**Supplementary Material:**

**Search Terms**

“making every contact count” OR “healthy conversation skill\*” OR “health chat\*” OR “every contact a health improvement contact”

AND

Accept\* OR Access\* OR Adher\* OR Attitude\* OR Awareness OR Barrier\* OR Begin OR Behaviour\* OR Belief\* OR Block\* OR Cease OR Cessation OR Change OR Compliance OR Comply OR Complie\* OR Confiden\* OR Constrain\* OR Decreas\* OR Delay\* OR Deliver\* OR Driver\* OR Efficacy OR Effect\* OR Enable\* OR Embed\* OR Encourag\* OR Enhance\* OR Facilitat\* OR Factor\* OR Hindrance\* OR Hinder\* OR Impact\* OR Impede\* OR Implement\* OR Improve\* OR Incentive\* OR Increas\* OR Influence\* OR Inhibit\* OR Initiate OR Intention\* OR Knowledge OR Motivat\* OR Norm\* OR Obstacle\* OR Obstruct\* OR Offer OR Opportunit\* OR Optimi?\* OR Percept\* OR Practice\* OR Prevent\* OR Provision\* OR Provid\* OR Promot\* OR Reduc\* OR Refer\* OR Refus\* OR Restrict\* OR Restrain\* OR Satisfact\* OR Support\* OR Sustain OR "Take up" OR Uptake OR Utili?\* OR View\* OR Willing\*

**Supplemental Table 1: Summary of studies included in the rapid systematic review of barriers and facilitators**

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| **Reference** | **Behaviour (as described in article)** | **Participants** | **Measure of behaviour** | **Country** | **Study sample trained in MECC prior to measure of behaviour?** |
| 1. Al-Doghether, M., A. Al-Tuwijri, and A. Khan, Obstacles to prevention intervention: Do physicians' health habits and mind-set towards preventive care play any role? Saudi Medical Journal, 2007. 28(8): p. 1269-1274 (Al-Doghether, Al-Tuwijri, & Khan, 2007) | Preventive intervention for alcohol, smoking, nutrition, human immunodeficiency virus (HIV), blood pressure control, etc. | Family and general physicians (164/182) from five health sectors of Riyadh | Self-report questionnaire | Saudi Arabia | No |
| 2. Ampt, A., et al., Attitudes, norms and controls influencing lifestyle risk factor management in general practice. BMC Family Practice, 2009. 10(59) (Ampt et al., 2009) | Lifestyle behavioural risk factor screening and management within a 45–49 year old health check consultation | 15 GPs and one practice nurse from two geographical areas in Sydney | Qualitative interviews (n=29) | Australia | No |
| 3. Brotons, C., et al., Prevention and health promotion in clinical practice: the views of general practitioners in Europe. Preventive Medicine, 2005. 40: p. 595-601 (Brotons et al., 2005) | Evidence-based health promotion and disease prevention recommendations in primary care | 2082 GPs listed from national colleges of each country | Self-report questionnaire | Eleven European countries | No |
| 4. Casey, D., Nurses' perceptions, understanding and experiences of health promotion. Journal of Clinical Nursing, 2007. 16: p. 1039-1049 (Casey, 2007) | Health promotion by enabling people to increase control over and to improve their health | Eight nurses from an acute 33-bed surgical ward | Qualitative observations and interviews | Republic of Ireland | No |
| 5. Chisholm, A., et al., Current challenges of behavior change talk for medical professionals and trainees. Patient Education and Counseling, 2012. 87: p. 389-394 (Chisholm, Hart, Lam, & Peters, 2012) | Behaviour change talk - engaging in theoretically derived effective behaviour change techniques for a wide range of health-related behaviour such as smoking, diet and exercise (e.g., goal setting and motivational interviewing) with patients | Medical professionals (doctors) and trainees (n = 29) in a large urban conurbation in the North West | Qualitative interviews | UK | No |
| 6. Dewhirst, S. and V. Speller, Wessex Making Every Contact Count (MECC) Pilot. 2015 (Dewhirst & Speller, 2015) | Making Every Contact Count | Staff from therapy services, diabetes services, occupational health, minor injuries, heart failure, respiratory teams, housing office in three pilot sites in Wessex | Self-report questionnaires (pre n=100, post n=101), qualitative interviews (pre n=14, post n=18), Organisation Assessment Tool (OAT) | UK | Yes |
| 7. Donoghue, G., et al., Assessment and management of risk factors for the prevention of lifestyle-related disease: a cross sectional survey of current activities, barriers and perceived training needs of primary care physiotherapists in the Republic of Ireland. Physiotherapy, 2014. 100: p. 116-122 (Donoghue, Cunningham, Murphy, Woods, & Aagaard-Hansen, 2014) | Assessment and management of behavioural risk factors | Primary care physiotherapists (163/220) | Self-report questionnaire | Republic of Ireland | No |
| 8. Donovan, H. and N. Davies, The value and contribution of nursing to public health in the UK: Final report. 2016 (Donovan & Davies, 2016) | Public health via making every contact count using all opportunities to provide accurate and up-to-date advice so that people are supported to make good lifestyle choices. | Nurses and commissioners | Self-report questionnaire (n=219) Qualitative interviews (n=16) | UK | No |
| 9. Elwell, L., et al., Patients' and practitioners' views on health behaviour change: A qualitative study. Psychology and Health, 2013. 28(6): p. 653-674 (Elwell, Povey, Grogan, Allen, & Prestwich, 2013) | Lifestyle behaviour change | Health professionals (n=13) in general practice surgeries in Leeds | Qualitative focus groups | UK | No |
| 10. Elwell, L., et al., Health professional perspectives on lifestyle behaviour change in the paediatric hospital setting: a qualitative study. BMC Pediatrics, 2014. 14(71) (Elwell, Powell, Wordsworth, & Cummins, 2014) | Lifestyle behaviour change brief advice | 33 health professionals (nurses, junior doctors, allied health professionals and clinical support staff in an acute children’s hospital | Qualitative interviews | UK | No |
| 11. Geense, W., et al., Barriers, facilitators and attitudes influencing health promotion activities in general practice: an explorative pilot study BMC Family Practice, 2013. 14(20) (Geense, van de Glind, Visscher, & van Achterberg, 2013) | Lifestyle interventions | Dutch GPs (n=16) and Practice Nurses (n=9) in primary care | Qualitative interviews (n=25) | Netherlands | No |
| 12. Jacobsen, E., et al., Perspectives on lifestyle intervention: The views of general practitioners who have taken part in a health promotion study. Scandinavian Journal of Public Health, 2005. 33: p. 4-10 (Jacobsen, Rasmussen, Christensen, Engberg, & Lauritzen, 2005) | Health promotion: administering preventive health checks and initiating health discussions on aspects of lifestyle | Five general practitioners | Qualitative focus groups | Denmark | No |
| 13. John Dawson Associates, Every Contact Counts: Evaluation of Training Programme for Front Line Staff. 2013 (John Dawson Associates, 2013) | Every Contact Counts | Front line staff in 8 organisations in Liverpool | Self-report questionnaire (n=75, 36 pre training / 39 post-training – train the trainer) (n=336, 168 pre training / 168 post-training - cascade training) Semi-structured interviews / focus groups | UK | Yes |
| 14. Lambe, B. and C. Collins, A qualitative study of lifestyle counselling in general practice in Ireland. Family Practice, 2010. 27: p. 219-223 (Lambe & Collins, 2010) | Lifestyle behaviour change | 56 primary health care practitioners (GPs, practice nurses, public health nurses, social workers, physiotherapists, occupational therapists) | Qualitative focus groups (n=6) | Republic of Ireland | No |
| 15. Laws, R., et al., An exploration of how clinician attitudes and beliefs influence the implementation of lifestyle risk factor management in primary healthcare: a grounded theory study. Implementation Science, 2009. 4(66) (Laws et al., 2009) | Lifestyle risk factor management | 23 clinicians (community nurses, allied health practitioners, Aboriginal health workers), five managers, and two project officers in three community health teams in New South Wales | Qualitative interviews (n=48) | Australia | No |
| 16. Laws, R., et al., "Should I and Can I?": A mixed methods study of clinical beliefs and attitudes in the management of lifestyle risk factors in primary health care. BMC Health Services Research, 2008. 4(44) (Laws et al., 2008) | Lifestyle risk factor management | Primary health care clinicians from three community health teams from two Area Health Services in the state of New South Wales | Self-report questionnaires (n=59) and qualitative interviews (n=22) | Australia | No |
| 17. McMahon, N. and C. Connolly, Health promotion knowledge, attitudes and practices of chartered physiotherapists in Ireland: A national survey. Physiotherapy Practice and Research, 2013. 34: p. 21-28 (McMahon & Connolly, 2013) | Health promotion: the process of enabling people to increase control over, and to improve their health | 2753 registered members of the Irish Society of Chartered Physiotherapists | Self-report questionnaires (n=526) | Republic of Ireland | No |
| 18. Nelson, A., C. de Normanville, and K. Payne, Making every contact count: an evaluation. 2013 (Nelson, de Normanville, & Payne, 2013) | Making Every Contact Count (MECC) | Key stakeholders (n=12) engaged in the delivery of MECC in organisations in Yorkshire, Humber and the North West of England | Qualitative interviews | UK | Yes |
| 19. Pattinson, L. and A. Jessop, The delivery of health improvement information during radiotherapy treatment: a survey of UK therapy radiographers. Journal of Radiotherapy in Practice, 2016. 15(2): p. 114-130 (Pattinson & Jessop, 2016) | Providing health improvement information to patients | Society and College of Radiographers (SCoR) (n=102) | Self-report questionnaires | UK | No |
| 20. Percival, J., Promoting health: making every contact count. Nursing Standard (2014+), 2014. 28(29): p. 37 (Percival, 2014) | Make every patient contact count | 40 nurses in London and Manchester | Self-report questionnaire | UK | Yes |
| 21. Royal Society for Public Health, Healthy Conversations and the Allied Health Professional. 2015 (Royal Society for Public Health, 2015) | Healthy conversations | Over 2000 Allied Health Professionals | Self-report questionnaires, qualitative interviews and focus groups | UK | Yes |
| 22. Tinati, T., et al., Implementation of new Healthy Conversation Skills to support lifestyle changes - what helps and what hinders? Experiences of Sure Start Children's Centre staff. Health & Social Care in the Community, 2012. 20(4): p. 430-437 (Tinati et al., 2012) | Healthy conversation skills | Sure Start Children’s Centre staff (n=110) attending one of 13 follow-up workshops in Southampton | Self-report questionnaires | UK | Yes |
| 23. Uscreates, Insight into patient and staff attitudes on the appropriates of receiving and delivering healthy lifestyle advice. 2012 (Uscreates, 2012) | Brief lifestyle advice | 49 doctors, nurses, health care professionals, health care assistants, rehab assistants, health trainers, clinic/reception staff, porters and house keepers in primary and secondary care in NHS Midlands and East | Qualitative interviews | UK | No |
| 24. Walkenden, S. and K. Walker, Perceptions of Physiotherapists about their role in health promotion at an acute hospital: a qualitative study. Physiotherapy, 2015. 101: p. 226-231 (Walkenden & Walker, 2015) | Health promotion via making every contact count | 22 physiotherapists in an acute inpatient setting | Qualitative focus groups (n=3) | UK | No |
| 25. Walter, U., et al., Putting prevention into practice: qualitative study of factors that inhibit and promote preventive care by general practitioners, with a focus on elderly patients. BMC Family Practice, 2010. 11(68) (Walter et al., 2010) | Preventive care | German general medical practitioners in Berlin and Hannover | Qualitative interviews (n=32) | Germany | No |
| 26. The Roundhouse Consultancy MK Ltd, Opportunities, barriers and enablers for 'Making Every Contact Count' (MECC) to be introduced into the optometry curriculum and workforce training and development. 2016 (The Roundhouse Consultancy MK Ltd, 2016) | Making every contact count | Practising optometrists and members of the Local Eye Health Network in the West Midlands | Interviews | UK | No |
| 27. Chisholm A, et al., Public health practitioners’ views of the ‘Making Every Contact Count’ initiative and standards for its evaluation. Journal of Public Health, 2018 (Chisholm A, Ang-Chen P, Peters S, Hart J, & J, 2018) | Making every contact count | 13 public health practitioners | Qualitative interviews | UK | Yes |

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| **Supplemental Table 2: Summary of barriers associated with delivery of MECC SBIs, as attributed by HCPs. Note that the number of mentions may differ from the number of references listed as some papers mentioned the barrier more than once.** | | | |
| **Barriers** | **Number of Mentions & References** | **Evidence Extract/Statement** | **COM-B component (TDF domain)** |
| **HCP** | | | |
| Lack of time | n = 23  (Al-Doghether et al., 2007; Ampt et al., 2009; Brotons et al., 2005; Casey, 2007; Chisholm et al., 2012; Dewhirst & Speller, 2015; Donoghue et al., 2014; Elwell et al., 2013; Elwell et al., 2014; Geense et al., 2013; John Dawson Associates, 2013; Lambe & Collins, 2010; Laws et al., 2009; McMahon & Connolly, 2013; Percival, 2014; Royal Society for Public Health, 2015; The Roundhouse Consultancy MK Ltd, 2016; Tinati et al., 2012; Uscreates, 2012; Walkenden & Walker, 2015) | “Time constraints added to the problem and even though doctors recognised that behaviour change had the potential to reduce disease and hence save time in the longer term, they also felt there was often limited time to address the issues, arguing that it was too demanding a task to simply ‘tack on’ at the end of a consultation.”(Chisholm et al., 2012) p391 | Physical Opportunity (Environmental Context & Resources) |
| Lack of training | n = 13  (Al-Doghether et al., 2007; Casey, 2007; Chisholm et al., 2012; Donovan & Davies, 2016; Lambe & Collins, 2010; Laws et al., 2008; McMahon & Connolly, 2013; Pattinson & Jessop, 2016; The Roundhouse Consultancy MK Ltd, 2016; Uscreates, 2012; Walter et al., 2010) | “This category describes the factors which nurses felt hindered their health promotion role; five factors were identified. These were lack of empowerment, the organisation of care, a lack of training and skills, heavy workload, and lack of time.”(Casey, 2007) p1043 | Psychological Opportunity (Cognitive and Interpersonal Skills) |
| Lack of evidence for effectiveness/appropriateness | n = 9  (Ampt et al., 2009; Chisholm et al., 2012; Dewhirst & Speller, 2015; Elwell et al., 2014; Geense et al., 2013; Jacobsen et al., 2005; Laws et al., 2008; Royal Society for Public Health, 2015; Walkenden & Walker, 2015) | “Participants felt that there was little visible evidence available to them to demonstrate the effectiveness of providing lifestyle change brief advice in this setting. This perspective stemmed from the uncertainty as to whether they would come into contact with the same patient and family again in the future.”(Elwell et al., 2014) p3 | Psychological Capability (Knowledge)  Reflective Motivation (Beliefs About Consequences) |
| Someone else’s responsibility/appropriateness of role | n = 8  (Ampt et al., 2009; Chisholm et al., 2012; Elwell et al., 2013; Laws et al., 2009; Laws et al., 2008; Nelson et al., 2013; Pattinson & Jessop, 2016; Uscreates, 2012) | “The GPs' perception of their professional role also influenced the amount of assessment, with one GP admitting to not asking about specific dietary intake as he "was not a dietician" and doubted the effectiveness of general dietary recommendations.”(Ampt et al., 2009) p4 | Reflective Motivation (Intentions, Beliefs About Capability, Professional Role/Identity)  Psychological Capability (Knowledge) |
| Lack of confidence | n = 7  (Chisholm et al., 2012; Dewhirst & Speller, 2015; Laws et al., 2009; Laws et al., 2008; Royal Society for Public Health, 2015; The Roundhouse Consultancy MK Ltd, 2016; Tinati et al., 2012) | “In contrast, low implementers tended to reveal a lack of knowledge/skills or confidence. "*Oh, I don't have the confidence...not through knowledge or understanding... just through the confidence to speak to the person about it* (Low implementer, team 1).”(Laws et al., 2008) p6 | Reflective Motivation (Beliefs About Capability) |
| Lack of funding (i.e. compensation/reimbursement/incentives) | n = 6  (Al-Doghether et al., 2007; Brotons et al., 2005; Chisholm A et al., 2018; Chisholm et al., 2012; Geense et al., 2013; The Roundhouse Consultancy MK Ltd, 2016; Walter et al., 2010) | “Others said they had referred patients to these programs in the past, but due to lack of proven effectiveness and reimbursements they stopped referring.”(Geense et al., 2013) p3 | Physical Opportunity (Environmental Context & Resources)  Automatic Motivation (Reinforcement) |
| Lack of knowledge | n = 5  (Laws et al., 2008; Pattinson & Jessop, 2016; The Roundhouse Consultancy MK Ltd, 2016; Walkenden & Walker, 2015; Walter et al., 2010) | “Key barriers identified were staff responsibility and lack of knowledge and training of therapy radiographers.”(Pattinson & Jessop, 2016) p2 | Psychological Capability (Knowledge) |
| Difficulty in dealing with challenging patients (e.g., do not listen, not ready to receive advice, want a ‘quick fix’, resistant or defensive/negative behaviour) | n = 5  (Laws et al., 2008; Nelson et al., 2013; Percival, 2014; The Roundhouse Consultancy MK Ltd, 2016; Walkenden & Walker, 2015) | “While low implementers also used some of these strategies, they expressed a number of concerns about client acceptance including being seen as judgmental, receiving negative reactions from clients and damaging the clinician-client relationship. "You know, we're on their turf, that's the way I look at it. We're a guest, we're a professional guest in their home, and we can't judge social issues you know" (Low implementer, team 1). "If I push how many cigarettes do you have a day, you know, they'd be saying 'why are you asking me this? I'm not coming here for drug and alcohol counselling, I'm coming here for a different issue" (Low implementer, team 2).”(Laws et al., 2008) p5 | Automatic Motivation (Emotion)  Reflective Motivation (Beliefs About Consequences, Beliefs About Capability) |
| Damaging to doctor patient relationship | n = 3  (Chisholm et al., 2012; Lambe & Collins, 2010; Laws et al., 2008) | “An interaction with a patient with whom a relationship was established made doctors feel that they were countering the work they had previously done to build the relationship and potentially risked damaging this. Participants contrasted the health benefits with the risks of damaging the doctor–patient relationship that they valued and many reported that they chose to prioritize maintaining this relationship, thereby avoiding behaviour change discussions.” (Chisholm et al., 2012) p393 | Reflective Motivation (Beliefs About Consequences) |
| Own (negative) lifestyle behaviour | n = 3  (Dewhirst & Speller, 2015; Laws et al., 2008; Walter et al., 2010) | “Physicians’ own health-related habits and their attitudes towards prevention were important determinants of their delivery of preventive care. GPs recommended preventative measures less often or with less conviction if they did not practice preventive measures themselves.”(Walter et al., 2010) p5 | Reflective Motivation (Beliefs About Capability)  Automatic Motivation (Emotion) |
| Problems getting referrals/Lack of referral options | n = 2  (Dewhirst & Speller, 2015; John Dawson Associates, 2013) | “Referrals were described as another ‘grey area’. Staff needed to know about the services available in the area and what they provided, and whether they were simply ‘signposting’ or more formally making a referral to them.”(Dewhirst & Speller, 2015) p9 | Physical Opportunity (Environmental Context & Resources) |
| Personal lack of interest in providing preventive services | n = 1  (Donoghue et al., 2014) | N/A | Reflective Motivation (Intentions) |
| Individuality in behaviour change needs (e.g., you can’t use one strategy for different people) | n = 1  (Elwell et al., 2013) | “Individuality in behaviour change needs: ‘you can’t use one strategy for different people’. Both patients and health professionals noted that different patients and health behaviours require different solutions and ‘one-size-fits-all’ and ‘change everything’ approaches were challenged: Marie (Health Professional): It’s individual, everybody’s different, they’re all different, you can’t use one strategy for different people.’ (929:931) (FG2).”(Elwell et al., 2013) p658 | Reflective Motivation (Beliefs About Capabilities)  Psychological Capability (Knowledge, Cognitive and Interpersonal Skills) |
| Lack of continuity of advice given | n = 1  (Elwell et al., 2014) | “Continuity of information was an area of concern in that patients could receive different information depending on who was delivering lifestyle change support. For example, one participant discussed the issue of different health care workers providing contrasting information and emphasised the need to be ‘singing from the same sheet’.”(Elwell et al., 2014) p4 | Physical Opportunity (Environmental Context & Resources) |
| Intervening too late | n = 1  (Elwell et al., 2013) | “Too late: ‘I’m no spring chicken anymore’. Concern about lifestyle change being encouraged when it is already too late to intervene was expressed by health professionals, and the view that intervention should begin in early childhood was presented.”(Elwell et al., 2013) p659 | Reflective Motivation (Beliefs About Consequences) |
| Ethical concerns about giving lifestyle advice (e.g., individual as part of a context) | n = 1  (Jacobsen et al., 2005) | “The GPs take the view that factors other than lifestyle have an influence on illness and symptoms; that lack of patient compliance is a serious problem; and that many patients live in circumstances that render trivial or pointless any attempt to change their lifestyle. The GPs have ethical misgivings on the following grounds: that it is problematic to focus one-sidedly on lifestyle changes if patients also live in circumstances likely to provoke illness; that there is a danger of making healthy patients ill; and that patients may develop a bad conscience if they do not succeed in changing their lifestyle, which may in turn damage the trust between doctor and patient.”(Jacobsen et al., 2005) p7 | Psychological Capability (Knowledge)  Reflective Motivation (Beliefs About Consequences) |
| Level of risk to the patient (e.g., if the patient already exhibited signs of poor nutrition (such as obesity), more intensive assessment of diet and physical activity would usually be undertaken) | n = 1  (Ampt et al., 2009) | “The level of risk to the patient appeared to inform the intensity of the assessment. For example, if the patient already exhibited signs of poor nutrition (such as obesity), more intensive assessment of diet and physical activity would usually be undertaken.”(Ampt et al., 2009) p4 | Reflective Motivation (Beliefs About Consequences) |
| **Patients (from the HCP perspective)** | | | |
| Lack of patient motivation to change | n = 10  (Al-Doghether et al., 2007; Chisholm et al., 2012; Donoghue et al., 2014; Elwell et al., 2013; Geense et al., 2013; Jacobsen et al., 2005; Lambe & Collins, 2010; Laws et al., 2009; Tinati et al., 2012; Walter et al., 2010) | “This may be related to patient resistance. GPs reported that many patients get offended if they raise the subject of lifestyle behaviours with them. Patients may not realise that their lifestyle behaviours are related to their condition and so ‘can get very shirty and think that we’re being judgemental’.”(Lambe & Collins, 2010) p221 | Reflective Motivation (Intentions) |
| Level of patient prior knowledge/awareness of need to change | n = 2  (Chisholm et al., 2012; Elwell et al., 2013) | “Further, patients’ awareness regarding the importance of behaviour change was thought to influence whether they would attempt to discuss these issues. For example, one participant (25, doctor, paediatrics) highlighted that with overweight children, it can seem futile to attempt to discuss behaviour change if the patient (and/or patients’ parents) were unaware that changes to behaviour were required.”(Chisholm et al., 2012) p392 | Psychological Capability (Knowledge) |
| Family and peer pressure for patients | n = 2  (Chisholm et al., 2012; Dewhirst & Speller, 2015) | “Family and peer pressure were often seen as a considerable barrier to changing healthy lifestyles. *‘But the families are also likely to be near to each other, in social housing you are likely to have families within walking distance of each other…so if there’s drug abuse going on from grandparents, that will be going on in all properties…’* [PCC] *‘And then another patient said to me again, his wife continues to smoke, so it’s very, very hard, that’s kind of a barrier…’* [SHFT].”(Dewhirst & Speller, 2015) p64 | Social Opportunity (Social Influences) |
| Patient ability to change | n = 1  (Chisholm et al., 2012) | One key factor centred upon patients’ ability to change: regardless of whether the doctor was skilled in techniques that were effective, there was a view that patients still might not be able to implement changes.”(Chisholm et al., 2012) p392 | Reflective Motivation (Beliefs About Capability) |
| Patient attitudes towards behaviour change | n = 1  (McMahon & Connolly, 2013) | “Respondents were asked to identify factors that both prevent and facilitate the undertaking of health promotion activities in practice. Time and resource constraints (i.e. staffing, funding) were identified by 62.2% (*n* = 265) of respondents as the primary factor limiting health promotion activities. This was followed by a lack of health promotion training 11.5% (*n* = 49), patient attitudes 5.6% (*n* = 24), service structure 4.7% (*n* = 20) and having an unclear remit 1.9% (*n* = 8).”(McMahon & Connolly, 2013) p25 | Reflective Motivation (Beliefs About Consequences) |
| View that non-clinical staff are not appropriate advice providers | n = 1  (Uscreates, 2012) | “Some warn that they would be openly hostile to attempts by non-clinicians to provide advice. In general, these patients respect the opinions of doctors above all. Others feel that all staff are capable of providing at least low-level advice and information, such as informing about a service or handing out a leaflet. However, while they are prepared to listen to advice from non-clinical staff, many feel they are more likely to act on advice from staff with medical qualifications – or would seek a second opinion from a clinician. Doctors are generally felt to be the most authoritative sources.”(Uscreates, 2012) p20 | Reflective Motivation (Professional Role/Identity) |
| **Organisational (from the HCP perspective)** | | | |
| Lack of resources | n = 5  (Chisholm A et al., 2018; Donoghue et al., 2014; Donovan & Davies, 2016; Elwell et al., 2014; Royal Society for Public Health, 2015) | “Access to health promotion resources was a problem at times and health professionals reported that resources such as leaflets were often not available when an opportunity to intervene presented; “I personally find that the leaflets aren’t available when you actually need them” (Allied Health Professional 8, 6.5 years in profession, not MECC trained).”(Elwell et al., 2014) p5 | Physical Opportunity (Environmental Context & Resources) |
| The organization of care (e.g., priority given to routine tasks, no continuity of care) | n = 3  (Casey, 2007; Chisholm A et al., 2018; Dewhirst & Speller, 2015) | “Most nurses indicated that the way care was organised was another barrier. Three nurses felt that the routine dominated and time was prioritised to complete the routine: …you know, you feel that sometimes you have a routine to… do and you have so many hours in the day just to carry it out and sometimes that (health promotion) can be put to second-best kind of thing…. (AO3).”(Casey, 2007) p1043 | Physical Opportunity (Environmental Context & Resources) |
| Focus on treatment vs prevention culture | n = 3  (Chisholm A et al., 2018; Lambe & Collins, 2010; Walter et al., 2010) | “To deliver lifestyle counselling, according to participants, would require a considerable reorganisation of the general practice setting because currently ‘the whole system is set up to write prescriptions’ (GP).”(Lambe & Collins, 2010) p221 | Physical Opportunity (Environmental Context & Resources) |
| Limited capacity of the practice (e.g., personnel and time) | n = 2  (Ampt et al., 2009; Chisholm et al., 2012) | “Those GPs who did fully assess nutrition, or specifically asked about physical activity, were influenced by other factors. These included the capacity of the practice (eg a nurse who undertook assessments), or the expressed interest of the GP in these risk factors.”(Ampt et al., 2009) p4 | Physical Opportunity (Environmental Context & Resources) |
| Lack of support from middle management | n = 1  (Dewhirst & Speller, 2015) | “Conversely there were organisational barriers, for example lack of support from middle management:  *‘it’s middle management will be the challenge…because they’re somehow managing the additional demands of having to release staff and monitor staff with MECC versus delivering their own work and their workloads…the challenges are often around…convincing them that’s it’s worthwhile...to invest at this early stage to get gains further on.’* [PCC].”(Dewhirst & Speller, 2015) p62 | Physical Opportunity (Environmental Context & Resources) |
| Access to further support for patients/clients | n = 1  (Dewhirst & Speller, 2015) | “In all the sites there were remarks about the services that they were able to refer patients or clients to for further support. In the City Council the connections with the Health Improvement Team and the Healthy Living Centre needed to be sustained and kept up to date:  *‘…I don’t think we’ve seen them since [the training]… I pop in there now and again with my tenants but …I don’t see the professionals… Something about them seeing you as a service to keep you up to date, you know and give you all the tools you need…even if they came here once a month and just said, oh we’re running this now…those things are available.’* [PCC].”(Dewhirst & Speller, 2015) p76 | Physical Opportunity (Environmental Context & Resources) |
| Complexity of recording system for MECC | n = 1  (Dewhirst & Speller, 2015) | “Recording both the initial MECC contact and any further contacts with other services was also found to be difficult and was frequently mentioned as something to sort out with further roll out.  *‘…these links definitely need to be stronger and seamless. We’re looking at …having an automated system for [smoking cessation], so that’s going to be really good, referrals will be a lot easier, and I think that needs to be a separate thing in itself, how can we refer much easier, and make it seamless.’* [HHFT].”(Dewhirst & Speller, 2015) p77 | Physical Opportunity (Environmental Context & Resources) |
| Lack of cooperation with other disciplines | n = 1  (Geense et al., 2013) | Secondly, GPs and PNs experienced barriers related to their own practice: they stated they have a lack of time in their consultations to discuss lifestyle issues with their patients. Moreover, they mentioned there is a lack of corporation with other disciplines.”(Geense et al., 2013) p4 | Physical Opportunity (Environmental Context & Resources) |
| Lack of empowerment | n = 1  (Casey, 2007) | “Some nurses reported that they felt disempowered in the system, in particular, in relation to medical personnel because doctors undervalued nurses’ perspective and experience: …I think doctors should listen to us a bit more… they should pay a bit more attention to what we have to say…. Sometimes I feel maybe it’s that they (the doctors) feel what is she, she’s only a nurse….(AO2).”(Casey, 2007) p1043 | Reflective Motivation (Professional Identity/Role, Beliefs About Capability)  Automatic Motivation (Emotion) |
| Contradictory government policy | n = 1  (Geense et al., 2013) | “At last, contradictory policy of the government is an experienced barrier as well: for instance GPs mentioned the inconsistent smoking policy (in 2008 smoking was banned in all restaurants, clubs and hotels but this was overturned in 2012).”(Geense et al., 2013) p4 | Physical Opportunity (Environmental Context & Resources) |
| The focus of acute settings on discharge | n = 1  (Walkenden & Walker, 2015) | “Barriers specific to the acute hospital setting identified by participants included the acutely unwell nature of patients and the focus on discharge: ‘I find that, in hospital, the pressure is to get them fit enough to be safe to manage very basic tasks at home and then our input is very minimal whilst they’re in the acute setting, um, so I find I am less talking about exercise and more about their activities of daily living.’ (Respondent 8, Band 6).”(Walkenden & Walker, 2015) p229 | Physical Opportunity (Environmental Context & Resources) |
| Absence of guidelines | n = 1  (Al-Doghether et al., 2007) | “Likewise, the physicians reported a lack of training and absence of clear guidelines to be a particularly significant hindrance to counselling in the areas of alcohol, nutrition, HIV, exercise, cholesterol, breast-feeding, and so forth.”(Al-Doghether et al., 2007) p1272 | Physical Opportunity (Environmental Context & Resources) |
| Lack of staff | n = 1  (Donoghue et al., 2014) | “The most common barriers cited were lack of time (74%, 20/163); uncertainty about what services to provide (66%, 108/163); limited access to other services, particularly dieticians (84%,137/163), smoking cessation officers (86%, 140/163) and professionals that provide alcohol addiction counselling (95%, 155/163); and lack of interest from patients (77%,126/163).”(Donoghue et al., 2014) p119 | Physical Opportunity (Environmental Context & Resources) |
| Lack of overview of health promoting programs in the neighbourhood | n = 1  (Geense et al., 2013) | “Thirdly, GPs and PNs stated they experience problems regarding the content of health promotion programs. According to them, there is a lack of proven (long-term) effectiveness, and next to this, there is no overview of existing programs in the neighbourhood.”(Geense et al., 2013) p4 | Physical Opportunity (Environmental Context & Resources) |
| Lack of privacy in hospital environment | n = 1  (Elwell et al., 2014) | “For example, it was felt that privacy was an issue, especially in relation to discussing lifestyle topics that may be perceived as sensitive, for instance talking about sexual health with young people; “we’ve got a four bedded bay area so conversations in there are difficult” (Nurse 26, 15 years in profession, not MECC trained).”(Elwell et al., 2014) p4 | Physical Opportunity (Environmental Context & Resources) |
| Lack of communication between organisations | n = 1  (Chisholm A et al., 2018) | “Lack of communication between organisations also worried participants that provider organisations were interpreting MECC differently in relation to training content.”(Chisholm A et al., 2018) p6 | Physical Opportunity (Environmental Context & Resources) |

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| **Supplemental Table 3: Summary of facilitators associated with delivery of MECC, as attributed by HCPs** | | | |
| **Facilitators** | **Reference** | **Evidence Extract/Statement** | **COM-B component (TDF domain)** |
| **HCPs** | | | |
| Part of role | n = 5  (Ampt et al., 2009; Elwell et al., 2014; Laws et al., 2009; Laws et al., 2008; Walkenden & Walker, 2015) | “GPs varied in their attempts to motivate their patients to change risk behaviour. This was discussed in the wider context of how much preventive care they were involved in generally, whether they felt effective as a motivator, and whether it was an expected role of GPs.”(Ampt et al., 2009) p4 | Reflective Motivation (Professional role/identity) |
| Rapport/relationship with patients | n = 4  (Casey, 2007; Chisholm et al., 2012; Elwell et al., 2013; Laws et al., 2008) | “Five nurses reported that building a rapport and getting to know the patient were important prerequisites for undertaking health promotion: I mean you build up a relationship with them in an intimate sort of way, you know…. (AO7).”(Casey, 2007) p1043 | Reflective Motivation (Beliefs About Consequences) |
| Training | n = 3  (Casey, 2007; Royal Society for Public Health, 2015; The Roundhouse Consultancy MK Ltd, 2016) | “Almost all the nurses reported that the provision of education training and skills in relation to health promotion would be extremely important in helping them to undertake and fulfil their health promotion role.”(Casey, 2007) p1044 | Psychological Capability (Cognitive and Interpersonal Skills) |
| Improved health in the future | n = 3  (Dewhirst & Speller, 2015; Elwell et al., 2014; Uscreates, 2012) | “reductions in hospital admissions; often a health promotion message could prevent future admissions not just on the mental health side but also on the medical and potentially the surgical side” (Nurse 30, 30 years in profession, not MECC trained).”(Elwell et al., 2014) p5 | Reflective Motivation (Beliefs About Consequences) |
| Benefits to patients | n = 3  (Dewhirst & Speller, 2015; Elwell et al., 2014; Laws et al., 2009) | “In contrast when participants had witnessed families having made changes to their lifestyles, offering support felt worthwhile. Although at the same time it was acknowledged that for some paediatric sub-specialties such opportunities rarely arise; “we notice some changes with them and that’s the rewarding bit then, is that you get some feedback and I think not all ward areas are that lucky that they’ve got the same people coming in and out” (Nurse 26, 15 years in profession, not MECC trained).”(Elwell et al., 2014) p3 | Reflective Motivation (Beliefs About Consequences) |
| Lifestyle behaviours of clinicians | n = 2  (Brotons et al., 2005; Laws et al., 2008) | “However for high implementers this was either not an issue, or was even an enabler. Two high implementers reported having changed some aspects of their own lifestyle and found this helpful when giving advice to clients. "being an ex-smoker I feel more qualified to give them advice" (High implementer, team 3). Other high implementers recognised that they had a lifestyle risk factor, but this did not deter them from providing intervention to others "because I feel I'm a little overweight, I sometimes feel a bit funny telling people what to eat...but it doesn't stop me doing it" (High implementer, team 3).”(Laws et al., 2008) p7 | Reflective Motivation (Beliefs About Capability)  Automatic Motivation (Emotion) |
| Improved relationships | n = 2  (Dewhirst & Speller, 2015; Tinati et al., 2012) | “If they had built a relationship with a parent and felt they would be receptive to this style of communication, they were more willing to practise their healthy conversation skills.”(Tinati et al., 2012) p433 | Social Opportunity (Social Influences) |
| Effectiveness of brief advice | n = 2  (Elwell et al., 2014; Laws et al., 2008) | “Value of intervention recognised but difficulty in assessing and measuring outcomes.”(Laws et al., 2008) p5 | Psychological Capability (Knowledge)  Reflective Motivation (Beliefs About Consequences) |
| Personal interests (e.g., interest in addressing drug and alcohol issues) | n = 1  (Ampt et al., 2009) | “Those GPs who had experience and interest in addressing drug and alcohol issues reported being consistent in assessing alcohol intake; others had increased this screening as a result of implementing the health check, and some others felt this screening was only possible during such a health check.”(Ampt et al., 2009) p4 | Reflective Motivation (Intentions) |
| Local knowledge | n = 1  (Donovan & Davies, 2016) | “Local knowledge was identified as being important in relation to detailed understanding of the local community and in relation to clients and service users being able to approach nurses. The situation is often diverse and relationship based and differs depending on the stability of the service provision and accessibility of data available about local populations. Concerns were expressed that if nurses have bases distant from the communities they are caring for this is not just inefficient in terms of travel time but distances patients and clients from professionals.”(Donovan & Davies, 2016) p21 | Reflective Motivation (Beliefs About Capabilities) |
| Reimbursement | n = 1  (Geense et al., 2013) | “Reimbursements and subsidies determine participation and development of health promotion programs.”(Geense et al., 2013) p5 | Physical Opportunity (Environmental Context & Resources)  Automatic Motivation (Reinforcement) |
| Benefits of using the skills | n = 1  (Tinati et al., 2012) | “Conversely, a good understanding of the new skills and their effectiveness facilitated implementation: Using them on people you know well. Using self-reflection. Seeing the benefits it had on others. (Participant 111).”(Tinati et al., 2012) p434 | Psychological Capability, (Knowledge)  Reflective Motivation (Beliefs About Consequences) |
| Opportunities to intervene | n = 1  (Tinati et al., 2012) | “Conversely, where staff were able to identify and create opportunities, this facilitated their implementation of the skills: Opportunities that make it easy to bring up healthy conversation skills i.e. if parents mention that they would like to lose weight or learn to cook. (Participant 14).”(Tinati et al., 2012) p434 | Reflective Motivation (Beliefs About Capabilities) |
| Positive preventive experiences | n = 1  (Walter et al., 2010) | “One GP, who normally had a skeptical attitude about prevention, talked about an example of successful prevention in a 65-year old woman who was previously a heavy smoker and had a very high cholesterol level: “She stopped after I told her again clearly what would happen [...]. I myself was astonished when she told me that after only a few weeks she had stopped smoking and now only needs medication to keep her blood pressure down, which she has got used to very well, has lost weight and has even enrolled at a gym. That is definitely a case where I would say that preventative guidance has at least helped” (HGP04). Positive remarks came from two physicians who explicitly stated that they enjoyed using preventative measures.”(Walter et al., 2010) p5 | Reflective Motivation (Beliefs About Capabilities)  Physical Capability (Skills) |
| Information about other services and where to refer | n = 1  (The Roundhouse Consultancy MK Ltd, 2016) | NA | Psychological Capability (Knowledge)  Physical Opportunity (Environmental Context & Resources) |
| Confidence | n = 1  (Laws et al., 2008) | “In the interviews, high implementers generally expressed more confidence in addressing lifestyle risk factors than did low implementers. "I guess I'm fairly comfortable in the way that I do it. I'm not often shown the door" (High implementer, team 1).”(Laws et al., 2008) p5 | Reflective Motivation (Beliefs About Capabilities) |
| Education (health promotion included in the undergraduate curriculum) | n = 1  (The Roundhouse Consultancy MK Ltd, 2016) | NA | Psychological Capability (Knowledge)  Physical Capability (Skills) |
| **Organisational (from HCP perspective)** | | | |
| Resources in terms of interventions and leaflets in their practice | n = 2  (Casey, 2007; Geense et al., 2013) | “Easy accessible health promotion programs due to broad inclusion criteria and affordability.”(Geense et al., 2013) p5 | Physical Opportunity (Environmental Context & Resources) |
| Staff availability | n = 2  (Casey, 2007; Geense et al., 2013) | “The majority of nurses indicated that more resources in terms of leaflets, finance, equipment, staff, support from management and resources for a health promotion specialist would help them in their health promotion role. (…) More than half the nurses identified the provision of more staff as an important facilitator.(Casey, 2007) p 1043 | Physical Opportunity (Environmental Context & Resources) |
| Management support | n = 2  (Casey, 2007; John Dawson Associates, 2013) | “Support from management in undertaking health promotion was also identified as an important facilitating resource. In the following excerpt the nurse felt that it was not only important that managers gave support to nurses, but that they should also act as role models: …if it… starts at the senior level and there’s good work practice in the ward, it’ll continue on and as people come in to the ward, they’ll gradually get into the routine of it and it’ll continue… good practice it’ll rub, rub off on everyone…. (AO6).”(Casey, 2007) p1044 | Physical Opportunity (Environmental Context & Resources)  Social Opportunity (Social Influences) |
| Support via professional networks | n = 1  (The Roundhouse Consultancy MK Ltd, 2016) | NA | Physical Opportunity (Environmental Context & Resources) |
| Continuity of care | n = 1  (Elwell et al., 2013) | “Continuity was also discussed in relation to patient experiences and the importance of not being referred to a number of different services to attain support. There was a belief that patients value provision of support from the same service over time. Maya discussed patient feedback in relation to this and felt that this continuity helped patient retention to lifestyle behaviour change initiatives, as it was helpful for patients to attain support from the same people:  Maya (Community Support Worker): I think some of the feedback we’ve had from patients, the ones that we’ve managed to retain on the programme, is that it’s because we haven’t passed them from pillar to post, it’s because it’s been erm well received because it’s an in house service, and because they see us here initially, they see us in a group session, they see us out in the community when we deliver the exercise sessions, so it’s continuous.  (121:128) (FG2)(Elwell et al., 2013) p668 | Physical Opportunity (Environmental Context & Resources) |
| Collaboration with other disciplines | n = 1  (Geense et al., 2013) | “Overview/ social map of disciplines and health promotion programs.”(Geense et al., 2013) p6 | Physical Opportunity (Environmental Context & Resources) |
| Signposting | n = 1  (Royal Society for Public Health, 2015) | “Keeping up to date with local services was a challenge for participants, with the wide range and ever-changing types of organisations AHPs can signpost to. A national database of information or signposting hotline were suggested as one way of bringing all of the signposting information together, although this was also recognised to be a challenge.”(Royal Society for Public Health, 2015) p19 | Physical Opportunity (Environmental Context & Resources) |

**Supplemental Table 4: Main characteristics and content details of interventions aimed at improving MECC**

| **Intervention** | **Delivery** | **Setting** | **Target Group** | **BCTs** | **Intervention functions** |
| --- | --- | --- | --- | --- | --- |
| 1. MECC Level 2 training.  Online training (TEnT PEGS toolkit for behaviour change conversation(Chisholm, Hart, Mann, & Peters, 2014))  http://www.tentpegs.info/tentpegs-resources.html | Online | Primary, Secondary, Community | HCPs  AHPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Demonstration of the behaviour  Behavioural practice/rehearsal | Education  Modelling  Persuasion  Training |
| 2. Health Education England E Learning for Health MECC eLearning resources.  Interactive learning resources to support people develop the knowledge and understanding to make every contact count by asking others about their health and wellbeing  <https://www.e-lfh.org.uk/programmes/making-every-contact-count/> | Online | Primary, Secondary, Community | HCPs  AHPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental consequences  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment | Education  Enablement  Modelling  Persuasion  Training |
| 3. Making Every Contact Count E-Learning Package for Essex.  E-learning module on Making Every Contact Count (MECC)  <http://www.meccessex.co.uk/> | Online | Primary, Secondary, Community | HCPs  AHPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about health consequences  Demonstration of the behaviour  Behavioural practice/rehearsal  Restructuring the physical environment | Education  Enablement  Persuasion  Training  Modelling |
| 4. MECC Online Training (Wessex)  Making Every Contact Count (MECC) toolkit has been developed as a practical guide to support the implementation of the programme.  <http://www.wessexphnetwork.org.uk/mecc> | Online  Written materials / guidelines | Primary, Secondary, Community | HCPs  AHPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment  Restructuring the social environment | Education  Environmental restructuring  Modelling  Persuasion  Training |
| 5. All our health guidance.  A call to action to healthcare professionals working with patients and the population to prevent illness, protect health and promote wellbeing.  <https://www.gov.uk/government/publications/all-our-health-about-the-framework> | Online  Written materials / guidelines | Primary, Secondary, Community | HCPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Credible source  Restructuring the physical environment | Education  Environmental restructuring  Modelling  Persuasion  Training |
| 6. Everyday interactions.  A tool to support healthcare professionals to better measure their public health impact in line with the aims of All Our Health.  <https://www.rsph.org.uk/uploads/assets/uploaded/2c2132ff-cdac-4864-b1f1ebf3899fce43.pdf> | Online Written materials / guidelines | Primary, Secondary, Community | Nurses  Midwives  Dentists  AHPs  Pharmacists | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment | Education  Enablement  Modelling  Persuasion  Training |
| 7. Healthy Living Pharmacy.  The Healthy Living Pharmacy framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.  <https://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/> | Online Written materials / guidelines | Primary, Community | Pharmacists  Pharmacy staff | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment | Education  Enablement  Modelling  Persuasion  Training |
| 8. CQUIN.  The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.  <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/> | Online Written materials / guidelines | Primary, Secondary | HCPs | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment  Restructuring the social environment | Education  Enablement  Environmental restructuring  Modelling  Persuasion  Training |
| 9. Making Every Contact Count E-Learning Package for West Midlands.  E-learning supports workers to build the prevention of poor health and the promotion of healthy living into their day-to-day business.  <http://learning.wm.hee.nhs.uk/node/33> | Online | Primary, Secondary, Community | Workers in health, social care, or the voluntary sector | Feedback on behaviour  Instructions on how to perform behaviour  Information about antecedents  Information about health consequences  Information about social and environmental  Demonstration of the behaviour  Behavioural practice/rehearsal  Habit formation  Restructuring the physical environment | Education  Enablement  Modelling  Persuasion  Training |

**Supplemental Table 5. Examples of how to implement relevant BCTs for targeting key TDF domains**

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| **BCT (and associated TDF domain)** | **Definition** | **Example of how to implement the BCT** |
| Prompts/cues (Environmental Context & Resources) | Introduce or define environmental or social stimulus with the purpose of prompting or cueing the behaviour. The prompt or cue would normally occur at the time or place of performance | * Place a prompt on the computer system to ensure MECC is completed before moving on through system. * Questionnaires assessing lifestyle behaviour could be handed out by receptionists for patients to complete in waiting room – patient handing this to HCP at start of appointment would be a prompt and would also involve the patient in actively opening this conversation, making MECC initiation easier. |
| Adding objects to the environment (Environmental Context & Resources) | Add objects to the environment in order to facilitate performance of the behaviour | * Provide checklist for MECC conversations, or provide checklists for appointment procedures that include MECC as a usual step. * Establish or simplify and streamline existing systems for recording MECC interactions and referring patients. * Provide materials for HCPs (e.g., leaflets on different risk factors, treatment or self-help options, top tips document with case studies of HCPs overcoming common barriers in various roles/specialisms. |
| Verbal persuasion to boost self-efficacy (Beliefs About Capabilities; Intentions) | Tell the person that they can successfully perform the wanted behaviour, arguing against self-doubts and asserting that they can and will succeed | * Provide regular line manager feedback persuading staff member they are capable of overcoming barriers to delivery of MECC discussing specific barriers to delivery for that staff member. * During face-to-face training sessions or workshops, include discussion on perceived barriers so that training can address these concerns. * Establish online communities with social network champions or other points of support who can encourage HCPs and problem solve. * Provide examples of MECC and show the HCP how they can successfully incorporate these strategies into short appointments, e.g., using videos from Health Education England. |
| Focus on past success (Beliefs About Capabilities) | Advise to think about or list previous successes in performing the behaviour (or parts of it) | * Encourage HCPs to remember occasions when they have had positive experiences delivering MECC; for example, where HCPs have successfully engaged in MECC conversations before. * Line managers could encourage focus on past success during feedback (however, may be important to avoid this strategy for HCPs who have not yet engaged in MECC or who have had negative experiences, as inability to recall past successes may reinforce perceptions of barriers). |
| Self-monitoring of behaviour (Beliefs About Capabilities; Beliefs About Consequences; Skills) | Establish a method for the person to monitor and record their behaviour(s) as part of a behaviour change strategy | * Provide a space for HCPs to record whether a MECC conversation occurred at the end of each appointment (e.g., a tick-box in existing systems for recording patient notes) and provide visual progress charts. * Encourage self-reflection at the end of consultations to note down where they delivered well and where improvements could be made (technique could be combined with other strategies such as developing a toolkit to overcome identified barriers). |
| Graded tasks (Beliefs About Capabilities; Skills) | Set easy-to-perform tasks, making them increasingly difficult, but achievable, until behaviour is performed | * Break down the behaviours required to deliver MECC into smaller steps or goals (e.g., focusing on one particular MECC-relevant behaviour at a time, focusing on one particular patient group at a time, starting by delivering MECC in settings such as the NHS Health Check where patients are more likely to be receptive) and set incremental goals for HCPs to build on this behaviour gradually (e.g., starting to deliver MECC in settings outside of the NHS Health Check, such as regular reviews of patients with long-term conditions). Ensure that the end-point is for HCPs to deliver MECC to all patient groups and not just those who are perceived to be more receptive and motivated for behaviour change. |
| Problem solving, including Coping Skills (Beliefs About Capabilities; Intentions) | Analyse, or prompt the person to analyse, factors influencing the behaviour and generate or select strategies that include overcoming barriers and/or increasing facilitators | * Ask HCPs to identify their own personal barriers to delivering MECC and ask them to list practical solutions for overcoming these barriers (or, if no solutions available, identify viable alternatives e.g., if no local services are available for referrals, direct patients to other resources such as digital tools). |
| Goal setting – Behaviour (Beliefs About Capabilities; Intentions; Skills) | Set or agree on a goal defined in terms of the behaviour to be achieved | * Encourage HCPs to set a goal (e.g., for a target percentage of patients seen for whom they will aim to initiate MECC conversations each day/week). |
| Social support – unspecified (Beliefs About Capabilities; Intentions; Social Professional Role and Identity) | Advise on, arrange or provide social support (e.g. from friends, relatives, colleagues,’ buddies’ or staff) or noncontingent praise or reward for performance of the behaviour. It includes encouragement and counselling, but only when it is directed at the behaviour | * Designate certain members of staff to act as community social support for other HCPs who may be less confident with delivering MECC. * Provide online network for HCPs to share concerns and solutions. |
| Social support – emotional (Beliefs About Capabilities; Intentions; Social Professional Role and Identity; Emotions) | Advise on, arrange, or provide emotional social support (e.g. from friends, relatives, colleagues, ‘buddies’ or staff) for performance of the behaviour | * Similar strategies to social support (unspecified) could be used, specifically to provide emotional support for HCPs who lack confidence/are worried or concerned about MECC conversations. |
| Social support – practical (Beliefs About Capabilities; Intentions; Social Professional Role and Identity) | Advise on, arrange, or provide practical help (e.g. from friends, relatives, colleagues, ‘buddies’ or staff) for performance of the behaviour | * Similar strategies to social support (unspecified) could be used, specifically to provide practical support for HCPs who experience barriers associated with resources (e.g., time, capacity, administrative requirements) and other practical issues. |
| Feedback – outcome (Beliefs About Capabilities; Beliefs About Consequences; Intentions) | Monitor and provide feedback on the outcome of performance of the behaviour | * Where possible, provide feedback to HCPs on numbers of patients who are engaging with services (e.g., seeing stop smoking advisers, enrolled at weight management services) |
| Self-talk (Beliefs About Capabilities) | Prompt positive self-talk (aloud or silently) before and during the behaviour | * Prompt HCPs to remind themselves of the benefits of MECC before patient interactions, and to encourage themselves of their likely successful performance; suggest this as a tip for dealing with anxiety around delivering MECC. * Encourage HCPs to write themselves encouraging notes/mantras. |