PHARMACY PRACTICE WORKSHOP

CONNECT-6

Operationalising motivational interviewing in medication counselling

Fahmi Hassan · Module training material

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When information is not enough

“Saya faham cara makan ubat. Tapi saya masih takut nak ambil.”

What would you say next?

01

Purpose

What you will practise

Recognise

Identify a suitable opening for CONNECT-6.

Not every encounter needs one — you will practise telling them apart.

Understand

Explore illness beliefs, emotions and practical barriers.

Most of today sits here, because it is the step most often skipped.

Respond

Use MI skills and co-create a feasible next step.

A step the patient helped design is the step they are likely to keep.

The six components

Three stages: build the relationship · explore and plan · strengthen the next step.

EN	MY	Focus
CONNECT	HUBUNG	Open the conversation and hear what matters.
CLARIFY	JELASKAN	Find the concern behind the behaviour.
COACH	BIMBING	Answer the concern the patient actually raised.
CHECK	SEMAK	Explore importance and confidence.
CREATE	RANGKA	Build a next step the patient can do.
COMMIT	KOMITED	Protect the plan and agree follow-up.

Developed for pharmacy conversations

Early evidence of improved simulated counselling performance.

Development

Theory synthesis, seven-expert consultation and a ten-pharmacist pilot.

Built for counselling in Malaysian pharmacy practice, not adapted from another setting.

27 pharmacists

Immediate pre–post roleplay evaluation in Selangor.

Participants drawn from MTAC, outpatient and inpatient services.

9.71 → 17.00 / 27

Mean total roleplay score; p = 0.002.

Pre-training SD 3.75; post-training SD 4.90; maximum possible score 27.

What the evaluation does and does not show

What it showed

Roleplay performance improved immediately after training.

Twenty-seven pharmacists, pre–post design, statistically significant change.

What it cannot show

No parallel control group; one region; simulated encounters; no long-term follow-up.

Improvement in adherence or clinical outcomes has not been demonstrated.

How to describe it

Early evidence of improved simulated counselling performance.

The forthcoming state guideline is implementation context, not further validation.

02

Foundations

Recognise the opening

Listen for a cue

Concern, ambivalence, difficulty, low confidence or a plan that is not working.

The cue is usually something the patient says without being asked.

Invite exploration

“Boleh kita bincang sedikit tentang perkara yang merisaukan puan?”

Ask permission first — an invitation is easier to accept than a question.

Use judgment

Consider willingness, time and clinical priorities; arrange another opportunity if needed.

An urgent clinical problem is handled first. A conversation can be scheduled.

Each foundation answers a question

WHO dimensions

Where might the barrier come from?

Five dimensions that stop you settling on “the patient forgot”.

Common-Sense Model

How does this illness make sense to this patient?

Today’s main focus — it explains the reasoning behind the behaviour.

HAPA

What helps intention become action?

Explains why a willing patient still does not follow the plan.

Look beyond the patient alone

Patient

Beliefs, understanding, memory and confidence.

What the patient thinks the medicine is for may not match the prescription.

Condition

Symptoms, illness burden and comorbidity.

A condition with no symptoms gives the patient nothing to act on.

Therapy

Complexity, adverse effects and treatment burden.

Count the daily doses before assuming motivation is the problem.

Barriers outside the consultation room

Use these as prompts in CLARIFY, not as an interrogation.

Social / economic

Support, resources, transport and daily responsibilities.

Cost, distance and caring duties sit outside anything you can prescribe.

Health system / team

Access, continuity and communication.

Appointment timing, supply and conflicting advice all shape adherence.

They interact

More than one dimension is usually in play at the same time.

A reminder cannot remove a transport barrier.

03

The Common-Sense Model

Understanding how patients interpret illness and regulate their response.

What makes this decision sensible?

“Bacaan saya dah normal. Jadi saya boleh berhenti makan ubat.”

What might “normal” mean to this patient?

Patients build an illness explanation

What shapes it?

Bodily experiences, family stories, previous care and information encountered.

An explanation can be internally coherent and still differ from the clinical one.

What does it influence?

What the patient notices, what they try, and what counts as improvement.

Ask what experience made this explanation convincing.

The model includes a feedback loop

Cue

Symptoms, results or information

Understanding

What is happening?

Emotion

How does it feel?

Coping

Manage the illness / manage distress

Appraisal

Did it help? What did I notice?

Experience can reinforce or revise the response.

Identity: “What is this illness?”

“Darah tinggi saya datang bila sakit kepala.”

Listen for

The illness label and the symptoms the patient links to it.

Many patients decide they have the illness only when they can feel it.

Explore

“Macam mana encik tahu tekanan darah encik sedang tinggi?”

Then ask what he notices on the days he feels well.

Cause: “Why did this happen?”

“Semua ini sebab tekanan kerja.”

Listen for

The patient’s own explanation of what caused the illness.

Stress, food, fate or family inheritance are all common explanations.

Explore

“Pada pandangan encik, apa yang menyebabkan keadaan ini?”

The cause a patient believes in shapes the solution they will accept.

Timeline: “How long will it last?”

“Bila bacaan elok, penyakit itu dah habis.”

Listen for

An expectation that illness is temporary, ongoing or comes and goes.

A short expected timeline makes stopping treatment feel reasonable.

Explore

“Encik jangka keadaan ini akan berlarutan berapa lama?”

Ask before correcting — the answer tells you what to address.

Consequences: “What will it affect?”

“Saya takut tak dapat jaga cucu lagi.”

Listen for

Expected effects on health, family, work and independence.

The feared consequence is often social rather than clinical.

Explore

“Apa kesan yang paling puan risaukan?”

Naming the specific fear makes it possible to respond to it.

Control: “What can help?”

“Ubat ini boleh bantu ke? Saya tak rasa apa-apa.”

Listen for

Beliefs about personal control and about treatment effectiveness.

These are two separate beliefs and may not move together.

Explore

“Apa yang puan harap rawatan ini dapat bantu?”

A medicine that produces no sensation is easily judged as doing nothing.

Emotion has its own influence

Explore the meaning and acknowledge the feeling.

Illness understanding

“I saw my mother undergo dialysis.” “What might happen to me?”

The belief is built from something the patient actually witnessed.

Emotional response

Fear, grief or uncertainty may shape what feels safe to do.

Avoiding the medicine can be a way of managing the fear, not the illness.

Coping is the response the patient tries

Managing the perceived threat

Taking treatment, seeking advice or changing daily routines.

Action aimed at the illness itself.

Managing distress

Seeking reassurance, avoiding reminders or postponing a decision.

Action aimed at the feeling — and often mistaken for carelessness.

A useful question: “Bila risau itu datang, apa yang puan biasanya buat?”

Appraisal: “Did my response work?”

“Saya tak ambil beberapa hari. Badan masih rasa sihat.”

Which result is the patient using to judge success?

The same behaviour can mean different things

Ask what is happening before choosing a response.

Patient A: misses doses

“I feel well, so I think I do not need them.”

Explore illness understanding. Information about the condition may help here.

Patient B: misses doses

“I want to take them; my shift changes every week.”

Explore practical feasibility. Information will not help here — a workable plan will.

Interpret the patient’s reasoning

“Saya ambil ubat bila pening. Bila pening hilang, saya rasa dah baik. Ayah pun dulu begitu.”

With your neighbour

Identify a possible belief, coping action and appraisal. Three minutes. Name the CSM dimension behind each one.

Then write

One open question that tests your interpretation. It should invite correction, not confirm what you already assume.

Use CSM to guide CLARIFY

Then address the specific concern collaboratively in COACH.

Explore meaning

What does the patient believe is happening?

Identity, cause, timeline, consequences and control.

Explore response

What do they do because of that understanding?

Coping with the illness, and coping with the feeling.

Explore feedback

What experience makes that response seem helpful?

Appraisal — the evidence the patient is using to judge success.

04

HAPA

Intention is not the same as action

Persuading an already-willing patient adds nothing.

The gap

Many patients intend to take their treatment and still do not.

“Saya memang nak ambil, tapi selalu terlepas.”

Two phases

HAPA separates forming an intention from carrying it out.

A different conversation helps in each phase.

Why it matters here

CHECK works on intention; CREATE and COMMIT work on action.

Offering a plan to someone with no intention rarely holds.

Motivational phase: forming the intention

CHECK explores all three before any plan is written.

Risk perception

Does this condition apply to me, and does it matter?

"Apa yang puan faham tentang keadaan kesihatan puan sekarang?"

Outcome expectancy

If I do this, will it be worth what it costs me?

"Apa yang puan harap berubah kalau rawatan ini diteruskan?"

Action self-efficacy

Do I believe I could start at all?

"Sejauh mana puan rasa boleh mulakan langkah ini?"

Volitional phase: turning intention into action

CREATE builds the plan; COMMIT protects it.

Action planning

Agree when, where and how — not only what.

“Bila dan di mana puan akan ambil dos pagi?”

Coping planning

Name the likely obstacle and the response to it in advance.

“Kalau rutin pagi puan terganggu, apa pelan kedua?”

Maintenance and recovery

Confidence to keep going, and to restart after a lapse.

A missed week is part of the plan, not proof that it failed.

Where a willing patient’s plan breaks

Add planning, not pressure.

The intention is already there

“Saya memang nak jaga kesihatan saya.”

More persuasion at this point adds nothing and can cost the relationship.

The plan has no time or place

“Saya akan cuba lebih teratur.”

Nothing here tells her what to do tomorrow morning.

There is no plan for the bad day

When a grandchild is unwell, the routine disappears.

Without a fallback agreed in advance, one hard week ends the plan.

05

MI Skills

MI gives the framework its manner

Help the patient voice their own reasons
and possibilities.

A collaborative conversation focused on a meaningful change.

Carry the MI spirit through every component

Partnership

Work with the patient's expertise in their own life.

You know the medicines; they know their days.

Acceptance

Respect perspective and informed choice.

Including the choice you would not have made.

Compassion

Attend to the patient's welfare.

The patient's interest ahead of the indicator on the screen.

Evocation

Invite the person's own reasons and resources.

Draw the motivation out rather than supplying it.

Notice the urge to correct immediately

Understand the concern before offering information.

The automatic response

“Jangan risau. Ubat ini penting. Puan mesti ambil.”

Well intended — but it argues with a concern you have not heard yet.

An exploratory response

“Puan mahu rawatan membantu, tetapi masih risau tentang kesannya.”

A reflection holding both sides invites the patient to say more.

OARS keeps the conversation open

Open questions	Invite a fuller account.	“Apa” and “bagaimana” open the conversation; “adakah” closes it.
Affirmations	Recognise a specific effort, value or strength.	Name the behaviour, not the person.
Reflections	Offer your understanding of meaning or feeling.	A statement rather than a question — it invites correction.
Summaries	Bring the main points together and check accuracy.	Useful before changing direction in the conversation.

Practise a reflection before advice

“Saya tahu ubat itu penting, tapi saya penat makan banyak ubat.”

Try it

Write a reflection that includes both sides. One sentence. No question mark, and no advice yet.

Compare

How does your response acknowledge the burden? Read two aloud and notice which one invites more.

Affirm effort without judging the person

Describe the effort you observed, not the character you assume.

General praise

“Bagus, puan pesakit yang baik.”

Judges the person — and implies there are bad patients.

Specific affirmation

“Puan cuba beberapa cara untuk uruskan ubat walaupun jadual puan padat.”

Names what she actually did, so it can be repeated.

Listen for language about change

Explore ambivalence without arguing against it.

Reasons to change

“Saya mahu bertenaga untuk jaga cucu.”

Explore: “Kenapa itu penting bagi puan?” — ask for more of it.

Reasons to stay as things are

“Saya takut kesan sampingan.”

Reflect: “Keselamatan itu sangat penting bagi puan.” Arguing against it only strengthens it.

Share information with Elicit–Provide–Elicit

Elicit

Ask what the patient knows or wants to know; seek permission.

“Apa yang puan dah dengar tentang ubat ini?”

Provide

Offer a short, relevant explanation in plain language.

One or two points that answer the concern they actually named.

Elicit

Ask what they make of it and how it fits their concern.

“Apa pandangan puan tentang maklumat tadi?”

Importance and confidence are different

Define one specific behaviour before asking either question.

Importance: 0–10

“Berapa penting perubahan ini bagi puan?”

Explore the reasons behind the rating. Then ask why not a lower number.

Confidence: 0–10

“Berapa yakin puan boleh melakukannya?”

Explore what would make it more feasible. Then ask what would move it up by a single point.

Break

We return to applying CONNECT-6.

06

Applying CONNECT-6

Six components, three stages

Adapt the flow to the patient's response.

01

Build the relationship

CONNECT

02

Explore and plan

CLARIFY · COACH · CHECK · CREATE

03

Strengthen the next step

COMMIT

Choose a suitable opportunity

Where would deeper exploration help—and what comes first?

	Situation	Response
A	A patient asks where to store a medicine and has no further concern.	Clear counselling and a check of understanding are enough.
B	A patient says: “I know the instructions, but I am afraid to start.”	The information has already been given; the barrier is somewhere else.
C	A patient describes an urgent new clinical problem.	Address the clinical need first, then arrange another opportunity.

Meet Puan Aminah

What would you want to understand before advising her?

Her situation

58 years old; living with type 2 diabetes.

A fictional case built for practice—not a patient record.

Her daily life

Lives with her daughter and grandchildren.

Her day is shaped by other people's routines as much as her own.

Her experience

Her mother had diabetes and died while receiving dialysis.

She has already seen where she believes this illness leads.

Begin with the patient’s experience

“Macam mana puan uruskan ubat sejak kali terakhir kita berjumpa?”

Listen

Allow the patient to describe what matters to her.

Resist filling the first silence.

Respond

Reflect meaning and acknowledge a specific effort.

Reflect once before asking your next question.

Open so the patient can say more

The first question decides how much you will hear.

A closed opening

“Ada masalah dengan ubat?”

Easily answered with “tiada”, and the conversation closes there.

An open opening

“Macam mana pengalaman puan dengan ubat ini sejak kali terakhir kita jumpa?”

Invites an account rather than a verdict.

Find the concern behind the behaviour

“Apa yang puan paling risau bila fikir tentang ubat ini?”

Use CSM

Explore the illness explanation and its emotional meaning.

What does she believe is happening, and how does it feel?

Use WHO dimensions

Check practical, treatment and service barriers too.

Belief and logistics usually travel together.

Check your interpretation

Offer your understanding as a draft, not a verdict.

Premature conclusion

“Puan cuma terlupa.”

Closes the exploration — and may simply be wrong.

Tentative summary

“Kalau saya faham betul, puan kurangkan ubat kerana risau tentang ginjal. Ada hal lain juga?”

Offered as a draft, so she is able to correct it.

Respond to the concern you uncovered

Before explaining

“Apa yang puan dah tahu tentang perkara ini?”

You may only need to fill a gap, not deliver a lecture.

After explaining

“Apa pandangan puan berkaitan maklumat tadi?”

Without this, you do not know what actually landed.

Give the information the concern actually needs

Permission first, then the specific answer.

Information without permission

“Ubat ini tak rosakkan ginjal. Puan kena ambil setiap hari.”

Answers a question she did not ask, and dismisses the fear behind it.

Information after permission

“Boleh saya kongsi apa yang kita tahu tentang ubat ini dan ginjal?”

Matches the explanation to the worry she named herself.

Explore motivation and feasibility

Why act?

“Apa yang puan harap akan berubah?” Importance ruler if helpful.

Motivation is about meaning, not about knowledge.

Can it work?

“Apa yang buat puan rasa boleh atau susah?” Confidence ruler if helpful.

Low confidence needs a smaller step, not a stronger reason.

What would you explore next?

“Penting itu 9. Tapi keyakinan saya cuma 3.”

Discuss

What does the gap suggest you should ask about? Importance is already settled; confidence is the work.

Try one question

“Apa yang paling menyukarkan puan untuk melakukannya?” Then make the step small enough to be possible.

Invite the patient’s ideas first

Ask

“Apa idea puan sendiri yang mungkin sesuai?”

Her idea will fit her day better than yours will.

Offer choices if useful

Ask permission to share a small menu of options.

Two or three options, then let her choose between them.

Co-design

Choose a feasible approach that fits the confirmed treatment plan.

Feasible for her this week, not ideal in principle.

Let the plan come from the patient

Ask before you suggest; offer a menu only once invited.

The pharmacist's plan

"Puan letak ubat sebelah cawan kopi dan ambil pukul 8 pagi."

Reasonable — but built from your routine, not from hers.

The patient's plan

"Apa waktu dalam rutin puan yang paling tetap setiap hari?"

A step attached to something she already does is more likely to hold.

Make the next step specific

Agree what, when, where and how — and when to review.

A broad intention

“Saya akan cuba lebih teratur.”

Nothing here tells her what to do tomorrow morning.

A concrete next step

“Mulai esok, saya akan semak jadual ubat selepas sarapan dan tandakan dos yang diambil mengikut arahan.”

Attached to something she already does every day.

Prepare for the difficult day

“Apa yang mungkin menghalang pelan ini minggu depan?”

Anticipate

Identify one likely obstacle with her. Ask which day of the week would be hardest.

Plan a response

Agree a practical backup and where to seek help. Decided now, while it is still hypothetical.

Plan for the difficult day, not the good one

Agree the recovery step before it is needed.

A plan for good days only

“Insya-Allah saya akan ambil setiap hari.”

Nothing has been agreed for the day the routine breaks down.

A plan with a fallback

“Kalau rutin pagi terganggu, saya akan semak semula sebelum tidur dan hubungi farmasi kalau tak pasti.”

The lapse becomes recoverable instead of a reason to stop.

Close with ownership and support

Patient summary

“Boleh puan ceritakan semula pelan yang kita persetujui?”

Her words, not yours — that is what makes it a check.

Follow-up

Agree who will review progress, how and when.

A named review turns a plan into a commitment.

Affirm effort

Recognise the patient’s contribution and invite further contact.

Leave the door open for the plan to be changed.

Follow the patient's response

Progress can be a clearer concern or an agreed future conversation.

A new concern appears

Return to CLARIFY or COACH as needed.

The order is a guide, not a sequence to be completed.

The patient is not ready

Acknowledge their choice, explore what matters and agree an acceptable next step if possible.

Pressing at this point usually costs you the next conversation.

Adapt to the counselling setting

MTAC

Explore recurring patterns and review earlier plans.

You have history and time — use both.

Outpatient

Focus on the cue that emerges and one priority concern.

One concern explored well beats six concerns mentioned.

Inpatient / discharge

Explore confidence in managing the plan at home and available support.

Ask who will help, and what happens on day three.

07

Demonstration

Watch for the turning points

Notice

Where does the pharmacist explore rather than assume?

Mark the moment the direction of the conversation changes.

Listen

Which reflection helps Aminah say more?

Write down the exact words used.

Track

How does the next step become hers?

Notice who says the plan out loud first.

Aminah: a collaborative conversation

“Saya mahu jaga kesihatan, tapi pengalaman kisah mak buat saya takut.”

Follow the conversation using your CONNECT-6 guide.

What changed in the conversation?

Understanding

What concern or belief became clearer?

And what would have been missed without asking?

Communication

Which exact phrase helped?

Quote it — you will want to use it tomorrow.

Ownership

What showed that Aminah had a say in the next step?

Look for her own words inside the final plan.

08

Peer Practice

Prepare to practise in pairs

Read only your own role information. Keep patient details private.

Round 1

A is pharmacist; B is Patient 1.

Ten minutes of conversation, then three minutes of feedback.

Round 2

B is pharmacist; A is Patient 2.

Same structure, roles reversed.

Use your resources: CONNECT-6 guide, your assigned role and the feedback sheet — kept open in front of you throughout.

Practise, switch roles, reflect

Aim for understanding and a patient-owned next step.

00–03	Read your roles.
03–13	Round 1 conversation.
13–16	Give specific feedback.
16–26	Round 2: switch roles.
26–29	Give specific feedback.
29–30	Write one learning point.

09

Debrief

What did it feel like to be the patient?

Share a moment

When did you feel heard—or rushed?

Describe the moment, not the whole conversation.

Name the behaviour

What exactly did the pharmacist say or do?

Specific behaviour, not a general impression.

Link it to practice

Which behaviour would you repeat?

Choose one you could actually use this week.

Work through the difficult moments

“The patient says very little.”

Use a reflection, allow silence and narrow the invitation gently.

Silence often comes just before the most useful sentence.

“I want to give advice immediately.”

Summarise the concern, then seek permission to share.

The advice lands better once the concern has been named.

“We cannot agree on a plan.”

Explore what remains unresolved and respect the patient’s choice.

An agreed next conversation is a legitimate outcome.

Choose one opportunity in your service

A likely cue

What patient statement would prompt you to explore?

Write the sentence you actually hear in your own service.

A feasible setting

When could you have this conversation?

Name the clinic, the session and the realistic number of minutes.

A practical support

What would help you use the guide and arrange follow-up?

A printed guide, a colleague to debrief with, a review slot.

10

Learning Check

What would you do next?

Illness belief

"I feel well, so the illness must be gone." What would you explore?

Which CSM dimension is doing the work here?

Confidence gap

Importance 9; confidence 3. What needs attention?

Which HAPA phase does this belong to?

No readiness

The patient does not want a change today. How would you respond?

What would you still want to leave the conversation with?

Six questions to take back

CONNECT · HUBUNG	“Macam mana puan uruskan ubat sejak kali terakhir kita berjumpa?”
CLARIFY · JELASKAN	“Apa yang puan paling risau bila fikir tentang ubat ini?”
COACH · BIMBING	“Apa yang puan dah tahu tentang perkara ini?”
CHECK · SEMAK	“Berapa yakin puan boleh melakukannya?”
CREATE · RANGKA	“Apa idea puan sendiri yang mungkin sesuai?”
COMMIT · KOMITED	“Boleh puan ceritakan semula pelan yang kita persetujui?”

Your next conversation

- Notice the opportunity.
- Understand the patient's reasoning.
- Build the next step together.

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