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# What are the barriers and facilitators for health and social care professionals accessing organizational wellbeing support services? A mixed-methods study

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## ABSTRACT

Recent years have seen increases in workers' stress levels and sickness absence rates. Organizations have increased the number of wellbeing support services they offer employees, but uptake has been poor. This study investigated barriers and facilitators to accessing organizational wellbeing support services. A two-study, mixed-methods design in health and social care employees was used. Study 1 conducted a directed content analysis of qualitative interview data based on the Theoretical Domains Framework (TDF) to identify barriers and facilitators. These were translated into survey items. Study 2 conducted a quantitative cross-sectional survey to assess whether the number of barriers and facilitators was associated with the likelihood of service use. Study 1 ( $n = 20$ ) created a survey list of 23 barriers and 23 facilitators. Study 2 ( $n = 162$ ) found that a greater number of facilitators was associated with a greater likelihood of service access, but number of barriers was not. We concluded that increasing facilitators may increase employee uptake of wellbeing support services. Facilitators include making access routes to services simple and efficient and circulating regular information to staff about available services.

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## Introduction

Stressors caused by the recent public health emergency, the Covid-19 pandemic, have negatively impacted workers' physical and mental health (Al-Ghunaim et al., 2021; Statistics Canada, 2023). A 2023 Canadian Labor Force Survey reported that 1 in 5 workers were reporting high or very high rates of work-related stress (Statistics Canada, 2023). In a 2022 international survey of over 120,000 employees, 1 in 2 reported experiencing a high degree of stress the previous day, an increase from 1 in 3 in 2009 (GALLUP, 2023). The impact of increased stress levels has been reflected in elevated sickness absence rates. In the US, 3.3% of workers were off work sick in January 2022, the highest percentage on record since 1978 (U.S. Bureau of Labor Statistics, 2022). In the UK, sickness absence rates in 2022 were the highest since 2004 (Office for National Statistics, 2023), with around 1 in 10 of all sick days attributed to poor mental health (Office for National Statistics, 2023). These statistics highlight the importance of considering the role of physical and mental health in causing sickness absenteeism and presenteeism when workers attend work despite being sick.

There have been particular concerns about work-related stress in the health and social care workforce (Vogt et al., 2023). There have also been growing concerns about burnout, the syndrome involving exhaustion and disengagement (Demerouti & Bakker, 2008). Health and social care workers were on the frontline of the Covid-19 pandemic, experiencing a range of stressors including redeployment, increased workloads, understaffing, exposure to people with Covid-19, shortages in personal protective equipment (PPE) and higher rates of potentially traumatic events related to death and dying (Al-Ghunaim et al., 2021; Vogt et al., 2023). Rates of burnout in medical professionals are now their highest on record (General Medical Council, 2023; Shanafelt et al., 2022) and some studies suggest that the pandemic has led around half of health professionals to consider leaving their jobs (Feng et al., 2022; Martin et al., 2023).

To address workers' stress and burnout, organizations have increased the wellbeing support services they offer. These can be conceptualized in different ways. For example, one approach is to consider whether they are (1) person-directed or (2) organization-directed (Panagioti et al., 2017). Person-directed interventions are those which consider employees without recognizing their context and can include, for example, stress-management workshops or mindfulness classes. Organization-directed interventions instead consider the employee is a worker in their organizational context. They aim to deliver organizational improvements to enhance worker wellbeing, including, for example, changing shift patterns or improving cafeteria facilities (Panagioti et al., 2017). Another approach is to consider whether interventions are primarily preventative or ameliorative (The Chartered Institute of Personnel

and Development, 2022). Preventative interventions can include health promotion services, such as mental health training, wellbeing days, and physical exercises programmes. Ameliorative interventions can include employee support services, such as counseling and employee assistance programmes (EAPs) which offer counseling and support to workers (The Chartered Institute of Personnel and Development, 2022).

A survey of 804 multi-sector UK organizations found that half had increased their wellbeing support for staff since the onset of the pandemic (The Chartered Institute of Personnel and Development, 2022). In the US, a survey of 1500 multi-sector workers found that 27% were offered mental health training (e.g., training for managers on supporting employees; training for employees on coping strategies) by their workplace in 2021. This was an increase from 17% in 2019 (Mind Share Partners, 2021).

Evidencing whether staff wellbeing support services are beneficial is challenging due to wide variations in what is offered. However, there is some evidence to suggest that they can provide tangible benefits, and a growing literature has studied the impact of EAPs. For example, one prospective, quasi-experimental study found that EAP users had lower depression and anxiety than non-users at 6-month follow up (Milot, 2019). Another prospective, quasi-experimental study found that employees who received EAP support had greater reductions in absenteeism and presenteeism than those who did not receive EAP support (Richmond et al., 2017). Furthermore, in a naturalistic study of workers receiving EAP counseling, improvements in anxiety, depression, and work productivity were observed (Attridge & Dickens, 2022). Similarly, in a systematic review of 153 studies investigating mindfulness interventions delivered in the workplace, findings indicated improvements in workers' anxiety, distress, anger, and physical health (Lomas et al., 2017). Providing wellbeing support is also consistent with workers' preferences. In a 2023 report of 1500 US workers, 64% reported that if their organization offered mental health treatment, this would be helpful for their mental wellbeing (Mind Share Partners, 2023).

Despite the availability of support services and a range of potential benefits, uptake of these services has typically been poor. For example, in an Australian study of 44 organizations, most reported that uptake of their EAP was 6% or less (Compton & McManus, 2015). In a recent UK evaluation of a psychological support service (Hinsby et al., 2022), only 0.3% of 140,000 eligible health, social care, and voluntary, community and social enterprise (VCSE) sector staff referred themselves (Hinsby et al., 2022).

Several reasons for low uptake have now been identified in recent qualitative research studies (Allsopp et al., 2023; Keyworth et al., 2022). Together, these suggest there are a range of barriers to access including a lack of awareness, complex referral processes, and concerns regarding

confidentiality. While useful, these studies have mainly used qualitative approaches which generate themes to reflect participants' lived experiences. These can deepen understanding but do not provide a holistic list of actions organizations can take to improve service uptake. Such a list would be useful in helping organizations to (1) assess their strengths and weaknesses in supporting their staff to access their wellbeing support services, and (2) identify specific actions they can take to improve uptake.

The present research addressed this gap through two studies. Our overarching aim was to generate a list of barriers and facilitators to accessing wellbeing support services which organizations can use to improve uptake. In Study 1, we aimed to (1) understand barriers and facilitators to staff accessing staff support services and (2) generate a list of barriers and facilitators in a survey format. In Study 2, we aimed to evaluate whether the number of reported barriers and facilitators were associated with awareness of and access to available organizational wellbeing support services.

## **Study 1**

### ***Materials and methods***

#### ***Design and ethics***

A qualitative exploratory research design was used. A semi-structured interview schedule was developed, consisting of open-ended questions with additional probe questions. The interviews aimed to elicit information regarding participants' views of personal wellbeing in their workplace. The interview schedule covered (1) wellbeing culture in the workplace, (2) awareness and access of wellbeing support services, and (3) the barriers and facilitators to healthcare workers recognizing the need for and seeking help (Supplementary File 1). Wellbeing support services were defined as: "strategies or services offered to support staff and volunteer wellbeing in your organization." A range of services were available to participants at this time, but none had access to an EAP. Ethical approvals were awarded by the School of Psychology, University of Leeds Ethics Committee (Ref: PSYC-440; Date: 18-1-2022). Organizational approvals were provided by the West Yorkshire Health and Care Partnership Research and Development Office.

#### ***Recruitment and participants***

Participants were recruited from organizations within one English regional integrated care system. Healthcare in England has been organized by these systems since 2022. They each comprise local healthcare, social care, and VCSE organizations. Forty-two of these systems exist altogether to provide complete national coverage. Advertisements for the study were

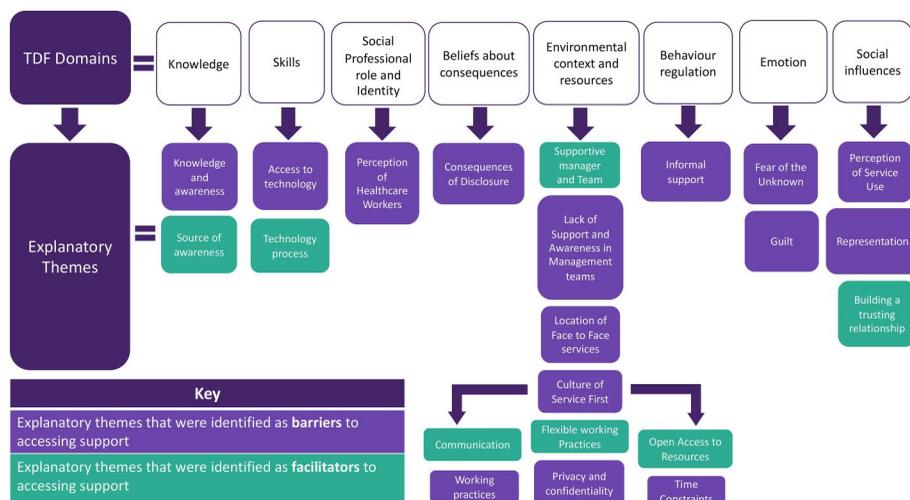
disseminated *via* email, posters, and social media announcements by these organizations. Employees were asked to contact the research team directly if they were interested in participating. The research team screened interested participants by first checking (1) that they worked or volunteered in one of the following sectors or organizations: healthcare, social care, or VCSE service organizations and (2) that this work or volunteering was based in the relevant integrated care system. We also asked if participants had ever used any organizational wellbeing support services, and used responses to recruit a balanced number of participants who had and had not accessed these services. Additional purposive sampling was utilized to recruit participants from a range of professional roles, genders, and ethnicities.

### **Procedure**

Interviews were conducted February 2022–May 2022. Participants were interviewed remotely by LP and EK and interviews were recorded and transcribed verbatim *via* Microsoft Teams. Participant demographics were collected during the interview which included gender, ethnicity, age group, occupational group, sector, and job role. Age group was measured in 10-year categories (under 20; 21–30; 31–40; 41–50; 51–60; 61–70; 71+). Participants received a £30 shopping voucher for participating as a gesture of thanks.

### **Analysis**

A directed content analysis (DCA) was used to code the transcribed data and group findings into categories which were based on the interview topics (Hsieh & Shannon, 2005). An unconstrained method of DCA was applied to allow for the development of categories inductively, which were mapped onto a categorization matrix as the framework for data analysis by LP (Elo & Kyngäs, 2008). Transcripts were read and identified barriers and facilitators were coded into categories. A subset of transcripts (10%) were coded separately by a second author (JJ), and discussion meetings held between these authors for triangulation. These categories were then collapsed into explanatory themes and mapped onto a matrix containing the Theoretical Domains Framework (TDF) (Atkins et al., 2017). The TDF is an integrative framework which identifies the 15 different domains which influence health professionals' behaviors, including social influences, environmental context and resources, social/professional role and identity, beliefs about capabilities, optimism, intentions, goals, beliefs about consequences, reinforcement, emotion, knowledge, cognitive and interpersonal skills, memory/attention and decision processes, behavioral regulation and physical skills (Atkins et al., 2017). A TDF domain was established as



**Figure 1.** The explanatory themes reflecting barriers and facilitators to accessing organizational wellbeing services listed under the domains of the theoretical domains Framework (TDF) to which they belong.

important and included when the domain was mentioned frequently and/or across the majority of the sample (Keyworth et al., 2019).

This process resulted in the generation of a list of barriers and facilitators within the TDF domains (Figure 1). To create the survey, we assessed how many separate underlying “factors” these captured. For example, if the barrier identified during the content analysis was “not having enough time to access support services,” the factor was “time.” Two items for each factor were then generated, one representing that factor as a “facilitator” and one representing it as a “barrier” (Table 1). For example, the facilitator in this case was, “*I have enough time to access support services*” and the barrier was “*I don’t have the time to access staff and volunteer support services.*” This approach ensured balance in the valence of the survey items.

## Results

Twenty participants took part in the interviews, including 12 who identified as women and eight who identified as men. Four participants were aged 21–30, nine were 31–40, five were 41–50 and two were 51–60. Six participants had clinical roles (one Physician Associate, one physiotherapist, one clinical pharmacist, and three nurses), and the remainder held administrative ( $n=1$ ), managerial ( $n=8$ ), coordinator ( $n=2$ ), or communications ( $n=3$ ) roles. Most participants worked for healthcare organizations ( $n=18$ ) with the remainder working for VCSE organizations ( $n=2$ ). Nine participants identified as White British, one as White Irish, two as White Other, five as Asian Pakistani, two as Asian Indian, and one as Asian

**Table 1.** List of facilitators and barriers toward staff accessing organizational staff wellbeing support services.

	Item	Domain/factor
1	I am knowledgeable about a range of support services and resources offered to healthcare staff and volunteers (F)	Knowledge/knowledge and awareness
2	I believe I could make time in my working hours to access support services for healthcare staff and volunteers (F)	Environmental context and resources/location of face to face services
3	I don't have the time to access staff and volunteer support services (B)	Environmental context and resources/time constraints
4	I would feel uncomfortable discussing my wellbeing concern with my manager (B)	Environmental context and resources/lack of support and awareness in management teams
5	I am unfamiliar with the support services and resources available to healthcare staff and volunteers (B)	Knowledge/knowledge and awareness
6	If I were to access support services I would feel pressured to do so outside of working hours (B)	Environmental context and resources/location of face to face services
7	People of my ethnicity are not represented in the staff who work in the support services, or featured in the resources they provide (B)	Social influences/representation
8	My colleagues have recommended support services to me (F)	Knowledge/source of awareness
9	I have supportive colleagues with whom I can have open and honest conversations (F)	Environmental context and resources/supportive manager and team
10	I would be comfortable with my employer or organization knowing about my wellbeing concern (F)	Beliefs about consequences/consequences of disclosure
11	People of my ethnicity will work within the staff support services, and be represented in the resources they provide (F)	Social influences/representation
12	my colleagues have never suggested I could access a support service (B)	Knowledge/source of awareness
13	The process of accessing support is too long or complicated (B)	Skills/access to technology
14	I am concerned about my employer or organization knowing about my wellbeing concern (B)	Beliefs about consequences/consequences of disclosure
15	My working practices are flexible and allow me to decide exactly how I use my time (F)	Environmental context and resources/flexible working practices
16	People of my gender will work within the staff support services, and be represented in the resources they provide (F)	Social influences/representation
17	I feel guilty about the idea of accessing support services (B)	Emotion/guilt
18	The process of accessing support is simple and easy (F)	Skills/technology process
19	I don't have supportive colleagues with whom I can have open and honest conversations (B)	Environmental context and resources/supportive manager and team
20	I have enough time to access support services (F)	Environmental context and resources/time constraints
21	People of my gender are not represented in the staff who work in the support services, or featured in the resources they provide (B)	Social influences/representation
22	I would prefer to use informal support, such as family or friends over accessing professional services/resources (B)	Behavior regulation/informal support
23	My manager is approachable and I feel comfortable discussing any wellbeing concerns with them (F)	Environmental context and resources/lack of support and awareness in management teams
24	I would feel stigmatized if I were to access support services or resources (B)	Social influences/perception of service use

*(continued)*

**Table 1.** Continued.

	Item	Domain/factor
25	I think that there is a hierarchy or priority to accessing support services (e.g., priority for clinical staff or those with significant wellbeing concerns) (B)	Social influences/perception of service use
26	I do not have flexibility in my working practices which restricts my ability to decide how to use my time (B)	Environmental context and resources/working practices
27	There is a lack of trust between staff/volunteers and the management in my organization (B)	Social influences/building a trusting relationship
28	I do not feel like there is any stigma attached to accessing support services or resources (F)	Social influences/perception of service use
29	I prefer the idea of using formal support services instead of speaking with family or friends about my problems (B)	Behavior regulation/informal support
30	I feel comfortable about the idea of accessing support services (F)	Emotion/guilt
31	My organization regularly communicates to its staff and volunteers about support services and resources (F)	Environmental context and resources/communication
32	There are good relationships between workers and managers in my organization, including a high level of trust (F)	Social influences/building a trusting relationship
33	I believe support services would treat all staff and volunteers who try to access them equally (F)	Social influences/perception of service use
34	I am not concerned about privacy and confidentiality when discussing my wellbeing at work (F)	Environmental context and resources/privacy and confidentiality
35	I am confident about the process of accessing support (F)	Emotion/fear of the unknown
36	My organization rarely shares information with employees about the support services which are available (B)	Environmental context and resources/communication
37	I am fearful of what will happen to my confidential information (e.g., if I disclose a mental health concern) (B)	Environmental context and resources/privacy and confidentiality
38	I am reluctant to access support as I am unfamiliar with the process (B)	Emotion/fear of the unknown
39	My organization puts priority on service delivery over my wellbeing (B)	Environmental context and resources/culture of service first
40	In my organization, healthcare workers are viewed as “superhuman” people who “just get on with it.” (B)	Social professional role and identity/perception of healthcare workers
41	My organization has a greater understanding of the importance of wellbeing since the outbreak of Covid-19 (F)	Covid-19 statement
42	My organization prioritizes the wellbeing of its staff (F)	Environmental context and resources/culture of service first
43	I have had positive experiences of accessing different types of staff and volunteer support services in the past (F)	Environmental context and resources/open access to resources
44	My organization recognizes that employees are human and need emotional support (F)	Social professional role and identity/perception of healthcare workers
45	I have had negative experiences of accessing different types of staff and volunteer support services in the past (B)	Environmental context and resources/open access to resources
46	My organization seems to have learned nothing about staff wellbeing during the Covid-19 pandemic (B)	Covid-19 statement

(B): barrier; (F): facilitator.

Other. Twelve participants had not accessed wellbeing support services through their workplace and eight participants had accessed these services.

Eight theoretical domains were identified which captured the barriers and facilitators to staff accessing wellbeing support services; (1) knowledge, (2) skills, (3) social professional role and identity, (4) beliefs about consequences, (5) environmental context and resources, (6) social influences, (7) emotion, and (8) behavior regulation (see [Figure 1](#)). Below, we list each domain followed by the barriers and facilitators which were identified within these domains ([Figure 1](#)).

### **Knowledge**

One barrier and one facilitator were described in relation to the domain “knowledge.”

**Knowledge and awareness (barrier).** Participants described a lack of knowledge or awareness of available support resources as being a barrier. They also described that if they did have an awareness of support being available it was superficial and limited, and they did not know how to initiate access.

*“You know, they advertise it. I would say, if I didn’t know about it, it would be hard for me to find it right?” (P4; Programme manager)*

**Source of awareness (facilitator).** Healthcare workers described the source of knowledge as being an important driver in compelling them to seek support. If the recommendation or information about a wellbeing service came from a trusted source, such as a colleague, especially if that colleague had accessed it previously, they felt more confident in seeking or accessing support themselves.

*“If somebody who has accessed the service, if there was again some kind of in in team meeting so if somebody would share their experience. To make it, yeah, again, to understand the process of stuff.” (P20; Administrator)*

### **Skills**

One barrier and one facilitator were described in relation to the domain “skills.”

**Access to technology (barrier).** Not being able to use or access a computer or device was considered a practical barrier to accessing wellbeing support. Furthermore, the complicated process of seeking support online was also discussed as a barrier; participants noted that they didn’t always know how to navigate the online resources or know where to look for them.

*“Then we have a bunch of staff, a section of staff that they don’t have access to IT. That’s a whole different world. The biggest barrier is finding it. On the Internet and I suppose for those who. For those who don’t have access to IT within the hospital.” (P4; Programme manager)*

**Technology process (facilitator).** Participants described the need for “simplification.” A key facilitator in enabling workers to access wellbeing support was to ensure that the process of seeking support was straightforward and involved simple online or telephone processes.

*“Just making it really simple and easy for them to go to and the way to do that is just taking things [resources] to them.” (P2; Communications officer)*

### **Social professional role and identity**

One barrier was identified in relation to the domain “social professional role and identity.”

**Perception of healthcare workers (barrier).** There was a perception held by some participants that healthcare workers are “super human” and that “they just get on with it.” This acted as a barrier to help-seeking, leading participants to keep working despite struggling with their mental health.

*“And that’s the message I think we need to get out and all the recognition that you know. So we’re not supermen and superwomen. You know we’re good, but we have needs as well and sometimes those needs are bigger than advertised because of the caring that we’re doing.” (P10; Health service manager)*

### **Beliefs about consequences**

One barrier was identified in relation to the domain “beliefs about consequences.”

**Consequences of disclosure (barrier).** Participants described that they feared that if they disclosed a wellbeing concern this may have an impact on their career. Participants felt that they may not have the same opportunities to progress if senior management were aware of wellbeing issues.

*“I’m not saying there would be any repercussions if you if you raised it with the manager, but I just feel like potentially... there’s kind of formal and informal conversations about mental health.” (P14; Communications officer)*

*“I only recognize a lot of people... they’re worried about the impact it will have on their on their own careers.” (P10; Health service manager)*

**Environmental context and resources**

Six barriers and four facilitators were identified in relation to the domain “environmental context and resources”; it was the most prominent domain identified during the analysis.

**Culture of “service comes first” (barrier).** Participants described an organizational culture of the “service comes first,” especially in clinical environments. Participants said that they felt they could not prioritize their own wellbeing needs and instead felt “pressure” to continue working.

*“I’m not really speaking for myself, but for my colleagues, the clinical frontline. They’re absolutely rammed and under this kind of like moral duty that they have and where they feel like they can’t take time off because it’s then affecting somebody else.” (P12; Health service manager)*

**Communication (facilitator).** Effective communication methods were described as a facilitator, in particular organization-wide communication. Participants said that they felt supported and better connected with their workplace if they were informed about organization-wide changes, event or news.

*“I think it is having more open, open communication about it face to face communication. Letting people know a bit more about the services there.” (P19; Physiotherapist)*

*“Daily emails have dropped down to three times a week, and now it’s a weekly update... It’s not necessarily just wellbeing, but there’s always a bit in there about look after yourself... and highlight resources as appropriate... it means a lot to me.” (P6; Strategic manager)*

**Time constraints (barrier).** Participants described feeling under notable time constraints and pressures to deliver a service. Lacking time meant they were unable to seek or access support when necessary as this cut into their already busy schedule. Participants also indicated that they did not feel able to access support in work time and that they were not willing to sacrifice their already limited personal time.

*“But some of them are really difficult to access. Some of them you have to access in your own time, and if and if you’re working shifts and you only have nights off, you know. 7:00 PM, while 7:00 AM and your counselling session or the mental health support is only available, you know 9 till 5.” (P2; Communications officer)*

**Supportive manager and team (facilitator).** Having a supportive manager and team enabled participants to discuss their wellbeing concerns and seek support in an understanding environment.

*“And also my manager ... He is ready to listen. Come to with any problems you’re going through, including mental health and wellbeing... he has reassured us that, you know there will be support provided. So it’s a very easy conversation with him.”(P15; Nurse)*

***Lack of support and awareness in management teams (barrier).*** Participants indicated that having an unsupportive manager and a manager that was unaware or uninformed about available resources was a significant barrier to accessing wellbeing support resources.

*“I would say that you know, personally to speak, speaking proactively and approaching something like this with my line manager isn’t something that would you know, I would feel that great about.” (P14; Communications officer)*

***Open access to resources (facilitator).*** Participants described that having access to both local and remote services was an important factor in accessing support. Having the choice to attend in-person services or to access remotely (*via* telephone or online) gave participants better flexibility and increased the likelihood that they would feel able to use the services.

*“Having a number. That’s readily accessible, like you know. So if they won’t be interested, at least there’s a number to say. Oh well, there’ll be one-to-one conversations available if they if I don’t want to attend the group. So I think a number is very important.” (P15; Nurse)*

***Location of face-to-face services (barrier).*** Participants described wanting to attend in-person services but this was not always feasible or possible due to their location. In-person services were not always located close to their workplace and a long travel distance was a significant barrier. Conversely, for some participants a face-to-face service that was hosted in their workplace was also undesirable as they wanted some mental distance from work.

*“A lot of the feedback was that people didn’t want ... to receive that care in their like work setting because that was where they were the carer. So they wanted like a break from that location. They wanted it to be somewhere different. They didn’t want to feel like they were at work.” (P1; Assistant engagement coordinator)*

***Working practices (barrier).*** Participants described some working practices as a barrier to seeking or accessing support resources. Having a lack of autonomy over their diary (a term commonly used by our participants to refer to their work schedule) or working practices, especially if they were based in a clinical environment, seriously impacted their availability to access resources.

*“I think people who work clinically, so like you’re a doctor or your physiotherapist or whatever, they are not going to have as much control over their diary. To book time to go and get mental health support.” (P6; Strategic manager)*

***Flexible working practices (facilitator).*** Participants described that having autonomy over their diary and their working practices allowed for flexibility in their availability. In having control over their diaries, participants felt that they were able to use their time more effectively, which included scheduling in time to improve their wellbeing.

*“You can access private support in work time like we can do flexible working to make that happen.” (P12; Health service manager)*

*“Myself I had it quite easy, but then you know a lot of it becomes about availability to access these services, and myself I have quite lot of flexibility in my schedule to actually achieve that.” (P3; Project manager)*

***Privacy and confidentiality (barrier).*** Participants described confidentiality as an important concern when seeking and accessing support services. A key aspect of their concern regarding confidentiality was a written record of their wellbeing issue existing and the potential for colleagues to discover this. Having total anonymity when using services was also desirable; a service based in their organization may pose the risk of being supported by a colleague.

*“We want to make sure that your private life is kept private. And if somebody sees me go into those pop up booths and then, Oh my, oh, she might be going through something ’cause obviously that’s like psychologists are there and also basically it’s mental health.” (P15; Nurse)*

*“You want that kind of level of privacy and the things that they want to be discussing. You’d probably want to know an outside organisation is doing that, you know? Because you want that level of power over privacy as well.” (P3; Project manager)*

### ***Social influences***

A total of two barriers and one facilitator were identified in relation to the domain “social influences.”

***Negative perceptions of service use (barrier).*** Many participants felt key wellbeing support services, such as counseling were reserved for clinical staff, and similarly that local mental health services were reserved for patients. Conversely clinical staff expressed that they felt that if they were perceived as needing mental health support this would negatively impact others’ perceptions of their competency as a clinician. Participants discussed feeling as though there is a hierarchy of need, and they should not access services unless they have pronounced mental health issues.

*“Particularly again for clinical people, there’s a lot of judgment attached to your clinical competencies and if you are, you know if you then disclose that y’all have things, some real mental health problems. What reflection does that have?” (P7; Health service manager)*

*“I think it’s throughout the NHS social care, because services are so stretched, you have to prioritize those most in need... this idea that you’re not unwell enough to access those services.” (P1; Assistant engagement coordinator)*

**Representation (barrier).** Participants described a lack of representation of your ethnicity, gender, or cultural group within the support resources deterred them from accessing support. The need to be able to relate to someone from a similar background was described as crucial; this point was particularly important to participants from minority backgrounds.

*“An increase in representation so that more people, for example, if you’re a man, you are in your in your preferred speak to another man or your woman and you look for speak to other woman or you, you know you’ve come from a certain background and you prefer to speak to someone from a certain background.” (P14; Communications officer)*

**Building a trusting relationship (facilitator).** Participants described that “trust” in both their management team and the organization was imperative when deciding to use workplace-based services. A trusting relationship with their therapist or service/resource provider was also an important enabler.

*“It quite depends on the relationship you have with your manager. So I would actually say it [location named] is actually having that open and honest relationship with him, so I could actually just say it to him. Yeah, things aren’t too good.” (P17; Governance manager)*

*“I do think it will involve time and little trust too because otherwise they wouldn’t be going to services like this [counselling] really.” (P16; Nurse)*

### **Emotion**

Participants identified two barriers relating to the domain of “emotion.”

**Fear of the unknown (barrier).** Participants discussed their fear of the unknown when considering accessing support resources. In particular, they feared not knowing what was involved in their chosen support method or not knowing the process of accessing support.

*“People don’t know what it entails, so they just kind of go by hearsay of what we think it might be, because nobody knows what it actually is. There’s a fear of the unknown.” (P6; Strategic manager)*

*“I don’t wanna keep saying fear again and again but a little fear of the unknown. You know, it’s like more unknown and so I suppose it’s kind of maybe that’s a barrier as well.” (P14; Communications officer)*

**Guilt (barrier).** Participants described their feeling of guilt when discussing the access of support resources. A key concern was that they would be a burden on an already stretched service. Having knowledge of the impact that mental health has on the healthcare sector influenced participants’ decisions to access resources.

*“Yeah, yeah, I see a bit more guilt. I think for me to go out and go on and I can go to services, it takes time out of my day. So it’s great that I can take time out of my day, but actually I’m not, I’m there to support everyone else.” (P19; Physiotherapist)*

### **Behavioral regulation**

One barrier relating to the domain “Behavioral regulation” was identified.

**Informal support (barrier).** Participants described that the use of informal support resources negated their need for formal or professional services. A variety of preferences for informal resources were discussed including the preference for these types of resources not having a “written record” and having an existing trusting or familiar relationship which is easily accessible.

*“So I think for me it’s friends or family. Yeah, if I ever had to discuss anything I will discuss it with friends and family. Because it’s more familiar.” (P19; Physiotherapist)*

### **Survey creation**

The 22 identified barriers and facilitators were scanned to assess how many separate underlying “factors” these captured. We determined that 18 barriers and facilitators only appeared once in the dataset (i.e., the factor they captured only appeared as either a barrier OR a facilitator). Two factors were reflected as both a barrier and facilitator within the dataset (i.e., the single underlying factor they captured was represented twice; once in its form as a barrier and once in its form as a facilitator). These two factors were (1) technology [appearing as both “access to technology (barrier)” and “technology process (facilitator)"]; and (2) working practices [appearing as both “working practices (barrier)” and

“flexible working practices (facilitator)”). As such, the 22 identified barriers and facilitators reflected a total of 20 factors. One factor [“representation (barrier)”) was divided into two to capture views of representation about both gender and ethnicity separately, leading to the generation of 21 factors altogether. Finally, a further two items were then added to capture experiences relating to the Covid-19 pandemic. This resulted in a total of 23 factors. Each factor was reflected in a “facilitator” and a “barrier” item on the questionnaire, leading to a final questionnaire containing 46 items (Table 1).

## **Study 2**

### ***Materials and methods***

#### ***Design and ethics***

A cross-sectional quantitative questionnaire was hosted online on the survey platform Qualtrics. Ethical and organizational approvals were the same as Study 1.

#### ***Recruitment and participants***

A similar participant recruitment strategy was used as that described in Study 1. However, in Study 2, rather than contacting the research team, participants were directed to the online survey where they read the Participant Information Sheet, provided informed consent, and continued to the survey items. Participants received a £5 shopping voucher for participating.

#### ***Procedure and survey items***

The survey gathered information regarding participant demographics, service use, service awareness, and facilitators and barriers. Demographics recorded included: age (recorded in categories: under 20; 21–30; 31–40; 41–50; 51–60; 61–70; 71+); gender; ethnicity; whether participants had a long-term illness or disability; caring responsibilities (for children/young people; other relatives or friends; or both); and work sector (healthcare; VCSE; social care; other). Participants were asked to state which services they were aware of from a list of nine wellbeing support services which were being provided by their integrated care system. They were then asked to state which services they had accessed from this same list of nine available services. Finally, they were asked to mark whether they agreed with the 46 statements reflecting 23 barriers and 23 facilitators to accessing services, using a 3-point scale (“agree,” “disagree,” “neither agree nor disagree”).

## **Analysis**

Quantitative responses were analyzed using descriptive statistics. For the purposes of inferential analyses, demographic variables were collapsed to form binary variables. As the number of barriers and facilitators did not conform to the normal distribution, correlation and regression analyses were bootstrapped (to 5000 samples with 95% confidence intervals using the percentile method), to enhance the robustness of the conclusions (Cheung & Lau, 2007; Wright et al., 2011). Bootstrapping does not require variables to conform to the normal distribution but instead resamples from the observed data to create a sampling distribution. Service awareness and service access were investigated both as continuous variables (indicating the number of services participants were aware of/had used) and as binary variables (indicating any vs. no awareness/access). First, correlations were conducted to assess for the presence of relationships between demographic variables, facilitators, barriers, and service awareness/use. The following variables were included in the correlations: Demographic variables [gender (man-woman), caring responsibility (yes-no), ethnicity (white-non-white), disability (yes-no)], facilitators (total number), barriers (total number), services accessed (total number), and awareness of services (total number).

To further understand the associations between barriers and facilitators with both awareness of, and access to, services, multiple linear regression analyses (where the outcome was total number of services) and logistic regression analyses (where the outcome was any service awareness/access vs. none) were performed. Barriers (total number) and facilitators (total number) were entered into these regressions as the independent variables. When interpreting effect sizes, we considered  $r=0.10$ ,  $r=0.30$ , and  $r=0.50$  as indicating small, moderate, and large effects, respectively, and  $r^2=0.01$ ,  $r^2=0.09$ , and  $r^2=0.25$  as indicating small, moderate, and large effects, respectively (Cohen, 1992; Ellis, 2010).

## **Results**

### **Participant characteristics**

One hundred and sixty-two responses were received. Thirty-six (22%) participants identified as men, 124 (77%) identified as women, 1 (0.6%) identified as non-binary and 1 (0.6%) preferred not to say. Participants were most commonly aged 41–50 ( $n=48$ ; 30%) or 51–60 ( $n=48$ ; 30%) followed by 31–40 ( $n=35$ , 22%), 21–30 ( $n=17$ , 10%), 61–70 ( $n=10$ ; 6%), 71 or older ( $n=3$ ; 2%) and 20 or under ( $n=1$ ; 0.06%). The majority of participants (137; 85%) were White British. Other participants were Indian (Asian or British Asian) (5; 3%); African (Black or Black British) (3; 1.9%); White and Black Caribbean (Mixed Heritage) (3;1.9%); Caribbean (Black or Black

British) (1; 0.6%); Pakistani (Asian or British Asian) (2; 1.2%); from another Asian or British Asian background (1; 0.6%); White and Asian (Mixed Heritage) (1; 0.6%); or from another ethnic group not listed (2; 1.2%). Thirty-eight (24%) participants reported having a long-term illness or disability, 123 (76%) reported no disability and 1 (0.6%) preferred not to say. Most participants (87; 54%) reported having no caring responsibilities. The remainder reported caring for children/young people (46; 28%), other relatives or friends (18; 11%) or both (10; 6%). Most participants worked in the healthcare sector (127; 78%), followed by social care (13; 8%) and the VCSE sector (11; 7%). Ten participants (6%) reported they worked in “another” sector and data was missing for 1 (0.6%) participant.

### ***Facilitators, barriers, and service awareness and use***

Participants reported between 0 and 22 facilitators, with a mean of 13.0, and between 0 and 18 barriers, with a mean of 4.9. Participants reported being aware of between 0 and 9 support services, with a mean of 2.07 and reported having accessed between 0 and 4 support services, with a mean of 0.68. Twenty-five (15.4%) participants reported not being aware of any of the support services, and 137 (84.6%) reported being aware of one or more. Eighty-eight participants (54.3%) said they had not accessed any of the available support services, and 74 (45.7%) said they had accessed one or more.

### ***Correlations***

A significant correlation with a large effect size was found between facilitators (total) and barriers (total) [ $r(154) = -0.562, p < 0.001$ ], showing that as facilitators increased, barriers decreased. A significant correlation with a moderate effect size was also found between the number of services participants were aware of and the number of services participants had accessed [ $r(154) = 0.346, p < 0.001$ ].

The total number of facilitators was positively correlated with a moderate effect size with awareness of the number of services [ $r(154) = 0.263, p < 0.001$ ] but not with number of services accessed [ $r(154) = 0.147, p = 0.068$ ]. The total number of barriers was negatively correlated with a moderate effect size with total number of services participants were aware of [ $r(154) = -0.251, p = 0.002$ ] but was not significantly correlated with number of services accessed [ $r(154) = -0.008, p = 0.919$ ]. Disability, ethnicity, caring responsibilities, and gender were not significantly related to access total [ $r(153) = -0.071, p = 0.383$ ;  $r(153) = -0.011, p = 0.891$ ;  $r(153) = -0.076, p = 0.349$ ; and  $r(153) = -0.089, p = 0.270$ , respectively]. Disability, ethnicity, and gender were not significantly related to awareness

**Table 2.** Regression analyses of associations between facilitators, barriers and awareness and access to staff wellbeing support services.

Outcome variable	Step	Variable entered	$\beta$	SE $\beta$	Total $R^2$	$\Delta R^2$
Awareness of at least one service	1	Total facilitators	0.152	0.005*	0.023	0.023
	2	Total facilitators	0.070	0.006	0.037	0.014
Awareness of number of services	1	Total barriers	-0.145	0.008	0.069	0.069***
		Total facilitators	0.262***	0.024		
	2	Total facilitators	0.176*	0.029	0.085	0.016
Access to at least one service	1	Total barriers	-0.153	0.036	0.035	0.035*
		Total facilitators	0.188*	0.007		
	2	Total facilitators	0.188*	0.007	0.039	0.004
Access to number of services	1	Total barriers	0.230	0.009	0.021	0.021
		Total facilitators	0.146*	0.013		
	2	Total facilitators	0.206*	0.016	0.029	0.008
		Total barriers	0.107	0.020		

\* $p \leq 0.05$ ; \*\*\* $p \leq 0.001$ .

[ $r(153) = 0.141, p = 0.082$ ;  $r(153) = -0.087, p = 0.283$ ;  $r(153) = 0.114, p = 0.159$ , respectively]. Caring responsibilities were associated with awareness with small effective size [ $r(153) = 0.184, p = 0.022$ ], such that people without caring responsibilities had greater awareness.

**Regressions**

**Awareness of services.** The first pair of regressions investigated whether barriers (total) and facilitators (total), were associated with (1) awareness of at least one service and (2) awareness of the total number of services.

The first regression assessed whether the number of facilitators and barriers reported was associated with awareness of at least one service. The overall regression model was marginally significant [ $F(2, 154) = 2.983, p = 0.054$ ] with a small effect size ( $r^2 = 0.037$ ) but neither facilitators ( $p = 0.525$ ) or barriers ( $p = 0.239$ ) were significant. For full regression results, see Table 2.

The second regression assessed whether the number of facilitators and barriers reported was associated with awareness of the total number of services. The overall regression model was significant [ $F(2, 154) = 7.120, p = 0.001$ ] with a small-to-moderate effect size ( $r^2 = 0.085$ ) and facilitators was also significant ( $p = 0.034$ ) with a small effect size ( $r^2 = 0.069$ ). Barriers was not significant, although the significance level did indicate the presence of a trend ( $p = 0.064$ ).

**Service access.** The second pair of regressions investigated whether barriers (total) and facilitators (total), was associated with (1) access to at least one service and (2) access to the total number of services (Table 2).

The first regression assessed whether the number of facilitators and barriers reported was associated with access to at least one service. The overall regression model was significant [ $F(2, 154) = 3.136, p = 0.046$ ] with a small effect size ( $r^2 = 0.039$ ), and facilitators were also significant ( $p = 0.019$ ) with a small effect size ( $r^2 = 0.035$ ) while barriers were not ( $p = 0.459$ ).

The second regression assessed whether the number of facilitators and barriers reported was associated with the total number of services accessed. The overall regression model was not significant [ $F(2, 154) = 2.313, p = 0.102$ ]. Facilitators were significantly independently associated with the number of services accessed ( $p = 0.034$ ) with a small effect size ( $r^2 = 0.021$ ) but barriers were not ( $p = 0.411$ ).

## Discussion

Study 1 identified a list of facilitators and barriers which participants described influenced the likelihood of accessing wellbeing support services. Study 2 suggested that reporting a higher number of facilitators was associated with a greater likelihood of having accessed available organizational wellbeing support services. There was also some evidence to suggest that a greater number of facilitators was associated with a greater awareness of available services. Evidence regarding the association between barriers and service awareness and access was weaker. Greater awareness of services was associated with greater service uptake. Effect sizes of significant associations varied from moderate-to-large for correlations and from small-to-moderate in the regressions.

These findings support results from previous qualitative studies which have explored factors influencing uptake using approaches which generate broader themes, such as thematic and framework analysis (Allsopp et al., 2023; Keyworth et al., 2022). In a study of 25 healthcare, social care, and VCSE staff, Keyworth et al. (2022) reported that organizational environments, fears around confidentiality, and clarity of communication of available resources were all important factors influencing the likelihood of staff accessing services. Similarly, in a qualitative study investigating the implementation of a staff wellbeing hub, Allsopp et al. (2023) identified managerial support, confidentiality concerns and knowledge of what services were available were important factors influencing service uptake. These themes are reflected in the list of facilitators generated in the current study. The current study extends these previous studies by identifying a wider range of facilitators and barriers based on the TDF. These recognize the importance of ease of access and feelings of guilt about access and identify the most prominent TDF domain as being environmental context and resources. The present study also advances these previous studies by

translating more complex themes into a list of concrete items. Organizations can use these items as a tool to (1) self-assess their culture and whether their staff are likely to access services which are offered, and (2) identify areas where they can intervene to increase rates of staff uptake.

These findings are timely and relevant, as staff stress levels and absence rates are currently at record-high levels (Office for National Statistics, 2023; Statistics Canada, 2023; U.S. Bureau of Labor Statistics, 2022). While many organizations internationally have increased their staff wellbeing services for employees (The Chartered Institute of Personnel and Development, 2022) this alone is unlikely to improve staff wellbeing. Indeed, while employees express a desire for their organizations to provide such services (Mind Share Partners, 2023), offering this in the absence of a supportive organizational culture is viewed negatively (Australian College of Applied Professions, 2021). In a 2021 representative survey of 1000 Australian workers, 1 in 2 felt their workplace had introduced mental health and wellbeing services to “tick boxes,” while actually showing little if any genuine concerns about worker wellbeing (Australian College of Applied Professions, 2021). The present study provides organizations with a concrete list of items which identify actions they can take to improve the likelihood their staff will use the services they provide. In doing this, organizations may improve service utilization, increase the likelihood that their staff will gain mental health benefits from their investments in these services, and also improve organizational wellbeing climate.

### ***Strengths and limitations***

Study 1 benefited from a diverse sample, including staff from a range of sectors and roles and from a range of ethnicities. A further strength was its inclusion of workers who had both accessed services and who had not accessed services. This approach enabled a range of views and experiences regarding facilitators and barriers to be accessed. It was limited by a reliance on a single modality of data collection, which was semi-structured interviews. It is possible that also using focus-groups may have further enriched the available data. It must also be acknowledged that some professional groups were only reflected by a single participant ( $n = 1$ ), so it cannot be assumed that their data is representative of their professional group.

Study 2 also benefited from a diverse sample which included participants from a range of sectors, ages, genders, and ethnicities. It had several limitations. First, it was limited by its reliance on a cross-sectional methodology which prevent any conclusions regarding causality to be drawn. Second, it was limited by a grouping of all services together for analysis. It is possible

that there are different barriers and facilitators for different types of support services, but findings from the present study do not enable this level of granularity to be identified. This is an important avenue for future research. Third, it should be noted that most effect sizes in the regressions were small. This may partly be attributed to “noise” created by the broad focus on a range of support services rather than a tighter focus on only one form of support service. Accordingly, our findings should be approached tentatively. Fourth, considering these foregoing limitations, the possibility of endogeneity, where an outcome variable is associated with error in the independent variable, must be considered.

As such, we recommend the Study 2 findings be considered preliminary, and a springboard for further work on this important topic. Fifth, we did not ask participants for their length of time working in their organization, which may have impacted their responses. Sixth, our sample size was small, and only a small proportion of participants accessed services which reduced our statistical power; future studies should use larger sample sizes to reduce the risk of Type 2 error.

In both studies, paid employees and volunteers were eligible to participate. However, as we did not explicitly ask participants to report if they were paid for their work, we cannot confidently ascertain the proportion of volunteers.

### ***Implications***

According to our research, specific facilitators organizations can put in place include:

- Encouraging managers to offer their staff flexibility to take up services, either by allowing them to access services during working hours or by allowing them to work flexible hours around their service access.
- Improving access routes to support services by making these simple and efficient, for example by offering a phone number rather than an online form.
- Circulating regular and clear information to all staff about the services which are on offer and how these can be accessed. All advertising materials should be representative of their staff groups, in terms of gender and ethnicity.

We consider our study preliminary and a springboard for further work investigating and addressing the uptake of wellbeing support services. Our findings suggest that framing factors in terms of facilitators rather than barriers is more likely to identify patterns of association. However, there are several questions which need to be addressed. First, there is a need to

understand which specific facilitators are the best predictors of support service uptake, so that efforts can be focused on these. Second, there is a need to understand if relevant facilitators vary by service. As EAPs have a growing evidence base of effectiveness, studies might usefully focus specifically on this form of service. Third, there is a need to understand whether facilitators can prospectively predict future uptake of services.

## Conclusions

There is a pressing need to improve employee wellbeing. Many organizations have responded positively to this by providing an increased number of staff wellbeing support services. However, uptake has been lower than expected. The present study provides a list of 23 facilitators who are associated with greater service uptake. Organizations can use this list to (1) assess their strengths and weaknesses in supporting staff to use services and (2) identify organizational actions they can take to increase service uptake by employees. Our findings should be considered in light of a range of limitations. They should be viewed as a preliminary study on this topic and a springboard for future research.

## Ethical approval

Ethical approvals were awarded by the School of Psychology, University of Leeds Ethics Committee (Ref: PSYC-440; Date: 18-1-2022). Organizational approvals were provided by the West Yorkshire Health and Care Partnership Research and Development Office.

## Author contributions

The study was designed by JJ, CK, and LP. LP and EK collected the data for Study 1 and LP collected the data for Study 2. LP, JJ, EK, and CK contributed to the analysis for Study 1. AA, KV, and JJ contributed to the analysis for Study 2. The manuscript was drafted by JJ and LP. All authors reviewed the manuscript and provided feedback.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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## Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## References

- Al-Ghunaim, T. A., Johnson, J., Biyani, C. S., & O'Connor, D. (2021). Psychological and occupational impact of the COVID-19 pandemic on UK surgeons: A qualitative investigation. *BMJ Open*, 11(4), e045699. doi:10.1136/bmjopen-2020-045699
- Allsopp, K., Varese, F., French, P., White, H., Chung, P., Hassan, A. A., Wright, S.-A., Young, E., Barrett, A., Bhutani, G., McGuirk, K., Huntley, F., Sarsam, M., Ten Cate, H., Watson, R., Willbourn, J., & Hind, D. (2023). Implementing psychological support for health and social care staff affected by the COVID-19 pandemic: A qualitative exploration of staff well-being hubs ('Resilience Hubs') using normalisation process theory. *BMJ Open*, 13(8), e071826. doi:10.1136/bmjopen-2023-071826
- Atkins, L., Francis, J., Islam, R., O'Connor, D., Patey, A., Ivers, N., Foy, R., Duncan, E. M., Colquhoun, H., Grimshaw, J. M., Lawton, R., & Michie, S. (2017). A guide to using the theoretical domains framework of behaviour change to investigate implementation problems. *Implementation Science: IS*, 12(1), 77. doi:10.1186/s13012-017-0605-9
- Attridge, M., & Dickens, S. P. (2022). Health and work outcomes of brief counseling from an EAP in Vermont: Follow-up survey results, client satisfaction, and estimated cost savings. *Sage Open*, 12(1), 21582440221087278. doi:10.1177/21582440221087278
- Australian College of Applied Professions (2021). *Australian College of Applied Professions – Nationally representative survey of Australian workers*. Retrieved October 27, 2021, from <https://www.acap.edu.au/wp-content/uploads/2021/12/Executive-Summary-ACAP-results-002-1.pdf>
- Cheung, G. W., & Lau, R. S. (2007). Testing mediation and suppression effects of latent variables: Bootstrapping with structural equation models. *Organizational Research Methods*, 11(2), 296–325. doi:10.1177/1094428107300343
- Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112(1), 155–159. doi:10.1037/0033-2909.112.1.155
- Compton, R.-L., & McManus, J. G. (2015). Employee assistance programs in Australia: Evaluating success. *Journal of Workplace Behavioral Health*, 30(1–2), 32–45. doi:10.1080/15555240.2015.998971
- Demerouti, E., & Bakker, A. B. (2008). The Oldenburg Burnout Inventory: A good alternative to measure burnout and engagement. In J. R. B. Halbesleben (Ed.), *Handbook of stress and burnout in health care*. Nova Science.
- Ellis, P. D. (2010). *The essential guide to effect sizes: Statistical power, meta-analysis, and the interpretation of research results*. Cambridge University Press.
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115. doi:10.1111/j.1365-2648.2007.04569.x

- Feng, J., Li, L., Wang, C., Ke, P., Jiang, H., Yin, X., & Lu, Z. (2022). The prevalence of turnover intention and influencing factors among emergency physicians: A national observation. *Journal of Global Health, 12*, 04005. doi:10.7189/jogh.12.04005
- GALLUP (2023). *State of the global workplace: 2023 report*. Retrieved October 26, 2023, from <https://www.gallup.com/workplace/349484/state-of-the-global-workplace.aspx#ite-506924>
- General Medical Council (2023). *National training survey: 2023 results*. Retrieved October 26, 2023, from [https://www.gmc-uk.org/-/media/documents/national-training-survey-2023-initial-findings-report\\_pdf-101939815.pdf](https://www.gmc-uk.org/-/media/documents/national-training-survey-2023-initial-findings-report_pdf-101939815.pdf)
- Hinsby, K., Wainright, N., Moores, L., Bates, J., Johnson, J., Keyworth, C., Pointon, L. & Alzahrani, A. (2022). *Evaluation of the West Yorkshire Staff Mental Health and Wellbeing Hub*. UK: University of Leeds. <https://doi.org/10.48785/100/98>
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. doi:10.1177/1049732305276687
- Keyworth, C., Alzahrani, A., Pointon, L., Hinsby, K., Wainwright, N., Moores, L., Bates, J., & Johnson, J. (2022). Barriers and enablers to accessing support services offered by staff wellbeing hubs: A qualitative study. *Frontiers in Psychology, 13*, 1008913. doi:10.3389/fpsyg.2022.1008913
- Keyworth, C., Epton, T., Goldthorpe, J., Calam, R., & Armitage, C. J. (2019). ‘It’s difficult, I think it’s complicated’: Health care professionals’ barriers and enablers to providing opportunistic behaviour change interventions during routine medical consultations. *British Journal of Health Psychology, 24*(3), 571–592. doi:10.1111/bjhp.12368
- Lomas, T., Medina, J. C., Ivztan, I., Rupperecht, S., Hart, R., & Eiroa-Orosa, F. J. (2017). The impact of mindfulness on well-being and performance in the workplace: An inclusive systematic review of the empirical literature. *European Journal of Work and Organizational Psychology, 26*(4), 492–513. doi:10.1080/1359432X.2017.1308924
- Martin, C. A., Medisauskaite, A., Gogoi, M., Teece, L., Nazareth, J., Pan, D., Carr, S., Khunti, K., Nellums, L. B., Woolf, K., & Pareek, M. (2023). Discrimination, feeling undervalued, and health-care workforce attrition: An analysis from the UK-REACH study. *Lancet, 402*(10405), 845–848. doi:10.1016/S0140-6736(23)01365-X
- Milot, M. (2019). The impact of a Canadian external Employee Assistance Program on mental health and workplace functioning: Findings from a prospective quasi-experimental study. *Journal of Workplace Behavioral Health, 34*(3), 167–191. doi:10.1080/15555240.2019.1609978
- Mind Share Partners (2021). *2021 Mental health at work report*. Retrieved October 26, 2021, from <https://www.mindsharepartners.org/mentalhealthatworkreport-2021>
- Mind Share Partners (2023). *2023 Mental health at work report*. Retrieved October 26, 2023, from <https://www.mindsharepartners.org/mentalhealthatworkreport-2023>
- Office for National Statistics (2023). *Sickness absence in the UK labour market: 2022*. Retrieved October 25, 2023, from <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2022>
- Panagiotti, M., Panagopoulou, E., Bower, P., Lewith, G., Kontopantelis, E., Chew-Graham, C., Dawson, S., van Marwijk, H., Geraghty, K., & Esmail, A. (2017). Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. *JAMA Internal Medicine, 177*(2), 195–205. doi:10.1001/jamainternmed.2016.7674
- Richmond, M. K., Pampel, F. C., Wood, R. C., & Nunes, A. P. (2017). The impact of employee assistance services on workplace outcomes: Results of a prospective, quasi-experimental study. *Journal of Occupational Health Psychology, 22*(2), 170–179. doi:10.1037/ocp0000018
- Shanafelt, T. D., West, C. P., Dyrbye, L. N., Trockel, M., Tutty, M., Wang, H., Carlasare, L. E., & Sinsky, C. (2022). Changes in burnout and satisfaction with work-life integration

- in physicians during the first 2 years of the COVID-19 pandemic. *Mayo Clinic Proceedings*, 97(12), 2248–2258. doi:10.1016/j.mayocp.2022.09.002
- Statistics Canada (2023). *Work-related stress most often caused by heavy workloads and work-life balance*. Retrieved October 25, 2023, from <https://www150.statcan.gc.ca/n1/daily-quotidien/230619/dq230619c-eng.htm>
- The Chartered Institute of Personnel and Development (2022). *Health and wellbeing at work survey report*. Retrieved March 24, 2022, from <https://www.cipd.co.uk/knowledge/culture/well-being/health-well-being-work>
- U.S. Bureau of Labor Statistics (2022). *TED: The Economics Daily*. Retrieved October 26, 2022, from <https://www.bls.gov/opub/ted/2022/7-8-million-workers-had-an-illness-related-work-absence-in-january-2022.htm>
- Vogt, K. S., Simms-Ellis, R., Grange, A., Griffiths, M. E., Coleman, R., Harrison, R., Shearman, N., Horsfield, C., Budworth, L., Marran, J., & Johnson, J. (2023). Critical care nursing workforce in crisis: A discussion paper examining contributing factors, the impact of the COVID-19 pandemic and potential solutions. *Journal of Clinical Nursing*, 32(19–20), 7125–7134. doi:10.1111/jocn.16642
- Wright, D. B., London, K., & Field, A. P. (2011). Using bootstrap estimation and the plug-in principle for clinical psychology data. *Journal of Experimental Psychopathology*, 2(2), 252–270. doi:10.5127/jep.013611