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# TARS Health Trainer Manual

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**T**rial of physical **A**ctivity assisted  
**R**eduction of **S**moking

# Health Trainer Manual

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# **TARS**

## **Health Trainer Manual**

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This manual incorporates adapted elements from the Department of Health *Health Trainer Handbook* with a narrowed focus on smoking and physical activity behaviours. It was developed following extensive testing and redrafting as part of the pilot trial (EARS) and benefits from learning acquired in adapting the Health Trainer role in other settings and for various populations, in particular the STRENGTHEN project.

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## Introduction to TARS

### TARS: **T**rial of physical **A**ctivity assisted **R**eduction of **S**moking

#### Background

TARS is a large multi-centred randomised controlled trial aiming to examine the impact of health trainer (HT) support to help people who do not wish to quit smoking to cut down and increase their physical activity (PA). It is concurrently taking place across four sites in the UK – Plymouth, Oxford, Nottingham, and South London. It is hoping to recruit 900 people in total, 450 of which will receive the HT intervention.

#### Rationale

Despite falling prevalence, smoking remains the main cause of preventable morbidity and premature death in England. It is estimated that the total cost to society of smoking in England is £13.9b, including £2b to the NHS. Tobacco control policies and individually targeted interventions have helped to reduce population smoking prevalence to about 17.0%. However, among those initially motivated to quit, after one year, only 4% of those attempting alone succeed. This increases to around 7% with NHS primary care support and around 15% with pharmacological and behavioural support in a NHS Stop Smoking Service (SSS) <sup>2</sup>.

***"Only 4% of people who attempt to quit alone will stay quit past one year"***

Existing guidelines <sup>3</sup> for smoking cessation focus on identifying a quit date and abrupt cessation. This is recommended with pharmacological and behavioural support because it has been believed that smokers cutting down prior to quitting may gain greater enjoyment from each cigarette and so find quitting even more difficult <sup>4</sup>.

Yet, large survey data in England show 50% of smokers claimed to be cutting down, of whom 63% were using no nicotine products or e-cigarettes <sup>5</sup>.

#### ***50% of people who smoke claim to be cutting down***

In a US survey interest in reduction in smoking was highest among those who were less interested in quitting and heavier smokers <sup>6</sup>. Also, smokers who do not intend to quit in the next month, but who cut down with the use of nicotine replacement therapy (NRT), are more likely to make a quit attempt and be abstinent at a later date <sup>7</sup>.

#### ***People who don't want to quit, but cut down, are more likely to go on to quit***

More recent guidance includes options for smokers who do not immediately wish to quit smoking, by using behavioural strategies with licensed nicotine-containing products (LNCPs). However, there is still a need for further research to identify effective behavioural approaches for smoking reduction, which may increase quit attempts.

There has been a rapid increase in the use of e-cigarettes over recent years, with some low grade evidence that e-cigarette use may lead to smoking cessation and reduction <sup>8</sup>. However, data from recent surveys suggest that the effects may be influenced by how and what kind of e-cigarettes are used. Only

daily use of 'tank' e-cigarettes may have any positive effect on quitting smoking.

***E-cigarettes can help people quit, but the type and how they are used are important***

E-cigarettes are not (at time of writing) part of standard guidance to help people reduce their smoking, but guidance does recommend the use of LNCPs (e-cigarettes are not 'licensed', therefore do not fall into the category of LNCPs or NRT). However, as an interesting aside, there is one licensed electronic cigarette owned by British American Tobacco.

**Why reduction programmes may work**

Cigarette smoking occurs as a result of a relationship between reinforced environmental cues and elevated internal cravings and urges to smoke. A reduction in smoking may disrupt these relationships so that cues are less likely to trigger an urge to smoke <sup>9</sup> and can be achieved by structured scheduling of smoking.

***Reducing smoking may disrupt habits making cues to smoke easier to resist***

This may involve having specific sequential goals for either reducing cigarettes per day or reducing smoking periods. Other mechanisms involve the following:

- 1) Increasing the length of time between cigarettes or decreasing the number of cigarettes smoked may reflect steps in moving from the identity of a heavy or moderate smoker to that of a light then non-smoker. Identity shifts are important in smoking cessation;

- 2) Increasingly longer periods between smoking a cigarette and smoking fewer cigarettes may progressively raise confidence to abstain, which may generate intentions to actually quit and reduce the risk of relapse;
- 3) A lower drug intake might reduce drug dependence increasing the ability to abstain completely.

**Use of reduction approaches & perceptions about smoking reduction**

Since the pilot trial (EARS) in 2011/12 <sup>10</sup>, the prevalence of use of any nicotine product has increased from just under 20% to about 30% in late 2015 <sup>11</sup>. Increases were mostly related to shifts in use of e-cigarettes (which were used less frequently by lower socio-economic groups). While use of e-cigarettes may be levelling off, there is a fear among a significant proportion that the use of e-cigarettes does not remove the risks to health from smoking <sup>12-14</sup>; though there is no evidence that such products carry anywhere near the health risks of tobacco smoking at present, at least in the short term <sup>8,15,16</sup>.

***A large number of smokers (60-70%) believe e-cigarettes are as, if not more, harmful than cigarettes***

There is evidence that without a clear reduction programme LNCPs can maintain an addiction by providing similar doses of nicotine as a cigarette, with similar reductions in withdrawal symptoms and urges to smoke, and satisfying experience <sup>18</sup>. Moreover, dual use of combustible cigarettes and electronic cigarettes or LNCPs is increasingly common but there is evidence that this dual use does not reduce

levels of carcinogens relative to smoking only combustible cigarettes <sup>16</sup>. There is also evidence that smokers typically underuse such products, which may limit their potential to promote smoking cessation <sup>5</sup>.

*Around 30-35% of smokers use an e-cigarette to help a quit attempt*

### Physical activity (PA) as an aid to smoking reduction & cessation

Evidence suggests that increasing exercise as an adjunct to standard stop smoking cessation programmes may have long term benefits on quitting. In the present context there may be two types of processes involved in how increases in PA influences smoking reduction and cessation, namely implicit and explicit ones.

### *Physical activity helps through IMPLICIT and EXPLICIT processes*

Implicit processes may be involved particularly if the focus is on increasing PA, rather than smoking reduction. For example, increasing PA may enhance mood and reduce stress, which reduces the urge to smoke. Explicit processes may be involved if the focus is on how best to cut down smoking, or support a quit attempt, specifically using PA. For example, exercise sessions (e.g., aerobic exercise) could help to manage cravings and withdrawal symptoms or weight management.

Theoretically, increasing PA may help reduction of smoking in several ways:

- 1) Evidence has shown a consistent reduction in urges to smoke and withdrawal symptoms, during and following exercise (for up to 30 minutes) compared with being

passive. Encouragingly, findings suggest relatively convenient forms of PA (e.g. 10 to 15 minutes of brisk walking) can be effective, particularly at a time when cravings are moderate to high, following a period of abstinence.

### *Moderate PA, such as a brisk 10 minute walk, can be effective in reducing cravings*

- 2) PA also appears to reduce reactivity to smoking cues, which have been shown to predict lapses and relapse during a quit attempt, and delays/extends the time until the next cigarette <sup>19</sup>.
- 3) PA may have neurobiological effects as suggested by functional Magnetic Resonance Imaging (brain scanning) <sup>20</sup>, and decreases in salience (shown by reduced attentional bias, using eye tracking technology) of smoking related stimuli <sup>21</sup>. In parallel work, animal research consistently suggests that exercise acutely reduces self-administered addictive substances through neurobiological processes <sup>22</sup>.
- 4) Increasing PA while cutting down (then quitting) may reduce weight gain. In prospective population surveys and trials weight gain and fear of weight gain is associated with reluctance to quit smoking and remain abstinent, especially among women and initially heavier smokers <sup>23-25</sup>, with an average of 7kg gained within a year of quitting <sup>26</sup> [41].

Increasing PA has been suggested as a useful strategy to prevent weight gain <sup>27</sup>, not only by increased energy expenditure, and metabolic rate, but also through self-regulation of energy intake, particularly emotional snacking <sup>28</sup> in response to withdrawal symptoms such as depression and anxiety <sup>29,30</sup>.

***Weight gain is a common barrier to quitting, PA can help overcome this***

- 5) As a result of increasing PA a smoker may begin to establish a different identity (eg, investing in personal fitness and improved respiratory function, and generally becoming a “healthy person”), which in turn may trigger a desire to reduce harm from smoking through reduction and ultimately quitting.
- 6) PA may be used as a deliberate strategy to reduce and distract from cravings. As acute cravings can often be short-lived, completing some PA is often a good strategy for getting through ‘difficult moments’.
- 7) PA as a prompt to notice poor fitness. Exerting yourself as a smoker can cause coughing and breathlessness. This can help to illustrate the negative effects of smoking on your physical wellbeing and trigger motivations towards change.

**The findings from the pilot trial (Exercise Assisted Reduction then Stop)**

The pilot trial, EARS, randomised 99 smokers, who wished to reduce smoking but not quit, to receive advice on smoking reduction/cessation (control) or client-centred behavioural support (by phone or face-to-face) for smoking reduction and increasing PA (The EARS intervention). Exploratory analysis <sup>35</sup> revealed the intervention group, compared with control, were significantly more likely to achieve at least 50% reduction in number of cigarettes smoked (39% vs 20%), to attempt to quit (22% v 6%), be abstinent up to 8 weeks after quit day (14% vs 4%), and be abstinent at 16 weeks (10% vs 4%).

***In the pilot trial, nearly ¼ of participants receiving the HT intervention made a quit attempt despite not wanting to at the beginning***

A higher proportion of the intervention group compared to the control group also reported using PA for controlling smoking: 55% vs 22% and 37% vs 16%, at 8 and 16 weeks, respectively. Delivery of the intervention was regarded by both providers and recipients as feasible and acceptable, with the focus on reduction rather than cessation being a particularly valued aspect, and important for trial recruitment <sup>36</sup>.

***In the pilot trial, the message and focus on reduction, NOT cessation, was highly valued***

The participants used a variety of behavioural smoking reduction strategies, sometimes supported with changes in PA, to control cravings. The study also provided valuable information about trial recruitment,

retention and intervention engagement and fidelity<sup>37</sup>.

### Why the research is needed now

Smoking cessation results in a wide range of health benefits, and reduces preventable health care costs. For those who do not immediately wish to quit, there is some evidence almost exclusively from pharmacological trials that smoking reduction approaches can lead not only to lower consumption of tobacco but also more attempts to quit smoking. The National Institute of Healthcare and Clinical Excellence (NICE) have identified an urgent need for more evidence for the effectiveness and cost-effectiveness of behavioural interventions (with and without pharmacological support) for smoking reduction, cessation induction and long-term cessation, for those wishing to reduce smoking but not quit.

*The National Institute of Healthcare and Clinical Excellence has outlined an urgent need for ways to support people who don't want to quit which will lead to more people quitting smoking*

Given that PA interventions can reduce weight gain after smoking cessation, increase smoking cessation, and possibly support smoking reduction and induce quit attempts and cessation among those not initially ready to quit there is a strong need to confirm the latter finding through the TARS trial. The value of the proposed intervention may be considerable as new ways are sought to improve multiple health behaviour change<sup>38</sup>. While smoking reduction and quitting is the primary focus of the proposed intervention, an intervention

that also increases health enhancing PA is likely to have additional physical and mental health benefits, especially since smokers tend to be less physically active. PA enhances mood and behavioural interventions with mood management components can increase long-term quit rates.

*Quitting is the primary end goal, but reduction is the pervading message of TARS. Quitting may never get talked about, unless the client feels confident to*

In summary, there is an urgent need for research involving behavioural and pharmacological approaches to reduce smoking among those not immediately ready to quit. This is what TARS is designed for.



## Components of the TARS intervention

The TARS intervention consists of several components, some practical and some theoretical, which fit together to form the TARS intervention. This is a brief summary of the elements to provide an overview of how they fit together, which are then explored in detail in the rest of the manual.

### The Health Trainer

#### *The original Department of Health Health Trainer*

The role of the HT was originally outlined in 2004 in a government white paper called *Choosing Health: Making Healthy choices easier*<sup>1</sup> which aimed to address issues relating to health inequality. The role of the HT was designed around the ethos of 'support from next door', where people from similar backgrounds and experiences to those they would be supporting would be trained to provide client centred motivational support to empower people who typically have little contact with traditional services to make changes in four health behaviours: PA, alcohol consumption, smoking, and diet. These four health behaviours have large impacts on public health, and tend to be more prevalent among low socioeconomic and disadvantaged groups<sup>38</sup>.

Working on a one to one basis with clients over multiple sessions, HTs would help people decide which one (or more) of the behaviours they wished to address and employ established/evidence based behaviour change techniques to support

people in making lasting change in the desired areas.

#### *The TARS Health Trainer*

The TARS handbook focuses more specifically on smoking reduction and increasing PA. It introduces similar approaches and key techniques that can help people decide whether, and what, they would like to change and how to do this. These techniques (referred to as the TARS 'Core Competencies') include:

1. Active participant involvement
2. Motivation building
3. Setting goals and discussing strategies for change
4. Reviewing efforts to change and problem solving
5. Managing social influences
6. Making the link between PA and smoking behaviour
7. Reinforcing identity shifts
8. Referring to specialist support

The role of the HT encompasses much more than advice, support, and signposting. It involves training people in skills to actively set their own behavioural goals and manage their own behaviour.

Building on the original HT competencies and techniques, the TARS HT role focuses on PA and smoking reduction (potentially leading to cessation) in equal measures, with emphasis on developing an understanding of how the two behaviours influence one another, particularly how PA can be an effective strategy for reducing smoking.

*The TARS HT focusses on physical activity and smoking behaviour in equal measures, and how the two behaviours influence each other*

Whilst discussions around other behaviors may be necessary to facilitate changes in these two behaviours, the primary targets for change are smoking *and* PA.

The worksheets from the original HT Handbook are adapted and incorporated in this manual to provide tools for working with clients if appropriate, however their use is not mandatory.

### Motivational Interviewing

The client centred approach of the HT is further enhanced by drawing on several principles and techniques drawn from something known as 'Motivational Interviewing' (MI). MI is an approach for how to 'be' as a practitioner, facilitator, or source of support when working with a client. It has been chosen for use in TARS as it is a client-centred style of interaction that promotes autonomy. It acknowledges the role of the client in making choices /being in **C**ontrol of whether to make a change and how to go about it.

***Motivational Interviewing is a way to 'be' as a practitioner, and the TARS HT draws on these principles***

Originally developed as a way to initiate difficult discussions about alcohol intake, MI has been widely shown to be an effective approach to support people to achieve behaviour change. The original HT role drew from some aspects of MI, however for this project (recognising the complex nature of addressing multiple behaviours), MI principles and techniques play a much larger role. MI fits well with SDT (the 3Cs) through providing a non-judgemental and supportive approach – the practitioner should 'come alongside' the client and guide, not tell, them to making decisions. The key principles of MI which permeate the TARS HT role are:

- **Express empathy**

- **Support self-efficacy (Competence)**
- **Roll with resistance**
- **Develop discrepancy**

People can lack motivation to change a behaviour because they either do not feel **CONFIDENT** that they can change, or that it is not **IMPORTANT** that they change at that moment in time.

***"People need a sense of CONFIDENCE and IMPORTANCE over changing a behaviour if change is to happen"***

Participants will likely see reducing or stopping smoking as important, but will often lack confidence (perhaps due to previous failed attempts).

The opposite is sometimes true of PA, where people believe they are relatively confident they could change, but they do not feel it is important.

Feeling comfortable in being able to assess someone's motivation in terms of importance and confidence, and support them to increase the importance and their confidence to change is fundamental for creating effective behaviour change.

Motivational interviewing is designed to help you do just this – assess, explore, and increase people's perceived importance and confidence for changing behaviour.

### Self Determination Theory

Interventions which are based on psychological theories of behaviour are shown to be more effective than those which are not. Self Determination Theory (SDT)<sup>39</sup> is a theory of behaviour which examines why people adopt unhealthy behaviours and provides an understanding

of what can be done to promote lasting behaviour change. It is this theory that the TARS intervention is based on. A part of SDT, known as 'basic needs theory' suggests that people have three fundamental needs which sustain behaviour:

1. To feel a sense of AUTONOMY or **C**ONTROL. People like to have to have a sense of control over their lives and to have a choice over what they do.
2. To feel **C**OMPETENT/confident. People like to feel like they are good at doing something and feel a sense of accomplishment.
3. To feel RELATED or a sense of **C**ONNECTEDNESS. Individuals need to feel a sense of being connected to other people and that their actions are approved of/accepted by others. This can also involve feeling connected to an environment or group identity (e.g. being a fan of a particular TV programme of football team). Although many people underestimate its importance, social approval is an extremely powerful motivator.

These aspects of SDT should underpin discussions about motivation to change, setting targets for change, interactions, and action-planning. In delivering TARS, all changes and behaviours should be focused on supporting these three needs, and in no way should conflict with an individual's

existing sense of their own control, competence, or connectedness (the '3Cs'). These ideas remain 'behind the scenes' from the point of view of the client, but should be at the forefront of the HT's thought processes and actions.

***All goals and changes should promote a sense of CONTROL, COMPETENCE, and CONNECTEDNESS for the participant***

When the 3Cs are met there is often a greater sense of wellbeing, which in turn can reduce the need to self-medicate with smoking, alcohol, or snacking.

**Piecing it together – Logic Model of how it works**

How the intervention works for each participant will be very individual, and the focus may change back and forth throughout the intervention. The diagram below illustrates how the intended processes, techniques, and competencies of the TARS HT are designed to fit together in a logical and progressive way.



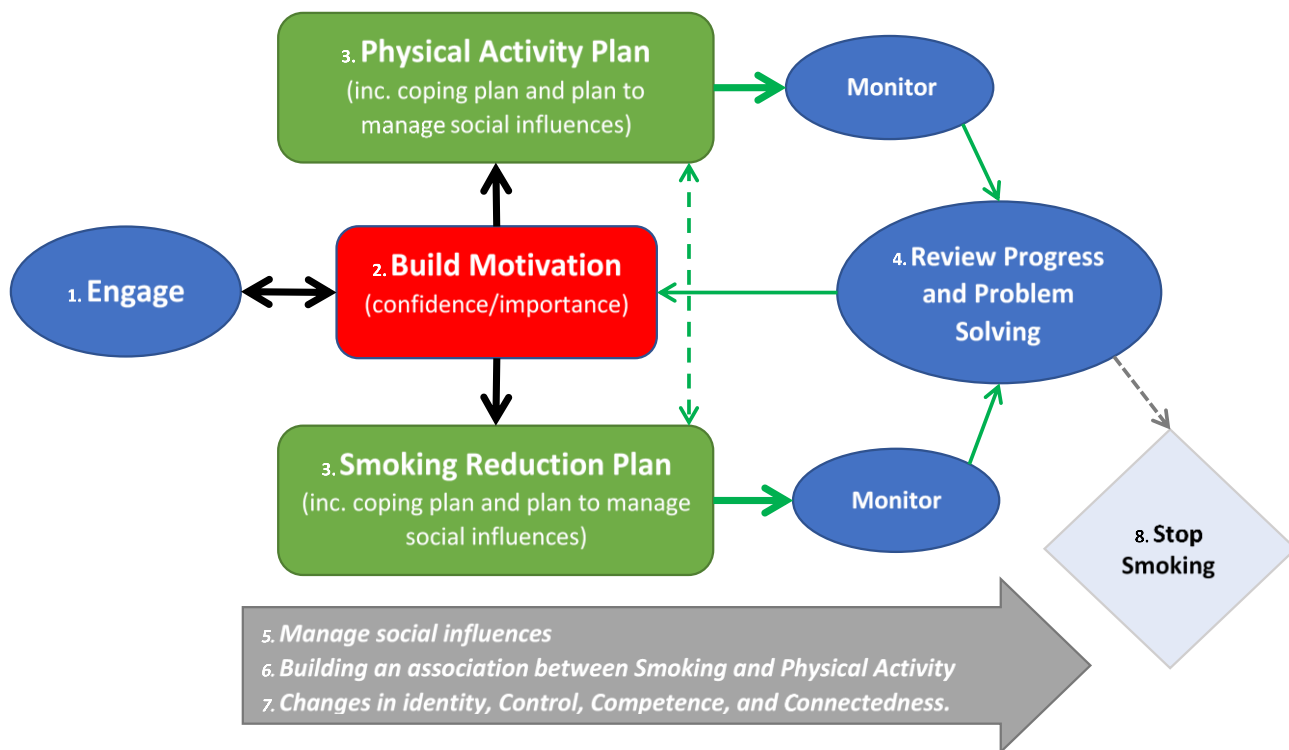


Figure 1 Logic Model/Diagram of intervention process

1. Active participant involvement
2. Motivation building
3. Set goals, and discuss strategies for change
4. Review efforts to change/problem solving
5. Manage social influences
6. Integration of concepts
7. Identify and reinforce identity shifts
8. Referral to specialist support

## Delivering the TARS Intervention

The intervention aims to support participants to make lasting change to their smoking and PA behaviour. It is client centred in that the goals and behaviours are decided by the participant and not dictated by the HT. The HT supports and guides the individual to making appropriate choices and, where appropriate, provides advice and guidance on the best ways to achieve their intended goals. It is important that you, as a HT, recognise your own limitations within the role of a HT, and act as a conduit to signpost and link the participant to other services which can provide support outside of your skill set should the issue arise (e.g. illicit substance use, trauma counselling, housing and monetary advice).

This manual provides a framework for how to achieve these aims, as well as defining where the HT support should end and when signposting and referring to other support may be more appropriate.

### Delivery Style

The style of delivery should be supportive and nurturing: empowering the individual to make decisions about their smoking and PA behaviours, fostering intrinsic (as opposed to extrinsic) motivation which is known to produce longer lasting behaviour change. The style is guiding (based around asking strategic questions and making strategic 'reflective statements' to guide the conversation along positive lines) rather than didactic and you should never find yourself telling the participant what to do – nobody likes to be told what to do!

*The participant makes the decisions, you should never find yourself TELLING the participant what to do*

Offering advice, with permission, is perfectly acceptable (as discussed later), but the participant should always remain in control of the direction and topic of the interaction (with certain caveats as discussed in the later sections 'Staying on topic' and 'Difficult conversations'). Although we are not offering a crisis service, it is likely that some clients' lifestyles will be chaotic and challenging and that they may present with situations that are not relevant to their current TARS goals but are important to them. In building and maintaining trust, it is essential that such issues are acknowledged and validated as important to the individual whilst bringing them back to the focus of the session. This is a fine balancing act for the HT. A good session will typically involve the client doing most of the talking.

MI encourages the practitioner to look at everything through "strength lenses" as opposed to "weakness lenses", focusing on the good, positive, and empowering aspects of any given situation. Approaching everything with your "strength lenses" on is an important aspect of MI.

*Everything should be viewed through 'Strength Lenses': always seeing the good, positive, and empowering aspects of any situation*

### Motivational Interviewing principles

Motivational interviewing is based on a set of four principles which should be followed at all times as much as possible<sup>40</sup>. The four principles are:

### *Express empathy*

Empathy (not sympathy) involves seeing the world through the client's eyes – thinking about things the way the client thinks about things, feeling about things the way the client feels, and sharing in an understanding of the client's experiences. Expressing empathy shows the client you understand the challenges they face, and when an individual feels understood they are more likely to open up about their true feelings and experiences of things. Importantly, when a client perceives empathy and understanding on the part of the practitioner, they will be more accepting of gentle challenges put to them, and less likely to become defensive. In order to express empathy, it is very important to take time to listen to clients and ensure that you understand what they are telling you about their experience.

### *Expressing empathy and seeing the world through the participant's eyes with a shared understanding makes for a much more productive practitioner-participant relationship*

Demonstrating empathy also assists in the development of a good relationship and building rapport where the participant feels comfortable with you as a practitioner. The participants are likely to have had long experiences of feeling 'judged' and being told what they should or shouldn't do ("smoking is bad for you", "you shouldn't smoke"), so by developing a real sense of empathy and adopting a non-judgemental approach with unconditional positive regard towards the client you will develop and maintain a trusting relationship from which change can be achieved.

### *Support self-efficacy*

A client's belief that change is possible is an important motivator in making a change. Self-efficacy can be understood as a client's

sense of personal mastery of a behaviour or their confidence to achieve it. It is very closely related to the idea of "Competence" from SDT (with many people considering it to be the same thing). For example, a client who regularly attends a local gym to use the weight machines could be expected to be high in self-efficacy for using those machines. However, a client who has never stepped foot into a gym is likely to have low self-efficacy for using such machines. Within MI, clients are responsible for choosing and carrying out the actions and changes they identify, and it is the practitioner's role to help them stay motivated – supporting self-efficacy is a great way to do this. It can be useful to highlight that there is no 'right' way to change, and that failure and setbacks are normal – change is never a smooth process, and clients are only limited by their own imagination as to the number of other plans they could try.

Identifying barriers and breaking them down (into easier steps) or finding possible solutions (problem-solving) are key methods for building self-efficacy to enhance motivation. Encouraging experimentation with initial small steps (e.g. building one ten-minute walk into your daily commute) can provide an experience of competence which leads to further progression (and an upwards spiral of achievement leading to increased confidence leading to further achievement). Exploring the clients past and times where they have been successful in making changes can also help to develop the belief they can be successful in making a change by highlighting skills and capacities they already have.

Providing vicarious experience (examples of other people's experience) can also increase a person's belief that they can achieve change. With permission (see 'elicit-provide-elicit' below) provide examples of how other people in similar situations to them have been successful in

making changes to demonstrate change is possible.

Ensuring clients set goals which they believe they can achieve is also important in promoting self-efficacy, and do not set themselves up for failure which may have a negative impact on self-efficacy. (See section on 'Goal Setting').

***Exploring past success, providing examples, setting realistic goals and highlighting there is no right' way to change can increase self-efficacy***

#### ***Roll with resistance***

An important principle of MI is not to fight client resistance to change, but instead to 'roll' with it to further explore and understand the client's views. Statements of resistance (e.g. *"There's no point in changing my smoking, other things are more important"*) are reflected on rather than challenged. The client's negative statement can be used as a basis to explore their reasons and beliefs around the statement (e.g. the facilitator might say *"you can't see any reason why reducing your smoking would be of any benefit for you"* or *"you are concerned that trying to stop smoking would have a negative effect on other things in your life"*). Challenging a statement will often lead to further escalation of the resistance – nobody likes to be told what to do or to be told that they are wrong! Using this approach of allowing the client to explore their resistance usually leads to a decrease in resistance as clients are not reinforced for becoming argumentative – it takes two to argue.

***It takes to two to argue – no one likes to be told what to do!***

There is no hierarchy in the client/practitioner relationship, and by exploring clients' concerns (through reflective statements like those above and

strategic questions to explore the situation further) the practitioner can guide the participant into examining new perspectives without imposing new ways of thinking.

#### ***Develop discrepancy***

Motivation for change occurs when an individual perceives a difference in where they are and where they want to be (or think they are). Discrepancy can be developed by guiding an individual to examine their current behaviour and how that relates to their future goals (or even to how they perceive their own behaviour). When clients realise their current behaviour does not match to how they perceive their behaviour or how it is leading them away from a positive future, motivation for change can increase. For example, a client may describe themselves as being physically active, but when encouraged to examine what they actually do (perhaps through a diary and pedometer) it may not be as much as they think it is, and therefore this is not leading them towards a broader future goal of being healthy – their current behaviour is incompatible with how they perceive themselves and what they would like to achieve longer term.

***Realising current behaviour is not compatible with how someone sees them self or how it is not getting them where they want to be can be a powerful motivator***

This can increase the importance (one domain of motivation – see 'Importance and confidence') for them to make a change. Exploring possible futures is a key technique here (e.g. *"what would life be like in 2 years' time if you had managed to cut down or even stop smoking? How would that be different if you were still smoking?"*). Developing discrepancy should not be

developed at the expense of the other principles, but should be gently encouraged to help client's see how their current behaviour may be leading them away from, rather than toward a positive vision of the future (something worth working towards) can be a key outcome of motivational interviewing.

### Motivational Interviewing techniques

To maintain the principles of MI, there are a number of 'micro-techniques' which should be applied to support the client centred, empathetic, understanding and trusting nature of the practitioner/client relationship. These are sometimes referred to using the acronym "O.A.R.S." (Open questions, Affirmation, Reflective listening and Summaries) and the techniques are outlined below.

#### Open questions

Open questions (as opposed to a closed question) are those which cannot usually be answered with a simple 'yes' or 'no'. It encourages the client to talk and begins the process of establishing a dialogue with the client rather than creating an interview type of environment (motivational 'interviewing' is often thought of as motivational *inter-viewing*, in that client and practitioner create a shared view of the topics discussed). Open questions are typically those containing 'what', 'why', 'where', 'when' and 'how'. It puts the impetus on the client to drive the conversation forward and encourages a sense of ownership within the client over the dialogue.

***Open questions promote a sense of ownership for the participant and encourages better dialogue***

A good example may be the first question you ask a client when meeting them for the first time, something along the lines of

*"What made you decide to take part in TARS?"*. It allows the client to reflect on the circumstances and thoughts which led them to attend the session, and will offer a chance to begin gaining understanding of why they are there and what may be important to them. Although, closed questions have their place and can be valuable at times, open questions should be favoured the majority of the time, particularly if the client is particularly quiet or not engaging. Open questions promote a dialogue which is not overpowered by the HT – it is acceptable (if not desirable) that at least 50% of the conversation comes from the client.

#### Affirmation

Affirmations can be powerful rapport builders. Different to praise, an affirmation encourages the client to reflect on and be proud of achievements for themselves, without seeking external validation. It is a reflection on any effort or talk that the client produces that supports (positive) behaviour change. An example might be when a client reports the changes they have made since the last session, despite difficulties, (e.g. reducing their smoking by half despite being faced with situations where they would usually smoke) and you as the HT, respond along the lines of *"You've cut your smoking in half, and managed to refrain from smoking in situations where it must have been very difficult, which shows you must have great self-control when faced with difficulties. How do you feel about that?"*. It is different from praise where the response may have been a simple *"Well done"* as it encourages the participant to focus on their own strengths, thus bolstering self-esteem.

***Affirming statements, rather than praising ones, can bolster self esteem***

This gives the client something to draw on when they are no longer being supported by you. Affirmations can also be powerfully



used when the client shows resistance, for example a client may say *"I really didn't want to be here today"*, a good affirmation would be *"You don't want to be here today, but you made it, I could be wrong, but it seems like if something is important enough to you, you will put yourself through a lot to achieve it"*. It creates a positive spin on something which on the face of it is quite negative – the "strength lenses" in full effect.

Other affirmations include commenting positively on an attribute: *"You're a strong person, a survivor"*. A statement of appreciation: *"I appreciate your openness and honesty"*. A compliment: *"I like the way you described that"*. An expression of hope, caring, or support: *"I hope the meeting goes well for you"*. Another important type of affirmation is to acknowledge the client's autonomy: *"I am not here to tell you what to do"*; *"you are the person who will decide what to do at the end of the day"*, *"I am more interested to know what you think about this"*.

### Reflection

Reflection is the most important aspect of active listening, and is usually the most commonly used MI technique. You will listen carefully to what the client is telling you, and occasionally reflect back to them what they have said to show you are listening and understand what they are saying. The focus of reflection within MI is predominantly on reinforcing or eliciting 'change talk' rather than 'sustain talk' – 'change talk' refers to dialogue around wanting to change, the negatives of current behaviour, or the positives or making a change, and 'sustain talk' refers to dialogue about the barriers to changing, the benefits of staying the same, or the negatives of changing.

**Reflections should focus on 'change talk' to help understand motivations for change**

An example would be: *"I want to cut down my smoking because it is causing me problems [change talk] but it is difficult because all my friends smoke [sustain talk]*. In this example, you would reflect back the 'change talk': *"reducing your smoking is important to you"* rather than the 'sustain talk', *"it would be hard because all your friends smoke"*. Acknowledging barriers is important to help identify ways to overcome them, but embellishing them too much can create resistance. When reflecting on barriers, it is always important to explore these with a view to eliciting possible solutions. In this instance, double-sided reflection (below) can be used effectively.

There are different types of reflection which can be used in powerful ways.

**Simple reflection** – a simple repetition or rephrasing of what the client has said, to show you have heard the client. Particularly useful when facing resistance as it shows you are not there to argue with them, and prevents further resistance:

**CLIENT:** I can't quit smoking, it's just too difficult, I mean all my friends smoke.

**HT:** Quitting smoking seems nearly impossible for you at the moment because you spend so much time with others who smoke.

**CLIENT:** Yes, that's right, but I would like to try.

**Amplified reflection** – Similar to simple reflection, but you reflect by amplifying or exaggerating what the client has said to the point where the client may disagree in order to encourage the client to reflect on what they have said:

CLIENT: I can't quit smoking, it's just too difficult, I mean all my friends smoke.

HT: I see. So you couldn't quit smoking because you feel you'd be too different from your friends and no longer fit in.

CLIENT: Well, it would make me different from them, but they might not really care as long as I didn't try and stop them smoking as well!

With amplified reflection it is important not to exaggerate too much and make the client feel like they are being mocked or made fun of.

**Double-sided reflection** – this reflects both the initial resistant 'sustain talk', but finishes by focusing on the 'change talk', in such a way it encourages the individual to focus on the change talk rather than the 'sustain talk':

CLIENT: But I can't quit smoking, it's just too difficult, I mean all my friends smoke.

HT: You can't imagine how you could not smoke when you're around your friends, and at the same time you're worried about how it's affecting you.

CLIENT: Yes, I guess I have mixed feelings, but I am concerned.

Double-sided reflections should always finish by reflecting the 'change talk' of the client. There is a natural tendency to follow on from what was last said and this will promote further change talk and keep the dialogue solution focused.

### *Summarising*

Summarising is really just a specialised form of reflective listening, where you summarise what the client has been saying to you after a period of dialogue. Summaries are an effective way to communicate your understanding of the client's situation, thoughts, and feelings, demonstrating a real interest in them and helping to develop rapport. The summaries should mainly focus on the 'change talk' and you should summarise with your 'strength lenses' on, particularly highlighting any ambivalence/discrepancy. You should summarise the salient (important) and relevant aspects of the interaction which will guide where the conversation goes next. For example, if the client has spent a good amount of time talking about things off-topic, only summarise the things relevant to the intervention aims which will guide the conversation where you want it to go next. Summaries can also be used to close out conversations and move on to other topics.

*Summaries help build rapport, emphasise 'change talk', and can be used to get conversations back on track*

Summaries can help the discussion stay on topic, by not summarising any 'off topic' conversation and focusing on the things relating to the target behaviours.

A key use of summaries is towards the end of a conversation exploring motivation. You can produce a 'grand summary' of the key things the client has said about what benefits there might be from changing (importance of change), what barriers there might be and how these might be reduced (confidence for change) and then offering it back to the client with a "Turning Point" question – e.g. "so where does that leave you?"; "weighing all that up, what do you think you will do?". This is a good way to

'funnel' the client towards making a decision about whether to change or not.

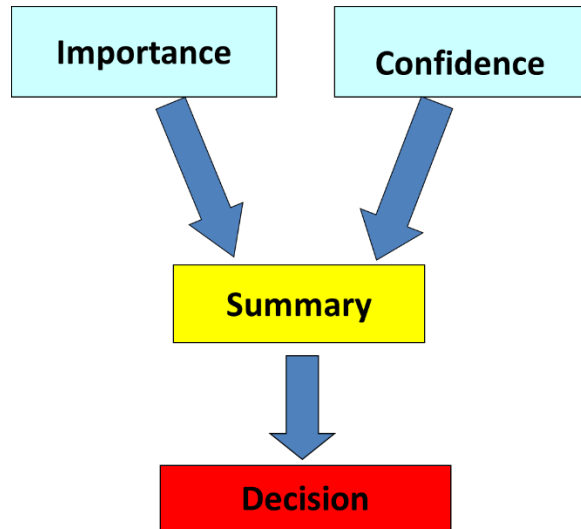


Figure 2 "Funnelling" towards a decision

### Shifting focus

A good way to reduce resistance is to simply shift the focus away from the resistant statement. It can sometimes be counterproductive to directly address resistant statements, and your goals may be better achieved by simply not responding to the resistant statement:

**CLIENT:** I can't quit smoking, it's just too difficult, I mean all my friends smoke.

**HT:** I think we're getting a bit ahead of things here. Let's not talk about quitting smoking here, there may be other options, and I don't think you should get too concerned with that right now. If we can just stay with where we are, and carry on talking through the issues, and later we can worry about what, if anything, you would like to do about your smoking.

**CLIENT:** OK, that's good.

This can be useful when you sense a client is particularly resistant as you are not confronting the resistance but rolling with it, and making it clear there is no judgement or pressure from you as the practitioner that they should be changing their behaviour.

### Reframing

This is an approach where you encourage the client to view things from a new perspective or different angle – almost encourage them to put their own 'strength lenses' on. For example, it is likely participants have had long experiences of people telling them what to do, and utterances such as "*she's such a nag*" or "*he's always on my case about it*", which you could reframe as "*this person must really care a lot about you to tell you something they feel is important for you, even though they know you will likely get angry with them*".

### Elicit-provide-elicite (ask-tell-discuss)

This is a simple technique which should be employed when you feel some advice or guidance could be beneficial (e.g. if the client is really struggling to develop ideas). It can be useful to present a 'menu' of options to see which one the participant thinks may be most useful to them. In order to keep the control of the dialogue on the client, you should ask the client's 'permission' to offer some advice or examples, and then find out what they think about it:

**HT:** Would it be ok if I told you what has worked for other people in similar situations, and what they have found useful? [elicit]

**CLIENT:** Yeah, sure.

**HT:** I worked with somebody a few weeks ago, in a very similar situation to yourself, who had similar concerns about their



smoking. They came up with the idea that to cut down, they wouldn't smoke at certain times of the day, say between 10am and 2pm, and then between 3pm and 8pm. They actually managed to cut down their smoking by half this way after a few days [provide]. How would you feel about that? [elicit]

CLIENT: I could try something like that, maybe with different times though.

### *Asking permission to provide information and then seeing what the participant thinks leaves them in control*

By doing this the client is not threatened and you are not telling them what to do, but offering ideas with their permission. It often provokes a response which can then be further explored as to what would make it difficult to achieve this change, and help drive a better understanding of the client's situation.

### **The stages of MI**

MI has several stages which lead to the end point of goal setting. The most important of these is undoubtedly the first (engaging), which builds rapport and establishes trust. Without this, it is unlikely anything meaningful will be achieved. The stages are not necessarily linear, and consultation will go back and forth between stages repeatedly, but a consultation always begins with engaging – if somebody is not engaged you cannot effectively move forwards.

**ENGAGING:** Shall we walk together?

**FOCUSSING:** Where shall we go?

**EVOKING:** Why are we going there?

**PLANNING:** How are we going to get there?

### *Engaging*

Engaging with a client and building a good relationship is fundamental to a successful intervention and the participant returning for multiple sessions. Building trust and rapport is particularly important with participants who are likely to be sceptical of 'services' and 'professionals' who in the past may have made them feel judged and less worthy because they smoke and that they should quit. Using open questions, affirmations, reflection, and summaries (OARS) is the perfect way to achieve this. It is not unreasonable to expect to spend at least half the first session 'engaging' with the participant.

Good questions to ask yourself to understand whether you're engaging with someone are:

- How comfortable are we? Does the interaction feel relaxed and personal?
- Do I understand this person's perspectives and concerns?
- Does this feel like a collaborative partnership?
- Am I able to settle down, free of distraction and temptation to do anything but engage?

We as practitioners and human beings have a natural tendency to want to right things – the 'righting reflex' – and as soon as possible begin setting goals and putting plans in place to make changes. This reflex needs to be put aside to effectively engage with someone.

### **Focusing**

After a period of engaging using reflection and summarising to guide the conversation, there will have been several 'bites' where discussion involved topics relevant to the aims of the study. Focussing involves directing the conversation towards these salient issues and identifying what the client wants to change, and that you are both focussed on the same thing. Good questions to ask yourself to see if you are focussing correctly are:

- Are the goals for change clear and agreed from both sides?
- Do I have different aspirations for change for this person?
- Do I have a clear sense of where we are going? Does the other person?
- Why are we talking about x, and not y?

If the client is on a journey, and you are the one holding the map, it is crucial you both have a clear understanding of where the client wants to go.

### **Evoking**

Evoking involves establishing the reasons the participant wants to change, and ensuring that the motivation for change is being fostered from within the participant, and not coming from you, the practitioner. Good questions to ask yourself to check you are evoking correctly are:

- What are this person's own reasons for wanting change?
- What change talk am I hearing and responding to?
- Is the 'righting reflex' pulling me to be the one arguing for change?

If you feel the motivation for change is not strongly rooted in the individual, return to engaging or focusing to better understand and foster intrinsic motivation.

### **Planning**

Planning is the final stage where the participant makes plans for how they are going to make the changes they want to achieve. It is based on action planning techniques described later on in this manual. Good questions to ask yourself to see if you are supporting planning effectively would be:

- What would be a reasonable next step toward change?
- What would really help this person to move forward and succeed?
- Do I fully understand the challenges and opportunities this person faces?

If you don't feel you understand well enough what the participant needs in order to progress, return to engaging/focusing/evoking.

### **Difficult conversations**

There will be times when the client reveals things which are off topic, and highly emotive (such as feelings of grief, or disclosure of highly distressing events). You as a HT are not trained to deal with such deep issues and should not attempt to explore these in depth. An important thing to remember is that ***you can do no harm by listening***. When a client begins talking about a highly emotive subject, cutting them off will likely shut down the relationship. Simply listen, use simple reflection and they will talk through the issue. When they reach a point where the topic feels nearly exhausted, take a moment to considerately highlight how you are not trained to deal with such issues, you are only trained to help with issues relating the smoking and physical activity behaviours, however you can support them in accessing more specialised help and support if this is something they would like you to do. This would act as 'signposting' which is within

## Delivering the TARS Intervention

the scope of the HT role, it just needs to be handled delicately at times in order to maintain the relationship you have established and ensure the client feels you do have their best interests at heart. Nearly all of the time, the client will appreciate your honesty in saying you are not trained to support them with that particular issue, and will respect you and trust you for knowing your own limitations and guiding them towards appropriate support.

There may also be times where the client reveals things to you for which you may need to break confidentiality (e.g. expressing intentions of self-harm/suicide, revealing acts or intentions relating to terrorism). If this happens, you should inform the client that you have concerns and should stop the session. You should inform them that you are obligated to inform the local Principal Investigator to ensure their and other people's safety. The Principal Investigator should be informed immediately following the session and appropriate action taken, recording all information that was disclosed and shared.

## Targets for change

There are some examples of targets for change relating to PA, smoking reduction, and both linked together which may be a helpful reference to think about when working with clients in Figure 3 below.

These are considered the key targets for change, and should be covered as important topics for all participants. Keep these targets in mind when working through the following sections on behaviour change skills, imagining how the skills could be applied to one or more of these targets for change.



Figure 3 Targets for change: Orange = Smoking, Blue = PA, Green = BOTH

## Basic behaviour change techniques

### Weighing up the pros and cons

*(adapted from the DoH HT Handbook)*

In the pilot trial, participants' main motivation for taking part was to reduce their smoking behaviour. This meant PA took a 'back seat' and was not addressed in as much depth as smoking behaviour. We expect similar in TARS, so to address this PA should be discussed as much as smoking.

One way of helping the client to become more certain about trying to change is to do a cost-benefit analysis. This involves the client working out the costs (cons) and benefits (pros) of not changing their behaviour, and also the costs (cons) and benefits (pros) of changing their behaviour (MI: developing discrepancy). Again, it is important that you don't just tell the client what the advantages and disadvantages might be, this is something that they need to work out for themselves to maintain a sense of control (one of the 3Cs) over the direction of the session. Just telling them or asking them to agree with you does not motivate the client to change and may even be demotivating, remember the principles of MI that you are working *with* the client, not telling them what to do.

Particular emphasis should be put on discussing the *pros* of becoming more **physically active** and the *cons* of staying the same.

Explore, with the client's permission (elicit-provide-elicite), whether they would find writing out the pros and cons of changing useful. If they think it would be useful, help the client to fill in, or fill out for them, the table on Balance Sheet 1 (appendix 1).

This will encourage them to think through the advantages and disadvantages of their behaviour change. If the client can think of more disadvantages than advantages, move on to Balance Sheet 2 (appendix 2) and discuss ways of reducing the disadvantages of behaviour change, and also the advantages and disadvantages of **not** changing their behaviour. Some clients may be surprised to be asked to list the advantages of a behaviour that is thought of as 'bad'; you could remind them that they wouldn't do the behaviour at all if there were absolutely no advantages in it for them.

By summarising this information, the risks involved in their behaviour are brought to the client's attention. See the Health Benefit Cards (appendix 3) for summaries of some of the risks involved in smoking and being physically inactive.

It is also important that the client has realistic expectations of what will happen if they change their behaviour. If a client has unrealistic expectations, they will be disappointed and might experience setbacks when the reality of changing their behaviour doesn't meet their expectations.

Bear in mind that, when weighing up the advantages and disadvantages of changing a behaviour, it's not just the number of these that are relevant. The importance of each advantage and disadvantage needs to be taken into account. The client may have come up with four disadvantages and 11 advantages, but if one of the disadvantages is extremely important to them, the disadvantage side may be equally weighted with the advantages.

Ask open-ended questions to gain more information from the client about their responses.



Ask the client to think about what their life would be like if they didn't change and if they did change. Reinforce the disadvantages of not changing and the advantages of changing.

Utilising MI principles through this process is important, particularly the focus on 'change talk'. This exercise will likely produce a lot of 'sustain talk', and it is therefore important for you as the practitioner, to skillfully reflect and reinforce the change talk using the strategies covered earlier in this manual.

### **Using the Physical Activity Diary and the Smoking Diary**

If a client is uncertain whether they want or need to change their behaviour, simply recording how much they smoke or are physically active every day may raise the client's awareness of their current behaviour. This can be an effective behaviour change technique in itself.

For example, clients who think they smoke 15 cigarettes a day, may be underestimating just how many they actually smoke because so much of their smoking behaviour has become autonomous and they do it without thinking.

A Physical Activity Diary and a Smoking Diary are provided in appendix 4 & 5. They are fairly simple and can easily be altered to help the client record the behaviour of their choice.

A combined smoking and PA diary are also provided in appendix 6.

These diaries can be reviewed in a similar way to the Behaviour Change Diary:

- Check if the client is using their diary. If not, what is making it difficult?  
Brainstorm solutions

- What can the diary tell you?
- What does the client think the diary can tell them about their behaviour?

### **Fridge magnets and pedometers**

We believe self-monitoring to be so important, you will have a fridge magnet and a pedometer (Figure 4) to give to each participant in the first session. The fridge magnet allows people to record their daily steps alongside how many cigarettes they smoke each day. You may need to explore the 'pros and cons' of using the pedometer and fridge magnet, and using them may become a goal in itself initially, using the following techniques to increase their motivation for using them.



Figure 4 Fridge Magnet and Pedometer

The pedometer and fridge magnet aim to help make the link between being physically active and smoking less, i.e. on days where they take more steps they may smoke less. Self-monitoring in this way will help reinforce this concept. If people are resistant to this idea, treating it like an 'experiment' to see what happens can reduce participants' resistance to trying it out.

NB: It is not always the case that people smoke less if they take more steps – some

people only smoke when they walk! Be wary of this if walking is the only time when a participant smokes.

### Importance and Confidence

Importance and confidence can be conceptualised as the two constructs which constitute motivation. We think they are so important we are assessing them at each assessment in the study for each health behaviour to see if they change as a result of receiving the HT support.

The relevance of having a high sense of confidence and importance is shown in Table 1 below.

		Confidence	
		LOW	HIGH
Importance	LOW	Change <b>LEAST</b> likely	Address <i>Importance</i>
	HIGH	Address <i>confidence</i>	Change <b>MOST</b> likely

Table 1 Relevance of IMPORTANCE and CONFIDENCE for change

Assessing importance and confidence could be applied to any of the targets for change in Figure 1. Particular attention should be paid to assessing and increasing participants' sense of importance and confidence over becoming more physically active.

A tool which is often used in MI is that of confidence and importance 'rulers'. When the participant gets to the point of revealing their hopes and ambitions it can be useful to ask them to rate both the importance and confidence for achieving it.

For example, the participant may say "*I would really like to quit smoking*", you might respond by asking "*On a scale of 1 to 10, 1 being not confident at all, and ten being extremely confident how confident are you that you could stop smoking?*". Whatever their response, try to use your 'strength lenses' and frame it a positive way, for example, if their response was a 3 out of 10, you could ask why they didn't score a 1 or a 2, which shows they must have some level of confidence. You then move on to what they think they need or could do to increase that number. Ways to increase this number are closely linked to using goal setting effectively, like making sure they feel their goals are realistic and achievable by breaking them down into smaller goals may help increase the score, as may changing the time frame (e.g. confidence to reduce smoking by 2 cigarettes a day compared to 15 cigarettes a day over the next week). Encouraging the client to reflect on previous successes, and how they achieved them, can also help to increase their confidence, as well as providing vicarious experience through stories of other's success, or exploring with them if they know of other people who have been successful and how they did it. Asking these questions may also help to reveal perceived barriers and threats to achieving change which can then be addressed via action planning. The same approach can be used to assess an individual's importance relating to a goal.

### Action Planning/Reviewing

Once the participant has decided upon a goal (or goals) they wish to work towards, you should help and guide them towards setting SMARTER goals which will foster and develop the 3Cs; that is, their goals should promote a feeling of control, competence, and (where possible) connectedness. An Action Plan and a Guide

to creating and Action Plan can be found in Appendix 7.

## SMART(ER) goals

SMART(ER) goals are:

**Specific:** goals should be precise and easily measurable. A vague goal would be “*I want to be healthier*”, whereas a specific one would be “*I want to walk the dog for at least 30 minutes on Mondays, Wednesdays, and Fridays in the morning before work*”. To help make goals more specific, prompt the participant to ask themselves questions such as:

WHAT are you going to do?

HOW are you going to do it?

WHERE are you going to do it?

WHEN are you going to do it?

WITH WHOM are you going to do it?

**Measurable:** The goal should be easily measurable and able to be determined if it was achieved or not. For example, walking the dog for 30 minutes on Mondays, Wednesdays, and Fridays for 30 minutes before work is measurable as the client can record whether or not they walked the dog and for how long they walked on each of those days. The vague goal of wanting to be healthier is not explicitly measurable. Making goals measurable makes them easier to review, easier for you to affirm achievements by the participant, as well explore details as to what prevented them from achieving the goal should they not have achieved it.

**Achievable:** Goals should ALWAYS be achievable and within the client’s capabilities. Goals which the client perceives as achievable with high confidence to achieve it makes it more likely they will achieve the goal. This also builds a sense of control and competence should they achieve the goal, promotes self-

efficacy and provides you as a practitioner with ample opportunities to affirm the client’s achievements and further bolster self-esteem. Setting a goal which is unachievable can damage a participant’s sense of control, competence, and self-esteem and can actually demotivate them to keep trying. This population is likely to have failed in attempts to change in the past, and whilst failure should be reframed as normal through the engaging, focussing and evoking process, every attempt to should be made to guide the client towards goals which they have high confidence they can achieve and present minimal chance of failure.

**Relevant:** Is the goal relevant to the client? Did it come from them or from you? It should have come from the client if you have followed the principles of MI correctly, but it is always worth checking that the client sees a clear link between the goal they are setting and how this will help them work towards and achieve their longer term ambitions about their health or how they feel.

**Timely:** Is the goal right for them to try and achieve in their current situation or do other things need to happen first? If so, the goal should have a time or date by which it should be achieved. If there is no time limit on achieving the goal it could go on and on being an aspiration without ever being achieved. When a goal can take a particularly long time to achieve, shorter term goals should be reached which provide stepping stones to the longer term goal with clear time limits for each progressive goal.

**Empowering/Enjoyable:** Will achieving the goal make them feel good about themselves? As much as possible, is it something that is enjoyment or will give them a sense of enjoyment? People rarely do things long term unless it is something they enjoy.



**Repeatable:** Is it something which is repeatable? Are the goals something they can imagine maintaining and keep going long term and well into the future? Lasting change will result from changes which can be sustained long term.

### Outcome goals

Outcome goals are those which somebody wants to achieve and usually reflect the main outcome or result of changing behaviour. They are usually longer term and characterised by the fact the individual cannot directly control the accomplishment of the goal, instead it is achieved by the completion of a series of other things that have to be accomplished along the way. An example might be *“I want to reduce smoking by half in three weeks”*. This is the outcome the individual wants to achieve, but to achieve this they must complete a series of behavioural goals along the way.

### Behavioural goals

Behavioural goals are those which help somebody achieve their outcome goal. If somebody outcome goal is *“I want reduce smoking by half in three weeks”*, some behavioural goals might be *“I will only smoke one cigarette at a time and not one after the other in the morning and at night”*. Another could be related to the processes we are encouraging, it may be that the goal is to *“Complete a PA diary each day before going to sleep, recording the number of steps I have completed from the pedometer”*. It could be to review progress weekly with the HT using completed self-monitoring diaries (See section on Diaries).

All goals should be thought of as short, medium, or long term. Outcome goals are usually medium and long term, and behavioural and process goals are shorter term.

## ABC Forms

*(adapted from the DoH HT Handbook)*

To decide how best to change behaviour, it is important to understand what is maintaining the behaviour. Behaviour is maintained by what happens before (antecedents) and what happens after (consequences). What was the situation or setting that resulted in the client behaving a certain way or doing something, and how did it make them feel: **A**t first, **B**ehaviour, **C**onsequence.

ABC forms (see appendix 8) can be useful in helping a client to figure out when they are more likely to do the desired behaviour (e.g. where, with whom, feeling like what...). The behaviour can be doing something (e.g. walking upstairs) or not doing something (e.g. not having a biscuit at the tea break). Explore if the forms are something the client may find useful, if so offer to complete the with the client, if not, continue to explore through discussion.

On each occasion that they performed the desired behaviour, the client records the antecedent: that is, what they were doing, who they were with or what they were feeling before they performed the desired behaviour.

Next the client records the consequences of their behaviour: that is, what happened afterwards. What did they feel like? What did they do next?

An ABC form gives you and the client the opportunity to review patterns of behaviour – what situations make the desired behaviour more likely and what situations make the desired behaviour less likely. This information is very helpful

in making action plans, and in identifying situations that are difficult and make setbacks more likely (see Preparing for setbacks).

## Rewards

*(adapted from DoH HT Handbook)*

People don't often think of rewarding themselves with treats, but this is an effective way of changing behaviour. Adding a system of rewards into a client's action plan can have a positive effect on their motivation to change their behaviour, and on increasing the likelihood that the behaviour will occur. You may sometimes hear rewards referred to as positive reinforcement. This term means using rewards to increase the chance that a behaviour will be performed.

Clients aren't restricted to only rewarding themselves when they achieve a goal. This is especially important if their overall goal is long term. Encourage clients to reward themselves when they achieve mini-goals too.

### What are rewards?

A reward can be anything that the client would value having or doing, e.g. praise or treats. Ask the client what kinds of things they would like as rewards for achieving mini-goals and main goals, and other little successes along the way. Rewards don't have to cost money. If the client can't think of any rewards, there are some examples in appendix 9.

Clients could also 'save up' for rewards. For example, spend the money that they would've spent on cigarettes on a reward, or save £1 for every day they do some PA, and spend the money on a reward at the end of the week/month.

## Warning!

Some types of reward could be **unhealthy**.

Encourage the client to choose rewards that would not affect their progress towards their goal. A worksheet for recording rewards can be found in appendix 10.

It is also important that you as the practitioner understand that rewards can foster extrinsic motivation over intrinsic motivation (people only do the behaviour because they want the reward), and as such they should be used sparingly. It is preferable to encourage the client to reflect on enhanced feelings of achievement and wellbeing through affirmations and reflections.

### 'If-then' rules (making a coping plan)

'If-then' rules (**if** problem-situation Y arises **then** I will do X to overcome the problem) can be used to pre-empt and reduce barriers to change. The situation becomes a trigger, or reminder, to perform the behaviour. For example, "**If** I am craving a cigarette when I am trying to not smoke, **then** I will take a brisk 10-minute walk."

A key type of problem-situation to consider for TARS is social influences and making a plan to manage these can be very useful as part of the action-planning process. Encourage the client to include 'if-then' plans with their action plan using the worksheet in appendix 11).

### Barriers and facilitators

In order to achieve goals, it is important to think what may make it difficult for clients to achieve their goal (barriers) and what will make it easier for them to achieve their goal (facilitators). If the client is happy to, ask the

## Delivering the TARS Intervention

client to fill in the barriers and facilitators worksheet (see appendix 12).

### Barriers

Examples of barriers may include:

- Lack of facilities/equipment
- Unsupportive friends/relatives
- Situations that make it especially difficult to perform the behaviour.

Discuss any barriers with the client and together come up with possible solutions to them. For example, a client wants to increase the amount of PA they do, but there is no one else available to look after their children while they exercise. However, if the type of PA they choose could include their children (for example, cycling together, playing in the park, walking to the shops), it is no longer a barrier. Situations that are likely to cause setbacks for the client are also barriers. For example, a person trying to give up smoking may find that when they drink alcohol it is a high-risk situation as they feel really tempted to smoke. Ask the client to think of any situations where the risk of a setback would be high, and together think of some strategies for managing them. For example, going to a place where smoking is banned, or asking friends not to smoke around you.

### Facilitators

Examples of facilitators may include:

- People who encourage/prompt the client
- Having access to facilities, for example, local sports centre, internet access in local library, local smoking cessation services

- Reminders or situations that can trigger the client to do the behaviour.

These include anything that makes it easier for the client to perform the behaviour.

Establish with the client what is likely to encourage the behaviour. Does the client already do the behaviour? What actions, reminders or situations trigger this behaviour? What can the client do to increase these positive reminders?

### Getting support

Planning where the client can get support for their behaviour change is also important. Ask the client to think of people who are likely to be supportive and encourage them to change. Together think of ways that the client can get the most benefit from these people, for example, spending more time with them, having a specific person to phone when they need encouragement. The community can also be a source of support, for example, self-help groups, exercise/sports teams, smoking cessation services. Help the client to identify any useful sources of support and encourage them to use them.

### Contracts

As with all aspects of the intervention delivery, completing a 'contract' is a completely optional task, but some people may find it useful to have a clear, written summary of what they are working towards, and it help to reinforce the collaborative nature of your relationship. Explain that some people find this kind of thing useful, some do not, and see how they feel about doing it (elicit-provide-elicit). If they think it would be useful, complete a Personal Health Guide (appendix 13 and ask the client to complete their own copy (or complete it for them) that you both sign.

This is a behaviour change ‘contract’ – making contracts has been shown to help people stick to their action plans and achieve their goals.

## Recording and Reviewing Behaviour Change

*(adapted from the DoH HT Handbook)*

It is important that clients measure and record their progress. This can motivate them when they see that they are succeeding, or tell them something may be wrong with the plan if they aren’t succeeding. People can often underestimate or overestimate how successfully they are changing their behaviour – such as underestimating the number of cigarettes they smoke or overestimating the time they spend exercising. Self-monitoring gives people a realistic picture of their health behaviour. Behaviour change is usually ‘up and down’ rather than smooth progress; looking back at past records can help people keep going during any ‘down’ phases. The Behaviour Change Diary will help clients to monitor their behaviour.

This diary can be used for three purposes:

1. To keep a record of behaviour before change is planned. This can be useful for people who are not sure what changes to make. Just recording behaviour (for example, number of cigarettes smoked a day) can help to change it in a desired direction (as a behaviour change technique, this is called self-monitoring).
2. When a goal has been set, the diary is used to record behaviour to see whether it is changing in the desired direction.
3. Using the diary can make people more aware of when they succeed, or don’t

succeed, in achieving their desired behaviours (for example, what situations, times of day, associated feelings etc.). This can help inform future action planning to make behaviour change easier.

It is designed to help the client to keep an accurate record of their behaviour. The comments column may be a useful tool for you and the client to judge how difficult they are finding it, and what could make it easier. Develop an action plan in advance for where and when to write the diary.

### *Is the client using their diary?*

Encourage the client to bring the diary to every meeting. Emphasise to the client that if they haven’t filled it in, bring it anyway, and you can fill it in together in the session and discuss ways of making it easier to fill in. During the session, explain the problems of trying to remember the past week and the types of inaccuracies that are likely, e.g. forgetting successes, especially if they are not feeling optimistic on that particular day. If the client doesn’t fill it in or bring it with them, find out why. Is there a literacy problem?

Does the client feel that they don’t have enough time? Does the client not like writing? Is the goal important enough to them? Did the client not have a plan for completing it? Try problem solving these issues together. Perhaps the client could record their progress on their mobile phone if they have one. Can they get family or friends to help them fill it in? Before the end of the first session, check that the client understands how and when to fill the diary in.

### *Review the diary in each session*

Review the diary at each meeting. Use affirmations to reinforce the client for filling it in and remind them why it is useful. Ask them what they think about what they did,

and then look at it together. Ask the client to talk about what was recorded and make sure you affirm something that they have done, however small, to boost their motivation and level of self-confidence.

### *What can the diary tell you?*

How successful the client was in achieving their goal will determine where you need to go next, and the Behaviour Change Diary is a useful indicator of this. For example, do you need to change the goal or change the Personal Health Guide?

## Reviewing Behaviour Change

This section provides a brief outline of the main points that need to be considered when reviewing behaviour change with a client.

### *Reviewing the Personal Health Guide and Behaviour Change Diary*

Reviewing the Personal Health Guide and the Behaviour Change Diary involves finding answers to the following questions:

- How have they been getting on with their plan to reduce smoking/increase PA/use PA to help reduce smoking? What was tried (and what was the goal)?
- With what effects (and did the client achieve any success)?
- What benefits were there?
- What difficulties were there?
- How did the client manage any difficulties?
- Were there any problems filling in the Behaviour Change Diary? How could

these be solved?

- How confident is the client that they can achieve their goal?
- Is the client getting enough support?
- What have the client and the HT learnt that could be useful when filling in future Personal Health Guides and Behaviour Change Diaries?
- Does the SMART goal or Personal Health Guide need changing? (This will depend on the review.)

**NB Affirm any success** – make sure you affirm something that the client has done, however small, to boost their motivation and level of self-confidence. This could include any progress made towards their goal, attending the meeting, filling in their Behaviour Change Diary or learning more about what they find difficult. Affirming the client may also improve your relationship with them and make communicating easier. Remind the client that successful behaviour change is a long process, and we need to build on each small success, learning from any setbacks. In affirming success, avoid praise (e.g. “that was really good”) that could be controlling, and use open questions to elicit client statements (e.g. “so how do you feel about your success in....?”).

## Maintaining Behaviour Change

### *Preparing for setbacks*

Changing behaviour is the first step; the next is to maintain that change.

Successful change is not a smooth process; it doesn't go in a straight line.



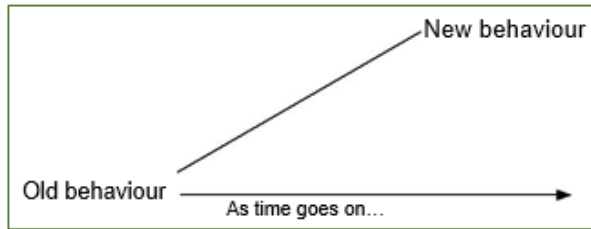


Figure 5 Change rarely happens smoothly

Successful change is more about ups and downs. People will experience setbacks along the way, but they can learn from these setbacks and this can help them to progress.

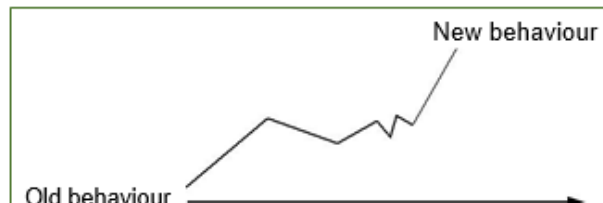


Figure 6 Change is not a smooth journey

## Setbacks

Everyone has setbacks from time to time, and it is important to explain this to the client early on. Encourage clients not to get disheartened when they experience setbacks, but rather to see them as an opportunity for learning. It will help the client to find out which situations are likely to lead to setbacks and which strategies are most helpful for them.

There are two main strategies for reducing setbacks:

The first is to find ways to avoid 'risky' situations, for example, going to the pub where you find it hard to refrain from smoking. The second is to develop ways of 'coping' when you find yourself in a 'high-risk' situation, for example, keep the pedometer with you as a reminder to use

PA to cope with cravings and urges. If the client is finding it difficult to remember triggers and strategies, they could try filling out an **A**t first - **B**ehaviour - **C**onsequences form. ABC forms can help the client work out what triggered a behaviour by thinking about how they were feeling/what was happening *before* they had a setback (at first), what the setback was (behaviour) and what happened as a result of that setback (consequences).

## 'High-risk' situations and 'if-then plans'

'High-risk' situations are those in which it is especially difficult to perform the desired behaviour. By thinking in advance about what clients' 'high-risk' or difficult situations are, they can plan in advance to avoid them, or to develop coping strategies when they happen. For example, clients may recognise that they are more likely to smoke when they are bored or stressed. They should be encouraged to think when these times might be and work out a plan for an alternative behaviour than smoking in these situations, for example, go for a walk, phone a friend.

Encourage the client to make 'if-then' plans.<sup>23</sup> 'If-then' plans specify when, where and how a client will perform goal-directed behaviours: 'If situation **y** arises **then** I will perform behaviour **x**.' 'If-then' plans are much more specific than behavioural plans.<sup>24</sup> For example, a behavioural plan about avoiding the temptation to eat unhealthy food might be:

"I will not smoke on my breaks at work."

However, an 'if-then' plan might be:

"If I feel tempted to smoke on my breaks at work then I will go for a brisk walk instead."

An 'if-then' plan requires you to specify exactly what you are going to do and when

and the situation you are going to do it in. They have been shown to be very effective in changing behaviour. Appendix 10 has a 'difficult situations and how I will cope with them' table. This should be reviewed regularly to check if the high-risk situations have altered or increased, and whether or not the coping strategies are successful.

Things you could do if your client has had a setback:

- **Review the goal** – look at the goal that was set. Was it realistic? If not, try setting another goal that the client will find easier to achieve. Agree that you set the goal too high before.
- **Barriers and facilitators** – were there barriers that the client hadn't thought about? If so, the Personal Health Guide needs to be changed. Were there enough facilitators built into the Personal Health Guide? **ABC form** – filling out an ABC form can help the client to work out what triggers and underpins setbacks.
- **Self-monitoring** – is the client still recording their behaviour? If they've stopped, it's easy for them not to realise why the setback has happened. Talk about what is making it difficult for the client to record their behaviour, and together come up with ideas that could help.
- **Difficult situations** – review or fill in the difficult situations table (appendix 10). Use the statement 'if I come across **x** (risky situation) I will do **y** (coping strategy)' to help the client think of alternative coping strategies (anything they can do or think to help them stay on track).
- **Support** – check that your client is receiving enough support from friends,

family and community. Talk about ways of getting more support, and provide information on the types of support available from the community.

- **Being realistic** – as well as having realistic goals, it's important that your client has realistic ideas about how their life will be different if they change their behaviour.

If the real life results of changing their behaviour don't meet their original expectations, clients can become disappointed and feel like all their hard work has not been worth it, and give up their new behaviour.

- **Rewards!** – it is important that your client rewards themselves when they achieve things like mini-goals. These rewards can give clients something to aim for, and can boost their motivation – encouraging them to keep going.

### Building Habits

Once a client has successfully changed a behaviour, the next stage is to maintain this behaviour and continue it into the foreseeable future. The new behaviour needs to become part of their lifestyle, an automatic habit that doesn't require effort or thinking.

### Mental “STOP” signs

When cutting down or stopping smoking, people often get a sudden urge or craving, or just find themselves starting the process of smoking on autopilot, without really thinking. There are ways of tackling these “in the moment” situations, and with enough practice people can often stop or control these impulsive urges to smoke.

Ask the client if they have any examples of having a temptation to smoke that seems impossible to resist. In what kind of situation are these cravings the strongest? Give the client time to respond and reflect any interesting observations (e.g. cravings are strongest when they wake up, when they are stressed, or when they are bored).

Introduce the **FIRST** step (ask-tell-discuss/vicarious experience) of putting up a mental STOP sign in front of them when they find themselves in one of these situations.



The sign is not there to forbid the behaviour, but to encourage them to pause and check their options – people need to give themselves a bit of time before deciding what to do.

The **SECOND** step is in this moment where they may decide to try and interrupt the normal process of smoking a cigarette by doing something differently. It could be by:

SUBSTITUTION (is there something healthier they could do instead?):

- Can they limit their response (only smoke one (or even half of one) cigarette instead of smoking two or three one after the other)?

- Could they do something to manage stress/boredom that could be triggering the craving? E.g. go for a brisk walk, complete some household tasks.

DISTRACTION (something that will absorb their attention/that they like):

- Go for a walk or do a 1 minute exercise routine
- Think about what the healthy alternatives might be
- Put it off for ten minutes and then see how they feel

SOCIAL:

- Phone a friend
- Try verbalizing the problem, e.g. say to someone "I'm struggling to think of a way to avoid smoking a cigarette".

PREVENTION:

- Take steps to avoid boredom or stress
- Build up some strong motivation/reasons for wanting to cut down (or stop) smoking

SELF-TALK (reminding yourself of your motivations for reducing smoking):

- Tap in to their deeper values and things that are important to them (e.g. reaching old age healthily, caring for your family, being able to play with grandchildren, being able to be physically active) to help them make the best choice in that moment.

The **THIRD** step is to keep trying different things and to reflect on progress. Over time the client can figure out what approach works best for them. People learn from experience, so the more often they try the better they will become at managing unwelcome urges to smoke. If it doesn't



## Delivering the TARS Intervention

work the first time that's OK, try it out several times as sometimes these techniques need practice.

Remember! If it only works a third of the time, they will still have reduced their smoking by a third which could have major benefits for the health and confidence to further tackle their smoking behaviour.

### **Support**

Check that the client is continuing to use the support they can get from friends, family and the community. Positive support and encouragement can act as a reward and increase the frequency with which the behaviour is performed.

### **Repetition**

Simply by repeating their new behaviour over and over it is more likely to become a habit. The more frequently a client performs the behaviour, the less time they spend deciding whether or not to do it and thinking about why they are doing it. As the client repeats the behaviour many times, it takes less conscious effort and attention, and then becomes a habit.

### **Rewards**

If the client continues to reward themselves for achieving their goals and mini-goals, this will act as positive reinforcement and encourage them to continue repeating their new behaviour. The strength of their habit will be increased.

### **Reviewing progress, benefits and outcomes**

Encourage the client to look back at what they have already achieved. Reinforce the benefits that changing their behaviour has

had or will have. Remind the client of the skills they have acquired. The fact that they have achieved behaviour change before should increase their confidence that they can do it again.

## **Endings**

You will start your work toward endings with clients from the outset of your engagement with them. In delivering the TARS intervention, you will be utilising a range of skills to develop trusting relationships with your clients in order to support them to develop and attain their PA and smoking related goals. It is therefore vital that you take steps to ensure that endings are positive in order that clients do not feel let down but rather, that they are able to build on what they have achieved with you and maintain any changes well in to the future.

It is also important to acknowledge the potential impact of endings on you as a HT. The necessary effort and care that is put into developing a working relationship with clients can make endings challenging for the HTs.

By being clear about the time limitations of the intervention, and managing expectations from the outset, you will be able to both develop trust and minimise the potential difficulties of ending a positive working relationship with your client.

One way to help people when coming towards the end of their time with you, is to begin discussions with them about becoming their own HT, as covered in the next section.

It may also be helpful that rather than a 'final' face to face session, you offer a couple of support phone calls to bring your support to an end.

## Becoming your own Health Trainer

*(adapted from the DoH HT Handbook, pp.59)*

For those clients who have successfully changed and maintained a behaviour, the next stage is taking the skills they have acquired and feeling confident to continue using them into the future to maintain any change, deal with setbacks, and make any further changes.

The HT's role at this point is to support the client in becoming their own HT. The client now has the appropriate skills and experience to change a behaviour and to maintain the change successfully.

Together with the client, summarise what the client has achieved and what they have learnt.

Give the client a few copies of relevant worksheets. These should include a Health Behaviour Check, a SMART goal worksheet, the Personal Health Guide, the Behaviour Change Diary and the Becoming your own HT sheet, together with any other worksheets you think they would find useful (or that the client wants).

The main points a client needs to know to become their own HT are:

- How to decide on a behaviour to change and weigh up how important it is to them (cost-benefit analysis, confidence ruler)
- How to set a SMARTER goal and fill in a Personal Health Guide
- How to keep and review a Behaviour Change Diary
- How to revise a Personal Health

## Guide

- Reminders about rewards, support, barriers and facilitators

By helping clients to feel confident in managing their own behaviour (being their own HT) it is more likely changes they have made will last. Worksheets to support a client becoming their own HT can be found in appendix 14.

## Advanced elements of supporting behaviour change

As a HT working within TARS there is an opportunity to develop a more advanced understanding of how best to support behaviour change. In any attempt to support behaviour change there is a chance, indeed a high possibility of several things:

1. That clients may fear or experience failure to achieve goals.
2. That clients feel they are changing for someone else and not because they really want to.
3. That they are doing something which is not in line with what others feels they should do.

Such emotional responses minimise the chance of sustained engagement in an intervention, like the one planned in TARS, and also successful changes in behaviour.

In contrast, HT support that limits failure, encourages ownership and control of the behavioural change, and provides or facilitates opportunities for social support, may be more likely to result in sustained engagement in the intervention, and hence successful changes in behaviour.

Here we consider the value and process of promoting self-determined behaviour. As discussed earlier, SDT predicts that real shifts in behaviour result from satisfying three essential psychological needs (called the 3Cs), which are having a sense of:

1. Competence: When an individual feels capable to affect a desired behavioural outcome.
2. Control: When an individual feels to have a sense of personal choice in deciding what to do.
3. Connectedness: When an individual feels secure within an environment while also fulfilling a need to feel connected to others.

Goal setting is a core part of the role of the HT. It is very easy to see how goals could be set that undermine all these needs. A HT could also communicate in a way that undermines these needs.

So there are two key elements for developing advanced behaviour change skills:

1. Negotiate with clients to ensure the actions planned will satisfy these core needs (i.e., 3Cs).
2. Communicate with clients in a way that will satisfy these core needs (i.e., 3Cs).

### Promoting physical activity to satisfy the 3 Cs

Supporting a client's increase in PA provides an opportunity for that individual to satisfy the three 'C's as follows:

**COMPETENCE** – By setting and achieving realistic goals an individual can build a sense of competence. [Equally, inappropriate goals can undermine a sense of competence, and clients with initially low self-efficacy may be quick to say, 'I told you so' when they experience failure.] Goals that are measurable provide an opportunity to gain a sense of achievement. Help the individual to identify these achievements

and link them to the client's efforts. Short-term goals can help to build into long-term achievements and again, with reflection, provide a sense of achievement.

**CONTROL** – Through a client centred approach, the client is involved in the goal setting process, and encouraged to link effort and success. Achievements linked to the role of the HT rather than the individual does not enhance a sense of control. Giving advice and information, when the individual could find this out for themselves can also undermine a sense of ownership and control or autonomy. The client should choose what activity to do, when, and where to do it.

**CONNECTEDNESS** – Quality PA experiences often involve other people, and the connection felt with others can be a strong motivator for that behaviour. The individual can also feel connectedness in the environment they are in – a sense of belonging where they feel secure and competent.

PA experiences which provide the individual with the satisfaction of these three Cs will see higher adherence rates. Activities which meet these needs for each individual will be vary greatly as different people put different values on different experiences. There is no 'one size fits all' activity, and tailoring action plans is crucial in developing an intrinsic motivation and sustained change.

## Advanced smoking behaviour change skills

As time increases between each cigarette, a smoker's withdrawal symptoms and cravings will begin to rise. This leads to an increase in negative mood states such as low mood, irritability, anxiety, tension, hunger and stress. Drug seeking behaviour (needing to smoke a cigarette) in order to alleviate these negative feelings is common. In a sense, a smoker's satisfaction from a cigarette comes from the alleviation of negative mood states – they smoke to feel normal.

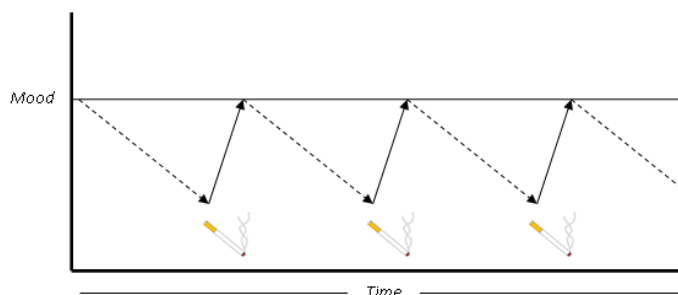


Figure 7 Smoking and impact on mood

It is worth noting that reported reasons for smoking are often paradoxical in nature – people will smoke both for stimulation and for relaxation. Nicotine is a stimulant which can increase perceived alertness and concentration, and yet also relieve stress. Despite reports that smoking relieves stress, it has been shown that smokers generally exhibit higher stress levels than non-smokers.

### Cue reactivity

People often smoke as a result of being exposed to a certain situation or cue (such as having a drink in the pub or after a meal). The desire for a cigarette is stimulated by a learned response to a given stimulus. This

is a form of classical conditioning where a conditioned response follows a conditioned stimulus is often developed over a long period of time and can be very hard to break. Psychological stress is often cited as a cue to smoking.

Cues provide opportunities for impulsive behaviour, which is not planned. So self-regulation and inhibiting a learned response (e.g. having a cigarette when offered one) is challenging. Learning 'what-if' strategies are often an important weapon to avoid lapses triggered by cues. The ABC forms in the *DoH HT Handbook* (p.33) can be a useful way to help people understand what causes them to smoke.

### Reasons for smoking and barriers to stopping

The reasons people smoke and the barriers which prevent people from quitting are often complex and numerous. Whilst TARS is primarily concerned with supporting people to cut down and not helping them to decide to quit, it is worth noting why people started smoking and the barriers to them stopping as they can relate strongly to the role of PA.

Reasons for smoking:

- Boredom
- Part of a social activity
- Used as a coping strategy for when things get stressful or difficult
- Weight management strategy
- Enjoyment
- Conditioned response to stimulus
- For stimulation
- For relaxation
- Habit.

Barriers to quitting:

- Lack of confidence (previous failure to quit)

- Fear of withdrawal symptoms
- Low motivation
- Belief that smoking isn't dangerous/denial (*"It won't happen to me"*)
- Peer pressure
- Social exposure
- Loss of smoking as a stress management tool
- Lack/cost/availability of nicotine replacement therapy (NRT)
- Powerful addiction of nicotine.

One important reason for sustaining smoking and for relapsing from a quit attempt is **weight gain**. Nicotine increases metabolism and suppresses appetite, so when someone stops smoking they will gain, on average, 7kg in 12 months. The weight gain is compounded by the potential replacement of the nicotine 'hit' with indulgent snacking and emotional eating. For many, even minimal weight gain is unacceptable, so strategies to prevent weight gain after smoking cessation are required.

### Abrupt quitting

Quitting smoking is not something which should be openly discussed with the participant unless they raise the topic themselves. Smoking reduction is a perfectly acceptable goal within the context of this intervention, as it is often seen as less threatening and much more achievable.

If an individual expresses a desire to quit at any point, you should explore their feelings towards seeking specialist help from the Stop Smoking Services, and signpost and support them in accessing the support. If they do not wish to access specialist support, use the *DoH HT Handbook* to support them with setting a quit date and explore behavioural strategies and plans to

support the quit attempt (including using PA as a coping strategy).

### Smoking reduction

Smoking reduction has not been advocated as an appropriate technique for quitting as it has been widely believed that increasing the amount of time between cigarettes will only increase the reward and satisfaction obtained from the cigarette when it is smoked, thus increasing the value and desire of each cigarette.

Research in this area is still in its infancy, but a recent review<sup>41</sup> has reported that there is no difference between abrupt quitting and cutting down to quit on long term cessation, but this is based on interventions involving Nicotine Assisted Reduction then Stop (NARS).

Several potential strategies for cutting down have been developed and proposed over recent years. Crucially they all hinge on breaking the conditioned responses to smoking stimulus. Unlike abrupt quitting, they aim to gradually breakdown learned routines and break habits which may increase confidence and desire to stop completely. The different strategies are presented in the following sections. (See appendix 15 for diagrammatic representations which may be useful to present to the client). All of the approaches have their pros and cons. The key will be to enable smokers to choose an approach to experiment with, and to help set a timescale for the rate of reduction, as part of the action planning process. Our ideal would be to reduce by 50% over no more than 4 weeks, and then consider further reductions. But there will be considerable variation in participants' responses and success. It is likely participants will begin with one approach, but move on to others as they find out which one works best for them.

### ***Hierarchical Reduction***

Certain cigarettes offer higher reward value than others and as such are harder to give up. The first cigarette in the morning (following overnight abstinence) is routinely reported to be the hardest to give up. It has even been suggested that the only question of importance in assessing a person's level of smoking dependence is 'how soon after waking do you smoke your first cigarette?'

Hierarchical reduction works by asking people to rank cigarettes in order of the easiest to the hardest to give up. Starting with the easiest, smoker's plan which ones they will give up on a specified time scale. It may be one a day over a two-week period or however the person feels best to progress, eliminating the easiest and eventually beginning on the harder cigarettes to give up, as confidence to go without a cigarette increases.

### ***Smoke Free Periods***

The Smoke free periods approach works by breaking an individual's day up into blocks of specified time periods (eg 30 mins). Depending on their routine (work etc) there may be periods where they do not smoke anyway, and periods where they smoke more. Using chart, smokers then go on to block out certain times of the day where they will not smoke (perhaps increasing by one 30-minute smoke free period per day) until they have reached a certain goal.

Importantly with the smoke free periods approach, there is no specified number of cigarettes which are being cut out or smoked. They can smoke as much as they like, but ONLY in the periods not identified as smoke free. This approach aims to break the behavioural pattern of smoking which will result in a decreased desire for smoking and a natural reduction.

### ***Scheduled Reduction***

The aim of the scheduled reduction approach is to systematically reduce at a specified rate, breaking habit and routine gradually. It begins with identifying how many cigarettes a person smokes in a day, and calculating how much time between each cigarette is needed to space them evenly through the day. For example, a 40 a day smoker, who is awake for 16 hours a day, would need to smoke a cigarette every 24 minutes to get through 40 in one day. Targets are then set to gradually increase the time between each cigarette with a specific end goal in sight.

Important to this method is the necessity to smoke at every specified time point, whether it's desired or not, which again helps to break the habit of smoking.

### ***Planned Reduction***

Perhaps one of the simplest ways to plan reduction, this approach works by setting targets for how many cigarettes will be smoked each day. Then each day begins with that number in their pocket, and purchasing additional ones is to be avoided.

The rate at which they reduce is determined by them and ultimately how much they want to reduce by and over what period. This approach fits particularly well with goal setting and action planning processes described in the HT Handbook.

### ***Electronic cigarettes and vaporisers***

In recent years, electronic cigarettes and vaporisers (e-cigs) have been developed as a novel way to deliver nicotine to the body in a fashion that mimics the act of smoking. It is estimated there are over two million e-cig users in the UK. They work by vaporising a liquid which is laced with nicotine to deliver the nicotine through pathways similar to that



of cigarette smoking, without the tar and hundreds of other toxic chemicals associated with the combustion of tobacco.

They offer a way of delivering nicotine to the body much quicker than traditional NRT and therefore offer a viable alternative to cope with withdrawal and craving when attempting to reduce or quit smoking. The liquids come in various nicotine strengths (6mg, 11mg, and 18 mg) the same way NRT does, and can be used to match a person's level of addiction. They cost a fraction of the price of traditional cigarettes and tobacco, hence their increasing popularity.

It is likely you will work with clients who see e-cigs as a viable alternative to smoking. If this is the case, it should be supported and explored as a way to help them reduce their cigarette smoking. Due to the uncertainty around their safety, however, you should encourage them to consider planning to reduce their e-cig use over time.

'Vape' shops are a good source of information for the participant should they be interested in trying electronic cigarettes, and they should be able to provide appropriate advice on what strengths and type of electronic cigarette to use based on their smoking levels.

## Advanced physical activity behaviour change skills

In the context of this intervention, we are thinking of PA in its broadest sense. Whilst it does include intense exercise such as going to the gym or running, it is also about lifestyle PA such as walking, gardening, or doing the housework, and just generally being more active.

***“If some of the benefits accruing from regular physical activity could be procured by any one medicine, then nothing in the world would be held in more esteem than that medicine”.***

**Francis Fuller 1705**

PA is widely accepted to benefit health both physically and mentally. Being regularly active decreases the risk of developing an extensive range of medical conditions such as: cardiovascular disease, diabetes, cancer, depression, anxiety, dementia, high blood pressure, osteoporosis, osteoarthritis, lower back pain and lowers the risk of falls among the elderly.

PA could be categorised in different ways, each of which may present different opportunities and barriers to becoming more physically active, namely:

**LEISURE:** Things that are done for fun and enjoyment.

**TRAVEL:** Choosing an active mode of transport such as walking or cycling.

**OCCUPATIONAL:** Some jobs can be very physically active.

**DOMESTIC:** Completing domestic tasks can consist of PA.

## Recommendations

The Department of Health recommends that for general health and wellbeing adults achieve at least 30 minutes of moderate intensity PA on at least 5 days of the week or 3 x 20 mins of vigorous PA for cardiovascular health. Activity does not have to be continuous for 30 minutes but can be in shorter 10-minute bouts throughout the day. Short bouts of moderate PA can relieve stress and tension, whilst improving a sense of pleasure and activation. By breaking PA into short bouts, it may become easier to meet the daily recommended dose in a sustainable way.

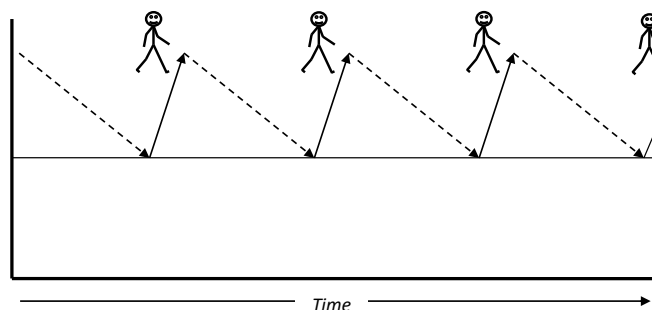


Figure 8 Physical activity and its impact on mood

## Barriers to increasing physical activity

Using a Decision-Balance sheet, as shown in the DoH HT Handbook (p.26) (see appendices 10 & 11), it is easy to identify the pros and cons of becoming more active. But the commonly cited barriers shown below are largely a function of how we introduce or use the terms sport, exercise and PA. Short bouts of brisk walking do not have the same barriers as signing up for an exercise class or joining a sports club.

Commonly cited barriers to different types of PA:

- *I've never done it*
- *I haven't got the time*
- *I wasn't good at sports at school*
- *I would feel silly*

- *Other people would make fun of me*
- *It won't help unless it hurts - 'No pain, no gain'*
- *It's sweaty and uncomfortable*
- *I'm too tired*
- *I would rather do something else*
- *It's expensive*
- *I think it will make me feel worse*
- *I don't have anyone to do it with*
- *I don't know where, when or how to start.*

individual, and may depend on several factors such as cardiovascular fitness, fatigue, previous experience, mood, and any existing physical disability. (See *Table 2*).

## **Domains of physical activity**

There are a number of factors which can influence how people relate to and perceive different types of PA. Seven aspects of PA should be considered when working with an individual: Frequency, Intensity, Time, Type, Environment, Social support and Timing (FITTEST).

### ***Frequency***

How often does the behaviour occur? Is it better to do some PA every day or just once in a longer block at weekends? For cardiovascular health, it does seem to be important to regularly exercise. Long periods of sedentary behaviour are increasingly being linked to increased risk of some health problems such as diabetes. The evidence is less clear for other conditions but we do know that even short bouts of activity can increase activation or energy levels, increase positive affect and reduce our natural psychological and physiological responses to stress or threatening situations. Therefore, repeated bouts may lead to an accumulated benefit over a period of time which one longer single session per week may not provide.

### ***Intensity***

How intense is the activity? How much effort or physical and mental discomfort does a person experience? The experience of how intense an exercise is can be highly

## Delivering the TARS Intervention

Table 2 Pros and Cons of different PA intensities

Intensity	What is it?	PROS	CONS
<b>VIGOROUS</b>  E.g. Running, hard cycling, squash, aerobics, circuit training, hard manual work, team sports	An activity that leaves you feeling (extremely) out of breath and unable to hold a conversation. Your heart rate will rise significantly and will often lead to high levels of perspiration. Breathing will become very rapid and heavy.	Evidence suggests it offers the most physical benefits for those who complete it.  Can offer a greater sense of achievement and 'feel good factor' for the right person.	Extremely off putting to most, especially people new to PA.  Can cause delayed muscle pain (not necessarily serious, just uncomfortable)  The risk of injury is greatly increased.  Often needs specialised equipment and environments (cost) to do it, with high levels of supervision.  For smokers it may exacerbate symptoms of breathlessness.
<b>MODERATE</b>  E.g. Brisk walking (complete 1 mile in around 15 minutes), cycling, effortful housework, gardening, golf, tennis, dancing, tai chi.	An activity which still allows you to hold a conversation, but you will still feel your heart rate rise, your skin warm and your breathing become slightly faster.	Is easily achievable for nearly everyone.  Easily accessible and can be done without high levels of supervision.  Still has significant benefits for health (national guidelines promote MODERATE activity)	People may not think of moderate activity as having any benefits (too easy)  Slightly increased risk of physical injury, but it is minimal
<b>LIGHT</b>  E.g. slow walking/strolling, easy housework, light gardening, yoga.	An activity which is very easy to complete, only slightly raises heart rate and does not require faster breathing.	It can be a good starting point for increasing motivation and confidence to complete PA for those with little or no experience.  Can increase confidence and self-belief in moving onto moderate activity.  Very small risk involved.  Any energy expenditure is better than sitting.	People may not think of it as having any benefits (although it is better than nothing!)

### Time

How long does the activity have to take place for? Is it in one long block or broken into smaller chunks?

- Presenting people with the task of walking or cycling continuously for an hour or even 30 minutes can seem daunting and lowers motivation and confidence. Breaking activity up can make it seem more achievable and easier to fit into people's lives.
- The national guidelines suggest 30 minutes of daily moderate activity can be achieved in blocks of 10 minutes. Therefore, someone could walk briskly to work or shops in the morning, take a short 10-minute walk at lunch time and walk home again and they would meet the minimal recommended guidelines for PA. This can often be perceived to be far more achievable than one longer walk.

### Type

PA takes many different forms and can serve many different purposes. It is important to know what *type* of PA a person believes they may enjoy/have enjoyed in the past. Running can be completely off putting for one individual, but potentially rewarding and enjoyable for another.

- Promoting an activity which a person does not enjoy will likely limit adoption and maintenance of that activity.
- It is important to consider that although an individual may not enjoy an activity of a certain intensity (such as jogging), they may however enjoy an alternative activity of a similar intensity but different mode (e.g. cycling).

- Certain modes of activity can also have time implications. For example, arranging a game of badminton can require travelling time, perhaps a minimum court booking of an hour, and may depend on facility opening times. Compare this with taking a walk, which needs little preparation and planning and can be completed at most times of the day.
- Different modes of activity can also have different cost implications. Cost is often a large barrier to the adoption and continued participation in certain activities. The cost of going for a walk is minimal compared to going for a cycle if the person does not own a bike.

### Environment

It is entirely plausible that the location in which an activity takes place will influence how an individual experiences that activity. Walking on a treadmill in a gym will provide an entirely different experience to walking through a country park, despite being the same *PA*. The experience of one exercise or yoga class may be entirely different to another class with a different instructor elsewhere.

It is also important to consider how an environment has the potential to damage an individual's confidence and motivation. For example, attending a heavily strength and weights orientated gym can be a highly off putting experience for a beginner or somebody with low physical self-esteem. A bad experience of a PA environment can make it highly unlikely for the behaviour to re occur.

### Social Support

Can be considered in two forms – in terms who the activity is done with and support from others for completing the activity.

Going for a walk with a friend can enhance the enjoyment of the activity, and agreeing to attend a new exercise class with a friend will enhance the motivation and confidence for continued attendance. Whilst it can often be reported that completing PA alone can offer enjoyment (a chance to 'get away from it all', to 'clear your head'), completing it with others can go some way to fulfilling the psychological need to feel connected with others.

Support from significant others (friends, family, partners, etc.) in relation to completing an activity is also important in adopting and maintaining new behaviours. It is important to explore ways that support can be found and elicited from those close to the people around them. For example, ask how a partner feels about them trying to become more active. If the people close to them understand their reasons for adopting new behaviours it is less likely they will be a negative influence or inadvertently create additional barriers. A person's confidence is also likely to grow if the people around them are supportive and encouraging of them trying new behaviours.

### *Timing*

What time of the day, or maybe week, are people completing PA? This is perhaps one of the less considered aspects of PA, but remains important none the less.

- It could be that a person aims to complete a walk first thing in the morning, but in reality they are pushed for time in the morning and simply cannot sustain it. Or, perhaps more detrimentally, the idea of going for a walk in the morning becomes a burden and adds pressure to them at a time when they feel they simply cannot fit it in, resulting in feelings of guilt for having not done it.
- It could also be that exercising vigorously or in a way that is unfamiliar in the

evening can result in disturbed sleep as a result of a raised body temperature and hormonal responses.

- A person may also gain enjoyment from completing the same activity at different times of day. For example, they may enjoy walking the dog early in the morning compared to late at night because of the different environments (light vs dark) and feelings of safety. They may also want to do it after a busy day to 'unwind'.



## Integrating smoking reduction and physical activity

There are numerous ways that PA and smoking may interact with each other in beneficial ways. Smoking is a 'stopping' behaviour and PA may be a 'starting' behaviour, so there is an element of replacing one behaviour with another. At a population level those who are more physically active are less likely to smoke. There is good evidence that a short bout of PA (such as a brisk walk) can reduce the desire to smoke and ease withdrawal symptoms.

Whilst the message being portrayed by the intervention is not one of smoking cessation but rather reduction, the main desired outcomes from the intervention are

concerned with quitting and remaining abstinent. It is important to remember this and quitting should not be discussed with the participants unless they express a desire to do so (ie, it is on their agenda, not the HT's agenda). The focus should always remain on reducing smoking behaviour and increasing PA.

The IMPLICIT and EXPLICIT ways PA may influence smoking behaviour are shown in table 3. These processes all have implications for promoting PA to help smokers to reduce and quit smoking. Given that coping with cravings and withdrawal symptoms is one of the main reasons why smokers find it difficult to cut down or quit, using PA as a coping strategy may be important. Just generally increasing PA may also have valuable indirect (implicit) benefits.

Table 3 IMPLICIT and EXPLICIT action of PA on smoking

EXPLICIT processes	IMPLICIT processes
<ul style="list-style-type: none"> <li>Weight gain management.</li> <li>Acute craving and tobacco withdrawal symptom management.</li> <li>Focus on increasing a positive behaviour (ie, PA) rather than reducing or quitting smoking.</li> </ul>	<ul style="list-style-type: none"> <li>General enhanced mood and reduced depression and anxiety from PA, reduces urge to smoke.</li> <li>General sense of enhanced mastery and self-perceptions, provides confidence to reduce smoking.</li> <li>Reduced importance and reward from a cigarette.</li> <li>Identity shift from a smoker to a non smoker/exerciser.</li> <li>Being in new environments where people don't smoke helps reduce conditioned response to smoke.</li> <li>Money for sport and exercise participation may lead to a re-evaluation of money spent on cigarettes.</li> <li>Feeling breathless when exercising may trigger fear appraisals about health status.</li> </ul>

### Acute physical activity management of cravings and withdrawal symptoms

Studies have consistently shown that during temporary smoking abstinence, when cravings are high, a short bout of PA (eg, a brisk 15 min walk or 5 mins of seated isometric exercise) reduces cravings and withdrawal symptoms. The effects last beyond the exercise, for at least as long as the exercise itself.

When smoking cues are introduced, PA has been shown to limit the increases in cravings. Also, a session of PA delays ad libitum smoking. It would therefore appear appropriate for smokers to explicitly use short bouts of PA to aid smoking reduction and quitting.

If smoking is based on the need to relieve negative mood states then a single bout of PA can help control withdrawal symptoms and relieve cravings, as shown in the Figure 9 below (a combination of Figures 7 & 8). Repeated exposure to PA, with enhanced mood, may help to increase a belief in the value of exercise for managing cravings and withdrawal symptoms.

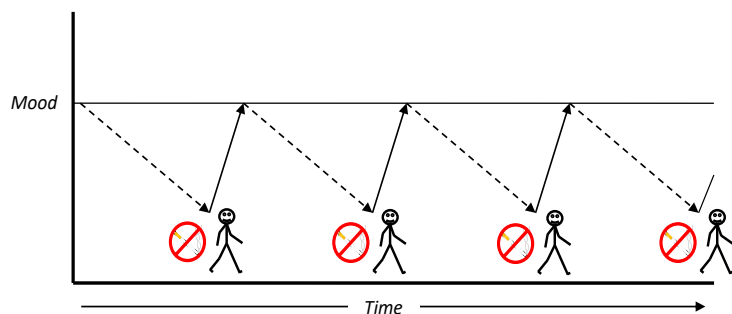


Figure 9 Replacing smoking with PA to increase mood

### Physical activity and weight gain

After smoking cessation, smokers (and particularly women) experience an average of 5-7kg weight gain within a year of quitting. Fear of this weight gain prevents many people from quitting. The effects on weight gain from smoking reduction are not known. Weight gain is a result of a slower metabolic rate without nicotine in the body and also emotional eating.

Increasing PA while cutting down (and quitting) may reduce weight gain not only by increased energy expenditure but also through improved control of energy intake (particularly via emotional eating).

### Multiple behaviour change outline

Smokers who quit are generally advised not to change PA and diet at the same time by the Stop Smoking Service advisors. However, simultaneous multiple behaviour changes at the time of quitting does appear to be possible for some people, especially when PA is considered in terms of short bouts of daily activity, rather than structured, facility-based exercise on 2-3 occasions per week.

The goal of the TARS intervention is to support multiple behaviour changes in a way that limits mental overload, but uses PA to facilitate smoking reduction. Figure 10 below shows clearly the ideal scenario, and captures the dual aims of EARS.

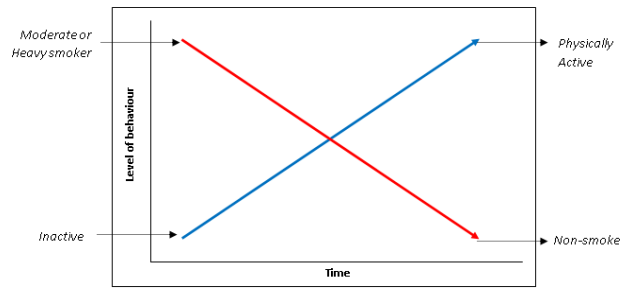


Figure 10 Interaction of changing both behaviours

It is important that the participants appreciate how PA can impact on smoking; some clients will already accept this based on past experiences. Others will need more persuasion and experimentation. But it is a key component of TARS.

Figure 10 could be used as a tool for generating initial discussions with smokers, alongside a Decision Balance sheet for the advantages and disadvantages of PA. Table 3 also highlights how PA may explicitly and implicitly support smoking reduction and cessation, and these could be used as a tool to prompt clients.

The EARS intervention sits inside a black box if you like, as shown in the figure below. Ideally, we have inactive smokers coming in and active non-smokers going out, based on the efforts of the HT in what is a complex intervention.



We would like to be able to describe it in a way that others could reproduce in future health services. But we accept that this may not be easy. The core competencies provide a framework for understanding

which intervention processes are key for delivery, and it is these which will constitute the bulk of the black box, which is then filled with unique attributes brought by the HT and the participant.

To be a truly client-centred intervention we need flexibility in how much support each smoker receives and when; it will not be a 'one size fits all' approach.

## Progression

Behaviour change is rarely a linear process, as the Figure 5 shows. The HT will help smokers to prepare for setbacks. Clients will increase PA and reduce smoking in a variable way, and could decide to quit at any point, if at all, within the initial 8 weeks of support. For one person, a 30 min walk on 5 days a week could be a great achievement that is worked towards over the 8 weeks, whereas others may accumulate shorter bouts within days. Reducing from 40 to 10 a day will require different progression compared with reducing from 20 to 10 a day.

Our early experiences of delivering the EARS intervention suggest that many smokers want to focus on smoking reduction initially, and already have ideas of which cigarettes to eliminate first. It then becomes a challenge to enhance any beliefs that PA maybe useful, as the remaining cigarettes pose a greater challenge to eliminate. HTs should not forget the focus of TARS on increasing PA.



## The Core Competencies of the TARS Health Trainer

The TARS HT role is built around eight core competencies, three of which are broken into two (to reflect their application to both smoking and PA behaviours). By using the MI principles and techniques along with the behaviour change skills to address the targets for change, these competencies should be successfully delivered.

It is thought that successful and skillful delivery of these competencies will produce the most successful outcome for the intervention in terms of smoking reduction, increases in PA, and ultimately quit attempts and remaining abstinent from smoking.

The competencies permeate all aspects of delivery, are reflected in the post session case notes, and will be used as an ongoing tool in supervision to help with understanding any difficulties that may be taking place. The logical, progressive, and cyclical nature of how these competencies work in delivering the intervention were shown in Figure 1.

Table 4 summarises the key features and techniques which may help deliver them successfully. How they are scored and rated, along with examples of what may make good or bad delivery, can be found in appendix 16.

## The Core Competencies

Table 4 The TARS Core Competencies

Item	Rationale	Key features	Intervention Techniques
1. Active Participant involvement	Participants who are in control of the decision making and not being 'told' what to do are more likely to make lasting change	<ul style="list-style-type: none"> <li>• Participant should be actively involved, being the one coming up with ideas</li> <li>• Discussion should be guided</li> <li>• A collaborative and shared decision making style</li> <li>• Participant should be empowered to take control</li> <li>• Interactions should be encouraging, respectful, and non-judgemental</li> <li>• The interaction should be individually tailored to the participant's needs</li> <li>• HT should engender a sense of warmth, genuineness, and empathy</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Ask-tell-discuss (elicit-provide-elicite)</li> </ul>
2a. Motivation building for cutting down (quitting)	Increasing motivation for changing a behaviour makes it more likely to happen	<ul style="list-style-type: none"> <li>• Exploring initial beliefs</li> <li>• Assessing importance and confidence</li> <li>• Exchange of information</li> <li>• Enhancing the perceived benefits</li> <li>• Enhancing self-efficacy</li> <li>• Developing discrepancy</li> </ul>	<ul style="list-style-type: none"> <li>• OARS to explore current and past behaviour</li> <li>• Pros and cons of change</li> <li>• Decisional balance scales (0-10 questions)</li> <li>• Exploring possible futures</li> <li>• Discussing past attempts to change</li> <li>• Providing vicarious experience</li> <li>• Explore barriers and possible solutions</li> </ul>
2b. Motivation building for physical activity			



3a. Self-monitor, set goals, and discuss strategies to reduce smoking	Self-monitoring and goal setting are two of the most effective behaviour change techniques (in combination with at least one other)	<ul style="list-style-type: none"> <li>• Discuss range of strategies for changing behaviour</li> <li>• Agree a verbal plan of action</li> <li>• Discuss self-monitoring</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Goal setting</li> <li>• Action planning</li> <li>• Self-monitoring</li> <li>• Deconditioning strategies</li> </ul>
3b. Self-monitor, set goals, and discuss strategies to increase physical activity			
4a. Review efforts to cut down smoking/problem solving	Reviewing progress and overcoming setbacks are important to achieve and maintain progress	<ul style="list-style-type: none"> <li>• Reflecting on progress</li> <li>• Review efforts to self-monitor</li> <li>• Affirming/reinforcing any successes</li> <li>• Discussing any setbacks</li> <li>• Setting new goals</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Affirmation</li> <li>• Reframing</li> <li>• Goal setting</li> <li>• Engaging social support</li> </ul>
4b. Review efforts to increase physical activity/problem solving			
5. Integration of concepts: building an association between PA and smoking reduction	Understanding how and utilising PA can positively support and enhance smoking reduction	<ul style="list-style-type: none"> <li>• Support an understanding of relationship between behaviours</li> <li>• Presenting rationale for how PA might help smoking reduction</li> <li>• Facilitate discussion of explicit and implicit processes</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Ask-tell-discuss (elicit-provide-elic)</li> <li>• Setting up an experiment (goal setting)</li> </ul>

## The Core Competencies

6. Identify and reinforce shifts towards being a more 'healthy person' or 'healthy living'	Identity shifts are powerful in supporting and maintaining behaviour change. Having a positive view of yourself (self-concept) is another fundamental human need, so positive changes in identity beliefs like this can be very strong motivators.	<ul style="list-style-type: none"> <li>• Picking up opportunities to reinforce positive shifts in identity relating to wanting to become a more healthy person</li> </ul>	<ul style="list-style-type: none"> <li>• OARS, particularly to highlight changes in participants thinking which may highlight shifts in identity</li> </ul>
7a. Engaging social support and managing social influences on smoking reduction	Positive and negative social influence can be strong facilitators and barriers for change and causing relapse or maintaining new behaviour. Therefore addressing them is a key priority.	<ul style="list-style-type: none"> <li>• Encourage client to engage positive social support for changing behaviour (both in making plans and carrying them out)</li> <li>• Support client to reflect on possible negative social influences and how to manage them</li> <li>• Social influences may be (1) INFORMATIONAL (e.g. helping to make plans, providing ideas), (2) EMOTIONAL (e.g. not putting pressure on them to continue a behaviour and accepting their decision to change), and (3) PRACTICAL (e.g. completing the change with them, helping to monitor progress and enact plans)</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Action planning</li> </ul>
7b. Engaging social support and managing social influences on physical activity			

<p>8. Referral to smoking cessation services</p>	<p>Referring to specialist services to support behaviours beyond the scope of the HT will maximise the chance of the behaviour change being successful</p>	<ul style="list-style-type: none"> <li>• Should the participant express a desire to stop smoking, their motivation for accessing specialist services available in their local area should be addressed.</li> <li>• Support for accessing specialist services should be provided if appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• OARS</li> <li>• Decisional balance</li> <li>• Referral completed (if appropriate)</li> </ul>
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## Pragmatics of delivery

The intervention is intended to be as flexible as possible, although it is not intended to act as 'crises support', so you will not be expected to be available to participants 24/7. Availability will be limited to your usual working hours, with provision for interim support from your co-worker(s) at times of illness and annual leave.

### Intervention session duration, timing and frequency

The intervention will offer up to 8 one to one sessions with participants over a period of 8 weeks from the first session, plus an additional 6 weeks support should the participant make a quit attempt. Sessions can be in person or via the telephone, to suit client preference and brief between session telephone (text/call) support can also be provided where required. The first session should take place as soon as possible after the participant has been allocated to you ideally within one week. It is expected that sessions will occur weekly, but this may be more or less frequently depending on the participant's need and preference. Some participants may require fewer sessions which is fine, it is all down to the participant's individual choice.

It is expected that the first session will last approximately 45-60 mins, with subsequent sessions lasting between 15-30 minutes. It is entirely acceptable for them to be longer or shorter according to the level of support required by the participant.

### Intervention session location and type

The first session should be conducted in person, but subsequent sessions (should it be the participant's preference) may be conducted over the telephone.

Face to face meetings should always occur in a safe, comfortable, and agreed location acceptable to the participant and to you.

Such locations could include:

- A GP practice
- A local community centre
- A local day centre
- A café
- A gym
- A local organisation frequented by the individual (e.g. rehabilitation centre; training centre)

Sessions should not take place in a participant's homes or in any unsupervised isolated community locations but somewhere without interruptions and without friends or family.

### Lone working

For your safety, when meeting a client in person out of normal office hours you will need to complete the lone worker policy (appendix 17) where you must provide your lone working link person with the location, start time, and expected finish time of the session before the session. You will be required to 'check in' with your designated link person by telephone once the session has finished. If you do not check in within 30 minutes of the expected finish time, your designated link person will attempt to contact you and if unsuccessful will begin contacting the location where the session took place and other relevant contacts. If you cannot be found, the police will be informed. It is therefore important this procedure is **strictly** adhered to without fail.

Should you find yourself in a situation where you are unable to speak about your current situation when your supervisor phones to check the session was completed, but you require immediate assistance or support, there is a 'code word' which should be

worked in to the conversation. Your supervisor will then initiate procedures for getting assistance to you.

### Recording of intervention sessions

As part of the research and supervision process, you will be required to audio record each session you deliver with a participant, with their permission. At the beginning of the first session, you will clearly explain the purpose of the recording and how it is to be kept strictly confidential and obtain signed consent (appendix 18) that the participant understands and is happy that your sessions will be recorded. It is important that clients understand that the recording is being made because the intervention is part of a research study and that it is being used to make sure that the intervention is working well and to support you in supervision. A script to support you to seek consent is included on the consent form as an aide memoir. If the participant declines as they do not feel comfortable to be audio recorded, it is no problem at all, but this must be recorded in the participant database (see page XX). When you begin each session, you will remind the participant that it is being audio recorded and check that they are happy with that, if not, do not record the session and note it in the participant database.

Don't worry about the sessions being recorded! The purpose of the audio recordings is to give us a better understanding of the how the intervention sessions are working, not to check up on you. Sample recordings will be listened to by your supervisor on a regular basis to help you where you may be facing difficulties, and to provide supportive feedback on how the sessions are going.

Details of how to record sessions and what to do with the audio files once they are

completed will be discussed in training and supervision.

### Post Session Case Notes and Reflective Practice

You will be required to complete post session case notes and reflections after every session (see appendix 19). They have multiple purposes, including:

- Helping you to reflect on and remember what happened in each session
- To provide information to the research team about what goals people are working towards and how these may change throughout the intervention
- To assist in supervision sessions where you may be having difficulties (see appendix 20 for supervision guide).

The forms are made up of several sections to help you remember the details of sessions for later uploading onto the database. The form should be completed ASAP after the session whilst it is still fresh in your mind, and then you can copy it and upload it to the database when you next have the time.

The post session case notes form includes the eight core competencies giving you a chance to reflect on how you were working with the client to try and meet these (not all competencies will be relevant at all times, but they should certainly always be in your mind, and this may help promote that). These will be useful to help you identify areas you may want to discuss in supervision.

### Participant Files

When you are allocated a new participant, you should begin a file for that participant, in which you will store paper copies of any work sheets, post session case notes, copies of signed consent forms (audio

recording and confidentiality agreement) and any other important information relating to that client. You should take this file with you each time you meet the client, and to supervision sessions as appropriate.

### Data Protection

#### *Participant files*

The outside of the file should have no identifiable information, nothing more than initials or participant ID number. This file should be stored in a locked filing cabinet when not in use in a secure office. When you are transporting the files, they should always be transported in a locked mobile filing case.

#### *Mobile phone*

Your mobile phone should always have a security code active, and should be set so it is required at all times. It should be set to 'auto-lock'.

#### *Voice recorders*

The encrypted **voice recorders** should be stored securely when being transported, and locked in a filing cabinet in a secure office when not in use.

#### *Laptop*

Your **laptop** should be set up so that your secure details are needed to log on. If you leave your laptop for any period of time, you should always lock it (short cut: 'windows button'+L)

#### *Emailing sensitive information*

Any sensitive or personal information should, where possible, not be emailed or shared with anybody. If, under exceptional circumstances, you have to email documents containing personal information, they should be password protected and encrypted before doing so. A password known only to yourself and the research team will be shared with you during training.

#### *Personal safety*

Should any concerns arise over your personal safety over the course of working with a client, this should be discussed with your supervisor as soon as possible. Your supervisor will escalate your concerns to the Principal Investigator and appropriate courses of action taken. Your personal safety, comfort, and wellbeing are the *number one* priority at all times.

You should ensure that your mobile phone is charged at all times.



## Example Intervention Progression (session by session)

Session	Aim	Content (may be transient across sessions depending on individual progress)
<b>1</b> <b>(face-to-face)</b>	<p>Introduction.</p> <p>Build rapport with patient.</p> <p>Explore patient beliefs about PA and smoking reduction.</p> <p>Assess and enhance motivation for change</p> <p>Action planning</p>	<ol style="list-style-type: none"> <li>1. Discuss collaborative approach and explore nature of the patient's smoking and physical activity habits, including daily routines.</li> <li>2. Build belief in the value of and importance of cutting down.</li> <li>3. Explore pros and cons of change</li> <li>4. Present 4 possible approaches to cutting down and ask participant to identify which is most appropriate to them.</li> <li>5. Explore PA history, interests, pros and cons of different forms of PA.</li> <li>6. Explore beliefs in PA as an aid to cutting down (explicitly – past experience?, and implicit effects)</li> <li>7. Develop intrinsic motivation for PA and cutting down.</li> <li>8. Present treatment structure, flexibility of sessions, organization of sessions.</li> <li>9. Explore tasks for next session, self-monitoring with weekly worksheet (fridge magnet and pedometer).</li> <li>10. This content can extend into and be repeated in subsequent sessions depending upon patient's readiness to change.</li> </ol>
<b>2</b> <b>(phone call)</b>	<p>Building commitment to increase PA and reduce smoking.</p> <p>Action planning.</p> <p>Review and problem solve.</p> <p>Provide feedback.</p>	<ol style="list-style-type: none"> <li>1. Review progress (tasks, new tasks, changes and barriers)</li> <li>2. Work through pros and cons of increasing and maintaining PA.</li> <li>3. Encourage self-monitoring with a weekly worksheet to identify PA level, and strengthen perceived links between PA and smoking levels.</li> <li>4. Support client in planning and goal setting for PA and continued reduction.</li> <li>5. Signpost client to PA opportunities if needed.</li> <li>6. Encourage a different reduction approach if the first approach has been unsuccessful.</li> <li>7. Revise strategy and plans if necessary (phone vs in person session).</li> <li>8. This content can extend into and be repeated in subsequent sessions depending upon patient's readiness to change.</li> </ol>

## Pragmatics of Delivery

<b>3</b> <b>(phone call)</b>	<p>Discussion of progress, outcomes and barriers. Support psychological needs associated with PA (the three Cs).</p> <p>Encourage belief in value of PA as a tool for coping with reduction.</p> <p>Provide feedback.</p>	<ol style="list-style-type: none"> <li>1. Assess progress with goals set at last session</li> <li>2. Facilitating PA experience – explore ways to build competence, autonomy and relatedness in an enjoyable way</li> <li>3. Discuss completion of goals, what they found easy or difficult and why (autonomy)</li> <li>4. Discussion of ‘barriers and facilitators’</li> <li>5. Discuss revision of goals, plan new goals (competence)</li> <li>6. Discuss how to progress with new goals to increase interaction with significant others (relatedness)</li> </ol>
<b>4</b> <b>(phone call)</b>	<p>Revise progress, discuss medium/long term goals.</p> <p>Continue to support psychological needs</p> <p>Encourage belief in value of PA.</p>	<ol style="list-style-type: none"> <li>1. Review previous goals, reflect on achievements and plan new goals – building a sense of competence</li> <li>2. Explore ways to build a sense of control (self-regulation) over PA behaviour and mood.</li> <li>3. Explore ways to build relatedness or connectedness through PA</li> </ol>
<b>5</b> <b>(phone call)</b>	<p>Discuss progress/changes in well-being.</p> <p>Barrier management and continuing activity.</p> <p>Establish/maintain (or progress to) PA and reduction targets</p>	<ol style="list-style-type: none"> <li>1. Promote self-regulatory skills and ownership of PA decisions/choices and reflect on progress on reduction</li> <li>2. Encourage quality social opportunities (connectedness) through PA participation.</li> <li>3. Maintain use of goal setting (worksheets if used)</li> <li>4. Discuss potential strategies to help maintain activity.</li> </ol>
<b>6</b> <b>(phone call)</b>	<p>Review maintenance strategies.</p>	<ol style="list-style-type: none"> <li>1. Highlight patients’ control over PA choices and effects on mood and smoking behaviour.</li> <li>2. Reinforce any changes in self-confidence related to PA and smoking reduction.</li> </ol>

	Reinforcing activity and revision.	<ol style="list-style-type: none"> <li>Review progress and explore how to manage relapse.</li> <li>Encourage reflection on situations which illicit undesirable behaviour (increases smoking) and explore ways to deal with these</li> </ol>
<b>7</b> <b>(phone call)</b>	Review maintenance strategies.  Reflect on achievements.  Consider long term maintenance/goals.	<ol style="list-style-type: none"> <li>Reinforce positive changes in behaviour to this point</li> <li>Reflect on the benefits gained from changing behaviour</li> <li>Emphasise distance travelled and achievements made, no matter how small</li> <li>Begin to discuss potential strategies for long term maintenance (eg identifying relapse)</li> </ol>
<b>8</b> <b>(face to face)</b>	Final discussions.  Exit strategy.	<ol style="list-style-type: none"> <li>Discuss triggers/cues to changes in PA and smoking behaviour</li> <li>Explore management and modification to strategies</li> <li>Consider positive experiences and how to re-engage in PA if relapse or smoking increases.</li> </ol>
<p><i><b>The sessions during a quit attempt may begin at any time up to session 8. There is an element of uncertainty in these timings and flexibility is essential.</b></i></p>		
<b>START OF QUIT ATTEMPT</b> <b>1</b> <b>(face to face)</b>	Goal setting.  Support psychological and behavioural needs.  Coping with cravings	<ol style="list-style-type: none"> <li>Discuss explicit use of PA as a coping strategy for cravings</li> <li>Build link between inactivity and elevated cravings (weekly worksheets on cravings and PA)</li> <li>Revise activity goals in line with quit attempt</li> </ol>
<b>QUIT ATTEMPT</b> <b>2</b> <b>(face to face)</b>	Review of progress.  Revision of goals.  Building three 'c's of activity	<ol style="list-style-type: none"> <li>Review progress of goals – what was easy what was hard.</li> <li>Explore situations and behaviours which elevated cravings and strategies to cope with these in future</li> <li>Reflect on nature and quality of PA (is it satisfying the three 'c's of Control, Competence, and Connectedness?)</li> </ol>

<b>QUIT ATTEMPT</b> <b>3</b> <b>(face to face)</b>	Review of progress. Revision of goals. Building three 'c's of activity Overcoming barriers	1. Review progress of goals – what was easy what was hard. 2. Explore situations and behaviours which elevated cravings and strategies to cope with these in future Reflect on nature and quality of PA (is it satisfying the three 'c's of Control, Competence, and Connectedness?)
<b>QUIT ATTEMPT</b> <b>4</b> <b>(face to face)</b>	Review of progress. Revision of goals. Building three 'c's of activity Overcoming barriers. Identifying smoking cues.	1. Review progress of goals – what was easy what was hard. 2. Explore situations and behaviours which elevated cravings and strategies to cope with these in future Reflect on nature and quality of PA (is it satisfying the three 'c's of Control, Competence, and Connectedness?)
<b>QUIT ATTEMPT</b> <b>5</b> <b>(face to face)</b>	Review of progress. Revision of goals. Building three 'c's of activity Overcoming barriers. Identifying smoking cues. Relapse prevention planning	1. Review progress of goals – what was easy what was hard. 2. Explore situations and behaviours which elevated cravings and strategies to cope with these in future Reflect on nature and quality of PA (is it satisfying the three 'c's of Control, Competence, and Connectedness?)

<b>QUIT ATTEMPT</b> <b>6</b> <b>(face to face)</b>	Review of progress. Revision of goals. Building three 'c's of activity Overcoming barriers. Identifying smoking cues. Relapse prevention planning	1. Review progress of goals – what was easy what was hard. 2. Explore situations and behaviours which elevated cravings and strategies to cope with these in future Reflect on nature and quality of PA (is it satisfying the three 'c's of Control, Competence, and Connectedness?)

## An example case study

Below is a detailed case study written from the first person point of view of the HT. Dialogue is interspersed with thoughts from the HT. It was not based solely on one participant from the EARS study, but a combination of several case studies brought together to create a narrative demonstrating how things may progress.

[Adapted from: Taylor, A.H. & Thompson, T.P. Patches and Plyometrics: Exercise and Smoking Cessation. In Andersen, M. B. & Hanrahan S. J. (2015). *Doing Exercise Psychology*. Human Kinetics: Champaign, IL.]

### Reducing One Step at a Time: David's Story

Our case study follows David, a middle-aged man currently out of work and looking for new employment, who has enrolled in a new intervention exploring ways to help reduce his smoking habits and get him to be more active.

At this first consultation, I (Tom) have not met with David before. All I am aware of is that this particular client does not feel ready to abruptly quit smoking at this point in time and is not contra-indicated for moderate physical activity.

*Tom (T): Good morning, David is it? My name is Tom, please, come in and take a seat.*

*David (D): Thank you, and thanks for seeing me. I've been meaning to look for some help for a long time now but never quite got round to it, you know?*

*T: OK, well done for taking this first step. Can I ask, why have you not got round to looking for help with your smoking?*

*D: Well, I guess, mainly because I don't really want to quit, well, I don't feel like I can at the moment, but I feel I need to do something about how much I smoke. I've been to those Stop Smoking clinics a long time ago, and it never worked for me. I mean, I managed to stop for a few weeks once, but that was it. I just didn't feel ready or like I could handle such a drastic change. It felt like I was being told what to do and being preached at. I know I shouldn't smoke, and I can't be doing with someone telling me that all the time, especially when my family are the same!*

*T: Sounds like it wasn't easy! Well I'm not here to tell you what you should or shouldn't be doing or changing, just here to support and help you explore ways you think you could make changes that suit you, as big or as small as you feel comfortable with. Was there anybody else who supported you through the process the last time you tried to quit? Did any friends or family attempt to quit with you?*

*D: No, it was just me. The family were supportive but didn't really understand how hard it was for me, you know? For them it was a simple case of "just stop," but it's not that easy!*

The immediate exchange has revealed David's somewhat negative experience in attempting to quit in the past. He has some scepticism of what he is about to enroll in, which is evident through his tone of voice, almost as though he is challenging me to tell him that he should stop smoking so he has an excuse not to engage with me. I sense he is quite a strong-willed character and not afraid to speak his mind. I make it clear to him that I will not be doing any prescribing of goals and that everything that takes place is down to him in an attempt to put him at ease and distance myself from the practitioners he has worked with in the past and begin to position myself alongside him in a supportive role.

Exploring reasons for previous failures and periodic success can be a powerful opening technique to elicit reflection over clients' own past behaviors and circumstances as to what caused the relative success or failure. In this brief dialogue it is clear that David was lacking support to promote self-determined behavior. With pressure to change coming from external sources, and goals being set by someone else, the control element of David's behavior was stripped away from him when trying to change. In my experience, offering support for individuals through a heavily client-centred approach without imposing external targets on them is nearly always well received, and often cited as one of the reasons for success when compared to a more traditional "telling" approach. To attempt to tell David what to do, particularly at this early stage, could be devastating to the engagement process and the development of trust and rapport between counselor and client. Adopting a motivational interviewing (Miller & Rollnick, 2002) approach with clients such as David will be important to encourage change. This approach will foster feelings of autonomy or control and satisfy one of the three constructs (autonomy, competence, and relatedness) of self determination theory (SDT), which proposes that satisfaction of these three needs drives behavior.

It is possible that the competence dimension of SDT was not being addressed in his past situations. It seems that he was pressured into making a quit attempt, and he didn't feel any sense of competence in achieving the changes, saying the changes were too drastic. It is clear to me that David needed a greater sense of control over his own behavior, and that using progressive goals would be key to avoid any sense of failure or undermine any feelings of competence. Further questioning over previous support when he failed to stop smoking revealed a sense that he lacked support and understanding from others. The third construct of SDT suggests that relatedness or connectedness is what supports and maintains behavior. David clearly lacked connectedness when trying to adopt his new behavior of "not smoking" and the reinforcement of his mental wellbeing through feeling related to others was absent. The failure to address these three fundamental behavioural determinants offers a reasonable indication as to why previous behavior change was not successfully sustained. In supporting David to set goals for change, encouraging and promoting change and ownership of his own sense of control, competence, and connectedness will be important.

Following some more discussion about David's past smoking behavior I steer the discussion towards his current behavior and attempt to explore how his smoking habits link with his daily routines and activities.

*T: David, if you would, could you take me through your typical day? From when you wake up through to going back to bed, describing how your day is structured and what*



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*you get up to? And as much as possible when you smoke your 25-30 cigarettes each day.*

*D: Sure thing. Well, as I mentioned, I'm currently out of work and have been for about six months now, so my days are a bit different to when I was working. At the moment, I probably get up about 8 o'clock, and I'll pretty much smoke straight away, before anything else, quite often a couple, one after the other before jumping in the shower. Then I'll make a cup of coffee, and I always have a cigarette with a coffee! To be honest, the rest of the day at the moment isn't filled with much. I do a bit of job searching and that, down at the job centre, but it's difficult at the moment. My wife works, and the kids go to school, so I just spend some time watching TV, and drinking coffee (which means a cigarette). In the afternoon I will take the dog for a walk, and just waste time until the kids get back from school and the wife gets back from work. The evenings are spent with the family, having dinner and such, putting the kids to bed, and watching TV again, not doing a lot really.*

*T: OK, great. You said you smoked 25-30 cigarettes a day, yet you have only mentioned a handful of those throughout your day – any more thoughts on when you might smoke, say, the other 20 you haven't mentioned?*

*D: To be honest, I don't really know! I just kind of smoke to fill the time, when I get bored and that. I guess a lot of the time I just smoke purely out of habit and without even thinking about it. I really couldn't list every cigarette I smoke throughout the day.*

By encouraging David to talk through his typical day and routine, it acts as the beginning of a reflective process about his own behavior. As the counselor, I have avoided any judgment statements and allowed David to come to the realisation that most of his smoking is largely driven by habit and not necessarily by need. It is common among smokers that they will have little idea of what, when, and how much they actually smoke. The majority of smokers are aware of the real dangers and consequences of smoking, and outlining the risks can come across as judgmental and distance the client from the counselor. A much better, and client-centred, approach than iterating the risks associated with smoking is to elicit from clients why they want to reduce or stop. It is likely they will have their own reasons for wanting to change their behavior and by finding out what those are, the importance for change can be developed in the right direction. For example, it would be futile to continually outline the dangers of smoking if they have openly admitted their motivation for stopping smoking is to feel fitter. Encouraging them to reflect on the pros and cons of change relating to their fitness levels and how they would feel would be much more helpful.

What David has also revealed through describing his typical day is a series of opportunities and threats to his desire to change. He has presented a list of stimuli that prompt him to smoke (i.e., cups of coffee and potential boredom) and activities that present opportunity for discussion around his physical activity (i.e., the dog walking, getting to the job centre) and the potential to progress the discussion to how the two behaviors link. He has made no reference to any pleasurable physical activity, and is clearly inactive in his day-to-day life. One of the important ways physical activity can be used to help address smoking habits is to attempt

to interfere with learned responses to cues by avoiding them or replacing them with alternative activities. Something we discuss in later consultations. So far David has not revealed his motivation for wanting to change his smoking behavior. Therefore, at this stage I am unaware of the importance he holds over changing his smoking levels. Assessing the importance clients place on changing behavior allows me to gain an insight into potential barriers to change, and through further discussion, as suggested previously, attempt to increase the importance the clients place on changing behavior. If we assume that motivation for a behavior consists of two dimensions, that of importance and of confidence, these two dimensions will need to be assessed.

*T: It seems your smoking is largely driven by habit throughout the day, and possibly boredom. Would you agree?*

*D: Yes, I think so.*

*T: And by coming in to see me suggests that you want to do something about your smoking?*

*D: Yes, definitely.*

*T: So if I may ask, what changes are you looking to make and why?*

*D: Well, I know I shouldn't smoke, as I've said, and recently I've noticed I'm coughing quite badly, and the other day highlighted that I need to cut down after I ran for a bus, only about one hundred metres, and when I got to the bus I had such a bad coughing fit people were staring. It made me realise how unfit I am, and smoking is a big cause of that. I don't feel ready to quit completely at the moment; there's too much going on in my life for such a big change, but I would like to cut down how much I smoke. I'm not getting any younger!*

*T: Sounds like it was quite an eye-opening moment for you. How important is it for you to cut down your smoking? Could you rate it between one and ten, one being not at all important and ten being incredibly important?*

*D: Oh, it's hugely important to me, you know? I have two young kids, and after the episode on the bus I don't want to be the kind of dad who can't take their children out to play or go swimming or something because I can't breathe! I would say it's a nine out of ten, if not a ten.*

*T: So it is very important to you to make some changes. Any thoughts on how much you would like to cut down by and how quickly?*

*D: Well, I guess at least half to start with, probably within a week. I would like to stop all together, but feel like that's not realistic at the moment.*

*T: How confident would you be to cut down by half in the next week? Again, could you rate your confidence between one and ten, one being not confident, ten being very confident?*

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*D: Well, if I'm honest with myself, to do half in a week, probably only a three or four out of ten.*

*T: Well, that's OK; you have some confidence in yourself. What would make that confidence higher?*

*D: Not sure really.*

*T: Would you mind if I told you about what other people have done in the same situation?*

*D: Go ahead.*

*T: Other people I have worked with have often found an initial target of reducing by half quite intimidating to begin with, and have broken down their targets a bit more. For example, setting a target of reducing by 5 cigarettes over the first week, or maybe by 1 a day over 7 days. What do you think about that?*

*D: What, only reducing by five? Oh yeah I could do that, put myself at an eight or nine out of ten for that.*

As is often the case, David had his own ideas about what changes he wants to make. The importance he holds over changing is quite high, but his confidence to change is relatively low. As discussed earlier, setting targets that individuals don't feel they can achieve can undermine their competence and could actually lower any confidence to change if they don't reach their target. To not take away their sense of control, offering stories of what others have found useful and asking what they think leaves them firmly in control of the decision making and goal setting. David also highlighted his motivation for change, that of wanting to feel healthier and be able to play with his children. The mention of wanting to feel healthier acts as a powerful cue for me to introduce physical activity. Through all of our dialogue, I am looking for cues to introduce the discussion of physical activity, and so far several have presented themselves. At this stage I do not want to act on them immediately to avoid coming across as being too pushy or not listening to his concerns.

David continues to talk about his private life in some more detail which I go along with to maintain our growing sense of rapport. The conversation turns towards the coming week and what he has planned, which I see as a good opportunity to get back on track to discuss goals for the following week, focussing on when he smokes and the associated enjoyment. I am keen to encourage David to complete some kind of self-monitoring to help him reflect on how much he smokes and to help him put a structure to his smoking habits.

*T: It sounds like you have quite a busy week coming up. Something I'd like to talk about is how you feel about keeping a record of how much you smoke and when. It's something other people have found useful in assessing how much they smoke, and perhaps more importantly, identifying which cigarettes they enjoy smoking throughout the day and why. We have some simple diary sheets, which you might find useful. How would you feel about doing that?*

*D: Yeah, sure. That won't be a problem. It's not something I've ever really done before, should be quite interesting.*

*T: OK, great. What others have done is note down when and why they have a cigarette and what they were doing at the time. It might be through habit, craving, something stressful happened, or maybe associated with something, like your morning coffee, and rate it based on how much satisfaction or enjoyment they get from each one. What do you think?*

*D: Yeah, no problem. Will be interesting because as you pointed out earlier, I'm not really sure how I get through so many cigarettes each day.*

*T: Excellent, that would give you a really good starting point to start thinking about which cigarettes you could cut out, some might be easier than others to begin with.*

*D: Sure, I mean, thinking about it I can probably think of a few which I could drop without too much problem, like the ones I smoke one after the other in the morning. I could try and just stick to one first thing in the morning instead of the two or three. What do you think?*

*T: That's something other people have found easiest as well, but it's really down to you and how you feel about doing that. How confident do you feel you could do that? Again, on a scale between one and ten?*

*D: Well, probably about a 6 or 7 I suppose.*

*T: That's pretty good. What do you think you could do to increase that to maybe an 8 or a 9?*

*D: Well, I suppose I could get in the shower after having one cigarette before having another one. That would kind of force me to break it up a bit. Yeah, I feel pretty confident I could do that.*

In this exchange David has reflected his earlier confidence statement that cutting down by only a couple of cigarettes to begin with feels more achievable, promoting greater feelings of confidence, than if he was to attempt more dramatic change. At this early stage, it is important for David to achieve any goals he sets and avoid any experiences of failure that might reinforce previous negative experiences of quitting and damage his self-efficacy. I feel happy with this initial goal, especially because he has agreed to self-monitor his smoking behavior, which has been shown to be a simple, yet powerful, behavior change technique. By asking him how he feels he could manage cutting out the cigarettes, he has provided his own strategies, which leaves him firmly in control of the goals and decisions, hopefully building his sense of autonomy. Interestingly, he has also come up with changing his behavior to interfere with his smoking habit rather than just using cognitive strategies, something that makes me optimistic that he will respond well to such strategies as we progress. Also, he has bought into the idea of recording when and how much he smokes, and is approaching it as a kind of experiment, saying it would be "interesting". This approach is non-threatening and leaves him with a sense that he is doing it for his own interest and not for my benefit, fostering his sense of control. If he had been

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resistant to the idea, I would have not pushed it at this stage and perhaps tried to explore it again in later sessions.

Tackling two behaviors simultaneously can be challenging. David has mentioned he doesn't feel ready to quit because "there's a lot going on" in his life, so I feel it is best to address his smoking behavior in the first instance and later introduce physical activity. Because reducing his smoking is David's main motivation for seeing me, I don't want to begin any solid plans around his physical activity behavior at this early stage, but do feel it is fitting to begin thinking about his daily activities with a view to building on his physical activity levels at the next session. I begin this dialogue asking about the importance he places on cutting down by using his health as a talking point, as he mentioned earlier. The intention is to reinforce positive outcome expectancies associated with him changing his behavior. Discussing the health benefits of reducing smoking invariably provides a good opportunity to introduce physical activity as an adjunct pursuit because it promotes similar health benefits to cutting down and quitting smoking.

*T: Throughout the session today you have mentioned a few concerns you have over your health related to your smoking, for example the bus incident, and wanting to be able to be fit enough to play with your children as you get older. I'd like to ask what kind of health benefits you think you would experience if you did cut down by, say, at least half?*

*D: Well, I would definitely say my breathing would get easier, you know, that's something I experienced a bit when I quit all those years ago, and hopefully I would be coughing less. I reckon I would also feel fitter and hopefully wouldn't have any more incidents like that one running for the bus! I mean I know it will reduce my risk of cancer and all those things as well, but in the short term, I'm not getting any younger, and just want to feel fitter and better about myself.*

*T: That's all very positive reasons for wanting to change your smoking, and all very real benefits you will experience if you do. In terms of feeling fitter and making your breathing easier, how do you think physical activity would link to that?*

*D: What exercise? There's no way you'll get me into a gym or anything like that! I'd probably have a heart attack or cough my guts up! Why would I want to do that?*

This response frustrates me because I failed to establish the nature of what I meant by physical activity, and I feel that David could distance himself from me if I cannot step back from a topic that is potentially alienating to him. I feel I have interrupted the flow of the session by abruptly introducing physical activity and can sense David's attitude towards me change slightly. Typically people associate activity with vigorous exercise, which is invariably not something inactive smokers will associate themselves with. Whether or not they admit it, their confidence for completing such activities will be extremely low and, therefore, threatening to them should I suggest it. I roll with this resistance and attempt to demonstrate empathy and reframe physical activity in a way that is more accessible to him, and I hope to get him back alongside me.

*T: Yeah I understand, and things like the gym are certainly not for everyone. I guess what I meant by physical activity was more general, in terms of anything that gets you up and about, maybe gets your heart pumping a little bit.*

*D: Like running for the bus?*

*T: Well yes, but even things that are less energetic, like you mentioned walking your dog most days, things similar to that. How achievable are things of that nature for you and how do you think that affects your health and how you feel?*

*D: OK, well I do walk a fair bit with dog, but it's not very intense. I don't really do a lot other than that, so can't imagine it helps that much.*

*T: How do you think you would feel if you didn't walk the dog regularly?*

*D: It's the only exercise I get really, so I suppose it must be doing something for my health. I guess I would be a lot worse if I didn't do it. I know I probably don't do enough exercise.*

*T: If you were to increase your activity, even a little bit, like perhaps walking the dog for a bit longer, or walking slightly faster, what sort of benefits would you expect?*

*D: I guess the usual things, like feeling fitter, probably make my breathing a bit easier, might even lose some weight I suppose if I did more.*

*T: Sounds like you think the benefits would be similar to cutting down your smoking?*

*D: Yes, I suppose they are.*

*T: And you have expressed that these are all important things to you in what you want to achieve for your future goals. How much do you think your current behavior supports you in achieving these goals of feeling fitter and healthier?*

*D: Now that I think about it, not very much I suppose.*

Several key things have taken place in this exchange. First, David has emphasized the outcome expectancy he places on reducing his smoking, which acts a precursor to later self-revaluation that takes place. Second, with some prompting, he has reframed physical activity away from vigorous exercise to the much more achievable idea of moderate physical activity. Finally, developing discrepancy between where he hopes to be in the future (in terms of his health) and his current behavior has started a process of self-revaluation as he realises that his current behavior may not enable him to reach his intended goals. The intention of making comparisons between stopping smoking and increasing physical activity was intended to initiate cognitions about how the two behaviors can complement one another, and I feel it was successful to some degree. We agree that as well as self-monitoring his smoking behavior, he is going to keep a record of what he does with his time in between each cigarette. I feel these targets enough for David to think about after the first session, and I hope the information will act as a prompt to strengthen the reflection on the link between his behavior and smoking habits (particularly his physical activity, or lack of physical activity, and his smoking). The goals he has arrived at will give an insight into his level of self-regulatory skill when I next see him, which will be informative as to how to progress. He leaves the first session with the self-monitoring sheets for recording his smoking behavior and daily routines with the intention to try to cut out the several consecutive cigarettes first thing in the morning.

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Reflecting on the first session, I feel it was mostly successful and have a reasonable level of confidence that David will return the following week. In terms of his readiness to change, for his smoking behavior he demonstrated being at the contemplation stage for cutting down, and I hope by the next session he will be progressing through to the action stage. For his physical activity behavior, although he describes long-term goals of wanting to be able to do more, it is not something he was contemplating at the time of the session. Through prompting reflection on the benefits of becoming more active, he has shifted from the pre-contemplation into the contemplation stage with tasks that should help to develop thoughts around his behavior. Next session I hope to support David in moving towards the action stage of initiating some increase in physical activity. I feel satisfied that introducing the behaviors sequentially, in terms of goal setting, was the right way to move forward with David.

When David returns the following week, his body language and general demeanour portray a sense of satisfaction with the previous week. He has his diary sheets with him, which is a positive sign. I ask to look them over and then encourage him to talk through how he found the task he set of monitoring his behavior.

*D: You know what, it was brilliant doing that. After the first two days I realised straight away that I was smoking more than I thought I was! I counted them up, and I was actually smoking 35-40 a day, which is more than I have always been convincing myself I smoke. That alone scared me. The fact I could have so little awareness and control over my smoking, it really was an eye opener.*

*T: I see, that is quite a big discrepancy. So how did that affect you?*

*D: Well, I thought, "am I really smoking that much?," you know, it kind of shocked me into thinking even more I need to cut down my smoking. That was it then, after the second day I thought to myself I really need to change this. So, as you can see for the third day onwards, I cut it down to about 20-25 a day, which to be honest wasn't a problem.*

*T: So just recording how many you're actually smoking made you realise how little control you had over it?*

*D: Yeah, that's right, and I felt like I want to take control back, rather than being controlled by it.*

*T: You mentioned it was easy to cut down to 20-25, how did you go about that?*

*D: Like we talked about, I only had one in the morning before showering and getting going, that was easy enough, because I thought about it after that first cigarette and realised I didn't actually want another one really, so I just waited. Then you see, I was actually doing that quite a lot through the day when I wasn't doing much, with my cups of coffee smoking two or three one after the other, so I just cut those out because I didn't really want them, and rating them on how much I enjoyed them it was obvious I wasn't actually enjoying them, just doing it out of habit and boredom. So I would have a cigarette with my cup of coffee and then get on and do something to distract myself. It wasn't always easy mind you, but it worked most of the time.*



David's revelations over the past week are indicative of him taking active control over smoking habits and demonstrate improved awareness of how and why he smokes. As is often the case with heavy smokers, the simple act of self-monitoring prompts and reinforces the self-re-evaluation of their behavior, often revealing they had little or no idea of their smoking habits that have become so ingrained in their day-to-day routines that awareness of the behavior is minimal. I feel pleased at David's response to the task, particularly how he describes using some kind of distraction technique to help cope with missing habitual cigarettes. He has cut out the cigarettes he felt would be easiest for him to miss. This approach is frequently used when smokers begin to cut down – the first cigarettes are easy to cut out and progress can be quick at the beginning. I am wary that as the easier cigarettes are cut out through simple behavioral changes, reducing the cigarettes David feels are pleasurable is going to be harder to tackle and more powerful techniques will be needed to address reduction the further he goes.

With more discussion around the sheets he has kept on his smoking, we identify the cigarettes he places most value on and gains the most enjoyment from. These typically consist of the first one in the morning, ones with a cup of coffee, and ones after eating. The remaining cigarettes he attributes to smoking out of boredom when he has little to do during the day. He admits to not enjoying them much but has lower confidence than I would hope for to cut these out, rating his confidence around a five out of ten. David shows good levels of self-regulatory skills, so I decide to push him on how he feels he could cope without these cigarettes, seeing an opportunity to introduce physical activity while continuing to assess his confidence for sustaining the changes he has made.

*T: Well, it seems you've made very good progress this week, and you are quite pleased with that, as you should be; it's not an easy thing to achieve. How confident do you feel that you can continue with the level you've reduced to this week?*

*D: I feel very confident actually. The ones I cut out were just habit, pure and simple. I wasn't even really enjoying them, you know? Was just smoking them for the sake of it, and that's just stupid. I don't feel like I really miss them.*

*T: That sounds positive. So you've cut out the cigarettes you smoke one after the other, and looking at your diary, it now leaves you smoking at pretty evenly spread intervals throughout the day, and often smoking in response to doing something, like your coffee, or after having lunch.*

*D: Yeah, that's about right.*

*T: So how important is it for you to cut down some more?*

*D: Oh, really important, like I said at the beginning I want to get down to at least half, which I thought would be down to about ten a day but that would actually be more than half! But I would still like to get down to ten a day, because then I would only be buying one pack of ten a day rather than up to two packs of 20, I'd save so much money!*

*T: So, looking at the diary of your cigarettes, which ones do you think would be easiest for you cut out next, over the next week perhaps?*

## Example Case Study

*D: Well, like we said, the one in the morning is probably my favorite, and the ones after food. I guess the times I smoke purely out of boredom, it would be good to get rid of those. That would cut out about another ten a day if I could do that.*

*T: Looking at what you've been doing over the past week and when you smoke, as you probably noticed, when you're doing something active you don't tend to smoke. It's interesting when you walk your dog each day, you don't seem to smoke, and you don't seem to smoke for about an hour after that walk. Compared to times where you've been watching TV or using your computer where you seem to smoke a lot more. Why do you think that is?*

*D: I don't know really. I guess when I'm out walking I don't really think about it, and it kind of seems a bit silly smoking when I'm walking, you know, doing something good and healthy and then having a cigarette; it doesn't really go together. But then when I'm at home bored in front of the TV it's something to do, and the temptations there all the time.*

*T: When you go out walking, you go for about an hour and a half without a cigarette, which shows you can go for quite a long time without one, but when you're at home it's more like every half an hour.*

*D: Yeah, that's about right.*

It has been a really important exchange of information at this point for working the conversation towards physical activity. It sounds like the initial changes David has made to his smoking behavior will be sustainable for him, and I hope to build on these changes by encouraging him to progress his targets further. By building on the discrepancies between his two behaviors I am hoping David will connect his more active behavior with his lower smoking levels. Physical activity seems to have been implicitly affecting his smoking behavior, and I am hoping he will make this connection more explicit and get him moving towards the contemplation and action stage of change to use physical activity to control his smoking habits.

*T: From what you've said, you don't feel the need for a cigarette when you're out walking and go for an hour and a half without one, and then when you're at home you smoke nearly every 30 minutes. You're obviously able to go for longer without a cigarette, so how could you use that from day to day to help reduce further?*

*D: Well, I suppose the obvious thing for me to try would be to try and extend how long it is between each cigarette I have? You know, instead of every half an hour try and make it only every hour or something like that.*

*T: That's a reasonable idea. That would reduce the total amount you smoke each day. How confident are you that you could extend each cigarette to an hour in between each one then?*

*D: Pretty confident I guess, because I do go for longer periods without one so I can do it, it's just coping with the boredom. I would have to distract myself.*

*T: Thinking about what your diaries show, what kind of things could you do to distract yourself?*

*D: Well, the best time for me not smoking is when I'm out walking the dog, you know, when my mind's off it, and I'm not thinking about it, so I suppose I could walk the dog for longer. He always needs more walking, and I'm the only one that does it.*

*T: Sounds like it could be a good idea. You usually walk the dog in the afternoon, right? What about the period in the morning when you smoke more, between breakfast and lunch?*

*D: I could take him for a walk in the morning as well I guess, wouldn't hurt, me or the dog.*

*T: How long would you walk for in the morning?*

*D: Probably about an hour like in the afternoon.*

*T: Would that be easy enough for you to do?*

*D: Oh yeah, no problem. It would certainly take my mind off the cigarettes like in the afternoon. I could definitely do that. Some mornings I have to go to the job centre so I couldn't do it then. But I suppose I could walk down there instead of jumping on the bus.*

*T: Sounds reasonable. It seems that you think doing something active helps take your mind off the cigarettes. How could you use that for when you start craving one, and you haven't got time for a walk?*

*D: Well, I could get up and do something, like clean the house or cut the grass or something; the wife would be pleased!*

David has started to make the explicit link between activity and controlling his smoking behaviour and cravings. He has also started to think about changing his daily behaviors, such as walking to where he needs to be, which is encouraging. Because he responded well to the self-monitoring of his smoking, I decide to suggest self-monitoring his activity as a useful way to encourage reflection on his daily activity. Like his smoking, where he has implemented goal setting and self-monitoring, it would be good to see him use similar techniques for his activity. Again, with his permission, I frame the suggestion as vicarious experience.

*T: Something other people have found useful for looking at their activity is using a pedometer, a little monitor you wear on your belt that counts how many steps you take each day. It gives them an idea of how much their activity changes on a day-to-day basis, and sometimes that links with how much they've smoked – so on days when they do less steps they smoke more. Is that something you would be interested in trying?*

*D: Yeah definitely, sounds good. It was useful to record how much I smoke, and I would be interested to see how much I walk when I'm with the dog.*

To start bringing the session to a close, I ask David to reiterate the goals he has set himself for the coming week: to continue with the reduction he has already achieved and continue self-

## Example Case Study

monitoring his smoking, to smoke no more than one cigarette every hour, to wear the pedometer each day and record his steps, to take his dog for an extra walk in the morning, and to think about doing something active when he finds his cravings are high. He has set an aim to reduce to 15 cigarettes a day by the end of next week, an aim with which he feels comfortable and confident. I am happy at this stage that he is still retaining a strong sense of control and autonomy over his goals and the changes he is making. Upon reflection I am aware he talks little about interaction with his family and friends, particularly in the evenings and how this interaction with others influences his smoking. I add it to my agenda for the next session as something to explore.

Up to this point David's progress has been exemplary, and he has faced little in the way of setbacks and obstacles. Although this situation is positive, it is likely there will be setbacks, and discussing coping strategies for when setbacks do occur will also be important to sustain his progress.

Over the next two sessions David continued to self-monitor his behaviour well demonstrating good levels of self-regulatory skills and reviewing the sheets he has completed has acts as a good way to identify successes and failures he may have experienced framing any failures and setbacks as good learning experiences. I have been keen to shift the focus towards his physical activity and over this period of a few weeks he has experienced some difficulties, but by exploring different options relating to physical activity he has set himself further goals (largely revolving around walking as an activity) which he deems to be more achievable and over which he feels more confident in sustaining. He has begun to explicitly link how his activity levels affect his smoking behaviour, and has started to explore options for involving significant others in his activity. He reports that on some days he has smoked less than ten cigarettes per day, something he is very proud of and resulted in noticeable boosts in his confidence, such a boost in fact that he has mentioned the idea of stopping smoking altogether. After some lengthy discussion around his desire to stop, he decides that he feels confident to make a quit attempt and due to the progress he has made I feel it is appropriate to support him in his plans. In addition to the goal of quitting he has made plans to explore physical activity options involving his family, such as swimming, and finding out information regarding the gym at the local leisure centre. After these sessions I am intrigued to see how well David does in achieving what are some pretty challenging goals.

When David returns the following week he is all smiles. He has clearly achieved some, if not all of his plans. Although his progress has been exemplary up to this point, quitting altogether is incredibly difficult, and I would not be surprised if he had experienced some degree of failure. So I begin by inviting him to tell me about his week, letting him start at which ever point he chooses.

*D: Well, I did it! I had my last cigarette! I know we talked about cutting it down again a bit more before stopping, but after I went along to that gym, they did the induction there and then, I came out and felt so good about myself, I thought, nope, that's it. I didn't have another cigarette that day, and haven't since. If anything, coming out of the gym I would*

*feel stupid, if not embarrassed about having a cigarette; it's just not something that goes together! I can't go to the gym every day as they told me, but I've been using my walking, exercise band, and the swimming, which we're doing twice a week, and I've been managing to cope. I've had the cravings, pretty badly at times, but I just make myself do something, and once I get over that initial craving, it kind of disappears. I know it's not been quite a week yet, but I feel confident I can keep this going.*

*T: That's fantastic David, well done!*

I am keen to reinforce any positive changes he has experienced since quitting and adopting the exercise. Off the back of this exchange I hope to discuss how he plans to maintain his abstinence and how to deal with any setbacks that may crop up in the future.

*T: So how do you feel now you've stopped for nearly a week?*

*D: I feel great, liberated almost. I feel like I don't have that craving in the back of my mind all the time, like it's been silenced. After I take some exercise or come back from my walk, I feel energised and ready to go – it's almost better than a coffee! My breathing is definitely better. I don't feel quite so out of breathe swimming now and managed to do more lengths of the pool this week so there's definitely an improvement there. The family are obviously happy I've stopped; they even commented that over the last few weeks I'm not coughing as much.*

*T: What you've achieved is remarkable, well done. Looking forward, how are you going to sustain what you've achieved? How will you deal with things when you find your cravings might come back? Maybe something stressful happens or you find yourself getting bored again. What things will you do to help with that?*

*D: The activity is definitely something I will continue with. I've actually started really enjoying it. What's the point in smoking if I'm doing these things? If the cravings do come back I will do what I've been doing, get the exercise band out, go for a walk, things like that, keep myself active and busy. I hope to go back to work at some point, which will keep me busy during the day, and then I can still do my walking or the gym in the evening. I feel so good about myself after doing some activity, and feel the differences in my health. I am confident it will last this time. Besides, the family wouldn't let me slip back to smoking or not going swimming now they're coming with me!*

After this session David and I meet twice more. He continues with his activity patterns, and in the last session he tells me he has a job interview that has boosted his self-esteem even more. He tells me of how he has been putting aside the money he used to spend on cigarettes to pay for his gym membership, and he still has enough left over to save towards a holiday for the family later that year. Towards the end of our sessions I felt completely superfluous – he was in control of his own behavior and knew what he needed to do. For me, this was evidence of success. He continued to be abstinent, and I am pretty sure he began losing weight!

## **Conclusion**

## Example Case Study

The path to quitting or reducing smoking is rarely linear, and one size does certainly not fit all. David's story is particularly exemplary in terms of the goals he achieved and how well he achieved them. A case like this is quite rare and more often than not clients will not progress so readily and will encounter more challenging barriers to change, often due to not having such a strong capacity for self-regulation. There is a variety of support available for smokers wishing to quit, but overcoming a nicotine addiction is incredibly difficult. As the case study demonstrated, the challenge of cutting down and quitting can be addressed through a variety of strategies to promote self-regulation of smoking behavior. Ultimately it is individuals' motivations to quit, the importance they place on quitting, and their experience and management of withdrawal symptoms that will determine how successful they are at changing their smoking habits. As demonstrated, motivation and confidence can snowball if tackled in the right way. Early change can be slow as individuals begin to reflect on processes and behaviors, but as is often the case, once the reflective process and self-re-evaluation begin, the change can become quite sudden.

Physical activity and its physical, mental, and emotional benefits make it an ideal adjunct to help counteract the negative effects of nicotine withdrawal. The timing of when physical activity is introduced to individuals who want to change their smoking behavior largely depends on their stages of readiness to change and their goals. The adoption of a new activity when going through the process of stopping a current one dovetails together in a nicely coherent fashion. Some smokers will find adopting a new activity harder than others, but it is not necessarily the amount or intensity of the activity that is important, more the benefit (both psychologically and physically) the individual experiences from it. By using physical activity as a replacement activity for their smoking they can still satisfy their need for a sense of control which may have been stripped from them through their smoking addiction. Physical activity presents, in almost all cases, a chance to satisfy an individual sense of autonomy, competence, and relatedness within their lives when addressing their smoking behavior. As smoking is reduced there is an ideal opportunity to engage in various forms of self-determined PA that rapidly become easier to do, and hence, result in improved perceived competence and physical self-perceptions.

# Appendices

## 1. Balance Sheet 1



The area in which I am thinking about changing is (e.g. my smoking behaviour, my eating behaviour)

.....

.....

.....

If I <b>DO</b> change my behaviour	
<div></div>	<div></div>
<div></div>	<div></div>

### How certain are you that you want to change this behaviour?

On a scale of 1 to 10, how *certain* (*sure*) are you that you want to change this behaviour? 1 = Not certain at all      10 = Very certain

Circle a number on the line below

Not certain at all   1-----2-----3-----4-----5-----6-----7-----8-----9-----10   Very certain



## 2. Balance Sheet 2



If you can think of more disadvantages than advantages of changing your behaviour, look at the disadvantages and discuss ways of reducing them.

Disadvantages of changing behaviour	Ways of reducing disadvantages
• .....	• .....
• .....	• .....
• .....	• .....

What are the advantages and disadvantages of NOT changing your behaviour?

If I <b>DON'T</b> change my behaviour	

How certain are you that you want to stay the same?

On a scale of 1 to 10, how *certain (sure)* are you that you want to stay the same? 1 = Not certain at all      10 = Very certain

Circle a number on the line below

**Not certain at all**   1-----2-----3-----4-----5-----6-----7-----8-----9-----10   **Very certain**

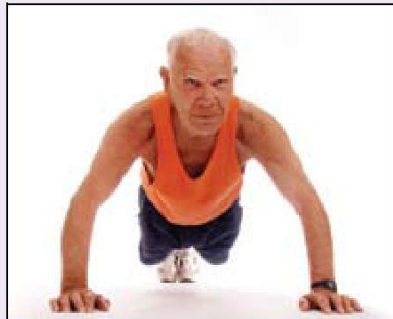
### 3. Health Benefits Cards

#### The benefits of giving up smoking

Reduce the chances of getting lung disease and heart disease  
Reduce the chances of getting cancer  
Being able to run/walk without getting out of breath  
Save money by not buying cigarettes  
Clothes and breath will smell better  
Sense of taste will improve  
Skin will look better  
Likely to live longer  
Smoking is banned in most public places



#### The benefits of increasing physical activity



Reduce risk of heart disease, high blood pressure, osteoporosis, diabetes and obesity  
Sleeping better  
Reduce some of the effects of ageing  
Joints, tendons and ligaments will be more flexible  
Help maintain a healthy weight by increasing metabolism (the rate we burn calories)  
Can relieve stress and anxiety and make you feel happier  
Increase energy and endurance levels

#### 4. Physical Activity Diary

Use this diary to record any physical activity you do throughout the week – this includes things like walking, using the stairs instead of the lift or carrying light loads as well as sports and going to the gym. Write down how long you do these activities for

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
<i>Pedometer Steps</i>							

## 5. Smoking Diary

Use this diary to record how many cigarettes you smoke throughout the week – writing in the diary each day will be easier than trying to remember how many you smoked at the end of the week. Scoring how much you enjoyed each cigarette (out of 10) can be useful to help figure out which ones to cut out

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							
<i>Total</i>							

## 6. Combined PA and Smoking Diary

This diary may allow for a more in depth look than the fridge magnet and pedometer at smoking and PA behaviours together, looking at types and times of PA relating to smoking patterns.

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	PA	Smoking	PA	Smoking	PA	Smoking	PA	Smoking	PA	Smoking	PA	Smoking	PA	Smoking
Morning														
Afternoon														
Evening														
<i>Total</i>														

7. Action Plan

My action plans

See “How to make Action Plans” for guidance on using this.

A goal I have is...

I aim to achieve this by... (a date)

In order to achieve my goal I will:

Possible obstacles and how I will deal with them

Use the scale below to judge how easy or hard it will be to keep this up for several years. If you plan scores 7 or less, adjust it or dump it.

Very hard							Very easy		
1	2	3	4	5	6	7	8	9	10
Would it be better to try something else?			Tweak the plan to make it easier to keep up.				Go for it!		

# How to make Action Plans

Action Plans are all about deciding what you are going to do to achieve a particular goal. Here is an example:

My goal: *to eat smaller portions of high calorie food at suppertime*

My action plans:

- *I will drink a large glass of water before I start eating supper*
- *I'll ask my partner to put more vegetables and less high-calorie food on the plate, and not to offer me seconds.*

Try to make your plans specific, by thinking about exactly **what** you are going to do, **when** or **where** you will do it, and **who** else might be involved.

**Remember:** Each change that you make will get you a certain way towards your weight target. Making several small changes can be the best way of reaching your goal.



**TIP:** *research shows that people who declare their plans are more likely to carry them out. You can do this by writing them down (this will also help you make them clear), or by telling them to someone else.*



## 8. ABC Form

<b>At first</b> Before you did the behaviour: • What were you doing? • What were you thinking? • What were you feeling? • Who were you with?	<b>Behaviour</b> What did you do?	<b>Consequences</b> What happened after this? How did you feel?
<i>e.g. I was feeling stressed because I was thinking about work.</i>	<i>e.g. I smoked a cigarette            OR I wanted a cigarette but I went for a walk instead)            OR            I wanted a cigarette but instead I took my dog out for</i>	<i>e.g. I really enjoyed the cigarette, but felt guilty afterwards. OR            I felt happy that I didn't give in, and I enjoyed spending time with my dog.</i>

## 9. Rewards

### Rewards – reminder sheet

Giving yourself little treats to reward yourself when you've made progress towards your goal can encourage you to keep going and make more progress. You don't have to wait until you've achieved your goal to reward yourself – remember that a big goal can be broken down into smaller mini-goals. Reward yourself for any mini-goals you reach, and any other small successes that you have along the way. Rewards don't have to cost money, but you can also 'save up' for rewards. For example, save £1 every time you do some physical activity, then at the end of the week or the month spend the money on a reward for yourself. If you can't think of many rewards, here are some examples:

#### Rewards that don't cost money

- Having a nice relaxing bath
- Borrowing a book or magazine
- Inviting friends round
- Having some 'me' time when you can do whatever you want to
- Listening to music
- Going for a walk
- Watching your favourite TV programme
- Doing some gardening
- Asking friends or family to look after your children so you can have some time for yourself
- Asking friends or family to notice and praise you when you have achieved something.

#### Rewards that cost money

- Buying yourself a CD/magazine
- Buying yourself new clothes
- Going to the cinema
- Buying yourself flowers
- Buying yourself sports equipment
- Going to a football match
- Going out for a meal
- Renting a DVD
- Booking a holiday or weekend break
- Buying yourself some perfume/ aftershave.

### Warning!

Try not to choose rewards that are unhealthy. For example, if you are trying to eat more healthily, rewarding yourself with a bar of chocolate every time you eat five portions of fruit and vegetables is not a good idea



## 10. Rewards – client worksheet

Use the table below to make a list of things you could reward yourself for, and what those rewards could be.

Things I will reward myself for	What will be my reward for this?

## 11. Difficult Situations

### Difficult situations and 'if-then' plans

#### Difficult situations

- Are there any situations that you can think of that could make it especially difficult for you to perform the behaviour? A time or a place or a feeling that might tempt you to go back to your old behaviour?

For example: on a Sunday night I get really stressed thinking about work on Monday, and I *really* want a cigarette.

Make a list of your difficult situations:

.....

.....

.....

.....

.....

.....

.....

Now make some plans for how to avoid these situations or make them more manageable. For each difficult situation, think of something you could do that would lower the chance of it interfering with your planned behaviour.

For example, **if** on a Sunday night I'm feeling stressed, **then** I will have a nice long bath and listen to some relaxing music instead of having a cigarette.

Fill in the table below with your difficult situations, and for each one, make an 'if-then' plan for coping with it.

Difficult situations If...	How I will avoid or cope with them Then...
<ul style="list-style-type: none"> <li>• .....</li> <li>.....</li> <li>.....</li> <li>• .....</li> <li>.....</li> <li>.....</li> </ul>	<ul style="list-style-type: none"> <li>• .....</li> <li>.....</li> <li>.....</li> <li>• .....</li> <li>.....</li> <li>.....</li> </ul>

## 12. Barriers and facilitators



### Unhelpful things/barriers:

**Places and things.** Is there anything about the things around me or the places I am in that makes it difficult to do this behaviour? What can I do to change this?

.....

.....

.....

.....

.....



b) **People.** Are there any people I spend time with who make it difficult to do this behaviour? What can I do to change this?

.....

.....

.....

.....

.....



c) **Thoughts and feelings.** Is there anything that I am thinking or feeling that makes it difficult to do this behaviour? How can I overcome these things?

.....

.....

.....

.....

.....

**Helpful things/facilitators:**

**Places and things.** Is there anything about my physical surroundings that makes it easier to do this behaviour? What can I do to use these helpful things?

.....

.....

.....

.....

b) **People.** Are there any people I spend time with who make it easier to do this behaviour? How can I ask them to help me?

.....

.....

.....

.....

c) **Thoughts and feelings.** Is there anything that I am thinking or feeling that makes it easier to do this behaviour? How can I encourage these thoughts and feelings?

.....

.....

.....

.....



### 13. Personal Health Guide

**My general goal is:**.....  
.....  
.....

#### **My specific goal**

**What** am I going to do?. .....  
.....

#### **My action plan**

**Where** am I going to do it? .....  
.....

**When** am I going to do it? .....  
.....

**With whom** am I going to do it? .....  
.....

#### **How will I know how I'm doing?**

It is important to measure and record your progress, so you can be motivated when you see that you are succeeding, and to work out what you can change if your plan is not working.

**What** will I record in my diary?

.....

**When** will I record it?

.....

**Where** will I keep my diary?

.....

#### **Client contract**

I will do the behaviour (as explained in the My specific goal section) and bring my behaviour change diary to the next meeting.

Client signature

.....

Date .....

#### **Health Trainer contract**

I will discuss with you your Behaviour Change Diary and how you got on when you bring it back at the next meeting.

Health Trainer signature

.....

Date .....

Date and time of next meeting:

## 14. Becoming your Own Health Trainer

You have successfully changed and maintained a new behaviour. The next stage is to take the skills that you have learnt and apply them to other areas of your life and other behaviours that you want to change. This sheet is a summary of the main points of behaviour change to help you remember all the skills you have learnt so far.

### Deciding on a behaviour to change

You could fill in the Health Behaviour Check again. If you can't decide whether or not you want to change a particular behaviour, it may be helpful to think about the benefits (good things that will happen) if you change your behaviour and the costs (less good things that will happen) if you change your behaviour (you could use a table like the one below).

If I DON'T change my behaviour

If I DO change my behaviour

Advantages

Disadvantages

Advantages

Disadvantages

### Setting yourself a goal and filling in a Personal Health Guide

Your goal needs to be **SMART**, not vague. For example, a vague goal would be "I'm going to drink less," a specific goal and plan would be "If I go to the pub on a weekday **then** I'm only going to drink one pint of lager."

Use the **SMART** goal sheet to check whether your goal is:

**Specific, Measurable, Achievable, Realistic and Timely.**

To check how confident you are that you can achieve this goal, use the confidence ruler to score your confidence out of 10:

**Not confident at all 1----2----3----4----5----6----7----8----9----10 Very confident**

If you score **7 or more**, fill in your Personal Health Guide.

If you score **less than 7**, you might need to think about what things may be making it difficult for you to do this behaviour, and how you can solve these problems. Ask yourself the questions in the box on the next page.



### Unhelpful things/barriers

a) **Places and things.** Is there anything about where I am or what is around me that makes it difficult to do this behaviour? What can I do to change this?

.....  
.....  
.....

b) **People.** Are there any people I spend time with who make it difficult to do this behaviour? What can I do to change this?

.....  
.....  
.....

c) **Thoughts and feelings.** Is there anything I am thinking or feeling that makes it difficult to do this behaviour? How can I overcome these things?

.....  
.....  
.....

Once you have answered those questions, check your confidence level on the ruler again. If you score 7 or more, fill in your Personal Health Guide. If you score less than 7, think about setting yourself a slightly easier SMART goal.

### Reviewing progress

If you have not arranged another appointment with your Health Trainer, make sure you set yourself a time limit for when you are going to review your progress.

- Make sure you have a plan of where and when you are going to fill in your Behaviour Change Diary.
- Regularly review your Behaviour Change Diary and Personal Health Guide: look back at your diary and think about what you have achieved.

If you were successful on every occasion, you could either continue with the same goal again next week, or set yourself a new, slightly harder SMART goal, and fill out a new Personal Health Guide.

Even if you didn't achieve your goal on every occasion, you will probably still find examples of when you were successful. Look at the times when you made some progress towards your goal – did you do anything differently or did you feel different compared with those times when you weren't as successful? Were there any people/places/things/feelings that made it easier to do your goal behaviour? Is there any way you can make more use of these helpful things?

If you are finding it too difficult to do your goal behaviour, think about what people/things/places/feelings are making it difficult for you. Can you change any of these to make it easier? If not, try setting yourself a slightly easier SMART goal, and fill out a new Personal Health Guide.

#### Remember:

- Reward yourself when you achieve parts of your goal as well as all of your goal.
- Make sure you are getting enough support and you are using it.

## 15. Smoking Reduction Approaches

### Hierarchical Reduction

Certain cigarettes offer higher reward value than others and as such are harder to give up. The first cigarette in the morning (following overnight abstinence) is routinely reported to be the hardest to give up. It has even been suggested that the only question of importance in assessing a person's level of smoking dependence is 'how soon after waking do you smoke your first cigarette?'

Hierarchical reduction works by asking people to rank cigarettes in order of the easiest to the hardest to give up. Starting with the easiest, smoker's plan which ones they will give up on a specified time scale. It may be one a day over a two week period or however the person feels best to progress, eliminating the easiest and eventually beginning on the harder cigarettes to give up, as confidence to go without a cigarette increases.

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM	1 <sup>st</sup> in the AM
Driving to work	Driving to work	Driving to work	Driving to work	Driving to work	Driving to work	Driving to work
Morning break	Morning break	Morning break	Morning break	Morning break	Morning break	Morning break
Before lunch	Before lunch	Before lunch	Before lunch	Before lunch	Before lunch	Before lunch
After lunch	After lunch	After lunch	After lunch	After lunch	After lunch	After lunch
Afternoon break	Afternoon Break	Afternoon break	Afternoon break	Afternoon break	Afternoon break	Afternoon break
Driving from work	Driving from work	Driving from work	Driving from work	Driving from work	Driving from work	Driving from work
1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening	1 <sup>st</sup> in the evening
Before dinner	Before dinner	Before dinner	Before dinner	Before dinner	Before dinner	Before dinner
After dinner	After dinner	After dinner	After dinner	After dinner	After dinner	After dinner
Last 1 before bed	Last 1 before bed	Last 1 before bed	Last 1 before bed	Last 1 before bed	Last 1 before bed	Last 1 before bed

### Smoke Free Periods

The Smoke free periods approach works by breaking an individual's day up into blocks of specified time periods (eg 30 mins). Depending on their routine (work etc) there may be periods where they do not smoke anyway, and periods where they smoke more. Using chart, smokers then go on to block out certain times of the day where they will not smoke (perhaps increasing by one 30 minute smoke free period per day) until they have reached a certain goal.

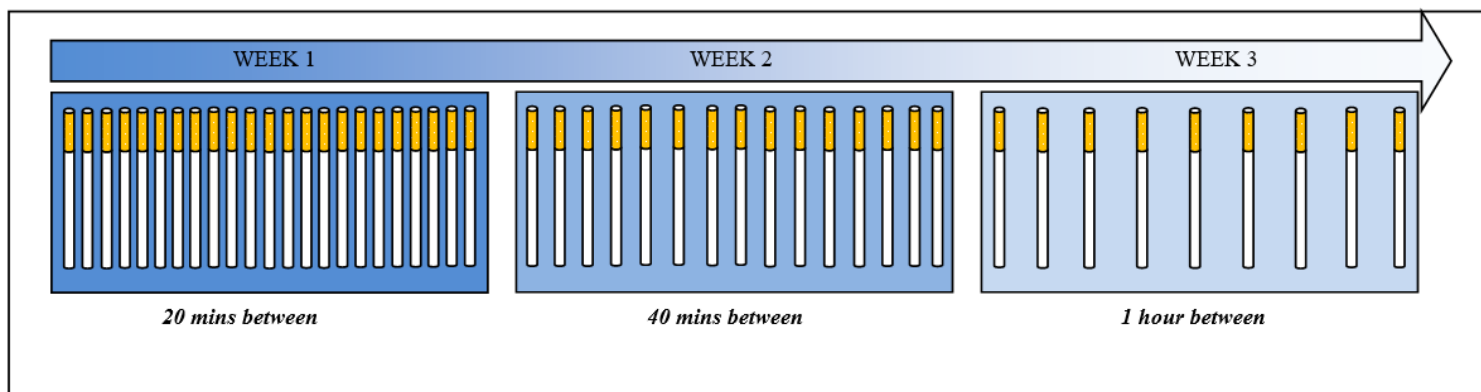
Importantly with the smoke free periods approach, there is no specified number of cigarettes which are being cut out or smoked. They can smoke as much as they like, but ONLY in the periods not identified as smoke free. This approach aims to break the behavioural pattern of smoking which will result in a decreased desire for smoking and a natural reduction.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
AM	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
PM	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>
	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>

## Scheduled Reduction

The aim of the scheduled reduction approach is to systematically reduce at a specified rate, breaking habit and routine gradually. It begins with identifying how many cigarettes a person smokes in a day, and calculating how much time between each cigarette is needed to space them evenly through the day. For example, a 40 a day smoker, who is awake for 16 hours a day, would need to smoke a cigarette every 24 minutes to get through 40 in one day. Targets are then set to gradually increase the time between each cigarette with a specific end goal in sight.

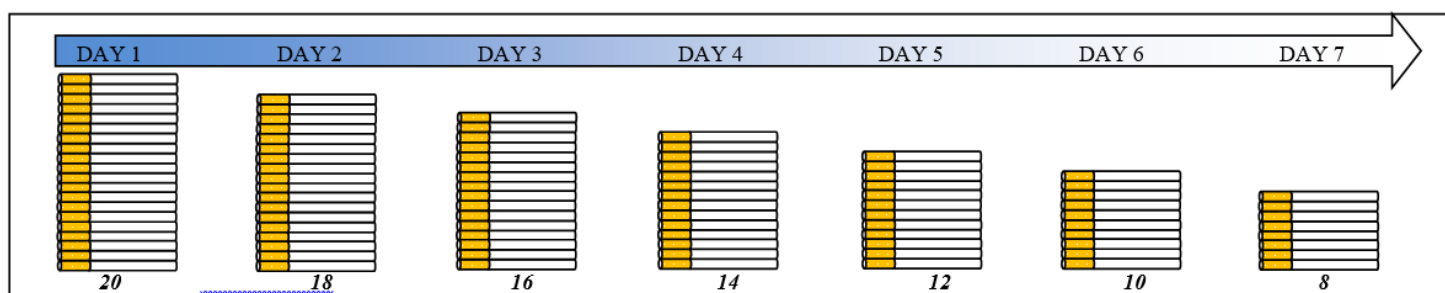
Important to this method is the necessity to smoke at every specified time point, whether it's desired or not, which again helps to break the habit of smoking.



## Planned Reduction

Perhaps one of the simplest ways to plan reduction, this approach works by setting targets for how many cigarettes will be smoked each day. Then each day begins with that number in their pocket, and purchasing additional ones is to be avoided.

The rate at which they reduce is determined by them and ultimately how much they want to reduce by and over what period. This approach fits particularly well with goal setting and action planning processes described in the HT Handbook.



## 16. Core Competencies

### ITEM 1: ACTIVE PARTICIPANT INVOLVEMENT

**Key features:** The HT should ensure the client is actively involved in the consultation. The idea is to maximise the smoker's autonomy as the main agent of change, developing intrinsic rather than extrinsic motivation, and encouraging her /him to be the person coming up with the desire to change behaviour. However, the smoker should not be allowed to ramble in an unstructured way and the consultation should be guided. A collaborative /shared decision-making style is appropriate and the HT may share his /her own expertise and ideas, using techniques such as elicit-provide-elicite (below). Overall, the smoker should be increasingly empowered to take control of her /his smoking and related physical activity behaviour. Interactions should be encouraging, respectful and non-judgemental (the opposite of a didactic, telling or persuading style of interaction). The smoker should ideally talk for at least half of the time. The interaction should also be *individually tailored* to the participant's specific information needs, beliefs, motivations and barriers. The HT should engender a clear sense of warmth, genuineness and empathy (within professional boundaries).

**Intervention techniques:** OARS (Open questions, Affirmation, Reflective listening, Summaries). Reflective listening may include simple reflections of content but may also be more sophisticated (e.g. amplified reflection; reflection with a twist) and used to direct the conversation or highlight key strengths or barriers. The Ask-Tell-Discuss (elicit-provide-elicite) technique should be used to exchange information (e.g. to address misconceptions, or offer helpful new information). The above empathy-building techniques and Individual tailoring should be used throughout the consultations - from the initial consultation through action-planning through to review /maintenance sessions.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- |   |  |
|---|--|
| 0 | Absence of active participant involvement techniques. A highly didactic /practitioner-led or 'lecturing' style of interaction, which may increase or sustain client's resistance |
| 1 | Minimal participant involvement or use of active participant involvement techniques. The practitioner dominates the discussion   |
| 2 | Appropriate use of participant involvement techniques, but not frequent enough. The practitioner sometimes dominates the discussion  |
| 3 | Appropriate and frequent use of participant involvement techniques. Teamwork evident, but some difficulties in content or method of delivery                                     |
| 4 | Appropriate and frequent use of participant involvement techniques. Minor problems evident (e.g. some reflection opportunities missed)   |
| 5 | Highly appropriate and regular use of participant involvement techniques, facilitating shared understanding and decision making. Minimal problems                                |
| 6 | Excellent / expert use of participant involvement techniques throughout all consultations. A clear sense of collaborative alliance is developed.                                 |

## ITEM 2a: MOTIVATION-BUILDING FOR CUTTING DOWN (QUITTING)

**Key features:** The HT should work with the smoker to explore initial beliefs about cutting down, and quitting (importance and confidence, triggers for smoking). The smoker's motivation and confidence for cutting down is built up/enhanced through the exchange of information and techniques to assess and enhance motivation – i.e. to enhance the perceived benefits (importance) of cutting down /quitting and confidence (self-efficacy) to take the actions needed.

**Intervention techniques:** OARS (Open questions, Affirmation, Reflective listening, Summaries) should be used specifically to explore current and past smoking behaviour, the pros and cons of cutting down and to develop discrepancies between current behaviour and desired behaviour (or outcomes). The decisional balance technique or 0-10 questions may be used to explore importance and confidence. Information should be exchanged on the pros and cons of cutting down and this and other techniques (exploring possible futures; discussing past quitting attempts) should be used to explore barriers and possible solutions to increase confidence about cutting down /quitting. Motivation-building should ideally happen around the start of the intervention process, although it can be further explored and reinforced at later (action-planning, review and maintenance) stages. Establishing self-rewards or incentives (e.g. saving money in a jar, planning rewards) may be part of the process for maintaining motivation.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process. NB: achieving a strong motivation is not necessary to score highly here – the aim is to explore motivation sufficiently to allow the client to be able to make an informed choice (which may be not to make any changes at this point in time)**

- |   |   |
|---|---|
| 0 | Absence (or very poor delivery) of motivation-building techniques. Motivation to cut down or quit smoking is assumed or not discussed                                     |
| 1 | Minimal use of (or poor delivery of) motivation-building techniques. Minimal exploration of either reasons for change or confidence about making changes.                 |
| 2 | Some use of motivation-building techniques, but the exploration of motivation to cut down or quit is not of sufficient depth or detail                                    |
| 3 | Appropriate use of motivation-building techniques. However, some difficulties evident (e.g. moving on to change talk before motivation is fully established)              |
| 4 | Appropriate and frequent use of motivation-building techniques relating to cutting down or quitting smoking. Minor problems evident (e.g. some inconsistencies)           |
| 5 | Highly appropriate and sufficient use of motivation-building techniques, facilitating a clear understanding of reasons for change and confidence issues. Minimal problems |
| 6 | Excellent / expert use of motivation-building techniques, facilitating a clear understanding of reasons for change and confidence issues. No real problems                |

## ITEM 2b: MOTIVATION-BUILDING FOR PHYSICAL ACTIVITY

**Key features:** The HT should work with the smoker to introduce PA as an aid to cutting down and quitting. They should explore initial beliefs about *increasing physical activity* (importance and confidence). The smoker's motivation and confidence for introducing new physical activity behaviours should be built up through the exchange of information and techniques to assess and enhance motivation – i.e. to enhance the smoker's perceived benefits and usefulness (importance) of physical activity and confidence (self-efficacy) to take the actions needed.

**Intervention techniques:** OARS (Open questions, Affirmation, Reflective listening, Summaries) should be used specifically to explore current and past physical activity behaviour, the pros and cons of increasing PA and to develop discrepancies between current behaviour and desired behaviour (or outcomes). The decisional balance technique or 0-10 questions may be used to explore importance and confidence. Information should be exchanged on the pros and cons of physical activity and this and other techniques (exploring possible futures; discussing past quitting attempts) should be used to explore barriers and possible solutions to adopting PA strategies /increasing PA. Motivation-building should ideally happen around the start of the intervention process, although it can be further explored and reinforced at later (action-planning, review and maintenance) stages.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process. NB: achieving a strong motivation or any changes is not necessary to score highly – the aim is to explore motivation sufficiently to allow the client to be able to make an informed choice about whether to change or not.**

- |   |   |
|---|---|
| 0 | Absence (or very poor delivery) of motivation-building techniques. Motivation to adopt physical activity strategies is assumed or not discussed                           |
| 1 | Minimal use of (or poor delivery of) motivation-building techniques. Minimal exploration of either reasons for change or confidence about making changes.                 |
| 2 | Some use of motivation-building techniques, but the exploration of motivation for physical activity is not of sufficient depth or detail                                  |
| 3 | Appropriate use of motivation-building techniques. However, some difficulties evident (e.g. moving on to change talk before motivation is fully established)              |
| 4 | Appropriate and frequent use of motivation-building techniques relating to physical activity. Minor problems evident (e.g. some inconsistencies)                          |
| 5 | Highly appropriate and sufficient use of motivation-building techniques, facilitating a clear understanding of reasons for change and confidence issues. Minimal problems |
| 6 | Excellent / expert use of motivation-building techniques, facilitating a clear understanding of reasons for change and confidence issues. No real problems                |

### **ITEM 3a: SELF-MONITOR, SET GOALS, AND DISCUSS STRATEGIES TO REDUCE SMOKING**

**Key features:** The HT should work with the smoker to discuss a range of strategies for reducing the amount of cigarettes smoked. They should agree a verbal plan of action, seeking to make this as specific as possible. They should discuss the use of self-monitoring to keep track of progress.

**Intervention techniques:** Goal-setting (with gradual /graded progression), Action Planning, Self-Monitoring, Deconditioning strategies. Any or all of the four distinct EARS strategies for cutting down (based on breaking the conditioned /automated link between smoking and reward and replacing this with consciously mediated strategies) may be presented and discussed. The action plan should normally be made verbally, but the HT should seek to make this as specific as possible in terms of “What, Where, When and Who with” and making the goal as SMART (Specific, Measurable, Achievable, Relevant and Time-related) as possible. The HT should introduce and discuss with the smoker the usefulness of self-monitoring of behaviours (number of cigarettes smoked, pattern of use). A specific plan for self-monitoring should be included in the action plan. The HT may also encourage self-monitoring of the contexts (social or environmental or emotional circumstances) in which problems /relapses might occur. Pre-empting and thinking of solutions for possible problems (making a coping plan) is also appropriate here and may involve the use of other recognised behaviour change techniques (e.g. engaging social support, stress-management).

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- |   |  |
|---|--|
| 0 | Absence (or very poor delivery) of action-planning techniques or discussion of smoking-reduction strategies  |
| 1 | Minimal use (or poor delivery) of action-planning techniques or discussion of smoking-reduction strategies   |
| 2 | Some use of action-planning techniques or discussion of smoking-reduction strategies, but not in sufficient depth or detail  |
| 3 | Appropriate use of action-planning techniques and discussion of smoking-reduction strategies. However, some difficulties evident (e.g. not setting up self-monitoring; plan generated more by the HT than by the smoker) |
| 4 | Appropriate use of action-planning techniques and discussion of strategies. Minor problems evident (e.g. the plan is a bit less specific than it could be)   |
| 5 | Highly appropriate and sufficient use of action-planning techniques and discussion of smoking-reduction strategies. Minimal problems   |
| 6 | Excellent / expert use of action-planning techniques and discussion of smoking-reduction strategies. No real problems  |

### **ITEM 3b: SELF-MONITOR, SET GOALS, AND DISCUSS STRATEGIES TO SET GOALS TO INCREASE PHYSICAL ACTIVITY**

**Key features:** The HT should work with the smoker to discuss ideas for introducing new physical activities that might help to reduce smoking. They should agree a verbal plan of action, seeking to make this as specific as possible. They should discuss the use of self-monitoring to keep track of progress, including offering a pedometer as a means of monitoring walking activity if appropriate.

**Intervention techniques:** Goal-setting (with gradual /graded progression), Action Planning, Self-Monitoring. Ideas for introducing relevant physical activities should be discussed. The action plan should normally be made verbally, but the HT should seek to make this as specific as possible in terms of “What, Where, When and Who with” and making the goal as SMART (Specific, Measurable, Achievable, Relevant and Time-related) as possible. The HT should introduce and discuss with the smoker the usefulness of self-monitoring of behaviours (using memory, a diary and /or a pedometer). A specific plan for self-monitoring should be included in the action plan. Pre-empting and thinking of solutions for possible problems (making a coping plan) is also appropriate here and may involve the use of other recognised behaviour change techniques (e.g. establishing prompts or cues to do physical activity).

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- |   |   |
|---|---|
| 0 | Absence (or very poor delivery) of action-planning techniques in relation to physical activity  |
| 1 | Minimal use (or poor delivery) of action-planning techniques  |
| 2 | Some use of action-planning techniques relating to physical activity, but not in sufficient depth or detail   |
| 3 | Appropriate use of action-planning techniques. However, some difficulties evident (e.g. no self-monitoring; plan generated more by the HT than by the smoker) |
| 4 | Appropriate use of action-planning techniques relating to physical activity. Minor problems evident (e.g. the plan is a bit less specific than it could be)   |
| 5 | Highly appropriate and sufficient use of action-planning techniques. Minimal problems   |
| 6 | Excellent / expert use of action-planning techniques relating to physical activity. No real problems  |



#### ITEM 4a: REVIEW EFFORTS TO CUT DOWN SMOKING / PROBLEM-SOLVING

**Key features:** The HT should work with the smoker to reflect on progress with *smoking reduction*. The HT should affirm /reinforce any successes. The smoker and HT should discuss any setbacks (reframing to normalise them, identifying barriers and exploring ways to overcome them). The HT and smoker should then set new targets (possibly including making an attempt to quit).

**Intervention techniques:** Use of OARS (Open questions, Affirmation, Reflective listening, Summaries) specifically to reinforce successes, to discuss setbacks, to identify barriers (including social or environmental contexts which increase cravings) and explore ways to overcome them (problem-solving). Reframing should be used to normalise setbacks. Goals /action plans should then be reviewed. There may also be some reflection on, and reinforcement of the smoker's skills in avoiding or managing relapse (building skills and self-efficacy). Problem-solving may involve the use of other recognised behaviour change techniques (e.g. engaging social support, stress-management).

**Using whole and half numbers, the level to which you think the HT has delivered this intervention process**

- |   |  |
|---|--|
| 0 | Absence (or very poor delivery) of progress review or problem-solving techniques in relation to smoking reduction  |
| 1 | Minimal use (or poor delivery) of progress review or problem-solving techniques  |
| 2 | Some use of progress review and problem-solving techniques in relation to smoking reduction, but lacking sufficient depth or detail  |
| 3 | Appropriate use of progress review and problem-solving techniques. However, some difficulties evident (e.g. not reinforcing successes, providing rather than eliciting possible solutions to problems)           |
| 4 | Appropriate and frequent use of progress review and problem-solving techniques in relation to smoking reduction. Minor problems evident  |
| 5 | Highly appropriate and sufficient use of progress review and problem-solving techniques, facilitating a clear understanding of the current situation and how to move forward. Minimal problems                   |
| 6 | Excellent / expert use of progress review and problem-solving techniques in relation to smoking reduction, facilitating a clear understanding of the current situation and how to move forward. No real problems |

#### ITEM 4b: REVIEW EFFORTS TO INCREASE PHYSICAL ACTIVITY /PROBLEM-SOLVING

**Key features:** The HT should work with the smoker to reflect on *progress with introducing relevant physical activities*. The HT should affirm /reinforce any successes. The smoker and HT should discuss any setbacks (reframing to normalise them, identifying barriers and exploring ways to overcome them). The HT and smoker should then revise the smokers PA-related goals.

**Intervention techniques:** Use of OARS (Open questions, Affirmation, Reflective listening, Summaries) specifically to reinforce successes, to discuss setbacks, to identify barriers and explore ways to overcome them (problem-solving). Reframing should be used to normalise setbacks. Goals /action plans should then be reviewed. There may also be some reflection on, and reinforcement of the smoker's skills in avoiding or managing relapse (building skills and self-efficacy).

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- |   |  |
|---|--|
| 0 | Absence (or very poor delivery) of progress review or problem-solving techniques in relation to the physical activity component of the intervention  |
| 1 | Minimal use (or poor delivery) of progress review or problem-solving techniques  |
| 2 | Some use of progress review and problem-solving techniques in relation to physical activity, but lacking sufficient depth or detail  |
| 3 | Appropriate use of progress review and problem-solving techniques. However, some difficulties evident (e.g. not reinforcing successes, providing rather than eliciting possible solutions to problems)           |
| 4 | Appropriate and frequent use of progress review and problem-solving techniques in relation to physical activity. Minor problems evident  |
| 5 | Highly appropriate and sufficient use of progress review and problem-solving techniques, facilitating a clear understanding of the current situation and how to move forward. Minimal problems                   |
| 6 | Excellent / expert use of progress review and problem-solving techniques in relation to physical activity, facilitating a clear understanding of the current situation and how to move forward. No real problems |

## ITEM 5: INTEGRATION OF CONCEPTS: BUILDING AN ASSOCIATION BETWEEN PA AND SMOKING REDUCTION

**Key features:** The HT should work with the smoker specifically to help her /him gain an appreciation of the relationship between physical activity and smoking. A clear rationale should be presented for how PA might be relevant to reducing smoking (e.g. as a distraction, as a way to reduce withdrawal symptoms such as stress or cravings, as a way to prevent weight gain when reducing smoking). However, both explicit processes (explanations) and implicit processes (learning from experience, disrupting usual patterns of smoking behaviour; reductions in withdrawal symptoms that the smoker is not consciously aware of) should be facilitated by the HT.

### Intervention techniques:

Explicit integration techniques might include a) developing (ideally using the elicit-provide-elicite information-exchange technique) an appropriate conceptualisation or rationale for increasing PA as an aid to reducing smoking b) setting up an experiment (to do some extra PA) and encouraging self-monitoring of links between physical activity and cigarette cravings, as well as on cigarette use. Implicit techniques might include setting up an experiment to see if it helps reduce smoking, with monitoring only of outcomes (cigarette use) and without trying to make a conscious link between PA and strength of cravings. Review of experiences with using PA and its impact on cravings or smoking behaviour may also be used in later sessions.

### Using whole and half numbers, score the level to which you think the HT has delivered this intervention process

- |   |  |
|---|--|
| 0 | The absence (or very poor delivery) of techniques to link PA to cravings or amount smoked  |
| 1 | Minimal use (or poor delivery) of techniques to link PA to cravings or amount smoked. No clear rationale linking PA to smoking reduction is understood by the client   |
| 2 | Some use of techniques to link PA to cravings or amount of cigarettes smoked, but not of sufficient depth or detail. Only a limited rationale linking PA to smoking reduction is understood by the client.                                 |
| 3 | Appropriate use of techniques to link PA to cravings or amount of cigarettes smoked. The rationale is at least partly understood by the client. Some difficulties evident (e.g. not addressing misconceptions, not using Ask-Tell-Discuss) |
| 4 | Appropriate use of techniques to link PA to cravings or amount of cigarettes smoked. The rationale is understood by the client. Minor problems evident (e.g. minor inconsistencies)  |
| 5 | Highly appropriate use of techniques to link PA to cravings or amount of cigarettes smoked. The rationale is well developed and understood. Minimal problems   |
| 6 | Excellent / expert use of techniques to link PA to cravings or amount of cigarettes smoked. The rationale is well developed and understood. No real problems   |

## **ITEM 6: IDENTIFY AND REINFORCE ANY IDENTITY SHIFTS TOWARDS BEING A MORE 'HEALTHY PERSON' OR 'HEALTHY LIVING'**

**Key features:** The HT should pick up on any opportunity to reflect or reinforce statements that the smoker makes relating to becoming or wanting to become a more healthy person in general.

**Intervention techniques:** Open questions, Affirmation, Reflective listening. Reflective listening may include simple reflections of content but may also be more sophisticated (e.g. amplified reflection; reflection with a twist) and used to direct the conversation or highlight key changes in thinking that may generalise to a change in the client's self concept or identity, particularly with regard to being a healthy person or living a healthy lifestyle.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process. It is recognised that there may only be a few, if any opportunities to deliver this aspect of the intervention. Hence, we expect scores to be relatively low for this item.**

- 0      Absence (or very poor delivery) of identity-building interactions
- 1      Minimal (or poorly delivered) identity-building interaction
- 2      Some identity-building interaction
- 3      Several examples of identity-building interaction. However, some difficulties evident (e.g. missed opportunities, talking at odds with the participant)
- 4      Appropriate use of identity-building interactions, taking almost all opportunities. Minor problems evident
- 5      Highly appropriate and sufficient use of identity-building interactions. Minimal problem
- 6      Excellent / expert use of identity-building interactions. No real problems

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## ITEM 7a: MANAGING SOCIAL INFLUENCES ON SMOKING REDUCTION

**Key features:** The HT should encourage the smoker to engage social support (to assist on making or carrying out plans) or manage social influences *on smoking behaviour*. Social support can be informational (helping to make plans, providing ideas), emotional (not putting pressure on the person to smoke/accepting their decision to cut down or quit), or practical (e.g. helping to monitor progress).

**Intervention techniques:** Open questions, Affirmation, Reflective listening and Summaries may be used to explore social influences and to identify possible problems and solutions relating to social influences.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- |   |  |
|---|--|
| 0 | Absence (or very poor delivery) of interactions around engaging social support or managing social influences on smoking behaviour  |
| 1 | Minimal (or poorly delivered) interaction around engaging social support or managing social influences   |
| 2 | Some interaction around engaging social support or managing social influences on smoking behaviour, but not in sufficient depth or detail  |
| 3 | Several examples of interaction around engaging social support or managing social influences. However, some difficulties evident (e.g. missed opportunities, talking at odds with the participant) |
| 4 | Appropriate use of interactions to engage social support or manage social influences on smoking behaviour, taking almost all opportunities. Minor problems evident                                 |
| 5 | Highly appropriate and sufficient use of interactions to engage social support or manage social influences. Minimal problems   |
| 6 | Excellent / expert use of interactions to engage social support or manage social influences on smoking behaviour. No real problems   |

## ITEM 7b: MANAGING SOCIAL INFLUENCES ON PHYSICAL ACTIVITY

**Key features:** The HT should encourage the smoker to engage social support (to assist on making or carrying out plans) or manage social influences on *physical activity*. Social support can be informational (helping to make plans, providing ideas), emotional (not putting pressure on the person to smoke/accepting their decision to cut down or quit), or practical (e.g. helping to monitor progress).

**Intervention techniques:** Open questions, Affirmation, Reflective listening and Summaries may be used to explore social influences and to identify possible problems and solutions relating to social influences.

**Using whole and half numbers, score the level to which you think the HT has delivered this intervention process**

- 0 Absence (or very poor delivery) of interactions around engaging social support or managing social influences on physical activity
- 1 Minimal (or poorly delivered) interactions around engaging social support or managing social influences
- 2 Some interaction around engaging social support or managing social influences on physical activity, but not in sufficient depth or detail
- 3 Several examples of interaction around engaging social support or managing social influences. However, some difficulties evident (e.g. missed opportunities, talking at odds with the participant)
- 4 Appropriate use of interactions to engage social support or manage social influences on physical activity, taking almost all opportunities. Minor problems evident
- 5 Highly appropriate and sufficient use of interactions to engage social support or manage social influences. Minimal problems
- 6 Excellent / expert use of interactions to engage social support or manage social influences on physical activity. No real problems

## ITEM 8: REFERRAL TO SMOKING CESSATION SERVICES

Was the issue of making an attempt to stop smoking raised and the response appropriately addressed (i.e. if desired, to make a referral/support access to NHS SSS or other specialist support available in the local area)?

Yes ☐ No ☐

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Below is some guidance on how these core competencies may be scored as part of the research process when session recordings are being reviewed. If it is helpful, a scoring approach could also be used in supervision sessions.

### The rating scale

The present seven-point scale (i.e. a 0-6 Likert scale) extends from (0) where the HT did not deliver the intervention element appropriately - either they didn't do it well or didn't do it sufficiently (low fidelity) to (6) where there is the element is delivered appropriately (high fidelity). Thus the scale assesses a composite of adherence to the intended intervention method and skill of the HT. To aid with the rating of items, an outline of the key features of each item is provided at the top of each section above. A description of the various rating criteria is given in the figure below. The examples are intended to be used as useful guidelines only, providing illustrative anchor points, rather than prescriptive scoring criteria.

### Adjusting for the presence of participant difficulties

Adjustments may be needed when participant difficulties are evident (e.g. excessive avoidance or resistance). In such circumstances, the rater needs to assess the HT's therapeutic skills in the application of the methods. Even though the HT may not facilitate change, credit should be given for demonstrating appropriate skilful interaction.

Competence level		Examples
Incompetent	0	Absence of feature, or highly inappropriate performance
	1	Inappropriate performance, with major problems evident
Novice	2	evidence of competence, but numerous problems and lack of consistency
	3	competent, but some problems and/or inconsistencies
Advanced Beginner	4	good features, but minor problems and/or inconsistencies
	5	very good features, minimal problems and/or inconsistencies
Competent		
Proficient		
Expert	6	excellent performance, even in the face of patient difficulties

\* The scale incorporates the Dreyfus system (Dreyfus, 1989) for denoting competence. Please note that the 'top marks' (i.e. near the 'expert' end of the continuum) are reserved for those HTs demonstrating highly effective skills, particularly in the face of difficulties (i.e. clients with high resistance to change; high levels of emotional expression; and complex situational barriers). Please note that there are 6 competence levels but 7 potential scores.

**When rating the item, you should first identify whether some of the 'Key Features' are present. If the HT includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them and delivers them well), the HT should be rated very highly. It is also possible not every item will be applicable in every consultation.** It is important to remember that the scoring profile for this scale should approximate to a normal distribution (i.e. mid-point 3), with relatively few scoring at the extremes.

## 17. Lone worker policy

### TARS Lone Worker Safety and Emergency Procedure

To be followed when visiting people out of normal office hours.

Lone Worker Action

Link Person Action

Ensure an up-to-date Lone Worker/ Health Trainer details sheet is held with the Local Principal Investigator, the other site researcher and the TARS project administrator. To include emergency contact details, home address, home phone number and car registration.

**In hours:** Complete Lone Worker/ Researcher visit record. Email appointment via outlook to that day's nominated link person.

If running late for the appointment ring/email link person who will note probable late start and finish time of the appointment.

Contact in-hours link person within **30 minutes** of planned end time of appointment.

*If no contact from lone worker within 30 minutes of advised end time, link person to text/phone lone worker on their mobile.*

*No answer or text reply within 10 minutes, repeat once more*

*No response. Link person to ring last visit and, if necessary, previous visits. Make a note of times and any calls made.*

*Link person to ring staff member's home telephone number and if necessary other contact numbers.*

*Still no trace of staff member*

*Link person to contact Project Lead*

*Project Lead unavailable.*

Confirm safe completion of session.

OR

If lone worker is concerned about their situation, do one of the following, if appropriate:

- Say you need something from your car – leave the building and phone link person
- Phone link person and give emergency code ("blue file") or ask for help
- Wait for clerical support to phone you.

*Link person/Project lead phones police*

*Link person phones police*



## 18. Consent to be Audio Recorded

### **TARS - CONSENT TO BE AUDIO RECORDED**

As part of the project we would like to know what is happening in sessions between the client and the health trainer. It is to help us understand what is working well, what is not working, and what can be improved. The recordings will be encrypted and stored securely and only the research team will have access to them. Any information used from the recordings will be completely anonymised so there is no way of identifying either the client or the HT.

Please read the following statements, tick if you understand and agree, and sign at the bottom to say you are happy with each statement:

- I am happy and agree to all sessions I complete with the Health Trainer being audio recorded, whether in person or on the telephone ☐
- I understand I can ask for the recording to stop at any time without giving a reason ☐
- I understand the Health Trainer will remind me before they start the audio recording in each session ☐
- I understand the recording is to help improve what is offered by the project, and to help the Health Trainers to improve their practice ☐
- I understand any information used from the recordings will be completely anonymous and no one will be able to identify it was me involved in the session ☐

Client:

SIGNED:..... PRINT:.....DATE:.....

Health Trainer:

SIGNED:..... PRINT:.....DATE:.....

**TWO COPIES TO BE COMPLETED, ONE TO BE KEPT BY THE CLIENT, ONE TO BE KEPT BY THE HEALTH TRAINER**

## 19. Post Session Case Notes



### FIRST SESSION

HT Initials:		Client ID:	
Session number:		Audio recorded:	YES / NO
Date:			
Type of session:		Location:	
Start Time:		End Time:	
Brief description of client's current situation (including smoking habits, physical activity levels, social networks, previous attempts to change, typical day, motivation for taking part etc)			
What did you do to assess and increase client's motivation (confidence and importance) for changing smoking and physical activity behaviours?			
What strategies did you discuss for changing behaviour?			
What attempts were made to make a link between the two behaviours? Do you feel the client engaged with the idea?			
What social influences does the client face, and what steps have been taken to try and manage these?			
Describe any action plans that were discussed or put in place (e.g. self-monitoring, goal setting, coping plans)			
What does the client hope to achieve by the next session?			
Time, date, and location of next session			



### SUBSEQUENT SESSIONS

HT Initials:		Client ID:	
Session number:		Audio recorded:	YES / NO
Date:			
Type of session:		Location:	
Start Time:		End Time:	
Brief description of any changes to client's current situation			
What did you do to review client's progress from last session?			
What strategies did you discuss for further changing behaviour (including problem solving, reframing, and reassessing and increasing motivation)?			
What attempts were made to make a link between the two behaviours? Do you feel the client engaged with the idea?			
What social influences does the client face, and what steps have been taken to try and manage these?			
Describe any new or adjusted action plans that were discussed or put in place (e.g. self-monitoring, goal setting, coping plans)			
What does the client hope to achieve by the next session?			
Time, date, and location of next session			

## 20. Supervision Guide

### TARS Supervision Guide

#### 1. THE PURPOSE OF SUPERVISION

##### 1.1. Reflective practice

Supervision will provide a safe, supportive and receptive forum for sharing issues and challenges experienced by Health Trainers while delivering the TARS intervention. Sharing and reflecting on issues and how to deal with them in both scheduled and needs based group and one-to-one supervision sessions will support the development of expertise in the delivery of the intervention.

##### 1.2. Professional development

Opportunities for professional development to support your delivery of the TARS intervention will be discussed. There is an expectation that TARS Health Trainers will be willing and committed to learn and develop skills required to deliver the intervention. Health Trainers should be open to receiving and offering support and challenges to their practice.

##### 1.3 Intervention fidelity

Supervision will support Health Trainer to ensure that the TARS intervention is being delivered as intended. Supervision may focus on aspects of delivery that are posing the greatest challenges to Health Trainers. A checklist of the core components of the intervention that are expected to be addressed by Health Trainers is included in the intervention manual. This checklist is intended to be used as both an aide memoir in practice and a tool to support supervision of intervention fidelity.

##### 1.4 Intervention development

Supervision is one way in which components/processes of the intervention to be added or removed can be identified. Members of the research team will attend some supervision sessions in order to support this and to support the development of the supervision process. All decisions to add or remove components of the intervention must be made in conjunction with the research team.

#### 2. ROLES AND RESPONSIBILITIES

##### 2.1. The supervisor will:

- Provide protected time and a safe environment for supervision;
- Be aware of, willing and able to advise the Health Trainer of appropriate sources of support should the supervisor not be able to provide this themselves;
- Liaise with member of the TARS research team to ensure availability of supervision cover in case of supervisor absence and confirm arrangements with Health Trainers;

## **2.2. The Health Trainer will:**

- Attend supervision sessions with a view to reflecting on their own practice;
- Ensure that supervision appointments are booked;

## **2.3. The supervisor and practitioner will:**

- Be flexible to meet the needs of practice while still ensuring protected time for supervision;
- Keep to agreed appointments and time allocation for supervision;
- Endeavour to make effective use of the allocated time for supervision; and
- Only take emergency calls during supervision sessions.

## **3. CONFIDENTIALITY**

All information discussed during supervision sessions is to be confidential, will be discussed professionally and with respect between both parties.

Confidentiality will only be breached and an appropriate person informed in the case of:

1. Information that either indicates a risk or harm to themselves or others or refers to a new crime committed or plans to commit a new crime
2. Undisclosed illegal acts
3. Information that raises concerns about terrorist, radicalisations, or security issues.

## **PRACTICALITIES**

### **5.1 Group supervision**

- Expectation of regular meetings with all Health Trainers present in each site (via Skype).
- Focus on generic issues
- Covering 'nuts and bolts': practical issues such as cross cover and caseload
- Cover challenges in practice of Motivational Interviewing principles
- Ask practitioners to use examples of clients and challenges to guide future work
- Use of group supervision to ensure that all practitioners are aware of risk issues
- Forum to enable skills development for practitioners.

### **3.1. Individual supervision for Health Trainers**

- Expectation of individual supervision as and when required either in person or via telephone
- Supervision contact should increase in frequency:
  - At commencement of intervention delivery;
  - When the supervisee experiences challenges/situations that require immediate discussion/resolution

### **3.2. Individual case management**

- It is expected that supervisors will meet with practitioners one to one either face to face or via telephone at least bi-weekly initially with ongoing frequency determined by client caseload/contact;
- Focus on specific cases;
- Cases to be selected for discussion should be guided by:
  - Clients who are not achieving goals;
  - Clients with whom the practitioner is having difficulty keeping contact/engagement;
  - Case selection guided by clients presenting with problems perceived as requiring supervisor input by practitioners rather than equal client focus; and
  - Periodically include full caseload in order to ensure that individuals who do not clearly present with problems are not overlooked.

Flag issues to escalate to group supervision during individual meetings.

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