

A Square Peg in a Round Hole? Approaches to Incorporating Lifestyle Counselling into Routine Primary Health Care

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Few studies have explored how lifestyle counselling can be integrated into routine practice for primary health care (PHC) clinicians working outside general practice. This paper describes the feasibility of models of lifestyle counselling developed for PHC clinicians working in community health services and the congruence with routine practice. Action research methods were used to develop and implement models of lifestyle counselling in three community health teams. Following a six-month implementation period, semi-structured interviews were conducted with a purposeful sample of participants (n=30) to explore the appropriateness of implementing risk factor management models in practice. Models were considered appropriate if they fitted the clinician's philosophy of practice, were relevant to existing work tasks, could easily be integrated into workflow and were perceived as being acceptable to the client. The approach to service delivery and team priorities were also important in influencing which models suited particular teams. Models of lifestyle counselling for PHC clinicians outside general practice should be tailored to the clinicians' and teams' way of working and thus may need to be discipline-specific. Engaging PHC clinicians and teams is important in developing models that are acceptable and feasible in everyday practice.

Key words: Lifestyle, Risk factors, Primary health care, Professional practice, Health education, Counselling

Chronic diseases account for more than 60% of the global burden of disease. This is expected to rise to 80% by the year 2020 (World Health Organization [WHO], 2005). Lifestyle risk factors such as smoking, poor nutrition, risky alcohol consumption and physical inactivity have been identified as the main preventable risk factors for chronic diseases worldwide (WHO, 2005). Primary health care (PHC) providers are particularly well-placed to address these risk factors as they have contact with large segments of the population, often through multiple contacts with patients and their families. This provides the opportunity to assess for lifestyle risk factors, develop action plans, monitor progress over time and refer to community support programs if required (Whitlock, Orleans, Pender, & Allan, 2002). Despite evidence from controlled trials supporting the effectiveness of brief interventions for lifestyle counselling in PHC (Goldstein, Witlock, & DePue, 2004; Kaner et al., 2007; Lancaster & Stead, 2004), levels of intervention in routine practice remain low (Fretts, Rodman, Gomez-Carrion, Goldberg, & Sachs, 2000; McAvoy, Kaner, Lock, Heather, & Gilvarry, 1999). This highlights the need for better understanding

of how risk factor management can be integrated into routine PHC practice (Glasgow, Goldstein, Ockene, & Pronk, 2004).

Many studies have investigated factors associated with lifestyle interventions in PHC, including perceived barriers and enablers. These have been shown to relate to clinicians' beliefs and attitudes (Laws et al., 2008), clinician self-efficacy (Borrelli et al., 2001; Braun et al., 2004; Kushner, 1995; Sciamanna et al., 2002; J. Young & Ward, 2001) perceived effectiveness of interventions (Borrelli et al., 2001; C Brotons et al., 2003; Fuller, Backett-Milburn, & Hopton, 2003; Hutchings et al., 2006; Lawlor, Keen, & Neal, 2000; Pelkonen & Kankkunen, 2001) and congruence with clinicians' roles (Brotons et al., 2005; Douglas et al., 2006; Douglas, Torrance, Teijlingen, Fearn, & Fulcher, 2004; Fuller et al., 2003; Lawlor et al., 2000) as well as structural and organisational factors including lack of time, reimbursement or organisational support (Braun et al., 2004; Brotons et al., 2005; Douglas et al., 2006; Hutchings et al., 2006; Kushner, 1995; J. Young & Ward, 2001). These studies have been largely cross-sectional and most have been conducted in general practice.

The “five As” model of counselling (assess, advise, agree, assist, arrange) has been proposed as an evidence-based approach to integrating the management of lifestyle risk factors into routine practice (Whitlock et al., 2002). This approach to behavioural counselling can be applied across a range of behaviours. Few studies, however, have explored how models of lifestyle intervention can be integrated into routine PHC. This is important given the large number of reported barriers for addressing risk factors and the low rates of intervention. In particular, there is little research about models of lifestyle intervention that are appropriate to PHC clinicians outside general practice, including primary and community health nurses, allied health practitioners and other health workers such as multicultural and Indigenous health workers (Fry & Furler, 2000).

The current study aimed to 1) develop and describe models of lifestyle intervention for primary health care clinicians working outside general practice and 2) explore why some models were perceived to be appropriate to implement in practice while others were not.

Methods

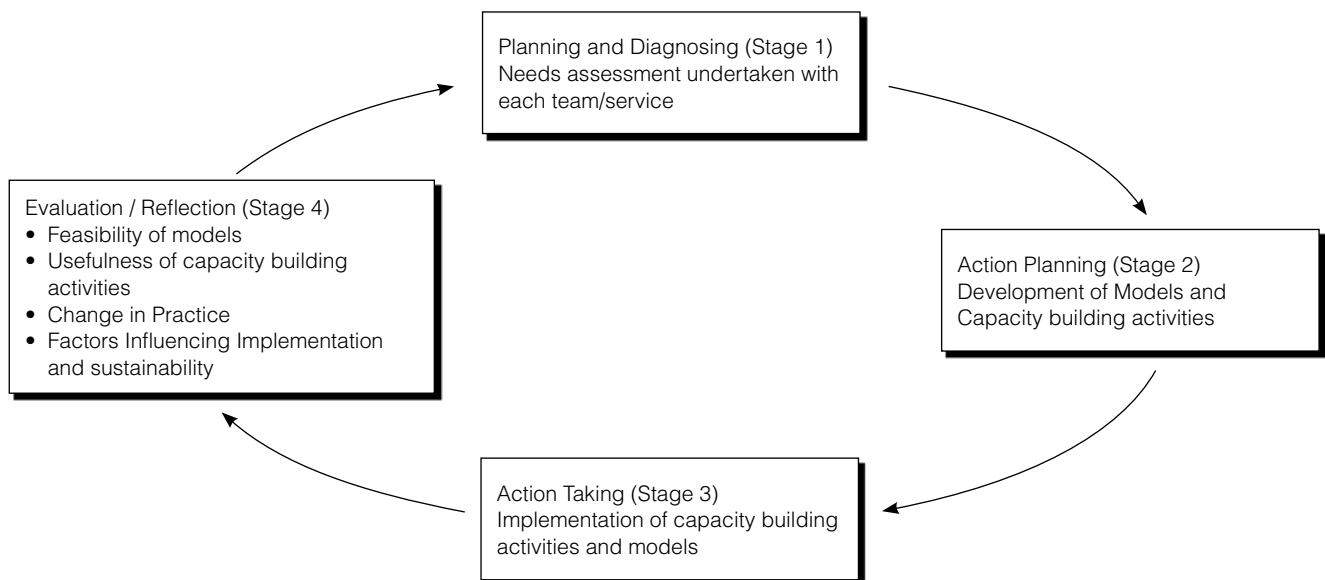
Study overview

This study took a case study approach, working with selected community health teams using action research methods. A case study approach

is considered preferable when “how” and “why” questions are being asked (such as how can risk factor management be integrated into routine work?) and when the phenomenon of interest (integration of risk factor management models into practice) cannot be disentangled from the context in which it occurs (the organisational setting [Yin, 2003]). The project also used action research methods to work collaboratively with each team. Action research engages practitioners in the research process and is characterised by a cyclical process of collecting information, feeding back and reflecting on data to implement change and generate new knowledge (Hampshire, 2000). In this study the action research methods involved four main stages (see Figure 1):

1. Planning and diagnosing: an initial needs assessment was undertaken with each team to understand current approaches to addressing lifestyle risk factors, barriers and enablers.
2. Action planning: consultations were undertaken with each team to develop appropriate models for lifestyle intervention and to identify capacity building activities.
3. Action taking: capacity building activities and models were piloted over a six-month period.
4. Evaluation and reflection: the feasibility of implementing the models and the usefulness of capacity building activities was explored and change in risk factor management practices examined.

Figure 1: Project Stages and the Action Research Cycle



Action research was considered particularly well-suited to this study as it enabled models to be developed collaboratively with each team. This was considered important in developing approaches that were feasible to implement in practice. Evidence also suggests that the use of action research can help promote changes in clinical practices (Galvin et al., 1999; Hampshire, Blair, Crown, Avery, & Williams, 1999; Waterman et al., 2007); hence, the use of action research methods was also considered an important component of the change process.

This paper will report on findings from the action research stages two to four, which relate to the process of developing and implementing models of risk factor management, and the extent to which these models were able to be integrated into routine practice. The findings from stage one have been reported elsewhere (Laws et al., 2008)

Description of participating teams/services

The study involved three community health teams from two area health services (AHS) in NSW, Australia. In NSW, AHS are responsible for providing all public hospital and community-based health care apart from general practice and are the second largest provider of PHC services to the general population after general practitioners (GPs [NSW Health, 2006]). Community health teams completed an expression of interest to be part of the research. Participants were selected on their capacity to take part in the research and to ensure variety in the types of health professionals involved and geographical location.

Team one ($n=35$) was a generalist community nursing team with enrolled and registered generalist community nurses¹ located across a metropolitan area, which predominately conducted home visits and saw clients for wound management, medication administration, chronic disease management and palliative care. The majority of clients were referred following discharge from hospital and were over 65 years of age. Team two ($n=16$) was a co-located multidisciplinary community health team (community/child and family nurses, allied health staff including a dietician, speech pathologist, occupational therapist, psychologist and social worker) from a rural area. Most clients were seen on an individual basis, either through home visits or at clinics held at the community health centre. Team three ($n=10$) consisted of PHC

nurses, Aboriginal health workers, and allied health clinicians providing largely health promotion and community development services to rural and remote communities that lacked easy access to other health providers, including GPs.

Model development

The research team worked with participating teams to decide how the clinicians would address risk factors (risk factor management models) and how this would be integrated into routine practice, supported, monitored and reported (Stage 2, Figure 1). The process varied, but involved a series of meetings with representatives of the team/service, and individual consultations with each health professional type or a team workshop. The research team developed a number of tools and resources to guide model development, including a list of key questions to be considered by teams/services (Box 1). The development of models was also influenced by the priorities of the organisation of which the teams were a part, by an initial needs assessment undertaken by the research team (stage 1), and by the information systems that were locally available.

Box 1: Key Questions Posed during the Model Development Process

What is the intervention/clinical model?

- Who undertakes risk factor management and with whom?
- Which risk factors are addressed (all or selected risk factors)?
- Which approach is taken to addressing risk factors (individual, group or community intervention, planned or opportunistic)?

What tools or systems are required to support risk factor intervention?

- How will risk factors be assessed?
- What training/ upskilling is required to support risk factor management practices?
- How is risk factor management reflected in service policies/procedures?
- How will risk factor activities be recorded in the clinical information system (CHIME)?
- How is risk factor management work led within the team?
- How is risk factor management reflected in team reporting and quality improvement?
- How can risk factor management activities be aligned to performance indicators for the service?

Semi-structured interviews

Following a six-month implementation period (stage 3), face-to-face interviews were conducted with a purposeful sample of participants to explore the appropriateness of risk factor management models and the usefulness of capacity building activities as well as other factors influencing implementation and sustainability (stage 4). This paper reports on the perceived appropriateness of models and emerging themes which help explain why some models were considered appropriate and others were not. "Appropriate" is defined in this context as being both feasible to implement in practice and acceptable to clinicians and clients.

A purposeful sample of clinicians were recruited by an evaluation officer (who had not been involved in the project implementation and was not known to the participants), reflecting the type of model implemented, professional role, length of professional experience, geographical location and views about the project (positive and negative). Clinicians were identified through discussions with team managers and through comments from a clinician survey at the end of pilot implementation period. Team managers, local project officers and senior community health managers in each area were also invited to participate. At least one clinician using each risk factor management model was interviewed except for those clinicians in a counselling role who had all left their positions at the time of the evaluation. Before interview, participants were sent a one-page questionnaire covering topics to be explored, allowing the interviews to focus in more detail on the specific responses of participants and providing richer information.

Interviews were audio-taped with participants' permission and transcribed for thematic analysis of the content using NVivo 7.0. An iterative thematic approach was used with repeated reading of the transcripts and coding of issues relevant to the research questions (Patton, 2002). Two researchers discussed the themes identified. Key findings were fed back and discussed with each team. Cross-case comparisons between teams and clinicians implementing different models highlighted key themes relating to the integration of models into routine practice.

Results

Thirty semi-structured interviews were conducted across the three teams. Interviews were conducted with clinicians (total: $n=23$ team one: $n = 9$, team two: $n =9$, team three: $n =5$), team managers ($n =3$), local project officers ($n =2$) and senior community health managers ($n =2$). Interviews with clinicians included generalist community nurses ($n =18$), allied health practitioners ($n =4$) and one Aboriginal health worker (Table 1).

Table 1: Characteristics of Clinicians Interviewed ($n=23$)

Variable	No (%)
Age Category	No (%)
18-24 years	1 (4)
25-34 years	2 (9)
35-44 years	10 (44)
45-54 years	7 (30)
55-64 years	3 (13)
Years of Clinical Experience	Mean (standard deviation), range
Working in the profession	22 (12), 0-43
Working in community health	9 (8), 0.4-30
Working in the current team	7 (7), 0.4-21
Gender	No (%)
Male	0 (0)
Female	23 (100)
Employment	No (%)
Part time	11 (48)
Full time	12 (52)
Clinician type	No (%)
Registered nurse	17 (74)
Enrolled nurse	2 (9)
Allied health	4 (17)
Team	No (%)
Team 1	9 (39)
Team 2	9 (39)
Team 3	5 (22)

Description of risk factor management models

Models were developed specific to each team and included individual, group and community approaches to risk factor management. All teams agreed to provide individual counselling for lifestyle risk factors, with different models for specific disciplines that varied according to the approach to counselling (planned or opportunistic) and scope (all or selective risk factors [Table 2]). A planned and comprehensive approach (model 1.1) was

considered appropriate for generalist staff as they already had an assessment process that included questions about lifestyle risk factors. Some allied health clinicians were open to including extra risk factors in their current assessments, while others were only comfortable addressing risk factors directly relevant to their professional role (planned and selective model 1.2). Those with a counselling role such as psychologists or social workers were opposed to screening because it did not fit with their client-led approach to care; they considered opportunistic intervention to be more appropriate to their professional role (opportunistic model 1.3). All teams/services opted for opportunistic follow-up when clients were next seen for the presenting issue or if re-referred to the service. Planned follow-up specifically for risk factor management was considered beyond the capacity of the services.

Team three adopted a broader approach that encompassed routine activities they engaged in, such as group education and community approaches (models 2 and 3). Group education sessions included one-off sessions (e.g., men's and women's health) and ongoing group programs (e.g., five-week health awareness program) in which lifestyle risk factors were addressed. Clinicians in this team reported spending around 50 per cent of their time undertaking community-focused

work, including community development (such as working with communities to identify strategies to improve social networks) and community-based health promotion activities (such as establishing local walking groups). These community-based approaches were seen to support counselling for lifestyle risk factors provided on an individual basis by addressing barriers to adopting a health lifestyle and determinants of risk-taking behaviour. These approaches were implemented by the team and were considered to fit well with their focus on community development, prevention and early intervention.

Appropriateness of risk factor management models

The number of clinicians who perceived the models as appropriate for routine practice following the six-month trial period is shown in Table 2. Most generalist nurses from across the three teams (15 out of 18) supported systematic screening for all lifestyle risk factors and providing brief intervention. In contrast, allied health clinicians (*n*=2) who adopted this approach considered it appropriate to screen but less feasible to offer interventions for lifestyle risk factors not related to their role. They preferred referring clients to support services rather than offering intervention themselves.

Table 2: Description of Risk Factor Management Models by Team and Discipline

Model Description	Discipline (Team) Using the Model	Number who Perceived to be appropriate*
1. Individual Intervention		
1.1 Planned and Comprehensive: Screening for all risk factors as part of the standard assessment process, offering brief intervention and referral as appropriate with opportunistic follow-up	Generalist community nurses (<i>n</i> =18, teams 1,2, and 3) Dietitian and Occupational Therapist (<i>n</i> =2, team 2)	15 out of 18 2 out of 2 (screening only)
1.2 Planned and Selective: Selective screening for specific risk factors relevant to the presenting issue, offering brief intervention and referral as appropriate with opportunistic follow-up	Speech pathologist and Audiometrist (<i>n</i> =2, team 2)	2 out of 2
1.3 Opportunistic: Offering brief intervention and referral as appropriate for risk factors identified opportunistically during the consultation with opportunistic follow-up	Counsellor, psychologist and social worker (<i>n</i> =3, team 2 and 3)	Not evaluated
2. Group Intervention		
Integrating education about lifestyle risk factors into group programs; e.g., women's health	All clinicians (<i>n</i> =10, team 3)	5 out of 5
3. Community Intervention		
Addressing risk factors at a community level; e.g., screening and intervention for risk factors at community events, establishing local walking groups	All clinicians (<i>n</i> =10, team 3)	5 out of 5

* Perceived to be Appropriate: models were considered to be appropriate if perceived by clinicians to be both feasible and acceptable to implement in practice following the trial implementation period.

Allied health practitioners (whose roles are not generally associated with addressing a broad range of lifestyle risk factors) considered a planned and selective approach appropriate but commented on the limited reach of interventions due to the small number of relevant clients seen. All clinicians interviewed in team three considered individual (planned and comprehensive approach), group and community approaches to be appropriate, as this was already part of their practice.

What makes models fit?

Five themes were identified which help explain why some models were considered appropriate to implement in practice by particular clinicians, disciplines and teams while others were not (see Table 3).

Table 3: Key Themes Explaining the Degree of Fit of Risk Factor Management Models across Teams and Disciplines

Themes
<p>Degree of fit with clinician role</p> <ul style="list-style-type: none"> • Extent to which lifestyle counselling is an established part of routine practice • Degree of fit with clinicians' philosophy of practice • Degree of relevance to existing work tasks and ease of integration into workflow. • Perception of client acceptance
<p>Degree of fit with team/service</p> <ul style="list-style-type: none"> • Degree of fit with the way the service operates • Degree of fit with the team/services' philosophy of practice

The extent to which lifestyle counselling is an established part of routine practice

Models appeared easier to integrate into routine practice when the approach was to some extent already part of the clinicians' role, particularly with generalist nurses implementing the planned and comprehensive model: "It was a part of our role anyway to ask about SNAP [smoking, nutrition, alcohol and physical activity], it's just now on a bigger scale" (nurse, planned and comprehensive model). In contrast, allied health clinicians who were attempting to integrate new approaches found that they lacked experience and thus confidence: "I think what I tend to do is assess. I suppose maybe it's based on how...personally confident I feel about offering anything more than that" (allied health, planned and comprehensive model).

The degree of fit with clinicians' philosophy of practice

Models were more likely to be seen as appropriate if they fitted with the clinician's philosophy of practice. For generalist community nurses this related to seeing lifestyle risk factor management as part of holistic care:

My approach is holistic health and wellness...so ultimately what I'm looking for is information to assist people being totally healthy and well...so continuing to assess and support lifestyle changes...I do believe it should continue to be part of our role. (nurse, planned and comprehensive model)

In contrast, clinicians who did not consider holistic care and prevention part of their practice philosophy may have found it more difficult to integrate risk factor management models into practice: "I suppose in some circumstances people might see it as a poor fit where they see community health as being just about looking after people after discharge from hospital" (manager). Clinicians' discipline, background and training were also considered important in influencing their philosophy of practice: "We are very holistic in terms of addressing the whole person's lifestyle but it hasn't traditionally ever focused on the risk factors... (allied health, planned and comprehensive model); "it depends on their discipline as to how well this links [risk factor management models] to their discipline and their training and their thinking" (manager).

Relevance to existing work tasks and ease of integration into workflow

Models were perceived to be more feasible to implement when risk factor management was directly relevant to the client's problem. This was particularly so for some generalist community nurses: "The smoking, the nutrition, the alcohol, the physical activity... should be part of the routine assessment for us to be able to get a good background as to how we're going to go about looking after these people" (nurse, planned and comprehensive model). The relevance of risk factor issues appeared to make it easier to integrate into the workflow: "I suppose you can incorporate the SNAP questions while you are doing the dressing; you can bring it up in conversation which is what I normally do" (nurse, planned and comprehensive model). However, other nurses ($n=2$) questioned the relevance of risk factor issues for older clients

and the impact of implementing risk factor management on their workload: “They certainly put an extra half hour or so on your assessment... They’re all aged care and if some should be drinking or anything, they’re certainly not going to change that late in life” (nurse, planned and comprehensive).

Integrating risk factor management into workflow was also difficult for allied health clinicians when SNAP risk factors did not directly relate to the client’s presenting problem:

I have no problems assessing for the risk factors and I just incorporate that now as part of my initial interview with a person but it’s the next steps that I have problems with...the timing to get back and to address those issues when you’re primarily there to do your specific role.” (allied health, planned and comprehensive model)

Understandably, allied health clinicians adopting a planned and selective approach did not report these difficulties as they selectively addressed risk factors relevant to the consultation: “Well often if it is a problem area it’s something that needs to be addressed to help for whatever reason they’re seeing me...” (allied health, planned and selective model).

Perception of client acceptance

Models appeared easier to integrate when clients were perceived as accepting the approach. “The general public expect now that when they come to us to get advice ...that these are the sorts of things that we will be asking them” (nurse, planned and comprehensive approach). On the other hand, a small number of nurses ($n=2$) reported that perceiving a lack of client acceptance was a barrier due to the negative impact this could have on the clinician-client relationship:

If you have an angry client who doesn’t really want you in the house anyway and they’ve got a baby ...if you turn around and say “do you smoke and do you drink”, they find it confronting.. I really have to, first and foremost, for the baby’s sake... maintain a relationship with the client. (nurse, planned and comprehensive approach)

Degree of fit with team/service

Models were seen as appropriate if they fitted with the way the service operated and the team’s philosophy of practice and service priorities (Table 2). For example, team three took a broader

approach to addressing risk factors because this fitted the way the service operated and the team’s priority of chronic disease prevention: “We have chronic disease prevention and early intervention as one of the five priority health areas...so it fits really well...into our core business... basically that’s what we’re funded to do” (team 3). In contrast, managers in teams 1 and 2 did not consider group or community approaches to be core business, as their focus was providing individual clinical services including post-acute care. In these teams it was considered more difficult to embed risk factor management due to the demands of post-acute care (team 1) and a lack of organisational clarity about the community nursing role (team 2):

We’ve not had that formal framework to say our community nurses should...as part of their core business...talk to their clients around risk factors. We know all those things are important. We haven’t articulated that’s what we want that workforce to do (team 2).

Discussion

This study describes three models of lifestyle intervention for PHC clinicians outside general practice and factors influencing the feasibility of integrating them into routine practice. Clinicians perceived models as appropriate if they fitted with their philosophy of practice, were relevant to existing tasks, could be easily integrated into workflow and were perceived as acceptable to the client. The fit between approaches to risk factor management and the team/service’s operation and priorities also influenced which models suited particular teams.

Our findings support the need to tailor models of lifestyle intervention to the clinicians’ and teams’ philosophy and way of working. They suggest a planned and comprehensive approach to individual counselling (systematically screening and intervening for all lifestyle risk factors) for generalist PHC clinicians working outside general practice. This could include generalist community nurses, child and family nurses, community nurses working in chronic disease care and Aboriginal health workers. In contrast, a selective approach to screening and intervention (only screening for risk factors most relevant to the presenting issue) or an opportunistic approach to intervention may be more appropriate for allied health practitioners, reflecting their more specialist role. Group

and community-based approaches supplement individual counselling and are likely to be suited to teams which already provide non-clinical services such as group education programs and community development activities. However, such approaches are unlikely to be feasible for most generalist community nursing services due to the emphasis on individual post-acute care and the move away from such approaches in recent years (Kemp, Harris, & Comino, 2005). Group education programs for management of behavioural risk factors in PHC are not widely available in Australia at present. In light of this, it is encouraging that group education programs for those at high risk of diabetes will now be funded through the Medicare Benefits Scheme and facilitated by divisions of general practice from July 2008 (Department of Health and Ageing, 2008). It will be important to facilitate access for the clients of community nurses to such programs.

Our findings extend current evidence about factors that influence risk factor management practices and highlight the importance of matching the models of lifestyle intervention to clinicians' way of working, including both the philosophy and the mechanics of practice. This is consistent with previous studies on research utilisation, which suggest compatibility with existing values and norms (Dennis, Hebert, Langley, Lozeau, & Trottier, 2002; Foy et al., 2002; Rycroft-Malone et al., 2004) and task relevance and workability is important in the uptake of new practices (Dobbins, Cockerill, & Barnsely, 2001; Foy et al., 2002). The findings are also in line with the normalisation process model proposed by May (May, 2006; May et al., 2007). This suggests that new practices need to be adapted to fit with existing tasks (such as integrating risk factor screening into existing assessment processes) in a way that is acceptable to clients; for example, not screening and intervening with clients until a rapport has been established. The overall approach will also need to reflect the way the team currently provides services.

While this study suggests that a range of approaches to lifestyle intervention in PHC are likely to be required depending on the role of different providers, significant challenges to integrating lifestyle interventions into routine PHC practice remain. These include lack of time and funding and low levels of confidence among clinicians in providing behavioural interventions (Brotons et al.,

2005; Bull, Schipper, Jamrozik, & Blanksby, 1995; Laws et al., 2008; J. Young & Ward, 2001). There are a number of alternative models to intervening for lifestyle risk factors both within and outside the PHC sector. There may be scope to review and expand the role of other PHC clinicians such as practice nurses and health care assistants to provide behavioural interventions, although workforce capacity remains an issue. Perhaps there is a need for a new breed of health care worker—"the health coach"—to work alongside existing PHC clinicians to provide more intensive lifestyle counselling and self-management interventions. Outside PHC, telephone support and internet-based programs have been shown to be an effective means of assisting individuals with lifestyle change (Kroeze, Werkman, & Brug, 2006; Oenema, Brug, Dijkstra, De Weerd, & De Vries, 2008; Pierce et al., 2004; Stead & Lancaster, 2002; R. J. Young et al., 2005). Community development and population health approaches that attempt to address the underlying determinants of risk-taking behaviour will also be critical, particularly for disadvantaged groups who are less likely to engage with individually focused interventions. It is likely, however, that a combination of all the above approaches will be required to reduce the prevalence of lifestyle risk factors in the community. Sustainability of initiatives and equity of access to interventions remains a challenge. Given the size of the PHC workforce and access to the general population, PHC providers are likely to remain important providers of intervention for lifestyle.

The findings have some limitations. They are based on a relatively small sample of clinicians from three community health teams within two area health services who tendered to be part of the research. Only a small number of allied health practitioners in the study and one model (opportunistic approach) could not be evaluated as these clinicians had left at the time of data collection. This limits the generalisability of the findings to other PHC clinicians and teams. This "case study" approach using action research, however, was well-suited to exploring the appropriateness of models in depth, and in the context in which the teams were operating (Yin, 2003). The cross-team and discipline comparisons also helped provide a more complete picture of the integration of risk factor management into the broader practice of PHC clinicians outside

general practice. Future research should address the sustainability of the models, what impact they have on clinician practices over time, patient satisfaction with different models of care, and how effective the models are in changing the lifestyle behaviours of clients.

This study provides important insights into factors to consider in integrating lifestyle counselling into routine practice. Models of lifestyle counselling for PHC clinicians outside general practice need to be tailored to the clinicians' and teams' way of working

and thus may need to be discipline-specific. Systematic screening and intervention for lifestyle risk factors may be best suited to generalist PHC clinicians and a selective or opportunistic approach to allied health practitioners. Consideration should be given to how models fit with the clinician's role, including both the philosophy and mechanics of practice as well as how models fit with the team's approach to service delivery and team priorities. This may help improve the integration of lifestyle counselling into routine PHC practice.

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Conflict of interest

Authors declare that there have been no conflicting interests in the conduct of this study.

Notes

- ¹ Registered nurses undertake a three-year tertiary education program. Enrolled nurses undertake training from 12 months to two years at a technical college receiving a certificate or diploma depending on the state. Enrolled nurses work with registered nurses to provide patients with basic nursing care. Within the project registered nurses undertook the initial client assessment and care planning and enrolled nurses assisted with the implementation of the care plan.

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