“I know there’s a net there”: Experiences of Focused Acceptance and Commitment Therapy (fACT) intervention; a new approach to psychological support in primary care

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Abstract

Psychological distress occurs at an increasing rate within society, with research into the levels of care showing a disturbing gap, especially in the “missing middle”. There has been a growing trend to increase access to mental health services by developing integrated care models within primary healthcare organisations in New Zealand in an attempt to deal with distress in earlier stages. Through semi-structured interviews, this research gained insight to the experiences of patients who participated in a fACT therapy service offered at a primary healthcare organisation in Palmerston North, New Zealand. Participants responses were transcribed and themes identified. By focusing on patients’ perceptions of value, and how they made sense of accessing psychological support services within primary care, three main themes emerged from the findings: expectations of care, stigma and processes. Findings showed that patients could be split into two different groups. The first, those with mild to moderate psychological distress, reported positive experiences including a reduction of stigma, increased access to services and an alignment with their holistic model of care. The second group, typified by those experiencing severe or chronic distress, were also positive in regards to the concept of the service, but were found to more often report negative experiences due to expectations, and value of care. Overall, patients who engaged in the fACT service were supportive of the ability to access mental health services directly from within their GP clinic. Their experiences led them to form strong opinions about the future of the service and its availability to others who are in distress. Issues around processes, such as consistency of care and time delays, and the effect this had on patients’ experiences, were also discussed in the findings. Recommendations for areas of future research were also discussed.

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Introduction

Psychological distress is at epidemic levels within New Zealand, with around one in five people experiencing a behavioural health or addiction issue each year (Oakley Browne, Wells and Scott, 2006; Colman, 2017). Across a lifetime, it is reported that behavioural or mental distress will be experienced by between 50% to 80% of people living in New Zealand, with evidence showing that these numbers continue to rise on an annual basis (Moffitt, Caspi, Taylor, Kokaua, Milne, Polanczyk and Poulton, 2010; Oakley Browne, et al., 2006).

In 2018, the New Zealand Government inquiry into mental health released a report - He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction - which found an increasing number of young people were showing signs of behavioural health issues, through acts such as self-harm. The report also found that the annual cost of behavioural health to New Zealand in a financial sense, excluding the human cost, was in excess of $12 billion each year, equating to 5% of gross domestic product (New Zealand Government, 2018). The report shone a light not just on the history of mental health within a New Zealand context, but alarmingly more so what could be in store for the country if trends within the health sector continued without an increase in resources and commitment. Prevalence for all behavioural disorders in New Zealand are some of the highest in the world when compared on a global scale, with almost all disorders having a moderate interference on a person’s life (Wells, Oakley Browne, Scott, McGee, Baxter and Kokaua, 2006). The most common types of psychological distress in New Zealand include anxiety, stress, trauma, depression and substance abuse, and are often co-morbid with other disorders or health conditions such as chronic pain or diabetes (New Zealand Government, 2018; Oakley-Browne et al., 2006). Trying to manage these chronic diseases whilst simultaneously treating behavioural health conditions can be complex and costly to both the patient and the health system (Kazak, Nash, Hiroto and Kaslow, 2017). Research from the

United States found that risk factors and largely preventable and modifiable behaviours, such as smoking, inactivity, alcohol use and poor diet, played a significant role in almost half of all premature deaths (Kazak, et al., 2017; Byrne, et al., 2016).

Globally, the World Health Organization (2017) estimates that nearly 1 billion people live with some type of behavioural or substance abuse disorder. Depressive disorders are expected to be the second most common cause of global disease burden by 2020, beaten out only by ischaemic heart disease (World Health Organisation, 2001). Despite this, only a third of people experiencing psychological distress seek professional help worldwide, leaving around two-thirds of those suffering from poor mental health without being seen or assessed by a healthcare specialist (World Health Organization, 2017).

In line with the growth of psychological distress prevalence in New Zealand, the number of people accessing behavioural health and services associated with addiction has also grown 73% in the 10 years to 2014 (Te Pou o Te Whakaaro Nui, 2014). The majority of people experiencing psychological distress and who reach out for help in New Zealand do so at a primary care level (Gauld, 2013), with around three-quarters of people with a diagnosed psychological disorder receiving care from their general practitioner (GP) (Goldberg, 1999; Dew, Dowell, McLeod, Collings and Bushnell, 2005). Large institutions for psychological patients were disestablished in the 1990s and instead, acute inpatient facilities for the most seriously affected are attached to general medical hospitals at some of the 20 state-funded District Health Boards across New Zealand (Smith and Jury, 2017). Funding for behavioural health is also given to a range of non-governmental organisations (NGOs) and Primary Health Organisations (PHOs) (Smith and Jury, 2017).

New Zealand is seen on a global level to have a strong primary health system, which is made up of largely independent, self-employed service providers, such as GPs, that receive

50% of their funding through PHOs (Stokes, Tumilty, Doolan-Noble and Gauld, 2017). Service users make up the remainder of the funding through charges set by individual GP practices, which usually range from around NZD$15 to $45 per appointment, with some further discounts available for low socio-economic or high needs patients (Stokes, et al., 2017). Research has found that the cost of accessing primary health care in New Zealand, despite the significant subsidy, remains a large barrier to access for service users (Jatrana and Crampton, 2009; Stokes et al., 2017). A large-scale New Zealand study found that people with an internalising disorder, such as depression, anxiety or bipolar, were three times more likely to not pick up a prescription item from a pharmacy due to cost when compared with those presenting at GPs with other diagnosis (Lockett, Lai, Tuason, Jury, and Fergusson, 2018). They were also more likely to be unable to make an appointment with their preferred GP within 24 hours, unable to attend their GP due to transport issues, and less likely to have a positive experience with their GP once they were eventually seen (Lockett, et al., 2018). These types of barriers, often linked with financial strain or socio-economic conditions, produce a "gatekeeper" situation, whereby patients are required to pay money at a primary care level to gain further access to a health care system which is often free of charge at a secondary district health board level (Jatrana and Crampton, 2009; Stokes et al., 2017; Bourgueil, Marek & Mousquès, 2009).

Given the rise in psychological distress in the community, issues around who gets care and how that care is initiated need to be considered. There are inherent issues around how and what symptoms a service user presents with at a primary care setting. Research has shown that patients who are affected by some type of behavioural health concern are likely to go to a doctor with different symptoms, often physical symptoms, and not view their concerns to be mental health related (Bushnell, et al., 2003). Within that initial consultation of just 15 minutes, GPs are required to not only assess what the patient is highlighting as their main concern, but also investigate underlying issues and undertake a broad measure general health screen (Stokes, et al., 2017). This is seen as a significant stressor for medical professionals who are often expected to deal with complex comorbid health conditions in a brief time, as well as concurrently assess a patient for psychological symptomatology (New Zealand Government, 2018). International research has shown that in some cases, there is a significant proportion of patients who are not diagnosed correctly by the GP when it comes to psychological issues (Goldberg, 1999; Dew, Dowell, McLeod, Collings and Bushnell, 2005). Reasons for this have been attributed to pressure from within the practice, lack of knowledge of assessment tools, insufficient referral services, socio-cultural factors, and models of doctor-patient consultation structure which may not provide flexibility (Dew, et al., 2005; Stokes, et al., 2017; Chew-Graham, Mullin, May, Hedley, and Cole, 2002). Competence and confidence also appear to be two of the biggest factors that dictate the level of diagnosis and care provided by GPs for psychological distress. Some research has found practitioners are more likely to provide a mental disorder diagnosis and offer non-pharmacological treatments for the diagnosis only if they undertook some additional training for treating psychological distress within their service (Naismith, Hickie, Scott and Davenport, 2001). This type of situation creates tension for both the service user and health professional; the client may feel their psychological needs are not being met by their GP whilst the GP may feel the service user is not being open about their symptoms, or the doctor themselves may feel a range of stressors which impede their ability to diagnose correctly. Numerous reviews into the New Zealand mental health system have highlighted issues around mental health presentations in primary care (New Zealand Government, 2018; Bushnell, et al., 2003). These types of concerns have been echoed by staff working in primary care in New Zealand, who also raised issues around gaps in social support, lack of continuity and inadequate availability of talk therapies (New Zealand Government, 2018). In the 2019

Budget announcement, the Labour-led coalition Government announced an injection of more than $455 million in to providing frontline access to mental health services through GPs and other primary care providers (Robertson, 2019). It was hoped the new initiative would help more than 325,000 people by 2023/24 through strengthening existing services with increased DHB funding that would trickle down to assist acute, primary and community-based needs through early intervention (Robertson, 2019). Much of the push behind the so-called ‘Wellbeing’ Budget has focused on the areas highlighted in the He Ara Oranga (2018) report, with programmes looking to be introduced that focus specifically on areas such as increasing the mental health workforce and access to different therapies - including brief therapies such as the one at the focus of this research (Robertson, 2019).

Notwithstanding evidence which shows psychological distress occurs at an alarming rate within society, especially in New Zealand where the suicide rate is one of the highest in the world (Ministry of Health, 2013), research into the levels of care for psychological distress show a disturbing gap, especially in the “missing middle” (New Zealand Government, 2018). Investment, resources and focus in New Zealand in the past have too often placed upon those in “crisis mode”, rather than a focus on prevention or early intervention (Minister of Health, 2005). National mental health plans have instead placed a focus on those who suffer “major” mental health issues, estimated to be around 3% of the adult population, leaving out provisions for the 17% who are estimated to experience “mild to moderate” psychological distress (Minister of Health, 2005). Historically, treatment of those who do reach out has also often been applied through a broad-brush approach of medication, rather than assessing the role of alternative therapies, support services, psychological interventions and wraparound care (New Zealand Government, 2018). According to the Health and Disability Commission (2018), the number of prescriptions for mental health-related medications in New Zealand has increased by 50% in the past decade and has continued to grow by 5% annually. That dominance on medication-based treatment, rather than recovery options, has raised concerns amongst mental health specialists, researchers and government departments (New Zealand Government, 2018). The 2019 Wellbeing Budget aimed to target these concerns head-on by placing increased importance on creating a more holistic and integrated healthcare model which would challenge and change many of the barriers currently in place for those seeking treatment for behavioural distress (Robertson, 2019).

Integrated Healthcare Models

Over the past 30 years, there has been a worldwide trend towards finding a healthcare model that is more organised, collaborative, community-based and seeks to allay much of the disparity between users within many Western health systems (Kroenke and Unutzer, 2017; Shortell, Gillies, Anderson, Erickson and Mitchell, 1996). Integrated healthcare models are often thought to provide such solutions by seeking to shift the perspective away from the hospital setting as being central to the healthcare system, and instead create the primary care setting as the main focal point to which other services wraparound (Shortell, et al., 1996). By recentralising the entire health system, it is hoped that integrated healthcare can offer a more unified delivery system that allows for primary care to work alongside mental healthcare, usually in the same location (Funderburk, Sugarman, Maisto, Ouimette, Schohn, Lantinga, … Strutynski, 2010). This concept allows for “health care for the whole person” (Kaslow et al., 2007) and acknowledges the crucial link between the types of interventions that can be used to assist mental health alongside other comorbid conditions such as pain management, chronic illness, substance abuse, high blood pressure and stress (Fischer, Heinrich, Davis, Peek & Lucas, 1997; Moore, Von Korff, Cherkin, Saunders and Lorig, 2000). As Fischer et al. (1997) so eloquently put it: “In effect, mental health professionals have evolved to treat disembodied persons and minds while physicians treat personless bodies.”

An integrated healthcare setup also addresses the reality that while more than half of people living with psychological distress will never seek mental health care, most will reach out to a primary care provider such as a GP, at least once a year, and often for issues associated with psychological problems (Funderburk et al., 2010; Strosahl, 1998). Some research has shown that around 20% of patients in primary care are referred to outpatient services that specialise in behavioural or mental health care, but of those referred patients, upwards of 30% to 50% never end up attending that first appointment (Fisher and Ransom, 1997). A further complicating factor of this is that more than half of all primary care clinicians report only sometimes, rarely, or never being able to offer “high-quality” referrals for their patients to outpatient behavioural health care (Trude and Stoddard, 2003). Integrated healthcare seeks to eliminate this dilemma and provide mental health services within the communities in which people are already connecting with.

According to Shaw, Rosen and Rumbold (2011), integrated care is based on principles of a shared vision of maintaining the patient’s perspective at the forefront of all decisions, as well as seeking to eliminate fragmentation between various levels of care. Fragmentation can occur within a number of services within healthcare, but is often most seen through the cultural and structural differences between general and specialist care, social care for adults and general healthcare, and cessation of care once hospital care ends and patients are discharged (Shaw, Rosen & Rumbold, 2011). Research has shown that when it comes to patient satisfaction with health services across the board, upwards of 20% report issues that can be directly attributed to fragmentation (Cumming, 2011).

Advantages of integrating behavioural health into primary care include more regular communication - both between healthcare teams themselves and also with patients, better education for staff working within the integrated healthcare team and a more streamlined experience for patients (Westheimer, Steinley-Bumgarner and Brownson, 2008). An integrated model allows for practitioners to refer within the same delivery system, eliminating the need to refer to outside services that may work with different care plans, providers and delivery expectations (Westheimer, et al., 2008). The flow on effect of these system changes is that, overall, patients report a more positive experience when being a part of an integrated system (Rollins, Wright-Berryman, Henry, Quash, Benbow, Bonfils, ... & Salyers, 2017). Another key area of integrated health is the ability to build relationships amongst different areas of the health system. When referring patients between departments and clinicians, a traditional model of health would see referrals take place through phone, email or letter (Fischer, Heinrich, Davis, Peek & Lucas, 1997). However integrated models of health focus on the "warm handover", the ability for seamless interactions between clinician, which eliminates the need for the patient to retell their story, experiences or symptoms to someone new each time (Fischer et al., 1997).

However, there are also some perceived challenges to an integrated healthcare model, especially when navigating the fine line between difference in approaches from those with a behavioural health background and those operating from a biomedical health model.

Cultural and logistical issues can arise when trying to merge together different types of health practitioners into one type of model (Westheimer, et al., 2008). An example of this could be seen in perceived areas of difference in expectation, such as with appointment times where GPs may work on a 15 minute time slot, but psychologists may require longer with patients.

Table 1

Comparison of traditional and integrated healthcare models

	Traditional model	Integrated model
Setting	Psychological services located at other buildings, separated	All services, including mental health, exist within primary health location
Communication with GPs	Written referrals, phone, email	Informal consultations, personal relationships, "warm handover"
Charting system	Client's notes kept extremely private, high levels of confidentiality	Shared file approach, GPs patient and other medical professionals can read all notes
Mental health clinician identity	Psychologist not seen as part of the medical team	Psychologist is "one of us", part of a wider team

Table adapted from Fischer, Heinrich, Davis, Peek & Lucas (1997).

This type of situation highlights different approaches to patient care and can hamper collaboration, despite good intentions (Kainz, 2002; Wrenn, Syed and Kasiah, 2015). Competing demands of provider time, especially in the primary care setting, will always remain a barrier within the system (Wrenn, Syed and Kasiah, 2015) and causes a scenario which involves innovative thinking to adapt.

Whilst the sharing of the same colocated space is seen as an advantage to many, some patients, especially when living in smaller cities or towns, may find the integration of services too intertwined (Westheimer, et al., 2008; Anwar, Joshi and Tan, 2015). Patients enrolled at integrated healthcare centres can expect that their private medical files will likely be stored, accessed and shared in a different way which will include more collaboration and therefore more room for potential privacy breaches (Anwar, Joshi and Tan, 2015). This can create a situation for potential embarrassment, descrimination, stigma, prejudice or victimisation of the patient (Anwar, Joshi and Tan, 2015). Integrated healthcare setups also rely on all members of the care team buying in to the multidisciplinary model, which often requires an increased level of education of health professionals, especially in areas where they may have less understanding (Anwar, Joshi, and Tan, 2015). An example of this would be GPs and nurse practitioners gaining more insight into psychological symptoms and treatment pathways within an integrated model, whilst receiving ongoing professional development in this area as options change and develop over time (Williams, Haarhoff & Vertongen, 2017).

Another challenging area around integrated care is defining and understanding the different concepts. One literature review on integrated care found 175 different definitions of integrated care (Armitage, Suter, Oelke & Adair, 2009), leading to what Kodner (2009) described as ‘the imprecise hodgepodge of integrated care’. The review found a key difference between the terms ‘integrated care’ and ‘integration’. Integrated care was considered an organising principle, focused on an aim for improved care of patients through coordination of services, whereas integration was seen as the specific methods, models and processes put in place to achieve that increased level of care (Armitage, et al., 2009).

In the New Zealand setting, integrated care has long been considered a solution to a fragmented model, a panacea to poorly-coordinated care which has flow on effects for planning, resources, funding and delivery (Cumming, 2011). More than 80 years ago, the New Zealand Social Security Act 1938 had ambitions of becoming the first “national health service” in the world, however, push back from doctors hindered such advancement (Stokes et al., 2017). This legacy has created a duality of services whereby GP practices and public hospitals run largely separate from each other, and means patients who have the ability to pay for primary care can then effectively navigate into the free public hospital system, leapfrogging waitlists and leaving behind those for whom cost is a barrier (Stokes, et al., 2017).

This also meant that in the past, mental health services were treated as an entity on their own, operating within a framework that treated psychological conditions in a silo (Williams, et al., 2017). For more than a century, those under the care of mental health professionals were often tucked away in psychiatric institutions, separated from community interaction - out of sight, out of mind (Williams, et al., 2017). When those institutions were finally closed, mental health care was pushed out into the communities but with little planning or preparation, which led to “turmoil” in the sector, according to Professor Mason Durie’s report to the Mental Health Commission (2012). The unrest caused by the changes created the environment that mental health exists within in the present day. Durie (2012) suggests that the current shift is now away from traditional models of mental disorders and instead a more holistic approach which looks at overall wellbeing across the lifespan of a person.

Therefore while the integrated care model seeks to provide a solution and refocus of the health system as a whole, there remains some work to be done to ensure a smooth and continuous flow of information and resources (Cumming, 2011) for which patients seek in their overall care.

Models of Care and Patient Experience

Traditionally, healthcare systems have been developed in a way in which the patient has not always been central to the models of care developed around them (Davis, Schoenbaum & Audet, 2005). This in turn has an effect on the way the patient reflects on the care offered and received. How a patient experiences their time within primary care, and when and what services they make use of are often attributed to the models of care in which they form around their experiences (Burt, et al., 2017; Andersen, 1995). This includes how a patient views their level of health and area of concern in terms of pain, symptoms or worry, and their assessment of the level of need and priority in relevance to others which results in their action or inaction of help-seeking (Andersen, 1995).

At the centre of a patient's experience when accessing primary health care for any medical, psychological or general concern is getting access to the type of care that works for them and meets their personal expectations in various ways (Davis, Schoenbaum & Audet, 2005). This is the cornerstone of patient-centred care, the preferred model of healthcare which has been rising in popularity over the past 30 years (Delbanco, Berwick, Boufford, et al., 2001; Epstein, Fiscella, Lesser, & Stange, 2010). Patient-centred care involves many different streams but overall as a concept has been described as "understanding the patient as a unique human being" (Balint, 1969). Creating an environment of patient-centredness therefore relies on building quality relationships both within organisations, and between patients and professionals working inside those organisations (Epstein, Fiscella, Lesser, & Stange, 2010; Berntsen, Høyem, Lettrem, Ruland, Rumpsfeld & Gammon, 2018). Further to this, other important factors and interactions crucial to a positive experience for patients include coordination of care, emotional support, access, continuity, education, inclusion of friends and family and smooth transitions through different healthcare settings (Peschel & Peschel, 1994; Mohammed, Nolan, Rajjo, Shah, Prokop, Varkey & Murad, 2016; Burt, et al., 2017).

Research has found that one of the biggest issues that patients face when accessing care is the issue of continuity between primary and specialist services (McGinnis, Stuckhardt, Saunders, & Smith, 2013). Another key reflection has shown that patients often view health systems as being disorganised, especially around referrals through to different services and follow-up care (McGinnis et al., 2013; Stremikis, Schoen & Fryer, 2011). Therefore, a combination of expectations, perception and lived experience can lead to how a patient views their overall care.

When drawing on their values and expectations while engaging with primary care such as their GP clinic, patients create their own individual model of care for which they form the basis of their experiences. Whether or not someone even chooses to engage in receiving formal treatment from within the healthcare system when they are feeling psychological distress in their lives can be a central driver of health behaviour in itself. This undertaking is often seen as a socially embedded process that brings into light not only the patient’s own beliefs and actions, but also of those who they interact within their communities, such as those who provide treatment or people they interact with socially (Pescosolido & Boyer, 2010). Research into why people decide to reach out while experiencing concerns around their coping abilities or mental health draw on several theories of help seeking. Some of the drivers or barriers of certain health behaviours can be described in research by using the sociobehavioural model, one of the most well known and fundamental models, based around three predictors of need, predisposing and enabling factors (Andersen, 1968).

The requirement for patients to assess their own personal need for care determines when they access health services, which services to use and whether or not they will use services that are available to them (Andersen, 1968). Further to this, social and cultural factors such as gender, ethnicity, beliefs, age and education also acts as a filter for health service use decisions, along with enabling characteristics such as having the knowledge and means to receive treatment (Andersen, 1968). Research has shown that patients often delay their help-seeking due to a belief that their symptoms may just disappear (Thompson, Hunt & Issakidis, 2004), an understanding that they can handle their concerns alone and without assistance (Andrade, Alonso, Mneimneh, Wells, Al-Hamzawi, Borges… & Florescu, 2014) or thoughts that the treatment offered would be ineffective (van Beljouw, Verhaak, Cuijpers, van Marwijk & Penninx, 2010). These predisposing influences on help-seeking would therefore have a flow on effect when assessing the uptake of health services that are available.

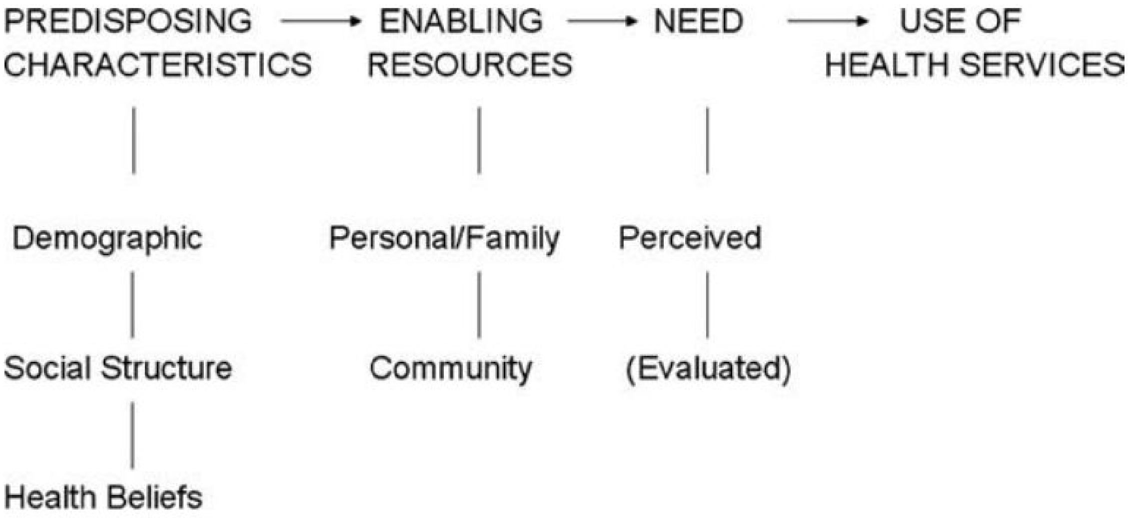

Figure 1. The sociobehavioural model (Andersen, 1968).

Demographic details as a predisposing characteristic are also influential on a person’s health-seeking behaviour. Research has shown that females are more likely than males to seek assistance for emotional distress and psychological care (Rickwood & Braithwaite, 1994; Doherty & Kartalova-O'Doherty, 2010), with men having a higher threshold of symptoms before they will engage with help-seeking (Biddle, Gunnell, Sharp & Donovan, 2004).

Based on Andersen’s (1968) model, the location of health services, access to transport, regularity of care and sufficient finances can also either hinder or assist in a person’s uptake of healthcare options and is therefore valid when looking at bringing together multiple services under the umbrella of shared or integrated care (Andersen, 1968; Kathol, Butler, McAlpine & Kane, 2010). The co-location also has other benefits, as highlighted by Strosahl (1996) who hypothesized that patients have a preference to receive emotional care at the same premise as other health conditions, such as a GP clinic, due to perceived reduced stigma.

Overall, an integrated healthcare model seeks to remedy many of the sociobehavioural issues raised within Andersen's (1968) model, by improving access to different communities as well as addressing many of the health beliefs that prevent initial interaction with health services at the time of concern.

Once a person decides to engage in help seeking for their need, they form an expectation in regards to what type of care they think they might receive. This can vary between who the practitioner is that they may deal with (GP, specialist) and what type of care or assistance they may be offered. Some research has shown that patients believe that GPs are the best-placed health professional to offer help to someone with depression, likely due to their perceived skill in the area and the level of trust placed in them as a provider (Strosahl, 1996). In terms of what type of help patients expect as a treatment option, around two-thirds are in search of counselling, with only one third wanting medication and just 5% of those experiencing depression are looking for a referral to a specialist (Brody, Khaliq & Thompson, 1997). Patients experiencing depression are also more likely to expect counselling over medication, and the preference for either is likely tied into spiritual beliefs and access to care (Cooper-Patrick, Powe, Jenckes, Gonzales, Levine & Ford, 1997).

Literature on patient experience shows a heavy reliance on traditional models of monitoring to capture a person's thoughts and feelings about a service, such as through the use of surveys (Burt, et al., 2017; Kontopantelis, Roland & Reeves, 2010; Sequist, Schneider, Anastario, Odigie, Marshall, Rogers & Safran, 2008). Whilst these conventional information gathering techniques may garner some useful information, research has shown various issues with the use of surveys. These include concerns around the manner in which the surveys are conducted, how information is analysed and what actual changes are implemented as the result of the surveys (Browne, Roseman, Shaller & Edgman-Levitan, 2010). Some research found that the use of basic surveys for patient satisfaction within primary care were only useful as a 'screener' and that more in-depth research was required to uncover themes and specific nuances of a patient's experiences (Roberts, Campbell, Abel, Davey, Elmore, Maramba,, ... & Burt, 2014). Providing a 'tick box' environment for patients to provide feedback is problematic. It can arguably be seen to be surface-level and lack the depth of enquiry and response that could result in meaningful and useful feedback for the healthcare provider (Asprey, Campbell, Newbould, Cohn, Carter, Davey & Roland, 2013). Some research has raised concerns around how user experience surveys are created and used, and call into question the effectiveness and representativeness of the survey design (Asprey, et al., 2013; Sargeant, Mann & Ferrier, 2005).

There can also be, critically, a gap between results from patient user feedback and the implementation of any changes or developments uncovered as part of the process (Graham, Flott, King, Gibbons, Jenkinson & Fitzpatrick, 2015). This brings into question the reasoning behind requesting feedback from patients in the first place, and the duty of care with acting on any responses received. Considering research shows a strong correlation between a patient's experience and improved health outcomes and adherence, more focus and understanding needs to be placed on how feedback can be integrated into a healthcare centre's processes. It also further strengthens the case for more qualitative research in the area which allows for an increased depth of knowledge and data gathering when compared to a simple tick-box exercise.

Clinician-Patient Relationship

When looking at the role that the relationship between a medical professional and their patient has on the patient's experience, research has shown that clinicians' ability to see patients as a "whole person" is routinely one of the most fundamentally positive aspects identified (Safran, Taira, Rogers, Kosinski, Ware & Tarlov, 1998; Street, Makoul, Arora & Epstein, 2009). To treat someone as a whole person, it is commonly thought that there are four key areas that are able to be focussed on in order to improve health - mechanical (such as surgery), chemical (use of medications), behavioural (such as diet changes) and psychological (therapy as an example) (Street et al., 2009). How a clinician explains what areas could be utilised in order to resolve the concerns that the patient may be having or symptoms they are experiencing will affect how the patient views the overall effectiveness of the treatment and how it fits within their model of care (Street, et al., 2009; Winter, Lawton, Langston, Ruckdeschel, & Sando, 2007). An example of this in action would be a patient who presents at a GP clinic with depression symptoms and only being offered the chemical response to healthcare (e.g. antidepressants) but not talked through other options of care such as behavioural (Exercise, diet) or psychological (therapy options). The lack of communication around treatment options may lead to a care plan that excludes the patient's own health beliefs and therefore make adherence less likely and a negative impact on the clinician-patient relationship (Street, et al., 2009).

This type of model, commonly referred to as the biopsychosocial model, centres on a person's wellbeing being the result of various moving parts that balances both the biological medical world with that which is more holistic in nature (Engel, 1977; Borrell-Carrió, Suchman & Epstein, 2004). The biopsychosocial model also allows for a circular causality interaction which can be used to describe, predict and prevent co-morbidities in some situations, such as a person experiencing depression after a serious medical event (Borrell-Carrió, et al., 2004). These types of causal explanations can have a large effect on how a patient views their world (Kirmayer, 1988), as well as solidifying the relationship between clinician and patient as one where the clinician's power is exercised carefully and from a patient-centred approach at all times (Mead & Bower, 2000; Borrell-Carrió, et al., 2004). This approach also allows for a space to be made for a patient's thoughts, views, beliefs and concerns to be heard, which allows for the humanisation of an interaction which can be clinical in approach (Bartz, 1999; Mead & Bower, 2000; Borrell-Carrió, et al., 2004). Some research has shown that where there is a deeper relationship between a patient and a GP, it is more likely that a larger number of issues or problems are raised during an appointment (Merriel, Salisbury, Metcalfe & Ridd, 2015). The flow on effect of this can be overall better care for patients and more efficient consultations for practitioners (Merriel, et al., 2015). The benefits of having that deeper connection can lead to a cultivation of trust between the two parties involved in the consultation, a routine key cornerstone feature of any patient experience with a health professional (Safran, et al., 1998, Skirbekk, Middelthon, Hjortdahl & Finset, 2011; Bell, et al., 2017). Research has shown that trust is the leading factor in a patient's satisfaction with their doctor, and that there are also direct correlations between trust levels, adherence and overall health outcomes (Safran et al., 1998).

Inherently interlinked with the trusting bond between patient and clinician in a health setting is that of continuity of care. Trust can only be built in a health setting where the patient interactions with clinicians makes sense to them, and where an environment of safety is built and nurtured through those relationships (Rhodes, Sanders & Campbell, 2014). Research has shown that whilst some patients with certain health conditions will forgo continuity with their regular GP due to urgency required, certain sectors - such as patients experiencing psychological distress, multimorbidities or palliative care - benefit from receiving continuity of care (Jeffers & Baker, 2016). The ability to offer this level of care is of course determined by many factors, including, chiefly, staff availability. In New Zealand, it is predicted that by 2023, there will be severe GP shortages due to an aging staff (Smith, 2017), with more than 40% of doctors aged over 50 years old (Ministry of Health, 2018). In rural centres in New Zealand, the situation is even more bleak with 75% of hospital managers already reporting that staff shortages are at serious or critical levels (Lawrenson, Nixon, & Steed, 2011; Goodyear-Smith & Janes, 2008). Coupled with this is an extreme shortage of psychologists and those trained to deliver a variety of psychological support to those experiencing mental distress (New Zealand Government, 2018). The New Zealand Government (2018) inquiry into mental health and addiction gives “immediate priority” to building the workforce in and around this area however time restraints due to delay in training times means that while the number of psychologists is expected to increase within the next decade, it is not expected that it will keep up with expected population growth (Ministry of Health, 2018). Bottlenecks for services in the New Zealand health system means while some people report valuable relationships with their GP, some patients experiencing different levels of mental distress have reported feeling ‘fobbed off’ with medication, rather than referrals to specialists or different care options (New Zealand Government, 2018). In some instances, backlogs of care are caused by patients opting to remain under the specialist mental health services teams which are free, rather than getting back into the primary care service - where fees are likely applicable - which again leads to increased pressures across the board (New Zealand Government, 2018). All of these factors combined create a health system which is under pressure and under performing which in turn has an effect on the access and experiences of those accessing the system at a patient level.

Potential Solution - Brief Therapy

Given the rise in interest in wanting to find a better way to service the mental health system in a way which benefits both patients and the wider health network, a number of solutions have been suggested. One that is currently growing in interest, both in New Zealand and internationally, is the concept of brief therapy integrated into primary healthcare (Fleming & Manwell, 1999; Strosahl, Robinson & Gustavsson, 2012). Designed to be used for a range of behavioural changes such as smoking cessation, diabetes, blood pressure, alcohol abuse and dietary modification (Fleming & Manwell, 1999), brief interventions have also found favour in treating mild to moderate anxiety and depression (Strosahl, Robinson & Gustavsson, 2012). On a practical level, brief therapy is defined not just by the session time constraints recommended in comparison to regular therapy, but also by the number of sessions it takes to complete. Studies have concluded that the length of treatment to be successful with a brief intervention can vary, however most suggest around three to four sessions are appropriate (Fleming and Manwell, 1999; Craske, Maidenberg & Bystritsky 1995). Many studies have found that rapid change can occur within a short number of visits, and that the biggest amount of change occurs right at the start, and progresses in a non-linear fashion (Angantyr, Rimner, Nordén & Norlander, 2015; Baldwin, Berkeljon, Atkins, Olsen & Nielsen, 2009; Mullin, Barkham, Mothersole, Bewick & Kinder, 2006).

In terms of defining brief therapy, Fleming and Manwell (1999) state that there are five essential elements of brief intervention, including (1) assessment and direct feedback, (2) negotiation and goal setting, (3) behavioral modification techniques, (4) self-help-directed bibliotherapy and (5) follow-up and reinforcement. These different stages of therapy can be seen in across a range of therapy interventions, such as Cognitive Behavioural Therapy (CBT; Beck, 1976) and Acceptance and Commitment Therapy (ACT; Strosahl, & Wilson, 1999) that have been adapted into ‘cut-down’ brief versions, with mixed results and effectiveness. The issue with much of the research on brief interventions is that there is a focus on the use of brief interventions for specific behavioural issues such as problem drinking or substance abuse (Fleming and Manwell, 1999; Bertholet, Daeppen, Wietlisbach, Fleming & Burnand, 2005; Rahm, Boggs, Martin, Price, Beck, Backer, & Dearing, 2015). There is a gap in the research when it comes to wider effectiveness studies for a broader patient base. Where research did go into other diagnosis, such as treating anxiety or depression, studies were fewer in number and unconvincing when looking at effectiveness. In a 2010 meta-analysis looking at the effectiveness of brief interventions for anxiety and depression in primary care, Cape, Whittington, Buszewicz, Wallace and Underwood (2010) found that Brief Cognitive Behavioural Therapy, counselling and Problem Solving Therapy (PST) were somewhat effective as treatment, but with less significant effect than the longer versions of the same therapy.

Where brief therapy does come into its own is in the primary care setting. The short consultation times involved with brief therapies ties in well with the time constraints often felt by primary care centres, so there is a natural fit in terms of workflow and implementation (Kroenke & Unutzer, 2017). Historically, brief therapy was developed as a way of treating the distress of large numbers of soldiers following the World Wars in the mid-1940s (Budman & Gurman, 1983; Samelson, 1977). The need to ‘cut-down’ often extended therapy programmes due to sheer volume of those in need of support meant psychological practitioners were required to be innovative with existing therapies. The flow down effect means that brief therapies are most commonly seen, especially in the United States, in clinics offering support to military veterans (Glover, et al., 2016). To this day, much of the research seen on brief therapies used to treat anxiety and depression continues to have a military link (Rudd, 2012; Eid, 2003).

Despite limited evidence regarding effectiveness for a primary care base, a push towards implementing brief therapies as a tool to treat frontline mental health continues. The New Zealand government’s (2018) report into mental health and addiction, He Ara Oranga, specifically highlighted brief therapies as an area that was needed for increased access to psychologists, therapies delivered by non-psychologists and e-therapies. The report said a focus was required explicitly for those with mild to moderate needs, and highlighted brief and group therapies as the vehicle in order to deliver such treatments (NZ Government, 2018). In New Zealand, the Primary Mental Health service (PMH) was set up in order to increase the access patients had to psychological support in the form of talk therapies and other forms of therapy. PMH services aim to allow for the extension of GP and nurse consultations, and to include brief interventions into general practice for mental health and alcohol and drug abuse support (New Zealand Health Ministry, 2017). All of New Zealand's 20 DHBs receive this funding, although many DHBs choose to contract out the work to other organisations to implement it within their specific communities (New Zealand Health Ministry, 2017). Moving forward, the New Zealand Government, as laid out in the He Ara Oranga report, hope to create local 'hubs' where people are able to access support for distress at a one-stop-shop type of set up (NZ Government, 2018). It is envisioned that these hubs will become a place where patients and their families can access immediate support through services such as talk therapy, clinical assessment, self-help, group and brief therapies without the need for referral to other locations or support services (NZ Government, 2018). These are all solutions that have been government implemented but were highlighted by the communities who responded to the Mental Health Inquiry in to the state of mental health services across New Zealand, released in 2018 (NZ Government, 2018). In this sense, whilst the evidence for engaging in brief therapy as a potential solution to mild to moderate distress is not directly at hand, it is anecdotally what communities are asking for and can be seen as a way forward through a crisis. Some barriers do exist to this, however. Kroenke and Unutzer (2017) found two main barriers to implementation - funding distribution and training. Budgets are often skewed towards treating those at the more serious end of the scale in terms of mental health distress, and therefore those in the mild to moderate category can be overlooked (Kroenke and Unutzer, 2017). This, in turn, can have its own flow on effects including the development of more serious distress, as well as a higher likelihood of pharmacological treatment which can result in being a more expensive option for health services in the long run (Kroenke and Unutzer, 2017). Another large barrier identified is that around training for brief therapies. Many GPs and primary health staff are not specifically trained in mental health, let alone treating it through brief therapy, so a gap in knowledge exists (Kroenke and Unutzer, 2017). This could likely be remedied by the practitioner themselves upskilling and training, or the introduction of specially trained therapists who are able to deliver the therapy directly.

Development of fACT

The need to apply an evidence-based therapy approach across a broad spectrum of distress that appears within primary care has resulted in one specific model being applied as a pilot programme in a primary care health centre in Palmerston North, New Zealand. In the instance of this healthcare centre, the behavioural care model chosen to be trialed within the primary care centre is known as Focused Acceptance and Commitment Therapy (fACT). FACT is a transdiagnostic model which focuses on strengths and change, conducted in a series of single sessions where the patient is required to make changes and seek further support, if required (Strosahl, Robinson & Gustavsson, 2012). Developed as a cut-down, more concise version of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 2009), fACT therapy focuses on using mindfulness techniques alongside a values-based action plan for tackling unwanted or distressing thoughts (Strosahl, Robinson & Gustavsson, 2012). It draws on concepts of Skinner's (1985) rational behaviorism, using techniques such as diffusion, and explores psychological flexibility around areas such as gaining perspective and the role of emotional avoidance (Strosahl, at al., 2012). The main idea behind fACT is that people can become 'stuck' at times in their lives, but are not 'broken' - and that distress can be dealt with by accepting the emotions and feelings behind the distress, and committing to change (Strosahl, et al., 2012). FACT is a so-called "third-wave" therapy, aimed at troubleshooting some of the problems raised in how CBT relates to a person's feelings, and instead focusing more on metacognition (Hayes, 2004).

In terms of efficacy of fACT, very little evidence currently exists to support its use within primary healthcare settings. Whilst there is more empirical data which relates to ACT, studies involving fACT are scarce. Glover, et al. (2016) provides some insight into patient outcomes using fACT, however, focuses on the therapy in use within a group situation, specifically with veterans. Outcomes from that study showed the largest effect patients' experienced was the increase in perceived quality of life, with some positive signs around decreased depressive symptoms (Glover, et al., 2016). Whilst this study shows some promise for the future of fACT in its application across various scenarios, it is problematic that there is not more research specifically focusing on fACT and its potential benefits for wider populations. Inconsistent research in this area does not allow for the full potential of new and innovative therapies to be recognised and as such, any research in this area is not only very warranted, but also necessary to the momentum of development, change and adaptation.

Research Questions

Much has been written on the process of integrating mental health services into primary care as part of an integrated healthcare model. But little research has been done on the experiences of those who have been through the process and how they see integrated healthcare fits within their own models of care. This research sets to gain insight into patients' perceptions of their value of care, and how the care they received through the fACT model at an integrated healthcare centre made sense to them. This study, a first of its kind in New Zealand, is unique because of its focus on the perspective of patients as they experienced the latest innovation and development in healthcare systems in the country.

Methodology

Current Study

This research investigates the experiences of patients who participated in the fACT therapy service offered at a primary healthcare organisation (PHO) in Palmerston North, New Zealand. It focuses on the patients' perceptions of the value of the therapy, and how they make sense of accessing psychological support services within an integrated healthcare centre.

FACT Service Within the PHO

To understand the methodology of this study, it is important to have an understanding of the fACT service as it sits within the PHO model, and how participants in this study represent the wider population of those who experienced the service. The fACT service, a combined project between PHO and Massey University Psychology Clinic, has been running since June 2018. Patients may be referred to the service by their GP, Nurse Practitioner or health clinician, where they will have an appointment with a trained psychologist, also referred to as Health Improvement Practitioners (or HIPs). The service has the equivalent of one Full Time Employee (FTE) allocated to the role, and the position has been serviced by between four to six different Massey psychologists since its inception.

In the 12 months to June 2019, the service saw 710 new cases, who took part in a total of 1601 sessions, including GP consultations. Of those patients, 86% identified as European, 8.5% Maori, 1% Pacific Islander, 0.4% Asian and 2.8% as other. Around three quarters of all patients who took part in the service identified as female, while one-quarter identified as male. Two patients did not identify as either gender. The most common age group for patients was 20-29 years old (21.3%) followed by those aged between 30-39 (18.9%). Only 7.2% of patients were aged 70 or over. The most prevalent issue for patients who were seen by a GP and then referred to the fACT service was anxiety (39%), followed by stress (14.2%) and depression

(13.7%). Other issues seen less frequently included sleep, adjustment, grief and coping. A majority of patients presenting at the GP did so with only a psychological complaint and no further health conditions (86%) but where a health condition was present, it was most commonly diabetes, heart or respiratory disease or cancer.

Overview of Study

A qualitative methodology was chosen to gain insight into the experiences of patients who had received fACT therapy within a primary healthcare setting. This approach was chosen due to the unique ability to offer a complimentary insight into a concurrent quantitative study on a service utilisation and outcomes of the same fACT service. Qualitative research is one of the most widely-used research methods, focused on the fabric of people's experiences, rather than the identification of cause and effect links (Camic, Rhodes & Yardley, 2003).

Advantages of using qualitative research, especially in this particular study, is the lack of current theory around such a burgeoning area is not considered to be a drawback, and instead further legitimises the use of the research method (Graebner, Martin & Roundy, 2012). It creates a sense of freedom for both the participant and the researcher not to subscribe to set theories and instead discover them naturally as the process unfolds. A further rationale for engaging in qualitative research is to gain insight into participants' experiences through their own words and allow them to reflect on their process of meaning-making (Camic, et al., 2003). By using their voice, participants are able to draw upon their own lexicon to ensure their experiences are accurately portrayed throughout the research, rather than a 'tick-box' type environment.

Semi-structured interviews were chosen as the data collection tool, and used to gather verbal descriptions of experiences for analysis. This type of structure for research interviews is one of the most popular methods within qualitative research as it allows subjective viewpoints to be probed, and in-depth responses to be gathered while still allowing some freedom for unknown quantities to arise (Bradford & Cullen, 2013; Evans & Lewis, 2018). The ability to draw together people's experiences into a comprehensive overview allows for reflections on participant's ability to make meaning of their reality and inner perceptions (Braun & Clarke, 2006; Vaismoradi, Jones, Turunen & Snelgrove, 2016).

Participants

Recruitment of Participants

All potential participants were registered patients of the PHO in Palmerston North, New Zealand. Any patient who was referred to the fACT team, made up of psychologists from the Massey University Psychology Clinic, and was aged over 18, was offered the opportunity to put their name forward for future research.

For those who had indicated they were happy to be considered for future research projects, PHO then provided a list to this researcher and a fellow Masters research student (Student A) whose research focused on a quantitative study of service utilisation and outcomes. A confidentiality form was signed by Student A to ensure the participants' information was held securely (Appendix 1). Student A and this researcher shared the duty of contacting, via phone, all patients who were potential candidates for taking part in the research. Two or more phone calls were made, with voicemail left for those who did not answer, and some were also contacted via text message. Student A and this study's researcher spoke from an agreed script (Appendix 2) which informed potential participants of their rights to decline to take part in the research, as well as expectations and information about each of the studies. They were advised that they could choose to take part in one, both or neither of the studies, and given assurances that their care from their healthcare provider would not be compromised based on their decision.

Whilst participants in this study needed to be at least 18-years-old and have completed their therapy sessions, some potential participants advised the researcher in their initial discussion that they were either aged under 18, or were on-going with their therapy so had been incorrectly identified by PHO staff as eligible. Once participants agreed to take part in this study, arrangements were made to meet in person with the researcher, either at their home or at a location agreed upon by both parties. It is acknowledged that there could be an element of social desirability bias with participants, whereby they may attempt to amend their responses to avoid embarrassment and be perceived in a positive way (Fisher, 1993). It was the researcher's experience that this was not as much of a factor in play as expected.

Participant Sample

Of the 10 participants who took part in this research, nine identified as female and one as a male. The youngest participant was 25 years old, and the eldest was 69 (M=45.5). All participants identified as Pākehā/Caucasian, and four also identified as Māori. Six were interviewed at home, three in public spaces such as at a cafe or library, and one at their place of work. All interviews were conducted in English. Preceding the interview, all participants were talked through an information sheet (Appendix 3) which gave details as to why they were being invited to participate, what the research involved, what happens to the information provided, their rights, and how they can participate. The information sheet was given to all participants to take away with them as it provided summaries on key questions regarding the research as well as contact details for both the researcher and supervisor. All participants then signed a consent form (Appendix 4) in person, which also granted permission for the interviews to be voice recorded. Participants were advised of their right to withdraw from the study and to have the voice recorder turned off at their request at any time.

Procedures

Data collection, in the form of interviews, with participants took place during June through to August 2019. The interviews with participants lasted for between 24 and 40 minutes (M=32 minutes) and took place at locations agreed upon by the researcher and participant. Some participants asked to be interviewed in their home, others were more comfortable at a neutral location such as a public library. The interviews were guided by a list of suggested questions or topics of discussion (Appendix 5). Questions were open-ended in nature, and conversations flowed naturally between the researcher and participant, as suggested by Rubin and Rubin (2005) and Choak (2013). The researcher used minimal prompts during the interview process, but on occasion would provide summaries when a participant lost their train of thought or had gone on to other topics during their response. The researcher was engaged in an active listening process, and used techniques such as empathetic responding (Louw, Todd & Jimarkon, 2011) and clarification throughout the interviews. Data collection ceased after 10 interviews were completed, once it was established that saturation had occurred.

Following the interviews, participants were identified in the research only by a number which had been allocated to them. All other identifying factors were removed from transcripts and files that were associated with their responses. Interviews were transcribed manually by the researcher, with use of two transcription applications, Trint and Sonix. Whilst no payment was provided for the participant's time, a $20 petrol voucher was posted to the participants following their involvement in the research as a koha. Participants who had indicated that they wished for a transcript of their interview to be returned to them were sent this and an offer was made to all participants to receive a summary of the findings of this study, of which all 10 participants indicated they would like.

Ethical Considerations

There are a number of ethical considerations that had to be taken into account with this research topic. Firstly, it was acknowledged that the participants of this study were likely to have had recent mental distress in their lives which had led to the referral to the fACT service. To ensure they felt supported through the interview, they were reminded before any interview took place that they could re-engage with the fACT service, free of charge. A decision to only include participants aged over 18 ensured the study focused on an adult population, and consent by proxy was not required. All participants were also advised of their rights to withdraw from the study. Informed consent was obtained for each participant, and various measures were taken to ensure the confidentiality of each participant was maintained, including the removal of any identifying details from the transcripts of the interviews and the researcher’s own files. An ethics application was submitted on 25 March 2019 and approved by the Massey University Human Ethics Committee Southern A 19/20 at a meeting held on 26 April 2019 (Reference: 4000020551).

Analytic Strategy

Qualitative approaches allow for a greater depth in regards to data analysis, adding a richness which adds layers to the discovery process, allowing a freedom to uncover and reveal themes of data as they emerge (Camic, et al., 2003). A qualitative approach allows for an exploration into the personal experiences and frames of references for a smaller sample of people, gaining insight into their perceptions of the wider world in which they operate (Smith, 2015).

Thematic analysis was used to analyse the qualitative data collected within this research project. Thematic analysis works by the researcher evaluating and interpreting responses from participants in an attempt to locate key themes, patterns in ideas and groups of thoughts in order to make sense of the data (Braun & Clarke, 2006; Aronson, 1995). By using thematic analysis, researchers are able to capture key responses that offer reflections or insights that relate back to the specific research questions (Nowell, Norris, White & Moules, 2017). Advantages of thematic analysis include flexibility which allows for unknowns to rise to the surface, and it is modifiable for various types of research (King, 2004). This type of analysis is also easily accessible for the researcher (Braun & Clarke, 2006) and its freedom from theoretical boundaries allows for a more responsive analysis based on the similarities and differences between participants (Braun & Clarke, 2006). Whilst there are a number of advantages to thematic analysis, there are some drawbacks which include the lack of structure in which to form foundational themes which can lead to inconsistencies (Holloway & Todres, 2003). Another potential disadvantage of thematic analysis is the inability to make assertions about the use of language with the data, as well as a lack of guidelines which can see the meaning-making or analysis phase more difficult to complete (Braun & Clarke, 2006).

In this study, an inductive approach was applied during the analysis stage, meaning there were no preconceived theories or framework identified before data was gathered, and instead the analysis was led by the responses identified within the data itself at completion (Guest, MacQueen & Namey, 2011; Nowell, Norris, White & Moules, 2017). An inductive approach allows for a researcher to be guided by the themes which arise during the process of interviewing and then further again while becoming familiar with the data (Blackstone, 2018; Guest, et al., 2011).

During the process of analysis, the researcher familiarised herself with the data both during the transcription of the interviews, and revisiting those transcriptions numerous times. Notes were made in regards to potential categories within each participant’s responses, and from there, themes were constructed. This process of coding is defined by Saldaña (2015) as attributing meaning, symbolism or essence-making to phrases, quotes and words. Once the themes were synthesized, the process of theorising began from which results were found.

Results

The analysis of the interview data gathered as part of this research resulted in a number of key themes and ideas that were regularly intimated in participants' responses. The concepts raised by participants were varied in nature, severity, content, exclusiveness and personal understanding.

One of the key notions identified in the data was that of two very differing experiences of the fACT service, based on attributes, diagnosis and previous interventions the participant had experienced. From this, two defined groups of participants could be categorised, and a clearer lens was able to be applied to each of the participant's responses when understanding which group they could be identified based on certain characteristics. Group 1 participants tended to present at their GP with a medical concern first, and later added in their mental health concern (whether unintentionally or intentionally). They reported that they were often first-time or non-recent users of mental health services, were not currently on psychological medication, and their presenting issues could be determined to be having a mild to moderate effect on their lives and wellbeing. Group 1 participants could be characterised as reluctant service users, unsure of how systems and services worked, and disclosed a general unease about how their experience would be received by both medical professionals and those around them (friends, family, colleagues etc).

Group 2 were markedly different and could be defined as experienced mental healthcare users. They disclosed having numerous touch points within the mental health sector, and frequently listed off various previous intervention experiences which included comments around being "committed" to Ward 21 (the acute inpatient mental health service at Palmerston North Hospital), receiving other types of therapy, could identify previous diagnosis (such as PTSD, bipolar, severe depression etc), reported being often highly medicated and had high comorbidity. Group 2 participants described having ingrained knowledge of the health system, particularly in the area of community mental health, and displayed a sense of 'expert' level knowledge in the area.

Table 2

Participants grouped by attributes, diagnosis and previous interventions

Group 1 (Minor-moderate)	Group 2 (Serious)
P1	P3
P2	P6
P4	P8
P5	P9
P7	P10

It is important that these two groups are identified throughout the findings as the results revealed vast differences in experiences between each of the two groups. This led to a considerable variation, which, if not clearly defined at the outset, would produce an incomplete picture of the overall experiences of those who took part in the fACT service. Across the results, there were areas where Group 1 and Group 2 participants were in agreement or had strong similarities in experiences, however similarly, there were also areas where large differences in experience could be identified. For ease of clarity throughout the results, partial or full quotations will be included to demonstrate and support key areas of interest in the findings, and participants will be identified only by a number and which group they belong to. The number of quotations used to illustrate each theme should not be viewed as being reflective of the prevalence or severity of the theme or sub-theme, but instead will offer some insight into the nature of the types of commentary presented around similar areas of interest.

When determining the major themes from the results of the research, responses from participants could be deemed to fit under three major themes which were: Expectations of care, Stigma, and Processes. Expectations of care is a theme which was identified by key discussions of the patient's experience, from their initial concern, to how they viewed medical authority, holistic health and treatment options. The second key theme of stigma was highlighted through discussions around perceptions of how participants viewed stigma which surrounded mental health as a whole and how and if this had an effect on their help-seeking for psychological distress. The third theme of processes was identified by responses that related to how the physical act of receiving the treatment within an integrated healthcare setting had an effect on their experience, from aspects such as communication, consistency of care and the mode of therapy.

Key Theme: Expectations of Care

As a theme, expectations of care was identified as an umbrella term to describe and link together varying responses that were interwoven with participants' experiences of the fACT service. Each person had certain expectations of how their initial consultation with a GP might go, how they believed they may be treated, or what interventions could be offered, as well as the feelings and emotions that they may experience during this process. There were four main sub-themes under expectations of care, which included initial concerns, treatment options, medical authority and holistic health.

Initial concerns.

None of the participants were aware of the existence of the fACT service at the PHO so their experiences differed from their expectations from the moment they were offered the service. Many had conceptualised how their appointment would run, including what areas may be discussed, how long they would be seen for and what outcomes the doctor would provide. It was during discussions around the initial GP appointment and approaching a clinician for help where the first signs of differences between Group 1 and Group 2 could be identified. Group 1 participants were more likely to present at the GP appointment with another condition or concern, usually medical, not linked with their psychological concerns.

"Well I was actually in an appointment with my GP for a different reason and then I just was having a bad day and just mentioned it to him because he felt like someone that I could talk to you about it. Yeah and he responded really well. And he then offered for me to consider the fACT opportunity and I said yes, so he just told me more about it and he got me set up with it." (Participant 1, Group 1)

"Well he just sort of, I mean, he was really good and just listened to what I had to say. Just, you know, offered some suggestions of where we could go to from there. And that was when he brought it up. I just thought 'Oh that sounds…' yeah, I mean I obviously couldn't stay burying my head in the sand for the rest of my life. So yea, I thought it sounded like a good idea." (Participant 5, Group 1).

Some Group 1 participants spoke about how their expectations when visiting the GP were that the initial concern would be dealt with and any secondary questions about their wellbeing or psychological assistance may or may not arise naturally. When the opportunity to discuss their concern did come up, they saw it as a ‘While I’m here’ type situation, and it was only then that the conversations about their psychological symptoms and the fACT service began.

“Well I wanted to ask her about, you know, what she thought I should do. So, you know, it just sort of seemed like the right time.”
(Participant 4, Group 1)

This was reported by participants to be a positive experience, one which they said they placed value in by having the ability to open up to their GP about an area in their life that was troubling them. Group 2 participants, often due to their previous interactions with mental health services, appeared to be more well-versed with how things worked with the health system and also reported being as open to giving the fACT service a go, albeit through an often cynical lens. Some even described feeling as though they had experienced such a range of services that they did not see any harm in adding another intervention to their previous help-seeking. They presented this in an almost humorous way, as if to defuse the seriousness of the situation. They were more likely than Group 1 to communicate having an initial concern that was based around a psychological query, and were upfront about that with their GP.

“Well yeah it was a good try, haha, to do something different. It seems strange but I've had a couple of occasions where I've been seeing some doctor and a locum comes in and they always try, ‘Whooa let's try something completely different.’”
(Participant 3, Group 2)

“To be honest, unless you're way up there, like, I shouldn't use that word but unless you're like "mental mental", you're not gonna be up in Ward 21 actually getting the help, because even they're turning away people that really, really need it because unless you are in an immediate danger, they do not have the time and it's not them being rude, they do not have the resources and the time. So where are you supposed to go to prevent yourself getting to that point?” (Participant 6, Group 2)

Overall, stark differences could be seen in the experience of taking their initial concern to a GP, and then how and when a discussion about psychological support was raised. These differences in help-seeking behaviours meant the experience of visiting the GP was different for each participant in terms of how they viewed their needs being met and feeling seen, heard and understood.

Treatment options.

Most participants, from both Group 1 and Group 2, expressed a belief that they were likely to be offered medication to assist with their distress or concern once it had been brought up in the consultation. Each participant indicated their own views on medication, with many saying they felt that they would avoid that route where possible for a range of personal reasons. Some described feeling as though there was a sense of expectation around being ‘patched and dispatched’ with medications by their GP, rather than engaging in a discussion around root causes for distress, or alternative measures.

“I've had doctors before tell me 'Oh we can trial you on this' and I'm like ‘I don't want drugs.’ If I wanted drugs, I can go down the road or something, that's not hard. It's better to try and deal with the root cause, not just cover it over. That's how addictions and everything happen.”

(Participant 6, Group 2)

"I was able to get instant help in a way which was really accessible, and yeah definitely better that way because I probably assumed that the doctor was going to say 'Oh here's some tablets' or 'Here's something else', or prescribe me something that I could take or and then advise I go and speak to somebody that way, but not actually set one [an appointment] up. Yeah and say that's your first port of call, which is what I wouldn't want anyway. Yeah that was really helpful."
(Participant 1, Group 1)

Where participants were not immediately offered medication, they reported their appointment to be a more positive experience because they believed the GP had listened to their particular situation and had made the right call to offer the fACT service as a viable alternative. The divide between groups 1 and 2 could, however, be seen in their deeper expressed beliefs around medication, where on the whole, Group 1 participants displayed a strong desire to avoid any reference or discussion of the topic.

"Like a while ago, about 18 months ago, when I first started seeing her about the same problems, there was discussion at that meeting about do I need some medical intervention? Do I want to take some pills? Do I want, I don't know, sleeping pills? Do I want antidepressants or anything like that? And I said at that stage that I wasn't sleeping, I kind of hit rock bottom then. And that maybe sleeping pills might have been a good idea. She gave me the script, I never took them. So that was as far as the medication went, she knows I'm not really big on that."
(Participant 7, Group 1)

Group 2 participants, revealing their previous experience with medications, were more open to discussing their current regime and future needs in that area. Some did, however, indicate feelings of discontentment around a perceived constant need to “show up” and “prove” that they were in need of ongoing medical support. As Participant 8 (Group 2) said:
“... they're very suspicious of you asking for things like sleeping tablets and tranquilizers and sort of coping mechanisms. Which is frustrating because they'll give you like a month of sleeping tablets, so that's sweet. But then you have to now go through the whole rigmarole again to do the whole thing. So there should be some more structure.”

Overall, Group 2 were much more open and relaxed in their discussions around medication and their experiences with being prescribed drugs from their GP to treat a psychological concern.

“I actually thought I'd end up getting assessed and yeah, and probably put on something. ‘Cause I was a lot more [agitated] at the time. Whereas, yeah, we got given some coping [skills], (Participant 6, Group 2)

This was in contrast with Group 1 who, on the whole, referenced medication or being prescribed something by talking around the topic, rather than directly discussing it using direct language. How a participant was approached around the use of medications had a large effect on how they viewed their overall experience - and this was the case for both Group 1 and Group 2.

Medical authority.

A common perception highlighted by all participants was that GPs would not be the person who could actually provide the “help” they probably needed. Many reported seeing the GP as a first step, someone who they said looks after the medical side of things but “not the head”.

“... because I mean that's what the GP is there for and I mean, they're not trained in psychology as they have, well like, we have a basis as a teacher, basic psychology knowledge but very basic.”
(Participant 4, Group 1)

Despite this acknowledgement that GPs play a certain role within the health system, Group 1 participants, in particular, were seen to place weight around the role of the GP as a medical authority. So while it was viewed that GPs were not psychological specialists, Group 1 tended to talk more about the belief that they were not ‘mentally unwell’ and in need of ‘help’ unless a doctor had determined as such. Some participants spoke of how they used their GP as a type of litmus test to their own mental health, checking in every now and then and placing it in the hands of the professional to determine whether further treatment past the GP stage was required.

“So I sort of felt like I needed somebody neutral. Or some, you know professional help, more than just family and friends. That's kind of why I keep going back to sort of checking in [to the GP] to make sure that I'm going. That kind of thing. And then if they spot something, I would hope that if there was something I said that would alert them to some problem or that I needed

some serious help, like I guess, spiraling into a hole kind of like that they would be like ‘Right you need to go here. This is what we're going to do.’”

(Participant 7, Group 1)

“I mean that's what you've got a doctor for. That's all part and parcel of the 'wellbeing' as a catchword of the day.”

(Participant 4, Group 1)

These types of belief patterns appeared to sit alongside a series of responses, especially from Group 1, in which participants reported comparing their situations to others, in order to validate their own experiences. Examples of this were seen when participants would use phrasing thought to down-play their own symptoms and feelings, and refer to others who were ‘worse off’.

“And the doctor did say, the receptionist did say ‘If you want to just speak to somebody earlier, let me know when I can see if I can work things and get you back in.’ But I felt like I probably wasn't really the one who was urgently needed to be seen in front of other people.”

(Participant 1, Group 1)

Participant 7 (Group 1) reported similar feelings:

“But inside me I feel more like are my problems big problems? They are obviously to me, but are they big to the next person? I know we all go through things and are they big compared to somebody else? Do I really need this service compared to somebody who could be utilizing it

more than me? That's kind of how I feel like, am I wasting their time? You know, do I just need to kind of harden up kind of thing? That's more how I feel about it you know."

She continued:

"But yeah to me in my mind, it's not this taboo thing, it's obviously serious enough because I'm still going and I'm getting the help that I need. So obviously I needed more than the doctor."

At the other end of the scale, Group 2 participants did not appear to experience the same authority seeking behaviours of their GP, and instead placed themselves as the 'experts'. They reported feelings of dismay and apathy in regards to how they had been treated in the past, and this appeared to have an effect on their more recent experience with the fACT service. Group 2 participants were more likely to report seeing GPs as a go-between to specialist services, as someone who could fulfil a service of referring on or writing out medical certificates. Participant 6 (Group 2) specifically referred to the '*illusion that doctors can fix everything*', and that '*if you're a head doctor, then you fix my head*', a reflection on the reported belief that GPs were not specialised enough to deal with psychological cases.

"It was helpful to get a different point of view and a different insight from somebody who is specifically working within that area. Whereas doctors are general. And sometimes I don't know, they're just following the book or guessing off the top of their heads."
(Participant 8, Group 2)

"It's a run around you know, and the frustration of having to, although the help is there, this constant battle of trying to constantly go back, start from scratch and tell your story, go through the whole bloody bullshit again, which was really, it can get you, you know."
(Participant 9, Group 2)

Group 2 participants reported feeling a real tension between themselves and their GP, and whilst they appreciated their status as a somewhat medical authority, they did so on a far lesser scale than Group 1 who held traditional views around the doctor-patient relationship.

Holistic health.

Another key subtheme was acknowledging what some described as taking care of the 'whole' person. As Participant 4 (Group 1) put it: *"Well it's total wellbeing and mental health, I guess nowadays that's a buzzword, is it? The total wellbeing and everything because it's part of it - Physical, mental and spiritual all together".* Both groups of participants, despite how they viewed a GP's role, shared a belief that the health system would benefit from being set up in a way which acknowledged that no one health professional could be responsible for looking after all aspects of a person's wellbeing.

"I'm a big supporter of holistic health. I think it needs to be everything, it needs to be GPs, even down to diet and exercise, it needs to be everything. And incorporated, for anyone really. Especially for chronic conditions, anything. I mean, to be completely honest, your body is not just if you treat one symptom, you're not treating your whole body. And I think that's why we have so many chronic conditions and so many mental health problems still in New Zealand. Well everywhere to be completely honest."

(Participant 10, Group 2)

How a person based their expectations of their care also appeared to have a flow on effect for some participants from how they saw other areas, such as that of treatment options. Participant 8 (Group 2) described this when she said:

“I want balance. I want the holistic healing as well as the other. I mean I wouldn't be taking medication if I could help it. I never wanted to take it ever. The first time was years and years ago when I got depression, I refused to take it. I thought what have I turned into? This isn't me, I'm not depressed, I don't need this.”

She continued:
“Mentally, emotionally, physically, and spiritually, we are all four things. And if you're out of balance with any of those… that's what I want with my life, I just want that balance.”

Some participants, especially those who identified with aspects of Te Ao Māori, expressed thoughts that a holistic stance was a crucial part of a patient’s wellbeing, and felt as though it as a priority within their own expectations of care.

As Participant 8 said: *“It's just probably part of who I am, as a kid growing up. I don't want to put it all into my Māori cultural side, but that is who we are as Māori.”*

Interestingly, even some participants who did not identify as Māori cited knowledge around concepts such as Te Whare Tapa Wha, and reported feeling positive towards the foundations of what it represents.

“I think when one part of my Te Whare Tapa Wha is affected, then the rest of me is affected. And I know that it has been, so in my view if I can fix it, that's not the right word but if I can get help for the problem area in my life, or with my well-being, then the rest of them will pick up and I do notice that other parts of my life improve a little bit when my mental well-being is addressed and I'm getting help.”
(Participant 7, Group 1)

“I thought this was better because it was getting more holistic. And you know these Māori *health care [initiatives]... Yeah, I've seen it in practice, it works really well.”*
(Participant 3, Group 2)

For those who did not identify as Māori, most said they had become familiar with the concepts of holistic wellbeing from that cultural perspective through their line of work, such as teaching, or tertiary study, such as nursing. They reported that despite not culturally identifying as Māori themselves, they believed the way of looking at overall health as a four-pillar approach was a positive one in which they personally valued.

Holistic health is an area where both Group 1 and Group 2 appeared to have similar beliefs, and displayed holding certain values in the same way. All participants described feeling as though the fACT service fitted within their model of care for all-round, ‘whole person’ care. They said they believed it to be not only beneficial for their own wellbeing, but also that of the wellbeing of others in society and who were in need of care.

As a whole, all of the participants had experiences that differed to their initial expectations of care, but described feeling positive and grateful about their overall involvement with the service despite it not being conventional or what they had planned for. There were marked differences in the responses to expectations of care between Group 1 and Group 2 when it came to areas such as medical authority, however holistic health appeared to be a sphere where both groups displayed similar beliefs and thought patterns.

Key Theme: Stigma

Participants in this study spoke at length about the stigma which surrounded mental health and help-seeking for psychological distress. To each person, stigma took on a different form, however it was experienced by all participants at some stage during their help-seeking or treatment process. There were marked differences in the responses and discussions held about stigma between Group 1 and Group 2, especially when it came to how the participant believed they would be perceived by others, and also what weight they applied to any self-stigma that may exist. Two main sub-themes emerged, the first of personal responsibility and the second of a fear of being 'found out' or labelled.

Personal responsibility.

While all participants acknowledged that there was a stigma which surrounded mental health across the board, Group 2 participants were more likely to claim that they were not affected by any stigma, and instead appeared to feel a type of responsibility towards others on their behalf. Often armed with more experience within the mental health system, Group 2 participants appeared to take on a 'big brother/big sister' type approach with their responses that concerned stigma. In most cases, Group 2 participants showed a type of bravado and almost pride in the sense that they were not 'victim' to stigma, but that from their position, they spoke of how they could see how 'others' may be affected. In this sense, Group 2 participants often displayed a type of 'othering' when it came to discussing stigma. They did this by using phrases such as 'they' or 'other' which created distance from their own personal experience.

“Other people might feel uncomfortable, they might feel like everyone's looking at them and that they know why they are there. Depending. I mean I've been dealing with this sort of stuff for a long time.”
(Participant 8, Group 2)

“I don't personally really care, but there are so many things going on these days for a lot of other people.”
(Participant 6, Group 2)

Group 1 participants displayed varying levels of personal responsibility in their responses. Whilst they too showed concern for how others may go within the system, those from Group 1 were more likely to reflect on their own personal reasons behind weighing up the possible stigma involved and actually receiving the help they desired. An example of this was seen when Participant 4 said:

“Yeah, but you know it could be different for other people I suppose, I guess there might be reluctant people because again, getting back to the stigma. Yeah, but for me it wasn't a problem because I just wanted some answers.”

This type of ‘you before me’ thinking appeared in other responses, where participants described feeling as though their personal experiences or concerns weren’t as ‘bad’ as the next person’s. It often led to a down-playing of their own symptoms or concerns. This type of reaction was more likely to be expressed by participants who belonged to Group 1; those who were characterised as being quite self-deprecating and not eager to be seen to put themselves ahead of others.

Fear of being found out and/or labelled.

Another key aspect of stigma that was uncovered in the findings was that of participants having to keep their mental health status ‘secret’. Many spoke of the advantages of being a part of an integrated healthcare setting which allowed them to ‘blend in’ with other patients who were there for a range of issues. There was a sense of a collective wellbeing which came from not really knowing what was going on with the person next to them in the waiting room, a theme that was particularly strong in the responses of those from Group 1.

“I think you don't feel as embarrassed in a way, because people don't know what you're there for. When you get called, they don't necessarily know who that doctor, who that person is, who's calling you for psychologists and that's what they are. And so I feel like that was quite good that way, to be in an environment where everyone is there to see somebody but you don't actually know what they're there to get seen about.”
(Participant 1, Group 1)

This sentiment of being able to ‘hide in plain sight’ was echoed by other participants and was a really strong subtheme around stigma. Often participants would make direct reference to comparisons of patients with physical ailments and unwellness that is able to be ‘seen’.

Participant 5 (Group 1): *“Well actually for me I feel like sort of softens the reality of what you're there for because it kind of just doesn't feel quite so, I don't know, I think when you go to a counselor you kind of feel like it's very, you know…”*

Interviewer: *“Like stigma attached to it?”*

Participant 5: *“Yeah yeah yeah. Yes. Because at the end of the day if you’re sitting in the waiting room, people wouldn't know if you were going for a head cold or a tummy bag or a broken ankle or a smear, they wouldn't know the difference, or counselling, so it's good.”*

Some participants mentioned the ability to ‘recognise’ others taking part in the fACT service by the pre-consult paperwork that some are required to fill out. Participant 4 (Group 1) alluded to acknowledging others she believed were also taking part in the fACT service, and how this affected her thoughts on the stigma surrounding that: *“Well you know unless it's obvious, you’ve got your foot in plaster or whatever, people don't really know why you're there or who you're seeing or why. Mind you I did notice a couple of times that I thought ‘Oh I thought that person was going to see that team’, mainly because of the work, you know the paperwork. But I mean anybody who didn't know wouldn't know what it was for. You're often given bits of things to fill in, you know update your info and goodness knows what else. But no, it didn't bother me, you know like the psychological stigma does sometimes, but you know it didn't. You know as I said, people don't really know why you are there.”*

Group 2 also found benefits in the physical shared waiting room reducing their perceived stigma around attending a health professional for their mental wellbeing. They often reported their experience through the lens of comparison with other occasions where they have interacted with mental health services, and due to this, spoke with authority.

“Yeah so there's no stigma there because it's perfectly camouflage and it's fine. Yeah, perfect camouflage. You know, it is just generally walking around.”

(Participant 9, Group 2)

“I've actually told a couple of people because they're complaining and all this and I'm like seriously get your butt in there. Look, it's free. It's inconspicuous. People just think you're in there to, I dunno, just getting your eyes checked or your eyesight, or getting more meds, not even an actual appointment.”

(Participant 6, Group 2)

“I'm very open. I've studied psychology and I certainly have been the one to push people and said you know it's nothing. It's like getting to talk to somebody and trying to sort your head out.”

(Participant 3, Group 2)

Another key concern that participants were thought to have in regards to perceived stigma was worrying about being labelled. This took on various forms, whether it was being labelled by the health professional, or just by others in their lives. Again there were some differences in responses based on Group 1 and Group 2’s experiences. Group 1 participants appeared to show a somewhat rudimentary base knowledge around what they believed a psychologist to be, or how and what their role might be in their recovery. This gap in their understanding appeared to heighten their fears around possibly being labelled, as many times they were still coming to grips with the realisation that they were ‘sick enough’ to be receiving specialist care. Participant 7 (Group 1) clearly explained this type of situation through her experience:

"...maybe I was just too scared or proud to reach out to, or maybe it was the cost thing I don't know. Or maybe I just didn't know enough about the service, what would be offered kind of thing. Or maybe it was that stigma 'Ooo somebody else to see'. I guess psychology is, it sounds like a big scary word that, not that you're sick but I mean that you need some serious help kind of thing. It's more the doctor to the surgeon kind of the principal, where the doctor, just go see them. But with the surgeon it's like 'Oh surgery!'. In that kind of concept to me, psychology seems to me more like 'Well you're seeing the doctor, now you have to see the surgeon' kind of thing. Not that there's anything wrong with that but it's just that stigma I guess around it."

Participant 4 (Group 1) reported having similar feelings about the perceived 'levelling up' of seeing a psychologist, and possibly her own stigma around what they do in their role.

"It was easy to be relaxed and to talk and you know whereas sometimes you think 'Ooo I'm with a psychologist. I might have to be careful what I say or they might think I'm nuts'".

In this comment, Participant 4 reflected on her concerns about the psychologist leading up to her appointment, in contrast with her experience which was different from what she had expected.

Responses from Group 2 that referenced labels being placed on the individual were of a similar vein to Group 1, although the tone and delivery of the discussion was very different. Where Group 1 appeared to reply from a place of fear or unknowing, Group 2 responses were lighthearted and somewhat comedic at times, almost as if to downplay the seriousness of the issue.

“I know it's really stupid considering I want to get into psychology, I do not want the label. I don't know whether it's because someone's going to go ‘Oh she's bipolar. She's got depression.’ More that I don't want something to be able to blame, like it's not my fault. I don't want that crutch to be able to go 'Oh I know I didn't get out of bed for three days but it's not my fault. I have a mental illness.” I don't need an excuse. I shouldn't, even with that, I mean okay, some people will use it as an excuse, I'm like ‘Nah you don't really have a mental illness, you have an excuse.’ Whereas you still should make yourself get up as if nothing else in spite of having it. Whereas I also know myself, if I've got something that I can use, on a bad day or whatever, I will use it.”
(Participant 6, Group 2)

“The stigma is large and to try to explain it “Well, the reason I don't have a business..” like I say “I used to, I'm nuts.” Haha. You know people don't really know what to say, you know what I mean? You can't just say why are you the way you are. Yeah. So the stigma is a big one. You know when you do people will look at you even weirder, so you're really in a bad situation.”
*(*Participant 9, Group 2)

For Group 2, despite the joking nature to some of their responses, they were - as a group - more likely to self-label themselves, either with a specific diagnosis or as ‘weird’ or ‘nuts’, throughout their interviews. They were also more likely to say that stigma was not an issue for them as they did not ‘care’ what others thought.

Overall, the anticipated or actual stigma felt by participants within both groups was mitigated somewhat by the setting of the integrated healthcare centre. The experience of accessing mental health services from a location which was familiar and acceptable to them was seen as positive.

Key Theme: Processes

The third and final key theme, processes, was identified by responses that related to how the physical act of receiving the treatment within an integrated healthcare setting affected participants' experience. All participants were registered patients with the PHO and as such had a base level understanding of what the health centre provided in terms of integrated care. Some participants spoke of using multiple services within the same complex, including physiotherapy and specialist clinics for specific health concerns, such as diabetes. None, however, were aware of the inclusion of psychologists as part of the integrated care model, until they were offered the fACT service by the GP or nurse practitioner. Despite this, all participants relayed positive comments around its suitability within the overall wellbeing service. As Participant 8 (Group 2) said: *"I was surprised it was even there. It just blew me away. I thought 'Wow'. I was going to say no to start with and I thought 'No, come on there's a reason for this. This is out there for a reason. Go try it and find out about it and see what happens'".*

Many participants highlighted practical aspects of the service, such as its physical location, as a welcomed and positive aspect of the service. Some expressed the physical toll that 'traipsing around' between doctors, specialists and other health professionals can have on someone who is already feeling demotivated, fatigued and not themselves.

The process of being referred to the service, and the processes within their ongoing care within the fACT service, were a key theme identified in the responses from participants. How the processes worked (or failed to work) had a direct effect on their experience, both positive and negative. Within the theme of processes, there were three subthemes that were identified, which included communication, consistency of care and mode of therapy.

Communication.

There were several aspects of communication that played a role in participant’s reported experiences within the service, which mainly involved reflections on handovers, first appointments and confidentiality. Delays in being able to access the service either from the first or subsequent appointments appeared to have a direct effect on each participant’s overall experience. According to those who lead the fACT project, when the system is working correctly, patients will be referred to a waiting psychologist to have an instant appointment with them. No participants in this research were seen immediately, and the average wait time for a first appointment was around two weeks. Most participants were referred to the service by their GP, with others given information by those acting in a nurse practitioner role. For the most part, the referral to the service went smoothly for participants, however the majority commented on the delay experienced from presenting at their GP clinic to seeing a member of the fACT team. Both Group 1 and Group 2 expressed strong feelings in regards to how they believe this had a direct effect on their overall experience. This was probably best described by Participant 8 (Group 2) who said *“There's no point in offering everyone an ice cream if they go to the ice cream shop and when they get there and all the bins are empty. Don't dangle carrots. People in these conditions don't need that.”*

There were some differences in how each of the groups appeared to frame the delays, however; Group 1 provided a balanced response in which they weighed up the positives of the service alongside the negatives, whereas Group 2 were stronger in their criticism, and more emotive in their responses.

“I think there was a three week waiting list. So that probably was one thing that wasn't ideal because I want to speak to somebody pretty much straight away… But yeah that was probably

not ideal because whenever you're given the opportunity to go and get a service and you're feeling in that place right there and then, and then the thought that you have to wait for that just maybe wasn't ideal."
(Participant 1, Group 1)

"It's really, really good because since I've been up here and come into [PHO name], their services have just improved and improved and improved. But they've also got busier. So it's really frustrating trying to get an appointment."
(Participant 2, Group 1)

The above comments are demonstrative of considered responses and reflections on the service, and how the specific delay in getting in to speak to someone in the fACT team had played out for them in the overall context of their experience. It reveals a level of measured contemplation, of balance, and of appreciation and gratitude. Despite not being happy with the delay in receiving the appointments from the fACT team, Group 1 were more likely to frame it as an inconvenience rather than a final nail. Group 2 participants were more likely to respond using more angered phrasing, and refer to more serious repercussions. Often their responses were laced with a type of contempt, bitterness and great displeasure about the timing delays.

"[It's] Huge. Because if you walk away from there and you can't get in for another month or two, things change within a month or two. Then you start feeling better or you're feeling worse. A person's life could be totally turned upside down within that time period. Or I could be feeling a lot better and go 'Oh nah, it's alright now.' Which is what does happen in my life."
(Participant 8, Group 2)

“To be completely honest though, as soon as they said it was going to take three weeks, it's like ‘Ohhh that could have been [a great service]’. I think that the idea in itself, as you said, absolutely wonderful. But the timeframe, it's not. People who have crisis going on, a three week wait is just too long.”

(Participant 10, Group 2)

Group 2 participants also spoke of feeling “rushed” in their appointments, with incorrect expectations delivered in terms of how long each appointment was scheduled for. This appeared to reveal more angst within a subset that, as a rule, had previous experience of other types of therapy and intervention. Many spoke of how they believed their sessions would or should take around one hour. As Participant 6 (Group 2) reflected:

“The first lady I've been with, she would do an hour with you. And then towards the last lady I ended up with, she was like ‘No actually it's supposed to be half an hour.’ So I'm wondering was I getting shoo'd out a lot faster?... Because I had originally been told it was an hour long appointment, so I’m just thinking ‘Oh I just got gypped out a half now. Plus I'd scheduled my day for an hour, not half an hour. So that's a bit odd. But yeah. They were like ‘Oh yeah, we've heard that she does that.’

This response was typical of the majority of Group 2 participants who responded in a way which could almost be seen as entitled. They believed they were ‘owed’ an hour, and if their sessions did not take up that full time, many commented on feeling rushed, or reflected on previous therapy experiences, such as with CBT, where sessions routinely took one hour.

Where Group 1 were almost apologetic for raising concerns about the delay in appointments, Group 2 were more likely to appear to reflect on this issue as a key let down in their experience.

Another key area of communication where participants appeared to place value on good communication was around the integrated healthcare protocols of sharing of notes between clinicians. This system allows the patient, GP, and any other health clinician associated with the clinic to be able to access the notes of any consultations left by the clinician. Traditionally, consultations with psychologists are conducted under the strictest of confidentiality, however within this model, that confidentiality is waived. Overwhelmingly, the majority of participants believed that this model - with increased and shared access to notes - was a positive move, and one which fitted within their holistic model of care. Participant 1 (Group 1) said that while she was not aware of the shared note system, she felt that in hindsight it offered her a type of reassurance. She continued:

“I suppose that in a way it's good for them to understand what's actually happening, mentally or psychologically, to them better prescribe or better help the way they can act towards it… and that's actually probably quite good to know what your GP will be able to check in on your notes, see where you're at. And so it's sort of that full circle process.”

Around a third of participants were not aware, until asked about it during this research interview, that the notes written by the psychologist were available to read by others within the PHO. For some, it took a few moments for them to digest how they felt about the situation. There were expressions of thoughts around how even if they felt uncomfortable with the idea of shared notes, they could see a wider perspective in which it would help them with their concerns and treatment in the long term. Some brought up concerns about people reading their notes when not authorised to as a breach of confidentiality, while others commented that while they did not have a problem with it, the fact that it was not highlighted to them did not sit entirely well.

“I suppose it's like anything you know I mean I had the same doctor for years and years and years and obviously that was confidential and his wife to keep the notes. Whereas now almost anybody can dial in, sort of thing. So not too happy about it but it's just yeah. It was nothing terribly, what would you say, terrible or anything like that.”
(Participant 4, Group 1)

A similar sentiment was expressed by Participant 6 (Group 2):
“I would have felt better if I'd known beforehand…. well let's face it, doctors know pretty much everything about you, more than most people would. So I suppose it's only fair that they know.”

This reflected a wide spectrum of responses when it came to communication, especially around reaching, exceeding or failing to reach expectations of care that patients placed on health professionals.

Consistency of care.

Another subtheme identified within the processes of the fACT project was that of consistency of care. The ability (or not) of participants to see the same psychologist to build a rapport and relationship with had a large effect on how they viewed their overall experience. For all participants who saw more than one psychologist during their visits with the fACT team, they reported this experience to be negative, and expressed feelings of loss, discomfort and annoyance with what they perceived to be a lack of momentum in their care. Both Group 1 and Group 2 consistently appeared to share similar experiences in terms of this situation. Issues raised included practical concerns such as the inability for receptionists to book with consistent psychologists, and delays in availability, right through to contention around what the lack of consistency could mean for someone who was experiencing severe distress or needed help more urgently. As Participant 2 (Group 1) said:

"I think any other person that's in a worse place than I was, and I felt at that time that I was in a really deep hole and I couldn't see my way out. And we were in a bit of a rut. If anybody was in a worse situation than my position, I think it might be a catalyst for them to do something if they couldn't see the same person all the time. So I think not just myself but for everybody, I think it's beneficial to see and stay with the same person."

"It's difficult sometimes to share these things, it's traumatic constantly having to repeat yourself." (Participant 9, Group 2)

One participant spoke of how she turned up to an appointment, and her expected psychologist was not there. She expressed feelings of disappointment that staff did not tell her before she journeyed to the PHO clinic and she believed it was a waste of her time and money as she did not feel comfortable "starting from the beginning again" with another therapist. In her opinion, she would have rather waited a further two to three weeks to see her psychologist of choice, rather than be slotted in with a new one - and this was an opinion shared by other participants who expressed a similar sentiment. Many participants shared thoughts around the rhythm and depth that they had achieved with their chosen psychologist and the value they placed in being able to build on that relationship during each appointment.

“In between appointments I think it was a couple of months because they were monthly appointments but I missed the middle month. Then, when I went to the second appointment, I really liked that lady. But I think she listened more but we also had that background so that she could kind of, she already had that history so I didn't have to say it all over again because that's one of my biggest things was going through this whole big thing of a few years worth and that's kind of more mentally draining for me too is reenacting and retelling this whole thing again. I liked the second lady that I went to.”

(Participant 7, Group 1)

“Just because they've got so full on, so busy that you kind of I get frustrated because you have to wait so long, by the time I actually have the appointment, things that out of my head that I had wanted to do that day, I'd worked through a process in my head about what I wanted to talk to [psychologist] about. But then because things that happened by the time I went back again the next when we could get an appointment, things that sort of gone out of my head because so much else had happened, do you know what I mean? It took me ages to get back into the thought process of what it was for that previous appointment time it should have been. And they didn't tell me that I wasn't seeing [psychologist], but had I known that I wasn't actually seeing [psychologist], I would have cancelled the appointment and made another one. I wouldn't have wasted my time to go all the way out there to find out I wasn't seeing [psychologist].”

(Participant 2, Group 1)

Where that rhythm had been interrupted, whether due to cancellation, delays in appointments, or booking errors, most participants reported experiencing a large drop in the perceived effectiveness of the intervention, which in turn created a negative experience.

“I had to cancel my appointment and then there was a period of nearly four to six weeks where we couldn't hook up. And they made a really big difference because like all things that we kind of set up and had done and just kind of like went sideways… it was almost like starting again at that point.”

(Participant 3, Group 2)

Some Group 2 participants spoke of how they had adapted their ‘speil’ in terms of their history and story, in order for it to be as concise and compact as possible. They described this behaviour often as a type of response to being shunted around different medical professionals, and almost needing to become an expert in their own situation in order to adapt to constantly changing and adapting environments.

“When it comes to like counselling and this sort of stuff, it's a bit annoying because you know you got to re-explain it all. Yeah whereas, I'm getting so used to it with the doctors anyway. I never see the same doctor. Yeah. So. I'm kind of getting used to giving a quick low down instead of a three hour conversation.”

(Participant 6, Group 2).

When it came to actually building a relationship with the psychologist or psychologists, participants were mixed in their reflections on this process and two clear types of experiences appeared to emerge. Where Group 1 participants appeared to make faster and stronger bonds with their psychologist, Group 2 were more critical of their therapist relationships.

“I was really happy with what they did and I was pleased that I got more than the one or two [sessions, that they thought they would be ‘allowed’]... And you know because I sort of felt when it was the final session, to me, that sort of felt appropriate because I didn't feel as though there were loose ends, or that they hadn't answered my question because from then on it was, like I said, it was okay you know, they didn't actually say you have to do this for yourself but basically that was implicit… They're all relaxed. Well particularly [Psychologist 1] and [Psychologist 2]. And they weren't judgemental or anything like that. And they were very positive in what they had to say.”
(Participant 4, Group 1)

“I felt really comfortable with her for these sessions. And yeah, it was really helpful to be able to speak to somebody who she seemed like was listening really well. So I did feel like I could talk to her and I could tell her things that I maybe wouldn't tell other people so that was helpful.”
(Participant 1, Group 1)

“[She was] Easy to talk to. She was very helpful and prepared to listen and give some good constructive, offered some good constructive solutions and things to do. That's why I felt really comfortable with her. And I didn't quite feel comfortable with somebody else.”
(Participant 2, Group 1)

Group 2’s experiences were overall more negative in tone and delivery, with a focus very much on what did not work for them. Their concerns often overlapped with other themes identified, such as that of experience of previous therapy as a comparison.

“I've got to say the one thing I do remember is that I always felt rushed. And that was probably because she was, you know, trying to get through and doing stuff. So yeah, I know that I felt rushed but I think that was maybe that I'm used to like having a full hour to try, and I think it was half an hour, 20 minutes.”

(Participant 3, Group 2)

“I've seen multiple psychologists, psychiatrists and counselors over the years, and some of them have been really good. But the majority either concentrate on something that's totally not related to why I'm there or the vast majority of people that I've seen honestly are not helpful. And it's just the same recycled stuff over and over and over and over.”

(Participant 10, Group 2)

Type of therapy.

This disconnect between an inability to form a deep therapeutic alliance with the psychologist, especially for Group 2, could come down to a variety of factors at play, including the lack of momentum and previous experiences, but another factor could include the actual type of intervention itself. A strong subtheme that emerged from participant’s reflections was their views and perspectives on fACT as a type of therapy. How they experienced fACT was highly dependent on their previous therapy experiences, as often the would contrast their latest experience with previous interventions. Group 1 participants were more likely to reflect positively on the fACT therapy, and referred to it in terms such as “quick”, “engaging” and “practical”.

“I think initially I felt like I wouldn't even really scratch the surface. But then I guess because I do quite a lot of meditation, well I try and practice mindfulness, and I think that I've felt quite a connection with that. You know, the grounding and that sort of thing. So I have actually found it

a lot more helpful and beneficial than what I really thought it would be. I thought it might be about fluffy, but she cuts to the chase quite quickly. Which was a bit scary. But that has actually been quite good… Just because I think it's really helped me to kind of, I don't know, be a bit more accepting of myself and the feelings I have. That it's OK... like more of a natural process than when you go to counselling and yeah it's not as confronting. Like when you go to counseling, you kind of go in and sit down and they're like so 'How have you been? What's been happening?' sort of thing. It's not as hard. It definitely feels like a softer approach. A bit more warm and kind of less clinical I guess."

(Participant 5, Group 1)

"And yeah I would say I was pretty surprised about how easy it was and how good it was that way. And yes it didn't go into a lot of depth but it was good at just pointing out those key issues and then giving some practical tips. So I feel like it's a good first step for moving people, for them to even just then after a while they can reevaluate things and if they want further help then they can go get further help. It just sort of maybe introduces them to the whole counselling sort of scene."

(Participant 1, Group 1)

"I hadn't really thought about how things were going to go, as I said I went in there looking for answers. And while I didn't actually get answers as such, there were strategies which I think added some value, you know, like I said they didn't actually say 'You have to do it yourself. We're just here to help you find it'."

(Participant 4, Group 1)

Group 2 participants appeared to share their experiences through a lens of expectation and negativity. Some spoke of feeling without hope of anything ‘working’ for them, and so reported viewing fACT as a different type of therapy that they could add to their ongoing list. Overall their responses were skeptical and reflected experiences that did not meet their expectations.

“I think I did better with the CBT because it was like I could see logic to it. And sometimes like you know 'Say this to yourself' just makes me want to go 'Pfft yeaaah'... Yeah and a lot of the time she's talking about holding the feeling and I'm looking at her to go "Ooohh eeeh?"... I've got to say I was never expecting as much, I want to call it the airy fairy hippy stuff. I really do. And I don't feel it's very fair…. I wasn't expecting all of the fluffy stuff and that was kind of a big shock to the old system. And that was certainly something that we identified as being, you know, she said you've got to stop your logic. One of the things she said was she lives and breathes this stuff every day, so to her... so to me it was like asking me to do stuff left handed... But then I think you know I'm also older and slightly more set in my ways than I'd like to think. So whether that and the fact that I've done counseling before you know it may have been factors that made me really struggle with this whole 'Hold your emotions', haha.”
(Participant 3, Group 2)

“I don't really follow these different schools of thought. No, it was just this very stock standard sort of experience in terms of speaking with somebody about this goes. But I mean, what can you do in an hour? To be fair.”
(Participant 9, Group 2)

Summary of Findings

One of the clearest elements to be identified within the findings of this study is how different of an experience a person can have of a service once certain factors are identified within groups of people. Three major themes, supported by nine subthemes, created a representation of the experiences reported by all of the participants within this study. Overwhelmingly, despite the personal experience that each patient within the fACT service had, there was a common understanding and belief that the inclusion of psychological support within primary care was a positive and supported move within the overall health system. This type of sentiment was shared by almost all participants, even those who expressed the opinion that they did not find value in the service. Overwhelmingly, participants believed that having psychological services within a primary care environment was a beneficial and logical service to have available to the wider community, and were supportive of a wider rollout nationwide that would hopefully mean more access to more people, but with fewer issues around wait times and consistency. As Participant 8 so succinctly summed up:

“It's left me with that thing in the back of my mind that I know they're there, I can reach out. And I can ask for help... If I start to fall, I know there's a net there that I can reach out for and hopefully they can catch me.”

Discussion

Background

This study looked at the experiences of ten people who were referred to the fACT service at a PHO clinic as part of a pilot programme to assess the integration of psychological support into a community health centre. When a person decides to reach out for support when they are feeling distressed, often their GP is their first port of call. How a person views their experience and care within this service can have an effect on the overall success of any treatment or intervention, as well as change their perspective on models of care. But what are patients' experiences? How do they feel about accessing mental health support within their local GP clinic? With an increased focus on preventative measures in the realm of the mental health sector, it is timely that this study was conducted given the lack of research in this area - especially when it comes to patient experience. This study sought to address that gap by allowing patients of the service to reflect on their experience, discuss the perceived value and pitfalls and give a voice to how the fACT service sat within their model of care. A qualitative approach was used to reflect the differing experiences and thoughts raised by each of the participants, which fed into an overall view of the service.

The literature review discussed previous research in the areas of mental health in New Zealand and internationally, as well as integrated care. It referred to research on patient expectations of care, the clinician-patient relationship and introduced research done on brief therapies, including fACT. What this highlighted was the lack of research completed on brief therapies as a whole, but even more so on the voices of those who have been through the intervention. Without highlighting the understanding of those first-hand experiences, previous research exists within the realm of facts and figures, scant of emotion or reality. Most importantly, due to these findings, the voices of patients who have first-hand experienced this service can now be heard.

The next section of this thesis will discuss the main themes and concepts that have emerged from the experiences of participants who engaged with the fACT service at the PHO in relation to literature relating to psychological support services within primary health care settings. It will examine the practical implications of the role of early interventions within a GP practice, and the acceptance of such innovations within the wider health system. It will discuss how communities may make sense of the development of future services, and highlight areas of interest in regards to successful implementation. Finally, this section will look at the limitations of this study and the implications for future research in this area for both clinicians and researchers.

Findings

In many ways, results from this research revealed just as much about those who believed they had positive experiences within the fACT service as those who reported negative experiences. Results showed two very different groups within the participants; Group 1, who reported as presenting with mild to moderate symptoms of distress, and for whom the fACT service was a largely positive experience. And Group 2, defined as experienced mental health system users with serious diagnosis and high levels of distress, who reported, for the most part, a more negative experience within the fACT service. The differences between these two groups can be explained in two different ways. Firstly, the service is not designed for those experiencing more serious psychological distress. As stated by A-tjak et al., (2015) and Matua Raki (2012), brief interventions are most effective on mild to moderate psychological concerns, where more serious interventions, in the form of multisystemic and specialist evidence-based therapies, are more suited to more complex and serious distress. This finding also reflects what Dath, Dong, Stewart and Sables (2014) found in that positive outcomes for brief interventions is rarely quickly achieved for those who are experiencing distress at such a high level that they meet a criteria for admission to secondary mental health services before beginning the intervention. Research released by the Ministry of Health (2019) in November showed that around 8.2% of adults in New Zealand reported having high or very high levels of psychological distress, which creates a difficult situation for GPs in terms of assessing the severity of those who present at their practice. Given the results of this research which shows the contrast in experience based on the level of distress and diagnosis, it is pertinent that GPs are trained and feel comfortable in their referral capabilities to ensure patients are given the appropriate care.

Secondly, as Robinson, Delgadillo and Kellett (2019) found, some patients with common mental health concerns may fall into two subgroups: One described as “gradual responders” - who may need as many as 26 sessions to have clinically significant improvement occur, and the other as “rapid responders”, those who report marked improvement within just four sessions. It is possible that the differences in experiences identified between Group 1 and Group 2 in this research can be explained by either of these two points, or a combination of them both. In this instance, the ability for a GP to identify which category a patient may fall into will have a significant effect on how they experience a service which is designed to be brief, succinct and rudimentary in nature. To be able to ascertain patient characteristics and dynamics successfully, GPs will be required to undergo specific training in which the importance of a correct and fitting referral are made clear, and that interventions are explained clearly in respect of who would benefit most from what therapy. Many GPs report feeling like they have a knowledge gap in the realm of mental health which leads to varying levels of competence within primary care (Stone, et al., 2019; Smith & Williams, 2016). Without full engagement from the practitioners who are first in line to assess and refer suitable patients to services, any type of new service, such as fACT will get limited buy in from the service users themselves (Smith & Williams, 2016).

Another finding from this research was the role of medical authority in shaping experiences. Participants in this study, particularly those from Group 1, placed a heavy weight on the role of a GP to be able to diagnose, prescribe, refer and acknowledge ‘unwellness’. This determined whether a participant believed themselves to be ‘worthy’ of help, placing a heavy emphasis on the doctor’s power within the doctor-patient relationship. As Gordon and Beresin (2015) wrote in their research on this dynamic, excellent clinical outcomes, whereby a patient reports a positive experience, are interlinked with the basis of the relationship provided by the doctor as the ‘expert’. Whilst some more recent research has revealed the role the internet has played in changing the dynamic of that relationship somewhat (Agius & Stangeland, 2016; Larsen, 2016), by providing more power to the patient through increased access to knowledge, this study shows that the traditional concept of a doctor’s authority remains for many patients. It continues to play a strong role in how a patient frames their experience and how they make sense of the relationship with their GP and in turn, their health condition.

The role of a holistic model of care has also been highlighted by the results of this study. All participants displayed strong and united feelings towards this approach in which the mind, body and spirit are treated as one. Robertson (2019) discussed holistic care as being a key focus for the New Zealand Government within the Wellbeing Budget, and as such, ring-fenced more than $230m towards developing mental health services to bring this to fruition through improved services which focus on early intervention. It is therefore timely that this research coincides with what appears to be a complementary directive from the health ministry. One approach raised by many of the participants was Te Whare Tapa Wha (Durie, 1985), a model developed through the lens of te ao Māori. Despite the model’s focus on the Māori world view, as opposed to the Westernised biomedical perspectives of the current New Zealand health system, Te Whare Tapa Wha appears, based on this research, to have value as a model across cultural boundaries. Many of the participants who raised the model or spoke of many of the key values and perspectives of the model, were of Pākehā descent. This perspective mirrors findings by Rochford (2004) and Fulder and Lafaille (2005) that show the cross-cultural application of similar holistic-based models could benefit groups across cultural boundaries, and create a synthesis and integration desired by those accessing the health system. It also reflects findings from He Ara Oranga (New Zealand Government, 2018) which showed that patients were frustrated at the current lack of a holistic response from mental health services, and that they would prefer more choice. Examples included in that report ranged from including more online counselling, rongoā Māori (traditional Māori healing) and talk therapies, Pacific healing, spiritual healing and mind–body practices such as mindfulness, “rather than a reliance on pharmacology”. This key finding warrants further research into how a model such as Te Whare Tapa Wha and other traditional Māori practice could be utilised in a cross-cultural situation with wider and broader application to the general population.

Another key finding from the current study is the way in which stigma is reduced for patients who seek psychological support from within an integrated healthcare setting. All participants expressed a belief that the ability to ‘hide’ their mental health concerns ‘in plain sight’ within the physical realm of the healthcare centre where their GP was located was a positive aspect of their experience. This finding is reflective of other research in the area, such as Rollins et al., (2017) and Royal Kenton et al. (2019) where it was found that users of the integrated health service viewed the co-location of services favourably because it reduced their perceptions of stigma. As Corrigan, Druss and Perlick (2014) put it, “Understanding stigma is central to reducing its negative impact on care seeking and treatment engagement” therefore this current research finding offers an insight in to barrier reduction for patients at that initial help-seeking level. There is currently very little research conducted in a New Zealand setting on stigma within an integrated healthcare facility so these findings are an important step in gaining an overall perspective on how patients could perceive a future move to a more collaborative healthcare system, and the role that will have on their help-seeking practices. Also, given the limited male voice within this study, the role that a service such as fACT could provide men who display much different help-seeking behaviours to women, often due to stigma-related issues, would further benefit the overall perspectives of how this service could be utilised on a wider and more diverse group of patients.

Participants in this study did offer some insight into practical ways they viewed the integrated care model could be improved. These included, but were not limited to, consistency of care, the vital role of not being able to build rapport, and having good processes. Each of these proved to be key to how a person experienced the service, and provided valuable, practical findings for future development. Patients wanted consistency and the ability to build a therapeutic alliance with their psychologist in whom they placed large amounts of trust. When processes, such as poor appointment booking systems that created barriers to building these types of bonds, let patients down, it had a negative effect on how they viewed their experience of the service. In this sense, the findings of this study further reflected what previous research (Newman, O'Reilly, Lee & Kennedy, 2015; Denneson, Cromer, Williams, Pisciotta & Dobscha, 2017) has found in terms of the importance of the therapeutic relationship between a patient and a medical professional.

There was a sense of gratitude for the service displayed by participants of this study, such as the fACT service at the PHO, to be available - especially free of charge - at their local GP practice. Many participants spoke of the ‘safety net’ feeling that the service provided them, in the sense that even if they do not make use of the service itself, the mere fact it is available has a positive effect on their experience. This finding is reflective of supporting research that shows that the availability of social support, even if not enacted, is enough to reduce the physical stress responses of psychological distress (Uchino & Garvey, 1997). This effect of essentially ‘buffering’ (Cohen & Wills, 1985) allows for a person to go through life’s stresses but with the knowledge that added support is available, therefore adapt and cope easier than someone who did not feel that buffer was there (Field, Gallas & Schuldberg, 2017).

Overall, participants displayed a general acceptance of accessing mental health support within a PHO setting and within an integrated healthcare framework. Interestingly, all participants were supportive of the move towards a more holistic, integrated healthcare system, despite any negative experience they may have had personally. There was a sense that the fACT service was for the “collective good”, and that the benefits of offering similar services more widely through the community would be seen as a positive move. Questions remain, however, in regards to the viability and effectiveness of implicating a programme with such little current research in the area.

Practical Implications

A separate report (Appendix 6) has been compiled for perusal by Massey Psychology clinic psychologists involved in the fACT service, detailing specific ways the researcher believes the findings from this study could be implemented in day-to-day practice. These practical and important specifics are not only key findings for this research, but show the benefit of using a qualitative method when gathering data on a service. Key learnings such as those detailed would not have been uncovered had just a quantitative study based on effectiveness been conducted. This qualitative research has allowed for the nuances of personality, emotion, reflection and individuality to be expressed in a useful manner which further legitimises the need for more research in this area.

Further Research

There are a number of ways further research could be used to develop, enhance and build upon the findings of this current study. Questions remain in regards to the best way that GPs can identify who would benefit the most from the fACT service. More needs to be known about both the levels of competence of the GPs to engage in this type of referral, as well as an increased knowledge around the effectiveness of the intervention and for what types of distress.

There is a distinct lack of any type of empirical evidence in regards to fACT, as current research often focuses on the more expanded ACT as an intervention. This is an important area that requires more research in terms of quantifying the differences between the two different types of delivery of the therapy, and the pros and cons of each within an integrated healthcare setting. As it stands currently, the lack of research in regards to fACT is a key area of concern when looking at possible implementation of the service on a wider scale. This further highlights the importance of this New Zealand-first study as an initial foray in to what needs to be a much wider and in depth look at an exciting new type of therapy. It would also be beneficial for further research to engage the areas around gender differences in experiences of the service, as well as differences amongst cultural groups. Despite the small number of ethnic minorities engaged in the service, research into potential barriers to utilisation may uncover relevant results to ensure the service is being accessed in the correct ways.

Limitations of Research

Qualitative research should be viewed through a lens of interpretation and as such, all results should be acknowledged as being a version of the participants' truth as they recall events, emotions or experiences. Also, given the small sample size of 10 people, the findings of this study cannot be generalised to all within a population. Similarly, this study focused on the experiences of those who engaged with one particular medical practice and as such, can not be seen as reflective of other integrated healthcare settings which may have different procedures and set ups.

Participants in this study were chosen at random from a self-referred group of patients and were not chosen on the grounds of ethnic background. Due to this, there is a gap in experiences reported by those in minority groups such as Māori, Pasifika, and Asian. Similarly, participants in this study were 90% female, so the voice of the male experience of the fACT service is not fully engaged from within this study, however, provides a possible tact for future studies to engage with moreso.

Whilst this study aimed to capture a range of perspectives on the fACT service, the experiences of those who did not engage in the study are of course excluded from the results. Importantly, those who were offered the service but either turned it down or dropped out and did not re-engage with the service for whatever reason are also not captured within this study. These patients hold important information in regards to their thoughts on accessing mental health services within an integrated healthcare model, and likely could hold diametrically opposed views on the fACT service which deserve to be acknowledged and explored in a more fulsome way.

Conclusion

Experiences described in this study give insight into two distinctly different patient perspectives of receiving psychological support within an integrated healthcare setting. How patients view the fACT service was seen through the lens of their past experiences, symptoms, model of care, stigma and expectations of care. Their involvement in the project was seen as positive to many of the participants, with even those who did not feel they gained personal insight, still believed there was a ‘collective good’ in the purpose of the project’s aims.

Data gathered from the study’s interviews indicated that those who reported negatively about their experiences had symptoms and a psychological history which meant they were potentially not good candidates for the type of intervention on offer. The possible training gaps for GPs in terms of what the fACT team’s capabilities and needs were, and who would best benefit from the service, is an area for future development amongst the primary care team. The question remains as to whether or not fACT is the correct type of brief therapy that should be engaged by primary healthcare centres in New Zealand to engage in patients experiencing low to moderate psychological distress. Whilst some elements of the therapy were well supported by participants, current research lacks robustness when it comes to effectiveness and outcomes and more research is required in this area.

There is a need to push back on the idea that people need to hit rock bottom before they are eligible for treatment for their mental health and general wellbeing. No health system would wait until every bone in your body was broken before accessing treatment, instead a person with a single broken arm would receive the care and support that it needed in order to provide the best chance of healing. Psychological support needs to be set up in a way in which it can be available as the earliest intervention for any distress. Findings from this research have both provided new understandings of patient experiences, as well as reiterated phenomena already described in supporting studies in regards to patient-doctor relationships, stigma, holistic health and social support. As this study shows, access to primary mental health services through community-based medical centres has positive and wide-reaching effects on the lives of those experiencing psychological distress in their lives. A first of its kind in New Zealand, and one of very few studies that has ever focused on the fACT service internationally, this research can be seen as a starting point in terms of referencing future areas of research which is needed in order to ensure more is known of the experiences of those who take part in an intervention that has been lauded as a future pathway of hope, but with little research to back up these claims. This thesis provides a platform of which a new future of mental health delivery within the primary health sector can be built upon, which with the right support and funding, could herald a new dimension to how mental health care is supported in New Zealand.

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Appendix 1: Confidentiality agreement

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Experiences of Focused Acceptance and Commitment Therapy (fACT) intervention; a new approach to psychological support in primary care

CONFIDENTIALITY AGREEMENT

I ALISON BURFIELD (Full Name - printed)

agree to keep confidential all information concerning the project - **Experiences of Focused Acceptance and Commitment Therapy (fACT) intervention; a new approach to psychological support in primary care**

I will not retain or copy any information involving the project.

Signature: ABurfield **Date:** 16/04/19

Appendix 2: Phone script

PHONE SCRIPT

*** Confirm identity of participant*

Hi, my name is Alison Burfield/Greer Berry. I am a Masters student with the School of Psychology department at Massey University.

About six weeks ago you met with one of our psychologists based at Kauri Healthcare, as part of a new service being trialed.

We are doing a study on the effectiveness and experiences of this new service and are inviting all people who have used it to consider taking part.

You indicated that you were happy for us to contact you to tell you a little bit more about the research we are doing. Is now a good time for me to tell you about the study?

** Yes or confirm alternative time to ring back ** *Not interested – thanks for your time*

Before you make any decisions about being involved in the research it is important for you to know that participation is entirely voluntary, and your choice will not affect any of the care you receive. All your information will be kept confidential, we won't access any of your medical records and your psychologist and medical team won't know whether or not you have taken part in the research.

The goal of this study is for us to find out whether the way the service was provided, i.e. having a few focused sessions with a psychologist, is helpful.

The way that we will find out this information is two-fold – one is by asking people to complete the same questionnaires that you did at the beginning of all of your appointments with the service and then comparing the results.

The other is by conducting a confidential interview with you in which you will talk about your experiences of the service. This will take about an hour.

You can take part in both, or one or the other, or choose not to take part at all.

Do any or both of the research options sound like something you would be interested in taking part in?

*** Yes/Maybe* *** No – thanks for your time*

Great. I will send you out:

- some more information about the project
- [Only for quantitative study] a consent form*(note: consent form will be handed to participant in person for those undertaking interviews)*
- [If relevant] a copy of the questionnaires – and a freepost envelope to return them to me.
- [If relevant] and Greer/ Alisonwill call you back in around a week to arrange a time for the interview to take place.

The information will also include the contact details of my supervisor if you have any questions.

Can I confirm your address please?

Thanks for your time.

*** Have Don's contact information in case any issues that need to be directed to him*

*** Have helpline & Kauri contact information available in case any issues with current distress. Patients can also refer themselves back to the psychology service.*

Appendix Three: Information sheet

Experiences of Focused Acceptance and Commitment Therapy (fACT) intervention; a new approach to psychological support in primary care

INFORMATION SHEET

Kia ora, my name is Greer Berry, and I am a Massey University Post-Graduate Psychology student completing my Master of Arts degree. The purpose of this project is to conduct research around the experiences of clients who have been involved in the delivery of the Focused Acceptance and Commitment Therapy (fACT) service at Kauri Health Care in Palmerston North.

This research project, a first of its kind in New Zealand, will look at your experiences of this brief therapy, and how well it fits with your expectations of care from your doctor and the health care team at Kauri Health.

Why have I been invited?

Before completing your fACT therapy, you indicated that you were interested in taking part in an interview about your experiences. You were then contacted by phone after your therapy finished to discuss if you would still like to take part. Participation is entirely voluntary and your choice will have no impact of the treatment you receive from Kauri Health Care or the fACT team.

What will I be asked to do?

Participants for this part of the research will take part in an interview with me, at a place that suits us both. The interview will take approximately 1 hour to complete. We do not expect the interview to be stressful at all, however, if you do experience any issues because of the interview, you are welcome to go back and visit the fACT team at Kauri Health Care without charge.

What will happen to the information that I provide?

All interviews will be voice recorded (with your permission). The recorded information will be transcribed for analysis. At this point, we will return the transcript of your interview to you for checking, in case you wish to change your mind about any details we have discussed. We will provide a free post envelope for the return of the transcript. If you have not returned it within four weeks of the date on the letter, then we will assume that you have approved its use in the study. The transcripts will remain completely anonymous. All identifying details will be kept quite separate from the interview information. The information will be analysed to reveal the experiences of all patients.

The findings will make up part of a Master's thesis, a report to Kauri Health and may be presented in scientific meetings or published in medical journals.

The data will be held securely by the researcher and research supervisor, and securely destroyed after a period of seven years following the research publication. I will not have access to any of your medical records or therapy notes at any stage.

Your Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study (within one month of the interview taking place);*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used;*
- *be given access to a summary of the project findings when it is concluded;*
- *ask for the recorder to be turned off at any time during the interview.*

How Can I Participate?

If we have not already arranged a time and place for the interview, I will be in touch with you shortly to discuss a suitable date for us to meet.

Before we begin the interview, I will require your written consent that you feel that you are comfortable with what is involved, so I encourage you to note down any questions you may have for us to discuss when we speak next.

No payment will be made for this interview, however you will be given a $20 petrol voucher as a thank you for your participation.

If you have any questions at any stage about any aspect of this research project, please do reach out via phone or email.

Thank you for your interest in taking part in this interview. I will be in touch again soon.

Ngā mihi,

Greer Berry

Project Contacts

Please contact Greer or Prof Chris Stephens if you have any questions about the project.

Researcher:

Greer Berry
[redacted]
Greer.Berry1@uni.massey.ac.nz

Supervisor:

Prof Chris Stephens

06 356 9099 ext. 85059
C.V.Stephens@massey.ac.nz

Compulsory Statements

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/20. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Appendix Four: Consent Form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Effectiveness of fACT therapy in a primary healthcare setting

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded (circle appropriate)

I wish/do not wish to have my interview transcript returned to me. (circle appropriate)

Please tick this box if you would like a summary of the findings of the research sent to you ☐

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

Appendix Five: Questions for interview

Proposed questions for fACT interview subjects

- Introduction of researcher
- Consent/confidentiality discussion
- Discussion from info sheet about the research, why, who etc
- Key terms and phrases revision (e.g. “fACT”, “intervention”, “therapy” etc)

INTRO QUESTIONS:

General questions to establish any relevant information such as age, identified gender, marital status, family, employment status, profession, ethnicity, living arrangement, education.

In general, questions will focus on:

- how clients view their model of care
- how fACT has delivered on their expectations of treatment
- client’s overall experience of fACT within an integrated family health centre model
- perceptions of stigma attached to receiving care within a primary health care setting
- levels of satisfaction and synergy between clients and primary health care teams.

OWN MODEL OF CARE

When approaching the GP with your initial concerns or issues, how did you imagine your consultation would go?

- Did you have a specific treatment plan you thought you might be offered?

EXPERIENCES OF FACT INTERVENTION

How was the fACT project first initially explained to you by the GP?

What were your first thoughts and feelings about the fACT intervention (before receiving it)?

What were your thoughts on the service following the first session of therapy? (how did it change/modify from initial thoughts)

What were your thoughts at the conclusion of therapy when compared with before you began fACT therapy?

How did you feel about the experience of receiving mental health care within your GP centre?

THOUGHTS ON MENTAL HEALTHCARE ACCESS

In regards to access to mental health services, before the fACT project, how did you rate your access to mental health services?

fACT EXPERIENCE

How soon did you see a member of the fACT team following your GP consultations? (e.g. immediately, within days, a week etc)

How many times did you see them in total?

How did you feel about being offered the fACT service?

- Did you have any hesitations or concerns?

Were you well informed about the fACT service or did you still have some concerns or questions?

(Questions around the ‘warm handover’ between practitioners)

Can you describe the relationship and how confident you felt with the fACT therapist in your first consultation?

How much insight did you gain in to your concerns for which you sought help for initially?

How did your experience of being referred to the fACT team differ to how you envisaged your treatment plan might go?

How did the experience of fACT therapy compare to other mental health services you may have accessed?

Did you feel it was appropriate for you to be sent to the fACT team?

Acceptability

Cost/feasibility (Free service, how did you feel about not having to pay for the service? Was this the removal of a barrier for you?)

EXPERIENCES OF FACT INTERVENTION

Satisfaction with service

Changes in functioning/symptomology

Would you recommend others to use the fACT service? Why?

Would you seek out fACT therapy in the future when feeling ‘stuck’ in your life? Why?

IF other MH experiences have been mentioned - Can you think of any barriers that you have had previously to accessing mental health care? (e.g. cost, stigma, lack of knowledge/awareness of where to go etc)

Appendix Six: Report to Massey/PHO

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

“I know there’s a net there”: Experiences of Focused Acceptance and Commitment Therapy (fACT) intervention; a new approach to psychological support in primary care

REPORT INTO PRACTICAL FINDINGS FROM fACT RESEARCH

Kia ora, my name is Greer Berry and I have recently completed my Masters thesis which looked at peoples’ experiences of the fACT service at Kauri HealthCare, run in conjunction with the Massey Psychology Clinic.

This report is to update relevant staff members involved in the project on the findings of my research into the experiences of patients who took part in the fACT project at Kauri HealthCare. It seeks to provide detailed specifics around ways in which feedback could be implemented in day-to-day practice and experiences could be assessed when looking into future research or reviews.

To read more detail into the findings of the study, my full Masters thesis will provide a fuller picture, however this brief report will showcase some key areas that may not have been included in the final thesis due to falling outside of the scope or major themes. Some of these findings include the anecdotal experiences of the researcher and as such, should be viewed through the lens of opinion and circumstance. Any recommendations should also be seen as such.

Key finding:

Participants appeared to fit into two categories - those with little to no previous mental health support service history, and those experiencing serious psychological distress with a long history of touchpoints within the mental health system, both in New Zealand and internationally.

Implication:

Those with minor to moderate distress reported much more positive experiences with the fACT team than those who had more serious concerns. From the interviews, it appears GPs and referring staff were referring everyone with psychological concerns to the service, with some more seriously distressed people reporting feeling like they had nothing to lose anyway, so they gave it a shot. What became clear was that past therapy experiences lead to the more distressed group to not connect as well with the fACT mode of therapy, and therefore experiences were more likely to be reported negatively. It also meant that there were areas within themes identified in the research where the two groups had quite different responses from each other, while in some areas where they reported similar experiences. The overwhelming pattern, however, was that the fACT modality within primary care did not appear to be the right type of therapy for those experiencing serious concerns, however they were supportive of the overall concept to help out others in a different place with their distress.

Future recommendation:

More research is required to observe whether this is a more widely experienced phenomena, and if so, referring parties (GPs, nurse practitioners) may wish to be more selective with types of referrals to ensure therapy modalities match distress levels. Whilst the fACT service may be practical for many seeking help, guidelines may need to be created around those who show more serious concerns if further research backs up these findings.

Other key findings:

- Expectations of care was a key issue which framed up the experiences of those who took part in the fACT project. Each person had certain expectations of how their initial consult with a GP might go, how they believed they may be treated, or what interventions could be offered, as well as the feelings and emotions that they may experience during this process.
- Treatment options were a big part of the experience for both Group 1 and Group 2 respondents. Neither group wanted to be “patched and dispatched” and the majority did not want to be offered medication and preferred talk therapy as an option.
- Group 1 respondents had a high level of medical authority placed on GPs and others within the health system, whereas Group 2 did not and actively challenged it.
- Holistic health was a huge driver for both Group 1 and 2. All participants spoke in some way about treating the mind and the body concurrently. One key finding out of the research was that many participants, even those that did not identify as Māori, had knowledge and liked the concepts behind the model of Te Whare Tapa Whā. This is a key area of future development in terms of assessing whether a model with such a high cultural component could in fact be rolled out across communities with wider ethnic and cultural backgrounds.
- Stigma was lessened by the setting of a primary healthcare centre for all participants. Some spoke of the ease of ability to “blend in” with other “sick” people, and this was a largely positive aspect of the overall experience for all participants.
- Few participants were aware that other members of the healthcare team could access their notes from their consultations with the psychologist, and there were mixed responses around the discussion of this topic. Some felt like even though they weren’t aware, they could see the advantages of the shared care system and it meant that people such as GPs were on the same page in knowing what was up with the patient and what had been discussed. Others spoke of privacy concerns, especially when it

came to knowing other people who worked at the PHO. This is a key area in terms of future communication with patients. Some said they were told this by their GP, others by the psychologist, and some only discovered it when they logged into their patient portal online where they saw all the notes (and therefore made the assumption others could too). Confidentiality in these circumstances should be a priority in terms of assuring patients of who is going to know what, and to avoid any negative experiences for both patients and practitioners.

- Some of the biggest practical responses around peoples' experiences related to their communication and processes involved with receiving care. Whilst all participants felt there was a need for psychological support services within a PHO setting, many felt that the booking system and consistency of care had a negative effect on their experience.
- Many participants spoke about time delays between being referred to the service, getting their first appointment, and then making subsequent appointments. All participants felt this had a negative effect on their experience as almost all of them had experienced one or all of these issues. Some participants highlighted the fact that when making that initial reach out for help, timeliness was crucial as often that's when they were feeling most in need of help. A delay of a week or two, or more, was not ideal and would prevent them from possibly accessing the service in future.
- Once forming a bond with a psychologist, some participants spoke of the frustration with trying to maintain appointments with the same person - often due to the administration staff being unaware of the effect that chopping and changing can have on the therapeutic bond, trust and consistency. This was a key area where patients felt improvements could be made, and where they felt let down or had a negative experience.
- Those who had experience with other types of therapy felt confused around the concept of fACT and many commented on not understanding the briefness of the therapy (in terms of consultation time, and duration of sessions) and as such, felt 'ripped off' or cut short in terms of what they were 'allowed'. In this sense, because they were comparing it to the likes of CBT sessions that lasted one hour, and therapy plans that extended across months, many felt like they required more information in regards to setting correct expectations. This would have prevented the feedback of feeling 'hurried' or 'not listened to' or discussions around feeling like the psychologist shortchanged them, and so on.

Overwhelmingly, participants believed that having psychological services within a primary care environment was a beneficial and logical service to have available to the wider community, and were supportive of a wider rollout nationwide that would hopefully mean more access to more people, but with fewer issues around wait times and consistency. As Participant 8 so succinctly summed up:

"It's left me with that thing in the back of my mind that I know they're there, I can reach out. And I can ask for help... If I start to fall, I know there's a net there that I can reach out for and hopefully they can catch me."

If you have any further questions about any of the points raised above from the research I conducted, please feel free to contact me.

Kind regards,

Greer Berry
[redacted]
greer@greerberry.co.nz