A Practical Guide to Health Behaviour Change
using the HCA approach
What needs to happen for people to take and sustain action?

Generic behaviour change pathway

- Knowledge & understanding
- Motivation & expectations
- Decision & commitment
- Planning
- Action
- Self-regulation

Decision Line
A Practical Guide to Health Behaviour Change using the HCA approach

Janette Gale
Health Psychologist
From the Authors

The Health Change Australia (HCA) approach is the product of 10 years of evolutionary work by a multidisciplinary team of clinicians who are passionate about attaining better health outcomes for their patients and clients. This work originated from the Kangaroo Valley Healthy Community Project, led by HCA founder and health psychologist, Janette Gale. The fundamental learning from this project was that if you ask people what information and services they need to attain better health, and try to provide these, you will have greater success at engaging the population in health change.

The same grassroots approach was used to develop the clinical practice model that is embodied by the HCA approach, the subject of this book and the training program used to teach this approach to clinicians and case managers. Janette Gale and the HCA training team are the authors of this Guide.

The HCA approach is now a clinical practice style that harnesses the knowledge, evidence-based behaviour change techniques and communication principles that are necessary for clinicians and case managers to effectively support client health behaviour changes in a multitude of contexts. The approach has been adopted by private practitioners, community health workers, rehabilitation, return to work and mental health workers and a number of corporate and public health services across Australia and internationally.

The HCA approach is embedded within a framework that bridges the gap between theory and practice, thus providing a unique, practical and systematic method for working with any client that attends a health consultation. By knowing how to identify and address barriers to change for clients and patients in a time-efficient manner, clinicians can achieve increased levels of adherence to their treatment recommendations and better health and quality of life outcomes for the people that they are there to serve.

Thousands of clinicians and case managers who have attended HCA training have contributed to the development of this approach over the years by stating their own professional needs and challenging HCA to provide an enduring framework to help them to better support their patients and clients. The end result of this process is contained in this book. It has been designed by health practitioners for health and community workers and clinicians working in any context. It can be used as an academic text, a practitioner’s desk top manual or as professional development reading for any person involved in supporting behaviour change in another human being. We hope that you find it helpful.
Acknowledgements

Special thanks to the Health Change Australia (HCA) training and office teams for content suggestions, clinical input, administrative support, tireless effort and exemplary professionalism in contributing to the ongoing development of the HCA approach and complementary teaching methods.

Thanks and acknowledgement are also due to the thousands of clinicians and case managers who have attended HCA training over the years and provided constructive feedback, challenged our thinking, and helped us to articulate a practitioner-friendly clinical approach to health behaviour change.
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About the HCA Guide

The HCA Guide (referred to as the Guide from now on) is based on the HCA Model of Health Change developed by Health Change Australia (HCA). The Guide is intended to help clinicians to learn and apply the practice principles, essential techniques and 10 step decision framework of the HCA approach.

This approach can be used in any health consultation where the client is required to, or would benefit from, taking action outside of the consultation environment. It can be employed to support behaviour change and self-management to:

- prevent or reduce chronic disease risk factors
- manage chronic diseases and health conditions
- support rehabilitation processes relating to recovery from illness or injury
- promote return to previous functioning and/or return to work
- promote client adherence to medical treatment recommendations
- improve general health and quality of life

What needs to happen for a person to take and sustain action?

The diagram on page viii and on the inside front cover of the Guide shows a generic behaviour change pathway that applies to any person who consciously considers engaging in particular behaviours or actions. The pathway suggests that people need to have a certain amount of knowledge and understanding of their situation in order to even think about taking action to change the situation. Then they need the motivation to take action. Why would people bother spending time doing things that are not important to them? However, having knowledge and motivation does not always lead to making a commitment to take action. This involves making a conscious decision to do something different from one’s current habits or actions.

Halfway down the pathway is a dotted line called the ‘decision line’. This is the point in the course of changing their behaviour where a person commits to taking action on a particular issue (if they get that far). The processes above the decision line are termed above the line processes and the processes below the decision line are termed below the line processes. Above the line, motivational factors tend to determine whether a person will commit to action and cross the decision line. Below the line, factors affecting self-efficacy (perceived ability or confidence) tend to act as barriers or facilitators (enablers) for taking and sustaining action.

Once a person makes a commitment to take action, some degree of planning is usually required for this to happen. Without adequate planning, often our intentions are not carried out, especially when barriers or obstacles get in the way. Things can also get in the way after we initiate action. Therefore, we need to be able to self-regulate our behaviour in order to persevere with planned changes and to eventually achieve our desired outcomes.
In summary, initiating and sustaining action requires a number of different processes to occur. Sometimes people negotiate these processes successfully on their own. However, a common reason that people do not improve their health outcomes is that they get stuck at one of the points in the behaviour change pathway and, therefore, fail to take or sustain action.

**Generic behaviour change pathway**

```
Knowledge & understanding

Motivation & expectations

Decision & commitment

Planning

Action

Self-regulation
```

Knowing that this pathway describes the behaviour change processes that people go through in order to follow treatment advice can allow clinicians, case managers and other professionals to identify where a client may get stuck and hence not take the required actions to improve their situation.

Above the decision line a client may benefit from assistance that builds or reinforces their motivation. Below the decision line, they may benefit from assistance that builds their confidence in taking action.
What stops people from taking action?

The acronym BEST categorises the four groups of potential barriers that can cause a person to become stuck along the way in the behaviour change pathway and stop them from achieving their goals:

1. **Behaviours**: actions and ingrained habits, lifestyle behaviours and planning or lack of planning
2. **Emotions**: emotional reactions to situations and thoughts and our moods, e.g. getting angry or upset for not achieving planned goals or actions and/or being anxious or depressed
3. **Situations**: financial resources, access to services, medical conditions, cognitive and physical abilities, social support and relationships and life circumstances such as doing shiftwork, sharing child custody, being a carer, travelling for work and living in a cold climate
4. **Thinking**: beliefs, attitudes, expectations, habitual thinking patterns, motivation and knowledge

Through understanding that barriers to action can take any or all of these forms, clinicians and case managers are better placed to recognise and problem-solve these barriers in their client consultations.

Why integrate a behaviour change framework into clinical consultations and programs?

Not all patients or clients need assistance to take the action required to follow lifestyle or treatment recommendations. Many people will successfully act on the advice given to them by clinicians or health authorities if they are ready, willing and able to do so. However, we know from experts such as the World Health Organization (WHO) and from the scientific literature that adherence to treatment and lifestyle recommendations is much lower than we would hope.

How do you know who will act on treatment advice and who will not? By integrating a framework that systematically looks for common barriers that stop clients from moving through the behaviour change pathway, clinicians and case managers can identify whether or not a client is likely to adhere to recommendations. This provides an opportunity for them to apply brief techniques to help their clients to overcome their barriers and achieve better health and quality of life outcomes.

As can be seen in the diagram on page x, the HCA approach provides clinicians with a health behaviour change (HBC) clinical pathway (see right hand column) using evidence-based (E-b) techniques to complement the usual clinical pathways (see left hand column) for the prevention and treatment of health conditions. It provides decision support and guidance to clinicians regarding which principles and techniques to use to increase a patient’s Readiness, Importance, Confidence and knowledge (RICK) in taking action to manage their health conditions and risk factors and to improve their quality of life. The HCA approach enables clinicians to use their existing skill base more effectively. It also provides time efficiency in their clinical practice by allowing them to quickly identify and target key adherence issues for patients.
Dual clinical pathways:
Usual clinical pathway and health behaviour change clinical pathway

Common lifestyle and treatment categories addressed using the HCA approach:

- engaging in treatment options associated with specific conditions and acute or chronic diseases
- using medications effectively
- engaging in self-management activities, such as self-monitoring
- attending physician, pathology, imaging, specialist and/or other referral appointments
- seeking out and considering health information and/or education
- engaging in rehabilitation exercises and activities
- regaining functional skills
- managing chronic pain and energy levels
- improving weight, eating habits, activity levels and other lifestyle factors
- addressing individual barriers that impact on non-adherence or poor adherence to treatment recommendations and/or lifestyle change options:
  - time management
  - stress- and mood-management
  - dealing with significant others in the client’s life who impact on their health management
  - addressing behavioural, emotional, situational and thinking barriers that impact negatively on the client’s health management
How does health coaching relate to the HCA Model of Health Change?

Health coaching programs have become a popular method to support people to engage in behaviour change for chronic disease prevention, chronic condition self-management and rehabilitation from injury or illness. The most common delivery methods for health coaching interventions are telephone-delivered consultations, face-to-face consultations or a combination of both, with or without web-based support.

HCA defines ‘health coaching’ as a practice in which clinicians apply evidence-based health behaviour change principles and techniques to assist their clients to adhere to lifestyle and treatment recommendations, for the purpose of achieving better health outcomes or quality of life.

Health coaching-based programs can use the HCA Model of Health Change (HCA approach) as a practice framework to guide their health coaching conversations and to collect data to track intervention and behaviour change processes and outcomes.

The following diagram shows where health coaching-based clinical consultations and programs sit in the health change spectrum. The HCA Model of Health Change (see second arrow in diagram below) can be used in any of the categories of practice in the four right hand columns (i.e. all categories except the first column, traditional consultations). However, most of the clinicians using the HCA approach do not identify themselves as health coaches, but rather as being client- or patient-centred in their orientation.

The health change spectrum:
Where do the HCA Model of Health Change and health coaching fit?

<table>
<thead>
<tr>
<th>Traditional medical &amp; allied health clinical consultations</th>
<th>Client-centred medical &amp; allied health clinical consultations</th>
<th>Client-centred clinical programs &amp; services</th>
<th>Wellness counselling &amp; coaching interventions</th>
<th>General counselling &amp; coaching interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on individualised assessment, treatment advice and/or education for specific conditions (conducted by clinicians)</td>
<td>Focus on individualised assessment, treatment advice and/or education for specific conditions + health behaviour change support (conducted by clinicians)</td>
<td>Focus on general recommendations and education for disease management, rehabilitation and/or lifestyle change for better health outcomes + health behaviour change support (conducted by clinicians)</td>
<td>Focus on general recommendations and education for general health and wellbeing + health behaviour change support (not necessarily conducted by clinicians)</td>
<td>Focus on improving general wellbeing and mental health + behaviour change support (not necessarily specific to health or conducted by clinicians)</td>
</tr>
</tbody>
</table>

biomedical focus health change focus psychosocial focus

HCA model of health change

health coaching
About the HCA Guide

Health change terminology

Patients, clients or people?
Some readers may be more comfortable using the term ‘patient’ and others will be more comfortable using the term ‘client’. HCA uses the terms patient and client interchangeably. Supporting health behaviour change is about understanding human nature. In the Guide we will generally use the term client to emphasise the active role that people are encouraged to take in health consultations, programs and services using the HCA approach. Additionally, the client may be the patient themselves or their carer, family member or other support person in their life.

Clinicians, case managers or health professionals?
The HCA approach can be useful for any person whose role is to support patients, clients or other people in taking some type of action. Hence the Guide can be used by nearly anyone including clinicians, case managers, health promotion workers, care coordinators, mental health workers, community workers, managers, teachers, carers, parents and anybody else in an education or care support role. The Guide uses the terms clinicians, case managers and health professionals interchangeably and the concepts presented in the Guide apply to any broad health context.

Actions, tasks or behaviour change?
The use of the term ‘health behaviour change’ in the Guide does not just refer to making significant lifestyle changes. Behaviour change in the context of the HCA approach refers to any action that a patient or client is advised to take or agrees to take. This includes one-off actions such as attending referral appointments, having medical tests and deciding whether or not to engage in a particular treatment option. It also includes more enduring behavioural changes such as altering diet and exercise patterns, quitting smoking or cutting down on alcohol use. Hence, the phrases ‘making changes’ and ‘taking action’ are used synonymously throughout the Guide. In fact the HCA approach can be applied to any behaviour change situation at all including clinical and case management roles, staff management and even managing your own teenagers and children!

HCA Model of Health Change or HCA approach?
The HCA Model of Health Change is the formal model underlying the HCA approach. In this book we will mainly use the term HCA approach to describe the use of the model in clinical practice, services and programs. The HCA approach supports behaviour change using a conversational style that integrates naturally with the tasks that clinicians and case managers typically engage in with clients, patients or consumers of their services.
Who is the HCA Guide for?

The HCA Guide has been designed to be used as a skills development supplement for clinicians, case managers and other health professionals who have completed training with Health Change Australia (HCA). However, it may also be useful for people who have not attended HCA training as prior knowledge is not assumed.

What is assumed is that the reader has a sound grasp of basic communication and counselling skills. If it has been a while since you learnt these basic skills, it may assist you to review them by attending a communication skills course or by doing further reading (see ‘References and Useful Reading’ on page xvii). Similarly, whilst the Guide includes basic motivational interviewing, solution-focused counselling and coaching techniques, and cognitive and behaviour change techniques, it may benefit you to complete further reading and/or formal training in these interviewing styles and techniques if they are not already part of your professional skill set.

The primary aim of using the HCA approach is to assist clients to adhere to medical treatment and lifestyle recommendations that would lead to better health outcomes and quality of life for the client.

This can include conducting medical, health and other assessments, providing education or information and actively promoting the clients’ understanding of their health conditions and the actions they can take to manage them. The approach takes into account the client’s physical, social, psychological and situational needs when assisting them to prioritise and pursue their health goals.

Health Change Australia takes the position that interventions providing patient-specific health advice should be conducted by qualified health professionals. Clinicians have a duty of care to encourage and support clients to pursue health-enhancing goals and to help them to prioritise the actions they take to benefit their health, based on their health conditions, clinical indicators and lifestyle risk factors. Hence the HCA approach is a directive rather than a completely non-directive style of practice. It balances a practitioner’s duty of care with a person’s right to choose.

How to use the HCA Guide

The Guide contains the following sections:

Section 1: The HCA Model of Health Change. Provides an overview of the HCA approach including a brief description of each of the steps in the 10 step decision framework. This section also includes additional tips on how to provide assessment, treatment advice and education using the HCA approach.

Section 2: Practice Principles. Introduces the practice principles that assist practitioners to use client-centred communication skills.

Section 3: Essential Techniques. Provides brief instruction on how to use the essential techniques required to identify and address potential barriers to commitment and action.
Section 4: Setting the Scene for Health Change. Provides tips on setting up consultation environments and documentation to be consistent with the HCA approach and how to explain the role of a practitioner to a client when using this approach.

Section 5: Above the Line Processes. Provides detail about each of the four steps used to identify and address barriers to change above the decision line. This section also includes additional tips on how to use the Personal Self-management Plan to guide clinicians and quickly document key behaviour change information.

Section 6: Below the Line Processes. Provides detail about each of the six steps used to identify and address barriers to change below the decision line during goal setting and action planning. This section also includes information about conducting review consultations.

The aim of the Guide is to help clinicians and case managers to know the ‘what’, ‘why’ and ‘how’ of supporting behaviour change in their clients in an individualised and sustainable way. To facilitate this, most of the topics include the following four sub-sections:

Why do this?

These sub-sections are included because reviewing the rationale for engaging in each of the processes and techniques discussed in the Guide helps to ensure that you have a good understanding of when and why you might apply specific principles and processes and use particular techniques. This should help you to apply the principles, techniques and decision framework of the HCA approach more effectively and efficiently.

What to do

These sub-sections provide brief guidance on what to consider in which order for particular processes and techniques. They also provide tips about how to handle particular situations depending on the client’s readiness, importance, confidence and knowledge in relation to the issue concerned.

How to do it

These sub-sections provide you with sample phrasing for how you might ask questions and/or provide information to clients for each health change process and technique. These examples are there to give you ideas about how you might phrase questions and statements in certain circumstances. They are not meant to be scripts that you should follow verbatim. Read through the suggestions and then think about what wording would be appropriate for your own clients.

Write your own words

These sub-sections invite you to write down your own words in the allocated space at the end of each sub-section. This allows you to adapt the phrases to suit your own language preferences and the cultural and social needs of your client population. Then you can try them out in your consultations.

The Guide is meant to be used as a working document. Write in it, highlight or underline relevant information. Write in the ‘Write your own words’ and ‘Write your own notes’ sections and use sticky notes to easily locate frequently used pages. In other words, personalise this book so that it becomes as relevant to your own needs as possible.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCA</td>
<td>Health Change Australia</td>
</tr>
<tr>
<td>Barriers</td>
<td>Barriers to change (or barriers to action) are things or situations that</td>
</tr>
<tr>
<td></td>
<td>may act as obstacles to the client engaging in or maintaining action.</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Facilitators or enablers for change are the techniques, people or</td>
</tr>
<tr>
<td></td>
<td>strategies that address, lessen or overcome identified barriers to</td>
</tr>
<tr>
<td></td>
<td>taking action.</td>
</tr>
<tr>
<td>BEST</td>
<td>Behavioural, Emotional, Situational and Thinking (barriers or facilitators</td>
</tr>
<tr>
<td></td>
<td>for change).</td>
</tr>
<tr>
<td>ANNTs</td>
<td>Automatic Neutral or Negative Thoughts (ANNTs) are unhelpful thinking</td>
</tr>
<tr>
<td></td>
<td>patterns that can be barriers to change.</td>
</tr>
<tr>
<td>PETs</td>
<td>Positive or Enabling Thoughts (PETs) are helpful thinking patterns that</td>
</tr>
<tr>
<td></td>
<td>can be facilitators of change.</td>
</tr>
<tr>
<td>Ask RICk®</td>
<td>Asking RICk refers to openly asking about a client’s Readiness, Importance,</td>
</tr>
<tr>
<td></td>
<td>Confidence and/or knowledge (RICK) in relation to making health behaviour</td>
</tr>
<tr>
<td></td>
<td>changes.</td>
</tr>
<tr>
<td>RICk Radar</td>
<td>Using your RICk radar refers to observing and interpreting body language,</td>
</tr>
<tr>
<td></td>
<td>tone of voice and other cues in order to infer a client’s level of</td>
</tr>
<tr>
<td></td>
<td>readiness, importance and confidence and to recognise ambivalence when</td>
</tr>
<tr>
<td></td>
<td>present.</td>
</tr>
<tr>
<td>HCA Decision Line™</td>
<td>The point in a consultation when a client decides that it is in their</td>
</tr>
<tr>
<td></td>
<td>own interest to change an aspect of their lifestyle or follow a particular</td>
</tr>
<tr>
<td></td>
<td>treatment recommendation and commits to taking some sort of action.</td>
</tr>
<tr>
<td>Above the Line Processes</td>
<td>These are the behaviour change processes that occur above the HCA decision</td>
</tr>
<tr>
<td></td>
<td>line. The aim is for clinicians to check and build client knowledge and</td>
</tr>
<tr>
<td></td>
<td>motivation and establish a commitment to take action.</td>
</tr>
</tbody>
</table>
### Below the Line Processes
These are the behaviour change processes that occur below the HCA decision line. The aim for clinicians is to check and build client confidence in taking and sustaining action.

### Decisional Balance
A problem-solving technique that examines the positive and negative consequences (pros and cons) of two sides of a decision in order to assist decision making. When used in conjunction with cognitive change techniques, this technique can increase a client’s perceived importance (and hence readiness) to engage in health behaviour change. Decisional balance is recommended for use particularly when a client is ambivalent about following treatment recommendations.

### Ambivalence
Uncertainty or indecision about whether or not to do something (e.g. to follow lifestyle or treatment advice or not).

### Lifestyle and Treatment Categories
General areas or broad categories in which a client can take action to achieve better health or quality of life outcomes. These broad categories are associated with long-term goals and aims. Examples can be found in the list on page x.

### Personal Self-management Plan
A summary table that lists and prioritises the lifestyle and treatment categories relevant to a particular patient or client in a particular type of consultation. It includes space to record the date and RICK levels for each category as these are sequentially addressed over time.

### Personal Goals
Goals that state specifically what a client is going to do to achieve better health or quality of life outcomes. These goals include details such as how much the client will do, how often they will do it, when they will start taking action and when they will review their actions. Personal goals describe a client’s intended actions, tasks or sets of behaviours. These are short- to medium-term goals or aims.

### Personal Action Plan
A plan for how the client is going to achieve a personal goal, i.e. a list of tasks or a step-by-step set of instructions for the client to follow. The amount of detail included depends on the client’s needs.
References and Useful Reading

Chronic Condition Self-management


Cognitive Behaviour Therapy


Ellis, A. (2004). *Rational Emotive Behavior Therapy: It works for me—it can work for you.* Amherst, Prometheus Books, New York, USA.

Decision Making/Decisional Balance


Goal Setting/Striving


Health Behaviour Change Models


About the HCA Guide

Health Coaching


Hope Theory

Motivational Interviewing

Relapse Prevention

Self Determination Theory (intrinsic/autonomous motivation)

Solution-focused Coaching Models

Stages of Change/Transtheoretical Model of Change


About the HCA Guide

Write your own notes:
Section 1

The HCA Model of Health Change™
**HCA Model of Health Change™**

Health behaviour change principles and processes applicable across the spectrum of health goals and clinical contexts

### 9 Practice Principles
- 3Cs: client centred, client choice, client control
- Call it as you see it
- Four aspects of goal setting
- One thing at a time, one step at a time, adding up over time
- The RICk principle
- First ask, then offer
- WAIT til 8
- Invite the client to write
- Trial & error

### 7 Essential Techniques
- Client first technique
- Menu of options technique
- Using your RICk radar
- Asking RICk
- Decisional balance technique
- Turning ANNTs into PETs
- Tracking & monitoring strategies

### 10 Step Decision Framework

<table>
<thead>
<tr>
<th>Step</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify clinical issues &amp; broad lifestyle &amp; treatment categories</td>
</tr>
<tr>
<td>2.</td>
<td>Prioritise &amp; choose a category</td>
</tr>
<tr>
<td>3.</td>
<td>Ask RICk ®</td>
</tr>
<tr>
<td>4.</td>
<td>Make a decision</td>
</tr>
<tr>
<td>5.</td>
<td>Generate personal goal options</td>
</tr>
<tr>
<td>6.</td>
<td>Choose &amp; refine an option</td>
</tr>
<tr>
<td>7.</td>
<td>Create an action plan</td>
</tr>
<tr>
<td>8.</td>
<td>Identify &amp; address barriers</td>
</tr>
<tr>
<td>9.</td>
<td>Ask RICk</td>
</tr>
<tr>
<td>10.</td>
<td>Consider review &amp; referral</td>
</tr>
</tbody>
</table>

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Section 1: The HCA Model of Health Change

This section provides an overview of the HCA Model of Health Change including the rationale for the HCA approach and suggestions on how to flexibly use the practice principles, essential techniques and 10 step decision framework. This section also includes a brief description of each of the steps in the 10 step decision framework along with the reasons for including each one.

In this section:

1. About the HCA approach
2. Overview of the HCA 10 step decision framework
3. How to flexibly apply the HCA Model of Health Change

Appendix:

A: Conducting Clinical Assessment, Treatment Advice and Education Using the HCA Approach
Section 1 | The HCA Model of Health Change

Write your own notes:
About the HCA approach

The HCA Model of Health Change is a clinical practice decision framework for integrating client-centred communication and behaviour change principles and processes into clinical consultations and programs. It provides practitioners with a ‘health behaviour change clinical pathway’ using evidence-based principles and techniques to complement the usual clinical pathways for prevention and treatment of health conditions. The purpose of the approach is to increase the likelihood that clients will act in accordance with lifestyle and treatment recommendations appropriate to their health condition/s and risk factors.

The processes of the HCA approach aim to actively identify and address behavioural, emotional, situational and thinking (BEST) barriers to change and to build patient skills in decision making, problem solving, planning and self-regulation. The HCA Model of Health Change bridges the gap between behaviour change theory and practice. It draws on principles and techniques used in motivational interviewing, solution-focused coaching and cognitive behavioural therapy (CBT). It also integrates numerous theoretical concepts from the evidence-based health behaviour change literature. For more detail about the HCA Model of Health Change and its theory base, see documents on the HCA website: www.healthchangeaustralia.com (the URL is also on the back of this Guide).

Three main tasks for practitioners using the HCA Model of Health Change:

1. To provide clients with health assessment, treatment recommendations and/or health education and referral advice in a way that reduces resistance and increases acceptance of this information. The aim is to assist clients to identify, understand and prioritise health-enhancing behaviour changes aimed at meeting or moving towards relevant clinical targets.

2. To assist clients to decide that it is in their own interests to adopt treatment recommendations and healthy lifestyle changes and commit to taking action. The aim is to increase client motivation and commitment to pursue health goals, with an emphasis on those goals with the most beneficial health outcomes for the client.

3. To develop a client’s problem-solving skills so that they are more systematic and successful in making decisions, planning, initiating and sustaining behaviour changes. The aim is to increase client self-efficacy in engaging in health-enhancing behaviours.

Components of the model

The HCA Model of Health Change is comprised of: a foundation of six recommended knowledge and skill sets for clinicians, a set of practice principles to guide the clinical communication style, a set of essential techniques to identify and address barriers to change and a 10 step decision framework which acts as a decision tool for clinicians to use in their consultations. The model is shown graphically in the diagram on the reverse side of the divider for this section of the Guide.
Recommended knowledge and skill sets

The first three of the six recommended knowledge and skill sets provide a foundation of client-centred skills and knowledge to facilitate evidence-based information exchange and clinical guidance in a way that increases acceptance and use of this information. The final three knowledge and skill sets provide the background to understanding how to help clients to identify and address behavioural, thinking and emotional barriers to change. The six knowledge and skill sets are:

1. health conditions and health promotion knowledge
2. health behaviour change theory
3. health behaviour change interviewing skills
4. behaviour change facilitation skills
5. cognitive change facilitation skills
6. emotion-management facilitation skills

Practice principles

Nine practice principles are drawn from the knowledge and skill sets listed above. These are described in Section 2: Practice Principles. These practice principles are practical prompts and tips that can help clinicians to develop and use client-centred communication skills and build rapport with their clients.

Essential techniques

Seven specific techniques are drawn from the knowledge and skill sets listed above. These are described in Section 3: Essential Techniques. All of these techniques are essential to use in order to identify and address common barriers to change. Three of the techniques are meant to be used in every client consultation to facilitate client-centred communication. The remaining four techniques are used only when particular types of barriers are present for a client.

10 step decision framework

The 10 step decision framework of the HCA Model of Health Change matches the generic behaviour change pathway that clients work through in order to take action (see page viii). It allows clinicians to assist clients to identify and prioritise their health changes, increase their motivation, make appropriate decisions and increase their confidence in engaging in sustainable behaviour change for a broad range of purposes. An overview of the framework and steps is given on page 5.

The framework is designed to be used as a conceptual decision tool. Most clinicians will already be using many of the behaviour change processes represented by the 10 steps. The steps can be used by clinicians as prompts to assess what processes they are already using and to identify others that might be worthwhile incorporating more consistently into their practice.
Overview of the HCA 10 step decision framework

The HCA 10 step decision framework is designed to be used in clinical consultations whilst providing some or all aspects of assessment, diagnosis, treatment advice and education. The 10 steps represent ten prompts for clinicians to identify and address common barriers to change that impact on client motivation, commitment and confidence in taking action on treatment advice. The practice principles and essential techniques are used in conjunction with the 10 step decision framework in order to do this.

The 10 step decision framework is not a set of instructions or procedures, but rather a conceptual framework that is meant to be used as a decision tool or clinical pathway for behaviour change. The steps highlight health change processes in the sequence in which they naturally occur when people consider issues about their health, decide whether or not to take action, choose a course of action and plan how to take that action. The aim of the framework is to guide clinicians and clients to answer the questions in the diagram below.

Key questions above and below the decision line

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>What can I do about my health?</td>
<td>Does the client know and understand the broad lifestyle &amp; treatment categories applicable to their condition/s?</td>
</tr>
<tr>
<td>Why should I do this?</td>
<td>Have they been assisted to collaboratively prioritise these?</td>
</tr>
<tr>
<td>Do I want to do this?</td>
<td>Are they ready, willing, able and committed to taking action?</td>
</tr>
<tr>
<td>What could I do?</td>
<td>What options do they have for taking action in a particular category?</td>
</tr>
<tr>
<td>What exactly will I do?</td>
<td>What is their personal goal and plan?</td>
</tr>
<tr>
<td>What might get in the way and what can I do about that?</td>
<td>Are they confident they can do this and what might get in the way?</td>
</tr>
<tr>
<td>What support do I need?</td>
<td>Will I review the client and what other support do they need?</td>
</tr>
</tbody>
</table>

The steps help clinicians to systematically consider and work with a client’s Readiness, Importance, Confidence and knowledge (RICK) in relation to acting on lifestyle advice and treatment recommendations. Depending upon a client’s RICK profile, different health behaviour change processes and techniques are recommended for the clinician to apply. For example, a different approach would be recommended for a client who did not think it was personally important to take action on a particular health issue compared with a client who did. The 10 step decision framework is shown in the diagram on page 6 and is discussed in brief in the following pages. More detail is provided in Section 5: Above the Line Processes and Section 6: Below the Line Processes.
Section 1 | The HCA Model of Health Change

The HCA 10 step decision framework

Set the Scene & Explain Your Role

1. Identify Clinical Issues & Broad Lifestyle & Treatment Categories
2. Prioritise & Choose a Category to Work On
3. Ask RICk®
4. Make a Decision
5. Generate Personal Goal Options
6. Choose & Refine an Option
7. Create an Action Plan
8. Identify & Address Barriers
9. Ask RICk
10. Consider Review & Referral

Setting the scene and explaining your role

A client-centred approach begins with setting up consultation processes and environments to be client friendly and to communicate accurate expectations to the client. This is the case regardless of whether the consultation is face-to-face, over the telephone or in group education sessions.

An important part of setting the scene is for a clinician or case manager to explain their role effectively to a client. When using the HCA approach the main message to communicate is that while part of a clinician’s role may be to provide assessment, education, treatment advice or referral, another important part of their role is to help the client to do the things they need to do to get the outcomes that are important to them. If a person understands the potential benefits that they stand to gain from this approach, it may reduce some of the resistance and anxiety often observed in clients in the health system.

Section 4: Setting the Scene for Health Change, includes detailed information about setting up client-centred consultation environments, including explaining your role.

The HCA decision line

The HCA decision line is included in the 10 step decision framework after Step 4 (see the dotted line in the diagram above). This is the same decision line as the one depicted in the generic behaviour change pathway on page viii. It represents the point in a consultation when a client makes a conscious decision that it is in their own interests to change an aspect of their lifestyle or follow a particular treatment recommendation. Not all clients will cross the decision line for a given health issue, regardless of whether it may be beneficial for them to do so.
The decision line is a reminder to clinicians that if a client does not perceive that there are benefits in taking action and has not made a firm commitment to do so, then health behaviour change is unlikely to occur or be sustained. In fact, trying to set goals with a client who is not ready to do so may increase the client’s resistance to accepting lifestyle and treatment advice. Hence, it is unwise to proceed below the decision line into personal goal setting and action planning until the client has indicated their intention to take action.

Above the decision line, the clinician’s task is primarily to support motivation building and decision-making processes in order to guide the client towards forming an intention to make health-enhancing changes. A brief motivational interviewing approach is used here.

Below the decision line, the main task is to engage the client in action-oriented processes such as implementation planning and problem-solving, and to build and support the client’s confidence in relation to their chosen goal/s. Here the clinician switches to a solution-focused coaching approach.

**Above the line processes**

Steps 1 to 4 of the HCA 10 step decision framework are called *above the line* processes. They facilitate knowledge and understanding, motivation, decision-making and commitment. They make no assumptions about the readiness of the client to engage in health behaviour change.

The *above the line* processes can proceed quite quickly. This is particularly so if a client meets all of the following criteria:

- they already understand their health issues
- they know and understand the lifestyle and treatment recommendations
- they are ready to take action
- they believe that it is personally important to do so

However, if the client does not meet these criteria, then the clinician is advised not to proceed below the decision line into action-oriented goal setting and planning processes. Instead, they would be encouraged to engage the client in processes aimed at building health knowledge and understanding as well as motivation and commitment to take action.

**Step 1** involves making sure that each client knows and understands the nature and consequences of their health conditions and risk factors (clinical indicators), their clinical targets and the broad categories of actions they can take to address their health issues over time. Step 1 includes any assessment and education required to identify these clinical, lifestyle and treatment factors. This process identifies the broad lifestyle and treatment categories that the client needs to work on over time to optimise their health and quality of life outcomes. It equates to building an overarching plan for health change.
These broad lifestyle and treatment categories are associated with long-term aims. The range of health issues and actions discussed will depend upon the nature of the consultation, whether profession specific (e.g. physiotherapy, dietetics, occupational therapy), program or disease specific (e.g. diabetes management, cardiac or injury rehabilitation, healthy pregnancy) or of a more general nature that addresses a range of health conditions (e.g. general medical consultations, case coordination contexts).

Step 1 flows naturally into Step 2, choosing one or two broad lifestyle or treatment categories to work on first in the current consultation. This step helps clients to prioritise which broad lifestyle or treatment categories they will start working on, given the self-management actions that they are already taking. Usually there will be a number of these general areas that a client could address to benefit their health. Depending upon the client’s clinical indicators and lifestyle risk profile, the clinician or case manager’s role is to help the client to choose alternatives that will be of particular benefit to them as an individual. Step 2 balances a clinician’s duty of care with a client’s right to choose what actions they will or will not take.

Once a lifestyle or treatment category has been chosen to focus on in a consultation, in Step 3 the clinician checks the client’s readiness, importance, confidence and knowledge (RICk) in addressing it. The RICK principle is used as a guide for practitioners to do this. There are many formal and informal ways to check RICk levels, but a conversational approach is usually the most client friendly.

The main aim for the clinician is to ensure that the client is prepared to work on the chosen issue and that they perceive there will be personal benefits in doing so. Importance and readiness both need to be relatively high in order to proceed below the decision line. However, it is possible to proceed below the decision line if a client has low confidence in making sustainable changes. This is because the below the line techniques all aim to set appropriate and realistic personal goals for the client and to increase or reinforce the client’s confidence in taking action.

Step 4 prompts clinicians to make a decision. Is the client ready, willing and able and do they have the information and understanding required to take action? If the answer is yes, the clinician and client can proceed to Step 5 below the decision line. If no, the clinician may invite the client to revisit processes at Steps 1 and 2 to address knowledge deficits and/or choose a different category to work on. If unsure, the clinician may engage the client in decision-making processes to help them to make a decision one way or the other.
Below the line processes

Steps 5 to 10 of the HCA 10 step decision framework are called below the line processes. They facilitate idea generation, planning and problem-solving.

These processes assume that the client is moderate to high in readiness to engage in health behaviour change and that they believe there will be personal benefits to gain by taking action. If these criteria are not fulfilled it may be wise to keep working above the decision line.

Step 5 involves generating multiple options for pursuing a broad lifestyle or treatment category. This can be achieved in two ways: by the clinician conducting an assessment and presenting alternative treatment options to the client or by collaborative problem-solving. The purpose of this step is to generate several personal goal options or courses of action for the client to choose from and to use as back-up options and alternative choices in the future.

Step 5 leads into Step 6 where the client chooses one or more options that will suit them to pursue as short- to medium-term personal goal/s. The clinician’s task is to ask a series of questions to assist the client to formulate a very specific behaviour-based personal goal and tailor it to the needs and abilities of the client. This includes stating exactly what the client intends to do, how much, how often, when they will start and when they will review the goal, as relevant.

In Step 7 the clinician and client collaboratively construct an action plan that details the various actions that the client needs to take to achieve their personal goal. The action plan is created by listing tasks that need to be carried out prior to the client pursuing their goal and strategies required to address the client’s anticipated personal barriers to achieving the goal. An action plan can be a written document or simply a mental list of tasks to do.

Steps 8 to 10 help to identify additional barriers and strategies and ensure that the client’s goal/s and action plan/s are workable. In Step 8 the clinician assists the client to consider potential behavioural, emotional, situational or thinking (BEST) barriers to action. Through discussion and questioning, the clinician normalises the occurrence of these barriers and assists the client to generate strategies to overcome or deal with them. The clinician explains and offers behaviour modification, cognitive change and/or emotion-management strategies for the client to try as necessary. Any relevant strategies are added to the client’s action plan.

When an action plan seems complete, in Step 9 the clinician considers or checks the client’s RICk levels in relation to the personal goal, given the items already in the client’s action plan. In particular, confidence is used as a gauge for whether or not a personal goal and action plan are appropriate for a client. The goal and plan are adjusted as necessary to ensure that the client leaves the consultation with a reasonably high level of confidence that they can take the agreed actions.

If time and circumstances permit, multiple personal goals can be worked on in a single consultation.
In **Step 10**, the clinician arranges follow-up contact and/or other support as necessary for the client and encourages a *trial and error* approach to health behaviour change attempts. This step includes discussion of referral to other services, clinicians or sources of information or support as relevant.

### Conducting review consultations

In review consultations, the process starts with reviewing, reinforcing and troubleshooting the client’s behaviour change attempts planned in the previous consultation. The topic of discussion for the review consultation is then collaboratively agreed by deciding whether to continue to work on the same personal goal/s (because the previous plan needs adjustment), to add or change to a new personal goal, or to move on to the next priority lifestyle or treatment category. The rest of the 10 steps are then worked through as appropriate.

Actions taken, personal goal attainment and clinical indicators are all periodically reviewed to monitor the client’s overall progress and to adjust the client’s goals as required. Personal action plans are reworked over time as the client experiences barriers to taking action and possible solutions are generated to address these challenges.

**When a client repeatedly presents without having done what was previously discussed, ask yourself:**

‘Is the client above the line or below the line in relation to their motivation and confidence to take action?’

To find out, *ask RICK*, i.e. check the client’s readiness, importance, confidence and knowledge in relation to their planned actions.

### Conducting clinical assessment, treatment advice and education using the HCA approach

Using the HCA approach does not require clinicians to completely change what they do. Whatever their role is, that remains the same. Using this approach clinicians would still perform the same clinical tasks that they expect to now, such as conducting an assessment, providing treatment advice, providing education and/or referring clients to other services or clinicians. What might change is the way that they carry out their task/s.

The table at Appendix A on page 15 provides some tips for how to combine the HCA approach with formal or informal assessment, treatment advice and education. The sequence of tasks in the Appendix A table may represent a slight shift away from how many clinicians currently conduct their consultations. This format can help them to structure their consultations to be more client-centred and less likely to inadvertently overwhelm their clients. It can also help them to use their time more efficiently.
How to flexibly apply the HCA Model of Health Change

The HCA approach is not a formal program or set of procedures. Rather it is a flexible framework that guides clinicians in supporting health behaviour change in any clinical practice or health program context, including group education sessions. It is a skills-based approach that requires ongoing skills development and support from clinical systems and health managers in order for it to be successfully implemented and embedded into practice.

Whilst the HCA Model of Health Change gives clinicians guidance about what to do to support behaviour change in various situations and at various points in a consultation, the principles, techniques and phrasing described in this manual are meant to be used flexibly and adjusted to suit individual clients and situations. The 10 step decision framework is not a list of 10 commandments. It is designed to be used as a decision-making aid, not a set of protocols or instructions. Clinicians need to be flexible in how they apply the information contained in the Guide.

If a client is ready, willing and able to carry out the required actions to improve their health, then they may require little or no behaviour change assistance. For example, if a client says ‘it’s important for me to do this and I will do it without any problems’, then it would be unnecessary to ask a lot of detailed questions about what they need to do to achieve their health goals and how they could increase their confidence. Clinicians only need to ask probing questions and engage in more detailed health change techniques if they think that the client will directly benefit from this. Nonetheless, it is still important to check that the client has actually committed to taking action and is being realistic in their expectations. Asking RICk provides a simple way of doing this.

Some clients will be low or moderate in willingness (importance) and/or ability (confidence) to do what they have been advised to do by a clinician or case manager. These clients will need more in-depth behaviour change support to help them to initiate and sustain action and to problem-solve around the things that might get in the way of them achieving their health goals.

If a client advises that they do not want to follow lifestyle or treatment recommendations and they fully understand the consequences of their actions, then it is not usually the role of a clinician or case manager to try to force them to comply (unless they are a danger to themselves or others). In this case a non-judgemental acknowledgement of the decision combined with an ‘open door’ policy for future contact is usually the best approach.

Who should we spend behaviour change time on?

1. Clients who are clearly not interested in your advice? ✔️
2. Clients who are undecided (ambivalent) or could not be bothered? ☑️
3. Clients who are motivated but lack confidence? ✔️
4. Clients who are clearly motivated and confident? ☒️
Consultation length

A consultation using the HCA approach should not take any longer than a traditional clinical consultation. The approach represents a qualitative change in practice style, not a set of additional tasks. An initial consultation focusing on behaviour change for self-management support using all of the steps in the decision framework and working through barriers to action should usually take no more than 30 minutes. This timeframe includes collecting some assessment data and providing targeted health and behaviour change education. It does not include time taken to conduct lengthy formal clinical assessments, collect significant amounts of research data or provide large amounts of education. You would need to add more time to include these tasks, just as you would in a traditional consultation.

A review consultation typically takes between 10 and 30 minutes. If barriers to change need to be identified and addressed or new goals added, consultations will be closer to 30 minutes. If the client is going well and has no extra goals to pursue, the consultation may finish quite quickly (closer to 10-15 minutes).

When you first start using the HCA approach, it may take a little longer than these indicative timeframes to incorporate new techniques. Like any skill, it takes practise to refine your technique.

Short consultations:

The time that a clinician has to spend with a client will also dictate the extent to which the clinician is able to act as a change facilitator. For practitioners who have very short consultations, the HCA Model of Health Change gives guidance as to which process would be useful to focus on in order to move a client along in the health behaviour change pathway. Usually this will be the first three steps in the 10 step decision framework. Subsequent steps can be used in future consultations, or left for someone else to do, as appropriate. It is generally better to get clients firmly to the decision line, than for those clients to leave a consultation with a task list that they have no intention of acting on. Once a person is committed to taking action, the rest often falls naturally into place.

The 10 steps in the decision framework are deliberately sequential. They are presented in the order that they need to be considered when working with a client. The amount of time spent on each step depends on the individual client and their personal knowledge, strengths and barriers to taking action. The HCA approach provides a framework so clinicians can use their consultation time effectively and efficiently by combining the traditional clinical tasks of assessment, treatment recommendations and health education with health behaviour change support. See Appendix A on page 15 for more information about combining the HCA approach with these clinical tasks.
By integrating a behaviour change support role into their practice, clinicians can often reduce their consultation times and also reduce their ‘no show’ rates and the number of clients who return again and again without having taken any significant action or improved their health outcome measures. When this happens, it is usually because a solid health behaviour change foundation was not laid in earlier consultations. The client may still be above the decision line.

**Tip:**

If your consultations continue to take longer than 30 minutes to include behaviour change support (including some, but not extensive assessment and education), then it may be that you are slipping into counselling mode, providing too much education to the client, or allowing the client to go off track too much into unproductive ‘story telling’.

**Consultation frequency**

Many clinicians have roles that allow them to see a client only once. In this situation it is tempting to try to provide as much information as possible in as much detail as possible because the client only has one opportunity to see you. What will the client do with all that information? Sometimes they will walk out overwhelmed and take no action at all.

Consider whether it might be a better use of time to provide an overview of what the client needs to do over time and give detailed information only for the things that they need to do straight away. The HCA approach collaboratively prioritises tasks with clients so that they are not overwhelmed and are more likely to start taking action in the clinical priority areas in a sustainable way.

In situations where review consultations are possible, schedule them according to the client’s needs. If the client has low confidence and/or low self-esteem, if feasible schedule a review consultation no later than two weeks after the first consultation. In some cases a one week gap may be best initially (if resources and circumstances allow).

Generally, two or three weeks between the initial consultation and the review consultation is a good standard timeframe to use. Four weeks is usually the longest time to allow between consultations and still keep the client engaged and on track. You would set a four-week interval between the initial and first review consultation only if the client was very confident of achieving their personal goal/s. When in doubt, ask the client.
Write your own notes:
## Conducting Clinical Assessment, Treatment Advice and Education Using the HCA Approach

<table>
<thead>
<tr>
<th>Clinical tasks</th>
<th>HCA principles and processes to adapt clinical tasks</th>
</tr>
</thead>
</table>
| **1. Pre-assessment**<br>(Setting the scene) | • Explain your role (using the HCA approach)  
• *First ask, then offer* assessment (check RICk for assessment)  
• Decide how much assessment is really required to meet the client’s needs  
• Advise the client:  
  o the length and purpose of assessment  
  o what you will do with the information  
  o how it will benefit them  
  o how you will help them afterwards |
| **2. Assessment**<br>(Step 1 above the decision line) | • Normalise general human behaviour such as over-eating, under-exercising and not taking medications or monitoring symptoms in a consistent way  
• Ensure that the client is not made to feel inadequate or feel blamed for their actions  
• Refrain from providing advice during the assessment  
• Get a general macro overview of the client’s clinical issues and behaviours and analyse and summarise these before making suggestions about goals or actions |
| **3. Provide treatment recommendations and macro level education**<br>(Step 1 above the decision line) | • Outline and briefly explain relevant lifestyle, treatment and referral recommendations  
• Ensure that the client has a good understanding of all of the lifestyle and treatment categories in which they need to take action over time in order to attain the best health and quality of life outcomes  
• Explain the overall rationale for taking action in each of the categories over time and indicate how this might personally benefit the client  
• Normalise the need for all clients with certain conditions and risk factors to take action in all the discussed categories  
• Discuss and emphasise the one thing at a time, one step at a time, adding up over time and trial and error principles as a way to engage in sustainable behaviour change  
• Refrain from providing micro level advice until after the client has an understanding of the macro level issues and a category for action has been selected |
### Clinical tasks

<table>
<thead>
<tr>
<th>4. Prioritise lifestyle and treatment recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Steps 2, 3 and 4 above the decision line)</td>
</tr>
</tbody>
</table>

- Collaboratively prioritise lifestyle and treatment categories (including referral if relevant) according to the amount of benefit the client would gain from taking action in each broad category
- Use clinical judgement and acknowledge client choice
- Ask what the client is already doing to address lifestyle and treatment macro level recommendations
- If it is not already obvious, ask RICk for categories that you work on in a consultation with the client (including referral options)
- If a client is ambivalent about working on a clinical priority, use the decisional balance technique to increase importance before engaging in goal setting

<table>
<thead>
<tr>
<th>5. Provide targeted micro level education</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Step 5 below the decision line)</td>
</tr>
</tbody>
</table>

- Provide more detailed information, education and personalised discussion for the first category for client action (you can work on other categories in detail later in the consultation or in review consultations)
- Use the client first technique and provide specific menus of options (e.g. types of medications, dietary choices, exercise options, home modifications and aids)
- Invite the client to select the personal goal option/s that will work best for them
- Consider using HCA menus of options (goal hierarchies) available in the HCA online Resource Library or create your own menus of options in order to suggest relevant personal goal options (see Appendix J for an example)

<table>
<thead>
<tr>
<th>6. Engage the client in personal goal setting and action planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Steps 6-10 below the decision line)</td>
</tr>
</tbody>
</table>

- Assist the client to understand exactly what they need to do on a daily basis in order to achieve their specific personal goals and progress towards their overall aim of managing their condition, reducing their risk factors and/or having optimal quality of life over time
- Help the client to identify and problem-solve any anticipated barriers to action/achieving their personal goals
- Check RICk to ensure the client is confident that they will complete the tasks that you have agreed
- Discuss trial and error before the consultation concludes
- *Invite the client to write* any points that they wish to review or remember after the consultation
Section 2
Practice Principles
Practice Principles

Client Centred
Client Choice
Client Control

Four aspects of goal setting

First ask, then offer

WAIT til 8

Inviting the client to write

One thing at a time
One step at a time
Adding up over time

The RICk Principle

Call it as you see it

Trial & Error

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Section 2: Practice Principles

This section provides an overview of the nine practice principles that operationalise client-centred communication when using the HCA approach. The practice principles apply at any time in a conversation with a client and at any step of the 10 step decision framework. They act as prompts and tips for clinicians to maintain a client-centred practice style.

In this section:

1. The 3Cs: client centred, client choice and client control
2. Call it as you see it (or hear it)
3. Four aspects of goal setting
4. One thing at a time, one step at a time, adding up over time
5. The RICK principle
6. First ask, then offer
7. WAIT til 8
8. Invite the client to write
9. Trial and error
Section 3

Essential Techniques
Section 3: Essential Techniques

This section provides descriptions and brief instructions for using seven essential behaviour change support techniques in conjunction with the HCA approach. The first three techniques can be used in any interaction with a client in order to request and provide information in a client-centred way and to gauge associated readiness, importance and confidence to take action. The remaining four techniques are for optional use to identify and address particular types of barriers to change.

All of the techniques can be used in a very brief manner and some can also be formally applied in a more systematic and detailed way, if time allows and circumstances require it. All of these techniques need to be applied in a client-centred manner.

Consider the extent to which any lines of questioning or specific phrasing are suitable for the person you are working with. Vary the techniques and language to suit the client and the circumstances. The sample phrasing examples used in this section and throughout the Guide are meant to be used as examples to teach the concepts, not to be used verbatim in consultations.

In this section:

1. Client first technique
2. Menu of options technique
3. Using your RICk radar
4. Asking RICk
5. Decisional balance
6. Turning ANNTs into PETs
7. Tracking and monitoring

Appendices:

B: Prompts for Decisional Balance
C: Sample Script for Decisional Balance
D: Prompts for Turning ANNTs into PETs
Section 4

Setting the Scene for Health Change
Setting the Scene for Health Change

- Explaining your role
- Setting up for face-to-face consultations
- Setting up for telephone consultations
- Documenting behaviour change
- Inviting the client to write
- Reporting & sharing information
Section 4: Setting the Scene for Health Change

This section contains suggestions about setting up your consultation environment and systems to be consistent with the HCA approach. It contains sub-sections on setting up face-to-face and telephone consultation environments, explaining your role to clients and inviting clients to take notes during consultations as well as documenting and reporting on health behaviour change processes.

In this section:

1. Explaining your role
2. Setting up a face-to-face consultation environment
3. Setting up a telephone consultation environment
4. Documenting health behaviour change information during consultations
5. Inviting the client to write during consultations
6. Reporting and sharing health behaviour change information with other clinicians

Appendices:

E: HCA Consultation Record
F: HCA Review Consultation Record
G: Sample Letter to Referring Clinician
Section 5
Above the Line Processes
HCA 10 Step Decision Framework
Above the Line Processes

Set the Scene & Explain Your Role

① Identify Clinical Issues & Broad Lifestyle & Treatment Categories

② Prioritise & Choose a Category to Work on

③ Ask RICk ®  ④ Make a Decision

Build Motivation

* Ask RICk is a registered trademark of HCA

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Section 5: Above the Line Processes

Steps 1 to 4 of the HCA 10 step decision framework are called *above the line* processes. They make no assumptions about the readiness of the client to engage in health behaviour change.

The *above the line* processes can proceed quite quickly. This is particularly so if a client meets all of the following criteria:

1. they already understand their health issues
2. they know and understand the lifestyle and treatment recommendations
3. they are ready to take action
4. they believe that it is personally important to do so

However, if a client does not meet these criteria, then the clinician is advised *not* to proceed below the decision line into action-oriented goal setting and planning processes. Instead, they would be encouraged to engage the client in processes aimed at building health knowledge and understanding as well as motivation and commitment to take action. The *above the line* steps are explained in detail in this section.

In this section:

Step 1: Identify clinical issues and broad lifestyle and treatment categories
Step 2: Prioritise and choose a category to work on
Step 3: Ask RICk
Step 4: Make a decision
Using a Personal Self-management Plan to bring together Steps 1-4

Appendices:

H: Sample Script for Steps 1-3
I: HCA Personal Self-management Plan
Section 6

Below the Line Processes
HCA 10 Step Decision Framework
Below the Line Processes

Decision Line
Ready to Take Action

- Generate Personal Goal Options
  - Choose & Refine an Option
  - Create an Action Plan
  - Identify & Address Barriers
  - Ask RICk ©
  - Consider Review & Referral

Build Confidence

* Ask RICk is a registered trademark of HCA
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Section 6: Below the Line Processes

Steps 5 to 10 of the HCA 10 step decision framework are called *below the line* processes. These processes assume that the client is moderate to high in readiness to engage in health behaviour change and that they believe there will be personal benefits to gain by taking action. If these criteria are not fulfilled, it may be wise to keep working above the decision line. The *below the line* steps are explained in detail in this section.

**In this section:**

- Step 5: Generate personal goal options
- Step 6: Choose and refine an option
- Step 7: Create an action plan
- Step 8: Identify and address barriers
- Step 9: Ask RICK
- Step 10: Consider review and referral
- Conducting review consultations

**Appendices:**

- J: HCA Menu of Options for Reducing Risk of Cardiovascular Disease and Diabetes
- K: HCA Personal Goal and Action Plan
### Key questions above and below the decision line

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</tr>
<tr>
<td>Why should I do this?</td>
<td>Have they been assisted to collaboratively prioritise these?</td>
</tr>
<tr>
<td>Do I want to do this?</td>
<td>Are they ready, willing, able and committed to taking action?</td>
</tr>
</tbody>
</table>

#### Decision Line

**Ready to Take Action**

<table>
<thead>
<tr>
<th>What could I do?</th>
<th>What options do they have for taking action in a particular category?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What exactly will I do?</td>
<td>What is their personal goal and plan?</td>
</tr>
<tr>
<td>What might get in the way and what can I do about that?</td>
<td>Are they confident they can do this and what might get in the way?</td>
</tr>
<tr>
<td>What support do I need?</td>
<td>Will I review the client and what other support do they need?</td>
</tr>
</tbody>
</table>

**Build Motivation**

**Build Confidence**