



**Western Cape  
Government**

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Western Cape Government Health

# **Make Every Contact Count:**

Supporting self-management through healthy conversations

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## Acronyms

<b>BMI</b>	Body mass index	<b>CHW</b>	Community health worker	<b>COPC</b>	Community Oriented Primary Care
<b>DMOC</b>	Differentiated Models of Care	<b>FBO</b>	Faith-based organisations	<b>HIV</b>	Human immunodeficiency virus
<b>ICCC</b>	Innovative Care for Chronic Conditions	<b>MECC</b>	Make Every Contact Count	<b>MO</b>	Medical officer
<b>NICE</b>	National Institute for Health and Care Excellence	<b>NCD</b>	Non-communicable disease	<b>NPO</b>	Non-profit organisation
<b>OT</b>	Occupational therapist	<b>PHC</b>	Primary Health Care	<b>OPEX CO</b>	Operations Executive Committee
<b>RC</b>	Registered Counsellor	<b>TB</b>	Tuberculosis	<b>TEXCO</b>	Top Executive Committee
<b>UK</b>	United Kingdom	<b>UHC</b>	Universal Health Coverage	<b>WCGH</b>	Western Cape Government Health
<b>WHO</b>	World Health Organisation				

# 1. Introduction

The Western Cape Government Health (WCGH) states that the provincial population is afflicted with a quadruple burden of disease namely:

- The level of trauma from inter-personal violence and road traffic accidents,
- The escalating burden of chronic diseases (including mental ill health and its associated risk factors),
- The twin burden of HIV with TB and,
- The conditions associated with maternal and child health.

In addition, the incidence of non-communicable diseases (NCDs) which consist mainly of cardiovascular diseases, cancers, respiratory diseases, diabetes and mental illness and its associated risk factors such as smoking and obesity is on the increase. Large proportions of these patients are undiagnosed, untreated or poorly controlled on treatment.

The 2030 vision for the WCGH is: "Access to person-centred, quality care from various perspectives including those of patients, staff, the community, the Department, spheres of government and strategic partners." Furthermore, Healthcare 2030 promotes strategies that support personal recovery, focussing on the development of self-management and the mobilisation of agency at an individual, household and community level in order to implement these strategies to effectively address the burden of disease, senior managers need to recognise that the province has the opportunity to deliver services in a different manner. In addition, the changing landscape due to the COVID-19 pandemic is also a precipitating factor for reviewing the WCGH current service delivery approach to counselling services in the Western Cape in an effort to address the burden of disease differently. The provincial Strategy asserts that services should be "geared towards prevention and health promotion with a complimentary capacity for curative, rehabilitative and palliative care thus enabling patients to regain skills and abilities for personal recovery and re-integration into family and community life." As we move closer to Universal Health Coverage (UHC), matters related to Community Health Workers (CHWs) and Mid- Level workers (e.g., enrolled nursing assistants, queue marshals etc.) are becoming more important to the health system as services need to be geographically aligned within the Community Oriented Primary Care (COPC) approach. Considering the above, there was a need to revise the current counselling model and define and clarify a future model for counselling.

HealthCare 2030 has outlined that the WCGH will further explore how, where and by whom counselling can be provided, what training and other resources will be required and how it could be implemented in a phased manner. The new counselling model will provide clarity on the services required by the department.<sup>1</sup>

## 2. Background

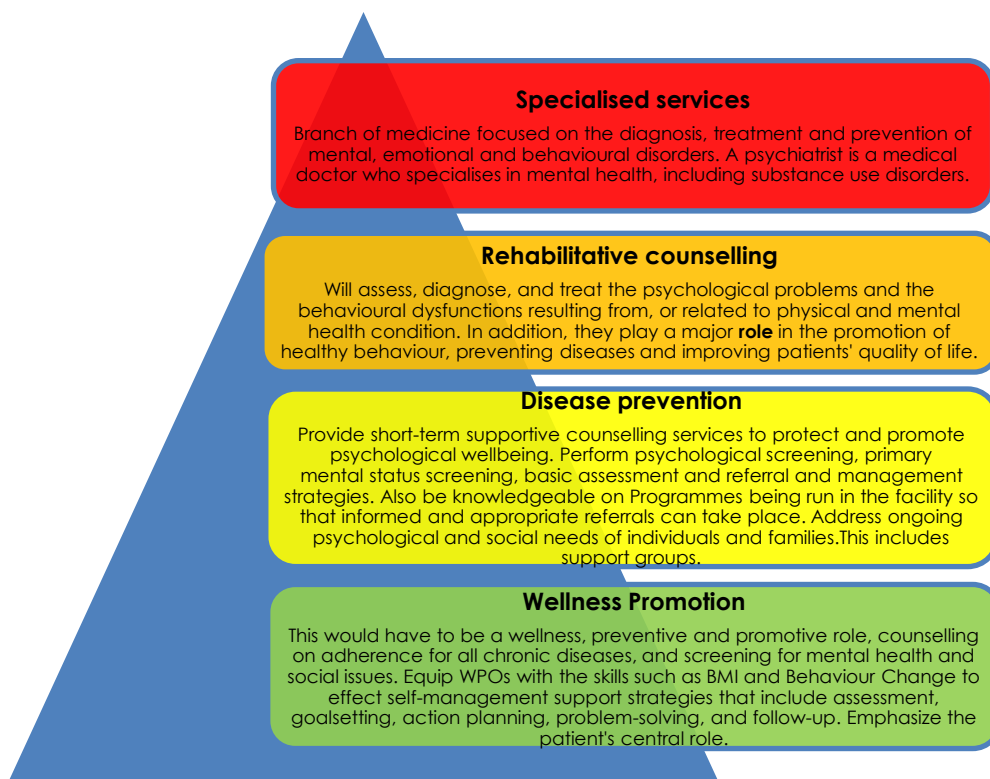
In 2018, the WCGH top management agreed in a meeting with non-profit organisations (NPOs) (who were delivering Home based Community services as well as those providing counselling services) that they would reconsider the Lay-Counsellor Model in the province. The current model for lay workers and mid-level workers has become outdated from different perspectives. For example, the emerging practice in the field of HIV care around testing has shifted globally and the need for counselling services has been a long standing need that has surfaced in various areas.

The first draft of the Western Cape Counselling Strategy, in consultation with services, was written with the intention of crafting an approach to counselling for the province that would include different levels of care, would reflect on the different human resources that are skilled in counselling as well as some of the activities related to counselling as a broader strategy that would form the basis for the department to make decisions and recommendations. In 2019, top management accepted a tiered counselling service model (see figure 1) where they recognised that there are different counselling needs at different service levels within the department.

## 2.1. Tiered counselling service model

The tiered counselling model focuses on a four-tiered model focusing on the following four categories; wellness promotion, disease prevention, rehabilitation and specialised interventions as illustrated in Figure 1.

**Figure 1: Tiered Counselling Service Model**



## 3. Purpose of the document

The crux of the reimagined future for 2030 is the focus on person-centeredness. Wellness is not a state of being but a proactive process of increasing knowledge and agency for making healthier lifestyle choices and for adapting to changing circumstances towards realizing, maximizing and mobilizing the fullest potential of self and others (Healthcare 2030). This document uses principles from the Innovative Care for Chronic Conditions (ICCC) framework and the Make Every Contact Count (MECC) approach. These frameworks help to outline a proposed paradigm shift for the way in which the Western Cape Government Health employees and partners can enhance the clinical encounter and facilitate behaviour change. In this document, counselling is not to be limited to mental health conditions nor behavioural counselling, in this strategy it is a combination

of preventive and promotive practices/counselling including things like treatment literacy, adherence support, behavioural counselling as well as psychosocial counselling.

Furthermore, the document serves as an outline of how the **Integrated Counselling Framework** can be incorporated into the existing health system to build a culture and environment that supports and facilitates continuous health improvement through each contact with people entering the health system. It outlines the environment that is needed to support health care providers to **Make Every Contact Count** in order to improve the health and wellness of citizens. This is in line with the Department's goal to move away from an all-consuming curative paradigm of treating illness and disease to one of prevention, promotion and wellness.

## 4. Scope of the strategy

- To improve person-centred quality of care through educating and empowering staff to better address health risk behaviour.
- To enhance the patient health seeking behaviour by providing the patients with a supportive environment
- To improve agency among patients to take responsibility of their health through the facilitation of brief interventions.

### 4.1 Defining counselling

Healthcare 2030 has highlighted that counselling is an essential part of a health care provider's work, from encouraging adherence to supporting behaviour change, and has an important role in increasing the promotive and preventive aspects of the clinical encounter. The aim of counselling is to emphasise the strengths and resources of the person to bring about effective behaviour change and well-being. Health care workers often want to help their patients bring about change to improve their health status, and counselling and healthy conversations is both an inherent part of the health care encounter itself and a useful referral resource when more extensive counselling is deemed necessary. Counselling can assist in addressing many risk behaviours that lead to high burden diseases as well as in decreasing their complications and ranges from encouraging adherence to supporting behaviour change and more. Through this strategy, counselling will be available through the primary care and community-based care platforms, allowing more extensive counselling for those with common mental disorders, as well as those requiring further assistance or encouragement in behaviour change.<sup>1</sup>

## 5. Counselling approach

### 5.1 Making Every Contact Count (MECC)

An organisation has several opportunities to improve health and well-being of patients, staff and the general public **by making every contact count**. The Making Every Contact Count (MECC) model was developed in the United Kingdom (UK) to assist all health facilities that are responsible for well-being, care and safety of the public to implement and deliver positive health messages to encourage the population to make better health behaviour choices. It focuses on capitalising on the existing opportunities within health facilities, during routine visits, to make a difference to

people's health and wellbeing. It is envisaged that by helping people to make changes to their lives, it is possible to prevent ill-health, improve overall health and reduce health inequalities.<sup>2</sup>

Furthermore, MECC helps organisations build a culture and environment that supports and facilitates continuous health improvement through each contact with people entering the health system. MECC needs to be embedded in the current service. MECC is not intended to be an “add-on” to an already busy environment and does not require staff to be behaviour change specialists or counsellors. It however entails adapting the way in which they engage with patients so that they are not enforcing their opinions onto them but are using a person-centred approach to address clients' needs holistically.

**Figure 2: The organisational environment<sup>3</sup>**

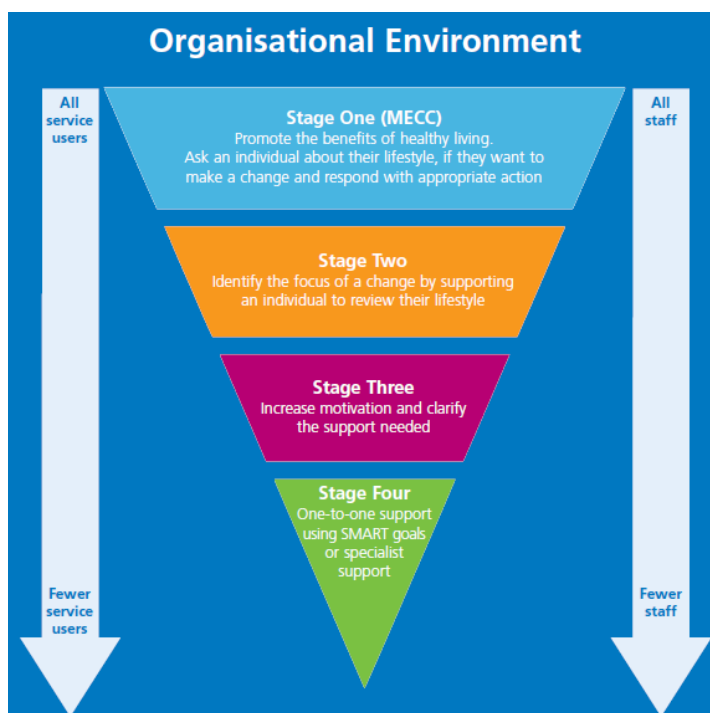


Figure 2 illustrates the patients journey bearing in mind that the journey may not always be a linear process. For instance, some patients will opt out of intervention at various levels resulting in fewer health professionals being required to intervene as the intensity of the required intervention increases. This means that all staff should be able to intervene at Stage 1, but as the patient proceeds along each stage, the level of skill required to provide the necessary intervention increases as well. Moreover, the number of patients requiring more skilled interventions will decrease as they will be helped earlier and only those who need the specialised service will be referred or they would have implemented the advice received in stage 1 or 2 and therefore have the necessary skills required to deal with a specific health problem.

The MECC approach acknowledges that telling people what to do is not the most effective way to help them realise the changes they want to make. Should we choose to implement MECC in this province, it would require us to provide training for staff and support front line staff to develop a different way of working with people to address health and wellbeing through:

- Learning how to spot opportunities to talk to people about their health and wellbeing
- Having healthy conversations

- Signposting to services that support people who want to make changes to improve their health

An evaluation report of MECC states favourable results. The findings of the evaluation indicated that MECC has the potential to deliver a significant public health resource at low cost and can be spread broadly across a wide variety of contexts. Moreover, MECC is a simple, non-technical behaviourally based dialogue focussed on facilitating an effective dialogue between service provider and client using healthy conversation.<sup>4</sup>

In a separate evaluation, Lawrence et al reported that the trained health professionals demonstrated significantly greater use of client centred skills to support behaviour change compared to untrained counterparts one year post training. Some of the barriers highlighted were the differing objectives of various professional groups. This could be based on differing assumptions about the roles of health professionals (treatment vs prevention). Furthermore, a service is only as effective as the system it operates within and considering that MECC largely acts as signposting patients to a more targeted health service its effectiveness is determined by what actually exists in the system.<sup>5</sup>

### 5.1.1 MECC in practice

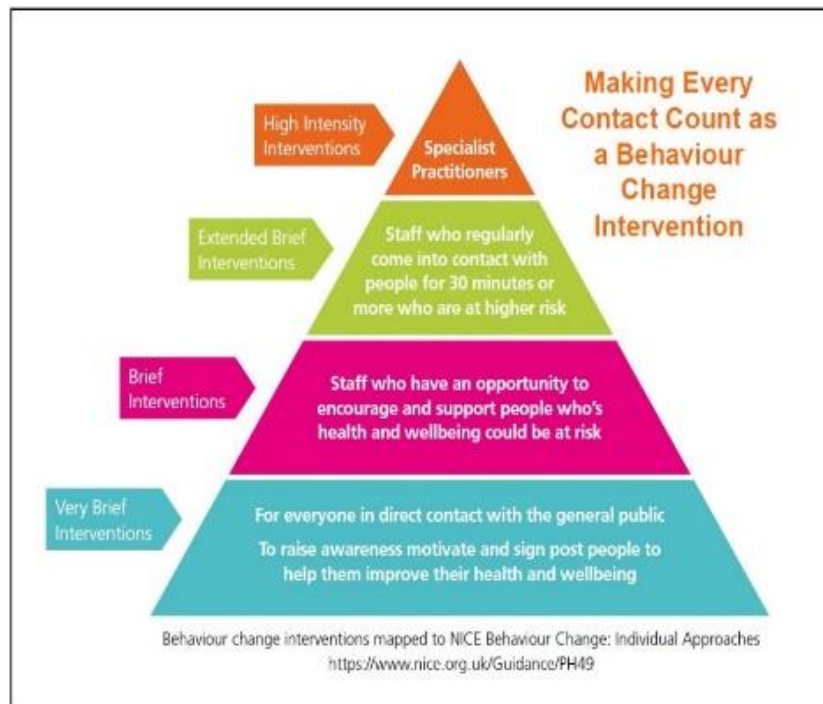
Patients often have complex, multi-faced needs that need to be addressed. For this reason, patients benefit from being asked about their health and want advice to be structured and focussed. This can be achieved through systematically promoting benefits of healthy living across the organisation, asking individuals about their lifestyle and changes they may wish to make when there is an appropriate time to do so, responding appropriately to lifestyle issues once raised and taking the appropriate action to either give the necessary information or refer individuals to the support they need. Using face to face training helps staff overcome barriers to engaging with individuals about behavioural risk and lifestyle factors. Making Every Contact Count means that all staff, when the opportunity arises, are confident and competent in starting a very brief conversation which will **help the person involved to consider change, feel encouraged and supported to change, and know where to go for further support** if they feel ready to change. MECC conversations are very brief: usually just 30 seconds -5 minutes. They are sometimes called "Chats for Change" or "Health Chats". A MECC chat is NOT focused on helping people to change their behaviour, as it is too short an interaction to do that. It IS focused on **helping people to think about changing by raising their awareness of issues, being encouraging and supportive of change, and signposting to further supporting agencies as well as linking them to appropriate care.**

Barriers to implementation include how staff feel about their own well-being, lack of leadership and organisational support, lack of access to information related to behavioural risk and lifestyle issues, timeframes of the intervention, feelings of uncertainty on when to engage with service users regarding their lifestyle choices. Therefore, full support from management is essential in the implementation of MECC. Moreover, staff need to take ownership of the implementation process if we want them to be fully engaged.

### 5.1.2 Behaviour change interventions as defined in the MECC

Behaviour change interventions involve a set of techniques, used together, to facilitate change in health behaviours in individuals, communities or whole populations.<sup>3</sup> MECC is the first level of a behaviour change conversation, delivered to anyone when appropriate opportunity arises with the aim to raise awareness, encourage, support and signpost.

Figure 3: Behaviour change interventions mapped to the MECC approach<sup>3</sup>



### 5.1.2.1 Very brief interventions

A very brief intervention can take from 30 seconds to a few minutes. It is mainly about giving people information or guiding them on where to go for help. It may include other activities such as raising awareness of risks or providing encouragement and support for change. It follows an “ask, advise, assist” structure.<sup>3</sup> It enables the delivery of information to people or signposting them to sources of further help. Encourage health, wellbeing and social care staff in direct contact with the general public to use a **very brief intervention** to motivate people to change behaviours that may damage their health. The interventions should also be used to inform people about services or interventions that can help them improve their general health and wellbeing.

### 5.1.2.2 Brief interventions

A brief intervention is an oral discussion, negotiation or encouragement, with or without written or other support or follow up. It may also involve referral to further interventions directing people to other options or more intensive support. Brief interventions can be delivered by anyone who is trained in the necessary skills and knowledge. Brief interventions are often carried out when the opportunity arises, typically taking no more than a few minutes to give basic advice (NICE, 2014). Encourage staff who regularly come into contact with people whose health and wellbeing could be at risk to provide them with a **brief intervention**. (The risk could be due to current behaviours, sociodemographic characteristics or family history.)

### 5.1.2.3 Extended brief interventions

Extended brief interventions are similar to brief interventions but usually last more than 30 minutes and consist of individually focused discussions. It can involve a single session or multiple sessions.<sup>3</sup> Encourage behaviour change service providers and other health and social care staff dealing with the general public to provide an **extended brief intervention** to people they regularly see for 30 minutes or more who: — are involved in risky behaviours — have a number of health problems — have been assessed as being at increased or higher risk of harm — have been successfully

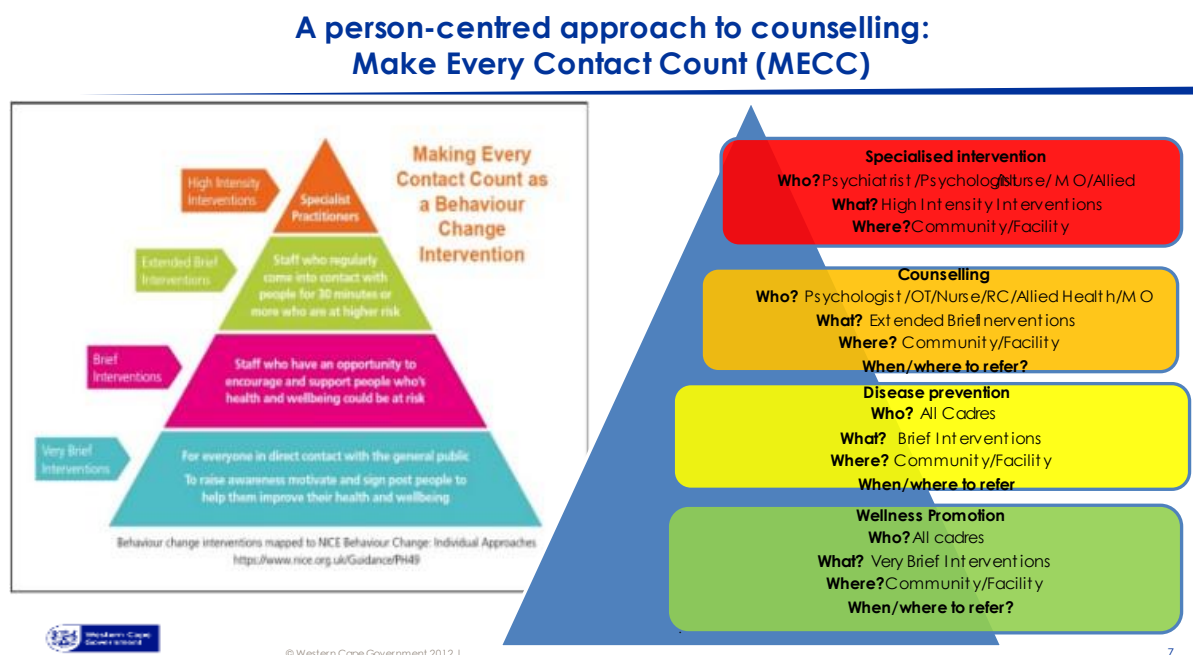
making changes to their behaviour but need more support to maintain that change — have found it difficult to change or have not benefited from a very brief or brief intervention.

#### 5.1.2.4 High intensity interventions

These are interventions facilitated by highly skilled mental health practitioners. High intensity interventions could involve more complex behavioural interventions such as cognitive behavioural therapy.<sup>3</sup> Encourage behaviour change service providers and practitioners to provide **high intensity interventions** (typically these last more than 30 minutes and are delivered over a number of sessions) for people they regularly work with who: — have been assessed as being at high risk of causing harm to their health and wellbeing (for example, adults with a body-mass index (BMI) more than 40 – see the NICE guideline on obesity prevention) and/or — have a serious medical condition that needs specialist advice and monitoring (for example, people with type 2 diabetes or cardiovascular disease) and/or — have not benefited from lower-intensity interventions (for example, an extended brief intervention).

#### 5.1.3 Applying MECC to the tiered counselling model

Figure 4: A person-centered approach to counselling



The figure above illustrates how brief interventions can be used within each tier to enhance existing interventions that are already taking place within the health system. It also identifies specific cadres of staff that will be able to render a counselling service at a particular level/tier.

## 6. Theoretical framework

### 6.1 Innovative Care for Chronic Conditions (ICCC) Framework

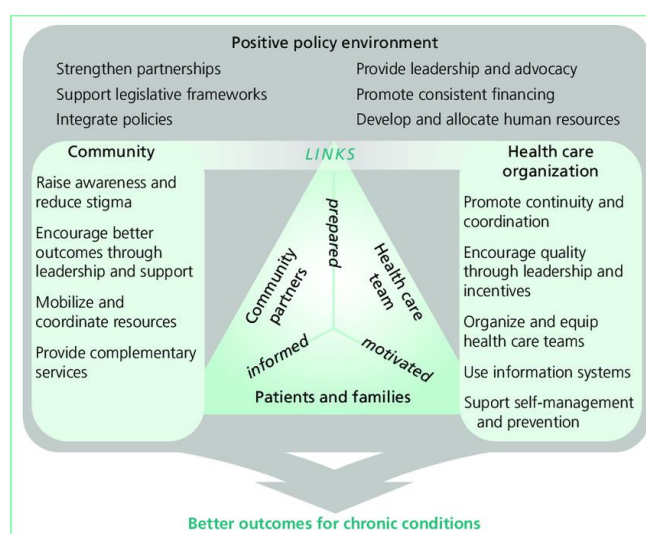
Growing evidence from around the world suggests that when patients receive effective treatments, self-management support and regular follow-up, they do better. Evidence also suggests that organized systems of care, not just individual healthcare workers, are essential in producing positive outcomes.

The World Health Organisation (WHO) was responsible for launching a project on *Innovative Care for Chronic Conditions (ICCC)*<sup>6</sup> in order to improve health care for chronic conditions. The management of all chronic conditions- non-communicable diseases, long-term mental disorders and certain communicable diseases, like HIV, are one of the greatest challenges facing healthcare systems worldwide. The ICCC is an important theoretical framework designed by the WHO to prepare policymakers, health-service planners and other relevant parties to take action that will reduce the threats chronic conditions pose to the health of citizens, the healthcare systems and the economy.

The ICCC framework acknowledges the broader policy environment that envelopes clients and their families, healthcare organisations, and communities. In addition, the framework recognises the role that decision makers and other leaders in healthcare play in initiating and influencing changes in health systems. The ICCC framework is based on a set of guiding principles: evidence-based decision making, population focus, prevention focus, quality focus, integration, and flexibility/adaptability, thereby accommodating changes within the system while remaining robust in dealing with constantly changing demands. These principles are in line with the vision of HealthCare 2030 and can also be useful when considering environment needed for an effective counselling strategy.<sup>6</sup>

The figure below demonstrates how the ICCC framework identified building blocks that can be integrated across the health system: micro level (client interaction level), meso level (community level and the healthcare organisation) and macro level (policy environment).

**Figure 5: ICCC Framework<sup>6</sup>**



Building blocks of the ICCC include the micro level, meso levels and macro level that are discussed in more detail in the sections below.

### **6.1.1 Micro level: Client interaction**

Central to the ICCC is the partnership between clients, families, communities and health organisations. The key building blocks at micro-level focus on prepared, informed and motivated clients and families, communities, and health organisations. According to the WHO (2002), this entails that clients and families be educated on their illness, signs and symptoms, be motivated to change their behaviours such as poor adherence and substance use, and be equipped with the necessary life skills such as self-management and self-monitoring required to change their behaviour. In terms of the healthcare teams, they should move away from purely biomedical approaches and work towards better interdisciplinary collaboration with clearly identified roles and responsibilities, while communities need to be prepared with the relevant information and resources to support clients effectively.<sup>6</sup>

### **6.1.2 Meso level: Healthcare organisation**

According to the ICCC framework, healthcare organisations have the potential to create the environment in which people can flourish.<sup>6</sup>The first building block for the health-care organisation is promoting continuity of care and coordination across all levels of care through improved communication across levels, as well as improved interdisciplinary collaboration as opposed to biomedically driven interventions. The second building block for the healthcare organisation is quality of care through effective leadership, with senior leaders in the health system buying into the required changes and lending support to the facilitation of the needed changes, as well as accelerating a shift in organisational culture. Ongoing monitoring and evaluation as well as quality improvement strategies are imperative to ensuring quality of care. The third building block for healthcare organisations is to organise and equip healthcare teams with the necessary resources, knowledge and skills to provide optimal care that transcends biomedical training, by including behavioural training. Effective communication skills which allow team members to work cooperatively and not in silos are essential. The fourth building block for healthcare organisations is to support self-management and prevention by informing clients and families regarding effective self-management strategies and to offer effective support in conjunction with education provided. The final building block for healthcare organisations is to use information systems to gather and organise data on treatment and health outcomes which can assist in improving planning and the standard of care.

### **6.1.3 Meso level: Community**

According to the ICCC framework, community resources are vital in filling important gaps in the service and complementing health services. The first building block for the community, raising awareness and reducing stigma, is important at community level. NPOs and leaders of international and local organisations all have a role to play in raising awareness and reducing stigma.<sup>6</sup>The second building block described by WHO (2002) is to encourage better outcomes through identifying leaders and recognised structures such as community health boards and faith-based groups that can align and support policies and practices. The third building block is to mobilise and coordinate resources by way of health prevention and promotion campaigns, assist in addressing risk factors, train and upskill community health workers, and liaise with sufficient resources in the community.<sup>6</sup>The fourth building block is to provide complementary services through partnering with relevant organisations to assist with education and self-management support in the community.

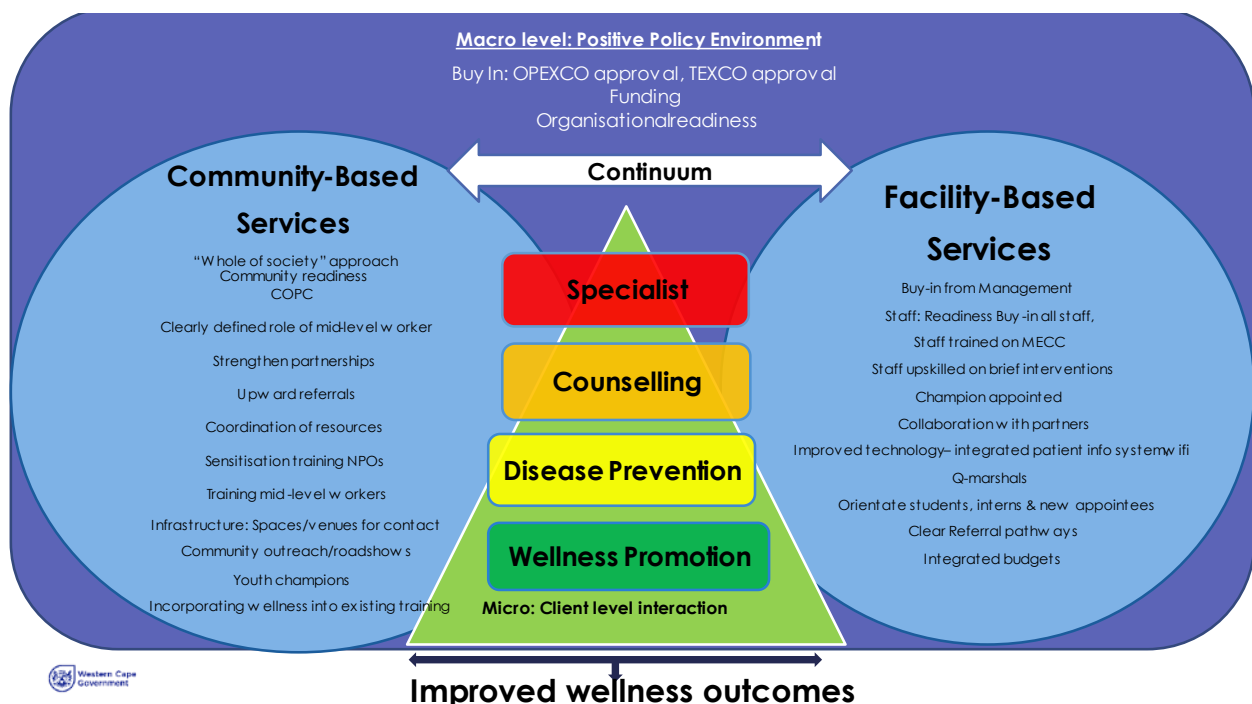
#### 6.1.4 Macro level: Positive policy environment

The first building block for a positive policy environment is providing leadership and advocacy. The ICCC framework recognises the role that decision makers and political leaders play in facilitating and creating awareness around policy changes in the health system. The second building block is to promote consistent financing as a means of ensuring and encouraging the implementation of innovative care strategies. The third building block is to develop and allocate human resources, and the fourth building block for a positive policy environment is the integration of policies to ensure minimal redundancies and fragmentation of policies as well as ensuring client-centred policies that cut across boundaries.

## 6.2 Applying ICCC to the Western Cape context: The Integrated Counselling Framework

As outlined in the ICCC framework, a comprehensive strategy for behaviour change needs a supportive environment and empowers people to gain more control over their health through making healthier lifestyle choices. The integrated counselling strategy framework for the province, **like the ICCC**, focuses on 4 levels that form building blocks to improved health and wellness in the province: the micro level (client interaction level), meso levels (healthcare organisation and community) and macro level (positive policy environment), See Figure 6.

Figure 6: Integrated Counselling- Framework



#### 6.2.1 Micro level Interaction: MECC

The efficacy of integrated behavioural counselling model relies on the partnership between clients, families, communities and health organisations. The key building blocks at micro-level focus on prepared, informed and motivated clients and families, communities, and health organisations. By implementing the tiered counselling model, it would entail that clients and families be educated on their illness, signs and symptoms, be motivated to change their behaviours and be equipped with the necessary life skills such as self-management and self-

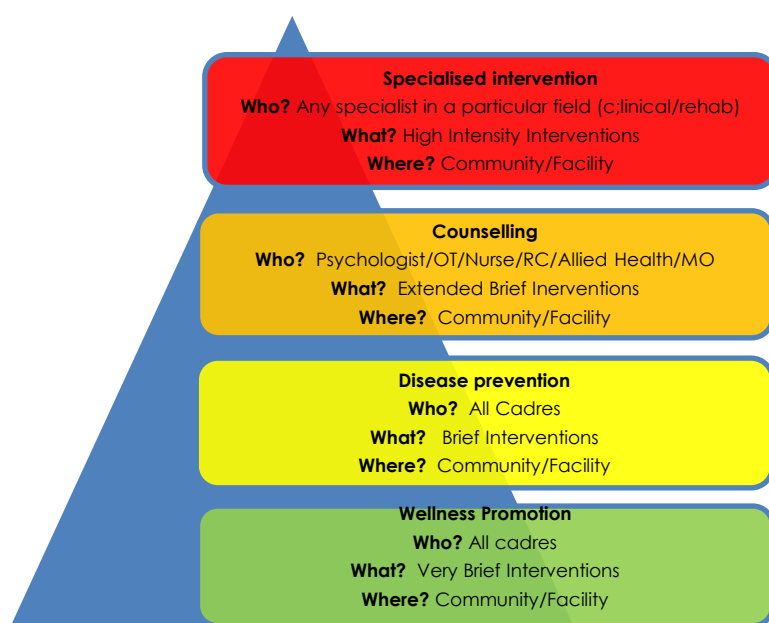
monitoring required to change their behaviour. In terms of the healthcare teams, they should move away from purely curative approaches and work towards person centred care. In this strategy framework, the revised tiered counselling model and MECC are integrated into the micro level (client interaction).

Using the principles of MECC, interventions should look for opportunities to engage with clients regarding their behaviour. The tiered counselling model looks at four aspects of counselling namely Wellness Promotion, Disease Prevention, Rehabilitation and Specialised care. Proposed intervention in the micro level is to “Make Every Contact Count (MECC)”. MECC helps organisations build a culture and environment that supports and facilitates continuous health improvement through each contact with people entering the health system. This Model has been developed to assist all health facilities that are responsible for well-being, care and safety of the public to implement and deliver positive health messages to encourage the population to make better health behaviour choices. The department therefore aims to align the tiered model to the MECC approach, by defining the level of counselling interventions in the model to that of the MECC.

It is envisaged that using this strategy will improve health and well-being among service users and staff as well as the general public to reduce health inequalities through enabling the understanding of the impact of social determinants on an individual's health and well-being. Implementation of this model will however require three essential components namely: **organisational readiness** (organisational development and support is critical for staff to implement MECC), **staff readiness** (staff need to be competent and confident in the ability to support lifestyle improvement should the opportunity arise) and **an enabling and empowering environment** (accessibility and usability of appropriate information to support the public to engage in lifestyle improvement opportunities).

### 6.2.1.1 Make Every Contact Count: Supporting Self-Management through Healthy Conversations

Figure 7: Revised tiered counselling model



The counselling service is intended to provide interventions that address personal health practices and underlying psychosocial problems across the wellness continuum. The counselling service model adopts a tiered approach as shown in figure 7. The first two tiers can be provided by all cadres of staff and can take place at community level as well as facility level. Tiers three and four require a more specialised intervention requiring clinical expertise. Each tier is explained in more detail below.

#### Tier 1: Wellness promotion

Wellness promotion refers to the process of enabling people to increase control over, and to improve, their health. It has a preventive and promotive role. It entails health Education, counselling and support on self-management for all health conditions as well as referring appropriately. Additionally, it includes screening all clients who enter the health system for mental health and social issues to identify psychosocial problems. It emphasizes the patient's central role and includes activities such as encouraging change, signposting to further supporting agencies, raising awareness, health education, treatment literacy, basic screening and referring, treatment literacy and treatment adherence counselling. **Wellness promotion uses a “Ask, advise and assist” approach.**

Training implications would be to equip all health care providers with the skills such as BMI and Behaviour Change to effect self-management support strategies that include assessment, goalsetting, action planning, problem-solving, and follow-up.

#### Tier 2: Disease prevention

Disease prevention can be defined as the prevention of clinical illness through early and asymptomatic detection and remediation of certain diseases and conditions that, if left undetected, would become clinically apparent and harmful. It entails the provision of short-term education to increase healthy behaviour and protect and promote psychological wellbeing. Activities include performing basic screening for diseases, psychological screening, primary mental status screening, providing information, encouraging healthy lifestyles and referral and management strategies. It requires staff to be knowledgeable on programmes or projects being run in the facility and/or community so that informed and appropriate referrals can take place. Address ongoing psychological and social needs of individuals and families. This includes support groups. Disease prevention uses a **“Ask, assess, advise and assist”** approach and can also be done through motivational interviewing, negotiation or encouragement and healthy conversations.


#### Tier 3: Counselling

Counselling takes place at facility level and patients are assessed, diagnosed and treated. It involves the prevention of disease progression and additional complications after clinical illnesses, or an acute episode or injury have manifested. It would consist of extended brief interventions such as problem-solving therapy. Counselling also plays a role in the promotion of healthy behaviour, preventing diseases and improving a patient's quality of life. It is performed by trained healthcare professionals like mental health nurses, clinical nurse practitioners, allied health, medical officers, registered counsellors and psychologists.

There are various levels of counselling as described in the table below. The registered counsellor is the first line counsellor and is responsible for containment and short-term counselling (up to 6 sessions). The psychologist would be responsible for therapeutic counselling which includes psychotherapy. And then context specific counselling would be conducted by any health

professional i.e. doctor, nurse, allied health professional to manage the counselling needs of the patient within a particular context and as per their specific needs.

**Table 1: Self-management support and treatment literacy vs counselling**  
Self-management support and treatment literacy vs. counselling

Self-management support and treatment literacy	Counselling	Healthy Conversations
<ul style="list-style-type: none"> <li>• Education (providing information)</li> <li>• Translating medical information into understandable language and formats</li> <li>• Offer support and ideas for adhering to treatment</li> <li>• Emphasise the importance of being proactive and making healthy lifestyle choices</li> <li>• Encourage clients to take responsibility for their own health</li> <li>• Provided by <b>the mid-level worker</b></li> </ul>	<ul style="list-style-type: none"> <li>• Provide client with strategies to deal with their condition</li> <li>• Facilitate behaviour change</li> <li>• Facilitate problem solving</li> </ul> <p>First line counsellors = <b>Registered Counsellors</b> : provide short-term counselling</p> <p>Therapeutic counselling: <b>Psychologists</b></p> <p>Context specific counselling: <b>Allied Health Professionals, Doctors, Nurses etc</b></p>	<p>Healthy conversations is a non-judgemental form of communicating, to support an individual to make a positive change to their behaviour. A healthy conversation means we are delivering more than a message, we are inviting the other person into the conversation with us.</p> <p><b>ALL Staff cadres</b></p> <div>  </div>



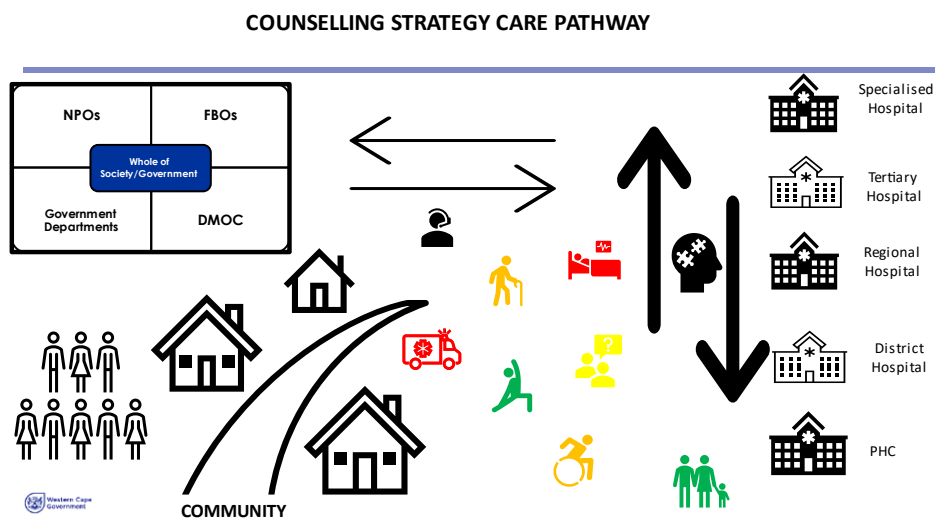
#### Tier 4: Specialised intervention

Specialised intervention is a short-term intense intervention based on the client's medical condition and/or mental health state as well as the clinician's scope of practice. It entails the provision of accessible information on the relevant conditions, treatment options, medication and crisis management. It also aims to medically stabilise patients and address poor health seeking behaviour that stems from deeper psychological problems. Specialised care takes place mainly at facility level. It enriches the branch of healthcare that is normally focused on diagnosis and medical treatment. It is a high intensity intervention conducted by specialist health care providers within a particular context.

The counselling model is not intended to replace any other duty of a particular staff member. Instead, it is envisaged that through adopting this approach the therapeutic interaction between patient and clinician will be enhanced. For the purpose of this strategy, counselling and specialised interventions should not be part of a community health worker's role. Counselling is, however, facilitated by a registered health care practitioner **ALL Health Care Providers**, need to be able to counsel patients at any point of contact by making use of **Brief interventions** (e.g., brief motivational interviewing).

### 6.2.1.1 Care pathway

**Figure 8: Counselling strategy care pathway**



Above proposes a care pathway that seeks to encourage preventive and promotive services rather than a curative bias. In the long run this approach should result in less patient visits and make more staff available for other services. Timeous referrals/nudges will assist patients in self-management in that counselling services will compliment management of chronic disease – psycho-social support will have greater meaning in the system. Staff at the bottom of this hierarchy do not have to be lay workers and mid-level workers but must be well-versed in conducting healthy conversations and ways of nudging patients when they require other services. We should, however, not necessarily assume that the patient will present themselves to the nurse in facility or the CHW in community first. Patients can enter the system at any level, they could enter directly at the point of service delivery.

The proposed care pathway makes provision for the patient to enter the service via various options either in the community or at facility level. Upward, downward, and diagonal referrals can be made depending on the patient's first point of entry into the system. If a counselling need has been identified in the community by a CHW a referral can be made directly to the facility where the appropriate cadre of staff will be identified. As this reference document is developed further, the community approach will need to consider outreaches, wellness centres, COPC spaces etc.

### 6.2.2 Facility- Based Services

In order to support the micro level interaction, there first needs to be buy-in from senior leaders and management as well as collaboration with partners. Identifying champions for implementation is also beneficial. Thereafter the focus can move to the sensitisation of staff, all staff will have to be informed of the MECC approach and all staff will need to be trained on MECC and brief behavioural interventions. It is important that all students, interns and new appointees should be trained on the counselling strategy as part of their orientation. A clear referral pathway should also be established across all levels of care to ensure effective continuity of care throughout the health system. It is also essential for healthcare organisations to use information systems to gather and organise data on treatment and health outcomes which can assist in improving planning and the standard of care.

### 6.2.3 Community-Based Services

It is important for the WCGH to have strong partnerships with community-based organisations. This will help to strengthen the “Whole of Society” and “Whole of Government” approaches to health and wellbeing. The core of the primary health care (PHC) platform will still be grounded in the COPC approach. With this comes the amendment of the NPO service packages and the training offered to NPOs. It is important to clearly define the roles of the mid-level workers and then upskill CHWs and lay counsellors. Wellness promotion should be incorporated into the existing training received by these staff. Mid-level workers need to be informed on appropriate upward referral pathways. Thus, sensitisation of NPOs and all relevant partners on the integrated counselling strategy, with a particular focus on the MECC approach would be essential in ensuring community readiness through informing and empowering all stakeholders.

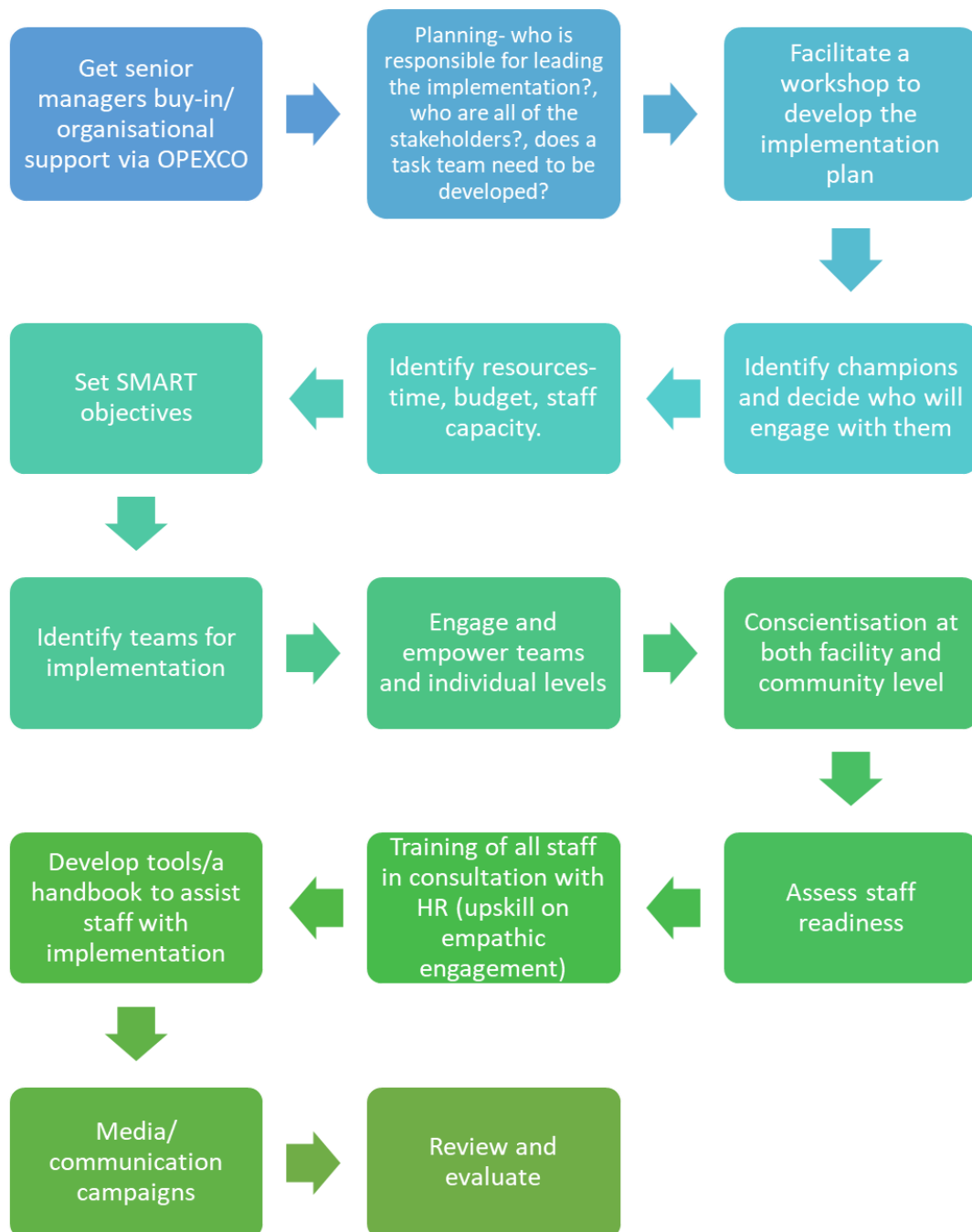
Resources and infrastructure will also play a vital role in filling gaps and supporting the counselling strategy. Venues or appropriate spaces for contact with community members are essential, whilst community outreaches and roadshows can also be effective.

### 6.2.4 Macro level: Positive policy environment

**Organisational readiness** is imperative for the successful implementation of the Integrated Counselling Strategy. Therefore, successful implementation of the Western Cape Counselling Strategy, is reliant on approval from both OPEXCO and TEXCO. In addition, **buy in from both Metro and Rural Health Services** is necessary. Secondly, adequate funding will have to be allocated to the rollout and implementation of the strategy/model.

The MECC approach is not supposed to add an additional burden onto already busy healthcare workers, however, **additional registered counsellor posts** will strengthen the human resources required for implementing this intervention at facility level.

## 7. Proposed implementation process



## 8. References

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**Western Cape Government Health**

**Chief Directorate: Emergency and Clinical Services Support**

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