

# **The Behaviour Change Counselling Index (BECCI)**

## **Manual for Coding Behaviour Change Counselling**

## MANUAL FOR CODING BEHAVIOUR CHANGE COUNSELLING

### Rationale

#### ***Behaviour change counselling***

Behaviour change typically involves changes in lifestyle and medication use, but can also apply to other behaviour change like using a new hearing aid, keeping liquid intake down (renal medicine) or adopting new ways of looking after ones feet (diabetes care). It is based on the principles of patient or client-centred counselling.

*Behaviour change counselling* has been described in Rollnick et. al. (2002). It involves using a wider range of skills than for *brief advice*, but not as wide as those involved when using *motivational interviewing*. Essentially, the practitioner encourages the patient to make their own decisions about behaviour change. A constructive and trusting atmosphere is used to explore the patient's feelings about the why and how of change. "The roles of the practitioner and recipient are more egalitarian than in the brief advice session. The practitioner using behaviour change counselling operates as an advisor to a client who is an active and engaged participant. The encounter is more collaborative than typically observed with brief advice, and greater attention is placed on building rapport. However, this does not necessarily require the intensity of relationship building essential to the good practice of motivational interviewing. Behaviour change counselling often has a 'task oriented flavour'. (Rollnick et al, 2002).

There is no single text on behaviour change counselling. The practical guidelines in *Health Behaviour Change: A Guide for Practitioners* (Rollnick et al 1999) merely provide one example of this counselling style. It was constructed in 2002 by a consensus group of trainers and practitioners in motivational interviewing, to describe those adaptations of motivational interviewing that embrace the patient-centred method for use in brief consultations (not therapy sessions) in healthcare and other settings. This was in response to a concern about an ever-increasing number of names being given to methods that had more similarities than differences. Behaviour change counselling was thought to be a suitable general term for attempts to conduct *a constructive conversation about change in which the practitioner tries to understand how the patient feels about change, by using mostly open questions and sometimes empathic listening statements*. Less emphasis is placed on exploring personal values, the directive use of empathic listening and deploying discrepancy, more characteristic of motivational interviewing.

#### ***BECCI***

This was constructed as an initial effort to measure the skills involved in behaviour change counselling. Our goal was to help the trainer as well as the researcher. Hence the small number of items on the checklist, designed to help trainers evaluate skills acquired in training by examining recordings of consultations. It might even be used in training itself, as a springboard for discussion and practice.

#### ***Who can use BECCI?***

To use BECCI, the rater should have a good basic knowledge of Behaviour Change Counselling and the checklist. To ensure this, raters should undertake background reading, watch a training video and gain an understanding of how the checklist works. The following tasks make up the minimum amount of training required before rating:

#### *Reading*

- Rollnick S, Mason P, and Butler C (1999) *Health Behaviour Change: A Guide for Practitioners* Edinburgh: Churchill Livingstone, Parts 1 and 2 (pp. 3 – 129)
- Rollnick S, Allison J, Ballasiotes S, Barth T, Butler C, Rose G and Rosengren D (2002) *Variations on a Theme: Motivational Interviewing and its Adaptations* in Miller W and Rollnick S (2002) *Motivational Interviewing: Preparing People for Change (2<sup>nd</sup> Edition)* New York: Guilford Press, Chapter 18 (pp. 270 – 283)

- Miller W and Rollnick S (2002) *Motivational Interviewing: Preparing People for Change (2<sup>nd</sup> Edition)* New York: Guilford Press, Chapters 4 and 5 (pp. 33 – 51)

#### *Training Video*

- Health Behaviour Change: A Selection of Strategies, An Aid for Trainers © Media Resources Centre, University of Wales College of Medicine 2001 (available from [edwardske@cardiff.ac.uk](mailto:edwardske@cardiff.ac.uk))

#### *BECCI*

- A copy of the manual and BECCI should be read thoroughly to ensure the rater understands how to use the checklist correctly.

### **Simulated versus ‘Real’ Consultations**

BECCI has been tested for reliability mainly on simulated consultations. It is hoped that in the future, it will be tested for robustness on ‘real’ consultations. Based on the minimal number of real consultations that have been rated, the simulated and real consultations appear to be very similar in nature, but it cannot be guaranteed that this will be the case in all simulated consultations. However, as BECCI is primarily an instrument for trainers, the likelihood is that in most cases the consultations will be simulated.

#### **Item choice**

BECCI contains items that concentrate mainly on practitioner behaviours. We realise that the main goal of BCC is to encourage the patient to talk about the how and why of change. However, the checklist is designed to assess the skills of practitioners, and it is not reliable to assess the practitioner’s performance based on the patient’s behaviour in the consultation.

We have deliberately restricted the selection of *practitioner behaviours* in a number of ways. Firstly, we have tried to steer clear of items that measure patient-centredness in its pure or more general form. Thus, even the items that elicit judgements about the practitioner’s handling of the consultation as a whole (Items 5, 6, 7, 8, 9 and 10) focus on talk about behaviour change. The rationale here is that if the practitioner succeeds in getting high scores for the items on behaviour change, the consultation will be a patient-centred one. BCC is a patient-centred method in itself. Secondly, we have selected a few key practitioner microskills to focus on (e.g. questions, empathic listening statements, summaries) rather than their combination into any of a large number of strategies, like pros and cons, assessment of importance and confidence, and so on.

*Invitation* does not occur in every consultation (where the practitioner invites the patient to talk about behaviour change). Sometimes because the practitioner does not do this, and sometimes because the practitioner does not get the chance. Therefore, item 1 is only scored when the practitioner has the chance, making a distinction between not being able to invite the patient to talk, and simply not doing it. It has been argued that either invitation occurs or it does not, leading some to believe that a dichotomous item rather than a scale would be more suitable for this item. However, it has been found during the development of the instrument that invitation can vary on a continuum of how well it is performed. There is a difference between the practitioner who asks if it is okay with the patient to talk about behaviour change and emphasises patient choice from the outset, the practitioner who says ‘You’ve been sent here by your doctor. How do you feel about that?’, and the practitioner who does not invite the patient to talk about behaviour change at all. Therefore, item 1 will remain a scaled item at this stage.

*Information exchange* again does not occur in all BCC consultations (sometimes because the patient does not request information, sometimes because it is not appropriate to give information), but when it does take place, we felt it was important to assess how skilfully this is done. Therefore, item 9 is only completed when it is applicable to the context

*Talking about targets* also does not occur in every consultation i.e. when the patient and practitioner talk about possible methods of how change can be achieved. Therefore, raters should only score item 11 when it is applicable to the context.

*Talk time* is a feature central to BCC. However, internal consistency reliability testing found that this item was not giving a reflective score of practitioner skill when correlated with the other items. As this feature is so important to the concept of BCC, we have chosen to exclude it from the scale to enhance its reliability, but include it as a separate ordinal item so that this information is still present and can be assessed by the trainer.

### **Scoring**

While completing the checklist, each item is accompanied by a Likert scale to reflect the degree to which the action was carried out. As a guide, circling each number would indicate that the action was carried out:

0 = *Not at all*, 1 = *Minimally*, 2 = *To some extent*, 3 = *A good deal*, 4 = *A great extent*

The main purpose of the checklist is to provide trainers and practitioners with a window into their consulting. Looking at scores on individual items is thus at the heart of this activity.

However, should an overall score be required, the mean across item responses is taken to give a Practitioner BECCI Score. The mean should be calculated as follows:

1. Take the mean of all the applicable items (i.e. add up the total score of the applicable items, and divide by that number of items).
2. If all items are applicable in that particular consultation, this mean is the Practitioner BECCI Score. If any of the items were not applicable in the consultation, proceed to step 3.
3. A technique known as 'mean substitution' is used for any items scored as 'not applicable'. The mean of the applicable items is the score to be used for the not applicable items. So, for example, if the mean of all other items is 2.87, this is the score that should be given to any items scored as not applicable. Proceed to step 4.
4. Now you have the scores for any not applicable items, recalculate the mean for all the items. This will give you the practitioner BECCI score.

You will find that by taking the mean score, the Practitioner BECCI Score corresponds to the points given on the Likert scales on the checklist. For example, if the Practitioner BECCI Score is 2.94, you will see that they have been practicing BCC 'a good deal', or a practitioner scoring 1.62 has been practicing BCC somewhere between 'minimally' and 'to some extent'.

### **References**

1. Rollnick S, Mason P, and Butler C (1999) *Health Behaviour Change: A Guide for Practitioners* Edinburgh: Churchill Livingstone
2. Rollnick S, Allison J, Ballasiotes S, Barth T, Butler C, Rose G and Rosengren D (2002) *Variations on a Theme: Motivational Interviewing and its Adaptations* in Miller W and Rollnick S (2002) *Motivational Interviewing: Preparing People to Change (2<sup>nd</sup> Edition)* New York: Guilford Press, Chapter 18

## Domain 1: Agenda Setting and Permission Seeking

### 1. The practitioner invites the patient to talk about behaviour change\*

*\*NB This item does not need to be coded if it is not applicable to the context*

A high score: The practitioner explicitly asks the patient's permission to talk about behaviour change, making it clear that the patient is not obliged to make any decisions regarding their behaviour.

*Example: 'Before we start, I'd just like to make it clear that I am not here to tell you what to do or to force you to make decisions you don't feel ready to make. I am here to understand you. We don't have to talk about anything you don't want to talk about. Now I understand your GP has sent you here to talk about your smoking. Would it be okay with you if we had a chat about that now?'*

A low score: The practitioner fails to ask the patient about a willingness to talk about behaviour change and does not give them an opportunity to speak, giving the impression that the patient has little choice in the matter!

Not Applicable: The patient goes straight into the interaction, without giving the practitioner a chance to invite them to talk about behaviour change.

### 2. The practitioner demonstrates sensitivity to talking about other issues\*

*\*(An issue can be anything of concern to the patient, whether it is connected to the behaviour in question or not)*

A high score: The patient is given choice in what to talk about, because, for example, the practitioner goes through an agenda setting process in which the patient is encouraged to talk about other health behaviours, or other issues not immediately connected to behaviour change.

*Example: 'So, since you've had your heart attack you've been asked to make a lot of changes. That must seem quite a lot to deal with at the moment. I know you've been sent here to talk about your smoking, but I'm wondering if there is anything else bothering you that you would rather talk about today'.*

A low score: The practitioner does not give the patient any choice about what to talk about, and proceeds with the consultation discussing in turn what s/he feels are the most important issues.

## Domain 2: The Why and How of Change in Behaviour

### 3. Practitioner encourages patient to talk about current behaviour or status quo

A high score: The practitioner encourages the patient to talk freely about what they both like and/or dislike about their current behaviour/status quo. They may do this in a variety of ways, for example through asking open questions or using empathic listening statements, to gain an understanding of the patient's perspective.

A low score: The practitioner does not actively encourage the patient to talk about what they like and/or dislike about their current behaviour/status quo.

#### **4. Practitioner encourages patient to talk about behaviour change**

A high score: The practitioner encourages the patient to talk freely about what they feel the positive and negative aspects of behaviour change would be for them. They may do this in a variety of ways, for example through asking open questions or using empathic listening statements, to gain an understanding of the patient's perspective.

A low score: The practitioner does not actively encourage the patient to talk about what they feel the positive and negative aspects of behaviour change would be for them.

#### **5. Practitioner asks questions to elicit how patient thinks and feels about the topic**

A high score: The practitioner uses a a range of (mainly open-ended) questions to draw as much information from the patient as possible about their thoughts and feelings towards the topic of behaviour change.

A low score: The practitioner does not ask the patient any questions regarding their thoughts and feelings about behaviour change, or asks only closed-ended questions that do not give the patient the opportunity to express their thoughts and feelings about the topic of behaviour change.

#### **6. Practitioner uses empathic listening statements when patient talks about the topic**

A high score: The practitioner uses a range of empathic listening statements while the patient is talking about behaviour change to clarify whether s/he has understood what the patient has said, and/or to encourage the patient to amplify further.

A low score: The practitioner makes no empathic listening statements when the patient is talking about behaviour change.

#### **7. Practitioner uses summaries to bring together what the patient says about the topic**

A high score: The practitioner summarises what the patient has said about behaviour change at several key points in the discussion to check their understanding of the patient's perspective.

*Example: 'OK, so just to recap on what we've spoken about so far, you feel that it's important to give up smoking for health reasons because you've had a heart attack. You also feel its important to give up for your family to stop them worrying about you. On the other hand, you've smoked for many years and tried to give up before. You don't feel confident that you would be able to stop if you tried. You have a stressful life and you feel smoking helps to relieve your stress. Does that sound right?'*

A low score: The practitioner does not summarise what the patient has said about behaviour change.

## Domain 3: The Whole Consultation

### 8. Practitioner acknowledges challenges about behaviour change that the patient faces

A high score: The practitioner regularly and explicitly acknowledges the challenges that may be facing the patient. This affirmation is done by focusing on the personal strengths that the patient has in the face of these challenges.

*Example: 'Goodness, I can see why it is so hard for you to give up. You have so much stress to deal with in your life right now. It must be really hard. But even though this is really difficult, you have already begun to make changes to your lifestyle following your heart attack, and you've managed to keep them up even though it's tough'.*

A low score: The practitioner does not make any explicit acknowledgment the challenges that face the patient, and does not focus on any of the personal strengths that the patient has.

### 9. When practitioner provides information, it is sensitive to patient concerns and understanding\*

\* This item does not need to be scored if it is not applicable to the context

A high score: The practitioner tries to understand what the patient knows and wants to know, and also elicits their personal reaction to information provided.

A low score: The practitioner gives information to the patient without asking whether the patient wants or needs information. The personal relevance of the information is not drawn out of the patient, but provided by the practitioner. A low score would also be given if the patient requests information from the practitioner, and the practitioner does not provide any.

Not Applicable: There is no information requested or exchanged within the consultation.

### 10. Practitioner actively conveys respect for patient choice about behaviour change

A high score: The practitioner openly acknowledges and accepts patient choice even if this does not fit in with practitioner's agenda. The practitioner does not put any pressure on the patient to change their behaviour.

*Example: 'At the end of the day, it's your choice. It's up to you if you want to make any changes, and it's about what is realistic and manageable for you. You don't have to do anything you don't want to do.'*

A low score: The practitioner does not acknowledge or accept patient choice.

## Domain 4: Talk about Targets

### 11. Practitioner and patient *exchange* ideas about *how* the patient could change current behaviour

*\*NB This item does not have to be coded if it is not applicable to the context*

A high score: The practitioner actively encourages the patient to brainstorm a number of strategies that may help them change their behaviour. With encouragement, the patient offers the most ideas, and the practitioner also makes suggestions.

A low score: The practitioner does not encourage the patient to brainstorm. There is no exchange about a range of possibilities. The patient does not suggest any. Instead, it is the practitioner only who suggests ideas for change.

Not Applicable: There is no discussion of targets within the consultation.

### Measure of Practitioner talk time

This indicator of practitioner talk time is there for information alongside the total BECCI score. Simply tick the box next to the item that best describes how much the practitioner talked within the consultation. As a guideline, the practitioner should be speaking approximately 50% of the time or less.