were analyzed using a direct content analysis approach to identify barriers or facilitators to undertaking HePPBes. Study 2: midwives and student midwives (n=505) participated in an online survey, informed by study 1, assessing demographics, HePPBes and cognitions about HePPBes. Hierarchical multiple regression predicted the influence of demographics, health status and cognitions about HePPBes on the number of HePPBes performed.
Results: Midwives perceived barriers to carrying out HePPBes, such as a requirement to perform an increasing amount of HePPBes. Facilitators, including strategies used by midwives to perform HePPBes, were identified. Significant predictors of the number of HePPBes performed, when controlling for years of experience and midwifery occupational status, were: belief that HePPBes were outwith the professional role ($b = -.105$, $p < .05$), confidence ($b = .182$, $p < .01$), motivation ($b = .145$, $p < .05$) and support from colleagues and resources ($b = .170$, $p < .01$).
Conclusions and implications: Midwives' perceived multiple barriers and facilitators to carrying out HePPBes. HePPBe performance was predicted by the belief that these behaviors were within the role of the midwife, confidence, motivation and perceived support from colleagues and resources. These findings were used to systematically develop a multiple behavior change intervention for, and in consultation with, midwives.

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By: emma.brown@leedsbeckett.ac.uk, Dr Emma Brown

A pilot trial of self-incentives for smoking cessation in routine and manual employees

Dr Emma Brown[1,2], Dr Debbie Smith[3,2], Professor Christopher Armitage[2]
[1]Leeds Beckett University, Leeds, United Kingdom. [2]University of Manchester, Manchester, United Kingdom. [3]Leeds Trinity University, Leeds, United Kingdom
Submitter email: emma.brown@leedsbeckett.ac.uk

Background/purpose: People in routine and manual (R&M) occupations (e.g., bar staff) are twice as likely to smoke than employees in professional occupations. Encouraging smokers to self-administer incentives contingent on cessation are effective in community and prison-based settings and have the potential to help employees who may struggle to attend cessation support. The aim of the present study was to gauge the feasibility and estimate the effect size associated with encouraging R&M employees to self-incentivise to promote smoking cessation.
Methods: Thirty-two smokers from R&M occupations were invited to take part in the study. Twenty-four participants agreed to take part and were randomised to: (a) form an overall plan to quit smoking (n=12), or (b) self-incentivise if they had not smoked at all by the end of each week (n=12). Feasibility was assessed through acceptance and completion rates. Chi square was used to generate effect sizes to inform future randomised controlled trials.
Results: Twenty-four of the 32 smokers approached completed the baseline questionnaire and were analysed on an intention-to-treat basis. At 1-month follow-up, one participant (1/12; 8%) in the control condition quit. In contrast, 58% (7/12; p = 0.08, d=0.83) of employees who self-incentivised on a weekly basis quit.
Conclusions and Implications: Use of self-incentivising implementation intentions are feasible and can be delivered outside of cessation support for employees. Furthermore, the medium-sized effect generated by the intervention suggests a fully powered randomised controlled trial is needed to assess the potential of self-incentivising to begin to address the inequality gap in smoking prevalence.
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By: emma.l.godfrey@kcl.ac.uk, Dr Emma Godfrey

Treatment fidelity in the Gait Rehabilitation in Early Rheumatoid Arthritis Trial (GREAT) feasibility study

Dr Emma Godfrey[1], Dr Mandeep Sekhon[1], Dr Gordon Hendry[2], Professor Nadine E. Foster[3], Dr Samantha Hider[3], Dr Marike van der Leeden[4], Dr Helen Mason[2], Dr Alex McConnachie[5], Professor Iain McInnes[5], Ms Aimie Patience[2], Professor Catherine Sackley[1], Professor Martijn Steultjens[2], Dr Anita Williams[6], Professor Jim Woodburn[2], Ms Aliya Amirova[1], Dr Lindsay Bearne[1]
[1]King's College, London, London, United Kingdom. [2]Glasgow Caledonian University, Glasgow, United Kingdom. [3]Keele University, Keele, United Kingdom. [4]VU University Amsterdam, Amsterdam, Netherlands. [5]University of Glasgow, Glasgow, United Kingdom. [6]University of Salford, Salford, United Kingdom
Submitter email: emma.l.godfrey@kcl.ac.uk

Background/purpose: Many people with early rheumatoid arthritis report foot pain and walking disability. Physiotherapists and podiatrists received a two-day bespoke training in a psychologically informed gait rehabilitation intervention (2 compulsory and 4 optional sessions delivered over 3/12), incorporating motivational interviewing (MI) and behaviour change techniques (BCTs), to address this. This study assessed fidelity of delivery within a feasibility study.
Methods: Four physiotherapists and two podiatrists delivered 78 sessions across three UK centres. The Motivational Interviewing Treatment Integrity (MITI) Rating Scale and a bespoke tailored treatment fidelity measures were used to assess fidelity to MI and core components plus BCTs. Two independent assessors rated audio recordings of sessions.
Results: 28 (80%) participants' data across 64 sessions were rated for core components and BCTs and 37 (50%) sessions were analysed for MI. Relational (score=4.4) and technical (score=4.2) aspects of MI were delivered with good fidelity. 6 core components and 7/17 BCTs in Session 1 were conveyed with high (over 80%) treatment fidelity. 5 core elements and 3/12 BCTs in Session 2 were provided with high fidelity. Sessions 3 and 4 reliably delivered 3/12 BCTs, while only one session 5 and 6 was delivered. Inter-rater reliability showed agreement of over 80% (range 82-87%) was reached for all sessions.
Conclusions and Implications: Clinicians delivered core components and MI with high fidelity, but not all BCTs. Treatment fidelity might be enhanced with further training or on-going support. Alternatively, the intervention could be amended to specify mandatory BCTs alongside optional ones, depending on the needs of individual participants.

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Results from a randomized trial of a novel patient-centered preventive intervention to reduce alcohol use among medically vulnerable youth

Dr Elissa R Weitzman[1,2], Dr Alexandra C Marin[1], Dr. Lauren E Wisk[3,1,2], Dr Sharon Levy[1,2]
[1]Boston Children's Hospital, Boston, USA. [2]Harvard Medical School, Boston, USA. [3]David Geffen School of Medicine, UCLA, Los Angeles, USA
Submitter email: elissa.weitzman@childrens.harvard.edu