The determinants of lifestyle counselling among practice nurses in Ireland

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Abstract

Aim: To assess the practice of lifestyle counselling among practice nurses (PNs) by measuring the frequency, perceived effectiveness and barriers to lifestyle counselling. *Methods:* A survey questionnaire was sent to all 77 PNs in an Irish health service administrative area (response rate = 69%). A focus group was subsequently conducted with ten PNs from this sample. *Results:* 43.8% (n = 21) and 45.8% (n = 22) 'always' promote physical activity and healthy eating with patients, respectively. Conversely, 29.2% (n = 14) of respondents stated they 'rarely' or 'never' counsel patients on risky drinking. Furthermore, a large number of PNs perceived themselves to be 'minimally effective' or 'ineffective' at helping patients to address smoking and risky drinking (47.6%, n = 20 and 63.6%, n = 28, respectively). Practice nurses perceived themselves to be the most appropriate people to provide lifestyle counselling. Education and the provision of accurate information is a key strategy used with patients. Insufficient time, however, was cited as the main barrier to lifestyle counselling by 73.8% (n = 31) of PNs.

Conclusion:

The traditional health education approach to lifestyle counselling predominates in practice nursing. And whilst practice nurses remain positive about lifestyle counselling, they require further support to address behaviours such as smoking and risky drinking in general practice.

Key words: Lifestyle counselling, health promotion, practice nurses, behavioural risk factors, general practice

Introduction

The behavioural risk factors of smoking, unhealthy diet, risky drinking and physical inactivity contribute significantly to preventable CVD (cardiovascular disease) morbidity and mortality (Fine et al., 2001). Lifestyle counselling interventions are an important and effective way to manage these risk factors in general practice (Whitlock et al., 2002; Ashenden et al., 1997).

In the UK, the practice of lifestyle counselling in general practice is becoming more frequent (McAvoy et al., 1999) irrespective of frequently cited barriers such as lack of time or training (Brotons et al., 2005; Cornuz et al., 2000). Although both General Practitioners (GPs) and PNs are positive about lifestyle counselling (Steptoe et al., 1999), PNs are more likely to counsel patients about lifestyle behaviours and believe that their efforts will be effective (Douglas et al., 2006). It has been suggested that the responsibility for prevention has been devolved from GPs to PNs in many primary care settings (Steptoe et al., 1999). Therefore it could be suggested that PNs are integral to the management of behavioural risk factors.

The European guidelines on CVD prevention in clinical practice in Europe (De Becker et al., 2003) recommend nine strategic steps to enhance the effectiveness of lifestyle counselling in general practice. Nonetheless, it is unknown whether PNs are following these strategic steps for multiple behavioural lifestyle counselling or whether the traditional model of health education in nursing still predominates (Karhila et al., 2003).

Methods

A mixed methods approach was applied consisting of quantitative (cross-sectional, self-administered postal survey) and qualitative (focus group) research components.

Participants

A non-probability sample of all 77 PNs employed in an Irish health service administrative area was selected for the questionnaire survey. The response rate was 69% (n = 53). A convenience sample of ten PNs from the same administrative area participated in the focus group.

Questionnaire Survey

The questionnaire was designed based on the findings of a comprehensive literature review. The questionnaire was piloted with a purposive sample

of seven PNs and three health service staff before dissemination. Respondents were asked to return their completed questionnaires within two weeks. A reminder letter and a second copy of the questionnaire were sent out to all non-respondents on the original return date. This was followed by a reminder phone call two days later.

Focus Group

The data obtained from the questionnaire was used to inform the development of the questions for the focus group topic guide. One focus group was convened in a non-clinical setting and followed procedures as described elsewhere (Krueger et al., 2000).

Data Analysis

The survey data was analysed using the SPSS v14.0 statistical package. Descriptive statistics were obtained for each variable. Responses to open questions were coded into groups by content analysis technique and introduced into the database as categorical variables. The results were presented as frequency counts of categories. All missing data was excluded from the analysis. Significance is assumed throughout at $p<0.05$. The recorded data from the focus group was transcribed verbatim. The data analysis and interpretation followed procedures described elsewhere (Krueger et al., 2000). Informed consent was obtained from participants and ethical approval was granted from the ethics committee of the HSE Dublin Mid-Leinster.

Results

Characteristics of participants

All survey respondents were female and three-quarters were aged between 31 and 50 years. Sample characteristics are shown in table 1. There were no significant differences between responders and non-responders for having a full-time PN employed in the practice or for practice involvement in secondary prevention programmes. All ten focus group participants were female with a similar demographic profile.

TABLE 1: Survey sample characteristics

Age, 31-50 years	40 (74%)
Female	49 (100%)
PN for <10 years[a]	37 (75.5%)
Full-time PN[b]	17 (35.7%)
No full-time PN[c]	19 (40%)
Practice involvement in secondary prevention programme	29 (64%)
Consultation length 11-15 mins[d]	29 (64.4%)
BMI	24.28 ± 3.07
Smokers	2 (4.5%)

Values are median (range) or *n* (%)
[a] Worked as a PN for less than 10 years
[b] Works as a full-time PN
[c] Works in a practice where there is no full-time PN
[d] Average length (in minutes) of patient consultation

Survey

Frequency and methods of promoting healthy lifestyle behaviours

Respondents regularly counselled patients on smoking, physical activity, healthy eating and weight management (see Table 2). Conversely, 29.2% stated that they 'rarely' or 'never' counsel patients on risky drinking. The most frequently cited strategic steps for lifestyle counselling were helping patients understand the relationship between lifestyle, health and disease (95.7%), involving patients in selecting risk factors to change (89.1%), involving other healthcare professionals (88.9%) and goal setting (87%). Designing an action plan with a patient was the least frequently cited strategy (26.1%).

TABLE 2: Frequency of responses to the question 'how often do you promote healthy lifestyle behaviours with patients?'

	Always n (%)	Very Often n (%)	Sometimes n (%)	Rarely / Never n (%)
Smoking	12 (25)	26 (54.2)	9 (18.8)	1 (2.1)
Physical Activity	21 (43.8)	18 (37.5)	9 (18.8)	0 (0)
Healthy Eating	22 (45.8)	22 (45.8)	4 (8.3)	0 (0)
Weight Management	11 (22.9)	25 (52.1)	12 (25)	0 (0)
Risky drinking	5 (10.4)	13 (27.1)	16 (33.3)	14 (29.2)

Attitudes to lifestyle counselling

Table 3 outlines respondent's perceived effectiveness at helping patients to change various health behaviours. A large percentage of respondents perceived themselves to be 'minimally effective' or 'ineffective' at helping patients to change the addictive behaviours of smoking and risky drinking (47.6% and 63.6%, respectively). Healthy eating was the behaviour associated with the highest perceived effectiveness with 29.5% of respondents reporting they were 'very effective' at changing a patient's dietary behaviour.

Respondents agreed that PNs are the most appropriate people to provide lifestyle counselling (83.3%) although approximately half (51.2%) felt that it was a difficult task.

Barriers to lifestyle counselling

Insufficient time was the main barrier to lifestyle counselling highlighted by almost three-quarters of PNs. Other barriers included the reluctance of patients to receive advice, lack of clear guidelines and insufficient educational materials for patients,

TABLE 3: Frequency of responses to the question 'how effective do you feel you are in helping patients change the following behaviours?'

	Very effective n (%)	Reasonably effective n (%)	Minimally / ineffective n (%)
Smoking	2 (4.81)	20 (47.6)	20 (47.6)
Physical Activity	7 (15.9)	31 (70.5)	6 (13.6)
Healthy Eating	13 (29.5)	28 (63.6)	3 (6.8)
Weight Management	6 (13.6)	22 (50)	16 (36.4)
Risky drinking	3 (6.8)	13 (29.5)	28 (63.6)

all cited by circa half of the respondents. Only 31% of respondents stated that they would be more likely to engage in lifestyle counselling if there was a financial incentive available.

Focus Group

Lifestyle Counselling Strategies and Approaches

Client-centred and collaborative approaches were identified by participants as good practice in lifestyle counselling. It was recognised that trying to elicit behaviour change without knowing an individual's life circumstances is ineffective. This strategy allows the PN *'to see what level of commitment I'm going to get, what are going to be the barriers'*. It is also important for PNs to remember that *'at the end of the day, the patient has rights as well. What if they don't want to change?'* One participant believed that patients should be asked *'what* [behaviour] *are you willing to work on'* in order to set an agenda for behaviour change discussions. This strategy allows patients *'to be responsible for their changes'* and it helps when you *'don't lecture them'*. However this portrayal of collaboration was not always supported by the language of other participants, where more directive health education was evident in some utterances such as: *'this is what you have to try and get to'*, *'you can tell them some strategies'*.

This educational approach was a dominant theme with the word 'education' being used frequently in the discussion. Participants stated that the provision of accurate information was a key element of their role and using plain English was an effective strategy to do so. People from lower socio-economic groups were identified as a priority group for health education. However, it was generally agreed that the health service *'should be educating them about how to feed themselves rather than throwing money at them'*.

The use of shock tactics also proved to be a very popular counselling strategy. It was understood that shock tactics work because they are visual, realistic and have *'a massive impact'* on patients. However it was also acknowledged that shock tactics do not work with all patients and that PNs should *'approach it very delicately'*.

Professional Support

The participants discussed the responsibility for lifestyle counselling in general practice. They were divided on a number of issues that generated strong feelings from several participants. It was agreed that GPs should be supportive of lifestyle counselling because if they are not, it *'raises questions around the very term continuing care'*.

The role of the GP was seen by two participants to be more medically oriented, due to differences in training whereby *'doctors treat patients like when someone goes in with a pain in your ear, that's all he wants to know about it'*. Several participants considered that PNs to be more approachable than GPs and to be more effective at helping patients understand information. This may be related to the way PNs *'talk in more plain English whereas the GPs talk high-falutent and they don't listen'*. These views were strongly challenged by a number of participants highlighting different experiences across practice locations.

Barriers to Lifestyle Counselling

A large number of participants agreed that general practice was the *'ideal setting'* for lifestyle counselling with patients. There are, however, significant barriers to this approach. Time was identified as one of the most important barriers to lifestyle counselling with patients. Some participants perceived lifestyle counselling as time-consuming and something that required dedicated or *'saved up time to do'*. A potential solution to this would be if GPs *'book them* [patients] *in and give them a longer slot'*. This is effective for patients because *'it really kicks in that they are coming back for something specific on lifestyle'*.

Patient compliance and the complexities of lifestyle behaviour change were also deemed important barriers. Consultations that were perceived as having failed were considered to be disheartening for PNs and can cause the nurse to *'sit back and say, I won't do that with the next person'*.

Discussion

The Practice of Lifestyle Counselling

The high frequency of lifestyle counselling for smoking cessation, physical activity, healthy eating and weight management identified in this study was considerably higher than reported in general practice elsewhere (Duaso and Cheung, 2002). This supports previous research indicating that PNs are more likely than GPs to counsel patients about lifestyle-issues (Douglas et al., 2006). This is important because irrespective of the counselling style adopted or the challenges faced by PNs, lifestyle counselling remains

highly prevalent and has considerable potential in general practice. Given the response rate of 69%, it is possible that these positive results reflect the views of the 'enthusiasts'. However the characteristics (albeit limited) of the non-responders were similar to the responders suggesting that the results are representative of the regional PN population.

The low frequency and perceived effectiveness of lifestyle counselling for risky drinking and smoking is a cause for concern, however. This may be explained by the fact that risky drinking and smoking are both addictive behaviours and could be viewed as being more difficult to address.

Professional Support

While general practice was perceived to be in a unique position to provide lifestyle counselling, the question of whose responsibility it is, was the subject of considerably more debate. Although the PN was deemed the most appropriate person to carry out lifestyle counselling, the perception that PNs have more time than GPs was strongly contested. It was very apparent that the relationship between PNs and GPs varied considerably in each practice. This was explained by differences in communication skills, client-centeredness and their support for lifestyle counselling. Considering that lifestyle counselling interventions are ineffective without GP involvement (Willaing et al., 2004; Little et al., 2001) and that PNs counsel patients more frequently (Douglas et al., 2006), this suggests that a 'whole practice' and systematic approach to lifestyle counselling in general practice is important.

Barriers

The identification of 'time pressures' as a major barrier to lifestyle counselling in this study is compounded by the fact that 40% of respondents work in a practice that does not employ any full-time practice nurse. This undoubtedly places greater pressure on the PN to provide routine treatment services. Although PNs consider lifestyle counselling to be a time consuming process, this is not supported by the literature. In the case of lifestyle counselling for smoking cessation, the intensity of the intervention (length in minutes) is not as important as providing frequent professional contact (Naidoo et al., 2004). Considering that the majority of survey respondents (64%) stated that the length of their average consultation was 11-15 minutes, it is possible that multiple brief interventions of 1-2 minutes could be incorporated into appropriate consultations over several months. Additionally, the idea of requesting GPs to book dedicated lifestyle counselling appointments for patients, as stated by one focus group participant, would be a potential solution.

Other important barriers highlighted in both the survey and the focus group were the difficulties associated with trying to change complex health behaviours and the reluctance of patients to receive advice. It could be suggested that this (particularly the latter) is a result of an over-reliance on a traditional, prescriptive approach to health education.

Considering the high rates of lifestyle counselling reported in this study, PNs are positive about the practice irrespective of the obvious barriers. This is supported by the finding that only 31% of survey respondents stated they would be more likely to engage in lifestyle counselling if there was a financial incentive available.

Lifestyle Counselling Strategies and Approaches

There was limited evidence in the present research to suggest that an empowering, client-centred and collaborative approach to lifestyle counselling is commonplace. This was particularly evident in the language used by focus group participants that reflected a more authoritarian, prescriptive and persuasive style. In agreement with previous research (Karhila et al., 2003), the provision of information and advice was frequently highlighted without reference to patient-participation or collaborative working. The suggestion of providing education on healthy eating to lower socio-economic groups clearly demonstrates a lack of a client-centred approach. Although it is an acknowledgement that socio-economic status is an important determinant of health it is also an indication that lack of information is the core issue. It should be noted that the use of the traditional approach to health education only emerged from the focus group discussion and was contested by two participants in particular. This was clearly illustrated by the intensity of a debate on which risk factor would be most appropriate to change if a patient had depression and also smoked. Although the survey indicated that 89% of respondents involved patients in selecting their own priorities for change (as recommended by research, Glasgow et al., 2004), a large number of participants felt that smoking should be addressed with the patient regardless of their life circumstances. This prompted two participants to highlight the importance of knowing an individual's circumstances and which risk factor they consider most important and are ready to change. This scenario was clearly divisive for the group and is an example of how strong the 'righting reflex' (Miller and Rollnick, 2002) can be, where practitioners feel it is their professional responsibility to provide information and advice that could make someone healthier.

In contrast to the findings of the focus group, the survey results indicated that many of the strategic steps to enhance the effectiveness of lifestyle counselling are being followed by a large percentage of respondents. However it is possible that survey respondents may have over-estimated their practice of lifestyle counselling. This could be explained by

social desirability bias whereby self-report surveys potentially reflect what the respondents think they should do (Brotons et al., 2005).

The support for using 'shock tactics' or 'fear appeals' by the group is worrying. Although fear appeals are a frequently used tool for mass media health messages, their misuse can be damaging to an individual (Witte and Allen, 2000). Despite this, there was consensus among the group that fear appeals should be used selectively and only when the individual has the will power to change.

In conclusion, this research suggests that although the rhetoric of patient-centred lifestyle counselling is evident in practice nursing, the traditional health education approach predominates. Practice nurses, however, regularly counsel patients about multiple lifestyle behaviours despite considerable barriers and without support structures. Therefore it is essential that they are supported to carry out lifestyle counselling as part of a systematic 'whole practice approach' to prevention in general practice. In particular, PNs should receive training in lifestyle counselling with a stronger emphasis on the addictive behaviours of risky drinking and smoking. Further research is required to assess the determinants of lifestyle counselling among GPs in Ireland as this will also impact on PNs working in their practices.

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References

Ashenden, R., Silagy, C. & Weller, D. (1997). "A systematic review of the effectiveness of promoting lifestyle change in general practice", *Family practice,* vol. 14, no. 2, pp. 160-176.

Brotons, C., Bjorkelund, C., Bulc, M., Ciurana, R., Godycki-Cwirko, M., Jurgova, E., Kloppe, P., Lionis, C., Mierzecki, A., Pineiro, R., Pullerits, L., Sammut, M.R., Sheehan, M., Tataradze, R., Thireos, E.A., Vuchak, J. & EUROPREV network (2005). "Prevention and health promotion in clinical practice: the views of general practitioners in Europe", *Preventive medicine,* vol. 40, no. 5, pp. 595-601.

Cornuz, J., Ghali, W.A., Di Carlantonio, D., Pecoud, A. & Paccaud, F. (2000). "Physicians' attitudes towards prevention: importance of intervention-specific barriers and physicians' health habits", *Family practice,* vol. 17, no. 6, pp. 535-540.

De Backer, G., Ambrosioni, E., Borch-Johnsen, K., Brotons, C., Cifkova, R., Dallongeville, J., Ebrahim, S., Faergeman, O., Graham, I., Mancia, G., Manger Cats, V., Orth-Gomer, K., Perk, J., Pyorala, K., Rodicio, J.L., Sans, S., Sansoy, V., Sechtem, U., Silber, S., Thomsen, T., Wood, D. & Third Joint Task Force of European and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (2003). "European guidelines on cardiovascular disease prevention in clinical practice. Third Joint Task Force of European and Other Societies on Cardiovascular Disease Prevention in Clinical Practice", *European heart journal,* vol. 24, no. 17, pp. 1601-1610.

Douglas, F., Torrance, N., van Teijlingen, E., Meloni, S. & Kerr, A. (2006). "Primary care staff's views and experiences related to routinely advising patients about physical activity. A questionnaire survey", *BMC public health,* vol. 6, pp. 138.

Duaso, M.J. & Cheung, P. (2002). "Health promotion and lifestyle advice in a general practice: what do patients think?", *Journal of advanced nursing,* vol. 39, no. 5, pp. 472-479.

Fine, L.J., Philogene, G.S., Gramling, R., Coups, E.J. & Sinha, S. (2004). "Prevalence of multiple chronic disease risk factors. 2001 National Health Interview Survey", *American Journal of Preventive Medicine,* vol. 27, no. 2 Suppl, pp. 18-24.

Glasgow, R.E., Goldstein, M.G., Ockene, J.K. & Pronk, N.P. (2004). "Translating what we have learned into practice. Principles and hypotheses for interventions addressing multiple behaviors in primary care", *American Journal of Preventive Medicine,* vol. 27, no. 2 Suppl, pp. 88-101.

Karhila, P., Kettunen, T., Poskiparta, M. & Lumatainen, L. (2003). "Negotiation in type 2 diabetes counseling: from problem recognition to mutual acceptance during lifestyle counseling", *Qualitative health research,* vol. 13, no. 9, pp. 1205-1224.

Krueger, P. & Casey, M.A. (2000). *Focus groups: A practical guide for applied research.* 3rd edn, Sage Publications, Thousand Oaks California.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. & Payne, S. (2001). "Preferences of patients for patient centred approach to consultation in primary care: observational study", *BMJ (Clinical research ed.),* vol. 322, no. 7284, pp. 468-472.

McAvoy, B.R., Kaner, E.F., Lock, C.A., Heather, N. & Gilvarry, E. (1999). "Our Healthier Nation: are general practitioners willing and able to deliver? A survey of attitudes to and involvement in health promotion and lifestyle counselling", *The British journal of general practice : the journal of the Royal College of General Practitioners,* vol. 49, no. 440, pp. 187-190.

Miller, W. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* 1st edn, Guildford Press, New York.

Naidoo, B., Warm, D., Quigley, R. & Taylor, L. (2004). 01/04/2004-last update, *Smoking and public health: a review of reviews of interventions to increase smoking cessation, reduce smoking initiation and prevent further uptake of smoking.* [Homepage

of NICE - NHS Health Development Agency], [Online]. Available: http://www.nice.org.uk/download.aspx?o=502729 [2007, 04/07/2007] .

Steptoe, A., Doherty, S., Kendrick, T., Rink, E. & Hilton, S. (1999). "Attitudes to cardiovascular health promotion among GPs and practice nurses", *Family practice,* vol. 16, no. 2, pp. 158-163.

Whitlock, E.P., Orleans, C.T., Pender, N. & Allan, J. (2002), "Evaluating primary care behavioral counseling interventions: an evidence-based approach", *American Journal of Preventive Medicine,* vol. 22, no. 4, pp. 267-284.

Willaing, I., Ladelund, S., Jorgensen, T., Simonsen, T. & Nielsen, L.M. (2004). "Nutritional counselling in primary health care: a randomized comparison of an intervention by general practitioner or dietician", *European journal of cardiovascular prevention and rehabilitation: official journal of the European Society of Cardiology, Working Groups on Epidemiology & Prevention and Cardiac Rehabilitation and Exercise Physiology,* vol. 11, no. 6, pp. 513-520.

Witte, K. & Allen, M. (2000). "A meta-analysis of fear appeals: implications for effective public health campaigns", *Health education & behavior : the official publication of the Society for Public Health Education,* vol. 27, no. 5, pp. 591-615.

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