

**Commissioning training for behaviour change
interventions: evidence and best practice in delivery**

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September 2008

Acknowledgements

Thanks are due to the members of the project steering group for this research who provided ongoing guidance throughout the production of this report. This report was commissioned and funded by Cheshire and Merseyside Public Health Network, Cumbria and Lancashire Public Health Network, Greater Manchester Public Health Network and the North West Teaching Public Health Network.

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Summary

Introduction

Encouraging healthy behaviour in relation to diet, physical activity, smoking, drinking and sexual health has the potential to improve people's health and quality of life. Current policy guidance identifies a key role for frontline staff, through everyday contact, in helping people to adopt and sustain healthier lifestyles through the use of behaviour change interventions. At a local level, building capacity and capability amongst public health practitioners and the wider workforce to deliver behaviour change interventions has been identified as key to achieving targets. Training has a key role to play, if staff are to deliver such interventions in a variety of settings, across a range of health issues, to a consistent standard, and with a high likelihood of success.

The Cheshire and Merseyside Public Health Network, Cumbria and Lancashire Public Health Network, Greater Manchester Public Health Network and the North West Teaching Public Health Network pooled resources to fund an evidenced-based resource to support the delivery of behaviour change interventions. The aim was to produce a set of guidelines to support those staff working in the field of health promotion and public health who have been tasked with delivering behaviour change interventions as well as those responsible for the commissioning of interventions and related staff training. A literature search was conducted using key social science and health databases to find evidence to support good practice in relation to delivering effective interventions and delivering effective training. This evidence was used to formulate best practice guidance.

Definitions

The review identified four commonly used behaviour change interventions: brief advice, brief interventions, motivational interviewing and social marketing. Establishing clear definitions for these types of intervention will help commissioners to determine the most appropriate approach.

Brief advice describes a short intervention delivered opportunistically which is normally focussed on a service user's reason for seeking help. It can be used to raise awareness of, and assess a person's willingness to engage in further discussion about, healthy lifestyle issues. Brief advice is less in-depth and more informal than a brief

intervention and usually involves giving information about the importance of behaviour change and simple advice to support behaviour change.

Brief interventions provide a structured way to deliver advice and constitute a step beyond brief advice as they involve the provision of more formal help, such as arranging follow-up support. Brief interventions aim to equip people with tools to change attitudes and handle underlying problems. As part of a range of methods, brief interventions may contain brief advice and may use a motivational interviewing approach in the delivery.

Motivational interviewing is described as a process of exploring a person's motivation to change through interview in order to assist them towards a state of action. The techniques used are adaptations of counselling skills and particular attention is paid to the listening skills of the interviewer. Motivational interviewing can be understood as an approach which can be adopted for delivering a brief intervention.

Social marketing describes a strategic approach, based on traditional marketing techniques, to delivering a programme of activities to encourage behaviour change. Emphasis is placed on understanding the life context and aspirations of individuals and their communities, which is then used to inform programmes that enable and encourage people to participate in positive health behaviour. This report does not cover social marketing as an approach because it is focussed on one-to-one interventions.

Best practice in relation to delivery of interventions

There is consensus within the literature that the manner in which behaviour change interventions are delivered will impact significantly on their effectiveness. Careful consideration needs to be given to the setting, personal circumstances of recipients of interventions, staff attributes and the process of delivery. There is also evidence to suggest that interventions with a clear and coherent theoretical grounding (such as the transtheoretical stages of change model) are more effective in producing longer-term changes in behaviour than those with no theoretical base.

Best practice in relation to training

There is good evidence to support the effectiveness of training in improving performance of behaviour change interventions and use of credible experts in the delivery of training is more likely to encourage receptiveness to the ideas presented. Good communication and interpersonal skills are fundamental to all behaviour change

interventions, whatever the lifestyle topic; training should focus on developing skills for assessing readiness to change, building rapport and facilitating discussion. Acquisition of a theoretical understanding of behaviour change interventions can improve the likelihood that staff will perform interventions while providing evidence for the efficacy of interventions will encourage staff to feel confident that their efforts will be successful.

The overall goal of training is to ensure that staff, from diverse backgrounds, working in a variety of settings, are trained to ask questions about specific health behaviours, to give advice and to offer effective support. Defining learning outcomes for training establishes what participants should know, understand, or be able to do at the end of the training and helps to achieve consistent standards amongst public health practitioners and across the wider workforce. Competencies for brief advice, brief interventions and motivational interviewing will differ and therefore require separate learning outcomes. By the end of the training, participants should be able to demonstrate knowledge, understanding and skills as detailed below.

Brief advice

Knowledge and understanding

- Understand the value of giving opportunistic brief advice in the context of an everyday staff-service user encounter.
- Understand the harmful consequences of the behaviour in question.

Skills: practical

- Ask details about the health behaviour in question.
- Assess a person's level of health risk.
- Deliver brief advice in an empathic, non-confrontational manner.
- Employ knowledge of appropriate services for signposting people to additional sources of support.

Skills: intellectual

- Distinguish between brief advice and brief intervention as distinct approaches to bringing about behaviour change.
- Judge when delivery of brief advice is an appropriate and relevant intervention.
- Use a self-reflective approach to delivering brief advice.

Brief intervention

Knowledge and understanding

- Explain the harmful consequences of the behaviour in question.

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- Recognise the evidence of effectiveness for behaviour change interventions in general and in relation to the specific health behaviour in particular.
 - Outline a range of theoretical models of behaviour change.
 - Discuss the stages of change model.

Skills: practical

- Identify people for whom a brief intervention is appropriate using validated screening tools.
- Ask and record details about the health behaviour in question and the actions taken and outcomes achieved.
- Assess a person's level of health risk.
- Assess a person's readiness to change.
- Use resources effectively to support the brief intervention.
- Employ knowledge of appropriate services for signposting people to additional sources of support.
- Deliver a brief intervention based on an explicit model of behaviour change comprising the following core elements:
 - client-directed discussion;
 - feedback of personal risk;
 - communication of responsibility towards behaviour;
 - giving advice to change behaviour;
 - providing a menu of ways to change behaviour;
 - expressing empathic understanding;
 - enhancing self-efficacy;
 - establishing behaviour change goals;
 - providing a follow-up to the brief intervention.

Skills: intellectual

- Distinguish between brief advice, brief intervention and social marketing as distinct approaches to bringing about behaviour change.
- Judge when delivery of a brief intervention is an appropriate and relevant approach to behaviour change.
- Judge when motivational interviewing is an appropriate and relevant approach to use as part of the delivery of a brief intervention.
- Appraise and record a person's readiness to change.
- Plan a structured behaviour change intervention, with due regard to the expressed needs of the individual.
- Use a self-reflective approach to devising and delivering a brief intervention.

Motivational interviewing

Knowledge and understanding

- Understand the role of motivational interviewing within the context of the delivery of behaviour change interventions.
- Express the core principles and values that underpin motivational interviewing.

Skills: practical

- Use listening skills to explore and evoke a person's motivation through helping them to identify the argument for change.
- Use a model of consultation based on empathy, collaboration and respect for autonomy.
- Create an interpersonal relationship which is conducive to change.
- Facilitate change, based on the expressed aspirations of service users, through support for self-efficacy.

Skills: intellectual

- Distinguish between brief advice, brief intervention and social marketing as distinct approaches to bringing about behaviour change.
- Judge when motivational interviewing is an appropriate and relevant approach to use as part of the delivery of a brief intervention.
- Use a self-reflective approach to using motivational interviewing, particularly in relation to the control of one's own values and beliefs.

The summary of the guidelines can be found via any of the websites for the North West Public Health networks or via the University of Chester website:

Cheshire and Merseyside Partnership for Public Health
www.champs-for-health.net

Cumbria and Lancashire Public Health Network
www.clph.net

Greater Manchester Public Health Network
www.gmphnetwork.org.uk

North West Public Health Teaching Network
www.nwph.net/nwtphn

University of Chester Centre for Public Health Research
www.chester.ac.uk/cphr

Chapter 1

Definitions of behaviour change interventions

1.1 Introduction

Developing preventative health care within the National Health Service (NHS) has been a consistent government priority within the United Kingdom (UK) for the last decade. The latest government White Paper, *Choosing Health* (Department of Health [DH], 2004) identified a number of priority areas for preventative health care: smoking, obesity, physical exercise, alcohol, sexual health and mental health (DH, 2004) and outlined the Government's ambition to achieve better public engagement with health, particularly in relation to the priority areas, in order to improve people's experiences of health and disease as well as their quality of life. Three principles underpin the Government's strategy for addressing these issues: ensuring that individuals can make informed choices, offering personalised services, and partnership working. Frontline staff working in public health and staff with responsibilities for health promotion have been tasked with playing a key role in helping people to adopt and sustain healthier lifestyles, particularly through the use of behaviour change interventions (DH, 2004).

One illustration of the role that frontline staff can play is the current policy emphasis on the opportunity presented by each service user contact with health and other public services for a public health intervention. There is substantial evidence to support the effectiveness of behaviour change interventions and there has been much advocacy for integrating such interventions into routine practice (Ubido et al., 2006). However, the National Institute for Clinical Excellence (NICE) identified a lack of strategic direction within healthcare services towards use of behaviour change interventions and reported uncoordinated use of a range of different behaviour change models, methods and theories which NICE has argued has blighted many attempts to implement successful intervention practices (NICE, 2007a).

The purpose of this document is to address some of the concerns expressed by NICE by:

- providing clear definitions of the different approaches of behaviour change;
- summarising the evidence of the effectiveness of such interventions;
- summarising the evidence on best practice in their delivery;

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- summarising the evidence on best practice in relation to staff training for using behaviour change interventions.

It is anticipated that the document will therefore be of use to those working in health promotion and public health who have been tasked with delivering behaviour change interventions as well as those responsible for the commissioning of interventions and related staff training.

1.2 Definitions

NICE public health guidance (2007a) on behaviour change states that attempts to support or promote behaviour change can be categorised into four areas:

- policy (legislation or workplace policies);
- education or communication (one-to-one advice or media campaigns);
- technologies (use of seatbelts or breathalysers);
- or resources (free condoms or access to leisure facilities).

This document is focussed on the delivery of education or communication interventions. Behaviour change interventions are grounded in behaviour change theory – either explicitly or implicitly – and seek to encourage people to cease or adopt singular or multiple behaviours. NICE guidance highlights the fact that interventions can be delivered at individual, household, community or population levels using various techniques (NICE, 2007a). A number of models of health behaviour change exist (NICE, 2007a) and there is some confusion regarding the terminology used to describe different methods. Numerous different terms are used within the literature to describe very similar behaviour change interventions: this document represents an effort to summarise the different types of intervention. The next section provides definitions for the most frequently occurring terms in the literature.

1.2.1 Brief advice

The charity PharmacyHealthLink, which works to help pharmacists promote and maintain health, describes brief advice as ‘pro-actively raising awareness of, and assessing a person’s willingness to engage in further discussion about healthy lifestyle issues’ (PharmacyHealthLink, 2007b, p.4). Brief advice is usually given opportunistically and linked to an individual’s reason for seeking help or using a service

(PharmacyHealthLink, 2007a). Brief advice is less in-depth and more informal than a brief intervention and usually involves giving information about the importance of behaviour change and simple advice to change behaviour (Gray, Eden, & Williams, 2007). It is expected that conducting brief advice should take around 3 minutes (PharmacyHealthLink, 2007a). Some sources use the term 'minimal advice' to describe interventions of this nature (see Stead, Bergson, & Lancaster, 2008).

Evidence for the effectiveness of brief advice

A Cochrane review of the evidence for brief advice in relation to smoking cessation concluded that simple advice given by GPs can increase quitting rates by between 1-3% (Stead et al., 2008). Some individual studies have shown higher quit rates for brief advice in relation to smoking (Meyer et al., 2008). There is also evidence to suggest that brief advice can be effective in increasing physical activity (Ogilvie et al., 2007) particularly when the advice is supported by written materials (Hillsdon, Foster, Cavill, Crombie, & Naidoo, 2005). In addition, there is direct evidence that brief advice from GPs can decrease alcohol use in adults (Fleming, Manwell, & Barry, 1999). In an evaluation comparing the effects of 5 minutes of brief advice and 20 minutes brief counselling on heavy drinkers in a primary care setting, a cross-national study found that both were effective and that prolonged interventions had no greater impact (Babor, Acuda, Campillo, Del Boca, et al., 1996).

Examples of use

A primary care trust in the Northeast of England developed a service where health improvement advice for smokers was delivered as part of all podiatry consultations (Gray et al., 2007). Staff received training in delivery of brief advice, and IT systems were developed to record the number of patients for whom smoking status was assessed and the number of smokers who received advice about quitting and were referred for specialist support. Over a 6 month period, smoking status was recorded for all 8,831 patients attending podiatry clinics; 1032 were identified as smokers and accurate records for the research were kept for 957 of these patients. In total, 795 (83%) patients were given brief advice to quit and 35 (4%) patients were referred to specialist stop smoking support services. A questionnaire was used to explore staff perceptions of the impact of the service on clinics and consultations. It was perceived that there was no additional financial outlay to deliver the service; the main costs of implementation related to staff time for planning and training, developing the information systems and analysing the data which were afforded through

improvements to existing budgets. Importantly, it was also found that the development did not prolong clinics.

Further sources of information

Hjalmarson, A., & Boëthius, G. (2007). The effectiveness of brief advice and extended smoking cessation counselling programs when implemented routinely in hospitals. *Preventive Medicine, 45*, 202-207.

PharmacyHealthLink with Department of Health. (2007). *Pharmacy meets public health: Guide to giving brief advice*. Retrieved September 10, 2008 from http://www.pharmacymeetspublichealth.org/pdf/Pharmacy_meets_Public_Health.pdf

Soderstrom, C. A., DiClemente, C. C., Dischinger, P. C., Hebel, J. R., McDuff, D. R., Auman, K. M., et al. (2007). A controlled trial of brief intervention versus brief advice for at-risk drinking trauma center patients. *The Journal of Trauma, 62*, 1102-11.

1.2.2 Brief intervention

Like brief advice, brief interventions involve 'opportunistic advice, discussion, negotiation or encouragement' (NICE, 2006a, p. 5). They are used quite frequently in a range of areas of health promotion and can be performed by a variety of health and community care professionals (NICE, 2006a). Interventions are typically used in a preventative manner, before the onset of more serious health problems related to an individual's behaviour (Aalto & Seppä, 2007). Although there is some discrepancy between definitions over the length of a session and the number of sessions involved, brief intervention sessions are typically of short duration, usually taking between 5 and 10 minutes (Lock, 2004a) and usually comprise 2-3 sessions (Alcohol Concern, n.d.). A brief intervention usually contains an assessment of a person's commitment to behaviour change, advice and sign-posting or referral to support services (West & Saffin, 2008).

Aalto and Seppä (2007) describe such interventions as providing a structured way to provide advice. The PharmacyHealthLink suggests that brief interventions constitute a step beyond brief advice and may involve the provision of more formal help to assist a person in behaviour change, such as arranging follow-up support or linking people into other local services (PharmacyHealthLink, 2007). Furthermore, brief interventions are described as having an additional goal to brief advice; that is, to equip people with tools to change attitudes and handle underlying problems (Babor & Higgins-Biddle, 2001).

Other terms used to describe brief interventions include 'level 1 interventions', 'brief counselling', 'minimal interventions', and 'limited interventions' (West & Saffin, 2008).

An effective approach for delivering brief interventions, as advocated within the literature, is utilisation of the principles of motivational interviewing, which constitutes an approach which can be incorporated into a brief intervention (Miller and Rollnick, 2002).

Evidence of the effectiveness of brief interventions

Brief interventions have been shown to 'consistently produce reductions in alcohol consumption' (Kaner et al., 2007). In a summary of the evidence for the effectiveness of brief interventions, Babor and Higgins-Biddle (2001) conclude that there is evidence to show that brief interventions can reduce overall level of alcohol consumption, change harmful drinking patterns, prevent future drinking problems, improve health, and reduce healthcare costs. Brief interventions are considered to be particularly time efficient, for example, brief counselling for alcohol interventions has been shown to be as effective as longer counselling sessions (Zimmerman, Olsen & Bosworth, 2000).

Examples of use

The Step-O-Meter (a pedometer) offers a proven means of encouraging an increase in physical activity: it is simple to use, can be used to monitor increases in activity and does not rely on people attending leisure facilities (Ubido et al., 2006). Five hospitals in Liverpool are taking part in the National Step-O-Meter Programme pilot. Each hospital has identified five members of staff to undergo training designed to enable frontline staff to deliver brief interventions about physical activity using Step-O-Meters to encourage more patients to increase their level of activity through walking.

The rationale for this is to help support the NHS to improve the health of its own staff and contribute to overall increases in physical activity in the population. For more information contact: Lina Toleikyte, Health Promotion Specialist, Sefton PCT, Tel: 0151 479 6550, email: Lina.Toleikyte@seftonpct.nhs.uk.

Further sources of information

Alcohol Concern. (n.d.). *Factsheet 15: Brief interventions*. Alcohol Concern, London.

Babor, T. F., & Higgins-Biddle, J. C., (2001). *Brief interventions for hazardous and harmful drinking: A manual for use in primary care*. WHO.

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- Lock, C. (2004). Screening and brief alcohol interventions: What, why, who, where and when? A review of the literature. *Journal of Substance Use, 9*, 91-101.
- Moyer, A., & Finney, J. W. (2004). Brief interventions for alcohol problems: Factors that facilitate implementation. *Alcohol Research and Health, 28*, 44-51.
- Ubido, J., Winters, L., Ashton, M., Scott-Samuel, A., Atherton J., & Johnstone, F. (2006). *Top tips for healthier hospitals: full report*. Liverpool Public Health Observatory and Cheshire and Merseyside Public Health Network.

1.2.3 Motivational interviewing

Motivational interviewing is described as a process of exploring a person's motivation to change through interview (Field, Hungerford & Dunn, 2005) in order to assist them towards a state of action (Shinitzky & Kub, 2001). The techniques used are considered to be adaptations of counselling skills typically for use in a healthcare setting. Particular attention is paid within this method to the listening skills of the interviewer which Rollnick (2005) describes as an important addition to staff's repertoire of communication skills. Motivational interviewing can be understood as an approach which can be adopted for delivering a brief intervention; the principles of this approach may be used to inform the way in which staff interact with clients. Miller and Rollnick (2002) have argued that the spirit which underlies motivational interviewing is more important than the techniques used. The approach can also be used to inform more intensive interventions as well as brief interventions.

Health coaching is a term used in the US to describe a technique similar to motivational interviewing. It is described as a 'client-centred or stage-based model' that 'addresses the psychological issues inherent in lifestyle management' (Butterworth, Linden, & McClay, 2007, p. 301). The technique has been commonly used in group settings, as part of a wider health management programme (Butterworth et al., 2007). Proactive counselling is also described as being very similar to motivational interviewing but adheres to more specific counselling techniques (Sieck, Heirich, & Major, 2004).

Evidence of the effectiveness of motivational interviewing

There is some evidence that motivational interviewing works but there are many unanswered questions about what works best and why (Rollnick, 2005). There is some evidence that motivational interviewing is more effective than brief advice in less ready-to-change smokers and excessive drinkers (Rollnick, 2005) and motivational interviewing techniques have been found to be most effective with people at the

precontemplation and contemplation stages (Zimmerman et al., 2000). A review of the effectiveness of motivational interviewing techniques found substantial evidence that this method provides an effective means of tackling substance abuse when used by non-specialists in substance abuse treatment. It also found that this method is helpful in encouraging engagement in more intensive substance abuse treatment (Dunn, Deroo & Rivara, 2001).

Examples of use

The research charity RAND developed and pilot-tested an intervention in the United States of America (USA) for use in primary care targeted at teens at risk of substance abuse disorders in later life (RAND, 2008). The intervention, Project CHAT, consisted of a 15 minute motivational interview. The project designers considered motivational interviewing techniques, such as expressing empathy and supporting self-efficacy, to be useful tools for tackling stigma and fear of disclosing substance use to an adult (RAND, 2008). They also considered that the method was culturally appropriate and acceptable to adolescents because of its emphasis on engaging people as active participants.

Interventions were carried out in a community-based primary care facility in Los Angeles County as part of the pilot. Eighty-one youths screened positive for possible substance use problems and were randomised to receive either Project CHAT or usual care. Forty-two teens (86% Hispanic and 52% female) completed the study and after 3 months, Project CHAT participants reported lower intentions to use marijuana in the next 6 months than participants not allocated to CHAT. Project CHAT participants also reduced their alcohol use compared to usual teens, although these results were not statistically significant. The study concluded that as primary care services are utilised by teenagers, the intervention poses an innovative way to reach many at-risk young people during regularly scheduled primary care appointments (RAND, 2008). For full details of this study see D'Amico, Miles, Stern & Meredith (2008).

Further sources of information:

DiLillo, V., Siegfried, N. J., & Smith West, D. (2003). Incorporating motivational interviewing into behavioural obesity treatment. *Cognitive and Behavioural Practice*, 10, 120-130.

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- Field, C., Hungerford, D. W., & Dunn, C. (2005). Brief motivational interventions: An introduction. *The Journal of Trauma, Injury, Infection and Critical Care*, 59, 21-26.
- Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural and Cognitive Psychotherapy*, 11, 147-172.
- Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: The Guilford Press.
- Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, 28, 325-334.
- Resnicow, K., Jackson, A., Wang, T., De, A. K., McCarty, F., Dudley, W. N., et al. (2001). A motivational interviewing intervention to increase fruit and vegetable intake through black churches: Results of the Eat for Life Trial. *American Journal of Public Health*, 91, 1686-1693.
- Resnicow, K., Dilorio, C., Soet, J. E., Borrelli, B., Hecht, J., Ernst, D. (2002). Motivational interviewing in health promotion: It sounds like something is changing. *Health Psychology*, 21, 444-451.
- Shinitzky, H. E, & Kub, J. (2001). The art of motivating behaviour change: The use of motivational interviewing to promote health. *Public Health Nursing*, 18, 178-185.
- Whitehead, B. (1997). Motivational interviewing. *Substance Misuse Management in General Practice Newsletter*, Vol 8.
- Wagner, C. C. & Connors, W. (2008). *Motivational interviewing: Resources for clinicians, researchers and trainers*. Retrieved August 27, 2008 from www.motivationalinterview.org

1.2.4 Social marketing

The term social marketing describes a method of behaviour change intervention which is broader than those already discussed. The concept offers a structure or framework, based on social change theory, with which to change behaviours that are detrimental to health or antisocial in nature (Kotler & Roberto, 1989 quoted in MacFayden, Tead & Hastings, 2003). The method usually involves a logical planning process for an intervention programme based on traditional marketing techniques and therefore, as MacFayden et al. (2003) have outlined, typically encompasses the following:

- consumer-oriented research;
- marketing analysis;
- market segmentation;
- objective setting;

-
- identification of strategies and tactics.

A social marketing campaign may well encompass one or more of the above methods of behaviour change but could also contain a broader strategy to disseminate information to a large number of people (Robertson, 2008). As with commercial marketing techniques, consideration needs to be given to the following areas when designing a strategy for using information to change behaviour: the source of the message, the content of the message, the channel through which it will be communicated, the characteristics of the audience and the desired outcome of the process (McGuire, 1989, cited in Robertson, 2008).

Social marketing contains a focus on voluntary behaviour change and rests on the assumption that behaviour change is governed by the principle of exchange, that is, the customer must perceive a benefit for changing his or her behaviour (MacFayden et al., 2003). Unlike the other behaviour change methods discussed here, there is a definite need within social marketing to address behaviour change at three levels: the micro (individual), the group, and the macro (society) level (MacFayden et al., 2003). Emphasis is placed on understanding the life context and aspirations of individuals and their communities, which is then used to inform programmes that 'enable and encourage people to participate in positive health behaviour' (National Consumer Council & DH, 2005, p. 2).

MacFayden et al. (2003) highlight seven areas for consideration when marketing a change in behaviour which are adapted from commercial marketing techniques:

- trialability of the behaviour (can it be tried before it is adopted?);
- ease of adoption of the behaviour;
- risks of adopting the behaviour;
- image of the behaviour;
- acceptability of the behaviour;
- necessity of sustaining the behaviour;
- cost of adopting the behaviour.

Other terms which might be used to describe a social marketing campaign might include 'mass media campaigns,' 'information campaigns' or 'multifaceted interventions'.

Evidence for the effectiveness of social marketing

Measuring the impact of social marketing campaigns can prove problematic as it may be difficult to isolate the effects of the campaign from other factors when exploring the impact of a long-term campaign (Robertson, 2008). However, several campaigns have been shown to be effective in relation to healthy eating, increased physical exercise, smoking prevention and tackling substance misuse (Robertson, 2008; Gordon, McDermott, Stead, & Angus, 2006). A review of the evidence of the effectiveness of social marketing in relation to health found that such interventions can work with a range of target groups, in different settings and concluded that social marketing provides a good framework for improving health at environmental and policy levels (Gordon et al., 2006). There is some evidence that the multifaceted nature of social marketing interventions is important to the impact they can have (Robertson, 2008).

Examples of use

AltN8 is a multifaceted project led by Blackpool Primary Care Trust aimed at reducing binge drinking and its negative impact amongst drinkers in their teens and older (including those aged up to 44 years). The project encourages drinkers to alternate alcoholic drinks with water or soft drinks or to alternate the days on which they drink to give their liver time to recover. The project has involved the distribution of merchandise to local pubs and clubs encouraging drinkers to request free water from licensed premises. For more information visit: <http://healthintelligence.bmj.com/hi/do/projects/project/ALC.LO.004.html>.

As social marketing entails an approach to behaviour change which is broader than the other intervention methods described here, best practice guidance in this document does not extend to social marketing campaigns. The guidance provided here however, may still be applicable to those elements of a campaign which involve one-to-one interventions.

Further sources of information:

Academy for Educational Development: <http://www.aed.org/Approaches/SocialMarketing/index.cfm>

Hussey, R. (2007). *Living better, living longer: Improving and protecting health in the North West*. Retrieved August 27, 2008 from http://www.northwest.nhs.uk/document_uploads/Board_Papers/06.%20Living%20Better%20Living%20Longer.pdf

McGuire, W. J. (1989). Theoretical foundations of campaigns. In R. Rice & C. Atkin (Eds.), *Public Communication Campaigns* (2nd ed.). London: Sage.

The Social Marketing Network, Canada: <http://www.hc-sc.gc.ca/ahc-asc/activit/marketsoc/>

Weinreich Communications, on-line resource: www.social-marketing.com

1.3 Theories of behaviour change

A number of different theories, drawn from the social and behavioural sciences, have been used to inform behaviour change interventions and there is evidence to suggest that interventions with a clear and coherent theoretical grounding are more effective in producing longer-term changes in behaviour than those with no explicit theoretical base (Hillsdon et al., 2005). NICE guidelines on behaviour change provide a comprehensive list of theories used to inform their findings (NICE, 2007a). An overview of the key theories used in the wider behaviour change literature is given here.

1.3.1 The transtheoretical stages of change model

The most frequently used theory of behaviour change is the transtheoretical stages of change model devised by Prochaska and DiClemente (1983). This model is organised around the stages of change process through which individuals are perceived to progress during intentional behaviour change, challenging the notion that behaviour change is a discrete event (Cancer Prevention Research Centre [CPRC], n.d.). The theory centres on individuals' decision making processes; social and biological factors are viewed as secondary influences experienced individually (CPRC, n.d.). The model defines five clear stages of readiness to change, as detailed below:

1. precontemplation: the individual has no plan to change behaviour;
2. contemplation: the individual is considering planning a change;
3. preparation: the individual is committed to changing within the next month;
4. action: behaviour modification is taking place;
5. maintenance: the individual has completed successful behaviour change after 3-6 months.

It is suggested that variation in readiness to change amongst individuals equates to variation in individual needs which means that tailored interventions are far more likely to achieve success (Rollnick, 2005; Coleman, 2004). This is, in part, due to the fact that

understanding a person's readiness to change and acknowledging barriers that he or she may face can improve service satisfaction as well as reduce any frustration staff delivering interventions may experience (Zimmerman et al., 2000).

The transtheoretical model encompasses a number of other behavioural theories such as Janis and Mann's decision making model (1977) and Bandura's self-efficacy theory (1989). Using the decision making model individuals are seen to weigh up pros and cons in behavioural choices that fall into four categories: personal instrumental gains from the behaviour; instrumental gains for others; personal disapproval, and, disapproval for others (CPRC, n.d.). Individuals re-evaluate the balance of the pros and cons of their behaviour along their progress route. The self-efficacy model measures the confidence an individual has to engage – or not – in specific behaviours, which increases as individuals move along the stage of change.

Further sources of information

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Janis, I. L., & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. New York: Free Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. *American Psychologist*, 47, 1102-1114.

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Velicer, W. F., DiClemente, C. C., Rossi, J. S., & Prochaska, J. O. (1990). Relapse situations and self-efficacy: An integrative model. *Addictive Behaviours*, 15, 271-283.

1.3.2 The health belief model

The health belief model is a psychological model used to predict behaviour in relation to health (University of Twente, 2004a). The model is based on the assumption that

individuals will change health behaviour if they perceive that a negative health condition can be avoided, have a positive expectation that recommended action will prevent a negative health condition, and that they have confidence in their ability to carry out a recommended action (University of Twente, 2004a). The model uses four constructs to determine a person's readiness to act: perceived susceptibility, perceived severity, perceived benefits, and, perceived barriers (University of Twente, 2004a).

Further sources of information

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Champion, V.L. (1984). Instrument development for health belief model constructs. *Advances in Nursing Science*, 6, 73-85.

Conner, M., & Norman, P. (1996). *Predicting health behaviour: Research practice with social cognition models*. Buckingham: Open University Press.

Eisen, M., Zellman, G. L., McAlister, A. L. (1992). A health belief model – social learning theory approach to adolescents' fertility control: Findings from a controlled field trial. *Health Education Quarterly*, Vol. 19.

Glanz, K., Lewis, F. M., & Rimer, B. K. (1997). *Theory at a glance: A guide for health promotion practice*. Baltimore: National Institute of Health.

Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health behaviour and health education: Theory, research and practice*. San Fransisco: Wiley & Sons.

Rosenstock, I. (1974). Historical origins of the health belief model. *Health Education Monographs*. Vol. 2 No. 4.

1.3.3 Social cognitive learning theory

Social cognitive learning theory claims that behaviour is explained by a reciprocal interaction between individuals and their environment (University of Twente, 2004b). The theory states that behaviour is determined by an individual's knowledge and skills, beliefs about the outcomes of action, confidence in their ability to take action, beliefs based on observation of others, and, responses to their own behaviour (University of Twente, 2004b).

Further sources of information

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Glanz, K., Rimer, B. K., & Lewis, F. M. (2002). *Health behaviour and health education: Theory, research and practice*. San Fransisco: Wiley & Sons.

Graham, S., & Weiner, B. (1996). Theories and principles of motivation. In D. C. Berliner & R. C. Calfee (Eds.). *Handbook of educational psychology* (pp. 63-84). New York: Simon & Schuster Macmillan.

1.3.4 Diffusion of innovations theory

The diffusion of innovations theory explores the conditions in which innovations in idea, product, or practice will be adopted by members of a given culture, considering the flow of information through networks and the influence of media as well as interpersonal contacts (University of Twente, 2004c).

Further sources of information:

Rogers, E. M. (1976). New product adoption and diffusion. *Journal of Consumer Research*, 2 (March), 290 -301.

Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). The Free Press: New York.

1.3.5 Other theories used to inform behaviour change interventions

A number of other theories of behaviour change are used to inform interventions. Azjen's theory of planned behaviour (cited in Robertson, 2008) states that attitudes towards behaviour are shaped by beliefs about outcomes of a behaviour and evaluation of the likelihood of those outcomes occurring. There is evidence to suggest that in complex situations people base their decisions on anecdotal evidence and past experience rather than statistical probabilities and often, greater emphasis is given to current events compared to those that are perceived as far-off (Jochelson, 2007). Azjen's theory also emphasises the impact of subjective norms on behavioural decisions, highlighting the impact of peer opinion on people's decisions (Robertson, 2008). This indicates the importance of information delivery within behaviour change interventions to challenging people's perceptions of what constitutes normal behaviour (Robertson, 2008).

The theory of persuasion devised by Petty and Cacioppo, 1986, (cited in Robertson, 2008) suggests that people apply differing levels of scrutiny to information according to their level of motivation to change. The continuum of scrutiny ranges from close scrutiny (requiring central processing) to peripheral processing, where little attention is paid. This theory is particularly useful in the planning of social marketing campaigns (Robertson, 2008).

Chapter 2

Good practice in delivery of behaviour change interventions

2.1 Introduction

There is consensus within the literature that the manner in which behaviour change interventions are delivered will impact significantly on their effectiveness. Careful consideration needs to be given to the setting, personal circumstances of recipients of interventions, staff attributes and the process of delivery. The next section provides guidance on best practice which primarily relates to structured brief interventions. Many of the recommendations are applicable to any method of behaviour change intervention however, and several examples are given which relate specifically to delivery of brief advice and use of motivational interviewing techniques.

2.2 The setting for interventions

A good deal of importance is afforded to the setting for any intervention within the literature. There is evidence to suggest that behaviour change interventions can be successful in a range of healthcare and community settings.

2.2.1 Healthcare settings

Primary care has been identified as a suitable setting in which to deliver behaviour change interventions, principally due to the large number of people using primary care services and the frequency with which the services are used (Lock, 2004a; Alcohol Concern, n.d.). It is estimated that 70% of the population visit their GP each year, and of significance for alcohol interventions, problem drinkers are known to consult their GP twice as often as other patients (Alcohol Concern, n.d.). Primary care settings are also considered suitable because of the opportunity afforded for continuous monitoring and repeated intervention (Babor & Higgins-Biddle, 2001). Evidence for the effectiveness of interventions for alcohol in primary care is good (Moyer, Finney, Swearingen & Vergun, 2002) and there is review-level evidence that brief advice in general practice significantly increases the chances of smoking cessation compared to receiving no advice (Naidoo, Warm, Quigley, & Taylor, 2004).

A review of opinion towards screening and brief intervention for alcohol in primary care found that experts in the field believed that new patient registrations, health and

lifestyle reviews and special clinics present the best opportunities for screening patients without causing offence (Heather, Dallolio, Hutchings, Kaner & White, 2004). There is little support for establishing routine delivery of alcohol interventions in primary care (Heather et al., 2004; Beich, Gannik & Malterud, 2002).

The large number of alcohol-related incidents which occur in Accident and Emergency (A&E) departments is said to render A&E an appropriate setting in which to offer brief interventions for problem alcohol consumption (Lock, 2004a; Conigrave, Harding Burns, Reznik, & Saunders, 1991; Alcohol Concern, n.d.) and the efficacy of interventions in this setting is well supported (Nilsen et al., 2008). Nilsen et al. (2008) have recently questioned the evidence in support of this setting however, suggesting that the impact of the traumatic incident itself on behaviour change needs to be explored along with the receptiveness of trauma patients to brief interventions. Though less extensive than the evidence for A&E interventions, there is some indication that interventions for alcohol misuse can be effective in general wards (Lock, 2004b) and there is also evidence to suggest that nurse-led interventions as part of hospitalised cardiac rehabilitation are effective in increasing smoking cessation rates (Naidoo et al., 2004).

Other health settings have been used successfully to deliver behaviour change interventions such as smoking interventions within dental practices (Naidoo et al., 2004) and weight management in paediatric clinics (West & Saffin, 2008).

2.2.2 Community settings

There is evidence to support the use of behaviour interventions in a range of other settings outside of health services. Schools have provided the setting for a number of health-based interventions with children and young people (West & Saffin, 2008). There is evidence to suggest that school-based peer interventions, particularly when coupled with mass media campaigns, are effective in preventing children from taking up smoking (Naidoo et al., 2004) and schools have been found to provide a good setting for drug abuse interventions (Winters, Leitten, Wagner & O'Leary Tevyaw, 2007). A range of different interventions, including multi-component interventions have been used within schools to address alcohol misuse with varying degrees of success (Jones et al., 2007).

In their review of the literature regarding brief interventions for childhood obesity, West and Saffin (2008) found a number of barriers to effective implementation of interventions in schools. They emphasise the limited resources available to teachers, particularly in relation to time; fears amongst teachers that they may stigmatise obese and overweight pupils or damage pupil self-esteem; and the limitation of brief interventions to challenge pupils' home environment. The review found that parental involvement in any intervention was important in achieving success.

Interventions targeting individuals in community settings have been shown to be effective in producing long-term changes in physical activity and are likely to be effective in producing mid- to long-term changes in physical activity (Hillsdon et al., 2005). In relation to smoking, there is review-level evidence to suggest that community-wide interventions based on social learning theory are effective in preventing the uptake of smoking in young people (Naidoo et al., 2004).

There are numerous examples of workplace interventions for alcohol interventions (Lock, 2004b; Roman & Blum, 1996), smoking interventions (Naidoo et al., 2004) and interventions promoting physical activity (Hillsdon et al., 2005). Workplace interventions for physical activity have been found to produce mixed results however (Hillsdon et al., 2005).

2.2.3 The physical environment

Rollnick, Mason and Butler (1999) recommend six essential considerations that should be given to the physical setting for any type of intervention:

- the opportunity within the type of consultation to listen to the individual;
- the level of privacy afforded;
- the ability to offer shared access to notes;
- the appropriateness of displays within the room such as wall posters;
- the style of dress of the person delivering the intervention;
- the introduction of everyone present in the room.

Rollnick et al. (1999) suggest that these factors may all contribute to the development of rapport between staff and service users.

2.3 Individual circumstances

In order to increase the likelihood that people are responsive to interventions, consideration needs to be given to individual circumstances. The individual's suitability for treatment, readiness to change behaviour and personal circumstances all need to be taken into account. In addition, consideration should be given to the evidence base for interventions with people of different ages, sex, ethnicities and socio-economic backgrounds.

2.3.1 Identifying the need for intervention: screening tools for substance misuse

Behaviour change interventions are preventative in nature and are not always appropriate for more pronounced problems such as alcohol dependence. For example, there is evidence to show that people with an advanced stage of alcohol risk may not find proactive counselling helpful (Sieck et al., 2004). A number of screening tools exist for establishing a person's level of alcohol use. In their manual for conducting brief interventions, Babor & Higgins-Biddle (2001) recommend that a standardised, validated screening tool such as the Alcohol Use Disorders Identification Test (AUDIT) is used. For examples of other screening tools see Primary Care Alcohol Information Service (n.d.) and Project Cork (2004).

Different tools may be applicable to different settings and can be chosen to accommodate time constraints. Fleming (2004) has produced a guide for determining which level of screening for alcohol is appropriate in a clinic setting.

2.3.2 Stage of change

As already discussed, there is widespread support for tailoring interventions to individuals' stage of change (Shinitzky & Kub, 2001; Zimmerman et al., 2000). Service providers' aspirations for their clients may be different to their clients' own aspirations and so it is necessary to establish how important change is to individuals in order to determine what level of information to offer (Rollnick, 2005). A number of assessment tools exist to establish readiness to change such as the Readiness to Change Ruler, which requires individuals to place themselves on a scale from ready to not ready (see Zimmerman et al., 2000), and the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), an instrument designed to assess motivation for

change in problem drinkers (Miller & Tonigan, 1996). Shinitzky and Kub (2001) provide an overview of several other tools for assessing a person's readiness to change.

Rollnick et al. (1999) draw attention to the fact that individuals may be at different stages of change for different types of behaviour and suggest that interventions for each behaviour modification should be tailored to the relevant stage of change. Zimmerman et al. (2000) suggest that an agenda-setting chart provides a useful way of determining which areas of their behaviour individuals may be willing to change and ensures that the individual maintains control of the agenda.

People can move back and forth through the stages of change model and it is necessary to consider individual current circumstances. It is suggested that people may be more amenable to behaviour change following significant life events or at key transition points in their lives, such as leaving school, becoming a parent or experiencing bereavement (NICE, 2007a). Rollnick et al. (1999) suggest that the immediate context of a meeting might determine receptiveness to the intervention and suggest that significant events may also negatively affect receptiveness to change. For example, it is proposed that a person who has just suffered a car accident may be too preoccupied to discuss behaviour change (Rollnick et al., 1999). With this in mind, staff are advised to reach out to clients regularly, regardless of their stage of change, in order to make them aware of the availability of support (Zimmerman et al., 2000).

2.3.3 Client profile

Within the behaviour change literature, attention has been paid to the impact of interventions on people from different backgrounds. In the section below, some of the evidence of the effectiveness of interventions with these groups is presented as well as recommendations for staff working with those groups. Miller and Rollnick (2002) provide a number of useful chapters for dealing with different client circumstances, including those involved with the Criminal Justice System, couples and those with mental health issues.

Age

There is evidence to support the effectiveness of a range of interventions across different age groups in the population. However, the literature contains comparatively little information regarding behaviour interventions in relation to children and young people (West & Saffin, 2008). There are few reviews or original studies on overweight

and obesity interventions for children aged 4-11 years, for example, and it has been suggested that the concepts and skills required of people in behaviour change, such as understanding obesity and how to tackle it can be too difficult for some younger children to comprehend (West & Saffin, 2008). Despite this, Miller and Rollnick (2002) have expressed confidence that motivational interviewing poses a promising approach for working with young people, though they acknowledge that using this type of work with this age group is relatively new.

There is some evidence to support interventions with young people to prevent smoking and alcohol misuse. For example, there is some evidence to suggest that community interventions for preventing uptake of smoking amongst young people are effective (Sowden & Stead, 2003). Evidence to support brief interventions in schools for prevention and reduction in alcohol use is limited and largely restricted to the USA (NICE, 2007b) but there is evidence to suggest that multi-component interventions, with family and school or community involvement can be successful in relation to physical activity (Sluijs, McMinn & Griffin, 2007). Baer and Peterson (2002) provide some useful advice for those seeking to approach behaviour change interventions with young people.

There is evidence to support the effectiveness of interventions at different life stages. For example, there is evidence to show that brief interventions for alcohol misuse can be effective amongst young adults (aged 18-39) (Monti et al., 2007; Hungerford et al. 2003). There is also review-level evidence to show that a variety of smoking cessation interventions can be effective for older adults, including counselling interventions, physician advice, buddy support programmes, age-tailored self-help materials, and proactive telephone counselling (Naidoo et al., 2004). There is also evidence to suggest that interventions to improve physical activity amongst adults aged 50 years and older can be effective in the mid- to long-term (Hillsdon et al., 2005).

Sex

While there is much evidence to support the effectiveness of brief interventions in relation to alcohol there is some concern about the evidence of the effectiveness of such interventions amongst women (Kaner et al., 2007). There is some disagreement over this issue, and several meta-analyses have found no important differences in relation to intervention outcomes for men and women (Whitlock, Polen, Green, Orleans & Klein, 2004; Moyer et al., 2002). There is also evidence to suggest that the same

smoking cessation interventions are effective for both men and women (Naidoo et al., 2004).

Ethnicity

Mossavar-Rahmani (2007) describes how important it is to understand clients' behavioural and cultural contexts in order to help them achieve change and highlights that there may be circumstances which are unique to ethnically diverse populations such as travel to host country, complex family obligations, limited financial resources and spirituality. In relation to obesity, Doak, Visscher, Renders and Seidell (2006) highlight the difficulty of introducing interventions in socially, ethnically and culturally diverse areas where people may have differing health beliefs and attitudes to diet. There is evidence to support the impact of interventions amongst different ethnic groups. For example, smoking cessation treatments have been shown to be effective across different black and minority ethnic groups but as discussed below, not all studies take into account the diversity of their population (Naidoo et al., 2004).

Socioeconomic circumstances

A review of the evidence for studies targeting people from lower socio-economic groups, people with lower education levels and ethnic minority groups found that many of the studies did not address the differential effectiveness of interventions among these groups, or how much the different aspects of interventions affected them (Naidoo et al., 2004). A King's Fund commissioned review of behaviour change interventions targeted at low-income groups found that information giving and goal setting were amongst the most effective techniques used with these groups of people (Michie, Jochelson, Markham & Bridle, 2008). The review, which focussed on interventions for smoking cessation, encouraging healthy eating, and promoting physical activity, concluded that these techniques may have been particularly helpful because of a lower knowledge and skills base amongst these groups (Michie et al., 2008).

2.4 The role of staff in the delivery of behaviour change interventions

There is a great deal of advice within the literature with regard to which professionals are best placed to perform behaviour change interventions and with regard to the skills and personal qualities which help to deliver effective interventions.

2.4.1 The professional role of the person delivering the intervention

There is some dispute within the literature as to whether staff should hold specialist qualifications in order to perform behaviour change interventions. In relation to alcohol, there is support amongst experts in the field for using staff who have specialist qualifications and experience of dealing with alcohol (Heather et al., 2004) while others suggest that this is unnecessary (Alcohol Concern, n.d.). It has been suggested that use of specialist alcohol workers to deliver interventions can be interpreted negatively by recipients given the stigma sometimes associated with formal alcohol interventions (Lock, 2004b). Careful attention therefore needs to be paid to individual preferences when considering who is most suitable to deliver interventions in relation to alcohol.

GPs

There is some agreement within the literature that GPs are well-placed to deliver behaviour change interventions (Heather et al., 2004) given their established relationships with patients, the level of respect which their role commands and their level of access to the population (Lock, 2004b). In a review of patients' perceptions of alcohol interventions in primary care, GPs were the preferred professional with whom to discuss alcohol issues (Lock, 2004b). There is evidence to suggest, however, that expert opinion on the role that GPs should perform in screening and brief interventions for alcohol is undecided (Heather et al., 2004).

Nurses

Nurses are considered to hold a suitable position for the delivery of behaviour change interventions given the level of health promotion work that they have increasingly come to perform in primary care and their repeated contact with patients (Lock, 2004b). There is particular support for the involvement of community psychiatric nurses and practice nurses in alcohol interventions (Heather et al., 2004). There appears to be some uncertainty regarding the responsibility of nurses for performing this role however, and poor role definition overall has been identified as a barrier to conducting interventions by nurses (Roche & Freeman, 2004). Research into nurses' experiences of alcohol intervention training found that almost all participants (98%) perceived health promotion to be part of their role and a further 95% perceived that screening for alcohol misuse should be part of their role (Deehan, McCambridge, Ball & Strang, 2002).

There is evidence to indicate patient support for nurse-led interventions (Roche & Freeman, 2004), some of which suggests that patients would prefer to receive

interventions from a nurse rather than doctor as they anticipate that nurses have more time to discuss lifestyle issues (Locke, 2004b). In addition, it has been suggested that alcohol and drug interventions are consistent with the role of a practice nurse (Roche & Freeman, 2004). Conversely, it has also been shown that some patients anticipate that nurses would lack relevant training to deal with, in particular, alcohol-related issues (Locke, 2004b) and that patients can be more likely to adhere to lifestyle changes recommended by a doctor rather than a nurse (Torke, Corbie-Smith & Branch, 2004).

Other health professionals

There is support amongst experts in the field for involvement from dieticians in relation to alcohol interventions (Heather et al., 2004) and there are examples of dietician-led brief interventions in relation to obesity for children and young people, and interventions for smoking cessation from dental professionals (West & Saffin, 2008). Sieck et al. (2004) advocate addressing behaviour change in relation to individuals' own concerns about their health or lifestyle; therefore training professionals from a range of areas of the health service means that any concerns raised by service users can be used as an opportunity to address behaviour change.

Non-medical staff

It is suggested that a medical background is not necessary for staff delivering behaviour interventions (Field et al., 2005). MacLeod, Hungerford, Dunn and Hartzler (in press) suggest that the formal role of the person delivering the intervention is less important than the skills he or she possesses to deliver an intervention. Service user views support this; one study found that patients attending health promotion clinics perceived a practitioner's ability to respond to their health concerns to be of greater importance than the type of professional running the clinic (Eggleston et al., 1995). Maryon-Davis (2005) has advocated training of non-medical staff to perform the role of 'lifestyle advisors' in support of the intervention work performed by clinicians.

NICE guidelines on interventions for alcohol in schools state that those people delivering interventions with children and young people need to have the trust and respect of the young people with whom they are working and recommend that teachers, school nurses and school counsellors should take on the task of delivering brief advice (NICE, 2007b).

2.4.2 Staff attributes

Several attributes are routinely identified within the literature as facilitating behaviour change interventions: the ability to develop rapport, sensitivity to individual circumstances and the ability to manage personal beliefs and attitudes within consultations. These are discussed in more detail below.

Rapport

It is reported that people respond positively to advice from someone with whom they have developed a relationship and rapport (Lock, 2004b). Developing and maintaining rapport during behaviour change interventions can present a challenge (Beich et al., 2002) particularly in a medical setting where behaviour change interventions represent a departure from typical practice, requiring professionals to assist the patient to seek out solutions to current or potential health problems rather than prescribe a course of action (Field et al., 2005). This requires staff to conduct consultations in a non-confrontational manner as the emphasis is shifted away from their authority (Field et al., 2005). Empathy plays an important role in achieving good rapport with clients. Displaying empathy allows staff to build trust and to generate useful information about clients which will assist interventions (Field et al., 2005).

Rollnick (2005) points out that receiving brief advice or participating in a brief intervention can leave individuals emotionally vulnerable, given the likelihood that the process may involve a discomfiting realisation for the recipient about the effects of his or her behaviour. It is suggested that staff have an ethical obligation to ensure that they are able to support people through this realisation stage (Rollnick, 2005). Having established or maintained rapport with individuals through a behaviour change intervention, it is suggested that support and monitoring of the individual is carried out by the member of staff who conducted the initial intervention (Heather et al., 2004).

Sensitivity to individual circumstances

Shinitzky and Kub (2001) emphasise that staff need to be understanding of a person's life context in order to help him or her effect change. Acknowledging the context of the meeting with any individual – for example whether they have been kept waiting or whether the appointment is scheduled late in the day – enables staff to gain an understanding of how the client might be feeling and how responsive they may be to a behaviour change discussion. It also ensures that people feel respected from the beginning of any interaction rendering any subsequent discussion easier (Rollnick et

al., 1999). Rollnick et al. suggest that staff need to feel and display genuine concern about individuals in order to develop a facilitative relationship.

Personal beliefs and attitudes

The literature suggests that the personal beliefs and attitudes of staff are likely to play a role in any behaviour change intervention (Roche & Freeman, 2004). For example, there is evidence to suggest that nurses who smoke have a more negative attitude towards giving smoking cessation advice and that those who have succeeded in quitting will be more enthusiastic (Hall et al. cited in Ubido et al., 2006). Similarly, negative beliefs on the part of staff towards certain behaviours are often detected by recipients of any intervention and can affect the development of rapport (Roche & Freeman, 2004; D'Onofrio et al., 2002); staff are advised to consider their use of language carefully in order to avoid stigmatising and isolating their service users (Lock, 2004a). Sieck et al. (2004) suggest that staff will perform more effectively if they focus discussion on an aspect of the behaviour change with which they are comfortable; for example, staff who are adverse to alcohol consumption may feel more comfortable discussing the physiological reasons for the recommended alcohol limits.

There is also concern that staff who are perceived to neglect healthy behaviours themselves may provide negative role models, hampering the intervention process. There is some evidence to suggest that this might be applicable to the delivery of obesity interventions by staff who are visibly obese (Doak et al., 2006).

2.5 The delivery process

Sieck et al., (2004) suggest that behaviour interventions require three basic elements: getting people's attention, overcoming avoidance, and encouraging change efforts. The following section outlines good practice which is applicable to each of these elements of the intervention.

2.5.1 A personalised approach

A repeated theme within the literature is the need to focus on the individual in any behaviour change intervention (Heather et al., 2004; Rollnick et al., 1999). A 'one size fits all' approach is redundant in behaviour change (Zimmerman et al., 2000) as personal circumstances and reasons for behaviour are unique. Staff are advised to tailor support to individual needs (Shinitzky & Kub, 2001) and to change the nature of

the support to suit needs as they change over time (NICE, 2006b). By adopting a personalised approach, clients can be made aware of the responsibility they must take for their own behaviour and for this reason staff are encouraged to personalise the risk factors when providing information (Zimmerman et al., 2000).

2.5.2 Raising the issue

In their introduction to using motivational interventions Field et al. (2005) emphasise the importance of the manner in which the topic of behaviour change is introduced. In relation to alcohol, the authors recommend that staff use the following guidelines to introduce a discussion:

- indicate that the discussion will be different from other behaviour change interventions that might have been experienced;
- indicate the anticipated duration of the discussion;
- outline goals and expectations of the discussion;
- indicate that a client-led approach will be taken.

Presenting an agenda prior to the introduction of any formal screening for alcohol use prepares people for the discussion (Zimmerman et al., 2000; Rollnick et al., 1999) and clarifies expectations of the consultation early on (Rollnick et al., 1999). Some staff may wish to adopt the use of tools for discussion such as an agenda setting chart (see Stott et al., 1995 quoted in Rollnick, 2005) or the concept of a stress bucket to talk about current lifestyle issues (see Rollnick et al., 1999).

It can be helpful to address health behaviour change within the context of an individual's overall health, and this is considered particularly important in relation to alcohol in order to avoid stigmatising people (Sieck et al., 2004). Sieck et al. advise that staff steer the conversation along the lines of any concerns clients may raise in order to maintain a non-judgmental health-oriented emphasis to the discussion. For example, staff may find an opening to discuss alcohol consumption with an individual who expresses concern about his or her weight (Sieck et al., 2004).

The Department of Health has produced a handbook for health trainers responsible for helping people to achieve health change (DH, 2008). The handbook contains tools for helping individuals to identify the impact of their behaviour on their health such as the Health Behaviour Check and Health Benefit Cards.

2.5.3 Client-directed discussion

Recipients of brief advice or brief interventions should be encouraged to play an active role in the intervention; an enquiring client is more likely to achieve behaviour change (Rollnick, 2005). Staff are advised to respect individuals' autonomy in order to encourage them to recognise the control they have over their own situation (Field et al., 2005). In addition to the impact on self-efficacy, this approach enables staff to identify ways in which to help individuals. If individuals are seen as the experts in their own lives (Shinitizky & Kub, 2001; Zimmerman et al., 2000) they can be encouraged to identify any barriers and facilitating factors they anticipate if they were to change their behaviour.

2.5.4 Discussion techniques

Field et al. (2005) have outlined four fundamental strategies for brief motivational interventions:

1. Open-ended questions.
2. Affirmations.
3. Reflections.
4. Summaries.

Open-ended questions encourage people to elaborate when discussing their circumstances and attitudes to change (Shinitizky & Kub, 2001). Affirmations help people to recognise their own strengths and help to build rapport, while reflections and summaries help to ensure good communication and to draw out meaning from any discussion (Field et al., 2005).

In relation to alcohol interventions, Field et al. (2005) suggest that asking people to describe a typical day when they drink helps to establish understanding of patterns of consumption. Using this technique to establish triggers for behaviour may prove useful in relation to other behaviour change interventions. Rollnick et al. (1999) describe a similar technique whereby clients are asked to describe their lifestyle; the authors emphasise that this exercise should not constitute a daunting interrogation but rather an opportunity for the individual to paint a picture of his or her life. This strategy is also helpful for establishing an individual's circumstances, for example, other commitments which might make change difficult (Rollnick et al., 1999).

The literature also encourages asking people to talk about their behaviour in order to see what knowledge they have regarding its effects. Field et al. (2005) suggest that most people are aware of the effects of their behaviour and advise that this technique can avoid provision of redundant information. Rollnick (2005) advocates an elicit–provide–elicit framework in order to: elicit what the patient knows and wants to know; provide information in a neutral fashion; and draw out the patient’s interpretation of its personal relevance.

Coleman (2004) advocates the *Five As approach to smoking cessation* to assist consultations regarding smoking:

1. **Ask** about smoking at every opportunity.
2. **Assess** smokers’ interest in stopping.
3. **Advise** against smoking.
4. **Assist** smokers to stop.
5. **Arrange** follow up.

The Department of Health handbook for health trainers contains advice on how to structure intervention discussions as well as example scripts for good practice (DH, 2008).

2.5.5 Self-efficacy

It is important to determine how confident people are in their own ability to effect change in order to identify strategies for support. Staff should endeavour to help individuals to see that they are in control of their own life (Shinitzky & Kub, 2001) and attempt to instil hope towards change (Zimmerman et al., 2005). Field et al. (2005) advocate the use of direct questions to assess confidence to change and questions to determine what would increase individuals’ levels of confidence.

2.5.6 Values and goals

Discussing clients’ goals will help them to identify whether these clash with their behaviour choice (Field et al., 2005). Staff should help people to consider how their values are related to goals in order to help them to identify reasons to change their behaviour (Field et al., 2005). Gently pointing out discrepancies between goals and current behaviour will hopefully lead individuals to weigh up the pros and cons of their

behaviour (Zimmerman et al., 2000). This technique involves eliciting motivation from the client rather than trying to instil it from the outside which demands that staff perform a more detached role in the consultation (Rollnick, 2005).

2.5.7 Change plans

Staff are encouraged to set change plans with clients in order to record goals and move change forward. These plans should be made through a collaborative effort between the client and member of staff (Sieck et al., 2004) but the targets should be determined by the client (Field et al., 2005).

Field et al. (2005) suggest four key elements to be included in a plan for change:

1. Setting specific goals.
2. Identifying high-risk situations.
3. Identifying strategies and people to offer support.
4. An evaluation of whether a formal assessment or treatment is needed.

The Department of Health handbook for health trainers contains information on tools for developing action plans with clients such as those for setting SMART goals and developing a Personal Health Guide (DH, 2008). It is important to document conversations and specific tasks to follow up in order to monitor people's progress (Zimmerman, et al., 2000). The Department of Health handbook also contains information on tools for monitoring behaviour change progress such as the Behaviour Change Diary (DH, 2008).

2.5.8 Dealing with resistance

If staff encounter resistance it is an indication that they need to change course to re-establish rapport (Field et al., 2005). Advocating change, coercion or using persuasion may encourage people to present counter arguments and defend their behaviour and so should be avoided (Field et al., 2005). Similarly, asking people 'why' they behave in a certain way can invite defence and justification for behaviour (Shinitzky & Kub, 2001). Staff should avoid the temptation to present a rational argument and should instead align themselves with the client and allow him or her to control the direction of the discussion (Rollnick, 2005).

2.5.9 Dealing with relapse

Relapse in behaviour change is a common occurrence (Dunn, Hungerford, Field & McCann, 2005; Zimmerman et al., 2000) which can easily be interpreted as failure. This interpretation can isolate people however and might lead them to avoid seeking further help. Labelling someone 'non-compliant' or 'unmotivated' is unhelpful and ignores the complexity of the behaviour change process (Zimmerman et al., 2000). Instead, it should be acknowledged that behaviour change is rarely a discrete event and, rather, involves individuals moving from one stage of change to the next: this will inevitably mean most people recycle through the stages of change (Zimmerman et al., 2000). When a relapse occurs staff are advised to ask people about their previous efforts: what helped them to maintain short-term change and what hindered their efforts? Something can be learned from every episode in the behaviour change cycle and shifting the focus of the consultation from failure to problem solving can be more productive (Zimmerman et al., 2000).

2.5.10 Accessibility

Information given needs to be appropriate to people's literacy level, their English language proficiency and their physical abilities, for example alternatives to information in written format need to be made available for people with visual impairments (NICE, 2006b). Staff need to employ creative methods and technologies in order to make interventions accessible to all, for example interventions can be made possible via telephone or internet (Velicer, Prochaska, & Redding, 2006). There is some evidence to suggest that internet-based interventions can attract high usage and can be successful in achieving change in self-reported alcohol consumption (Linke, Murray, Butler & Wallace, 2007).

2.5.11 Use of incentives

A Kings' Fund review of the evidence found that financial incentives can be effective in encouraging people to perform simple behavioural tasks such as attending a behaviour change session but are less effective in addressing long-term change of complex behaviours (Jochelson, 2007). The review authors concluded that incentives only facilitate short-term impacts because they crowd out intrinsic motivations which resurface in the longer term. Incentives also fail to address individuals within their social context (Jochelson, 2007). The review found that financial incentives could lower economic barriers to entry into behaviour change initiatives (such as travel costs, for

example) but that using sanctions to promote behaviour change was likely to reinforce people's sense of failure and reduce self-efficacy (Jochelson, 2007).

2.5.12 Evaluating the quality of the intervention

Staff are advised to reflect on client responses in order to assess the quality of any interaction (Field et al., 2005). Careful attention should be paid to the language clients are using to assess whether messages are being understood and accepted. Formal assessment tools exist to measure adherence to motivational interviewing codes of practice; for more information about the Motivational Interviewing Skill Code and the Motivational Treatment Integrity see: www.motivationalinterviewing.org (Field et al., 2005).

Further sources of information

The SIPS programme

The Screening and Intervention Programme for Sensible Drinking (SIPS) is a research project being led by St George's University of London and the University of Newcastle which aims to identify the most appropriate, acceptable and cost effective screening methods, brief intervention techniques, and methods of implementation effective in three different settings: primary health, A&E and the Criminal Justice Service. More information can be found at <http://www.sips.sgul.ac.uk/faqs.php>.

Health trainers

Health Trainers are accredited NHS trainers based in the community who offer practical advice and support to people who have expressed an interest in changing their behaviour. People may be referred to a local health trainer from a variety of sources, including general practice (DH, 2004). Health trainers act as guides to help people achieve change. The Department of Health handbook for health trainers contains a list of useful sources relating to all aspects of a behaviour change interview including goal setting; action planning; self-monitoring; self-efficacy; rewards and setbacks.

Department of Health. (2008) *Improving health: Changing behaviour, NHS health trainer handbook*. London: Department of Health.

Department of Health. (2005). *Alcohol misuse interventions: Guidance on developing a local programme of improvement*. London: Department of Health.

Chapter 3

Training staff to deliver behaviour change interventions

3.1 Introduction

This section highlights best practice from the literature with regard to delivering training to professionals to enable them to deliver effective interventions. Guidance is given in relation to who should deliver and receive training, the content of training sessions, the methods of training to employ, and how to establish clear learning outcomes to ensure the quality of training.

3.2 Barriers to delivering interventions

The literature suggests that there is some resistance amongst professionals towards delivery of behaviour change interventions which stems from a range of perceived barriers to successful implementation. The key concerns of a range of different professionals are outlined below in order to provide some of the key areas which training needs to address.

3.2.1 Damage to professional relationship with service users

Amongst staff with an established relationship with service users, particularly GPs, there is some concern that delivery of behaviour change interventions conflicts with maintenance of rapport (Beich et al., 2002). In particular, there is concern that unwanted advice can annoy clients (Coleman, 2004). In addition, staff may fear stigmatising people by approaching sensitive issues such as weight management (West & Saffin, 2008).

3.2.2 Anticipation of poor success

Anticipation that behaviour change will not be achieved is reported to deter staff from attempting to deliver interventions (Roche & Freeman, 2004). Perceiving that people do not listen to advice and are not motivated to change behaviour can act as deterrents to addressing behaviour change (Coleman, 2004). There is a need to disseminate information about the evidence for the efficacy of interventions to increase confidence in the methods (Heather et al., 2004).

3.2.3 Lack of incentives

Lack of professional reward for interventions is cited as a barrier to implementing intervention programmes (Alcohol Concern, n.d.) and this is reflected by suggestions from GPs that responding to alcohol and other drug-related problems is not part of their role (Roche & Freeman, 2004).

It has been suggested that financial incentives would motivate some staff to deliver interventions more routinely (Richmond et al., 2005). There is some disagreement over the use of incentives however, and Heather et al. (2004) found little support amongst experts in screening and brief intervention for alcohol for financial incentives as a means to encourage routine screening. Similarly, a pilot scheme which gave financial reward to general practices according to the number of smoking cessations achieved amongst patients found that almost all of the participating GPs and practice nurses were negative about the payment (Coleman, Wynn, Stevenson & Cheater, 2001). Some participants in the scheme questioned the ethics of payment suggesting that lifestyle advice should be part of routine practice and that payment might promote inappropriate use of interventions (Coleman et al., 2001).

3.2.4 Lack of organisational support for interventions

It has been suggested that the organisation of the healthcare system gives staff little confidence that they will be able to effect behaviour change interventions successfully (Alcohol Concern, n.d.). Lack of time, faculty expertise, training sites and institutional support have been cited as barriers to implementing successful intervention programmes (Roche & Freeman, 2004).

Lack of time to conduct interventions is a frequently cited problem (Coleman, 2004). Training therefore needs to consider the environment in which staff are working and provide realistic targets for implementing interventions. GPs have reported that they would appreciate assistance on how to use limited time most effectively for smoking interventions (Richmond et al., 2005). Evidence also needs to be disseminated to support the efficacy of interventions conducted within a limited time frame. For example, there is review-level evidence that any contact time with a clinician (both physician and non-physician) is effective at increasing abstinence rates in smokers; effectiveness is shown to increase with longer sessions and with multiple sessions (Naidoo et al., 2004).

A randomised controlled trial of three different strategies for implementing alcohol interventions in general practice found that significant structural and organisational barriers hindered efforts in primary care (Kaner, Lock, McAvoy, Heather & Gilvarry, 1999). Uncertainty about whether behaviour change is within a person's professional remit has been reported to be a barrier to delivery (Burrell, Sumnall, Witty & McVeigh, 2006). Similarly, omission of behaviour change responsibilities from organisational policies can lead to doubts about authority to deliver such interventions (Burrell, Sumnall, Witty, & McVeigh, 2006). It has been reported that GPs anticipate improved uptake of smoking cessation practices if more support was provided through improved practice infrastructure (Richmond et al., 2005) and there is support amongst alcohol intervention experts for clear referral protocols to assist people working in primary care which it is believed would encourage staff to deliver screening and intervention for alcohol (Heather et al., 2004). In addition, there is support amongst primary care staff for the creation of guidelines for alcohol screening and interventions (Aalto, Pekuri, & Seppä, 2003). Provision of guidelines for smoking cessation interventions in Australia has also been shown to improve confidence amongst primary care staff (Richmond et al., 2005). Organisational support for behaviour interventions has also been found to be an important factor in encouraging healthcare professionals to initiate interventions for obesity in Scandinavia (Melin, Karlström, Berglund, Zamfir & Rössner, 2005).

3.2.5 Lack of knowledge

A perceived lack of knowledge can deter staff from undertaking interventions. Lack of knowledge in relation to areas of behaviour can lower staff confidence whilst poor knowledge of referral processes and available sources of support can also hinder interventions (West & Saffin, 2008).

3.2.6 Lack of skills

A commonly cited barrier to conducting interventions, particularly amongst GPs, is having a lack of skills and confidence (Roche & Freeman, 2004; Zwar & Richmond, 2006). The perceived complexity of the behaviour change encounter can lead staff to avoid addressing the topic (West & Saffin, 2008) and many other commonly cited barriers reflect the skills gap and poor confidence of staff. For example, staff in primary care have reported difficulty identifying those patients in need of alcohol interventions (Aalto et al., 2003) and other staff report perceived lack of diagnostic aids as an obstacle to addressing lifestyle issues (Alcohol Concern, n.d.). GPs have also reported

that they do not address smoking issues with patients because they find it difficult to impress the importance of stopping on smokers or they do not know how to deal with those not motivated to stop (Coleman, 2004). Similarly, staff report that they find it difficult to raise the topic of behaviour change (Roche & Freeman, 2004; Zwar & Richmond, 2006).

There is enthusiasm amongst health professionals for further training to develop and improve the necessary skills for delivery of behaviour interventions. For example, GPs have been found to believe that appropriate training would facilitate uptake of smoking interventions within general practice (Richmond et al., 2005) and nurses have been reported to request further training to develop their screening and health promotion roles (Owens & Gilmore, 2000).

3.3 Evidence of the impact of training

There is good evidence to support the effectiveness of training in improving performance of behaviour change interventions. A review of training programmes designed to encourage healthcare professionals to deliver smoking cessation interventions found that professionals were more likely to perform intervention tasks following training (Lancaster, Silagy & Fowler, 2000). It has been suggested that it can be difficult to change negative beliefs amongst staff about behaviour but research has shown that it is possible to achieve change in practice without changing attitudes (D'Onofrio et al., 2002). Similarly, evaluation of the Preston Alcohol Brief Intervention Training Pack found that confidence and understanding of issues related to alcohol amongst healthcare staff were improved through training as well as staff skills in delivery of interventions (Burrell, et al., 2006). A recent review of the literature on obesity interventions amongst young people suggested that the majority of barriers posed to delivery of such interventions can be overcome by specialist training (West & Saffin, 2008).

3.4 Who should deliver the training?

It is important that trainees respect the authority of the trainer in order for training to be effective; use of 'credible experts' in the delivery of training will more likely encourage receptiveness to the ideas presented (Fleming, 2004, p. 61). Miller and Rollnick (2002) suggest caution, however, when enlisting the help of trainers from outside agencies who may not understand the context of the participants' work and have no established

rapport with participants. Enlisting the help of respected colleagues to facilitate training can help to legitimise intervention practices; these professionals will also be more able to suggest solutions to problems that staff might envisage (Fleming, 2004).

3.5 Targeting attendees

Trainers need to ensure that they capture their audience's attention and help staff to prioritise behaviour change intervention training. Health practitioners often have heavy workloads and other training commitments (Deehan et al., 2002) and it is acknowledged that training in smoking cessation is neglected amongst doctors in particular (Ubido et al., 2006). Training should therefore be tailored to fit into staff work schedules (West & Saffin, 2008). Consideration should be given to other barriers staff may face to attending training. Deehan et al. (2002) identified a number of barriers to attending behaviour intervention training experienced by nurses which could be classified as relating to either personal or work commitments. Lack of childcare was a primary concern to staff, as well as the unavailability of staff cover to enable time off for training and prior commitments staff had to other training. Offering a choice of dates, times and venues can help people to overcome practical barriers to attending training. Offering lunchtime and school term-time sessions can assist many staff with other work and family commitments (Deehan et al., 2002). Deehan et al. (2002) have suggested a number of methods for reaching staff whose time may be limited:

- using self-directed training packages (although there is little evidence to support the efficacy of self-directed training);
- appointing health promotion specialists to advise other staff;
- utilising existing networks of nurse professional development;
- incorporating specific behaviour change intervention training (such as for alcohol) into existing chronic disease training.

Training should also be targeted at those professionals based in a suitable context for delivery of behaviour change interventions and Burrell et al., (2006) suggest that management staff should be targeted before other staff in order to ensure managerial support for interventions and to encourage incorporation of interventions into standard practice.

3.6 Training content

It is important to consider what can realistically be achieved in the allotted time when determining the content of a training session (Rollnick et al., 1999). When time is limited, Rollnick et al. suggest that trainers consider what supplementary work participants may reasonably be expected to do outside of the training session, for example, further reading or practising techniques. Martino, Haeseler, Belitsky, Pantaloni & Fortin, (2007) provide a good description of a 2 hour training session in motivational interviewing.

In guidance written specifically for the teaching of Rollnick et al.'s (1999) method of behaviour change, the authors suggest that conveying the spirit of their theory to participants should be a priority for trainers. The topics covered below have been identified within the literature as important components of any intervention training. Trainers are advised to prioritise the components according to the needs of their participants.

3.6.1 Evidence for the efficacy of interventions

There is support for the inclusion of information about the efficacy of behaviour change interventions within training to encourage staff to feel confident that their efforts will be successful (Zwar & Richmond, 2006).

3.6.2 Theories of behaviour change

There is evidence to suggest that acquisition of a theoretical understanding of behaviour change interventions can improve the likelihood that staff will perform interventions. In a longitudinal study of the impact of an ongoing training course for obesity interventions in primary care, Melin et al. (2005) found that providing practitioners with theoretical background had a significant impact on whether practitioners initiated obesity interventions.

3.6.3 Topic specific training

Knowledge within the field of behaviour which staff are addressing is vital to their ability and confidence to deliver effective interventions. Research amongst primary care staff in relation to providing advice about physical activity identified a need to improve knowledge about physical activity in order to motivate staff and enable them to give

effective advice to patients (Douglas, Torrance, van Teijlingen, Meloni & Kerr, 2006). Raising awareness of current normative practices in relation to different behaviours renders training more relevant and training should set interventions within behaviour management pathways (West & Saffin, 2008). Similarly, a review of expert opinion in the field of alcohol screening and intervention also found that there was strong support for more education in alcohol-related issues (Heather et al., 2004) and a need for training that provides staff with clear health messages about alcohol has been identified (Lock, Kaner, Lamont & Bond, 2002). Better knowledge of the issues related to different types of behaviours is also associated with challenging negative staff attitudes towards behaviour; this has been found to be particularly relevant in relation to obesity interventions (Melin et al., 2005).

3.6.4 Skills for assessing readiness to change

Being able to assess an individual's stage of change is a vital skill. Training should include information on, and demonstration of, assessment tools to aid staff. Findings have shown that dissemination of behaviour change intervention guidelines within primary care can provide an effective way to improve staff confidence in assessing smokers' readiness to change (Richmond et al., 2005).

3.6.5 Skills for building rapport and facilitating discussion

As already discussed, staff may need help in learning how to address behaviour change issues and additional training, devoted to integrating behaviour change interventions into general practice helps to overcome reluctance to address the issue (Sieck et al., 2004). Miller and Rollnick (2002) warn trainers not to assume the strength of participants' listening skills. While listening may comprise a large part of the role which staff perform in their professional occupation, Miller and Rollnick stress that the skills required for reflective listening, particularly in relation to motivational interviewing, may differ from those which staff already have. Trainers are advised to encourage participants to describe how they use reflective listening in their work, giving examples from their experiences (Miller & Rollnick, 2002). Another approach advocated, which mirrors that used in behaviour change interventions, is to ask participants to rate their own competence and interest in improving their listening skills. This can instigate discussion and encourage participants to reflect on their own current practice (Miller & Rollnick, 2002).

It can be difficult for some professionals to hand decision making over to the client and skills need to be taught for encouraging client-directed consultations (Rollnick, 2005). Rollnick (2005) suggests that using the 'elicit-provide-elicit' framework for effective communication is a teachable skill. Staff also need to learn how to cope with adverse client reactions (Lock et al., 2002). Research into obesity interventions suggests that staff should receive training to deal with client concerns and distress which might be unique to certain behavioural issues (Michie, 2007).

3.6.6 Learning how to deal with different client groups

Evaluation of the Preston Alcohol Brief Intervention Training Pack (Burrell et al., 2006) identified a gap in the training related to dealing with different client groups. Participants in the evaluation study perceived that they needed more information on how to tailor the information they had been given to the needs of young people, the elderly, people with mental health problems, and families (Burrell et al., 2006). Guidelines produced for smoking cessation interventions in general practice in Australia were shown to help staff deal with a range of different patient circumstances such as pregnant women and those with a mental illness. Staff who used the guidelines were less convinced that they provided them with the skills to deal with people from culturally or linguistically diverse backgrounds (Richmond et al., 2005) which suggests that other support mechanisms may need to be considered to enable staff to deal with cultural and linguistic diversity.

3.7 Delivery of training

The best practice guidance in relation to delivery of interventions is applicable to the way in which training is delivered. For example, Miller and Rollnick (2002) suggest that the principles of motivational interviewing are best taught through example and encourage trainers to exude the style of intervention they wish to impart to trainees during training sessions. Trainers should, therefore, give consideration to the setting, individual circumstances and discussion techniques as discussed above.

3.7.1 Understanding the audience

Rollnick et al. (1999) suggest that learning the skills for behaviour change interventions should be considered as a process of refining professionals' existing repertoire of skills, rather than replacing one skills set with another. Training should therefore be made

relevant to the target audience and tailored to participants' level of knowledge, in order to make best use of professional time (Burrell et al., 2006) and to enhance learning effectiveness (Carpenter, Watson, Raffety & Chabal, 2003). There are several models of learning, including the facet-based learning approach, which advocate assessment of a learner's knowledge and development of lessons that build upon that pre-existing knowledge (Carpenter et al., 2003). Where possible, Miller and Rollnick (2002) suggest that trainers should attempt to adapt training sessions to suit individuals' personal learning preferences. They suggest that this level of flexibility is more easily afforded through employment of a co-facilitator who may be able to co-ordinate alternative activities within a training session.

Training also needs to be made applicable to trainees' professional roles and to the type of relationship they have with service users (Melin et al., 2005). Rollnick et al. (1999) emphasise that, just as staff wish to effect change in the behaviour of their clients, so trainers seek to effect change in the behaviour of training participants within client consultations and so effort should be made to consider the point of view of participants. Trainers should therefore explore the occupational remit of their training group prior to the delivery of any training session to ensure that training content relates to the everyday practice of participants (Rollnick et al., 1999). For example, prior to investment in brief intervention training for primary care staff North Tyneside Primary Care Trust conducted a series of focus groups with local healthcare professionals in order to determine their predisposition towards brief interventions (Alcohol Concern, 2008). By using language appropriate to the participants' field of work and addressing the everyday workplace problems encountered by those attending training, trainers can ensure that training material will be made more relevant (Rollnick et al., 1999).

Miller and Rollnick (2002) also suggest that trainers draw on participants' everyday clinical experience in order to shape the training. They advise that trainers draw on real cases, design exercises to address common challenges faced by the participants and make use of recordings or transcripts from clinical settings.

In addition, trainers should give consideration to the context of the training session: whether attendance has been made compulsory for participants; who has initiated the training session and what benefit there is for attendees (Rollnick et al., 1999). This will help to establish the participants' expectations of the course and will help the trainer to determine how receptive participants may be to ideas about intervention methods (Rollnick et al., 1999).

3.7.2 Group size

When determining the best methods for delivering training, consideration should be given to the number of people attending any particular training session. Rollnick et al. (1999) propose that group discussion provides an essential component of behaviour change intervention training and suggest that full engagement from all participants can be limited in groups of 20 or over. However, smaller group work within sessions of larger numbers provides a solution to this and Rollnick et al. suggest that sessions of this size might benefit from the attendance of an additional facilitator. It is also advised that trainers are sensitive to any fears that participants may have in sharing their thoughts and opinions before colleagues or their contemporaries given that behaviour intervention training might require staff to reflect on their own style of interaction with service users (Rollnick et al., 1999).

3.7.3 Training format

Miller and Rollnick (2002) have listed some of the benefits of delivering training via workshops; they propose that suspension of everyday practice to attend a workshop gives people time to reflect, meet colleagues, observe peers in action and discuss clinical issues. However, they also highlight some of the limitations of workshop formats and encourage trainers to consider methods more closely aligned to everyday clinical practice. Miller and Rollnick (2002) suggest that detachment from everyday experience that might occur in a workshop setting can make learning seem abstract and more difficult to apply to real-life experience. They also question the validity of a one-off group session where it is difficult to tailor teaching to individuals' skill level, learning styles and occupational context. An alternative approach might consist of on-site consultation from a trainer or peer consultation (Miller & Rollnick, 2002). These methods allow trainees to develop skills over time through a process of practice, feedback and encouragement (Miller & Rollnick, 2002). Outreach visits, where one-to-one advice is delivered to practitioners have been shown to be successful in changing physician behaviour (Soumerai & Avorn, 1990). Brevity, repetition and reinforcement were found to be key elements in effecting change in this study (Fleming, 2004).

3.7.4 Using multiple methods

Use of traditional didactic teaching methods alone is not considered effective in encouraging staff to alter professional practice (Fleming, 2004). West and Saffin (2008) found that training in relation to obesity interventions commonly combines theory-based

didactic teaching with skills-based sessions. The Preston Alcohol Brief Intervention Training Pack was well-received by health professionals and evaluation of the training showed that it met participant expectations for the majority (Burrell et al., 2006). The training pack encourages use of several different teaching methods as the following overview of the training shows:

- An outline of the format and objectives for the training session.
- Presentation of contextual information.
- Practical exercises such as quizzes and group discussion.
- Handouts with background reading materials, screening and brief intervention materials.

A GP training project in Belgium trialled a similar training format, encompassing didactic training, written exercise and video observation or role play that received a positive evaluation, providing support for a multiple method approach (Thijs, 2007).

There is some evidence however, to suggest that practice can be improved through didactic methods. Handmaker, Hester and Delaney (1999) found that a single screening of a twenty-minute training video was successful in improving motivational interviewing skills. In post-intervention testing, participants who viewed the instructional video displayed greater empathy towards clients, and were found to be effective at minimising client defensiveness and supporting self-efficacy (Handmaker et al., 1999). Trainers should therefore consider the value of incorporating concise elements of didactic teaching into training. Rollnick et al. (1999) emphasise the importance of allowing participants the opportunity to reflect on information presented in this way. They state that, when presenting new ideas, group discussion or individual reflection allows participants to consider their own ambivalence towards theory or ideas and to formulate questions (Rollnick et al., 1999).

3.7.5 Role play

There is widespread support for use of simple role-play exercises in training (Schwartz et al., 2007; Fleming, 2004; Carpenter et al., 2003; Babor & Higgins-Biddle, 2001). Training should equip staff to deliver interventions immediately to ensure that no knowledge is lost (Burrell et al., 2006) and simulated encounters are helpful as they allow rehearsal of techniques before they are used in a professional setting (Fleming, 2004). Miller and Rollnick (2002) suggest that offering a demonstration for role play

may facilitate subsequent practice amongst trainees and suggest that participants are encouraged to explore mistakes made during practice in order to relieve any pressure. MacLeod et al. (in press) successfully used videotaped demonstrations of brief interventions prior to role-play activity in their study to train surgical interns.

Rollnick et al. (1995) suggest four ways of approaching role play: in unobserved pairs; in trios, where one person adopts the role of observer; in a 'fish bowl' performance to the wider training group who provide feedback; or in front of a video recorder with feedback provided from peers or trainers afterwards. These options present the opportunity for participants to receive feedback on the interview style, content and level of rapport developed (Babor & Higgins-Biddle, 2001). Guidance for delivery of alcohol interventions suggests that training should allow participants to take turns performing the staff and client role and to receive feedback (Babor & Higgins-Biddle, 2001). There is support for peer-reviewed feedback (Fleming, 2004) and Martino et al. (2007) emphasise the importance of providing prompt feedback to performance. Where participants are given the opportunity to observe their own practice via video recording, Miller and Rollnick (2002) suggest that they are encouraged to reflect upon their own work prior to receiving feedback from trainers in order to build confidence. Research into motivational interview training in the USA found that feedback on audio recordings from a clinical psychologist was well-received and valued by participants (Schwartz et al., 2007).

Motivational Interviewing via Role-play Internet Simulation is a training method adapted from a motivational interviewing approach devised by Rollnick, Mason and Butler (1999) to teach healthcare professionals how to conduct brief smoking cessation interventions. Carpenter et al. (2003) designed and evaluated the effectiveness of the web-based training tutorial amongst healthcare professionals working in a number of settings and found that the teaching method was cost effective and easy to use for participants and the emphasis on self-directed learning allowed professionals to concentrate learning in their areas of greatest training need.

3.7.6 Follow-up support

Follow-up support as a method of reinforcing training is supported by the literature (Fleming, 2004). When comparing three different methods of training to encourage implementation of alcohol intervention in general practice, Kaner et al. (1999) found that this was crucial. The research found that surgeries provided with programme

guidelines but no demonstration of the intervention programme were less likely to implement it (intervention rate 44% [19]) than those surgeries receiving face-to-face training and a demonstration of the programme (56% [24]). Surgeries receiving ongoing telephone support in addition to the training as described above were more likely again to implement screening and intervention (71% [30]). The practices receiving ongoing support were also more likely to implement the programme with greater accuracy and researchers found that the relatively low cost of providing telephone support rendered this the most cost effective method of intervention (Kaner et al., 1999).

Similar findings have been made in relation to smoking cessation training (Richmond, Mendelsohn, & Kehoe, 1998) and training in the delivery of an obesity intervention programme where staff received ongoing support for a period of 30 months following initial training. Support was delivered via pre-arranged meetings with an assigned supervisor as well as via telephone to staff at the obesity unit responsible for training (Melin et al., 2005). Fleming (2004) suggests that feedback on performance should be ongoing and that it should be delivered in a timely fashion in order to be effective.

As well as increasing uptake of interventions, follow-up support can improve skill acquisition (Thijs, 2007; Miller & Rollnick, 2002). A two month follow-up assessment of attendees of a motivational interviewing course found that skills had deteriorated since immediate post-training evaluation (Baer et al., 2003). Following evaluation of a motivational interviewing training session for health professions in the field of obesity, researchers in the USA determined that future sessions they ran would be supplemented with a DVD demonstrating clinical scenarios to enable trainees to obtain a booster to the session (Schwartz et al., 2007).

Rollnick et al. (1999) suggest that it is good practice to evaluate any training delivered. They recommend that trainers evaluate whether the training methods chosen facilitated learning, whether all content of the session was afforded appropriate attention, and whether respect was given to both the trainers and the trainees. The Department of Health handbook for trainers contains an example training evaluation form which provides a useful checklist when devising training content (DH, 2008).

3.8 Establishing training outcomes

The overall goal of training is to ensure that staff from diverse backgrounds, working in a variety of settings, are trained to ask questions about specific health behaviours, to give advice (either opportunistically in terms of brief advice or more systematically through the delivery of a structured brief intervention), and to offer effective support. The following section outlines a framework for providing behaviour change intervention training, which may be of use to both those who commission, as well as those who provide, training. The framework for smoking cessation training devised by Bullen, McRobbie, Whitaker and Glover (2008) has been used to inform the development of learning outcomes. The learning outcomes have been written to reflect the essential learning that the training has been designed to develop; thus they indicate what participants should know, understand, or be able to do at the end of the training. Competencies for brief advice, brief interventions and motivational interviewing will differ and so are presented separately below.

3.8.1 Learning outcomes for brief advice

By the end of the training, participants should be able to demonstrate knowledge, understanding and skills as detailed below.

Knowledge and understanding

- Understand the value of giving opportunistic brief advice in the context of an everyday staff-service user encounter.
- Understand the harmful consequences of the behaviour in question.

Skills: practical

- Ask details about the health behaviour in question.
- Assess a person's level of health risk.
- Deliver brief advice in an empathic, non-confrontational manner.
- Employ knowledge of appropriate services for signposting people to additional sources of support.

Skills: intellectual

- Distinguish between brief advice and brief intervention as distinct approaches to bringing about behaviour change.
- Judge when delivery of brief advice is an appropriate and relevant intervention.

-
- Use a self-reflective approach to delivering brief advice.

3.8.2 Learning outcomes for brief interventions

The outcomes for this section have been informed by National Institute on Alcohol Abuse and Alcoholism, (1999) but will be applicable to training for brief intervention with a range of behaviours. By the end of the training, participants should be able to demonstrate knowledge, understanding and skills as detailed below.

Knowledge and understanding

- Explain the harmful consequences of the behaviour in question.
- Recognise the evidence of effectiveness for behaviour change interventions in general and in relation to the specific health behaviour in particular.
- Outline a range of theoretical models of behaviour change.
- Discuss the stages of change model.

Skills: practical

- Identify people for whom a brief intervention is appropriate using validated screening tools.
- Ask and record details about the health behaviour in question and the actions taken and outcomes achieved.
- Assess a person's level of health risk.
- Assess a person's readiness to change.
- Use resources effectively to support the brief intervention.
- Employ knowledge of appropriate services for signposting people to additional sources of support.
- Deliver a brief intervention based on an explicit model of behaviour change comprising the following core elements:
 - client-directed discussion;
 - feedback of personal risk;
 - communication of responsibility towards behaviour;
 - giving advice to change behaviour;
 - providing a menu of ways to change behaviour;
 - expressing empathic understanding;
 - enhancing self-efficacy;
 - establishing behaviour change goals;
 - providing a follow-up to the brief intervention.

Skills: intellectual

- Distinguish between brief advice, brief intervention and social marketing as distinct approaches to bringing about behaviour change.
- Judge when delivery of a brief intervention is an appropriate and relevant approach to behaviour change.
- Judge when motivational interviewing is an appropriate and relevant approach to use as part of the delivery of a brief intervention.
- Appraise and record a person's readiness to change.
- Plan a structured behaviour change intervention, with due regard to the expressed needs of the individual.
- Use a self-reflective approach to devising and delivering a brief intervention.

3.8.3 Learning outcomes for motivational interviewing

By the end of the training, participants should be able to demonstrate knowledge, understanding and skills as detailed below.

Knowledge and understanding

- Understand the role of motivational interviewing within the context of the delivery of behaviour change interventions.
- Express the core principles and values that underpin motivational interviewing.

Skills: practical

- Use listening skills to explore and evoke a person's motivation through helping them to identify the argument for change.
- Use a model of consultation based on empathy, collaboration and respect for autonomy.
- Create an interpersonal relationship which is conducive to change.
- Facilitate change, based on the expressed aspirations of service users, through support for self-efficacy.

Skills: intellectual

- Distinguish between brief advice, brief intervention and social marketing as distinct approaches to bringing about behaviour change.
- Judge when motivational interviewing is an appropriate and relevant approach to use as part of the delivery of a brief intervention.

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- Use a self-reflective approach to using motivational interviewing, particularly in relation to the control of one's own values and beliefs.

3.9 Training resources

These sources may provide further help to trainers in the planning and implementation of training. Resources specific to staff working in the fields of alcohol and smoking are listed, as well as more general resources which might be applicable to any type of behaviour change intervention training.

3.9.1 Alcohol

The following training resources for alcohol interventions are based around a list recommended by Babor & Higgins-Biddle (2001).

Anderson, P. (1996). *Alcohol and primary health care. (WHO Regional Publications, European Series, No. 64)*. Copenhagen: WHO, Regional Office for Europe.

College of Family Physicians of Canada. (1994). *Alcohol risk assessment and intervention (ARAI) package*. Ontario: College of Family Physicians of Canada.

Heather, N. (1995). *Treatment approaches to alcohol. (WHO Regional Publications, European Series, No. 65)*. Copenhagen: WHO Regional Office for Europe.

Hester, R. K. & Miller, W. R. (Eds.). (1989). *Handbook of alcoholism treatment approaches: Effective alternatives*. Elmsdorf, NY: Pergamon Press.

McRee, B., Babor, T. F. & Church, O. M. (1992). *Alcohol screening and brief intervention*. Project NEADA, University of Connecticut, School of Nursing. *Ordering information may be obtained from: the U.S. National Clearinghouse on Alcohol and Drug Information: www.health.org or call 1-800-729-6686.*

Miller, W. R. (1999) *Enhancing motivation for change in substance abuse treatment*. Rockville, MD: U.S. Department of Health and Human Services, SAMHSA/CSAT.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). (1997). *Training physicians in techniques for alcohol screening and brief Intervention*. Bethesda, MD: National Institute of Health.

Sanchez-Craig, M. (1994). *Drink Wise: How to quit drink or cut down*. Toronto: Addiction Research Foundation.

Sanchez-Craig, M. (1996). *A therapist's manual: secondary prevention of alcohol problems*. Toronto: Addiction Research Foundation.

Sullivan, E., & Fleming, M. (1997). A guide to substance abuse services for primary care clinicians. *Treatment improvement protocol series*. Rockville, MD: U.S. Department of Health and Human Services.

U.S. Preventive Services Task Force. (1989). *Guide to clinical preventive services*. Baltimore: Williams & Wilkins.

3.9.2 Smoking

The Smokescreen Programme

Copeman, R. C., Swannell, R. J., Pincus, D. F., Woodhead, K. A. (1989). Utilization of the "Smokescreen" smoking-cessation programme by general practitioners and their patients. *The Medical Journal of Australia*, 151, 83-7.

GPs Assisting Smokers Programme (GASP)

Litt, J., (2002) How to provide effective smoking cessation advice in less than a minute without offending the patient. *Australian Family Physician*, 31, 1087-93.

A programme widely disseminated in Switzerland

Cornuz, J., Humair, J. P., Seemater, L. et al. (2002). Efficacy of resident training in smoking cessation: A randomised, controlled trial of a program based on application of behavioural theory and practice with standardized patients. *Annals of Internal Medicine*, 136, 131.

A programme supported by the Irish College of General Practitioners

Velicer, W. F., Prochaska, J. O., & Redding, C. A. (2006). Tailored communications for smoking cessation: Past successes and future directions. *Drug and Alcohol Review*, 25, 49-57.

Smoking Cessation in Practice Approach

Hodgson, P. & Thompson, H. (2008, June 30). Smoking cessation in practice (SCIP): Creating sustainable delivery systems for smoking interventions. Paper presented at the UK National Smoking Cessation Conference, Birmingham. Retrieved September 12, 2008 from http://www.uknsc.org/2008_UKNSCC/presentations/patricia_hodgson_web.html

Reducing Children's Exposure to Secondhand Smoke Training: Smoke Free Merseyside Passive Smoking Campaign

Contact: Linda Harper, Tobacco Control Co-ordinator, The Roy Castle Lung Cancer Foundation. Tel: 0151 794 8998. E-mail: training@roycastle.org

3.9.3 General behaviour change

Martino, S., Haeseler, F., Belitsky, R., Pantalon, M., & Fortin, A. H. (2007). Teaching brief motivational interviewing to Year three medical students. *Medical Education, 41*, 160–167.

White, L. L., Gazewood, J. D., & Mounsey, A. L. (2007). Teaching students behaviour change skills: description and assessment of a new motivational interviewing curriculum. *Medical Teacher, 29*, 67-71.

The Motivational Interviewing Network of Trainers

The Motivational Interviewing Network of Trainers (MINT) is an international collective of trainers in motivational interviewing and related methods (for example, behaviour change counselling, brief advice) who offer training for trainers. Their website contains details of training events and resources for practitioners:

<http://motivationalinterview.org/training/mint.htm>

Counselling & Psychotherapy Training Institute – Stand-alone modules

The Edinburgh based institute offers a series of stand-alone modules in various time limited and evidence-based counselling modalities offered in conjunction with Napier University, subject to validation. Amongst the modules on offer is *Counselling Skills & Motivational Interviewing*. For more information visit: <http://www.cpti.info/index.htm>
University of Virginia medical School motivational interviewing curriculum

Workshops for pharmacists

The Centre for Pharmacy Postgraduate Education at the University of Manchester is developing workshops to help pharmacists improve their skills in brief advice. For more information visit <http://www.cppe.ac.uk>

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- Academy for Educational Development: <http://www.aed.org/Approaches/SocialMarketing/index.cfm>
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