Motivational Interviewing

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Xarelto® (rivaroxaban) prescribing information and adverse event reporting can be found on the last page of the workbook.

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Welcome to the course!

The overall aim of the course is to help you to improve at using motivational interviewing in brief conversations with patients about behaviour change.

The course is:

- Modular and multi-media
- Based on motivational interviewing and behavioural science
- Skills-based with encouragement to practice between modules
- Contains demonstrations and tip sheets
- Provides links to additional resources
- Supports implementation of NICE guidelines

THE COURSE IS DIVIDED INTO FOUR MODULES

Module 1 Motivational Interviewing (MI): Introduction to the course

The aim of this module is to help you develop your confidence and skills in:

- Raising the topic of change in a non-threatening way
- Checking what the patient already knows
- Sharing information in a person-centred way

The topics we cover include:

- Motivational interviewing
- Ambivalence and readiness to change
- Open questions
- How to raise the subject of change without triggering defensiveness
- Using the Ask-Share-Ask strategy

Module 2 is called MI Evoking and Strengthening

The aim of this module is to develop your confidence and skills in:

- Evoking and developing arguments in favour of change from the patient
- Strengthening confidence about change

The topics we explore in the module include:

- Noticing and strengthening 'Change Talk'
- Tools for building importance and confidence
- Making affirmations and reflections

Module 3 is called MI Deciding and Planning

The aim of this module is to develop your confidence and skills in:

- Making the transition in the conversation from evoking to planning
- Developing collaborative, person-centred change plans

The topics include:

- Summarising
- Asking the key question
- Using open questions to strengthen commitment
- Relapse prevention and implementation intentions

Module 4 is called MI Integrating and Improving

The aim of this module is to develop your confidence and skills in:

- Using brief interventions in daily practice, for a range of issues and conditions
- Getting better at brief interventions over time

The topics include:

- When to offer brief interventions
- Brief interventions and weight management, CVD risk reduction and medication taking
- Tailoring the conversation to the person's level of readiness to change
- Getting better at brief interventions over time

Motivational Interviewing:

Module 1

Introduction to the course

Module 1

What is Motivational Interviewing?

A collaborative, goal-oriented style of communication that pays particular attention to the language of change. The goal is to strengthen a patient's motivation, confidence and commitment to change. This is done with acceptance and compassion.

The spirit of the approach is a PEACEful one:

Partnership: This is something you do with someone, not to them. It is collaborative, seeking to reduce hierarchy or status differences. Imagine there being 'two experts in the room'.

Empathy: You are very much trying to see the world from the other person's perspective and communicating this attempt at understanding them.

Acceptance: You accept that they are the decision maker, they have autonomy, and they don't have to do what's best (in your view) for their health.

Compassion: The focus is on the prevention of current and future suffering.

Evoking: You very much want to 'draw things out' of the patient. MI is optimistic and solution-focused. It assumes people are not broken and in need of fixing, but are rather stuck. They probably have all the resources within them to move forward. Your job is to discover and strengthen those resources in partnership with them!

MI is also a GUIDING STYLE. Of course, there are times when, as a clinician, you need to tell and instruct a person what to do — e.g., during an examination, or when teaching good inhaler technique. However, MI is much more about guiding and coaching — and moving into and back from other styles as the context or need dictates (which is another important skill).

The principles of the approach include:

Resist the righting reflex. This is your desire to fix things. There is nothing wrong with the righting reflex, after all, you want things to get better for the person. However, when it comes to behaviour change, jumping in and trying to fix a person, or jumping in with unasked for advice, can sometimes get in the way.

Understand and explore their motivations for change. It doesn't matter how many reasons you have for a person to change — what matters is how many reasons they have. So be curious. Ask open questions. Let the person talk themselves into changing.

Listen with empathy. Spend time listening to understand, not to respond. Really try to imagine what it might be like to be that person. Try to see the world from their perspective.

Empower the person, encouraging optimism and hope that things can improve. This will help them make changes that will lead to improvement.

Support effort and self-efficacy. They need to have the confidence that they could change, if they chose to.

Avoiding arguing, as this can damage the relationship and reduce the probability of self-directed change.

Develop discrepancy. This is the sense of a mismatch between where the person is and where they wish to be or their current behaviour and their values. These may be the engine for behaviour change.

And also…

Roll with resistance. As and when you notice any resistance, try to 'roll with it' like a boxer rolling with a punch, perhaps with empathic listening.

CONTENTS

Module 1

What is Motivational Interviewing?

The four processes of MI are:

Engaging: You are always working on developing and maintaining patient engagement in the conversation. Ask relevant open questions. Get the person talking. Use empathic listening. Let them choose what to talk about (for at least some of the time!). Be attentive to signs of reduced engagement and make corrections.

Focusing: These conversations are about something, they have a focus. If you are being patient-focused then they should choose the focus, but there are still things you may wish to talk about. So, agree an agenda. Ask permission to talk about a topic. Sometimes you will need to refocus the conversation back onto what you wanted to talk about. Sometimes the conversation changes focus over time.

Evoking: Seek to draw things out of the patient, with open or socratic questions.

Planning: If the patient decides to change, then it is time to transition to planning. However don't rush into planning. Try to stay in evoke mode, drawing ideas about how to change, when, how much, and with what kind of help, from the person.

Core Skills — using your OARS (open questions, affirmations, reflections and summaries)

In motivational interviewing, we refer to using your OARS: open questions, affirmations, reflections and summaries. We will be exploring these in more detail as the course progresses. Let's look at open questions.

Open questions, as you know, tend to be hard to answer with one word. They increase the chance that a person may start talking and thinking, which is what we want in conversation-based behaviour change. MI makes a lot of use of open questions, and several of the tools and strategies we share on this course start with an open question.

Here are some examples of open questions you might use in conversations about behaviour change:

- 'Where should we focus our conversation today, to make it as helpful as possible for you?'
- 'What do you know about some of the benefits of regular physical activity?'
- 'How important is it for you to do something about your smoking?'
- 'What are your three best reasons for changing?'
- 'What are your thoughts about drinking less?'
- 'What are your thoughts about…?'
- 'What are your concerns about your treatment?'
- 'How might you best go about that?'
- 'What would that be like for you?'
- 'How can we best help and support you?'

Ambivalence

Ambivalence is a core concept in MI and behaviour change. It is the state of being in two minds about something; of both wanting and not wanting something at the same time, for instance, to drink less, change job, become more active and take medication regularly.

It is normal, natural, non-pathological and very common. We are all ambivalent about something!

This helps us see that our patients are perhaps 'stuck' and that our job may be to help them to explore their ambivalence, think things through for themselves and decide what is best for them. It can also help us see that when we 'push' people to change, they sometimes 'push back' by coming up with the reasons they have not to change.

Module 1

What is Motivational Interviewing?

The Ask Share Ask technique

Often in healthcare we can fall into the 'yes, but…' trap. For instance, you say 'could you do this...?' they say 'yes, but...' you say 'what about this..?' they say 'yes, but…'

For this reason, and others, it is often better to ask what the patient already knows about a topic, or their thoughts about an issue, before you jump in and share your knowledge, ideas and suggestions. A further advantage of using this strategy is you get to learn about any unhelpful or incorrect beliefs that the patient may hold at an early point in your conversation with them.

You can find more detail about the ask-share-ask technique in the appendix.

Readiness to change

People vary in their readiness to change, in their motivation to change. In MI, we are conversing with people in a way that seeks to help strengthen their readiness. We explore this in more detail in future modules, but simply put, people are more likely to change when:

A. It is important for them to change and they have good reasons to change
B. They believe that they can change (self-efficacy)

So, a lot of what we will be doing in this course is exploring how to discover and strengthen a person's own reasons for change, whilst also strengthening their confidence that they can change.

THE ASK-SHARE-ASK TECHNIQUE

Suggested tasks for the week

- Use the Ask-Share-Ask technique at least 5 times during the week, to help you understand what a patient already knows about a topic before you start sharing information (if you need to)
- Ask some different open questions than the ones you are used to, and notice what happens

My Personal Plan for getting better at MI skills for behaviour change

What are my 3 best reasons for getting better at MI and brief interventions?

What 2—3 things will I do to ensure that I get the most from this course?

This week's recommended tasks for getting better at brief conversations around behaviour change, are to ask different open questions to the ones you are used to, and to use the Ask-Share-Ask strategy at least 5 times. Answering the following questions will help you do this:

When will I do these 2 tasks or activities? Please be specific, for example, during particular clinics or sessions, or with particular patients, etc.

Do I need to practice or prepare before I use the approach with patients? For example, with a colleague, just practising saying things out loud, having some notes to remind me, etc. If so, what will I do to practise or prepare?

What do I predict might happen if I ask different open questions from the ones I typically ask, and use the Ask-Share-Ask technique several times this week?

Motivational Interviewing:

Module 2

MI Evoking and Strengthening

Module 2

MI Evoking and Strengthening

CONTENTS

The aim of this module is to develop your confidence and skills in:

- Evoking and developing arguments in favour of change from the patient
- Strengthening confidence about change

And the topics we explore include:

- Noticing and strengthening 'Change Talk'
- Tools for building importance and confidence
- Making affirmations and reflections

Change Talk

As you know, MI is a person-centred, collaborative conversational style to help people change by exploring and helping to resolve their ambivalence (or mixed feelings) about change. It is an approach that pays particular attention to language.

Early on in the development of the MI approach and whilst working in drug and alcohol settings, Bill Miller (clinical psychologist and co-creator of MI) noticed that if you created the right conditions in the relationship (including non-judgement, warmth and empathy) many people started to come out with what he called 'self-motivating statements'.[1] These were their own arguments in favour of change. However, if you started to argue with people, tried to persuade them to change, confronted them or tried to shame them, then these 'self-motivating' statements were much less likely to occur.

We now call these clients' utterances 'Change Talk' and in MI we try to:

1. Evoke it, bring it out of the client
2. Notice it when it happens
3. Strengthen or develop it if we notice it

Types of Change Talk

The different types of Change Talk can be remembered by the acronym DARN-CATS.

Desire language, such as:	I want to… I prefer… I wish...
Ability language, such as:	I could… I can… I have… I know how to...
Reasons, such as:	It would help me to… It would stop...
Need:	I must… I need to… I really ought to… I've got to…
Commitment language:	I will… I am going to… I definitely will...
Activation:	I am ready to… …I am confident that I can… It's time to…
Taking steps:	I have already started…

How to elicit Change Talk from your patient

Perhaps the two most important things are to:

1. Create the right conditions by paying attention to such relationship factors as non-judgement, acceptance, alliance, trust, warmth and empathy. This will give people the freedom to talk about their thoughts and feelings about change without worrying too much about your reaction.
2. Ask skilful open questions, such as:

   How important is it for you to perhaps do something about [your drinking]?

   What are your 2—3 best reasons for [becoming more active]?

   What are your concerns about [your current stress levels]?

   If you decided to [lose weight], how might you get started?

Ref 1: Miller, W.R. & Rollnick, S. (2013) Motivational Interviewing: Helping people to change (3rd Edition). Guilford Press.

Module 2

MI Evoking and Strengthening

CONTENTS

How to strengthen Change Talk when you hear it

To strengthen Change Talk, consider using your EARS:

- Elaboration: Ask the patient open questions. For example, if they said they used to enjoy walking, ask 'where did you used to go?'. If they mention that they have tried to stop smoking in the past, ask 'how did you go about it?' and/or 'what might you do differently this time?'.
- Affirmations: Notice and comment on something that is right with them. For example, 'you're pretty motivated', 'your health is important to you', 'looking after your family means a lot to you' (see section on affirmations later).
- Reflect it back: Use an empathic listening statement, for example, (depending on what they said) 'you're worried things might get worse if you don't change', 'you've done it before and you think you could do it again', 'you would get a sense of achievement'.
- Summarise: Make sure you include any Change Talk you hear in any summary you might offer later in the conversation, perhaps before asking the key question… 'So, what's next for you?'.

3 strategies for eliciting Change Talk

1. The importance-scaling question
2. The confidence-scaling question
3. Exploring two possible futures

Offering Affirmations

It is not uncommon for patients to sometimes feel judged or criticised, if not by you, then by others, or even themselves.

Affirmations are statements by you about what is right with them, rather than what is wrong with them. They tend to be short, genuine and different from general praise ('well done', 'that's great') or compliments, in that they 'point' to something specific about the person.

This might be:

Values — what matters to them

Any achievement or success, however small

Strengths — what is right with them

The effort they are making, with or without success

Affirmations might sound like:

'You're the kind of person who cares a lot for other people…'

'You're someone who can stop smoking — you managed to quit for 3 weeks'

'You didn't want to come today, but you did anyway. I appreciate the effort that took'

'You're really trying with your weight, even though you find it a struggle'

'Being the best mum you can be is really important to you'

'Managing your diabetes well is something you're really trying to do'

Module 2

MI Evoking and Strengthening

Reflections

Remember those OARS — Open Questions, Affirmations, Reflections and Summaries?

Well, it's time for the R

Reflections are statements we make after someone has said something, to help them feel listened to. Reflections are also known as reflective listening, active listening and empathic listening.

Reflective listening is a very active process — you need to pay close attention to what the person is saying and try to imagine how they might be feeling and what they are meaning. In a way, you are making a guess about their inner state and what is going on inside them. When you reflect back to the person with something they said it can help the other person understand themselves better, whilst also encouraging them to keep talking. Like all skills, reflective listening requires practice, discipline and will improve with experience.

There are different types of reflective listening, which include:

> Repeating, where you just repeat an element of what they have said.

> Rephrasing, where you slightly rephrase what they said, changing one or two words.

> Paraphrasing, which involves a more major rephrasing. You infer meaning and reflect back with new words. You add to and extend what was actually said.

> Reflection of feeling, where you paraphrase back and emphasise the emotional dimension of what they have said or seem to be experiencing. This might also involve you using a metaphor, e.g., 'you feel pulled in different directions,' or 'this would be a massive weight off your chest'.

Useful Reflection or Affirmation Starters

Here are some phrases you might experiment with, to help you get started with a reflection or affirmation. Remember, you are not trying to question or gather facts from the person, but communicating your attempt to understand them.

It's important to you that…

You really care about…

You're hoping…

You want…/want to…

You need…

You're realising…

You're finding…

You're learning that…

It feels like…

It seems like…

You've been really thinking about…

You've put a lot of thought into…

You're the kind of person who… [often affirming a character trait]

And that shows a lot of… [often affirming a character trait]

On the one hand…on the other… [end with Change Talk]

In some ways…in other ways… [end with Change Talk]

Part of you realises that…

You're tired of the same thing…

You really want to make a change…

You're willing to really work on…

Module 2

MI Evoking and Strengthening

Five recommendations for empathic listening

1. Make efforts to understand people's experiences and to demonstrate this understanding.
2. Do not parrot their words back or reflect only the content of those words.
3. Use different forms of empathic responses, including:
   > straightforward responses conveying understanding of their experience
   > responses that validate their perspective
   > responses that try to bring their experience to life using evocative language
   > responses that aim at what is implicit but not yet expressed in words.
4. Do not assume:
   > they are mind readers
   > that your experience of understanding them will be matched by them feeling understood.
5. Offer empathy for the other person.

Suggested tasks for the week

You may already be doing this, but if you aren't, consider:

1. Each day, try to offer 3—4 patients an affirmation.
2. Each day, try to offer patients 2—3 reflective listening statements — to help them feel understood and heard.
3. Use the importance-scaling question 4—5 times during the week — to draw out from the person their reasons for change.
4. Use the confidence-scaling question 4—5 times during the week — to evoke from the person their ideas about why they think they could change and how to become more confident.
5. Use the 2 possible futures question 4—5 times during the week — to help the person become more aware of the personal implications of changing versus not changing.
6. If you hear Change Talk coming from patients, try to develop it further by using your E.A.R.S. — asking for elaboration, making an affirmation, reflecting it back, and incorporating it into a summary.

Module 2 skills development plan

What are my 3 best reasons for getting better at eliciting, noticing and strengthening Change Talk, offering affirmations and developing my empathic listening skills?

When exactly will I practice the following skills? (Please be specific, for example, particular clinics or sessions, or with particular patients, etc.)

The importance-scaling question	
The confidence-scaling question	
The two possible futures exercise	
Offering affirmations	
Using more reflective listening statements	

Module 2

MI Evoking and Strengthening

Do I need to practise or prepare before I use the approach with patients? For example, with a colleague, just practising saying things out loud, having some notes to remind me, etc. If so, what will I do to practise or prepare?

What do I predict might happen if I practise these tools and techniques 5 or more times this week?

NOTES

Motivational Interviewing:

Module 3

MI Deciding and Planning

Module 3

MI Deciding and Planning

CONTENTS

The aim of this module is to develop your confidence and skills in:

- Making the transition from evoking to planning
- Developing collaborative, person-centred change plans

And the topics we explore include:

- Shared Decision Making
- Summarising
- The key question
- Open questions to strengthen commitment
- Relapse prevention
- Implementation intentions

Shared Decision Making

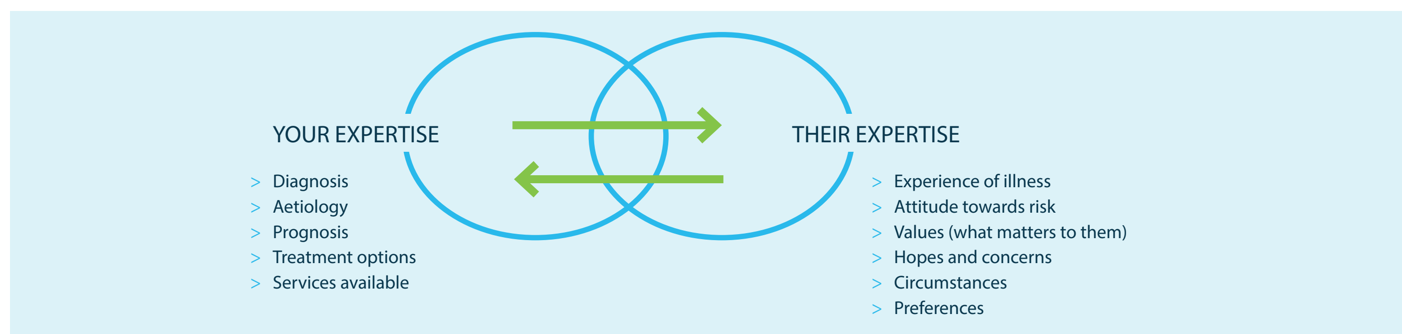
One definition of shared decision making is:

> A process in which clinicians and patients work together to choose tests, treatments, management, or support packages based on clinical evidence and patients' informed preferences.

Angela Coulter and Alf Collins.
Making shared decision making a reality
The King's Fund

One helpful way of thinking about shared decision making is that there are two experts in the room — each with their own area of expertise:

Fig.1. Two Experts in The Room



One thing MI enables and supports is shared decision making. Shared decision making could also be regarded as patient decision making, as they are the ones deciding whether or not to change, with your coaching and support.

Summarising

Summaries involve you saying back to the person some of the things that they have said.

You can use one summary at the start of the session if you have seen the person before, for example:
"Last time we met, we spoke about X and Y. You said you were going to A and B, and I said I would look into P and Q."

You can use a summary to:

- Help to structure the session
- Help people to feel listened to, heard and understood
- Illustrate progress

Consider using them periodically to:

- Check understanding
- Change direction
- Link together the main points
- Lead into the key question "so…what's next for you?"

Module 3

MI Deciding and Planning

Summarising continued

Perhaps ask permission to summarise before you do it. For example, 'Would it be ok if I summarise to check I have understood everything?'

Depending on what the person has said, a summary might sound something like:

'So, to summarise…'

'Your main concerns are about losing your independence…'

'And you've noticed you've also lost some confidence…'

'We have talked about ways of staying independent and becoming more confident, and you felt getting out of the house each day, for instance walking in the park with a friend, would be a good first step'

'You also felt it might be good to talk with your son about your worries'

Transition to Planning

As you may recall, the 4 processes in MI are engaging, focusing, evoking and planning.

Typically, planning for change takes place towards the end of the conversation, once you have established empathy and rapport. It usually occurs once the person has talked about change in a particular area (diet, smoking, weight loss, medication taking, etc) and you have evoked or drawn out from them some Change Talk — their reasons for change, concerns about the status quo, ideas for moving forward, etc.

Signs that it may be time to transition into the planning phase of the conversation include:

There is less 'sustain talk' — arguments in favour of staying the same, reasons why they can't change.
There is increased Change Talk — the person talking about reasons for changing, thoughts about how to change.
There may be questions about change — 'how should I ….' 'how often do I need to…'
They may start envisioning what it would be like after any change
You may hear 'commitment language' or resolve — 'I'm ready to…'
You may hear the TS of DARN-CATS: Taking steps — 'I've already done X and Y'

The key question

The 'key question' is an open question you ask to discover what the person is going to do. It can be helpful to ask the person the key question after a summary, when you have summarised back to them their personal reasons for changing. The question can take several forms:

> So, what's next for you?
> What do you think you will do?
> Where do you go from here?
> What do you think the next step is?
> What, if anything, will you do now?
> What do you think your options are from here?
> If you have decided now is the right time for change, how might you go about getting started?
> What small thing might you be able to do this week?

So, for example, and depending on what has previously been said, asking the key question might go something like this:

'So, can I summarise? Your main concerns are about losing your independence… and you've noticed you've also lost some confidence… We talked about ways of staying independent and becoming more confident, and you felt like getting out of the house each day, for instance walking in the park with a friend, would be a good first step. You also felt it might be good to talk with your son about your worries… So Mary, what do you think you will do?'

Module 3

MI Deciding and Planning

Strengthening Commitment

Once a person has decided to make a behaviour change, then it may be time to gently draw a plan from them. Try to develop a plan with them rather than adopting the expert role and developing a plan for them.

These open questions can help:

'When will you get started?'

'What's the first thing you might do?'

'How will you judge if you are being successful?'

'Where would you like to be in, say, 4—5 weeks?'

'How long do you think it might be before you notice any changes?'

'What do you think you will notice first?'

'Who can help you be successful?'

'What help do you want from them?'

Relapse Prevention

As you well know, failure or relapse back to an earlier stage of change are very common outcomes for patients after attempting to change.

Having the person think about the obstacles they may face and how they will manage these obstacles can be very helpful (a.k.a. anticipatory coping).

Once you have drawn out a plan for change from the person, perhaps using some of the questions above, consider asking:

'I'm wondering, what might get in the way of your plan?'

'How might you find a way around that if that happened?'

'Is there anything else which might get in the way of your plan?'

'What could you do if that happened?'

This can help the person generate what are known as implementation intentions. They are statements of the form 'if such and such happens, then I will do x'. For instance:

"If I am with people and they encourage me to drink, I will politely tell them I'm ok thanks, and if they persist, I will ask them to please stop asking me."

"If I notice I want to eat because I am getting bored, I will get up and go for a short walk, or start reading a book, or call a friend."

Generating a personal change plan

In busy clinical settings you may not have time to do this, but it can be helpful for some people to have these questions written down for them or a personal change plan to fill in at home. The headings in the plan might include:

- The changes I am planning to make are…
- The reasons I am planning to make these changes are…
- I will know I've been successful when …
- People who can help me include…
- And what I want from them is…
- Things that might get in the way of my plan include…
- What I will do if this happens is…
- I will review my plan on…

Module 3

MI Deciding and Planning

CONTENTS

Suggested tasks for the week

1. Continue to use some of the tools and strategies from previous modules, such as importance and confidence-scaling and two possible futures.
2. Continue to offer patients empathic reflections, summaries and occasional affirmations.
3. Offer 4—5 patients a week a summary of any conversation about change and then ask them the key question: 'So, what do you think you will do?'
4. Try to draw out a personalised plan from 4—5 patients each week.
5. Don't forget to ask them the questions:

   'What might get in the way of your plan?'

   'How will you find a way around that?'
6. Ask some patients if they would like to complete and take away a personalised change plan worksheet.

Module 3 skills development plan

What are my 3 best reasons for getting better at summarising back Change Talk, asking the key question, and then drawing out a person-centred plan from the patient?

When exactly will I practice the following skills? (Please be specific, for example, particular clinics or sessions, or with particular patients, etc.)

Summarising Change Talk followed by the key question.

Using open questions to draw up a person-centred plan.

Do I need to practise or prepare before I use the approach with patients? For example, with a colleague, just practising saying things out loud, having some notes to remind me, etc. If so, what will I do to practise or prepare?

What do I predict might happen if I practise these tools and techniques 5 or more times this week?

CONTENTS

Motivational Interviewing:

Module 4

MI Integrating and Improving

Module 4

MI Integrating and Improving

The aim of this module is to develop your confidence and skills in:

- Using brief interventions in daily practice
- A range of issues and conditions

And the topics we explore include:

- Resistance — and how to reduce it
- What are brief interventions?
- When to offer brief interventions
- Examples of brief interventions
- Tailoring your approach to the patient's level of readiness
- Getting better at brief interventions over time

Resistance

The MI view of 'resistance' to change is that it:

> Emerges from the interaction
> Goes up and down
> Is influenced by your behaviour
> Is commonly strengthened by confrontation

If you wish to increase the amount of resistance to change you experience each day, then consider:

> Telling people what to do
> Jumping in with unasked-for advice
> Overestimating a person's readiness to change
> Taking away control
> Confronting force with force

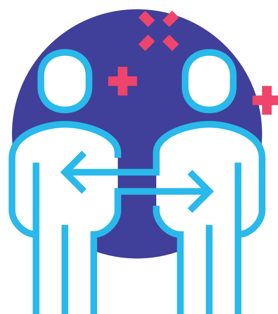
To reduce the amount of resistance you experience, consider:

> Using lots of empathic listening
> Emphasising personal choice and autonomy — that it's their decision
> Asking permission to talk about something or share advice
> Avoiding arguing

It can also be helpful to break down resistance into two different categories:

Sustain talk: This is about behaviour. It may involve the person talking about the reasons they want to stay as they are, or don't feel they can change. This is just a manifestation of their ambivalence or low confidence about change and is normal. Empathise with them.

Discord: This is about the relationship. It may involve the person expressing frustration with the service — 'you are always late, I've been waiting over an hour' — or perhaps something you said — for example, 'you have no idea what it's like' or 'it's none of your business whether or not I get vaccinated'. Again, empathic listening may be best, or even apologising.



Module 4

MI Integrating and Improving

CONTENTS

Brief interventions

This course is all about helping you become more skilled and confident in delivering brief interventions. So, what are brief interventions?

Brief interventions are time-limited conversations with patients which may involve discussion, negotiation and encouragement. They may be accompanied by written or other support or follow-up. They may also involve a referral for further interventions, directing people to other options and/or more intensive support. They are often carried out when the opportunity arises and typically take no more than a few minutes.

Adapted from: NICE Guidance PH49. Behaviour change: individual approaches. Available at: https://www.nice.org.uk/guidance/ph49. Accessed October 2023

Very brief interventions might take from 30 seconds to a couple of minutes and mainly involve giving people information or directing them where to go for further help. However, they might also involve raising awareness of risks and providing encouragement and support for change.

Extended brief interventions are similar in content to a brief intervention, but usually last about 20—30 minutes and consist of an individually-focused discussion which may involve a single session or multiple brief sessions.

When might you deliver a brief intervention?

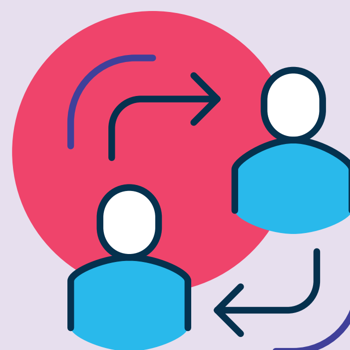
There will be many times when you are already, or might consider, delivering brief interventions, including:

- When initiating a new medication
- When you think the person might benefit from behaviour change
- After sharing results of a test or screening for example, adult health check, blood results, etc
- After diagnosing a condition for example, high blood pressure, angina, diabetes
- When a topic comes up spontaneously for example, weight, diet, medication-taking, stress
- When you pick up on an unhealthy trend for example, weight gain
- When seeing a patient after discharge from hospital for a condition with a behavioural component

Ten tips for delivering brief interventions

MI is a conversational style and mindset ideally suited to help you deliver more and better brief interventions. Here are 10 top tips:

1. Be empathic and collaborative
2. Ask open-ended questions to draw things out from them
3. Find out what they know or think first
4. Share information in a non-judgemental way
5. Avoid jumping in with unasked for advice or lecturing
6. Always remember — they are the decision maker, not you
7. Avoid arguing and roll with any resistance
8. Don't expect them to change
9. Don't assume readiness or try to rush them into planning
10. Try to elicit Change Talk, and develop it further if you hear it



Module 4

MI Integrating and Improving

Here are some specific tips for offering brief interventions in specific areas:

Tips for brief interventions for reducing cardiovascular risk

NICE guidance recommends the following approach:

1. Adopt a systematic strategy to identify patients likely to be at high risk
2. Follow NICE guidance on risk assessment tools
3. Use everyday, jargon-free language
4. Find out what, if anything, they have already been told about their CVD risk, and how they feel about it
5. Explore their beliefs about what determines their future health
6. Assess their readiness to make a change to their lifestyle, undergo investigations or take medication to lower their risk
7. Assess their confidence in making any of the above changes
8. Involve them in developing a shared plan

Adapted from NICE guidance CG181: Cardiovascular disease: risk assessment and reduction, including lipid modification. Available at: https://www.nice.org.uk/guidance/cg181. Accessed October 2023

Please refer to the NICE guidelines for additional information

Using the Ask-Share-Ask approach to get started

Ask Do you know what can influence your risk of developing heart disease or having a stroke?

[listen]

Ask May I tell you about some [other] risk factors?

Share: Some of the most important risk factors are:

- > Smoking
- > Blood pressure
- > Diet
- > Weight
- > Physical activity levels
- > Blood cholesterol levels
- > Drinking habits

Ask: What do you make of what I've just said?

Depending on what they say, and the time you have available, consider using one or more of the strategies shared in previous modules, for example, scaling questions, two possible futures, etc. Or ask open questions like:

'How important is it for you to reduce your risk of CVD?'

'What are your 2—3 main reasons?'

'If you decided to try to reduce your risk, which area do you think you would look at changing first?'

'How confident are you that you could make helpful changes and keep them up?'

'How would you get started?'

Module 4

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CONTENTS

Tips for brief interventions to improve medication taking

1. Be patient-centred and non-judgemental
2. Adopt a no-blame, frank and open approach, making it easy for the patient to report non-adherence
3. Understand if any non-adherence is intentional or unintentional
4. Tailor the conversation according to type of non-adherence
5. Encourage the patient to explore their doubts and concerns about the medication
6. Ask what they know, believe or understand about the medication and their need
7. Share information about the aims of the treatment
8. Offer them information relevant to their condition
9. Make information accessible — using pictures, large print, right language, etc
10. Share with them things you can do to help them, for example, changing medication, dosage, packaging, systems
11. Share with them things that help other patients remember to take their medication
12. Ask if there is anything else they need to know

Adapted from: NICE CG76: Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Available at: https://www.nice.org.uk/guidance/cg76. Accessed October 2023

Please refer to the NICE guidelines for additional information

Using the Ask-Share-Ask approach to get started

Ask What do you know about how this medication helps people?

[listen]

Ask May I tell you a little bit more?

Share: One of the most important things this medication does is X, and as a result, people are much less likely to experience or develop Y.

Ask: What do you make of what I've just said?

Depending on what they say, and the time you have available, consider using one or more of the strategies shared in previous modules, for example, scaling questions, two possible futures, etc. Or ask open questions like:

'What concerns do you have about continuing to take this medication?'

'What is your understanding of what might happen if you stop taking this medication as often as we recommend?'

'If you decided to take this medication as prescribed, what might get in the way?'

'How might you find a way around that?'

'Can I share with you what some of my other patients have found helpful?'

Module 4

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'Who might be able to help you with this medication?'

Tips for brief interventions for helping adults lose weight

1. Assess the person's view of their weight and possible reasons for any weight gain
2. Explore beliefs about healthy weight and weight loss approaches
3. Find out what the person may have already tried, how successful this has been, and what they learned from the experience
4. Explore eating patterns and physical activity levels in a non-judgemental way
5. Assess their readiness to change (e.g., diet, physical activity or both) and strengthen it
6. Asses their confidence about changing (e.g., diet, physical activity or both) and strengthen it
7. Share and explore things other people find helpful, including referral to a local service
8. If they decide to change, draw out a person-centred plan
9. Ask about likely obstacles and ways around them, people who might be able to help and what they might want from them
10. Ask if there is any additional support they would find helpful and offer a follow-up

Adapted from: NICE CG189: Obesity: identification, assessment and management. Available at: https://www.nice.org.uk/guidance/cg189. Accessed October 2023

Please refer to the NICE guidelines for additional information

Using the Ask-Share-Ask approach to get started

Ask What do you know about how some people go about losing weight and keeping it off?

[listen]

Ask May I share a few more things which seem helpful?

Share: Some people:

> Focus on eating more healthily, rather than going on a diet
> Find ways to become more active, to live a more active lifestyle, finding something they enjoy
> Have had success by joining a local weight loss group, or being referred to a local exercise programme
> Have found apps helpful

Ask: What do you make of what I've just said?

Depending on what they say, and the time you have available, consider using one or more of the strategies shared in previous modules, for example, scaling questions, two possible futures, etc. Alternatively, ask open questions like:

'How important is it for you to lose weight, eat more healthily, and become more active?'

'What are your 2—3 main reasons for wanting to change?'

'If you decided to make some changes, what does success look like for you?'

'And if you don't make any changes, what are your thoughts about the future?'

'What do you think you would look at changing first?'

'How confident are you that you could lose weight and keep it off, if you set your mind to it?'

'How would you get started?'

'Who could help you be successful?'

Module 4

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How to tailor the conversation to your patient's level of readiness

One popular model for thinking about readiness to change is the 'stages of change' model of Prochaska and DiClemente[1] , which suggests that people pass through different stages on their way to more permanent behaviour change. For instance:

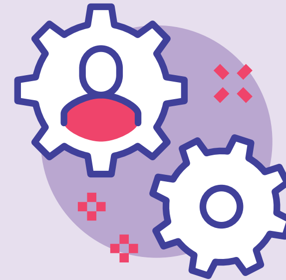
A. Pre-contemplation: Not thinking about change

B. Contemplation: Thinking about change

C. Preparation: Preparing to change, but not started yet

D. Action: Starting to change

E. Maintenance: Keeping up the change



And then another stage or process:

F. Relapsing: going back to an earlier stage of change

While the spirit and principles of motivational interviewing remain the same, the particular open questions you might use, or goals you might have, may vary according to how ready you feel the person is to change.

(see table on page 33)

Getting better at MI and brief interventions

You get better at MI the same way you get better at any skill, by knowing what to do and then practising, preferably with feedback and reflection.

Options for deliberate practise to get better at MI in clinical settings include:

- Deciding to practise particular techniques in particular clinics with particular patients
- Practise generating and offering reflections and affirmations whilst listening to a TV or radio interview, pressing pause when you want to respond. (Best done when no-one else is around!)
- Having a coaching practice session with a colleague

Options for getting feedback include:

- Recording (with permission) some of your health coaching conversations, and then scoring them using a validated scoring measure
- Sending off a recording or transcript of a conversation (with consent and data protection measures in place) to someone trained in coding MI and getting some personalised feedback
- Asking patients how helpful they found the conversation with you and, more importantly, why it was helpful? And then perhaps ask them how the conversation might have been more helpful to them

Suggested tasks for the week

1. Continue to practise using your O.A.R.S – open questions, affirmations, reflections and summaries.
2. Continue to offer some patients the importance-scaling and confidence-scaling questions, as well as two possible futures.
3. Continue to practise and get better at the ask-share-ask technique.
4. Try to offer 4—5 patients brief interventions each day.
5. Ask 1—2 patients each day for some feedback about how helpful they found their conversation with you, what in particular (if anything!) they found helpful, and how the conversation might have been more helpful to them.
6. Consider listening to a TV or radio interview, occasionally pressing pause and offering the speaker a reflection, affirmation or even a summary of some of the things they have been talking about.

[1]Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51(3), 390–395

Module 4

MI Integrating and Improving

CONTENTS

Module 4 skills development plan

What are my 2—3 best reasons for getting better at brief interventions, for example, around weight loss, cardiovascular risk reduction or medication-taking?

What are my 2—3 best reasons for asking some patients how helpful they found talking with me, and why?

When exactly will I offer more brief interventions and ask for feedback on the conversation? (Please be specific, for example, particular clinics or sessions, or with particular patients, etc.)

Do I need to practise or prepare before I use the approach with patients? For example, with a colleague, just practising saying things out loud, having some notes to remind me, etc? If so, what will I do to practise or prepare?

What do I predict might happen if I ask 5—6 patients how helpful they found the conversation with me, what they found helpful, and how it could have been more helpful?

NOTES

Motivational Interviewing:

Appendices

Appendices

Some open questions to experiment with

Some open questions to experiment with:

'Where should we focus our conversation today, to make it as helpful as possible for you?'

'What do you know about some of the benefits of regular physical activity?'

'How important is it for you to do something about your smoking?'

'What are your 3 best reasons for changing?'

'What are your thoughts about drinking less?'

'Looking forward 1—2 years, how would you like your life to be?'

'Looking forwards and just imagining that you were able to eat more healthily whilst on the road….what would that be like for you?'

'And how might you go about it, if you did decide to change?'

'How confident are you that, if you put your mind to it, you could be successful?'

'Why are you somewhat confident? Why do you think you might well be successful?'

'What would have to happen to improve your confidence?'

'How might you best go about that….?'

'What would that be like for you?'

'What strengths do you have?'

'How can we best help and support you?'

'What are your concerns about your treatment?'

'What might you do first?'

'What do you think you might notice first?'

'How might you get started?'

'Who can help you be successful?'

'What help do you need from them?'

'What might get in the way of your plan?'

'How could you find a way around that?'

Appendices

Ask-Share-Ask technique

Sharing information and advice using the Ask-Share-Ask technique

In MI, we try to 'resist the righting reflex' (the desire to 'fix' the person) and try not to offer unasked for advice (to avoid falling into the 'yes…but…' trap).

However, the fact of the matter is you do have lots of potentially useful information to share with people, information which can help them come to the right decision for them and/or increase their chances of successfully changing.

In MI we pay attention to both timing and method.

Regarding timing, it is often better to find out what the person already knows first, before you offer to share some additional or even corrective information.

Regarding technique, a lot of practitioners find the 'ask-share-ask' approach helpful.

What to say

'May I ask, what do you already know about [how this medication works, the benefits of physical activity in cancer, healthy eating, the long term effects of drinking too much on the body, etc]?'

or

'Can I share with you some of the things other people find helpful when trying to [behaviour change]?'

If they say yes, be matter of fact, for example:

- 'One of the ways this medication works is …', 'one of the benefits of physical activity in cancer is …', 'Some people I've helped to do this have found A and B and even C helpful …'

Then ask:

- What do you make of this? OR what does this mean for you?

Why use this tool?

- Understand what the person already knows or believes — including unhelpful or incorrect things
- Provide them with bite-sized information and advice they may find useful
- Avoid the traps of telling them things they already know, overwhelming them with new information, and the 'yes, but…' trap
- Help them make an informed decision, even if you don't feel it's the right one!

Tips

- Don't share too much information. Perhaps just 3 distinct points. You can always share more later
- Use an open question such as 'what do you make of what I've just shared with you?' at the end, not a closed question like 'does that make sense?'
- Don't tell them what to do with the information, or tell them what to do 'and that means that you should….'
- Don't be surprised if they become curious and ask for a bit more information about one or more things that you said
- Don't jump in with advice and suggestions
- If you feel you must give them the information without asking permission, say something like 'I don't know what you make of this but we often find that people who X sometimes find Y…'

Appendices

3 strategies for Module 2

CONTENTS

The Importance-Scaling Question

What to say:

'I'm wondering, how important is it for you to [become more active, lose weight, leave the house more, eat better, take your medication as prescribed, stop smoking, do something about your drinking, etc]?'

'Perhaps you could indicate on a scale of 0—10 where 0 is not at all important and 10 is very important?'

Then depending on what they say:

'You said 5. Why 5, and why not a lower number?'

'What are some of your personal reasons for becoming more active? [Or something else]'

Why use this tool?

- Helps them think about and talk about their reasons for becoming more active
- Help them learn more about their own motivations
- Learn more about what matters to them
- Perhaps strengthen their reasons for changing
- Demonstrate you are a good listener
- Understand more about their situation
- Continue to develop the alliance
- Notice any Change Talk (desire, reasons, need, hopes, etc)
- Make an affirmation if the opportunity arises
- Help them feel listened to, heard and understood

Tips

- Evoke their reasons for changing
- Use empathic listening / reflections
- Ask for elaboration, e.g.: 'In what way..?', 'Tell me more about…', 'What would that be like for you if…?'
- Evoke more reasons if they are there. Ask: 'Are there any other reasons? What else?'
- Make affirmations — noticing/commenting on their values, the effort they are making, their strengths or some of their achievements

The Confidence-Scaling Question

What to say:

'I'm wondering, how confident are you that, if you did decide to [behaviour change] that you could keep this up for, say, 3—4 months? Again, on a scale of 0–10 where 0 is not at all confident and 10 is very confident?'

'You said [e.g. 4]. Why 4? You could have said 1 or 2.'

'Why do you think you could successfully [behaviour change] if you put your mind to it?'

'Are there any other reasons why you think you could make this change?'

'And any other reasons…?'

'What would have to happen for your confidence to be, say, a 5 or a 6? What would help you to become more confident?'

Perhaps if you have some ideas about what might be helpful:

'Can I share with you some things other people have told me they find helpful when [change]?'

'What do you make of those ideas?'

Why use this tool?

- Build the person's self-efficacy or confidence in their ability to make change
- As some people start to think about how they might go about changing, they can become more ready to change
- Develop the alliance
- Notice and strengthen any Change Talk, e.g., 'how would you go about that…?'
- Help them feel listened to, heard and understood

Tips

- Don't jump in with unasked-for advice
- Continue with your active, empathic listening
- Make affirmations — noticing/commenting on their values, the effort they are making, their strengths or some of their achievements

Appendices

3 strategies for Module 2

Two possible futures

What to say:

Let's imagine for a moment that you decide that now is the right time for you to change, and we meet up in [10 weeks' time, 6 months' time, a year] or you've managed to change your [physical activity levels, eating habits, smoking, medication taking, drinking habits, etc] and keep the change going…

'What would things be like for you? What might have changed? What is the best that things might be?'

Active listening. Perhaps some additional open questions.

'What else might be different?" …and how might you be feeling?'

'and now let's imagine for a moment that you decide that now is not the right time for you to change, and we meet up in a year or so and your [physical activity levels, eating habits, smoking, medication taking, drinking, etc] has stayed the same…'

'What would that be like for you? How might things be different?'

Active listening. Perhaps some additional open questions.

'And What about that concerns you the most?'

Summarise:

'So if you were to change, you think that A, B, and C might happen, but if you stay as you are you feel that X, Y and Z might happen'

'Is that about right?'

(This can be a good time to ask what we call the key question: "so, what's next for you, what do you think you will do?")

Why use this tool?

- To help them articulate the consequences of both change and no change without the pressure of actually needing to do anything. Think of it as a hypothetical look over the fence.
- Develop the alliance
- Strengthen any Change Talk
- Increase commitment language
- Increase discrepancy — between their desired future and current behaviour
- Help them feel listened too, heard and understood

Tips

- Evoke their reasons for changing
- Use empathic listening / reflections
- Ask for elaboration, e.g.: 'In what way..?', 'Tell me more about…', 'What would that be like for you if…?'
- Evoke more reasons if they are there. Ask: 'Are there any other reasons?', 'What else?'
- Make affirmations — noticing/commenting on their values, the effort they are making, their strengths or some of their achievements

Appendices

Sheets for Module 3

CONTENTS

Making a Decision: The Key Question

What to say:

Offer the person a summary of key things you have talked about and explore together about the topic or behaviour change:

'So [name] some of the reasons you feel you could [move more, eat better, take your medications as prescribed, drink less, stop smoking, etc] are X and Y and Z, and you feel that A and B and possibly C would help you become even more confident of making this change. You think that if you did decide to change, you would notice X, Y and Z and if you don't change you are concerned because you feel that perhaps X, Y and Z might happen. Is that right?'

Then ask what we call the key question:

'So, what's the next step for you? What do you think you will do?'

Why use this tool?

- Help the person come to (an informed decision) about what they will do
- Deliver good quality shared decision making
- Key step towards developing any personalised plan
- Stops you falling into the 'rush to planning' trap where you overestimate the person's readiness to change and start goal setting before they have decided to change

Tips

- Don't expect the person to change — many people decide to stay as they are
- Don't be surprised if they remain unsure or undecided. If they do, just empathise
- If they say: 'what do you think I should do?' — perhaps tell them that you can't make this decision for them. It depends on what matters most to them, and everyone is different. However you can explore the options with them. Something like that.
- If they remain unsure, perhaps suggest some options, for example,

  'Well you could stay the same, that's fine. Or you could go away and think about it some more, perhaps with someone else. Or you could decide to get started, perhaps in a small way. Do those sound like your main options? So, what do you think you will do?'

Agreeing a Personalised Change Plan

Only use this if the person has decided to change.

What to say:

Here are some open questions to help draw the plan out from the person. This is typically better than you coming up with a plan for them.

'When will you get started?'

'What's the first thing you might do?'

'How often do you think you will do that?'

'How will you judge if you are being successful?'

'Where would you like to be in, say, 4—5 weeks?'

'How long do you think it might be before you notice any changes?'

'What do you think you will notice first?'

'Who can help you be successful? What help do you want from them?'

'When will you talk to them?'

'What might get in the way of your plan?'

'How might you find a way around that?'

'What help would you like from me?'

Why use this tool?

- A decision to change is important, but having a plan increases the chances of successful change
- Thinking about how to change in some detail can help build confidence
- Thinking about potential obstacles and ways around them in advance may help the person cope when such obstacles arise

Tips

- Evoke — draw ideas out from them
- Be gentle, don't rush
- Don't be surprised if people become a bit hesitant about specifying when they will change and how often they will do things. This is natural and normal
- If they do, empathise, for example, 'you're finding it hard to get started.'
- You may wish to get them to write their 'change plan' down

Appendices

Table for Module 4

Stage of change	Stage of change Pre-contemplation: Not thinking about change	Contemplation: Thinking about change	Planning Decided to change but not yet changed	Action Taking action and maintenance
Possible task	Raise the topic in a way that minimises defensiveness and resistance	Explore ambivalence about change. Elicit and strengthen Change Talk. Help them come to a decision	Help them come up with a personalised plan	Help them be successful
Techniques or questions	What do you know about: • The causes of heart disease and strokes? • How this medication works? • The most effective ways to lose weight? • Some of the benefits of becoming more active?	• How important is it for you to…? • Why might you want to…? • How confident are you that you could (do X) if you decided to…? • What might help you become more confident about (doing X)? • Let's imagine you did change, how do you think things might be different in 6 months' time? • Let's imagine you don't change, how do you think things might be different in 6 months' time? • Can I summarise? • What do you think you will do?	• How might you get started? • What might be the easiest thing to do? • What else might you do? • When will you do this? • How often do you think you will do this? • What do you think you will notice first? • Where would you like to be in 4—5 weeks' time? • Who can help you be successful? • What kind of help might you want from them? • What might get in the way of your plan? • How could you find a way around that?	• Last time we met I remember you said you were going to …. How's it been going? • What have you noticed since you made this change? • What are your plans for the future? • Have you had any difficulty keeping up the change? • What did you do? • Is there any help we can offer, or any support you need?

BAYER

Xarelto® (rivaroxaban) 2.5, 10, 15 and 20 mg film-coated tablets & 1mg/ml granules for oral suspension
Prescribing Information
(Refer to full Summary of Product Characteristics (SmPC) before prescribing)

Presentation: 2.5mg/10mg/15mg/20mg rivaroxaban tablet & 1mg/ml granules for oral suspension. **Indication(s):** *2.5mg* Xarelto, co-administered with acetylsalicylic acid (ASA) alone or with ASA plus clopidogrel or ticlopidine, is indicated for the prevention of atherothrombotic events in adult patients after an acute coronary syndrome (ACS) with elevated cardiac biomarkers. Xarelto, co-administered with acetylsalicylic acid (ASA), is indicated for the prevention of atherothrombotic events in adult patients with coronary artery disease (CAD) or symptomatic peripheral artery disease (PAD) at high risk of ischaemic events. *10mg* Prevention of venous thromboembolism (VTE) in adult patients undergoing elective hip or knee replacement surgery. Treatment of deep vein thrombosis (DVT) & pulmonary embolism (PE), & prevention of recurrent DVT & PE in adults (see W&P for haemodynamically unstable PE patients). *15mg/20mg* Prevention of stroke & systemic embolism in adult patients with non-valvular atrial fibrillation with one or more risk factors such as congestive heart failure, hypertension, age ≥ 75, diabetes mellitus, prior stroke or transient ischaemic attack (SPAF). Treatment of DVT & PE, & prevention of recurrent DVT & PE in adults (see W&P for haemodynamically unstable PE patients). *Paediatrics: 1mg/ml* – Treatment of VTE and prevention of VTE recurrence in term neonates, infants & toddlers, children, & adolescents aged less than 18 years after at least 5 days of initial parenteral anticoagulation treatment. Treatment of VTE & prevention of VTE recurrence in children & adolescents aged less than 18 years & weighing from 30 kg to 50 kg (for 15 mg) / above 50 kg (for 20 mg) after at least 5 days of initial parenteral anticoagulation treatment. **Posology & method of administration:** *2.5mg* – Oral *b.i.d.* dose; patients should also take a daily dose of 75 – 100 mg ASA or a daily dose of 75 – 100 mg ASA in addition to either a daily dose of 75 mg clopidogrel or a standard daily dose of ticlopidine. Start Xarelto as soon as possible after stabilisation, including revascularisation for ACS, and should not be started until haemostasis is achieved in successful lower limb revascularisation for symptomatic PAD; at the earliest 24 hours after admission & at discontinuation of parenteral anticoagulation. If dose is missed take next dose, do not double the dose. *10mg* – *hip or knee replacement surgery:* Oral *o.d.* dose; initial dose taken 6 to 10 hours after surgery provided haemostasis established. *DVT & PE:* When extended prevention of recurrent DVT and PE is indicated (following completion of at least 6 months therapy for DVT or PE), the recommended dose is 10 mg *o.d.*. In patients in whom the risk of recurrent DVT or PE is considered high, such as those with complicated comorbidities, or who have developed recurrent DVT or PE on extended prevention with Xarelto 10 mg *o.d.*, a dose of Xarelto 20 mg *o.d.* should be considered. *15mg/20mg* – Take with food *SPAF:* 20 mg orally *o.d. DVT & PE:* Adults – 15 mg *b.i.d.* for 3 weeks followed by 20 mg *o.d.* for continued treatment & prevention of recurrent DVT & PE; Children & adolescents – calculate dose based on body weight: body weight <30kg refer to the SmPC for Xarelto 1mg/ml granules for oral suspension; body weight 30-50kg take 15mg *o.d.*; body weight >50kg take 20mg *o.d*.. Monitor child's weight & review regularly. Xarelto is not recommended for use in children below 18 years of age in indications other than the treatment of VTE and prevention of VTE recurrence. *All strengths* – Refer to SmPC for full information on duration of therapy & converting to/from Vitamin K antagonists (VKA) or parenteral anticoagulants. ***Special populations:*** Patients undergoing cardioversion: Xarelto can be initiated or continued in patients who may require cardioversion. Patients with non-valvular atrial fibrillation who undergo PCI (percutaneous coronary intervention) with stent placement: There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [creatinine clearance 30 – 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation & undergo PCI with stent placement. ***Renal impairment:*** mild (creatinine clearance 50-80 ml/min) – no dose adjustment; *2.5mg /10mg* – moderate (creatinine clearance 30-49 ml/min) – no dose adjustment. *15mg/20mg* – adults with moderate (creatinine clearance 30-49 ml/min) & severe (creatinine clearance 15-29ml/min) – *SPAF:* reduce dose to 15mg *o.d., DVT & PE:* 15 mg *b.i.d.* for 3 weeks, thereafter 20mg *o.d.* Consider reduction from 20mg to 15mg *o.d.* if patient's bleeding risk outweighs risk for recurrent DVT & PE; children & adolescents with moderate or severe renal impairment (glomerular filtration rate <50 mL/min/1.73 m^2) – not recommended; *All strengths* – Severe impairment: limited data indicate rivaroxaban concentrations are significantly increased, use with caution. Creatinine clearance <15 ml/min – not recommended. ***Hepatic impairment:*** Do not use in patients with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C ***Paediatrics:*** Only for treatment of VTE & prevention of VTE recurrence. **Contra-indications:** Hypersensitivity to active substance or any excipient; active clinically significant bleeding; lesion or condition considered to confer a significant risk for major bleeding (refer to SmPC); concomitant treatment with any other anticoagulants except under specific circumstances of switching anticoagulant therapy or when unfractionated heparin is given at doses necessary to maintain an open central venous or arterial catheter; hepatic disease associated with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C; pregnancy & breast feeding. Presence of malignant neoplasms at high risk of bleeding. *2.5mg* – concomitant treatment of ACS with antiplatelet therapy in patients with a prior stroke or transient ischaemic attack; concomitant treatment of CAD/PAD with ASA in patients with previous haemorrhagic or lacunar stroke, or any stroke within a month. **Warnings & precautions (W&P):** Clinical surveillance in line with anticoagulant practice is recommended throughout the treatment period. Discontinue if severe haemorrhage occurs. Increasing age may increase haemorrhagic risk. Patients with active cancer: the individual benefit of antithrombotic treatment should be weighed against the risk for bleeding. Gastrointestinal or genitourinary tract tumours have been associated with an increased risk of bleeding. Patients with CAD/PAD: after recent revascularisation procedure of the lower limb due to symptomatic PAD, if required, a dual antiplatelet therapy with clopidogrel, should be short-term, long-term dual antiplatelet therapy should be avoided. Xarelto in combination with other antiplatelets is not recommended. Xarelto should be discontinued at the first appearance of a severe skin rash, or any other sign of hypersensitivity in conjunction with mucosal lesions. 1mg/ml oral suspension - sodium benzoate may increase jaundice in newborn infants (up to 4 weeks old). *Not recommended:* in patients with an increased bleeding risk (refer to SmPC); in patients receiving concomitant systemic treatment with strong concurrent CYP3A4- & P-gp-inhibitors, i.e. azole-antimycotics or HIV protease inhibitors; in patients with prosthetic heart valves; for patients with a history of thrombosis diagnosed with antiphospholipid syndrome; Xarelto should not be used for thromboprophylaxis in patients having recently undergone transcatheter aortic valve replacement (TAVR); *2.5mg* treatment in combination with antiplatelet agents other than ASA & clopidogrel/ticlopidine, patients after recent lower limb revascularisation procedures due to symptomatic PAD with a previous stroke or TIA receiving dual antiplatelet therapy; *10mg/15mg/20mg* in haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy; *1mg/1ml* in children less than 6 months of age who at birth had <37 weeks of gestation, a body weight of <2.6 kg, or had <10 days of oral feeding; in children ≥1 year old with moderate or severe renal impairment (glomerular filtration rate <50 mL/min/1.73 m^2); in children ≤1 year old with serum creatinine results >97.5th percentile. *Use with caution:* in patients treated concomitantly with medicines affecting haemostasis; when neuraxial anaesthesia or spinal/epidural puncture is employed; in patients at risk of ulcerative gastrointestinal disease (prophylactic treatment may be considered); *2.5mg* in patients ≥75 years of age or with lower body weight (<60kg); in CAD patients with severe symptomatic heart failure. Patients on treatment with Xarelto & ASA or Xarelto & ASA plus clopidogrel/ticlopidine should only receive concomitant treatment with NSAIDs if the benefit outweighs the bleeding risk. *2.5mg/10mg* in patients with moderate renal impairment concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations; *15mg/20mg* in patients with renal impairment concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations; *1mg/ml* in children with cerebral vein & sinus thrombosis who have a CNS infection. *All strengths* – There is no need for monitoring of coagulation parameters during treatment with rivaroxaban in clinical routine, if clinically indicated rivaroxaban levels can be measured by calibrated quantitative anti-Factor Xa tests. Xarelto tablets contains lactose. **Interactions:** Concomitant use with strong inhibitors of both CYP3A4 & P-gp not recommended as clinically relevant increased rivaroxaban plasma concentrations are observed. Avoid co-administration with dronedarone. Use with caution in patients concomitantly receiving NSAIDs, ASA or platelet aggregation inhibitors due to the increased bleeding risk; use with caution in patients concomitantly receiving SSRIs/SNRIs due to a possible increased bleeding risk. Concomitant use of strong CYP3A4 inducers should be avoided unless patient is closely observed for signs & symptoms of thrombosis. **Pregnancy & breast feeding:** Contra-indicated. **Effects on ability to drive & use machines:** syncope (uncommon) & dizziness (common) were reported. Patients experiencing these effects should not drive or use machines. **Undesirable effects:** *Common:* anaemia, dizziness, headache (in children: very common), eye haemorrhage, hypotension, haematoma, epistaxis (in children: very common), haemoptysis, gingival bleeding, GI tract haemorrhage, GI & abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting (in children: very common), increase in transaminases, pruritus, rash, ecchymosis, cutaneous & subcutaneous haemorrhage, pain in extremity, urogenital tract haemorrhage (menorrhagia *very common* in women <55 yrs treated for DVT, PE & prevention of recurrence, common in female adolescents after menarche), renal impairment, fever (in children: very common), peripheral oedema, decreased general strength & energy, post-procedural haemorrhage, contusion, wound secretion. *Serious: cf. CI/Warnings & Precautions – in addition:* thrombocytosis, thrombocytopenia (in children: common), Stevens-Johnson syndrome/Toxic Epidermal Necrolysis, DRESS syndrome, anaphylactic reactions including shock, angioedema & allergic oedema, occult bleeding/haemorrhage from any tissue (e.g. cerebral & intracranial, haemarthrosis, muscle) which may lead to complications (incl. compartment syndrome, renal failure, anticoagulant-related nephropathy or fatal outcome), syncope, tachycardia (in children: common), hepatic impairment, cholestasis & hepatitis (incl. hepatocellular injury), increases in bilirubin (in children: common), blood alkaline phosphatase & GGT, increased conjugated bilirubin, jaundice, vascular pseudoaneurysm following percutaneous vascular intervention, eosinophilic pneumonia. Prescribers should consult SmPC in relation to full side effect information. **Overdose:** In the case of an overdose, the patient should be observed carefully for bleeding complications and other adverse reactions. A specific reversal agent is available, refer to the SmPC for andexanet alfa. **Legal Category:** POM. **Package Quantities & Basic NHS Costs:** *2.5mg* – 56 tablets: £50.40. *10mg* – 10 tablets: £18.00, 30 tablets: £54.00 & 100 tablets: £180.00. *15mg* – 14 tablets: £25.20, 28 tablets: £50.40, 42 tablets: £75.60, 100 tablets: £180.00; *20mg* – 28 tablets: £50.40, 100 tablets £180.00; Treatment Initiation pack (42 tablets of 15mg, 7 tablets of 20mg): £88.20 *1mg/ml* – 100ml bottle: £9.00, 250ml bottle: £18.00 **MA Number(s):** *Great Britain: 2.5mg* – PLGB 00010/0708. *10mg* – PLGB 00010/0705. *15/20mg* – PLGB 00010/0706, 0707, 0709. *1mg/ml* – PLGB 00010/0746. *Northern Ireland: 2.5mg* – EU/1/08/472/025-035, 041, 046-047. *10mg* – EU/1/08/472/001-010, 022, 042-045 *15mg/20mg* – EU/1/08/472/011-016, 017-021, 023-024, 036-040, 048-049. *1mg/ml* – EU/1/08/472/050-051 **Further information available from:** Bayer plc, 400 South Oak Way, Reading, RG2 6AD, U.K. Telephone: 0118 206 3000. **Date of preparation:** July 2023

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Adverse events should be reported.
Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in Google Play or Apple App Store.
Adverse events should also be reported to Bayer plc.
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