National Undergraduate Curriculum for Chronic Disease Prevention and Management

Part 1: Making Every Contact Count for Health Behaviour Change

Facilitator Guide

A collaboration between the Health Service Executive and Higher Educational Institutions in Ireland

MAKING EVERY CONTACT COUNT

hi Healthy Ireland

AUTHORSHIP National Undergraduate Curriculum Working Group.

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1 This Curriculum was designed for undergraduate education however it is also relevant for graduate students at first point of entry to health profession education.
Part 2 *Self-Management Support for Chronic Disease* is currently being developed.

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UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh


UCD
DUBLIN


lyit
Institiúid Teicneolaíochta
Leitir Ceanainn
Letterkenny Institute
of Technology


DCU


Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin


GMIT
INSTITIÚID TEICNEOLAÍOCHTA NA GAILLIMHE-MAIGH EO
GALWAY-MAYO INSTITUTE OF TECHNOLOGY


IT Sligo
An Institiúid Teicneolaíochta, Sligeach


INSTITUTE OF TECHNOLOGY
TRALEE


Institiúid Teicneolaíochta Cheatharlach
INSTITUTE of TECHNOLOGY
CARLOW
At the heart of South Leinster


NUI Galway
OÉ Gaillimh


AIT
Connect & Discover


RCSI


UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH


DUNDALK
INSTITUTE OF TECHNOLOGY
INSTITIÚID TEICNEOLAÍOCHTA
DHÚN DEALGAN


Waterford Institute of Technology
INSTITIÚID TEICNEOLAÍOCHTA PHORT LÁIRGE


HSE
Seirbhís Sláinte
Níos Fearr
á Forbairt
Building a
Better Health
Service

Abbreviations

BI	Brief Intervention
BMI	Body Mass Index
CD	COPD Chronic Obstructive Pulmonary Disorder
CDP	Chronic Disease Prevention
EBI	Extended Brief Intervention
HBC	Health Behaviour Change
HBC-CDPM	Health Behaviour Change for Chronic Disease Prevention and Management
HEI	Higher Educational Institution
HI	Healthy Ireland
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
HSI	Heaviness of Smoking Index
LWG	Local Working Group
ICPCD	Integrated Care Programme for Prevention and Management of Chronic Disease
MI	Motivational Interviewing
NHS	National Health Service
NICE	National Institute for Care and Excellence
NSG	National Steering Group
NWG	National Working Group
RCN	Royal College of Nursing
SBIRT	Screening, brief intervention and referral to treatment
TILDA	The Irish Longitudinal Study on Ageing
WHO	World Health Organisation

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Glossary of Terms

Curriculum
A plan or design guiding all activities, education and training upon which education provision is modelled.

Curriculum Development
Refers to the broad process of developing all aspects of the curriculum from production to evaluation of its operation.

Curriculum Design
An activity directed at structuring the content and process of the curriculum, including the curriculum philosophy, model, matrix mapping. It is a sub-component of curriculum development (Quinn, 2000, p. 50).

Curriculum Manual
The document containing all relevant information on the curriculum, including curriculum development, facilitators guide, content and teaching resources.

Making Every Contact Count
A programme being implemented within the HSE to support the prevention of chronic disease by promoting lifestyle behaviour change.

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Forewords

Dr Stephanie O'Keeffe, National Director, Strategic Planning and Transformation, HSE

The majority of chronic diseases can be prevented by supporting people to make healthier lifestyle choices. As a health service we can make a significant difference to the health and wellbeing of our population by looking at how we do our work, looking at our structures and by valuing the knowledge and expertise of our staff and health care professionals. *Healthy Ireland (HI) - A Framework for Improved Health and Wellbeing 2013-2025* (Department of Health, 2013) was adopted by the Irish Government in 2013 in response to worrying trends in our population health. This cross-governmental Framework, which is being rolled out by the Department of Health, sets out clear goals for improving our health and wellbeing. In addition, it outlines clear routes and strategies, including a focus on addressing the social determinants of health and on individual lifestyle behaviour change interventions, to help achieve these goals.

In mid-2015 the HSE published its first *Healthy Ireland in the Health Services National Implementation Plan (2015-2017)* (Health Service Executive, 2015). Reducing the burden of chronic disease is one of the three strategic priorities set out in this Plan. One of the priority actions in this Plan was to develop and implement a Health Behaviour Change Framework *Making Every Contact Count,* for healthcare professionals as evidence shows that health advice and information is key to unlocking significant behaviour change in our service users. The *Making Every Contact Count* Programme asks all health care professionals to include lifestyle interventions for prevention in all of their clinical contacts with patients throughout the health service. As part of this our existing workforce is being trained to have the necessary knowledge and skills to support patients to make lifestyle behaviour changes as part of continuous professional development.

However, we also need to consider the healthcare professionals of the future - those who are currently completing undergraduate training programmes through our Higher Education Institutions. These individuals will have an extremely important role in driving and sustaining the impact of *Making Every Contact Count* into the future. Educating young professionals in health behaviour change methodologies is an important element in our overall strategy to reducing the burden of chronic diseases and is a related priority action in our HI plan.

It was with this in mind that the HSE sought the establishment of a collaboration between the Health Services and the Higher Education Institutions in Ireland, with responsibility for delivering undergraduate healthcare professionals training programmes, to develop a standard undergraduate curriculum for healthcare professionals for health behaviour change and chronic disease prevention.

The development and implementation of this standard national curriculum will be a key factor in equipping our healthcare professionals with the knowledge, attitudes and skills to address lifestyle behaviour issues with their future patients and support *Making Every Contact Count. Making Every Contact Count* provides a unique opportunity for healthcare professionals to support their patients in changing their lifestyle behaviours.

I welcome the collaborative process that has resulted in this curriculum and I look forward to seeing this curriculum integrated into undergraduate programmes for all healthcare professionals across all Higher Education institutions over the coming years and indeed in helping to create a workforce for the health service that will *Make Every Contact Count* for years to come.

Dr. Orlaith O'Reilly, National Clinical Advisor and Programme Group Lead for Health and Wellbeing, Strategic Planning and Transformation

Evidence shows that advice and intervention by healthcare professionals has the potential to unlock significant behaviour change for patients. Our services and our healthcare teams have enormous potential to influence the health and wellbeing of the people for who we provide care. Ireland has a population of almost 5 million, there are approximately 30 million contacts within the health service annually each providing an opportunity to *Make Every Contact Count* for chronic disease prevention by making lifestyle changes. The Healthy Ireland survey shows that there is considerable scope for health improvement in terms of lifestyle behaviour risk factors for the development of chronic disease. This coupled with the potential number of contacts creates the perfect opportunity.

Making Every Contact Count is a programme being implemented within the Health Service to support the prevention of chronic disease by promoting lifestyle behaviour change. It aims to capitalise on the opportunities that occur every day for every healthcare professional to support patients to make a lifestyle behaviour change.

The Health Service is currently implementing a number of reforms which will support the prevention of chronic disease prevention and the implementation of *Making Every Contact Count.* The newly established Integrated Care Programme for Chronic Disease Prevention and Management aims to ensure that people receive seamless care at the lowest level of appropriate complexity. An essential element of the model of care is supporting people to reduce and manage their lifestyle risk factors.

The delivery of *Making Every Contact Count* will require leadership at all levels throughout the organisation, but clinical leadership will be particularly important in changing the culture to prevention. Implementing *Making Every Contact Count* will require training and upskilling of both existing healthcare professionals and future healthcare graduates with the skills necessary to support lifestyle behaviour change in their patients.

Professor Eileen Savage, Chair of the National Working Group, and Head of School, Catherine McAuley School of Nursing and Midwifery, Brookfield Health Sciences Complex, University College Cork

I am delighted to write a foreword from an educational perspective for this first edition of the *National Undergraduate Curriculum for Chronic Disease Prevention and Management: Making Every Contact Count for Behaviour Change.* This curriculum represents a landmark in higher education in Ireland because it is the first time that a collaborative approach has been adopted in health education such that all healthcare disciplines throughout the Higher Education Institutions (HEIs) were involved in developing a national standardised curriculum. This collaboration also involves the Health Service Executive (HSE), specifically, the Health and Wellbeing Division.

This manual is intended to be a comprehensive resource to support the education of undergraduate students across all healthcare disciplines in chronic disease prevention and management through brief intervention training to promote healthy lifestyle behaviour changes, known as '*Making Every Contact Count'.* These disciplines include Dentistry, Nursing, Medicine, Midwifery, Occupational Therapy, Pharmacy, Physiotherapy, Public Health, Podiatry, Social Work, and Speech and Language Therapy. Undergraduate education rather than postgraduate education offers the best timing to prepare students for *'Making Every Contact Count'* since it will orientate them towards chronic disease prevention from the outset of their clinical careers. The large numbers of healthcare students graduating from undergraduate programmes in Ireland offers a critical mass for targeted education. The potential of an educated critical mass cannot be underestimated in terms of making a real difference to chronic disease prevention and management in healthcare services.

This National Curriculum on *'Making Every Contact Count'* is directly relevant to and part of Ireland's national framework for action to improve health and wellbeing of the people of Ireland (Healthy Ireland). Students therefore will be equipped with knowledge, skills, and attitudes to become competent healthcare professionals in responding to current national healthcare priorities which in this case relates to lifestyle behaviour changes for chronic disease prevention and management.

A critical feature of the development of this National Curriculum is the alignment between the HSE and the HEIs. This alignment is a real strength since it bridges the education-health service gap that too often is a feature of undergraduate programmes. The continued alignment and collaboration between the HSE and the HEIs will be a necessary ingredient to successful implementation and evaluation of this curriculum. This alignment and collaboration will serve as a model for transforming undergraduate education of future healthcare professionals for *Making Every Contact Count* and beyond.

Executive Summary

The challenge of reducing the incidence and burden of chronic disease in Ireland is currently being addressed by the Irish Government through a number of innovative initiatives. A key strategic development has been the establishment of a national framework to support the health and wellbeing of all people in Ireland; *Healthy Ireland: A Framework for Improved Health and Wellbeing* (Department of Health, 2013). In response to *Healthy Ireland,* the Health Service Executive (HSE) prioritised to reduce the burden of chronic disease in Ireland, leading to the development of a National Brief Intervention Model known as *Making Every Contact Count*. *Making Every Contact Count* is a method of promoting and encouraging healthy lifestyle behaviours and health behaviour change (HBC) through routine day-to-day contact between healthcare professionals and individuals. It is about changing culture through a focus on prevention and promotion of health as a priority. A key goal of *Making Every Contact Count* is to support healthcare professionals learn the skills required to effectively deliver brief interventions enabling the promotion of healthy lifestyles and HBC.

The HSE acknowledged the importance of embedding the impetus for HBC for chronic disease prevention and management among undergraduate healthcare students. Graduate healthcare professionals would then have the skills that are required to support individuals to lead healthy lifestyles and contribute to the overall aim of reducing the burden of chronic disease.

Therefore, a collaboration between the HSE and Higher Educational Institutions (HEI) was formed to develop an Undergraduate Curriculum to address HBC for chronic disease prevention and management.

A comprehensive Curriculum on *Making Every Contact Count* for Health Behaviour Change for Chronic Disease Prevention and Management (HBC-CDPM), presented herein, was developed through the combined efforts and consultations of key representatives across the Health Services and HEIs nationwide.

This Curriculum Manual provides details on the curriculum development processes and the content needed to successfully deliver the Curriculum in undergraduate healthcare programmes. The Manual is presented in two sections:

- **Section 1** deals with aspects related to curriculum development, design, integration, assessment and evaluation.
- **Section 2** four Units of Study are presented and key learning tools including power point presentations, activities, web links, discussion points and reflective exercises are incorporated.

The four Units of Study contained in the Curriculum are:

Unit 1 ***Health and Personal Wellness***

Unit 2 ***Lifestyle Behaviours and Personal Responsibility for Health***

Unit 3 ***Communication for Healthy Lifestyles and Health Behaviour Change***

Unit 4 ***Making Every Contact Count: Providing Opportunistic Brief Interventions***

Each unit of study consists of up to six Lessons of one or two-hour duration. Lessons may be delivered face-to-face or the option of online delivery is available; individual institutions may upload the content onto their Virtual Learning Environment and deliver the Curriculum online. The skills components of the Curriculum require face-to-face learning. The content of the Curriculum may be incorporated into existing modules and delivered over the duration of the programme or it may be delivered as a standalone module.

The Undergraduate Curriculum on *Making Every Contact Count* for HBC-CDPM is a testament to the innovative efforts being carried out to address the challenges of targeting chronic disease prevention and management in Ireland. Continued collaboration between key stakeholders in the HSE and HEIs to prepare healthcare professionals and healthcare students to Make Every Contact Count for health and HBC will expectantly contribute to the overall aims of chronic disease prevention and management, and reduce the burden of chronic disease.

The curriculum, including supporting powerpoint slides, can be downloaded from the link below:

www.hse.ie/mecc-undergradcurriculum

Introduction

The Undergraduate Curriculum Manual on *Making Every Contact Count* for Health Behaviour Change-Chronic disease Prevention and Management (HBC-CDPM) is a comprehensive resource to assist educators in preparing undergraduate healthcare students in Ireland to deliver basic HBC and CDP interventions. The Curriculum is designed to facilitate integration into existing undergraduate curricula within individual Schools across the Higher Education sector targeting a range of healthcare disciplines; Medicine, Nursing, Midwifery, Dentistry, Dietetics, Pharmacy, Physiotherapy, Podiatry, Public Health, Psychology, Speech and Language Sciences, Occupational Health Sciences and Social Care. In providing a recommended framework and educational resources we encourage individual Schools to adapt the Curriculum to meet local or disciplinary needs. Therefore, the Curriculum, although standardised across health science courses, has flexibility regarding implementation. Each individual School has scope to integrate components of the Curriculum with other relevant existing modules as they see fit.

In response to the requirements set out by the Irish Government's *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025* (Department of Health, 2013) the HSE set an agenda to support HBC across the health services and highlighted an action to;

> ***"Strengthen collaboration with colleges, universities and professional training bodies to include health and wellbeing and prevention modules in relevant undergraduate and postgraduate training courses" (Health Service Executive, 2015, p. 18).***

The HSE collaborated with HEIs nationwide to develop this standardised undergraduate Curriculum on *Making Every Contact Count* for HBC-CDPM. A National Steering Group (NSG) was set up with key stakeholders from the HSE and HEIs to oversee this development and implementation. A National Working Group (NWG) was established and comprised one member from each HEI (representing all Schools within health sciences) with ultimate responsibility for the development of the Curriculum content. Local Working Groups (LWG) were formed within each HEI to inform key aspects of curriculum development and implementation such as identifying the learner content, approaches, assessments and evaluation of the Curriculum[3].

A collaborative statement was developed and agreed by all parties involved and four guiding principles were approved.

The guiding principles to support collaborative relations are as follows:

1. ***Working together involves valuing a collective and national approach to Curriculum development for a common purpose.***
2. ***Meaningful collaboration is facilitated through a coordinated and cooperative exchange of ideas, information, knowledge, experiences, and teaching/learning resource materials relevant to developing a National Curriculum.***
3. ***Mutual trust between all collaborators fosters a climate of reciprocity and greater opportunities for shared achievements.***
4. ***Effective collaboration involves working together on all aspects of planning, implementing and evaluation of the National Curriculum.***

3 A number of HSE publications were consulted during the development of this Manual. Key information has been directly replicated in parts, to provide context, with permission from the relevant bodies and is referenced accordingly.

This Curriculum Manual is composed of two sections:

Section 1: Lecturer's/Facilitator's Guide

In Section 1 we present a guide for educators on all aspects of the Curriculum inclusive of the aims of the Curriculum and Curriculum Manual, the underlying philosophy of the Curriculum, and Curriculum development processes. Sub-sections are presented dealing with implementing/integrating the Curriculum, assessment of learning, and Curriculum evaluation.

Section 2: Curriculum Content

In Section 2 we present the learning content for *Making Every Contact Count* for HBC-CDPM. We identify four Units of Study or content areas:

Unit 1 *Health and Personal Wellness*

Unit 2 *Lifestyle Behaviours and Personal Responsibility for Health*

Unit 3 *Communication for Healthy Lifestyles and Health Behaviour Change*

Unit 4 *Making Every Contact Count: Providing Opportunistic Brief Interventions*

For each Unit or topic area we provide the learning content permitting easy interpretation and utility across HEIs irrespective of local resources. A variety of teaching strategies including case studies, discussions and reflective exercises, power point presentations, readings and skills based learning are presented. Each HEI can work with the learning materials as face-to-face lectures, online or blended approaches to delivery. Skills training for brief intervention must be face-to-face delivery.

The methodology explaining the development of the Curriculum is presented in Appendix 1.

Communication with Professional Bodies

The development of this Curriculum has been communicated to the following Regulatory and professional bodies to gain their support:

Association of Occupational Therapists Ireland

Dental Council of Ireland-Irish Dentist Associations

Health and Social Care Professionals Council CORU

Irish Association for Counselling and Psychotherapy

Irish Association of Speech and Language Therapists

Irish Association of Social Workers

Irish Nutrition and Dietetic Institute

Irish Society of Chartered Physiotherapists

Medical Council of Ireland

Nursing and Midwifery Board of Ireland

Pharmaceutical Society of Ireland

Psychological Society of Ireland

Society for Chiropodists and Podiatrists of Ireland

Health Context: Background and Rationale

Incidence of Chronic Disease in Ireland[4]:

The Irish Longitudinal Study on Ageing (TILDA) has shown that 38% of Irish people over 50 years old have one chronic disease and 11% have more than one (Barrett et al., 2011; Savva et al., 2011, p. 3). The major chronic diseases of diabetes, cardiovascular and respiratory disease (over 65 years for respiratory disease) will increase by 40% (2007 – 2020) due to an ageing population and increasing population levels of obesity (Balanda et al., 2010; Dublin Institute of Public Health, 2010). Incidence of all cancers in the Irish population are predicted to increase from more than 28,480 in 2014 to between approximately 60,000 to 65,000 cases in 2040 (National Cancer Control Programme, 2014).

4 The information contained in Health Context: Background and Rationale section was provided with -permission for replication here by the HSE. The following documents were utilised: Health Service Executive (2017b). *Making Every Contact Count*: A Health Behaviour Change Framework and Implementation Plan for Health Professionals in the Irish Health Service. Health Service Executive, Dublin. Health Service Executive. (2015). Healthy Ireland in the Health Services: National Implementation Plan 2015-2017. Health Service Executive, Dublin.

In terms of lifestyle behaviour risk factors for the development of chronic disease, Irish population data indicates that there is considerable scope for health improvement as shown in Table 1 Healthy Ireland Survey (Department of Health and Children, 2017). These findings give an indication of the extent of the problem, yet also highlight that a significant percentage of those currently engaged in unhealthy behaviours are contemplating making a change for the better.

Table 1: Summary of Main Findings from Healthy Ireland Survey 2016 and 2017

Health Behaviour	Healthy Ireland Survey Findings
Smoking (2017)	• 22% of the population smoke. • 18% smoke daily and 4% smoke on occasion. • 13% of smokers are trying to quit, and 16% are actively planning to quit.
Alcohol (2017)	• 39% of drinkers binge drink[5] on a typical drinking occasion. • 22% of drinkers binge drink at least once a week, and 40% do so at least once a month.
Diet and Nutrition (2017)	• 37% eat the recommended amount of fruit and vegetables daily (i.e. at least 5 portions). • 35% consume snack foods daily, while 16% consume sugar-sweetened drinks daily.
Clustering of Unhealthy Behaviours (2016)	• Four types of unhealthy behaviours were included in this analysis: smoking, binge drinking, consuming less than five portions of fruit or vegetables daily and sedentary behaviour[6]. • 62% reported having at least one unhealthy behaviour, with 21% having multiple (two or more) unhealthy behaviours. • 16% of men eat unhealthy foods on a daily basis and binge drink on a typical occasion (compared with 6% of women). • 9% of men eat unhealthy foods on a daily basis and smoke (compared with 7% of women).
Physical Activity (2016)[6]	• 65% are aware that people should be active for at least 150 minutes every week. • 56% think they undertake physical activity at a sufficient level.

Source: Healthy Ireland Survey 2016 Summary of Findings (Department of Health and Children, 2016) and Healthy Ireland Survey 2017 Summary of Findings (Department of Health and Children, 2017).

5 Six or more standard drinks on a typical drinking occasion

6 Physical Activity and Clustering of unhealthy behaviours not reported for 2017, Healthy Ireland Survey 2016 Summary of Findings provided.

Addressing the prevention and management of chronic disease is a pressing priority for the Health Service in Ireland and for health services around the world. Ireland, in common with other developed countries, is reforming its health services to meet this challenge. *Healthy Ireland A Framework for Improved Health and Wellbeing 2013-2025* (Department of Health, 2013) has helped to create a national movement with the aim of supporting all people in Ireland to enjoy the best possible health and wellbeing.

In response, *Healthy Ireland in the Health Services National Implementation Plan 2015-2017* was developed and published with 122 actions. National Policy Priority Programmes for alcohol, healthy eating and active living, tobacco free Ireland, healthy childhood and positive aging have been established to lead and deliver the implementation of evidence based policy to support the prevention of chronic disease (Department of Health and Children, 2016) (Figure 1).

A national framework and implementation plan for self-management support for chronic conditions: Chronic Obstructive Pulmonary Disease (COPD), Asthma, Diabetes and Cardiovascular Disease was launched by the HSE in November 2017. Support for HBC is a key element of self-management support and is a key recommendation of the framework (Health Service Executive, 2017a). In addition, prevention, self-management support and chronic disease management are incorporated into the ongoing reform and development of the national clinical programmes.

Examples of other policies relevant to health service reform are presented in Appendix 1.

Figure 1: National Policy Priority Programme

Under the strategic priority Reducing the Burden of Chronic Disease key actions are outlined in relation to implementing a national Brief Intervention Model through the programme *Making Every Contact Count* and the inclusion of health and wellbeing prevention modules in relevant undergraduate training courses for healthcare professionals.

In addition, the development of the *Integrated Care Programmes (Clinical Strategy and Programmes Division)* is a major element of reform to the health and social care system in Ireland. The Integrated Care Programme for Prevention and Management of Chronic Disease (ICPCD) aims to develop a series of integrated solutions for individuals with chronic disease, to ensure that people can be cared for at the lowest level of appropriate complexity. An essential element in an integrated pathway of care will be helping people reduce and manage their risk factors for chronic disease and prevent chronic disease occurring or deteriorating. *Making Every Contact Count* will enable all healthcare professionals to support patients to do this. The Integrated Care Programmes will ensure that *Making Every Contact Count* is incorporated within their clinical designs.

Making Every Contact Count for HBC-CDPM

Making Every Contact Count is a programme being implemented within the HSE to support the prevention of chronic disease by promoting lifestyle behaviour change. The health behaviours which are the focus of this programme are the four main lifestyle risk factors for chronic disease: tobacco use; physical inactivity; harmful alcohol consumption; and unhealthy eating.

Making Every Contact Count is about healthcare professionals using their routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change. To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. This approach will allow healthcare professionals to move to a position where discussion of lifestyle behaviour is routine, non-judgemental and central to everyone's role. To enable a culture of health promotion and prevention in the Irish health service, health care professionals will be asked to make each routine contact they have with patients count in terms of chronic disease prevention.

As shown in Table 2, Ireland has a population of almost 5 million, with approximately 30 million contacts with the health service annually. To promote chronic disease prevention, it is important for healthcare professionals to harness these opportunities and make every contact count.

Table 2: Average Health Service Contacts in a Year

4.59 million	People live in Ireland
3 million	Have a consultation with a clinical consultant
5 million	Public Health Nursing contacts
1.8 million	Have a Medical Card
1.43 million	People receive either inpatient or day case treatment
68,000	Babies born
20 million	Prescriptions filled
1.3 million	Dental Visits
1.2 million	Patients seen in an Emergency Department

Source: Healthy Ireland in the Health Service – National Implementation Plan 2015 – 2017 (Health Service Executive, 2015)

Health advice and intervention opportunities have the potential to unlock significant behaviour change for patients. Having supportive conversations about change is one way to encourage people to make lifestyle behaviour changes. Making HBC a core component of the daily interactions between healthcare professionals and patients in the health service is crucial to this systematic change. The *Making Every Contact Count* framework provides a structure to do this. This framework is the national framework for HBC in the health service (Figure 2) (Health Services Executive, 2015) and sets out how interventions to support lifestyle behaviour change need to be integrated into our health service.

The focus of health behaviours in this framework are the four main lifestyle risk factors for chronic disease: tobacco; physical inactivity; alcohol and unhealthy eating. The framework for *Making Every Contact Count* is presented as a pyramid with different levels (Figure 2). Each level represents an intervention of increasing intensity, with the low intensity interventions at the bottom of the pyramid and the specialised services at the top. Implementing the *Making Every Contact Count* framework seeks to begin the process at the basic level of brief advice and brief intervention. In practice this will mean that all healthcare professionals and healthcare assistants will need to be trained to a level that enables them to conduct a brief intervention with their patients and their families (see the *Making Every Contact Count* framework document for more detail (Health Service Executive, 2017b).

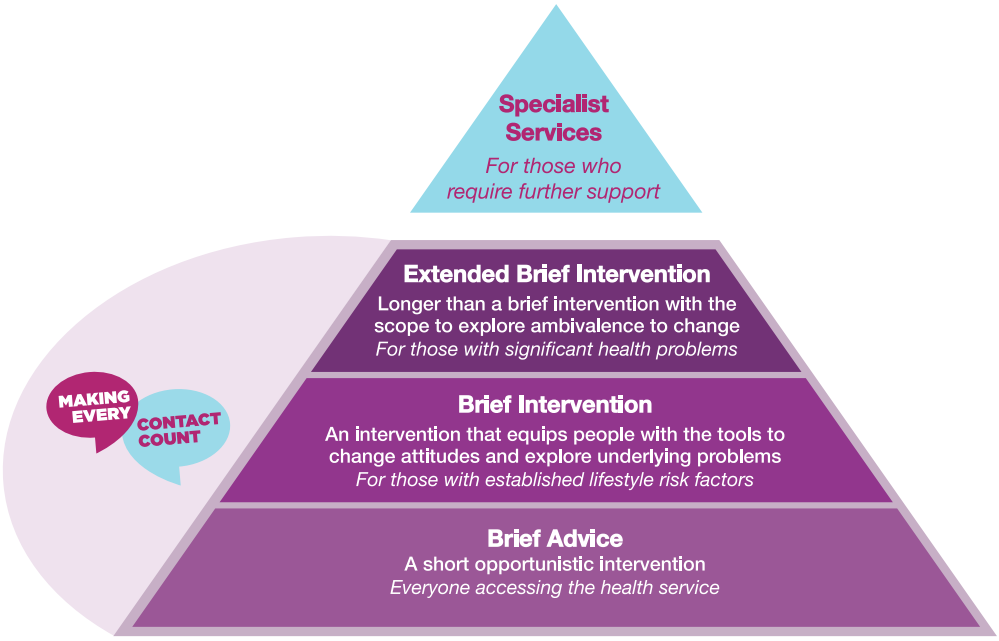

Figure 2: *Making Every Contact Count* Framework (HSE) 2017b

To implement *Making Every Contact Count* within all sectors of the health service a number of actions are required in four key areas:

1. ***Organisational** - involving a culture and environment that supports continuous health improvement and has systems in place to embed Making Every Contact Count in all services and divisions.*
2. ***Staff initiatives** - including engagement, learning, training and skills development is crucial to the integration of Making Every Contact Count within the health service.*
3. ***Patient empowerment** is essential if patients are to engage with their healthcare professional about making a behaviour change.*
4. ***Stakeholder Partnership** - involving the HSE working with key external affiliates such as HEIs, Professional Associations and Healthcare Professionals not employed within the HSE is central to the success of Making Every Contact Count.*

The implementation plan details a number of high level actions necessary over the next five years to ensure that *Making Every Contact Count* will be integrated into routine health service delivery. One of the key actions in implementing *Making Every Contact Count* is upskilling existing HSE staff to routinely conduct brief interventions through a nationwide training programme available to all staff. In addition, to support long term sustainability of *Making Every Contact Count*, training healthcare students at undergraduate level in the skills and knowledge to enable healthcare professionals to deliver interventions is key. In addition, embedding the underlying principles of patient centred care and the culture change required is also important. The HSE is committed to supporting the training of healthcare professionals at undergraduate level to deliver lifestyle behaviour change interventions and is supporting this collaboration to achieve this.

Education Context: Background and Rationale

Academic institutions play a key role in shifting the focus from chronic disease treatment and management to prevention. This can partly be achieved at undergraduate level by equipping future healthcare graduates with the skills necessary for HBC for CD prevention. Thus, in time, health services are geared toward disease prevention and health and not focused primarily on treatment and management of disease. The HSE's *Health and Wellbeing Division: Operational Plan 2016* proposed a collaboration with HEIs to develop a behaviour change module for healthcare students. This collaboration provides a prime opportunity in Ireland to develop and implement this standardised Curriculum across all undergraduate healthcare programmes.

To the best of our knowledge, there is no standardised National Curriculum in undergraduate education for all healthcare students in any country in the world. Therefore, this National Curriculum marks an exciting opportunity for Ireland to take an international lead in promoting a culture of chronic disease prevention and management through HBC among undergraduate healthcare students.

Brief interventions within the context of education for healthcare professionals are addressed in the literature with reference to SBIRT (Screening, Brief Intervention, and Referral to Treatment) programme, Motivational Interviewing (MI) some of which specifically refers to brief MI, Brief Interventions (BI), and *Making Every Contact Count*.

The SBIRT Programme

The SBIRT programme, originating in the US, was designed to promote systematic identification of patients with substance abuse disorder (Kowalchuk et al., 2014; Scott et al., 2012; Tetrault et al., 2012). The core principles of SBIRT curricula are concerned with raising the issue of substance use, offering patient information on healthy behaviours and screening for substance abuse, providing brief advice and referral to additional services (Scott et al., 2012). Research carried out in six states in the US demonstrated that following SBIRT implementation there were significant improvements in reported illicit drug use and heavy alcohol use at 6-month follow-up compared to baseline (Madras et al., 2009). SBIRT has also been used beyond the context of substance abuse focusing on alcohol and tobacco

use (Connors et al., 2012). To date, the SBIRT programme has been implemented mostly with the medical profession during residency, that is, following graduation from undergraduate degree programmes (Kalu et al., 2016; Pringle et al., 2012; Scott et al., 2012). This literature provided some useful insights, for example; Pringle et al. (2012) discuss developing, implementing, and evaluating SBIRT as a medical and residency programme raising the following points which informed the design of the Curriculum on *Making Every Contact Count* for HBC-CDPM:

- ***Collaborative development and implementation of a curriculum across multiple sites is feasible***
- ***Materials for students include handouts and power point presentations; flexibility is needed in use of power point presentations so that lecturers can add information if needed***
- ***While content may be standardised, each site has flexibility in presenting the material to suit its specific needs***
- ***Central access to course materials is needed; programme can be delivered using blended learning or traditional face-to-face approaches***
- ***Knowledge, skills, and attitudes need to be considered in assessing programme participants***
- ***Identification of champions for implementation in each site is important to shepherd curriculum implementation***
- ***Process evaluation of implementation needs to be built into the programme***

Other authors raised similar points about having a standardised curriculum while at the same time allowing flexibility in terms of delivery (Kalu et al., 2016; Scott et al., 2012). Kalu et al. (2016) added that:

- ***One Curriculum can be designed for multiple healthcare professional groups***
- ***Observation of skills is more accurate for assessing skill acquisition compared to pen and paper tests.***

A critical point made by Scott et al. (2012) is that there needs to be a commitment and reinforcement at executive/senior level to ensure the adoption and implementation of the Curriculum.

Motivational Interviewing

Motivational interviewing (MI) courses to support behavioural change have been delivered at undergraduate level across a range of healthcare programmes, most notably, dentistry. Black et al. (2016) noted that MI is a patient-centred approach to counselling individuals to change lifestyle behaviours that pose risks to their health. Although first developed in the 1980s to address excess addiction problems, MI is now used across a range of health related behaviours including diet, smoking and exercise (Black et al., 2016; Curtis, 2015).

Skillfull communication lies at the core of MI and this is a consistent message articulated extensively by researchers and educators in the literature specific to undergraduate education for healthcare students (Curtin et al., 2014; Hohman et al., 2015; Howard & Williams, 2016; Lupu et al., 2012; Martino et al., 2007; Mounsey et al., 2006), all of whom draw on the work of Millner and Rollnick (2010) on MI. There are four principles that guide MI, depicting a process of skilful communication when interacting with patients. These are: listening; understanding the motivation and values of patients; resisting the urge to inform patients on what needs to be done, also known as the 'righting reflex'; and empowering the patients (Black et al., 2016). The communication is described as patient-centred focused on exploring ambivalence and resistance regarding their behaviours (Howard & Williams, 2016; Mounsey et al., 2006). The tone of the communication is described as empathetic and non-judgemental (Martino et al., 2007; Mounsey et al., 2006). The combined skills of communication for effective MI are described as: reflective listening; open questioning; affirmative conversation; collaborative conversations; and elicitation of talk focusing on change (Black et al., 2016; Howard & Williams, 2016; Martino et al., 2007; Mills et al., 2017).

Concerns about MI being targeted primarily at qualified healthcare professions have been raised on the premise that motivational skills need to be introduced in undergraduate education (Curtin et al., 2014; Hohman et al., 2015). According to Hohman et al. (2015) higher education institutes need to be cognisant of the job readiness of their

graduates, hence the argument in support of MI at undergraduate level. To further support their argument for MI training at undergraduate level, Hohman et al., (2015) noted that fiscal challenges of training qualified staff exist in terms of expense and time. To this they added that teaching facilities within the education sector, compared to real life settings, are more conducive to facilitating MI training.

Other issues raised in the literature concerning MI in undergraduate education include: year of delivery; duration of programme; pedagogical approaches and integration into existing curriculum. There is little discussion or consensus in the literature regarding the most appropriate year for delivery of MI training in undergraduate education or on which components of MI are best taught incrementally over time. However, the skills component of MI was taught in year 3 of curricula in the majority of literature reviewed (Curtin et al., 2014; Haeseler et al., 2011; Howard & Williams, 2016; Martino et al., 2007).

Considerable variation on the duration of MI courses is evident. For example, Mills et al. (2017) delivered an enhanced MI curriculum to first year dental hygiene students over the course of two semesters. The first semester involved ten consecutive fifty minute sessions incorporating theory and skills of MI. The second semester involved a critical analysis of change talk shown on a video in class as well as a talk by an expert on MI lasting almost two hours. In contrast, much shorter courses lasting just two hours focusing on essential skills component of MI for medical students are evident, and which are referred to as brief MI (Haeseler et al., 2011; Mills et al., 2017). The duration of other courses reported include a two-day intensive workshop for dental students (Curtin et al., 2014) and a two year course as part of overall curriculum for social work students (Hohman et al., 2015).

Regarding pedagogical approaches to delivering MI, there is consensus in the literature that multi-modal methods are needed (Bray et al., 2013; Hohman et al., 2015; Lupu et al., 2012; Millner & Rollnick, 2010; Mills et al., 2017; White et al., 2007). In addition to didactic delivery on theoretical aspects of MI, methods specific to facilitating the practical application of MI include video-demonstration of change talk, role play, practising with 'mock' patients, and real life practical application in clinical settings.

Approaches to assessment of student learning were found to vary in the literature. The various approaches include: clinical skills assessment based on standardised problem-focused patient cases, using a rating scale incorporating the skills of MI taught (Haeseler et al., 2011); clinical skills assessment in practice laboratory using self-assessment quizzes, confidence and attitude survey, and assessment of MI performance using a Behavioural Change Counselling Index (Lupu et al., 2012); written responses to video assessment of simulated encounters scored by faculty on a pre-determined instrument coded for various MI skills (Hohman et al., 2015); audio recordings of student application of MI skills followed by student self-assessment of confidence and faculty assessment of students' recorded interactions (Mills et al., 2017); and video recording of a student interview with standardized patients assessed against pre-determined criteria reflecting MI skills (Mounsey et al., 2006). Although approaches to assessment vary, a consistent pattern across the literature is the focus on performance assessment. It should be noted however that most assessment approaches above were reported within the context of studies including post-test/quasi-experimental designs (Hohman et al., 2015; Lupu et al., 2012; Mills et al., 2017) and a randomized controlled trial (Mounsey et al., 2006). The literature offers little insight into the feasibility of implementing the various approaches to performance assessment in an undergraduate curriculum which may involve large student cohorts. As noted by Lupu et al. (2012) assessment of MI skills compared to assessing knowledge can be challenging to implement in a curriculum.

Outcomes associated with MI training of undergraduate students compared to students not trained in MI skills or compared to baseline measures prior to implementing an MI curriculum include: greater person-centred engagement aimed at behavioural change (Bray et al., 2013); greater proficiency in facilitating change talk using standardised patient cases but no differences in person-centred counselling skills or collaborative change planning (Haeseler et al., 2011); no differences in MI skills when taught using standardised patients compared to role play (Mounsey et al., 2006); increased frequency and depth of reflections and better equipped to offset communication roadblocks and closed questioning (Martino et al., 2007); better use of MI skills when mock patients were used compared to role play or written dialogues (Lupu et al., 2012); and increased confidence in their abilities to apply MI in their practice (Martino et al., 2007; Mills et al., 2017).

Although outcomes of MI training for undergraduate students of healthcare disciplines are positive on the whole, there are challenges in implementing this training into overall curricula. According to Bray et al. (2013) educators are constantly challenged to find space in curricula for emergent innovations such as MI training which requires making space by freeing up or modifying existing content. With reference to dental hygiene education, Bray et al. (2013) noted that MI training needs to be integrated into overall curricula with consideration to other subject matter including but not limited to patient education, tobacco cessation, dietary counselling, and care plan presentation. These authors proposed a structure-process-outcome model to support full integration into the curriculum. Structure is concerned with resources, providers, organisational settings. For example, faculty development as a structural requirement draws attention to the need for faculty training and expertise in behavioural training to support 'buy in' for implementation of MI within the undergraduate curriculum. Other structural aspects of integration relate to timing and duration of delivery. Process places emphasis on methods of delivery, practice application, and assessment. Finally, outcome relates to evaluating the programme from multiple perspectives including faculty development, student competency in delivering MI, patient outcomes, and programme outcomes such as exit surveys (Bray et al., 2013).

Brief Interventions and *Making Every Contact Count*

A brief intervention, as defined in the public health guideline *'Behaviour Change: Individual Approaches'* involves:

> ***"Oral discussion, negotiation or encouragement, with or without written or other support or follow-up. It may also involve a referral for further interventions, directing people to other options, or more intensive support" (NICE (National Institute for Care and Excellence) 2014, p.46).***

The NICE guidance aims to tackle behaviours that damage people's health including alcohol and drug use, poor dietary patterns, smoking, unsafe sexual behaviour, and inadequate physical activity. It is stated that anyone who is trained in the necessary knowledge and skills can deliver a brief intervention, and that these interventions which typically take as little as a few minutes are carried out when the opportunity arises (National Institute for Care and Excellence, 2014). The guidance document differentiates, a brief intervention and an extended brief intervention which typically lasts more than 30 minutes. A key recommendation in the guidance document is that all health and social care practitioners involved in helping to change people's behaviours are trained in brief interventions (National Institute for Care and Excellence, 2014). In the UK, a range of educational materials are available to healthcare professionals delivering behavioural change interventions (Fuller, 2015).

As a response to the NICE (2014) guidance, in the UK, the National Health Service (NHS) issued a report stating that every healthcare professional should Make Every Contact Count (NHS, 2016). This means that every contact between a healthcare professional and patient should be used as an opportunity to promote health and wellbeing, particularly in the risk factor areas of diet, tobacco, physical inactivity and alcohol. Nurses throughout the UK have since received *Making Every Contact Count* training facilitated by the Royal College of Nursing (Percival, 2014).

However, evidence on implementing *Making Every Contact Count* into undergraduate curricula in the UK is scant to date and somewhat fragmented with just some schools developing their own curriculum independently. Delivery of brief intervention training is not standardised nationally across undergraduate programmes in the UK. For example, a comprehensive trainer handbook on brief interventions for undergraduate nursing students Public Health Practice: Offering Brief Interventions for Healthy Lifestyles Training Programme for Pre-Registration Nurses was developed collaboratively between Cheshire and Merseyside Public Health Network ChaMPs and four health educational institutions (ChaMPs (Cheshire and Merseyside Public Health Network), 2010). Elsewhere, *Making Every Contact Count* for physical activity resulted in the development of an undergraduate interdisciplinary exercise medicine resource on physical activity in the prevention and treatment of chronic diseases, designed to build healthcare professional capacity in the NHS workforce (Gates, 2016).

In contrast to the literature on motivational interviewing, there is less written about brief interventions in undergraduate curricula. According to O'May et al. (2016) current curricula for students preparing to be 'future professionals' in healthcare are inadequate in the area of behavioural change through brief intervention. With a specific focus on alcohol brief interventions, O'May and co-researchers explored knowledge and attitudes concerning alcohol use and related interventions among final year students studying either occupational therapy or nursing. Knowledge and attitudes were assessed before, during and after a brief intervention workshop. All students reported positive attitudes towards alcohol brief intervention and as future professionals they had a role to play in support in behavioural change. They identified a need for education throughout their curricula and not just in the final year of a programme. Gaps in knowledge relevant to conducting a brief intervention such as alcohol unit calculation and application improved following the workshop. The researchers concluded that alcohol brief intervention should be embedded in all undergraduate curricula including medical and social care courses so that they are ready trained with appropriate skills and confidence when they join the healthcare workforce.

In conclusion, the evidence from the educational literature overall supports the case for behavioural change training in undergraduate curricula for all students preparing to be healthcare professionals. In light of national developments in the UK in response to the NICE (2014) guidance as best evidence for behavioural change, a Curriculum focusing on *Making Every Contact Count* using brief interventions in this standardised undergraduate Curriculum is a positive step toward building capacity for Ireland's future healthcare professionals.

Section 1:
Lecturer/Facilitator Guide

Aims of the Curriculum and Curriculum Manual

This standard National Undergraduate Curriculum on *Making Every Contact Count* for HBC-CDPM was introduced in recognition of, and in response to, the changing health needs of our society. The focus on chronic disease prevention has intensified internationally, along with the provision of brief advice and brief interventions to promote healthy lifestyles. In Ireland, qualified healthcare staff currently receive training in *Making Every Contact Count*. The introduction of HBC-CDPM to undergraduate curricula which incorporates the learning and skills necessary for *Making Every Contact Count* is a way of instilling the values of chronic disease prevention in the early stages of healthcare careers.

The Aims of the Curriculum are:

- ***To provide a national standardised approach to teaching the skills of behaviour change.***
- ***To introduce Health Behaviour Change for Chronic Disease Prevention and Management education in all healthcare professional education settings nationwide.***
- ***To provide undergraduate healthcare students with basic health behaviour change skills, knowledge and attitudes in preparation for clinical practice.***
- ***To foster national collaboration on health behaviour change and chronic disease management education across the Higher Education Sector in Ireland.***

This Manual provides healthcare educators with a comprehensive resource to facilitate the teaching and learning of *Making Every Contact Count* for HBC-CDPM. The Manual is designed to provide clear guidance to educators on the provision of all aspects of the Curriculum, including underpinning philosophies, course content, teaching strategies, assessments and evaluation.

A key aim of this Manual is to inform HEI educators of the topics and learner content for *Making Every Contact Count* for HBC-CDPM. The Curriculum contains four Units of Study and each Unit contains the learning content required for integration within existing curricula across HEIs.

A variety of teaching strategies are presented including case studies, discussions, learner activities, reflective exercises and skill based learning. The option of delivering the Curriculum face-to-face, online or in blended format is available, the skills component requires face-to-face delivery.

The context in which the Curriculum was developed is presented incorporating the background rationale, competency framework and methodology. The methodology is presented in Appendix 1.

The aim of the Curriculum Manual is:

To provide educators with a national standardised educational resource on Making Every Contact Count for HBC-CDPM targeting all undergraduate healthcare students.

Competency Framework

This is a competency-based Curriculum. On completion of undergraduate healthcare courses it is required that healthcare students are competent healthcare professionals. The term “competency” has become significant in undergraduate healthcare courses, together with the identification of the key competencies required of competent practitioners across disciplines. Specifying competencies to shape and frame curricula fosters knowledge, attitudes, values and skills which are considered to be core curricular requirements (Madsen & Bell, 2012). Competencies are broad, overarching requirements and a number of measurable or observable learning outcomes/ behaviours stem from each competency. Competency-based education is described as “a framework for designing and implementing education that focuses on the desired performance characteristics of healthcare professionals” (Gruppen et al., 2012).

Competencies need to be integrated across an entire curriculum and be reflected in the structure, content and assessment processes of the curriculum.

Changing epidemiological trends and a growing emphasis on HBC, chronic disease prevention, and self-management, call for the identification of a specific set of core healthcare competencies. The development of a focused collection of health-promoting competencies to address current health promotion educational requirements is therefore needed. This necessity is internationally recognised (Frenk et al., 2010) and the skills needed to assess lifestyle behaviours and encourage and support HBC signify a distinctive set of competencies (Dean et al., 2014). The National Curriculum detailed in this manual comprises of four Units, building towards the development of competencies in delivering brief interventions for *Making Every Contact Count* for HBC-CDPM. Each Unit focuses on development of specific competencies. For each competency learning outcomes are identified which must be achieved in order to become competent in that Unit of Study. This National Curriculum is intended for undergraduate healthcare professional educational programmes and contains content common across healthcare professions, while also allowing for inclusion of unique content within professions, in accordance with the specific requirements of individual courses. We present a competency framework to guide the development of this National Undergraduate Curriculum for *Making Every Contact Count* for HBC-CDPM (Table 3).

Table 3: Competency Framework

Unit	Competency	Learning Outcomes
1. Health and Personal Wellness	1.1 Demonstrate an understanding and awareness of health, lifestyle influences on health and key health recommendations	1.1 Assess attitudes and behaviours towards own health and wellbeing 1.2 Define health with reference to the key concepts and determinants of health 1.3 Assess and interpret health status data for the Irish population 1.4 Promote key health messages and recommendations
2. Lifestyle Behaviours and Personal Responsibility for Health	2.1 Demonstrate an understanding and awareness of health behaviour and the process of health behaviour change	2.1 Describe health behaviours and the factors which influence behaviour 2.2 Identify aspects of lifestyle behaviour that affect health and wellbeing 2.3 Assess health risks associated with lifestyle behaviours 2.4 Overcome the challenges of changing health behaviours to address risk factors

Unit	Competency	Learning Outcomes
3. Communication for Healthy Lifestyles and Health Behaviour Change	3.1 Communicate in a supportive, encouraging manner for health behaviour change	3.1 Analyse the principles of interpersonal communication for health behaviour change 3.2 Adopt a person-centred approach to communicating for health behaviour change 3.3 Communicate in a supportive, non-directive manner with individuals 3.4 Demonstrate effective communication skills in the context of health conversations with individuals 3.5 Demonstrate the core elements of communication in practice for health behaviour change 3.6 Identify opportunities to integrate *Making Every Contact Count* into everyday consultations so that you can carry out brief interventions 3.7 Demonstrate an understanding of raising the issue of healthy eating, alcohol and drug use, physical activity and tobacco use in routine and regular conversations with patients 3.8 Observe and reflect on video footage of healthcare professionals interacting with patients in a variety of scenarios
4. *Making Every Contact Count:* Providing Opportunistic Brief Interventions	4.1 Optimise every opportunity for brief advice and brief interventions for healthy lifestyle behaviour for chronic disease prevention and management 4.2 Demonstrate effective integration of knowledge, skills and attitudes in the delivery of brief interventions	4.1.1 Describe the theoretical and practical context for *Making Every Contact Count* for health behaviour change 4.1.2 Identify individuals for whom a brief intervention is appropriate 4.2.1 Use validated screening and assessment tools to assess individual's readiness to change and respond to this assessment supportively 4.2.2 Deliver a brief intervention in an empathetic and non-confrontational manner using the principles of motivational interviewing 4.2.3 Assess own performance in delivering brief intervention using self-reflective practice 4.2.4 Demonstrate the procedure for signposting and referral to support services 4.2.5 Understand how to maintain accurate records in patient documentation/medical chart of delivery of a brief intervention, and how to flag further actions for follow-up

Curriculum Philosophy and Design

A fundamental question that guided development of this Curriculum was: *What is the best way to teach HBC* for chronic disease prevention and management? The core philosophy underpinning this Curriculum is subject-centred learning (Morrison-Saunders & Hobson, 2013). Subject-centred learning involves interactive learning "where space is created for the students to enter into their own engagement with the subject in a shared pursuit with the teacher, resulting in more effective teaching and learning" (Morrison-Saunders & Hobson, 2013, p. 212). It is the subject that unites the teacher and the student and this requires the teacher to genuinely engage with the subject in ways that inspire their students to enter into a relationship with that subject. In citing the work of Hagström and Lindberg (2012) with reference to translating the philosophy of subject-centred learning into practice, Morrison-Saunders and Hobson (2013, p. 220) noted that:

> *"Knowledge cannot be transmitted so teachers must make learning possible and students must learn. The teacher must give up the idea of transmitting knowledge by lecturing or by prescribing books to be learnt. Communicative ways of learning make education a joint project for teachers and students" (p. 220).*

This is a competency based curriculum designed around four vertical and two horizontal strands (Figure 3). Consistent with our philosophy of student-centred learning, at the core of competency based learning and education is a focus on mastery of clearly defined competencies (EDUCAUSE, 2014). Competency has been defined in the professional clinical context as: "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual, and the community being served." (Epstein & Hundert, 2002, p. 226). A competency based curriculum focuses on 'mastery learning' with the goal of helping learners achieve competencies needed for undertaking professional roles relevant to the health needs in their country (Chacko, 2014). For this Curriculum, mastery learning is concerned with HBC for chronic disease prevention and management in Ireland.

This National Curriculum is designed around four vertical and two horizontal strands as shown in Figure 3.

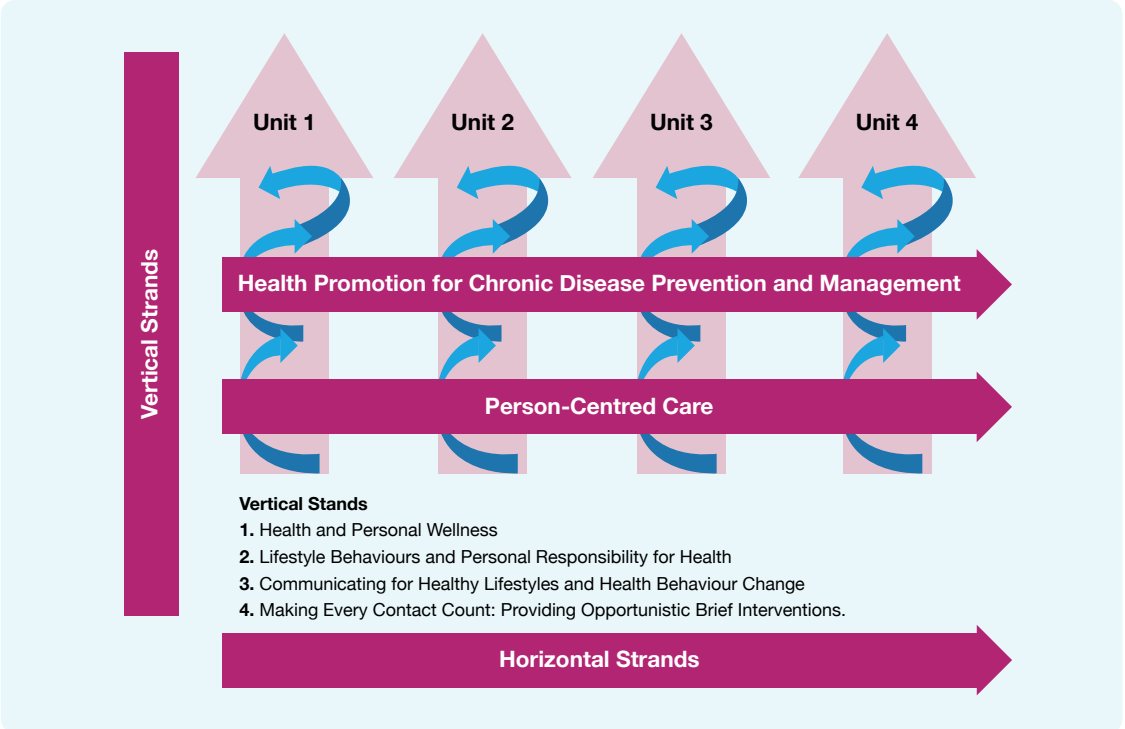

Figure 3: Curriculum Framework: Chronic Disease Prevention and Management Part 1: *Making Every Contact Count* for Health Behaviour Change

Vertical strands refer to subject matter that builds on previous course work such that there is a sequence to learning (Torres & Stanton, 1982). Four vertical strands, informed by a literature review and stakeholder consultation, depicting the subject areas for this Curriculum are:

1. **Health and Personal Wellness**
2. **Lifestyle Behaviours and Personal Responsibility for Health**
3. **Communicating for Healthy Lifestyles and Health Behaviour Change**
4. ***Making Every Contact Count*: Providing Opportunistic Brief Interventions**

Horizontal strands refer to basic concepts that are integrated from one subject area to another and therefore offer continuity to learning in the curriculum (Torres & Stanton, 1982). This Curriculum has two horizontal strands (Figure 3). These are:

1. **Health Promotion for Chronic Disease Prevention and Management**
2. **Person-Centred Care**

The horizontal strand of Health Promotion for Chronic Disease Prevention and Management in this Curriculum emphasises disease prevention in the undergraduate education of healthcare students. In this strand, students are facilitated to promote healthy lifestyle choices and behaviours that prevent the onset of chronic disease(s) or optimise health in individuals living with a chronic condition. This approach is in accordance with the World Health Organisation (1986) *Ottawa Charter* calling for changes in professional education and training to facilitate the reorientation of health services towards health promotion. In Ireland, the Health Service Executive (2011) published The Health Promotion Strategic Framework, stating a need to re-orientate health and social services to include "the development of the skills and capacity of those outside the Health Promotion workforce to adopt a stronger evidence-based health promoting role" (p. vi). Further still, it is stated in this framework that a *health promoting health service:*

> ***"begins by recognising that every healthcare contact is a health improvement opportunity and that all healthcare staff have a role to play" (p. 16).***

Similarly, and more recently, a report from the HSE's Prevention of Chronic Disease Programme stated that "the aim of the programme is to make every healthcare contact…count in order to prevent morbidity and mortality from chronic disease" (Jennings, 2014, p. 9).

The National Health Service (2016) in the UK has defined *Making Every Contact Count* as

> ***"an approach to behaviour change that uses the millions of day-to–day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing" (p. 6)***

In advocating for a health promoting curriculum on HBC for chronic disease prevention and management through '*Making Every Contact Count*', the following principles apply:

- ***Positive lifestyle behaviour choices at population level are key to creating 'Healthy Ireland'***
- ***Lifestyle change more than any other personal healthcare activity is considered to be the best way to prevent the onset of chronic disease***
- ***A personal philosophy that emphasises health leads to health promoting behaviours for better health***
- ***Changing health behaviours can be complex and challenging for individuals and requires targeted support from healthcare professionals***
- ***Every brief contact with individuals in a healthcare context counts towards encouraging and helping people to make healthier choices to achieve positive behavioural changes in the longterm***

Person-centred care is a core concept of this Curriculum which, in broad terms, is characterised by quality personal, professional and organisational relationships involving service users (individuals and their families), healthcare professionals and healthcare systems (Epstein & Street, 2011). The concept of person-centred care has evolved from a primary focus on relationships between service users and healthcare professionals (Greene et al., 2012). The emphasis for this Curriculum is therefore on relationships between service users, healthcare professionals and healthcare students across the range of healthcare disciplines.

Definitions of person-centred care vary and there remains no universal definition of this concept. A sample of definitions on person-centred care gleaned from the literature are presented in Appendix 3. Person-centred care is a concept embraced in some national documents in Ireland concerning health such as the *National Standards for Safer Better Healthcare* (Health Information and Quality Authority (HIQA), 2012, p. 19).

> ***"Person-centred care and support services places service users at the centre of all the service does, values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy".***

Also, person-centred care is strongly evident in *Future Health* (Department of Health, 2012); and *Person-Centred Care and Support: Supporting Services to Deliver Quality Healthcare* (Health Services Executive, 2013).

There is little evidence of person-centred care being defined or viewed within the context of HBC regarding lifestyle risks. This paucity of attention to person-centred care as core to HBC is evident in the literature at large. Given the context of this Curriculum on *Making Every Contact Count* to promote positive health behaviours, the definition from the National Institute for Care and Excellence (2014) (NICE) is adopted to support this Curriculum. This definition states that:

> ***"Using a 'person-centred' approach, services work in collaboration with service users as equal partners to decide on the design and delivery of services. This approach takes into account people's needs and builds relationships with family members. It also takes into account their social, cultural and economic context, motivation and skills, including any potential barriers they face to achieving and maintaining behaviour change. Person-centred care involves compassion, dignity and respect" (NICE, 2014).***

Furthermore, the principles of person-centred care supporting this Curriculum are derived from international literature in this area (Constand et al., 2014; Greene et al., 2012; Health Innovation Network, 2016; McCormack et al., 2010; Morgan & Yodar, 2012; The Health Foundation, 2014). These principles, applied to the context of HBC are as follows:

- ***Knowing the patient and recognising individuality and diversity in terms of lifestyle behaviours.***
- ***Building relationships with the patient to build trust towards active and informed engagement in lifestyle behaviour changes for positive health and wellbeing.***
- ***Showing the patient dignity, compassion and respect in supporting them towards health behaviour change and in ways that takes account of their preferences and approaches.***
- ***Being holistic in assessing a patient's needs and in providing health behaviour change information and intervention.***
- ***Seeing the patient as having potential to be competent and an expert in managing their health behaviours with a goal of preventing and/or managing chronic diseases.***
- ***Supporting the individual to recognise and develop his/her strengths and abilities that are enabling towards positive lifestyle behaviours.***
- ***Effectively communicating with the patient about health behaviour change in ways that are empowering and sensitive to the patient's needs.***
- ***Empowering the patient towards shared decision making with healthcare professionals and towards responsibility for one's own health.***

Curriculum Implementation and Integration

In this part of the Manual, guidance is offered on the implementation and integration of *Making Every Contact Count* for HBC-CDPM in the undergraduate/graduate entry[7] course. Although this is a national, standardised Curriculum, we recognise that differences exist between Schools and professional curricula and therefore recommend the use of professional specific literature to provide relevance and application to support student learning. We also encourage the modification of case studies to reflect the professional curriculum under study. We promote innovative methods to deliver the Curriculum, or components of it, for example, interdisciplinary learning may be an option in some HEIs.

The prospects of a new national Curriculum[7] for all undergraduate healthcare programmes generates many questions from educators and programme co-ordinators, for example;

- Who will deliver the Curriculum?
- How will we deliver it?
- Is there support for educators?
- How will it be assessed?
- How can it be integrated into existing curricula?

Undergraduate healthcare curricula are already reaching content capacity and we acknowledge the challenges of integrating new material into existing programmes. This section of the manual looks at some of the possible ways of integrating the Curriculum for *Making Every Contact Count* for HBC-CDPM into established healthcare programmes.

Many of the theories and skills embedded in the Curriculum for *Making Every Contact Count* for HBC-CDPM are not new and are already delivered in existing teaching. It is likely that there will be many opportunities in your programmes to incorporate content for *Making Every Contact Count* for HBC-CDPM into existing Lessons. However, some components of the Curriculum may be new, such as training in Brief Intervention skills, and these topics may require specific curriculum time. The duration of the Curriculum is 20 hours, distributed across four Units. The recommended timeframe for each Unit is provided in Section 2. The content of the Curriculum may be delivered over the entire programme or in block times at the discretion of each school.

In order to integrate the National Curriculum in Schools and courses in HEIs nationally the competency framework of the Curriculum on *Making Every Contact Count* for HBC-CDPM needs to be examined at course level and existing curriculum content identified to establish what is already being covered in a given curriculum. It is then important to decide which additional topics from the National Curriculum need to be included in the programme and where the relevant topics should be situated e.g. at what point in the programme are topics taught relevant to *Making Every Contact Count* for HBC-CDPM that can be augmented by inclusion of content from the National Curriculum? There is scope to integrate the topics that are to be covered in this Curriculum into a number of existing subject areas and some examples are offered in Table 4.

7 This Curriculum is also relevant for graduate students at first point of entry to health profession education.

Table 4: Units of Study

***Making Every Contact Count* for HBC-CDPM Unit**	**Subjects that could incorporate *Making Every Contact Count* for HBC-CDPM Topics**
1. Health and Personal Wellness	Health Promotion Public Health Professional Issues
2. Lifestyle Behaviours and Personal Responsibility for Health	Health Promotion Public Health Professional Issues
3. Communication for Healthy Lifestyles and Health Behaviour Change	Communication Health Promotion Public Health Professional Issues
4. *Making Every Contact Count:* Providing Opportunistic Brief Interventions	Clinical Modules Health Promotion Public Health

Preparing for Implementation

We suggest that one member of academic staff at each institution is identified to lead the staff from each department/school at every institution are implementation of this Curriculum. The following questions should be considered in preparation for this:

- What content from this new Curriculum is already taught as part of the existing undergraduate curriculum?
- Who teaches it?
- Who could potentially teach content of this new Curriculum for *Making Every Contact Count* for HBC-CDPM?
- Where in the programme can we implement *Making Every Contact Count* for HBC-CDPM?
- What resources do we have?
- What support or training is needed to implement this Curriculum for *Making Every Contact Count* for HBC-CDPM?

Implementation Exercise

We recommend that an exercise is carried out at course level to identify where the learning outcomes and competencies of this Curriculum are already addressed within existing curricula (See Implementation Plan Appendix 4). Once it is evident where content already exists it is important to consider the timing or placement of this Curriculum content in the overall undergraduate Curriculum. We have carried out an exercise to demonstrate how this Curriculum can be incorporated into three separate Schools, UCC Nursing, WIT Nursing and UL Medicine (Appendix 5).

We offer recommendations on content location within undergraduate curricula (Section 2). However, we advise that final decisions regarding content location be reached at local level.

For *Making Every Contact Count* for HBC-CDPM, once it is known what components of this Curriculum are already in place it must then be decided whether any changes are required to ensure that content meets HBC-CDPM learning outcome requirements. Also, consideration must be given to whether or not the new material should replace any existing content.

Building Capacity

This is a new Curriculum and therefore it is necessary to raise awareness and ensure that staff are familiar with it. Gaining the support of HEI professionals and students is paramount to its successful implementation. Supporting staff to ensure that they are prepared to successfully deliver the Curriculum is also important. It is worth identifying available resources/personnel who already have a vested interest in the area of HBC-CDPM to help raise awareness and support for the Curriculum. A World Café event was held in May 2017 with members of the SG, NWG, LWGs, Heads of Schools and Programme Directors as well as key lecturers on the topic areas of health promotion and health behaviour change, representing diverse health care Schools across HEIs (see Appendix 6 for list of attendees). The purpose of the World Café was to create a platform to support open collaborative conversation between diverse disciplines and Schools. The conversations which took place at the event were used to shape the next stages of the development process including implementation planning (see Appendix 7 Report from World Café Event).

A training workshop facilitated by Professor Joan Mary Davis, School of Allied Health, Southern Illinois University was held in May 2017. Thirteen HEI representatives and two representatives from the HSE attended the workshop which focused on strategies for implementing the Curriculum (see Appendix 8 for list of participants).

Targeted training on the provision of Brief Interventions in the context of *Making Every Contact Count* will be available for HEI staff. Finally, it is necessary to map the competencies of this Curriculum with each Regulatory Body's requirements to demonstrate alignment of the *Making Every Contact Count* for HBC-CDPM Curriculum with existing frameworks.

Challenges and how they may be addressed

One of the challenges of integrating the Curriculum is the issue of teaching large groups. Given the skills-based nature of some of the *Making Every Contact Count* for HBC-CDPM Curriculum, we advocate for small groups to facilitate learning new skills. This may be difficult in some programmes and we therefore urge educators to consider the best approach they can adopt for skills teaching to large numbers.

Adaption of existing tools and resources (for example, using Technology Enhanced Learning techniques) may be the best way to achieve successful implementation of this new Curriculum for *Making Every Contact Count* for HBC-CDPM.

Assessing Student Learning

Assessment is a fundamental curricular component, which can *"define what students regard as important, how they spend their time and how they come to see themselves as students and then as graduates. Students take their cues from what is assessed rather than from what lecturers assert is important"* (Brown et al., 1997, p. 7).

There are numerous ways to assess the array of learning in undergraduate healthcare curricula. In a UK based study of undergraduate medical education in 1998, the average number of strategies used to assess knowledge was 16 (Fowell et al., 2000). The authors recommended that methods of assessment should relate to the aims, objectives and learning outcomes of the Curriculum and that collaboration and sharing of expertise between those developing assessment strategies is necessary.

There are a number of competencies and learning outcomes in this Curriculum with many potential ways to assess their achievement among students.

HBC for chronic disease prevention and management is an area that is not universally well developed in healthcare professional undergraduate curricula in Ireland, evidenced by a national mapping exercise completed by the NWG developing this Curriculum (Appendix 4). The impetus for assessment should be supportive of the continued acquisition of skills in brief advice and brief interventions. Any assessment process should reflect that this Curriculum provides a foundation in this area and the core purpose of assessment should be to offer constructive feedback and motivate students to become proactive in the promotion of HBC.

Formative assessment is therefore the recommended approach to assessment for this competency based Curriculum for *Making Every Contact Count* for HBC-CDPM. This type of assessment offers feedback to students on their progress without jeopardising their overall course progress and does not acquire marks or grading (Chacko, 2014).

This is a student centered Curriculum where the impetus is on learning by doing and experiencing. Therefore, it logically follows that assessment should be on "assessment of doing". We provide some examples of formative assessment strategies for this Curriculum (Appendix 9). Assessment strategies are flexible and with variations across Schools and disciplines, we encourage adaptation where required. Some programmes may in fact choose to include suggested formative assessments as a summative assessment.

Options for assessment include assessing each unit independently or assessing units in a combined way. In addition, an online assessment strategy, such as developing multiple choice questions, is an option for assessment. For some Schools the competencies and learning outcomes of the Curriculum could be placed in a clinical log book for clinical sign off.

Evaluation

Curriculum evaluation is a critical component of assessing the effectiveness of a new Curriculum.

One of the primary purposes of curriculum evaluation is to establish whether the aims and objectives of the curriculum have been achieved. Evaluation is a process which involves planning, gathering information and dissemination of findings to the relevant stakeholders (Quinn, 2000).

There are a number of ways to evaluate curricula and information can be generated from a variety of sources.

This is a new national standardised Curriculum and a strategic plan is in place for its overall evaluation.

There are three inter-related yet distinct aspects to the evaluation of this Curriculum:

1. **Implementation Monitoring**
2. **Curriculum Evaluation**
3. **Content Review**

1. Implementation Monitoring

Monitoring implementation will fall under the remit of the NWG and will be led by the Project Manager who will continue to provide liaison between the HSE and HEIs. Plans for monitoring implementation will continue to evolve in line with curriculum implementation.

2. Curriculum Evaluation

Dedicated evaluation resources are required to successfully evaluate the Curriculum. The Donabedian framework incorporating Structure, Process, Outcome, is proposed as the framework for evaluation of this Curriculum (see Table 5).

Table 5: Evaluation Framework for the Curriculum

Structure	Process	Outcome
• Group Membership (NSG, NWG, LWG) • Terms of Reference • Communications • Support and Training for HEI Professionals • Raising Curriculum Awareness	• Curriculum Development • Curriculum Manual • Curriculum Content (Delivery Methods/ Models) • Assessment strategies	• Curriculum Implementation • Integration • Learning outcomes achieved

Strategies for Evaluation

A number of approaches to curriculum evaluation are planned, including surveys, focus groups and analysis of written student reflections. The information gathered from the evaluation process will be used to assess the overall effectiveness of the Curriculum. The information generated by the curriculum evaluation process will provide important feedback which will be used to improve undergraduate healthcare student's educational preparation for the provision of Brief Interventions.

Facilitator/Student Survey

Questionnaires are commonly used to gather information for evaluation purposes. We have prepared sample questionnaires to evaluate the overall Curriculum across HEIs (Appendix 10). Programme evaluators will be in place to distribute (possibly using survey monkey), collate and analyse the data generated from the questionnaires including;

1. Standardised questionnaire for students
2. Standardised questionnaire for relevant HEI professionals

Focus group discussion

Focus groups are a useful way of gathering perspectives from a number of viewpoints. Holding focus group discussions with HEI professionals and students will be used as an important way of generating additional feedback on predetermined aspects of the Curriculum.

Analysis of Student Written Reflections

It is proposed that a number of anonymous student written reflections (consented), on the provision of brief interventions in practice, will be reviewed and qualitatively analysed to assess key issues pertaining to the preparedness, confidence and student ability in the provision of brief interventions.

This process will offer rich information on how well students are being prepared and supported for brief intervention in clinical practice. This method of evaluation was successfully used as a method used to evaluate an Integrated End-of-Life Care curriculum for medical students (Ellman et al., 2016).

3. Content Review

The content of the Curriculum will require review and updating. Ultimate responsibility for overseeing the review rests with the HSE. The content review will be informed by findings from the evaluation. The review group will be comprised of members of the NWG and nominated experts. Curriculum review will occur every two years and as required based on any emergent information impacting on the content.

Table 6: Example of Evaluation Questions for Different Stakeholders

Higher Educational Institution	How effectively is *Making Every Contact Count* for HBC-CDPM integrated into curricula across Schools?
Individual Teachers	Am I delivering this Curriculum effectively? Have I been adequately supported to enable me deliver *Making Every Contact Count* for HBC-CDPM education? Are students engaging with the material? Are students linking with and/or applying the content to clinical practice?
Students	What am I learning or gaining from this Curriculum? What did I find good/bad about the Curriculum? Can I identify areas for improvement?
Health Service Executive/Public	In the longer term what is the impact of implementing *Making Every Contact Count* for HBC-CDPM in undergraduate education?

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Section 2:
Curriculum Content

Introduction

There are four Units of Study or content areas identified for this Curriculum. We approached the development of each content area to include an interactive discussion with the objective that dialogue would encourage students to reflect on the topics and examine their own attitudes to health, lifestyle behaviours and to the provision of brief interventions (BI). Each Unit is evidence based and written to facilitate face-to-face or online delivery. Accompanying each Unit is a powerpoint slide pack where the key discussion areas are outlined.

Unit 1

Health and Personal Wellness

The content of Unit 1 is geared toward student lifestyle, health choices and personal wellness. It is an introductory Unit exploring the concept of health and how students perceive health in general, and their own personal health. The topic of lifestyle is explored in conjunction with risky behaviours especially among university students. Current Irish guidelines are explored in relation to alcohol and drug use, smoking, physical activity and diet and the key health messages are discussed in the context of health promotion.

Unit 2

Lifestyle Behaviours and Personal Responsibility for Health

The topic of health behaviours is dealt with in Unit 2. Students are presented with theories on health beliefs and behaviours. The focus of Unit 2 continues to be student centred and students are encouraged to think about the challenges of changing lifestyle behaviours. Various models of behaviour change are presented and the topic of healthcare students as health promoters is introduced in preparation for Unit 3, where the focus shifts from personal lifestyle behaviour change to communicating with others about health and health behaviour change (HBC).

Unit 3

Communicating with Individuals about Promoting Healthy Lifestyle Behaviours

In Unit 3 the communication skills that are required to successfully talk about health with others are explored. Students are asked to participate in a number of skills-based activities to become familiar with the skills which are necessary for HBC. Students are broadly introduced to the topics of *BI* and *Motivational Interviewing (MI)* in preparation for Unit 4 where students will be taught the skills of BI. Included in Unit 3 is the ELearning *Making Every Contact Count* Training Programme.

The eLearning course consists of six modules in total. Modules 1 and 6 are core eLearning modules and form the basis of all successful health conversations with patients and are key in the study of HBC. The content of these core modules is transferrable to all interventions, irrespective of the topic area. Modules 2-5 are eLearning topic knowledge modules on the *Key Lifestyle Behaviours important for Chronic Disease Prevention* and Management and are designed to give you basic information on each topic area to support you in discussing lifestyle choices.

Module 1: Introduction to Behaviour Change

Module 2: Healthy Food for Life

Module 3: Alcohol and Drug Use

Module 4: Tobacco Free Ireland

Module 5: Get Ireland Active

Module 6: Skills into Practice Module

There is an online summative assessment following the eLearning modules, and a certificate of completion will be issued once all modules and assessments are complete.

Unit 4

Making Every Contact Count: Providing Opportunistic Brief Interventions

In Unit 4 students will examine the theoretical and practical context for BIs for HBC. Here, students will practice the delivery of a BI in an empathetic and non-confrontational manner using the principles of MI.

Key referral pathways and signposting will also be covered in this Unit.

The accompanying slide packs for each Unit can be accessed and downloaded from www.hse.ie/mecc-undergradcurriculum

Unit 1:
Health and Personal Wellness

Unit 1 Health and Personal Wellness

Duration: 5 hours
Recommended Programme Placement: Year 1
Lesson Plan

Unit 1 Learning Outcomes	1.1 Assess attitudes and behaviours towards own health and wellbeing 1.2 Define health with reference to the key concepts and determinants of health 1.3 Access and interpret health status data for the Irish population 1.4 Promote key health messages and recommendations	
Lesson 1 Defining Health **1 Hour**	• Introduction to Unit 1 • Introduction to Lesson 1 • Introduction to the topic of health and what it means to different people • Definitions of health • Key concepts and definitions relating to health • Self-perceived health status of people in Ireland	**Activity 1.1** Rating self-perceived health status
Lesson 2 The Biopsychosocial Model of Health **1 Hour**	• Introduction to Lesson 2 • Brief recap Unit 1 Lesson 1 • Introduction to Biopsychosocial Model • Dimensions of Biopsychosocial Model • Illustration of Biopsychosocial model through case studies	**Activity 1.2** Rating self-perceived biological, psychological, and social health. **Activity 1.3** Factors contributing to personal health and well-being **Activity 1.4** Reading 2 case studies followed by analysis
Lesson 3 Lifestyle Influences on Health **1 Hour**	• Introduction to Lesson 3 • Brief Recap Unit 1 Lessons 1 and 2 • Introduction to Lifestyle and relevance to chronic disease prevention • Brief introduction to determinants of health • Four lifestyle areas critical to chronic disease prevention (diet, exercise, tobacco use, alcohol intake) • Irish data on lifestyle risks	**Activity 1.5** Rating of individual perceptions of lifestyle risk factors

Lesson 4 **Key Health Messages** **2 Hours** Hour 1 Field Activity Hour 2 Tutorial feedback on field activity	**Hour 1 Field Activity** • Read Key Health Messages Fact sheet • Carry out field activity **Hour 2 Tutorial** • Tutorial based Lesson providing feedback on field activity	**Activity 1.6** Field activity; exploring the prominence of health behaviours and health messages in the community
Core Reading	Naidoo, J., and Wills, J. (2016) *Foundations for Health Promotion 4th Edition.* ISBN: 9780702054426	
Accompanying Slide Pack for Unit 1	www.hse.ie/mecc-undergradcurriculum	

Unit 1 Health and Personal Wellness

Making Every Contact Count

Making Every Contact Count is a programme being implemented within the HSE to support the prevention and management of chronic disease by promoting lifestyle behaviour change. The health behaviours which are the focus of this programme are the four main lifestyle risk factors for chronic disease: tobacco use; physical inactivity; alcohol and drug use and unhealthy eating.

Making Every Contact Count is about healthcare professionals (HCPs) using their routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change. To do this, the Health Service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. This approach will allow HCPs to move to a position where discussion of lifestyle behaviour is routine, non-judgemental and central to everyone's role.

As a healthcare student and future HCP you will be asked to make each routine contact that you have with patients count in terms of chronic disease prevention and management.

Introduction to Unit 1

In Unit 1 you will explore the concept of health, think about your own views on health in general and your personal health. Lifestyle and risky behaviours especially among university students will be examined. *Key guidelines for health* will be explored in relation to alcohol, smoking, physical activity and diet with the key health messages discussed in the context of health promotion.

Unit 1: Health and Personal Wellness

Lesson 1: Defining Health

Duration: 1 Hour

PPT Title – Unit 1 Lesson 1:
Defining Health

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 1

In this Lesson you will learn about definitions of health as well as a model of health that takes account of physical, psychological and social aspects of health. You will have an opportunity to reflect on your own health and to do some exercises rating your perceptions of your own health.

Health

Here, we examine what is meant by health. This Curriculum is underpinned by the core principles of health promotion for chronic disease prevention and person-centred care. We firstly examine what "health" means. As this Unit progresses, and throughout all units, you will start to see how the concepts of health, health promotion and person-centred care are inter-related.

Health is a broad concept which can mean different things to different people. Our perceptions and views on health and our health priorities are shaped by a wide range of influential factors such as age, gender, family, upbringing, culture, ethnicity and social, economic and political environment. One universal feature of health is that it is generally of great importance and value to most people and societies at large.

Defining Health

One of the most commonly cited definitions of health is from the World Health Organisation (WHO) which is an organisation of the United Nations with a particular concern for international public health. In 1948, the WHO defined health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (World Health Organisation, 1948).

- **What are your thoughts on the WHO definition of health?**
- **Is this "state" of complete health realistic or achievable?**
- **How would you define health?**

In Ireland, the Government has a framework for improving the health and well-being of all individuals by 2025 called *Healthy Ireland* which states that a Healthy Ireland is:

> ***"where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility" (Department of Health, 2013).***

How does the Healthy Ireland definition of health compare with the WHO definition or with your definition of health?

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How does the *Healthy Ireland* definition of health compare with the WHO definition or with your definition of health?

Have you noticed that the WHO and the Healthy Ireland definitions both include mental health as well as physical health? Traditionally, and still today, mental health is often viewed and interpreted in a negative discourse with a focus on mental ill-health rather than positive mental health and well-being. This discourse is reinforced by the delivery of mental health services which tend to focus on treatment of mental health rather than the promotion of mental health (Barry & Jenkins, 2007). Also, the health services for patients and individuals with chronic diseases mostly address their physical health needs but there is now growing attention to the importance of addressing their mental health needs. Mental health is linked to physical health and problems with mental health may in fact contribute to lifestyle risk behaviours (Harrington et al., 2010).

Mental health promotion aims to achieve mental health and emotional well-being of individuals and the general population. It is a positive concept that focuses on enhancing the strengths of individuals and communities whilst also addressing the needs of those already suffering mental health issues or those at risk of mental health problems (Barry & Jenkins, 2007).

The WHO has stated that there is 'no health without mental health' and have highlighted that it is more than the absence of mental illness (World Health Organisation, 2004). The WHO (2004) definition reflects the changing approach to mental health promotion:

> ***" A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (p.1).***

- **Do you think mental health is viewed as a positive or negative concept?**
- **Do you think the WHO definitions of mental health are relevant to health today?**
- **In your view, what relevance is mental health to preventing chronic disease?**

During your undergraduate programme, it will be almost impossible to talk or read about health without encountering other terms linked to health. Table 1.1 provides some example of the different terms (referred to as concepts) you can expect to find.

Table 1.1: Key Concepts and Definitions

Biomedicine	Focuses on the causes of ill-health and disease within the physical body. Associated with the practice of medicine and contrasts with a social model of health.
Disease	The medical term for a disorder, illness or condition that prevents an individual from achieving full functioning.
Health	Is the state of complete mental, physical and social well-being of an individual, not merely the absence of disease or illness.
Ill Health	Is a state of poor health when there is some disease or impairment, not usually serious enough to curtail all activities.
Illness	Is a disease or period of sickness that affects an individual's body or mind and prevents them achieving his / her optimal outputs.
Well-being	Is the positive feeling that accompanies a lack of ill health and illness and is associated with the achievement of personal goals and a sense of being well and feeling good.

Source: Naidoo and Wills (2016)

As you will see from these concepts, the definitions vary to include negative or positive perspectives. The negative perspective focuses on disease and illness whereas a positive perspective focuses on good health and well-being.

Pause for Reflection and Discussion

Think about the healthcare profession or area that you are preparing for in your undergraduate degree. To what extent do you think the above concepts are more or less relevant to your professional/discipline area?

Just as there are different terms and concepts relating to health in the literature, individuals also have different perceptions of health. An individual's perception of health is his/her own idea of what health is and what being healthy means. This illustrates the relevance of person-centred care in this Curriculum and one of its core principles: recognising diversity.

In many countries now, national health surveys are being conducted to determine the health of its nation. For example, in Ireland, surveys are conducted annualy to obtain data on the health status of the population, known as the Healthy Ireland Survey (Department of Health and Children, 2017); please see Table 1.2 for information on the most recent results of this survey. In addition, details of the self-perceived health status as reported by the Central Statistics Office (2016) are presented in Figure 1.1.

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Table 1.2: Summary of Main Findings from Healthy Ireland Survey 2016 and 2017

Health Behaviour	Healthy Ireland Survey Findings
Smoking (2017)	• 22% of the population smoker. • 18% smoke daily and 4% smoke on occasion. • 13% of smokers are trying to quit, and 16% are actively planning to quit.
Alcohol (2017)	• 39% of drinkers binge drink[8] on a typical drinking occasion. • 22% of drinkers binge drink at least once a week, and 40% do so at least once a month.
Diet and Nutrition (2017)	• 37% eat the recommended amount of fruit and vegetables daily (i.e. at least 5 portions). • 35% consume snack foods daily, while 16% consume sugar-sweetened drinks daily.
Clustering of Unhealthy Behaviours (2016)	• Four types of unhealthy behaviours were included in this analysis: smoking, binge drinking, and consuming less than five portions of fruit or vegetables daily. • 62% reported having at least one unhealthy behaviour, with 21% having multiple (two or more) unhealthy behaviours. • 16% of men eat unhealthy foods on a daily basis and binge drink on a typical occasion (compared with 6% of women). • 9% of men eat unhealthy foods on a daily basis and smoke (compared with 7% of women).
Physical Activity (2016)[9]	• 65% are aware that people should be active for at least 150 minutes every week. • 56% think they undertake physical activity at a sufficient level.

Source: Healthy Ireland Survey 2016 Summary of Findings (Department of Health and Children, 2016) and Healthy Ireland Survey 2017 Summary of Findings (Department of Health and Children, 2017)

The most up to date Healthy Ireland Survey is available from:
http://health.gov.ie/healthy-ireland/research-and-data/

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8 Six or more standard drinks on a typical drinking occasion

9 Physical Activity and Clustering of Unhealthy Behaviours not reported for 2017, Healthy Ireland Survey 2016 Summary of Findings provided.

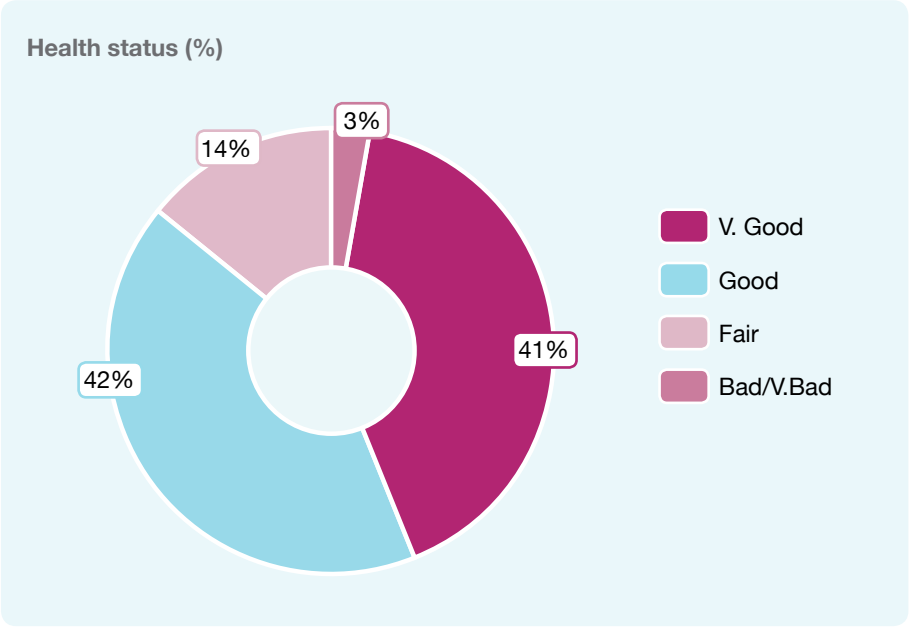

Figure 1.1: Self-perceived health status of all persons in Ireland aged 15 years and older

(Adapted from National Health Survey, 2015, published by CSO 2016); Available at http://www.cso.ie/en/releasesandpublications/ep/p-ihs/irishhealthsurvey2015/ct/)

Pause for Reflection and Discussion

- **Think about the results presented in the pie chart in Figure 1.1 on the overall picture of the health of the nation in Ireland.**
- **Are the results in anyway surprising to you?**
- **What results are more or less surprising?**

While each individual has a self-perception of health status, this perception will change overtime across the lifespan because it depends on various factors such as age, gender, socio-cultural status, education, and lifestyle again highlighting the importance of recognising the need for person-centred care when supporting individuals to think about their health and lifestyle behaviours. The following Table 1.3 shows results of perceived health status according to socio-demographic status from the 2015 National Health Survey in Ireland.

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Useful data to begin to introduce students to the social determinants of health.

Table 1.3: All people aged 15 years and over classified by self-perceived health status, 2015

Self-perceived health status (%)				
	Very Good	Good	Fair	Bad/Very Bad
State	**41**	**42**	**14**	**3**
Sex (Male/Female)	40/42	43/41	14/13	3/4
Age Group				
15-24	51	40	8	2
25-34	50	41	8	1
35-44	48	41	9	2
45-54	42	42	12	4
55-64	34	42	19	6
65-74	24	47	25	5
75+	15	46	32	7
ILO Economic Status				
In employment	50	42	7	1
Unemployed	32	52	15	2
Not economically active	30	40	23	7
Disability status (Yes/No)	10/45	28/44	42/10	21/1
Nationality (Irish/non-Irish)	42/36	41/47	14/15	3/3
Region				
Border	38	43	15	3
Midland	35	45	15	5
West	39	42	15	4
Dublin	43	41	13	3
Mid-East	43	41	13	3
Mid-West	41	42	14	2
South-East	41	40	16	3
South-West	41	44	12	4
Deprivation/affluence				
Very affluent	47	42	9	2
Affluent	44	41	13	2
Average	43	39	15	3
Disadvantaged	40	43	14	3
Very disadvantaged	30	45	19	6

Adapted from the CSO 2016 data on the survey.
Available at http://www.cso.ie/en/releasesandpublications/ep/p-ihs/irishhealthsurvey2015/

Similar to the previous discussion, think about the results presented in Table 1.2 above. Are the results in anyway surprising to you? What results are more or less surprising?

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Written to support face-to-face or online delivery including activities and discussion points.

Now that you have seen the results of a survey on self-perceived health status of people living in Ireland, let's see how you would rate your own health:

Activity 1.1 : Rate your health on a scale of 1-10

Not at all Healthy									**Completely Healthy**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating									

Rate your health on a scale from 1-10

Key Reading

Department of Health (2013) *Healthy Ireland: A Framework for Improving Health and Wellbeing 2013 – 2025*. Dublin: Department of Health.

Health Service Executive (2017) *Making Every Contact Count*: *A Health Behavior Change Framework and Implementation Plan for Health Professionals in the Irish Health Service.* Dublin: Health Service Executive.

Summary

In this Lesson we explored some of the definitions of health. We talked about the *Healthy Ireland* Framework and the self-perceived health status of the nation. In the next Lesson we will look at the biopsychosocial model of health and you will be asked to participate in some activities based around this model.

Unit 1: Health and Personal Wellness

Lesson 2: The Biopsychosocial Model of Health

Duration: 1 Hour

PPT Title – Unit 1 Lesson 2:
The Biopsychosocial Model of Health

Introduction to Lesson 2

In this Lesson we look at the biopsychosocial model of health and you will be asked to participate in some activities based around this model including rating your self-perceived physical, mental, and social health. You will also be asked to reflect on the case studies provided.

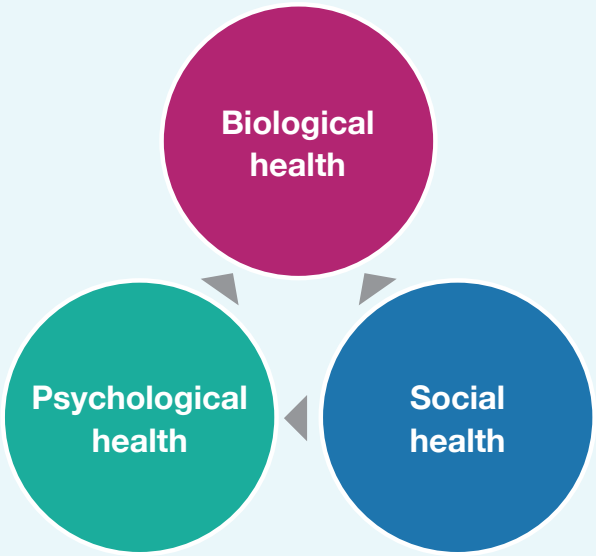
Recap Unit 1 Lesson 1

Can you remember what was covered in Lesson 1?

In Lesson 1 we explored some of the definitions of health. We talked about the *Healthy Ireland* Framework and the self-perceived health status of the nation based on the findings from a National Health Survey conducted in Ireland.

The Biopsychosocial Model of Health

The biopsychosocial model of health is a holistic, integrated approach to health recognising the role that behavioural, social and physical factors play in our experiences of health (Dogar, 2007). Biological, psychological and social influences constantly interact and influence causes, treatment choices and the outcome of illnesses. Health and illness are a consequence of the interplay of biological, psychological and social factors. An individual's health, susceptibility to disease, subjective experience of illness and recovery processes are influenced by biological and psychosocial factors (Dogar, 2007; Engel, 1978; Schwartz, 1982). The following diagram illustrates a model of biopsychosocial health (Figure 1.2).



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Written to support face-to-face or online delivery including activities and discussion points.

Critical discourse around BPS model and others e.g. biomedical may be considered in other areas of curriculum as applicable to individual healthcare student groups/ disciplines.

Activity 1.2 Self Perceived Dimensions of Health

In this activity, you are being asked to rate your health for each of the dimensions of the biopsychosocial model of health. A brief explanation of each dimension is given.

Worksheet 1.2 self-perceived dimensions of health

Biological Health: this dimension is concerned with physical and physiological status including the functioning of the body. In other words, a body that is working well physically and physiologically is a healthy body. This dimension refers to the mechanistic functioning of the body.

Rate your biological health on a scale from 1-10

Not at all Healthy									Completely Healthy
1	2	3	4	5	6	7	8	9	10

Jot down reasons for your rating

Social Health: this dimension is concerned with the ability to establish and maintain relationships with other people, it also incorporates cultural and environmental influences on experiences and occurrence of illness.

Rate your social health on a scale from 1-10

Not at all Healthy									Completely Healthy
1	2	3	4	5	6	7	8	9	10

Jot down reasons for your rating

Psychological health: being psychologically healthy is about recognising and dealing with emotions including anger, stress, joy and being able to cope with and express emotions appropriately. Psychological factors play a role in how we experience and react to illness.

Rate your psychological health on a scale from 1-10

Not at all Healthy									Completely Healthy
1	2	3	4	5	6	7	8	9	10

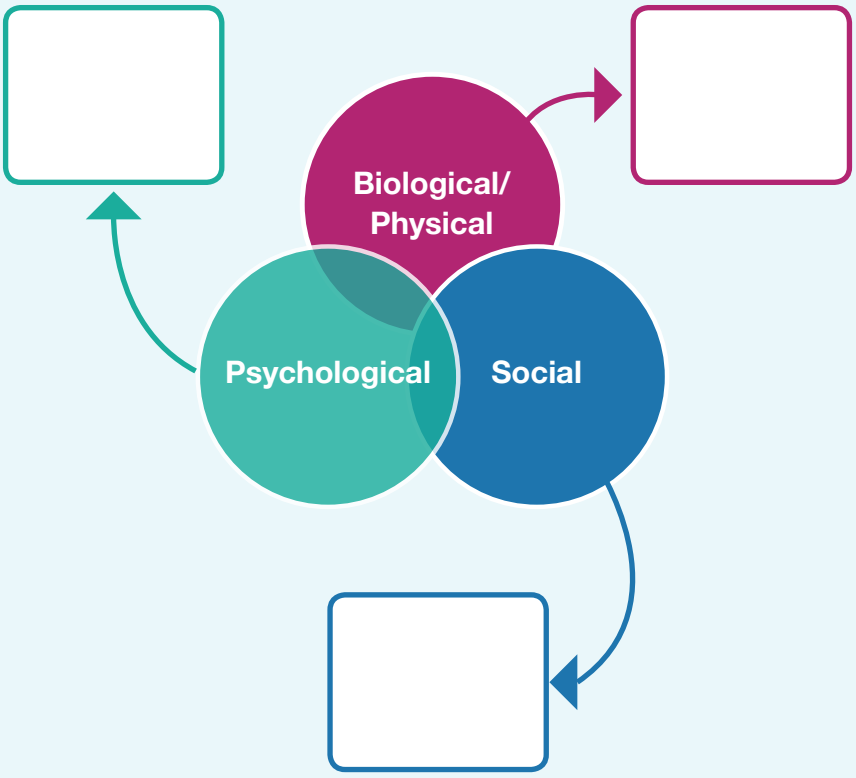
Jot down reasons for your rating

GUIDANCE NOTES FOR FACILITATORS

For Activity 1.2 (face-to-face/ online). Present as worksheet (provided with this Lesson). Students are not required to share their ratings only if they wish. Focus instead on their understanding of what each dimension means.
If online consider providing a summary (anonymized) of ratings for all students to see.

Activity 1.3 The Biopsychosocial Model of Health

The biopsychosocial model of health recognises that there are many facets contributing to health and well-being. Think about your life at the moment and see how various physical / biological, social and psychological factors contribute to your health and well-being. How many of these factors are interlinked or overlap? Some of the reasons that you noted earlier when rating each dimension of health may be applicable here. In each box, jot down all the factors that are important to you or that you do to stay healthy and well.



How adequately do you think the biopsychosocial model of health captures all aspects of health that are important to you? Are there other dimensions of health that you would add to this model?

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points

If face-to-face, a flip chart could be used to take feedback.

Allow open brainstorm and expand new thoughts.

Now that you have been introduced to the biopsychosocial model and have considered its relevance to your health, the following two case studies offer examples of a holistic account of an individual's health:

Activity 1.4 : Case studies

Please read the following case studies bearing in mind the biological, psychological and social health influences. Once you have read these case studies, we will discuss each one.

Case Study One: John, aged 22 years

John is 22 years old. He left school at 16 and has been working in construction since then; he is considered to be a good worker and gets on well with his colleagues and supervisors. Unfortunately, because of the recession, there has been a slow-down in work and John has been let go. Others who had formal qualifications and trades have been kept on. Since then John has been doing some part time work for other builders and neighbours. His old workmates have encouraged him to go back to college or to do a trade but John feels he cannot afford it and doesn't want to bother his parents as his Dad is out of work and is suffering from depression. Due to his reduced income he has had to move in with his sister and her young family, John is helping her with child minding and general odd jobs. He used to regularly play football with friends a few times a week and go for a few pints afterwards but lately he has been attending less frequently as he feels unfit, he also can't afford to socialise with this gang and instead finds it cheaper and easier to have cans at home with his brother in law. John goes to see his GP because he is having trouble sleeping but also says he feels constantly exhausted. He is also anxious about what he is going to do with his life. He says he sees no way out of his situation and is conscious that he is becoming a burden on his sister.

Case Study Two: Tara, aged 19 years

Tara is 19 years old, she is a first year student in university, undertaking a 4 year Nursing Degree programme. She left home 10 weeks ago and moved in with other students in rented accommodation near to the college. Until now Tara has enjoyed the comfort of her parent's home cooked meals after school, regular exercise with her school football team and a relatively structured study plan which she adhered to in the quiet of her home environment.

Lately, Tara has found that she is snacking a lot through the day at college. She doesn't always mean to but she doesn't have time for breakfast and there are so many high calorie snacks available at the college restaurant. So she consoles herself that it's not all her fault.

Exercise is a think of the past because she no longer plays football. She feels that she if beginning to get a bit stressed about college assignments and exams. She can't seem to study in the noisy rented accommodation and she doesn't want to stay out too late at the library. She is unable to sleep through the night and feels exhausted during the day.

GUIDANCE NOTES FOR FACILITATORS

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- **In keeping with the philosophies of health promotion for chronic disease prevention and management and person-centred care, underpinning this Curriculum, consider the case studies and respond to the questions provided. Take each case separately:**
- **What aspects of the case study seem most relevant to each dimension of health – biological/physical, social and psychological?**
- **Do any of the factors impacting on health interact or overlap?**
- **What solution(s) might you come up with for each situation?**
- **What barriers to improving health might be encountered by John/Tara?**

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Handout Unit 1 Lesson 2
Activity 1.2:
Rating Self-Perceived Biological, Psychological, and Social Health

In this activity, you are being asked to rate your health for each of the dimensions of the biopsychosocial model of health.

Biological Health: this dimension is concerned with physical and physiological status including the functioning of the body. In other words, a body that is working well physically and physiologically is a healthy body. This dimension refers to the mechanistic functioning of the body.

Rate your biological health on a scale from 1-10

Not at all Healthy									**Completely Healthy**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Jot down reasons for your rating

Social Health: this dimension is concerned with the ability to establish and maintain relationships with other people, it also incorporates cultural and environmental influences on experiences and occurrence of illness.

Rate your social health on a scale from 1-10

Not at all Healthy									**Completely Healthy**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Jot down reasons for your rating

Psychological health: being psychologically healthy is about recognising and dealing with emotions including anger, stress, joy and being able to cope with and express emotions appropriately. Psychological factors play a role in how we experience and react to illness.

Rate your psychological health on a scale from 1-10

Not at all Healthy									**Completely Healthy**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Jot down reasons for your rating

Unit 1: Health and Personal Wellness

Lesson 3: Lifestyle Influences on Health

Duration: 1 Hour

PPT Title – Unit 1 Lesson 3:
Lifestyle Influences on Health

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 3

In Lesson 3 you will be introduced to the topics of lifestyle behaviours and the lifestyle areas that can adversely influence health.

Recap Unit 1 Lessons 1 and 2
Can you remember what was covered in Lesson 1 and 2?

In previous Lessons we explored some of the definitions of health. We talked about the *Healthy Ireland* Framework and the self-perceived health status of the nation based on the findings from the National Health Survey. We looked at the biopsychosocial model of health and you participated in some activities based around this model; including self-rating your self-perceived dimensions of health and reflecting on case studies.

Lifestyle

Lifestyle involves the behaviours and activities that make up an individual's daily life. These behaviours are important to promoting health and are especially important to preventing the onset of chronic diseases particularly diabetes, cardiac disease and respiratory disease. These chronic conditions, along with cancer, are among the leading causes of mortality (death) in Ireland and in the world.

A healthy lifestyle prevents the onset of chronic disease. At the personal level, having a philosophy about good health being desirable and achievable has potential to lead to health promoting behaviours for better health. Therefore, it is important to consider a person-centred approached when working with people to promote health and positive lifestyle changes and behaviours.

Many countries including Ireland have the prevention of chronic disease as a government priority with a specific focus on improving lifestyle behaviours. The *Making Every Contact Count* National Curriculum is an example of how Ireland is implementing a prevention strategy.

Just as one's lifestyle can influence positive health, so too can lifestyle lead to poor health and chronic disease. Lifestyle behaviours are therefore key determinants of health. Other determinants of health are:

- The social and economic environment, and,
- The physical environment

According to the WHO, it is important to keep in mind that the context of people's lives determine their health. Individuals may not be able to directly control many determinants of health such as income and social status, level of education, health service access. Therefore,

> ***" blaming individuals for having poor health or crediting them for good health is inappropriate" (World Health Organisation, 2017).***

Available at: http://www.who.int/hia/evidence/doh/en/

Although individuals may not have control over all the factors or determinants that influence their health, they can be helped to make healthier lifestyle choices and that can be adapted to their personal needs. Adopting a person-centred and biopsychosocial approach to the assessment of individual needs should assist in the provision of targeted health information and intervention.

Health promotion is a key role of all professional groups working in healthcare. Health Promotion is defined by the Ottawa Charter as "the process of enabling people to increase control over and to improve their health"; it focuses on promoting and protecting the positive health and wellbeing of individuals, groups and communities (World Health Organisation, 1986). In preventing the leading chronic diseases in Ireland (diabetes, cardiac disease and respiratory disease), there are four key lifestyle areas that are critical to address. These are:

- Unhealthy eating
- Tobacco use
- Physical activity
- Alcohol and drug use

Each of the above four lifestyle areas are risk factors that can adversely influence health. Here is a snapshot of some findings from surveys on lifestyle behaviours specific to Ireland including predictions on future lifestyle trends. Three major surveys that offer national data in Ireland are:

- *Department of Health and Children (2009) SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland.* Available at: https://www.publichealth.ie/sites/default/files/documents/files/slan.pdf
- *Central Statistics Office (2016) Irish Health Survey 2015.* Available at: http://www.cso.ie/en/releasesandpublications/ep/p-ihs/irishhealthsurvey2015/ and http://health.gov.ie/wp-content/uploads/2015/10/Healthy-Ireland-Survey-2015-Summary-of-Findings.pdf
- Department of Health and Children (2016) *Healthy Ireland Survey 2016; Summary of Findings.* Dublin: Stationary Office.

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Written to support face-to-face or online delivery including activities and discussion points.

Table 1.4: Lifestyle Behaviours/Associated Health in Ireland (Risk factors for chronic disease)

Irish Health Survey (2015) Aged 15 years or over			
Healthy Eating	**Physical Activity**	**Smoking**	**Alcohol use**
35% OW[1]	32% high	23% smoke	40% harmful per month
18% obese	37% moderate	28% ex-smokers	53% weekly
61%M[2] vs 45% F[3] OW or obese	31% low	24%M vs 21%F	39% binge drink
Increase by 65yr e.g.: 55-64yrs = 40% OW & 23% obese.	M: 40% high vs F: 24%	Smokers: 19% at 15-24yrs vs 32% at 25-34yrs followed by decrease to 18% at 55-64yrs and then 12% at 65yrs+.	24% weekly 60%M vs 46%F weekly
	At 45-64yrs: high=38% to 33% M vs 25%-18% F; low =26%-32%M vs 33%-44%F.		Weekly: 39% drink at 15-24yrs vs 63% at 55-64yrs vs 59% at 65yrs+

SLÁN (2007): Survey of Lifestyle, Attitudes and Nutrition in Ireland			
Healthy Eating	**Physical Activity**	**Smoking**	**Alcohol use**
39% OW	24% High[4]	29% smoke	10% excess
24% obese	47% Moderate[5]	19% ex-smoker	46% weekly
M: 45% OW vs 24% obese F: 32% OW vs 25% obese	29% Low[6]	31%M vs 27%F	13%M vs 6%F excess
≤ by 65yr e.g.: 45-64yrs = 45% OW & 32% obese.	M: 32% high; 42% moderate; 26% low.	Smokers: 39% at 18-29yrs vs 25% at 45-34yrs followed by decrease to 18% at 55-64yrs and then 12 & at 65yrs+.	53%M vs 38%F weekly
		64yrs vs 14% at 65yrs+.	13% excess at 18-29yrs vs 9% at 45-64yrs vs 6% at 65yrs+
	F: 16% high; 53% moderate; 31% low. At 45-64yrs: ≥ moderate (51%) & ≤ high (21%).		at 65yrs+.

1 Overweight
2 Male
3 Female
4 Vigorous at least 1500 mins/wk over 3 days OR 3,000mins/wk of combined activity over 7 days
5 Vigorous activity x 20mins over 3 or more days OR moderate activity x 30 mins over 5 days OR at least 600 mins/wk over 5 days
6 Individuals who do not meet high or moderate category.

- **What differences in trends can you see from 2007 to 2015 for each of the risk factors?**
- **What factors do you think might have influenced the change in trends?**
- **Do any of the findings surprise or even shock you? If yes, which ones and why?**

These survey findings are intended to raise your awareness of lifestyle risks in our everyday lives. These risks lead to negative impacts on our health and ultimately can lead to one or more chronic diseases. Tackling these risk factors is a crucial step in the prevention of chronic disease. Consider the old saying that:

Prevention is better than cure

Activity 1.5: (Use handout to complete this activity)
Individual perceptions of lifestyle risk factors.

Having looked at the Irish data for lifestyle risks, let's now look at how you perceive yourself to be at risk. You will not be obliged to share this information with your peers. Rather, the purpose of the activity to become aware of what you perceive to be your level of risk. Just as individuals' perceptions about their health status differ and are subjective noted earlier in Lesson 1, so too are individuals' perceptions about lifestyle risk factors subjective. Often times, an individual's perception of risk is not informed by accurate facts of what counts as a level of risk e.g. the amount of alcohol consumed, the amount of physical activity per week; or dietary intake.

Rate how you perceive your dietary lifestyle risk on a scale from 1-10									
No Risk									**High Risk**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									

Rate how you perceive your tobacco lifestyle risk on a scale from 1-10									
No Risk									**High Risk**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									

Rate how you perceive your activity lifestyle risk on a scale from 1-10									
No Risk									**High Risk**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									

Rate how you perceive your alcohol lifestyle risk on a scale from 1-10									
No Risk									**High Risk**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

In preparation for Lesson 4, provide students with the Factsheet and Activity guidance handout 1.6 (provided at the end of this Lesson) and instruct students on carrying out the field activity before the Tutorial based session where they will be required to provide group feedback on their observations.

See Lesson 4 for more information.

Summary

This completes Lesson 3. Between now and the next tutorial based Lesson you are being asked to carry out a field activity in groups of four or five. You will be provided with a factsheet on the key health messages and an *Activity Guidance Handout 1.6,* to direct you to carry out an observation exercise on lifestyles and health promoting messages. You will be required to write brief notes on your observations as you will be asked as a group to present these findings at the tutorial following the field activity.

GUIDANCE NOTES FOR FACILITATORS

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Handout Unit 1 Lesson 3 Activity 1.5
Individual Perceptions of Lifestyle Risk Factors

Rate how you perceive your dietary lifestyle risk on a scale from 1-10									
No Risk									High Risk
1	2	3	4	5	6	7	8	9	10
Jot down reasons for your rating.									

Rate how you perceive your tobacco lifestyle risk on a scale from 1-10									
No Risk									High Risk
1	2	3	4	5	6	7	8	9	10
Jot down reasons for your rating.									

Rate how you perceive your activity lifestyle risk on a scale from 1-10									
No Risk									High Risk
1	2	3	4	5	6	7	8	9	10
Jot down reasons for your rating.									

Rate how you perceive your alcohol lifestyle risk on a scale from 1-10									
No Risk									High Risk
1	2	3	4	5	6	7	8	9	10
Jot down reasons for your rating.									

Hand out Unit 1 Lesson 3 Activity 1.6:
Field Activity

In groups of 4/5 carry out the following activity:

You are now being asked to do a self-directed field visit with an observation exercise on lifestyles and health promoting meassages. The field visit involves taking note of the patterns of behaviour of other people as you walk around your College/University and also any other place that you would normally spend time in your everyday life e.g. your home town, walking through any public place. As you stroll around, or pause and sit to observe, take note of the age profile overall of people you meet/see. Also, take note of people's behaviours that you think are relevant to health. Is there anything in particular that strikes you as 'risky' about these behaviours or as positive in promoting health. Observe for evidence of health promoting information in your town, university and community.

***Use the fact sheet provided on the key health messages and monitor where you see evidence of these messages in your everyday surroundings.**

Write brief notes on your observations as you will be asked as a group to present these findings at the tutorial following the field activity.

Time required to complete this activity:

Field Activity: 1 hour

Tutorial 1: hour

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Handout to accompany Unit 1 Lesson 3 Activity 1.6:
Fact Sheet - Key Health Messages

1. Tobacco Use

- Did you know that that the World Health Organisation has classified smoking as a chronic disease?
- Cigarettes contain many health harming ingredients and many more are created in the burning process that happens when cigarettes are smoked.
- The ingredients in cigarettes are not only harmful to the smoker but the smoke from cigarettes also contains many health harming compounds which can cause adverse health effects to people who are in the environs of smokers on a regular basis.

Why do people smoke?

Tobacco use is a complex behaviour influenced by a range of physiological, behavioural and cognitive factors which is why people continue to smoke, despite widely publicised evidence of the health, social and financial burden it causes.

Key Messages: Smoking Cessation

Quitting smoking has many benefits. Take some time to examine the benefits of quitting smoking that are presented in the next Table:

Benefits of Quitting

Within 20 minutes	Blood pressure drops, pulse rates drops to normal, body temperature of hands and feet return to normal
Within 8-12 hours	Carbon monoxide levels in the blood start returning to normal and within a few days are the same as the non smokers
Within 24-48 hours	Risk of heart attack begins o decrease
Within 48 hours	Ability to smell and taste improves
Within 72 hours	Breathing gets easier as bronchial tubes relax.Lung capacity increases
Within 3 weeks	Carbon monoxide levels in the blood start returning to normal and within a few days are the same as the non smokers
Within 2-3 months	Blood pressure drops, pulse rates drops to normal, body temperature of hands and feet return to normal
After 1 year	Carbon monoxide levels in the blood start returning to normal and within a few days are the same as the non smokers
After 1 year	Carbon monoxide levels in the blood start returning to normal and within a few days are the same as the non smokers
Within 10-15 years	Risk of heart attack falls to the same as someone who has never smoked. Risk of lung cancer falls to half a non-smoker and the risk of cancer of the mouth, throat, oesophagus, bladder. Cervix and pancreas decreases.

For more information visit www.quit.ie

2. Alcohol and Drug Use

When we drink an alcoholic beverage, there are so many variables that it is difficult to keep track of how much alcohol we are consuming. Glasses, cans and bottles come in different sizes. Different drinks contain different percentages of alcohol. The simplest way to measure your intake of alcohol is in Standard Drinks.

What is a standard drink?

In Ireland, a standard alcoholic drink contains about 10 grams of pure alcohol. A standard drink is:

- a small glass of wine (100 ml, 12.5% volume), (a bottle of wine at 12.5% alcohol contains around seven standard drinks)
- a pub measure of spirits (35.5 ml)
- a half pint of beer or lager (284 ml)
- an alcopop (275 ml bottle)

Key Messages: Alcohol

Weekly low-risk drinking guidelines

Key Messages: Alcohol Use

The Department of Health has set low-risk drinking guidelines for adults as outlined in above. In addition, it is recommended:

- Not to consume more than 6 standard drinks on any one occasion
- To have 2-3 alcohol free days each week to minimise tolerance and habit formation

Your liver can only remove about one standard drink per hour.

For more information visit www.askaboutalcohol.ie

3. Physical Activity

Being physically active is one of the most important steps that people of all ages can take to improve their health and wellbeing.

Key Messages: Physical Activity

National Guidelines for Physical activity

The National Guidelines on Physical Activity for Ireland (Department of Health and Children, 2009), outlined below, aim to increase physical activity and reduce the levels of overweight and obesity among Irish people.

Moderate Activity	Vigorous Activity
Increased breathing and heart rate, but still able to carry on a conversation. Warm or sweating slightly, comfortable pace.	Breathing heavily, cannot keep a conversation going, faster heart rate and sweating and concentrating hard.

For more information visit
www.getirelandactive.ie

4. Healthy Eating

Dietary factors are the most important risk factors undermining health and wellbeing in every single country in the World Health Organisation European Region. Research shows that excess consumption of foods high in fats, salt and sugar, as well as low levels of vegetables and fruit intake, play a significant role in increasing our risk of developing chronic diseases such as heart disease, type 2 diabetes and cancer.

Key Messages: Healthy Eating

The current guidelines for healthy eating in Ireland have been set by the Department of Health (Department of Health, 2016).

- Limit high fat, sugar and salt foods from the top shelf of the Pyramid to no more than once or twice a week
- Eat more fruit, salad and vegetables; at least 5 to 7 servings a day
- Use the Pyramid as a guide for serving sizes and remember that portion size matters

For more information visit
http://www.healthyireland.ie/health-initiatives/heg/

References:

Department of Health. (2016). *Healthy Food for Life – the Healthy Eating Guidelines and Food Pyramid.* Dublin. Available at: https://www.healthpromotion.ie/hp-files/docs/HPM00796.pdf

Department of Health and Children. (2009). *National Physical Activity Guidelines.* Dublin. Available at: https://health.gov.ie/wp-content/uploads/2014/03/active_guidelines.pdf

Unit 1: Health and Personal Wellness

Lesson 4: Key Health Messages and Recommendations

Duration: 2 Hours

Hour 1 Field Activity
Hour 2 Tutorial Feedback from Field Activity

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 4

In this Lesson the key messages from Healthy Ireland recommendations are explored in the context of health promotion including: 1) tobacco use 2) alcohol and drug use 3) healthy eating, and 4) physical activity.

Hour 1 Field Activity

Key Reading

Read the Fact Sheet accompanying this Lesson, Fact Sheet Key Health Messages, this will provide you with a basic understanding of some of the information that you will need to enable health promoting conversations in your professional healthcare career. More information on each of the topics is available on the following websites:

Tobacco:	www.quit.ie
Alcohol:	www.askaboutalcohol.ie/
Drugs:	www. Drugs.ie
Physical activity:	www.getirelandactive.ie
Healthy eating:	http://www.healthyireland.ie/health-initiatives/heg/

Activity 1.6 Group Activity: Field activity
Carry out some research in your own communities

You are now being asked to do a self-directed field visit with an observation exercise on lifestyles and health promoting messages. The field visit involves taking note of the patterns of behaviour of other people as you walk around your College/University and also any other place that you would normally spend time in your everyday live, e.g. your home town, walking through any public place. As you stroll around, or pause and sit to observe, take note of the age profile overall of people you meet/see. Also, take note of people's behaviours that you think are relevant to health. Is there anything *in particular that strikes you as 'risky' about these behaviours or as positive in promoting health.* Observe for evidence of health promoting information in your town, university and community. Use the fact sheet provided on the key health messages and monitor where you see evidence of these messages in your everyday surroundings. Keep notes of your observations and in the next lesson you will be asked to share your thoughts on what you observed.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Hour 2 Tutorial Feedback from Field Activity

Recap Unit 1 Lessons 1, 2 and 3

Can you remember what was covered in previous Lessons?

Facilitators can remind students of what they learned in Lessons 1-3 Then students present and discuss findings from the field activites.

In previous Lessons we explored some of the definitions of health, the Healthy Ireland Framework and findings from the National Health Survey. We looked at the biopsychosocial model of health and you explored your self-perceived dimensions of health. We explored lifestyle behaviours and the lifestyle factors which can adversely influence health.

It is important to know the key health messages that promote positive lifestyle choices and contribute to a *"Healthy Ireland"*. We will look at the four key lifestyle behaviours Figure 1.3 and explore the key health recommendations for each topic.

Figure 1.3: Key Lifestyle Behaviours important to Chronic Disease Prevention

Feedback

Students will be given an opportunity to provide feedback and discussion on their field activity findings.

Summary

In this Lesson we talked about the four key lifestyle behaviours (tobacco use, alcohol and drug use, healthy eating and physical activity) including the impacts of the lifestyle behaviour on health. You carried out a field activity and observed the behaviours and health promoting messages evident in your communities.

GUIDANCE NOTES FOR FACILITATORS

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References

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Health Service Executive. (2017). *Making Every Contact Count: A Health Behavior Change Framework and Implementation Plan for Health Professionals in the Irish Health Service.* Dublin.

Naidoo, J., & Wills, J. (2016). *Foundations for Health Promotion* (4th ed.). Kent, UK: Bailliere Tindall.

Schwartz, G. (1982). Testing the biopsychosocial model: The ultimate challenge facing behavioral medicine? *Journal of Consulting and Clinical Psychology, 50*(6), 1040.

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World Health Organisation. (2017). The determinants of health. Available at: http://www.who.int/hia/evidence/doh/en/

Unit 2:
Lifestyle Behaviours and Personal Responsibility for Health

Unit 2 Lifestyle Behaviours and Personal Responsibility for Health

Duration: 4 hours
Recommended Programme Placement: Year 1 or 2
Lesson Plan

Unit 2 Learning Outcomes	2.1 Describe health behaviours and the factors which influence behaviour 2.2 Identify aspects of lifestyle behaviour that affect health and wellbeing 2.3 Assess health risks associated with lifestyle behaviours 2.4 Overcome the challenges of changing health behaviours to address risk factors	
Lesson 1 **Health Behaviour** **1 Hour**	• Introduction to Unit 2 • Introduction to Lesson 1 • Brief recap of Unit 1 • Health behaviours • Activity 2.1 Personal Health Behaviour Questionnaire • CVD Risk Factors • Summary	**Activity** 2.1 Personal Health Behaviour Change (HBC) Questionnaire
Lesson 2 **Student Health Behaviour** **1 Hour**	• Introduction to Lesson 2 • Brief recap of Unit 2 Lesson 1 • Student data – Health Behaviours • Research findings/Papers reading • Discussion Points • Summary	2.2 Critical Reading Activity
Lesson 3 **Behaviour Change** **1 Hour**	• Introduction to Lesson 3 • Brief Recap of Unit 2 Lesson 1 and 2 • Changing behaviours • Activity 2.3 • Summary	2.3 Decisional Balance Personal Health Behaviour Questionnaire
Lesson 4 **Theories of Health Behaviour Change** **1 Hour**	• Introduction to Lesson 4 • Brief Recap Unit 2 Lesson 1-3 • Theories of Health Behaviour Change • Trans-theoretical Model of Behaviour Change • Health Belief Model • COM-B Model • Healthcare Student as Health Promoter • Summary	2.4 Health Promotion Topic
Core Reading	Naidoo, J., and Wills, J. (2016). *Foundations for Health Promotion 4th Edition.* ISBN: 9780702054426; Chapter 1 and Chapter 2.	
Accompanying Slide Pack for Unit 2	www.hse.ie/mecc-undergradcurriculum	

Unit 2: Lifestyle Behaviours and Personal Responsibility for Health

Making Every Contact Count

Making Every Contact Count is a programme being implemented within the Health Service Executive (HSE) to support the prevention and management of chronic disease by promoting lifestyle behaviour change. The health behaviours which are the focus of this programme are the four main lifestyle risk factors for chronic disease; tobacco use; physical inactivity; alcohol and drug use and unhealthy eating.

Making Every Contact Count is about healthcare professionals (HCPs) using their routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change. To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. This approach will allow the health profession to move to a position where discussion of lifestyle behaviour is routine, non-judgemental and central to everyone's role.

As a healthcare student and future HCP you will be asked to make each routine contact that you have with patients count in terms of chronic disease prevention and management.

Introduction to Unit 2

In this Unit we look specifically at health behaviour practices among student groups. You will be asked to explore a personal health behaviour which you would like to change (Activity 2.3), and we will examine some of the theories of behaviour change.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Unit 2: Lifestyle Behaviours and Personal Responsibility for Health

Lesson 1: Health Behaviour

Duration: 1 Hour

PPT Title – Unit 2 Lesson 1:
Health Behaviour

Do you remember any definitions of health?

Recap Unit 1

Can you remember what was covered in Unit 1?

In Unit 1 *Health and Personal Wellness,* you looked at the topic of health and explored various definitions of health.

We discussed the biopsychosocial model of health where you were asked to think about your own personal health and to self-rate your physical, social and psychological health.

In Unit 1 you were briefly introduced to the topic of health behaviours and the factors which influence health behaviour and the relationship between health behaviour and health. We understood that adopting a healthy perspective leads to health promoting behaviours for better health.

Health behaviours

What do you think the term health behaviour means?

- Anything a patient does in response to internal or external events.
- Behaviours are physical events that occur in the body and are controlled by the brain

Definitions

- Health behaviours are activities undertaken by a patient believing him/herself to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage (Kasl & Cobb, 1966).
- "…any activity undertaken for the purpose of preventing or detecting disease or for improving health and well-being" (Norman & Conner, 1996).

Health Behaviours Versus Health Outcomes

Sometimes there is confusion between desired health outcomes and the health behaviour needed to achieve that outcome. For example, the health outcome may be a reduced BMI or reduced waist circumference for a patient that would like to lose weight; however the health behaviour required to achieve this outcome may be any of the following activities; increased activity, cycling to work instead of driving and/or reducing sugar intake.

Which of the following are health behaviours?

Aiming to eat 3 pieces of fruit a day	
Reducing blood pressure	
Having the confidence to ride a bike	
Losing weight	
Walking in the park	
Drinking non-alcoholic beer on a night out	
Reducing cholesterol	
Speaking with a louder voice	
Walking to work instead of driving	

GUIDANCE NOTES FOR FACILITATORS

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Activity 2.1:
Personal Health Behaviour Questionnaire

Complete the Personal Health Behaviour Questionnaire accompanying this Lesson

The exercise on **Activity 2.1** will demonstrate that most of us incorporate healthy (and unhealthy) behaviours into our everyday lives as a matter of routine. Of course, some people are more health conscious than others, and some are more ready to take risks with their health than others.

GUIDANCE NOTES FOR FACILITATORS

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Health Influences

So what is it that influences our behaviour? Why do we behave the way we do?

There are numerous factors which influence our health behaviour for example;

- Opinions of our family, friends, those we respect and admire and want to model ourselves on, media, superstitions.
- Shifting focus on preventive health

Health behaviour: cause and effect?

It has been suggested that 50% of mortality from the ten leading causes of death is due to behaviour. Doll and Peto (1981) reported estimates of the different potential causal factors related to types of cancer and concluded that smoking accounted for 30% of all cancer deaths; alcohol for 3%; diet for 35% and reproductive and sexual behaviour for 7%. Overall, about 75% of all deaths due to cancer are related to lifestyle behaviour – over which people have choice.

Does this information surprise you?

Of course the picture is more complex. What other factors can you think of that could be responsible for poor health?

Let's look at some of the social influences on our health and health behaviour

Social and economic disadvantage

Harmful health behaviour (smoking, unhealthy diet, lack of physical activity etc.) is not the **only** cause of poor health. It is well known that social and economic disadvantage is strongly linked with damaging health behaviour and creates most difficulty in adopting new healthier behaviour. This reinforces the importance of adopting a person-centred approach to health promotion ensuring that all factors, including social influences of health and health behaviours are considered.

The Alameda County Study conducted in 1965 in California in the United States was one of the first studies to identify health behaviours predictive of mortality.

Figure 2.1: Lifestyle factors predicting mortality

GUIDANCE NOTES FOR FACILITATORS

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Health Determinants

Our health is influenced by a range of intrinsic and extrinsic factors. These interrelationships are captured in the Dahlgren and Whitehead (1991) "Policy Rainbow" or "Social Determinants of Health Model" (Figure 2.2).

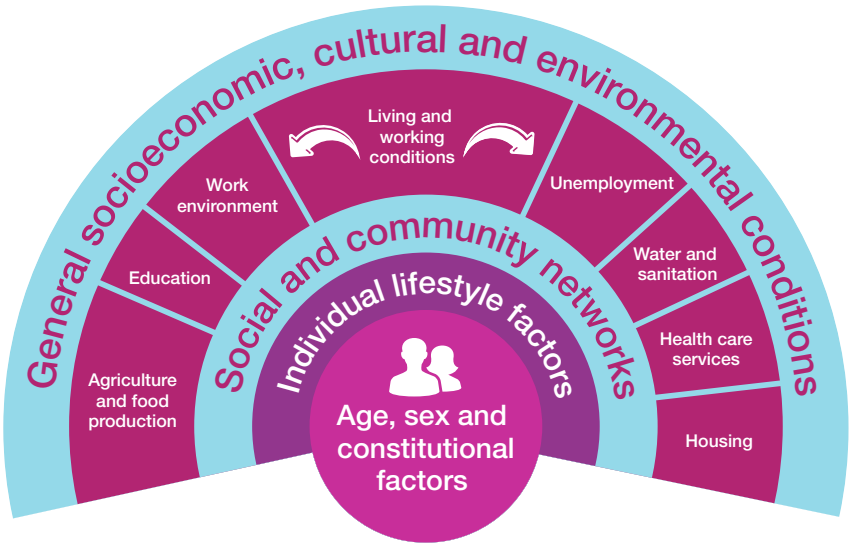

Figure 2.2 Dahlgren-Whitehead Model

According to Dahlgren and Whitehead (1991), factors such as age, sex and genetics are non-modifiable and cannot be altered to promote our health. There are multiple other factors however or "layers of influence" which are modifiable such as:

1. **Personal behaviours and lifestyles**
2. **Support and influence within communities which can sustain or damage health**
3. **Living and working conditions and access to facilities and services**
4. **Economic, cultural and environmental conditions such as standards of living or employment.**

The core of Dahlgren and Whitehead's model contains the non-modifiable factors (biological and genetic traits). These elements play a key role in determining health and are non-modifiable which means that they are not influenced by health promotion strategies.

There are a number of other key health determinants which are modifiable and are depicted as layers extending from the core of the model:

Layer 1: Individual Lifestyle Factors, This layer refers to the lifestyle "choices" or behaviours we adopt such as smoking, alcohol and drug use, unhealthy diet etc.

Layer 2: Social and Community Networks. This layer refers to our family, friends and broader social supports which can play a positive and protective role in health.

Layer 3: Living and Working Conditions. Here the model refers to basic needs including sanitation, food, housing. Also included are factors such as access to healthcare, education, welfare services and amenities.

Layer 4: General Socio-Economic, Cultural and Environmental Conditions. The factors represented here (employment, salary, taxation etc.) are thought to have direct influence on government's spending capacity influencing health and social policy priorities.

How could this model be applied in the context of a person-centred approach to health promotion for chronic disease prevention?

Summary

In this Lesson we explored health behaviours. We looked at what is meant by the term health behaviour. We focused on the factors which influence health behaviours and we examined the relationship between health behaviour and poor health. In Lesson 2 we are going to look in more detail at health behaviours among students, what the research tells us about students and health, and you will have an opportunity to offer your opinions on the topics.

GUIDANCE NOTES FOR FACILITATORS

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Handout Unit 2 Lesson 1 Activity
2.1 Health Behaviour Questionnaire

What behaviours do you routinely adopt to prevent yourself getting ill, and to maintain or promote good health? List these behaviours in the categories below:

Behaviour which prevents ill health
(e.g. taking daily vitamins)

.....
.....
.....

Behaviour which promotes good health
(e.g. taking regular exercise)

.....
.....
.....

Behaviour which sustains good health
(e.g. brushing/flossing teeth three times a day)

.....
.....
.....

Now make a list of some of your behaviour that you would consider to be "unhealthy"
(e.g. smoking; not getting enough leisure or relaxation)

.....
.....
.....

Do you hold any inconsistent behaviours?
(e.g. eating a healthy, calorie controlled diet but not taking any exercise)

.....
.....
.....

Which behaviour has changed over time, and why
(e.g. did you smoke when you were a teenager, or drink more alcohol than you do now? Have you recently started exercising regularly?)

.....
.....
.....

Behaviour that has changed	**Reason for change**
.....	.....
.....	.....
.....	.....

Unit 2: Lifestyle Behaviours and Personal Responsibility for Health

Lesson 2: Student Health Behaviour

Duration: 1 Hour

PPT Title – Unit 2 Lesson 2:
Student Health Behaviour

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 2

In this Lesson we are going to focus on health behaviours in student populations and you will be provided with recommended reading and guided questions.

Recap Unit 2 Lesson 1
Can you remember what was covered in Lesson 1?

In Lesson 1 we explored health behaviours. We looked at what is meant by the term health behaviour and we focused on the various influences on our health behaviours. We examined the relationship between health behaviour and poor health.

Health Behaviours among Student Populations

Research indicates that undergraduate student's lifestyle practices are not always optimal and raising awareness about healthy lifestyle behaviour is important at undergraduate level (Mazurek Melnyk et al., 2016).

Read this quote, it is a response from a university student to research on the smoking ban in public places in the USA. What conflicting health messages are evident?

"When you're drunk in a bar, you want to smoke constantly. When you have to go outside to smoke you won't smoke as much". (Berg et al., 2011)

First year university students are known to gain weight due to poor eating habits and lack of exercise (Gropper et al., 2012). This causes concern because obesity, poor dietary habits and physical inactivity are risk factors for cardiovascular disease, cancer and diabetes (World Health Organisation, 2006).

Pause for Reflection and Discussion

- **Think about your diet and exercise patterns**
- **Do you eat a healthy balanced diet?**
- **Do you exercise regularly?**

Another lifestyle risk for university students is that they can suffer from high stress levels, (Ferrara, 2009) and from increased incidence of depression and anxiety (Eisenberg et al., 2012).

Most people at some point or other feel worried, stressed or even down about things that are going on in their lives. Difficult experiences in life, of whatever sort, can have an impact on our mental health.

We all go through tough times. When we do, little things can make a big difference to how we feel and how we cope with life's ups and downs.

Just like we all have physical health, we also all have mental health. Our mental health operates along a scale from feeling well to feeling unwell. Every day, we experience these ups and downs.

The following website may be a useful resource to learn more about how to mind your mental health but will also provide information on what do to if you or someone you care about needs more support: www.yourmentalhealth.ie/

Pause for Reflection and Discussion

- **Think about your psychological health.**
- **Can you think of positive ways in which students can promote psychological health?**

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Activity 2.2: Reference Papers
Choose any one of the papers referenced here.
Read the paper and consider the questions listed below.

Key Reading

1. Lovell, G., Sharman, R., & Lane, B. (2015) "A cross-sectional investigation of depressive, anxiety, and stress symptoms and health-behaviour participation in Australian university students", *Nursing and Health Sciences,* 17, pp. 134–142.
2. Montauti, S.B., & Bulmer, S.M. (2014) "A Research Update on Correlates of Heavy Episodic Drinking Among Undergraduate College Students", *American Journal of Health Education, 45*(3), pp. 142-150.
3. Morrell, H., Cohen, L., & Dempsey, J.P. (2008) "Smoking Prevalence and Awareness Among Undergraduate and Health Care Students", The *American Journal on Addictions,* 17, pp. 181–186.
4. Berg, C.J., Lessard, L., Parelkar, P.P., Thrasher, J., Kegler, M.C., Escoffery, C., Goldade, K., & Ahluwalia, J.S. (2011) "College student reactions to smoking bans in public, on campus and at home", *Health education research, 26*(1), pp. 106-18.

- **What are the key messages from the paper you have read?**
- **In your experience, is this a true reflection of the lifestyle practices mentioned?**
- **Can you think of ways to improve student health behaviours?**

Summary

In this Lesson we talked about health behaviours among student populations and looked at some of the literature on the topic. In the next Lesson we are going to talk about changing personal health behaviours.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

These papers are examples and my be substituted with other programme specific material

Unit 2: Lifestyle Behaviours and Personal Responsibility for Health

Lesson 3: Behaviour Change

Duration: 1 Hour

PPT Title – Unit 2 Lesson 3:
Behaviour Change

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 3

In this Lesson we are going to talk about changing health behaviours. You will be asked to complete an activity on a personal health behaviour you would like to change and we will address some of the challenges of behaviour change.

Recap of Unit 2 Lessons 1 and 2
Can you remember what was covered in previous Lessons?

In previous Lessons we looked at behaviour change, factors which influence our health behaviour and the health behaviours of student groups.

Changing Behaviours

The main reason why someone might want to change a behaviour is because, on balance, that behaviour has a negative value to them.

Our society, on the whole, assumes that to adopt health promoting or healthy behaviour is 'better' than persisting with unhealthy behaviour. One of the key principles related to *Health Promotion for Chronic Disease Prevention* is that lifestyle change is considered to be the best way to prevent the onset of chronic disease.

Health behaviours can be classified into 2 types

1. Those that **impair health** (e.g. smoking, eating a high fat diet, excessive binge drinking, unsafe sexual practices, sedentary lifestyle).
2. Those that **protect and promote** health (not smoking, having regular health and screening checks, regular dental checks and necessary repairs, eating a balanced diet, regularly taking the recommended amount of exercise, drinking alcohol within low risk drinking guidelines, and so on).

Unit 2 Lesson 3 Activity 2.3:
Decisional Balance

Think of a health behaviour that you would like to change and complete the Decisional Balance Personal Health Behaviour Activity accompanying Unit 2

Reasons to stay the same (Resistance/Barriers)	Reasons to change (Motivation)
List the positives of staying the same?	**List the negatives of staying the same?**

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Changing behaviours can be challenging yet it is a central aspect of health promotion for chronic disease prevention.

Health Behaviours
People practice health behaviours for a variety of reasons. Some behaviours are adhered to because they *promote or benefit* health e.g. getting enough sleep and always eating breakfast; other behaviours are practised to *avoid health risks,* for example not smoking cigarettes and keeping your weight within recommended healthy limits; other habits maintain good health, such as having regular dental check-ups and engaging in regular exercise.

People may of course practice apparently inconsistent health behaviours. For instance, someone may eat a high fat diet because they don't want to offend the person who is preparing their food and yet take regular exercise to compensate and may also be a committed non-smoker.

Similarly, behaviour may change over time as people's life circumstances change.

So why do we behave the way we do?

People acquire healthy and unhealthy behaviours through learning processes, either by direct experience or through observing the behaviour of others. If the behaviour becomes well established it tends to become habitual - that is the patient often performs it automatically or without awareness.

Think of the smoker who, despite having a heavy cold and bronchial cough, reaches automatically for the packet of cigarettes to light up after lunch.

Think of the woman on a diet who automatically eats the leftovers from her children's plates without considering that these add to her calorie intake. Changing behaviour implies learning new habits to replace those that have become established practice.

Changing health behaviours is not an easy task. It is difficult to change your own behaviours and the power point presentation Changing Behaviours will remind you of the difficulties attached to changing a given behaviour. You can begin to imagine the challenges involved in encouraging somebody else to change a given health behaviour.

Summary

In this Unit we explored the topic of behaviour change and some of the reasons why a patient would want to change a health behaviour. You were asked to think about changing a personal health behaviour and we addressed some of the challenges of behaviour change.

In Lesson 4 we are going to look at some of the theories that have been written to help explain behaviour change and how behaviour change occurs.

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See PPP Unit 2 Lesson 3 Changing Behaviours

Unit 2: Lifestyle Behaviours and Personal Responsibility for Health

Lesson 4: Theories of behaviour change

Duration: 1 Hour

PPT Title – Unit 2 Lesson 4:
Theories of Behaviour Change

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 4

In this Lesson we are going to talk about the theories that have been written to help explain behaviour change and how behaviour change occurs.

Recap Unit 2 Lessons 1-3

Can you remember what was covered in Lessons 1-3?

In previous Lessons we looked at health behaviour, influences of health behaviour, student health behaviours and the challenges of changing behaviours.

Theories of Behaviour Change

Why are Behaviour Change Models Important?

Behaviour change models help to understand why people behave the way that they do so that they can be encouraged and supported to make and maintain healthy lifestyle choices.

Behaviour change can be very complex, particularly encouraging individuals to adopt healthy behaviours.

Behaviour change models can make it easier to understand the process of health behaviour change. Many models and theories have been developed to understand and explain the influences on health related behaviours.

We will explore the following models:

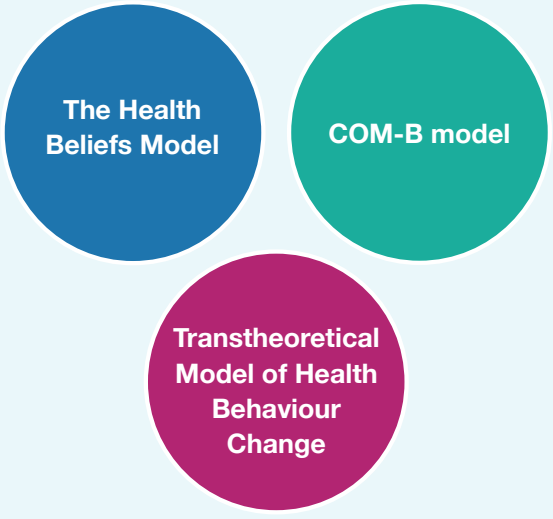

Figure 2.3: Models of Behaviour Change

We will begin with the Trans-Theoretical Model of Health Behaviour Change

1. The Trans-Theoretical Model of Health Behaviour Change

The Trans-Theoretical Model of health behaviour change is also known as the cycle of change and was developed by Prochaska and Di Clemente. The model posits that HBC takes place over a series of stages and that interventions should reflect this (Prochaska & DiClemente, 1992).

Prochaska theorised that people have different levels of motivation and readiness to act on a health behaviour and therefore therapeutic interventions should be stage matched; it can also be used to guide the individual through the various stages (Prochaska & Velicer, 1997).

The five stages of change are:

- Pre-contemplation: Patient feels that current health behaviour is not a problem and is therefore not considering change.
- Contemplation: Patient is thinking about making a HBC but is ambivalent about doing so.
- Preparation: Patient is ready to change their health behaviour and is starting to make plans on how to do this.
- Action: Patient is actively working at making health behaviour changes.
- Maintenance: Patient is focussing on maintaining the health behaviour changes they have made.
- Another important stage that sits outside the stages of change model is Relapse, where a patient has regressed into old health behaviours.

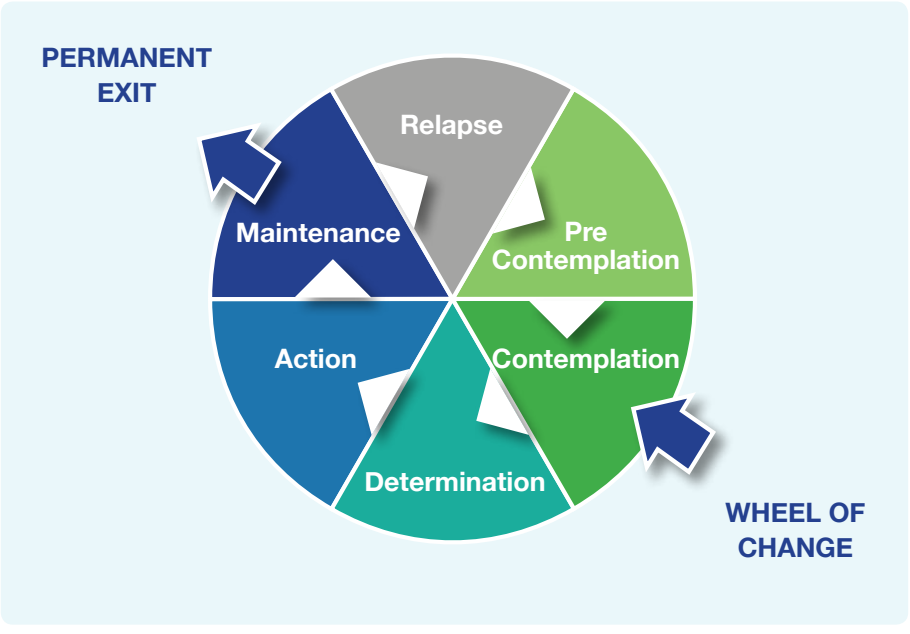

Figure 2.4: Stages of Change (Prochaska & DiClemente, 1992)

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Noted that some of the models referreed to are dated however it has been agreed to include them as an umbrella to encourage broad understading of all as they are still evident and in use.

- **Can you recall any health behaviour that you have changed or thought about changing?**
- **Can you relate to any of the stages mentioned here?**

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The core construct proposed by Prochaska's theory reflects the individual's relative weighing of the pros and cons of change (Prochaska & Velicer, 1997). In the early stages the cons of changing outweigh the pros, as one progresses through the cycle the cons are decreasing and are surpassed by the pros and in the final stages the pros outweigh the cons. Evidence has shown that when health programmes or services are 'stage-matched' to suit the individuals they have more success in recruitment, retention and progress in smoking cessation, the model has also been applied to treatment of addictive behaviours with success, however patients with addictive behaviour often recycle through the process a number of times before they exit (Prochaska & DiClemente, 1992, p. 149; Prochaska et al., 1993; Prochaska & Velicer, 1997).

Next we will look at the Health Belief Model

2. The Health Belief Model

The Health Belief Model proposes that to change behaviour in relation to their health, people need to have a signal or prompt to take action (Naidoo & Wills, 2016). This model highlights the role of beliefs in decision-making. It suggests that whether or not people change their behaviour will be influenced by an individual assessing the feasibility of making the change, the benefits of adopting the change versus the cost (social, monetary, effort etc.).

The Health Belief model postulates that people make considered judgements about the value of the behaviour to them; the relative strength in which they perceive the threats of continuing the behaviour; the perceived seriousness of the health problem and their perceived susceptibility of succumbing to it.

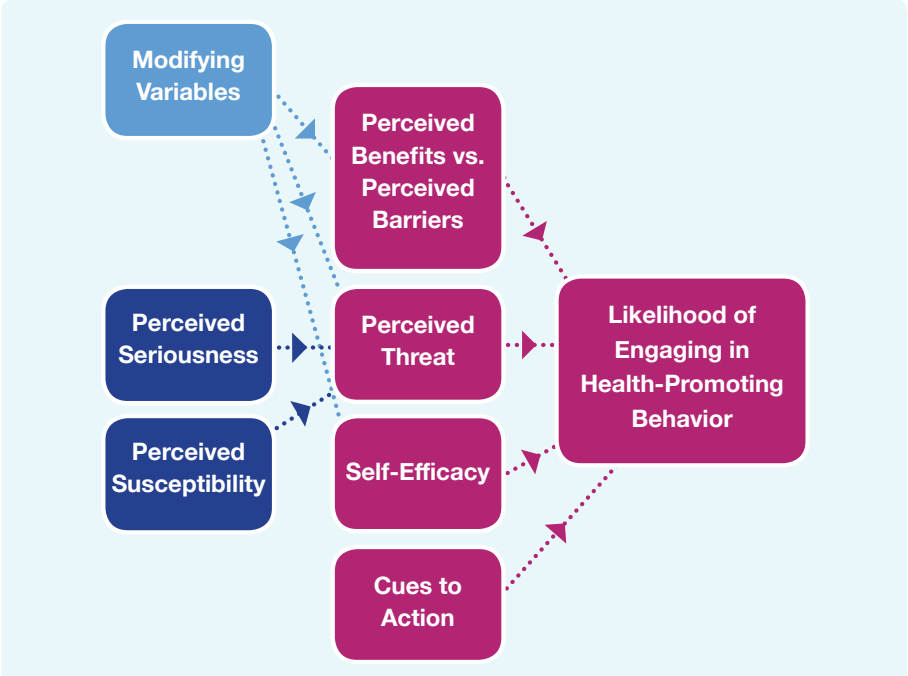

Figure 2.5: The Health Belief Model (Becker, 1974)

The Health Belief Model further postulates that in weighing up the balance of likelihood (the pros and cons) of contracting a health problem, people arrive at a decision as to whether the perceived benefits of changing behaviour outweigh the perceived barriers or costs of changing.

For example, the perceived barriers to taking regular exercise might include:

"It will cost me a lot of money to join a gym";

"I don't look good in shorts, everyone else will look really trim and healthy";

"I haven't got the time"; "I don't want to turn into a fitness freak",

"I'm too old to start exercising – the gym will be full of youngsters".

The outcome of weighing the perceived barriers against the perceived benefits will determine whether or not the patient embarks on an exercise regime!

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The next model that we are going to look at is the COM-B Model

3. COM-B Model (Michie et al., 2011)

When discussing behaviour change frameworks, Michie et al. (2011) suggest that "none are comprehensive and conceptually coherent". While distinction is often made between population-level and individual-level interventions this is not always practical, for example, a national smoking cessation programme run through GP clinics could be viewed as a population programme, however the advice and support is provided to the individual during their GP appointment in the clinic, so it could also be considered an individual-level approach (Michie et al., 2011); "In order to choose the interventions likely to be most effective, it makes sense to start with a model of behaviour" (Michie et al., 2011, p. 3). The behaviour change wheel has been developed with the aim of overcoming the limitations of former models and frameworks of behaviour change. The benefits of this framework are that is has been derived "from classifications already available and therefore covering concepts that have previously been considered to be important, and using an over-arching model of behaviour to link interventions to potential behavioural targets" (Michie et al., 2011, p. 7).

In developing the Behaviour Change Wheel authors sought to develop a "systematic method that incorporates an understanding of the nature of the behaviour to be changed, and an appropriate system for characterising interventions and their components that can make use of this understanding" (Michie et al., 2011, p. 2).

Michie et al. (2011) explain the 'COM-B' system, the central component of the behaviour change wheel, as follows:

Capability, opportunity and motivation interact to generate behaviour that in turn influences these components. The COM-B element helps to understand the behavioural issue to be addressed. For example, in the case of overweight children of school age, capability might identify a lack of understanding among parents and teachers on portion sizes and an inability to read food labels correctly. Motivation in this case could refer to lack of confidence or perceived need by parents and teachers to make changes to portions or food purchases and the influence of pester power from children. The final element in the behavioural analysis is Opportunity. In this example it might be a perceived lack of time to look at labels and correctly divide portions was an issue as well as support from other children and adults in the family or classroom.

The COM-B system: Behaviour occurs as an interaction between three necessary conditions

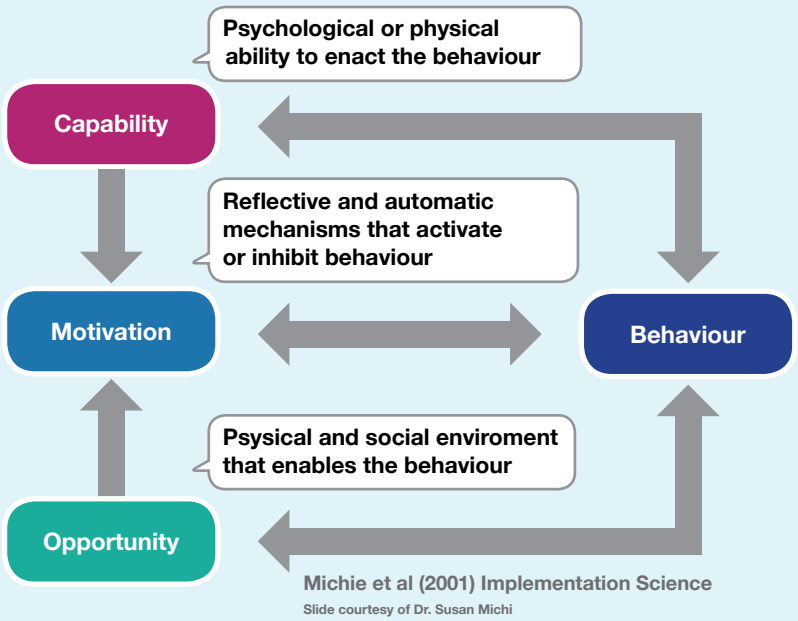

Figure 2.6: The COM-B System (Michie et al., 2011)

Here is some recommended reading and a short video to help explain the COM-B Model

Key Reading

Michie, S., M Van Stralen, M., and West, R. (2011) 'The behaviour change wheel: A new method for characterising and designing behaviour change interventions', *Implementation Science, 6*(1), p. 42

Sinnott, C., Mercer, S., Payne, R., Duerden, M., Bradley, C., and Byrne, M. (2015) 'Improving medication management in multimorbidity: development of the Multimorbidity Collaborative Medication Review and Decision Making (MY COMRADE) intervention using the Behaviour Change Wheel', *Implementation Science,* 10, p. 132.

The Behaviour Change Wheel.

Professor Susan Michie, behaviour change expert at UCL provides an insight into her theories and her unique approach to behaviour change. GACDmedia.

Published on 26 Nov 2013

https://www.youtube.com/watch?v=XKwLplsPapc

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Healthcare Students as Health Promoters

In Unit 1 we talked about the key health recommendations and the importance of promoting health and healthy behaviours. Everyone who works as a healthcare professional (HCP) is involved in the promotion and improvement of the health and well-being of individuals/patients. As you study to become a HCP it is important to reflect on what health promotion means to you and to reflect on your role as heath promoter.

- **Think for a moment about the following:**
- **As a healthcare student, what role in health promotion do you play?**
- **What skills do you think are needed to promote health in others?**
- **Can you think of a time when you have promoted health in others?**

Some argue that to effectively promote health in others you should lead a healthy lifestyle. Ideally, HCPs should lead a healthy lifestyle as they are perceived to be role models for individuals and communities (Alpar et al., 2008; Staib et al., 2006). For example, the lifestyle practices of HCPs could sway whether or not they broach lifestyle conversations with patients. Lock et al. (2002) found an apparent reluctance among HCPs to address alcohol consumption with their patients due to their own use and enjoyment of alcohol (Lock et al., 2002). Equally, personal health practices can influence counselling skills effectiveness (Alpar et al., 2008).

Do you agree with these statements?

Adopting healthy lifestyle behaviours as students could positively influence how you approach health promotion and your future professional practice as a health promoter. However, some of the research on this topic demonstrates suboptimal lifestyle practices among healthcare student groups, for example, medical students' alcohol intake was found to be relatively high despite potentially greater knowledge of the harms and risks associated with it (Davoren et al., 2015; Newbury-Birch et al., 2000). Irish evidence has found that 65% of medical students reported hazardous drinking, the second highest student group in that study. A UK study found just under half of medical students studied reported high risk and hazardous drinking levels and 27% reported binge drinking (Davoren et al., 2015; Newbury-Birch et al., 2000). Also in the UK, Pre-registration nurses were found to have relatively poor health practicing behaviours (Blake et al., 2011). As future HCPs and health advocates, especially in areas such as alcohol and drug use. It would be concerning if these behaviours were to continue given that they may become obstacles to effective health promotion. These are examples of poor health behaviour practices, there are numerous health promoting and healthy lifestyle behaviours that student groups participate in. Are you aware of any initiatives which promote health within your college?

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Activity 2.4: Group Discussion

In groups, decide on a health promotion topic that you consider to be an important area for student groups. How do you think that, as a healthcare student, you could successfully promote this health promotion topic among your peers? Feedback to the rest of the group

GUIDANCE NOTES FOR FACILITATORS

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Summary

In this Lesson we looked at some theories that have been written to help explain behaviour change and how behaviour change occurs; focusing on the Trans-Theoretical Model of Health Behaviour Change, The Health Belief Model and the COM-B model. We addressed the role of the student as health promoter. In the next Unit Communication for Healthy Lifestyles and Health Behaviour Change we will explore the communication skills you need to effectively talk to others about health and health behaviour change.

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Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Duration: 6 Hours
Recommended Programme Placement: Year 2
Lesson Plan

Unit 3 **Learning Outcomes**	3.1 Analyse the principles of interpersonal communication for health behaviour change (HBC) 3.2 Adopt a person-centred approach to communicating for HBC 3.3 Communicate in a supportive, non-directive manner with patients for HBC 3.4 Demonstrate effective communication skills in the context of health conversations with patients 3.5 Demonstrate the core elements of communication in practice for HBC 3.6 Identify opportunities to integrate Making Every Contact Count into everyday consultations so that you can carry out brief interventions 3.7 Demonstrate an understanding of raising the issue of healthy eating, alcohol and drug use, physical activity and tobacco in routine and regular conversations with patients 3.8 Observe and reflect on video footage of healthcare professionals interacting with patients in a variety of scenarios	
Lesson 1 **Communication Skills for Brief Intervention** **1 Hour**	• Introduction to Unit 3 • Brief Recap Units 1 and 2 • Introduction to Lesson 1 • Talking about health and the skills needed for health conversations. • Communication skills necessary for health conversations • Active listening and open questioning	**Activity** 3.1 Active Listening 3.2 Open Questioning
Lesson 2 **Communicating for Health Behaviour Change** **1 Hour**	• Introduction to Lesson 2 • Brief Recap Unit 3 Lesson 1 • Communicating for assessment and motivation to change • Brief Intervention (BI) based scenarios	3.3 Patient Healthcare Professional (HCP) Interaction Scenarios
Lesson 3 **Interacting for Behaviour Change** **1 Hour**	• Introduction to Lesson 3 • Brief Recap Unit 3 Lesson 1 and 2 • Videos demonstrating patient and healthcare provider interactions in the context of motivational interviewing (MI) • Critique communications skills used by the healthcare professional in the video using a framework for critical appraisal provided	3.4 Video Critique

Lesson 4 and 5 **eLearning *Making Every Contact Count*** **3 Hours**	Six online modules Module 1: Introduction to Behaviour Change Module 2: Alcohol and Drug Use Module 3: Healthy Food for Life Module 4: Tobacco Free Ireland Module 5: Get Ireland Active Module 6: Skills into Practice Module Available at: URL Link to HSEMECC Microsite	
Core Reading	Rollnick, S., Mason, P., & Butler, C. (1999). Health Behavior Change: A Guide for Practitioners (1st ed.). London: Churchill Livingstone.	
Accompanying Slide Pack for Unit 3	www.hse.ie/mecc-undergradcurriculum	

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

GUIDANCE NOTES FOR FACILITATORS

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Making Every Contact Count

Making Every Contact Count is a programme being implemented within the HSE to support the prevention of chronic disease by promoting lifestyle behaviour change. The health behaviours which are the focus of this programme are the four main lifestyle risk factors for chronic disease; tobacco use; physical inactivity; alcohol and drug use and unhealthy eating.

Making Every Contact Count is about healthcare professionals (HCPs) using their routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change. To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. This approach will allow HCPs to move to a position where discussion of lifestyle behaviour is routine, non-judgemental and central to everyone's role.

As a healthcare student and future HCP you will be asked to make each routine contact that you have with patients count in terms of chronic disease prevention.

Lesson 1: Communication Skills for Brief Intervention

Introduction to Unit 3

In this Unit you will be introduced to the concept of communication with a focus on talking about health, promoting healthy lifestyle behaviour and health behaviour change (HBC).

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Lesson 1: Communication skills for Brief Intervention

Duration: 1 Hour

PPT Title – Unit 3 Lesson 1:
Communication Skills for Brief Intervention

GUIDANCE NOTES FOR FACILITATORS

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Introduction to Lesson 1

In this Lesson you will learn about the communications skills that you will need as a HCP to effectively communicate with patients about Health behaviour changes (HBCs). You will spend time learning and experiencing active listening skills as well as learning how to 'ask the right questions'. These skills will form the basis of conducting Brief Interventions (BI) and Motivational Interviewing (MI) which will be discussed further in Lessons 2 and 3 and in depth in Unit 4.

Recap Unit 1 and 2

Can you remember what was covered in Units 1 and 2 ?

In Unit 1 *Health and Personal Wellness,* you were introduced to the topic of health and to the *Healthy Ireland Framework* and we explored various definitions of health. We discussed the biopsychosocial model of health where you were asked to think about your own personal health and to self-rate your physical, social and psychological health. We explored how these elements are inter-related.

We also looked at some statistics from the Irish Health Surveys (2015, 2016 and 2017) (Central Statistics Office, 2016) and discussed how these have changed since the *SLÁN* (2007) Survey (Department of Health and Children, 2009).

In **Unit 1** you were also briefly introduced to the topic of lifestyle influences on health behaviours and health. You self-rated your perceived health risk for diet, tobacco, physical activity and alcohol. The key health messages were presented, which are important messages for you to know personally and in your role as health promoter.

In **Unit 2** *Lifestyle Behaviours and Personal Responsibility for Health* you explored health behaviours with a specific focus on the health behaviour practices of student groups. You were introduced to the topic of HBC and you were asked to think about a personal health behaviour that you would like to change.

We examined some of the theories of behaviour change namely: The Trans-Theoretical Model of Behaviour Change, the Health Belief Model and the COM-B Model. The role of the healthcare student as health promoter was introduced.

Let's talk about "talking about health"

Effectively communicating with the patient about HBC in ways that are empowering and sensitive to the patient's needs is one of the core principles of person-centred care. Communication is a key element in promoting healthy lifestyle behaviour.

Pause for Reflection and Discussion

- **What are the things you currently engage in to ensure a healthy lifestyle?**
- **What might you like to change?**
- **How do you feel when people talk to you about your health?**
- **When your family members or friends ask you about your lifestyle behaviours?**
- **Do you get defensive because you think they are interfering? or**
- **Do you feel that they only ask because they care?**
- **Do you think that they are nagging and not concerned?**
- **Does the conversation ever end in conflict?**

Consider the magnitude of illnesses, chronic diseases and risk factors for ill health that HCPs have to address with their patients. Now imagine that you are a patient and a HCP wants to talk about HBC. Talking about communication is important when it comes to HBC because talking about health and lifestyle behaviours can be a sensitive issue. Here is an example of some elements which help to make a "health conversation" successful. Can you think of anymore?

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Figure 3.1 Key Elements for Communicating about Health

Engaging with people using the key elements outlined in Figure 3.1 allows for improved communication and the development of open and respectful professional relationships.

(A) Being *Person-centred* enables honest conversation to take place between the HCP and the patient about their lifestyle behaviour in a way that is supportive and empowering for the patient and respectful of their circumstances. It also allows the patient to hear the health messages and can motivate them to take small steps towards actions that will impact positively on their health.

(B) Showing *Empathy* towards the patient helps the HCP to understand and feel the emotions of the patient. This can help them understand the complexities of lifestyle behaviour change for the patient.

(C) Being conscious and avoiding *judging* others based on your own standards will help health conversations to be more open and effective. It is important to make a conscious effort not to be critical of the actions or thoughts of others.

(D) Support and Self-efficacy: Communicating effectively will support the patient to help themselves by building their confidence in their ability to change their own health behaviour and also to direct them to supports available if they wish.

- **Can you think of any challenges HCPs encounter when communicating with patients for HBC?**
- **What skills do you think are needed to communicate effectively for HBC?**
- **What factors promote and impede conversations about HBC between patients and HCPs?**

GUIDANCE NOTES FOR FACILITATORS

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Patient-Centred Approach

(A) A patient-centred approach to communicating for HBC may improve interactions between patients and HCPs. With this approach, patients are provided with opportunity to identify and actively plan to resolve health behaviour risks. Person- centred care recognises the importance of individuals having a partnership role with healthcare professionals in managing their health (Furze, 2015).

Please see the WHO video on Person-centred care: https://www.youtube.com/watch?v=pj-AvTOdk2Q

To achieve a Person-Centred approach to HBC the following communication skills are required:

Figure 3.2: Person Centred Approach to HBC, adapted from Rollnick et al. (1999)

(a) Use of Reflective listening focuses on the emotional overtones of a message (looking for relationship between content and emotional aspect of the message).

- Consciously **pick up on some key words/phrases the patient used** and introduce them into your own side of conversation
  - E.g. 'It sounds as though you are feeling guilty because you started drinking again'
  - 'You sound really frustrated because you haven't lost as much weight as you hoped'

(b) Clarifying and Summarising: every so often sum up in a few succinct sentences what has been discussed. Summaries can help to bring focus to a session (drawing the strands together)

- E.g. 'Before moving on I would like to go over with you what I think we have accomplished so far…'

Clarification: seeking to understand the message by asking for more information

- E.g. "I'm not sure I understand what you mean; can you give me an example?"
- "You stated earlier that you were concerned about your blood pressure. Can you tell me more about what concerns you?"

GUIDANCE NOTES FOR FACILITATORS

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(c) Verbal and Non-verbal prompts: Listening involves not only **hearing** but also understanding **linguistic, paralinguistic (e.g. tone of voice)** and non-verbal aspects of the message (remember non-verbal makes up most of an interaction). You need to be sincerely **attentive** and find ways to demonstrate that you have taken in what has been said to you and show that you value the speaker and their opinion e.g. nod of the head, sitting forward and interested.

(d) Asking simple open-ended questions

Questions should be kept simple and encourage the patient to tell more of their story rather than elicit yes/no responses. This is discussed in more detail below.

GUIDANCE NOTES FOR FACILITATORS

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Listening Skills used in Communicating and Promoting Healthy Lifestyles

Why are active listening skills important?

A person-centred approach for HBC involves active listening. HPCs must listen to their patients and understand their readiness to change, the importance of change to them and their confidence in their ability to change.

- Listening is fundamental to healthcare communication. Think about what it means to listen actively. Enabling someone to talk about a problem or concern is known as engaging and relational listening.
- We need to also think about what obstacles people must overcome to listen well (Duck & McMahan, 2015).

- **Think of a time you really felt listened to?**
- **How did you feel? How did you react?**
- **How did you know the person was actively listening to you?**
- **Think of a time you didn't feel listened to?**
- **How did you feel? How did you react?**
- **How did you know the person wasn't listening to you?**

Take notes on flip charts to facilitate discussion.

One of the key aspects of active listening is understanding what it is that the patient is saying. The only way to ensure this is to confirm with the patient. It is important that words are not just repeated back to the patient. It is necessary to seek clarifications. To do this HCPs must summarise what the patient has said or to ask questions to gain clarity.

When you ask a patient a question, you need to actively listen to the response

Figure 3.3: Active Listening

Becoming an Active Listener

- Often you, 'the listener', is frequently pausing merely awaiting the opportunity to speak again.
- Active listening means more than simply being there and letting peoples' words reach you.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Figure 3.4: Active Attentive Listening

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Listening and Self-Awareness

Listening is strongly linked to the concept of self-awareness - listening to oneself, to others and self-disclosure

- **Listening to oneself** and being aware of one's own thoughts and feelings, posture and actions is vital in improving the skill of listening to others.
- **Listening to others** = detaining one's own autobiography (avoiding the temptation of relating the patients story back to your own story).
- Eliminate internal sources of distraction and concentrate on the patient.
- Increased awareness of own values, beliefs, feelings and prejudices will enhance active listening and focus on the patient and his/her needs, however we must be able to regulate our own emotional state so we can focus on the patient.

Paraphrasing: helps the patient elaborate more on cognitive aspects (content) of message:

- Involves repeating back to patient in **your own words** what they have told you (i.e. you take the patient's original message and transform it into your own words without losing the meaning of the message). This demonstrates you have been listening and prevents misinterpretation of information.

Figure 3.5: Paraphrasing

Activity 3.1: Active Listening

Practice the skill of active listening in pairs. Talk about what you did last weekend. You cannot interrupt each other, just ask questions to clarify and then feedback each other's story to gain confirmation that you have heard correctly.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Asking the Right Questions

Now that you have spent some time listening we are going to discuss "talking" and the type of questions to use in the promotion of HBC.

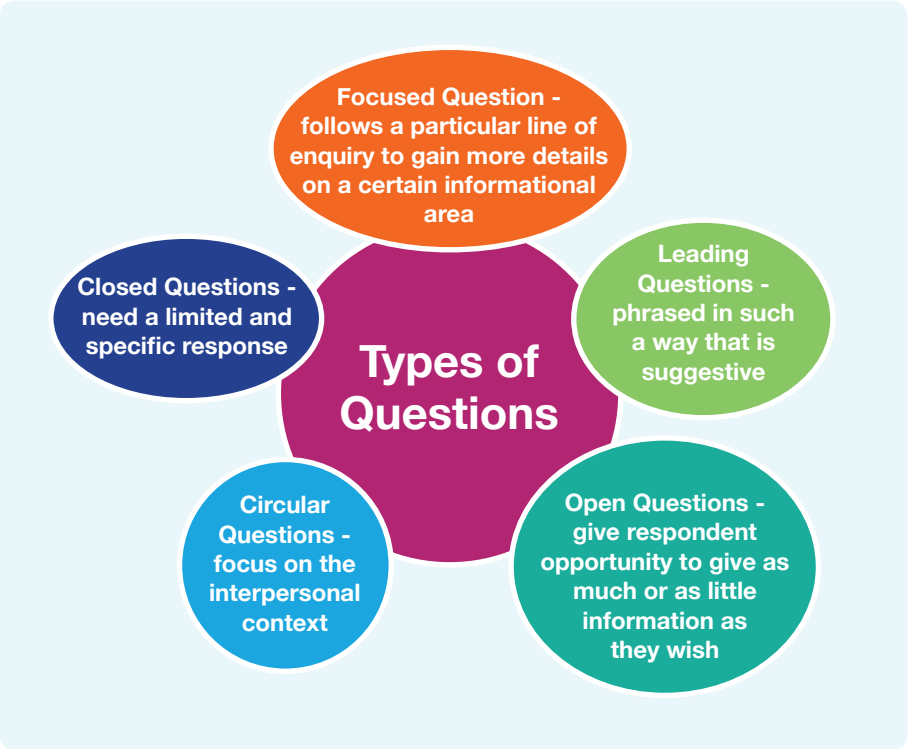

Figure 3.6: Types of Questions

Examples of Types of Questioning

- **Focused Question** – Tell me the ways in which you find quitting difficult?
- **Leading Questions** – I guess you must find quitting difficult?
- **Open Questions** – Tell me about how it was for you to stop smoking?
- **Circular Questions** – The last time you quit, what was most helpful?
- **Closed Questions** – Was it difficult when you stopped smoking before?

Combining Open and Closed Questions

- The best option in HCP-patient communication is to use a **combination of open and closed questions.**
- Use open questions at the outset of an interaction to explore the patient's perspective /obtain broad information. It is best to follow up with prompts, paraphrasing, repeating and closed questions to clarify points and elicit more specific information.
- Using a combination encourages patients to talk, demonstrates the HCPs interest in listening to what the patient has to say and enables the HCP gather specific information needed – as a result the patient feels valued and cared for as an individual.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Examples of useful questions

Can you tell me a little about…..?

How can I help you with…..?

Help me understand…..?

How would you like things to be different…..?

What are the good things about…..?

What are the not so good things about…..?

When would you be most likely to…..?

What do you think you will lose if you give up…..?

What have you previously tried to change…..?

What do you want to do next…..?

Activity 3.2: Open ended questions

"Asking open ended questions is very important when it comes to talking about health and HBC."

"Work in pairs, pick a health topic that you both agree to discuss. Each person is to ask the other five open-ended questions about that topic."

- **Did you find it difficult to ask open questions?**
- **If so, what was difficult about it?**
- **What kind of open questions did you ask?**

Summary

In this Lesson we discussed the importance of "talking about health conversations". To help individuals achieve HBC you must develop a particular set of communication skills. We looked at the importance of active listening and asking the right questions for HBC. In the next Lesson we are going to introduce the topics of Brief Intervention (BI) and Motivational interviewing (MI).

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Take notes on flip charts to facilitate discussion.

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Lesson 2: Communicating for Health Behaviour Change

Duration: 1 Hour

PPT Title – Unit 3 Lesson 2:
Communicating for Health Behaviour Change

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lesson 2

In this Lesson you will gain an understanding of what a brief intervention (BI) is and how to conduct one. We will also discuss motivational interviewing (MI) and its key elements. Using the communication skills discussed in Lesson 1 we are going to explore some of the ways you may ask individuals about changing behaviours, known as the assessment of importance and confidence. You will have an opportunity to reflect on two scenarios and respond to the questions provided.

Recap Lesson 1

Can you remember what was covered in Lesson 1?

In Lesson 1 we discussed "talking about health". We explored some of the issues around having health conversations. We addressed the fact that talking about health can be a sensitive issue and that developing effective communication skills is fundamental to successful health conversations. We discussed how active listening and the use of open questions can be beneficial in supporting HCPs to have a person-centred discussion with their patient about health behaviour and lifestyle changes.

Effective communication skills are a necessity when it comes to providing a brief intervention.

Brief intervention (BI) involves opportunistic advice, discussion, negotiation or encouragement and can be delivered by a range of HCPs, typically within 3-10 minutes. BI may include one or more of the following:

- MI techniques
- An assessment of the individual's commitment to change
- Offer pharmacotherapy and/or behavioural support
- Self-help material and referral to more intensive support

BI has been shown to work, for example in smoking cessation. Intervention from HCPs has been shown repeatedly, in randomised controlled trials to increase the percentage of smokers who quit and remain abstinent for 6 months or more (Health Education Authority, 2000).

Further evidence shows that:

1. One in eight people will lower their alcohol consumption following a BI (Raistrick et al., 2006).
2. The evidence shows that a BI doubles a patient's chances of making a successful quit attempt (West et al., 2015).

Motivational Interviewing

There is a certain type of communication process associated with HBC which is called *motivational interviewing (MI)*. Here is a brief introduction to MI which will help you to understand the importance of developing specific skills necessary for communicating for HBC.

MI is a patient-centred behavioural change practice which elicits and reinforces a patient's intrinsic motivation to change behaviour.

MI is currently being used by a variety of HCPs to deliver improved outcomes across a range of settings, including primary health care (Anstiss, 2009). A review of MI intervention studies promoting health behaviours has shown that MI can have a positive effect on a range of health behaviours, including physical activity (Martins & McNeil, 2009). The process would be to support patients in becoming more active using MI which encourages, rather than directs, and strengthens patients' intrinsic motivation to change.

MI is defined as:

> ***" A collaborative, person-centred form of guiding to elicit and strengthen motivation for change" (Millner & Rollnick, 2010, p. 130).***

MI involves the use of:

1. The following key skills to carry out an effective intervention – Open-ended questions, Affirmations, Reflective listening and Summarising (Known by the acronym OARS).
2. In addition, a number of useful tools have been developed:
   a. Scaling questions exercise (0-10).
   b. Decisional balance.

We have already covered the skills for MI in Lesson 1 and we will look at some of the tools in this Lesson.

Scaling questions

We are now going to discuss the Assessment of Importance and Confidence:

Communication for HBC involves establishing the level of *importance and confidence* patients place on changing a given behaviour. Asking simple questions such as "how important is it for you to quit smoking if 0 is not important and 10 is very important" and "how confident are you that if you tried to stop you would succeed if 0 is not confident and 10 is very confident" (Rollnick et al., 1999).

When we start talking about HBC we must establish how motivated a patient is to change or their "readiness to change". Rollnick et al. (1999) suggest a simple assessment using a scale from 0-10. Once the patient responds to this assessment the HCP can then encourage the patient to verbalise their reasons for their responses.

If individuals are highly motivated to change they will most likely affirm this with self-motivating statements. Alternatively, if they only score 3-4 then the HCP could ask questions such as what a 4 means to the patient, and why a 4 and not a 3 (so they get a sense of where they are at in terms of readiness in a way that helps build their self-belief). MI is trying to build intrinsic motivation – so it is trying to build up and affirm a patient's own self efficacy.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

These tools are not core material but useful to explain behaviour and behaviour change. The skills are core material and essential to the lesson.

We need to explore patient readiness, willingness (importance), and ability (confidence).

A patient could be very willing to change and feel ready and yet may not feel very able to make the changes themselves – so we need to examine all of these to understand what a patient might need to help effect change here.

The HCP could also ask "what could make you move higher up the scale?" This may be a good opportunity to ask the patient to consider the pros and cons of change or the cost and benefits of change. Can you remember discussing this in Unit 2 when we talked about the theories of behaviour change?

These scales may be useful for you:

On a scale from 1-10 how important is it to you to change ..... (health behaviour)									
Not Important									**Very Important**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									
.....									
.....									
.....									
.....									

On a scale from 1-10 how confident are you about changing ..... (health behaviour)									
Not Important									**Very Important**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Jot down reasons for your rating.									
.....									
.....									
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Decisional balance

We have already used the decisional balance in Unit 2 in a reflective practice exercise when we explored the pros and cons of a change you would like to make yourself and also looked at the pros and cons of not changing. We will revisit this again in Unit 4 in more detail.

Effective communication - Recap

You will recall the figure below from the last Lesson on the important components of effective communication. It might be useful to consider this when looking at the two scenarios in the next exercise.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

These scales are teaching tools to help underrstand behaviour change and ambivalence and not recommended necessarily for use in practice and note that they are not used in video demonstration.

Figure 3.7: Key Elements for Communicating about Health

Let's look at two possible interactions in healthcare settings and reflect on how these scenarios address the communication skills that we have been talking about. We also ask that you group into pairs to carry out some role play.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Activity 3.3: Real Life Scenarios

Read the following two scenarios and respond to the prompts provided

Scenario 1

(A nurse and a patient are talking while the nurse is changing the patient's dressing, in a ward in an acute hospital setting. The patient is a suitable candidate for a BI, she has had minor surgery to her left hand).

Patient

I loved to go outside for a walk before, a few years ago. But I was a lot slimmer and fitter than I am now.

Nurse

Walking is a good way to get exercise. Do you ever go out for a walk anytime now?

Patient

Not really, but I loved the outdoors.

What do you think the nurse should say/ask next to use this opportunity to provide a brief intervention?

Pair up with another student, one acts the role of nurse and the other the patient, carry on with this conversation as an opportunity for brief intervention.

Scenario 2

(Patient is attending a follow up appointment with his GP after suffering a heart attack 10 days ago)

GP

How have you been feeling since your discharge from the hospital?

Patient

Not too bad I suppose no pain or anything. I think worry is the biggest problem at the moment, that I might have another heart attack.

GP

That's understandable, but the fact that you have no pain is a very positive sign and is what we would be hoping for at this stage. Is there anything else that is worrying you?

Patient

Well, I know in the hospital they told me that I shouldn't be smoking… I am trying, really hard and I was doing very well. But I slipped up and I smoked 2 cigarettes last Sunday night.

GP

Well it is very hard, and it sounds like you were doing quite well, stopping smoking is one of the most important things you can do for your heart at the moment because it is such a big risk factor for heart attacks.

Patient

I know…I'm very disappointed in myself.

GP

I know you are but a slip isn't unusual at this early stage. Have you smoked again since?

Patient

No

GP

Well that's good. Let's look at what we can do to make sure that you don't have another slip.

Patient

Thanks doctor, that sounds good.

Reflect on this interaction. Do you think that this was a positive conversation, give reasons for your response?

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Summary

Talking about health and encouraging HBC in others is a complex process. Developing effective communication skills to achieve HBC is key to success. The skills of active listening, asking open questions, assessing importance of change and motivation to change and carrying out these skills with non-judgemental attitudes, person-centeredness and respect are patterns that you will build on and develop over your career as HCPs.

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Lesson 3: Interacting for Behaviour Change

Duration: 1 Hour

PPT Title – Unit 3 Lesson 3:
Interacting for Behaviour Change

Introduction to Lesson 3

In this Lesson we are going to observe a range of videos focusing on the skills that you need to carry out "health conversations" with individuals. We will watch a number of healthcare interactions and you will critically evaluate the HCPs' communication skills.

Recap Lesson 1 and 2

Can you remember what was covered in Lessons 1 and 2?

In Lesson 1 we discussed "talking about health". We explored some of the issues around having health conversations. We addressed the fact that talking about health can be a sensitive issue and that developing effective communication skills is fundamental to successful health conversations. In Lesson 2 you were introduced to communication skills needed for MI.

In this Lesson you will watch a number of videos, and critique the communication skills displayed in the video.

Remember the interaction is going well if…

The patient is talking themselves toward an action plan and the HCP is asking simple questions and clarifying.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

How do you know when you are communicating correctly for HBC?

Indications of effective communication for HBC adapted from Rollnick et al. (1999, p. 34)

Figure 3.8: Communicating Effectively for HBC

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Activity 3.4: Video Critique

You will observe a range of videos and with a focus on the healthcare interactions you will critically evaluate the healthcare professional's communication skills in groups. What interpersonal communication skills did you observe? Look out for use of the communication skills you have discussed in this Unit.

Video Critique. View videos through the following link: www.hse.ie/mecc-undergradcurriculum

In groups, discuss the interactions that you have watched on the videos.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Please note: A printable version of this handout is available on Page 130 of the curriculum.

Did the healthcare professional demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide examples here
A. Use of Interpersonal Communication Skills		
Use of positive non-verbal communication Give examples		
Use of Reflective Listening Give examples		
Demonstrate empathy Give examples		
B. Encourage Dialogue		
Assess how important it is for the patient to change behaviour Give examples		
Assess how motivated the patient is to change behaviour Give examples		
Ask open-ended questions Give examples		

Provide opportunity for the patient to speak Give examples		
C. Adopt a patient-centred approach		
Use of appropriate vocabulary easily understood by the patient Give examples		
Provide information that was geared toward the patient's readiness to change Give examples		
Overall comments		

Summary

In this Lesson you were introduced to the communication skills necessary for HBC which you will continue to develop over the course of your healthcare programme and professional career. We discussed some of the elements involved in communicating effectively such as person-centeredness, non-judgemental attitudes, being respectful and supportive. We practiced the skills of active listening and asking open-ended questions.

In Unit 4 you will utilise these skills to practice the provision of BIs in preparation for *Making Every Contact Count* in your healthcare student role.

Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change

Lesson 4-5: Online eLearning for Making Every Contact Count

Duration: 3 Hours

PPT Title – Unit 3 Lesson 4-5:
Online eLearning for *Making Every Contact Count*

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Introduction to Lessons 4-5

This Lesson consists of six eLearning modules. These eLearning modules will cover the basics of health behaviour change (HBC) as well as information on four different risk areas and a skills practice module. This eLearning training was developed through collaboration between the HSE, Higher Education Institutions (HEIs) and subject matter experts in the fields of HBC and experts in the health policy areas of healthy eating, physical activity, tobacco and alcohol and drug use. This eLearning course can be assessed online at: www.makingeverycontactcount.ie

Recap Lesson 1-3

Can you remember what was covered in Lesson 1-3?

In Lesson 1 we discussed “talking about health”. We explored some of the challanges around having health conversations. We addressed the fact that talking about health can be a sensitive issue and that developing effective communication skills is fundamental to successful health conversations.

In Lesson 2 you were introduced to the communication skills needed for successful health conversations with patients. The importance of person centred communication was discussed highlighting the use of active attentive listening and asking open-ended questions to develop open and honest dialogue with patients.

You learned about BIs and MI. You also worked through various video scenarios that you might encounter in your work as a HCP.

Making Every Contact Count - eLearning Modules

Duration: Approx. 25 Minutes per Module

The eLearning course consists of six modules in total. Modules 1 and 6 are core eLearning modules and form the basis of all successful health conversations with patients and are key in the study of HBC. The content of these core modules is transferrable to all interventions, irrespective of the risk factor area. Modules 2-5 are eLearning knowledge modules on *the Key Lifestyle Behaviours important to Chronic Disease Prevention and Management* and are designed to give you basic information on each policy area to support you in discussing lifestyle choices.

Module 1: Core Learning: Introduction to Behaviour Change

Module 2: eLearning Knowledge Module: Alcohol and Drug Use

Module 3: eLearning Knowledge Module: Healthy Food for Life

Module 4: eLearning Knowledge Module: Tobacco Free Ireland

Module 5: eLearning Knowledge Module: Get Ireland Active

Module 6: Core Learning: Skills to Practice Module

There is an online assessment on completion of the six modules in the eLearning course and a certificate of completion will be issued when you have completed all modules.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Module 1: Introduction to Behaviour Change

Duration: Approx. 25 minutes

Aim

The aim of this module is to increase your knowledge of HBC and to develop your confidence in carrying out a BI with patients.

By completing this module we will help develop your skills to enable you to:

- Identify opportunities to integrate *Making Every Contact Count* into everyday consultations so that you can carry out brief interventions.
- Describe the approach and skills underpinning effective brief interventions.
- Describe how you can enquire about the risk factor and support patients in changing their lifestyle behaviour.

Module 2: Alcohol and Drug Use Duration:

Duration: Approx. 25 Mins

The aim of this module is to increase your knowledge and support you to develop your confidence in raising the issue of alcohol and drug use in routine conversations with patients

By completing this module, you will have the knowledge needed to:

1: Communicate the health risks and harms of alcohol and drug use.

2: Inform patients of the benefits of reducing alcohol consumption and drug use.

3: Screen for alcohol consumption levels and drug use to identify those at risk.

4: Signpost patients to the supports available to help them reduce the harm from these substances.

Module 3: Healthy Food for Life

Duration: Approx. 25 Mins

The aim of this module is to increase your knowledge and support you to develop your confidence to raise the issue of healthy eating in routine and regular conversations with patients.

By completing this module and associated work-based activities you will have the knowledge needed to:

1: Outline the prevalence of poor dietary habits in Ireland and the associated risk factors.

2: Communicate key messages on healthy eating to patients.

3: Signpost patients to practical resources to help them make changes.

Module 4: Tobacco Free Ireland

Duration: Approx. 25 Mins

The aim of this module is to increase your confidence to raise the issue of smoking in routine and regular conversations with patients and support them to make a quit attempt.

By completing the module and associated work-based activities you will have the knowledge needed to:

1: Communicate the risks and harm caused by smoking.

2: Inform patients of the benefits of quitting and offer strategies to help them quit.

3: Signpost patients to local and national quit support services.

4: Support and promote tobacco free environments.

Module 5: Get Ireland Active

Duration: Approx. 25 Mins

The aim of this module is to increase your knowledge and support you to develop your confidence to discuss physical activity in routine and regular conversations with patients.

By completing this module and associated work-based activities you will have the knowledge to:

1: Outline the prevalence of physical activity in Ireland and the associated risk factors.

2: Communicate key messages on physical activity to patients.

3: Signpost them to practical resources to help them make changes.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Module 6: Skills to Practice Module

Duration: 25 minutes

Aim

By completing this module, you will see how to carry out an effective BI with a patient. This module brings together all the knowledge from the previous modules and demonstrates how to do this in a series of recorded interventions with a range of HCPs.

By completing this module you will be able to:

- Recognise how best to carry out effective Brief Interventions.
- Identify how to seek permission for and raise the issue of lifestyle behaviour with a patient in a supportive way.
- Develop your confidence in applying what you have learned to carry out Brief Interventions in a patient-centred and non-judgemental way.
- Know how to incorporate the *Making Every Contact Count* Recording Tool into your intervention.

Summary

These eLearning modules are designed to introduce you to the basic skills and knowledge for you to conduct a brief intervention with your patient. These modules may be accessed at any time in order to help you refresh and increase your confidence in engaging with health conversations with patients.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

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Unit 4:
Providing Opportunistic Brief Interventions

Unit 4 *Making Every Contact Count:* Providing Opportunistic Brief Interventions

Duration: 5 hours
Recommended Programme Placement: Year 2,3 or 4
Lesson Plan

Unit 4 Learning Outcomes	4.1.1 Describe the theoretical and practical context for *Making Every Contact Count* for health behaviour change (HBC) 4.1.2 Identify patients for whom a brief intervention (BI) is appropriate 4.2.1 Use validated screening and assessment tools to assess patients readiness to change and respond to this assessment supportively 4.2.2 Deliver a BI in an empathetic and non-confrontational manner using the principles of motivational interviewing (MI) 4.2.3 Assess own performance in delivering BI using self-reflective practice 4.2.4 Demonstrate the procedure for signposting and referral to support services 4.2.5 Understand how to maintain accurate records in patient documentation/medical chart of delivery of a BI, and how to flag further actions for follow-up	
Lesson 1 **Recap of Units 1-3** **Theoretical and practical context for brief interventions for HBC** **2 Hours**	• Recap Unit 1: Lifestyle choices and personal behaviours, Unit 2: Lifestyle behaviours and personal responsibility for health, Unit 3: Communication for Healthy Lifestyles and Health Behaviour Change • Outline what brief advice, BIs and MI are and the differences between them as distinct approaches to behaviour change • Identify opportunities for BI in your role as a HCP	**Activity** Activity 4.1 Access the most recent Healthy Ireland Survey Activity 4.2 Video Critique Activity 4.3 Use of Tools in Behaviour Change Activity 4.4. Identify scenarios when it may not be appropriate to raise the issue of lifestyle behavior change with a patient
Lesson 2 **Brief intervention approach including assessment, screening and recording** **2 Hours**	Skills Workshop • Use validated screening and assessment tools to assess a patient's readiness to change and respond to this assessment supportively • Deliver a BI in an empathetic and non-confrontational manner using the principles of MI • Assess your own performance in delivering a BI using self-reflective practice	Activity 4.5 Practice carrying out a brief intervention using Real Play Activity 4.6 Practice managing challenging statements

Lesson 3 **Signposting and referral to support services** **Duration:** **1 Hour**	• Identify additional services and specialists to whom you can refer patients who require additional supports • Maintain accurate records of the BIs that were delivered in reports and/ or medical charts and how to flag further actions for follow-up	4.7 Group Activity Signposting and referral to support services
Core Reading	Rollnick, S., Miller, WR., Butler, CC. (2008). *Motivational Interviewing in Healthcare. Helping patients change behavior.* (1st ed.). London: Guilford Press.	
Accompanying Slide Pack for Unit 4	www.hse.ie/mecc-undergradcurriculum	

Unit 4: *Making Every Contact Count:* Providing Opportunistic Brief Interventions

Lesson 1a: Recap of Unit 1-3

Lesson 1b: Theoretical and Practical Context for Brief Interventions for Health Behaviour Change

Duration: 2 Hours

PPT Title – Unit 4 Lesson 1:
Lesson 1a: Recap Unit 1-3
Lesson 1b: Theoretical and Practical Context for Brief Interventions for Health Behaviour Change

Introduction to Lessons 1a and 1b

- Outline what brief advice, brief interventions (BIs) and motivational interviewing (MI) are and the differences between them as distinct approaches to health behaviour change (HBC).
- Identify opportunities for BI in your role as a healthcare professional (HCP).
- Identify patients for whom a BI is appropriate.
- Identify situations when BIs may not be appropriate.

Introduction to the Unit of Study

In Unit 4 we are going to learn how to Make Every Contact Count by learning and practising the skills which are needed to provide opportunistic brief advice and to undertake BIs. We will be using the tools and techniques which you have explored in Unit 3, and will practise applying them in a BI.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Making Every Contact Count

Making Every Contact Count is a programme being implemented within the HSE to support the prevention and management of chronic disease by promoting lifestyle behaviour change. The health behaviours which are the focus of this programme are the four main lifestyle risk factors for chronic disease; tobacco use; physical inactivity; alcohol and drug use and unhealthy eating.

Making Every Contact Count is about HCPs using their routine consultations to empower and support people to make healthier choices to achieve positive long-term behaviour change. To do this, the health service needs to build a culture and operating environment that supports continuous health improvement through the contacts that it has with individuals. This approach will allow healthcare professionals to move to a position where discussion of lifestyle behaviour is routine, non-judgemental and central to everyone's role.

As a healthcare student and a future HCP you will be asked to make each routine contact that you have with patients count in terms of chronic disease prevention, when appropriate.

Recap Units 1-3

In Unit 1 Health and Personal Wellness, you were introduced to the topic of health and to the Healthy Ireland Framework and we explored various definitions of health.

We also discussed the biopsychosocial model of health where you were asked to think about your own personal health and to self-rate your physical, social and psychological health. We explored how these elements are inter-related. You were also provided with some statistics from Irish health surveys.

Did you know that health surveys are carried out in Ireland each year?

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Activity 4.1: Healthy Ireland Survey

Access the most recent Healthy Ireland Survey

Healthy Ireland surveys are carried out annually and are available at the following link: www.health.gov.ie

In Unit 1 you were briefly introduced to the topic of lifestyle influences on health behaviours and health and you self-rated you perceived health risk for diet, tobacco, activity and alcohol.

What other key health determinants can you think of?

Unit 1 ended with a presentation of the Key Health Messages, which are important messages for you personally and in your role as health promoter.

Recap Unit 2

In Unit 2 Lifestyle Behaviours and Personal Responsibility for Health you explored health behaviours with a specific focus on the health behaviour practices of student groups. You were introduced to the topic of HBC and you were asked to think about a personal health behaviour that you would like to change.

We examined some of the theories of behaviour change. We looked at the Trans-Theoretical Model of Behaviour Change, the Health Belief Model and the COM-B Model.

What can you remember about these models?

Pause for Reflection and Discussion

- **Think about a health behaviour that you have ever changed.**
- **Consider the following prompts.**
- **What made you change the behaviour?**
- **Was it difficult to change?**
- **What helped you to change your behaviour?**
- **What factors made it difficult to change the behaviour?**
- **Did you relapse at any time? How many times?**
- **What has helped you to sustain the behaviour change?**

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Noted that some of the models referreed to are dated however it has been agreed to include them as an umbrella to encourage broad understading of all as they are still evident and in use.

Recap Unit 3

In Unit 3 *Communicating with Individuals about Promoting Healthy Lifestyle Behaviours for HBC* we explored the communication skills which are necessary for health behaviour change. You were broadly introduced to the topics of BI and MI in preparation for the skills that you will learn in Unit 4.

You will have completed the modules from the Making Every Contact Count training programme.

Pause for Reflection and Discussion

- **Do you remember the communication skills required to communicate effectively for HBC?**

Pause for Reflection and Discussion

- **At the beginning of each Unit you have heard about *Making Every Contact Count***
- **Can you explain what is meant by the term *Making Every Contact Count*?**

Making Every Contact Count

- *Making Every Contact Count aims to prevent chronic disease.*
- *It is about enabling healthcare professionals to use routine consultations to support patients to make HBC to achieve positive health outcomes.*
- *This will result in patients being routinely asked about the main lifestyle behaviours - smoking, alcohol and drug use, diet, physical activity and weight management for child and adult obesity.*
- *Disease prevention and health improvement is every HCPs' responsibility.*

The main lifestyle behaviours we have looked at are:

Figure 4.1: Key Lifestyle Behaviours important to Chronic Disease Prevention

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

How to Make Every Contact Count

As you know, lifestyle behaviours play a role in health and in disease prevention and health improvement is every HCPs' responsibility.

To ensure that we *Make Every Contact Count* we need to become proficient at providing BIs using an **MI approach** (Introduced in Unit 3).

You have already covered some of the theory behind the **MI approach** to HBC from *Unit 3,* and we are going to discuss MI further in this Lesson. Firstly, let's take a look at the *Making Every Contact Count* Framework for delivering behaviour change interventions:

Figure 4.2 outlines the model for behaviour change from the *Making Every Contact Count* Framework. Table 4.1 provides a further explanation of the model.

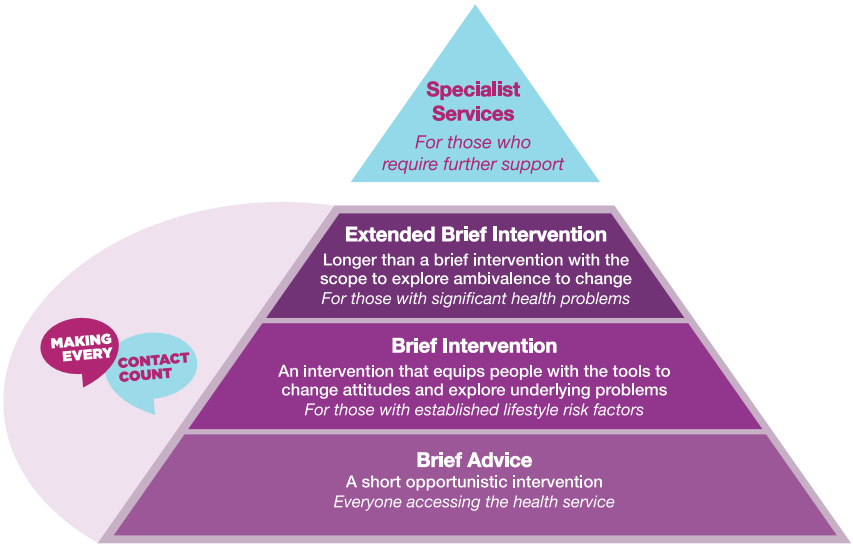


Figure 4.2: *Making Every Contact Count* **Framework (HSE) 2017**

We will now talk about each of the four levels in the *Making Every Contact Count* Framework, including brief advice, BI, extended BIs and specialist services. We will watch a video demonstrating each approach in practice.

Level 1: Brief Advice

Brief advice is defined as a short opportunistic intervention that directs people where to go for further help for modifying unhealthy behaviours. The aim of this type of opportunistic advice is to raise awareness of the impact of a lifestyle behaviour on the individual and to refer/signpost the patient to further supports. Brief advice is less in-depth and more informal than a BI and usually involves giving information about the importance of behaviour change and simple advice to support a change in behaviour (See Unit 4, Lesson 3, for further information about services and support).

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Key components

- Ask about behaviour
- Advise on the need for behaviour change
- Act to refer or signpost people to additional support (3As)

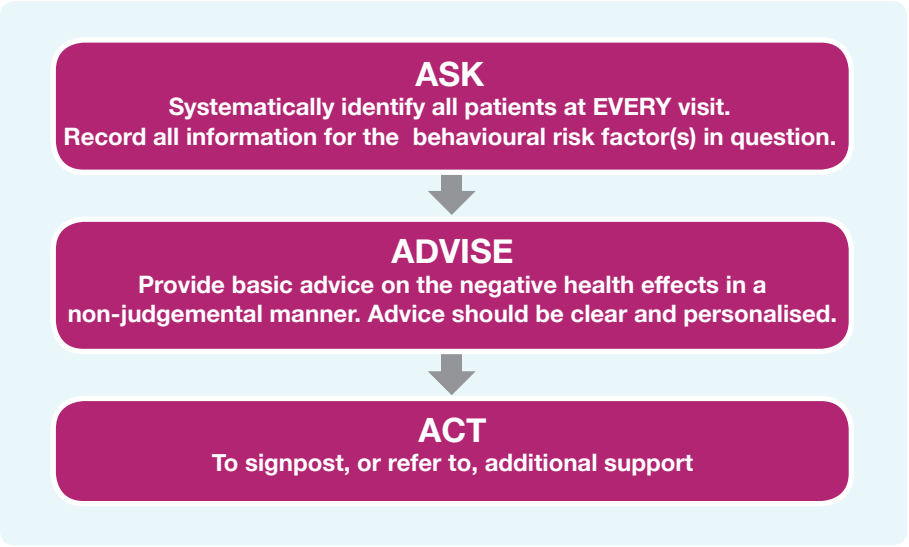


Figure 4.3: The 3As Framework

Target Audience for Brief Advice:

Everyone accessing the health service

Watch the video demonstrating brief advice:
www.hse.ie/mecc-undergradcurriculum

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Level 2: Brief Intervention (BI)

BI is defined as an intervention that aims to equip people with tools to change attitudes and explore underlying problems. It involves discussion, negotiation and encouragement with or without follow-up by the healthcare professional. The aim of a BI is to raise awareness of the risks associated with the behaviour, to equip people with the skills to change and signpost to further supports.

In Unit 3, you learned about effective communication skills for promoting behaviour change. As part of a range of methods, BIs may contain a *patient-centred discussion,* and may use an MI approach in their delivery.

A useful framework for delivering a BI is the 5 As. The *Making Every Contact Count* programme recommends the use of the 5As Framework as a guide for carrying out a brief intervention.

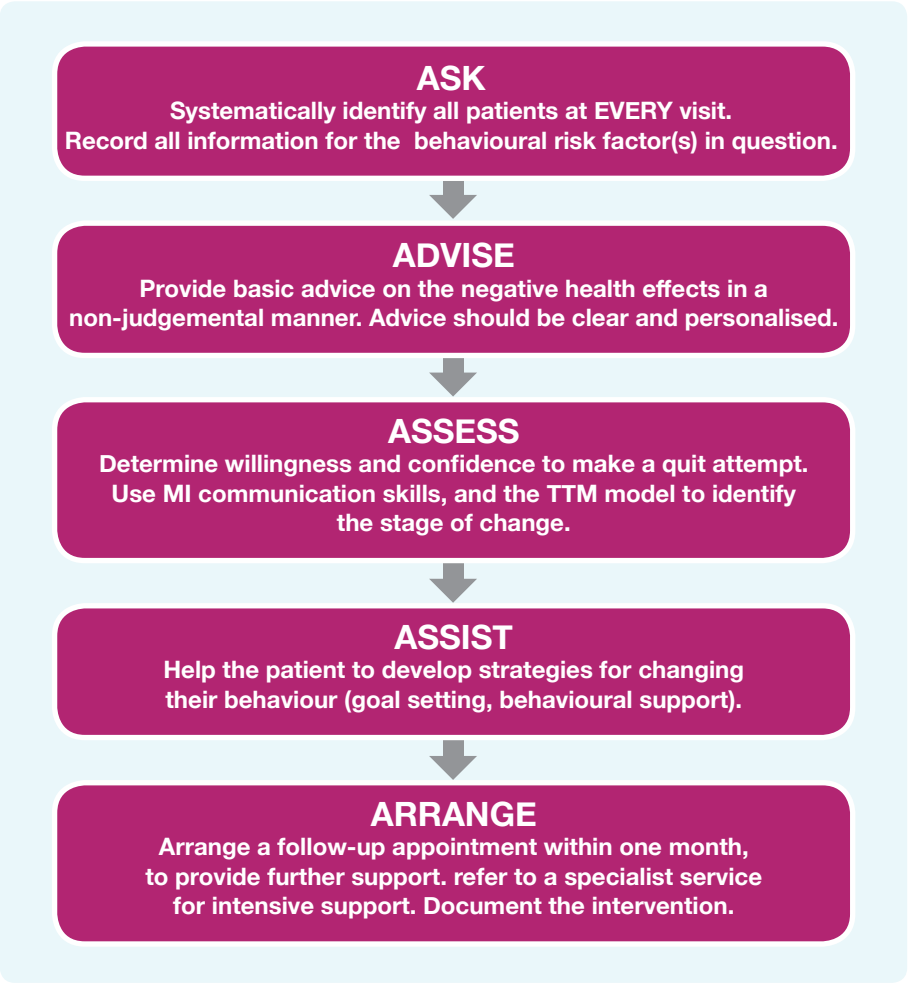


Figure 4.4: The 5As Framework for Brief Intervention for Health Behaviour Change[10]

Target Audience for a Brief Intervention:

Patients with established lifestyle risk factors or chronic condition

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

10 The 5As framework for Brief Intervention for Health Behaviour Change. Source: World Health Organisation (2014) Toolkit For Delivering the 5a's. For more information on the application of the 5As framework, see http://www.who.int/tobacco/publications/smoking_cessation/9789241506953/en/

Watch the video demonstrating brief intervention:
www.hse.ie/mecc-undergradcurriculum

Activity 4.2: Video Critique
Critique the video using the handout provided

Video Critique

Did the healthcare professional demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide examples here
A. Use of Interpersonal Communication Skills		
Use of positive non-verbal communication Give examples		
Use of Reflective Listening Give examples		
Demonstrate empathy Give examples		
B. Encourage Dialogue		
Assess how important it is for the patient to change behaviour Give examples		
Assess how motivated the patient is to change behaviour Give examples		
Ask open-ended questions Give examples		

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

A suite of video scenarios have been produced as part of the Making Every Contact Count training programme and can be accessed using the URL above. These scenarios have been produced using a range of HCPs and various lifestyle behaviour change issues. You can choose which scenario is most relevant to the student group you are delivering this curriculum to.

Provide opportunity for the patient to speak Give examples		
C. Adopt a patient-centred approach		
Use of appropriate vocabulary easily understood by the patient Give examples		
Provide information that was geared toward the patient's readiness to change Give examples		
Overall comments		

GUIDANCE NOTES FOR FACILITATORS

A suite of video scenarios have been produced as part of the Making Every Contact Count training programme and can be accessed using the URL above. These scenarios have been produced using a range of HCPs and various lifestyle behaviour change issues. You can choose which scenario is most relevant to the student group you are delivering this curriculum to.

Level 3: Extended Brief Intervention

Extended brief intervention (EBI) is similar in content to a brief intervention, but usually takes longer and consists of an individually focussed discussion and follow-up.

The aim of an EBI is to raise awareness of the risks associated with the risk behaviour and to equip people with the skills to change.

An EBI-based discussion involves more intensive MI skills. Useful tips for delivering an EBI involve:

Exploring ambivalence regarding behaviour change within the patient.

For **EBI**, use exercises such as:

1. OARS Conversation skills (outlined in next section);
2. The 80:20 Rule
3. The 0-10 scaling exercise (outlined in next section);
4. The Decisional Balance Sheet exercise (outlined in next section).

Target audience for an extended brief intervention

Patients with significant health problems

Patients who have found it difficult to change, or haven't benefitted from a BI

Patients who are involved in risky behaviour, or have been identified as at increased risk of harm

Watch the video demonstrating an extended brief intervention www.hse.ie/mecc-undergradcurriculum

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Level 4: Specialist Services

Specialist services are defined as interventions which are delivered by a specially trained HCP to support an individual through a complex behaviour change.

As a HCP, your role is to refer complex cases to appropriate specialist support services. Examples of these services may be a smoking cessation counsellor *(smoking)*, an addiction counsellor *(alcohol or drug use),* a dietician *(diet),* a physiotherapist *(exercise),* a weight management programme *(diet/exercise).*

Target audience for specialist services

Patients who require further support, and have not benefitted from BI or EBI

Patients who are at high risk of causing harm to their health or wellbeing

Patients with a serious medical condition that needs specialist advice and monitoring

Watch the video demonstrating an example of a specialist service www.hse.ie/mecc-undergradcurriculum

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Table 4.1

Please note that the examples of staff or patients given are not exclusive to those named here. In the implementation of this framework service managers will need to identify those who are best placed to conduct and receive the relevant level of intervention (Source: Health Service Executive (2017) *Making Every Contact Count*: A Health Behavior Change Framework and Implementation Plan for Health Professionals in the Irish Health Service. Dublin).

	Brief Advice	Brief Intervention	Extended Brief Intervention	Specialist Services
What is it	A short opportunistic intervention that directs people where to go for further help	An intervention that aims to equip people with tools to change attitudes and explore underlying problems[28] It involves discussion, negotiation and encouragement with or without follow-up[27].	An extended brief intervention is similar in content to a brief intervention but usually lasts longer and consists of an individually focused discussion and follow-up[27]	A high intensity intervention delivered by specifically trained health professionals to support a patient through a behaviour change
Aim of the intervention	To raise awareness of the impact of lifestyle behaviour on the individual and to refer / signpost the patient to further supports.	To raise awareness of the risks associated with the behaviour, to equip people with the skills to change and signpost to further supports.	To raise awareness of the risks associated with the behaviour and to equip people with the skills to change. To explore ambivalence about changing.	To provide intensive support to a patient in relation to a specific health behaviour.

Key Components	- **Ask** about behaviour
	- **Advise** on the need for behaviour change
	- **Act** to refer or signpost people to additional support (3As)
		A patient centred discussion using motivational interviewing techniques to
		- **Ask** about the behaviour
		- **Advise** on the need for behaviour change
		- **Assess** readiness to change
		- **Assist** with
		  - exploration of the barriers and benefits of behaviour change
		  - identifying options for change
		  - goal setting
		- **Arrange** referral to more intensive support if appropriate (5As)
			A patient centred discussion using more intensive motivational interviewing techniques to
			• Explore ambivalence regarding behaviour change with the patient.
			• Work with the patient to resolve this ambivalence
			• Identify options for change and sets goals.
			This exploration usually results in an intervention that is of longer duration than a brief intervention.
				Components will be determined by the intervention being offered such as:
				Motivational Interviewing; Solution Focused Therapy (SFT); Cognitive Behaviour Therapy (CBT)
				Counselling
				The opportunity to conduct a BI/ EBI for health behaviours other than their area of expertise may be appropriate as part of this intervention.

	Brief Advice	Brief Intervention	Extended Brief Intervention	Specialist Services
Who gets the intervention	Everyone accessing the health service	People with established lifestyle risk factors for chronic disease	People who: • are involved in risky behaviour • have been assessed and identified as increased risk of harm • have multiple health problems • engaging in a self- management programme have successfully made changes to their behaviour but need more support to maintain change • have found it difficult to change or have not benefited from brief advice or brief intervention	People will be referred to this specialist support for lifestyle behaviour change who have: • not benefited from lower intensity interventions • been assessed as being at high risk of causing harm to their health and wellbeing • a serious medical condition that needs specialist advice and monitoring
Examples of who could conduct the intervention	All health professionals and healthcare support staff with regular and extended patient contact such as healthcare assistants	Health professionals who have opportunities to see patients on a regular basis. Examples include though not exclusively: - Hospital doctors and consultants - GPs, practice nurses, - All hospital and community nurses and midwives - Allied health professionals such as physiotherapists; occupational therapists and dietitians. - Pharmacists - Dentists	Health professionals who have the opportunity to see a patient on a regular basis and have greater capacity to carry out this more intensive intervention such as - Practice nurses - Clinical nurse specialists and allied health professionals who deliver chronic disease self-management support programmes such as Cardiac / Pulmonary Rehab and Diabetes Programmes. - Smoking cessation advisors	Health Professionals who have intensive / specialist training and /or have a recognised Qualification in the relevant areas such as CBT, SFT and Counselling for example: - Smoking cessation practitioners - Dietitians - Addiction counsellors - Psychologists - Counsellors - Mental health professionals trained in CBT

Motivational Interviewing (MI)

You learned about active listening skills for MI in Unit 3. To recap, MI is described as a process of exploring a patient's motivation to change through interview in order to assist them in moving toward change.

Simply giving patients advice to change is often unrewarding and ineffective. Telling, judging and advising may not be the most effective ways of bringing about behaviour change. In an MI structured conversation, the HCP does not attempt to persuade the individual to change. The patient is allowed and encouraged to voice their own uncertainties and problem-solve themselves.

Conversations using the principles of MI can be used by a range of HCPs in a range of settings.

MI is deliberately non-confrontational – the key questions within the conversation are:

- ***'What are some of the good things about your present behaviour?'***
- ***'What are the not-so-good things about your present behaviour?'***

Other key elements and strategies include:

- Expressing empathy by the use of active listening (see Unit 3)
- Avoiding arguments by assuming that the individual is responsible for the decision to change
- Supporting self-efficacy and optimism for change
- 'Rolling with resistance' rather than confronting or opposing it

Resistance to change is a common occurrence in HBC interventions, and a patient may be defensive in response to a perceived attack on their current behaviour. To avoid making a patient feel threatened or confronted about health risk behaviours, it is important to respect a patient's resistance, express empathy and approach the conversation in a non-judgemental manner.

MI is often a more intensive intervention than a BI carried out by a HCP but the approach and ethos of MI is applicable in helping a HCP to deliver a more effective BI with patients.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

Four Useful Tools for a MI Structured Conversation:

The following techniques provide a teaching tool to help students understand behaviour, behaviour change and ambivalence to change.

1. Conversation using OARS acronym

O – Open-ended questions

- Cannot be answered in one word
- Create forward moving momentum
- Encourages the patient to talk and express themselves
- Helps establish an atmosphere of trust and acceptance

A – Affirming the patient

- Noticing what is right about someone
- A recognition and acknowledgement – of strengths, values, effort, achievement
- More than simple praise: 'well done'

R – Reflective listening

- Help the patient feel listened to and understood
- Check you have understood them correctly
- Encourage the patient to keep talking
- Sometimes help the patient understand themselves better

S – Summarising

- Summaries involve capturing elements of what the patient has been saying, and saying them back without any advice giving or interpretation or judgement.

2. The 80:20 Rule

In an MI structured conversation for HBC, it is important to remember that your role as a HCP is to guide the conversation and engage in active, reflective listening.

The patient should do **80%** of the talking, and the healthcare professional the other **20%**.

The patient's view must be heard and listened to, even if you think they are incorrect.

3. The Bubbles Technique

The bubbles technique is a useful tool to use to identify which behaviour you will discuss with a patient. It helps patients with multiple lifestyle issues to identify the behaviour that they feel they would like to discuss and also keeps a record of the other behaviours.

The bubbles technique involves asking a patient about a number of lifestyle behaviours:

Question: Tell me about your smoking ?

HCP writes the word smoking on a page and circles it

Repeat this process for other behaviours. Ask the patient if there is any other lifestyle behaviour they would like to discuss.

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

These tools are not core material but useful to explain behaviour and behaviour change.

HCP should end up with a page like the following:

Figure 4.5: The Bubbles Technique

HCP then asks the patient to pick which lifestyle factor they would like to talk about today.

4. The Decisional Balance exercise

One exercise that may help a patient clarify their barriers to successful behaviour change is to list in one place the benefits and costs of changing or continuing their current behaviour. Seeing the full array of costs and benefits can make it easier to decide if you should change.

Table 4.2: Decisional Balance Sheet

	Disadvantages	Advantages
No Change		
Change		

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

5. The 0-10 scaling question

You can use a 'scaling question' for solution focussed approaches to help the patient think about and articulate their reasons for changing their behaviour, asking:

On a scale from 1-10 how important is it to you perhaps become more active?									
Not Important									**Very Important**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Assume they said 4. You might then ask:

'Why 4 and not lower? Why is it important to you?

See what they say. Use reflections to help them develop their arguments for change.

Perhaps ask:

'And why else?'

Keep fishing for reasons. **Do not ask:** 'why isn't it higher?'

We want people to articulate and strengthen their reasons, their motivation.

As they verbalise their reasons, they may become more real for them.

Then perhaps ask to summarise back the reasons **they** have for becoming more active.

Activity 4.3: Personal Behaviour change

In groups of 2, think of a behaviour that you would like to change and use the Decisional Balance Sheet and the 0-10 Scaling Question on the handout provided to assist you.

Feed back to the group on how useful you found these tools.

Key Reading

Van Buskirk, K.A., and Wetherell, J.L. (2014) 'Motivational Interviewing Used in Primary Care. A Systematic Review and Meta-analysis', *Journal of Behavioral Medicine, 37*(4), pp. 768-780.

Rollnick, S., and Miller, W.R. (2012) *Motivational Interviewing: Helping People Change (Applications of Motivational Interviewing) (Third Edition).* London: Guildford Press.

Watch the video demonstrating motivational interviewing
www.hse.ie/mecc-undergradcurriculum

GUIDANCE NOTES FOR FACILITATORS

Written to support face-to-face or online delivery including activities and discussion points.

There will be times when BI is not appropriate and need advise students when in doubt to ask a supervisor.

Activity 4.4: Challenging scenarios
Identifying scenarios when it may not be appropriate to raise the issue of lifestyle behaviour change with a patient

GUIDANCE NOTES FOR FACILITATORS

There will be times when BI is not appropriate and need advise students when in doubt to ask a supervisor.

Making Every Contact Count is about raising the issue of lifestyle behaviour change routinely with patients. However, a BI may not always be appropriate.

Scenarios when it may not be appropriate to raise the issue of lifestyle behaviour with a patient

Level of Risk

Some patients may have complex care needs and BIs may not be sufficient to address these. E.g. CAGE scores for alcohol consumption may indicate alcohol dependency, which may require Specialist Services. Screening tools are explained in the next Lesson.

Timing of the intervention

Even when a BI is appropriate for a patient's level of risk, the timing for delivering a BI must be carefully considered. E.g. not appropriate during sensitive treatment visits, delivering bad news, etc.

Lesson 4 will discuss how to maintain accurate records and flag patients for follow-up. Recognise the limitations of your role in delivering BIs in relation to specific health behaviours, and choosing which lifestyle topic to discuss with a patient.

Often patients present with multiple risk factors for chronic disease or with multiple problem lifestyle behaviours. As a HCP you can't discuss all behaviours at every contact with patients so it is important to prioritise which behaviour to discuss with the patient.

The bubbles technique is a useful tool to use to identify which behaviour you will discuss with a patient.

Watch the video demonstrating using the bubbles technique to identify which behaviour to focus on with a patient www.hse.ie/mecc-undergradcurriculum

Summary

In this Lesson we have revisited each of the units which you have studied in relation to HBC and BIs so far. We have explored brief advice, BIs and MI and the differences between them as distinct approaches to HBC. We identified opportunities for BI in your role as a HCP. We also identified patients for whom a BI is appropriate and situations when BIs may not be appropriate. In Lesson 2 we will look at assessment, screening and recording of BI and carrying out BIs.

Handout Unit 4 Lesson 1 Activity 4.2:
Video Critique

Did the healthcare professional demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide examples here
Use of positive non-verbal communication Give examples		
Use of Reflective Listening Give examples		
Demonstrate empathy Give examples		
B. Encourage Dialogue		
Assess how important it is for the patient to change behaviour Give examples		
Assess how motivated the patient is to change behaviour Give examples		
Ask open-ended questions Give examples		
Provide opportunity for the patient to speak Give examples		
C. Adopt a patient-centred approach		

Use of appropriate vocabulary easily understood by the patient Give examples		
Provide information that was geared toward the patient's readiness to change Give examples		
Overall Comments		

Handout Unit 4 Lesson 1 Activity 4.3:
Decisional Balance and Scaling Worksheet

Decisional Balance Sheet		
	Disadvantages	**Advantages**
No Change		
Change		

On a scale from 1-10 how important is it to you to become more active?									
Not Important									**Very Important**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Unit 4: *Making Every Contact Count:* Providing Opportunistic Brief Interventions

Lesson 2: Brief Intervention Skills workshop

Duration: 2 hour

PPT Title – Unit 4 Lesson 2:
Brief Intervention approach including assessment, screening and recording

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

- Use validated screening and assessment tools to assess a patient's behavioural risk factors and respond to this assessment supportively.
- Deliver a Brief Intervention (BI) in an empathetic and non-confrontational manner using the principles of motivational interviewing (MI).
- Assess your own performance in delivering a BI using self-reflective practice.

Recap Lesson 1

In Lesson 1 you discussed the theory of brief advice, BI and MI for health behaviour change (HBC).

Screening Tools for Identifying Behavioural Risk Factors

Screening of patients using a validated method or tool is the first step in identifying people that are at risk of developing (or worsening) a health problem as a result of a health behaviour.

Screening tools should be quick and easy to use so that they can be routinely applied by appropriately trained staff accurately within a few minutes.

Once an individual is identified as 'at risk' for an illness, a treatment pathway should determine the appropriate course of action – whether this involves brief advice, BI, extended brief intervention (EBI) or Specialist Services. There should be no delay in treating identified patients.

Some commonly used screening tools for lifestyle health behaviours are:

Smoking

1. Heaviness of Smoking Index

The Heaviness of Smoking Index (HSI) was developed as a test to measure nicotine dependence by using two questions from the Fagerström Tolerance Questionnaire and the Fagerström Test for Nicotine Dependence: time to first smoking in the morning and number of cigarettes per day. It uses a six-point scale calculated from the number of cigarettes smoked per day (1-10, 11-20, 21-30, 31+) and the time to first cigarette after waking (less than/equal to 5 minutes, 6-30 minutes, 31-60 minutes, and 61+ minutes). Nicotine dependence is then categorised into a three-category variable: low (0-1), medium (2-4), and high (5-6). The HSI provides a simple way for healthcare professionals (HCPs) to classify their patients and help in prescribing dependency-based treatments.

Key Reading

Heatherton, T.F., et al. (1989) 'Measuring the heaviness of smoking: Using self-reported time to the first cigarette of the day and number of cigarettes smoked per day', *Addiction, 84*(7), pp. 791–800.

Fagerström, K. (2012) 'Determinants of tobacco use and renaming the FTND to the Fagerström Test for Cigarette Dependence', *Nicotine and Tobacco Research,* 14, pp. 75-78

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

2. Calculation of Pack - Years

It is calculated by multiplying the number of **packs** of cigarettes smoked per day by the number of **years** the patient has smoked. For example, 1 **pack-year** is equal to smoking 20 cigarettes (1 **pack**) per day for 1 **year**, or 40 cigarettes per day for half a year, and so on. Research shows that among smokers, patients with ≤ 15 pack-year history of smoking have a longer median survival than patients who had smoked > 15 pack years

Key Reading

Janjigian, Y.Y., et al. (2010) 'Pack Years of Cigarette Smoking as a Prognostic Factor in Patients with Stage IIIB/IV Non-Small Cell Lung Cancer', *Cancer,* 116(3), pp. 670-675.

Alcohol and Drug Use

The Audit C Tool

1. How OFTEN do you have a drink containing ALCOHOL?

Never	SCORE 0
Monthly or less	SCORE 1
2-4 times a month	SCORE 2
2-3 times a week	SCORE 3
4 or more times a week	SCORE 4

If NEVER – tick LOW RISK in Q4

2. How MANY drinks containing 10 grams of alcohol do you have on a typical day when drinking?

1-2	SCORE 0
3-4	SCORE 1
5-6	SCORE 2
7-9	SCORE 3
10 or more	SCORE 4

3. How OFTEN do you have 6 or more drinks (10 grams each) on one occasion?

Never	SCORE 0
Less than monthly	SCORE 1
Monthly	SCORE 2
Weekly	SCORE 3
Daily or almost daily	SCORE 4

Total ALCOHOL SCORE

4. To assess ALCOHOL RISK to health
(Tick risk level based on total ALCOHOL Score)

Total SCORE 0-4	**Low Risk**
Total SCORE 5-7	**INCREASED RISK** Go to Q5
Total SCORE 8-12	**HIGH RISK** Go to Q6

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

5. ACTION INCREASED RISK
(Tick ALL actions taken)

GIVEN brief advice / brief intervention	☐
RECOMMENDED that patient discuss with GP and complete FULL AUDIT assessment	☐
Patient declined / not interested	☐
No action documented	☐

6. ACTION HIGH RISK
(Tick ALL actions taken)

Offered REFERRAL to health professional	☐
Patient declined / not interested	☐
No action documented	☐

Drug use is assessed using the DUDIT screening tool but you first need to ask the patient one question:

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

If the answer is never, reinforce abstinence. Any positive result requires further assessment using DUDIT screening tool. The DUDIT tool can be accessed through the following website: www.drugs.ie/NDRICdocs/protocol1/templates/DUDIT.pdf.

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

Healthy Eating: If a BMI greater than 25 is recorded a BI in relation to healthy eating and physical activity should be delivered to the patient by the HCP. Assessment of weight and health risk involves using two key measures:

Classification	BMI(kg/m2)	
	Principal cut-off points	Additional cut-off points
Underweight	**<18.50**	**<18.50**
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	**18.50 - 24.99**	**18.50 - 22.99**
		23.00 - 24.99
Overweight	**≥25.00**	**≥25.00**
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	**≥30.00**	**≥30.00**
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Table 4.3: Adapted from WHO, 1995, WHO, 2000 and WHO 2004.

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

2. Waist circumference

Measuring waist circumference helps screen for possible health risks that come with overweight and obesity. If most of your fat is around your waist rather than at your hips, you are at a higher risk of heart disease and type 2 diabetes. This risk goes up with a waist size that is greater than 35 inches for women or greater than 40 inches for men. To correctly measure your waist, stand and place a tape measure around your middle, just above your hipbones. Measure your waist just after you breathe out.

Physical Activity

The National Guidelines on Physical Activity for Ireland are based on international expert evidence and describe appropriate levels of health enhancing physical activity for the Irish population.

The following questions on the *Making Every Contact Count* recording tool help to identify if patients are achieving the guidelines for physical activity. The graphic below outlines the National Physical Activity Guidelines as a reminder when interpreting the results of the questions below (Health Service Executive, 2017)

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

Physical Activity Questions

1. In a typical week, how many days have you been physically active (PA) for total of 30 minutes or more?

- 0 days (Inadequate) ☐
- 1-4 days (Inadequate) ☐
- 5-7 days (Adequate) ☐
- Unable to be physically active ☐
- No information available ☐

2. If FOUR days or less, in a typical week have you been PA for either 150 minutes moderate or 75 minutes vigorous activity?

- Yes (Adequate) ☐
- No (Inadequate) ☐
- No information ☐

3. Action patient reporting inadequate physical activity

(Tick ALL actions taken)

- GIVEN brief advice /brief intervention on benefits of physical activity ☐
- DIRECTED to National website ☐
- Patient declined/not interested ☐
- No action documented ☐

Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes

Recommended Physical Activity is at least 30 minutes of moderate intensity physical activity 5 days per week

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

Recording your interventions – *Making Every Contact Count* Recording Tool

The aim of *Making Every Contact Count* is to identify patients who are at risk from their current lifestyle behaviours and carry out a BI to support them to make a lifestyle behaviour change to improve their risks. Recording this information on patient records is an important part of implementing this programme as HCPs can then review when an issue has been raised in the past and how an intervention was conducted. While some HCPs currently record this information on patient records this doesn't happen in a consistent way.

The *Making Every Contact Count* recording tool has been developed to record information on:

1. Patient lifestyle risk factors in relation to smoking, physical activity, healthy eating and alcohol.
2. Any intervention that a HCP carries out having identified a risk from the patient's lifestyle behaviours.

The intention is that this recording tool will eventually be incorporated into electronic patient records as they develop within all health services across Ireland in hospitals and primary care services. Currently the questions on the recording tool have been integrated into electronic patient records across all maternity hospitals in Ireland. These questions have also been incorporated into GP practice systems.

You will encounter this recoding tool in many ways on placement and as you proceed to work in Irish health services and indeed you could encounter this tool as part of a paper patient record in many services. When on placement or working in the health service you should ask a supervisor for information on how the tool is being used and integrated into the particular service you are working in.

You may also encounter the tool in your clinical placement logbook where you can record when you conduct an intervention and the outcome.

GUIDANCE NOTES FOR FACILITATORS

There will be times when BI is not appropriate and need advise students when in doubt to ask a supervisor.

Note to student to ask a supervisor or senior staff member in the service how recording of information is carried out within the service and what local policies and procedures are in place to guide this.

Note to students when recording information in their log book in relation to interventions do so anonymously without identifying and particular patient .i.e. no patient names or other identifying factors.

Handout:
***Making Every Contact Count* Recording Tool**

(Add scores from Questions 1-3)

Smoking Status and Intervention

1. Do you SMOKE any tobacco products?

- Current (daily or occasional) ☐
- Ex-Smoker (gave up 6 months+) ☐
- Never ☐
- Unknown / not asked ☐

If non-smoker/ex-smoker/unknown / not asked move to next section

2. ACTION IF PATIENT IS A SMOKER
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention ☐
- **DIRECTED** or **REFERRED** to HSE cessation services / QUIT service ☐
- **PRESCRIBED/REFERRED** for Pharmacotherapy ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

Alcohol Status and Intervention

1. How OFTEN do you have a drink containing ALCOHOL?*

- Never ☐ SCORE 0
- Monthly or less ☐ SCORE 1
- 2-4 times a month ☐ SCORE 2
- 2-3 times a week ☐ SCORE 3
- 4 or more times a week ☐ SCORE 4

If NEVER – tick LOW RISK in Q4

2. How MANY drinks containing 10 grams of alcohol do you have on a typical day when drinking?*

- 1-2 ☐ SCORE 0
- 3-4 ☐ SCORE 1
- 5-6 ☐ SCORE 2
- 7-9 ☐ SCORE 3
- 10 or more ☐ SCORE 4

3. How OFTEN do you have 6 or more drinks (10 grams each) on one occasion?*

- Never ☐ SCORE 0
- Less than monthly ☐ SCORE 1
- Monthly ☐ SCORE 2
- Weekly ☐ SCORE 3
- Daily or almost daily ☐ SCORE 4

Total ALCOHOL SCORE ☐

4. (Tick risk level based on total ALCOHOL Score)

- Total SCORE 0-4 ☐ **Low Risk** *Go to body weight*
- Total SCORE 5-7 ☐ **INCREASED RISK** *Go to Q5*
- Total SCORE 8-12 ☐ **HIGH RISK** *Go to Q6*

5. ACTION INCREASED RISK
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention ☐
- **RECOMMENDED** that patient discuss with GP and complete FULL AUDIT assessment ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

A Standard drink contains 10g of pure alcohol, equivalent to:

- half pint lager or pub measure spirit or small glass wine

Recommended Max Standard drinks per week is
- 11 for women • 17 for men

Body Weight (BMI) Status and Nutrition Intervention

If the patient has had unplanned weight loss in the past 3-6 months or is unable to eat or drink. Providing weight loss advice is not appropriate at this time.

1. BMI Status

Height _____

Weight _____

BMI _____

2. BMI Categories

Underweight	BMI <18.5	☐
Normal weight	BMI18.5 –24.9	☐
Overweight	BMI 25 – 29.9	☐
Obese	BMI >30	☐
BMI not done		☐

3. ACTION BMI 18.5 – 24.9 Normal Weight
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention ☐
- **DIRECTED** to national guidelines on healthy eating ☐
- **PRESCRIBED/REFERRED** for Pharmacotherapy ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

4. ACTION BMI 25 – 30 INCREASED RISK
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention on benefits of weight reduction ☐
- **DIRECTED** to resources to help ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

5. ACTION BMI <18.5 HIGH RISK
BMI >30 HIGH RISK

- **REFERRED** to Dietitian/Specialist Services ☐
- **Patient declined/not interested** ☐
- **No action documented** ☐

Physical Activity Status and Intervention

1. In a typical week, how many days have you been physically active (PA) for total of 30 minutes or more?

- 0 days (Inadequate) ☐
- 1-4 days (Inadequate) ☐
- 5-7 days (Adequate) ☐
- Unable to be physically active ☐
- No information available ☐

2. If FOUR days or less, in a typical week have you been PA for either 150 minutes moderate or 75 minutes vigorous activity?

- Yes (Adequate) ☐
- No (Inadequate) ☐
- No information ☐

3. ACTION PATIENT REPORTING INADEQUATE PHYSICAL ACTIVITY
(Tick ALL actions taken)

- **GIVEN** brief advice / brief intervention on benefits of weight reduction ☐
- **DIRECTED** to resources to help ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes

Recommended Physical Activity is at least 30 minutes of moderate intensity physical activity 5 days per week

Blood Pressure Status and Intervention

1. Have you been diagnosed with High Blood Pressure?

- Yes ☐
- No ☐
- Unknown ☐
- **Patient declined / not interested** ☐
- **No action documented** ☐

2. ACTION HIGH BLOOD PRESSURE
(Tick ALL actions taken)

- **GIVEN** brief advice /brief intervention on benefits of salt, alcohol, weight reduction, and increasing PA ☐

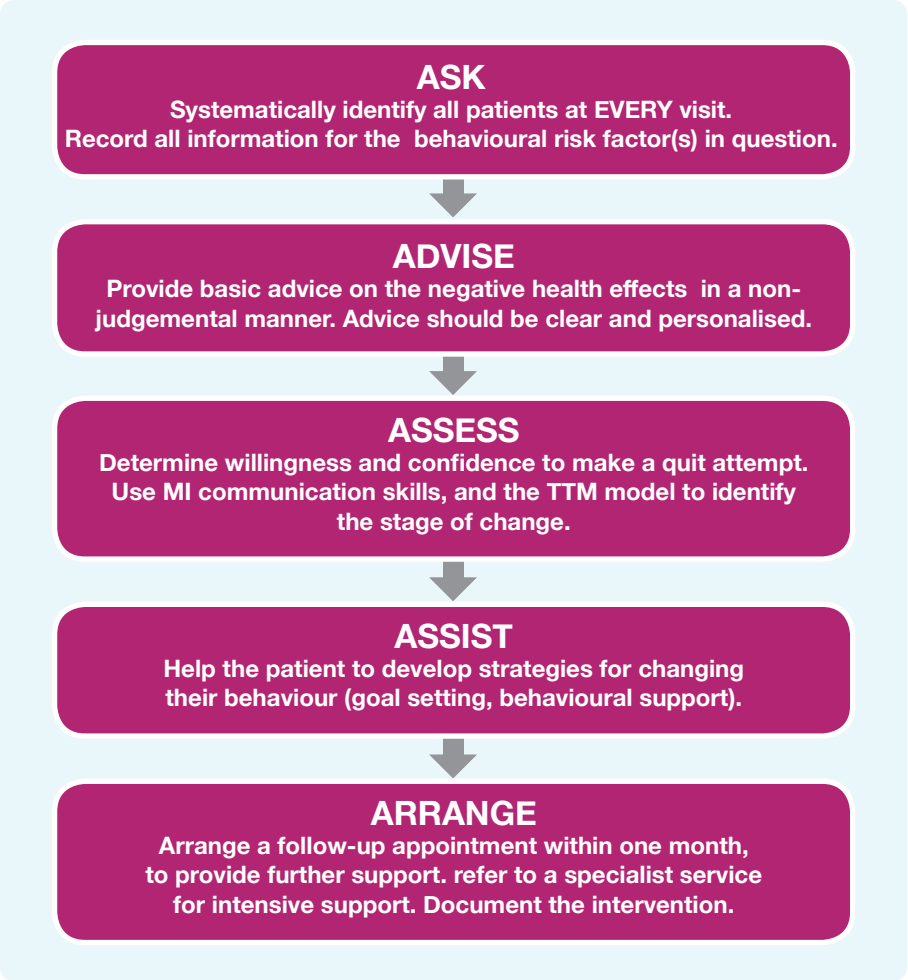
Delivering a Brief Intervention - Skills Workshop

We are now going to practice applying what we have learned in relation to carrying out a BI.

The framework below provides a useful reference for when you are conducting a BI to ensure that you cover all aspects.

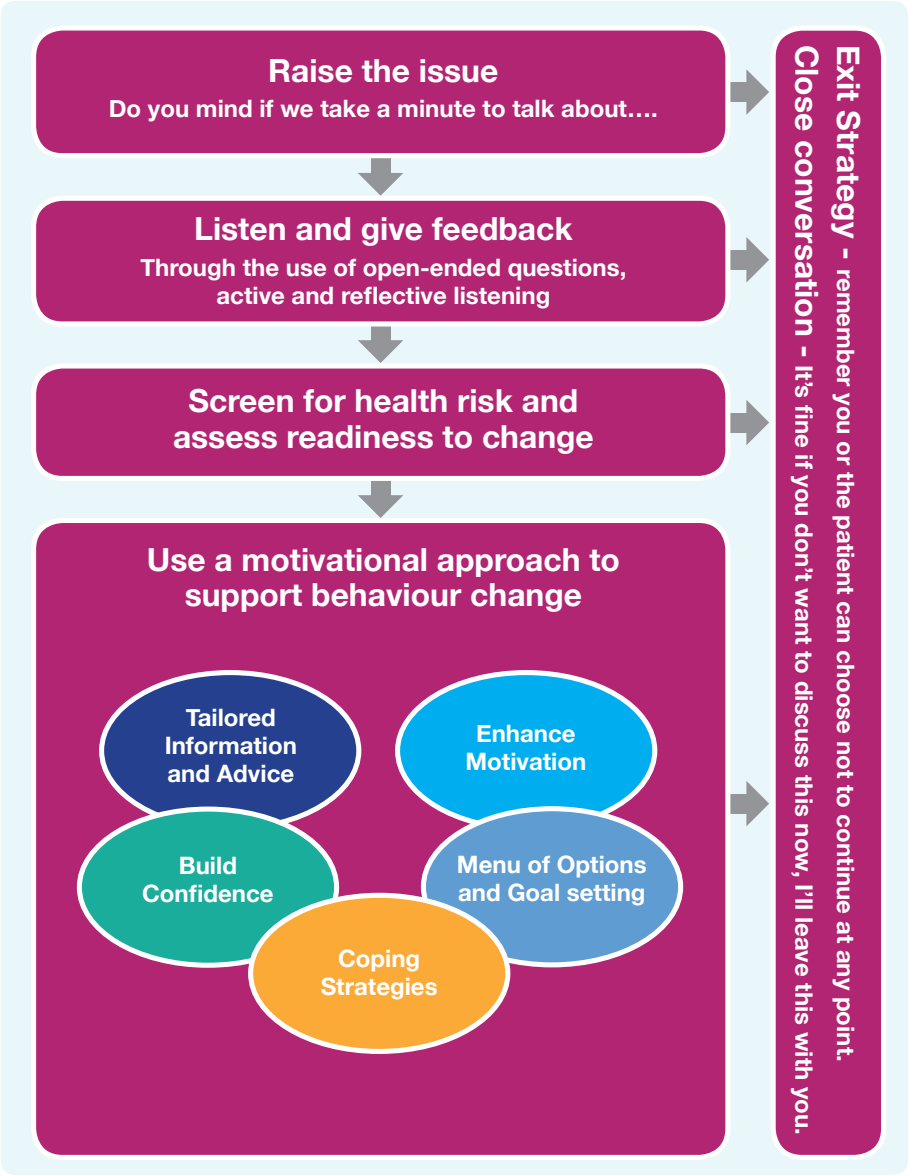
Throughout the brief intervention remember to:

- Develop and maintain rapport and empathy
- Emphasise the patient's personal responsibility for their own decisions
- Remember the 5 As



GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.



Reproduced with kind permission from Delivery of Alcohol Brief Interventions: A Competency Framework © NHS Health Scotland and NHS Education for Scotland 2010.

Activity 4.5:
Practice carrying out a BI using Real Play

You are going to use a "Real play exercise" to practice carrying out a BI. Pick a personal lifestyle behaviour that you would like to change and that you are comfortable discussing in your small group. Alternatively, you can pick a behaviour that you may have come across in your clinical training to date.

In groups of 3, students take turns to role play each of the following roles:

HCP: *try to imagine being in the patient's situation. What stage of change do you think he/she is at? What processes are important for them right now that you could target in your intervention?*

The HCPs' task is to:

1. Identify the stage of change that the patient is at.
2. Which type of intervention would be suitable for this type of patient.
3. Record at least three open-ended questions you may wish to ask the patient.
4. Use the 0-10 scaling exercise to explore ambivalence with the patient.
5. Use the Decisional Balance exercise to identify barriers and facilitators to HBC.
6. Provide factual information neutrally, and correct any misinformation.
7. Use a patient-centred approach.
8. Remember the OARS principles.
   - Open-ended questions
   - Affirmations
   - Reflective listening
   - Summarising skills

Patient: *What are the barriers to change for you? What do you think are the advantages and disadvantages to HBC for you right now? What other factors are important to you at the moment? How responsive are you to an intervention from the HCP? How do you react to their conversation with you?*

Observer: *Observe the interaction between the HCP and patient. Can you identify the skills the HCP is using, and how they impact on the patient? Who is doing most of the talking? What is the quality of the interaction – how do you think the patient feels?*

GUIDANCE NOTES FOR FACILITATORS

Face-to-face classroom delivery.

Note:

Students should be instructed to use the Tools and technique handouts to support this session.

Use Observer Checklist Handout provided with this Lesson

Handout:
Observer Checklist

Did the HCP demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide examples here
B. Use of Interpersonal Communication Skills		
Use of positive non-verbal communication Give examples		
Use of Reflective Listening Give examples		
Demonstrate empathy Give examples		
C. Encourage Dialogue		
Assess how important it is for the patient to change behaviour Give examples		
Assess how motivated the patient is to change behaviour Give examples		

Ask open-ended questions Give examples		
Provide opportunity for the patient to speak Give examples		
C. Adopt a patient-centred approach		
Use of appropriate vocabulary easily understood by the patient Give examples		
Provide information that was geared toward the patient's readiness to change Give examples		
Overall Comments		

Allow

- 10 minutes for each real play
- 3 minutes for your feedback

Be strict about time.

However……. unlike in real life, in these real plays the participants can ***'rewind the tape'*** if they get stuck, do something wrong or want to improve the interaction. They can ask one another for help, and then continue with the real play.

Activity 4.6: Practice managing challenging situations

- **Format – class discussion**
- **Facilitator reads out examples of challenging statements from the patient, and the class identify at least three responses to these statements using the MI skills covered in Unit 3 and Unit 4.**

Statement 1:
"I've tried to exercise more so many times in the past and it just doesn't work"

Statement 2:
"What's the point – the damage is done already"

Pause for Reflection and Discussion

- **Pause for Reflection and Discussion**
- **How did that exercise go for you?**
- **Have you encountered challenging conversations in your training to date?**
- **How did you react in these situations?**
  skills covered in Unit 3 and Unit 4.

GUIDANCE NOTES FOR FACILITATORS

Face-to-face classroom delivery.

Note:

If time allows in the classroom the video below showing a HCP outlining how they have dealt with challenging statements can be viewed or alternatively students can be directed to view in their own time.

Summary of lesson

In this Lesson you have learned about screening tools for each of the lifestyle areas and viewed the *Making Every Contact Count* Recording Tool for use in patient records. You have also had the opportunity to practice a BI and assess your own performance in doing so. In the next and final Lesson in relation to *Making Every Contact Count* you will explore signposting and referral services to support you with the "Arrange" part of the BI.

Unit 4: *Making Every Contact Count*: Providing Opportunistic Brief Interventions

Lesson 3: Signposting and Referral to Support Services

Duration: 1 Hour

PPT Title – Unit 4 Lesson 3:
Signposting and Referral to Support Services

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

Lesson Aims: What you will cover in this Lesson

The aim of Lesson 3 is to outline what needs to happen next. You will learn to:

- Identify additional services and specialists to whom you can refer patients who require additional supports.
- Maintain accurate records of the nature of BIs that were delivered in reports and/or medical charts and how to flag further actions for follow-up.

Recap Lesson 1-3

Lessons 1 and 2 outlined what brief interventions are, when such interventions are appropriate, and gave you the practical skills for delivering BIs.

In Lesson 2 you practiced MI skills for delivering a BI for HBC. You touched on the topic of screening and looked at some of the screening instruments which are used in practice.

Identifying additional services and specialists to whom you can refer patients who require additional supports.

Changing lifestyle behaviours and maintaining healthier choices is extremely challenging. It is therefore important that patients who receive BIs are linked with additional services and resources that can provide them with ongoing support to achieve positive long-term behaviour change.

Handout:
Fact sheet - Key Health Messages

Signposting and Referral to Support Services

Making Every Contact Count

All Healthcare professionals are being asked to make each routine contact with patients count by helping support people to make healthy lifestyle choices. We can do this by

- providing clear, consistent health messages
- Building patient confidence through person-centred conversations
- signposting to further sources of support

This factsheet provides information on where and how to signpost and refer patients for further support following a Brief Intervention.

Over the course of your clinical placement, If you are unsure what advice to give a patient or where to signpost or refer, ask a more senior staff member in your department for advice on the option for each patient.

In addition to these resources you should check out what is available locally to support patients to change their lifestyle behaviours.

Smoking Cessation

The evidence shows that a brief intervention doubles a patient's chances of making a successful quit attempt. Smokers are four times more likely to quit and stay quit using behavioural support and medication

Support available

Signpost patients thinking about quitting to www.quit.ie which provides a range of information and supports for patients who are thinking about quitting including how to access more intensive support.

- Free helpline: 1800 201 203
- Email support: support@quit.ie
- Free text support: text QUIT to 50100.
- Facebook: facebook.com/HSEquit.
- Twitter: @HSEQuitTeam
- 'One-to-one' support: Smoking Cessation clinics.

Referral to Specialist Services

Patients can self-refer to specialist smoking cessation support by accessing information on www.quit.ie or you can refer patients to the Quit service through local referral systems.

Alcohol and Drugs

A brief intervention is a highly effective approach for tackling harmful alcohol consumption. One in eight people will lower their alcohol consumption following a brief intervention and recent research has found that brief interventions can also be effective in reducing drug use.

Support available: Alcohol

www.askaboutalcohol.ie provides a one-stop-shop for information and supports to help patients cut down and maintain low risk drinking behaviours.

The website also provides:

- Online information on alcohol
- County-by-county service finder to help connect people to support and counselling services.
- Online support resources
  - Self-assessment tool
  - Drinks calculator
  - Tips for cutting down
  - Tips for staying on track

Support available: Drugs

www.drugs.ie provides a one stop shop for information and supports to help patients that are taking drugs. It provides

- Online information on drugs and alcohol
- County-by-county service finder to help connect people to support and counselling services.
- Online drug test self-assessment
- Online live help chat service: This is a free, secure and confidential online chat service 1 800 459 459

It is available during the following times: 10:00am-1:00pm and 2:30pm-5:00pm, Monday to Friday

Signposting and Referral to Support Services

Drug and Alcohol Helpline

The HSE runs a confidential alcohol and drugs helpline 1800 459 459

This helpline provides support, guidance and referral to **anyone** with a question or concern related to drug and alcohol use

If you are unsure about the most appropriate help needed for your patient, you can find out more information by:

- Calling the HSE Drug and Alcohol Helpline: 1800 459 459
- Emailing helpline@hse.ie
- Use your local service finder for your area: ww.askaboutalcohol.ie/where-to-get-help/

If you need urgent help, contact the patient's GP or nearest Emergency Department

Referral to specialist/ addiction services

As a healthcare professional you can refer patients with alcohol or drug addiction to an addiction service, but it is often difficult to know when to do so. Any patient with alcohol or drug dependence needs to be referred to a specialist addiction service. Patients can also self refer to these services.

Physical activity

1 in every 12 patients are likely to increase their physical activity following an intervention from a healthcare professional.

Support available

Most patients will need some support to be more active so some suggestions include:

- Give them the booklet Get Active Your Way and encourage them to take the activity challenge
- Check out www.getirelandactive.ie for information, hints and tips
- Follow Get Ireland Active on Facebook, Twitter and Instagram for regular motivation and support from the HSE
- Be aware of local initiatives that your patients may find helpful, e.g. Local Sports Partnership programmes, walking clubs, local Saturday morning parkrun or FitforLife

If the patient has a medical condition and is worried about being more active, suggest they visit their GP for a check up.

Healthy Eating

There is evidence that brief interventions that communicate specific healthy eating messages (e.g. Increase fruit and vegetables, limit high fat, sugar and salty foods, reduce portion size) can help support people to eat healthily.

Support available

http://www.healthyireland.ie/health-initiatives/heg/

Check out the Healthy Food for Life resources on the HSE website

- Be aware of local initiatives that your patients may find helpful, e.g. community cooking programmes
- For those who want to lose weight, signpost them to local community based weight management support groups, e.g. Weight Watchers or Slimming World

Referral to specialist services

If the patient has a medical condition that needs specialist input, refer them to a dietitian.

Order health information leaflets at
www.healthpromotion.ie/publications

Activity 4.7: Signposting and Referral

In groups, visit the websites identified on the Signposting and Referral to Support Services Handout

Try and identify the information outlined.

Did you find any additional useful information?

Present back to the class with an outline of what is available for each lifestyle area.

GUIDANCE NOTES FOR FACILITATORS

Written to support face to face or online delivery including activities and discussion points.

Maintaining accurate records of the nature of BIs that were delivered in reports and/or medical charts and flagging further actions for follow-up.

After you have spoken with a patient about a lifestyle behaviour and/or delivered a BI it is important that there is an accurate record of this in their medical chart. This is important so that the behaviour is documented (for example, the patient's smoking status) and that other HCPs interacting with the patient know what actions were taken. It is also important to flag any actions for follow-up in the future. In some settings you will be able to record information on the *Making Every Contact Count* recording tool.

When recording information in a medical chart/ *Making Every Contact Count* recording tool, as discussed in the last Lesson, you should state:

1. What lifestyle behaviour(s) you asked the patient about.
2. What screening tools (if any) you used and the outcomes of these (for example, Audit C).
3. What actions you took (for example, whether you gave the patient brief advice/ brief intervention and/or what additional resources and/or services you provided information on).
4. Any additional information that is important for follow-up (for example, following up with the patient about their smoking status at future visits or other lifestyle behaviours that were not discussed during this visit but that should be addressed in the future).
5. For students on clinical placement, this information may also be flagged to the clinical supervisor.

Key Reading

Health Service Executive (2013) National standard for tobacco cessation support programme. Dublin: Health Service Executive.

Pause for Reflection and Discussion

What are the identified supports which are available to you as HCP to support lifestyle behaviour change?

What supports do these services provide directly to patients in relation to behaviour change?

What direct referral services are available to you in your role as a HCP to which you can refer patients to?

In your role as a HCP, is it always necessary for you to refer or signpost a patient to change their behaviours?

Summary Unit 4

In Unit 4 you learned how to Make Every Contact Count and you practiced the skills which are needed to provide opportunistic brief advice and to undertake BIs. You covered the theory of brief advice, BI and MI and the differences between them as distinct approaches to HBC.

You Identified opportunities for BI in your role as a HCP and identified the patients for whom a BI is appropriate and times when a BI may not be appropriate.

You were introduced to validated screening and assessment tools to assess a patient's readiness to change and how to respond to this assessment supportively. You were also introduced to the *Making Every Contact Count* Recording Tool. You had opportunity to assess your own performance in delivering a BI using self-reflective practice.

You have now completed the *Making Every Contact Count* Undergraduate Curriculum content lessons. Included in this has been the completion of the HSEs' *Making Every Contact Count* elearning training modules. These modules have been developed so that all healthcare professionals can revisit them again and again and particularly to engage with the Extend My Learning sections of: Do more, Learn More, Read More to help you integrate BIs as part of routine clinical practice with every patient.

Handout Unit 4 Lesson 1 Activity 4.3:
Decisional Balance and Scaling Worksheet

Decisional Balance Sheet		
	Disadvantages	**Advantages**
No Change		
Change		

On a scale from 1-10 how important is it to you to become more active?									
Not Important									**Very Important**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Handout Unit 4 Lesson 2 Activity 4.5:
Observer Checklist

Did the HCP demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide examples here
F. Use of Interpersonal Communication Skills		
Use of positive non-verbal communication Give examples		
Use of Reflective Listening Give examples		
Demonstrate empathy Give examples		
G. Encourage Dialogue		
Assess how important it is for the patient to change behaviour Give examples		
Assess how motivated the patient is to change behaviour Give examples		
Ask open-ended questions Give examples		
Provide opportunity for the patient to speak Give examples		

C. Adopt a patient-centred approach		
Use of appropriate vocabulary easily understood by the patient Give examples		
Provide information that was geared toward the patient's readiness to change Give examples		
Overall Comments		

References

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Appendices

Appendix 1 Methodology

The approach to developing this Curriculum was national and collaborative between the HSE and the Higher Educational Institutions (HEIs) of Ireland. This collaboration involved the establishment of a National Steering Group, a National Working Group and Local Working Groups in each HEI. The establishment of both the National Steering Group and National Working Group was initiated by the HSE. The Local Working Groups in each HEI were established by the HEI representatives on the National Working Group. Collectively, representation from the HSE and HEIs across all working groups included expertise on health behaviour change (HBC) and chronic disease prevention and management, drawing from a range of healthcare disciplines and professions.

A systematic approach to curriculum development was adopted involving four stages (Quinn, 2000):

1. Exploratory
2. Design
3. Implementation
4. Monitoring and Review.

1 Exploratory Stage

The exploratory stage involved matrix mapping of existing curricula and a literature search to identify relevant evidence to inform the Curriculum.

- A *matrix mapping exercise* was conducted to identify existing curricula on HBC and CDP for undergraduate healthcare students across all HEIs. The curricular components mapped in tabular form included: programme title; module title; broad aims; theoretical content and pedagogical approaches; skills content and pedagogical approaches; practical or 'real life' exercises; approaches to assessment; and key learning resources for students. A key observation noted from this mapping exercise was the variation across HEIs on the delivery of content about HBC for CD prevention. Overall, there were some consistencies relating to theoretical content such as theories of behavioural change, health promotion and disease management. However, it was apparent that many of the existing curricula lacked a strong focus on skills or experiential training with few providing training in brief intervention (Appendix 4 offers a selection of examples of the matrix mapping exercises). In addition, approaches to assessment relating to HBC and CDP relied largely on pen and paper exercises rather than skills assessment. This exploratory mapping offered important insights into strengths and weaknesses of existing curricula. In particular, the strengths identified across various curricula became very useful resources in designing this National Curriculum on HBC and CDP.
- *A literature search* was carried out to retrieve relevant evidence to support the development of this Curriculum. Key terms for the search with various combinations applied were curricula/ curriculum, development, undergraduate, healthcare, lifestyle behaviour change, lifestyle choices, self-management, chronic disease prevention, person-centred care, philosophy, brief intervention and *Making Every Contact Count*. The searches were carried out in the electronic databases Cinahl and Medline. We also searched for government publications, key reports and other grey literature using google searches.

A critical path analysis of the exploratory stage of the project is presented in Tables 7 and 8.

Table 7: Critical Path Analysis 2015/2016

Sep 2015	Dec 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dev 2016
SG Established											
	NWG con-firmed										
		LWGs Formed									
		Matrix Mapping Existing Curriculum									
			Literature Search								
								Curriculum Manual Development/Writing			
									Presentations to raise awareness across Schools		

Table 8: Critical Path Analysis 2017

Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dev 2017
Drafting Curriculum Manual											
	Learning Outcomes submitted to Teaching and Learning Curriculum Committees										
		Correspondence with professional Bodies									
				World Café Event							
				Workshop on Imple-mentation							
			Curriculum Manual review								
								Phased Curriculum Implementa-tion			
								Ongoing Implementation Monitoring			

Development of the competency framework

The competencies for this Curriculum were developed following a lengthy collaborative. Firstly, we performed an in-depth review of key documents and literature and drafted a preliminary competency framework. We engaged in a number of national consultative workshops which involved consultation, review and amendment by members of the NWG. The competencies were further reviewed by LWG members across HEIs to inform the development process and drafting of the final competency framework. As the project progressed competencies were re-visited to ensure that they were visible, accurate, achievable and sustainable.

Curriculum Design

In the design stage of curriculum development key members were identified to direct the planning, formation and validation of the curriculum (Quinn, 2000). We drew on the expertise from members of the NWGs and LWGs to inform the philosophy and design of this Curriculum. We reviewed curricula published in healthcare literature and engaged with both national and international competency frameworks for core healthcare professional undergraduate programmes.

Validation: The Curriculum was presented to the SG and LWGs for validation purposes.

Support for facilitators: In conjunction with the development of the curriculum, support and training will be available for educators involved in the delivery of the programme.

The *Implementation and Monitoring and Review* components of curriculum development are dealt with in detail in Section 1.

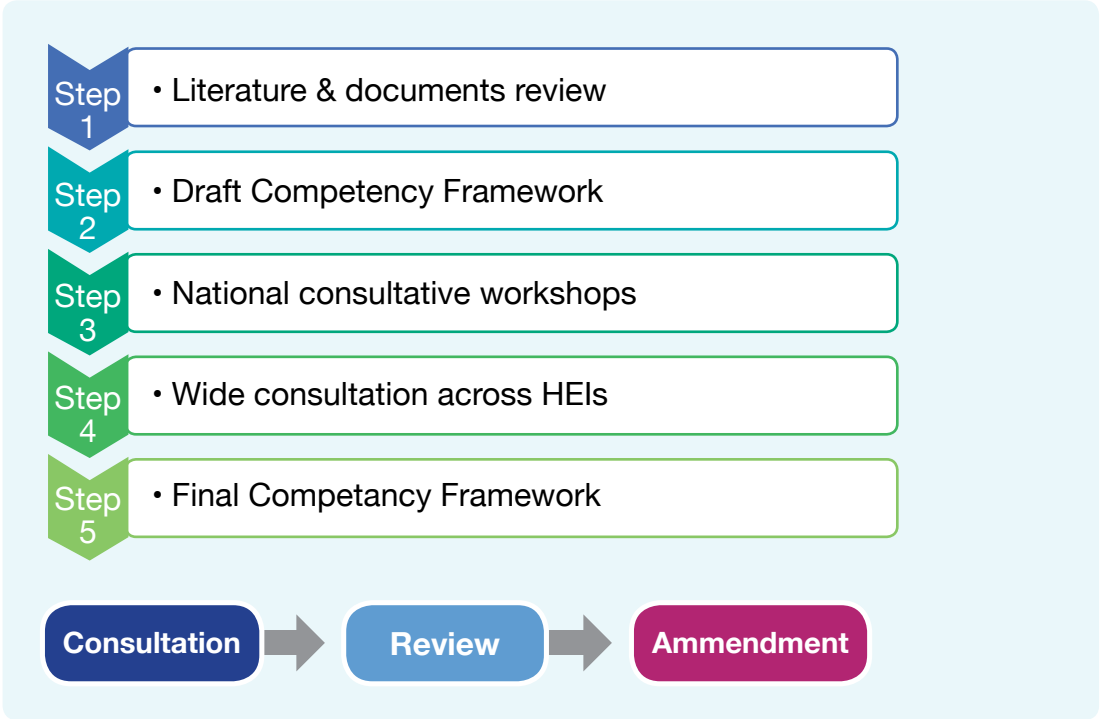


Figure 4: Development of the Curriculum Framework

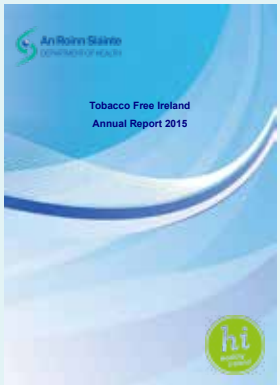
Appendix 2
Policies for chronic disease prevention

A Healthy Weight for Ireland Policy and Action Plan 2015 – 2025 recommends that all healthcare staff are trained to deliver a brief intervention to promote physical activity and a healthy diet.

Available at: https://health.gov.ie/wp-content/uploads/2016/09/A-Healthy-Weight-for-Ireland-Obesity-Policy-and-Action-Plan-2016-2025.pdf

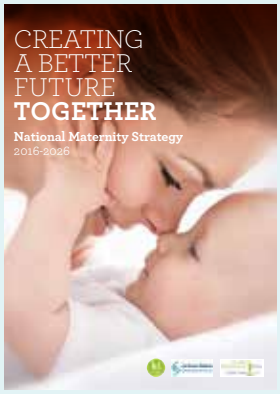
The *National Physical Activity Plan for Ireland (2016)* highlights how physical activity is a key part, not only in the prevention of chronic diseases, but also in the treatment plans of those with certain chronic diseases particularly in the early stages. The need for staff in the health service to develop the skills to support patients to make health behaviour changes is also emphasised.

Available at: http://www.getirelandactive.ie/Professionals/National-PA-Plan.pdf



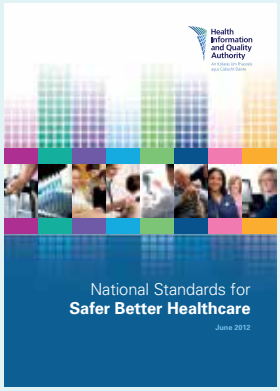
The *Tobacco Free Ireland Action Plan (2015)* recommends that all frontline healthcare workers are trained to deliver interventions for behaviour change in relation to tobacco use as part of their routine work.

Available at: https://health.gov.ie/wp-content/uploads/2017/03/Tobacco-Free-Ireland-Annual-Report-2015.pdf



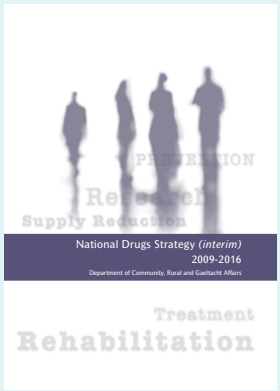
The *National Maternity Strategy (2016 – 2026)* advocates for a focus on health and wellbeing to ensure that babies get the best start in life and that mothers and families are supported and empowered to improve their own health.

Available at: http://health.gov.ie/wp-content/uploads/2016/01/Final-version-27.01.16.pdf



The *National Standards for Safer Better Healthcare* (HIQA) sets out the key principles of quality and safety that need to be applied to all healthcare settings. Whilst a number of these standards refer to the broad elements of health and wellbeing for patients, Standard 1.9 and 4.1 set out specific criteria which healthcare facilities need to reach in order to support patients to maintain and improve their health. In addition, the standards include the development and support of an environment and culture that promotes better health and wellbeing for both patients and staff. These standards are strong drivers for the implementation of *Making Every Contact Count* in the Irish context.

Available at: http://www.drugs.ie/downloadDocs/2017/National-Standards-for-Safer-Better-Healthcare.pdf



The *National Drugs Strategy (Interim) 2009 - 2016* recommends the implementation of screening programmes and brief interventions against the hazardous and harmful use of alcohol.

Available at: https://www.drugsandalcohol.ie/12388/1/DCRGA_Strategy_2009-2016.pdf

Appendix 3
Person-Centred Care Definitions

Reference	Definition and Web link (where applicable)	Context
Institute of Medicine (2001)	Person-centred means "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p.3). Available at: https://www.ncbi.nlm.nih.gov/pubmed/25057539	IOM's strategy for a new health system for the 21st Century in the USA with an emphasis on quality improvement.
WHO (2007)	A people centred approach "involves a balanced consideration of the rights and needs as well as the responsibilities and capacities of all constituents and stakeholders of the healthcare system" (p. 5) Available at: http://www.wpro.who.int/health_services/people_at_the_centre_of_care/documents/ENG-PCIPolicyFramework.pdf	A policy framework for people centred healthcare published by WHO's Western Pacific Region.
Health Innovation Network, South London (2016)	"Person-centred care is a way of thinking and doing things that sees the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome" (p. 1). Available at: http://healthinnovationnetwork.com/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf	A document on what is meant by person centred care and why it is important to high quality healthcare.
Morgan & Yodar (2012)	Person-centred care is an approach to care characterised by the following defining attributes: "(a) holistic, (b) individualized, (c) respectful, and (d) empowering" (p. 8). Available at: Morgan, S., & Yodar, L. (2012). A Con-cept Analysis of Person-Centered Care. Journal of Holistic Nursing, 30(1), 6-15.	A concept analysis on person-centred care.

HIQA (2012)	"Being person-centred means providers communicate in a manner that supports the development of a relationship based on trust. Good communicate and the provision of adequate information sources ensures that service users make informed decisions about their care, including informed decision making to give or refuse consent to treat-ment" (p.19). Available at: https://www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf	Part of *National Stand-ards for Safer Better Healthcare* in Ireland, which include a standard specific to Patient-Centred Care and Sup-port.
The Health Foundation UK (2014)	Person-centred care involves health and social care professionals working "collaboratively with people who use services. Person-centred care supports people to develop knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and healthcare. It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect" (p.3). Available at: https://www.health.org.uk/sites/health/files/PersonCentredCareMadeSimple.pdf	A document on person-centred care from the Health Foundation, an independent charity in the UK working to im-prove healthcare quality.

Appendix 4
Implementation Exercise and Examples of a Selection of Matrix Mapping Exercises Informing Curriculum Development

To be completed for each Healthcare Programme within each HEI
Implementation Plan Template

Undergraduate Curriculum for Health Behaviour Change for Chronic Disease Prevention and Management:						**Implementation Plan** **Please Complete this Section:**					
HEI Name	**Programme**	**Approximate Student Numbers**	**Unit**	**Year**	**Lesson**	**Lesson Covered in Existing Module Yes/No**	**If Yes Please state: Module Name/Code/ Year**	**Will it be continued in this module?** **Yes/No**	**If No** **Please state: Proposed Implementation Placement Module Name/ Code/Year**	**Module Lead** **Please state:** **Name and Contact**	**Comments**
			1 Health and Personal Wellness	1	Lesson 1 Defining Health						
					Lesson 2 The Biopsychosocial Model of Health						
					Lesson 3 Lifestyle Influences on Health						
					Lesson 4 Key Health Messages						

11 This Curriculum is intended for delivery over your entire programme however it may be delivered in block format. The recommended years for delivery for each Unit are provided however this is a guide only.

This implementation plan was developed before the eLearning modules were finalised and may vary from the final version.

Undergraduate Curriculum for Health Behaviour Change for Chronic Disease Prevention and Management:						**Implementation Plan** **Please Complete this Section:**					
HEI Name	**Programme**	**Approximate Student Numbers**	**Unit**	**Year**	**Lesson**	**Lesson Covered in Existing Module Yes/No**	**If Yes Please state: Module Name/Code/ Year**	**Will it be continued in this module?** **Yes/No**	**If No** **Please state: Proposed Implementation Placement Module Name/ Code/Year**	**Module Lead** **Please state:** **Name and Contact**	**Comments**
			2 Lifestyle Behaviours and Personal Responsibility for Health	1 or 2	**Lesson 1** Health Behaviour						
					Lesson 2 Student Health Behaviour						
					Lesson 3 Behaviour Change						
					Lesson 4 Theories of Health Behaviour Change						

Undergraduate Curriculum for Health Behaviour Change for Chronic Disease Prevention and Management:						**Implementation Plan** **Please Complete this Section:**					
HEI Name	**Programme**	**Approximate Student Numbers**	**Unit**	**Year**	**Lesson**	**Lesson Covered in Existing Module Yes/No**	**If Yes Please state: Module Name/Code/ Year**	**Will it be continued in this module?** **Yes/No**	**If No** **Please state: Proposed Implementation Placement Module Name/ Code/Year**	**Module Lead** **Please state:** **Name and Contact**	**Comments**
			3 Communication for Healthy Lifestyles and Health Behaviour Change	2 or 3	**Lesson 1** Communication Skills for Brief Intervention						
					Lesson 2 Communicating for Health Behaviour Change						
					Lesson 3 Interacting for Behaviour Change						
					Six online modules Module 1: Introduction to Behaviour Change Module 2: Alcohol and Drug Use Module 3: Healthy Food for Life Module 4: Tobacco Free Ireland Module 5: Get Ireland Active Module 6: Skills into Practice Module Available at: URL Link to HSEMECC Microsite						

Undergraduate Curriculum for Health Behaviour Change for Chronic Disease Prevention and Management:						**Implementation Plan** **Please Complete this Section:**					
HEI Name	**Programme**	**Approximate Student Numbers**	**Unit**	**Year**	**Lesson**	**Lesson Covered in Existing Module Yes/No**	**If Yes Please state: Module Name/Code/ Year**	**Will it be continued in this module?** **Yes/No**	**If No** **Please state: Proposed Implementation Placement Module Name/ Code/Year**	**Module Lead** **Please state:** **Name and Contact**	**Comments**
			4 *Making Every Contact Count*: Providing Opportunistic Brief Interventions	3 or 4	**Lesson 1** Recap of Units 1-3						
					Lesson 2 Theoretical and practical context for brief interventions and health behaviour change						
					Lesson 3 Brief intervention approach including assessment, screening and recording						
					Lesson 4 Signposting and referral to support services Duration:						

A Selection of Matrix Mapping Exercises Informing Curriculum Development

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
Nursing and Midwifery	**DKIT**	Management of Diabetes and Obesity Year 3 Elective	Design, implement and evaluate a health promotion intervention aimed at treating and preventing obesity and diabetes	Exercise interventions included in contact hours	Part of scheduled clinical placement	Continuous
		Health Education Across the Lifespan Year 3 Core	Utilise skills and knowledge to provide a person-centred approach to health education/promotion for people with Intellectual Disability	Part of scheduled clinical placement	Part of scheduled clinical placement	Group Project
		Nursing the Person with a Physical Illness Year 2 Core	Appraise targeted health promotion and health prevention initiatives and policies designed to target those with a severe or chronic mental health illness	Part of scheduled clinical placement	Part of scheduled clinical placement	Final Exam
	GMIT	Approaches to Chronic Illness Management and Prevention. Stage 4	The module facilitates a wide-ranging exploration of the concept of chronicity and the burden of chronic disease. It examines the challenges and approaches to improving patient outcomes in chronic disease from population based preventative strategies through to end stage management	Not explicit	Not explicit	Continuous assessment
		Health Promotion Stage 3	Providing students with a grasp of the principles of the practice of health promotion focussing on the role of the nurse promoting health within a range of settings.	Particular clinical/ populations focus on alcohol, obesity, smoking, physical activity, mental health, suicide prevention.	Not explicit	Continuous assessment

12 This is a selection of the mapping exercises received, it is not inclusive of all the mapping exercises from each School or Programme.

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Change and Education Stage 4	Develop an awareness of the importance of change management within nursing and healthcare – the importance of promoting change through education of healthcare practitioners and users. Develop an understanding of methods of promoting a change culture within the practice environment.	Design plans for teaching colleagues and patients	Not explicit	Continuous assessment
		Social Issues in Health and HealthCare. Stage 2	Enable Students understand how social factors and conditions contribute to health status and social well-being. The social model of health, health and social inequality and social issues in healthcare. This module also explores the social role of the nurse – in particular the social role of the contemporary nurse as an agent for social change	Not explicit	Not explicit	Continuous assessment
		The Psychiatric Nurse as an agent for change. Stage 4	Examination of the professional role of registers psychiatric nurses and how that governs practice. Evaluation of the leadership role of the psychiatric nurse. Develop an understanding of the theories of change management. Develop an understanding of how to promote a culture of change within the practice environment.	Explores the role of the nurse as an educator and the use of 'self' as an agent of practice change	Not explicit	Exam
		Health Promotion. Stage 4	Promoting health as an integral part of the role of the nurse and develop critical understanding of the principles and practice of health promotion. Understand concepts, definitions, approaches to and models of health promotion. Understand the history and development of health promotion at national and international level. Explore ethical issues in relation to health promotion	Not explicit	Not explicit	Exam

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
	WIT	Introduction to Health and Disease Year 1	The concept and theories of health. The role of international, national and local organisations in health promotion. The nurse as a health promotor in a range of healthcare settings and the skills needed	Not explicit	Enquiry Group Work on Case Studies -	Exam
		Introduction to Health Promotion and Health Behaviour Change Year 2	Models of and approaches to health promotion: medical, educational, behavioural, empowerment, societal or political; primary, secondary and tertiary levels; health promotion as health protection, prevention and health Helping people change health behaviours: Behaviour change models and the Health Belief model: the value of communication, motivational interviewing and brief intervention in changing behaviour Changing patterns of health and illness Applying health promotion theory to a range of practice settings and within their own discipline Blended learning- Delivered over 6 hours face-to-face with weekly online activities	Limited practice in seminar groups on communication for health promotion and motivational interviewing skills – 2 hours in groups of 10 students.	Enquiry Group Work on Case Studies -	Exam
		Introduction to Chronic Disease Prevention Year 3	Skills in health promotion: teaching, presentation, use of resources, identifying needs, planning frameworks, evaluating initiatives. Using models to plan health promotion interventions. Health promotion with key groups and settings across the lifespan for their discipline with a focus on chronic diseases. Ethical issues in health promotion	Not explicit	Enquiry group work on case studies	Exam

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
	ITT	Prevention and Management of Chronic Illness Year 3 (10 credits)	To build upon existing knowledge of health and health promotion and apply this to the prevention and management of chronic illness. In addition to this, the learner will develop the knowledge and skills needed to manage chronic illness and support the individual's self-management of their illness. Population health approach / settings underpin the module. Key content includes: Transtheoretical model of behaviour change and Chronic Care Model.	Hands on practical skills via the workshops and also in associated areas which correspond to the topic chosen for their assessment.	Experiential time spent in an older person's residence developing a Reusable learning objective (R.L.O.) for hand therapy. Schools for an activity based RLO etc.	Continuous assessment (50% development and presentation of RLO, 50% assignment reflecting wider content of the module).
	DCU	Specialist Approaches in Nursing Practice 2 NS320	To enable students to explore the principles and practice of primary healthcare, community health nursing and population health	Some guest speakers from the community provide practical examples of how chronic disease burden is addressed in community e.g. Community Intervention Teams and Public Health Nurse with a particular focus on chronic disease and health education	Students placements on other modules link with this theoretical module.	Essay
		Health /Nursing Informatics NS324 Core	Explain to students the principles underpinning eHealth, specifically the transformation programme to new care delivery models in accordance with WHO and national policy agendas	Practice focused module includes case study	Not explicit	Not explicit

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		General Nursing 5: Care of the Adult NS373 Core	To enable students to review principles and practices required to deliver nursing care to patients with range of disorders but of relevance Hope to introduce Brief Intervention Smoking Cessation Training as part of the module in the coming year. Analyse the concepts of health and health promotion. Debate key principles of health promotion and how they underpin healthcare delivery to individuals, family and community. Examine health promotion policy development from a national and international perspective. Explore health promotion models. Identify relevant approaches to health promotion delivery. Critique the role of the nurse in meeting the health promotion needs of different patient groups.	Not explicit	Not explicit	Exam on patient care scenarios
		NS213 Core Clinical and Health Issues for Child and Adolescent With Intellectual Disability	Develop their knowledge and skills of the health needs of the child and adolescent with an intellectual disability and to assist the individual experience optimum health and well-being.	None relevant identified	Not explicit	Course Work 30% objective structured clinical examination (OSCE). End of semester formal examination 70%

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NS315 Core Specialist Approaches to Nursing Practice: People with Intellectual Disabilities(ID) with a Mental Health Problem	Students will have a theoretical and practical knowledge of identifying, assessing and planning the evidence based interventions for people with ID who may have a mental health problem. Classifying and describing the major mental health issues within society will be acquired during the module course.	The students will engage in discussions and assessment projects that will advance their knowledge, skills and communication techniques with people with ID who need to understand and, take ownership, plan a future and/ or maintain a healthy mental position.	Each student will complete specific assessments with reliable and valid tools used in practice. Presentations from staff who are leading in the areas and influencing the future of these mental health promotion services	Assessment is ongoing throughout the semester. Presentations, short questions and attendance monitoring are some of the techniques used to increase shared learning in class
		NS4515 Core Practice module and Health promotion activity as prescribed learning	The aim of this project is to enable the student to develop the skills to plan a health promotion activity for an individual or group of people with an intellectual disability.	Health Promotion Activity (Intellectual Disability) while on a 8 week placement	Health Promotion Activity drawn up in collaboration with the CPC, the preceptor and nursing unit staff while using an inclusive principle working with and for people with intellectual disabilities	Report of 1500 words on Health Promotion Activity (Intellectual Disability)

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NS211Psychiatric Mental Health Nursing 2	This module will assist students to develop their knowledge and skills in formulating and planning care with people who have mental health problems. Students will be introduced to interventions that support and promote mental health well being	12 hours of practical skills which covers topics like: (1) Talking and listening to people who experience distress (2) Care planning and goal setting (3) motivational interviewing. The module also has mental health service user involvement.	Not explicit	Continuous assessment
		NS328 Working with Complex Needs	This module aims to equip students with the knowledge and skills required to assess, plan and evaluate care for people at risk or with complex mental health needs. Students will be introduced to interventions that support and promote mental health well-being for people with complex needs	None	Not explicit	Exam
	UCC	NU 1047 Introduction to communication skills Year 1	Communication in chronic illness – active listening and questioning	Role play	Not explicit	Reflective project - drawing on both their nursing and psychological knowledge and skills

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NU1058 Support of the individual and the family in diagnosis of a chronic condition or disability in society	Ensuring that nurses recognise the particular needs of people with disabilities and work towards promoting and improving their health. Developing an awareness of social policy interventions for improving health and wellbeing, with a particular focus on disability.	No	No	Exam
		NU2057Management of acute and chronic conditions in the primary (community) healthcare context including perspectives on enabling self-management of chronic illnesses.	Chronic conditions including approaches to health promotion, nutrition and medication management. Sensitivity towards individuals with acute and chronic conditions. Face-to-face	No	No	Exam
		NU2058 Nursing and applicable principles of science for individuals with varying acute and chronic conditions including approaches to health promotion, nutrition and medication management.	Fundamental principles of nutrition as well as individuals' food and eating practices in a variety of contexts.	No	No	Exam question related to health promotion
		NU2059 Healthy active aging, consideration of evidence based practice in the care of the older adult.	How nurses can collaborate with and advocate for older people to promote their health and wellbeing	No	No	Exam

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NU3078 Current major population health issues in the local national and global context. Lay beliefs relating to health, wellness and illness. Factors that affect motivation. Scope of and approaches to health promotion. Planning and design of health promotion initiatives (a community perspective).	Theories of change. The role of the nurse in health promotion (a community perspective, with particular reference to marginalised groups). Professional challenges in relation to Health Promotion.	Yes	No	the design of a health promotion information leaflet (100 marks)). and Continuous assessment
		NU3079 Nursing and applicable approaches to health promotion, nutrition and medication management. Discuss person-centred approaches to nursing care showing sensitivity towards individuals with acute and chronic conditions.	Chronic disease management and nursing - re various chronic conditions Sociocultural influences on health behaviours. lifestyle behaviours. The nurse's role in primary, secondary and tertiary prevention.	No	No	Exam
		NU 3090 Introduction to epidemiology, public health and health promotion, key issues in public health. Nursing: Globalisation and health, lay beliefs relating to health, wellness and illness. Factors that affect motivation. Scope of and approaches to health promotion.	Planning and design of health promotion initiatives (a community perspective). Theories of change. The role of the nurse in health promotion (a community perspective, with particular reference to marginalised groups). Professional challenges in relation to Health Promotion.	No	No	the design of a health promotion information leaflet (100 marks).

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NU4078 Principles and practices of effective and therapeutic helping, drawing on relevant counselling approaches and skills with individuals	Identify factors that contribute to effective/ineffective communication when working with individuals and members of the healthcare team. Explore the impact of stress on effective therapeutic communication and personal management of stress.	Role play	Not explicit	Essay
	UL	NM4161 Communication and Interpersonal relationships in Nursing & Midwifery	To introduce skills and knowledge necessary for the development of respectful, equitable and effective communication in nursing and midwifery practice. The development of students' communication and interpersonal skills will be facilitated so as to enhance professional and therapeutic relationships	Communication skills for brief intervention and communication for assessment and motivation to change	Role play, demonstrations, Paired exercises	PRT Examination and Poster Presentation
		NM4147 Mental Health Nursing and Complex Care	To develop students' knowledge, understanding and nursing management of individuals experiencing a range of contemporary issues and complex mental health difficulties	Screening, Detox management safety planning, behaviour modification, CBT	Role play, demonstrations,	Written assignment/ examination, skill examination
		NM4163 Nutrition for Nursing Practice	To providing undergraduate students with an understanding of key nursing contributions to person centred care in relation to nutrition	Clinical skills development	Case scenarios re behaviour change	Written assignment/ examination, OSCE examination
		NM4181 Person Centred Medical Nursing	To build on the philosophies and fundamentals of person centred nursing and introduce students to the principles of acute medical nursing	Clinical skills development	Case scenarios re behaviour change	Written assessment/ examination, OSCE examination

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NM4092 Introduction to Health & Health Promotion common to nursing and midwifery programmes	To introduce the concepts of health, health education and health promotion to nursing and midwifery students and provide the necessary foundation to develop the competence in the promotion of health	Skills associated with health education and promotion e.g. motivational interviewing	Role play and Case scenarios	Assignments Group Presentation and written examination
	UCD	NMHS 10210 Promoting Wellness in Childbearing Women	How Healthy are you? Health history questionnaire is completed by each student at the beginning of the module to raise the topic of their own attitudes and behaviours towards health & wellbeing	BSc Midwifery		Health promotion poster and abstract
		NMHS 30980 Biopsychosocial issues in clinical Practice	Health Behaviour Theory and its application in clinical practice. Students are introduced to the Health Belief Model (HBM) and Theory of Planned Behaviour (TPB). Diabetes is used as an exemplar with these theories to help student's understanding of health behaviours as seen in the general population. Reference to the students own health behaviours is made throughout the discussion.	BSc Nursing (General, Mental Health and Integrated Children's and General).		Students may choose to discuss this topic as part of their assignment.
		NMHS30650 Cultural Competence In Clinical Practice	Cultural Knowledge and cultural awareness in relation to health and wellbeing.	Elective		Part of an assignment based on a cultural encounter.
		NMHS32450 Health Promotion and Sociology	Part of 3 different lectures topics: Tobacco Obesity, Healthy eating, physical activity and exercise. Self-reflection on attitudes, practices and thoughts about alcohol intake, smoking, exercise and nutrition.	BSc Nursing (General, Mental Health and Integrated Children's and General)		May be integrated into part of an exam question.

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		NMHS32450 Health Promotion and Sociology	Socio-ecological model. 5 layers of influence that influence behaviour in bi-directional manner: Intrapersonal, Interpersonal, Community, Institution and Public Policy.	BSc Nursing (General, Mental Health and Integrated Children's and General		May be an exam question or integrated into part of an exam question.
Medicine	**UL**	BM4021 - professional competencies 1	This module comprises a range of topics that increasingly required by a competent and reflective medical practitioner. These include, among others, Health Psychology, - Social and community aspects of healthcare, Public Health Medicine, Biostatistics, - Health Promotion and Disease Prevention, etc. Students must demonstrate an appreciation of the behavioural sciences in relation to medicine. Can explain the importance of health promotion and disease prevention	Not explicit	Not explicit	Exam
		BM4004 – medicine The Core Curriculum is outcome focused, being centred on common clinical conditions relevant to medicine that all students must be able to manage by the time of their graduation	Students must demonstrate an appreciation of the behavioural sciences in relation to medicine and explain the importance of health promotion and disease prevention	This module based predominantly on an apprenticeship model in the clinical setting aims to develop students' knowledge of common medical conditions and clinical presentations in the area	Not explicit	Exam and OSCE

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
	RCSI	JC1: Clinical Competencies and Early Patient Contact (CC/EPC	To introduce students to a patient early in their medical education in order to foster an appreciation of: 1) the doctor's professional responsibilities; 2) the importance of the patient doctor relationship; and 3) the patient experience of chronic illness. EPC2: Living with a chronic illness: The challenges faced by patients living with a chronic disease, the impact a chronic disease on a patient's family, social and cultural influences on health EPC3 GP Visit preparation 1 - General Practice: The doctor patient relationship; social and cultural influences on health; primary, secondary and tertiary prevention; chronic disease management	Communication skills	Not explicit	Clinical skills assessment (OSCE
		JC2: Health, Behaviour and Patient Safety (HBPS)	To develop the students' knowledge and understanding of psychosocial, developmental and ethical factors that influence health, behaviours and quality healthcare, and develop team working and reflective practitioner skills.	Not explicit	Not explicit	Individual assignment: Application of Team project: End of year written examination: Multiple choice

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		JC3 Public Health Epidemiology (PHE)	To teach students basic epidemiology and public health medicine principles, concepts, and procedures useful in the surveillance and investigation of health states and the planning and provision of services.	Not explicit	Not explicit	Continuous assessment: 1) MCQ quizzes 2) Individual exercise: real data. 3) Team-based project appraising a public health research paper and selecting suitable prevention strategies to reduce or prevent the health problem.
		JC3: Neuroscience (NS)	(Overall learning objectives not relevant but final lecture on Psychotherapy applicable to behaviour change)	Not explicit	Not explicit	Anatomy card signings and MCQ 'quizzes'
		IC2 Tropical Medicine (TM)	Main routes and risks of HIV transmission (e.g., sexual risk factors); strategies for HIV prevention and control (education, sexual prevention, prevention of spread through intravenous drug use, prevention of mother to child transmission)	Not explicit	Not explicit	Clinical pathological case or 2 short notes; MCQs

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		IC2: Smoking Cessation Training workshop	To teach students motivational interviewing skills and allow them to apply these in practice	Motivational interviewing	Not explicit	Not explicit
		SC1 General Practice (GP)	GP Health promotion: The role and challenges of health promotion in Primary Care; definition of health promotion; potential barriers; screening and the behaviour change cycle; the Stages of change model; intervention strategies to promote health; motivational interviewing techniques to change behaviour	Not explicit	Workshops, GP clinical	Continuous clinical skills assessment
	TCD	Human Development, Behavioural Science and Ethics 1st	Childhood adversity. Display an awareness of the potential origins of risky health behaviours in childhood adversity, and barriers to change that this creates. Social Psychology. Display an awareness of the relation between attitudes/ dispositions and behaviours, the role of cognitive dissonance in belief and behaviour change particularly in regard to smoking, theories of social influence. Cognitive psychology. Display an awareness of the role of cognitive biases in attributions for the behaviour of self and others, as well as how schema influence perceptions and the relevance of this for health-behaviour change.	Not explicit	Not explicit	Problem-based learning tutorials assessment, reflective diary, end of year written exam.

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Communication skills (as part of Fundamentals of Clinical and Professional Practice) Year 2	Doctor-patient communication. Communication skills. Understanding patients' perspectives. Involving patients. Working with patients to identify and achieve health behaviour goals. Shared decision making and negotiating. Face-to-Face	Not explicit	Simulated role play with professional actors	OSCE
		Psychiatry and Psychology Applied to Medicine Year 3	Health Behaviour Change. Understand models of health behaviour change and their practical application. Personality and communication. Understand how personality shapes behaviour. Assessment of eating habits and body image. Understand role of cognitions on eating health behaviours, as well as potential interventions. Stress, perfectionism and groups. Understand role of group dynamics on health behaviour change, and the inter-relation between stress and coping behaviours. Sick-role and illness behaviour. Understand how sick-role can influence health behaviours.	Not explicit	Not explicit	Written essay
		Year 4 Public Health and Primary Care	Primary Care: Importance of disease prevention in primary care a) role in prevention of different members of the practice team b) describe primary, secondary and tertiary prevention	Not explicit	Not explicit	Not explicit

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
	NUIG	Medical Professionalism 'Health and Society' year 2	Theory of behaviour change, behaviour change models, evidence base for health behaviours and behaviour change techniques.	Not explicit	Not explicit	Exam
		Special Study Module 'Getting Better at Behaviour Change' Year 4	Theory of behaviour change, Behaviour change models, Evidence base for health behaviours and behaviour change techniques. Practical: Introduction to motivational interviewing techniques, open-ended questions, reflective listening, affirmations, summarising, recognising / eliciting change talk, managing resistance, addressing ambivalence.	Not explicit	Not explicit	OSCE
Dentistry	**UCC**	DS1003 preclinical	Theoretical –face-to-face Thinking and Learning Styles Motivation Learning and Adaptation Language and Communication Development and Differentiation Personality and Individual Difference Behaviour and Health	Communication skills Personal Experience and Self Perspective taking (VTS) Awareness Listening Skills Emotion Empathy/Rapport Facilitation skills	Role play	Exam

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		RD2007 Preclinical	To acquaint students with the complexity of interpersonal interactions in the dental setting" Theoretical –face-to-face Mental Health and Wellbeing -Identify the biopsychosocial determinants of health and wellbeing Predicting Health Behaviours -Theory of planned behaviour -Protection Motivation Theory -ABC model -Stages of change TTM	Not explicit	Role play	Written exam/ Learning log/ oral
		RD3008 Determinants of behaviour and health	Not explicit	Not explicit	Not explicit	Written exam
		RD4002 Determinants of behaviour and health	Not explicit	Fundamental Principles of Motivational Interviewing in relation to Smoking Cessation/Oral Health promotion	Role play	Osce

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
	TCD	Smoking Cessation	On successful completion of this section, students should be able to: •Recognise the impact on general health and common diseases associated with smoking. •Recognise the oral conditions and implications associated with smoking. •Know the prevalence of smoking and the sources of this information. •Identify the effective public policies in place helping to reduce smoking rates. •Explain the principal features of nicotine addiction. •Identify the stages of change associated with assessing a patient's readiness to quit. •Identify the therapies used to help smokers quit and the evidence base for these therapies. •Identify the 5A's and 5R's methods used in smoking prevention and cessation. •Formulate smoking cessation programmes for patients in their care.	Not explicit	Methods of Teaching and Student Learning: Lectures, reflective diary and product presentations	Methods of Assessment: Completion of reflective diary, written assessment, clinical application and clinical credits

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
Dental Hygienist	**TCD**	Brief Interventions for Smoking Cessation Year 1	knowledge, skills and attitudes that will prepare the students to provide smoking prevention and cessation counselling in an effective and confident manner to their patients.	Not explicit	Lectures, reflective diary, clinical application, product presentations and role play	Completion of skills practice, reflective diary, written assessment and clinical application
		Health Psychology Year 2	This section is a direct continuation of the Psychology elements of Section in Year 1 and students are expected to build on those learning outcomes, but clearly demonstrate a higher level of skill and mature application of their experience. Rationale and Aim: The purpose of this module is to give students an overview of the biopsychosocial model of psychology and models of learning with a view to predicting behaviour and how behaviour can be learnt and changed.	Not explicit	Lectures, applying theories to case-based scenarios	Health Psychology is assessed in the Cardiology, Paedodontics and Health Psychology Paper held in Hilary Term Year

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
Physiotherapy	**TCD**	Exercise medicine; prescription and rehabilitation	Define physical activity, exercise and physical fitness Identify the health benefits of physical activity and its relationship with common medical conditions …. Know the recommended Irish and international minimum physical activity guidelines…. Provide a framework to use for any behaviour change discussion with a patient Know the evidence and describe a theoretical approach to prescription of exercise in the management of specific disorders and populations.	Not explicit	Not explicit	Not explicit
	RCSI	Final Physiotherapy Vascular – Advanced Physiotherapy Practice	To assess health needs of individuals and plan prevention and health promotion programmes accordingly	Not explicit	Case studies	Assignment
		Final Physiotherapy Health Promotion – Advanced Physiotherapy	To develop and implement health promotion strategies Models and approaches to health promotion Planning, implementing and evaluation of health Exercise prescription	Not explicit	Not explicit	Assignment

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Final Physiotherapy Advanced Physiotherapy Practice 1 (Women's health, Paediatrics and Sports Physiotherapy)	Discuss the evidence-based medical and physiotherapeutic management of selected women's health, paediatric and sports injuries and syndromes, including behaviour change interventions	Developing knowledge and skills for use in clinical practice. Understanding the specific needs of these populations. Practical skills of field fitness testing, including multistage fitness test, body composition testing etc.	Case study	Written examination Viva / practical examination (Sports Physiotherapy only)
	UCD	PHTY 30050 Clinical Exercise	-Role of Exercise in prevention and management of chronic disease -Risk factors for chronic disease - evidence based exercise interventions - behavioural approaches to increasing Physical activity/ facilitating behaviour adoption and adherence - self monitoring of health behaviours including wearable technology			Evidence based wiki Exercise Prescription Clinical skills/ Oral exam Exercise E Portfolio which includes reflection on own behaviours

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		PHTY 20050 Strength and Conditioning	-Lifestyle Disease -Physical Activity for Health Role of Exercise and Physical Activity in maintaining good health- Risk Factors for ill health Promoting physically active lifestyles			-Exercise E Portfolio Development of - Exercise Programme for sedentary Individual-Group Project -Development of Exercise Video
		PHTY 30010 Physio Cline Ed 3 PHTY 30020 Physio Cline d 4 PHTY 30030 Physio Clin ed 5 PHTY 30190 Physio Clin Ed 6 PHTY 30030 Physio Clin ed PHTY 40670 7				Undergraduate learning portfolio
		PHTY 20160 Neurology I	Stroke prevention Importance of exercise to optimise function, prevent progression of chronic neurological disease / reduce related disability			

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Physiotherapy in the Clinical Specialties PHTY 40690	Paediatric obesity Care of the elderly Physiotherapy in antenatal care Occupational physiotherapy and ergonomics (X10 hour lectures). Risk factors and prevention Assessment MDT Family and patient centred management Adoption healthy behaviours promoted Promotion of physical activity in special populations			Group project MCQ
		PHTY 40680 Professional Prac 4	-Motivational Interviewing - Pain –CBT approaches - Exploring Health determinants / public health approaches Lecture + workshops x 4 hours Cognitive behavioural therapy 4 hours - workshop re health promotion/ public health approaches			

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		PERS 20130 Psychology of Sport and Health 1	Psychological Theories relating to sport and Exercise Social cognitive theory Trans theoretical Model Theory of Planned Behaviour Motivation-Motivational Climate Motivation-Self-determination Theory			MCQ, written assignment Written Paper
		PHTY 20050 Strength and Conditioning	Prevention of Lifestyle related Disease Workshops addressing lifestyle factors			E Portfolio includes self-reflection
		PERS 20130 Psychology of Sport and Health 1	Understand how psychological factors can influence health behaviour change			Lecture Case studies Group exercises

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
Radiation Therapy	**TCD**	Psychology and Communication I Year 1	To understand the psychology of health-related behaviour change, and to enhance communication skills by deepening understanding of patients' perspectives	Not explicit	Not explicit	Assignment
		Psychology and Communication II Year 2	To build on the foundation principles covered in Psychology and Communication I, and to further understand the psychology of health-related behaviour change, and to enhance communication skills as they apply to the radiation therapy setting. Of special relevance, the lecture series addresses the following: Recognising Signs of Distress in Cancer Patients Patient-centred Care A Patient's Perspective of Radiotherapy Culturally Competent Communication	Not explicit	Not explicit	Assignment/ role play/ reflective piece
Paramedic	**UL**	GM3001 - managing health in the home and in the community	The purpose of this module is to provide students with the knowledge, skills and competencies to manage health and well-being within their own home and within their communities	Not explicit	interactive and problem-focussed. Students will participate in the learning environment through engagement in teaching learning and assessment strategies for example, lectures, discussions, group work, self-directed learning,	Not explicit

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		GM4033 - population health and emergent care	The module will provide a framework for paramedics working in the community and will explore the concepts of health and population health and, in particular, will focus on public health models, the wider determinants of health and the measurement and impact of health inequalities. The module will also consider the principles of community development from a primary care perspective.	Not explicit	Not explicit	Not explicit
Pharmacy	**RCSI**	Men's and Women's Health Year 3 (proposed)	This module aims to comprehensively cover all aspects of men's' and women's' health, including health promotion, and therapeutic strategies in conditions affecting men and women at various stages of life, from sexual maturity through contraception, pregnancy, breastfeeding, menopause and andropause.	Assessing symptoms presenting in the pharmacy Signposting to other healthcare professionals Supporting adherence and self-care Safe use of medical devices Reviewing of therapies prescribed / prescribing sciences Monitoring patients for clinical outcomes and effectiveness of therapy Communication skills	Simulations using video-case patients, simulated practice of patient care including counselling, adherence discussions, approaches to self-care, management of adverse events and promotion of healthy behaviours Weekly visit to teaching hospital and bedside teaching relating to this module Patient contact session Health promotion activity	Formative: Weekly assessment of communication skills in simulated cases, case-based MCQ and SNQs, OSCE Summative: Case-based MCQ and SNQ, OSCE

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Stages of Life: The Changing Body and Medicines Handling Year 3 (proposed)	This module presents a global view of pharmaceutical care from conception to death, and outlines the factors affecting and informing evidence-based management of patient needs throughout. Upon completion of this module, students will appreciate the diverse requirements of these various populations…… screening and promotion of healthy behaviours and self-care	Assessing symptoms presenting in the pharmacy Signposting to other healthcare professionals Supporting adherence and self-care Safe use of medical devices Reviewing of therapies prescribed / prescribing sciences Monitoring patients for clinical outcomes and effectiveness of therapy Communication skills	Simulations using video-case patients, simulated practice of patient care including counselling, adherence discussions, approaches to self-care, management of adverse events and promotion of healthy behaviours Weekly visit to teaching hospital and bedside teaching relating to this module Patient contact session	Formative: Weekly assessment of communication skills in simulated cases, case-based MCQ and SNQs, OSCE Summative: Case-based MCQ and SNQ, OSCE

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Malignant Disease: Optimising Prevention and Patient Care Year 3 (proposed)	The aim of this module is to expose students to the specialised oncology knowledge base and pharmacy skills required to become competent in the pharmaceutical care of cancer patients and also to promote health improvement and cancer prevention	Supporting adherence and self-care Reviewing of therapies prescribed / prescribing sciences Communication skills	Simulations using video-case patients, simulated practice of patient care including counselling, adherence discussions, approaches to self-care, management of adverse events and promotion of healthy behaviours Weekly visit to teaching hospital and bedside teaching relating to this module Patient contact session	Formative: Weekly assessment of communication skills in simulated cases, case-based MCQ and SNQs, OSCE Summative: Case-based MCQ and SNQ, OSCE

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Global Health Year 4 (proposed)	This module aims to enable the students to further their understanding of health and illness at a global scale. They will look at health and disease at a population level and apply skills in data analysis and evidence-based practice to consider some of the major challenges facing the world in terms of communicable and non-communicable disease including public health approaches to managing their spread	Using population-level data in decision making Communication skills and cultural awareness Promoting health at the individual and population levels Facilitating health behaviour change	Seminars Practical sessions Communication skills training Data use sessions	OSCE Case-based project work/ continuous assessment
		Patient Care and Society Year 5 (proposed)	This module aims to enable the students to further their understanding of 'complex' patients. Students will explore how social factors, including being homeless, imprisoned, abusing drugs and/or alcohol, suffering mental health difficulties, being a member of a minority group (e.g. an immigrant population), suffering a chronic disease, or in long term care facilities impacts on patients in different ways.	Not explicit	Simulations using video-case patients, simulated practice of patient care including counselling, adherence discussions, approaches to self-care, management of adverse events and promotion of healthy behaviours Videoed communication sessions	OSCE Case-based project work/ continuous assessment

Programme	Institute	Module Code/Year	Theory/Content	Skills	Real Life Exercises	Assessment
		Decision Making in Complex Care Year 5 (proposed)	This module aims to give students an understanding of how pharmacists contribute to the clinical care of complex patients, in primary, secondary and tertiary settings. Students will work in groups to develop advanced care plans, for patients with comorbidities. Students will explore the principles of pharmacoepidemiology and drug safety, the use and effect of drugs in defined populations. In addition, students will be able to demonstrate and apply the fundamental principles of pharmacoeconomics. The role of the pharmacist as a prescriber will be discussed, in relation to local and international jurisdictions	Not explicit	Simulations using video-case patients, simulated practice of patient care including counselling, adherence discussions, approaches to self-care, management of adverse events and promotion of healthy behaviours Completion of HTAs	OSCE Case-based project work/ continuous assessment

Appendix 5
Exercise on Integrating the Curriculum to inform Planning and Development

HEI- University College Cork **Programme- BSc in General Nursing**				
Domain	**Competency**	**Behaviour**	**Nursing (General) UCC Existing Modules**	
			Core Components Covered	**Elements covered**
Lifestyle Choices and Personal Wellness	1.1 Manages health behaviour risk factors for chronic disease prevention	1.11 Examines own attitudes and behaviours towards health and wellbeing 1.12 Identifies aspects of their life that affect their health and wellbeing 1.13 Understands the challenges of changing health behaviours to address risk factors 1.14 Demonstrates awareness of health risks associated with behaviours	SC1015 NU4078 NU4087	NU1032 NU1048 NU2057 NU2058 NU3078 NU3079 NU4046
Lifestyle Behaviours and Personal Responsibility for Health	2.1 Motivates individuals to access relevant information and services for healthy lifestyle behaviour	2.11 Acts as a resource to individuals when seeking relevant information for healthy lifestyle behaviours 2.12 Actively seeks to understand what information and supports individuals want 2.13 Educates and empowers individuals to take personal responsibility for their health 2.14 Recognises individuals who need additional specialist support	NU3078	NU2057 NU2058 NU3079 NU4078

13 Integrating Exercises were carried out during the earlier stages of Curriculum development and the content areas have since been refined i.e. from Domains, Competencies and Behaviours to Units of Study, Competencies and Learning Outcomes. See Methodology Appendix 1.

HEI- University College Cork **Programme- BSc in General Nursing**				
Promoting Healthy Lifestyle Behaviours. What can Healthcare Students do?	3.1 Ensures Health Behaviour Change is at the centre of healthcare practice	3.11 Routinely assess for risk factors 3.12 Encourages individuals to take responsibility for changing adverse lifestyle behaviours 3.13 Contributes to a culture of health behaviour change and chronic disease prevention	NU3078 NU4087	NU2057 NU2058 NU3079
Communicating with Individuals about Promoting Healthy Lifestyle Behaviours	4.1 Communicates in a supportive, encouraging manner for health behaviour change	4.11 Adopts a "person-centred" approach to individuals 4.12 Conveys clear, understandable information about lifestyle behaviour change 4.13 Communicates in a supportive, non-directive manner with individuals for HBC 4.14 Works collaboratively with individuals for HBC 4.15 Recognises individual's wishes, needs and preferences in a non-judgemental manner 4.16 listens to individuals and respects their views and concerns	NU1047 NU3078 NU4046 NU4078	NU1032 NU1048 NU2057 NU2058 NU3079
Making Every Contact Count: Providing Opportunistic Brief Interventions	5.1 Optimises every opportunity for brief advice and brief interventions for healthy lifestyle behaviour for chronic disease prevention 5.2 Demonstrates competency in the delivery of brief advise and interventions	5.11 Identifies and utilises every opportunity for giving brief advice 5.12 Identifies patients for whom a brief intervention is appropriate 5.21 Delivers brief advice and brief interventions in an emphatic and non-confrontational manner 5.22 Documents details of brief interventions 5.23 Adopt a self-reflective approach to brief intervention interactions	Currently this content is not delivered due to lack of resources* It will be incorporated in NU3078 and NU4087 *2 hours had been allocated in NU3078 for Brief Interventions however it was unfeasible to deliver to 170 students requiring 8 tutorials (would also need reps from the HSE to come to deliver the skill as no educators had received training in this). Also hoping to deliver brief intervention to 4th year students NU4087 but this also required a rep from the HSE to deliver the training.	

Guide to Existing Modules UCC Nursing			
Year	**Code**	**Module**	**Relevant Content**
1	SC1015		
1	NU1032	Fundamental Knowledge and Skills for Nursing Practice	The caring role of the nurse in relation to patient: eating and drinking, mobility, personal hygiene, health and safety in the workplace, elimination; bio-physical and social health (including sleep, rest, and social interaction, sexuality and death and dying). Emphasis on subjective and objective patient assessment and the documentation and reporting of such assessments. In addition, there will be a focus on introducing strategies that create a culture of safety when providing holistic care to patients in relation to their activities of daily living.
1	NU1047	Introduction to communication skills	Introduction to Psychology for Healthcare with a particular focus on self and identity, communication, lifespan development, stress, adaptation, and coping. Introduction to communication skills for Nursing practice, with a particular focus on person-centred therapeutic communication. Verbal and non-verbal communication, listening, questioning, and responding to individuals and their families in different healthcare contexts. Personal and professional growth in their caring and healing role through the development of self-awareness, respect for dignity of others, compassion, empathy and sensitivity towards others in their care. Concept of self and caring for the self. Introduction to the evidence underpinning therapeutic relationships.
1	NU1048	The Profession of Nursing: Professional Practice, Law and Ethics	The purpose and role of the general nurse within the cultural, global healthcare and multidisciplinary team context. Nurses as carers and healers. Nursing as a discipline. Professional regulation and legislative framework. The nursing process and nursing care delivery systems. Roles and scope of practice in relation to student nurse role and registered general nurse roles. Introduction to nursing within a legal and ethical framework (the scope of practice, the code of professional conduct, and the Nurses and Midwives Bill/Act 2011). Introduction to contemporary professional issues and debates in general nursing (advocacy, empowerment, and accountability and their importance in terms of professional and patient safety).
2	NU2057	General Nursing with Adults and their Families - … I	Management of acute and chronic conditions in the primary (community) healthcare context including perspectives on enabling self-management of chronic illnesses.
2	NU2058	General Nursing with Adults and their Families - … II	Nursing and applicable principles of science for individuals with varying acute and chronic conditions including approaches to health promotion, nutrition and medication management.

Guide to Existing Modules UCC Nursing			
Year	**Code**	**Module**	**Relevant Content**
3	NU3078	Health Promotion and Primary Healthcare in a General Health Context	Definitions of health and population health. Role of biological factors, individual lifestyle factors, social and community influences, living and working conditions, the physical environment, and general socioeconomic cultural and political conditions in determining health. Inequalities in health. Current major population health issues in the local national and global context. lay beliefs relating to health, wellness and illness. Factors that affect motivation. Scope of and approaches to health promotion. Planning and design of health promotion initiatives (a community perspective). Theories of change. The role of the nurse in health promotion (a community perspective, with particular reference to marginalised groups). Professional challenges in relation to Health Promotion.
3	NU3079	General Nursing with Adults and their Families III - …	Nursing and applicable approaches to health promotion, nutrition and medication management. Discuss person-centred approaches to nursing care showing sensitivity towards individuals with acute and chronic conditions.
4	NU4046	The Therapeutic Value of the Arts within Nursing, Midwifery and Healthcare	The concepts of birth, health, illness, disability, healthcare and nursing as metaphors in the arts. The arts as therapeutic modalities across the lifespan. Media such as music videos, movies, television, poetry and literature. Visual arts expression and creation. Visual art as a conversation tool. Visual Arts therapy: drawing, painting, sculpture, plastic and spatial design. Art observation and workshops.
4	NU4078	Communication Skills and Personal Wellbeing for Nursing Practice	Principles and practices of effective and therapeutic helping, drawing on relevant counselling approaches and skills with individuals. Self-awareness and self-care, focusing on students' well-being and regulation of stress. Awareness of cultural differences and their impact on communication.
4	NU4087	General Nursing Practice	Clinical practice (under supervision) in general nursing units/contexts with an emphasis on the five domains of clinical practice (1. Professional/ethical practice, 2. Holistic approaches to care and the integration of knowledge, 3. Interpersonal relationships, 4. Organisational and management of care, 5. Personal and professional development) and Promoting health and wellbeing of patients and their families. Protected Reflective Education on Practice (PREP) to incorporate sessions relating to the five domains of clinical practice.

HEI- Waterford Institute of Technology **Programme- BSc in General Nursing**				
Domain	**Competency**	**Behaviour**	**Year**	**Currently covered- Module** **Core Components Covered**
Health and Personal Wellness	1.1 Manages health behaviour risk factors for chronic disease prevention	1.11 Examines own attitudes and behaviours towards health and wellbeing 1.12 Identifies aspects of their life that affect their health and wellbeing 1.13 Understands the challenges of changing health behaviours to address risk factors 1.14 Demonstrates awareness of health risks associated with behaviours	1 1 4	Personal and Professional Development Health and Psychosocial Studies 1 Health and Psychosocial Studies 3
Lifestyle Behaviours and Personal Responsibility for Health	2.1 Motivates individuals to access relevant information and services for healthy lifestyle behaviour	2.11 Acts as a resource to individuals when seeking relevant information for healthy lifestyle behaviours 2.12 Actively seeks to understand what information and supports individuals want 2.13 Educates and empowers individuals to take personal responsibility for their health 2.14 Recognises individuals who need additional specialist support	2 4	Health and Psychosocial Studies 2 Health and Psychosocial Studies 3
Promoting Healthy Lifestyle Behaviours. What can Healthcare Students do?	3.1 Ensures Health Behaviour Change is at the centre of healthcare practice	3.11 Routinely assess for risk factors 3.12 Encourages individuals to take responsibility for changing adverse lifestyle behaviours 3.13 Contributes to a culture of health behaviour change and chronic disease prevention	1-4	Nursing Experience Modules 1-7

HEI- Waterford Institute of Technology **Programme- BSc in General Nursing**					
Communicating with Individuals about Promoting Healthy Lifestyle Behaviours	4.1 Communicates in a supportive, encouraging manner for health behaviour change	4.11 Adopts a "person-centred" approach to individuals 4.12 Conveys clear, understandable information about lifestyle behaviour change 4.13 Communicates in a supportive, non-directive manner with individuals for HBC 4.14 Works collaboratively with individuals for HBC 4.15 Recognises individual's wishes, needs and preferences in a non-judgemental manner 4.16 listens to individuals and respects their views and concerns	1 3 4	Health and Psychosocial Studies 2 Chronic Illness Management Consolidation of Skills for Nursing Practice	
Making Every Contact Count: Providing Opportunistic Brief Interventions	5.1 Optimises every opportunity for brief advice and brief interventions for healthy lifestyle behaviour for chronic disease prevention 5.2 Demonstrates competency in the delivery of brief advise and interventions	5.11 Identifies and utilises every opportunity for giving brief advice 5.12 Identifies patients for whom a brief intervention is appropriate 5.21 Delivers brief advise and brief interventions in an emphatic and non-confrontational manner 5.22 Documents details of brief interventions 5.23 Adopt a self-reflective approach to brief intervention interactions	2 1-4	Health and Psychosocial Studies 2 Nursing Experience 1-7	

University of Limerick **Programme - Medicine**					
Domain	**Competency**	**Behaviour**	**Module Title**	**Main Aim and content**	**Assessment**
Health and Personal Wellness	1.1 Manages health behaviour risk factors for chronic disease prevention	1.11 Examines own attitudes and behaviours towards health and wellbeing 1.12 Identifies aspects of their life that affect their health and wellbeing 1.13 Understands the challenges of changing health behaviours to address risk factors 1.14 Demonstrates awareness of health risks associated with behaviours	BM4021 - professional competencies 1 (Year 1) BM4022 - professional competencies 2 (Year 2	The Professional Competencies modules involve the consideration of health and illness in the wider context of family, cultural groups and community. The modules focus on the ethical and legal frameworks of medicine and on personal and interpersonal skills appropriate to lifetime medical practice. This module comprises a range of topics that increasingly required by a competent and reflective medical practitioner. These include, among others, Health Psychology, - Social and community aspects of healthcare, Public Health Medicine, Biostatistics, - Health Promotion and Disease Prevention, etc. The Human Doctor component of the modules examines how being a doctor can affect one's self and advocates a mindfulness-based, stress management approach to self-care in medicine Students must demonstrate an appreciation of the behavioural sciences in relation to medicine. Can explain the importance of health promotion and disease prevention A variety of formats are used for teaching and learning relating to professional competencies, including lectures, small group tutorials, seminars, workshops and project work.	Questions on Exam Paper Assignments Reflections Station in OCASE
Lifestyle Behaviours and Personal Responsibility for Health	2.1 Motivates individuals to access relevant information and services for healthy lifestyle behaviour	2.11 Acts as a resource to individuals when seeking relevant information for healthy lifestyle behaviours 2.12 Actively seeks to understand what information and supports individuals want 2.13 Educates and empowers individuals to take personal responsibility for their health 2.14 Recognises individuals who need additional specialist support			
Promoting Healthy Lifestyle Behaviours. What can Healthcare Students do?	3.1 Ensures Health Behaviour Change is at the centre of healthcare practice	3.11 Routinely assess for risk factors 3.12 Encourages individuals to take responsibility for changing adverse lifestyle behaviours 3.13 Contributes to a culture of health behaviour change and chronic disease prevention			

University of Limerick **Programme - Medicine**					
Communicating with Individuals about Promoting Healthy Lifestyle Behaviours	4.1 Communicates in a supportive, encouraging manner for health behaviour change	4.11 Adopts a "person-centred" approach to individuals 4.12 Conveys clear, understandable information about lifestyle behaviour change 4.13 Communicates in a supportive, non-directive manner with individuals for HBC 4.14 Works collaboratively with individuals for HBC 4.15 Recognises individual's wishes, needs and preferences in a non-judgemental manner 4.16 Listens to individuals and respects their views and concerns	BM4003 - general practice / primary care (Year 3)	Teaching and learning is directed at the attainment of competence in the diagnosis and management of a range of problems commonly encountered in general practice. Students must demonstrate competence in the diagnosis and management of a range of problems commonly encountered in General Practice. This module based predominantly on an apprenticeship model in the clinical setting aims to develop students' knowledge of a common medical conditions and clinical presentations in the area of Primary Care/General Practice. Teaching and learning in General Practice/Primary Care will occur in the General Practice setting, in one of the five 'Primary Care Teaching Networks' affiliated to the UL Graduate Medical School. In the clinical setting involving real patient's students must demonstrate competence in a range of clinical skills relevant to the clinical discipline of General Practice/ Primary Care. In particular students must; Demonstrate proficiency in communicating with and taking a history from patients in the above discipline, from their relatives and from others where relevant. Demonstrate proficiency in communicating as a patient advocate. Demonstrate an appreciation of the behavioural sciences in relation to medicine. Explain the importance of health promotion and disease prevention.	Questions on Exam Paper Station in OCASE
Making Every Contact Count: Providing Opportunistic Brief Interventions	5.1 Optimises every opportunity for brief advice and brief interventions for healthy lifestyle behaviour for chronic disease prevention 5.2 Demonstrates competency in the delivery of brief advise and interventions	5.11 Identifies and utilises every opportunity for giving brief advice 5.12 Identifies patients for whom a brief intervention is appropriate 5.21 Delivers brief advise and brief interventions in an emphatic and non-confrontational manner 5.22 Documents details of brief interventions 5.23 Adopt a self-reflective approach to brief intervention interactions			

Appendix 6
Attendees at the World Café Event

Attendees at the World Café Event	
Health Service Executive	
Orlaith O'Reilly	Health Service Executive
Maria O'Brien	Health Service Executive
Marie Killeen	Health Service Executive
Mairéad Gleeson	Health Service Executive
Regina Black	Health Service Executive
Aileen Scott	Health Service Executive
Aoife Ni Chonchúir	Health Service Executive
Carmel Mullaney	Health Service Executive
Dublin City University	
Pamela Hussey	School of Nursing and Human Sciences
Patrick Doyle	School of Nursing and Human Sciences
Anne Matthews	School of Nursing and Human Sciences
Michael McKeon	School of Nursing and Human Sciences
Sheelagh Wickham	School of Nursing and Human Sciences
Angela Cocoman	School of Nursing and Human Sciences
Mary Rose Sweeney	School of Nursing and Human Sciences
Dundalk Institute of Technology	
Brid Delahunt	Department of Nursing, Midwifery and Health Studies
Catherine O'Connor	Department of Nursing, Midwifery and Health Studies
Galway-Mayo Institute of Technology	
Maggie Wood	Department of Nursing, Health Sciences and Social Care
Carmel Heaney	Department of Nursing, Health Sciences and Social Care
Trinity College University	
Aileen Patterson	School of Medicine
Catherine Darker	School of Medicine
Neil Fleming	School of Medicine
Agnella Craig	School of Medicine
Deirdre Connolly	School of Medicine
Patrick Murphy	School of Medicine
Yvonne Howell	School of Dental Science
Joe Barry	School of Medicine
Fiona Wilson	School of Medicine
Gobnait Byrne	School of Nursing and Midwifery
Institute of Technology Tralee	
Anne Cleary	School of Health and Social Sciences
Jackie Ruttledge	School of Health and Social Sciences

Attendees at the World Café Event	
Sinead Flaherty	School of Health and Social Sciences
Institute of Technology Carlow	
Paula Fitzpatrick	Department of Science and Health
Mary Dowling	Department of Science and Health
University College Cork	
Carol Condon	School of Nursing and Midwifery
Anna O'Leary	School of Nursing and Midwifery
Margaret Bermingham	School of Pharmacy
Sonja Vucen	School of Pharmacy
Geraldine Daly	Department of Speech and Hearing Sciences
Dawn O'Sullivan	Project Manager
Eithne Hunt	Occupational Science and Occupational Therapy
Irene Hartigan	School of Nursing and Midwifery
Eileen Savage	School of Nursing and Midwifery
University College Dublin	
Crea Carberry	School of Medicine
Caitriona Cunningham	School of Public Health, Physiotherapy and Sports Science
Mary Murphy	School of Nursing, Midwifery and Health Systems
Celine Murrin	School of Public Health, Physiotherapy and Sports Science
Patricia Fitzpatrick	School of Public Health, Physiotherapy and Sports Science
Royal College of Surgeons in Ireland	
Lisa Mellon	Department of Psychology
Michelle Flood	School of Pharmacy
Maria Pertl	Department of Psychology
Anne Hickey	Department of Psychology
National University of Ireland, Galway	
Verna McKenna	School of Health Sciences
CatherineAnne Field	Discipline of Health Promotion
University of Limerick	
Pauline Boland	Department of Clinical Therapies
Anne Fahy	Department of Nursing and Midwifery
Khalifa Elmusharaf	Graduate Entry Medical School
Dympna Tuohy	Department of Nursing and Midwifery
Waterford Institute of Technology	
Miriam Farrell	Department of Nursing and Health Care
Lorraine Dillon	Department of Nursing and Health Care
Suzanne Denieffe	Department of Nursing and Health Care

Appendix 7
Report World Café Event

A note offering a distillation of the conversations at the World Café Event re the National Undergraduate Curriculum on Health Behaviour Change for Chronic Disease Prevention and Management held on 4th May 2017

Introduction

Professionals in busy roles – be they health educators or staff designing policy and delivering health and social services – are often juggling several priorities at the same time. In all that busyness, it can be a challenge to take time to think together across institutions and professional disciplines in an open-ended and developmental manner. This note is a reflection on what happened when key leaders decided to take a risk and invite HEI staff to stand back from the busyness and consider their contribution to educating the next generation of healthcare professionals about their role in addressing the prevention and management of chronic disease in a variety of contexts. The National Working Group members wanted to enhance a sense of shared endeavour and inspire new ways of working across education/health institutions.

The purpose was to figure out how higher education institutions might further shape the on-going development of a National Undergraduate Curriculum for Behaviour Change for Chronic Disease Prevention and Management. This unique and carefully choreographed event, was designed to build relationships so that participants could generate additional insight and buy-in through working with dialogue, interaction, peer support and critical inquiry. It drew on a variety of large group/creative methodologies and most especially the 'essentials' of a World Café method, creating a bespoke and surprising environment that required energy, dialogue and intimacy.

Each individual involved will continue with their own sense-making process and figuring out appropriate actions. At the same time, the Working Group met with the facilitators, Liz Hayes and Margaret Barry from Corporate Community, to analyse the World Café event and assess what had been learned about how educators might further contribute to chronic disease prevention and management with a starting point of developing a National Undergraduate Curriculum. Margaret and Liz crafted this document for participants as a reminder/reflection from the day.

A reminder of the context

"In spite of previous commitments and re-commitments to primary care this is still not reflected in investment and the priority given to it: we're still focused in health on treatment and cure. The Healthy Ireland Framework proposes an approach to keeping people healthy for longer while also acknowledging that solutions are complex in this context. This 'High Level Framework' is accompanied with an implementation plan that will have practical and tangible outcomes. The '*Making Every Contact Count*' programme fits within this overall HSE Framework.

Irish demographics will result in increasing numbers of older people, in particular, affected by chronic disease that will create challenges and costs to them as well as putting demands on the economy and the wider health budget. Like other EU countries, 'prevention' receives little of the health budget – here, Ireland is at about 1% of expenditure, with an average in the EU of 2.8%." (Brief summary offered by Ms Marie Killeen from the National Office for Health and Wellbeing and co-chair of the National Working Group.

A way of working that worked

The Working Group members (and a few additional helpers!) shared a sense of achievement – having successfully brought together such a broad range of people from such a range of disciplines and institutions – who then proceeded to work together in really constructive, critical and positive ways. The welcome, intent and design of the day together created an energetic sense of common purpose that was sustained to the end. There was a great deal of invisible preparatory work that helped to make sure that the focus was sustained. There was room for everything: negativity, positivity, critical questioning and useful ideas for implementation. The surprise was that so much is possible when the conditions are adjusted to encourage openness; colleagueship and people are prepared to work as peers across institutions, sectors and hierarchies.

Highlighting some critical questions

When academics gather, one can be assured on some critical questioning and interrogation of concepts and proposed actions. As the role of tutors and facilitators emerges further in delivering this co-designed undergraduate programme - the working group concluded that, over time, these questions could shape an agenda for further innovation. For example:

- Given the knowledge about and the extent to which social determinants impact on health and wellbeing, how can the Curriculum content and its delivery ensure that 'victim-blaming' does not become an unintended consequence?
- Does the Curriculum sufficiently address the need to have a mental health focus alongside the attention to chronic health prevention and management? Furthermore, should there not have been a specific focus on mental illness/ depression within this Curriculum?
- While 'the strapline' of '*Making Every Contact Count*' helps to focus on health literacy and lifestyle choices in the context of chronic disease - how can we know that every contact is appropriate?

As health educators across different disciplines generated these shared questions and concerns, it became obvious that the sites of engagement, for chronic disease management, treatment and care differ across the health spectrum. For example, some disciplines like physiotherapists or pharmacists may already be practising in what might be regarded as less formal or emotionally charged spaces by people who require services. But a patient in a crisis scenario in an acute hospital setting may not be in a fit state to address their long-term health issues.

The predominant, more medically driven assumptions that inform the design and delivery of health services was highlighted. Therefore, a programme of this nature needs to address the more fundamental cultural shifts that will enable a greater ease with 'contacts' that encourage self-responsibility and work from an assumption of 'partnering' through mutual respect and shared expertise.

Sustainability and inter-professional responsibility

The " *Making Every Contact Count*" Undergraduate Curriculum may have been informed by a desire to begin with educating the next generation of Healthcare professionals. But these conversations cited some of the complexities of implementing a national programme. Professor Eileen Savage in her explanation of the purpose and make-up of the Working Group noted the reality of differential power and how specifics such as timelines, accreditation and class size will impact on how the Curriculum is delivered. These matters are an essential component when considering the parameters of legitimising knowledge and skills development.

Participants also proposed engaging with pre-registration and post-graduate students while also achieving the endorsement of Regulatory bodies. Supporting the interfaces between the academy and workplace learning and continuing professional development was also stressed as being important for newly qualified healthcare professionals.

Collaboration/peer support across academic institutions

It became obvious that current under-graduate programmes such as the Health and Leisure degree in Tralee IT already address health from the perspective of behaviour change. Also, the RCSI has committed funding to sustaining as approach to education for/in a primary care context. These kinds of initiatives and the generosity with which many examples were shared, suggest that the professional development of health educators in conditions that create peer learning and critical reflection is worthy of consideration.

In the afternoon, the participants worked in their respective institutional groups or smaller networks to figure out the progress of the local working groups in introducing the Curriculum. Feedback suggested that experiences differed but the opportunity to meet as colleagues across disciplines in a 'neutral' and 'off-site' space provided an impetus for relationship building and future collaboration.

There was also a suggestion that the Curriculum Manual should be reviewed in light of the insights gathered. The Local Working Groups left with a greater awareness of the need to

comment on the current draft and 'own' its development as well as keeping in touch with the National Working Group. Lessons and experience from the introduction of other curricula such as for older people's care and issues of elder abuse could also be considered.

Sustaining implementation and innovation as a focus for the future

The National Working Group provides a unique opportunity to develop a National Curriculum – about change in health, and to do it in a way that is aligned and relevant to emerging health policy. At the same time, it subtly undermines the dominance of the 'illness' model and opens up more of a 'staying well' perspective. Early in the day, it was acknowledged that this is a ground-breaking endeavour to work across key areas of concern – including – smoking, alcohol, diet and exercise – to create interventions. On another level it has encouraged a practical focus in a context where there are significant differences between institutions, approaches and understandings of what needs to be addressed. As a consequence of the success of this national gathering of heath disciplines across of Higher Education Institutions, some key ideas around building on this work were suggested:

- This is a unique professional development opportunity and it creates the possibility to **influence inter-professional collaboration and cross-institutional engagement.** Leadership is critical to championing this Curriculum at both local and national level in the first instance.
- **The evaluation of Phase One** around the initial introduction of the Curriculum should be put in place immediately. This could also include international research that would inform questions of on-going development and sustainability.
- The c**reation of synergies across HEIs and between the HEIs and the HSE and across disciplines** at a national level is full of potential for reshaping thinking and culture both across the academy and in the health service. It was suggested that the World café events should become a more regular phenomenon and that students and patients could also be included in these conversations.
- Some conceptual framing from the HSE that addressed the recurring concerns around the **contextual understanding informing the programme** was recommended. The social determinants, psychosocial and mental health aspects of the conditions that are the focus of this programme are central to the understanding of how these conditions come about, may then be addressed. Such an understanding of the context would also support seeing the MECC intervention's proper limits and potential.
- Some kind of repository on-line to gather resources, promote the Curriculum and engage other professional agencies was also suggested.

Conclusion

As the team tasked with designing and facilitating this event, we are very appreciative of the Working Group's courage in taking a risk with an unfamiliar way of working. The event depended on trust, cooperation and being prepared to take up less familiar roles and standpoints. The on-going role of HEIs in contributing to the prevention and management of chronic disease goes way beyond the introduction of a generic or 'one-size fits all' approach. It will take imagination and senior buy-in at institutional level to create a sustainable programme with the under-graduate Curriculum as the current key component and hold the balance between standardised /mandatory engagement and the existing knowledge and expertise of the academy.

Finally, it is hard to believe that so many people were meeting and thinking together for the first time. Towards the end of the day, it was suggested that Ireland could be a pioneer in shaping new paradigms around chronic disease management and prevention given the relatively small scale of the HEI sector and the health service respectively. As purveyors of the potential for living networks to address challenging questions and issues in our time, we are excited by such obvious potential. Your willingness to find practices that enable work across boundaries while still acknowledging a diversity of opinion and experience is warmly commended and we wish you continued success for the next phase in this exciting phase work.

Liz Hayes

Margaret Barry

Corporate Community

www.corpcom.ie

Appendix 8
List of Attendees at Workshop on Implementation

Attendees at the Workshop on Implementation, 12th May 2017	
Maria O'Brien	*Health Service Executive*
Marie Killeen	*Health Service Executive*
Anna O'Leary	*University College Cork*
Dawn O'Sullivan	*University College Cork*
Lorraine Dillon	*Waterford Institute of Technology*
Niamh Spratt	*Institute of Technology, Carlow*
Anne Cleary	*Institute of Technology, Tralee*
Maggie Wood	*Galway-Mayo Institute of Technology*
Caitriona Cunningham	*University College Dublin*
Celine Murrin	*University College Dublin*
Anne Fahy	*University of Limerick*
Louise Larkin	*University of Limerick*
Dympna Tuohy	*University of Limerick*
Lisa Mellon	*Royal College of Surgeons in Ireland*
Sheila Wickham	*Dublin City University*
Aileen Patterson	*Trinity College Dublin*
Deirdre Connolly	*Trinity College Dublin*

Appendix 9
Assessment

Assessment Example 1

You are required to carry out a reflective exercise on the provision of a Brief Intervention for Health Behaviour Change.

(Where it is not achievable for students to practice the skills of HBC in the clinical setting, we recommend that alternatives are offered within individual HEIs such as simulated exercises with other peers)

Please complete the following

Where did the interaction take place? i.e. Clinical setting or classroom based exercise

Describe what happened/Details of the event	
What did you consider to be the health risks associated with the health behaviour you were encouraging the individual to change?	
Do you feel that you understood what information and supports the individual wanted?	
Did the individual require additional specialist support to help them achieve the health behaviour change?	
What were the positive and negative aspects of the event for you as a student?	
If you could change something about this event, what would it be?	
What communication skills did you use in this interaction?	
Are there any skills that you feel you need to develop further to enable you to carry out effective brief advice/ interventions?	
What was the procedure for documenting the event in the clinical setting? (Not relevant if classroom based)	

Student name _____

Preceptor name _____

Assessment Example 2

Here is a dialogue between a patient who has recently been discharged from hospital after an admission with shortness of breath and palpitations and her GP. Please read the dialogue and answer the questions provided:

Patient

…well I get palpitations and now the cardiac specialist has told me that this is called A-Fib.

That worries me a lot and I know that smoking isn't helping things.

(GP decides that the patient will respond to an assessment of importance and confidence in relation to smoking cessation).

> ***GP***
>
> How would you feel about giving up smoking? If 0 was "not important to you at the moment" and 10 was "very important", what number would you give yourself?

Patient

Maybe 4

> ***GP***
>
> And if you decide to give up smoking how confident are you that you would succeed? If 0 was "not confident" and 10 was "very confident" what number would you give yourself?

Patient

Probably 8, because I'm a very determined person and if I put my mind to something then I would usually succeed…. But I know that it wouldn't be easy at all. I don't know, I hadn't really thought too much about it. I know deep down that I shouldn't smoke. They're no good.

> ***GP***
>
> So if you decided to give up you are very confident that you would succeed but you are still unsure if it is the right time to give up?

Patient

Well yes, it's almost like I wish I didn't smoke, but I don't want to have to try give them up.

> ***GP***
>
> Have you ever tried to give them up before?

Patient

No

> ***GP***
>
> It sounds like you really don't want to be a smoker, you are confident that you could stop and perhaps there is just a little bit of fear there about committing to it and trying?

Patient

Yes, that sounds about right, I'd hate to have cravings you know, or start eating more because I wanted a cigarette.

GP

Do you know that there are lots of supports for people to help stop smoking?

Patient

Well I know that there are patches but that's about it.

GP

Would you like some more information about the supports which are available to help you stop?

Patient

Ok I suppose

GP

Why don't I give you some information to take with you, have a read and come back to me in a day or two and we can talk some more?

Patient

Ok so, I'll do that, thank you.

Respond to the following questions and support your responses with reference to relevant literature.

1) Do you think that this is an example of a positive or negative conversation between a patient and healthcare professional?

   Give reason for your answer.

2) Comment on the skills of motivational interviewing evident in the interaction?

3) Comment on the extent to which the patient was weighing up the pros and cons of change?

4) As a healthcare student is there anything that you would change to improve the interaction?

Assessment Example 3

You are required to promote the Healthy Ireland Framework within your University and to raise awareness of the Key Health Messages as specified by the National Policy Priority Programmes (HSE) targeting University Students.

You may design a poster/webpage/newsletter.

Assessment Example 4 Objective Structured Clinical Examination OSCE

Did the healthcare provider demonstrate proficiency in the following areas?	Score from 1-5 (5 is best use of skill and 1 is least)	Provide feedback on score
A. Use of Interpersonal Communication Skills		
Use positive non-verbal communication		
Use of Reflective Listening		
Demonstrate empathy		
Obtain behavioural history (including past efforts to change)		
B. Encourage Dialogue Assessment of Importance and Motivation		
Explore Decisional Balance		
Assess how important it is for the patient to change behaviour		
Use change rulers		
Assess how motivated the patient is to change behaviour		
Ask open-ended questions		
Provide opportunity for the patient to speak		
Help Patient identify a goal		
Help Patient build an action plan		
C. Adopt a patient-centred approach		
Use of appropriate vocabulary easily understood by the patient		
Provide information that was geared toward the patient's readiness to change		
Total Score		
Overall Comments		

Appendix 10
Evaluation Questionnaires

Higher Educational Professional

Evaluation Questionnaire

National Undergraduate Curriculum on *Making Every Contact Count* for Health Behaviour Change for Chronic Disease Prevention and Management

Thank you for taking the time to complete this questionnaire.
Your contribution will assist us in making ongoing improvements to the Curriculum

14 Please note that this questionnaire is given as an example and not as a standardised tool for evaluation

The Questionnaire consists of two sections:

Section 1

Q1) Are you: Male ☐ Female ☐

Q2) Which Higher Educational Institution do you work in?

Q3) What is your current position?

Q4) Which healthcare programme/s do you teach?

Medicine	☐	Dentistry	☐
Nursing	☐	Dietetics	☐
Physiotherapy	☐	Pharmacy	☐
Social Studies	☐	Radiology	☐
Podiatry	☐	SALT	☐

Q5) Do you have expereince of teaching in the area of health promotion?

Yes ☐ No ☐

Q6) Do you have previous experience of teaching the skills of providing brief advice/brief interventions?

Yes ☐ No ☐

Q7) Were you aware of the development of a National Standardised Curriculum on Health Behaviour Change for Chronic Disease Prevention and Management?

Yes ☐ No ☐

If Yes, how did you find out about the Curriculum?

Q8a) Are you currently involved in teaching the Curriculum on Making Every Contact Count for HBC-CDPM?

Yes ☐ No ☐

If Yes

Q8b) Do you teach:

Theoretical components ☐ Skills components ☐

Theoretical and skills components ☐

Q9) Did you receive formal training to prepare you for teaching Making Every Contact Count for HBC-CDPM?

Yes ☐ No ☐

If Yes Please Specify

_____

Q10) Do you feel that you are adequately prepared to teach Making Every Contact Count for HBC-CDPM?

Yes ☐ No ☐

Q11) Can you identify ways in which you could be better supported to teach *Making Every Contact Count* for HBC-CDPM?

_____

_____

_____

Section 2 Curriculum Manual *Source University of Maryland Extension Curricular Tool

Before completing this section you must have engaged with the Curriculum Manual on *Making Every Contact Count* for HBC-CDPM. If this does not apply to you please skip this section.

Please think about the Curriculum Manual on *Making Every Contact Count* for HBC-CDPM and complete the following:

Circle your answers for each item

Content	Effective	Good	Fair	Ineffective	Comments
1 Theoretical foundation	**Effective** The Curriculum is based on current education and behavioural change theory and research. The theoretical underpinnings of the Curriculum are described.	**Good** All content except one or two pieces is based on current education and behavioural change theory and research. The theoretical underpinnings of the Curriculum are mostly described.	**Fair** More than one or two pieces of the Curriculum are not based on current education and behavioural change theory and research. The theoretical underpinnings of the Curriculum are not described in detail.	**Ineffective** The Curriculum is not based on cur-rent education and behavioural change theory and research. The theoretical underpinnings of the Curriculum are not described.	Not enough information, not applicable, etc.
2 Research based Content	**Effective** The content of the Curriculum is re-search based, accurate, and current.	**Good** The content of the Curriculum is mainly effective - all but one of the key components of effective Curriculum (research-based, accurate, and current) are addressed.	**Fair** The content of the Curriculum is missing more than one of the key compo-nents of effective Curriculum - re-search-based, accurate, and current.	**Ineffective** The content is not research-based, accurate, or current.	

3 Balanced Viewpoint	**Effective** The Curriculum presents a balanced view of the topic, recognising any aspects that are not yet clearly understood or open to debate.	**Good** All content except one or two pieces presents a balanced view of the topic, recognising any aspects that are not yet clearly understood or open to debate.	**Fair** More than one or two pieces of the Curriculum do not present a balanced view of the topic, failing to recognise any aspects that are not yet clearly understood or open to debate	**Ineffective** The Curriculum presents a onesided view of the topic, failing to recognise any aspects that are not yet clearly understood or open to debate.	
4 Learning Objectives	**Effective** Includes clear, measurable learning and behavioural objectives. Objectives are clearly linked to theoretical underpinnings	**Good** All content except one or two pieces is tied to clear, measurable learning and behavioural objectives. Objectives are mostly linked to theoretical underpinnings.	**Fair** More than one or two pieces of the Curriculum are not tied to clear, measurable learning and behavioural objectives. Objectives are poorly linked to theoretical underpinnings.	**Ineffective** Does not include clear, measurable learning and behavioural objectives.	

Professional HealthCare Student Competency Evaluation QuestionNaire

National Undergraduate Curriculum on *Making Every Contact Count* for Health Behaviour Change for Chronic Disease Prevention and Management

Thank you for taking the time to complete this simple questionnaire.

The questionnaire is divided into two short sections and your contribution will assist us in making improvements to the Curriculum

15 Please note that this questionnaire is given as an example and not as a standardised tool for evaluation

Section 1

Q1) Are you: Male ☐ Female ☐

Q2) Which Higher Educational Institution do you attend?

_____

Q2) Which healthcare programme do you study?

Medicine	☐	Dentistry	☐
Nursing	☐	Dietetics	☐
Physiotherapy	☐	Pharmacy	☐
Social Studies	☐	Radiology	☐
Podiatry	☐	SALT	☐

Q3) What year of your current programme are you in?

Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐

Q4) Were you aware of the development of a National Standardised Curriculum on Health Behaviour Change for Chronic Disease Prevention and Management?

Yes ☐ No ☐

If Yes, how did you find out about the Curriculum?

_____

_____

_____

Section 2

Please rate the following on a scale from 1-5 “not at all prepared- completely prepared”

How well prepared do you currently believe you are to:	1 Not at all prepared	2 Slightly Prepared	3 Somewhat Prepared	4 Mostly Prepared	5 Completely Prepared
1 Assess attitudes and behaviours towards own health and wellbeing					
2 Define health with reference to the key concepts and determinants of health					
3 Assess and interpret health status data for the Irish population					
4 Promote key health messages and recommendations					
5 Describe health behaviours and the factors which influence behaviour					
6 Identify aspects of lifestyle behaviour that affect health and wellbeing					
7 Assess health risks associated with life-style behaviours					
8 Overcome the challenges of changing health behaviours to address risk factors					
9 Analyse the principles of interpersonal communication for health behaviour change					
10 Adopt a person-centred approach to communicating for health behaviour change					
11 Communicate in a supportive, non-direct manner with individuals for HBC					

12	Demonstrate effective communication skills in the context of health conversations with individuals					
13	Demonstrate the core elements of communication in practice for health behaviour change					
14	Identify opportunities to integrate Making Every Contact Count into everyday consultations so that you can carry out brief interventions					
15	Demonstrate an understanding of raising the issue of healthy eating, alcohol and drug use, physical activity and tobacco in routine and regular conversations with patients					
16	Observe and reflect on video footage of Healthcare professionals interacting with patients in a variety of scenarios					
17	Describe the theoretical and practical context for *Making Every Contact Count* for health behaviour change					
18	Identify individuals for whom a brief intervention is appropriate					
19	Use validated screening and assessment tools to assess individual's readiness to change and respond to this assessment supportively					
20	Deliver a brief intervention in an empathetic and non-confrontational manner using the principles of motivational interviewing					

21 Assess your own performance in delivering brief intervention using self-reflective practice					
22 Demonstrate the procedure for sign-posting and referral to support services					
23 Understand how to maintain accurate records in patient documentation/medical chart of delivery of a brief intervention, and how to flag further actions for follow-up					