Supporting people in making positive behaviour change: the Transtheoretical Model and Motivational Interviewing.

Abstract

In 2016, the Making Every Contact Count (MECC) framework was introduced in the UK and Ireland. The initiative seeks to exploit the daily contacts between healthcare staff and the public as opportunities to promote positive change in people's health. As ill health is linked to modifiable risk factors, behaviour change is vital. MECC focuses on four domains: healthy eating, physical activity, reducing alcohol consumption and smoking cessation, which are not always easy topics for healthcare practitioners to raise and discuss. Mental health clients are at increased risk of various health problems meaning such interventions are important in mental health nursing. Raising such topics requires sensitivity and tact if the intervention is to be successful and the therapeutic relationship maintained. The stages of change and motivational interviewing are regularly utilised theories in relation to implementing the MECC approach. This article provides a brief overview of these theories and how they can be implemented by mental health nurses to support behaviour change.

Aim and Intended Learning Outcomes

This article aims to increase knowledge and understanding of how to apply the principles and skills from the Transtheoretical Model (TTM) and Motivational Interviewing (MI) theories, to provide tailored and individualised brief interventions for mental health clients. After reading this article and completing the timeout activities you should be able to:

- Understand the MECC framework
- Recognise the stages of change according to the TTM
- Apply the stages of change to MI
- Apply MI to your clinical practice.

Introduction

Health promotion has long been recognised as a vital aspect of healthcare. The first international conference on health promotion led to the Ottawa Charter and defined health promotion as "the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986, p.18). Health promotion operates on three levels of intervention: preventing illness (primary), stopping illness progression (secondary) and reducing the harm caused by an existing illness (tertiary) (Phillips, 2019). The relatively poor physical health outcomes for those with mental health difficulties have been highlighted and calls made for mental health nurses to support clients to improve their health (Nash, 2023).

The UK and Ireland published their Making Every Contact Count (MECC) policies and frameworks in 2016 (Health Service Executive, 2016; Public Health England, 2016). These documents are remarkably similar and seek to take advantage of the daily interactions between health professionals and the public by encouraging brief interventions that could improve physical and mental health. To do this they promote a behavioural change approach which aims to deliver targeted and individualised interventions that promote healthy behaviour change and signpost clients towards supports that could help them make these changes (Public Health England, 2016).

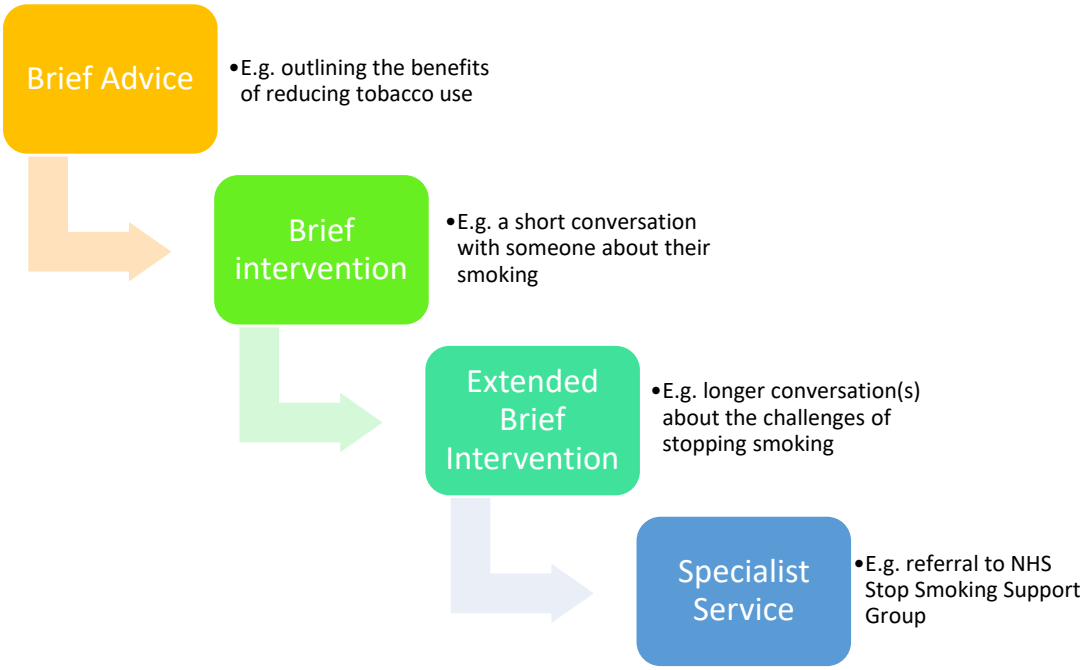
MECC focuses on modifiable risk factors, that is behaviours that individuals engage in that negatively impact health, particularly related to tobacco, alcohol, exercise and diet. These behaviours greatly contribute to an individual's risk of various problems including diabetes, weight

gain, cardiovascular and respiratory disease (Public Health England, 2016). Furthermore, for many people, this risk is increased with the co-occurrence of two or more of these risk factors which greatly increases the risk of mortality and morbidity (Public Health England, 2016). If mental health nurses can help people change these behaviours, the individual's potential risk of disability and ill health can be reduced. The MECC model outlines increasing levels of intervention related to behaviour change which are summarised in Figure 1.

Timeout 1:

Think about the MECC framework and its focus on promoting healthy behaviour change related to alcohol, tobacco, exercise, and diet. Consider the clients you have worked with over the last month. What are the behaviours that you typically come across in your work that effect their health? What do you currently do to address these behaviours?

Figure 1: MECC model (adapted from Health Service Executive (2016) and Public Health England (2016))



Developing personal skills for people to live healthier lives is one of the five health promotion actions outlined in the original Ottawa Charter (Phillips, 2019). Thus, nurses require the necessary skills to engage clients in conversations about their health. Although recently published reviews on the MECC framework have reported an dearth of empirical evidence to support its effectiveness, study findings support its flexibility as a standardised framework that can increase staff confidence and generate awareness and motivation for behaviour change in clients (Nichol et al., 2023; Parchment et al., 2023). A recent qualitative evaluation of MECC in the Northeast of England, emphasised that the MECC framework requires tailoring by health practitioners to enable the delivery of individualised support that is co-produced (Harrison et al., 2022). The recognition of this necessity for co-production and individualised care resonates with the principles of the recovery-orientated approach that is fundamental to current mental health nursing practice (Health Education England, 2020). The TTM and MI are theories frequently associated with MECC, and provide examples of competencies that are now commonly incorporated into international mental health nursing curricula (International Council of Nurses, 2024)

The transtheoretical model (TTM) is a model for integrating psychotherapy in relation to behaviour change and one key component is the development of recognisable stages of change (Prochaska & DiClemente, 1982). These stages have evolved over time but typically involve pre-contemplation, contemplation, preparation, action, maintenance, and relapse. This model helps us understand where a client is at in relation to making a change, allowing us to tailor interventions accordingly. MI on the other hand, is defined as a "particular way of talking with people about change and growth to strengthen their own motivation and commitment" (Miller & Rollnick, 2023, p. 3). TTM is frequently used to help us understand a client's readiness to change, and MI is used to guide conversations to facilitate behaviour. While they are separate theories they overlap considerably and are frequently used together, most notably by the developers of MI (Miller & Rollnick, 2002).

Timeout 2:

The last step in MECC is referring individuals to appropriate services for specialist care. Imagine you were working with a client with one of the behaviours MECC targets: alcohol, tobacco, exercise, and diet. Identify two services, one online and one offline, related to each of these behaviours that you could refer or direct your client to for additional support.

Transtheoretical model (Stages of Change)

The TTM is one of the most used methods targeting behavioural change management (Hashemzadeh et al., 2019; Lustria et al., 2013). Originally developed in the 1980s, as a model that could be used to understand behaviour change related to smoking cessation (Prochaska & DiClemente, 1983), this framework has since evolved into an integrative theoretical concept for

tailoring lifestyle change interventions (Lustria et al., 2013). The basic tenet of this model asserts that behavioural change does not occur spontaneously, rather, it is a cyclical process that people go through and is impacted throughout by various factors (Prochaska & DiClemente, 1982). Considering the range of modifiable lifestyle behaviours known to impact physical and mental health, such as sleep, substance use, diet and exercise, this model may be regarded as especially applicable in the context of mental health nursing. Aligning with the principles of person-centred care, the TTM enables mental health nurses to effectively tailor interventions and strategies, meeting people "where they are at" within the context of their own lives (Metcalfe, 2024). Research indicates it is an effective and adaptable approach to behaviour change, across diverse health populations (Hashemzadeh, 2019).

According to this model, people pass through five stages of change in the adaption of a new behaviour: precontemplation, contemplation, preparation, action, and maintenance. (Prochaska & DiClemente, 1982) The founding authors also describe ten processes that drive behaviour change throughout these stages, including consciousness-raising, self-re-evaluation, self-liberation and stimulus control. Additional key factors that impact the processes of change during these stages are self-efficacy and decisional balance (Prochaska & DiClemente, 1983).

Precontemplation is the stage that precedes any curiosity or desire to change a behaviour. Here, people often lack awareness of a problem and have little insight into a need for change or the benefits that it might bring. At this point, it is important for nurses not to focus merely on changing or stopping a behaviour. Instead, by using MI techniques, nurses can plant seeds of curiosity in the individual as to how their current behaviours may be inhibiting them and the potential benefits of change (consciousness raising).

Contemplation involves self-re-evaluation and sees people becoming aware of a potential need for change. Whilst some ambivalence may remain, people are considering the potential benefits and costs of changing or maintaining their behaviour. Assisting people in weighing up pros

and cons (decisional balance), exploring people's beliefs and feelings about change (self-efficacy) and identifying strengths and barriers, can be pivotal supports provided at this point through collaborative nursing care.

In the preparation stage, people have attained the knowledge, insight, and awareness necessary to be self-motivated in planning their behaviour change. Collaborating with people to set achievable and realistic goals related to a desired behavioural change is vital at this point. Nurses can assist individuals in pre-empting potential challenges that may arise and recognising the personal coping skills and supports that are available to them when this happens. This allows for the individual to simultaneously believe that change is possible and be committed to achieving it (self-liberation).

The action stage is the point in the process where people are actively implementing the planned behavioural change. An individual at this stage may require support through encouragement, reassurance, and instilling hope to remain motivated about their ability to continue in achieving their desired goal.

In the final maintenance stage, the desired behavioural change has been achieved and efforts are focused on maintaining the changes. Nurses can support individuals in relapse prevention by helping to identify precipitating events that may trigger a need to engage in the old behaviour and by assisting them in the development of alternative strategies that can resolve these needs. These strategies can involve modifying environments and exposure to triggers (stimulus control) which can ultimately help to reduce the likelihood that previous behaviours will reemerge.

Time out 3:

Reflect on a client whom you have cared for in the past who would have benefitted from changing their behaviour(s). This could have been related to smoking, alcohol, diet or exercise. Did you

attempt to engage them in a discussion about making this change? How did they respond? What stage of change was the individual at?

Motivational Interviewing

Motivational interviewing (MI) is an approach to talking with people about behaviour change that was first articulated by William Miller in relation to alcohol use (Miller, 1983). It is defined as a "particular way of talking with people about change and growth to strengthen their own motivation and commitment" (Miller & Rollnick, 2023, p. 3). It has been research and refined resulting in its adoption into various areas of healthcare practice including substance misuse, mental health, and physical health settings.

Ambivalence

Miller (1983) questioned the traditional view of denial in alcohol counselling and treatment. When clients did poorly, this was typically attributed to some intrinsic defect such as denial, not engaging properly with the programme or having an "alcoholic personality", and when they did well, the success was typically attributed to the programme (Miller, 1983). By contrast, MI recognised that in most cases, clients recognised their substance use was causing problems but also perceived disadvantages to changing this behaviour. Ambivalence, simultaneously wanting and not wanting something, is a normal response to change, as people often perceive positives and negatives of change (Miller & Rollnick, 2023). A frequent response to ambivalence is to continue with the status quo. Should someone intervene and promote change in one direction, it is likely that the person, who sees both positives and negatives of change, will articulate the reasons against changing. Clients weigh up the pros and cons of change in a process Miller and Rollnick (2023) label as decisional

balance (Figure 2). From his first article on MI, Miller recognised that clients tend to believe what they say to themselves more than what they hear from another (Miller 1983).

Figure 2 – The decisional balance (adapted from Miller & Rollnick (2002))

Statements against change became known as “sustain talk” and are associated with not changing while the opposite, statements towards change, are referred to as “change talk” and are a key focus of MI (Miller & Rollnick, 2023). MI encourages an open and empathic approach to discussing change with elicits change talk and avoids attempts to push towards change which paradoxically tends to elicit sustain talk. MI reframes denial or resistance from the client as comprising two factors; 1) sustain talk or reasons not to change and 2) discord or tension in the therapeutic relationship (Miller & Rollnick, 2023). MI encourages the practitioner to view sustain talk and discord as signs they ought to consider a different approach. Instead of advocating for change by advising the client why they ought to change, MI explores this ambivalence and elicits the client’s own reasons for change.

An example of eliciting change talk employs a technique called the importance ruler, where a client is asked on a scale of 1 to 10, how important it is for them to make a change, such as improving their diet. Should they say 5/10, right in the middle, there are two broad options of follow up questions. One option is to focus on why it is not higher by asking something like "why is it only 5?" The other option is to examine why it is so important, asking something like "why is it 5 and not 0?". The first question is likely to result in sustain talk that downplays the need for change such as "I have more pressing things to worry about" while the second question is likely to elicit change talk such as "I'm worried about my health." These change statements are much more likely to increase motivation.

Time out 4:

Think about a client you have worked with recently who would have benefited from behaviour change. Put yourself in their shoes and consider the following questions. What benefit might there be for them in not making the change? Are there negatives, from their perspective, in not changing? Now consider it from the other side. What benefit might there be for them in changing? Might there be negatives of making this change?

The spirit and tasks of MI

Miller admits that the early writings on MI focused too much on techniques. In practice, when people attempted to use these techniques "on" clients they did not seem to be effective (Miller, 2023). In addition to the skills the spirit of MI refers to the underlying assumptions and beliefs about how to work with clients in a manner that promotes collaboration and compassion (Miller & Rollnick, 2023). The spirit of MI has four elements; partnership, acceptance, compassion, empowerment, which are listed in Table 1 (Miller & Rollnick, 2023). The first element is that MI

involves collaboration, or a partnership between the client and practitioner. Both individuals bring their knowledge and resources to work together in a manner that avoids coercion. The second element is acceptance, of the client's worth and worldview, as well as their right to self-determination. Acceptance of a client's position is not the same as agreeing with it but rather, that this stance instils respect within the therapeutic relationship (Miller & Rollnick, 2023). Compassion is the third element and promotes a focus on what is in the client's best interest. The fourth element, empowerment, recognises that the client is responsible for actioning change and the practitioner cannot create it, only support it. An acceptance of a client's choice and autonomy without attempts to force change, often yields a less defensive response (Miller & Rollnick, 2023).

There are also four broad and overlapping "tasks" in MI, (Miller & Rollnick, 2023).

1. Engaging – The initial task involves developing a helping relationship with the client which is primarily achieved using classic counselling skills such as empathic listening and a non-judgemental approach. This phase encourages honest engagement between the practitioner and client to create an environment where the client feels willing and able to consider change.
2. Focusing – MI then seeks to focus the work on a particular direction which comes from the client and examples include steps to improve their physical health, mood, or behaviours. At this point, there is a collaboration between the practitioner and the client in working towards a broad goal.
3. Evoking - The third task involves the practitioner deliberately eliciting the client's reasons for change, or change talk, in line with their goals. For example, a client may have identified smoking less as a broad goal and during the evoking stage, the nurse seeks to elicit from them the reasons why this change is important. As they outline their reasons for changing, they are more likely to move in that direction.

4. Planning – the final task is the "how" to change. The plan comes from the client and the role of the practitioner is to support them in actioning it. A client looking to smoke less may pick from a menu of options such as nicotine replacement, hypnosis or only buying cigarettes every second day. During this time, the client may lose focus, or the plan may not work and so the practitioner supports the plan whilst providing reassurance that change is possible.

These tasks are seldom linear, and a client's goals may change. MI also outlines the communication skills required by the nurse alongside the indicators as to when they might be used effectively to facilitate progression through the tasks.

Time out 5:

Imagine you have met a client who it might be appropriate to employ behaviour change skills with. In MI the first task is engaging, where you develop a good working relationship. How might you do this? Which skills from the OARS are you likely to use and how? Are there key things you might want to say or ask? Are there things you probably should avoid saying? When will you know you are moving from engaging to focusing? What skills might be used to help identify a focus or goal?

Table 1: The spirit and tasks of MI

Spirit	**Tasks**
1. Partnership	1. Engaging
2. Acceptance	2. Focusing
3. Compassion	3. Evoking
4. Empowerment	4. Planning

The practice of MI

Since its inception, MI has articulated four key skills to use as well as common traps to avoid. These key skills are common within professional therapeutic relationships and are likely to be familiar to mental health nurses. They are often shortened to the acronym OARS: open-ended questions, affirmations, reflections, and summaries (Miller & Rollnick, 2023). Open-ended questions are questions which invite full responses and encourage clients to elaborate (Miller & Rollnick, 2023). While closed questions are sometimes thought of as questions that can be answered with "yes" or "no", many other questions, such as age, gender, how much you drink, etc, can be answered with equally brief responses and are therefore, also closed questions. Affirmations take the form of statements that show appreciation for or compliments the client and demonstrate an understanding of the client's perspective. Examples include "it's good to see you again" or "I don't know if I would have coped with that as well as you have". Reflections involve the practitioner restating what the person has communicated to them. While much communicates is verbal, some is non-verbal or implied and the messages sent through both mediums can be reflected (Miller & Rollnick, 2023). A simple reflection uses the client's own words or may paraphrase them. More complicated reflections involve reiterating something that is alluded to in what the client says or how they say it (Miller & Rollnick, 2023). For example, a client may say "I really wanted to drink last night" and based on their body language, the nurse might infer that their desire to drink was triggered by feelings of anger. They could reflect this by saying "you were pretty angry last night". Reflections can be very useful as they are typically perceived as non-confrontational and demonstrate the nurse's interest in understanding their perspective. reducing the likelihood of discord. In short, it facilitates a more helpful conversation. Summaries involve periodically bringing together several items that have been discussed and presenting them back to the client in a longer reflection. They are typically utilised at the end of a session but can also be used to draw several discussion points together throughout the interaction (Miller & Rollnick, 2023). This can be beneficial as it is a form of reflective listening, and it can also set the foundational scene before moving to the

next phase. For instance, after a few minutes discussing why a client wants to lose weight, a nurse might summarise the reasons provided and then follow up with an open question such as “given all these reasons to work on your weight, what approach would be most helpful to you?”

The OARS are typically used throughout the various tasks of MI. The nurse is deliberately directive and uses the OARS skills selectively to elicit the individual’s reasons to change. Thinking in advance about how someone is likely to respond to a question helps to guide the appropriate use of the OARS skills. Asking a client *why they smoke?* is an example of an open question but is unlikely to elicit change talk while asking them *what concerns they have about smoking?* is more likely to elicit change talk. During engaging, where the focus is on building a working relationship, reflecting accurately what is being communicated and conveying acceptance and concern is fundamental. Affirmations such as “it’s great that you were able to hold onto your job with all that has been going on for you” can also be useful. Focused reflections and open questions are often used to encourage the client to consider changes they could make, such as “given all that’s going on with you what change would you like to make?” The evoking task requires interventions that elicit change talk while avoiding sustain talk. The practitioner needs to be careful with their reflections and the questions they ask (Miller & Rollnick, 2023). In planning the client is encouraged to set short term goals that move them in the direction of their overall goal and identify the supports available to achieve it.

Timeout 6:

Evoking involves examining the client’s reasons for making a change – the goal is to evoke change talk and reduce sustain talk. Again, thinking about a client you are working with. Can you identify times when the conversation veered towards sustain talk? How could you have used the OARS to elicit change talk instead?

In addition to the skills that MI promotes, several potential traps to avoid have been articulated. These traps typically result in the nurse deviating from the spirit, principles and skills of MI and are listed in Table 2. For example, the expert trap occurs when the nurse advises the client as to what they should do and ignores the client's expertise on themselves (Miller & Rollnick, 2023). The result often involves the practitioner talking more and the client feeling like they are being lectured to. For example, there is valid empirical evidence that cannabis can have negative effects on mental health, however many clients feel that it helps them cope with various problems. Simply telling them the statistics on cannabis, when a client is seeking help for anxiety, is unlikely to build a therapeutic relationship, as the nurse is not addressing the problem the person is presenting with. Similarly, the persuasion trap involves the nurse articulating one side of the client's ambivalence, such as telling them the reasons why they should stop smoking. As a result, the client is likely to articulate the opposing reasons as to why stopping smoking may not be a good idea to them, resulting in sustain talk. The time trap occurs when the practitioner is overly ambitious with what can be achieved within a given timeframe, potentially overwhelming the client. For example, if after a few minutes discussing a client's tobacco use, they are asked "what do you want to do about it?" and they indicate that they are unsure, it is best not to try and push them into deciding. In this case, more time may be needed to explore their ambivalence. Finally, the wandering trap is almost the opposite of the time trap and instead of rushing too quickly, too much time is dedicated to simple chatting about various topics without any real focus or direction.

Table 2: Key skills to use (OARS) and traps to avoid

4 Key skills	**Traps to avoid**
1. Open ended questions 2. Reflections	1. Expert trap 2. Persuasion trap

3. Affirmations 4. Summarise	3. Time trap 4. Wandering trap

Time out 7:

Consider the MI traps: expert, persuasion, time and wandering traps. In your work, are there times when you may have stumbled into these traps? If so, which trap? Considering the OARS skills from MI, how might you handle this differently if confronted with the same situation?

MI and Stages of Change

While the stages of change are a separate theory to MI, they align closely and have been used in tandem. As outlined earlier, MI has four tasks which are central to its practice: engaging, focusing, evoking, and planning. While these tasks do not align perfectly with the stage of change, there are commonalities. In the engaging and focusing stages, the client is likely to be in the pre-contemplation or contemplation phase and the focus is on developing a working relationship and identifying initial goals to work on. The evoking and planning stages in MI appear to loosely align with the preparation and action stages of change respectively. These stages are outlined in table 3 along with the type of client statements that may be offered at each stage.

It is worth considering how change talk appears in different stages. Miller and Rollnick (2023) recognise that while change talk is useful, not all change talk is equal, and can indicate different readiness and commitment to change. A client voicing a desire or reasons to change are likely to be moving in the direction of change, a useful occurrence, particularly in the early stages. But to move from talking to acting on change requires more action-oriented change talk which is often elicited using targeted questions such as “seeing as you are worried about the effect your

drinking is having on your health, what would you like to do about it?" The aim is that this will help to progress towards action, but a response indicating uncertainty from the client may be an indication that more work is needed before moving on to the planning phase.

Table 3: stages of change, change talk and corresponding MI tasks

Stage of change	***Client vocalisation of the change***	***MI tasks***
Pre-contemplation	I don't have a problem	Engaging
Contemplation	I may have a problem	Focusing
Preparation	I could…..	Evoking
Action	I am going to…	Planning
Maintenance	I did….	

Figure 3: Motivational interviewing

Figure 3 diagrammatically summarises motivational interviewing. The skills are used to elicit change talk and resolve ambivalence. These processes lead to behaviour change – the outcome.

Finally, MI is focused on behaviour change and maintaining this focus on the overall behaviour goal can make it easier for mental health nurses to ask questions that are more likely to elicit change talk.

Conclusion

Supporting individuals to make healthy changes is an integral aspect of nursing. Nurses regular contact with clients means they are ideally placed to support healthy behaviour change and elicit the intrinsic motivation required to achieve and maintain those changes. To provide recovery orientated and person-centred care, nurses need to recognise that health promotion and associated behavioural change strategies are central to all healthcare sectors including mental health. Approaches such as the TTM, are useful in helping nurses to gain an understanding of an individual's readiness to change and when incorporated with the principles of MI, they can provide the key interventions required to elicit behaviour change action. Furthermore, these theories can inform mental health nursing practice and therapeutic communication, to ensure that care is delivered in a manner that is meaningful to their clients.

Key points

5. The MECC framework encourages nurses to take advantage of opportunities to have targeted health promoting conversations with clients as part of routine clinical practice.
6. The TTM model highlights that clients can be at different stages of the change process, from pre-contemplation to maintenance. Effective practice requires nurses to identify which stage a client is at and intervene accordingly.
7. Ambivalence is a normal part of change. The more change talk is encouraged and sustain talk reduced, the more likely a client will be to achieve change.

8. Clinical skills such as the OARS, when used carefully, can elicit change talk and promote healthy behaviour change.

Further Reading

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