NICE PUBLIC HEALTH PROGRAMME GUIDANCE
BEHAVIOUR CHANGE

1st meeting of the Programme Development Group
Wednesday 5 July 2006, Derwent Room, NICE,

MINUTES

Attendees:	*Members* Charles Abraham, Mildred Blaxter (Chair), Vicky Cattell, Vimla Dodd, Christine Godfrey, Miranda Lewis, Terence Lewis, Ray Pawson, Wendy Stainton Rogers, Stephen Sutton, Martin White, Ann Williams. Co-opted members: Roisin Pill Julia Fox-Rushby *NICE* Chris Carmona, Alastair Fischer, Jane Huntley, Mike Kelly, Lesley Owen, Catherine Swann, Clare Wohlgemuth. *NICE observers* Marta Calonge-Contreras, Amanda Killoran, Patti White, *Review Team:* Fiona Harris, Ruth Jepson.
Apologies:	Karen Jochelson, Miranda Mugford, Jennie Popay, Robert West, David Woodhead.
Audience:	Members of the PDG, CPHE behaviour change team, review team.

ACTION POINTS HIGHLIGHTED IN YELLOW

Agenda Item	**Minutes**	**Action:**
1. **Welcome and introductions** (Mildred Blaxter)	Round table introduction.	
2. **Ways of working, code of conduct and confidentiality agreement** (Mildred Blaxter)	***Relevant papers:*** *BC1-1a: PDG ways of working paper* *BC1-1: Code of conduct for PDG members* *BC1-2: Confidentiality agreement* Mildred indicated that PDG meetings would operate with members having equal weight of voices. Members were reminded that they are not representing organisations but are present as individuals.	

Members will be expected to attend 80% of meetings, and need to give appropriate notice of absence and if possible forward comments on the material for discussion beforehand. The importance of confidentiality was stressed, both of papers and recommendations. It was explained that meetings will be tape recorded but these are confidential and will later be destroyed. Minutes will not attribute comments to individuals.

PDG members to sign and return confidentiality forms. **PDG Members**

3.

Declaration of interests

(Julian Lewis)

Julian Lewis provided an introduction to declarations of interest. He stated that the NICE Board are likely to agree on the final declarations of interest policy soon. Julian will forward this to PDG members as soon as this occurs.

He outlined the four main areas of interests that should be declared:

1. Personal – a member is directly in receipt of benefit.
2. Non-personal – the unit or department you are responsible for stands to benefit from the guidance.
3. Specific – your work relates to matters under discussion.
4. Non-specific – your work relates generally to matters under discussion.

It is necessary to declare interests so that the general public know the foundations on which recommendations are based and to allow for transparency in the process.

Declaration of interests are made when PDG members are appointed and then annually. The Chair of the Committee decides whether members should withdraw from the meeting. Mike Kelly elaborated on interests that were particular to the public health field, for example, membership of particular religious groups when involved in guidance concerning sex and relationship education, being a member of a pro/anti smoking lobbying group when involved in guidance concerning smoking cessation might constitute conflicts of interest and certainly interests which should be declared..

It was concluded that if in doubt, declare an interest.

A roundtable of declarations took place:

- Charles Abraham – involved in research in behaviour change.
- Christine Godfrey -an active researcher but not funded, she is a trustee and executive member of The Society of the Study of Addiction and a trustee of the alcohol and health research group at the University of the West of England. She is also a member of the cardio-vascular group at the Faculty of Public Health.
- Miranda Lewis - runs the behaviour change programme at IPPR funded by *Pru Health* and *Norwich Union* both of whom sell health insurance.
- Wendy Stainton Rogers -personal research into sex and behaviour change, her faculty also undertakes research into social exclusion and provides training material for professional competence.
- Stephen Sutton - actively engaged in research in behaviour change with funding from MRC, DH and NHS R & D and various medical charities.
- Martin White - actively involved in research in behaviour change, a member of the Regional Tobacco Control office funded by the Department of Health .

- Roisin Pill - not an active researcher but is a consultant and advises her old department on research in behaviour change topics (primary care setting)
- Fiona Harris- author of this review and working on another review for NICE.
- Catherine Swann - technical lead for this programme, also a trustee for a clinic for children in Brighton which provides homeopathic treatments for disadvantaged children.
- Mildred Blaxter a researcher so might be in the market for research grants. Is a trustee for the Institute of Alcohol Education.
- Julia Fox-Rusby – NICE are funding work to be presented in December. Funding is received from the Welsh Assembly on physical activity and economic theory. Her academic group undertakes work for pharmaceutical companies which has relevance for treatments of coronary heart disease.

Julian Lewis

The Chair, concluded that none of these interests were in conflict with the topic at hand today.

Julian Lewis will take these declarations to the Board and will let us know if there are any issues.

4.

Overview of guidance process, dates of meetings and key process dates

(Jane Huntley)

Relevant papers:
BC1-3: Overview of key dates
BC1-4: Overview of the guidance process

Jane highlighted that the December meeting date has been changed and will now take place on the 11th December 2006. Gerard Hastings's team, review number 3, will be presented in two parts, firstly on 6th September 2006 with the final part being presented on 4th October 2006. Environmental behaviour and Road Safety will be presented on 6th September and Marketing and Advertising will be presented on 4th October.

PDG members

Jane asked members to note that Nicole Clement no longer works for NICE so please email Gisela Abbam or Jane Huntley instead.

Jane presented paper BC1-4. Discussion arising from presentation:

It was commented that the process in this programme regarding the health economics is different from other programmes in that the economic data are usually presented with each review but here one economic review will be presented at the end of the process. This review will be on the topic of coronary heart disease. However, the team may also do some economic modelling based on evidence from all the effectiveness reviews using the evidence shown to be effective. It was also pointed out that not all the reviews for this programme are about effectiveness but about learning from other areas. It will not therefore be possible to have health economic data on all reviews.

NICE Team

It was asked whether there will be a statement indicating what the guidance will save the NHS in the long run, as this is the incentive PCTs need to change their behaviour/practice. The response was that while this is difficult to calculate we would do our best to do so. It was also commented that NICE chose CHD for the economic analysis as we knew there would be a lot of data in this area.

Concerns were raised that this guidance would overlap with other NICE guidance. The response from the NICE team was that checks are in place to prevent this from occurring.

5.

The NICE evidence review process: forming recommendations (Catherine Swann)

Relevant papers:
BC1-5: "Chapter 6 – Creating Recommendations" from the NICE Public Health Methods Manual
BC1-6: Forming recommendations presentation

Catherine drew attention to the glossary of terms and BC1-5, and then presented BC1-6.

Discussion arising from presentation:

The subtle differences in the wording of evidence statements was discussed, such as the various terms used to describe the effect of an intervention, for example, 'insignificant effect, inconclusive effect, little effect', it was felt that there was need for definitions of such terms so as for PDG members to be able to understand the differences and interpret correctly. In responding, the NICE team remarked that this issue has been raised in other PDGs. It was agreed that a lexicon needs to be devised to counter this issue that is caused by the different reporting styles of review authors. Ruth and Fiona could possibly help devise this lexicon. This matter should be referred back to the NICE methodology team for further consideration when the process and methods manuals are revised.

Ruth Jepson/ Fiona Harris

The importance of noting that interventions evaluated at an individual level are much more likely to show positive outcomes than those operating at community level was highlighted.

It was also remarked that it would be helpful if evidence statements were categorised and presented according to characteristics of the study, such as population, setting. The NICE team responded that, in the process of forming a set of draft recommendations, the internal programme team had indeed grouped evidence statements in such a manner. It was agreed that it would be useful to see a list of the evidence statements according to these categories; Catherine Swan will circulate this document to PDG members. An open email system will be used to exchange ideas on the draft recommendations, A further iteration will be brought to the next PDG meeting.

Catherine Swann

The usefulness of having statistics presented alongside evidence statements was raised, as this may help overcome the issues associated with difficulties of interpreting the terms used to describe the effect of an intervention. The response was that this was a difficult task as few review authors have performed meta analysis on the included studies, however, if these data proved crucial it was possible to go back to the primary studies to retrieve such data. The usefulness of considering the CONSORT statement was raised. In trying to interpret evidence statements the possibility of asking practitioners at the fieldwork stage was also suggested.

The issue of the description of the intervention being vague or unclear was raised, It follows that basing a recommendation on evidence, which although very sound methodologically, did not specify the intervention,

was inherently problematic. Accurate descriptions of interventions are the lynch pins of the implementability of recommendations.

6.

Introduction to the evidence

(Mildred Blaxter Ruth Jepson / Fiona Harris)

Relevant papers:
BC1-7: Overview of the evidence presentation
BC1-8: A review of the effectiveness of interventions, approaches and models at individual, community and population levels that are aimed at changing health outcomes through changing knowledge, attitudes and behaviour.

It was noted that there had been a clerical error and that paper BC1-7 had inadvertently also been headed as BC1-8, the code for the review document.

Ruth presented BC1-7.

Discussion arising from presentation:

The PDG discussed horizon scanning. It was noted that there are a couple of reviews (including data on socio-economic status) that should be published soon. Also a Health Education Authority publication on healthy eating and ethnicity review appears not to have been included. The pDG noted that there would be an opportunity for the findings of new research to be included, but that there would be a cut off date for its inclusion. It was also noted that NICE always have a set date for the updating of published guidance which is usually between 3 and 5 years. If it is known that research will be published soon but after the cut off date, then the guidance might contain a proviso that it might be updated earlier. The PDG members were asked to inform the NICE team if they felt any relevant publications had been missed

PDG members

There were concerns about how sensible it was to exclude all publications connected with screening as it was felt valuable studies may be missed. It was agreed that the NICE team would revisit this issue concerning the exclusion of screening studies.

NICE team

A query about whether counselling is only effective when delivered by physicians was raised. If so, it was remarked that very few physicians in the field will actually counsel patients but rather they will refer patients elsewhere such as to the practice nurse. It was noted that the evidence showed that counselling was effective in a range of formats.

The idea of producing a taxonomy for the arranging of evidence statements was discussed. It was agreed that Charles Abraham, Martin White and Catherine Swann will discuss producing this taxonomy straight away.

Charles Abraham/ Martin White/ Catherine Swann

The importance of being clear about the difference between knowledge and attitudes and how they are measured was discussed. It was remarked that whereas knowledge does not often result in behaviour change, attitude was much more likely to. It was stressed that knowledge and attitude are not the same concept.

The need for more detail about interventions was raised, such as in the case of media interventions, who delivers the message and how? A general observation was made that the levels of compression that occurs in a review of reviews means that findings may be incomplete.

Further clarification was asked for regarding how gaps in the evidence were identified, as it was felt there were many more gaps that could have been highlighted. It was noted that gaps were identified by the review team on the basis of scientific and political interest , such as the issue of inequalities. It was mentioned that perhaps one of the most important things in identifying gaps is to make research recommendations, for example, hurdles to behaviour change. In making research recommendation the more precise the more likely they are to be implemented. .

The question was raised as to why we were limited to making ten research recommendations. It was explained by the NICE team that this is defined by the NICE Guidance document template. However the PDG can draw up a long list of recommendation which will be taken forward. It was also commented that we have good links with ESRC.

A query was raised regarding the work of Davey Smith and why his work had not been picked up in the data search for this review. It was speculated that this might be owing to the screening filter. It was commented that this work will probably be picked up in the literature search for review number one but the NICE team will check.

The review team indicated that in total 92 reviews were included in the report. It was noted that relevant papers may have been excluded. The NICE team did remind PDG members that there will be an opportunity during the consultation stage for authors and others to propose additional papers.

NICE team

A query was raised as to whether papers considering policy initiatives had been captured. The review team reasoned that papers has been selected on the basis of quality rather than content.

Queries regarding NICE's scoring system were raised. It was noted that as well as methodological quality applicability to UK settings was also assessed.

The idea of using guidance from other sources such as customs and excise, who collect data on cigarette sales in an area, was suggested, this data could be used to assess smoking cessation in an area rather than the PCTs target based approach which counts a smoking cessation success as having quit for 4 weeks. It was confirmed by the NICE team that other evidence is considered in the guidance production process.

7.

Evidence review: Discussion of evidence statements

(Group work)

(Mildred Blaxter)

PDG members were split into three groups to consider the evidence with a view to forming recommendations:

Group 1

Specific Issues:

- Surprise findings included that of hypnotherapy not being effective. It was agreed that the evidence was robust but that it contradicted lay belief.
- Another specific issue concerned evidence statement number nine, regarding the effectiveness of the stages of change based approach – it was noted by the NICE team that another review team had interpreted these results differently and that it was felt

there might be an error with the original paper so it will need to be re-visited. **Review team**

- There was a typing error with evidence statement number 10, 'motivational intervention' should actually be 'motivational interviewing'.

General Issues

- It was noted that the database DARE needs to be added to the glossary.
- The group were interested in whether there were any studies on internet based interventions, termed 'e-health'; by limiting ourselves to review level material we would miss out on recent innovation?
- The need to tease out what the effective and ineffective aspects of interventions are was identified as important, possibly going back to the original paper. It is important to know what to attribute success to.
- There is a need to be clear about what settings interventions actually work in.
- There is a need to consider ways of bringing in other sources of evidence so as to tie in evidence on the broader determinants of health.
- It is important to have clear statements about what does not work and where the gaps are so as to improve our overall picture.
- There was also a discussion regarding the use of different outcome measures, for example, delaying the onset of smoking is considered to have some benefits, for example, if an intervention in a school does not effect on overall smoking cessation but does delay the uptake of smoking it will have reduced the overall exposure for those children. Therefore, we need to be sensitive to different outcome measures.
- It was commented that when referring to behaviour having changed we should be referring to sustained behaviour change, this is especially important when considering QALYs. We need data on relapse. Maybe it is the case that different interventions are needed to bring about change and different interventions are needed to sustain change. We possibly need recommendation for behaviour change maintenance.

Consideration of the draft recommendations

- It was felt that if a general statement about the effectiveness of an intervention was made that there was then a need to tease out the subtleties behind this, for example, counselling, if we say it is effective do we know it is equally effective across a range of behaviours?
- The need for cost effectiveness data arose after a discussion of the recommendation regarding effectiveness of brief and intensive interventions, for example, in relation to implementation and the potential reach of an intervention, a brief intervention might be less effective than an intensive intervention but if it is cheaper to implement if might be able to reach a greater proportion off the target population.

Group 2

Evidence statements 34 – 39

- There is little information about the specific content of the interventions

- There is no information about cost-effectiveness to balance the evidence
- Given current knowledge, evidence for the use of biomarkers is inconclusive
- There is no good evidence for the TTM
- There are also environmental considerations which should be considered, eg the provision of council pools and gymnasia
- Given the evidence, if the task were simply to increase physical activity then we would recommend an individual approach including a set of specific components

Evidence statements 40 – 43

- Some particular settings based work (school/employment) may be more effective, however, content is still vital. We need to know which intervention exactly. What does it look like?
- We need to tease out whether the school/workplace interventions are compulsory or voluntary

Evidence statements 44 – 46

- No recommendations on the basis of this

Evidence statements 58 – 59

- It was felt that 'counselling' was a meaningless term in the absence of specifics about the nature of the counselling

Evidence statements 60 – 66

- If marginal cost is small then 61 is relevant. This needs modelling.
- Context is also important, for example whether tuck shops continue to sell sweets and crisps
- What is the minimum level of behaviour change which we consider to be worthwhile?
- A blood pressure reduction of 1mmHg in an individual is meaningless, but across a whole population is huge
- The point-of-sale information from supermarkets is promising
- Terms like 'multi-component intervention' are meaningless and should be avoided
- The group were keen to make recommendations about MPH curricula, especially in regard of the TTM

Evidence statements 86 – 88

- Need clarity about phrases like "promote positive attitude" – what exactly is meant by attitude and how is it measured?

A number of additional statements would be generated by this group.

Group 3

- the group was frustrated by not know what the review team had excluded
- more attention needs to be paid to the setting of the intervention.
- All sexual health and drug studies based in the USA should be discounted as the culture and legal frameworks very different to UK.
- An error in the statement 53 was identified. There were no psychological studies it was psychosocial.
- The formulation of statements is interesting but the wording is ambigious. For example, what does 'behavioural counselling

intervention mean? What is meant by reducing alcohol consumption? What/who are problem drinkers?
- The group would hesitate to make a recommendation on counselling as it is very difficult to access counselling services.
- The formulation of statements is too bland – we need to ensure that we don't exclude other public health settings by just focussing on the NHS
- We need to understand that the term brief intervention means very different things in different settings and under different topics.
- it is not that more research is needed into inequalities it is that all studies should look at a measure of social class.

The draft recommendations were discussed in detail:

- 1. the first sentence looks promising, but we would need to add brief behavioural counselling.
- 4. put to one side (crumple) the evidence appears to be poor.
- 6. Looks promising
- 7. not helpful to lump too many areas together. This could become two separate recommendations one on mass media and one on legislation.
- 8. potentially promising but as stated it is not useful.
- 9. Looks promising

Overall summary

It was mentioned that with regards to the evidence statement concerning stages of change, given the amount the country has invested in this approach it would seem necessary for the evidence to state that the approach is 'ineffective', not 'sometimes effective'.

None of the groups had time to discuss research recommendations. The NICE team will continue to develop a list of these recommendations as the different reviews come in and they will be revisited at a later stage.

Overall, it was concluded by all groups:
- that there was a need for greater specificity in the language used in the recommendations, as at present they are too vague, such as terms like 'counselling'.
- that the components of interventions need to be unpacked.
- that the relationship between knowledge and attitudes needs to be teased out and borne in mind when constructing recommendations.
- there is a need to consider the potential counter effectiveness of recommendations.

The need for a consensus on features of interventions was raised as necessary for next time.

The idea of the review team presenting the evidence statement differently to the PDG, was raised, with the idea that evidence statements should be listed arranged by population/community and also by content of intervention/theory, target population, setting, person delivering the intervention, mode of delivery. There is a need to present empirical data alongside evidence statements. This would help PDG members make better sense of them. The NICE team will discuss internally the presentation of the evidence statements. **NICE team**

The feeling that this afternoons workshop had been a 'ground clearing ' exercise was mentioned, the NICE team remarked that this was normal but would probably become less onerous at each PDG meeting.

If there is demand, a web-board can be set up so as to allow PDG members to continue these debates. PDG members to consider if they would like a web board to be set up.

At the next meeting we will look at the next review and then revise the recommendations from today's review. **PDG members**

The draft recommendations discussed today will be emailed to all PDG members with an invitation for members to respond to the recommendations.

The need to retrieve more about the content of recommendations from original studies was raised so as to make recommendations effectively implementable. **NICE team/ PDG Members**

The review may be revised prior to publication prior, to take account of errors and minor mistakes..

Secretary's note – it may not be possible to revise the way in which evidence tables are presented as all reviews have been commissioned. However the CPHE team consider the suggestions made for subsequent commissions.

DATE OF NEXT MEETING: ***Wednesday 6th September 2006, Strand Palace Hotel, London***

MEETING PAPERS TO BE MAILED: ***24th August 2006***