BEHAVIORAL HEALTH AND FOOD SAFETY

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Behavioral Health and Food Safety

- Behavioral Health – “actions individuals take that affect their health”
  Effective and efficient inspections must consider this process

- Social and Environmental Factors – essential part of noncompliance – inspections are not abstract but encompass a dynamic mix of factors, shifting based on situation and client

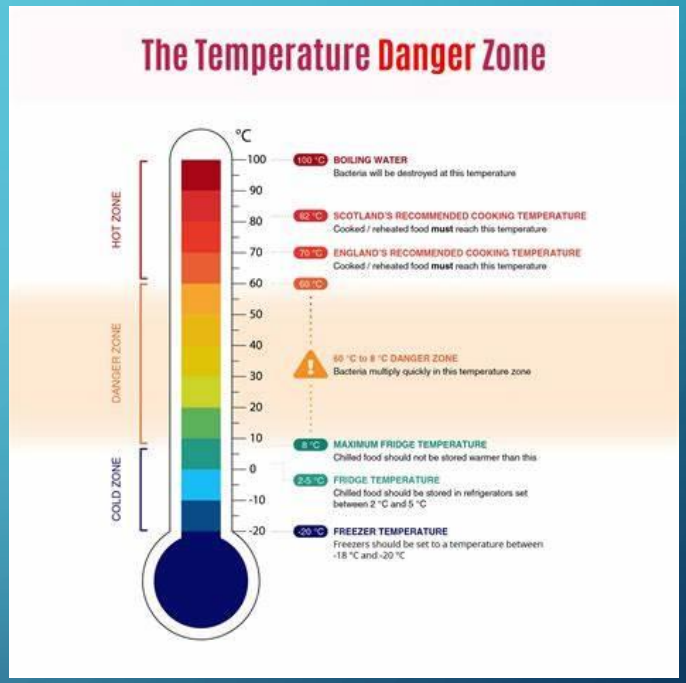
- Introducing the Concept - *how do clients process information and recommendations?*
  - Complicated process – attitudes, beliefs, prior knowledge all are influences
  - Adults learn differently than children - ‘empty vessel’ fallacy about adult learning
    - adults consider information before acting – knowledge is not enough
    - Wright, Feun 1983 – food service training study showed statistically significant result in client attitudes but not sanitation scores – difficult to do skills training in a classroom

❖ Health behaviors and decision-making are rational, considered processes
  - Process is long term, on going, evolving – not just during the 90 minute site visit
  - Communication is key – *what (knowledge - information) and why* (persuasion – marketing - networking) to do it but also *how (skills, modeling and practice)* to do it

Behavioral Health and Food Safety

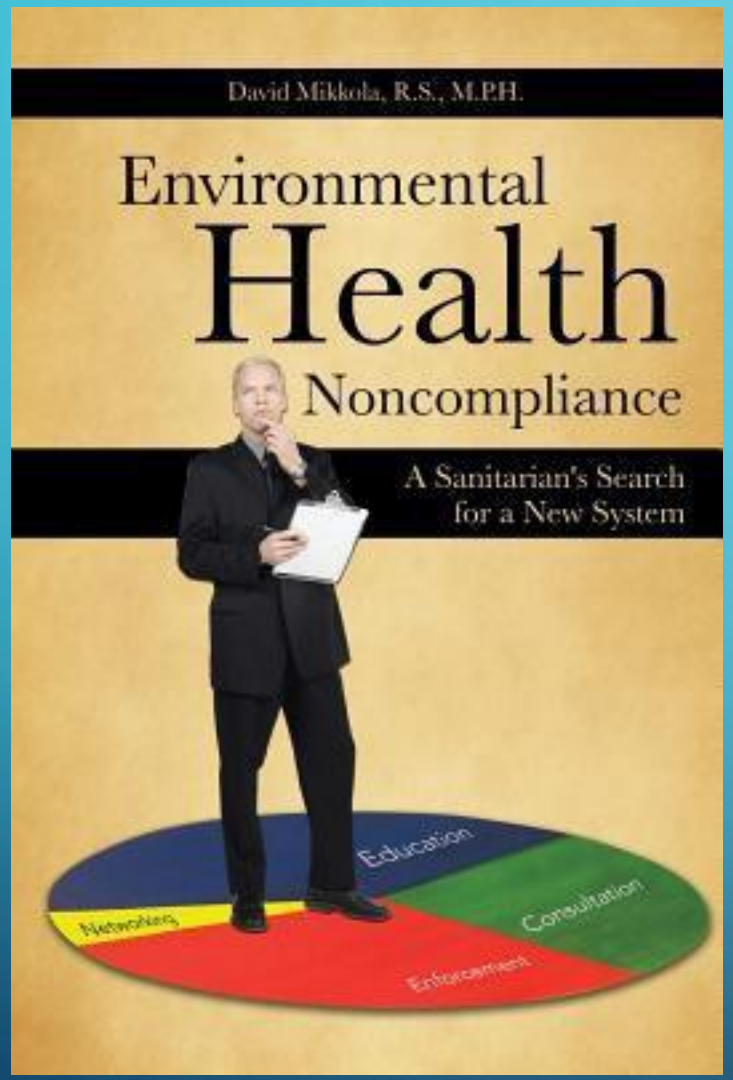
Employee Hygiene

Cleaning and Sanitizing



Safe Food Temperatures

WHY?



Why Does Behavioral Noncompliance Persist?

Searching for New Solutions

Any ideas?

ENGINEERING (CONSULTING)

EDUCATION

NONCOMPLIANCE ‘BLACK BOX’ – Consider Health Behavior to Fill the Void

ENFORCEMENT

FOOD SAFETY EDUCATION Month

Behavioral Health and Food Safety

- Objections to changing the system

  - Health educators – *sanitarians are technicians and enforcement officers, not educators*
  - *- Education – Lecturing, Handouts? NO!*
  - Sanitarians – *system is adequate as it is* – (clients are recalcitrant)

    Sanitarians would appear weak – *just the opposite*

    Changes would not be approved by matching fund audits – *change is neither radical nor time consuming (sanitarians already use the concepts)*

- Objections make networking difficult – *networking is critical*

- Existing system may be effective in some cases but inefficiencies are time consuming, expensive and labor intensive

  Overemphasis on one factor may cause *more* noncompliance

  - Enforcement? – Clients are petrified into inactivity, become hostile, stop being proactive

    Fear arousal in the presence of a single enforcement factor, is a real concern.
  - Education? – Sanitarians appear weak and indecisive, clients may wait and do nothing

Behavioral Health and Food Safety - 2

- Enforcement and education are important but are not a complete explanation –

- Enforcement is needed for truly recalcitrant clients … however
  - Noncompliance persists even with stringent enforcement programs
  - Food safety concerns continue and persist – time/temperature, employee hygiene
  - Too much emphasis on enforcement – expensive

- Education provides knowledge but neither persuades nor markets the concepts
  - Client attitudes and beliefs can only be gauged on site
  - Networking is essential to continue the educational process

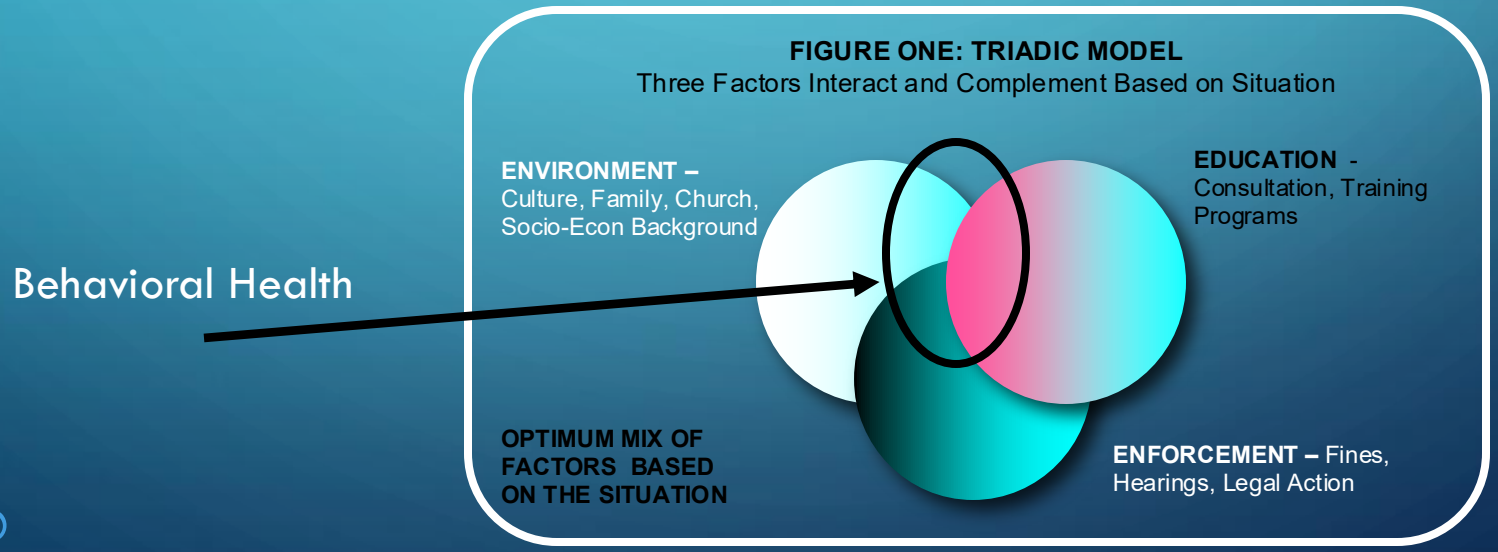
Behavioral Health –

Fills gaps where enforcement and education are lacking

Defines comprehensive models on which to base compliance action plans

Incorporates best aspects of the existing system, adds social, environmental factor

Dynamic approach, shifting emphasis based on situation and client – some clients will need no persuasion but continual skills training, others with experience and skills may need motivation, etc.

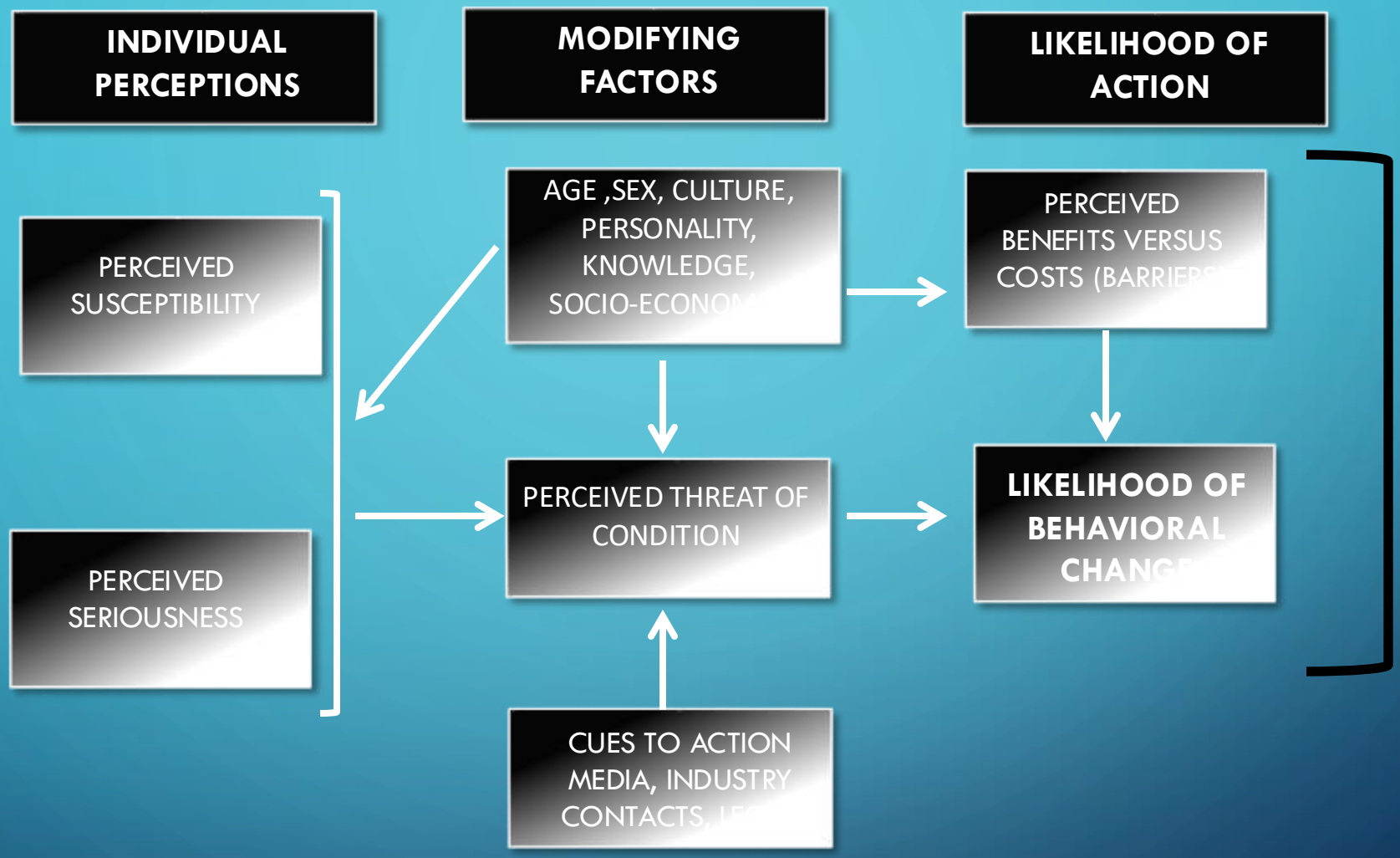


Health Belief Model

Dr. Rosenstock

- See Nancy Janz and Marshall Becker 'The Health Belief Model: A Decade Later' Health Education Quarterly¨ Spring 1984

- **1950s – Irwin Rosenstock and Godfrey Hochbaum – USPHS**
- **Faced with the risk of tuberculosis, people refused free offers of screening and consultation – Why? (perceived fatalism)**
- **Model sets up five questions clients process before they decide whether or not to act –** *food service clients will process inspections similarly - the human factor in interactions*



Self-Efficacy – factors from Social Learning Theory – Albert Bandura

HEALTH BELIEF MODEL – EXPLAINING HEALTH BEHAVIOR
SANITARIAN'S TASK – USE FACTORS TO ASSESS NONCOMPLIANCE
Adapted: Glanz, Rimer and Lewis eds. Health Behavior and Health Education John Wiley 2002 p. 52

Health Belief Model

During the site visit, be aware of weak points and strengthen them (ongoing process)

I. PERCEPTIONS OF THE PROBLEM – ex. Handwashing to lower risk of contamination (virus, bacteria) Is the problem clear to me? Is it Important and severe enough that I need to act?

II. PERCEPTIONS OF THE CHANGE – ex. Wash for 20 seconds, soap and hot water. Is the reason clear? Will the problem affect me (my facility) to the point where a change is needed? Will the proposed change resolve the problem? (Objection: Everyone knows how to wash their hands – why be so strict?)

III. BARRIERS TO CHANGE – Available handsinks? Time provided? Extra supplies? Are there obstacles (financial, physical, labor)? (If #I and #II aren't strongly positive, the client might 'find' or 'create' barriers

IV. CUES TO ACTION – Am I motivated to act? Is the change consistently enforced? Does everyone else do it? Family, friends and colleagues all support this change. It might take time but customers and employees will like it (public relations). Neighboring restaurants all are doing it. My child at school is learning it.

V. PERCEIVED SELF-EFFICACY – Social Learning Theory – Modeling and practice are critical - The individual must believe the behavior is attainable, that they are confident in their ability to perform the required task, without looking foolish. Modelling the behavior and allowing supervised practice are essential.

Health Belief Model –

Suggestions for using health behavior concepts

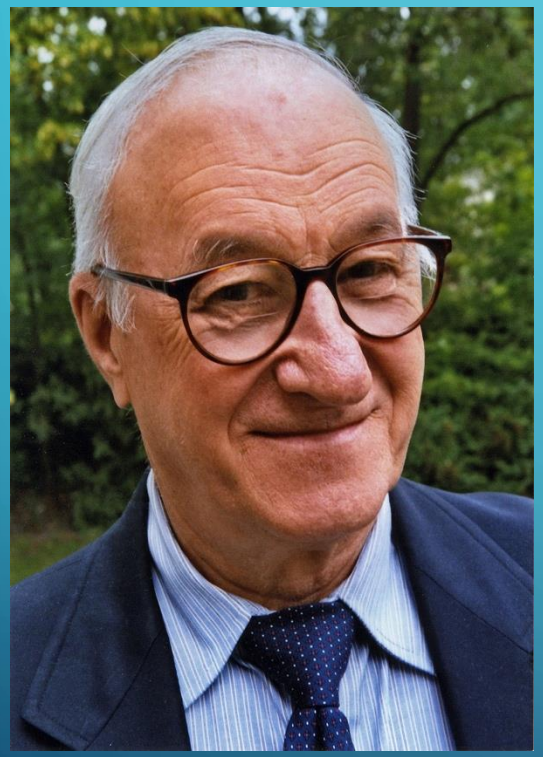
1. Sort out the client's objections and hesitancy to change.
2. Explain the public health *science*, the importance of change – reasons for the law
3. Interview before the inspection is important – then, keep communicating throughout the inspection - ask the client to accompany you.
4. Emphasize the human aspect – reduce anxiety as much as possible
   - If you don't know an answer to a question, find out and return.
   - Be comfortable but share your own background and interests
5. Acknowledge obstacles to change but push for a commitment - a stated *intention to act, especially in a specific time,* is a good predictor of further actions.
   - Return for a cup of coffee, a conversation and to check on progress
   - Repeat site visits show interest and involvement
6. Perceived self-efficacy is an important predictor of lasting change – if behavior is modeled by significant people, if practice is reenforced, even new skills will be attempted – over and over, research cites this factor as essential and critical
7. Public health networking is important –health educators, nurses, public relations experts, schools can help distribute information and be persuasive.
9. Training is highly valued in many cultures – if you teach, talk about it.

HEALTH BELIEF MODEL - ROLES FOR SANITARIANS

Table adapted from Janz, Chamption and Strecher The Health Belief Model in Glanz, Rimer and Lewis, editors Health Behavior and Health Education: Theory, Research and Practice, Ed. 3 San Francisco: John Wiley & Sons 2002 pp. 45-66

HEALTH BELIEF PHASE	Phase Defined	Strategies
PERCEIVED SUSCEPTIBILITY	Belief about the possibility of getting the condition	Discuss illness case studies (links to current violations), especially those in the vicinity, the wide range of susceptibility to illness and high risk cases; the individual's personal risk and responsibility (i.e. eating out, preparing food for others); misinformation about food safety revealed during the inspection
PERCEIVED SEVERITY	Belief about the condition's serious effects	Discuss impact (economic, personal) of condition on individuals, the facility and the community.
PERCEIVED BENEFITS	Belief that the mandated action will resolve the condition	Review costs and benefits of compliance, eliminating excessive or imagined costs; provide lists of service providers; make complicated actions manageable by separating them into phases.
PERCEIVED BARRIERS	Belief about the costs (economic and otherwise) of the mandated action	Be a resource, model and educator to the facility and individual; diffuse objections to change. If possible, intercede with others (community agencies, facility owners) to help overcome barriers. Be present in the community through networking.
CUES TO ACTION	Pressures (internal and external) to change behaviors	Increase site visits, make community presence known to the facility, emphasize consistency to all facilities. Reenforce positive progress, bring pressure about relapse and negative actions. Discuss and initiate legal consequences at the first sign of recalcitrance.
PERCEIVED SELF-EFFICACY	Perceived belief in one's ability to take action	Improve and expand available education and training efforts on site and through networking; model ideal behaviors during site visits, allowing time to practice.

SOCIAL LEARNING THEORY – ALBERT BANDURA



Social Learning Theory considers how both environmental and cognitive factors interact to influence human learning and behavior.

So, while a food service client may be strongly motivated and persuaded by food safety concerns and while they may know a great deal about food safety, they may be discouraged by environmental factors, their perceived low self efficacy and/or aspects of the site inspection.

CONCLUSION

- Qualifier – decades of research on public health issues, very little on environmental health (food safety, swimming pools) - Any takers?
- References –
  - Health Belief Model

- Janz, Nancy, et. al. The Health Belief Model in Glanz, Rimer and Lewis, ed. Health Behavior and Health Education: Theory, Research and Practice Ed. 3 (San Francisco: John Wiley & Sons 2002)
- Janz, Nancy and Becker, Marshall 'The Health Belief Model: A decade later' Health Education Quarterly Spring, 1984 11 (1) pp. 1-47

  - Social Learning Theory – environmental component

- Bandura, Albert Social Foundations of Thought & Action: A Social Cognitive Theory (New Jersey: Prentice-Hall 1986)
- Bandura, Albert Social Learning Theory (New Jersey: Prentice-Hall, 1977)