volume 22 issue 5
March| 2022

www.ehps.net/ehp

The European Health Psychologist

Bulletin of the European Health Psychology Society

Editorial

March 2022 Editorial

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This issue of the *European Health Psychologist* magazine is dedicated to aspects, opportunities, and barriers around translating health psychology research into practice. As health psychologists, we are working on all aspects of health and well-being, not only through our theoretical lens but also in a very practical way. We are therefore delighted to present the current issue to you because it is at the interface of research and practice. In addition, Warner et al., share their reflections and suggestion about how to make the upcoming EHPS conference in Bratislava more sustainable.

In this issue **Ainslea Cross'** piece is about engaging with health care professionals to integrate health psychology research into practice. Cross reflects on several strategies that health psychologists can use to collaborate with health care professionals such as seeking out collaborations and identifying priorities of the organisations that you want to collaborate with.

Sebastian Potthoff, Dominika Kwasnicka, Ainslea Cross, Urszula Ambrozy, Anne van Dongen, Gill ten Hoor, Keegan Knittle, Jiyoung Park, Gjalt-Jorn Peters, & Noa Vilchinsky are all editors of the Practical Health Psychology blog (PHP), a blog that translates health psychology research into recommendations for practice. In their piece they tell us about their lab series entitled 'Chartering New Territories in Practical Health Psychology' that took place during the 2021 EHPS conference. Moreover, some of the national editors share their tips and process how to translate the blog posts into their first language. Finally, the authors share some recommendations how to translate health psychology research into practice.

Robert Portman, Andrew Levy, Anthony Maher and Stuart Fairclough share their experience on developing a community-based peer mentorship intervention to support behaviour change in diverse health settings such as "Exercise Referral Schemes" (ERS). The intervention they present is based on the social identity approach and the authors enrich their intervention by also taking the constructs social and peer support into account. Their commentary provides a rational for grounding a community-based based peer mentorship intervention through the lens of the social identity approach. The authors discuss some common barriers and offer person-centred solutions guided by social identity principles for developing a peer mentorship intervention within an ERS setting.

Roseanna Brady, Anna Moore, & Paulina Kuczynska share their experience delivering a health psychology consultancy during the pandemic. In their piece they outline and reflect on a consultancy focussed initially on addressing vaccine hesitancy amongst the public during the early rollout of Covid-19 vaccines in the UK. Later, this approach was expanded to health care professionals following the UK government vaccine mandate introduced in November 2021.

In their position paper: "Task Force for the Sustainability of EHPS conferences" **Lisa M. Warner, Claudia Teran-Escobar, Anna Janssen, Radomír Masaryk, Lucia Rehackova, Bríd Bourke & Vera Araújo-Soares** on behalf of the EHPS Special Interest Group "Equity, Global Health, and

Sustainability" reflect on the global and environmental impact that scientific conferences have had in the past and the forthcoming EHPS hybrid conference might have. The authors provide excellent information about travel options to Bratislava and about steps that we all can take to make the conference more sustainable. They are also asking the EHPS members for more suggestions and to fill in a brief questionnaire about food preferences.

We hope you enjoy reading this issue as much as we did.

Angela & Pamela

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Original Article

Engaging with health care professionals to integrate health psychology research into practice

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Health psychology research has increased its profile in recent years, as we are publishing more research articles than ever and have an increasing number of host journal titles to take our work to. The European Health Psychology Society (EHPS) community presents a wealth of high quality research every year at the conference. The main audience of our conference and journal articles is health psychology researchers, which is positive because we are creating an incremental science that pushes the agendas of open science and novel methodologies whilst integrating cognition, emotion, behaviour and physiological processes. However, creating multidisciplinary research teams that potentially offer pathways to embedding research into health care practice can be challenging for those of us working in predominantly health psychology teams. What unites the health psychology research community is the challenge of designing, conducting and reporting research that can benefit communities through the application of our research in practice to improve patient care or public health. We have a research-practice implementation gap (Dubois, Gomez, Carlson & Russell, 2020; Haines, Kuruvilla & Borchert, 2004): a healthy supply of high quality health psychology research, most of which is mainly read by other health psychology researchers. Few health psychology researchers actively work on the implementation of their research and evidence into practice to improve the delivery of routine care and health care systems. Presseau, Byrne-Davies, Holtham et al., (2020)'s conceptual review of the translation of health behaviour change research into practice argues for a greater focus on implementation alongside innovation in health psychology to promote wider-scale impact. Their recommendations include: 1) enhancing systematic reviews conduct by reporting health behaviour change interventions with a discussion of implementation readiness; 2) considering implementation at the early stages of research; 3) extend and develop health behaviour change science to understand and change the behaviour of individuals at multiple levels to enable and deliver health behaviour change interventions in practice; 4) develop implementation science capacity within health psychology.

In this article, I will outline some of the solutions to addressing the research-practice gap in health psychology, and provide ways in which we can start to consider how our research agendas may align with health care practice and the work of practitioners involved in the organisation and delivery of care. This article is a reflective piece by an academic-practitioner in health psychology designed to give my insights into the opportunities to engage with health care professionals (HCPs), based on my experiences as a Health Psychologist working in a Cardiovascular Diseases hospital clinic, and as a University researcher and academic involved in developing and testing health psychology interventions and training future psychologists. This article is intended to help you reflect on your implementation strategies by considering the ways in which you may be able to engage with local HCPs and services and how they

might benefit from your research and enhance the work you do.

Opportunities for engaging with HCPs throughout the research process

Health care professionals (HCPs) are key stakeholders in research as they can play a vital role in the evaluation of evidence and practical constraints, which is a central component of the new framework for developing and evaluating complex interventions (Skivington et al., 2021). The first step to HCP engagement is to think of the unique selling point of your research and have clear reasons for wanting to work with HCPs. This might be informed by the stage of your research. Presseau et al (2020) recommend considering implementation at the early stages of your research. At the ideas stage of research design, you might want clinical insight into a specific long term health condition, the treatments, or the way in which care is currently delivered. Or, you may want to know what the current challenges are in delivering care, particularly in these times where the health care system is rapidly evolving to respond to the demands of the pandemic (Douglas et al., 2020) and an increasing aging population managing multiple long term conditions (Dhere, 2016; Parker et al., 2019). If you are at the analysis or dissemination stage of a project, you might be looking for ways to apply your research in practice. In which case, start to consider where your research might have the most impact and clinical relevance. Your work may have relevance for informing care pathways, the delivery of care, clinical assessment/measurement methods or public health and policy. Forming HCP collaborations at the early stages of the research may be useful for developing ideas for future projects. Developing long-term collaborative partnerships with HCPs through establishing ideas for a series of related studies in a specific area can also lead to greater overall research impact.

Engaging with Psychologists working in Practice

One of the clearest routes to embedding your research into practice and creating impact would be to engage with a Practitioner Health Psychologist or other Practitioner Psychologists, such as Clinical, Counselling, Forensic Psychologists that work with a client group or health care setting that closely relates to your research interests. Practitioner Health Psychologists typically provide direct clinical care for clients across a wide range of health conditions, including cardiovascular diseases (including cardiovascular rehabilitation, hypertension management, surgical interventions etc.), pain management, cancer, diabetes, sexual health/HIV, chronic fatigue syndrome, organ transplant, weight management, burns and plastic surgery, neuropsychology and cystic fibrosis (Division of Health Psychology, British Psychological Society, n.d). Practitioner Psychologists are employed across different health care settings, including general practice (primary care) and hospital service (specialist day clinics and surgical/treatment wards), public health teams and government.

As well as providing direct clinical care for individuals and groups, practitioner psychologists are often research active, but commonly report challenges in research capacity (McHugh, Corcoran & Byrne, 2016). HCPs often struggle to fit research into limited time, with limited funds, often without the support or encouragement of surrounding research teams. HCPs can benefit from health psychology researchers' research expertise and supervision, while researchers can benefit from clinicians' practical experience and knowledge, along with potential links to service users

interested in contributing to research studies (Lampropoulos et al., 2002). Developing collaborations with those working in research and practice would inform health psychology research from a clinical care view point, thus enhancing the likelihood of the research findings and implications being adopted by other practitioner psychologists.

Embedding your research into direct clinical care and health care practice are not the only pathways to impact. Additional opportunities to influence practice through your research can be created by supporting psychologists working in practice with the advisory role that they have. Practitioner psychologists offer advice and consultation on patients' psychological care to members of the multidisciplinary team. They may also provide advice, consultation and training to staff working with individuals and groups across a range of agencies and settings (e.g. social work, mental health teams, general practice/primary care). Therefore, it may be helpful to consider the ways in which your research might be used by psychologists in their advisory roles and discuss how this might be achieved.

Developing collaborations with HCPs and clinical professional networks

One of the biggest barriers to engaging with HCPs is a lack of time, on both sides. To overcome this, consider ways in which you can make HCP engagement and implementation easy, timely and relevant through adopting solutions in this article. To foster new collaborations, consider the range of HCPs that could potentially benefit from your research interests and the evidence you have gathered from your research so far. Health Psychology research is often of interest to medical and nursing colleagues, as well as those working in allied health professions -including physiotherapists and rehabilitation services, occupational therapists, dietician/weight management teams, public health, government.

Once you have identified the type of professional(s) that you could collaborate with, the next step is to consider if you need to engage on a clinical care level, i.e. those who are involved in care delivery, or on a management or commissioning level, i.e. where you want to influence models of care (delivery or guidelines). If your research has wide-ranging interest, you might want to engage with a professional group that looks after the. interests of its members, such as an equivalent to the EHPS e.g. Occupational Therapy Europe, or you could focus on a specific health condition (e.g. the European Hypertension Society etc.).

Before making contact, do some research to identify shared interests: what research do they already do? What are their research ambitions? Some University-Hospital organisations may have a clear research strategy and website of current projects, such as the one I work in: https://www.leicestersresearch.nhs.uk/ . You should also identify the current clinical and health priorities, both locally and nationally, as this will help you to reflect on your shared ambition and your mutual values for collaboration. As a researcher, you can provide expertise in terms of high quality evidence-based approaches for optimising their patient care.

One of the fundamental factors in forming collaborations with HCPs is to demonstrate genuine interest in understanding the realities of clinical practice at this moment and communicating a desire to support them with the best available health psych evidence. This might be achieved through shadowing clinics or key meetings, honorary roles within health organisations, or offering teaching or collaborative research. Most of us had little practical experience during our health psychology training; one way we can gain valuable insight into the way care is delivered and the overall patient experience is to explore the

possibility of arranging opportunities for shadowing clinics or placements through honorary contracts or volunteering. You may be able to design an Embedded Researcher (ER) role to implement a collaborative joint university-health care owned research agenda to facilitate collaborative working between researchers and end-user stakeholders (i.e. HCPs and patients). ER allows researchers to experience the 'worldview' of the health care system, its members and their partners, but also requires the researcher to assess their experience in light of academic knowledge (see Cheetham et al., 2018).

Using language that connects and resonates with health care professionals is key to engaging with HCPs, so consider using the wording and key terms used in relevant national strategies (particularly the terms used in clinical targets) and policies, as well as clinical guidelines.

In summary, this reflective article highlights strategies for developing collaborations with health care professionals to implement research into practice. These include engaging with practitioner psychologists working in health, clinical, forensic or counselling psychology, as well as identifying key health care professionals and the health care setting most relevant to your research. The article also highlights the importance of working with health care professionals to co-create research that is informed by health care practice experience to maximise the opportunities of implementing health psychology evidence into practice.

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Original Article

Chartering New Territories In Practical Health Psychology

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Introduction

Health Psychology plays a key role in developing and disseminating evidence, theories and methods that contribute to our understanding of health behaviour change. However, translation of this evidence into improved care for patients and the public is often lagging behind (Grol, 2001). The Practical Health Psychology (PHP) blog (www.practicalhealthpsychology.com) is an initiative affiliated with the European Health Psychology Society (EHPS), which recognises the need for mobilising the wealth of knowledge in our fields, and making that knowledge accessible to practitioners who work at the front line to implement evidence into practice. During the 2021 EHPS Conference the PHP blog convened a Lab Series entitled '*Chartering New Territories In Practical Health Psychology*' to enable an interactive discussion on how to make Health Psychology more practical and increase the real-life impact of our discipline (Screenshot 1). In this article we report on the activities and outcomes of the Lab Series, including an introduction to the PHP blog, reflections from National Editors, and top tips for translating research into practice.

Disseminating practical health psychology

Each month the PHP blog translates short blog posts based on peer-reviewed research and expert opinions into 28 languages, and utilises a network of National Editors and a coordinated social networking strategy to ensure broad reach of these posts (by now, to 41 countries). In the last year alone, our website has had 106,633 site visits, which is a 73% increase from the previous year. This year we published a free online book: https://practicalhealthpsychology.com/e-book/ which has been downloaded more than 4,900 times (as of March 2022). This free e-book, *Practical Health Psychology* Volume 1, contains all posts published by the blog since its inception through till the end of 2020 (32 posts in total and introduction written by the Lead Editors). We hope that it will make the contents of the blog even more accessible for readers and help open another channel of dissemination. Our Media Team (Urszula Ambrozy, and Rebecca Amy Nourse) aims to maximise reach of our blog by disseminating each post via Facebook (@practhealthpsy; 545 followers), Twitter (@PractHealthPsyc; 1319 followers), Instagram (@practicalhealthpsychology; 197 followers), and LinkedIn (https://www.linkedin.com/company/practical-health-psychology-blog).

Why language matters

At the heart of the PHP blog are our 53 National Editors representing 41 countries, who work to ensure that blog posts are translated into 28 languages. For each language, one or more National Editors are in charge of the translation and dissemination of the blog posts. In this process, many lessons are taught and learned, ranging from process-optimising to dealing with cultural sensitivities. During these lab-series, three National Editors shared their vision and experiences:

Jiyoung Park (South Korea)

As a PHP Korean national editor, every month translating a blog post is not an easy task in my busy daily life. However, this is such a valuable opportunity and experience for me, and I want to share it. When I receive a blog post, I first check whether it is a familiar issue for me or not, because I thought that without sufficient prior knowledge, high quality interpretation is impossible. And then, I translate blog contents line by line. Next, I send this material to another Korean National Editor to check the content and psychological terms. Given that Health Psychology is not well advanced in South Korea I had to identify potential readers of the PHP blog. After much research I managed to connect with the Korean Health Psychological Association (KHPA) who agreed to start a special newsletter for the blog. The role of PHP National Editor requires more time and effort than I expected, especially in the translation process, but the learning and gain in this process is really worth it for me. Also, you can easily get support from other PHP Editors. Therefore, I would like to say to those who are hesitant to participate in our team, let's do it together! If you have a passion for PHP, then it is worth engaging in it!

Anne van Dongen (Netherlands)

Translating the blog has been a great way for me to keep up my 'Health Psychology Dutch' while living abroad for six years. I think the blog is such a great initiative because as researchers sometimes we get caught up in doing good and interesting research that we forget non-researchers may not understand. This blog is a great way to translate our research to everyday healthcare practice. I love to read the blogs myself, including the links to relevant literature, and I have used them in preparing lectures or when I need to know something general about a topic I am not too familiar with. Translating from English to Dutch, I don't come across the massive barriers that my fellow National Editors come across as we share the same script and direction of writing. However, it is more difficult than I initially thought as sentence structure is different, and some English words, like 'self-efficacy', do not have a proper translation into Dutch. I use a translation website and have started a PHP dictionary with common word translations. I always tweet and facebook the new blog, and mention it in any guest lectures for, e.g., nurses. I always use it in informal talks with practitioners when they show interest in Health Psychology in general or in a specific topic.

Noa Vilchinsky (Israel)

In Israel, the main challenge is to adapt the content of each blog post to the Israeli culture and the Hebrew language. We encountered the technical necessity to always keep remembering to indent the text to the right, since Hebrew is written from right to left. Another challenge emerges from the fact that Israel is composed of a Hebrew-speaking majority but also a large minority of citizens who speak Arabic. To make the posts enticing for the Arab readers as well, we are in

need of an additional layer of translation- to the Arabic language. To cope with the load of translations, and make it an educational experience, the Hebrew translation is done by all the members of the PSYCHO-CARDIOLOGY RESEARCH at LAB-Bar Ilan University under my supervision- the local Hebrew Editor. This way, the students get the opportunity to contribute to this important international project and at the same time to broaden their knowledge of practical Health Psychology. The lab manager and the head editor review and finalise the drafts, and only then they are sent to the main PHP editorial center. We have found this process to be efficient, feasible, and valuable.

Top tips when translating research into practice

Sitting snugly in the ivory tower, it's hard to forget how similar its inhabitants are. One's colleagues often work in a similar field, speaking in the same scientific language. However, when working with colleagues who studied in different fields or have different technical or practical backgrounds, many communication-related challenges may emerge. This refreshing change also comes with a series of challenges. In this brief contribution, five tips were discussed that aim to help address these challenges: five tips that, not surprisingly, also resurface in the recommendations for writing the PHP blog posts.

First, "take your neighbour seriously". This refers to the need to communicate without relying on shared mental models. This means that not only will people not know specific theories, but they may not even know the concept of theories, or be familiar with other things we take so for granted that we don't realise how they form core elements of our vocabulary.

Second, "don't leave your academic integrity at the door of the ivory tower": even when interacting with the general public (perhaps even especially then), you're responsible for carefully representing the state of the art. This means that given that you cannot rely on shared mental models, it is especially important to clearly articulate boundary conditions, weaknesses, and limitations. While academics often spot these habitually, this will not be the case of people outside the ivory tower.

Third, "everything should be as simple as possible, but not simpler": simplify your message as much as possible, but within the constraints set by the preceding principle. This means that while the absence of the ability to rely on a shared vocabulary may tempt you to "dumb down" your messages, leaving out the things that are harder to convey, this approach has its own risks. Empowering people with grossly simplified messages runs the risk of inadvertently equipping them with a hammer that will make everything look like a nail to them

Fourth, "less is less but more is too much": you have to accept that your communications can cover less ground than you're used to. This follows more or less necessarily from the previous three tips. Given that most concepts, including relatively basic concepts, will have to be explained, and there is only so much that can be omitted or simplified while still communicating accurately, you have to get used to being able to convey less in your translations to practice.

Fifth, "actions speak louder than words": it is important to provide specific, actionable recommendations. This is important for two reasons. First, clear recommendations provide concrete examples of your messages and what they imply, scaffolding those onto practice. Second, sometimes your audience will just want to know what to do, not caring much about the why. By making sure you always clearly communicate recommendations, you also reach that more action-oriented segment.

These tips and the related challenges were presented at the hand of the case of Party Panel, a

Dutch annual semi-panel determinant study where the determinants of five nightlife-related risk behaviors were discussed. Despite the hopes to present the resulting determinant structures to the practitioners responsible for the development of behavior change interventions, it turned out that the target audience could not work with the CIBER plots representing these structures (Peters, & Crutzen, 2018). In response a series of brief animations was developed (available at https://partypanel.nl/youtube-playlist). These brief movies illustrate the discussed principles: for example, of the entire determinant structure, only a few intervention suggestions could be recommended.

Interactive discussion

During our interactive discussion, attendees used the online platform Flinga to contribute new ideas for increasing the reach and impact of the PHP blog. Some attendees suggested ways to increase engagement between authors and readers, including adding a picture of the author to the top of each new post and having authors make themselves available for interviews or Q&A sessions after their posts appear online, e.g., via Twitter. This might also be expanded to have short podcasts covering each post, or perhaps a YouTube channel in which authors could use short videos to further engage audiences with their blog post topics. Another suggestion was to increase the number of languages into which the blog is translated and, specifically, to add an Arabic language. Attendees also suggested that more could be done to increase involvement of healthcare professionals in the blog, perhaps by getting ideas for blog topics from them or by involving their patients or service users in sharing their experiences of Health Psychology in practice. Education was another area for potential growth and impact, with some suggesting that each blog post could be accompanied by a few slides that could be used for teaching students or healthcare professionals. Finally, attendees suggested that the blog's impact could be increased by strengthening links with existing national and international societies and networks, perhaps by using LinkedIn, national newspapers or other publications. The full results of this exercise can be viewed at https://edu.flinga.fi/s/EA8N37N.

The Practical Health Psychology Blog team has ambitious plans to progress the initiative in the coming years. We will be working collaboratively with our National Editors and with our Media Team to maintain and increase the engagement and involvement with healthcare practitioners around the world encouraging them to apply Health Psychology findings into practice.

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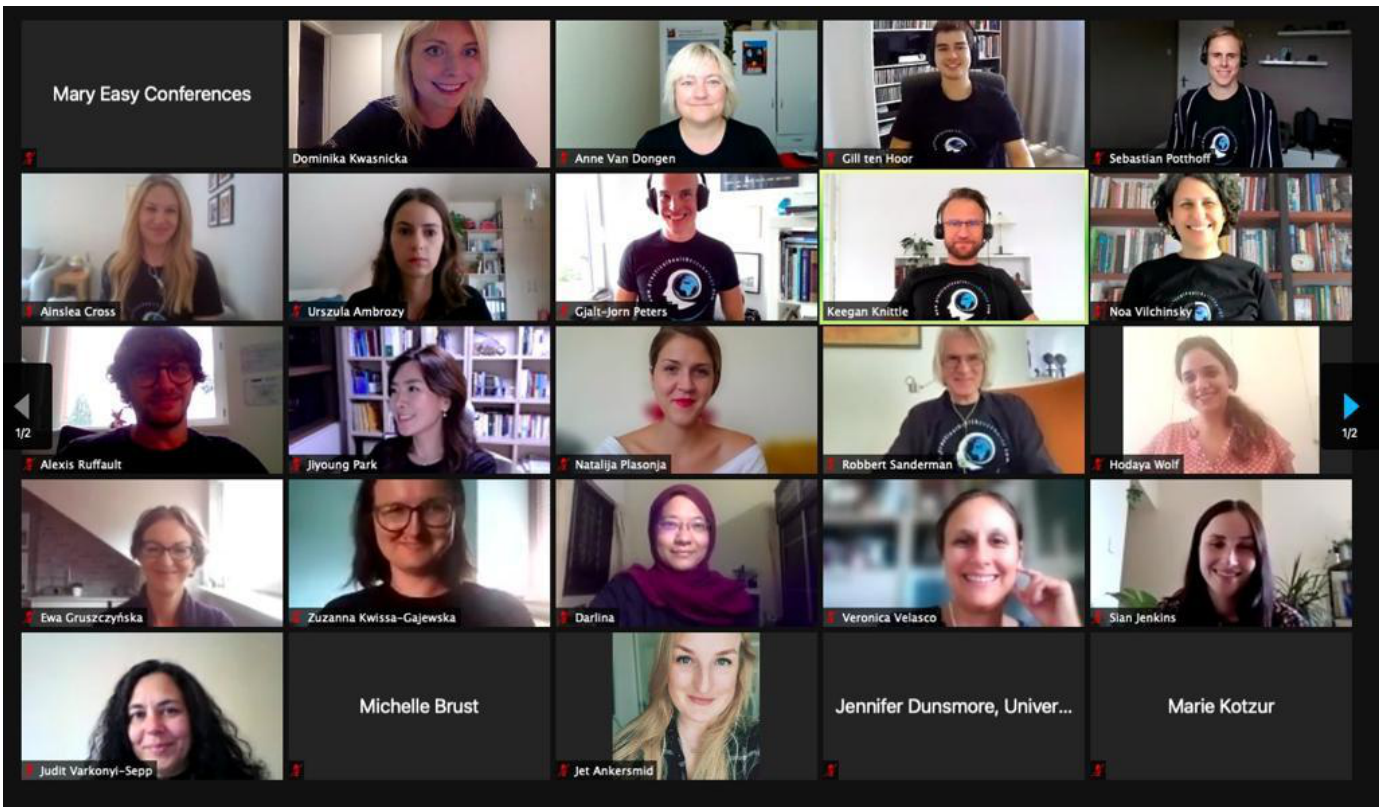
Screenshot 1



Original Article

A Commentary on the Development of a Physical Activity Community-Based Peer Mentorship Intervention: Theoretical and Practical Insights from the Social Identity Approach

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Abstract

The use of social identity theorising to inform public health interventions is a conceptually salient, yet currently underutilised approach. The social identity approach elaborates on the primary psychological mechanisms underpinning social identification, as well as providing supporting evidence for the plethora of health and well-being benefits that are derived from being a member of social groups. Notwithstanding, to date there remains little practical guidance for how the social identity approach can be harnessed to inform the development of complex behaviour change interventions which take place in diverse public health settings, such as Exercise Referral Schemes (ERSs). This article presents a summary overview of how the social identity approach was used to inform the development of a bespoke peer mentorship-based intervention for ERSs. As such, we provide a case study example outlining the practical implementation of the social identity approach within a diverse public health context. Some critical reflections are discussed that have broader relevance for other public health interventions that seek to embed peer support provision.

Keywords: *Peer Mentorship, Exercise, Group Membership*

Utilising theory to develop complex health behaviour change interventions can enhance intervention effectiveness (Prestwich et al., 2015). The decision making and application of theory, however, to inform the development of behaviour change interventions are seldom reported in-depth. Intervention Mapping frameworks (e.g., Fernandez et al., 2019) represent a positive step towards the better reporting of health-related behaviour change interventions. However, we argue that scholars should seek to further delineate their reasoning for using psychological theory and its proposed application at the onset of intervention development. Doing so will ensure transparent theoretical decision making at the onset of intervention development and ensure its saliency, utility and fidelity within a given health context. Accordingly, the current article provides an insight behind why and how the theoretical principles underpinning the social identity approach informed the development of a peer mentorship intervention designed to enhance physical activity engagement in a community public health setting.

During the initial intervention development stage, we adopted a social identity approach (Tajfel & Turner, 1979) as it affords a theoretical perspective into the social relations underpinning peer dynamics. According to the social identity approach, when perceived similarity with members

of a given social group is high, individuals are more likely to experience a sense of belonging and social connectivity (i.e., identifying as 'we' and 'us' rather than 'I' and 'me'). The giving, receiving and interpretation of support from others is often structured by identity-based relationships between the support provider and the recipient (Haslam et al., 2012). We sought, therefore, to design an intervention that established positive peer relations through a mutual sense of shared social identity for promoting physical activity engagement.

The theoretical mechanisms underpinning an intervention are contingent upon the context in which it is delivered (Pawson & Tilley, 1997). As such, we adopted a person-based approach (Yardley et al., 2015) towards intervention development to ensure the appropriateness of our theoretical position in the context of those who will be using the peer intervention. The context for our peer intervention was a community-based exercise referral scheme (ERS). ERSs are short-term physical activity interventions for adults (≥18 years) who are: (1) experiencing or recovering from one or more physical and/or psychological health conditions and (2) are deemed to be insufficiently physically active (<150 mins moderate-to-vigorous physical activity/week), or (3) engage in prolonged bouts of sedentary behaviour (NICE, 2014). ERSs are accessed by heterogenous populations who vary by age, sex and health status, key demographic criteria which routinely inform initial perceptions of similarity among exercise group members (Dunlop & Beauchamp, 2011). As such, the extent to which ERS participants are demographically dissimilar to one another can markedly reduce opportunities for shared social identity development relative to other public health settings. Such contexts are well suited to social identity-informed interventions which seek to promote a wider perception of 'usness' amongst group members. A developed and internalised sense of 'usness' can reduce and transcend outward perceptions of intra-group dissimilarity (Haslam, Reicher & Levine, 2012). The following section outlines how we utilised the social identity approach to develop a bespoke peer mentorship intervention for ERSs.

Initially, we conducted a qualitative needs analysis with key stakeholders (i.e., ERS staff and ERS clients) to ground the development of the intervention in an understanding of the perspective and psychosocial context. Among the most salient findings (Portman et al., 2022) were that the ERS was non-group based and ERS sessions, held within local community gyms, could simultaneously be accessed by non-ERS members. This flexible participatory format created confusion over whether those who were accessing the gym at the same time were fellow ERS users like themselves or if they were non-ERS everyday gym users. ERS clients cited this ambiguity as a barrier which inhibited their willingness to instigate and reciprocate social interaction with other ERS gym users. Stakeholder interviews also revealed contrasting preferences and expectations for peer mentorship among ERS clients. Some sought to develop friendships, others were content with making small talk and others indicated no keen desire for direct social interaction. Consequently, the community ERS environment hindered the development of a shared sense of ERS social identity due to 1) a lack of clarity surrounding a defined group membership, and 2) a lack of distinct norms for group behaviour and conduct in terms of social contact preferences.

Our interviews with ERS stakeholders found that former ERS clients who had successfully completed their ERS programme can act as peer mentors to provide ERS clients with an additional, dependable source of social support (Portman et al., 2022). Specifically, ERS peer mentors acted as advocates and propagators of a shared sense of ERS social identity through offering one-to-one social support to ERS clients and by acting as exemplary ERS social identity role models. ERS clients and

providers reported their prototypical peer mentor preferences in terms of demographic characteristics, personal characteristics, and roles (Portman et al., 2022). Participants emphasised the need for peer mentors to have completed the ERS and to have experience of managing a personal physical and/or psychological health condition. ERS clients considered an ERS peer mentor's age and gender to be largely inconsequential relative to their ability to demonstrate the personal characteristics of empathy, positivity and a good sense of humour. A summary of prototypical ERS peer mentor roles is provided in Table 1.

We know from the social identity approach to leadership that leadership effectiveness is determined, at least in part, by the extent to which followers perceive leaders as prototypical members of their chosen group (van Knippenberg & Hogg, 2003). Our intervention development phase was able to capture the prototypicality of an ERS peer mentor as defined by those who accessed and delivered an ERS (Portman et al., 2022). In doing so, ERS clients were able to capture a sense of themselves in the embodiment of a peer mentor(s) and to perceive a shared sense of social identity (i.e., 'we' and 'us') with peer mentors who represented their personal values, beliefs and behaviours. Overall, the recruitment and introduction of ERS peers increased the availability of emotional, motivational and informational support to ERS clients. These categories are broadly consistent with previous peer and social support literature (Dennis, 2003). However, grounding such roles within an overarching social identity approach will increase the likelihood that offered support will be interpreted positively and acted upon by intended recipients of support (Haslam et al., 2012). In this regard, cultivating a perceived shared sense of social identity should be considered fundamental to effective peer support provision. Preliminary findings showed ERS peers contributed towards increased feelings of comfort and belonging among ERS clients (Portman et al. 2021), factors that may play an influential role in participants' continued adherence to ERSs.

Social identity building interventions to date have primarily focussed on organisational (Steffens et al., 2014) and/or sports group (Waldhauser et al., 2021) contexts. These groups differ to ERS settings in two meaningful ways: 1) there is more likely to be at least a fundamental similarity upon which social identity can be formed; and 2) these groups are unlikely to experience widespread group member turnover to the same extent as that commonly reported among 12-week ERSs (Pavey et al., 2012). Critically, the social identity informed ERS peer mentorship intervention presents a means to integrate social identity building constructs within public health settings with high group member turnover. ERS peer mentors represent a

Table 1. Prototypical ERS peer mentor roles according to ERS clients and providers.

Role type	Description and example
Practical	Non-specialist assistance operating gym equipment E.g., demonstrate how to access pre-set programmes on exercise machines
Informational	Answering questions related to the ERS process E.g., provide details of supervised session times
Motivational	Share details of own ERS journey E.g., discuss how personal barriers to ERS completion were overcome
Emotional	Welcoming new clients and showing on-going interest in client welfare E.g., socially interact with clients on a one-to-one and one-to-many basis

reliable and dependable source of social support for individual ERS users, as well as acting as a bridging link to facilitate social interaction amongst ERS users themselves, thus creating an opportunity for a social identity to develop.

Moreover, we know that social identities are most influential when perceived group-member similarity is high (Haslam et al., 2012), whereas ERS users are largely heterogenous in age, gender and health status, and their individual ERS-related successes (i.e., increased physical activity) are not co-dependant on the successes of others. As such, the ERS setting represents a challenge to the peer mentors' social identity building roles, as they must possess the requisite interpersonal and communicative skills with which to establish rapport and supportive relationships with a diverse array of ERS users. From a theoretical perspective, leaders who demonstrate multiple identity prototypicality are perceived to be more effective (Steffens et al., 2018). By fostering a shared sense of identity via perceived similarity in one or multiple domains, these leaders can demonstrate and promote a sense of 'usness' between themselves and individual group members within diverse intra-group settings (Steffens et al., 2018). For example, ERS peer mentors can demonstrate their similarity to different ERS group members according to one or many of the following characteristics: (1) age, (2) health condition, (3) physical capabilities, (4) life experience(s) and/or (5) sense of humour. In this regard, ERS peer mentors perform multi-faceted roles by providing direct one-to-one support, assisting ERS users towards adopting a singular overarching ERS social identity, and negotiating and reconciling any existing social identities that may be present among distinct ERS sub-groups (i.e., among ERS users of a similar age, gender or health status). Ultimately, though challenging, it is within these diverse settings where peer mentor roles can potentially yield the most positive gains for group social identity development. Without ERS peer mentors, the onus for establishing rapport and accessing support from others is transferred back to individual ERS users who may have contrasting preferences for social interaction and/or differing levels of proficiency in establishing and maintaining social interaction, which may inhibit subsequent social identity adoption.

This commentary provides a rationale for the saliency of grounding a community-based based peer mentorship intervention through the lens of the social identity approach. We raise some issues and offer person-centred solutions guided by social identity principles for developing a peer mentorship intervention within an ERS setting. Capturing a contextualised understanding of how social identity theorising operates can help inform the development of peer interventions in diverse public health settings. Moving forwards, peer interventions can benefit by first identifying existing central components of a group identity and having an appropriate, context-specific mechanism by which to amplify and promote them among the wider group (e.g., peer mentors). In addition, whilst specific peer mentor roles may vary across contexts, the overarching support structure should be underpinned by the pursuit of establishing positive peer mentor-mentee relationships that are rooted in perceived similarity. From a social identity perspective, skilled peer mentors are those who can cultivate a sense of 'usness' by identifying and communicating existing shared characteristics, ideals and experiences between themselves and others (Haslam et al., 2012). Further benefits are likely to be achieved when peer mentors can promote greater perceived similarity among group members themselves. This practice has the potential to increase the availability of social support on a short-term basis whilst also creating a supportive network(s) that may persist beyond the end of an intervention.

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Original Article

Health psychology consultancy: an example of practice during pandemic

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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

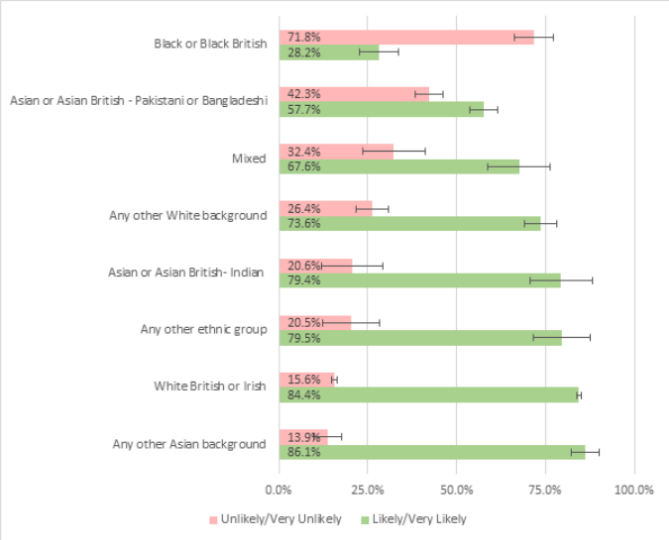
The client in this instance is responsible for education and training of health professionals at an NHS acute hospital trust which delivers services across multiple sites in England. In January 2021, the Trust set up a mass Covid-19 vaccination centre. The client organised training for vaccinators - 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).

Acknowledgement

We would like to thank Dr Jane Walsh at University College Galway, who shared findings from her research on vaccine hesitancy in Ireland and UK which informed our work.

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Position Paper

How to make EHPS conferences more climate-friendly

First ideas for the 2022 meeting of the European Health Psychology Society

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After two years of EHPS conferences held online, EHPS 2022 is going "hybrid" for the first time. Although this new format brings some challenges, it offers opportunities for urgently needed climate actions we can take as a community. According to the latest Intergovernmental Panel for Climate Change report, the world's CO2 emissions need to be reduced to zero by 2050 to avoid a tipping point (IPCC, 2022). Even though political and transformative decisions are necessary to reach this goal, everyday consumer decisions have an important impact. Here we reflect on some of the opportunities the hybrid conference offers, share first ideas on how to make future EHPS conferences "greener", and ask for feedback and ideas for future steps we as individuals and a community can take.

1.Preparation

1.1 Online or in-person attendance

In-person conferences are important activities that enable sharing of the latest research and supporting good quality networking. Many EHPS members have forged friendships and collaborations lasting entire personal and professional lives. Nevertheless, the impact of an in-person conference on the environment is significant. Attending an in-person event produces approximately 840 kg of CO2 equivalent per person (Tao et al., 2021), which equals to charging a Smartphone an impressive 102,180 times (EPA, 2021), or a 5,100 km drive by a compact car (using E85 fuel; Myclimate). While transport is the most important source of greenhouse gas emission associated with in-person conferences (Bossdorf et al., 2010; Tao et al., 2021; van Ewijk & Hoekman, 2021), accommodation and food should not be neglected, as they represent around 13% to 18% of conference emissions (Bossdorf et al., 2010). Switching from in-person to virtual conferences can potentially reduce their carbon footprint by an impressive 94% (Tao et al., 2021). Besides being more climate-friendly, online conferences can be more inclusive as it may be easier for participants with lower financial resources or from farther away to attend, as shown by increased attendance rates and similar satisfaction rates compared to in-person events (Yates et al., 2022).

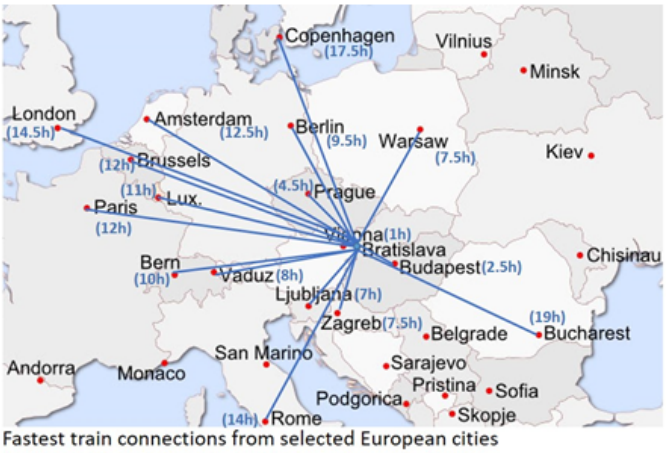
1.2 Traveling to Bratislava and accommodation

The decision to travel to the conference in person will mean that some of us will consider alternative travel options to keep the impact on the climate as small as possible. For many, this will mean challenging their priorities or making trade-offs. For example, a train trip from Amsterdam to Bratislava produces about 84% less CO2 emissions compared to flying[1] (according to Ecopassenger, also see Travelandclimate). Although trains might be the slower option, they offer opportunities to network, arrange pre- and post-conference meetings, finally read those books or provide feedback on that paper, enjoy city breaks, and have civilised meals. Traveling by train offers a great opportunity to enjoy the diversity of landscapes that Europe has to offer, something impossible to do when traveling by air. For those who would like to make their trip even more scenic this year, the ferry from Vienna to Bratislava is almost as fast as the train (approx. 75-90 versus 60 minutes) and comparable in emissions (approx. 2.8 litres diesel per passenger one way, Twin City Liner Ferry). There is also a cycle path along the Danube river (with pubs dotted along), connecting Bratislava with Vienna, and many other European cities (see EuroVelo paths 6, 9, or 13).

Photo by Willian Justen de Vasconcellos on Unsplash

[1] approx. total CO2 emissions with climate factor for air travel 307 kg, for trains 49 kg on Ecopassenger

The 2022 EHPS conference starts on a Tuesday, so those who are time-conscious may choose to take a night train, or travel later on Monday. Bratislava can be reached in under 5 hours by train from Budapest, Prague, or Vienna (1 hour!), in about 9 hours from Zurich, Dresden, Venice, Zagreb, and Warsaw. Trains from Paris, Amsterdam, and Brussels take around 12 hours (all with slower but more comfortable night trains to Vienna as well). If booked in advance, train travel can even be the cheapest option. These travel search engines may assist in searching and booking a train trip to beautiful Bratislava: Omio, German Railway, Trainline, Rail Europe, NightJet-Trains. Once at the railway station in Bratislava, the old town is only a



Fastest train connections from selected European cities
Map from www.freeworldmaps.net/europe/europe-capitals.jpg

15-minute walk away. As all-conference and social venues will be in the Old Town, bringing comfortable shoes is a further tip for the trip.

In case flying is unavoidable, it is still possible to reduce its impact on the climate by taking the most direct flight, changing to a train from the closest larger airport (Vienna), or choosing an airline that emits fewer greenhouse gasses.

As any trip to Bratislava from another country will inevitably produce emissions, offsetting these may be a good alternative for some (e.g., Myclimate, Atmosfair, Goldstandard). As emission offsetting cannot reverse environmental damages already done, the better decision is to always use

travel options with the least emissions (e.g. using trains for distances under 700 km, or cycling).

1.3 Booking accommodation in Bratislava

The conference will be held at the Crowne Plaza Hotel, which is located in the heart of the city centre. All venues should be within walking distance, with the farthest one being the University auditorium at 1000 meters from Crowne Plaza. Booking accommodation close to the city centre reduces commuting. More eco-friendly accommodation can be found using common search tools with eco-filters ("Travel Sustainable properties" within booking.com or "Green" within TripAdvisor). Some of the results are, however, large hotel chains that buy eco-certificates and should not be preferred over smaller hotels, especially hostels or apartments shared with colleagues (Google finds several apartments that at least label themselves "eco"). An accommodation's policies and practices on their use of renewable energies (as well as recycling, food waste, single-use hygiene articles, water-saving, re-use of towels, etc.) may guide our choices. Even if the accommodation is further away, it is easy to get around in Bratislava either by cycling (e.g. bike rentals: VisitBratislava Bikesharing, Rekola, ANTIK) or by using a tram.

2. During the conference

Together with Easy Conferences (the organising company), this year's local organising team has already done a lot to make the in-person conference more climate-friendly. The conference venues are easy to walk to and within walkable distance from points of interest. There will be no single-use conference bags, and the conference program and abstract books will be published online only. Once the conference is over, delegates will be asked to leave their conference name badges at the site to be re-used by Easy Conferences.

All catering services are advised to avoid single-use plastics and must source their ingredients as locally as possible. Lunch will be served as a buffet at the hotel cafeteria to reduce waste and packaging, and to enable delegates to avoid sandwiches with food they may not eat, (plastic) bottled water, or crisps in plastic bags (sometimes the defaults at previous conferences). Lunches for delegates attending meetings during lunchtime will be packed as eco-friendly as possible. The tap water in Bratislava is of good quality, and there are contactless drinking fountains available around the city. Bringing a refillable bottle will help translate "green intentions" into action.

As climate-friendly food options can be chosen by the majority of the delegates and have a considerable impact on the total conference carbon footprint (EAT-Lancet Commission by Willett et al., 2019; Neugebauer et al., 2020; van Ewijk & Hoekman, 2021), the organising team is keen to reduce meat and dairy products and make vegetarian and vegan food options available and attractive.

Tell us what you think about introducing vegetarian/vegan lunches or vegetarian/vegan days at in-person EHPS conferences, possibly starting in Bratislava, with four optional and very quick questions here (takes 2 minutes).

3. After the conference: Assessment of EHPS conference on climate

The conference organizing team will send a survey to the EHPS community after the conference. This will help them evaluate the conference experience, and ask a few questions about how delegates travelled to Bratislava and

Dubrovnik (for comparison). We will analyse this data anonymously and estimate the overall climate impact of the in-person conference in 2019 to the hybrid format in 2022.

4. Further ideas and inspirations are highly appreciated

If you have any further ideas on how to reduce the carbon footprint during the conference, or good tips for other delegates on how to travel more sustainably (e.g. planning on coming by bike, or taking the train despite a long distance), tag us on Twitter to share them!

#sustainableEHPS & Special Interest Group @Ehps4G.

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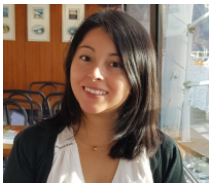

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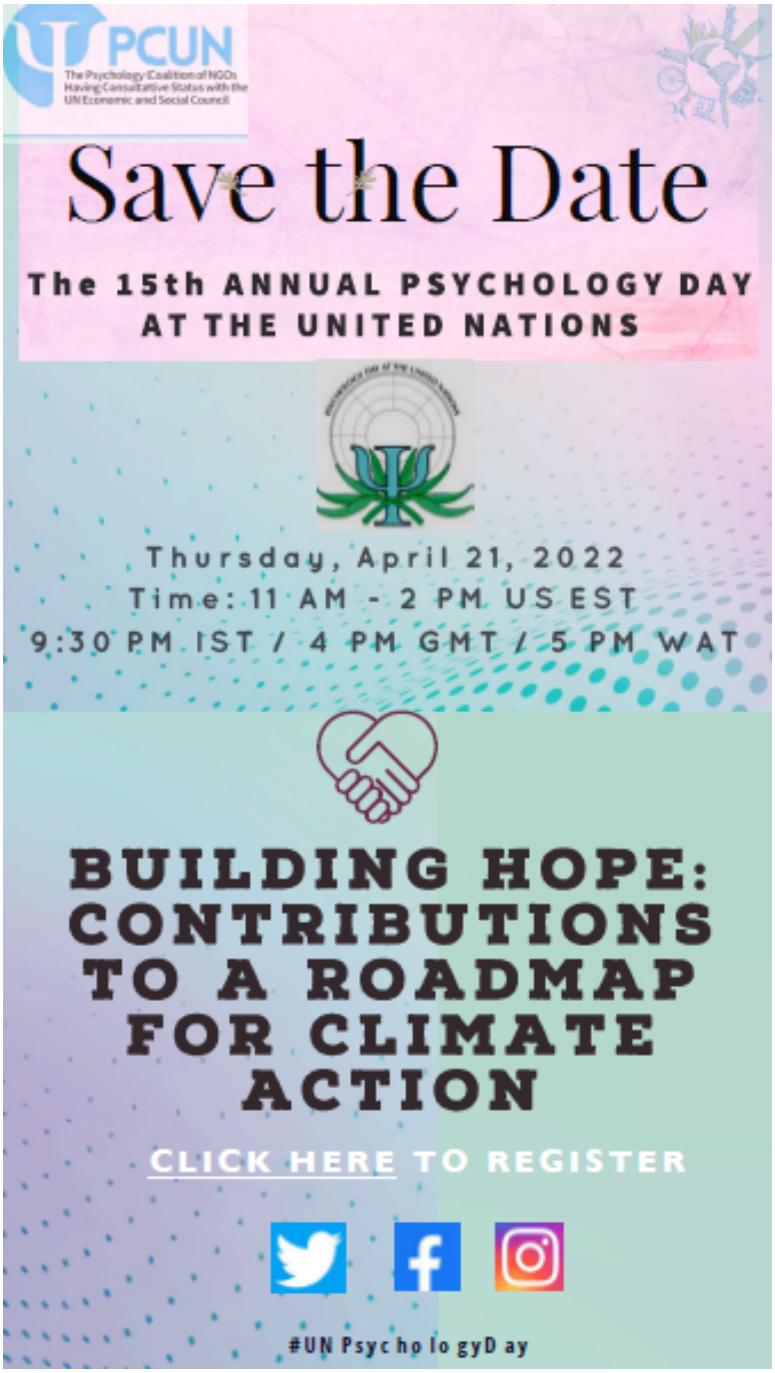
Upcoming Events



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Writing Impactful Research Policy Briefs Online Workshop

Wednesday 27 April 2022
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By taking part in this workshop, participants will:

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- Know how to use images and graphics to communicate key findings effectively
- Be able to develop credible, impactful and measurable recommendations based on their research
- Know how to develop an impact assessment for a research brief

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Vivi Antonopoulou
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NIHR Applied Research Collaboration North East and North Cumbria

Welcome: Harold Takooshian, Vera Araujo-Soares Psychology Coalition at the United Nations

This global workshop is hosted by the PCUN. For details on PCUN, contact: takoosh@aol.com
For details on this workshop, contact behaviourchange@ucl.ac.uk

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