



House of Lords Science and Technology Select Committee
Call for evidence: Behaviour Change

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Summary

A1 About Swanswell

- A1.1 Swanswell is a national charity that helps people overcome drug, alcohol and other problem behaviour. Our core competence, developed through **41 years'** experience, is behaviour change, particularly addictive behaviour.
- A1.2 Swanswell is delighted to provide evidence to the House of Lords Science and Technology Committee Behaviour Change Enquiry. Our evidence is summarised in section A.2 below. Section B provides further information about Swanswell to provide a context for our evidence. Section C provides our evidence in full, including illustration drawn from research evidence, our own validated service delivery and development programmes and our extensive experience of interaction with the statutory sector in the delivery of behaviour change programmes.
- A1.3 Swanswell is able to provide further illustrative evidence if you would like to hear more at an oral hearing. We are also happy to invite committee members to visit Swanswell to experience our work and hear at first hand from our service users.

A2 Our evidence in summary

Research and development

A2.1 *What is known about how behaviour can be influenced? What special considerations apply to addictive behaviour?*

A2.1.1 In summary, we know that:

- Brief interventions are effective in changing behaviour
- Motivation relies on engagement and answering the 'what's in it for me?' question
- Structured interventions work well changing offending behaviour

A2.2 *What are the policy implications of recent developments in research on behaviour change?*

A2.2.1 Nudges in the 'right' direction are significantly outplayed by nudges towards unhealthy choices. We therefore believe that the policy implications of research findings encouraging the 'nudge' approach to behaviour change are that either the investment good nudges has to balance potentially opposing messages, or the power the commercial and retail sectors has to be mobilised into the 'nudge' campaigns by promoting healthy choices.

A2.2.2 A further policy implication of 'nudge' is to embed learning creatively into groups who are already engaged for other purposes. This – in turn – requires greater joining up of initiatives across government.

A2.3 *Is there adequate research capability within the United Kingdom to support the current pace of developments in behaviour change policy interventions? Is there sufficient funding for the evaluation of behaviour change interventions?*

A2.3.1 The Third Sector has a lot of research capability which is underfunded or excluded from certain funding streams. This inhibits the evaluation of behaviour change interventions developed in the Third Sector.

Translation

A2.4 Are there adequate structures and expertise across government and the public services more generally to support the translation of research developments in behaviour change into policy interventions?

A2.4.1 We are aware that regionalisation of statutory sector commissioning inhibits sharing of learning and good practice which, in turn, gives rise to duplication of developments rather than building upon those that are already known to work.

A2.4.2 The absence of shared practice and larger scale research capacity works against the creation of clear policy interventions so, building upon the example given above, there is no policy imperative to embed hospital liaison into alcohol treatment services.

A2.4.3 What is not in place is the mapping across from the Third Sector to policy interventions.

Policy design and evaluation

General

A2.5 What should be classified as a behaviour change intervention?

*A2.6 How should different **levels** of intervention (individual, organisational, community and national) and different **types** of intervention (legislative, fiscal, educative) interact in order to achieve policy goals more effectively?*

A2.7 Should behaviour change interventions be used in isolation or in combination with other policy interventions?

A2.7.1 Behaviour change interventions work best when they are systemic rather than specific. Joining up behaviour change interventions is therefore essential for sustained success.

A2.7.2 Active involvement of families and carers in the treatment of substance misusers has a significant impact on positive outcomes for behaviour change.

Practical application

A2.8 Have publicly funded behaviour change interventions been both evidence-based and subject to effective evaluation? How successful have such interventions been?

A2.8.1 In the drug treatment field, publicly funded behaviour change interventions are subject to significant scrutiny via the National Treatment Agency (NTA). Research published via the NTA and independently shows them to have been relatively successful in reaching their objectives.

A2.8.2 Lessons learnt through evaluation of behaviour change interventions take a long time to translate into changed practice within an approved framework and even longer to translate into commissioned practice. So the effectiveness of evaluation is compromised by lack of pace and the success of interventions is compromised by lack of flexibility to encompass new evidence rapidly.

A2.9 Within government, how are the lessons learnt from the success or lack of success of behaviour change interventions fed back into the design of future interventions? Are lessons learned from industry and voluntary sector behaviour change activities also taken into account?

A2.9.1 In our experience, within government lessons are learnt very slowly and enacted even more slowly.

A2.9.2 Effective services using well evidenced methods delivered in the Third Sector are viewed with scepticism by the statutory sector no matter how much of an evidence base is provided.

A2.10 What mechanisms exist, at national and local government level, to provide advice and support during the design, piloting, implementation and evaluation of behaviour change interventions in order to ensure that they achieve intended policy goals and also cultural changes within government and public services more generally?

A2.10.1 What we experience is a short term approach to behaviour change intervention development, lack of funding, and absence of clear and effective mechanisms through which results can be shared.

Cross-government coordination

A2.11 What mechanisms exist within government to coordinate and implement cross departmental behaviour change policy interventions?

A2.11.1 We are not aware that any mechanisms exist.

A2.12 What mechanisms exist within government to cascade learning and best practice on behaviour change policy interventions?

A2.12.1 There are few mechanisms for broader dissemination across the public sector and there is very little support from central/local government to try to cascade learning.

A2.12.2 We also challenge the implicit assumption in the term 'cascade' that learning has to be 'top down'.

Ethical considerations

A2.13 When is it appropriate for the state to intervene to influence the behaviour of members of the public and how does this differ from when it is appropriate for the commercial or voluntary sector to intervene? In particular, when should this be done by outright prohibition and when by measures to encourage behaviour change? Are some methods of producing behaviour change unacceptable? Which and why?

A2.13.1 There has to be a balance of state, commercial and voluntary sector intervention. For example, prosecution for certain offences related to drug/alcohol misuse is important if society is to be protected from the consequences of offending behaviour.

A2.13.2 State intervention is appropriate to ensure that messages which are designed to encourage indulgence in particular, potentially harmful, behaviours are balanced by encouragement to adopt healthy behaviour.

A2.13.3 Ethically, interventions which produce an outcome which is more damaging than the behaviour which they seek to change are unacceptable.

A2.13.4 Where addictive behaviour is concerned, there is an ethical imperative not to replace one addiction with another – for example, transferring from drink to drugs or vice versa.

A2.14 Should the public be involved in the design and implementation of behaviour change policy interventions and, if so, how? Should proposed measures for securing behaviour change be subject to public engagement exercises or consultation? Should they be piloted? Do considerations differ in the case of interventions aimed at changing addictive behaviour?

A2.14.1 People who have not experienced a particular problem are unlikely to engage with consultations about behaviour change programmes and – if they do – their input is likely to be coloured by stereotypical views of those exhibiting the problem behaviour. So public involvement may not provide the best route forward.

A2.14.2 It is important to understand what works and what doesn't work by seeking service users' views and involving them in the development.

A2.14.3 Pilots are important so that we can learn more easily what does and doesn't work and seek appropriate input from service users.

International comparisons

A2.15 What lessons can be learnt from previous successful or unsuccessful behaviour change interventions in other countries? Which countries provide the most helpful examples of best practice? Are behavioural change interventions generally transferable between different societies

A2.15.1 Many countries provide excellent examples of best practice – we provide examples from Australia, USA and Europe.

A2.15.2 In our experience, models for behaviour change are generally transferrable.

Tackling obesity

A2.16. The Committee would particularly welcome submissions on behaviour change interventions, whether in the public sector, the private sector or by voluntary organisations, designed to tackle obesity, in the United Kingdom or internationally,

A2.16.1 Our methods – particularly structured brief interventions - are transferrable into areas of behaviour change beyond our traditional expertise in drug and alcohol misuse. We have successfully achieved this transfer into violence prevention and, more recently, alleviation of sexual dysfunction.

B. About Swanswell

B1 Swanswell is a national charity that helps people overcome drug, alcohol and other problem behaviour. Our core competence is behaviour change, particularly addictive behaviour. We have over **41 years'** experience helping people to change their lives for the better, so they can feel well, do well and be happy. Because of the high quality service we provide, **98%** of our service users say they would recommend Swanswell to others.

B2 Community alcohol services

B2.1 In Coventry and Warwickshire, Swanswell provides community alcohol services across tiers 2 and 3, in line with Models of Care for Alcohol Misusers. In 2009/10 we provided alcohol treatment to **2,667** individuals, helping them live happier lives and saving money for the state services that alcohol dependency can impact on.

B3 Drug treatment services

B3.1 In Birmingham, we deliver one of the largest community drug services in the UK, where according to the Home Office we run 'one of the best developed shared care schemes in the country'. In 2009/10, **3,010** people received drug treatment at Swanswell and we effectively kept **90%** of them in treatment (which is above the target of 87% set by our commissioners).

B3.2 **85%** of people in our drug treatment service benefit from our shared care scheme. This means they can come and see us in their local GP practice, and we work closely with their GP to offer them comprehensive support that addresses all their needs, including healthcare needs. We're currently in over **120** GP practices across the West Midlands region.

B4 Supporting people

B4.1 We provide supporting people services, helping people in Coventry and Warwickshire with the practical issues caused by their substance misuse (e.g. housing, money, training and employment). We support them to develop new skills, empowering them to improve their quality of life. **81%** of people who use our supporting people services achieve their goals and are able to live independently as a result of our help (which exceeds the target of 80% set by our commissioners).

B5 Criminal justice

B5.1 We run a criminal justice programme in Birmingham which supports people to understand the link between their substance misuse and their offending behaviour. The programme achieves a **71%** reduction in rates of offending, with **67%** of offenders completing the programme (which exceeds our goal of 60%).

B5.2 Other services we provide in partnership with the Criminal Justice System are:

- Drug Intervention Programmes (DIP)
- Alcohol Treatment Requirements (ATR)
- Accredited National Probation Service programmes – Offender Substance Abuse Programme (OSAP), Low-Intensity Alcohol Programme (LIAP) and Drink Impaired Drivers (DIDs) programme
- Services for Priority and Prolific Offenders (PPOs)

B6 Carers support service

B6.1 We provide a carers support service, working closely with the substance misuse treatment service in Barnsley, to support people affected by a loved one's substance misuse. For every person with a drug and/or alcohol problem there is usually at least one carer. We give them much needed emotional and practical support, which not only meets their needs but enables them to better support their loved one. The service also provides help to individuals in treatment, speeding up service user recovery.

B7 Excellence in service development

B7.1 Swanswell is an ambitious, market-leading service provider. We develop new services according to identified needs. We will draw upon the validated outcomes that we have obtained from our service developments to inform our evidence to this inquiry.

B8 Swanswell's evidence

B8.1 Swanswell's evidence is set out in full in Section C, including illustrations drawn from research and our own validated delivery and development programmes, together with our extensive experience of working with the statutory sector. We are able to provide further illustrative evidence if you would like to hear more at an oral hearing. We are also happy to invite committee members to visit Swanswell to experience our work and hear at first hand from our service users.

C Our evidence in full

Research and development

C1. *What is known about how behaviour can be influenced? What special considerations apply to addictive behaviour?*

C1.1 Your inquiry has, no doubt, had access to extensive literature reviews setting out the body of research evidence underpinning behaviour change methods and processes.

C1.2 Swanswell would like to draw your attention to the National Treatment Agency (NTA) 'Review of the effectiveness of treatment for alcohol problems'¹ published in November 2006 and available at:

http://www.nta.nhs.uk/uploads/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf

C1.3 This research built upon a 'Mesa Grande' project which summarised the results of 381 trials of treatment outcome published before 2001 to provide accessible information on the effectiveness of alcohol treatment. The research identifies Brief Intervention, Motivational Enhancement and Cognitive Behavioural Therapies as of particular merit, but it is also notable that therapist characteristics account for up to **50%** of treatment outcomes. Treatment fidelity and competent delivery are also recognised as important elements

C1.4 Swanswell works with behaviour change, especially in the context of drug and alcohol misuse (addictive behaviour). We have applied the findings from research evidence, including that cited above, to develop new interventions which provide the basis of our evidence to this inquiry. In summary, we know that:

C1.5 **Brief interventions are effective in changing behaviour**

C1.5.1 Every year, around **360,000** incidents of domestic violence are linked to alcohol misuse², and each incident costs the UK economy an estimated **£9,000**. Since 2008 Swanswell has developed and piloted a six week brief intervention programme for alcohol related domestic violence offenders. It focuses on reducing the offenders' drinking and encouraging offenders to make different choices after examining with them their thinking, behaviour and actions. This brief intervention pilot achieved **73% zero-reoffending rate**.

C1.6 **Motivation relies on engagement and answering the 'whats in it for me?' question**

C1.6.1 In 2010 we piloted a three day workshop with a cohort of five female drug users combining practical interventions focusing on hair, beauty and fashion. The service users were encouraged to participate in the workshops through the 'hair and beauty' theme, which proved to be a powerful engagement tool. None of the service users dropped out and all attended all three days, which is a notable achievement given the chaotic nature of the service user group.

C1.6.2 The workshops included exercises through which the women explored their self esteem and confidence in a safe and encouraging environment. The evaluation of the workshop and follow up session with the women highlighted increased motivation through self belief that life change goals were achievable. It resulted in significant, sustained positive action by all five participants, e.g.:

- beginning a methadone detox after being on a maintenance script for 12 years
- enrolling on a course to get back into the workplace
- becoming drug free because she believed it was possible

'I've learnt that it's not hard to actually get up and try something new'.

Mandy, Swanswell service user

C1.6.3 In 2008-10 Swanswell also trialled alcohol awareness self-help groups, to encourage people, who may not have identified themselves as problem drinkers, to moderate their drinking. This trial did not achieve its objective. Our findings show that people are not motivated to attend groups or raise their awareness of something that they do not consider to be a problem. Where we achieved some success in this trial, it happened by making the alcohol awareness messages subsidiary to the achievement of specific goals with which existing groups are already engaged – such as working with football teams to improve their performance on the pitch.

C1.7 Structured interventions work well changing offending behaviour

C1.7.1 We have developed and piloted 12 week structured intervention programme designed to help offenders make the connection between their drug use and their offending behaviour. It helps them to recognise triggers and deal with them differently. It achieved a retention rate on the programme of **67%** (compared to DIP attendance rate of 36%). The first cohort on the programme included **30%** Prolific and Priority Offenders. Our programme achieved a **71% reduction in rates of drug use and associated drug-related offending.**

C2. *What are the policy implications of recent developments in research on behaviour change?*

C2.1 Recent research identifies that encouragement to make the right/healthy decision for one's own wellbeing works, rather than defining or prohibiting the things that aren't good for the individual. This, in turn, generates the concept that that people can be 'nudged' in the right direction.

C2.2 However, if small nudges towards healthier lifestyles through behaviour change are to be effective they have to be in balance with the array of promotional messages which reinforce, for the individual, previous unhealthy choices. We draw the following example from our experience of alcohol awareness campaigns in comparison with the marketing and promotion of alcohol.

C2.3 The Institute of Alcohol Studies factsheet 'Alcohol and Advertising'³ available at: <http://www.ias.org.uk/resources/factsheets/advertising.pdf> identifies that in 2004 **over £200million** was spent on alcohol advertising. Extrapolating spend on other promotional activity such as link ups with sporting events produced an estimated UK expenditure of **over £800million**. Contemporary increases in internet-based promotion may well have increased the reach of advertising at lower cost.

C2.4 The House of Commons Health Select Committee⁴ identified that Government spending in 2009/10 on alcohol information and education campaigns was **£17.6m**. This amounts to **less than 2%** of the prudently estimated spend on alcohol promotion.

- C2.5 From this, we conclude that the nudges in the ‘right’ direction are significantly outplayed by nudges towards unhealthy choices. We therefore believe that the policy implications of research findings encouraging the ‘nudge’ approach to behaviour change are that either the investment in good nudges has to balance potentially opposing messages, or the power of the commercial and retail sectors has to be mobilised into the ‘nudge’ campaigns by promoting healthy choices.
- C2.6 We also know, from our piloting of alcohol awareness groups which was referenced in our answer to question one above, that people have to be engaged before they can be nudged. We know that it is difficult to encourage people to engage if they do not see what’s in it for them. An alternative is to engage people where they are a ‘captive audience’ and mobilise peer groups in support of behaviour change.
- C2.7 Swanswell carried out a consultation in March 2010, asking young adults in alcohol and drug treatment, with experience of using drugs and/or alcohol when they were under 18 years old, what support would have helped them to change their behaviour. **54%** thought their substance misuse became problematic when they were under 18. They told us that if they had had someone in their peer group with whom they could check out their drinking or drug use they might have changed their behaviour at an earlier time in their lives before they became dependent. One person said:
- ‘Services should use some of the young people affected by drugs as role models and sources of information for the kids just beginning to get involved in drugs. Be there for people so they know they are not alone.’*
- C2.8 We have used this research to inform our work with young people and we are currently developing a screening tool that will engage young people, together with a peer support model.
- C2.9 A further policy implication of ‘nudge’ is therefore to embed learning creatively into groups who are already engaged for other purposes. This – in turn – requires greater joining up of initiatives across government.
- C2.10 An example of where such a policy initiative could change behaviour on a large scale is the inclusion of alcohol awareness into training for learner drivers. Swanswell works in the criminal justice system with people convicted of drink-driving. We deliver an accredited Drink Impaired Drivers’ (DIDs) programme which has run for over 100 cohorts with over **850** people completing the course successfully, learning how to change their drinking behaviour when driving. Many offenders tell us that, if they had known when they started driving what they learn on a Drink Impaired Drivers (DIDs) course, they would not have offended.
- C2.11 We know that driving lessons attract a high proportion of young people and that young people are disproportionately inclined to use alcohol irresponsibly. We also know that learner drivers are motivated to learn because they want their license. And they pay for their lessons themselves, so there is no cost to the state. Therefore including alcohol awareness in driver training programmes has the potential to change the behaviour of people at risk of alcohol misuse at no cost to the taxpayer. But this requires government departments of Health, Transport and Justice to join up their thinking.
- C3. *Is there adequate research capability within the United Kingdom to support the current pace of developments in behaviour change policy interventions? Is there sufficient funding for the evaluation of behaviour change interventions?*

- C3.1 Within the Third Sector, there is a significant amount of small-scale research being undertaken and pilots developed but little opportunity to convert small scale pilots into larger trials from which evidence based practice can be disseminated. This silo effect gives rise to duplication and slows down change. The Third Sector has a lot of research capability which is underfunded or excluded from certain funding streams despite its creativity and cost effective approach. This inhibits the evaluation of behaviour change interventions developed in the Third Sector.

Translation

- C4. *Are there adequate structures and expertise across government and the public services more generally to support the translation of research developments in behaviour change into policy interventions?*
- C4.1 We are aware that regionalisation of statutory sector commissioning inhibits sharing of learning and good practice which, in turn, gives rise to duplication of developments rather than building upon those that are already known to work. For example, the Alcohol Concern HubCAPP⁵ (hub of commissioned policies and practice) which can be found at: <http://www.hubcapp.org.uk/home.htm> includes reference to Swanswell's Hospital Liaison Service through which we have achieved an **80% non-readmission rate**. It also includes reference to several other, more recently developed and similar services none of which have, to our knowledge, referenced the learning that we generated and would have been delighted to share.
- C4.2 The absence of shared practice and larger scale research capacity works against the creation of clear policy interventions so, building upon the example given above, there is no policy imperative to embed hospital liaison into alcohol treatment services.
- C4.3 We also note that this question itself excludes the Third Sector. A great deal of innovative work in research is undertaken in this sector and it is the sector where there is more opportunity and ability to translate research developments into behaviour change models quickly, effectively and efficiently. The sector, historically, is underfunded and unrecognised although this is beginning to change. However, what is not in place is the mapping across from the Third Sector to policy interventions

Policy design and evaluation

General

- C5. *What should be classified as a behaviour change intervention?*
- C6. *How should different **levels** of intervention (individual, organisational, community and national) and different **types** of intervention (legislative, fiscal, educative) interact in order to achieve policy goals more effectively?*
- C7. *Should behaviour change interventions be used in isolation or in combination with other policy interventions?*
- C7.1 Swanswell's experience supports research evidence that behaviour change interventions work best when they are systemic rather than specific. A systemic approach has to encompass both what the service user changes and who is involved in those changes.

- C7.2 For example, at Swanswell we join up Supporting People services, which address practical requirements such as finance, housing, nutrition and hygiene, with treatment services for drug and alcohol misuse. Our service users often express appreciation for the practical support that they have received, telling us it has enabled them to make changes to their behaviour, because what they have changed is broader than just changing their drug and alcohol use.
- C7.3 Research tells us that the active involvement of families and carers in the treatment of substance misusers has a significant impact on positive outcomes for behaviour change. We deliver carers services in the treatment service in Barnsley so we know that carers want advice, guidance and to be involved to facilitate behaviour change which can impact severely on family life and wellbeing of all. Our experience shows that involving families and carers in treatment works in changing addictive behaviours quicker and more effectively in the long term. For every person with a drug and/or alcohol problem, there is usually at least one carer. It's estimated that carers looking after those with a drug and/or alcohol problem save the NHS and other state services **£3,935** a year for each user⁶.

Practical application

- C8. *Have publicly funded behaviour change interventions been both evidence-based and subject to effective evaluation? How successful have such interventions been?*
- C8.1 In the drug treatment field, publicly funded behaviour change interventions are subject to significant scrutiny via the National Treatment Agency (NTA). Research published via the NTA and independently shows them to have been relatively successful in reaching their objectives.
- C8.2 However, in our experience, lessons learnt through evaluation of behaviour change interventions take a long time to translate into changed practice within an approved framework and even longer to translate into commissioned practice. So we find that commissioned practice can fall behind the curve of best practice. An example of this is the criticism of drug treatment strategy towards harm reduction which measures success by counting the number of people in treatment and, therefore, works against practice which seeks to achieve recovery and exit from treatment.
- C8.3 So the effectiveness of evaluation is compromised by lack of pace and the success of interventions is compromised by lack of flexibility to encompass new evidence rapidly.
- C8.4 At Swanswell, we often don't wait for the new framework, having gone ahead with our own evaluation of what works and doesn't in order to use up to date best practice with our own service users.
- C9. *Within government, how are the lessons learnt from the success or lack of success of behaviour change interventions fed back into the design of future interventions? Are lessons learned from industry and voluntary sector behaviour change activities also taken into account?*
- C9.1 In our experience, within government lessons are learnt very slowly and enacted even more slowly. We do not experience government as having the capacity to assimilate practical learning from behaviour change interventions or to disseminate it effectively so that it informs service design. Our response to question four above, concerning dissemination of learning about hospital liaison services, provides a good example of how regionally-based services do not have mechanisms for sharing practice and therefore repeat learning rather than building upon it.

C9.2 We welcome the opportunity to provide evidence to this inquiry as a Third Sector organisation can show within our submission that our sector holds a body of knowledge about what works and doesn't work when achieving behaviour change. We are also used to translating what we have learnt into actions much quicker so that the impetus isn't lost – a lesson national and local government could use. However, what we have learnt is that effective services using well evidenced methods delivered in the Third Sector are viewed with scepticism by the statutory sector no matter how much of an evidence base is provided. For example, we recently bid to deliver a drug treatment service in the North of England based on our shared care services in Birmingham. Our bid was rejected largely because the commissioners could not envisage that what we achieve in Birmingham was possible at all, or translatable into their locality. Subsequently we hosted a visit for the NTA Regional Manager who emailed on his way home to say:

'It's not often I say this but I am genuinely impressed and enthused by what I have seen and heard today. I'm still gobsmacked at how you have managed to develop such a vibrant and active shared care system'

C9.3 Although we were delighted to receive his comments, they add to our frustration that good practice from the Third Sector is not readily believed or embraced. As far as we know, none of the practice that so impressed the NTA Manager has, to date, been adopted in his region, although we have offered to help them to do so.

C10. *What mechanisms exist, at national and local government level, to provide advice and support during the design, piloting, implementation and evaluation of behaviour change interventions in order to ensure that they achieve intended policy goals and also cultural changes within government and public services more generally?*

C10.1 What we experience is a short term approach to behaviour change intervention development. In Warwickshire, for example, when we developed the alcohol-related domestic violence intervention referenced in our response to question one above, we were given a year's funding by the local authority at short notice and developed a well evaluated brief intervention for domestic violence offenders which elicited a **73% non recidivism rate**. It works well but we were unable to progress to a bigger trial of the intervention through lack of funding and absence of clear and effective mechanisms through which the results can be shared outside Warwickshire, even though the benefit and cost saving of the intervention was stark and evidenced - for every £1 spent on our alcohol and domestic abuse programme, the nation saves at least **£9**. There has to be a longer term approach to developments and better support for implementation and evaluation, otherwise we lose the progress made.

Cross-government coordination

C11. *What mechanisms exist within government to coordinate and implement cross departmental behaviour change policy interventions?*

C11.1 We are not aware that any mechanisms exist. What we have experienced when we approached the then Transport Minister with the idea to integrate an alcohol awareness programme in the driving theory test in the UK, referenced in our response to question two above, was that we were simply passed from one department to another. Because our idea did not fit within a single policy area, we experienced a lack of capacity to engage with the idea within each Department, so no one was able to follow it up with us despite our repeated attempts to do so.

C12. *What mechanisms exist within government to cascade learning and best practice on behaviour change policy interventions?*

- C12.1 In our experience there are few mechanisms for broader dissemination across the public sector, as our response to question nine concerning our experience with commissioners in the North of England evidences. We also find that there is very little support from central/local government to try to cascade learning. For example, we understand that the Alcohol Concern HubCAPP facility, referenced in our response to question four, has had funding withdrawn and will cease.
- C12.2 We also challenge the implicit assumption in the term ‘cascade’ that learning has to be ‘top down’. From our experience there are very many grass roots, community-based and Third Sector organisations, like Swanswell, which are able to develop best practice and deliver significant outcomes.

Ethical considerations

- C13. When is it appropriate for the state to intervene to influence the behaviour of members of the public and how does this differ from when it is appropriate for the commercial or voluntary sector to intervene? In particular, when should this be done by outright prohibition and when by measures to encourage behaviour change? Are some methods of producing behaviour change unacceptable? Which and why?*
- C13.1 What we have learnt from our experience of the need for a systemic approach, as referenced in our response to question seven above, is that there has to be a balance of state, commercial and voluntary sector intervention. For example, prosecution for certain offences related to drug/alcohol misuse is important if society is to be protected from the consequences of offending behaviour. Mandatory attendance on Swanswell’s behaviour change programme by offenders has been shown to work well in changing offending behaviour and this has been recognised by the police and probation services where we deliver this. It gets over the need to answer the ‘what’s in it for me’ question which we referenced in our response to question one above by providing a clear and unequivocal consequence of a failure to engage.
- C13.2 Our response to question two above, concerning the promotion of alcohol by the drinks industry, provides a further example of where state intervention is appropriate to ensure that messages which are designed to encourage indulgence in particular, potentially harmful, behaviours are balanced by encouragement to adopt healthy behaviour. The regulation of sales and advertising, or unit pricing of alcohol, is an example of where the state and the commercial sector can work together to create a behaviour change. But we shouldn’t kid ourselves that commercial interests are benign so we also have to answer the ‘what’s in it for me?’ question for the commercial sector if they are to engage wholeheartedly.
- C13.3 Ethically, interventions which produce an outcome which is more damaging than the behaviour which they seek to change are unacceptable. Where addictive behaviour is concerned, there is an ethical imperative not to replace one addiction with another – for example, transferring from drink to drugs or vice versa. We are also aware that some of our service users are desperate for change and therefore vulnerable to suggestions that specific belief systems will produce the results they seek.
- C14. Should the public be involved in the design and implementation of behaviour change policy interventions and, if so, how? Should proposed measures for securing behaviour change be subject to public engagement exercises or consultation? Should they be piloted? Do considerations differ in the case of interventions aimed at changing addictive behaviour?*

- C14.1 In our experience, which comes primarily from work with addictive behaviours, people who have not experienced a particular problem are unlikely to engage with consultations about behaviour change programmes and – if they do – their input is likely to be coloured by stereotypical views of those exhibiting the problem behaviour. So public involvement may not provide the best route forward.
- C14.2 But we also know, from our own development programmes, that very good ideas come from people who are living with problem behaviour or who have already taken steps to overcome it. So it is important to understand what works and what doesn't work by seeking service users' views and involving them in the development. For example, at Swanswell, we have started to run a form of Dragon's Den which we call Debbie's Den (Debbie Bannigan is our Chief Executive) where service users can pitch their ideas for service developments.
- C14.3 Pilots are important so that we can learn more easily what does and doesn't work and seek appropriate input from service users. Swanswell has adopted a service development model which incorporates, within an action research methodology, a small scale pilot to work out how to deliver an intervention and to obtain initial evidence of outcomes. From this we can decide whether the intervention is worth further examination, what should be trialled and how the trial should be evaluated.

International comparisons

- C15. *What lessons can be learnt from previous successful or unsuccessful behaviour change interventions in other countries? Which countries provide the most helpful examples of best practice? Are behavioural change interventions generally transferable between different societies*
- C15.1 It is important that we know and take into account the lessons learnt in the behaviour change field in other parts of the world. Much of the current treatment models in the UK came from practice development in Australia. We are currently developing an intervention for people with alcohol related brain injury in the UK and we have used some of the innovatory practice which has come from criminal justice services in Australia. The USA is developing models of groupwork practice using new media and there are organisations such as EATA which disseminates current European research and best practice in treatment, so we know that many countries provide excellent examples of best practice.
- C15.2 In our experience, which includes working within multi-cultural communities of Birmingham, models for behaviour change are generally transferrable provided that, as noted in the National Treatment Agency (NTA) 'Review of the effectiveness of treatment for alcohol problems' cited in our response to question one above, we recognise that communities tend to segment according to particular faith allegiances.

Tackling obesity

- C16. *The Committee would particularly welcome submissions on behaviour change interventions, whether in the public sector, the private sector or by voluntary organisations, designed to tackle obesity, in the United Kingdom or internationally, in order to examine:*
- a) the latest developments in the evidence-base in relation to changing eating and physical activity behaviour;*
 - b) who are the most effective agents for the delivery of behaviour interventions to tackle obesity;*
 - c) how current behaviour change interventions tackle obesity and what use is made of available scientific evidence;*
 - d) whether such interventions are appropriately designed and evaluated; and*
 - e) what lessons have been learnt and applied as a result of the evaluation process.*

C16.1 Swanswell does not have direct experience of behaviour change relating to obesity. However, we know that our methods – particularly structured brief interventions - are transferrable into areas of behaviour change beyond our traditional expertise in drug and alcohol misuse because we have successfully achieved this transfer into violence prevention and, more recently, alleviation of sexual dysfunction.

D References

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