“It’s one less thing I have to do”

DOES REFERRING PATIENTS TO A CO-LOCATED PSYCHOLOGY SERVICE IMPACT ON THE WELL-BEING OF PRIMARY CARE HEALTH PROVIDERS?

A thesis presented in partial fulfilment of the requirements for the degree of Master of Science in Psychology at Massey University.

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Abstract

The aim of this research was to investigate if the impact of a co-located psychological service as a resource for Primary Care Providers to refer patients with mild to moderate mental health needs, would impact on the well-being of the providers at work. Mental health services in New Zealand are under constant strain, recently acknowledged by the Government's injection of millions of dollars into those services. Innovative approaches are needed to reduce the burden on primary and secondary care settings, and to improve access to timely psychological support for those in the community who need help.

Focused Acceptance and Commitment Therapy is a brief and timely intervention that focuses the patient on the "here and now" issue. FACT services are delivered by Psychologists working in a clinic located in a large primary care practice in the lower North Island. Participants in this study were recruited from this primary care practice who had recently introduced co-located psychology services. Participants were General Practitioners, Nurse Practitioners and Registered Nurses who referred patients to the FACT service. Data was analysed using thematic analysis following 15 minute interviews with each of the participants. The main findings were that participants reported that the increase in resources (i.e. the FACT service) decreased demands on participants and increased their well-being at work. Analysis also identified three realistic changes: longer consultation / follow up times; reduced paperwork; and increased staffing, which may reduce the demands on participants and support their wellbeing:

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Chapter One: Introduction

Mental health care in New Zealand has reached a crisis point with primary, community and secondary services no longer being able to provide timely support to the number of patients who are presenting for help. The New Zealand Ministry of Health estimates 17% of the New Zealand population has mild to moderate mental health and /or addiction issues at any one time (Ministry of Health, 2020b). Most people with mental health issues will present to a Primary Care Provider, in the first instance. This puts the Primary Care Provider in the unique position of being able to recognise and treat problems at an early stage (Adler et al, 2015). The high number of people presenting initially to primary care with mental health issues makes primary care an ideal place to integrate mental health services.

Support for this concept is evidenced by the Government Inquiry into Mental Health and Addiction that was announced in early 2018. The report, *He Ara Oranga,* was presented to the Minister of Health in December 2018. A clear and strong recommendation from the *He Ara Oranga* report was the need for greater primary care involvement in mental health and wellbeing and the provision of training and resources to support this (Ministry of Health, 2018).

However, Primary Care providers are feeling the burden of not being able to meet the mental health needs of the population (Ministry of Health, 2019b). In the Medical Workforce Survey 2018 published by the Medical Council of New Zealand, MidCentral District Health Board was reported to have 3.7% of the national population but only 2.5% of the proportion of General Practitioners working in New Zealand (Medical Council of New Zealand, 2018). This on-going and increasing pressure can have negative effects on the well-being of Primary Care Health Professionals (Hall, Johnson, Watt, & O'Connor, 2019).

Integrating mental health into primary care

In order to help address this burden the New Zealand government is injecting millions of dollars into health care to extend the provision of mental health services at the primary and community care levels, with the intent that services will be provided by counsellors, psychologists, health coaches and health improvement practitioners (New Zealand Government, 2019). In his public address providing details for additional mental health positions the Minister of Health, Rt Hon David Clark said that the concept is for people to have confidence and the ability to identify and talk with people in need, leading to earlier intervention and help (Clark, 2019). These positions should support people with mild to moderate mental health needs. This effectively places mental health services within primary care, and, where possible, within the same location.

Primary health care in New Zealand is following the path of other Western countries with the consolidation of medical practices and the development of community health hubs. This consolidation sees a variety of services being offered from one location such as primary care, radiology, audiology, maternity, physiotherapy and psychological support (Gupta & Denton, 2008). The impetus for such a redesign in primary care health services comes from a need to reduce health costs and improve the experience of the patient (Scott et al, 2017). Given that the primary care setting is usually the first point of contact for people with physical and psychological concerns it is a good point at which to provide co-located services (Lamm, Stone, & Rebon, 2020). This effectively becomes a 'one-stop' shop for patients who may need wrap-around services and who can access these within one location.

Kates et al. (2018), acknowledge that collaborative activities have different meanings in different circumstances and it is therefore important to be clear on definitions. Collaborative care sees professionals working as separate entities who communicate regarding common patients. Integrated care has professionals working together, including sharing resources, for all patients within the practice. Inter-professional care sees a communal approach to treatment planning and goal setting with each professional having an equal role in the care of the patient. Examining professional communication, Mundt and Zakletskaia (2019), identified a link between professional communication and job satisfaction which indicates that a collaborative approach could be benefical in terms of well-being for health professionals. Collaborative care is the focus of the current study.

Kroenke and Unutzer (2016), offer a definition of collaborative care as one where "patients perceive that they are getting a separate service from a specialist, albeit one who works closely with their physician" (p. 406) thereby assuming a 'linked up' service. Although the provision of services appears seamless to the patient, behind the scenes there is definite demarcation of services visible to the service providers. In the mental health context Kates et al. (2018), define collaborative care as a "process whereby primary care and mental health providers share resources, expertise, knowledge and decision-making" (p. 3) while Oyama (2016), notes that each provider has their own site and systems but explicitly communicates about the shared client. In the qualitative study by Waring and Bishop (2010), they found that professionals defined collaboration as an essential opportunity to strategize however a lot of this was undertaken spontaneously, such as "water cooler" conversations, providing a less formalised form of collaboration. Effectively this means informal and undocumented conversations exist between providers about the care and welfare of a shared client. The ability to have these 'water cooler' conversations was noted by Waring and Bishop (2010), as an opportunity to

build trust and to share experiences, which also feeds into the well-being of the health care provider. It is noted however, that collaborative care can be provided outside of a co-located setting.

There are numerous studies that examine the role of mental health services in collaboration with primary care however these studies generally focus on the benefits and barriers from the patients' perspective. There is little research looking at the well-being and experience of Primary Care Health Providers where mental health services are collaboratively provided, allowing patients to be seen in a timely manner.

The current study seeks to understand whether a collaborative working relationship is seen to provide a perceived increase in job resources for Primary Health Providers, which could have a positive effect on well-being and staff retention. It also looks at other opportunities to make realistic changes that may impact on the workload of practitioners and could positively impact on well-being.

Benefits and Barriers to co-locating mental health services with Primary Care

The MaGPIe Research Group (2003), indicated there was debate about the effectiveness of mental health services being managed in the primary care setting from a provider perspective. Since then Blount (2019), reported that physicians indicated greater job satisfaction where patients' needs were being met, even if it wasn't by themselves. Burnout rates were reduced when there was a "behavioural specialist[s]" (p. 34) on staff. Similarly De Marchis et al. (2019), found that where a physician perceived a patient's social needs were able to be met, the physicians were less likely to report burnout. While social needs were not defined the research addressed social determinants of health (low income, poor education, unemployment,

inadequate housing) and it is noted those patients affected by social determinants of health are more likely to exhibit mental health concerns (Kung et al., 2019).

In summary, research is clear that there are benefits to collaborating with co-located psychology services within primary care for the patient however there is little research that identifies improvement to the well-being of primary care providers.

Structure of the Current Thesis

Chapter one describes the current provision of primary care in New Zealand and the role of mental health services within primary care. Chapter two reviews literature on psychological therapies that could be provided in primary care and how an ultra-brief therapy has been selected as the most appropriate service for psychologists to deliver out of a large primary care practice in the lower North Island. Chapter three will look at General Practitioner well-being in the workplace and the impact of job demands and resources on well-being. Following this the primary research aims of the current study with methods will be outlined in Chapter four. Finally, Chapter five will discuss the findings and main results, comparing to existing literature, together with limitations of the study and areas for future research.

Chapter Two: Literature Review

Primary Care and Mental Health Care in New Zealand

During the 1930s the New Zealand Labour Government set up a comprehensive national health service with the intention of providing universal free access to health care for all through General Practitioners, hospitals and maternity care (Gauld, 2013). However, a totally free system was never realized and a dual system of public and private health care developed.

Twenty District Health Boards (DHBs) in New Zealand are responsible for providing health care in their regions. They fund primary care health services through Primary Health Organisations (PHOs). These Primary Health Organisations are in turn responsible for ensuring the provision of many primary care services including services in the community and services provided by General Practitioners. Primary care services are largely run as businesses with services provided by General Practitioners. General Practitioners are commonly the first point of contact in non-emergency situations. The businesses set their own fees for consultation with the government subsidising that fee and patients[1] being liable for the balance.

The doctor-led model of primary care generally sees a patient phone the practice for an appointment, and then present to see a doctor at their enrolled practice at some stage, although anecdotally it is noted that this could be many days later. The traditional doctor-led clinic has a doctor-practice nurse ratio of approximately 1:1, (Adams & Carryer, 2019), with a doctor-

[1] It is recognized that health care providers use the word *patients* when describing people using their services. Psychologists, Counsellors and Behavioural Health Practitioners use the word *clients*. For the purpose of this research, the word *patient* will primarily be used.

patient ratio of 1:1200 (Wells, 2018). Alternatively, patients can attend an urgent care primary health clinic and receive same day treatment however this is unlikely be with their regular General Practitioner and may potentially cost more if the clinic is not at the patient's enrolled practice. Many patients are presenting to hospital emergency departments as an alternative (Butun, Linden, Lynn, & McGaughey, 2019; Weber, Hirst, & March, 2017). This is an alternative as secondary care is free to access in New Zealand for residents.

The New Zealand health service is currently facing a crisis in its ability to care for people who are facing mental health and addiction issues. There are a number of social determinants that are factors in poor mental health including sub-standard housing, unemployment or low paid work, family violence, loneliness and social isolation (Alegria, Ne Moyer, Falgas Bague, Wang, & Alvarez, 2018; Cunningham et al., 2018). For Māori, cultural discrimination, colonisation and the intergenerational effects of these have had additional impacts on mental wellbeing (Paterson et al., 2018; Reid, Varona, Fisher, & Smith, 2016). For the rainbow community (LGBTQI+) poor mental health is the result of stress caused by stigma, violence and discrimination (Fraser, 2019).

People may avoid attending general practice services even when required for a range of reasons: the stigma associated with having mental health needs; fear of the unknown; lack of money; lack of transport, and other reasons. Any of these circumstances may influence a person's ability to seek medical help (Elers, Te Tau, Dutta, Elers, & Jayan, 2020; Jatrana & Crompton, 2009). This can lead to more serious health issues in the future (Wilson, Bushnell, & Caputi, 2011).

Pressure on Primary Care Providers

Two significant barriers are identified as having a significant impact on General Practitioners' well-being: shortage of General Practitioners and time constraints in patient consultations (Hall, Johnson, Watt, & O'Connor, 2019; Murray, Murray, & Donnelly, 2016).

The current crisis in General Practitioner numbers is two-fold. Firstly it is recognized that there is a lack of medical students selecting general practice as a career choice (Parker, Hudson, & Wilkinson, 2014; Verstappen, Webster, Rudland, Wilkinson, & Poole, 2019), which together with an anticipated population increase (Statistics New Zealand, 2020), will have a negative impact on general practices. The crisis is also being fueled by an anticipated 'wave' of retirements of older doctors, with 47% of the 5000 - strong workforce indicating they will retire within the next decade (Chisholm, 2019).

In order to help address this concern New Zealand introduced the role of Nurse Practitioners to the healthcare workforce. Nurse Practitioners work to a different scope to that of a registered nurse and their role includes treatment, issuing prescriptions and ordering laboratory and diagnostic tests (Ministry of Health, 2019). Adams and Carryer (2019), found that in order to address the General Practitioner crisis it is necessary to develop and progress the roles of Nurse Practitioners at a national level however the establishment of the Nurse Practitioner workforce has been slow to be adopted in New Zealand (Adams, Boyd, Varryer, Bareham, & Tenbensel, 2020).

Increasingly General Practitioners and Nurse Practitioners are expected to perform their duties with additional demands placed on them such as time constraints, the inability to provide timely

additional services, consumer-driven demands and clinical complexity (Murray, Murray, & Donnelly, 2016).

A major source of stress for the General Practitioner in the primary care setting is the time constraints placed on patient consultations (Von dem Knesebeck, Koens, Marx, & Scherer, 2019). Scheduled General Practitioner appointments are generally for 15 minutes (Health Navigator New Zealand, 2020), and Gupta and Denton (2008), found that the majority of patients concerns can be dealt with within that time. However, it is widely accepted that appointments with General Practitioners may be delayed leaving providers running behind schedule with Torres, Jarillo Soro, & Casas Patino (2018), noting that the complexities of mental health needs have the ability to push times out.

Deveugele, Derese, van den Brink-Muinen, Bensing, & De Maeseneer (2002), compared primary care consultation times across six European countries and found the average consultation time with a General Practitioner was 10.7 minutes. Barratt and Thomas (2019), concluded that Nurse Practitioner consultations were similar with an average of 10.1 minutes for a consultation. It is noted however that after the consultation the Practitioner then needs to undertake additional tasks such as writing up notes, making referrals, ordering tests and consulting with colleagues. It has been identified that consultations that had a psychosocial or behavioral aspect to them were longer than those primarily focused on biomedical issues (Deveugele et al., 2002; Pollock & Grime, 2003; Torres et al., 2018). These consultations may require more time as most patients present with a physical complaint and the subsequent interaction between the patient and practitioner elicits the mental health issue (Torres et al., 2018; Anjara et al., 2019).

In their research on General Practitioner coping and resilience Cheshire et al. (2017), found that General Practitioners regarded ten minute consultations as inadequate, they generally exceeded this time, and this resulted in them not being able to take sufficient work breaks. Due to the longer length of consultations for mental health issues, this suggests that these issues should be referred on wherever there is a more appropriate place for mental health issues to be addressed. While not all primary care appointments run late due to patients with mental health issues, it is a component and addressing the issue may have positive outcomes for the patient, provider and practice (Dew, Dowell, McLeod, Collings, & Bushnell, 2005).

Definition and prevalence of mild to moderate mental health problems

The World Health Organization (WHO) defines mental health as a "state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community" (World Health Organization, 2005, p. 12).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the primary classification scheme used to identify mental disorders that are manifested with behavioural, biological, cognitive, emotional, intrapersonal or social features. It also includes a general category that refers to issues related to symptoms of mental disorders which cause distress in life, such as unemployment or negative social interactions (Salem Press Encyclopedia of Health, 2020).

The most common mental disorders both in New Zealand and internationally are depression, anxiety, stress, alcohol and substance abuse and eating disorders (New Zealand Guidelines Group, 2008). The prevalence of mental disorders in New Zealand has been found to be around 17% of the population at any one time (MaGPIe Research Group, 2003; Wells, 2006).

However, a subsequent study by Moffitt et al. (2010), identified that the retrospective prevalence of lifetime common mental disorders may be as high as 57%. The lifetime prevalence of anxiety disorders is estimated at 25% and mood disorders at 20% (Lockett, Lai, Tuason, Jury, & Fergusson, 2018). The prevalence of mental health disorders of anxiety, mood and substance misuse were higher in Māori women (33%) and Māori men (25%) than non-Māori groups (Baxter, 2010; Kopua, Kopua, & Bracken, 2020; Rangihuna, Kopua, & Tipene-Leach, 2018). This confirms a high need for affordable, timely and brief support for those experiencing mental illness.

What does mental health look like in New Zealand at the moment?

Mental health services are provided in a 'stepped approach' allowing a person to step in and out of services (and up and down levels) as they need. The majority of funding for mental health services is allocated to the 20 District Health Boards who in turn contract or provide a range of services through primary care, community organisations, and in-patient (hospital-based) services (Allan, 2018).

The number of people in New Zealand accessing services for mental health needs is increasing with Allan (2018), identifying a 73% increase in access to services in the decade 2006/07 to 2016/17, a figure that is consistent with international trends (Ministry of Health, 2019b). The increase is due to a number of factors such as population growth; improved reporting capabilities of service providers; growing social awareness and increasingly open discussions on mental health issues (Ministry of Health, 2019b), in additional to social determinants of health (Alegria et al., 2018; Cunningham et al., 2018). All of this has placed pressure on services which provide support and help (Cunningham et al., 2018).

Primary Care

The usual first point of contact for support for mental health is the General Practitioner in primary care (Bindman, Forrest, Britt, Crampton, & Majeed, 2007; Kates et al., 2018). Depending on the nature of the disorder the provider may prescribe medication, or refer for counselling or psychological or psychiatric support. They may also provide emotional support and advice on sleep and exercise or any combination of these.

In 2005 the New Zealand Ministry of Health provided a mental health funding model for service delivery models that were different across the country in order to meet differing needs. The intention was for the funding to target priority groups who had a higher prevalence of mild to moderate mental health and addiction problems (Lockett et al., 2018). These priority groups were Māori, youth and those in low socioeconomic situations. Unfortunately, the reality has not met the aspiration. Lockett et al. (2018), found that patients with mild to moderate mental health needs were less likely to get timely access to primary health care, were less likely to have access to transport to attend appointments and were less likely to be able to meet the cost of attending the doctor or collecting prescription items then those patients without mental health issues. This has resulted in priority groups missing out on the services that were specifically designed to be beneficial to them.

Research into mild to moderate mental health conditions such as depression has found that patients' issues were often medicalized due to time constraints on practitioners (Chew-Graham, Mullin, May, Hedley, & Cole, 2002), or patients' inability to pay for 'talk' therapy sessions. Access to counselling is severely limited for those without the means to pay a private provider (Dew et al., 2005). Medications such as anti-depressants are subsidized by the Government in

New Zealand whereas access to counselling is not, therefore patients were often offered medical solutions rather than psychological ones.

Poghosyan et al. (2019), explored primary care providers' perspectives on delivering mental health services in primary care and noted that a lack of time undermined the delivery of mental health services, with priority being given to physical ailments. Faced with time constraints, primary care providers found mental health concerns are often not addressed in favour of physical illnesses (Dew et al., 2005). Kates et al. (2018), found that whilst 'first contact' providers' (p. 1) were able to provide mental health support, many were either not well-trained or well supported to recognise and treat mental health problems. The later research of Poghosyan et al. (2019) concurred. Kates et al. (2018), also identified that mental health issues were not identified in a significant portion of patients presenting to primary care. In addition to time constraints the lack of identification of mental health issues could be due to a lack of confidence by the clinician in identifying and addressing psychological issues (Sadock, Perrin, Grinnell, Rybarczyk, & Auerbach, 2017).

Primary care providers are the gatekeepers to other service providers (such as secondary and community care) by coordinating and managing access through referrals (Bindman et al., 2007; Gupta & Denton, 2008). The majority of mental health services in New Zealand are provided by psychologists, psychiatrists or counsellors[2] in primary and private care, and in secondary care the majority of services are provided by mental health nurses and social workers. The

[2] There is a growing body of literature that is referring to counsellors as behavioural health specialists, health improvement practitioners, or health coaches as another job title. For this research these terms are used to indicate any profession that provides mental health support in NZ.

ability to provide assistance to these patients in a primary care setting could potentially free up some resources in the secondary service for those with more significant needs although it is noted that there is a finite number of mental health professionals.

Secondary Care

Secondary mental health services in New Zealand are funded by the Ministry of Health through District Health Boards to provide support to those with severe mental illnesses. The majority of referrals to secondary care mental health services comes from primary care. According to the New Zealand Guidelines Group (2008), where an urgent referral is made to secondary care the person should be seen within seven to ten days, or sooner if services are available. Immediate referral can be made where there is "serious suicidal intent, psychotic symptoms or severe self-neglect" (p. xvi). The use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 sees around 10,000 people per year compulsorily admitted to secondary services (Ministry of Health, 2018). There is variation across District Health Boards in waiting times for secondary mental health services and variation in the ability to access these services (Ministry of Health, 2012). The secondary services workforce is recognized as being overwhelmed (Ministry of Health, 2018) by both the number of referrals into the system and the lack of providers to deal with those referrals (Glover et al., 2016).

Community and Private Care

Help and support are available in the community with non-government organisations and private businesses offering services such as counselling, crisis support, respite care, drop-in centres, phone and text support. The He Ara Oranga report identified that those services are important to both clients and current providers across the continuum of care (Ministry of Health, 2018).

Who is missing out on mental health services through primary care?

Youth, the elderly and Maori are populations who are at high risk of missing out on mental health services particularly where social isolation is a factor in their lives (Calati et al., 2019; Hammig, 2019). Youth are more likely to experience suicidal thoughts, self-harm and report bullying than any other population group (Cunningham, 2018).

Youth are identified as missing out on services because of their age. Ministry of Health (2012), identified "a lack of awareness, reluctance to seek help and under-treatment" (p 40) of youth. Biddle, Donovan, Gunnell, and Sharp (2006), identified that 16 – 24 year olds did not recognise primary care as the place to receive help for mental health. It is noted that the Biddle et al. (2006), cohort was small and further research into help seeking behaviours could identify if this could be generalized across the population.

Currently if a young person requires mental health support and they present to a practice, if they are not deemed as in need of urgent or immediate care they are referred to secondary or community services (New Zealand Guidelines Group, 2008) with very limited immediate support being available. This time delay may see the youth not re-present for the follow-up appointment. Additionally cost may be a barrier to accessing community services.

Whilst common mental health disorders decline as aging occurs, there is a correlation between medical and physical health problems which can manifest as age-related conditions and a need for psychological support to attend to these conditions (Suls, Green, & Boyd, 2019). New Zealand has an aging population, many people are living longer with comorbidities, and age-related conditions such as dementia are becoming significant. Patients who live in residential

aged care facilities may miss out on psychological services due to an inability to attend a primary care practice due to lack of money for a taxi, inability to use public transport, or lack of a driver's license. They may also not recognise that there are services available for them. Mental health concerns can lead to frailty, disability and an earlier death if left untreated (Amare et al., 2020).

Māori

The He Ara Oranga report (2019) identified that a Western approach to mental health for Māori was not always helpful and often excluded a holistic approach to well-being. Taken together with inequities in health and social care for Māori it is not surprising that Baxter et al. (2006), reported 51% of Māori identified with mental health issues during their lifetime, however half of Māori with serious mental health needs had no contact with health services (Baxter, 2010) compared to 20% with an unmet need among the general New Zealand population (Ministry of Health, 2020a). A 12-month prevalence of mental health issues was reported as 30% for Māori (Baxter et al., 2006) compared to 24% for New Zealand European (Ministry of Health, 2020).

Why does there need to be a change?

Primary care providers, who are more often the referrers into secondary services, are increasingly frustrated at the inability to provide real time access to psychological care and this is reiterated in the recent Government inquiry (Ministry of Health, 2018). Real time access to intervention may have the effect of unclogging an overly burdened secondary care system (Glover et al., 2016). Access to secondary care services is usually via a referral from primary care services and only accessible for a person with severe mental health needs. General

Practice New Zealand (2019), identified that referral services tend to be overwhelmed by demand, and often need to restrict their already tight access criteria in order to keep services open (p. 5).

The He Ara Oranga report identified that the needs of New Zealanders and the New Zealand Mental Health workforce were not being met because of a lack of funding and resources (Ministry of Health, 2018). In recognition of this the Government announced an immediate $6 million injection into primary care specifically to support people with mild to moderate mental health issues with the purpose of supporting General Practitioners in providing immediate care for these patients via on-site psychological support. Research suggests that co-located specialist services (such as psychological services) could improve access to care for those with common mental health issues (Sunderji, Kurdyak, Sockalingam, & Mulsant, 2018; World Health Organization, & World Organization of Family Doctors, 2008), and therefore relieve the burden from the primary care provider. Many DHBs and primary health organisations are now considering how they can provide psychological services through collaborative care with primary care providers.

Chapter Three: Acceptance and Commitment Therapy

There is growing interest in the use of brief or ultra-brief interventions such as Acceptance and Commitment Therapy (Shapiro et al., 2003) for patients with mild or moderate mental health needs as it is not realistic to deliver conventional multi-session treatment options in the primary care setting (Strosahl, 2013). The imbalance of demand and availability of psychology services makes brief interventions attractive. Referring people to conventional psychology sessions (greater than six sessions) and with sessions lasting more than 30 minutes is not possible due to workforce capacity limitations and impacts on the ability for patients to get 'same day' sessions (Shepardson, Buchholz, Weisberg, & Funderburk, 2018).

Immediate therapy supports patients who are seeking support when their emotive state is high and who are likely to then cancel or fail to attend appointments when their distress levels drop (Strosahl, 2013). Therefore the ability for primary care providers to refer to immediate, timely and brief support may be most beneficial to patients presenting with mild to moderate health needs who attend primary care while their distress levels are high. Nordmo, Monsen, Hoglend, and Solbakken (2020), noted that brief therapies were not appropriate for those with higher mental health needs as they required longer-term intervention.

There is no standard definition of what constitutes brief psychotherapy. Farber (2020), states that brief psychotherapy has "the intentional use of time limits" (p. 407) however it is not clear whether these limits are in relation to the number of sessions or length of each session. Strosahl (2013), and Strosahl, Robinson and Gustavsson (2012), refer to brief therapy as "time-effective" where patients are seen in the number of sessions it takes to get optimal benefit for that patient, be it four sessions or 12. In this approach there is no restriction placed on the

number of sessions as the patient's motivation for therapy dictates the number of sessions required. Recent studies indicate that brief psychotherapy tends to comprise ten sessions or less (Cuijpers, Karyotaki, de Wit, & Ebert, 2020; Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Zhang et al., 2018) with Shapiro et al. (2003), referring to ultra-brief therapy as six or fewer sessions and Robinson, Delgadillo, and Kellett (2020), referring to therapy with between four and twenty four sessions. There is even less research into the duration of a session within brief or ultra-brief therapy. However shorter sessions have been found to be effective with a review by Nieuwsma et al. (2012), finding that brief psychotherapies are an effective treatment option for depression, with six sessions of 30 minutes being sufficient to generate a change in wellbeing for the patient.

There is support for the use of brief therapies in primary care with the meta-analysis of Zhang et al. (2018), on Problem-Solving Therapy (PST), a 'here and now' focused therapy which is typically delivered in seven to ten sessions, showing a significant treatment effect when delivered in primary care for people with depression when compared to the control group. The meta-analysis showed an average session time of 30 minutes. The average number of sessions in this meta-analysis exceeded eight, consistent with at least some definitions of brief therapy as mentioned above (Nieuwsma et al, 2012; Cape et al, 2010).

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) (pronounced as the word, not the initials) is an approach to psychotherapy that promotes new patterns of behaviour which focuses the patient on their present situation (Zhang et al., 2018). There is a large body of research looking at ACT as an effective therapy that can support a range of people with mild to moderate mental health issues (Strosahl, Robinson, & Gustavsson, 2012; Kroska, Roche, & O'Hara, 2020).

ACT processes have been found to be helpful for long term conditions, anxiety, stress, burnout, depression, substance abuse and managing pain, to name a few, because it targets negative thoughts and behaviours and focusses the person on the 'here and now' (Fung, 2015; Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013; Swain, Hancock, Dixon, & Bowman, 2015) with A-Tjak et al. (2015), noting particularly high efficacy with ACT when looking at depression and anxiety.

Acceptance and Commitment Therapy uses therapeutic processes that aim to alter psychological inflexibility and allow the individual to be aware of thoughts and behaviours, and to be accepting of these (Hayes et al., 2013). The six core therapeutic processes in ACT are set out in Figure 1.

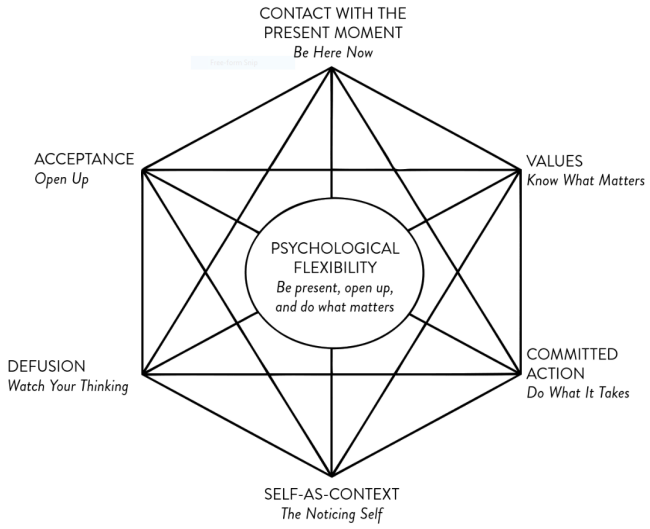

Figure 1: Six core therapeutic processes of ACT

What is the theory behind ACT?

ACT is a therapy based on Relational Frame Theory (RFT). Broadly put, RFT looks at the relationship between language and stimuli, and the context of this relationship. Complexity arises in that any such relationship has contextual meaning in each particular environment for that person. A key conclusions of this theory is that negative thoughts cannot easily be put

aside as they are based on historicial learning processes which cannot be overwritten. Negative thoughts and feelings can become embedded as a person's subjective reality and lead to the individual 'getting stuck' in their negative thoughts (Strosahl, Robinson, & Gustavsson, 2012). This leads to negative emotions and negative behaviours (Karekla, Karademas, & Gloster, 2019). A positive change in atttiude can arise from actively acknowledging emotions and thoughts rather than attempting to suppress or change them (Harris, 2019).

Psychological flexibility

ACT aims to develop psychological flexibility enabling negative thoughts, feelings and emotions to be accepted, acknowledged, given only the attention they are due, and put into the context of the individual's personal values. Psychological flexibility is defined as recognising and adapting to situational demands; shifting mindsets or behaviours; maintaining a balance with important values; being aware of one's own values; and demonstrating behaviours that reflect these values (Karekla, Karademas, & Gloster, 2019). Masuda et al. (2020), operationalised the opposite, psychological inflexibility, as the cognitive and behavioural efforts that lead to the avoidance of unwanted psychological experiences. This over-investment in avoidance results in poor daily living because the individual is not living in the present or doing the things that are important to them. The anticipated outcome of developing psychological flexibility is increased resilence, understanding and psychological well-being which result in a better quality of life.

What is FACT and why use it?

As the New Zealand Government is committed to providing more access to mental health services through primary care, ACT services are seen as an appropriate option to support the needs of both distressed patients and overworked General Practitioners. A mode of ACT that

is increasing in popularity is Focused Acceptance and Commitment Therapy (FACT), which is focused on the limited time available and the need to address the current situation for the patient. Strosahl, Robinson, and Gustavsson (2012), define FACT as "a simple, consolidated, uniform … approach to human behaviour change that allows the clinician to apply the same treatment principles across a broad range of problems" (How is FACT New? paragraph 1). The aim of FACT is to provide effective therapy in one to six sessions of 20 to 30 minutes each (Strosahl, Robinson, & Gustavsson, 2012), although Arroll (2016), states that the number of sessions is generally two to three. FACT is rooted in three overarching principles: cognitive defusion; being present; and knowing what matters (Arroll et al., 2021). FACT therapy helps to focus the patient, provide an understanding that avoidance techniques are not workable, and provide a pathway to actions that allow the patient to choose a life course based on personal values.

Despite an extensive search of literature, there was only one article that examined the efficacy of FACT therapy. FACT focuses the patient on the current problem and challenges them to confront their defences and anxieties in order to move forward. Results from Glover et al. (2016), showed the effectiveness of this approach in group-based sessions with veterans in primary care. The FACT sessions improved quality of life, reduced depression, anxiety and stress, and improved psychological flexibility. Berry (2019), and Burfield (2019), have researched patients' perceptions of FACT therapy in New Zealand and found support for the efficacy of FACT within primary care.

Warm hand-overs

One intention of a FACT service co-located within a primary health care practice is to allow referrers to do a warm handover, or to be able to 'hand off' patients in need of mental health

support to behavioural change therapists with minimal delay. Pace et al. (2018), described a warm handoff as "primary care clinicians … directly introducing the patient" to the therapist. They hypothesised that warm handovers would build trust and reduce the patient's feeling of stigma which would, in turn, improve attendance at future behavioural health sessions. Of the 2690 participants who were referred for short-course therapy in their study, only 21% (n =221) received a warm handover, with 71% being seen between 1 and 30 days after the initial appointment with a healthcare professional. Only 150 participants were seen on the same day as the warm handover. It is recognised that there is a drop-out rate prior to treatment with Ong, Lee, and Twohif (2018), noting that 15.9% of participants booked in for cognitive behavioural therapy did not start their sessions.

In the research of Pace et al. (2018), 221 patients who were referred to short-course therapy were directly introduced to the counsellor however that did not guarantee they would be seen immediately, with a delay between the warm handover and actual appointment. They did not find an increased attendance rate despite the warm handover, with 40% of participants who were scheduled for therapy not attending. Had these patients had the benefit of a same-day session as well as a warm handover then the non-attendance rate may have been reduced, as it is more difficult for a patient to refuse directly to meet the psychologist than to not attend a booked appointment.

Research conducted by Burfield (2019), on the service provided in the current study found that 34% (n = 245) of clients referred to the FACT service during a 12 month period were seen on the same day as their referral. The remaining patients received an appointment for a later time. Burfield (2019), does not discuss why the majority of patients were deferred for more than one day but did note that 66% (n = 766) of patients were seen within one week of referral.

In summary, brief therapy services provide an opportunity for more people presenting to primary care with mild to moderate mental health needs to be seen in a prompt and timely manner using a therapy that provides tools and resources for the patient to acknowledge their distress and to interact with their emotions in a positive manner. The ability for General and Nurse Practitioners to refer patients to a service should have the benefit of providing them with more time for other patients, and to be assured that the patient is getting the most appropriate support and help. It is envisaged that this will have a positive effect on the well-being of General and Nurse Practitioners and this is explored in the next chapter.

Chapter Four: Stress and Well-being

Some social scientists have concentrated on burnout and stress at work as a focal area for the management of job demands and resources. However, the potential to research the positive psychological aspect of well-being and its effect on workers and organisations has become an area of interest in the past few decades (Gardner & Parkinson, 2011; Dodge, Daly, Huyton, & Sanders, 2012; Magyar & Keyes, 2019). Given that a significant portion of an adult's life is spent working, understanding how an individual maintains psychological well-being and the ability to remain in and thrive within their chosen profession is an obvious area of interest. Steger, Dik, and Duffy (2012), report that 'many people want their careers and their work to be more than a way to earn a pay check … they want their work to mean something' (p. 322).

This chapter looks at work-related stress and what causes it. Looking at demands upon individuals and the resources available to meet these demands, this chapter considers the implications of unmet needs on employees. Burnout is a component of work-related stress. The chapter looks at how burnout manifests behaviorally, physiologically and psychologically, and the effect on the roles in primary care. However not all people who work in stressful situations experience burnout. Engagement, job satisfaction and autonomy are factors in work well-being even when demand is high and resources low. Finally stress and well-being in healthcare and how to consider work environments that empower individuals to be well at work will be reviewed.

What is work stress?

Quick and Henderson (2016), conceptualize occupational (or work) stress as a response to "a broad set of occupational and work demands as well as environmental stressors" (p. 1). These demands can produce a strain in the short term and physical, mental and behavioral changes in the long term (Ganster & Rosen, 2013). Stress is a process, involving assessing a stressor or demand, evaluating whether there are sufficient resources to address it, and then expending effort to overcome, manage or reduce that stressor (Harrison & Stephens, 2019). Any sustained negative psychological affect can lead to an inability to adjust to circumstances and change, lack of assertiveness, lack of control or poor time management (Thompson, 2009), which are all reflective of stress.

Causes of stress

Harrison and Stephens (2019), say workplace stress is inescapable, although as discussed later not all stress has a negative effect on the worker. There are a number of possible causes of workplace stress which could be grouped into categories such as physical (noise, heat); task-related (excessive work-loads, job demands); role-related (ambiguity of role); or social (poor leadership, feeling under-appreciated) (Foy, Dwyer, Nafarrete, Hammond, & Rockett, 2019).

Foy et al. (2019), report that employers are spending "billions of dollars annually related to employee lost time claims, increased health costs and decreased employee productivity due to work related stress" (p. 1741). The inability of individuals to deal with work related stress can lead to poorer physical (increased heart rate, muscle tension, hypertension); psychological (unhappiness, anxiety); or behavioural (substance abuse) outcomes (Islam, Mohajan, & Datta, 2012; Quick & Henderson, 2016). Employee stress is strongly associated with absenteeism and is a reflection of dissatisfaction at work (Merrill et al., 2013). Research by Schmidt et al.

(2019), looked at pharmaceutical company employee well-being, absenteeism and presenteeism and concluded that reducing job stress correlated with a rise in productivity and lowered costs.

The impact of stress is often evident in healthcare given the high emotional demands and significant stressors placed on workers (Mohr, Jacobs, McCabe, & Alley, 2014). The majority of people presenting to a General Practitioner/Nurse Practitioner do so because they are unwell, either physically or psychologically. They seek medical help in order to 'get better'. The expectation is that primary care providers will provide the tools and resources to make the majority of their clients 'better', and providers may experience stress when they feel that they are unable to do this (Cheshire et al., 2017). The high expectations placed on the health care provider may be coupled with the inability to change clients' situations, adding to practitioner stress (Epstein, Whitehead, Prompahakul, Thacker, & Hamric, 2019). Significant stressors include patient demands (Bakker, Schaufeli, Sixma, Bosveld, & Van Dierendonck, 2000), workload, increased paperwork and administrative tasks (Hall et al., 2019), and long working hours (Bartels, Peterson, & Reina, 2019).

In primary care settings, some General Practitioners find their decision-making, knowledge and autonomy challenged (Hall et al., 2019; Cheshire et al., 2017; Bakker et al., 2000) as patients have greater access to a wide source of health-related information and are demanding active involvement in their care (Shrank, 2016). General Practitioners are also finding that they are seeing patients with more complex and chronic health needs, including mental health needs, and these interactions can be emotionally demanding (Bakker & Demerouti, 2017). In addition, resource limitations on primary health care can affect the ability of practitioners to provide timely help, and referrals to other services increasing the burden on staff within those

services (Kung et al., 2019). A shortage of nurses and physicians in general in health care is increasing practitioner workloads (Shanafelt, & Noseworthy, 2017).

Chronic workplace stress can manifest as distress. In their analysis of literature on psychological distress Ridner (2004), proposed that psychological distress is the combined result of stressors and the responses to those stressors when this combination is harmful to the individual.

A component of distress that is often specific to those working in the social sector, especially in roles that interface with people, is moral distress. Moral distress is defined as "occurring when one knows the right thing to do, but institutional constraints make it nearly impossible to take the right action" (Hamric, Borchers, & Epstein, 2012, p. 1). Examples of these constraints could be clinical (lack of continuity of care); internal (lack of knowledge of alternative treatment plans) or external (lack of administration support), or any combination of these (Hamric, Borchers, & Epstein, 2012). Moral distress is characterized by emotions such as anger, frustration and guilt, and can manifest through physical and or psychological symptoms (Hamric, Borchers, & Epstein, 2012). Vehvilainen, Lofstrom, and Nevgi (2018), studied moral distress experienced by academics when dealing with plagiarism. They found a range of emotions expressed (hate, anger, annoyance, disappointment, guilt) when student plagiarism was detected and academics were required to 'do something about it'. The moral distress arose from dealing with the student, university, peers, and processes combined with an inability to change the initial circumstances, and dealing with feelings associated with failing the student. In their work on moral distress and social work Marson and McKinney (2019), identified that ongoing moral distress affected wellbeing and presented as a loss of empathy and compassion,

absenteeism, job dissatisfaction, turnover and burnout. Stress and distress that are not successfully managed place an individual at risk of burnout (Valeras, 2020).

Burnout is a phenomena that is specific to an organizational context. In 2019 burnout was added to the World Health Organization's International Classification of Disease, recognizing that this was "an occupational phenomenon and not a medical condition" (Valeras, 2020, p. 96). Burnout is defined as a "prolonged response to chronic emotional and interpersonal stressors on the job" (Maslach & Leiter, 2016, p. 351). Bakker and Wang (2019), explain that burnout has a negative impact on functioning and performance at work because of an inability to perform well and lack of motivation to do so. Burnout can be linked to the inability to balance expectations (job demands) with the resources available to meet those demands (Bakker, & Demerouti, 2017). The characteristics of burnout are exhaustion, cynicism and reduced professional efficacy (Upadyaya, Vartiainen, & Salmela-Aro, 2016; Valeras, 2020).

Exhaustion is a potential outcome of long-term stress and may be evidenced by the individual seeking to cope with this by distancing themselves emotionally and cognitively (Maslach, Schaufeli, & Leiter, 2001). Cynicism (or depersonalization) is the interpersonal component of burnout and can see the individual responding negatively or callously to the job or becoming detached from the job, peers and clients (Maslach, 2006). This characteristic usually comes after a prolonged period of emotional exhaustion. Reduced personal efficacy refers to feelings of incompetence, lack of achievement and lack of productivity (Maslach, 2006). This is driven by a lack of resources available to undertake the job in a satisfactory manner, as perceived by the individual, as well as a lack of social support, and it is linked with feelings of reduced personal accomplishment. Reduced personal efficacy is closely linked to exhaustion and

cynicism as it is challenging to feel a sense of accomplishment when exhausted and cynical (Maslach, Schaufeli, & Leiter, 2001).

Initially the focus of research into employee burnout was on social services such as teaching, nursing, and social work, because of the increasing reliance on professionals for help and support to deal with physical and mental health issues (Schaufeli, Maslach, & Marek, 1993). There is now a plethora of research looking at burnout in health care (West, Dyrbye, Erwin, & Shanafelt, 2016). Trockel et al. (2018), noted that attention on the well-being of doctors is increasing, because of the impact this has not only on the doctors themselves but on their work colleagues, organizations, patients and the economy.

Burnout is a recurrent theme in the latest survey by The Royal New Zealand College of General Practitioners (2019), which noted that 26% of respondents reported feeling burnt out. The implications can include early retirement (Cheshire et al., 2017); poorer health (physical, psychological and behavioural) (Quick & Henderson, 2016; Salvagioni et al., 2017; Williams, Rathert, & Buttigieg, 2020), not recommending general practice as a career to medical students (The Royal New Zealand College of General Practitioners, 2019), and patient safety incidents (Hall et al., 2019). This not only impacts on individual well-being but can have consequences for patients (Hall et al., 2020).

Burnout is often shown by absenteeism (Hall et al., 2020) or an intention to leave. Intention to leave is reflected in the survey by Linzer et al. (2009), who found that 35% of the General Practitioners surveyed indicated an intention to leave within 5 years due to burnout, which was higher than the number of General Practitioners in general who intended to retire in this time frame. In their recent study of attributable costs of physician burnout Han et al. (2019),

estimated an average annual cost of $US7,600 per physician ($NZ10,700) related to turnover and reduced productivity.

Several studies have addressed the spillover between burnout and work engagement, and life satisfaction. While this study does not address issues of work-family balance, it is acknowledged that the workload of a General Practitioner/Nurse Practitioner could contribute to work/life imbalance and the subsequent desire to leave the profession (Bakker, ten Brummelhuis, Prins, & van der Heijden, 2011; The Royal New Zealand College of General Practitioners, 2019).

In order to understand the impact of burnout on workers, organisations and the economy, well-being has become a popular research topic among organizational psychologists (Bakker, 2015; Magyar & Keyes, 2019). Wellbeing is a feeling of satisfaction and being fulfilled as a person with a focus of happiness and positive affect (Alagaraja, 2020). Two broad aspects of wellbeing have been identified. Subjective or hedonic wellbeing is focused on emotions and comprises three aspects: high pleasant affect, low negative affect and high life satisfaction (Dodge et al., 2012). In contrast, wellbeing which is cognitively based and focused on satisfaction with life is referred to as eudaimonic wellbeing (Huta & Waterman, 2014).

Hedonic wellbeing is about pleasure and enjoyment leading to happiness. It is not clear if the definition includes the absence of distress or if distress is mitigated by the inclusion of pleasure (Huta & Waterman, 2014). According to Diener, Lucas, and Scollon (2009), good and bad events affect happiness but people adapt to changing situations and over time return to a state of hedonic neutrality or well-being, so hedonic wellbeing is reflective of moods and feelings on a day to day basis (Grant & McGhee, 2020).

Eudaimonic wellbeing is based on self-determination, psychological wellbeing and living the best life that you can. At its core are components identified by Ryff and Singer (2008), as self-acceptance; positive relationships; personal growth; purpose in life; being able to master one's own environment; and autonomy. However Grant and McGhee (2020), states that eudaimonic well-being is not as clearly defined and requires further clarity. Ryff and Singer (2008), also define eudaimonic well-being as flourishing as opposed to mere happiness. Proctor and Tweed (2016), conceptualises eudaimonic wellbeing as an individual progressing and developing towards a good life, and argues that the definition of eudaimonic wellbeing should include virtue (defined as having high moral standards), an interesting concept given the recognition of moral distress as a workplace stressor.

The two forms of well-being imply that it is possible to have low happiness (hedonic wellbeing) but high job satisfaction (eudaimonic wellbeing) or high happiness but low meaningfulness (Straume & Vitterso, 2020). For example Nikolaev (2018), found higher satisfaction with most life domains in people with higher education, but lower happiness due to less free time. (Merida-Lopez, Extremera, Quintana-Orts, & Rey, 2019) found perceived workplace social support related to higher job satisfaction and happiness in a group of Spanish social workers even when that support was low. Understanding the conceptualization of hedonic and eudaimonic wellbeing provides an awareness of how primary care providers' emotional and cognitive states play a role in work well-being. Well-being at work influences a person's self-esteem and plays a crucial role in quality of life and satisfaction (Almeida, Bowden, Bloomfield, Jose, & Wilson, 2020).

Components of Work Well-being

Individual well-being at work is made up of components such as engagement (eudaimonic), job satisfaction (hedonic), workplace wellbeing and work/life balance (Shanafelt & Noseworthy, 2017; De Simone, 2014).

Work Engagement

Maslach and Leiter (2008), place engagement at one end of a continuum with burnout at the opposite end. Work engagement is a motivational process which is linked to feelings of inspiration, high energy levels and enthusiaism and immersion in work activities (Xanthopoulou, Bakker, & Fischback, 2013). Work engagement has positive consequences for health and wellbeing (Upadyaya, Vartiainen, & Salmela-Aro, 2016) which is evidenced by positive affect and behaviour, gives a sense of identity, purpose and belonging (Cunningham et al., 2018; Dodge et al., 2012) and is characterised by energy, involvement and efficacy (Schaufeli & Bakker, 2004). Employees who are engaged are effective in their work, have control over their work activities, provide positive feedback and appear to carry their enthusiasm and energy outside of the work environment (Bakker & Demerouti, 2008). In his review of literature Schaufeli (2012), concluded that "engaged employees work hard because for them it is challenging and fun" (p. 5). Bakker, van Veldhoven, and Xanthopoulou (2010), conducted a study that examined what managers could do to secure employee well-being. Their hypothesis was that a combination of high job demands AND high job resources would lead to task enjoyment and a commitment to the organisation. Their findings indicated that employees thrived on high job demands if there were sufficient job resources.

Job Satisfaction

The most common definition of job satisfaction is referred to by Diener and Diener-McGavran (2008), as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences" (p. 394). This conceptually includes components of emotion, cognition and behaviour. Job satisfaction comes from inter-related variables including autonomy, involvement, career development, goal orientation and responsibility to name a few. Whilst job satisfaction is an important component of well-being, alone it does not appear to instill the same amount of vigour that work engagement offers. Schaufeli (2012), describes job satisfaction as contentment and calmness which contrasts to the alertness and excitement of engagement.

Workplace / Organisational Well-being

"Organisations are created by humans and as such are subject to the experience of emotions" (Weinberg, 2007, p. 24). The well-being of an individual may influence the well-being of the organization and vice versa (Van Veldhoven & Pecci, 2015; Weinbergx, 2007.

Dollard, Tuckey, and Dormann (2012), argue that providing a positive psychosocial climate in an organizational context alleviates high emotional resource use and therefore reduces burnout. A positive psychosocial climate is reflected in a balance of concerns by management about employees' psychological health and productivity (Dollard & McTernan, 2011). This was supported by Loh, Idris, Dollard, and Isahak (2018), who found that a positive psychosocial climate reduced burnout and promoted well-being of the individual and the organization.

Whilst there is increasing recognition of the importance of well-being of health professionals there is not as much recognition of the role or importance of an organisation's structure and systems for wellbeing (Shanafelt et al., 2016). Maintaining well-being is of particular interest as General Practitioners and Nurse Practitioners in primary care in New Zealand have indicated that they are stressed, burnt out and looking to change occupation or retire (The Royal New Zealand College of General Practitioners, 2019). The next section looks at how well-being is maintained or lost due to job demands and job resources.

Theory

Hobfoll (1989), was concerned about the lack of clarity on the concept of stress, citing previous work as being ambiguous and not open to empirical testing. Defining psychological stress in the Conservation of Resources model, Hobfoll (1989), cites stress as a reaction to an environment in which there is a threat that resources expended will be greater than the perceived gain from expending them. In developing the Conservation of Resources model he theorized that individuals will seek to create and maintain a likelihood of positive reinforcement and avoidance of loss situations. Resources are the physical, psychological or social factors that help an individual achieve a goal (Schaufeli & Bakker, 2004).

Job Demand – Resource Model

The Job Demands – Resources (JD-R) model was developed to examine predictors of employee well-being, engagement and burnout (Bakker, 2018) by examining the link between demands of a job and the resources available at an individual and organizational level to meet those demands (Kaiser, Patras, Adolfson, Richardon, & Martinussen, 2020). The model focused on how high demands such as workload coupled with a lack of resources (for example lack of time, lack of autonomy) led to employee burnout. A large amount of research has

focused on people working within social agency jobs such as health and education (Bakker & Demerouti, 2017; Bakker, Demerouti, & Euwema, 2005; Schaufeli & Bakker, 2004) as levels of stress in healthcare professionals were high in comparison to the rest of the working population (Cohidon, Wild, & Senn, 2020).

Bakker and Demerouti (2017), summarise the assumptions of the JD-R model. Firstly there are characteristics of a job that can be catergorised as either job demands or job resources. The next assumption is that job stress and burnout happen when job demands are high and job resources are low (Bakker, ten Brummelhuis, Prins, & van der Heijden, 2011). The third assumption is that job demands are assoicated with energy depleting processes (exhaustion) and motivational processes (engagement). Finally, job resources buffer the negative effect of job demands (Bakker, Demerouti, & Euwema, 2005). Figure two shows the assumptions of the JD-R model (Schaufeli, 2017).

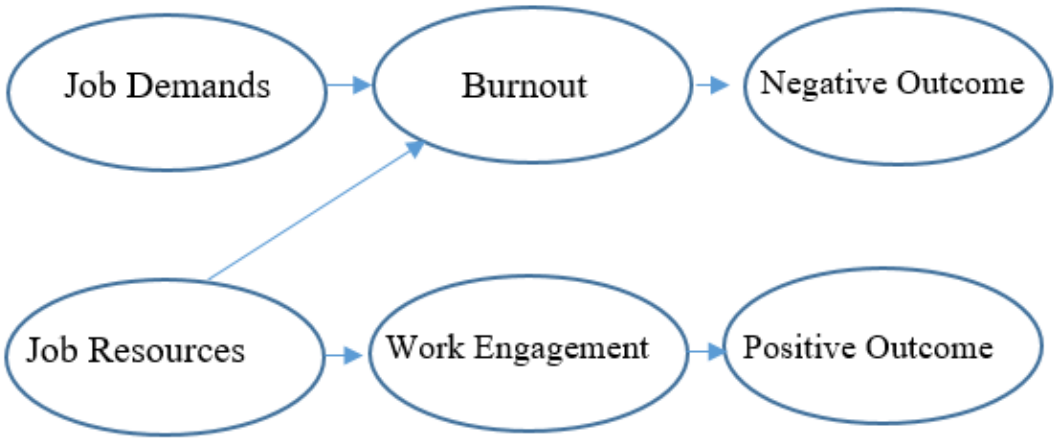

Figure 2: Interaction of JD-R model on health and motivation

Job Demands

Demands are components of employment which require sustained physical or psychological effort and are associated with physiological or psychological cost (Bakker & Demerouti, 2017). Examples of job demands are work overload, emotional job demands, low social support, role ambiguity, physical job demands and work-life conflict (Bakker, Demerouti, & Euwemz, 2005; Bakker & Demerouti, 2017). These demands may place undue stress on an employee and have a negative psychological effect, leading to burnout.

Job resources

The JD-R theory also focuses on the organisation's responsibility to ensure that employees have resources available to them in order to meet the demands required of them (Schaufeli, 2017). Job resources are the physical, psychological, social or organisational aspects of a job that are required in order to operate at an expected level on the job (Bakker & Demerouti, 2017) and to meet work goals (Kaiser et al., 2020). Examples of job resources are autonomy, skill variety, performance feedback, and opportunities for growth (Bakker & Demerouti, 2017). Job resources act as a buffer to job demands and can have a positive effect on well-being even when job demands are high (Bakker, Demerouti, & Euwema, 2005). Where an employee is challenged at work by demands but has sufficient resources to moderate them, they may find work challenging and stimulating for personal growth, learning and development, providing motivation to continue (Bakker & Demerouti, 2007).

The model proposes that where job resources are limited, one of two different responses may be evoked that have consequences for well-being and commitment to the job (Upadyaya, Vartiainen, & Salmela-Aro, 2016). These processes are either energy-depleting or motivational processes (Schaufeli & Bakker, 2004) and are shown in Figure 3.

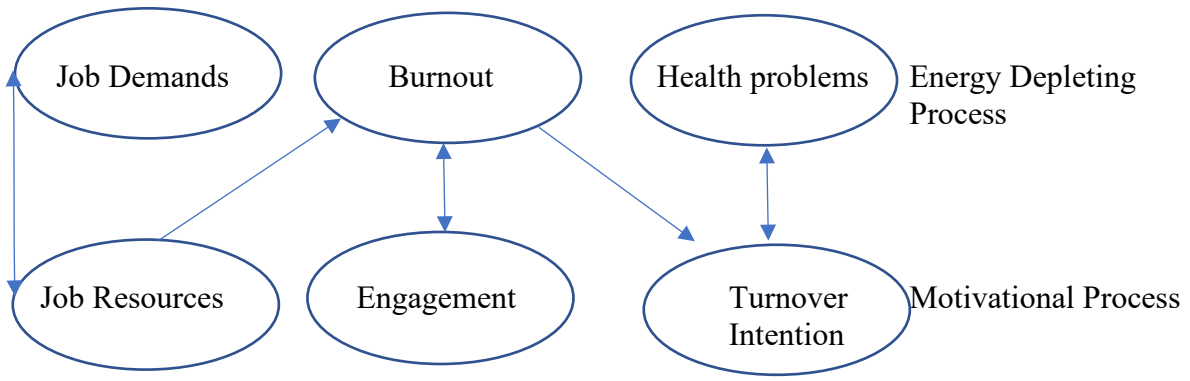

Figure 3: Relationship of Job demands and resources to energy depleting or motivational processes

Motivated employees work to improve their work situation which improves personal resources and leads to a greater capacity to deal with work situations (Kaiser et al., 2020). Stressed employees however may disengage from tasks, be demoralised and show exhaustion (Kaiser et al., 2020).

Optimistic attitudes and positive emotions help to build personal resources and broaden the ability to deal with stress situations or adverse conditions (Lazarus & Folkman, 1984; Fredrickson, 2001). Positive emotions tend to expand an individual's ability to think and act in a broader way, so that the individual feels engaged, fulfilled and has a sense of achievement when stretching their boundaries (Gilbert & Kelloway, 2014). These attitudes and emotions have an effect on wellbeing. Bakker, Demerouti, and Euwema (2005), found that in more than 50% of cases where employees indicated high levels of work overload and emotional demands, they did not indicate high levels of burnout if they had autonomy (a job resource). Autonomy appeared to help with managing job demands. High job demands and low job resources contribute to burnout whereas an abundance of job resources contribute to work engagement

and wellbeing, even in the presence of high demands (Schaufeli, 2017). The original findings of the JD-R model showed that job demands were the 'unique predictors of exhaustion' (Bakker & Demerouti, 2017, p. 274). An intervention increasing resources may contribute to both reducing or preventing burnout and fostering engagement. This, in relation to health care workers, implies that employees who have adequate resources available to them will demonstrate greater engagement in their work.

Stress, wellbeing, demands and resources in healthcare

Medical students often seek a healthcare pathway as they have a desire to help and heal. The General Practice Pathway offers an opportunity to not only see a variety of health conditions and behaviours, in itself challenging, but to interact and build relationships with a wide range of people (The Royal New Zealand College of General Practitioners, 2020).

There are numerous studies examining work stress and wellbeing in the healthcare sector as this may be at higher risk of exposure to stressors than the rest of the working population (Bakker et al., 2000; Cohidon, Wild, & Senn, 2020). Stress commonly occurs when demands are greater than the resources available to deal with them, as can occur in the context of a rising demand for services (Linzer et al., 2009). It is imperative the relationship between well-being and a positive psychological relationship with work is researched, particularly with a reduction in General Practitioner numbers and their increasing workloads. As already discussed, presentations to general practices in New Zealand for health care have increased by 73% over the past 10 years (Allan, 2018) however the number of medical professionals available to meet that demand has not matched the increase. This, coupled with patients presenting with increasingly complex conditions, comorbidities and mental health needs, is affecting the wellbeing of primary care health professionals. Even so, not all health care professional are

feeling the strain of increased demands and many are thriving on the opportunities that arise. This is particularly evident where the resources available are perceived to be sufficient to meet requirements.

In their 2019 study Le Floch et al. (2019), sought to examine positive factors related to job satisfaction among General Practitioners. This European research found that General Practitioners, in order to have job satisfaction, wanted job autonomy; professional education and the ability to have strong relationships with their patients. These are not necessarily components that can be found in a busy, under-resourced General Practice in New Zealand today. In their study of front line nurse managers' Kath, Stichler, Ehrhart, and Schultze (2013), found that decision authority and autonomy were the most important buffers against stress. This suggests that the same would apply to General Practitioners and Nurse Practitioners who, although they potentially have a higher level of authority and autonomy than front line nurse managers, are still reliant on the availability of additional services such as mental health services for patients with mild to moderate mental health issues.

To summarize, the JD-R model proposes that well-being at work is affected by the relationship with job demands and the resources available to meet those demands. An imbalance can lead to energy depletion resulting in stress and burnout. A perception of a balance of resources can increase motivation with positive outcomes in terms of job satisfaction and engagement and result in well-being of the individual at work. Providing additional resources to health care providers that reduce the demands on them can have a positive effect on well-being.

The present study

A large primary care practice in the lower North Island has been working in conjunction with a Psychology service to provide collaborative services for patients who present to the primary care practice with mild to moderate psychological distress. The psychology services are co-located within the primary care practice and are based on Focused Acceptance and Commitment Therapy (FACT).

The study set out to answer the following key questions:

1) Did referring patients to the FACT service impact practitioner work well-being?
2) What realistic changes to the working environment would make a difference to practitioner well-being?

It is argued that the ability for primary care providers to refer patients to timely support will reduce work-related stress by reducing workload and providing additional support for clients. It is also argued that some realistic changes to the work environment could be identified to improve the well-being of health care providers.

Chapter Four: Research Design

Methodology

A qualitative approach was used for this study. This approach allows for understanding motives, feelings, values, attitudes and perceptions (Ograjensek, 2016). It also gives the opportunity to use open, exploratory questioning (Miles & Gilbert, 2005). Given that there is a limited body of research looking at General Practitioner experiences of co-located services in New Zealand, the research sought to explicitly report on the views of those referring clients to the service. There was also the opportunity to ask participants to reflect on their work well-being at the current time and to suggest changes to improve this.

Analytic Strategy

Data were analysed and interpreted using Thematic Analysis with an inductive orientation as described by Clarke and Braun (2019). Thematic Analysis first appeared as a method in the 1970s but has since matured into an individual approach to the analysis of qualitative data (Braun & Clarke, 2014). This approach provides for a robust, systematic framework of coding the data and then identifying patterns across the data as they relate to the research question (Braun & Clarke, 2014). An inductive approach allowed for the 'generalisation and justification' (Gibbs, 2012), of common and repeated data. Using the explicit phases of Thematic Analysis (Braun & Clarke, 2006), the typed transcripts were read and re-read by the researcher. Initial coding was done across the complete data set and this coding lead to the identification of themes. The researcher then produced thematic maps. This process allowed for refinement of the themes as well as adding, combining or discarding initial themes as analysis progressed.

To enhance credibility of the findings, the analysis was reviewed independently by a supervisor who was not involved in collecting the data. The scripts were read separately identifying meanings and initial impressions of the data. Clarke and Braun (2019), argue that coding should not be checked for agreement as it is a reflective and subjective approach taken by the researcher. However, they agree with sharing the coding with an experienced supervisor for reflection on the assumption-making which was part of the process in this research. It is acknowledged that any researcher may come with a level of bias particularly if they have prior knowledge or understanding of the phenomena being researched. However, it is now understood that bias is unavoidable when coming to know something (Braun & Clarke, 2006). This process of conducting qualitative research allowed the researcher to reflect on her understanding of health and primary care. It was also an opportunity of personal growth reflecting on the nature of primary care not from a client perspective but from the perspectives those working within primary health care.

Ethical approval

Meeting the Health and Disability Ethic Committee (HDEC) and Massey University Human Ethics Committee requirements, this research was judged to be low risk. The researcher was not advised who received an invitation, and who declined to participate. Consent was assumed by participants being available and participating in the interview. All data were anonymised.

Research site

At the General Practice facility where this research is based, enrolled patients are seen by General Practitioners, Nurse Practitioners and/or registered nurses. Where it is deemed clinically appropriate, referrals to the co-located psychological FACT service can be made by General and Nurse Practitioners and Registered Nurses. Wherever possible the patient's initial

FACT appointment is on the same day as their appointment with the health provider. However, if the psychologist is unavailable or the patient seeks to delay the referral then a booking can be made through the facility's shared booking system.

During 2018, employees of the practice were invited to attend a two-day FACT training course held on-site. Continuing education has been via debriefing sessions with the FACT psychologists although these are not scheduled regularly as workloads increase. FACT services are provided on-site by six registered psychologists. The FACT service is operational three full days and two half days per week.

Participant characteristics

Study participants were recruited from a large primary care practice that has a co-located Psychology service available for the practice to refer directly into. Participants included General Practitioners, Nurse Practitioners and Registered Nurses who had referred patients to the co-located clinic from commencement of the service until February 2019. Participants were invited to take part in the study via an email from the primary care booking clerk. An information sheet was attached to the email. Participants self-selected by either accepting the interview invitation, declining it or not responding to the invitation.

Twenty-four participants initially indicated that they would participate in the research. However fifteen participants subsequently declined due to having left the practice, being on sick leave or annual leave, or being too busy to participate. Over the two-day interviewing period nine participants were interviewed (six male and three female). The average length of time as a registered practitioner was 15.5 years.

Data Collection

Interviews were booked into each participant's patient booking calendars and were identified only as a FACT interview. Booking slots were for 15 minutes, the standard appointment time with a General Practitioner. The interviewer conducted the interviews in the participant's consulting room. The interviews were audio-recorded and manually transcribed.

Interview

A semi-structured interview schedule was prepared (Table 1). The interview was designed to take no longer than 15 minutes. Three questions related specifically to the FACT service and the last question referred to participant work well-being.

Table 1: Interview questions for referrers to FACT services.

Interview questions	
Question number	
1	Tell me your experience of FACT.
2	Could you tell me if your experience of FACT has had an effect on the way you practice?
3	I'm interested in wellbeing and whether FACT has had any influence on practitioners. What you do think?
4	What would be one realistic thing that you think would make a difference to your work wellbeing?

The findings and discussion of the current research are presented in the following chapter. Presenting findings and discussion in the same chapter allows the researcher to discuss specific themes in conjunction with the analysis of the interviews (Anderson, 2010). Where quotes have

been used participants are identified by codes with (GP) identifying General Practitioners, (NP) a Nurse Practitioner and (RN) a registered nurse.

Chapter Five: Findings and Discussion

Facing a mental health crisis in New Zealand, the current government is injecting millions of dollars into the provision of mental health services to support those with mild to moderate mental health needs, through primary and community care. Given that health care providers working in primary care are currently over-stretched and over-whelmed (Norful, Swords, Marichal, Cho, & Poghosyan, 2019), this study sought to examine the impact of being able to refer patients in a timely way, to the co-located FACT psychology service, on the well-being at work of primary care providers. It also looked to understand what realistic changes could be made to the practitioners' work environment to enhance their own well-being. It is argued that the ability for a primary care provider to refer a patient to timely support will reduce their own stress and workload and therefore have a positive impact on their well-being. In addition, some changes to systems and processes could be perceived as beneficial to the well-being of the General and Nurse Practitioners.

The analysis of the interview data identified three main themes:

- Practitioner experiences of the FACT service and how that impacts on well-being, with several sub-themes:
    - value to clients but is there value to the primary care provider?,
    - understanding of the referral criteria,
    - lack of faith in the service deliverables of FACT,
    - professional development
    - improving communication about the service
    - perceptions of the patients' experience.
- The well-being of practitioners and how it might be supported.

- Practitioners' experiences of using the additional resource of the FACT service and referral processes

The co-located FACT service was an additional resource offered to the primary care practice. Where the clinical judgement of the practitioner was that patients would benefit from ultra-brief psychological therapy in order to reduce distress then the patient could be referred to the same day service. JD-R model suggests that an increase in resources would have a positive influence on the referrer's well-being.

Perceived value of the FACT service for clients but is there value for the referrer?

Participants indicated that the ability to refer patients to a timely, appropriate psychological service was beneficial for the patient. They also identified the FACT service as a good resource to allow them to refer patients to an appropriate services however, participants struggled to explicitly identify a direct relationship between FACT services and their own well-being. (Miller-Matero et al., 2016), found that the ability to refer patients to psychological support had a direct influence on positive physician wellbeing by reducing stress levels. Eighty two percentage (n = 62) of referrers within their study, who referred to the co-located psychology service said their stress levels decreased with psychologist involvement in their patient's care. Participants in this study did identify that the FACT service was the appropriate place for their patient and implicit in this is the suggestion that referring the patient to an appropriate service does relieve the practitioner of the burden of providing a service. For example, one General Practitioner said "*I really want people just to find the right place for their issue … and FACT is a better place for them to get counselling then me cos I'm not a counsellor*" (GP03).

Participants reflected on the value of the service noting "*it's very difficult to get into [the FACT service] they're very popular*" (GP04); "*it's been great that they've been available*" (RN02); and "*it's been a very nice service to have here to offer some people*" (GP03). There is a sense

that having an additional service available to distressed patients is beneficial to both the patient and the provider: “just that presence” (RN01).

Overall, there was overwhelming support by participants for the FACT service, including the ability to get prompt help for patients, and the service was viewed as a positive experience for both the patient and the practitioner. This positive experience has an effect on job satisfaction as defined by Schaufeli (2012), as contentment and calmness. This sense of satisfaction enhances motivational processes (Schaufeli & Bakker, 2004), which in turn has a positive effect on the well-being of the provider.

Practitioner understanding of referral criteria for FACT

When asked to describe their experience of FACT, most participants offered a description of the services and who could be referred to the service. These descriptions simplistically explained the nature of the clinic and correctly described the issues that FACT therapy could help with: *“a series of visits to help certain conditions that they may be experiencing in their lives mainly anxiety”* (RN02) and *“the ones I refer … tend to be mild end of the scale [and] have fairly encapsulating problem” (*GP03*);* and *“quick access to psychological sort of urgent care” (*GP02*).*

Participants had different understandings of the criteria required to refer patients to the FACT service. Some participants indicated that referrals were for acutely distressed patients only, with one participant describing the service as: *“my understanding of the FACT programme is the most distressed they are the better it will become” (*GP02*)*. Participants generally understood it as being a service for patients who were significantly distressed but not suicidal, which allowed for immediate counselling.

Alternatively, some participants saw the FACT service as an alternative when a referral to community or secondary health services was not a timely option, e.g. "*[If I] can't get someone to see the PHO counsellors I wonder if I can get them into FACT" (*GP04*).* A participant queried whether the right people are being referred to FACT: *"people that go to a FACT consult are ones that don't really ... have a major problem".* Conversely, other participants lamented the inability to refer seriously or acutely unwell patients to the service: *"[I] need ability for FACT to see my acutely distressed unwell'* and *"it's [FACT service] missing people who are in acute distress" (*GP04*).*

This researcher did not expect to find such variation in defining who would meet the referral criteria. Referral to the FACT service is based on the patient exhibiting mild to moderate mental health needs AND the clinical judgement of the referrer that the patient needs such a service AND that they would benefit from the service. The lack of clarity in understanding the referral criteria suggests three ideas: there is a knowledge gap with referrers not clearly understanding ultra-brief services and why the service is specific to patients with mild to moderate mental health needs; participants are referring patients with high mental health needs to the service to ensure that the patient gets some immediate help, which is in direct conflict with referral guidelines; the referrer is making inaccurate referrals to ensure their patient gets help. Although providers as a whole were positive in their review of the FACT services, there is potential that the lack of clarity about referral criteria could mean that the referrers were not referring patients for whom the service was intended. This lack of clarity and certainty could also adversely affect the wellbeing benefits that could come from the FACT service.

In deciding the most appropriate treatment pathway, primary care providers use their clinical judgement in deciding the severity of a person's mental health. Most clinical decisions occur

with a sense of urgency as referrers are subjectively determining whether a referral to the FACT service would be beneficial. Clinical judgement is generally formed by communication between the health care professional and the patient. Based on observations the primary care provider will ask questions and then form a tentative assessment of what the patient may require. Clinical judgement often requires quick decisions based on observation and analysis, and the need for urgency often means judgements are based on clinical training and instincts rather than reflections and detailed analysis (Creavin et al., 2017). Raybould (2019), found a sense of uncertainty and anxiety reported by General Practitioners in mental health consultations, but there is little information on how her participants' clinical judgements resulted in mental health diagnoses. However it is understood that urgency and anxiety on an on-going basis can have a negative psychological impact on the health provider (Quick & Henderson, 2016). Given that a practitioner has a limited window of opportunity to use clinical judgement to make a decision about the seriousness of a mental health issue, and that it is unlikely that mental health would be their area of expertise, then referring on to a psychologist who can make an informed clinical decision is, in fact, a sensible choice.

The research of Burfield (2019) also found that inappropriate referrals were being made to the service, with 46% of patients referred being subsequently classified as having severe mental health needs. They suggest two reasons for this. Firstly, practitioners may perceive this as the only option for the patient as secondary services are overwhelmed (Ministry of Health, 2018). In his 2020 report into mental health and addiction services in New Zealand Allan (2020), noted only that 47% of people are getting the required mental health services within 48 hours, with 25% waiting more than three weeks. Practitioners in this study felt that a referral to the FACT service would be better than no referral at all or a delay in accessing services, noting that a patient with urgent mental health needs should be seen within seven to 10 days (New

Zealand Guidelines Group, 2008). Secondly, as discussed above participants were not clear on the referral criteria into the FACT clinic. It is also possible that discrepancies in referral criteria could reflect a desire for autonomy. Clinicians may feel that the guidelines are too restrictive and the service would meet the patient's current needs. In their systematic review of primary care clinical guideline adherence for managing lower back pain Slade, Kent, Patel, Bucknall, and Buchbinder (2016), reported that some clinicians found guidelines to be restrictive and stifled professional autonomy. It would be interesting to examine referral pathways and perceptions of autonomy in more depth. Autonomy links to well-being as it allows for self-determination and is a key factor in job satisfaction (Le Floch et al., 2019), and a major buffer against stress (Kath et al., 2013).

Lack of faith in what FACT can deliver

The interviews established a lack of understanding about the deliverables of the FACT service with many commenting that the session were "*rushed"; "too short";* or *"not in-depth enough"*. They also reflected on *"psychology(sic) doing 30 minutes of appointment" (*GP02*); "half an hour appointments" (*GP05*); "They're meant to only see them once" (*GP03*)*. Limited faith in what can be achieved by a FACT service suggests that it might not be helping provider well-being. If the provide felt their patient was being well looked after and they no longer needed to be concerned for that patient their well-being could increase, however believing the service will not help their patient does not alleviate stress or impact positively on well-being.

The study by Burfield (2019), of FACT services delivered at this health care service found that the average session (excluding the initial session) was 37.45 minutes with a range of 15 – 90 minutes, and 94% (n = 576) attending 1 – 4 sessions. One participant commented that "*they* [patient] *finding it quite rushed*" *(*GP04*),* saying that a small percentage of patients who had had previous counselling indicated that the session was too short. This may indicate that

refresher training is needed for referrers so they are clear that the sessions are designed to focus on the 'here and now' and not historical events. The majority of participants did like the idea that they knew who was delivering the FACT service and they could pass that knowledge to the patient.

A-Tjak et al. (2015), stated in their meta-analysis of the efficacy of Acceptance and Commitment Therapy that it was superior to other treatments for anxiety and depression, addiction and somatic complaints, all identified as mild to moderate mental health conditions by the World Health Organization (2013). The systematic review by Robinson et al. (2020), of dose-response effects in relation to routinely delivered psychological therapies found 4 to 24 session were sufficient to enact change for those with common mental health conditions although they did not comment on length of sessions. In their work currently in pre-press Nordmo, Monsen, Hoglend, and Solbakken (2020), agreed with Robinson et al. (2020), and noted that patients with higher mental health needs had a slower overall change and did not benefit from brief therapy. The understanding regarding referral criteria and deliverables may be mixed as the FACT service appears to be accepting all referrals to it. The opportunity for greater collaboration between the primary care providers and the psychology services could address this issue.

Professional development

Participants also indicated that General Practitioners should be delivering FACT services as part of a medical consultation. This may indicate a desire for professional development in psychology or counselling and could be considered in further research. Continual professional development engages the individual with their work and is a motivational process which has a positive impact on well-being (Xanthopoulou, Bakker, & Fischback, 2013). Raybould (2019),

found very few General Practitioners trainees undertook specialist mental health training. She also noted that general practices are not adequately structured toward General Practitioners providing mental health services, noting in particular the length of consultation time. However, in her recent research Raybould (2019), reported participants' positive experiences when they could refer patients to the clinical psychology service, and also that some General Practitioners were excited by the challenge of providing mental health counselling to patients. Further training and skills development in this area could also improve understanding of the FACT referral criteria the focus, strengths and limitations of the FACT approach.

Improving communication about the service

Participants felt that regular feedback from the FACT service's psychologists regarding the number of correct referrals into the service, and learning about the outcomes for their patients, would have a beneficial effect on practitioner wellbeing. Participants also desired a stronger relationship with the Psychologists who provided the FACT services. *"We need to have a little bit of feedback from the team themselves [referring to the FACT team] (*RN02*); "Are we referring the right sort of people ... are they appropriate?" (*RN02*).* This uncertainty could have a negative effect on referrers if they are unclear whether they are providing the most relevant service to their patient. Uncertainty can contribute to stress if a referrer finds their decision-making challenged, even if it is an internal challenge (Cheshire et al., 2017; Hall et al., 2019). Ensuring a feedback loop can have positive effects on health care providers where they are able to develop their personal resources through on-going interaction with the FACT service providers (Gilbert & Kelloway, 2014).

Blount (2019), discusses the need for training and education from the mental health provider perspective. Reiter, Dobmeyer, and Hunter (2018), in defining a Primary Care Behavioral (PCBH) Model, recognise education between the behavioural health provider and the Primary

Care team should be a core component of an integrated service. They recognise that informal 'water cooler' conversations could provide learning opportunities but also acknowledged the benefit of formal education, albeit by way of lunchroom meetings. Continual education would be beneficial to both the primary care practice and the Psychology team. Feelings of support can lead to engagement and optimism, components of wellbeing (Cunningham et al., 2017; Schaufeli & Bakker, 2004). Mundt and Zakletskaia (2019), recently examined the link between professional communication and job satisfaction and found primary care health professionals who were immersed in a communication network with work colleagues exhibited higher job satisfaction when engaged in face to face communications. Job satisfaction is an important component of well-being and is effective in motivating employees (Bakker et al., 2005).

Hall et al. (2020), found in their study of primary care physicians in the United Kingdom that poor physician wellbeing was likely to result in patients being referred to other services as physicians remove themselves from responsibility and relieve themselves of the emotional and cognitive burden. Tzartzas et al. (2019), concurred in their later study that a referral from a General Practitioner to a specialist often involved emotionally charged interactions with the patient which affected the decision-making process. Kushnir et al. (2014), found that high referral rates of primary care physicians were correlated with burnout, finding that having an in-depth conversation with a patient was too demanding and that a referral was the appropriate action to take for provider wellbeing.

Overall, improving how participants understand the concept of FACT services from referral criteria to length and number of sessions has the potential to impact on decision-making regarding referral and treatment pathways for patients. Where participants did not have a clear understanding of the nature of services provided by the Psychologists then there was the

potential that patients might miss out on counselling services due to not being referred. Improving practitioner knowledge of the service and supporting a feedback mechanism with the FACT service should increase connectedness, autonomy and engagement, having an overall effect on wellbeing (Waring & Bishop, 2010). But that effect may only be felt with the knowledge that patients with mild to moderate mental health needs are receiving prompt support. It may not improve wellbeing if the primary care provider believes that there is no clear, timely pathway for those patients with greater needs and this could be reflected in anxiety or negative affect in their work.

Improvements to the FACT services

Most participants were supportive of the FACT service and were reluctant to criticise the process of referral and service provision. Asked if their experience of FACT had affected the way they practice or influenced the way their peers practiced, most participants said that the ability for the patient to see a practitioner who was specifically trained for mental health concerns was beneficial. Comments such as *"you can just hand over to a psychologist that know way more about mental health issues then I do" (*NP01*)*; *"You can offer them [patients] something which is helpful for them" (*RN02*)*; and *"It's one less thing I have to do" (*GP03*)* reflect that the reduction of demands on them personally will improve their well-being in the work environment.

Identifying improvements to the FACT service, participants spoke of expanding the service to different population groups who may be missing out. Participants indicated that youth and the elderly were missing out on FACT services. However in her recent research of this co-located psychology service Burfield (2019), found an age range of 14 – 92 years for patients attending

FACT sessions, although the majority (70%) of patients were between 20 – 59 years. Again, this indicates that there needs to be clarity as to who can be referred to services.

One participant wanted to see FACT services made available off-site for elderly people who are experiencing "*life changing events" (*NP01*),* noting that the elderly might benefit from group/family counselling and that FACT could be the vehicle for delivery. This suggests that it may be valuable for Psychologists to consider whether referral for group therapy may be an alternative treatment methodology, however this is outside the scope of this research.

The findings reflect previous studies in which primary care providers recognised a lack of behavioural health training in themselves and saw the benefit of being able to refer to a specialist service (Blount, 2019; Gerdes, Yuen, Wood, & Frey, 2001; Raybould, 2019; Torrence et al., 2014; Westheimer, Stanley-Bumgarner, & Brownson, 2008). Participants in this study did note some practical issues that they thought would make the referral process from primary care to psychological services smoother or required further attention to find a solution.

No appointments available immediately

One of the key features of the FACT service in its development was the ability for psychologists to receive patients as soon as possible after their medical consultation (often referred to as a warm handover or warm handoff). However the reality is that more patients are being seen via a booked appointment then a warm handover (Burfield, 2019). This is due to either the patient choosing not to proceed to an immediate appointment, or immediate appointments not being available.

A proportion of FACT appointments are left open for warm handovers each day but a patient may need to be booked in at a future date if the psychologist is not available. There was anecdotal evidence that administrators were booking patients into restricted warm handover appointment slots when patients rang for second and subsequent appointments. The flow-on effect meant reduced warm handover slots were available.

In order to stem the flow of pre-booked appointments, the primary care practice restricted the ability to book appointments more than 24 hours ahead of time. A participant spoke of a cumbersome work-around to book a future appointment. This included setting a future computer task, actioning that task on the appropriate day by booking the appointment and then advising the patient. Cresswell, Mozaffar, Williams, and Sheikh (2017), found that informal work-arounds such as this were not approved by management but were deemed necessary by the workers to manage perceived limitations of the system. The use of any work-around is a concern as it implies that organisational processes and procedures are not being followed. The original protocols were developed to ensure the smooth running of an organization based on a quality service. Any 'ad hoc' changes or informal modifications to protocol can see the quality link broken (Patterson, 2018). In addition, this process does not guarantee that the patients will get their preferred appointment time, and having to develop a system work-around in order to get a patient with mental health needs an appointment at an appropriate time adds an administrative burden to practitioners and reduces any potential well-being benefit.

Patient not ready for immediate appointment

Practitioners noted that the ability to ensure patients were seen for psychological distress takes the worry away from themselves but also noted that patients might not be ready for immediate support: *"they sometimes aren't in the space to see someone on the day so when they get*

*another opportunity a few days down the track they go for that" (*RN01*).* Some participants were concerned with "*how do I get the patient to see a psychologist?"(*GP04*).*

General Practitioners noted that attendance at a FACT session prior to a medical consultation would benefit both the patient and General Practitioner in terms of focus. GP02 spoke about referring the patient to FACT services before the primary care consultation because they are "*so high*" (in reference to an emotive state) and having FACT sessions first reduces the number and length of primary care consultations. RN01 agreed saying if they go to FACT first in a distressed state *"then by the time they come back to us [primary care] it's a different person ... they've calmed down".*

The FACT service receives all direct referrals from the primary care provider therefore whether a patient is referred by a Registered Nurse, Nurse Practitioner or General Practitioner does not matter. Given that it may be appropriate for a patient to see a psychologist prior to (or even instead of) a General Practitioner, Gunn and Blount (2009), described a co-located psychology service within primary care as having the ability to assist medical professionals and staff with patients' mental health needs. There is potential for a triaged patient to be referred directly to the FACT service. The patient could then present to the health provider after the FACT session only if there was a biomedical need. A feedback loop of shared patient records should ensure a safety net is in place for the patient. This change to process could reduce the work demands on the practitioner. Any reduction in demand while not reducing the resources available will have a positive effect on the well-being of health care providers.

It was interesting to hear participants discuss patients' expectations of the FACT service. One participant commented "*one or two who don't like it".* This participant also thought that FACT

sessions are a 'one-off' and "*they expect an hour to listen to them*" *(*GP04*).* Overall, participants indicated that they were able to review patient notes and see whether the patient was attending sessions or that they were able to maintain an ongoing clinical/patient relationship: .

"I followed up with them about two weeks later and they just said it was the best thing you know. It just helped them turn everything around. They knew that they were in a situation and we weren't going to fix that situation but certainly helped them deal with it" (RN01)

In such instances there was a relationship between the referrer and the patient in that the referrer subsequently saw the patient and was able to follow up on the FACT session. A relationship between the practitioner and the patient is a core element to overall wellbeing. Job satisfaction is linked to social connectedness and a primary care provider can get this sense of connectedness through on-going relationships with patients (Salyers, Rollins, Kelly, Lysaker, & Williams, 2013). When there is an on-going relationship less time is needed to develop rapport which directly impacts on wellbeing in terms of workload and time constraints.

Primary Care Provider Well being

Participants were asked "*If you had one realistic thing that would make a difference to your work wellbeing what would that be?"* Participants appeared reluctant to discuss improvements for themselves, preferring to focus on their patients, however, the analysis of the interviews identified sub-themes that could address wellbeing at work. The role of a practitioner is often viewed as altruistic, it is self-less and it is delivered by individuals who have a view of serving others not themselves (Scott, Wright, Brenneis, Brett-MacLean, & McCaffrey, 2007; The Royal New Zealand College of General Practitioners, 2020). Further probing by the interviewer drew out themes that primarily centered on resourcing and how an increase in a

variety of resources would improve participants' work well-being. A study of responses identified three sub-themes under this heading:

- Longer consultation times / follow up time
- Reduced Paperwork
- Human resources

Longer consultation times / follow up time

The present study confirms the finding that time constraints on a Primary Care Provider are a major factor in work stress (Von dem Knesebeck, Koens, Marx, & Scherer, 2019). Raybould (2019), reported General Practitioners describing a lack of time during a consultation to undertake a mental health review. Most participants in this study indicated that the primary resource that would help improve their work well-being would be more patient contact time and the ability to follow up on actions resulting from that consultation. Participants said *"[I Need] time to tie up loose ends"* and *"15 minutes can't even write my notes".* They also identified the stress that results from being constantly rushed *"longer consultations .... the stress of working fast all the time is just endless .... It's stressful" (*GP04*).*

Consultations that are deemed to be too short can give rise to practitioner stress and burnout (Irving, 2017). Brown, Gregory, and Gray (2020), discuss consultation length and the need for a longer period of time in order to ensure wellbeing for the patient and the provider. Interestingly in their United Kingdom paper they suggest an average consultation time of 15 minutes, which is the time allocated in New Zealand General Practices and which the participants in this study deemed not sufficient to consult with the patient and undertake tasks that might fall out of that consultation, for example, referral letter to specialist care, following

up on test results. Parker, Hudson, and Wilkinson (2014), and Irving et al. (2017), found short consultations had a negative impact on physician workload and stress.

Another participant stated that "*it takes 10 minutes just to get to the point" (*GP01*).* This created challenges around social connectedness and rapport, and raises the question as to whether professional development would benefit primary health providers who are time-poor and need to seek clarity of the patient's issue in a short period of time. (Miller, Scherpbier, van Amsterdam, Guedes, & Pype, 2019) identify inter-professional education in primary care as a multi-layered approach to engaging a wide range of people from a wide range of roles to collaborate together to improve systems, safety and individual professional practice. Engaging people in additional activities such as educational sessions may not appear practical in the short-term, but the ability to work collaboratively with peers and to address challenging systems may provide long-term benefits for the health providers. This result is consistent with Parker, Hudson, and Wilkinson (2014), who found "consultation with patients experiencing emotional concerns took time to do well and these consultations often overran" (p. 265). Referrers indicated that it often took time to get to the true nature of the presentation and it may be nearer the end of the appointment that the psychological issue is noted or raised.

Participants identified a need to work outside normal hours saying *"you can't fit everything in 15 minutes … so I'm writing letters at night and phone calls" (*GP04*).* The need to continue work activities outside of hours can have an impact on providers' work/life balance. The impacts can be psychological (stress) and physical (sleep deprivation, fatigue). The consequences of not working these extra hours are additional hours the following day, or risk to the patient. The provider is in a 'no win' situation which can have a significant impact on wellbeing.

Paperwork

The burden of paperwork was identified separately. *"I was going to say less paperwork but that's not realistic" (*GP06*).* The burden of paperwork is under-represented in the body of literature on well-being. McRae and Hamilton (2006), link poor clinical satisfaction with the amount of paperwork and do not see the implementation of electronic medical records (EMR) as mitigating this. They report that EMR allow for a quantitative review of the administrative burden on clinicians and this is a potential future research avenue. Interestingly the introduction of the EMR was not seen as a resource for health care providers, but a demand. Administrative and paperwork burdens increase workload which is strongly associated with burnout and intentions to leave the occupation (Hall et al., 2019). Participants identified a possible solution to the paperwork burden by having health care assistants perform some of these tasks.

Human Resources

Some practitioners queried whether there was the ability to develop the staff already on-site, citing the use of Health Care Assistants to undertake some clinical tasks that carry less responsibility such as phoning patients with test results as "*Something HCAs could do (*RN02*)".*

The primary care practice has Health Care Assistants working within the practice, although they too are likely to feel stretched for time and may feel they are doing duties outside of their role. However, practitioners thought that there was specific work that could be done by someone other than themselves. Recent research from Germany by Senft, Wensing, Poss-Doering, Szecsenyi, and Laux (2019), found that having health care assistants in primary care

was associated with a reduction in hospital admissions, specialist consultations, and medication costs. However, they did not find a reduction in GP consultations by involving health care assistants in routine tasks so greater involvement may not reduce the consultation demands on GPs. Should Health Care Assistants be able to undertake some of the tasks such as follow up phone calls or ensuring test results were available, this could increase provider wellbeing by reducing their job demands. The perception of having more resources available to practitioners may be enough to lessen the demand on them.

Limitations

This study should be considered in light of its limitations. The research was reliant on the participants' memory of how consultations which had a mild to mental health component had been managed prior to the introduction of the FACT service and how the introduction of the service had impacted on them. In addition, there may have been other changes made at the practice prior to the implementation of the FACT service which could make it difficult to determine the impact the FACT service itself had on well-being.

There is little information on what impact patients presenting with mild to moderate mental health needs had on the demands and resources available to practitioners prior to the introduction of the FACT service. Practitioners may have responded to these patients by referring them to off-site community services and may have felt that this was an adequate process in itself.

The research was also limited by the sample size. A number of potential participants declined interviews for a variety of reasons and it was not possible to recruit additional participants or rearrange the interview period to a more appropriate time. The length of the interviews was

also limiting. A consultation session of 15 minutes had been booked for each interview but in this short period of time it was challenging for the researcher to engage with the participant, establish rapport and listen to their stories. The participants may have been mindful that participating in the research was in lieu of seeing a patient at that time which may have affected their engagement with the researcher.

A final limitation is in the use of qualitative research itself which is limited by the difficulty in verifying the results. The extent to which the results of the current study support the implementation of the FACT Service as a resource for improving wellbeing in primary care health professionals should be considered in light of the limitations noted above.

Future Research

As discussed above this study is limited by the inability to measure wellbeing prior to the implementation of the co-located FACT service. Considering the financial support that is being offered by the Government for the inclusion of additional behavioural support services in the community for people with mild to moderate mental health needs, it could be useful to undertake baseline studies of organisations prior to implication of such services. The opportunity to conduct research prior to and following implementation of any co-located brief therapy services should allow for a more robust discussion on the benefits or disadvantages of such services as a resource for increasing work wellbeing.

Consideration should also be given to the feasibility of measuring the wellbeing of all workers in primary care, examining the link between the ability to refer distressed patients immediately to mental health services and the impact on staff well-being. The presentation of a distressed patient impacts not only on nursing staff and practitioners but could impact on administration, frontline, telephony staff and healthcare workers.

In addition to the measures above, the current study identified three areas for future research which were outside the scope of this study but could be considered in light of health care provider wellbeing and adjustments to organisations systems that may impact on wellbeing.

Triaging patients in distress prior to seeing a practitioner

Participants saw the triage facility within General Practice as being an ideal place to determine if the patient was presenting with mental health distress, and if so involving the FACT service prior to any General or Nurse Practitioner involvement. This may result in fewer practitioner consultations as the patient's issues would be addressed by the FACT service. This may only be feasible when a person presents who is in obvious distress otherwise all patients would need to be triaged for mental health prior to the practitioner appointment.

Electronic Medical Health Records

The availability of electronic medical health records for both patients and providers has been seen as an effective way to share health information. However consideration needs to be given to whether providers see this as a resource, making their role easier, or a demand, and the subsequent effect on the wellbeing of providers. Broadly speaking the introduction of the records could add a level of urgency as patients want immediate access to information such notes, results, tests, and medication lists. The computer-based resource may not have reduced the burden of paper at all.

Healthcare Assistants

Recent research suggests that the use of healthcare assistants in primary care can have a reduction on the use of secondary services (Senft et al., 2019), but there is little evidence for the reduction of consultations for practitioners when health care assistants perform routine tasks. However, participants believed that there was a role for healthcare assistants in

supporting their work and exploring this further could help to provide support to practitioners where they deem it necessary to support their workload and improve services.

Conclusion

It was argued that the increase in psychological resources for practitioners to refer patients with mild to moderate mental health needs, would have a positive effect on the individual well-being of referrers into the service. While participants were supportive of the service they struggled to identify it as a single source of improvement to work well-being. Instead they cited a number of additional resources that needed to increase in order to enhance their well-being in the workplace, such as increased patient contact time and less paperwork. As cited by Bakker, and Demerouti (2017), the increase of one resource alone is not necessarily enough to increase wellbeing at work. Each participant was able to identify changes (additional resources) that they believed would enhance their job satisfaction and work engagement. The primary resources identified were more time, more administration support, and professional development education. This study suggests while the ability to refer patients to the ultra-brief therapy had a positive outcome on well-being for both the participant and the patient it cannot be determined if this resource alone had an effect of improving work well-being.

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