Public Health Programme Guidance

Behaviour Change - Consultation on Draft Scope
Stakeholder Comments Table

28th February 2012 – 27th March 2012

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Bangor University	2. d	2	If the scope of the document and process is for the entire UK, then there needs to be inclusion of Welsh, NI and Scottish policy documents.	NICE guidance is for England only, although other parts of the UK may wish to consider adapting it for use in their local settings.
Bangor University	3. e and 4.3. Question 3 and General	4 8	This section captures what is perhaps the most important insight that contemporary behaviour change (BC) research has identified. That is, the reflective/ automatic distinction referred to (or Kahneman's S1 and S2 etc.). A critical next step is to **raise awareness of this reflective/ automatic distinction and its implications to health practitioners**. This will then act as a catalyst to a greater implementation of effective BC techniques. Once a practitioner is aware of this, they can focus on (1) reducing automatic triggers of unhealthy behaviours (e.g. addictive cues); (2) increasing automatic triggers of healthy alternative behaviour (e.g. developing healthy habits and routines through implementation intentions); and (3) engaging reflective processes at critical decision points (e.g. re-appraisal, see Metcalfe and Mischel, 1999). It is fair to say that health research has traditionally focused on this latter category.	Thank you for your comment – where relevant evidence is available, the committee will consider the points you raise as they develop the guidance.
Bangor University	3. d	4	Any study of, or intervention with the goal of behaviour change needs to address the different stages of change and the different cognitive, emotional and social processes involved therein i.e. in initiation /execution/implementation of change, the persistence of change, including management of relapse. Bangor's FP7 grant of medication adherence (also behaviour that needs changing) has published a taxonomy to this effect (BJ Clin Pharm, Vrijens, B et al, 2011, A new taxonomy for describing and defining	Thank you for your comment – the committee will consider the available evidence on a range of approaches.

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			adherence to medications).	
Bangor University	4.1.2.	5	By ignoring the role of 'families' in the focus of the document, the context of behaviour is being partially ignored which is unfortunate.	Thank you for the comment, the role of the family, for example in terms of social support for an individual attempting behaviour change would not be excluded – where relevant evidence is available, the committee will consider a range of approaches. However, , interventions focussed on changing the behaviour of the family as a group are not included, since the focus of this particular guidance is on individual behaviour change.
Bangor University	4.2.2. d and General	6	This is an effective foundation. The conceptual approach encompasses the three bullets points in the comment above (on Section 3.e, page 4) i.e. choice architecture can (1) reduce unhealthy behavioural triggers, (2) increase healthy triggers, and (3) engage an individual's reflective system when necessary.	Thank you for your comment. The committee will consider the available evidence this and also a range of other interventions and approaches.

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			This framework should be a fundamental basis for policy and process review towards sustainable behaviour change.	
Bangor University	4.3. Question 1 & 2	7	From the perspective of a limited resourced Government, questions 1 and 2 are the most important to address. We have some evidence already but not exhaustive. The specifics/ populations/ theories work can follow, once Government has a toolkit of effective and sustainable techniques. A further question might be to assess whether it is more effective to focus on (1) automatic processes or (2) reflective processes – particularly given that much of human behaviour appears to be driven automatically (and see next comment).	Thank you for your comment/ The committee will consider the available evidence this and also a range of other interventions and approaches
Bangor University	4.3 Question 1b	7	Automatic 'bad' habits are highly resistant to change and as the document says, historically we have focused on addressing conscious, reflective processes. We need more innovative solutions to impulsive and habitual behaviours.	Thank you for your comment. The committee will consider the available evidence this and also a range of other interventions and approaches
Bangor University	4.3 Questions 2 & 3	7 & 8	It is not clear whether one size will fit all. Whilst there are clearly universal underlying mechanisms (automatic vs reflective processes), the social dynamics of specific 'problem behaviours' of say eating or drinking are very different from the 'private' behaviour of sex. Reaerch in this area will have implications for the rolling out of any large scale technique for multiple behaviours.	Thank you for your comment. As above, the committee will consider the available evidence this and also a range of other interventions and approaches
Bangor University	4.3 Question 4	8	Cultural variation in influences on, and beliefs about, behaviour are crucial and often neglected.	Thank you for your comment. Cultural variations would be included in this

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				question.
Bangor University	Appendix B	12	Very few models and theories acknowledge the fundamental reflective/ automatic distinction in processing and behaviour. This realisation has come in large part from neuroscientific research into brain and behaviour. Only when theorists acknowledge that there are multiple parallel brain networks competing for behavioural control (and incorporate this into their models) will more accurate theories of behaviour change be developed.	Thank you for your comment
British Association for Sexual Health and HIV	3 b	3 of 16	Suggest adding sexual risk behaviour to the list of diet, smoking and alcohol as an area which needs guidance in regard to which technique/s would be most effective to bring about change, and very importantly stratified by specific populations (young people, MSM etc). Furthermore given the recent report from RCP/BASHH regarding the interplay between excess alcohol and 'unsafe sex' behaviour it would be a missed opportunity not to include sexual risk behaviour in this	Thank you for your comment. Behaviours listed in 3b) were not meant to be an exhaustive list – 3c) includes references to HIV prevention and 4.2.1 a) lists the specific behaviours this guidance will cover, which includes sexual risk behaviour.
British Association for Sexual Health and HIV	4.1.2	5 of 16	Suggest lower age limit should be 16; areas to be addressed by the guidance such as smoking/sex are legal and prevalent at this age, some of the evidence is based on studies including this age range, other NICE guidance in relation to sexual heath for young people includes this group, they bear a disproportionate burden of sexual ill health, particularly girls, and if the guidance is to look at behaviour change sustainability surely the earlier the intervention the better; before it is well-established 'habitual behaviour'.	Thank you for your comment – we agree and have lowered .the age limit to 16 and above.
British Psychological Society	General		The BPS suggests that mention be made of the workplace as a potential arena for supporting behaviour change through health promotion programmes.	Thank you for your comment. The workplace is not excluded from this

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				scope as a setting for behaviour change interventions. The committee will consider the available evidence on a range of interventions and approaches,
British Psychological Society	General		We consider that further exploration is needed of the types of persuasive message that work best in brief safer sex interventions (Blanton *et al*., 2001), particularly as it is known that fear messages often do not have the desired impact on behaviour change (Aggleton *et al*., 1994). *References:* Aggleton, P., Davies, P. & Hart, G. (1994). *AIDS: Foundations for the Future*. Philadelphia, PA US: Taylor & Francis. Blanton, H., Van den Eijnden, R.J.J.M., Buunk, B.P., Gibbons, F.X., Gerrard, M. & Bakker, A. (2001). Accentuate the Negative: Social images in the prediction and promotion of condom use. *Journal of Applied Social Psychology*, *31(2)*, 274-295.	Thank you for your comment and for this information. We are working with our review team to develop systematic literature searches and review protocols that will identify relevant published and unpublished evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant unpublished references in your response to this

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				call.
British Psychological Society	3d	4	The BPS suggests the following references are also relevant in highlighting the importance of a theoretical basis for intervention design and evaluation by adding the following references: Borrelli, B. (2011). The Assessment, Monitoring, and Enhancement of Treatment Fidelity In Public Health Clinical Trials. *Journal of Public Health Dentistry*, *71(Suppl.1)*, S52-S63. Glanz, K. & Bishop, D.B. (2010). The Role of Behavioral Science Theory in Development and Implementation of Public Health Interventions. *Annual Review of Public Health*, *31*, 399-418. Noar, S.M., Benac, C.N. & Harris, M.S. (2007). Does Tailoring Matter? Meta-Analytic Review of Tailored Print Health Behavior Change Interventions. *Psychological Bulletin*, *133(4)*, 673-693. Noar, S.M. & Zimmerman, R.S. (2005). Health Behavior Theory and Cumulative Knowledge Regarding Health Behaviors: Are we moving in the right direction? *Health Education Research*, *20(3)*, 275-290. Trifiletti, L.B., Gielen, A.C., Sleet, D.A. & Hopkins, K. (2005). Behavioral and Social Sciences Theories and Models: Are they used in unintentional injury prevention research? *Health Education Research*, *20(3)*, 298-307.	Thank you for your comment. We are not able to reference all relevant works within the scope, which simply outlines what the guidance will and will not cover. In developing the guidance, We are working with our review team to develop systematic literature searches and review protocols that will identify relevant published and unpublished evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant unpublished references in your response to this call.

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British Psychological Society	4.1.2	5	The BPS is unclear of the rationale underlying the decision to confine the scope of this guidance to adults. Children are the next generation at potential risk from the leading causes of mortality in the UK today. The health behaviours under review are often developed from a young age, as are the psychological cognitions that are determinants of these behaviours. If no future guidance on this topic is currently planned for children, young people and their parents, we recommend that this be considered or, alternatively, that the scope of the current guidance be extended to include this population.	Thank you for your comment. We agree that it is important to produce guidance on behaviour change for children. A range of published NICE public health guidance deals with behaviour change and children in specific topic areas (for example, prevention of smoking in school-age children http://guidance.nice.org.uk/PH14, physical activity http://guidance.nice.org.uk/PH17), and further guidance is in development (for example, on obesity / weight management http://guidance.nice.org.uk/PHG/Wave24/20). In addition, we will include the issue of generic theory and approaches for children and

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				behaviour change in a future topic selection workshop.
British Psychological Society	4.2	5	Safer sex is important to all sexually active individuals regardless of age, gender or sexual orientation (Nusbaum & Rosenfeld, 2004) and it has been shown that more is needed to promote safer sex in the general population (Bowleg, 2011). The BPS therefore recommends that specific attention be paid to this topic in the development of this guideline. *References:* Nusbaum, M. & Rosenfeld, J. A. (2004). *Sexual Health Across the Lifecycle*. Cambridge: Cambridge University Press. Bowleg, L. (2011). The "Forgotten": Where are the heterosexually active men in HIV prevention theory, research and interventions?. *Psychology & AIDS Exchange*, *36 (Spring)*, 1-6.	Thank you for your comment. We are working with our review team to develop systematic literature searches and review protocols that will identify relevant published and unpublished evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant unpublished references in your response to this call.
British Psychological Society	4.2	5	The older population has largely been ignored in safer sex interventions, possibly contributing to the rise in diagnoses of sexually transmitted infections in this population (Bodley-Tickell *et al*., 2008). The BPS therefore recommends that particular attention be paid to the promotion of safer sexual behaviour in older adults.	Thank you for your comment. We are working with our review team to develop systematic literature

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			Reference: Bodley-Tickell, A., Olowokure, B., Bhaduri, S., White, D.J., Ward, D., Ross, J.D.C., Smith, G., Duggal, H.V. & Goold, P. (2008). Trends in Sexually Transmitted Infections (Other than HIV) in Older People: Analysis of Data from an Enhanced Surveillance System. *Sexually Transmitted Infections*, *84(4)*, 312-317.	searches and review protocols that identify relevant published and unpublished evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant unpublished references in your response to this call.
British Psychological Society	4.2.1	5	As sedentary behaviour is a separate issue and a large contributor to the development of obesity, the BPS recommends this also be considered when reviewing physical activity levels.	Thank you for your comment. Sedentary behaviour is not excluded from the scope – however, the final guidance will depend on the availability, quality and content of the available evidence.
British Psychological Society	4.2.1.a)	5	The BPS suggests the replacement of “specify” with “be specifiable in terms of”.	Thank you. We have made this change.
British Psychological Society	4.2.1 a)	5	The BPS suggests that the identifiability of those receiving the intervention	Thank you for your

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	Footnote 2		may be a helpful dimension by which to characterise the difference between individual and population-level interventions. For example, interventions could be classed as 'individual-level' where it is possible for all recipients to be identified and as 'population-level' where this is not possible.	comment. Our review team will develop a coding frame for interventions as they identify and assess the evidence, based on recent publications in this area.
British Psychological Society	4.2.1. b)	6	The BPS recommends that "or theoretical domain (Cane *et al*., in press)" be added after the brackets here. Recent attempts to map behaviour change techniques to functions and domains have found the latter to be more informative, as most behaviour change techniques in these individual-level interventions have the function of "enablement". The functions mapping is more informative for community and population interventions. *References:* Cane J, O'Connor D, Michie S. (in press) Validation of the Theoretical Domains Framework for use in behaviour change and implementation research. *Implementation Science.*	Thank you for your comment but we are unable to refer to publications that we are not able to access and assess
British Psychological Society	4.2.1. c)	6	The BPS recommends that: "and received by identifiable individuals" be added to the end of this sentence as, for example, a postal intervention delivered automatically would not count as an individual-level intervention since it could not be known which individuals had received it. Cases where individual receipt can be ascertained (e.g. individuals logging onto a computer programme or attending a mass screening programme), would count as individual-level interventions.	Thank you for your comment. Our review team will develop a coding frame for interventions as they identify and assess the evidence, based on recent publications in

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				this area.
British Psychological Society	4.2.2 b-d	6	Because all behaviour occurs within a context, it is not possible to divorce individually targeted/delivered interventions from the population and community-level contexts within which they sit. It is also not possible to divorce reflective, self-regulatory approaches to behaviour change from impulsive, associative and environmental approaches, as most behaviour change results from a combination of these. The challenge for this guidance will be to focus on the interventions specified in 4.2.1c whilst recognising the interactive nature of behaviour change techniques with each other, their mode of delivery and context.	Thank you for your comment. The committee will consider the available evidence on the issues that you raise.
British Psychological Society	4.3, question 1b	7	The BPS suggests that this review should specify that the evaluation of long term effectiveness is based on six months post intervention completion rather than six months post baseline (we are assuming that the use of a six month time-frame is based on the maintenance stage of the Transtheoretical Model of Change; Prochaska & DiClemente, 1983). There are discrepancies in the literature where some authors use "post-intervention" to mean after the start of an intervention while others use the same term to mean after the finish of the intervention. Clarity is essential here as these differences will have obvious consequences. Reference: Prochaska, J.O. & DiClemente, C.C. (1983). Stages and Processes of Self-Change of Smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*, 390-395.	Thank you for your comment. 6 months was referring to follow-up. This has been clarified. The 6 month time frame is not based on the TTM.
British Psychological Society	4.3, question 2	7	It may be that there are some techniques which are only effective in certain stages for certain behaviours. For example, an intervention with an element of	Thank you for your comment. The recommendations included

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			threat appraisal may motivate someone to contemplate and prepare to stop smoking; however, if someone is already committed to stopping, this technique may be redundant and constructs such as control may be more influential. Therefore, the BPS suggests that this question and any future guidance based on it may need to be broken down by stages as well as by behaviours.	in the final guidance will depend upon the committee's discussion of the available evidence, and we cannot pre-empt those discussions or recommendations in the scope.
Centre for Health Promotion Research, Leeds Met University	general		I am disappointed with the emphasis on 'interventions' and 'techniques' throughout the draft scope and the lack of focus on addressing health inequalities and supporting those people who are disadvantaged and/or marginalised to improve their health. There is a growing evidence base around lay engagement (eg volunteers, peers, community health champions, health trainers) to improve health and reach the so called 'hard to reach' which clearly demonstrates that it can be effective in supporting behaviour change, but also that lay engagement has to be properly supported if it is to work well. We need to think beyond interventions around particular topics (eg smoking) to cross cutting strategies to embed lay engagement to supporting behaviour change in organisations, particularly if we want to work with disadvantaged and marginalised communities and encourage a peer led, client centred approach.	Thank you for your comment. We undertake equity audit throughout the guidance process and look at the differential impact of all recommendations. Appendix B, potential considerations highlights this. Where evidence is available, the committee will consider the impact and effectiveness of interventions in relation to a range of different populations. The guidance process will ensure that no vulnerable group is discriminated against. Please note that we are dependent on the available evidence – if evidence pertains to disadvantaged ad vulnerable groups then it will be reported.

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				As stated in 4.3 Key Question 2: we will be reviewing evidence for effective techniques that can be used to tackle a range of behaviours.
Centre for Health Promotion Research, Leeds Met University	4.2.2	Page 6	Separating out individual behaviour change from community and population change flies in the face of health promotion theory and practice which emphasises the interconnections between these levels. For example evidence from evaluations of health trainers and community health champions demonstrates that people find it much easier to make and maintain changes in behaviour if their environment supports this – eg there are community activities such as cook and eat sessions that they can join and safe green spaces for them to walk in. If the guidance doesn't reflect this it will miss importance evidence and make the mistake of seeing people just as individuals rather than as part of communities.	Thank you for your comment. As highlighted in section 2f) we recognise that behaviour change is most likely to occur and be sustained through a combination of population, community and individual-level interventions. NICE's original behaviour change guidance (http://guidance.nice.org.uk/PH6) acknowledged this, and following the consultation on the proposal to update the guidance (http://guidance.nice.org.uk/PH6 /ReviewDecision/pdf/English) we were confident that the principles around this issue remained valid. The current guidance is a partial update of the original guidance, allowing us to focus in more detail on new research around individual approaches, and choice

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				architecture. We anticipate that this updated guidance will be used in conjunction with the original guidance.
Centre for Health Promotion Research, Leeds Met University	Question 3	Page 8	Being a non professional, a lay person or a peer need to be recognised as important characteristics – evidence from research into lay health worker roles shows that the fact that someone is a peer and not a professional is very important to many people and a key reason why they engage and start to determine the changes they want to make.	Where relevant evidence is available on the issue you raise, it will be considered by the committee in developing the guidance.
Department of Health	General		I do have a comment on the scope of activities which the draft scope is set to cover. It states that it will be aimed at "Health promotion and disease prevention interventions aimed at changing an individual's health-related behaviour, specifically in relation to smoking, alcohol, diet, physical activity and sex." - well that's fine but there is no mention of behaviours related to mental health and wellbeing. Given the Government's emphasis (in the cross-Government MH Strategy, No Health Without Mental Health) on public mental health and wellbeing, this seems to me a crucial omission. I think it should read ".....specifically in relation to smoking, alcohol, diet, mental wellbeing, physical activity and sex"	Thank you for your comment. We recognise the importance of mental health and wellbeing in the production and maintenance of health related behaviours. The proposed behaviour change guidance is a partial update of PH6, guidance on behaviour change originally published in 2007. As well as reviewing theories and models of behaviour change in general, as part of the guidance development process the original Programme Development

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				Group considered a comprehensive evidence review that assessed the evidence on behaviour change approaches in interventions around healthy eating, physical exercise, smoking, alcohol misuse, sexual risk taking (in young people) and illicit drug use. In the report of the 2011 Science and Technology sub-committee, the House of Lords recommended that NICE update the original guidance – in particular, the sub-committee wanted 'more explicit advice on how behaviour change techniques could be applied to reduce obesity, alcohol abuse and smoking' (House of Lords 2011). This is why, for some of the evidence reviews that will inform this

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				guidance update, we plan to focus on these specific topics – to update the original guidance, and to do as the House of Lords asked of us. However, where we are able to identify evidence in relation to the topic-based reviews about mental health and wellbeing and its impact on the implementation and effectiveness of intervention, then – as with a range of other factors - it will be included in our evidence reviews and carefully considered by the Programme Development Group as they draft their recommendations.

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Jenny Craig	Question 1 a and b	7	The key unique way in which the Jenny Craig programme works for weight management is that it offers weekly 1:1 telephone consultations. Weight-loss program participants who had a brief, monthly personal contact intervention - most often a 10-15 minute phone conversation - regained less weight than participants who were in a Web-based intervention or self-directed program, according to a study in the March 12 issue of JAMA, the Journal of the American Medical Association. JAMA. *2008;299[10]:1139-1148*. The consultations are led by consultants trained in behavioural change techniques namely motivational interviewing, goal setting, self-monitoring. The reference by Rock et al. *in JAMA (JAMA. 2010;304(16):(doi:10.1001/jama.2010.1503)* showed that compared with usual care, the Jenny Craig structured weight loss program resulted in greater weight loss over 2 years which demonstrates the long term effectiveness of this style of programme The Jenny Craig menu features a variety of prepared meals and snacks which are convenient models for nutritional balance. Research has shown that portion-controlled pre-packaged meals can be more effective in helping people lose weight and reduce heart disease risk compared to people preparing their own meals on a conventional weight loss plan. *Hannum SM, Carson L, Evans EM, et al. Use of portion-controlled meals enhances weight loss in women. Obesity Res. 2004;12:538-546*	Thank you for your comment. We are working with our review team to develop systematic literature searches and review protocols that will identify relevant available evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant references in your response to this call.
Jenny Craig	Question 5	8	With regards to Maintenance, the Jenny Craig programme realises that in order to prevent weight re-gain after the end of a dieting period, clients still need to continue with behaviour change practices and physical activity. Further, it has a system in place which helps to control excessive intake such as continuing to watch portion sizes and monitoring intake and being mindful of what is in the food they are eating.	Thank you for your comment. Where relevant evidence is available on the issue of behaviour maintenance, it will be considered by the committee.

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NHS Direct	General		NHS Direct welcome the guideline and have no comments on the scope consultation.	Thank you.
Perfect Portion Control Ltd/ The Diet Plate	B/	6	Behaviour techniques not mentioned but maybe should be considered as this is a relatively new resource? The Diet Plate has only anecdotal evidence of behavioural change through its continued use. The evidence shows that as people have a tangible calibrated plate and bowl that "visually guides" (automatic response) to portion sizes there weight loss is considerable. Secondly the plan provides a healthy diet automatically and is reinforced with continual education (reflective) through the products lifetime of use. Cost considerations - The products are priced at £19.45 per head, (a lifetime one off purchase) excluding the 8 week course which is £160, this we intend to deliver commercially from 1st April 2012. A clinical trial is needed to prove our anecdotal outcomes regarding behavioural change, however, meanwhile I can access over 6,000 people to survey how much weight they have lost and how much weight they have been able to keep off because their attitudes to food have changed. I may also be able to get statistics from Worcestershire PCT who has been using Diet Plate for over a year now with all their weight management groups?	Thank you for your comment. We are working with our review team to develop systematic literature searches and review protocols that will identify a wide range of relevant available evidence. In addition, NICE will be issuing a call for evidence to all stakeholders to support the production of this guidance, and we would be very grateful if you could submit relevant references in your response to this call
Perfect Portion Control Ltd/ The Diet Plate	Q5	Page 8	Patients and clients who use the Diet Plate, express how easy it is to follow, how educational it is, how they can't "unlearn" once they are educated "visually" by its continued use. How using the Diet Plate differs from an ordinary plate because they "project" the responsibility of the portion size to	Thank you for your comment – please see our comment above.

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			the calibrations on the plate, rather than allow the decision for portion size to be made on a blank plate. We have found that people who lend their plate or stop using them put weight back on, while those who continue to use them and follow the maintenance plan tend to remain at their goal weight. The portion sizes reflect in their minds even when out to dinner away from the product, this keeps them in check. For weight maintenance, the same plate and bowl is used – with one difference, and that it is, they are given two days a week to choose treats or attend a party where tempting food is available. We have taken the "guilt" out of weight loss and empowered them with tangible, attractive offer. What is missing in changing some ones behaviour is the visual aspect, which Diet Plate provides. It is all well and good giving people advice and information but if they still have to count calories or points or change their diet out of all recognition then this brings willpower into play and eventually the automatic process of their old behaviour creeps in. To truly change some ones behaviour education must be constant for months if not years, it has to be made as easy as possible so the person can't rely on old excuses for failure. To this end, we have developed an alternate therapy in the form of a Hypnosis programme on CD called the Diet Plate Success Accelerator, which will augment the whole process. And, all of this in the privacy of the patients own home. The cost of the hypnosis programme is just £10.	
Perfect Portion Control Ltd/ The Diet Plate			In fact, failure needs to be taken out of the equation as does, denial of food. These two factors are what the Diet Plate ethos is based on as we make it as	Thank you for your comment. We are not able to provide

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			easy as possible for a person to alter their diet, to that of a healthy one by the design of the plate and bowl. We offer a moment by moment approach and we support people throughout, so that they change their lifestyles with an understanding of the consequences if they don't. And of course this is a whole family approach to healthier living. I appreciate that I need to find someone to clinically trial this independently of my comments and any help in that matter would be greatly appreciated.	support in finding research partners or funds.
Public Health Wales	2c	1	The sentence "There will be a particular emphasis on the techniques and skills practitioners need to help people sustain their behaviour change" should also contain the word 'resources'.	Where there is available evidence about the resources required for interventions – including training and skills – it will be considered by the committee. We will be commissioning economic analysis to accompany the evidence reviews which will consider the cost effectiveness of the recommendations in more detail. We will also work with our implementation team to produce resources, including costing information that will assist those wishing to put the guidance into practice.
Public Health Wales	3e	4	The assertion that "Traditional health promotion and education has mainly focused on people's reflective processes" is not one that will be recognised by	Thank you for your comment. The committee will consider the

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			professional health promotion specialists? Indeed most behaviour change interventions used in the field in the last two decades have been very explicit about the need to work with individuals in identifying coping strategies for dealing with the 'automatic' responses suggested.	available evidence on a range of interventions and approaches. –
Public Health Wales	4.1.2	5	It doesn't make sense to exclude children and young people under the age of 18yrs. Most inappropriate health behaviours including sexual behaviour, smoking, alcohol, physical & sedentary activity and particularly eating behaviours develop in childhood and adolescence. To only consider behaviour change interventions in adulthood suggests 'closing the stable door after the horse has bolted', allowing such behaviours to become more ingrained and therefore harder to address whilst also risking propagating health inequalities.	Thank you for your comment. The age limit for this guidance has been lowered to 16 years. Furthermore, there is NICE public health guidance both published and in development that deals with behaviour change in children and young people in specific topic areas, such as smoking (http://guidance.nice.org.uk/PH14), obesity (http://guidance.nice.org.uk/PHG/Wave24/20), and physical activity (http://guidance.nice.org.uk/PH17). We will also add behaviour change and children into a future topic selection meeting.
Public Health Wales	4.2.2	6	Whilst recognising the scope of this review is focused on individual behaviour change interventions, it is nonetheless disconcerting that the guidance is ignoring the role of wider intervention techniques as described particularly in	Thank you for your comment. As highlighted in section 2f) we recognise that behaviour

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			a) through d). As identified in the introduction, the evidence of effectiveness of sustained individual behaviour change is weak at best. This is principally because individual behaviour is moulded by the social, economic and physical environment, so sustainability is inevitably going to be influenced by these same factors. In other words we will be revisiting these strategies on a regular basis until such time as policy makers, practitioners and researchers start to join the dots and acknowledge the importance of a collective approach to behaviour change in which individual behaviour change techniques are allied to precisely the wider social policy, fiscal & legislative strategies being excluded from this review.	change is most likely to occur and be sustained through a combination of population, community and individual-level interventions. NICE's original behaviour change guidance (http://guidance.nice.org.uk/PH6) acknowledged this, and following the consultation on the proposal to update the guidance (http://guidance.nice.org.uk/PH6 /ReviewDecision/pdf/English) we were confident that the principles around this issue remained valid. The current guidance is a partial update of the original guidance, allowing us to focus in more detail on new research around individual approaches, and choice architecture. We anticipate that this updated guidance will be used in conjunction with the original guidance. Finally, this new guidance is the first in an anticipated suite of guidance on different aspects of behaviour change, and we expect to

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				address and update the issues you raise in the context of future referrals. .
Public Health Wales	Q3 Expected outcomes	8	Do we really expect to find 'social skills' systematically described and analysed in the research that informs the guidance?	Thank you for your comment. We are working with our review team to develop an appropriate search strategy and review protocol, including forensic search techniques, that will identify relevant evidence – we will also supplement this evidence with expert testimony on key issues, where appropriate. While we may find that the evidence on the role of social skills is sparse or of poor quality, there was sufficient literature for it to be identified during scoping as a potentially important factor. The final recommendations and guidance will depend upon the full range of evidence that is identified by the reviews and considered by the committee.
Public Health Wales	Q4	8	One of the significant problems with present approaches to behaviour change is the simplistic level of defining target groups. If there's one thing that social	Thank you for your comment. "Different population groups" in

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			marketing theory has taught us it is the need for much more sophisticated segmentation of populations. This question needs to capture more about sub-cultures if we really want to understand influences on and strategies for addressing health behaviours.	this section is intended to cover a range of sectors of the population, as you suggest.
Public Health Wales	General		There needs to be a stronger recognition of the role of neurobiology in the development of health behaviour. Emerging research shows the critical influence of brain development during adolescence from about 12 to 24yrs and its natural impact on risk taking health behaviour. Any strategy for addressing such behaviours will need to account for these changes.	Thank you for your comment.
Royal College of Paediatrics and Child Health	General		Children are key in behaviour change – they tend to be more flexible, their habits eg starting smoking can be long-lasting, and surely the value of any behavioural change is greater the earlier it takes place. There is some evidence base for behavioural change in adolescents – for example motivational interviewing and it seems wasteful to ignore at least older children.	Thank you for your comment. We agree that it is important to produce guidance on behaviour change for children. The age limit for this guidance has been lowered to 16 years. Furthermore, there is NICE public health guidance both published and in development that deals with behaviour change in children and young people in specific topic areas, such as smoking (http://guidance.nice.org.uk/PH14), obesity (http://guidance.nice.org.uk/PHG/Wave24/20), and physical

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				activity (http://guidance.nice.org.uk/PH17). We will also add behaviour change and children into a future topic selection meeting.
Royal College of Paediatrics and Child Health	General		It is a regrettable omission to exclude <18 year olds from this guidance since there is the potential in childhood and adolescence to modify behaviours early on that will otherwise have adverse health impacts long term (e.g. obesity, smoking-related ill health). Unless separate public health guidance on behaviour change is planned for <18 year olds, then this guidance is inequitable.	Thank you for your comment. Please see our response above – in addition, please note this guidance is a partial update of behaviour change guidance published in 2007, which focused on adults – although we have lowered the age limit in this update to 16.
Royal College of Paediatrics and Child Health	General		At the moment, this draft scope makes no reference to vulnerable groups such as those with disabilities and mental illness, who are likely to require modified approaches to behaviour change. Hopefully this will be covered as this guidance is developed.	Thank you for your comment. The scope does make specific reference to the differential impact of intervention on people from different groups, including socio-economic groups, ethnic groups, and so on. The committee will consider the available evidence on these factors as it develops

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				recommendations. We also undertake equity audit throughout the guidance process and look at the differential impact of all recommendations on different groups of the population Appendix B, potential considerations highlights this and we have now included specific reference to disabilities and sexual orientation in this section. The guidance process will ensure that no vulnerable group is discriminated against. Please note that we are dependent on the available evidence – if evidence pertains to vulnerable groups then it will be reported.
Royal College of Paediatrics and Child Health	3e	4	How will this apply to individuals with disabilities who may have eating disorders, not understand healthy eating or need therapies to remain mobile? Many disabled people are overweight and have poor health. They lack	Thank you for your comment and the reference.

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			opportunity to join in mainstream services including leisure. Health outcomes for learning disabled people are recognised as being particularly poor - see the Best Practice Guidance "World Class Commissioning for the health and wellbeing of people with learning disabilities" (Gateway reference 12376).	Please see response above.
Royal College of Paediatrics and Child Health	3e	4	Health promotion and education inequalities start in childhood where children with disabilities have difficulty, without huge battling by parents, accessing the services necessary to prevent these health inequalities developing and progressing.	Thank you for your comment. We agree that it is important to produce guidance on behaviour change for children. The age limit for this guidance has been lowered to 16 years. Furthermore, there is NICE public health guidance both published and in development that deals with behaviour change in children and young people in specific topic areas, such as smoking (http://guidance.nice.org.uk/PH14), obesity (http://guidance.nice.org.uk/PHG/Wave24/20), and physical activity (http://guidance.nice.org.uk/PH17). We will also add behaviour change and children into a future topic selection meeting.
Royal College of Paediatrics and	4.2	5	Will guidance be provided on how these behaviour changing activities will be	We are dependent on

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Child Health			delivered for people with disabilities, including learning disabilities?	the available evidence – if evidence pertains to the effectiveness of behaviour change techniques in people with disabilities then it will be reported. People with disabilities are not excluded from the populations covered in this guidance.
The Royal College of Midwives	Title: Behaviour change at individual level		The RCM consider that the title may be misleading in light of the points outlined below concerning the purpose and nature of the supporting model being proposed.	Thank you for your comment.
The Royal College of Midwives	**General**		This guideline is aimed at behavioural change which implies that the individual has established a behaviour that warrants changing via some behavioural change therapy (Rollnick and Millar 2008). In many circumstances, the public health remit of the health professional does not require behavioural therapy to meet that remit. For example, under the title of public health, a midwife will promote breastfeeding to individual women, however within this context, behavioural therapy is neither required nor appropriate as a health compromising behaviour such as formula feeding has not begun. Nevertheless, the careful systematic and theoretical design of the public health programme is required. There is therefore a need for a clearer definition of behavioural therapy with examples of when such therapy is and is not appropriate.	Thank you for your comment. This guidance is not going to focus on behavioural therapy, but on interventions with individuals aimed at changing behaviour. Such interventions would be delivered in the context of an identified need for change. It will also consider the evidence on 'choice

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				architecture' ('nudge' interventions) that focus on changing environmental cues and behavioural choices. We recognise that public health professionals and practitioners work in a range of settings and contexts and will not always be focusing on change - this guidance will support them in those aspects of their work that deal with individual behaviour change. There is a wide range of NICE public health guidance, both published and in development, that can support other activities.
The Royal College of Midwives	General		The proposed Behavioural Change Wheel by Michie et al. Implementation Science 2011, 6:10(http://www.implementationscience.com/content/6/1/10) states that the aim of the model is to create "*a system that places no priority on an individual, group or environmental perspective – all have equal status in controlling behaviour*". In the context of this guideline, it is important to either move the emphasis away from that of "individuals" and thus capture the	Thank you for your comment. The guidance is a partial update of guidance on behaviour change published by NICE in 2007, which

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			design and evaluation process associated with target sub-groups OR re-visit the suggested use of this model. It seems unhelpful to use a guidance model that argues that individuality is problematic – but instead focuses on the more comprehensive systematic process. While the RCM considers the work on the development of this model is commendable, it is important to consider the further evidence outlined below.	deals also with community and population based intervention. This guidance will focus on updating and expanding recommendations around individual interventions, and choice architecture. The scope references Michie et al (2011) as one of several in recent years that have developed work around taxonomies of different intervention. This guidance will focus on individual level behaviour change techniques (BCTs) – and since there is a large number of BCTs, , a system of grouping these is required. There are 4 potential ways of groupings: looking at intervention functions (as in the behaviour change

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				wheel), research indicating how professionals categorise behaviour change techniques together, taking theories and looking at commonalities, or identifying which theories are associated with which behaviour change techniques, and grouping accordingly. As stated in 4.2.1 b) we will include "Behaviour-change techniques grouped according to the function of the intervention (see for example, Michie et al. 2011d) unless evidence suggests a better alternative."
The Royal College of Midwives	General		The scope needs to include evidence from the previous systematic application of the theoretical model called ARCS (by Keller 1986) that has been applied within health care . Developed by educational psychology and instructional systems academics at Florida State University, this model offers a macro-theory of motivation, volition and performance, a meta-synthesis of the	Thank you for your comment. Please note that the scope provides an overview of what we will and will not be covering in the guidance and is not

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			theories of human motivation and volition; a taxonomy of the key motivational and volitional characteristics of an instructional and motivationally designed programme, process questions, motivational measures of effectiveness (available open source), and a distinct interactive, action research process. The first application of this model to health care (*funded by Research and Development Northern Ireland Office*) has demonstrated its potential and value and could offer an alternative model for programme designers to consider.	intended to cover all specific interventions and theories. The committee will consider the available evidence on a range of different interventions.
The Royal College of Midwives	4.2.2		It is not clear why activities in relation to national policy will not be covered. It would also be useful to include activities relating to 'choice architecture' in the scope of this guideline.	Thank you for your comment. Currently NICE Public Health guidance does not make recommendations on national policy – however, we will be including choice architecture in this update.
The Royal College of Midwives	4.3		The RCM agrees with the key questions and outcomes in the draft.	Thank you for your comment.
Royal College of Nursing	General	general	The Royal College of Nursing welcomes proposals to develop this guidance. It is timely and appropriate.	Thank you for your comment.
Royal College of Nursing	General	general	The draft scope seems comprehensive	Thank you for your comment.
Royal College of Nursing	4.2.2	6	We wonder what is being recommended for behaviour change which falls	Thank you for your

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			outside the remit and this draft scope. Will this be covered elsewhere? Where and When? If it will not be covered elsewhere, it would be helpful to know why not?	comment. There is a wide range of NICE public health guidance both published and in development that deals with aspects of behaviour change in specific topic areas. Furthermore, the current guidance is a partial update of the NICE 2007 behaviour change guidance (http://guidance.nice.org.uk/PH6), which also covered community and population based intervention. We anticipate that, subject to topic selection and referral processes, this update will be the first in a new suite of guidance focusing on behaviour change.
Sustrans	General		Thank you for the opportunity to comment on this draft scope. It seems clear that if the tide is to be turned on the seemingly inexorable growth in lifestyle-related non-communicable diseases, our approach to behaviour change will	Thank you for your comment.

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			need to become much more effective.	
Sustrans	General		The scope contains a number of references to examples of behaviour change techniques. These all come from the 'good' side – approaches which seek to encourage healthy behaviours. We suggest that it might be valuable to consider the approaches taken in sectors such as computer games, junk food manufacture and retailing, motor industry etc: professionals in these sectors have often been very successful in promoting change towards unhealthy behaviours, and it might be possible to learn a lot from their strategies and techniques.	Thank you for your comment. We did attempt to access some of this evidence during the development of the original NICE behaviour change guidance published in 2007, however such data is often commercial and so not possible to obtain. Where possible, we will supplement the evidence reviews for this guidance with expert testimony in key areas.
Sustrans	General		It might be helpful to make it clearer in the scope, and later on in the guidance itself, that some effective behaviour change approaches, although they may have a positive impact on health-related behaviour, may be funded, delivered and evaluated by other sectors, such as transport. They may not set health-related objectives, and their monitoring and evaluation may overlook the health impacts: to identify these approaches and their outcomes it may be necessary proactively to investigate work in these other sectors.	Thank you for your comment – we recognise that many public health and health improving interventions may be delivered outside of a health setting. We expect that the transition of public health into local authorities currently underway will further strengthen the role that other sectors play in delivering health. No sector has been excluded from this scope – the committee will consider the

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				available evidence in relation to the outcomes in section 4.3 of the scope on a range of interventions delivered in different settings.
Sustrans	4.2.1	5	We note that currently, only *'health promotion and disease prevention interventions'* will be covered. We urge rewording this, along the lines of *'interventions, whether or not designed with overt and explicit health objectives, which have the effect of creating change towards health promoting and disease preventing behaviours'*.	Thank you for your comment- the 2007 guidance did consider interventions outside of health and the majority of the principles outlined in that guidance will remain unchanged – this guidance is a partial update of the 2007 guidance, aiming to develop new recommendations on individual interventions and for the most part the focus will be on health related interventions.
Sustrans	4.2.1	5	An example of the point above might be Personalised Travel Planning (PTP), previously delivered under the name TravelSmart. Wherever PTP and similar approaches have been used, they have led to changes in travel behaviour from sedentary to active modes, but individual local projects may still take place without targeting, measuring or reporting the impact on physical activity levels, because physical activity is not an objective of the (generally transport-focused) funder.	Thank you for your comment. Published evidence would need to provide details of outcomes described in section 4.3 and be within scope (i.e. not those areas detailed in 4.2.2).
Sustrans	4.2	5/6	We would like to sound a note of caution about the distinction between what will be covered – *'interventions changing an individual's … behaviour'* – and	Thank you for comment. Please see our response to your

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			what will not – *'community or population-level … interventions'*. Some very effective behaviour change techniques, while individual-focused in their implementation, are planned, managed and delivered at community level. So, again, PTP is typically delivered across a community, with the largest UK project to date targeting 50,000 households, although the point of engagement is at household level and, indeed, within the home. Could this distinction therefore be clarified, so that large-scale but individually focused approaches are not accidentally excluded?	comment on 4.2.1 above – this guidance is a partial update to the 2007 guidance, and is focusing on individual interventions and also on choice architecture. We anticipate that the current guidance will be helpful when read and used in conjunction with the original guidance, which deals with population and community level interventions. We anticipate that we will update and develop new guidance in these areas, subject to topic selection and referral processes, in the near future.
Sustrans	4.2.2.c	6	We note that joint approaches, combining individual-focused interventions with the community or population level (which we take to mean environmental or social change) will not be included. We suggest you might reconsider this, so that the final guidance can be free to describe the desirability of a multi-component approach where environmental and social changes support and are supported by individual-focused behaviour change techniques. Sustrans' view is that in our field – behaviour change from sedentary motorised transport to active travel – the greatest change is likely to result from an integrated package of interventions, including elements such as	Thank you for your comment. We recognise that behaviour change is most likely to occur and be sustained through a combination of population, community and individual-level interventions, and this guidance will now include interventions on 'choice architecture' in addition to individual approaches – please see our response to your comment above. Furthermore,.

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			improvements to walking and cycling infrastructure, communications programmes and changes to social culture, as well as individual-focused behaviour change actions.	a suite of guidance on behaviour change, including behaviour change at population and community level, will be the subject of future NICE public health guidance.
Sustrans	4.3	7/8	Subject to the comments above, we feel the questions and desired outcomes in section 4.3 are good. We look forward to benefiting from the final guidance.	Thank you for your comment – we look forward to receiving your feedback on the draft guidance in due course.