# Self-Management Support

Self-management support is the assistance caregivers or health professionals give patients with chronic conditions with the intent to encourage daily decisions that improve health-related behaviours and clinical outcomes. Self-management support can be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership.

A recent systematic review by the Health Foundation in the UK suggests that some general components have been found to work well to provide self-management support including:

- involving people in decision making,
- emphasizing problem solving,
- developing care plans as a partnership between service users and professionals,
- setting goals and following up on the extent to which these are achieved over time,
- promoting healthy lifestyles and educating people about their conditions and how to self-manage,
- motivating people to self-manage using targeted approaches and structured information and support,
- helping people to monitor their symptoms and know when to take appropriate action,
- helping people to manage the social, emotional and physical impacts of their conditions,
- proactive follow up, and
- providing opportunities to share and learn from other service users.

**More information and resources can be found at http://improveselfmanagement.org**

Adapted from De Silva, D. (2011) Evidence: Helping people help themselves. The Health Foundation 2011

# Motivational Interviewing

Motivational Interviewing (MI) is a directive, non confrontational client-centered counseling style for eliciting behaviour change by helping clients to explore and resolve ambivalence[1]. It respects the client's autonomy to choose if, when, and how to change[2].
**MI i**ncorporates **four basic principles**[3]

1. Expression of empathy through the use of reflective listening.

2. Developing discrepancy
   - With the use of specific questions the person sees the discrepancy between their problem behaviour and their personal goals. Example: *"I want to be able to run and play with my grandchildren (*personal goal), *but my smoking* (problem behaviour) *is making it hard for me to do* this with my *grandchildren.*

3. Rolling with resistance
   - When the individual expresses resistance to change. The health care provider would use reflective pt and "roll with the resistance". Don't focus on resistance or get caught up in arguing the reasons for behaviour change.

4. Supporting self-efficacy
   - Embodies the notion of the person 's confidence or self -efficacy to make change. When the individual identifies barriers to change, the health care provider can enhance the person's confidence (*self-efficacy*) to make change, by addressing these barriers. Encouraging the person to focus on mastery experiences, their strengths and resources, can help them overcome barriers to change.

[1] Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy,* 23, 325-334
[2] Hettema,J., Steele, J., & Miller, W.R. (2005). Motivational interviewing1-111.
[3] Miller, W. R., and Rollnick, S. (2002), Motivational Interviewing: Preparing people for change. New York, NY, US: Guildford Press

## Characteristics of a MI Style include[4]:

- Seeking to understand the person's frame of reference, by using reflective listening
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- Expressing acceptance and affirmation. (Accept and affirm how difficult it is to change)
- Eliciting and selectively reinforcing the person's own self motivational statements, expressions of problem recognition, concern, desire and intention to change, and ability to change. (Sounds like you really want this)
- Monitoring the person's degree of readiness to change, and ensuring that resistance is not generated by jumping ahead of the person. (Don't encourage them to make goals to change when they are not ready or in the Pre-contemplative stage)
- Affirming the person's freedom of choice and self-direction

**REMEMBER**

**O: O**pen-ended questions

**A: A**ffirmation of the individual's strengths, efforts and intentions

**R: R**eflection – reflect back on patient's statements

**S: S**ummarize

[4] Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? Behavioral and Cognitive Psychotherapy, 23, 325-334

# Care-planning

Fundamental to care planning is the principle of patient-centred care which places the patient as the focus of any healthcare provision. The focus is on the needs, concerns, beliefs and goals of the patient rather than the needs of the systems or professionals. The patient feels understood, valued and involved in the management of their condition. Patients are empowered by learning skills and abilities to gain effective control over their lives versus responsibility resting with others. (Michie, Miles & Weinman, 2003).

**A care plan typically includes:**

- Mutually agreed list of problems
- Patient defined goals
- Medical management, including medications
- Prioritised action plan/interventions/steps/tasks - based on SM needs of patient and their carer
- Crisis or contingency planning with written information re early warning signs/red flags & action to take
- Who is responsible for what with sharing of responsibility
- Key action plan in person‘s preferred language
- Time for review & follow up

## Three Steps to Care Planning

Three steps to care planning is an attempt to combine features of common approaches to care-planning into one simple model. Care planning can range from very simple and brief for someone with mild disease or risk factors through to comprehensive, multidisciplinary care planning for someone with severe disease or a life limiting condition as outlined below.

**Step 1: Assess and identify**

- assess and identify important issues, beliefs, knowledge, lifestyle and mental health risk factors as well as self-management capacity and motivation.

**Step 2: Collaboratively set the agenda and agree on goals and actions**

- collaboratively agree on what are the important issues to consider and then identify patient-centred goals and actions to address these areas

**Step 3: Assist & Arrange Follow Up**

Once you have both agreed on some goals and an initial action plan, assist patients/clients to:

- Find reliable and useful additional health information and social support
- Access community or self-help programmes
- Check for any barriers that may get in the way
- Use a problem-solving approach and write down solutions and chosen options
- Close the encounter on a positive note that reinforces the goal and action plan as a contract of sorts between the two of you. Both sign the care plan and give the client a copy to take home
- Encourage patients/clients to take their care plan to every visit and ask each healthcare provider to write a brief summary note in their care plan
- Regular and sustained follow-up is crucial for the success of goal-setting and action-planning. Follow-up includes problem-solving of barriers to goal achievement

Adapted from Auckland District Health Board. Self-Management Support Toolkit, 2011.
http://www.wrpho.org.nz/documents/self_management_toolkit.pdf