Original Article

Health psychology consultancy: an example of practice during pandemic

Roseanna Brady
Psychology for Health Associates, UK
Anna Moore
Health Education England, UK
Paulina Kuczynska
Psychology for Health Associates, UK

Introduction

In this paper we outline, and reflect on, several strands of consultancy with one client during the coronavirus pandemic. The consultancy focused on addressing vaccine hesitancy, initially amongst the public during the early rollout of Covid-19 vaccines in the UK, and later amongst health professionals following the UK government vaccine mandate introduced in November 2021. The urgency of the work, involving novel hypotheses about how and where vaccine hesitancy would present, required us to be fast and flexible in our responses, learning through practice and continuous evaluation how best to adapt and respond. We will not describe that work in detail in this paper. Rather, we will explore some of the challenges in delivering consultancy in the context of uncertainty, and scarce resources. Our aim in writing this article is to stimulate dialogue within the health psychology community on how best to deliver consultancy, and we welcome communications from the community in this regard.

Consultancy in health psychology

The British Psychological Society Stage 2 professional qualification requires candidates to submit "a specifically defined piece of work that is negotiated and conducted by the consultant directly with the client" (BPS, 2020). While the outcome of consultancy is often a defined piece of work, in the complex environment in which client 'problems' exist, the consultant's greatest value is often to ask questions that enable the client to arrive at their own solution. The consultant might or might not then be involved in design and delivery of that solution.

Social psychologist and organisational development expert Edgar Schein (2016) advocates an approach to consultancy which he calls 'humble consulting', where the consultant and client work to "figure (things) out together". Schein describes a model of *process consultancy* where the consultant approaches the client as a partner and helper, who is authentic, curious, caring, and committed. The consultant does not own the problem, and attempts to avoid being "content seduced", i.e., focusing on solutions or defined pieces of work commissioned by the client, asking instead what the client is *really* concerned about, which might lead to a different solution.

In practice, as Schein (2016) acknowledges, there are times when the more traditional *doctor* model of consultancy (problem diagnosis and solution definition), and the *expert* model (consultant provides expertise to help others to resolve problems) are appropriate. In this article we briefly illustrate all three models in the context of a specific consultant-client relationship, and the urgent challenges of Covid-19 vaccine hesitancy[1] (VH). The first phase of the work, a training programme for vaccinators, fits with a doctor model of consultancy. The second phase, responding to

[1] Vaccine Hesitancy is defined by the World Health Organisation as "reluctance or refusal to vaccinate despite the availability of vaccines" (WHO, 2019)

the UK government vaccine mandate for healthcare workers, fits with process consultancy. The third aspect, briefing the client on communication with vaccine hesitant staff, fits with the expert consultant model.

Client and context

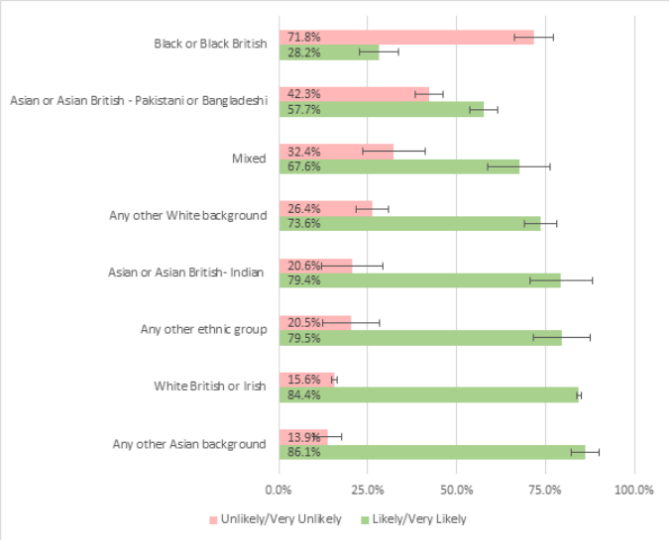
The client in this instance is responsible for education and training of health professionals at an NHS acute hospital trust which delivers services across multiple sites in England. In January 2021, the Trust set up a mass Covid-19 vaccination centre. The client organised training for vaccinators - health professionals, volunteers, and army medical personnel. Training included online learning developed by Public Health England not including vaccine hesitancy. Vaccine hesitancy training is still not included in national guidance for vaccination centres (UK Health Security Agency, 2021).

The context for the consultancy was unusual: hospital staff were adapting to a fast-changing environment, with huge demands on resources in the face of a novel and highly dangerous virus (Timmins & Baird, 2022). This created a training need for new roles, new working practices, and new treatment pathways, placing heavy demands on the education department. Several thousand vaccinations were being administered weekly at the mass vaccination centre from January 2021 (data supplied by the client). Having previously worked with the client on several projects, the consultant (RB) entered into a dialogue with the client to explore the possibility of addressing VH in the vaccination centre. The reasons for that are explored below.

Covid-19 vaccine hesitancy

During 2020/2021, several publications drew attention to likely levels of hesitancy (e.g., Robinson et al., 2021) and predicted lower levels of vaccine uptake than would be needed for 'herd protection' which were assumed to be in the region of 90% (Pollard & Bijker, 2021). These concerns were borne out in the November 2020 UK Household Longitudinal Study which showed low levels of intention to accept a vaccine amongst some ethnic communities (Figure 1).

Figure 1 Intentions to accept Covid-19 vaccination in UK at November 2020



Source UK Household Longitudinal Study Nov 2020 data

We identified a review and guidance which used the Capability Opportunity Motivation - Behaviour model (Michie, et al, 2011), a widely accepted framework for addressing behaviour change, to identify potential influences on vaccine uptake (Bateman et al, 2021) and drew on expert advice from the World Health Organisation (WHO, 2020) to address three areas of influence: Complacency, Confidence, and Convenience. We considered how vaccinators might address these influences in their interactions with people presenting for vaccination (Table 1). It occurred to us that some individuals might still be ambivalent about accepting a vaccine for several reasons. For example, they might feel pressure from others to accept a vaccine while

Table 1 Potential targets for intervention

Potential Influence [a]	Recommendation [b]	How [c]	Potential influences [d]
Complacency	Increase perception of the risk of contracting Covid-19	Provide information	Second and subsequent doses
	Increase perception of the severity	Explain the potential severity of the illness (Covid-19)	Recommend vaccine to others
		Explain that being vaccinated reduces risk of getting Covid-19	
	Increase understanding of the importance of vaccination	Provide information on how being vaccinated can help to reduce transmission and protect people who are vulnerable	
Confidence	Increase trust and confidence in the safety and effectiveness of the Covid-19 vaccine		Acceptance of specific vaccines

[a] Convenience, e.g., location of vaccination centres, access to parking, hours of opening etc., was not something that vaccinators could influence; [b] adapted from Bateman et al. (2020); [c] potential to address during vaccination when vaccine hesitancy is evident; [d] these reflect our initial hypotheses.

having reservations about doing so; they might accept a specific vaccine while being unwilling to accept another; they might intend to accept a single dose only; and some individuals might be prepared to accept a vaccine for themselves while discouraging family members from doing so.

The spirit in which we approached this was that of trying to help with an urgent and important pandemic response within the remit of the client, i.e., training vaccinators. There was little time and few resources to enable us to assess the feasibility of an education intervention. Nonetheless, together with the client we agreed that developing a VH learning module was an opportunity not to be missed. An education fellow (AM), employed part-time at the Trust, was assigned to work one day per week alongside the consultant to deliver several aspects of the consultancy.

During January and early February, before committing precious resources to developing training, we consulted widely amongst stakeholders - educators and vaccinators at the vaccination centre and experts across the Trust, because stakeholders "have the power to influence, enhance or curtail" engagement in any consultancy project (Cope, 2010, p. 162). Vaccinators confirmed that they encountered VH daily. Other stakeholders consulted supported developing a training initiative and provided helpful advice.

We based the training intervention on Motivational Interviewing (MI). There is evidence of increased intention to accept vaccination following MI interventions (e.g., Gagneur et al., 2018), and increased uptake of vaccination (e.g., Coley, et al., 2020). Several authors recommended using MI to address hesitancy towards Covid-19 vaccines (e.g., Lewandowsky et al., 2020). This evidence was used to inform the initial work co-developed by RB and PK. Although several studies supporting use of MI in VH have been published since, we found no

studies reporting outcomes for MI training of vaccinators.

Training vaccinators in MI skills – doctor model of consultancy

Despite the lack of published data to support our hypotheses, we agreed with the client to proceed, given the support of stakeholders, and urgency due to speed of the vaccine rollout. During January and February 2021, several thousand people each week were being vaccinated, peaking in late February at 1,600 per day (data supplied by client). Each day of delay was a missed opportunity to make a difference. An e-learning model fitted best with avoiding a burden on vaccinators' and educators' time, although we later developed a blended learning approach (to include face-to-face training) considered to be more effective than e-learning alone (Alqahtani & Rajkhan, 2020).

It is outside the scope of this paper to describe the consultancy project in detail. However, we present a summary of key aspects in Table 2.

Vaccine Mandate – process and expert models of consultancy

In November 2021, the Secretary of State for Health announced the intention to mandate Covid-19 vaccination for all healthcare staff in the UK. At that time, fewer than 80% of staff at the Trust were known to be vaccinated. With the client, we considered the potential impact on unvaccinated staff: they risked dismissal, and some might accept a vaccination contrary to their beliefs and values, to avoid dismissal. We also anticipated that Trust leaders would be gravely concerned about maintaining services if they were forced to dismiss even small numbers of clinical staff in the context the high number of vacancies across the NHS (British Medical Journal, 2022) as well as absences due to Covid-19.

To address this, we engaged in process consultancy involving dialogue with the client to work together to find ways to be helpful in addressing these issues (Schein, 2016). Amongst the questions explored were: What plans did the Trust have to respond to the mandate? What barriers were there to understanding the beliefs and concerns of unvaccinated staff about vaccines? What impact would the mandate have on line managers relationships with unvaccinated staff?, and several other questions.

This led to a joint client-consultant decision to (a) prepare a briefing for line managers on how best to have compassionate and non-judgemental conversations with staff about the mandate and (b) a series of webinars aimed at staff who were unvaccinated. In this work, the consultant (RB) engaged in expert consultancy, providing expertise in communication skills as well as sharing learning from the work in vaccine hesitancy. The consultant also briefed the webinar speakers on how best to convey compassion and build trust in responding to questions raised and to encourage staff to explore their ambivalence about Covid-19 vaccines with experts across the Trust.

Summary and Reflections

Through consultancy, we engaged in a novel approach to addressing vaccine hesitancy by developing a blended learning programme in MI skills for vaccinators. Despite the unusual level of urgency to deliver the work, we approached it with professionalism in line with standards one would expect from health psychology practitioners. For example, we scoped the work – assessing and formulating what needed to be done and how, by whom and by when; we engaged widely with key stakeholders prior to agreeing what would be delivered and agreeing outcomes; we clarified

Table 2 Summary of Training initiative: example of 'doctor model' of consultancy

Aspects of consultancy	Key activities
Engagement	Initial dialogue with client using "humble enquiry"
	Identified and consulted with stakeholders including Education Team Lead, Matrons, Clinical Director, Managing Director and Quality Improvement Lead at mass vaccination centre, Inclusion Board chair, Public Health Lead, Partnership and Development Lead
	Agreed ambition for the work (rapid development of e-learning to be included in induction of all vaccinators and available to existing vaccinators) which took account of available resources and speed of vaccination rollout
Evidence gathering	Reviewed key literature and Guidance on VH
	Sought data on vaccine hesitancy relevant to the geographical area
	Read policies and processes involved in vaccination
	Reviewed existing vaccinator training
	Focus groups and surveys of vaccinators
	Structured interviews with people attending for vaccination
Scoping and planning	Agreed objectives (focus on vaccinator communication)
	Checked assumptions (who would do what, when, and how) and dependencies (e.g., storyboard for film to be embedded in e-learning prior to setting filming date)
	Agreed a communication plan (when, what, who)
	Risk assessment (what might impact delivery, stakeholders, outcomes)
Contracting*	Agreed outcomes – specified learning objectives (MI skills applied to VH), content, duration and format of training, measures of effectiveness (changes in vaccinator knowledge and use of MI skills in practice)
	Specified deliverables (draft content and design for review, film storyboards for modelling MI in practice, editing deadlines, consultations feedback on materials)
Developing content	Circulated proposal to deliver e-learning for MI skills for vaccinators
	Results of focus groups and surveys of vaccinators to feed back into content
	Results of structured interviews of people attending for vaccination to feed back into content
Implementation	Work with education team to pilot the e-learning mid-March 2021
	Embed e-learning in vaccinator induction
	Offer e-learning to established vaccinators
	Gather feedback and observe practice
	Establish workshops to develop MI skills and model practice
	Train the trainer model plus MI teaching resources
Monitoring and evaluation	Monitor uptake (e-learning database)
	Continuous observation of practice
	Survey vaccinators to assess learning and practice
	Review learning from project and benefits of introducing MI to other areas of practice

*Contracting was effectively done in stages: (1) initial scoping prior to agreeing development of e-learning; (2) development and implementation of e-learning; (3) development of blended learning to include workshops and brief MI training skills sessions using MI teaching resources for use in vaccination centre.

assumptions (e.g., about access to client resources for filming and uploading the e-learning content and about how the vaccinator trainers would engage with the MI training); we documented agreements and discussions and reported regularly on progress, identifying risks and challenges and engaging with the client on possible solutions; we continuously evaluated the work and adapted to meet need in circumstances that changed continually.

On the other hand, we were limited in resources, both time and material. We could have done some things better, or differently, and will consider that in our final evaluation. Ideally, we would have taken more time to assess feasibility, especially in relation to assessing acceptability of the training amongst educators and managers at the vaccination centre or to measuring outcomes such as impact on vaccine uptake although, it is difficult to see how we could have done so given the complexity of influences involved. This may be an area of interest for researchers. Certainly, it would be difficult to make a case for introducing VH training for vaccinators across services without robust outcomes data. Interestingly, feedback from vaccinators revealed enthusiasm for MI and recognition of its value in other healthcare roles.

We encountered some resistance to our recommendations as to how line managers should speak with staff about the vaccine mandate which, given more time, we might have been able to address through engagement and dialogue. In consultancy work, it is normal to encounter resistance to change (Cope, 2010) and it takes time to work with that resistance, time we did not have in this instance.

We attempted to survey a larger sample of people attending for vaccination as a way of testing our hypotheses. We encountered resistance from leaders who wished to confine the survey questions to more general questions about the experience of being vaccinated. Had we engaged further with those leaders using the qualitative data which supported our hypotheses we might have made a stronger case. In turn, data collected might have supported a case for including vaccine hesitancy in training for vaccinators across vaccination centres.

Accessing output of the research community, and other experts in behavioural science, on VH gave us the confidence to respond to and adapt our work in a situation of great urgency and uncertainty. It is unlikely that this work, given the uncertainties due to pandemic and lack of published evidence to support our hypotheses, would have been commissioned without the trust developed over time and based on a 'consultant as helper' approach, as advocated by Schein (2016).

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Dr Roseanna Brady
Principal at Psychology for Health Associates
bradykbs@msn.com

Dr Anna Moore
Population Health Fellow, Health Education England
anna.moore2@nhs.net

Paulina Kuczynska
Associate at Psychology for Health Associates
paulinekuczynska@hotmail.com