Obesity Prevention
Finding the right words

COMPaRE-PHC

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Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010
(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)

1990

2000

2010

Source: Behavioral Risk Factor Surveillance System, CDC.
Workshop Plan

1. Why people choose not to listen to advice to change unhealthy behaviour
   - Why patients don’t present or don’t return
   - Barriers to referrals from General Practice and Primary Health care

2. Interactive activity

3. Anything else??
The two most significant barriers to successful weight management interactions and consultations

One type of intervention you currently think works well
The blame game...

- The industry
- Poor lifestyle behaviour choices
- Genetics
- Poor education and information
- Sugar! Sugar! Sugar!
- Insufficient exercise
- Yo yo diets
- Let the scientists and experts fight over that...

In the meantime- pts aren’t heeding advice and health professionals are stuck
Learning from each other?

**Australian study says**: traffic lights, reducing advertising are most cost effective - less so, diet and exercise interventions

**NZ** - Syllabus to be added as integral GP training to maximise nutritional advice, to describe a diabetic or cholesterol lowering diet, discuss weight loss strategies, diet and lifestyle.
- Outcomes based

**NHS Chairman** - Educate people about the cost of their health
- particularly “lifestyle choices like obesity“
“More than 2 out of 3 premature adult deaths is due to behaviour initiated in teens”

(WHO 2002)

Morbidity and mortality driven largely by chronic conditions and behavioural factors....diabetes, obesity etc

2014: WHO states we should be concentrating on childhood obesity rather than a constant attention to adult obesity
1995: TADS foundation - Tobacco, Alcohol and Other Drugs
University of Auckland (and World Health Organization)

- engaging general practices in implementing brief interventions
  at community and national level

- TADS development and implementation of BI training for
  PHC, Māori, Pacific and Youth

- Funded by NZ Ministry of Health Mental Health Directorate
TADS had a philosophical and funding commitment to holistic wellness and prevention (primary health care)

*BUT*

the brief interventions approach was based on advice and treatment for addictions (medical care)
TADS Research: Qualitative and Action

- We started with patients - 5 years wide consumer input

- Evaluations from 6000 trained participants, focus groups, PHC, Māori, Pacific, Youth and literature searches

- Continually assessed and refined ideas, methods and materials inside and outside training workshops

- Supported by District Health Boards, NZ Ministry of Education, NZ Ministry of Health Public Health Directorate for the pilot research

- Patients in essence became the researchers
Missing in Action

- No international screening tools specific to lifestyle behaviour and mental health risks
- Many missed opportunities in general practice and little or no attention to prevention

**Needed:**
- A non-threatening entry point into the person’s world of personal behavioural practices (the TADS PACT®)
- A language of engagement as a generic form of communication (the TADS BOI approach)
The barriers to change..

**Patients:**
- Advice, information, health messages not helpful
- Emphasis on health professionals rather than patient-attitudes, behaviour and language
- ‘Ready’ doesn’t mean ‘willing’ and ‘able’
- Screening reduces trust

**Practitioners:**
- Lacked confidence.. ? how to raise the issue
- Frustration... ‘difficult’ patients/ ignored advice/time waster
- Often too late and not enough time or compensation
“Agree?”

- “if somebody’s very, very interested and wants information I know they’re going to be compliant and lose weight” (Nurse Practitioner)

- “you can normally tell with overweight people when you first meet them...you can categorize them as to how well you think they’re going to do” (Primary Health Care Nurse)

- “if I have known them and their family for quite a while they are more likely to listen to me and take the advice given” (Practice Nurse)

- “if I have imparted enough education but the patient continues to ignore my advice, this is their choice and patient responsibility is important” (Practice Nurse)
Obesity in UK ‘could be far worse than predicted’


- ‘family doctors to raise the issue with overweight patients ... GPs should be trained and paid to start conversations about weight
- hard-hitting obesity campaigns similar to smoking cessation
- earlier intervention and encourage members of the public to take sensible steps to help themselves
- reluctant to start the conversation- subject is emotive
- awarded quality outcome framework points, to increase salary for raising the issue and providing guidance ‘
Weight management interactions..

1. What is the main outcome you hope to achieve from each weight management conversation?

2. What are two essential ingredients for engaging with a patient?

3. Name two of the biggest obstacles to achieving this:
   a) for your patient and
   b) for you
Order of Importance??

- Weight loss meds
- Dieting
- Physical activity
- Lifestyle behaviour change
- Bariatric and other surgery
- Address mental health issues
The conversation in general practice

- Advice
- Instruction
- Motivation
- Goal setting
The change from BI to BOI

**Brief Interventions (BI)**

- Based on addictions, treatment
- Practitioner driven
- Short term aim
- Targeted behaviours and only those ‘at risk’
- Time inefficient
- Frequent consultations and duplication

**Brief Opportunistic Interactions (BOI)**

- Based on early prevention
- Driven by the patient - person focused
- Long term aim
- All ages, ethnicities, multi behaviours including mental health risks
- Time effective (in the context of other work)
- Opportunistic interactions - no duplication and no appointments
Person focused...or patient centred?

- Person focused: Preventative and holistic, not disease focused, driven first and foremost by the patient in any behavioural change encounter and identifies what is happening in the relationship (Starfield 2011; Docherty 2013)

- Patient centred: a patient's desire for information and for sharing decision making, based on their disease or illness (Stewart 2001)
The invisible but essential playmaker that should be present in all preventative strategies, public health policy and behavioural change approaches.

The embryonic and potentially unhealthy personal behavioural practices usually in the absence of visible symptoms or identified ‘problem’ behaviour.

The most significant piece of the prevention and behavioural change conundrum which has never been addressed.

The TADS PACT© and BOI process address this fully - person focused.
Getting to the Source....the TADS PACT®

- tobacco smoking
- mild/mod anxiety
- stress
- sexual practices
- medication adherence
- alcohol
- violence
- anger
- gambling
- relationships
- weight
- physical activity
- other drugs
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Do you often feel that it is difficult to control what or how much you eat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your weight sometimes affect the way you feel about yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
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</table>
TADS Youth PACT© Pilot 2006

Behaviours & mental health risks personally identified
Behaviours chosen to change

N = 132
Decile 1-10
Year 10’s (14 yrs)

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<thead>
<tr>
<th>Behaviour</th>
<th>Identified</th>
<th>To Change</th>
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<tbody>
<tr>
<td>Tobacco</td>
<td>54</td>
<td>23</td>
</tr>
<tr>
<td>Alcohol</td>
<td>107</td>
<td>8</td>
</tr>
<tr>
<td>Other Drugs</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>Gambling</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>Feel ok about my sexual activity</td>
<td>58</td>
<td>0</td>
</tr>
<tr>
<td>Sad more than happy</td>
<td>49</td>
<td>12</td>
</tr>
<tr>
<td>Control anger</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>Stress</td>
<td>66</td>
<td>27</td>
</tr>
<tr>
<td>Different to Mates</td>
<td>40</td>
<td>12</td>
</tr>
<tr>
<td>Afraid of</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Enjoy regular exercise</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Weight Issues</td>
<td>66</td>
<td>25</td>
</tr>
</tbody>
</table>
Case Study Josh

- Joshua sent by the teacher to the school nurse to discuss his weight problems- his third such visit. Both Joshua and the nurse had reported ‘no progress’.

- Post TADS training: Nurse offers Josh the PACT© rather than discuss his weight. He fills out the PACT©. No behavioural change discussion takes place at that visit.

- Then what?
Nursing and Medical students 21-34yrs n=104

TADS Adult PACT © 2004-2005

Behaviours and Mental Health risks personally identified

Behaviours chosen to change

- Tobacco: 15
- Alcohol: 10
- Other Drugs: 4
- Gambling: 36
- Depression: 21
- Stress: 12
- Anxiety: 27
- Anger: 2
- Violence: 0
- Physical Activity: 30
- Weight Issues: 32
Are you still going to the gym?

I’m glad to hear you’re not drinking so much now

‘It’s really important that you take your medication if you don’t want another heart attack….’

How much weight have you lost?

How many cigarettes do you smoke each day?

What do you enjoy most about going to the gym?

What is the main benefit you are noticing by not drinking so much?

What is the one thing you dislike most about taking pills?

What’s the thing you’ve noticed most about eating differently?

What do you like about smoking? And what's not so great about it?
Barriers to referral from PHC

- Practitioner and patient attitudes
- Obesity management versus obesity prevention (lifestyle behaviour or medication)
- Practitioners slow to adopt guidelines
- Population health/ prevention/ disease management confusing
The role of general practice nurses in weight management referrals

- CNE with multi providers all competing
- Rx companies
- PHOs
- DHBs
- MoH Guidelines
- Little expertise in the field...
- Referrals to Jenny Craig, Weight Watchers
- Autobiographical stories
Self Management of Joe Bloggs (aged 65) ...NZ style

- Diabetes review
  - January
- CarePlus
  - April
- ABC Smoking Intervention
  - August
- CVD risk Assessment
  - December
The Role Model Conundrum
There is no such thing as a difficult patient.
Less is More

Tell me what you already know about diabetes?

What worries you most about having diabetes?
Empathy is a Skill

‘I know how you feel’. Not empathy

‘I can’t imagine how you must be feeling; tell me what it’s like for you right now’” Empathy

The ability to sense what someone is feeling, to hear and paraphrase and mean it - genuineness shows

Not autobiographical – your story is not helpful
MR WILSON,
YOU'RE A FULL-BODIED
DRINKER, NICELY MATURER
AND SHOWING A
GENEROUS NOSE.
Do you believe that........?

1. The person OUGHT to change
2. The person WANTS to change
3. The person’s health is the prime motivating factor for change
4. If he/she decides not to change, interaction has failed
5. Patients are either motivated to change or not
6. A tough approach is always best
7. Regular advice is the best approach
8. I’m the health professional. He/she is likely to follow my advice
Is it Ok to???

- be 15-20 kgs overweight
- get drunk occasionally
- have a couple of drinks every night
- smoke tobacco
- smoke cannabis regularly
- play the pokies twice a week
- take anti depressants when depressed and anxious
- inject IV heroin
Reframing the conversation

Example 1: Exercise

Patient:  “I’m doing my exercise.”

Practitioner:  “Great. How many times are you going to the gym each week now?
(The presumption is that the patient is actually going to the gym, and if not, then they should be – this indicates a judgment call)

Practitioner using BOI language:  “Tell me what you enjoy most about going to the gym?”

(The emphasis is not on ‘going to the gym’ and allows the person to offer a more honest response without feeling targeted and may say “Actually I’m not going at all...” )
Example 2: Alcohol

Patient: “I’m not drinking so much now”

Practitioner: “Great. Now how about doing something about that weight?” (The presumption is that the good advice is succeeding and so the practitioner moves on to the next instruction.)

Practitioner using BOI language: “What is the main benefit you are noticing by not drinking so much?” (The patient will focus on the ‘main benefit’ rather than whether he/she is actually drinking less. If they have not reduced their drinking they will not be able to think of a ‘benefit’. The honest answer is uncovered without any coercion).
Example 3: Diet

Patient: “I’m sticking really well to my diet”.

Practitioner: “That’s good to hear. How much weight have you lost?” (This not only presumes the person is conforming to their diet but the practitioner is indicating he/she would like more proof.)

Practitioner using BOI language: “What’s the main thing you’ve noticed about eating differently?” (The word ‘weight’ is not included, the question focuses on any benefits that have accrued, which allows for a more honest response and an opportunity to assess if any actual changes are being made).
Summary...

- Knowledge is of limited value if a person can’t apply it.
- Individual’s real need is usually related to something with higher priority than your need.
- The connection has to be made by both patient and practitioner.
- This is not about addictions, excuses, denial or lack of motivation.
- You will sow many seeds!
Ponder this...

- If **WE** learn how to change our communication attitudes and behaviour towards our patients they will connect with us

- It’s not how much we say but how we speak to our patients that is the key to changing behaviour

- When we change our language and interactive engagement we transform the consultation

- Electronic communication will never replace the face and soul of someone you can see

- Switching the power from health professionals to patients is not always easy but hugely satisfying
Making it a part of our daily lives

Doing it

Dealing with the real hard parts

Making small changes

Weighing the pros and cons

Snapshot of personal behavioural practices (The PACT)

Not thinking about it

The Behavioural Change Pyramid

Docherty 2005
I hope that in years to come mankind will look back on this era, during which the obese were stereotyped as being people of poor character and lacking in self control who lived lives of apparent debauchery, as one to be ashamed of.

Anon
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TADS Training Programme

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