BCDF
BEHAVIOUR CHANGE
DEVELOPMENT FRAMEWORK

NHS
Health Education England

Behaviour Change Development Framework

Developing a Behaviour Change Competency Tool

Technical Report (Part 1)

June 2020

Wessex School of Public Health

www.behaviourchange.hee.nhs.uk

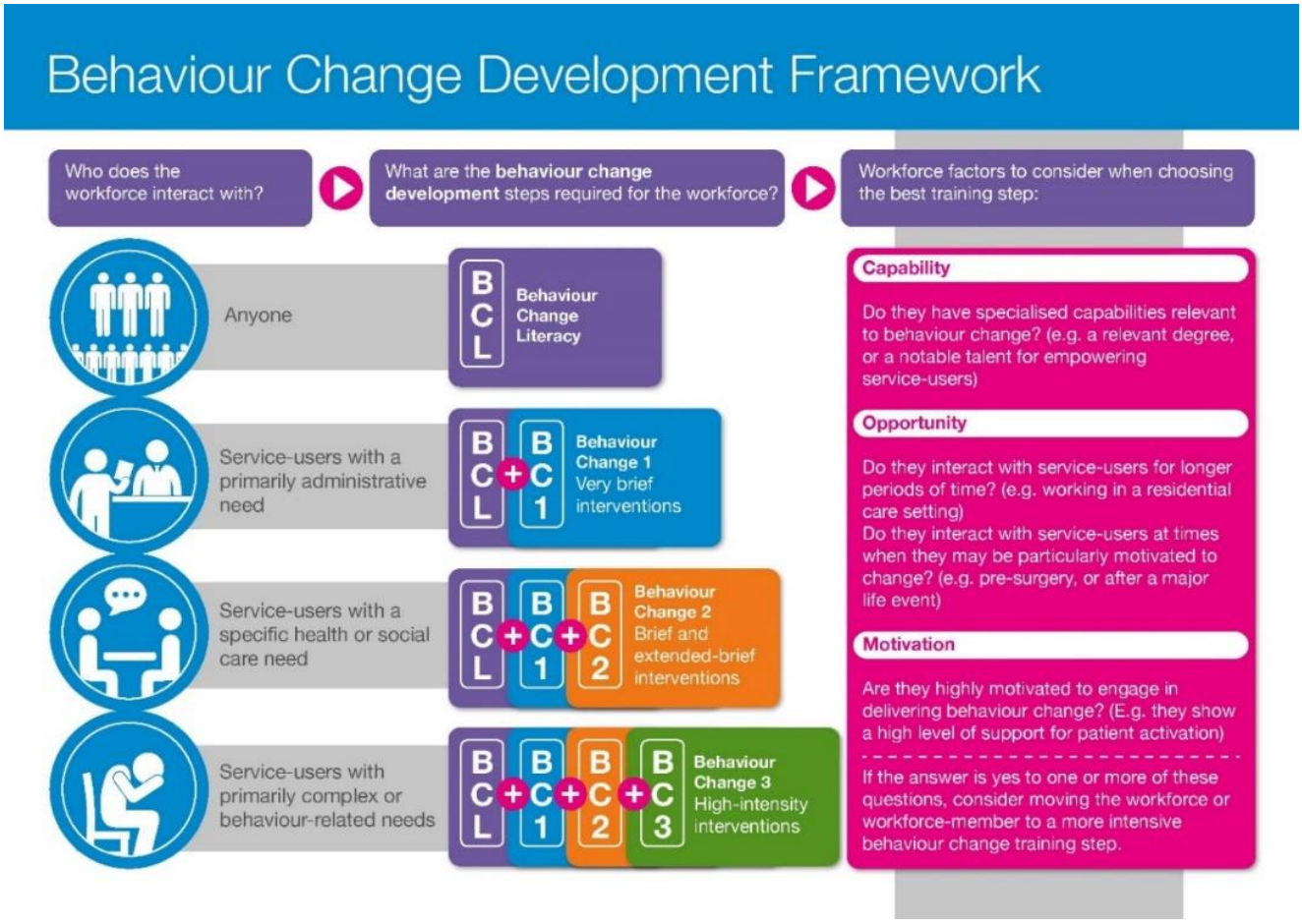
1. Introduction

The Behaviour Change Development Framework (BCDF) is a resource to support workforce segmentation for behaviour change training and development. The BCDF comprises of four levels of evidence-based behaviour change training (Figure 1) and a suite of tools and products. These include: a Level Assessment Tool, Behaviour Change Literacy learning packages and a toolkit of existing resources.

The Competency Tool developed here outlines the skills and knowledge requirements of each level of training, i.e. what the learner will be able to do upon completion of training. It is intended that this will then be used to develop learning outcomes and resources for training and enable training and education providers to map their training against the competencies.

This report outlines the process of deriving the competencies and provides a cross reference to existing behaviour change and person centred frameworks for information.

Figure 1: Behaviour Change Development Framework



Aims

To develop a simple competency tool for levels 1, 2 & 3 of the BCDF which could then be used to develop learning outcomes and training resources at a later stage for each of the BCDF levels.

2. Method

Mapping

At the commencement of this project two behaviour change frameworks were mapped to the BCDF levels, these were the Dixon Johnston Behaviour Change Competency Framework[1], and the HEE Person Centred Approaches Framework[2].

The mapping also took account of the NICE Guidance for Individual Behaviour Change[3] and the Prevention and Lifestyle Behaviour Change Competence Framework[4].

The next step was to review this mapping in detail to understand which elements of the two key frameworks were considered to be relevant to the different BCDF levels. A set of tables were produced with the detailed wording of the indicated items. This identified some issues such as: repetition, whether items have been included at the right level (by reference to the Dixon Johnston intensity level), and heavy weighting at BC2. The original mapping had proposed transitional levels but it was agreed that for the purposes of skill development there needed to be clear steps of progression between levels and so these were removed and the transitional level items were assigned to one or other level.

The Dixon Johnston Framework identifies items as being for either Low, Medium or High Intensity. By their definitions Low Intensity would largely relate to BCDF Level BC1, Medium to BC2 and High probably to BC3, although there may be some overlap with BC2. However, it was found that the original selection of some items had included ones that were probably out of the scope for the BCDF level proposed, so these were reassigned.

After reviewing the items in this way and assigning them to the BCDF levels as they have been defined, simple competencies were drafted to capture the essence of what someone should be able to do if competent at each of the BCDF levels. Reviewing the content of the other frameworks helped to inform the wording of the draft competencies and sub-competencies. This was an iterative process with discussion with the advisory group at all points before moving on to the next draft.

Consultation

The draft competencies went out to consultation between February – April 2020 using an online survey platform. There were twenty responses to the online survey and a small number of email responses.

Overall, very positive support was received for the competencies, respondents found the competencies clear, understandable and capturing what they would expect to see for each of the BCDF levels (see Table 1).

Table 1: BCDF Competency Development Consultation Responses Summary

Question	% Yes	% No
Q3 Throughout the terms 'service user', and occasionally 'individual' have been used. Is this acceptable as a generic description?	94.7	5.3
Q4 Is the overall structure of the competencies and sub-competencies clear and understandable?	84.2	15.8
Q5 Is the language used to describe the competencies and sub-competencies clear and understandable?	84.2	15.8
Q6 Do the competencies capture what you would expect to see on completion of training from a learner at this level, if we are aspiring to develop a qualified behaviour change workforce? (BC1)	87.5	12.5
Q7 Much of the detailed content of the training material will be in the learning resources. Are there any additional knowledge, skills or behaviour change techniques that should be included in the learning resources at this level? (BC1)	46.7	53.3
Q8 Do the competencies capture what you would expect to see on completion of training from a learner at this level, if we are aspiring to develop a qualified behaviour change workforce? (BC2)	93.7	6.3
Q9 Much of the detailed content of the training material will be in the learning resources. Are there any additional knowledge, skills or behaviour change techniques that should be included in the learning resources at this level? (BC2)	57.1	42.9
Q10 Do the competencies capture what you would expect to see on completion of training from a learner at this level, if we are aspiring to develop a qualified behaviour change workforce? (BC3)	86.7	13.3
Q11 Much of the detailed content of the training material will be in the learning resources. Are there any additional knowledge, skills or behaviour change techniques that should be included in the learning resources at this level? (BC3)	73.3	26.7

A number of issues were raised which led to helpful discussion and agreement on presentational and wording points. These included:

- The need for comment on the importance of reflection and supervised practice, which has been included in the introductory remarks
- A potential confusion between the terms ‘techniques’ and ‘methods’ which has been resolved by only using the word technique when it refers to a specific Behaviour Change Technique
- In final presentations of the material the context and potential application of the competencies needs to be clear
- Indicating the relationship with, or alignment to, other professional qualifications would be helpful as part of the wider BCDF programme of work
- Recognition that the competencies themselves do not provide the depth and detail for training that will be produced in the accompanying resources

In addition, there were helpful comments on specific wording or phrasing that led to minor changes to make the competencies clearer.

The following pages outline the final version of the competencies and indicate for information the key source items from the Dixon Johnston and Person-Centred frameworks.

3. References

[1] *Dixon D & Johnston M (2010) Health Behaviour Change Competency Framework: competences to deliver interventions to change lifestyle behaviours that affect health.*

[2] *Fagan P, de Longh A, Harden B & Wright C (2017) Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support. A core skills education and training framework. HEE, Skills for Health, Skills for Care*

3 NICE (2014) Behaviour change: individual approaches. Public Health Guideline 49

4 NHS Yorkshire & The Humber (2010) Prevention and Lifestyle Behaviour Change. A Competence Framework

Behaviour Change Development Framework

Competency Tool with cross referencing to items from Dixon Johnston and Person Centred frameworks

The Competency Tool describes the competencies, that is the knowledge and skills that would be expected at each level of the Behaviour Change Development Framework, for practitioners to effectively deliver behaviour change interventions at each of these levels. The competencies described below are drawn from published behaviour change theory, evidence-based approaches and person-centred approaches frameworks. A further phase of this project will develop learning outcomes and training resources, and identify existing routes to training and education that achieve these competencies.

It is important to note that this builds upon the existing resources to develop Behaviour Change Literacy which provides the underpinning knowledge about health behaviour and behaviour change. The training steps build incrementally so that each step requires having the competencies described for the previous level.

Face-to-face training and reflective learning are recommended for Behaviour Change levels 1 and 2. The competencies at Behaviour Change level 3 require that learners draw on a range of theories and techniques to enable them to adapt their practice in response to the needs of their service users. Therefore, Behaviour Change 3 is underpinned by reflective learning and guided by supervision provided by a qualified and experienced practitioner.

The third column in the tables identifies those items from the other frameworks that have informed the wording of the competencies and sub-competencies and their position in the BCDF.

Behaviour Change 1 – Very brief interventions for service users with a primarily administrative need

Behaviour Change Level 1 training provides the knowledge and skills required to provide very brief interventions when opportunities occur in the normal course of work. This level is for workers who typically engage with people who have an administrative need. A typical behaviour change conversation at this level will take from 30 seconds to a few minutes. It is mainly about encouragement and support to change, giving people information and directing them where to go for further help.

BCDF Competencies and sub-competencies		**Relevant elements of DJ and Person-Centred frameworks**
BC1 1. Recognise and act upon opportunities to support behaviour change in service users, as they arise in your routine work.	Be able to: a) recognise the opportunity to have a conversation with a service user and choose to take the opportunity b) ensure confidential conversations take place in private, quiet and comfortable places c) initiate a discussion about health behaviours d) identify what is important to the individual e) use a range of communication skills and language appropriate for an individual's needs and understanding	Includes elements from Person-Centred Approaches Step 1 – Conversations to engage with people. DJ F5. Ability to engage client DJ BC1. Knowledge of Health behaviour and health behaviour problems
BC1 2. Use appropriate methods to open a conversation about behaviour change and elicit a response.	Be able to: a) use open ended questions to engage with the service user b) check if there is something an individual wants to discuss c) enable a service user to engage and explore a range of options including taking no action	Includes elements from Person-Centred Approaches Step 1 – Conversations to engage with people. DJ F5. Ability to engage client Requires understanding of the impact of conversations and different verbal and non-verbal communication styles

BC1 3. Depending on the response, use appropriate techniques to motivate and encourage engagement with behaviour change.	Be able to: a) ask open questions to explore and understand the individual's situation and what matters to them b) provide general information about the behaviour and behaviour change in a manner that can be easily understood c) reassure and encourage the individual to believe in themselves and the possibilities of improvement d) let the individual know you understand how they are feeling by being empathetic e) reflect on what they have said using their words f) summarise what they have said during the conversation	Includes elements from Person-Centred Approaches Step 2 – Conversations to enable and support people DJ Techniques for Motivation Development M20 Reassurance - Encourage client to believe in herself/himself and the possibilities of improvement (e.g. by non-specific supportive comments e.g. 'you'll do fine') M17 General information - Provide general information about the behaviour and behaviour change M12 Social support (emotional) - Provide &/or id potential sources of empathy and give generalised positive feedback M10 Information about the behaviour - Provide information about antecedents or consequences of the behaviour, or connections between them, or behaviour change techniques F10. Ability to deliver information
BC1 4. Provide further information to support behaviour change.	Be able to: a) Provide relevant and accurate information or advice in a manner that enables a service user to choose whether or not to take it b) Support a service user to make a decision and plan together the way forward c) Provide information and signpost to additional resources or support relevant to the health behaviour	Includes elements from Person-Centred Approaches Step 2 – Conversations to enable and support people DJ F10 Ability to deliver information

Behaviour Change 2 – Brief and extended brief interventions for service users with a specific health or social care need

Behaviour Change Level 2 training provides the knowledge and skills required to support behaviour change in service users with an identified health or social care need. This level is for workers who mostly engage with people who have a health or social care need. These may extend from a few minutes to up to 30 minutes, and may be delivered in one session or over multiple sessions.

BCDF Competencies and sub-competencies		**Relevant elements of DJ and Person-Centred frameworks**
BC2 1. Use appropriate methods to explore service user motivation to change behaviour.	Be able to: a) form a collaborative relationship where the service user and professional work as a team, engaging in and exploring a potential way forward b) undertake a generic assessment, based on behaviour change theory, of the individual's personal situation and what matters to them, including suitability for behaviour change or referral c) help the service user identify and select relevant health behaviour issues for change	PCA Step 2 DJ BC7 Capacity to implement behaviour change in a manner consonant with its underlying philosophy 1. Capacity to form and maintain a collaborative stance 2. A capacity to form a collaborative relationship with the client, based on an active stance which focuses on enabling the client and the health professional to work as a team 3. An ability to balance the need to structure consultations as against the need to allow the client to make choices and take responsibility 4. An ability to avoid implementing behaviour change in a manner which becomes didactic, directive, intellectual or controlling DJ BC2. Ability to undertake a generic assessment DJ BC10. Ability to carry out health behaviour problem solving 1. An ability to identify health behaviour problems facing the client, which may be appropriate for a problem-solving approach 2. An ability to explain the rationale for problem-solving to the client

		3. An ability to help the client to select problems, usually on the basis that problems are relevant for the client and are ones for which achievable goals can be set 4. An ability to help the client specify the problem(s), and to break down larger problems into smaller (more manageable) parts DJ BC7 Maintaining a problem-solving perspective 5. An ability to avoid seeing the client themselves as a problem, but to maintain a problem-solving approach to the client's health behaviour problems 6. An ability to maintain a problem-solving attitude in the face of difficulties and frustrations
BC2 2. Select appropriate behaviour change techniques for the service user and the issue.	Be able to: a) take a problem-solving approach to identifying possible solutions b) select and skilfully apply the most appropriate behaviour change intervention techniques: i. identify the social, environmental and emotional causes of behaviour and its consequences ii. support decision-making by generating alternative courses of action and weighing them up iii. elicit self-motivating statements and evaluation of	DJ BC10. Ability to carry out health behaviour problem solving 5. An ability to identify achievable goals with the client, bearing in mind the client's resources and likely obstacles 6. An ability to help the client generate ("brainstorm") possible solutions 7. An ability to help the client select a preferred solution 8. An ability to help the client plan and implement preferred solutions 9. An ability to help the client evaluate the outcome of implementation, whether positive or negative DJ BC6 draws on knowledge of behaviour change models as in BC3 DJ M1 Antecedents & consequences - Record antecedents and consequences of behaviour (e.g. social and environmental situations and events, emotions, cognitions)

	behaviour to reduce resistance to change iv. support attitude change and encourage a different perspective on behaviour by reframing v. provide opportunities for social comparison c) help service user to identify individual, social, environmental and professional barriers and facilitators that might affect intervention implementation d) work professionally and ethically with groups of service users, engaging individuals and encouraging discussion	M8 Behavioural experiments Identify and test hypotheses about the behaviour, its causes and consequences, by collecting and interpreting data M13 Decision-making - Generate alternative courses of action, and pros and cons of each, and weigh them up M15 Motivational interviewing - Elicit self-motivating statements & evaluation of own behaviour to reduce resistance to change M21 Reframing - Encourage client to adopt a different perspective on behaviour in order to change attitude M3 Social comparison - Provide opportunities for social comparison, i.e. comparison between self and other people (e.g. contests and group learning) DJ F12 Ability to recognise barriers to and facilitators of implementing interventions DJ F6 Ability to work with groups of clients
BC2 3. Develop and agree a plan of action for behaviour change in collaboration with the service user.	Be able to: a) manage expectations, including the frequency and duration of the intervention and what is expected from the individual b) agree goals for the intervention and ensure they are realistic, attainable, timely and measurable c) agree a contract of behaviour change with the individual	PCA Step 3 Conversations with people to collaboratively manage highest complexity and significant risk DJ F9. Ability to Manage Expectations of the Intervention DJ BC4. Ability to agree goals for the intervention 1. An ability to help the client generate their own goals for the intervention, and to reach a shared agreement about these, by helping them: 1.1. to translate vague/abstract goals into specific and concrete goals

	d) structure the consultations and adhere to an agreed agenda e) identify and/or provide sources of social support f) work in a coordinated way with service user's family, carers and advocates, and other professionals g) support individual to develop plans to overcome barriers to behaviour change	1.2. to identify goals which will be subjectively and objectively observable and potentially measurable (i.e. to ensure that if change takes place it will be noticeable to the client and to others) 2. An ability to work with the client to ensure that goals are realistic, attainable and timely DJ M5 Contract - Generate a contract of agreed performance of target behaviour with at least one other, written and signed or verbal DJ BC8. Ability to structure consultations 1. An ability to structure consultations 2. An ability to share responsibility for consultation structure & content 3. An ability to agree and adhere to an agreed agenda DJ M16 Social Support (nonspecific) - Provide and/or identify sources of non-specific social support
BC2 4. Review progress with service user.	Be able to: a) provide feedback using agreed measures and self-monitoring to review progress on behaviour change, and adapt the goal where appropriate b) review how individual has coped with risky situations and barriers c) help to prevent relapse by identifying future risky situations and appropriate coping strategies	DJ BC9 Ability to use measures and self-monitoring to guide behaviour change interventions and to monitor outcome DJ A9 Coping planning - Identify and plan ways of overcoming barriers DJ A17 Relapse prevention - Identify situations that increase the likelihood of the behaviour not being performed and apply coping strategies to those situations

BC2 5. Agree end point or closure of support with service user.	Be able to: a) end the intervention in a planned manner and help service user identify any concerns they may have about the closure of support b) plan for maintenance of behaviour change including identification of other resources that might provide maintenance support c) self-reflect on what worked well or could have been improved, and identify key learning points	DJ BC12. Ability to end the intervention in a planned manner and to plan for long-term maintenance of gains after intervention ends 1. An ability to terminate the intervention in a manner which is planned, and to signal plans for termination at appropriate points throughout the intervention 2. An ability to plan for maintenance of behaviour change after the end of the intervention

Behaviour Change 3 – High-intensity interventions for service users with primarily complex or behaviour related needs

Behaviour Change Level 3 training provides knowledge and skills required to deliver high-intensity interventions, for people who have not benefited from lower intensity interventions and who are at higher risk to their health and well-being. This level is for workers who mostly see people who have complex needs linked to behaviour. These are usually over 30 minutes and provided over multiple sessions.

BCDF Competencies and sub-competencies		**Relevant elements of DJ and Person-Centred frameworks**
BC3 1. Provide extended support for behaviour change and long-term maintenance.	Be able to: a) adapt interventions in response to service user feedback b) help service users use self-monitoring procedures that are relevant and meaningful to them to guide behaviour change interventions and to monitor outcome c) plan for maintenance of behaviour change after the end of the intervention d) help service users identify other resources to help them maintain their behaviour change	DJ F8. Capacity to adapt interventions in response to client feedback 1. An ability to accommodate issues the client raises explicitly or implicitly, or which become apparent as part of the process of the intervention: 2. An ability to respond to, and openly to discuss, explicit feedback from the client which expresses concerns about important aspects of the intervention 3. An ability to detect and respond to implicit feedback which indicates that the client has concerns about important aspects of the intervention DJ BC9 5.1-5.2. Ability to use measures and self-monitoring to guide behaviour change interventions and to monitor outcome DJ BC12. Ability to end the intervention in a planned manner and to plan for long-term maintenance of gains after intervention ends 2. An ability to plan for maintenance of behaviour change after the end of the intervention

		DJ BC12 2.2. ability to help clients identify other resources that might help them maintain their behaviour change (e.g. weightwatchers, websites, gym membership)
BC3 2. Provide support for behaviour change to those at particular high risk of ill-health, complex needs or multiple morbidities.	Be able to: a) understand behaviour change taxonomies and implement behaviour change theories and models in a flexible manner b) select and skilfully apply the most appropriate behaviour change intervention techniques matched to the complex needs of the service user (including but not limited to): i. assertion training ii. goal setting iii. general problem solving iv. graded tasks v. prompts	DJ BC5. Capacity to implement behaviour change models in a flexible but coherent manner DJ BC6. Capacity to select and skilfully to apply the most appropriate behaviour change intervention method 1. An ability draw on knowledge of behaviour change models and methods and on professional experience in order to select from the complete range of behaviour change techniques, and skilfully apply them in a manner which is: 1.1. matched to the needs and capacities of the client DJ M18 Assertion Training - A combination of techniques used to teach client interpersonal communication to help them express emotions, opinions, and preferences (positive and negative) clearly, directly, and in an appropriate manner DJ A1 Goal setting - Identify and set a behavioural goal DJ A22 General problem solving - Engage client in general problem-solving DJ A11 Graded tasks - Set easy tasks to perform, making them increasingly difficult until target behaviour is performed P2 Prompt - Identify a stimulus that elicits behaviour (inc. telephone calls or postal reminders designed to prompt the behaviour)

BC3 3. Provide support for behaviour change to those with mental or physical vulnerabilities.	Be able to: a) select and skilfully apply the most appropriate behaviour change intervention techniques matched to the capacities of the service user b) structure consultations and maintain appropriate pacing in response to service user need work collaboratively with service users to manage service user behaviours that are potentially counter-productive	DJ BC6 1.1. Capacity to select and skilfully to apply the most appropriate behaviour change intervention method 1. An ability draw on knowledge of behaviour change models and methods and on professional experience in order to select from the complete range of behaviour change techniques, and skilfully apply them in a manner which is: 1.1. matched to the needs and capacities of the client DJ F11 1-3. Capacity to structure consultations and maintain appropriate pacing 1. An ability to maintain adherence to an agreed agenda and to 'pace' the consultation in a manner which ensures that all agreed items can be given appropriate attention (i.e. ensuring that significant issues are not rushed) 2. An ability to balance the need to maintain adherence and pacing while being appropriately responsive to client need: 3. An ability to balance the need to maintain an appropriate pace v following up important issues raised by the client

BCDF
BEHAVIOUR CHANGE
DEVELOPMENT FRAMEWORK

NHS
Health Education England

Behaviour Change Development Framework

Developing the Knowledge Base for the Behaviour Change Competencies

Technical Report (Part 2)

January 2021

Wessex School of Public Health

www.behaviourchange.hee.nhs.uk

Developing the Knowledge Base for the Competencies Technical Report

Following the publication of the agreed Behaviour Change Competencies, the next step was to determine what learners would need to know in order to progress through the behaviour change levels. This was to inform the development of future resources, and to ensure that the knowledge base for learners built on the Behaviour Change Literacy resource, and grew in a stepwise fashion as learners' competency progressed. It was also important that this was a sufficient but focussed description of knowledge requirements that could be readily accessed. Note that in addition to areas of underpinning knowledge, this also contains knowledge *about* behaviour change methods and techniques, but not the skills to deliver them. These will be separately outlined in a subsequent stage of the project.

Statements of knowledge and understanding were derived and discussed, and where necessary explanatory notes were added to explain the scope of the statement in more detail. Existing health behaviour change courses were reviewed for their content and were noted as potential sources of learning for each level. Obviously many of the courses also contain education and training on behaviour change skills, and their content does not map exactly but they provide useful sources for signposting in future resources.

Once an agreed set of Knowledge Base statements were achieved a consultation was set up using Survey Monkey. This included some targeted invitations to review the materials to ensure feedback from key professionals in behaviour change. Following the survey the advisory group reviewed the comments and made changes as necessary.

Consultation results

There were 16 respondents from across England, the majority in the SE region but with representation from most regions, and also from Scotland. There was a good spread of professional backgrounds and academic disciplines from: health psychology, behaviour change, public health, and workforce development, including some from clinical settings.

Question	% Yes	% No
Is the language used to describe the Knowledge Base clear and understandable?	100.0	
Is the Knowledge Base for Behaviour Change Level 1 appropriate and sufficient for this competency level?	87.5	12.5
Is the Knowledge Base for Behaviour Change Level 2 appropriate and sufficient for this competency level?	87.5	12.5
Is the Knowledge Base for Behaviour Change Level 3 appropriate and sufficient for this competency level?	94.0	6.0
Do the Knowledge Base levels build in an appropriate manner across the competencies?	100.0	

The responses demonstrate a high approval rating for the content of the Knowledge Base at each level, the language used, and the way the content builds across the levels.

Many additional comments and helpful suggestions were made. There was some confusion from a very small number of respondents with the competencies, who gave comments on the competency wording too. These had been presented alongside for completion, and to demonstrate the relationship between the Knowledge Base and the competencies. When presenting these materials finally it must be made clear how the Competencies, Knowledge and (eventually) Skills are linked.

Some detailed and helpful comments on language and content were made and a few minor amendments to the statements have been made. Many respondents provided useful additions to the information about potential courses for signposting, and also offered professional advice and expertise going forward.

Respondents commented that:

> *The language is very clear and easy to understand*
>
> *Helpful in describing requirements but also how someone might go about achieving these*
>
> *Great, comprehensive but not too long*
>
> *Excellent, clear, easy to understand, and easy to imagine how they might apply across a range of contexts without being vague*
>
> *I think the skills escalator works well and makes sense*

The following sections provide the Competencies and Knowledge base in full, and the additional material in terms of the explanatory texts and courses to guide further resource development.

Developing the Knowledge Base for the Behaviour Change Competencies - Technical Report

Behaviour Change Development Framework
Behaviour Change Competencies and Knowledge Base

The following tables outline the Behaviour Change Competencies at each level of the Behaviour Change Development Framework, with their accompanying knowledge requirements in the Knowledge Base. The completed package will also include identification of the Behaviour Change Skills required at each level. Educational resources including more detailed description of the elements of the knowledge base and signposting to courses covering the required material, will also be provided. The same will be developed for the skills component. Underpinning all will be a statement of the professional and ethical expectations of behaviour change practitioners.

Behaviour Change Level 1

Competencies and sub-competencies
BC1 1. Recognise and act upon opportunities to support behaviour change in service users, as they arise in your routine work. Be able to: a) recognise the opportunity to have a conversation with a service user and choose to take the opportunity b) ensure confidential conversations take place in private, quiet and comfortable places c) initiate a discussion about health behaviours d) identify what is important to the individual e) use a range of communication skills and language appropriate for an individual's needs and understanding **BC1 2. Use appropriate methods to open a conversation about behaviour change and elicit a response.** Be able to: a) use open ended questions to engage with the service user b) check if there is something an individual wants to discuss c) enable a service user to engage and explore a range of options including taking no action **BC1 3. Depending on the response, use appropriate techniques to motivate and encourage engagement with behaviour change.** Be able to: a) ask open questions to explore and understand the individual's situation and what matters to them b) provide general information about the behaviour and behaviour change in a manner that can be easily understood c) reassure and encourage the individual to believe in themselves and the possibilities of improvement d) let the individual know you understand how they are feeling by being empathetic

e) reflect on what they have said using their words
f) summarise what they have said during the conversation

BC1 4. Provide further information to support behaviour change.
Be able to:
a) Provide relevant and accurate information or advice in a manner that enables a service user to choose whether or not to take it
b) Support a service user to make a decision and plan together the way forward
c) Provide information and signpost to additional resources or support relevant to the health behaviour

Knowledge Base

BC1 K1. Basic knowledge of physical and mental health risks in adults, and of behavioural risk factors for diet, activity, alcohol and smoking
BC1 K2. Knowledge of basic communication skills and their benefits, including use of open-discovery questions, affirmation, reflection and summaries
BC1 K3. Knowledge and understanding of the social determinants of health and how they influence health behaviours

BC1 K4. Know how to look for credible and up to date information about local, regional and national services and support available

Behaviour Change Level 2

Competencies and sub-competencies

BC2 1. Use appropriate methods to explore service user motivation to change behaviour.

Be able to:

a) form a collaborative relationship where the service user and professional work as a team, engaging in and exploring a potential way forward
b) undertake a generic assessment, based on behaviour change theory, of the individual's personal situation and what matters to them, including suitability for behaviour change or referral
c) help the service user identify and select relevant health behaviour issues for change

BC2 2. Select appropriate behaviour change techniques for the service user and the issue.

Be able to:

a) take a problem-solving approach to identifying possible solutions
b) select and skilfully apply the most appropriate behaviour change intervention techniques:
    i. identify the social, environmental and emotional causes of behaviour and its consequences
    ii. support decision-making by generating alternative courses of action and weighing them up
    iii. elicit self-motivating statements and evaluation of behaviour to reduce resistance to change
    iv. support attitude change and encourage a different perspective on behaviour by reframing
    v. provide opportunities for social comparison
c) help service user to identify individual, social, environmental and professional barriers and facilitators that might affect intervention implementation
d) work professionally and ethically with groups of service users, engaging individuals and encouraging discussion

BC2 3. Develop and agree a plan of action for behaviour change in collaboration with the service user.

Be able to:

a) manage expectations, including the frequency and duration of the intervention and what is expected from the individual
b) agree goals for the intervention and ensure they are realistic, attainable, timely and measurable
c) agree a contract of behaviour change with the individual
d) structure the consultations and adhere to an agreed agenda
e) identify and/or provide sources of social support

f) work in a coordinated way with service user's family, carers and advocates, and other professionals
g) support individual to develop plans to overcome barriers to behaviour change

BC2 4. Review progress with service user.
Be able to:
a) provide feedback using agreed measures and self-monitoring to review progress on behaviour change, and adapt the goal where appropriate
b) review how individual has coped with risky situations and barriers

BC2 5. Agree end point or closure of support with service user.
Be able to:
a) end the intervention in a planned manner and help service user identify any concerns they may have about the closure of support
b) plan for maintenance of behaviour change including identification of other resources that might provide maintenance support
c) self-reflect on what worked well or could have been improved, and identify key learning points

Knowledge Base

BC2 K1. Knowledge of physical and mental health behaviour and risk factors and in-depth or detailed knowledge of one or more health risks, relevant to service user needs.

BC2 K2. Knowledge and understanding of the social determinants of health and how they influence health behaviour
BC2 K3. Knowledge of group dynamics and how to facilitate working with groups
BC2 K4. Know about current models of behaviour change theory and how to influence behaviour change

BC2 K5. Know about behaviour change techniques, and understand the application of selected specific behaviour change techniques including: problem-solving approaches, decision-making, social support and comparison, action planning and goal setting, outcome measures and self-monitoring
BC2 K6. Knowledge of communication methods for structuring a behaviour change conversation including: agenda setting, managing discord, resolving ambivalence, reframing and building self-efficacy

BC2 K7. Knowledge of models of reflective practice and their use

Behaviour Change Level 3

Competencies and sub-competencies

BC3 1. Provide extended support for behaviour change and long-term maintenance.

Be able to:

a) adapt interventions in response to service user feedback
b) help service users use self-monitoring procedures that are relevant and meaningful to them to guide behaviour change interventions and to monitor outcome
c) plan for maintenance of behaviour change after the end of the intervention
d) help service users identify other resources to help them maintain their behaviour change

BC3 2. Provide support for behaviour change to those at particular high risk of ill-health, complex needs or multiple morbidities.

Be able to:

a) understand behaviour change taxonomies and implement behaviour change theories and models in a flexible manner
b) select and skilfully apply the most appropriate behaviour change intervention techniques matched to the complex needs of the service user (including but not limited to):
    i. Behavioural practice/rehearsal: prompt practice or rehearsal a behaviour in order to increase habit and skill
    ii. Conserving mental resources: advise on ways of minimising demands on mental resources to facilitate behaviour change.
    iii. Problem solving: analyse, or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators.
    iv. Action planning: Prompt detailed planning of performance of the behaviour
    v. Reduce negative emotions: Advise on ways of reducing negative emotions to facilitate performance of the behaviour

BC3 3. Provide support for behaviour change to those with mental or physical vulnerabilities.

Be able to:

a) select and skilfully apply the most appropriate behaviour change intervention techniques matched to the capacities of the service user
b) structure consultations and maintain appropriate pacing in response to service user need
c) work collaboratively with service users to manage service user behaviours that are potentially counter-productive

Knowledge Base

BC3 K1. Know how to structure and pace a consultation while being mindful of and empathetic to the mental and physical vulnerabilities the service user may have.

BC3 K2. Knowledge of living with complex long-term conditions and multiple morbidities, and the barriers and enablers for services users to self-manage their conditions.

BC3 K3. Knowledge of self-management tools to explore the impact of the service user's health issues, symptoms and behaviours, for example: formulation, persistent pain cycle and symptom diaries

BC3 K4. Knowledge of the Behaviour Change Techniques Taxonomy and understand how to select and apply the most appropriate behaviour change techniques to support the service user to manage their condition and symptoms. Including (but not limited to): behavioural practice/rehearsal; conserving mental resources; problem solving; action planning and reduce negative emotions.

Developing the Knowledge Base for the Behaviour Change Competencies - Technical Report

Behaviour Change Development Framework
Additional material for resource development

For the consultation on the Knowledge Base it was felt necessary to indicate the scope in some areas of the knowledge required, this is provided below under the heading of Explanatory text, and has been amended if necessary following consultation. At this point not all the knowledge items have further text descriptors. As resources are developed it will be necessary to include more description of the areas covered, and signpost to existing courses or sources of further information. Some of the suggestions of courses for signposting include those developing behaviour change skills in addition to knowledge. It is envisaged the final resource will encompass knowledge and skill development, and provide a comprehensive overview of access to further education and training.

Behaviour Change Level 1
Knowledge Base **BC1 K1**. Basic knowledge of physical and mental health risks in adults, and of behavioural risk factors for diet, activity, alcohol and smoking **BC1 K2**. Knowledge of basic communication skills and their benefits, including use of open-discovery questions, affirmation, reflection and summaries **BC1 K3**. Knowledge and understanding of the social determinants of health and how they influence health behaviours **BC1 K4**. Know how to look for credible and up to date information about local, regional and national services and support available
Explanatory text **BC1 K2** **Open-discovery questions**: Closed questions typically elicit a yes/no answer, whereas open discovery questions seek more information or ask someone to say something about how they view their world, to give new information or insight. Open discovery questions are non-judgemental questions that begin with ‘what’ and ‘how’. Other open questions (beginning where, when, who or why) may also be used. **Affirmations**: Affirmations are statements and gestures that recognize client strengths and acknowledge behaviours that lead in the direction of positive change, no matter how big or small. Affirmations build confidence in one’s ability to change. **Reflections**: Reflective listening involves repeating parts of what the other person says, but not as questions. The simplest form is repeating or rephrasing the contents of what is said, repeating back some words. Paraphrasing involved restating the meaning of what they have said, and feeling reflection, reflects back your impression of a feeling that they might be experiencing or something that really matters to them.

Summaries: Summarizing helps to ensure clear communication by checking understanding, and drawing information together. Dependant on the response to summary statements may lead into next steps for planning for change.

Courses for signposting for knowledge and skills development

HEE

- Alcohol Identification & Brief Advice: Primary Care Pathway Part 1 Alcohol facts
- Nutrition & Obesity: Obesity Introduction
- Physical Activity & Health: Part 1 Importance of PA; Part 2 The health benefits of PA
- All Our Health: Smoking & Tobacco; Adult Obesity; Alcohol; CVD; Physical Activity (very basic)
- Alcohol & Tobacco Brief Interventions: Part 2 Very Brief Advice Smoking
- MECC Session 1 - What is MECC and why is it important
- MECC Session 2 - How to have a MECC conversation
- MECC Session 3 - Signposting
- Five ways to Wellbeing
- Behaviour Change Literacy

PH Scotland

- Very Brief Advice on smoking
- Raising the issue of physical activity

Sport England Physical Activity guidance, Active Partnerships guidance, local public health teams

Mental Health (Talking Therapy or online support) and citizen advice bureau (or Local Authority support)

K1: All Our Health: incl. mental health & wellbeing. Connect 5. K2: Give examples of affirmation and examples of empathy. K4: knowledge of roles such as social prescriber's/link workers?

UCL Centre for Behaviour Change; SEPIA [Specialised Education for Professionals in Applied] Health

Behaviour Change Level 2
Knowledge Base **BC2 K1**. Knowledge of physical and mental health behaviour and risk factors and in-depth or detailed knowledge of one or more health risks, relevant to service user needs. **BC2 K2**. Knowledge and understanding of the social determinants of health and how they influence health behaviour **BC2 K3**. Knowledge of group dynamics and how to facilitate working with groups **BC2 K4**. Know about current models of behaviour change theory and how to influence behaviour change **BC2 K5**. Know about behaviour change techniques, and understand the application of selected specific behaviour change techniques including: problem-solving approaches, decision-making, social support and comparison, action planning and goal setting, outcome measures and self-monitoring **BC2 K6**. Knowledge of communication methods for structuring a behaviour change conversation including: agenda setting, managing discord, resolving ambivalence, reframing and building self-efficacy **BC2 K7**. Knowledge of models of reflective practice and their use
Explanatory text **BC2 K3** *NHS Institute for Innovation & Improvement* Working with Groups. Improvement Leaders Guide https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.3-Working-with-Groups.pdf **BC2 K4** **Health Belief Model** The Health Belief Model is a long established psychosocial model that explains individual's health behaviours in terms of their attitudes and beliefs. It predicts people will take action to promote health if they perceive themselves to be *susceptible* to a condition with perceived *severity*, and that the *benefits* of a particular course of action outweigh any *costs.* In addition their sense of *self-efficacy* i.e. their belief in their ability to carry out the recommended action also influences the likelihood of behaviour change. **Theory of Planned Behaviour**

This behavioural theory builds on the recognition of the role of individual beliefs and attitudes by including the influence of *subjective norms*. These relate to what people think other people think they should or shouldn't do, and how motivated they are to comply. These social influences may come from significant others such as peers and media role models, and through cultural norms. The individual's *perceived behavioural control,* a concept similar to self-efficacy, reflects their sense of power over the situation which influences their ability to turn behavioural intentions into action.

Stages of Change

This model focusses on the behaviour change process and recognises that individuals have varying levels of motivation or readiness to change at different stages of the change process.

Five stages of change are described:

Precontemplation describes individuals who are not considering changing their behaviour; *Contemplation* is when someone considers making a behaviour change; *Preparation* when a person makes a serious commitment to change; *Action* when a change is initiated; and *Maintenance* when the changed behaviour is sustained. People may relapse and cycle around the stages again which is seen as a normal part of behaviour change process.

COM-B

This model recognises the need to understand behaviour in the context in which it occurs. COM-B stands for Capability Opportunity Motivation – Behaviour. For a behaviour to occur there must be:

Capability – the individuals must have the physical strength, knowledge, skills, stamina etc to perform the behaviour

Opportunity – there needs to be a conducive physical and social environment for the behaviour to occur i.e. it must be accessible, affordable, socially acceptable and timely

Motivation – individual motivation to perform the behaviour needs to be strong enough to do the behaviour rather than not.

BC2 K5

1.1 **Goal setting (behaviour)**

Set or agree a goal defined in terms of the behaviour to be achieved e.g. a daily walking goal

1.2 **Problem solving**

Analyse, or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators e.g. identifying specific triggers to drinking alcohol and develop strategies for avoiding them, or managing emotions.

1.3 **Goal setting (outcome)**

Set or agree a goal defined in terms of a positive outcome of wanted behaviour e.g. set a weight loss goal

1.4 **Action planning**
Prompt detailed planning of performance of the behaviour (must include at least one of context, frequency, duration, and intensity) e.g. plan the performance of taking a run before work on certain days of the week.

1.5 **Review behaviour goal(s)**
Review behaviour goal(s) with person and modify goal(s) or behaviour change strategy in light of achievement. This may lead to re-setting the same goal, a small change in that goal or setting a new goal, or no change.

1.7 **Review outcome goal(s)**
Review outcome goal(s) with person and modify goal(s) in light of achievement. This may lead to re-setting the same goal, a small change in that goal or setting a new goal, or no change.

1.8 **Behavioural contract**
Create a written specification of the behaviour to be performed, agreed on by the person, and witnessed by another.

2.3 **Self-monitoring of behaviour**
Establish a method for the person to monitor and record their behaviour(s) as part of behaviour change strategy e.g. provide a pedometer and form for recording daily steps

2.4 **Self-monitoring of outcome(s) of behaviour**
Establish a method for the person to monitor and record the outcome(s) of their behaviour as part of a behaviour change strategy e.g. record daily wright over a set period on a graph

3.1 **Social support (unspecified)**
Advise on, arrange or provide social support (e.g. from friends, relatives, colleagues,' buddies' or staff) or noncontingent praise or reward for performance of the behaviour. E.g. advise person to call a 'buddy' when they experience the urge to smoke

3.2 **Social support (practical)**
Advise on, arrange, or provide practical help (e.g. from friends, relatives, colleagues, 'buddies' or staff) for
performance of the behaviour

3.3 **Social support (emotional)**

Advise on, arrange, or provide emotional social support (e.g. from friends, relatives, colleagues, 'buddies' or staff) for performance of the behaviour e.g. take a partner or friend to a health appointment

6.2 **Social comparison**
Draw attention to others' performance to allow comparison with the person's own performance
Needs development of resources drawing on the Health Trainers approach from:
Michie et al *Improving Health: Changing Behaviour. NHS Health Trainer Handbook*
Department of Health https://core.ac.uk/download/pdf/18619054.pdf

BC2 K6
Agenda setting
Agenda setting is a collaborative process through which the professional and the service user decide how best to use the session time by constructing an agenda of items that they both wish to discuss.

Managing discord
Discord is a normal human response to feeling pressured or challenged to do something about which a person is ambivalent. It may include arguing, interrupting, discounting, or ignoring. The professional's role is to manage discord productively.

Resolving ambivalence
Ambivalence represents a service user's experience of simultaneously feeling two ways about changing their behaviour; for example, concurrently wanting to make a change while also feeling reticent to do. The professional's role is to help the individual resolve ambivalence by responding appropriately to both sustain talk and change talk.

Reframing
Reframing is a way of reflecting what the individual has said in a new light by offering a new and positive interpretation of negative information. Reframing acknowledges the validity of the individual's raw observations, but offers a new meaning.

Building self-efficacy
Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change, through recognizing the client's strengths and enabling them to believe change is possible

BC2 K7
A reflective practitioner thinks about their practice, consciously analyses their decision-making, draws on theory and evidence and relates this to what they do in practice.

Kolb's reflective model is referred to as experiential learning. Kolb's learning cycle describes four stages: *Concrete experience* – doing / having an experience; *Reflective*

observation – reviewing / reflecting on the experience; *Abstract conceptualisation* – concluding / learning form the experience; *Active experimentation* – planning or trying out what you have learned. It is essentially a Plan Do Study Act (PDSA) cycle which is based on consciously thinking about an event or aspect of practice and considering how to improve it.

Gibb's reflective cycle gives further structure to learning from experience, and adds the element of thinking about your feelings and emotions regarding the experience. It provides six steps to structure the reflection: *Description* of the experience; *Feelings* and thoughts about the experience; *Evaluation* of the experience, both good and bad; *Analysis* to make sense of the situation; *Conclusion* about what you learned and what you could have done differently; *Action plan* for how you would deal with similar situations in the future, or general changes you might find appropriate.

Courses for signposting for knowledge and skills development

HEE

- Behaviour Change Literacy
- Alcohol & Tobacco Brief Interventions: Part 3 Alcohol; Part 4 Alcohol & tobacco
- Alcohol Identification & Brief Advice: Primary Care Pathway Part 2 Identifying risk; Part 3 Implementing brief advice & Delivering brief advice
- Nutrition & Obesity: Identifying overweight & obesity risk factors; Guiding & enabling behaviour change
- MECC e-learning https://www.e-lfh.org.uk/programmes/making-every-contact-count/
- NHS website https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/

PH Scotland

Stop Smoking Advisers

training should have a few key features: behaviour-focused, evidence-based, examples include Cog behavioural therapy, advanced motivational interviewing skills etc.

Could be useful to sign post to UCL's Centre for behaviour change as they provide bespoke training relating to behaviour change. https://www.ucl.ac.uk/behaviour-change/training/bespoke-training

Contact local specialist health promotion services for further support / advice / resources

Mental Health First Aid training. K6: How will the professional know how to manage discord, resolve ambivalence? Is it worth giving some examples or stating where they would be expected to/could get this training?
HEE Wessex and the Faculty of Healthy Conversation Skills has developed a range of MECC-based interactive skills trainings these should be included as appropriate

Behaviour Change Level 3
Knowledge Base **BC3 K1**. Know how to structure and pace a consultation while being mindful of and empathetic to the mental and physical vulnerabilities the service user may have. **BC3 K2.** Knowledge of living with complex long-term conditions and multiple morbidities, and the barriers and enablers for services users to self-manage their conditions. **BC3 K3**. Knowledge of self-management tools to explore the impact of the service user's health issues, symptoms and behaviours, for example: formulation, persistent pain cycle and symptom diaries **BC3 K4.** Knowledge of the Behaviour Change Techniques Taxonomy and understand how to select and apply the most appropriate behaviour change techniques to support the service user to manage their condition and symptoms. Including (but not limited to): behavioural practice/rehearsal; conserving mental resources; problem solving; action planning and reduce negative emotions.
Explanatory text **BC3 K2** Challenges include living with undesirable physical and emotional symptoms (e.g. chronic fatigue, pain, anxiety); cognitive, social and financial factors and the therapeutic alliance. **BC3 K3** **Formulation**: is a CBT tool for mapping out the interconnected thoughts emotions, behaviours, and physical symptoms that a service user is experiencing. It also helps practitioner and service-user pinpoint where to focus their treatment. **Persistent Pain Cycle**: This tool helps the service user to visualise the problems and behaviour that occur when living with persistent pain. **Symptom Diaries**: A symptom diary enables tracking and examination of the onset and intensity of symptoms, including triggers and factors that bring symptom relief.

Reduce negative emotions:
Advise on ways of reducing negative emotions to facilitate performance of the behaviour. E.g., the use of CBT strategies such as thought records and behaviour activation to manage low level mental health issues, or draw on Acceptance and Commitment Therapy (ACT) or mindfulness-based strategies to build resilience to difficult emotions.

BC3 K4
Behavioural practice/ rehearsal:
Prompt practice or rehearsal of the performance of the behaviour one or more times in a context or at a time when the performance may not be necessary, in order to increase habit and skill.

Conserving mental resources:
Advise on ways of minimising demands on mental resources to facilitate behaviour change. E.g. use of medicine management tools, mapping of resources, use of social support.

Problem solving:
Analyse, or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators. E.g. to manage worry or anxiety or develop strategies for coping.

Action planning:
Prompt detailed planning of performance of the behaviour (must include at least one of context, frequency, duration and intensity). Context may be environmental (physical or social) or internal (physical, emotional or cognitive) (includes 'Implementation Intentions'). e.g. plan how they will fit their behaviour change into their routine, pace their activities, or prevent relapse.

Reduce negative emotions:
Advise on ways of reducing negative emotions to facilitate performance of the behaviour. E.g., the use of CBT strategies such as thought records and behaviour activation to manage low level mental health issues.

Courses for signposting for knowledge and skills development

At this level the intensity of training, the need for qualification, and the importance of supervision should be highlighted

UCL should be a good resource for this, ideal level is at the masters, post grad cert level plus supervised practice