Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Original Research

Equipping providers with principles, knowledge and skills to successfully integrate behaviour change counselling into practice: a primary healthcare framework

M. Vallis[*], *D. Lee-Baggley*, *T. Sampalli*, *A. Ryer*, *S. Ryan-Carson*, *K. Kumanan*, *L. Edwards*

Primary Care, Nova Scotia Health Authority & Dalhousie University, Halifax, Canada

ARTICLE INFO

Article history:
Received 8 May 2017
Received in revised form
6 October 2017
Accepted 25 October 2017

Keywords:
Behaviour change
Counselling
Competency
Communication skills
Chronic disease

ABSTRACT

Objectives: There is an urgent need for healthcare providers and healthcare systems to support productive interactions with patients that promote sustained health behaviour change in order to improve patient and population health outcomes. Behaviour change theories and interventions have been developed and evaluated in experimental contexts; however, most healthcare providers have little training, and therefore low confidence in, behaviour change counselling. Particularly important is how to integrate theory and method to support healthcare providers to engage in behaviour change counselling competently. In this article, we describe a general training model developed from theory, evidence, experience and stakeholder engagement. This model will set the stage for future evaluation research on training needed to achieve competency, sustainability of competency, as well as effectiveness/cost-effectiveness of training in supporting behaviour change.

Design and Methods: A framework to support competency based training in behaviour change counselling is described in this article. This framework is designed to be integrative, sustainable, scalable and capable of being evaluated in follow-up studies.

Results and Discussion: Effective training in behaviour change counselling is critical to meet the current and future healthcare needs of patients living with, or at risk of, chronic diseases. Increasing competency in establishing change-based relationships, assessing and promoting readiness to change, implementing behaviour modification and addressing psychosocial issues will be value added to the healthcare system.

* *Corresponding author*. Behaviour Change Institute, Primary Care, 6960 Mumford Rd, Halifax, Nova Scotia B3H 4P1, Canada. Tel.: +1 902 789 9545.
E-mail address: tvallis@dal.ca (M. Vallis).

https://doi.org/10.1016/j.puhe.2017.10.022
0033-3506/

Introduction

Modifiable health behaviours, including smoking, poor diet, inactivity, alcohol misuse, insufficient sleep and medication nonadherence are pivotal to health outcomes.[1–5] Health behaviour change is possible,[6–8] although individual and system barriers exist.[9] Population base rates of healthy behaviours are low, especially multiple behaviours (e.g., not smoking and being at a healthy weight and being active and eating healthy[10]); therefore, behaviour change is essential to chronic disease management. However, the effectiveness of chronic disease management is impacted by broad health services delivery challenges. First, a gap exists between resources and need. Second, services are reactive to disease onset, not preventative. Third, diseases that dominate resources are related to the low rates of health behaviours cited previously. Although theory and evidence support behaviour change interventions,[11] skilled behaviour change counselling at the level of the patient–provider interaction is uncommon. Knowledge translation to build capacity at the level of the primary care healthcare provider (HCP) is pivotal.[12] Yet knowledge translation of behaviour change counselling into primary care settings is made challenging by a number of factors, including the vast number of behaviour change theories and specific interventions from which to choose; the fact that many providers find counselling complex and time consuming; and behaviour change, when it occurs, is often short term, not long term. Our team is composed of behavioural psychologists, and our goal is to propose a training framework that can be operationalized and evaluated to address competency, complexity, and effectiveness/cost-effectiveness. In this article, a comprehensive, organized model for training HCP in behaviour change counselling is presented. We realize that this does not answer questions regarding competency, complexity, and effectiveness/cost-effectiveness. However, such research needs to rest on a cohesive framework to guide evaluation. It is our intention to follow this article with a research program that evaluates how to best implement training and support sustained behaviour change.

For this article, behaviour change refers to new patient behaviours consistent with HCP recommendations (e.g., stopping smoking); behaviour change theories are models of how behaviour arises and can be altered (e.g., stages of change); behaviour change interventions (methods) are coordinated activities to change behaviour (e.g., the 5As of smoking cessation); and behaviour change counselling is the intervention, knowledge and skills of HCPs that foster behaviour change via the patient–provider relationship. Behaviour change counselling defines how HCPs guide individuals from not doing to doing the recommended behaviour. Behaviour change counselling relies on theories and interventions to facilitate behaviour change and does so by identifying sequential steps that guide the provider to empower the individual to engage in and sustain health behaviours in the face of barriers. We label these steps as behaviour change counselling principles. These behaviour change counselling principles are based on established evidence on how to foster behaviour change. The purpose of this article is to describe these principles and the knowledge and skills needed to implement them competently. This is a very complex field, and we see the first step as the identification of a model to guide training. It needs to be recognized that training cannot be a single entity (e.g., a 4 h workshop delivered by an expert from away) but must be adaptable to HCP, setting and time factors. Nonetheless, the field would benefit from the identification of a common approach to establishing competency in behaviour change counselling within a HCP's scope of practice. Based on the model we propose here, our group will follow up with evaluation studies regarding the training requirements to achieve competency, sustainability of training, and effectiveness/cost-effectiveness evaluations. This work occurs within the Behaviour Change Institute (BCI; Primary Health Care [PHC], Nova Scotia Health Authority [NSHA]).

Lack of knowledge translation regarding behaviour change counselling limits the outcomes at the levels of direct care, programs, and systems.[13] A recent review of interventions and policies influencing primary care supported initiatives like continuous medical education with audit and feedback, clinical decisions supports, collaborative teams, communication skills and cultural competence.[14] Recent commentaries have also highlighted the lack of effective uptake of behaviour change interventions.[14] Our work makes use of continuing education, decision supports, and communication skills in collaborative teams to describe a comprehensive, scalable training program to achieve competence and confidence in behaviour change counselling. This framework integrates numerous established theoretical models and evidence-based methods to maximize practicality. Sustained behaviour change is complex and can be influenced by a multitude of factors. Contextual factors such as time can have a great impact on interventions. If one has 20 min to discuss a behavioural issue with a patient this is very different than having 5 min. Competency would be different in these two contexts. The amount of training required to achieve competency would be influenced by such factors. For instance, asking patients about their perceived need for starting a medication and their perceived concerns about taking the medication can take very little time. Yet assessing these perceptions (a validated health beliefs assessment called the Needs and Concerns Analysis[15]) can help understand adherence (the patient with high perceived concerns and low perceived need is less likely to be adherent than the patient with high perceived need and low perceived concerns) in a very brief period of time and at an acceptable level of competency. The concept of minimal intervention has been helpful to many providers. Having a comprehensive model of how behaviour change counselling could proceed would help address these contextual issues. As another example, a primary care provider might achieve competency by the use of minimal intervention strategies (ask permission to give advice; use questions not statements) where the standard of competency for a social worker (help resolve ambivalence concerning problem drinking) might be higher. These differences in competencies are appropriate given that different practitioners have different scopes of practice. The behaviour change counselling skills from this framework are meant to be used in a way that is consistent with the healthcare provider's scope of practice.