Masterclass:
Ask a psychologist:
What works in behaviour change?

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Outline

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Why do we need to change behaviour?

Key challenges for primary care: example of obesity

How do we change behaviour? Brief and very brief interventions for behaviour change (e.g. MECC)

Habits? How to encourage health-promoting 'habits' and reduce health-impairing 'habits'

Top tips for clinical practice

Outline

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Why do we need to change behaviour?

Global Burden of Disease 2019

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Outline

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Key challenges for primary care: example of obesity

The case of obesity (as a long-term condition)

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- 28% adults in NI are living with **obesity** (defined as body mass index (BMI) ≥30kg/m^2); more than 2/3 excess weight
- **Obesity is a health outcome:** complex, multi-factorial chronic disease, requires life-long management
- Dietary trends are highly concerning; amongst other behavioural determinants (sleep hygiene, stress, PA, screen time, etc.)
- Disproportionately impacts people from lower socioeconomic groups; rising rates in children of concern
- Important to consider that obesity/body size viewed differently amongst different cultural groups

Obesity: Complex Aetiology, Early-life factors

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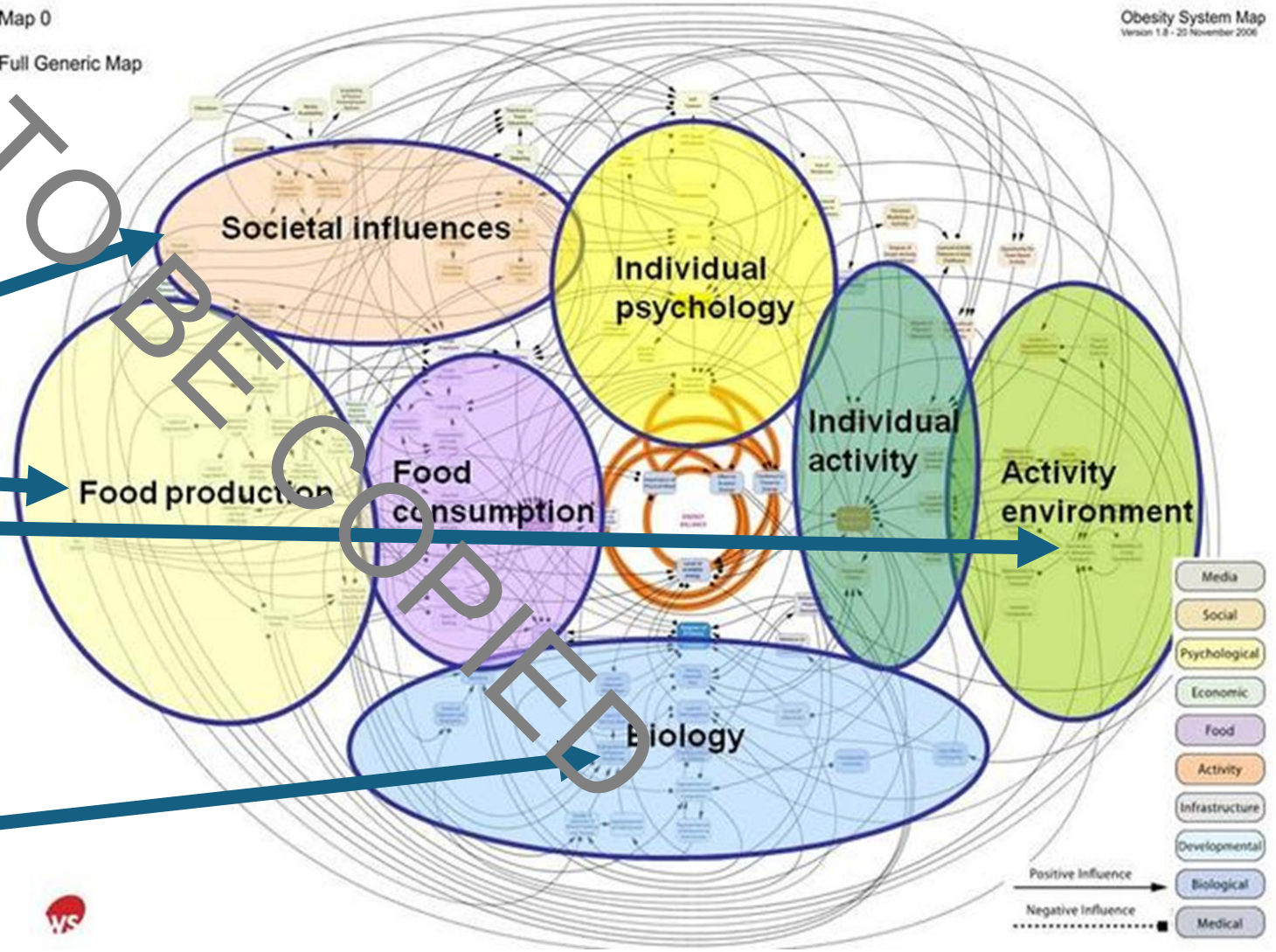
NOTE: WHAT WE EAT AND HOW ACTIVE WE ARE IS JUST ONE PIECE OF THE PUZZLE

WIDER SOCIETAL/ ENVIRONMENTAL INFLUENCES ARE IMPORTANT DRIVERS OF OBESITY

ROLE OF BIOLOGY/GENETICS IS OFTEN FORGOTTEN ABOUT!



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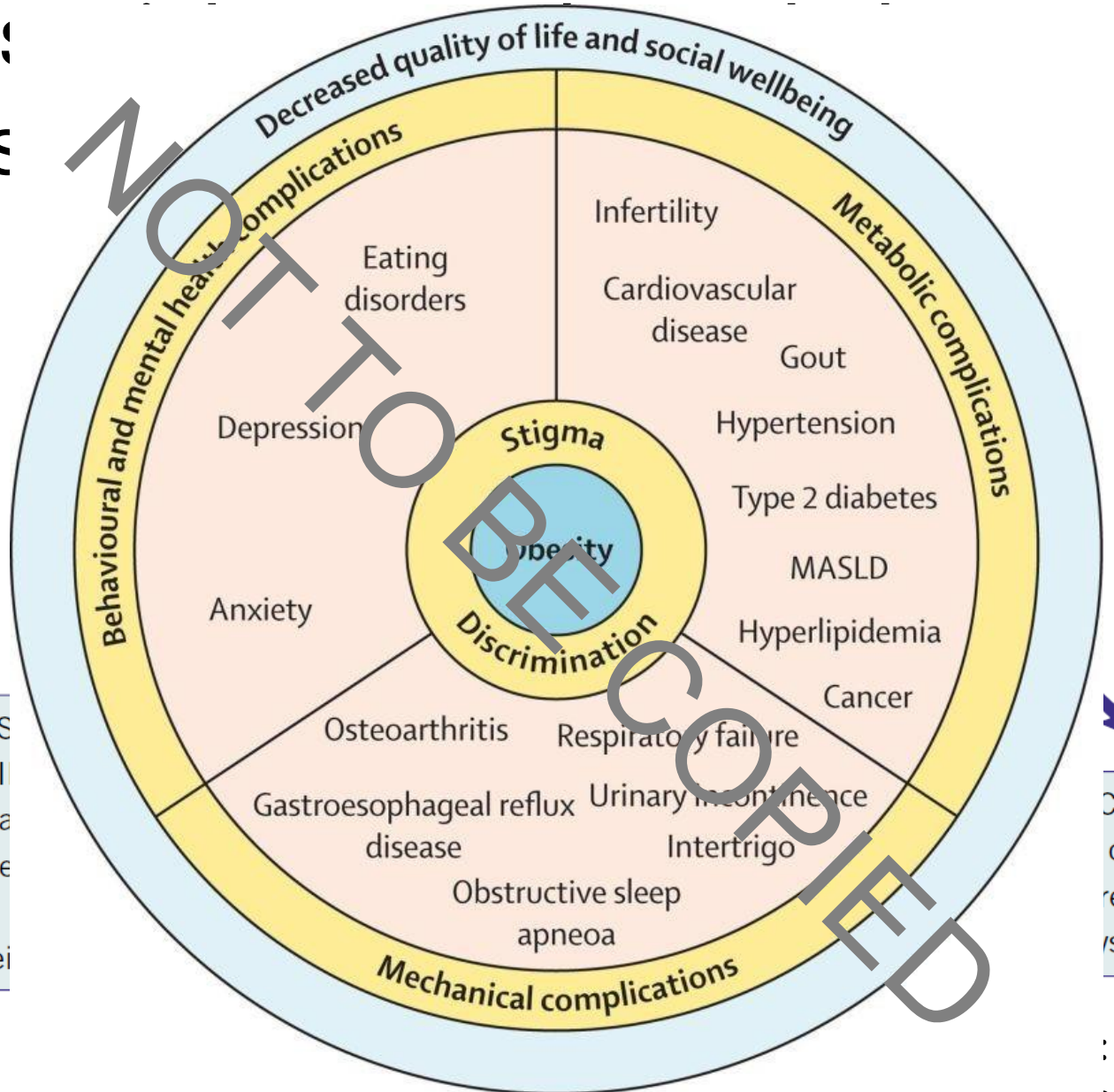
conceptualis



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: Addressing policy, practice and research priorities. British Psychological Society, 2019

Lancet, Obesity in Adults https://doi.org/10.1016/ S0140-6736(24)01210-8

Challenges for weight management in NI

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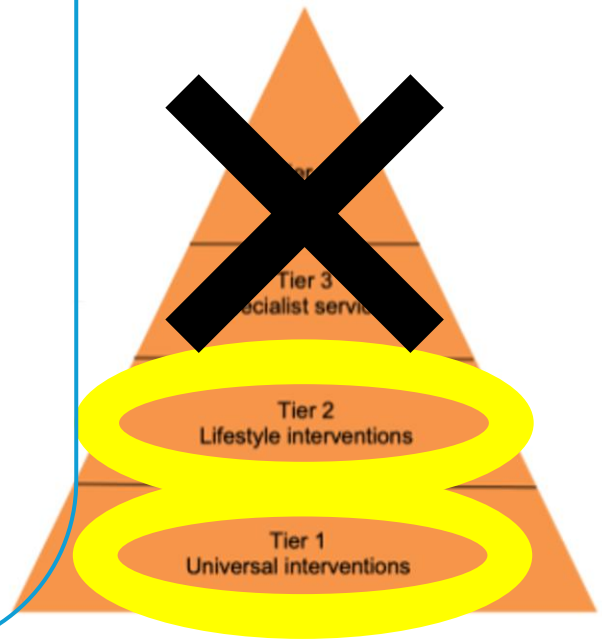
- Lack of a clear obesity care pathway
- New strategy for obesity prevention launched NI and plans for an Regional Obesity Management Service (adults) to launch in 2026
- NI: Multi-component weight-management services (WMS) limited
- Mainly commercial programmes (paid for); limited NHS-funded programmes (e.g. GP exercise referral); reliance on self-management strategies; generic health promotion
- Ireland: HSE and RCPI established a **National Clinical Programme for Obesity** in 2017 - multi-specialist and multi-disciplinary groups



Rapidly evolving landscape - understanding of obesity and obesity treatment/management

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- **e.g. EASO Obesity Taxonomy, EASO Framework for the diagnosis, staging and management of obesity in adults (2025)**
- **e.g. Lancet Diabetes & Endocrinology Commission on the definition and diagnostic criteria for clinical obesity (2025)**
- **e.g. NICE Guidelines - Overweight and obesity management NICE guideline Published: 14 January 2025**
  www.nice.org.uk/guidance/ng246
- **e.g. NICE Quality Standard - Overweight and obesity Published: Aug 2025**
  https://www.nice.org.uk/guidance/qs212/resources/overweight-and-obesity-management-pdf-7554747153353
- **National Physical Activity and Sedentary Behaviour Guidelines for Ireland: For people living with chronic conditions**

Lack of NHS obesity care in NI raises concerns

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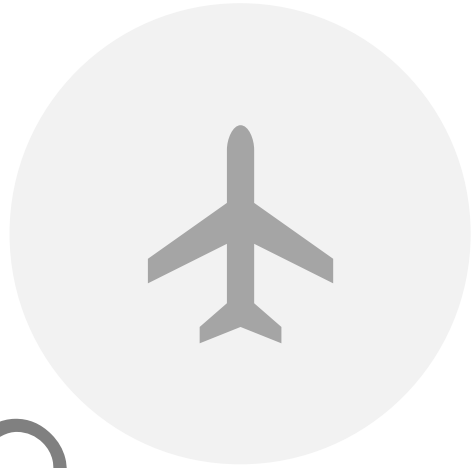
FAKE MEDICATIONS (OFTEN INJECTABLES)



BARIATRIC TOURISM (LACK OF APPROPRIATE PRE- AND POST OP CARE)

Outline

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How do we change behaviour? Brief and very brief interventions for behaviour change (e.g. MECC)

How do we change health behaviour?

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Making Every Contact Count

How NICE resources can support local priorities

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The MECC approach

Making Every Contact Count (MECC) is an evidence-based approach to improving people's health and wellbeing by helping them change their behaviour. The NHS Long Term Plan reminds us that every 24 hours the NHS comes into contact with more than a million people at moments that bring home the personal impact of ill health.

The MECC approach enables health and care workers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing.

Public Health England and Health Education have worked with organisations in health and social care to produce a range of practical resources to support this approach. They align with our guidelines on behaviour change.

This approach is a requirement of the NHS standard contract. It also supports the emphasis on prevention that's part of the Long Term Plan. This includes:

- increasing the support available to help people to manage and improve their own health and wellbeing
- ensuring that behavioural interventions are available for patients, service users and staff.

MECC uses brief and very brief interventions, delivered whenever the opportunity arises in routine appointments and contacts. Very brief interventions take from 30 seconds to a couple of minutes.

The person is encouraged to think about change and offered help such as a referral or further information. A brief intervention involves a conversation, with negotiation and encouragement,

Based on 4 A's - Ask, Assess, Advise, Assist

Published 2014, updated 2019 and links in 2025

NICE – Behaviour Change Guidance

NICE National Institute for Health and Care Excellence

NICE guideline

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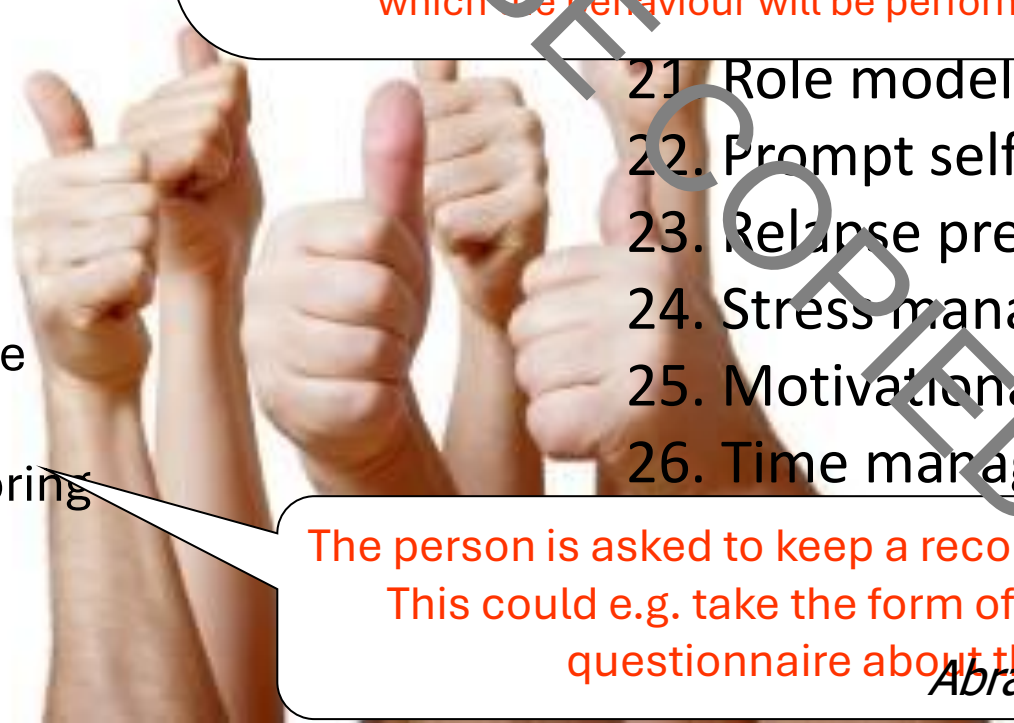
Behaviour change: individual approaches

Public health guideline
Published: 2 January 2014

A Taxonomy of Behaviour Change Techniques (BCTs) – you will

1. General information
2. Information on consequenc
3. Information about approval
4. Prompt intention formati
5. Specific goal setting
6. Graded tasks
7. Barrier identification
8. Behavioral contract
9. Review goals
10. Provide instruction
11. Model/ demonstrate
12. Prompt practice
13. Prompt self-monitoring
14. Provide feedback

Involves detailed planning of what the person will do including, at least, a very specific definition of the behaviour e.g., frequency (such as how many times a day/week), intensity (e.g., speed) or duration (e.g., for how long for). In addition, at least one of the following contexts i.e. where, when, how or with whom must be specified. This could include identification of sub-goals or preparatory behaviours and/or specific contexts in which the behaviour will be performed.



21. Role model
22. Prompt self talk
23. Relapse prevention
24. Stress management
25. Motivational interviewing
26. Time management

The person is asked to keep a record of specified behaviour/s. This could e.g. take the form of a diary or completing a questionnaire about their behaviour.

Abraham & Michie, 2008

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CALO-RE taxonomy for diet and PA

1. Provide information on consequences of behaviour in general
2. Provide information on consequences of behaviour for the individual
3. Provide information about others' approval
4. Provide normative information about others' behaviour
5. Goal setting (behaviour)
6. Goal setting (outcome)
7. Action planning
8. Barrier identification/Problem solving
9. Set graded tasks
10. Prompt review of behavioural goals
11. Prompt review of outcome goals
12. Reinforcing effort or progress towards behaviour
13. Provide rewards contingent on successful behaviour
14. Shaping
15. Prompting generalisation of a target behaviour
16. Prompt self-monitoring of behaviour
17. Prompt self-monitoring of behavioural outcome
18. Prompting focus on past success
19. Provide feedback on performance
20. Provide instruction
21. Model/ Demonstrate the behaviour
22. Teach to use prompts/ cues
23. Environmental restructuring
24. Agree behavioural contract
25. Prompt practice
26. Use of follow up prompts
27. Facilitate social comparison
28. Plan social support/ social change
29. Prompt identification as role model/ position advocate
30. Prompt anticipated regret
31. Fear Arousal
32. Prompt Self talk
33. Prompt use of imagery
34. Relapse prevention/ Coping planning
35. Stress management
36. Emotional control training
37. Motivational interviewing
38. Time management
39. General communication skills training
40. Provide non-specific social support

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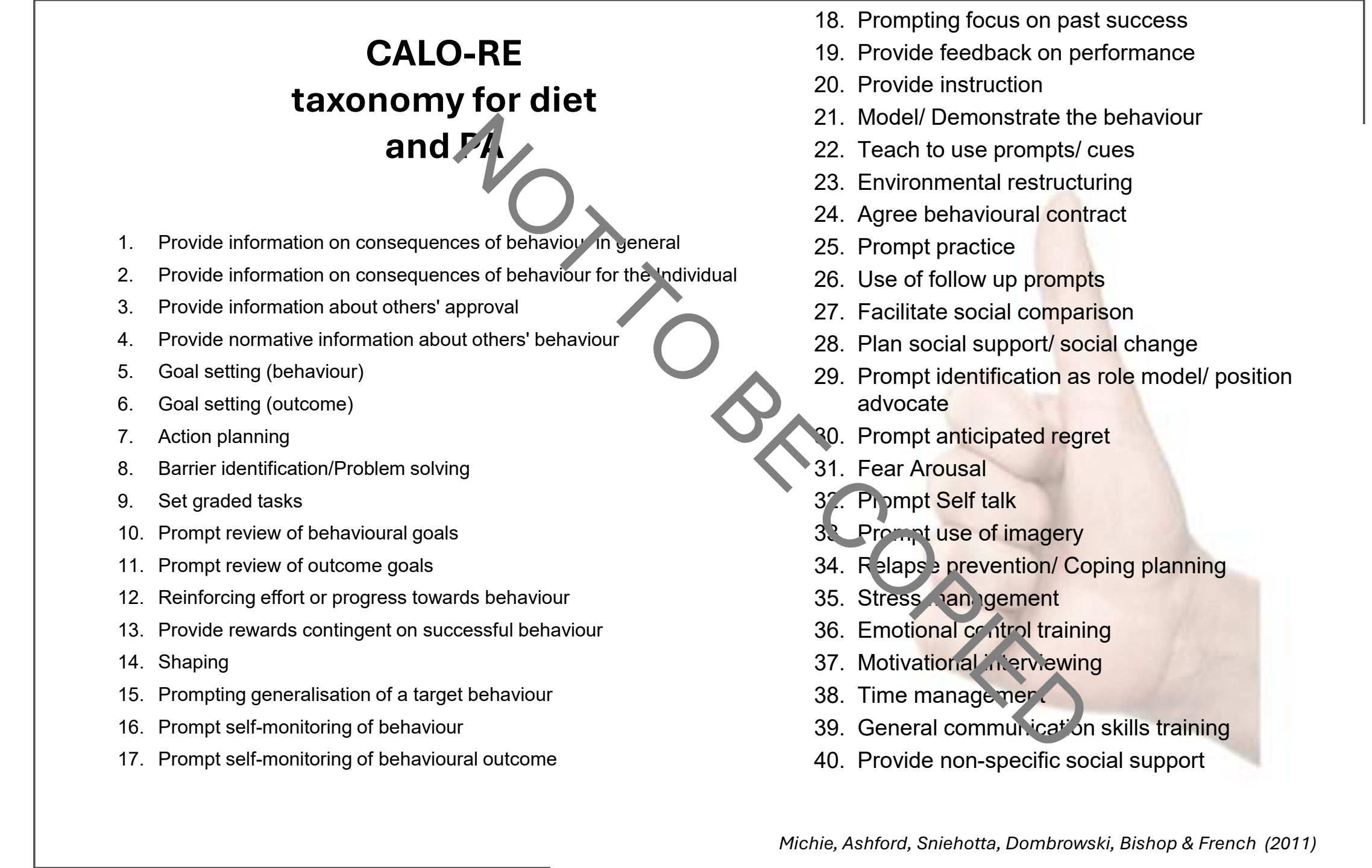

Michie, Ashford, Sniehotta, Dombrowski, Bishop & French (2011)

How can you integrate this into practice?

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- Treat patients for what they've come for – patient-centred, non-judgemental, non-stigmatising manner

- Use appropriate and sensitive language to raise the issue of weight (when appropriate) and discuss behaviours to identify any possible change targets – don't assume behaviour is 'unhealthy'

- Evidence-based BCTs (strategies for changing behaviour) particularly useful for weight management:
  - Self-monitoring, goal-setting, problem solving, relapse prevention, habit formation, reviewing goals

Effective Psychological and Behavioural Interventions in Obesity Management

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asoi | ICPO | National Clinical Programme Obesity | HSE

Clinical Practice GUIDELINE for the Management of Obesity in Adults in Ireland

Effective Psychological and Behavioural Interventions in Obesity Management

Ó Gráda C[i], Byrne M[ii], Gaynor K[iii]. Chapter adapted from: Vallis M, Macklin D, Russell-Mayhew S. Canadian Adult Obesity Clinical Practice Guidelines: Effective Psychological and Behavioural Interventions in Obesity Management (version 1, 2020). Available from: https://obesitycanada.ca/guidelines/behavioural. ©2020 Obesity Canada

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Cite this Chapter

ASOI Adult Obesity Clinical Practice Guideline adaptation (ASOI version 1, 2022) by: Ó Gráda C, Byrne M, Gaynor K. Chapter adapted from: Vallis M, Macklin D, Russell-Mayhew S. Available from: https://asoi.info/guidelines/behavioural/ Accessed [date].

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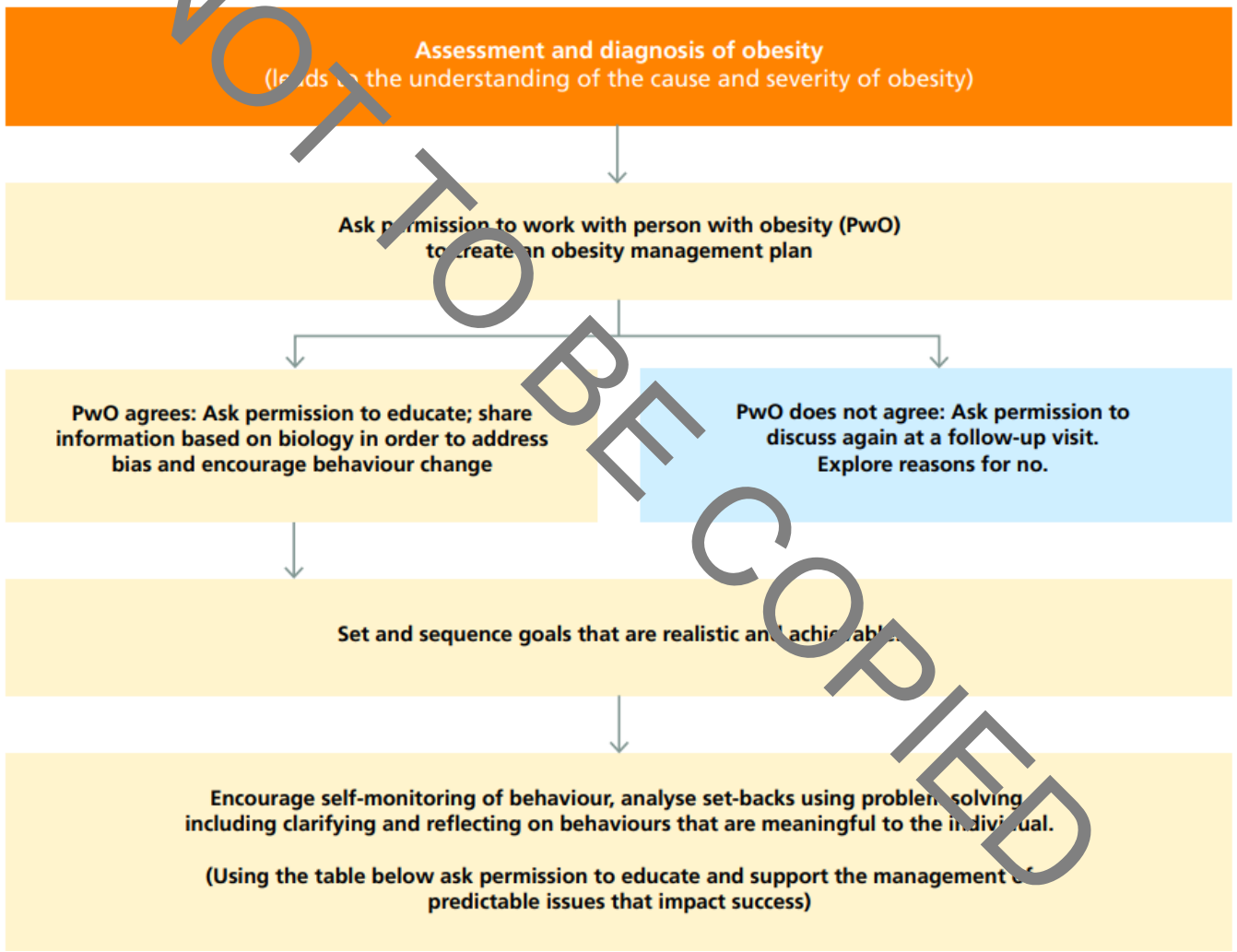
Figure 1: **Healthcare Professional Model**



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RESEARCH INSIGHT:
Exploring the experiences and motivations of adults living with excess weight regarding Weight Management Services (WMS): Findings from a cross-sectional survey conducted in Northern Ireland (NI).

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Kyle E, Kelly A, Woodside JV, **McGowan L***

Queen's University Belfast

Sample Characteristics (N=228)

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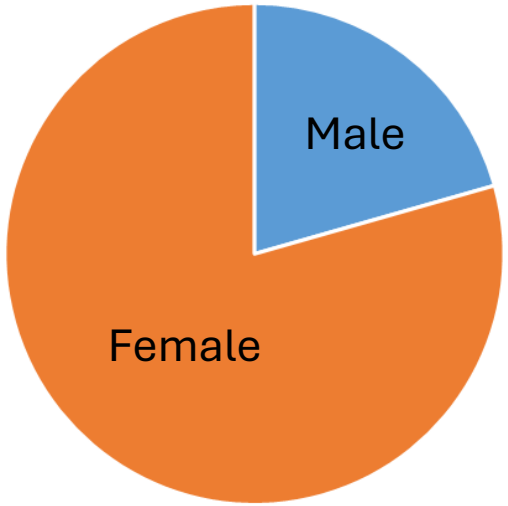
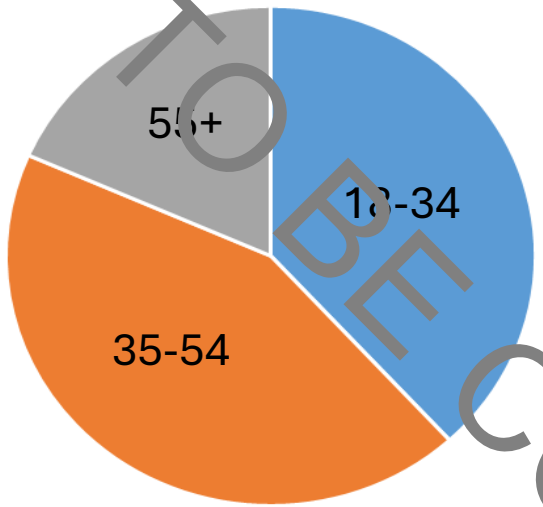
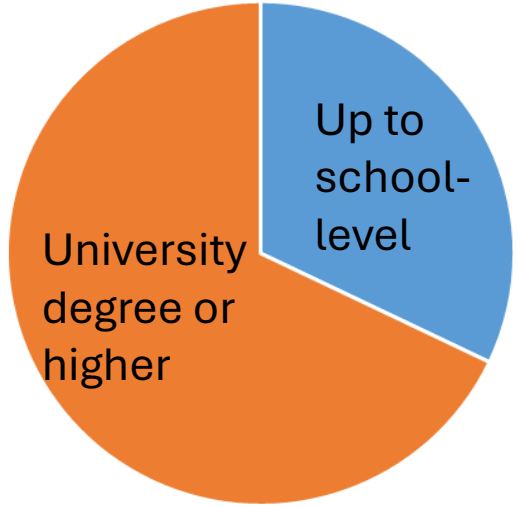






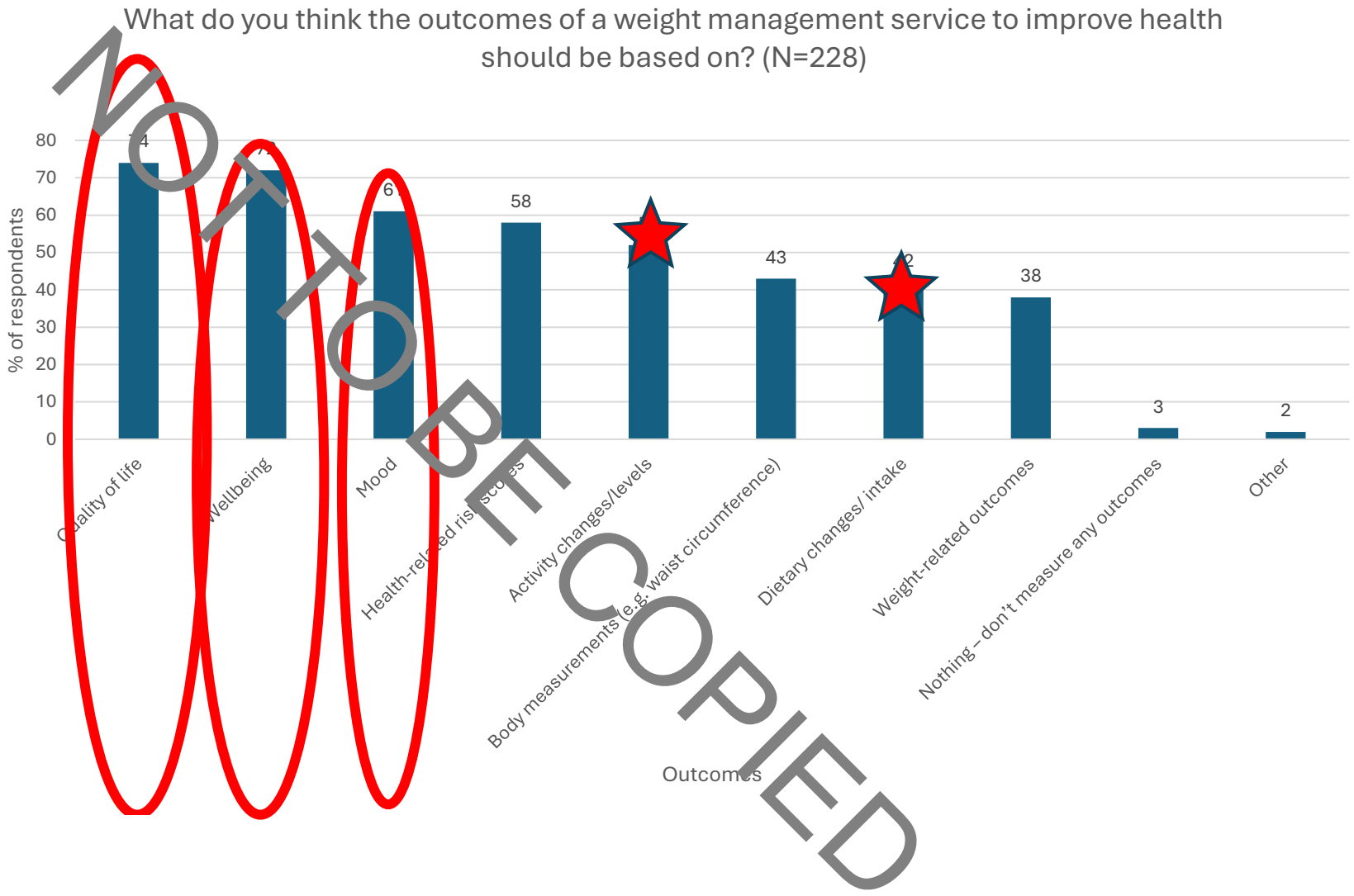
More than 9/10 adults who would like to manage their weight have **NOT** sought WMS

All had experience of living at a higher weight; 85% currently (47.8% LwO)

Views about future weight-management services

- Participants preferred ongoing support
- Either free or low cost
- Delivered by a combination of professionals
- Blended online/face-to-face
- Short programme session lengths

KEY ROLE FOR PSYCHOLOGICALLY-BASED SERVICES/ INTERVENTIONS



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Outline

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Habits? How to encourage health-promoting ‘habits’ and reduce health-impairing ‘habits’

Support Behaviour Change – Habits?

- One approach with promise for facilitating dietary behaviour change and is novel to this population is that of **habit-formation**
- Over time, behavioural repetition in response to a cue/context leads to 'habitual behaviour' which can be enacted with less conscious awareness, less subject to motivation
- Focuses on development of health-promoting dietary (and physical activity) behaviours
- Example – eating **fruit** with **breakfast every day (where breakfast is cue)**
- USP - may with longer-term behaviour change – less reliant on cognitive effort

How do we form habits?
Repetition of a behaviour in the presence of consistent stimuli/cue until 'automaticity' (habit strength) acquired[1]

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1Quinn JM, Pascoe A, Wood W, Neal DT. Can't control yourself? Monitor those bad habits. Personality Soc Psychol Bull. 2010;36:499–511.

RESEARCH INSIGHT: Habits

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- **Healthy Feeding Habits Study (McGowan et al. 2013)**
  - Home-based
  - Parents and preschoolers
- **Ten Top Tips for a Healthy Weight (Beeken et al. 2017)**
  - Adults with obesity – diet and physical activity
  - Primary care delivery (nurse) – talked over a leaflet
  - Habit-change interventions **probably** lead to weight loss at 3 months (Moderate certainty evidence) (2B) – RACGP evidence review
- **HHIPBe Study**
  - Support pregnant women who enter pregnancy at higher weight
  - PPIE at all stages
  - Feasibility & acceptability shown; +ve behaviour changes and highly acceptable; +ve trends in weight outcomes

McGowan, L., Cooke, LJ., Gardner, B., Beeken, R., Croker., Wardle, J. (2013) Healthy feeding habits: efficacy results from a cluster-randomized, controlled exploratory trial of a novel, habit-based intervention with parents. *American Journal of Clinical Nutrition,* 98 (3):769-77

Beeken, R., Leurent, B., Vickerstaff, V. et al. A brief intervention for weight control based on habit-formation theory delivered through primary care: results from a randomised controlled trial. Int J Obes 41, 246–254 (2017).

Outline

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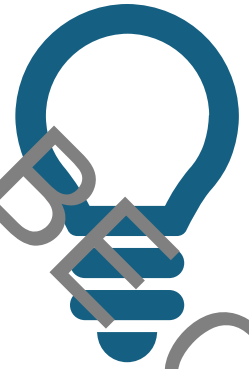
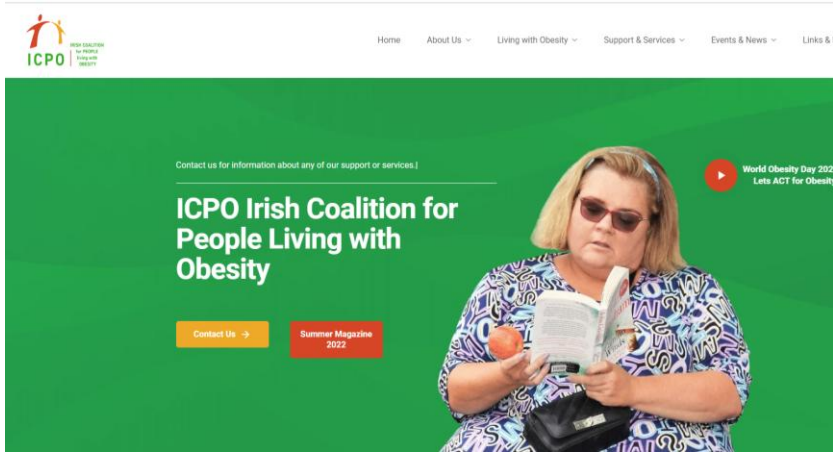


Top tips for clinical practice

Avoid weight stigma



Guidelines for Communicating Obesity

I: Respect Diversity and Avoid Stereotypes

II: Use Appropriate Language and Terminology

III: Conduct Balanced and Accurate Coverage of Obesity

IV: Select Appropriate Pictures and Images of Individuals Affected by Obesity

~~fat~~
~~excessive fat~~
~~obese~~
~~chubby~~
~~large~~
~~heavy~~

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Use non-stigmatising imagery – free images available: https://ecpomedia.org/image-bank/

Photo Credits: All ECPO Image Bank: https://ecpomedia.org/image-bank/image-bank-category/

Always use person-first language

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USEFUL EXAMPLES

"My patient is affected by obesity"
instead of "My patient is obese"

"The man with obesity was on the walking path"
instead of "The man on the walking path was very obese"

(EASO) European Association for the Study of Obesity, https://cdn.easo.org/wp-content/uploads/2018/12/16195533/EASO-People-first-Language_Version-5-RGB-for-screen.pdf

Identifying and Assessing Obesity (NG246)

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- Obesity definition based on BMI (most common approach) based on weight relative to height (kg/m^2)
- "Use BMI as a practical measure of overweight and obesity. Interpret it with caution because it is not a direct measure of central adiposity."
- "In adults with BMI below 35 kg/m^2, measure and use their waist-to-height ratio as well as their BMI, as a practical estimate of central adiposity. Use these measurements to help to assess & predict health risks (e.g. T2D/CVD)
  - **Waist-to-height ratio** – linked to cardiometabolic health
  - Start managing comorbidities as soon as they are identified; do not wait until the person has lost weight

New NICE QS Overweight and Obesity


Overweight and obesity management

Quality standard
Published: 5 August 2025

www.nice.org.uk/guidance/qs212

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Advice for maintaining changes and support for improving their health and wellbeing

• receive feedback and monitoring at regular intervals for a minimum of 1 year so they can get help if they are not maintaining changes

• have well-rehearsed action plans (such as 'if–then' plans) that they can easily put into practice if they are not maintaining changes

• have thought about how they can make changes to their own immediate physical environment to prevent weight regain

• have the social support they need to maintain changes

• are helped to develop routines that support the new behaviour (note that small, manageable changes to daily routine are most likely to be maintained) i.e., HABITS

• are offered a range of options for follow-up sessions after an intervention active phase

And ensuring that weight management interventions encourage people to make lifelong behavioural changes and prevent future weight gain, by:

• fostering independence and self-management (including self-monitoring)

• encouraging dietary behaviours that support weight maintenance and can be sustained in the long term (for example, emphasise that national programmes

• promoting healthy eating like NHS Better Health can support overweight and obesity management)

• emphasising the wider benefits of keeping up levels of physical activity over the long

term

• discussing strategies to overcome any difficulties in maintaining behavioural changes i.e., PROBLEM SOLVING

• encouraging family-based changes

• discussing sources of ongoing support once the intervention or referral period has

ended

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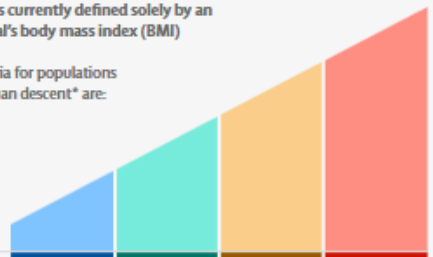
Diagnosing clinical obesity

Limitations of the current definition of obesity

Obesity is currently defined solely by an individual's body mass index (BMI)

The criteria for populations of European descent* are:



Diagnosis	Underweight	Normal	Overweight	Obesity
BMI (kg/m²)	Under 18.5	18.5 to 24.9	25 to 29.9	30 and over

*Criteria for other ethnic groups are different

- Although BMI is **useful** for identifying individuals at increased risk of health consequences...
- It **is not** a direct measure of fat
- It **does not** establish the distribution of fat around the body
- It **cannot** determine when excess body fat is a health problem

Relying on BMI alone to establish if someone has obesity is problematic as this can inaccurately classify a person as having or not having excess body fat, and also lead to under-diagnosis of many whose health is impaired and over-diagnosis of many who are healthy.

#	1	2	3	4
BMI (kg/m²)	28.2	30.1	36.2	36.2
Diagnosis	Overweight	Obesity	Obesity	Obesity
Excess body fat?	✔ Yes	✖ No	✔ Yes	✔ Yes
Signs and symptoms?†	✖ No	✖ No	✖ No	✔ Yes
Notes	Under-diagnosis of obesity	Over-diagnosis of obesity	Obesity with preserved health	Obesity with ongoing illness

Limitations of BMI-based diagnosis

People with excess body fat do not always have a BMI above 30, meaning that their health risk can go unnoticed.

Individuals with high muscle mass (eg, athletes) tend to have high BMIs despite normal fat mass. Diagnosing such people as having obesity or a disease is inappropriate.

Some people with excess body fat (and high BMI) can nevertheless maintain normal organ function and an unhindered ability to conduct daily activities (hence, they have no illness); others instead manifest objective evidence of ongoing illness. Current definition and measures of obesity do not reflect health/illness at individual level and are therefore inadequate for disease diagnosis.

†Signs and symptoms of organ dysfunction due to excess body fat

Read the *Lancet Diabetes & Endocrinology* Commission on the definition and diagnostic criteria of clinical obesity online at: www.thelancet.com/commissions/clinical-obesity

Diagnosis and management of clinical and preclinical obesity

Diagnosis

1 Excess body fat?
The first step in such a diagnosis is confirming excess body fat, which can be achieved via one of the following three criteria:

- At least one measurement of body size and BMI
- At least two measurements of body size, regardless of BMI
- Direct body fat measurement, such as a DEXA scan

No → **2 No obesity**

Yes → **3 Obesity**
Confirmation of excess body fat should be followed by further assessment to establish whether an individual with obesity has an illness

4 Medical history, physical examination, and standard blood test
- Are there signs/symptoms of organ dysfunction?
- Does the individual experience limitations of day-to-day activities?

No signs/symptoms and no limitations | Yes, signs/symptoms of organ dysfunction | Yes, limitations of day-to-day activities

5 Is organ dysfunction obesity related? No / Yes

→ Preclinical obesity
→ Clinical obesity

Measurements of body size
The Commission defines three measurements of body size that can be used to confirm excess body fat:

- Waist circumference ≥102 cm for men* ≥88 cm for women*
- Waist-to-hip ratio >0.90 for men* >0.85 for women*
- Waist-to-height ratio >0.50 for all*

Excess body fat can pragmatically be assumed if BMI is >40 kg/m²

*White Caucasions only. Criteria for other ethnic groups may be different

Management
This new diagnosis approach will support evidence-based, personalised prevention and treatment, ensuring more efficient and cost-effective use of resources

Preclinical obesity management
Focus on risk reduction and prevention of progression to clinical obesity or other obesity-related diseases

- Health counselling for weight loss or prevention of weight gain
- Monitoring over time
- Active weight loss interventions in people at higher risk of developing clinical obesity, and other obesity-related diseases

Clinical obesity management
Focus on improvement or reversal of organ dysfunction

- Evidence-based treatment and management, with an aim to fully regain or improve functions
- Treatment type should be informed by individual risk—benefit assessments and decided via an active discussion with the patient
- Success should be assessed by improvement of signs and symptoms, rather than measures of weight loss

Read the *Lancet Diabetes & Endocrinology* Commission on the definition and diagnostic criteria of clinical obesity online at: www.thelancet.com/commissions/clinical-obesity

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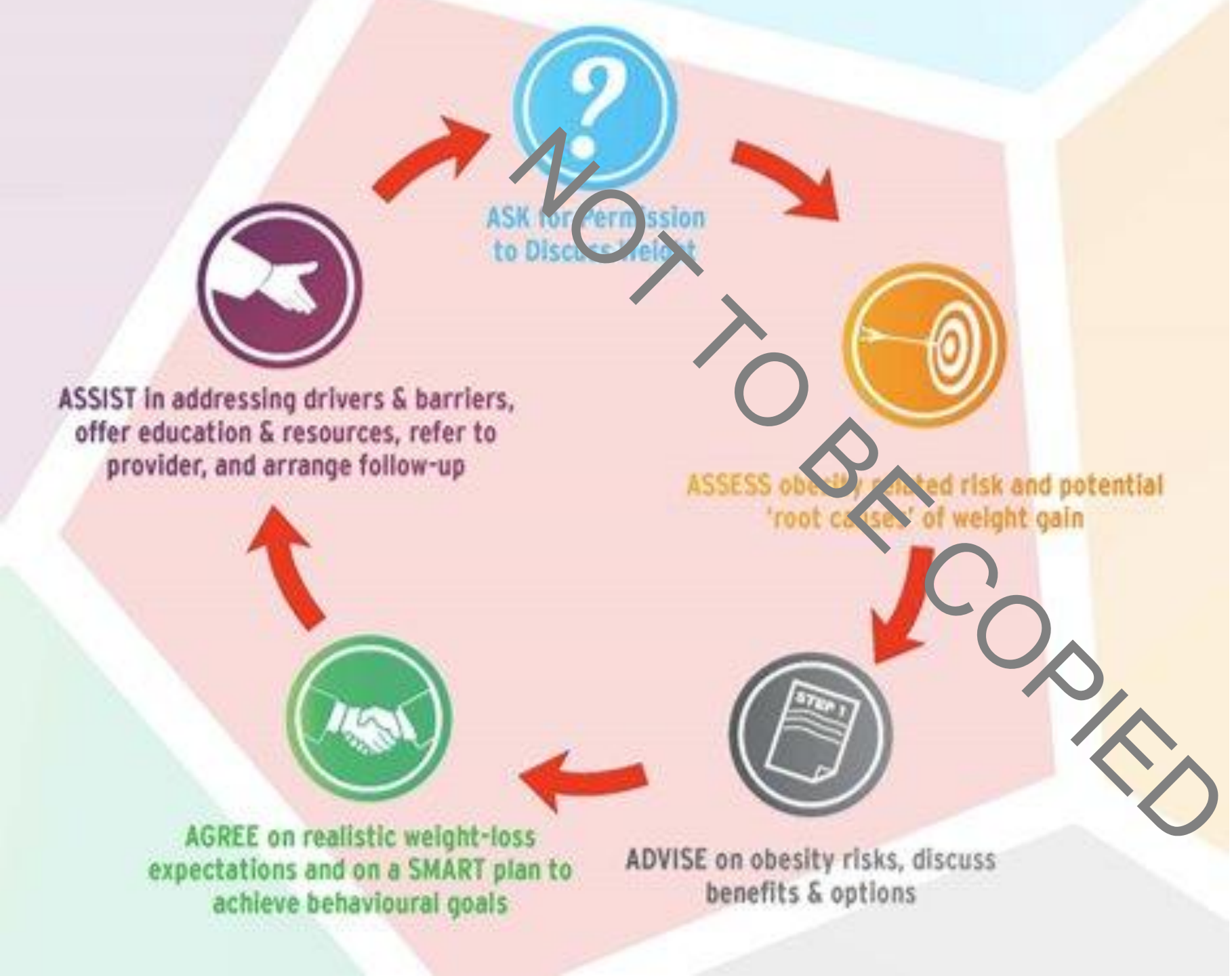

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5 A's:

Ask
Assess
Advise
Agree
Assist

Credit:
@DrSharma
Obesity Canada

Consider helpful, patient-centred and appropriate targets

*Obesity is ***not*** a behaviour – but behavioural modification is part of obesity management*

- Multicomponent behavioural interventions are preferred – targeting diet quality, physical activity with embedded behaviour change strategies – focus on gains to health not weight loss

- However, 5-10% weight loss – **can bring clinically significant health benefits** – improves chronic disease risk factors, as well as quality of life, mental health etc.:
    - E.g. blood pressure, cholesterol, triglycerides, insulin sensitivity, mental health
    - **Cost-effective** way for policy makers to reduce **weight-related disease health-care costs (Ahern et al. 2022)**

- Most lose approx. 3% on community-based programmes and can have positive impacts for people beyond weight (e.g. no harm to mental health (Theodoulou et al., 2022)

- Greater weight loss associated with drug treatment (GLP/GLP&GIP) and surgery (typically specialist (or private services)

- Weight loss maintenance considerations should be included in all approaches including discussion about weight re-gain being an expected biological response

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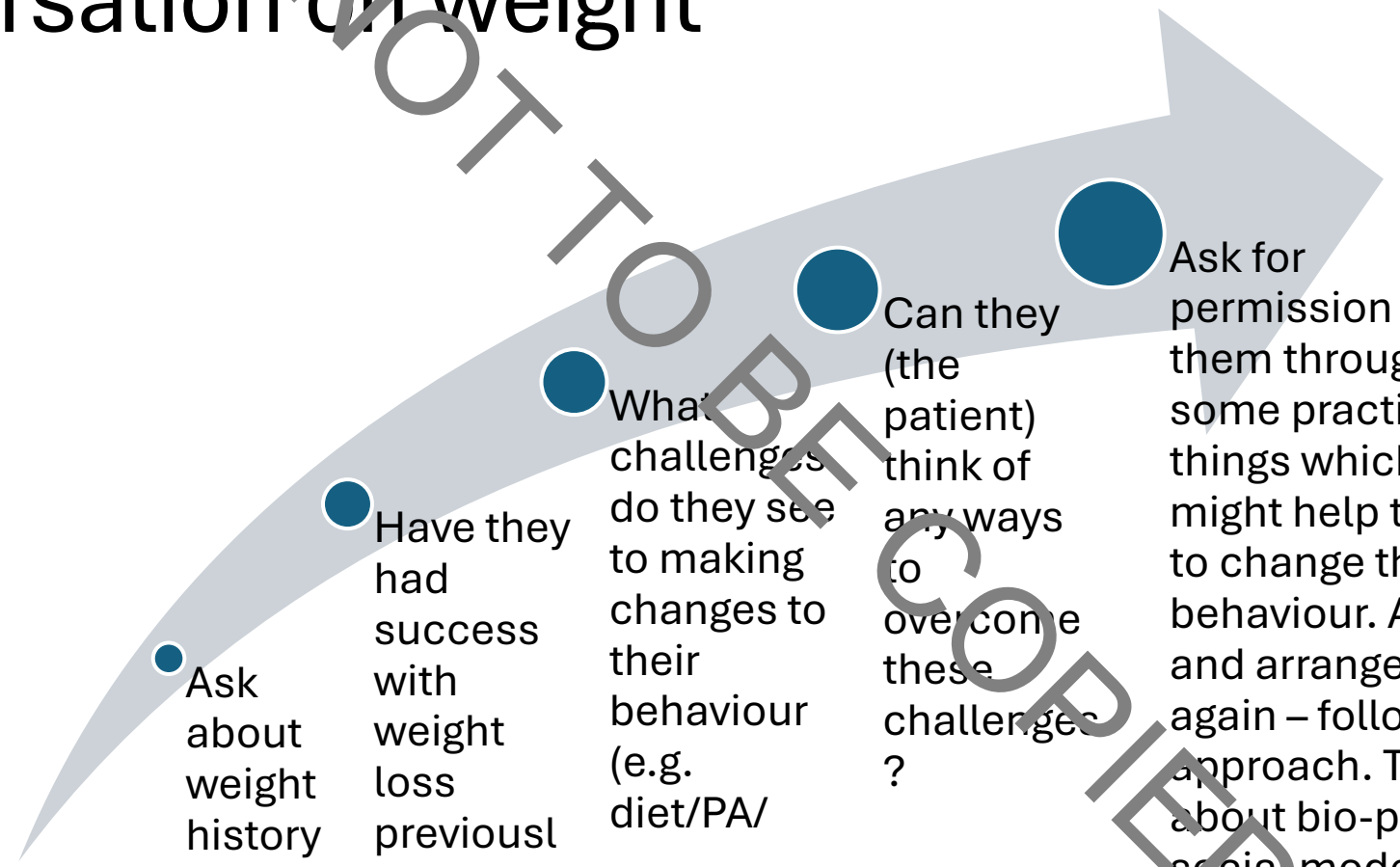
Consider barriers and facilitators to a supportive conversation on weight



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Forming Habits: Practical Tip

Tool for patients:

Make a new healthy habit

1. Decide on a goal that you would like to achieve for your health.

2. Choose a simple action that will get you towards your goal which you can do on a daily basis.

3. Plan when and where you will do your chosen action. Be consistent: choose a time and place that you encounter every day of the week.

4. Every time you encounter that time and place, do the action.

5. It will get easier with time, and within 10 weeks you should find you are doing it automatically without even having to think about it.

6. Congratulations, you've made a healthy habit!

My goal (e.g. 'to eat more fruit and vegetables')

_____

My plan (e.g. 'after I have lunch at home I will have a piece of fruit')

(When and where) _____ I will _____

Consider using a tick sheet to monitor your progress in the early phases of trying to adopt a new habit – tick each day (Mon-Sun) when you manage to carry out the behaviour you are trying to make habitual.

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Adapted from 'Box 1. A tool for patients': Gardner B, Lally P, Wardle J. Making health habitual: the psychology of 'habit-formation' and general practice. Br J Gen Pract. 2012 Dec 1;62(605):664-6 [50].

Think about Obesity, EDs and Stigma

Need to think about disordered eating in the context of higher weight

Challenge of screening and services for those with possible Eds such as binge-eating disorder is much higher prevalence than in general public in those seeking WMS (~45%)

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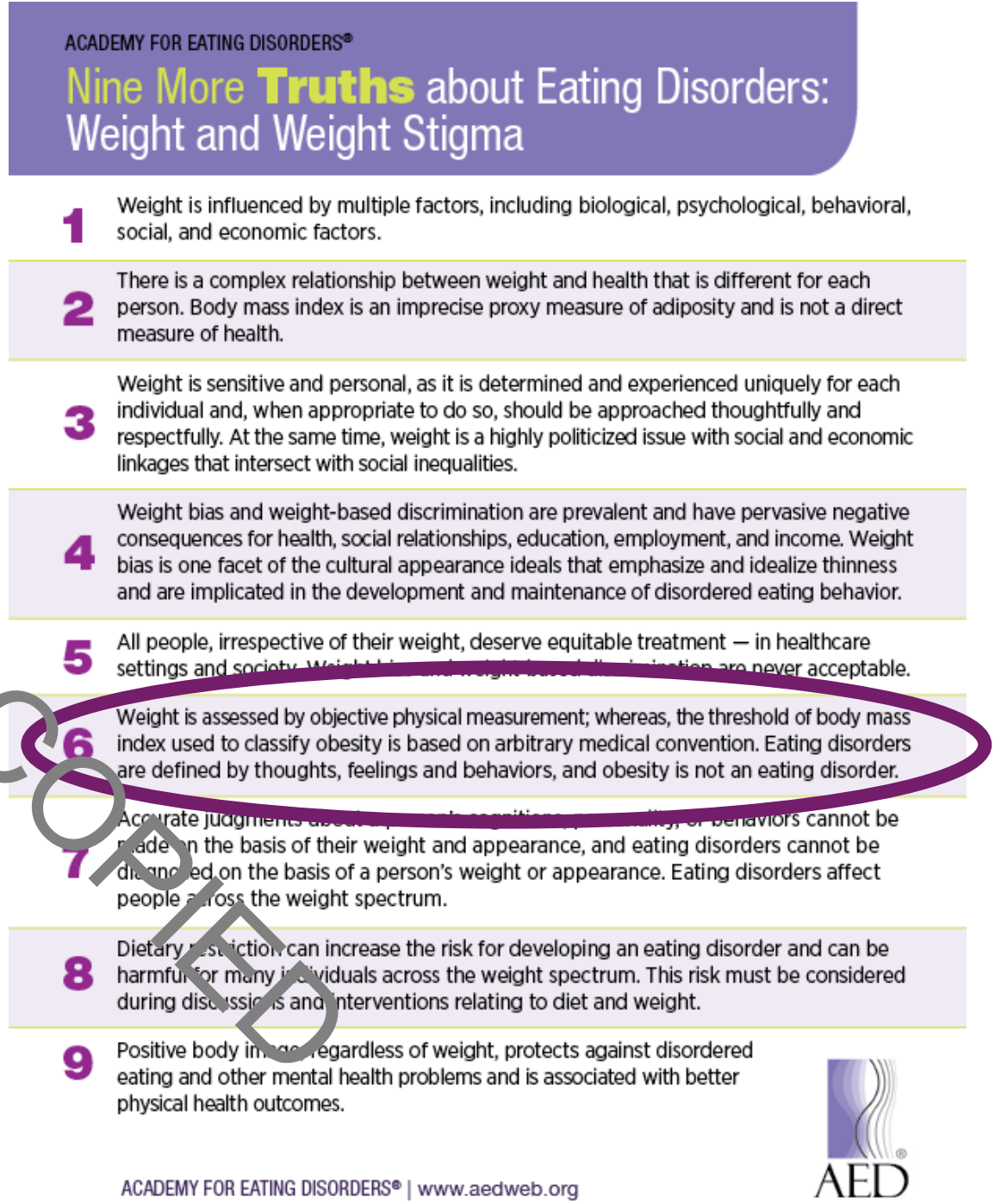

ACADEMY FOR EATING DISORDERS®

Nine More **Truths** about Eating Disorders: Weight and Weight Stigma

1. Weight is influenced by multiple factors, including biological, psychological, behavioral, social, and economic factors.
2. There is a complex relationship between weight and health that is different for each person. Body mass index is an imprecise proxy measure of adiposity and is not a direct measure of health.
3. Weight is sensitive and personal, as it is determined and experienced uniquely for each individual and, when appropriate to do so, should be approached thoughtfully and respectfully. At the same time, weight is a highly politicized issue with social and economic linkages that intersect with social inequalities.
4. Weight bias and weight-based discrimination are prevalent and have pervasive negative consequences for health, social relationships, education, employment, and income. Weight bias is one facet of the cultural appearance ideals that emphasize and idealize thinness and are implicated in the development and maintenance of disordered eating behavior.
5. All people, irrespective of their weight, deserve equitable treatment — in healthcare settings and society. Weight bias and weight-based discrimination are never acceptable.
6. Weight is assessed by objective physical measurement; whereas, the threshold of body mass index used to classify obesity is based on arbitrary medical convention. Eating disorders are defined by thoughts, feelings and behaviors, and obesity is not an eating disorder.
7. Accurate judgments about [illegible] or behaviors cannot be made on the basis of their weight and appearance, and eating disorders cannot be diagnosed on the basis of a person's weight or appearance. Eating disorders affect people across the weight spectrum.
8. Dietary restriction can increase the risk for developing an eating disorder and can be harmful for many individuals across the weight spectrum. This risk must be considered during discussions and interventions relating to diet and weight.
9. Positive body image, regardless of weight, protects against disordered eating and other mental health problems and is associated with better physical health outcomes.

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Take-home messages

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01

Supporting patients with behaviour change should be within the remit of all. Take a person-centred, non-stigmatising approach to all behaviour change conversations. Use models and frameworks to guide this.

02

Seek training opportunities for embedding behaviour change skills and 'healthy' conversations into routine healthcare delivery e.g. 'Making Every Contact Count' (MECC) – follow NICE evidence on behaviour change and Irish Clinical Guidelines.

03

Consider principles of habit formation (repetition in response to a consistent cue) to encourage development of 'habitual behaviours' - less reliant on conscious effort, though be mindful these are likely low intensity with small impacts.

QUEEN'S UNIVERSITY BELFAST

THANK YOU.

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JOIN **The Association for the Study of Obesity** – and be part of the NI Network!

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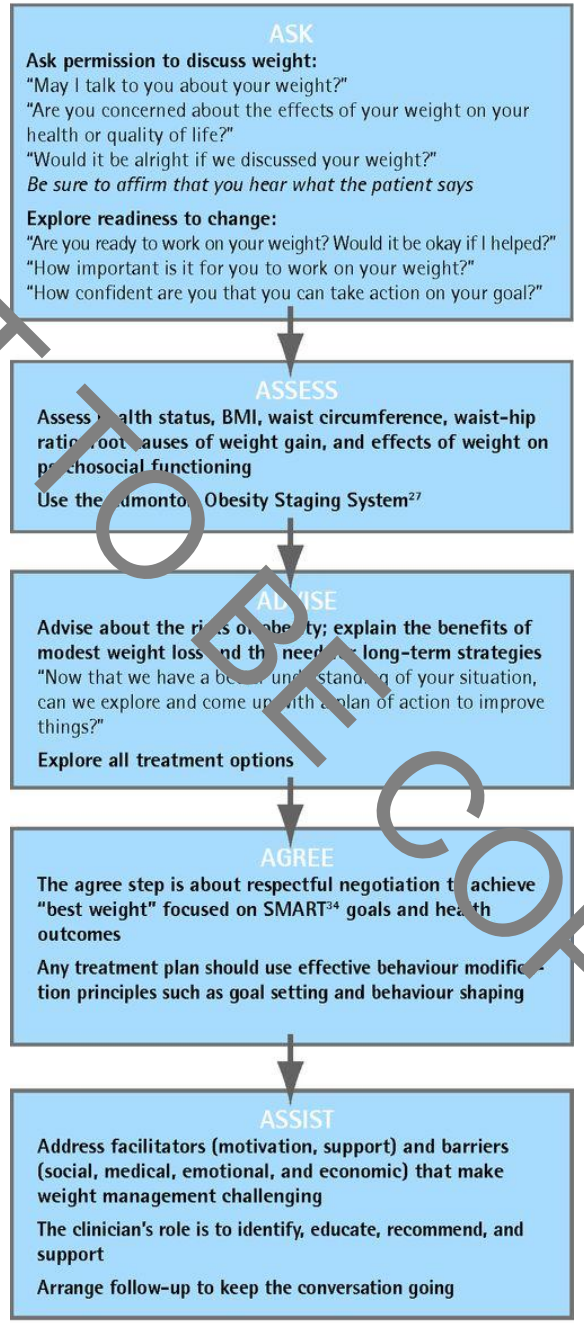
- UK's foremost organisation dedicated to the understanding, prevention and treatment/management of obesity
- ASO Membership is open to obesity researchers, healthcare professionals, clinicians, academics, scientists, and students who are working and/or studying in the field of obesity and to others who have a particular interest in this area
- https://www.aso.org.uk/
- One/two free events per year in NI if a member – obesity-focused
- UK Congress on Obesity (UKCO) – annual flagship event for obesity in UK

Figure 1. The 5 *As* for obesity counseling



BMI—body mass index, SMART—specific, measureable, achievable, rewarding, timely.

Modified 5 As:
Minimal intervention for obesity counseling in primary care

Michael Vallis, Helena Piccinini–Vallis, Arya M. Sharma and Yoni Freedhoff
Canadian Family Physician January 2013; 59 (1) 27-31;

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