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Research Article

"You Go There and You are Welcomed and People do not Judge": A Reflexive Thematic Analysis of Service Providers' and Users' Views of Brief Health and Wellbeing Conversations within the Third and Social Economy Sector

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Brief health and wellbeing conversations within the Third and Social Economy (TSE) sector (groups or organisations operating independently to family and government with social justice as the primary aim) could help to reduce health inequalities through increased access to disadvantaged populations. This study aimed to explore the acceptability of health and wellbeing conversations such as within the TSE, including their existence without specific training. A qualitative design was adopted, utilising semi-structured, one-to-one interviews. Service providers ($n = 15$) and users ($n = 5$) across a variety of TSE settings including charities and religious settings were interviewed, most of whom had not received no specific training in initiating and engaging in health and wellbeing conversations. Reflexive thematic analysis was applied using Nvivo. Five themes were identified; TSE as an ecosystem of empowerment, an existing community-initiated style of health and wellbeing conversations, readiness to engage in brief health and wellbeing conversations, capabilities of TSE as determined by external factors, and apprehension towards health and wellbeing conversations. Generally, the safe and empowering TSE environment naturally fostered health and wellbeing conversations, mostly initiated by service users. The TSE shows a readiness to conduct health and wellbeing conversations through existing infrastructure, partnerships, expertise, and an ambition for social justice. Barriers include fear of worsening the situation such as damaging strong and trusting relationships with service users, safeguarding concerns, and the instability and uncertainty of funding within the TSE. Relevant recommendations in light of these findings are made, including that the TSE is appropriate for the conduct of health and wellbeing conversations, and funding would provide cost efficiencies for its delivery at scale. Specific training within the TSE should focus on actively initiating health and wellbeing conversations and addressing fears of adverse consequences.

1. Introduction

A preventative approach to the rise in noncommunicable diseases (NCDs) including cardiovascular disease, cancers, and type 2 diabetes is most cost-effective compared to treatment [1]. Particularly, lifestyle behaviours such as alcohol consumption, smoking, poor diet, and lack of physical activity are costly to both the individual and wider economy [2–5]. For example, tobacco can be attributed to 8 million deaths each year, costing the global economy a total of 1.4 trillion dollars [3]. Whilst the long-term legacy of COVID-19 on lifestyle behaviours is still unknown, any effect only adds to increasing trends of obesity and overweight [6], alcohol consumption [7], and physical inactivity [8, 9]. Although cigarette sales have fallen, sales of other nicotine based products are rising [3]. Given that targeting such behaviours are considered amongst the "best buys" for the prevention of NCDs in terms of cost-effectiveness [1],

national and global agendas have subsequently drawn focus on lifestyle behaviour [10, 11]. Similarly, a rise in mental illness such that the global reduction in disability adjusted life years is comparable to that of cardiovascular disease [12] demands a multifaceted approach to intervention including prevention through promoting mental health and wellbeing [13].

By nature, brief interventions are cost-effective in comparison with more intensive health interventions [14, 15] and have been repeatedly demonstrated to be effective in improving health behaviours in the short term including smoking [16], alcohol [17], physical activity [18], and diet [19] and may even help to prevent depression [20], reflected by national guidelines to deliver brief interventions [21–24]. Brief interventions involve a conversation around the target topic or behaviour that usually makes use of existing interactions although the specific approach adopted within brief interventions can vary widely. For example, brief advice focuses on the provision of healthy lifestyle messaging such as information on alcohol risk and harm [25], whilst brief motivational interviewing focuses on encouraging service users to identify their own solutions to barriers to change [26]. One person centred and holistic UK-based approach to brief interventions is Making Every Contact Count (MECC), an initiative initially implemented within healthcare settings that builds upon the evidence base of brief interventions for single behaviours, but the focus of the conversation is led by the individual's wants and needs concerning lifestyle change [27, 28], concurrent with the person-centred agenda of national and global healthcare [10, 29] and the prevention agenda [1]. MECC is opportunistic in that it makes use of existing everyday conversations between service providers and users and may involve the provision of brief advice, support, and encouragement to change and signposting to further services where necessary [27]. Existing literature has indicated that the key facilitators to brief health and wellbeing conversations such as MECC within healthcare settings include training that is valued by staff [30], strong relationships with service users [30, 31], and knowledge of and availability to signpost [30]. Conversely, worry of damaging relationships with service users [30], not viewing prevention as part of their role [31–33], and time [30–34] are the most frequently cited barriers.

Brief health and wellbeing conversations within the Third and Social Economy Sector (TSE) [35], which includes all not for profit groups and organisations operating independently to the government that individuals are free to join and are outside of the family or household [36], have the potential to provide unique benefits given that service providers are able to develop close relationships with service users [35], contrasted against an average GP consultation time of nine minutes in the UK [37]. There is also evidence that the TSE is better able to access seldom heard groups including those of lower SES [38] and that specific TSE groups including faith-based settings may be particularly best placed to access individuals of ethnic minorities to deliver health interventions [39–41]. Given the increased access to those of low SES, useful conversations within the TSE may also include the social determinants of health such as finance, housing, and employment. Indeed, national MECC guidelines describe the umbrella term of MECC plus [27] to include the wider determinants of health, an increasingly relevant and implemented approach due to the postpandemic cost of living crisis [42, 43] although the included topics and specific approach of MECC plus differs regionally. Thus, brief health and wellbeing conversations within the TSE have the potential to contribute towards reducing health inequalities, an increasingly important global aim [29]. Furthermore, preventative interventions delivered by volunteers are low cost [44]. Through the shared goal of health promotion, both healthcare and the TSE can conduct brief health and wellbeing conversations during existing opportunities, ultimately strengthening its impact [45].

To date, there has been very little research on the application of brief health and wellbeing conversations settings outside of healthcare. One study found that the acceptability of introducing health and wellbeing checks for firefighters to deliver was lower than the addition of responding to cardiac arrests because health and wellbeing checks were perceived to align less with firefighters' core role [46], mirroring a reported barrier within healthcare. The only available study evaluating the delivery of brief health and wellbeing conversations within the TSE focused on the delivery of MECC within the TSE [35]. Interestingly, MECC training was perceived to reinforce and provide further guidance for existing practice rather than adding a novel approach, indicating that brief health and wellbeing conversations already occur within TSE settings. Themes congruent to findings within healthcare included time pressures and staff capacity and health promotion not being viewed as relevant or part of service providers' role. However, MECC training improved staff confidence to in initiating and conducting health and wellbeing conversations. Contrastingly, unique themes to TSE settings included the underlying uncertainty of funding for services, a high turnover of staff and volunteers, and level of contact varying from one-off to repeated.

However, the aforementioned existing qualitative evaluation [35] mainly focused around strategic MECC implementation at the national and local programme level instead of individual level health and wellbeing conversations. For example, some of the benefits cited related to the social aspect of group activities such as making new friends and working together, which are likely not applicable to individual conversations. Also, faith-based settings were not included [35], which have been found to be feasible hosts for the delivery of brief health interventions [47, 48]. In addition, given that the TSE commonly serves those of low SES, it is important that any approach to the evaluating brief health and wellbeing conversations within these settings includes topics such as housing, finance, and employment, particularly as brief health interventions such as MECC can be perceived as elitist as they set the same expectations for service users across varying levels of SES [35]. Thus, further exploration of brief health and wellbeing conversations such as MECC within the TSE would benefit from increased inclusion of frontline workers and service users including

from within faith-based settings, views on conversations around the social determinants of health, and assessing the feasibility and acceptability of one-to-one conversations around health and wellbeing and their social determinants.

Therefore, the aim of the current qualitative interview study was to explore the acceptability of brief health and wellbeing conversations to target health behaviours and their social determinants within the TSE through the perspectives of both service users and providers. To further explore whether health and wellbeing conversations occur anyway without the need for training, the current study included service providers who had not received any specific training to deliver brief health and wellbeing conversations. Given that MECC (and MECC plus) is an approach that holistically includes a range of health and wellbeing topics including the social determinants, interviews also explored MECC specifically. Findings will inform on the types of brief health and wellbeing approaches that are most acceptable to service providers and users and how training may need to be adapted for TSE settings, if needed at all.

2. Methodology

Reporting of the methodology adhered to the consolidated criteria for reporting qualitative research (COREQ, see Supplementary Material 1) [49], with the caveat and acknowledgement that many items are not appropriate for nonpositivist reflexive thematic analysis [50].

2.1. Design. The current study adopted a qualitative design, utilising semistructured, one-to-one interviews with service users and providers from a range of TSE sites. As the research on brief health and wellbeing conversations within the TSE is in its infancy, a qualitative exploratory design was selected as most appropriate to provide a deeper understanding of the topic. The current study adopted a critical realist epistemological position [51], as analysis of individual subjective experiences was valued although the study aimed to form generalisations across the TSE sector.

2.2. Ethical Approval. This study received ethical approval from the Faculty of Health and Life Sciences at Northumbria University (reference: 49176) and data collection took place between August 2022 and January 2023.

2.3. PPI Panel. A person and patient involvement (PPI) panel, consisting of three service providers from TSE groups and organisations, provided feedback on the topic guides and recruitment strategy during one online panel meeting. Amendments made in response to PPI feedback were the inclusion of questions to explore the impact of COVID-19 on health and wellbeing conversations within the organisation.

2.4. Sampling Strategy. Service providers and users from TSE settings in the North East of England aged ≥18, whether they had received training in conducting brief health and wellbeing conversations or not, were included in the current study. This study adopted a mixture of sampling strategies; purposive to identify participants across a variety of different roles, settings, and sociodemographic characteristics including SES, convenience to utilise existing relationships between the primary researcher (BN) and service providers from the TSE, and snowball to allow access to service users. Sampling of service providers aimed to capture both who worked and volunteered, small groups to larger organisations, a range of genders and ages, faith-based and secular groups, and those who had and had not received MECC training. Sampling of service users aimed to sample a mixture of genders and ages from numerous TSE groups or organisations. To determine the sample size, the model of information power was applied to estimate ideal target size apriori from the aim, specificity of sample, use of theory, interviews, and analysis strategy [52]. The aim was broad, sampling purposive, analysis critical realist in its approach, and a rapport was built with the participants; however, the primary researcher (BN) possessed limited interviewing experience. Therefore, the estimated target sample size was 20, with service users making up at least a quarter of the total sample size to adequately represent both sides of the interaction.

2.5. Recruitment. Participants were recruited from a number of channels including social media (Facebook, LinkedIn, and Twitter), advertising the recruitment poster on site, and word of mouth. Via email, on site, and social media, the recruitment advert was sent or displayed, and interested potential participants contacted the primary researcher (BN) via the contact details provided on the recruitment poster. In circumstances where snowball sampling or recruitment on site was applied, TSE organisations acted as gatekeepers to participants, completing an organisational consent form prior to recruitment. Gatekeepers provided information sheets to potential participants who could register their interest via an expression of interest form. In addition, the primary researcher (BN) visited some TSE settings (both those of some of the participants and additional charities) to record reflective notes about the TSE setting to inform analysis.

2.6. Data Collection. Two semistructured topic guides (Supplementary Material 2) were developed for service providers and users, respectively. Topic guides included an exploration of the TSE site, types of conversations, conversations around health and wellbeing (alcohol, diet, physical activity, smoking, and mental health), conversations around the social determinants of health (finance, housing, and employment), and experiences of training and future training needs. Question terminology only included MECC if the participants had previously received training in MECC; otherwise, participants were asked about health and wellbeing conversations and brief interventions. Although there were separate topic guides for service providers and users, topic guides were implemented flexibly for participants from TSE settings where the distinction between

service provider and user was less clear, or for a minority of participants who were both service users of one or more organisations, and volunteers for others. The topic guide was piloted with a MECC researcher prior to interviews commenced, and it was agreed that it was most appropriate to retain a question to probe the impact of the COVID-19 pandemic after each section rather than adding one general question at the end. Participant interviews were also used to inform a strategic behavioural analysis to assess the implementation and content of MECC training within TSE settings (OSF preregistration: https://osf.io/45jyg/?view_only=0579aa38913844b59b72412c432b6969).

One-to-one interviews were conducted by the primary researcher (BN) online via Teams ($n = 9$) on site of the TSE group or organisation ($n = 8$) or in a café ($n = 3$), depending on the preference of the participant. The primary researcher (BN) is a female PhD student with a background in health psychology. Many participants were familiar with the researcher and had already built a rapport either through previous connections or visits to the TSE setting. The researcher introduced themselves to participants as a PhD student exploring brief health and wellbeing conversations such as MECC. If arranged via email, the participant information sheet was provided to potential participants on first contact with the primary researcher (BN). Providing potential participants were still happy to participate, a date and time was arranged for an interview and the consent form was sent. If arranged by a gatekeeper, the participant information sheet and consent form was provided in person by the primary researcher (BN) on the date of the arranged interview. Participants were provided with a distinct information sheet and consent form depending on whether they identified themselves as a service user or provider. After attaining informed written consent, the study was reiterated verbally before recording began. The topic guide was applied flexibly based on participant responses during the interviews, which lasted between 28 minutes and 1 hour 52 minutes. After the interview concluded, the participants were sent a debrief sheet which explained how participants could withdraw up to one month after participating. Whilst the participation of service providers was voluntary, service users were provided with a £15 retail voucher after the interview as a reimbursement for their time. Audio recordings either via Teams or through an audio recorder were then transcribed verbatim and fully anonymised on transcription before audio recordings were deleted. As participants provided explicit consent, the anonymised transcripts were then uploaded onto the UK Data Service public repository [53], in accordance with open science practices and to allow the use of transcripts for future research.

2.7. Analysis. In keeping with a critical realist position, data analysis flexibly followed the 6-step iterative process [54] of reflexive thematic analysis [55]. Thus, to assist in familiarisation with the data, all transcription and analysis was conducted by the primary researcher (BN), facilitating an immersion in the data [56]. Reflective field notes were recorded during interviews, when visiting and observing TSE sites, and after seminal interviews to draw upon during data analysis. Reflexive practice is considered a key part of thematic analysis in interacting with the data [54] and also encourages transparent research. Inductive coding was applied to develop semantic and latent codes. Themes were generated both through building and combining subthemes and directly from codes and reflexive notes which were then specified into subthemes. Given that reflexive thematic analysis embraces the perspectives and experiences of the researcher, positivist techniques such as independent coding of transcripts were not applied [50]. Instead, to further develop themes through interacting with another perspective, the primary researcher (BN) met with another member of the research team (CH), a highly experienced qualitative researcher, throughout data analysis to discuss and elaborate on themes. All data analysis was conducted via Nvivo 12 Pro [57].

3. Results

3.1. Sample. 20 service providers ($n = 15$, coded as SP) and users ($n = 5$, coded as SU) were interviewed (participant characteristics are displayed in Table 1). The sample generally showed a good range across all demographic characteristics collected (See Tables 1 and 2). Age of service providers and users ranged from 31 to 72 and 24 to 61, respectively. Participants represented at least 15 different TSE settings, ranging across faith-based settings, youth clubs, and charities with focuses such as substance abuse, homelessness, employment, ageing, cancer, food provision, and community wellbeing (details of each participant are displayed in Table 2). Most participants were service providers who had not received MECC training, and most service user participants were female. Only three service providers had received MECC training (marked with an M).

3.2. Themes. The overall coding framework within Supplementary Material 3 displays all five themes and their subthemes, and example codes and quotes for each.

3.2.1. Theme 1: TSE as an Ecosystem of Empowerment. Although the umbrella term of TSE captured huge variation in the types of groups and organisations sampled, including in their scale and focus, their nonjudgemental and affirming undercurrent remained constant. Much of the language used throughout interviews with both service users and providers reflected the TSE as a safe, inclusive, egalitarian, holistic, welcoming, and empowering environment. There was an acknowledgement that at the point of access, service users often suffer from loneliness and low self-esteem and accessing TSE services itself may negatively impact their self-perceptions related to pride and dignity. This was particularly apparent for service user participants that were new mothers who reported a sense of failure in accessing support. Thus, service providers intentionally acted on preserving and amplifying pride and self-esteem.

> SU2: *"in like all honesty, I was embarrassed about using it. You know, I really was, because, and I think a lot of people are. I think I felt a bit like I'd failed. And that I was having to ask for help, and I think that's really really sad, and they*

Table 1: Participant characteristics ($n = 20$ unless stated otherwise).

Characteristics	*n*	%
Gender		
Male	8	40
Female	11	55
Agender, trans, and nonbinary	1	5
Age		
18–24	1	5
25–34	3	15
35–44	3	15
45–54	3	15
55–64	6	30
65–74	4	20
Involvement within TSE (n = 15)		
Volunteer	7	47
Paid employment	8	53
Nature of TSE involvement		
Service provider (only)	14	70
Service user (only)	5	25
Service user and provider	1	5
TSE organisation/group		
Faith-based setting	3	15
Charity	14	70
Youth club	2	10
Informal	1	5

must get that a lot, and almost like having to, when I first met them like having to explain my situation, almost as if like, this is the reason why to kind of justify it. But they never felt made me feel like that, to be honest with you… but the thing is though the lovely thing was, that you go there and you are welcomed and people don't judge"

To reflect holistic values and a recognition of the social determinants of health, TSE groups and organisations often provided service users with resources to empower and enable change, including IT and cooking equipment. Furthermore, for faith-based settings, the influence of faith on health and wellbeing was inherent to conversations too.

SP9: *"whether you have anxiety, or whether you feel shit about yourself, that there's something bigger than that, that there's a God who loves you, and that, now that might be part of the conversation really"*

Most participants felt a strong sense of connection to TSE groups or organisations, both service users who felt comfortable and safe, and service providers who felt a strong affinity to the organisation and a sense of reward, whether working or volunteering. The relationship between service provider and user was more informal and fluid than dichotomous terms suggest, and many trusting relationships were built both between service users and with providers.

3.2.2. Theme 2: An Existing Community-Initiated Style of Health and Wellbeing Conversations. These trusting relationships alongside an empowering environment organically encouraged opportunistic health and wellbeing conversations both between peers and with service providers, without receipt of MECC training. Both service providers and users cited instances of health and wellbeing conversations, including around the social determinants that naturally occurred as a result of a guest speaker, event, common experiences, the interpersonal skills of the service provider, or the wider sociopolitical context. These conversations were mostly initiated by the service user and emphasised active listening, empathy, empowerment, and signposting and referral. In some cases, service providers reported instantly provided signposting or referral as a way of indirectly addressing a conversation instead of engaging in a health and wellbeing conversation. The most relevant topics of these health and wellbeing conversations included the social determinants of health such as for financial advice and to find out benefits entitlement, with some participants noting the urgency of these areas before health and wellbeing can be addressed. A minority of service providers specifically cited Maslow's hierarchy of needs as a framework for approaching conversations with service users. Mental health was the most accepted topic perhaps reflecting a changing landscape towards openness of mental health conversations, with this topic perceived as particularly relevant by service providers within faith-based settings.

SP11: *"health is one thing, wellbeing is our business. So yeah, so I am quite inter-, over the years have done quite a lot of stuff thinking about wellbeing. So yes, I think that is important, and I think the church generally has been quite involved in trying to help with things about wellbeing"*

In contrast to participants who had received MECC training, service providers who had not received MECC training were less likely to initiate health and wellbeing conversations and were reluctant to provide advice.

SP12: *"that's why I don't really initiate, especially because of mental health, I don't initiate anything. If someone wants to talk to me, they'll come and talk to me. And when they come and talk to me, not only will they want to speak to me, but they will be willing to listen to what I have to say. Because when you impose yourself on somebody, that's when it backfires"*

Provision of advice was prevented by many barriers, as many participants noted their lack of expertise as a healthcare professional as preventing them from providing information on health and wellbeing. There was also an emphasis on service providers not wishing to tell service users what to do to avoid potentially damaging their strong and trusting relationships.

SP12: *"a lot of people like to jump and give advice"*

Figure 1 demonstrates the generally held belief of participants that the provision of advice, particularly when the individual did not possess the resources needed for health behaviour change, would have no or even negative impacts on the recipient.

Table 2: Details of each participant.

Participant	Involvement with the TSE	Involvement with MECC
Service providers (n = 15)		
SP1	Volunteer at a substance abuse charity in an urban area of the NE	
SP2M	Youth worker at a TSE youth club in a rural area of the NE	MECC trained
SP3	CEO of a cancer support charity in an urban area of the NE	
SP4	Volunteer at a charity providing support in IT and employment skills in an rural area of the NE	
SP5	Volunteer at a food bank in an urban area of the NE	
SP6	Business and engagement advisor at a charity for older people in an urban area of the NE	
SP7	Volunteer at a patient advocate charity and service user in an urban area of the NE	
SP8	Volunteer at a TSE youth club in a rural area of the NE	
SP9	Vicar at a church in an urban area of the NE	
SP10	Volunteer for numerous informal mutual aid and community groups in an urban area of the NE	
SP11	Vicar at a church in a rural area of the NE	
SP12	Volunteer at a mosque in an urban area of the NE	
SP13	Progression coach at a homelessness charity in an urban area of the NE	
SP14M	Senior manager at a health promotion charity in an urban area of the NE	MECC trained and MECC trainer
SP15M	CEO of an employment charity for young people in an urban area of the NE	MECC trained and MECC trainer
Service users (n = 5)		
SU1	New parent accessing a community development charity in an urban area of the NE	
SU2	New parent accessing a community development charity in an urban area of the NE	
SU3	Accessing a women's charity and chronic condition group in a rural area of the NE	
SU4	Accessing an IT and employment skills charity in a rural area of the NE	
SU5	Accessing an IT and employment skills charity in a rural area of the NE	

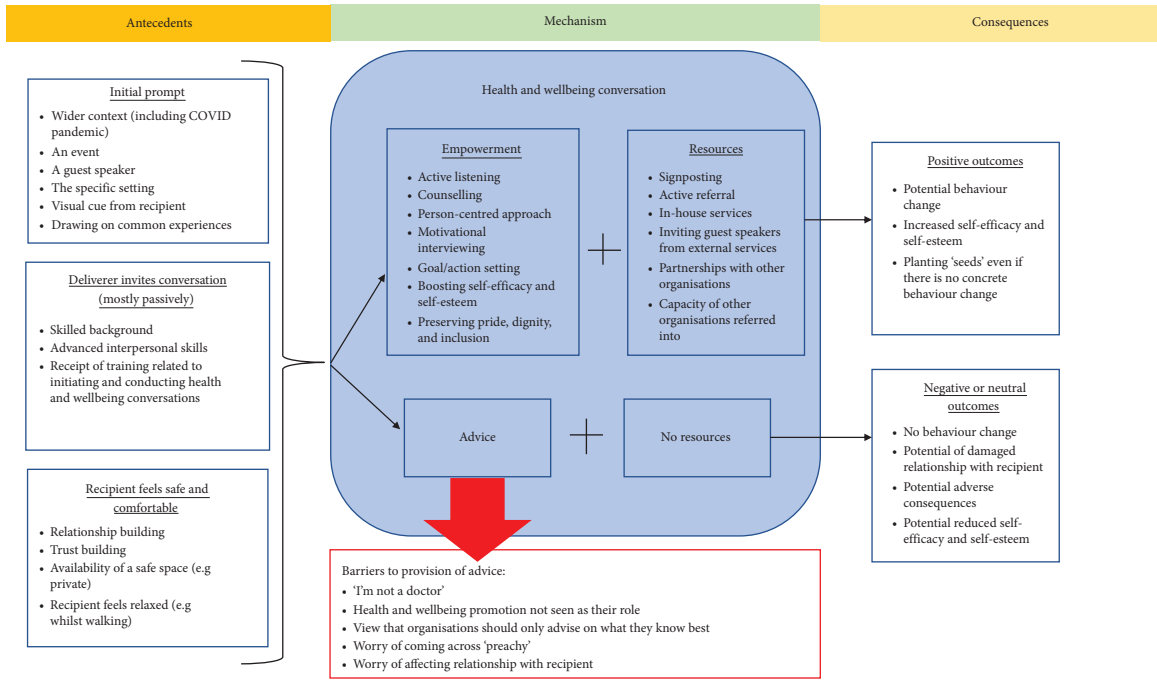

Figure 1: A diagram to outline the interpretation of health and wellbeing conversations and their perceived outcomes within the TSE.

3.2.3. Theme 3: Readiness to Engage in Brief Health and Wellbeing Conversations. Despite very few service providers having received training in brief interventions including MECC, service providers generally showed a capacity, willingness, and ability to engage in brief health and wellbeing conversations. The passion and enthusiasm service providers possessed for their group or organisation to serve others often extended to an openness to receiving training on and engaging in health and wellbeing conversations. Furthermore, all service providers were highly skilled, with

backgrounds including counselling, teaching, youth work, psychology, medicine, nursing, and social work. The experience and skills service providers already possessed facilitated health and wellbeing conversations including interpersonal skills, ability to signpost and hold person entered conversations, and an understanding of appropriate opportunities for health and wellbeing conversations. In addition to an ability and willingness, the TSE is well connected across services, facilitating signposting and referral, but also TSE organisations often possessed multiple services in house to encourage health and wellbeing.

SU2: *"I think because it's such a holistic approach, the centre offers everything, and I think that's the setup for it"*

Figure 1 demonstrates how the safe and empowering TSE environment combined with a readiness naturally fosters health and wellbeing conversations within the TSE, which was generally believed particularly by service providers to induce positive outcomes, even when not resulting in concrete health behaviour change.

3.2.4. Theme 4: Capabilities of TSE as Determined by External Factors. Despite a readiness for health and wellbeing conversations within the TSE, there were multiple factors outside of service providers' control that acted as a barrier to health and wellbeing conversations such as MECC. The main barrier to long-term planning of any intervention was the instability and uncertainty of funding such that TSE groups and organisations often operated from one grant to the next, with little scope to manage long-term plans for initiatives such as MECC. This barrier was particularly apparent for smaller TSE organisations or groups in comparison to national established charities.

SP13: *"what we acknowledge is, 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"*

Also, operations of the TSE were strongly influenced by changing landscapes, the most obvious being the COVID-19 pandemic, which forced many TSE services online and subsequently reduced the opportunity for health and wellbeing conversations. However, COVID-19 also placed a higher focus on specific topics such as mental health and provided access to a new online community of service users, and many participants felt that operations had returned back to "normal." For participants from faith-based settings, a changing landscape towards secularisation acted as a barrier to partnerships that could facilitate health and wellbeing conversations and meant service providers often felt held back within conversations with a fear of being "preachy." Also, health and wellbeing conversations relied on the recipient being open to the conversation and willing and motivated to receive it.

3.2.5. Theme 5: Apprehension towards Health and Wellbeing Conversations. Despite a general enthusiasm towards health and wellbeing conversations within the TSE, a minority of service users and providers were reluctant to discuss anything outside of the service the TSE organisation or group provided. Specifically, there was a dichotomy between those who endorsed holistic values within the TSE and those who felt that services should operate in silos, with one service to address one need.

SP5: *"we're just a food bank that delivers food"*

This was perhaps linked to the perception possessed by those who were not MECC trained that service providers must be an expert in health and wellbeing to provide advice or initiate conversations around health and wellbeing. Many service providers emphasised they were "not a doctor," which either prevented them from approaching health and wellbeing conversations with service users completely or acted as a limit to the level of intervention they felt was appropriate, such as applying active listening rather than providing information. Similarly, the recognition of service users that service providers were not health professionals restrained how appropriate and productive they perceived health and wellbeing conversations with service providers to be. Service users either felt uncomfortable talking about their health and wellbeing or a sense of guilt in expecting support around health and wellbeing from service providers, presenting avoidance in discussing their own health and wellbeing during the interview.

SU5: *"I don't want to offload me stuff onto people"*

Contrastingly, service providers from faith-based settings felt that service users often lacked boundaries in sharing health concerns with them.

SP11: *"And so somebody might say to me, can I show you, I'll just.. Well actually no, it's just not, it's not appropriate, "oh right I suppose, it's just the wound." It's just not appropriate. That is quite common"*

Furthermore, some service providers were hesitant to initiate health and wellbeing conversations due to anticipation of adverse consequences such as dealing with safeguarding issues, experiencing physical risk, damaging existing relationships with service users, opening a "can of worms" without the time or knowledge to appropriately address it, or further damaging the self-esteem of service users if they are unable to make changes regarding their health or wellbeing.

SP14M: *"there's nothing worse than opening a can of worms, because once the can of worms is open and you can't put the lid back on it, not for that person, so you need to know where you can signpost them to, and who can help"*

Some of the barriers to health and wellbeing conversations indicated a need for setting-specific training. For example, service providers and users varied in which topics they felt were most relevant and easiest to discuss with service users. Whilst a healthy diet was perceived as

a sensitive and challenging topic for some participants, one service user indicated weight as a more socially acceptable topic for new mothers in a mother and baby setting. Also, some service providers indicated a lack of confidence and knowledge in certain topics as a barrier to health and wellbeing conversations, demonstrating a potential benefit of MECC training. Of those service providers who had received MECC training, participants emphasised the importance of training as interactive, such as being held in-person to encourage discussion and allow opportunities to ask questions, and including role play of MECC scenarios and conversations. Although acceptable to MECC trainees, a single MECC session was generally considered to be insufficient to provide the confidence, knowledge, and skills to deliver MECC training and either required MECC trainees to attend multiple sessions or to draw upon their existing skills and experience.

4. Discussion

This is the first study to explore the acceptability of brief health and wellbeing conversations within the TSE. Five themes were identified; TSE as an ecosystem of empowerment, an existing community-initiated style of health and wellbeing conversations, readiness to engage in health and wellbeing conversations, capabilities of TSE as determined by external factors, and apprehension towards health and wellbeing conversations. This study demonstrated that although conversations around health and wellbeing and its wider determinants already occur within TSE settings, adopting a specific approach is needed, namely, they focus on empowerment including boosting self-esteem, waiting for service users to initiate, motivational interviewing, providing resources and opportunities for behaviour change, and active listening. The TSE is well prepared for health and wellbeing conversations, with established partnerships and existing services for signposting and referral and skilled, passionate, and enthusiastic service providers with a drive for social justice. However, not all service providers show the same willingness for holistic health and wellbeing conversations and not all service users expect or want to discuss their own health and wellbeing within the TSE. Also, service providers are limited by the uncertainty and instability of funding, preventing long-term goals around the implementation of complex interventions including MECC to facilitate brief health and wellbeing conversations.

Some of the findings highlighted within the current study reflect those of the only existing study of MECC within the TSE [35], including the notion that MECC training strengthened existing practice rather than providing a completely new framework and encouraged service providers to be more proactive in promoting health behaviour change. Barriers identified across both studies include funding uncertainty, worry of negatively impacting existing relationships with service users, lack of service users' motivation to change, and the influence of social determinants in an individual's ability to change. This study also noted individual differences in whether service providers felt health and wellbeing conversations were relevant to their role [35], with many participants noting that a healthcare professional would be more appropriately placed to conduct them. Only service providers who had not received MECC training perceived this barrier, perhaps indicating that MECC training helps to address this barrier. Interestingly, the barrier of health and wellbeing conversations as not perceived as part of the role of service providers is also established within healthcare roles [30, 31, 33, 58, 59], indicating a need to communicate appropriateness of brief health and wellbeing conversations across settings and roles. For example, training to encourage brief health and wellbeing conversations that emphasises and utilises the many existing transferable skills of service providers within the TSE may encourage an increase in confidence in one's skills and, subsequently, an increase in engagement in of health and wellbeing conversations within the TSE. Indeed, other barriers including being uncomfortable to discuss health and wellbeing with service users particularly if not conducting the recommended health behaviours themselves [34], worry of damaging existing relationships [33, 58–61], and dependence of the service user's willingness and motivation to change [31, 33, 58, 61] are also shared, indicating important barriers that should be addressed by training irrespective of setting. However, the current study revealed barriers unique to TSE settings including barriers of a perception of risk for service providers (both of physical attack and in difficulty in handling safeguarding issues), the need to address more immediate socioeconomic needs before addressing lifestyle behaviours in line with Maslow's hierarchy of needs [62], and instability of funding, indicating a need to tailor training and support to address these TSE specific barriers. Although the cultural university of Maslow's hierarchy of needs is contested [62], the theory provided a helpful way for service providers to frame their views that social determinants must be addressed to effectively elicit health behaviour change, a position that is generally agreed upon within existing literature [63].

Health and wellbeing conversations within the TSE without the provision of MECC training emphasised inviting conversations around health and wellbeing rather than asserting them on the community. Interestingly, provision of advice was fraught with the highest number of barriers, despite evidence to support the effectiveness of brief advice on individual behaviours such as smoking and alcohol [64], and literature within healthcare settings finding that advice is the default intervention expected within interactions and anything beyond that perceived as less acceptable [30]. Participants within the current study instead provided examples of existing health and wellbeing conversations that demonstrated organic use of many MECC-related skills including active listening and open discovery questions, reflecting a brief motivational interviewing approach which also possesses supporting evidence of effectiveness [26, 65]. Indeed, the use of open discovery questions is the skill most readily applied after MECC training [30, 66–69] in place of advice giving [30, 70]. The frequent use of open discovery questions without MECC training identified within the current study indicates that this ability is routed in existing advanced interpersonal skills of service

providers, whereas skills relating to provision of advice is inherent to the roles and training of healthcare professionals. Also, some participants were more likely to provide signposting or referral to avoid discussing health behaviour change with them, an observation also identified within healthcare contexts [58]. Thus, existing health and wellbeing conversations may be more similar than first perceived to MECC currently delivered within health and social care settings. However, even if provision of advice is no longer an included mechanism of MECC conversations, service providers within the TSE would still benefit from training on how to initiate health and wellbeing conversations that emphasise interpersonal skills and motivational interviewing.

Of those who had received training in MECC, participants discussed the importance of interactive training which a face-to-face format facilitated. For example, role play of scenarios was not always a part of MECC training, despite participants valuing the chance to simulate MECC conversations to consolidate MECC related skills. Furthermore, simulation of professional skills is a valid and feasible method of education within healthcare [71] and encourages motivation and use of clinical and nonclinical skills [72]; thus, role play as included within MECC training for the TSE may facilitate the delivery of MECC within these settings. However, it is noted that role-played encounters can differ hugely through differences in behaviour of the recipient [73, 74], perhaps explaining why MECC training, even if including role play, is often not translated to behaviour change [30, 75].

4.1. Implications for Practice. Given the findings of the current study, delivery of training to encourage brief health and wellbeing conversations such as MECC training within the TSE should acknowledge that health and wellbeing conversations already occur and highlight and demonstrate the numerous transferable skills that service providers already possess that can be applied to support their delivery. Training should focus on how to initiate conversations and provide accurate and useful information such as recommended alcohol intake, as the only instance of this recalled by participants was from a service provider from a healthcare background. In accordance with previous research, this study indicates that rather than the delivery of advice, an emphasis on communication and motivational interviewing skills within training may be most useful within the TSE. In a wider sense, this study has demonstrated the potential of the TSE to contribute to public health, justifying the inclusion of the TSE to help achieve the World Health Organisation's goals of people centred and integrated care [76].

4.2. Strengths and Limitations. A main strength of the current study is that the findings provide a frontline view of health and wellbeing conversations within the TSE from both the perspective of those providing and receiving them. Subsequently, the findings provide a useful indication of the acceptability of health and wellbeing conversations such as MECC in practice. Furthermore, a representative sample was achieved across types of TSE groups and organisations, urban and rural areas, age, and gender, facilitating generalisability across the TSE. It may be perceived as either a strength or a limitation that only three participants had received MECC training. As most participants were not familiar with MECC or indeed any training to encourage brief health and wellbeing conversations, the current findings provide a viewpoint of the health and wellbeing conversations that are already occurring naturally, providing a clearer idea of what specific training service providers from the TSE would benefit from. However, the limited representation of those who have received MECC training means no conclusions can be drawn around the acceptability of MECC training and how it is applied in practice. Also, the low representation of service users in comparison to service providers due to pragmatic limitations of accessing service users is recognised as a key limitation, restricting the conclusions that can be drawn about the acceptability of health and wellbeing conversations from the perspectives of service users with the TSE. Service users are seldom heard within MECC research [35], identifying a need to invest more effort in accessing and including service users. Finally, to protect anonymity ethnicity of participants was not collected, although given that residents in North East of England are predominantly White [77], it remains uncertain how acceptability of health and wellbeing conversations differs for ethnic minority groups.

5. Conclusions

Health and wellbeing conversations occur within the TSE without specific training, fostered by the safe and empowering environment. However, the delivery of advice poses the most barriers, and service providers generally wait for service users to initiate. Also, influenced by the wider sociopolitical context, mental health is the most acceptable topic to discuss within the TSE, particularly within faith-based environments, where discussion of faith and spirituality is inherent to these conversations. Training to encourage brief health and wellbeing conversations within TSE settings should focus on how to initiate health and wellbeing conversations and play an active role in assisting individuals to realise health behaviour change. Furthermore, training delivered to faith-based settings should acknowledge and embrace the role faith has on mental health conversations, working with this integral element rather than ignoring it. Any training would ideally be offered in person, with the opportunity to role play scenarios and conversations to translate training into practice. Future research would benefit from assessing the acceptability and utility of specific approaches to brief health and wellbeing conversations within the TSE including access to MECC training its impact on future practice. Given that brief motivational interviewing was found to be the most acceptable approach within the TSE, it may also be of particular relevance for future research to assess motivational communication, a conversation style that applies skills comparable to those applied within motivational interviewing [78, 79].

Data Availability

Participant transcripts are available here: https://reshare.ukdataservice.ac.uk/856448/.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Supplementary Materials

Supplementary Material 1: COREQ checklist for reporting of qualitative studies. Supplementary Material 2: Topic guides for participants. Supplementary Material 3: Coding framework. (*Supplementary Materials*)

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