

# A guide to Adherence in CF



Gary Latchford  
Alistair Duff

Department of Clinical and Health Psychology  
St James's' University Hospital  
Leeds

## About this Guide

If someone is struggling with adhering to their medical treatment, some approaches tend to work better than others.

In general, giving advice tends not to work if someone is not ready to hear it. Instead, it risks pushing them into feeling more resistant. In this situation, a conversation is needed to help them think about their choices. This conversation should help them to identify barriers to change, the potential reasons for change, to explore both and move towards planning and action.

If someone is ready to change, advice can often be very helpful. Even then though, some ways of giving advice are better than others.

This guide summarises what we know about adherence and why some people do not adhere – or rather, why most people don't adhere at times. It uses theoretical models to inform our understanding of the factors that affect adherence, and provides a structure to guide your intervention. It also includes several handouts which you can use with patients, and may hopefully find useful.

Remember, though, that no one approach is guaranteed success. The best bet is always to combine approaches, as we have here, but even then there will always be some people who do not change and continue to be non-adherent, at least for the moment. However, there will be people who do change and if they do, the results will always make it worthwhile trying.



## Adherence in CF

Our starting point is that adherence in CF is tricky. This doesn't mean that we accept it if people don't adhere without trying to intervene, but it does mean that if we are to stand a chance of influencing people so that they have better adherence, we need to know what's going on.

We know that sticking to treatment plans in a whole variety of medical conditions, is poor (time and again research has indicated that 30 - 50% of patients with chronic conditions do not take their medicines as directed) and this includes CF. It does depend a little on how we define adherence, for example, keeping to all the treatment recommendations every day without fail versus having some fully adherent days and other poorly adherent days. Patterns of non-adherence have important effects. In general, most people with chronic conditions that require an active treatment regimen are only partially adherent, and CF is no different. A good definition of optimal adherence is that someone takes;



- ✓ **The right drug**
- ✓ **The right amount**
- ✓ **The right way**
- ✓ **At the right time**

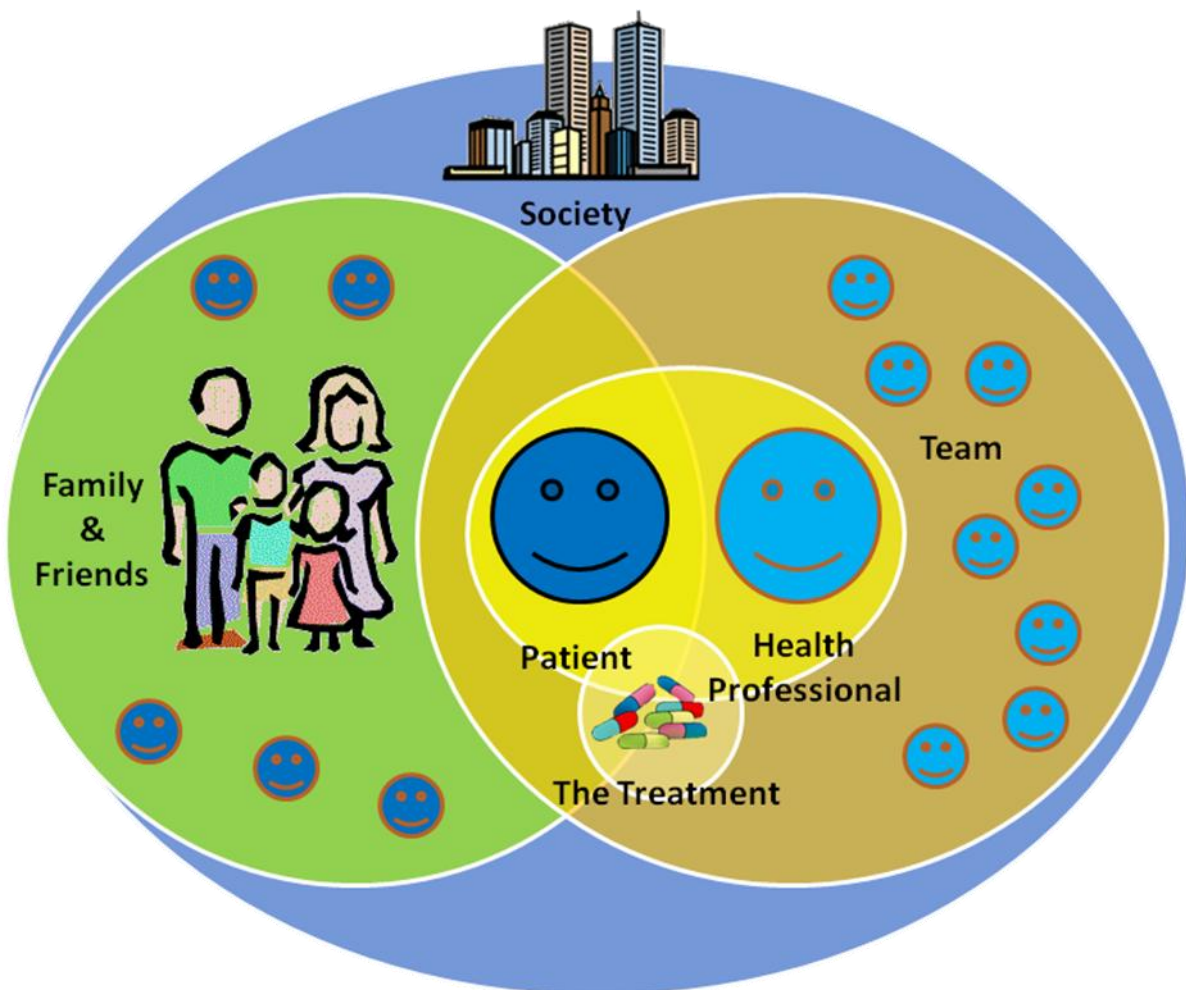
We believe that poor adherence is becoming particularly important in CF. We are in an era where those born during the past decade are told to “realistically expect to live in to their 50s” (Dodge et al, 2007). We are also on the cusp of a new phase of CF care, where genetic mutation class will determine treatment and disease-progression. However, in both cases, if treatment goals are to be met, good adherence is vital. We also know that sub-optimal adherence is the single biggest reason why therapies fail (Osterberg & Blaschke, 2005) and leads to poor health outcomes (Patterson et al, 1993; Eakin et al, 2011). Specifically, sub-optimal adherence is thought to;

- Increase morbidity and mortality
- Lead to discontinuation of treatments thought ineffective
- Lower quality of life (QoL)
- Increase dosing effects, resulting in drug-resistance, over-treatment and side-effects (Di Matteo et al, 2002)

We're not going to labour all this. We think the CF community is acutely becoming all too aware of these issues (which we have covered in the comprehensive reference at the end).

Our interest is ***what are we to do about it?***

## Understanding Adherence



It's pretty obvious that many factors influence adherence. We start here by presenting a summary of the evidence for what factors affect adherence. But we've come up with a model which allows us to organise these and suggest practical ways of doing something about it.

The diagram above tries to conceptualise the important influences. We'll now go through them one by one.



### 1 Society

Adherence rates vary between cultures. There are a number of reasons for this – such as attitudes to the health service and medications, but we can't really change that for our patients. It does introduce the useful idea of social norms though; in other words, what we think others believe. This is extremely influential. Changes in social norms are behind the huge drop in drink-driving in the UK for example - there's a sense that everyone now agrees that it is wrong. The other crucial factor is the social resources of individuals (i.e., money, education etc). Some people are less able to take on big changes in their lives without support.



## 2. Family, partner and friends

These usually represent the main sources of support and they can have a big influence on them. It's therefore often useful to involve them in consultations about adherence – for patients of all ages.

For children, family disagreements, over-involvement and poor communication are associated with adherence problems. This is thought to impact negatively on CF health outcomes, via the family's incapability to optimise treatment adherence (Patterson et al 1993). A useful notion about family dynamics is the tension between centrifugal and centripetal forces. Normal adolescent drives have a **centrifugal** effect on the nuclear family – a desire to leave and become independent. When a teenager has a chronic illness however, the opposite effect occurs (i.e., a **centripetal** one), resulting in a continued reliance on parents, parental anxieties and difficulties in “letting go”.



## 3. The team

The team sets the tone of patient expectations about adherence (Much more on this later!)



## 4. The treatment

It's vitally important to measure adherence accurately. This information can then be used sensitively as part of your intervention. Some treatments are more difficult to adhere to, though simplifying a regimen is no guarantee of success by itself! Generally adherence is poorer if the regimen:

- Is difficult or complicated
- Is time consuming
- has no immediate feedback to tell you you've done it right
- has no immediate benefit but plenty of negative consequences
- is intrusive and makes CF 'visible'



## 5. The patient

Many important factors within the patient affect adherence and reflect different barriers to change:

### *Behavioural barriers:*

- Memory – e.g., forgetting to take the medication (Dziuban et al, 2010)
- Procrastination – e.g., putting off changing a routine
- Lack of organisation – e.g., running out of time
- Knowledge – e.g., not knowing what to do (very common, though the reasons may be complex and not simply a result of not having the information).

In children there are particular issues, including oppositional behaviour, time-management problems, side-effects (e.g., taste, nausea) and difficulty with swallowing pills (Modi & Quittner 2006). In adolescents and young people the most common barriers are lack of time, forgetfulness and an unwillingness to take medication in public (George et al, 2010; Dziuban et al, 2010; Bregnballe et al, 2011) . Furthermore, in this group there is a potential association between the number of reported barriers and, (i) the perceived burden of care and, (ii) levels of adherence (Bregnballe et al, 2011).

#### *Psychological barriers:*

These are harder to spot and may involve fear, lack of confidence... and beliefs (beliefs about the illness, beliefs about what I should do, and beliefs about the medicines).

Beliefs about the illness includes **perceived susceptibility** (“will it be bad if I don’t change”), **perceived severity** (“how serious will it be if the worst happens?”) and **costs/benefits** (“if I change will I be OK, and how much of a pain will changing be?”).

Beliefs about what to do include: **what are my values?** (“How much does being good about my medicines matter to me?”), **what sort of a person am I?** (“What have I done in the past?”), **subjective norms** (social pressure) (“what do others think I should do - my doctor, friends, mum etc. - and how much do I care?”) and **self-efficacy** (confidence) (“could change if I wanted to?”). This can be summarized as;

- **What do I expect to happen?**
- **How important is to me?**

Beliefs about medicine are also very important. These have been described by Rob Horne (1999, 2003, 2005) as relating to a balance between **necessity** (“how much do I need It”) and **concerns** (“will I get any adverse effects?”). We think it’s useful to consider three questions patients will be asking themselves about treatment;

- **Do I need it?**
- **Will it work?**
- **What are the side effects?**

Patients filter all advice through pre-existing beliefs before deciding what to do.



#### **6. The health professional (you)**

Obviously an incredibly influential part of the process! So, you will be our main focus.

## Interventions: team work

Teams convey expectations to the patient. If the team convey a culture in which good adherence is the norm, and patients are supported to achieve this, the social norms of the Centre and expectations of the patients, change. A good example of this was the Minneapolis CF Centre under the directorship of Warren Warwick. This centre came to public attention when Warwick was the focus of an article called 'the Bell Curve' published in 'The New Yorker' (Gawande, 2004). Warwick's approach was for the team to convey the expectation of 100% adherence whilst making it clear that achieving this was a joint effort. As well as up-to-date care, the team focused on:

- **Developing good communications skills**
- **High expectations of adherence conveyed consistently**
- **Honest partnership between team and patient if problem identified, and creative and flexible problem-solving**

### *Communication and collaboration*

Warwick acknowledges problems inherent in medical environments in that patients and health professionals use words differently. He emphasised clarity and conveying information clearly ("Assumptions are dangerous....always talk and listen out their assumptions") and the importance of risk information, helping patients understand and make informed decisions. He stresses the importance of getting good information from the patient/family – in context of an honest conversation.

### *Adherence*

Warwick acknowledges the reality and the challenges of adherence openly with his patients, noting the high demands of time and effort and seeing non-adherence as normal. In a subtle but very clever move, he re-construes non-adherence as the patient 'experimenting'.

*"If CF Staff do not ask about experimentation by patients or fail to listen....it is hard to improve the treatment...there is a major breakdown in the joint battle against CF."*

In all communication, though, he consistently stresses the importance of adherence. He is always honest about own stance, setting very high standards for the team, the patient, and the family.

### *Collaboration with families*

He encourages honesty and an open relationship, and an expectation of a reciprocal relationship.

*"You will need to work very hard to make this collaboration successful."*

## Putting this into practice

Whilst many interventions for adherence problems are single-clinician led, there are very good opportunities for teams to re-shape how they approach their patient group. Here are five ideas;

1. Sign up to the 'Warren Warwick' principles
2. If working with children of high school age and above, see them on their own at the beginning of the clinic consultation. The aim of this is to;
  - **Build young people's confidence** in speaking to doctors on their own
  - **Engage** young people in discussions about their health care
3. Identify those patients whose adherence is persistently problematic (and for whom initial attempts to address it have failed)
4. Establish a regular "adherence clinic" (either actual or virtual):
  - **Actual;** establish a regular clinic (no less frequently than monthly) although cross-infection guidelines may pose challenges to practicalities
  - **Virtual;** hold monthly case note review of the group of patients

The staff group running 'the Clinic' would have as few members of the wider CF team as possible and be as consistent as possible (including a psychosocial professional if available)

5. Establish a 'key-worker' system. This could be integrated in to adherence clinics or run independently within the wider CF team. The key worker could be any member of the MDT, but one with whom the patient already has a good relationship. The Key Worker would then take responsibility for implementing adherence initiatives (all of which are discussed soon in this document). But to summarise, these duties would include, discussing and understanding the adherence issue, establishing a truly collaborative relationship, setting and agreeing treatment goals, liaising and supporting the patient in their efforts to change in between clinics/reviews.



## Interventions: individual work

In the context of the Team, we focus on six stages of work with patients to increase adherence;

1. Establishing truly collaborative relationships by engaging and connecting with patients
2. Assessment
3. Negotiate (with whom, what, how?)
4. Motivate
5. Plan
6. Monitor and review

**Connection**

- Listening to, and understanding, what is difficult about living with an illness and adhering to its treatment regime, enhances the qualities of that clinician-patient relationship with empathy and understanding
- This allows the patient to discuss matters openly and honestly and facilitates them feeling connected to the clinician/team
- Having such conversations enhances the clinician's skills as s/he has more accurate information upon which to base decisions/actions

### 1 Engage and connect

Interventions begin with discussion. Yet, to talk about things effectively with patients, we need to engage and connect with them. Schools of medicine which believe that the physical examination of patients is of vital importance, teach “bedside medicine” that involves good old-fashioned touching, looking and listening. But the ‘art’ of the physical exam and history-taking is not easy to master.

Communication problems are the second most common complaint in the NHS (Healthcare Commission, 2007). Perhaps this is unsurprising given that physicians often underestimate just how much interaction and discussion patients want (Fielding and Duff, 1999).

In an evaluation of national communication skills training programmes in cancer care, doctors were more patient-focused and increased their use of empathy in clinical settings by 70% (Fallowfield et al, 2002).

In CF care, we need to learn from these initiatives and accept that investing time in developing good communication skills pays huge dividends in engaging patients.

The foundation of good communication is listening. (Some say this is why we have two ears but only one mouth!) Listening and understanding helps shape consultations to derive maximum clinical information from patients.

But good-listening is not a passive process and involves more than sitting silently. Active listening leads to patients becoming actively engaged in their healthcare and to true collaboration between them and their health professional. It also leads to more honest – and ultimately more useful – information.

Even with the best of intentions though, it's difficult to get it right and healthcareers inevitably need a good deal of practice.

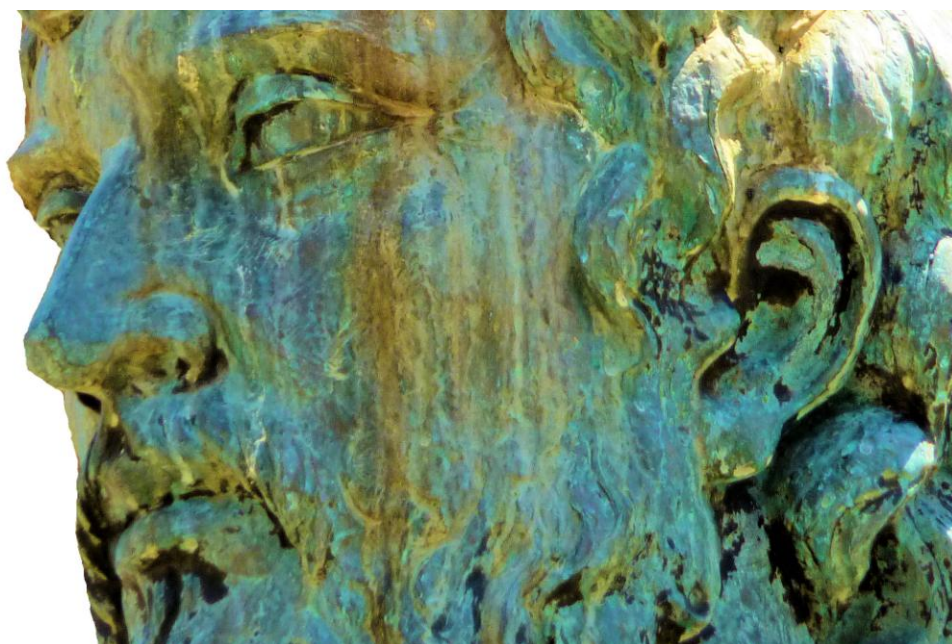
### Active listening

*We need to listen:*

- For the content of the message
- To the feelings of the speaker
- Without interrupting
- Without judging

*We need to respond by using OARS*

- Open-ended questions
- Affirmations
- Reflections
- Summaries



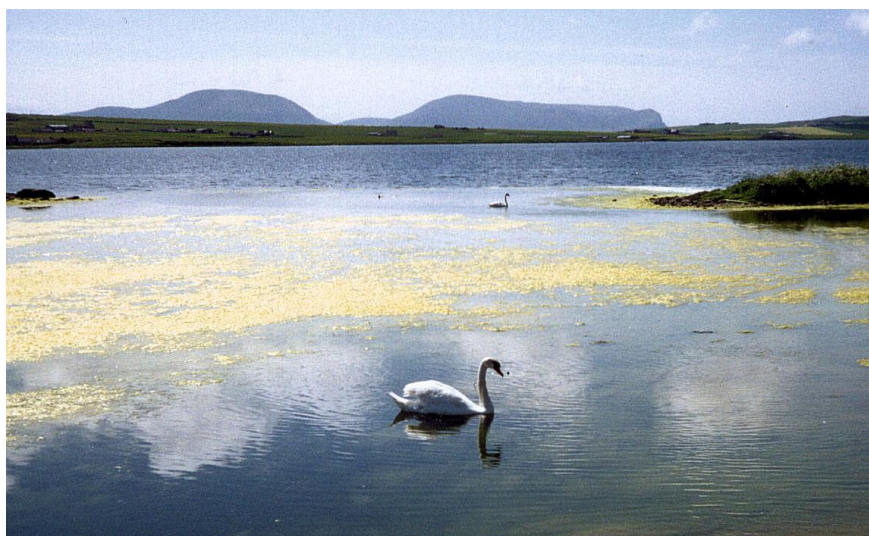
**Open ended questions** are very useful for getting a conversation going. You probably use these a lot and they are great for opening up a conversation. They also prevent you from making the mistake of assuming you know what's going on for someone or how they feel.

**Affirmations** help to keep the conversation positive. It's important that your encouragement and support is genuine, and this can have a significant effect on the course of the conversation. One way of doing this is to make statements of recognition of patient strengths.

**Reflective listening** refers to reflecting back what a patient has said. Reflection can be simple and intuitive – such as reflecting back the main content of a statement (**content reflection**). This is the simplest response to resistance: nonresistance - repeating the patient's statement in a neutral form. It acknowledges and validates the patient's voice and shows you are listening. For example:

- Patient: *This has been a rough few weeks for me*
- Interviewer: *It sounds like things aren't going well.*

Reflection can also be complex and powerful, however, such as reflecting back a meaning from earlier in a conversation which has a bearing on what someone has just told you (**meaning reflection**). You won't be surprised to hear that as with most skills, this get easier with practice! This is a powerful way of helping someone to talk, and to think about something, such as changing their behaviour. For example:



- Patient: *I've been so good at taking the medication then I got fed up and missed them all weekend*
- Interviewer: *You feel upset because you feel as if you've let yourself down.*

Meaning reflections give you the opportunity to help move the conversation on to more meaningful topics, showing you are listening and also showing that you understand. It may seem quite a risky thing to attempt, but if said in the right way will almost always result in a deeper understanding, even if you are wrong – your patient will tell you what is really going on!

**Summaries** seems such a simple technique, but it is surprising how powerful it is for a listener to actively pull together what someone has been saying and reflect it back to them. Sometimes this really does produce novel insights. It refers to pulling together things the patient has said and presenting them back in a brief summary.

Becoming good, active listeners leads to patient-engagement. People who become engaged in their care have the knowledge, skills and confidence to manage their health and healthcare and become activated to do so. Confidence is thought to be the key to successful transitioning from passive to active engagement. But this is an important step, as it is the degree to which patients become activated in their care that has been shown to have lasting health outcomes (Roehr, 2010).

So we firmly believe that it is the combination of an *actively-listening clinician* and an *actively-engaged patient* that leads to truly collaborative relationships. And once formed, these relationships can be put to very good use.

## Collaboration

In a truly collaborative relationship;

- Clinicians can hold open and honest discussion with patients and get key messages across
- Patients feel they have an element of control over their treatment regime. They become informed and knowledgeable about CF and their care, and can then negotiate with their team from an informed perspective.



Collaboration is the key to success. Without it, patients will not trust the team with the truth about how they are coping and how well they are really doing with their adherence. They are also less likely to believe and follow advice.

## Collaboration

- Formula for true collaboration

$$(E + C) \times n = \text{Col}$$

(Engaging + Connecting) x n of consultation = Collaboration

## 2. Assessment

Good assessment is vital. This not just a focus on current adherence behaviour – though this is important – assessment should include all of the factors that may influence adherence behaviour. In general then, a full assessment should;

- **Establish current behaviour**
- **Establish current knowledge**
- **Explore current beliefs**
- **Explore role of family/friend partner**
- **Explore resources**
- **Explore barriers/facilitators**
- **Explore any problem situations in detail**

These largely reflect the model earlier explaining the main influences on adherence. A handy guide to question areas can be found in the accompanying toolkit, together with some blank diary sheets (very useful for finding out what is actually happening), and a blank form to use for something known as ABC-R. The latter refers to a simple psychological technique for discovering more about what is going on in an important situation, such as a treatment that is regularly missed.

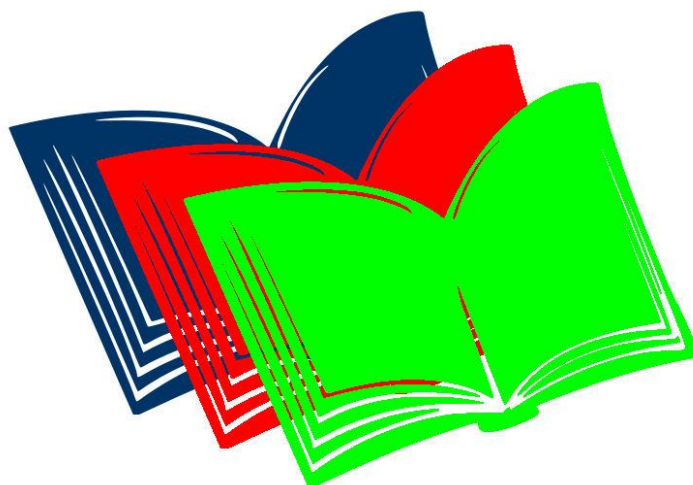
**A**ntecedents   **B**ehaviour   **C**onsequences   -   **R**evuew

ABC-R stands for; **antecedents** (what happens before), **behaviour** (what happens at the time) and **consequences** (what happens afterwards). The 'R' stands for **review**, and encourages the patient to try to make sense of the form themselves after they have completed it. The best way to approach the form is to encourage patients to write everything down in the columns – what they were doing physically, what they were feeling and what they were thinking. It takes a little practice at first, but it quickly becomes an important tool for assessment. More than that, the process of filling in any diary actually starts to shift beliefs as the person completing it becomes more aware of events and their own role in them. It's not unusual to find diary-keeping actually has an impact on the behaviour being observed.

### *Knowledge and understanding*

Although general knowledge about CF has not been directly linked to adherence rates, treatment-specific understanding has (Kettler et al, 2002).

Some patients and their families don't have the knowledge or skills to adhere, some choose to suppress information as part of their coping style, while others perceive themselves as knowledgeable and adherent, but make informed choices not to take their treatment as asked. In this sense, they hold different treatment goals from their clinicians.



Information gaps in CF knowledge and misunderstandings are reported to be as high as 33% in mothers of school-age children (Levers-Landis et al, 1999). While lack of written treatment plans can significantly contribute to this (Modi and Quittner, 2006) even where such plans exist levels of understanding are further influenced by the quality of interactions with health professionals.

### *Technique: giving and receiving information*

Sometimes during an assessment you will become aware of a lack of knowledge (and potential barrier). Giving information is an important part of most health professional's role, but there are ways of improving it (and increasing the likelihood that things will be remembered). This includes providing a written summary and using a picture board or play with children, but most importantly the principle that unless the patient or family are actively listening and engaged with you, they won't process the information and it will never become a memory – "memory is the residue of thought" (Willingham, 2009). The diagram on the next page summarises the elicit-provide-elicite technique which gets around this.

## A guide to giving advice

1 Are they ready for advice? If unsure, ask permission: "is it OK if I give you some advice on that?"



2 Check understanding first: "what do you know about this already?"



3 Give the information. Be neutral, if possible: "We've found that others have found this helpful" "the research tells us that..."



4 Check understanding again: "what do you make of that?"

Remember, if someone is going to remember what you have said, they need to be engaged and ready to listen first, and then they need to process the information after you have given it.

## Negotiate (with whom, what, how?)

So far, we have made much of investing the time in engaging and connecting with patients to achieve truly collaborative relationships. But now it's time to consider how to put this relationship to use and reap some of the dividends. Remember the principles of true collaboration result in;

- Open and honest conversations
- Listening to and understanding an actively engaged patient
- Getting key messages across



It is within the context of the truly collaborative relationship that discussion and negotiation about treatment plans can effectively take place.

Clinicians in CF teams often find themselves facing the following dilemmas:

*“Do we run the risk of compromising care by agreeing to a reduced treatment regime, with the hope we find a starting point that the patient can adhere to?”*

*“Is it better that the patient adheres to their treatment once a day everyday, rather than twice a day infrequently?”*

*“How much treatment does the patient need to adhere to in order to remain well?”*

*“Is taking 50% of prescribed treatment acceptable if it achieves symptom control?”*



Although as teams we hold clinical responsibility and cannot overtly condone supporting a reduced regimen, we need to balance this with a healthy dose of realism about what the patient will actually do when they are discharged from an in-patient stay or leave clinic.

In many cases we need to ***share the dilemma*** with the patient, starting off the discussion along the lines of...

*“As your doctor, I have the responsibility to provide you with the best possible care and advise you on a treatment plan that will achieve this. However, what I hear you say is that sticking to this plan is such hard work for you right now that it can’t be done. Where do **WE** go from here?”*

### Sharing the dilemma (or negotiating change)

We need to consider three things in negotiations.

**Who** do we need to negotiate with?

*Patients, parents, carers, partners, siblings*

**What** do we need to negotiate?

*Only those aspects of treatment that the patient cannot adhere to optimally*

**When** do we negotiate?

*When we are sure that the patient has good knowledge and understanding of the treatment in question AND...*

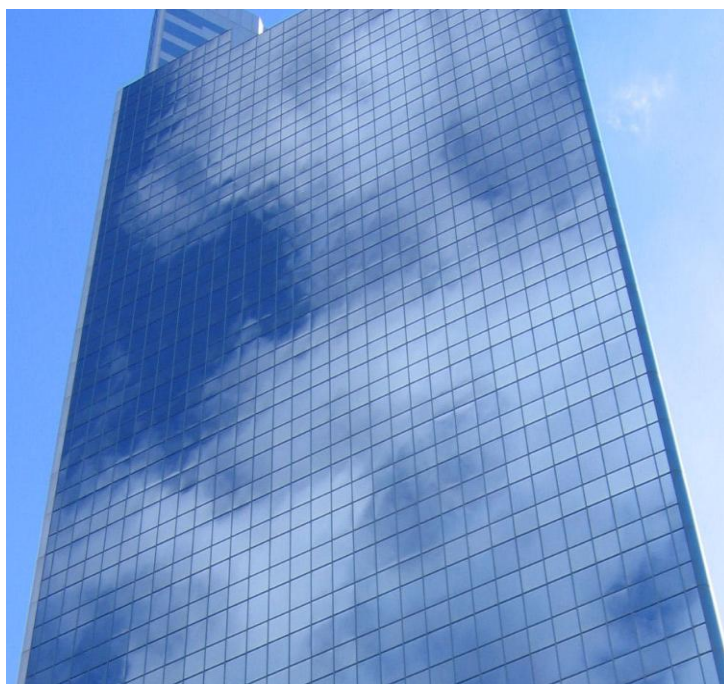
*When traditional attempts to support the patient adhering have failed*



## Motivate

Once a baseline treatment plan has been negotiated and agreed between the team and the patient, clinicians must convey the imperative for change within the safety of the truly collaborative relationship. This needs to incorporate the patients' own beliefs and goals (about CF and their lives).

By focusing on incompatible or inconsistent beliefs and goals, patients become aware of the problems themselves, although they are likely to know these already and be very well versed in concealing them (the basis of psychological defending). The theory of "cognitive dissonance" is a useful concept to understand this.



Cognitive dissonance was proposed by Leon Festinger (1957) to be a feature of situations in which people are struggling with a choice about changing, which is making them feel uncomfortable – such as when there is something someone feels they ought to do but they are not doing it (e.g., filling out a tax return, giving up smoking, taking medication - or all three!). This conflict itself makes people uncomfortable and produces a momentum towards change if handled in the right way.

We need to use our active listening skills to listen out for discrepancies between patients' thoughts and behaviours (this is often referred to as 'developing discrepancies'). We can then assess how important patients believe it is to change (i.e., to increase their adherence), and how confident they are in achieving it. (See 'assessing importance and confidence', using scaling questions and the decisional-matrix, in the toolkit).

## 5. Plan

First step: work out what the goals are. It's tempting just to leave this vague, to agree on something like 'take all my medicines' or 'just get better', but unless the goals are clear change will be tricky, and it will also be impossible to work out whether change has been successful. The best way to establish goals is to make them SMART - Specific, Measurable, Attainable, Relevant and Time-bound. This way you can: be very clear about what the goals are, make sure it is possible to measure them, be realistic, reinforce that the goals are worth aiming for, and suggest that they can all be achieved in a reasonable time. However, it's usually best to start with a small preliminary step to build up confidence. (There's a blank form for recording SMART goals in the toolkit).

Once the goals are agreed, you can start to complete a change plan. Again, it's best to write things down and be specific – don't leave anything vague. Writing a change plan (there's another blank form in the toolkit), commits someone to change and reminds them of their reasons. It begins to focus on what they will actually do, as well as consider what things may make the change easier (and harder). Generally, people are more likely to do something if they write it down and make more of a commitment to it.



The key to successful change is planning. Although it's tempting for most people to be impatient for change once they have decided to do it, launching into it without preparation is likely to lead to failure at the first hurdle. At the same time, the second most common reason for failure is not to begin at all – even when a decision has been made, it's easy to put off actually *starting*.

Whenever someone starts to change they meet obstacles - ones that will trip them up, or stop them from starting in the first place! This leads us directly to a very useful strategy – **Implementation Intention Plans** (IIP). Chances are you have never heard of them, but research has shown clearly that using one will double the chances of a behaviour change occurring. And increasing the odds of success is not to be sniffed at.

IIPs are actually pretty sensible. They involve sitting down and anticipating all the obstacles to getting started and all the obstacles that may derail the attempt. Next possible solutions are generated. This is all pretty helpful but the next step is crucial: obstacles and solutions need to be written down in a format that leaves no room for doubt about what will happen;

If \_\_\_\_\_ happens, then I will do this \_\_\_\_\_

There's yet another blank form in the toolkit and we recommend you try it! Remember, during the planning process all your experience and knowledge will prove very helpful for your patient. Remember also not to slip into 'expert mode', telling them what to do. Instead ask if it would be helpful to tell them about what others have found useful. 'Guiding' is a very apt description of this process – advising, listening and adapting to the needs of your patient.

Don't forget to use the elicit-provide-elicited model when giving advice. The main focus is on planning, but keep checking in with your patient that they are still committed to change.

How do you choose between the different ways of achieving change? It might appear obvious, or it might be tricky to choose, or seem that change is impossible. One useful technique is to use problem-solving to generate possible solutions. This works particularly well when the patient or family is involved in generating them. There is a guide to problem solving and - you've guessed it - a blank pro-forma to use in the toolkit. Briefly, problem-solving involves exploring possible ways of achieving change together, writing them all down, selecting one to try and commit to doing it.

As you put a plan together with a patient, there are some other strategies that you might find useful too. The aim of any behaviour change is to make it routine, so that the behaviour becomes automatic (habitual). In the early days, you might deliberately add the behaviour to an already established routine so that it is assimilated into a daily activity or routine, or you might use a prompt/cue to serve as a reminder for the patient. Examples of prompts/cues are;

- Mobile phone alarms, stickers, placing medications in location where they will be seen
- Incorporate into an existing routine or behavioural sequence and use as a cue (e.g. teeth brushing)
- Use friends/family/partner (that the patient identifies) as a source of reminding and support

Another useful technique is to encourage your patient to visualise possible problems and imagine dealing with them successfully using the pre-planned responses that you have worked out together in. The process of visualising this actually makes it much more likely that they will cope better in real life.

Also, don't forget the important role played by the patient's beliefs, as discussed earlier. It may be that these surface as you plan, so be prepared to discuss them.

The final tip is to use reinforcement. It's a common myth that the most powerful way to change behaviour is to threaten punishment. Actually, reinforcement is a far stronger force, and you can use this to your advantage in helping a patient plan change. Spend time establishing what they might do to reward themselves if they succeed in changing – and make it very clear what this is to be and when it can be awarded. Recording this is very useful. (Guess where the blank form for this is). It's important that the rewards are actually taken as it mentally links the behaviour and something positive. Of course the very best reinforcements are psychological – the sense of being in control, of doing the right thing and being proud and confident. So reinforce these as much as possible.

## Monitor and review

The final stage is to monitor what happens after a patient initiates change. The rewards sheet can be used for this and from learning from experience. It's important to build in time to review progress, to take time to reflect on successes and to revise the plan if it is not working. Above all, it's important to keep morale up, to keep the focus on change. Change is not easy and it often requires several different attempts to succeed.

One last tip; when people achieve change sometimes they forget to give themselves credit for it. Sometimes they respond with something like; 'it's nothing special - I should have done it ages ago anyway'. Maybe this is because they feel guilty at having needed support to change. In these situations it's important to normalise the process – to remind them that everyone struggles with change and to point out how well they have done. If you had planned a reward, see if you can ensure that your patient has followed through with it.

The best way to ensure that someone continues to make changes is to help them see for themselves that the changes they have made are positive.



## Toolkit

In the accompanying toolkit you'll find a number of handouts and tools that can be copied and used with patients contemplating changing their adherence behaviour. This includes all of the following:

### Assessment questions to map influences on adherence

Weekly diary (Version 1)

Weekly diary (Version 2)

ABC-R chart

Readiness ruler

Scaling questions

Scaling questions (Steps version)

Thinking about pros and cons

Thinking about likes and dislikes

SMART goals sheet

Change plan

Implementation Intention Plan

Problem solving guide

Problem solving blank work sheet

Rewards plan sheet



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This guide was written by Gary Latchford and Alistair Duff

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