

## Collaborative Decision-Making and Brief Interventions

According to the Institute for Clinical Systems Improvement *Primary Prevention of Chronic Disease* Guideline, addressing these issues should be done via collaborative decision-making and brief interventions (2010, pp. 17-19). The following information is from this portion of the ICSI Guideline. In brackets [ ] is the corresponding SHIP Prevention in Health Care step as well as the 5A's step for those who are familiar with the 5A's.

**Collaborative Decision-making** requires that all persons clarify their individual values and priorities, with help from their providers if they wish, so that they may decide on their desired goals and specific interventions.

There is no best or easy approach to this step of the decision-making process. Patience, insight and care are required to recognize different perspectives and to achieve a respectful and balanced discussion about making lifestyle changes for better health.

**Brief Interventions** consist of feedback of screening data designed to increase motivation to change behaviors, simple advice, health education, skill building, and practical suggestions. Specific elements of brief interventions include:

- present screening results [SHIP: Screen; 5A's: Ask/Screen];
- identify risks and discuss consequences [SHIP: Counsel; 5A's: Advise];
- provide medical advice [SHIP: Counsel; 5A's: Advise];
- identify and agree on short- and long-term measurable goals [SHIP: Counsel; 5A's: Assist];
- solicit patient commitment [SHIP: Counsel; 5A's: Assess readiness to change];
- give advice and encouragement, assist with motivation, skills and supports [SHIP: Counsel; 5A's: Assist]; and
- arrange follow-up support and repeated counseling [SHIP: Refer; 5A's: Arrange], including referral if needed.

**Readiness to Change (RTC)**, developed by Prochaska, has been applied to a wide range of specific behaviors, such as smoking cessation, seat belt use, sunscreen use, physical activity, healthier eating, and alcohol use. Sets of standardized questions have been developed for these specific behaviors and embedded in many health risk assessments (*Prochaska, 2005 [A]*).

There is good evidence that the readiness to change stage is a strong predictor of subsequent improvement in some chronic diseases, but there is only weak evidence supporting the effectiveness of lifestyle interventions that are based on an individual's "stage of change" or "readiness to change" (*Riemsma, 2003 [M]*).

A less structured collaborative decision-making process, involving simply asking people about their individual priorities, goals and preferred areas of focus, seems to be sufficient. It may also be helpful to include periodic assessments as to how patients are feeling regarding self-efficacy, general optimism, motivation, volition, commitment to change, and viewed importance of change (*Armitage, 2004 [A]*; *Nothwehr, 2006 [D]*; *Resnicow, 2003 [B]*; *Tinker, 2007 [D]*), as these may

predict initiation of behavior change and continuation of the healthy behavior. In addition, describing a person as being in a "precontemplation" stage, or someone as "not ready to change" may not be appropriate and may result in missed opportunities for positive change (*Nothwehr, 2006 [D]; van Sluijs, 2004 [R]; Verheijden, 2004 [C]*).

**Motivational Interviewing (MI)** is defined as a client-centered, directive counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Rather than telling a client what changes to make, the interviewer elicits "change talk" from them, taking into account an individual's priorities and values. There is considerable evidence to support the use of motivational interviewing as a brief intervention for treating substance abuse disorders (*Dunn, 2001 [M]; Resnicow, 2002 [R]*).

Applying motivational interviewing techniques to healthy behaviors related to alcohol and substance abuse is supported by evidence. Lifestyle behaviors requiring a change in behavior may respond to motivational interviewing techniques, as opposed to discontinuing or initiating a behavior that may not respond to these techniques (*Resnicow, 2002 [R]*). On the other hand, brief motivational interviewing to address an assortment of lifestyle changes has been found to have an effect (*Rubak, 2005 [M]*).

Motivational interviewing can be incorporated into an assortment of settings from health care to workplace with non-physician providers conducting a large portion of the interventions (*Resnicow, 2002 [R]*).

**Combined Interventions**, focusing on all aspects that need attention and on which the patient is willing to work, do not appear to be viewed as unduly daunting or discouraging for patients to attempt. Primary providers should not position themselves as barriers to positive change by unnecessarily narrowing patient's opportunities for change; there is no evidence in the literature that patients are only able to address a limited number of issues at any one time, and several studies indicate that offering a menu of opportunities for behavior change does not jeopardize the probability of change (*Aldana, 2005a [A]; Babor, 2004 [R]; Goldstein, 2004 [R]; Millen, 2004 [B]; Pronk, 2004a [D]*).