Life on a waiting list: How do people experience and cope with delayed access to a community mental health center?

In our interview study, people found the waiting time for treatment at a community specialist mental health center to be hard and frustrating, yet they also developed valuable coping strategies, write Eva Biringer and colleagues.

BY: Eva Biringer, Bengt Sundfør, Larry Davidson, Miriam Hartveit and Marit Borg

Accessibility and availability of health services are typically described as core elements of quality in health care (World Health Organization, 2000), and waiting time is a central element with respect to access to services (Gulliford, Figueroa-Munoz, Morgan, Hughes, Gibson, Beech, & Hudson, 2002). In general, service users, health care professionals, policy makers, and health care managers regard waiting lists as negative, and great effort is taken to reduce them within the health care system (Cayirli & Veral, 2003; Kreindler, 2010). Despite these efforts, waiting is more the rule than the exception in many Western public health care systems. In Norway, for instance, mean waiting time for access to adult mental health specialist care is 55 days (Norwegian Directorate of Health, 2014). In accordance with the legislation and guidelines of the Norwegian Directorate of Health, persons referred for moderate or severe conditions have a right to prioritized specialist health care within 2 to 12 weeks (within 18 weeks for most addictive disorders and less than 65 work days for persons < 23 years).

In Norway, 75 community mental health centers (CMHCs) were established from 1998 to 2008 during a major national reform aiming at a more decentralized organization of specialist mental health care (Norwegian Ministry of Social and Health Affairs, 1998). These CMHCs provide public specialized mental health care to most service users in need of evaluation or treatment by specialists. In addition to general psychiatric in-and out-patients units such centers offer psychoeducative courses and team interventions targeted on early intervention or rehabilitation. Service users are most often referred to the centers by their general practitioner, and specialists at the CMHC prioritize incoming referrals at a weekly basis. Referred persons are routinely informed about whether they are granted the right to prioritized health care and the maximum expected waiting time in a letter sent them instantly after the specialist has given priority to their referral.

Previous research on physical health services has shown that waiting time is associated with lower quality of life, poorer social and physical functioning, and poorer health status (Oudhoff, Timmermans, Bijnen, & Van Der Wal, 2004; Oudhoff, Timmermans, Knol, Bijnen, & Van der Wal, 2007; Sampalis, Boukas, Liberman,
A few studies have investigated the predictive value of length of waiting time for clinical and general health outcomes, and some of these (Lynch, Campbell, Clarck, Dymbar, Goldstein, Peng, Stinson, & Tupper, 2008; Sampalis et al., 2001), but not all (Best, Noble, Ridge, Gossop, Farrell, & Strang, 2002; Nilsdotter & Lohmander, 2002; Oudhoff et al., 2007) have found that longer waiting time predicts poorer health outcome.

In mental health care, previous studies have revealed high no-show rates after periods of waiting prior to treatment entry (Reitzel, Stellrecht et al., 2006; Gallucci, Swartz, & Hackerman, 2005; Glyngdal, Sørensen, & Kistrup, 2002; May, 1991) and reduction of waiting time leading to lower no-show rates and number of acute crisis admissions to psychiatric hospitals (Williams, Latta, & Conversano, 2008). However, although waiting is a frequent and important barrier to treatment in mental health and substance use care (Redko, Rapp, & Carlson, 2006; Sturm & Sherbourne, 2001), little research has been undertaken to investigate the impact of waiting on quality of life or social and physical functioning in people with mental health problems. Some research has been carried out within the addictive services. In an ethnographic study using interviews with persons who had substance abuse and/or dependence disorders referred to substance abuse services, Redko et al. (2006) showed that waiting was experienced as very frustrating. For instance, one of the participants described waiting as being in a «catch 22» situation as she was only sitting at home, not being able to apply for a job or doing other meaningful activities (Redko et al., 2006). Participants in their study used several strategies to cope with waiting. Some of the participants attended Alcoholic Anonymous (AA) or Narcotic Anonymous (NA) meetings, some went on an intentional binge or overdose in order to get fast tracked to treatment, while others maintained abstinence in the period prior to the start of treatment.

A recent narrative review that included 20 qualitative studies by Lucock, Gillard, Adams, Simons, White, and Edwards (2011) reported that people with severe mental problems in general used a wide range of strategies in their everyday struggle to cope with their symptoms; work or education, creative activity, physical exercise, healthy living, structured routines, and spirituality were all perceived as helpful (Lucock et al., 2011). Support from others and engagement with community activities, living and working in the community, developing a sense of self, coping, optimism and hope, and medication were highlighted as important self-care strategies.

There is reason to believe that experiences and coping strategies developed early in the illness course predict later outcomes (Bird, Premkumar, Kendall, Whittington, Mitchell, & Kuipers, 2010; Morriss, Faizal, Jones, Williamson, Bolton, & McCarthy, 2007). Unfortunately, little is known about how people who have just recently sought help experience the waiting time prior to treatment and what they do to help themselves while they are waiting for treatment. Consequently, we performed the present study in order to to elicit, describe, explore, and begin to understand the expectations, experiences, and coping strategies of people waiting for treatment at a CMHC. The following three research questions were developed:
1. What expectations do people have about waiting for treatment at a community mental health center?

2. How do people waiting for treatment at a community mental health center experience the waiting time?

3. What do they do to cope with their mental health problems while on a waiting list?

Method

Context, recruitment, and sample.
The study recruited participants from a typical community mental health center in Norway providing specialist mental health services to a geographic area of four communities (34,000 inhabitants) in the western part of the country. The Center has outpatient clinics, outreach services, and two inpatient units for adults in addition to child and adolescent mental health services. All participants except two were referred to the CMHC by their general practitioner. Participants received information about the project in a letter sent them while they were on the waiting list and as they were recruited by their therapist at the start of treatment. The first ten participants who agreed to participate in a semi-structured interview were interviewed. However, one participant was excluded because it turned out he had his first appointment at the center the same day he was referred, and he had no prior experience with waiting for treatment. All participants provided written informed consent to participate in the study. Approval for the study by the Regional Committee for Medical Research Ethics was applied for, but the Committee referred the study to the Norwegian Social Science Data Services, which approved of it (ref. no. 22920/2).

Participants ranged from 18 to 54 years in age (five out of the nine were younger than 30 years), four were women and five were men. One of the included participants had been admitted the same day she sought help but was interviewed about her experience of waiting for previous admittances. Mean waiting time for the remaining eight was 41 days (range 4–81 days). At the time of the interview, the number of consultations of the seven who were attending the outpatient clinic ranged from 0 to 6 (mean 3), and 29 days was the mean duration of stay at the ward for the two inpatients. Table 1 shows participants’ characteristics, such as living situation, work and education, mental health or addiction problem (based on self-reports provided in the interviews), type of service currently referred to and previous contact with specialist services.

TABLE 1: Participants’ characteristics; living- and work situation, mental health or substance abuse problem, and type of health care services. (P = participant.)
<table>
<thead>
<tr>
<th>P</th>
<th>Living situation, education, and work</th>
<th>Mental health or substance abuse problem</th>
<th>Type of service currently referred to and previous contact with specialist services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Married, part time job</td>
<td>Many years of chronic body pains, fatigue</td>
<td>First time outpatient services</td>
</tr>
<tr>
<td>2</td>
<td>Cohabiting, pregnant, almost completed college, not employed</td>
<td>Social anxiety, extensive cannabis use</td>
<td>First time ambulatory services, previous child and adolescent psychiatric services</td>
</tr>
<tr>
<td>3</td>
<td>Single, living with parents, college completed, not employed</td>
<td>Depression, anxiety</td>
<td>First time outpatient, previous child and adolescent psychiatric services</td>
</tr>
<tr>
<td>4</td>
<td>Married, children, high level of education, fulltime job</td>
<td>Bipolar type II, periods of high alcohol intake</td>
<td>First time outpatient services</td>
</tr>
<tr>
<td>5</td>
<td>Married, fulltime job</td>
<td>Depression</td>
<td>First time outpatient services</td>
</tr>
<tr>
<td>6</td>
<td>Living with mother, not employed</td>
<td>Substance and alcohol abuse, social anxiety, depression, probable attention deficit disorder</td>
<td>Contacted by ambulatory team, previous use of outpatient services</td>
</tr>
<tr>
<td>7</td>
<td>Living with parents, working full time, previously unemployed</td>
<td>Depression, anxiety, just quitted daily cannabis smoking</td>
<td>First time ambulatory services</td>
</tr>
<tr>
<td>8</td>
<td>Living alone, one child, higher level education partly completed, not employed</td>
<td>Recurrent psychoses</td>
<td>Inpatient, past hospitalizations</td>
</tr>
<tr>
<td>9</td>
<td>Living alone, not employed</td>
<td>Alcohol abuse, social anxiety, depression, socially isolated</td>
<td>Inpatient, many past hospitalizations</td>
</tr>
</tbody>
</table>

**User-involved collaborative research.**

Involving persons with service user experience in mental health research is a relatively recent inclusion, although the notion of service user involvement in the development of mental health services is well established (Borg, Karlsson, & Kim, 2009; Telford & Faulkner, 2004). Ward, Thompson, Barber, Ammitage, Boote, Cooper, and Jones (2010) suggested three reasons – moral/ethical, political, and methodological – for involving service users in research, and Moltu, Stefansen, Svisdahl, and Veseth (2013) recently demonstrated that co-researchers with experience as service users increase the quality of research by ensuring relevance and usefulness of the research (Moltu et al., 2013).

The aims of user involvement in the present study were, within a reflexive-collaborative framework, to create valid research questions, to build trust and increased accessibility to the phenomena explored, and to provide support to the
participants in terms of understanding what the study was about and the meaning of interview questions. Service users from the «expert-by-experience» panel of MoodNet, a regional research network in Western Norway (Moltu et al., 2013), took part in development of the present project. The semi-structured interview guide was developed in collaboration with and piloted in a collaborative session with the expert-by-experience panel, and a co-researcher (BS) from the expert-by-experience panel took an active part in interviews, data analysis, and dissemination of results.

**Semi-structured interviews.**
The semi-structured in-depth interviews were conducted at the CMHC and lasted approximately one hour. The participants were invited to choose alternative settings, such as their home, a café, or another public place, but all of them chose to be interviewed at the CMHC. The interview guide invited the participants to reflect on themes such as earlier and current mental health problems, experiences of help seeking, referrals and waiting time, experiences with mental health care, and what self-help the person had tried to handle mental health problems. «Can you tell me how waiting for the first appointment feels/felt?», » What do/did you do while you are/were waiting for the first appointment?», and «Does/did anything of this help?» are examples of questions asked about waiting time. In case of emotional distress after the interview the interviewer would assist the service user contact the therapist (however, none of the participants showed signs of such distress at the end of the interviews). Interviews were audiotaped and transcribed verbatim.

**Analysis.**
As the objective of the study was to explore how individuals with mental health problems experience health care, a hermeneutic-phenomenological approach was chosen (Giorgi, 2009; Laverty, 2003). Through reflexive collaboration and exchange of ideas with service users during the entire research process, we aimed to expand our understanding of the lived experience of the participants and their everyday life experiences, and to provide a context for the readers’ understanding of findings. Acknowledging that the researcher’s own involvement and pre-understandings may impact on which knowledge is produced, reflexivity was emphasized throughout the research process (Giorgi, 2009; Laverty, 2003; Moltu et al., 2013). A data-driven stepwise procedure in line with thematic analysis was used. Thematic analysis is a method for identifying, analyzing, and reporting patterns, or themes, in data (Braun & Clarke, 2006). In our study, data analysis proceeded as follows:

1. The first author read all material and defined the preliminary themes. Using N’Vivo 9.0, she then systematically coded all text material. Content from the theme «waiting time» was coded as a separate parent node with subnodes.

2. During a collaborative two-day workshop in June 2014, the text material within the theme «waiting time» was read, analyzed, and discussed by MB, BS, and EB until a common understanding about semantic and latent constructs underlying the material and consensus about final categorization of contents were reached.
Based on the categorization and common understanding reached in the workshop, the first author then prepared the results, using coded text material. To ensure validity of findings, the results were compared with the original transcripts and reviewed by BS and MB. Below, study participants are referred to as P1 … P9, and the members of the research group are referred to by their respective initials (BS, EB).

Results

The analysis resulted in the following themes regarding waiting time: «Expectations about waiting», «The experience of waiting: Shortcomings and struggles with everyday issues», and «Coping with symptoms and challenges by being active and taking control».

Expectations about waiting.
The participants revealed the following expectations with regard to waiting: Several of the participants felt that they needed treatment sooner than when they actually received it, and if free to choose, all of them would have preferred shorter waiting time. Their expectations about waiting was based on what their friends or other service users of the center had told them, the letter of information routinely sent from the center to users after they had been granted the right to receive treatment, general knowledge (for instance from media), and earlier experiences. Like this man, who found waiting hard to endure the first time he was referred to specialist mental health care, participants with previous experience with being on a waiting list seemed to have adjusted their expectations accordingly:

P4: «Back then I thought it was bad not to get in as things were really bad. I had to wait about three weeks or something like that… And when one thinks that ‘Alright, it is now this really is needed’…, then of course it was worse… So that period of waiting was much worse. This time I was prepared for it.»

None of the participants seemed to know much about the therapy they were waiting for. One participant mentioned that, at this stage, information from the center about what was going to take place at the first session of therapy would have been helpful.

The experience of waiting: Shortcomings and struggles with everyday issues.
Most of the participants found the time on the waiting list problematic and challenging, experiencing both hardships in their everyday lives and fears about the upcoming treatment. Despite expending effort in their daily activities, several participants felt exhausted much of the time and experienced frequent inadequacy, both at work and home, like this woman described:

P1: «I was working and I struggled with handling my everyday life, and after I had been [at work] a few hours I was exhausted… And then I just tried to take the dog [for a walk]… and my home, that was absolutely last on the list… There really was a lot resting upon me…»
An industrial worker who suffered from alcohol abuse, social anxiety, and depressive symptoms said this about his waiting period:

P9: «It [waiting] is only negative, because you don’t manage to get on with anything because you’re only waiting… So you don’t manage to do anything else…»

A young unemployed woman who suffered from anxiety and depressive symptoms said this about the waiting period:

P3: «I was kind of like cornered or trapped.»

Many of the participants had experienced being anxious about their first consultation while waiting. A young woman with some earlier experience with mental health services who suffered from severe anxiety in social situations described how she used to struggle with handling her anxiousness before the first treatment session:

P2: «I shut it out […]. I try not to think about it […].»

EB: «What do you do then? When you shut it out?»

P2: «I block it out. I just ignore it… I don’t want to think about it.»

BS: «So you just deal with it on the [same] day?»

P2: «Yeah, or the day before, then I get really anxious… That’s when I’ll most likely start freaking out… But now it’s much better because they come to my place, or to my mums, so I haven’t really felt it that much…»

Notably, she said that this fear had been relieved once she was offered regular home visits by the outreach team of the CMHC.

However, some participants said that despite having to struggle with their emotional problems while waiting, they also experienced a sense of relief during the period after they had been referred. For instance, a middle-aged woman saw her referral as a sign that her general practitioner believed in her and that he was willing to try a new approach to address her problems; while waiting she found it comforting that she had actually been referred to the CMHC and soon was to receive new treatment.

Coping with symptoms and challenges by being active and taking control.
The participants described how they had taken on active roles in their struggle to endure the waiting time and to recover. For instance this woman used all her strength to carry on from day to day, in the hope of getting better from her fatigue and chronic body pains:

P1: «So I guess I was more focused on how to manage to continue, to get back up on my feet again, and start a new day again…»

Despite their emotional challenges, most of them had developed strategies to maintain a certain level of activity. They struggled to be persistent in continuing everyday life tasks: Those who had a job had gone to work, full or part-time, and
several tried to keep their house and garden clean and tidy. Furthermore, regular physical exercise or going for walks in nature was emphasized as a means to alleviate tension, improve sleep, and feel better. A depressed young woman said this about what she had done to help herself while waiting:

P3: «[…] I exercised. […]»

EB: «Yes, was there anything else that helped?»

P3: «Actually, being with friends… talking to them actually…»

Several of the participants also were conscious about keeping up contact with friends and family as they felt being with others helped alleviate symptoms. Another young woman with social anxiety who had just quit education due to her mental health problems said this about what she found helpful:

P2: «Maybe I watch some TV… Maybe I see a film… Maybe I lie down and listen to some music… and sometimes (laughs) I pull out one of my schoolbooks…»

EB: «Do any of these things help?»

P2: » Music… I have always found peace in music… I make music myself…I sing, play guitar… I play most instruments… It has been something for me to fall back upon… Music and animals…»

Some of the participants who had pets found great comfort in them. For instance, the same woman stated:

P2: «…I have always really loved horses… because I’ve always felt more at ease around big animals – they don’t judge you… they don’t… don’t answer back… but at the same time… they trust you».

EB: «Can you talk about your feelings when…»

P2: «So much more than I manage to face people… Horses and dogs… they’re like…you don’t need to say anything either, for they like, they just look at you, and they kinda know…»

BS: «Yeah… Also they appreciate that you are there…»

P2: «Yeah, that you’re there…»

BS: «Imagine it was like that among us people as well…»

Although several of the participants were frustrated about having to wait for treatment and reported that they felt anxious about the first appointments, waiting time was also seen as an opportunity to prepare themselves for treatment. Examples of this included thinking about what to say in the first consultation and looking up information about their symptoms and treatment. One participant with a bipolar spectrum condition had used the waiting period to gather information about his problems, and by the time he saw his therapist, he had already diagnosed himself correctly.
Discussion

In line with findings of reduced quality of life during the waiting time (Oudhoff et al., 2004; Oudhoff et al., 2007; Sampalis et al., 2001) most participants in the present study found the waiting time to be hard and frustrating. Being put on a waiting list represented a shift for patients. Some of them started worrying about the beforestanding treatment while others felt relieved that they had been referred for therapy. The study further revealed that, while waiting, people show desperate creativity in finding ways of dealing with their emotional challenges and the impact that mental distress has on their everyday lives: Within the context of their daily life, the participants tried to keep up with routines, such as going to work and performing domestic duties, seeing family and friends, exercising, and doing other activities that helped alleviate symptoms. The participants invariably developed active coping strategies through which they effectively directed their own activities toward specific aims, such as feeling better, getting rid of inner tensions, or improving sleep. Exercising, going for walks in nature, and being with others or with animals were most often mentioned as helpful. Several participants also used the waiting time to search for help from sources other than the specialist services, for instance, from the internet and by thinking through what to say to the therapist at the first consultation. All of these activities reflect the individuals’ eagerness to understand their mental health problems and to find ways of dealing with them.

The findings reflect the central elements in recovery, namely that recovery is holistic, strength-based, focused on empowerment, and involves hope and meaning in life (Davidson, O’Connell, Tondora, Lawless, & Evans, 2005; Slade, Leamy, Bacon, Janosik, Le Bouthillier, Williams, & Bird, 2012) and that the process of recovery takes place not only in the therapist’s office but rather in the person’s ordinary life, involving an interplay of contextual factors, such as family, friends, work and other activities, and health care services (Borg & Kristiansen, 2008; Borg & Davidson, 2008; Iwasaki, Coyle, & Shank, 2010; Lal, Ungar, Leggo, Malla, Frankish, & Suto, 2013; Salzmann-Erikson, 2013; Tew, Shule, Slade, Bird, Melton, & Le Bouthillier, 2011; Topor, Borg, Mezzina, Sells, Marin, & Davidson, 2006; Topor, Borg, Di Girolamo, & Davidson, 2011). Challenging the view of many clinicians who regard waiting as a period of passivity, deterioration, and cause of learned helplessness (Brown, Parker, & Godding, 2002), the present study showed that participants worked hard in order to take control of their problems and find ways to manage their symptoms before actually starting treatment. Similar coping strategies as those reported by participants in the present study, however, have also been reported in previous studies not specifically investigating the waiting period (Deegan, 2005; Mayes, 2011; Lucock et al., 2011; Veseth, Binder, Borg, & Davidson, 2011). In the perspectives of recovery and from a prognostic point of view, these developed strategies are important as they probably affect the courses of the individual trajectories of the mental health problem over the longer term (Pavalko, Harding, & Pescosolido, 2007; Pescosolido, 2014).

Timeliness is an important factor in quality of care (Committee on Quality of Health
Care in America, 2001; Nolan, Resar, Haraden, & Griffin, 2004). According to the present study and earlier research service users regard quick access into services as significant (Redko et al., 2006). From clinical and public health perspectives, early access is important as it probably leads to better prognosis (Bird et al., 2010; Morriss et al., 2007). Consequently, it is imperative that the findings that people use the waiting time to develop strategies to deal with their problems should not be used as an argument in favor of the view that waiting per se is useful. Mental health services have employed a variety of strategies, including referring service users to self-help resources and providing brief interventions in the waiting period, in order to influence waiting times (Williams, Latta et al. 2008; Vallerand and McLennan 2013), and findings from the present study also suggest that specialist mental health centers should consider providing people on a waiting list with information about self-care and self-management strategies that they might try out while waiting.

Limitations.
The process of engaging in an on-going reflexive analysis is difficult (Finlay, 2002). Two of the researchers who planned and performed the study had professional backgrounds in mental health care, and although aware of the danger of how their preconceptions and attitudes could affect questions asked and conclusions drawn, intersubjective elements may have influenced data collection and analysis. However, the study was performed within a reflexive-collaborative framework, and active participation by the co-researcher with experience as a service user helped the researchers with professional backgrounds to better understand what participants were trying to communicate (Moltu et al., 2013). The study included nine participants. Although some might find this is a limited number, we argue that the study provides a deeper understanding of experiences by persons waiting for mental health care, and we believe the findings add to the present body of evidence despite the limited number of participants. Further, the common types of mental health problems studied and the typical setting of a CMHC support the degree of transferability of findings. The results should therefore be of relevance for psychiatrists and other health care professionals as well as for persons with mental health issues. Finally, information was partly retrospective, and we cannot exclude the presence of recall bias in the information provided.

Conclusions

The waiting period is hard to endure and accessibility to mental health specialist services in terms of waiting time should definitely be reduced. However, the study also shows that people waiting for treatment at the community mental health center act as active agents in their own lives by taking control over problems, by developing new coping strategies, and by actively using their existing daily routines and activities, such as work, sport activities, and social networks, to make themselves feel better. The findings also imply that the self-learned coping strategies used within the context of the person’s everyday life while waiting for therapy are valuable tools both for the service user and the therapist and that they may
represent important prognostic factors.

Community mental health centers could be more helpful by providing people on a waiting list with information about self-care and self-management strategies that they could try out. Further research should focus on how people work on their recovery within their everyday life, how service users and health professionals could better work together to achieve common goals, and to what extent coping strategies predict later illness courses and outcomes. On a system level, the questions of how mental health care services could better help services users cope during the period they have to wait for treatment, and how mental health care could be better organized in order to improve accessability, should be further explored.

References


Committee on Quality of Health Care in America (2001). *Crossing the quality chasm:*


Citation


Abstract

The aim of this paper is to explore how people waiting for treatment at a community specialist mental health center experience the time between referral and the first consultation. Within a collaborative-reflexive framework, nine service users were interviewed about their experiences with waiting for treatment. Three main themes were identified: «Expectations about waiting», «The experience of waiting: Shortcomings and struggles with everyday issues», and «Coping with symptoms and challenges by being active and taking control». While waiting, participants actively relied on their existing daily activities and social networks to feel better. The coping strategies they developed may be valuable tools for service users and their therapists, and the strategies may represent important prognostic factors for recovery.

**Keywords**: community mental health center, coping, expectation, experience, mental health, recovery, self-management, waiting.

**Author affiliations**: Eva Biringer – Department of Psychiatry, Helse Fonna Local Health Authority, Haugesund, Norway, & Regional Research Network on Mood Disorders (MoodNet), Bergen, Norway; Bengt Sundfør – Regional Research Network on Mood Disorders (MoodNet), Bergen, Norway; Larry Davidson – Department of Psychiatry, Yale University School of Medicine, New Haven, USA; Miriam Hartveit – Department of Psychiatry, Helse Fonna Local Health Authority, Haugesund, Norway, & Research Network on Integrated Health Care, Helse Fonna Local Health Authority, Valen, Norway; Marit Borg – Faculty of Health Sciences, Buskerud and Vestfold University College, Drammen, Norway, & Regional Research Network on Mood Disorders (MoodNet), Bergen, Norway.

**Contact information**: Eva Biringer, Helse Fonna Local Health Authority, P. O. Box...
Acknowledgement: The authors thank service users, health professionals, and leaders at the Stord Community Mental Health Center, and the expert-by-experience panel of the Regional Research Network on Mood Disorders in Western Norway (MoodNet) for their kind cooperation.

This is a peer-reviewed paper.

Eva Biringer

Eva Biringer is a senior researcher at Helse Fonna Local Health Authority, Norway.

Bengt Sundfør

Bengt Sundfør is a service user experience consultant at Regional Research Network on Mood Disorders (MoodNet) in Norway.

Larry Davidson

Larry Davidson is a professor of psychology at Yale University School of Medicine.

Miriam Hartveit

Miriam Hartveit is a doctoral student at Helse Fonna Local Health Authority, Norway.

Marit Borg

Marit Borg is a professor at the Department of Health Sciences, Buskerud and Vestfold University College, Norway.