

Person centered health promotion: learning from 10 years of practice within long term conditions

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Abstract

The utilization of person centered care is highlighted as essential for health promotion, yet implementation has been inconsistent and multiple issues remain. There is a dearth of applied research exploring the facets of successful implementation. In this paper, a person centered wellbeing program spanning various groups is discussed outlining the central principles that have allowed for successful outcomes. The main data emerges from 10 years of pragmatic pre-post service evaluation. Measures of functional capacity and wellbeing were captured using validated measures. The method for this paper is a narrative exploration of the theory and practices that can explain the continual improvement the clinics have achieved over 10 years. Core principles relate to connecting with people, connecting through groups, and connecting with self. The operationalization and theoretical explanation of these principles is outlined alongside 10 years of data which shows sustained improvement in a range of outcomes. The discussion of these principles posits essential factors to prioritize to advance the implementation of person centered care in health promotion for long term conditions.

Keywords: keyword 1. Person centered care 2. health promotion 3. implementation 4. behavior change 5. primary care

1. Introduction

Long terms conditions represent the largest threat to global mortality and an unsustainable demand on health services worldwide [1]. By the age of 50 half the United Kingdom (UK) will have one long term condition. Worryingly, long term conditions demonstrate a progressive trend and there is now a high prevalence of people with three or more disorders. Multimorbid status leads to a decreased quality of life, increased risk of premature death alongside placing additional demand on health and social care [2]. The burden of long term conditions also leads to an expanding proportion of people who are less functionally capable, have lower health literacy, and respond poorly to usual care [3,4].

Yet, much of the established burden of long term conditions could be mitigated through engagement in a cluster of health behaviors [5]. Patient, or person, centered care (PCC) is a fundamental practice to activate people in self-care and develop

self-management skills [6]. The characteristics of PCC is contested, yet there is an established value associated with PCC. The inability to define PCC relates to its application in complex settings which rely on human interpretation, social meaning, volition, interpersonal characteristics, and organizational context [7–11]. Furthermore, the theoretical underpinning of PCC is rarely articulated, and written guidelines increase reductionist practice that lacks relevance in real life settings [12,13]. For the most part PCC lacks an awareness of self and relies heavily on unconscious processes [14]. Therefore, data and reflections from successful theory led practice presents useful learning and generalizability [15].

Despite primary care being a central setting to operate person centered health promotion it is often met with multiple barriers [16–18]. The traditional medical model assumes a paternalistic prescription model that conflates the complexity of health promotion and is inappropriate to support the adoption of PCC [19]. This culture is widespread in health promotion delivery where services fail to acknowledge the social environment, practitioners are impinged to respond to individuals' values, and services try to operate PCC in a rigid manner that is not conducive to real life [20,21].

In the UK, there has been a proliferation of conservative approaches which are envisaged to support the operationalization of health promotion, yet these approaches have had negligible impact on patient outcomes [22–24]. Moreover, there is little evidence that these approaches mitigate the medical culture that can lead to detachment from service users and emotional suppression compromising the implementation of PCC [8].

Despite policy commitments to utilize preventive medicine, PCC, social and behavioral science, and holistic practices [25–27] the translation to practice has been poor. There have been recent calls to provide examples of behavioral science from applied practice outlining the successful factors of PCC adoption [28]. The Marjon Health and Wellbeing (MHW) approach is a UK person centered wellbeing intervention which is utilized across numerous long-term conditions. The aim of this paper is to present the pragmatic data of 10 years of practice, the broad clinic principles and assigned theoretical underpinnings of practice, and the operational tools that have been used routinely through the years.

2. Materials and Methods

The health programs started in 2009 and all services now adopt the same overarching principles and structure yet retain a degree of flexibility to tailor delivery to individual groups and commissioners. Typically, groups meet for two hours per week for a period of 4–6 weeks and engage with a multidisciplinary approach that encourages self-management of health issues. During each program participants are introduced to physical activity, mindfulness, cognitive behavioral assumptions, sleep hygiene, and healthy eating with appropriate signposting (see [28]) for intervention overview & data procedures and processing). The evaluation of programs is a pragmatic pre-post design. Previous research has appraised discrete cohorts from an empirical stance [28, 29). The current paper proposes a model which explains the continual successful pattern of outcomes. The entirety of the dataset is provided for visual support alone. The model was developed from engaging in reflective dialogue with program architects, service users and clinic leads, consulting the literature to best re-describe core principles in a theoretical sense and articulating routine practices that have endured across the ten years in evidence-based terms.

Table 1. Demographics of the program participants

Variable	Outcome
Total people	1230
Age	52± 14.6
Female	61.7%
Index of Multiple Deprivation	12960 ± 8988

3. Results & Discussion

In line with the call to present examples of successful applied theory led practice the current paper outlines the core facets which have allowed for the implementation of PCC. It is argued that principles covering; connecting with people, connecting through groups, and connecting with self encapsulate the success of the programs. Practices typically focus on increasing autonomous motivation, practices of humanism and enhancing perceptions of control, providing and facilitating social support and changes in group identity, and transformative learning many of which are known to enhance adherence to services in long term conditions [30].

3.1 Dataset

Since its initiation in 2009, 1230 people (Table 1) have attended the cancer and chronic pain programs. Due to the history of the programs (pilots, changes in funders, dynamic resource allocation) and evolving metrics over time the completeness of the dataset has been impacted and experimental designs have not been possible. Despite varying sample sizes across the variables measured significant improvements were identified in all performance measures including aerobic fitness (7%), handgrip (3%), and total weekly energy expenditure (59%). Disease specific outcomes also indicated positive changes in functional capacity. Individual aspects of a cancer quality of significantly altered between timepoints for 11/15 of the survey components. Back pain disability showed a 16% reduction and back flexion and extension endurance increased by approximately 21% and 32% respectively.

3.2 Connecting with people

Underpinning theory

The overarching culture is one of humanistic practice and operates to ensure the patient's values and preferences guide care via an unconditional positive regard for them [31]. The unconditional positive regard influences change through a natural actualizing theory in humans [32]. However, the MHW acknowledges that compassionate care is only one aspect of PCC. The organizational culture provides the epicenter for the approach as it does not have an enduring obligation to medical values and there is an intentional commitment to uphold the focus on the person holistically across multiple staff roles [33]. The adoption of practice based on mutual respect and person led discussions provides an increased contextualization of care and acceptability for individuals increasing self-determined motivation. The setting mitigates many of the medical cultural assumptions through a demedicalization of practice. The work operates to extinguish expert-patient assumptions about knowledge and encourages people to explore non-prescribed treatment options within a setting that decreases medical social control [35].

Practices

The spirit of Motivational Interviewing (MI) provides a tangible way to operationalize humanistic care [36]. Collaboration, compassion, and acceptance are implemented to increase self-actualization and to shed a dysfunction centric approach. Introducing patients to a range of opportunities and tools, along with an ongoing information exchange and thorough group reflection, is the primary way evocation is operated. Practices to support intrinsic motivation include the provision of choice, providing rationale for advice and activities, exposing patients to new challenges and environments and setting homework, providing positive feedback, and developing social relationships and a group identity [37]. Groups are co-delivered by university students which is envisaged to demedicalize the programs by creating equal partnerships and minimizing power relationships [38]. Support workers provide individuals with a contact point and safety net to try things, feel genuine devotion of care, understand the new environment, converse about their life and barriers, and gain basic skills in new environments [39]. Lastly, the setting provides an antidote to the medical model as it has a history of collaborative teaching and a culture that supports individual prosperity. These provisions address key mechanisms of successful care including patients feeling believed, supported, encouraged, and in control during their educational experience [40].

3.3 Connecting through groups

Underpinning theory

The small group format draws on the principles of Social Identity Theory which propose that increasing social connectiveness shapes attitudes, cognitions, and behaviors and valued membership can increase wellbeing [41]. Group structural elements impact the internalization of social identity, and the creation of opportunities for reappraisal and interaction can modify the perceived norms for certain identities within specific contexts [42]. Additionally, the programs operate education through experiences, modelling, and group learning to target attitudes, self-efficacy, and norms as per the Social Cognitive Theory [43].

Practices

Connections and group belonging need facilitating and key features are implemented in the MHW. Groups sizes tend to be 4-10, occur in same condition cohorts, have planned and frequent breaks for interaction and sharing, and have personable and credible facilitators. Practices to activate social theoretical constructs crosses over with previous practices like MI and autonomous care. In brief, the facilitator adopts techniques including checking understanding, encouraging contributions, outlining sessions, paraphrasing, providing examples, discussing outcome expectations, motivation and confidence, prompting social learning, validation and comparisons [44]. These practices operationalize many well-known behaviors change techniques that are also imbedded in the programs (see table 1). For example, participants are taken into a gym environment and offered a choice of what they would like to experiment with. Students demonstrate activities, persuade individuals about capability, and provide a reflective opportunity for people to experience exercise in a safe environment supporting biofeedback, reattribution of the cause of pain and discomfort, and information on the consequences of behaviours.

3.4 Connecting with self

Theoretical underpinning

The pedagogical approach mirrors Transformational Learning to build autonomous and liberated individuals. Transformative learning leads to a change in an individual's embodied frames of reference [45]. The format provides open experiences for individuals to challenge their identity; as individuals tend to reject ideas that do not correspond with their preconceptions [46,47]. In line with a previous facet of theory [35] there is not a paternalistic drive to make people confirm to medical assumptions, instead the approach looks to enhance human flourishing and perceived control on wellbeing. There is a focus on holism and activating the patient in their health via shifts in self-concept [48]. The outcome of the approach is to increase the learner's capacity to critically evaluate experiences and take action [47].

Practices

The MHW provides an avenue for individuals to reflect and challenge thoughts, acknowledge automatic thought processes, develop new ideas and experiment in a safe environment [49]. Additionally, the programs generate an environment where individuals are encouraged to be active members in the education provisions. The lead practitioner pledges an explicit commitment to practice in ways that support the patient's identity by addressing the needs for attachment, comfort, occupation, and inclusion increasing the patient's self-worth and a sense of feeling valued [50]. The programs involve multicomponent experiential learning where individuals are supported to experiment with a range of tools that they are encouraged to try and either adopt or reject based on their preference. The accumulation of knowledge, skills, and confidence is achieved through a broad lens of elements that may be useful for their health.

4. Conclusion

Despite the enthusiasm to transition healthcare to a preventive model, routine practice has not modified on a large scale. The discussion of the pragmatic, but essential, facets to operate PCC is underexplored. This discussion provides a noteworthy example on what should be prioritized for PCC implementation to support health promotion. The model outlines central factors that can mitigate the challenges in PCC. Firstly, an organizational commitment to, and culture conducive of PCC, is needed which can enhance the operation of humanistic practices, and demedicalization care. Staff should plan practice to enhance self-determined motivation in participants. Socialization and small group work supports changes in wellbeing and identity and helps deconstruct typical medical/patient power relationships. The paper presents key design and facilitator approaches that have endured through the years which resonates with the literature [44,51]. Lastly, services should include Transformational Learning practices creating an established pedagogical template to empower patients to rehearse elements along with reflecting, and re-evaluating, aspects that may be important to their health. The model provides pragmatic modifications that are needed to initiate an advantageous shift in PCC and behavioral science implementation in the treatment of long term conditions

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References

1. Institute for Health Metrics and Evaluation Global Burden of Disease Study 2017. **2018**, 1–7.
2. Barnett, K.; Mercer, S.W.; Norbury, M.; Watt, G.; Wyke, S.; Guthrie, B. Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *Lancet* **2012**, *380*, 37–43, doi:10.1016/S0140-6736(12)60240-2.
3. Coulter, A.; Robers, S.; Dixon, A. Delivering better services for people with long-term conditions. **2013**, 1–28.
4. Wolff, J.L.; Starfield, B.; Anderson, G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Arch. Intern. Med.* **2002**, *162*, 2269–2276, doi:10.1001/archinte.162.20.2269.
5. Milani, R. V.; Lavie, C.J. Health care 2020: Reengineering health care delivery to combat chronic disease. *Am. J. Med.* **2015**, *128*, 337–343, doi:10.1016/j.amjmed.2014.10.047.
6. Coleman, K.; Austin, B.T.; Brach, C.; Wagner, E.H. Evidence On The Chronic Care Model In The New Millennium. **2009**, 75–85, doi:10.1377/hlthaff.28.1.75.
7. Zoffmann, V.; Hörnsten, Å.; Storbækken, S.; Graue, M.; Rasmussen, B.; Wahl, A.; Kirkevold, M. Translating person-centered care into practice: A comparative analysis of motivational interviewing, illness-integration support, and guided self-determination. *Patient Educ. Couns.* **2016**, *99*, 400–407, doi:10.1016/j.pec.2015.10.015.
8. Burks, D.J.; Kobus, A.M. The legacy of altruism in health care: The promotion of empathy, prosociality and humanism. *Med. Educ.* **2012**, *46*, 317–325, doi:10.1111/j.1365-2923.2011.04159.x.
9. Langberg, E.M.; Dyhr, L.; Davidsen, A.S. Development of the concept of patient-centredness – A systematic review. *Patient Educ. Couns.* **2019**, doi:10.1016/j.pec.2019.02.023.
10. Nye, A.; Connell, J.; Haake, R.; Barkham, M. Person-centred experiential therapy (PCET) training within a UK NHS IAPT service: experiences of selected counsellors in the PRaCTICED trial*. *Br. J. Guid. Couns.* **2019**, *47*, 619–634, doi:10.1080/03069885.2018.1544608.

11. Pawson, R. The Realist Foundations of Evidence-Based Medicine: A Review Essay. *Evaluation* **2018**, *24*, 42–50, doi:10.1177/1356389017746718.
12. Dewing, J.; McCormack, B. Editorial: Tell me, how do you define person-centredness? *J. Clin. Nurs.* **2017**, *26*, 2509–2510, doi:10.1111/jocn.13681.
13. Green, J. The role of theory in evidence-based health promotion practice. *Health Educ. Res.* **2000**, *15*, 125–129, doi:10.1093/her/15.2.125.
14. Owen, I.R. Exploring the similarities and differences between person-centred and psychodynamic therapy. *Br. J. Guid. Couns.* **1999**, *27*, 165–178, doi:10.1080/03069889908256262.
15. Entwistle, V.A.; Cribb, A.; Watt, I.S.; Skea, Z.C.; Owens, J.; Morgan, H.M.; Christmas, S. “The more you know, the more you realise it is really challenging to do”: Tensions and uncertainties in person-centred support for people with long-term conditions. *Patient Educ. Couns.* **2018**, *101*, 1460–1467, doi:10.1016/j.pec.2018.03.028.
16. Berenguera, A.; Pons-Vigués, M.; Moreno-Peral, P.; March, S.; Ripoll, J.; Rubio-Valera, M.; Pombo-Ramos, H.; Asensio-Martínez, A.; Bolaños-Gallardo, E.; Martínez-Carazo, C.; et al. Beyond the consultation room: Proposals to approach health promotion in primary care according to health-care users, key community informants and primary care centre workers. *Heal. Expect.* **2017**, *20*, 896–910, doi:10.1111/hex.12530.
17. Huijg, J.M.; Gebhardt, W.A.; Verheijden, M.W.; van der Zouwe, N.; de Vries, J.D.; Middelkoop, B.J.C.; Crone, M.R. Factors Influencing Primary Health Care Professionals’ Physical Activity Promotion Behaviors: A Systematic Review. *Int. J. Behav. Med.* **2015**, *22*, 32–50, doi:10.1007/s12529-014-9398-2.
18. Clark, A.M.; Hartling, L.; Vandermeer, B.; Lissel, S.L.; McAlister, F.A. Secondary prevention programmes for coronary heart disease: A meta-regression showing the merits of shorter, generalist, primary care-based interventions. *Eur. J. Cardiovasc. Prev. Rehabil.* **2007**, *14*, 538–546, doi:10.1097/HJR.0b013e328013f11a.
19. Speake, H.; Copeland, R.J.; Till, S.H.; Breckon, J.D.; Haake, S.; Hart, O. Embedding Physical Activity in the Heart of the NHS: The Need for a Whole-System Approach. *Sport. Med.* **2016**, *46*, 939–946, doi:10.1007/s40279-016-0488-y.
20. Rutter, H.; Savona, N.; Glonti, K.; Bibby, J.; Cummins, S.; Finegood, D.T.; Greaves, F.; Harper, L.; Hawe, P.; Moore, L.; et al. The need for a complex systems model of evidence for public health. *Lancet (London, England)* **2017**, *390*, 2602–2604, doi:10.1016/S0140-6736(17)31267-9.
21. Olsen, C.F.; Bergland, A.; Debesay, J.; Bye, A.; Langaas, A.G. Striking a balance: Health care providers’ experiences with home-based, patient-centered care for older people—a meta-synthesis of qualitative studies. *Patient Educ. Couns.* **2019**, doi:10.1016/j.pec.2019.05.017.
22. McCambridge, J.; Saitz, R. Rethinking brief interventions for alcohol in general practice. *BMJ* **2017**, *356*, doi:10.1136/bmj.j116.
23. Robson, J.; Dostal, I.; Sheikh, A.; Eldridge, S.; Madurasinghe, V.; Griffiths, C.; Coupland, C.; Hippisley-Cox, J. The NHS Health Check in England: An evaluation of the first 4 years. *BMJ Open* **2016**, *6*, 1–10,

- doi:10.1136/bmjopen-2015-008840.
24. Bickerdike, L.; Booth, A.; Wilson, P.M.; Farley, K.; Wright, K. Social prescribing: Less rhetoric and more reality. A systematic review of the evidence. *BMJ Open* **2017**, *7*, doi:10.1136/bmjopen-2016-013384.
 25. Public Health England Improving people's health: Applying behavioural and social sciences to improve population health and wellbeing in England. **2018**, 57.
 26. Greenhalgh, T.; Papoutsi, C. Spreading and scaling up innovation and improvement. *BMJ* **2019**, *365*, 1–8, doi:10.1136/bmj.l2068.
 27. Hower, K.I.; Vennedey, V.; Hillen, H.A.; Kuntz, L.; Stock, S.; Pfaff, H.; Ansmann, L. Implementation of patient-centred care : which organisational determinants matter from decision maker ' s perspective ? Results from a qualitative interview study across various health and social care organisations. **2019**, 1–14, doi:10.1136/bmjopen-2018-027591.
 28. Bloxham, S.; Barter, P.; Scragg, S.; Peers, C.; Jane, B.; Layden, J. Person-Centered, Physical Activity for Patients with Low Back Pain: Piloting Service Delivery. *Healthcare* **2016**, *4*, 28, doi:10.3390/healthcare4020028.
 29. Bloxham, S.R.; Layden, J.; Jane, B.; Peers, C.; Scragg, S. The longitudinal effects of a physical activity programme on the physical fitness and disability of back pain patients: Service evaluation. *J. Back Musculoskelet. Rehabil.* **2020**, *33*, 7–13, doi:10.3233/BMR-170856.
 30. Eynon, M.; Foad, J.; Downey, J.; Bowmer, Y.; Mills, H. *Assessing the psychosocial factors associated with adherence to exercise referral schemes: A systematic review*; 2019; Vol. 29; ISBN 0000000258791.
 31. Rogers, C. Rogers_Conditions_for_therapeutic_change. *J. Consult. Psychol.* **1957**, *21*, 95–103, doi:10.1037/h0045357.
 32. Wilkins, P. Unconditional positive regard reconsidered. *Br. J. Guid. Couns.* **2000**, *28*, 23–36, doi:10.1080/030698800109592.
 33. Carlström, E.D.; Ekman, I. Organisational culture and change: Implementing person-centred care. *J. Heal. Organ. Manag.* **2012**, *26*, 175–191, doi:10.1108/14777261211230763.
 34. Podlog, L.W. Self-determination Theory: A Framework for Enhancing Patient-centered Care. 359–362, doi:10.1016/j.nurpra.2016.04.022.
 35. Conrad, P. The Discovery of Hyperkinesis : Notes on the Medicalization of Deviant Behavior Author (s): Peter Conrad Stable URL : <http://www.jstor.org/stable/799624> . THE DISCOVERY OF HYPERKINESIS : NOTES ON THE MEDICALIZATION OF DEVIANT BEHAVIOR *. **1975**, *23*, 12–21.
 36. Miller W.R. & Rollnick, S. *Motivational interviewing helping people change*; 3rd ed.; Guilford press: Guilford, 2012; ISBN 1609182278.
 37. Kilpatrick, M.; Hebert, E.; Jacobsen, D. Physical Activity Motivation: A Practitioner's Guide to Self-Determination Theory. *J. Phys. Educ. Recreat. Danc.* **2013**, *73*, 36–41, doi:10.1080/07303084.2002.10607789.

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38. Liberati, E.G.; Gorli, M.; Moja, L.; Galuppo, L.; Ripamonti, S.; Scaratti, G. SC. *Soc. Sci. Med.* **2015**, doi:10.1016/j.socscimed.2015.03.050.
 39. Queen, M.; Combined, B.; Ma, H.; Bloxham, S.; Brown, P. Impact of an exercise programme on sustaining physical activity for recovering cancer patients : a qualitative study. **2016**, *4*, 230–240.
 40. Howarth, M.; Warne, T.; Haigh, C. Original Article Pain from the Inside : Understanding the Theoretical Underpinning of Person- Centered Care Delivered by Pain Teams. *Pain Manag. Nurs.* **2014**, *15*, 340–348, doi:10.1016/j.pmn.2012.12.008.
 41. Tajfel, H. *Human groups & social categories: studies in social psychology*; 1981;
 42. Haslam, C.; Jetten, J.; Cruwys, T.; Dingle, G.A.; Haslam, S.A. *The New Psychology of Health*; Routledge: 1 Edition. | New York : Routledge, 2018., 2018; ISBN 9781315648569.
 43. Bandura, A. Health promotion by social cognitive means. *Heal. Educ. Behav.* **2004**, *31*, 143–164, doi:10.1177/1090198104263660.
 44. Borek, A.J.; Abraham, C.; Greaves, C.J.; Gillison, F.; Tarrant, M.; Morgan-Trimmer, S.; McCabe, R.; Smith, J.R. Identifying change processes in group-based health behaviour-change interventions: development of the mechanisms of action in group-based interventions (MAGI) framework. *Health Psychol. Rev.* **2019**, *13*, 227–247, doi:10.1080/17437199.2019.1625282.
 45. Mezirow, J. Transformative learning. **1997**, 201–204.
 46. Hulme, M. *Why we disagree about climate change*; cambridge univeristy press: cambridge, 2009;
 47. Armitage, D.; Marschke, M.; Plummer, R. Adaptive co-management and the paradox of learning. *Glob. Environ. Chang.* **2008**, *18*, 86–98, doi:10.1016/j.gloenvcha.2007.07.002.
 48. Hibbard, J.H.; Mahoney, E. Toward a theory of patient and consumer activation. *Patient Educ. Couns.* **2010**, *78*, 377–381, doi:10.1016/j.pec.2009.12.015.
 49. Sharpe, J. Understanding and unlocking transformative learning as a method for enabling behaviour change for adaptation and resilience to disaster threats. *Int. J. Disaster Risk Reduct.* **2016**, *17*, 213–219, doi:10.1016/j.ijdrr.2016.04.014.
 50. Fazio, S.; Pace, D.; Flinner, J.; Kallmyer, B. The Fundamentals of Person-Centered Individuals With Dementia for. **2018**, *58*, 10–19, doi:10.1093/geront/gnx122.
 51. Cane, J.; Richardson, M.; Johnston, M.; Ladha, R.; Michie, S. From lists of behaviour change techniques (BCTs) to structured hierarchies: Comparison of two methods of developing a hierarchy of BCTs. *Br. J. Health Psychol.* **2015**, *20*, 130–150, doi:10.1111/bjhp.12102.