A Refreshing Change. Perspectives of Health Improvement Practitioners in Aotearoa New Zealand. A Reflexive Thematic Analysis.

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Abstract

New Zealand is integrating mental health and addiction services into primary care, in line with global trends. Health Improvement Practitioners (HIPs), registered healthcare professionals, provide Focused Acceptance and Commitment Therapy-based interventions to patients with mild-to-moderate mental health care needs. With brief, unscheduled appointments, the HIP model is a new way to deliver psychological services. New Zealand literature on the programme is limited, and no (known) studies have explicitly focused on the HIP practitioner's perspective. To understand how HIPs experience the role, what aspects work well for them and what aspects less well, ten HIPs (nine female; one male) from practices throughout New Zealand were interviewed. Analysis was guided by Braun and Clarke's reflexive approach to thematic analysis - primarily inductive and oriented to experiential meaning. The analysis produced five main themes: *'It took time to fully embrace the model', 'I feel satisfied at the end of my day', 'When it's busy, its good', 'Promoting the role is a burden', 'It's given me a bit of a spring in my step'*. Findings indicated HIPs are satisfied with their role but find promotion tasks burdensome. Not having enough clients negatively impacts HIPs' experience of their role. Low referrals may arise from a lack of training/understanding of the HIP role among the practice team (who refer to the HIP service). Future research could be directed here. The HIP programme has many strengths, is supported by a motivated and optimistic workforce, and is providing New Zealanders with a refreshing change in the mental health and wellbeing space.

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Perspectives of Health Improvement Practitioners in Aotearoa New Zealand

Chapter One

Prevalence rates of psychological distress are increasing globally, and depression is predicted to become the leading cause of disability by 2030 (World Health Organisation [WHO], 2017). In New Zealand, where demand for mental health services has increased by almost 60 per cent since 2008 (Coleman, 2017 as cited in Williams, Haarhoff, & Vertongen, 2017), rates of distress are similarly concerning. The latest New Zealand Health Survey (2021/21) showed that nearly one in ten (9.6%) adults aged 25 and over had experienced psychological distress in the past four weeks (Ministry of Health, 2021a). This figure has more than doubled since 2011/12, when the rate was 4.5%, nearly one in five (Ministry of Health, 2019).

One in five New Zealanders is estimated to have experienced a mental health condition (meeting diagnostic criteria) in the past year (Mathieson, Stanley, Collings, Tester, & Dowell, 2019). New Zealand has one of the highest youth suicide rates in the OECD (Mental Health Foundation, n.d.), which has increased over the last decade (New Zealand Mental Health and Wellbeing Commission [MHWC], 2021b).

The Covid-19 pandemic and associated restrictions have disrupted New Zealanders' lives, causing stress, uncertainty (Ministry of Health, 2021c), greater inequity, and negatively impacting the wellbeing of many (MHWC, 2021b). Young people, in particular, were adversely affected, with higher than usual levels of psychological distress and family harm reported during lockdowns (MHWC, 2021b).

With psychological distress growing globally and in New Zealand, the problem of undertreatment has become more pronounced.

New Zealand's 'missing middle'

Historically, mental health services were targeted at the 3% of the population whose needs were most severe (Williams et al., 2017), leaving those with mild-to-moderate mental health needs with few options (Mathieson et al., 2019). Mental health funding (for severe conditions) was revised to extend to 5% of the population, and provision for mental health services for mild-to-moderate needs increased (Williams et al.) via primary mental health initiatives (PMHIs). While these initiatives did extend general practitioner (GP) consultations and improve support service pathways, access criteria meant only 15% of the population benefited (Mathieson et al., 2019). Those who meet the requirements to access mild-to-moderate services still face long waitlists (Government Inquiry into Mental Health and Addiction [Government Inquiry], November 2018).

Individuals not meeting the severity threshold for specialist care, termed 'the missing middle' (Government Inquiry, 2018), are a concern to GPs. GPs estimate that a quarter of primary care patients are estimated to have mild-to-moderate mental health conditions in New Zealand (Mathieson et al., 2019), yet, according to GPs, "as few as 22% of mild-to-moderate syndromes are formally treated" (p.2). While demand for mental health services has increased over the past decade, demand for mental health services from this group has increased the most (Coleman, 2017 as cited in Williams et al., 2017). This group have been asking for support, but the services have not been there.

New Zealand is currently implementing mental health and addiction services into primary care to address this treatment gap. One of the new behavioural healthcare models being implemented is the Health Improvement Practitioner (HIP) model – a model specifically targeted at addressing the unmet needs of individuals with mild-to-moderate concerns. Health

Improvement Practitioners (HIP) are health professionals working within the new framework to deliver brief interventions to clients in primary care.

This thesis aimed to conduct a qualitative study with a sample of HIP practitioners to gain insight into their experience of the new role and find out, from their perspective, what aspects of the new role work well and what aspects less well.

Chapter overview

The HIP programme tackles many barriers to care identified in the Government Inquiry and presents a promising solution to New Zealand's mental health crisis. How HIP practitioners experience this new healthcare role has not been explicitly studied.

This thesis aimed to conduct a qualitative, interview-based study with a sample of HIP practitioners to gain information about their experience working within the new HIP model and find out, from their perspective, what aspects work well and what aspects less well.

Chapter Two will describe the origins of HIP programme and the HIP programme in New Zealand. Chapter Three will use the Four-frame model (Bolman & Deal, 2017) to frame the critique of the existing literature relating to the HIP programme's implementation into primary care from structural, human resource, political and symbolic/cultural perspectives. Chapter Four will detail the methods used in this thesis to collect and analyse data. Ethical issues, the author's reflexivity and limitations are included here. Chapter Five will present the findings, and the final chapter will present the discussion and conclusions.

Chapter Two

The HIP programme in New Zealand

New approaches in psychological care

Several major shifts in mental healthcare have gained traction in recent years.

Transdiagnostic therapy vs. diagnosis-specific therapy

Cognitive behavioural therapy (CBT) has been the predominant psychological intervention used for clients with mild-to-moderate mental health presentations in New Zealand (Williams et al., 2017). This approach heavily emphasises assessment, and treatments are adjusted according to different diagnoses (e.g., disorder-specific, CBT for depression). For the clinician, this approach to psychological care requires knowledge of many interventions and multiple sessions with clients. The mental disorder/diagnosis paradigm that conceptualises psychopathology as arising from distinct and disordered processes is being challenged by new ways of thinking about mental health and wellbeing.

In the past two decades, interest in transdiagnostic therapies has greatly intensified with promising empirical support (Ruiz et al., 2020). Conceptualising psychopathologies as sharing common underlying processes (Vujanovic et al., 2017), transdiagnostic therapies can be applied to many mental health conditions (Bidwell, 2016), a considerable benefit over disorder-specific protocols (Ruiz et al.).

Some studies have found transdiagnostic therapies to be as effective as single disorder protocols in treating depression and anxiety disorders (Barlow et al., 2017, as cited in Ruiz et al.). Examples of transdiagnostic therapies include Acceptance and Commitment Therapy

(Hayes, Strosahl, & Wilson, 2009), third-wave CBTs, and mindfulness-based interventions (Vujanovic et al., 2017).

Brief intervention vs. traditional multi-session therapy

Another trend in recent years in psychological care has been the emergence of shorter therapies. In New Zealand, brief interventions, ultra-brief interventions and brief therapy are not interchangeable terms. Brief therapy is a short duration of traditional therapy, available to clients whose needs sit at a higher level of stepped care (Te Pou, 2022). In contrast, brief interventions refer to low-intensity, initial response interventions provided to clients whose needs sit at lower levels of stepped care. In some studies brief intervention sessions are as short as five minutes, others up to an hour (Beyer, Lynch, & Kaner, 2018). Common among therapies with time limits, though, is the idea that time can be an effective therapeutic tool (Gálvez-Lara et al., 2019).

The advantages of shorter interventions are numerous and empirical support is growing (Ruiz et al., 2020). Parity of brief interventions with traditional psychological interventions was demonstrated in a large British randomly controlled trial where conventional CBT treatment provided by psychologists was compared to a brief intervention delivered by junior health professionals (Richards et al., 2016 as cited in Bidwell, 2016).

Integrating mental health services into primary care

New Zealand is following the global trend of integrating mental health services into primary care WHO (2012), and the rationale for this is compelling. In New Zealand, between 50-70% of mental health concerns are already managed exclusively in primary care (Mathieson et al., 2019). The placement of mental health services in primary care is also a way to address the high number

of undetected mental health disorders in the community and the high comorbidity of chronic health conditions with mental health disorders (Williams et al., 2017).

There is strong empirical support for the effectiveness of the integrated model of care. For example, a meta-analysis conducted by Hunter et al. (2017) evaluated 29 studies of the Primary Care Behavioral Health (PCBH) model – a prominent integrated model in the US - and concluded that the integrated model yields positive clinical outcomes.

Integrated primary mental health and addiction services in New Zealand

In 2018 the New Zealand government conducted a comprehensive review of the national mental health services (Government Inquiry, November 2018). The report developed from the inquiry, He Ara Oranga, proposed many changes and prompted the NZD$1.9 billion Wellbeing Budget-19 (New Zealand Labour Party, 2019).

Acknowledging the treatment gap and barriers to care for the missing middle, He Ara Oranga called for more early support services and treatment options for common problems and better integration of mental health with primary care. The government apportioned $455 million of Wellbeing Budget-19 explicitly towards this directive which has taken form in a programme of work called the Access and Choice Programme (Ministry of Health, 2020). The initial focus of this programme has been the implementation of the Integrated Primary Mental Health and Addictions (IPMHA) framework. Other priorities are to develop Kaupapa Māori, Pacific, and youth frameworks (Ministry of Health, 2021d).

The rollout of integrated primary mental health and addiction services (integrated MHA services) within this framework began in late 2019 (Ministry of Health, 2021d). Pilot trials of the HIP programme began in 2017, though, so was established in some general practices earlier.

The Health Improvement Practitioner model

The origins of the HIP model lie in Patricia Robinson and Kirk Strosahl's Primary Care Behavioural Health (PCBH) model. This model grew out of their work in the 1980s. They developed one of the first brief interventions for primary care – a therapy for depression (less than three hours) co-managed by psychologists and primary care providers (Robinson & Strosahl, 2009).

The PCBH model consists of two distinct behavioural health models, each with a dedicated healthcare practitioner. A behavioural health consultant works within the Behavioral Health Consultancy (BHC) model, and a health coach works within the Integrative Health Coaching (IHC) model. New Zealand piloted the models in 2017 (Appelton-Dyer, Andrews, Reynolds, Henderson, & Anasari, 2018), and both roles have been adapted and incorporated into the new integrated framework.

Closely modelled on the BHC model, the HIP model amalgamates trends in psychological healthcare and offers brief evidence-based, transdiagnostic interventions to primary care patients experiencing mild-to-moderate mental health or physical health concerns (Ministry of Health, 2021b).

Health Improvement Practitioner services

HIP interventions are brief (twenty to thirty minutes) and follow a standard format (Robinson & Strosahl, 2009). HIP sessions include a contextual interview and functional analysis (Appelton-Dyer et al., 2018) and focus on quickly identifying client values and the difficulties they face (Bidwell, 2016). HIP practitioners use Focused Acceptance and Commitment Therapy (FACT) principles to motivate change and build client self-efficacy (Strosahl, Robinson, & Gustavsson, 2012). Clients leave HIP sessions with a behavioural-based plan (Appelton-Dyer et al., 2018) and wellbeing tools.

HIP services are available to general practices' enrolled populations and are ideally accessible on the same day they seek support. Instead of referring patients to secondary services or external counselling, GPs and nurse practitioners can directly book patients into the HIP service or hand patients over to the HIP practitioners for an immediate or same-day session (a 'warm-handover').

Services are free, do not require a mental health or addiction diagnosis and are available to anyone of any age whose thoughts or actions impact their wellbeing (Pou, 2022). HIP practitioners see individuals and groups and can support various concerns. The most frequently reported issues as of June 2021 included: lifestyle, substance use, anxiety, chronic conditions, depression, relationship issues, sleep, and grief (New Zealand Mental Health and Wellbeing Commission [MHWC], 2021a).

As well as providing brief interventions to patients, HIPs educate the general practice team about the HIP model and work to extend the reach of the HIP service into the community by developing pathways and group interventions (Appelton-Dyer et al., 2018).

The Health Improvement Practitioner role

HIP practitioners are mental health professionals employed by primary health organisations (PHOs) who work in general practices across New Zealand, where integrated MHA services have been established. HIPs work alongside GPs and nurse practitioners (as well as other new integrated service roles; the health coach and Awhi Ora support worker.)

The integrated approach is a very different way of working to traditional psychotherapy (Dobmeyer, 2018). Where the conventional therapist has scheduled appointments and a caseload of clients, HIP practitioners don't have caseloads, can have half their day or more unscheduled, and most clients only come in once (Robinson, n.d.). Where the traditional therapist provides a high level of care intensity across a narrower problem-scope, the HIP practitioner provides low-intensity care across a broad problem scope. Where the traditional therapist role has high autonomy, the HIP practitioner works within the practice team, and the GP maintains overall clinical responsibility for the client (Robinson).

HIP practitioners need to be registered under the Health Practitioners Competence Assurance (2003) Act, the Addiction Practitioners Association Aotearoa New Zealand (Dapaanz), or the Social Work Registration Authority An additional four days of face-to-face training and several practical observation days is required. HIP practitioners generally have psychology/psychotherapy, nursing, occupational therapy and social work backgrounds (Te Pou, 2022).

The theoretical basis of the HIP intervention

Focused Acceptance and Commitment Therapy (FACT). Acceptance and Commitment Therapy (ACT) (Hayes et al., 2009) is a well established and effective transdiagnostic treatment

that conceptualises human suffering to be underpinned by a limited number of processes (Strosahl et al., 2012). These processes collectively constitute 'psychological inflexibility', inflexible and problematic ways of relating to uncomfortable or negative thoughts, emotions, memories, or sensations (Strosahl et al.). The problematic ways people react to negative internal experiences often involve avoidance-type behaviour or cognition. This avoidance response takes people away from engaging in valued action, which the ACT model sees as a central mechanism underpinning human vitality (Strosahl et al.).

Focused Acceptance and Commitment Therapy FACT is a condensed version of ACT and is the theoretical basis for the HIP intervention. The model's authors claim FACT can be applied almost any kind of human problem (Strosahl et al., 2012). FACT helps clients transform how they relate to uncomfortable or distressing emotions, thoughts and sensations. Instead of avoiding those experiences, FACT encourages clients to accept the presence of those experiences – to view emotions as just emotions, sensations as simply sensations, memories and thoughts as only memories and thoughts (Strosahl et al.). FACT helps clients shift their focus, connect with their values and make changes in their lives consistent with those values (Strosahl et al.).

Chapter Three

The Four-frame model and the HIP practitioner perspective.

"The world simply can't be made sense of, facts can't be organised, unless you have a mental model to begin with. That theory does not have to be the right one, because you can alter it along the way as information comes in. But you can't begin to learn without some concept that gives you expectations or hypotheses" (Hampden-Turner, 1992, p. 167).

The HIP programme can be examined from a range of perspectives. This thesis used Bolman and Deal's Four-frame model (Bolman & Deal, 2017) to frame the literature on the programme's implementation into New Zealand and the implementation of similar programmes overseas.

The Four-frame model is a widely used management tool that separates dominant theories, ideas and assumptions from multiple disciplines about how organisations function into four different frames: the Structural Frame, the Human Resources Frame, the Political Frame, and the Symbolic/Cultural Frame. Considering the literature on the HIP programme from these different perspectives will extend and enhance understanding of the working environment for HIP practitioners.

The Structural Frame draws on organisational principles (e.g. maximising efficiency, specialisation of labour) and is essentially concerned with how work tasks and responsibilities are coordinated (Bolman & Deal, 2017). Examining the HIP programme through the Structural Frame puts the spotlight on structural aspects of the programme, such as the goals, objectives, role functions, and outcome measurements.

The Human Resource Frame is concerned with people and relationships and draws on the theory around human needs, emotions, and values. Examining the HIP programme through this frame focuses on working teams, effective relationships and the skills and supports employees need to do and enjoy their work.

The Political Frame is rooted in theory on power and is concerned with how individuals and groups with competing interests negotiate and compromise for scarce resources. Examining the HIP programme through this frame looks at agendas, alliances between parties, issues of influence and control.

The Symbolic/Cultural Frame draws from anthropology, mythology, and social constructionism theory and sees organisations as cultures imbued with symbols, stories, archetypes, and rituals. Examining the HIP programme through this frame looks at the meaning and influence of these constitutive elements that produce organisations' culture and identity.

The Four-frame model has been used effectively in healthcare research. For example, (Thompson et al., 2008) found the model effective for investigating perceptions of professionalism in pharmacy education, and Lowe, Plummer and Boyd (2018) used the model to examine nurse practitioners' perceptions of integrating their role into primary care in Australia. Lowe credited the model with exposing the complexity of the integration process and helping to identify and highlight issues contributing to the role's underutilisation.

Issues noted in prior literature of relevance to the implementation of the HIP programme are summarised using the Four-frame model in Figure 1. A complete examination of the HIP model is beyond the scope of this thesis.

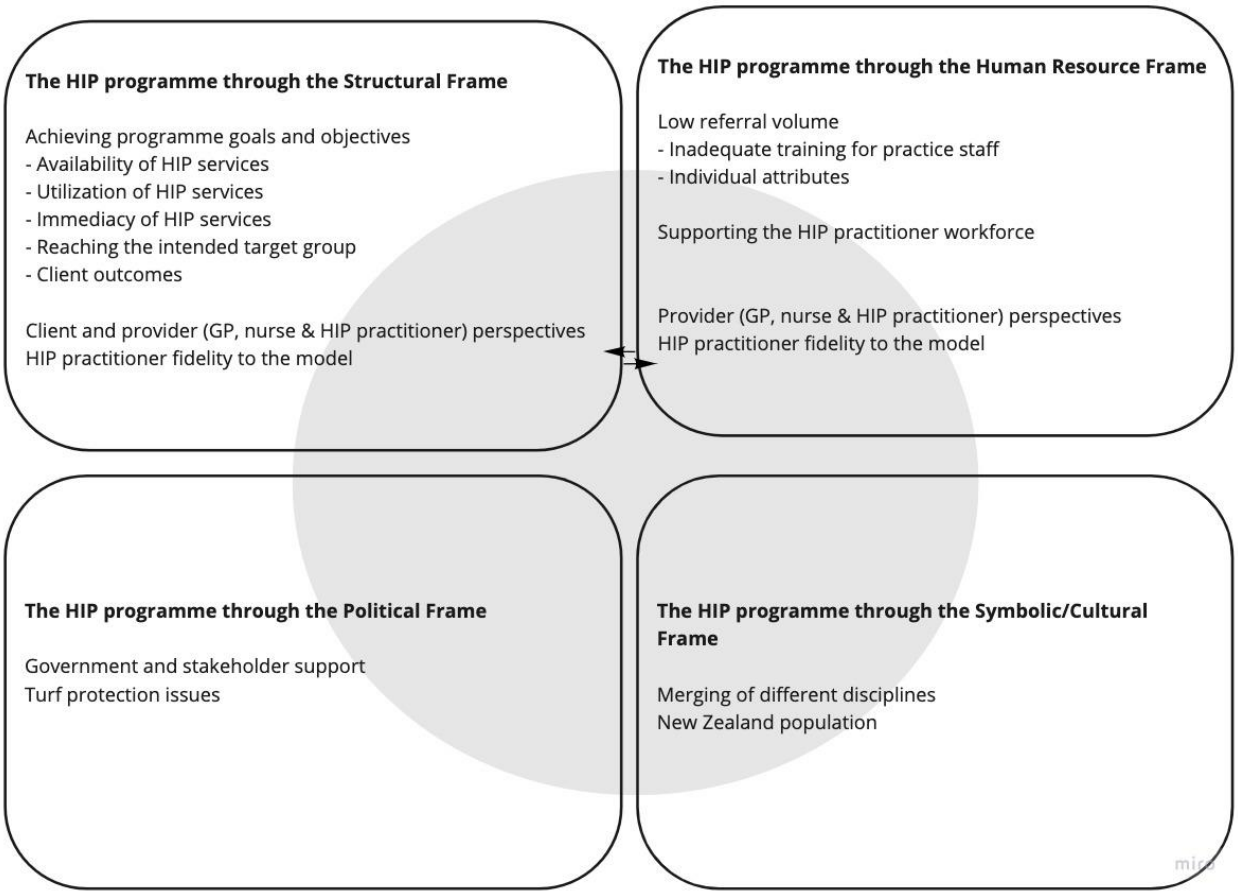

Figure 1. Aspects of the HIP programme identified in the literature relevant to the HIP practitioner's experience of the role and categorised using the Four-frame model.

The HIP programme through the Structural Frame

Achieving programme goals and objectives

Availability of HIP services. Official metrics on the rollout of the HIP programme indicate that despite disruptions from COVID-19, the programme is "on track to meet the target of 325,000 people accessing these new services annually by the end of 2023/2024" (Ministry of Health, 2021, p. 5). As of 30 September 2021, integrated MHA services have been established in 16 of the country's 20 district health boards (DHBs) and 277 general practices (Ministry of Health, 2021d). However, the rollout of these services does not address all barriers to access. Services

are not yet available everywhere; primary care is not always the first port of call for all groups in the community (The Initial Commission, 2020); and the cost to see a GP (a prerequisite for the HIP service) is a significant barrier for many (Ministry of Health, 2021a).

Utilisation of HIP services. In September 2021, close to 11,000 people used integrated MHA (including HIP) services, and 17221 sessions were delivered (Ministry of Health, 2021d). Data from the pilot trials reported good uptake of referrals by clients; 92% of clients referred to the HIP service used the service (Appelton-Dyer et al., 2018).

Several overseas studies on similar programmes reported underutilisation or inappropriate use of services (Farb et al., 2018; Dobmeyer, 2018). Whether this is an issue in New Zealand's rollout was not established in the literature review.

Immediacy of HIP services. In terms of the programmes' objective of 'immediate care', MOH data reported that 43% of people using integrated MHA services (including HIP services) were seen on the same day they asked for support. The vast majority were seen within 3-5 days.

Reaching the intended target group. Intended as a programme to provide low-intensity interventions to a mild-to-moderate need group, several New Zealand studies have however reported that clients using HIP services routinely present with high distress and high support needs (Appelton-Dyer et al., 2018; Burfield, 2019; Berry, 2020). Intended also to provide support for a range of health conditions, both New Zealand and overseas studies indicate a marked dominance of mental health presentations over physical health issues (Beehler et al., 2017), with most common client presentations including depression and anxiety (Alberta Health Services, 2012; Appelton-Dyer et al., 2018; Burfield, 2019).

In New Zealand, the presence of the health coach role (working alongside the HIP to address physical concerns) raises the potential for an overlap of roles/functions (Appelton-Dyer et al., 2018). The Synergia report recommended clarifying each role's function and fit in primary care (Appelton-Dyer et al.).

Client outcomes. Several New Zealand and overseas quantitative studies report that most patients who used HIP services (or similar services overseas) improved (Appelton-Dyer et al., 2018; Burfield, 2019; Berry, 2020; Alberta Health Services, 2012). However, outcomes for clients with more severe presentations were more mixed. A common limitation of these efficacy studies is that measuring change is challenging as many clients attend only one session.

Client and provider (GP, nurse & HIP practitioner) perspectives. Qualitative data shows positive client feedback (Appelton-Dyer et al., 2018; Alberta Health Services, 2012), and indicate that clients appreciate the safety net that the HIP service provides (Berry, 2020). Where client feedback was less positive was around the brevity of the HIP intervention, where some patients felt the intervention was too short (Alberta Health Services).

Though limited, the available qualitative data indicates that HIP practitioners support this way of working and that GP satisfaction with the new role is high (Appelton-Dyer et al., 2018). Overseas interview data from providers and physicians are similarly positive, with GPs in the Alberta Health Project particularly appreciating the onsite presence of the HIP (Alberta Health Services, 2012). In the Alberta Health Project evaluation, GPs and (HIP) practitioners felt they had the opportunity to offer interim support to patients, de-escalate mental health issues and reduce the number of referrals to secondary psychiatric services (Alberta Health Services). Where provider feedback was less positive was again around the brevity of the intervention.

Both GPs and HIPs in the Alberta Health Services indicated the intervention's brevity was a barrier and that the limited number of sessions was not adequate for some patients (Alberta Health Services).

Practitioner fidelity to the model. Another key focus of prior research on the HIP model has examined how closely the HIP model in theory maps onto the HIP model in practice. Mixed practitioner adherence to the 30-minute session was reported by (Appelton-Dyer et al., 2018; Burfield, 2019; Beehler et al., 2017), with sessions often running over time. Beehler looked at 21 studies of integrated service programmes overseas, and reported practitioners found adhering to the 30-minute session challenging due to complex client presentations and the demands of assessment *and* treatment in a short time frame. New Zealand HIP practitioners expressed similar views, sharing that assessment is difficult with 'talkers' who take a long time to answer questions and that the model cannot be followed precisely in high distress and complex cases (Appelton-Dyer et al., 2018). Other 'consistency of care' issues (Berry, 2020) included several follow-up sessions, and long wait times for appointments.

The HIP programme through the Human Resource Frame

Low referral volume. The HIP services are not utilised just by virtue of being available in general practice. Reflecting on the challenge of integrating the HIP model into primary care, the authors remarked: "Regardless of the commonsense appeal of integration, it still has to be 'sold' at the level of the line physician" (Robinson & Strosahl, 2009, p. 8). While the benefits for both clients and practice team are evidenced – and the presence of the HIP practitioner should 'free up' the GPs and nurse practitioners, several studies overseas have reported issues with low referrals (Farb et al., 2018; Dobmeyer, 2018). Several studies flagged building and maintaining

practice team buy-in as an issue**.** In examining the entry of integrated services into six organisations overseas, (Farb et al., 2018) found that translating 'in-theory' staff support to action was difficult. Dobmeyer (2018) similarly remarked that "interdisciplinary functioning does not necessarily improve when a behavioural health provider joins the primary care team" (p. 1).

Inadequate training for practice staff. A lack of knowledge and insufficient training for the practice team were identified as contributing issues (Farb et al., 2018; Dobmeyer, 2018). The amount of training that practice staff receive on the HIP model in New Zealand is unclear. Burfield's study noted two days of training for the primary care staff, but attendance was only for those interested. Nonetheless, a strong recommendation of the New Zealand pilot evaluation, and other studies, was to educate the whole practice in the integrated model, not just the HIP practitioners (Appelton-Dyer et al., 2018).

Individual attributes. GP and HIPs were also suggested to influence practice team referrals, with HIPs who are 'confident, articulate and comfortable creating space for the new role' reported to have to form effective relationships within the practice team (Appelton-Dyer et al.).

Supporting the HIP practitioner workforce. Although two hundred health professionals had undergone HIP training in New Zealand as of the end of June 2021 (New Zealand Mental Health and Wellbeing Commission, 2021a) there are recruitment and workforce shortages (New Zealand Mental Health and Wellbeing Commission).

The importance of building up and supporting the workforce was a strong request from stakeholders in responding to the MOH update report (SIL Research & Ministry of Health, 2021). Counsellors are currently precluded from taking on HIP roles which some service providers would like to see (New Zealand Mental Health and Wellbeing Commission, 2021a). The Kia Kaha report recommended increasing mental health and addiction training for nurses, social workers and occupational therapists and improving the attraction and retention strategies (Ministry of Health, 2020, p. 36).

There has been little elaboration on how HIP practitioners have experienced adjusting to unscheduled rosters, delivering brief interventions, and taking in-session notes (Appelton-Dyer et al., 2018). The high needs of some clients in the New Zealand pilot trials raised concern about burnout (Appelton-Dyer et al.). While supervision and more support for HIPs were implemented, anecdotal reports close to the workforce suggested that stress and staff turnover are still problematic.

The HIP programme through the Political Frame

Government and stakeholder support. The establishment of integrated MHA (including HIP) services has five-year government funding from the Wellbeing-19 budget (Ministry of Health, 2021d). While stakeholder opinion on the new services is generally optimistic, it's "a positive step forward" (Ministry of Health, 2020, p. 65), New Zealand's healthcare system is "a complex network of initiatives and relationships" (Appelton-Dyer et al., 2018, p. 7) and one media publication suggest there are some political issues. A recent newspaper article reported some counsellors are concerned the HIP model is replacing the brief therapy service and is not adequate for the high distress levels in the community (Cate Broughton, 2021).

Turf protection issues. Some overseas studies that have looked at integrated primary care models have identified 'turf protection' issues. In Lowe et al.'s (2018) study of nurse practitioner integration into primary care in Australia, although many nurses felt doctors supported the role, others felt the integration of the role was impeded by doctors feeling pushed out. In Farb et al.'s (2018) study of six US organisations taking up an integrated model, in organisations where implementation had been rapid, staff reported feeling "frustrated, threatened, and unsupported" (p.10).

Interviewees in the Synergia report felt the integrated approach was supported but acknowledged "it's not a quick fix" (Appelton-Dyer et al., 2018, p. 24).

The HIP programme through the Symbolic/Cultural Frame

Merging different disciplines. The medical profession and psychology are disciplines with their own cultures, symbols, rituals, spaces and ways of working. Information on how HIP practitioners navigate this new 'in-between' space is lacking, though perspectives of health professionals who have adjusted to integrated primary care models have been examined, and challenges were identified. In Lowe's (2018) study of nurse practitioner integration, the "embedded cultural differences of the medical profession and the nursing profession" were identified as hindering integration (p. 997). Kaitz found the positioning of the physician at the 'top of the hierarchy', with psychologists and behavioural health providers in supporting roles frustrated psychologists (Kaitz & Ray, 2020). In Farb et al.'s (2018) studies of integrated services in the US, organisations that focused on culture change and allowed the practice team to become familiar with the new behavioural healthcare (HIP) role were more successful in

establishing rapport, buy-in and effective workflow processes. In contrast, organisations adopting a top-down structural approach had more difficulty (Farb et al.).

New Zealand population. Some feedback from HIPs in the Synergia report (pilot trial evaluation) suggested the model could be better adapted for New Zealand's Māori and Pacific populations (Appelton-Dyer et al., 2018). Work is underway to adapt and align the HIP model to Māori and Pacific healthcare frameworks (Ministry of Health, 2020).

Aims and scope of this thesis

There is limited New Zealand qualitative data on the HIP model, and where available, the GP and patient perspectives have dominated. Much of the available New Zealand data is drawn from government or industry rather than academic reports and often reports on the suite of integrated primary MHA services (rather than HIP services specifically). The two New Zealand master's level theses on the HIP model drew from the same pool of participants in the same area of the country. This thesis aims to fill this gap in the literature and conduct a qualitative study to examine the HIP programme from the HIP practitioner's perspective.

Semi-structured individual interviews were used to collect first-hand verbal accounts from participants to address the research question: **How do Health Improvement Practitioners in Aotearoa New Zealand experience their role? From their perspective, what aspects of the role work well and what aspects work less well?**

Chapter Four

Methodology

Semi-structured interviews were used to collect the data, and Braun and Clarke's (2019, 2020) reflexive approach to thematic analysis (reflexive TA) guided the data analysis. These methodologies fit the exploratory aims of the thesis and its critical realist perspective. An experiential orientation to the data meant analysis of interview data was primarily inductive. Codes and themes were developed at the semantic level of analysis, and the findings produced were descriptive, illustrative, and grounded in the participants' words.

Participants. Ten HIP practitioners participated (see Table 1). The participant group consisted of one man and nine women who identified as New Zealand/Māori, New Zealand/Pasifika, New Zealand/European, New Zealand/Overseas heritage, and European/British. The ages of six participants fell in the 30-49 year bracket, and the ages of four participants fell in the over 50 year bracket. Participants were employed by three different primary health organisations (PHOs) and worked in clinics of varying sizes in urban and rural settings throughout New Zealand. Participants held healthcare registrations in nursing, occupational therapy, psychology and social work. Only two participants worked full-time in the HIP role, and most had been in the role less than one year.

None of the participants were known to the author, and none withdrew from the study. One participant disclosed they were not a current HIP (but had been previously). Data from this participant was down-weighted in the final analysis.

Table 1

Participant group characteristics

		N=10
Indicated ages	30 – 49 years	6
	50 years or over	4
Identified genders	Male,	1
	Female	9
Identified ethnicities	New Zealand/European, New Zealand/Māori, New Zealand/Pasifika, New Zealand with overseas heritage, and European/British	**
Hours of work as a HIP	Full-time (37.5 hours per week)	2
	Part-time (20 hours per week and over)	5
	Part-time (under 20 hours per week)	2
	No current HIP hours*	1
Tenure in HIP role	Less than six months	5
	Six months up to 1 year	1
	One year up to 18 months	2
	18 months or over	2
Identified healthcare registrations	Nurse practitioner	4
	Occupational therapist	3
	Psychologist	2
	Social worker	1
Clinic location	New Zealand: North Island, South Island, urban and rural, large cities and small towns	**
PHO Employer	Three separate public health organisations (PHOs)	**

Note. * Not a current HIP. **Not specified to preserve participant anonymity.

Data collection procedures

Recruitment. Recruitment took place between November 2020 and January 2021 and used a purposive sampling method. The author contacted (via email/telephone) six HIP managers from three different PHOs (contact details sourced from Internet searches) and emailed information about the study (see Appendix 1, Invitation to HIP managers; and Appendix 2, Participant information form). Managers were invited to forward this information to the HIP practitioners in their practices. The information form detailed the study's purpose, methods, participant rights and kohā and the research team's contact details. The form invited HIP practitioners to contact the author directly (via email/telephone) if they chose to participate in the study. HIP managers were not informed whether any HIP practitioners from their organisation participated.

Ten respondents were interviewed, at which point recruitment ceased. Ten interviews were considered sufficient to provide relevant data given the project timeframes and were an appropriate number for the qualitative methodology.

Interview procedures. The interview method was used for its suitability in collecting experience type data (Braun & Clarke, 2013). The semi-structured format allowed the interviews to be consistent yet flexible enough for the author to bring in new questions to gain clarity. Focus groups were discounted due to uncertainties around the Covid-19 pandemic, concerns about confidentiality and group and social biases.

The author conducted all interviews in February 2021. Two interviews were face-to-face at HIP clinics in Auckland and eight were via Zoom (Zoom, 2021). The 30-minute interviews were during office hours. Before each interview, the author introduced herself, talked through the

project, and answered questions. At the close of each interview participants were asked if they had anything else they would like to share. Interviewees each received a $30 Whitcoull's e-gift voucher.

Interviews were recorded (video or audio-only as requested by participants) using the Samsung Voice Recorder and Zoom Video Communications applications. Confidentiality was protected by following Zoom's privacy/data storage protocols (Zoom, 2021). Recordings were saved to the authors' password-protected devices and deleted from the authors' password-protected Zoom account. Recordings were accessed by the author only, and all video and audio recordings were deleted from all devices after transcription.

Recordings were manually transcribed and anonymised by the author within two weeks of each interview. Non-verbal interaction transcription was limited to laughter, long pauses and inaudible content. Transcripts were checked for accuracy and to check that the placement of punctuation did not change the implied meaning of the content. Participants were emailed a copy of their transcript to review and amend. No amendments were requested, though one participant submitted additional reflections via email.

Interview guide. The initial six questions asked about demographic and professional background information, tenure in the HIP role and hours of employment (see Appendix 3: Interview guide).

The seven main questions were open-ended and inquired about:

1. a description of participants' typical workday. Prompts included: number of clients per day, types of interventions used, common client presentations, and feelings about the physical workspace.
2. reflections on how the transition from delivering 'traditional' psychological therapy to the HIP model of care had been. Prompts included: feelings about the intervention's brief format, the 'generalised' content, and working in primary care.
3. aspects of the role participants felt worked well for them, and those they felt did not work so well.
4. how participants felt at the end of the workday. Prompts included: what a good day versus a difficult day looked like.
5. the support that participants had in their role.
6. how participants felt their experience as a HIP had impacted them.
7. the changes participants would make to improve the role if they had a magic wand.

Ethical considerations. Consideration was given to the ethical principles laid out by the New Zealand Health and Disability Committee, the Massey University Code of Ethical Conduct for Research and the Te Are Tika Guidelines for Maori Research. It was decided that this project was low risk and there a low-risk notification was made to the Massey University Human Ethics Committee (see Appendix 4: Low risk notification, Massey University Human Ethics Committee).

Informed consent. Written or verbal consent was obtained from all participants. Participants signified they had been informed of their rights, their involvement in the study was voluntary, and they permitted the interview to be recorded (see Appendix 5: Consent form).

Confidentiality and data management. Participant and workplace details were kept confidential to the author. Transcripts were anonymised and potentially identifying information was omitted. Correspondence with participants was via their work or personal email accounts as requested by them. Interview recordings were deleted immediately after transcription. Remaining project data was stored securely throughout the study. Upon completion of the project, remaining data will be stored securely for five years, then deleted.

Anonymity. Given the role's infancy and presumed small workforce, particular care was taken to ensure participant anonymity. To mitigate the risk that participants could be identified from their data, demographic and professional background information was tabulated to describe the group as a whole (rather than individual participants).

***Employment relationship*.** To respect the employer/employee relationship, managers were approached initially (rather than the HIP practitioners directly). This transparency offered an assurance to participants that their managers approved. It was not disclosed to managers whether their HIP practitioner had participated or not, which maintained participant's confidentiality.

Data analysis procedures

Reflexive thematic analysis. Data were analysed using Braun and Clarke's *reflexive* thematic analysis (reflexive TA) approach (Braun & Clarke, 2019, 2020). Braun and Clarke

conceptualise thematic analysis not as a singular method but rather as a methodology encompassing several varieties (e.g. coding reliability, codebook), which can be used in both positivist and qualitative research. Braun and Clarke's reflexive TA is of the 'reflexive variation' category (Braun & Clarke, 2021, p. 7). Braun and Clarke's (2006) publication is credited with popularising thematic analysis in recent years (Byrne, 2021). Reflexive TA updates the 2006 version and more clearly differentiates the approach (Braun & Clarke, 2021). This thesis adheres to their latest publication.

Reflexive TA is an appropriate method of data analysis for this thesis because it sits squarely in the qualitative paradigm and fully "embraces the qualitative paradigmatic assumptions that meaning and knowledge production is situated and contextual" (Braun & Clarke, p. 8). While firmly a qualitative methodology, reflexive TA is not a "fully-embedded methodology" (p. 5), so it works with different epistemological and ontological framings of knowledge production (Braun & Clarke).

The flexibility to suit different qualitative paradigmatic and epistemological assumptions means the method works with almost all types of research questions (Braun & Clarke, 2013). The method also embraces researcher subjectivity and values and sees this process as a part of the knowledge production process (Braun & Clarke, 2021).

Situating the analysis. The theoretical assumptions about knowledge production and meaning that inform this research project have implications for how reflexive TA can be used. The unique placement of this project's assumptions on epistemological and ontological continuums is outlined here, as are the related repercussions for the type of reflexive TA used.

Braun and Clarke emphasise how theoretical positioning falls on continuums rather than dichotomies (Braun & Clarke, 2021) which this thesis acknowledges.

Analysis informed by a critical realist perspective. The epistemological continuum that frames conceptualisations and assumptions about knowledge production and meaning-making sets the essentialist view at one end and the constructionist perspective at the other. Where essentialism assumes that language articulates and reflects inner meanings and experiences (Byrne, 2021) constructionism sees language as constructing our social reality and constructing those inner meanings and understandings.

The critical realist perspective that informs this thesis sits between essentialist and constructionist epistemologies and draws from both doctrines (Butler-Kibser, 2018). The critical realist perspective, on the one hand, holds the view that an external reality (that can be researched) exists but also holds the view that our knowledge of reality is always perspectival; 'partial, incomplete, and fallible' (Maxwell, 2008, as cited in Butler-Kibser, p. 14).

Adopting a critical realist perspective means we can accept that participants' words reflect a *close* reality of *their* meaning and experience (not anyone else's) and acknowledge that there are numerous other valid interpretations of reality. Conscious too of constructionist underpinnings, the critical perspective appreciates the constructive processes of the research in coding (Byrne, 2021) and researcher subjectivity is acknowledged and explored. This analysis perspective is suited to the research question, which seeks to explore participants' experiences and interpretations rather than pre-determined theoretical constructs.

An experiential orientation to the data. This thesis took an experiential orientation to analyse the data, which means that participant's experiences and interpretations are prioritised

over the researcher's (Byrne, 2021) and that participants' words can be considered to communicate a "relatively transparent" representation of their individual experience (Braun & Clarke, 2021, p. 11). In contrast, a critical orientation focuses on *how* participants expressed their views (Braun & Clarke) and the social discourses that shape social reality.

The methodology is appropriate as this thesis aims to get close to participants' thoughts, feelings and experiences to learn what they consider meaningful. In assuming that language reflects internal personal states (Bryne, 2021), the experiential approach will allow this thesis to make claims about the participants' thoughts, feelings and meanings. While still acknowledging the influence of the researcher's subjectivity, this orientation allows for a degree of 'telling it like it is' (Braun & Clarke, 2021).

An inductive approach to data analyses. On an inductive/deductive continuum, an inductive approach to analysis means that meaning is derived from the data (Byrne, 2021) - participants' words and their implied meanings. Deductive analysis, in contrast, ascribes meaning to data that is derived from theory.

Analysis in this thesis was predominately inductive, so coding and theme development stayed 'grounded in the data'. Acknowledging, though, that in reflexive TA, 'pure' induction is not possible as "you cannot enter a theoretical vacuum when doing TA" (Braun & Clarke, 2021, p. 5). An inductive inquiry was appropriate for the thesis because no pre-determined theories were brought in, the research question was exploratory, and the aim was to stay close to participants' experiences.

Primarily semantic coding of data. In line with the inductive inquiry approach, data coding was also conducted mainly at a semantic level of analysis. Semantic codes reflect 'surface level' explanations, while codes produced at a latent level of analysis ascribe meaning to the data extracts informed by theory.

Reflexive TA procedures. Braun and Clarke's six-phase approach to reflexive TA (Braun & Clarke, 2021).

1. *Data familiarisation and writing familiarisation notes.* Transcribing the interviews manually meant close engagement with the data, and the author noted initial thoughts, reactions and reflections in this phase.
2. *Systematic data coding*. Data coding was complete (rather than selective), meaning that the entire data set was coded for "anything and everything of interest or relevance" (p. 206). NVivo software initially used to code the data set was replaced by hardcopy transcripts, highlighters, post-it notes, scissors and an extra-large board.

   Coding was a recursive process that entailed returning to the dataset and revising codes numerous times. Multiple codes were applied where data extracts appeared to relate to several topics. Braun and Clarke material helped steer the author away from single word codes to codes that 'capture the essence' and 'evoke the data'.
3. *Generating initial themes from coded and collated data.* Codes were grouped by topic/idea to produce clusters, forming the initial themes. Braun and Clarke's conceptualisation of a theme is a "pattern of shared meaning, united by a central concept or idea" (Braun & Clarke, 2013, p. 15) that tells a particular story about how a specific cluster of codes relate. Exploring the links between codes was again an active and

iterative process. Some initial themes were expanded into sub-themes. Producing thematic maps aided the refinement of themes and sub-themes. Themes were discussed and refined with input and guidance from thesis supervisors.

4. *Developing and reviewing themes.* Coded extracts relating to each theme were collated. Themes were sense-checked against the coded extracts and against the entire dataset to ensure the data supported themes. Compelling participant excerpts were extracted to support each theme..
5. *Refining, defining and naming themes.* Themes were named carefully (to stay close to the meaning of the data), and used participant quotes were used where possible.
6. *Writing the report.* Writing up the findings deepened and clarified the analysis of the themes.

Chapter Five

Analysis

Consistent with the stated aims and theoretical framework of the thesis, data analysis was principally inductive and oriented to experiential meaning of the data. The analysis produced five main themes and twelve sub-themes. Themes were primarily descriptive and supported by illustrative participant quotes. The analysis is conceptualised visually in a thematic map (see Figure 2).

Thematic Map of Analysis on the Health Improvement Practitioner experience

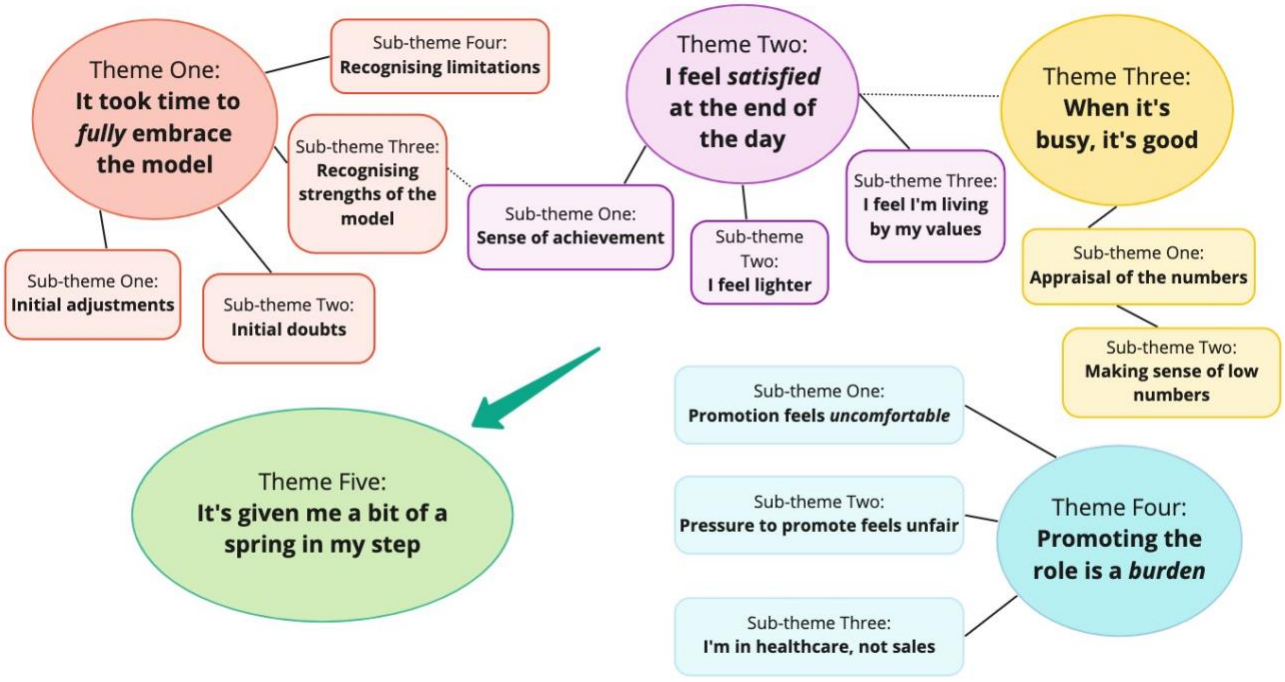

Figure 2. Thematic map of analysis on the Health Improvement Practitioner experience.

Theme one: It took time to *fully* embrace the model

This theme drew on similarities in participants' accounts of adjusting to the HIP model. Sub-theme one captured early adjustment experiences, and sub-theme two, common initial doubts. Sub-theme three assembled key strengths participants identified in the model, and sub-theme four, views on the model's limitations.

Sub-theme one: Initial adjustments. Participants' accounts of their early days in the role depict a stressful induction. Stepping into a *new* healthcare role, using a *new* healthcare model, being (usually) the first HIP practitioner in a clinic (similarly new to the HIP model) was a lot to adjust to. Moving from conventional therapy and 50-minute sessions to the HIP intervention and 30-minute sessions presented challenges for some; learning to work quickly, take concordant notes, ask fewer questions, and focus on one or two functional problems rather than address underlying issues. With the need to also learn new systems and promote the role to staff and clients, it is no wonder that participants felt overwhelmed.

> *Like, I'm still trying to get my head around how the clinic works, the MedTech system, you know, like building a relationship with the staff and the model, and being observed, and you want me to approach patients? It's just all too much (P10).*

Sub-theme two: Initial doubts. Stepping into the role feeling unconfident was not uncommon. Several participants shared they had early doubts about the model and their ability to use it.

> *I think my early sort of experience was that…was my own kind of scepticism and ambivalence around, you know, what can you really do for someone in 30 minutes (P4).*

> *I was not very confident to start with because it is a new model. But I suppose the more feedback I gained from clients about the helpfulness of the interventions, the more confident I've felt in using the model (P1).*

Those doubts decreased over time which participants chiefly attributed to time using the model and feedback. Many explained how they know the model works from the positive feedback and high in-session ratings they receive. One participant told how sometimes clients come into the clinic for something else and pop their head around her door to say, *hey, you know that really works. It's made a difference (P6).* Others shared how they can sometimes see improvement within a single session.

> *You know, I can see people, even physically, change from within half an hour. Somebody who may come in really distressed or in tears, go out with a sense of calmness (P1).*

Poignantly, some participants shared that they know the model works because they use it themselves.

> *I teach these skills to people, but I also see them being really effective on use on myself and with the people that I work with (P4).*

Despite some initial hesitations, at the time of the interviews overall opinion of the model was resoundingly positive.

> *The model is brilliant. I've gone from feeling not that confident about it to actually wanting to bring it into every aspect of my life because I think it is such a good model (P1). Overall, it's incredibly positive (P5).*

Sub-theme three: Recognising strengths of the model. Participants voiced appreciation for many aspects of the HIP model; the model's focus on the here and now, connecting with

values, cultivating accountability, making changes, and setting achievable goals. Commendations were assembled around the model's brevity, the model's action orientation, and the model's helpful structure.

The brief session. Despite the 30-minute session being an initial challenge, for the most part, participants did not feel constrained by the brief session. The majority asserted the timeframe was sufficient for most clients, most of the time, and not usually problematic for them, as practitioners, to adhere to.

> *The majority of the time, it's not an issue to stay within that 30-minutes, even 20 minutes (P6).*

Moreover, most endorsed the brief session and credited the brevity with bringing focus and efficiency into the session. Several reflected that, in longer sessions, things can get lost and people can go down rabbit holes.

> *I actually think setting the expectation of 30 minutes is really good – it's a positive thing. It just seems to help focus people, like, to really get to the core quite quickly. I've never had a sense that people feel rushed around that (P1).*

Action-orientation. Positive feedback also spotlighted the model's focus on taking action. That the client walks away with a plan and has something concrete to work on were frequently flagged as strengths of the model. Occupational therapists seemed especially attuned to the close fit of the HIP model to the practice and philosophy of occupational therapy.

> *It's about doing and doing things differently, and my sort of core belief is that activity is...a way of healing (P5).*

Participant 10's thoughts on the HIP model illustrate her thinking around the benefits of the brief format and focus on action.

> *I actually quite like the fact that it is brief, one-off and really to the point, and that the patients walk away with a plan. Because I think you can be a bit more to the point, you know? 'What are you going to do about this? What are you actually going to do about it?' So, it's not like talking therapy where you just hear them problem talk a lot, but then there is no solution and, like, just a lot of validating from your end. But really, that's not getting the patient anywhere – they are still stuck in the same problem (P10).*

The helpful structure. The model's helpful structure was also commended for its support, guidance and ease of use for practitioners, and facilitation of change for clients. Participant 4 eloquently explained how the structure guides clients to a '*light bulb moment'* when they recognise that their actions do not align with the person they want to be.

> *Getting people to that point is really powerful…they basically write their own plan. So, you know, the last part of the session can go really… quickly because the person is actively thinking about all the things they really want to do (P4).*

Sub-theme four: Recognising limitations. Participants shared an assessment that the HIP intervention is helpful for most clients but not everyone.

> *Every now and again, you get someone who is really highly distressed, and, you know, you feel like you haven't done much to support them (P4).*

In discussing aspects of the model participants felt did not work so well, several participants pointed to the rigidity around adhering to the model's single session ideal. One participant said this had been 'drilled in' during training to the point where she felt reluctant to book follow-ups. One participant felt constrained by the single session ideal at times and shared that she would often like to provide follow-ups to clients *knowing they could benefit from learning a few more skills and focus on a few more areas (P2).* Another explained how it is nice sometimes as a practitioner to check up on clients and see how they are doing (P8).

Interestingly, despite calling for more flexibility around follow-ups, most participants were surprised at the effectiveness of just a couple of sessions.

> *Most people seem to get the help they need in one to two sessions (P1).*
>
> *I've probably been surprised by how much you can… how valuable people find just a short session. It's just kind of reinforcing the value of what can happen in a short period (P8).*

Theme Two: I feel *satisfied* at the end of the day

Throughout the interviews, the HIP role was described as enjoyable, interesting, and rewarding, and, for the most part, participants reported feeling positive at the end of the day.

While the initial months may have been challenging, many participants considered the HIP role less stressful than other roles. Reflecting on prior positions where caseloads had been high and waitlists long, the HIP role was described as welcome by several.

> *I remember about a month after I started, my daughter actually saying to me, 'Your new job must be really boring because you don't come home stressed and moaning about your work colleagues and stuff'. And I thought, well yeah, it's a good job if my kids are noticing that I'm more relaxed at the end of the day (P6).*

Across the board, participants shared that becoming a HIP had been a good personal and professional move, and several remarked on an improved work/life balance.

> *That is sort of one of the reasons why I chose this job - because of family. I need work-life to not be stressful and not so yeah full-on. So, it fits well (P10).*

Commentary on their sense of job satisfaction clustered in several areas. Sub-themes suggested that participants derived a sense of achievement from their work (sub-theme one), felt able to detach from work (sub-theme two), and felt their work has meaning (sub-theme three).

Sub-theme one: Sense of achievement. Many participants shared feelings of achievement at the end of the workday, similar to participant 4.

> *I just have a general sense that I've been really helpful and made a bit of a difference with people (P4).*

Some participants indicated how the practical nature of their work (less note-writing and more client face time) supports their sense of doing something useful, something constructive. Others recognised how positive feedback from clients and the practice staff team continually affirms their work's utility and value. Warm handovers - supporting clients and practice staff in the moment – felt particularly satisfying, providing participants with an immediate sense of achievement.

> *What brings me the most job satisfaction, I think, is seeing people immediately on the same day they present where they…kind of don't expect it…or they are kind of really surprised or elated when they get some support for stuff they may not have previously gotten support for (P9).*

Sub-theme two: I feel lighter. Some of the participant's commentary around feeling satisfied in their role highlighted a shared feeling of lightness in the HIP role. Participants' portrayals connected this sense of lightness to the physical and mental ways they feel they can detach from their work.

Tasks completed during the workday. The fact that client notes are done in-session and the HIP role does extend to case management means work tasks are generally completed during the day. Being able to detach from work, go home, and "do whatever" (P4) was a source of satisfaction.

> *The day is encapsulated in itself. When you are finished, you are finished (P3).*

'Lighter' scope. The fact that the HIP practitioner works within the practice team and that the GP retains clinical responsibility for clients also supports participants' detachment from work.

> *I don't feel like I'm carrying anything. I'm with the team (P5).*
>
> *I feel lighter; I've got this shared responsibility (P3).*

Participant 4 reflected on previous roles and shared how working with people with high-risk

> *plays on your mind all the time. It's not that I'm not seeing those people now, but I'm working with them in such a different way. I'm not their case manager; I'm not responsible for their risk, assessment and treatment plans. I'm there to provide a behavioural health intervention…I just feel lighter, I think. (P4).*

Participant 10 shared that when feeling conflicted, as when she felt she could have done something else with a client or should have followed up, that she manages that discord by reminding herself that case-managing is not her role, and she works part-time hours.

While the model's scope (that it is not therapy) alleviates expectations about what can be achieved in 30 minutes, the structure of the model provides reassurance that there are safeguards in place. The practitioner has received the client's in-session feedback during the session and knows the client has a plan. Participant 4 explained:

> *Even though you might see people presenting with fairly significant risk, you've kind of got that confidence behind you that there is a plan in place, that there are services available for them in the evenings, and that worst-case scenario, you can check back with them in the morning (P4).*

The HIP role's scope, a source of job satisfaction for some, was a point of contention for one participant. Not being allowed to use her nursing registration was viewed as a constraint on her expertise.

> *Legally or job description-wise, I am not meant to talk about medication, although if a GP asks me for my opinion, I would give it (P1).*

Another participant also expressed feeling uncertain about some boundaries of the HIP role and stepping on others' professional toes.

> *I think what I'm challenged by is the idea…of saying (to GPs), ''hey well, I could see that person', or, you know, ''they are going on meds, should it be skills before pills?' (P3).*

Sub-theme three: I feel I'm living by my values. A third cluster of responses indicated that participants' sense of job satisfaction might be underpinned by a sense of purpose and

meaning they derive from their work. Several expressed that the model aligns with their values and principles and that this harmony positively impacts them.

> *It's probably the first role…that I feel like I'm really doing what I was put on Earth to do…I guess I came into the role as a health professional as being able to help people instead of like writing reports…so that part of it is wicked, and I love that I am actually really doing something that can have quite an impact on the community here, potentially over time; and it's much sort of bigger picture than just one or two people long term, so that's very cool (P8).*
>
> *As I have immersed myself into it, I really stand for the idea that you can change a person's life or help change a person's life just in small doses…I feel that since I've started doing this stuff…It's hard to work in another way (P9).*

Theme Three: When it's *busy*, it's good

This theme identifies commonalities in the experiences of participants who reported being busy in their roles and those who reported being relatively quiet. With variable client presentations and unscheduled rosters, most participants reported on the fluctuation of their schedules day-by-day.

> *The day is not predictable at all (P1).*
>
> *You either seem to be absolutely flat out, or you've got nothing happening at all (P3).*

To offer an average number of clients per day, participants tended to approximate a mid-way range between their busy and quiet days. Estimated averages varied considerably, from 4 to 6 clients per day to 8 to 10.

My average is…six, I'd say…a number of days I've had nine or ten, and then there has been some days where I've had maybe three or four. So, I would average six to seven. (P1).

The numbers are not comparable with different work hours, but participants' subjective descriptions of their days similarly showed variability. Some described their days as generally quite busy, while others as relatively quiet. Some participants reported few bookings in advance, while others said that protecting slots for same-day bookings could be a challenge, as demand for HIP services was so high.

Sub-theme one: Appraisal of the numbers. The way participants talked about their client numbers was telling, and a clear preference to be busy stood out. One participant considered her average of 8 or 9 clients per day to be *actually pretty good (P4).* Another remarked that *a good day would be eight* but added *that doesn't happen (P10*).

They want us to see 8-10 per day, but that is not always possible (P2).

Participants reporting higher client numbers did so with noticeably more ease than participants reporting lower client numbers. Several qualified their higher numbers externally, expressing gratitude and luck in joining clinics where the HIP model had been embraced.

I was in a clinic that wanted me there - they were switched on to what the role was. I was lucky in that respect, I think (P6).

In contrast, those reporting lower client numbers did so with discomfort. Several quotes illustrate this unease.

Not having any people is sometimes the worst thing(P5)

When you are quiet, everyone else is busy, so you feel really useless (P10).

Common in some of the reflections of participants who were less busy was an internalising attribution stance that suggested feelings of self-doubt.

> *If you've got a really light day, that can be harder because you feel like…well, I mean you find things to do, but you start questioning yourself, what I am not doing right, you know (P3).*

When asked to compare a good day versus a difficult day, several explicitly responded that a good day is a busy day, and a difficult day is a quiet day.

Sub-theme two: Making sense of low numbers. With HIP clients typically referred into the service by the practice team, in discussing low numbers, participants' comments hovered around factors thought to affect this referral process.

For the most part, participant responses shared confidence that low referrals do not reflect a lack of practice team support but rather other factors/issues impacting the referral process (clinic environment, systems, characteristics of the patient population and practice staff). According to participant 9, the initial introduction of the role into practice may have been insufficient.

> *I think where there is some doubt or hesitation; I don't really blame them. I sometimes think maybe we could've done a better job, like implementing or socialising the whole practice to the model. Maybe we could have somehow warmed them or socialised them a bit earlier on or gone about doing that stuff in a slightly different way (P9).*

One participant suggested that in a small practice, *you simply don't have the volume coming in to be able to funnel into the HIP role* (P3). She calculated that *GPs would need to refer her every*

4th patient to fill her schedule. Conversely, another participant felt smaller practices made it easier to connect with staff and that in large, busy clinics, staff can get *too busy to give us handovers (P9).*

One participant speculated that her rural location could account for high HIP service numbers and might reflect the lack of other mental health services options. Another participants' predominantly student population meant some weeks could be very quiet.

Other environmental factors considered to affect referral rates were the proximity of the HIP room to the clinical rooms and whether the HIP room had a dedicated space or a room that changed day-to-day.

Several systems factors were also identified. One participant explained how GP and nurses routinely book half-hour appointments at her practice, so they have more time to talk with patients, which affects the rate of referrals. Another participant felt the fact that GPs at his clinic cannot book HIP appointments themselves but nurses and reception staff can was a big barrier (P9).

Participants also conjectured how different characteristics of staff members (e.g., age, work style) could affect their tendency to refer.

> *A couple of people, and it tends to be the younger ones, just use you like a prescription, you know, like we've got a young GP - she is brilliant, she's got it, I see lots of her clients. And other GPs are a bit more - I don't know whether they forget or whether they are just pickier, so I guess it just depends on people's style of work, and there's another GP here that I hardly see anybody from (P5*).

Only one participant offered a more jaded explanation;

I don't know why, but no matter how many times I say it, some people just don't get it. Some people just don't want to be on board. It's just too much work, it's just another thing they have to do, you know, they just don't want to add the extra, and even though it's just a quick introduction, they just want to get on to the next patient (P10).

Theme Four: Promotion of the role is a burden

One of the hardest things about being a HIP is having to promote (P4).

During the interviews, participants discussed strategies they use to increase client numbers.

- *Promotion to the practice team*. Reminding the practice team about the HIP service, their availability, and the range of referrals they can take on.
- *Community outreach initiatives and development of pathways*. Developing pathways with practice nurses and health coaches (e.g., using smoke-free sessions to talk about other substance use), connecting with the community via orientation days, engaging with local health professionals and supporting people who have been through emergency departments.
- *Direct promotion to patients*. Contacting enrolled patients who might find the service helpful.

  Today I've seen one patient, and then the rest of the time, I've just been calling people with (health condition omitted) *and basically just telling them they should come and see the doctor, get a review, and introducing myself. And if they want lifestyle support, they can come and see me. Not very exciting (P10).*

> *If I'm around and there's no patients really…I look on the queue and look at all the patients that are here and pick which ones I think would find the service useful; that's how I get patients (P10).*

The topic of promotion was contentious. Participants' commentary expressed collective discomfort and a strong preference to see clients—contention clustered around three prominent themes.

Sub-theme one: Promotion feels uncomfortable. Promoting the role to the practice team was a common source of frustration and uncomfortable feelings. Continually reminding staff of their presence and the presentations they could take on got one participant feeling like a broken record.

> *You have to keep reminding them what you can offer; people get a bit stuck with 'oh that's who - they do depression' (P5).*

For some, staying on practice staff radar meant being visible - hanging out at the nurse's station and floating about common areas - which got one participant feeling like a bit of a nuisance at times and another feeling in other's way.

> *Going to the nurse's station, and I just hang out there quite a lot because they are the ones that hand me patients, mostly (P10).*
>
> *'Hey, got anyone for me? Is there anyone you've triaged that you think I might be able to help with? (P9).*

Talking about direct promotion to patients elicited strong feelings of discomfort among participants. Participant 10's excerpt describes the unease of approaching clients and suggests an underlying fear of rejection.

> *And when you're approaching patients yourself – so they call it cold-crashing - you don't know how they are going to receive it. You know some have been really successful, but others have been like 'I don't even wanna see you, I just want to see the doctor', and that's fine you just let them walk out, but if you're doing that a lot, it really wears you down, you know. It kind of makes you feel a bit like defeated and like 'oh god, what I am even doing here' and then it kind of makes you doubt like 'oooh should I approach this next patient'...it creates a bit of anxiety, or like avoidance of approaching people again. But then you are kind of like, well I need to see people, so it's a real tension" (P10).*

Participant 3 described discomfort with direct promotion, which circled around feeling conflicted about imposing on others.

> *I don't want to be in a sales role, and I'm not cold calling. Like one of the ideas is to cold call high-user patients, but it's almost like telling them to come in; they've got a problem. You know, I don't like doing that. If they are here and they have the need, I'll see them and if we're deciding to say run a workshop on this issue, then contacting them, but not…I don't like imposing onto other people a need that might not be there. (P3).*
>
> *And it's not like you can talk to people and just chit… Here it's like you're on your own, and if you're talking to people, you feel like you're in their way (P10).*

Sub-theme two: Pressure to promote feels unfair. Another cluster of data connected to the theme 'that promotion is a burden' was the pressure some participants felt to promote HIP services and increase their numbers. Most participants declared not feeling pressured to increase numbers, but some cautioned that this could become an issue.

> *I don't feel any pressure from the PHO. PHO is awesome. I work for two different PHOs. Both of them are equally supportive (P3).*
>
> *I think it depends how far they take it; if they start saying, well, you're getting performance managed because you're only seeing an average of 4 people a day… if I get really pressured by that, then I think that will be a conflict (P5).*

Two participants, however, described considerable pressure. Similarities their responses indicated this experience substantially detracted from their enjoyment of the role.

> *They (PHO) are quite pressurising… The notion that I don't have ten people today, 'God what I am going to do'. It's not a good place to be (P2).*

Both commentaries carried undertones of unfairness. Participant 10 described how the pressure around numbers felt undue because the narrow focus on the HIP overlooks other factors and takes the spotlight off the PHOs' promotion efforts (which many participants felt should be increased).

> *And a lot of it is out of your control, but you seem to be put in a position where you have to make it happen. So that is a really hard spot to be in. You know what I mean? It's just, it's just sometimes not nice… Yeah, I felt like a lot of the groundwork should have been done before we arrived, but we had to do a lot of that hard work (P10).*

From participant 2's perspective, feelings of unfairness stem from the unexpectedness of the promotion aspect of the role and the lack of understanding and acknowledgement that it takes time to build up numbers.

> *'It was never marked out - this notion of 8-10 a day as a performance indicator because you know if it were… (P2).*
>
> *It takes a while to grow into the role… and it's not just the HIP growing into the role; it's all the population of the surgery staff who need to grow into it. And at the moment, there is not much recognition that this is a learning curve for a lot of people, and it can't just fall on the HIP alone. Although, you know, they make noises that they want it to, and they're quite critical if you don't, in fact (P2).*

Sub-theme three: I'm in healthcare, not sales. Another cluster of responses suggested that part of participants' discomfort with promotion arises from a conflict with their role identity, wherein participants' view of themselves as healthcare professionals clashes with the promotional expectations of the role. Several participants explicitly voiced this conflict, emphasising they identify with healthcare (not sales).

> *I'm not a salesperson. I'm in health. I shouldn't have to be touting for patients, but that's what they want (P2).*

Several broadened the discussion and questioned the appropriateness of targets in mental health more generally.

> *The whole thing, the whole PHO structure of it, revolves around recording how many people we see, and there is sort of an un…there is a pressure there about getting in a*

> *number of clients, and that bothers me because that doesn't really fit. Like I feel if you've seen three people today and you've stopped somebody killing themselves, that's just as valuable as seeing ten people who you might not have done a very good job [with], and there doesn't seem to be any room to talk about the quality of your interactions (P5).*

While not an enjoyable part of the role, some participants accepted that a degree of promotion was necessary.

> *I do get that it is about population health and seeing enough people, and part of my job is - and it is really explicit. Part of my job is making sure that I'm doing that outreach and getting enough people in, and I get that, but I don't… If I get really pressured by that, then I think that will be a conflict (P5).*

Adopting an optimistic frame, several were hopeful that overtime promotion would not feature so heavily in the role;

as it becomes more of a common thing, it will be less of a hard sell (P5).

Then we won't have to work quite as hard to promote ourselves like we are at the moment. (P4).

Theme Five: It's given me a bit of a spring in my step

A refreshing change. A message of optimism was carried through the interviews. Many welcomed the new approach and felt that something different, more holistic, something in primary care, was needed in mental healthcare. For one participant who had felt burnout and *a bit over it, to be honest*, the role had given her *a renewed sense of hope (P1).*

While participants were optimistic about the model's ability to meet the needs of New Zealanders, some were more confident than others.

> *I firmly believe that because of these HIP roles… people will get the help that they require quickly and more effectively (P1).*

One participant felt the model *can work* but needs more belief from doctors (P10), another thought that the model *should* work well, *in theory, if HIPs get access to the people who are just kind of starting with that sort of low-level anxiety and depression and distress* (P6).

Pioneering attitude. The upbeat flavour of the interviews indicated that many aspects of the model work well for participants. In discussing challenges and aspects of the role that work less well, participants mostly adopted a pioneering attitude and optimistic stance that settling-in crinkles would be smoothed out over time. Many concluded their interviews with positive summations of the model, with the caveat that *there is still some way to go (P9).*

Chapter Six

As described and critiqued in Chapters Two and Three, prior studies on the HIP and other integrated models have not exclusively examined the HIP practitioner's experience. Addressing this gap in the literature, this thesis sought to understand from the HIP practitioners' perspective: *What the experience of being a HIP is like? What aspects of the HIP role work well, and what aspects of the HIP role work less well?*

The analysis produced five main themes, key findings that characterise the HIP practitioners' experience as a journey of overcoming early doubts, adjusting to new ways of working, embracing the model and building up belief over time. HIPs appreciate numerous aspects of the model (its brevity, structure, in-feedback, working with FACT action orientation, values, efficacy) and enjoy aspects of their role (its scope and shared responsibility, working in a team, the GP setting, receiving positive feedback). Becoming a HIP for many is a fulfilling and transformative experience that positively impacts both professional and personal life spheres; the values of the model so intuitive, they become entwined with one's own. As one participant expressed, *FACT becomes part of you.*

The HIP experience is not entirely rosy, and the experiences of HIP practitioners can look very different. Those with low client numbers and those perceiving pressure to promote their role had more negative experiences and feelings. All found the promotion aspects of the role hard, a discord that may arise from conflicting ideas about their identity as healthcare professionals and that targets (number of clients) do not fit with mental health. HIPs identified

several aspects drawbacks of their role, including having to promote the role, the single session ideal, and not having enough clients and referrals.

Overall HIP practitioners in this study were optimistic about the model's future in New Zealand.

The remainder of Chapter Six will discuss these findings in light of the earlier research on the HIP and other integrated model programmes, noting areas of overlap, differences, and the thesis's contributions to the knowledge base of the HIP role in New Zealand. The implications of these findings, in terms of the HIP programme in New Zealand, will be discussed using the Four-frames model. Chapter Six ends with the thesis's conclusion and limitations, suggesting focus areas for future research and recommendations.

Discussion

HIP practitioners are generally satisfied with the role. HIP practitioners' role satisfaction supports the sentiments of earlier studies (Synergia report, the Alberta services project). The interview format of the current thesis allowed greater investigation into this satisfaction and suggested a sense of achievement and meaning underpins it. Mastery and purpose are core drivers of motivation at work (Pink, 2009, as cited in Bolman, 2017).

Interestingly, the potential for burnout, raised in the Synergia report and reported anecdotally, was not supported. While some participants reflected on a stressful induction, at the time of interviews, nearly all participants cited feeling satisfied with their role and or satisfied at the end of the day (even who said they at times felt overwhelming busy).

Implications for the HIP programme through the Four-frames. High job satisfaction indicates a good job fit. When job fit is good, employees derive satisfaction and meaning from their work, and organisations get the "talent and energy they need to succeed" (Bolman, 2017, p. 134). A motivated and satisfied HIP workforce is a strength and protective factor in the HIP programme's human resource frame. Knowing what current HIPs enjoy about the role could be gainfully applied to practice to address retention and recruitment issues.

Similarly, knowing that promotion is burdensome and some HIPs feel constrained by some aspects of the model's scope and structure can also be used to provide more clarity to new candidates and improve role fit and retention.

Some HIPs struggle with low client numbers. Although surprising to learn that some HIP practitioners struggle with low client numbers, underutilisation of integrated behavioural health programmes is not uncommon. Farb (2018) and (Dobmeyer (2018) similarly reported underuse in several overseas studies, as did the nurse practitioner programme integrating into primary care in Australia (Lowe et al, 2018).

This thesis builds on this earlier research and provides insight into how underutilisation impacts participants (leads to them doubting themselves and feeling unproductive). As clients are referred to the HIP service by the practice team, it is understandable that HIPs look to this workflow system when trying to make sense of low numbers. Low referrals was an issue discussed by Farb (2018) who found that in-theory support does not always translate to practical support, the dominant view of this thesis was that low referrals do not reflect negative buy-in or lack of practice team support, but rather reflect other factors - in particular, lack of understanding of the HIP model/role.

Implications for the HIP programme (through the Structural and HR frames). Underutilisation of HIP services is a problematic structural flaw, and structural flaws need addressing (Bolman, 2017). Underutilisation indicates that, in some areas, the HIP programme is not achieving its prime objective, jeopardising the programme's success.

As detailed above, issues within the HR frame (e.g., lack of understanding of the model) can contribute to underutilisation. Equally, underutilisation can create problems in the HR frame; "if employees have too little work, they become bored and can get in other people's way" (Bolman, 2017, p 89).

Figure 3. conceptualises how referrals, HIP service utilisation, and HIP practitioner experience may relate using the Four-frame model.

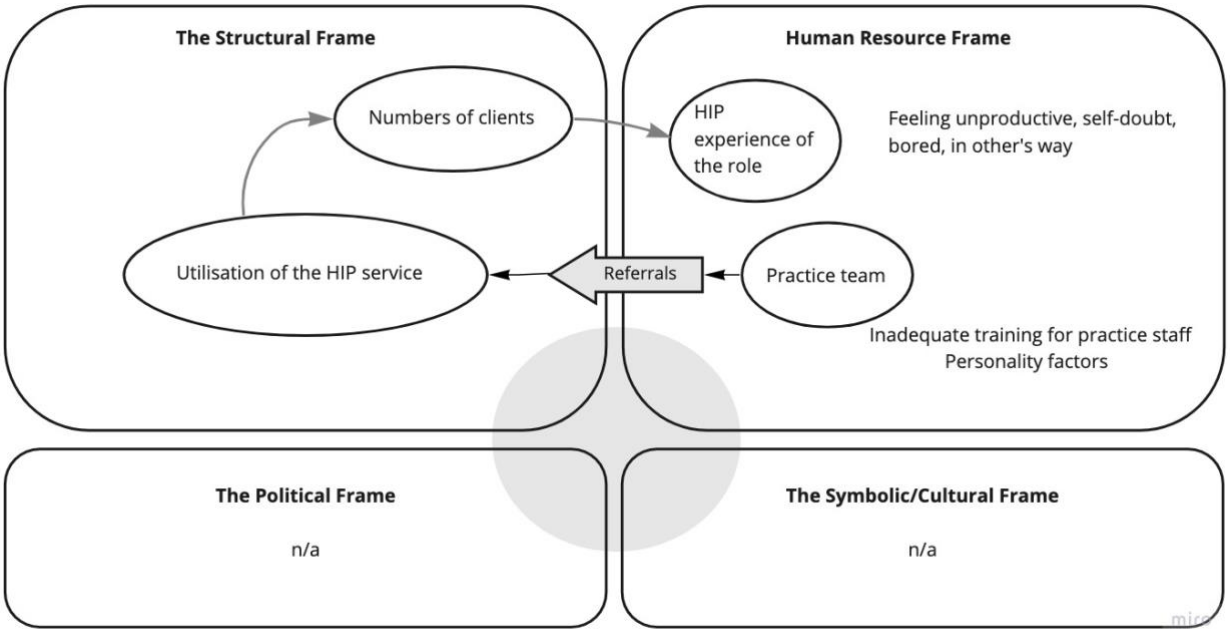

Figure 3. Conceptualisation of how referrals, HIP service utilisation, and HIP practitioner experience may relate using the Four-frame model.

Promoting the role is a burden. The topic of promotion was not prominent in the literature review. Participants' strong disinclination towards this part of their role made it a salient theme of this thesis and illuminated a new avenue for consideration and future research.

Implications for the HIP programme (through the HR frames). HIP's unease with the promotional aspects of their role has a heavy foot in the programme's HR frame. While HIPs may make accommodations for this aspect - because the position is new, there is so much that they enjoy, and they want the model to succeed – this may weaken over time.

We are still finding our feet. HIP practitioner's comments and previous research indicates some issues are yet to be smoothed out. The call from participants in this thesis that it takes time is grounded in their own experience. Just as they took time to adjust to the new model and new ways of working, they acknowledge practice teams and clients and clinics, and PHOs also need time. This is consistent with prior research about implementation programmes.

Conclusion

In response to the national inquiry into mental health and addiction (Government Inquiry, 2018), the HIP programme, providing immediate, free, early support services in primary care, presented a promising solution. Findings from this thesis, grounded in the words of ten HIP practitioners, support that view. The core component of the HIP programme, the FACT-based intervention, is robust and well supported by practitioners. With solid structural

architecture and a motivated workforce in the human resource frame championing the model, the outlook for HIP practitioners and the HIP programme overall looks promising and on track to provide New Zealanders with a refreshing change in the mental health and wellbeing space.

Future research

Future research could be beneficially directed towards identifying and examining factors that affect the referral process. Quantitative future inquiries could establish the prevalence of underutilisation or assess the programmes' impact on referrals to secondary care. A follow-up qualitative study with another sample of HIP practitioners may support or challenge the findings of this thesis.

The feasibility and utility of the HIP model applied to other early intervention settings, such as telephone, text, or web support, would be highly valuable.

Limitations

The findings, recommendations and stated implications of this thesis need to be considered in light of several limitations. The small participant group, ten participants, draws from just three PHOs. While an appropriate number for this study, it is apt to emphasise that findings cannot be generalised or considered representative.

Data collection occurred under level 2 Covid restrictions (February 2022). Some recommendations/findings may be timebound (client numbers at clinics may have been less than usual).

This study does not reflect changes to the HIP practitioner training implemented after data collection. Clinics included in this study were at various stages of implementation – some relatively new. A study of only practices with well-established programmes may provide a better picture of integration.

The thesis used the Four-frame model as a tool, but the commentary was concentrated on the Structural and HR frames. Considering all frames is important to build a comprehensive picture of the programme, and further investigation into political and cultural/symbolic issues would flesh out understanding.

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Appendices

Appendix 1: Invitation to HIP managers

Example of the recruitment email sent to PHO HIP managers

Attachments: Participant Information Sheet and Participant Consent Form

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Dear (HIP Manager)

I am conducting a qualitative research study looking into how **Health Improvement Practitioners in Aotearoa New Zealand experience their role.**

This project is part of my Master of Arts (Psychology) degree and complements other Massey University studies that have considered the role from the perspectives of patients and other health professionals.

I've attached the Participant Information Sheet which details the project, and, with your permission, I would like to invite the HIPs at (PHO name) to participate in a confidential 30-minute interview.

If they choose to participate, their participation will be confidential, their interview material anonymized, and their personal and professional information de-identified. Any information that connects the HIPs (or PHO name) to the interview material will not be published.

Thank you so much for looking over this and please let me know if I may give you a call.

Yours sincerely,

Gillian Gilbride

Gillian.Gilbride.1@uni.massey.ac.nz / 022 1945-315

Supervisors: Dr Don Baken and Dr Dianne Gardner
D.M.Baken@massey.ac.nz / D.H.Gardner@massey.ac.nz

Appendix 2: Participant information sheet

PARTICIPANT INFORMATION SHEET

How Health Improvement Practitioners in Aotearoa New Zealand experience their role.

Kia ora, my name is Gillian Gilbride. I am a Master of Arts (Psychology) student at Massey, currently researching the experiences of Health Improvement Practitioners.

The Health Improvement Practitioner (HIP) role was introduced in 2016, and my thesis research is one of a number of studies which we are carrying out to evaluate this role from the perspective of clients, other health practitioners and the HIPs themselves.

As a current Health Improvement Practitioner, I would like to invite you to take part in my study. I hope to interview seven practitioners. Each interview will take around 30 minutes and will be carried out on Zoom. If you are Auckland-based, I can arrange a kanohi-ki-te-kanohi (face to face) interview if you prefer.

Findings from the study will be presented in my thesis and in a report. A summary of the findings can be sent to you, if you wish, when the study is finished next year.
Participants will each receive a $30 Whitcoulls e-gift card in appreciation of your time and input.

Participation is voluntary and confidential. If you decide to take part, you do not need to answer any questions that you don't want to, and you can ask for the recorder to be turned off, or for the interview to be ended, at any point.

Access to interview recordings will be restricted to myself only. Recordings will be stored securely on a password-protected computer and deleted as soon as I have transcribed them.
Participant names will be not be included in the transcripts. I will send you a copy of your transcript to review.

Your demographic and professional information will be de-identified, and information that could connect you or your workplace with your answers will not be released.

My supervisors will have access to anonymized transcripts and de-identified information only.

I have sought permission from your practice manager to contact you but, beyond this, your employer is not involved in the project and will not be told whether you participated in the project or not. If you would like to discuss participation in this project with your manager, please do so.

If you would like take part in the study, or if you'd like more information**,** please email or call me, or my supervisors. Our contact details are below.

Yours sincerely,

Gillian Gilbride

Gillian.Gilbride@outlook.co.nz or 022 1945-315
Supervisors: Dr Don Baken, D.M.Baken@massey.ac.nz / Dr Dianne Gardner, D.H.Gardner@massey.ac.nz

"This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics), email humanethics@massey.ac.nz. "

Appendix 3: Interview guide

Interview guide

Date: Time & place: Interviewee:

Kia ora, my name is Gillian Gilbride. Thank you for agreeing to this interview. This interview is part of my thesis project which aims to understand the experience of the Health Improvement Practitioner in New Zealand.

The interview should take around 30 minutes. I have six background questions and seven main interview questions for you.

Your interview will be anonymized and information that could identify you or your workplace will not be published. If you would prefer not to answer a question, please say so.

Do you have any questions about the Participant Information Sheet or Consent Form? Do you have any other questions before we start?

Background questions

Q1. Approximately how many hours a week do you work as a Health Improvement Practitioner?

Q2. How long have you worked as a Health Improvement Practitioner (or Wellness Advisor/ Behavioral Health Consultant)?

Q3. What is your professional background (or what work were you doing before)?

Q4. Which age bracket are you in 20-29, 30-39, 40-49, 50-59, 60+, or would you prefer not to say?

Q5. Do you identify as male, female, other, or would you prefer not to say?

Q6. Do you identify as Maori, New Zealand/European, Pasifika, other, or would you prefer not to say?

Main interview questions

Q1. What does a typical workday for you as a Health Improvement Practitioner look like?

Probes:

- How many clients do you typically see in a day? And in a week?
- What types of brief or ultra-brief interventions do you typically use?
- What kinds of clinical presentations do clients typically present with?
- What is the physical space that you work in like?

Deeper probes: *What is that like for you? / How you feel about that? How do you feel in this space?*

Q2: The HIP model is a very different way for mental health professionals to deliver psychological care. Can you reflect on how this has been for you?

Probes:

- In terms of delivering brief interventions (i.e., 30-minute sessions & 4 session limits)
- In terms of delivering more generalized interventions (e.g., FACT)
- In terms of working within primary care (i.e., at the GP clinic in an integrated team)

Deeper probes: *How did you feel about that? Does the model allow you the flexibility you need to support the clients you see?*

Q3: What aspects of the HIP way of working, work well for you? And what aspects of the HIP way of working, do not work so well for you?

Deeper probes: *What do you think this might be due to (e.g., training, personality or model factors)? Do you think other HIPs share your opinion/ have a similar experience?*

Q4: How do you feel at the end of your workday?

Probes:

- What does a really good workday look like?
- What does a really difficult workday look like?

Deeper probes: *Can you describe an example? What is that like for you? What do think is behind those days? When you have a day like that, how do you reflect on it? What other aspects of the role brings you enjoy/ do you find challenging? Do you often have days like that?*

Q5: What supports you in your role? (e.g., people, the training, the model, self-care) Deeper probes: *What does having this support mean to you?*

Q6: Reflecting on the wider context of your life and who you are as a person and as a health professional, how do feel your experience as a HIP impacts on you?
(Or re-phased: How do you feel your experience as a HIP shapes or fits into your life?)

Probes: *In terms of your work/career life, your home/personal life, or your sense of identity/ your life story?*

Q7. If you had a magic wand, what changes would you make to improve the HIP role?

Deeper probes: *If that happened, what would that mean to you/ for you?*

End of interview

Q8: Is there anything else you would like to share with me regarding your experience as a HIP?

Thank you

Would you prefer me to send your $30 Whitcoull's e-gift voucher to your *personal* or *work* email? (Present in person for in-person interviews).

I will send you a copy of your interview transcript within two weeks (date). Would you prefer me to send transcript to your *personal* or *work* email?

If you would like to amend your transcript, please let me know within two weeks of receipt of your transcript.

Thank you for your time and your insights.

Appendix 4: Low risk notification, Massey University Human Ethics Committee

Email: 18 November 2020 at 2:08 PM, humanethics@massey.ac.nz<humanethics@massey.ac.nz>

HoU Review Group
Ethics Notification Number: 4000023282
Title: How do Health Improvement Practitioners (HIPs) in New Zealand experience their role?

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director (Research Ethics),
email humanethics@massey.ac.nz. "

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish require evidence of committee approval (with an approval number), you will have to complete the application form again answering yes to the publication question to provide more information to go before one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

You are reminded that staff researchers and supervisors are fully responsible for ensuring that the information in the low risk notification has met the requirements and guidelines for submission of a low risk notification.

If you wish to print an official copy of this letter, please login to the RIMS system, and under the Reporting section, View Reports you will find a link to run the LR Report.

Yours sincerely
Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and
Director (Research Ethics)

Appendix 5: Consent form