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The use of motivational interviewing in community nursing

Patricia Day, Jill Gould, Gayle Hazelby

While lifestyle-related conditions such as heart disease, obesity and diabetes are on the rise, district nurse numbers are falling. At the same time, traditional methods for providing lifestyle advice on factors such as smoking, alcohol intake and exercise have proven to be ineffective. This article examines how a technique called motivational interviewing, which seeks to build a partnership with the client, can promote positive change by strengthening the person's own motivation to change.

KEYWORDS:
■ Long-term conditions ■ Lifestyle ■ Motivational interviewing

The vulnerability of house-bound patients is becoming harder to ignore. This population make up the majority of a district nurse's caseload. Recent decreases in social care funding have placed an extra burden on both hospital and community-based care, while services for older clients with complex needs are at crisis point. Six consecutive years of budget cuts have meant 26% fewer people are getting help (King's Fund, 2016). At the same time, the 'gateway' of primary and secondary care is under increasing pressure with a 15% rise in GP appointments between 2010 and 2015 — the largest increase being among older people — and 18% more older clients requiring emergency admission to hospital (King's Fund, 2016).

The little research available on the activities undertaken by district nursing services also shows an increase in the volume and complexity of caseloads (Maybin et al, 2016), while between 2009 and 2014 there was a 28% reduction in the total number of full-time equivalent district nurses (Health and Social Care Information Centre [HSCIC], 2015). This decline shows no sign of abating; the number of full-time equivalent district nurses decreased by a further 13.6% between 2014 and 2016 (HSCIC, 2016; Maybin et al, 2016).

As well as increased pressures and declining staff groups, the context of care has changed. The main threats to health are now lifestyle related. Although people are living longer, their quality of life is worsening, with higher rates of ill-health and disability. In England, for example, 15.4 million people (over a quarter of the population) have a long-term condition, i.e. heart disease, diabetes, etc, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008, to 2.9 million in 2018) (Department of Health [DH], 2012).

People with long-term conditions consume a significant proportion of healthcare resources in England (50% of all GP appointments and 70% of days spent in hospital beds), while their care absorbs 70% of hospital and primary care budgets (NHS England, 2014).

LIFESTYLE

These long-term conditions also include lifestyle-related risk factors. Among the most significant causes of ill-health are obesity, smoking, alcohol intake, poor diet and a lack of physical activity, and little progress has been made in these areas — one in five adults still smoke, one-third of people drink too much alcohol and 50% of women do not get enough exercise (NHS England, 2014).

Obesity is at epidemic levels and rising, with over 60% of adults overweight or obese (HSCIC, 2013). An analysis of the global burden of disease has found that 'not only is obesity increasing, but no national success stories have been reported in the past 33 years' (Ng et al, 2014). In the UK, 63% of the population takes less than 30 minutes of physical activity five times a week, compared to 16% in Greece for example, while on average the British eat fewer than three portions of fruit and vegetables a day, compared to over five a day in Italy.

The consequences of these unhealthy lifestyles are proving costly to individuals and society. To take just one example, Diabetes UK (2014) estimates that the NHS is already spending around £10 billion a year on diabetes. Almost three million people in England are living with the condition and another seven million are at risk of becoming diabetic. As NHS England (2014) stated, 'Put bluntly, as the nation's waistline keeps piling on the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.'

Smoking and alcohol

Although smoking levels are improving overall, it remains the main cause of preventable ill health,

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Practice point

Housebound patients with anxiety or low mood find themselves having to access emergency services inappropriately. This encourages a lack of autonomy and self-efficacy. Motivational interviewing can promote empowerment in considering a wider range of strategies.

being involved in many conditions such as cancer, heart disease and stroke. However, smoking rates are reducing, with recent statistics showing an increase in the number of 'quitters' or those identifying a 'quit date' (Public Health England, 2015).

Alcohol intake shows disturbing trends with increases in binge drinking and alcohol-related deaths. Alcohol is the third biggest behavioural risk factor for disease and death in the UK after smoking and poor diet. In 2011, there were nearly 6,800 deaths directly related to alcohol, and an estimated 15,000 attributable to alcohol in England, while rates of alcohol consumption have risen over the past 50 years, and in contrast to other European Union countries, incidence of deaths due to liver disease in the UK is increasing (Department of Health [DH], 2014).

The five big killers — heart disease, stroke, cancer, lung and liver disease — account for more than 150,000 deaths per year among under 75-year-olds in England alone and the DH estimates that 30,000 of these are entirely avoidable (DH, 2014).

PROVIDING LIFESTYLE ADVICE

Despite advice from the National Institute for Health and Care Excellence [NICE] (2014) that evidence-based psychological approaches to consultations promote client autonomy and enable behaviour change and should underpin district nursing practice, traditional methods of providing advice on lifestyle issues have proved ineffective (NHS England, 2014).

The evidence base for effective interventions in behaviour change is increasing, however. In particular, motivational interviewing has been shown to be effective in all of the risk-taking behaviours (Miller and Rollnick, 2013). There are NICE guidelines and Cochrane reviews that support the use of motivational interviewing for exercise and healthy eating (obesity), smoking, alcohol and substance misuse, and mental health (Lai et al, 2010; Smedslund et al, 2011; Lindson-Hawley, 2015).

District nurses have a highly dependent caseload and are likely to respond to this demand by problem-solving for clients and attempting to come up with solutions to their lifestyle issues. Motivational interviewing is far removed from this approach, placing emphasis instead on uncovering a person's intrinsic motivation to make changes. It is a gentle style of communication that promotes autonomy and personal choice and is a skill that can be taught. It may require nurses to unpick their entrenched behaviours and habitual approaches to communication, however, and it may also involve unlearning or resisting the so-called 'righting reflex' (Miller and Rollnick, 2013).

What is motivational interviewing?

Motivational interviewing works by allowing clients to work through their issues and developing a plan which works for them. It is 'a person-centred, goal-directive counselling method for resolving ambivalence and promoting positive change by eliciting and strengthening the person's own motivation to change' (Miller and Rollnick, 2002).

More simply put, unless a change is in the person's interest, it will not happen. This may be contrary to currently accepted practice in district nursing, where the clinical requirements of a district nurse's caseload may demand an emphasis on 'quick fixes' and professionally led decision-making.

With motivational interviewing, however, change arises through its relevance to the person's own values and concerns. Evoking the client's 'story' is seen as essential in making a difference to their health outcomes. District nurses are highly skilled in communicating with housebound, vulnerable older people, for example, and will be working within the 'spirit of motivational interviewing' (Miller and Rollnick, 2013). District nursing practice has evolved from being professionally led to being more client directed. An example of this would be in the management of leg ulcers. District nurses discuss the available options with the client to enable informed choice. Skilled assessment at the client's own pace and evoking their 'story' can help in identifying their treatment priorities, such as comfort over healing time. This is likely to promote concordance with a treatment plan.

Motivational interviewing seeks to develop the core conditions of a therapeutic relationship — warmth, empathy, unconditional positive regard, genuineness and congruence — which transcend generational boundaries in fostering equal partnerships in care (Rogers, 1951).

Autonomy and collaboration are core in motivational interviewing consultations. This involves the promotion of self-care. An example may be working out a plan for the client to monitor blood sugars and self-administer insulin. This is particularly important in conversations about behaviour change with older patients, who may be forced into positions of dependence within healthcare systems.

Motivational interviewing...

With the relationship at the core of a motivational interviewing approach, once trust is established, there is scope to explore options. For example, accepting the patient's decision not to treat leg oedema with compression may result in poor outcomes initially, but if trust has been established, this can allow opportunity for the patient to re-evaluate and reach a different decision.

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OARS

- **Open question:** avoid why? Use instead: What is it about that? Tell me about? How?
- **Affirm:** *not to be confused with praise*, comment on an attribute
- **Reflection:**
  - **Simple,** stays close to what person says, repetition or slight rewording, gives reassurance
  - **Complex,** paraphrasing, adds meaning, checks understanding
- **Summary:** useful to shift focus or end a session

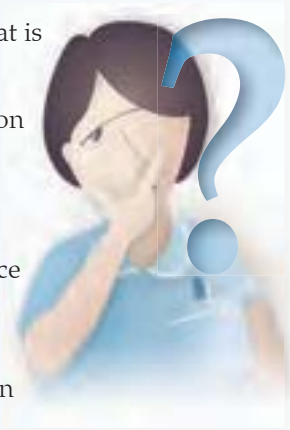

Figure 1.
The 'OARS' framework.

An internal conversation using motivational interviewing about a client's options could start with:

- What may be useful?
- Stop
- Think...
- Is this effective...?
- What may be more effective...?

Motivational interviewing is directional and seeks to guide the client towards change. However, it also allows clients to make their own decisions about what they want to achieve. This means that patients can, for example, choose which dressings they have on their wounds, which medications they receive for pain, where they want to sleep and how much they engage with treatments. Their decisions may be contrary to medical advice, but within the spirit of motivational interviewing, practitioners should be non-judgemental and accepting, even if they may disagree with client choices. This challenges a paternalistic approach and is in line with respect for human rights, dignity, preferences and concerns (Nursing and Midwifery Council [NMC], 2015).

There are useful frameworks within the concept of motivational interviewing that seek to engage clients in discussions about behaviour change. Learning motivational interview skills includes using the 'OARS' framework (Rosengren, 2009) (*Figure 1*). While most people are ambivalent towards change, the OARS framework is very good at encouraging people to articulate their ambivalence about changing their behaviour. This articulation helps to move people towards change, by uncovering their intrinsic motivation and tipping the balance towards 'change talk'.

Reflective listening is a key tool in motivational interviewing (Miller and Rollnick, 2002), and involves interpreting what clients say to strengthen their motivation for change. Skilful reflection is unlikely to provoke resistance and may be a useful strategy to use with older people who have 'heard it all before' (see *Figure 1*). Change may be particularly difficult for older people due to familiar patterns of behaviour and anxiety about the risks associated with behaving in a different way.

Listening for change talk is an essential component of motivational interviewing. Change talk is important as it is linked to action (Miller and Rollnick, 2013). For example, when a patient says 'I really need to stop smoking', this should be supported by the practitioner as it is likely to lead to change. Other examples of change talk statements may include:

- 'I would like to...'
- 'I want to...'
- 'Life is unbearable… something needs to change…'

Discrepancy between a client's behaviour and their values and beliefs can also promote change (Miller and Rollnick, 2013). For example, a patient who is a long-term smoker and is now a great grandparent may see this as an incentive to change. This can be applied to older people who want to remain healthy for family and friends but who may be behaving in ways which compromise their health.

Hope for recovery is also known to improve outcomes. Clients may lose hope for the future and fostering a sense of purpose and quality of life is embedded within the spirit of motivational interviewing.

A strategy known as 'elicit, provide, elicit' (EPE) is also a useful tool in motivational interviewing and can help to avoid providing unsolicited advice. EPE involves finding out what clients know, providing extra information if required and then asking what they think (Miller and

Remember...

Patient consent and capacity always need to be established, as 'best interest' decisions can be made if capacity is lacking.

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Rollnick, 2013). This approach could particularly appeal to older clients who are likely to have knowledge and wisdom in abundance. It can allow the practitioner to build on what clients already know.

RECOMMENDATIONS FOR PRACTICE

Recommendations for district nursing practice include engaging with motivational interviewing to expand understanding of its core principles and the training required. This may involve advocating for motivational interviewing as a transferable skill set in which to 'make every contact count' (Health Education England, 2017).

District nursing teams could ask for training in motivational interviewing and access resources, such as the list of motivational interviewing trainers on the motivational interviewing website (www.motivationalinterviewing.org). At the same time, embedding motivational interviewing within pre-registration and post-registration nursing curriculums could be the way forward for skills and knowledge development.

CONCLUSION

Change is required in healthcare services to improve general health, but directive approaches have proven to be ineffective in preventing many long-term conditions. Working collaboratively with clients will enable district nurses to set achievable targets, which are sensitive to the client's particular needs.

District nurses have a crucial role to play in chronic disease management for highly vulnerable clients, and evidence-based psychological methods of communication are likely to make a difference to this population's health. JCN

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KEY POINTS

- While lifestyle-related conditions such as heart disease, obesity and diabetes are on the rise, district nurse numbers are falling.
- At the same time, traditional methods for providing lifestyle advice on factors such as smoking, alcohol intake and exercise have proven to be ineffective.
- This article has examined how a technique called motivational interviewing, which seeks to build a partnership with the client, can promote positive change by strengthening the person's own motivation to change.
- District nurses have a crucial role to play in chronic disease management for patients with long-term conditions, and evidence-based psychological methods of communication are likely to make a difference to this population's health.