



# Factors influencing application of behavioural science evidence by public health decision-makers and practitioners, and implications for practice

Kristina Curtis, Emmie Fulton, Katherine Brown\*

Health Behaviour & Interventions Research, Centre for Advances in Behavioural Science, Faculty of Health & Life Sciences, Coventry University (Joint with Public Health Warwickshire), United Kingdom of Great Britain and Northern Ireland

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## ABSTRACT

The National Institute of Health and Care Excellence (NICE) in the UK recommends behavioural science evidence underpins public health improvement services. In practice, level of implementation varies. This study is the first to explore factors affecting use of *behaviour*-specific evidence by public health decision-makers and practitioners for design and delivery of health improvement services. Twenty semi-structured interviews were conducted, along with a review of the commissioning cycle with public health decision-makers and practitioners across a range of health improvement fields (e.g. weight management). Interviews were informed and analysed using the Theoretical Domains Framework (TDF). Limited comprehension of behaviour change, challenges identifying specific behaviour change strategies and translating research into practice were prevalent. Local authority processes encouraged uptake of evidence to justify solutions as opposed to evidence-driven decision-making. Some decision-makers perceived research evidence may stifle innovation and overwhelm practitioners. Potential facilitators of research use included: ensuring uptake and implementation of evidence is compulsory within commissioning and its potential to show value for money. A strong belief in local evidence and achieving outcomes were identified as barriers to research evidence uptake. Social and environmental challenges included cultural, political, and workload pressures and journal article accessibility. Embedding behavioural science systematically into public health practice requires changes throughout the public health system; from priorities set by national public health leaders to the way in which relevant evidence is disseminated. Framing factors affecting use of behavioural science evidence using the TDF is helpful for identifying the range of interventions and support needed to affect change.

## 1. Background

The most prevalent causes of death and morbidity are attributable to non-communicable disease (NCD) which has been identified as due in considerable part to health-related behaviour (e.g. smoking, poor diet, lack of physical activity) (Glanz and Bishop, 2010). Yet, health behaviour change evidence is not typically forefront in public health departments' health improvement service planning and delivery. Instead, the focus is typically on epidemiological and clinical evidence relevant to communicable and NCD (Pine and Fletcher, 2014).

### 1.1. Evidence informed decision-making and public health

To improve population health, greater adoption of evidenced-based interventions is recommended (Brownson et al., 2009). There is therefore an impetus for public health professionals to use evidence-informed decision-making (EIDM) (Armstrong et al., 2014; Yost et al., 2014). EIDM comprises systematic processes integrating scientific evidence with contextual factors such as local relevance, available resources and community and political preferences to inform decisions related to policy, programmes and practice (Yost et al., 2014; Armstrong et al., 2013; Peirson et al., 2012). EIDM benefits public health through more efficient use of resources, decision-making at both community and system levels, and greater chance of effective

*Abbreviations:* BCTs, behaviour change techniques; COP, communities of practice; EBPH, evidence based public health; EIDM, evidence informed decision making; NICE, National Institute for Health and Care Excellence; NCD, non-communicable disease; TDF, Theoretical Domains Framework; WHO, World Health Organisation; PPI, patient and public involvement; TUPE, transfer of undertakings (protection of employment)

\* Corresponding author at: Health Behaviour & Interventions Research, Centre for Advances in Behavioural Science, Faculty of Health & Life Sciences, Coventry University, Priory Street, Coventry CV1 5FB, United Kingdom of Great Britain and Northern Ireland.

E-mail address: [k.brown@coventry.ac.uk](mailto:k.brown@coventry.ac.uk) (K. Brown).

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programmes being implemented (Brownson et al., 2009; Yost et al., 2014; Meagher-Stewart et al., 2012; van de Goor et al., 2017).

In this paper we focus on public health decision-making, within the context of service commissioning, and how it is informed by research evidence from the behavioural sciences. Behavioural science can be defined as an interdisciplinary approach to the study of human behaviour (Glass and McAtee, 2006) encompassing disciplines including psychology, sociology, anthropology and economics. We focus particularly on health behaviour change theory and evidence as this reflects our expertise but are cognisant of wider relevant literature.

Underpinning interventions with theory is a key recommendation of the UK Medical Research Council's framework for developing and evaluating complex interventions (Craig et al., 2008). This is supported by systematic reviews suggesting that health behaviour change interventions are more effective when underpinned with theory (Webb et al., 2010; Cole-Lewis and Kershaw, 2010). Within the context of public health, such approaches offer the opportunity to underpin the design and delivery of health improvement services with content derived from evidence about what works to change relevant behaviours. Despite pressure to demonstrate public health services are evidence-based (Orton et al., 2011; Milat et al., 2015), requirements to draw on this type of evidence are typically quite cursory.

### 1.2. The local authority context

In England, where this research was conducted, public health departments are housed within local authorities, subject to local government regulations and answerable to elected council members. They are largely focused on commissioning of services by other providers from the private, public sector or third sector. Because each local department operates independently from others they are often configured in different ways but are typically divided into teams that deal with Health Protection, Health Improvement, and Health Intelligence.

### 1.3. The complexities of public health research evidence

Effective public health programmes must support behaviour change at individual, organisational and community levels (Glanz and Bishop, 2010). Whilst the science base is developing, it is unwarranted to refrain from using the existing evidence base when designing and delivering health improvement interventions (Brownson et al., 2009). International organisations (e.g. World Health Organisation) support the need for underpinning population-focused programmes with behavioural science evidence, yet the degree to which evidence-based approaches are implemented varies (Milat et al., 2015). Within the UK, NICE produces public health guidance informing commissioning and practice (Orton et al., 2011). Public health guidelines [PH6] and [PH49] ([https://www.nice.org.uk/Guidance/ph6\\_n.d.](https://www.nice.org.uk/Guidance/ph6_n.d.); National Institute for Health and Care Excellence, 2014) focus on behaviour change approaches, however, genuine impact of this guidance remains unclear.

### 1.4. Active ingredients in health behaviour change interventions

According to Brownson and colleagues (Brownson et al., 2009), a fundamental component of EIDM (referred to as evidence-based public health (EBPH)), is the translation of effective interventions to new populations. To do this, the authors maintain that practitioners need to identify the most effective components or 'active ingredients' of an intervention (Brownson et al., 2009). Within behaviour change science, these 'active ingredients' have been defined as 'behaviour change techniques' (BCTs) and represent the observable and measurable components that directly bring about change in a target behaviour (Michie et al., 2014). For example, BCT taxonomies (see Abraham and Michie, 2008; Michie et al., 2011) have been used to specify BCTs associated with more effective childhood weight management

interventions such as: Prompt specific goal setting; Self-monitoring; Instruction on how to perform the behaviour; and Plan for social support (Curtis et al., 2015). Decision-makers' understanding and practitioners' use of such BCTs in public health services remains unexplored.

### 1.5. Previous research investigating barriers to research evidence uptake

To date, the majority of studies investigating barriers to research evidence uptake have focused on clinical, health services and health policy evidence (Armstrong et al., 2013; Mitton et al., 2007). Previous research has not looked at behavioural science research evidence uptake, nor included public health practitioners. This paper focuses on decision-makers (defined as those that make management decisions about public health services including financial and delivery aspects) and practitioners, (defined as those that make decisions pertaining to individual service users) (Abraham and Michie, 2008). We focus on health improvement services targeted at people identified as having lifestyle-related health-problems, as these require greater emphasis on health behaviour change than health promotion activities (e.g. tier 2 weight management services, stop smoking services, sexual health services) and are a major remit of public health departments in the UK. In line with Armstrong and colleagues (Armstrong et al., 2011), we refer to behavioural science research as research drawn from evaluations assessing the effects of interventions on health outcomes. Until now there has been limited use of theory to understand influences on public health decision-makers and practitioners' behaviours. Adopting a theoretical approach allows the generation of replicable methodologies for classifying factors influencing staff behaviour and providing potential 'targets for knowledge translation interventions' (Bonetti et al., 2010: 1).

### 1.6. Theoretical underpinnings of the research

The current research utilises the Theoretical Domains Framework (TDF) (Francis et al., 2012; Cane et al., 2012) which unites theoretical constructs from multiple behaviour change theories. The TDF classifies 14 domains including 'Knowledge', 'Skills', 'Beliefs about capabilities' and 'Emotion', known to influence behaviour and offer potential targets for change (Steinmo et al., 2016). The TDF has been used to study a range of health professionals behaviours (Fuller et al., 2014; Patey et al., 2012; Curran et al., 2013; French et al., 2012; Bussi eres et al., 2012) and offers 'an inclusive, rather than selective, approach to exploratory research in the field of implementation' (Francis et al., 2012: 6). Exploratory, qualitative research is appropriate where existing research data are limited and the TDF is used in the current research to address the question, 'which theoretical domains conceptualise the factors that influence staffs' use of behaviour change evidence for the commissioning, design and delivery of public health improvement programmes?'

In addition, we considered, 'how do these findings map to stages involved in commissioning such programmes, and where might this provide opportunities to change practice?'

## 2. Methods

### 2.1. Study design

This was an interview-based qualitative study. Ethical approval was granted by Coventry University. Interviews (vs focus groups) were chosen to avoid the influence of others' views (Reeves et al., 2008) previously highlighted as important (Wye et al., 2015). A further interview with a decision-maker and consultation of commissioning documents were used to map the commissioning process for weight management services. The account was added to and verified by another decision-maker.

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