorer health choice because you've reduced the amount you smoke, and you've made other life adjustments to compensate for your smoking.

HCP offers another affirmation of Jason's actions, supporting self-efficacy. HCP also affirms Jason's own knowledge of the health risks in this summary or information Jason has provided. The summary is given with a reframe—focusing on the positive aspects of Jason's action and knowledge.

On the one hand, you know that making changes to your smoking behaviour is important, and on the other hand you believe that it would be very difficult for you to stop smoking altogether. Tell me about your concerns.

HCP develops discrepancy by using a double-sided reflection. HCP doesn't ask if Jason has concerns, but assumes he does and asks about them without using a question.

Jason: Well, I know that smoking is not good for you. But my life is really stressful right now and I need to relax. Work is hectic and the kids are always on the go here and there and they need money for this and that. My wife and I are going through a rough patch right now. She's always on my case about working too much and not spending time with her and the kids, not doing stuff around the house. But it takes money to keep the kids in sports and stuff and to renovate the house. I have to work. Smoking is my one way to relax and I don't need another hassle right now. So don't try to get me to quit.

If the HCP had used a question above, Jason may have stopped to think of a reply that would minimize his smoking. Questions get people to think, while simple statements such as "Tell me about…" let people continue on an emotional track. This may arouse emotions, a good strategy for people in the Precontemplation stage of change.

HCP: Jason, I won't try to make you do anything you don't want to do. It is entirely up to you whether you continue to smoke or not. It sounds like you have a lot on your plate right now and maybe now is not the time to be talking about changing smoking behaviour.

HCP reinforces the concept of responsibility, letting Jason know he is in control of his own life. HCP affirms Jason's perception of being overwhelmed in the reflection of feeling.

Jason: Yeah. Well I'm glad that somebody understands what's going on for me. I'm not ready to think about quitting right now. I feel like I'm doing something good by running and that's enough right now.

Jason feels like the HCP is on his side and turns the conversation back to what is important to him right now.

HCP: I agree that increasing your level of activity is a healthy choice. Unfortunately, you won't be able to run for awhile on this ankle. Let's talk about how you can heal this sprain, then what you can do to prevent one in the future by gradually increasing your activity.

HCP moves in the direction that Jason has chosen for health behaviour change and offers assistance.

If at some point in the future you do feel ready to talk more about changing your smoking behaviour, just let us know and we'll do whatever we can to support you.

HCP lets Jason know that there will be assistance available in the future if he changes his mind about quitting smoking.

Typical Scenario:

Precontemplation Stage (Resigned)

Jason is middle-aged and smokes 1-1/2 packs per day. He knows that smoking is bad for his health, but likes it and thinks it would be really hard to quit. He tries to look after his health in different ways (healthy eating, not too much alcohol) and thinks that those healthy choices balance out the harms of smoking. The individual has come to primary care with a badly sprained ankle.

HCP: Hi Jason. This is a pretty bad sprain. How did this happen?	*Establishing Rapport*
Jason: Well, I've been trying to get in better shape and I took up jogging recently. I was at the track and I guess I pushed myself too hard. I was trying to finish one last lap, but I had overdone it and ended up going over on this foot. I should have walked the last couple of laps to cool down.	
HCP: What makes you say that you "pushed yourself too hard"?	*Open-ended Question that focuses on a key aspect of Jason's tale and uses reflection.*
Jason: Well, I was out of breath and had a stitch in my side, but I wanted to finish that last lap, so I kept running.	
HCP: Getting more exercise is a good idea, but it is important to start slow and build up gradually. Getting short of breath and feeling pain is our body's way of telling us to change something. You probably did work too hard too fast. There are other causes of shortness of breath. I would like to explore those as well, if that is okay with you?	*HCP affirms Jason's choice to exercise and provides some information about how to do it. HCP slowly introduces idea of smoking by referring to other causes.* *HCP asks permission to talk about other causes.*
Jason: Sure.	
HCP: Do you smoke Jason?	*Directly asks about smoking.*
Jason: Yeah, I smoke. I know that it is bad for you, so I do other things to make up for it. I eat healthy food, I don't drink much at all, and now I'm exercising more again. I don't think that my smoking is the issue. I think I pushed myself too hard too fast.	*Jason shows some resistance—rationalizing his smoking and attributing his symptoms to other causes. He tries to distance himself from the consequences by saying 'you' instead of 'me.'*
HCP: Good health consists of a combination of factors, including personal behaviours such as diet, exercise, alcohol consumption and smoking. Its great that you are eating healthy foods and increasing your exercise. Smoking is part of the health equation. Tell me more about your smoking and how it fits into your life.	*HCP rolls with resistance by affirming again Jason's positive health choices while at the same time providing some information.* *HCP acknowledges role of smoking in Jason's life while asking to hear more about it.*

Jason: Well, I know that smoking is part of the equation. I know that it's not good for me, why do you think I'm trying to do other things to make up for my smoking? Smoking is how I relax. I've tried to quit in the past, but it's too hard. I don't need that kind of stress in my life. Sure, if I really wanted to and I didn't have other things going on in my life I could quit, but it isn't worth the hassle.

Jason is feeling a little less defensive and willing to acknowledge he knows it is not good for him. He says he can't quit—has tried in the past and failed. For some individuals who lack confidence, their resignation sounds more defensive than hopeless. But Jason is clearly saying he can't quit.

HCP: I hear you Jason. Smoking is an important part of your life—it's how you relax. You know that smoking is dangerous to your health and it's really hard to quit. I'm not going to tell you you have to quit. That's a decision that only you can make. Quitting smoking is one of the most important changes anyone can make to improve their health so it is important for you to consider it. If you wanted to quit there are things I could do to help you. There may even be some new things that you didn't have the last time you changed your smoking behaviour. Do you want to tell me more about your previous experiences with change?

HCP affirms the benefits Jason derives from smoking and his knowledge and actions. HCP chooses not to reflect Jason's lack of confidence, but focuses on his strengths and gives responsibility for change to Jason.

HCP provides direct advice about benefits of change without using the word "should".

HCP asks permission to continue the conversation by asking "Do you want to…?"

Jason: Well, I tried to go cold turkey 2 years ago. It was hell. My nerves were shot. I was a bear to live with. I couldn't concentrate at work and my boss got on my case about mistakes. My wife finally bought me a pack of cigarettes and told me to start again or she would leave. I lasted 6 weeks, that's all.

Jason feels comfortable enough to continue talking. He again talks about his 'failure'.

HCP: That sounds like a pretty hard learning experience. Without any support you made it for 6 weeks though. That shows that you have a lot of guts and determination. Once you put your mind to something, you stick to it. What do you think might have helped you be more successful at that quit attempt?

HCP supports Jason's self-efficacy by reframing his experience in the reflection. From 'failure' to 'guts, determination and stick-to-itness'.

HCP uses open-ended question to further communicate to Jason that he himself has the answers.

Jason: Well, you're right about having no support. My buddies were betting on how long I would last! I think that was why I went as long as I did. I wanted to prove them wrong. My wife was good at first, but my moodiness got to her after a while and she ran out of sympathy pretty quick. She's never smoked so she has no idea what it's like.

Jason lets the HCP know that he feels the HCP is on his side.

HCP: Getting support from others who know what you're going through has been really helpful for others that have quit smoking. Those supports are available. What else do you know about what helps people to successfully quit? Have you heard about other aids, maybe from people you know who have quit or from things you've read?

HCP selects the parts of Jason's response to reflect—focusing on aspects supporting change, such as getting support from someone who has been there, and avoids sidetracking to talk about unsupportive behaviours. Open-ended Questions again support Jason's self-efficacy.

Jason: Well, I know about the patch or that gum that some people use. And I've heard about acupuncture or hypnosis, but I think those things are pretty far fetched. Maybe the patch or the gum but not any mumbo-jumbo.

HCP: Many people find that nicotine replacement therapies, like the gum or the patch, help them get through the early cravings. Others have found help with other techniques. There are many ways to quit. I have some reading material here that you can take with you if you like. I would also like to refer you to the Smokers' Help Line if that is okay with you? They'll call you and answer any questions you have and discuss some options with you. You'll be much better informed about what is available to support you if you decide you want to quit smoking. You can also make another appointment with me so we can further discuss this after you've spoken to the people at Smokers' Help Line. How does that sound to you?

HCP again chooses to affirm Jason's knowledge without getting sidetracked into talking about his opinions of 'mumbo-jumbo' or talking about therapies with less evidence to support them.

HCP asks permission to refer for further assistance in a sensitive manner, while still keeping the behaviour change counselling very brief.

HCP leaves Jason in control of decision.

Typical Scenario:

Contemplation Stage

Audrey is a young single parent who smokes. She would like to quit to improve her health and to be a good example to her children, who both get frequent chest infections. But her life is stressful and she doesn't know how to cope without cigarettes. She is worried about withdrawal, and that she might get even more stressed and miserable.

HCP: Well Audrey, it looks like you were right and Tyler has another chest infection. He'll need another round of antibiotics to help clear this up. I would like to talk to you about some things we can do to help prevent him from getting more infections in the future. Would that be okay?	*Builds on previous contact and relationship.* *Affirms Audrey's 'diagnosis' of her son's problem and tries to bring Audrey on-side by using "things <u>we</u> can do" and asks permission.*
Audrey: Yeah. But the medicine will make him better, right? He'll be okay, right?	*Audrey identifies what her chief concern is.*
HCP: Yes Audrey, Tyler's chest infection can be treated. I am concerned, however, about the number of chest infections he and his sister get. The antibiotics work for now, but eventually the kids will become resistant to the effects of the antibiotics and they will need stronger and stronger medications. There is also the risk of permanent damage from the infections. It is important to do all we can to help prevent them from getting the infections in the first place. What do you know about things that contribute to chest infections?	*HCP acknowledges that she/he has heard Audrey's concern and responds to allay it, while at the same time providing information and expressing concern.* *HCP advises that preventing future infections is a priority and asks an open-ended question to see what Audrey already knows.*
Audrey: I don't know. Do they need warmer winter clothes?	
HCP: Well, it is always important to make sure the kids are dressed properly to go outside in the cold weather, but that really has little to do with their chest infections. One of the things that can be done to help prevent chest infections is to reduce the exposure the children have to second-hand smoke. I know you smoke Audrey. Do you smoke in the house?	*HCP affirms Audrey's response, even though it was incorrect, in order to build confidence. At this point, HCP gets more directive and provides some information and asks a direct question. There is a danger Audrey could become defensive, but the HCP has a prior relationship to build on.*
Audrey: Yes, I do. I try not to smoke in front of the kids. I try to smoke in a different room or when they are sleeping. I know that I shouldn't let them see me smoke. But sometimes its hard.	
HCP: You are trying to set a good example for your children and you don't want them to smoke. I know that you love your children. Tell me more about what is hard for you.	*HCP offers a reflection of the emotional content of what Audrey said and expresses empathy by focusing on "what is hard" for Audrey.*

Audrey:	Well, I don't have a lot of money, and my ex never gives me any. The kids are good, but they are a handful. I can't keep up with them and then they get cranky and whiney. My nerves are frazzled all the time. Sometimes I think I will scream or cry or just lose it. Smoking is what keeps me sane. I can't imagine what things would be like if I had to quit. I don't think I could do it.	*Audrey uses the openness of the invitation to talk about what is hard, though it is not directly related to smoking. She is letting the HCP know what is important in her life and what her barriers to change are.*
HCP:	Your life with 2 small children is pretty hectic and you have to handle it on your own. You're under a great deal of stress, and that is pretty typical for single moms like you. You're not alone in feeling that way. Smoking helps you to relax and feel in control and quitting smoking feels like it would be too difficult right now.	*HCP expresses empathy by again reflecting the emotional content of Audrey's communication.* *HCP acknowledges the benefits of smoking for Audrey.*
Audrey:	Yeah. I just couldn't do it.	*Audrey confirms that expressed empathy was accurate.*
HCP:	Audrey, I would like to ask you a couple of questions to help me understand what's happening for you around your smoking right now. The first one is about how important you think it is for you to quit smoking. On a scale of 1 to 10, where 1 means that you feel it is not at all important for your health or that of your children to quit and 10 means that you feel it is very important for you to quit, what number would you give yourself right now?	*HCP uses scaling questions to determine how important quitting smoking is for Audrey and how confident she is that she can change. This will help the HCP determine what type of assistance to offer Audrey.*
Audrey:	I would say it is very important. Like and 9 or a 10. But I can't quit. I told you that.	
HCP:	I know that you said it would be difficult to quit. So that is my second question. On a scale of 1 to 10 where 1 means that you have 0% confidence that you could quit if you tried and 10 means that you are 100% confident that you could quit, what number would you give yourself right now?	*HCP stays congruent with what Audrey is saying and responds to the difficulties of change instead of congratulating her on how high her importance score is. It is important not to push for change or appear like a cheerleader.*
Audrey:	Well, I never tried to quit before, so I can't say I know for sure that I couldn't do it. But I'm so scared of what it would be like and how bad the cravings would be. I'm worried that I might not be able to handle it at all.	*Audrey offers more information, but does not answer the question.*
HCP:	So what number would you give yourself Audrey?	*HCP gently urges answer & avoids sidetrack.*
Audrey:	I guess I would have to say a 2 or a 3. I really don't think I can do it. Please don't make me.	Audrey tells the HCP she feels powerless.

HCP:	Audrey I can't make you quit, and I won't even tell you you should quit. That is your decision to make. You know how important it is for you to consider quitting because you gave yourself a 9 or a 10 on the importance scale. You just don't feel a lot of confidence in yourself to be able to do it right now. You have a lot to deal with and it is normal to feel two different ways about making a big change like quitting smoking.	*HCP responds first to Audrey's sense of panic and stresses that Audrey is responsible for her own decisions.* *HCP uses a summary to sum up the various points of the conversation thus far.*
	You've had other big changes in your life before. What has helped you be able to cope with and make those big changes?	*HCP, who knows Audrey, tries to support self-efficacy by asking about past successes and skills.*
Audrey:	What other changes? You mean like having the kids or when Jake left me?	*Audrey downplays her strengths.*
HCP:	Those are 2 pretty big changes for sure. How did you manage them?	*HCP offers affirmations and asks an open-ended question as further affirmation.*
Audrey:	Well, sometimes I don't feel like I managed them at all. They just happened. And I smoke more now than I did before those changes.	*Audrey again downplays her strengths.*
HCP:	So having the kids and separating from Jake were not your choice. They just happened to you. And you used smoking to cope with those things.	*HCP offers a reflection of the content here with subtle emphasis on how helpless Audrey is. This has to be done carefully and works in part because of the prior relationship.*
Audrey:	Well no. I mean I wanted the kids. And I knew that Jake and me weren't good together. But it was hard and I do smoke to help my nerves. I'm scared of what my nerves would be like if I quit.	*It works because Audrey now begins to talk about strengths.*
HCP:	So in the past you've chosen to make some really big changes in your life and you've been successful at those changes. You have found ways to cope with them. One of the ways you have coped is by using smoking to help you relax. Tell me about some of the other ways that you've coped.	*HCP offers affirmations and summarizes past successes. HCP subtly reframes Audrey's smoking as a coping strategy, not a failure. Open-ended question to ask for more information and to keep Audrey talking about strengths.*
Audrey:	Well, I guess I got support from my mom and dad and my friends. They help me.	*This works, as Audrey continues to provide positive statements.*
HCP:	When you decide that there is something you want or need to do you have been successful in the past at making those changes. Getting support from other people and finding ways to relax when you feel stressed out are 2 methods you have used to be successful at those changes. There is no reason to think that if you decided to make another change in the future, like quitting smoking, that you would not also be successful. You already have some good coping skills, and we could probably think of some more if we had more time.	*HCP summarizes again to make use of an opportunity to roll the current positive statements in with the previous one and let Audrey hear a longer list of her strengths and supports.* *HCP again subtly reframes smoking—now it is one method of relaxation that Audrey makes use of, hinting that there are others.*

If you are willing, I would like to refer you to the Smokers' Help Line. Someone from there will call you to talk about smoking and some options for quitting. You don't have to decide today to quit. By talking to these people, you will get some more information to help you make a choice about what you want to do and how you want to do it. I'm also going to give you some information to take home and read when you have time. If you do decide to quit smoking there are many ways that I could help you. I'm willing to talk more about it if you want to make another appointment. Would you like me to get someone from Smokers' Help Line to give you a call?

HCP offers lots of affirmations as Audrey's confidence is so low.

HCP makes transition to end the discussion but does not do so abruptly.

HCP provides information and emphasizes Audrey's responsibility for making her own decisions.

Audrey: I guess so. I do want to quit. I just wish I could. I don't know if I can.

Audrey reverts to negative self-talk.

HCP: You don't have to decide right now. It is important to think about it, but you will know when you are ready and there will be help available to you when you are ready.

If the HCP had time, they could try to get more positive self-talk, but emphasizing personal control is a good way to end a brief intervention.

Typical Scenario:

Preparation Stage

The HCP is a nurse specializing in cardiac rehabilitation. A woman attends the clinic after receiving a diagnosis of stable angina. She is overweight, gets very little exercise, smokes and eats a lot of fast foods.

HCP:	Hi Justine. How are you doing today?	*Begins with open-ended question to allow Justine to set agenda.*
Justine:	Well, I guess I am doing okay. I have been taking the medication the doctor gave me and I haven't had anymore pains. I'm still worried about what could have happened. I guess it still could happen.	
HCP:	You're feeling scared that you may experience more angina pains and that is a perfectly natural reaction. You are taking your medication and so far that is helping.	*HCP reflects emotional content and normalizes experience. Affirms medication use.*
	Justine, you have been referred here so that you can learn more about your angina—what causes it and how you can control it. I'm here to provide you with information you may need and to support you to make any decisions you may want to regarding changes to your lifestyle to help prevent further angina attacks. Where would you like to start?	*HCP advises what the service is about and emphasizes Justine's responsibility for making decisions.* *Open-ended question lets Justine set agenda.*
Justine:	Well, I did a lot of reading since I was in the hospital. I know that angina is caused by a shortage of blood to my heart, or not enough oxygen or something like that. My blood vessels are narrowed. My cholesterol is bad. I guess I'm supposed to quit smoking and eat more healthy foods and exercise more and lose weight and stop drinking and anything else you can think of. I guess if I want a life I'm supposed to change my whole life.	*Justine lets HCP know that she has some knowledge and is fearful about the changes she has read she should make in her life.*
HCP:	You are 100% correct about the cause of angina. The heart muscle is not getting enough oxygen due to narrowed blood vessels. Smoking and high cholesterol make it worse, you're right about that as well. And all of the other lifestyle issues you mentioned also contribute to angina—being overweight, too much stress, not enough exercise. The good news for you is that your angina is stable right now and the medication is working. You likely will want to make some lifestyle changes. You don't need to make them all at once. Every change you make will help.	*HCP starts with confirming Justine's knowledge by summarizing and affirming what Justine said.* *HCP offers reassurance that not all changes have to made at once and even small changes are going to be helpful.* *HCP does not move to agenda setting here, but lets things proceed at Justine's pace as she has given this a lot of thought.*
Justine:	I know that I need to make some changes. I've been thinking about it all the time since I was in the hospital. I know I need to quit smoking. I want to quit. I've wanted to quit for a long time now, but it seemed so hard. But now I have a really good reason, don't I?	*Justine chooses the agenda.*

HCP:	You are a good reason to quit smoking. It sounds like quitting is pretty important to you. On a scale of 1 to 10, where 1 is not important at all and 10 is very important, how important do you believe it is for you to stop smoking?	*HCP subtly reframes the risk. Justine hinted at as a motivator, to be about her life and living. Moves to a scaling question to determine stage of readiness for change.*
Justine:	Well, in light of what happened, I guess it is high. 9 or 10?	
HCP:	A 9 or 10. Quitting smoking is really important to you. I'm going to ask you another question using a scale. On a scale of 1 to 10, where 1 is not confident at all and 10 is totally confident, how confident are you that you could quit smoking if you decided to?	*HCP acknowledges response but does not assume that because importance is high, Justine is ready to change. HCP moves to scaling question to determine confidence.*
Justine:	Well, that is another thing isn't it? I guess I would have to say about 7 or 8.	
HCP:	7 or 8. That is confident. Why so high?	*HCP seeks self-motivational statements that support change, so asks what makes confidence so high.*
Justine:	If you had asked me that before I went to the hospital, I would have said 4 or 5. But now, I have more reasons to quit. My family has said they want me to quit. I think they will help me. It is something I know I have to do, and I want to. I really do. I know it won't be easy, but I just have to do it. I don't want to die. And I've been thinking that if I quit smoking, then I might feel better and be able to exercise more. Right now, I get so out of breath and sweaty if I try to do anything, even taking long walks. And I don't like that feeling. It makes me scared that I'm going to have a heart attack. Then I start to feel panicky.	*Justine is obviously in the Preparation stage of change as she has done a great deal of thinking about and research into her condition. She is making all of the arguments for change herself.*
HCP:	Well Justine, you are right again. If you stop smoking, you will be able to breath easier and that will make physical activity easier for you to do. Having support from family and friends is very important when making changes like quitting smoking. Believing in yourself that you can do it is also a key factor. It sounds like you are well on your way to being able to make a change in your smoking. What else do you think would be helpful and how can I help you plan for this change?	*HCP simply summarizes all of the self-motivating statements Justine has already made, then asks an open-ended question to elicit more ideas, subtly planting the idea of making a plan.*
Justine:	Well, I guess I could just quit, cold turkey. Isn't that what they say is the best way?	
HCP:	Many people do quit that way. Those who do it that way often pick a quit date and make plans before that date about how they will deal with urges or temptations to quit. Others use different methods of quitting. What do you know about other methods? Have you tried any in the past, or do you know of other people who have quit using other methods?	*HCP cautiously affirms Justine's idea while suggesting a menu of options that may be more successful. It is usually best to get the individual to identify options first, but here the HCP asks Justine to add to the list.*

Justine: Well, I know about things like the patch or the gum. Someone told me to cut back—to count my cigarettes for one day, then only smoke half that number and later cut that number in half until finally I'll be smoking none. Does that work?

HCP: As I said, there are many ways to quit. Different things work for different people. We will find the one that works for you. It is important to have a plan. Let's talk about some of the things that might get in the way of your quitting. Maybe as we identify those and problem solve around them, we'll get more of a clear idea of what the best way for you to quit will be. How does that sound to you?

HCP acknowledges other methods suggested by Justine and emphasizes the need for a plan. When individuals try to rush to change without a plan, it is a good idea to gently ask about possible barriers to change to help them develop realistic plans.

Typical Scenario:

Action Stage

Angie is a 23 year-old single mother with 4 young children. She has recently given birth to her youngest. The HCP is a public health nurse who is doing a home visit as part of the Families First program.

HCP: Hi Angie, how are you doing today?

Angie: Look, I know the drill here. This is not my first baby, okay. I know what I'm doing. I'm breastfeeding fine and all of that. If you really want to help me, you can help me get the patch. That's what I need from you.

Angie clearly identifies that she has her own agenda for this visit and the wise HCP will follow this agenda in order to build rapport.

HCP: You mean the nicotine patch? Are you planning to quit smoking Angie? I'd…

HCP tries to keep up with Angie's needs and asks a question to clarify, making an assumption that Angie is talking about a nicotine patch.

Angie: I'm not planning to quit, I already have. I quit 3 days ago. I'm going out of my mind. I've had 2 cigarettes in 3 days. Don't go telling me that 2 cigarettes means I haven't quit, okay. I know that. I've been relapsing. But I have to quit because Mark has bad asthma. My mom had to rush him to Emergency the other day. If I don't quit, I could kill my son with my smoking. After I had those cigarettes, I was so scared I just sat by his bed all night, making sure he was okay. So I have to stay quit. Help me with that!

Angie is typical of many individuals who jump into Action after a traumatic event, but have not resolved all of their ambivalence or developed a plan to follow.

Angie's mistaken idea that any smoking after moving into action is a 'relapse' or failure is also typical of many. Smoking during the Action stage of change is part of the process of learning, not failure.

HCP: Wow Angie. Mark's asthma attack must have been a terrifying experience for you. I know that you love your children and are the best parent you can be for them. Your decision to quit smoking to help Mark is a generous and courageous one. I will support you with this change in any way that I can.

HCP attempts to slow Angie down by offering affirmations and reflecting the emotional content of what she is communicating.

Angie: Can you get them to pay for the patch for me? I need to do something now, but I can't afford that patch. I don't know what else to do. I'm going crazy and I have 4 kids to look after. I can't be a basket case. I felt like such a failure when I smoked, but I know I'm going to give in again if I don't get some help.

Angie is still focused on one idea. She is communicating that she feels out of control.

HCP: Angie, lets take a deep breath and slow down here for a minute, okay. I am going to help you. You are not in this alone. It is not unusual to be experiencing what you are when you first quit. There are many things that we can do to help you to feel calmer and more in control. Nicotine replacement therapies, like the patch, can be helpful and so can other things…

HCP again attempts to slow Angie down by offering reassurances and suggesting that there are options that will help Angie to feel more in control. The HCP even uses those words.

Angie: Are you telling me that I can't have the patch? That I have to do "other things" to quit? What other things? I'm going to lose it soon if I don't get some help.

Angie's one track mind and inability to listen are common in people withdrawing from nicotine.

HCP: Angie, I know that you feel worried right now. I am not saying that you can't have the patch, or that I won't help you with that. The patch may not be the best option while you are breastfeeding, but gum, or an inhaler may work better for you. There are other techniques you can use, along with nicotine replacement, that will help you to quit. The first thing you need to always remember is that you are not a failure. Quitting smoking is difficult and going from what you used to smoke, over a pack a day, to 2 cigarettes in 3 days is a tremendous achievement. You can be proud of yourself. You are not a failure.

The HCP does not get sidetracked into trying to convince Angie of anything. The HCP continues to reflect emotional content, then provide information in a slow, steady voice that mimics the calm he/she is trying to get Angie to feel.

HCP offers affirmations of Angie's accomplishments and expresses empathy with the use of the word 'failure' .

Angie: I'm not? I feel like one. They said that if a mother smokes when she's pregnant, that can cause asthma. Did I make Mark sick? Will my other kids be sick? How can I stay quit?

Angie acknowledges that the empathy was accurate. Angie asks for information.

HCP: Many things can contribute to asthma. Your willingness to learn about asthma and to make changes that will benefit Mark, and your other children as well as yourself proves that you are a good mother, Angie. You can't change what happened in the past. You are already changing the present by quitting smoking and I can help you continue with that and with other changes in the future.

HCP provides the requested information while maintaining the message that Angie is a good mother. HCP summarizes again Angie's accomplishments. HCP continues to speak in a slow, steady voice to help Angie focus and calm down.

We need to develop a plan for your to follow that will help you quit. In the beginning you may occasionally give in to the urge to smoke, but that is to be expected and you can learn from those experiences. You wanted to talk about nicotine replacement therapy, so lets start there. Would you like some information about how the different products work so you can choose one that will work best for you?

HCP does not offer detailed information about withdrawal effects here as Angie is not attentive enough to retain that kind of information right now.

HCP goes back to the agenda Angie set originally—NRT.

Angie: Yeah, I do, but how will I pay for it? I can't afford that stuff.

HCP: Lets take this one step at a time. Let's look at what might work for you, then we'll look at how to make that work. That's one reason I want to talk about other supports, in addition to the nicotine replacement therapy. Lets start with one thing and then move on to the next. Slow and steady wins the race, right?

HCP acknowledges Angie's concerns, but does not get sidetracked. HCP directs Angie towards calmness and planning.

Angie: I know I have to slow down, but I am so worried about what to do. I feel panicky.

Finally, the repeated message to 'slow down' from the HCP gets through to Angie.

HCP: You are scared about the seriousness of Mark's asthma, and you are scared that you won't be able to quit. Some of your panicky feelings are also a normal part of the withdrawal process. Nicotine helps people to feel relaxed by increasing dopamine in your brain. Dopamine is what makes you feel good and relaxed, and when you stop using nicotine, your brain doesn't get as much of that calming feeling from dopamine. Nicotine replacement therapy can help with that, but so can simple things like taking a few deep breaths, or taking a warm bath or shower. Lets try the deep breaths together before we go on to look at the different types of nicotine replacement therapy.

HCP reflects emotional content of Angie's communication and takes opportunity to provide some information now that Angie is starting to slow down and hear things.

HCP uses opportunity to teach Angie a simple coping skill that will answer her need for immediate help.

Because Angie has rushed prematurely into Action, this session may be longer than normal to get her onto a more stable track.

Typical Scenario:
Maintenance Stage

Steve is a 57 year old man who quit smoking 9 months ago after a myocardial infarction. The HCP is a cardiac rehab nurse conducting a routine follow-up with Steve. The nurse has known him since his first referral.

HCP: So Steve, how are things going for you today?

Steve: Well, not too bad, I guess. I don't know.

HCP: Sounds like you're not too sure. Tell me about it.

HCP reflects emotional and factual content.

Steve: Well, I'm trying to stick to the diet. I still go for my walks and I enjoy that. I still haven't passed my physical to go back to long haul driving though, so I'm still stuck at a desk in dispatch. I hate that.

HCP: You're feeling like all the effort you've put into making changes isn't paying off for you.

Because of past relationship with Steve, HCP tries a reflection that heightens the emotional content—'effort is all for naught.'

Steve: Well, not exactly. I mean, I know I likely would have had another heart attack by now if I hadn't changed. I'm grateful for the help, don't get me wrong. But I don't know.

This allows Steve to respond with a positive self-statement and get some perspective.

HCP: You don't know what Steve?

HCP gently probes for more info by repeating Steve's words.

Steve: I don't know how much longer I can keep it up unless I get back to doing something I love. I mean, I hate that desk! I want to be back in my rig and out of the city. I try to stay positive, but it gets me down. The other day I caught myself heading out into the parking lot to have a smoke with the secretaries. I haven't thought about a cigarette in a while now, but the other day I almost slipped. That discouraged me.

Steve's quick response to these techniques is due in part to the established relationship he has with the HCP.

HCP: You really miss your old job and the freedom of the open road. No matter how many changes you've made, you still don't have that back yet. I know that is your goal.

HCP reflects and summarizes content from previous sessions here.

Steve: Yeah. Well, sometimes I don't think it will ever happen. Then I get to wondering if all the changes are worth it. I've been thinking about that cigarette for a couple of days now. I thought I was over the cravings. If I have to go through all that again, I don't know.

HCP: After making big changes like you have Steve, it is not unusual to have down periods when you question if you can maintain those changes. And that is particularly true of quitting smoking. Urges and cravings sometimes come up so unexpectedly, they hit you out of the blue.

HCP normalizes Steve's experience while offering affirmations. HCP uses opportunity to provide information that Steve needs to understand his current ambivalence. Ambivalence often returns in the maintenance stage.

Steve: That's sure what happened to me all right. Bang, there it was. I keep thinking about it. I don't want to start up again that's for sure, but I don't know what will happen.

Steve acknowledges accurate empathy.

HCP: Well, lets go back and review how you dealt with the cravings when you were having them regularly. How were you successful then?

HCP is directive in suggesting course of action, but softens it by asking for past successes to support self-efficacy.

Steve: Well, I did that 4 D thing. I almost forgot them. It's drink water, delay, do something else. I can't think of the other one. What was it again?

HCP: Deep breathing.

HCP offers prompt but does not interrupt flow of positive self-statements.

Steve: Oh yeah. Deep breathing. They worked before. You mean that other people start thinking about smoking again, even after all this time?

HCP: Yes, it is pretty common. Some people don't catch themselves like you did. They actually have a cigarette before they even realize it. But even if that happens, it is not the end of the world. That is an opportunity to learn what else they need to put into their plan. That's where you are at now. This is an opportunity to look at what else you can put into your recovery plan and to help you stay quit.

HCP normalizes and offers more affirmations. HCP then advises Steve that even if he smokes, it is not a failure, but a learning opportunity. This is an important part of relapse prevention.

Steve: That helps, actually. I was feeling like a real loser, you know. Lost my license, lost my health, and maybe now I was going to lose the one good thing I did, which was quitting.

HCP: You have regained your health Steve, not lost it. With all your hard work, you are much healthier than you were when you had your heart attack. You've also gained a lot of skills that you've put to good use from stopping smoking. You've used those to help you get active and to help you change your diet. Don't sell yourself short. You have come a long, long way. You can be proud of yourself.

The affirmations of the HCP are meaningful because they are based on long-term knowledge gained through an ongoing relationship.

Appendix C:
Evidence for Health Behaviour Change Counselling

- Smoking, obesity and maintaining a sedentary lifestyle are epidemic and literally deadly habits worldwide. They are the products of multiple factors ranging from basic genetics and biology to large-scale social influence via the media. They require comprehensive interventions at all levels. Psychological interventions aimed at promoting habit change and relapse prevention are essential components of all health care planning around these habit disorders (Dubbert, 2002; Niaura & Abrams, 2002; Wadden, Brownell & Foster, 2002).
- Getting people to adhere to complex healthcare treatment programs and to use them to their full benefit often requires psychological intervention methods.
- Programs designed to help "at risk" individuals change health-risky habits are highly effective (Ockene & Ockene, 1992). However, many people fail to follow medical advice about making such changes (Burke et al., 1997).
- In one study, only 7% of people with diabetes adhered fully to all aspects of their required treatment regimen (Cerkoney & Hart, 1980). The complications of poorly controlled diabetes are expensive in both human and fiscal terms. They include heart disease, kidney failure, blindness, and limb amputations.
- Health Canada reports that hypertension is the number one reason that "baby boomers" (35-64 year olds) make office visits to primary care physicians. However, up to 50% of people who require antihypertensive medication stop using their medication within the first year of prescription (Burke et al., 1997). Uncontrolled hypertension puts people at dramatically increased risk for such costly morbid events as stroke and heart attacks.
- Adherence to cardiovascular-risk-reducing eating plans may be as low as 13%, depending on the nature and duration of the regimen (Burke et al., 1997).
- Individuals who report high stress in their lives and who have not learned effective coping strategies are less likely to adhere to treatment recommendations than individuals who report low stress or than those who have learned effective stress-management skills (Kurtz, 1990).
- Barriers to cardiovascular risk reduction are not primarily biological. The most important barriers include: personal factors, family factors, health care provider and health care system factors, occupational factors, community factors and legislation (Glasgow et al., 1999).
- Healthcare initiatives that help individuals assess and address these barriers in their lives have a positive effect on treatment adherence (Glasgow et al., 1999; Kaplan, 2000; Terris, 1999).
- Specialized client-centred motivational interviewing methods help promote self-management of health problems. These methods emphasize the importance of a collaborative therapeutic alliance between the provider and the individual and empathic listening as catalysts to promote health behaviour change (Miller, 2002; Miller & Rollnick, 1991).
- People progress through different stages as they try to make changes necessary to modify health-risky habits. Treatment methods must be linked directly to the individual's stage of change to promote healthy behaviour change (Prochaska, Norcross & DiClemente, 1995).
- Evidence-based strategies for improving adherence include several psychological interventions, such as value clarification, changing "decisional balance", promoting self-monitoring, behavioural skill training, family support, self-efficacy enhancement, contingency contracting and self-management contracts (Burk et al., 1997; Lorenz et al., 1996).

- Tobacco dependence is a chronic condition that often requires repeated intervention. Because effective tobacco dependence treatments are available, every patient seen in a health care setting who uses tobacco should be offered at least one of these treatments: those willing to try to quit should be provided with identified treatments and those unwilling to try to quit should be provided with brief intervention that is designed to increase their motivation to quit (Fiore et al., 2000).
- There is substantial evidence of the benefits of screening and brief intervention for alcohol problems in primary health care settings. Evidence to date suggests that brief interventions can work for cannabis, benzodiazepines, amphetamines, opiates, and cocaine (Henry-Edwards et al., 2003).
- The 5-A's construct has also been applied to brief primary care interventions for a variety of other behaviours, including patient-centred nutrition counselling (Ockene et al., 1995) and physician-based activity counselling (Pinto et al., 2001).

Appendix D:
Glossary of Terms

5-A Model: A framework for HCPs working in primary care or other settings to structure brief interventions for behaviour change. An evidence-based practice recommendation.

Active Listening: In counselling theories, active listening skills include asking open-ended questions, reflecting factual and emotional content of communications back to a client, summarizing key points of a client's communications, and offering affirmations to a client about the work they are doing. In Motivational Interviewing, active listening skills are given the acronym OARS. Active listening is considered a necessary skill set for any counselling activity.

Behaviour Change Counselling: A type of intervention that is based on Motivational Interviewing principles. It is a person-centred, directive style of counselling that focuses on increasing motivation for change by resolving ambivalence about change (5 to 30 minutes).

Brief Advice: A type of intervention used in opportunistic settings to provide on the spot information and advice about a health behaviour. Particularly useful in tobacco and alcohol use reduction (3 to 5 minutes).

Confidence: From the perspective of Motivational Interviewing, confidence is the same as self-efficacy. It is one of three components that make up motivation. The other two are importance and readiness.

Decisional Balance: An activity that has the individual weigh the benefits and costs of continuing their current behaviour against the benefits and costs of making a change in that behaviour.

FRAMES: An acronym for the necessary components when giving advice during a Brief Advice intervention. FRAMES represents: feedback, responsibility, advice, menu, empathy and self-efficacy.

Importance: From the perspective of Motivational Interviewing, importance describes the relative value an individual places on a particular behaviour, as well as the value he/she places on changing that behaviour. It is one of three components that make up motivation. The other two are confidence and readiness.

Intervention: Actions taken to bring the issue of potential or actual health problems to the attention of the affected individual, and to improve motivation for behaviour change to reduce harm.

Motivational Interviewing: A counselling style that identifies an individual's ambivalence about their behaviour as the primary reason that the individual does not change that behaviour. The style is person-centred, avoids resistance and advice-giving, and emphasizes active-listening skills to help resolve ambivalence (30 to 60 minute sessions over an extended period of contact).

Processes of Change: Concept in the TTM that identifies the internal and external experiences and activities that enable individuals to move from one stage of change to the next. The ten processes of change are divided into two categories: Cognitive/Experiential and Behavioural.

Readiness: From the perspective of Motivational Interviewing, readiness indicates where, in a hierarchy of individual needs, making a particular behaviour change ranks for an individual. It is one of the three components that make up motivation. The other two are importance and confidence.

Self-Efficacy: The belief an individual has in his/her own ability to do something. A lack of self-efficacy or self-confidence often prevents individuals from making changes that they know to be in their own best interests.

Stages of Change: Concept in the TTM that describes the temporal aspect of the behaviour change process, as well as describing the levels of motivation or readiness for making behaviour change. The six stages are: Precontemplation, Contemplation, Preparation, Action, Maintenance and Termination.

Transtheoretical Model of Change (TTM): Describes how individuals make intentional change in their behaviours; the stages they go through, the processes they use, the decisions they make about what is important to them, and the steps to building self-efficacy for change.

Appendix E:
References

Bandura, A. (1977). Self-efficacy: Toward a Unifying Theory of Behavioral Change. *Psychological Review*, vol. 84, p. 191-215.

Bandura, A. (1997). *Self-Efficacy: The Exercise of Self-Control.* New York: Freeman.

Babor, T.F. & Higgens-Biddle, J.C. (2001). *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care.* Geneva: World Health Organization.

Barry, K.L. (1999). *Brief Interventions and Brief Therapies for Substance Abuse.* Rockville, MD: U.S. Department of Health and Human Services.

Breslin, J.J. & Skinner, H. (1999). Critical Perspectives on the Transtheoretical Model and Stages of Change. In: J.A. Tucker, D.M. Donovan & G.A. Marlatt, *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies.* New York: The Guilford Press.

Burke, L.E., Dunbar-Jacob, J.M., & Hill, M.N. (1997). Compliance with cardiovascular disease prevention strategies: A review of the research. *Annals of Behavioral Medicine*, vol. 19, p.239-263.

Cancer Care Nova Scotia (November 2005). Health Professional Counselling to Support Behaviour Change Physical Activity Counselling: Let's get moving. *In Practice: Cancer Information for Primary Caregivers*, vol. 2, no. 5.

Center for the Advancement of Health (2001). *Integration of Health Behavior Counseling in Routine Medical Care: Executive Summary.* Washington, DC: Center for the Advancement of Health.

Cerkoney, K.A., & Hart, I.K. (1980). The relationship between the health belief model and compliance of persons with diabetes mellitus. *Diabetes Care*, vol. 3, p. 594-598.

College of Family Physicians of Canada (1994). *Alcohol Risk Assessment and Intervention (ARAI): Resource Manual for Family Physicians.* Mississauga, ON: Author.

Connors, G.J., Donovan, D.M. & DiClemente, C.C. (2001). *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions.* New York: The Guilford Press.

Costanzo, C., Walker, S.N., Yates, B.C., McCabe, B. & Berg, K. (November 2006). Physical Activity Counseling for Older Women. *Western Journal of Nursing Research,* vol. 28, no. 7, p. 786-801.

Curry, S.J. & Kim, E.L. (1999). Public Health Perspective on Addictive Behavior Change Interventions: Conceptual Frameworks and Guiding Principles. In: J.A. Tucker, D.M. Donovan & G.A. Marlatt, *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies.* New York: The Guilford Press.

de Shazer, S. (1985). *Keys to Solutions in Brief Therapy.* New York: W.W. Norton.

DiClemente, C.C. (2003). *Addiction and Change: How Addictions Develop and Addicted People Recover.* New York: The Guilford Press.

DiClemente, C.C. & Prochaska, J.O. (1998). Toward a Comprehensive, Transtheoretical Model of Change: Stages of Change and Addictive Behaviors. In: W.R. Miller & N. Heather (Eds.). *Treating Addictive Behaviors*, (2nd. Ed.). New York: Plenum Press.

Donovan, D.M. & Rosengren, D.B. (1999). Motivation for Behavior Change and Treatment Among Substance Abusers. In: J.A. Tucker, D.M. Donovan & G.A. Marlatt, *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies.* New York: The Guilford Press.

Dosh, S.A., Holtrop, J.S., Torres, T., Arnold, A.K., Baumann, J. & White, L.L. (2005). Changing Organizational Constructs Into Functional Tools: An Assessment of the 5 A's in Primary Care Practices. *Annals of Family Medicine, vol. 3, (suppl. 2),* s50-s52.

Dubbert, P.M. (2002). Physical activity and exercise: Recent advances and current challenges. *Journal of Consulting and Clinical Psychology, vol. 70,* p.526-536.

Elford, R.W., MacMillan, H.L., Wathen, C.N. & The Canadian Task Force on Preventive Health Care. (November 2001). *Counselling for Risky Health Habits: A Conceptual Framework for Primary Care Practitioners.* CTFPHC Technical Report #01-7. London, ON: Canadian Task Force.

Evers, K.E., Prochaska, J.M., Prochaska, J.O., Driskell, M.M., Cummins, C.O. & Velicer, W.F. (2003). Strengths and Weaknesses of Health Behavior Change Programs on the Internet. *Journal of Health Psychology,* vol. 8, no. 63, p. 63-70.

Fiore, M.C., Bailey, W.C., Cohen, S.J., et. al. (October 2000). *Treating Tobacco Use and Dependence.* Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service.

Glanz, K., Lewis, F.M. & Rimer, B.K. (1997). *Health Behaviour & Health Education: Theory, Research & Practice,* (2nd Ed.). San Francisco: Jossey-Bass Inc.

Glasgow, R.E., Wagner, E.H., Kaplan, R.M., Vinicor, F., Smith, L. & Norman, J. (1999). If diabetes is a public health problem, why not treat it as one? A population-based approach to chronic illness. *Annals of Behavioral Medicine,* vol. 21, p. 159-170.

Glasgow, R.R., Whitesides, H., Nelson, C.C. & King, D.K. (2005). Use of the Patient Assessment of Chronic Illness Care (PACIC) with Diabetic Patients. *Diabetes Care,* vol. 28, no. 11, p. 2655-2661.

Henry-Edwards, S., Humeniuk, R., Ali, R., Monterio, M. & Poznyak, V. (2003). *Brief Intervention for Substance Use: A Manual for Use in Primary Care.* Geneva: WHO.

Herzog, T.A., Abrams, D.B., Emmons, K.M., Linnan, L.A. & Shadel, W.G. (1999). Do Processes of Change Predict Smoking Stage Movements? A Prospective Analysis of the Transtheoretical Model. *Health Psychology,* Vol. 18, No. 4, p. 369-375

Horbay, R. (1996). A Change - Stage Matching Transtheoretical Approach To Problem Gambling. *Developments,* Vol. 16, Issue 5, Dec/Jan. Calgary: Alberta Alcohol and Drug Abuse Commission.

Kaplan, R.M. (2000). Two pathways to prevention. *American Psychologist,* vol. 55, p. 382-396.

Kurtz, S.M.S. (1990). Adherence to diabetes regimens. Empirical status and clinical applications, *Diabetes Educator,* vol. 16, p. 50-56.

Lorenz, R.A., Bubb, J., Davis, D., Jacobson, A., Jannasch, K., Kramer, J., Lipps, J., & Schlundt, D. (1996). Changing behaviour: Practical lessons from the Diabetes Control and Complications Trial. *Diabetes Care,* 19, 648-652.

MacGregor, K., Handley, M., Wong, S., Sharifi, C., Gjeltema, K., Schillinger, D. & Bodenheimer, T. (2006). Behavior-Change Action Plans in Primary Care: A Feasibility Study of Clinicians. *Journal of the American Board of Family Medicine,* vol. 19, no. 3, p.215-223.

Mash, B. (2003). Motivating behaviour change in the diabetic patient. CME Vol. 21, No. 10. http://www.sahealthinfo.org/motivational/motivational.pdf (downloaded January 2007).

Miller, W.R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy,* Vol. 11, p. 147-172).

Miller, W.R. & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change* (2nd Ed.). New York: Guilford Press.

Miller, W.R. (2002). What really triggers health behavior change? [Abstract]. *Annals of Behavioral Medicine,* vol. 24, Supplement, xii.

National Institutes of Health. (January 2007). *Helping Patients Who Drink Too Much: A Clinician's Guide.* NIH Publication No. 07-3769. Washington, DC: National Institute on Alcohol Abuse and Alcoholism.

Niaura, R. & Abrams, D.B. (2002). Smoking cessation: Progress, priorities, and prospectus. *Journal of Consulting and Clinical Psychology,* vol. 70, p.494-509.

Ockene, I.S. & Ockene, J.K. (1992). *Prevention of coronary heart disease.* Boston, Little, Brown & Co.

Ockene, J.K., Ockene, I.S., Quirk, M.E., et al. (1995). Physician training for patient-centered nutrition counseling in a lipid intervention trial. *Preventive Medicine,* vol. 24, no. 6. p. 563-570.

Pinto, B.M., Lynn, H., Marcus, B.H., DePue, J. & Goldstein, M.G. (2001). Physician-based activity counseling: Intervention effects on mediators of motivational readiness for physical activity. *Annals of Behavioral Medicine,* vol. 23, no. 1, p. 2-10.

Prochaska, J.O., Norcross, J.C. & DiClemente, C.C. (1995). *Changing for Good.* New York: Avon Books Inc.

Prochaska, J.O., Redding, C.A. & Evers, K.E. (1997). The Transtheoretical Model and Stages of Change. In: K. Glanz, L.F. Marcus & B.K. Rimer, (Eds.). *Health Behaviour & Health Education: Theory, Research, and Practice,* (2nd Ed.). San Francisco: Jossey-Bass.

Rehman, L., Thompson, A., Campagna, P., Pickard, T., Bennet, T.L. & Perks, A. (September 2003). *Physical Activity Counselling by Healthcare Professionals in Nova Scotia: The Need for a Consistent Message, Final Report.* Halifax: Dalhousie University.

Roberts, L.J. & McCrady, B.S. (February 2003). *Alcohol Problems in Intimate Relationships: Identification and Intervention.* Washington, DC: National Institutes of Health.

Rollnick, S. & Miller, W.R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy,* Vol. 23, p. 325-334.

Rollnick, S., Allison, J., Ballosiotes, S., Barth, T., Butler, C.C., Rose, G.S. & Rosengren, D.B. (2002). Variations on a Theme: Motivational Interviewing and Its Adaptations. In: W.R. Miller & S. Rollnick, (Eds.). *Motivational Interviewing: Preparing People for Change,* (2nd Ed.). New York: The Guilford Press.

Rollnick, S., Butler, C.C., McCambridge, J., Kinnersley, P., Elwyn, G. & Resnicow, K. (2005). Consultations about changing behaviour. *British Medical Journal,* vol. 331, p. 961-963. www.bmj.com (downloaded January 2007).

Rollnick, S., Heather, N. & Bell, A. (1992). Negotiating behaviour change in medical settings: The development of brief motivational interviewing. *Journal of Mental Health,* Vol. 1, p. 25-37.

Rollnick, S., Mason, P. & Butler, C. (1999). *Health Behavior Change: A Guide for Practitioners.* New York: Churchill Livingstone.

Rosen, C.S. (2000). Is the Sequencing of Change Processes by Stage Consistent Across Health Problems? A Meta-Analysis. *Health Psychology,* Vol. 19, No. 6, p. 593-604.

Spencer, L., Adams, T.B., Malone, S., Roy, L. & Yost, E. (2006). Applying the Transtheoretical Model to Exercise: A Systematic and Comprehensive Review of the Literature. *Health Promotion Practice,* vol. 7, p. 428-443.

Terris, M. (1999). The development and prevention of cardiovascular disease risk factors: Socioenvironmental influences. *Preventive Medicine,* vol. 29, S11-S17.

Tomlin, K.M. & Richardson, H. (2004). *Motivational Interviewing & Stages of Change: Integrating Best Practices for Substance Abuse Professionals.* Center City, MN: Hazelden.

Tucker, J.A. & King, M.P. (1999). Resolving Alcohol and Drug Problems: Influences on Addictive Behavior Change and Help-Seeking Processes. In: J.A. Tucker, D.M. Donovan & G.A. Marlatt, *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies.* New York: The Guilford Press.

University of New South Wales (March 2004). *Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Risk Factor Management.*
http://www.cphce.unsw.edu.au/CPHCEWeb.nsf/resources/CGPISresources6to10/$file/snap5as.pdf

University of Wales College of Medicine (2002). *The Behaviour Change Counselling Index (BECCI): Manual for Coding Behaviour Change Counselling.* Cardiff: University of Wales.

Velasquez, M.M., Maurer, G.G., Crouch, C. & DiClemente, C.C. (2001). *Group Treatment for Substance Abuse: A Stages of Change Therapy Manual.* New York: The Guilford Press.

Velicier, W.F., Prochaska, J.O., Fava, J.L., Norman, G.J. & Redding, C.A. (1998). *Detailed Overview of the Transtheoretical Model of Change.* http://www.uri.educ/research/cprc/TTM/detailedoverview.htm

Wadden, T.A., Brownell, K.D. & Foster, G.D. (2002). Obesity: Responding to the global epidemic. *Journal of Consulting and Clinical Psychology, vol. 70,* p.510-525.

Whitlock, E.P., Orleans, C.T., Pender, N. & Allen, J. (2002). Evaluating Primary Care Behavioral Counseling Interventions: An Evidence-based Approach. *American Journal of Preventative Medicine,* vol. 22, no. 4, p. 267-284.

Zweben, A. & Fleming, M.F. (1999). Brief Interventions for Alcohol and Drug Problems. In: J.A. Tucker, D.M. Donovan & G.A. Marlatt, *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies.* New York: The Guilford Press.