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Qualitative exploration of the views and experiences of Making Every Contact Count (MECC) within service providers and users within the Third and Social Economy (TSE) sector: a reflexive thematic analysis of semi-structured interviews

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Background

- Making Every Contact Count (MECC) encourages brief, opportunistic advice around health and wellbeing (PHE, 2016). Implementation of MECC currently includes the Third and Social Economy (TSE) sector; groups or organisations operating independently to family and government with social justice as the primary aim. However, there is minimal existing research in this area.

Aims:

- To assess the barriers and facilitators of implementation of MECC within the TSE
- To evaluate whether health and wellbeing conversations already occur within these settings, without the need for MECC training.

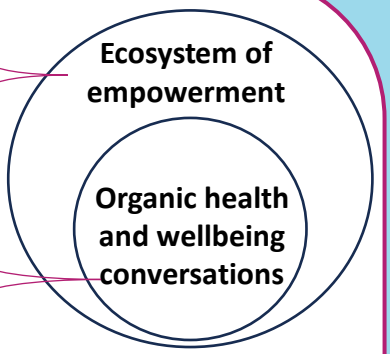
Methods

- **Sample:** Purposive sampling to capture a wide variety of TSE settings including charities, religious settings, and youth clubs. To explore whether MECC conversations are already occur without formal MECC training, service provider participants did not need to have received MECC training.
- **Procedure:** 20 qualitative semi-structured interviews with service users (n = 5) and providers (n = 15). Topic guide explored experience with MECC and existing health and wellbeing conversations including around physical activity, diet, smoking, alcohol, and social determinants including housing and finance.
- **Data analysis:** Reflexive thematic analysis (Braun and Clarke, 2012) using Nvivo.

Themes

'you go there and you are welcomed and people don't judge'

TSE is a safe and inclusive space, emphasising self-efficacy, self-esteem, pride and empowerment, holistic values, and building trusting relationships



'sometimes it's that asking twice. It's nearly you giving them permission to say well you can talk about it'

This environment naturally fosters health and wellbeing conversations without specific training. Unlike traditional MECC conversations, they emphasise passivity (i.e waiting for the service user to initiate, listening without provision of advice)

Facilitators:

Readiness to deliver MECC: Service providers already possessed experience and skills to facilitate MECC, were enthusiastic and passionate about their organisation, and already had access to services for signposting and referral.

'I think because it's such a holistic approach, the centre offers everything, and I think that's the setup for it'

Barriers:

'we're just a charity, and we're funded by people who give us donations. And if the donations stop, we won't be there tomorrow'

Apprehension towards health behaviour change conversations: A minority of participants felt that organisations should operate in silos, perceived MECC as risky or equivalent to safeguarding, or thought it may 'open a can of worms' or damage existing relationships.

Capabilities of TSE determined by external factors: Uncertainty and instability of funding and resources within the TSE delayed MECC implementation. MECC is also dependent on the service users' motivation to change

Conclusions

MECC training should be adapted for TSE settings, with an acknowledgement that conversations around health and wellbeing already occur. Service providers within the TSE particularly would benefit from training on how to initiate conversations around health and wellbeing and play an active role in assisting the person to realise health behaviour change.

References

Public Health England (2016). Making every contact count (MECC): consensus statement. Public Health England, 201, 1-18.

Braun, V., & Clarke, V. (2012). Thematic analysis. American Psychological Association.