Communication skills for health promotion: brief intervention and advice

Abstract

Nurses are often the best placed health professionals to deliver opportunistic health promotion by using brief intervention and advice in their encounters with patients and relatives. These encounters may be as short as 30 seconds, but even in that time evidence shows that, by adopting key motivational communication skills, nurses can be effective in engaging and motivating patients towards behaviour change. This article outlines the recommendations and evidence-based strategies that can be delivered in time-limited patient encounters to promote healthier lifestyles.

Introduction

Health promotion has become a key role in nursing, as emphasised by the NMC (2018) standards of proficiency and the Five Year Forward Review (NHS England 2014). Indeed, the Covid pandemic has illustrated the importance of tackling underlying health conditions to reduce the burden of preventable illness (Office for Health Promotion 2021). Health promotion is defined by the World Health Organization (WHO) as empowering people to improve their own health (WHO 1986), therefore, practitioners delivering health promotion need to go beyond simple health education to also deliver empowerment interventions that can enhance people's capabilities and motivation to adopt more healthy behaviour.

Behaviour change is embedded in the Making Every Contact Count (MECC) approach. Making Every Contact Count supports the delivery of short, person-centred, interventions in everyday clinical encounters to support patients in making healthier lifestyle choices (PHE (Public Health England) 2016). The MECC approach to health promotion is person-centred and asset-based that means recognising the individual's specific needs and situation, and making use of the person's particular strengths to give them the resources to make changes. In the MECC Consensus Statement, PHE (2016) suggests that nurses are best placed to deliver behaviour change health promotion on a one-to-one basis with patients and family members, especially opportunistically in their daily contacts with patients. This means that nurse practitioners can call upon their existing skills in communication, relationship-building and partnership-working with patients to deliver effective individual-level health promotion (NICE 2014).

The MECC health promotion approach targets the most high-cost behaviours of smoking, alcohol use, obesity, physical activity, and mental health, recommending effective communication that includes brief intervention and behaviour change techniques (PHE 2016). These approaches have been evidenced and practised particularly for substance use (Babor et al 2017, Frost et al 2018), but show transferability to other health-related lifestyle behaviours. Brief intervention (BI) demonstrates effectiveness in reducing falls risk (Pires et al 2017), managing stress and anxiety (Roy-Byrne et al 2009), smoking cessation (Bowden et al 2010), cancer risk reduction (Mills et al 2021) and for increasing physical activity (Scott et al 2019). Recently, Bourhill et al (2021) found that applying multiple behaviour change techniques encourages obese people to attend weight management

clinics. The potential for BI remains to be explored across a wider range of modifiable health challenges.

What are brief interventions?

Brief interventions are essentially short discussions with patients that deliver motivational health promotion targeted at lifestyle habits and behaviour change (Senior and Craig 2019). Brief interventions can be used opportunistically and incorporated into informal communication when health promotion is indicated (Fuller 2015). The NICE guidelines for individual behaviour change approaches (2014) define three types of brief intervention:

1. Very brief interventions between 30 seconds to two minutes, delivering brief advice or highlighting a health problem, often with the aim to reduce risk of mortality and morbidity.
2. Brief intervention of up to five minutes, that includes discussion and encouragement, and may include a referral or signposting to further support.
3. Extended brief intervention which may last over 30 minutes or may include multiple sessions. These sessions may require specific training for working with higher-risk or complex needs patients.

Initially developed for working with people with harmful alcohol use, BI is described as a common-sense engagement approach for patients who lack the ability to change their lifestyle on their own (McCambridge and Cunningham 2013). It offers the practitioner a time-limited structure with which to give targeted health advice and behaviour change support, often when the opportunity arises. Senior and Craig (2019) describe BI as aiming to increase the patient's insight into their health-related behaviours, to reduce harm and assist in initiating change.

Brief intervention communication techniques stem from the motivational interviewing (MI) counselling approach (WHO 2010). This approach originally provided person-centred support to help someone towards changing their drinking behaviour (Miller and Rollnick 2013), but it offers effective communication techniques adaptable for short opportunistic health promotion (WHO 2010, McCambridge and Cunningham 2013). Motivational interviewing has also been applied effectively to health issues such as medicine adherence (Gesinde and Harry 2018), oral hygiene (Rigau-Gay et al 2020), increasing exercise for type 2 diabetes patients (Galle' et al 2018), and improving self-help in multiple sclerosis (Dorstyn et al 2020).

Miller and Rollnick (2013) based MI on the transtheoretical model of behaviour change (Prochasta and DiClemente 1983) to promote motivation and self-belief for people who are 'stuck' in a set behaviour pattern and believe they cannot change (Babor et al 2001). The WHO guidelines (2010) for brief intervention recommend the model as it provides an explanation of motivation, and also facilitates assessment of readiness to change, assisting the practitioner to deliver the appropriate motivational support. Evidence shows the effective application of the model within behaviour change approaches for a range of chronic diseases and lifestyle-related risks (Scruggs et al 2018, Hashemzadeh et al 2019, Nakabyashi et al 2020).

The process of change in this model starts with pre-contemplation, in which the person has no notion of making changes, and moves towards contemplating change, planning how to change, taking action and then establishing a new behaviour routine (see Figure 1). The first two or three stages are likely to be the most relevant in BI, which aims to create ambivalence about existing attitudes and beliefs to help the person think about change (contemplate) and perhaps assist in planning a change (NICE 2014). Motivational communication in MI or BI aims to elicit 'change talk' (Miller and Rollnick 2013) by the patient, which reflects their state of ambivalence and indicates they may be contemplating changing their current health lifestyle.

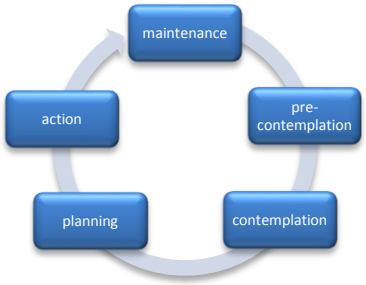

Figure 1: Illustration of Prochaska and DiClemente's model of behaviour change (1983).

Individuals at pre-contemplation stage may be either in denial that there is a problem, or a believe that it cannot be changed. Moving to contemplation may show their increasing ambivalence and a shifting of attitude or belief, indicated by change talk. Examples of the stages are given in Box 1.

Box 1: Examples of statements indicative of stage of behaviour change (Holt and Rooke 2020 p 267-269)

Pre-contemplation – 'I've tried everything but nothing really works for me so I just have to face it.'

Contemplation – 'I may be able to give it another go.'

Planning - 'I've decided that I am definitely going to quite smoking after my holiday…'

Action – 'I've managed to cut down but not completely.'

Maintenance – 'I feel so much better. I haven't had a cigarette for 4 months...'

Eliciting 'change talk'

Change talk is any statement from the person that indicates change. Statements such as '*I have to stop drinking'* (SAMHSA 2019 p10) would contrast with sustain statements that indicate reluctance to change such as '*I can manage my life just fine without giving up the drug'* (SAMHSA 2019 p11). The main goal in BI or MI is to increase the amount of change talk and reduce the amount of sustain talk. Miller and Rollnick (2013) indicate that the key techniques to eliciting change talk are asking open questions and reflective listening, both of which are built on a person-centred philosophy of approach.

Philosophy of approach for Brief intervention and motivational communication

Both MI and BI use a range of behaviour change techniques based on a person-centred, individual approach that is non-judgemental and empathetic, and established on a collaborative partnership between practitioner and patient (Babor and Higgins-Biddle 2001, PHE 2013, NICE 2014). Platt et al (2016) demonstrated that nurses are particularly effective in delivering brief alcohol interventions in primary care by being able to build trusting nurse-patient relationships.

The motivational interviewing approach is based on four principles of effective communication (Miller and Rollnick 2013):

1. Empathy
2. Developing discrepancy/ambivalence
3. Rolling with resistance
4. Supporting self-efficacy

Empathy is particularly emphasised in MI, revealing its substance use origins in which patients may feel labelled or shamed by their behaviour (WHO 2010), and likely to be as important for similar issues such as obesity and smoking. It is also important that problem-solving is based on the individual's own values and contexts in which they work and live, their own characteristics and capacities for change (NICE 2014). This person-centred focus will include the patient's motivation and self-belief; how much they want to change their behaviour and whether they feel able to change. Therefore, encouraging self-efficacy through positive reinforcement of what they already can do should be a priority when these present as barriers.

Working with the patient's priorities and values requires finding these barriers and overcoming them without nagging or preaching, but encouraging the person to a state of ambivalence where they may be on the cusp of change. Babor and Higgins-Biddle (2001 p 6) advise avoiding resistance with hazardous drinkers by discussing the behaviour rather than labelling the person:

> *'Hence, discussion of hazardous drinking or alcohol dependence is preferable to labeling a patient as a binge drinker or an alcoholic. This will allow patients to focus on changing their drinking behaviour without feeling defensive about the terms being applied to them.'*

Supporting self-efficacy means encouraging the patient to feel in control and empowered, and able to make changes. The MECC principles are based on a whole-systems approach to behaviour change (the COM-B model) which incorporates the individual's socio-economic factors as well as psychological barriers or enablers for behaviour change (Michie et al 2011). Motivational communication focuses on developing positive psychological factors, explained in the model as:

1. Capability: The person feels capable of changing – they have self-belief and confidence
2. Opportunity: The person feels they have the opportunity and resources or support
3. Motivation: The person has the motivation or the desire to change

These three elements are 'the key ingredients necessary for successful behaviour change' (The Training Tree 2015 p 2), and can guide the practitioner to frame the health promotion approach.

Delivering motivational communication

Very brief intervention

It is recommended that, for very brief interventions of up to two minutes (PHE 2013, NICE 2014), practitioners adopt the 3 'A's of ASK, ADVISE, ASSIST:

ASK an open question about the Issue. This is described this as the 'door opener', for instance '*Why is it so important to make this change right now*'? (The Training Tree 2016 p 16)

ADVISE by giving relevant information that is specific for the individual, for instance, '[*are you] aware that you are 4 times more likely to successfully quit if you get support from Stop Smoking Services rather than going it alone?*' (The Training Tree 2016 p 14).

ASSIST by signposting to further information or support, such as suggesting a trusted website.

Very brief interventions are likely to be deployed when time is very limited and the issue is not currently a serious health risk. The aim for a very brief intervention is to prevent or reduce the risk of harm (NICE 2014).

Brief intervention

Brief intervention is defined as a discussion up to 30 minutes focused on behaviour change and may include a referral for more specialist support (NICE 2014). The 3 'A's strategy is also recommended by PHE for brief interventions (PHE 2013) but where time is available, and the person presents with a more serious risk of harm, this could also include assessment – ASK, ASSESS, ADVISE, ASSIST (4 'A's) (The Training Tree 2015). Assessment becomes more important when a more structured intervention is required for follow-up or referral. This may include an assessment tool or protocol, for example taking a body mass index measurement. This would be useful in providing objective data with which to focus the brief intervention discussion.

A strategy for such brief intervention delivery, known as FRAMES, is recommended by the WHO (2010) and may be a useful way to approach BI (see Box 2).

Box 2: FRAMES strategy for brief intervention adapted from WHO (2010)

FEEDBACK – Give personally relevant feedback to the person
RESPONSIBILITY – Accept the person is responsible for their own behaviour and choices
ADVICE – Give advice on how to reduce risk of harm
MENU OF OPTIONS – Present options to allow the person to choose strategies most suitable for their situation
EMPATHY – Use a non-judgemental approach, avoiding labelling and stigma
SELF-EFFICACY – Encourage the person's confidence and belief they can change.

FRAMES incorporates similar principles to MI, emphasising the importance of using reflective listening and objectiveness to demonstrate empathy. The WHO underlines that this is 'an important contributor to how well the client responds to the interaction' (WHO 2010 p 15).

The FRAMES, 3 'A's and 4 'A's strategies demand specific communication skills in their delivery. Beckwith and Beckwith (2020) outline the OARs acronym from Miller and Rollnick (2013) as the core communication skills for creating an effective motivational communication technique (Box 3).

Box 3: OARS acronym of communication tips for BI and MI (Beckwith and Beckwith 2020)

OARS:
Open-ended questions
Affirmations – seeing and highlighting the positive
Reflections – highlighting the ambivalence; bringing change-talk to consciousness
Summarising – demonstrating listening and understanding, and reminding the person of their change talk and identified priorities.

There is however limited evidence on specific communication strategies within MI, whether using FRAMES, 3 'A's or OARS (PHE 2016), despite much evidence for their effectiveness as an overall BI approach for behaviour change (NICE 2014). However, as a guide to effective delivery, Holt and Rooke (2020) adapt Rollnick's practice checklist for nurses to ensure communication style is in line with the principles of MI:

1. The nurse is speaking slowly
2. The patient is doing much of the talking – about behaviour change
3. The nurse is listening carefully, only directing the interview at appropriate stages
4. The patient is working hard and asking the nurse for advice and information
5. It is as if the nurse and the patient are putting the pieces of a jigsaw together to reveal the full picture.

(Holt and Rooke 2020 p275)

NICE (2014) and PHE (2016) recommend that practitioners delivering extended behaviour change interventions with higher-risk patients, such as those with a BMI of over 40, patients who are substance dependent or have complex needs, will need specific training in cognitive behavioural and motivational approaches. However, this should not prevent all practitioners in their routine practice asking about patients' health concerns, assessing need and offering referral. Initial contact with patients with more complex behaviour needs by health care practitioners can initiate early detection and referral through the process of taking the opportunity to ask and broach the subject.

Summary

Brief intervention and advice is evidenced as an effective individual-level health promotion intervention that utilises the existing relationship-building skills nurses already possess. While the approach is based on counselling techniques designed for complex behaviour issues, the basic communication techniques are compatible with a person-centred care approach, and support nurses in the delivery of the MECC principles. Importantly, brief intervention and advice is a time-efficient intervention that provides nurses with an effective tool to make a difference to their patients, even when time is short.

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