Health psychology and advanced communication skills for prescribers

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An introduction to the principles of health psychology that can be applied during consultations with patients.

Communication skills

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By the end of this article, you will be able to:

- Apply the principles of health psychology, COM-B and models of behaviour change to your consultations in practice;
- Establish the reasons for a patient's medication-taking behaviours within a consultation;
- Outline how you would conduct an effective consultation to fully explore a patient's beliefs and preferences;
- Understand how the principles of MI and SDM could be applied to your own practice.

RPS Competency Framework for All Prescribers

This article aims to support the development of knowledge and skills related to the following competencies:

- Domain 1.4: Assesses the communication needs of the patient/carer and adapts consultation appropriately;
- Domain 1.5: Demonstrates good consultation skills and builds rapport with the patient/carer;
- Domain 3.1: Actively involves and works with the patient/carer to make informed choices and agree a plan that respects the patient's/carer's preferences;
- Domain 3.2: Considers and respects patient diversity, background, personal values and beliefs about their health, treatment and medicines, supporting the values of equality and inclusivity, and developing cultural competence;
- Domain 3.3: Explains the material risks and benefits, and rationale behind management options in a way the patient/carer understands, so that they can make an informed choice;
- Domain 3.4: Assesses adherence in a non-judgemental way; understands the reasons for non-adherence and how best to support the patient/carer;
- Domain 5.1: Assesses health literacy of the patient/carer and adapts appropriately to provide clear, understandable and accessible information.

Introduction

Use of advanced communication skills, such as shared decision-making (SDM, see Box) and motivational interviewing (MI), can help prescribers to engage and empower patients, by encouraging them to take responsibility for and be active participants in decisions about their health. These approaches also strengthen the patient–practitioner relationship. Emotional intelligence — the ability to perceive, use, understand, manage and handle emotions — is an essential attribute needed by a practitioner when engaging in these advanced communication skills, enhancing and underpinning effective communication.

This article outlines some of the health psychology theories that underpin these approaches and provides practical considerations for prescribers on how to apply these skills effectively when consulting with patients.

It is recommended that you read this article in conjunction with these resources from *The Pharmaceutical Journal*:

- 'Principles of person-centred care for prescribing';
- 'How to build and maintain trust with patients';

- ‘How to demonstrate empathy and compassion in a pharmacy setting‘;
- ‘Communication techniques for prescribing‘.

To help further expand your prescribing skills, additional related articles are linked throughout. You will also be able to test your knowledge by completing a short quizat the end of the article.

Behavioural science and health psychology

Given the increasing complexity and diversity of healthcare needs, facilitating SDM at an individualised level requires advanced communication skills (see Box). Development of these skills can be aided by an understanding of behavioural science and health psychology. Behavioural science is a discipline that seeks to understand health-related choices and behaviours; it also explains why person-centred care and SDM are crucial to improved health outcomes.

Looking at variations in clinical outcomes through a behavioural lens highlights why failing to establish an empathetic, open conversation that considers the patient’s needs, circumstances and beliefs can result in non-adherence to treatment. The ideal outcome of an SDM conversation is a collaboratively designed and agreed plan for treating or managing a condition, which could involve the patient engaging in one or more health-related behaviours. This may include taking medication, such as the physical act of using an inhaler or swallowing a dose of medication; attending monitoring appointments; making lifestyle changes; self-monitoring; or engaging in other self-management behaviours.

Box: Importance of shared-decision making

Person-centred care, where care is tailored to the individual’s needs, circumstances and values, is increasingly considered best practice, leading to improved patient outcomes and stronger patient–provider relationships[1]. Shared decision-making (SDM) forms a central tenet of person-centred care and is a pillar of the Prudent Healthcare[2] and Realistic Medicine[3] initiatives that have been advocated in Wales and Scotland, respectively.

SDM is a process whereby a healthcare professional and their patient collaborate to make health-related decisions[4]. SDM draws on the expertise of both parties but involves more than simply bringing together the prescriber’s knowledge of diagnosis and treatment options and the patient’s preferences and values.

The SDM process starts from the point of diagnosis, where an understanding of the patient’s experience of the condition and how it affects their life is considered, alongside the prescriber’s knowledge of the potential aetiology of the symptoms presented providing a precursor to decision-making[5,6]. SDM continues towards the goal of reaching an

agreement about managing the condition by exploring the patient's beliefs and considering their preferences, goals and values. The risks, benefits and consequences of treatment options and health-related behaviours would also be considered.

In many cases, SDM will be an ongoing process where decisions are revisited periodically[7]. The National Institute for Health and Care Excellence SDM guidance should be familiar to all pharmacists and provides links to useful resources, including patient decision aids, that can support consultations.

Health psychology focuses on how psychological, biological and social factors influence health, illness and healthcare[8]. Itis aimed at understanding and influencing behaviour to improve wellbeing, focusing specifically on health-related issues. It also seeks to understand people's experiences of health and illness, supporting individual and population-level wellbeing by studying how people manage their health. An important part of this is exploring communication between patients and healthcare professionals and designing interventions to promote health and prevent disease.

Understanding how beliefs can influence behaviour

To understand how beliefs influence healthcare decision-making, it is helpful to look at two health psychology theories: Leventhal's Common-Sense Model of Self-Regulation (CSM) and Horne's Necessity-Concerns Framework (NCF)[9,10]. These provide valuable insights into patients' perceptions of illness and treatment, as well as their role in decision-making processes regarding their healthcare.

The CSM suggests that individuals form a cognitive model of their health condition, known as an 'illness representation'. This is informed by their beliefs, perceptions and interpretations of various aspects of the condition, including its identity (the symptoms or diagnosis), timeline, consequences, causes and controllability. Illness representations are influenced by personal experiences, cultural beliefs, social interactions and information from healthcare professionals and other sources. The CSM suggests that illness representations play a critical role in the choice of health-related coping behaviours, as often these are where individuals tend to choose behaviours that make sense to them based on their own illness representation for that condition. By understanding and exploring illness representations, prescribers can address common misconceptions and support beneficial health-related behaviours[9,11].

The NCF focuses on beliefs about the necessity of medications and concerns about the potential adverse effects or long-term consequences[10]. It suggests that patients are more likely to adhere to a medication regimen if they have a strong belief in the necessity of the medication and fewer concerns about its use[10]. For example, an individual prescribed an antihypertensive treatment may not perceive the necessity of treatment owing to its asymptomatic nature, whereas an individual who is prescribed HRT for the management of menopausal symptoms may see the direct benefit owing to symptom improvement. In parallel with this, patients may have concerns about antihypertensive medication or HRT,

which may therefore impact negatively on their motivation to adhere to the treatment. By exploring a patient's beliefs about treatment, further insight can be gained on their reflective motivation to take a particular medication.

The Perceptions and Practicalities Approach (PAPA) brings together the NCF and the CSM, providing a framework for understanding medication-taking behaviour[12,13]. The PAPA suggests the attributes necessary for medication adherence are the motivation to adhere (perceptions) and the ability to adhere (practicalities). The PAPA acknowledges that both motivation and ability may be driven by intrinsic factors that are specific to the individual, while incorporating the influence of external factors, acknowledging the influence of external triggers and the individual's opportunity to adhere.

PAPA advocates a three-step approach for healthcare professionals to support patients with their medication-taking:

- Address necessity beliefs by communicating the rationale for the personal necessity of treatment;
- Elicit and address concerns and information needs; and
- Explore the practicalities involved in seeking care, obtaining a diagnosis and the ability to access and use subsequent prescribed treatment.

Exploring medicine-related behaviour

As a prescriber, it is likely that a significant proportion of your work to facilitate shared decision-making will focus on medications and evidence-based approaches have been developed to support this. The 'Medicine-related consultation framework' (MRCF) offers a structured approach to engaging patients in shared decision-making about their medications[14]. Based on the Calgary-Cambridge Model of consultation and the PAPA, the MCRF is specifically tailored to incorporating medication-related issues within the consultation and optimise therapeutic outcomes by establishing a collaboratively-designed treatment plan[15]. The MRCF outlines how to identify and address pharmaceutical problems specific to medication-taking, by exploring patients' illness representations, beliefs about necessity and concerns, while considering their ability to follow a treatment plan.

The MRCF has been used as the basis of teaching consultation skills to undergraduate and postgraduate pharmacy students in universities throughout the UK; however, recent advancements in health psychology and behavioural medicine have enhanced our understanding of behaviour and can be related to SDM and pharmaceutical care.

The COM-B model of behaviour

The COM-B model of behaviour provides a framework for understanding the barriers and facilitators to behaviour change, integrating multiple psychological theories of behaviour[16]. In its simplest form, the COM-B model suggests that to enact a 'Behaviour' (B), an

individual needs the ‘Capability’ (C), ‘Opportunity’ (O) and ‘Motivation’ (M) to do so (see Figure 1[16]).

Understanding the components of the COM-B model can help prescribers to appreciate the aspects of capability, opportunity and motivation necessary for an individual to engage in SDM, collaborate on a shared decision regarding their healthcare and enact any behaviour agreed through the SDM process. By systematically assessing and discussing patients’ capabilities, opportunities and motivations, healthcare professionals can tailor their approaches to support patients’ active involvement in the decision-making process.

Considering medication-taking behaviour, Jackson *et al.* demonstrated in 2014 that most of the factors affecting treatment non-adherence could be mapped directly to one of the sub-components of the COM-B model, showing the utility of the framework for prescribers [17]. Similarly, a learning activity for pharmacy students found that barriers and facilitators for adherence to a ‘mock medicine’ reported by the students could be classified in terms of the COM-B model[18].

Motivational interviewing

MI is a method that specifically addresses an individual’s motivation to change behaviour. This is a patient-centred style of consulting that can be useful in guiding conversations with patients about healthy lifestyle choices and health-related behaviour change. Prescribers need to consider the patient holistically when considering and presenting treatment options, and this may include discussion on lifestyle factors such as diet, smoking and physical activity, which can influence treatment success.

MI is a brief intervention model designed to help individuals low in motivation to move towards a state of action, aimed to change a certain health-threatening behaviour[19]. The ‘spirit of MI’ is that it is both collaborative and evocative, aimed to work with individuals to draw out their own perceptions and goals through positive change talk[20]. In change talk, an individual is encouraged to express in their own words their feelings and motivations towards a behaviour change, rather than the views of the practitioner, and is linked to more successful outcomes[21].

MI also honours autonomy; in that it is the patient’s ultimate responsibility to make the change. All behavioural change theories are designed to increase an individual’s self-efficacy — their self-belief that they can achieve an outcome. MI is based on advanced research knowledge from social psychology and has linked to Rogers’ theory of the critical conditions for change, which describes the positive impact of a supportive environment for fostering change[22]. It also links to Deci and Ryan’s self-determination theory, which recognises that a sense of being supported by key people, such as healthcare professionals, can increase an individual’s motivation[23].

For healthcare professionals conducting MI, there are four steps :

1. ‘**Engaging**’ the individual involves building a rapport and establishing the relationship to facilitate a safe space for the conversation;

2. '**Focusing**' is forming an agreement between healthcare professional and individual, which specifically identifies the health-related behaviour or goal, and the focus of the conversation;

3. '**Evoking**' is then aimed to establish the reasons why the individual would like to make a change to that behaviour, helping them to draw out and articulate their own individual reasons (also known as change talk);

4. '**Planning**' helps the individual to work out how they can make a change, by forming a manageable plan or deciding on the next step to take[24].

There is often a need to move between and around these steps during a MI, allowing both a goal, and the tangible achievable steps towards a change in behaviour to be realised.

It is recognised that taking an MI approach to the consultation is as important as what is actually said[25]. The main principles of MI delivery can be summarised with the mnemonic 'RULE', described in the Table below[26].

For more information on how pharmacists can use motivation interviewing during conversations with patients, see: 'Using motivational interviewing to improve medicines adherence.'

Navigating conversations around health behaviours and choices with patients

A patient's willingness to engage in discussions about a decision or behaviour is an important determinant of the success of that interaction. Some patients may feel unprepared or surprised to be engaged in a discussion involving a shared decision, particularly if that patient holds a more traditional or paternalist view of how a consultation is structured and is expecting to be given instructions rather than asked for their input. Some patients may be reluctant to be involved in a decision, through concerns about taking on the responsibility for a decision or making a wrong decision and instead seek the prescriber's view of what they think they should do[27].

A crucial factor in a patient's ability to engage in a consultation is their understanding of their health situation. Health literacy encompasses the individual characteristics needed to understand, appraise and use information to make decisions about health, and the capacity to articulate and action these decisions. Patients need to be able to understand and process information about their health to make informed decisions[28]. In England, an observational study sampled 64 health materials and analysed how well these were understood by a representative sample of individuals using identified competency thresholds. The study found that 43% of adults sampled do not have adequate literacy skills to routinely understand health information and 61% of adults do not have adequate numeracy skills to routinely understand health information[29]. It is important that prescribers do not make assumptions about a person's health literacy status and are proactive in ensuring they fully understand the information being shared.

Employing communication skills

Prescribers need to ensure that they regularly use communication techniques that check the patient's understanding of the information that is being provided. Examples include using the 'teach back' method, where the patient is asked to state in their own words what the need to know or do, and 'chunk and check' where information is divided into manageable quantities or 'chunks', with the prescriber checking the patient's understanding of each chunk before moving on[30]. For more on basic communication skills and techniques, see: 'Communication techniques for prescribing'.

Health literacy is modifiable by improving the patient's knowledge and skills through education and empowering them to learn more about health and illness. This can be facilitated by adopting interventions to improve communication between the prescriber and patient, such as visual communication, simple plain language, graphic displays and culturally competent resources[31].

Shared decisions should be revisited over time, as a patient's confidence or willingness to play an active role in SDM may change[32]. It is also the case that their preferences and goals will evolve in response to disease progression and changes in their life circumstances. A person's capability, opportunity and motivation to engage with their potential treatment options is important to explore and incorporate, even if they choose to have minimal involvement in the decision-making process.

Figure 2 summarises some of the important skills prescribers require to deliver effective advanced communications techniques in patient consultations.

The following case study explores how a prescribing pharmacist can use advanced communication skills during a routine consultation.

Case in practice

Patient profile

Paul is a 46-year-old male presenting to the healthy living clinic ran by his GP practice prescribing pharmacist. He is an accountant from Cardiff, married to Yvonne and has three teenage children. He was diagnosed with hypertension three months ago and takes ramipril 5mg once daily for this. He smokes 20 cigarettes per day, drinks around 16 units of alcohol a week, and his BMI is 27. Paul has been calculated to have a QRISK score of 10[33]. He has been referred to the clinic for a discussion following on from a recent GP appointment reviewing his high blood pressure, where his most recent reading was 145/92mmHg.

Discussion on health beliefs

The pharmacist starts by asking Paul about his understanding of his condition. Paul explains that he has never had any health issues previously, so it was a shock to be diagnosed with hypertension. He had not experienced any symptoms from having high blood pressure, and he does not feel any different now he is taking medication. When the pharmacist asks about his attitudes towards medication, investigating adherence, Paul reports that he strives to take his medication every day because he does not want to have a heart attack.

The pharmacist explains that hypertension is asymptomatic, so symptoms aren't a reliable measure of blood pressure. They explain that while hypertension is a long-term condition, if Paul's blood pressure can be maintained at 140/90 mmHg or below, his risk of developing cardiovascular outcomes, such as stroke or a heart attack, will decrease.

Discussion on lifestyle factors

The pharmacist asks Paul about his current lifestyle and what he enjoys about it. Paul is happy at home and eats a good, varied diet. He enjoys drinking and socialising with friends, and this is important to him in unwinding after the working week.

The pharmacist asks about what worries him about his current lifestyle. Paul mentions that his job is stressful and inactive, and he finds it hard to find time to exercise around work and family life, despite enjoying sport. Paul explains that smoking and drinking have been part of his lifestyle since his 20s. Until his hypertension diagnosis, he has never really been worried about his health or the impact of these behaviours.

The pharmacist tells Paul about his QRISK score and explains what this means. They explain how Paul's different individual and lifestyle factors can contribute to this score, and that for many people along with taking antihypertensive medication, addressing other aspects of their lifestyle can also help to keep blood pressure in the target range and bring the QRISK score down.

The pharmacist asks Paul his thoughts on this. Paul is aware that his current lack of exercise, smoking and drinking are unhealthy behaviours, but that he has not really thought about these until receiving his hypertension diagnosis. He has often thought

about stopping smoking but has never committed fully to this.

The pharmacist asks Paul to rate his current motivation for change out of 10 (he reports a 6/10), and then asks him what it would take to increase this to an 8/10. This prompts Paul to consider his lifestyle, family and behaviour. Paul said that the thought of his teenage children starting smoking would increase his motivation to change.

Discussion about choice of treatment

The pharmacist explains to Paul that his blood pressure is still on the high side and ideally needs to be reduced further, which could be attempted through lifestyle changes, prescribing additional medication or increasing the dose of his current medication. The pharmacist explains that Paul has a choice about his treatment and offers Paul a decision support tool (NG136 Patient decision aid on how do I control my blood pressure? Lifestyle options and choice of medicines [nice.org.uk]) to help explain the options available, including doing nothing, and the potential impact of making lifestyle changes.

Paul understands that his lifestyle is contributing to his hypertension and CV outcomes risk and would like to address this before considering further medication. Paul suggests that he could start with his smoking, as this is the behaviour that concerns him most. Paul explains he has often considered doing this but never had a ‘reason’ to stop before. Now that he has teenage children this may be the motivation he needs to stop.

Next steps

The pharmacist supports and encourages Paul with this choice, and signposts Paul to the local smoking cessation service. They explain what the service provides and the different resources including nicotine replacement treatments that are available. They also provide some leaflets to support what they have discussed. They make a follow-up appointment with Paul for three weeks’ time to review how he is getting on and ensures he has contact details of the clinic should he wish to discuss anything further. They close the consultation by checking Paul’s understanding and agreement with the plan, and Paul leaves the clinic feeling motivated.

Reflection points

Reflect on a recent patient consultation. How did you ensure the conversation was patient-centred? What questions could you ask in future consultations to explore the patient’s health beliefs and values?

How you present and discuss options may be different for each patient. Reflect on the success of strategies have you used in the past when sharing information. How did you ensure the patient understood the information and felt able to ask questions? Did you use any resources to support your conversation, for example, a shared decision-making tool?

When making a shared decision about treatment, how could you explore the patient's capability, opportunity and motivation to enact the behaviour?

Knowledge check

Expand your scope of practice

The following resources expand on the concepts described in this article:

The behaviour change wheel: a guide to designing interventions

The Public Health Wales Behavioural Science Unit has produced a series of tools that guide the reader the stages of developing behaviour change interventions. 'Improving health and wellbeing: a guide to using behavioural science in policy and practice' provides an introduction to the use of behavioural science and a stepwise guide for developing behaviour change interventions:

- Tool 2: 'Behavioural diagnosis: how to collect behavioural insights' covers how to gather actionable insights about your target behaviour and target population;
- Tool 3: 'Behavioural diagnosis: mapping insights and selecting intervention functions' works through mapping insights and selecting intervention types;
- Tool 4: 'Behavioural diagnosis: selecting implementation types' explores implementation options;
- Tool 5: 'Identifying and applying behaviour change techniques', introduces behaviour change techniques — what they are, how to identify and deliver them in your setting;
- Tool 6: 'Evaluating behaviour change interventions' has been developed in collaboration with the central evaluation team at Public Health Wales and covers the key points to consider when planning how to implement and evaluate an intervention.

National Institute for Health and Care Excellence guidelines: 'Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence'

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